BRISBANE SOUTH OLDER PEOPLE'S HEALTH AND WELLNESS STRATEGY 2019–2024

March 2019

Queensland Government

Metro South Health

phn BRISBANE SOUTH

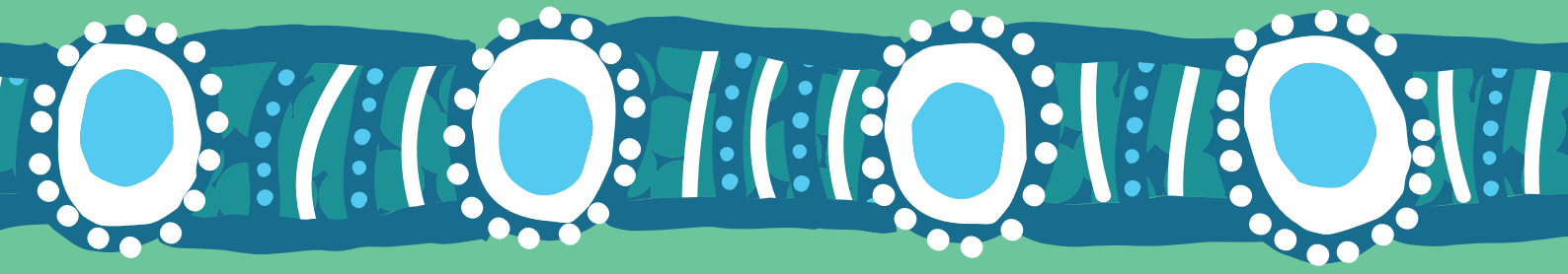
An Australian Government Initiative

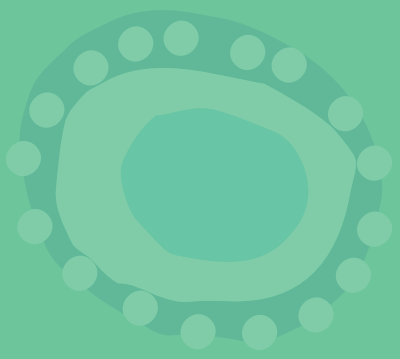
BAUGULL NYUNGAI
GURUMBA BIGI
MAROOMBA BIGGEE

We acknowledge the Traditional Custodians of the land on which we live and work, and of the many different nations across the wider Brisbane south region.

We pay our respects to the Elders, past, present and emerging, as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation. We acknowledge any Sorry Business that may be affecting the communities as a whole.

In the spirit of reconciliation, partnership and mutual respect, we will continue to work together with Aboriginal and Torres Strait Islander peoples to shape a health system which responds to the needs and aspirations of the community.





CONTENTS

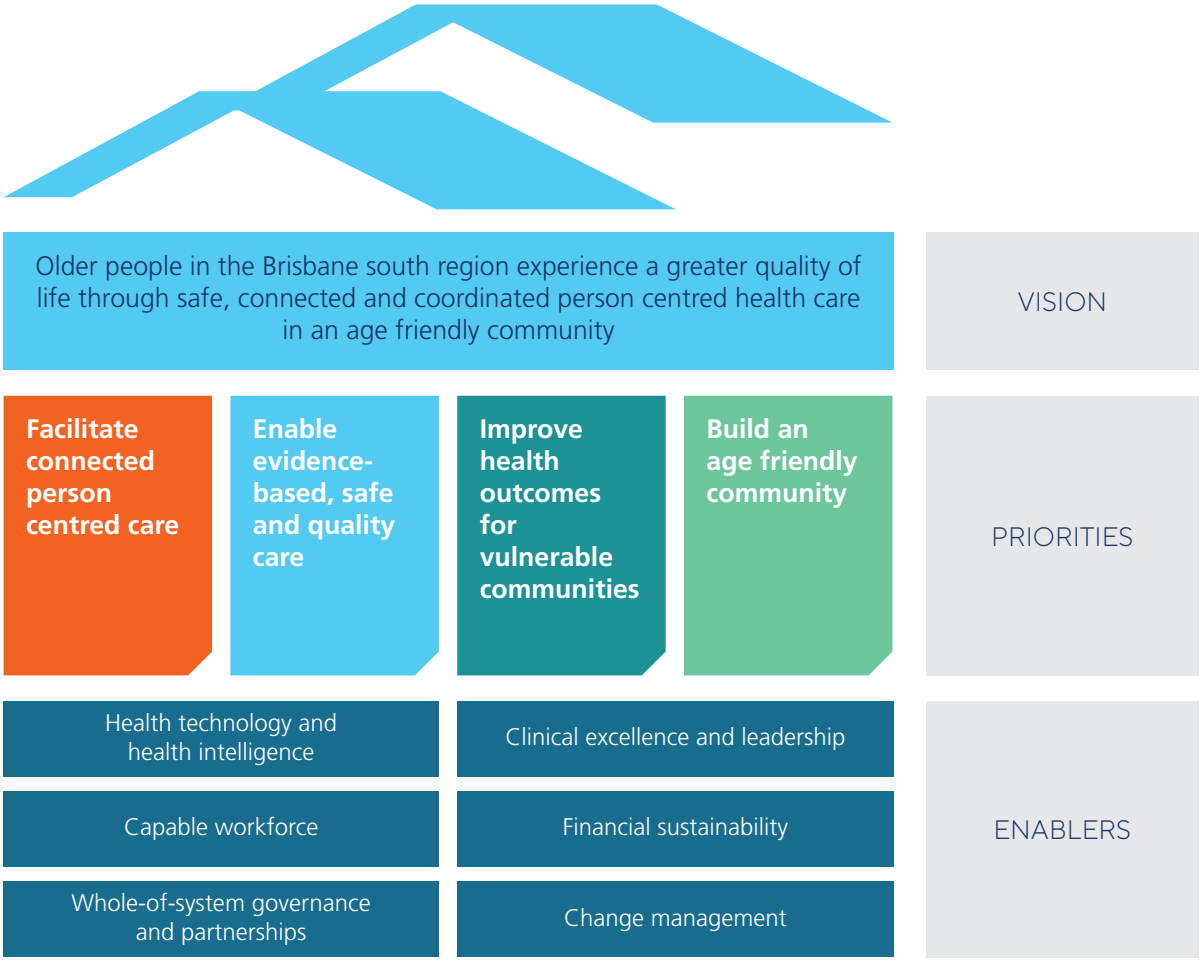
INTRODUCTION

Brisbane South PHN and Metro South Health are committed to ensuring that every person can live a long life and in good health. They have jointly developed the Brisbane South Older People's Health and Wellness Strategy 2019-2024 (The Strategy).

The Strategy strengthens the foundations that guide organisational and service development in the Brisbane south region and provides a framework for collectively responding to national and state policy and health sector reform. The Strategy defines the population health priorities, roles and responsibilities of Metro South Health, Brisbane South PHN and the partnerships with other providers and entities. This 'whole-of-system' approach will facilitate the delivery of quality older person centred services that are integrated and will support seamless transitions and continuity of care between hospital, primary health care and community settings.

The Strategy has been developed by a joint steering committee, including executives and clinical leaders from both organisations and was endorsed in December 2018 by Metro South Health and Brisbane South PHN Boards for action. The Strategy will be accompanied by a five-year Brisbane South Older People's Strategy Action Plan (to be developed early 2019) and will be delivered through the Brisbane South Older People's Health and Wellness Strategy Committee, a joint committee of Brisbane South PHN, Metro South Health and other partners. The roadmap outlined in The Strategy (page 6) provides a high-level overview of the timeline for action and indicators of success.

Figure 1: Brisbane South Older People's Health and Wellness Strategy 2019-2024



Vision, priorities and enablers

The shared 'whole-of-system' vision is **'older people in the Brisbane south region experience a greater quality of life through safe connected and coordinated person centred health care in an age friendly community'**. In order to successfully achieve this vision, four key priorities have been identified:

Figure 2: Key priorities of The Strategy

Translation of these priorities into action is underpinned by critical enablers discussed in more detail on page 10.

Broader Metro South Health and Brisbane South PHN shared vision

Together, Metro South Health and Brisbane South PHN are committed to collaboratively providing 'whole-of-system' health leadership. Our commitment to co-operative and collaborative relationships at all levels of our organisations is formalised through Metro South Health and Brisbane South PHN Partnership Protocol (2017).

Metro South Health and Brisbane South PHN both recognise that neither party on their own can achieve the 'whole-of-system' vision for older people in our region. For this vision to be successful both parties have committed to the development and maintenance of a culture of cooperation and collaboration, continuously acting in good faith, and continuing to develop mutual respect, trust and support.

Ongoing engagement with stakeholders and partners

The Strategy was jointly developed between Metro South Health and Brisbane South PHN and informed by extensive stakeholder engagement from consumers and carers; health providers; emergency services; community groups; aged care peak bodies; research institutions; local councils; state government; and advisory groups, councils and Boards of Brisbane South PHN and Metro South Health.

Brisbane South PHN and Metro South Health will continue to engage and work in partnership with key stakeholders throughout the implementation of The Strategy, recognising that we cannot achieve these goals alone.

CONTEXT AND LOCAL NEEDS

The Strategy has been informed by the Council of Australian Governments (COAG) health reform agenda; national, state and local policies; local population health needs analysis; capacity and service mapping; stakeholder engagement; and international and national literature and evidence.

COAG Health Reform Agenda

In February 2018 the COAG leaders agreed to four strategic priorities for reform in our health system: improving efficiency and ensuring financial sustainability; delivering safe, high-quality care in the right place at the right time; prioritising prevention and helping people manage their health across their lifetime; and driving best practice and performance using data and research. All leaders have committed to explore and implement options to drive down the number of avoidable hospital admissions, including through better coordinated primary care[1].

Commonwealth Aged Care Policy

The aged care policy environment has undergone significant transformation in recent years. In 2015 the Commonwealth Government implemented aged care reform and established My Aged Care. My Aged Care features a centralised contact centre to provide information and register and screen clients for home, respite or residential care. Continuing Commonwealth aged care reforms are extensive and ongoing, driven by the Tune and Carnell-Patterson reviews and the Royal Commission into Aged Care Quality and Safety[2].

Queensland Health Strategy

Queensland Health's 10-year vision is outlined in My Health, Queensland's Future: Advancing Health 2026. This plan guides investment in health over the long term and re-orients the health system to be more flexible and innovative. Its vision is to make Queenslanders amongst the healthiest people in the world by 2026. Queensland Health is currently (2018) developing an Older People's Health Strategy which aims to support healthy ageing through the delivery of better health services for older people.

Health needs of older people in Brisbane south

The Strategy was informed by a detailed current state analysis of needs and priorities informed by local population health data, a service mapping exercise, capacity and demand analysis and stakeholder consultation. Meeting the needs of Brisbane south's culturally diverse older people is a priority[3]. By 2026, 16% of people in the Brisbane south region will be over 65-years-old. Cardiovascular disease is the leading cause of illness in older people in Brisbane south, followed by cancer, and nervous system and sense organ disorders. Diabetes is a significant cause of disease for 60 to 74-year-old Indigenous Australians living in our region. Life expectancy for older people in Logan and Scenic Rim is lower compared to the rest of the Brisbane south region[4].

1 https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-9-february-2018
2 https://agedcare.health.gov.au/aged-care-reform
3 Aged Care Diversity Framework, Commonwealth Department of Health, 2017
4 Brisbane South PHN older person's health needs assessment, 2018

KEY POPULATION HEALTH STATISTICS FOR BRISBANE SOUTH

BY 2026

42% MORE PEOPLE WILL BE AGED OVER 65 YEARS

with the number of people aged over 75 increasing by 60% (relative to 2016 population levels).

13%

OF BRISBANE SOUTH RESIDENTS ARE OVER 65-YEARS-OLD

(141 633) residents are over 65 years old; the highest numbers of older adults live in Capalaba, Mt Gravatt, Cleveland-Stradbroke, Wynnum-Manly and Springwood-Kingston (2016).

29%

BORN OVERSEAS

(462 448) of people in the Brisbane local government area are born overseas, more than any other LGA in Queensland.

Health service challenges for older people in Brisbane south

The environment in which older people's health and wellness services are currently planned, designed, developed, commissioned and delivered within Brisbane south is complex. This complexity is in many ways attributed to the complicated assignment of jurisdictional responsibilities across the aged care system as described in the following contextual factors.

System fragmentation

Older people accessing health services in Brisbane south often experience a lack of integration and coordination between a range of providers such as hospital, primary health care and community services. The local system of both health and social services can be difficult to understand and navigate, particularly in stressful or difficult times. Consumers and carers require more support to better manage care in community settings, thus reducing pressure on health services. Consumers, carers and families have limited access to respite services across the region.

Complexity of older peoples' health and social support needs

Older people experience complex diseases that are dynamic in nature requiring a range of interventions and support approaches at different times through the ageing journey. A person centred model of care is required to address this interplay of social, mental health and physical health needs in the context of the person and their living well goals and aspirations. Health promotion, health literacy, health screening and early end-of-life care planning in primary care is necessary to maintain quality of life and prevent both unnecessary intervention and strain on families.

Health and aged care workforce considerations

Our health and aged care workforce capability and capacity requires further development to better align with and meet future needs. New roles and skills are necessary for the workforce to deliver more cost-effective, innovative models of care to meet future demand, along with recruitment and retention strategies to ensure a sustainable workforce.

Societal considerations

Discrimination against older people, including elder abuse, can and does occur in health services and in the community. A focus on the needs of diverse and vulnerable groups (including Aboriginal and Torres Strait Islander peoples) is required, along with a shift toward person centred re-enablement and empowerment. A greater focus on community and strengths-based approaches is also required, moving away from traditional medical and institutional models. Carers and families that provide care for older people need more support and education.

Service pressures and increasing demand for care

Our hospitals, emergency departments, rehabilitation and Residential Aged Care Facilities (RACFs) are experiencing increasing demand, financial constraints and pressure. Long stays in hospital are known to have detrimental impacts on health outcomes for older people and a greater focus on preventing admissions (where possible) in addition to getting people back to their home sooner is required. There is an opportunity to improve safety and reduce critical incidents in our hospitals which can result in preventable death and disability. The availability of residential aged care places and home care packages is less than is required. There is a shortage of health services appropriate for culturally diverse and Aboriginal and Torres Strait Islander people including residential aged care and other community and primary health care services.

The following roadmap outlines the timeline of actions in The Strategy to address these challenges and priorities.

PRIORITY 1: FACILITATE CONNECTED PERSON CENTRED CARE

GOAL: Care is accessible close to home, well-coordinated and easy to navigate. Older people and their carers and families are engaged in care decisions. Care is focused on prevention and promoting quality of life.

High impact actions aligned to our shared vision	2019	2020	2021	2022	2023
1.1 Care is coordinated and easy to navigate					
1.1.1 Pursue opportunities for the shared development and responsibility for a whole-of-region integrated assessment function (ACAT, RAS), and continue the Metro South Health plan to implement an integrated and responsive Metro South Health community-based supportive service for older people.	■				
1.1.2 Working with project 'What matters to Bill and Betty', establish a cycle of older people's journey mapping and review (across the continuum of care) for priority health conditions that includes: a) key pathways and consumer flow b) complications in accessing services such as wait times, out of pocket expenses, transport, transition between services c) reliability, efficacy, efficiency and responsiveness of services d) workforce interactions and information sharing.	■				
1.1.3 Explore innovative models of care that improve the delivery of person centred, connected care and support the sustainability of the health care system.	■	■	■	■	■
1.1.4 Engage with partners to ensure strategic alignment across existing Metro South Health Dementia, Aged Care and Rehabilitation services and End of Life health service plans.	■	■	■	■	■
1.2 Engage people and deliver care closer to home					
1.2.1 Complete planning, secure funding and implement the GEMITH (Geriatric Evaluation and Management in the Home) model.	■				
1.2.2 Increase choices for consumers as to where they die (at home, RACF, hospice, hospital).	■	■			
1.3 Prevention, promotion and quality of life					
1.3.1 Collaborate with GPs to increase the use of dementia screening and assessment tools at pivotal points in an older person's life such as the 75-years and older health assessments, especially in geographical regions with high dementia prevalence. (In collaboration with Dementia Australia and RACGP, scope the feasibility of trialling dementia screening and assessment tools in geographies where high prevalence of dementia is identified in the Brisbane south region).			■	■	■
1.3.2 Increase the capacity and capability of RACF and in home care workforces to proactively apply evidence-based deterioration assessment tools to enable timely referral to primary healthcare providers. Design and implement related care pathways and escalation processes to enable appropriate clinical support.			■	■	
1.3.3 Progress opportunities for initiating Advance Care Planning in the primary care environment. Work with GPs to embed ACP conversations during health checks such as: a) 45 to 49-year-old health assessment for people at risk of developing chronic disease b) 75-years and older health assessment c) on diagnosis of a chronic or life limiting illness d) 55-year-old health assessments for Aboriginal and Torres Strait Islanders e) for people 60-years and older who are enrolled on a GP Management Plan or Team Care Arrangement.	■	■	■	■	■

PRIORITY 2: ENABLE EVIDENCE-BASED, SAFE AND QUALITY CARE

GOAL: Care is timely, high quality and safe. Services are continuously improving informed by consumer experience, clinical leadership, research and value for money. The health workforce is well-equipped to meet local needs.

High impact actions aligned to our shared vision	2019	2020	2021	2022	2023
2.1 Evidence-based and informed care-consumers, clinicians, research					
2.1.1 Continue to support translational research, evaluation and benchmarking opportunities across priority clinical areas, such as UTIs and medication adherence. Progress opportunities in relation to dementia, delirium, falls, depression, incontinence, social isolation, and behavioural and psychological symptoms of dementia.					
2.1.2 Engage and form partnerships with industry bodies, GPs, community centres and RACFs with a view to increase influenza vaccinations for older people.					
2.1.3 Rebalance system capacity through addressing gaps in the provision of older people's services and explore better value models for outpatient dental and oral health, palliative care, dementia, mental health, re-ablement, rehabilitation.					
2.1.4 Establish a cross-sectoral older people's health and wellbeing leadership group that will action effective clinical relationships to support service innovation, continuous quality improvement, and service integration. (Membership could consist of palliative care, advance care, rehabilitation, geriatrics, community based aged care, dementia, transition care, mental health, and allied health. Invitees with subject matter expertise can be included as relevant such as GP Liaison Officers, ambulatory care and consumer flow leaders, public health, population health units, consumers and carers).					
2.1.5 Work with stakeholders and carers to strengthen community led wrap around service models for older people.					
2.1.6 Enhance family and carer education, information and support to enable informed decisions about their loved ones care needs, and their own bereavement requirements.					
2.2 Timely, high quality and safe care					
2.2.1 Develop a plan to be applied systematically, that aims to reduce hospital and aged care facility acquired injuries such as falls.					
2.2.2 Support the identification and treatment of addiction and mental illness in older people through commissioning psychological services in RACFs and encouraging standard screening upon admission.					
2.2.3 Support older people living at home through provision of value-based home care services, e.g. wound management pilot project.					
2.3 Capable, well equipped workforce					
2.3.1 Collaborate with stakeholders to co-design and enable the delivery of a workforce development strategy which focuses on: a) upskilling RACF and in home care workforce b) attracting and rewarding GPs c) improving gerontic content in clinical training pathways d) attracting skilled clinicians in geriatric medicine in both the hospital and community settings.					
2.3.2 Increase the capacity and confidence of the primary care workforce to deliver high quality primary care and end-of-life services including an increased utilisation of GP Management Plans and Team Care Arrangements for those with identified needs.					

PRIORITY 3: IMPROVE HEALTH OUTCOMES FOR VULNERABLE COMMUNITIES

GOAL: Care is equitable and responsive to population health needs. Services are socially and culturally acceptable and appropriate.

High impact actions aligned to our shared vision	2019	2020	2021	2022	2023
3.1 Equitable and responsive to population health needs					
3.1.1 Identify and implement place and evidence-based targeted strategies to reduce the number of preventable deaths for 40 to 85-year-old men.					
3.1.2 Develop a bowel cancer screening primary health and health literacy strategy focussed on increasing uptake of screening through targeting general practices in geographical areas associated with low screening rates.					
3.1.3 Increase the use of risk stratification approaches to improve the use of healthcare and social services data to identify people who would benefit from increased primary care interventions to improve health outcomes.					
3.1.4 Target primary care interventions for smoking cessation, alcohol consumption, diet and physical activity at key points across the lifespan (45-year-old health checks).					
3.2 Socially and culturally appropriate					
3.2.1 Support better access to the aged care system for vulnerable populations through commissioning service navigation or care coordination solutions.					
3.2.2 Implement targeted health literacy campaigns to improve self-management and access to preventative and early intervention health services for vulnerable groups by health condition, social/cultural group and/or geographical region.					
3.2.3 Continue implementation of the planned approach to prioritisation of SpotOnHealth HealthPathways for older people, vulnerable groups, dementia, palliative care and other high prevalence disease areas.					
3.2.4 Establish and strengthen opportunities to partner with community-based organisations that specialise in identified vulnerable subpopulations to increase access to preventative and early intervention in wellness and primary care settings.					

PRIORITY 4: BUILD AN AGE FRIENDLY COMMUNITY

GOAL: Partnerships across health and social services create supportive community environments that promote wellness and quality of life for older people, their carers and families.

High impact actions aligned to our shared vision	2019	2020	2021	2022	2023
4.1 Building partnerships and supportive communities					
4.1.1 Engage with regional partners to develop a suite of principles of practice across the whole health system based on the objectives articulated by the World Health Organisation.					
4.1.2 In collaboration with Palliative Care Queensland, explore the utility and application of compassionate communities for palliative and end-of-life consumers.					
4.1.3 Collaborate with local government to identify and promote age friendly initiatives including: a) accessible environments b) social connectedness c) preventative health and wellness activities targeting older people.					
4.1.4 Explore the availability of financial and non-financial support opportunities to progress Age Friendly Community Strategy initiatives in the Brisbane south region, including collaborating with the Department of Communities, Disability and Seniors.					
4.2 Supporting consumers, carers and families					
4.2.1 Encourage a system that provides person centred clinical, cognitive, functional, and cultural support that older people need to meet and maintain their living well aspirations.					
4.2.2 Increase carer support options including the availability of respite services, through public, private and NGO partnerships.					
4.2.3 Promote early intervention and assessment of hearing and sight impairments to alleviate risk of accidents and isolation which leads to reduction in physical and social activities.					
4.2.4 Increase awareness of early osteoporosis prevention through targeted campaigns focussed on calcium intake and weight bearing exercise and increased opportunities for osteoarthritis prevention through education on appropriate physical activities.					

STRATEGY ENABLERS

Translation of The Strategy priorities and actions into successful outcomes will need to consider and address key enablers as illustrated below:

Figure 3: Enablers underpinning The Strategy

Health technology and health intelligence

Developing a region wide health intelligence function and analytical capability will enable services to better respond to the identified needs of consumers and communities. Well managed information across the continuum of care allows services to observe and respond to trends that can be used to anticipate and inform ongoing quality improvement. Health technology solutions are required to support a patient centred approach, including real-time shared care between providers, consumers and carers working as a team. Actions set out in the Brisbane South PHN Digital Health Strategy and the Metro South Health Information Communications Technology Strategic Plan provide the foundations for better connected and integrated older people's care.

Clinical excellence, leadership and engagement

Leadership, partnership and stronger relationships between health organisations and clinicians will support the realisation of outcomes and actions outlined within The Strategy. Clinicians (including medical, nursing and allied health professionals across the continuum of consumer care) hold vital knowledge required to inform prioritisation, model of care design and performance improvement actions. This includes both clinical expertise and point of care relationships with consumers and other services involved in care. Evidence and experience demonstrate that clinical engagement is a key enabler in quality improvement that can drive better performance in health care organisations.

Capable workforce

Building the capability of clinicians and care workers to deliver evidence-based, safe and quality care for older people has been identified as one of the most significant challenges facing the health and aged care sectors. Changing models of care driven by policy reform, evidence and demand will lead to a shift in the required skills and demand on the health and clinical workforce. For example, providing more care in community settings rather than hospital settings including a move from inpatient service to provision of integrated care through community-based services will require changes to the nature and skills base of the workforce. There is a trend in the health sector towards a greater need and investment in a workforce with more generalist skills, allowing for more effective and targeted use of the skills of specialists (medical, nursing, allied health). It is likely that new roles will need to be established along with a new scope of practice and responsibilities.

Financial sustainability

The current ongoing increase in health expenditure is not sustainable. As people age, their health needs tend to become more complex with more services required to meet health needs at a higher cost to the health system. It is estimated that older Queenslanders on average have 10 years of life with significant disease burden[5]. In the Brisbane south region, hospital admissions increased per capita by 19% from 2012-2013 to 2016-2017 and are estimated to increase across the state by a further 67% over the coming decade to 2027[5].

Ensuring health services are financially sustainable in the medium to long-term requires considered action from all levels of the system[6]. Quality of life for older people is central to the vision of The Strategy, with key actions aiming to reduce the burden of disease, keeping older people well in the community for as long as possible and respecting older people's end-of-life plans. This includes actions that will reduce avoidable hospital admissions through early intervention and targeted and evidence-based initiatives that address regional population health priorities.

Whole-of-system governance and partnerships

The stakeholders involved in shaping The Strategy are committed to a whole-of-system response, working together to implement The Strategy successfully. Governance and leadership (page 13) to deliver The Strategy will enhance existing relationships across multiple sectors and organisations.

There is increasing recognition that determinants of health often lie outside the 'traditional health system' and health services alone do not determine older people's quality of life and health outcomes. To improve health outcomes for older people in Brisbane south, relationships and partnerships outside the 'traditional health system' with other agencies will be strengthened and joint initiatives explored. Strong linkages with consumers and carers, health and social services providers, RACFs and community organisations are required to build an age friendly community where high-quality principles of practice are applied wherever older people choose to access services.

Service silos often occur as a result of funding, for example, state governments fund public health and hospital services, and the Commonwealth Government funds primary care through Medicare, home care packages and RACFs. As the maturity of partnerships evolve through the implementation of The Strategy there may be opportunities for regional co-commissioning of older people's health services. Co-commissioning can connect and align health care resources of the wider health system, making care more person centred and integrated by joining up multiple funding streams.

Change management

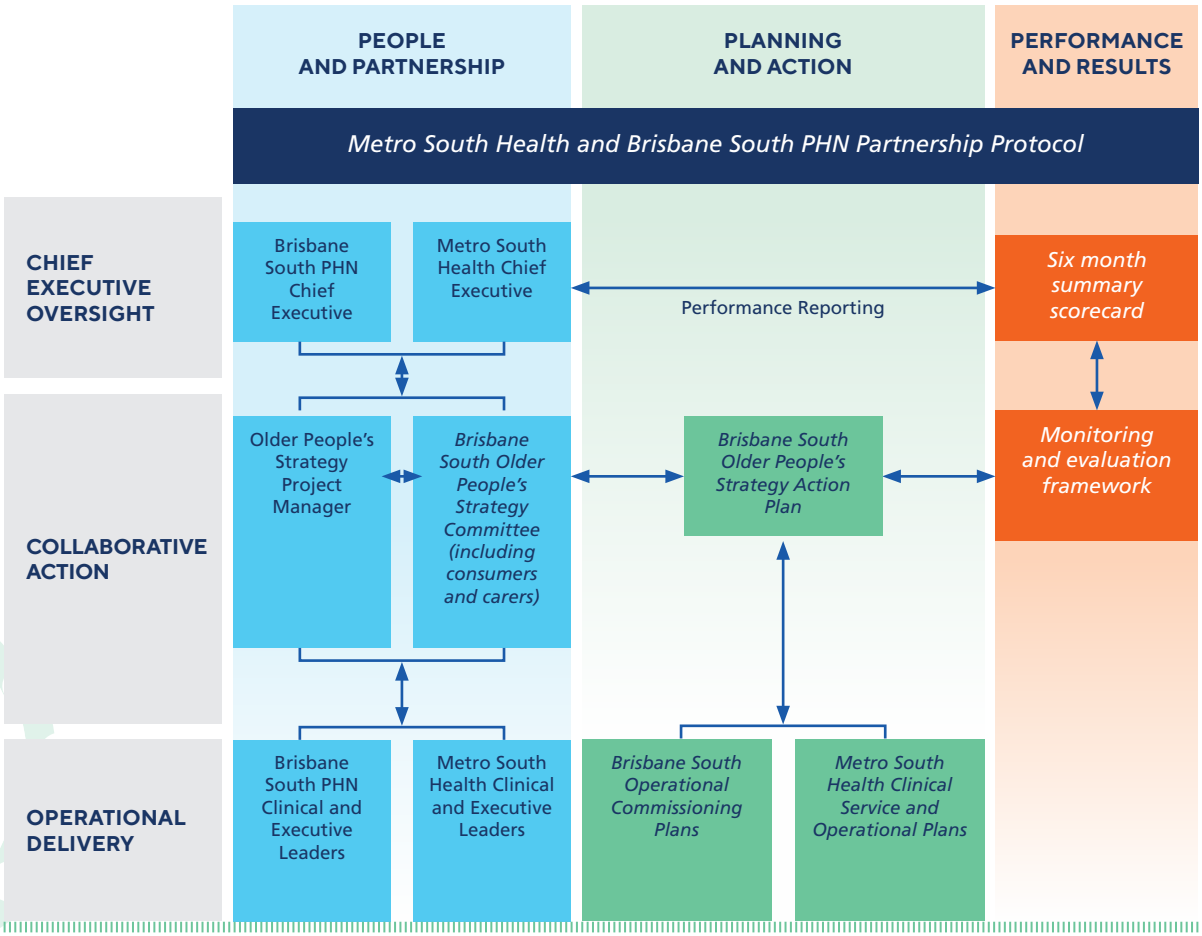
A structured and planned approach to change will be developed for the actions required to implement The Strategy ensuring engagement of all relevant stakeholders. Continual monitoring of change activities and assurance activities will help mitigate risks and reduce the potential for negative experiences for stakeholders – particularly consumers. Clinical leaders and executive leaders of Brisbane South PHN and Metro South Health will be engaged through change readiness assessments along with providers, consumers and regional stakeholders to ensure successful implementation of change.

5 Queensland Chief Health Officer Report, 2018
6 Building better foundations for primary care, Grattan Institute, 2017

GOVERNANCE, IMPLEMENTATION AND OUTCOMES EVALUATION

Governance of The Strategy will be managed within the arrangements outlined in the current Metro South Health and Brisbane South PHN Partnership Protocol.

Figure 4: Governance, implementation and reporting



Metro South Health and Brisbane South PHN Chief Executives and executive leadership teams carry a collective accountability for delivering on The Strategy's vision. Prioritising the development of operational plans, cascading from the Brisbane South Older People's Strategy Action Plan, will provide the strategic foundations to embed sound governance structures to support planning and service delivery across Brisbane south. As identified by the joint steering committee in the early development of The Strategy, one of the functions of the Brisbane South Older People's Strategy Committee will be to identify and monitor the progress of all older people related projects in the region to ensure alignment and avoid duplication.

The solutions within The Strategy are the joint responsibility of Metro South Health and Brisbane South PHN. Successful implementation of The Strategy will require engagement of clinical leaders within Metro South Health, GPs, community organisations, private sector clinicians, residential aged care providers, in home care workers, local councils, universities and peak bodies.

The roadmap within The Strategy provides an overview of the staging and sequencing of actions for each of the key priority areas. Together, Metro South Health and Brisbane South PHN will develop a Brisbane

South Older People's Strategy Action Plan identifying the linkages, dependencies and relationships with strategic enablers and other programs, in addition to performance indicators for each action.

The Strategy will be delivered through the Brisbane South Older People's Strategy Committee, a joint committee of Brisbane South PHN, Metro South Health and other partners, including consumers/carers. Resourcing to drive The Strategy implementation is the shared responsibility of Brisbane South PHN and Metro South Health with actions embedded into operational plans. This commitment also includes jointly funded project manager positions responsible for progressing key activities identified in The Strategy and providing 'backbone support' for the Brisbane South Older People's Strategy Committee. A structured project management approach will be used to coordinate and report on progress and achievement.

The Brisbane South Older People's Strategy Committee reports to the Chief Executive Officers' of Brisbane South PHN and Metro South Health on a six-monthly basis regarding the progress of the five-year Brisbane South Older People's Strategy Action Plan.

Outcomes, monitoring and evaluation

A research institution (university) evaluation partner will provide expert advice to the Brisbane South Older People's Strategy Committee. A performance framework based on the Quadruple Aim[7] will be developed to monitor the progress of activities, track expected outputs and quantify outcomes. Figure 5, on the following page, outlines the relationship between priorities, actions and outcomes.

7 Institute for Healthcare Improvement, 2017

Figure 5: Strategy Program Logic including Quadruple Aim outcomes[7 and 8]

PRIORITIES	ACTION AREAS	OUTCOMES	QUADRUPLE AIM OUTCOMES
Facilitate connected person centred care	1.1 Care is coordinated and easy to navigate 1.2 Engage people and deliver care closer to home 1.3 Prevention, promotion and quality of life	**EFFECTIVENESS OF CARE** • Services are effective and reduce the need for readmissions. • Service users make their expected and sustained recovery following treatment. • Carers are supported to provide high-quality support.	IMPROVED EXPERIENCE OF CARE • Care tailored to the needs of an individual • Coordinated and comprehensive care • Safe and effective care • Right care in the right time in the right place by the right team • Increased skills and confidence to manage one's own health
Enable evidence-based, safe and quality care	2.1 Evidence-based and informed care – consumers, clinicians, research 2.2 Timely, high quality and safe care 2.3 Capable, well equipped workforce	**QUALITY OF CARE** • People are safeguarded against potential harms. • People have access to timely and responsive services. • People who use services have a good experience of care.	IMPROVED COST EFFICIENCY AND SUSTAINABILITY • Efficiency and effectiveness of service delivery • Maximising revenue and minimising waste and duplication • Increased access to primary care • Value-based services • Performance based commissioning
Improve health outcomes for vulnerable communities	3.1 Equitable and responsive to population health needs 3.2 Socially and culturally appropriate	**POPULATION HEALTH** • People are prevented from dying prematurely. • People are able to stay well.	IMPROVED HEALTH OUTCOMES • Reduced disease burden • Improved quality of care • Increased focus on health promotion and prevention • Increased flexibility and scope for innovation • Improvement in individual behaviours and physical health
Build an age friendly community	4.1 Building partnerships and supportive communities 4.2 Supporting consumers, carers and families	**QUALITY OF LIFE** • People who use health and care services and their carers report a good quality of life. • People can remain independent and are able to manage risks associated with this. • People are able to have choice and control over their condition and the services they receive. • People can manage their condition and/or frailty to prevent complications.	IMPROVED PROVIDER EXPERIENCE • Increased clinician and staff satisfaction • Evidence of leadership and team-based approach • Quality improvement culture in practice • Practicing at peak of scope • No net loss of income

7 Institute for Healthcare Improvement, 2017
8 Mid-Nottinghamshire, Better Together Programme, Outcomes Framework Report, 2014

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