YORKE AND NORTHERN
LOCAL HEALTH NETWORK

YORKE PENINSULA HEALTH SERVICE PLAN 2019

Considering the catchment areas of:

- **Central Yorke Peninsula (Maitland) Hospital and Health Service**
- **Southern Yorke Peninsula (Yorketown) Hospital and Health Services**

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

Table of Contents

1. Executive Summary

Yorke Peninsula Health Services, comprising the Central Yorke Peninsula Health Service (Maitland Hospital) and the Southern Yorke Peninsula Health Service (Yorketown Hospital) are part of the Yorke and Northern Local Health Network (YNLHN). Both hospitals are classified as smaller grant funded hospitals and provide emergency, acute inpatient care, and outpatient services with renal dialysis provided at Maitland Hospital. Aged Care is provided at *Melaleuca Court Nursing Home* - a stand alone facility at Minlaton, with state funded aged care beds available at Maitland Hospital**.**

Country Health Connect offers a wide range of community, in-home and residential aged care, early childhood and disability support services.

Other non government health services in the catchment include a community hospital based at Ardrossan, the Minlaton Health Centre which provides health clinics and emergency services.

The catchment area includes all the the townships of the Yorke Peninsula south of Moonta and Kadina including Maitland, Minlaton, Ardrossan, Yorketown, Port Victoira, Port Rickaby, Port Vincent, Edithburgh and surrounding communities.

This Service Plan reflects the overarching future plan for health service provision in the area. The plan provides a range of information and data from a variety of sources, which highlight recent patterns of service delivery. Analysis will continue to inform a collaborative approach with other key service providers to plan and develop services to meet the changing needs of the catchment population in the medium term.

This Service Plan identifies a range of service initiatives which will support the provision of safe, quality services closer to home and is underpinned by a number of key strategic drivers, including: Country Health SA Local Health Network Strategic Plan 2015 - 2020, Clinical Services Capability Framework, SA Health Strategic Plan 2017-2020, Country Health SA Community and Consumer Engagement Strategy, A Partnership Framework for Health Advisory Councils and Country Health SA and the SA Health Aboriginal Cultural Respect Framework.

A co-design service planning process was led by the Yorke Peninsula Health Service Planning Steering Group (the Steering Group), supported by the YNLHN, SA Health Rural Support Service Planning Team and a wide range of clinicians who were engaged through workshops and focus groups in 2019. Broader and ongoing involvement of clinicians will be essential to progress service initiatives.

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

Emergency Services

Maintain level 2 emergency services for both Maitland and Yorketown, enhance patient care and provide patient journey improvements.

ES1. Explore sustainable staffing requirements for emergency service demand.

ES2. Review current Accident and Emergency areas for improvement of work flows and the patient journey.

ES3. Explore the potential for increased mental health emergency support.

ES4. In partnership with SA Ambulance, investigate demand and requirements for expanded paramedic services and support, including considering a community paramedic model for the Southern Yorke Peninsula area.

ES5. Investigate ability to increase out of hospital strategies to support emergency service avoidance.

Medical Inpatient Services

Maintain level 2 medical inpatient services and enhance patient care at both Maitland and Yorketown Hospitals.

IS1. Improve communication systems to enhance patient centred holistic care.
IS2. Enhance services for patients with a mental health condition.
IS3. Improve management and appropriate support for patients with drug and alcohol conditions.
IS4. Explore the ability to prevent avoidable admissions.
IS5. Build up local community confidence and awareness in the services provided.
IS6. Explore options for continuation of midwifery service provision post-natal care.
IS7. Review ageing hospital infrastructure for meeting of standards, improved patient flow and safer patient outcomes.
IS8. Exploring recruitment and retention opportunities.

Surgical and Anaesthetic services

Maintain the level 3 surgical and anaesthetic services (and review when Yorketown Hospital upgrade is completed) by considering the following:

SS1. Complete Yorketown Hospital upgrade to procedural room.
SS2. Ensure compliance with National Safety and Quality Health Service (NSQHS) Clinical Care Colonoscopy standards.
SS3. Define the services required to best meet the needs of the catchment.
SS4. Review of equipment that is not be included in the procedure redevelopment.
SS5. Review emergency service procedures requiring sedation.
SS6. Investigate the feasibility of nurse proceduralists and nurse sedationists for Yorketown.

Mental Health Services

Maintain and enhance the level 2 mental health inpatient care provided by the hospital and expand the level 4 ambulatory care provided by the Yorke Peninsula Community Mental Health Team

MH1. Improve service provider and community awareness and understanding of regional mental health stepped care continuum.
MH2. Enhance the services and infrastructure provided by the Yorketown and Maitland hospitals to best meet the needs of clients with a mental health condition.
MH3. Explore opportunities to expand current mental health services.
MH4. Proactively identify mental health service needs across the stepped care continuum.
MH5. Explore ways to work with family, carers and advocates of clients with a mental health condition to develop community programs that meet the needs of the community.
MH6. Enhance infrastructure/physical environment within the community mental health service.
MH7. Improve mental health services and support provided to Aboriginal consumers and the Point Pearce Aboriginal Community.
MH8. Enhance recruitment and retention of skilled mental health workforce.

Community and Allied Health services

Maintain and enhance allied and community health services with a focus on the following areas:

CH1. Improve access to the National Disability Insurance Scheme (NDIS) for clients in need.
CH2. Increase the range of community restorative services provided to at risk groups.
CH3. Improve awareness and understanding of referral pathways.
CH4. Explore opportunities to improve chronic disease management.
CH5. Build networks to support collaboration to improve the health and wellbeing of the community.
CH6. Explore ability to support allied health and Community Nursing staff to upskill into specialist roles.
CH7. Improve services for Aboriginal community members.

Aged Care Services

Maintain and enhance the services provided by the health services and the Community Aged Care services provided by Country Health Connect.

AC1. Improve hospital infrastructure and coordination to accommodate aged care specific needs.
AC2. Partner with relevant organisations (e.g. Country Primary Health Network - PHN) to increase the range of wellness activities provided in the community.
AC3. Support consumers and their carers to negotiate the My Aged Care portal and engage providers.
AC4. Review Aged Care Support Services to improve access and reduce waiting times.
AC5. Investigate the feasibility of additional Aged Care Support Services.
AC6. Review dedicated staffing for Aged Care positions.
AC7. Increase and enhance the hospital avoidance programs.
AC8. Coordination and collaboration across sectors for focus meetings to support the patient journey for complex clients eg mental health.
AC9. Implement appropriate recommendations from the Aged Care Royal Commission.

Palliative Care Services

PC1. Explore opportunities to access funding and staff availability/capacity for a service that meets community need (including a 24/7 service).
PC2. Improving the patient journey for palliative care patients.

In addition to these service priority areas, opportunities to strengthen workforce and infrastructure will be key enablers for this plan. The particular areas considered a priority for workforce include, recruitment and retention, increasing specialist roles, ongoing culture and leadership development along with specific strategies for nursing, allied and community health and medical officers. The YNLHN leadership and the YNLHN Board will have an operational oversight role in the implementation and monitoring of this plan.

2. Project Background and Context

2.1 Strategic Enablers

The YNLHN is committed to continuing to address the Country Health SA Local Health Network (CHSALHN) Strategic Plan 2015-2020 while they instigate the process of developeding their own strategic plan.

As outlined in the CHSALHN Strategic Plan 2015-2020, work will continue on increasing access to services for country residents by investing in infrastructure and providing services as close to home as safely as possible, to reduce the need for people to travel to Adelaide.

This Strategic Plan sets the vision and direction for the health care system in rural South Australia to provide safe, high quality, accessible health care, tailored to the needs of country residents. The plan supports the vision and direction of the SA Health Strategic Plan and builds on the 10 year Local Health Service Plans which were developed as part of the Strategy for Planning Country Health Services in South Australia.

The SA Heath Strategic Plan 2017-2020 aims to support South Australians to be healthy, enjoy a great quality of life and experience a safe, contemporary and sustainable health care system, underpinned by three key roles for SA Health to:

- Lead: enable, protect, guide and support the health and well-being of all South Australians.
- Partner: collaborate with a diverse range of partners so that South Australians benefit from a full range of health and well-being services.
- Deliver: directly provide evidence informed, high quality services across our communities from beginning to end of life.

The following principles will guide the implementation of strategic actions:

Unified

Design and implementation of these initiatives will involve a collaborative approach, involving people from across SA Health and, when appropriate, partners from outside SA Health.

Flexible

The team that implements strategic actions will require a mind-set that is willing to adapt and change to achieve outcomes and suit the dynamic environment. A focus on the outcomes that are to be achieved supersedes the need to follow the predetermined steps – adjustments to methodology are progressively made to achieve goals and manage risks.

Nimble

A nimble approach to strategic action implementation requires defining clear outcomes and a high-level implementation plan, and then an adaptable approach and willingness to change during the planned implementation. Each stage of an initiative is implemented based on careful planning of that stage, rather than waiting on a detailed plan of the full initiative or project. As subsequent stages are planned in more detail, they will be informed by the experience and learning of earlier stages.

Primary Drivers

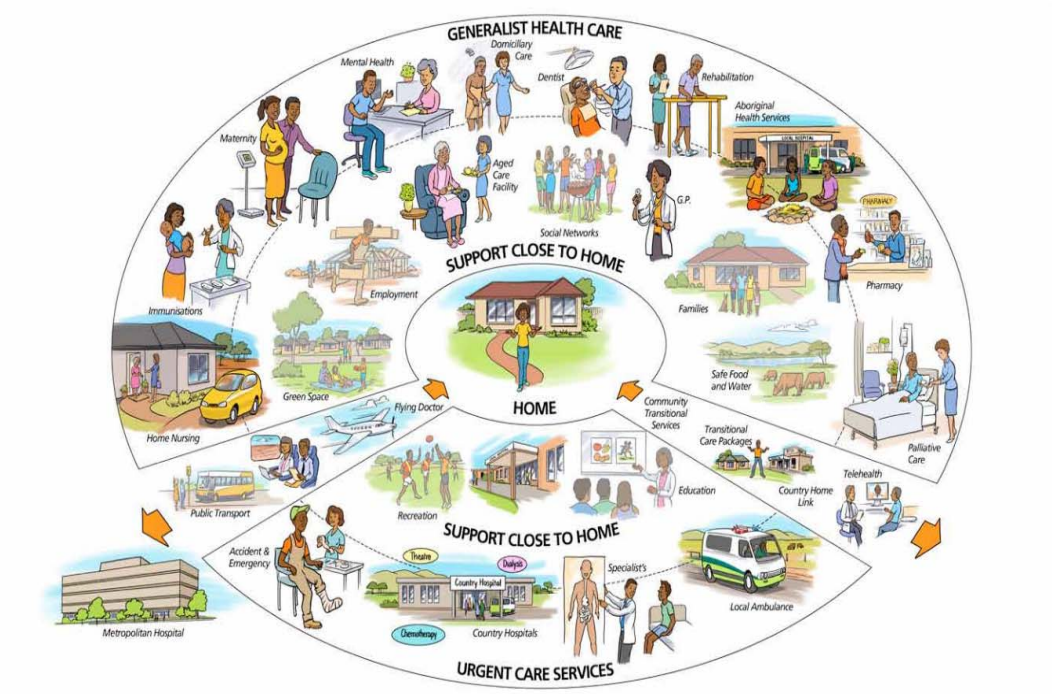
The primary drivers to achieve an effective Health Service Plan include:

- Reviewing current service models in line with the key principles and priorities identified in the CHSALHN Strategic Plan 2015-2020, SA Health Strategic Plan and the SA Health Aboriginal Cultural Respect Framework.
- Partnerships with the Royal Adelaide Hospital (RAH), Flinders Medical Centre (FMC), Women's and Children's Hospital (WCH) – for step down care and reducing emergency presentations and admissions to metropolitan services.
- Ensure the development and implementation of safe, high quality, equitable, accessible and efficient services delivered close to home.
- Improve patient access and flow across the system of care.
- Improve the consistency and quality of care.
- Implement evidence based, state-wide models of care.
- Reduce episodes of unplanned hospitalisations for all population groups.
- Improve collaborative working relationships with other service providers.
- Culturally appropriate and respectful physical facilities and services for Aboriginal people.
- Increase the ability to recruit and retain the required workforce.
- The workload and transport pathways of SA Ambulance Service (SAAS).
- Service models which will have the flexibility and capacity to respond to and meet the changing health and wellbeing needs of the population over the next 10+ years.

2.2 Governance

The LHN has a Governing Board which is responsible for the overall governance and oversight of local service delivery, including governance of performance and budget achievement, clinical governance, safety and quality, risk management and fulfilment of the Governing Board functions and responsibilities.

The Governing Board is responsible and accountable to the Minister for Health and Wellbeing.



The health services in the area, in partnership with general practitioners, will 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.

Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Its describes integrated systems that 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.

2.3 Yorke Peninsula Health Service Catchment Profile

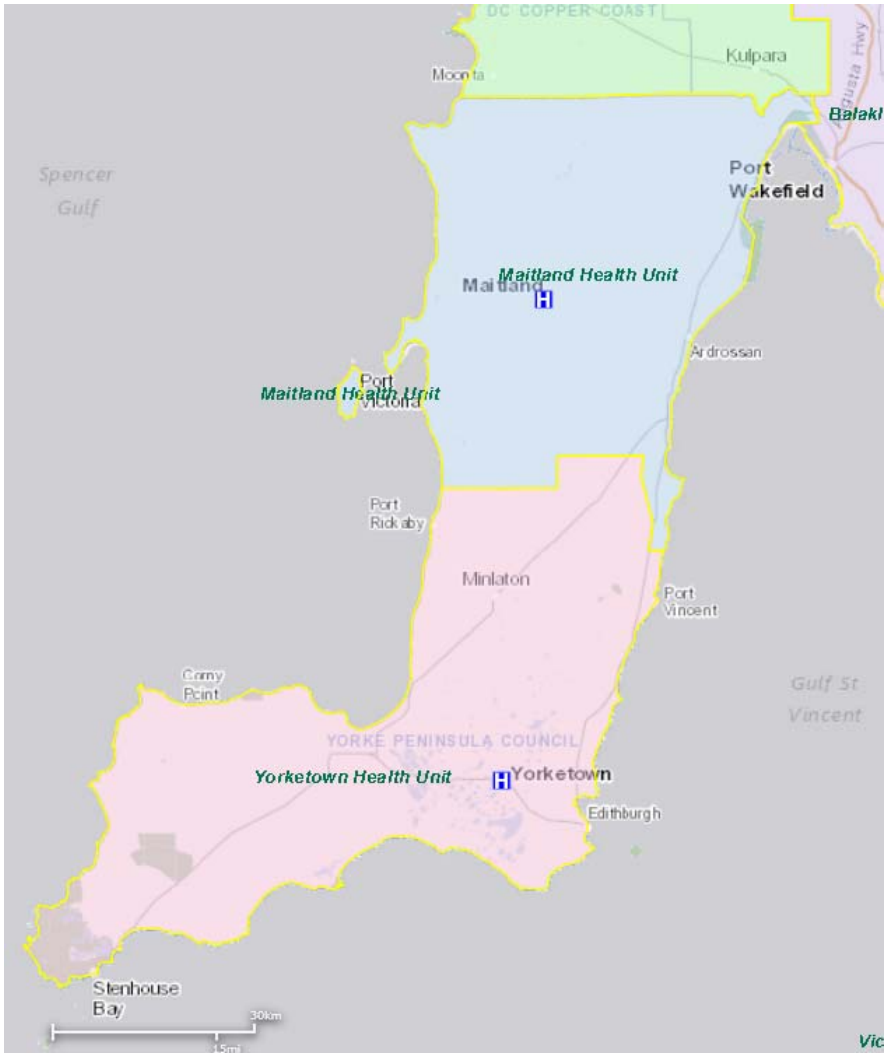
The Australian Bureau of Statistics (ABS) defined Yorke Peninsula - South Statistical Area 2 (SA2). The geographical catchment area for the Yorketown Hospital is the Yorke Peninsula – South SA2, and also includes part of the Yorke Peninsula – North SA2 (shared with the Maitland hospital catchment).

The Maitland Hospital is physically located in the Yorke Peninsula – North SA2. The geographical catchment area for the Maitland Hospital is part of the Yorke Peninsula – North SA2 (shared with the Yorketown Hospital).

Therefore, for the purposes of defining the geographic core catchment area of Yorketown and Maitland areas, the following ABS defined Statistical Area 1 (SA1s) have been used for the Yorke Peninsula – North SA2:

Maitland Hospital			Yorketown Hospital
4112701	4112710	4112716	4112703
4112702	4112711	4112719	4112704
4112706	4112712	4112720	4112705
4112707	4112713	4112721	4112717
4112708	4112714		4112718
4112709	4112715		

Map 1: Yorke Peninsula core catchment area



Population

The 2018 Estimated Resident Population of the Southern Yorke catchment is 11,308, with 14.0% aged under 14 years, and 33.2% aged over 65 years. The Southern Yorke catchment has a much lower proportion of persons aged 0-44 years compared to the SA population, and a much higher proportion of persons aged over 65 years.

2.6% of residents in the Southern Yorke catchment identify as Aboriginal and 1.3% speak a language other than English at home. The Southern Yorke catchment has a higher proportion of Aboriginal persons compared to the rest of the SA country population, but lower when compared to the SA population. The Southern Yorke catchment has a lower number of people from a CALD background when compared to the rest of the SA country population and SA population.

Table 1: Population profile for Yorketown and Maitland catchments

	Maitland Catchment		Yorketown Catchment		YNLHN	SA total
	No.	%	No.	%	%	%
Total Population	4,977		6,331		75,324	1,736,422
Males	2,573	51.7%	3,300	52.1%	50.3%	49.4%
Females	2,404	48.3%	3,031	47.9%	49.7%	50.6%
0-14 years of age	748	15.0%	832	13.1%	16.6%	17.7%
15-24 years	370	7.4%	500	7.9%	10.1%	12.6%
25-44 years	789	15.9%	921	14.5%	18.8%	25.7%
45-64 years	1,426	28.7%	1,966	31.1%	28.8%	25.6%
65-84 years	1,419	28.5%	1,871	29.6%	22.5%	15.8%
85 years & over	224	4.5%	242	3.8%	3.1%	2.6%
Aboriginal Torres Strait Islander *	240	4.9%	73	1.2%	2.7%	2.0%
CALD (Speaks a language other than English at home) *	79	1.6%	96	1.6%	2.8%	16.5%

Source: ABS, Population by Age and Sex, Regions of Australia, cat. No. 3235.0, released 29 Augusta 2019
**Source: ABS, 2016 Census, SA2 Geographical Classifications, viewed 16/08/2017, via Tablebuilder*
http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240

The Yorke Peninsula region attracts a high number of tourists (particularly family groups with children) significantly increasing the size of the catchment population during school and other seasonal holiday periods.

Population Growth & Projections

The resident population of Southern Yorke catchment is expected to decline by 2031

Table 2. Medium Stable Population Projections, 2016 - 2031

Area	2016	2021	2026	2031
Unincorporated Yorke SLA*	0%	0%	0%	0%
Yorke Peninsula – North SLA**	-0.9%	-0.9%	-1.0%	-0.7%
Yorke Peninsula – South SLA***	-1.0%	-0.4%	-2.9%	-4.0%

**all of this SLA in the Maitland catchment*
***this SLA split between Maitland catchment (69%), and Yorketown catchment (31%)*
****all of this SLA in the Yorketown catchment*
Source: http://www.dpti.sa.gov.au/planning/population, accessed 9/03/2016

Population projections are based on the 2011 Census of Population and Housing. These population projections should not be regarded as forecasts, but as calculations of future populations based on particular assumptions about future fertility, mortality and migration. Actual future populations will vary from these projections.

Health & Socioeconomic Status

Overall, the YNLHN experiences lower levels of socioeconomic disadvantage when compared with other areas of South Australia.

Self-reported health status of residents in the YNLHN for 2017 were 84.3% excellent, very good or good and 15.7% fair or poor.

The top five chronic diseases reported by residents in the YNLHN in 2017 were Arthitis (26.1%), Asthma (20.5%), Diabetes (8.6%), CVD (7.8%) and Osteoporosis (6.3%)

Compared with other more isolated communities in country South Australia, there are a range of (albeit limited) local and intrastate transport options available, including some community and patient transport schemes.

Transport from Yorketown to Adelaide is available three times per week, and from Wallaroo to Adelaide, several days a week. A health bus (Yorke Peninsula Community Transport and Services Inc.) travels from Yorketown to Adelaide, via Minlaton and the Copper Coast, Monday-Friday for people to attend medical appointments.

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2.4 Service Planning Process

The service planning process was led by the Yorke Peninsula Health Service Planning Steering Group, with representation from the Yorke Peninsula Health Advisory Council, Yorke and Northern regional leadership, Mailtand Hospital and Community Health staff, Ardrossan Community Hospital, Aboriginal Consumer representative, Mental Health, the Yorke Peninusla Council, the Local Member for Narungga and the Rural Support Service Planning and Population Health Team. Further details of the memberships are provided in Appendix A.

The role of the Steering Group was to:

- Supporting a positive culture of collaboration.
- Identify health improvement priorities
- Provide advice to 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.
- Provide advice on future self-sufficiency of the Hospital and Health Services in the catchment.
- Provide feedback on recommendations and priorities as they are developed.
- Identify and engage 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.

Health Service Utilisation Data

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. Insights from this analysis included:

- The Maitland Hospital has 16 multiday beds and 12 state funded nursing beds available, with an combined average of 16.7 occupied each night in 2017-18.
- The Yorketown Hospital has 23 multiday beds available, with an average of 5.8 occupied each night in 2017-18.
- In 2017-18, the top 5 same-day separation types for residents of the Southern Yorke catchment at the Yorketown and Maitland Hospitals by number of separations were Adult Medical, Dialysis, Adult Surgical, Paediatric Medical, Paediatric Surgical and Mental Health (equally). For the same time period, the top 5 same-day separation types accessed outside of the Southern Yorke catchment by number of separations were Adult Medical, Adult Surgical, Dialysis, Paediatric Surgical and Paediatric Medical (equally).
- In 2017-18, the top 5 multi-day separation types by number of separations for Southern Yorke residents at the Yorketown and Maitland Hospitals were Adult Medical, Adult Surgical, Mental Health, Paediatric Medical and Non-Acute Remainder. For the same time period, the top 5 multi-day separation types accessed outside of the Southern Yorke catchment by number of separations were Adult Surgical, Adult Medical, Mental Health, Obstetric and Paediatric Surgical.
- There were 1,645 emergency presentations at the Maitland Hospital in 2017-18. This is broken down by 136 triage 1 or 2, 375 triage 3, and 1,134 triage 4 or 5 presentations.
- There were 1,460 emergency presentations at the Yorketown Hospital in 2017-18. This is broken down by 58 triage 1 or 2, 249 triage 3, and 1,153 triage 4 or 5 presentations.
- In 2017-18, there were 51 births for women from the catchment. Of this number 54.9% were at public hospitals outside of the YNLHN.

Clinical Engagement

A clinician workshop was held on the 2 May 2019 at the Minlaton Golf Club as part of the co-design service planning process for the Yorke Peninsula Health Services. It was attended by a range of key stakeholders including local general practitioners, Health Advisory Council members, local and regional health services staff, Country Health SA managers and a range of external clinical service providers.
Over 40 participants attended, representing agencies including the SA Ambulance Service, Country SA Primary Health Network, the Ardrossan Hospital and Country Health SA. The workshop commenced with dinner and a data gallery. All participants were able to view, discuss and provide comment on a range of information and statistical data on the current services provided and best practice principles. Key highlights from the data that participants raised in informal discussions included:

- Ageing population.
- Transport limitations.
- Workforce – difference between FTE and people on the ground and the current age of the workforce.
- SA Ambulance services and the impact of the lack of volunteers.
- Seasonal trends / visitors to the Yorke Peninsula during holidays and the impact on services.

Small group workshops were also held on the priority areas below as identified by the steering group:

1. Aged Care inclunding Hospital Avoidance/Residential Care/Home Care
2. Community Services including Allied Health/Chronic Disease/Drugs and Alcohol
3. Mental Health
4. Palliative Care
5. In hospital services including Medica/Surgical/Anaesthetics/Accident & Emergency

The groups were asked to consider current strengths and challenges, what opportunities exist for the future, workforce and the patient journey. The key themes for each priority area that were identified from the focus group discussions were presented to the steering group.

Overall the clinician workshop was considered very positive with 96% of participants agreeing that the workshop was useful for future service planning and that the diversity of key stakeholders attending this workshop was useful and appropriate. Additionally, 100% of participants felt they were able to contribute their advice towards building sustainable services in the Southern Yorke Peninsula.

Community and Consumer Stakeholder Engagement

The Southern Yorke Peninsula Steering Group sought feedback from patients and their families during the month of July 2019 via the distribution of a postcard titled ***What would you like to tell us?***


The steering committee have been engaging health providers in the area and now wish to hear from the community in relation to the priority areas identified:

- Aged Care
- Mental health
- Hospital services
- Community services and allied health
- Palliative Care

...or anything else that is important to you about future health services.

What would you like to tell us?

Postcard collection boxes are located at the Maitland Hospital, Minlaton Health Centre, Yorketown Hospital or local information centre.

Or you can hand it back to a Health Advisory Council member.

We will consider all feedback and develop a plan that meets our community's needs. We will share that plan with our communities.

These postcards were distributed via hospitals and health services in Yorketown, Maitland, Ardrossan and Minlaton during the month of July. A link to the question ***What would you like to tell us?*** was also made a vailable via the HAC facebook page along with a generic email address for responses.

Themes from responses were clearly palliative care, allied health, ageing population, access to general practitioners and awareness of services. Other issues mentioned include drug and alcohol and access to mental health services out of hours.

The responses were all received from the Matiland and Yorketown drop points.

Consumer views were identified as an important component of the service planning and in particular a process of ongoing engagement and in-depth targeted consultation regarding implementation of the plan.

See attachment B for summary of community resposnes.

3. Service Plan

3.1 Service Capacity

Maitland and Yorketown Hospitals are small grant funded hosptials providing a range of accident and emergency, acute inpatient, elective surgery, community health, mental health and various associated and clinical support services to their communities.

Melaleuca Court Nursing Home is a stand alone 35 bed Commonwealth funded Residential Aged Care facility based at Minlaton.

Minlaton Health Centre provides health clinics and emergency services.

Private local general practitioners (GPs) provide medical and procedural services to the hospitals and health services, and the GPs are supported by a predominantly visiting medical specialist service.

There is one private community owned hospital in the area located at Ardrossan. The Ardrossan Community Hospital is a 22 bed hospital with a 24 hour accident and emergency and provides medical and surgical nursing, minor surgery, a high dependency unit, palliative care and coronary care. The hospital also has a 26 bed residential aged care facility and a health centre for visiting specialists and allied health workers, dental practice and physiotherapy service.

3.2 Clinical Services Capability Framework

It is essential that all service planning and development considers the key strategic enablers as described in 2.1 and be undertaken in consultation with local Health Advisory Council's, staff and other key stakeholders. The SA Health Clinical Services Capability Framework (CSCF) 2016 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 hospitals. It is an important tool for state-wide strategic planning by defining 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 the way clinical services are described and identifies interdependencies that exist between clinical areas.

3.3 Timeframes

The Steering Group has endorsed this plan to focus on improvements for the next three to five years and beyond.

3.4 Service Priorities

An overview of the proposed service priority areas for the hospitals of Maitland and Yorketown are:

Emergency Services

Current	Proposed
Service Description Summary: Maitland and Yorketown provide: • Level 2 providing on-site, 24-hour access to emergency registered nursing staff trained in triage and advanced life support (adults and paediatrics) and triage of all presentations. • Capable of providing treatment for minor injuries and illnesses and treatment of acute illnesses and injuries. • Provides resuscitation and stabilisation, prior to admission and/or transfer to higher level service. • Medical practitioner available on-call on-site 24 hours. Minlaton Health Centre provides accident and emergency service during normal business hours. This service is provided by the Minlaton Medical Practice. There were 1,645 emergency presentations at the Maitland Hospital in 2017-18. This is broken down by 136 (9%) triage 1 or 2, 375 (22%) triage 3, and 1,134 (69%) triage 4 or 5 presentations. There were 1,460 emergency presentations at the Yorketown Hospital in 2017-18. This is broken down by 58 (4%) triage 1 or 2, 249 (17%) triage 3, and 1,153 (79%) triage 4 or 5 presentations. There were 1,005 emergency presentations at the Minlaton Health centre in 2017-18. This is broken	**Service Description Summary:** Maintain level 2 emergency services for both Maitland and Yorketown, enhance patient care and provide patient journey improvements. **Summary of Service Improvements for both Maitland and Yorketown:** ES1. Explore sustainable staffing requirements for emergency service demand considering: o Increase the ability to recruit and retain the required workforce. o Implement recruitment and retention strategies with support from the LHN. o Explore the option of staff working in Wallaroo accident and emergency to gain experience and upskilling. o Education and training of Maitland emergency service nursing staff and GPs on the new South Australian Virtual Emergency Service (SAVES) unit for virtual support. o Continue to provide Advanced Life Support training for staff on site – currently five instructors across the two sites. o Further education for staff to increase capacity to manage the use of CPAP/BiPAP machines for short term management of Acute Pulmonary Oedema, Heart failure, Chronic Obstructive Pulmanary Disease presentations. ES2. Review current accident and emergency areas for improvement of work flows and the patient journey including: o Review of clinical nurses stations and work area layouts to meet demands, Yorketown emergency area considered too small. o Review of access area for Yorketown, no undercover area for arrival of patient or pick up of patient by car/taxi. Explore options for under-cover pick up and drop off point at the front of the hospital. o Assess both accident and emergency areas against the SA Health Emergency Department Guidelines. o Consider current issues around privacy for patients and investigate appropriate solutions. ES3. Explore the potential for increased mental health emergency support considering:

Current	Proposed
down by 63 triage 1 or 2 (6%), 290 triage 3 (29%), and 652 (65%) triage 4 or 5 presentations. **Current Capacity:** Both Yorketown and Maitland currently have limited capacity for accident and emergency services. The service is provided by two local GPs and is heavily supported by locums	o Staff training to increase confidence and skills. o Training for inpatient and accident and emergency staff on Mental State Examination (MSE) and Risk Assessment. o Older Persons Mental Health / Rural and Remote Consultation Service. o Facilities to ensure private and confidential multipurpose rooms. o The expedition of mental health transfers to metro facilities to ease the burden of extra staffing and rosters, to be discussed at the local liaison groups with SA Ambulance Service (SAAS). o Access to Child and Adolescent Mental Heatlh Services (CAMHS) support for both emergency presentation response and staff training and education, promotion of the new 1300 number. ES4. In partnership with SAAS, investigate demand and requirements for expanded paramedic services and support including considering a community paramedic model for the Southern Yorke Peninsula area. o Understanding the impacts of paramedic emergency response/assessment compared to volunteer transfer on SAAS staff, Yorketown and Maitland Hospital emergency services staff and patient acuity on presentation to emergency services. ES5. Investigate ability to increase out of hospital strategies to support emergency service avoidance considering: o Expand Better Care in the Community program for Yorketown to include diabetes and respiratory and consider introducing the program in Maitland. o Increase knowledge and skills to use the SAVES system. ES6. Implemeent Acute Stroke Pathways that are being developed by the Rural Support Service for the 53 regional hospitals (8 country stroke thrombolysing services being developed).
Items for consideration: • Partner with mental health for opportutnies for service improvements for patients with a mental health condition.	

Medical Inpatient Services

Current	Proposed
Service Description Summary: Maitland and Yorketown provide: • Level 2 service provided as 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. **Current Capacity:** The Maitland Hospital has 28 acute and nursing care beds available, with an average of 16.7 occupied each night in 2017-18 (16 acute and 12 nursing beds). There were 1,423 separations at the Maitland Hospital in 2016-17 and 1,625 in 2017-18. The Yorketown Hospital has 23 multiday beds available, with an average of 5.8 occupied each night in 2017-18. There were 965 separations at the Yorketown Hospital in 2016-17 and 812 in 2017-18.	**Service Description Summary:** Maintain level 2 medical inpatient services and enhance patient care at both Maitland and Yorketown Hospitals. **Service Improvements Summary for both Maitland and Yorketown Hospitals:** IS1 Improve communication systems to enhance patient centred holistic care considering: o Information sharing between hospital and medical practices regarding process changes, and patient care requirements referral/discharge. o Admission pack review (include release of information). o Standardise process for discharge summaries for nursing and doctors at Maitland Hospital. o Provision of GP summaries for patient on admission with current medications and dosages. o Continuation of GP meetings at both Ardrossan and Maitland, reinstatement of meetings at Yorketown o Post natal care – exploring options under the new LHN midwifery model. IS2 Enhance services for patients with a mental health condition considering: o Access to Mental Health Specialist Nurse roles – dedicated nurse consultant position across Wallaroo/Maitland and Yorketown. o Increase access and timely response to in-reach services provided by the community mental health team. o Training and education to build staff capacity to assess acuity and appropriate care needs. IS3 Improve management and appropriate support for patients with drug and alcohol conditions considering: o Strengthen linkages with Drug and Alcohol Services South Australia (DASSA) and advocate where appropriate for additional service. o Additional training and clear guidelines according to regulation on how care should be appropriately provided/referred for patients with drug and alcohol addictions/withdrawal.

	IS4 Explore the ability to prevent avoidable admissions considering: o Development of multi-disciplinary team meetings with community nursing and allied health services to prevent or reduce length of admissions, improve management of chronic conditions e.g. diabetes, respiratory, cardiac. o Expand Better Care in the Community program for Yorketown to include diabetes and respiratory and consider introducing the program in Maitland. o Continue with the implementation of Residential Transitional Care Packages. o Explore opportunities for recently trained Stoma Therapy Nurses to be integrated into community health services and obtain funding to provide this service in the community. o Employ a dedicated Discharge Planning Nurse for Maitland and Yorketown – across community and acute (to be located in community health) – based on the patient journey nurses at other units. o Instigate discussions with Maitland HQ clinic to explore if the practice nurse could undertake infusions in the clinic to reduce the workload of the inpatient setting at the hospital. If infusions are continued at the hospital need a purpose built space (not a bed). IS5 Build up local community confidence and awareness in the services provided through positive stories in YNLHN newsletter the local newspaper (YP Country Times) and all of staff meeting opportunities to share positive stories. IS6. Explore options for continuation of midwifery service provision post-natal care: o Investigate and advocate for current Wallaroo model to extend to support lower Yorke Peninsula families. o Participate in the LHN and any statewide midwifery workforce projects (current midwifery staff are nearing retirement). o Improve coordination and communication processes of postnatal midwifery care for women and their families who transfer back from Adelaide following birth. o Monitor patient journey to identify further improvement opportunities. o Reduce delays in accessing post-natal support following birth (i.e. CaFHS linkages, timely communication/referrals).

	IS7. Review ageing hospital infrastructure for meeting of standards, improved patient flow and safer patient outcomes including: o Increased purpose built dementia facilities where funding opportunities arise and improve access to timely accommodation. o Identify opportunities for a mental health quiet area. o Implementation of bathroom hubs to create single ward bathrooms at Maitland and complete remainder of rooms at Yorketown. o Upgrade palliative care area including a kitchen area at Maitland. IS8. Exploring recruitment and retention opportunities: o LHN wide leadership of recruitment and retention of GPs and specialised nurse roles eg renal. o Implementation of the Rural Health Workforce Strategy. o Promoting Southern Yorke Peninsula as an attractive location. o Arrangements with visiting specialists to ensure consistent services. o Establish a nurse exchange between country and metro units (and Wallaroo and Port Pirie) to support skill development in complexity of care required.
Items for consideration: • Partner with mental health for opportutnies for service improvements for patients with a mental health condition.	

Surgical and Anaesthetic Services

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Service Description Summary:

Yorketown Hospital is classified as Level 3 which is provided in the hospital setting with designated but limited surgical, anaesthetic and sterilising services.

Manages:

- Surgical complexity I procedures with low to high anaesthetic risk.
- Surgical complexity II procedures with low to high anaesthetic risk.
- Surgical complexity III procedures with low to medium anaesthetic risk.
- Surgical complexity IV procedures with low to medium anaesthetic risk.
- May be offered 24 hours a day and may include day surgery (not currently).
- May also provide emergency surgical services (not currently).

Capacity:

Ability to cater for inpatients and day procedural patients.

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Service Description Summary:

Maintain the level 3 surgical and anaesthetic services (and review when hospital upgrade is completed) by considering the following:

Service Improvements Summary:

S1. Complete Yorketown Hospital upgrade to procedural room.

S2. Ensure compliance with Nastional Safety and Quality Health Service (NSQHC) Clinical Care Colonoscopy standards.

S3. Define the services required to best meet the needs of the catchment considering:

- o Analysis of self-sufficiency data to understand service profile needs.
- o Identify opportunities for additional scope work within our catchment ie those travelling to Adelaide or Wallaroo.
- o Maintaining procedural services for colonoscopies.
- o Review ability for inclusion of endoscopies.

S4. Review of equipment that is not included in the procedure redevelopment ie. new scopes with digital cameras (computer access in theatre) for clinical capability of scopes and improved information provided to patients and discharge planning.

S5. Review accident and emergency procedures requiring sedation – equipment for tidal CO2 monitoring (Maitland and Ardrossan) and staff.

S6. Investigate the feasibility of nurse proceduralists and nurse sedationists for Yorketown.

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Items for consideration:

- Complete Yorketown Hospital upgrade to procedural room and review the Clinical Services Capability Framework for assessment of level.

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Mental Health Services

Current	Proposed
Service Description Summary: Maitland and Yorketown hospital provides level 2 services based on the (CSCF): • Capable of providing limited short-term or intermittent inpatient mental health care to low-risk/complexity voluntary adult mental health consumers. • Provides general healthcare and some limited mental health care 24 hours a day, delivered predominantly by team of general health clinicians within a facility without dedicated mental health staff (on-site) or allocated beds. • Medical services provided on-site or in close proximity to provide rapid response at all times. • Service provision typically includes: assessment, brief interventions and monitoring; consumer and carer education and information; documented case review; consultation-liaison with higher level mental health services; and referral, where appropriate. Yorke Peninsula Community Mental Health Team (ambulatory) provides level 4 services based on the (CSCF): • Capable of providing short- to long-term or intermittent non-admitted mental health care to low and moderate risk/ complexity voluntary and, if authorised to do so, involuntary adult mental health consumers. • Youth consumers older than 15 years and older persons – aged 65 and older – may access this service where clinically and developmentally appropriate, and in line with policy and procedural documentation of the adult service. • Delivered predominantly by multidisciplinary team of mental health professionals who provide local mental health care service via hospital	**Service Description Summary:** Maintain and enhance the level 2 mntal health inpatient care provided by the hospital and expand the level 4 ambulatory care provided by the Yorke Peninsula Community Mental Health Team. **Service Improvements Summary:** MH1. Improve service provider and community awareness and understanding of regional mental health stepped care continuum, with respect to the following services: 1. YNLHN Mental Health Services. 2. Rural and Remote Mental Health Services (Barossa Hills Fleurieu LHN). 3. Country SA PHN commissioned primary mental health services. MH2. Enhance the services and infrastructure provided by the Yorketown and Maitland hospitals to best meet the needs of clients with a mental health condition though: o Mental Health Team to support a review of hospital infrastructure to identify environmental needs for consumers presenting with mental health concerns. Examples could include: 1. Enhancing emergency response by providing access to low stimulus room near accident and emergency area and sensory modulation resources. 2. Dedicated mental health inpatient room on acute ward with ligature points reviewed. o Improved Digital Telehealth Network (DTN) capability in accident and emergency area.

based outpatient clinic or day program, community mental health clinic or home-based care.

- Service provision typically includes: multi-disciplinary assessment and targeted interventions by mental health professionals; care coordination/case management; consumer and carer education and information; documented weekly case review; some group programs; primary and secondary prevention programs; consultation-liaison with lower and higher level mental health services; and referral, where appropriate.

Service Capacity Summary

Yorketown and Maitland Hospitals provide:

- Voluntary admissions to mental health consumers who are able to be appropriately managed in a general hospital environment.
- Initial mental health assessment (mental state examination and risk assessment).
- GP led care planning, medication management, referral and consultation/liaison to higher level mental health services.
- Facilitation of transfer of involuntary patients to approved mental health treatment centres.

Community Mental Health Team provide the following in-reach services to the hospital:

Business hours (Mon-Fri 9-5pm)

- Specialist mental health assessment, crisis intervention and care planning.
- Brief intervention and care coordination.
- Support for discharge planning.
- Facilitation of telepsychiatry assessments.
- Consultation and liaison with Emergency Triage and Liaison Service (ETLS) and psychiatry services.

Afterhours

- Access (via 131465) to rural and remote ETLS (24/7) includes access to on-call psychiatrist and emergency telepsychiatry.

- Enhancing existing services by providing mental health education to GPs, nursing staff and local SAAS to increase skills, and confidence for managing patients locally in both inpatient and emergency settings.
- Training for inpatient and accident and emergency staff on Mental State Examination (MSE), Risk Assessment and deteriorating mental health patient.
- Consider separate Mental Health and Emergency Services Local Liaison Group for Southern Yorke Peninsula to support inter-agency collaboration and improved consumer care plans.

MH3. Explore opportunities to expand current mental health services including:

- Integrated Mental Health Inpatient Unit in YNLHN (based in Port Pirie).
- Establish a peer mental health workforce within the community mental health teams.
- Increase access to psycho-social support services by working with non-government organisation (NGO) Individual Psychosocial Rehabilitation and Support Services (IPRSS) partners to establish support workers in Minlaton.

MH4. Proactively identify mental health service needs across the stepped care continuum and liaise and advocate with the Country PHN to commission services that will help address service gaps, including:

- Timely access to community based psychology.
- Access to primary mental health care services for young people such as Headspace.
- Access to a broad range of psychosocial supports for consumers that do not meet NDIS criteria.
- Continuation and expansion of the Clinical Care Coordination Mental Health Nurse Program into GP clinics.

Community Mental Health Team Ambulatory services • Specialist mental health assessment, crisis intervention and care coordination for voluntary and involuntary consumers 16 years and over presenting with serious and/or severe mental health conditions. • Operates Monday-Friday 9am-5pm. • Duty work service. • Assertive community intervention. • Therapeutic intervention. • Multi-disciplinary team. • Visiting Consultant Psychiatrist. • Access to Tele-psychiatry assessment. • Community and service provider access to 24/7 urgent mental health assistance via Rural & Remote ETLS 131465. Maitland Hospital had 42 mental health separations in 2016-2017 and 61 in 2017-2018 while Yorketown had 37 in 2016-2017 and 33 in 2017-2018. This represents about 3% of total separations at Maitland and 4% of total separations at Yorketown. Maitland Hospital had 44 mental health Accident and Emergency presentations in 2016-2017 and 60 in 2017-2018 and 45 in 2018-2019 while Yorketown had 30 in 2016-2017 and 31 in 2017-2018 and 32 in 2018-2019. This represents about 4% of total separations. The Yorke Peninsula Community Mental Health team had 513 clients in 2016-2017 with 5 555 contacts and 523 clients in 2017-2018 with 7 004 contacts.	o Drug and alcohol services. o Mental Health Early intervention/Education programs within schools. MH5. Explore ways to work with family, carers and advocates of clients with a mental health condition to develop community programs that meet the needs of the community: o Work collaboratively with the Country Health SA Mental Health Experts by Experience consultants on consumer and carer participative initiatives. o Increase completion of Your Experience Survey (YES) and Carer Experience Survey (CES) and use feedback for service improvement initiatives. o Explore partnership opportunities with local suicide prevention networks such as SOS. MH6. Enhance infrastructure/physical environment within the community mental health service to better meet the needs of consumer/carers: o Improve the therapeutic environment within consulting room spaces at Minlaton Community Health Service. MH7. Improve mental health services and support provided to Aboriginal consumers and the Point Pearce Aboriginal Community: o All mental health Staff to complete Cultural Awareness Training (beyond Moodle). o Review of mental health service provision to Point Pearce in consultation with Yorke Peninsula Aboriginal Health and Sonder Social and Emotional Wellbeing Team. MH8. Enhance recruitment and retention of skilled Mental Health workforce by:

	o Establishing and monitoring an annual key performance indicator (KPI) for student placement numbers within the YNLHN mental health service. o Implement and monitor the Mentally Healthy Workplace Action Plan. o Encourage general nursing staff to complete accelerated mental health nursing qualifications – 12 week Professional Certificate with some leading onto Graduate Diploma. o Hold aside vacancies in the community mental health team where capacity exists to create graduate pathways for nursing or allied health via Nursing Transition to Professional Practice Program (TPPP) or allied health PPP. o Improve community health infrastructure to enhance staff working environments.
Items for consideration: • Review of facilities to ensure private and confidential multi-purpose rooms which can be used by local/visiting clinicians and mental health clients. • Work with Nursing for opportutnies for service improvements for patients with a mental health condition attending Accident and Emergency or as inpatients.	

Palliative Care Services

Current	Proposed
Service Description Summary: • Provides quality end of life care (level 1) including assessment, triage, care coordination and clinical management, bereavement risk assessment and bereavement care for patients with uncomplicated needs associated with end of life care. • Services provided during business hours and provided in the home, community, hospital or residential aged care facility. • Provided primarily by primary and acute care teams. • Has formal links with a palliative care services for purposes of referral, consultation and access to specialist care as necessary. The health service has no such dedicated palliative care funding. Patients are put on an end of life package which includes additional care to stay at home. These services include: nursing care, domestic assistance, personal care and other services and are provided by community health nursing staff. In 2016-2017 Yorketown Hospital had 6 separations equating to a Length of Stay of 60 days while in 2017-2018 it was 10 separations equating to 61 days. In home services and community services were also provided by Nursing staff.	**Service Description Summary:** To maintain level 1 palliative and end of life care while exploring opportunities to extend into some areas of level 2 provision in particular access to medical officers with credentials in palliative medicine. **Service Improvement Summary** PC1 Explore opportunities to access funding and staff availability/capacity for a service that meets community need (including a 24/7 service): o Recognition of palliative care as a complex area and funded specifically and appropriately, both in hospitals and community. o Explore the opportunity for palliative trained nurses to work within both hospital and community setting to provide continuity of care. o Possibility of increasing Palliative Care Co-ordinator position to two 0.5FTE positions for improved availability for both medical and nursing staff. o Increasing services from five days per week to seven days/week to assist and accommodate End Of Life Packages at Southern Yorke Peninsula to come in line with Northern Yorke Peninsula. o Explore the funding of increasing Palliative Care Consultant visits to monthly rather than three to four monthly (also for GP training and staff information sessions). o Improving education opportunities for nurses in both hospitals and community to recognise the difference between end of life nursing and acute care nursing. PC2. Improving the patient journey for palliative care patients by: o Improving the cost and availability of end of life medications in the community (medical officers with palliative care credentials can assist). o Ensuring appropriate communication channels exist between community health and hospital for seamless care. o Ensuring regional model meets the needs of Yorke Peninsula patients including staff cover and backfill of Palliative Care Co-ordinator.

	o Reviewing dedicated palliative care areas in the hospitals including kitchen area at Maitland.
Items for consideration: • Explore the funding possibility of increasing Palliative Care Consultant visits. • Reviewing dedicated palliative care areas in the hospitals including kitchen area at Maitland. • Implemetnation of any relevant actions in the Rural Support Service Palliative Care Plan currently being developed.	

Allied & Community Health

Current	Proposed
Service Description Summary: Services comprised of an 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: o Social Work. o Podiatry. o Speech Pathology. o Dietetics. o Occupational Therapy. o Physiotherapy. o Community Nursing. o Diabetes Nurse Education. o Home Based Support Services. o Mental Health. 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. **Current capacity** All of the above services are available via referral within the Yorke Peninsula catchment. At Minlaton there are three	**Service Description Summary:** Maintain and enhance Allied and Community Health services. **Service Improvements Summary:** CH1. Improve access to the National Disability Insurance Scheme (NDIS) for clients in need considering: o Responding to increasing demands. o Continue to expand services to consumers with disabilities receiving NDIS packages. o Linking with local NDIS providers. o Linking with Baptcare to support clients to access NDIS. CH2. Increase the range of community restorative services provided to at risk groups within the community considering: o Use of allied health assistants. o 7 day service. o Address social isolation and improve community connectedness. o CHSP/HACC/HCP funded programs. o Continue to modify and expand to meet the growing needs of consumers in community aged care according to current and future consumer directed care model and the Aged Care Standards and Aged Care Rights. o Link with family and advocates to support community managed drug and alcohol programs. o Link with Carers SA to support carers to access appropriate support services. o Address social isolation and improve community connectedness. o Develop referral pathways for consumers to access restorative services. o Number of home based services and ability to age in home is putting pressure on other services e.g. SAAS and Community Transport

consulting rooms utilised by visiting allied health, specialists and private providers. Mental health, CAHFS and CAHMS also have services available from this site. All serviced utilise the one mental health video vonferencing (VC) unit that is used by all services. The following services are provided on Yorke Peninsula from Minlaton, Maitland and Wallaroo: o Commonwealth Home Support Program (CHSP), Home and Community Care (HACC), Home Care Packages (HCP) post-acute, inpatient allied health services, palliative care. o CHSP and HCP Home Based Services. o CHSP Day Centre two days per week. o Post-acute, plliative care and CHSP equipment. o Community Transition Care Packages (TCP). o Community Nursing Services including Department of Veteran Affairs (DVA), post-acute care, CHSP, HCP, nursing services across five days only. o Aged Care Assessment Team (ACAT). o Aboriginal Liaison Service provided at Maitland Hospital. o Additional Aboriginal Health Services and support provided to the catchment area from Moonta and Maitland. o Child Health and Development allied health services provided to the Yorke Peninsula catchment from Kadina. A range of private visting services are also available as well as services funded by the Primary Health Network eg Sonder.	CH3. Improve awareness and understanding of referral pathways for community and allied health services considering: o Service mapping to understand service needs and gaps. o Clear and well-defined referral pathways. o Role of PHN in building awareness and education. o Improving the patient journey from hospital to home, enabling patients to access appropriate support services. CH4. Explore opportunities to improve chronic disease management including: o Target the identified chronic disease “domains” identified within the Yorke Peninsula population (eg diabetes, heart disease, obesity, osteoarthritis, mental health etc). Evidence suggests exercise is a positive influence in the management of all of these conditions. o Flexible, multi-disciplinary opportunities to support communities to understand all the facets of lifestyle that contribute to chronic disease and reduce hospital admissions. o Increase access to allied health services eg. dietetics, speech pathology that currently travel from Wallaroo. o Explore options for additional clinical and office space at Minlaton to ensure both public and private services can be provided eg Sonders requirements for increasing client numbers at Yorketown and porivision of clinical space at Minlaton. CH5. Build networks to support collaboration to improve the health and wellbeing of the community considering: o Develop an open communication mechanism between state, private and federal services (ie forum). o Support personalised care and coordination in partnership with general practice, emergency departments, inpatient services and effective discharge planning for many consumers with long term chronic conditions. o Explore partnership opportunities to link up services eg Sonder to do health promotion talks/activiites. o Improve relationships between community and allied health staff, acute staff, GPs and transport services to provide quality linked up services across the care continuum. o Explore opportunities to reduce Potentially Preventable Admissions.

	CH6. Explore ability to support Allied Health and Community Nursing staff to upskill into specialist roles considering: o Improved relationships with GP and specialists. o Access to training and development. o Increase telemedicine capacity to provide supported advice and access to specialist care. CH7. Improve services for Aboriginal community members considering: o Cultural competence training for mainstream staff. o Aboriginal consultant roles across services to support connections between clients and staff. o Redefinition of the Aboriginal Liaison Officer role to support patient journey to provide support.

Items for consideration:

- Advocacty for a seven day service.
- Increase awareness/networking/promotion of all services and referral pathways within the Yorke Peninsula.
- Focus on attraction and retention strategies including community support, child care and education in collaboration with local council and other stakeholders.

Aged Care (Geriatric Medicine)

Current	Proposed
Service Description Summary: Maitland and Yorketown provide: Level 2 services: • Ambulatory and/or inpatient care to clients who are medically stable and who generally require low complexity care. Care may be provided in home or community settings and/or in healthcare facilities, including multipurpose health centres. • Delivered by nurses and/or allied health professionals in partnership or liaison with higher level service. • Capacity to deliver limited multidisciplinary interventions. • May have outreach services from higher level services and could include visiting services and services accessed through telehealth facilities. • Services for clients either referred, transferred or returned from higher level service to continue treatment in their local environment following subacute or acute episode during which more complex care was required. • Inpatient care managed by medical practitioner. • Clear intervention plan developed ensuring care is co-ordinated if mutli-disciplinary care is required. • Service is networked with higher level services to ensure clients have access to other members of multidisciplinary team and to facilitate patient transfer, if needed. YNLHN offers a range of aged care services in hospital, in the community and at its Residential Aged Care facilities. Maitland Hospital – Chapel Wing (12 state funded beds). Minlaton Melaleuca Court (35 commonwealth funded beds). In 2018-19, 52 Aged Care packages were offered (Inclusive of 29 Aboriginal/TSI packages).	**Service Description Summary:** Maintain and enhance the services provided by the health services and the Community Aged Care services provided by Country Connect. **Service Improvements Summary:** AC1. Improve hospital infrastructure and coordination to accommodate aged care specific needs considering: o Increase purpose built dementia facilities where funding opportunities arise and improve access to timely accommodation at Melaleuca Court to service catchment area. o Response and services for delirium management. o Quiet area for aged when presenting to emergency areas. o Disability access. o Early onset chronic disease / illnesses for persons over 65 years. o Implementation of bathroom hubs to create single ward bathrooms at Maitland and Melaleuca Court (up to four people mixed gender shared) and complete remainder rooms at Yorketown. o Upgrade palliative care area including kitchen area at Maitland. AC2. Partner with relevant organisations (eg. PHN) to increase the range of wellness activities provided in the community including: o Targeted physical activities. o Day activity programs – Commonwealth Home Support Program. o Primary health care programs. o Chronic disease prevention.

Home care packages are provided by a range of organisations for residents in Northern Yorke, Southern Yorke and Lower North). Current six to twelve month wait for high care (Level 3/4) packages. **Commonwealth Home Support (CHSP)** provided by various providers: o Base level in home support (up to four hours / fortnight). o Allied health and nursing. o Gardening. o Domestic assistance. o Social support (shopping, personal care). o Group and individual. **Aged Care Support Services** o **Geriatrician** – monthly, fully booked three to four month wait. o **Dietician –** monthly. o **Podiatry –** public fortnightly and regular private providers. o **Speech Therapist –** private and public weekly. o **Mental Health:** o One psychiatrist visits. o Mental health support – Occupational Therapist, Nurse, Social Worker. o Sonder – Diabetes to GP practices, counselling support, Aboriginal and/or Torres Strait Islander support. **GP visits -** Regular weekly visits to small country towns. **Transitional Care Program – accessible TCP -** Currently to Maitland and Yorketown Hospitals. Timely availability of services by Community Nursing in the consumers home/clinic. Yorke Peninsula Aged Care Managers network meeting three monthly at alternating sites.	AC3. Support Consumers and their carers to negotiate the My Aged Care portal and engage providers. o Improve access to COTA SA and Country Health Connect programs and services and raise awareness of services available. o Engage interim services for consumers waiting for a package. AC4. Review Aged Care Support Services to improve access and reduce waiting times. o Geriatrician – increase frequency of visits: - Improve access to visiting specialist. - Review tele medicine for repeat consultations. o Dietician – increase frequency of visits: - Improve access to visiting dietician from Northern Yorke Peninsula. - Review tele med for repeat consultations. o Mental Health: - Additional psychiatrist visits – does take new clients. - Succession planning / support for current provider. o Dental services: - Access to visiting and mobile dental services. - Access to financial support to consumers cost reduce the financial burden and access support for consumers. o General practitioner and visiting services: - Explore technology to improve access to GPs and specialist review for residents, particularly the immobile resident / or behaviours where SAAS transport is the only option. - Investigate the feasibility of a visiting nephrologist to the area, possibility of a hub service.

Other Yorke Peninsula Residential Aged Care (beds): o Moonta (77) – with Dementia support. o Ardrossan (26). o Eldercare – The Village (60) – 10 beds Dementia support, Elanora (35) and South Park (18).	o Community Nursing and Allied Health services: - Increased access to seven day Community Nursing and allied health services and include 24 hour care as identified ie. high care and end of life care. o Physiotherapy – increase frequency of visits: - Review participation/access to the Allied Health in Aged Care model for Chappel Wing and Melaleuca Court. AC5. Investigate the feasibility of additional Aged Care Support Services including: o Rehabilitation : - Identifying funding sources. - Specialist staffing. - Identify dedicated appropriate area for rehabilitation services. - Identifying opportunities for hydrotherapy access. o Home dialysis. o Community transport for consumers with complex care needs as currently a carer is required to accompany the consumer. o Linking with the Older Persons Rural and Remote Consultation Liaison Service. AC6. Review dedicated Staffing for Aged Care positions: o Recruitment and retention – various issues across all disciplines. o Knowledge and skills in general geriatric care principles and practice. o Sharing staff / resources for Southern Yorke Peninsula community, residential and hospitals. o Investigate the appointment of a dedicated Aged Care Nurse Practitioner with a community and aged care focus for improved collaboration with nursing, allied health and GPs. Resident loads within aged care facilities especially managing residents identified with behaviour issues and complex needs and medications. o Consider the appointment of an aged care coordinator position at 0.2 FTE for Maitland o coordinate care for the residents, complete audits and clinical indicators

	AC7. Increase and enhance the Hospital avoidance programs by: o Accessing Consumer Awaiting Placements (CAP) . o Increasing access to accommodate and manage residents waiting for nursing home beds. AC8. Coordination and collaboration across sectors for focus meetings to support the patient journey for complex clients eg mental health: o Yorke Peninsula Aged Care Managers network meeting three monthly at alternating sites – increase membership to include Yorkie Peninsula community o Complex – Souther Yorke Peninsula Community Nursing, allied health (physiotherapy and occupational therapy as required) GP, acute nursing and/or Executive Directors of Nursing meeting for Maitland and Yorketown. o Mental health review feasibility for mental health liaison meeting for Maitland and Yorketown – SA Police, mental health and nursing. o Develop resident journey for transport by SAAS from nursing homes for GP appointments or review in accident and emergency. AC9. Implement appropriate recommendations from the Aged Care Royal Commission (when completed).

Items for consideration:

- Implementation of the Comprehensive Care of Older People Model of Care 2017 as identified in proposed section above.
- Rehabilitation service – pool / hydrotherapy.
- Increased access to dementia specific accommodation.
- Explore opportunities for Aged Care Nurse Practitioner role.
- Regional Aged Care/Mental Health networking meetings (Yorke Peninsula Aged Care Network membership to include community).
- Review recommendations from the Aged Care Royal Commission (when completed).

OTHER CLINICAL AREAS

Renal Services

Current	Proposed
Service Description Summary: Two Renal Dialysis chairs at Maitland Hospital • Two sessions per day. • Service available Monday to Saturday . • Holiday bookings for some clients visiting the area • Support provided to home based/self-care clients. • May provide long term care to post op transplant patients, where appropriate. • Direct care from registered nurses trained in haemodialysis and peritoneal dialysis (if provided). • Access to social worker and dietitian experienced in managing renal patients . • 24 hour access to a registered medical specialist – Nephrology . In 2017-18 there 687 separations and 886 in 2018-19. **Capacity** Future capacity if numbers required to expand service to be a six day service (2 sessions per day).	**Service Description Summary:** Maintain and enhance current renal services. **Service Improvement Summary** RS1. Continue to monitor the local patients "patient journey: to ensure that patients are receiving services closest to home. RS2. Participate in LHN and country wide recruitment and retention activites for recruitment of renal nurses and explore opportunities for training of current staff in renal. RS3. Investigate the possibility of providing low level chemotherapy for the renal area.
Items for consideration: • Monitor and keep informed of the process for a proof of concept trial for a multipurpose chemotherapy/renal dialysis infusion unit model within Country as part of the Exanding Country Cancer Services program.	

Clinical Support Services

CSCF descriptors	Service Capacity	Proposed service or area to explore
Diagnostic Medical Imaging	Level 1 Provides low-risk ambulatory care services during business hours and may provide some limited after hours services. o Involves a mobile or fixed, general x-ray unit and is predominantly delivered by x-ray operators. o Computed radiography equipment is available to acquire images and facilitate image transfer. o Must be able to provide resuscitation and stabilisation of patient emergencies until transfer or retrieval to a back-up health facility. o 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. o Transfer occurs within 24 hours.	Maintain current services.
Pathology	Level 2 o No on-site laboratory, but has access to point-of-care testing. o Qualified staff available to collect and transport specimens to nearest laboratory. o May have on-site blood storage, but cross-matched blood - managed by off-site laboratory - is available locally, where this is applicable to the facility. o Initial operating theatre frozen sections performed.	Maintain current services.
Pharmacy	Level 1 o Provides services to ambulatory populations with low medication risk. o Prescriptions can be filled at local pharmacies at major towns.	Maintain existing pharmacy arrangements.

3.5 Other factors for consideration

3.5.1 Capital / Infrastructure / Equipment

A master plan for long term capital, infrastructure and equipment requirements will be developed and will include the following specific capital and equipment considerations outlined in the Service Priority tables:

- Purpose built dementia facilities.
- Implementation of bathroom hubs to create single wards
- Upgrade palliative care area at Maitland.
- Accident and Emergency areas for improvement of work flows.
- Undercover parking area for Accident and Emergency area for Yorketown.
- Clinic spaces
- Review of equipment that is not included in the Yorketown redevelopment.
- Dedicated mental health inpatient room on acute ward.
- Low stimulus room near accident and emergency area

3.5.2 Workforce

Ongoing workforce planning will be a key consideration and should be undertaken in consultation with the LHN People and Culture Directorate, including the Developing Our Leadership and Culture approach.

Future opportunities and implications from the work currently being developed through the Rural Health Workforce Strategy project will also be considered as recommendations emerge.

General workforce supports:

- Use of Allied health assistants.
- Implement Recruitment and retention strategies with support from the LHN.
- Explore the option of staff working in Wallaroo accident and emergency to gain experience and upskilling.
- Education and training of Maitland emergency service nursing staff and GPs on South Australian Virtual Emergency Service (SAVES)
- Continue to provide ALS training for staff on site.
- Further education for staff to increase capacity to manage the use of CPAP/BiPAP short term to manage acute pulmonary oedema, Heart failure, COPD presentations.
- Implementation of the Rural Health Workforce Strategy.
- Implement and monitor the Mentally Healthy Workplace Action Plan.

The specific workforce Nursing considerations identified through the service planning process include:

- Participate in LHN and Department wide recruitment and retention programs.
- Sustainable staffing requirements for Accident and Emergency service demand.
- Discharge Planning Nurse for Maitland and Yorketown.
- Nurse proceduralists and nurse sedationists for Yorketown.
- Increasing Palliative Care Co-ordinator position.
- Review dedicated staffing for aged care positions.
- Sepecialised nurse roles eg Renal.
- Establish a nurse exchange between country and metro units .
- General nursing staff to complete accelerated mental health nursing qualifications.

Service Plan Endorsement

Committee/ Responsible Person	Signature	Date Endorsed
Yorke Peninsula Health Services Planning Steering Group	-	5 December 2019
Yorke and Northern LHN, Executive Committee	Roger Kirchner 	6 December 2019
Yorke and Northern LHN, Governing Board	Endorsed at YNLHN Governing Board	17 December 2019

For more information

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Appendix A: Yorke Peninsula Health Services Steering Group TOR

Purpose

The purpose of this Steering Group is to provide advice and direction to Country Health SA Local Health Network (CHSALHN) to guide the development of a Yorke Peninsula Health Service Plan.

Scope of the Service Plan

The Service Plan will provide a framework for identifying and evaluating potential future service options for Health Services in the Yorke Peninsula catchment to meet the future needs over the next three years and beyond with a review recommended every 18 months.

Steering Group Role

The Steering Groups primary role is to:

- Provide advice to the Yorke and Northern Board as well as the CHSALHN 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 both communities to determine the future implications for the Health Service.
- Provide advice on future self-sufficiency of the 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

Chair:

- Regional Director, Yorke and Northern Region, Roger Kirchner

Members

- YN LHN Governing Board Chair, Vanessa Boully
- Yorke Peninsula Health Advisory Council; Presiding Member Dot Marschall, Member; Rod Thomas, Helen Tucker
- Medical Practices:
  - Yorketown Medical Practice; Dr George Kokar, Leeanne Warren
  - Minlaton Medical Centre; Heather Joraslfsky, Dr Joanne Marshall
  - Medical HQ Maitland; Dr Timothy Bromley, Dr Rod Pearce, Paul Rugari, Dr Eleanor Daniels
  - Ardrossan Medical Centre; Practice Manager Craig Shrubsole,
- YNR Medical Administration Trainee, Dr Anil Gopal

- Yorketown Hospital
  - Sharon Godleman, EO/DON
  - Simon Taylor, Tanya Gutsche - Nursing representatives
- Maitland Hospital
  - Tony Hughes Acting EO/DON
  - Lindi Brokenshire, Grant Badenoch - Nursing representatives
- Ardrossan Community Hospital, Jodie Luke EO/DON
- Community Health Representatives;
  - Vicki Hill – Healthy Aging Team Leader
  - Susan Edwards, Community Nurse
  - Peter Burford, Social Worker
  - Shane Warrior, Aboriginal Health
  - Michael O'Loughlin, Aboriginal Elder from Point Pearce
- YNR Corporate Services, Paul Fahey (Manager), Lisa-Ann Watson (Facility Services Manager)
- Regional Director of Nursing, Tracy Haynes
- Regional Manager Mental Health, Lucas Milne
- Yorke Peninsula Council
  - Mayor Darren Braund
  - CEO Andrew Cameron
- Member for Narungga, Fraser Ellis MP
- Sonder, Nathan Mercurio Community Health Manager.
- YP Community Transport Manager, Julie Mason
- CHSA Planning and Population Health: Kim Hewett, Leeanne Stringer

Ex-Officio

- YNR Business Support Officer, Tracie Hawkins

Member responsibilities

The Yorke Peninsula Health Services 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 approximately 9 months
- Seeking and encouraging input from broader stakeholders
- Declaring any conflicts of interest
- Adhering to CHSA data protocols, including not publishing, or releasing data to any other party, without appropriate authority from the Department of Health & Ageing.
- Operating in an environment based on respectful behaviours

Resources

CHSALHN will provide staff to support the Steering Group including:

- Arrange meetings, agendas, note taking (summary and action items)
- Distribution of materials and other administrative functions
- preparation and analysis of required data
- Engaging other stakeholders as required

Steering Group Operations

The Steering Group will operate by:

- Ensuring a quorum, which will consist of half the members, plus one (18)
- Making decisions, by consensus, about what to recommend to CHSALHN
- Having a written summary of discussion, comments, recommendations and actions from each meeting prepared in the form of a meeting summary and formal minutes
- Circulating meeting minutes to the Steering Group one week prior to the next meeting.

Meeting Schedule

Meeting Frequency

- Meetings will be held on the third Thursday of the month from 12.00pm to 1.30pm. Videoconferencing will be available. Light lunch will be provided

Location

Minlaton Health Centre, Community Room.

Process Timeline

1st Meeting of Steering Group: • Setting the Scene • Development of Terms of Reference	**December 2018**
2nd Meeting of Steering Group: • Initial analysis of demographic and health utilisation data profile and identify other data requirements • Agreement on catchment area • SWOT of current and future service • Determination of wider clinician engagement approach	**January 2019**
3rd, 4th Meeting of Steering Group • ongoing analysis of demographic and health utilisation data profile and identify other data requirements • Planning for clinician and consumer engagement	**Feb/March 2019**
5th Meeting of Steering Group • Clinician engagement • Consumer engagement	**Apr/May 2019**
6th Meeting of Steering Group: • Further analysis of demographic and health utilisation data • Consideration of recommendations / feedback from the clinician engagement workshops (March, April) • Consideration of future demand across inpatient, A&E, community health and outpatients • Develop recommendations about future service options for draft service plan	**June 2019**
7th Meeting of Steering Group: • Consideration of final draft service plan • Identification of any further analysis required • Evaluation of approach	**July 2019**

Appendix B: Community engagement summary

SUMMARY OF COMMUNITY FEEDBACK
EMAIL & POSTCARDS JULY 2019

- Better access to doctors.
- Increased allied health services.
- Community buses to hospitals and doctors clinic / Retain health bus services.
- Increased palliative care services / Keep palliative care services, reduce the need to go to Adelaide for this / Ageing population – palliative care services required into the future / Each hospital to have a nice palliative care room.
- More help with mental health and services for people taking drugs / Increase drug and alcohol support services.
- Increased primary health care services that are sustainable, too much money going to admin/cars etc. Consolidate.
- Availability and cost of allied health services and access to these.
- Better access to GP's and mental health providers outside of 9-5pm.
- Important to keep personal relationships with health providers.
- Services to be provided by locals not fly in fly outs.
- People being sent home from hospital too quickly, or it's a public holiday Monday.
- Basic health services support locally to keep our services.
- Rehab service at gym is very good.
- Need more rehab, including access to hydrotherapy
- Go to Minlaton then get transferred, just go to Maitland in the first place.
- Lucky to have what we have.
- Staff do their best with what they have.
- Not enough health professionals trained in the area.
- Not sufficient staff to care for aged care / not enough people trained in aged care / Employ some local young people into nursing or caring roles.
- Aged care – clear information about the services available.
- Confusion remains about aged care packages, 1, 2, 3 & 4.
- Often aged care provider companies do not date changes on their literature and as such a client or carer could be reading/researching information that is outdated. This is a challenge to keep current information available.
- Maybe using mediums such as Maitland Matters could alleviate some of this ignorance.
- Terminology and language used in information and forms are confusing to people.
- Given the aim is to keep people out of care/hospital/hostels/nursing homes while maintaining productive lives in their homes longer, does the initial assessment stage really meet all the needs of the aged care clientele of the YP?

KEY THEMES
Palliative Care services
Allied health services
Awareness of services – promotion of services
Local service provision – local staff – locally trained

Appendix C: Glossary

A&E – Accident and Emergency

ABS – Australian Bureau of Statistics

ADAC – Anti-neoplastic drug administration course

AHP – Allied Health Professional

BMI – Body Mass Index

CaFHS – Child and Family Health Services

CALD – Culturally and Linguistically Diverse

CCoOP – Comprehensive Care of Older People Model of Care

CHSALHN – Country Health South Australia Local Health Network

CHSP – Commonwealth Home Support Program

CSCF – SA Health Clinical Services Capability Framework

CSSD – Central Sterilisation Services Department

CT - Computed Tomography

DASSA – Drug and Alcohol Services South Australia

DTN – Digital Telehealth Network

DVA – Department of Veteran Affairs

EA – enterprise agreements

ECP – Extended Care Paramedics

ED – Emergency department

ENT – Ear Nose and Throat

ETLS – Emergency Triage and Liaison Service

FTE – full time equivalent

GP – General practitioner

HAC – Health Advisory Council

HACC – Home and Community Care

LSCS – Lower Segment Emergency Section

MH – Mental Health

MSE – Mental State Examination

Multi day separations - a discharge from hospital following admission for more than 24 hours

NDIS – National Disability Insurance Scheme

NGO – Non Government Organisation

NP – Nurse Practitioner

OACIS – Electronic clinical information system

PCOC – Palliative Care Outcomes Collaboration

PHN – Primary Health Network

RAC – Residential Aged Care

RAH – Royal Adelaide Hospital

RCPA - Royal College of Pathologists of Australasia

RSS – Rural Support Service

SA2: Statistical Area 2 - is the third smallest geographical area defined in the Australian Statistical Geography Standard (ASGS), and consists of one or more whole Statistical Areas Level 1 (SA1s)

SAAS – South Australian Ambulance Services

Same day separation - a discharge from hospital less than 24 hours after admission

SAVES - South Australian Virtual Emergency Services

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

Self-sufficiency – inpatient activity undertaken within hospitals and health service sites within the geographical catchment area

Separations (SEPS) - the process by which an episode of care for an admitted patient ceases

SLS – Safety Learning System

SPOC – Single Point of Contact

VC – Video conferencing

YNLHN – Yorke and Northern Local Health Network

YES – Your Experience Survey

YP Country Times – Wallaroo local newspaper