Yorke Peninsula
10 Year Local Health Service Plan
2011 - 2020

Yorke Peninsula and
Northern Yorke Peninsula
Health Advisory Councils
Yorke & Lower North Health Services
Country Health SA Local Health Network
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Date: 4 July 2011
1. Executive Summary

Background and context

The hospitals and health services of the Yorke Peninsula - Wallaroo, Maitland (including Minlaton Health Centre and Melaleuca Court residential aged care facility), and Yorketown, form part of the Yorke & Lower North (Y&LN) Health Service cluster\(^1\). These sites provide a range of accident and emergency, acute inpatient, elective surgery, maternal and birthing, community health, aged care and various associated and clinical support services to their communities. Private local general practitioners (GPs) provide medical and procedural services to the hospitals and health services, and the GPs are supported by a predominantly visiting medical specialist service. The Aboriginal Health Team, part of the Y&LN Community Health Service, provides services for Aboriginal people.

The Y&LN Health Service Cluster Executive Group (the Executive Group)\(^2\) has taken the lead and determining role in the development of the draft Health Service Plan. The Yorke Peninsula and Northern Yorke Peninsula Health Advisory Councils (HAC) have worked closely with the Executive Group in the planning and implementation of the community consultation, the development of the needs analysis, and the review and community consultation of the draft plan. A Local Liaison Planning Officer was appointed in June 2009 to work with the Executive Group and the HACs in the implementation of the planning process across the cluster.

A cluster-wide community, staff, and stakeholder engagement consultation strategy was developed with the Executive Group and HACs, and implemented during July/August 2009. A letter to the householder with a survey was mailed to all residents and the HACs convened focus group discussions and public meetings. Staff and stakeholders were consulted via workshops, focus groups, letters/surveys. GPs and medical specialists were given the opportunity to provide feedback either individually or through the Yorke Peninsula Division of General Practice (YPDGP).

Feedback was accepted up until 15 December 2009. Results were collated and analysed during December and January 2010.

Generally, community respondents indicated they did not want to lose the services they have. Many identified the ageing population and the implications for health services provision into the future. The resounding theme around aged care services was, ‘would they be available locally when we need them’. Community and stakeholders were asked to identify both the service delivery gaps and the health priorities faced by the community.

Service priorities where gaps/issues with existing services were identified by community:

- Waiting times for services – predominantly waiting for an appointment to see a GP or specialist.
- Access to GPs, and to lesser extent medical specialists.
- Communication and information – access to information about services and being able to understand health information.
- Patient journey – transport and the associated costs and upheaval, discharge planning.

Health priorities identified by community:

- Drug and alcohol services – not enough services, lack of prevention and early intervention.
- Chronic disease and conditions – predominantly diabetes, cancer and obesity, treatment/management and healthy lifestyle options.
- Health needs of an ageing population – in-home and residential, available locally.
- Community based care – community health and out of hospital services (including outpatient services).
- Oral health – access, cost, availability of private and public dental services.

In February 2010, a two-day needs analysis workshop with selected staff and key stakeholder participants was held at Maitland. Existing health services were reviewed using the SWOT (strengths,
weaknesses, opportunities, threats) framework and future priorities identified. The priorities, in the context of community feedback, service profile data and information, and local/State/National strategic plans and directions, were developed into the major developments and recommendations in this Plan.

**Key components of the draft Plan**

The key evidence which supported the maintenance of existing services includes geographic remoteness/isolation including the right for people to access safe services as close to home as possible within the available resources, an increasing and ageing population, a significant Aboriginal population, high to average levels of socioeconomic disadvantage, limited availability of flexible and affordable transport options, the reliance on volunteer ambulance crews in most areas, and, the condition of roads on the Yorke Peninsula.

To sustain and maintain current services is the primary focus of the Plan - including 24/7 emergency care and acute inpatient, nominated elective surgery, maternal and birthing, community health (including outpatients, out of hospital strategies, allied health), mental health (including drugs and alcohol services), in-home and residential aged care, medical specialists, respite and rehabilitation, palliative care, clinical support services, and oral/dental health services. The ongoing involvement and participation of GPs and general practice in the planning, development and delivery of health services is essential in sustaining and maintaining the current service profile.

**Recommendations**

- Expanded drug and alcohol service – focus on prevention and early intervention.
- Expand team midwifery care for expectant and new mothers on the Yorke Peninsula.
- Review elective surgery services at Yorke town.
- Explore opportunities for using existing infrastructure more effectively such as dialysis chairs at Maitland used for other same-day treatment (e.g. intravenous infusions).
- Develop a culturally sensitive bereavement counselling role as an integral part of a palliative care service.
- Improve patient journey – better discharge and pre-admission planning; and, review transport and accommodation options and support for clients travelling to other centres for health care; improve use of telehealth.

To enable the provision of quality health services to communities on the Yorke Peninsula, recruitment and retention of a suitably skilled workforce is needed; a flexible, responsive transport system; a robust information and communications (ICT) infrastructure for data collection and analysis, communication, and telehealth/telemedicine modalities; further development and maintenance of relationships/partnerships both formal and informal with government and non-government service providers; all underpinned by sound operational infrastructure and systems.
2. Catchment summary

Introduction

The Yorke Peninsula region includes the catchment areas encompassed by Yorketown, Maitland and Wallaroo Hospitals. The catchment extends more than 197 kilometres from Marion Bay at the base of the Peninsula to the upper-most boundary north of Wallaroo.

The catchment includes the townships located within the District Councils of Yorke Peninsula, Copper Coast, and sections of Barunga West (excluding the township of Pt Broughton).

Yorketown, at the lower end of the Peninsula is located 128 kilometres from Wallaroo and 226 kilometres from Adelaide. Maitland is located 52 kilometres from Wallaroo and 167 kilometres from Adelaide and Wallaroo is located 157 kilometres from Adelaide. The map below highlights this catchment area.

Source: www.atlas.sa.gov.au
Population

The resident population for the catchment is 25,957 (DPLG 2011 Population Projections), with approximately 54% of this population residing in the Wallaroo catchment area. People from Aboriginal and Torres Strait Islander backgrounds comprise 2.2% of the total population compared with 3.1% across country South Australia. In the Maitland area, Aboriginal and Torres Strait Islander people represent 5.5% of the catchment population. Approximately 1.3% of the population speak a language other than English at home, compared with 3.9% across country South Australia.

The proportion of the population in the 0-14, 15-24 and 25-44 year age groups is slightly lower, and in the 65 and over age groups slightly higher, when compared to both country and all of South Australia (refer Table 1). The projected population for the catchment area is estimated to increase by 12% to the year 2021. In the past 5 years the population in the Wallaroo catchment area has increased significantly (7%). The fertility rate for the region (average 2.3) is above replacement level and higher than the South Australian rate (1.82). The indirect standardised death rate for the region is slightly higher (average 6.9) than the South Australian rate (6.1).

The Yorke Peninsula region attracts a high number of tourists (particularly family groups with children) significantly swelling the size of the catchment population during school and other seasonal holiday periods. Approximately 430,000 overnight visitors and 640,000 same day visitors travel to the region each year.
Table 1: Yorke Peninsula catchment population

<table>
<thead>
<tr>
<th>Cluster No.</th>
<th>Wallaroo</th>
<th>%</th>
<th>Maitland</th>
<th>%</th>
<th>Yorketown</th>
<th>%</th>
<th>South Australia %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>14,036</td>
<td>5,368</td>
<td>6,553</td>
<td>25,957</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Country SA %</th>
<th>South Australia %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>50.4%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Females</td>
<td>49.6%</td>
<td>50.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Wallaroo</th>
<th>%</th>
<th>Maitland</th>
<th>%</th>
<th>Yorketown</th>
<th>%</th>
<th>South Australia %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 years</td>
<td>2,402</td>
<td>17.1%</td>
<td>873</td>
<td>16.3%</td>
<td>1,059</td>
<td>16.2%</td>
<td>20.4%</td>
</tr>
<tr>
<td>15-24 years</td>
<td>1,297</td>
<td>9.2%</td>
<td>511</td>
<td>9.5%</td>
<td>607</td>
<td>9.3%</td>
<td>11.4%</td>
</tr>
<tr>
<td>25-44 years</td>
<td>2,797</td>
<td>19.9%</td>
<td>924</td>
<td>17.2%</td>
<td>1,171</td>
<td>17.9%</td>
<td>25.1%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>4,209</td>
<td>30.0%</td>
<td>1,680</td>
<td>31.3%</td>
<td>2,096</td>
<td>32.0%</td>
<td>27.3%</td>
</tr>
<tr>
<td>65-84 years</td>
<td>2,948</td>
<td>21.0%</td>
<td>1,215</td>
<td>22.6%</td>
<td>1,463</td>
<td>22.3%</td>
<td>13.9%</td>
</tr>
<tr>
<td>85 years and over</td>
<td>384</td>
<td>2.7%</td>
<td>165</td>
<td>3.1%</td>
<td>157</td>
<td>2.4%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Groups</th>
<th>Wallaroo</th>
<th>%</th>
<th>Maitland</th>
<th>%</th>
<th>Yorketown</th>
<th>%</th>
<th>South Australia %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal &amp; Torres Strait Islander*</td>
<td>180</td>
<td>1.4%</td>
<td>279</td>
<td>5.5%</td>
<td>55</td>
<td>0.9%</td>
<td>514</td>
</tr>
<tr>
<td>CALD (language other than English at home)*</td>
<td>170</td>
<td>1.4%</td>
<td>67</td>
<td>1.3%</td>
<td>77</td>
<td>1.3%</td>
<td>314</td>
</tr>
</tbody>
</table>

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

The majority of the region is considered remote and isolated, with some areas in the North considered outer regional. Overall, the region experiences high to average levels of socioeconomic disadvantage, including lower median individual, family and household incomes than for total South Australia. The prevalence of chronic disease in the region for people aged 16 years and over is slightly higher for arthritis and diabetes.

The Yorke Peninsula is a centre for agricultural activity and fishing, and is home to numerous primary industries. Agriculture and fishing, health care and social assistance, and retail trade account for the three largest employment industries in the region.

Compared with other more isolated communities in country South Australia, there are a range (albeit limited) of local and intrastate transport options available, including some community and patient transport schemes. Transport from Yorketown to Adelaide is available 3 times per week, and from Wallaroo to Adelaide, 7 days a week. A Health Bus (Yorke Peninsula Community Transport and Services Inc.) travels from Yorketown to Adelaide, via Minlaton and the Copper Coast, Monday-Friday for people to attend medical appointments.
3. Needs Analysis summary

Introduction

As part of the Yorke & Lower North cluster 10-year health service planning process, the Yorke Peninsula undertook a needs analysis to capture the strengths, weaknesses, opportunities and threats (SWOT) of existing services and future directions.

A workshop was held at Maitland on two consecutive days with key staff and stakeholders, and members from the respective Healthy Advisory Councils. Participants reviewed all existing services using the SWOT framework. This information was collated and considered with the information from the service profiles, community and stakeholder consultations and existing local/State/National strategic directions and plans. The completed needs analysis was distributed to senior staff, nurses, GPs and other stakeholders for feedback.

Community, staff and stakeholder engagement and consultation

A key part of the 10-year health service planning has been to engage the community and other stakeholders and offer them the opportunity to provide feedback about service gaps and issues. The Yorke and Lower North (Y&LN) Executive Group and the HACs identified community groups and stakeholders and determined the level of engagement required to meet the needs of the planning process. GPs were invited to participate on an individual basis or through the YPDGP. Medical and other visiting specialists responded to a survey posted to them.

The community, staff and stakeholder engagement activities took place during July – December 2009 with active involvement from both HACs. The HACs were provided with support and a resource toolkit prior to commencing their community engagement activities. Senior staff were given a presentation at the Senior Staff Forum (August 2009) and asked to ‘workshop’ the survey questions with their workgroups.

A 3% response rate was received from the community survey on the Yorke Peninsula. HAC members facilitated community focus group discussions (17), and encouraged people to return the survey. The stakeholder forums were well attended and participation was enthusiastic. Managers/team leaders/supervisors engaged with their staff and feedback was received from 26 staff workgroups (cluster-wide).

Social determinants of health (such as community infrastructure and capacity, fresh food, affordable goods and services, family and other support networks, employment), and access to responsive health services were identified by 60% of community respondents as key factors contributing to a healthy community.

The key themes from the Yorke Peninsula community, staff and stakeholder consultations included:

- Communities do not want to lose the services they currently have access to locally. A&E services were identified as a basic/minimum service needed locally by 59% of community respondents; community health services by 71%; acute inpatient services by 36%; and aged care services in-home and residential by 52%.
- Waiting times (for an appointment when unwell), and access to GPs, and to a lesser extent medical specialists. The significant gap payments required are barriers to people accessing medical specialist services.
- The social determinants of health – issues/gaps/problems with community infrastructure and capacity, access/affordability of healthy food and lifestyle choices, feeling safe.
- Chronic disease/conditions – diabetes, cancer, obesity, asthma, renal disease – access to services, support groups, lifestyle programs.
- Drugs and alcohol – lack of services, prevention and early intervention, effect on communities, exacerbation of mental health and relationship problems.
- Aged care services – ability to meet the increasing demands of an ageing population.
- Communication and information about health services and health conditions – how to access services, where to access easy to understand information.
Patient journey – preadmission and discharge planning; transport – access, availability, affordability, flexibility; accommodation availability and affordability if travel is required to access services.

The gaps/issues/problems identified were generally associated with access (including waiting times, availability of service when required (local or otherwise), lack of health professionals to provide the service). Patient journey issues were a common theme including cost, available transport options, and upheaval to family.

Knowing what services were available and how to access them was a key theme. Generally, staff and stakeholder responses reflected the communities; some were specific to their discipline or workgroup.

**Priorities identified through the needs analysis**

The priority needs for Yorke Peninsula identified through the needs analysis were primarily the maintenance of current services across all sites – 24/7 emergency care, acute inpatient, elective surgery, maternal and birthing, community health (including outpatients, out of hospital strategies, allied health), mental health (including drug and alcohol services) aged care, medical specialists, respite and rehabilitation, palliative care, clinical support services and oral/dental health services.

The key evidence supporting maintenance of these services includes geographic remoteness/isolation – the right for people to access safe services as close to home as possible within the available resources; an increasing and ageing population; a significant Aboriginal population; high to average levels of socioeconomic disadvantage; limited availability of flexible and affordable transport options; the reliance on volunteer ambulance crews in most areas; and, the condition of roads on the Yorke Peninsula.

**Key priority areas**

- High levels of socioeconomic disadvantage highlight the need for expanded drug and alcohol services that provide early intervention and prevention; integrated with Statewide service (DASSA) and other primary health care programs.
- The distance to the nearest facility, the availability and affordability of transport and accommodation, and an increasing and ageing population determines the need to review elective surgery at Yorketown and explore alternate service options. This is in the context of successfully recruiting and retaining a skilled workforce, maintaining/replacing infrastructure and equipment, and complying with accreditation standards to provide a safe service within available resources.
- The ageing community, a significant Aboriginal population, increasing rates of chronic disease and the distance to the nearest facility provide an opportunity to utilise day-treatment renal dialysis ‘chairs’ for other treatments at Maitland, for example, intravenous infusions.
- A fertility rate above the State average, the relatively young age structure of the Aboriginal community, and the consolidation of maternal and birthing services to Wallaroo makes expansion of team midwifery care for expectant and new mothers a priority on the Yorke Peninsula.
- An ageing population and the rise of malignant neoplasms as a proportion of the disease burden determines that bereavement counselling is an integral part of a palliative care service.
- A culturally sensitive Aboriginal palliative care service (including bereavement) is integral to a holistic approach to Aboriginal health and wellbeing.
- The challenges associated with distance, an ageing and socioeconomically disadvantaged population, and consolidation of some services at Wallaroo emphasises the need to improve discharge and pre-admission planning; and, review transport and accommodation options and support for clients travelling to other centres for health care.

The SWOT highlighted the necessity of recruiting and retaining a suitably skilled workforce (including GPs, medical and other specialists); having a flexible, responsive transport system; the need for robust ICT infrastructure for data collection and analysis, communication, and telehealth/telemedicine modalities; the importance of relationships/partnerships both formal and informal with government and...
non-government service providers; and, the need for sound operational infrastructure and systems to be able to provide quality health services to Yorke Peninsula communities.

The key elements identified in the needs analysis process that impact across Yorke Peninsula Health Services include:

- 2010-2013 Rural Primary Health Service Agreement – Wakefield (Minlaton).
- 2011 HACC Agreements.
- 2009-2010 Aboriginal Primary Health Care Access Program (APHCAP).
- 2009-2010 Healthy for Life.
- 2010-2011 CHSALHN Schedule for GP Plus Funds.
- Yorke Peninsula Community Transport & Services Inc – Health Bus (under review).
4. Local implications of Statewide plans

The Strategy for Planning Country Health Services in South Australia (the Strategy), 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. It sets out how to achieve an integrated country health care system so that a greater range of services are available in the country, and 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 current 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.

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
- Connecting local patients with pathways to higher level care needs
- Reducing 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 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.

**Yorke & Lower North Health Services – Values and Guiding Principles**

Values:
- **Honesty** – being transparent in the way we work
- **Integrity** – being consistent both publicly and privately
- **Respect** – valuing diversity
- **Equity** – being fair in our dealings
- **Quality** – achieving excellence through innovation and learning.

Guiding Principles:
- **Creating an environment where collaboration is the norm**
- **Igniting and keeping passion for our goals**
- **Striving for innovation and improvements**
- **Fostering a passion for excellence in service**
- **Genuinely caring for the wellbeing of our peers and community.**

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3 Yorke & Lower North Health Services Operational Plan July 2009 – June 2010
## 6. Service Delivery Plan

### 6.1 Core Services to be Sustained

**Note:** Services only provided directly in particular catchment areas are indicated by the initial: W=Wallaroo; M=Maitland (incl. Minlaton & Melaleuca Court); Y=Yorketown

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Service Description</th>
<th>Target Group</th>
<th>Directions over next 10 years</th>
</tr>
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<tbody>
<tr>
<td>Community &amp; Allied Health (includes outpatients and out of hospital strategies)</td>
<td>Local primary health care initiatives, chronic disease services, community nursing services, Domiciliary Care, day care activities, counselling, health promotion programs and specific out of hospital strategies</td>
<td>All people in YP catchments – with focus on: Early childhood, Youth, Disabled, Frail/Aged, Aboriginal people</td>
<td>Maintain and enhance existing community health and out of hospital services/programs&lt;sup&gt;4&lt;/sup&gt;; Expand/improve drug and alcohol services – prevention and early intervention; Further develop early childhood intervention services (development of the Child Development Unit at Wallaroo – waiting for approval and funding of a coordinator); Program focus on chronic disease/conditions – diabetes, cancer, ischaemic heart disease, obesity, renal disease and other recognised health priorities&lt;sup&gt;5&lt;/sup&gt;; Client-centred, culturally appropriate aged care services; Develop a culturally sensitive bereavement counselling service; Develop respite services that are culturally appropriate; Develop a ‘one-stop-shop’ approach to accessing services (e.g. many services can be accessed from one point); Provide health education using a settings approach&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Access to Aboriginal health, drug and alcohol services, community mental health (adult and child), child and youth health services</td>
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<td></td>
<td>Access to local and visiting Allied Health services</td>
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<td></td>
<td>Delivery of culturally appropriate local aged care packages (HACC, CACP)</td>
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<td></td>
<td>Primary Health Care clinics – Pt Pearce, Moonta</td>
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<td></td>
<td>Primary health care initiatives</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Service</td>
<td>24 hour, 7 day/week emergency triage and assessment; emergency trauma and resuscitation, mental health service through telehealth</td>
<td>All people who live on, or visit, the YP</td>
<td>Maintain current 24/7 emergency access across all sites, with higher level of service at Wallaroo (e.g. emergency surgery); Review and reorient after hours emergency care model for Minlaton; Develop and implement a model for nurse led clinics to improve the management of triage category 4 and 5 clients</td>
</tr>
<tr>
<td></td>
<td>24 hour, 7 day/week emergency surgical procedures (W)</td>
<td></td>
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<td></td>
<td>Appropriately staffed and supported by medical and nursing staff</td>
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<sup>4</sup> Includes Rural Primary Health Service (RPHS) Agreement for Minlaton Centre 2011-13  
<sup>5</sup> Chronic Disease Action Plan for South Australia 2009-2018  
<sup>6</sup> A settings approach to health promotion focuses on the setting or place where people work/play; emphasis is on environment rather than personal behaviour; not disease-focussed
<table>
<thead>
<tr>
<th>Section</th>
<th>Services and Remarks</th>
</tr>
</thead>
</table>
| **Acute Inpatient Care** | - Treatment for/management of appropriate (non-life threatening) conditions and minor surgical procedures  
- Inpatient diagnosis, monitoring and treatment of appropriate conditions  
- Admissions for more complex and higher risk treatment for medical, surgical, birthing, mental health beds, renal dialysis, paediatrics (W)  
- Admissions for management of minor (lower risk) assessments and treatments; Intermediate care including recuperative care  
- Admissions for acute medical, same day or overnight surgery, mental health chemotherapy (W,Y)  
- Birthing (W)  
- Access to renal dialysis chairs (M)  
- Access to General Practitioner Practice service to provide both acute illness management and General Practitioner consulting for less severe illnesses  
- All people who live on, or visit, the YP  
- Maintain current sites and range of services  
- Improve pre-admission and discharge planning for Aboriginal clients and the frail/aged with multiple and complex health issues (Wallaroo, Maitland and Yorketown)  
- Explore opportunities for utilising Maitland dialysis chairs on days when not used for dialysis  
- Implementation of a regional four-chair chemotherapy unit at Wallaroo  
| **Elective Surgical** | - Major procedures  
- Minor surgery (W,Y)  
- Operating theatre staffed and equipped to support a range of lower risk and appropriate surgeries (W,Y)  
- Access to visiting elective surgical specialists (W,Y)  
- All people who live on the YP  
- Maintain existing elective surgical service and explore growth potential at Wallaroo  
- Develop a pre-admission clinic model (Maitland & Yorketown – residents having surgery at Wallaroo)  
- By 2015 review the appropriateness of elective surgery at Yorketown in line with available resources and contemporary standards  
| **Maternal & Birthing Services** | - Antenatal and postnatal care including access to community midwifery services and parenting programs (W,Y)  
- Admissions for maternal and neonatal care (W,Y)  
- Low risk, single births, 24 hour, 7 day/week  
- All women having babies, and their families Focus on:  
  - Aboriginal women  
- Maintain level 3 perinatal services at Wallaroo  
- Maintain level 1 perinatal services at Maitland and Yorketown  
- Extend culturally sensitive team midwifery model for ante and postnatal care to Yorke Peninsula  

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7. SAAS 2008, Defining the Road Ahead, Country Service Delivery Model V1.4  
8. Statewide Cardiology Clinical Services Plan – January 2010  
9. SA Health Statewide Chemotherapy Administration Program 2010  
10. Standards for Maternal and Neonatal Services in South Australia 2009, SA Department of Health  
11. Standards for Maternal and Neonatal Services in South Australia 2009, SA Department of Health  
<table>
<thead>
<tr>
<th>Service Area</th>
<th>Key Activities</th>
<th>Target Population</th>
<th>Additional Activities</th>
</tr>
</thead>
</table>
| **Medical Specialist Services** | - Access to range of visiting medical specialist services | All people who live on the YP | - Maintain current visiting medical specialists – consulting, general treatment and procedures.  
- Negotiate better public client access to specialists; resolve gap payment issue.  
- Implement protocols/process for recruitment of medical specialists.  
- Explore opportunities for local pain clinics.  
- Increase use of telehealth (teleconferencing and videoconferencing) to increase local access to medical specialists. |
| **Mental Health** | - Local admissions for mental health  
- Respite and short stay options (Y)  
- 24 hour, 7 day/week emergency mental health service via telehealth (W,Y)  
- Access to community mental health services  
- Access to specialist mental health services via visiting specialist or telehealth  
- Access to psychosocial rehabilitation support services (W,Y) | All people who live on, or visit, the YP | - Maintain 24/7 emergency mental health service (using telemedicine); local admissions for voluntary clients.  
- Focus on programs стратегии to deal with drugs and alcohol – prevention, early intervention; integration of current services (DASSA).  
- Improve access to specialist drug and alcohol staff.  
- Build on existing early intervention models of primary mental health care in partnership with GPs and other providers.  
- Implement a program of Mental Health First Aid for the community. |
| **Rehabilitation** | - Admissions for recuperative and maintenance care  
- Community/home based rehabilitation support (W,M)  
- Centre based day therapy (W) | All people who live on, or visit, the YP | - Maintain admissions for recuperative care (down-transfers) across YP.  
- Explore opportunities to expand Transitional Care Packages to all sites (and private residential aged care providers).  
- Extend the arthroplasty prehabilitation program across the cluster.  
- Develop community-based rehabilitation options. |
| **Respite Services** | - Access to residential aged care respite (W,M)  
- Access to hospital aged care respite  
- Access to in-home respite (W,M) | All people who live on, or visit, the YP | - Work towards a flexible, responsive, coordinated model of respite across the Y&LN cluster that provides access to residential/hospital respite TCPs, and alternative models of respite.  
- Multi-Purpose Service (MPS) model for Maitland. |

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13 South Australia’s Mental Health & Wellbeing Policy  
14 South Australia’s Mental Health & Wellbeing Policy  
15 Statewide Rehabilitation Services Plan 2009-2017
<table>
<thead>
<tr>
<th>Health Services Framework for Older People 2009-2016</th>
<th>16. Integrated with Statewide Clinical Network for Palliative Care (July 2009)</th>
</tr>
</thead>
</table>

**Aged Care**
- Domiciliary care in home and the community
- Inpatient admissions for elderly, including respite care
- Low and high care residential aged care (W,M)
- Access to ACAT and aged care packages (W,M)
- People on YP – frail, elderly, their carers and family; Aboriginal elders
- Maintain and enhance current services – inpatient admission for the elderly; respite; lifestyle and leisure activities; carer support
- Maintain residential aged care where currently provided
- MPS model for Maitland, Minlaton and Yorketown
- Support older people recover from illness and injury through restorative approaches
- Culturally appropriate aged care packages – HACC, CACP

**Palliative Care**
- Inpatient admissions for palliative care
- Access to in-home support
- All residents of YP
- Maintain and improve current capacity to manage inpatient palliative care clients
- Development of a culturally sensitive, integrated bereavement service across YP
- Develop a community-based support network
- Explore models for palliative care to enable provision of higher levels of care

**Clinical Support Services**
- Point of care testing
- Access to pathology services (W,M)
- Access to pharmacy services
- Access to general X-ray capabilities
- Access to ultra sound capacity (W,Y)
- Access to range of diagnostic services to support medical, surgical and emergency service profile (W)
- Access to emergency O negative blood (W)
- All residents of YP
- Expand point-of-care testing at all sites
- Maintain existing general radiology and pathology services (W), improved blood service
- Maintain local area services – basic x-ray, access to pathology service via courier, pharmacy service; access to results via the Internet
- Develop the role of the Y&LN cluster Clinical Governance group to manage issues regarding drugs and therapeutics, working closely with Statewide Clinical Networks

**Oral Health (Dental)**
- Access to oral surgery and visiting specialist outpatient consultation (Y)
- Inpatient low technology specialist services (Y)
- All residents of YP
- Focus on:
  - Early childhood
  - Elderly
  - Aboriginal community
- Build the capacity/sustainability of current primary dental care available locally – public/private mix; visiting and local
- Early intervention strategies for oral/dental health and hygiene integrated into programs
- Oral health assessments included in all health checks
### 6.2 Strategies for new/expanded services

**Service objective:** Palliative Care – Expand the palliative care service to include an integrated, culturally sensitive bereavement service for the Yorke Peninsula\(^{18}\)

**Target group:** People suffering a bereavement, their families/carers

**Critical milestones:** Development of an appropriate culturally sensitive model of care; recruitment/training of a bereavement counsellor/s

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
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</table>
| o A bereavement counselling and support service is available to the YP communities (recognising that bereavement is a distinct area of grief and loss) | o Work with palliative care and Aboriginal health teams to develop a culturally sensitive model of care  
 o Recruitment of suitably qualified bereavement counsellor  
 o Training for Aboriginal health workers – palliative care and bereavement | 2010 2011 |

**Service objective:** Maternal and Birthing – Extend the current Wallaroo Team Midwifery model of care across Yorke Peninsula

**Target group:** Pregnant women and their families

**Critical milestones:** Team midwifery model implemented on Yorke Peninsula

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
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</table>
| o Women from the Yorke Peninsula birthing in Wallaroo will receive ante and postnatal care locally from a team midwife | o Recruit midwives into the program  
 o Collaboration with local GPs  
 o Education of women – safe service delivery, accessing a midwife; process etc | 2010 – 2011 2010 and ongoing 2010 and ongoing |

**Service objective:** Community Health Services and Statewide Services – expanded drug and alcohol counselling service with a prevention and early intervention focus

**Target group:** Youth

**Critical milestones:** An interagency plan to address drug and alcohol issues

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
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</table>
| o Sustainable drug and alcohol services with a prevention and early intervention focus, responsive to community need | o Integration of culturally sensitive prevention and early intervention strategies into primary health care programs\(^{19}\)  
 o Increase access to skilled specialist drug and alcohol staff – e.g. an early intervention worker  
 o Improve partnerships with other agencies – e.g. DASSA, YP Youth Advisory Council, Aboriginal Community Elders and AHAC, SAPOL | 2010 and ongoing 2011 2010 and ongoing |

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\(^{18}\) Palliative Care Services Plan 2009-2016  
\(^{19}\) Including APHCAP and Healthy for Life Programs
**Service objective:** Community Health Services – expand and enhance chronic disease services  
**Target group:** People with a chronic disease  
**Critical milestones:** Implementation of an improved model of service delivery for chronic disease management

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
</table>
| o Sustainable chronic disease services with a prevention and early intervention focus, responsive to community need | o Reorient services to prevention and early intervention  
o Develop partnerships between community health services, acute services, residential aged care services and non-government organisations  
o Improve, through up-skilling, utilisation of the workforce  
o Ongoing training of staff and community in chronic disease self-management | 2010 and ongoing  
2010 and ongoing  
2010 and ongoing  
2010 and ongoing |

**Service objective:** Acute Inpatient Services – development of a regional four-chair chemotherapy administration unit[^20]  
**Target group:** People requiring chemotherapy  
**Critical milestones:** Implementation of service delivery model for chemotherapy administration

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Strategies</th>
<th>Time Frames</th>
</tr>
</thead>
</table>
| o Sustainable regional chemotherapy administration service at Wallaroo | o Implementation of the SA Health Statewide Chemotherapy Program 2010 for a four-chair chemotherapy unit utilising existing facilities wherever possible  
o Education and training for clinicians | 2010 and ongoing  
2010 and ongoing |

[^20]: SA Health Statewide Chemotherapy Administration Program 2010
7. Key Requirements for Supporting Services

7.1 Safety & Quality

**Objective:** Maintenance and ongoing improvement of the quality and safety of our health services within the available resources

**Critical milestones:** Australian Council on Healthcare Standards (ACHS) and other accreditation maintained by all sites; meet performance targets for safety

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Quality, Risk and Safety systems across all Y&amp;LN sites resulting in improved outcomes for health care consumers</td>
<td>o Development of a cluster-wide Quality, Safety and Risk Unit; QRS Management Committee</td>
<td>o Ongoing development of a cluster-wide Quality, Safety and Risk management system that ensures compliance with legislation, codes of practice and accreditation standards</td>
</tr>
<tr>
<td>o Quality, Risk and Safety systems across all Y&amp;LN sites resulting in a physically and professionally safe working environment for staff</td>
<td>o Development of a cluster-wide Clinical Governance framework</td>
<td>o Promote a safety culture</td>
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<td>o Local quality and safety committees</td>
<td>o Ongoing development of the cluster-wide Clinical Governance framework</td>
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<td>o Implementation of the new CHSALHN OHSW&amp;IM Manual</td>
<td>o Continue patient safety programs and initiatives</td>
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<td></td>
<td>o Use of clinical practice guidelines and standards</td>
<td>o Ongoing contribution and participation in the country-wide accreditation and policy framework</td>
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<td>o Participate in local and State Clinical Networks</td>
<td>o Implement Team Steps™ across the cluster</td>
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<td>o Injury prevention and injury management – staff</td>
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<td></td>
<td>o OH&amp;S/patient safety programs and initiatives – e.g. Red Dot and Green Box (Falls Prevention) programs; ‘Greensleeve’ program (Respecting Patient Choices)</td>
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<td></td>
<td>o Advanced Incident Management Systems (AIMS) reporting and follow-up</td>
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<td>o Y&amp;LN consumer feedback policy and procedures</td>
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<td></td>
<td>o Australian Council on Healthcare Standards (ACHS), Aged Care Standards, HACC and other relevant accreditation processes</td>
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<td>o Partnership plans with Workcover</td>
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<td></td>
<td>o Data collection and analysis to support planning and development to meet community need</td>
<td>o Implementation of shared drive (ICT) across the cluster</td>
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<td></td>
<td>o Using Client Management Engine (CME) and other prescribed data collection and management programs</td>
<td>o Improved data collection and analysis using the systems available to improve safety and quality</td>
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<td>o Improved utilisation of data and information collected to inform best practice</td>
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<td>o Partner with general practice to utilise data collected by GPs – e.g. capture a more complete community health profile</td>
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### 7.2 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

**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>
| - YP 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 – bus, taxi – various subsidies available  
- SA Ambulance Service (SAAS) for local emergency response and retrieval  
- HealthDirect  
- HealthLink (referral service)  
- Support visiting medical and other specialist services | - Consider access options as an integral part of planning any service or activity  
- Support and enhance visiting medical and other specialist services in the Lower North  
- Recognition and further development of the role/relationship with practice nurses  
- 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 – those visiting locally and within the cluster  
- Working with other service providers (e.g. YPCTS, SAAS, RFDS) to maximise available services |
| - When this isn’t practicable, responsive, flexible and affordable transport options are available | - Yorke Peninsula Community Passenger Service – Health Bus, Community Bus and ‘Dial-a-Ride’  
- Royal Flying Doctor Service (RFDS) for metro 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 |
## 7.3 Cultural Respect

**Objective:** Provide culturally sensitive services for Aboriginal people that meet their health and wellbeing needs  
**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>
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</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 – e.g. nursing cadetships  
○ Staff orientation program includes cultural respect training  
○ Cultural awareness initiatives – e.g. flying the Aboriginal flag at hospitals  
○ Aboriginal Impact Statements | ○ Continue to engage with the Aboriginal communities – by Health Advisory Councils and Y&LN service providers  
○ HACs to engage with Aboriginal Health Team, Aboriginal Health Council, Aboriginal Elders Group, AHAC  
○ 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 |
## 7.4 Engaging with our community

**Objective:** Develop and implement a community engagement and communication strategy

**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>
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</thead>
<tbody>
<tr>
<td>o The community is kept informed and up to date about health services and provided with health information they can understand</td>
<td>o Some formal and informal ad hoc communication with the community about current services and issues – newsletters, public notices</td>
<td>o Development and implementation of a coordinated and consistent community communication strategy – e.g. service directories, newsletters, local media, Internet-based communication; provide non-threatening opportunities for feedback/comment</td>
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<td>o Link with statewide strategies aimed at improving health literacy</td>
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<td>o The community provides feedback in a structured manner to assist in the ongoing planning and development of services</td>
<td>o HACs develop an ongoing community engagement and consultation plan, taking into account minority groups, the disabled and Aboriginal community (and Aboriginal Health Team, Aboriginal Health Council, Aboriginal Elders Group, AHAC)</td>
</tr>
<tr>
<td></td>
<td>o Consumer feedback mechanisms – e.g. complaints, satisfaction surveys</td>
<td>o Relationship building between HACs, Y&amp;LN representatives and other key community organisations and groups</td>
</tr>
<tr>
<td></td>
<td>o Health Advisory Councils</td>
<td>o Ongoing contribution to and participation in the country-wide community engagement and consumer participation policy framework</td>
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<td>o Consumer initiated forums and support groups</td>
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<tr>
<td>o Services are supported by a sustainable volunteer workforce</td>
<td>o Recruitment and screening of volunteers</td>
<td>o Increase targeted recruitment of volunteers – volunteers suitable to a particular service, e.g. drivers, palliative care, mental health</td>
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<td></td>
<td>o Community awareness education</td>
<td>o Raise community awareness through education</td>
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<td>o Recognition of volunteers and the contribution they make</td>
<td>o Links with statewide organisations – e.g. Volunteering SA&amp;NT</td>
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<td></td>
<td></td>
<td>o Links with NGOs</td>
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<td></td>
<td>o Review and standardise policies and procedures for recruiting and screening volunteers</td>
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<td>o Coordination of volunteers across the cluster</td>
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### Local Clinical Networks

**Objective:** Build coordinated and seamless links between health and related services/providers across the Yorke Peninsula, Y&LN cluster and CHSALHN

**Critical milestones:** Sustainable governance and team structure across the cluster

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
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</thead>
</table>
| o The residents of the Yorke Peninsula have access to quality, client focussed health services that are safe, and are provided within the resources available | o Y&LN Governance Structure and Operational Plan\(^{21}\)  
o Good, basic infrastructure for workforce – e.g. team structure  
o Partnerships and working relationships with other private and NGO agencies (e.g. CHAP, Divisions of General Practice, YPCTS)  
o Partnerships and working relationships with Statewide Services (DASSA, C&YHS, CAMHS, Yarrow Place) | o Creating an environment where collaboration is the norm  
o Consolidation of Y&LN Community Health Service structure  
o Consolidation of Y&LN Corporate Services structure  
o Strengthen relationships and networks with Statewide Services to build the local capacity of the service e.g. DASSA, C&YHS, CAMHS, Yarrow Place  
o Continue to build on existing relationships and partnerships with public/private/NGO agencies; where possible avoid competing for funding  
o Integrated and enhanced programs that support general practice – e.g. practice nurses, mental health, chronic disease management  
o Seek Commonwealth health promotion programs and initiatives that integrate with local initiatives |

\(^{21}\) Governance and operational plans developed by the Y&LN Health Service cluster in 2009 to provide strategic and operational direction in accordance with SA Health Strategic Directions, CHSALHN Executive and Executive Director of Service Operations
8. Resources Strategy

8.1 Workforce

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

**Critical milestones:** Implementation of new models of service delivery e.g. team midwifery, succession planning; Improved support for Aboriginal people in the health services

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

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

**Critical milestones:** An infrastructure and equipment plan developed for the cluster

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
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</thead>
</table>
| o Infrastructure and equipment that meets standards and supports existing and future service delivery | o Preventative maintenance programs  
o Minor works planning  
o Capital works planning  
o Clinical Networks and other CHSALHN programs have provided equipment – e.g. point-of-care testing (iCARnet); ECG machines (CHSALHN A&E project)  
o Funding infrastructure from operating budget  
o Using local capital funds to upgrade equipment and develop infrastructure (e.g. donations, bequests, community fund raising)  
o Aged care capital funds  
o Other funding sources – e.g. one-off funding for specific infrastructure of equipment | o Develop infrastructure and equipment plan for the cluster  
| | o Develop and implement a strategic asset and maintenance register (data base) to assist forward planning  
| | o Prioritise across the cluster for infrastructure and equipment upgrades and redevelopment  
| | o Develop business cases for priority needs to pursue funding opportunities  
| | o Partnership with other agencies who have a vested interest in health infrastructure and equipment – e.g. general practice, local government |
### 8.3 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:** Establishment of MPS for Maitland/Minlaton/Yorketown

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Sustainable resources for the Yorke Peninsula to provide the services identified by community need</td>
<td>o Funding agreements with the State and Commonwealth – e.g. RPHS, HACC o Annual budget process – cluster-wide o Country staffing methodology o CHSALHN budget saving strategy</td>
<td>o Workforce strategy integrated with service planning and development o Improved use of data and information to determine changes in level of need so appropriate responses can be made o Explore new and alternate funding options e.g. partnering with other organisations in funding applications o Pursue MPS funding model for Maitland, Minlaton and Yorketown o Partnership with other agencies who have a vested interest in health infrastructure and equipment – e.g. general practice, local government</td>
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### 8.4 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>
</table>
| o Patient journeys reduced | o Telehealth and telemedicine – e.g. Rural and Remote Mental Health  
                        o ICT that supports point-of-care testing  
                        o Pathology and radiology results available via the Internet | o CareConnect Strategy – country rollout  
                        o Reduce patient journey by providing greater telehealth opportunities – e.g. specialist consultations via videoconference  
                        o Improve staff skills and confidence in using ICT modalities in daily practice  
                        o Explore opportunities/options for tele-radiology  
                        o Expand point-of-care options |
| o Safer practice           | o ICT connectivity across the cluster via a shared drive  
                        o Data collection and analysis – e.g. CME  
                        o Professional development – e-based interactive skills development programs | o Improve ICT connectivity with general practice  
                        o Improve data collection and analysis to assist with ongoing planning  
                        o Improve range and opportunities for on-line staff professional development  
                        o Improve access to eHealth and Telehealth for practitioners and clients |
## 8.5 Risk Analysis

**Objective:** Identify and manage the risks associated with implementation of the planned strategies

**Critical milestones:** A risk management and policy framework for the cluster

<table>
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<th>Outcomes</th>
<th>Existing Strategies Sustained</th>
<th>Strategies for the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Successful implementation of the service directions identified in the 10 Year Health Service Plan on the Yorke Peninsula</td>
<td>o Y&amp;LN Quality, Risk &amp; Safety Key Objectives and Programs 2009-2011 &lt;br&gt; o Y&amp;LN QRS Unit and QRS Committee &lt;br&gt; o Risk register</td>
<td>o Develop an implementation, monitoring and review strategy for the 10 Year Health Service Plans across Y&amp;LN cluster – early identification of risks &lt;br&gt; o Ongoing contribution and participation in the CHSALHN Risk Management policy framework and activities &lt;br&gt; o Greater uptake and utilisation of data collection and monitoring tool</td>
</tr>
</tbody>
</table>
9. Appendix

9.1 Leadership Structure

The Y&LN Executive Group has led the planning process, guided the development of the Plan, liaised with the Health Advisory Councils, and will oversee the ongoing monitoring and review of the Plan.

9.2 Methodology

June 2009 Planning structure established; Local Liaison Planning Officer (LLPO) appointed; HACs engaged in the planning process.

July/August 2009 Community, staff and stakeholder engagement strategy planned in partnership with HACs.

Sept-Dec 2009 Community, staff and stakeholder engagement strategy implemented; local plans and past consultations reviewed by LLPO.

The community and stakeholder engagement strategy for Yorke & Lower North (Y&LN) cluster involved:

- A community survey – a letter and survey was delivered via Australia Post to all householders in Yorke Peninsula. The survey was available on the HAC websites for electronic submission.
- A letter and survey to visiting specialists and private/visiting allied health provided information and an opportunity for written feedback.
- Community focus group discussions and public meetings facilitated by HAC members.
- Stakeholder workshops held on Yorke Peninsula involved non-government and Statewide health service providers.
- Staff focus discussion groups held at every site in the cluster.

Dec 09-Mar 2010 Findings consolidated in needs analysis – workshops with staff and stakeholders, feedback on draft needs analysis via email (nursing, senior staff, executive group, GPs).

Mar-April 2010 Draft Health Service Plan ready for CHSALHN Steering Committee, HACs and community consultation.

April-May 2010 Community consultation on draft Health Service Plan for the Yorke Peninsula.

June 2010 Re-draft Plan to include community feedback; plan to HACs for endorsement.

30 June 2010 Final Plan submitted to CHSALHN for sign off by the Minister.

9.3 Review Process

The Y&LN Executive Group will develop a review process in direct response to CHSALHN policy and direction.

Generally, community respondents indicated community discussion forums (at least annually) would provide an opportunity for ongoing community engagement and consultation. Active HAC involvement and leadership in this process was seen as important. Utilisation of Internet based communication alternatives were recommended to keep communities up to date.
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>ACAT</td>
<td>Aged Care Assessment Team</td>
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<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
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<td>AHAC</td>
<td>Aboriginal Health Advisory Committee</td>
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<tr>
<td>CACP</td>
<td>Community Aged Care Package</td>
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<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Service (Statewide Service)</td>
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<td>CHAP</td>
<td>Country Home Advocacy Program</td>
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<td>CHSALHN</td>
<td>Country Health SA Local Health Network</td>
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<tr>
<td>CME</td>
<td>Client Management Engine</td>
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<tr>
<td>C&amp;YHS</td>
<td>Child &amp; Youth Health Services (Statewide Service)</td>
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<tr>
<td>DASSA</td>
<td>Drug &amp; Alcohol Services SA (Statewide Service)</td>
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<tr>
<td>DPLG</td>
<td>Department of Planning and Local Government</td>
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<td>ECG</td>
<td>Electrocardiography</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HAC</td>
<td>Health Advisory Council</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<td>iCARnet</td>
<td>Integrated Cardiac Assessment Regional Network</td>
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<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
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<tr>
<td>LLPO</td>
<td>Local Liaison Planning Officer</td>
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<tr>
<td>MPS</td>
<td>Multi-Purpose Service</td>
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<tr>
<td>NGO</td>
<td>Non-government organisation</td>
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<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
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<tr>
<td>OHSW&amp;IM</td>
<td>Occupational Health, Safety, Welfare and Injury Management</td>
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<tr>
<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
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<tr>
<td>RPHS</td>
<td>Rural Primary Health Service</td>
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<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>SWOT</td>
<td>Analysis of strengths, weaknesses, opportunities and threats</td>
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<tr>
<td>TCP</td>
<td>Transitional Care Package</td>
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<tr>
<td>Y&amp;LN</td>
<td>Yorke &amp; Lower North Health Services cluster of CHSALHN</td>
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<tr>
<td>Y&amp;LN Executive Group</td>
<td>Provides strategic and operational direction for the cluster; Membership – Director Y&amp;LN Health Services; Manager – Corporate Services; Director – Community Health; Director – Out of Hospital Services; and two Directors of Nursing</td>
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<tr>
<td>YP</td>
<td>Yorke Peninsula</td>
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<tr>
<td>YPCTS</td>
<td>Yorke Peninsula Community Transport &amp; Services Inc</td>
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<tr>
<td>YPDGP</td>
<td>Yorke Peninsula Division of General Practice</td>
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