Government of South Australia

Health
Yorke and Northern
Local Health Network

Burra Hospital, Snowtown Memorial Hospital and Riverton District Soldiers' Memorial Hospital Service Plan.

(Including Hospital, Community and Allied Health and Mental Health services).

November 2024

Foreword

It is with great pleasure that I introduce the Service Plan for Burra Hospital, Riverton District Soldiers' Memorial Hospital, and Snowtown Memorial Hospital on behalf of the Yorke and Northern Local Health Network (YNLHN) Executive Committee.

This comprehensive plan encompasses hospitals, Country Health Connect, and mental health services and aligns with the overarching vision outlined in the YNLHN Clinical Services Plan 2023 – 2028. Furthermore, the plan links closely with other service plans completed for other sites within YNLHN: Balaklava, Clare, Crystal Brook, Laura, Port Broughton, Port Pirie, Mid North, Wallaroo, Yorke Peninsula, and Community and Allied Health services.

At the heart of this service plan lies the invaluable feedback and insights provided by our community. By capturing and incorporating their voices into our planning processes, we are better equipped to deliver services that truly meet the needs of our diverse population.

I extend my thanks to the steering group for their dedication and oversight throughout the development of this plan. Their tireless efforts have been instrumental in shaping a roadmap that will guide and strengthen our clinical and community-based services now and into the future. Additionally, I would like to thank the countless clinicians and community members who generously shared their expertise and perspectives, enriching the depth and scope of our service plan.

As we embark on this journey, let us remain steadfast in our commitment to excellence, collaboration, and continuous improvement. Together, we have the opportunity to make a profound and lasting impact on the health and wellbeing of our community.

Roger Kirchner

Chief Executive Officer

Yorke and Northern Local Health Network

Photo credit: Front page image

Image title: Overlooking Burra

Captured by Maddison Taylor, Winner of 2023-2024 Calendar Competition, Goyder Regional Council

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Acknowledgement

We acknowledge the Kaurna and Ngadjuri people as the Aboriginal Custodians of the Land and Waters within the Footprint of the area this Service Plan represents.

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

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

1. Steering Group Membership

Chairperson	
Verity Paterson	Chief Operating Officer, Yorke and Northern Local Health Network (YNLHN)
Members	
Kerin Colgan	Executive Officer/Director of Nursing and Midwifery, Burra Hospital and Snowtown Memorial Hospital, YNLHN
Amy McKerron	Executive Officer/Director of Riverton District Soldiers' Memorial Hospital, YNLHN
Brian Stevens	Presiding Member, Balaklava and Riverton Health Advisory Council
Neville Michael	Presiding Member, Lower North Health Advisory Council
Ann Alder	Consumer Representative
Cassandra McNeil	Community and Allied Health Services Representative, YNLHN
Lesley Hall	Clinical Nurse, Riverton Hospital, YNLHN
Mary Alletson	Nurse Unit Manager, Burra Hospital, YNLHN
Brett Humphrys	Director Strategy, Planning and Partnerships, YNLHN
Tracey Stringer	Senior Design Consultant, Planning and Population Health, YNLHN
Nicholas Schubert	Manager, Planning and Population Health, Rural Support Service

We want to extend our appreciation and acknowledgment to Aboriginal Elder, Angelena Harradine, for her invaluable contributions to our health service plan. Angelena's insights, wisdom and dedication to community have been instrumental in shaping a service plan that is culturally sensitive, inclusive, and responsive to the needs of Indigenous people.

2. Executive Summary

The Burra Hospital, Riverton District Soldiers' Memorial Hospital (Riverton Hospital) and Snowtown Memorial Hospital Service Plan (the Plan) outlines the comprehensive vision for healthcare delivery at these sites over the next five years.

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

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

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

Facilitated by a local steering group comprising stakeholders from diverse backgrounds, a series of priority recommendations across key service areas were identified. These priority areas encompass:

- Aboriginal Health
- Aged Care
- Mental Health
- Emergency Care
- Medical Inpatients
- Community and Allied Health Services
- Collective Service Improvements

Emphasis is also placed on enhancing infrastructure, digital technology, workforce capabilities, and patient experience to support these service priorities. To ensure effective implementation and risk mitigation, an implementation plan will be developed and reviewed, detailing key leads and timeframes for each priority area. Implementation risks will be managed as part of a Network-wide strategy to support the delivery of effective outcomes.

In line with the YNLHN Integrated Planning Framework, the YNLHN Executive Committee will oversee and monitor the progress of this plan, reporting to the Governing Board. The Quality Risk and Safety Operations Committee (QRSOC) at each site will review implementation plans, including success measures, to ensure continuous improvement and accountability.

Although the plan focuses on seven priority areas, it recognises the interconnectedness of services and highlights the importance of integrated collaboration across all aspects of healthcare delivery to ensure high-quality outcomes. Continued engagement of clinicians, consumers, staff, and stakeholders will be pivotal to advancing the initiatives outlined in the plan, fostering a responsive and resilient healthcare system tailored to the needs of the catchment population.

2.2 Summary of Service Improvement Recommendations

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

Aboriginal Health	• Aboriginal people will have access to culturally safe and appropriate initiatives determined by local communities. • Identify innovative ways to grow the Aboriginal workforce. • Support access to appropriate services.
Aged Care	• Improve access to specialist services and mental health support services. • Expand, support and build the capacity of the aged care workforce. • Work in partnership with aged care services in the region to enhance consumer access and improve service quality. • Encourage innovation and improve quality of care for enhanced aged care excellence. • Improve and redesign facilities infrastructure to accommodate growing demand for complex care.
Emergency	• Ensure the community can access timely and safe urgent care and emergency stabilisation. • Continue to develop strategies to reduce potentially preventable admissions. • Improve awareness of services available.
Medical Inpatients	• Review, improve, and redesign facilities' infrastructure to provide safe, accessible services. • Identify innovative ways to attract and retain the required workforce. • Continue to develop the Transition Care Program service model, identifying a key site for the area. • Identify and implement strategies to reduce patient journey barriers.
Mental Health	• Enhance infrastructure to best meet the needs of mental health clients. • Explore mental health service improvement opportunities for the lower north area. • Explore opportunities to build the capacity of the Mental Health workforce. • Build culturally responsive mental health services. • Improve awareness and understanding of services available for community.
Community & Allied Health	• Improve discharge planning and coordination. • Develop sustainable and effective service models. • Expand, support, and build the capacity of the workforce. • Improve awareness and understanding of the range of services provided by Community and Allied Health Services. • Review and improve infrastructure to accommodate community and allied health services.
Collective Service Improvements	• Continue to assess the utilisation of digital technology to facilitate secure, high-quality service delivery and enable access to services as close to home as possible. • Foster a culture of innovation and continuous improvement across the LHN. • Identify innovative ways to attract and retain workforce. • Support access to appropriate services.

3. Background and Context

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

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

The Plan aims to provide a framework for identifying and evaluating potential future service options for the health services to meet the needs of consumers in the Burra, Riverton and Snowtown catchments over the next five years and beyond.

Overseen by the Burra, Riverton and Snowtown Service Plan Steering Group, the Plan has been developed using a co-design approach involving extensive collaboration with our consumers, clinicians, staff, Health Advisory Councils, YNLHN Executive and the Governing Board.

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

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

3.1 Strategic enablers

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

SA Health and Wellbeing Strategy 2020 – 2025

The SA Health and Wellbeing Strategy 2020 – 2025 sets the scene for health system planning, providing the overarching vision for the next level of more localised and connected service planning.

The aim and goals of this strategy provide a focus for the improvement efforts across the system to improve the health and wellbeing of all South Australians by striving to:

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

SA Health Planning Framework

The SA Health Planning Framework was developed as a resource to strengthen health system and health service planning, align the process of planning across the system and to define governance, roles and responsibilities in planning.

The Framework supports the SA Health and Wellbeing Strategy 2020-2025 and is intended to align closely with the SA Health Commissioning Framework March 2020 and the SA Health Performance Framework 2020-2021.

The purpose of the framework is to:

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

Other strategic enablers that have informed the service plan

Several other strategic enablers, such as frameworks, plans and forums, have informed the development of the Plan and will continue to be essential to support the implementation of the identified strategies:

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

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

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

YNLHN Clinician Engagement Strategy 2021-2026

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

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

We will engage with our clinicians:

- to ensure the provision of effective health services.
- to ensure and improve the safety and quality of health services.
- in the planning and design of health services.
- in the monitoring and evaluation of service delivery.

YNLHN Consumer and Community Engagement Strategy 2020-2025

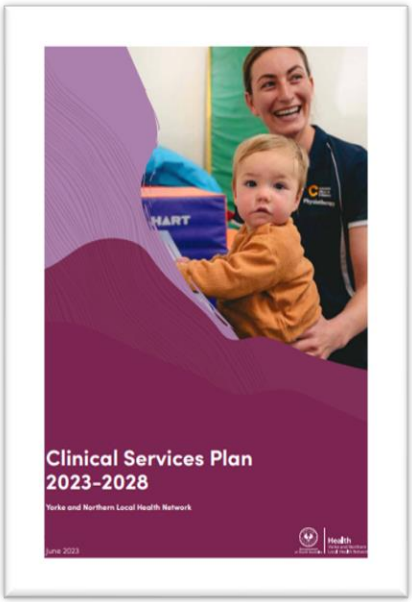
The YNLHN Consumer and Community Engagement Strategy 2020-2025 was released by the YNLHN Governing Board in April 2021. This development of the strategy was supported by comprehensive community consultation to ensure it highlights the value and importance of the consumer's voice and how we will continue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

YNLHN Clinical Services Plan 2023-2028

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

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

Integral to the implementation of the Plan is a commitment to ensure all recommendations in each priority table are considered and reviewed in conjunction with the YNLHN Clinical Services Plan 2023-2028.



4. Service catchment profile

The Burra Hospital catchment area includes the gazetted localities of Apoinga, Baldina, Booborowie, Booborowie North, Brady Creek, Burra, Burra Eastern Districts, Burra North, Canowie, Canowie Belt, Collinsville, Emu Downs, Farrell Flat, Franklyn, Gum Creek, Hallelujah Hills, Hallett, Hanson, Koonoona, Leighton, Mongolata, Mount Bryan, Mount Bryan East, North Booborowie, Pine Creek, Porter Lagoon, Terowie, Ulooloo, Whyte Yarcowie, Willalo, Wonna, Worlds End and surrounding communities.

The Burra Hospital is physically located within the Australian Bureau of Statistics (ABS) defined Goyder Statistical Area 2 (SA2). The geographical catchment area for the Burra Hospital is part (58.0%) of the Goyder SA2. This SA2 also extends into the catchment area for Eudunda Hospital (located in the Barossa Hills Fleurieu Local Health Network (BHFLHN).

The geographical catchment area for the Burra Hospital is part (58.0%) of the Goyder SA2.

The Riverton Hospital catchment area includes the townships of Black Springs, Giles Corner, Manoora, Marrabel, Navan, Rhynie, Riverton, Saddleworth, Steelton, Stockport, Tarlee, Tarnma, Tothill Belt, Tothill Creek, Waterloo, Woolshed Flat and surrounding communities.

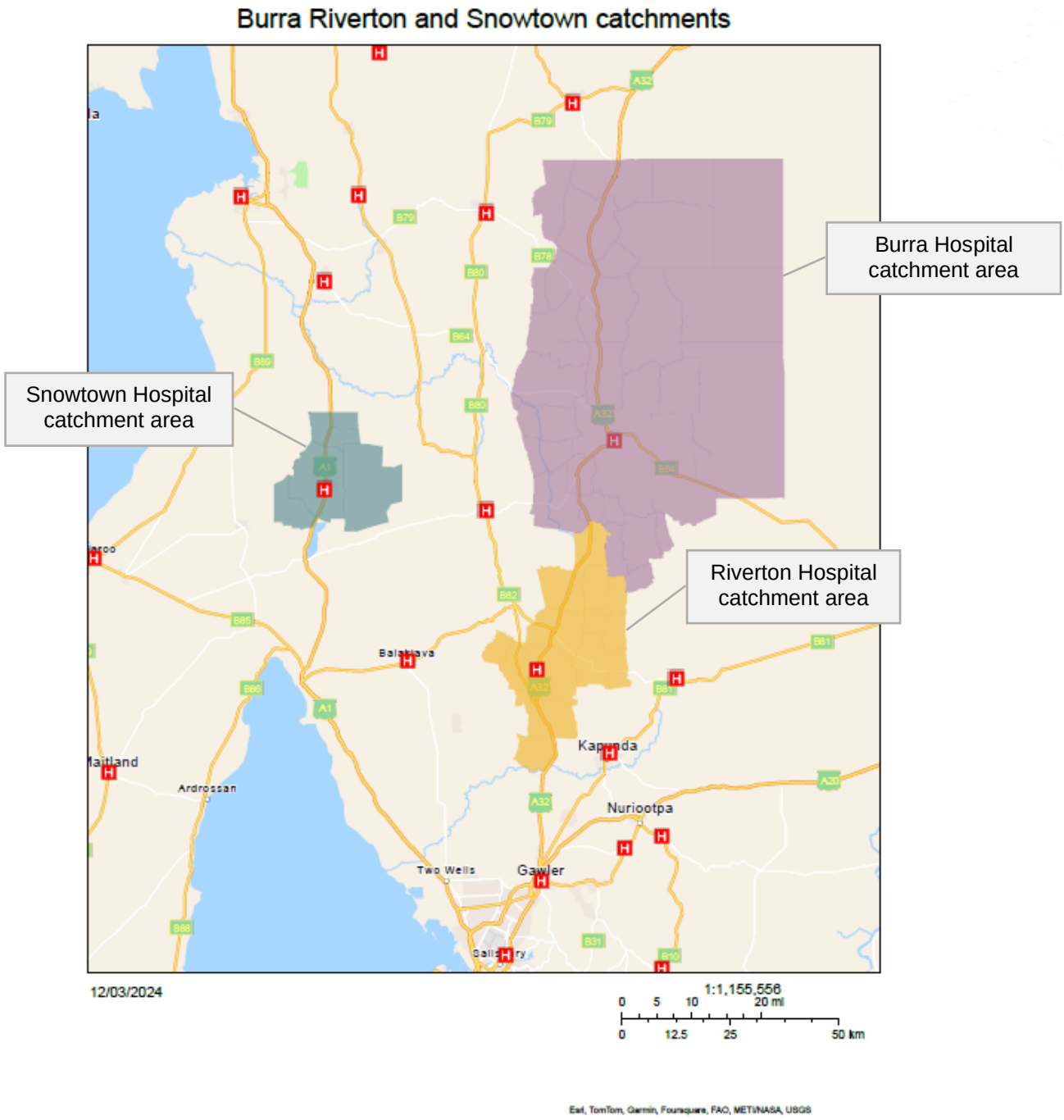
The Riverton Hospital is physically located within the Gilbert Valley SA2. The geographical catchment area for the Riverton Hospital is part (54.6%) of the Gilbert Valley SA2. This SA2 also extends into the Clare catchment.

The Snowtown Hospital catchment area includes the townships of Barunga Gap, Burnsfield, Condowie, Hope Gap, Lake View, Snowtown and surrounding communities.

The Snowtown Hospital is physically located within the Wakefield – Barunga West SA2. The geographical catchment area for the Snowtown Hospital is part (6.2%) of the Wakefield – Barunga West SA2. This SA2 also extends into the catchment areas for Balaklava, Clare, Port Broughton, and Wallaroo.

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

Map: Burra, Riverton and Snowtown Catchments

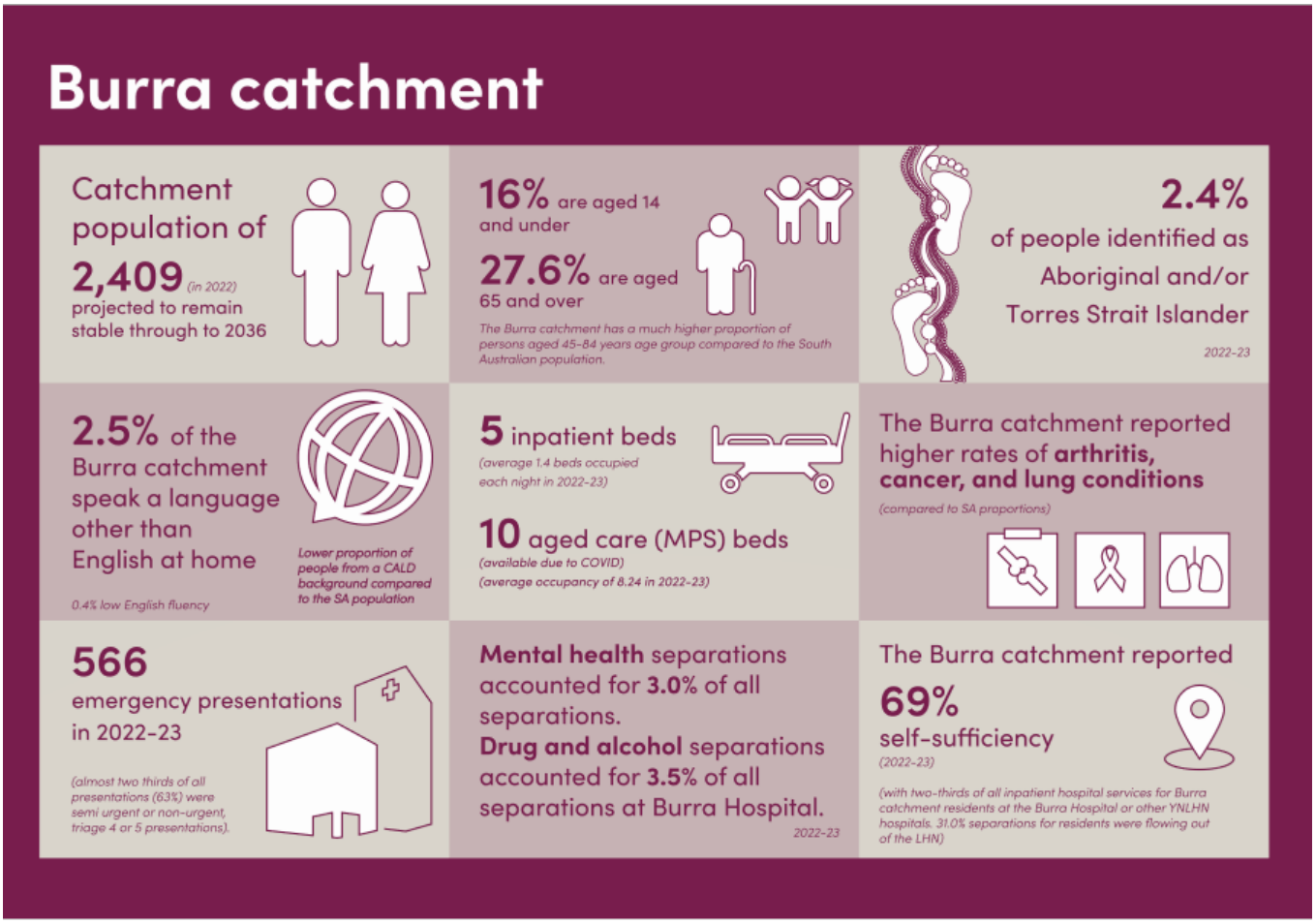


Source: SA Health Data and Reporting Services Branch, Burra catchment indicated by pink shading, Riverton indicated by yellow shading and Snowtown by light green shading.

4.1 Catchment Snapshots

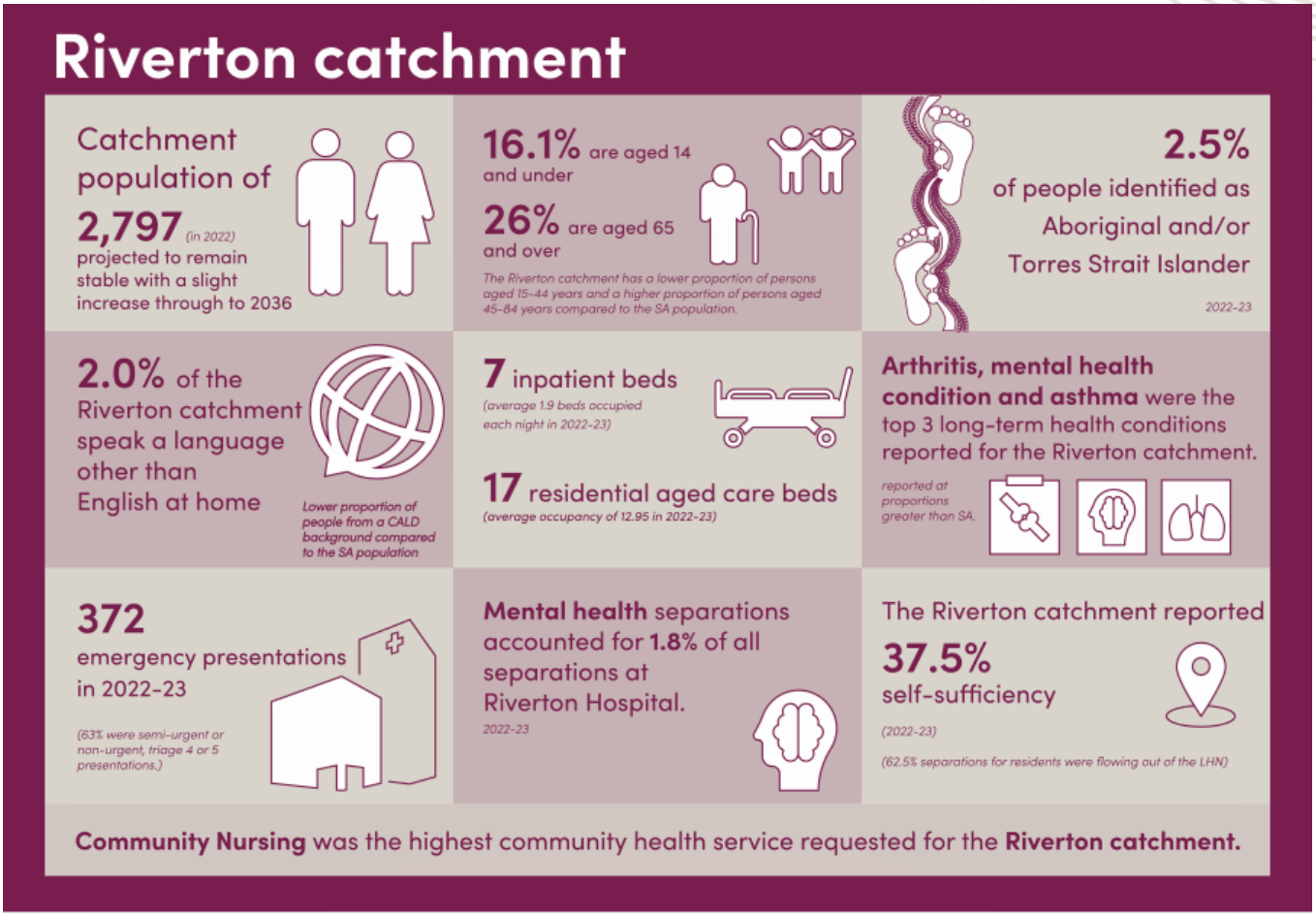
4.1.1 Burra Snapshot

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



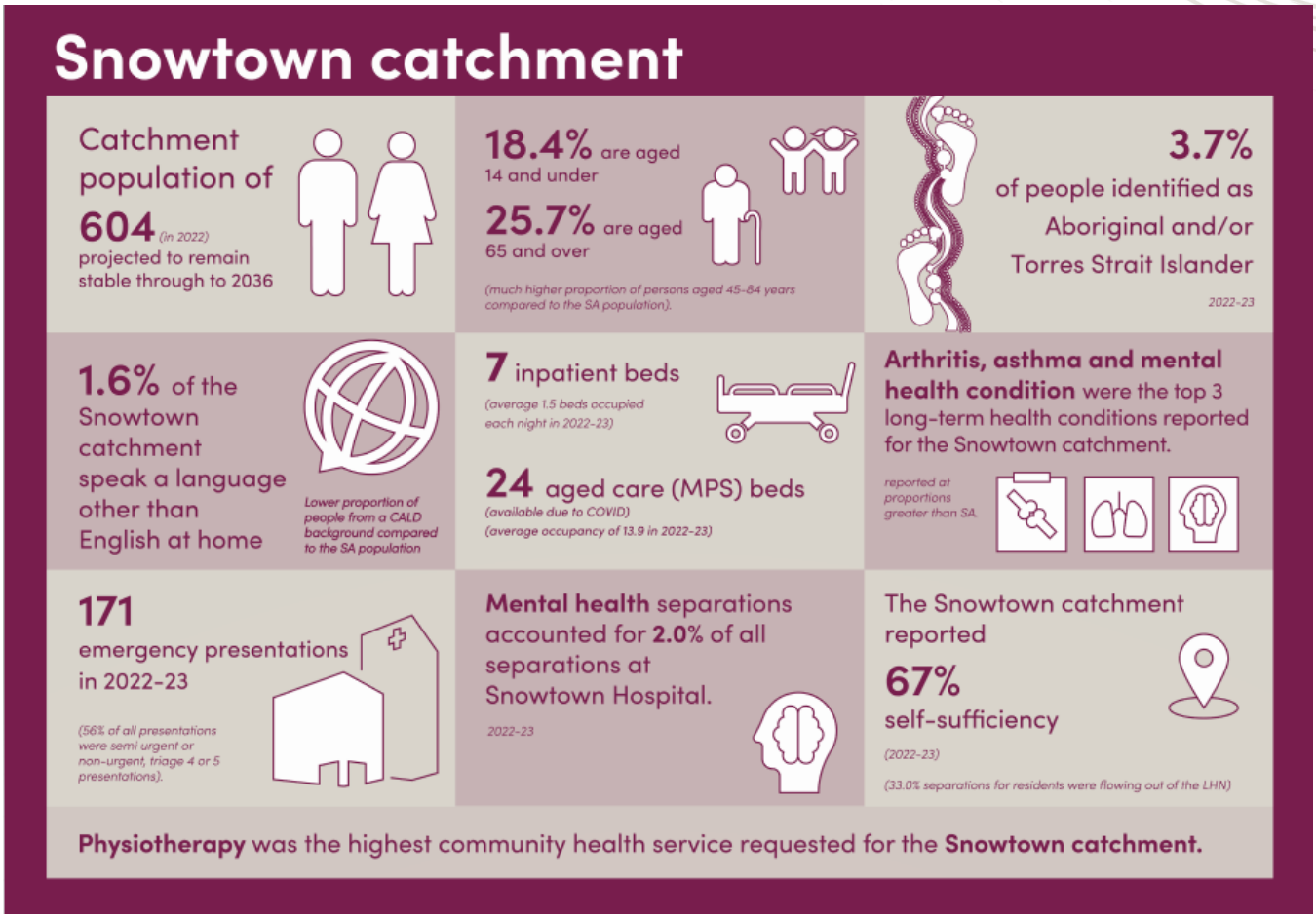
Sources: 2021 Census data, 2021/22 activity data/CCME data, Aged Care Liaison Officer.

4.1.2 Riverton Snapshot



Sources: 2021 Census data, 2021/22 activity data/CCME data, Aged Care Liaison Officer.

4.1.3 Snowtown Snapshot



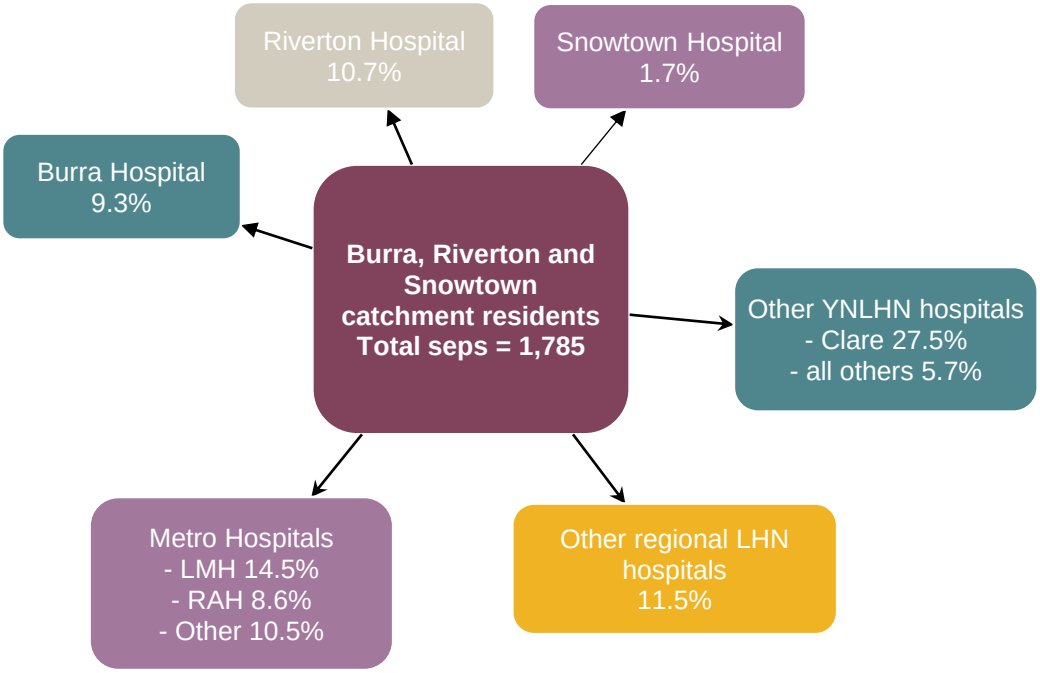
Sources: 2021 Census data, 2021/22 activity data/CCME data, Aged Care Liaison Officer.

4.2 Where residents are going for services (service flows/self-sufficiency).

Examining service flows or "self-sufficiency" involves measuring the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital, elsewhere within their LHN or elsewhere within SA.

Burra, Riverton and Snowtown self-sufficiency was reviewed to enable discussions and recommendations about appropriate pathways to higher-level clinical services and enhancing access to services as close to home as possible.

A summary of service flows for each site (2022-23) is depicted below.



5. Service planning process

5.1 Overview

The service planning process was led by the Burra, Riverton and Snowtown Service Planning Steering Group, comprising representatives from local Health Advisory Councils, YNLHN Executive, consumers, hospital and community health staff (full details of the membership and the role of the steering group are provided on page 4).

This group convened monthly to implement the co-design health service planning framework. Various stakeholders, including clinicians, consumers, community members, and others, contributed to developing the service plan through workshops, surveys, focus groups, and interviews.

The responsibilities of the steering group included gaining a thorough understanding of the current services, identifying opportunities, brainstorming ideas for enhancements, and drafting a service plan based on insights gathered from the engagement activities and quantitative and qualitative data analysis.

The steering group also endorsed a 'service profile' containing demographic and service utilisation statistics, which formed the basis for the data gallery showcased at the Clinician Engagement Workshop.

After each meeting, a summary detailing discussions, issues, and action points was compiled and circulated.

5.2 Engagement Strategies

5.2.1 Clinician Engagement

Various engagement methods were employed to involve clinicians and consumers in developing the Plan, integrating their input with relevant data and best practices.

A clinician engagement workshop was held on 20 March 2024, as part of the co-design planning process for Burra, Riverton, and Snowtown Health Services, encompassing hospital, community health, and mental health services. The workshop, attended by 55 participants representing a range of clinical stakeholders, was supplemented with an online survey to gather feedback from those unable to attend.

Workshop format

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

General medical (including cancer care, palliative care, obstetrics, surgical services)

- Mental Health
- Aged Care
- Out of Hospital Strategies

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

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

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

5.2.2 Community engagement

The steering group endorsed a community engagement process to gather input from community members, consumers, and stakeholders regarding hospital, community and allied health services and mental health services in the Burra, Riverton, and Snowtown areas.

The engagement aimed to collect feedback regarding current services, challenges, and opportunities from community, consumer, and partner organisations to assist the steering group in determining future service directions.

The approach used various methods to inform the general community and key partners about feedback opportunities. Communications included articles in newsletters, targeted Facebook posts and flyers in the local community.

During December 2023 and January 2024, the following opportunities were provided:

Hard copy surveys and flyers promoting *"Have your say!"* were distributed within Burra, Riverton and Snowtown.

Four sessions were held, and a total of 114 people took the time to drop in and talk to us: **25** in Burra, **44** in Snowtown and **45** in Riverton.

Posters with a QR code link to an electronic survey were distributed in all communities , al with hard copies. Survey return boxes were provided at local pharmacies, supermarkets, hospitals and medical centres.
A total of **79 completed surveys** were received**:** 60 electronic and 18 hard copies.

Community members were invited to indicate via the survey if they were interested in sharing their experiences, and as a result **two consumer interviews** were conducted.

5.3 Consumer stories

Stories and feedback from our consumers provide us with real-life experiences that help identify improvement opportunities. These stories were chosen to demonstrate the issues these consumers faced when accessing health services and what would have improved their experience. *(Names and place of residence changed for confidentiality, stories are included with consumer permission).*

Patient Story 1 - Lynn from YNLHN

Lyn's journey as the primary carer for her husband, who battles a complex and rare migraine condition, offers a poignant insight into the intricate challenges faced by families navigating the healthcare system.

Despite their ongoing battle with the severity of these migraines, misconceptions about migraines persist. Her husband's condition, encompassing three types of migraines, including hemiplegic migraines mimicking strokes, occurs frequently, causing cognitive decline and dementia.

Lyn's challenges extend beyond her husband's illness. Their teenage son, grappling with his father's illness and his own stresses, finds himself adrift in a sea of uncertainty. The strain of caregiving weighs heavily on him, challenging his relationships and prompting his withdrawal from school. Bullying exacerbates his distress, highlighting the need for resilience and mental health support services, which are often scarce in rural communities.

Navigating the healthcare system has posed significant challenges, compounded by limited neurologists in rural areas. Financial and geographic barriers hinder access to healthcare, particularly emergency services. Mental health support is scarce, and many programs are short-term, increasing the family's stress. Furthermore, patient-centred care, support for carers, and difficulty finding health care professionals with an understanding of and ability to manage unique conditions have added further stress. Additionally, challenges in accessing programs like the National Disability Insurance Scheme further compound their difficulties.

The complexity of their situation highlights the need for improved holistic care, patient-centred care, long-term support, and patient advocacy within the healthcare system. Furthermore, it highlights the urgent need for improved mental health services and comprehensive support for families navigating the complexities of rare health conditions.

Patient Story 2 – Leigh from YNLHN

Leigh and his family relocated from interstate to the lower north due to his wife's various health challenges and the need to have ready access to medical services.

Living in a small country town posed challenges as his wife battled chronic hydrocephalus and vaso-spatic angina, requiring frequent hospital visits and specialised care, often necessitating transfers to Adelaide for long periods due to limited local treatment options. Delays in diagnosis and misunderstandings regarding her condition highlighted challenges in accessing timely and appropriate healthcare. The importance of accessing specialised units like the cardiac unit at Queen Elizabeth Hospital was evident throughout the story, as were the struggles the family faced in accessing transport options.

Advocacy for improved rural health policies, such as incentivising GPs to work in rural areas and considering international recruitment to address workforce shortages, were highlighted by Leigh as possible solutions. Challenges with accessing ambulance services manned by volunteers in a small town, limited community transport options, and concerns about future access to healthcare were also raised. Additionally, the importance of having access to local services like pharmacies, local hospitals and community-driven initiatives such as support groups played pivotal positive roles in their healthcare journey.

Despite positive experiences with the National Disability Insurance Scheme and local support services, Leigh highlighted the need for better promotion of available healthcare services.

Overall, Leigh's story illustrates the challenges with accessing specialised care, the need to increase our clinical

workforce, the need to have services closer to home where possible and the value and importance of local community support.

5.4 Consumer Feedback

"Older adults are struggling with technology and don't know how to access services".

"People don't know what services are out there, and when you finally get approval for your services then there isn't anyone to do the service".

"Care coordination and navigation of the system is difficult".

"When I go to the hospital, it's such a relief. I really have confidence and it's just a relief that it's right there in town."

"We have a good GP, but we only have one."

"We don't know what is out there".

"Paediatric services more allied health service with proper rooms set up to meet their needs e.g., kids OT and Speech being run in a tiny office in Riverton that's not inviting".

"Staff at the hospital need to know what is available from Country Health Connect. Sometimes people are discharged and haven't known about options available to

"Access to a gym would be really great for the community, especially if it was free or low cost, Podiatry and Physio are really important services."

"24-hour access - If there is an emergency we can drive to the hospital, if need be, the nurses assess the situation and if they feel the need, call a doctor and one arrives within a half hour. How good is that?!".

Snowtown – "The Doctor, chemist and hospital are all onsite: a one stop shop"

6. Service Plan

Clinical Services Capability Framework

The SA Health Clinical Services Capability Framework (CSCF) 2016 has been designed to guide an integrated health service planning and delivery approach in South Australia. The CSCF is a set of 30 service modules for clinical service areas. The modules detail the minimum service and workforce requirements, risk considerations, and support services needed to provide safe and quality care at South Australian hospitals. It is an important tool for state-wide planning, 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 describing clinical services and identifies interdependencies between clinical areas.

For regional LHNs, it helps to plan what services can safely and reasonably be provided close to home and what services will need to involve travel to, and partnership with, a metropolitan-based tertiary health service.

The Department of Health and Wellbeing (DHW) is currently undertaking a review of the CSCF modules.

The information in the service improvement priority tables below relates to the CSCF level criteria currently assigned to YNLHN Health Units.

Service Capacity

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

- Burra Hospital has 5 acute beds and has 10 aged care beds.
- Riverton Hospital has 7 acute beds and 17 aged care beds.
- Snowtown Hospital has 7 acute beds and 24 aged care beds.

YNLHN Community and Allied Health Services (Country Health Connect) offers a variety of allied health and specialty nursing services, including centre-based and community-based options.

Mental health services are provided as both centre-based and community-based services and are located off-site.

Priority measures of success

We have integrated Priority Success Measures into the Plan as part of our commitment to excellence in healthcare delivery and patient outcomes. These measures identify our priorities for the first 12 months and systematically track and evaluate our performance, enhancing the quality and effectiveness of our services to ensure our patients receive the highest standard of care.

7. Service Improvement Priorities

The priority table below outlines the proposed service planning priorities for the Burra Hospital, Riverton Hospital, Snowtown Memorial Hospital & Country Health Connect and mental health services.

7.1.1 Aboriginal Health

Current Service Summary
In our health unit catchments, the Aboriginal population proportions are Burra 2.4%, Riverton 2.5%, and Snowtown 3.7%. Hospital separations for Aboriginal individuals were Burra 2.5%, Riverton 0.5%, and Snowtown had none. Emergency presentations were Burra 3%, Riverton 0.8%, and Snowtown 0.6%. Lower North Community Health has 3% of Aboriginal clients accessing Country Health Connect services.
Future Service Proposal
The proposed strategies are vital for supporting Aboriginal people within the YNLHN. Ensuring we have a dedicated and skilled workforce that delivers exceptional consumer care is crucial. The successful implementation of these strategies will rely on coordinated efforts and commitments from all service departments within the LHN, aligning with each service priority table for comprehensive impact. Furthermore, these efforts must align with the National Safety and Quality Health Standards and the Closing the Gap targets, reflecting a holistic approach to improving healthcare outcomes for our Aboriginal communities.

Service Improvement Recommendations	
AH 1: Aboriginal people will have access to culturally safe and appropriate initiatives determined by local communities.	
AH 1.1	Provide localised cultural awareness training for staff to increase responsiveness to local Aboriginal consumers and community members.
AH 1.2	Integrate trauma-informed care principles and training into the service to ensure sensitive and effective support for individuals affected by trauma.
AH 1.3	Work in partnership with the YNLHN Aboriginal Health Team to understand Aboriginal health needs and implement targeted strategies to improve health and wellbeing.
AH 1.4	Encourage and increase Aboriginal participation in service and program co-design, delivery, and evaluation to ensure their values and knowledge are incorporated.
AH 1.5	Create a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islanders.
AH 1.6	Support the implementation of the Aboriginal Maternal & Infant Care (AMIC) Service.
AH 1.7	Support the deliverables in the YNLHN Reconciliation Action Plan and subsequent plans.
AH 1.8	Improve the identification of Aboriginal and Torres Strait Islander people in medical records.

AH2: Identify innovative ways to grow the Aboriginal workforce.	
AH 2.1	Increase the number of Aboriginal people who are employed across the local services e.g., acute services, community health, aged care, and administration.
AH 2.2	In conjunction with the LHN, develop a strategy to nurture Aboriginal students into care pathways, providing mentorship and support for career development.
AH3: Support improved access to appropriate services.	
AH 3.1	Increase links with the YNLHN Aboriginal Health teams to improve access to services for Aboriginal people living in the local catchments.
AH 3.2	Increase staff and consumer knowledge of services offered by the Aboriginal Health Teams and continually promote current services.
AH 3.3	Improve prevention, early detection and management of chronic disease targeting prevention programs including the monitoring and review of care plans.
AH 3.4	Collaborate with NGOs and local agencies to improve health and wellbeing of Aboriginal individuals living in the catchment areas.
AH 3.5	Identify, link and support Aboriginal consumers to access tailored support groups that address their unique needs, fostering a community-driven approach to holistic wellbeing and cultural empowerment.
AH 3.6	Investigate resources required to support cultural protocols.

Priority measures of success

- 100% of staff have completed cultural awareness training within 12 months.
- All Aboriginal consumers are offered appropriate opportunities to provide feedback on the sensitivity and effectiveness of support and information received.
- Increased numbers and percentages of Aboriginal participants are involved in program co-design, delivery, and evaluation.
- Culturally appropriate welcoming environments at each site are designed and delivered in consultation with local Aboriginal communities.
- Evidence of improvement in prevention, early detection, and management of chronic diseases (measured through health outcomes and care plan reviews).
- Increased numbers of Aboriginal employees.

7.1.2 Aged Care

Current Service Summary
The Burra Hospital has ten aged care beds available and is a Multi-Purpose Site (MPS). The Riverton Hospital has seventeen aged care beds and is a Residential Aged Care (RAC). The Snowtown Hospital had seventeen aged care beds and is a multipurpose site. Commonwealth Home Support Programme (CHSP) services are provided by Country Health Connect. Home Care Packages are provided by Non-Government Organisations (NGO).
Future Service Proposal
Maintain and enhance the services provided by the health services and assist the community to access aged care services.

Service Improvement Recommendations	
AC1: Improve access to specialist services and mental health support services.	
AC 1.2	Advocate for increased access to geriatricians and geriatrician nurse practitioners within the LHN and raise awareness of available services to meet the needs of the ageing population.
AC 1.2	Lobby for funding to bridge gaps in mental health services for older persons.
AC 1.3	Establish an agreed service model for allied health services provided in residential aged care, including funding allocation.
AC2: Expand, support and build the capacity of the aged care workforce.	
AC 2.1	Explore scholarship opportunities and traineeships in partnership with the Local Health Network and local schools/education facilities.
AC 2.2	Identify funding streams for increased Allied Health Professionals (AHPs) to bolster support services within programs.
AC 2.3	Investigate the feasibility and viability of support roles to enhance falls prevention programs and the health and wellbeing of aged care residents.
AC 2.4	Streamline volunteer onboarding processes, consider volunteer coordination time and promote the expansion of the volunteer workforce, including linking with the volunteer visitor scheme.
AC 2.5	Investigate opportunities to increase diversional therapy time and funding allocation.
AC3: Work in partnership with aged care services in the region to enhance consumer access and improve service quality.	
AC 3.1	Develop closer links to enhance the utilisation of the Care Finder program to improve access and promote available aged care options.

AC4: Encourage innovation and improve quality of care for enhanced aged care excellence.	
AC 4.1	Work closely with the LHN to enhance food services by employing an Executive Chef, Dietitian and Speech Pathologists to ensure compliance with current aged care standards.
AC 4.2	Investigate mentorship programs within our workforce to share knowledge and expertise and support the navigation of our systems. Additionally, mentorship should be implemented for staff when out in the community to bolster recruitment and retention.
AC 4.3	Explore partnerships with universities and TAFE to facilitate research and education opportunities in aged care.
AC 5: Improve and redesign facilities infrastructure to accommodate growing demand for complex care.	
AC 5.1	Develop dementia-friendly spaces and care environments at Snowtown and Riverton.
Burra	
AC 5.2	• Investigate the feasibility of a maxi lifter from the balcony to the garden. • Review, reconfigure and refurbish the dining area to make it more homely and spacious. • Upgrade and renovate acute rooms and bathrooms.
Riverton	
AC 5.3	• Upgrade access to outdoor area. • Develop ensuite bathrooms for each room. • Renovate and modernise the communal areas.
Snowtown	
AC 5.4	Continue to upgrade the garden environment.

Priority measures of success

- Increased access to a range of specialist services.
- Increased number of Allied Health Professionals (AHPs) and support workers within programs, supported by identified funding streams.
- Improved lifestyle and wellbeing of consumers monitored through quality indicators.

7.1.3 Emergency

Current Clinical Service Capability
Burra, Riverton and Snowtown provide level 2 emergency services based on the Clinical Services Capability Framework (CSCF), including: • on site, 24-hour access to nursing staff and triage of all presentations. • capable of providing initial treatment and care for all presentations and provide interim care to enable rapid transfer of major trauma. • provide resuscitation and stabilisation prior to transfer to higher level service. • medical practitioner available on call 24 hours.
Current Service Summary
There were 566 emergency presentations at the Burra Hospital in 2022-23, consisting of 28 triage 1 or 2 presentations,180 triage 3 presentations, and 358 triage 4 or 5 presentations. There were 372 emergency presentations at the Riverton Hospital in 2022-23, consisting of 33 triage 1 or 2 presentations, 122 triage 3 presentations, and 217 triage 4 or 5 presentations. There were 171 emergency presentations at the Snowtown Hospital in 2022-23, consisting of 31 triage 1 or 2 presentations, 44 triage 3 presentations, and 96 triage 4 or 5 presentations. The current service model is: • A Registered Nurse offers assessment and treatment, and a doctor is available on call. • 24/7 service meeting triage times. • GP led on call service. • South Australian Virtual Emergency Service (SAVES) can be accessed from 7.00pm to 7.00am for category triage 3, 4 and 5 presentations. • Stabilisation and resuscitation of critically unwell patients. Coordinate and collaborate remotely with Metropolitan services for care prior to transfer. • Coordinate and collaborate care with South Australia Ambulance Service MedSTAR state-wide retrieval services. • Admit and manage where appropriate.
Future Service Proposal
Ensure safe accident and emergency care is provided by Burra Hospital, Riverton District Soldiers' Hospital & Snowtown Memorial Hospital to meet future demand.

Service Improvement Recommendations	
ED1: Ensure access to timely and safe urgent care and emergency stabilisation.	
ED 1.1	In line with the YNLHN Clinical Service Plan and in conjunction with the SAAS, GPs, partner agencies and clinicians, explore and develop a sustainable emergency service workforce model.
ED 1.2	Foster innovative models of care through strong interagency relationships with SAAS, GPs and other relevant agencies within the LHN.
ED 1.3	Design and plan infrastructure upgrades to enable evolving models of care.

ED 1.4	Understand diagnostic capabilities of each site to ensure accurate and timely assessment and improve linkages with larger sites to support provision of x-ray and SAAS transfers.
ED 1.5	Investigate options and establish more supportive, streamlined, and efficient liaison pathways for up-transfers from small sites.
ED 1.6	Explore innovative ways of delivering responsive mental health care to people who present to local Emergency Departments with mental illness, including digital technology options to access mental health services and Emergency Triage Liaison Service (ETLS).
ED2: Continue to develop strategies to reduce potentially preventable admissions.	
ED 2.1	Work closely with GP clinics to develop a strategy to ensure complex repeat emergency department presentations are identified and referred to appropriate services.
ED 2.2	Continue to work with community health to expand and grow chronic disease management programs.
ED3: Improve workforce confidence and capability in emergency responses to domestic, family and sexual violence by:	
ED 3.1	Linking with the YNLHN vulnerable consumers role and participating in the rollout of the 'Ask, Assess, Respond' training.
ED4: Improve awareness of services available.	
ED 4.1	Increase community awareness about local emergency department services and GP services, including how and when to access them.
ED 4.2	Increase promotion of statewide telephone support services in emergency departments and widely within our communities, including: • Mental Health Triage Service: 13 14 65 • Lifeline: 13 11 14 • Alcohol and Drug Information Service (ADIS): 1300 13 1340 • 13YARN-for Aboriginal and Torres Strait Islander communities: 13 92 76. • Child & Adolescent Virtual Urgent Care Service (08) 8161 7000. • HealthDirect – 1800 022 222.

Priority measures of success

- Improved awareness of available services within the community.
- Reduced numbers of people re-presenting to the Emergency departments.
- Improved access to a range of mental health services.

7.1.4 Medical Inpatients

Current Clinical Service Capability
All sites provide level 2 medical services based on the SA Health Clinical Services Capability Framework (CSCF): • Provide both an ambulatory and inpatient service, including overnight nursing care for patients under the care of medical practitioners. • Inpatient services are usually provided for low to medium-acuity, single-system medical conditions with significant but stable co-morbidities.
Current Service Summary
The Burra Hospital has five inpatient beds available. In 2022-23, a daily average of 1.4 beds were occupied overnight (where patient length of stay was greater than 24 hours in total). The Riverton Hospital has seven overnight stay beds available. In 2022-23 a daily average of 1.9 beds were occupied overnight (where patient length of stay was greater than 24 hours in total). The Snowtown Hospital has seven overnight stay beds available. In 2022-23 a daily average of 1.5 beds were occupied overnight (where patient length of stay was greater than 24 hours in total). All sites provide: • day and inpatient overnight care for medical patients for both planned and unplanned admissions. • stablisation of patients prior to transfer where higher level of care is required. • liaison with metropolitan services to coordinate care prior to transfer. • palliative care.
Future Service Proposal
Maintain level 2 medical inpatient services and enhance patient care by seeking a range of overall service improvements.
Service Improvement Recommendations

MI 1: Review, improve, and redesign facilities infrastructure to provide safe, accessible services.	
MI 1.1	Improve security for all sites.
MI 1.2	Continue to upgrade accommodation options to attract staff.
MI 1.3	Review areas for ancillary staff.
Burra	
MI 1.4	• Update driveway for the ambulance and front entrance. • Upgrade toilets in the Doctors' area to improve disabled access. • Update foyer area. • Update dentist, podiatry/physiotherapy room • Improve signage for GP clinics.

Riverton	
MI 1.5	• Identify and develop hot desk areas. • Upgrade bathrooms.
Snowtown	
MI 1.6	• Improve lighting in the car park. • Redesign unused area at the end of hospital. • Improve the driveway in the carpark, including considering a ramp.
MI 2: Identify innovative ways to attract and retain the required workforce.	
MI 2.1	Maximise the capabilities of nursing staff by ensuring they are leveraged to their full scope of practice.
MI 2.2	Consider alternative healthcare models for areas where there may be future shortages of General Practitioners (GPs), ensuring continuity of care and access to essential services.
MI 2.3	Explore opportunities to increase the support roles, based in hospitals to provide assistance on the ward and with telehealth.
MI 2.4	Work in partnership with the local GPs and the RDWA to support initiatives for the recruitment and retention of GPs to ensure sustainable services for the future.
MI 3: Continue to develop the TCP service model, identifying a key site for the area.	
MI 3.1	• Increasing access to allied health services • Identifying clear referral pathways from larger sites • Developing the infrastructure to encompass a homely environment • Increasing education for staff to focus on restorative care • Developing a coordinator role • Link into the development of the YNLHN service model.
MI 4: Improve and address patient journey barriers.	
MI 4.1	Expand telehealth service models to improve remote communication and accessibility with GPs, Specialists and allied health, fostering enhanced healthcare delivery.
MI 4.2	Investigate strategies to support re-enablement following post-acute care in metropolitan service.
MI 4.3	Explore options to have a Lower North patient liaison nurse for complex clients to ensure a smooth transition from hospital to community-based settings.
MI 4.4	Create streamlined processes to support sites in discharge planning.
MI 4.5	Improve flow coordination with metropolitan health services and within the Local Health Networks (LHNs) to ensure patients receive the right service at the right time.
MI 4.6	Develop relationships with rural liaison nurses in metropolitan health services to support the patient journey for consumers, ensuring comprehensive use of patient flow hub.
MI 4.7	Improve the process for referrals to community services to ensure follow-up occurs to prevent re-presentation.
MI 4.8	Support the creation of improved referral pathways to facilitate timely discharge and alternative care solutions for NDIS clients and long-stay type patients awaiting residential aged care.
MI 4.9	Advocate for Patient Assisted Transport Scheme to continue to streamline administrative processes.

Priority measures of success
• Completion of key infrastructure improvements. • Reduced reliance on agency nursing through increased retention and improved recruitment. • Reduce the incidence of people representing for recurring conditions.

7.1.5 Mental Health

Current Clinical Service Capability
Burra, Riverton and Snowtown hospitals provide level 2 adult acute inpatient mental health services based on the Clinical Services Capability Framework (CSCF). This is described as: • 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.
Current Service Summary
The Lower North Community Mental Health Service, based in Clare, provides a specialist mental health service for individuals experiencing a severe mental illness with complex needs and significant functional impairment. The service provides mental health assessment, crisis intervention and care coordination, for people aged from 16 years old. The support is offered through an outreach community mental health model, with a strong emphasis on liaison with other health professionals and linkages with Non-Government Organisations to provide continuity of care as individuals experience improvements in their functioning. Provides: • Assertive community intervention. • Multi-disciplinary team. • Visiting consultant psychiatrist. Psychiatry and after-hours support are provided by the Emergency Triage Liaison Service (ETLS) telephone service based in Adelaide. All referrals are managed by the Lower North team and are triaged via the rostered duty worker.
Future Service Proposal
Maintain current services, work in partnership to improve mental health service literacy and implement a range of service improvements.
Service Improvement Recommendations

MH1: Enhance infrastructure to best meet the need of mental health consumers.	
MH 1.1	Identifying and redesigning mental health low stimulus environments in the hospital using the *Regional Local Health Networks Guidelines for Quiet Rooms in Country Hospitals (February 2022).*

MH 2: Explore mental health service improvement opportunities for Lower North.	
MH 2.1	Collaborate with the "new non-acute psychosocial support program" to promote the service.
MH 2.2	Work collaboratively with other mental health programs to enhance access, improve referral pathways, and coordinate across the levels of mental health needs.
MH 2.3	In conjunction with key partners, identify opportunities to develop mental health alternate options for the Lower North.
MH 2.4	Enhance knowledge of the range and level of mental health services offered by NGOs and the YNLHN.
MH 2.5	Advocating and addressing geographical challenges by extending services like Lifeline Connect, Clare to Snowtown and employing strategies such as technology to overcome geographic barriers.
MH 2.6	Improve coordination of common client care processes across services linking with GPs and Pharmacists, sharing information considering secure messaging and accessing clinical information to improve clinical interventions.
MH 3: Explore opportunities to build the capacity of our workforce.	
MH 3.1	Strengthening the knowledge, skills and capacity of acute staff in our local hospitals to manage acute presentation and provide mental health clients with a consistent approach to care.
MH 4: Build culturally responsive mental health services.	
MH 4.1	Improve and co-design culturally safe services tailored to the needs of Aboriginal people and their communities in a mental health tiered level of care.
MH 5: Improve awareness and understanding of services available for community.	
MH 5.1	Support community awareness of mental health services through events targeting both the community and service providers.
MH 5.2	Work closely with NGOs and the community to promote crisis care and early intervention services.
MH 5.3	Collaborate with local services providers, including GPs, to enhance community engagement and awareness of current services and referral pathways.
MH 5.4	Increase the promotion of statewide telephone support services within our communities, including: • Head to Health Phone Service: 1800 595 212. • Lifeline:13 11 14. • Regional Access: 1300 032 186. • Suicide Call Back Service: 1300 651 467. • Mental Health Triage:131465.
MH 6: Continue to explore and review digital technology to enable safe, high-quality service provision.	
MH 6.1	Improve linkages with mental health and community health staff, especially for shared consumers, by implementing flags or indicators to streamline communication and collaboration.
MH 6.2	Investigate a shared clinical record for broad access and seamless information sharing across services, enhancing collaboration and continuity of care.

MH 6.3	Expand the amount and type of telehealth service offerings, including dedicated locations for virtual consultations, across the lower north to increase access to care and reduce travel times and associated costs for consumers.
MH 6.4	Investigate options to support clients with secure access and bandwidth to expand technology capability in the home.

Priority measures of success

- Redesigned mental health spaces within the hospital setting.
- Community and service provider awareness of mental health services are increased within the next 12 months.

7.1.6 Community and Allied Health

Current Service Summary

Community and Allied Health employs the following health professionals:

- Podiatry
- Speech pathology
- Dietetics
- Occupational therapy
- Social Work
- Physiotherapy
- Allied health assistants
- Diabetes nurse educators
- Registered and enrolled nurses.

Multi-disciplinary teams provide a comprehensive range of community and hospital-based health services via individual assessment, one-to-one therapy, group work, community education, and in-home care. Referrals are prioritised according to clinical and service priority.

In addition to the above services, the LHN provides the following services:

- National Disability Insurance Scheme (NDIS) Services, child (0-8 years old) and adult programs
- Palliative care, End of Life Program (EOLP)
- Aged Care Assessment Team (ACAT)
- Rapid Intensive Brokerage Scheme (RIBS)
- Breakaways Group (NDIS support group)
- Rehabilitation ambulatory service
- Commonwealth Home Support Programme (CHSP)
- Short-term restorative care
- Child Health and Development (CHAD)
- Community nursing service (including specialist nurse services)
- Diabetic Education service
- Transitional Care Packages (TCP)
- Strength & Balance classes
- Aged Care Day Centre Programs.

Future Service Proposal

Maintain current services whilst exploring opportunities to grow services to meet future demand by seeking a range of service improvements.

Service Improvement Recommendations

AC 1: Improve discharge planning and coordination.	
AC 1.1	Initiate a process to communicate for early discharge between hospital and community health for proactive discharge information sharing and multi-disciplinary coordination.
AC 1.2	Explore the opportunity to implement a Patient Journey Coordinator for the lower north region to facilitate smooth transition and complex discharges.
AC 1.3	Investigate opportunities to link with the flow hub to improve communication for metropolitan discharges.
AC2: Develop sustainable and effective service models.	
AC 2.1	Investigate the demand for a chronic condition service, including group programs for the Lower North.
AC 2.2	Explore and advocate for the addition of a McGrath Breast Cancer Nurse and a Prostate Cancer Nurse for the Lower North.
AC 2.3	Increase access to allied health & specialty services across the Lower North, such as lymphoedema, continence programs, burns, stoma and upper limb services.

AC 2.4	Identify new and untapped funding sources through Activity-based Based Funding commissioning and Medicare to increase Community and Allied Health services.
AC 2.5	Evaluate grant funding vs activity-based funding models to determine the most effective approach for sustaining services.
AC 2.6	Investigate options to integrate care workers into the Transitional Care Packages Team to deliver timely services at home.
AC 2.7	Improve awareness for healthcare providers of short-term restorative care services to improve service uptake.
AC 3: Expand, support, and build the capacity of the workforce.	
AC 3.1	Implementation of supervision, coordination, and allocation management to support allied health assistants and clinical support officers across all programs
AC 3.2	Advocating for advanced scope of practice for allied health professionals to enhance service capabilities.
AC 4: Improve awareness and understanding of available community and allied health services.	
AC 4.1	Develop a local communication strategy to promote available health services and how to access them.
AC 4.2	Promote services to the community through the aged care newsletter, Community Passenger Transport, HAC meetings and local newsletters.
AC 4.3	Improve cross-service communication to address gaps in patient care and support, focusing on better information sharing among hospital and community health services and increased family involvement in patient care.
AC 4.4	Establish strength and balance classes at Burra and Snowtown.
Burra	
AC 4.6	Investigate and develop the underutilised space and gym equipment for: • strength and balance classes, • transitional care clients • physiotherapy clients • and other health and lifestyle activities
Riverton	
AC 4.7	Establish Community and Allied Health activities in identified spaces.
Snowtown	
AC 4.8	Evaluate the potential to use underutilised spaces for aged care programs.

Priority measures of success

- Increased community and staff awareness of community services as evidenced through staff and community surveys.
- Strength and balance classes are implemented at Burra and Riverton within the next 12 months.
- Number of new services introduced.

8. Collective Service Improvements

Current Service Summary	
The following proposed strategies are considered essential in achieving our desire to have a strong committed workforce who provide excellent consumer care across the YNLHN. These proposed strategies will require coordinated and committed implementation from all service departments across the LHN and are to be considered in conjunction with each specific service priority table.	
Service Improvement Recommendations	
CS 1: Continue to assess the utilisation and viability of digital technology to facilitate secure, high-quality service delivery as close to home as possible.	
CS 1.1	Support staff with education and upskilling throughout the implementation of the electronic medical records.
CS 1.2	Expand telehealth options to support access to GPs, specialists, allied health and specialist nursing services.
CS 1.3	Continue to optimise the use of SA Virtual Emergency Service (SAVES) and the SA Virtual Care Service and explore options to increase the use of SAVES to support staff within the region, e.g. how do we link with larger sites.
CS 1.4	Advocate for improved public access to broadband services.
CS 2: Foster a culture of innovation and continuous improvement across YNLHN.	
CS 2.1	Encourage innovation initiatives like the innovation challenge for allied health professionals, fostering creativity and service improvement.
CS 2.2	Create avenues for more research opportunities within the LHN to drive evidence-based practices and continuous improvement.
CS 2.3	Explore funding options, training programs and dedicated resources to nurture a research culture.
CS 3: Identify innovative ways to attract and retain the required workforce.	
CS 3.1	Support the implementation of the Rural Health Workforce Strategy, which includes strategies to improve recruitment and retention.
CS 3.2	Work closely with CenStaR team to ensure an effective and responsive approach to recruitment that meets local needs.
CS 3.3	Develop partnerships with local schools and education facilities to support work experience, cadetships and traineeships.
CS 3.4	Explore opportunities to provide young professionals with guidance and mentorship considering: • networking opportunities • professional development • shadowing opportunities • peer mentorship and buddy systems.
CS 3.5	Address workforce shortages by developing targeted strategies, including: • promoting Enrolled Nurse training programs • explore aged care traineeships • encouraging progression from Enrolled Nurse to Registered Nurse roles.
CS 3.6	Offer accommodation options for staff within the YNLHN to attract staff into the region.
CS 3.7	Collaborate with the Rural Support Service deployment program to address and support staff shortages.

CS4: Support access to appropriate services.	
CS 4.1	Work closely with our partners to improve transport and accommodation options to ensure a smooth patient journey.

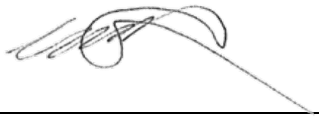
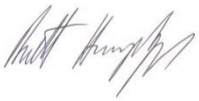
Priority measures of success

- The number of patients using telehealth services is increased.
- 100% of nursing staff will be trained in the use of the Electronic Medical Record (EMR) within the next 12 months.
- Increased confidence level in the use of EMR post-training.
- Increase in the number of healthcare professionals recruited and retained.
- Increased work experience, cadetships, and traineeships for young professionals.

9. Clinical Service Enablers

Service and CSCF descriptor level	Service Capacity	Proposed Service Improvement
Diagnostic Medical Imaging	• Level 1 services are provided at Gawler and Clare.	• Continue to work with transport providers to ensure improved access for consumers needing to travel to Clare of Gawler for medical imaging services.
Pathology All sites Level 2	• No on-site laboratory but have access to point-of-care testing. • Qualified staff available to collect and transport specimens via a SA Pathology courier to the nearest laboratory for all sites. • Blood pathology collection for Burra, Riverton and Snowtown currently attended by hospital nursing staff 7 days a week.	• Work with SA Pathology to explore opportunities to increase the number of seven-day courier services for Burra and Snowtown.
Pharmacy All sites Level 1	• Provides services to ambulatory populations with low medication risk. • Prescriptions can be filled at local pharmacy at Burra, Riverton and Snowtown where accessible, efficient, and clinically appropriate.	• Maintain existing arrangements with local Pharmacies. • Continue supply of medication out-of-hours via Rural and Remote medication Policy and Procedure. • Implement SA Pharmacy project recommendations.

10. Endorsement

Responsible Person	Signature	Date
Roger Kirchner Chief Executive Officer, YNLHN.		20/08/2024
Verity Paterson Chief Operating Officer, YNLHN.		22/08/2024
Melissa Koch Executive Director Community and Allied Health, YNLHN.		**08/08/2024**
Kerin Colgan Multi Campus Executive Officer Director of Nursing Burra Hospital and Snowtown Memorial Hospital, YNLHN.		**07/08/2024**
Amy McKerron Executive Officer / Director of Nursing and Midwifery Riverton District Soldiers' Memorial Hospital, YNLHN.		**07/08/2024**
Debra Papoulis Director Mental Health Services, YNLHN.		20/8/2024
Rochelle Griffin Executive Director Nursing and Midwifery, YNLHN.		21/08/2024
Brett Humphrys Director Strategy Planning and Partnerships, YNLHN.		**07/08/2024**

11. Abbreviations and Definitions

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

Aboriginal	Aboriginal persons - This plan respectfully uses the term 'Aboriginal', rather than 'Indigenous', to refer to people who self-identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander.
CenSTaR	CenSTaR is the Yorke and Northern LHNs Central Staffing and Recruitment pathway that coordinates recruitment and placement of Nurses, Midwives, AINs and Carers through a streamlined, specialised pathway.
Chronic condition	A disease or condition that usually lasts for 3 months or longer and may get worse over time. Chronic diseases tend to occur in older adults and can usually be controlled but not cured. The most common types of chronic disease are cancer, heart disease, stroke, diabetes, and arthritis.
Co-design	Refers to a participatory approach to designing solutions, in which community members are treated as equal collaborators in the design process. Co-design is a well-established approach to creative practice, particularly within the public sector.
Culturally and linguistically diverse (CALD)	Culturally and linguistically diverse (CALD) persons: Defined as persons who speak a language other than English at home.
Community Health – County Health Connect	The majority of community health services in the YNLHN are provided under the branding of Country Health Connect (CHC). CHC provides a range of health, aged care and disability services to people in their homes, Local Health Network hospitals, residential care facilities and other community settings. Services are provided across multiple programs by multi-disciplinary staff teams of allied health professionals, allied health assistants, nurses, coordinators, Aboriginal health workers, personal care attendants, ancillary staff and home support workers.
Multi-disciplinary Team	A multi-disciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.
Model of care	A "Model of Care" broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.
Potentially Preventable Admission (PPA)	A potentially preventable hospitalisation is an admission to hospital for a condition where the hospitalisation could potentially have been prevented through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary care and community-based.
South Australian Population Health Survey (SAPHS)	The South Australian Population Health Survey is a state-wide population health survey managed by Wellbeing SA, which aims to monitor the health status of all South Australians. The SAPHS has been collecting information about the health of South Australians since July 2018.

South Australian Virtual Emergency Service (SAVES)	The SAVES program operates from 7pm to 7am, seven days a week for 28 participating rural hospitals across South Australia and links doctors with patients and their local nurses in country emergency departments via the existing Telehealth Network, enabling face-to-face consults using video conferencing equipment. Experienced rural GPs provide remote medical assistance to patients who have been triaged by the nursing staff at local emergency departments.
SAAS MedSTAR Emergency Medical Retrieval Service	SAAS MedSTAR is South Australia's single emergency medical retrieval service.
SA1	Statistical Area 1: the fourth smallest geographical area defined in the Australian Statistical Geography Standard (ASGS). Consists of one or more whole Mesh Blocks.
SA2	Statistical Area 2: the third smallest geographical area defined in the Australian Statistical Geography Standard (ASGS). Consists of one or more whole Statistical Areas Level 1 (SA1s).
Self-sufficiency	Self-sufficiency measures the proportion of hospital services provided at the local hospital for residents who live in the local catchment. It shows where people from the local catchment are accessing public hospital services; the local hospital, elsewhere within their LHN or elsewhere within SA (activity that 'flows out').
Separations (Seps)	Hospital inpatient activity (separations) - A hospital inpatient 'separation' is a completed episode of care of an admitted patient, generally concluding with their discharge from hospital, transfer to another healthcare facility or in-hospital death. Generally, separations are used to show inpatient activity within this profile.
Triage **(Australasian Triage Score – ATS)**	The Australasian Triage Scale (ATS), known commonly as "Triage" is a clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient and aims to ensure that patients presenting to emergency departments (EDs) are treated in the order of their clinical urgency and allocated to the most appropriate assessment and treatment area. The ATS utilises five categories from Category 1 – an immediately life-threatening condition that requires immediate simultaneous assessment and treatment – to Category 5 - a chronic or minor condition which can be assessed and treated within two hours.

For more information

Yorke and Northern Local Health Network

Telephone: (08) 86 384575

sahealth.sa.gov.au/yorkeandnorthernlhn

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