Child and Adolescent Health Service Submission to the Sustainable Health Review

Background about CAHS

The Child and Adolescent Health Service (CAHS) provides services to support the health, wellbeing and development of the children and young people of Western Australian and is the only health service provider serving a population age group rather than geographic area.

CAHS aims to ensure that young people get the best start in life through health promotion and early intervention using a patient and family centred care approach. We support children and young people through metropolitan community and mental health services, the State's only dedicated paediatric hospital and support to other hospitals and health services across the State.

Key strategies for future focus

Where our focus needs to be

1. **Shift the focus from acute services to the community**

There is an overwhelming body of evidence demonstrating the critical importance of providing preventive community child health services in the early years. Frequently cited cost-benefit ratios from the US suggest that for every dollar invested in services for preschool age children, there will be a $2 to $2.60 return to society. New models of care should be based on the premise of care in the community, rather than treatment in the acute hospital setting.

In Child and Adolescent Community Health, child and school health nurses are a significant resource and are a cohort that represents opportunities for improving health outcomes for children. This workforce forms the backbone of a low cost investment shown to have significant return on investment for children and their families. This group is also positioned to work with some of the most vulnerable children and families in the community. Enhancing the services provided by child and school health nurses along with the provision of additional Aboriginal health workers and stronger links to social services will significantly benefit the community. This should be considered a high priority for review and expansion of the scope for this group of services. With limited upskilling, this group could also provide a wide spread skilled network that could actively support the delivery of more complex care in the community.

In the Child and Adolescent Mental Health Service, there is continued evidence of benefits in community health services to support children and young people and ultimately prevent the need for inpatient admissions. Investment in the currently underresourced community mental health services will be welcome and much needed

2. **Early intervention**

Investment before birth and during early childhood yields the highest lifetime return, with later investments yielding an ever diminishing rate of return. Children who experience significant adversity during the early years are at increased risk of poor health outcomes in adulthood, including heart disease, chronic pulmonary disease, cancer, substance abuse, depression and other mental health conditions. The potential lifetime costs to the health system of failing to address these causative factors during early childhood are enormous. In addition for those

children requiring therapy having this in early childhood results in far better outcomes for the child, their development and their schooling. To eradicate or at least minimise waitlists in this area should be a goal.

Specific and continued investment in early intervention mental health services would likely improve long term community outcomes by decreasing serious ongoing mental health issues and hopefully reducing the self-harm, in particular suicide, in a growing number of children and young people in WA.

Prevention and promotion

There is wide recognition, both nationally and internationally, of the enormous potential to influence a child's health, educational and social outcomes through effective, preventative interventions aimed at reducing stress-inducing burdens on families that are beyond the capacity of the medical care system alone to address. All high-income countries, including Australia, implement early identification and intervention community based services to all children, adolescents and families. This includes better utilisation of known prevention and early interventions with known populations of high-risk.

CAHS is the only health service providing both acute and community services across the metropolitan area. This provides a significant opportunity for the future. Evidence strongly supports the benefits of investment in a strong early childhood programs supporting both children and young people and their families.

3. Mental health

The increased incidence and severity of mental health issues in children and young people is well documented. Support in this area needs to increase with a well-documented role for community-based and specialist programs supporting the inpatient services. Declines in per capita funding have continued in child and adolescent mental health programs and a substantial increase in investment is needed to meet demand.

Partnerships with the Department of Education and other stakeholders have shown great improvements in the case management of children needing mental health support. These networks build the case for more formalised cross-functional programs to better support families. Other networks could include Family Court, Department of Communities, juvenile justice, primary health alliance, police, coroner's court, legal aid, drug and alcohol services and various NGO partners.

4. Aboriginal health

Health outcomes and immunisation coverage rates for Aboriginal children and young people are significantly lower than average and targeted programs for this group must continue. Services must be accessible for families and include targeted, culturally secure clinics, improved data capture to ensure early identification and follow up with Aboriginal families, improved integration of care for Aboriginal families through increased collaboration and communication between mainstream child health services and Aboriginal child health services. These must be adapted to meet the needs of families in each local area. In addition all efforts should be made to have permanent positions for Aboriginal staff in these programs. Where gains are evident, the health status of Aboriginal people will still remain at a lower rate than for non-Aboriginal people and any benefits are only likely to become evident in the long-term.

Therefore the cycle of time limited “project programs” must cease and stable funding should be provided to programs that are shown to have positive results and to allow for better realisation of long term outcomes.

5. Childhood obesity

Childhood obesity is a serious public health challenge and is becoming an increasing problem in very young children. This is important, not only because of tracking to poorer health outcomes in later life but also because, at a health system level, overweight and obesity represents a major economic burden. The Australian Bureau of Statistics National Health Survey 2014-15 reported the rate of obesity in 2-4 year olds at 8.7%. A recent Australian study tracked health costs and health service utilisation for a cohort of overweight and obese children aged 2-4 years, reporting that over a three year period, obese children were 2-3 times more likely to be hospitalised and their healthcare costs were 1.6 times those of healthy weight children weight. The state must develop programs similar to smoking in the past where there is a concerted community effort, which is multi-agency and able to be developed at multiple touch points by a raft of different staff. Child health nurses and school health nurses are the obvious most common interface for CAHS, however, primary health care will need to play a substantial part if any program is to be successful. Rapid research should be undertaken to identify if any community wide programs exist that WA could adapt and implement.

6. Better access to personal health records

A UK White paper identified that there is substantial evidence that direct access to health records for patients creates not only better understanding of their health condition and improved continuity of care, but also that this provides one of the greatest returns on investment. The momentum towards access to personal health records is growing and WA Health must equip itself to deliver on consumer need for this. Electronic records are urgently required across our entire system. Any new system must be able to interface with the Commonwealth My Health Record, but also ideally allow access to patients to read their record via password access.

7. Outcome focused

Targets should be set against patient and client outcomes, rather than transactional key performance indictors which do not always align with real outcomes that make a difference to patients, clients and families. Rather, targets should be set with consumer input and should align with measurable, real outcomes.

8. Increase transparency of health data

The publishing of core health service outcomes as suggested by Hugo Mascie Taylor is critical to driving safety improvements. We need to extend the use of live dashboards to reflect performance against targets at the service, department and ward level. All Health Service Providers are working towards this and should be allowed to progress this in their own way. If there is a need for standardisation then a minimum data set and timeline for implementation should be agreed.

Enablers to deliver key strategies

What we need to do to ensure that the strategies are implemented

1. **Community infrastructure**

As the requirement to deliver more care in the community grows, a need for investment in the physical infrastructure to support the wide network of community services is required. While community health services are currently relatively well resourced from a workforce perspective, both community health and mental health services are provided in poorly designed and, in some cases, dilapidated facilities that do not provide disabled access or appropriate settings to deliver care. In considering this investment, facilities should be designed with maximum flexibility to enable partnerships with other agencies and / or not for profit organisations. A business case proposing the co-location of community health and mental health services is being finalised by CAHS. Ideally these facilities should also be technology enabled so that in the future families will not need to necessarily attend the facility to receive the services.

2. **Partnerships with other government agencies and NGOs**

Various government departments and non-government organisations serve the same client groups and we must be better at integrating our services to the same families.

Work must continue to formalise partnerships and support GPs better to manage chronic care patients in the community. We can learn from our peers in other states in this, and many other areas. This includes working to provide integrated services; sharing information, establishing agreed care plans and supports for patients and carers.

While there is currently a regional engagement program with the Department of Communities, there is significant opportunity to formally explore the development of shared programs with pooled funding and shared outcomes.

3. **Contemporary mix of staff**

There is a need to look at how we staff our programs, For example, ensuring we have healthcare professionals practicing at the top of scope while increasing the use of roles such as nurse practitioners and Aboriginal health staff to support them. A contemporary mix of staff is needed to ensure we better support families, while maximising our use of staffing levels and minimising cost. Further work must be done in trying to determine what the future workforce requirements look like. All work done to date is based on a model that is in place now rather than trying to conceptualise what it should look like in the future utilising enablers such as technology and partnerships.

4. **Easier access to trial innovation**

A rapid cycle process for trialling innovation is needed; this is possible while also maintaining the governance required. Currently the implementation of new models frequently requires a business case with multiple sign offs. This can be a protracted process. Often the start of programs is delayed due to recruitment issues. WA must move to a model that enables organisations to test new models and rapidly adapt them with minimal bureaucratic process.

There also must be an absolute acceptance that some will fail and that this is appropriate. Failure has to move from being a negative to being a positive and part of innovation cycles.

A more coordinated focus on research across WA Health would help to minimise overlap or duplication and provide more strategic focus rather than single, siloed research programs at the local level. There is a need to integrate research with clinical expertise and translation of research into clinical practice better; within our health service and externally.

5. Telehealth

The use of video conferencing and telehealth both within our organisations and externally with families, primary care clinicians and NGOs needs to increase; the evidence demonstrating health outcomes is strong. It also allows specialist services to be spread across the state, including remote access to help build the skills of staff across WA. Currently telehealth is seen as a service to support country, however, with transport and parking issues, where possible telehealth options should be available. In addition consideration should be given to using standard technology which is accessible to all via personal devices at the patient and family end and ready to go technology at the clinician end.

6. Safety and quality remains the focus

The delivery of services which are safe and delivering quality outcomes must stay at the forefront. Minimising variation must become standard and the tools and technology to support clinicians in this should be rapidly developed. A digital record with pathways and decision support is a core platform to do this well.

In addition we should strongly encourage and value 'bottom up' safety, quality and research initiatives to sit equally alongside 'top down' initiatives. Initiatives should continue to aim to embed a continuous quality improvement and improving safety and quality of care across our service and programs into our culture. Encouraging students to be active participants with the inclusion of quality improvement and clinical safety in all curriculums would assist in driving the required cultural change.

7. Better consumer engagement

Stronger and broader partnerships with patients, clients and their families are vital. Real engagement will lead to better outcomes for all patients and their families. Possible way of progressing and maintaining partnerships could include:

- Establishing mechanisms for consumer input into governance systems and ensure ongoing partnerships with consumers at all levels of the organisation.
- Strengthening consumer partnerships in planning, designing and reforming services.
- Measure, evaluate, monitor and improve the consumer experience.
- Improving engagement with hard-to-engage consumers and those who do not usually provide feedback.
- Strengthening knowledge and understanding of consumer perspectives within the workforce.
- Exploring the role of technology in developing and maintaining consumer partnerships.

8. Better staff engagement

Worldwide there is growing recognition of the importance of clinical engagement and the link to patient safety. Engagement of all staff results in a highly performing organisation and therefore work has commenced across all services to improve the engagement. It would be useful to have a well validated mechanism to measure engagement and to show improvements across the years. Standardised use across WA would enable both sharing of ideas and a degree of benchmarking.

As staff needs change across the generations, programs to support staff will clearly need to change. Currently staff are articulating a need for organisations to show they care and to recognise staff effort. Staff recognition and wellness programs are essential and must be central within strategic planning. Developing a values-based culture will be critical to continuing to strive for a safer system, where the patient or client remains the focus with a well-supported workforce.

9. ICT innovation

It is clear that a digital record of some form is one way to enhance care and improve communications between clinicians. However, the biggest gains are when decision support can be embedded and when the system can be used to reduce variation in care. Importantly there are differences between what has been implemented between different hospitals. These differences should be formally analysed so that the system can learn from these variances and this can be considered prior to further investment.

An Electronic Medical Record needs investment and a state-wide solution that is truly integrated.

We need to integrate more contemporary uses of technology to help in what we do, for example a simple change to broaden use of SMS reminders to reduce DNAs, increased use of tablets to educate families at the bed-side, use existing and develop own apps to help in patient education. This must ensure an equitable distribution of technological resources across all aspects of health, not just hospital settings.

10. Transition to Adult Services

For some time transition for children from paediatric to adult services has been a focus. Despite this it continues to not be done well for many patients. Issues that require addressing include differences in service provision and support available, which health service young people with complex needs transition to and stress on both the young person and their families about leaving the care of teams they have frequently had a long relationship with. This angst is only worsened as often that concern is shared by the CAHS treating team as they are acutely aware there are differences between paediatric and adult services. For example there is no equivalent Eating Disorders Program in adult health services for young people to access. Adult services also do not provide as many supports such as consumables free of charge as the paediatric service does. Whilst patients should be able to access their needs via NDIS or previously disability services, there continue to be gaps. An agreed protocol should be developed and form part of the health service SLAs to ensure no child falls through gaps and health services are not in conflict as to which service young people will transition to.