



Government of **Western Australia**
Department of **Health**

Waste Not – Want Not

Clinical Senate of Western Australia
16 March 2018

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Overview

The first meeting of the Clinical Senate of Western Australia for 2018 was held on 16 March at Fraser's Function Centre, King's Park, Western Australia.

The topic for debate was "Waste Not: Want Not".

The Western Australian (WA) health system faces the ongoing challenge of providing high quality health care within a restricted financial environment. From 2017, the Clinical Senate ran three debates to identify priorities to ensure the WA health system could manage the costs associated with healthcare into the future.

The first debate built on the Review of Safety and Quality in the WA health system led by Professor Hugo Mascie-Taylor. Clinicians at this debate ranked the top clinical indicators to measure safety and quality of health services with consideration being given to the importance of continuous improvement and system accountability.

The second debate saw the Senate partner with Ms Robyn Kruk AM, Independent Chair of the Sustainable Health Review (SHR) to reflect on the way we deliver health care and how to establish and maintain a sustainable healthcare system. For this debate clinicians identified metrics for system change.

The March 2018 debate, Waste Not: Want Not was the last of the debate series where clinicians reflected on how their practice impacts on expenditure and ways to reduce waste and manage costs. Senators were asked to consider their role as champions for change and consider both personal and professional responsibilities to minimise waste. The focus for debate was to provide clear recommendations on practical ways to reduce waste and increase productivity for both the system manager and health service boards.

The Director General (DG), Dr David Russell-Weisz introduced the Waste Not: Want Not debate and highlighted that sustainability is about safety, quality and better patient experience as well as clinical and financial performance.

The DG reminded senators that the growth in the cost of healthcare has not been accompanied by an equivalent increase in services to the community or improvement in health outcomes. Therefore, he called on senators to work with consumers to identify opportunities to reduce waste across the system.

Present at the debate were a range of experts from across the health services, health service boards, universities, community and primary care and from government and non-government agencies.

Aim

The aim of the day was to hear from the collective voice of clinicians to:

- a) discuss strategies for waste reduction; and
- b) determine recommendations for system change.

Process

Prior to debate, attendees received a list of pre-reading to inform them on background to the topic of the upcoming debate.

The debate included several keynote addresses which set the context for debate and informed discussion. During the plenary session expert witnesses provide additional information including insight into what is happening locally, nationally and internationally as well as considering the consumer perspective.

Working groups then determined practical strategies for change in four key areas and recommendations for both the Director General as System Manager and Health Service Boards.

The full program and list of presenters and expert witnesses are provided in Appendix 1 and Appendix 2. Presentations from the day can be found on the Clinical Senate website: <http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia>

Report in full

Presentations

Welcome and Chair's address

Ms Robyn Collard, a Nyungar elder, opened the session and offered a Welcome to Country.

Ms Tanya Basile, Chair of the Clinical Senate, introduced the topic and stated the debate Waste Not: Want Not was the last in a series of three debates considering how clinical practice impacts on expenditure and how we can better manage the costs associated with healthcare delivery into the future.

She challenged senators to identify areas of waste across their health services and to make practical suggestions for change. The aim of the day was to develop policy recommendations designed to address waste in four areas: transition in care, environmental, implementation science and clinical practice.

In closing, Ms Basile reminded participants that the Clinical Senate operates on Chatham house rules. Feel safe to ask about any aspect of this topic and to state your opinions freely. Challenge respectfully, enquire earnestly and learn and share your experiences – this, she stated, is how we grow.

Director General's Response

The DG of the WA Health Department (DoH), Dr David Russell-Weisz reported back on the outcomes from the previous debate at which senators considered priorities and identified metrics for system change to inform the SHR. He thanked senators for their contribution which he stated, "had significantly contributed to both the interim and final reports".

He spoke briefly on the review of the Senate being conducted by the Nous Group and indicated it would consider the future role and operations of the Senate under the new governance structure. The DG informed senators that a survey considering the role and impact of the senate would be sent to all members and alumni. He encouraged senators to complete the survey and take part in focus groups for the review.

The DG introduced the Waste Not: Want Not debate and highlighted that sustainability is about safety, quality and better patient experience as well as clinical and financial performance. The DG reminded senators that the growth in the cost of healthcare has not been accompanied by an equivalent increase in services to the community or improvement in health outcomes. Therefore, he called on senators to work with consumers to identify opportunities to reduce waste across the system to enable reinvestment in necessary health care.

He requested that outcomes be considered across the spectrum from prevention through to clinical work, where every clinical decision is also a resource decision. He asked that Senators reflect on areas of significant waste, locations of services, bi-products of waste where more energy efficient practices are required, and opportunities to improve clinical efficiencies across the system.

He called on senators to consider the criteria required to identify low value services and determine how to best engage consumers and clinicians around changes.

Executive Sponsor, Dr James Williamson, Assistant Director General, Clinical Excellence Division, DoH provided the opening talk "Waste: from bench to bedside" to set the scene for debate. Citing the SHR, he stated health costs have tripled in the last 10 years, increasing \$3 billion to 6 billion. WA public hospital costs are 20% more than the national average for public hospitals which significantly impacts on the WA State debt. He outlined that there were

several keys to a sustainable future as outlined by the SHR; patient first, value for money, healthy lifestyles, partnerships across sectors, technology and improvement. He also noted that there is opportunity for improvement in the reduction of waste. He asked participants to help understand and appreciate the extent of wastage across the health system and identify priorities for change. Referring to prevalence of waste in research, Dr Williamson shared evidence that over 50% of scientists believed their research was not reproducible and many medical and clinical research studies could not be replicated.

Dr Williamson spoke of fraud in research which, although rare, could be very wasteful and expensive when it occurred. Trial design, publication bias, governance, priority setting and suboptimal research impact were also key facets of waste in research. Dr Williamson highlighted by way of contrast that WA has been a world leader in maximising data linkage and other innovative research approaches which has created significant research value. He emphasised the need to involve patients early on in the prioritisation and development of research agenda and that there is a need for pre-linked data and improved governance over ethics processes.

Dr Williamson next considered aspects of patient care leading to waste, citing adverse events which can lead to very expensive legal claims, prolonged stays in hospital and remedicalisation. He raised the issue of over treatment and over diagnosis using the example of management of cancer patients and reflected on how efforts in the United Kingdom (UK) to reduce the use of procedures for which there was little evidence, were met with public backlash. He contrasted this with evidence of clinical improvement in areas of under diagnosis and under treatment of certain conditions such as sepsis.

Finally, he referenced Realistic Medicine (UK), a movement which considers shared decision making, building a personal approach to care, managing risk better, reducing harm and waste, reducing unnecessary variation in practice and outcomes, and the need for clinicians to become improvers and innovators.

Dr Williamson identified several models which can be used to inform change. A unified modelling approach of data, Intensive Healthcare, showed promise in reducing waste.¹ Other models mentioned included the concept of a 'learning health system' (LHS) and the Collaborative for Healthcare Analysis and Statistical Modelling (CHASM) work being undertaken at the University of Western Australia (UWA) led by Dr Alistair Vickery and Dr David Whyatt. The CHASM's vision is to improve access to appropriate health care, improve equity in health, and optimise health outcomes employing more systematic ways to enable clinicians to learn from mistakes and providing feedback with real-time data.

He concluded his presentation by challenging senators to consider "What can you do?"

Dr Matthew Anstey, Intensivist, Sir Charles Gairdner Hospital and Chair, Advisory Group, Choosing Wisely Australia highlighted opportunities for reducing waste in healthcare.

In opening his talk he spoke of the principles of value-based health care delivery which has the overarching goal in health care is improving health outcomes for the patient, and should not focus on access, cost containment, convenience, or customer service.

He then addressed why waste matters and gave some examples of waste:

- By products of health care
- Unnecessary administrative complexities e.g. navigating between public and private health care systems, hospital based care versus community care
- Fraud
- Duplications of services; and

¹ Buchan I, Winn J, Bishop C. A unified modeling approach to data-intensive healthcare. 2009. In: The Fourth Paradigm [Internet]. Washington: Microsoft Corporation, [cited 16 March 2018]; 91-7. Available from: https://www.microsoft.com/en-us/research/wp-content/uploads/2016/02/4th_paradigm_book_part2_buchan.pdf

- Inappropriate investigations

Dr Anstey spoke about the national initiative [Choosing Wisely Australia](#) which is aimed at:

- Starting a national conversation about tests, treatment and procedures that provide no benefit to the patient and in some cases may cause harm
- Focusing on high quality care, and supporting conversations between the consumer and clinician
- Basing services on the best available evidence and what care is truly needed.

Dr Anstey presented the Australian perspective noting the following:

- There is a problem with over testing (82%)
- Medical practitioners have a responsibility to help reduce over testing (94%)
- There is considerable demand from consumers for unnecessary testing
- Medical practitioners believe they have influence in reducing over testing (91%)
- More than half of practitioners 'often' discouraged patients to request tests they think are unnecessary (56%)

He described that the issues with over testing is that not all tests add value and they can expose the consumer to undue risk of harm; as well as the unnecessary cost to the health system and the patient. It was noted that often unnecessary tests are occurring as they have become part of a routine group of tests.

Dr Anstey then shared a range of Australian and local examples of waste reduction projects and practices. He also shared several international examples of evidence based change. Successful projects can be noted to focus on local implementation, are clinician led and have a commitment to implementation and evaluation.

Important considerations for an organisation when adapting programs to reduce waste in health include:

1. Make sure the initiative is relevant to your business
2. Identify the costs of the program
3. Consider existing constraints to implementation
4. Align activity with clinical standards
5. Determine how to change patient and clinical behaviours within the constraints of a work day
6. There is a need for champions as well as project support staff
7. The importance of continued measurement using a variety of available measures (manual, finance, activity)
8. The importance of partnering with finance units

Consumer involvement

Dr Anstey stated there is a national movement supporting both consumers and clinicians to have a conversation about what is appropriate care. Five questions have been identified for consumers to ask their doctor:

1. Do I really need this test or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?
5. What are the costs?

Dr Anstey closed by challenging senators to consider how to choose the right range of tests for patients and how to manage patient's expectations.

Ms Pip Brennan, Executive Director, Health Consumers' Council WA addressed the consumer and carer view with regard to waste reduction. She then highlighted the importance of moving from clinician led to consumer and clinician co-led care to reduce waste across healthcare delivery. Throughout her talk she emphasised the importance of listening to and learning from patient stories.

Ms Brennan spoke of the Clinical Senate as a place for change and suggested that early engagement with consumers would reduce resistance at a later point. Referencing Mark Jaben at the [School for Change Agents](#) and the science behind resistance she stated, there are many barriers to change but in terms of this senate debate, the one that gets to the heart of the issue, is when do we engage?

Ms Brennan spoke of 'reactance' which is the instantaneous reaction to being told what to do. It is the "unpleasant motivational arousal that emerges when people experience a threat to or loss of their free behaviours."² This is what happens when choice is removed, people react to the change that affects them and is often referred to as resistance. Resistance can be mitigated if more consideration is given to who you involve and when.

Ms Brennan shared her opinion of Choosing Wisely Australia as a potential enabler for change through its clinician-led and consumer-centred approach. She suggested that the focus of engaging clinicians and other health professionals to lead the initiative is what sets Choosing Wisely apart from other quality improvement campaigns.³

Citing the ABC Four Corners media report *Wasted*⁴ she shared several stories demonstrating there is the genuine need to provide a range of patient experiences and stories of concern about waste in the system. These stories confirmed that most consumers do not understand enough about health care waste and ineffective procedures to make an informed choice. She acknowledged that patient expectation often leads to the need to be referred on for specialist services and/or additional tests.

She identified that WA Health's platform [Patient Opinion](#) is assisting patients using our health service to tell their story. Ms Brennan stated that Patient Opinion uses the power of stories to create an impetus to make things better and to drive change when needed. She shared several stories from Patient Opinion that reflected issues related to cost, poor care, inappropriate testing and in one instance referral to inappropriate care. Alternatively, some stories demonstrated public understanding of, and sensitivity to, the constraints that health services are constantly under. The website can assist us to consider not only how we treat people but to understand their journey, and how to improve delivery of care and services across our health system. She emphasised that many of these stories do lead to positive change.

She closed by suggesting that community leaders need to be activated to influence others and to drive change. She shared this final thought from the School for Change Agents which estimates that it only takes 3% of people in the organisation or system to influence 85% of the other people.

Plenary

The plenary session was opened with a presentation from Dr Stephen Duckett, Director of Health Programs, Grattan Institute who shared some of his extensive research in reducing

² Steindl C, Jonas E, Sittenthaler S, Traut-Mattausch E, Greenberg J. Understanding psychological reactance: New developments and findings. *Zeitschrift fur Psychologie / Journal of Psychology* 2015;223:205-14.

³ Choosing Wisely Australia. Join the conversation: Promoting better conversations about the appropriate use of medical tests, treatments and procedures. [Internet]. 2017 [cited 16 March 2018]. Available from: <http://www.choosingwisely.org.au/getmedia/042fedfe-6bdd-4a76-ae20-682f051eb791/Choosing-Wisely-in-Australia-2017-Report.aspx>

⁴ Four Corners. Wasted: the unnecessary testing and treatments choking the health system and making patients ill [Internet]; 2015. [cited 16 March 2018]. Available from: <http://www.abc.net.au/4corners/wasted-promo/6804372>.

waste in healthcare systems and also challenged clinicians to consider how to champion the change of evidence based practices.

He criticised a culture in medicine called “tribal practice” where we have the power to dismiss data, peer review and consumer feedback.

The Q&A session with Dr Duckett focused around driving change and included the following highlights:

- Consider if the culture is right when we are paid for what we do and not for the outcome; we reward long waitlists without reviewing practice; we have the threat of penalties but we are yet to see penalties defined or enforced
- Accreditation without the use of patient surveys, public opinion, and public reporting is less valuable
- We must consider how to publicly display, respond to, and manage clinical variation
- Consider the measures that are relevant to clinicians
- All measures should be replicable
- Invest in innovation if you want to drive change
- Provide continuous feedback and transparent analysis to staff on performance and clinical outcomes
- Transparent review of hospitals and services by using independent reviewers
- Importance of measuring performance using indicators which are relevant to clinicians

His closing comments were that implementing changes is not easy and do not underestimate the challenges. Change requires a change in behaviour of both clinicians and consumers. There is a need for brave ideas, to be hungry for change and not be complacent, risk averse or apathetic.

Plenary discussion

A broad range of experts participated in this session providing additional insight into other initiatives across the health services and identified areas of opportunity for change.

Throughout the discussion clinicians identified issues that fell into two categories: the waste of time for clinicians and patients and the waste of money for both patients and the system.

Waste of time related to:

- Inefficient systems
- Location of services
- Poor understanding of expectations
- Duplication of mandatory training
- Poor infrastructure and obsolete technology
- Disconnected care
- Poor use of data linkage
- Increased length of stay as a result of hospital acquired complications

Waste of money:

- Variation in care
- Hospital acquired complications or injury
- Overuse of diagnostic testing and prescribing
- Poor product knowledge
- Poor product management
- Underutilisation of full scope of practice

- Inability to translate research into practice

To enable change to occur it was highlighted that there needed to be champions for change, metrics to identify low value services and better use of technology. There was strong support for accountability for waste reduction through the use of key performance indicators, targets for waste reduction, waste audits and publically reported benchmarking.

Clinicians identified the following areas for change:

Transition in care:

There is the need to establish the value chain to ensure the right care, to the right people, at the right cost.

This could include:

- Improving access to information will reduce the waste due to: error, time and duplication of tests
- Establishing common patient identifiers
- Enhancing care coordination
- Sharing records between public, private and community

Environmental:

Every decision you make is a resource decision.

To reduce environmental impacts there is the need to:

- Focus on reducing single use items to reduce the environmental impact
- Share practical examples around reuse, recycle or repurpose across health services
- Rotate or redistribute stock in accordance with the use by dates
- Measure environmental waste through waste reporting

Clinical Practice:

Every decision you make has a cost.

This could include:

- Identifying variations in practice by using open and transparent measures of clinical practice performance to drive change
- Adopting the principles of Choosing Wisely
- Using the Antibiotic Stewardship model and applying these principles to diagnostic stewardship
- Embracing the practice of determining goals of care
- Addressing the impact of privacy laws on practice
- Reviewing the value of outpatient services and transfer care as appropriate (e.g. GP, specialist or patient)
- Partnering with consumers to improve health literacy around the value and cost of treatment
- Identifying areas where small investments can lead to large savings both at local sites and system wide
- Displaying the cost of items, tests and diagnostic procedures so that clinicians can make an informed choice

Implementation Science:

The value of bench top research must be measured at the point of translation at the bedside (better decisions at point of care).

This could be achieved by:

- Providing evidence based practice while managing patients' expectations of their care
- Establishing more visible benchmarking of data to effect change
- Analysing data at the ward level and in real time
- Investing in research outputs by designing and measuring the uptake in clinical practice
- Providing leadership and capacity support to deal with identified examples of clinical variation
- Ensuring robust research governance to reduce research fraud
- Using evidence to match the health workforce to State's needs (e.g. generalists vs. super specialists)
- Ethics and research committees to ensure that any approved research should have potential benefits to patients

Working groups

The senators broke into small working groups in order to develop recommendations for waste reduction in the four key areas. The working group session used a combination of GroupMap technology and the Senate voting paddles to decide on the top recommendations. The notes from each group can found at Appendix 3.

Senators developed nineteen recommendations with the top 16 ranked put forward to the DG and HSBs for consideration.

Closing remarks

The Senate Deputy Chair, Dr Jeanette Ward, shared her take away messages in closing the debate for the day. She highlighted that the key challenges for sustainable health reform were design and structure, ensuring dynamic flows of meaningful data and information from those who have it to those who need it to make decisions. Every Senator can lead this movement in their workplace. She encouraged everyone to take these lessons back to their workplace. Clinician engagement is key to change. There is no need to wait for permission to redesign for impact.

Executive Sponsor, Dr James Williamson summarised the day highlighting key points. These included issues related to the waste in out-of-date outpatient systems. He lauded models in eastern states where consumers and GPs are driving reform. He stressed the importance of early engagement with consumers with co-led initiatives leading to improved outcomes. Finally, he called on clinicians to consider how their practices waste not only their time but that of consumers.

In addressing environmental waste, Dr Williamson supported immediate local action as there was no lack of strategies for each of us to change our practices. He highlighted Choosing Wisely, the impact of shared decision making and the importance of end of life conversations as important components in the waste debate. He recognised that implementation was difficult and there was the need for investment in a better WA model to expand capability in this area.

Dr Williamson reminded Senators of the importance of data to inform decision making as a necessary component, stressing the need for data to be more readily available. Data must also be used more sensibly and shared more broadly, in a useful format that is easily understood.

Finally, there was the need to prioritise how strategically to determine "the best bang for the buck". The DoH and Health Service Providers must work together and identify mutual future priorities. He closed as he opened by asking senators to consider what they could do and to act.

Conclusion

The wealth of information produced on the day was synthesised by Senators to form sixteen recommendations. They will be presented to the Director General and Health Service Provider Boards for consideration and action.

Clinicians are in a unique position to play a significant role in driving change that reduces waste across health practices; waste reduction that impacts on our environment and evidence of waste identified by consumers of health care services.

The recommendations that follow outline practical actions and key strategies to tackle waste across our health services.

In conclusion, the three recent Senate debates have highlighted common themes of the value of clinician engagement to champion change that will lead to a system that is not only sustainable into the future but also educated in the value of reducing harm to people and the planet!

Clinical Senate Recommendations

That the System Manager:

Transition in Care

1. Reviews privacy settings limiting access to patient care information which is vital for acute care decision making e.g. PSOLIS access in ED.
2. Implements a population wide media campaign to the Choosing Wisely 5 questions across all healthcare sites. <http://www.choosingwisely.org.au/resources/consumers/5-questions-to-ask-your-doctor>
3. Develops a care coordination framework that includes the use of digital health technologies by 2020.

Environmental

4. Produces a benchmarked report annually across hospitals for key waste areas and makes the report publically available.

Clinical Practice

5. Based on the success of the Antimicrobial Stewardship in reducing associated cost and harm, reviews opportunities to develop a similar program aimed at Diagnostic Stewardship by 2019.

Implementation Science

6. Undertakes an economic analysis to consider the implications for quality of care, cost effectiveness and health outcomes of a super specialist vs generalist comparison model to meet future workforce needs.
7. Acknowledges the current limitations of HealthPoint and develops a more efficient way for clinicians to access evidence-based guidelines and promote sharing of ways to increase evidence uptake.

That Health Service Boards:

Transition in Care

1. Conduct a review of outpatient service models to identify opportunities for improved system efficiencies. Areas of consideration should include: opportunities for care closer to home using alternative workforce models and telehealth service options.

Environmental

2. Implement barcoding with pricing to facilitate stocktaking, rotation of stock close to expiring and financial awareness among staff.
3. Work with the System Manager to implement integrated electronic records in order to reduce paper waste by 20% each year.

Clinical Practice

4. Implement and support Choosing Wisely.
5. Ensure that early conversations are undertaken with patients and family regarding goals of care and future treatment decisions/preferences. This should include the provision of information about prognosis and end-of-life care planning. These conversations will be formally documented by patients in an Advance Health Directive (MR00H) /Advance Care Plan (MR00H.01) or by clinicians in a Goals of Patient Care Summary (MR00H.1), and communicated within the discharge summary (and uploaded to My Health Record).

Regular audits to determine compliance with the Advance Care Planning Policy, as it relates to the formal use of Advance Health Directives (MR00H) and Goals of Patient Care Summary (MR00H.1). This can be achieved through an increased uptake measured by explicit incremental percentages that are agreed with Health Service Boards every year.

6. Ensure where specialties are required to contribute to a state or national database, variations in practice above the 90th centile are reflected to the contributing specialty for validation. When there is a validated variance above the 90th centile, the contributing specialty has a responsibility to report an action plan to their corresponding health service board to address any validated variance.

Implementation Science

7. Develop an opt out system for the sharing of patient medical records / information to all relevant healthcare providers.
8. Invest in Units of Innovation targeted to reduce waste and openly share outputs across the system.
9. Ensure that all staff has allocated work time to examine safety and quality issues. The areas for innovation are determined by the organisation's strategic plans.

Appendices

Appendix 1: Program

Waste Not: Want Not

Friday 16 March 2018
Fraser's Function Centre, 60 Fraser Avenue
Kings Park, Western Australia

7:45am – 8:30am	Registration	Tea & coffee		
8:30am – 9:35am Presentations				
Executive sponsor:	Dr James Williamson, Assistant Director General, Clinical Excellence Division			
Facilitators:	Mr Bevan Bessen and Mr Will Bessen			
8:30am	Welcome to Country	Ms Marie Taylor		
8:35am	Senate update	Ms Tanya Basile		
8:45am	Director General's response - SHR metrics for change	Dr David Russell-Weisz		
8:55am	Waste: from bench to bedside	Dr James Williamson		
9:10am	Models for reducing waste in healthcare	Dr Mathew Anstey		
9:25am	Waste Not: Want Not – Consumer View	Ms Pip Brennan		
9:35am – 10:00am	Morning tea			
10:00am – 12:15pm Plenary				
10:00-10:20	Introductory talk – Dr Stephen Duckett			
10:20-10:40	Q&A			
10:40-12:15	Discussion and debate			
Additional Expert Witnesses	Professor Fiona Wood, Professor Kingsley Faulkner AM, Dr Oliver Waters, Mr Troy Palmer, Dr Jodi Graham, Professor Suzanne Robinson, Dr Frank Jones, Dr Jacquie Garton-Smith, Clinical Associate Professor Susan Benson, Associate Professor Alistair Vickery, Dr Ian Dey, Dr Sue Taylor, Ms Stephanie Dowden, Dr Audrey Koay, Ms Amanda McKnight, Dr Tim Inglis, Dr Marianne Wood, Mr Richard Jarvis, Dr Damien Wallman and Mr Nicholas Coulter.			
Invited Guests	Ms Deborah Karasinski, Ms Yvonne Parnell and Dr Neale Fong.			
12:15pm – 1:00pm	Lunch			
1:00pm - 2:40pm Working Groups				
	Group 1 Transition in Care	Group 2 Environmental Waste	Group 3 Implementation Science	Group 4 Clinical Practice
2:40pm – 3:00pm	Afternoon tea			
3:00pm - 3:30pm Final Session – Voting and next steps				
3:00pm	Discussion and voting on recommendations			Bevan Bessen and Will Bessen
3:15pm	Closing remarks			Dr James Williamson
3:25pm	Deputy Chair's summary			Dr Jeanette Ward
3:30pm	Close			

Appendix 2: Presenters and Expert Witnesses

- Ms Robyn Collard, Nyungar Aboriginal Elder
- Ms Tanya Basile, Chair, Clinical Senate of Western Australia
- Dr David Russell-Weisz, Director General , Department of Health WA
- Dr James Williamson, Assistant Director General, Clinical Excellence Division, Department of Health WA
- Dr Matthew Anstey, Intensivist, Sir Charles Gairdner Hospital and Chair, Advisory Group, Choosing Wisely Australia
- Ms Pip Brennan, Executive Director, Health Consumers Council WA
- Dr Stephen Duckett, Director of Health Programs, Grattan Institute, VIC
- Professor Fiona Wood AM, Head of State Burns Centre, Fiona Stanley Hospital
- Professor Kingsley Faulkner AM, Chair, Doctors for the Environment Australia and Board Member, East Metropolitan Health Service Board
- Dr Oliver Waters, Gastroenterologist, Fiona Stanley Hospital
- Mr Troy Palmer, Senior Policy Officer, Perth Children’s Hospital Project
- Dr Jodi Graham, Medical Co-Director, Planning and Evaluation, Department of Health WA
- Professor Suzanne Robinson, Theme Leader for Health Systems and Health Economics, School of Public Health, Curtin University
- Dr Frank Jones, General Practitioner, Murray Medical Centre
- Dr Jacquie Garton-Smith, Hospital Liaison GP, Royal Perth Hospital
- Clinical Associate Professor Susan Benson, Consultant Clinical Microbiologist, Infectious Diseases Physician, PathWest, Fiona Stanley Hospital
- Associate Professor Alistair Vickery, Head of General Practice, The University of Western Australia
- Dr Ian Dey, Emergency Physician, Fiona Stanley Hospital
- Dr Sue Taylor, Clinical Head, Department of Surgery, Osborne Park Hospital
- Ms Stephanie Dowden, Director, NursePrac Australia
- Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, Department of Health WA
- Ms Amanda, McKnight, Nurse Co-Director, Sir Charles Gairdner Hospital
- Dr Tim Inglis, Microbiologist, PathWest, QEII Medical Centre
- Dr Marianne Wood, Public Health Medical Officer, Aboriginal Health Council of Western Australia
- Mr Richard Jarvis, Manager, Patient Support Services, Royal Perth Bentley Group
- Dr Damien Wallman, Anaesthetist, Sir Charles Gairdner Hospital
- Mr Nicholas Coulter, Senior Clinical Planner, Child and Adolescent Mental Health Service
- Ms Deborah Karasinski, Chair, Child and Adolescent Health Service Board
- Ms Yvonne Parnell, Board Member, South Metropolitan Health Service Board
- Dr Neale Fong, Chair, WA Country Health Service Board

Appendix 3: Working Group Session Notes

Clinical Senate of WA Waste Not, Want Not Friday, 16 March 2018

Overview

Clinical Senators and invited Expert Witnesses attended a Clinical Senate event on Friday, 16 March 2018 at Fraser's in King's Park.

The focus of the Senate was 'Waste Not, Want Not' with participants exploring the following four areas of waste in the health system:

- Transition in care
- Implementation science
- Clinical practice
- Environmental

This Report captures the outputs of the Working Group session.

Process

The Working Group sessions used a combination of GroupMap technology and the Senate voting paddles to determine the top recommendations.

The process steps for the Working Groups session were:

1. Participants formed eight self-selecting groups focused on one of the four waste areas and discussed the topic to form recommendations, inputted by a digital scribe via GroupMap
2. Participants broke into smaller pairs or triads with a device to reflect across all four areas, adding comments to any existing recommendations and allocating 3 'likes' in each area for the recommendations they deemed critical.
3. Participants reformed in their original groups to reflect on the top 'liked' recommendations in their topic area and note any duplication for the facilitators to consider prior to paddle voting.
4. The Senators voted across a set of 19 recommendations (compiled from the 5 -6 top 'liked' recommendations in each topic).

The full dataset for each Working Group session topic area is captured in the following pages. This includes the key themes emerging from each group as well as the small group input and commentary.

WORKING GROUPS SESSION

Transition in Care

Key Themes

The key themes for transition in care were:

Theme	Reference to Table Below
The System Manager and HSPs working together to deliver care closer to home through an updated care coordination framework and outpatient model including WACHS regional coordination	Points 4, 6, 7, 11 and 12
Access to a comprehensive patient electronic health record for all practitioners at the point of care, including assistance from the System Manager to review privacy settings to patient care information	Points 1, 3, 8 and 14
Promotion of Digital and Telehealth plus a review of Medicare benefits to ensure greater uptake	Points 5 and 9
System Manager implements a population wide media campaign to encourage client self-management programs of acute and chronic disease including education and advocacy and use of Choosing Wisely 5 questions	Point 2
Focus on youth and adolescent transitions , including incorporating transition aspects of the WA Youth Health Policy into HSP Service Level Agreements	Points 10 and 13

Detailed Group Work- Transition in care

The input and commentary from small groups is included below in detail.

Title	Comments
What are your recommendations for reducing waste in TRANSITION IN CARE?	
1. Clinicians within WA health sites and public/private partnership hospitals including EDs should be able to access my health record and all investigations (completed within WA Health or Primary Care) at the point of care at all times.	<ul style="list-style-type: none"> ▪ Including Public private partnerships ▪ Includes pathology and radiology and all investigations and all discharge summaries etc. ▪ All WA health sites should implement IT systems to allow interface with MyHR. ▪ Seems absurd that clinicians can't access this presently
2. System Manager implements a population wide media campaign to encourage client self-management programs of acute and chronic disease including education and advocacy and use of Choosing Wisely 5 questions	<ul style="list-style-type: none"> ▪ Need patients to be aware of 5 questions as a way of increasing discussion with their health providers and setting patient expectation that doing nothing maybe more advantageous than doing something.
3. DOH WA to review privacy settings limiting access to patient care information which is required for acute care decision making (e.g. PSOLIS access in ED)	<ul style="list-style-type: none"> ▪ Privacy should not trump optimal clinical care ▪ Policy and legislation to implement comprehensive patient centred health record at point of care ▪ Across private and public sectors ▪ There are other recommendations relating to this one we also like in relation to sharing / access to information but have only 'liked' this one
4. The System Manager and HSPs working together to deliver care closer to home needs to be properly actioned by: <ul style="list-style-type: none"> ▪ Supporting a rural generalist model ▪ Moving non-tertiary care to secondary sites ▪ Chronic disease management move to primary care. ▪ Investment in primary prevention. ▪ Promoting all clinicians to work to the top of their scope of practice, especially Allied Health Professionals and General Practitioners. 	<ul style="list-style-type: none"> ▪ Broadening from medical models ▪ Ensuring ongoing access to clinical expertise in nursing and allied health sectors ▪ Awareness of costs applicable to patient before moving patient to secondary sites on discharge ▪ Use primary and secondary care more effectively to stop loading tertiaries ▪ Move generalist procedures to secondary care (e.g. fracture NOF, laparotomies etc.)
5. Digital Health including Telehealth and wearable device should be promoted as a care coordination / transition of care solution across Metro and WACHS areas	
6. HSPs to increase access to care coordination and navigation for clients with complex needs throughout the patient journey (IP, OP & Primary Care)	<ul style="list-style-type: none"> ▪ Includes transition from paediatrics to adult services
7. HSPs update outpatients model to urgently apply best practice to include more consumer centred community based care including use of telehealth, nurse practitioners, GP, Medical Specialists Allied health, AHP with establishment of new models by mid 2019	<ul style="list-style-type: none"> ▪ Support this if the outpatient waiting list is reduced by redirecting patients ▪ Needs further exploration

8. HSPs to prioritise access to and implementation of a comprehensive patient electronic health record for all practitioners.	<ul style="list-style-type: none"> ▪ As per my health record ▪ Between public and private, and secondary and primary healthcare.
9. System manager to review current Medicare benefits across the private and public sector to increase uptake of Telehealth services.	<ul style="list-style-type: none"> ▪ Commonwealth issue. ▪ And for virtual clinics where surveillance is required, but the patient is not necessarily needing to be seen in person.
10. WA Health to incorporate transition aspects of the WA Youth Health Policy into HSP Service Level Agreements to ensure accountability and uptake of the policy across WA.	
11. WACHS to implement a coordinated centralised transport and clinical expertise service for regional clients	<ul style="list-style-type: none"> ▪ Needs to be regionally based and regionally decided due to regional differences
12. Develop a care co-ordination framework that provides a scaffolding for all activities related to care co-ordination and transition of care across sectors	<ul style="list-style-type: none"> ▪ This would include practical tools and education resources
13. HSPs and partners to promote further linkages into adolescent primary health providers	<ul style="list-style-type: none"> ▪ This might link up well with the comment re WA Youth Health policy
14. WA Department Health should explore the use of unique patient identifiers to cover multiple sectors	<ul style="list-style-type: none"> ▪ i.e. one unique number across all WA

Implementation Science

Key Themes

The key themes for implementation science were:

Theme	Reference to Table Below
Health services work together to develop a common useful set of relevant quantitative indicators for waste to promote benchmarking and competition plus cultural change initiatives required	Points 3, 5, 6, 13, 14, 15 and 16
System Manager to develop a more efficient way for clinicians to access evidence-based guidelines and promote sharing of ways to increase evidence uptake	Points 1, 8, 9 and 17
Health Service Providers have an opt out system for the sharing of patient medical records and information to all healthcare providers within 12 months	Point 2
WA Health recognises that an excess of super-specialities compared with generalists able to work at independent comprehensive practice is not sustainable and therefore undertake supply / demand analyses and match a workforce to the State's needs . Plus reconsider the wasteful approach to system-wide standardised mandatory training, credentialing, HR	Point 4 and 7
Grants for research conducted in WA Health system must have a research plan for transfer of the arising evidence into a systematic review and promotion of evidence-based practice within a specified timeline and scalable across the system	Points 10, 11, 12 and 18

Detailed Group Work- Implementation Science

The input and commentary from small groups is included below in detail.

Title	Comments
What are your recommendations for reducing waste in IMPLEMENTATION SCIENCE?	
1. WA Health recognises the limitations of HealthPoint currently and requires HSS to develop a more efficient way for clinicians to access evidence-based guidelines and promote sharing of ways to increase evidence uptake within 6 months	
2. Health Service Providers have an opt out system for the sharing of patient medical records and information to all healthcare providers within 12 months	
3. WA Health create a working party to explore inventive ways to introduce or adapt financial incentives for outcomes rather than activities including models of care and hospital pathways	
4. WA Health recognises that an excess of super-specialities compared with generalists able to work at independent comprehensive practice is not sustainable and therefore undertake supply / demand analyses and match a workforce to the State's needs. This requires the health department to negotiate with training colleges.	<ul style="list-style-type: none"> ▪ Consider substitution models whereby other professional groups can be used more efficiently (e.g. Allied Health led clinics). ▪ Promote all professions working to their full scope of practice
5. The system manager investigates a mechanism to use advanced analytics to identify trends and patterns across multiple large data intakes.	<ul style="list-style-type: none"> ▪ Better resourced Business Intelligence Units with robust linkages and partnerships with Patient Safety & Quality / clinical champions / QI projects enabling user-friendly data reporting. ▪ Allocation more of business intel resources to clinical performance improvements vs financial monitoring.
6. Health services work together to develop a common useful set of relevant quantitative indicators for waste to promote benchmarking and competition.	
7. WA Health adopts a less wasteful approach to system-wide standardised mandatory training, credentialing, HR etc. and ensures the IT systems enable this	
8. HSP's ensure that all staff have allocated work time during the week to examine safety and quality issues with the areas for innovation determined by the organisation's strategic plans.	
9. The system manager has a formal process for education and training of clinical staff on the implementation of published clinical guidelines and evidence based recommendations.	<ul style="list-style-type: none"> ▪ Implement systems to make clinicians accountable ▪ Also make administration accountable to promote adequate resourcing

10. Grants for research conducted in WA Health system must have a plan for transfer of the arising evidence into a systematic review and promotion of evidence-based practice within a specified timeline and scalable across the system	
11. HSP executives direct researchers to have an implementation plan for their research findings.	
12. Health service ethics committees and research governance committees ensure that any research approved should have potential benefits to patients.	
13. WA Health adopts and adapts the IHI Waste Framework to develop a tool to enable facilities to measure and act to reduce (as frequently as appropriate) their waste in three dimensions: clinical, operational and administrative. WA Health enables new approaches to reduce waste in each of these three dimensions (admin waste: produce a cost calculator; ensure meeting rooms without chairs; hold meetings close to patient care; reward committees who meet their KPIs etc.)	<ul style="list-style-type: none"> ▪ A number of these should be joined re accountability, targets and cultural change to waste
14. WA Health develop a system and culture that requires waste to be reported as an adverse event.	
15. WA Health invest in a scheme to produce leaders from all disciplines at every level who will champion waste action	
16. WA Health to have a central innovation hub that responds to "prioritisation / needs" for WA health, and pushes project teams out to sites to implement.	
17. The system manager have a mechanism for staff on the coalface to challenge and offer comments to department published clinical guidelines and evidence based recommendations.	
18. Health services promote current available structured training in conducting research to all clinical staff (i.e. allied health, nursing and medical)	

Clinical Practice

Key Themes-

The key themes for clinical practice were:

Theme	Reference to Table Below
The goals of care , including end of life care where appropriate, should be discussed (and documented) at every major touch point of patient contact during the provision of healthcare.	Points 3 and 4
Choosing Wisely to be implemented and supported universally within HSPs	Point 1
Specialties reporting against variances in practice and action planning to address any validated variance	Point 2
Monitor unnecessary Pathology and Radiology against diagnostic guidelines	Points 5 and 10
Consumer driven advocacy regarding privacy of patient information and access to an electronic medical record	Points 6 and 8
Developing policy and practice guidelines on the basis of contemporaneous and broad based shared data	Points 7, 13 and 15
Review of outpatient services and adherence to clinical pathways for top 5 DRGs	Points 9, 12 and 14

Detailed Group Work- Clinical Practice

The input and commentary from small groups is included below in detail.

Title	Comments
What are your recommendations for reducing waste in CLINICAL PRACTICE?	
1. Choosing Wisely to be implemented and supported universally within HSPs	<ul style="list-style-type: none"> ▪ HSP's endorse choosing wisely and provide financial and FTE resources to embed this over the next 2 years ▪ All health service boards, implement the Choosing Wisely Program across their health services by 2019
2. Where specialties are required to contribute to a state or national database, variations in practice above the 90th centile are reflected to the contributing speciality for validation. When there is a validated variance above the 90th centile, the contributing specialty has a responsibility to report an action plan to their corresponding health service board to address any validated variance.	<ul style="list-style-type: none"> ▪ Need someone to be designated as the "policeman" ▪ The offending department would likely be disconnected from practise guidelines. Offer both the carrot and the stick as a solution. ▪ Open communication, clinicians need information about their own practice. Part of clinical improvement and reflective practice ▪ Relies on the availability of feedback from existing mandatory reporting databases ▪ Who has responsibility, and accountable to whom?
3. The goals of care, including end of life care where appropriate, should be discussed (and documented) at every touch point of patient contact during the provision of healthcare.	<ul style="list-style-type: none"> ▪ Burden of process outweighs benefit. Need pragmatic application vs mandated in all contexts ▪ Every <i>major</i> touchpoint... I just want to enjoy my breakfast in peace. ▪ Needs to be done in clinic before an operation as by the time patients come into hospital or have a complication it is too late to discuss this! More use of Advanced Care Directives and public education of the existence of these with GP's to be empowered to start this discussion with patients and family. ▪ Expectation vs realistic expected outcome ▪ Measurement: "The health service provider regularly audits the compliance with policy related to the documentation of goals of patient care and advance health care directives in x % per annum."
4. Early conversations with patients and family regarding goals of care, including prognosis and end of life planning	<ul style="list-style-type: none"> ▪ Starting in primary care ▪ This will need further development regarding its measurability (and other SMART) characteristics. ▪ These can also serve as an opportunity to identify and flag patients likely to develop complex needs within the system earlier rather than at the end stage, so that care can be planned and co-ordinated including community and hospital.
5. Pathwest to produce and agree on guidelines for pathology testing and HSPs to take responsibility for overseeing compliance in	<ul style="list-style-type: none"> ▪ Traffic lighting system to assign levels of authority of requesting particular tests (e.g. more complex and expensive tests need to be

requesting	signed and reviewed by a consultant).
6. The clinical senate promotes a consumer action to drive the process of reviewing the Privacy Act as it applies to healthcare.	<ul style="list-style-type: none"> ▪ That the System Manager address the increasing fragmentation in patient information by legally mandating the sharing of patient information across HSP's. ▪ Specifically, that the current state of conservative sharing of patient information is prohibiting good clinical care in many cases.
7. All policies that are endorsed by a HSP should be publically accessible, both through WA health, and to the general public.	<ul style="list-style-type: none"> ▪ Up to date versions of these policies should be available contemporaneously. ▪ Are these necessarily relevant, or understandable, by the general public?
8. The system manager invests in a state-wide electronic medical record that interacts with existing electronic health systems.	<ul style="list-style-type: none"> ▪ The sharing of contemporaneous data to directly influence direct individual patient care and the construction of best practice guidelines and policies.
9. The System manager leads a review of outpatient services to reduce waste and improve efficiencies	<ul style="list-style-type: none"> ▪ Remove incentive to stop repeat sessions
10. The System manager, endorsed through the contracting Area Health Service, to monitor unnecessary Pathology and Radiology against diagnostic guidelines	<ul style="list-style-type: none"> ▪ Need data linkage and adequate clinical information to judge whether pathology and radiology service was or wasn't against guidelines. Who will act as the system manager, and is this person qualified to make such a judgement? ▪ Additionally, should variance be noted, what is the mechanism of addressing this?
11. Consider best use of available clinical resources and specialties via substitution models which allow expanded scope of practice (e.g. Advance Scope Practitioners such as Physios in ED, Speech Therapist endoscopy)	
12. HSPs to be responsible for complying with clinical care pathways for the top 5 DRGs	
13. Develop guidelines and policy with the assistance of technology to allow multiple departments to construct the same policy at the same time.	<ul style="list-style-type: none"> ▪ For example, shared emergency and ward based management guidelines in the paediatric population.
14. Patient centred care, not flow centred care	
15. Developing policy and practice guidelines on the basis of contemporaneous and broad based shared data	
16. Based on the success of Antibiotic stewardship in reducing associated cost and harm, the system manager implements a similar program across WA health for diagnostic stewardship by 2019.	

Environmental Waste

Key Themes

The key themes for environmental waste were:

Theme	Reference to Table Below
Hospital leadership to join Practice Green Health or Healthier Hospitals plus implement programs to reward individual behaviour (e.g. 'Break the Rules' campaign or 'lights out for last one out' policy)	Points 4, 5, 7, 10, 13, 19 and 21
Barcoding with pricing to enable easier stocktaking and rotation of stock close to expiring between Departments and wards, stickers indicating recyclability and a system for practical sharing of resources (e.g. Gumtree for hospitals)	Points 1, 6, 14, 17, 18 and 22
Reduce paper waste with integrated electronic records	Point 2
System Manager to implement a shared waste report for hospitals and increase visibility of initiatives	Points 3 and 20
Infrastructure and planning initiatives (e.g. install LED lights, use solar panels, more public transport)	Points 8, 9, 11, 12, 15 and 16

Detailed Group Work

The input and commentary from small groups is included below in detail.

Title	Comments
What are your recommendations for reducing ENVIRONMENTAL WASTE?	
1. Barcoding with pricing to enable easier stocktaking and rotation of stock close to expiring between Departments and wards	<ul style="list-style-type: none"> ▪ For pharmaceuticals, devices, imprest items ▪ Health supply chain to do barcoding of imprest. Costings per item can be obtained from supplier and the item labelled.
2. Reduce paper waste with integrated electronic records	<ul style="list-style-type: none"> ▪ ICU electronic records needing to be currently printed on transfer of patients to ward; theatre records needing to be printed for patient notes ▪ Intra and inter hospital ▪ Yes! ▪ Responsibility with HIN
3. System Manager to implement a shared waste report. Currently each hospital submits a waste report monthly to DoH but it is not returning back to the users (i.e. clinicians don't know, hospitals don't know how they are doing compared to other hospitals).	<ul style="list-style-type: none"> ▪ We submit reports? ▪ How would we measure this? We have to be careful to compare apples with apples when comparing hospitals. This could be valid within hospital and to identify trends of a particular hospital. ▪ Suez and DoH responsibility.
4. Encourage leaders of key hospitals to join Practice Green Health or Healthier Hospitals to build positive reputation and messaging (would require some project support potentially to set up initially)	
5. HSPs to implement a 'lights out for last one out' policy	<ul style="list-style-type: none"> ▪ Reminder stickers by doors ▪ Movement sensors ▪ Automatic light switch off based on movement sensors or timer
6. Set up an environmental hub on Healthpoint to work as the 'gumtree of stuff' and have the governance to allow equipment etc. that is no longer being used to go to other areas plus the sharing of ideas.	<ul style="list-style-type: none"> ▪ See loan library recommendation ▪ Combine gumtree idea
7. WA Health staff have a "Break the Rules" campaign to facilitate getting the right waste reduction strategies implemented. See School for Change Agents Module 3: IHI Leadership Alliance Breaking the Rules for Better Care	
8. Upgrade to LED lights	<ul style="list-style-type: none"> ▪ e.g. theatre lights to reduce heat, improve visibility and therefore aid operating ▪ Great recommendation ▪ Consider use of solar panels
9. All new buildings and renovations to comply with green standards and waste disposal best practice	
10. Education of health profession students regarding sources of environmental waste and strategies to reduce this	
11. Recycle water	
12. Renewable energy sources	<ul style="list-style-type: none"> ▪ e.g. solar panelling

13. Report a dripping tap week	
14. Gumtree for WA health (i.e. electronics etc. to send to where it might be needed)	
15. Funding for virtual clinics	<ul style="list-style-type: none"> ▪ e.g. for surveillance clinics to save patients time and money for travel (carbon footprint)
16. QEII site needs to have better transport options that are not cars (i.e. CAT bus route from Shenton college as light rail is not here yet)	
17. The system manager investigate the process of stock rotation through rural sites for stock with high cost and limited shelf life, in order to minimise the waste of expensive medications or disposable clinical tools.	
18. Loan library for equipment	
19. Turn off lights...how to get it to happen...messaging	
20. Visibility of projects across the system (i.e. one health service often not aware of what is happening across other places)	
21. SCGH has partnered with SUEZ to have a cardboard bailer and they recycle	
22. How do we know things are single use or recyclable unless it is marked recyclable? Therefore have stickers to recycle.	

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