GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
Title	[redacted]
Organisation	
First Name(s)	[redacted]
Surname	[redacted]
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

☐ I do not want my submission published

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Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

Implement midwifery led models of care for all women - safe, efficient, improved outcomes, frees up GP's and Obstetric doctors to focus on women with risks, provides continuity and care coordination so that vulnerable women and babies don't fall through the cracks of fragmented care, attracts and retains midwives in the system when working across the full scope of practice, less unnecessary and expensive interventions, improved consumer satisfaction, increased rates and duration of breastfeeding - which includes all the life long health benefits of breastfeeding for mothers and babies (overwhelming evidence in support of these models). Good examples of this are Bunbury and Broome MGP and the KEMH Family Birth Centre / Community Midwifery Program. All maternity hospitals should be required to offer these models of care,

Create legislation to enable Endorsed midwives to admit public patients to public hospitals to increase access to midwifery care for those who need it most and can least afford it (for all the reasons stated above) and improve access to care for rural and remote women. When obstetric /anaesthetic doctors leave small communities then birthing services are closed leaving women without access not only to birth services but antenatal and postnatal care as well. Offer incentives for Endorsed Midwives to set up practice in rural and remote communities as they are far more cost efficient than expensive locum medical doctors (ask for some data on the money spent for locum and visiting medical practitioners in country WA). This will improve women's access to maternity care via Medicare funded midwifery antenatal and postnatal care in the community, even where birthing services can't be offered.

A single electronic maternity health record capable of being shared between all care providers (govt, community, NGO and privates); capable of communicating with all diagnostic providers for ease of access results; capable of community with differing IT systems used in practice (i.e. GP Medical Director etc). Improves continuity, reduces risk of service duplication, improve accessibility to diagnostics / clinical history in emergency presentations and during transfers of care. currently inordinate amounts of midwifery, medical and clerical time are spent chasing diagnostics results which often get lost in the 'paper-based' system, end up lying around near fax machines or worse filed in the wrong patients records. Tests often have to be duplicated because clinicians can't access results - expensive, time consuming for all involved and wasteful.

Review the Senate Inquiry into Patient Assisted Travel recommendations and then direct funding and implementation of those recommendations. Many woman and babies are forced to dislocate from their country home to the only tertiary maternity providers of maternity care in the metropolitan and there is no woman or family friendly accommodation support and the financial support is abysmal - this means women avoid care in order to stay local and because they can't afford to re-locate. RFDS often transport women for urgent assessment who then discharge against advice and return to their local communities by any means they can. Many would stay if they can bring their partner, a support person or their other young children. The appropriation of the current Ronald McDonald house at PMH when PMH re-locates to the new PCH would be perfect for this means!

Urgent action to address the dire situations regarding the social determinants of health - obesity, illicit drug use, alcohol use particularly in regional centres with minimal resources to manage them (dieticians, social workers, alcohol and drug centres, rehab) this will take a generation to change and the impact on acute health services and the current children that are affected will be lifelong unless addressed, this may include creation of a statewide telehealth services for social work, dietetic and counselling services in all country towns.

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Undertake a cost /benefit analysis of some routine practice introduced into maternity care that lacks any robust evidence to support it such as (1) routine screening for Group B Strep at 36 weeks and intrapartum antibiotic prophylaxis when point of care testing is readily available (2) screening for Gestational Diabetes via Oral Glucose Challenge test when HbA1C is a better predictor and more acceptable to women (3) routine administration of anti-D to all women with negative blood groups when non-invasive testing is available for fetal RhD status - the UK predict this would save $750 000 per year, let alone the reduced stress for women, less risk associated with multiple blood tests, multiple unnecessary administrations of a blood product (anti-D) 4) Serial antenatal ultrasounds without true clinical indications

Remove perverse incentives toward unnecessary intervention / fee for service in Obstetrics - [redacted] Fund the birth episode (not the type of birth) and then add a loading for complexity via coding for conditions

Fund care required by unqualified babies who do not require admission to the Special Care Nursery - with the increase in antibiotic prophylaxis for Group B strep screening, increasing rates of Maternal diabetics and Obesity, increased birth interventions leading to higher rates of jaundice and new means to treat jaundice at the bedside (without incubators) means the babies who could receive this additional level of care at the bedside with their mothers, have to be separated from the mothers in Special Care Nurseries just so hospital can receive adequate funding to provide that care - the Commonwealth Circular on the Care of the Qualified Newborn was written in 1997 and needs a serious contemporisation so babies aren't separated from their mothers unless truly clinically indicated and hospitals are funded appropriately for this care that is over and above that needed for unqualified babies (well babies care for completely by their mothers).

The current system for reporting clinical incidents (Datix /CIMS) does not allow simple extraction of data for sharing of lessons from maternity care incidents - vaginal birth is the highest volume DRG in the state, maternity care has inherent and significant risks and ranks 3rd for highest speciality to result in medico-legal claims. It beggars belief that we cannot easily shared lessons learned that would be applicable across all maternity sites. We need a standard set of KPI's developed in conjunction with clinicians to measure and benchmark across the state and nationally - including for small, low volume maternity services.
Acess to face-to-face professional development for country maternity services is limited due to expense, infrequency of ability of service providers to reach the 18 country maternity services, inability to release all local staff to attend the short course that are available. We need a central team of multi-disciplinary trainers and affordable programs to offer a WA country wide to meet the needs of all maternity clinicians.
Care coordination between country and metro is difficult, when the clinicians responsible for managing the emerging clinical situation are often left to coordinate discussion with specialists from metro, liaising with RFDS / SJA / NETSWA for retrieval, negotiating a bed with the receiving hospital etc. There is no one point of call for Obstetrics and Newborn advice and retrieval to support often a sole practitioner at the local site - with our vast geographic locations a central point of contact service is needed (such as that offered in Queensland). This would improve continuity and safety for patients, reduce times for retrieval, reduce frustration for frontline clinicians and improve access to the right care at the right time in the right place.

Reduce over use / over reliance on diagnostic pathology and imaging tests - junior doctors without confidence order full suites, senior doctors order diagnostics before even assessing the patient, registrars want diagnostics to

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discuss with their consultants - whatever happened to clinical assessment, clinical skills then use of limited diagnostics to confirm / deny a diagnosis. There is significant overuse of C-Reactive Protein testing without evidence to support its reliability as a diagnostic test - causing unnecessary bleeding of newborns, unnecessary overuse of IV antibiotics and potential long term damage to the newborn microbiome with the well documented long term sequelae of that antibiotic use (allergies, weakened immunity, childhood mental health issues and obesity etc etc)

Extremely Inefficient Human Resources systems and processes - up to 10 different forms, 6 - 7 delegated approvals and now up to 4 months to recruit a front line clinician and that is assuming all the required forms don't' get lost in one of the multiple approval steps along the way. Front line managers (all clinicians) are so bogged down in administrative tasks that could be undertaken by administrative /clerical support people or a directorate business manager. Clinician managers need administrative support to allow them to focus on providing safe, clinical care - it is a much better use of clinician expertise and potentially far cheaper to use business support officers for these administrative tasks (minute taking, recruitment processes /paperwork, stock ordering, OHS, equipment and building maintenance etc)