



Government of Western Australia  
North Metropolitan Health Service

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# **Sustainable Health Review Submission**

26 October 2017





Government of **Western Australia**  
**North Metropolitan Health Service**

Ms Robyn Kruk AM  
Chairperson, Sustainable Health Review  
Department of Health

Dear Ms Kruk

Thank you for the opportunity to contribute to the Sustainable Health Review (the Review). The North Metropolitan Health Service (NMHS) Board is very supportive of the Review and has taken the opportunity to consider its Terms of Reference, the impact on our organisation and what we can offer by way of learnings and suggestions.

We have canvassed the views of our employees and leadership teams to inform the ideas and themes in this consolidated submission, and we have also actively encouraged clinical teams and professional groups to submit their own submission to the Review to ensure that their specific issues, concerns and ideas are raised.

As you are aware Board has recently prepared a *Draft NMHS Strategic Plan 2017-2021*, which is being finalised, post-feedback from our employees. Many of our strategies support the areas that have been identified for the Review's attention. The Board expects NMHS to deliver patient centred, integrated, high quality and financially sustainable healthcare and has put in place measures to ensure our hospital and health service network is able to implement and monitor such expectations.

NMHS is committed to being part of an interdependent healthcare system that is focussed on the best outcomes for our patients, and we look forward to having a shared 10-year WA State Health Plan that provides us with clear direction for the future.

Please find enclosed a summary of our initial deliberations for your consideration.

We look forward to commenting on your interim report in due course, and in the meantime please do not hesitate to contact my office if you would like any further information or to discuss any aspects of our submission.

Kind regards

Professor Bryant Stokes AM  
Board Chair  
North Metropolitan Health Service

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# NMHS Board priorities

The Board acknowledges that the current health system in WA is unsustainable. WA has been fortunate to have had an economic boom and as a result we have benefited from an unprecedented capital works program that has delivered new hospitals and facilities across metropolitan and country areas. Simultaneously, we faced a population boom that changed the demographics across WA and presented us with new health workforce challenges.

The difficult task of reviewing and reforming our services must now begin in earnest and we have to do this together with our partners in primary and community care, as well as our colleagues in the private health sector.

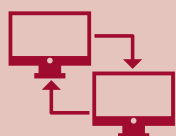
While the subsequent sections outline the ideas generated by our employees in more detail, the Board has identified the following priorities areas it would like considered by the Sustainable Health Review Panel:



The focus needs to shift from hospitals to primary and community providers, and new models of care need to be developed and supported by contemporary workforce models.



Engaging our workforce will be essential to the successful implementation of changes to our system. They are at the coalface with our patients every day and we need their knowledge, experience and emotional resilience to enable change.



Information technology systems need to be more relevant and accessible to patients and clinicians. It will be impossible to provide world class care without world class IT systems to support us.



Hospitals need to be maintained, and in some cases, rebuilt. King Edward Memorial Hospital and Graylands Hospital are in urgent need of attention and decisions need to be made now to support service relocation and redevelopment in the near future.



WA needs a purchasing model that clearly articulates the role of services and provides clarity about the services that are to be delivered. We must reduce duplication and increase our efficiency as one seamless healthcare system, not as individual health service providers.



Appropriate medical equipment needs to be available to all service providers.



Patients must be encouraged to continue to use their private health insurance and private providers as much as possible. Further erosion of the private hospital sector will continue to challenge the public health system.



Funding for healthcare in Australia is unnecessarily complicated and inefficient. Medicare funding could be provided to the State, which could then be held responsible for ensuring that care is accessible and available from appropriate service providers. Funding could then be linked to the patient journey and be provided across the spectrum of services including primary, dental, mental and acute health services.



## Empowering patients



- ▶ **Patients (or carers, where appropriate) should be the keeper of their own health information and data.** We currently disempower patients from taking responsibility for their patient information and records. We refer patients to specialists for further interventions without supporting the patient to make decisions about their health and health care needs.
- ▶ **Manage the expectations of the public and patients.** At the moment, there is no ceiling for services. The public (and our clinicians) expect that all services are equitably available to all patients. We must have a conversation with the public as to what is realistic and evidence-based, particularly concerning beginning and end-of-life care, and with patients who are not willing to take any personal responsibility for their life choices.
- ▶ **Support patients to look after themselves.** Where possible we should encourage patients and their carers to learn about their health and illnesses, and support them to treat themselves. For example, this could include developing training programs to support carers in providing insulin injections – training that is currently provided to young people and their parents, but is not regularly available to older patients and their carers.
- ▶ **We need to consider ‘navigators’ to help patients (and clinicians) with navigating complex health, disability and aged care systems.** Navigating through the various systems is exhausting and wasteful. We must provide patients and service providers with greater visibility and clear information about what, where and when services are available. This supports improved access, discharge and outcomes.
- ▶ **Outreach positions that link community and hospital services.** Dedicated resources and expertise needs to be developed to support the assertive management of patients out of hospital and into community services. We should encourage ‘community admissions’ where the GP retains ownership/ responsibility for their patient and they are responsible for having discussions with their patient about post-acute care (e.g. accessing allied health or other community support services).
- ▶ **We need pathways out of hospital.** WA Primary Health Alliance (WAPHA) is working with secondary and tertiary services to develop pathways into hospital. Although there has been some initial positive signs that the pathways have improved the quality and accuracy of referrals to specialists, unfortunately WAPHA does not have a mandate to develop pathways out of hospital. This is a key priority for hospitals who often do not understand the range of primary and community care services available to support discharge.





## Focus on prevention and early intervention



- ▶ **Similar to the UK, patients should be registered/linked to a General Practitioner (GP).** Patients should be encouraged to seek care from a GP prior to attending acute hospital services and their GP should source community-based services to support recovery.
- ▶ **Minimising inappropriate Emergency Department (ED) presentations - De-incentivising the ED as the first port of call for non-emergency presentations.** The inappropriate use of Emergency Departments for free care or free medicines needs to be de-incentivised. Patients who use an Emergency Department for services that could be provided by a GP should be redirected to an alternative provider and advised that they will be charged a fee for service, similar to when they attend a GP.
- ▶ **Improve access to early intervention and treatment for pregnant women, infants, children and young people with mental health problems.** With suicide and self-harm rates escalating every year, we must redirect mental health funding to the most vulnerable in our community and where we can create good mental health and change the trajectory of a life. The earlier in life the intervention the greater the long term savings for the community, with the first 1000 days of life identified as the most cost effective and determinative of lifelong health and wellbeing, including mental health. Without greater investment in this area we will continue to be responding to crises and require more inpatient beds.
- ▶ **Ensure a greater focus on dental care to support a healthy life.** Many patients find private dental care cost prohibitive and will therefore delay treatment and live with pain, accepting this is normal. This impacts their daily lives, results in depression and increases their usage of pain medication. Poor dental health is associated with other poor health outcomes including cardio-vascular disease (endocarditis), dementia, respiratory infections and complications of diabetes. Delayed treatment is not cost-efficient and better access to services that charge reasonable rates is important. WA does not have enough private dentists, resulting in the continuation of state-provided Dental Health Services. Bulk billing for dentists, similar to GPs, should be considered to support those in need.
- ▶ **Consider reasonable end-of-life care and reinvest in early intervention.** As a community we need to be reflecting on the value of investing in futile care and stop expecting and providing excessive care to elderly and frail patients. Discussion with the community about the options of redirecting funding to prevention and early intervention, based on the evidence and a cost benefit analysis, is urgently required. Clinicians need to provide honest expert opinions to families about the best way forward to reduce a patient's suffering and avoid interventions that won't improve someone's quality of life. For example, a patient who is 92 years of age, in a nursing home, with dementia, is unlikely to have wanted urgent surgery to fix an abdominal aortic aneurysm. Within 24 hours of admission all elderly inpatients should have end-of-life discussions and we should clarify the care that we can provide should patients deteriorate.
- ▶ **Patients in nursing homes should receive care in-situ and not be transferred to acute hospitals unless absolutely necessary.** All patients in aged care facilities should, at admission, be strongly encouraged to complete an Advance Health Directive so that their wishes, or the wishes of their next of kin are clear, and the action for escalating care is consistent with their wishes. General Practice services should be mandatory in nursing homes to ensure patients receive appropriate aged care support, and that they are not overprescribed medications by a range of different care providers. Geriatricians, psychogeriatricians and other specialists could provide more outreach to nursing homes, rather than automatically defaulting to an inpatient admission. All patients in aged care facilities should have end-of-life discussions and an Advanced Health Directive.



## Engaging communities



- ▶ **Good health and social determinates.** Health services will not be able to innovate and reform their services in isolation. There must be greater connectivity and partnership between service providers, such as education, housing and community services. We should encourage the Service Priority Review to emphasis recommendations that ensure all agencies (public and contracted) focus on priority populations to collectively improve health outcomes and reduce the burden of disease on our community and economy.
- ▶ **Improve patient care by integrating interdependent systems.** The United Kingdom has had some success in demonstrating that when health, care and support are 'integrated', patients receive person-centred, coordinated, and tailored services to support their needs and preferences. This means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered. The £3.8bn Better Care Fund (BCF) was announced by the British Government in June 2013 to enable the transformation of integrated health and social care. The BCF was a single pooled budget to support health and social care services to work more closely together in local areas. We will need a similar radical approach to support such as transformation.
- ▶ **Patients must receive integrated mental and general health care in the community and hospital.** Mental health patients often have their general health needs overlooked following diagnosis or surgery, and general health patients often have their mental health needs overlooked. We must reduce the stigma of mental illness and make mental health part of everyone's clinical competencies.
- ▶ **Ensure that pre- and post-natal social support is available in the community for low-risk women.** Patients should not be required to attend a hospital for these services. Services for everyone, including high risk populations, such as Aboriginal and Culturally and Linguistically Diverse women, should be widely available in the community. Where there is family domestic violence, appropriate referrals should be made to services with expertise.
- ▶ **Reduce barriers to patient flow.** Whilst unintended, there are barriers to patient flow as patients transfer between hospitals. In some cases, patients are re-triaged or they are not always readily transferred without considerable negotiation by clinicians or consumers/carers advocates. There needs to be disincentives to prevent transfer blockages. For example, funding could be withheld when secondary care is being provided out of region or when a transfer from a tertiary hospital exceeds the number of agreed bed days.
- ▶ **Patients who do not require acute inpatient care should have alternative accommodation options.** Acute hospitals are still the default option for people who need permanent accommodation with or without aged care, disability or mental health support services. This could be addressed with an integrated system of care, rather than developing new services or projects to address these issues.



## Alternative service models



- ▶ **Shift non-acute services in hospitals to the community.** Secondary and tertiary hospital services provide a range of outpatient services that are currently available or could be developed in the community and primary care sectors.
- ▶ **Health Services need to transfer disability-related services to the community sector.** Due to the delay in the implementation of National Disability Insurance Scheme (NDIS) in WA, there is little planning or clarity about the transfer of these services to alternative community providers.
- ▶ **Use of telehealth should be as business-as-usual and mandated by policy.** Telehealth could be used for all outpatient follow-up where there is no physical contact required with the patient. This could be a policy decision for the entire health system, which would significantly reduce patient travel and costs and reduce the outpatient services footprint in hospitals.
- ▶ **Develop locally accessible community and health service hubs.** Wherever possible community hubs should be developed to provide local access to primary, social and community services. Specialist health services such as maternity, mental health, dental, paediatrics and other specialities could attend and use local facilities rather than build standalone services/clinics. Priority areas for hubs would be where the most vulnerable and under-served populations live.
- ▶ **Preliminary testing at point of care.** Further work should be escalated to encourage more testing to be done at the point of care. For example, some preliminary testing could be undertaken in ambulances on the way to an ED and in General Practices.
- ▶ **Develop a WA Health plan to establish a benchmark for IT capability across all health services.** Currently in WA there is great disparity between what IT is available and what technology is used across the health services, with little consistency and no plan to bring IT capability or services into line.
- ▶ **Greater investment in health from philanthropy.** Systems need to be available to enable Health Service Providers (HSPs) to use philanthropy to support and develop health care. Other countries and cultures often demonstrate a strong collective sense of responsibility to invest in health. It is not unusual for commercial companies and private families to support local health services over many years and generations, and for new hospitals/services/wards to be completely or partially funded by philanthropy. Whilst we have some examples, such as Mr and Mrs Sarich who generously provided funding for the construction of the Sarich Neuroscience Research Institute, this is still an exception in WA.
- ▶ **Sustainable safe and innovative services.** Short term funding enables innovation for short periods of time, but care needs to be taken to ensure funding is not only made available for clinical care, but also infrastructure and training. Short term funding for 'pilot projects' has not proven efficient and there is a perception that services are being 'defunded'.
- ▶ **Enhance home care.** Wherever possible and appropriate, the system should encourage more treatment being offered at home. The continuation of services such as chemotherapy in the home and insulin home visits would divert people from hospital services.





## Infrastructure that supports safety and innovation



- ▶ **Advocate for an early decision to urgently relocate King Edward Memorial Hospital (KEMH) to the QEII Medical Centre Campus.** While there has been considerable investment in hospital infrastructure across WA, specialist services for women and newborns have not been addressed. The lack of an emergency department at KEMH and the regular transfer of women and newborns to Sir Charles Gairdner Hospital (SCGH) and Princess Margaret Hospital (PMH) respectively, demonstrate that the current infrastructure at KEMH is not contemporary. The relocation will allow more efficient and coordinated care for women and newborns with access to comprehensive imaging and Intensive Care Unit (ICU) facilities in SCGH and Perth Childrens Hospital (PCH).

The relocation of this hospital to the QEII Campus and integration with SCGH and PCH will improve care and reduce costs in the longer term.

- ▶ **Modern acute and community mental health services.** The decommissioning of Graylands, the relocation of services and the ongoing development of the community mental health sector must be a priority. Currently the facilities do not meet community expectations and continue to promote institutional care.
- ▶ **Contemporary facilities and equipment improves everyone's safety.** Maintenance of facilities and equipment within current acute hospitals must be made a priority for patient and employee safety. There are a number of new hospitals in metropolitan and country WA and many patients are now able to access excellent facilities; however, this is unfortunately not the case throughout the majority of the NMHS hospital/services network.



## Leadership and Culture



- ▶ **Listen to the patient experience and better engagement.** By respectfully listening and recording patient feedback we can reduce the need for patients to 'repeat their story', enhance their confidence in an expert opinion, support them to make the right choices for themselves and address concerns and complaints informally and more directly.
- ▶ **Greater transparency regarding our safety and quality performance.** The NMHS Board has led the way in making NMHS safety and quality performance data available to the public. The NMHS Annual Report 2017 includes information regarding the patient experience, as well as the number and nature of serious clinical incidents that occurred in 2016/17.

Additionally, the Board has directed the Health Service to make available a Safety and Quality Performance dashboard on the NMHS website from January 2018. The dashboard will enable members of the public and employees to see NMHS performance information, including complaints, compliments and clinical incidents. This initiative is seen as an important step towards further transparency and building confidence and trust with the community.

- ▶ **Support shared learning and development across health, community and primary care sectors.** This will encourage the sharing of areas we have in common - particularly values, culture and a focus on person-centred care, as opposed to looking inwards at our respective services and individual priorities.



## Promoting innovation



- ▶ **We must have an integrated patient information system across providers.** Overwhelmingly, the lack of an integrated patient information system across the various service providers is the single biggest frustration for both patients and clinicians. A patient information system that is accessible across the patient journey through primary, public, private and community services would improve patient outcomes, safety and quality, enable many reforms and reduce waste. This should include maternity records and child health records.
- ▶ **We need to support innovative and integrated medicine such as genomics and phonemics, which have the potential to change patient outcomes and clinical practice.** Proactively using these new areas of medicine can fundamentally change the way we prevent, diagnose, treat and monitor illness, and provides the opportunity to have more precise and tailored treatments. The ability to harness this is dependent on further developing our capacity, capability and infrastructure needed to support the integration of genomic and phonemic technology into the health system (particularly with regards to clinical use, workforce, education, data security, cost-effectiveness and research).

Current evidence suggests that genomic medicine in WA is improving diagnosis and reducing unnecessary testing. Promoting access to improved or best practice medical care as well as unlocking new knowledge for innovation will have a long term effect by reducing expenditure to other government departments (e.g. disability services and education).

- ▶ **Support service delivery through translational and innovative research, with Key Performance Indicators (KPIs) for HSPs.** All research undertaken by HSPs should focus on improving patient care and we should be clear about research that is not a priority. It would be useful to strengthen the focus of research in Service Agreements and develop research KPIs to ensure that we reduce duplication, promote collaboration and develop specific areas of expertise.

The WA Translation Research Network is an important step in the development of an integrated research community in WA and will provide a valuable mechanism to promulgate knowledge across service providers.

We have developed a NMHS Research Strategy to provide strategic and operational direction within our service. A key priority is to provide greater coordination, quality control and governance across our various hospitals and to encourage a Research Network led by a Director of Research.

- ▶ **Improve access to mobile technology to improve clinical efficiency and effectiveness at the point of care.** Health services have increased governance and require more documentation to support patient safety, handover and compliance reporting. Most of this is manual, often duplicated and away from the bedside. Rather than becoming paper-less, hospital patient files are being filled with more forms and hand written documentation, which could be mitigated by the use of more mobile technology.
- ▶ **Use digital and clinical innovation to extend our market share and profitability.** WA health services could become a provider of choice to a lucrative Asian market, provide more support to patients in the Northern Territory or South Australia and reduce costs to the WA public.



## Investing in a modern and healthy workforce



- ▶ **Look after the physical and emotional wellbeing of our employees and volunteers.** The demand and pressure of both work and personal lives of our employees (particularly those in mid-life who have multiple carer responsibilities) will not be abating and the opportunities for error will therefore increase. Investing in employees to ensure that they are emotionally resilient and appropriately skilled in their roles will be essential.
- ▶ **Regular learning and development opportunities should be made available for all employees.** Whilst learning and development opportunities are part of some industrial agreements, access to learning opportunities is not equitable and many employees do not have the opportunity to attend any education sessions (aside from mandatory training). Ideally, we should offer all employees with training that aligns to their professional development goals, as identified in recent performance appraisals. This would support all employees in maintaining and developing new skills, being open to new ideas, learning from other services and presenting our success to others.
- ▶ **Support alternative models of service provision.** There could be greater utilisation of senior nursing and allied health workforce to lead outpatient services. Referral for a medical consult could be the option of last resort, not the first.
- ▶ **Encourage alternative workforce models.** To date there has been little progress in NMHS with the introduction of lower cost and substitute workers e.g. nursing or allied health aides.
- ▶ **Medical staffing benchmarks would benefit all HSPs to support safe models of care.** The recent increase in medical staff has been significant, particularly following a period when medical staffing numbers were low (early in the 2000s). However since then, activity in some areas has decreased, yet medical staffing has increased. Benchmarks would support services to retain medical staff at levels that support patient safety.
- ▶ **Improve our partnerships with teaching institutions.** The health system must develop closer partnerships to ensure graduate teaching and training is evidence-based and leading-edge. HSPs spend considerable funds teaching graduates basic skills or providing bridging programs that were once available at university (e.g. mental health nursing programs).



## Purchasing and Commissioning



- ▶ **Develop a mature and locally-informed purchasing model.** We need a transparent purchasing model whereby all service providers (community and health) have an understanding of the quality and quantity of services being purchased and provided. We will continue to foster duplication and a lack of trust in each other, if we do not understand what other service providers have been contracted to provide (e.g. general and mental health community agencies) and what accountability, clinical governance and quality control arrangements are expected. Without this knowledge, clinicians feel uncomfortable supporting patients to make informed choices about what services they can receive, where and when.
- ▶ **Better definition, alignment and appropriate funding of state and state-wide services provided by HSPs.** We need clear definitions about the difference between state-wide and state services and how these are funded.

The Clinical Services Framework (CSF) is not robust enough and enables services to duplicate effort. The CSF doesn't articulate what sub-specialties each respective hospital should provide. The system would benefit from clarity about which tertiary hospitals should provide specific sub-specialities (particularly those that are high-cost, low-volume), rather than allow the services to develop sub-specialities at their discretion. This should be reinforced in respective Service Agreements.

Despite an increase in our population, we still do not have the population that requires three tertiary hospitals in the Perth metropolitan area. To meet population needs in the future, we need to be planning for a tertiary hospital in the northern metropolitan area.

- ▶ **Cease providing highly specialised healthcare in multiple hospitals and develop a state-wide comprehensive plan for care of patients with rare conditions.** Defining those services which are best delivered by centres where care can be coordinated is an essential component of delivering high cost, low volume care for certain patients.

Continue to purchase from Eastern States providers, those services which are best delivered in centres of excellence due to very low volume. Due to our population size, while care closer to home is preferred, it may not always be economically viable or clinically safe to provide all very low-volume high-cost services in WA.

- ▶ **Specialist models of care must be clearer and health services incentivised to prioritise their local populations.** Currently there is little incentive for hospitals to accept responsibility for repatriating their patients who don't require a specialist service and who are in hospitals outside of their geographical area.

For example, Sir Charles Gairdner Hospital recently introduced a new endovascular clot retrieval service, which is a highly effective treatment to restore blood flow to the brain in patients affected by ischaemic stroke. This intervention is very specific and, if after determining that it is not an appropriate treatment option, patients should be transferred back to their respective geographical hospital. Unfortunately this does not usually happen and as a result SCGH has become the default service for all patients with suspected stroke.

- ▶ **Greater focus on safety and quality performance in Service Agreements.** The Service Agreements should focus more on safety and quality and consider disincentives for poor performance. For example, this could include the reduced payment for services with high numbers of MRSA bloodstream infections or occasions where we have caused harm. Alternatively there could be public recognition and incentive payments for services with exemplary care and performance.

The NMHS Board is supportive of the report and recommendations prepared by Professor Hugo Mascie-Taylor in the WA Health Safety and Quality Review and will ensure that the service is proactive in its continuous improvement.





## Reduce duplication and waste



- ▶ **Take responsibility of our environmental footprint and create KPIs for environmental sustainable behaviours.** Employees and patients practice recycling and reduce waste at home and they should be encouraged to do so at work. Environmental sustainability and performance indicators could be part of Service Agreements and recommended to the Service Priority Review. This also applies to equipment and consumables, where disposable equipment is being purchased over reusable due to (short term) cost benefits.
- ▶ **Reduce unnecessary diagnostic testing and surgical interventions that are not evidence-based.** Clinicians should be encouraged to consider the cost of all tests and interventions and feedback should be provided to high users or those who significantly vary in practice from the norm. Until the real cost of tests and interventions are accurately charged to individual services, there will be no incentive for clinicians to more carefully consider the request for tests.
- ▶ **Further improvements in pathology.** Errors in pathology are not only wasteful, but can also result in a delay to treatment or potentially cause harm to patients. Hospitals are provided with regular information from PathWest regarding the number of tests undertaken at each service, as well as data regarding the many different types of errors that occur in the collection of pathology samples. Services should be encouraged to actively review this information and address areas of concern. Lab and non-lab (clinical staff) errors in collects can also be compared and performance could be incentivised. HSP performance could be made public and compared to national averages, as data is submitted to national monitoring programs.
- ▶ **A focus on procurement and contract management should see further savings, but could be better supported.** HSPs should be encouraged to procure services together to ensure that the potential for savings is maximised. Greater engagement with clinicians on products and equipment will ensure all service needs are met, not just the needs of tertiary hospitals.

Procurement processes are currently lengthy and complex - with some equipment taking up to 12 months to be delivered, which leaves little room for responding to emergencies.

- ▶ **Review corporate and support services to identify local and shared service opportunities.** While HSPs have authority and autonomy under the new Health Services Act 2016, there may be further opportunities beyond the current services provided by Health Support Service to reform corporate support services.

HSPs should be encouraged to review all corporate functions to ascertain what the essential services are, where governance needs to be retained locally and what advantages there may be to purchase expertise from a Shared Service. This could include some functions within workforce, business intelligence, facilities management, procurement, transactional finance functions and clinical planning.

Clinical support services such as biomedical services, catering, CSSD, library services and Freedom of Information services could also be reviewed.

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