Central Gippsland Health Service Health Plan 2012–2022

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Foreword

In May 2011 the Victorian Government released the Victorian Health Priorities Framework 2012–2022 along with the Metropolitan Health Plan, outlining key outcomes, attributes and improvement priorities for the Victorian Healthcare system.

The development of the Rural and Regional Health Plan in December 2011 was the next critical step to demonstrate the Government's commitment to developing a long term plan for a sustainable health care system. The Rural and Regional Health Plan has provided the framework required to enable the CGHS Board to meet its governance responsibilities with regard to health service planning and to develop a local health care system capable of meeting the changing needs of our population.

The CGHS health plan outlines CGHS application of the Rural and Regional Health Plan. A comprehensive Evidence and Policy Informed Needs Assessment is the companion document and technical paper informing our plan.

The needs assessment, conducted within a population health planning context, brings together the relevant planning and service delivery frameworks, with the broader evidence base, provided through the literature, national strategy documents and peak organisations with the technical information relating to the population we serve.

The other critical dimension of the needs assessment was the identification of community preferences and priorities to inform our plan. This was achieved by engaging the community through a community-led consultation process, where community representatives supported by an independent social researcher, designed and conducted a community consultation for this purpose.

The CGHS Health Plan 2012–2022 acknowledges CGHS is part of a complex health system and we share the Victorian Government's aim to develop a service that has the capacity

> *to deliver innovative, informed and effective healthcare that is responsive to people's needs … and delivered through improved collaboration and interaction between providers at the regional level, with a greater emphasis on supporting evidence based patient pathways and support for communities to be healthier.*

I encourage our community and the providers of health care in our region and beyond, to provide us with feedback on our plan so that your input will inform the implementation of our Board's vision for our health service.

John Sullivan
Board Chair

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Executive summary

In May 2011 the Victorian Government released the Victorian Health Priorities Framework 2012–2022 along with the Metropolitan Health Plan, outlining key outcomes, attributes and improvement priorities for the Victorian Healthcare system.

The development of the Rural and Regional Health Plan in December 2011 was the next critical step to demonstrate the Government's commitment to developing a long term plan for a sustainable health care system. The Rural and Regional Health Plan has provided the blueprint for the *Central Gippsland Health Service, Health Plan 2012–2022*.

The CGHS Health Plan represents a key deliverable of our 2009 Strategic Plan. Our health plan recognises the individual characteristics and attributes of our region and population and addresses the particular issues facing our community.

The plan, informed by detailed service delivery plans, will support us to implement a comprehensive service delivery capability framework, capable of aligning all the capability dimensions of CGHS: people; business processes; facilities and equipment; information and communication technologies; knowledge and accountability / governance.

The plan understands that our population is ageing much more rapidly than all Victoria and Australia and as a consequence will be characterised by higher than average prevalence of chronic disease, disability and health service utilisation.

The plan recognises the need for CGHS to build on existing relationships and collaborative approaches within the Gippsland region and sub-region and to continue to build care pathways for people to facilitate access to appropriate and cost effective care.

The highlights of the plan include how CGHS will:

- act to be part of an adaptable rural and regional health system that is tailored to the needs and circumstances of our community and support collaborative, clinically appropriate and cost effective service delivery
- Build on the existing configuration with Gippsland and beyond and build on the developing sub-regional or area-based approach to service delivery
- Support and enable the systematic use of clinical guidelines and evidence informed patient pathways to enable our community to receive appropriate and timely care in the most appropriate setting
- Build on the existing Gippsland health service partnering arrangements to better support people as they move between service providers and settings
- Clarify our roles, responsibilities and desires with regard to the implementation of the Victorian Public Health and Wellbeing Plan 2011–2015
- Support the workforce capability development required to sustain and grow our workforces capability and capacity
- Support Latrobe Regional Hospital to strengthen their clinical leadership responsibilities in the region and to enable us to meet our sub-regional responsibilities

Introduction

In 2009 CGHS updated its strategy and committed to undertake comprehensive health planning within a population health framework. This plan is the product of two and half years work involving a large number of staff across all care settings and two community and consumer representative groups. The work has more recently benefited from the release of the Victorian Health Priorities Framework 2012–2022 in May 2011, which articulates the key outcomes, principles and priorities for the Victorian healthcare system for the next 10 years.

Subsequently, the government developed a *Rural and Regional Health Plan* along with a supporting technical paper. The *Rural and Regional Health Plan* presents the government's response to the unique health and health system issues and experiences in rural and regional Victoria. The actions are informed by the best available evidence and in many cases draw on examples of innovation and effective health service practices already in operation across rural and regional Victoria. Case studies throughout the document highlight some of these innovative practices.

The CGHS Health Plan is our response to the specific health and health system issues and experiences in our region and planning area. The plan draws on both the evidence base and examples of innovation and effective health service practices to enable the development of a service framework and service mix that reflects *our* capacity and capability to address the population health needs of our community in an appropriate and cost effective manner and over time.

Our plan outlines the actions that CGHS needs to make in order to work more closely with other service providers within and across sectors, to embrace innovation and support our people to adapt to new models and ways of delivering healthcare. Some of these changes will build on work already begun and in particular the work being done with regard to care coordination and evidence informed patient care pathways.

Like the Victorian government, CGHS has adopted a 10-year timeframe to allow us the time to embed actions into routine service delivery and enable changes in the health status of our population to be measured over time.

This plan contextualises the Metropolitan Health Plan, the Health Capital and Resources Plan, the Rural and Regional Health Plan and the Victorian Public Health and Wellbeing Plan for CGHS. In this regard we have taken a top down approach.

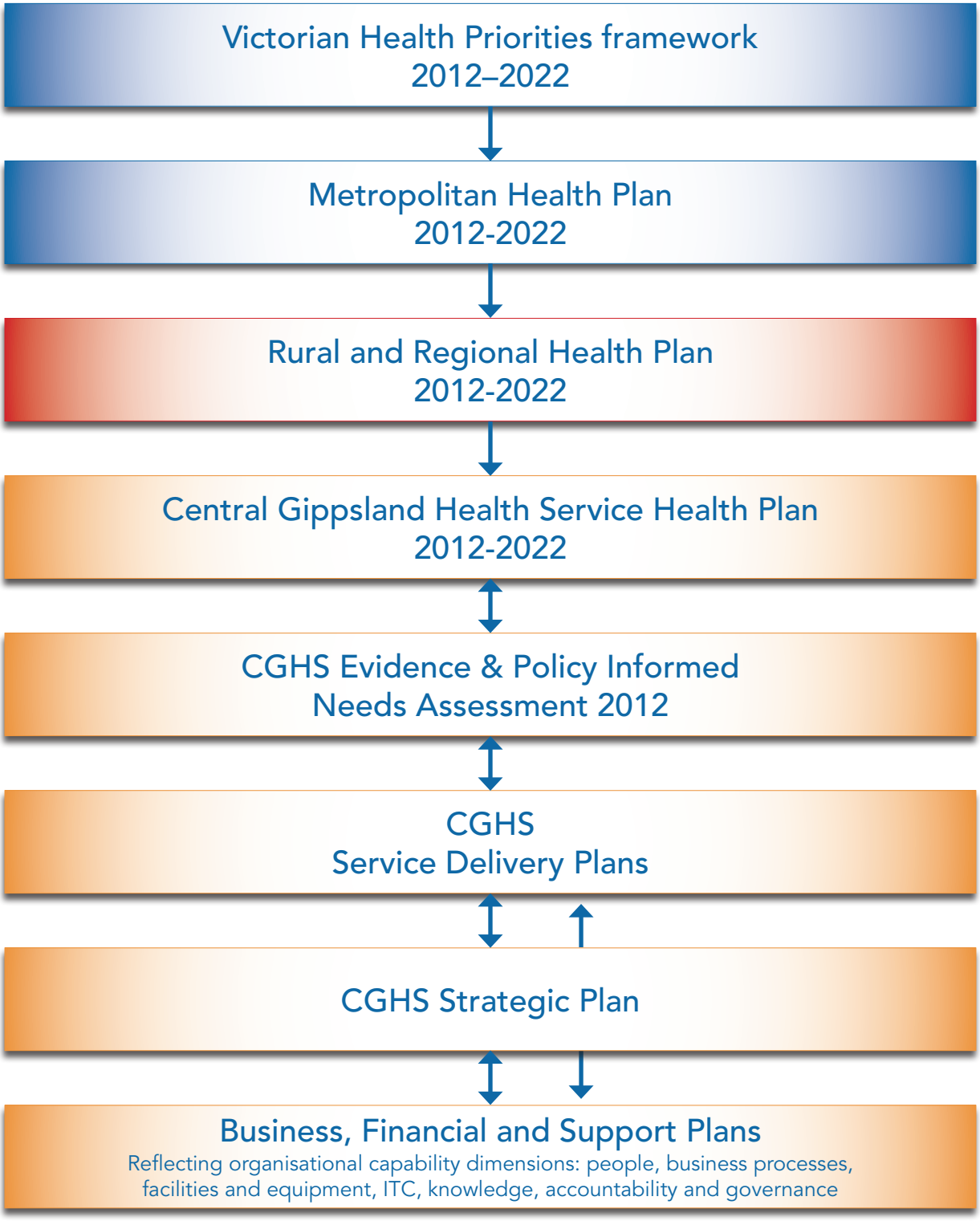
The CGHS Health Plan also contextualises the specific issues facing our community by integrating the recommendations of comprehensive evidence and policy informed needs assessment, incorporating a community-led consultation process, to inform detailed service delivery plans.

The needs assessment methodology is based on an understanding of the major health and wellbeing challenges associated with a changing national, regional and local demographic and the related illness burdens. The methodology also deals with the local relevance of these challenges and illness burdens along with other local issues and priorities identified through the development of local health and wellbeing and demographic profiles.

The needs assessment serves as the "technical paper" informing our health plan and in this regard the CGHS plan integrates a "bottom up" approach.

Central Gippsland Health Service Planning Framework

Central Gippsland Health Service's planning is based on a service delivery capability model. Service delivery capability is concerned with aligning all the capability dimensions of CGHS: people; business processes; facilities and equipment; information and communication technologies; knowledge and accountability / governance, to enable us to do the work we need to do in order to achieve our desired outcomes.



The Victorian Health Priorities Framework 2012–2022

Central Gippsland Health Service is part of complex Victorian health system in which a range of services are funded through multiple sources and across a broad range of settings. The range and mix of services provided is described as the continuum of care. Figure 1 below provides a representation of the Victorian health system highlighting the funding sources by service type.

Figure 1 Representation of Victorian Health System Highlighting funding sources by service type

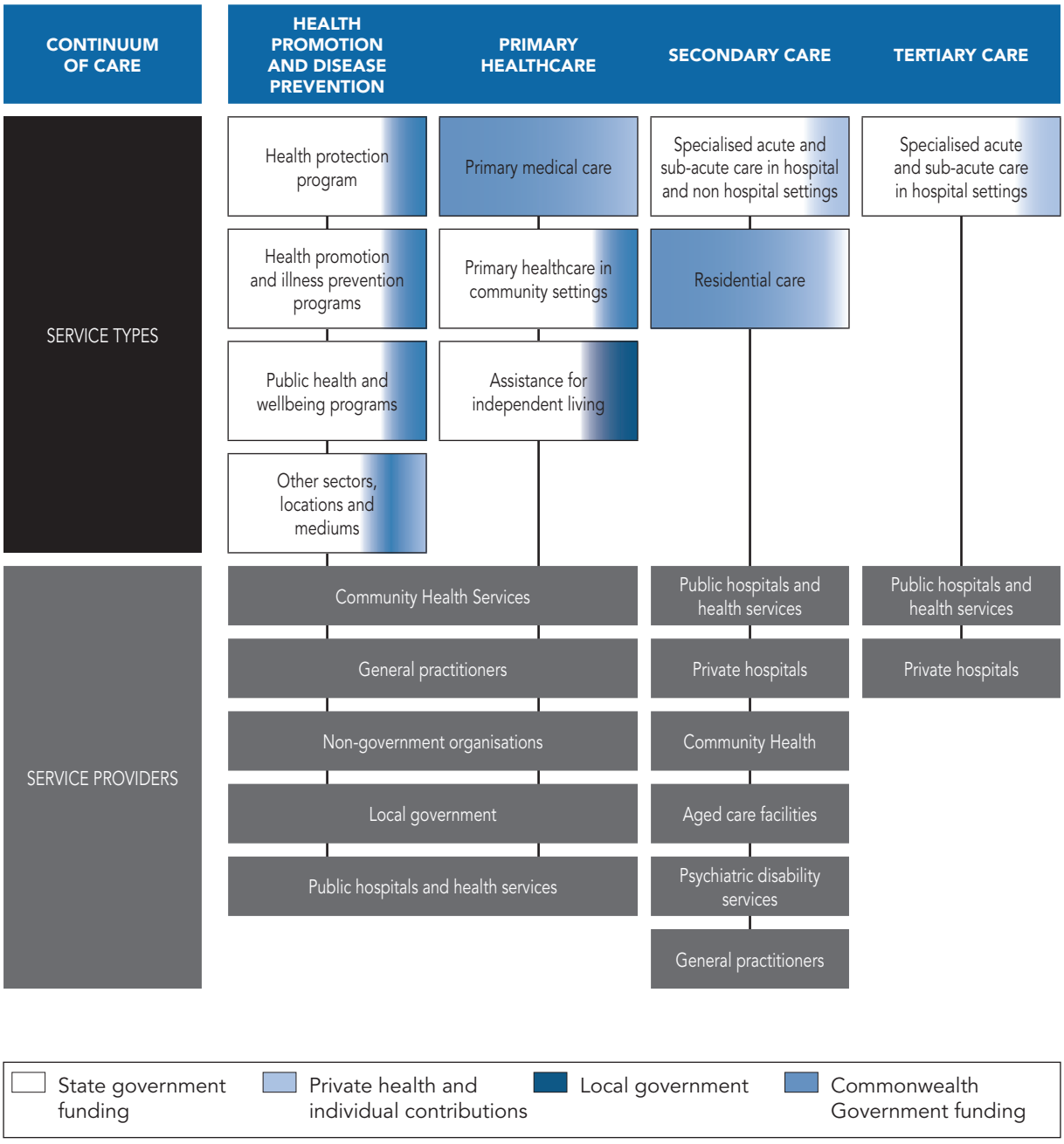
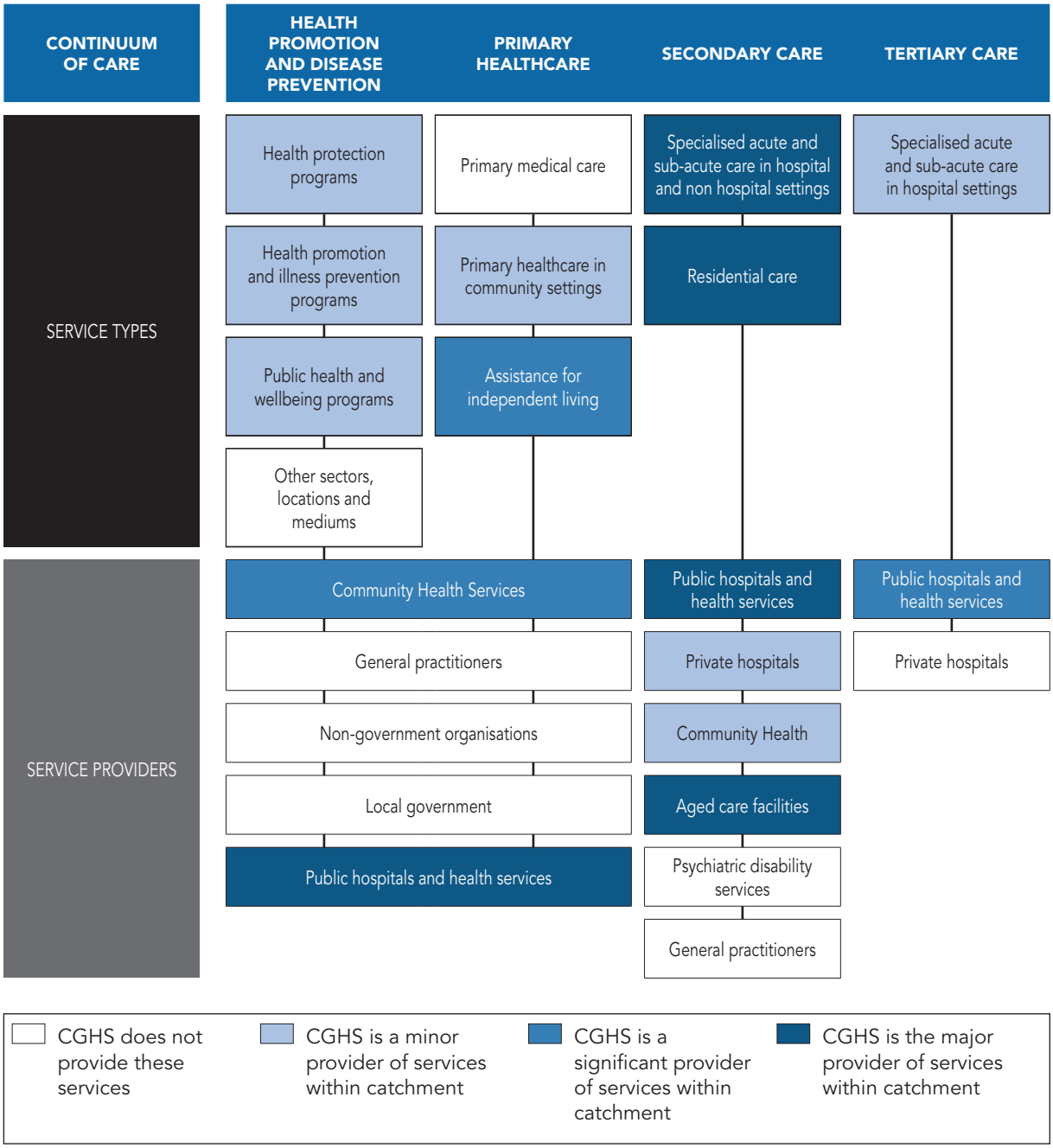


Figure 2 highlights where CGHS has a role within the system. CGHS is unusual being both a sub-regional and an integrated health service providing a broad range of primary health and community support services, including home and community care service usually provided through local government.

Figure 2 CGHS role within the system



Best healthcare outcomes possible

The government's vision is that by 2022 Victoria's health system will be responsive to people's needs and rigorously informed and informative. With the system being responsive to people's needs the government expects the following outcomes:

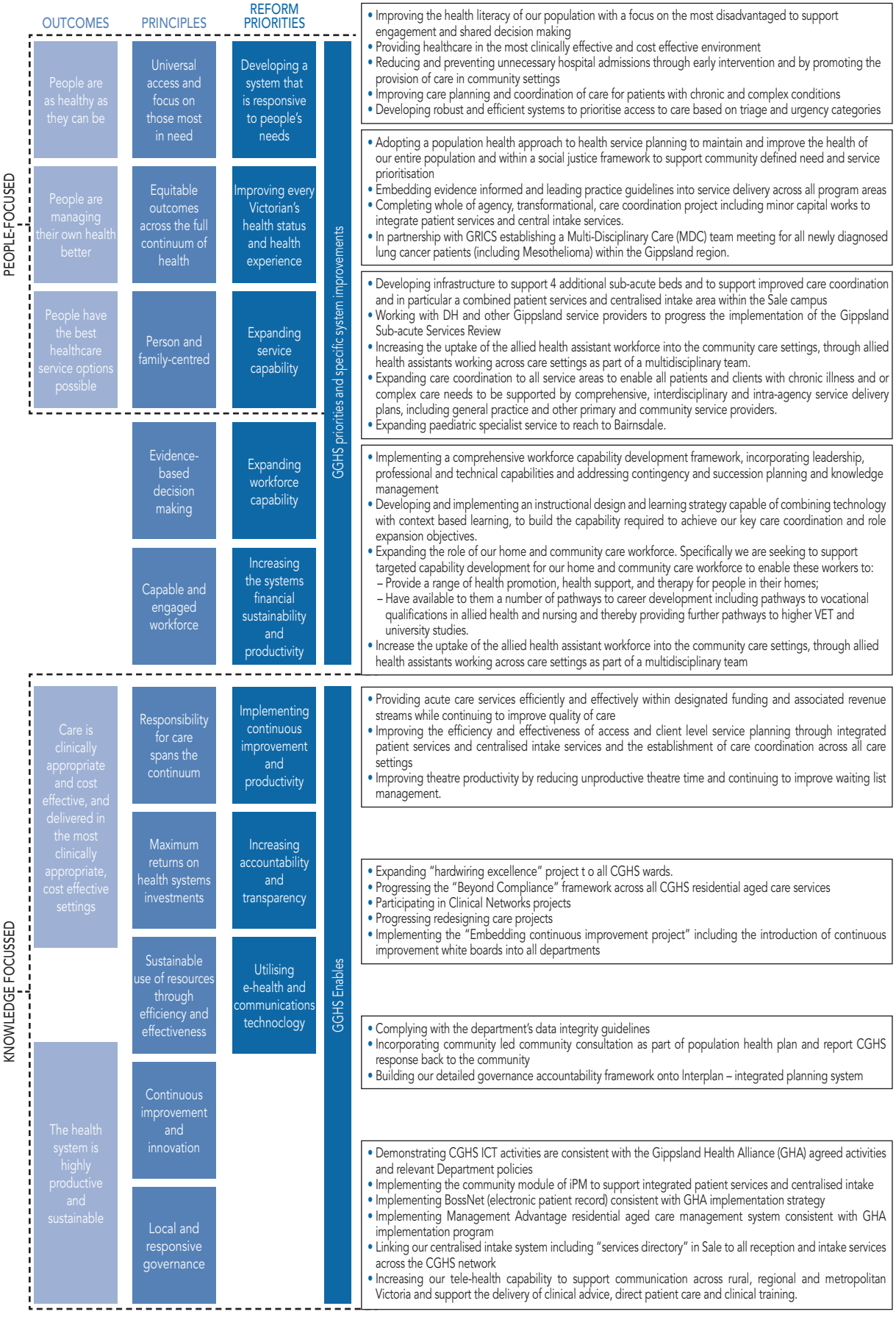
- People are as healthy as they can be (optimal health status)
- People are managing their own health better
- People enjoy the best health care service outcomes possible

By being rigorously informed and informative the system is expected to produce the following outcomes:

- Care is clinically appropriate and cost effective and delivered in the most clinically appropriate and cost effective service settings
- The health system is highly productive and health services are sustainable

CGHS's vision is consistent with that of the government since we have a vision of safe and healthy community where everyone feels they are valued, supported and have the opportunity to participate. We have identified our role is to provide the health and community services that will best meet the current and future needs of our community.

Figure 3. Victorian health priorities framework 2012-2022 and CGHS priority responses.



The rural and regional healthcare system

Rural and regional health services in Victoria play an integral role in supporting rural Victorians to be as healthy as they can be. This role includes the delivery of a range of services from health promotion and primary health through to providing acute inpatient services, mental health and drug services, aged care services and end-of-life care.

Rural and regional health services and the staff and volunteers who work within them have strong relationships with the local communities in which they are located. They contribute to the economic viability of many rural and regional towns and assist to build the social fabric of the local community.

The current organisation of the system

CGHS is part of rural and regional healthcare system made up of a diverse range of public, private and not-for-profit providers. Public health services in rural and regional Victoria include hospitals, community health and other community based services, mental health services, drug and alcohol services, bush nursing centres, ambulance and other transport and aged care services.

Public health services across rural Victoria include hospitals, bush nursing hospitals, general practices and medical specialists, privately funded allied health providers and aged care services. The sector also includes numerous not-for-profit organisations offering a range of health services and health-related support services such as transport and home based assistance. Local government and other government agencies are also providers of a range of health-related services including maternal and child health, school health and home and community care (HACC) programs.

Unlike other Australian states, the government in Victoria has a significant role providing public residential aged care. Rural and regional health services are major providers of these residential aged care services.

Services provided at the local level

Small rural health services, private hospitals, bush nursing centres, non-government organisations, registered community health centres, private medical and allied health services and residential aged care services are all integral components of the local service delivery system.

Small rural health services, other Victorian government-funded health services, such as general practitioners (GPs) and allied health providers are often inextricably linked. In many communities small rural health services and private hospitals engage visiting medical specialists to provide care. GPs often work in partnership with publicly funded health services to support the delivery of timely medical care, including procedural services in their local hospital.

Local organisations work together and with a range of partners at the local level. This collaboration extends to organisations that provide health services at the sub-regional and regional levels and is fundamental to supporting the ongoing sustainability of local health services

CGHS: a sub-regional health service and a network of local public, private and not-for-profit health service providers.

Services delivering care at the sub-regional level often provide a range of more complex services. CGHS is categorised as a sub-regional health service providing a range of more complex services than those delivered by small rural health services. CGHS is also a network of local public, private and not-for-profit services.

CGHS is a relatively complex health care network made up of 2 public hospitals located in Sale and Maffra, both with public sector residential care facilities on campus; a private, not-for-profit, hospital and residential aged care facility located in Heyfield; a not-for-profit residential aged care and independent living facility in Maffra; community health centres or services in Sale, Maffra, Rosedale and Loch Sport; and a community rehabilitation centre, located on the Sale campus, providing a range of allied health and rehabilitation services both in the centre, in people's homes and outreaching to other CGHS and non-CGHS facilities and services.

In addition CGHS is an integrated health service which provides a range of services, usually by local government, and in particular HACC funded, home support and maternal and child health services.

Clinical education and training is an important role for CGHS. CGHS provides clinical placements to support undergraduate education and training for medical, nursing and allied health staff, and rotations for specialist nursing, allied health and medical education, including GP proceduralists. Our education and training role is an important part of our workforce recruitment and retention strategy.

CGHS as a provider of both local and more complex sub-regional services provides a bridge between the lower complexity services provided by CGHS and other services in East Gippsland and the more complex services provided by Latrobe Regional (LRH). CGHS has a close relationship with Yarram and District Health Services (YDHS). YDHS is located 60 kilometres south east of Sale and is a local health service that provides a broad range of primary health, community support, acute and residential aged care services for the population in and around Yarram. Patients from Yarram and district requiring higher level care access services from CGHS, LRH and further afield based on availability and capability.

Bairnsdale Regional Health Services (BRHS), located 70 kilometres to the east of Sale, is also a public sub-regional health service providing a broad range of health services, including the more complex.

BRHS has less capability with regard to emergency care, maternity and neonatal services, critical care, anaesthetics and paediatric medicine.

LRH acts as a health care hub serving a regional population with the critical mass to support and effectively utilise expensive technology, a highly specialised workforce and a comprehensive range of diagnostic and support services. Unlike other regional health services LRH, with the significant exception of mental health services, is not a provider of community health services. LRH manages inpatient and community-based mental health services for all of Gippsland with service delivery teams decentralised and collocated with a number of sub-regional and local health services including a large team located on CGHS's Sale campus.

CGHS has similar capability as LRH with regard to maternity services, neonatal care, general paediatrics, general medicine and general surgery. LRH also has higher level capability for critical care, emergency care, anaesthetics, renal services, orthopaedic surgery and a range of procedural specialties, including vascular surgery. LRH is the regional cancer centre and auspices the Gippsland Regional Integrated Cancer Service. LRH is also the radiation oncology provider in partnership with the Alfred. Going forward it is expected that LRH will establish a cardiac catheterisation service.

This plan acknowledges the need to prioritise and increase our effort in regard to sub-regional planning or area based planning and the development of integrated pathways for people from lower to higher complexity services.

The workforce and workforce development and training

With a workforce of over 1100 people CGHS is a major employer in the region. Our people make a significant contribution to the social and economic fabric of the region. The relationship is a mutual one since we rely on local people to deliver or support the delivery of healthcare through either employment or volunteering; CGHS enjoys the support of over 650 volunteers.

Our workforce capability development strategy includes a commitment to enabling local people to access training and development opportunities in our local community and to support learning and employment pathways within CGHS.

Workforce capability development within a service delivery capability approach is underpinned by two key principles. The first principle recognises the need to provide client-, rather than profession-centric care, with the second principle relating to the deployment of the health workforce based on service need rather than professional groupings or constraints of an educational award.

Integral to this approach is the need to build workforce self-sufficiency through the development of learning and career pathways within CGHS including pathways from VET to university education linked to career development. For example CGHS is currently training a significant allied health assistant workforce with a view to increasing our service capacity and providing pathways for allied health assistants to tertiary qualifications and career development.

Collocated on our Sale campus is the East Gippsland Rural Clinical School of Monash

University. The rural clinical school has enabled us to strengthen our links with the university sector and allowed an increasing number of medical students to undertake extended clinical placements within our services and associated medical practices. Subsequently pathways to local medical internships have been established through the Gippsland Rural Intern Training Program.

CGHS is a member of the Gippsland Clinical Placement Network established to support clinical placement for a growing number of nursing and allied health undergraduate students. In 2011 we provided over 8000 clinical placement days.

CGHS also provides graduate and transition nursing programs in addition to a post graduate nursing and midwifery program. This strategy aims to enable us to retain our "home grown" graduates, provide career pathways within CGHS and meet current and future specialised nursing workforce needs.

Service integration

CGHS, as a Victorian rural health service, is an independent organisation with its own board of management. CGHS has strong relationships with health services in our region and in particular our planning area of central and east Gippsland. In recent years the relationship has extended to sub-regional, population-based strategic planning. This work has facilitated a co-ordinated approach to service development and supported a "linked up" approach to the delivery of timely, quality health care as close to home as possible.

Gippsland population-based health planning undertaken in 2007 provided a blueprint for service planning that continues to inform service development within our planning area.

Improvements to service co-ordination and integration are also being achieved through integrated and or decentralised regional services, programs and alliances, such as the Gippsland Integrated Cancer service; Gippsland Palliative Care Consortia; Gippsland Area Mental Health Services; DH facilitated Gippsland Health Services Partnership; Wellington Primary Care Partnership and Gippsland Medicare Local.

A number of strategies are being developed to improve the co-ordination and integration of services that support frail older people to retain independent lifestyles and remain socially engaged in the community. These outcomes are systematically linked to the goals and objectives of our Care Co-ordination and HACC Workforce Redesign projects, for example.

Recommendations from our evidence and policy informed needs assessment, described in later sections of this report, include numerous strategies and actions to be taken by CGHS to support our frail older people.

Governance

The Department of Health is responsible for planning, policy development, funding and regulation of health service providers and activities which promote and protect the health of Victorians. This includes a range of public health services, public hospitals and more than 700 external organisations that provide health, mental health and aged care services in metropolitan, rural and regional Victoria.

CGHS operates under a system of devolved governance, with a board of management providing local oversight of health service planning and provision. Local governance enables a close connection between health services and our community, enabling accountability for and responsiveness to the specific healthcare needs of our community.

The CGHS Health Plan represents an important response from CGHS towards both the implementation of current government health policies and demonstrating accountability for and responsiveness to the specific health care needs of our population.

Moving CGHS and the rural and regional health system forward

To remain sustainable and robust the rural and regional healthcare system must continue to evolve and change in response to the challenges it faces. This will require elements that are working well to be strengthened, with further support to enable clinically appropriate and cost-effective practice to be achieved across the health system.

Rural and regional people should have timely access to the range of appropriate services within their regional area. While most rural

communities have relatively good access to a range of health services close to home, there is often a need to travel to receive more complex care. Improved area-based planning and development of system capacity should aim to reduce the amount of variability in the level and type of services available across regions.

The CGHS health plan is based on an understanding that we work across a geographical area and of the role we play in providing a modern, collaborative and coordinated health system. Our overarching service delivery capability model is based on the understanding of our need to continue building the capacity and capability required to meet the emerging and changing service needs of our population.

Our plan acknowledges that if the health system is to meet the full range of needs of people living across rural and regional Victoria, then we must work closely with our regional hospital, neighbouring sub-regional health service and the smaller locally-based health services that are part of our broader catchment. This approach also extends to specialist metropolitan health services, enabling our population to access a range of appropriate services when they are required.

We recognise that some services are appropriately provided at a state-wide level or at the regional level where there is a critical mass of activity, workforce and expertise to deliver clinically appropriate and cost-effective care. This plan describes the strategies and actions we will take to improve access to these services.

Our plan understands and acknowledges that LRH as our regional hospital is expected to continue to provide a strong leadership role within the catchment. This includes supporting service provision through improved coordination and outreach, and providing clinical advice and specialist support when required to services located in sub-regional and local areas.

CGHS has already developed strong collaborative relationships with LRH, BRHS, YDHS and other local health services in our planning area. We are already taking advantage of opportunities to share resources, including the specialist clinical workforce.

The CGHS health plan builds on this work and also clarifies our roles and responsibilities as a sub-regional health service working collaboratively within an area-based planning environment.

In doing so we will help to reduce service duplication and support the delivery of clinically appropriate and cost-effective services across our planning area.

Our plan gives consideration to our service capability, describing how we will work collaboratively to increase our capacity in delivering more sustainable specialist services, over the longer term, for our population.

We will support the development of integrated care networks to formally bring together local health professionals from across the public, private and not-for-profit sectors. These local networks will support the implementation of state-wide clinical guidelines by developing pathways that better support the care needs of people locally. By working together, clinicians will be better placed to understand the unique role they each play in the delivery of care across the continuum.

Residential aged care is also a cornerstone of the rural and regional health system. CGHS is a major provider of residential aged care in the Wellington Shire. The CGHS health plan describes what we will do to develop appropriate services to meet the needs of older people in rural and regional communities and support the effective functioning of the broader health system.

Key challenges for the health care system in rural and regional Victoria

The *Rural and Regional Health Plan* describes the key challenges facing the health care system, broken down to the people-focused and system-focused challenges.

The people-focused challenges include:

- Reducing the disparity in health behaviours and health outcomes among rural Victorians
- Addressing the social determinants and

relative disadvantage experienced by some rural and regional communities (these are significant drivers of poorer health outcomes and health status)

- Improving the health literacy of all rural and regional Victorians with a particular focus on the most disadvantaged

The system-focused challenges include:

- Reducing unnecessary and avoidable variability of service access across rural and regional areas
- Ensuring service design and capacity is flexible enough to respond to the changes in demand across rural and regional Victoria
- Developing a better understanding of rural and regional health outcomes
- Ensuring a viable rural and regional health service system

CGHS response to key challenges for the healthcare system

CGHS's health planning model, informed by a comprehensive, population-level health needs assessment, is capable of addressing the seven system-wide reform priorities established through the Victorian health priorities framework.

Figure 3 describes actions currently being undertaken to address the system-wide reform priorities. An evidence and policy informed needs assessment has produced hundreds of recommendations that are set out in the service planning section of this document. The outcomes of the needs assessment take the form of recommendations and have been mapped to both broad service delivery areas and the focus areas of the Victorian Public Health and Wellbeing Plan 2011–2015.

CGHS Health Plan, Part B: Evidence and policy informed needs assessment 2012

A comprehensive needs assessment underpins and acts as the technical paper informing our health plan. The needs assessment methodology is comprehensive because it brings together:

- Detailed health and demographic information relating to our population;
- The relevant evidence base, with regard to effective responses across the service delivery domains from primary prevention to chronic disease management;
- The related planning and service delivery frameworks including leading or good practice; with
- Community identified priorities established through a community led consultation process.

The needs assessment forms the companion document to CGHS Health Plan 2012-2022.

CGHS Service Capability Framework in 2012

Table 1. Current level of service delivery capability

Service	Level	Service description	Staffing	Support Services	Location / infrastructure
Emergency department	4	• Available 24*7. • Provides resuscitation, stabilisation, initial management of all emergencies and definitive care for most except some complex presentations, which are referred within the network or to a facility able to provide a higher level of service. • Regional referral role in the adult retrieval system.	• Designated ED Medical Director with training and experience in emergency medicine. • Designated medical practitioner(s) in the ED 24*7. • Access to some clinical sub-specialties with on call access after hours available. • Designated ED nursing staff 24*7, nursing unit manager and registered nurse(s) with emergency nursing experience or qualifications on-site 24*7.	• Pathology and radiology available 24*7. • Operating suites available during business hours with on call access after hours)	• Purpose designed and equipped area with designated assessment, treatment and resuscitation areas.
Critical care – ICU CCU	2 (II)	• An ICU is for the management of patients with life threatening or potentially life threatening.	• Specialist medical practitioners with credentials and defined scope of practice • Designated nursing staff with ICU/CCU experience and or qualifications onsite 24*7.	• Pathology and radiology available 24*7.	• Purpose designed and equipped area.
Neonatal services	(2) High	• Uncomplicated 32 weeks gestation or more, or birth weight at least 1300 grams: includes growing pre-term and convalescing infants. • Incubator care for infants who are sick or pre-term, requiring oxygen less than 60 per cent, • Cardiorespiratory monitoring, short term intra-arterial blood pressure monitoring, close observation – for example Neonatal Abstinence Syndrome. • Short term ventilator care pending transfer (less than 6 hours). • Depending on local facilities and personnel, option for nasal CPAP within NSAC guidelines, • Exchange transfusion.	• Paediatricians on site to advise on neonatal service and clinical care. • Consultant paediatrician on call, available in hospital consistent with hospital protocol. • Paediatric registrar and/or HMOs on site 24 hours day. • Designated senior nurse/midwife with neonatal experience and managerial responsibility. • Designated nurse with midwifery or paediatric qualification in charge of nursery for each shift if continuously occupied. • On site access to physiotherapist, social worker, interpreters, continence advisor and dietitian.	• Diagnostic services, including 24 hour blood and specimen collection. • 24 hour access top pathology and point of care pathology. • 24 access to radiology including obstetric ultrasound. • Full range of blood and blood products available 24 hours a day. • Crossed matched blood readily available. • On-site pharmacy with 24 hour access.	• Conforms to DH design guidelines. • Isolation faculties as per Neonatal Services Guidelines. • Facilities for stabilisation prior to retrieval of newborn infants.
Paediatrics	ND[1]	• Integrated service model including community (home and centre based), specialist community paediatric medical clinic and acute inpatient services. • Acute inpatient services include some general and sub-specialty surgical capability including ENT.	• Specialist Paediatricians available 24 hours. • Access to a comprehensive range of allied health staff, including staff with paediatric training and expertise • Registered nurses with paediatric qualification and or expertise, staff the unit 24 hours when occupied.	• Pathology and radiology available 24*7. • Operating suites available during business hours with on call access after hours	• Dedicated community paediatrics clinic. • Dedicated paediatric unit as part of the Women's and Children's Ward • Paediatric areas within community rehabilitation centre.
Maternity services	4 (plus)	• Management of moderate and selected high risk pregnancies including management of labour, birth and puerperium at 32 weeks gestation or more	• Specialist obstetrician on staff to advise on obstetric service. • Specialist obstetricians available on call 24/7 and or GP obstetrician credentialed for advanced obstetric care including C Section • A designated obstetric registrar and / or HMO on site 24/7(currently available on call 24/7). • Shared care program available for pregnancy care for low risk women from the local area • Consultant anaesthetists available 24/7 on call. • Anaesthetics registrar on site 24/7 (currently available normal working hours). • Paediatricians on site to advise on neonatal service and clinical care.	• Blood and specimen collection service on site 24 hours a day. • 24 hour access to pathology or point of care pathology. • Radiology available on call 24 hours a day. • Obstetric ultrasound service available on call 24 hours a day. • Full range of blood and blood products available 24 hours a day. • Cross-matched blood readily available. • Blood storage facilities on site. • On site pharmacy with 24 hour access. • Drugs available through Imprest System. • Established referral pathways to specialist mental health practitioners and facilities.	• Designated room/space for birthing. • 24 hour access to fetal monitoring and interpretation • Ability to determine fetal acid/base balance • Portable ultrasound located in birthing area with staff trained to use and interpret results. • Equipment to support adult and neonatal resuscitation.

Table 1 cont…

Service	Level	Service description	Staffing	Support Services	Location / infrastructure
Maternity services cont…	4/5 cont…		• Consultant paediatrician on call, available in hospital consistent with hospital protocol. • Paediatric registrar and/or HMOs on site 24 hours day. • Midwives rostered 24 hours. • Designated midwifery educator either part or full time. • A designated senior nurse/midwife with neonatal experience and managerial responsibility. • A designated nurse/midwife responsible for further education and training, including in-service • Experience in resuscitation of neonates. • A registered nurse/midwife should be in charge of the nursery on each shift if it is continuously occupied. This person must have a midwifery or paediatric qualification and should have high dependency Level 2 experience. • Other registered nurses/midwives should have some neonatal • High dependency experience and/or have completed the Level 2 course. • On site access to physiotherapist, social worker, interpreters, continence advisor and dietitian.	• Established referral pathways to specialist services – local or regional. • QUIT Smoking Support Program. • Established referral pathways to Child FIRST and Child Protection Services. • Established referral pathways and communication with Maternal and Child Health Nurses (M&CHN).	
General Surgery	3–4	• Available 24 hours. • Provides a combination of procedures that have a moderate to high level of complexity, magnitude or risk to patients with an extensive range of co morbidities ASA Class 1-4.	• Specialist medical practitioners with credentials and defined scope of practice.	• Pathology and radiology available 24 hours. • Post-operative care ward and ICU.	• Purpose designed and equipped area with 2 general and 1 endoscopy theatre
Orthopaedics	ND[1]	• Limited capability including 24 hours emergency and in patient stabilisation, treatment for minor uncomplicated conditions and referral	• 24 hour access to general surgeons and physicians. • No 24 hour availability specialist orthopaedic staff. • Visiting orthopaedic surgeon performs relatively minor surgery.	• Pathology and radiology available 24 hours. • Post-operative care ward and ICU.	• Operating room facilities to support minor orthopaedic (not suitable for joint replacement surgery)
Cancer services	ND[1] (QLD, level 4)	Medical oncology • The service manages relatively moderate-risk systemic therapy protocols with a low risk of neutropaenic sepsis. • The service provides ambulatory care under a visiting registered medical specialist with credentials in medical oncology and inpatient care under a registered medical specialist with credentials in internal medicine. • The service can administer initial (first cycle) courses for a limited number of protocols where ordered and directly supervised by a visiting registered medical specialist with credentials in medical oncology.	Medical • Local supervision by a registered medical specialist with credentials in internal medicine with an interest and experience in medical oncology where inpatients are treated. • A registered medical practitioner available 24 hours • A registered medical specialist with credentials in internal medicine and with experience in medical oncology available 24 hours, with access—24 hours—to a Level 5 or 6 medical oncology service for emergency advice • Access—within 24 hours—to outpatient/consultative services by a registered medical specialist with credentials in medical oncology or clinical haematology, with provision for telephone consultation for complications of treatment and admissions for complications	• On-site (or a documented process for) access—within 24 hours—to renal dialysis, respiratory, cardiology and infectious diseases services • Access to a central venous access service • Access to clinical genetics/medical genetics service • Have outpatient / outreach services (tele-health).	• Dedicated oncology unit for day procedures and inpatient services provided through general medical ward.

1 ND = Not determined: capability framework not yet developed or released

Table 1 cont…

Service	Level	Service description	Staffing	Support Services	Location / infrastructure
Cancer services cont…	ND1 (QLD, level 4) cont…	• The service also provides systemic therapy to patients diagnosed with breast, colorectal, lung, prostate and upper gastrointestinal malignancies, or palliative management. • The service has the capacity to provide timely after-care to patients receiving autologous transplants elsewhere. The pathology turnaround time is usually within 2 hours and is particularly important in order to manage any complications of treatment, regardless of whether the patient is receiving palliative or curative care. • The service is part of a service network with higher level services, ensuring access to information related to the latest evidence-based care and treatments.	Nursing • A senior registered nurse in charge on each shift • Access to a minimum of two registered nurses • Two registered nurses appropriately trained and competent for checking chemotherapy prescriptions before treatment is administered • Access to a registered nurse with specialised knowledge and experience in medical oncology, at a Level 5 or 6 medical oncology service, for advice, as required Allied health • Access to rehabilitation services • Access to social worker, occupational therapist, physiotherapist, speech pathologist and psychological and emotional support services • A nutrition team available, as required.		
	2 (minus)	Palliative Care Community • Provides comprehensive clinical care (including complex symptom and pain management) and psychosocial and spiritual care, bereavement support and access to respite care • Arrangements for 24 hour coverage to meet needs of community palliative care patients and their families and carers • Provision of interdisciplinary care by qualified providers • Protocols for access to psychiatry and/or psycho-oncology and/or appropriate mental health services • Experience and provision of advanced care planning and end of life care with clear protocols for timely referral to inpatient services • Inter-disciplinary assessment of patient care needs and exploration of patient goals, expectations and choices for place of care, liaison with inpatient services, and provision of information to other providers • Provides advisory and consultation services to generalist providers • Provides a palliative care volunteer program • Substantive involvement of other clinical practitioners (including, but not limited to, general practitioners, other generalist and specialist medical practitioners, clinical nurse consultants and nurse educators from other clinical fields, Aged Care Assessment Service [ACAS] teams, bereavement specialists, aged care services)	• Comprehensive inter-disciplinary team including medical practitioner with specialist qualifications in palliative medicine, specialist nursing (may include nurse practitioner) and allied health, psychological, social and spiritual support roles with qualifications and experience in palliative care • Staff may have joint appointments across care settings • Coordinator of volunteers	• Staff provide advice and consultation to Level 1 services • Formal protocols to support Level 1 community services • Leadership role in activities such as consortia clinical advisory groups • Formal links and referral arrangements with a range of specialist palliative care services • Participation and involvement in coordinating activities through the regional palliative care consortia	• Facilities for the provision of psychosocial support and counselling services away from home

Table 1 cont…

Service	Level	Service description	Staffing	Support Services	Location / infrastructure
Cancer services cont…	2 (minus)	Palliative Care Inpatients • Provides a broad spectrum of care and has the capacity to manage most palliative care patients including physical and psychosocial needs • Inter-disciplinary approach • Experience and provision of advance care planning and end of life care with clear protocols for timely referral to community services • A patient management pathway that is inclusive of interdisciplinary assessment, liaison with community-based service providers, discharge planning and provision of discharge information to primary care providers • Formal linkages to support Level 1 services • Undergraduate and postgraduate teaching (registrars, trainees, students) • Provide education and support in specialist palliative care within the health service • Some outreach education and support to generalist and community based services • Participation in palliative care research and quality improvement projects	• Interdisciplinary team made up of medical and nursing staff with specialist qualifications in palliative care (access to palliative care medical specialists through consortia), and allied health, psychological, social and spiritual roles with experience and/or specialist qualifications in palliative care • Regular involvement of medical practitioner with specialist qualifications(visiting service through consortia) in palliative medicine (who may work across other health services) • Provision of on-call or other after-hours support by medical staff with experience in palliative care • Access to other allied health, psychological, social, spiritual and clinical roles supporting psychosocial and spiritual care needs of palliative care patients, carers and families	• Access to designated palliative care beds (Level 2 or 3) and/or acute inpatient beds • Capacity to provide access to accommodation for family and carers if required • Access to a facility that will support family meetings • Tele-health facilities • Access to equipment loan and other services to support return home for palliative care patients	• Palliative care suite part of medical ward (requires significant physical upgrade)
Sub-acute services	2	• Geriatric evaluation and management	• Nursing, allied health and specialist medical services	• Close proximity to acute and related support services	• Sub-acute unit within medical wards at Sale and Maffra with an environment suitable for sub-acute patient care
	2	• Sub-acute ambulatory care services	• Nursing, allied health and specialist medical services	• Centre is in close proximity to acute and related support services	• Specifically designed centre and centre staff providing home based services
	2/3	Rehabilitation • Dedicated rehabilitation program with more than a single stream including stroke and orthopaedic patients. Able to provide definitive care for a number of rehabilitation streams with some outpatient clinics that require further development.	• Interdisciplinary team led by Director of Aged Care and Rehabilitation (specialist physician) • Access to a comprehensive range of allied health staff. • Sub-acute unit within medical ward staffed by experienced nurses.	• Close proximity to acute and related support services	• Sub-acute unit within medical ward with an environment suitable for sub-acute in patient care

CGHS Service Capability Framework in 2012

Table 2. Service delivery capability 2012 and expected capability 2022

Service	Level 2012	Level 2022	System changes and improvement required to maintain or build capability
Emergency department	4	4	Maintain current capability for staffing, support services and location/infrastructure
Critical care – ICU CCU	2 (11)	2 (11)	Maintain current capability for staffing, support services and location/infrastructure. Focus on critical care capability with regard to medical specialist workforce including our physician and anesthetist workforce.
Neonatal	2 high	2 high	Maintain current capability for staffing, support services and location/infrastructure
Paediatrics	ND[2]	In development	Maintain current capability for staffing, support services ad location/infrastructure
Maternity Services	4 (plus)	4 (plus)	Maintain current capability for staffing, support services and location/infrastructure. Review capacity to recruit an additional staff consultant anaesthetists.
Maternal and Child Health	ND	ND	Maintain current capability for staffing, support services. Consider co-location with antenatal services
General Surgery	3-4	3-4	Maintain current capability for staffing, support services and location/infrastructure.
Orthopaedics	ND	ND	Maintain current capability for staffing, support services and location/infrastructure.
Cancer Services	ND (QLD–4)3[3]	ND	Maintain current capability for staffing and support services. Upgrade oncology unit infrastructure on current location.
Palliative Care Community	2 (minus)	2	Maintain current capability for support services and location / infrastructure. Expand our specialist nursing palliative care workforce. Consolidate staff integration across the care settings to enable comprehensive exchange of client information as well as support capability development. This should include rotational exchange across the settings. Build the capacity, capability and integration of volunteers and community carers. Continue to build relationships with the visiting Palliative Care consultants (in partnership with the Gippsland Region Palliative Care Consortium). Participate in the Palliative Care Outcomes Collaboration (PCOC) data collection and provide this information back to our community through our quality of care report. Continue to engage in the palliative care patient satisfaction monitor program (through Department of Health) and use this information to continually improve services. Engage in the National Self-Assessment Program for Palliative Care Standards.
Palliative Care Inpatient	2 (minus)	2	Maintain current capability for support services. Upgrade palliative care suite on current location. Expand our specialist palliative care workforce. Consolidate staff integration across the care settings to enable comprehensive exchange of client information as well as support capability development. This should include rotational exchange across the settings. Build the capacity, capability and integration of volunteers and community carers. Participates in the Palliative Care Outcomes Collaboration (PCOC) data collection and provide this information back to our community through our quality of care report. Continue to engage in the palliative care patient satisfaction monitor program (through Department of Health) and use this information to continually improve services.
Sub-acute Geriatric Evaluation and management	2	2	Maintain current capability for staffing, support services and location/infrastructure
Sub-acute Rehabilitation	2–3	3	Increase access to outpatient clinics and increase allied health workforce by training and employing allied health assistants to achieve a 1:1 ratio of allied health therapist EFT to allied health assistant EFT.
Sub-acute Community rehabilitation	2	2	Maintain current capability for staffing, support services and location/infrastructure
Oral Health	ND	ND	Redevelop to enable the establishment of additional dental chair and add to workforce to enable chair to be fully productive

2 ND = Not determined: capability framework not yet developed or released

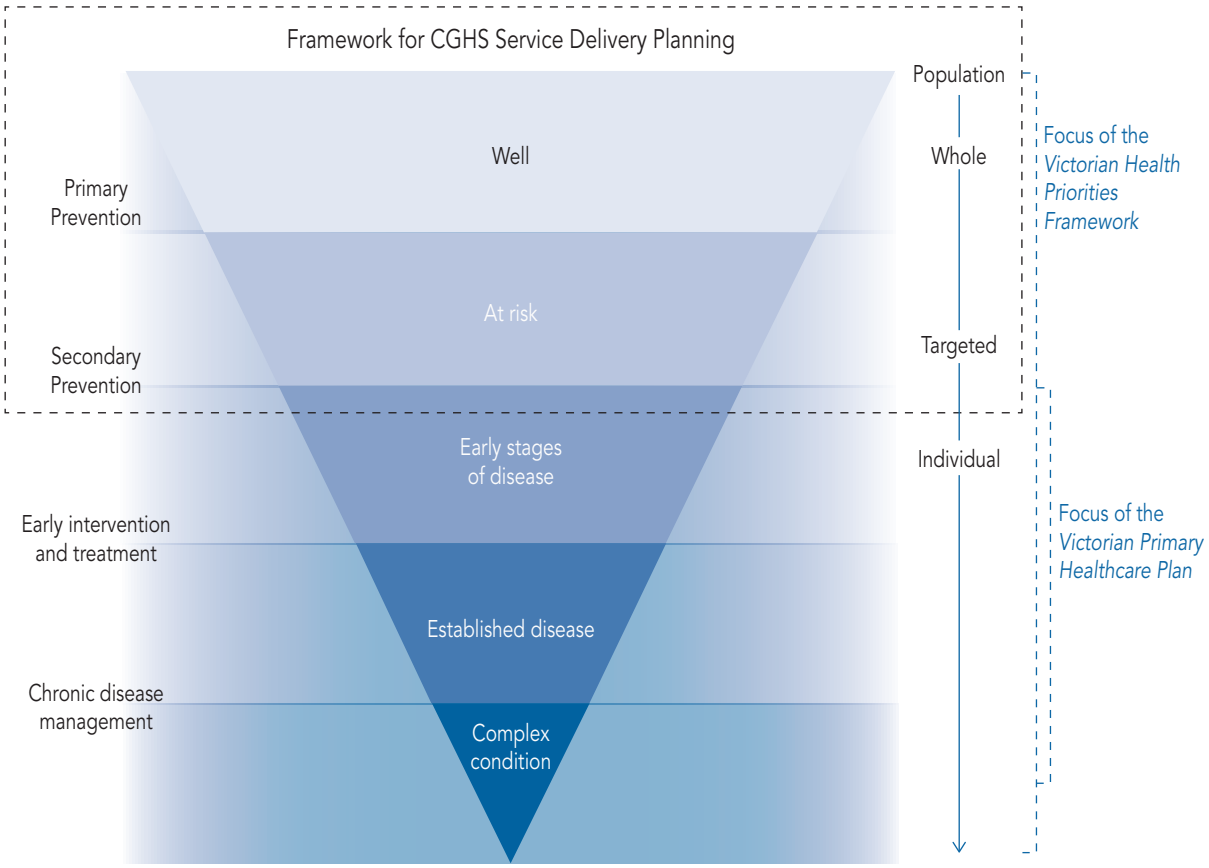
3 http://www.health.qld.gov.au/cscf/docs/23_med_onc.pdf accessed December 17, 2012

Detailed service delivery planning

The CGSH Health Plan has used a "top down, bottom up" approach. The Victorian Health Priorities Framework 2012-2022 and The Victorian Rural and Regional Health Plan have provided a framework and determined people and system focused priorities for all Victorian public health services. The CGHS Evidence and Policy Informed Needs Assessment has determined our response to the specific health and health system issues and experiences in our region and planning area. The needs assessment draws on the evidence base, effective service delivery frameworks and examples of innovation and effective health service practices to enable the development of a service framework and service response that reflects our capacity and capability to address the health needs of our community.

This section details the recommendations from the needs assessments in the form of strategies or actions to be implemented over time. Where relevant the strategies have been presented in the context of the continuum of care consistent with the focus of the Victorian Public Health and Wellbeing Plan. Primary, secondary and tertiary care is treated as sub sections of the early intervention and treatment phases of the care continuum.

The strategies and actions have also been allocated to related CGHS service delivery and departmental plans and represent the key contextual driver for our service delivery capability framework.



Aboriginal Health

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Participate in the Victorian Government Koolin Balit program and continue to participate in the Gippsland Regional Closing the Health Gap initiative. This includes participating in sub-regional and regional forums, which currently include: • Closing the Health Gap Regional Advisory Committee • Closing the Health Gap Central and West Gippsland Sub regional Consortium • The recently established Kookin Balit program which may supersede the above programs	Aboriginal Health Plan Community Services Plan
Continue to engage with our local community in partnership with Ramahyuck District Aboriginal Corporation (RDAC). Include a representative from the Aboriginal community on the Community Liaison Group.	Aboriginal Health Plan Consumer and Community Participation Plan
Continue to develop and implement a program of cultural competency for staff and volunteers. This is a requirement of recruitment and ongoing staff development programs.	Workforce Capability Development Plan
Build on the already welcoming environment that is provided, through display of artwork, flags, acknowledgment plaques and cultural celebrations. This will include the Aboriginal flag on display at all facilities; participation in the annual NAIDOC celebrations.	Cultural Diversity Plan All Service Delivery Plans
Implement the CGHS Aboriginal Employment Strategy 2012-2015	Aboriginal Health Plan Workforce Capability Development Plan
Continue informal and formal networking between CGHS and RDAC. Currently a quarterly meeting with RDAC practice manager and staff, and Director Community Services and staff. Also involve DH representatives.	Community Services Plan
Conduct regular service information sessions between RDAC and CGHS to provide knowledge and understanding of available services. Invitations to RDAC to attend CGHS staff meetings and CGHS staff attending RDAC staff meetings.	Aboriginal Health Plan Community Services Plan
Engage in the required review of Improve Care for Aboriginal People (ICAP) reporting and regional discussion of opportunities for improvement.	Aboriginal Health Plan
Review transport assistance scheme for patients/clients; ensure programs such as VPTASS are utilized to the optimum; ensure staff have the knowledge and understanding of this program.	Community Services Plan Care Coordination Program Plan
Incorporate action on reconciliation in the Aboriginal Health Plan	Aboriginal Health Plan
Continue the Aboriginal Allied Health Assistant traineeship program.	Workforce Capability Development Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Continue as a smoke free environment. Offer smoking cessation programs to patients/clients and staff/volunteers. This should particularly be targeted to mothers of young children (through Women's and Children's Unit, and the Maternal and Child Health Service), and for young people through health promotion programs.	Maternity Services Plan Youth and Early Years Plan Health Promotion Plan
Actively engage with RDAC service providers in patient/client care coordination processes.	Care Coordination Program Plan
Reduce the number of Aboriginal people leaving the emergency department at their own risk or prior to treatment, including follow-up by the Aboriginal Liaison Officer and analysis of trends that can identify key issues for these clients and strategies to overcome them.	Emergency Department Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Include recommendations for Aboriginal and Torres Strait Islanders through other relevant case studies in the evidence and policy informed needs assessment.	All Service Plans
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Include recommendations for Aboriginal and Torres Strait Islanders through other relevant case studies in the evidence and policy informed needs assessment.	All Service Plans

Ageing

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
CGHS employment and people management practices, policies, procedures and values reflect our responsibility to enable workforce participation and our objective to benefit from older people continuing to work for CGHS as long as possible.	CGHS Staff Health and Wellbeing Plan
Accept shared responsibility for, and develop strategic partnerships to implement the National Preventative Health Strategy and the Victorian Public Health & Wellbeing Plan 2011-2015.	Strategic Plan Health Promotion Plan
Act early and engage with individuals, families and communities, throughout the life course, in settings where people live, work and play, to support people to make healthy life choices.	Youth and Early Years Plan Health Promotion Plan
Prioritise three health promotion programs for older people per year: eg Life! Taking action on Diabetes; seniors, 'Go for your life' and 'Well for life; and Living longer living stronger.	Health Promotion Plan
Draw on the Victorian mental health reform strategy and in particular focus efforts on reducing social isolation for older people and fostering active community participation.	Home Support Services Plan Community Services Plan Community and Consumer Participation Plan
Support the national cervical screening and bowel screening programs.	Health Promotion Plan
Support the Aboriginal health promotion and chronic care partnership program through our Aboriginal Liaison Group and Chronic Disease Network Group.	Aboriginal Health Plan Consumer and Community Participation Plan
Update our heat wave plans on a regular basis and support the Wellington Shire Council in their heat wave response efforts.	Heat Wave Plan
Fully implement CGHS capability development framework to support the development of the required staff capability across all service delivery and care settings to support the integration of services and programs and enable access for people to a highly integrated and coordinated service delivery system.	Workforce Capability Development Plan
Place a high priority on the implementation of the Beyond Compliance initiative across the CGHS aged care network.	Residential Aged Care Services Plan
Support the recommendations of the Department of Health Gippsland sub-acute services review as they relate to recommended increases in capacity and capability.	Sub-acute Services Plan
Develop a CGHS definition for person centred and inclusive health care.	Care Coordination Program Plan
Build a detailed understanding across our workforce of the principles underpinning person centred, inclusive health care and build the capability to embed these principles into the way we work.	Care Coordination Program Plan IC4OP Plan
Develop and implement a centralised intake system at CGHS as a" front end" to highly integrated and coordinated service delivery system.	Care Coordination Program Plan
Continue to prioritise active participation in the Wellington PCP and to benefit from PCP staff and membership involvement in our care coordination and service integration approaches and strategies.	Community Services Plan Care Coordination Program Plan
Maintain and enhance our relationship with Wellington Shire Council to enable effective sharing of information relating to our awareness of the needs of older people and our working together to enable access for older people to facilities and services and to support their participation in community life.	Strategic Plan Community Services Plan
Identify a "key contact" within the senior staff at the Council to support the relationship.	Strategic Plan
Factor the needs of older people into strategic land use and facilities planning and engage with Council in the early planning stages of projects.	Strategic Plan
Consider the needs of older people when working with Council to determine the future use of the sporting facilities and grounds adjacent to the Sale campus of CGHS.	Strategic Plan
Incorporate age friendly design in all infrastructure projects.	IC4OP Plan
Participate in the local "Let's Get Connected" project, with a view to explore further opportunities for demand-responsive transport services to help older people move around their community. As part of this work review the use CGHS owned buses and transport services.	Health Promotion Plan Community Services Plan
Advocate, along with local government and other community organisations, such as the Committee for Wellington, to increase public transport options for the wellington populations.	Strategic Plan Health Promotion Plan
Support people to access information relating to transport options.	All Relevant Service Plans
Develop and review fees polices for transport services with an understanding of the relationship between affordability and access and that an inability to pay should not deny access.	Community Services Plan

Ageing cont…

PRIMARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Take opportunities to provide information relating to transport subsidies, concessions and special offers.	All Relevant Service Plans
Develop an understanding within CGHS services of our role to support people to transition from driving to non-driving (generally as part of care coordination activities), including providing psycho-social support and by assisting with access to alternative forms of travel.	Community Services Plan
Support older workers to balance the competing demands in their lives, such as having carer responsibilities, by providing reduced or flexible working hours; role changes and or redesign; re-skilling etc	All relevant service plans
Build on early work being undertaken to make VET training available to all staff with pathways to both higher qualifications including university qualifications and career pathways, including career change	All relevant service plans
Build on existing relationships with the education and training sector to maximise access to VET though flexible learning pathways and RPL processes that understand the significant life based learning older people have achieved.	Workforce capability and learning services plan
Build support for collective action within the health service sector to encourage high levels of articulation between VET and university qualifications, including guaranteed places for students progressing to higher qualifications	
Support role and career change for older people through effective career, planning and capability matching	Human Resources Management Plan
Build on workforce redesigning projects for allied health and HACC to continue to increase our capacity and capability to grow a local health and aged care workforce. This will include providing "earn as you learn" pathways to qualifications and to facilitate progression to higher qualifications and career development.	Workforce capability and learning services plan Home and Community Support Services Plan
Develop new models for volunteering programs that include communication strategies that address physical, operational and attitudinal problems facing many older volunteers and also address ageism and promote intergenerational solidarity, mentoring and leadership	Volunteer Services Plan
Develop an understanding of the importance of social inclusion with regard to promoting health and independence and build this understanding into how we provide services for people.	All relevant service plans
Learn what represents an effective mix of face to face, phone, print based and online options for responding to the information needs of older people in our catchment.	All relevant service plans
Determine how we can support or further support programs and or access to programs and community based groups such as men's sheds, U3A and neighbourhood houses.	Home and Community Support Services Plan
Support access to the new seniors online initiative through the redeveloped Victorian Seniors Card website.	ICT Services Plan
Be vigilant regarding CGHS compliance with equal opportunity legislation and regulations	Human Resources Management Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Build an understanding, within CGHS, of the age- related risk factors for mental health problems and the relationship between physical wellbeing and mental wellbeing.	Mental Health Plan
Place a very high priority on falls prevention strategies across all care settings and programs to reflect leading practice. Utilise the recent Cochrane Review for evidence of the most effective falls prevention interventions e.g. Home based exercise programs.	All Relevant Service Plans
Establish a falls and balance rehabilitation outpatient clinic, overseen by our rehabilitation physician consistent with level 3 sub-acute capabilities	Sub-acute Services Plan
Develop a volunteering strategy that promotes volunteering for older people and people with disabilities, including disability associated with mental illness, as a health promoting strategy.	Volunteer Services Plan Health Promotion Plan
Advocate for older clients and patients to prevent their goals and aspirations being overshadowed by those of their family or significant others.	All relevant service plans
Utilise the services of the Public Advocate to protect the rights of our older clients and patients where beneficial.	All relevant service plans

SECONDARY PREVENTION cont...	
RECOMMENDATION	**RELATED PLANS**
Support the Elder Abuse Prevention Strategy and its ongoing implementation within the health service.	All relevant service plans
Support awareness raising activities including gaining support of the PCP to raise awareness of elder abuse in the community.	Community Services Plan
Responding to the increasing demand for residential and community aged care is a key challenge for CGHS and will require a coordinated response from all of our networked services and a close ongoing relationship with Heyfield Hospital and Stretton Park Hostel. It is recommended that Heyfield Hospital and Stretton Park Hostel determine the feasibility of expanding their residential aged care services consistent with the expected undersupply for their catchment, taking into account expected increased demand for accommodation suitable for people with dementia	Strategic Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Develop and implement a learning program designed to build the capability of our workforce to better identify emerging mental health problems in older people and include this learning in our HACC and Allied health workforce redesign projects.	Mental health services plan Home Support Services Plan
Prioritise and resource respite program for carers and older carers of people with a disability (including disability associated with mental illness).	Aged and Disability Services Plan Home Support Services Plan
Focus efforts on providing more diverse options for respite.	Aged and Disability Services Plan Home Support Services Plan
Focus even greater effort on providing information to carers and carer support groups.	Aged and Disability Services Plan Home Support Services Plan
CGHS home support workforce redesign project will build the capability and capacity of this workforce to support health maintenance and improvement, detect early signs of health decline and support early intervention, including increased self-management support and improved access to therapy	Home Support Services Plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
CGHS Care Coordination Program will integrate the principles, goals, objectives, key strategies and service guidelines relating to the 'Active Service Model' Hospital Admission Risk Program (HARP), the Improving Care for Older People, and the Early Intervention in Chronic Disease in Community Health programs.	All Relevant Service Plans
All CGHS services for older people will have 'reablement focus' CGHS Care Coordination project will provide the vehicle to embed a reablement focus and a person centred, goal orientated approach across all programs supporting older people and people with chronic disease and or complex care needs	All relevant services plan
CGHS Care Coordination Program will support the ongoing improvement of our Early Intervention in Chronic Disease in Community Health initiative by enabling a multi-disciplinary approach with interdisciplinary processes, providing highly integrated and coordinated care. The focus of which will be on client centred decision making, self-management and health independence.	All Relevant Service Plans
Increase our capability and capacity to implement dementia friendly practices across our care settings.	Aged and Disability Services Plan All Relevant Service Plans

Cancer

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Support access to and use of nicotine replacement therapy.	Health Promotion Plan
Promote health education activities to discourage the uptake of smoking and to support quitting and harm minimisation.	Health Promotion Plan
Maintain a no-smoking policy on the grounds of the health service.	Health Promotion Plan
Maintain the health service's policy on alcohol consumption on health service grounds.	Health Promotion Plan and CGHS Staff Health and Wellbeing Plan
Support and provide health education activities to encourage fruit and vegetable intake.	Health Promotion Plan
Make fruits and vegetables readily available for patients and staff in the health service.	Health Promotion Plan and CGHS Staff Health and Wellbeing Plan
Support health education activities to encourage sporting and active recreational activities, and substitution for car travel.	Health Promotion Plan
Promote physical activity among staff in the health service	Health Promotion Plan and CGHS Staff Health and Wellbeing Plan
Support and participate in the SunSmart campaign for CGHS.	Health Promotion Plan and CGHS Staff Health and Wellbeing Plan
Provide and support health education on the risks of solarium use.	Health Promotion Plan
Create / maintain shady areas through vegetation and hardscape on the grounds of the health service.	Health Promotion Plan and CGHS Staff Health and Wellbeing Plan
Ensure all preventive strategies and actions for cancer are evidence based and or informed by national guidelines.	Health Promotion Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Promote health education activities to discourage excess alcohol use and to support alcohol rehabilitation/harm minimisation.	Health Promotion Plan
Build CGHS's capacity to support the delivery of alcohol rehabilitation services.	Mental Health Plan
Have a requirement that clinical pathways and practice minimise the exposure of patients, staff and visitors to medical radiation.	Medical Imaging Plan All Relevant Service Plans
Support cancer screening strategies and actions to be informed by national clinical guidelines and evidence using current Cochrane reviews and national clinical guidelines.	Cancer Services Plan Medical Imaging Plan
Undertake a review of up to 300 colonoscopies in terms of indications for performing the procedures compared to the national clinical guidelines.	Surgical Services Plan Health Information Plan
Support colorectal cancer screening and management to be informed by Clinical Guidelines for Surveillance Colonoscopy.	Surgical Services Plan
Support BreastScreen Victoria to promote mammography for women aged 50 to 69 years once every two years.	Health Promotion Plan Medical Imaging Plan
Support health education activities targeted at the general community and General Practitioners to encourage participation in breast screening.	Health Promotion Plan
Maintain a high capacity/capability for screening mammography, breast ultrasound, breast biopsy and histopathology and minimise waiting times	Surgical Services Plan Medical Imaging Plan
Support the implementation of the National Cervical Screening Program through health education activities targeted at the general community and General Practitioners to encourage participation in the National Cervical Screening Program.	All Relevant Service Delivery Plans
Maintain a capability for performing gynaecological procedures in the health service, and minimise waiting lists.	Surgical Services Plan
Maintain access to histopathology with effective turnaround times for results.	Cancer Services Plan
Promote evidenced based screening for prostate cancer	Health Promotion Plan

Cancer cont…

EARLY INTERVENTION TREATMENT AND CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Maintain a high capacity/capability for medical imaging, including a minimum 64 slice CT and minimise waiting times	Cancer Services Plan Medical Imaging Plan
Support high quality curative services for colorectal cancer by: • Maintaining a high capacity and capability for colorectal surgery and intensive care and minimise waiting times. • Applying the clinical practice guidelines for the prevention, early detection and management of colorectal cancer.	Cancer Services Plan Surgical Services Plan
Support initiatives to increase diagnostic accuracy for skin cancers among General Practitioners.	Surgical Services Plan
Maintain our surgical capability and capacity to remove skin cancers	Surgical Services Plan
Support access to curative services for prostate cancer by: Reviewing our capability and capacity to provide urological surgery	Cancer Services Plan
Continue to participate in and contribute to the Gippsland Regional Integrated Cancer Service to: • Promote best practice in cancer care. • Network with leaders in cancer care. • Access continuing professional development opportunities in cancer care. • Develop and implement collaborative, inter-agency and multidisciplinary models of care for patients with cancer. • Prioritise recommendations for disadvantaged groups in the community, such as: Indigenous Australians, socio-economically disadvantaged people and overseas-born Australians • Maintain clear referral pathways for radiation oncology with Latrobe Regional Hospital and metropolitan health services.	Cancer Services Plan Aboriginal Health Plan Medical Imaging Plan Surgical Services Plan
Monitor the implementation and application of the NHMRC Clinical Guidelines for treatment of cancers.	Cancer Services Plan Medical Imaging Plan
Monitor the Cochrane Reviews to enable policies, procedures and treatments to be informed by current evidence.	Cancer Services Plan Medical Imaging Plan
Integrate CGHS care coordination with cancer care and continue to develop a multidisciplinary supportive care program	Cancer Services Plan
Support high quality curative services for lung cancer by : • Coordinating the GRICS Multidisciplinary Care meetings for lung cancer at CGHS. • Monitoring the application of the NHRMC Clinical Practice Guidelines for the Treatment of Lung Cancer.	Cancer Services Plan Medical Imaging Plan
Support high quality curative services for breast cancer by: • Maintaining our capability for breast surgery in the health service, and minimizing waiting times. • Support reciprocal referral pathways to and from local breast care nurses	Cancer Services Plan Surgical Services Plan

Cardiovascular Disease

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Incorporate membership of the WHO Health Promoting Hospitals and Health Services program into the CGHS Staff Health and Wellbeing Plan.	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Apply CGHS values & DH Integrated HP principles in decision making and service & program development activities.	All Relevant Service Plans
Build the capability and capacity of CGHS and the CLG and CNG to support evidence based health promotion and prevention activities	Community and Consumer Participation Plan Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Continue to provide opportunities to engage individuals and consumer groups in decision making and strategic planning	Strategic Plan Community and Consumer Participation Plan
Continue to train and support staff to apply the principles of person centred care in individual care and care coordination	All Relevant Service Plans
Incorporate cultural competence into our orientation and ongoing education programs	Workforce Capability Development Plan Cultural Diversity Plan
Establish or maintain partnerships across organisations and sectors wherever possible, to maximise the reach of health promoting activities, reducing duplication and improving capacity	Health Promotion Plan
Actively participate in the implementation and evaluation of Gippsland Closing the Gap strategy	Aboriginal Health Plan
Actively participate in and inform evidence based healthy lifestyle strategies as part of the Wellington Shire Council's Municipal Public Health Plan.	Health Promotion Plan
Fully implement Healthy choices: food and drink guidelines for Victorian public hospitals	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support strategies that encourage local food outlets to participate in healthy food award/accreditation schemes Support local healthy eating programs in schools and the workplace	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Promote and support breastfeeding using the National Breast Feeding Strategy 2010-2015 Guidelines	Maternity Services Plan Youth and Early Years Plan Health Promotion Plan
Support a whole of organisation approach to healthy eating	Health Promotion Plan CGHS Staff Health and Wellbeing Plan All Relevant Service Plans
Support local initiatives such as community gardens, and healthy cooking programs	Health Promotion Plan
Work with Indigenous organisations/groups and individuals to adopt and adapt the Victorian Aboriginal nutrition and physical activity strategy 2009–2014	Health Promotion Plan Aboriginal Health Plan
Establish CGHS as an Active Place supporting staff to participate in physical activity Hold regular social sporting events, including team sports with representation across the organisation Encourage CGHS staff to enter teams in local activities (often fundraising programs) Support regular walk/ride to work programs and campaigns	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support Wellington Shire Council initiatives for improved walking infrastructure and open recreation spaces	Health Promotion Plan
Discourage smoking at all points of care	All Relevant Service Plans CGHS Staff Health and Wellbeing Plan
Support local smoke-free environments	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support local awareness programs relating to alcohol and other drugs for parents	Youth and Early Years Plan Maternity Services Plan Health Promotion Plan
Provide opportunistic information on the risks associated with cannabis use	Health Promotion Plan
Promote and accept diversity and social inclusion in policies, programs, activities, communication and organisational activities	Strategic Plan All Relevant Service Delivery Plans Cultural Diversity Plan CGHS Staff Health and Wellbeing Plan

Cardiovascular Disease cont…

PRIMARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Improve mental health promotion across all settings, Including our work place	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Implement strategies to develop a resilient workplace	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support initiatives for a more tolerant workplace ensuring people's preferences are respected and acknowledged	Cultural Diversity Plan CGHS Staff Health and Wellbeing Plan All Relevant Service Plans
Implement The Gippsland Closing the Gap Strategic Action Plan initiatives targeting risk factors recommending ; culturally safe, competent and appropriate health services; and an increase in the number of local Aboriginal and Torres Strait health care providers and leaders.	Aboriginal Health Plan Cultural Diversity Plan Strategic Plan
Monitor cultural safety and competency – raise awareness and support	Cultural Diversity Plan Workforce Capability Development Plan
Continue to recruit and train a local Aboriginal health workforce	Workforce Capability Development Plan Strategic Plan Aboriginal Health Plan
Progress the CGHS HACC Workforce Redesign Project	Home Support Services Plan Community Services Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Support staff, patients and clients to quit smoking	Health Promotion Plan
Support pregnant mothers to cease smoking	Maternity Services Plan Youth and Early Years Plan Emergency Department Plan
Support strategies targeting parents and teenagers efforts to quit smoking	Community Services Plan Mental Health Plan
Support local alcohol accords and activities to minimise harm to young people	Health Promotion Plan
Support and participate in suicide prevention strategies to at-risk populations	Mental Health Plan Health Promotion Plan
Support health coaching approaches to working with people at high-risk of CVD	All Relevant Service Plans
Support workplace initiatives targeting staff at risk of CVD	CGHS Staff Health and Wellbeing Plan Health Promotion Plan
Support disadvantaged individuals and groups to be included in workplace and community initiatives	Strategic Plan Community and Consumer Participation Plan
Utilise the 'Management of Absolute Cardiovascular Disease, 2012', published by the NHMRC in conjunction with the National Vascular Disease Prevention Alliance as the most up to date evidence based approach to risk assessment and management through the following management algorithms and summaries: Risk Assessment and Management Algorithm: Adults aged 45 years and over without known history of CVD Risk Assessment and Management Algorithm: Aboriginal and Torres Strait Islander adults aged 35 years and over without known history of CVD Risk management summaries: High, medium and Low risk	All Relevant Service Plans
Implement and monitor evidence based protocols for clients presenting with hypertension/AF and TIA	All Relevant Service Plans
Apply the NHF guidelines for hypertension in clinical settings	All Relevant Service Plans
Monitor stroke performance against national targets and improve allied health responsiveness	Sub-acute Service Plan Medical Services Plan Health Information Plan
Apply, monitor and evaluate the updated 2011, Guidelines for the Management of Acute Coronary Syndromes (ACS)	Medical Services Plan Emergency Department Plan Health Information Plan

Cardiovascular Disease cont…

EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Participate in community alcohol and other drug strategies to reduce the impact of drug and alcohol abuse	Health Promotion Plan
Initiate and support local mental health strategies that tackle stress in the workplace,	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Promote the Know your Numbers Strategy across the workplace	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support all care staff to be familiar with the FASE principles. Promote FASE alerts during National Stroke Week	All Relevant Service Plans
Continue to support the implementation of the 2010 Clinical Guidelines for Stroke and associated CGHS stroke pathways	All Relevant Service Plans
Determine the reason for not achieving benchmark performance with regard to swallowing and physiotherapy assessments for stroke patients and take action to achieve the desired level of performance.	Emergency Department Plan Medical services Sub-acute Services Plan
Consider home based as well as centre based cardiac rehabilitation programs and ensure maintenance programs are available for all participants.	Sub-acute Services Plan Community Services Plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Utilise evidence based health coaching to provide tailored support to people at high risk of/or with CVD including people with diabetes	All Relevant Service Plans
Support all care staff to be familiar with the modifiable risk factors supporting them to engage clients in lifestyle changes using evidence based health coaching principles	All Relevant Service Plans
Continue to develop capability for CDM across all care settings utilising the principles of health coaching and current evidence which includes person centred care coordination and case management	All Relevant Service Plans
Focus maintenance programs on group activities with an education component and consider recruiting participants with similar health maintenance needs rather than cardiac rehabilitation specifically (such as CVD, diabetes, hypertension, obesity and arthritis)	Sub-acute Services Plan Community Services Plan
Implement and monitor use of 2011 updated National Hearth Foundation Guidelines for Diagnosis and management of chronic heart failure (CHF) and Physical Activity for people with CVD	All Relevant Service Plans

Dementia

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Support healthy lifestyle health promotion activities to make the link between physical health and brain health.	Health Promotion Plan CGHS Staff Health and Wellbeing Plan All Relevant Service Delivery Plans
Support the Gippsland Dementia strategy to coordinate an inter-agency website and service directory that highlights local services and what to expect from them	Community Services Plan Home Support Services plan Aged and Disability Services Plan
Develop flexible workplace strategies to enable older workers to remain in the workplace (see aged care recommendations).	CGHS Staff Health and Wellbeing Plan Human Resource Management Plan
Highlight the importance of annual health checks including brain health and mental health	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Identify and implement relevant awareness programs for people at risk of dementia	Health Promotion Plan
Promote and facilitate life-long learning opportunities and social connectedness programs for people at risk.	Community Services Plan Home Support Services Plan
Support the establishment of a local dementia special interest group involving a geriatrician, GPs, community health services and other stakeholders.	Strategic Plan Aged and Disability Services Plan
Enable the principles of the 'Active Service Model' and person centred, coordinated care into the Care Coordination and HACC workforce redesign projects	Home Support Services Plan
Promote quality of life to carers and treat carers as a client in their own right	Home Support Services Plan Community Services Plan
Up skill acute staff to ensure they are able to identify and respond to clients presenting with a history of cognitive changes and early stages and extend dementia friendly care practice to acute and other relevant settings	Medical and Surgical Services Plan
Utilise the Care Coordination project for continuous improvement by regularly gathering feedback about critical transitions such as from home to hospital, from clients/carers.	Care Coordination Program Plan
Develop dementia resources to meet the needs of diverse groups	Community Services Plan Residential Aged Care Services Plan Cultural Diversity Plan
Continually monitor carer needs and establish a range of education and support programs tailored to their needs	Home Support Services Plan Residential Aged Care Services Plan
Continually support and monitor carer health and wellbeing.	Home Support Services Plan Residential Aged Care Services Plan Community Services Plan Emergency Department Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Coordinate an inter-agency brochure & web links that highlight local services and what to expect from them. Include checklists for those concerned about their memory, and what the 'normal' ageing process is.	Aged and Disability Services Plan
Support GP practices that are providing leadership in the development, coordination, and monitoring of multi-professional protocols for diagnosis of and early intervention for dementia	Aged and Disability Services Plan
Increase staff capability across all settings, with regard to dementia awareness, early diagnosis and the use of recommended screening tools.	Workforce Capability Development Plan
Support social workers and counsellors to work effectively with families/carers and clients following diagnosis of dementia.	Sub-acute Services Plan
Support clients over 65yrs who have a history of cognitive changes to be screened for dementia	All Relevant Service Plans
Coordinate responsive and flexible home, centre and residential respite care that meet the social, cultural, language specific and personal preferences of clients and their families	All Relevant Service Plans

Dementia cont…

EARLY INTERVENTION AND TREATMENT cont…	
RECOMMENDATION	**RELATED PLANS**
Monitor the evidence of risk for people with or at risk of dementia requiring an anaesthetic. Develop information and resources to inform clients (at risk of dementia or with dementia) of the risk of anaesthetics and post anaesthesia Alzheimer's	Medical Services Plan Surgical Services Plan
Integrate elder abuse into mandatory training program	Workforce Capability Development Plan
DEMENTIA CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Promote awareness and encourage early and end of life planning, substitute decision makers, advanced care planning & completion of an advanced care plan. Support all residents/clients to have an advanced care plan that respects their rights and preferences. Determine how advanced care plans can be stored and located, in client files, when needed.	All Relevant Service Plans Health Information Plan
Up skill carers/families and staff on managing various dementia related behaviours	Workforce Capability Development Plan Home Support Services Plans
Continually monitor and benchmark dementia care against good practice guidelines, specifically Alzheimer's Australia Quality Dementia Care Standards. Include residents/carers and families in this process	All Relevant Service Delivery Plans
Continually up skill medical, nursing, HACC, and allied health staff in identification and contemporary management of pain for people with dementia.	Workforce Capability Development Plan
Support staff to remain current in terms medico legal issues relating to end of life care.	Workforce Capability Development Plan
Continue to support good practice with regard to minimizing the use of physical or chemical restraints, for people with dementia across all care settings	All Relevant Service Plans

Diabetes

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Work with Wellington Shire PCP and MPHP to support the implementation of health promotion programs aimed at lifestyle modification	Health Promotion Plan
Apply a health promoting and preventive approach in the clinical setting that is strengths based and within a context of client empowerment	All Relevant Service Plans
Establish a workplace health promotion team to implement evidence based workplace health strategies recommended in each of the case studies.	CGHS Staff Health and Wellbeing Plan
Review function, canteen and kiosk menus to meet health food guidelines.	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Promote the local walking/bike trials as accessible exercise options for people at risk of diabetes	Health Promotion Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Develop protocols across care settings for screening for diabetes for all clients presenting at risk of diabetes type 2.	All Relevant Service Plans
Refer clients who present with obesity and physical inactivity to lifestyle modification programs	All Relevant Service Plans
Promote the use of pharmacological interventions for the prevention of type 2 diabetes in high risk individuals	All Relevant Service Plans
Refer clients with impaired glucose tolerance to lifestyle modification programs	All Relevant Service Plans
Implement the use of the AUSDRISK assessment across all clinical settings for people from age 40.	All Relevant Service Plans
For ATSI Clients, undertake the AUSDRISK assessment from the age of 18 yrs. and repeat every three years	All Relevant Service Plans
Support community based health education programs to be: evidence based; include multiple strategies; are socially marketed; designed to send a few clear messages; can be sustained; and engage individuals and families where possible.	Health Promotion Plan
Support all programs and interventions for risk screening to be culturally appropriate and accessible.	All Relevant Service Plans Cultural Diversity Plan
Review CGHS capability and capacity to providing bariatric surgery to prevent/delay progression to type 2 diabetes in people who are morbidly obese	Surgical Services Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Ensure the AUSDRISK score ≥ 12 is recommended for case detection when the primary purpose of risk assessment is to detect undiagnosed type 2 diabetes	All Relevant Service Plans
Ensure laboratory testing is the preferred option for case detection (type 2 diabetes requires two positive laboratory blood tests on separate days unless the plasma glucose is unequivocally elevated in the presence of acute metabolic decompensation or obvious symptoms).	All Relevant Service Plans
Ensure clients at high risk are referred for follow up screening: • • people with impaired glucose tolerance (IGT) or impaired fasting glucose (IFG) • • women with a history of gestational diabetes mellitus (GDM) • • women with a history of polycystic ovary syndrome (PCOS) • • people presenting with a history of a cardiovascular disease (CVD) event (e.g. myocardial infarction, stroke) • • people on anti-psychotic medication	All Relevant Service Plans
Ensure all clients with identified risk factors for type 2 diabetes are provided with appropriate advice on risk factor reduction	All Relevant Service Plans
Ensure people with IGT are warned of the risks of developing diabetes and are followed up with annual testing for diabetes	All Relevant Service Plans
Consider socio-economic factors when developing programs for screening undiagnosed type 2 diabetes	Health Promotion Plan
Review the role of diabetes educators to reflect current evidence of effectiveness.	Community Services Plan
Review the management of children newly diagnosed with Type 1 diabetes to reflect current evidence of the benefits of home-based care.	Youth and Early Years Services Plan

Diabetes cont…

CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Recruit a physician with endocrine or diabetes sub-specialty/interest within physician establishment.	Medical Services Plan
Determine the appropriateness of reporting our insulin pumps services as a specialist outpatient clinic.	Sub-acute Services Plan
Utilise the National Evidence Based Guidelines for Patient Education with the following structure: **Setting**: Primary care, hospital, and community gathering places. **Structure**: Group: Long term group programs with regular reinforcement; Culturally appropriate program, client orientated, evidence based, delivered by a multidisciplinary team focusing on lifestyle changes & psychological outcomes, **Content**: Client orientated/directed, based on the principles of self-management, include an exercise component at each session, theoretically based and tailored to the needs of socioeconomically disadvantaged populations. Facilitate the use of web 2 technologies to support client self-management **Lay led**: Train and support interested participants to become supportive long term program leaders	Sub-acute Services Plan Medical Services Plan Community Services Plan
Implement a recall and review system that utilises social media and other web 2 technologies	Sub-acute Services Plan
Utilise contemporary client led, evidence based pathways and clinical guidelines for people with diabetes, that are person centred, culturally appropriate and easy to understand and use.	All Relevant Service Plans
Participate in the Victorian Department of Health Integrated Diabetes Care Program	Sub-acute Services Plan
Support the capacity and capability of staff across all care settings (including home support Staff) in the principles and approaches to self management for people with chronic disease.	All Relevant Service Plans
Utilise contemporary technologies to enable the client-centred care using programs that are easy to understand and use.	All Relevant Service Plans
Implement and monitor the use of the national evidence based guidelines for the diagnosis, prevention and management of chronic kidney disease (CKD) as part of the structured care for all clients with a diagnosis of type 2 diabetes See guidelines http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/di18-diabetes-kidney-disease.pdf	Sub-acute Services Plan Community Service Plan
Implement and monitor the use of the National Evidence Based Guideline for Blood Glucose Control in Type 2 diabetes. See guidelines: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/di19-diabetes-blood-glucose-control.pdf	Sub-acute Services Plan Community Services Plan
Implement and monitor the use of the 3 Centres Clinical Guidelines for the management and follow up of women with gestational diabetes.	Maternity Services Plan Youth and Early Years Plan
Review the need for regular glucose self-monitoring in clients with Type 2 diabetes.	Sub-acute Services Plan Medical Services Plan

Disability

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Participate in local area planning to support, advocate and enable people with a disability to be included in CGHS and community events as spectators, organisers, staff or volunteers.	Community Services Plan
Encourage, support and facilitate volunteer access for people with a disability	Volunteer Services Plan
Facilitate and support strong social networks for people with disability.	All Relevant Service Plans
Monitor adherence and effectiveness of access to buildings, construction of new buildings and residential care against 2010 Disability standards	Engineering Services Plan
Support increased community awareness of the benefits of universal design.	Aged and Disability Services Plan
Adopt the mandated conformance levels for web access	Aged and Disability Services Plan
Develop printed and electronic information in an accessible format and use multiple formats based on people's preferred method or form of communication.	Aged and Disability Services Plan Community and Consumer Participation Plan
Improve and promote organizational advocacy for the rights of people with a disability	Aged and Disability Services Plan
Improve the reach and effectiveness of complaint mechanisms for people with a disability	Aged and Disability Services Plan
Enable people with disability to be active participants in the civic life of the community, including as board members and elected representatives.	Aged and Disability Services Plan
Support independent advocacy to protect the rights of people with disability.	Aged and Disability Services Plan
Monitor decision-making safeguards for people with disability, including accountability of guardianship and substitute decision-makers.	All Relevant Service Plans
Improve organisational awareness of the benefits of employing people with disability.	Aged and Disability Services Plan Human Resource Management Plan
Reduce barriers and disincentives for the employment of people with disability.	Aged and Disability Services Plan Human Resource Management Plan
Encourage innovative approaches to the employment of people with disability	Aged and Disability Services Plan Human Resource Management Plan
Improve employment, recruitment and retention of people with disability.	Aged and Disability Services Plan Human Resource Management Plan
Develop and maintain policies and practices that support employees with a disability.	Aged and Disability Services Plan Human Resource Management Plan
Have employment materials available in accessible formats.	Aged and Disability Services Plan Human Resource Management Plan
Develop and maintain a reasonable adjustment policy.	Aged and Disability Services Plan
Facilitate improved employment outcomes with local school based and employment traineeships for people with a disability.	Aged and Disability Services Plan Human Resource Management Plan
Be informed about issues relating to disclosure of disability.	Human Resource Management Plan
Advocate for the provision of specialist disability support to assist older informal carers.	Aged and Disability Services Plan Home Support Services Plan
Support service approaches that give information, choice and control to people with disability.	All Relevant Service Plans
Audit the accessibility of CGHS buildings and establish a schedule of modifications.	Engineering Services Plan
Treat carers as clients within their own rights.	All Relevant Service Plans
Develop innovative learning strategies and supports for students with disability on work placement.	Workforce Capability Development Plan
Promote leadership development for people with disability.	Workforce Capability Development Plan
Actively communicate and consult with people with a disability by actively involving them in the planning, development, delivery, monitoring and review of services.	All Service Area Plans
Participate in local area planning to develop appropriate self-directed service responses for people with a disability	Community Services Plan
Provide information, resources, tools and skills to enable people with a disability and their families and carers to plan for and direct care and support systems.	All Relevant Service Plans

Disability cont…

PRIMARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Develop staff capability to implement self-directed approaches for people with a disability.	Workforce Capability Development Plan
Facilitate a strong interface between disability services, and CGHS	Community Services Plan
Address issues specific to people with a disability as part of health promotion programs such as: oral health nutrition, physical activity, mental health, drug and alcohol and sexual and reproductive health programs.	Health Promotion Plan
Provide regular recognition to carers for their role and unpaid work. Provide opportunities for recognition for children and young people in caring roles, and information/ support/services tailored to their ages and needs.	Aged and Disability Services Plan Volunteer Services Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Improve the care coordination across the continuum in order to better meet the health needs of people with disability.	Care Coordination Program Plan All Service Plans
Promote carer allowances and advocate for improved financial support for carers	Community Services Plan
Provide flexible respite options	Aged and Disability Services Plan
Support carers to participate in paid work by providing additional respite and support and provide employers with "working with carers" information	Aged and Disability Services Plan Home Support Services Plan
Provide regular carer information programs	Aged and Disability Services Plan Home Support Services Plan
Enable carers to be in touch with others going through the same issues in ways that suit them (in person, online, through publications etc).	Aged and Disability Services Plan Home Support Services Plan
Provide regular recognition to carers for their role and unpaid work.	Aged and Disability Services Plan Home Support Services Plan
Link carers to state and national peak bodies	Aged and Disability Services Plan Home Support Services Plan
Provide opportunities for recognition for children and young people in caring roles, and information/ support/services tailored to their ages and needs.	Home Support Services Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Improve access to timely, comprehensive and effective early intervention for people with disability.	Aged and Disability Services Plan Sub-acute Services Plan
Provide support for people with disability with heightened vulnerabilities to participate in community and legal processes.	Aged and Disability Services Plan
Support the development of innovative and flexible support models for people with high and complex needs, including supported accommodation and community and family living approaches using the principles of self-directed and person centred.	All Relevant Service Plans
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Build capability and capacity across the continuum of care to diagnose and treat the health and co-morbid conditions of people with a disability.	Workforce Capability Development Plan All Relevant Service Plans

Diversity

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Utilise the following indicators as KPIs for our Cultural Diversity Plan (CDP) • Numerator: The number of senior managers who have undertaken leadership training for cultural responsiveness ∠ Denominator: The total number of senior managers / Target 80% • Numerator: Number of CALD consumers/patients identified as requiring an interpreter and who receive accredited interpreter services ∠ Denominator: Number of CALD consumers/patients presenting at the health service identified as requiring interpreter services Target 100% • Numerator: Number of community languages used in translated materials and resources ∠ Denominator: Total number of community language groups accessing the service / Target 80% • Numerator: Number of CALD consumers/patients who indicate that their cultural or religious needs were respected by the health service (as good and above) / Denominator: Total number of CALD consumers/patients surveyed on the Victorian Patient Satisfaction Monitor (VPSM) or other patient satisfaction survey / Target 80% • Numerator: Number of staff who have participated in cultural awareness professional development ∠ Denominator: Total number of employed staff within the current two year period / Target 70%	Cultural Diversity Plan
Develop and implement a Cultural Diversity Plan (CRP) that reflects the population profile for the Wellington Shire and meets the DH requirements for a HACC Diversity Plan	Cultural Diversity Plan
Report performance against the implementation of CDP through the Quality of Care Report.	Cultural Diversity Plan
Enable the memberships of the CLG and CDNG to reflect the population profile of the Wellington Shire	Community and Consumer Participation Plan
Implement the DHS Language Services Policy and monitor performance	Cultural Diversity Plan
Have in place Policies and Procedures to support staff working with CALD consumers and carers to provide culturally sensitive services	Cultural Diversity Plan
Allocate resources to support the CLG and CDNG to support cultural responsiveness Enable the CLG and CDNG to continue to develop new and improved initiatives and resources for cultural responsiveness	Community and Consumer Participation Plan
Collect, analyse and share data regarding CGHS cultural responsiveness	Cultural Diversity Plan
Enable access to appropriate interpreters and translations	Cultural Diversity Plan All Service Plans
Continue to partner with Gippsland multicultural organisations to inform service development	Cultural Diversity Plan
Nominate a senior manager who has responsibility for the CDP Plan and KPIs	Cultural Diversity Plan Community Services Plan
Set a target to develop a cultural profile of staff at CGHS that reflects the profile of the community	Strategic Plan Human Resource Management Plan
Utilise our complaints mechanism to monitor any lack of provision of interpreters and why this may have occurred	Cultural Diversity Plan
Monitor the use of interpreter services through medical files and compare the use of services with the report available through the Department of Health (regional office)	Health Information Plan
Review and where necessary update policies, and procedures for consent so that they are inclusive of CALD and the role of interpreters and family	Cultural Diversity Plan
Monitor feedback on the use of interpreters in decisions about treatment and care planning	Cultural Diversity Plan
Monitor the need for appropriate translations, signage, commonly used consumer/ patient forms, education and audio visual materials, in languages other than English for predominant language groups	Cultural Diversity Plan Community and Consumer Participation Plan
Monitor and develop initiatives to track miscommunication errors for CAL D consumers/patients Conduct regular audits of cultural competence	Cultural Diversity Plan
Provide resources for the provision of culturally appropriate meals (vegetarian, Halal, Kosher, etc.)	Cultural Diversity Plan Food Services Plan
Provide cultural sensitivity training for all staff on a regular basis and regularly evaluate the effectiveness of the training	Workforce Capability Development Plan

Diversity cont…

PRIMARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Include CALD responsiveness in all position descriptions and capability development planning as required	Human Resource Management Plan
Update population cultural profile following ABS Census every 5 years.	Cultural Diversity Plan
Gay Lesbian Bisexual Transgender and Intersexual Consumers	
Support our services to be GLBTI inclusive	Strategic Plan
Provide staff training on issues effecting GLBTI people and how to respond in a positive way	Workforce Capability Development Plan
Review practices across all of our services against GLBTI Standards for HACC services	Home Support Services Plan Cultural Diversity Plan
Communicate a message of welcome to GLBTI through the CLG, CDNG and across all services displaying GLBTI posters and promoting GLBTI services to the community. eg through GLBTI media	Community and Consumer Participation Plan Cultural Diversity Plan
Review how consumers would like information about sexual orientation, gender identity recorded and informing consumers how it is used and stored, seeking consent before sharing information	Community and Consumer Participation Plan Cultural Diversity Plan
Monitor performance of our confidentiality policies and procedures.	Health Information Plan
Only collect information about sexual orientation and gender identity if it is directly related to and reasonably necessary for the services' functions or activities, and is only collected from the individual it relates to	All Service Plans Health Information Plan
Encourage intake and assessment staff to include GLBTI information in their service orientation processes: although it can be confronting to ask an older person a direct question about sexual orientation or gender identity, by including an 'other' category in options for gender, and a 'same sex relationship' category in a marital status question can indicate that such information is welcome	Community Services Plan
Develop links with local GLBTI social support and information services	Community Services Plan
Contact Gay and Lesbian Health Victoria for information and resources to support planning	Community Services Plan
Children and Family Services	
Support and understand the positive outcomes for GLBTI-parented children.	Maternity Services Plan Youth and Early Years Plan
Provide education for staff about GLBTI issues and provide an opportunities for staff discuss and explore how they are meeting the needs of GLBTI clients.	Workforce Capability Development Plan Cultural Diversity Plan All Relevant Service Plans
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Monitor adverse events involving communication with CALD consumers/clients	Community and Consumer Participation Plan Cultural Diversity Plan Health Information Plan
Monitor and analyse trends relating to complaints lodged from CALD consumers/patients	Community and Consumer Participation Plan Cultural Diversity Plan
Utilise consumer feedback to develop programs that are culturally appropriate	Cultural Diversity Plan All Relevant Service Plans
Aged Care (GL BTI)	
Support the rights of GLBT people in residential care to be safe with (including being culturally safe) cultural expression, intimacy and sexual expression, and privacy (given that not everyone will be comfortable)	Residential Aged Care Services Plan
Provide additional care for seniors with dementia and others with limited cognitive ability who may not have the capacity to understand when and where it is safe to disclose their sexual or gender identity	Residential Aged Care Services Plan Home Support Services Plan
Deliver respectful, informed and non-heterosexist assistance for personal activities, such as bathing for transgender people including those who with ageing, may experience difficulty maintaining gender roles and appearance	Residential Aged Care Services Plan Home Support Services Plan
Protect GLBTI clients from discrimination from other staff, clients, visitors and families, and respond appropriately when discrimination is experienced.	Residential Aged Care Services Plan Home Support Services Plan

Diversity cont…

EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Establish processes to identify and manage potential homophobia and transphobia amongst staff and clients.	Workforce Capability Development Plan All Relevant Service Plans
Support the early assessment of children showing conflict between their gender identity and gender of upbringing to identify support needs.	Youth and Early Years Plan Cultural Diversity Plan All Relevant Service Plans
Support access to GLBTI-sensitive counselling during family conflict or breakdown	Community Services Plan
Build up and regularly review a directory of GLBTI-friendly or specific counselling services, medical services and support groups to which consumers can be referred as needed.	Community Services Plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Support HIV positive clients so they are not quarantined or mistreated by other staff, clients or visitors.	All Relevant Service Plans

Injury

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Focus on workplace injury prevention should be strengthened further through a realigned occupational rehabilitation and injury management program as part of a comprehensive staff health and wellbeing program.	CGHS Staff Health and Wellbeing Plan
Continue to support Gippsland PCP initiatives such as the 'best start' and 'early years program' and continue to integrate established tools and resources into early childhood services.	Health Promotion Plan Youth and Early Years Plan Sub-acute Services Plan
Encourage broader representation on the CGHS Consumer Liaison Group to include a key stakeholder of early childhood development.	Consumer and Community Participation Plan
Engage and collaborate with local providers of injury prevention activities.	Health Promotion Plan Emergency Department Plan
Gain a more detailed understanding of why the rate of falls appears to be higher for people living in the Wellington LGA and develop strategies, in collaboration with other organisations and sectors to reduce the burden associated falls injuries.	Health Promotion Plan Home Support Services Plan Sub-acute Services Plan
Continue to support Gippsland PCP initiatives such as the 'mental health and well-being program' and utilise established tools and resources	Health Promotion Plan
Encourage broader representation on the CGHS Consumer Liaison Group to include representation from the 15 to 24 age group	Community and Consumer Participation Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Include a strong focus on identification of risk factors and determinants of injury with regard to our Care Coordination Project as it extends into the emergency department.	Emergency Department Plan
Take the opportunity provided through our HACC Workforce Redesign Project to identify our client's risk factors and determinants of injury and support early invention, including support through health coaching and improving our client's health literacy.	Home Support Services Plan
Engage with internal and external providers of injury prevention activities and programs and develop collaborative pathways for clients	All Relevant Service Plans
Increase the capability of emergency department and other service delivery staff to identify and respond to suicidal clients.	Emergency Department Plan Workforce Capability Development Plan
Regularly undertake reviews of intentional harm data to identify trends and interventions to prevent the current trend.	Emergency Department Plan Health Information Plan Health Promotion Plan
Develop best practice guidelines and pathways for care in the management of self-harm and alcohol related injury Inclusive of risk assessments and referral options through care coordination processes	Emergency Department Plan Medical Services Plan Surgical Services Plan
Incorporate prevention strategies relating to the risk factors and determinants of injury into CGHS health promotion plan and Aboriginal Health Plan.	Health Promotion Plan Aboriginal Health Plan
Continue to support and work within the Victorian DH framework for collaborative action to prevent falls and fall-related injury.	Health Promotion Plan Residential Aged Care Services Plan
Continue to develop CGHS policy and procedures and quality activities which support prevention of injuries due to falls.	All areas service plans
Continue to provide falls prevention clinics and determine our capacity to extend the clinics to other locations within the Wellington LGA with older populations such as Loch Sport.	Sub-acute Services Plan Community Services Plan
Support Wellington Shire 'healthy living' initiatives and PCP 'physical activity' initiatives	Health Promotion Plan Sub-acute Services Plan Community Services Plan
Support the ongoing CGHS 'allied health assistant' initiatives to include evidenced based practice relating to the prevention of falls and fall-related injuries.	Sub-acute Services Plan
Continue to develop strategies and initiatives for addressing national medication safety principles in all care settings with established links to GPs and community pharmacies	All Relevant Service Plans

Injury cont…

SECONDARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Promote the awareness of preventative strategies through the CLG and CNG and key stakeholder groups such as the U3A and CALD groups	Consumer and Community Participation Plan Health Promotion Plan
Support closing the gap initiatives and continue to stimulate local discussion on improving Aboriginal and Torres Strait Islander peoples' safety by supporting local community leaders with safety promotion and injury prevention priorities.	Aboriginal Health Plan
Support local safety promotion and injury prevention policies and strategies that address the key social, environmental and behavioral factors, and provide good examples of dealing with the underlying alienation and disadvantage of Aboriginal and Torres Strait Islander peoples.	Aboriginal Health Plan
Continue to develop the 'closing the gap' initiatives focused on the management of ATSI issues in the emergency department.	Aboriginal Health Plan Emergency Department Plan
Engage with local providers of drug and alcohol programs and develop collaborative communication and referral pathways between key stakeholders i.e. Care Coordinators, CGHS GP Unit, GP practices, CGHS emergency department and LRH mental health services.	Emergency Department Plan Mental Health Plan Community Service Plan
Improve data collection and or utilisation with regard to alcohol related injury presentations and associated interventions and management.	Emergency Department Plan Health Information Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Maintain our current capability with regard to emergency and critical care, general medical and surgery, including related support services such as pathology and medical imaging	Emergency Department Plan Medical Services Plan Surgical Services Plan Medical Imaging Plan
Review our capability and capacity to provide emergency care and definitive treatment for people with injuries involving fractures.	Emergency Department Plan
Develop formal pathways for people whose injuries require orthopaedic surgery at LRH, such as for fractured neck of femur, to enable timely treatment and recovery and enhance LRH's capacity to provide a regional service by minimizing the time in a bed at LRH and thereby enabling LRH to focus on the part of the patient journey that requires their higher level capability.	Strategic Plan Emergency Department Plan Surgical Services Plan
Develop best practice guidelines and pathways for care in the management of childhood injury. Inclusive of risk assessments and referral options through care coordination processes	Emergency Department Plan Youth and Early Years Plan Community Services Plan
Develop improved strategies and initiatives for addressing best practice guidelines for the management of patients with alcohol related injuries.	Emergency Department Plan Medial Services Plan Surgical Services Plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Develop improved strategies and initiatives for addressing best practice guidelines for rehabilitation and management of injuries relating to all causes.	Sub-acute Services Plan Community Services Plan
Continue to develop the capability of the home support workforce to take a reablement approach to service delivery.	Home Support Services Plan Sub-acute Services Plan
Utilise the AHAs in healthy lifestyle group programs for people with chronic disease at risk of injury	Sub-acute Services Plan

Maternity Services

PRIORITY 1 ACCESS	
RECOMMENDATION	**RELATED PLANS**
Plan to maintain our existing maternity and neonatal services capability.	Maternity Services Plan Strategic Plan
Support the development of the Gippsland Rural Maternity Services Plan and implement or modify the recommendations of this plan to be consistent.	Maternity Services Plan
Promote the use of the National Helpline in all forms of information provided about maternity services across the region, Seek feedback on the number of calls received.	Maternity Services Plan Health Information Plan
Provide stakeholders with objective information and resources about the range of services, pathways, performance and quality of care, workforce capabilities and detail any gaps with strategies to address these.	Maternity Services Plan Health Information Plan
Provide women with relevant maternity performance and quality of care information in a manner that is easy to understand.	Maternity Services Plan Health Information Plan Community and Consumer Participation Plan
Utilise social media, CGHS Website, and other relevant media technologies to provide the information	Maternity Services Plan Community and Consumer Participation Plan
Develop and establish a midwifery model of care for normal risk women to access midwifery managed maternity care	Strategic Plan Maternity Services Plan
Develop a continuity of carer/s program whereby the same group of midwives work across the continuum of maternity care	Maternity Services Plan
Consider supporting eligible midwives to access clinical privileges and admitting practice rights	Maternity Services Plan
Engage independent midwives in local and subregional planning	Maternity Services Plan
Utilize and support the full scope of practice for midwives	Maternity Services Plan Workforce Capability Development Plan
Promote the full range of maternity (private, independent, primary) services to women	Maternity Services Plan
Promote the National Ante Natal Guidelines across our planning area	Maternity Services Plan
Consider extending the continuity carer model to 2 weeks post natal	Maternity Services Plan Youth and Early Years Plan
Formalise, document and evaluate defined referral processes and pathways across the Wellington East Gippsland planning area.	Maternity Services Plan
Utilise adult learning principles to support women to understand the value and importance of maintaining and holding the Victorian Maternity Record (VMR)	Maternity Services Plan
Monitor the use of the VMR by all stakeholders as a continuous improvement strategy.	Maternity Services Plan Health Information Plan
Mandate the use of the VMR as part of clinical privileges and admitting rights	Maternity Services Plan
Develop a strategy for using videoconferencing and other e-technologies to allow women to access specialised care, maternity care information and support while remaining in their local communities.	Maternity Services Plan
Adopt the maternity ISBAR Communication tool for Clinical handover,	Maternity Services Plan
Review the need to maternity and early childhood nursing capabilities for community health nurses in the more isolated parts of the region	Maternity Services Plan Workforce Capability Development Plan
Develop a strategy for using videoconferencing and other e-technologies to allow women to access specialised care, maternity care information and support while remaining in their local communities.	Maternity Services Plan
PRIORITY 2 SERVICE DELIVERY	
RECOMMENDATION	**RELATED PLANS**
Progress and further support the current initiative to support vulnerable families through early intervention and coordination of care across the continuum. Integration with external services and agencies including Child FIRST Gippsland and the Department of Human Services.	Maternity Services Plan
Undertake continuous improvement project to improve service integration across the care continuum for maternity services.	Maternity Services Plan
Develop an internal and peer review process to review maternity clinical indicators, mortality and morbidity reports and other data to support continuous improvement.	Maternity Services Plan Health Information Plan

Maternity Services cont…

PRIORITY 2 SERVICE DELIVERY cont…	
RECOMMENDATION	**RELATED PLANS**
Collaborate with other services and programs to develop and or support strategies to reduce the rate of teenage pregnancies	Maternity Services Plan Health Promotion Plan
Investigate the options of Birthing on Country for ATSI people.	Aboriginal Health Plan Maternity Services Plan
Develop and implement strategies to increase in the number of Aboriginal women accessing antenatal programs	Aboriginal Health Plan Maternity Services Plan
Maternity services health information and documentation contain fields for obtaining specific cultural, language and family preferences. These issues are discussed and documented in early pregnancy	Health Information Plan Maternity Services Plan
Support local Aboriginal people to undertake midwifery training	Aboriginal Health Plan Workforce capability and learning services plan
Review existing accommodation and transport support mechanisms for women and key family members who travel to access appropriate levels of maternity and neonatal care.	Strategic Plan Maternity Services Plan
Monitor and evaluate the use of recommended national and state screening programs.	Maternity Services Plan
Review the capability of all staff in using perinatal mental health screening and provide ongoing professional development to maintain competency	Maternity Services Plan Workforce Capability Development Plan
Regularly review the journey of women experiencing depression to ensure they have had timely referral	Maternity Services Plan Mental Health Plan Youth and Early Years Plan
Monitor any separation of mothers and babies receiving mental health services	Maternity Services Plan Mental Health Plan Youth and Early Years Plan
Monitor and evaluate the perinatal outcomes for at risk women and their babies as a continuous improvement activity	Maternity Services Plan Youth and Early Years Plan Health Information Plan
Monitor and evaluate the use of evidence based guidelines for breastfeeding	Maternity Services Plan Youth and Early Years Plan
Evaluate breastfeeding rates at 3months and 6 months to identify areas for improvement	Maternity Services Plan Youth and Early Years Plan
Engage with vulnerable women to improve access to appropriate maternity services	Maternity Services Plan
Work with Monash IVF services to determine our capacity and capability to support the service.	Maternity Services Plan
PRIORITY 3 WORKFORCE	
RECOMMENDATION	**RELATED PLANS**
Develop a maternity workforce capability development strategy that supports utilising the full scope of practice for midwives and monitor increased productivity, performance and retention.	Maternity Services Plan Workforce Capability Development Plan
Maintain and if possible expand clinical training places for maternity professionals	Maternity Services Plan Workforce Capability Development Plan
Utilise available scholarships for the maternity workforce	Maternity Services Plan Workforce Capability Development Plan
Support regional maternity services workforce strategies to improve access to local maternity care	Maternity Services Plan
Support regional maternity services workforce strategies to improve access to training and development	Maternity Services Plan Workforce Capability Development Plan
Continue to support increased numbers of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications	Maternity Services Plan Workforce Capability Development Plan Aboriginal Health Plan

Maternity Services cont…

PRIORITY 4 INFRASTRUCTURE	
RECOMMENDATION	**RELATED PLANS**
Monitor and evaluate the use of national and local consultation and referral pathways and guidelines	Maternity Services Plan
Monitor and evaluate the effectiveness of transfer information across the local and subregional catchment as a continuous improvement strategy	Maternity Services Plan
Implement that National Maternal e-health record once it becomes available	Maternity Services Plan
Utilise tele-health technologies across the region and subregion catchment to improve access to specialist services	Maternity Services Plan ICT plan
Develop a woman-centred model of care based on the National Childbirth Association guidelines and informed by women in consultation with other stakeholders. Develop a rigorous methodology to monitor and evaluate the model	Community and Consumer Participation Plan Maternity Services Plan Youth and Early Years Plan Health Information Plan
Adopt, monitor and evaluate the National Maternity Services Capability Framework when it becomes available.	Maternity Services Plan Workforce Capability Development Plan
Review transport, accommodation and support for ATSI and women in the isolated parts of the catchment to improve access to maternity services.	Maternity Services Plan Aboriginal Health Plan
Consider and support ways to enable access for women to alternative birthing options,	Maternity Services Plan
Relevant definitions e.g. woman-centred care, are agreed to and acknowledged by all stakeholders	Maternity Services Plan
Increase the number of women accessing PBS and MBS subsidies for services provided by eligible midwives	Maternity Services Plan
Achieve WHO baby friendly accreditation	Maternity Services Plan
Following completion of the development of evidence based patient care pathway for the unwell neonate focus on pathways for vaginal delivery and delivery by caesarean section.	Strategic Plan Maternity Services Plan

Mental Health

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Evaluate CGHS roles and responsibilities within the Gippsland PCP joint initiatives and widely disseminate the results of effective promotion and prevention activities to key mental health care stakeholders within CGHS.	Health Promotion Plan Mental Health Plan
Support programs such as those designed to : encourage positive parenting practices; develop optimistic and resilient children; and develop collaborative communication and referral pathways to birthing, child maternal health and emergency services.	Youth & Early Years Plan Sub-acute Services Plan Maternity Services Plan
Identify and promote workplace environments that enhance mental health, and facilitate their development	Strategic Plan CGHS Staff Health and Wellbeing Plan
Utilise the DH Evidence Base Mental Health Promotion Resource for workplace and program initiatives	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Adopt health promotion activities that widely inform and encourage people to adopt mentally healthy lifestyle choices. i.e. coping strategies that enable resilience in the face of life stressors	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Facilitate staff capability for early detection or mental health issues	Workforce Capability Development Plan All Relevant Service Plans
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Seek the support of LRH and relevant community service providers to establish a CGHS mental health working group. This group will be responsible to develop collaborative evidence based practice (based on Mental Health Clinical Guidelines and Standards) protocols and pathways using a recovery orientated approach across the CGHS catchment. The protocols and pathways need to include prevention, early intervention, treatment and specifically include: • clinical processes for recognising and treating depression with the development of supportive pathways for appropriate low risk inpatient management. • clinical tools for recognition of depressive symptoms, particularly in people from high-risk groups, such as adolescents, women after childbirth, older people in residential care, people presenting repeatedly with somatic symptoms, people exposed to major life stressors, and Aboriginal people and Torres Strait Islanders. • protocols to deal with high-risk situations within CGHS clinical settings. • the development of 'no wrong door' principles to improve access to appropriate mental health services. • develop management plans and best practice pathways for complex mental health clients who access multiple service providers for care and crisis management. • processes to support appropriate treatment models for Aboriginal peoples and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds with mental health issues. • support ongoing workforce capability development for staff across all care settings. • Build mental health literacy through promotion activities and community education—specifically, improve recognition of depressive symptoms and disorders and knowledge regarding the availability and efficacy of different treatment options • processes for evaluating and monitoring clients presenting with frequent episodes of mental health issues e.g. self-harm • monitor annual mental health presentation trends to identify areas for health promotion and early intervention • ongoing review of clinical tools and pathways for assessing, monitoring and reviewing delirium and depression in the residential care settings	Mental Health Plan Workforce Capability Development Plan Health Information Plan Residential Aged Care Services Plan

Mental Health cont…

CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Work with LRH, community service providers and consumers to evaluate models of care for people of all ages with mental health and alcohol and other drug issues.	Aboriginal Health Plan Mental Heath Plan
Build cultural competence to support culturally appropriate mental health and drug and alcohol treatment models for Aboriginal peoples and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds	Workforce Capability Development Plan Cultural Diversity Plan
Adopt the principles of Recovery Orientated Mental Health Services across all care settings	All service delivery plans
Build the capability of staff in residential and community aged care to identify early signs and symptoms and the management of depression in older people.	Aged and Disability Services Plan Residential Aged Care Services Plan Workforce Capability Development Plan
Build staff, consumer and community literacy with regard to mental health to reduce the stigma associated with mental health and alcohol and other drug issues and improve the quality of care.	Workforce Capability Development Plan

Muscular Skeletal and Arthritis Conditions

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Build our capability and capacity to be a health promoting health service and support Wellington Shire MPHP actions for healthy lifestyle programs.	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Promote the importance of regular exercise in post-menopausal women	Health Promotion Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Monitor the implementation of the NHMRC Clinical Guidelines for the treatment of osteoporosis in Australian residential aged care facilities with regard to consensus recommendations for fracture prevention	Residential Aged Care Services Plan
Utilise and monitor the NHMRC Clinical Guidelines for health professionals: "Prevent the next fracture. Health professional guide"	Residential Aged Care Services Plan Home Support Services Plan
Support clients with osteoarthritis to increase physical activity as part of their care /service delivery plan	Care Coordination Program Plan Medical Services Plan Surgical Services Sub-acute Services Plan
Continue to develop staff capability and capacity to support physical activities for clients in residential care.	Residential Aged Care Services Plan
Provide daily physical activity programs as part of routine residential care.	Residential Aged Care Services Plan
Screen all clients in residential care for Vitamin D and Calcium levels and provide supplements where appropriate.	Residential Aged Care Services Plan
Support prescribers of medications for arthritic conditions to have currency with regard to the evidence base using the Cochrane Data base and NHRMC Clinical Guidelines and recommendations.	Pharmacy Services Plan
Develop the capability of AHAs to lead Tai Chi group programs.	Sub-acute Services Plan
Support PAG leaders and support staff to lead Tai Chi as part of the regular PAG program.	Home Support Services Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Monitor the implementation of the NHMC clinical guidelines for best practice management of acute and chronic whiplash-associated disorders	Emergency Department Plan
Monitor the application of the NHRMC Clinical Guidelines for the diagnosis and management of early rheumatoid arthritis.	Relevant service delivery plans
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Continue to develop workforce capability in chronic disease management and active service model	All Relevant Service Delivery Plans Workforce Capability Development Plan
Support therapist to engage with peak bodies and continually monitor the evidence of effective therapies and establish rate based indicators to measure effectiveness of interventions for muscular skeletal and arthritis conditions.	Sub-acute Services Plan
Build capability and capacity of all direct care staff to support self-management approaches to managing chronic disease	All Relevant Service Delivery Plans
Focus on group exercise programs, bringing people together with similar needs and with a Tai Chi component with regard to rehabilitation, PAG and other relevant program areas.	Sub-acute Community Services Plan Home Support Services Plans
Provide access to copies of brochures and information on conditions provided by the Arthritis Foundation http://www.arthritis.org/ and Arthritis Australia http://www.arthritisaustralia.com.au/	Emergency Department Plan Sub-acute Services Plan Home Support Services Plan Medical Services Plan
Increase the number of locality based group exercise programs to address wait lists and the benefits of group exercise and social connectedness	Sub-acute Services Plan Community Services Plan

Obesity

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Support the development and implementation of the Wellington Shire Municipal Public Health and Wellbeing Plan.	Health Promotion Plan
Full implement the Victorian Department of Health - Healthy Choices: food and drink guidelines for Victorian public hospitals	CGHS Staff Health and Wellbeing Plan Food Services Plan Health Promotion Plan
Continue to develop and implement healthy food policies across the agency	CGHS Staff Health and Wellbeing Plan Food Services Plan Health Promotion Plan
Support the kiosk to provide healthy food and support healthy eating by reducing options of sugar and high carbohydrate, high kilojoule based drinks and snacks	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Support a culture of healthy eating across the agency and wider community.	Health Promotion Plan Staff health & wellbeing plan Food Services Plan
Promote local community based healthy food initiatives and programs within the health service	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
Explore ability to provide patients and clients with healthy food information from the Better Health Channel	Health Promotion Plan
Encourage and support the social club to assist the adoption of healthy workplace eating programs	Health Promotion Plan
Ensure relevant staff are familiar with the Victorian Aboriginal nutrition and physical activity strategy 2009–2014	Aboriginal Health Plan Health Promotion Plan
Support the development and implementation of the Wellington Shire Municipal Public Health and Wellbeing Plan to include: the Active Places program to help communities with low levels of physical activity to participate more frequently in sport and recreation; the Premier's Active Families Challenge to encourage Victorian families to undertake regular physical activity; the Ride2School program, supporting schools and assisting young people to incorporate physical activity into every day by choosing active modes of transport to and from school.	Health Promotion Plan
Support the Wellington Shire Council to: Continue to improve access to sporting and recreational facilities coordinating the resources available Support planning for walkability, open space, active transport and local transport solutions to make it easier for people to take part in community life	Health Promotion Plan
Support active workplace programs e.g.: Walk to work Ride To work 10000 steps twice yearly Subsidized gym access. Active prizes for all raffles and fundraising Fun Runs After work and lunch time walking groups	Health Promotion Plan CGHS Staff Health and Wellbeing Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Include BMI and refer all clients at risk who measure outside the recommended range, to health promotion programs	All Service Area Plans
Where appropriate include advice and support for weight loss, physical activity and healthy nutrition based on the principles of My Health My Life and Health Coaching.	Community Health Service Plan Home Support Service Plan Sub-Acute Service Plan
Identify and respond to the barriers for low income people to adopt healthy food and exercise behaviours	Health Promotion Plan All Relevant Service Plans
Monitor the National Preventative Taskforce for updates on evidence guidelines and practices	Health Promotion Plan
Impalement the National Breastfeeding Evidence Based Guidelines with protocols and support for breastfeeding in all relevant settings	Maternity Services Plan Youth and Early Years Plan
Support at risk mothers with nutritional advice	Maternity Services Plan Youth and Early Years Plan
Monitor the implementation of the NHMRC Dietary Guidelines for Children and Adolescents in Australia	Maternity Services Plan Children Services Plan

Obesity cont…

EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Establish multidisciplinary evidence based self-help, social support and group programs, to address weight management, for peer support and social connectedness	Sub-acute Services Plan Community Services Plan
Monitor the implementation of the HACC Active Service Model	Home Support Services Plan
Implement clinical guidelines for obesity management for adults and children across all relevant settings	All Service area plans
Refer and support children & adolescents who are overweight and obese to appropriate services and group programs e.g. dietitian, psychologist,	Youth and Early Years Plan Sub-acute Services Plan
Consider establishing multidisciplinary group programs for families and adolescents who are overweight or obese using social networking and media that is appropriate	Youth and Early Years Plan Sub-acute Services Plan
Monitor and evaluate all multidisciplinary group program based on the evidence and effectiveness of programs to meet nutrition and exercise program outcomes for clients	Sub-acute service plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Support the development a Gippsland bariatric strategy that details the capability of each health service and describes pathways for people requiring both elective and emergency treatment. The pathways and local protocols should include: • a plan based on the patient's needs "door to door"; • protocols and algorithms for safe handling, equipment, staffing, and preoperative and postoperative needs; • Evidence based recommendations for the purchase and use of proper assistive equipment. http://bariatrictimes.com/maintaining-dignity-of-patients-with-morbid-obesity-in-the-hospital-setting/	Strategic Plan Bariatric services plan All Relevant Service Plans
Build the capability of direct care staff to establish group programs using the principles of chronic disease management and apply the philosophies and values of health coaching to support clients to make healthy choices	Workforce Capability Development Plan All Relevant Service Delivery Plans.
Take advantage of all access points and utilise our care coordination program to provide ongoing support and for clients with obesity, where possible and in a manner consistent with our values relating to patient/client centred care.	Community Services Plan All Relevant Service Plans

Oral Health

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
A workforce and infrastructure capability review is recommended to identify: the potential to increase our dental chairs to five; to outsource denture work through the Oral Health Consortium or public /private partnership; the potential extended scope of practice for dental assistants and the opportunity to implement a traineeship program for dental hygienists as an entry point to a local employment and education pathway in oral health Continue to work with DHSV to maximise productivity across the service	Oral Health Plan
Actively participate in and monitor the implementation of the Gippsland Oral Health Plan	Oral Health Plan
Support the Wellington Shire Municipal Public Health Plan for Oral Health and take responsibility for the implementation of relevant Oral Health aspects of the plan.	Oral Health Plan Health Promotion Plan
Implement and maximise opportunities such as the Teen Dental Scheme http://www.health.gov.au/internet/main/publishing.nsf/content/dental-teen and the Chronic Disease Management Scheme http://www.health.gov.au/internet/main/publishing.nsf/Content/Dental+Care+Services	Oral Health Plan
Explore participation in graduate, student and international graduate programs.	Oral Health Plan
Provide pathways from VET to university training for oral health / dental workforce.	Oral Health Plan
Support the training and development of local Aboriginal Oral Health Workers.	Aboriginal Health Plan Oral Health Plan
Build capability to support oral care for health care workers	Workforce Capability Development Plan Oral health plan Health Promotion Plan
Advocate and support the completion of fluoridation across the catchment	Health Promotion Plan
Build oral health literacy across our organisation and community.	Health Promotion Plan Oral health plan CGHS Staff Health and Wellbeing Plan
Implement oral health assessments and oral health education across all care settings and all relevant programs.	All Relevant Service Plans
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
That CGHS explore further preventative and early detection approaches. For example to develop pathways for women attending the CGHS public antenatal clinic to include dental treatment in their antenatal care and encourage good oral health for mothers and their children. This would include enrolling children in a public recall system from an early age and supported through M&CH nurse visits.	Maternity Services Plan Youth and Early Years Plan Oral health Plan
Ensure patients or clients identified with risk factors or determinants of oral health disease, in any care setting, can be referred for further assessment and ongoing care where required, and in the case of complex clients through our care coordination program	All Relevant Service Plans
That we gain a better understanding of why dental conditions are our second ranked ambulatory care sensitive condition for Wellington LGA.	Oral Health Plan Health Information Plan
Introduce oral health assessments and oral health care across all care settings	All Relevant Service Delivery Plans.
Check smoking statues at initial dental visit and on review	Oral Health Plan
Refer all clients who smoke to a smoking cessation program	Oral Health Plan
Approach smokers in a non-judgmental way and advise them of the links between smoking, periodontal disease and general unwellness	Oral Health Plan
Support Maternal and Child Health Nurses to assist in providing oral health care services for families at high risk.	Youth and Early Years Plan Oral health plan
Bring dentists, dental therapist/oral health therapists together with M&CH nurses to improve common understanding and expectation around identification of oral health issues/risk and agreed actions	Youth and Early Years Plan Oral health plan
Integrate oral health care into all primary and community health and home support services.	Community Services Plan Sub-Acute services plan Home Support Services Plan

Oral Health cont…

SECONDARY PREVENTION cont…	
RECOMMENDATION	**RELATED PLANS**
Support the use of fluoride varnish programs for high-risk young children	Health Promotion Plan Youth and Early Years Plan
Support and encourage supervised tooth brushing programs including Smiles 4 Miles.	Youth and Early Years Plan Sub-acute Services Plan
Support targeted oral health care for pregnant women and babies at risk –	Maternity Services Plan
Integrate oral health care into cardiac rehabilitation and other programs targeting people with CVD	Sub-acute Services Plan Cardiac rehabilitation plan
Inform home support workers and other aged care workers of the importance to undertake oral health care as part of personal care	Home Support Services Plan Residential Aged Care Services Plan Aged and Disability Services Plan
Ensure policies, procedures and practices in residential care are consistent with the Better Oral Health in Residential Aged Care (DOHA, 2009)-	Residential Aged Care Services Plan
Monitor the provision of oral health examination for eligible residents of aged care facilities	Residential Aged Care Services Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Raise the profile of oral health across all care settings and make staff aware of the links between poor oral health and other diseases.	Health Promotion Plan Oral health plan CGHS Staff Health and Wellbeing Plan
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Undertake an oral health assessment on people who are underweight and refer for early intervention as appropriate	All Relevant Service Delivery Plans
Integrate oral health care into diabetes education programs -	
Screen people with COPD for periodontitis and refer for assessment and treatment	Sub-acute Services Plan
Commence group programs for people with advanced oral health disease as part of a chronic disease program	Sub-acute Services Plan Oral Health Plan
Integrate oral health assessment into all assessment tools	All Service Area Plans
Raise awareness of the links between aspiration pneumonia and poor oral health	Residential Aged Care Services Plan Home Support Services Plan
Improve the knowledge and awareness of the links between obesity and periodontitis	Health Promotion Plan
Ensure people with disabilities undertake regular oral health screening	Sub-acute Services Plan Home Support Services Plan
Include oral health assessments as part of pain management programs	Sub-acute Services Plan
Ensure people with advanced oral health disease have regular access to dental services and relevant group programs	Oral Health Plan All Service Area Plans
Discourage the use of alcohol based mouth washes by people with periodontal disease	All Relevant Service Delivery Plans
Work with local ATSI services to support the training and development of Aboriginal Oral Health Workers	Aboriginal Health Plan
Continue to support the implementation of the Gippsland Closing the Gap plan	Aboriginal Health Plan
Build capability for all oral health staff in applying the principles of chronic disease management	Oral Health Plan Workforce Capability Development Plan

Palliative Care

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Support the capability development of district nurses interested in specialising in palliative care, to build a specialist nursing palliative care workforce	Workforce Capability Development Plan Palliative Care Plan
Support palliative care staff to undertake regular palliative placement in specialist facilities via the Program of Experience in the Palliative Approach (PEPA) program	Palliative Care Plan Workforce Capability Development Plan
Provide regular palliative care in-service programs for staff across all care settings	Workforce Capability Development Plan
Develop the capability of all residential care staff to support a palliative approach to residential care	Workforce Capability Development Plan Residential Aged Care Services Plan
Develop the capability of the home support workforce to maximise their contribution as part of the palliative care team	Workforce Capability Development Plan Home Support Services
Build workforce capability to support culturally appropriate care for palliative care clients	Cultural diversity Plan Palliative Care Plan
SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Work with Aboriginal liaison officer to identify palliative care gaps/needs in the aboriginal community	Aboriginal Health Plan Cancer Services Plan Palliative Care Plan
Monitor ongoing needs for palliative clients and carers i	Cancer Services Plan Palliative Care Plan
Provide comprehensive clinical and psychosocial care/support	Cancer Services Plan Palliative Care Plan
Include ATSI organisations in all aspects of Palliative Care Planning and service development	Aboriginal Health Plan Palliative Care Plan Cancer Services Plan
EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Advocate for clients with mental health disorders, disabilities, chronic disease, people from CALD backgrounds, people with dementia and SES disadvantaged to ensure they are supported with client focused and needs based palliative care programs	Palliative Care Plan Cultural Diversity Plan All Relevant Service Delivery Plans
CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Support the consistent use of a bereavement assessment framework	Palliative Care Plan
Support the consistent use of a validated "carers stress index" tool for carers of palliative clients	Cancer Services Plan Palliative Care Plan
Integrate practices across hospital and community care to support consistency in end-of-life care	All Service Area Plans
Review palliative care admission/assessment protocols/tools to support easy and timely access to inpatient services when required	Palliative Care Plan
Redevelop our palliative care suite to provide a more homelike environment with facilities to enable carer and family involvement in patient care and or support.	Palliative Care Plan Strategic Plan
Develop our service to met or exceed the National Standards (NSAP)	Palliative Care Plan
Provide specialist palliative care when and where it is needed	Medical Services Plan
Continue to provide after-hours clinical support to clients and carers	Palliative Care Plan
Undertake regular quality programs/audits which include auditing CGHS services against national and state guidelines and standards and in particular the Victorian Palliative Capability Framework and Guidelines for a Palliative Approach in the Community Setting.	Palliative Care Plan
Regularly review pain management practices across all palliative care settings to ensure national pain management guidelines are followed.	All Service Area Plans

Palliative Care cont…

CHRONIC DISEASE MANAGEMENT cont…	
RECOMMENDATION	**RELATED PLANS**
Develop client-centred pain management capability and approach across all care settings	All Relevant Service Plans Workforce Capability Development Plan
Build our capability for palliative care consistent with the National Palliative Care Strategy: Maintain a close and collaborative relationship with the Gippsland Palliative Care Consortium. Provide information for the general community and General Practitioners to encourage and de-stigmatise the use of palliative care services. Develop and retain a dedicated palliative care workforce and build the capability of the district nursing workforce to support palliative care. Develop, implement and continually evaluate the health service's palliative care and advanced care planning processes, and the coordination of these into other aspects of patient care.	Palliative Care Plan Home Support Services Plan
Support the visiting specialist palliative care medical workforce in Gippsland.	Palliative Care Plan Medical Services Plan

Youth and Early Years

PRIMARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Provide evidence based antenatal programs in settings that are accessible to all women utilising the 3Cs Collaborative clinical guidelines. http://3centres.com.au/guidelines/	Maternity Services
Review the structure of maternity and maternal and child health services with a view to maximise service integration and coordination of care.	Strategic Plan Maternity Services Plan Youth and Early Years Plan
Emphasise the importance of immunisation in prenatal and postnatal education and parenting programs	Maternity Services Plan Youth and Early Years Plan
Implement the 3cs Collaborative clinical guidelines for breast feeding http://3centres.com.au/guidelines/	Maternity Services Plan Youth and Early Years Plan
Support 100% breastfeeding until the age of 6 months across all relevant settings	Maternity Services Plan Youth and Early Years Plan
Provide settings suitable for breast feeding.	Strategic Plan
Support the availability of professional and peer support to prolong breastfeeding	Maternity Services Plan Youth and Early Years Plan
Continue to support the adoption of the Maternal and Child Health Services Standards (2009) for immunisation and adopt the RCH Clinical Guidelines for Immunisation. http://www.rch.org.au/clinicalguide/cpg.cfm?doc_id=5215	Maternity Services Plan Youth and Early Years Plan
Promote available financial incentives to parents to encourage them to immunise their children	Youth and Early Years Plan
Support the Wellington Shire Council to provide local accessible family sporting/recreational activities that focus on physical activity	Health Promotion Plan
Promote and facilitate access to local public health dental services for children 0-12.	Oral Health Plan
Support families with information on good oral health behaviours.	Oral Health Plan
Support campaigns to fluoridate water supplies where possible See Oral Case Study	Oral Health Plan
Focus on injury prevention in ante-natal, postnatal and children and family programs. In particular the causes: community play areas, unguarded staircases, dim lighting, lead contamination, unsecured chemicals and medications, fire prevention equipment, unfenced swimming pools or dams) or the family parents' work and hobbies.	Maternity Services Plan Youth and Early Years Plan
Ensure good access to emergency care for young children. Implement and monitor the use of the RCH Clinical Guidelines http://www.rch.org.au/clinicalguide/index.cfm and Paediatric Clinical Network Guidelines for all Paediatric Presentations. http://health.vic.gov.au/clinicalnetworks/paediatric.htm	Emergency Department plan
Support Wellington Shire Council strategies and social support programs designed to promote caring neighbourhoods where children are valued and supported to achieve their potential.	Health Promotion Plan
Support hearing screening programs in early years	Maternity Services Plan Youth and Early Years Plan
Support local tobacco & AOD control, smoke cessation actions and strategies aligned with the Wellington Public Health and Wellbeing Plan and local liquor accords	Health Promotion Plan
Support the development of local resources for young families that are culturally appropriate and locally relevant	Community and Consumer Participation Plan
Support evidence based sexual health programs and promote bulk billing for younger women that enable access to contraception	Community Services Plan
Support the Wellington Shire Council's community safety programs	Health Promotion Plan Youth and Early Years Plan
Improve community awareness of SIDS and preventative strategies particularly in the neonatal care unit.	Maternity Services Plan

SECONDARY PREVENTION	
RECOMMENDATION	**RELATED PLANS**
Adopt the Department of Health recommendations to develop substantive roles for Allied Health Assistants across acute, sub-acute and community services.	Strategic Plan All Service Area Plans
Target and provide transport for high risk women and Aboriginal women to attend antenatal classes Focus on breastfeeding, Nutrition, alcohol and smoking cessation and reduction in other risk behaviours	Maternity Services Plan Youth and Early Years Plan
Support mothers of low birth weight babies to breast feed and to cease smoking if relevant.	Maternity Services Plan Youth and Early Years Plan
Emphasise the importance of cessation of smoking across all care settings and particularly in women of childbirth years	Maternity Services Plan Youth and Early Years Plan
Support indigenous families in the ante-post natal period to have their children immunised	Maternity Services Plan Youth and Early Years Plan
Continue to support and promote community Quit programs	Maternity Services Plan Youth and Early Years Plan
Support access to affordable local sexual and reproductive health services and programs and target young women (and their partners) who are at risk of teenage pregnancy including indigenous and socio-economically disadvantaged youth.	Maternity Services Plan Youth and Early Years Plan
Support and advocate for effective programs for young people with disabilities, and in particular programs that: involve young people in the design, oversight and evaluation; have clear outcomes; and ongoing funding.	Home Support Services Sub acute Services Plans
Support young teenage mothers with accessible high quality ante and post natal care using the 3centres Collaboration Clinical Guidelines.	Maternity Services Plan Youth and Early Years Plan
Support the early identification of relationship issues and refer to appropriate family and social support counselling services and programs	Maternity Services Plan Youth and Early Years Plan
Identify children at risk of homelessness and refer to relevant services.	Maternity Services Plan Youth and Early Years Plan
Support and promote the effectiveness of accessible financial counselling	Maternity Services Plan Youth and Early Years Plan
Assess, support, refer and ensure access to quality services for children and families with the following risk factors - financial difficulties, social isolation, domestic violence, mental health problems, disability, alcohol and substance misuse and the lack of safe and affordable housing	Maternity Services Plan Youth and Early Years Plan
Use the Indigenous Risk Impact Screening (IRIS) tool in the relevant settings e.g. acute/accident and emergency/outpatients	Emergency Department Plan
Seek out and adopt proposed Paediatric Clinical Network Guidelines and indicators developed for AOD in young people	Childrens Services Plan Sub-acute Services Plan
Work with the regional mental health services to enable young people to inform and participate in service development.	Mental Health Plan
Support triage staff to be aware of referral pathways for young people demonstrating at risk and self-harm behaviours using the RCH Clinical Guidelines. http://www.rch.org.au/clinicalguide/index.cfm	Emergency Department Plan
Promote access and use of Living Is For Everyone (LIFE) world-class suicide and self-harm prevention resource	Mental Health Plan

EARLY INTERVENTION AND TREATMENT	
RECOMMENDATION	**RELATED PLANS**
Meet with regional and subregional early childhood intervention service providers to establish and clarify service responsibilities and, develop a service agreement or MOU (or similar) that details responsibilities, referral pathways, case management, service delivery and funding	Sub-acute Services Plan
That CGHS seeks to implement the following recommendations of the Gippsland Paediatric Allied Health Reform Project: a. That over time, services seek to lift the levels of paediatric allied health services provided through the community health funded program to be at least consistent with other regions of rural Victoria. b. That Paediatric allied health service providers form partnerships to support sub-regional collaborative models. These collaborations would principally support professional networking, a platform for standardisation of how the public health system responds to families at intake, and a focal point for connection with tertiary institutions. c. That Department of Health funded service providers create models that support growth in paediatric allied health services that can be funded (in part) through the Medicare Benefits Scheme. d. That Department of Health funded service providers maximise models of care to make more effective use of the available workforce including Allied Health Assistants. e. That Paediatric allied health service providers develop a decision making database for referral and intake.	Sub-acute Services Plan
Maintain our existing neonatal critical care capability	Maternity Services Plan
Adopt, implement and monitor the use of peak body clinical guidelines, standards and models of care: • The 3centres Collaborative Clinical Guidelines for maternal and newborn services, • The Royal Children's Hospital Clinical Guidelines • The Victorian Paediatric Network Guidelines, indicators and outcomes (under development) • The Victorian Paediatric Rehabilitation Service Model of Care • The Maternal and Child Health Standards	Maternity Services Plan Youth and Early Years Plan Children's services plan Sub-acute Services Plan
Support family counselling and programs that focus on children's resilience.	Maternity Services Plan Youth and Early Years Plan
Collaborate with the Victorian Paediatric Rehabilitation Service Model of Care to develop a local model of care/service which is coordinated, child/family centred and enables children with rehabilitation needs local options.	Sub-acute Services Plan
Participate in the State ECIS Reform project.	Sub-acute Services Plan
Advocate for local Centres for Independent Living for young people with disabilities	Sub-acute Services Plan Home Support Services Plan
Support the most suitable ECIS organisation to become a local FASCIA funded panel provider.	Community Services Plan Sub Acute services plan
Adopt evidence informed practices aligned with the reconceptualised and reconfigured ECIS system http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/intervention/ecislitrevexsumdec2010.pdf	Sub-acute Services Plan
Advocate for local centres for Independent Living for young people with disabilities	Home Support Services Plan Community Services Plan
Focus on nutrition and other protective behaviours in early intervention programs.	Sub-acute Services Plan Youth and Early Years Plan
Promote access to affordable local sexual and reproductive health services and programs and target young women (and their partners) who are at risk of teenage pregnancy including indigenous and socio-economically disadvantaged youth.	Community Services Plan Youth and Early Years Plan
Support and advocate for effective programs for young people with disabilities, and in particular programs that: involve young people in the design, oversight and evaluation; have clear outcomes; and ongoing funding.	Home Support Services Plan Sub-acute Services Plan
Support young teenage mothers with accessible high quality ante and post natal care using the 3centres Collaboration Clinical Guidelines.	Maternity Services Plan Youth and Early Years Plan
Assess, support, refer and ensure access to quality services for children and families with the following risk factors - financial difficulties, social isolation, domestic violence, mental health problems, disability, alcohol and substance misuse and the lack of safe and affordable housing.	Maternity Services Plan Youth and Early Years Plan

Youth and Early Years cont…

CHRONIC DISEASE MANAGEMENT	
RECOMMENDATION	**RELATED PLANS**
Continually monitor and review the adoption of the Paediatric Clinical Network Guidelines for all Paediatric services	Sub-acute Services Plan
Streamline intake processes across service jurisdictions to avoid duplication and confusion for families Intake process needs streamlining across Gippsland.	Care Coordination Program Plan
Define and review case management/ care coordination and advocacy services for families of children with special needs.	Care Coordination Plan Sub-acute Services Plan
Provide cultural sensitivity training for all clinical staff and Board of Management and frequently measure cultural competence	Workplace Capability and Learning Services Plan
Develop and implement the RCH Clinical Guidelines for Mental State Examination and enable access to assessment and treatment young people at risk of suicide.	Emergency Department Mental Health Plan
Ensure there are referral pathways and case management to follow up for at Risk Aboriginal young people. (Especially those presenting with Alcohol and Other Drug issues/problems and mental health issues/problems)	Emergency Department Plan Aboriginal Health Plan
Adopt the RCH Clinical Guidelines for Substance Abuse for all young people presenting with AOD issues. http://www.rch.org.au/clinicalguide/	Emergency Department Plan Medical Services Plan
Provide training for ED and other front line staff in dual diagnosis to support Aboriginal people who present with mental health and substance abuse issues.	Emergency Department Plan Aboriginal Health Plan
Refer all Aboriginal people presenting with AOD and Mental health issues to culturally appropriate services	Emergency Department Plan Aboriginal Health Plan
Determine the level of need for a local Aboriginal Mental Health Liaison worker	Aboriginal Health Plan Mental Health Plan
Work with AOD and mental health services to enable continuity of care and support for individuals upon returning to their community post alcohol and drug and or mental health treatment.	Care Coordination Plan Mental Health Plan
Improve training of triage staff to recognise and act on suicide and self-harm intent and have referral pathways in place	Emergency Services Plan
Determine if and how CGHS might support Ramahyuck to address the specific needs of Aboriginal people who are in the transition from the justice system, mental health and AOD services	Aboriginal Health Plan
Similarly determine if and how CGHS might support Ramahyuck to provide: • substance use prevention • conflict resolution • parenting skills • budgeting • adult education training programs.	Aboriginal Health Plan
Refer to the Injury and Oral Health Case Studies for other recommendations relevant to youth and early years.	All Relevant Service Plans
Adopt the RCH Clinical Guidelines for all paediatric injury presentations	Emergency Department Plan

Glossary

Aboriginal and Torres Strait Islander	Aboriginal and Torres Strait Islander people are those people of Aboriginal or Torres Strait Islander descent who identify as an Aboriginal or Torres Strait Islander and are accepted as such by the community in which they live.
Allied health	A range of health professionals including but not limited to audiologists, chiropractors, dietitians, exercise physiologists, occupational therapists, orthoptists, orthotists, prosthetists, osteopaths, pharmacists, podiatrists, physiotherapists, psychologists, radiographers, radiation therapists, sonographers, social workers, speech pathologists and diabetes educators.
Allocation (as in resource allocation within the health system)	Denotes decisions made about how, where and for whom resources are spent. Allocation can occur at multiple levels, for example, through allocation of the government budget to how an individual health service allocates its resources.
Ambulatory-care-sensitive conditions	Conditions for which hospitalisation is thought to be avoidable with the application of preventive and primary care management.
Capacity	Refers to the amount of services able to be offered, or the number of patients able to be cared for, by the system or a service provider. Common capacity constraints include too few beds or too few staff.
Chronic and complex conditions	Chronic condition: A condition of at least six months' duration that can have a significant impact on a person's life and requires ongoing supervision by a health professional, for example, asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.
Complex care needs	People with complex care needs have multiple health, functional and/or social issues and are at risk of functional decline and/or hospital admission.
Clinical guidelines	Guidelines for clinical practice (clinical guidelines) are statements developed systematically in order to assist practitioners and patients to make decisions about appropriate healthcare for specific circumstances.
Clinically appropriate	Describes care that from a medical perspective (as opposed to, for example, a financial perspective) is deemed fitting, and is ideally considered best practice.
Clinician	Denotes any health professional.
Community-based services and settings	Health and wellbeing services and service locations (which may include care in the home) that are designed to meet a community's needs locally, that is, close to where people live.
Comorbidity	Either the presence of one of more disorders (or diseases) in addition to the primary disease or disorder, or the effect of such additional disorders or diseases.
Configuration of the health system	Denotes how we organise health services to deliver the outcomes we want.

Continuum of care	The collective term for all components of care in the health system. **Protection.** Government actions to help the whole state's population (as opposed to individuals, to whom the remaining seven components pertain), for example, in relation to preparing the community for emergencies, protection against communicable diseases, and the protection of environmental health. **Health promotion.** Activities that help you make decisions about actions and behaviour that lead to good health. **Illness prevention.** Activities that help you make decisions about actions and behaviour that help prevent you from becoming ill. **Primary care.** Primary care occurs at a patient's first point of contact with the medical or healthcare system. There are two types of primary care: Primary medical care is the care you receive at your first point of contact with the medical system, most often, your GP. **Primary healthcare** is the care you receive at your first point of contact with the healthcare system, for example, when you see a physiotherapist because you have a sore back. It is traditionally delivered in community health centres or through private allied health providers. **Secondary care.** The care you receive when primary care is not enough. Secondary care is more technical, intensive or complex than primary care. **Tertiary care.** Tertiary care is specialised care usually provided on referral from primary or secondary care. **Quaternary care.** Quaternary care is the next step up again in technicality, intensiveness and/or complexity of care; it is highly specialised and operates at a state-wide level, for example, trauma care and some organ transplants. **Rehabilitation.** The service you need to 'get back on your feet' after ill health. **End-of-life care.** The care you receive when you are dying.
Coordinated services or care	Care coordination is the deliberate organisation of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services. Organising care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.
Early intervention	Denotes an act of intervening, interfering or interceding with the intent of modifying the outcome either early in a person's life course or early in the progression of a disease.
E-health technology	E-health technology denotes electronic tools and resources used in healthcare; these include electronic medical records, remote monitoring, tele-health and bedside clinical decision support.

Evidence (as in 'evidence-based' and 'evidence-informed')	Accumulated knowledge from medical practices, experience and research. Often used in the context of decision making – decisions wherever possible should be based on evidence and not primarily motivated by other considerations (such as past practice or expediency).
Fiscal responsibility	The responsible collection (taxation) and use (expenditure) of government revenues. Often connotes transparency and accountability.
Healthcare	The prevention, diagnosis and treatment of disease, illness, injury and other physical and mental impairments. The healthcare system is focused on the wellbeing of individuals – in contrast, the field of public health (see 'Public health') focuses on the wellbeing of populations.
Health literacy	An individual's ability to read (or otherwise apprehend), understand and use healthcare information to make decisions about their health and follow instructions for treatment.
Indigenous status	Indigenous status refers to those people of Aboriginal or Torres Strait Islander descent who identify as an Aboriginal or Torres Strait Islander and are accepted as such by the community in which they live.
Integrated care network	Integrated care networks will bring local clinicians and health service organisations together to develop area-based approaches that respond to people with priority clinical conditions. These networks will support the local implementation of clinical guidelines and care pathways which are developed by the Statewide Clinical Networks. The networks will facilitate better patient access to appropriate services within their local area, ensuring care is provided in line with clinical guidelines. The networks are especially important in the delivery of clinically appropriate and cost-effective care for those with complex and chronic conditions.
Knowledge-focused	An emphasis on knowledge and information (see also 'Evidence').
Knowledge management	How information and knowledge is managed – that is, collected, stored, analysed, shared and used.
Medicare Locals	Funded by the Commonwealth Government, Medicare Locals will be established across Australia as part of a nationwide network of primary healthcare organisations. Medicare Locals will support health professionals to improve the delivery of primary care services at a local level and to improve access to after-hours primary care.
Palliative care	Specialised healthcare provided by experts with training and experience in supporting people living with a terminal illness and their families.
Patient pathway	A picture or model of the procedures and administrative processes that a patient experiences when moving through the healthcare system.
People-focused or people-centred	An emphasis on individuals (patients, carers, and their family members). Often contrasted with 'system-focused' or 'service-focused', and used to denote the importance of designing care and delivery of care primarily around the needs and experiences of people, not of the system or services.

Primary care	Primary care occurs at a patient's first point of contact with the medical or healthcare system. There are two types of primary care: Primary medical care is the care you receive at your first point of contact with the medical system, most often, your GP. Primary healthcare is the care you receive at your first point of contact with the healthcare system, for example, when you see a physiotherapist because you have a sore back. It is traditionally delivered in community health centres or through private allied health providers.
Private health sector	Comprises health and wellbeing services primarily funded by individuals through insurance payments, and managed by organisations that are independent of government (for example, churches and for-profit companies).
Provider (as in health provider or service provider)	An individual who or organisation that provides services related to health and wellbeing.
Public health	What we do as a society to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment (see 'Healthcare'), on populations rather than individuals, and on the factors and behaviour that cause illness and injury.
Public health sector	Comprises health and wellbeing services primarily funded by citizens through the taxation system, and managed by or on behalf of, the government.
Self-care	Activities undertaken by an individual to promote their own health, prevent disease, limit illness and restore their own health. Self-care is typically undertaken without health professional assistance but is informed by the knowledge and skills of health professionals.
Statewide Clinical Networks	Statewide clinical networks are collaboratives bringing together health professionals, patients, consumers, carers and organisations to work across boundaries, applying principles of cooperation and partnership and focusing on patients to improve access, equity and quality of healthcare. Networks create awareness that all areas are linked within a coordinated system, with each part playing an important role.
Sub-acute	Care for patients requiring short-term, complex medical and/or rehabilitation interventions. Typically used as an alternative to acute hospital admission or continued hospitalisation.