Government of South Australia

Health
Yorke and Northern
Local Health Network

Community and Allied Health Service

SERVICE PLAN

2021-2026

Forward

On Behalf of the Leadership Team of the Yorke and Northern Local Health Network (YNLHN) I am pleased to present the Service Plan for the YNLHN Community and Allied Health Service 2021 -2026. This is one of a series of service plans for YNLHN which will guide our future service provision in an evidence informed and collaborative manner with our consumers and community at the heart.

We care for the people in Yorke and Northern communities and are committed to growing our health services and providing exceptional health care closer to home.

The service planning process has enabled us to be responsive to our local communities and work together to design a future that meets our community's needs. This plan will help us in progressing our vision to be leaders in exceptional rural healthcare, delivering safe, high-quality holistic services that improve the health and wellbeing for all in the Yorke and Northern communities.

This plan provides a blueprint for the future of Community and Allied Health services for the communities in YNLHN that will support and promote the best health outcomes by embedding client driven quality care into the service design. Ongoing communication and connections both internally and externally will enable this plan to be realised.

I would very much like to thank the Steering Group for the enormous amount of energy and time spent in overseeing this planning project and to the many clinicians, stakeholders and community members for their valued input to shape this plan

Yours sincerely

Mellissa Koch

Executive Director Community & Allied Health

Yorke and Northern LHN

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Disclaimer:

Document prepared by the Rural Support Service (RSS), Planning and Population Heath Team to assist the YNLHN Community and Allied Health Service Planning Steering Group with future planning for YNLHN Community and Allied Health Service.

This document has been developed to support planning within the Yorke & Northern Local Health Network (YNLHN). The data may not be published, or released to any other party, without appropriate authority from the Department for Health and Wellbeing.

While care has been taken to ensure that the material contained in this document is up-to-date and accurate, the RSS and YNLHN accepts no responsibility for the accuracy or completeness of the material, or for outcomes related to use of the material.

1. Executive summary

The Yorke and Northern Local Health Network (YNLHN) covers 77,783 square kilometers and provides a range of health services including hospital, aged care and community and allied health. The YNLHN provides allied and community health services across the LHN from three broad sites in YNLHN; Mid North Community Health Service (covering Port Pirie, Booleroo, Jamestown, Orroroo, Peterborough, Crystal Brook, Port Broughton, Laura and Gladstone), Yorke Peninsula Community Health Service (covering Wallaroo, Minlaton, Maitland, Yorketown, Point Pearce) and Lower North Community Health Service (covering Balaklava, Burra, Riverton and Snowtown).

The health services in the YNLHN, in partnership with other service providers, manage the patient journey from primary care in the community, through acute care and back to primary care, supported by efficient processes, clinical protocols, information sharing and a team approach to achieving safe, high quality care.

This Service Plan (the Plan) aims to provide a blueprint for the future of community and allied health services across the YNLHN communities that will support and promote the best health outcomes by embedding client driven quality care into the service design. The Plan was developed using a range of information and data which highlight population needs and recent patterns of service delivery and provides a framework for identifying and evaluating potential future service options for the YNLHN community and allied health service to meet the needs of the YNLHN catchment over the next five years and beyond. It is the first plan to consider a specific service stream across the YNLHN.

The planning process was led by the YNLHN Community and Allied Health Service Planning Steering Group (the Steering Group), supported by the YNLHN, Rural Support Service Planning and Population Health Team and a wide range of clinicians who were engaged through workshops, surveys and discussion in 2020. Broader and ongoing involvement of clinicians will be essential to progress service initiatives.

The YNLHN Board will have governing oversight of the plan and the YNLHN Community and Allied Health Clinical Seniors Leadership Group will have an operational oversight role in the implementation and monitoring of this plan.

The specific service priority areas identified for community and allied health include aged care, National Disability Insurance Scheme (NDIS), paediatrics and youth, intermediate care and hospital prevention, Aboriginal health and rehabilitation and specialised care. These areas will be the core focus, however it must be noted that these services do not operate in isolation and it will be essential to continually strive to work in integrated ways across sectors and priority areas to ensure effective quality service are provided. Details of the improvement opportunities for these areas are summarised on page 5 and 6.

In addition to these service priority areas, opportunities to strengthen workforce, accessibility and patient journey will be key enablers for this plan. The particular areas considered a priority for workforce are outlined on page 33 and 34.

The following service priority areas emerged throughout the YNLHN community and allied health service planning process with a range of specific service improvements:

Aged Care

Maintain and enhance aged care services within the YNHN community settings and develop suitable support mechanisms to assist access by:

- Developing a YNLHN aged care specific model of care.
- Building partnerships to support collaboration to improve the health and wellbeing of the aged community.
- Supporting access to appropriate services.

Rehabilitation and Specialised Care

Develop service improvement opportunities in identified rehabilitation and specialised care priority areas to provide easy access to the most appropriate care by:

- Support a model of care which will have the flexibility and capacity to equitably respond to and meet the health and wellbeing needs of the population.
- Improve patient journey.
- Build networks to support collaboration in improving community health and wellbeing.
- Explore models that support skill development and availability of a workforce for specialised care and rehabilitation services.
- Using an equity across the LHN lens develop and expand relevant specialised services.
- Expand rehabilitation services and opportunities for all clients within the LHN.
- Improve Infrastructure and facilities to support effective specialised care and rehabilitation services in YNLHN health units.

Intermediate Care

Develop and promote a best practice intermediate care service by:

- Promotion of services available with YNLHN allied and community health (A&CH) service.
- Build the workforce requirements to meet the needs of a best practice intermediate care service within YNLHN.
- Streamline access and communication to improve intake into intermediate care service.
- Improve the patient journey.
- Develop a flexible model of care across the continuum.

National Disability Insurance Scheme (NDIS)

Maintain and enhance a best practice and responsive NDIS service across YNLHN:

- Develop a quality NDIS workforce to service the needs of the YNLHN population.
- Improve access to flexible streamlined NDIS service across the YNLHN.
- Develop formal partnerships with other NDIS providers within the LHN.
- Co-design a YNLHN strategic direction for NDIS services.

Aboriginal Health

Maintain and enhance Aboriginal health services across YNLHN and support Aboriginal health workforce:

- Promotion of services available and increased engagement with community and Aboriginal health team by community and allied health services.
- Support Aboriginal health workers' role.
- Support Aboriginal health workforce.
- Improve equity of Aboriginal health services across YNLHN.
- Develop strategic partnerships to further improve services for Aboriginal communities and clients.

Paediatrics and youth

Maintain paediatric services and enhance youth services provided in YNLHN:

- Enhance opportunities to provide a sustainable quality paediatric and youth workforce.
- Build networks to support collaboration in improving paediatric/youth health and wellbeing.
- Enhance opportunities for referrals.
- Harness and utilise appropriate technology.
- Strengthen early intervention approach.
- Improve infrastructure and facilities to support effective paediatric and youth services in YNLHN health units (particularly Riverton, Balaklava, Peterborough and Kadina).

2. Project background and context

The health system in South Australia is complex and diverse. It is essential that service planning is performed with adequate consideration of, and integration with, the system as a whole. Health service planning affords us the opportunity 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 to articulate a future plan for meaningful service provision priorities.

The majority of community and allied health services in regional South Australia are provided under the branding of Country Health Connect (CHC). Country Health Connect provides a range of health, aged care and disability services to people in their homes, LHN hospitals, residential care facilities and other community settings. Services are provided 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. Triage and referral for most of regional South Australia across all CHC programs is managed by the Country Referral Unit (CRU). Community Mental Health Teams provide specialised mental health services to residents in regional areas. Although these teams are often co-located with community health services and use the same data capture system, they are a separate service group with different funding, oversight and referral structures.

2.1 Strategic enablers

Several strategic frameworks and enablers have informed and provided strategic direction for the YNLHN Community and Allied Health Service Plan. These include the Yorke and Northern Local Health Network Strategic Plan 2020-2025, SA Health Strategic Plan 2017-2020, SA health and Wellbeing Strategy 2020 - 2025, YNLHN Consumer and Community Engagement Strategy, Draft YNLHN Clinician Engagement Strategy, National Aboriginal Cultural Respect Framework and the Rural Health Workforce Strategy (RHWS).

The YNLHN strategic plan 2020-2025 outlines how we will best care for our communities, move with future health trends, enhance our workforce, foster strong partnerships and optimise technology and innovation, to ultimately become leaders in delivering exceptional healthcare, closer to home. With a vision to lead by providing exceptional rural health care the YNLHN will deliver safe, available, high-quality, whole of health services that improve the health and wellbeing for all in the Yorke and Northern communities. We will do this by the following strategic goals and values: -

GOALS

- Our Network – Care responsive to the needs of our communities
- Our Services – Creatively designed quality services
- Our Staff – A skilled, engaged, collaborative workforce
- Our Partnerships – Partnerships for healthier communities
- Our Future – Optimised digital technology and innovation

VALUES

- Equity – We are passionate about fairness in our communities and respect cultural diversity
- Integrity – We own our actions, and we are true to ourselves and others
- Care – We treat people with respect and dignity
- Excellence – We strive for excellence in the delivery of our services
- Engagement – We genuinely listen to each other and involve our communities to shape our network
- Innovation – We actively seek new ways of doing things and make them happen

The SA Health and Wellbeing Strategy 2020-2025 has a vision for South Australians to experience the best health in Australia. It envisages a future where South Australia's health system is trusted and highly valued, recognised and respected for excellence, a preferred work destination, and a source of learning and inspiration. It aims to improve the health and wellbeing of all South Australians through the following 4 goals (summarised from the Strategy):

Goal 1:	Improve community trust and experience of our health system.
Goal 2:	Reduce the incidence of preventable illnesses.
	Improved management of conditions and care.
Goal 3:	Improve the capability for people to manage their health and wellbeing.
	Improve health workforce capability to embrace participatory approach to health care.
Goal 4:	Improve patient experience through adopting emerging technology and contemporary practice. Equity of outcomes through efficiency and commissioning for need.

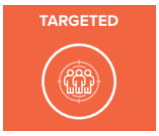
The 5 overarching strategic themes from the SA Health and Wellbeing Strategy 2020-2025 will form a guide for the implementation of strategic actions by considering the following:

TOGETHER

We will work in partnership with all our stakeholders to develop patient centered solutions and service improvements to the meet the needs of our community. We will work with our clinicians and community to continually seek their views and input that will inform how we work

We will work to build and maintain the trust of our community.

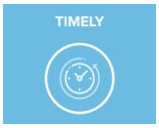
We are committed to providing safe, reliable and high quality treatment and care



We will provide services targeted to meet the priority health needs in our community. These service interventions will be based on the right evidence and our efforts will be motivated to address the disparities on our communities.

We will work with our consumers to tailor our services to meet their unique individual needs.

We will balance safe clinical management with personal needs and preferences.

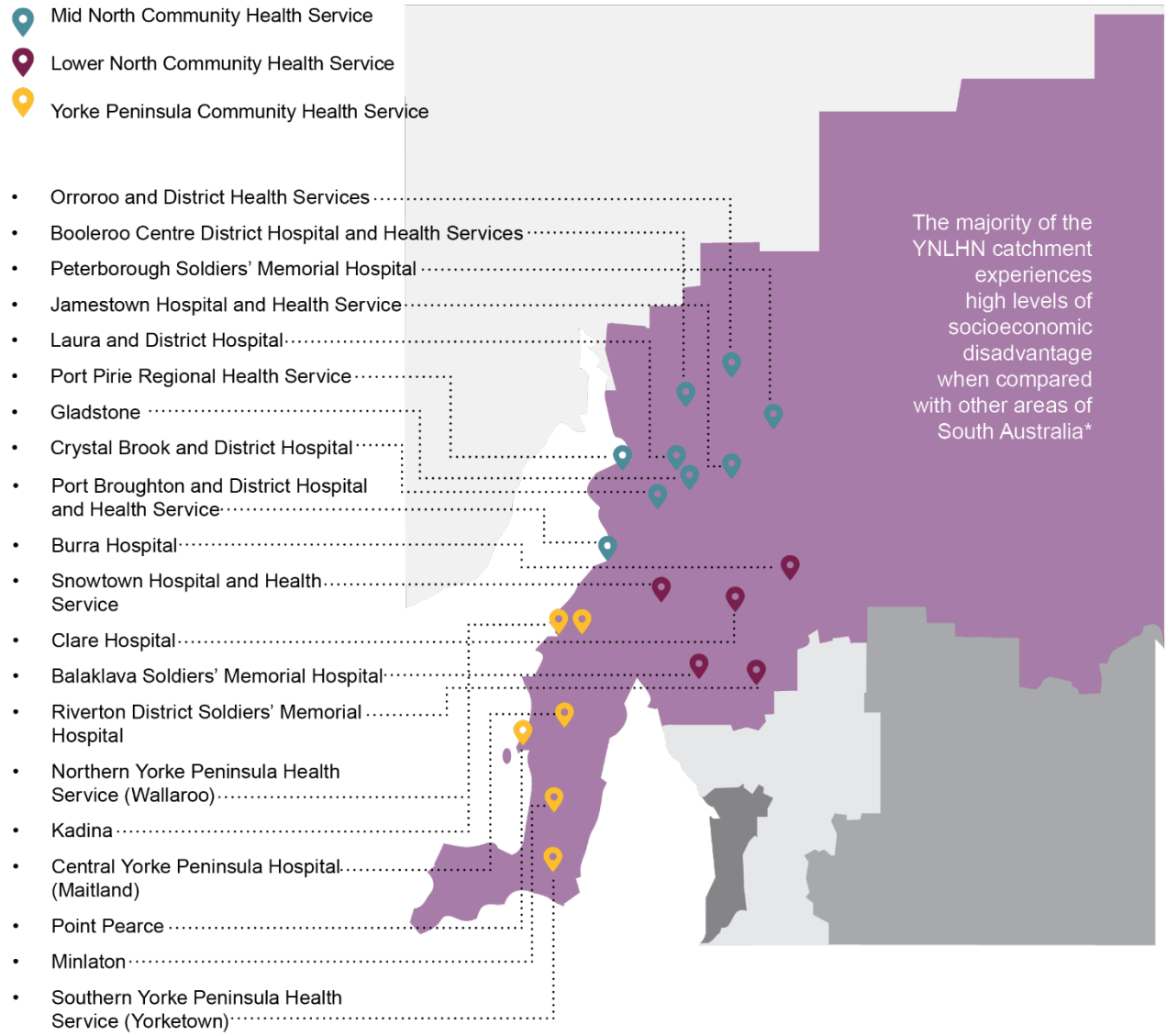


We will enable flexible systems to deliver timely and appropriate health care that is accessible in the right place at the right time.

2.2 YNLHN community and allied health catchment profile

Core Catchment

The YNLHN consists of 16 health units (three activity based funding/casemix sites, nine grant funded hospitals and four Multi-Purpose Services), eight Commonwealth-funded Residential Aged Care facilities and incorporates Country Health Connect Yorke and Northern. The health units in the YNLHN are listed on the map below.



Core catchment quick stats

75,324 catchment population.**

16.6% aged under 14 years.

25.6% aged over 65 years (> SA).

2.7% identify as Aboriginal and Torres Strait Islander (> SA).

2.8% speak a language other than English at home (CALD background).

The resident **population of the YNLHN** is expected to **grow** by 2036 by 1.6% with the **80+ age group** projected to grow by 15.6%. The largest catchment increase is **Wallaroo** with 4.1%.

**According to SEIFA (The 'Index of Relative Socio-economic Disadvantage). **2018 estimated resident population.*
>SA = larger numbers when compared to the South Australian population.

Health status

The South Australian Population Health Survey (SAPHS) indicates the top five chronic diseases reported by residents in the YNLHN in 2019-20 were arthritis (41.2%), asthma (18.3%), diabetes (14.3%), cardiovascular disease (13.3%) and osteoporosis (8.1%). In 2019-20 there were higher levels of high blood pressure (28.8%), long term alcohol risk (18.1%), overweight (34.7%), and obesity (43.4%) for the YNLHN than for all of SA.

Community and allied health utilisation

Community Health Activity data is collected via CCCME (Country Consolidated Client Management Engine) which is the client based data management program used by Country Health Connect and Community Mental Health Teams. Whilst 2017-18 data was used to make decisions in regards to this plan, updated 2018-19 data shows similar results and indicated:

- New referrals totaled 20,631 with the top 5 service requests physiotherapy, occupational therapy, dietician, community nursing and community mental health.
- A total of 13,061 unique clients with 996 (7.6%) of those identified as Aboriginal. The health unit with the highest number of unique clients was Mid North Community Health Service (CHS) with 6,434 clients and 545 (8.5%) of these identifying as Aboriginal.
- A total of 252,192 one to one client contacts and 13,372 group contacts. The health unit with the highest number of one to one contacts was Mid North CHS (125,298) whilst the health unit with the highest number of group contacts was also Mid North CHS (7,951).
- The top five disciplines by number of unique clients were administrative officer, physiotherapist, registered nurse, occupational therapist and allied health assistant.
- The top five disciplines by number of one-to-one (1:1) client contacts were occupational therapist, registered nurse, physiotherapist, paramedical/therapy aide and enrolled nurse.

2.3 Service planning process

The service planning process was led by the YNLHN Community and Allied Health Service Planning Steering Group. Established in October 2019, the Steering Group met regularly (pausing momentarily during 2020 due to the global COVID-19 pandemic) and were supported by the Rural Support Service, Planning and Population Health Team in the co-design health service-planning framework. A range of clinicians, consumers and stakeholders contributed to the development of the service plan via participation in workshops, surveys, and focus groups throughout late 2019 and 2020.

The role of the Steering Group was to:

- Provide advice to the YNLHN executive and the 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 community and surrounding catchment to determine the future implications for the community and allied health service.
- Provide feedback on recommendations and priorities as they are developed.
- 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.

The Steering Group analysed a range of:

- Health utilisation data.
- Population trends.
- Patient journey trends
- Key influencing factors.

The Steering Group endorsed a service profile that was the foundation of the data gallery provided for a local clinician workshop. A range of health utilisation data, identifying trends and key influencing factors was analysed.

Clinician, consumer and stakeholder engagement

A variety of engagement methods were identified and used to assist the Steering Group in developing a Service Plan that adequately considers real-world experience alongside the relevant data and contemporary best practice.

Clinician engagement was key to the planning process, with a workshop held on 14 October 2020 in Wallaroo to engage feedback from staff, stakeholders and partners. It was attended by a range of clinical stakeholders including YNLHN clinical staff, (nursing and allied health), local allied health workforce, residential aged care, tertiary study representatives, and the YNLHN executive. A list of both attendees and apologies is listed in Appendix B. Furthermore, invited attendees were that were unable to attend the workshop were offered an online survey to obtain their feedback. Key leads were contacted for consultation throughout the planning process.

The clinician workshop included a data gallery of service utilisation information and best practice principles. Small focus group discussions were held focusing on the strengths, opportunities, challenges and key strategic advice on the following priority areas. The patient journey, accessibility and workforce were also considered.

1. Aged care
2. Aboriginal health
3. Intermediate care / hospital prevention
4. NDIS
5. Rehabilitation and Specialised services
6. Paediatrics and youth

Overall, the clinician workshop was considered very positive with all participants agreeing that the workshop was useful for future service planning and 94% of participants agreeing that the diversity of key stakeholders attending this workshop was useful and appropriate. Additionally, 91% of participants felt they were able to contribute their advice towards supporting and promoting best health outcomes for the communities of YNLHN.

In addition to this clinician workshop, a specific online survey was distributed to clinicians and stakeholders who were unable to attend the clinician workshop engagement session. This survey was also used to gather data from a wider group of stakeholders including partner organisations, other clinicians, staff and community, including 50 members of the YNLHN consumer network. The intent of this survey was for respondents to share their views on the strengths, challenges, opportunities, population or community trends and partnerships, that exist in relation to the community and allied health services available to residents in YNLHN. The results from this survey was collated and shared with the Steering Group. This information has been incorporated with the clinician engagement findings to complete the priority service tables starting on page 13.

3. Service plan

3.1 Service description

YNLHN community and allied health services comprised of experienced multi-disciplinary teams providing 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.

Community Health employs the following allied health and other professionals:

- Social work.
- Podiatry.
- Speech pathology.
- Dietetics.
- Occupational therapy.
- Physiotherapy.
- Community nursing.
- Diabetes nurse education.
- Home based support services.

All referrals for inpatients are a priority 1 referral and will receive a response within 48 hours. The response may not be a visit to the hospital depending on the clinical complexity for the patient, and may instead be a telephone response to conduct an initial assessment and plan for a hospital visit or referral to community health post discharge. Referrals are prioritised according to clinical and service priority.

3.2 Service capacity

The following community and allied health services are provided within the YNLHN:

- Commonwealth Home Support Program (CHSP), Home and Community Care (HACC), Home Care Packages (HCP) post-acute, inpatient allied health services.
- Podiatry, occupational therapy, speech pathology, social work, dietetics, physiotherapy, palliative care.
- Environmental Health Centre.
- End of Life Programme (EOLP).
- National Disability Insurance Scheme Services, (NDIS) child 0-7 years old, and adult program.
- CHSP and HCP Home Based Services.
- CHSP Day Centre.
- Post-acute, palliative care and CHSP equipment.
- Community and residential Transition Care Packages (TCP).
- Rehabilitation services.
- Rapid Intensive Brokerage Scheme (RIBS).
- Diabetic education service.
- Community nursing services (nursing services across seven days in Port Pirie and Wallaroo and five days for other locations), post-acute care, CHSP, HCP.
- Health and wellbeing adviser.
- Integrated Primary Health Care Service.
- Aged Care Assessment Team (ACAT).
- Aboriginal Liaison Service provided at Maitland, Wallaroo and Port Pirie hospitals. Additional Aboriginal health services and support provided to the catchment areas from Moonta, Maitland and Port Pirie.
- Child health and development (0-7 years) CHAD.

A range of private visiting services are also available as well as services funded by the Primary Health Network e.g. Sonder.

Current service capacity described in the tables below may be variable depending on funding, staffing and service priorities.

3.3 Service priorities

The priority tables below outline the proposed service planning priorities for YNLHN community and allied health services for the next five years and beyond.

3.3.1 Paediatrics and youth

Current	Proposed
Service description summary: The YNLHN child health and development (CHAD) team works across the LHN for clients aged 0-7 years with occupational therapy, speech pathology, physiotherapy, social work, dietetics, allied health assistants and podiatry as part of the team. Both 1:1 and group services are provided. There is no specific allocation for youth (8-18 years) service provision within YNLHN. **Current service capacity:** *Paediatrics* CHAD has regional commitments across the YNLHN and service sites on a weekly/ fortnightly or needs basis depending on the demographic or area. Group services are also provided across the LHN including –	**Service description summary:** Maintain paediatric services and enhance youth services provided in YNLHN. **Service improvements summary:** **PY1. Enhance opportunities to provide a sustainable quality paediatric and youth workforce** • Explore recruitment and retention opportunities for age specific services (8-18 years). • Explore access to funding and staff availability to match age specific services (8-18 years) – e.g. social/life skills etc. • Investigate professional development funding and plan for all C&AH staff trauma training and other identified professional development gaps. • Increase allied health assistant scope of practice/credentialing in the paediatric/youth space • Develop suitable incentives to attract and retain staff (e.g. minimise short term contracts and housing/relocation support, student placement opportunities). **PY2. Build networks to support collaboration in improving paediatric/youth health and wellbeing** • Formalise partnerships with key stakeholders to break down barriers to quality holistic care for paediatric/youth clients. ○ Private/public confidentiality. ○ Coordinating one key case-manager. ○ Interagency meetings.

Current	Proposed
play2grow, talking toddlers, emotional regulation, SPOT groups (these are tailored depending on the needs of the community). There are currently a range of partnerships and interagency forums including maternal, neonatal and paediatrics group, Child and Family Safety Network Meetings, state-wide CHAD clinical network meeting, Interagency Consultancy Group and the Family Safety Framework. *Youth* NDIS clients aged 8-18 years may be seen on an as needs basis if there is capacity and the discipline has appropriate skills and resources available. This is determined in consultation with the CHAD team leader and is on an ad-hoc basis and generally time limited.	• Explore opportunities to share resources to benefit the client (space, vehicle ownership, case manager etc.). • Increase collaboration with stakeholders to support families transition to other providers. • Explore opportunities to link with other services (e.g. metro/country, NDIS) to support clients. • Develop inter agency strategies to ensure access and availability of appropriate quality flexible services to all clients within LHN (low socio-economic status, remote location). • Build relationships with universities to support employment pathways, research and evaluation learnings. **PY3. Enhance opportunities for referrals** • Improve awareness and understanding of referral pathways. • Develop a warm referral pathway to support reduced waiting times for those clients at high risk. **PY4. Harness and utilise appropriate technology** • Evaluate and embed COVID-19 technological learnings (e.g. new modes of therapeutic care). • Develop and maintain age appropriate technological infrastructure, and equipment. • Utilise appropriate technology to support travel challenges. **PY5. Strengthen early intervention approach** • Identify and partner with Country SA Primary Health Network (PHN) and other agencies who deliver health promotion/primary health care/early intervention opportunities, especially for youth and Aboriginal and/or Torres Strait Islanders. **PY6. Improve infrastructure and facilities to support effective paediatric and youth services in YNLHN health units (particularly Riverton, Balaklava, Peterborough and Kadina)** • Review current infrastructure and facilities to ensure standards are being met (particularly in regards to space, privacy and safety). • Identify opportunities to improve infrastructure and facilities where needed.
Items for consideration: • Updated 2021 CHAD model of care	

3.3.2 Intermediate care

Current	Proposed

Service description summary:
 	
Intermediate care services is a multidisciplinary community based service that aims to support hospital avoidance and earlier supported discharge for patients with chronic conditions and/or complex care needs within the YNLHN region.
 	
The services also support:
• Integration between hospital and community providers.
• A single point of entry for access to the full suite of intermediate care services as required.
• Episodic, criteria led interventions, prioritised for those at high risk of admission/presentation.
• Comprehensive screening and assessment of health and psychosocial needs/risk factors.
• Person centred care provided on site or in the home setting and supporting client education and self-management.
 	
Referrals are prioritised according to clinical and service priority.
	Service description summary:
	
	Develop and promote a best practice intermediate care service.
	
	Summary of service improvements:
	
	IC 1. Promotion of services available with YNLHN A&CH service
	• Develop internal and external strategies to promote services available within YNLHN.
	  ○ Create opportunities for staff to self-promote quality of services and availability as identified in Mid North Needs Assessment.
	  ○ Harness technology to promote services, linking with communications to promote current services (e.g. google, Facebook etc.).
	  ○ Increase primary health care settings and medical practice knowledge and access to innovative services available (e.g. virtual clinical care).
	  ○ Internal education of access to Rapid Intensive Brokerage Service.
	  ○ Promote Better Care in the Community services including cardiac and pulmonary rehabilitation programs.
	
	IC 2. Build the workforce requirements to meet the needs of a best practice intermediate care service within YNLHN
	• Expand scope of allied health assistant's role to support specialised care.
	• Establish a formal mentoring or exchange program between country and metro specialised care areas.
	• Improve workforce culture, communication and relationships by regular planned role shadowing (acute/aged/C&AH). Including discipline based and multi-disciplinary role shadowing.
	• Audit staff discipline/skills and locations to determine gaps in FTE, position descriptions and geographic client needs.
	• Support the Rural Health Workforce Strategy (RHWS) strategies pipeline workforce model (grow your own) and clinical leadership capability, capacity and sustainability.
	
	IC 3. Streamline access and communication to improve the intake to intermediate care service:

Current	Proposed
Current service capacity: Intermediate care provides: • Better Care in the Community. • Rapid Intensive Brokerage Scheme (RIBS). • Allied health services. • Early Youth and Child Program (EYPC). • Diabetes education service. • Aboriginal health services. • Community nursing.	• Review and streamline internal and external referral process (metro, acute, self and general practitioners) in consultation with stakeholders. • Executive Director C&AH (or similar) to create dialogue and awareness with metropolitan LHNs and stakeholders re referral process and quality. • Improve communication, working relationships and patient care timelines. • Encourage early intervention in acute settings to prevent admission or reduce length of stay (e.g. C&AH to provide in-reach services to emergency services). • Harness the learnings from metropolitan in reach programs and producing evidence to demonstrate impact. **IC 4. Improve the patient journey considering:** • Partnering with private providers to enable clients to access appropriate care (e.g. while waiting for TCP to begin). • Develop new prehab/rehabilitation models – including opportunities for restorative care involving integrated multi-disciplinary team. • Support the development of an ambulatory rehabilitation model of care for YNLHN. • Continue to grow preventative exercise programs such as Moovers and Groovers and Strength for Life. • Strengthen relationships with metropolitan providers to improve share care models. • Review, streamline and promote Nurse led ambulatory service (NLAS) referral pathways and ensure patients are informed of their options. • Investigate opportunities to grow respiratory and sleep study clinics across the YNLHN **IC 5. Develop a flexible model of care across the continuum** • Consider streams of care around functions (e.g. palliative care, aged care, rehabilitation etc.) • Embed learnings from the midwifery model of care evaluation to further support C&AH workforce flexibility to provide care where it is geographically needed. • Examine opportunities to create funding streams from a range of programs to allow more flexibility re how/where services are provided to meet staffing and community needs. • Establish an agreed funding model to be applied to allied health services provided in residential aged care including quality improvement activities such as upskilling and training staff.

Current	Proposed
	• Investigate the demand for an adequately resourced chronic condition service including respiratory and cardiac services in Clare. • Investigate opportunities to increase nursing FTE in diabetes services within Clare, Wallaroo and surrounding towns. • Investigate opportunities to expand allied health services where current referral levels are high. • Investigate improvements in metropolitan discharge planning to support extended clinical advice and related consumables for new and emerging complex care needs – (e.g. wound care). • Review current multidisciplinary models to improve consumer outcomes and equity.
Items for consideration: •	

3.3.3 Rehabilitation and Specialised care

Current	Proposed

Service description summary:
 	
Rehabilitation is range of care and recovery options where multidisciplinary teams work in partnership with clients to identify their own individual needs and goals to direct their care and services. Provided in a range of settings including home based and community settings rehabilitation support, some infrequent in hospital services and residential facilities.
 	
Specialised care is specific care areas of growth where the provision of the care is based on current resources and staff skills, looking for a more needs based approach.
 	
Regular group and 1:1 sessions focusing on rehabilitation and specialised care across the LHN.
 	
Current service capacity:
 	
Multidisciplinary services are provided for post-operative, orthopedic and post-acute care.
 	
One-on-one (1:1) services are provided across the LHN including:
 	
<u>Mid North</u>
	Service description summary:
	
	Develop service improvement opportunities in identified rehabilitation and specialised care priority areas to provide easy access to the most appropriate care
	
	Service improvements summary:
	
	RS1. Support a model of care which will have the flexibility and capacity to equitably respond to and meet the health and wellbeing needs of the population
	• Map services across the YNLHN and develop strategies to make these equitable and close to home as possible across the LHN (e.g. hand therapy in Port Pirie).
	• Investigate flexible models of care available (including culturally appropriate and rehab in the home) and replicate within YHLHN
	• Enhance current infrastructure and equipment to support specialist services.
	• Consider funding models to residential aged care sites for targeted and individualised Allied Health and allied health assistant support.
	
	RS2. Improve patient journey
	• Build and strengthen networks with metro stakeholders re services and programs available within YNLHN thereby improving patient journey from metro to country.
	• Encouraging and support the use of virtual clinical care and telehealth in the most appropriate way to clients and staff.
	• Increase local community confidence and awareness of the services and programs provided across YNLHN.
	  ○ Improve website/SharePoint with consumer input/stories.
	  ○ Map public/private services and advertise these.
	  ○ Develop a directory.
	  ○ Utilise SharePoint.

Current	Proposed

• Pulmonary and cardiac rehabilitation.
• Chronic condition management.
 	
<u>Lower North</u>
• Respiratory support.
• Lymphedema clinic.
 	
<u>Yorke Peninsula</u>
• Pulmonary and cardiac rehabilitation available Maitland and Wallaroo.
• Lymphedema and stomal therapy clinics available Wallaroo.
 	
Group services are also provided across the LHN including:
 	
<u>Mid North</u>
• Port Pirie – strength and balance (Movers and Groovers), pulmonary rehab, cardiac rehab, strength for life, lower limb rehab, antenatal classes, lymphedema and hand therapy.
• Booleroo – strength and balance.
• Wirrabara – strength and balance.
• Port Germain – strength and balance.
• Orroroo – strength and balance, strength for live.
• Jamestown – strength and balance, hydrotherapy.
• Crystal Brook – antenatal classes.
	• Collaborate with key stakeholders to strengthen early intervention and wellness opportunities (e.g. Emergency service referrals to Better Care in The Community [BCC] programs).
	• Consider an intake officer role for initial assessment.
	
	RS3. Build networks to support collaboration in improving community health and wellbeing
	• Develop a learning consortium of agencies and education providers working collaboratively and providing education opportunities and upskilling in specialised areas
	• Partner with private providers and acute care to improve interagency support and understanding
	• Strengthen partnerships with metro stakeholders in specialised areas (increasing timely quality referrals)
	
	RS4. Explore models that support skill development and availability of a workforce for specialised care and rehabilitation services
	• Consider/expand student led models of care (including allied health assistants) to build skills in specialised areas (e.g. credentialing pathway and strengthened clinical supervision).
	• Invest in skill development in specialised areas with equity across the LHN.
	• Expand the allied health assistant model of care to better support rehabilitation and specialised services within the LHN.
	• Extend rural generalist pathway.
	• Embrace allied health as part of the care team in hospitals.
	• Consider use of private providers within residential aged care and hospital sites to address shortage of allied health.
	
	RS5. Using an equity across the LHN lens develop and expand relevant specialised services
	• Consider developing/strengthening/expanding the following specialised areas within the LHN with a focus on equity:
	  ○ Wound care.
	  ○ Access to rapid intensive psycho geriatric evaluation and management.
	  ○ Burns link.

Current	Proposed
<u>Yorke Peninsula</u> • Wallaroo - post operative lower limb rehabilitation, hydrotherapy, stomal therapy clinic, lymphoedema clinic, cardiac rehabilitation, pulmonary rehabilitation and strength + balance class, antenatal. • Maitland – cardiac and pulmonary rehab with BCC. <u>Lower North</u> • Clare - exercise, balance, joint replacement and hydrotherapy groups, antenatal. • Balaklava – exercise and balance groups. Transitional Care Packages (95 available across the state). Restorative Care Packages (8 available across the state). There are currently a range of partnerships and interagency forums including: Peterborough: Our Thriving Community Leadership Group etc.	○ Expand stoma clinics with a focus on skill development and succession planning. ○ Continence service. ○ Cancer services: ▪ Breast care nurse model. ▪ Chemotherapy (patient and metro confidence in local services. ○ Palliative care. ○ Specialised care options in mental health. ○ Exercise physiology. ○ Better Care in the Community. ○ Restorative programs. ○ Lymphoedema services. ○ Podiatrist medication prescription. ○ Hand therapy. ○ Rehab services. ○ Modified barium swallow assessment. ○ Voice prosthesis. ○ Respiratory and sleep study clinics • Utilise digital technology to grow and support specialised services. **RS6. Expand rehabilitation services and opportunities for all clients within the LHN** • Consider expanding rehabilitation services across the LHN for inpatients and outpatients. • Liaise with metro counterparts to ensure patients transferred back to LHN have access to timely intensive rehab opportunities. • Investigate upskilling opportunities for all rehabilitation services (including geriatric and high intensity rehab). • Extend TCP capacity in Port Broughton.

Current	Proposed
The current rehab and specialised care workforce is variable depending on discipline and allocated based on demand.	• Explore why TCPs cannot be provided in casemix hospitals. **RS7. Improve Infrastructure and facilities to support effective specialised care and rehabilitation Services in YNLHN health units** • Review current infrastructure and facilities to ensure standards are being met (particularly in regards to space, privacy, safety and client need). • Identify opportunities to improve infrastructure and facilities where needed.
Items for consideration: • Linkages with Wallaroo, Clare, Port Pirie and Balaklava Service Planning • ZED Managing and Consulting Aged Care – YNLHN Aged Care review. • Linkages with YN LHN Rehabilitation model of care project	

3.3.4 NDIS

Current	Proposed

Service description summary:
 	
The NDIS is a Commonwealth-funded national scheme to support those living with disability aged under 65 years to access support and services that help them live the life they choose. Country Health Connect is a registered South Australian NDIS provider.
 	
Current service capacity:
 	
YNLHN provide both 1:1 and group services across the lifespan along with advocacy and support.
 	
NDIS coordinators liaise with KUDOS and Baptist Care to manage referrals, quoting and service agreements for child and adult services
 	
<u>0-7 years</u>
 	
The healthy families team currently allocates approximately 60% staff time across all disciplines to NDIS. 8.3 full time equivalent (FTE) of the CHAD team is NDIS funded.
 	
<u>Adult therapy services</u>
 	
From within existing resources a degree of ad hoc Community and Allied Health
	Service description summary:
	
	Maintain and enhance a best practice and responsive NDIS service across YNLHN.
	
	Service improvements summary:
	
	N1. Develop a quality NDIS workforce to service the needs of the YNLHN population
	• Develop an innovative recruitment and retention strategy for NDIS allied health professionals:
	  ○ Consider incentives (training, housing, after hours opportunities).
	  ○ Student placements.
	  ○ Increase equity across the LHN with NDIS staff and services.
	• Support regular upskilling opportunities for staff providing adult NDIS services.
	• Link in with other NDIS service providers for workforce planning opportunities.
	• Develop an NDIS workforce plan and risk matrix for YNLHN considering increasing future needs of NDIS services/staff and associated support required by staff (infrastructure, facilities, supervision, training etc.).
	• Partner with Uni Hub to encourage home-grown students/employees.
	
	N2. Improve access to flexible streamlined NDIS service across the YNLHN
	• Advocate for flexibility within NDIS guidelines to explore funding and other potential services available while clients are waiting for their package of care.
	• Streamline and coordinate waitlists for assessments, development of plans and provision of services.
	• Improve transition process between NDIS age groups and programs.
	• Identify gaps within our demographics and re-orientate to meet demands.
	• Collaborate with other service providers and consumers to develop and promote a database of NDIS providers within the LHN, the services they provide and how to access this.
	• Promote YNLHN community and allied health as the organisation of choice to engage with for navigating NDIS within YNLHN considering:

Current	Proposed
professionals provide NDIS services across all disciplines to adults including: • *Occupational therapy (OT)*: equipment, home modifications, assistive technology. • *Physiotherapy (PT)*: gym exercise programs and maintenance (currently at capacity). • *Speech Pathology (SP)*: Goal orientated care plans for post-acute/post stroke/brain injury, oral eating/drinking reviews and episodic care for Augmentative and Alternative Communication (AAC) devices. Out of scope - allied health assistants group support, SP ongoing/maintenance therapy, PT equipment prescription, rehabilitation, OT assistive technology level 4, discharging adult OT/PT clients. Extensive waiting lists, with service at capacity.	○ Transitioning families onto NDIS. ○ Setting goals. ○ First point of call re NDIS service availability. **N3. Develop formal partnerships with other NDIS providers within the LHN** • Focus on the needs of the community and increase collaboration, communication and coordination between NDIS providers within YNLHN identifying ways to complement each other and share skill base. • Hold a 6-12 month forum for NDIS providers in YNLHN to review current services, identify gaps and plan for the future. • Investigate opportunities for cross professional development/supervision, shared flexible recruitment strategies and client transitions across services. • Consider lessons learnt from other services (e.g. aged care and CHAD multi-disciplinary team (multi D) model). • Collaborate with aged care stakeholders to develop appropriate residential services for aged NDIS: ○ (Multi D respite or residential accommodation services/facilities). **N4. Co-design a YNLHN strategic direction for NDIS services** • Development of NDIS business model • Assess the public versus private ethical considerations of care provision by YNLHN and define our core business. • Seek consumer input on how NDIS is working – consider care for specific vulnerable groups (e.g. Aboriginal and remote communities. • Embed a continual review process to address ongoing changing client demand. • Develop a transition process across the lifespan/programs. • Working in partnership with NDIS planners and other providers to improve timeliness and transition from general community and allied health services to a NDIS package. • Continue an early intervention focus and consolidate what we do well in this space. • Consider a policy on the wait time for NDIS for those not able to access a package.

Current	Proposed
	• Develop a process to oversee the quality and safety standards across the YNLHN.
Items for consideration: •	

3.3.5 Aboriginal health

Current	Proposed

Service description summary:
 	
YNLHN Aboriginal health teams provide a range of culturally appropriate services to Aboriginal and Torres Strait Islander people across the YNLHN. Service delivery centre's include the Tarpari Wellbeing Centre and GP Plus (Port Pirie), Point Pearce Health Centre, Yanggalagawi (Moonta), Nurungga (Maitland).
 	
Current service capacity:
• Chronic condition management.
• Screening services including child and adult health checks.
• Pregnancy and early childhood outcomes.
• Primary health care / early intervention.
• Home care services (southern only).
• Social and emotional wellbeing.
• Drug and alcohol services including prevention and early intervention.
• Hospital liaison.
• Home Care Packages (southern only).
	Service description summary:
	• Maintain and enhance Aboriginal health services across YNLHN.
	• Support Aboriginal health workforce.
	
	Service improvements summary:
	
	A1. Promotion of services available and increased engagement with community and Aboriginal health team by Community and Allied Health services
	• Develop methods to promote services within community (word of mouth, Facebook, newsletters, TV).
	• Consult with consumers (both non-attendees and current clients) to understand barriers to access and continued engagement with the service outside of the Aboriginal health teams.
	• Promote Aboriginal health services to other service providers (internal and external).
	• Identify opportunities to build trusting relationships between community and the health service considering:
	  ○ Regular community connection sessions – meet and greets.
	  ○ Staff training to develop skills in culturally appropriate first point of contact conversations.
	• Support increased health promotion activities e.g. mobility provided previously by the Rainbow Healing Bus or something similar.
	• Explore opportunities to advocate for residential aged care to be culturally appropriate.
	
	A2. Support Aboriginal Health Workers (AHW) role
	• Support AHWs living within community.
	• Develop incentives to increase number of Aboriginal health workforce considering:
	  ○ Training – available locally.
	  ○ Promote AHW roles within community.
	  ○ Improve career pathways (e.g. NT pathways and Aboriginal health practitioner roles, and appropriate classifications).

	○ Investing in Aboriginal health workers. ○ Identify and reduce barriers for recruitment. **A3. Support Aboriginal health workforce** • Consider employment of a Child and Family Health Services Aboriginal specialised clinician. • Support for AHWs across the region (consider geographic isolation and opportunities to connect as teams). • Ensure consistent allocated midwife for each Aboriginal maternity patient to develop positive engagement and support follow up. • Maintain an Aboriginal specific general practice clinic service (explore options across YNLHN). • Value, recognise and empower AHW to provide strong advocacy for their clients. • Identify methods to reduce turnover of staff across services for consistent allied health and nursing service provision to Aboriginal and Torres Strait Islander consumers. • Aboriginal health team to be supported by all other teams to provide safe and effective services across the LHN. • Community and Allied Health Services to work alongside Aboriginal health team ensure consistent communication, collaboration, training: ○ Investigate capacity to support work shadowing and mentoring opportunities (non-Aboriginal workers shadowing AHW and vice-versa). • Identify, maintain and utilise current staff strengths within workforce. • Explore recruitment and retention opportunities considering: ○ AHW practitioner roles. ○ Professional development opportunities. ○ Training scholarships and/ or traineeships for Aboriginal people. ○ Investigate and reduce barriers for Aboriginal employment/recruitment (e.g. Implementation of casual AHW role/pool to assist with AHW leave and succession planning). • Invest in innovative all YNLHN staff cultural learning (not just Aboriginal health). **A4. Improve equity of Aboriginal Health services across YNLHN** • Map service availability across YNLHN and identify gaps in areas.

	• Develop a consistent whole of LHN wide Aboriginal health service to improve accessibility, consistency, flexibility and culturally appropriate facilities. • Invest in seeking knowledge and support from other LHNs and states. **A5. Develop strategic partnerships to further improve services for Aboriginal communities and clients** • Build networks and strengthen collaboration with key stakeholders to link up services and cover gaps to meet the needs of clients (e.g. Nunkuwarrin, CAHFS, Uniting Communities, General Practice and Sonder). • Investigate ways to support the continuation of general practice clinic. • Consider formal partnership with universities to improve research opportunities (improve data capturing, apply consumer engagement context and measurements/evidence of improvement in health).
Items for consideration: • This table has been developed with a broad view of Aboriginal health within the YNLHN community and allied health service. While the current capacity and services are listed of the Aboriginal health teams the service improvements contextualise the required community and allied health commitment to the health and wellbeing of our Aboriginal and Torres Strait Islander consumers, families and communities.	

3.3.6 Aged care

Current	Proposed

Service description summary:
 	
The Healthy Ageing Team works across the LHN for clients 65+ years, and/or 50 years or older (45 years or older for Aboriginal and Torres Strait Islander people) and on a low income, homeless, or at risk of being homeless, providing ACAT assessments, homecare, day centers/programs, respite, flexible care, personal assistance, equipment and home modifications, and social activities.
 	
Allied and community health disciplines supporting aged clients include community nursing, occupational therapy, speech pathology, physiotherapy, social work, dietetics, podiatry, allied health assistants and home support workers. A visiting geriatrician provides support.
 	
Current service capacity:
 	
Both 1:1 and group services are provided through the Commonwealth Home Support (CHSP) funding.
 	
Ad hoc residential aged care support by allied health professionals.
	Service description summary:
	
	Maintain and enhance Aged Care services within the YNHN community settings and develop suitable support mechanisms to assist access.
	
	Service improvements summary:
	
	AC 1. Develop a YNLHN aged care specific model of care
	• Develop coordinated and supported specific student led model services considering:
	  ○ Increase opportunities for flexible student placements.
	  ○ All students completing projects that are aged care focused.
	  ○ Engaging students to value add services e.g. Hamill House model (residential aged care services).
	  ○ Increased student opportunities and grow own workforce (e.g. Broken Hill model).
	• Support a specific and planned workforce model to meet increased demand for health care plans:
	  ○ Develop flexible workforce models across sites/sectors.
	  ○ Build supportive and collaborative networks to ensure workforce in small communities is sustainable (e.g. care worker agency and private clinicians).
	  ○ Invest in cadetship/traineeships.
	  ○ Ensure all staff have adequate supervision/support/clinical oversight.
	  ○ Promote working within aged care as a career option of choice.
	• Expand Allied Health model of care for residential aged care services:
	  ○ Recommend allied health to be part of the care team and involved in initial assessment process with a focus on restorative/early intervention care.
	  ○ Encourage collaboration between residential aged care and allied health re quality improvement strategies.

In home support (up to four hours per fortnight per client) including: • Allied health and nursing. • Gardening. • Domestic assistance. • Personal care. • Social support (shopping, appointments, meals/cooking, outings). • Group and individual. • Carer respite. • Transport. Healthy ageing teams also provide community support workers for domestic assistance, personal care and social support for Transition Care Packages, palliative care, under 65 community care, NDIS and post-acute where circumstances require assistance. .	○ Improve awareness and understanding of referral pathways by residential aged care nursing staff. **AC 2. Build partnerships to support collaboration to improve the health and wellbeing of the aged community.** • Develop formal partnerships, networking and collaboration between NGO and Government providers to support client outcomes ○ Simplify processes for clients to acquire support and to access services ○ Health care plan collaborative arrangements to ensure providers can work in partnership for the benefit of the client • Improve awareness and understanding of referral pathways: ○ Education of medical practices and hospital staff, particularly during discharge. **AC 3. Support access to appropriate services** • Support culturally appropriate services for communities: ○ Provide for clients from other cultural backgrounds. ○ Assist Aboriginal consumers being supported both in home and if residential care is required ensuring it is culturally appropriate and within the local area. ○ Investigate negotiating My Aged Care red tape which limits access/flexibility to services, particularly for those who are transient. ○ Develop and promote flexible and streamlined transition points to services. • Increased access to specialised services: ○ Enhanced and supported psychogeriatric assessments. ○ Raise the profile of allied health and their role in the psychogeriatric assessment area. ○ Ensure social work access in aged care. ○ Investigate a nurse practitioner model for psychogeriatric assessments. ○ Support increased skill development around psychogeriatric care. ○ Appropriate home based services community support worker and coordinators training general and specific to consumer.

	• Establish flexible and appropriate care options for younger people: ○ Ensure supports to navigate the appropriate funding systems.
Items for consideration: • ZED Managing and Consulting Aged Care – YNLHN Aged Care review. • Current organisational structure within healthy aging teams regarding clinical oversight and staffing. • A separate process will be undertaken to develop a Home Care Package service model in YNLHN.	

3.4 Other factors for consideration

Linkages to the following planning processes and plans will be important in the implementation phase:

- Linkages with Clare, Port Pirie and Balaklava planning.
- Ongoing master planning activities within YNLHN including the creation of a hub at each case mix site
- Linkages with Rural Health Workforce Strategy (RHWS).
- Specific workforce plans have been developed or are under development including:
    - SA Rural Allied Health Workforce Plan.
    - SA Rural Nursing and Midwifery Workforce Plan.
- Current partnership with SA Health Performance and Commissioning Team to review the intermediate care program.
- Digital Health SA, Regional Analysis, YNLHN.
- Mid North Needs Assessment considerations.
- Access framework considerations.

The following enablers have been drawn out of the Service Improvements Summary outlined in the service priority tables.

3.4.1 Capital/infrastructure/equipment

A range of strategies regarding long-term capital, infrastructure and equipment requirements have been identified in the service priority tables:

- Improve infrastructure, facilities and equipment to support effective specialised care and rehabilitation services in YNLHN health units to ensure standards are being met (particularly in regards to space, privacy, safety and client need).
- Improve infrastructure, facilities and equipment to support effective paediatric/youth services in YNLHN health units particularly Riverton, Balaklava, Peterborough and Kadina.
- Harness and utilise appropriate technology (e.g. COVID-19 learnings, age appropriate technological infrastructure and equipment).
- Ensure that Community & Allied Health infrastructure needs are highlighted within master planning activities to create a hub at each of the case mix sites

3.4.2 Workforce

Workforce planning is a key enabler of the plan and should be undertaken in consultation with the Rural Health Workforce Strategy Implementation Manager and the Director, People and Culture, YNLHN.

Concurrently to this plan being developed the Rural Health Workforce Strategy has developed and released for consultation draft Rural Nursing and Midwifery and Allied Health Workforce Plans. These draft plans have been considered during the development of the YNLHN Community and Allied Health Service Plan with the themes of both RHW draft plans closely aligning to the workforce objectives within the YNLHN Community and Allied Health Service Plan as evidenced below.

Consultation Draft SA Rural Allied Health Workforce Plan themes

- Building a skilled workforce.
- New and sustainable workforce models for rural health care.
- Developing a collaborative and coordinated health system.

Specific workforce considerations identified through the YNLHN Community and Allied Health Service Planning process have been outlined in the service priority tables and include:

Maintain a sustainable workforce including:

- Professional development for trauma training and other identified professional development gaps.
- Address gaps in FTE, based on scope of practice, services and geographic client needs.
- Support the Pipeline workforce model and clinical leadership.
- Develop an NDIS workforce plan and risk matrix for YNLHN considering increasing future needs of NDIS services/staff and associated support required by staff.
- Develop flexible workforce models across sites/sectors.
- Promote working within community and allied health.

Build a highly skilled workforce including:

- Increase AHA scope of practice/credentialing (specialised care, rehab)
- Upskilling programs mentoring/exchange programs and role shadowing across acute/aged/Community and Allied Health (Intermediate, Adult NDIS)
- student led models of care
- credentialing pathway and strengthened clinical supervision
- Extend rural generalist pathway

Retention and recruitment strategies including:

- Minimise short term contracts offer housing/relocation support and encourage student placements.
- NDIS specific allied health professionals.
- Link in with other NDIS service providers for workforce planning opportunities.
- Partner with unihub to encourage home-grown students/employees.
- Invest in cadetship/traineeships.
- Consider use of private providers within residential aged care and hospital sites to address shortage of allied health staff.

Aboriginal health

- Support Aboriginal health workers living within community.
- Develop incentives to increase number of Aboriginal health workforce considering (training, AHWs, specialised clinician roles, career pathways, allied health professional roles).
- Identify methods to reduce turnover and transiency.
- Support work shadowing and mentoring opportunities.
- Invest in innovative all YNLHN staff cultural learning (not just Aboriginal health).

3.4.3 Governance

Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. It describes an integrated system to maintain and improve the reliability and quality of patient care, as well as improve patient outcomes, including the following five criteria:

Governance and quality improvement systems - there are integrated systems of governance to actively manage patient safety and quality risks.

Clinical practice - care provided by the clinical workforce is guided by current best practice.

Performance and skills management - managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high-quality health care.

Incidents and complaints management - patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.

Patient rights and engagement - patient rights are respected and their engagement in their care is supported.

Acknowledgments

We acknowledge the Aboriginal Custodians of the Land and Waters within the Footprint of the Yorke and Northern Local Health Network. 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 pay respect to the cultural authority of Aboriginal people who have advised us during the service planning process and who have provided valued cultural consultancy in the development of this service plan.

The Yorke and Northern LHN Community and Allied Health Service Planning Steering Group would like to thank the many clinicians, stakeholders and consumers who gave their time, expertise and views to work with us to develop this service plan.

Members of the YNLHN Community and Allied Health Service Planning Steering Group

- Melissa Koch - Executive Director Community & Allied Health, YNLHN
- Cass McNeil – Community & Allied Health Operations Manager
- Fiona Murray – YN LHN Allied Health Advisor
- Viv London – Healthy Living Team Leader
- Sean Broadfoot – Clinical Support Team Leader
- Tracey Stringer – Patient Journey Team Leader
- Meagan Reeve – Senior Clinical Podiatrist
- Edith Joseph - Senior Clinical Physiotherapist
- Hannah Reichstein - Senior Clinical Dietitian
- Jo Pilgrim - Senior Clinical Speech Pathologist
- Sonia Thornton - Senior Clinical Occupational Therapist
- Esther Miller – Healthy Families Team Leader
- Sue Kain- Community Nursing and Palliative Care Team Leader
- Tim Garfield – Community Nursing
- Barb Daw – Aboriginal Health Team Leader
- Tracey Davies/Erin Martin, Clinical Senior Social Worker
- Kerry Dix – A/Manager Planning and Population Health
- Deb Schutz – Population Health Development Officer, Planning and Population Health
- Allison Stringer – Business Services Manager

4. Service Plan Endorsement

Committee/ Responsible Person	Date
 **Yorke and Northern LHN Community and Allied Health Service Planning Steering Group Chair, Cassandra McNeil**	13th July 2021
 **Yorke and Northern LHN, Executive Director Community & Allied Health, Melissa Koch**	13th July 2021
 **Yorke and Northern LHN, Chief Executive Officer, Roger Kirchner**	20th August 2021

Appendix A: Steering Group Terms of Reference

YNLHN Community and Allied Health Service Planning Steering Group

Scope and Purpose

The purpose of the Steering Group is to provide advice and direction to Yorke and Northern LHN (YNLHN) to guide the development of a Community and Allied Health Service Plan.

Scope of the Service Plan

The Service Plan will provide a framework for identifying and evaluating potential future service options for the provision of Community and Allied Health Services across the Yorke & Northern Local Health Network to meet the needs of the Community Health catchment over the next 10 years and beyond. The Service Plan will provide recommendations as to most effective utilisation of available Community and Allied Health resources.

Roles and Responsibilities

The Steering Groups primary role is to:

- Provide advice to Regional YNLHN executive 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 Yorke and Northern Local Health Network catchment to determine the future implications for the Health Service specifically in relation to access to Allied Health Services.
- Provide advice on future self-sufficiency of Community and Allied Health Services.
- Provide feedback on recommendations and priorities as they are developed
- 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

Membership and Meeting Information

Membership

Core membership comprises of the following:

Chair:

- Fiona Murray – YN LHN Allied Health Advisor

Members:

- Melissa Koch - Executive Director Community & Allied Health, YNLHN
- Viv London – Healthy Living Team Leader
- Cass McNeil – Community & Allied Health Operations Manager
- Sean Broadfoot – Clinical Support Team Leader
- Tracey Stringer – Patient Journey Team Leader
- Meagan Reeve – Senior Clinical Podiatrist
- Edith Joseph - Senior Clinical Physiotherapist
- Hannah Reichstein - Senior Clinical Dietitian
- Jo Pilgrim - Senior Clinical Speech Pathologist
- Sonia Thornton - Senior Clinical Occupational Therapist
- Esther Miller – Healthy Families Team Leader
- Sue Kain- Community Nursing and Palliative Care Team Leader
- Tim Garfield – Community Nursing
- Gail Marshall or Barb Daw – Aboriginal Health Team Leader
- Tracey Davies/Erin Martin, Clinical Senior Social Worker
- Kerry Dix – A/Manager Planning and Population Health
- Deb Schutz – Population Health Development Officer, Planning and Population Health
- Emma Kuhlmann - Senior Project Officer

Member responsibilities

The Yorke & North Local Health Network Community and Allied Health Service Planning Steering Group has been established in recognition of the skills, knowledge and experience that the members can bring to the planning process. The responsibilities of members include:

- A willingness and ability to attend and participate in meetings of the Steering Group over a period of up to 12 months
- Encouraging input from broader stakeholders
- Declaring any conflicts of interest
- Adhering to Yorke and Northern LHN data protocols, including not publishing, or releasing data to any other party, without appropriate authority from the Department of Health & Wellbeing
- Operating in an environment based on respectful behavior's

Resources

The YNLHN will provide staff to support the Steering Group including:

- arranging meetings, agendas, note taking (summary and action items)
- distribution of materials and other administrative functions

Rural Support Service will provide staff to support the Steering Group including:

- preparation and analysis of required data
- facilitating engagement of other stakeholders as required

Steering Group Operations

The Steering Group will operate by:

- Ensuring a quorum, which will consist of 7 members
- Making decisions about what to recommend to YNLHN Executive by consensus.
- Having a written summary of discussion, comments, recommendations and actions from each meeting prepared in the form of minutes
- Circulating meeting minutes to group members prior to the commencement of the next meeting via email and providing hard copies of meeting papers to members at the meeting.

Meeting Frequency

Meetings shall be held on first Wednesday of the month from 9th October 2019.

Location: Port Pirie and videoconference

Process Timeline

1st Meeting of Steering Group: • Setting the Scene, terms of reference • Initial analysis of demographic and health utilisation data profile and identify other data requirements • Agree on the catchment • SWOT of current and future service	9th October 2019
2nd Meeting of Steering Group: • Determine wider clinician engagement approach • Further analysis of demographic and health utilisation data • Discuss initial future service options	6th November2019
Clinician Engagement Workshop • Further focus group work	August - Sept 2020
3rd, 4th Meeting of Steering Group: • Consider recommendations / feedback from the clinician engagement Workshop • Consider future demand across xxx services • Recommend future service options for draft service plan	Oct - Dec 2020
5th Meeting of Steering Group: • Consider final draft service plan. • Determine any further analysis required • Evaluate approach	Feb 2021

Appendix B: Clinician Workshop attendance

A clinician engagement workshop was held on the 14 October 2020 as part of the co-design health service planning process for the YNLHN Community and Allied Health Service Plan. It was attended by a range of clinical stakeholders including YNLHN clinical staff (acute and community health), private Allied Health Providers, Aged Care providers, University staff and YNLHN executive.

Attendance

SURNAME	FIRST NAME	ORGANISATION
1. BENNETT	Liz	YNLHN
2. BREBNER	Chris	Flinders University
3. BUSSENSCHUTT	Brooke	YNLHN
4. BUTLER	Deb	YNLHN
5. CARMICHAEL	Maeve	YNLHN
6. COOMBES	Jo	Department for Child Protection (DCP)
7. CROSS	Coralie	YNLHN
8. DIX	Kerry	Rural Support Service
9. DOHNT	Karlee	YNLHN
10. DYMMOTT	Ali	Flinders University
11. EADES	Michael	YNLHN
12. EDWARDS	Alyse	YNLHN
13. GOEHRING	Megan	YNLHN
14. GODLEMAN	Sharon	YNLHN
15. HAWKINS	Tracie	YNLHN
16. HEIN	Nicole	YNLHN
17. HIGGINBOTTOM	Narelle	Helping Hand
18. JACKSON	Sue	YNLHN
19. JACOB-DONNELLY	Skye	YNLHN
20. KAIN	Sue	YNLHN
21. KOCH	Mel	YNLHN
22. LARWOOD	Jacqueline	YNLHN
23. LAWRIE	Lynore	YNLHN
24. LIU	Neal	YNLHN
25. MARTIN	Erin	YNLHN
26. MCNEIL	Cass	YNLHN
27. MILLER	Esther	YNLHN
28. NORTON	Hannah	YNLHN
29. NUGENT	Maureen	Helping Hand
30. PLAYER	Leonie	YNLHN
31. PRYOR	Janette	YNLHN

32.	REICHSTEIN	Hannah	YNLHN
33.	KELLY	Tyler	Advanced Physio Solutions
34.	RENDELL	Nick	Advanced Physio Solutions
35.	SCHUTZ	Deb	Rural Support Service
36.	STRINGER	Allison	YNLHN
37.	STRINGER	Tracey	Rural Support Service
38.	TRENGOVE	Amy	YNLHN
39.	WATKINS	Sue	YNLHN
40.	WELKE	Kerry-Lee	YNLHN
41.	YOUNG	Sarah	YNLHN
42.	YOUNG	Nigel	Thrive Health Group
43.	ZWAR	Joyti	UniSA
44.	HOSKIN	Ann-Marie	YNLHN
45.	HEWETT	Kim	Rural Support Service
46.	FALCONE	JAN	YNHN
47.	CROUCH	Rosanne	Rural Support Service
48.	BENNETT	Liz	YNLHN
49.	BREBNER	Chris	Flinders University

Apologies

SURNAME	FIRST NAME	ORGANISATION
1. DAW	Barbara	YNLHN
2. AFFORD	Mikell	YNLHN
3. BROADFOOT	Sean	YNLHN
4. CRISP	Anita	Uni Hub
5. RICHARDS	Samantha	Helping Hand
6. ZUBERNICH	Alan	Regional Development Australia
7. REEVE	Megan	YNLHN
8. LONDON	Viv	YNLHN
9. HOGG	Gemma	NDIS
10. GARFIELD	Tim	YNLHN
11. JOSEPH	Edith	YNLHN
12. LEHMANN	Andrea	YNLHN
13. KAVAHAGH	Margaret	NDIS
14. KNIGHT	Rob	DoE

Appendix C: Glossary

ABS – Australian Bureau of Statistics

ACAT – Aged Care Assessment Team

AHA – Allied Health Assistant

AHP – Allied Health Professional

AHW – Aboriginal Health Worker

BCC – Better Care in the Community

CaFHS – Child and Family Health Services

CALD – Culturally and Linguistically Diverse

CAMHS – Child & Adolescent Mental Health Service

CCCME – Country Consolidated Client Management Engine, a client based community health data collection program

CHAD – Child Health and Development

CHC – Country Health Connect

CHS – Community Health Service

CHSP – Commonwealth Home Support Program

COPD – Chronic Obstructive Pulmonary Disease

COVID-19 - an infectious disease causing a worldwide pandemic in 2020

CRU - Country Referral Network

DTN – Digital Telehealth Network

DVA – Department of Veteran Affairs

ED – Emergency Department

EOLP – End of Life Programme

FTE – full time equivalent

GP – General practitioner

HAC – Health Advisory Council

HACC – Home and Community Care

HCP – Home Care Packages

INTERMEDIATE CARE - a multidisciplinary community based service that aims to support hospital avoidance and earlier supported discharge for patients with chronic conditions and/or complex care needs within the YNLHN region.

LHN – Local Health Network

MH – Mental Health

MID NORTH NEEDS ASSESSMENT – numerous needs assessments conducted by university students on placement

NDIS – National Disability Insurance Scheme

NGO – Non Government Organisation

NLAS – Nurse Led Ambulatory Service

OT – Occupational Therapy

PHC – Primary Health Care

PHN – Primary Health Network

RAC – Residential Aged Care

RAH – Royal Adelaide Hospital

RHWS - Rural Health Workforce Strategy

RIBS – Rapid Intensive Brokerage Scheme

RSS - Department for Health and Wellbeing - Rural Support Service

SA – South Australia

SAMSS - South Australian Monitoring and Surveillance System

SAVES - South Australian Virtual Emergency Services

SEIFA – Socio-economic Indexes for Areas (Index of Relative Socio-economic Disadvantage)

TCP – Transition Care Program

TOR – Terms of Reference

UNIHUB - partnership with established universities around Australia allowing students in the region access university education without having to leave their home town.

YNLHN – Yorke and Northern Local Health Network

For more information

Roger Kirchner
Yorke and Northern Local Health Network
Port Pirie Regional Health Service
Cnr The Terrace & Alexander Street
Telephone: (08) 86 384575

sahealth.sa.gov.au/yorkeandnorthernlhn

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