HUGHENDEN

OUTBACK TOWN, ENDLESS HORIZONS

Hughenden Place-Based Health Planning Project

Co-design activities - Part 1 Summary

Draft 23 February 2023

Introduction

The three-year Integrating Health Care Planning for Health and Prosperity in North Queensland Project (or place-based planning project) aims to improve the responsiveness of health services to the health needs of communities in the Northern Queensland region using a place-based planning approach.

It is funded by the Cooperative Research Centre for Developing Northern Australia Ltd (CRCNA), which is part of the Australian Government's Cooperative Research Centre Program (CRCP), with a financial contribution from the Tropical Australian Academic Health Centre (TAAHC), and in-kind contributions from project partners.

This project will empower local community stakeholders to participate in health care planning that aims to meet the needs of their own community. Overall, the project is expected to deliver benefits and positive impacts to individuals and communities, in terms of improved health care and wellbeing. Additionally, health services may also benefit as a direct result of the project activities through more efficient, re-designed health care delivery.

Methods

The Hughenden Community Advisory Network (CAN) is the local reference group and members will oversee and guide the project. A series of four co-design workshops is planned involving community members, service providers, managers and other key stakeholders to identify issues and explore solutions. If you are unable to attend a workshop, a one-on-one meeting can be arranged with a project team member so you can share your views.

Part 1 workshops were held on 9th and 10th November, 2022 at the Railway Social Club in Hughenden. One was held in the evening and one in the morning. To date there has been a total of 27 participants: 18 attended a workshop with a further 9 participants through interviews. Further interviews are planned with participants over the next couple of weeks.

Organisations represented included:

- Community Advisory Network
- Flinders Shire Council
- North West Community Group
- Prairie State School
- Qld Country Women's Association
- Queensland Ambulance Service
- Queensland Health – local and regional representatives
- Rural Health Management Services
- Visiting allied health services
- Yumba Co-op

Summary of Discussions

This preliminary report documents the ideas and experiences shared during community consultation undertaken in part 1 of the co-design process. Feedback is welcome on this document. Research team members are available to undertake interviews with anyone else interested in contributing to this part of the project.

What is important to the community in Hughenden (Essential basket of services / supporting principles)

- People of Hughenden community matter as much as those living in bigger cities
- Having a general sense of good well-being, feeling safe and helping each other when we can
- Access to services locally, eg. local doctor and medicines
- Access to specialists
- Access to after-hours health services
- Access to local public transport and appropriate patient transport subsidy scheme for people requiring travel to regional centres
- Services need to be flexible to adapt to changing broader community needs and flexible to patient need eg. Home visits, increasing population
- Preventive health - keeping people active and healthy affordable food options
- Ageing population needs - being able to stay in own home for as long as possible, and when it comes time to go into care this can be done in the community, not to go away to an unknown place - support for independent living, intermediate care places, high care, dementia care, palliative care and respite support for carers.
- Care is appropriate to local Aboriginal and Torres Strait Islander people, new/transient multicultural workers and visitors/tourists (incl grey nomads)
- Trust in service providers, and a shared understanding of what services are available and how they can be accessed.

Where people go for help

Established local services

- **Hughenden Multipurpose Health Service (MPS)** - acute care, aged care and palliative care beds, community services.
- **Hughenden Doctors Surgery** first point of call for primary health care needs.
- **QAS** service - one officer covering a large area.
- **Flinders Shire Council** - Community care programs and aged care accommodation.
- **Hughenden Pharmacy** - over the counter and prescription medications.

Visiting services

RFDS facilitates emergency retrievals.

Public / private visiting services including:

- Heart of Australia vehicle,
- BreastScreen,
- Physiotherapists,
- Chiropractor,
- Some public dental services (speciifc eligibility criteria),
- Optometrists
- Reproductive health
- psychologists, speech therapist, occupational therapist, physiotherapist and exercise therapist.
- BodyFix from Charters Towers. Alliance rehabilitation. North West Remote Health, AOD services from Lives Lived Well, private dental and skin checks. See services table for full list.

Virtual services accessed locally

- Telehealth has become more prevalent which fills gaps.

Access to services elsewhere

- Some residents travel for services that can't be accessed locally:

Richmond 110kms

Charters Towers 248kms

Townsville 383kms,

Longreach 327kms.

Community strengths

- ✓ **Positive lens** - the community generally sees itself as **resilient**, community is the heartbeat, family ties considered important with professional assistance available by asking the right people.
- ✓ **Supportive safe community for people living with dementia** – everyone knows everyone, people will keep an eye out for each other
- ✓ **Community champions** – formal and informal relationships support, share knowledge and help access
- ✓ **Activities that support physical wellness for children and adults** both professional and general exercise options such as the many safe walking paths, the well-lit lake paths and the newly opened 24 hour accessible community gym.
- ✓ **Numerous clubs** to cater for those who want to use them, including netball, gymnastics, rugby, tennis, swimming, and riding and others come and go depending on who has what passion while living in town. There are two pubs, and a volunteer run Railway Social Club.
- ✓ **Public transport** between towns heading east and west includes Rex Flights, train services and a fully sealed road in both directions.
- ✓ **Travel subsidies** are available if requested
- ✓ **A permanent GP** and one Resident Medical Officer – can access urgent appointments same day
- ✓ **Qualified Pharmacist/Chemist** – has local pharmacy and access to medicines
- ✓ **Community nurse is a midwife** and able to support mums and bubs
- ✓ **Support for kids** – school breakfast programs, safe community, available activities
- ✓ **Community care transport** – for aged care clients; financially disadvantaged
- ✓ **Welcoming community** – embraces new services and people
- ✓ **Flinders Shire Council** – proactive and supportive, promotes and supports development
- ✓ **Community Advisory Network (CAN)** – welcomes new service providers and links them into local network, willing to participate/support in projects and initiatives
- ✓ **Calendar of visiting services by Allied Health Assistant**
- ✓ **Allied Health Assistant able to follow-up with patients** between services visiting
- ✓ **Visiting service providers are community-minded and patient focused -** are flexible to meet patient goals, and responsive to community need

Priority population groups

Aged population	Mums and bubs / paediatrics	Emerging multicultural workers/ families	Indigenous health	Men's health esp farmers

Health concerns (current and future)

Ageing population Mobility, dementia, aging farmers, trip hazards and falls, no intermediate or high care options, palliative care. No support for aged patients trying to access aged care services, access funding or applications to nursing homes	**Chronic diseases** Arthritis, diabetes, cardiac disease, renal dialysis and managing chronic pain.	**Mums and bubs, early childhood development** Going through a baby boom. Antenatal and post-natal care requires visits to Townsville. Support to identify developmental delays early and access support services Lots of kids up to 18 years present to MPS. Kindy is at capacity.	**Mental health, stress, anxiety** 'People are tired from drought, floods, covid' Hard for people to raise issues.	**Domestic Violence** The time it takes for a scene to be attended to and lack of knowledge as to where or who to go to for help. Nearest safe house is Charters Towers.
Obesity Need good, healthy food that's affordable	**Substance abuse** There is an alcohol and drug culture Violence toward staff when presenting at MPS.	**Aboriginal and Torres Strait Islander kids** Poor nutrition, teeth neglected, scabies. No transport to access services and school.	**Disability** Growing need for NDIS services, as well as more timely assistance for people who don't come under the NDIS umbrella. Many undiagnosed.	**Dental care** Once every 6 weeks. Restrictions on access to dental care (billing). Kids have bad teeth. No access to urgent dental care.
Affordability of health care • Both parents are working to keep up with bills. Kids less guided. Less resources. Health and food expensive. Preventive health important • GP is now bulk billing only pensioners and HCC; out of pocket can be approx $60				

Barriers, gaps and limitations

Broad areas for improvement	Discussion / Examples raised in consultation
Community capacity (knowledge and skills)	▪ Health literacy ▪ IT accessibility - it is difficult for the increasing aging population who are falling behind when it comes to navigating services that require access to the internet. ▪ Telehealth suits those who are comfortable with this process but problematic for aged residents who can't see or hear well enough. ▪ Turnover of visiting services staff results in lack of trust and slow referrals. ▪ Travel to Townsville/Charters Towers disrupts homes and family routinesPeople not interested in health, it is too hard ▪ People don't understand long term ramifications of what might be minor health concerns now eg. smoking ▪ Life skills is a gap – need budgeting and household support, getting to appointments; Some Indigenous families change phones and numbers regularly when out of credit; Lots of appointment notifications are done by text; Won't answer calls if private number (think it is centrelink) and hospital is private numbers ▪ Mental health issues are hard for people to raise
Communication	▪ Awareness of services - community members don't know when, and where, to access services. ▪ Understanding services – knowledge of service/program criteria and referral processes ▪ The siloing of information between the hospital, the surgery, visiting services, community care makes timely provision of services problematic. ▪ Communication between hospitals eg. discharge planning ▪ The Flinders Post, a free local notice booklet, which used to be the go to source of information and events has changed editorial hands and doesn't seem to provide the same service as in the past.
Coordination and consistency	▪ Allied Health services can be inconsistent depending on the personnel availability – impacts trust ▪ The co-ordination and communication between services and base locations, and the general feeling is they have their own agenda that doesn't always take into account the isolation of clients, eg releasing a patient who may have to wait for public transport and many hours of travel home with little or limited support. ▪ No local coordinator to manage discharge planning advice (if received) ▪ No social worker or support for aged patients trying to access aged care services, access funding or applications to nursing homes ▪ Time of release can be problematic – patients arrive in community at late hours – no transport and access to medications ▪ Challenges with information and collaboration following client discharge from Townsville Hospital eg. patients discharged and some sent home on the bus with no coordination locally to ensure client returns home safely ▪ Coordination of specialist appointments in Townsville; often people may have appointments scheduled across multiple days/weeks resulting in a lot of travel required**Some multi-agency** meetings but care coordination could be improved eg. between primary care (GP and pharmacy), MPHS and service providers (e.g. Council – Community Care, visiting allied health)

Broad areas for improvement	Discussion / Examples raised in consultation
Cultural	▪ Limited input into service planning by Indigenous community ▪ Some feel there is a lack of connection with providers 'white coat syndrome' ▪ Regimentation at facilities causes anxiety for some clients
Accessibility and service limitations	▪ Hughenden MPS - minimal staff available for after-hours care, safety concerns; Tsv don't understand that when back up is needed it is a long way away. No local casual nurse pool. Eg. patient falls, drug affected presentations - QPS could be out of town on other jobs. ▪ QAS is staffed by one officer who is responsible for an area that ranges from Pentland to Julia Creek, 405km and The Lynd to Muttaburra, 430 km. An area of 174,150km. The solo QAS officer covers huge distance to retrieve from property accidents or heart arrests, which means the town can be without QAS cover for many hours. Results in delays. Back up provided by QFS. Local vehicle doesn't have hydraulic equipment so a lot of manual handling. ▪ GP surgery doesn't open on Saturdays and there can be up to a 3 week wait to get a non-urgent appointment with the doctor. No longer a bulk billing service which impacts adversely the 38.5 % lower income families in the shire. Some reported no issues as concession card holders are still bulk-billed. ▪ Pharmacy – not open on the weekend and Christmas break; MPS supplies pharmaceuticals when pharmacy is closed (acute only, not over the counter medications). ▪ Telehealth vs face to face. Can get Escripts but if no fax will post documents resulting in delays. Better than nothing but not good enough. ▪ Allied health services not visiting enough. Supporting exercise programs in between visits ▪ Very few allied health services offer out of hours appointments ▪ Recruitment and retention of health professionals in visiting services ▪ Limited number of Indigenous workers ▪ Limited carer support – not much respite available, carer gateway ▪ Limited dental – restricted by eligibility requirements, DBS billing practices, only visits every 4 weeks ▪ Limitations in aged care home packages ▪ HACC has poor accessibility to the hospital for after-hours care. ▪ Limited access to timely imaging – x-rays are done by local staff (operators) who have Extended rural and remote area licence – can do basic imaging ▪ Limited access to blood tests – done by nurses on weekdays, sent to QH lab ▪ Limited antenatal / postnatal care as can't have ultrasound done locally ▪ Some providers not delivering services they are funded to provide
Policies / Systems	▪ No access for all relevant local staff to ieMR for sharing or viewing records – can't access discharge summaries ▪ Can't access medical history info on people esp out of hours ▪ Discharge planning doesn't consider challenges of smaller town e.g. access to medication, how you going to get home ▪ Travel subsidies don't take into account delays in service delivery, ie having to stay an extra night or more because of delays by the service provider. ▪ Travel subsidies don't cover eyes or dental ▪ Patient travel is sometimes unreasonable considering procedures eg. No allowance to go day earlier when preparing for colonoscopy or stay day later when eyes require dilating. ▪ Appointments cancelled via text whilst driving to Townsville

Broad areas for improvement	Discussion / Examples raised in consultation
	▪ Some patients are not eligible to fly and have to take the bus, which is not appropriate for some, also have to find your own way home ▪ To be eligible for travel subsidy an appointment with the doctor is required and the referral is 'faxed' to the hospital who issue the documents, but all other arrangements have to be managed by the patient who may have limited knowledge of accommodation or access to transport to and from appointments. ▪ QAS communications - issues especially after hours when a call centre does not know where the call is coming from eg. an accident happened north of Hughenden and an ambulance was sent from Mt Isa, a minimum of 6 hours' drive away. ▪ Independent living units – bar fridges too low for some residents; only some have cooking facilities. A communal kitchen but residents aren't allowed to use it. ▪ Delays in HR paperwork results in staff not accepting positions and going elsewhere ▪ ROI – Release of Information – can allow sharing of information but is controlled and requested by the patient/consumer
Confidentiality	▪ Confidentially for clients is a constant concern – small town everyone knows everyone ▪ A perceived stigma and uncertainty re confidentially for mental health, domestic violence or substance abuse issues ▪ We tend to assume that people want information shared eg. discharge plans. Some people may choose to access care in other towns and not want information shared with local service providers, or referrals for follow-up made. ▪
Infrastructure	▪ Access to local public transport eg no taxi, uber cars, rental cars, school bus ▪ Start-up costs for health professionals and visiting services high. ▪ Location of hospital – no transport and heat so people don't go ▪ The need for refurbishment and restoration of services at the Hospital ▪ No disability access to the front door of the hospital ▪ Upgrade needed to residential care facility within the MPHS ▪ Some visiting services have no base ▪ No comfortable gathering place for Indigenous community eg. community hub
Workforce and planning	▪ Recruitment and retention across all disciplines ▪ Workforce shortages ▪ Maximising available resources between providers ▪ Shared planning and resource allocation ▪ Planning for economic growth in the Shire ▪ No social worker, podiatrist, ▪ No nurse navigators or care coordinators ▪ No nurse unit manager (to buffer between staff and DON – NUM could do more staff management and DON can do more facility management); ▪ No on-site support for Betts Street residents (was available previously) ▪ No gerontologist currently to oversee aged care plans
Service gaps identified by participants	▪ No renal chairs (staff training implications) ▪ No aged care facility for intermediate and high care – limited residential care beds (6) available at MPHS

Broad areas for improvement	Discussion / Examples raised in consultation
	▪ No emergency housing ▪ No safe house, nearest is at Charters Towers ▪ No social services –housing (centrelink office operates 4 days per week ▪ Transport – no public transport for community or service providers who fly in ▪ No broadly available family support services
Telecommunications	▪ Poor coverage by telecommunication services, limited Optus coverage and black spots for Telstra. This improving but still some concerns by out of town people. ▪ When electricity goes out, affects telecommunications which have limited backup battery storage, which in turn impacts mobile phones and personal alert alarms.
Other external issues	▪ Some govt funding for disability / home care for ramps bathroom reno's etc, but homes are older, costs higher, limited local trades people.

Ideas for making things better

- An easily accessible 'Community Champion' who is known to be helpful as a source of knowledge and assistance for various community needs and service providers.
- Improving health literacy of community, increase awareness about services
- Flexibility of service, coming to the home of the client.
- More education programs aimed at the young people and improving knowledge of 'country'.
- Need clear and transparent pathway for all patients whether it be broken legs/arms, difficult childbirth, etc for referrals back here to the community nurse, GP and hospital so if that person presents again need to know what is going on (discharge planning summaries)
- Need consistency of visiting allied health staff - trust takes a few months to build up and referrals can be slow.
- Schedules – people need reminders to attend appointments
- Better, more purposeful communication between services, family services and mental health and physical needs and services.
- Development of an intermediate and high care facility to fill the gap between independent living (Betts St units) and the hospital aged care beds (6). This may be an opportunity to advocate for a privately run facility.
- Finding opportunities to improve health literacy/education about services and self- management.
- Secure renal chairs at the hospital along with the chemo-therapy chairs.
- Timely support for people with special needs
- New providers need an entry point – should be through Community Advisory Network; also info into My Community Directory
- Telehealth could be used to mitigate travel
- Linking in to 24 hour mental health services in Townsville
- Volunteer first responders to support the QAS officer
- Support a group of local people to do mental health first aid training
- Upgrade the present X-ray machine as well as staff training to use it, eg. staff trained to use ultrasound machine for the growing number of antenatal clients
- Community garden - The patch New not-for-profit group
- Kids / Youth - Role of schools in teaching basic skills about how to do general living activities, youth group, Existing facilities/infrastructure not being used that could be repurposed to create space for kids activities. The lake is great for family activity.
- Re-purposing some of the unused spaces in the community, creating a youth centre, men's shed, women's shed, IT support, Aboriginal and Torres Strait Community Hub on country to encourage a better understanding of 'place/country', having the younger and older generations share knowledge.
- Proposed QH upgrade of hospital - 25 beds in new hospital? – original plan for about 20 for aged care, however this needs to be flexible to changing community needs eg. from high care MPS situation to servicing mother and babies.
- Repurpose old hospital for aged care or dementia – could have one wing for safety of dementia patients. some rooms for allied health services and specialists; also purpose fit spaces for dental and ophthalmologist
- Better chronic disease management, ex physio could be used more for cardiac rehab, diabetes, long term rehab. Face-to-face on the ground and zoom and telehealth can contribute.
- Health hub and all services can come together - facility that everyone comes to will improve communication, networking, coordination, provide supportive environments.
- Creating an Indigenous CAN with potential links to Richmond

- Further development of visiting services calendar to include service/program criteria and referral processes
- Clarify expectations about health provider roles and constraints
- Need a social worker or nurse navigator or coordinator to manage care coordination and support patients navigate systems
- Independent living units need full size fridges and cooking facilities or access to communal kitchen
- MPS FTE needs to be flexible to meet demand
- Business case to THHS for additional FTE for night shifts to improve safety for residents and staff
- Business case to THHS for NUM
- Opportunity to explore scope of practice of Allied Health Assistant
- Nursing staff upskill via secondments to Charters Towers and Townsville
- Could access appropriate additional services via telehealth eg. Dietician is predominantly advice
- Need family support services to help with budgeting and household support, getting to appointments
- Mental health issues – need to have people on the spot to have a conversation 'situational crisis'
- Improve care coordination by sharing of information and client consent
- More community-based health planning, place-based - looking at services, needs and providers
    - need to be careful with demand is it is sometimes misrepresented
    - identify members, strategic partners, customers, competitors

Where to from here?

If you have any further information you feel has been missed through the consultation or would like to clarify points in this summary, please contact a team member. The findings from the initial co-design activities will be explored further to provide additional details, define possible service gaps and inform planning for the second round planned being held in March 2023. Drawing on the ideas discussed through the first round, this second round will explore in more depth strategies/initiatives to improve health care and service delivery and look at identifying priority actions.

Please pass this summary on to other agencies or community members who you think would be interested in being part of the project. The project team are keen to reach as many people as possible to ensure that everyone living and / or working in Hughenden are informed about this project and involved where interested.

More info or want to be involved?

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