South Coast

10 Year Local Health Service Plan

2011 – 2020

South Coast Health Advisory Council
South Coast District Hospital
Southern Fleurieu Health Service
Country Health SA Local Health Network
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Date: 01 July 2011
We acknowledge this land as the traditional lands for the Ngarrindjeri and Kaurna people and that we respect their spiritual relationship with their country. We also acknowledge the Ngarrindjeri and Kaurna people as the custodians of the Murray/Riverlands and Adelaide Plains/Yankalilla region and that their cultural and heritage beliefs are still as important to the living Ngarrindjeri and Kaurna people today.

1. Executive Summary

Background and context

The South Coast Health Advisory Council who represent the South Coast District Hospital (SCDH) and Southern Fleurieu Health Service (Community and Allied Health service) have taken the lead and determining role in the development of the draft Local 10 Year Health service Plan, with the support of the Country Health SA Planning Projects Team. The South Coast Health Advisory Council Inc (SCHAC) has worked closely with the health service in the planning and implementation of the community engagement as well as the review of findings and development of the Plan.

A Local Liaison Planning Officer was appointed in January 2010 to work with the Executive group and the Health Advisory Council (HAC) in the planning and implementation phases of the community consultation and needs analysis processes.

From mid January 2010 the Planning Officer liaised with and provided questionnaires to a range of key stakeholders including the Health Service Executive, Patient Journey Coordinator, Medical practices and GP Network South.

Interviews were conducted with a range of key stakeholders within public and private health networks and statewide services. All information from community, staff and key stakeholder consultations was reviewed and utilised to inform the 10 Year Health Service Plan. Other information including leakage data from the South Coast catchment to metropolitan health units and outpatient clinics was obtained and analysed. The SCHAC has been briefed on all consultation outcomes during this process.

The overall vision supported within the plan is that in 10 years time (2020) 80% of the Southern Fleurieu area population have access to services that meet 80% of their health care needs within the local area.

Through this vision, priority needs identified through the needs analysis process which informed the planning process will be addressed.

Enhanced Primary Health Care

- Partnerships and collaboration across organisations such as those evidenced within the SA Inner Country Health Network will result in better health outcomes for the population.
- Increased flexible funding arrangements that support changing models of care and enable greater provision of outpatient, day patient and community based care is enabled through effective partnerships to maximise expertise and funding streams.
- Strengthened primary and community based care and transition services to and from hospital via the Better Care in the Community initiative (incorporates self managed care for chronic disease).
- Funded early intervention, illness (disease) prevention and health promotion initiatives.
- Redesigned aged care support infrastructure to support GP Plus initiatives.

“A high quality and effective acute care system depends, in part on robust primary health care, community care and post acute care services being in place” (SA Health Submission to the National Health and Hospitals Reform Commission)

Linked Public Transport System For The Southern Fleurieu

It is essential to the success of the above vision that an integrated public transport system connecting townships between Goolwa, Pt Elliot and Victor Harbor is developed.
**Increased Capacity To Care For Local Population**

Clinical Governance to support the local General Practitioners will be enhanced by the implementation of an Integrated Health Care Centre. This will enable access to both residential and visiting specialist care, recruitment and retention of a skilled health care workforce, training capacity in the areas of obstetrics, anaesthetics and procedures for local GPs. It will also provide opportunity for building links to tertiary health services and utilising e-health technology.

- Increased AND redesigned disability support.
- Increased access to timely mental health specialist care.
- Utilisation of e-health technology.

Ensure that emergency department in South Coast District Hospital is appropriate to the population health needs of the Southern Fleurieu community

**Health Promotion**

Support the provision of opportunities for exercise eg. sporting fields / clubs and healthy lifestyle support.

**Key Recommendations:**

**Providing Services Closer To Home:**

1. Liaise with Adelaide Health Service (formerly Central Northern Adelaide Health Service and Southern Adelaide Health Service) to address the leakage to metropolitan services).
   - Identify the services that are more appropriately accessed throughout the Southern Fleurieu catchment based on the changing health needs of the population in the catchment and work to repatriate services back to the local area.
   - Identify the services that will continue to be accessed in metropolitan Adelaide as Mt Barker expands its role in line with statewide plans.
   - Explore a medical link between Flinders Medical Centre Emergency Department (ED) and South Coast District Hospital ED in the first instance, building capacity for collaboration regarding more complex inpatient management in the future.

2. Implement Integrated Health Care Centres (IHCC) at Goolwa and Yankalilla. The IHCC will deliver:
   - Increased opportunities for provision of specialist services
   - Development of multidisciplinary care models
   - Enabled early intervention and prevention strategies
   - Enabled health promotion strategies
   - Increased mental health workforce
   - Integrated private and public allied health services
   - Enhanced midwifery and early childhood intervention services
   - Development of an aboriginal health strategy
   - Links to the ideal environment for medical and allied health education at undergraduate and post graduate level at the Mt Barker IHCC (GP Superclinic).

3. Link to the Orthopaedic Post Acute Rehabilitation service at Strathalbyn and District Health Service based on best practice and with metropolitan rehabilitation services as aligned with the Statewide Rehabilitation Plan.

4. Link to the Arthroplasty Clinic at Mt Barker

5. Resource surgical services at South Coast District Hospital to meet population health demand.

6. Resource the maternity services at South Coast District Hospital to meet population health demand.

7. Improve and enhance services to Aboriginal people by working with other service providers to improve accessibility

8. Recruitment and retention of a skilled workforce across disciplines and infrastructure to support best practice service delivery models to ensure future models of care are provided in a quality safety framework.
Enhanced Primary Health Care
The area health service will work closely with strategic partners including the General Practice Network South (GPNS) to enhance Primary Health Care.

1. Increase access to and services for early intervention for children and youth.
2. Develop an Early Childhood and Family Centre integrated closely with other service providers.
3. Increase hospital avoidance by greater integration with the aged care sector to ensure streamlined services, adequate provision of aged care beds, community care packages and health care services for older people at home.
4. Implement the Health Service Framework for Older People 2009 – 2016 as a priority. Establish a Level 4 Older People’s Health Services including inpatient Geriatric Evaluation and Management or ‘GEM’ units and support across the Southern Fleurieu.
5. Introduce a flexible suite of ambulatory community and hospital based services with multiple access points to be available to older people, and include day rehabilitation programs and rehabilitation in the home.
6. Consider mobile support teams for aged care and mental health needs.
7. Provide a Level 4 Palliative Care Service as described in the Palliative Care Services Plan 2009-16.
8. Source physicians for the Hills, Southern Fleurieu, and Kangaroo Island (HSFKI) cluster; to increase access to specialist care locally. There would be a combination of resident and visiting services.
9. Increase models that support changing models of care and enable greater provision of outpatient, day patient, and community based care regardless of age.
10. Ongoing cultural awareness program for all health service providers. Cultural respect will improve with the continuation of a dedicated education program for all staff and community as well as engagement and consultation with culturally and linguistically diverse (CALD) communities.
11. Ongoing engagement with the Aboriginal community and implement a local strategy for improving Aboriginal health; including breaking down service delineation barriers.
12. Implement a men’s health program.

Linked Public Transport System For The Southern Fleurieu
South Coast Health Advisory Council and Country Health SA seek a review of the current public transport system with a view to increased access to rehabilitation, outpatient departments, ambulatory centres, community and acute services across the Southern Fleurieu.

Improve access to health care by innovation in transport including a ‘bee-line’ (free scheduled transport) concept for residents over 65 years or who need public transport to access health care.

Increased Capacity To Care For Local Population
1. Implement a formal local clinical governance structure that evidences links with the statewide clinical networks.
2. Increase access to diagnostic results.

Increased And Redesigned Disability Support.

Increased Access To Timely Mental Health Specialist Care.
1. Establish, strengthen and continue collaborations that are currently happening across the Hills, Southern Fleurieu and Kangaroo Island Cluster.
2. Improve mental health services by clear links to tertiary visiting services, strong governance and implementation of a local 24/7 on call service response capability within the local service networks.
3. Work with DASSA and strengthen links with Divisions of General Practice (gPNS) general practitioners (GPs), and nurse practitioner programs. Implement training of health providers in the use of screening and brief intervention tools; training of GP prescribers; DASSA community pharmacy program links to local pharmacies; partnerships across health, alcohol, tobacco and other drugs (ATOD) and mental health services.
4. Explore local models of care to better manage people, who are affected by alcohol and other
drugs, including those experiencing co-morbidity.
5. Implement a Youth Centre.

**Utilisation Of E-Health Technology.**
1. The patient journey will be improved by the Implementation of e-health.
2. ICT capacity is built in to all capital works redesign and care modelling:
   • Access to e-health is essential to meet current and future models of care.
   • ICT connectivity at outreach centres across the Hills Area.
   • CHSA has equity of access to e-health with metropolitan health services and units within
     CHSA have equity of access.
   • Education program for all staff relative to their role to support e-health, including visiting
     GPs and specialists.

**Ensure That Emergency Department In South Coast District Hospital Is Appropriate To The**
**Population Health Needs Of The Immediate Community**
1. Build the Emergency Department capacity at South Coast District Hospital – including capital
   works to redesign the Emergency Department to meet current Australian Standards.

**Health Promotion**
1. Ensure that the community is engaged in the ongoing review and implementation of the 10
   Year Health Service Plan.
2. Improve aged care with strong health promotion programs, providing opportunity to reduce
   social isolation, and a workforce development strategy that focuses on the development of
   aged care specific or blended nurse practitioner roles.
3. Continue effective community engagement to ensure that the Southern Fleurieu community is
   health literate and supports consumer / volunteer / carer programs
4. Advocate for increase funding for the public dental service to meet population demand.

**Key components of the Plan**

Key evidence which supported the strengthening of existing services as well as the development of
new programs includes:
• The community’s right to access services close to home within available resources.
• A high degree of socioeconomic disadvantage.
• High risk factors (alcohol consumption, high blood pressure, obesity, physical inactivity and
  smoking) in comparison to the overall South Australian total.
• Higher prevalence of chronic disease (arthritis, asthma, cardiovascular disease and mental
  illness) in comparison to the overall South Australian rate.

The key outcomes of the needs analysis were:
• To sustain, maintain and develop services to meet the growth and needs of the community
  including 24/7 emergency services, acute inpatient care, elective surgery, aged care, community
  and outpatient care, palliative care, clinical support services, medical specialty
  services, mental health and Aboriginal health care.

The Plan aims to expand into areas including:
• Improve and enhance transport services to the elderly and young people to improve the
  patient journey.
• Improved partnerships between State and Commonwealth aged care services with a focus on
  maintaining people in their homes or as close to home as possible utilising hospital avoidance
  strategies.
• Ensure equity in health outcomes for health service catchment residents.
• Seamless service within and across health sectors.
• Increase and enhance respite services across the age spectrum.
• Increase early intervention strategies for children and young people – especially in regard to mental health and substance misuse.
• Improve and enhance referral system for clinicians to streamline access to health services.
• Increase and enhance consumer, carer and community participation.
• Increase early intervention focus for Aboriginal and culturally and linguistically diverse populations to reduce crisis management.
• Provision of an outreach centre for health promotion and early intervention at Goolwa.
• Improve skill of workforce in accessing resources (eg. grant applications).
• Improve and enhance the use of information and communications technologies (ICT) capabilities and e-health.
• Ensure clear and transparent clinical governance for any new models of care.
2. Catchment summary

Introduction

The South Coast Hospital is located within the Victor Harbor Local Council area and covers the Southern Fleurieu region of South Australia. The Southern Fleurieu includes townships within the Victor Harbor, Yankalilla and Alexandrina – Coastal Statistical Local Areas (SLA) including Victor Harbor to the south, Cape Jervis to the south west, Myponga and Mount Compass to the north, Finniss to the east, and Goolwa and Port Elliot to the south east (see map below). Victor Harbor is situated approximately 83 kilometres from the Royal Adelaide Hospital and 71 kilometres from the Flinders Medical Centre.


Population

The resident population for the Southern Fleurieu is 32,923 (DPLG, 2011 Population Projections). People from Aboriginal and Torres Strait Islander backgrounds comprise 1.0% of the catchment population compared with 3.1% of the total country South Australian population. Approximately 2.6% of the population speak a language other than English at home, compared with 3.9% across country South Australia.

The total population of the Southern Fleurieu catchment has increased by approximately 15% (5,000 persons) in the five year period between 2006 and 2011. When compared with the overall population structure of country South Australia, the Southern Fleurieu has a significantly lower proportion of the population under 45 years, and a significantly higher proportion of the population in the 45 and over age groups. More than one-quarter of the catchment population is over the age of 64 years. Based on Planning SA data (high stable projections), the population is expected to increase significantly to the year 2021. In particular, Victor Harbor and surrounds is a major focal point for non-metropolitan growth in South Australia. The fertility rate for the Alexandrina-Coastal SLA is higher than replacement level (2.15) and higher than the average South Australian rate (1.82). The fertility rates for Victor Harbor and Yankalilla SLAs are lower than replacement level (average 1.92) and slightly higher than the South Australian average. The standardised death rate for the catchment ranges from 5.0 – 5.7, slightly lower than the average South Australian rate (6.1).
The Southern Fleurieu area (including Victor Harbor, Goolwa and Yankalilla) attracts a large number of tourists each year. In 2007-2008 there were 125,000 visitors to these three major centres. The Schoolies Festival in Victor Harbor is classified as a major event and attracts 10,000 high school leavers during November each year.

Table 1: Southern Fleurieu population

<table>
<thead>
<tr>
<th>No.</th>
<th>%</th>
<th>Cluster* No.</th>
<th>Cluster* %</th>
<th>Country SA %</th>
<th>SA total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>32,923</td>
<td>98,235</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>16,089</td>
<td>48.9%</td>
<td>48,662</td>
<td>49.5%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Females</td>
<td>16,834</td>
<td>51.1%</td>
<td>49,573</td>
<td>50.5%</td>
<td>49.8%</td>
</tr>
<tr>
<td>0-14 years of age</td>
<td>5,105</td>
<td>15.5%</td>
<td>18,403</td>
<td>18.7%</td>
<td>20.4%</td>
</tr>
<tr>
<td>15-24 years</td>
<td>2,967</td>
<td>9.0%</td>
<td>10,908</td>
<td>11.1%</td>
<td>11.4%</td>
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<tr>
<td>25-44 years</td>
<td>6,090</td>
<td>18.5%</td>
<td>22,183</td>
<td>22.6%</td>
<td>25.1%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>9,266</td>
<td>28.1%</td>
<td>27,997</td>
<td>28.5%</td>
<td>27.3%</td>
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<tr>
<td>65-84 years</td>
<td>8,194</td>
<td>24.9%</td>
<td>16,236</td>
<td>16.5%</td>
<td>13.9%</td>
</tr>
<tr>
<td>85 years and over</td>
<td>1,301</td>
<td>4.0%</td>
<td>2,507</td>
<td>2.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>ATSI**</td>
<td>272</td>
<td>1.0%</td>
<td>681</td>
<td>0.9%</td>
<td>3.1%</td>
</tr>
<tr>
<td>CALD (Speaks a language other than English at home)**</td>
<td>707</td>
<td>2.6%</td>
<td>2,360</td>
<td>2.8%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

*Adelaide Hills, Southern Fleurieu and Kangaroo Island Cluster total

Source: Projected population by age and sex – SLAs in South Australia, 30 June 2011, Department of Planning and Local Government

**Source: 2006 ABS Census

Socioeconomic factors

On the basis of Australian Bureau of Statistics’ measures of remoteness, the Southern Fleurieu catchment has been identified as inner regional which indicates reasonable proximity to service centres including Adelaide when compared with other country locations. However lack of accessible transport options for local residents has been highlighted as a major concern in a range of recent consultations. The socioeconomic status for most of the catchment area is lower than the country South Australian average. This is also reflected in lower than State average median individual, family and household incomes. Older adults aged 65 years and over have been highlighted as a population with special needs given the high proportion of the catchment population in this age group.

Based on data which monitors the trends of diseases, health related problems, risk factors and other issues across major regional areas, the Hills Mallee Southern region demonstrates similar levels of risk factors for alcohol consumption, obesity, blood pressure, cholesterol, physical inactivity and smoking when compared with country South Australia overall. The prevalence of chronic disease for persons aged 16 years and over in the Hills Mallee Southern region demonstrates a slightly lower prevalence of diabetes and a slightly higher prevalence of existing mental illness when compared to country and total South Australia.

Alongside tourism, the Southern Fleurieu region is significant for primary industry, and diversified agriculture and viticulture. Milk, sheep, pig and poultry meat are among the highest contributors to the region's gross value of agricultural production. Many traditional beef and sheep properties have been converted to horticulture properties, while growth crops include wine grapes, olives, vegetables and berries. Retail trade, accommodation and food services to support the tourism industry accounts for approximately 22% of employment in the catchment, followed by health care and social assistance (12%); construction (11%), manufacturing (9%) and agriculture (8%).
3. Needs Analysis summary

The South Coast Hospital, in partnership with the local Health Advisory Council, undertook the needs analysis drawing on information from a range of sources including consultations with community, stakeholders and Health Service executives and staff, Health Service Profile data, and other data sources. The following provides a summary of the outcomes of the needs analysis process.

**Priority Needs**

Priority needs identified through the needs analysis process include:

- Recruitment and retention of a skilled health workforce.
- Creating effective partnerships to maximise expertise and funding streams.
- Redesigning aged care support infrastructure to support GP Plus initiatives.
- Increasing / redesigning disability support.
- Increase access to timely mental health specialist care.
- Improve ‘Better Care in the Community’ (incorporating self managed care for chronic disease).
- Improve access to health care by innovative transport services and explore a ‘bee-line’ (free scheduled transport) concept for residents over 65 years.
- Utilise e-health technology.
- Identify clear links to tertiary health services as part of an integrated health system.
- Clarify clinical governance for medical support.
- Increase and enhance support for physical activity programs.
- Improve access to health promotion for men, including the moderation of alcohol intake.
- Monitor emergency responses to ensure that they meet the demands from increases in tourism.

**Models of Care**

Current models of care that support redesign to meet demographic needs into the future include:

- Early childhood services.
- Youth services.
- Drug and alcohol services.
- Elective surgery.
- Emergency management.
- Cancer oncology / chemotherapy/ palliation.
- Palliative care.
- Rehabilitation and restorative care.
- Aged care.

**Methodology used to identify community needs**

Community consultation was fostered through a number of formal and informal stand alone and ongoing forums. The South Coast Health Advisory Council, at its AGM in March 2009, sought community feedback which identified issues relating to lack of transport and the increasing demand for health and wellbeing services for the high and increasing number of residents 65 years and over. Previous formal community engagement in service planning for the South Coast was considered including community planning, capital master planning, workforce planning and population health forums. Ongoing community engagement and collaboration will continue with existing networks including population health groups, local government, other government networks, clinicians and local GPs. Section 9.2 describes the process in further detail.
Consultation methodology

The South Coast Health Advisory Council provided questionnaires to the local community. 131 responses were received from across the age profile, particularly from those over 41 years of age. Questionnaires were provided to all staff and health service providers for South Coast District Hospital.

SCHAC members consulted various community groups to capture their priorities for the local Health Service Plan.

Key Priorities

Key priorities have been identified through the planning process and include the following:

1. Development of strategies to minimise the leakage to metropolitan services from the catchment area.
   a. Identify the services that are more appropriately accessed locally based on the changing health needs of the population in the catchment.
   b. Identify the services that are more appropriately accessed in metropolitan Adelaide.
   c. Improve partnerships between Southern Fleurieu Health Service and Flinders Medical Centre (FMC) and South Coast District Hospital Emergency Departments (in the first instance for the management of more patients).

2. Identify if the current site of South Coast District Hospital and Southern Fleurieu Health Service is the right site to redevelop to meet the future health care needs and models of care for the community. Act on the best available evidence for cost effectiveness and community health outcomes.

3. Conduct a feasibility study regarding the development of an Integrated Health Care Centre (IHCC) at Victor Harbor co-located on a Greenfield site for acute inpatient, ambulatory, community, dental, outpatient, palliative and SA Ambulance Service (SAAS) services.

4. Work in collaboration with the Hills area to develop an Orthopaedic Post Acute Rehabilitation Service at Strathalbyn and District Health Service based on best practice and with metropolitan rehabilitation services as aligned with the Statewide Rehabilitation Plan.

5. Develop a youth friendly service to improve and increase access to and services for early intervention for youth (potentially within the IHCC).

6. Develop an Early Childhood and Family Centre (potentially within the IHCC).

7. Improve and enhance services to Aboriginal people by working with other service providers to improve accessibility. Ongoing cultural awareness program for all health service providers. Implement the local Strategy for Improving Aboriginal Health in consultation with the Aboriginal community.

8. Ensure services have capacity to meet the population health demand for elective surgery in SCDH catchment.

9. Increase access to medical specialist through improved partnerships with Flinders Medical Centre.

10. Improve access to diagnostic investigations / results.

11. Improve and enhance rehabilitation services for orthopaedic post acute rehabilitation of post acute clients both locally or returned clients from metropolitan services.

12. Improve and enhance the patient journey by implementation of e-health; increased local access to specialist care; increased investment in, and greater integration with, the aged care sector; increased community packages and health care services for older people at home; improve the transport system for access to rehabilitation, outpatients, ambulatory centres and acute services.

13. Maintain appropriate resources to facilitate the delivery of dialysis services from local Renal Dialysis Unit.

14. Continue effective community engagement to ensure that the Southern Fleurieu community is health literate and engaged in the implementation of the 10 year Plan.
15. Maintain an infrastructure to support volunteer / carer programs, including the coordination of volunteer services.

16. Improve mental health services by establishing clear links to tertiary visiting services, inclusive leadership and governance and the implementation of a local 24/7 on call emergency mental health response service response. Introduce a mobile support team that meets mental health needs.

17. Work with DASSA to improve services for drug and alcohol related services including links with Mental Health Services, GP Divisions (GP Network South), GPs, and nurse practitioner programs. Implement training of health providers in the use of screening and brief intervention tools; training of GP prescribers; improve links between DASSA community pharmacy program and local pharmacies.

18. Explore the feasibility of the establishment of appropriate care for stabilisation and withdrawal at SCDH for people who are affected by substance abuse, including those experiencing comorbidity.

19. Improve aged care services by implementing the Health Service Framework for Older People 2009 – 2016 as a priority. In addition increase health promotion programs for aged care services to reduce social isolation. Development of acute assessment and management units in the country level 4 site. Introduce mobile support teams for aged care. Support the model with a workforce development strategy that focuses on the development of aged care specific or blended nurse practitioner roles.

20. Introduce a flexible suite of ambulatory community and hospital based services with multiple access points to be available to older people, and include day rehabilitation programs and rehabilitation in the home.

21. Increase hospital avoidance by increased investment in, and greater integration with, the aged care sector to ensure streamlined services, adequate provision of aged care beds, community packages and health care services for older people at home.

22. Implement the Palliative Care Services Plan 2009-16.

23. Access to a visiting respiratory physician for the Hills/Southern Fleurieu/Kangaroo Island (HSFKI) cluster.

24. Provision of flexible models of care for outpatient, day patient, and community based care for all population groups.

25. Provide resources to implement a men’s health program.


27. Development of a business case to redesign the Emergency Department (ED) building on investment from 2007 to meet current Australian Standards, and build an ambulatory care centre that facilitates outpatients, ambulatory care, chemotherapy, palliation, rehabilitation, renal dialysis.

28. Provide an appropriately resourced public dental service to meet population demand.

29. Implement a formal local clinical governance structure that evidences links with statewide clinical networks.

30. Strong partnerships between SCDH and SFHS and other service providers and agencies to ensure that services are delivered in a collaborative model reducing duplication.
4. Local implications of Statewide plans

The Strategy for Planning Country Health Services in South Australia, endorsed in December 2008, builds on the vision in South Australia’s Health Care Plan 2007-2016, South Australia’s Strategic Plan, and the SA Health Aboriginal Cultural Respect Framework and sets out how to achieve an integrated country health care system so that a greater range of services are available in the country, meaning fewer country residents will need to travel to Adelaide for health care.

The Strategy identifies the need for significant changes to achieve a sustainable health system that addresses the contemporary challenges facing the health system. The main factors contributing to an increasingly unsustainable health system include the ageing population, increasing prevalence of chronic diseases, disability and injury, poorer health of Aboriginal people and people of lower socioeconomic status, and increasing risks to society from communicable diseases, biological threats, natural disasters and climate change.

Health services located in areas in close proximity to Adelaide including Victor Harbor, Mount Barker and Gawler are subject to urban growth but have a rural mode of service delivery. These services’ catchment areas extend into designated country areas and services will be jointly planned across both country and metropolitan areas. This approach aims to support the services to expand as their rural catchment grows, with the advantages of being relatively close to metropolitan services.

A number of Statewide Clinical Service Plans have been developed or are currently under development providing specific clinical direction in the planning of services. Interpreting these plans for country South Australia and specific health units is an important element of the planning process for Country Health SA. The enabling factors which are demonstrated across the statewide clinical plans include:

- Multi-disciplinary teams across and external to the public health system.
- Patient focused care.
- Care as close to home as possible.
- Teaching and research integrated in service models.
- Integrated service model across the continuum of care.
- Streamlining access to specialist consultations.
- Increasing use of tele-medicine.
- Improving Aboriginal health services.
- Focus on safety and quality.
- Recruiting and developing a workforce to meet future service models.
- Engaging closely with consumers and community.
- Developing the infrastructure to meet future service models.
- Clinical networking and leadership.
- Connect local patients with pathways to higher level care needs.
- Reduce progression to chronic disease for at risk populations.

Strategies within the Statewide Clinical Service Plans which support the achievement of local needs have been integrated through the 10 Year Local Health Service Plans.
5. Planning Principles

The Strategy for Planning Country Health Services in South Australia set out important principles which have been used to guide the local planning which include:

1. Focusing on the needs of patients, carers and their families utilising a holistic care approach.
2. Ensuring sustainability of country health service provision.
3. Ensuring effective engagement with local communities and service providers.
4. Improving Aboriginal health status.
5. Contributing to equity in health outcomes.
6. Strengthening the IT infrastructure.
7. Providing a focus on safety and quality.
8. Recognising that each health service is part of a total health care system.
9. Maximising the best use of resources.
10. Adapting to changing needs.
Common Priorities in the Hills/Fleurieu/Kangaroo Island Cluster:

**Service Directions:**
- In 10 years 80% of the population will have access to services that meet 80% of their needs within the local area.
- Reduce admissions to metropolitan hospitals.
- Increase respite services in order to enhance independence and avoid hospital admission.
- Expand GP Plus services and new models of care.
- Improve the service capacity of local hospital Emergency Departments.
- Establish Integrated Health Care Centres (IHCC).
- Increase resources to meet local population health demand.
- Increase access to Psychiatrist services.
- Enhance access to culturally sensitive Aboriginal health services.
- Ensure alignment and links to statewide plans for Palliative Care, Rehabilitation and Older Persons.
- Expand the capacity of Early Childhood and Youth services.

**Key Enablers:**
- Establish seamless referral processes across hospital, GPs and community based services.
- Support local community health transport solutions.
### 6. Service Delivery Plan

#### Core Services to be Sustained

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Service Description</th>
<th>Target Group</th>
<th>Directions over next 10 years</th>
</tr>
</thead>
</table>
| Community Health Promotion and Prevention Programs | **Local Area**  
- Access to chronic disease self management programs, domiciliary care, Aboriginal health, community nursing and midwifery services, drug and alcohol services, community mental health (adult and child), counselling and allied health services.  
- **District**  
- Specialised chronic disease practitioners eg. diabetes educators, chemotherapy  
- Diabetes management, women’s health, Aboriginal health, early learning for families team, youth program  
- Clinics and home visiting services, primary health care focussed providing a range of community type services including immunisation and oxygen services | **Southern Fleurieu community and travelling visitors**  
- Seasonal accommodation workers |  
- Ongoing staff development in the delivery of services that respond to community demand including:  
  - Post acute management  
  - Palliative care  
  - Expansion of staffing capacity to address ageing workforce issues  
- Increase staff for early childhood area include physiotherapist, occupational therapist, speech pathologist and family worker  
- Implement a youth centre – to support large number of disengaged youth from school and other significant youth issues  
- Increase availability of drug and alcohol programs/services  
- Increase resources to meet increasing population demand for early intervention strategy implementation eg. podiatry, women’s health workers, dieticians  
- See section 6.2 |

| South Coast Carers Support Program        | **Carers in the community**  
- Ongoing and long term development of carer support model, friends of carers groups and volunteer support in the project | |  
- Continue to engage the community and key stakeholders to support carers:  
  - SA Carers Support Model  
  - HACC service agreements  
  - Positive Aging Taskforce 10 Year Plan  
  - Friends of carers support group  
- See section 6.2 |

| Community Health & GP Plus Strategies     | **Local Area**  
- Access to chronic disease self management programs, domiciliary care, Aboriginal health, community | **Southern Fleurieu community and travelling visitors** |  
- Restructure community health services to provide committed leadership for the development of CCSM approaches across the campus.  
- Increase services to meet the demographic need and the burden of |

---

1. Strategy for Planning Country Health Services in South Australia
<table>
<thead>
<tr>
<th>District</th>
<th>People with dementia</th>
<th>Allied Health</th>
<th>Emergency Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>nursing and midwifery services, drug and alcohol services, community</td>
<td>• Expansion into overnight respite and other</td>
<td>• Local access to broad range of</td>
<td>• 24 hour service 7 days a week reliant</td>
</tr>
<tr>
<td>mental health (adult and child), counselling and allied health services</td>
<td>day centre type activities to be based at the</td>
<td>allied health services (eg, physiotherapy,</td>
<td>on local GP ‘on call’ roster consistent</td>
</tr>
<tr>
<td>District</td>
<td>centre</td>
<td>occupational therapy, social work,</td>
<td>with all Local Area services</td>
</tr>
<tr>
<td>• Specialised chronic disease practitioners eg. diabetes educators,</td>
<td>• Ongoing staff specialisation in the delivery of</td>
<td>speech pathology, podiatry, dietician)</td>
<td>District services for level 1 surgery</td>
</tr>
<tr>
<td>chemotherapy</td>
<td>dementia services</td>
<td></td>
<td>including simple fracture management</td>
</tr>
<tr>
<td>• High level provision of post acute and hospital avoidance services</td>
<td>• Increased access to local geriatric assessment</td>
<td></td>
<td>and caesarean sections</td>
</tr>
<tr>
<td>• Cancer oncology services. Establishment of an Outpatient Department</td>
<td>• Increased access to local geriatric assessment and specialist services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinic with specialists who would consult and supervise the</td>
<td>• See section 6.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>administration of the more toxic drugs that are not administered at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>local level currently and support local access to chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement a designated ambulatory care centre for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Renal dialysis</td>
<td>• See section 6.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Various types of transfusions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Post acute assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Rehabilitation assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• See section 6.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Care Dementia Service</td>
<td>People with dementia</td>
<td>Services for Australian Rural and Remote Allied Health (SARRAH) identified several models in 2009. Enablers for effective coordination of care identified in the document and via the service planning process are:</td>
<td></td>
</tr>
<tr>
<td>• Day care model specifically designed to provide services to clients</td>
<td>• Expansion into overnight respite and other</td>
<td>• Information and communication</td>
<td>o Separate space for agitated patients or grieving family</td>
</tr>
<tr>
<td>with memory loss, supported by ongoing staff development</td>
<td>day centre type activities to be based at the</td>
<td>technology</td>
<td>o Adequate physical infrastructure to manage people presenting</td>
</tr>
<tr>
<td>• People with dementia</td>
<td>centre</td>
<td>o Partnerships - shared leadership of a broad range of health and human services at the local level to deliver on specified impacts and outcomes</td>
<td>o Safe workplace such as exit door if patients become agitated or violent</td>
</tr>
<tr>
<td>• Ongoing staff specialisation in the delivery of dementia services²</td>
<td>• Ongoing staff specialisation in the delivery of dementia services²</td>
<td>o Practice standards - agreed minimum standard of service coordination practice</td>
<td>o Improved office area including space for needed technology, including computers, fax, phones etc</td>
</tr>
<tr>
<td>• See section 6.2</td>
<td>• Ongoing staff specialisation in the delivery of dementia services²</td>
<td>o Support staff to input data for the ED register, collection of files from medical records or collation of notes for transfer or</td>
<td>o Support staff to input data for the ED register, collection of files from medical records or collation of notes for transfer or</td>
</tr>
</tbody>
</table>

² South Australia's Dementia Action Plan 2009-2010
³ Services for Australian Rural and Remote Allied Health (SARRAH) (2009). *Models of Primary Health Care Services: A submission to the Hon Warren Snowdon, Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery*
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| Acute Inpatient Care                         | • Medium level acute services including step down services from tertiary hospitals for local community  
• District services for surgical, birthing, chemotherapy and renal dialysis  
• South Coast local community  
• Visiting tourists  
• SA residents with holiday houses  
• Schoolies Festival  
• Increase capacity to admit and treat more complex medical conditions, hence improving the patient journey, reducing ambulance transfer costs and attracting a workforce to meet South Coast needs into the future  
• See section 6.2                                                                                                                                                                                                                      |
| Elective Surgical                            | • Local Area services  
• District services including joint replacement  
• People who require plastic reconstructive surgery or more complex skin lesion removal  
• Southern Fleurieu community  
• Identify specialists to fill gaps in the current service provision eg. plastics  
• Maintain and enhance sustainable elective surgery infrastructure and resources to meet the demand for Southern Fleurieu  
• Recruitment and retention strategies for a skilled workforce to provide the service                                                                                                                                                                                                             |
| Maternal & Birthing Services                 | **Local Area**  
• Midwifery Led Care  
  o Antenatal and postnatal care  
  o Shared Care Programs  
  o Access to community midwifery services and parenting programs  
• Pregnant women, foetus and infants  
• An increase in antenatal visits managed by midwives with a close working relationship with GPs  
• Expand on midwifery led care currently in place  
**District**  
• Low risk, single birth, theatre and staffing for caesarean sections 24 hours a day, 7 days a week  

| Medical Specialist Services                  | **Local Area**  
There are currently no resident medical specialists  
Southern Fleurieu community and travelling visitors  
• Access to visiting:  
  o Oncologist  
  o Palliative care specialist  

---

4 Strategy for Planning Country Health Services in South Australia
### Mental Health
**Local Area services**
- Primary mental health care
- Shared care management with local GP
- Local admissions for mental health
- 24 hour 7 day/week emergency mental health service by telehealth

**People of all ages and across the continuum of care who have a mental health issue or illness**
- Work towards an integrated (co-morbidity) system for the local area - develop pathways, so that "every door is the right door"<sup>5</sup>
- Implement a communication system when the model of care is clear
- Continue to provide voluntary local admissions
- See section 6.2

### Rehabilitation
**Mix of local area services and district area services**
- Inpatient immediate post operative rehabilitation for joint replacement and other orthopaedic surgery
- Transitional Care Packages
- Community and home based rehabilitation support, centre based day therapy, multi-discipline outpatient rehabilitation and aquarobics/tai chi classes

**People who have orthopaedic procedures, including arthroplasty**
- People over 65
- Work in collaboration with the Hills area to develop Orthopaedic Post Acute Rehabilitation Service at Strathalbyn and District Health Service based on best practice and with metropolitan rehabilitation services as aligned with the Statewide Rehabilitation Plan<sup>6</sup>
- Further develop services including:
  - GEM program
  - TCP type initiatives
  - Workforce development models for allied health (insert restructure)
  - Workforce training to improve capacity for the aged and frail population
  - Restructure community health services to provide committed leadership for the development of Rehabilitation services across the campus.
  - Ongoing development of the BCIC program to improve support for rehabilitation type models aimed at promoting wellness.

### Respite Services
**Access to:**
- Domiciliary Care
- Residential care
- Transitional Care Packages
- Day centre
- Volunteer programs
- Organised in home respite
- Emergency only hospital admission for respite

**Other than people with dementia all people requiring respite**
- Improved access to day centres
- Explore opportunities to increase respite options to avoid hospital admission
- Continue existing links to the community eg. respite in residential care

### Aged Care
**Aged care assessment provided by SFHS**
- Psycho-geriatric support - regional services

**Southern Fleurieu community and travelling visitors**
- Enhance falls assessment, prevention & intervention capacity by the development of exercise, strength and balance programs.
- Clarify HACC funding and services
- Further develop GEM program capacity to include culturally sensitive

---

<sup>5</sup> Stepping up Report, Social Inclusion Report

<sup>6</sup> Statewide Rehabilitation Service Plan 2009-2017
<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Ageing Program supported</td>
<td>by HACC service agreements local agreements with the Housing Trust and GPs, and the Tumake Yande 5 Year Plan</td>
</tr>
<tr>
<td>• Aboriginal Ageing Program supported by</td>
<td>services for local Aboriginal populations. See section 6.2</td>
</tr>
<tr>
<td>HACC service agreements local</td>
<td></td>
</tr>
<tr>
<td>agreements with the Housing Trust and</td>
<td></td>
</tr>
<tr>
<td>GPs, and the Tumake Yande 5 Year Plan</td>
<td></td>
</tr>
<tr>
<td>• Southern Fleurieu and Murray Mallee</td>
<td></td>
</tr>
<tr>
<td>Positive Aging Taskforce Plans</td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td>• Community and inpatient palliative care</td>
<td>Establish Ambulatory Day Centre</td>
</tr>
<tr>
<td>care service</td>
<td>See section 6.2</td>
</tr>
<tr>
<td>• Consultancy service for pain and</td>
<td></td>
</tr>
<tr>
<td>symptom management</td>
<td></td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td></td>
</tr>
<tr>
<td>• Point of care testing for INR, Troponin</td>
<td>See section 6.2</td>
</tr>
<tr>
<td>• Pathology access on site (State Pathology)</td>
<td></td>
</tr>
<tr>
<td>• and 24 hours on call</td>
<td></td>
</tr>
<tr>
<td>• Access to pharmacy services</td>
<td></td>
</tr>
<tr>
<td>• Jones &amp; Partners radiology on site</td>
<td></td>
</tr>
<tr>
<td>• Blood service</td>
<td></td>
</tr>
<tr>
<td>• Helipad</td>
<td></td>
</tr>
<tr>
<td>Oral Health</td>
<td>Advocate to increase funding to meet the population needs</td>
</tr>
<tr>
<td>• SA Dental Service on site</td>
<td>There is an urgent need for dental technician and dental services to</td>
</tr>
<tr>
<td>• Southern Fleurieu community</td>
<td>nursing homes</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td></td>
</tr>
<tr>
<td>• Renal dialysis chairs</td>
<td>Develop operational plan that contains but is not limited to:</td>
</tr>
<tr>
<td>• People who require renal dialysis</td>
<td>Quantitative and qualitative evaluation of the service 12 months after</td>
</tr>
<tr>
<td>• Southern Fleurieu community</td>
<td>full implementation to inform future service delivery (including</td>
</tr>
<tr>
<td>• Advocate to increase funding to meet the</td>
<td>community consultation)</td>
</tr>
<tr>
<td>population needs</td>
<td>Relocate the service to the Ambulatory Day Centre when available</td>
</tr>
<tr>
<td>Youth Services</td>
<td></td>
</tr>
<tr>
<td>• Range of health promotion and primary</td>
<td>Continue to work with key stakeholders eg.</td>
</tr>
<tr>
<td>health care programs</td>
<td>Whalers Housing</td>
</tr>
<tr>
<td>• Youth</td>
<td>Centrelink</td>
</tr>
<tr>
<td></td>
<td>Families SA (financial counselling/support only)</td>
</tr>
<tr>
<td></td>
<td>Drug and alcohol services</td>
</tr>
<tr>
<td></td>
<td>SAPO Drug Action Teams and Community Programs</td>
</tr>
<tr>
<td></td>
<td>Drug Diversion Program</td>
</tr>
<tr>
<td></td>
<td>Church groups who offer assistance to the whole of community including</td>
</tr>
<tr>
<td></td>
<td>young people</td>
</tr>
<tr>
<td></td>
<td>TAFE SA – IVEC and pre-employment programs as well as training programs for</td>
</tr>
<tr>
<td></td>
<td>the whole of community</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Strategies for new / expanded services

**Service objective:** Improved integration and coordination of health care across the Southern Fleurieu by increasing investment in prevention, early intervention and chronic disease management: eg. deliver the GP Plus Strategy for the Southern Fleurieu

**Target group:** Southern Fleurieu population

**Critical milestones:** Integrated Health Care Centre (IHCC) at Victor Harbor (if this is not advised following a feasibility study consider a ‘virtual’ integration of care)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
</table>
| * Increased opportunities for provision of specialist services*  
* Development of multi-disciplinary care models*  
* Enabling early intervention and prevention strategies*  
* Increasing the mental health workforce*  
* Integrating private and public allied health services*  
* Creation of an ideal environment for medical and allied health education*  
* Increased capacity to increase services at the SCDH and SFHS* | *As a priority commission a feasibility study into the development of an Integrated Health Care Centre (IHCC) including optimum business modelling at Victor Harbor engaging all stakeholders:*  
 o Local GPs and General Practice Network South  
 o Other health service providers both private and public  
 o Victor Harbor Private Hospital  
 o SAAS  
 o Local Councils  
 o Aged care sector  
 o Business entrepreneurs  
 o Complementary therapists  
 o Specialists  
 o Universities and training bodies  
 o Community | TBD  
CHSA to lead this initiative |

---

7 Strategy for Planning Country Health Services in South Australia  
8 Chronic Disease Action Plan for South Australia 2009-2018
**Service objective:** Increase community health promotion and prevention programs for early childhood and youth services

**Target group:** Children and youth

**Critical milestones:** Implement a Youth Centre and an Early Childhood and Family Centre

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
</table>
| • Increased capacity to provide early childhood / youth services  
• Increased allied health staff for early childhood / youth area  
• Youth feel welcomed into service provision  
• Youth are engaged in their own improved models of care  
• Youth are introduced to volunteer work  
• Youth are recognised and valued members of the community | • Recruitment of allied health staff and specialist nursing staff who have specific passion and expertise in the area  
• Maintain high rates of child immunisation.  
• Improve parental health literacy.  
• Implement physical activity & nutrition focused primary prevention for children & families.  
• Engage youth in finding solutions to:  
  o Youth mental health needs  
  o Disengaged youth from school / family  
  o Family stress  
  o Transport barrier  
  o Depression and anxiety  
• Identify ways to involve Aboriginal youth who do not readily identify with mainstream youth initiatives | TBD  
SFHS |

---

9 Strategy for Planning Country Health Services in South Australia

10 Primary Prevention Plan 2011-2016
**Service objective:** Increase participation in health promotion and illness prevention programs for Aboriginal and Torres Strait Island residents

**Target group:** Aboriginal and Torres Strait Islander residents

**Critical milestones:**
- Ongoing cultural awareness program for health service providers
- Ongoing engagement with the Aboriginal community

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved cultural awareness for all health service providers</td>
<td>• Improve and enhance services to Aboriginal people by working with other service providers to improve accessibility</td>
<td>TBD</td>
</tr>
<tr>
<td>Increased access to services for Aboriginal people</td>
<td>• Assist with transport for services only available in metropolitan or regional centres.</td>
<td>In place</td>
</tr>
<tr>
<td>Improved patient journey for Aboriginal people</td>
<td>• Increase the availability of comprehensive primary health care services.</td>
<td>In Place</td>
</tr>
<tr>
<td>Better care in the community and hospital avoidance for Aboriginal people</td>
<td>• Further develop GEM program capacity to include culturally sensitive services for local Aboriginal populations.</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>• Distinguish Aboriginal heritage from Torres Strait Islander heritage on health forms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health forms must be read out to all people to address literacy and numeracy skill potential deficit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Address the social determinants of health:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o SCHAC to work with the community to resource an Aboriginal community house</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o SCHAC to source a bus for Aboriginal residents attending events / funerals, medical appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o SCHAC to work with Local Council and Housing SA to address the lack of public housing for Aboriginal people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implement the SA Inner Country Health Network HSFKI Alliance, Strategy for Improving Aboriginal Health in the Southern Fleurieu</td>
<td></td>
</tr>
</tbody>
</table>

11 Strategy for Planning Country Health Services in South Australia
12 Healthy for Life Action Plan 2009/10
13 Aboriginal Health Care Plan 2010-2016
**Service objective:** Increase capacity in acute care  
**Target group:** People who require elective surgery  
**Critical milestones:** Funding to meet the population health demand for elective surgery in SCDH catchment

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved patient journey</td>
<td>Expand sustainable elective surgery infrastructure and resources to meet the demand for Southern Fleurieu</td>
<td>TBD</td>
</tr>
<tr>
<td>Services provided closer to home</td>
<td>Develop local Arthroplasty capacity in line with model developed in the Adelaide Hills.</td>
<td>SFHS</td>
</tr>
<tr>
<td>Utilisation of a current resource</td>
<td>Build community capacity to enable early discharge eg:</td>
<td>In place</td>
</tr>
<tr>
<td>Decreased burden on metropolitan public health system</td>
<td>o Community health post acute packages of care</td>
<td>Clarification</td>
</tr>
<tr>
<td></td>
<td>o Access to Orthopaedic Post Acute Rehabilitation Service at Strathalbyn</td>
<td>needed</td>
</tr>
<tr>
<td></td>
<td>o Ambulatory care capacity at SCDH</td>
<td></td>
</tr>
</tbody>
</table>

**Service objective:** Explore options to manage more complex medical conditions at SCDH  
**Target group:** People with chronic disease who require stabilisation / investigation  
**Critical milestones:**  
- Access to specialist medical oversight  
- Access to diagnostic results

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved patient journey</td>
<td>Strengthen utilisation of clinical networks</td>
<td>TBD</td>
</tr>
<tr>
<td>Services provided closer to home</td>
<td>Link to Integrated Health Care Centre</td>
<td>Essentially</td>
</tr>
<tr>
<td>Utilisation of a current resource</td>
<td>Strengthen utilisation of ICT</td>
<td>requires</td>
</tr>
<tr>
<td>Decreased burden on metropolitan public health system</td>
<td>Work with the SA Inner Country Health Network HSFKI Alliance</td>
<td>additional</td>
</tr>
<tr>
<td></td>
<td>In partnership with local GPs and other key stakeholders explore the possibility of resident medical services for the Emergency Department and oversight of more complex medical conditions for admitted patients</td>
<td>funds</td>
</tr>
<tr>
<td></td>
<td>Explore the possibility of a medical staff link between the FMC ED and SCDH ED</td>
<td></td>
</tr>
<tr>
<td></td>
<td>??registrar rotation-unlikely due to supervision requirement.</td>
<td></td>
</tr>
</tbody>
</table>
**Service objective:** Building sustainability capacity for volunteer and carer support programs

**Target group:** Members of the community who are interested and able to volunteer their time and expertise

**Critical milestones:**
- Continual community engagement
- A community that is health literate
- Infrastructure to support volunteer programs – eg. a funded volunteer coordinator position

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames +progress</th>
</tr>
</thead>
</table>
| • The current volunteer workforce will be maintained  
• Younger people/others will become engaged in volunteering  
• ‘Burn out’ due to overburdening of volunteers will be avoided  
• Critical programs will be continued eg. Southern Fleurieu Cancer Support and Resource Group | • Find new models for volunteer support as the population continues to age and people stay in the workforce longer  
• Establish dedicated resources, training and systems to better support the work of volunteers.  
• Resolve transport barrier  
• Fund a volunteer coordinator role | TBD  
No funds currently |
**Service objective:** ‘Mental Health for All’
**Target group:** All age groups

**Critical milestones:**
- Identify clear links to tertiary visiting services
- Implementation of new Mental Health Act from 1st July 2010
- Implementation of new Model of Care for Country Mental Health
- Implementation if comprehensive telehealth network across CHSA by December 2010

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames +progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Equity of access to specialist care</td>
<td>- Implement provisions of the new Mental Health Act from 1st July 2010</td>
<td>SFHS</td>
</tr>
<tr>
<td>- Equity of outcomes with metropolitan / state services</td>
<td>- Provide access at the local level to expanded and upgraded telehealth network across CHSA</td>
<td>ICNMH funds</td>
</tr>
<tr>
<td>- Contribute to reduction in suicide rate</td>
<td>- Implement comprehensive Mental Health Workforce Development Plan to meet the future workforce needs</td>
<td>SFHS</td>
</tr>
<tr>
<td>- Promotion of optimum quality of life for people with mental disorders</td>
<td>- Identify opportunities for and implement e-health</td>
<td>Community feedback requested a time frame</td>
</tr>
<tr>
<td>and / or mental health problems</td>
<td>- Work towards an integrated system for the local area – eg. develop pathways so that ‘every door is the right door’</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>- Establish access to psychiatrist across the cluster</td>
<td>ICNMH funds</td>
</tr>
<tr>
<td></td>
<td>- Implement robust Local Mental Health Service Network as per Country Mental Health Model of Care, linking with metropolitan health services</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>- Establish new service partnerships with NGOs to support intermediate care services</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>- Implement a communications system when the model of care is established</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>- Ensure consumer, carer and community participation</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>- Aboriginal Mental Health:</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>o Build on the Aboriginal mental health team from Rural and Remote Mental Health Service – Aboriginal psychiatry and Aboriginal mental health consultant and workers</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>o Build the Aboriginal mental health workforce within local teams</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>o Build on the cultural safety knowledge base within mental health system</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>o Work closely with Aboriginal health within CHSA and Aboriginal controlled enterprises</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>o Transition from crisis management to early intervention</td>
<td>SFHS</td>
</tr>
</tbody>
</table>

14 South Australia’s Mental Health and Wellbeing Policy
**Service objective:** Mental health emergency response

**Target group:** All people who are having an acute mental health episode and present to the Emergency Department or their local GP

**Critical milestones:** Emergency care – provided in conjunction with the Rural and Remote Mental Health Emergency Triage and Liaison Service for 24/7 support and over time to implement a local 24/7 on call service response capability within the local service networks

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Services consistent with CHSA Mental Health Model of Care based on:</td>
<td>- Work with Inner Country Mental Health Team to implement a streamlined response to acute mental health need</td>
<td>TBD</td>
</tr>
<tr>
<td>o Recognition of the need to reform the health care system</td>
<td>- Engage youth in planning to ensure that the service is accessible and acceptable to youth</td>
<td>CHSA</td>
</tr>
<tr>
<td>o The concepts of ‘right care, right time, right place, right person/team’</td>
<td>- Explore the opportunity for a mental health nurse practitioner role</td>
<td>Plans being discussed May 2011</td>
</tr>
<tr>
<td>o An understanding of the importance of patient journey principles in health care design</td>
<td>- Redesign the Emergency Department at SCDH to provide a safe environment for clients and staff using available funding</td>
<td></td>
</tr>
</tbody>
</table>
**Service objective:** Working in partnership with DASSA to improve health outcomes for adults and young people with alcohol, tobacco, drugs (ATOD), mental health and associated co-morbidities\(^{15}\)

**Target group:** All people with ATOD and mental health issues / co-morbidities, particularly focused on youth

**Critical milestones:**
- DASSA links with GP Divisions (GP Network South), GPs, and nurse practitioner programs
- Training of health providers in the use of screening and brief intervention tools
- Training of GP prescribers will be minimal – will mainly take the form of guidelines issued by Drugs of Dependence Unit
- DASSA Community Pharmacy Program links to local pharmacies
- Partnerships across health, ATOD and mental health services

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
</table>
| - Clinical policies and procedures and services for the assessment, management and treatment of clients presenting with ATOD issues and co-morbidity which relates to the CHSA – Mental Health Model of Care and the CAMHS Model of Care  
  - Provision of education and support for translation of upskilling around ATOD and mental health and co-morbidity into practice for hospital, community health services and NGO employees  
  - Provision of support for hospital clinicians for the management of people admitted to hospital for ATOD, mental health and co-morbid conditions  
  - Utilisation/liaison with nurse practitioner and/or clinicians with Graduate Diploma in Addictions and Mental Health or other relevant qualifications, in the planning, support, educative, assessment, treatment and management roles  
  - Capacity in the early identification and treatment intervention of ATOD and mental health problems among primary health care services | - Sustainable care for young people as per adult mental health services model of care. This may include the establishment of appropriate care for the stabilisation and detoxification of people, including those experiencing co-morbidity at the main cluster Hospital  
  - Good linkages across hospital and community based specialist services for seamless referral, community and hospital based care and follow-up  
  - Provision of ongoing in-service education for all clinical employees  
  - Capacity building in primary health care services is required to maximise the early identification and treatment intervention of ATOD problems through the delivery of training and support programs to primary health service providers in the use of alcohol, tobacco and other drug screening tools and associated brief interventions (eg, the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)) | TBD  
  Use of RIBS for counselling by DASSA worker |

\(^{15}\) Stepping up Report, Social Inclusion Report
**Service objective:** Aged Care: Health promotion programs

**Target group:** Residents over 65 years

**Critical milestones:**
- Resourcing for programs
- Opportunity to reduce social isolation
- Development of acute assessment and management units in country level 4 site
- Workforce development strategy that focuses on the development of aged care specific or blended nurse practitioner roles

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimum bone density, strength, agility, medication management, oral health and mental stimulation for older residents in the Southern Fleurieu area</td>
<td>Commence succession planning for Aboriginal Elders who currently participate in strategic planning for the community</td>
<td>SFHS</td>
</tr>
<tr>
<td>Opportunity to remain in own home for longer periods of time, and the option of aging in place</td>
<td>Redesign care to meet the outcomes as specified in the Health Service Framework for Older People 2009-16</td>
<td>Railway Cottage service currently provides to the limit of its funds.</td>
</tr>
<tr>
<td>Reduced negative impact due to social isolation</td>
<td>Increase opportunity for socialisation, physical and mental stimulation</td>
<td></td>
</tr>
<tr>
<td>Outcomes of the Framework for Older People 2009-16 will become a reality when:</td>
<td>Contribute to the development of solutions to the transport barrier</td>
<td></td>
</tr>
<tr>
<td>- Older people have healthy lives at home</td>
<td>Plan for increased services to meet dementia needs</td>
<td></td>
</tr>
<tr>
<td>- Older people experience wellness, functional independence and enhanced resilience</td>
<td>Restructure community health services to provide committed leadership for the development of CCSM approaches across the campus.</td>
<td></td>
</tr>
<tr>
<td>- Access to ‘right service, right time, right place and right team’</td>
<td>Restructure community health services to provide committed leadership for the development of Rehabilitation services across the campus.</td>
<td></td>
</tr>
<tr>
<td>- Quality care at end of life with dignity and respect</td>
<td>Improving strength &amp; balance &amp; preventing falls.</td>
<td></td>
</tr>
<tr>
<td>- Promote independence &amp; social connectedness.</td>
<td>Promote independence &amp; social connectedness.</td>
<td></td>
</tr>
<tr>
<td>- Establish programs to promote the health &amp; wellbeing of carers.</td>
<td>Establish programs to promote the health &amp; wellbeing of carers.</td>
<td></td>
</tr>
<tr>
<td>- Promote healthy ageing through physical activity, improving nutrition (including under-nutrition).</td>
<td>Promote healthy ageing through physical activity, improving nutrition (including under-nutrition).</td>
<td></td>
</tr>
</tbody>
</table>

---

16 Health Services Framework for Older People 2009-2016  
17 Primary Prevention Plan 2011-2016
**Service objective:** Aged Care Hospital Avoidance / Better Care in the Community

**Target group:** Residents over 65 years

**Critical milestones:**
- Increased investment in, and greater integration with the aged care sector to ensure streamlined services, adequate provision of aged care beds, community packages and health care services for older people at home
- Increased flexible funding arrangements that support changing models of care and enable greater provision of outpatient, day patient, and community based care
- Arrangements that will help address country service access issues

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who are over 65 who reside in nursing homes or their own home who have an acute illness are supported in the most appropriate location for care</td>
<td>Strengthen primary and community based care and transition services to and from hospital</td>
<td>TBD</td>
</tr>
<tr>
<td>People who are over 65 and have a chronic illness are managed as much as possible in their residential care facility or their own home</td>
<td>Strategies to support residential aged care facilities to ensure access to primary health care on site and support ‘dying in place’</td>
<td>Palliative care SCDH team will support Homes.</td>
</tr>
<tr>
<td>Increased access to ambulatory care for oncology, chemotherapy, rehabilitation and post acute follow up</td>
<td>Redesign services at SCDH to facilitate ambulatory care</td>
<td>SFHS</td>
</tr>
<tr>
<td>Improved patient journey, better health outcomes and a reduced cost to the health care system</td>
<td>Ongoing engagement with the recipients of care, support groups, local GPs and key stakeholders</td>
<td></td>
</tr>
<tr>
<td>Early discharge and hospital avoidance achieved</td>
<td>A partnership model with government agencies to address mental health needs for older people including working with the non-government sector</td>
<td></td>
</tr>
<tr>
<td>Avoidance of Emergency Department presentation achieved</td>
<td>Research successful models nationally and internationally</td>
<td></td>
</tr>
<tr>
<td>Establish Level 4 Older People’s Health Services</td>
<td>Establish Geriatric Evaluation and Management (GEM) team to promote a strong focus on minimising loss of function, independence and confidence through multi-disciplinary input, timely access to neuropsychological assessment, diagnostic and imaging services and co-ordinated care</td>
<td>SFHS</td>
</tr>
<tr>
<td></td>
<td>Build strong links with mental health services, palliative care services, rehabilitation services, cancer care and stroke care</td>
<td>Links already in place</td>
</tr>
<tr>
<td></td>
<td>Explore advanced practice nurses and aged care nurse practitioner roles, working in collaboration with gerontologists</td>
<td>TCP residential be in place SCDH</td>
</tr>
<tr>
<td></td>
<td>Facilitate the progress of older people through the right care pathways in a timely manner and enable better clinical outcomes, reduced functional decline and improved efficiency of inpatient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement specialist programs to help staff understand the special needs of older people who become ill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen community based, specialist advice and support, ambulatory and home based, transition care and care awaiting placement</td>
<td></td>
</tr>
</tbody>
</table>

---

18 Chronic Disease Action Plan for South Australia 2009-2018
### Service objective: Men’s health
**Target group:** Young and adult men  
**Critical milestones:** Resources to implement a men’s health program

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduction in chronic medical condition due to alcohol intake</td>
<td>• <strong>Develop capacity to respond to the health needs of men.</strong></td>
<td>SFHS</td>
</tr>
<tr>
<td>• Reduction in violence</td>
<td>• Implement Programs:</td>
<td></td>
</tr>
<tr>
<td>• Reduction in motor traffic accidents</td>
<td>o Alcohol awareness, impact on health and social structure</td>
<td></td>
</tr>
<tr>
<td>• Increased health and wellbeing for youth and men</td>
<td>o Domestic violence awareness, link to alcohol and impact on social structure</td>
<td></td>
</tr>
<tr>
<td>• Increased health and wellbeing for women and children</td>
<td>o Men’s health awareness</td>
<td></td>
</tr>
</tbody>
</table>

### Service objective: GP Plus strategies
**Target group:** Residents over 45 years  
**Critical milestones:** Introduce a multi-disciplinary, multi-agency Better Care in the Community Committee / Working Party

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People with chronic illness better managed in the community, reducing the need for hospital admission and improving the patient journey</td>
<td>• Restructure community health services to provide committed leadership for the development of Rehabilitation services across the campus.</td>
<td>TBD</td>
</tr>
<tr>
<td>• Reduced presentation to the local and metropolitan hospital Emergency Departments</td>
<td>• Ongoing development of the BCIC program to improve support for rehabilitation type models aimed at promoting wellness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chronic disease self management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Build collaborative working systems with acute care, community care and local GPs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increased access to specialist counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Source a visiting respiratory physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increased flexible funding arrangements that support changing models of care and enable greater provision of outpatient, day patient, and community based care including arrangements that will help address country service access issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengthen primary and community based care and transition services to and from hospital</td>
<td></td>
</tr>
</tbody>
</table>

19 Strategy for Planning Country Health Services in South Australia  
20 Chronic Disease Action Plan for South Australia 2009-2018
**Service objective:** Implement a Level 4 Palliative Care Service

**Target group:** All people in need of palliation

**Critical milestones:**
- Formal links with Level 6 palliative care at RGH / other cluster resources
- Recurrent funding to implement the service

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames + progress</th>
</tr>
</thead>
</table>
| Palliative care needs met for the southern Fleurieu population | Implement programs for:
  - Multi-disciplinary teams
  - Specialist nurse input
  - Specialist GP input
  - Recruitment and retention of a skilled workforce
  - Formal links with Level 6 Palliative Care at RGH
  - Access to chemotherapy and ambulatory care at SCDH | Work within the timeframes as set out in the Palliative Care Services Plan 2009-2016. Chemotherapy chairs to be placed at SCDH when funds available—plans currently being discussed. |
| Improved patient journey | | |
| Opportunity to die with dignity and as pain free as possible in choice of place eg. home, hospice, residential care, hospital | | |
**Service objective:** Clinical support services  
**Target group:** Acute, ambulatory and community care recipients  
**Critical milestones:** Access to e-health

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames +progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved coordination of care</td>
<td>• Purchase ultrasound equipment for maternity service – for use by midwives</td>
<td>To be funded</td>
</tr>
<tr>
<td>• Improved patient journey</td>
<td>• Increase out of hours access to x-ray and higher radiology services</td>
<td>Some out of hours</td>
</tr>
<tr>
<td>• Better Care in the Community</td>
<td>• Identify opportunities for and implement e-health:</td>
<td>radiology available</td>
</tr>
<tr>
<td>• Increased quality and safety for the services provided</td>
<td>o Telehealth consultations/assessment</td>
<td>on w/ends</td>
</tr>
<tr>
<td></td>
<td>o Good e-clinical records management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Integration of services via shared medical records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Electronic decision support (ie high level electronics tools for decision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>making for risk assessment and early intervention)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Electronic referral tools that embed the assessment tools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shared/integrated separation summaries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Enhanced point of care testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.of.care testing in place.</td>
</tr>
</tbody>
</table>
### 7. Key Requirements for Supporting Services

**Safety & Quality**

#### Objective:
Maintenance and ongoing improvement of the quality and safety of health services within the available resources. 

#### Critical milestones:
Australian Council on Healthcare Standards (ACHS) and other accreditation maintained by all sites.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| - Quality, risk and safety (QRS) systems across all Southern Fleurieu sites resulting in improved outcomes for health care consumers  
- Quality, risk and safety systems across all Southern Fleurieu sites resulting in a physically and professionally safe working environment for staff | - Development of a cluster-wide QRS Unit; QRS Management Committee  
- Development of a cluster-wide clinical governance framework  
- Local quality and safety committees  
- Implementation of the new CHSA OHSW&IM Manual  
- Use of clinical practice guidelines and standards  
- Participate in local and state clinical networks  
- Injury prevention and injury management - staff  
- OH&S/patient safety programs and initiatives – eg. Red Dot and Green Box (falls prevention) programs; ‘Greensleeve’ program (Respecting Patient Choices)  
- Advanced Incident Management Systems (AIMS) reporting and follow-up  
- Southern Fleurieu consumer feedback policy and procedures  
- Australian Council on Healthcare Standards (ACHS), Aged Care Standards, HACC and other relevant accreditation processes  
- Partnership plans with Workcover | - Ongoing development of a cluster-wide quality, safety and risk management system that ensures compliance with legislation, codes of practice and accreditation standards  
- Promote a safety culture  
- Ongoing development of the cluster-wide clinical governance framework  
- Continue patient safety programs and initiatives  
- Ongoing contribution and participation in the country-wide accreditation and policy framework |
| - Data collection and analysis to support planning and development to meet community need | - Implementation of shared drive (ICT) across the cluster  
- Using Client Management Engine (CME) and other prescribed data collection and management programs | - Country roll-out of CareConnect electronic health record project and other ICT initiatives  
- Improved data collection and analysis using the systems available to improve safety and quality  
- Improved utilisation of data and information collected to inform best practice |
Patient Journey

**Objective 1:** Access to health services as close to home as possible; where this isn’t possible or practicable, access to affordable, flexible and responsive transport options

**Objective 2:** Improved pre-admission and discharge planning; improved care coordination and case management

**Critical milestones:** Community communication strategy launched/implemented

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Southern Fleurieu residents are able to access safe, culturally sensitive and quality health services as close to home as possible | • Community cars and volunteer drivers  
• Access to public transport with various subsidies available  
• SA Ambulance Service for local emergency response and retrieval  
• HealthDirect  
• HealthLink (referral service)  
• Midwifery Led Care  
• Visiting specialists  
• Community services | • Consider access options as an integral part of planning any service or activity  
• Increase the use of telehealth/telemedicine and point-of-care testing to avoid unnecessary patient journeys  
• Increase community uptake of HealthDirect  
• Improve information to community, GPs and other service providers about services available locally or within the region  
• Encourage GPs to refer to visiting specialists – locally and within cluster  
• Working with other service providers (eg. SAAS, RFDS) to maximise available services  
• Implementation Level 4 Palliative Care Service, Level 4 Aged Care Service and strengthen links to the Mt Barker Integrated Health Care Centre |
| • Responsive, flexible and affordable transport options are available | • Southern Fleurieu Community Passenger Transport  
• SAAS and Royal Flying Doctor Service (RFDS) for metropolitan emergency response and retrieval  
• Discharge planning – local hospital/health service; rural liaison nurses at metropolitan hospitals | • Improved communication and coordination between service providers for better pre-admission and discharge planning  
• Ongoing review of transport options to meet changing community needs |
**Objective:** Provide culturally sensitive services for Aboriginal people that meet their health and wellbeing needs – either through mainstream or Aboriginal Health Services  
**Critical milestones:** Ongoing community engagement by HACs; annual mandatory cultural awareness training

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Health services provided for Aboriginal people in a culturally sensitive and respectful way | • Implementation of culturally respectful policies and procedures; position descriptions; contract terms and conditions  
• Provision of a range of culturally sensitive primary health care services  
• Aboriginal Workforce Plan - employment opportunities provided for Aboriginal people – eg. nursing cadetships  
• Staff orientation program includes cultural respect training  
• Cultural awareness initiatives – eg. flying the Aboriginal flag at hospitals  
• Aboriginal Impact Statements | • Continue to engage with the Aboriginal communities – by Health Advisory Councils and Southern Fleurieu service providers  
• HACs to engage with Aboriginal Health Team, Aboriginal Health Council, Aboriginal Elders Group, AHAC  
• Implement the principles and actions in the Strategy for Improving Aboriginal Health in the Southern Fleurieu  
• Priority on recruiting Aboriginal people and up-skilling current employees  
• Ongoing cultural respect and awareness training  
• Improve the understanding and utilisation of Aboriginal Impact Statements |
## Engaging with our community

### Objective 1: Develop and implement a community engagement and communication strategy
### Objective 2: Continue recruiting volunteers and building their capacity
### Critical milestones: Development of a community communication strategy; implementation; evaluation; ongoing development

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The community is kept informed and up to date about health services and provided with health information they can understand</td>
<td>- Some formal and informal ad hoc communication with the community about current services and issues including newsletters, public notices</td>
<td>- Development and implementation of a coordinated and consistent community communication strategy eg. service directories, newsletters, Internet-based communication; provide non-threatening opportunities for feedback/comment</td>
</tr>
<tr>
<td>- The community provides feedback in a structured manner to assist in the ongoing planning and development of services</td>
<td>- Consumer feedback mechanisms – eg. complaints, satisfaction surveys</td>
<td>- HACs develop an ongoing community engagement and consultation plan, taking into account minority groups, the disabled and Aboriginal community (Aboriginal Health Team, Aboriginal Health Council, Aboriginal Elders Group, AHAC)</td>
</tr>
<tr>
<td>- Services are supported by a sustainable volunteer workforce</td>
<td>- Recruitment and screening of volunteers</td>
<td>- Increase targeted recruitment of volunteers suitable to a particular service including drivers, palliative care, mental health</td>
</tr>
</tbody>
</table>

### Outcomes

- The community is kept informed and up to date about health services and provided with health information they can understand

### Critical milestones:

- Development of a community communication strategy
- Implementation
- Evaluation
- Ongoing development
Local Clinical Networks

**Objective:** Build coordinated and seamless links between health and related services/providers across the Southern Fleurieu cluster and CHSA

**Critical milestones:** Southern Fleurieu governance structure and operational plan implemented

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Residents of the Southern Fleurieu have access to quality, client focussed health services that are safe, and are provided within the resources available | • Southern Fleurieu Governance Structure and Operational Plan\(^22\)  
• Good, basic infrastructure for workforce – eg. team structure  
• Partnerships and working relationships with other private and NGO agencies (eg. CHAP, Divisions of General Practice, Country North Services)  
• Partnerships and working relationships with Statewide Services (DASSA, C&YHS, CAMHS, Yarrow Place) | • Creating an environment where collaboration is the norm  
• Consolidation of Southern Fleurieu community health service structure  
• Explore formal pathways with Repatriation General Hospital for palliative care and specialist geriatric management  
• Consolidation of Southern Fleurieu corporate services structure  
• Strengthen relationships and networks with statewide services to build the local capacity of the service eg. DASSA, C&YHS, CAMHS, Yarrow Place  
• Continue to build on existing relationships and develop formal partnerships with public/private/NGO agencies; avoid competing for funding; avoid duplication of services  
• Integrated and enhanced programs that support general practice – eg. practice nurses, mental health, chronic disease management  
• Seek Commonwealth health promotion programs and initiatives that integrate with local initiatives  
• Implement a SA Retrieval Service video link in ED |

\(^22\) Governance and operational plans developed by the Southern Fleurieu Health Service cluster in 2009 to provide strategic and operational direction in accordance with SA Health Strategic Directions, CHSA Executive and Executive Director of Service Operations
## 8. Resources Strategy

### Workforce

**Objective:** Maintain a skilled and experienced workforce equipped to meet the changing health environment

**Critical milestones:** NA

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Sustainable workforce strategy | • Southern Fleurieu Operational Plan – Workforce (one of five key operational areas)  
• Credentialing of qualified medical staff  
• Accreditation of specialist staff – eg. diabetes nurse educators  
• Recruitment to existing vacancies  
• Recruitment – eg. relocation assistance, housing assistance  
• Health LEADS  
• Aboriginal nursing cadetships | • Ongoing development and implementation of the Southern Fleurieu Operational Plan  
• Improved succession planning for senior management positions – eg. ongoing support of Clinical Leadership Program, Health LEADS, improved mentoring opportunities  
• Building relationships/partnerships with tertiary institutions – local and metropolitan  
• Targeted recruitment of medical specialists to meet identified community need – eg. paediatrician  
• Undertake workforce planning – proactive response to ageing workforce and changing models of clinical care; focus on health promotion and prevention/early intervention  
• Develop a service model for ‘sharing’ staff across the cluster – eg. midwives, dialysis nurses, casual pool  
• Focus resources for professional development around core business  
• Explore nurse practitioners models – A&E, palliative care, chronic disease  
• Increase opportunities and support for Aboriginal employment within health  
• Ongoing development of local clinical networks and participation in statewide clinical networks  |
| | • Staff feel supported and valued | • Building relationships/partnerships with general practice and GPs  
• Support the development of a staffing methodology for allied health; and, development of career pathways  
• Explore opportunities to support local GP training and upskilling, improve collaboration  
• Develop cluster-wide staff recognition strategy | • Professional development program across disciplines/work groups; mandatory training  
• Retention incentives  
• Clinical leadership program  
• Local clinical networks  
• Performance management process |
### Infrastructure

**Objective:** A planned approach to maintaining and developing infrastructure and equipment to meet future service requirements, and within the resources available  
**Critical milestones:** NA

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Infrastructure and equipment that meets standards and supports existing and future service delivery | • Preventative maintenance programs  
• Minor works planning  
• Capital works planning  
• Clinical networks and other CHSA programs have provided equipment – eg. point-of-care testing (iCARnet); ECG machines (CHSA A&E project)  
• Funding infrastructure from operating budget  
• Using local capital funds to upgrade equipment and develop infrastructure (eg. donations, bequests, community fund raising)  
• Aged care capital funds  
• Other funding sources – eg. one-off funding for specific infrastructure of equipment | • Prioritise across the cluster for infrastructure and equipment upgrades and redevelopment  
• Develop business cases for priority needs to pursue funding opportunities  
• Partnership with other agencies who have a vested interest in health infrastructure and equipment – eg. general practice, local government  
• Develop business case for an upgrade to the ED building on investment from 2007 and a purpose built Ambulatory Care Centre |
**Finance**

**Objective:** Increase the efficiency and effectiveness in the allocation of resources, balanced with the provision of services as close to home as possible.

**Critical milestones:** NA

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| Sustainable resources for the Southern Fleurieu to provide the services identified by community need | Funding agreements with the State and Commonwealth – eg. RPHS, HACC  
Annual budget process – cluster-wide | Workforce strategy integrated with service planning and development  
Improved use of data and information to determine changes in level of need so appropriate responses can be made  
Explore new and alternate funding options eg. partnering with other organisations in funding applications  
Partnership with other agencies who have a vested interest in health infrastructure and equipment – eg. general practice, local government  
Feasibility study into the development of an Integrated Health Care Centre (IHCC) at Victor Harbor |
## Information Technology

**Objective:** Improve ICT connectivity to enhance telehealth/telemedicine and communication opportunities

**Critical milestones:** Telehealth model established

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient journeys reduced</td>
<td>Telehealth and telemedicine – eg. Rural and Remote Mental Health</td>
<td>CareConnect Strategy – country rollout</td>
</tr>
<tr>
<td></td>
<td>ICT that supports point-of-care testing</td>
<td>Reduce patient journey by providing greater telehealth opportunities – eg. specialist consultations via video conference</td>
</tr>
<tr>
<td></td>
<td>Pathology and radiology results available via the Internet</td>
<td>Improve staff skills and confidence in using ICT modalities in daily practice</td>
</tr>
<tr>
<td></td>
<td>ICT connectivity at Goolwa outreach centres</td>
<td>Explore opportunities/options for tele-radiology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand point-of-care options</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electronic Decision Support (decision making for risk assessment and early intervention)</td>
</tr>
<tr>
<td>Safer practice</td>
<td>ICT connectivity across the cluster via a shared drive</td>
<td>Improve ICT connectivity with general practice</td>
</tr>
<tr>
<td></td>
<td>Data collection and analysis – eg. CME</td>
<td>Improve data collection and analysis to assist with ongoing planning</td>
</tr>
<tr>
<td></td>
<td>Professional development including e-based interactive skills development programs</td>
<td>Improve range and opportunities for on-line staff professional development</td>
</tr>
</tbody>
</table>
Risk Management

**Objective:** The risk of harm to the recipient of care across the continuum of care is controlled and health needs are understood

**Critical milestones:** NA

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
</table>
| • Successful implementation of the service directions identified in the 10 Year Local Health Service Plan | • The Strategy for Planning Country Health Services in SA set out important principles which have been used to guide the local planning  
• Population health principles implemented | • A formal risk assessment is conducted on the consequences of not implementing the strategies for the future as identified in the 10 Year Health Service Plan  
• Implement strategies which have the most impact on improved health outcomes for people who reside in the Southern Fleurieu area  
• Any strategy that indicates an unacceptable risk to the recipient, or cost burden due to implementation will be reassessed for an alternative model of care  
• Incorporate the 10 Year Health Service Plan planning principles into the ongoing monitoring and review process when implementing the 10 Year Health Service Plan |
9. Appendix

9.1 Leadership Structure

The Southern Fleurieu Health Service 10 Year Local Health Service Plan was developed by Country Health SA via the Hills, Southern Fleurieu, Kangaroo Island Cluster Executive Team in collaboration with the South Coast Health Advisory Council Inc. (SCHAC). The Plan considered the statewide health initiatives, health improvement plans and the directions identified to improve population health by the SA Inner Country Health Network Alliance.

9.2 Methodology

The Southern Fleurieu Health Service 10 Year Local Health Service Plan has been developed following consultation with the local community, including key stakeholders. The Plan addresses community health needs considering services already in place, existing infrastructure, capacity to attract workforce to provide services, the demographic, geography, burden of disease, health service utilisation, statewide SA Health initiatives, expected population growth and expected tourism development in the next 10 years. It is the intent of the Plan to identify strategic issues which impact on the social determinants of health, so that the Plan may address the cause and not only the symptoms of less than optimal health outcomes for the community.

Community consultation was fostered through a number of formal and informal stand alone and ongoing forums.

Previous formal community engagement in service planning for Southern Fleurieu has included:

<table>
<thead>
<tr>
<th>Title</th>
<th>Contact</th>
<th>Year completed</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Coast Master Plan</td>
<td>City of Victor Harbor</td>
<td>2007</td>
<td>Public consultation by the City of Victor Harbor and Alexandrina Council. To guide future growth and development of the South Coast region, an area covered by the two local Councils.</td>
</tr>
<tr>
<td>Master Development Planning Study, SCDH</td>
<td>Jill Cooper, EO/DON, SCDH</td>
<td>June 2007</td>
<td>Review of existing and projected health services needs and capital assets, and development of a Master Development Plan for the immediate and longer term needs of the Hospital.</td>
</tr>
<tr>
<td>Recruitment and Retention in the Fleurieu Health and Aged Care Sector</td>
<td>Fleurieu Regional Development Board</td>
<td>December 2008</td>
<td>To inform Fleurieu Regional Development’s consideration of the need and opportunity to provide regional recruitment support to the health and aged care sector (Stage 2) through provision of a broad description of the current and future workforce needs, issues and potential responses.</td>
</tr>
<tr>
<td>Local Councils</td>
<td>Council Planners</td>
<td>Ongoing</td>
<td>Population planning projections, open space and residential land usage, youth planning (Victor Harbor), family planning (Victor Harbor).</td>
</tr>
<tr>
<td>South Coast Health Advisory Council AGM</td>
<td>SCHAC Members</td>
<td>March 2009</td>
<td>Issues raised relating to lack of transport and the increasing demand for health and wellbeing services for the high and increasing number of residents 65 years and over.</td>
</tr>
<tr>
<td>Southern Fleurieu Positive Aging Taskforce</td>
<td>Meets bi-monthly</td>
<td></td>
<td>Ongoing concern about lack of transport, increasing demand for services for the elderly, frail aged, young disabled, etc.</td>
</tr>
</tbody>
</table>

Source: South Coast District Hospital, May 2009
Ongoing community engagement and collaboration networks include:

- Southern Fleurieu Positive Aging Taskforce.
- Southern Fleurieu Carers Forum.
- Southern Fleurieu Cancer Support and Resource Group.
- Fleurieu Regional Community Services Advisory Committee.
- Southern Fleurieu Youth Advisory Committee.
- Southern Fleurieu Youth Network.
- YWCA of Adelaide.
- Riverdance: Community wellness forum involving Centrelink, GP Network South and Country Health SA.
- Other government agencies.
- GP Network South.
- Local general practitioners.

**Consultation methodology**

The SCHAC provided questionnaires to the local community. 131 responses were received from respondents across the age demographic: <20=3, 21-40=20, 41-60=44, 60+=64. SCHAC questionnaires were provided to all staff and health service providers for South Coast District Hospital and Southern Fleurieu Health Services. SCHAC members consulted various community groups to capture their priorities for a local 10 Year Health Service Plan. These included:

- Riverdance Goolwa.
- South Talk.
- Hospital volunteers.
- Victor Harbor High School.
- Playgroup.
- Cancer support groups.
- Busy Bees.
- Care and Share.
- Young Mums.
- PE Gardens.
- Pt Elliot Primary School student counsellor.
- Individuals.
- Southern Fleurieu Mental Health Team.
- Attended the Community Health Forum held on 16th February, 2010.

9.3 Review Process

The Southern Fleurieu 10 Year Health Service Plan implementation and impact will be reviewed quarterly in the first year and bi-annually for the duration of the Plan.

Committees reviewing the 10 Year Health Service Plan will include:

- South Coast Health Advisory Council.
- Hills, Southern Fleurieu, Kangaroo Island Cluster Executive Team.
- SA Inner Country Health Network Alliance – link to Health Improvement Plans.

The Terms of Reference for the Review (methodology) to be decided collaboratively between the three key committees. However the review must include community and other stakeholder engagement and consultation.
### 9.4 Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>24/7</td>
<td>24 hours / 7 days a week</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
</tr>
<tr>
<td>AHAC</td>
<td>Aboriginal Health Advisory Council</td>
</tr>
<tr>
<td>ASSIST</td>
<td>Alcohol, Smoking and Substance Involvement Screening Test</td>
</tr>
<tr>
<td>ATOD</td>
<td>Alcohol, Tobacco and Other Drugs</td>
</tr>
<tr>
<td>C&amp;YHS</td>
<td>Child and Youth Health Service</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service (Statewide Service)</td>
</tr>
<tr>
<td>CHSA</td>
<td>Country Health South Australia</td>
</tr>
<tr>
<td>CME</td>
<td>Client Management Engine</td>
</tr>
<tr>
<td>DASSA</td>
<td>Drug and Alcohol Services SA (Statewide Service)</td>
</tr>
<tr>
<td>DDU</td>
<td>Drugs of Dependence Unit</td>
</tr>
<tr>
<td>DPLG</td>
<td>Department of Planning and Local Government</td>
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<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FMC</td>
<td>Flinders Medical Centre</td>
</tr>
<tr>
<td>FTE</td>
<td>Full-time Equivalent</td>
</tr>
<tr>
<td>GEM</td>
<td>Geriatric Evaluation and Management</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HAC</td>
<td>Health Advisory Council</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HSFKI</td>
<td>Hills, Southern Fleurieu, Kangaroo Island</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td>IHCC</td>
<td>Integrated Health Care Centre</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
</tr>
<tr>
<td>OHSW&amp;IM</td>
<td>Occupational Health, Safety, Welfare and Injury Management</td>
</tr>
<tr>
<td>QRS</td>
<td>Quality, Risk, Safety</td>
</tr>
<tr>
<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
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<tr>
<td>RGH</td>
<td>Repatriation General Hospital</td>
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<tr>
<td>RPHS</td>
<td>Rural Primary Health Services</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SAAS</td>
<td>SA Ambulance Service</td>
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<tr>
<td>SAPOL</td>
<td>SA Police</td>
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<tr>
<td>SCDH</td>
<td>South Coast District Hospital</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SCHAC</td>
<td>South Coast Health Advisory Council</td>
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<tr>
<td>SFHS</td>
<td>Southern Fleurieu Health Services</td>
</tr>
<tr>
<td>SLA</td>
<td>Statistical Local Area</td>
</tr>
<tr>
<td>TCP</td>
<td>Transitional Care Package</td>
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