Government of South Australia

Health
Yorke and Northern
Local Health Network

Crystal Brook and District Hospital, Laura and District Hospital and Port Broughton District Hospital and Health Services

Service Plan

Crystal Brook, Gladstone, Laura and Port Broughton

(including hospital, Country Health Connect and mental health services)

February 2024

Foreword

On behalf of the Yorke and Northern Local Health Network (YNLHN) Executive Committee, I am pleased to present the Service Plan for Crystal Brook and District Hospital, Laura and District Hospital and Port Broughton District Hospital and Health Services.

This plan incorporates hospitals, Country Health Connect and mental health services. It complements the YNLHN Clinical Services Plan 2023 – 2028, which sets the future direction for integrated and innovative services across the Local Health Network (LHN) catchment area. Furthermore, the plan links closely with other service plans completed for other sites within YNLHN: Balaklava, Clare, Port Pirie, Mid North, Wallaroo, Yorke Peninsula, and Community and Allied Health services.

Plans covering the remaining areas of the LHN (Riverton, Burra and Snowtown) will be completed in the next 12 to 18 months.

This service plan captures what the community has told us is important to them and will guide and strengthen our clinical and community-based services now and into the future.

I wish to thank the steering group for their commitment and time overseeing the development of the plan and the many clinicians and community members who took the time to provide their valuable input.

Roger Kirchner

Chief Executive Officer

Yorke and Northern Local Health Network

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Acknowledgment

We acknowledge the Nukunu and Narungga people as the Aboriginal Custodians of the Land and Waters within the Footprint of this Service Plan.

We respect their spiritual relationship with their country and acknowledge their cultural beliefs are an important focus of the past, present and future.

We acknowledge Elders and emerging Leaders. We also pay respect to the cultural authority of Aboriginal people who contribute towards these services.

Steering Group Membership

Chairperson	
Roger Kirchner	Chief Executive Officer, Yorke and Northern Local Health Network (YNLHN)
Members	
Tess Noonan	Executive Officer/Director of Nursing and Midwifery, Crystal Brook and District Hospital and Port Broughton Hospital, YNLHN
Ryan Ackland	Executive Officer/Director of Nursing, Booleroo Centre Hospital and Laura Hospital, YNLHN
Lisa O'Dea	Nurse Unit Manager, Crystal Brook Hospital, YNLHN
Monique Button	Presiding Member, Port Broughton District Health Advisory Council
Brian Higgins	Presiding Member, Southern Flinders Health Advisory Council
Elizabeth Bennett	Maternity Unit Manager, Yorke and Northern Midwifery Group Practice, YNLHN
Deb Papoulis	Director Mental Health, YNLHN
Barbara Daw	Patient Journey Team Leader / Community and Allied Health Services Representative, YNLHN
Brett Humphrys	Director Strategy, Planning and Partnerships, YNLHN
Dr Alison Edwards	General Practitioner, Broughton Clinic
Dr KC Chen	General Practitioner, Crystal Brook Medical Practice
Kim Hewett	Senior Service Design Consultant, Planning and Population Health, Rural Support Service
Tracey Stringer	Senior Design Consultant, Planning and Population Health, YNLHN
Kirsty Palmer	Administration Support Officer, YNLHN (ex-officio)

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1. Executive Summary

The Crystal Brook District Hospital and Health Service, Laura and District Hospital and Health Service and Port Broughton District Hospital and Health Services Plan reflects the overarching future plan for health service provision in its catchment area of the YNLHN for the next five years and beyond.

The plan provides a range of information and data from a variety of sources that highlights recent patterns of service delivery and future population projections. The analysis will continue to inform a collaborative approach with key service providers to plan and develop services that meet the changing needs of the catchment population in the medium term.

The service plan identifies a range of initiatives that will support the provision of safe, quality services closer to home and is underpinned by several key strategic drivers, including:

- SA Health Clinical Services Capability Framework (CSCF)
- SA Health and Wellbeing Strategy 2020-2025
- SA Health Planning Framework
- YNLHN Strategic Plan 2020-2025
- YNLHN Clinical Services Plan 2023-2028
- YNLHN Consumer and Community Engagement Strategy 2020-2025
- YNLHN Clinician Engagement Strategy 2021-2026
- YNLHN Reconciliation Action Plan 2023-2024
- National Aboriginal Cultural Respect Framework 2016-2026

The service plan will assist the YNLHN to align with the Department of Health and Wellbeing's (DHW) desire to deliver a commissioning program which is strategic, collaborative and focused on population health outcomes. Implementation of key initiatives within the service plan will require an ongoing collaborative approach with other key service providers in order to shape services to meet the needs of the catchment population in the medium to long term.

A local steering group was convened in December 2022 to lead the service planning process. A wide range of consumers, community members, clinicians and other key stakeholders were engaged throughout the process.

The broader and ongoing involvement of clinicians, consumers, executive and other key stakeholders will be essential to progress service initiatives within the plan.

The specific service priority areas identified by the steering group were themed into six priority areas:

- Aged care
- Aboriginal health
- Mental health
- Emergency
- Medical inpatients
- Community and allied health

In addition to these service priority areas, opportunities to strengthen infrastructure, digital technology, workforce and improve the patient journey will be key enablers for this plan.

The YNLHN Executive Committee will oversee the implementation and progress of the plan and report outcomes to the YNLHN Governing Board. Additionally, an implementation plan will be developed and reviewed by the Quality Risk and Safety Operation Committee (QRSOC) at each site.

The six specific priority areas will be the core focus of the implementation plan; however, it must be noted that these services do not operate in isolation from each other. It will be essential to continually strive to work in an integrated way across priority areas to ensure effective quality services are provided.

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1.2 Summary of service improvement recommendations

The following service priority areas emerged from the service planning process with a range of specific high priority service improvements:

Accident and Emergency	• Review current accident and emergency areas for improvements to functionality • Develop and support the workforce to optimise provision of emergency services • Explore and expand models that improve emergency care and positively influence the patient journey.
Aged Care	• Redesign and increase space functionality to meet aged care standards • Support consumers and their carers to negotiate the My Aged Care portal and engage providers • Develop a sustainable and effective service model for aged care services to meet community need • Enhance community-based strategies to support the older person to stay safely within their home • Support access to appropriate services • Boost connections between the community and aged care services.
Medical Inpatients	• Review, improve and redesign facilities infrastructure to provide safe accessible services • Explore opportunities to introduce new models of care to meet community need • Investigate opportunities for sustainable and safe surgical and maternity services at Crystal Brook • Continue to develop the Transitional Care Program (TCP) model of care and short-term restorative rehabilitation programs for Port Broughton and Crystal Brook • Continue to develop clear, accessible and timely referral pathways for all services • Improve support and management for patients with mental health and or drug and alcohol issues • Continue to collaborate with local GPs to build a sustainable medical service model.
Mental Health	• Enhance infrastructure to best meet the needs of mental health consumers • Explore mental health service improvement opportunities and growth of new services to meet community need • Improve awareness and understanding of referral pathways for mental health services • Explore opportunities to building the capacity of our workforce • Support improved pathways for women and their families accessing perinatal mental health services.
Community and Allied Health	• Redesign and increase infrastructure for future growth of services • Continue to develop strategies to reduce preventable admissions • Develop sustainable and effective service models • Improve awareness and understanding of community and allied health services and referral pathways
Aboriginal Health	• Aboriginal people will have access to culturally safe and appropriate initiatives determined by local communities • Highlighted throughout each service cohort are strategies to improve the patient journey for Aboriginal people.
Collective Service Improvements	• Identify innovative ways to attract and retain workforce • Improve and address patient journey barriers • Improve our digital technology to enable collaboration for effective care coordination and streamlining reporting requirements • Build partnerships and networks with public and private providers to support and improve the health and wellbeing of the community.

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2. Project background and context

Service planning developing a strategic approach to improving health service delivery as part of the broader system to meet the current and emerging health needs of populations, catchments or specific clinical stream cohorts.

The health system in South Australia is complex and diverse. Therefore, it is essential that service planning is performed with adequate consideration of and integration with the system as a whole. Health service planning allows us to build on the broad strategic directions of the health system, investigate local health service data, examine integration with the system at large, explore population trends and consumer needs, and articulate a future plan for meaningful service provision priorities.

This service plan aims to provide a framework for identifying and evaluating potential future service options for the health services to meet the needs of consumers in the Crystal Brook, Laura and Port Broughton catchments over the next five years and beyond.

Overseen by the Crystal Brook, Laura and Port Broughton Steering Group, the plan has been developed using a co-design approach involving extensive collaboration with our consumers, clinicians, staff, Health Advisory Councils and the YNLHN Executive and Governing Board.

Co-design is more than just consultation; it involves reflection on the current environment and a joint exploration of creative solutions to local issues. There is an emphasis on local leadership, acknowledging the expertise of our staff by utilising their knowledge and experience to work with our consumers at the centre of the planning process. This ensures the development of respectful partnerships, demonstrated shared understanding and a commitment to co-create our future services.

The co-design process involved reviewing a broad range of data, underpinned by state and national policies and evidence based best practice, to support our clinicians and consumers to determine appropriate future key service priorities and service improvement initiatives. All models of care consider clinical risk and efficiency.

2.1 Strategic enablers

Several strategic frameworks and enablers have informed and provided strategic direction for the plan. These include:

SA Health and Wellbeing Strategy 2020 – 2025

The SA Health and Wellbeing Strategy 2020 – 2025 sets the scene for health system planning, providing the overarching vision for the next level of more localised and connected LHN service planning. The aim and goals of this strategy provide a focus for the improvement efforts across the system to improve the health and wellbeing of all South Australians.

The goals of the Health and Wellbeing Strategy are to:

- improve community trust and experience of the health system
- reduce the incidence of preventable illness, injury and disability
- improve the management of acute and chronic conditions and injuries
- improve the management of recovery, rehabilitation and end of life care
- improve individual and community capability to enhance health and wellbeing
- improve the health workforce to embrace a participatory approach to health care
- improve the patient experience with the health system by positioning ourselves to be able to adopt cost-effective emerging technologies and contemporary practice

- improve the value and equity of health outcomes of the population by reducing inefficiencies and commissioning for health needs.

SA Health Planning Framework

The SA Health Planning Framework was developed as a resource to strengthen health system and health service planning, align the process of planning across the system and to define governance, roles and responsibilities in planning. The Framework supports the SA Health and Wellbeing Strategy 2020-2025 and is intended to align closely with the SA Health Commissioning Framework March 2020 and the SA Health Performance Framework 2020-2021.

The purpose of the framework is to:

- support planning concepts to align with identified key focus areas of population health needs
- provide the SA Health system with a high-level understanding of our approach to planning
- provide the SA Health system with an understanding of how planning activities are prioritised
- support the increase of efficiencies through the improved decision-making and appropriate planning
- provide a high-level explanation of the connection between planning, commissioning and infrastructure planning
- support a collaborative and integrated approach to planning to aid in providing safe, high-quality services.

Other strategic enablers that informed the service plan

Several other frameworks, plans and forums have informed the development of the Crystal Brook and District Hospital, Laura and District Hospital and Port Broughton District Hospital and Health Services Health Service Plan and will continue to be essential in implementation:

- South Australian Rural Medical Workforce Plan 2019-2024
- South Australian Rural Aboriginal Health Workforce Plan 2021-2026
- Aboriginal Health Care Framework 2023-2031
- South Australian Mental Health Services Plan 2020-2025
- SA Rural Nursing and Midwifery Workforce Plan 2021–2026
- SA Rural Allied and Scientific Health Workforce Plan 2021–2026
- Rural SA Ambulance Service Workforce Plan 2020–2025

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Yorke and Northern Local Health Network (YNLHN) Strategic Plan 2020-2025

The plan has been developed in close collaboration with staff, consumers and key stakeholders, in line with the YNLHN Strategic Plan 2020-2025.

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YNLHN Clinician Engagement Strategy 2021-2026

The YNLHN Clinician Engagement Strategy 2021-2026 outlines how the YNLHN will engage and work together with clinicians to plan, design, and deliver health services during 2021-2026.

Our clinicians have a high level of influence over consumer care and require the organisation's support with resources and collaborative leadership to professionally deliver health services to the local communities.

- We will engage with our clinicians:
- To ensure the provision of effective health services.
- To ensure and improve the safety and quality of health services.
- In the planning and design of health services.
- In the monitoring and evaluation of service delivery.

YNLHN Consumer and Community Engagement Strategy 2020-2025

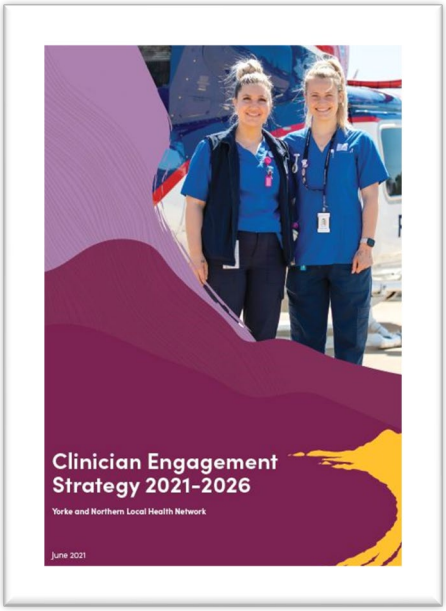
The YNLHN Consumer and Community Engagement Strategy 2020-2025 was released by the YNLHN Governing Board in April 2021. This development of the strategy was supported by comprehensive community consultation to ensure it highlights the value and importance of the consumer's voice and how we will continue to partner with our consumers and community members to improve and deliver genuine consumer-centred health services.

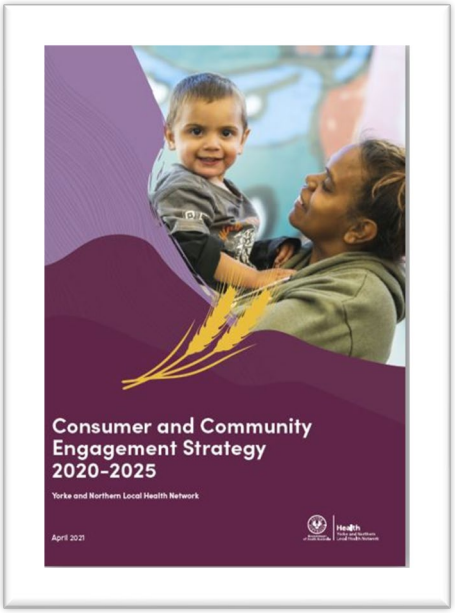
YNLHN Clinical Services Plan 2023-2028

The YNLHN Clinical Services Plan 2023-2028 describes the future aspirations for the delivery of safe, high quality, efficient and effective services as close to home as possible for all in the Yorke and Northern communities.

It outlines our clinical service priorities over the next five years to ensure we can improve our levels of self-sufficiency where safe and sustainable. The plan represents an important step in our journey to provide services that enhance the health and wellbeing of our consumers, promote innovation in the design and delivery of contemporary services and will align closely and underpin our local service plans.

Integral to the implementation of the Crystal Brook and District Hospital, Laura and District Hospital and Port Broughton District Hospital Service Plan is to ensure all recommendations in each priority table is considered and reviewed in conjunction with the YNLHN Clinical Services Plan 2023-2028.





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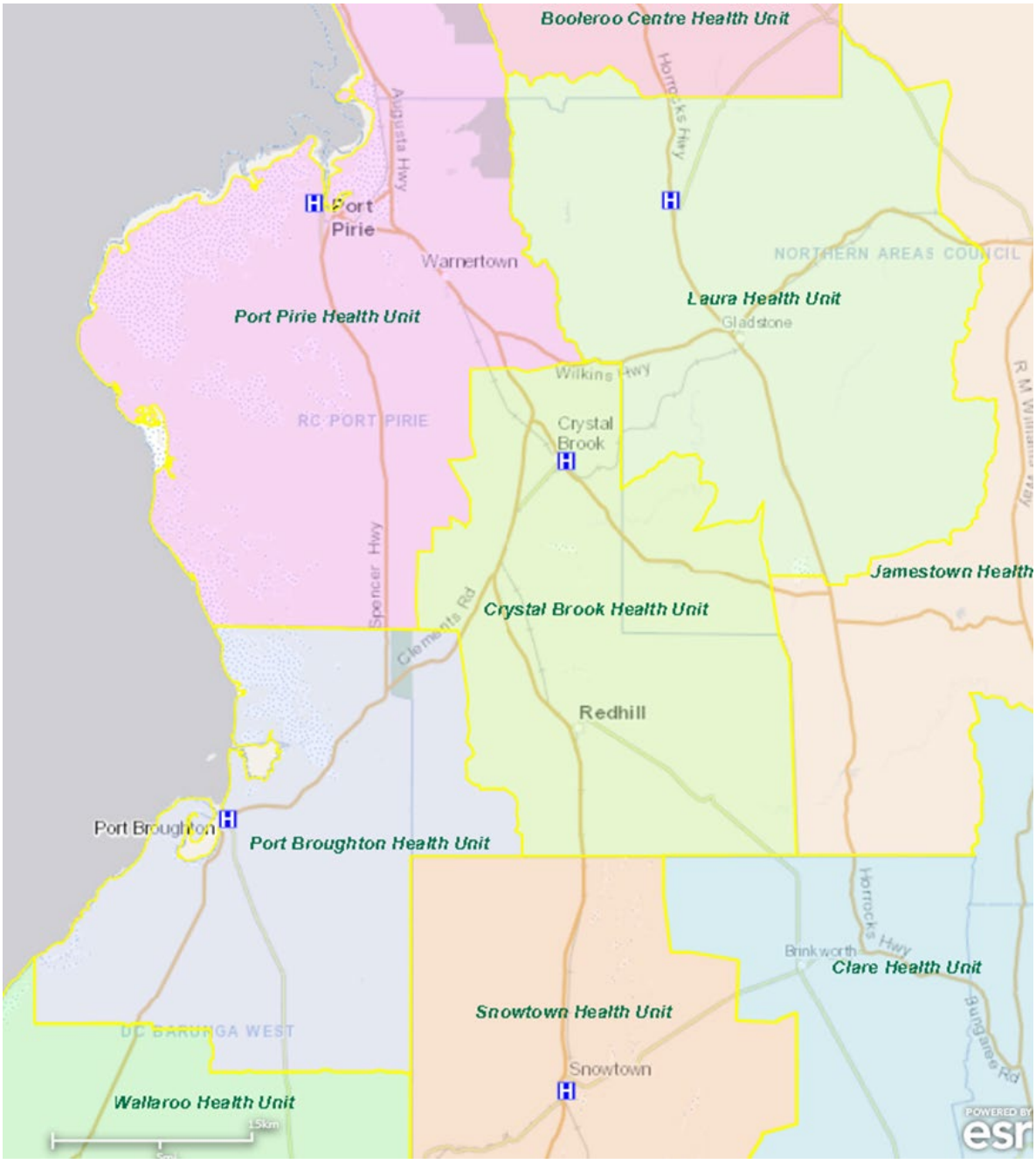
3. Service catchment profile

The Crystal Brook Hospital is physically located in the Port Pirie Region SA2. The geographical catchment area for the Crystal Brook Hospital (Health Unit) is part of the Port Pirie SA2, and also extends into part of the Jamestown SA2. The Laura Hospital is physically located in the Jamestown Statistical Area 2 (SA2). The geographical catchment area for the Laura Hospital (Health Unit) is part of the Jamestown SA2. The Port Broughton Hospital is physically located in the Wakefield – Barunga West SA2. The geographical catchment area for the Port Broughton Hospital (Health Unit) is part of the Wakefield – Barunga West SA2.

Further information on geographical catchments areas for health units and regional Local Health Networks is available on the www.sahealth.sa.gov.au/regionalhealth.



Source: SA Health Data and Reporting Services Branch,
Crystal Brook catchment indicated by light green shading; Port Broughton by light purple shading and Laura by light green shading

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Snapshot of Crystal Brook

Catchment population of
2,097

Total resident population of Crystal Brook catchment is projected to remain stable with a small growth by 2036.

24%
are aged aged 65+ and 20% are aged 14 years and under

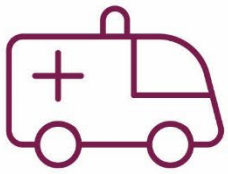
(higher proportion aged 14 and under and much higher proportion aged 65-84 compared to SA Population)

2.4%
of people in the catchment area identify as Aboriginal and/or Torres Strait Islander

2.5%
of people in the catchment area speak a language other than English at home

(lower proportion compared to SA Population)

1,041
emergency presentations in 2021/22



112 triage 1 or 2 presentations, 253 triage 3 presentations, and 676 triage 4 or 5 presentations

81%
self-sufficiency* in 2021-22.
19% separations flowed out of YNLHN

13
inpatient beds
with average 5.6 occupied each night (2021-22)

12
aged care beds
with average 10.3 occupied each night (2021-22)

55
pregnant women cared for.

34 of those women birthed at Crystal Brook

Home help was one of the highest one to one contacts for community and allied health with

1,492 contacts

Crystal Brook catchment residents were more likely to report **arthritis, diabetes, heart disease and mental health problems**
compared to South Australian and Australian rates.

Sources: 2021 Census data, 2021/22 activity data / CCCME data, Aged Care Liaison officer.

self sufficiency = *Self-sufficiency measures the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital or LHN, or elsewhere within SA.

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Snapshot of Laura

Catchment population of **2,008**

Total resident population of Laura catchment is projected to remain stable with a small growth by 2036.

25% are aged aged 65+ and 18% are aged 14 years and under

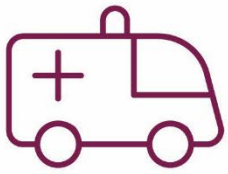
(much higher proportion aged 65-84 compared to SA Population)

3.2% of people in the catchment area identify as Aboriginal and/or Torres Strait Islander

2.4% of people in the catchment area speak a language other than English at home

(lower proportion compared to SA Population)

604 emergency presentations in 2021/22



57 triage 1 or 2 presentations, 231 triage 3 presentations, and 316 triage 4 or 5 presentations.

73.5% self-sufficiency* in 2021-22.
26.5% separations flowed out of YNLHN

5 inpatient beds with average 2.7 occupied each night (2021-22)

12 aged care beds with average 10.8 occupied each night (2021-22)

Home help was one of the highest one to one contacts for community and allied health with **1,455** contacts
(Laura and Gladstone)

Laura catchment residents were more likely to report **arthritis, and diabetes**
compared to South Australian and Australian rates.

Sources: 2021 Census data, 2021/22 activity data / CCCME data, Aged Care Liaison officer.
self sufficiency = *Self-sufficiency measures the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital or LHN, or elsewhere within SA.

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Snapshot of Port Broughton

Catchment population of

1,747

Total resident population of Port Broughton catchment is currently projected to remain stable with a small growth by 2036, however there is potential significant growth due to land division applications.

26%
are aged aged 65+ and 18% are aged 14 years and under

(much higher proportion aged 65-84 compared to SA Population)

2.5%
of people in the catchment area identify as Aboriginal and/or Torres Strait Islander

0.8%
of people in the catchment area speak a language other than English at home

(lower proportion compared to SA Population)

960
emergency presentations in 2021/22

34 triage 1 or 2 presentations, 148 triage 3 presentations, and 778 triage 4 or 5 presentations.

74.6%
self-sufficiency* in 2021-22.
18.6% separations flowed out of YNLHN

16
inpatient beds
with average 4.3 occupied each night (2021-22)

27
residential Transitional Care Packages (TCP) supported at Port Broughton

2022/23

Home help was one of the highest one to one contacts for community and allied health with

1,757 contacts

Port Broughton catchment residents were more likely to report **arthritis, diabetes, asthma, heart disease and cancer**
compared to South Australian and Australian rates.

Sources: 2021 Census data, 2021/22 activity data / CCCME data, Aged Care Liaison officer.
self sufficiency = *Self-sufficiency measures the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital or LHN, or elsewhere within SA.

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4. Service planning process

4.1 Overview

The service planning process was led by the Crystal Brook, Laura and Port Broughton Steering Group with representation from local Health Advisory Councils, GP Clinics, YNLHN Executive, hospital, and community health staff (full details of the membership and the role of the steering group are provided on page 4).

The steering group met monthly in the implementation of the co-design health service planning framework. A range of clinicians, consumers, community members and stakeholders contributed to the development of the service plan via participation in workshops, surveys, focus groups and interviews.

The role of the steering group was to:

- Gain a comprehensive understanding of the current service and context
- Define insights into the opportunities that exist
- Identify ideas for future improvements
- Develop a draft service plan based on advice and recommendations from engagement processes and the examination of quantitative and qualitative data.

The steering group endorsed a 'service profile' containing population and service utilisation data, that provided the foundation for the data gallery displayed at the clinician engagement workshop. In addition, following each steering group meeting, a meeting summary outlining discussion points, issues, and actions were prepared and distributed.

4.2 Engagement

4.2.1 Clinician engagement

Various engagement methods were identified and used to assist the steering group in developing a service plan that adequately considers meaningful active discussions with clinicians and consumers alongside the relevant data and contemporary best practices.

A clinician engagement workshop was held on the 17 May 2023 as part of the co-design planning process for Crystal Brook, Laura and Port Broughton Health Services. The process considers hospitals, community health and mental health services. The workshop was attended by a range of clinical stakeholders, including YNLHN clinical staff (nursing, mental health and allied health), aged care providers, local GP representatives, South Australian Police Service (SAPOL), South Australian Ambulance Service (SAAS), Health Advisory Council Presiding Members and representatives from YNLHN Executive.

55 participants attended the workshop. An online survey was also provided to ensure there was an opportunity for those who could not attend to provide feedback.

Workshop format

The workshop commenced with dinner and the opportunity view a data gallery. Participants were able to view, discuss, ask questions and provide comments on a large range of information and statistical data related to current services. Small table discussions were held in groups, each focusing on a specific priority service area selected by the service planning steering group including:

- General medical (including cancer care, palliative care, obstetrics, surgical services)
- Mental health
- Aged care
- Out of hospital strategies
- Patient journey

Implications for the workforce, infrastructure and priority population groups were also considered as part of each of the groups' discussions.

Participants were able to choose two groups to join for a 30 minute discussion. The following questions were used to guide the conversations:

- What are our current strengths and challenges?
- What opportunities exist for the future? What will help or hinder?
- What strategic advice would you provide to the steering committee?

4.2.2 Community engagement

The service planning steering group endorsed a community engagement process to gain community, consumer and stakeholder input on hospital, Country Health Connect and mental health services in the Crystal Brook, Laura and Port Broughton catchment areas.

The aim of the engagement was to gain feedback regarding current services, key challenges and opportunities from perspectives of community, consumers and partner organisations to assist the steering group to determine future service directions.

The approach used a range of methods to inform the general community and key partners about feedback opportunities.

During April and May 2023, the following opportunities were provided:

- Drop in sessions
- Focus groups
- One to one interviews
- Electronic surveys via a QR code promoted on flyers at local health services and public notice boards
- Hard copy surveys available at the local pharmacies, medical centres, supermarkets and the hospital within each town and in smaller surrounding towns
- One on one telephone feedback

Communications about the approach included:

- Articles in local newsletters
- Media articles
- Radio and television interviews
- Targeted Facebook posts
- Updates via the local Health Advisory Committees

Over 400 hard copy surveys and flyers with the QR code linking to the electronic survey were distributed within Bute, Crystal Brook, Laura, Gladstone and Port Broughton. Survey return boxes were provided at local pharmacies, supermarkets, hospitals and medical centres. A survey specifically for young people was promoted at local schools.

A total of 165 completed surveys were received, 101 electronic, 55 hard copies and 9 responses from young people.

Community members were invited to indicate via the survey if they were interested in sharing their experiences, and as a result four consumer interviews were conducted. One consumer was identified through the Aboriginal Health Experts by Experience register.

Four focus groups were conducted with a total of 56 participants attending the following groups:

- Laura and District Combined Probus Club (32)
- Port Broughton Community Shed (6)
- Port Broughton Lifestyle Group (6)
- Port Broughton Day Centre (12)

Four “drop-in and have your say sessions” were held in the following towns with a total of 117 attendees:

- Crystal Brook (30)
- Gladstone (23)
- Laura (23)
- Port Broughton (41)

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4.2.3 Our consumers

Consumer stories

Stories and feedback from our consumers provide us with real life experiences to help identify opportunities for improvements. These stories were chosen to demonstrate the issues these consumers faced when accessing health services and what would have improved their experience.

Jenny's story – mental health

Jenny has moved from Adelaide to a small country town in the Mid North. She has struggled with anxiety and depression for many years.

"My main concern is the mental health capacity here. It's almost non-existent. I don't drive, mainly due to my mental health, so getting to Pirie is a problem for me. I do have a psychologist, she is in Adelaide; we do telehealth. But she and I have learned that telehealth is not as effective as face to face. When using telehealth, you can miss cues and you tend to miss out on the important things that you would usually add into the conversation. Sometimes you've got delays and pixelation, so some part of your brain knows it's not real. I find myself editing out things that I really should be talking about. I'm assuming it's the same for other people. It's more valuable face to face, but it's hard getting to Adelaide."

Jenny highlighted other challenges such as transport not being easily accessible or affordable. *"There is a bus that runs once a day so it means you have to have an overnight stay, so you need to consider if you can afford it. I know that there is a scheme where I can ask for that money back (PATS). It is not ideal as you still need to pay upfront which is hard if you don't have that money".*

Jenny reinforced that patient centered care is essential *"I know what I have been through, so I am the best person to understand what is happening with my body. I know how to listen to my body. It has been like 25 years that I have struggled with anxiety and depression".*

Jenny went on to discuss the lack of promotion of services. *"I am concerned about the lack of crisis care promotion that is available. It would be good to have information in the library, pubs, community blackboards. Beyond Blue and helplines would be useful. There is little knowledge of any services here. There's nothing promoted that might make it easier for people to access services."*

John's story - aged care services

John, a hard-working farmer, dedicated his life to the farm alongside his wife Jenny. Over the years, John's health gradually deteriorated, making it difficult for them to continue living on the farm. Hence, they made the decision to move into town until Jenny was no longer able to care for John full time at home.

"We needed some assistance so had an aged care assessment. There is so much information I was trying to read and understand it all. There isn't anywhere that supports people like me that aren't educated, no one explained that you can have "care at home". It's that simple wording that is needed. I just didn't know what people meant by a package. So, we muddled through".

"I think what's actually needed is someone that can help you through the system in easy plain language. Our age group aren't used to computers, so it needs to be kept simple. People don't know where to go. Community nursing are great, but they just don't have the capacity".

Support groups are useful, "*I used to go to Alzheimer's group, it was a small group that met monthly. It was great to be with others that have similar situations. The group was very helpful for everyone. Unfortunately, it stopped, and I don't think it's going again".*

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Consumer Feedback

"Mental health services could be more accessible and active in the community to dissolve stigma around

"I have diabetes and my feet got really bad was meant to be admitted to hospital. The hospital organised a cannula and I was able to go to the hospital for 4 x daily IV therapy. I was then able to continue to go to work in between time. A good outcome".

"I feel safe raising my family in a town with a local hospital. It's also reassuring for our aging parents. It's a wonderful service to have available in town".

Assistance with communicating to My Aged Care and knowledge of our home services, needs to be available to people born before computers".

"There is little knowledge of any services here there's nothing promoted that might make it easier for people to access services."

"Childcare is a challenge for staff, sometimes they would like to work more but aren't able to access childcare".

"Extension to community-based services to include services that older people cannot do themselves such as cleaning windows inside and outside (not much sense doing outside and not inside) as one gets older encouraged not to get on step ladders etc, also gardening, most older people find starting and mowing lawns etc not possible".

"We try to keep people in their own homes for as long as possible. We are told carers need to look after themselves and do the things we would like to do. If there is no care that we can have a day doing things and no family in the area how can this happen. Even if we could have respite for a day in hospital or aged care would be helpful. It also means we won't need to miss out of family events".

"The health system is extremely difficult to navigate, and the local health nurse is bombarded with people in complete frustration".

"Having Doctors, visiting Doctors and Specialists, Midwives and Nursing staff and hospitals available to meet our local needs is a critical factor in keeping our communities functioning".

5. Service Plan

Service capacity

The three hospitals included in this plan are part of the YNLHN. They are small grant-funded hospitals providing a range of accident and emergency, acute inpatient, community health, mental health, and various associated clinical support services.

- Crystal Brook and District Hospital has 13 acute beds and 12 aged care beds.
- Laura and District Hospital has five acute beds and 12 aged care beds.
- Port Broughton District Hospital and Health Service has 16 acute funded beds.

Yorke and Northern Community and Allied Health Services (Country Health Connect) provide a range of centre-based and community-based allied health and specialty nursing services. Community health services are co-located on site. Furthermore, Gladstone Health Centre is managed by Country Health Connect. Mental health services are provided as both centre-based and community-based services and are located off-site. Maternity services are provided at Crystal Brook and District Hospital and are supported by the YNLHN Midwifery Group Practice.

Clinical Services Capability Framework

The SA Health Clinical Services Capability Framework (CSCF) 2016 has been designed to guide a coordinated and integrated approach to health service planning and delivery in South Australia. The CSCF is a set of 30 service modules for clinical service areas. The modules detail the minimum service and workforce requirements, risk considerations and support services to provide safe and quality care at South Australian public hospitals. It is an important tool for state-wide planning and defines the criteria and capabilities required for health services to achieve safe and supported clinical service delivery. It also provides planners and clinicians with a consistent approach to how clinical services are described and identifies interdependencies between clinical areas. For regional LHNs, it helps to plan what services can safely and reasonably be provided close to home and what services will need to involve travel to and partnerships with a metropolitan-based health services.

The information in the service priority tables below is articulated regarding the CSCF level criteria currently assigned to Crystal Brook and District Hospital, Laura and District Hospital & Port Broughton District Hospital and Health Services.

Service improvement priorities

The priority tables below outline the proposed service planning priorities for Crystal Brook and District Hospital, Laura and District Hospital & Port Broughton District Hospital and Health Services for the next five years and beyond.

Accident and Emergency

Current Clinical Services Capability

Crystal Brook, Laura and Port Broughton provide level 2 emergency services based on the Clinical Services Capability Framework (CSCF), including:

- on site, 24-hour access to nursing staff and triage of all presentations
- capable of providing initial treatment and care for all presentations, and provide interim care to enable rapid transfer of major trauma
- provide resuscitation and stabilisation prior to transfer to higher level service
- medical practitioner available on call 24 hours.

Current Service Summary

There were 1,041 emergency presentations at the Crystal Brook and District Hospital in 2021-22. This is broken down by 112 triage 1 or 2 presentations, 253 triage 3 presentations, and 676 triage 4 or 5 presentations.

There were 604 emergency presentations at the Laura and District Hospital in 2021-22. This is broken down by 57 triage 1 or 2 presentations, 231 triage 3 presentations, and 316 triage 4 or 5 presentations.

There were 960 emergency presentations at the Port Broughton Hospital in 2021-22. This is broken down by 34 triage 1 or 2 presentations, 148 triage 3 presentations, and 778 triage 4 or 5 presentations.

- A registered nurse offers assessment and treatment, and a doctor is available on call.
- 24/7 service meeting triage times.
- GP led on call service.
- South Australian Virtual Emergency Service (SAVES) can be accessed from 7.00pm to 7.00am for category 3, 4 and 5 presentations.
- Includes medical imaging – plain film X-Ray.
- Provide triage, assessment and treatment of all presentations including planned and unplanned presentations.
- Stabilisation and resuscitation of critically unwell patients.
- Minor procedures.

- Coordinate and collaborate remotely with Metropolitan services for care prior to transfer.
- Coordinate and collaborate care with SAAS MedSTAR state-wide retrieval services.
- Admit and manage where appropriate.

Future Service Proposal	
Maintain the level 2 accident and emergency care provided by Crystal Brook and District Hospital, Laura and District Hospital & Port Broughton District Hospital and Health Services to meet future demand by seeking improvements in the following areas:	
Service improvement recommendations	
AE1: Review current accident and emergency areas for improvements to functionality:	
AE1.1	Assess and review Laura Emergency Department for workflow improvements, including equipment and fixtures.
AE2: Develop and support the workforce to optimise provision of emergency services:	
AE2.1	Link and contribute to the YNLHN Security Working Party to develop strategies to support staff and patient safety.
AE2.2	Establish a program with larger sites to provide opportunities for interested staff to upskill in emergency care and optimise training opportunities.
AE 3: Explore and expand models that improve emergency care and positively influence the patient journey by considering:	
AE3.1	Working closely with GP clinics to develop a strategy to ensure complex repeat emergency department presentations are identified and referred to appropriate services.
AE3.2	Exploring innovative ways of delivering responsive mental health care to people who present to the Emergency Department.
AE3.3	Working collaboratively with metropolitan hospitals to develop models that support GPs to have the ability to bypass emergency departments and have a bed allocated when transferring to metropolitan area.

AE3.4	In conjunction with the LHN, review and develop a service model to improve linkages with larger Yorke and Northern sites to support provision of timely x-ray, access to on call GPs and SAAS transfers to improve the patient journey.
AE3.5	Working closely with Community and Allied Health to improve referral pathways by ensuring “a no wrong door policy” when accessing allied health services and ensure that referrals are attended to in a timely manner.
AE3.6	Increasing promotion of statewide telephone support services in emergency departments and widely within our communities including: • Mental Health Triage Service 13 14 65 • Lifeline 13 11 14 • DASSA Alcohol and Drug Information Service (ADIS) – a confidential telephone counselling, information and referral services for the general public, students and health professionals, staff by trained professionals with experience in the alcohol and other drug field. • 13YARN (13 92 76) for Aboriginal and Torres Strait Islander communities – a 24/7 national crisis support line for Aboriginal and Torres Strait Islander people feeling overwhelmed or having difficulty coping. • Healthdirect – 1800 022 222.

Aged Care

Current Service Summary
Crystal Brook and Laura are multipurpose sites, have 12 beds each and share staff across the aged care and acute settings. Port Broughton have the capacity to have residential Transitional Care Packages as required. Home Care Packages are delivered through Country Health Connect.
Future Service Proposal
Maintain and enhance the services provided by the health services and assist the community to navigate aged care services:
Service Improvement Recommendations:
AC1: Redesign and increase space functionality to meet aged care standards considering:

AC1.1	Redesigning bathrooms at Crystal Brook and Laura (removing double rooms and shared bathrooms).
AC1.2	Room size in future infrastructure upgrades.
AC2: Support consumers and their carers to navigate the My Aged Care portal and engage providers:	
AC 2.1	Improve access and raise awareness of services available from Council on the Ageing South Australia (COTA SA) and Country Health Connect.
AC2.2	Provide accessible information both online and in person about the range of services that are available and update local newsletters about services and good new stories.
AC2.3	Continue to support frontline staff with training to enhance their understanding of how to work effectively with low health literacy populations and ensure all resources are in plain simple language.

AC2.4	Engage interim services for consumers waiting for a care package and communicate effectively regarding available options.
AC3: Develop a sustainable and effective service model for aged care services to meet community need:	
AC3.1	Establish an agreed service model for allied health services provided in residential aged care, including funding and strategies to upskill and train staff.
AC3.2	Build capacity for allied health assistants to supervise therapeutic intervention e.g. exercises in between allied health professionals (AHP) visits.
AC3.3	Explore opportunities to increase residential aged care diversional therapy time and increase volunteer time.
AC3.4	Advocate for increased in home and short-term respite (in hospital) services for consumers in the catchment area.
AC3.5	Investigate opportunities to increase geriatrician services across the YNLHN (including Nursing Practitioners).
AC3.6	Identify the capacity of each site to manage bariatric and high-risk residents and develop a LHN wide pathway that supports consumers to access a safe environment within the right service.
AC4: Enhance community based strategies to support older people to stay safely within their homes:	
AC4.1	Work closely with our partners to promote transport services available for medical appointments.
AC4.2	Increase Home Care Package workforce including home care and maintenance and gardening staff.
AC4.3	Advocate for increased Strong and Steady sessions, leisure and lifestyle hours and expand awareness about these programs in the region.
AC 5: Support access to responsive services:	
AC5.1	Assist Aboriginal consumers to be supported in their homes and if residential care is required, ensure care is culturally responsive and within the local area.

AC5.2	Installation of cultural artworks at sites, co designing with Aboriginal Elders.
AC5.3	Increase Aboriginal Home Support Workers in the local area, considering gender specific roles.
AC5.4	Link with Non-Government Organisations (NGOs) to access Care Finder services to support vulnerable populations to access aged care services.
AC 6: Boost connections between the community and aged care services:	
AC6.1	Link closely with LHN and partners to map current services, including public, private services and NGOs and develop a communication strategy to promote services.
AC6.2	Develop a formal leisure and lifestyle network within the YNLHN to support the diverse options available to consumers.
AC6.3	Investigate options to develop a community of practice for private and public aged care services.
AC6.4	Investigate options for joint committees (e.g., medication advisory committee), information sharing, and innovation across agencies.
AC6.5	Seek support from partners, Council and Regional Development Australia (RDA) to find and apply for grants.
AC6.6	Grow programs with schools and kindergartens to enhance mutual support for leisure activities e.g., Crystal Brook Aged Care and the kindergarten relationship.
AC6.7	Investigate access to transport for medical and community services for consumers living in Gladstone and Wirrabara.

Medical Inpatient Services

Current Clinical Services Capability

All sites provide level 2 medical services based on the Clinical Services Capability Framework (CSCF):

- Providing both an ambulatory and inpatient service, including overnight nursing care and patients under the care of medical practitioners.
- Inpatient services usually provided for low to medium acuity, single-system medical conditions with significant but stable co-morbidities.
- Crystal Brook provides level 3 adult surgical services and obstetric services.

Current Service Summary

The Crystal Brook Hospital has 13 inpatient beds available, with an average of 5.6 occupied each night in 2021-22.

The Laura Hospital has five inpatient beds available, with an average of 2.7 occupied each night in 2021-22.

The Port Broughton Hospital has 16 inpatient beds available, with an average of 4.3 occupied each night in 2021-22.

All sites provide:

- day and inpatient overnight care for medical patients for both planned and unplanned admissions
- stabilisation of patients prior to transfer where higher level of care is required
- liaison with metropolitan services to coordinate care prior to transfer
- palliative care
- Crystal Brook provide surgical and obstetric services.

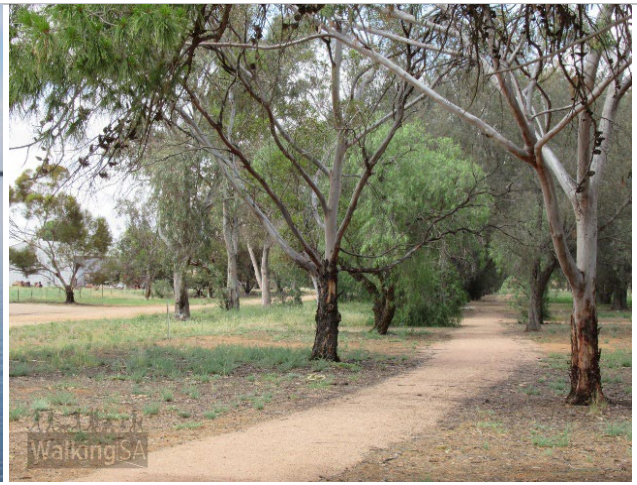
Future Service Proposal

Maintain level 2 medical inpatient services and enhance patient care by seeking improvements in the following areas:

Service Improvement Recommendations:	
MI 1: Review, improve and redesign facilities infrastructure to provide safe accessible service:	
MI.1	Improve security at nurses' stations for all sites. Develop a master plan for each hospital health site: **Crystal Brook:** • Paint acute rooms, relocate the SAVES unit, examine future acute facility needs. • Install swipe card access to all areas. **Laura:** • Refurbish ensuite bathrooms. • Improve security by installing security card access. • Paint acute rooms. • Upgrade the electrical system. **Port Broughton:** • Relocate the medication room at Port Broughton District Hospital • Complete the kitchen project. • Support the courtyard and accommodation development project.
MI 2: Explore opportunities to introduce new models of care to meet community need:	
MI2.1	Develop a business case for a YNLHN Discharge Planner role to manage complex discharges, considering a multidisciplinary approach and exploring revenue options to support the model.
MI2.2	In conjunction with the LHN develop a model of care to support cancer clients to have treatment closer to home.
MI2.3	Continue to develop and evaluate the multi-disciplinary meetings for complex clients to ensure seamless service, support and coordination of care.

MI2.4	Explore opportunities that enable all clinicians to work to their full scope of practice by mapping credentials/skills across all sites.
MI2.5	Support the implementation of the Aboriginal Maternal & Infant Care (AMIC) Service.
MI2.6	Develop a local in-service model of care for Aboriginal people in the local catchment area.
MI3: Investigate opportunities for sustainable and safe surgical and maternity services at Crystal Brook considering:	
MI3.1	Explore the feasibility and viability of a range of low-risk surgical and maternal services to meet consumer needs: • Investigate infrastructure needs • Sustainable workforce models, including suitably credentialed operating theatre staff. • Compliance with emerging standards • Investigate contemporary models of care.
MI3.2	Develop a network wide referral pathway for consumers to access high risk surgical services and maintain referral pathways for high-risk birthing.
MI4: Continue to develop the Transition Care Program (TCP) model of care and short-term restorative rehabilitation programs for Port Broughton considering:	
MI4.1	• Investigate opportunities to increase diversional therapy for TCP patients. • Increase access to allied health services. • Develop clear referral pathways for transfer from larger sites.
MI 5: Continue to collaborate with local GPs to build a sustainable medical service model:	
MI5.1	Work in partnership with the local GPs and the Rural Doctors Workforce Agency (RDWA) to support initiatives for the recruitment and retention of GPs to ensure sustainable service for the future.
MI5.2	In conjunction with the LHN, implement strategies in the SA Rural Medical Workforce Plan 2019-24.
MI5.3	In conjunction with the LHN, advocate for a local YNLHN rural generalist training program.

MI6: Continue to develop clear, accessible and timely referral pathways for all services by:	
MI6.1	Strengthening linkages with local GPs, allied health professionals, metropolitan stakeholders and mental health service providers to increase understanding about available services and programs.
MI 7: Improve support and management for patients with mental health and or drug and alcohol issues considering:	
MI7.1	• Strengthened linkages with DASSA to enhance services for consumers presenting with alcohol and other drug issues. • Review the YNLHN model of care with expanded DASSA service availability. • Increase YNLHN staff skills to work with patients with drug and alcohol withdrawal.



Mental health

Current Clinical Services Capability

The Crystal Brook, Laura and Port Broughton Hospitals provide level 2 mental health acute adult/youth inpatients based on the Clinical Services Capability Framework (CSCF):

Capable of providing limited short-term or intermittent inpatient mental health care to low-risk/ complexity voluntary adult mental health consumers.

Provide general health care and some mental health care 24 hours a day, delivered predominantly by one or more general health clinicians within a facility without dedicated mental health staff (on site) or allocated beds. Medical services are provided on site.

Service provision typically includes assessment, brief intervention and monitoring, consumer and carer education and information, documented case review, consultation-liaison with higher-level mental health services and referral, where appropriate brief and/ or basic assessment and intervention, consumer and carer education, primary care and prevention programs and referral where appropriate.

Voluntary admissions to mental health consumers who can be appropriately managed in a hospital environment.

Initial mental health assessment (mental state examination and risk assessment).

Current Service Summary

The Mid North Mental Health Team Ambulatory Service operates Monday to Friday 9am to 5pm providing:

- Specialist mental health assessment, crisis intervention and care coordination for voluntary and involuntary consumers aged 16 years and over presenting with serious and/or severe mental health conditions.
- Duty work service.
- Assertive community intervention.
- Multi-disciplinary team.
- Visiting consultant psychiatrist.
- Access to tele- psychiatry assessment.
- 24/7 urgent mental health assistance via rural and remote Emergency Triage and Liaison Service (ETLS) 13 14 65.

Future Service Proposal

Maintain level 2 mental health inpatient services and level 4 ambulatory mental health services from Mid North Mental Health Team by seeking improvements in the following areas:	
Service Improvement Recommendations	
MH1: Enhance infrastructure to best meet the need of mental health clients considering:	
MH1.1	Identify and redesign mental health low stimulus environments.
MH2: Explore mental health service improvement opportunities and growth of new services to meet community need:	
MH2.1	Continue to explore new and innovative ways to deliver services to meet the needs of communities with populations of under 5,000 people.
MH2.1	Foster the pathway for people living in the catchment to increase access to the Mental Health Alternate Care Service in Port Pirie.
MH2.3	Investigate access to sub-acute services (stepdown care from hospital to the community) and develop peer support models with NGOs to support clients returning to their community.
MH2.4	Seek to improve integration and collaboration between acute services and our mental health team to support consumers with mental health conditions.
MH2.5	Explore digital technology options to increase access to mental health services and ETLS within the emergency department and for acute admissions.
MH2.6	Work closely with NGOs and the community to promote crisis care and early intervention services.
MH3: Improve awareness and understanding of referral pathways for mental health services considering:	
MH3.1	Work collaboratively with the Primary Health Network, to develop clear, easily accessible information about the mental health services provided by NGOs and YNLHN and referral pathways (no wrong door policy) for service providers.
MH3.2	Foster linkage between local clinicians and statewide eating disorder services for more specialised interventions.

MH4: Support improved pathways for women and their families accessing peri mental health services including:	
MH 4.1	• Linking closely with the Mid North Mental Health Team • Targeted training and capacity building for the YNLHN Midwifery Group Practice • Working closely across services and agencies e.g., Child and Family Health Service (CaFHS) to ensure continuum of care and a seamless service • Linking with statewide peri natal services, including telehealth options.
MH5: Explore opportunities to build the capacity of our workforce by:	
MH5.1	Strengthening the knowledge, skills and capacity of acute staff in our local hospitals to manage acute presentations and provide mental health clients with a consistent approach to care.
MH5.2	Seeking opportunities for staff to attend Mental Health First Aid and Trauma Informed Care Training.
MH5.3	Working towards having an Aboriginal employee with mental health skills in the mental health team to support services for Aboriginal people.

Community and Allied Health

Current Service Summary	
Community and Allied Health employs the following health professionals:	
• Podiatry • Speech pathology • Dietetics • Occupational therapy • Social Work	• Physiotherapy • Allied health assistants • Diabetes nurse educators • Registered and enrolled nurses. • Aboriginal health workers
Multi-disciplinary teams provide a comprehensive range of community and hospital-based health services via individual assessment, one-to-one therapy, group work, community education, and in-home care. Referrals are prioritised according to clinical and service priority. In addition to the above services, which are all available throughout the LHN other services include:	
• National Disability Insurance Scheme (NDIS) Services, child (0-8 years old) and adult programs • Better Care in the Community (BCIC) – support from Wallaroo • Palliative care, End of Life Program (EOLP) • Aged Care Assessment Team (ACAT) • Orthotics and Prosthetics (OandP) • Aboriginal health • Rapid Intensive Brokerage Scheme (RIBS)	• Short term restorative care • Child Health and Development (CHAD) • Community nursing service (including specialist nurse services) • Diabetic education service • Commonwealth Home Support Program (CHSP) • Community Connections • Transitional Care Packages (TCP) • Rehabilitation ambulatory service • Strength & balance classes
Future Service Proposal	
Maintain current services whilst exploring opportunities to grow services to meet future demand by seeking improvements in the following areas:	

Service Improvement Recommendations:	
AC1: Redesign and increase infrastructure for future growth of services considering:	
AC1.2	Upgrade and modernise community health facilities at all sites.
AC1.2	Increasing security, technology and resources e.g., more cars in vehicle fleet as services grow.
AC2: Continue to develop strategies to reduce potentially preventable admissions:	
AC2.1	Investigate the demand for an adequately resourced chronic condition service, including respiratory services, across sites and increase access to support groups.
AC2.2	Promote the role of the Health and Wellbeing Advisor to improve connectedness across services.
AC2.3	Advocate for increased investment to support early intervention, health promotion and primary health care approaches to improve the management of chronic conditions.
AC2.4	Identify alternative support and access pathways for consumers who do not meet the NDIS criteria and strengthen the knowledge, skills and capacity of staff to provide disability services.
AC2.5	Explore and expand diabetes clinics at each site and identify a dedicated time for the Gladstone Health Centre.
AC3: Develop sustainable and effective service models considering:	
AC3.1	Work collaboratively with the NGOs, Council, and community to develop community wellbeing hubs, implementing a range of targeted initiatives to support the holistic physical, mental and social wellbeing of individuals and the community.
AC3.2	Ensure the current nursing service and allied health service models grow with forecasted demand.
AC3.3	Investigate innovative telehealth programs to enable the Port Pirie chronic condition focused program to reach out across the LHN.

AC3.4	Continue to advocate for End-of-Life Choice Package funding for our LHN to ensure sustainability of our community-based programs considering access to out of hours services.
AC3.4	Develop a hub at Gladstone for nursing and home-based services and work towards a seven-day service for all sites.
AC3.5	Expand the multi-disciplinary gestational diabetes clinics at each health service.
AC4: Improve awareness and understanding of services available and referral pathways for community and allied health considering:	
AC4.1	Investigate opportunities to develop patient navigator roles to support people with My Aged Care, NDIS, Country Health Connect, links to statewide services such as the Registry for Senior Australians (ROSA) and referral processes to other services (locally based).
AC4.2	Develop a communication strategy to promote available health services and how to access them.
AC4.3	Codesign accessible resources with consumers, clients and their families about services available in the YNLHN.
AC4.4	Promote the Nightingale Nurse Program* for palliative care consumers with a dementia diagnosis.

* Nightingale Nurse Program: Specialist nurse-led support provides strategies and advice to support people living with advanced dementia, their families and care providers, through an online platform.

Collective Service improvements across all priority areas

Current Service Summary	
The following proposed strategies are considered essential in achieving our desire to have a strong committed workforce who provide excellent consumer care across the YNLHN. These proposed strategies will require coordinated and committed implementation from all service departments across the LHN and are to be considered in conjunction with each specific service priority table.	
Service Improvement Recommendations	
CS1: Aboriginal people will have access to culturally safe and responsive initiatives determined by local communities through:	
CS1.1	Improving our cultural respect, and ensuring we offer a safe and welcoming environment that supports people to identify as Aboriginal and/or Torres Strait Islander. Ensuring our workforce at all levels receive ongoing cultural learning that is embedded in everyday practice.
CS1.2	Increasing the number of Aboriginal people employed across local services, e.g., acute services, community health, aged care and administration.
CS1.3	Increasing knowledge of services offered by the YNLHN Aboriginal Health Team.
CS1.4	Supporting the deliverables in the endorsed YNLHN REFLECT Reconciliation Action Plan May 2023 – May 2024 and subsequent plans.
CS1.5	Improving the identification of Aboriginal and Torres Strait Islander peoples in medical records.
CS2: Identify innovative ways to attract and retain workforce:	
CS2.1	Identify accommodation options for new and contracted staff and continue to upgrade and modernise current facilities.
CS2.2	Develop site succession plans, growing leadership opportunities for prospective managers.
CS2.3	Advocate for increased childcare options in the local area and link with Regional Development Australia to follow up the submission to the Royal Commission into Early Childhood Education and Care on behalf of Yorke and Mid North communities.

CS2.4	Work closely with CenStaR team to ensure an effective and responsive approach to recruitment that meets local needs.
CS2.5	Continue to actively participate in promoting traineeships and work experience to enhance local recruitment opportunities and build local workforce.
CS2.6	Invest in additional allied health and community nursing positions in areas that are under resourced and develop succession plans for specific specialist roles in clinical areas that exist in our current staffing (e.g., Lymphoedema, continence, hand therapy, cardiac, diabetes, respiratory, aged care).
CS2.7	Increase workforce recruitment by working with councils to promote and showcase the benefits for working rurally.
CS2.8	In partnership with the YNLHN staff and relevant government and non-government organisations, explore the opportunities to create local shared workforce and volunteer models to meet mutual service needs.
CS2.9	Partner with schools and aged care services to create opportunities for local employment and promote career pathways for sustainability.
CS2.10	Contribute and connect to the development of a LHN workforce strategy: • Continue to partner with private providers regarding supports for a sustainable rural allied health workforce in the catchment. • Increase access to scholarships, education, professional development, and networking opportunities for staff. • Develop flexible service models and employment opportunities to support staff. • Consider learnings from the Rural Health Workforce Strategy Pipeline Project and implement where relevant. • In conjunction with the medical workforce, promote career pathways for high school students. • Explore peer support programs for staff as a way to support, retain and develop the local workforce. • Increase Aboriginal Maternal Birthing Program workers for additional services for Aboriginal families.
CS3: Improve and address patient journey barriers:	
CS3.1	Improve linkages with metropolitan hospitals including Rural Liaison Nurses to support improved patient journey and provision of timely discharge planning, considering the option of a dashboard to support planning, including the recognition of people in country hospitals waiting transfer options.
CS3.2	In conjunction with our partners, map transport services to ensure access to inter-town and intrastate transport options are accessible and are widely promoted. Continue to build innovative transport service models.

CS3.3	Advocate for a bigger emphasis on early intervention and primary care services at local sites and link with the council and the LHN to access appropriate grants.
CS3.4	Continually promote Patient Assistance Transport Scheme (PATs).
CS3.5	In partnership with PATs, investigate the potential of increased access to upfront payment and access to Mid North Community Passenger Network.
CS3.6	Advocate for a streamlined process to ensure people who are up-transferred to metropolitan hospitals and health care services are routinely provided with transportation to return home and are not discharged without a travel / accommodation plan in place.
CS3.7	Continue to work and strengthen connectivity with SAAS and other partners to support positive transition between services.
CS3.8	Increase Aboriginal Liaison Officers across the service catchment to improve access to services for Aboriginal people.
CS3.9	Improve the patient journey for Aboriginal people including seamless transition for patients, medical records and referrals across the system.
CS3.10	Streamline processes and develop efficiencies for short term respite at Crystal Brook in collaboration with Community Health teams.
CS4: Improve our digital technology to enable collaboration for effective care coordination and streamlining our reporting requirements:	
CS4.1	Involve, prepare and upskill staff in the use of Sunrise Electronic Medical Records (EMR).
CS4.2	Ensure WIFI is available in all areas for each health unit.
CS4.3	In conjunction with the LHN, improve systems and technology to enhance service delivery: • Extend the use of telemedicine to enhance local care delivery and support for all sites. • Extend use of Sunrise EMR to enable its current full functionality and have one integrated medical record across hospital and community health sites. • Identify and implement learnings from the ICT Aged Care Systems review to streamline clinician reporting requirements, administration supports and improve connectivity with other IT systems.

	• Expand the amount of telehealth including dedicated locations for virtual consultation, across the region to increase access to care and reduce travel times. • Identify black spot areas and advocate for improved services for mobile phone, GRN and internet service coverage in the catchment area. • Optimise the use of home tele monitoring (Virtual Clinical Care - VCC). • Expand the use of iPads and technology capability in the home (including notes and reporting). • Link with statewide services to explore options for secure communication/messaging systems across the LHN. • In conjunction with the PHN implement, educate and embed digital technology into our aged care spaces.
CS5: Build partnerships and networks with public and private provider to support and improve the health and wellbeing of the community considering:	
CS5.1	Advocating for increased access to state-wide services such as DASSA, rape and sexual assault services, CaFHS, Child and Adolescent Mental Health Services.
CS5.2	Map current services provision for young people and link with NGOs and advocate for Headspace services within the LHN.
CS5.3	Advocating for hoarding and squalor services in the local area.
CS5.4	Advocating for local face to face victim of crime services.
CS5.5	Collaborate and consult with local councils, to monitor the impact of future planning to ensure health services keep up with population growth.

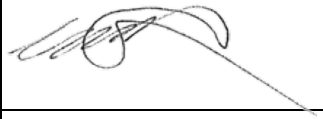


Clinical Support Services

Service and CSCF descriptor level	Service Capacity	Proposed service improvement
Diagnostic Medical Imaging All sites Level 1	• Provides low-risk ambulatory care services during business hours and may provide some limited after-hours services. • Involves a mobile general x-ray unit and is delivered by x-ray operators. • Computed radiography equipment is available to acquire images and facilitate image transfer. • Must have documented processes with a public or suitably licensed private health facility for patient referral and transfer to/from a higher level of service.	• Maintain existing services on all sites • Consider upskilling/training credentialled staff to increase the capacity to undertake simple x-rays. • Advocate for the availability of an MRI service in YNLHN. • Ensure up to date, compatible Information Communication Technology (ICT) systems to enable digital platforms to link. • Audit medical imaging equipment and update as required. • Continue to work with transport providers to ensure improved access for consumers needing to travel to Port Pirie and Wallaroo for medical imaging services.
Pathology All sites Level 2	• No on-site laboratory but have access to point-of-care testing. • Qualified staff available to collect and transport specimens via a SA Pathology courier to the nearest laboratory for Crystal Brook • May have on-site blood storage, but cross-matched blood - managed by the off-site laboratory - is available locally, which is applicable to the facility. • Blood pathology collection for Laura currently attended by hospital nursing staff on weekdays.	• Work with SA Pathology to explore opportunities to increase to a seven-day courier service. • Explore opportunities for SA Pathology to establish pathology collection services Laura and Port Broughton.

Service and CSCF descriptor level	Service Capacity	Proposed service improvement
Pharmacy All sites Level 1	• Provides services to ambulatory populations with low medication risk. • Prescriptions can be filled at local pharmacy at Crystal Brook, Laura and Port Broughton where accessible, efficient, and clinically appropriate.	• Maintain existing arrangements with local Pharmacies. • Continue supply of medication out-of-hours via Rural and Remote medication Policy and Procedure. • Implement SA Pharmacy project recommendations.

6. Service Plan for Endorsement

Responsible Person	Signature
Roger Kirchner Chief Executive Officer, YNLHN	
Verity Paterson Chief Operating Officer, YNLN	
Melissa Koch Executive Director Community and Allied Health, YNLHN	
Ryan Ackland Multi Campus Executive Officer Director of Nursing Booleroo Centre District Hospital and Health Services Laura and District Hospital, YNLHN	
Tess Noonan Multi Campus Executive Officer / Director of Nursing and Midwifery Port Broughton District Hospital and Health Services Southern Flinders Health - Crystal Brook Campus, YNLHN	
Debra Papoulis Director Mental Health Services, YNLHN	
Rochelle Griffin Executive Director Nursing and Midwifery, YNLHN	
Brett Humphrys Director Strategy Planning and Partnerships, YNLHN	

Appendix 1 Glossary and Definitions

ABS	Australian Bureau of Statistics
AHP	Allied Health Professional
AMIC	Aboriginal Maternal and Infant Care
CaFHS	Child and Family Health Service
CAMHS	Child and Adolescent Mental Health Services
CHAD	Child Health and Development
CHC	Country Health Connect
COTA SA	Council of the Ageing South Australia
CSCF	Clinical Services Capability Framework
DASSA	Drug and Alcohol Services South Australia
ED	Emergency Department
ETLS	Emergency Triage Liaison Service
FTE	Full time equivalent
GP	General Practitioner
GRN	Government Radio Network
HCP	Home Care Package
ICT	Information and Computer Technology
LHN	Local Health Network
MDT	Multi-Disciplinary Team
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
PATS	Patient Assisted Transport Scheme

PHN	Primary Health Network
PPA	Potentially Preventable Admissions
RAC	Residential Aged Care
RDA	Regional Development Australia
RDWA	Rural Doctors Workforce Agency
SA	South Australia
SAAS	South Australian Ambulance Service
SAPOL	SA Police
SAVES	South Australian Virtual Emergency Service
Sunrise EMR	Sunrise Electronic Management Record
TCP	Transition Care Program
VCC	Virtual Clinical Care
YNLHN	Yorke and Northern Local Health Network

Aboriginal	Aboriginal persons - This plan respectfully uses the term ‘Aboriginal', rather than ‘Indigenous', to refer to people who self-identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander.
CenSTaR	CenSTaR is the Yorke and Northern LHNs Central Staffing and Recruitment pathway that coordinates recruitment and placement of Nurses, Midwives, AINs and Carers through a streamlined, specialised pathway.
Chronic condition	A disease or condition that usually lasts for 3 months or longer and may get worse over time. Chronic diseases tend to occur in older adults and can usually be controlled but not cured. The most common types of chronic disease are cancer, heart disease, stroke, diabetes, and arthritis.
Co-design	Refers to a participatory approach to designing solutions, in which community members are treated as equal collaborators in the design process. Co-design is a well-established approach to creative practice, particularly within the public sector.

Culturally and linguistically diverse (CALD)	Culturally and linguistically diverse (CALD) persons: Defined as persons who speak a language other than English at home.
Community Health – County Health Connect	The majority of community health services in the YNLHN are provided under the branding of Country Health Connect (CHC). CHC provides a range of health, aged care and disability services to people in their homes, Local Health Network hospitals, residential care facilities and other community settings. Services are provided across multiple programs by multidisciplinary staff teams of allied health professionals, allied health assistants, nurses, coordinators, Aboriginal health workers, personal care attendants, ancillary staff and home support workers.
Multi-disciplinary Team	A multidisciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.
Model of care	A “Model of Care” broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.
Potentially Preventable Admission (PPA)	A potentially preventable hospitalisation is an admission to hospital for a condition where the hospitalisation could potentially have been prevented through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary care and community-based.
South Australian Population Health Survey (SAPHS)	The South Australian Population Health Survey is a state-wide population health survey managed by Wellbeing SA, which aims to monitor the health status of all South Australians. The SAPHS has been collecting information about the health of South Australians since July 2018.
South Australian Virtual Emergency Service (SAVES)	The SAVES program operates from 7pm to 7am, seven days a week for 28 participating rural hospitals across South Australia and links doctors with patients and their local nurses in country emergency departments via the existing Telehealth Network, enabling face-to-face consults using video conferencing equipment. Experienced rural GPs provide remote medical assistance to patients who have been triaged by the nursing staff at local emergency departments.
SA1	Statistical Area 1: the fourth smallest geographical area defined in the Australian Statistical Geography Standard (ASGS). Consists of one or more whole Mesh Blocks.
SA2	Statistical Area 2: the third smallest geographical area defined in the Australian Statistical Geography Standard (ASGS). Consists of one or more whole Statistical Areas Level 1 (SA1s).

Self-sufficiency	Self-sufficiency measures the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital, elsewhere within their LHN or elsewhere within SA (activity that 'flows out').
Separations (Seps)	Hospital inpatient activity (separations) - A hospital inpatient 'separation' is a completed episode of care of an admitted patient, generally concluding with their discharge from hospital, transfer to another healthcare facility or in-hospital death. Generally, separations are used to show inpatient activity within this profile.
Triage **(Australasian Triage Score – ATS)**	The Australasian Triage Scale (ATS), known commonly as "Triage" is a clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient and aims to ensure that patients presenting to emergency departments (EDs) are treated in the order of their clinical urgency and allocated to the most appropriate assessment and treatment area. The ATS utilises five categories from Category 1 – an immediately life-threatening condition that requires immediate simultaneous assessment and treatment – to Category 5 - a chronic or minor condition which can be assessed and treated within two hours.

Appendix 2 Terms of Reference

Scope and Purpose

The purpose of this Steering Group is to provide advice and direction to the Yorke and Northern Local Health Network (YNLHN) Governing Board and Executive to guide the development of a health service plan for Crystal Brook & District Hospital, Laura & District Hospital and Port Broughton District Hospital and Health Services.

The Service Plan will provide a framework for identifying and evaluating potential future service priorities to address the future health needs over the next five years and beyond for communities in the Crystal Brook, Laura and Port Broughton catchment. The service plan will focus on service needs across the continuum, including services outside of the YNLHN. It will integrate with the YNLHN-wide Clinical Service Plan (under development) to inform and establish a comprehensive evidence-based plan to prioritise new reforms and commissioning investment.

Principles

The steering group will consider the following principles throughout all stages of the management of their business:

> transparency and ethical responsibility

> identification and resolution of conflicts of interest

> accountability

> monitoring and evaluating of performance, based on evidence and outcomes.

Steering Group Role

The Steering Groups primary role is to:

> Provide advice to the Yorke and Northern Executive and Governing Board on future scope of services and capacity required based on the data, local knowledge and best practice clinical standards.

> Review existing and projected health utilisation data to quantify future service profiles.

> Consider existing plans for the YNLHN to determine the future implications for the health service.

> Provide advice on future self-sufficiency of the health service.

> Develop system-level insights based on investigation of diverse consumer experiences and seeking to understand challenges and pain points that consumers experience.

> Provide feedback on recommendations and priorities as they are developed.

> Examine local service integration with the system at-large.

> Identify and engage other stakeholders as required to contribute to the service planning process.

> Receive ideas, advice and recommendations from any consultation processes and ensure its consideration in the development of the Service Plan.

> Ensure that a draft service plan balances feasibility, desirability and viability.

Reporting

The Crystal Brook, Laura and Port Broughton Steering Group reports to the YNLHN Executive Committee.

Principles for planning

> Valuing and recognising the importance of our partners, agencies and community and their role in planning.

- Be creative in our thinking and our solutions.
- Local voice is essential.
- Authentically seek cultural advice and build partnerships for this to occur
- Aboriginal voice as a priority.
- Communication and accountability to community.
- Transparency.
- Responsive - planning that is congruent with community need.
- Prioritising safe and quality services.
- Good data to drive decision-making.

Membership and Member Responsibilities

Membership

Membership is to be determined by Chief Executive Officer taking into account LHN needs.

Membership comprises:

Chair:

- Roger Kirchner, Chief Executive Officer, YNLHN

Members

- Monique Button, Presiding Member, Port Broughton District Health Advisory Council,
- Brian Higgins, Presiding Member, Southern Flinders Health Advisory Council.
- Dr. Alison Edwards, GP Representative, Port Broughton
- Dr KC Chen, GP Representative, Crystal Brook.
- Melinda Yelland, Nurse Unit Manager, Port Broughton Hospital.
- Ryan Ackland, Executive Officer/Director of Nursing, Booleroo Centre and Laura.
- Tess Noonan, Executive Officer/Director of Nursing, Port Broughton and Crystal Brook.
- Lisa O'Dea – Nurse Unit Manager, Crystal Brook Hospital.
- Annette Campbell – Nurse Unit Manager, Laura Hospital.
- Barbara Daw, Community Health representative, YNLHN.
- Sue Jackson, Acting Executive Director of Nursing and Midwifery, YNLHN
- Elizabeth Bennett, Yorke and Northern Midwifery Group Practice, YNLHN. Elise Bell (proxy).
- Deb Papoulis, Acting Director Mental Health, YNLHN
- Tracey Stringer, Senior Project Officer, YNLHN
- Brett Humphrys, Director of Strategy, Planning and Partnerships.
- Kim Hewett, Senior Design Consultant, RSS.
- Kirsty Palmer, Administration support, YNLHN (Ex-Officio)

Other persons may be co-opted as required for one or more meetings.

Conflict of Interest

All members must consider their personal circumstances and declare at the start of the meeting any conflict of interest that they may have with any item on the agenda.

Member responsibilities

All members of the committee are to present the views of their respective areas/directorates but make consensus decisions that are in the best interests of the whole of the LHN.

Committee members' behaviour is to be in accordance with the SA Public Sector Code of Ethics and relevant SA Health Policies and Directives including those encompassing

- Respectful Behaviours
- Organisational Development
- Employee Relations
- Occupational Health Safety and Welfare

Confidentiality

From time to time the Committee may need to discuss matters 'In Confidence' or hold matters 'In Confidence' until they have been finalised.

The Chair will decide what elements of the discussion should be released and when, providing the Chief Operating Officer is kept informed of all matters of importance.

Action Items and Working Parties

Where Members are tasked with actions between meetings they are required to give due consideration to completing all action items within the agreed timeframes.

If required, Executive Officer/Minute Taker support may be provided through agreement with the Chairperson.

Routine reports, briefs and all documents being prepared by members for the agenda are to be provided to the Executive Officer/Minute Taker not less than 7 days prior to the meeting. Meeting Procedures

Decision making

Decisions will be made by consensus. If a consensus cannot be reached then the Chairperson will negotiate with the committee or make a decision on behalf of the committee.

Where consensus cannot be gained and the Chairperson makes a decision on behalf of the Committee this will be recorded in the minutes.

Meeting Frequency

Meetings will be held monthly with videoconference/teams available on the 1st Monday of each month, 5.30pm.

Quorum

A quorum is half of the core members plus one.

Committee Functions

Executive Officer/Minute Taker

The Executive Officer/Minute Taker is responsible for

- preparation of the agenda in consultation with the Chair

- taking of minutes and action items
- distribution of all papers pertaining to the meeting
- co-ordination of guest speakers and other attendees
- meeting room preparation including electronic media use
- catering if required
- providing additional assistance to members and working parties between meetings for action items

Agenda

All routine items and reports for the agenda are to be provided to the Executive Officer/Minute Taker not less than 7 days prior to the meeting.

The agenda shall be prepared and distributed by the Executive Officer/Minute Taker along with all reports and supporting papers at least 5 days prior to the meeting.

The tabling of late items and items on the day of the meeting will be at the discretion of the Chair.

Minutes

Minutes are to be prepared and forwarded to the Chairperson for consideration no more than one week post the meeting date. Minutes will be distributed to all members, providing they did not have a conflict of interest in a matter, along with an action list within 14 calendar days of the meeting.

Meeting Minutes are to be provided to the Chief Executive's Executive Assistant (or other identified person) for the Chief Executive Officer and Executive Committee.

The Chair will maintain all relevant records on behalf of the Committee and make all records available to the Chief Executive Officer or delegate.

Actions

Between meetings the Executive Officer/Minute Taker will liaise with all persons who have responsibility for action items.

The Executive Officer/Minute Taker may, at the discretion of the Chairperson, provide assistance to members in order for them to undertake action items as determined and agreed by the Committee. Such assistance could include meeting co-ordination, agenda preparation, minor research or collation of data and information.

Communications

The Executive Officer/Minute Taker will undertake or prepare for the Chair formal notifications and advice messages that may be required to other Committees, Executives or Chief Executive Officer.

Evaluation

The Committee will evaluate its performance having regard to the principles and requirements of the Terms of Reference and the overall objective of the Steering groups work to gain assurance that the decisions and actions taken and members' progress toward the strategic direction for the LHN as established and determined by the CEO and Executive.

Process Timeline

1st Meeting of Steering Group: • Setting the Scene	**December 2022**

• Development of Terms of Reference • SWOT of current and future service • Initial analysis of demographic and health utilisation data profile and identify other data requirements • Agreement on catchment area	
2nd and 3rd Meeting of Steering Group: • Ongoing analysis of demographic and health utilisation data profile and identify other data requirements • Determination of wider engagement approach • Plan and conduct community/consumer/key stakeholder engagement • Plan clinician engagement for both sites	**February/March 2023**
4th Meeting of Steering Group • Ongoing analysis of demographic and health utilisation data profile and identify other data requirements • Plan clinician engagement for both sites • Consideration of recommendations / feedback from the community engagement workshops • Conduct community engagement as required	**April 2023**
5th Meeting of Steering Group • Clinician engagement workshop	**May 2023**
6th and 7th Meeting of Steering Group • Ongoing consideration of recommendations / feedback from the clinician engagement workshops and community engagement • Consider suitable models of care. • Co-develop future service options for draft service plan	**June 2023**
7th Meeting of Steering Group: • Consideration of draft service plan • Identification of any further analysis required	**July 2023**
8th Meeting of Steering Group: • Consideration of final draft service plan for endorsement by Executive and board • Evaluation of approach • Service Plan launch	**September 2023**

Government of South Australia | Health
Yorke and Northern
Local Health Network

For more information

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Interpreter

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