

# Foundations for Country Health Services

The WA Country Health Service Strategic Plan 2007 - 2010





## Acknowledgements

We would like to acknowledge the expertise and dedication of the many individuals and organisations working to improve the health of country Western Australian who have contributed to this document, and all those who provided feedback during the consultation period between October 2006 and January 2007.

Foundations is available electronically on the WA country Health Service website at [www.wacountry.health.wa.gov.au](http://www.wacountry.health.wa.gov.au)

## Foreword

This 'Foundations for Country Health Services' document (Foundations) sets out WA Health's strategic plan for strengthening health services across country Western Australia over the next three years.

In entering its fifth year of operation, the WA Country Health Service has reached an important milestone. With the benefit of hindsight and lessons learned, we can confidently reinforce our earliest vision of reform for country health services, which was outlined in the Country Health Services Review in 2003. I am delighted to report that significant progress has been achieved since we made our recommendations four years ago. The time has now come to reassess where we have come to and where we are going, to check the strength of our foundations, so to speak.

Foundations is presented at a time when public health services across Western Australia are being re-equipped to better meet the needs of a changing community, to respond to new resource, capability and capacity issues and to take timely advantage of new technologies and practices in clinical and patient care. Whilst the development of Foundations has been guided by the overall State health reform agenda, this document also affirms the distinct and unique needs and challenges of our country health system. Our overarching aim is to build the capacity and sustainability of rural health services to achieve better health outcomes for country Western Australians.

There is no question that sustaining country health services against the backdrop of increasing and widespread workforce shortages, especially for inland and remote communities, will always be a test. As will be the pressure to find ways for responding to the poorer health status of country populations, particularly amongst Aboriginal people whose life expectancy and health is far worse than that of non-Aboriginal people.

We know that the traditional system of health services does not adequately meet the health needs of country people and that health services working in isolation cannot maintain their services (a situation likely to get worse with relentless workforce shortages). Most importantly, we know that our future success depends on developing new methods and models of delivery that ensure continuity and sustainability of services.

The reforms set out in Foundations will improve the health services available to people living in country Western Australia. We will work closely with country communities and other health and related service providers when planning for, reviewing, re-designing and enhancing country health services. We know it is important that information is shared openly and that all views are considered, so everyone has a clear understanding of the issues facing country communities and how these impact on health decision making. The District Health Advisory Councils will be critical in our consultation processes.

We have set a challenging three-year horizon for Foundations. This is not to say everything in this new agenda for country health services can be fully achieved in this time. Rather, our experience, based on the Country Health Services Review, is that a document like this has a currency of around three years before it requires evaluating and refreshing.

The Foundations for Country Health Services is not another plan to justify or even vent the sorts of frustrations and difficulties being faced by country health systems around the world. It is a genuine attempt to equip the WA country health system with a solid reform program and agenda over the next three years that will hold strong in the years to come.

We do not claim to have found miracle solutions, although we are confident that the opportunity that Foundations brings for increased understanding and discussion, and for stronger clinical and working partnerships between metropolitan and rural services will go a long way in helping us achieve a more seamless approach to safe and high quality patient care for country health consumers.

I would like to thank the large number of our own staff, other health providers, health experts and community representatives who have provided input into the development of this document. Many people participated in the themed workshops and forums between July and September 2006. These immensely valuable discussions and debates led to the development of the final draft of Foundations that was distributed for comment in October 2006. Over 60 feedback submissions were received by mid-January 2007 and these have informed this final Foundations document.

The continued commitment of all stakeholders to work together in partnership, within and between regions and between country and metropolitan providers, is critical to achieving the changes required and is already evident in many parts of our system.

I look forward to strengthening partnerships with our stakeholders and to engaging rural and remote communities to ensure the objectives for country health are achieved.

Christine O'Farrell

**CHIEF EXECUTIVE OFFICER  
WA COUNTRY HEALTH SERVICE**

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# Section 1:

## The WA Country Health Service

### Introduction

The WA Country Health Service (WACHS) is the largest country health system in Australia, providing an extensive range of health services across an area of 2.55 million square kilometres for a combined population of 454,000 people – almost one quarter of the State's population. The population includes over 44,900 Aboriginal Western Australians.

The service delivery challenge is characterised by the variety of health needs of an extremely diverse resident population that is dispersed across vast distances. Rapid growth in some centres and a large transient and travelling population in many tourist, coastal and remote areas adds to the complexity of planning and delivering health services.

Prior to 2002, Western Australia's (WA's) country health system consisted of over 40 separate organisations configured mainly around individual towns, with services governed by individual health boards. In 2002, WA's rural health services were restructured into two organisations: the WA Country Health Service and the South West Area Health Service. The merger of these organisations occurred officially on 1 July 2006, with delivery of services through the seven regional health networks that now comprise the 'new' WA Country Health Service.

The WA Country Health Service directly employs more than 8,500 full and part-time staff, which equates to around 5,700 full time equivalent (FTE) staff. This includes over 2,300 FTE nurses and 180 FTE salaried doctors. Approximately 150 Visiting Medical Officers (GPs and specialists) also form a vital part of our clinical workforce.

Our services are dispersed across the State and include:

- 6 regional hospitals
- 15 district hospitals (integrated district health services)
- 50 small hospitals (including 29 multi-purpose services)
- 26 mental health services
- 3 multi purpose centres
- 8 gazetted nursing posts and 39 remote area nursing posts
- 2 State government nursing homes
- Community health services (53 locations)
- Child health services (168 locations).

WACHS also has a significant role as a landlord. It owns 500 houses/units and leases a further 150 houses/units for staff. Health employees are among the largest identifiable employee groups outside the metropolitan area. As residents and consumers they play an important role in the life and economy of the communities in which they work.



## Service Activity

The seven regional health networks provide a diverse range of services.

In 2005/06 these included:

- 315,464 emergency department visits
- 91,684 hospital inpatient discharges, including:
  - 2,251 mental health
  - 6,518 obstetrics
  - 27,607 surgical
  - 46,497 medical
  - 8,811 dialysis
- More than 244,000 acute inpatient bed days
- 4,446 births in WACHS hospitals
- More than 440 residential aged care places
- 82,255 doctor outpatient clinics
- Over 285,000 community health occasions of service
- Nearly 264,000 allied health occasions of service
- 4,397 (4.7%) inpatient transfers to Perth hospitals.

In addition:

- Over 51,000 patient trips for specialist care were subsidised by the Patient Assisted Travel Scheme (PATS), including 9,300 trips to regional centres and 41,800 trips to metropolitan hospitals and clinics, and
- More than 200 visiting specialists (metropolitan and regional) provided services in country areas across 30 specialties and sub-specialties.

## Funding the WACHS Regional Health Networks

The State Government's investment in the WACHS' regions has risen steadily since 2002/03.

Operating expenditures in each region are detailed in Table 1.

**Table 1: Operating Expenditure in the WACHS regions**

Region	2002/03 \$m	2003/04 \$m	2004/05 \$m	2005/06 \$m
Goldfields	61.24	64.36	68.39	72.53
Great Southern	55.09	59.08	64.43	68.83
Kimberley	75.15	78.01	82.41	90.18
Midwest	54.74	57.66	60.49	65.65
Pilbara	80.64	82.28	87.58	89.61
South West	102.98	113.00	122.06	134.35
Wheatbelt	75.15	79.01	83.09	84.22
Regional Totals	504.99	533.40	568.45	605.37

A further \$606 million was allocated in 2004 for a 10-year capital works program to support country health reforms. Projects include the rebuilding or renovation of all regional hospitals, the replacement of a number of other older or unsuitable facilities and upgrading staff accommodation.

## Our Partners

We (the WA Country Health Service) share our responsibility for improving and protecting the health of country Western Australians with a range of partners that are active in the provision of country health care. The coordination and planning of services to achieve health improvements consistently involves contributions from:

- Aboriginal community-controlled health organisations
- Australian government agencies
- Community, carer, aged and sporting groups
- District Health Advisory Councils and the Health Consumers' Council
- Disability Services Commission
- Industrial and professional associations
- Local government
- Metropolitan health services and providers of visiting services
- Non-government organisations, including Silver Chain Nursing Association
- Private health providers, including rural GPs, specialists and allied health practitioners
- Royal Flying Doctor Service
- Safety and quality organisations
- St John Ambulance Australia and country ambulance volunteers
- Training and research organisations, including universities and TAFEs
- The Western Australian Department of Health and other State government departments
- Workforce agencies, including the WA Centre for Rural and Remote Medicine, and
- A network of suppliers and businesses that support the day-to-day activities of health provision.

We will work in partnership with all of our country health service stakeholders to provide a safe, high quality, accountable and sustainable health care system.

## Section 2: The context for change

### WA Health Reform

The 2004 Report of the Health Reform Committee (The 'Reid Report') provided a vision for the Western Australian health system aimed at improving the health of Western Australians and ensuring that the growth in health expenditure is sustainable.

Implementation arrangements for The Reid Report reforms were summarised in the policy document *WA Health Strategic Intent 2005 - 2010*<sup>1</sup>, which set out WA Health's Purpose, Vision and Strategic Directions, and which continues to guide reform across the whole of the public health system in WA.

**Figure 1: WA Health Strategic Intent 2005 - 2010**

Our Purpose:	To ensure healthier, longer and better lives for all Western Australians.
Our Vision:	To improve and protect the health of Western Australians by providing a safe, high-quality, accountable and sustainable health care system.
Our Six Strategic Directions:	Healthy Workforce, Healthy Hospitals, Healthy Partnerships, Healthy Communities, Healthy Resources and Healthy Leadership.

The *Reid Report* also provided specific guidance and endorsement for the positioning and development of services in rural and regional Western Australia, including:

- Endorsing the vision for country health services as outlined in the Country Health Services Review.
- Confirming that multi-purpose services and integrated district health services should continue to be developed in collaboration with local service providers and the Australian Government to provide more comprehensive, accessible and sustainable health services to small rural communities.
- Endorsing proposals to develop regional hospitals into regional resource centres in Geraldton, Broome, Port Hedland, Kalgoorlie, Bunbury and Albany to provide more locally based, accessible hospital care, where clinically appropriate.
- Confirming that opportunities for telehealth as a component of the integrated care system should continue to be explored.
- Directing that formal links between the country and metropolitan area health services, which

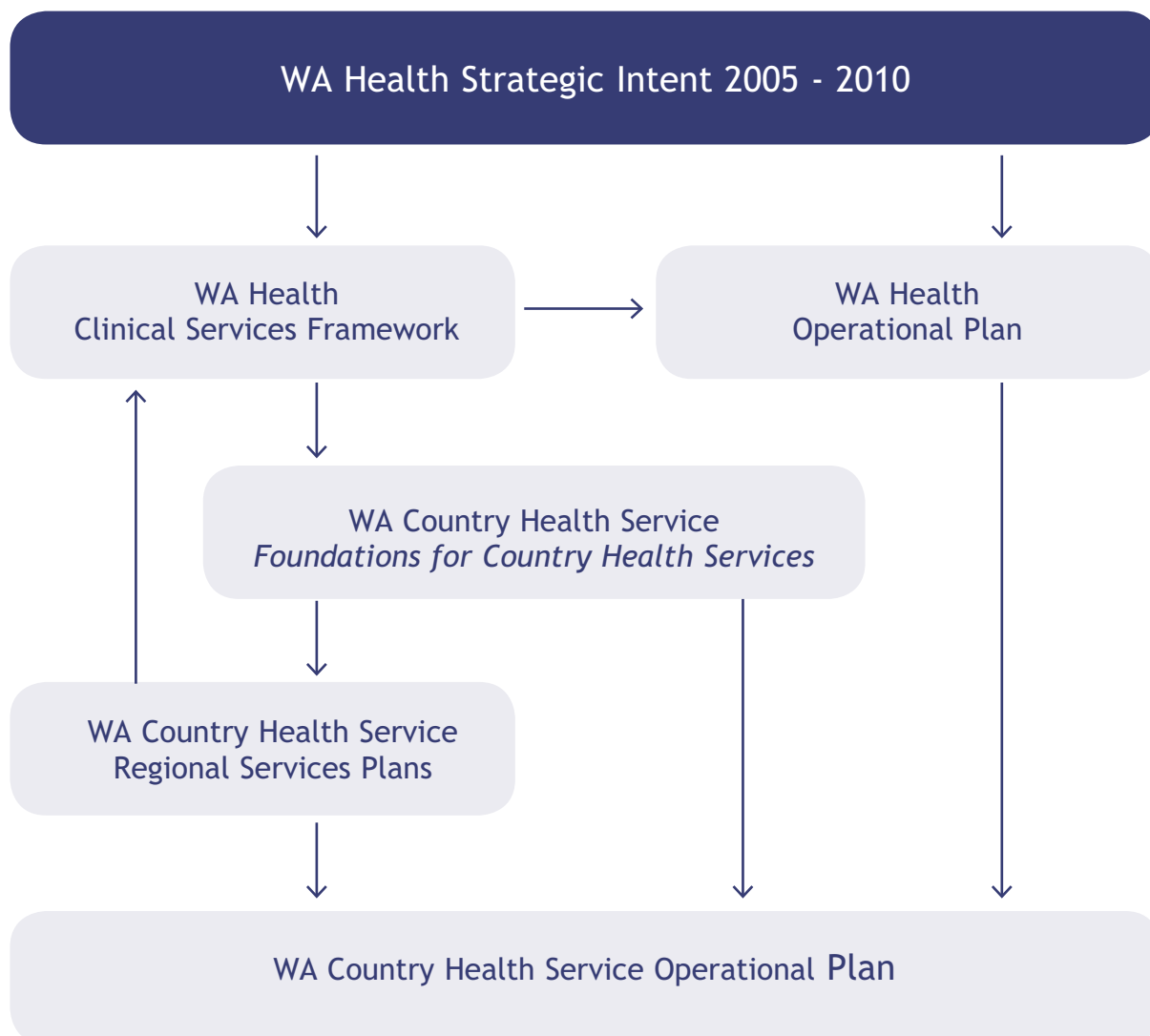
<sup>1</sup> See <http://www.health.wa.gov.au/HRIT/publications/> for access to the Reid Report, the WA Health Strategic Plan 2005-2010 and the WA Health Clinical Services Framework

ensure regional patients have timely access to tertiary health care and up-to-date professional expertise, should be clearly described. The performance agreements of the metropolitan area chief executive officers should explicitly include these linkages.

## Foundations for Country Health Services 2007 - 2010

Foundations is the WA Country Health Service strategic plan for reforming and strengthening health services across country Western Australia over the next three years to June 2010. It builds on the reforms outlined in *The Country Services Review, 2003* and aligns to the *WA Health Strategic Intent 2005 - 2010*, as shown in Figure 2.

Figure 2: The Integration of WA Health and WA Country Health Services Strategic Planning



## Country Health Reform To Date

Following the publication of the 2003 Country Health Services Review, WACHS initially focused on consolidating the more than 40 separate organisations into six regional services and on building the capacity of the regional hospitals to provide a broader range and complexity of services within the regions. More recently we have focused on realising the benefits of being an integrated rural health system. Some of our key achievements in implementing the six WA Health strategic directions are outlined in Appendix 1.

## Drivers for Country Health Reform

Consistent with national and international studies, the Reid Report identified that current and future demand for health services could not be managed simply by increased investment, and that services could not continue to be provided in traditional ways. Health services need to be reformed in order to better respond to community health needs, to deliver greater health benefits with the available resources, to improve service quality and safety, to improve access for all country West Australians and to ensure the long-term sustainability of services.

Five major issues are driving the need for country health services to be reformed. These are:

1. Population growth and change
2. Workforce shortages, specialisation of the medical workforce and the evolution of medical technology
3. The higher burden of disease in country WA
4. Greater patient safety and quality improvement expectations
5. Escalating costs and complex logistical challenges of rural health service provision.

### 1. Population Growth and Change

The overall country population is forecast to increase by 13% between 2001 and 2011. A range of population changes are also occurring, such as:

- Booms in mining areas, including the Pilbara, Boddington and Esperance/Hopetoun
- Significant growth in the South West and coastal towns
- A longer-living, ageing population with higher incidence of chronic conditions
- An increasing younger Aboriginal population and significant and persistent disparities between the health status of Aboriginal and non-Aboriginal people.

The following graphs illustrate population ageing trends; country mortality rates compared with the State average; and WACHS Aboriginal population compared with the State average. The data shows that the Kimberley, Pilbara, Midwest and Goldfields regions have higher rates of mortality and higher percentages of Aboriginal population compared with the State average.

Chart 1: Regional residents aged 70+ and ATSI aged 50+<sup>2</sup>

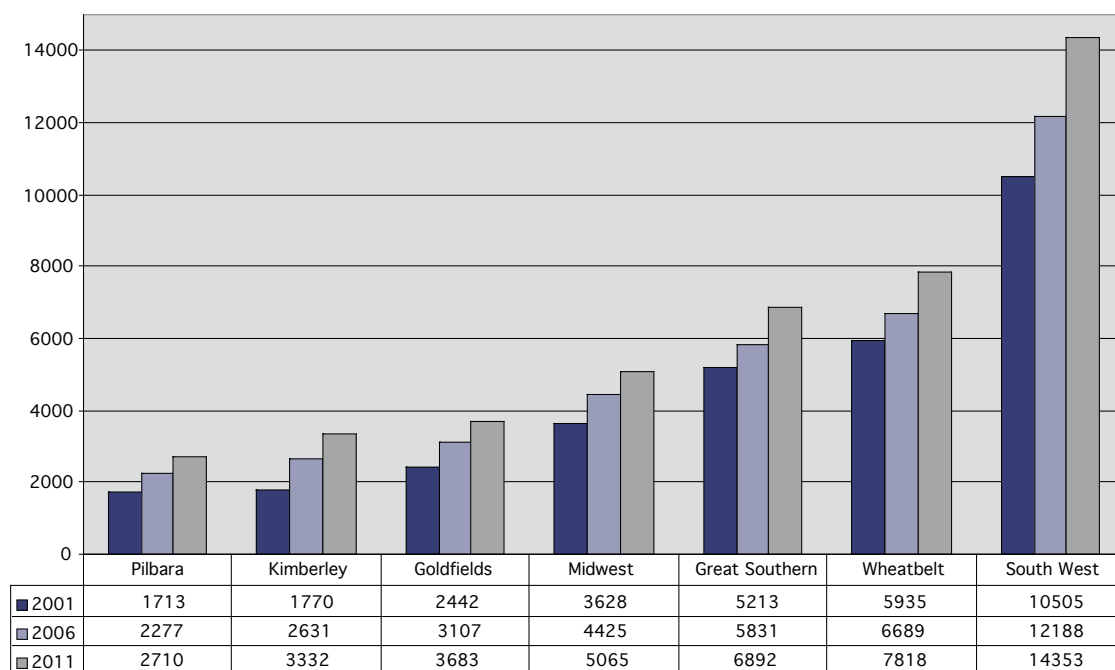
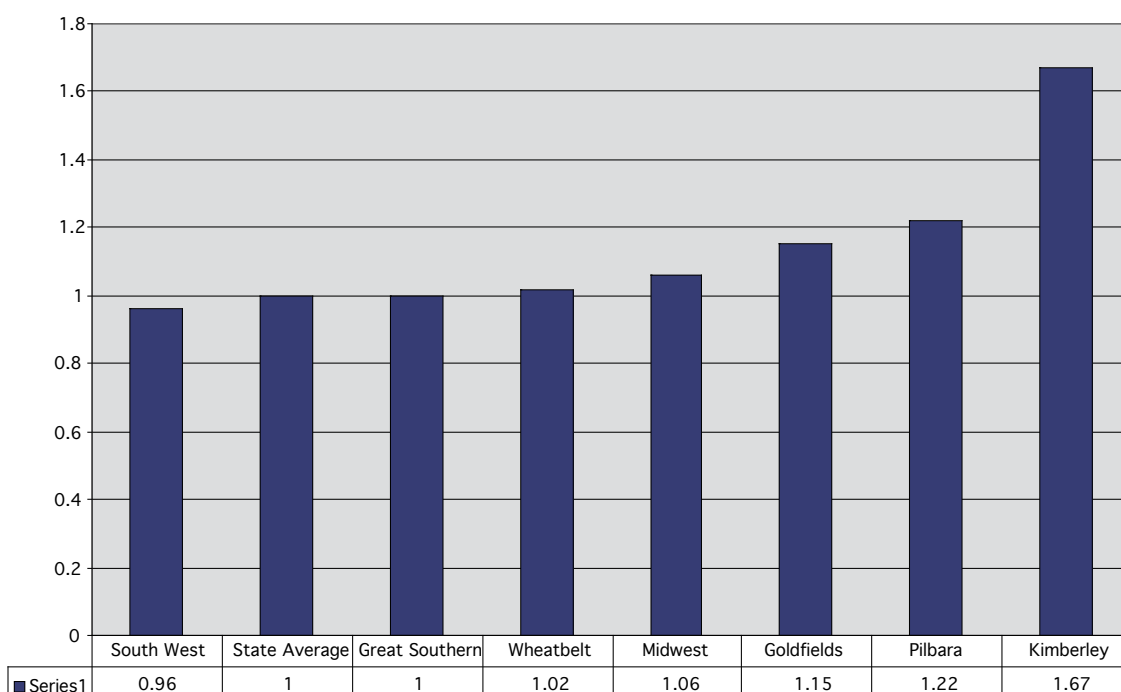
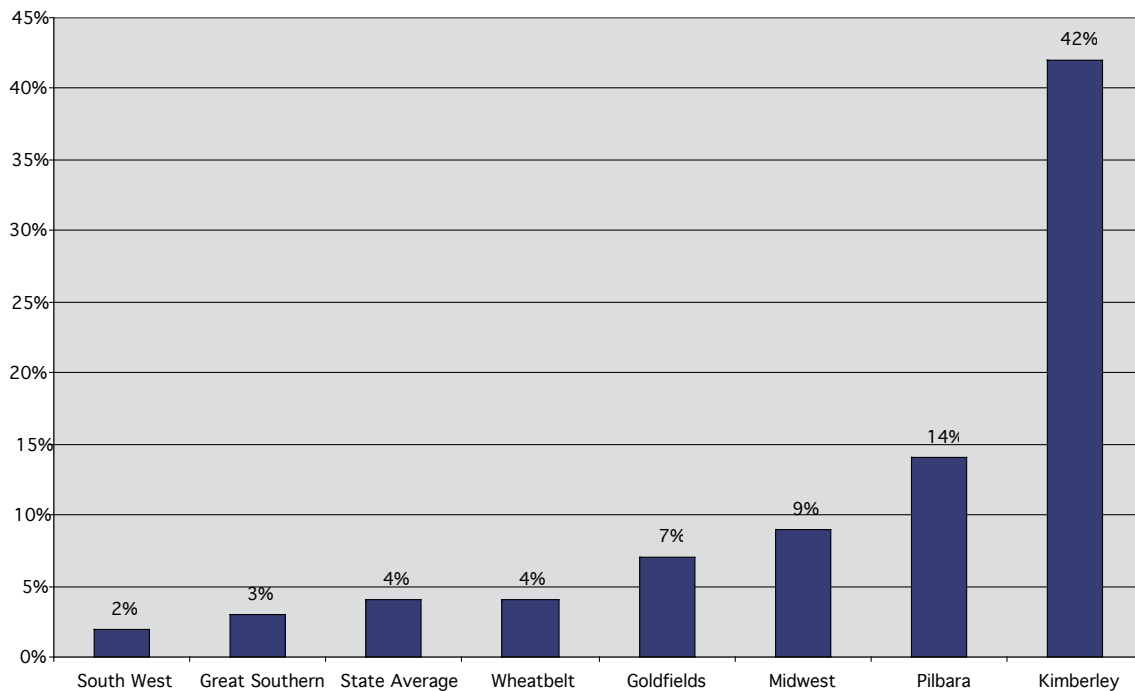


Chart 2: Regional mortality compared to the State average, 2004



2 (2001 actuals, 2006 and 2011 projections)

**Chart 3: Aboriginality as a percentage of total population**

## 2. Workforce shortages, specialisation of the medical workforce and the evolution of medical technology

Workforce shortages exist across most disciplines including nursing, some allied health areas, medicine and some key support positions that are essential for health operations management. The shortages are exacerbated by:

- Competition for skilled health workers within Australia and globally
- Preference for metropolitan/coastal lifestyle and jobs
- Employees' desire for shorter working hours and less stressful jobs.

The continuing strong trend towards medical sub-specialisation offers the country system little comfort. Country health services rely heavily on a generalist medical workforce. Country doctors have to be able to move easily between family medicine and emergency medical and procedural activity. It is projected that the country will have a lower supply of multi-skilled generalist doctors in the future. Even country specialists need to have a broad range of skills and expertise. Better coordination of the medical workforce throughout the regions and more flexible and responsive linkages with metropolitan medical services will, therefore, be far more critical in the future.

Additionally, an increasing number of highly specialised technologies are only available in the metropolitan area, due to their high costs and relatively low levels of activity.

### 3. The higher burden of disease in country WA

The health status of the people of Western Australia and the quality and availability of health services is extremely high by international standards, in both rural and metropolitan areas. This is demonstrated by such measures as mortality rates and life expectancy. The country population, however, carries a higher burden of disease and has poorer health status than the State average. This is clearly demonstrated by Chart 2 (above), which shows the impact of this poorer health status in terms of rural mortality rates compared with the State average. The National Healthy Horizons framework<sup>3</sup> provides directions and priorities for states and territories to improve the health of rural Australians over a five-year period to 2007. The report finds that, “The highest level of health disadvantage is in remote areas of the nation and health status progressively improves with increased population density and infrastructure”.

The poorer health status in country WA is largely a result of the higher proportion of Aboriginal people living in remote areas, with their significantly poorer health outcomes compared with other Australians.

Service reform is needed to better equip WACHS to address the health inequality of rural Western Australians. Mental illness and renal disease are becoming two major areas of demand upon country services and resources. WACHS hospitals are in the main, however, poorly adapted to deal with mentally ill patients presenting as medical emergencies and, while renal disease in the Aboriginal population is largely preventable, resources are concentrated at the end stages of treatment.

### 4. Greater patient safety and quality improvement expectations

The community has high expectations of access to a broad range of primary and specialised health services. Delivering these, whilst ensuring that patients are safe from the preventable harm and hazards known to be inherent in modern health care, is a special challenge in rural settings. In particular, issues such as recruitment, retention and professional support are more difficult than elsewhere and are compounded by factors such as distance, low volumes of activity, increasingly specialised healthcare demands and minimal access to peer support.

### 5. Escalating costs and complex logistical challenges of rural health service provision

The State government, in line with other governments, has established a health financing policy that requires WA Health to perform within its allocated budget, with an annual funding increase of 5.5%. The combination of increasing demand for health services resulting from population growth and ageing, and from increasing workforce costs resulting from shortages and from the increased costs of advances in medical practice and technology, makes the financial outlook for the WA Country Health Service extremely challenging.

An extensive program of health service and infrastructure reform is being progressed to ensure services in WA are able to operate on a sustainable financial basis in future. Innovative new programs are being implemented to help reduce the demand on acute hospital beds and to ensure appropriate services for the future.

It is essential that all health resources be directed to effective and efficient services, which provide the best prospects for responding to health needs and priorities. Country people must have acceptable levels of access to these services, whether local, within the region or from Perth.

3 Healthy horizons: A framework for Improving the Health of Rural, Regional and Remote Australians, Outlook 2003 - 2007, a Joint Development of the Australian Health Ministers' Advisory Council's National Rural Health Policy Sub-Committee and the National Rural Health Alliance.



## Section 3:

# The WA Country Health Service Strategic Intent

### Reform Directions

The primary drivers of reform for the country health system are identified above. We now need to define the new directions to take in order to respond to these drivers and develop a more robust and sustainable country health system for the future.

The WA Country Health Service has adopted the WA Health Purpose and Vision and its three ‘new strategic directions’ for reform of country health services are outlined below. Specific objectives and key actions linked to these are discussed and detailed in the following sections of this plan.

#### Networking Health Services

Better connecting people and services, whether within regions, between regions and metropolitan hospitals or among the different providers in the country, is vital to improving both access to health services and the efficiency and effectiveness of those services.

The 2003 Country Health Services Review introduced the concept of the Regional Network Model. The benefits of some aspects of this model are already becoming evident and, with continued effort over the next few years, we will deliver further positive results. Future priorities include:

- Further implementation of the regional hospital role delineation (or ‘hub and spoke’) concept, which identifies the roles of all hospitals and health services within a regional health network
- Effective regional services planning and operations management to ensure that services in each region are well coordinated and are tailored to most effectively respond to local needs
- Greater collaboration between medical, nursing and allied health staff across regions, to ensure that patients receive seamless health care irrespective of how they enter the system and to ensure small communities receive good access to primary-health care
- Ensuring an effective emergency care network in each region.

We will also improve the quality and safety, and therefore the health outcomes, of our services by pursuing a culture in which clinical practice is routinely reviewed and strengthened through good clinical governance practices.

### Building Healthier Communities

We believe that we can make better use of the available human and financial resources, by rebalancing our effort and investment across the continuum of services. WACHS aims to direct more resources into:

- Disease and injury prevention, earlier intervention and smarter management of chronic diseases
- Providing more services to people in home and community-based settings, especially with a view to maintaining the health and independence of older people
- Developing the mental health and alcohol and drug response capacity of all service units and regional programs
- Improving Aboriginal health.

### Strengthening and Modernising the Country Health System

The WA Country Health Service is facing major challenges in sustaining high quality and accessible services in an environment of increasing demand and workforce shortages. We will re-evaluate our management and support systems across the whole WA Country Health Service, and within each regional health network, and consolidate those where there may be duplication of effort. New and innovative ways to increase the efficiency and effectiveness of our management and support systems will be developed.

## Reform Objectives and Actions

Specific objectives and actions underpin each reform direction and are summarised in the tables over the next few pages. The actions will be implemented progressively over the next three years.

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 1: Networking Health Services</b>	
1) Integrated, well-planned and well-coordinated networks of health services in each region, which work in collaboration with key local, regional, and metropolitan service providers.	<ol style="list-style-type: none"> <li>1. Develop Regional Clinical Services Plans, in collaboration with regional and metropolitan service providers and District Health Advisory Councils, to ensure that services in each region are well coordinated and are tailored to most effectively respond to local needs.</li> <li>2. Lead the coordination of services across all providers in each region including rural doctors, Aboriginal health service providers, private and non-government services and local government.</li> <li>3. Undertake a role delineation review to clarify the roles and responsibilities of all WACHS services.</li> <li>4. Review the locations at which obstetrics services, anaesthetic services and residential aged care services are provided.</li> </ol>
2) Strong and effective District Health Advisory Councils that represent local communities in the planning and delivery of health services.	<ol style="list-style-type: none"> <li>5. Train, resource and promote the role of District Health Advisory Councils in country communities to inform the planning and delivery of safe, quality health services.</li> </ol>
3) Improved regional self-sufficiency and metropolitan-country linkages.	<ol style="list-style-type: none"> <li>6. Contribute to the development of country appropriate models of care through active participation in the WA Health Clinical Networks.</li> <li>7. Review and implement the WACHS Specialist Services Plan.</li> <li>8. Review and strengthen the area and regional management structures and their functions.</li> <li>9. Implement regional strategies to ensure country residents receive elective surgery within the WA Health recommended time frames.</li> </ol>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 1: Networking Health Services</b>	
4) Services provided by small country hospitals meet the needs of local communities more effectively.	10. Communities where small hospitals are located will be provided with the opportunity to work with WACHS to review and re-design local health services.
5) Improved administration, coordination and responsiveness of patient transport.	<p>11. Build the capacity of patient transfer coordination in each region.</p> <p>12. Streamline the administration of PATS through greater regional and central coordination and more flexible and simplified application processes.</p> <p>13. Communicate the scope and eligibility of PATS to country doctors and their patients.</p> <p>14. Work with remote Aboriginal communities to improve transport for people from these communities to health services.</p>
6) Safe and sustainable air and road inter-hospital transportation.	<p>15. Implement relevant recommendations of the national Royal Flying Doctor Service review in partnership with the Australian Government.</p> <p>16. Establish agreement with the Royal Darwin Hospital to accept inter-hospital patient transfers from the East Kimberley.</p> <p>17. Work with St John Ambulance Australia to ensure the availability of reliable ambulance services to all country communities.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 1: Networking Health Services</b>	
7) A tiered, integrated emergency care network in each region.	<p>18. Determine the emergency capability of all sites consistent with their role delineation and define minimum standards of response, for example relating to access to emergency triage.</p> <p>19. Develop systems for regional hospitals to provide emergency expertise to smaller and more remote sites.</p> <p>20. Extend the use of call centre technology for after hours emergency triage in small communities.</p> <p>21. Develop protocols and establish a coordinated service to provide clinical advice and management of transfers of emergency and critically ill patients from country emergency departments in collaboration with RFDS, SJAA and metropolitan hospitals.</p>
8) Optimal use of country emergency departments.	<p>22. Establish primary care-type clinics in emergency departments for non-emergency presentations.</p> <p>23. Implement reforms to access Medicare funding for primary care services provided from small hospitals.</p> <p>24. Undertake community education on the appropriate use of emergency services.</p>
9) Enhanced available skilled emergency workforce.	<p>25. Increase the number and expand the role of nurse practitioners providing emergency care.</p> <p>26. Progressively recruit emergency specialists in each regional hospital.</p> <p>27. Develop psychiatric emergency capability in each regional hospital.</p> <p>28. Use telehealth and call centre technologies to build and maintain staff skills in emergency care.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 1: Networking Health Services</b>	
10) A strong workplace culture of service quality, patient safety and workforce accountability.	<p>29. Develop a WACHS annual Patient Safety and Quality plan.</p> <p>30. Establish regional clinical governance structures that ensure quality and patient safety is a primary consideration in all service plans and service evaluation.</p> <p>31. Develop service standards based on the best available evidence and research.</p> <p>32. Ensure the WACHS orientation program emphasises patient safety and quality.</p> <p>33. Ensure WACHS performance agreements with all clinical and patient support staff include a requirement that all staff undertake ongoing training and skills maintenance regarding their patient safety and quality responsibilities.</p> <p>34. Provide high-quality clinical supervision in all patient-care areas and have clinical supervisors monitor clinical systems for quality of care.</p>
11) Robust performance information and monitoring systems to support clinical practice and to provide safe service delivery environments.	<p>35. Develop and maintain a reliable workforce recruitment system to ensure that only staff who are qualified, experienced and credentialed to work within an appropriate scope of practice are recruited.</p> <p>36. Develop systems to involve clinicians in the review of clinical practice and outcomes through bodies such as medical advisory committees and clinical practice review committees.</p> <p>37. Develop and implement performance monitoring, reporting and evaluation systems and performance targets.</p> <p>38. Develop and implement systems to identify and manage risks to patient safety across all health services including, for example, the review, re-design or discontinuation of unsafe services.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 1: Networking Health Services</b>	
	<p>39. Develop systems to improve incident and adverse event reporting, analysis and investigation.</p> <p>40. Implement the Patient First Program in partnership with District Health Advisory Councils and the Office of Safety and Quality.</p> <p>41. Provide training in advocacy to District Health Advisory Councils and seek their feedback on safety and quality reports.</p>
12) Evidence based and innovative population health services.	<p>42. Establish primary care, child health and community health early intervention and prevention programs including, for example, maternity and early years interventions and parenting programs, adolescent and transition-from-school strategies, and family years interventions, through innovative models that engage the community.</p> <p>43. Improve access to primary care, child and community health and Aboriginal health services through greater use of allied health assistants.</p> <p>44. Introduce a common set of evidence-based standards and interventions for primary care, child health and community health covering target groups and eligibility criteria.</p> <p>45. Develop a coordinated disease control program and provide training to population health and acute service staff in communicable disease management.</p> <p>46. Build health promotion and disease prevention capacity across all country hospitals and health services.</p> <p>47. Provide a more coordinated and consistent contribution to environmental health issues in remote and Aboriginal communities.</p> <p>48. Implement self-care initiatives, particularly amongst Aboriginal communities.</p> <p>49. Work in collaboration with the Australian Government to develop new services through the Australian Better Health Initiatives program.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 2: Building Healthier Communities</b>	
	<p>50. Increase mental health promotion and illness prevention services across all ages.</p> <p>51. Evaluate the effectiveness of WACHS population health activities, applying action research and learning approaches.</p>
13) Innovative community based ambulatory care services.	<p>52. Establish 'hospital in the home' services in each region.</p> <p>53. Establish the Rural Home Link program including a Rural Home Link telephone line to enable better coordination of discharge planning for country patients who are leaving metropolitan hospitals.</p> <p>54. Implement the Aboriginal Meet and Assist program in Perth to better support and transport Aboriginal patients from remote locations arriving for treatment in Perth and to improve discharge planning processes for regional Aboriginal patients.</p>
14) Innovative community based chronic disease management services.	<p>55. Establish a chronic disease management coordination service to improve access to services for people who are living with chronic disease and coordinate services to help these people better manage their issues at home.</p> <p>56. Implement community based chronic disease management programs in each region.</p>
15) Robust disaster and pandemic preparedness and response planning.	<p>57. Develop Regional Health Disaster Plans in close consultation with other key partners to ensure the provision of appropriate health disaster management responses to protect country communities.</p> <p>58. Develop area wide and regional pandemic influenza management plans that will apply to hospitals, other healthcare providers, residential care facilities, emergency and essential services and Aboriginal communities.</p>



Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 2: Building Healthier Communities</b>	
16) Alcohol, smoking and other drug strategies that are relevant and appropriate to rural and remote areas in partnership with the Drug and Alcohol Office and the Tobacco Control Branch.	<p>59. Implement the Brief Intervention Program and Smoking Policy in health service sites.</p> <p>60. Collaborate with other providers of drug and alcohol services, tobacco control agencies and statewide health promotion campaigns to achieve 'country-appropriate' programs and coordination at a regional level.</p> <p>61. Develop capacity to admit patients into regional and district hospitals for detoxification from alcohol and drugs and work in partnership with local community drug service teams and Aboriginal services to ensure that patients have an appropriate plan for ongoing treatment.</p> <p>62. Identify and support medical officers in each regional centre and selected towns to provide limited pharmacotherapy services, and complement the services of general practitioners in the regions with local support from community drug service teams and central support from the Drug and Alcohol Office.</p>
17) Accessible, integrated and coordinated health services for Aboriginal people.	<p>63. Redesign services in collaboration with local Aboriginal communities to better meet Aboriginal primary, community and environmental healthcare needs.</p> <p>64. Strengthen regional or sub-regional Aboriginal Health Planning Forums, host and fund an annual statewide conference of regional Aboriginal health planning forums, and work with partner agencies to develop and implement regional Aboriginal health action plans.</p> <p>65. Provide Aboriginal-managed services operating from WA health facilities with levels of support equivalent to those of WACHS remote services.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 2: Building Healthier Communities</b>	
18) Culturally appropriate planning and delivery of services.	<p>66. Establish a WACHS Aboriginal health reference group in partnership with the Office of Aboriginal Health that reports to the WACHS Chief Executive Officer.</p> <p>67. Implement the WA Health Cultural Respect Implementation Framework across all services including all staff participating in cultural awareness education and training.</p> <p>68. Develop strategies for Aboriginal input into regional service planning and decision making.</p> <p>69. Review the provision of aged care services to Aboriginal people and develop and implement culturally secure practice guidelines to better meet the needs of Aboriginal communities.</p>
19) Improved access to specialist mental health advice, support and tertiary services.	<p>70. Engage service providers including Aboriginal Community controlled agencies, GPs and other non-government organisations in statewide and regional mental health strategy development.</p> <p>71. Develop and introduce innovative workforce models including mental health nurse practitioners and support workers.</p> <p>72. Explore collaborative arrangements between mental health and alcohol and drug services including collocations, mergers, shared care protocols and case management.</p> <p>73. Use visiting psychiatrists from regional or metropolitan centres to increase mental health outreach services.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 2: Building Healthier Communities</b>	
20) Primary, community, emergency and other hospital services are able to manage and provide non-specialist mental health care.	<p>74. Expand and clearly identify the roles of public health, primary health, child and community health and general hospital staff and services in mental health care.</p> <p>75. Develop the expertise of emergency staff, other staff and general practitioners to manage mental health presentations competently and confidently, for example through training, telehealth and tele-psychiatry.</p>
21) Increase the focus on services that maintain the health and independence of older people	<p>76. Develop community-based services that maximise the independence of older people.</p> <p>77. Expand early discharge and community rehabilitation services for older people.</p> <p>78. Introduce the Residential Care Line to provide residential aged care services with telephone advice and support that will enable them to manage sick patients who do not require transfer to an acute service.</p>
22) A coordinated, integrated and efficient network of community and residential aged care services in each region.	<p>79. Appoint aged care coordinators in all regions.</p> <p>80. Strengthen aged care services and skills by utilising the expertise of visiting geriatricians and telehealth.</p> <p>81. Review the current arrangements for residential aged care services to improve efficiency and quality of care.</p> <p>82. Make better use of the skills of registered nurses by increasing the number of patient care assistants employed for non-nursing duties</p> <p>83. Meet relevant national standards for community and residential aged care services.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 3: Strengthening and Modernising the Country Health System</b>	
23) Make the best use of available resources through improving budget accountability, financial planning, resource allocation and financial management systems.	<p>84. Improve budget allocation and accountability across WACHS.</p> <p>85. Review and strengthen WACHS' financial planning and financial management systems.</p> <p>86. Roll out of the Oracle financial management system throughout WACHS.</p> <p>87. Work with the Office of Aboriginal Health to identify and resolve information and other gaps in the financing and delivery of Aboriginal health services to increase service coordination and funding transparency.</p> <p>88. Consolidate support services to provide area wide services from specific regional centres or head office.</p>
24) All available revenue resources are accessed.	<p>89. Improve systems for recovering the costs of eligible services from Medicare, DVA, Workers Compensation, private patients and other sources.</p> <p>90. Pursue partnerships with private sector and non-government community organisations that offer benefits for country health services.</p>
25) Workforce planning, recruitment and retention align to services planning and strategic directions.	<p>91. Establish a central workforce unit to develop consistent and innovative approaches to workforce strategy, clinical employment and new clinical roles.</p> <p>92. Ensure workforce planning and employment arrangements support the introduction of new flexible service delivery models, such as mobile clinical teams.</p> <p>93. Improve the service and support arrangements for visiting medical practitioners.</p> <p>94. Develop comprehensive rural employment and remuneration packages for WACHS clinical staff.</p> <p>95. Develop systems that assist clinical staff to transfer more easily within the WA health system.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 3: Strengthening and Modernising the Country Health System</b>	
	<p>96. Improve the recruitment, assessment, orientation and training of Overseas Trained Doctors through partnerships with workforce agencies.</p> <p>97. Work with educational institutions to ensure tertiary educators are encouraging and preparing trainees to take on challenging roles in rural and remote settings.</p> <p>98. Develop and implement a WACHS Aboriginal workforce strategy to increase the number of Aboriginal employees in health service delivery by 10% per year.</p> <p>99. Implement the WA Health 'nursing hours per patient day' nursing workforce methodology across all hospitals.</p>
26) Innovative workforce models and new types of practitioners to support contemporary health services.	<p>100. Extend the use and role of nurse practitioners in providing emergency care, mental health care and in remote locations.</p> <p>101. Extend the use of therapy assistants, clinical support workers and patient care assistants throughout WACHS.</p> <p>102. Introduce innovative and flexible service models such as mobile clinical teams to address critical gaps, especially at smaller sites or in remote areas.</p>
27) WACHS is an employer of choice.	<p>103. Increase access to training for regional doctors and other clinicians through locum support, relevant education and training (including through greater access to telehealth), consultancy advice and rotating posts.</p> <p>104. Implement the WA Health bullying and harassment education programs across WACHS.</p> <p>105. Develop new strategies to improve safety for staff working in remote locations.</p> <p>106. Develop, promote and implement flexible and family friendly work practices.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 3: Strengthening and Modernising the Country Health System</b>	
28) Build more supportive and collaborative working with rural doctors.	107. Progressively implement the WACHS related recommendations from the Engaging Rural Doctors consultation report 2006 over the next three years.
29) Timely and comprehensive information management systems	<p>108. Consolidate clinical and corporate information systems to support analysis, reporting and decision-making.</p> <p>109. Provide data analysis tools to support the WACHS reform program and improved service delivery.</p> <p>110. Identify business opportunities that will strengthen support the WACHS reform program and strategic intentions.</p> <p>111. Collaborate with private and non-government country health services to allow for sharing of information across health and related service providers.</p>
30) Enhanced information and communication technology.	<p>112. Establish an area wide ICT support team.</p> <p>113. Implement consistent, robust and scalable ICT across WACHS through planned replacement of ICT infrastructure.</p> <p>114. Upgrade network infrastructure including increased bandwidth capacity and implementation of new telephone and telehealth systems.</p> <p>115. Develop an ICT Disaster Recovery/Business Continuity plan.</p>

Objectives What we want to achieve	Actions What we will do
<b>Reform Direction 3: Strengthening and Modernising the Country Health System</b>	
31) Improved access to specialist services and staff training through telehealth and other e-health technologies.	<p>116. Improve access to consultancy and specialist support services by expanding the capacity of tele-health, tele-psychiatry and other e-health technologies.</p> <p>117. Establish statewide diagnostic imaging services in the areas of wound management, ophthalmology and otology (especially to Aboriginal communities).</p> <p>118. Implement chronic disease monitoring within the home using video conferencing to enhance patient self-management ('Pathways Home' demonstration project).</p> <p>119. Improve access for the families of patients in metropolitan hospitals, enabling the families to 'visit' the patients via video conferencing.</p> <p>120. Improve clinical supervision, education and training, peer review and support through enhanced use of and access to telehealth, tele-psychiatry and net-meeting technology.</p>
32) WACHS facilities are replaced or redeveloped in accordance with WACHS reform directions, identified needs and role delineation.	<p>121. Carry out the major projects identified for development over the next three years in the 10 year Capital Investment Plan.</p> <p>122. Explore opportunities for co-location of private or non-government sector services with our public health facilities.</p>
33) Improved asset maintenance and management.	<p>123. Ensure our assets are maintained at appropriate levels and remain relevant to strategic reform directions.</p> <p>124. Include WACHS facilities occupied by Aboriginal Medical Services in the WACHS asset maintenance program.</p>

## Section 4:

# Reform Direction 1

## Networking Health Services

### Introduction

The development of integrated service delivery networks is a key strategy for WACHS. Stand-alone health facilities and services will not be able to maintain comprehensive, high quality services in an environment of rising costs, workforce shortages and increasing levels of specialisation. An integrated approach is needed such that each service component has a clear role in the overall system of health care and all services work together and support each other in a coordinated way.

At a regional level, the development of fully integrated health networks will ensure that services are not working in isolation but are supported by the broad range of other health services provided across the region. This will result in better access to health services for patients, and better support for health workers.

Role delineation specifies the level of care to be provided at each site and for each specialty, and identifies the associated clinical support services required to deliver that level of care safely and in compliance with current standards. Role delineation underpins the development of regional health networks and will be an important component of regional services planning.

This section examines five key components of WACHS' services that will benefit significantly from the development of health networks and role delineation:

- Regional health networks
- Country hospitals
- Access to services through better patient transport
- Improvements in our emergency response
- The quality and safety of our services.

### Regional Health Networks

#### Intent

The WA Country Health Service will integrate all of the services that it provides within each region into a single, integrated system of care to deliver health services and programs according to their role delineation.

#### The Regions

WACHS delivers health care services to country WA through seven regions, configured around natural geography and health catchment patterns. Each of the seven regions provides an extensive range of health services, including hospital, mental health, aged care, public health, community health, primary health, Aboriginal health, child health, pharmacy and health transport services.



Six of the regions were established in 2002.

On 1 July 2006, the South West Area Health Service was incorporated into the WA Country Health Service to form a seventh region.

Following this, WACHS reviewed the regional boundaries and, from September 2006, the hospitals and health services in Carnarvon and Exmouth were incorporated into the Midwest region.

Hospital and health services in Onslow remain part of the Pilbara region.

The boundaries of the other regions remain unchanged.

### *New Names for the Regions*

For simplicity and ease of reference the regional health network names are now:

- Goldfields
- Great Southern
- Kimberley
- Midwest
- Pilbara
- South West
- Wheatbelt.

Other essential providers of health care within the regions include private general medical practitioners, private and visiting medical specialists and allied health professionals, non-government and community-based organisations, Aboriginal community controlled health organisations, and other government agencies.

The interface between WACHS' hospitals and health services and the primary and other health services provided by others is fundamental to achieving good health outcomes. Recent consultations with rural doctors, for example, have highlighted areas where more effective relationships with general practitioners will reduce duplication and provide a more comprehensive service to the community. We will develop these improved relationships, both with the private general medical practitioners who provide most primary care and secondary hospital based medical services in the South of WA, and with the doctors directly employed either by WACHS or by community controlled Aboriginal medical services who provide most of these medical services in the North. Similarly, consultation with Aboriginal health services has highlighted the need to work closely with Aboriginal primary and environmental health services.

The effective networking of all of these services will ensure they function dynamically within each region to give better outcomes to patients and communities.

### *Regional Resource Centres*

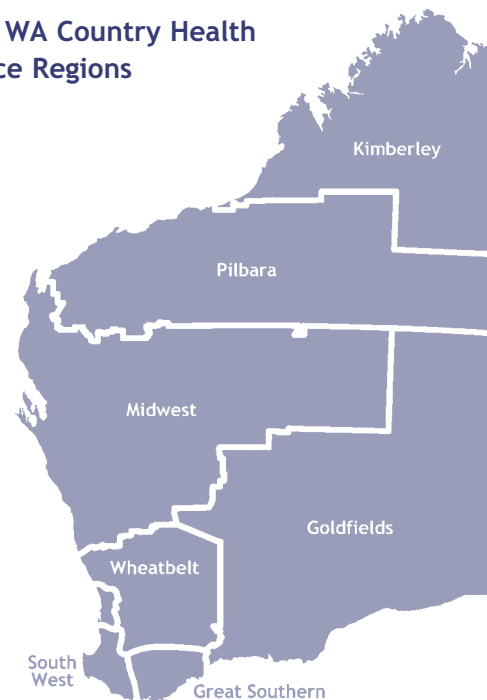
The 2003 Country Health Services Review proposed that one hospital in each region should be developed to be the 'regional resource centre'. Regional resource centres are intended to be the 'hub' part of a 'hub and spoke' model, whereby the services provided by the regional resource centre form the hub of an integrated network of services that spans the smaller hospitals and

health services across the entire regional health network. Regional resource centres are intended to provide a broad range of functions and services including:

- Being the regional acute and emergency care referral centre and supporting an integrated network of acute and emergency care services across the regional health network.
- Coordination of all health programs across the regional health network, including mental health, population health, aged care and a range of specialised services such as obstetrics and cancer care.
- Arranging outreach services to smaller hospitals and health services across the regional health network including, for example, visiting specialists.
- Providing primary and community health care services to support the regional hospital and the surrounding community including, for example, allied health, community nursing, mental health and aged care.
- Providing support services across the regional health network including, for example, pharmacy, patient transport coordination and clinical staff support and development.
- Maintaining effective linkages with metropolitan services, including coordinating the availability of specialist advice and visiting services from Perth to the regions.

The regional executive teams will ensure that the broad range of regional resource centre functions and services are provided effectively.

**Map: WA Country Health Service Regions**



### *Service integration*

Over the last few years WACHS has focused on the urgent need to enhance acute care services in regional hospitals. During the next three years we will also focus on planning, coordinating and integrating all health services across each region in response to the needs of the community.

Regional directors will take responsibility for better integrating services to improve continuity of care for patients. Patients who present at emergency departments or who are discharged from hospital will be connected with appropriate post-acute management services or chronic disease management services to improve and maintain their health upon return to the community and to reduce re-admissions.

### Inter-Regional and Metropolitan Linkages

There are many highly specialised services that, because of their high costs and the low numbers of people using the service, can only be provided in the metropolitan area. Country health services and patients will continue to rely on the metropolitan area to provide access to specialist services and expertise not available locally, and good linkages are essential to improve patient access to these services and to ensure smooth flow between metropolitan and country services.

The formation of the WA Country Health Service has provided country services with a single point of reference, from which to engage with metropolitan services. The result has been service improvements and expansions in a number of areas. The most outstanding examples are the growth of telehealth, the successful implementation of the new Aboriginal Meet and Assist service, the growing number and involvement of visiting specialists to the regions, the increase in mental health services and the overall increased coordination of the medical workforce.

The establishment of Clinical Networks (also known as Health Networks) in the WA Health system has the potential to bring about significant improvements in the support available to rural clinicians and in the coordination of treatment for rural patients. Clinical Networks will provide a renewed focus on preventing illness and injury and on maintaining health. Seventeen Clinical Networks have been established so far. The aim of each is to improve the integration and coordination of clinical services through interaction and collaboration between service providers and other stakeholders across institutional health service boundaries. WACHS will be actively involved in this new development.

In addition, WACHS has initiated a range of professional networks that bring together staff from the same disciplines or clinical areas across all regions. These networks provide a forum for advancing strategic service reforms, for providing professional support and for identifying and sharing good practice.

### Future Directions

Our priorities for the development of health networks over the next three years are as follows:

***Objective 1: Integrated, well-planned and well-coordinated networks of health services in each region, which work in collaboration with key local, regional and metropolitan service providers.***

The effective coordination of health services across providers, and the integration of services across health disciplines, will deliver a single system of care offering patients improved access to services, and offering health service providers improved support.

WACHS will develop comprehensive regional clinical services plans that describe the roles and capacity of all facilities and services and the relationship between them. These will be consistent with the role delineation in the WA Health Clinical Services Framework 2005 - 2015. Regional services include acute, emergency care, primary and population healthcare, mental health, aged care, Aboriginal health, specialised medical, allied health and transport.

Regional health services in the future will be based on the health needs of the country population to ensure equity across regions, on efficient and effective service models and on innovative and evidence-based best practice. Demographic and epidemiological data analysis and service modelling will be an integral part of the regional service planning.

### *Key Reform Actions*

We will:

1. Develop Regional Clinical Services Plans, in collaboration with regional and metropolitan service providers and District Health Advisory Councils, to ensure that services in each region are well coordinated and are tailored to most effectively respond to local needs
2. Lead the coordination of services across all providers in each region including rural doctors, Aboriginal health service providers, private and non-government services and local government
3. Undertake a role delineation review to clarify the roles and responsibilities of all WACHS services
4. Review the locations at which obstetrics services, anaesthetic services and residential aged care services are provided.

### ***Objective 2: Strong and effective District Health Advisory Councils that represent local communities in the planning and delivery of health services.***

Developing sustainable health services across country WA will require effective relationships with country communities. Strong and active District Health Advisory Councils (DHACs) will be critical in building and sustaining these relationships.

### *Key Reform Action*

We will:

5. Train, resource and promote the role of District Health Advisory Councils in country communities to inform the planning and delivery of safe, quality health services.

### ***Objective 3: Improved regional self-sufficiency and metropolitan-country linkages.***

Many country residents do not have the same ready access to health services as people living in metropolitan areas. Access for country residents, especially for those living in more remote areas, those who are Aboriginal or from other cultural backgrounds and those who have disabilities, is often complicated by difficulties of travel, accommodation and communications.

Increasing the self-sufficiency of the regional hospitals to provide secondary-level acute care will limit the need for patients to transfer to Perth for treatment. At the same time, improving links with metropolitan health services will provide country residents with better access to statewide and tertiary specialist services that are based in Perth.

### *Key Reform Actions*

We will:

6. Contribute to the development of country appropriate models of care through active participation in the WA Health Clinical Networks
7. Review and implement the WACHS Specialist Services Plan
8. Review and strengthen the area and regional management structures and their functions
9. Implement regional strategies to ensure country residents receive elective surgery within the WA Health recommended time frames.

## Country Hospitals

### Intent

Each country public hospital will provide services according to its agreed role delineation to ensure regional communities receive appropriate and safe care from qualified and proficient health professionals in facilities suitable for the purpose and in accordance with current standards.

### Role Delineation of Country Hospitals

The WA Country Health Service is responsible for 71 hospitals plus three multipurpose centres (see Appendix 3). These hospitals provide a mix of emergency care, outpatient clinics, acute inpatient medical and surgical services and residential aged care. The hospitals fall into three groups:

- Regional hospitals
- Integrated district health services
- Small hospitals.

The range and scope of services that each hospital is designated to provide is called its role delineation. The WA role delineation framework was first described in the

*Country Health Service Review* in 2003 and later confirmed by *The Reid Report* and the *WA Health Clinical Services Framework 2005 - 2015*. The broad role delineation for WACHS hospitals is set out in Table 2.

The following is a guide to the services that WACHS aims to provide at each hospital. The full range of services denoted by each level may not currently be available at all sites. Levels of services in WACHS hospitals are defined in Appendix 2 - *Clinical Services Role Delineation Definitions*.

**Table 2: WA Country Health Services Clinical Services Delineation Matrix**

WACHS ROLE DELINEATION Clinical Service/Level	Regional Hospitals	Integrated District Health Services	Small Hospitals
Medical Services	4	2/3	1/2
Surgical Services	4	2/3	1/2
Emergency Trauma Services	4	2/3	1/2
Obstetric Services	4	2/3	1/2
Paediatric Services	3/4	2	1
Rehabilitation Services	4/5	3	1
Prevention and Promotion Services	5	3/4	1/2/3/4
Primary Care Services	4/5	3	1/3
Ambulatory Care Services	4	2/3/4	1/2
Mental Health Services	3/4	2/3	1/2
Clinical Support	3/4	2/3	1

WACHS will refine the role delineation for each hospital through regional services planning processes.

This hospital role delineation framework is based upon a ‘hub and spoke’ concept that identifies the roles of all hospitals within their regional health network. Defining the services that each hospital provides helps to ensure the broadest scope of services within each region, at a level of safety and quality expected by the community. A summary of the role and function of WACHS’ hospitals is included below.

### *Regional Hospitals*

The WA Country Health Service operates six regional hospitals at Albany, Broome, Bunbury, Geraldton, Kalgoorlie and Port Hedland. They form the ‘hub’ of the ‘hub and spoke’ network for their region and act as the regional referral centre for:

- Diagnostic, secondary-level acute and procedural (surgical) services
- Emergency and outpatient care
- Specialist services (eg obstetrics) and the coordination of outreach specialist services.

In the Wheatbelt, the dispersed population has resulted in the development of four integrated district health services instead of a single regional hospital. The population relies more heavily on accessing services in Perth. It is anticipated that the majority of specialist services for Wheatbelt residents will continue to be provided in Perth, or by visiting specialists.

### *Integrated District Health Services*

The 15 integrated district health services are based at Busselton, Carnarvon, Collie, Derby, Esperance, Katanning, Kununurra, Margaret River, Merredin, Moora, Narrogin, Newman, Nickol Bay (Karratha), Northam and Warren (Manjimup). These services provide:

- Diagnostic, emergency, acute inpatient and minor procedural services
- Low-risk obstetrics (where GPs who have skills in obstetric procedures and midwives are available and where the level of activity supports a safe clinical service)
- Aged care services (where required)
- Coordination for acute, primary and mental health services at the district level.

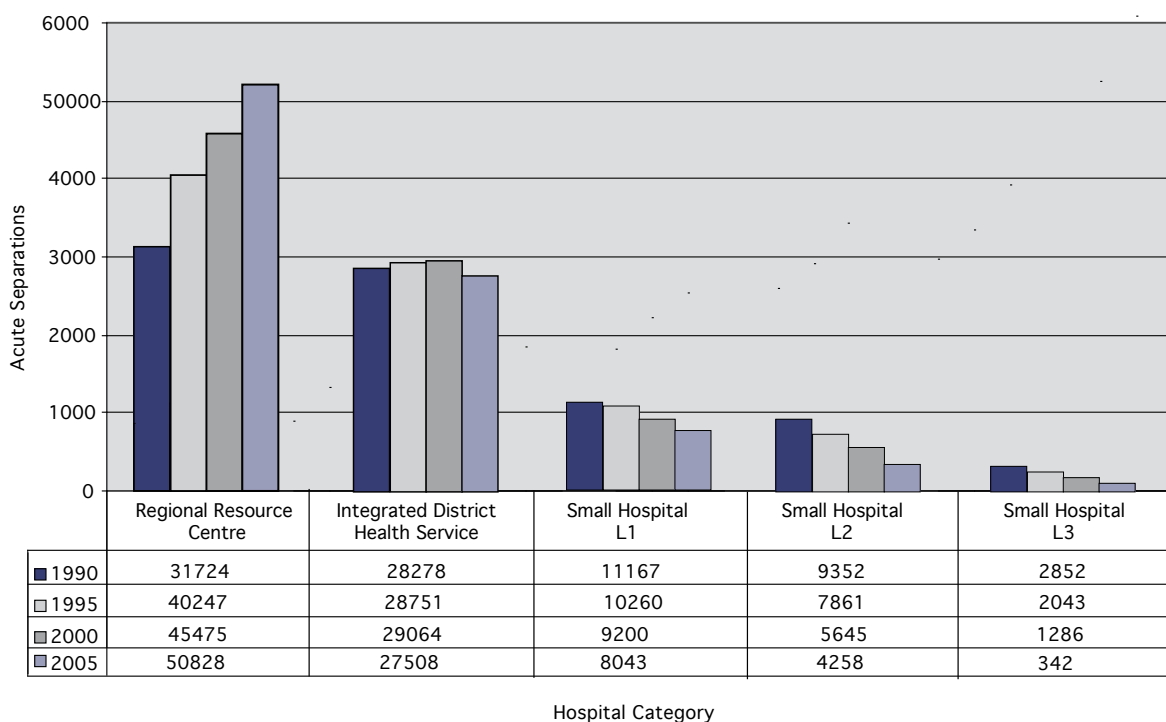
### *Small Hospitals*

Fifty small country hospitals and three multi-purpose centres provide:

- Emergency care services
- Residential aged care services
- Some acute medical and minor surgical services
- Primary care services.

Over time many small country hospitals have changed their focus from providing acute inpatient care to a stronger role in providing residential aged care. As a result many now have very low volumes of acute inpatient activity. While these small hospitals may have maintained staff and ward facilities designed for acute inpatient hospitals, increasingly they do not have the number of available doctors, the technological capacity or a sufficient volume of activity to provide acute inpatient services to contemporary standards.

Chart 4 illustrates the rapid decline in small hospital acute inpatient activity. It shows the number of acute inpatient discharges from all our hospitals between 1990 and 2005.

**Chart 4: WA Country Health Service Acute Separations Trend**

It is notable from the data that:

- Acute inpatient activity at the six regional hospitals has increased by 60%.
- Acute inpatient activity has remained relatively stable across the 15 medium sized integrated district health services. However, the lower activity levels for Merredin, Moora and Newman in 2005 are more comparable to activity in the same period for the top third Level 1 small hospitals.
- Acute activity has declined in all the small hospitals. On average, it has been reduced:
  - > By 28% in the Level 1 Small Hospitals
  - > By 54% in the Level 2 Small Hospitals
  - > By 88% in the Level 3 Small Hospitals.

The pattern of change across the 50 small hospitals and three multi-purpose centres is not consistent. These hospitals have been separated into three groupings based upon their level of inpatient activity in 2000 and 2005.

#### ***Level 1 Small Hospitals - more than 250 acute inpatient discharges a year***

There are 16 small hospitals in this group: Bridgetown, Dalwallinu, Denmark, Donnybrook, Exmouth, Fitzroy Crossing, Halls Creek, Harvey, Kellerberrin, Kununoppin, Laverton, Meekatharra, Plantagenet (Mt Barker), Roebourne, Tom Price and Wyndham.

### *Level 2 Small Hospitals - more than 100 and less than 250 acute inpatient discharges a year*

There are 26 small hospitals in this group: Augusta, Beverley, Boddington, Boyup Brook, Bruce Rock, Corrigin, Cunderdin, Gnowangerup, Goomalling, Kojonup, Kondinin, Lake Grace, Leonora, Narembeen, Norseman, Northampton, Onslow, Paraburdoo, Pemberton, Quairading, Ravensthorpe, Southern Cross, Wagin, Wongan Hills, Wyalkatchem-Koorda and York.

In addition, the multi-purpose centres in Kalbarri and Dongara also provide some hospital-type services.

### *Level 3 Small Hospitals - less than 100 acute inpatient discharges a year*

There are eight small hospitals in this group: Dumbleyung (no acute inpatient activity in 2005), Morawa, Mullewa, Nannup, North Midlands (Three Springs), Pingelly, Wickham and Yarloop<sup>4</sup>. In addition Jurien Bay multi-purpose centre has no inpatient services.

It is recognised that these small hospitals also contribute to the sustainability of small communities by delivering local aged care services, by helping to attract and retain doctors and other services, and by providing local employment. Maintaining the profile of services currently provided from these hospitals commits a significant proportion of the WACHS' budget to providing services that are no longer considered the most appropriate to meet community health needs. Changing the focus of small hospital services provides the opportunity to review how their facilities and resources can be better applied to deliver improved health services to their communities.

We will apply three key principles as we strive to address health solutions for very small country towns in the future:

- WACHS has an ongoing commitment to provide health services to these towns
- Health funding should be used to address priority health needs in these towns
- WACHS will engage and collaborate with small communities to assist them to get the best possible long-term value from their health resources.

## **Future Directions**

Over the last few years, WACHS has focused on building the acute care capability of the regional hospitals. In many small communities, traditional hospital-based services are being used less and less frequently and are becoming increasingly difficult to staff as well as more expensive to manage. The health needs of the community are also changing, with the growing impact of an ageing population and the increasing prevalence of chronic disease.

We will now direct more effort towards working with local communities, DHACs, doctors, nurses, allied health and support staff to improve the effectiveness of our small hospital services, and to jointly plan better ways of using health resources in small communities, to deliver services that more effectively maintain health, prevent avoidable emergency department attendances and admissions, and support people in their own communities. We will also direct more effort towards the effective management of chronic disease in the community, in order to delay or prevent acute illness and reduce the need for hospitalisation.

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<sup>4</sup> Yarloop hospital inpatient services ceased in 2006, and other community health services have been expanded.



Rural doctors are generally the gatekeepers to our country health system and are in the unique position of responding to patient needs both through primary care and in hospital settings. The role and views of rural doctors are particularly important to the development of greater service flexibility and continuity of care between hospital and primary care services.

***Objective 4: Services provided by small country hospitals meet the needs of local communities more effectively.***

This can be achieved in many ways such as changing opening hours and rosters, changing the services provided or broadening the staff skill base and changing roles .

***Key Reform Action***

10. Communities where small hospitals are located will be provided with the opportunity to work with WACHS to review and re-design local health services.

## Improving Access to Services Through Better Patient Transport

### **Intent**

Transport systems are vital for good access to all health services. WACHS will work collaboratively with transport providers to seek the best transport solutions for rural patients, especially for emergency care.

### **Transport Options**

There are multiple providers of patient transport in rural WA:

- The Royal Flying Doctor Service (RFDS) with 11 aircraft, and St John Ambulance Australia (SJAA) with over 300 country ambulances, are the major providers of emergency transport responses and inter-hospital transfers.
- Hospital, community health and mental health staff, volunteers and vehicles are used to transport people to and from appointments.
- Other non-government providers, including Aboriginal Medical Services and Home and Community Care (HACC) services, have an important role in assisting patients to access services.
- For non emergency transport, the majority of patients travel by their own private vehicle or use mainstream transport services – including commercial air, rail and road services – often with financial assistance through the Patient Assisted Travel Scheme (PATS), which subsidises approximately 51,000 trips per annum at a cost of \$14 million.

The lack of commercial transport services in the more sparsely populated areas of the North West of WA can make transport within regions difficult and is a barrier to accessing services across the regional health network.

Complex logistical coordination is often required to bring patients to services. This is a particular concern for people from remote communities where private ownership of vehicles is low, distance to

health services is often considerable and compounding factors such as poverty, family responsibilities, poor roads and seasonal flooding enter into play.

*The Sentinel Event Report 2003 - 2005* (Department of Health) and recent *Adverse Incident Management System (AIMS)* data have both identified inadequate transport coordination as a contributing factor to poor patient outcomes. This issue is a priority area for the future.

Transporting the patient is not the only way, and not always the best way, of improving access to services. Other options are also being further developed, including visiting services and telehealth.

### **Future Directions**

Integrated transport services are crucial to the successful operation of the regional health networks. Improved intra-regional transport services will enable rural residents to access services closer to home. The *WA Country Health Service Transport Review* in June 2005 recommended that WACHS increase its capacity to coordinate patient transport and accommodation to deliver a seamless, well integrated service for patients and increase our expertise in health transport policy and planning.

By increasing local access to specialist and diagnostic services, WACHS may slow the growth of referrals to Perth, but will not necessarily reduce them. The demand for travel and accommodation assistance under PATS grows at approximately 7% per annum.

The administration of the PATS scheme varies between regions and lacks the consistency and efficiencies of a centrally coordinated model. The development of transport coordination functions within each regional health network will mean improved coordination of patients' transport and medical appointments.

### **Objective 5: Improved administration, coordination and responsiveness of patient transport.**

#### **Key Reform Actions**

We will:

11. Build the capacity of patient transfer coordination in each region
12. Streamline the administration of PATS through greater regional and central coordination and more flexible and simplified application processes
13. Communicate the scope and eligibility of PATS to country doctors and their patients
14. Work with remote Aboriginal communities to improve transport for people from these communities to health services.

### **Objective 6: Safe and sustainable air and road inter-hospital transportation.**

The demand for inter-hospital transfers has grown, with an average annual rate rise of 6.7% between 2002 and 2005. This has lengthened retrieval times for major service providers such as the RFDS and SJAA and has stretched and eroded their capacity to respond to emergency needs. In addition, the current ambulance system, operating from over 160 separately managed sub-stations, relies heavily on local volunteers and is under increasing pressure, with gaps emerging in ambulance rosters.

### Key Reform Actions

We will:

15. Implement relevant recommendations of the national Royal Flying Doctor Service review in partnership with the Australian Government
16. Establish agreement with the Royal Darwin Hospital to accept inter-hospital patient transfers from the East Kimberley
17. Work with St John Ambulance Australia to ensure the availability of reliable ambulance services to all country communities.

## Improving our Emergency Response

### Intent

WACHS will provide accessible, safe and timely responses to all hospital emergency presentations through an integrated emergency response network in each region. To support this network we will develop transport and transfer arrangements collaboratively with the Royal Flying Doctor Service and St John Ambulance Australia.

### Emergency Services

Emergency services are core business for all country hospitals. Emergency departments deal with a range of emergencies from life-threatening events, to primary care (GP-type) presentations, and to psychiatric presentations. The level of emergency response available will differ at each hospital site, based on workforce and infrastructure capacity and capability and projected activity levels.

The RFDS and SJAA are critical partners in emergency care management. Timely transport for the rapid and safe retrieval of patients to an appropriate emergency service is critical to best patient outcomes.

Demand for emergency care has grown over recent years, and is expected to continue to rise as populations grow and age, particularly in the South West and the Kimberley. This has placed increasing demands on some emergency departments. In other areas of smaller or declining populations, activity is falling to a level where it is difficult to support a safe emergency service.

The urgency and complexity of presentations at all country emergency departments is also increasing, especially in triage categories 2 and 3<sup>5</sup>. This has implications for the rural workforce in terms of additional skills and time required to treat patients appropriately.

### Future Directions

WACHS delivers emergency care to rural communities in collaboration with RFDS and SJAA, who are critical partners in providing stabilising treatment and transport to the appropriate country or metropolitan hospital site. We will improve the integration of emergency services through the development of triage and referral protocols in accordance with the

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<sup>5</sup> Australasian College for Emergency Medicine, PO6 November 2000, Policy Document - The Australasian Triage Scale

WA Health emergency care guidelines<sup>6</sup>. We will also develop strategies to ensure that all triaged patients are seen within the appropriate timeframe according to the Australasian Triage Scale<sup>7</sup>.

WACHS will continue to develop partnerships with tertiary hospital emergency departments and to forge greater collaborations with other metropolitan hospital critical care services.

Our capacity to staff rural emergency departments is constrained, in part by the changing workforce and the desire for shorter working hours and less stressful jobs. As a consequence, we need to concentrate the limited specialist emergency staff available into regional hospitals, to enable up-skilling, supporting and educating emergency staff across the regional health networks. In addition, we will explore opportunities to expand the role of emergency care nurse practitioners and to establish separately staffed GP/primary care clinics in our larger regional centres.

Future emergency services management will be underpinned by clear role delineation that explicitly identifies levels of capacity and capability at each hospital (a tiered response) and reduces the risk that arises when transport providers ‘shuttle’ patients between hospitals.

#### ***Objective 7: A tiered, integrated emergency care network in each region.***

##### ***Key Reform Actions***

We will:

18. Determine the emergency capability of all sites consistent with their role delineation and define minimum standards of response, for example relating to access to emergency triage
19. Develop systems for regional hospitals to provide emergency expertise to smaller and more remote sites
20. Extend the use of call centre technology for after hours emergency triage in small communities
21. Develop protocols and establish a coordinated service to provide clinical advice and management of transfers of emergency and critically ill patients from country emergency departments in collaboration with RFDS, SJAA and metropolitan hospitals.

#### ***Objective 8: Optimal use of country emergency departments.***

The reduction in private General Practitioners (GPs) hours of work is likely to continue to impact on the future demand for public emergency services, especially in larger towns where the majority of GPs are based. There is an increasing expectation from communities and local government that WACHS will be the default provider of GP-type primary care services from emergency departments. WACHS cannot sustain the cost and personnel required to treat primary care type presentations in emergency departments across 74 hospitals and

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6 <http://intranet.health.wa.gov.au/circulars/pdfs/7500.pdf> and <http://intranet.health.wa.gov.au/circulars/pdfs/7131.pdf>

7 [http://www.acem.org.au/media/policies\\_and\\_guidelines/P06\\_Aust\\_Triage\\_Scale\\_-\\_Nov\\_2000.pdf](http://www.acem.org.au/media/policies_and_guidelines/P06_Aust_Triage_Scale_-_Nov_2000.pdf)

multi-purpose centres. We will explore opportunities for separately staffed clinics that are able to access Medicare funding, and for nurse practitioners to supplement, or substitute for, the current shortage of doctors.

### **Key Reform Actions**

We will:

22. Establish primary care-type clinics in emergency departments for non-emergency presentations
23. Implement reforms to access Medicare funding for primary care services provided from small hospitals
24. Undertake community education on the appropriate use of emergency services.

### **Objective 9: Enhanced available skilled emergency workforce.**

The low level of emergency presentations at some small hospitals can expose patients to the risk of being treated by staff whose skills are not current or can cause delays in accessing services from a better-equipped centre. This can be exacerbated in locations where staff turnover is high.

Mental health and drug and alcohol presentations at emergency departments can be complex, absorb a significant amount of staff time and require special clinical skills. We will develop the skills, confidence and capacity of our staff to deliver emergency responses across the spectrum of emergency presentations and to deliver this capacity through innovative workforce models.

### **Key Reform Actions**

We will:

25. Increase the number and expand the role of nurse practitioners providing emergency care
26. Progressively recruit emergency specialists in each regional hospital
27. Develop psychiatric emergency capability in each regional hospital
28. Use telehealth and call centre technologies to build and maintain staff skills in emergency care.

## **Improving the Quality and Safety of Country Health Services**

### **Intent**

Develop a culture of safety and quality throughout the country health system that produces high quality, safe and patient-centred services.

### **Quality and Safety**

Patients expect to receive high quality and safe health care services whenever they encounter the health system. There is compelling evidence from many countries and healthcare settings that a significant gap exists between potential and actual outcomes in relation to quality and safety. WACHS faces special challenges in providing consistently high quality and safe services in country settings, including:

- Problems in attracting, retaining and maintaining the skills of an often limited clinical workforce

- Difficulties in providing consistently high quality services to a geographically dispersed population with diverse health needs
- Ensuring that the most effective services are provided within the available resources
- Ensuring services are culturally secure.

Nine nationally endorsed dimensions of safety and quality in health care services can be used for judging performance. These are effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuous services, capability and sustainability<sup>8</sup>.

In country areas, there can be conflict between these dimensions. For example, providing locally accessible hospital services in small rural and remote communities may be at odds with the dimensions of safety and sustainability. Developing appropriate and sustainable regional networks of health services is, therefore, a key foundation for delivery of high quality and safe services.

The system by which the health service supports clinicians and others to practise at the required quality and safety standards is known as clinical governance.

The four pillars of the WA Health Clinical Governance model<sup>9</sup> are:

- Clinical performance and evaluation
- Professional development and management
- Clinical risk
- Consumer value.

### Future Directions

The development of effective clinical governance, consistent with major national commitments to improve the quality and safety of the health system, is a key reform objective of the WA Health Reform Committee. For country health services, this will require a cultural shift from our traditional way of thinking and working, towards a new culture underpinned by commitment, competence and understanding of the way in which better health and practice standards can be achieved. To achieve this WACHS will:

- Demonstrate leadership at all levels through personal participation, mentoring and encouraging and enabling staff involvement in quality and safety initiatives
- Explicitly include consideration of the dimensions of safety and quality in service planning and role delineation
- Engage consumers in safety and quality planning and evaluation processes
- Base clinical decisions on the best available evidence and assessment of risk
- Develop service standards based on the best available evidence
- Promote continuous improvement through the application of tools such as the accreditation process

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8 National Health Performance Framework Report: National Health Performance Committee, August 2001, A report to the Australian Health Ministers Conference.

9 WA Health Clinical Governance Model can be accessed at [www.clinicalgovernance.health.wa.gov.au](http://www.clinicalgovernance.health.wa.gov.au)

- Provide services only where clinical risks are manageable
- Ensure that workforce planning and management processes place priority on clinical safety and quality
- Foster a culture of safety in dealing with workforce and system performance
- Ensure that the workforce applies their relevant professional standards.

WACHS will seek innovative and pragmatic solutions to the challenges and difficulties of providing consistently high-quality and safe services in country settings into the future.

Partnerships with the Office of Safety and Quality, rural GPs and patients are among the important strategies that have proved effective to date in developing a culture of safety and quality. We will also implement the Patient First Program, which encourages patients to understand and exercise their rights and responsibilities.

There is significant anecdotal evidence that high clinical standards are common across WACHS services. However, there are relatively few objective measures that provide assurance that services are safe and of a consistently high standard across the country area over time. Knowing and understanding the extent to which intended service outcomes are being met is critical.

The low level of acute inpatient activity in many small hospitals can generate safety and quality risks. In situations where these hospitals have staffing and ward configurations designed for an acute inpatient hospital but increasingly do not have the medical or technological capacity or sufficient volume of activity to safely provide acute inpatient services, staff can become de-skilled and unable to manage some medical conditions competently or confidently. Patient safety can also be compromised at sites where continuity of services such as anaesthetics or procedural general practice cannot be guaranteed.

Where expert advice or evidence demonstrates that patient safety is at risk at a particular location, WACHS services will be reviewed and will be either reconfigured or discontinued at that location in order to manage the risk to patient safety and quality of care.

***Objective 10: A strong workplace culture of service quality, patient safety and workforce accountability.***

***Key Reform Actions***

We will:

29. Develop a WACHS annual Patient Safety and Quality plan
30. Establish regional clinical governance structures that ensure quality and patient safety is a primary consideration in all service plans and service evaluation
31. Develop service standards based on the best available evidence and research
32. Ensure the WACHS orientation program emphasises patient safety and quality
33. Ensure WACHS performance agreements with all clinical and patient support staff include a requirement that all staff undertake ongoing training and skills maintenance regarding their patient safety and quality responsibilities

34. Provide high-quality clinical supervision in all patient-care areas and have clinical supervisors monitor clinical systems for quality of care.

***Objective 11: Robust performance information and monitoring systems to support clinical practice and to provide safe service delivery environments.***

***Key Reform Actions***

We will:

35. Develop and maintain a reliable workforce recruitment system to ensure that only staff who are qualified, experienced and credentialed to work within an appropriate scope of practice are recruited
36. Develop systems to involve clinicians in the review of clinical practice and outcomes through bodies such as medical advisory committees and clinical practice review committees
37. Develop and implement performance monitoring, reporting and evaluation systems and performance targets
38. Develop and implement systems to identify and manage risks to patient safety across all health services including, for example, the review, re-design or discontinuation of unsafe services
39. Develop systems to improve incident and adverse event reporting, analysis and investigation
40. Implement the Patient First Program in partnership with District Health Advisory Councils and the Office of Safety and Quality
41. Provide training in advocacy to District Health Advisory Councils and seek their feedback on safety and quality reports.



## Section 5:

### Reform Direction 2

# Building Healthier Communities

## Introduction

The Australian Government's Healthy Horizons report<sup>10</sup> and a recent report by the Royal Australasian College of Physicians<sup>11</sup> demonstrate that people in rural and remote areas of Australia have poorer health status than their metropolitan counterparts. Analysis of health data indicates that many health conditions suffered by the country community are avoidable or can be managed in the community, reducing the need for hospitalisation. Examples include diabetes, chronic obstructive pulmonary disease, asthma and congestive cardiac failure.

The health of the community depends on a complex range of factors including lifestyle, housing, employment, education, occupational and environmental factors such as access to good drinking water and healthy food. Responsibility for good health is shared among individuals, families, communities and the government. Lifestyle factors can promote good health or place people at increased risk of disease. Country residents are more likely than their metropolitan counterparts to smoke tobacco, drink alcohol in hazardous amounts, be overweight and be physically inactive. Young males have higher suicide rates than their metropolitan counterparts.

The health system alone cannot address all of the health issues of country communities, as there are social, family and environmental factors that impact on the health of people and populations. A range of government and non-government agencies and the community must work together to address the factors that affect community health. Building the ability of the community to improve the health and well-being of its members is vitally important.

Community development and capacity-building strategies include engaging and involving all sections of country communities, including people from Aboriginal and other diverse cultural backgrounds and people with disabilities, and relevant agencies in setting priorities and planning services, educating the community through health promotion, undertaking early intervention and prevention programs, upgrading transport services and improving environmental health.

The WA Country Health Service has identified the following four priorities for future investment and effort:

- Focusing on, and re-investing in, primary and community health activities that can be demonstrated to improve the health of the country population
- Improving the health of Aboriginal people

10 Healthy horizons: A framework for Improving the Health of Rural, Regional and Remote Australians, Outlook 2003 - 2007, a Joint Development of the Australian Health Ministers' Advisory Council's National Rural Health Policy Sub-Committee and the National Rural Health Alliance.

11 Royal Australasian College of Physicians, Inequality and health: a call to action, Policy statement, Royal Australasian College of Physicians, 2005

- Building capacity to respond to mental health issues within all services so as to provide a broader base of services to protect, maintain and improve the mental health of regional communities
- Supporting healthy ageing in the community through services that maintain health and independence.

This section examines these four priority areas and sets out objectives and future directions for the WA Country Health Service. It includes the key actions that WACHS will take to achieve significant improvements in these areas over the next three years.

## Protecting and Improving the Health of Country Communities

### Intent

WACHS will direct greater efforts and investment towards activities that deliver measurable health improvements for the population of country WA. A parallel aim is to reduce acute service demand.

### Population Health Services

Population health activities include:

- Public health (communicable disease control and epidemiology)
- Environmental health
- Primary care
- Child and community health
- Health promotion.

### *Public and environmental health*

WACHS' public and environmental health activities focus on monitoring the health of the community and establishing programs to address major health risks. Strategies include epidemiology, communicable disease control, environmental health programs, disaster management and pandemic preparedness, and the identification of population health issues and health inequities.

WACHS is the major provider of public health services in country WA and is a significant provider, together with local government, of environmental health services. We are supported by the WA Health system through such bodies as the Communicable Disease Control Directorate, the Office of Aboriginal Health, the Environmental Health Division, the Health Protection Group and the Population Health Policy Branch. Other significant providers include Aboriginal community-controlled health organisations and divisions of general practice.

Major environmental health issues include the potentially adverse health impacts of industrial, mining and residential developments and the complex issues of environmental health in Aboriginal communities. WACHS recognises that there is the potential for gaps and duplication in services and a need for coordination of the strategies and activities of multiple agencies at the regional level.

Country WA has rates of disease and injury that are significantly higher than the State average for sexually transmitted infections, diabetes, cancer, renal failure, suicide and road trauma. The prevalence of risk factors, such as poor nutrition, smoking, misuse of alcohol and other drugs and

environmental health issues, are well documented as being significantly higher in country areas and in Aboriginal communities.

In addition, WACHS has a responsibility to support the Department of Health to fulfil its obligations under the *Emergency Management Act*, 2005, by ensuring a structured response to public health emergencies at local and regional levels, including natural disasters such as floods and cyclones, and other disasters affecting large populations such as terrorist threats, epidemics and pandemics. These responsibilities include the provision of health disaster management services during any emergency that involves a multi-agency response, multiple casualties or a public health threat. All health services must also have a planned response to any pandemic such as the threat of avian influenza (bird flu).

#### *Primary care, child and community health and health promotion*

Primary care, child and community health and health promotion services are essential elements of our regional health networks and include:

- Early years/childhood, antenatal and parenting interventions,
- Child and family health services in the home, clinic and school setting
- Health promotion and communicable disease minimisation and management
- Allied health services in acute and/or ambulatory care settings
- Prevention, early detection and management of chronic disease
- Community mental health services
- Dental services.

National, State and local governments, general practitioners, Aboriginal community-controlled health organisations and other non-government organisations are also significant providers of primary care and child and community health services. We are committed to working together with these and other service partners to improve service coordination, to make the best use of all resources and to reduce confusion for consumers.

Chronic diseases are a leading cause of hospitalisation, illness and death in Western Australia. While the causes are complex, chronic diseases share a number of risk factors including poor nutrition, physical inactivity, smoking and alcohol.

There is evidence to demonstrate that \$1 spent on early intervention in the early years saves up to \$15 in later years by preventing health and social difficulties<sup>12</sup>. Health promotion and illness prevention services for child and maternal health can help avoid future chronic disease by encouraging parents to establish healthy lifestyles in the children's early years (and even before they are born), when the children are most vulnerable to risk factors. A focus on ante-natal care, maternal and child health and mental health, particularly in the early years, will enable children to gain maximum benefit from education and social opportunities.

Reducing the risk of mental illness and preventing falls in older people are additional priorities, together with preventing diabetes and heart disease, especially for the Aboriginal population. For those who already have a chronic disease, early intervention and improved management of chronic disease can reduce dependence on the health system and enhance quality of life.

12 Schweinhart, L. J., Montie, J., Xiang, Z., Barnett, et al. (in press). Lifetime effects: The High/Scope Perry Preschool study through age 40. (Monographs of the High/Scope Educational Research Foundation, 14). Ypsilanti, MI: High/Scope Press and Savings to Government from Home Visits to High-Risk Families (Elmira County New York, 1987)

## Future Directions

Funding for prevention services, early detection and intervention services, ambulatory care services, and injury and chronic disease management has lagged behind funding for acute services. WACHS will work to redress this imbalance and to ensure that all primary care services, child and community health services and health promotion services offer measurable and improved benefits to the country community. We will target at-risk and high-risk groups, and respond to trends for increased ambulatory care and chronic disease management service models.

Future priority areas include Aboriginal health, child and maternal health, mental health, obesity, chronic disease, communicable diseases, sexually transmitted and blood-borne infections, supporting people with disabilities, disaster preparedness, major pandemics, alcohol, drug and smoking issues, and injury prevention.

An ageing population, the increasing focus on wellness and independence and the increasing potential for care in community settings will raise the demand for primary and community health services. Our challenge will be to develop new primary and community care service responses within the resources available for WA Health, and will involve using resources in the most effective manner possible.

We will research and implement the most effective service models and partner with other service providers, especially GPs, to develop priorities and targets and to ensure that our services are effectively coordinated.

Prevention, preparedness, response and recovery activities will be identified to promote a coordinated health emergency management framework for country health services in support of Westplan Health and Westplan Human Epidemic, and to minimise disruptions to health services. These activities will be conducted in collaboration with hazard management, combat and support agencies such as the Department for Community Development, police and the armed forces.

## *Objective 12: Evidence based and innovative population health services.*

### *Key Reform Actions*

We will:

42. Establish primary care, child health and community health early intervention and prevention programs including, for example, maternity and early years interventions and parenting programs, adolescent and transition-from-school strategies, and family years interventions, through innovative models that engage the community
43. Improve access to primary care, child and community health and Aboriginal health services through greater use of allied health assistants
44. Introduce a common set of evidence-based standards and interventions for primary care, child health and community health covering target groups and eligibility criteria
45. Develop a coordinated disease control program and provide training to population health and acute service staff in communicable disease management
46. Build health promotion and disease prevention capacity across all country hospitals and health services

47. Provide a more coordinated and consistent contribution to environmental health issues in remote and Aboriginal communities
48. Implement self-care initiatives, particularly amongst Aboriginal communities
49. Work in collaboration with the Australian Government to develop new services through the Australian Better Health Initiatives program
50. Increase mental health promotion and illness prevention services across all ages
51. Evaluate the effectiveness of WACHS population health activities, applying action research and learning approaches.

***Objective 13: Innovative community based ambulatory care services.***

***Key Reform Actions***

We will:

52. Establish 'hospital in the home' services in each region
53. Establish the Rural Home Link program including a Rural Home Link telephone line to enable better coordination of discharge planning for country patients who are leaving metropolitan hospitals
54. Implement the Aboriginal Meet and Assist program in Perth to better support and transport Aboriginal patients from remote locations travelling to Perth and to improve discharge planning processes for regional Aboriginal patients.

***Objective 14: Innovative community based chronic disease management services.***

***Key Reform Actions***

We will:

55. Establish a chronic disease management coordination service to improve access to services for people who are living with chronic disease and coordinate services to help these people better manage their issues at home
56. Implement community based chronic disease management programs in each region.

***Objective 15: Robust disaster and pandemic preparedness and response planning.***

We will work with key hazard management and other support agencies to ensure the effective delivery of health disaster management responses and recovery activities.

***Key Reform Actions***

We will:

57. Develop Regional Health Disaster Plans in close consultation with other key partners to ensure the provision of appropriate health disaster management responses to protect country communities.

58. Develop area wide and regional pandemic influenza management plans that will apply to hospitals, other healthcare providers, residential care facilities, emergency and essential services and Aboriginal communities.

***Objective 16: Alcohol, smoking and other drug strategies that are relevant and appropriate to rural and remote areas in partnership with the Drug and Alcohol Office and the Tobacco Control Branch.***

Current statewide programs to reduce the harmful effects of drug and alcohol and smoking are not always appropriate for rural and remote areas and we need to work with drug and alcohol services and tobacco control agencies to develop relevant strategies for country communities.

***Key Reform Actions***

We will:

59. Implement the Brief Intervention Program and Smoking Policy in health service sites
60. Collaborate with other providers of drug and alcohol services, tobacco control agencies and state-wide health promotion campaigns to achieve ‘country-appropriate’ programs and coordination at a regional level
61. Develop capacity to admit patients into regional and district hospitals for detoxification from alcohol and drugs and work in partnership with local community drug service teams and Aboriginal services to ensure that patients have an appropriate plan for ongoing treatment
62. Identify and support medical officers in each regional centre and selected towns to provide limited pharmacotherapy services, and complement the services of general practitioners in the regions with local support from community drug service teams and central support from the Drug and Alcohol Office.

## Improving the Health of Aboriginal People

### **Intent**

WACHS will work to improve Aboriginal health outcomes through sustained, systematic, coordinated and integrated approaches in partnership with key providers of Aboriginal health services.

### **Health Services for Aboriginal People**

The WA Country Health Service is one of Australia’s largest providers of health services to Aboriginal people. Every year we manage over 26,000 hospital separations, 87,000 bed days and 200,000 accident and emergency presentations for Aboriginal people. In addition, we offer public and environmental health services, allied health services, medical specialist services and community health services to Aboriginal communities.

Though Aboriginal people make up only 11% of the WA country population, approximately 30% of all WACHS' activity relates to services to Aboriginal people (ranging from over 50% in Kimberley to approximately 10% in Great Southern). Aboriginal health outcomes in Western Australia remain poor. Within country WA in 2004 the Aboriginal population had a mortality rate 2.6 times that of the non-Aboriginal population and the rate of hospital admissions for Aboriginal people compared with non-Aboriginal people was 3.1 times greater. Mental health and child protection issues are also very significant for Aboriginal people.

In comparison to the non-Aboriginal country population, Aboriginal communities are relatively young due to higher birth rates and lower life expectancy. Chronic disease rates, including mental health problems, are also frequently higher at both younger and older ages.

A number of health conditions prevalent amongst the Aboriginal population drive the need for acute care. For example, renal disease affects the need for local dialysis services, and mental health and social and emotional issues impact on access to drug and alcohol services and inpatient admissions. A stronger focus on primary health care, chronic disease prevention, early intervention and management, and environmental health is needed to improve the health of the Aboriginal population.

WACHS' responsibilities for monitoring and delivering public and environmental health services will increase under the proposed new *Public Health Act* and in line with the trend towards focusing Aboriginal health services in larger Aboriginal communities of 100 or more residents.

The development of regional hospitals has reduced travel to Perth for secondary services. However, this regional approach has accentuated a number of health system gaps that affect Aboriginal people's ability to access health services. These include:

- The limited availability of affordable transport and accommodation for long and complex patient journeys
- The need for increased flexibility in services in smaller towns to address specific local needs, such as home dialysis or dialysis within the community's health facilities
- A requirement for increased outreach service models instead of static service models to Aboriginal communities
- A lack of understanding of cultural issues and respect for cultural practices by health services.

### Future Directions

To make the best use of resources and have a real impact upon Aboriginal health outcomes, the multiple providers of Aboriginal health services need to work in partnership, rather than in isolation or competition. We will promote this objective throughout country WA and pay special attention to ensuring that in locations where Aboriginal community controlled primary health services are the sole health service providers (eg within the western and central desert areas), support from and access to the regional health networks are optimised.

Aboriginal primary and environmental health services are recognised as vital partners in front line efforts to improve Aboriginal health outcomes across the country. WACHS will seek the full participation of Aboriginal medical services in regional services planning processes and will foster local opportunities to better integrate service delivery.

Aboriginal peoples' experience of health service delivery is that it often fails to deliver a culturally respectful service. The WA Health Cultural Respect Implementation Framework, released by the Department of Health in 2006 across all regions, will lead to the development of strategies to foster greater cultural respect in WACHS services. Strategies will be needed to engage Aboriginal people in service planning and to increase the numbers of Aboriginal people working in WACHS services.

People from Aboriginal and Torres Strait Islander backgrounds do not have access to appropriate aged care services in some regions. The Kimberley region has a strong emphasis on cultural security in aged care services, but in other regions where the Aboriginal population is smaller, culturally appropriate services are not always as well developed.

Increasing the employment of Aboriginal people is an important strategy to improve the health of the Aboriginal community. To date there has been a very low rate of Aboriginal staff employment across WACHS and no systematic Aboriginal employment policy or practice. The role and contribution of Aboriginal health workers in the health system lacks definition and there has been limited focus applied to the appropriate use of key Aboriginal health worker skills such as community development.

Addressing these health system issues will enable Aboriginal health priorities - child and maternal health, mental health, environmental health, chronic disease such as renal disease and alcohol and drug services - to be addressed within a comprehensive, flexible and outreach-orientated health system.

#### ***Objective 17: Accessible, integrated and coordinated services for Aboriginal people.***

Working with the Office of Aboriginal Health and the Australian Government Office of Aboriginal and Torres Strait Islander Health, WACHS will explore opportunities to collaborate with Aboriginal communities, Aboriginal community controlled health organisations and other service providers. We will agree on areas of exclusive and shared activity and we will reconfigure services and develop new models to better meet the needs of the local population and reduce service gaps and duplication.

#### ***Key Reform Actions***

We will:

63. Redesign services in collaboration with local Aboriginal communities to better meet Aboriginal primary, community and environmental healthcare needs
64. Strengthen regional or sub-regional Aboriginal Health Planning Forums, host and fund and annual statewide conference of regional Aboriginal health planning forums and work with partner agencies to develop and implement regional Aboriginal health action plans
65. Provide Aboriginal-managed services operating from WA health facilities with levels of support equivalent to those of WACHS remote services.



### *Objective 18: Culturally appropriate planning and delivery of services.*

#### **Key Reform Actions**

We will:

66. Establish a WACHS Aboriginal health reference group in partnership with the Office of Aboriginal Health that reports to the WACHS Chief Executive Officer.
67. Implement the WA Health Cultural Respect Implementation Framework across all services including all staff participating in cultural awareness education and training
68. Develop strategies for Aboriginal input into regional services planning and decision making
69. Review the provision of aged care services to Aboriginal people and develop and implement culturally secure practice guidelines to better meet the needs of Aboriginal communities.

## **Improving and Expanding Mental Health Services**

### **Intent**

WACHS, in consultation with the Department of Health's Mental Health Division, will develop the capacity of general health services and specialised mental health services to provide more comprehensive, accessible and coordinated responses to the prevention and treatment of mental illness in rural WA.

### **Our Mental Health Services**

Mental health is a major health issue for all communities in Western Australia. Mental illness currently represents the third highest burden of disease, with one in five people experiencing a significant mental health problem during their life.

There are a broad range of mental health services available in country WA including:

- Primary mental healthcare provided by general practitioners and WACHS primary and community health services
- Mental health promotion and illness prevention services targeting risk factors such as drugs and alcohol
- Inpatient and emergency mental healthcare provided in hospitals
- Call centre-based support, information, referral and crisis management services through Rural Link and South West 24
- Specialist inpatient and community-based mental health services for children and adolescents, adults and older people with severe and enduring mental illnesses such as bipolar affective disorder, schizophrenia and moderate/severe depression
- Authorised adult inpatient units at Albany, Bunbury and Kalgoorlie regional hospitals.

There are multiple providers of mental health services and a complex framework for service

delivery involving the Australian Government; the WA State Government Departments of Disability Services, Police, Justice, Education and Community Development; private; non-government; and voluntary service providers.

WACHS has six specialist mental health units providing services across the seven regions. Highly specialised state-wide mental health services such as forensic psychiatry, specific adult inpatient programs, trans-cultural services, eating disorder programs and child and adolescent inpatient care services are normally provided only in the metropolitan area, but have some outreach to rural areas through visiting specialists and tele-psychiatry.

Access to the available mental health services is difficult for many country residents and especially for Aboriginal people living in more remote areas.

Access is often complicated by difficulties of travel, accommodation and communications and by the limited availability of specialist services.

Safety of mental health clients and staff can pose an additional challenge, particularly in more remote locations.

### **Future Directions**

Factors such as increased patient expectations, the growth, change and ageing of the population and the growing misuse of alcohol and drugs will significantly increase the demand for mental health services in rural areas over the next few years. The challenge in responding to increasing demands is compounded by the general shortage of mental health professionals, the difficulties in attracting and retaining specialist mental health staff in rural and remote areas and the lack of skills and knowledge about caring for people experiencing mental health issues by other health staff.

WACHS aims to improve access to mental health services, reduce service gaps and duplication and expand mental health early intervention, prevention and community based services. A mental health unit is also being developed at Bunbury and we will assess the need for a mental health unit as part of the Broome Regional Hospital redevelopment.

We intend to develop a more consistent and comprehensive partnership approach, in collaboration with the Mental Health Division and other mental health providers, to the provision of country mental health services across the spectrum covering promotion and prevention, early intervention, emergency care, acute care, continuing care and rehabilitation.

We will also seek to develop the capacity of our health services across the system to manage with skills and confidence all patients who have mental health issues.

The safety of mental health clients and staff will be a high priority in regional services planning and delivery.

***Objective 19: Improved access to specialist mental health advice, support and tertiary services.***

***Key Reform Actions***

We will:

- 70. Engage service providers including Aboriginal community controlled agencies, GPs and other non-government organisations in statewide and regional mental health strategy development
- 71. Develop and introduce innovative workforce models including mental health nurse practitioners and support workers
- 72. Explore collaborative arrangements between mental health and alcohol and drug services including collocations, mergers, shared care protocols and case management
- 73. Use visiting psychiatrists from regional or metropolitan centres to increase mental health outreach services.

***Objective 20: Primary, community, emergency and other hospital services are able to manage and provide non- specialist mental health care.***

***Key Reform Actions***

We will:

- 74. Expand and clearly identify the roles of public health, primary health, child and community health and general hospital staff and services in mental health care
- 75. Develop the expertise of emergency staff, other staff and general practitioners to manage mental health presentations competently and confidently, for example through training, telehealth and tele-psychiatry.

## Maintaining the Health and Independence of Older People

### Intent

WACHS will strive to redesign the way services are provided to the elderly. In partnership with GPs, we will place greater emphasis on services that maintain the health and independence of older people and on improving the efficiency and quality of our residential aged care services.

### Our Aged Care Services

WACHS is a significant provider of community-based aged care, residential aged care and hospital-based respite care for older people. Currently WACHS provides care to over 440 aged care residents in 48 of its 74 hospitals and multi-purpose centres. Thirty-five of these facilities receive funding through the Multi-Purpose Service Program (MPS). WACHS also manages Australian Government funded nursing home beds in Derby, Port Hedland and Kununurra and is the provider of Carelink in the Pilbara, Kimberley and Midwest.

Aged care services are principally funded by the Australian Government through MPS, the Home and Community Care Program (HACC), the Residential Aged Care Program, the Long Stay Older Patients Program and Carelink.

It is estimated that over 14,000 country residents (31% of the population in the HACC target age group) receive HACC services each year. Only 6% of aged people in Australia live in residential aged care. Most elderly people prefer and expect to remain living in the community, where they are often supported by family, friends and neighbours. Support for carers is a critical component of successful aged care services.

In many areas of WA, WACHS has to consider the transient older tourist population who present with demands for medication and equipment on their travels around Australia.

### Future Directions

A key aim of WA Health reform is to prevent avoidable admissions to acute hospital care. While comprising 11% of the population, those 65 years and over account for 29% of hospital admissions and 43% of total bed days<sup>13</sup>.

Working in partnership with other aged care providers will be a key strategy in our endeavours to strengthen rural and regional aged care services in a manner that is consistent with the vision in the State Aged Care Plan of 'Independence, well-being and quality of life for older people' through responsive health and aged care services.

WACHS will establish an aged care management function in each regional network in order to better coordinate the planning and delivery of aged care services, minimise duplication of processes (as in the case of multiple assessments) and better up-skill and support staff. This will help to integrate aged care staff, including staff in HACC, Aged Care Assessment Teams (ACAT) and residential aged care providers, and create links with other providers such as Silver Chain Nursing Association, local government, church-based agencies and the private sector.

In collaboration with our aged care partners, WACHS will develop coordinated programs for chronic disease management, rehabilitation, preventive services (e.g. prevention of falls) and community-based alternatives (e.g. 'hospital in the home') to reduce unnecessary hospitalisations.

Many small country hospitals have become the default residential care providers, with and without MPS funding support. This residential aged care model, whereby small numbers of beds are spread across a large number of small country hospitals does not necessarily make the best use of limited health funding and resources. Through regional services planning we will designate sites to be the future providers of aged care services.

In addition, WACHS recognises that many of the older low-care facilities were designed for acute inpatient care, do not meet contemporary residential aged care standards and are not appropriate for the increasingly complex needs of older residents. Factors that contribute to this complexity include the residents' need to access care while maintaining their connection to family, and the providers need to attract good staff and to renew and revitalise facilities. The skill set of hospital staff can often be under-utilised in aged care or may not meet the increasingly specialised needs of the elderly. WACHS will provide support for hospital staff and GPs to access geriatric expertise and up-skilling.

In seeking accreditation under the Australian Council of Healthcare Standards, We will benchmark aged care services against relevant national Residential Aged Care Standards and HACC National Service Standards.

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13 A Healthy Future for Western Australians: Report of the Health Reform Committee, March 2004.

In order to keep older people well, maintain them in the community and prevent hospital admissions, investment in aged care services must be realigned to better respond to the need for community-based and restorative services. While the provision of locally based services demands a balance between accessibility and affordability, the importance of these services to the community means that we must develop solutions that will meet community needs in a more sustainable manner.

***Objective 21: Increase the focus on services that maintain the health and independence of older people.***

***Key Reform Actions***

We will:

- 76. Develop community based services that maximise the independence of older people
- 77. Expand early discharge and community rehabilitation services for older people
- 78. Introduce the Residential Care Line to provide residential aged care services with telephone advice and support that will enable them to manage sick patients who do not require transfer to an acute service.

***Objective 22: A coordinated, integrated and efficient network of community and residential aged care services in each region.***

***Key Reform Actions***

We will:

- 79. Appoint aged care coordinators in all regions
- 80. Strengthen aged care services and skills by utilising the expertise of visiting geriatricians and telehealth
- 81. Review the current arrangements for residential aged care services to improve efficiency and quality of care
- 82. Make better use of the skills of registered nurses by increasing the number of patient care assistants employed for non-nursing duties
- 83. Meet relevant national standards for community and residential aged care services.

## Section 6:

### Reform Direction 3

# Strengthening and Modernising the Country Health System

## Introduction

This section describes WACHS' three-year priorities for the key systems and processes that underpin or support the provision of healthcare across Western Australia:

- Making the most of our financial resources
- Building a healthy workforce
- Working with rural doctors
- Managing and improving our organisational information and communication systems
- Developing the right infrastructure.

Our strategic intent is to consolidate and standardise some of our corporate and reporting functions through the WACHS area office to ensure that our area-wide functions better meet the governance and support requirements of a modern health system. We envisage a future where many of our support processes are re-engineered to ensure that their capabilities have a similar 'look and feel' to staff wherever they work across the State.

## Making the most of our Financial Resources

### Intent

WACHS will manage its financial resources to maximise the effectiveness and efficiency of health service delivery for the benefit of the community.

### Resourcing Country Health Services

Health services currently account for over 24% of the Western Australian State budget. In recent years, expenditure in the State healthcare system was increasing by an average of approximately 8.5% per annum which is consistent with other states and territories in Australia and internationally.

In common with those other governments, our State government recognised that this growth trend in health expenditure placed an unsustainable burden on public finances. The government's financing policy for health has therefore introduced a policy for annual funding growth of 5.5% in the forward years of the government term. Foundations is presented within the framework of the government's annual growth funding policy for Health.

Chart 5: WA Country Health Service Revenue 2005/06

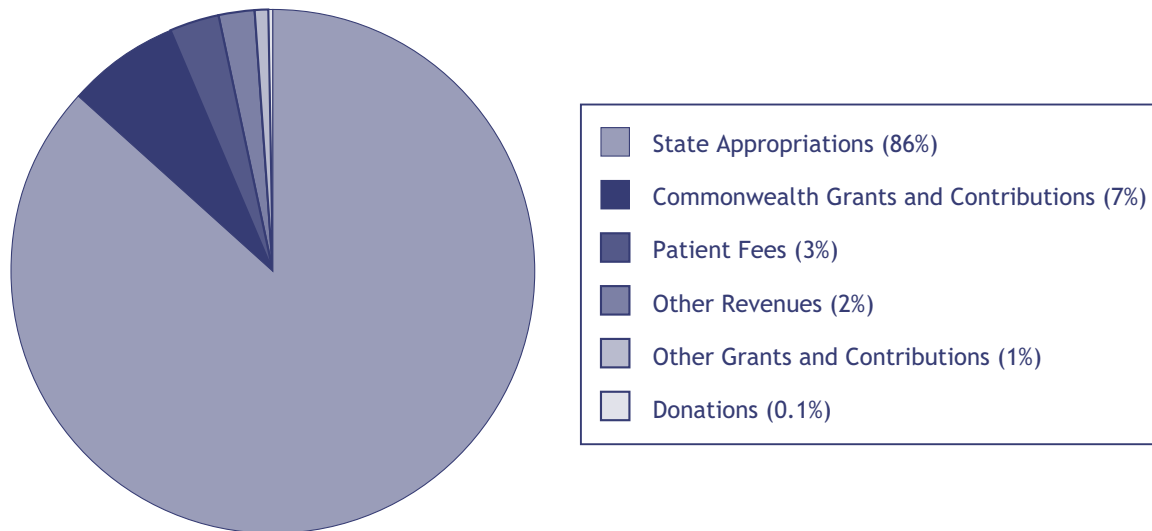
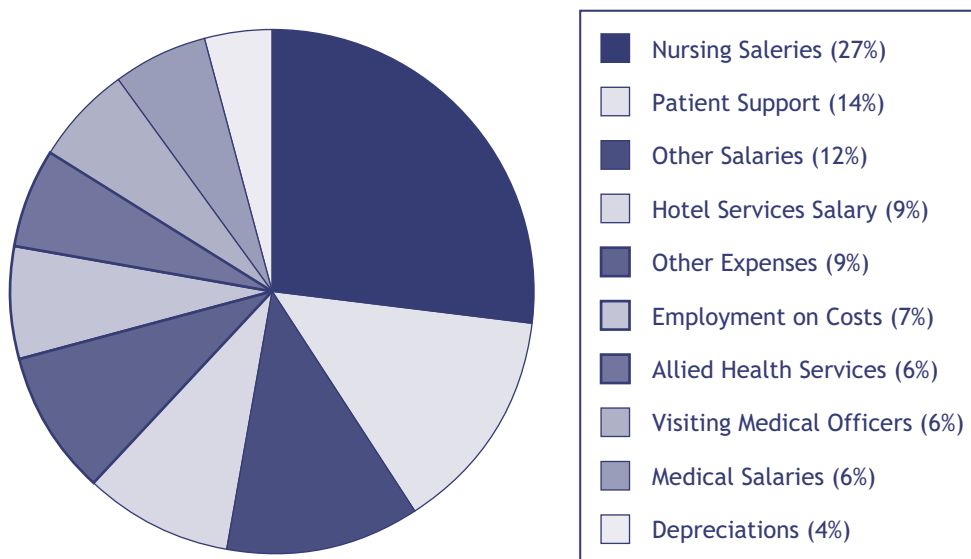


Chart 6: WA Country Health Service Expenditure 2005/10



It is more expensive to provide health services in country communities than in metropolitan areas due to the geographically dispersed sites and higher prices generally. Increases in workforce costs have been particularly significant and have resulted from supply shortages and imperatives to reduce clinical working hours to safer levels.

The present approach of WACHS to resource distribution is largely based on historical budgets, partly in recognition of the resourcing requirements of hospital-based services. This approach has severely limited our ability to respond to changing service needs across country areas, such as increasing demand for regional hospital services and diminishing demand for acute and specialist hospital services in smaller towns.

### Future Directions

We are committed to maintaining health investment in rural and remote areas. WACHS must, however, respond to the significant resource challenges by improving the efficiency and effectiveness of health services to meet increasing demands and costs within the resources available. Simultaneously, we must:

- Address the greater burden of disease in country WA, particularly in the Aboriginal population
- Operate as the sole provider of all healthcare services to some country communities
- Deliver high-quality and safe health services to sparse and widely distributed communities with varying health needs.

Over time, WACHS will adjust resource distribution to:

- Support a better balance between prevention and promotion activities, primary and community care, inpatient services, emergency care and continuing care
- Begin to address the greater burden of disease in remote areas, particularly in relation to the Aboriginal population.

We have embraced a number of Australian Government and State government initiatives to increase the viability and flexibility of small services. These include the Multi-Purpose Service (MPS) program, the Regional Health Service (RHS) program and initiatives of the Council of Australian Governments (COAG) such as the Australian Better Health Initiative. In the future it will be more important than ever to work closely with all levels of government and the community to explore new options for increasing the effectiveness and efficiency of country health services.

Redistribution of resources to meet community health needs will be made in close consultation with all relevant local stakeholders and communities.

WACHS will refocus our systems to increase efficiency and improve services to consumers and clinicians at both the regional and area health service levels. System changes will translate into practical responses to the challenges of ensuring quality health provision in a State where some locations and communities are experiencing unprecedented growth and others diminution. The resulting population shifts generate constant changes in health profiles.

WACHS can also decrease some of the higher costs of providing services in country areas by streamlining systems and taking a unified approach across all regions.



**Objective 23: *Make the best use of available resources through improving budget accountability, financial planning, resource allocation and financial management systems.***

**Key Reform Actions**

We will:

- 84. Improve budget allocation and accountability across WACHS
- 85. Review and strengthen WACHS' financial planning and financial management systems
- 86. Roll out of the Oracle financial management system throughout WACHS
- 87. Work with the Office of Aboriginal Health to identify and resolve information and other gaps in the financing and delivery of Aboriginal health services in order to increase service coordination and funding transparency
- 88. Consolidate support services to provide area wide services from specific regional centres or head office.

**Objective 24: *All available revenue sources are accessed.***

In country areas, WACHS is often the sole provider of health services. In some instances, this provides opportunities to secure additional revenue, which will allow WACHS to provide enhanced services.

**Key Reform Actions**

We will:

- 89. Improve systems for recovering the costs of eligible services from Medicare, DVA, Workers Compensation, private patients and other sources
- 90. Pursue partnerships with private sector and non-government community organisations that offer benefits for country health services.

## Building a Healthy Workforce

### Intent

WACHS will strive to build a skilled, stable and motivated workforce that meets the needs of the diverse country population. We will achieve this through a focus on workforce planning, attraction and retention, the development of innovative new workforce models, cultivating partnerships with other employers and providers and striving to be an employer of choice.

### The Country Health Workforce

WACHS currently employs over 8,500 staff (full and part time). These staff have diverse professional backgrounds: in medicine, nursing, allied health, health-worker and patient-care assistance. Support staff include cooks, orderlies, clerical and administrative staff and managers. The rural health workforce is also made up of an extensive network of private GPs, and resident and visiting specialists. GPs who undertake some surgical procedures form the backbone of rural health services.

Our capacity to recruit and retain staff is affected by:

- A projected reduction in national workforce growth from 170,000 pa to 12,500 pa by the year 2020 as a result of the slow population growth combined with an ageing population
- An ageing workforce – the current average age of the WA Health workforce is 44
- Increasing employee demand for flexible, family friendly working arrangements and reluctance to work long hours or on call.

It is estimated by 2022 there will be a gap of 35% in respect of medical practitioners and nurses within the WA public system, with varying shortages across the allied health professionals. A further difficulty is that public sector health employers plan their needs for staff and undertake recruitment in relative isolation. Sometimes public sector health employers compete with each other to recruit the same person.

In rural areas, shortages will become more pronounced in general practice, specialist medical areas, nursing and some allied health areas<sup>14</sup>. The need to increase services in mental health, Aboriginal health and aged care will exacerbate workforce shortages in these areas.

### Future Directions

It will not be enough to rely on traditional supply and demand approaches to resolving country workforce issues into the future. We also need to consider closely areas such as education, training and leadership, workforce planning, new and innovative service delivery models and work redesign, flexible working arrangements and staff support if we are to ensure the provision of quality, safe and sustainable services. We will also participate in and contribute to planning for a sustainable rural health workforce at national, state, regional and community levels.

Our priority is to develop and deliver new models of health care to address the expected workforce gaps and skills shortages. Developing the role of nurse practitioners so they can dispense medications and order diagnostic tests in remote areas that do not have a GP is one strategy already being progressed.

The rising number of medical student places and the establishment of the Notre Dame Medical School will help supply doctors to country health services in future years. However, considerable reliance on overseas trained doctors (OTDs, also referred to as international medical graduates) to provide services will continue. The challenge is to ensure that all OTDs providing services in rural areas have adequate orientation to the operational and diverse cultural characteristics of health service delivery in country Western Australia.

A well supported, trained and valued workforce that promotes diversity will improve attraction and retention rates and lead to improvements in the safety and quality of services and patient care. We will consider the results of the WA Health employee survey and develop key organisational competencies to match workforce skills and experience with the needs of the health service and the patient. We will also find ways to better support access to further education and training for staff, particularly in small sites where low staff numbers mean staff are often unable to leave the clinical setting to attend training.

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14 Workforce Projections 2002-2022, Population Ageing and the WA Public Sector Workforce

We will encourage staff at all levels to demonstrate leadership and will facilitate leadership development of senior staff and managers. We will also encourage the mentoring of less experienced staff so they build on their skills and capabilities as they take up early supervisory and management roles.

***Objective 25: Workforce planning, recruitment and retention align to services planning and strategic directions.***

***Key Reform Actions***

We will:

91. Establish a central workforce unit to develop consistent and innovative approaches to workforce strategy, clinical employment and new clinical roles
92. Ensure workforce planning and employment arrangements support the introduction of new flexible service delivery models, such as mobile clinical teams
93. Improve the service and support arrangements for visiting medical practitioners
94. Develop comprehensive rural employment and remuneration packages for WACHS clinical staff
95. Develop systems that assist clinical staff to transfer more easily within the WA health system
96. Improve the recruitment, assessment, orientation and training of Overseas Trained Doctors through partnerships with workforce agencies
97. Work with educational institutions to ensure tertiary educators are encouraging and preparing trainees to take on challenging roles in rural and remote settings
98. Develop and implement a WACHS Aboriginal workforce strategy to increase the number of Aboriginal employees in health service delivery by 10% per year
99. Implement the WA Health 'nursing hours per patient day' nursing workforce methodology across all hospitals.

***Objective 26: Innovative workforce models and new types of practitioners to support contemporary health services.***

***Key Reform Actions***

We will:

100. Extend the use and role of nurse practitioners in providing emergency care, mental health care and in remote locations
101. Extend the use of therapy assistants, clinical support workers and patient care assistants throughout WACHS
102. Introduce innovative and flexible service models such as mobile clinical teams to address critical gaps, especially at smaller sites or in remote areas.

*Objective 27: WACHS is an employer of choice.*

#### **Key Reform Actions**

We will:

103. Increase access to training for regional doctors and other clinicians through locum support, relevant education and training (including through greater access to telehealth), consultancy advice and rotating posts
104. Implement the WA Health bullying and harassment education programs across WACHS
105. Develop new strategies to improve safety for staff working in remote locations
106. Develop, promote and implement flexible and family friendly work practices.

## **Working with Rural Doctors**

### **Intent**

WACHS will take a leadership role in strengthening relationships with rural doctors, including GPs, salaried medical officers and visiting and resident specialists, and involve them more actively in hospital and health service planning and decision making. We will work with partner workforce agencies to develop strategies to attract, recruit, and retain the rural medical workforce and ensure that they are fully prepared for rural practice.

### **The Rural Doctor Workforce**

Doctors form a central component of the rural health workforce. Primary health services are largely provided by GPs through their private GP practices. In towns with a hospital, local GPs, contracted as visiting medical officers (VMOs), often provide all the medical services for these facilities. In larger district and regional hospitals, the demands on their private practice and the needs of a busy hospital has meant that many GPs have been unable to provide the range and volume of services sought by the hospital, and salaried medical officers have been employed. In the North West of the State, it is especially difficult for GPs to run viable private practices, and salaried doctors working for either WACHS or the local Aboriginal Medical Service provide most medical services. Across rural WA, there are almost 600 doctors, approximately 150 of whom have VMO arrangements with WACHS, and a further approximately 180 of whom are directly employed by us as salaried medical officers.

Strong working relationships between rural doctors and public health services managers are critical to good service coordination and seamless patient care. In 2006, WACHS commissioned the WA Centre for Remote and Rural Medicine (WACRRM) to undertake a consultation program across the State to seek rural doctors' views about rural health planning, gaps in services, relationships and ideas about change and reform required over the next 5 to 10 years. The consultations reached 361 rural doctors (54% of the workforce) as well as 40 visiting specialists and 30 medical students.

Overall the consultations found that rural doctors largely enjoy working in rural WA and value the rural lifestyle and challenges and opportunities of rural practice. However, the doctors identified a number of themes that cause them stress and frustration and that may influence upon their decisions to stay and provide services to the community.

They include lack of involvement in local and regional health service planning, sometimes poor relationships with the local hospital managers and lack of supports for doctors and their families, particularly for overseas trained doctors who sought, for example, improved information and orientation to rural practice and locum relief. The doctors consulted also acknowledged the difficulties in maintaining the medical workforce in some areas and the need to explore other workforce models such as nurse practitioners.

### Future Directions

The final report of the consultations, *Engaging Rural Doctors*, is being published by WACHS, and the key actions described in that report will be progressively implemented. A Reference Group has been established with representation from the key rural workforce agencies. This group oversaw the design and implementation of the consultation process and will remain in place to assist with the implementation of the findings. Of the 50 key actions in the report, approximately two thirds fall to WACHS to implement. These will be integrated into our operational planning.

*Objective 28: Build more supportive and collaborative working with rural doctors.*

### Key Reform Action

We will:

107. Progressively implement the WACHS related recommendations from the *Engaging Rural Doctors* consultation report, 2006 over the next three years.

## Managing and Improving our Organisational Information and Communications Systems

### Intent

WACHS will strengthen its information management systems and information and communications technologies (IM and ICT) to enable effective communications, informed decision-making and better health system performance.

### What is IM and ICT?

IM and ICT underpins all service delivery and management and consists of a number of systems and technologies such as:

- Telephone and computer systems
- Information systems including patient records and systems to manage service activity, finances and staff
- Emerging technologies, including digital imaging and telehealth.

Significant progress has already been made towards defining and establishing an IM and ICT environment that will support WACHS' services and meet information management commitments with WA Health.

WACHS has focused on strategies that standardise information and technology environments to facilitate statewide sharing of services, integration of systems, development of common policy and alignment with national directions for connectivity and information interchange.

WACHS will continue to contribute to the following WA Health IM and ICT initiatives:

- Replacement and improvement of state-wide health information systems such as patient administration, clinical information, pharmacy, pathology and radiology systems
- Replacement of corporate state-wide systems such as finance, supply, human resource and electronic rostering systems
- Development of WA Health ICT Shared Services
- Development of a state-wide central data repository and the provision of a set of common business intelligence tools
- Integration of systems to allow for sharing of patient information across health service providers to ensure all relevant clinicians have access to current medical records and discharge summaries.
- Implementation of the whole-of-health internet/intranet web redevelopment and training.

## Future Directions

### *Objective 29: Timely and comprehensive information management systems.*

Access to good quality and timely information is vital to continuous monitoring and improvement of performance for WACHS as a whole, for individual regions and for local services. WACHS is committed to improving information systems across our health service and to providing the mechanisms to coordinate and better manage information to support the development of new service delivery models and effective and sustainable service delivery.

### *Key Reform Actions*

We will:

108. Consolidate clinical and corporate information systems to support analysis, reporting and decision-making
109. Provide data analysis tools to support the WACHS reform program and improved service delivery
110. Identify business opportunities that will strengthen and support the WACHS reform program and strategic intentions
111. Collaborate with private and non-government country health services to allow for sharing of information across health and related service providers.

***Objective 30: Enhanced information and communication technology.***

Access to appropriate technology and network communications is essential for the delivery of effective services and timely provision of information.

***Key Reform Actions***

We will:

- 112. Establish an area wide ICT support team
- 113. Implement consistent, robust and scalable ICT across WACHS through planned replacement of ICT infrastructure
- 114. Upgrade network infrastructure including increased bandwidth capacity and implementation of new telephone and telehealth systems
- 115. Develop an ICT Disaster Recovery/Business Continuity plan.

***Objective 31: Improved access to specialist services and staff training through telehealth and other e-health technologies.***

Telehealth and other e-health technologies improve access to specialist clinical and imaging services for rural patients and clinicians, support the delivery of care closer to home where possible and allow cost effective education and up-skilling for the country workforce, through video-conferencing and self-paced learning programmes.

***Key Reform Actions***

We will:

- 116. Improve access to consultancy and specialist support services by expanding the capacity of telehealth, tele-psychiatry and other e-health technologies
- 117. Establish statewide diagnostic imaging services in the areas of wound management, ophthalmology and otology (especially to Aboriginal communities)
- 118. Implement chronic disease monitoring within the home using video conferencing to enhance patient self-management ('Pathways Home' demonstration project)
- 119. Improve access for the families of patients in metropolitan hospitals, enabling the families to 'visit' the patients via video conferencing
- 120. Improve clinical supervision, education and training, peer review and support through enhanced use of and access to telehealth, tele-psychiatry and net-meeting technology.

## Developing the Right Infrastructure

### Intent

The future development and location of health facilities will be determined by informed planning decisions to ensure that new and refurbished facilities support modern service delivery needs.

### Infrastructure Planning and Development

WACHS currently manages approximately \$0.5 billion of building assets. However, many health facilities are old, outdated or inappropriate for current health service delivery. Acute-care hospital beds are often under-utilised in smaller towns and aged persons needing residential care are inappropriately placed in acute-care hospital beds. Many old buildings have undergone several repairs and upgrades but are now at the point of requiring either major redevelopment or replacement.

A new capital investment program of \$627m over ten years commenced in 2004 and is enabling WACHS to address its priorities for the development of our facilities. We are applying a rigorous capital planning approach to all of our investment decisions, which involves formal assessment and quantification of population needs, utilisation rates and ongoing operational costs and includes structural cost/benefit and risk analysis of all options, including whether a facility is required.

Planning for new and revitalised facilities based on the continued development of regional health networks is well advanced and gives priority to the development of regional resource centres (regional hospitals), the upgrade or replacement of facilities that have outlived their usefulness and the needs of staff accommodation.

The projects completed to date include:

- Geraldton Health Campus stage 1
- Warburton Clinic
- Looma Clinic
- Halls Creek Multi-Purpose Centre
- Broome - CT scanner room and equipment
- Kununurra residential aged care addition
- Port Hedland - residential care stage 1
- Margaret River Hospital upgrade
- Moora Multi-Purpose Centre



### Future Directions

New infrastructure designed to provide a physical environment that supports the delivery of high quality, safe and contemporary health services is necessary to replace ageing hospitals. Rigorous capital planning will ensure old and inappropriate facilities will be progressively replaced or redeveloped to:

- Create infrastructure consistent with role delineation and strategic reform directions to ensure long term sustainability
- Provide safe and appropriate levels of emergency care within an integrated network
- Change the focus from low occupancy acute settings to primary and community-based care
- Accommodate expanded primary care services
- Develop residential aged care facilities that can meet the increasingly complex care needs of residents.

The major planned capital projects over the next three years include:

Project	Status
Derby Acute Inpatient Ward and Ambulatory Care Centre	First stage (Dental Services) completed Overall completion due mid 2007
Kununurra New Dental Clinic and Development	Due for completion mid 2007
South West Health Campus - Inpatient Mental Health Unit Expansion and New Mental Health	Clinic Due for completion end 2007
Bunbury - Replacement Dental Clinic	Due for completion end 2007
Denmark Multi Purpose Centre	Construction to commence early 2007
Fitzroy Crossing Multi Purpose Centre	Construction has commenced due for completion early 2008
Port Hedland Regional Resource Centre Stage 2	Architect appointed design work due for completion mid 2007
Albany Regional Resource Centre Stage 1	Business case early 2007
Broome Regional Resource Centre Stage 1	Tenders called late 2006
Carnarvon Redevelopment Stage 1	Tenders to be called early 2007
Kalgoorlie Regional Resource Centre Stage 1	Business case due early 2007
Busselton - new hospital	Business case due mid 2007
Morawa and Perenjori Multi Purpose Centre	Tenders close early 2007

WACHS also has a \$24 million capital investment allocation to revitalise and expand staff housing. It is now possible to address an acute shortage of appropriate staff accommodation in the Pilbara, Kimberley, Gascoyne and Goldfields regions.

The staff accommodation program for the next three years includes the following projects:

- Construct 10 new staff houses Port Hedland \$5m
- Purchase 4 new residential blocks at Pretty Pool, Port Hedland \$800,000
- Construct new staff quarters (24 units) Port Hedland \$7m
- Construct/Purchase house Newman \$3m
- Purchase housing complex Meekatharra (26 units/houses/duplexes) \$1.3m
- Purchase 4 new houses Kalgoorlie \$1.2m
- Purchase 5 one bedroom units Kalgoorlie \$650,000
- Construct 4 two bedroom units Fitzroy Crossing \$1.9m
- Construct two town houses Camballin \$670,000
- Refurbish existing staff houses Pilbara \$2.5m
- Refurbish existing staff houses Derby \$700,000.

The maintenance of an ageing building stock is placing increasing pressure on operating budgets and has resulted in a steadily increasing deferred-maintenance liability. We will improve our management of maintenance requirements to ensure that our facilities support strategic healthcare objectives, comply with statutory regulations, deliver minimised whole-of-life costs and meet duty of care obligations.

***Objective 32: WACHS facilities are replaced or redeveloped in accordance with WACHS reform directions, identified needs and role delineation.***

***Key Reform Actions***

We will:

121. Carry out the major projects identified for development over the next three years in the 10 year Capital Investment Plan
122. Explore opportunities for co-location of private or non-government sector services with our public health facilities.

***Objective 33: Improved asset maintenance and management.***

***Key Reform Actions***

We will:

123. Ensure our assets are maintained at appropriate levels and remain relevant to strategic reform directions
124. Include WACHS facilities occupied by Aboriginal Medical Services in the WACHS asset maintenance program.

## Section 7: The Way Forward

*Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010* provides the strategic direction, objectives and actions for the reform of country health services. It lays the ‘foundations’ on which to build sustainable health services throughout rural Western Australia over the next three years and beyond. The overall aim in progressing the country health service reforms outlined in *Foundations* is to continue to deliver safe, high quality and appropriate health services to country people to improve the health of rural Western Australians, deliver better value for money from the available funding and increase the long-term sustainability of country health services.

### Progressing Implementation

The successful implementation of *Foundations* over the next three years will require us to engage with rural communities and establish joint partnering arrangements with the many providers of health services to the country population, including GPs, non-government services, local shires and metropolitan health services.

Translating some of the objectives and actions proposed in *Foundations* into better health outcomes for rural and regional communities will occur through the development of locally tailored and detailed regional clinical services plans. These will describe how health services across our seven regional health networks will be developed to respond to the strategic directions set out.

A detailed implementation framework has also been developed, which provides a governance structure and methodology for coordinating the implementation of the objectives and actions in *Foundations*. The project implementation plans will describe the specific tasks, timeframes, milestones, deliverables, outcomes and measures of success to be achieved for each of the projects and will take account of the interdependencies between projects.

We are committed to engaging our staff, rural doctors, DHACs, metropolitan service providers and our many other country health service partners in the implementation of the planned changes. The extensive program of consultations with rural doctors recently managed through the WA Centre for Remote and Rural Medicine which provided a clear indication that rural doctors want to be actively engaged in future regional services planning.

We believe regular communication on the progress of the reforms is essential and will ensure stakeholders understand the reform program, are assured progress is occurring and have the opportunity to offer input into the implementation. A communication strategy will be developed as part of the implementation plan and will include up-to-date information posted on the WA Country Health Service website at [www.wacountry.health.wa.gov.au](http://www.wacountry.health.wa.gov.au)

*Foundations* will be reviewed in early 2010 to inform the strategic directions for the WA Country Health Service into the future.

We look forward to working with all parts of the WA health system, with rural communities and others to implement the actions set out in *Foundations* and to reporting on our progress and achievements.

## Appendix 1: Country Health Reform to date

Following the publication of the 2003 Country Health Services Review, WACHS initially focused on consolidating the more than 40 separate organisations into six regional services and on building the capacity of the regional hospitals to provide a broader range and complexity of services within the regions. More recently we have focused on realising the benefits of being an integrated rural health system. Some of the key achievements in implementing the six strategic directions are shown below.

### Healthy Workforce

We have increased the clinical workforce in our hospitals and health services by over 140 positions since 2002/03.

There have been many highly successful specific workforce initiatives, for example:

- The 'Ocean to Outback' Program for new nurse graduates offers invaluable insight and hands-on experience for nursing graduates who want to receive training in rural and remote WA.
- The country Nurse Practitioner Program has been established with 5 nurse practitioners accredited and 21 sites designated to date.
- The Therapy Assistant Training Program provides training to allied health assistants to improve access to allied health services in remote areas. Training includes access to Certificate III (Health Service Assistant - Allied Health) and can be accessed using video-conferencing.
- A Rural Student Placement Website has been established to encourage and support students to undertake rural placements during undergraduate years.
- Funding has been increased to support students to undertake rural placements. Between 2002 and 2005, 68 country undergraduate Allied Health Scholarships were awarded and 80% of scholarship holders have secured employment with the WA Country Health Service to date.
- Access to education and training has been enhanced through videoconferencing applications.
- The Rural and Remote Allied Health Competency Framework has been established.
- Access to therapy services has been improved for people with a disability through the agreement of a Memorandum of Understanding with the Disability Service Commission.

### Healthy Hospitals

Building the capacity of our hospital system to increase and improve services has been an important focus. Some of our achievements are as follows:

### Capital redevelopment

Following endorsement of the 2003 Country Health Services Review, the government committed \$627 million over 10 years to an extensive capital rebuilding program. Projects include replacing or upgrading regional, district and smaller hospitals and increasing the staff accommodation available. Forty five accommodation units have been purchased or built since 2003.

Since the 2003 review, Stage one of Geraldton Hospital has been completed. New hospitals have been completed or commenced in South Hedland, Halls Creek, Moora and Ravensthorpe. Hospitals have been redeveloped or upgraded in Kununurra, Derby, Quairading, Northam and Margaret River. The paediatric ward of Albany hospital has been upgraded.

Country resources have also been boosted across the regions with the acquisition and/or installation of new equipment including:

- 16-slice Computed Tomography (CT) scanners for Broome, Port Hedland, Northam and Albany
- 10 ultrasound machines
- 13 new mobile x-ray machines
- 7 general x-ray machines
- New C-arm fluoroscopy units for Nickol Bay and Geraldton
- Teleradiology capabilities fitted at all radiography sites.

### Transport

A Transport Review was completed in 2005 and identified better ways to coordinate access to health services within country regions across all forms of transport, including primary evacuation (transport from point of occurrence of illness or accident to health care facility), inter-hospital transport, public transport and private transport. Funding for the Patient Assisted Travel Scheme has been increased and a new 'Meet and Assist' service has been developed to support Aboriginal and other patients needing special help when they are transferred to Perth for treatment.

### Growth in renal dialysis services

Renal dialysis services have been expanded in Port Hedland and Kalgoorlie and new services have been established in Albany and Broome. Renal satellite services are now available in Albany, Broome, Bunbury, Geraldton, Kalgoorlie and Port Hedland. A new pilot service, 'supported community-based dialysis', has also been established at Derby Aboriginal Medical Service.

### Improvements in mental health services

The Kalgoorlie mental health inpatient unit is now fully functioning and funding has been approved for the expansion by 18 beds of the acute psychiatric unit in Bunbury. Additional consultant psychiatrists have also been appointed in both Kalgoorlie and Albany.

Two specialist mental health after-hours telephone services, Rural Link and South West 24, have been established.

Two new mental health beds have been included in the new Geraldton Hospital, where the first emergency department mental health nurse has also been appointed.

Funds have also been allocated for new community-supported residential units in Albany, Bunbury, Busselton and Geraldton.

### Increased specialist services

We have created a number of new specialist positions in regional health networks, including positions in:

<b>Goldfields</b>	- obstetrics, psychiatry, public health, paediatrics
<b>Great Southern</b>	- psychiatry, orthopaedics, general surgery
<b>Kimberley</b>	- paediatrics, pharmacy, general medicine, psychiatry
<b>Midwest</b>	- paediatrics
<b>Pilbara</b>	- general surgery, obstetrics/gynaecology
<b>South West</b>	- paediatrics, psychiatry and emergency medicine.

### Telehealth

With the development of a telehealth strategic plan, increased telehealth services are now provided in psychiatry, neurology, geriatric medicine, joint replacement clinics, developmental paediatrics, gastroenterology and pain management. Clinical consultations and reviews have increased from 1003 consultations and reviews in 2003/04 to 2276 consultation and reviews in 2005/06. Videoconferencing is also used extensively for training and professional development

## Healthy Partnerships

WACHS has forged partnerships with universities, the Institute for Child Health Research and Healthway in a range of projects such as the *Mentally Healthy* 'Act-Belong-Commit' campaign in Albany, Esperance, Geraldton, Kalgoorlie, Karratha and Northam.

Partnerships have also been developed with Aboriginal Medical Services and health promotion non-government organisations to better coordinate local services and make best use of the funding available, for example in Fitzroy Crossing and a number of Australian Government funded Building Healthy Communities initiative including programs in Carnarvon and Denmark.

WACHS has worked collaboratively with the Combined University Centre for Rural Health to establish the Allied Health Assistant Program.

WACHS and Disability Services Commission work in partnership to enhance primary and community therapy services to people with disabilities who live in country areas and to ensure available funding for these clients is used as effectively as possible.

## Healthy Communities

### District Health Advisory Councils

Seventeen District Health Advisory Councils plus an Aboriginal Health Council in the Great Southern have been established to improve the effectiveness of our community engagement. The model has been evaluated and seven additional District Health Advisory Councils are now being established in the South West in 2006.

## Population Health

The establishment of population health units in every region has increased the coordination and coverage of our services. Innovative new services have been developed, such as the men's health 'Pit Stop' program, which was developed for rural WA and has now been introduced across all regions and interstate and the Telethon award-winning SPOTS pre-primary development program has been established in the Murchison. New programs intended to address the issue of sexually transmitted infections were introduced in the Kimberley, Pilbara and Goldfields in 2004/05.

WACHS featured strongly in the 2006 Healthway Awards with Goldfields, South West, Great Southern and the Kimberley Population Health units being recognised for their achievements.

## Aged Care

The Leading Practice Development Program, funded by the Australian Government, has led to the introduction of best practice standards for aged care services in the Midwest and Wheatbelt regions. The program includes a toolkit to ensure that these standards can be rolled out across all regions.

## Dental Services

The provision of public dental services in rural communities has been expanded in Broome, Esperance and Derby. The construction of a new dental clinic in Kununurra is due for completion in 2006 and tenders have been let to construct a new 10 chair dental clinic in Bunbury. The rural dental scheme has attracted 12 dentists recruited for country vacancies since May 2004.

## Care in the Community

WACHS has worked with local communities in Paraburdoo, Wickham and Dumbleyung to increase the range of community-based services provided and, thereby, to develop more effective and sustainable models of health care. This will ensure that more resources go into maintaining people within the community and/or their homes.

## Healthy Resources

Multi-Purpose Service (MPS) funding has been increased significantly in recent years and WACHS is continuing to access funding from the Australian Government Department of Veterans' Affairs, the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme and other Australian Government funding programs.

Partnerships developed with mining companies, the Australian Government Office of Aboriginal and Torres Strait Islander Health (OATSIH) and Australian Customs have enabled WACHS to expand services across regions. For example, \$1.5 million collaboration with the Australian Government has led to improvements in primary health care services for Aboriginal people living in the Wheatbelt.

## Healthy Leadership

Leadership throughout country health services has been markedly improved through the consolidation of the 47 previous country health organisations into a single area health service, with strong regional and head-office teams. For example:

We have strengthened our corporate governance systems through:

- Merging the corporate and financial management systems of the WACHS head office and the regions
- Supporting the establishment of shared corporate services through the Health Corporate Network
- Improving and integrating information systems
- Enhancing our occupational safety and health capacity.

We have established area-wide leadership and professional support for nursing, medical services, population health, mental health, allied health, telehealth and medical imaging, coordinated from our head office in Perth.

In addition, over 70 country staff have participated in leadership development training.



## Appendix 2:

### Clinical Services

### Role Delineation definitions

MEDICAL		
Generalist	Type I Sub-specialties	Type II Sub-specialties
Physician	<ul style="list-style-type: none"> <li>■ Cardiology</li> <li>■ Dermatology</li> <li>■ Endocrinology</li> <li>■ Gastroenterology</li> <li>■ Geriatric medicine</li> <li>■ Neurology</li> <li>■ Renal Medicine</li> <li>■ Rheumatology</li> <li>■ Venereology</li> <li>■ Paediatrics</li> <li>■ Respiratory Medicine</li> </ul>	<ul style="list-style-type: none"> <li>■ Clinical Haematology</li> <li>■ Clinical Microbiology</li> <li>■ Immunology</li> <li>■ Medical Oncology</li> <li>■ Palliative Care</li> <li>■ Radiotherapeutic Oncology</li> <li>■ Genetics</li> <li>■ Clinical Infectious Diseases</li> </ul>

SURGICAL		
Generalist	Type I Sub-specialties	Type II Sub-specialties
General Surgeon	<ul style="list-style-type: none"> <li>■ Ear, Nose and Throat</li> <li>■ Obstetrics and Gynaecology</li> <li>■ Ophthalmology</li> <li>■ Orthopaedics</li> <li>■ Urology</li> </ul>	<ul style="list-style-type: none"> <li>■ Cardiothoracic</li> <li>■ Neurosurgery</li> <li>■ Plastic surgery</li> <li>■ Transplant Surgery</li> <li>■ Vascular Surgery</li> </ul>

LEVEL OF SERVICE	
Inpatient Services	Ambulatory Services

Nil	No service available	Nil	No service available
1	Outpatient care - RN and visiting GP. In remote areas possibly support via telephone.	1	GP only.
2	Outpatient and inpatient care - plus 24 hour GP cover and limited visiting general specialists for outpatient services only.	2	GP and outpatient clinic at discharge hospital. Limited access to generalist domiciliary nursing.
3	Outpatient and inpatient care - plus visiting general specialists (low-risk obstetrics and elective surgery).	3	Visiting specialist. Some hospital avoidance/hospital substitution. Some early discharge services. Access to generalist domiciliary nursing and some allied health.
4	Outpatient and inpatient care - plus resident general specialists plus visiting Type I sub-specialist, plus some junior medical staff.	4	Links with HACC. Increasing range and complexity of hospital avoidance/substitution/early discharge. Chronic disease programs. Visiting medical specialist. Good access to generalist allied health/nursing staff.
5	Outpatient and inpatient care - plus visiting Type II sub-specialists plus some medical staffing plus HDU. May include some research and training.	5	Specialist medical/nursing/allied health staff. Increased range and complexity. HACC integration. Enhanced diagnostics. Teaching and training role.
6	Statewide services, including Type II sub-specialists and research/education/training.	6	Research role. Fully integrated ambulatory care services. Fully integrated diagnostics.

Definitions are also provided for primary care, prevention and promotion, as well as diagnostic and support services in the WA Health Clinical Services Framework 2005-20015 available at <http://www.health.wa.gov.au/HRIT/publications>.

## Appendix 3: List of Gazetted<sup>15</sup> Hospitals, Multipurpose Centres and Nursing Posts

### Gazetted Hospitals

#### Regional Hospitals

- 1 Albany
- 2 Broome
- 3 Bunbury
- 4 Geraldton
- 5 Kalgoorlie
- 6 Port Hedland

**Total Regional  
Hospitals = 6**

#### District Hospitals

- 1 Busselton
- 2 Carnarvon
- 3 Collie
- 4 Derby
- 5 Esperance
- 6 Katanning
- 7 Kununurra
- 8 Margaret River
- 9 Merredin
- 10 Moora
- 11 Narrogin
- 12 Northam
- 13 Newman
- 14 Nickol Bay (Karratha)
- 15 Warren (Manjimup)

**Total District Hospitals = 15**

#### Small Hospitals

- 1 Augusta
- 2 Beverley
- 3 Boddington
- 4 Boyup Brook
- 5 Bridgetown
- 6 Bruce Rock
- 7 Corrigin
- 8 Cunderdin
- 9 Dalwallinu
- 10 Denmark
- 11 Donnybrook
- 12 Dumbleung
- 13 Exmouth
- 14 Fitzroy Crossing
- 15 Gnowangerup
- 16 Goomalling
- 17 Hall Creek
- 18 Harvey
- 19 Kellerberrin
- 20 Kojunup
- 21 Kondinin
- 22 Kununoppin
- 23 Lake Grace
- 24 Laverton
- 25 Leonora
- 26 Meekatharra
- 27 Morawa

- 28 Mullewa
- 29 Nannup
- 30 Narembeen
- 31 Norseman
- 32 North Midlands  
[Three Springs]
- 33 Northampton
- 34 Onslow
- 35 Paraburdoo
- 36 Pemberton
- 37 Pingelly
- 38 Plantagenet
- 39 Quairading
- 40 Ravensthorpe
- 41 Roebourne
- 42 Southern Cross
- 43 Tom Price
- 44 Wagin
- 45 Wickham
- 46 Wongan Hills
- 47 Wyalkatchem - Koorda
- 48 Wyndham
- 49 Yarloop
- 50 York

**Total Small Hospitals = 50**

**Total WACHS  
Gazetted  
Hospitals = 71**

<sup>15</sup> Hospitals officially recognised under the Hospital and Health Services Act, 1927

## Gazetted Multi Purpose Centres (MPCs)

### Multi Purpose Centres

- 1 Dongara
- 2 Kalbarri
- 4 Jurien Bay
- 3 Lancelin  
(Managed by Silver Chain)
- 5 Leeman  
(Managed by Silver Chain)

**Total Multi Purpose Centres = 5**

## Gazetted Nursing Posts

### Nursing Posts (NP) / Health Centres (HC)

- 1 Kambalda HC
- 2 Kukerin HC
- 3 Mukinbudin NP
- 4 Northcliffe NP
- 5 Tambellup NP
- 6 Wickepin NP
- 7 Williams NP
- 8 Wiluna (Ngangganawili) HC

**Total Gazetted Nursing Posts = 8**

## Remote Area Nursing Posts

### (Non Gazetted - as designated under the Poisons Regulations 1965)

- 1 Abrolhos Island
- 2 Balgo Hills (Wirrimanu)
- 3 Billiluna 26
- 4 Bremer Bay
- 5 Burringurrah Comm. Health Centre
- 6 Cervantes
- 7 Coonana
- 8 Coral Bay
- 9 Cue
- 10 Doduan
- 11 Gibb River Station
- 12 Imintji
- 13 Jerramungup
- 14 Jigalong (Puntuturnu)
- 15 Kalumburu
- 16 Kunawarritji (Well 33)
- 17 Lake Varley
- 18 Lombadina
- 19 Looma
- 20 Marble Bar
- 21 Menzies
- 22 Mount Barnett (Kupungarri)
- 23 Mount Elizabeth
- 24 Mount Magnet
- 25 Mount House
- 26 Mowanjum Comm. Health Centre
- 27 Mulan
- 28 Noonkanbah (Yungngora)
- 29 Nullagine
- 30 One Arm Point
- 31 Oombulgurri
- 32 Parnngurr (Cotton Creek)
- 33 Punmu
- 34 Sandstone
- 35 Tjuntjunjarra (Paupiyala Tjarutja)
- 36 Wangkatjungka
- 37 Warmun
- 38 Yalgoo
- 39 Yandeyarra

**Total Remote Area Nursing Posts = 39**

## Appendix 4:

# Actions for the WA Country Health Service arising from the 'Engaging Rural Doctors' Report 2007

The recommendations from the 'Engaging Rural Doctors' report that are the responsibility of WACHS to progress are as follows:

Actions to support the broad rural doctor workforce

1. The reference group accepts the concerns expressed by rural doctors about safe hours. The employers agree to consult with the AMAWA and develop policy on safe hours suited to the various care, demand and workplace settings. The employers also agree to develop transition arrangements for rural centres to improve areas where there are currently safe hours concerns. Specific actions will include addressing safe hours concerns in the North West. It is suggested that this could be actioned by identifying one location to develop and test the efficacy of a flow chart and practical tools for doctors and managers to better manage workloads prior to their wider implementation.
2. WACHS will examine workloads and how practice and patient management is handled in the North West, as a matter of urgency and prior to the next dry season, with a view to joint management of workloads within the context of budget requirements. The approach will seek to develop solutions jointly between management and local doctors and may consider nurse practitioners, junior doctors and may, as an example, include restructuring outpatient clinics to be managed in a community setting.
3. The group recommends to all employers that they commit in principle and through concerted and progressive action over the next twelve months to a standard of on-call at 1:3. The group also recommends that where there are on-call situations of less than 1:3, the employers review and monitor patient safety risks and doctor workloads, and develop and deploy available solutions so as to avoid clinical risks. The employers agree that this will be done with the involvement of the affected clinicians. The group recognises that on-call duties are part of a safe hours package, and respects the importance of manageable workloads as a key attraction and retention element for rural and remote doctors.
4. WACHS regional directors will carry leadership responsibility to bring key stakeholders together to address emerging clinical issues. WACHS Area Office will support new approaches and change management.
5. Employers will endorse and support the establishment of more flexible family friendly arrangements for medical practitioners over 55 years (in recognition of service), part time doctors and doctors with parental responsibilities or who have special needs. These needs will be taken into account in negotiating on-call requirements with public hospitals without automatic penalty to their admission rights. It is recognised that hospitals must maintain adequate in and out of hours medical cover.

6. WACHS will explore options for child day care services for staff. Financial support will be sought from key external stakeholders.
7. Employers should (potentially matched by the Australian Government) fund a bursary support for child secondary education (boarders) to be used as a retention benefit and focused on areas of identified retention problems and poorer relative access to secondary schooling. Criteria will be developed and administered by WACRRM. WACHS agrees to undertake this for salaried hospital and public health doctors.

## Actions to improve relationships

8. WACHS commits to improving communication and relationships between managers and doctors based on mutual respect. Specific areas for action include:
  - Responding to doctors' written and verbal concerns/issues in a timely manner;
  - Attending doctor practices at least six monthly for open discussion;
  - Informing and involving doctors in clinical and related decisions and so avoiding the risks of last minute written directives;
  - Seeking input from doctors for clinical equipment planning and purchasing and relevant budget submissions.

The reference group encourages other health service providers to apply similar standards to ensure a good level of engagement and communication between health service managers and rural doctors.

9. WACHS will explore mechanisms to improve access to rural based mental health professionals and review the criteria applied by mental health services for access, with particular focus on managing co-morbidities. Opportunities under the new COAG and MBS initiatives will be examined for community based mental health in collaboration with Divisions.
10. WACHS and the Royal Flying Doctor Service (RFDS) will review emergency protocols and the management of patient transfers. It is suggested that there should be a greater level of integration between RFDS and hospitals.
11. WACHS will distribute Medical Service Agreements and associated remuneration offers to doctors at least three months prior to the expiry of previous agreements. Doctors will be given sufficient time to negotiate to address local issues.

## Actions on rural health planning

11. The group acknowledges inadequate past involvement of doctors in clinical service planning. WACHS will involve doctors in the planning of clinical services and observe the following protocols:

- Where clinical service plans are available they will be distributed to all doctors within the local catchment area;
  - Locums and doctors new to the district should be provided with access to local plans as part of their orientation; and
  - Doctors will be engaged in the regional clinical services planning being undertaken in 2007.
12. Vehicles for engaging doctors in planning will be agreed locally with the involvement of the Division of General Practice, resident and visiting specialists.

## Actions to address emerging workforce shortages

13. Attraction and retention of the rural medical workforce is dependant upon modern information and communication technology to support patient care, communication and connectivity between hospitals, doctors' surgeries and other clinical services. It is recommended that WACHS urgently address this key result area.
- As an interim measure, hospitals and divisions should examine the introduction of terminals/ laptops to allow doctors working in hospitals access to their surgery records.
14. WACHS and WACRRM will consider the application and implementation of the Australian Centre for Rural and Remote Medicine (ACRRM) curriculum into Western Australia for proceduralists (currently under pilot in Queensland). This will include examination of the potential for UK "general registered" doctors to be included into the ACRRM program in preparation for hospital based positions in rural WA.
15. WACHS and WACRRM will explore the establishment of metropolitan hospitals as training centres for rural proceduralists which also enable staff rotations between metropolitan and rural centres.
16. WACHS will pilot arrangements to integrate ambulatory and primary care services currently provided by a range of service providers and examine alternative models for the provision of these services. These models will be developed and piloted following discussion with rural doctors, health advisory groups and local government. In particular WACHS will pursue running multidisciplinary, ambulatory care and primary care services from a general practice model under a pilot arrangement.
17. Rural doctors should develop, pilot and implement arrangements for extending the role of practice nurses. WACHS should extend the role and coverage of nurse practitioners within the country health system and including in accident and emergency departments.
18. WAGPET will expand the concept of learning hubs, allowing more PGY1 and 2s to train and learn in regional centres.

## Actions to address specific areas of aggravation

19. The reference group acknowledges that the Patient Assisted Travel Scheme (PATS) is a complex scheme to administer and doctors have reported that in some circumstances the administration of the system has contributed towards poor clinical care. WACHS will review the scheme to address the key issues raised by rural doctors and to introduce a more responsive and accessible system for referring general practitioners and consumers.
20. Multiple specialist visits during the course of treatment over a 12 month period should be approved once through PATS, avoiding the need for multiple revisits to doctors.
21. WACHS will ensure that doctors are provided with information on visiting specialist visits and the procedures/work they will undertake within the region to enable more referrals to regional visiting specialists.
22. WACHS will develop coordinated regional systems covering visiting specialists, outpatient bookings, transport, and financial and practical assistance with travel and accommodation arrangements.
23. The shortage of locums is a nationwide problem. The reference group recommends priority be given to solo practices and Aboriginal Medical Services for locums providing leave relief. WACRRM will evaluate the locum program in WA and explore ways to improve its effectiveness. There will be a strong focus on building capacity, retaining the existing rural medical workforce and reducing the over reliance on locum doctors to fill medium to longer term position vacancies. WACHS and WACRRM will work together to improve medical recruitment, build local capacity, reduce vacancy durations, improve doctor orientation, and support professional development.
24. WACHS is committed to specific action focused on reducing paperwork, including:
  - Exploring annual cashed out payments for hospital services as an alternative to individual patient billing/hospital invoices for rural doctors;
  - Implementing paperless systems and medical records;
  - Streamlining credentialing processes including extending the period admission rights are provided; and
  - Engaging with doctors locally about key aggravations with paperwork and examining ways to reduce the load.
25. Wide debate is required on flexible delivery systems for medicine in rural areas including examination of the costs and benefits associated with salaried systems and VMP systems of delivery (undertaken by WACHS and RDAWA). This assessment will include associated on-costs, impact on patient management, recruitment and retention, locum demand and the potential for de-skilling of private GPs. This will build upon the recent experiences in Geraldton and the pros and cons of the model as described in the consultation process in that region.

WACHS will be undertaking regional service planning in the first six months of 2007. This will provide an opportunity for doctors to be involved in regional health service planning, including debate over models of service delivery.



26. Examination of the role and functions of the Medical Advisory Committees (MAC) will be undertaken by WACHS in conjunction with RDAWA to address concerns that these committees have lost their focus and credibility.

## Actions supporting Overseas Trained Doctors

27. WACRRM and WACHS will continue to explore opportunities to facilitate a minimum of four weeks paid orientation for non proceduralists and explore methodologies for skills assessment for proceduralists.
28. WACRRM will advocate for change to access to Medicare and emergency evacuations for overseas trained doctors located in areas of need. WACHS will investigate options to waive public hospital fees for rural overseas trained doctors working in areas of unmet need.

## Actions to support rural specialists

29. Teaching hospitals should provide locums for rural resident specialists. This may be achieved by requiring tertiary institutions to take a statewide support role for the relatively fragile rural specialist workforce. This could be by rotations of consultants who have rural placements included within their employment contracts. This will also have the effect of improving the understanding of rural settings by metropolitan consultants.
30. The reference group recommends the establishment of advanced specialist training posts in rural areas and the upskilling of resident clinicians supported through teaching hospitals.

## Actions to address Aboriginal Medical Service issues

31. State, Territory and Australian governments should consider their approaches to health planning in conjunction with Aboriginal Medical Services to address the issue of “bungee planning” and ensure planning and consultation approaches recognise cultural preferences and norms.

## Appendix 5: Acronyms and Health Terms

ACAT	Aged Care Assessment Team
ACCHO	Aboriginal Community Controlled Health Organisation
ACHS	Australian Council of Healthcare Standards
AIMS	Advanced Incident Management System
CDCD	Communicable Disease Control Directorate (WA Health)
COAG	Council of Australian Government
DAO	Drug and Alcohol Office
DHAC	District Health Advisory Council
DOH	Department of Health (WA)
DVA	Department of Veterans Affairs
ED	Emergency Department
FTE	Full time equivalent (means 1 full time staff position)
GDP	Gross Domestic Product
GP	General Practitioner
HACC	Home and Community Care Program
HPG	Health Protection Group
ICU	Intensive Care Unit
IMG	International Medical Graduate
IM & ICT MHD	Information Management and Information Communications Technology
MHD	Mental Health Division
MPC	Multi-Purpose Centre
MPS	Multi-Purpose Service
MVIT	Motor Vehicle Insurance Trust
NGO	Non-government organisation
OAH	Office of Aboriginal Health
OATSIH	Office of Aboriginal and Torres Strait Islander Health (Section of Australian Government Department of Health and Ageing)
OTD	Overseas Trained Doctor
PATS	Patient Assisted Travel Scheme
PCHS	Primary and Community Health Services
RFDS	Royal Flying Doctor Service
RHS	Rural Health Services (Section of Australian Government Department of Health and Ageing)
SCNA	Silver Chain Nursing Association
SJAA	St John Ambulance Australia

TBC	Tobacco Control Branch
VMP	Visiting Medical Practitioner
WACHS	WA Country Health Service

## Explanation of health terms

The following seeks to simply explain health terms used in this document. They are mostly based on WA Department of Health definitions and glossaries.

Acute care	Care in hospital for people who have become suddenly unwell or who have been injured and need hospital treatment to cure, relieve or reduce the severity of the illness or injury. It also includes care to perform tests to diagnose illness, therapy, care for women in labour and care for people having surgery.
Allied Health	Includes health professionals other than doctors and nurses such as physiotherapists, occupational therapists, clinical psychologists, speech pathologists, social workers, dieticians, podiatrists and audiologists.
Ambulatory care	Health care including diagnosis, observation, treatment and rehabilitation that is provided on an outpatient (non hospitalised) basis. This may include services provided at home or in the community.
Emergency care	Care provided when someone is experiencing a major trauma e.g. a serious or critical condition or injury that could be life threatening. People may be admitted to acute care from emergency care into a hospital bed or may be sent home depending on the assessment of the care required.
Episodes of Care	Episodes of care are phases of treatment or periods of care and could be for just 1-2 days in acute care or for several weeks undergoing rehabilitation. A person may be admitted to hospital for acute care and then be moved to a different type of care e.g. rehabilitation. This would count as 2 different episodes of care.
Multi-Purpose Centres	A Multi Purpose Centre is where a number of health services are co-located at a single site.

Multi-Purpose Services	A Multi Purpose Service is a health facility that, through the pooling of State and Commonwealth funds allows a hospital to provide a range of health, aged care and other community services to a small rural community.
Occasions of service	<p>Any single examination, consultation, treatment or other health care service provided to a patient by any health service department e.g. emergency, occupational therapy, radiology, speech pathology or physiotherapy department.</p> <p>Occasions of service may be provided within a hospital's emergency department, in out-patient clinic settings or may be provided off the hospital site in community settings or private homes, and may involve consultation and/or treatment to an individual client or to a group of clients.</p>
Primary care	The medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system. Primary care is most often by general practitioners.
Residential care	The care provided to older people in residential facilities and small hospitals who are no longer able to safely care for themselves in their own homes.
Resources	The term 'resources' in Section 5 - Making the Most of our Resources specifically refers to health funding. In other parts of the document the term 'resources' generally refers to a mixture of the funding, the buildings and other infrastructure, the equipment, the staff and the volunteers that make up WACHS.
Role delineation	The range and extent of services that each hospital or health service is designed to safely provide is called its role delineation.
Secondary care	Care provided by a larger country hospital or a specialist community service such as a community mental health team. Secondary health care is provided to patients with conditions which require more specialised professional skills and in facilities which can provide more complex treatment.

Separations	A separation occurs once a patient is discharged from a hospital, transferred to another health unit or dies.
Stakeholders	In this document this term refers to the organisations that provide or are involved in health care or related services to country communities.
Tertiary care	Care provided to people with less common or more serious conditions or those who require highly complex or costly forms of diagnosis and treatment. In WA all tertiary care is provided by metropolitan hospitals (eg Sir Charles Gairdner Hospital and Royal Perth Hospital).
Triage	The process of assessing and sorting people attending emergency department based on their condition to determine who needs treatment first.
Volume of activity	The number of patients using a service e.g. the number of patients who were admitted to a small hospital in one year.

## Appendix 6: WA Country Health Service Contact List

Name	Street Address	Postal Address	Phone	Fax
Chief Executive Officer	189 Wellington Street Perth 6000	PO Box 6680 East Perth BC 6892	9223 8526	9223 8598
Executive Director Area Operations	189 Wellington Street Perth 6000	PO Box 6680 East Perth BC 6892	9223 8524	9223 8599
Area Director Health Service Enhancement	189 Wellington Street Perth 6000	PO Box 6680 East Perth BC 6892	9223 8540	9223 8599
Area Director Corporate & Finance	189 Wellington Street Perth 6000	PO Box 6680 East Perth BC 6892	9223 8542	9223 8599
Regional Director Kimberley	'Yamamoto' Unit 4 9 Napier Terrace Broome 6725	Locked Bag 4011 Broome 6725	9194 1615	9194 1666
Regional Director	Wheatbelt Unit 2, Avon Mall 178 Fitzgerald Street Northam 6401	PO Box 690 Northam 6401	9622 4350	9622 4351
Regional Director	Goldfields The Palms 68 Piccadilly Street Kalgoorlie 6430	PO Box 716 Kalgoorlie 6430	9080 5710	9080 5724
Regional Director Midwest	Shenton St Geraldton 6530	PO Box 22 GERALDTON 6531	9956 2209	9956 2421
Regional Director	Pilbara Morgans Street Port Hedland 6721	PO Box 63 Port Hedland 6721	9158 1795	9158 1472
Regional Director Great Southern	Callistemon House Warden Avenue Albany 6330	PO Box 165 Albany 6331	9892 2662	9842 1095
Regional Director South West	Floor 4, Bunbury Tower 61 Victoria Street Bunbury 6230	No Postal Box address	9781 2350	9781 2381



# Delivering a Healthy WA

