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

Ms Robyn Kruk AM
Chair
Sustainable Health Review
via email to: SHR@health.wa.gov.au

Dear Robyn

RE: Submission to WA Health Sustainable Health Review

Thank you for the opportunity to make a submission to the Sustainable Health Review (SHR).

South Metropolitan Health Service (SMHS) recognises the need to adapt in order to provide sustainable health services and care for our population into the future.

In order to prepare our submission, SMHS engaged with its workforce in several ways and undertook in-depth and considered discussions. The result is attached and provided on behalf of SMHS.

It is understood that submissions to SHR will be made public and SMHS is very open to this level of transparency in relation to our submission.

Again thank you for the opportunity.

Yours sincerely

Mr Rob McDonald
BOARD CHAIR

Mr Paul Forden
A/CHIEF EXECUTIVE

27 October 2017

Attach: SMHS Submission WA Health Sustainable Health Review

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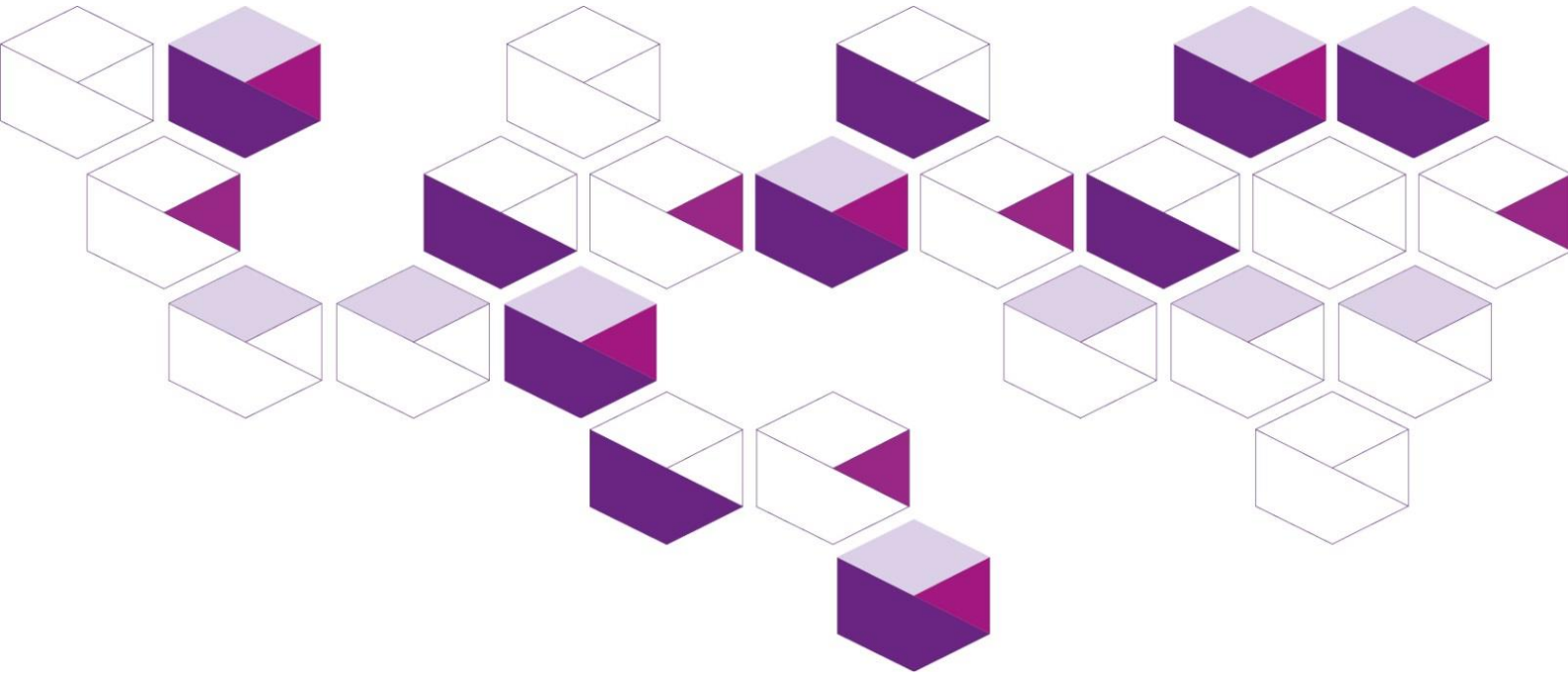
Government of **Western Australia**
South Metropolitan Health Service

Submission to the WA Health Sustainable Health Review

27 October 2017



Contents

Executive summary

The South Metropolitan Health Service Board (SMHS) is delighted to provide its forward looking vision for transformational change in health services to the Sustainable Health Review Team. The submission recommendations are summarised in Appendix 1 under the Sustainable Health Review (SHR) six themes being:

- Quality and Value
- Patient Pathway and Experience
- Financial Sustainability
- Prevention, Promotion and Partnerships
- Digital Innovation and Research
- Workforce and Culture

To inform the submission, SMHS consulted widely including a staff Survey Monkey questionnaire and a series of workshops with both clinical and operational leaders within the organisation.

The South Metropolitan Health Service (SMHS) is responsible for providing acute and sub-acute clinical services for a population of more than 630,000 people across 3,300 square kilometres across the southern half of Perth. It has a hospital network which consists of:

- Fiona Stanley Hospital (including the State Rehabilitation Centre)
- Fremantle Hospital
- Rockingham General Hospital
- Murray District Hospital
- Peel Health Campus (which is a privately operated public hospital).

SMHS also undertakes a range of community based mental health; sub-acute; rehabilitation and aged care; allied health; post-natal care; and health promotion services.

Additionally, SMHS shares the following metropolitan service responsibilities with the other Health Service Providers (HSPs):

- SMHS is responsible for delivering Rehabilitation in the Home (RiTH); Community Physiotherapy Service (CPS) and Complex Needs Coordination (CoNeCT).
- NMHS are responsible for public health disease control services.
- EMHS provides Aboriginal specific programs.

For sustainable quality health care, for our growing and aging population, a significant shift to prevention and early intervention is required from our current hospital based, crisis management model. HSPs must transition from a hospital centric model to a model that focuses on building of our populations' health and well-being.

While preventative health is considered a shared responsibly across all levels of government, industry and business, there appears to be little coordinated national, state or health service effort. Initiatives to improve the health of Western Australians at either an individual or population level requires a multi-agency, government, non-government and community approach. This requires a coordinated, multi-faceted investment over the longer term (not three year terms).

The *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2015* outlines multiple issues and concerning data about services to our communities. The SMHS Board agrees with the issues raised such as "… expenditure on mental health services is heavily reliant on costly acute services…" and "… there is an urgent need to expand the system to boost community-based services…" These and other key issues outlined in this report are important matters that need to be addressed as a matter of priority.

To achieve this, the following should be implemented:

- Significant refinement in patient centred pathways of care across the continuum.
- Investment in the delivery of effective prevention, health promotion and early intervention services based on origins of disease.
- Delivering patient care in partnerships with key providers including other government, generally social service departments, primary care, and private providers.
- The configuring of services that can be more appropriately delivered in the community rather than hospital settings.
- The embracing and embedding of digital technologies including telehealth, to enable the delivery of patient-centred care in settings other than the hospital.
- The establishment of flexible interdisciplinary workforces who can work across different treatment modalities and settings.
- A transparent approach to funding reform which considers the needs of the populations that each health service serves.
- The recommendations and actions outlined in the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025 require review, funding and implementation.
- It is also the considered view of the SMHS Board that WA Health learns from the Reid review and embarks on a bipartite agreement to recommendations to ensure complete and effective implementation.

Summary of recommendations

Strategic planning

1.1 Government develop a bipartisan approach to health strategy including models of care, workforce and health prevention programs and agree on seven (7) year strategies, reviewed on the fifth (5th) year.

1.2 Funding models are reviewed and established over 3 to 7 years to enable Healthcare organisations to develop medium and long term financial planning, which is critical for multi-billion dollar organisations. (Controls would be required to prevent any cumulative overspend.)

Incentives modern approaches to health services and intervention

2.1 Funding model should be within a risk-adjusted population-based payment system tied to key outcome indicators.

2.2 Patient reported outcome measures for selected health interventions are adopted and are regularly reported by HSPs.

2.3 The purchasing and funding models are realigned to incentivise and support partnership and collaborative approaches to care to prevent unnecessary presentations to EDs and hospital admissions and have patients treated in the most appropriate setting.

2.4 Develop an agreed set of hospital avoidance performance indicators and processes to measure improvements to ensure improvements in health outcomes are achieved.

2.5 HSPs should be managed against focused preventative health management plans, linked to population needs, with achievable outcome measures

2.6 All parties in WA Health develop a considered position on the implementation of the MBS Billable Specialist Outpatient Service framework for HSPs to consider as a strategy to expand service delivery in targeted specialities.

2.7 A primary prevention strategy is developed that includes the coordination of legislative, health promotion and social marketing strategies, to address lifestyle related illness.

2.8 Key Performance Indicators (KPIs) developed for Governmental Departments to develop and align plans to collectively improve the health and well-being of the WA population.

End-of-life care

3.1 An open debate commences with the population in respect of realistic end-of-life expectations.

3.2 Acute hospital pathways are developed to ensure end-of-life planning is formalised and where possible redirected into community based palliative care services with appropriate funding models.

Mental health care pathways and governance

4.1 A long term plan to be developed state-wide for moving towards a crisis prevention strategy of service delivery. This should also consider the accommodation needs of the homeless and other community members who are at a higher risk of vulnerability when they have a mental health condition.

4.2 Implement the recommendation in the *Mental Health Plan* to introduce mental health observation areas to expedite the commencement of treatment and provide a more therapeutic environment than an ED.

4.3 The role of separate Commissioners of Mental Health Services and acute services be reviewed

4.4 Undertake a system-wide review of child; adolescent and youth mental health services across the continuum of care.

4.5 Implement the WA Mental Health, *Alcohol and Other Drug Services Plan 2015-2025.*

Primary referral pathways for acute services

5.1 HSPs in collaboration with primary care develop clearly defined intake and referral criteria for all services in the public health system, with information readily available to referrers, patients and carers.

5.2 HSPs referral pathways inclusion criteria include pathology and radiological investigations be undertaken by the referring health service provider.

5.3 Implement a patient reported outcome measures (PROMs) questionnaires, as a way of collecting information about whether the health care interventions actually make a difference to our patients lives.

5.4 Implement a patient focussed approach to the booking of outpatient appointments to increase the likelihood that patients attend their appointment and subsequently reduce the waste associated with did-not-attends and increase access to care.

5.5 Realign investment in supported home and community care, shared care and step down services, for the ongoing treatment and management of conditions including chronic disease, mental health and palliative care.

5.6 Mandate HSPs to use Choosing Wisely, Atlas of Variation or similar, evidence based guidelines to evaluate services and disinvest from those services considered to be of low or no value to patients.

5.7 Develop a proactive approach to work with and inform the community and consumers of health best practice models of care.

5.8 Develop and implement a WA-wide strategy for Telehealth.

Improve ability to share patient information

6.1 Promote and support the adoption of My Health Record.

6.2 Remove the barriers to transmitting information electronically between health service providers are removed to allow GPs and other health service providers, controlled access to health ICT systems, particularly for diagnostic results and selected medical information of their patients.

6.3 Remove the barriers to clinician driven telehealth delivered care, including processes to support the reliability and interoperability of technology and infrastructure, and workforce capability.

6.4 HSPs work collaboratively to develop a common strategy and operational plan to improve interoperability across the HSPs and the sharing/transfer of information between health service providers.

6.5 WA Health mandates the procurement and implementation of ICT systems to achieve interoperability across public health and other health service providers and relevant government departments e.g. Department of Child Protection.

6.6 HSPs, for planning purposes, have access to relevant data systems including those held by the DoH and Primary Care and likewise have access to HSP held data.

6.7 There is improved transparency between the DoH and HSP's on how the data is extracted, collated and used for reporting and purchasing purposes.

Review of system-wide contracts

7.1 The system manager improves its management and communication for key contracts utilised by the HSPs. Alternatively, a single HSP be identified to manage these contracts in-line with existing processes established by SMHS and NMHS to manage multi-HSP contracts.

7.2 PathWest services be defined as a separate entity and operate on business principles to improve service cost and efficiency.

7.3 The budget for HSS services is provided to HSPs and HSPs pay for services purchased from the support service provider.

Improve asset management planning and maintenance

8.1 WA Health investigate funding models that would ensure the allocation and quarantining of the agreed best practice funding level and apply a standardised approach to expenditure of these funds.

Enable HSP led design of future workforce requirements

9.1 The purchasing and funding model supports models of care with allied health professionals and nurses working to their full scope of practice.

9.2 Consider legislative change to further enable specific allied health and nurse prescribing.

9.3 Consider opportunities to formally recruit under-graduates in support service roles.

9.4 HSPs lead the industrial and employment conditions negotiations in an effort to better align workforce requirements to service demands to improve productivity and efficiency.

9.5 Review of current WA Health recruitment policy and practices and implement changes to create a more flexible and agile system that meet the needs of HSPs.

9.6 Barriers are removed to enable honorary clinical specialist relationships between HSPs, to enable specialist advice for patients being treated in another HSP.

9.7 The DoH and HSPs take a leadership role and mandate only those service providers who legitimately employ apprentices and trainees within their firms are eligible to be considered as a supplier of goods and services into the future.

1. Strategic planning

A pivotal component of the SMHS Board's strategic plan is to *"s*trengthen relationships with our community and partners", to ensure we develop agility across services to most appropriately and efficiently meet our community's needs. To develop this agility it is imperative for SMHS to take a population health planning and service delivery approach to service planning. Such an approach would benefit from a more predictable and cohesive approach to services delivery. It would be helpful if programs, particularly those that have a health preventative component have longer funding cycles. This would be achieved by such programs having a 'bipartisan approach' with short, medium and long term goals. The SMHS Board recognise that governments of different political persuasions have varying strategic platforms but consider that there are many common themes that would benefit from a bipartisan approach to policy. Such an approach would reduce the inefficient 'rebranding' of service initiatives which often have the same goal.

Recommendations

1.1 Government develop a bipartisan approach to health strategy including models of care, workforce and health prevention programs and agree on seven (7) year strategies, reviewed on the fifth (5^{th}) year.

1.2 Funding models are reviewed and established over 3 to 7 years to enable Healthcare organisations to develop medium and long term financial planning, which is critical for multi-billion dollar organisations. (Controls would be required to prevent any cumulative overspend.)

2. Incentivise modern approaches to health service prevention and intervention

Funding mechanism for HSPs Healthcare delivery is often reactive, episodic and provided in the hospital setting. Our communities have free and relatively easy access to hospitals in the metropolitan region and hospital services are primarily output-based rather than outcome focussed. This is a challenging paradigm to shift for communities and clinicians alike, but it is essential that proactive, holistic and preventative models of care are established. To ensure that such models are successful it is necessary for a simultaneously realignment of incentives and for genuine community and stakeholder engagement.

The purchasing and funding models for HSPs are currently not amenable to supporting hospital avoidance and substitution strategies. Funding models that work on the right care being delivered in the right place at the right time are imperative to facilitate practice change. There is an opportunity to embed such models across the health business and to develop mutually beneficial partnerships to improve health outcomes. This would require HSPs to be funded to re-invest and partner in services that are not purely hospital services.

The activity based funding (ABF) system in WA, while providing increased transparency and understanding of the cost drivers within the system, does not lend itself to alternate models of care. ABF does not invest in, or incentivise HSP clinicians to change treatments/care modalities to implement improved processes and contemporary models of health care. SMHS is not advocating eliminating ABF rather it is used as the standard recognised price of reimbursement between the HSPs for the transfer of activity, for example elective surgery or emergency services.

The two tiered Government funding model inhibits a strong primary/acute/specialist care interface and results in a siloed approach to care. This particularly affects patients with complex co-morbid care needs. There is a need to strengthen partnerships with other health and social support providers to improve care coordination and referral pathways.

There are very limited opportunities to grow or increase activity to manage demand within the current funding model and budget allocation. Unlike the Eastern states, Western Australia has not progressed to the same extent to access the Commonwealth MBS/PBS as source revenue. In mid-2016 the Department of Health (DOH) presented to HSPs the MBS Billable Specialist Outpatient Service Project June 2016, a draft framework that articulated how HSPs could establish MBS billable clinics as a way of addressing unmet demand. A number of issues/concerns remain unresolved stalling the implementation of the initiative.

The misuse of alcohol and other drugs (AOD) is a significant problem in Western Australia. It is estimated that over 40 percent of patients that present in general outpatient clinics consume alcohol at an unhealthy level and that 20 percent of hospital admissions are hospital related[1&2]. Significant investment has been put into law enforcement, communities and health in an effort to reduce the impact of AOD in our society. Less investment has been given to helping people avoid using drugs in the first instance. As evidenced with the smoking success, re-aligning investment 'downstream' may be more effective and efficient. An investment in primary prevention with a multi-governmental and multi-tiered agency approach is required to address these issues.

Opportunities exist to:

- Expand prevention and early intervention to improve health literacy and decrease the burden of chronic disease in the community.

- Strengthen partnerships with other health care providers to manage patients in primary care and reduce General Practice (GP) type Emergency Department (ED) presentations and patient preventable hospitalisations (PPHs).

- Strengthen collaborative and integrated care arrangements with General Practice through Comprehensive Primary Care (CPC) practices (aka Healthcare Homes) to deliver care closer to home in the primary care setting. This could include shared funding or bundled payments.

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1. Johnson NA etal. Prevalence of unhealthy alcohol use in hospital outpatients. Drug Alcohol Depend. 2014 Nov 1; 144:270-3. doi: 10.1016/j.drugalcdep.2014.08.014. Epub 2014 Aug 28.

2. Indig D, Copeland J, Conigrave KM. Comparing methods of detecting alcohol-related emergency department presentations. Emerg Med J. 2009 Aug; 26(8):596-600. doi: 10.1136/emj.2008.067348. PubMed PMID: 19625559.

- Community and home based services and care with patients and community service providers able to access specialist care advice when required. This should reduce hospital admissions for patients with conditions such as COPD, diabetic complications, pyelonephritis and long term mental illness.

- Develop systems that improve discharge planning and clinical handover from hospitals to primary care providers to reduce hospital readmission and support management in the community.

- Build stronger partnership with residential aged care facilities to better manage their residents with acute care and end of life needs within the nursing home setting. This would reduce unnecessary disruption for these vulnerable patients; reduce ED presentations and provide an improved quality of care.

- Work more closely with the Commonwealth government through the Primary Health Networks and local government, to develop a primary prevention strategy that includes the coordination of legislative, health promotion and social marketing strategies, to address lifestyle related illness.

SMHS believes a risk-adjusted population-based payment system, where the Government facilitates HSPs to look after the health needs of their respective populations, be implemented. Prevention is better than cure and as such HSPs need to be incentivised to reduce costs by improving the health of the whole population. The private health insurance companies have recognised this and provide for example free boot camps for their members to keep them healthy. All new models should be tied to key quality and patient outcome indicators. It would allow more flexibility to change services and models of care; to better meet patient need; reward the treating clinicians for improvements in quality and cost; and encourage the partnering with primary care and other service providers in shared care models to improve the patient journey and outcomes.

Recommendations

2.1 Funding model should be within a risk-adjusted population-based payment system tied to key outcome indicators.

2.2 Patient reported outcome measures for selected health interventions are adopted and are regularly reported by HSPs.

2.3 The purchasing and funding models are realigned to incentivise and support partnership and collaborative approaches to care to prevent unnecessary presentations to EDs and hospital admissions and have patients treated in the most appropriate setting.

2.4 Develop an agreed set of hospital avoidance performance indicators and processes to measure improvements to ensure improvements in health outcomes are achieved.

2.5 HSPs should be managed against focused preventative health management plans, linked to population needs, with achievable outcome measures.

2.6 All parties in WA Health develop a considered position on the implementation of the MBS Billable Specialist Outpatient Service framework for HSPs to consider as a strategy to expand service delivery in targeted specialities.

2.7 A primary prevention strategy is developed that includes the coordination of legislative, health promotion and social marketing strategies, to address lifestyle related illness.

2.8 Key Performance Indicators (KPIs) developed for Governmental Departments to develop and align plans to collectively improve the health and well-being of the WA population.

3. End-of-life care

The ability to extend the end-of-life for patients has increased dramatically over recent decades. Whether the quality of life for these patients has improved or diminished has not been fully researched. What is known is that clinical practices in acute care settings remains relatively unchanged in terms of the utilisation of interventions and intensive care therapies at the end-of-life, and this has the potential to delay a timely referral to appropriate palliative care services. Statistics show hospital admissions in the last year of life average approximately eight admissions per person or 44 days. Despite the advances in health care technologies a person centred approach to their end-of-life care is important[3].

It is necessary to ensure considered and appropriate end of life care is embedded in clinical practice across HSPs; aged care facilities and general practice. Opportunities exist, in collaboration with consumers, carers and clinicians, to build on the foundational work undertaken by the Cancer and Palliative Care Health Network to systematically implement end-of-life care planning and Goal of Patient Care (GOPC) in accordance with patient wishes.

Recommendations

3.1 An open debate commences with the population in respect of realistic end-of-life expectations.

3.2 Acute hospital pathways are developed to ensure end-of-life planning is formalised and where possible redirected into community based palliative care services with appropriate funding models.

3 Reference Australian Institute of Health and Welfare 2016, Australia's health series no.15.Cat. no. AUS199 Canberra: AIHW

4. Mental health care pathways and governance

SMHS believes an area requiring special consideration for reform is mental health services across the continuum of care and lifespan. For many people with mental health conditions, navigating timely access to the right care in the right place with the right team can be difficult and often results in crisis presentation to hospitals. Patients are waiting too long in EDs for beds, referral and discharge to supported community care. Additionally, it must be recognised that mental health care cannot be disassociated with the need to ensure there is appropriate housing, accommodation; stepdown and interim accommodation to ensure the most vulnerable are discharged to an environment that will support them improving their health.

There are opportunities to improve the referral pathways and integration of care between HSP mental health services, GPs and community based primary care providers to meet patients' needs in a holistic, recovery focussed service model.

Child (<16 years), adolescent (16-17 years) and youth (18-24 years) access to appropriate mental health referral pathways and services have been described by clinicians "as broken and at a crisis point", and requires urgent attention so we stop failing these young people. This will require new thinking, new service delivery models and new workforce.

EDs across WA frequently have this cohort of patients waiting for considerably more than four hours. This is not in the best interest of the patient, other patients or staff. Whilst some patients may have mental health problems, many often present following excess alcohol or drug intake. The whole process of decision making is extremely slow.

The Mental Health Commission (MHC) is responsible for the purchasing and allocation of funds for specialist mental health services. While this may have improved the identification of the expenditure in mental health, accountability, roles and responsibilities within the mental health system remain confused. This has also been identified by Professor Mascie-Taylor in his report *(Review of Safety and Quality in the WA health system: A strategy for continuous improvement 2017.)* The various reporting requirements for HSPs including to the MHC, the Chief Psychiatrist and the DoH Office of Mental Health bring into question where accountability and responsibility lies.

Recommendations

4.1 A long term plan to be developed state-wide for moving towards a crisis prevention strategy of service delivery. This should also consider the accommodation needs of the homeless and other community members who are at a higher risk of vulnerability when they have a mental health condition.

4.2 Implement the recommendation in the *Mental Health Plan* to introduce mental health observation areas to expedite the commencement of treatment and provide a more therapeutic environment than an ED.

4.3 The role of separate Commissioners of Mental Health Services and acute services be reviewed.

4.4 Undertake a system-wide review of child; adolescent and youth mental health services across the continuum of care.

4.5 Implement the *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025*.

5. Primary referral pathways for acute services

It is acknowledged for many health conditions the patient pathways across primary, secondary and tertiary care are not clear to the HSPs, referrers and patients. There is a risk therefore HSPs patients being accepted into a service and then becoming stuck reducing the likelihood of the best possible outcome for the patient or value for the tax payer.

WA Health needs to work with stakeholders to define core services for primary, secondary and tertiary care. This would then lead to the elimination of duplication across services. Additionally, WA Health needs to work with stakeholders to disinvest in low value services, practices and treatments including procedures, devices, diagnostics, programs and pharmaceuticals. Such disinvestment would provide opportunities for reinvestment into gaps in service particularly in earlier intervention and prevention strategies. Disinvestment would require an appropriate methodology, clinical, political and public consultation, agreed measures, and a rethink of the motivators within a fee-for-service funding model. It is a challenging but necessary cultural shift in service provision, looking at quality and not quantity and outcomes rather than output.

Telehealth has the potential to play a much more significant role than at present. Change is required to address the challenges impacting the health system including increasing demand, financial and workforce constraints and in Western Australia, the tyranny of distance. Telehealth development has tended to focus on telephone and visual communication and should be expanded to include a suite of digital health technology both synchronous and asynchronous, for the virtual management of patients. Telehealth should be used to provide new models of healthcare and management with a focus on health care closer to the consumer and their primary carer, improving access and equity and in raising the quality of care with better continuity of care and patient led management.

To date Telehealth service development has been service driven rather than consumer driven. Additionally it has generally been considered only within the public health provided system with little or no integration or linkage with private providers.

A lack of standardisation of infrastructure has led to some inter-operability issues. Additionally, some fundamental prerequisites inhibit effective telehealth implementation e.g. WiFi and Bossnet not available across the health system.

Recommendations

5.1 HSPs in collaboration with primary care develop clearly defined intake and referral criteria for all services in the public health system, with information readily available to referrers, patients and carers.

5.2 HSPs referral pathways inclusion criteria include pathology and radiological investigations be undertaken by the referring health service provider.

5.3 Implement a patient reported outcome measures (PROMs) questionnaires, as a way of collecting information about whether the health care interventions actually make a difference to our patients lives.

5.4 Implement a patient focussed approach to the booking of outpatient appointments to increase the likelihood that patients attend their appointment and subsequently reduce the waste associated with did-not-attends and increase access to care.

5.5 Realign investment in supported home and community care, shared care and step down services, for the ongoing treatment and management of conditions including chronic disease, mental health and palliative care.

5.6 Mandate HSPs to use Choosing Wisely, Atlas of Variation or similar, evidence based guidelines to evaluate services and disinvest from those services considered to be of low or no value to patients.

5.7 Develop a proactive approach to work with and inform the community and consumers of health best practice models of care.

5.8 Develop and implement a WA-wide strategy for Telehealth.

6. Improve ability to share patient information

The lack of a coherent ICT strategy across WA Health has resulted in a number of interoperability issues between the clinical ICT systems within and between HSPs and the broader primary care sector. This compromises the ability to share clinical information at referral to and handover and discharge from HSPs, and results in administrative duplication and the expensive duplication of clinical diagnostics, particularly radiological and pathology.

Virtual healthcare can significantly improve patient access, potentially reduce health costs and improve the patient experience. To date there has been little incentive to embrace this technology and change the way we deliver care across the system. Opportunities exist within current service models and modalities of care in all settings to embrace and implement virtual healthcare to increase patient responsibility and self-directed care to improve patient outcomes.

The inclusion of patients and carers in the decision making process for options for ongoing care should be integral to the sharing of patient information.

At a system level there are issues in reconciling DoH and HSP data, system rules and processes. These issues impact on the ability to align service delivery, purchased activity and reporting between DoH and HSP. This lack of transparency between DoH and HSPs data collection systems leads to a level of mistrust and difficulties in the collection and analysis of data for planning at all levels.

Recommendations

6.1 Promote and support the adoption of My Health Record.

6.2 Remove the barriers to transmitting information electronically between health service providers are removed to allow GPs and other health service providers, controlled access to health ICT systems, particularly for diagnostic results and selected medical information of their patients.

6.3 Remove the barriers to clinician driven telehealth delivered care, including processes to support the reliability and interoperability of technology and infrastructure, and workforce capability.

6.4 HSPs work collaboratively to develop a common strategy and operational plan to improve interoperability across the HSPs and the sharing/transfer of information between health service providers.

6.5 WA Health mandates the procurement and implementation of ICT systems to achieve interoperability across public health and other health service providers and relevant government departments e.g. Department of Child Protection.

6.6 HSPs, for planning purposes, have access to relevant data systems including those held by the DoH and Primary Care and likewise have access to HSP held data.

6.7 There is improved transparency between the DoH and HSP's on how the data is extracted, collated and used for reporting and purchasing purposes.

7. Review of system-wide contracts

DoH purchases services from a range of non-government providers including Silver Chain for sub-acute, community and care coordination services and St Johns Ambulance for patient transport and transfer. The practical requirements of these contracts, including any obligations that sit with DoH (and by extension the HSPs) are not clearly communicated. Further, there is limited transparency from DoH on purchased activity, price, reporting or customer and user forums to enable feedback through the formal contract process. This has the potential to result in duplication of services purchased, poor care coordination and patient care and isolated siloed service models within the prescribed scope of practice.

The value is achieved through sound contract management and performance monitoring processes across the entire life of the contract. WA Health needs to expand its focus during the procurement process to consider more comprehensive and standardised contract management processes and resourcing post contract award. Further, WA Health needs to standardise the skill sets and role expectations of contract managers to include the requirement to communicate how key contracts are structured; how users can best apply the contract to achieve the intended value; and to communicate to users and other interested stakeholders the key risks, performance metrics and activity of key contracts.

Recommendations

7.1 The system manager improves its management and communication for key contracts utilised by the HSPs. Alternatively, a single HSP be identified to manage these contracts in-line with existing processes established by SMHS and NMHS to manage multi-HSP contracts.

7.2 PathWest services be defined as a separate entity and operate on business principles to improve service cost and efficiency.

7.3 The budget for HSS services is provided to HSPs and HSPs pay for services purchased from the support service provider.

8. Improve asset management planning and maintenance

WA Health is inconsistent in their approach to asset management, upgrade and replacement planning for buildings, infrastructure and medical equipment. WA Health lacks a single comprehensive asset management and maintenance system and does not have a standardised approach to contracting for planned maintenance and prioritising asset and medical equipment replacement. Whilst a clear priority on asset management and maintenance is required by legislation, there is a perception in the system that many other elements are underfunded.

WA Health, like all WA Government agencies, receives capital funding for new buildings, equipment and infrastructure. There does not seem to be consideration given that these new or upgraded assets are often larger and more complex to manage and maintain, often resulting in the recurrent operational expenditure not reflecting the change in complexity and quantity of the asset base particularly within an ABF framework.

As the majority of asset maintenance is drawn from operational funding it is often moved down the priority list in lieu of funding other parts of the service. This is further exacerbated because the underfunding of assets in early years does not have a visible and immediate consequence and because the expenditure on asset management is not linear. The impacts are usually experienced in the out-years when assets fail earlier than their useful life or require major upgrades earlier than would be required had annual maintenance been conducted.

Sinking funds or quarantined accounts with clear drawdown criteria would better standardise the allocation of funding in-line with best practice and would extend the useful life of WA Health assets.

Recommendation

8.1 WA Health investigate funding models that would ensure the allocation and quarantining of the agreed best practice funding level and apply a standardised approach to expenditure of these funds.

9. Enable HSP led design of future workforce requirements

Key issues identified for change in practice or reform to ensure HSPs have the workforce they require to deliver health care now and into the future fall into the following areas:

- industrial awards and conditions
- human resources and employment management systems
- changing roles for the current workforce and expanded scope of practice
- commitment to apprenticeships and trainees.

Allied health is a highly trained and under-utilised workforce. This is due in part to the traditional narrow focus or specialisation of this workforce, and hindered by perceived erosion of their roles by the nursing and medical workforce. Many pilot projects have been run with allied health professionals working in an expanded or advanced scope of practice to demonstrate the efficacy of alternative models of care. In most cases, however, this has not resulted in a sustained change in practice or service models, with a return to traditional models of care.

Allied health professions are well placed to proactively intervene in a care pathway, as the first contact (e.g. orthopaedic physiotherapists triaging referrals and assessment); direct referrals to medical specialists (e.g. psychologist to pain specialist); prescribing equipment and consumables (e.g. home enteral nutrition); and making admission decisions (e.g. into subacute care; short stay) and criteria-led discharge.

The nursing profession, similar to allied heath, should also be considered in respect of expansion of roles and responsibilities. For example, unlike a number of other states, WA does not have nurse endoscopists. There are also broad opportunities to have nurse led discharges across some hospital specialities.

The current industrial awards and conditions can be restrictive with limited flexibility to respond to daily demands and changing service models. There is little ability to provide opportunities to employees and appropriately reward undergraduates within the current system. Approximately 75 percent of any HSP budget is salaries and wages.

Overly bureaucratic workforce management processes, including cumbersome and restrictive recruitment practices, impact the ability to recruit the right people to the right job in a timely manner. Staff transferring between HSPs are regularly required to repeat a pre-employment health assessment prior to commencing at the new HSP. This at times delays commencement.

There are multiple human resource management systems operating across WA Health with staff transferring between HSPs required to be taken off one system if it differs to the transferring HSP or DoH e.g. Lattice (paper based) and My HR (electronic system). These result in double handling, duplication and time lag in getting the information processed.

Apprenticeships and traineeships within the health sector in Western Australia have a remarkable potential to assist build Australian society and provide a dignified education pathway for quality employment. Apprenticeships and traineeships, particularly in skilled traditional trades, such as some areas of nursing, personal care and information technologies are of crucial importance to the Australian society.

The main five types of employees within the health sector are permanent or fixed term employees, casual employees, apprentices, trainees, employment agency staff, contractors and sub-contractors.

The health sector will have a continuing reliance on a variety of trades, including those associated with food trades, construction, maintenance, engineering, electro technology and telecommunications, air conditioning and refrigeration and certain divisions of nursing. Large shortages in trades and trainees in these key industrial categories are expected within the next few years.

A significant number of Australian apprentices and trainees do not complete their training. There are a range of issues that commonly emerge from the research about reasons for non-completion, including workplace or employer issues, lack of support, low wages and not liking the work, as well as literacy and numeracy concerns.

Recommendations

9.1 The purchasing and funding model supports models of care with allied health professionals and nurses working to their full scope of practice.

9.2 Consider legislative change to further enable specific allied health and nurse prescribing.

9.3 Consider opportunities to formally recruit under-graduates in support service roles.

9.4 HSPs lead the industrial and employment conditions negotiations in an effort to better align workforce requirements to service demands to improve productivity and efficiency.

9.5 Review of current WA Health recruitment policy and practices and implement changes to create a more flexible and agile system that meet the needs of HSPs.

9.6 Barriers are removed to enable honorary clinical specialist relationships between HSPs, to enable specialist advice for patients being treated in another HSP.

9.7 The DoH and HSPs take a leadership role and mandate only those service providers who legitimately employ apprentices and trainees within their firms are eligible to be considered as a supplier of goods and services into the future.

This document can be made available in alternative formats on request.

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