WESTERN AUSTRALIA

Independent Governance Review
Health Services Act 2016

Independent review of WA health system governance

August 2022

The Panel acknowledges that the performance of our review was conducted across the lands of many Nations within Western Australia, and we pay our respects to the traditional custodians of those Nations and to their Elders past and present. We particularly acknowledge and thank the many Aboriginal people and Aboriginal-managed organisations that contributed directly to the outcomes of this review.

The independent governance review panel appointed by the Minister for Health, comprised of:

- Ms Kym Peake – Chair
- Ms Jo Gaines
- Dr David Rosengren
- Mr Gary Smith

Contents

Executive summary

An independent review of governance of the WA health system was established to examine the operational and practical effectiveness of governance structures set out in the *Health Services Act 2016* ('the Act') and their impact on patient experience and outcomes.

The Act established board-led Health Service Providers (HSPs) legally responsible and accountable for delivering health care to their communities.

The Department of Health, referred to as the System Manager, became responsible for managing the 7 HSPs including North, South and East Metropolitan Health Services, WA Country Health Service, Child and Adolescent Health Service, PathWest Laboratory Medicine WA and Health Support Services.

The Independent Panel's (the Panel) findings and recommendations have been shaped by extensive engagement with stakeholders throughout WA.

Overall, the Panel's findings and recommendations show that the WA devolved governance model is maturing and should be retained.

Devolved governance structures have enabled HSPs to connect with their communities and find pragmatic ways to begin to work with primary, community, Aboriginal health, aged care and disability services to deliver more person-centred care closer to home. There are positive signs of maturing clinical governance and improved delivery of shared services. Health spending is more sustainable, with clearer accountability for HSP boards and executive teams to make best use of resources.

Many stakeholders reflected on WA's response to the COVID-19 pandemic, with positive examples of collaboration, rapid mobilisation of new ways of delivering care and leadership from the System Manager. WA's health system was able to push the envelope in implementing evidence-based strategies informed by data, technology adoption and working across organisational and sectoral boundaries.

The Panel has heard however that decision-rights across the system should be clarified to reduce duplication of effort and improve the consistency of experience for patients and the workforce.

The Panel is recommending changes to responsibilities within the public mental health system and clearer mandates within the system for the delivery of major projects, ICT and procurement in response to this feedback.

Most participants in the review have called for better alignment between different parts of the current WA health system and improved mechanisms for consumer and clinician engagement, rather than major structural change.

The experience of the COVID-19 pandemic showed that WA's health system is strongest when it works together.

As the WA health system shifts from an emergency management footing, the opportunity to adopt a 'new normal' should not be lost.

To date, devolved governance processes and practices have emphasised individual accountability for performance.

HSPs should remain accountable for providing a positive experience in receiving and delivering care, managing their budgets and partnering with their local communities to improve health outcomes.

The System Manager and HSPs should institutionalise co-operation, adopting an alliance governance model to accelerate execution of systemwide reform and jointly develop patient-first, innovative and financially sustainable care.

This does not require any change to the structure of the System Manager and HSP board governance.

The following report outlines a blueprint for maturing and enhancing governance processes and practices and fine-tuning allocation of responsibilities and decision-rights.

The most important shift in governance should be toward stronger collective responsibility for system and population health outcomes.

This shift requires HSPs to work together to make best use of capacity across the system and direct patients to the best care options that can meet their needs the soonest.

The next stage of governance should provide stronger systemwide direction and formalise collective leadership on improving consumer experiences and population health outcomes. Involving consumers, primary and community sectors and Aboriginal health services in decision-making will be critical to optimising value from public health care.

There needs to be a more consistent approach to the employment and training of staff to ensure a better experience for staff and a greater ability to utilise them to support the system and patient outcomes.

Better use and sharing of data, evidence and innovation will enable earlier identification of risks, collective approaches to solving shared problems, and sharing of good ideas.

WA's health system is underpinned by strong relationships. These relationships and informal forums are not a substitute for embedding structured approaches to collective leadership outside of an emergency context.

WA's health system would benefit from a deliberate approach to creating the conditions for a learning health system and re-energising the delivery of the Sustainable Health Review (SHR), based on:

- shared responsibility for statewide health outcomes with clear obligations for HSPs to co-operate with one another and the System Manager formalised in the Act and through an Alliance Agreement
- the System Manager assuming responsibility for commissioning all State-funded physical and mental health services and adopting an approach to performance management that is data-driven and based on joint problem-solving, while maintaining graduated responses to quality, safety and performance issues
- a more consistent employment experience and access to learning and development opportunities for the health workforce
- greater support to spread innovation, accelerate digital enablement and improve processes of care – driven by clinicians and consumers
- further actioning of the System Manager's strategic leadership, major projects and risk management role
- clearly identifying activities and decisions that require statewide consistency as compared with those that warrant more local discretion to ensure operational effectiveness and agility
- maturing the use of data to provide insights on system and population outcomes, with higher performance expectations for improved health outcomes for Aboriginal people throughout WA
- a deliberate focus on partnering with primary care providers, Aboriginal health services and other community service sectors to share data, integrate patient records and align incentives for integrated care.

Structure of the report

The report is presented in 3 parts:

1. Part 1 outlines the Panel's observations about strengths of the existing devolved governance model and its operation in practice
2. Part 2 outlines the Panel's findings on key opportunities for improvement
3. Part 3 outlines the recommended actions to capture those opportunities.

Consistent with our terms of reference, the Panel refers to the stewardship, commissioning, and assurance functions of the department as 'System Manager' responsibilities. All recommendations that refer to the System Manager should be read as applying equally to all staff across the Department of Health.

In the process of implementing proposed improvements, the Panel recognises that the Minister, System Manager and HSPs may refine specific recommendations to best achieve their strategic intent. Where this occurs, we would simply encourage system participants to be transparent about their reasons.

Part 1: Strengths of WA's health system governance

Overall, the Panel concluded that WA's health system has operated well since the establishment of the Act, including during the significant challenges posed by the COVID-19 pandemic. The Panel's observations about strengths of the current governance model and practices the model supports are summarised below.

The Panel conducted 3 workforce consultation sessions attended by over 200 staff members. The combined feedback from staff on the strengths of the WA health system are summarised at Figure 1.

Figure 1: WA health system workforce consultation

The WA devolved governance model established under the Health Services Act is appropriate and should be retained

Experience from across Australia and Western Australia's own history demonstrates the impact of system governance on quality, safety and the value of health care. The previous iteration of boards in WA had seen the governance for metropolitan health services invested in one board. This concentration of governance contributed to the lack of active involvement of the board in safety and quality issues and inadequate systems in place to monitor and report adverse clinical incidents.

Systems that are too highly centralised tend to lack clarity of roles and accountabilities. The scale of operations makes it difficult to remain responsive to local communities, ensure strong clinical governance at every hospital and ensure that public expenditure is sustainable and delivering value.

Systems that are too devolved can equally lead to unacceptable variation in care and risks of harm. Hospitals are complex, high-pressure environments where mistakes can occur and patients are often already frail. All hospitals need strong processes to minimise the risk and consequences of human error. It is also why hospitals need strong oversight and support by system managers to protect patients from serious failings in local quality and safety systems and facilitate systemwide improvements.

Western Australia's Health Services Act provides a strong enabling legislative base from which the WA health system can achieve positive outcomes for patients and their families now and into the future. The governance architecture implemented since 2016 is a strong platform to provide a balance of central coordination, systemwide consistency and local HSP accountability and innovation.

> '…there are many favourable aspects of the current model of governance and the establishment of HSPs as independent authorities has had a positive impact on access to care, patient safety, and staff engagement. The current governance model translates into positive outcomes for the community.'
>
> HSP submission

The devolved system stood up under pressure during the pandemic

The WA health system demonstrated its capacity to be agile and develop swift responses to a complex, enduring emergency. HSPs continued to fulfil their role in delivering health care. All parts of the system pulled together to adapt to changing knowledge and circumstances.

Industrial partners and HSPs reflected on the benefits of forums that were created to support flows of information, rapid mobilisation of new service models, and collaboration across the WA health system. This feedback has informed recommendations about enduring governance mechanisms to support clear strategic directions, strategic alignment and joint problem-solving.

There are strong examples of collaboration to deliver key reforms

There are several strong examples of the system demonstrating the ability to deliver key reforms through strong relationships, collaboration and cooperation, including:

- **Voluntary Assisted Dying** – Backed by strong leadership from the WA Government, the system planned and implemented the Voluntary Assisted Dying reforms.
- **Telehealth** – Triggered by the COVID-19 pandemic, the system came together to expand and accelerate the delivery of telehealth service.
- **Human Resources Management Information System business case** – HSS, HSPs and the System Manager collaborated on a business case for a new HRMIS to modernise payroll and rostering practices.

Devolved financial responsibility has ensured expenditure growth is more sustainable

The SHR reported that spending on health in WA more than doubled between 2009–2019, without a commensurate improvement in outcomes in population health and acute care. Without intervention, health spending was projected to reach 38 per cent of the State budget by 2026–27.

The devolved governance model has been effective in helping to bring health spending to a more sustainable level. The devolution of financial responsibility to HSPs means boards and executive teams have greater visibility and accountability for their budgets and expenditure.

Each year the Independent Hospital Pricing Authority (IHPA) publishes an annual National Efficient Price (NEP) Determination for public hospital services. The NEP underpins activity-based funding across Australia for Commonwealth funded public hospital services.

The NEP has 2 key purposes. The first is to determine the amount of Australian Government funding for public hospital services, and the second is to provide a price signal or benchmark about the efficient cost of providing public hospital services.

There is a lag in the NEP set by the IHPA, with a growing gap between the growth rate recognised by IHPA and the necessary growth rate for the WA health system to meet demand and COVID-19 catch up.

WA has strong systems to assure quality and safety

WA has a well-developed system of critical incident reporting, and a clear framework for the System Manager to intervene in response to identified quality, safety or performance issues. When errors do occur, WA has the right systems in place to ensure problems are reported, reviewed and addressed. The Panel heard that HSP Board Clinical Sub-Committee Chairs have appreciated the introduction of a community of practice for professional development and shared learnings.

WA's shared services make an important contribution to quality, safety and the value of health care

The value of a centralised public pathology capacity and integrated procurement and supply chain service has been demonstrated during the COVID-19 pandemic, enabling WA's health system to speed up and expand testing, ordering of personal protective equipment (PPE) and other critical supplies, and avoid waste.

PathWest is well embedded in the system. Cost-pricing projects underway will provide important insights to guide appropriate ordering of pathology tests.

HSS as a peer to HSPs provides an efficient and effective way for cross-system insights to be gathered and shared. This is demonstrated by the role HSS has played in coordinating HSP collaboration on workforce issues, as occurred during the COVID-19 Rapid Recruitment process in early 2020.

The System Manager has demonstrated the benefits of a strong leadership to facilitate statewide co-operation and systemwide capacity building.

The System Manager has demonstrated the benefits of having strong, engaged leadership functions. For example, they have been able to rapidly redeploy expertise and resources to respond to an unprecedented challenge to the health system throughout the COVID-19 pandemic. The WA Health Digital Strategy is another example of system leadership, which has guided whole of system collaboration and investment decisions.

Individual HSPs have led innovations to deliver higher quality care that is safe, sustainable, person and family-centred, equitable and clinically effective.

There are multiple examples of HSPs investing in innovation to implement new models of healthcare services and health technologies to remove barriers to access and improve the experience and outcomes of care.

Child and Adolescent Health Service (CAHS) developed the Children's Antimicrobial Management Program (ChAMP). The ChAMP application is a new and easy way for clinicians to access antimicrobial information while treating children at Perth Children's Hospital. A prototype of the ChAMP application has been developed with and for the clinicians utilising a human-centred design thinking methodology.

East Metropolitan Health Service has implemented Health in a Virtual Environment (HIVE) that offers 24-hour, remote monitoring of patients throughout hospitals by clinical experts, supported by digital technologies and artificial intelligence.

The North Metropolitan Health Service (NMHS) Innovative Future Program ran the inaugural NMHS Shark Tank inviting staff to pitch their ideas to a panel of judges, resulting in 6 fully supported projects. The creative ideas ranged from process automation to introducing virtual reality for patient care. The Innovative Future Program has helped to support 39 projects, which are either completed or underway across NMHS.

South Metropolitan Health Service (SMHS) has enhanced patient feedback mechanisms with the roll out of Care Opinion and launch of My Say survey for inpatients in July 2020. The My Say survey enables SMHS to receive real time patient experience feedback down to ward level with responses monitored through the SMHS safety and quality committees.

The WA Country Health Service (WACHS) Command Centre supports doctors and nurses in country hospitals and nursing posts by providing ready access to specialist clinicians who use technology, videoconferencing and real time data to support delivery of quality patient care. The Command Centre brings together services in a 24/7 'virtual' clinical and operational hub. New services recently added to the Command Centre are an Acute Patient Transfer Coordination Service to oversee safe and efficient patient transfers to and from regional and metropolitan hospitals and an Advanced Patient Monitoring System that uses advanced technologies and real time information to support doctors and nurses to detect and respond to unwell patients in country hospitals and nursing posts.

Part 2: Overview of opportunities for improvement

Many of the themes from the Panel's consultations and analysis of previous health system reviews align with experiences in other jurisdictions that have transitioned from more centralised governance models. All jurisdictions have finessed governance practices and decision-rights over time.

The Panel's findings on opportunities to enhance WA's health system governance are summarised below.

Engaged leadership by the System Manager will drive strategic alignment and delivery of high impact strategic initiatives

The governance arrangements intend for the System Manager to be strongly engaged across the system. This includes establishing the strategic direction for the health system and the guardrails for HSPs' operating environment to support HSPs to be successful and ensure that they are accountable.

A long-term health strategy published at regular intervals will provide clear strategic directions, inform investment in foundational reforms and guide system-wide actions to continuously improve value from health care. An interim health strategy should reflect the existing priorities of the SHR and the emerging whole of government priorities, especially in promoting Aboriginal outcomes.

The efficiency and effectiveness of the devolved structure will further improve, leading to greater benefits for the WA community, as the System Manager continues to step into the strategic leadership space. The role of System Manager does not just rest with the Director General, it is the sum of the collective efforts of everyone working in the Department of Health.

A stronger risk capability would help to identify and manage systemwide risks

Risk and strategy management are not currently well aligned. Risk is described by system participants as an inherent feature of health care delivery and risk management as a compliance exercise. As a result, the risk matrix (used to identify consequence and likelihood of individual risks) is interpreted inconsistently across the system. Different types of risk (operational, project and program, strategic, infrastructural, work, health and safety) are not consolidated by the System Manager into a single risk overview. Opportunities to use risk information in the design of strategic initiatives are therefore likely to be missed. A stronger risk capability should ensure system risks are identified, maintained under consistent criteria and managed within consistent risk management tools.

There should be greater collective accountability for health system performance and population health outcomes

> 'Due to a multitude of factors, HSPs have become too 'inward looking', focused primarily on the needs of the organisation, 'their catchment' and their local community, and too little on the needs of system, the patient perspective and journey, and all of WA as a whole.'
>
> HSP submission

Agreeing on a shared narrative for the devolved governance system will help to maintain and enhance strategic alignment. All system leaders need to be aligned to the fundamental goals of the devolved model and commit to shared outcomes. Shared responsibility and obligations to the system as a whole should be reflected in the Act.

In WA, HSPs are held to account for their individual performance. This motivates competition to improve individual performance, but collaboration to progress shared objectives. Improving equity of access to care and optimising system capacity, for example, relies heavily on relationships, a collaborative culture and good will.

Other jurisdictions are progressively adopting structures and processes to formalise and support the exercise of collective responsibility for system performance and population health outcomes.

WA should evolve its devolved governance into an alliance governance model so that collaboration, information sharing and networking are the norm. If the model is to work efficiently and effectively, each part of the system must recognise its obligations to one another and to the system as a whole. The System Manager and HSPs should collaboratively develop an outcomes performance framework and a joint program that promotes an integrated and whole of systems approach to care.

Systemwide governance structures should also enable the primary care and Aboriginal health sectors to partner in SHR implementation planning.

Board accountability can be enhanced with fine-tuning of decision-rights, reporting relationships and through learning and development

HSP boards are the agents of the Minister for Health and are responsible for ensuring effective clinical and corporate governance frameworks are established to support standards of patient care and services.

Boards identified a number of barriers to meeting their accountabilities including lack of clarity around systemwide priorities, the employment relationship with the HSP Chief Executive (CE) and structured input into systemwide decision making. All of these barriers can be addressed through fine-tuning of governance arrangements, including clarity on strategic directions and guardrails for HSP operations, shifting the employment relationship with CEs, a framework for retained earnings, and participation in system leadership forums.

Guidance to board members about their responsibilities and boundaries, through induction and learning and development, would also assist board effectiveness.

Consumers and clinician engagement should be embedded in local and systemwide governance

Around the world, and in many Australian states, system managers are partnering with patients, clinicians and managers to lift the safety, quality and value of health care. While consultations identified pockets of good practice in WA, consumer and clinician representatives expressed little confidence that their views were brought together in decision-making.

Consumers, carers and families are seeking stronger engagement and influence at every level of the health system – from the point of care to local governance and systemwide decision-making. The health workforce also identified opportunities to strengthen clinically-led mechanisms to share innovations and support structured approaches to tackling variations in quality, safety and health outcomes. Both groups described forums such as the Clinical Senate, clinical networks and Consumer Advisory Councils as relying on advocacy, rather than being embedded in system governance as sources of expertise and partners in driving systemwide improvements.

Cultural security of public health services and improvements in Aboriginal health and wellbeing should be embedded across the system

The need for a stronger Aboriginal voice is recognised in the stewardship of the health system and within each individual HSP. Building cultural security and the provision of health care that is culturally respectful and non-discriminatory needs to be a high priority for the system. Collaboration in the design and commissioning of services and support to transitioning the delivery of government run primary healthcare services to Aboriginal community-controlled organisations where appropriate will assist in improving health outcomes. The continued expansion of community-based care will improve health outcomes and reduce avoidable emergency department presentations and hospital admissions.

The provision of culturally appropriate health care will be enhanced by increasing the number of Aboriginal people in the workforce. Specific strategies are required to increase the number of Aboriginal people in the health workforce and improve access to training opportunities in the communities in which they live.

A reallocation of responsibilities for statewide policy and services would enable improved operational efficiency and impact

NMHS manage a broad range of specialist services on behalf of the WA health system, impacting on their operational efficiency. Rapid consideration should be given to reducing the breadth and scale of NMHS' service delivery to ensure that specialist services are able to receive sufficient support and development.

There is also a need to strengthen strategic policy leadership, streamline responsibilities and enhance governance over health responses to children at risk and victim survivors of family violence. Clearer accountabilities and support for system development will assist the WA health system to be active partners in earlier intervention and prevention of harm and acquit recommendations from the Royal Commission into Institutional Abuse.

Mental health responsibilities should be consolidated, with independent oversight to strengthen accountability

> 'Transformation also requires a genuine commitment to embedding sustainable, diverse and robust Lived Experience Leadership within the System Manager, HSPs and the MHC (Mental Health Commission) in governance and leadership roles.'
>
> Non-government advocacy organisation

There is no single point of accountability or authority for public mental health. Neither the System Manager nor the Mental Health Commission (MHC) has whole of system visibility. Previous reviews have recommended the development of a systemwide service plan that incorporates all providers and describes service access, models of care or pathways and coordination of services. The development of more integrated services is hampered by the fragmentation of commissioning responsibilities. The MHC purchases the majority of Alcohol and Other Drugs (AOD) and mental health services from HSPs and non-government organisations but does not have input into the design of facilities that affects the delivery of some services. The System Manager also purchases significant mental health activity for example in emergency departments, mental health observation areas and patient transport services.

To strengthen commissioning and accountability, the System Manager should be given responsibility for AOD and mental health policy, planning, commissioning and clinical assurance. To drive improvements in system capacity, flow and outcomes, early priority should be given to increasing step-up and step-down services and liaising with the Department of Communities on the impact of National Disability Insurance Scheme (NDIS) planning and supports for psycho-social disability on hospital demand.

There should be a deliberate effort to grow employment opportunities for people with lived experience to work across the WA health system. HSPs would also benefit from stronger mental health leadership on their boards and executive teams.

The role of the MHC should shift to providing independent oversight. MHC should hold the System Manager and HSPs to account for the performance of the mental health system, including through conducting inquiries on the request of the Minister and reporting to parliament. The MHC should maintain responsibility for primary prevention, reducing stigma and promoting consumer inclusion and engagement.

The System Manager should provide guidance on the level of discretion available to HSPs

> 'I think the System Manager should take a greater leadership role by providing more in terms of frameworks within which the HSPs should operate. This would increase the standardisation and efficiency of the system as a whole.'
>
> Public consultation survey respondent

The System Manager should clearly describe processes, practices and decisions that benefit from statewide consistency and those that warrant more local discretion to ensure operational effectiveness and agility.

A policy defining the required level of consistency may be relevant to all HSPs (for example requirements to comply with whole of government procurement or employment policies) or may be relevant to a sub-set of HSPs (for example reporting requirements for HSPs delivering statewide services).

Commissioning practices could better support innovation and performance improvement, as well as performance management

> ....'would welcome the System Manager delivering a strategic commissioning role, where funding is aligned with systemwide priorities, and tied to clear outcomes measures that reflect the goals of the system.'
>
> HSP submission

Simpler performance agreements, targeted use of incentives and a partnership approach to performance dialogues would help to improve strategic alignment across the health system.

Performance dialogues are important for accountability. Performance interventions should continue where quality, safety or financial issues arise.

Performance discussions should also be an opportunity to share data, identify good practice that could benefit patients at other HSPs and identify how the System Manager could support innovation and performance improvement.

Formalising local collaborative commissioning can help to integrate and coordinate care pathways between acute, primary and community care

The National Health Reform Agreement envisages collaborations to jointly plan and fund services at a local level to improve the interface between acute, primary and community care and support delivery of care in home and community settings.

There are positive examples of HSPs working with local partners to plan care pathways for people living with chronic disease, manage aged care transitions and co-ordinate suicide prevention initiatives, especially in regional WA.

However, the Panel heard that this work is typically organised and supported through individual relationships.

A more formalised model for collaboration between local State and National commissioning authorities, underpinned by new financial arrangements, would increase the sustainability and value of integrated care.

Enhanced use and sharing of data would strengthen system planning, improvement and assurance

All data should be shared openly and transparently to improve patient outcomes and experiences, unless there is a reason not to do so such as patient confidentiality. The processes around which data is shared should provide a consistent source of truth to assist in properly informed decision making.

HSPs must have an obligation for full transparency with the System Manager having responsibility for facilitating a single source of truth for performance data and developing a performance dashboard to share the information.

Real time data to optimise system capacity and flow

Improved access to real time data on acute hospital capacity and patient flow would enable the System Manager to coordinate capacity load share across the system. The proposed State Health Operations Centre will make it easier for the System Manager to exercise this coordination function and should be prioritised.

Better access to HSP planned care demand and capacity data will also support systemwide service planning. The System Manager should use this data to optimise equity of access to services across WA, enhance predictive analytic capabilities and inform new investment in service delivery capacity.

A whole of system workforce strategy and more consistent workforce management will help to improve the employee experience

The ability to attract and retain staff and ensure that there is appropriate flexibility and mobility across the system is critical to ensure best patient outcomes. Workforce development would be supported by more consistent interpretation and implementation of employment policies and more timely recruitment processes.

The move to a more connected model of system governance, the standardisation of employment processes and practices across the HSPs and the centralisation of key functions to HSS and the System Manager will be critical to addressing these issues and if implemented effectively, can be achieved within the current employment framework.

A systemwide workforce strategy would enable WA's health system to better meet its workforce requirements. Central leadership is required to co-ordinate, facilitate and track the impact of actions to address labour shortages, align workforce models to future service models and maintain a value proposition for a current and prospective clinical and support workforce.

Developing the capacity of the Major Health Projects Directorate would reduce delivery risks

A Major Health Projects and Infrastructure Directorate has been established in WA to support HSPs in delivering an infrastructure pipeline. The role of this directorate should be further enhanced to co-ordinate expertise and input from across the health system to plan future investments and ensure major hospital redevelopments and new builds are delivered on time, on budget and aligned with strategic directions in care delivery. This would also help the system to retain and share project management expertise. A partnership approach with HSPs will be required. The focus should be on leveraging major facility developments to accelerate digital enablement and transform how care is provided.

All parties should commit to the shared service model to leverage collective purchasing power

The more that the WA health system can use its combined purchasing power to leverage better value by aggregating HSP volumes to reduce costs, the more funding there is available to direct towards clinical services.

HSS is established to facilitate whole of system contracts and analyse where whole of system contracts can be established and used to deliver value for all HSPs and the System Manager.

Consultations revealed mixed commitment to leveraging HSS' collective purchasing capability and inconsistent adherence to whole of government procurement policies designed to boost local manufacturing and support Aboriginal businesses. In contrast, other jurisdictions are realising significant savings from greater use of statewide contracts – money that can be reinvested into frontline clinical care. Stronger accountability and support for social procurement policies are also delivering on broader government objectives. The same gains are possible in WA but will require a stronger mandate for HSS. HSPs are more likely to offer support if there is stronger customer representation in HSS' governance and regular reporting on customer benefits from its activities.

ICT roles and responsibilities should be clarified to help accelerate digital enablement and investment

> 'There is a pressing need for a user-friendly EMR [Electronic Medical Record] system with integrated systems and programs to facilitate better information sharing, aid clinical decision-making and continuity of care, and reduce clinical risk.'
>
> Non-government public submission

Digital enablement provides opportunities to improve the quality, safety and sustainability of care and the experience of working in the WA heath system. The COVID-19 pandemic has generated momentum for using technology differently to support the regional workforce, support self-management of chronic conditions and improve access to care. WA lags other jurisdictions in the development of systems to provide real time information about system capacity and flow and sharing of clinical information to support decision-making at the point of care.

A digital strategy has been agreed and has guided investment decisions. A new Digital Health Directorate has been announced within the System Manager to help translate this strategy into a program of projects. The next step is to build an operating model for delivering this program of projects over a number of years, while delivering value for consumers and clinicians from each incremental step in building digital maturity. This requires clarity on roles and responsibilities.

The System Manager should retain responsibility for maintaining rolling digital strategies, with HSS confirmed as the lead agency for ICT development. These strategies should clearly describe how and when to deploy digital tools, and how to combine virtual and physical health care to improve the experience of delivering and receiving care. In this role, HSS would work with HSPs and the new Digital Health Directorate to develop policy frameworks defining ICT principles and standards and an architectural model to align data, applications and infrastructure. HSS should also lead strategic procurement of core ICT systems and applications and support HSPs in deploying solutions to realise benefits for their consumers and workforce.

HSPs should adhere to this policy framework when implementing statewide core systems and comply with statewide standards when they select, procure and support their own local systems.

Strong connections with other government agencies will support strategic alignment and decision-making

Consultations highlighted critical interfaces and interdependencies between the health system and other government services. The education and training system is critical to building local workforces. The COVID-19 pandemic has highlighted the importance of whole of government collaboration in major statewide emergencies. Interfaces with community services and agencies are important to addressing social determinants of health, reducing risks of child maltreatment and family violence, and delivering on whole of government priorities to close the gap in outcomes for Aboriginal people.

Consultations also emphasised the benefits of earlier engagement with central government, including with the Department of Treasury on system planning and performance and with the Department of Treasury and the Office of Digital Government to support digital enablement of the WA health system through major ICT and infrastructure projects.

WA should embrace and embed positive impacts of new ways of working in the post COVID-19 transition

The Panel heard that post COVID-19 recovery should not be understood as a return to business as usual.

At a national level, jurisdictions have acknowledged that the response to COVID-19 included many novel approaches to providing health services, with national discussions about what can be accelerated through the demonstration of new technologies and sharing data to develop innovative models of funding and delivering care.[1] WA should seize these opportunities.

The combined feedback from staff attending the workforce consultations on opportunities for improvement are summarised at Figure 2.

Figure 2: WA health system workforce consultation – opportunities for improvement

1 National Health Reform Agreement Long Term Health Reforms Roadmap, 14 October 2021, https://www.health.gov.au/resources/publications/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap

Part 3: Recommended actions to deliver improvements

Engaged system leadership – strategy and risk management

Strategy management

The Act should require the preparation and publication of a long-term health strategy ('the strategy'), informed by clinician and consumer engagement.

The strategy should establish an outcomes performance framework to guide joint system and local service development. The performance framework should apply to the System Manager and HSPs and promote an integrated and whole of systems approach to care. Shared outcomes would be reflected in the Minister's statement of expectations and embedded through corporate plans of all system participants.

> 'A State Health Plan will galvanise the system around a set of clear, collectively owned directions, ensure equitable access to high-quality health care across the state, and stimulate investment in immediate and long-term priorities.'
>
> HSP submission

Given disruptions caused by the COVID-19 pandemic, an interim health strategy should reflect priorities from SHR and emerging whole of government priorities. For example, WA's health system should play a leadership role in the delivery of WA's Closing the Gap implementation plan and Aboriginal Empowerment Strategy given disparities in health outcomes for Aboriginal people.

The ability of the WA health system to implement reform would be strengthened by:

- the System Manager maintaining momentum from strategy development through to implementation planning and execution, including through focusing on a small number of high-impact activities at a time
- HSPs improving their capability to adhere to systemwide strategy and integrate into their operations
- System Manager and HSPs sharing data to enable better insights on the impact of reform initiatives.

An outcomes performance framework would help the system to measure the impact of SHR on population health and system performance. A supporting program logic for SHR would map how the 8 enduring strategies and associated reform initiatives help to establish the necessary conditions to meet outcome indicators (with an aggregate assessment of the contribution of each strategy to each outcome indicator). A performance dashboard should be designed to provide the Minister, system leaders and central government with insights on how well reform initiatives are being delivered and whether they are achieving desired outcomes and any necessary refinements.

The System Manager should lead delivery of the SHR and subsequent long-term strategies, including through the continued development of rolling capital, digital and workforce strategies and clinical service plans (including for mental health and Aboriginal health services).

Service agreements should then establish output performance frameworks for HSPs to measure the desired change in the quality, quantity and nature of outputs, how well output indicators have been delivered and their impact on patient and system outcomes.

> 'By having a systemwide strategic focus, resources and capacity could be devoted to solving state-level challenges that sit beyond the jurisdiction of any one HSP, for example a strategic review of neurological services or a review of the clinical services framework as a whole.'
>
> HSP submission

Long-term strategic directions and priorities would help all participants across the sector to understand the overall direction and align their own operational planning and targeting of innovation efforts. Other stakeholders would also benefit – for example education providers could provide stronger advice on how they could help to develop the required workforce for the future, including volume of recruitment, types of occupations and required working practices.

Codifying expectations for clinician and consumer engagement would provide a powerful signal of the importance of their experience and expertise. Codes of expectations could express the values to guide engagement and the mechanisms and processes to practically support inclusion and participation in the planning, design, governance and delivery of reform and direct care.

Risk management

Strategy and risk management processes should inform one another.

Risk oversight is currently focused on specific projects and programs (for example the SHR program). A risk register is also maintained and reported as a dashboard periodically to the Department Executive Committee (DEC) to assist in consistent review of current identified risks at a granular level.

The WA health system would benefit from the development of a systemwide risk profile on which to base assess the severity and contagion effect of risks across the health system and inform strategic planning. A stronger risk capability should ensure system risks are identified, maintained under consistent criteria and managed within consistent risk management tools.

Currently this whole of system risk profile is hampered by:

- some HSPs being unwilling to share risk information with the System Manager
- inconsistent interpretation of the risk matrix (used to identify consequence and likelihood of individual risks)
- a lack of integration between risk and strategy management functions – so risk assessments are not factored in the design and prioritisation of strategic initiatives and advice to government on investment in critical operational capabilities such as cyber security
- a lack of accumulation of different types of risk (operational, project and program, strategic, infrastructural, work health and safety) into as single risk overview, with DEC relying on a Risk Dashboard reporting regime that instead consolidates individual granular risk data
- a lack of dedicated leadership and fragmentation of risk and assurance functions across System Manager and wider departmental functions, with varying levels of resource capacity across these groups, and a level of confusion or frustration as to the primary risk and assurance function responsible for developing a collective health risk view.

Recommendations

1. That the Act is amended to require the Minister for Health to prepare:
    a. a long-term health strategy with a minimum 10-year horizon, which will:
        i. guide HSPs in protecting and promoting people's physical and mental health and wellbeing against clearly defined outcomes
        ii. explicitly address how the health portfolio will contribute to whole of government priorities to tackle social determinants of health and improve health outcomes for priority cohorts
    b. a code of expectations for consumer engagement in the health sector
    c. a code of expectations for clinical workforce engagement in health system development and improvement.
2. That the Department of Health publish rolling capital, digital and workforce strategies and clinical service plans – including for mental health and Aboriginal health – to support delivery of the long-term health strategy, in consultation with a system leadership forum and other key stakeholders.
3. Given disruptions caused by the COVID-19 pandemic and the importance of progressing system priorities:
    a. an interim health strategy should reflect existing priorities from the 2019 Sustainable Health Review and emerging whole of government priorities, especially in Aboriginal affairs
    b. a program logic for the interim health strategy should be developed which includes:
        i. an outcomes performance framework to measure the impact of the interim health strategy, Sustainable Health Review and the delivery of reform initiatives, with specific outcome indicators for priority population groups including Aboriginal people
        ii. mapping how reform initiatives will help establish the necessary conditions to meet outcome indicators (with an aggregate assessment of the contribution of strategic initiatives to each outcome indicator)
        iii. performance dashboards to provide the Minister, System Manager, HSP boards, central agencies and system leadership forums with insights on how well outputs are being delivered and whether they are achieving outcomes
    c. the first long term health strategy should be completed within 2 years of the gazetting of the legislative amendments.
4. That the delivery of health strategies is supported by existing legislative requirements for:
    a. the System Manager to produce an operational plan setting out actions the department will take to support delivery of health strategies – with the operational plan subject to a full review every 3 years and an annual update
    b. HSPs to produce an operational plan outlining key initiatives to implement systemwide priorities, while responding to local needs – with the operational plan subject to the same review cycle as the System Manager (full review every 3 years and an annual update).
5. That the System Manager improve the maturity of risk management by:
    a. establishing a Health Chief Risk Officer, carrying a mandate to build a risk strategy and framework and build risk analysis capability
    b. developing a systemwide risk profile, which accumulates operational, project and program, strategic, infrastructural and occupational health and safety risks into a single risk overview.

Stronger collective responsibility for outcomes

> 'Greater collaboration amongst HSPs, particularly around matters that impact on more than one HSP, would add value and minimise HSP siloing. This currently happens in an ad hoc manner but could be done in a more systematic way, particularly with the support of the System Manager.'
>
> HSP submission

The current devolved governance model creates an environment where individual HSPs interact with the System Manager, MHC, Health Support Services (HSS) and PathWest to advance local health outcomes.

HSPs outlined the benefits of competition in driving service improvements, innovations in models of care and development opportunities for their workforce.

Competition can be a useful tool to drive ambition for improvement.

Building either a competitive or collaborative culture between HSPs is not the end goal in and of itself – it is merely the means to achieving better HSP and system outcomes.

Engaging the health workforce, consumers and partners in primary, specialist, Aboriginal health and community sectors is a more effective strategy to optimise system capacity and performance, and improve the value of health care.

Building a predominantly collaborative culture, where HSPs share best practice, jointly solve problems and are connected to service partners is likely to result in the best system outcomes for consumers and the health workforce.

Consumer and workforce groups identified opportunities to share knowledge and spread local innovations. Success stories are not always shared across hospitals, so do not benefit the majority of patients. Disparities in access and health outcomes for Aboriginal people and rural communities were identified.

Existing forums such as the Health Executive Committee (HEC) and Mental Health Executive Committee (MHEC) have enabled the Director General and Mental Health Commissioner to engage with HSP CEs to manage live issues and co-ordinate the pandemic response.

Informal and ad hoc forums enable board chairs to discuss issues of common interest and engage clinicians and consumers on specific topics, but these forums have no formal relationship to HEC/MHEC.

WA should evolve its devolved governance model so that collaboration, information sharing and networking are the norm. The structure of WA's devolved governance system would not need to change.

The Act should be amended to recognise HSPs obligations to the system as a whole and to one another. The System Manager and HSPs should institutionalise co-operation, by becoming joint signatories to an Alliance Agreement.

This agreement would establish stronger obligations on HSPs to advance systemwide priorities, and support one another to deliver safe, accessible and appropriate care in an efficient manner.

Alliances work best when there is a balance between clear rules and trust. HSPs should be accountable and improve their capability to adhere to mandated requirements. Where they have more discretion, they should be accountable for the impact of their decisions on each other. While local context should inform local cultures, cultural alignment amongst health service leaders should also be expected. HSPs should support each other's outcomes and performance and they should hold each other to account for doing so.

For example, the Alliance Agreement might provide for sharing of workforce, capacity and expertise, where this is in the best interests of the system and the community. By defining shared outcomes and specifying priorities for collective leadership, the agreements should act to normalise collaborative ways of working, without constraining co-operation on decisions or activities outside the terms of the agreement.

Alliance governance should also facilitate engagement with primary and community care and private hospital and ambulance service operators to plan and deliver seamless services across the continuum of care (see recommendation 8b and 29).

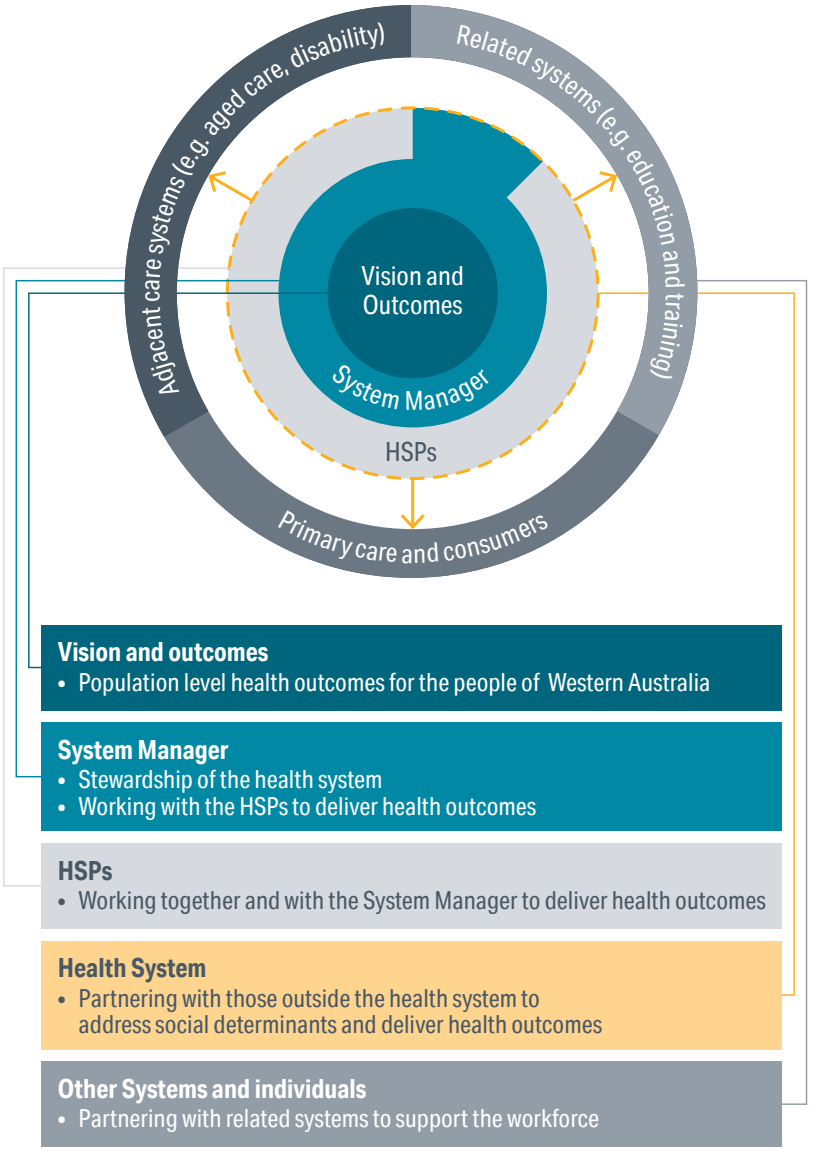
Consumers, carers and families should be recognised, valued and supported as partners in the design and delivery of statewide health strategies and the development of local services (see recommendations 8b, 8c, 8e, 14 and 20).

The WA health system should become more connected to the rest of government – providing more transparency to central agencies about its performance (see recommendations 3b, 25e and 34). The System Manager should lead interagency collaboration to provide policy direction for operational partnerships with other agencies to implement Royal Commission recommendations, support whole of government health and mental health promotion, and tackle health inequities among Aboriginal people, children in state care, people living with a disability and people experiencing or at risk of homelessness (see recommendation 3a and 13).

Alliance governance requires greater transparency and open flows of information. The System Manager and HSPs should collect and use real time data to manage system capacity and flow, prioritise improvement projects and inform the design of new services, pathways, roles and partnerships (see recommendations 36 and 37).

Figure 3 illustrates relationships and collaborations that should be formalised to strengthen strategic alignment and collective accountability for outcomes.

Figure 3: Collective accountability for outcomes in a devolved governance model



Collective leadership forums

HEC could continue to serve as a useful forum for information sharing and issues management.

The System Manager should also bring system leaders together, including HSP board chairs and CEs and the Clinical Senate Chair, to collectively lead the long-term strategic development of the WA health system. The Mental Health Commissioner should be invited to observe these meetings when mental health services, partnerships and performance are being discussed.

Agendas for this leadership forum should be focused on strategic issues such as:

- future demand reduction and demand management strategies
- new models of care and associated implications for workforce, digitisation and capital planning
- strategic workforce planning and development
- advice from clinical networks on statewide safety and quality improvement goals, continuous improvement of meaningful and useful measures of clinical quality and safety, and unwarranted clinical practice variation
- identifying operational practices of concerns and how these should be addressed, including greater standardisation of solutions
- opportunities to strengthen community engagement in health protection and promotion, mental health, Aboriginal health and chronic disease management.

Leadership forums created within the Mental Health and AOD sectors should be maintained, with information flows through to the System Leadership Advisory Council and System Leadership Forum.

Stronger partnerships with services that contribute to population health outcomes would assist in addressing social determinants of health and reducing avoidable hospitalisations. A formal advisory group should be established, bringing together the knowledge, experience and expertise from the Western Australia Primary Health Alliance (WAPHA), Aboriginal Health Council of Western Australia (AHCWA), private hospital and ambulance operators, National Disability Insurance Agency, the residential aged care sector and consumer representatives.

The System Manager should also regularly engage with education and training providers to share insights and jointly progress strategic workforce initiatives.

> 'The creation of a governance structure that supports each of the HSPs, with an annual conference on strategic issues would also provide opportunities to better collaborate, share learnings and achieve greater strategic alignment across the health system.'
>
> HSP submission

Recommendations

6. That the Act is amended to recognise HSP obligations to the system as a whole, and to one another, including:
    a. ensuring the effective and efficient use of public health system resources and the best interests of patients and other users of public health services throughout the State
    b. delivery of services in partnership with primary and community care to address barriers to access and maximise community health and wellbeing
    c. planning and provision of health services that address the health needs of the people who live or work in regional WA
    d. committing to achieve health equity for Aboriginal people including through partnering with Aboriginal health organisations to deliver culturally competent health care.
7. That systemwide collaboration is driven through:
    a. the System Manager and all HSPs entering into an Alliance Agreement detailing how these whole-of-system obligations will be met
    b. the Health Minister's annual statement of expectations reinforcing the collective leadership priorities
    c. opportunities for the Minister and Director General to meet with board chairs as a collective (this could precede new system leadership forums).
8. That the System Manager facilitate stewardship of WA's public health system, through:
    a. a System Leadership Forum chaired by the Director General of the Department of Health and including HSP board chairs and Chief Executives, and the Chair of the Clinical Senate
    b. a System Leadership Advisory Council, enabling strategic engagement of WA Primary Health Alliance, Aboriginal Health Council of Western Australia, private hospital and ambulance operators, National Disability Insurance Agency, the residential aged care sector and consumer representatives
    c. maintaining the Mental Health Leadership Advisory Council, Community Mental Health Alcohol and Other Drug Council and Aboriginal Advisory Group enabling strategic engagement of public and community based mental health and AOD sectors, as well as lived experience leadership and culturally secure consultation and advice
    d. maintaining the Ministerial Advisory Panel to support strategic workforce planning and development, and consistent application of workforce policies
    e. revitalising the Clinical Senate and clinical networks to facilitate clinician and consumer engagement in statewide policy and planning development, and priorities for quality improvement.

Clear expectations and support for HSP board accountabilities

> 'Enabling the HSP boards to focus on governance and not management would optimise functioning of HSPs.'
>
> HSP Executive Group submission

HSP boards are the Minister for Health's point of accountability and should retain responsibility for setting strategic directions for their HSP so they deliver on systemwide strategies, policies, standards and outcomes.

As noted above, boards should also have explicit accountability to ensure their decisions benefit the WA health system as a whole and to co-operate with other HSPs, WAPHA, Aboriginal health organisations and the System Manager (see recommendation 6).

Many boards, and particularly board chairs, have strong relationships with a wide range of stakeholders, including with the Minister and the Department of Health Director General.

Some board chairs expressed concerned about constraints on their ability to acquit their responsibilities without clarity on strategic directions, mandated requirements and direct reporting lines between the board and HSP CEs.

There is a risk that confusion about board accountabilities allows boards to be inadvertently drawn into operational matters rather than the desired strategic and oversight focus.

Guidance to board members about their responsibilities and boundaries, through induction and learning and development, would assist board effectiveness. A number of other jurisdictions have annual forums for health service boards to provide an opportunity for professional development and networking.

> 'Currently there are few formal forums for cross-Board collaboration and building a sense of collective responsibility for the performance of the system. When it does occur, it tends to be self-initiated and focused on the problem or issue at hand.'
>
> HSP submission

A more structured Board Chairs Council, and involvement in the recommended Strategic Leadership Forum would strengthen system stewardship (see recommendation 8a). A community of practice for chairs of quality and safety committees has recently been created, which supports professional development and sharing of good practice in developing and implementing clinical governance arrangements within their respective HSPs. Boards may also wish to consider whether communities of practice would be beneficial in other specialist areas of board responsibility including consumer and clinician engagement and monitoring and improving the quality of mental health services.

Board remuneration is periodically reviewed by the Public Sector Commission. As the WA health system implements the recommendations in this report, it would be timely to reassess levels of remuneration against other WA and interstate benchmarks.

The System Manager has a well-developed intervention framework to respond to performance concerns, including concerns about clinical or corporate governance.

Accountability of boards to the Minister could be enhanced through targeted use of provisions within the Act that enable the Minister to appoint an advisor to a board for a specified period, if the Minister considers that such an appointment will assist the board to address performance concerns.

The advisor would act as the Minister's delegate on the Board. They would not be a member of the board. Their role would be to:

- attend meetings of the board and observe its decision-making processes

- bring expertise and provide constructive advice or information to the board to assist it in understanding its obligations under the Act and/or support remediation of identified performance challenges
- advise the Minister and the Director General on any matter relating to the HSP.

The importance of a structured Consumer Advisory Committee for each HSP was also raised by stakeholders, noting that WACHS has multiple to respond to the needs of regional communities.

Continuous professional development of boards, HSP management and the broader health workforce should include a focus on partnering well with consumers, carers and families to make best use of their experience, expertise and insights.

The Panel also notes the importance of the boards building the capacity of the consumer, carer and family representatives to assist in informing deliberations.

The Panel heard mixed views about the level of prescription of representation on HSP boards. While recognising the importance of skills-based boards, the Panel found that local responsiveness would be strengthened through inclusion of board members with mental health clinical experience, the Chair of the Consumer Advisory Committee and Aboriginal representation.

The Panel also heard from HSP boards that the ability to retain earnings would equip HSPs to advance agreed strategic priorities, improve practice and manage non-recurrent operating expenses. The Panel supports the development of a framework for retained earnings, in consultation with the Department of Treasury. The retained earnings framework should provide clarity to boards about the level of earnings that can be retained and permissible applications of the funding. In applying retained earnings, HSPs should remain compliant with mandatory policies set by the System Manager and HSS (see recommendations 20 and 45a). Any expenditure should advance priorities in service and alliance agreements and should not create recurrent expenses.

Recommendations

9. That the Act is amended to strengthen corporate governance and accountability so that HSP CEs are employed by their HSP board, with appointment and termination decisions requiring the concurrence of the Department of Health Director General.
10. That the Act is amended to mandate consumer representation on HSP boards and Board Quality and Safety Committees and representation on HSP boards by:
    a. the Chair of the Board's Consumer Advisory Committee
    b. a member with mental health expertise
    c. a member who is an Aboriginal Person nominated by the Aboriginal Health Council of WA.
11. That the System Manager develop a governance framework for HSP boards and provide support for its implementation, including through:
    a. a comprehensive board member skills matrix and induction program and providing ongoing development support including through an annual forum, tools and resources, and a learning and development program
    b. providing guidance on board evaluations
    c. guidance on the levels and permitted applications of retained earnings, developed in consultation with the Department of Treasury
    d. commissioning the WA Public Sector Commission to review board chair and member remuneration.
12. That HSP board chairs recommit to 2 communities of practice to facilitate collaboration and sharing of information, noting that these forums are not decision-making forums:
    a. a Council of Board Chairs
    b. Quality and Safety Chairs community of practice.

Partnering with consumers, families and carers

Better health outcomes are achieved when health professionals, services and systems work in partnership with consumers, patients, carers and families and communities.

The Panel heard positive feedback from consumers, families and carers about improvements in communication and engagement – particularly by young healthcare professionals and in rural communities.

However, our consultations found that the focus on partnering with consumers and their supporters is not consistent across the State, leading to variation in consumer participation, experience and outcomes.

> 'Not all HSPs see the value of consumer involvement in the same way, which is underlined by the experiences of some consumer representatives feeling as if they are there just to "tick a box"'.
>
> Consumer submission

The Panel asked consumer groups what mattered most to them, and what improvements could be made to enable their meaningful involvement at all 3 levels of health care: the direct care level, the service level and the system level.

Consumers indicated they wanted to participate in their own health care, as do their family and carers. They also want to participate in service design, delivery and quality improvement and provide feedback, ideas and personal experiences to drive change. They want to participate in governance, planning and policy development, in particular to have input to strategies to improve equity of access and personalised care, enhance information and support to build health literacy, enable greater consistency of experience and improve health care quality and safety.

Consumer groups reflected that:

- Carers and families do not consistently feel valued as part of care teams and more navigation support would improve patient experience and access to care.
- There is a lack of visibility in how the System Manager obtains consumer input and limited lived experience or mental health clinical expertise represented in System Manager and broader departmental staffing.
- The Act specifies that there needs to be 3 clinicians on every board but providing less specificity about consumer members, with some HSPs appointing clinicians with lived experience rather than bringing more diverse voices onto the board.
- Consumer feedback is not being systematically applied to improving the quality, safety and experience of care with inconsistent implementation of systems such as Care Opinion and variable representation of consumers on HSP board safety and quality committees.
- HSPs often seek consumer input on their own ideas and initiatives, but there is less support for consumer-led or consumer-initiated ideas.
- There are few mechanisms for regional consumers to influence the design of metro-based services to better meet rural consumer need.

Many felt that consumer involvement had been sidelined during the early stages of the COVID-19 pandemic and hadn't regained momentum.

> '... the importance of consumer, carer and community perspectives at the highest levels of governance is reiterated by ensuring these perspectives are explicitly included on Health Service Providers (HSP) Boards and the Department of Health, Health Executive Committee.'
>
> Consumer advocacy body

David Gilbert introduced the concept of patient leadership in health care improvement – where patients work alongside government, managerial and clinical leaders to impact organisational change, education and training and health service delivery and policy.[2]

The basic principle of patient leadership is to extend consumer engagement beyond techniques to capture patient experiences, to actively involving a consumer voice in problem-solving. Gilbert argues persuasively that having patients as partners means looking at problems differently and widening the array of options for improvement.

The International Association for Public Participation has a useful framework commonly used in designing consumer and family participation in the design of health policy and services.[3] Figure 4 illustrates practical ways to engage along this spectrum of participation.

Figure 4: Approaches to incorporating lived experience into policy and service design

	Inform	Consult	Involve	Collaborate	Empower
Goal	To provide consumers, carers and families with balanced and objective information to assist in understanding the problem, alternatives, opportunities and/or solutions	To obtain feedback, analysis, ideas, wisdom, alternatives and/or decisions from consumers, carers and families	To work with consumers, carers and families through the design process to ensure their experiences, concerns, ideas and aspirations are invited, understood and considered	To partner with consumers, carers and families in each aspect of the decision – including the development of alternatives and the identification of preferred solutions	To place final decision-making in the hands of consumers, carers and families
Promise to consumer/ carer/family	"We will keep you informed"	"We will listen and acknowledge your concerns, experiences, ideas and aspirations and let you know how these influenced decision-making"	"We will work with you to ensure your concerns, experiences, ideas and aspirations are reflected in the decisions we make"	"We will partner with you to identify solutions and make decisions together"	"We will implement the solutions you identify"
Ways to engage	• brochures • website • fact sheets • digital stories	• surveys and data • focus groups • structured interviews • journey mapping • point of care encounter	• workshops • focus groups • world cafes • design days	• consumer and carer/family advisors • consumers, carers and family members included in projects, working groups • councils and advisory committees	• delegated decision making to consumers, carers and families • creating digital stories

2 Gilbert, D. The Patient Leadership Triangle, 2020

3 International Association for Public Participation, 2006

The Panel has made recommendations to mature shared decision-making and strengthen consumer engagement in service design and development throughout the report. These recommendations are cross-referenced below.

A visible and deliberate commitment to inclusion and participation of consumers and their supporters will help to spread good practice and build confidence and capability to partner well.

There should be greater representation of people with lived experience in System Manager and MHC staffing, with more patient oriented lay roles established across the system (see recommendation 16 and 38d).

Local and system governance should promote greater diversity in consumer voices, formalise opportunities for input to service and systemwide strategy and planning, and better support consumer-led service redesign (see recommendations 8b, 8c, 8e and 20).

Stronger connections between consumer advisory committees and HSP boards would strengthen consumer input to local decision-making and capability building. The Panel found that local responsiveness would be strengthened through the inclusion of the Chair of the HSP Consumer Advisory Committee on the board (see recommendation 10).

A legislated code for consumer engagement and associated policy framework on use of endorsed patient experience tools such as Care Opinion would provide consistent guidance on how to make best use of the richness of experience and expertise of consumers, carers and families (see recommendation 1b and 20).

These enhancements would better position WA's health system for any future emergencies.

Aboriginal people living long, well and healthy lives

Aboriginal people experience significantly poorer health outcomes. Improving equity of access and outcomes requires specific strategies which must be developed and delivered through engagement with Aboriginal people.

The National Agreement on Closing the Gap emphasises shared decision-making with Aboriginal Community Controlled Organisations and empowering Aboriginal people to make and participate in decisions about their futures. WA's Aboriginal Empowerment Strategy and the SHR commit to capacity building and shifting resourcing to Aboriginal-led programs and services.

The WA Aboriginal Health and Wellbeing Framework 2015–2030 sets 6 strategic directions and priority areas to achieve a vision of Aboriginal people living long, well and healthy lives. The framework together with the broader strategic intent of the System Manager specifies the requirements to strengthen and embed improvements in Aboriginal health and wellbeing across the system.

The strategic directions include providing health care that is equitable, accessible, safe, culturally respectful and non-discriminatory. This is supported by specific strategies designed to increase the number of Aboriginal people in the health workforce and transfer resourcing to Aboriginal-led services to improve local access and improve cultural safety and support to Aboriginal people seeking health care.

The Panel also notes the relatively strong focus on cultural awareness and competence training across the public health system and urges continued and ongoing focus in this area to ensure all services are culturally secure. Continuing to grow community based care will improve health outcomes and reduce avoidable emergency department presentations and hospital admissions.

The Panel acknowledges the work that has already been undertaken but has recommended further actions to drive improvements in health outcomes for Aboriginal people. These recommendations are cross referenced below.

The Panel has recommended that a long-term health strategy be published with a minimum of a 10-year horizon, supported by rolling strategies and clinical service plans that include the provision of Aboriginal health services. The immediate priority should be on progressing implementation of the systemwide and whole of government strategies and initiatives identified in the SHR that deliver positive impact on Aboriginal health outcomes (see recommendation 3).

For example, consultations emphasised that early priority should be given to driving cultural security of public health services and transitioning management of government-run primary health clinics to Aboriginal community controlled organisations, with appropriate transitional support to ensure long term sustainability.

The Panel also heard how important it is for collaborative design and commissioning of mental health services to continue to engage Aboriginal community-controlled organisations, families and community members and embed social, cultural and emotional wellbeing principles and practices in new models for community mental health services. The Panel strongly agrees with feedback from consultations that consistent and public championing of the need to address institutional racism and shared decision-making must be driven through leadership from all senior staff in the health system.

The Panel acknowledges the leadership of the AHCWA. To strengthen an Aboriginal voice in all decision-making, the Panel recommends that AHCWA is invited to participate on a new system leadership advisory council (see recommendation 8b). The Panel also recommends maintaining the Aboriginal Advisory Group in mental health and mandating Aboriginal representation on each HSP board nominated by AHCWA (see recommendations 8c and 10). This is consistent with the National Agreement on Closing the Gap with a commitment to build and strengthen the formal structures for Aboriginal people in decision-making forums.

> '...recommends that health service planning be led by local stakeholders and based on local community needs assessments, ensuring services reflect the specific needs (including cultural needs) of a local community.'
>
> Peak body public submission

The Panel has recommended the introduction of a joint stewardship and performance management model to guide the commissioning relationship between the System manager and HSPs. Joint problem-solving requires transparency of shared data and evidence about what really matters to achieve better outcomes. Performance dashboards will enable system leaders to track performance over time. The Panel recommends the reporting on specific Aboriginal health metrics as part of these dashboards (see recommendations 3b and 25c).

The Panel also recommends that the performance metrics demonstrate a clear and positive bias for higher performance in outcomes benefitting Aboriginal people as it is recognised that delivering the same level of care to all Western Australians will result in the same gap in health outcomes for Aboriginal people (see recommendation 26d).

Consultations highlighted those specific indicators reflecting a cultural concern by Aboriginal people in accessing health services, such as discharge and early departure statistics, together with medical indicators around life expectancy and healthy birth weight should continue to be a strong educational focus for health services.

The National Health Reform Agreement envisages the development of localised governance and funding structure to integrate Commonwealth and State funded services for particular groups of patients and types of care. The Panel is recommending that 3 local commissioning authorities be created and that early priorities would include mental health and chronic disease management. Aboriginal Community Controlled Health Organisations will be a critical partner in this process with collaboration strengthened through a structured consultation process (see recommendation 29c).

The provision of culturally appropriate health care will be enhanced by increasing the number of Aboriginal people in the health workforce. The Panel is also of the view that it is important to provide opportunities for Aboriginal people to be trained in many roles and where appropriate receive that training in the communities in which they live.

The System Manager should work with educational institutions to expand the opportunities for Aboriginal people in remote communities to be trained in skilled clinical and non-clinical roles, including as nurses, allied health professionals and doctors. As a priority, nursing training should include clear pathways to gain enrolled qualifications with progression through to registered nurse training and qualifications.

The opportunity for more remote learning and supervision as experienced during the COVID-19 pandemic needs to continue to be explored to provide opportunities for regional people to be trained and employed within their communities.

The Panel also supports the introduction of a classification structure for Aboriginal Health Practitioners and recognises the need to ensure that the introduction of these positions is supported through regular cultural safety training (see recommendation 43c).

The Panel further notes that the State Government has adopted the recommendations of the Ministerial Taskforce into Public and Mental Health Services for Infants, Children and Adolescents aged 0–18 years in WA which includes the creation of Aboriginal mental health workers with clear roles, capabilities and career pathways.

> 'The improvement in Aboriginal employment across the WA health system in recent years is welcome, as a larger Aboriginal workforce will help to improve cultural safety.'
>
> Peak body public submission

As a purchaser of goods and services, the WA health system has the opportunity to support local Aboriginal businesses through the implementation of the State Governments Aboriginal Procurement Policy. HSS should reference this policy in its procurement policy framework and monitor adherence on behalf of the System Manager (see recommendation 45a).

The COVID-19 pandemic continues to stretch health systems around the world. The WA health system has demonstrated its capacity to rapidly mobilise new ways of delivering services, including the use of telehealth services. The Panel heard that communication and service delivery for Aboriginal communities would be enhanced through local community engagement on culturally secure and effective emergency responses, particularly in regional and remote areas of WA.

The Panel has recommended that community engagement on emergency responses is considered as part of a whole of government review of the management of the COVID-19 pandemic (see recommendation 55).

Reassigning responsibilities for statewide policy and services

The Panel consultations indicated a broad level of comfort with the current configuration of health services. The key strategic document of the System Manager is the Clinical Services Framework, which should be considered as the blueprint for decision-making. Clinical commissioning and configuration activities, either market driven or driven by a HSP, should be done in alignment with the Clinical Services Framework and in recognition of the System Manager's role to provide independent analysis and recommendations regarding contested areas.

The existing allocation of statewide services within North Metropolitan Health Service and systemwide support for health responses to child safety and family violence were identified through consultations as areas for improvement.

North Metropolitan Health Service

The NMHS catchment area covers almost 1,000 kilometres, with a population of 738,640 people, representing 28 per cent of WA's total population. NMHS provides a full range of highly specialised multi-disciplinary services, including a broad range of acute medical, surgical, women's health, emergency, outpatient and rehabilitation services. They also manage over 20 statewide specialist services on behalf of the system, impacting on their operational efficiency. This is reflected in higher admitted cost per weighted activity unit compared to other metropolitan services.

The Panel recommends that further analysis is undertaken by the System Manager to rapidly identify options to reduce the breadth and scale of NMHS' operations with a particular focus on alternative delivery options for some statewide services. Guiding principles that take a whole of health view and incorporate value and outcomes considerations should be used to make these service delivery decisions, as well as utilising service agreements between HSPs to clearly set funding and reporting arrangements for these services.

Consultations identified the option to shift dental services to PathWest or to CAHS. This will not be sufficient to materially reduce complexity for NMHS. Other near-term options should be identified with NMHS Board and management.

In the longer term, further consideration could also be given to how best to support specialist women's services.

Both of these services are critical to population health outcomes and would benefit from dedicated support and development.

Family violence and child safety responses

The Panel heard that there would be benefit in strengthening strategic policy leadership, streamlining responsibilities and enhancing governance over health responses to children at risk and victim survivors of family violence.

Systemwide policy and operational support for child safety is currently led by CAHS for children aged 0–12. Allegations of sexual abuse for children over 12 are referred to the Sexual Assault Resource Centre at the King Edward Memorial Hospital.

Health responses to family violence are co-ordinated by NMHS. The responsibility of specialist units in each of these HSPs includes liaising with policy areas of the Department of Communities on strategic policy development.

The Strategy and Governance Division of the System Manager also plays a role in interagency liaison and strengthening information sharing and collaboration between health and social services. A memorandum of understanding (MOU) between the Department of Health and the Department of Communities is under development. As part of these responsibilities, the Strategy and Governance Division is co-ordinating targeted initiatives to connect vulnerable children to health services and improve health outcomes for children in out of home care.

This division also co-ordinates Health's role in addressing recommendations arising from the Royal Commission into Aged Care Quality and Safety and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability.

The Chief Nursing and Midwifery Office within the Clinical Excellence Division is the executive sponsor for delivery of recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse.

A Human Services Director Generals Group is overseeing progress in delivery of Royal Commission into Institutional Responses to Child Sexual Abuse, including information sharing between health and other government-funded services.

Policy materials on responses to child maltreatment and family violence include a combination of non-negotiable obligations (for example reporting of suspected sexual abuse of a child) and guidance on good practice.

The Panel considers that interagency policy liaison should be consolidated within the System Manager, with the MOU with Department of Communities finalised as a matter of priority responsibility. The Strategy and Governance Division could take responsibility for this MOU and associated system development, reporting, accelerating guidance on multi-agency information sharing and advising the Strategic Leadership Forum on mandatory policies required to deliver on recommendations from various Royal Commissions.

Further consideration should also be given to which area of the System Manager should assume responsibility for commissioning and monitoring of social services commissioned from non-government organisations.

Specialist units within HSPs could continue to lead training and practice development support across the health system. There would be value in consolidating child safety responsibilities within a single HSP. Reporting lines and resourcing of these operational support functions should be clarified to ensure responsibilities and accountabilities are well defined, with sufficient senior leadership on strengthening risk assessment, information sharing and trauma-informed practice. Consideration should also be given to designating lead roles in each HSP for child safety and family violence.

Recommendations

13. That the System Manager review responsibilities for statewide services and health responses to vulnerable groups and prioritise:
    a. rapid identification of options to reduce the breadth and scale of North Metropolitan Health Service scope of service delivery
    b. clarification of responsibilities for policy leadership, commissioning and operational responses to child safety and family violence
    c. finalisation of a MOU with the Department of Communities and an operational model for information sharing to promote wellbeing and protections for children and victim survivors of family violence.

Mental health commissioning and oversight

> 'The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 identifies the need for services, as much as possible, to provide integrated models of care, in the community, in order to provide for a balanced mental health system. It is also essential that services are co-designed with stakeholders, especially people with lived experience.'
>
> Government submission

Successive reviews of WA's mental health system have identified critical gaps in meeting the increasingly high levels of need among infants, children, adolescents and adults.

Consistent with other jurisdictions in Australia, WA does not have an organised mental health system. Individual services (whether funded by the State or the Commonwealth) are fragmented, operating separately from one another. Access to care is affected by where people live, and the circumstances of their family and life. People living with mental illness and other conditions such as poor physical health, disability or substance use can find it particularly difficult to access services. These services are often not sufficiently integrated to respond to people's needs and preferences.

While not unique to WA, the experience of seeking help from multiple services and navigating a complex system places further stress on individuals and their families and carers and increases the risk of slipping through gaps and being lost to essential support services.

The WA government has accepted SHR recommendations to improve models of care, harness the expertise of people with lived experience and clinicians, and join up services and supports to promote mental health and wellbeing.

Effective system governance will be critical to delivering these system improvements.

Throughout its consultations, the Panel has received positive feedback about the MHC's engagement with consumers, carers and families. However, the Panel has also heard about the negative impacts of:

- the lack of 'single point accountability' for the performance and improvement of the WA public mental health system
- fragmentation in the exercise of strategy, planning, funding and performance management functions and an inadequate overall view on safety and quality across state and Commonwealth funded services
- the absence of an integrated, collaborative clinical leadership framework, including senior clinical roles at the System Manager, MHC and within HSPs
- inadequate workforce planning and co-ordinating mechanisms to maximise recruitment campaigns and training positions
- variable engagement with consumers, supporters and clinicians at a local level, and a lack of systematic collection of consumer, carer and referrer experiences of services.

A central point of accountability

> 'The current organisational structure is such that no single person or entity is responsible for the operational delivery of mental health in WA. This results in poor coordination, communication, collaboration, accountability and, most importantly, poor patient outcomes.'
>
> Union public consultation submission

The Panel agrees that there needs to be a stronger central point of accountability for setting AOD and mental health strategic directions, and system development.

The System Manager should be given responsibility for AOD and mental health policy, planning, commissioning, performance management and clinical assurance. This will reduce overlaps in responsibility with the MHC and streamline commissioning processes for HSPs.

A dedicated Mental Health Directorate should be created within the System Manager, providing leadership on AOD and mental health service delivery and mental health workforce development.

This Mental Health Directorate should assume responsibility for setting strategic direction, mandatory policy frameworks, system planning and commissioning, funding and performance management, and workforce development. As noted elsewhere in this report, it will be critical that these functions are delivered in partnership with HSPs and WAPHA (see recommendation 30).

To drive improvements in system capacity, flow and outcomes, early priority should be given to increasing step-up and step-down services and liaising with the Department of Communities on the impact of NDIS planning and supports for psycho-social disability on hospital demand.

The directorate should employ people with lived experience of mental illness, addiction or psychological distress and people with lived experience of caring for someone living with mental illness or addiction, including in leadership positions.

The SHR identified gaps in measures to understand whether mental health services are making a difference to improving people's health outcomes and experience. The new directorate should prioritise reviewing and updating mental health and AOD performance measures to provide better insights on patient experience and outcomes. These measures and population mental health statistics should be reported publicly (see recommendations 3, 25b, 26b, 33, 35).

A redesigned funding and commissioning model is discussed separately in this report (see recommendations 22–27). A consolidated service agreement framework and Ministerial Statement of Priorities would provide an opportunity to elevate AOD and mental health system priorities in a new annual cycle of priority setting, joint problem-solving and performance review. Local commissioning authorities will assist in linking pathways of care across sectors and catchment boundaries, while supporting an equitable distribution of service development across the State (see recommendations 29–31).

The new Mental Health Directorate should liaise with other units within the System Manager on infrastructure planning, workforce development, cultural safety and clinical safety and quality monitoring.

In addition to a dedicated directorate, a mental health improvement unit should be created within the Clinical Excellence Division. This unit should drive collaboration across HSPs on quality improvement priorities, informed by data and evidence, and directed toward embedding contemporary and multidisciplinary approaches in services.

The Chief Medical Officer, Mental Health (currently within the MHC organisational structure) should move into the Clinical Excellence Division and work with the dedicated Mental Health Directorate to provide clinical leadership and strengthen consumer and community-focused clinical care.

Priorities identified through the Panel's consultations include:

- reducing the use of seclusion, restraint and compulsory treatment
- developing peer-support roles
- embedding best practice in responding to people who have experienced trauma
- supporting the expansion of Aboriginal led services that embed social and emotional wellbeing principles and practices into community models of care.

Prioritising AOD and mental health in health strategies

The Minister should publicly communicate alcohol and other drugs and public mental health priorities in the long-term health strategy, with supporting clinical service plans developed by the System Manager and a deliberate focus on the AOD mental health workforce in workforce development strategies (see recommendations 1 and 2).

Operational priorities would be captured through the annual Ministerial Statement of Priorities for HSPs.

> 'It is therefore recommended that the Statement of Expectations process be replicated, specifically for mental health, to ensure that the Minister for Mental Health is directly involved in setting mental health priorities for the HSP boards in a clear, explicit and transparent manner.'
>
> Government public submission

Stronger whole of government leadership

Promotion of mental health and wellbeing requires whole of government leadership and commitment. Schools, employers, community services, transport services and regional development bodies all have a critical role to play in creating the conditions for improved wellbeing and suicide prevention.

Whole of Government leadership on mental health and wellbeing should be driven through an interdepartmental committee chaired by the Director General of the Department of Premier and Cabinet (DPC).

Stronger health system leadership

> '...it is recommended that each HSP appoints a single senior executive leader responsible for mental health and makes this executive a member of the HSP's executive leadership group. Where this person is not a clinician, it is also recommended that they work closely with a senior clinical mental health leader. The two executive positions should have the authorisation of the HSP Chief Executive to speak on behalf of the HSP on mental health matters so they can inform HSP boards about their mental health services and issues facing them.'
>
> Government submission

Collaborative leadership on strategic directions to improve mental health outcomes and monitor progress in delivering system reforms, should be facilitated through the System Leadership Forum and System Leadership Advisory Council.

The Community Mental Health Alcohol and Other Drug Council, Mental Health Leadership Advisory Council and Aboriginal Advisory Group should be retained, supported by a lived experience leadership group, with a reporting line through to the System Leadership Forum (see recommendation 8c).

Senior leadership within HSPs should also be strengthened in two ways:

- HSP boards should have mandated representation of a member with mental health expertise (see recommendation 10 b).
- Each HSP should also create a senior mental health executive position, to provide a clear point of accountability for the performance of mental health services. This executive should directly report to the HSP CE.

Expanding Aboriginal-led services and co-designing new models of care to embed emotional and social wellbeing principles and practices

Aboriginal communities and community-controlled services should participate in the design and delivery of mental health and AOD services. Aboriginal people should be able to choose to receive care within Aboriginal community-controlled organisations, mainstream services, or a mix of both. Irrespective of where treatment, care and support are delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive and respectful.

The Panel recognises the strengths of the WA Statewide Specialist Aboriginal Mental Health Service (SSAMHS) model, which combines specialist clinical interventions with engagement of family and traditional healers identified by people with mental illness and their families through community networks. SSAMHS is focused on delivering improved access to mental health services for Aboriginal people and a career structure to encourage recruitment and retention of Aboriginal staff.

Consistent with the recommendations of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA, future models of care for children and adults should build on the SSAMHS to integrate social and emotional wellbeing principles in community-based services. Collaborative design processes should continue to engage Aboriginal children, families, carers and community members.

Capacity building of Aboriginal community-controlled organisations should be prioritised to provide Aboriginal people with choice of where to receive care and support. HSPs should be accountable for partnering with Aboriginal community-controlled organisations to provide primary consultation, secondary consultation and shared care.

The Strong Spirit, Strong Mind emphasises cultural security in workforce development across AOD, mental health and broader human services sector. While maintaining commitment to this program, responsibilities for building the Aboriginal mental health workforce should shift from the MHC to the Mental Health Directorate, working in partnership with AHCWA, the proposed Strategic Workforce Development Unit and the Clinical Excellence Division.

Refreshing the role of the MHC to strengthen oversight and accountability

The MHC should shift to providing oversight and hold the System Manager and HSPs to account for the performance of the public mental health system.

The Act should be amended to empower the MHC to conduct inquiries into matters that support its objectives, on the request of the Minister.

The MHC should separately report each year on the performance of the WA's public mental health system, progress in implementing strategic reform initiatives and recommendations from any formal inquiries requested by the Minister.

As discussed earlier in the report, there should be more emphasis on experience and outcomes indicators in this performance reporting (see recommendation 3, 25 and 26b).

MHC should continue to support improvements in the engagement of people with lived experience (consumers, carers, families and supporters) in decision-making, the design and delivery of services and collection of consumer-completed, and family-and-carer-completed performance indicators.

The Panel recommends that MHC convene a lived experience leadership group to provide opportunities for members to support each other, access professional development, and broaden the strategic expertise available to systemwide governance forums. Creating this forum would be natural next step in MHC's leadership on capacity building and integrating lived experience voices into systemwide governance structures.

MHC should retain responsibility for primary prevention and mental health promotion. As part of their mental health promotion function, MHC should also lead work across the WA public mental health system and the broader community to reduce stigma, systemic racism and encourage help-seeking and help-offering behaviours.

The MHC will require appropriate expertise and clear separation from the System Manager and HSPs to effectively exercise these functions, especially its oversight responsibilities.

For example, an expert advisory board could be established under the Act, to provide the MHC with access to strategic advice in performing its functions. Relevant knowledge, skills and experience would include someone with lived experience of mental illness or psychological distress, someone with lived experience as a family member or carer, and expertise in mental health promotion, service delivery and data analytics.

Recommendations

14. That the Act is amended to:
    a. shift responsibilities for policy, planning, commissioning, performance management, workforce development and clinical assurance of public mental health services to the System Manager
    b. establish primary prevention and oversight functions for the Mental Health Commission, including for example:
        i. reporting on the performance of the WA public health system and progress in delivering against committed system reforms
        ii. undertaking inquiries into matters that support its objectives and public reports containing its findings, on the request of the Minister
        iii. supporting people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system
        iv. addressing stigma related to mental health
    c. establish an advisory board to provide strategic advice to the Mental Health Commission in exercising its functions, with membership that provides a suitable mix of knowledge, skills and experience, including lived experience and expertise in mental health promotion, service delivery and data analytic
    d. enable the Mental Health Commission to access performance information and administrative data necessary to fulfil its functions.
15. That the System Manager:
    a. create a new Mental Health Directorate to provide a central point of accountability for the alcohol and other drugs, and public mental health system, with responsibility for:
        i. setting strategic direction, mandatory policy frameworks, system planning and commissioning, funding and performance management
        ii. updating of performance measures to provide public information about the experience and outcomes of the alcohol and other drugs and public mental health system, in consultation with the Patient Safety and Clinical Quality Directorate
        iii. collaborating with other units within the System Manager on capital planning and development and strategic workforce planning
    b. create a dedicated mental health improvement unit in the Clinical Excellence Division to lead clinical safety and quality monitoring and improvement across mental health and alcohol and other drugs services
    c. work with the Mental Health Commissioner and Director General of the DPC to establish an appropriate interdepartmental committee chaired by the Director General of DPC to drive whole of government leadership on mental health and wellbeing.
16. That more opportunities are created for people with lived experience to participate in the WA health system, including:
    a. the employee cohort within the Mental Health Directorate and the Mental Health Commission include people with lived experience of mental illness, addiction or psychological distress and people with lived experience of caring for someone living with mental illness or addiction
    b. The Mental Health Commission establishing a Lived Experience Leadership Group to provide peer support and professional development to people with lived experience and provide a source of expertise into the range of systemwide leadership forums.
17. That each HSP employ a senior mental health executive position, reporting directly to the Chief Executive.

Establishing clear guardrails for the WA public health system

The Panel received consistent feedback from HSPs that the role of the System Manager is not clearly understood.

> 'An HSPs efficiency and effectiveness can be impacted by the lack of clarity around roles and responsibilities between the System Manager and the HSP. It is unclear to HSP's whether the SM [System manager] is, or should be, primarily focussed on policy and performance, or if it should be a facilitator and problem solver of systemwide problems.'
>
> HSP Executive Group submission

The Act gives the Director General of the Department of Health responsibility for the overall management of the health system.

The functions of the System Manager further define this responsibility, emphasising stewardship, leadership, commissioning and management of a range of health protection and non-clinical activities. These roles are distinct from the operational management responsibilities of HSPs.

Through its stewarding role, the System Manager is responsible for facilitating and actively contributing to solving systemwide problems and optimising health outcomes relative to costs. The System Manager has a critical role in rigorously measuring value from public health care and advising government on policy changes and investment priorities (see recommendation 25, 26, 33, 34, 35). In partnership with HSPs, the System Manager can help to identify and remove barriers to value from health care and support local communities, clinicians, consumers, carers and families, administrators, support staff and other health and community services to work together to improve the experience and outcomes of health care (see recommendation 8).

The System Manager exercises leadership by supporting the Minister to prepare a long-term health strategy and works with HSPs to improve health outcomes relative to costs and support workforce development (see recommendations 1, 2,4a, 35, 38). This leadership role includes communicating collective goals and government priorities. It also involves facilitating collective discussions about strategic risks and performance and sharing of good practice and innovation (see recommendations 4b, 7, 8, 28).

The System Manager enables and assures the operational management responsibilities of HSPs through advice to government on investment priorities, planning and commissioning services, setting standards and mandatory policies, and facilitating and managing non-clinical functions such as complex capital projects (see recommendations 15, 19, 21, 22, 23 24, 25, 27, 37, 41, 44).

The use of the language 'System Manager' was useful in the early implementation of the Act but is also creating confusion within the department. Ceasing to draw a distinction between 'System Manager' and 'Department of State' functions would not change the functions of the department but is likely to bring greater alignment to how those functions are performed.

Defining processes, practices and decisions to be standardised and when local flexibility is important for operational effectiveness

Consultations emphasised that the roles, responsibilities and boundaries of responsibilities exercised by the System Manager and HSP boards should be more clearly defined to provide clear guidance on the level of discretion available to HSPs.

This will require the System Manager to clearly describe processes, practices and decisions that benefit from statewide consistency and those that warrant more local discretion to ensure operational effectiveness and agility.

The WA health system could adopt a framework for clearly defining what is negotiable and what is not, based on:

- Prescribed requirements: mandatory activities, standards and processes to standardise practice to enable comparability or to reflect evidence of best practice.
- Permitted adaptation with guard rails: providing guidance on desired outcomes and evidence, while permitting HSPs to adapt to local conditions.
- Wider discretion: activities and strategic outcomes where freedom to act locally within the unique contexts of each HSP are essential, and the inability to do so would reduce operational effectiveness and agility.

A policy defining the required level of consistency may be relevant to all HSPs (for example requirements to comply with whole of government procurement or employment policies) or may be relevant to a sub-set of HSPs (for example reporting requirements for HSPs delivering statewide services).

Figure 5 illustrates this framework for the System Manager to establish degrees of freedom for critical processes, practices and activities.

Figure 5: Consistency vs discretion framework

		Degree of freedom		
		Prescribed requirements	**Localised adaption**	**Wide discretion**
Coverage of HSPs	**All**	Systemwide consistency	Systemwide tailoring	Systemwide innovation
	Subsets	Segmented consistency	Segmented tailoring	Segmented innovation

The Panel found that existing legislative and governance mechanisms are sufficient to embed this framework.

The Act provides for the Director General to establish policy frameworks, where consistency of processes or practices will materially support the quality, safety, efficiency or experience of receiving or delivering care. Consistency of processes or practices (for example in collection and reporting of data) may also be necessary to enable effective monitoring of system and population outcomes. The Panel is also recommending that the Act be amended to authorise the CE of HSS to issue binding policy frameworks for procurement and ICT related activities (see recommendation 45). Policy frameworks can be reinforced through service agreements and the performance management cycle.

Currently these frameworks contain a mix of prescribed requirements and guidance on good practice.

It would be preferable for the System Manager and HSS to limit the content of mandatory policy frameworks to prescribed requirements, with sufficient detail to enable consistent implementation.

> 'The policy frameworks are broad and provide limited direction only. There is a lack of detail to ensure consistent application across each HSP.'
>
> Specialist education provider

Other guidance documents can be used to share evidence and feedback from consumers and clinicians. Guidance materials should have a different look and feel to mandatory policy frameworks, to avoid confusion as to their status and intent.

Building on existing policy frameworks, the consultations identified 9 early priorities to be prescribed through binding policy frameworks. These 9 areas for standardisation are included in the recommendations below.

As further issues of concern arise, the System Manager should work collaboratively with HSP board chairs, CEs and other stakeholders to agree to solutions and identify the appropriate level of standardisation or local discretion for that solution, with:

- solutions that require consistent implementation across the system communicated through policy frameworks
- Director General directions issued to individual HSPs to address serious performance or safety concerns
- clinical and corporate governance guidelines enabling flexibility to customise evidence on good practice to local contexts.

Recommendations

18. That the Department of Health cease to draw a distinction between 'System Manager' and 'Department of State' functions, so that all functions are directed toward improving the performance of the public health system and health outcomes for the people of Western Australia.
19. That the System Manager formally provide clear guidance on the level of consistency and discretion available to HSP by progressively determining whether decisions and activities fall into one of 3 categories:
    a. Prescribed requirements: mandatory activities, standards and processes to standardise practice (for example; to enable comparability, to reflect evidence of best practice or to ensure compliance with government policies)
    b. Permitted adaptation with guard rails: providing guidance on desired outcomes and evidence, while permitting HSPs to adapt to local conditions
    c. wider discretion: activities and strategic outcomes where freedom to act locally within the unique contexts of each HSP are essential, and the inability to do so would reduce operational effectiveness and agility.
20. That the System Manager prioritise the updating and consolidation of 9 policy frameworks prescribing mandatory requirements for:
    a. patient flow between HSPs, based on need
    b. record keeping and movement of health records between HSPs
    c. performance, risk and financial reporting, providing a consistent format for reporting, and data standards for output and outcome measures
    d. clinical incident management and notification requirements
    e. integrity requirements
    f. workforce data collection and reporting, providing a consistent format and data standards
    g. capturing consumer, carer and family feedback about the experience of care through endorsed patient experience tools
    h. employment conditions, processes and practices, including whole of government requirements
    i. clinical teaching and training placement obligations.
21. That the System Manager publish prescribed requirements in a consolidated online repository of policy frameworks, with alerts provided to HSPs on any updates.

Simpler and more strategic service agreements

Planning, resourcing and performance management of HSPs are currently core functions of the System Manager and MHC.

The Act requires HSPs to enter into service agreements with the System Manager and the MHC.

Service agreements are an important instrument to translate the strategic intent of devolved governance into practice, by:

- articulating the role and responsibilities of HSPs and the System Manager
- translating health system strategic directions and priorities into resource allocation, service delivery and performance monitoring
- setting performance expectations and establishing accountability for improvements in performance
- improving resource allocation, workforce optimisation and budget discipline.

A 2020 review of the service agreement framework found that the framework had improved the transparency of, and accountability for, expenditure across the health system and established clear escalation processes in response to performance issues.

The Panel endorses the recommendations of the 2020 review, including the development of a more strategic service agreement and longer service agreement periods for HSPs.

A draft bill was introduced into parliament in 2021 which (amongst other changes) will enable service agreements for up to 3 years.

In their submissions to the Panel, HSPs reinforced the key themes of the review. They sought more input into service agreement negotiations, a mechanism to engage with the Department of Treasury on system planning and performance and greater alignment between systemwide goals and priorities, resource allocation and performance expectations. Longer terms were favoured to provide greater certainty for their own operational planning.

> 'The SLAs have also become less detailed over time and do not provide a written understanding of the roles, responsibilities and obligations of either party in meeting mutually agreed service standards or activity targets within budget parameters. They are also largely based on retrospective activity rather than allowing for future growth and opportunity.'
>
> HSP Executive Group

Service agreements, together with mandatory policy frameworks, should set clear direction for the system, requiring consistency where appropriate and ensuring a strong oversight of quality, safety and equity.

The WA Service Agreement contains more black-letter legal drafting compared to other jurisdictions. During the Panel's review, we heard this drafting style is intended to educate and inform HSPs of the relevant provisions of the Act that underpin a particular power or function. This approach is more consistent with a purchaser-provider relationship.

Plain English drafting will not reduce accountability for performance but will enable clearer identification of strategic priorities and reflect a partnership approach to long-term planning and joint problem-solving.

A single service agreement, including all government funding (for health and mental health), including:

- activity-based funding
- program funding, for example for population health initiatives
- other financial incentives for innovation, improvement and capability development including the ability to retain earnings (see recommendation 11c) and shared risk incentive funding (see recommendation 27).

The agreement should also clarify priorities and performance expectations.

Recommendations

22. That the System Manager continue to implement the recommendations from the 2020 Review of the Service Agreement Framework, including:
    a. increasing the strategic focus of the Service Agreement, by better co-ordinating strategic prioritisation, planning, purchasing and performance functions within the System Manager and within a new model service agreement
    b. clarifying and streamlining the processes involved in the service agreement negotiation and administration cycle, enabled through:
        i. documenting the negotiation and administration cycle and opportunities for HSPs to input into priority setting
        ii. creating more space for long-term planning by shifting to 3-year agreements with annual update to funding and purchasing schedules
        iii. integrating physical and mental health service expectations into a single agreement
    c. redesigning the resource allocation model to increase transparency and drive performance.
23. That the System Manager develop a plain English model service agreement that includes:
    a. identification of a small number of high-impact government priorities and outcomes for the system, including key actions required to advance Sustainable Health Review priorities as implementation planning matures
    b. performance targets for the highest priority key performance indicators, aligned to strategic priorities and outcomes – with an assessment framework against each of these targets (aligned with the 4-scale escalation process).
24. That a single Service Agreement is provided to HSPs which covers all State funding, including:
    a. activity based funding for physical and mental health services
    b. any specific program funding
    c. any financial incentives for HSP innovation, improvement and capability development.

Joint stewardship and performance management

Consistent with WA's outcomes-based budgeting, a systemwide outcomes logic should underpin joint stewardship and performance management.

As noted earlier in the report, an outcomes performance framework and associated dashboards, would help to describe how well the WA public health system is delivering outputs and achieving outcomes and should encompass accountabilities for the System Manager and HSPs (see recommendation 3b).

Figure 6 illustrates a joint stewardship and performance management model to guide the commissioning relationship between the System Manager and HSPs.

The System Manager should engage with higher performing HSPs through joint problem solving, sharing data and good practice, and targeted funding to reinforce and amplify high performance.

A mature 2-way performance dialogue will only be successful if both participants (the System Manager and HSPs) collaborate on how to improve service and systemwide performance.

The System Manager should be prepared to take on responsibility for delivering or facilitating policies to support HSP activities. Shared data should be applied whenever possible to track against HSP and systemwide performance trajectories to assess whether operational plans are likely to succeed. All parties need to share information and insights that helps the other contribute to achieving outputs and outcomes – and contribute evidence of good practice.

Figure 6: Joint stewardship and performance management

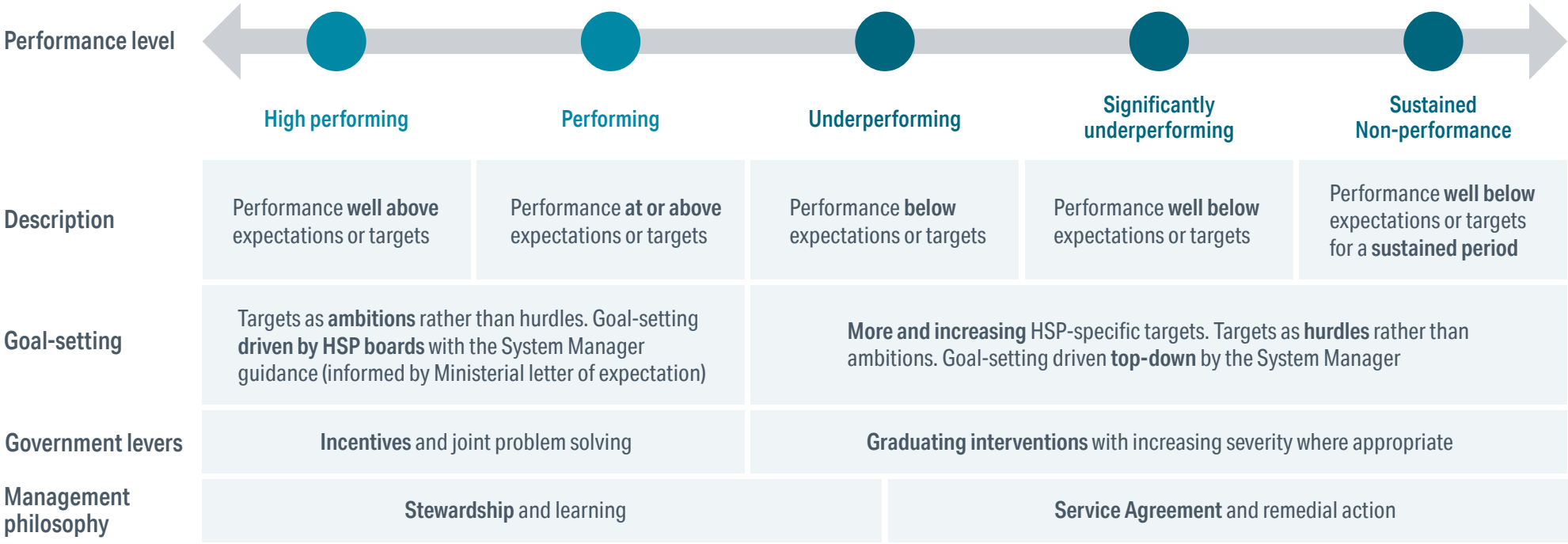
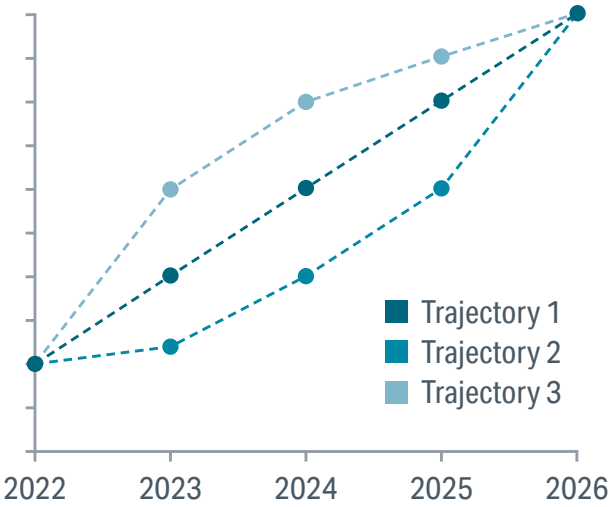


Figure 7 summarises the principles to guide performance and problem-solving discussions.

Figure 7: Guiding principles for performance and problem-solving sessions

1. Clear output/outcomes and plan



The basis for shared problem solving should be clarity on the outputs/outcomes the HSP is aiming for and its intended **trajectories**

2. Transparency of data and evidence

Use **shared data** whenever possible and track against the HSPs intended trajectories to judge whether plans are likely to succeed

The System Manager and HSPs should contribute evidence of best practice and an evolving **understanding of what really matters**

HSPs should commit to **evaluating activities** and the rigour of aiming for statistically significant results where possible

3. Accelerating outcomes

The System Manager should be prepared to take on responsibility for delivering or facilitating policies to **support HSP activities**

The System Manager and HSP should **share information/insights** that helps the other contribute to achieving outputs and outcomes, including broader system outcomes

The System Manager and HSPs should be prepared to **experiment with ideas and activities**, but also be willing to 'fail fast'

The relationship between the System Manager and each HSP should be predicated on HSPs demonstrating:

- effective governance frameworks that exist around both clinical and corporate governance and to ensure effective financial and operational performance
- clear acceptance of accountability to deliver funded activities, health outcomes and service outputs (through their operational plan) and adherence to binding policy frameworks (see recommendations 4 and 20)
- the development and maintenance of a positive performance culture within their organisation
- commitment to working with the System Manager and other HSPs on areas of collective responsibility
- commitment to working with other parts of health, disability and aged care and educational providers to improve population and system outcomes (e.g. with HSS, PathWest, MHC, WAPHA, Aboriginal health services, unions, professional colleges, universities and TAFEs).

Performance expectations

Service agreement headline performance metrics should be relevant to the accountability obligations and provide clear, timely and consistent visibility on progress against agreed deliverables. Consistency of performance data is essential. The System Manager should establish clear data definitions in relation to all agreed performance metrics and there should be a single source of truth reporting site accessible to stakeholders to ensure consistent presentation and to support benchmarking.

Service agreements currently focus on a range of quantitative performance indicators. The agreements do not explicitly link key performance indicators to system priorities.

The value of performance discussions would increase if a combination of qualitative (outcome focused) and quantitative (output focused) indicators were grouped under domains that directly reflect strategic directions for the system.

Specific domains could include:

- consumer engagement and patient-centred and outcome focused care
- evidence based care in the best location at the right time
- stewardship of sustainable service delivery
- equitable access to culturally safe care, including a priority focus for Aboriginal people
- workforce engagement and a positive workforce culture and environment.

Clear expectations should be set around unacceptable deviations from deliverables particularly when there is a direct relationship to adverse health outcome. Consideration should be given to the inclusion of 'never events' within the performance framework. Examples include >24 hr stays in the emergency department, >2yr wait for elective surgery.

Aboriginal people experience significant differential health outcomes and improving equity of access and outcomes should be specified within service agreements. Delivering the same level of care to all West Australians will result in the same gap in health outcomes for Aboriginal people and proportionate differential performance metrics should be specified. Differential performance may be delivered by reducing thresholds for access (reduced wait time targets for planned care) or higher focus on 'never events'. Engagement with Aboriginal community leaders may help to further define and implement these opportunities.

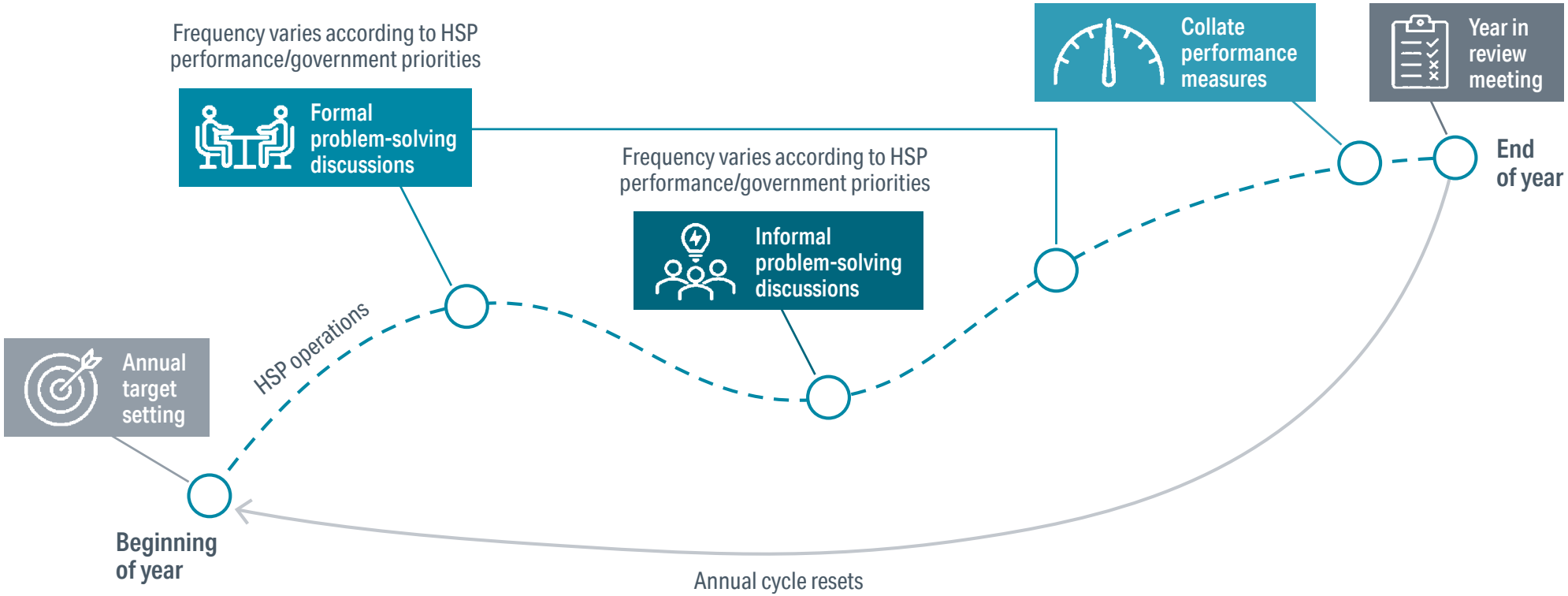
Performance monitoring

> '... It is particularly important that the System Manager has robust processes to gather live qualitative and quantitative information to monitor the performance of HSPs and take remedial action when required.'
>
> Non-government advocacy organisation

Any lower performing HSPs should be managed through more formal and directive performance management and support to improve performance, with graduating interventions to de-risk worsening performance or respond to non-compliance with a binding policy framework.

An annual performance management cycle for HSPs should support this focus on performance assurance and actions to advance local and statewide priorities. This annual cycle is illustrated in figure 8.

Figure 8: Components of annual performance management cycle



The Department of Treasury should be invited to participate in an annual performance review meeting. This would improve visibility of HSP performance and their longer-term trajectory, and gain insights on future priorities, service developments and local conditions.

Recommendations

25. That the System Manager lead a change process to embed accountability for adherence to prescribed requirements and strategic outcomes, including through:
    a. an enhanced relationship and positive performance management system and annual performance cycle for HSPs, focused on joint problem-solving
    b. further developing a health outcomes performance framework with clear outcomes and output performance indicators aligned to health strategies and capturing consumer, supporter and workforce experiences
    c. performance dashboards that provide standardised reporting against a health outcomes performance framework including reporting on specific Aboriginal health metrics
    d. clearly defined graduated performance interventions
    e. engagement of the Department of Treasury in an annual performance review meeting with each HSP.
26. That the performance metrics included in the health outcomes performance framework and associated performance dashboards demonstrate:
    a. alignment with legislative obligations, delivery of government commitments and alignment with the system strategic plan
    b. a balance between qualitative (outcome focused) and quantitative (output focused) performance
    c. clarity on agreed unacceptable deviations and identified 'never events'
    d. a clear and positive bias for higher performance outcomes benefitting Aboriginal people.

More support for innovation and improvement

Previous reviews have emphasised the importance of establishing structured support for sharing innovation and systemwide collaboration for improvement. The Panel reinforces the importance of the potential for greater incentivisation for local clinician led improvement and innovation aligned to system priorities.'

> '…Innovations that would shift the system to more community focused care are not actioned as they are not directly related to hitting the targets.'
>
> Public consultation survey respondent

Flexible commissioning

In the medium term, service agreements could incorporate specific funding levers targeted at incentivising the delivery of high value care and the commitment to contemporary service delivery models.

Where activity-based funding is available for a contemporary service model such as telehealth, incentivisation would be driven through fractional payment for delivery below an agreed target and above level payments for delivery exceeding the target. This motivates shift to contemporary care with high performing HSPs being able to reinvest in value improving opportunities.

Underperformance would be managed through the performance management cycle.

Where no activity-based funding stream is available, such as community-based hospital avoidance models of care, an incentive funding pool would need to be top-sliced from the total purchasing pool. Shared risk models can then be leveraged where HSPs are encouraged to implement innovative models with mutually agreed outcomes and recurrent funding committed upon demonstration of successful implementation.

Workforce growth and retention is another opportunity for incentive agreements. An example would be shared risk funding for increasing the new graduate workforce underwritten by the System Manager but with clawback of funding if targets are not met.

Financial incentives could include allowing HSPs to retain earnings to reinvest in improvement initiatives and internal capabilities (including digital capabilities) aligned with statewide service, infrastructure and ICT strategies and plans (see recommendation 11c).

> '…HSPs and their staff appear not to be incentivised to support coordinated care between general practice and state-funded programs and services, nor are they incentivised to support integrated care initiatives that improve the interface between general practice, hospitals and other health services – the kind of outcomes anticipated from the Sustainable Health Review.'
>
> Professional body public submission

Clinical leadership

Clinical leadership is critical to innovation and improvement in health care. The Panel found that WA's health system would benefit from greater investment in emerging clinical leaders and stronger clinical engagement in system leadership.

The Clinical Excellence Division of the System Manager has prioritised its assurance functions and does not currently use its vantage point and economies of scale to coordinate, encourage and facilitate improvement efforts across the system.

The Clinical Senate and clinical networks are established mechanisms to bring collective knowledge, experience and wisdom to create innovative solutions to improve health outcomes and the experience of delivering and receiving care.

The ability of the Clinical Senate to contribute ideas and solutions is hampered as they do not participate in the Health Executive Committee and there is no formal accountability for their recommendations to be actioned. Compared to other jurisdictions the Senate is positioned as an advocacy group than a strategic partner.

A revitalised Clinical Senate, stronger mandate for clinical networks and collaboration on other clinically-led mechanisms for systemwide improvement initiatives would help to share local innovations and support structured approaches to tackling variations in quality, safety and health outcomes (see also recommendation 8e).

Recommendations

27. That the System Manager develop shared risk incentive funding within service agreements to support HSPs to prioritise contemporary models of care and high value care initiatives.
28. That the System Manager support sharing of innovation and systemwide collaboration for improvement through:
    a. revitalising the role and influence of the Clinical Senate and clinical networks in designing and leading improvement projects
    b. strengthening clinical engagement, including engaging emerging clinical leaders in system improvement processes.

Local collaborative commissioning

> '…the Review must make recommendations to address the disconnect between the stated commitment of the Health Service Providers and their boards and the lack of operational engagement of the core primary healthcare network'.
>
> Peak body submission

Many of the survey responses and submissions to the Panel emphasised that stronger collaboration with Aboriginal health services, primary care, aged care and disability services would help to improve consumer experience and reduce avoidable hospital demand.

The Panel heard about localised examples of HSPs working with local partners to plan care pathways for people living with chronic disease, manage aged care transitions and co-ordinate suicide prevention initiatives, especially in regional WA.

However, the Panel also heard that this work is typically organised and supported through individual relationships.

The involvement of primary, disability and aged care sectors in strategic leadership forums (see recommendation 8b) and greater support for local service integration would make it easier for services to work together and share good practice.

> 'Beyond WA health services, a much wider network of community services delivers care and support to people in their homes and communities, and it is important to leverage existing expertise and leadership.'
>
> Peak body public submission

The National Health Reform Agreement envisages collaborations to jointly plan and fund services at a local level to improve the interface between acute, primary and community care and support delivery of care in home and community settings.

Commonwealth and State commissioning authorities should foster a local learning system to trial and improve joint ways of working. Collaborative commissioning practices should be built on shared outcomes and data analysis, collaborative models of planning, active participation of local clinicians and consumers in the design of services, creative use of workforce capabilities and alignment of incentives and performance monitoring.

Experience from other jurisdictions demonstrates the practical benefits of building local commissioning expertise and targeting joint planning and service development to specific groups of patients and particular health needs. Local collaboration is important to ensure geographic, demographic and cultural contexts are explicitly factored into the design of health services. Targeting specific priorities can help to build momentum on delivering care in the least acute setting appropriate to the patient's need and integrate care across a patient's journey, so they experience continuity of care. Clinical and consumer engagement can be purposeful about connecting virtual and physical health care, the redesign of referral pathways, and appropriate decision-supports. Shared care approaches have been shown to support a stronger focus on prevention, wellness and empowering patients to be active partners in their own care.

A targeted approach to shared care also enables a shared view on opportunities to trial different workforce models to share capacity to improve service access. Real-time data and common performance indicators enable commissioning bodies and local practitioners to monitor patterns of service demand and usage and the impact of integrated service models on patient experience and outcomes. Fostering local learning systems, based on shared evidence, insights from data and consumer feedback, and collective compassionate leadership creates the conditions for continuous improvement.

The Panel recommends the creation of 3 local commissioning authorities responsible for leading collaborative planning and funding of services on behalf of the WA health system.

The authorities should operate at arms-length from HSPs and service the north, south and east of the State. Operating across HSP catchments will assist in improving equity of access and avoid any conflicts of interest in commissioning of services.

The commissioning authorities would be jointly accountable with WAHPA and Aboriginal health services for designing local care pathways and commissioning services to improve care and outcomes for defined populations.

These authorities should also partner with other commissioning bodies – such as the National Disability Insurance Agency and local aged care authorities to share analytics and co-ordinate the design of care models and pathways that make best use of collective expertise and resources. New workforce models should also be explored, including multi-disciplinary care team models, use of secondary consultation and creative use of professional capabilities to improve care and outcomes (see recommendation 38).

The Panel recommends that the System Manager confirm early priorities for local commissioning, recognising that this will require negotiation with the Australian Government Department of Health and the Independent Hospital Pricing Authority.

Mental health and chronic disease management for senior Western Australians have been identified in consultations as potential early priorities for local collaborative commissioning.

Given differences in service availability, geography and demographics, commissioning authorities should have discretion to agree with their partners how best to work with local service providers and professional groups. Each commissioning authority should use data to design service pathways and models, based on local needs analyses.

> '....consumers and carers are often the people who experience the fragmentation and lack of integration across the various elements of the health system and as such, can add significant value to how those relationships could be improved.'
>
> Consumer peak body public submission

Each commissioning authority should work with local partners to:

- define shared goals and a common focus on improving consumer experience and equity of access to appropriate care
- drive the design of step-up and step-down service models to ensure safe and timely transitions between hospital and community-based services and prevent unnecessary hospital presentations
- support consumer, carers and family participation in the design and implementation of new models of care and care navigation supports
- build a shared view on how to advance interoperability of patient records to improve patient convenience and multi-disciplinary collaboration
- share insights about flows and consequences of new care models and options to support health service coverage
- drive whole of community approaches to tackling the social determinants of health and measure the outcomes
- build a shared view on workforce planning and development
- foster a learning system to support continuous improvement and innovation.

Expenditure and outcomes reporting and evaluation of both collaborative commissioning practices and pathways, and models of care should be established quickly. This will enable learning, refinement of commissioning practices and service models and sharing of good practice.

Experience and outcome measures should track whether care models reduce avoidable hospital admissions and improve access to appropriate care in the community.

Over time as processes and practices are developed, there may be value in standardising aspects of collaborative commissioning occur across WA.

The innovative funding pool under the National Health Reform Agreement and bundled primary care payments could be applied to support redesign of incentives for collaborative commissioning of acute and primary care in mental health and in particular chronic disease streams.

The System Manager should support early trials of collaborative commissioning by facilitating:

- linking of administrative data to inform locally designed care pathways and models of care for defined populations
- access to other enablers, such as digital technologies, business analytics, implementation support, quality and safety programs, and professional development programs for commissioning authorities and participating practitioners and managers
- engagement with professional bodies on new workforce models, which lift the status of primary care and generalists, support greater use of nurse practitioners and allied health roles in care teams, and facilitate career medical officer and procedural GP pathways (see recommendation 38b)
- funding reform, including necessary approvals for commissioning authorities to trial innovative payment models
- measurement of aggregate costs, health outcomes, impacts on hospital (including emergency department) demand and opportunities for long-term cost avoidance from collaborative commissioning models
- sharing of insights and good practice between commissioning authorities.

All efforts should be made to incorporate hospital activity funding into the funding parameters for early collaborative commissioning. Discussions have been underway with the Commonwealth on opportunities for collaborative commissioning for some time. The Panel recognises that the inclusion of funded hospital activity in a regional commissioning model would require approval by the Commonwealth and the Independent Hospital Pricing Authority.

Recommendations

29. That local commissioning authorities are created to support planning, resourcing and performance management of mental health and targeted chronic disease management services with:
    a. the System Manager retaining responsibility for setting the policy and funding parameters for collaborative commissioning and overseeing the performance of local commissioning authorities
    b. three skills based local commissioning authorities servicing the north, south and east of the State and given responsibility to join up key pathways of care
    c. structured consultation processes be established to include Aboriginal health, primary health and aged and disability services.
30. That devolution of planning, resourcing and performance management of mental health services and a targeted chronic disease stream is staged, with:
    a. local commissioning authorities initially taking responsibility for local assessment of the needs of their populations, and in designing at scale trials for new service and funding models for mental health and wellbeing services and for a targeted chronic disease stream
    b. these authorities progressively assuming additional responsibilities, starting with at least one authority leading a co-commissioning trial with Commonwealth commissioning authorities to test and track:
        i. alignment and co-ordination of funding incentives and potentially innovative payment models
        ii. improved information-sharing and cross-sectoral collaboration in the design and delivery of services
        iii. shared use of workforce capabilities
        iv. co-ordinated monitoring of performance by holding service providers to account for outcomes, monitoring the strength of provider partnerships, assessing quality and safety through data collection including consumer perspectives and provide leadership and support on improvement, innovation and integration.
31. That the System Manager lead a program of sustained development of commissioning capabilities within the System Manager and with the 3 new local commissioning authorities to drive ongoing collaboration and sharing of good practice.

Data access and information flows

> 'Standardised data capture across HSPs for accurate benchmarking and KPI measurement'
>
> Workforce consultation response

The WA health system produces vast amounts of data but there is currently inconsistency in how data is reported to HSP boards, the Minister and the System Manager. This makes it difficult to translate data into knowledge and knowledge into practice to improve the consistency of clinical and performance outcomes.

Some HSP boards view System Manager assurance and oversight functions as an encroachment on their own responsibilities. This misunderstands the role of the System Manager to actively contribute to increasing value from public health care and assure government and the community that all HSPs are consistently providing high-quality, safe services and continuously improving the value of health care.

All data should be shared openly and transparently unless there is a reason not to do so, such as to ensure appropriate protections for patient privacy and confidentiality.

Continuing to mature integration and use of data will provide richer insights on population health and systemwide trends, helping to identify areas for improvement and investment. Better insights can inform improvement strategies and models of care.

Full transparency must be expected of HSPs – the withholding of critical information on health roundtable reports and financial and risk information diminishes trust and places the system at unacceptable risk. Reporting can be streamlined to reduce administrative burden, but it also needs to be enhanced to improve insights for system planning, commissioning, emergency management and performance management.

Alliance governance requires greater transparency and open flows of information. The System Manager and HSPs should collect and use real time data to manage system capacity and flow, prioritise improvement projects and inform the design of new services, pathways, roles and partnerships. There should be an increased focus on patient experience and outcomes, staff wellbeing and workplace culture – all of which impact on quality of care.

The System Manager should continue to negotiate with the Australian Government Department of Health to access and link Commonwealth data sets to enable shared insights on aggregate costs, health outcomes and hospital demand arising from total Commonwealth and State health expenditure.

The System Manager should also be responsible for reporting to government and the wider community about public health system performance to improve the accessibility and comparability of performance information.

Performance dashboards should be developed to support:

- performance discussions with an individual HSP
- collective discussions with HSP board chairs and CEs about whole of system strategic risks, performance challenges and improvement priorities
- transparency for the Minister and central government
- public reporting of health system performance.

The performance dashboards should provide standardised reporting against a health outcomes performance framework including reporting on specific Aboriginal health metrics (see recommendation 25).

Recommendations

32. That HSPs are accountable for more streamlined, open and transparent sharing of data with the System Manager, while maintaining appropriate protections for privacy and confidentiality.
33. That the System Manager facilitate a single source of truth for performance data in a consistent format to reduce duplicative reporting, ensure consistency of access and interpretation, and support timely benchmarking.
34. That the System Manager develop performance dashboards and take responsibility for sharing performance information with the Minister, central agencies and the community.
35. That the System Manager continue to mature measurement and evaluation of health outcomes and expenditure, including through:
    a. collaborating with the Australian Government Department of Health and WA Primary Health Alliance to measure the impact of total health expenditure on health outcomes and hospital demand
    b. working with the Office of Digital Government to incorporate adult population health statistics into the existing whole of government linked child population health data sets to inform and track the impact of preventative and population health initiatives.

Real time data to optimise system capacity and flow

> 'There is a significant need for greater visibility of the performance of public health services in real-time, 24 hours a day, 7 days a week'.
>
> HSP submission

Real time functional performance data on acute public hospital facility capacity and flow is essential to ensure the system can flex and respond to demand surges. The System Manager requires granular visibility of real time acute system capacity to enable tactical system support. Central visibility of capacity and flow requires integration of ambulance, emergency department, and procedural and overnight bed capacity. As data capability matures, it would be desirable to also build central visibility of private sector, primary care and subacute sector capacity.

The proposed State Health Operations Centre will provide operational capability to establish and manage escalation processes in response to capacity constraints at an individual HSP or across the HSP network. This will enable strategic load share of activity across the system during peak demand times, optimise the movement of patients across HSPs for step-up to higher level care or step-down care, coordinate access to private sector capacity and optimise balance between emergency and planned care activity.

> 'Use of business intelligence and other data systems to inform service need and to be able to see, in real time, where service delivery pressures exist to enable prompt action/responses.'
>
> Workforce consultation response

Data informed business intelligence should also be optimised to assist strategic and operational planning to manage equitable and timely access to planned care. The System Manager should oversee a single source of data including inflows, activity and outflows for planned outpatient care and procedural services. This will allow collaborative engagement across the HSP network to optimise capacity.

Recommendations

36. That the proposed State Health Operations Centre be prioritised with activities informed by real time data on acute hospital capacity and patient flow, enabling tactical coordination of capacity load share across the system.
37. That the System Manager utilise HSP planned care demand and capacity data to:
    a. improve equity of access to services across WA
    b. enable predictive modelling
    c. inform service delivery capacity investment decisions.

A system approach to workforce strategy development and management

Workforce pressures are a particular area of concern across the health system with the issue being raised consistently by stakeholders. The need to ensure the health system attracts and retains staff is critical to the delivery of health services. It is well documented that there is a national and international shortage of experienced clinical and support staff and that this will continue for the foreseeable future as demand for health services grows.

The COVID-19 pandemic has exposed the structural weaknesses in the WA health with a reliance on the use of overseas workers for extended periods of time. This practice has also denied the opportunity for local citizens to have access to rewarding, skilled jobs in their communities. Strategic planning should focus on working with our learning institutions to train the local skilled workforce of the future.

The ability to attract and retain staff and ensure that there is appropriate flexibility and mobility across the system is critical to ensure best patient outcomes. Employment practices and processes are highly fragmented resulting in a system that is not agile enough to respond to needs of its patients or the workforce.

Health employees should be encouraged to develop their skills and advance their careers. Mobility and flexibility to move throughout the system is important in this regard and the standardisation of employment practices across the system will facilitate this.

The move to a more connected model of system governance, the standardisation of employment processes and practices across HSPs and the centralisation of key functions to HSS and the System Manager will be critical to addressing these issues. This can be achieved within the current employment arrangement through the implementation of the recommendations of this report.

Tracking the delivery and impact of these measures will be critical to building the value proposition of the WA public health system. The employment model may need to be revisited if effective collaboration is not achieved and progress cannot be made in improving recruitment processes, the consistency of workforce experience and career pathways.

Central leadership on workforce development

> 'There is no effective workforce planning across the WA health system with individual HSPs essentially in competition for labour with no consideration given to system priorities.'
>
> Union submission

Recommendation 26 of the SHR outlined the need for an integrated workforce information system to support workforce planning and to support linked information including payroll and all human resources functions. It also highlighted the need for a 10-year health and social care workforce strategy to be developed including a focus on training, placements, interdisciplinary approach to care and regional care delivery.

System managers across the country have historically been challenged to guide workforce development, relying mostly on local governance systems that, although often effective, lack consistency and economies of scale. WA is no exception. Workforce support functions are dispersed across the System Manager and HSPs. There are isolated stories about workforce initiatives that are not shared across the system. The COVID-19 pandemic has only reinforced the need for central leadership to co-ordinate, facilitate and track the impact of actions to address labour shortages, align workforce models to future service models and maintain a value proposition for a current and prospective clinical and support workforce.

The Panel notes that the System Manager has commissioned external assistance to develop a new Human Resources Management Information System (HRMIS) and a 10-year health and social care workforce strategy.

The strategy should consider the future leadership and executive structure, with a view to maintaining cost control while enabling HSPs to respond to changing demands. The System Manager should continue to review applications for new executive positions and determine their appropriate classifications consistent with broader public sector policies.

Workforce data collection and reporting has been identified as an early priority for action by the Panel. We note the contract to develop HRMIS and that the project completion date is June 2025. The Panel recommends that this project be fast tracked and that the project completion date be bought forward.

A Strategic Workforce Development Unit should be established within the System Manager to provide leadership including engagement with the health workforce, professional leads, Chief Information Officer (CIO) and partnerships with HSPs and professional and industrial partners. This will be critical to delivering these strategies to develop the pipeline to boost the local workforce, develop new roles and improve career pathways in physical and mental health.

Tackling inconsistencies in employee experiences

The Panel's consultations highlighted the inconsistencies in experience for employees across the health system and the confusion, complexity and duplication that has occurred as a result. Many employees work across HSPs and must navigate different policies and systems. There is duplication of effort by HSPs and for employees, who must comply with the unique requirements of each HSP on what are fairly standard workforce matters.

> 'There are a wide range of matters where each HSP has developed a unique policy and/or approach to the application of employment conditions or entitlements. In addition to this unnecessary duplication, there is an absence of thought for the many people who work across HSPs and must navigate different expectations and systems depending on where they are working that day.'
>
> Union public consultation submission

This inconsistency in the application of the terms of awards, agreements and government policy has also resulted in industrial disputation.

The fragmentation of responsibilities and capabilities detracts from the ability of the system to develop best practice employment policies and processes, and to implement them consistently. Examples of issues raised by staff include the use of contracts, family friendly working arrangements, working from home and access to training and development.

Mandatory policies should be introduced that require compliance with the terms and conditions of awards and agreements, government policy and legislation (see recommendation 20h). Ongoing processes should be embedded in the system that allow the System Manager and HSPs to share best practice and jointly solve problems to ensure consistency in policy development and implementation (see recommendations 8d and 25a).

Timeliness in recruitment

There are several practices within the health system that create delays in the employment of new staff. These practices have resulted in workarounds which undermine the oversight, governance and management of the health workforce. It has impacted on the integrity of workforce data and capacity of the system to recruit and retain staff.

There are existing practices which have resulted in a complex process by which a new position number (PN) is created, often taking 6 to 9 months. This process is required even where there is no change to the responsibilities or pay. Due to the complexity and length of the PN creation process, multiple employees are employed on an ongoing basis against a single PN rather than creating a new PN. The process to create an employee number is simple and can be facilitated through HSS very efficiently. This has become common practice.

Current data provided to the Panel demonstrated the extent of the problem with approximately 32,890 people employed against just 5,537 position numbers within both the System Manager and HSPs. As a result, the only accurate employee data is currently derived from the payroll system so is always retrospective.

There are a number of flow-on effects from this arrangement including:

- a lack of organisational structure that clearly identifies staffing needs across the system
- an inability to monitor staff vacancies and respond appropriately to ensure best clinical outcomes
- a significant mismatch between the PN data and employee number data resulting in a lack of transparency that undermines the ability to properly assess workforce needs in the short term and future workforce strategic planning
- the number of people permanently employed against the PN resulting in many ongoing employees being retained on contract, which has a number of financial and personal implications for those individuals
- undermining the ability to advertise secure employment arrangements in order to attract and retain staff.

It is recognised that in circumstances where there are backfilling arrangements in place that other employees will be held against an existing PN, but this should only occur in clearly defined circumstances as is common practice across the Western Australian public sector.

The creation of PN for employees should occur as a priority and is not dependent on the implementation of the new HRMIS system.

The existing end-to-end recruitment process also results in delays in bringing on staff and while it is acknowledged that significant efforts have been made to streamline this process, there are inherent delays in the system because of the fragmented employment practices between HSPs.

Standardisation of recruitment practices and processes, and greater utilisation of the capacity of HSS to manage more of the end-to-end recruitment process will drive further efficiencies and improve the timeliness of the system.

A centralised website that provides an opportunity for potential employees to understand the breadth of the employment opportunities across the health system and promotes the system as an employer of choice should be established. The website should allow for individual HSPs to promote themselves in a positive light and describe their offerings in a positive way. The website should be used as the reference point for all advertised positions removing the need to individualise adverts except in unique circumstances.

During the early stages of the COVID-19 pandemic, HSS created standardised requirements around issues such as pre-employment health and safety checks and fit testing and coordinated the recruitment of the additional workforce. All HSPs utilised these employees and accepted the veracity of the onboarding process.

These standardised practices should be maintained to ensure a streamlined process to recruit new employees but also to provide flexibility across the system. Currently all HSPs have their own version of the onboarding process and employees are required to undertake the process each time they move between HSPs.

Pool recruitment processes are also underutilised within the health system. The use of pool recruitment for identified occupational groups can add significant efficiencies when employing staff noting however, that the final selection decision should rest with the HSP but that when making the decision to employ, the onboarding process has been largely completed.

> '... systemwide recruitment pools could reduce duplication of effort and create a more streamlined, consistent experience for potential WA health system employees. More agile approaches to allocating nursing staff across the system would prevent HSPs competing for the same resources where there is a limited capacity in the market'.
>
> HSP public consultation submission

Training and future workforce supply

Workforce supply is a critical issue facing the sector and is both a short-term and long-term issue that requires significant and sustained attention. The Panel notes the System Manager has commissioned work on a 10-year health and social care workforce strategy.

Consultations highlighted university fee subsidies, through Commonwealth supported places, as critical to building a sustainable pipeline of medical practitioners.

Ongoing investment in training and development opportunities for existing staff will also be important to retain and develop staff as the future leaders of the system. Staff feedback highlighted the desire for an organisation with a culture of learning embedded in the system for all staff including non-clinical staff.

> 'Recognition of learning as part of core business.'
>
> Workforce consultation response

Training and learning opportunities should be clearly articulated and made available and supported by mentoring. Consistency of training opportunities across HSPs was also noted and the need to recognise and carry the recognition of the training undertaken, when moving between HSPs.

Staff also expressed a desire to have more mobility across the system and that this should be actively encouraged and facilitated as an opportunity to share experiences and learning across health to grow, innovate and sustain good practice.

> 'Shared resourcing/knowledge pools across the health system for different areas which enable expertise to be shared.'
>
> Workforce consultation response

Stakeholders also emphasised the importance of generalist roles and more flexible deployment of competencies to address labour gaps and improve job satisfaction. Consumer representatives also emphasised the importance of patient-oriented roles (alongside clinician-led roles) to support consumer engagement and system navigation.

Systemwide collaboration will be critical to design and test different ways of deploying competencies and designing jobs to continuously improve the experience of receiving and delivering care, to provide staff the opportunity to work to their full scope of practice and to support the introduction of new models of care.

The Panel notes that the profession of the Aboriginal health practitioner is nationally accredited and registered to provide safe, high-quality care to Aboriginal and non-Aboriginal people. The review supports the establishment of Aboriginal health practitioner positions to support better health outcomes for Aboriginal people and would recommend that priority be given to training a local workforce particularly in regional locations. The introduction of these positions should be supported through regular cultural safety training.

The Panel further notes that the State Government has adopted the recommendations of the Ministerial Taskforce into Public and Mental Health Services for Infants, Children and Adolescents aged 0–18 years in WA which includes the creation of Aboriginal mental health workers with clear roles, capabilities and career pathways.

Placements

> 'Workforce planning will require shared responsibility from the Universities, HDWA [Health Department WA], the Area Health Services, Commonwealth Health Department of Australia, but also the Medical Specialist Colleges and Societies who control the advanced training places.'
>
> Medical School

The over reliance on trained and skilled overseas staff has been exposed during the COVID-19 pandemic. The solution to this requires a systemwide response, working together with our educational institutions including stronger obligations on the HSPs to support the development of a locally trained workforce.

Most clinical students cannot graduate without undertaking practical placements as a mandatory component of their studies. There is no structured process within the health system to coordinate the placement of students and it is almost primarily relationship based. Difficulties accessing clinical placements for students in training and the competition for them was raised as the significant barrier to growing local workforces.

Universities and TAFEs have individual relationships with hospitals and HSPs and work through key personnel to secure places for their students. Places are often cancelled at very short notice and there is no planning at a hospital or HSP level that identifies local or system need for different occupational groups. Competition exists between occupations for limited placement positions.

A systemwide placement program should be established in consultation with the chief clinical officers that identifies the required skill mix across existing and new roles in the health system, and the system capacity to facilitate placements, and coordinates the placement of students with educational institutions.

Dedicated resources are required to ensure that this program is properly implemented. This includes a placement unit to manage the relationship with the education sector, HSPs and the chief clinical officers and a dedicated resource within the hospitals to support the placement program. This unit could reside within HSS with the policy and strategy work being undertaken by the Strategic Workforce Planning Unit within the department.

Obligations for the HSPs to participate in the program should be detailed in their service agreements and in a Clinical Teaching and Training mandatory policy.

Consideration should be given to embedding a requirement to facilitate placements as part of any service agreements with private hospitals undertaking work on behalf of the WA health system.

Consideration should also be given to exploring the placement opportunities that exist within the WA Primary Health Networks, Aboriginal health organisations and the aged care sector with WA health system providing a leadership and coordinating role.

The opportunity to support newly qualified graduates in a structured way also needs to be considered. HSPs preference for experienced employees actively works against the local training strategy with this often resulting in overseas staff being employed. Structured support through dedicated resources will assist HSPs to employ more local newly qualified graduates and will help address this issue.

Regional workforce

> 'Increased linkage with rural and remote medical centres to offer clinics in varied settings - allied health as well as medical. Excellent learning opportunity and better provision of localised care for clients.'
>
> Workforce consultation response

Clinical outcomes for regional patients will be supported by the shift to a networked model of system governance that embeds a shared culture of responsibility for the performance of the public health system. Critical to this is the provision of a skilled workforce in regional and remote Western Australia supported by services delivered in the metropolitan area.

There are several complimentary strategies that should be considered including the training of more regional community citizens as the future workforce and through structured fly in fly out arrangement (FIFO) built into contracts for identified clinical staff primarily based in the metropolitan area.

> 'Ability to work fly-in fly-out drive-in drive-out; subsidised accommodation; transition assistance from metro to regional; support/network groups to find friends'
>
> Workforce consultation response

The training of a local workforce should be done in consultation with the education providers and professional colleges and utilise a range of tools including remote learning and supervision. These tools have been deployed during the COVID-19 pandemic and should be expanded to provide opportunities for regional people to be trained and employed within their communities.

Particular attention should be paid to the need to support the training of Aboriginal people within the health workforce including Aboriginal health practitioners, nurses and doctors. As a priority this should include clear pathways to gain Aboriginal health practitioner and enrolled nurse qualifications with progression through to registered nurse training and qualifications.

> 'Greater employment of Aboriginal health workers, liaison officers and practitioners to improve communication, engagement and quality of service to our Aboriginal community. Especially for statewide services trying to reach out.'
>
> Workforce consultation response

Staff feedback indicated support for temporary deployments and short and long rotations into regional and remote locations. This included structured arrangements built into specific designated positions with agreement that the employee would work across metropolitan and regional locations on regular rotation built into the employment contract. Issues that need to be addressed include access to housing, employee safety, training, mentoring and the appropriateness of existing allowances.

> 'A structured program to allow for swaps of staff i.e., rural nurses swap with tertiary nurses for twelve-week placements.'
>
> Workforce consultation response

Clinical outcomes will also be supported through the implementation of governance arrangements that support the timely transfer of patients based on need and the enhanced use of telehealth arrangements supported through HSPs.

The Panel also supports the introduction of a classification structure for Aboriginal health practitioners and recognises the need to ensure that the introduction of these positions is supported through regular cultural safety training.

Recommendations

38. That a Strategic Workforce Development Unit be established within the System Manager, with responsibility for monitoring systemwide workforce capacity and working with the health workforce, professional leads, local commissioning authorities, HSPs and professional and industrial partners to:
    a. ensure standard employment policies, practices and processes are implemented across HSPs
    b. develop new roles, expand scopes of practice, support the training of the future workforce and deploy competencies to meet system demand and deliver new models of care
    c. support career pathways for generalist roles, such as career medical officer and procedural GPs
    d. develop patient-oriented lay roles to work alongside clinical roles and support consumer engagement and system navigation
    e. provide advice to the Director General on health executive roles and classifications.
39. That the implementation of Human Resource Management Information System be fast tracked to ensure mobility across the system and consistent reporting of workforce data in order that workforce planning and issue identification can be implemented as a priority.
40. That as part of the Human Resource Management Information System implementation, a single employee number is assigned to a staff member and continues with them if they move between HSPs.

41. That the consistency of experience for the health workforce is improved through:
    a. mandatory policies on specific issues including compliance with awards and agreements, state government legislative and policy requirements with clear accountabilities for the implementation
    b. an ongoing collaborative process on systemwide issues for industrial relations, mandatory training competency requirements and human resources policy development
    c. the creation of a dedicated unit for industrial relations and human resources expertise and advice within the System Manager to ensure a consistent application of award and agreement entitlements and policies across HSPs.
42. That timeliness of the recruitment of staff and mobility throughout the system is increased by maintaining and enhancing process and practices in recruitment adopted during the COVID-19 pandemic, including through:
    a. creating a position number (PN) for each ongoing position and limiting the employment of additional staff against a single PN for backfilling arrangements in clearly defined circumstances and for specific periods of time
    b. only requiring an application to the central reclassification committee where a new job definition form is required
    c. the further centralisation of the recruitment processes to Health Support Services with mandatory streamlined processes around advertising and onboarding employees but with the final selection decision remaining with the HSP
    d. the implementation of pool recruitment processes by Health Support Services for identified occupational groups with the final selection decision remaining with the HSP.
43. That strategies be implemented to support the future workforce needs of the WA health system including:
    a. continuing to advocate to the Australian Government to open up Commonwealth supported places to support a sustainable pipeline of medical practitioners
    b. the facilitation of training and development opportunities for existing staff across all occupational groups and the rotation of employees between HSPs to support professional development and good clinical practice
    c. that an Aboriginal health practitioner classification structure be created
    d. that a centralised placement program and unit be established to manage placements with an obligation for the HSPs to participate in the program detailed in their service agreements and in a Clinical Teaching and Training mandatory policy
    e. define structured support for new graduates and systemwide pathways to employment and career progression through the 10-year health and social care workforce strategy
    f. working with educational institutions to increase the opportunities to train regional and remote citizens to become the local workforce
    g. developing structured arrangements to support metropolitan staff to work in regional and remote locations (fly-in fly-out and drive-in drive-out).

Central major projects capability

> '... the system requires significant uplift in its capabilities in major program and change delivery (including the technical components of that) to successfully implement the large number of major reform programs currently planned (e.g., major digital transformation programs and multiple infrastructure projects).'
>
> HSP submission

Work has commenced on both a long-term infrastructure plan and the implementation of the digital roadmap which will guide future decisions about major project investments. This will build on the existing pipeline of major digital projects such as electronic medical records and new hospitals, hospital rebuilds and upgrades. New builds include Bunbury, Geraldton, Newman, Tom Price, Laverton, Meekatharra, Fremantle, Joondalup, Peel, the new Women's and Newborns hospital and the future Graylands hospital reconfiguration. ICT and infrastructure requirements for health and mental health delivery will continue to evolve as the population grows, new models of care are developed and assets age.

The future capital works program and long-term system outcomes should be supported by the development of a rolling infrastructure plan that prioritises future new builds, redevelopments and repurposing of existing assets, including consideration of non-built innovative solutions, against a statewide health strategy (see recommendation 2). This should ensure that decisions can be made to manage systemwide risks, reduce variation and enable standardisation of fit-for-purpose health infrastructure across the State. This also provides opportunities to consider the infrastructure needs and specifications against new models of care and future needs.

The governance responsibility for overseeing the delivery of previous ICT and infrastructure projects has resided within the individual HSPs in most instances. This approach risks fragmentation of the expertise for managing complex projects across multiple HSPs and works against coordinating a pipeline of work across the health system from a systemwide perspective that builds corporate knowledge and attracts and retains experience. This also hinders the ability to leverage expertise from outside the WA health sector.

A Major Health Projects and Infrastructure Directorate has been established within the System Manager to provide stewardship, governance, negotiations at whole of government level and assurance to the delivery of all major projects. The role and capability of this directorate should be enhanced.

The directorate should be responsible for the initiation of all major hospital redevelopments, new hospital projects and high-risk projects. These responsibilities should include the development of the business case, project definition planning document, design, securing the funding from government, overseeing delivery and ensuring the facility is ready to commence commissioning. Importantly, this directorate would carry the governance, direction, project management, reporting responsibilities for these projects following government approval and stakeholder engagement.

Whilst maintaining ultimate accountability for the projects as a function of the System Manager, the directorate would work closely with multiple implementation stakeholders, such as HSS where the project relates to digital enablement as part of these projects. This is dealt with in more detail below.

For each project, the directorate will coordinate the relevant subject matter experts, engage with the relevant HSP and organisations to ensure delivery of the project is in line with agreed functional requirements and interdependencies and operational needs are understood. For example, the directorate should be accountable for ensuring alignment between physical infrastructure, digital capabilities, service models, the overall long-term health strategy and clinical planning. A joint leadership group should be established for each project and co-chaired by the System Manager and the relevant HSP.

The relevant HSP would lead the clinical commissioning of the facility and would report through to the Steering Committee (see below) with the directorate overseeing this work.

The directorate should also work with the relevant HSP on a program of community engagement throughout the design and build process.

This approach mirrors the decision taken in other states to centralise their capital works programs.

Minor capital works, low risk projects and ICT investments aligned to relevant HSPs' strategic plans would continue to be managed by HSPs, in a manner that is consistent with statewide policies and standards.

A skills-based steering group should be established to provide oversight and risk management of the portfolio of major projects. Skills sets should include engineering, project management experience in delivering large, complex projects and clinical skills.

Recommendation

44. That the role of the Major Health Projects and Infrastructure Directorate in the department be expanded and strengthened with responsibility to oversee the planning, development and delivery of major projects and capital works supported by project-based leadership groups and a whole of portfolio skills-based steering group.

A stronger mandate for HSS in procurement and digital enablement

> 'When working well, shared services unlock economies of scale and efficiencies; provide the opportunity to pilot innovative/contemporary systems or processes; embed consistencies and coherence across those functions supported by the shared service; and enable HSPs to be agile and responsive to the external environment.'
>
> HSP submission

Procurement

Business support functions at an individual health service level are not optimising value and efficiency. In 2020–21 WA's health system procured $4.8 billion through contracts. While a few contracts make up a significant proportion of this annual value (e.g. Fiona Stanley Hospital Serco contract, Joondalup Hospital, St John of God Midland Hospital, St John's Ambulance service), there are significant pharmaceutical, prosthetics, surgical and medical instruments, PPE and other clinical and non-clinical consumables amount to more than $500 million annually.

At the time of this review, there are a total of 3,847 contracts across the WA health system with the Department of Health managing 675, HSPs managing 1,992 and HSS managing 1,180. It is important that the best value for money is achieved for every contract. The more that the WA health system can use its combined purchasing power to leverage better value by aggregating HSP volumes to reduce costs, the more funding there is available to direct towards clinical services.

HSS is established to facilitate whole of system contracts and analyse where whole of system contracts can be established and used to deliver value for all HSPs and the System Manager. Consultations revealed mixed commitment to leveraging HSS' collective purchasing capability and inconsistent adherence to whole of government procurement policies designed to boost local manufacturing and support Aboriginal businesses.

> 'Current areas of role ambiguity (particularly in ICT, procurement and workforce) result in confusion. Roles are sometimes exercised inconsistently or ineffectively which negatively impacts the system's performance.'
>
> HSP submission

All parties should commit to the shared service model to leverage collective purchasing power, protect the security of supply chains and maximise opportunities for procurement from local and Aboriginal suppliers.

HSS should be confirmed as the central hub for procurement activity and empowered to:

- leverage the collective purchasing power of the WA public health system
- drive improvements in procurement processes by setting procurement policies that guide procurement activities retained by HSPs
- take responsibility for commissioning statewide goods and services (with the exception of pathology services).

HSS should drive value for money and customer experience by:

- increasing goods purchased by HSPs under statewide contracts (negotiated by HSS or the Department of Finance)
- identifying categories of expenditure that should be centrally purchased and distributed
- providing stronger guidance on governance and planning of categories of procurement managed by HSPs
- improving procurement practices, for example procurement-to-pay processes, digitising reconciliation processes and optimising quality and safety through product sourcing decisions
- monitoring and managing adherence to legislative requirements under the *WA Jobs Act 2017*, *Procurement Act 2020* and whole of government policies, including the Western Australian Industry Participation Policy and Statewide Aboriginal Procurement Policy
- influencing supplier behaviour and making sustainable practice a condition of doing business with WA's public health system.

Statewide purchasing of goods and services currently managed by other HSPs (for example linen services) should progressively be consolidated into HSS, with a timetable agreed as part of the 2022–23 performance cycle.

To identify categories of expenditure that should be centrally purchased, HSS should work with the System Manager and HSPs, through the Strategic Leadership Forum, to agree the criteria for statewide and localised procurement and rapidly assess existing local contracts to identify:

- contracts that would clearly benefit from a statewide approach
- contracts where there are possible benefits from a statewide approach
- contracts that would clearly benefit from a localised approach.

The Strategic Leadership Forum should authorise HSS to negotiate new statewide arrangements where clear benefits have been identified.

A more detailed review of contracts in the second category can then follow, to enable the Strategic Leadership Forum to determine whether they should be renegotiated by HSS on a statewide basis, or continue to be purchased locally.

Performance targets and measures for HSS should be refined to reflect these stewardship responsibilities.

Customer engagement in HSS decision-making and direct engagement with clinicians will help to align procurement decisions with system priorities and contemporary models of care. This will ensure HSS can support the best patient experience and care, and equip doctors, nurses, allied health and administrative teams with the supplies and equipment they need to do their jobs.

ICT and digital enablement

Clinically-led digital health solutions that are well integrated with physical delivery of health care can help to improve patient safety and patient experiences. Designed well, digital tools can assist multidisciplinary clinical teams and referring practitioners to work together to connect health care throughout the patient journey. Patients and their supporters can be empowered to be active partners in their own care and access all kinds of health care from the convenience of their own home. This has transformative implications for rural health, where distance to bulk billing care has long been a barrier to early, effective treatment.

Patient convenience and operational efficiencies can also be achieved through streamlining referral management and patient flow. Integrating large volumes of disparate data across the care continuum in a secure and scalable environment, can support the System Manager and HSPs to identify capacity constraints and population health trends, enabling faster and better decision making. Clinicians can be empowered to access new evidence and insights and consult with more senior or specialist practitioners to make informed clinical decisions, resulting in better patient outcomes.

The COVID-19 pandemic has accelerated the development of digital solutions to integrate data and provide virtual care for patients. There is an opportunity to build on this progress, and leverage new hospital builds, to increase digital capabilities.

A stronger operating model for digital enablement, with clearly defined roles and responsibilities for ICT development, will be required to realise these opportunities.

Clarifying roles and responsibilities for digital enablement

> 'There are considerable challenges with determining the roles and responsibilities between SM [System Manager], HSS and HSPs with regards to ICT provisioning and management of the applications and the environment.'
>
> HSP Executive Group submission

The Panel notes the existence of ICT experience and capability across the spectrum of HSPs, HSS and the System Manager. These distributed ICT workforces should work collaboratively and operate within a common strategy and policy framework to align their decisions and activities, while retaining distinctive roles and reporting lines within their own organisations.

System Manager responsibilities

The WA Health Digital Strategy was released by the System Manager in 2020 that creates visibility of intended ICT and application capability that should be implemented to support the delivery of health services.

A rolling digital strategy should be maintained, aligned to priorities of the long-term health strategy (see recommendations 1 and 2). These strategies should clearly describe how and when to deploy digital tools, and how to combine virtual and physical health care to improve the experience of delivering and receiving care.

The Panel notes there is an existing Chief Clinical Information Officer (CCIO) within the System Manager, who will support a new senior executive within the System Manager to lead digital health strategy and planning.

The senior executive should be responsible for the translation of the long-term health strategy to digital enablement and monitoring of the continued alignment of the digital portfolio with statewide health priorities.

HSS responsibilities

Whilst acknowledging a number of digital projects have been progressed, the Panel would recommend the WA Health Digital Strategy be supported by:

- an integrated program plan for delivery of digital projects
- an ICT policy framework that mandates ICT principles and standards and an architectural model to link data and applications and enhance analytics
- a portfolio management model to measure and monitor systemwide ICT costs, timing, resourcing and risk parameters.

Connecting these elements of ICT policy and management will enable the System Manager, HSPs, HSS and external technology providers to perform complementary roles and deliver interoperable ICT capability.

HSS should be confirmed as the lead agency for systemwide ICT development, under direction and service agreement management from the System Manager.

As the lead agency, HSS should be responsible for:

- leading the development and implementation of a WA health system ICT policy framework
- procuring and supporting implementation of statewide core systems and ensuring compliance with statewide data and ICT standards
- providing specialist software maintenance and support services to users of key applications (eg. electronic medical records)
- maintaining WA health system ICT infrastructure
- reporting on all ICT programs at a portfolio level, allowing the ICT Executive Board to understand the risk, cost, timing, resourcing and scope resourcing profile of ICT infrastructure and digital health applications
- working closely with the Data Linkage Unit within the System Manager, WAPHA and Aboriginal Health Council to support linkage of clinical and public health data to inform clinical service planning, population health initiatives and emergency management responses
- defining appropriate cyber-security and privacy protections
- defining data custodianship for data linkage projects.

The HSS Chief Information Officer should be recognised as the Chief Information Officer for the WA health system and lead the development of ICT principles and standards, data and application architecture. The HSS CIO should also manage procurement of ICT solutions and support deployment of those solutions within HSP environments.

HSS should recruit a Chief Technology Officer and experienced staff in ICT portfolio management delivery to support the CIO in fulfilling augmented responsibilities.

HSS should collaborate with HSPs and have ongoing visibility of digital health priorities. This will ensure clarity on when statewide solutions are required to achieve interoperability, efficient pricing and effective change processes and when HSPs can advance digital developments themselves. This will also allow HSS to support and nurture local HSP ICT initiatives and opportunities for innovation.

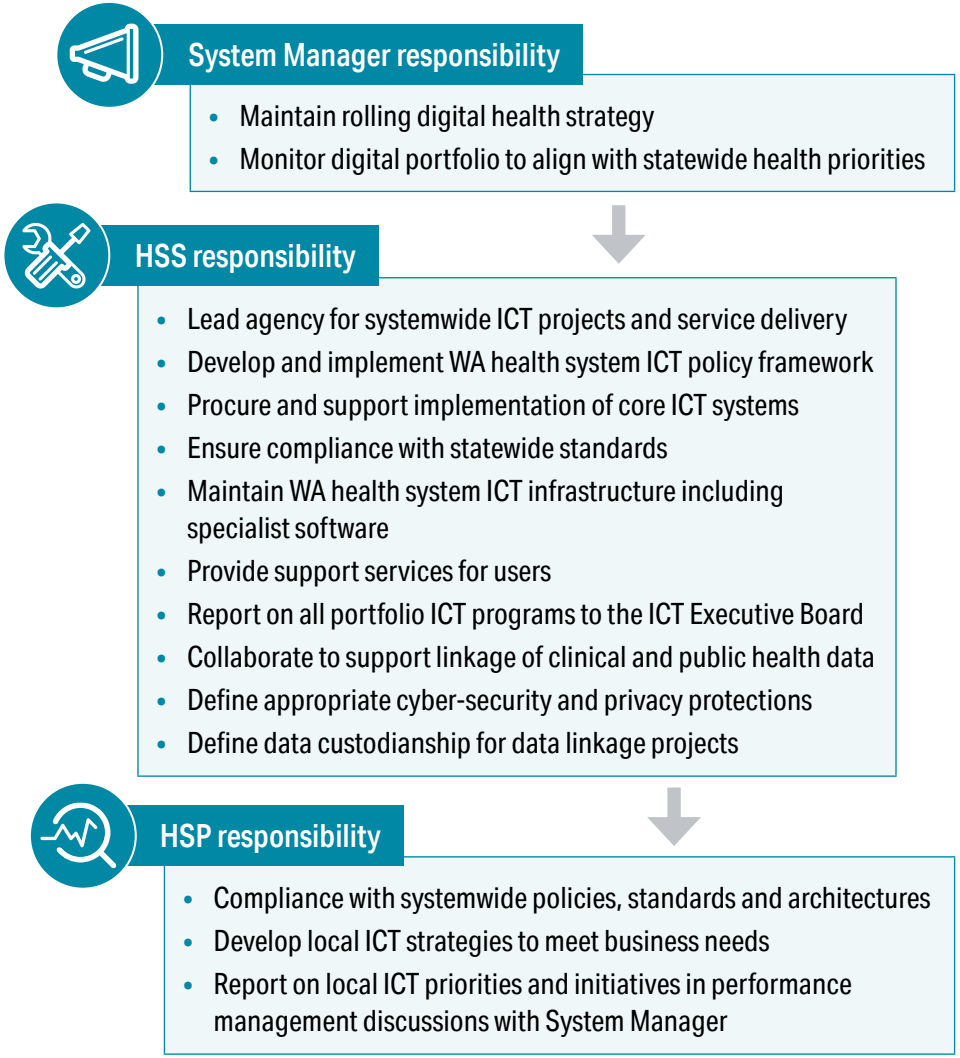
These responsibilities should be reflected in the System Manager's service agreement with HSS.

HSP responsibilities

HSPs should adhere to the policy framework, when working with HSS to implement systemwide core systems. They should also apply systemwide standards and architecture to ensure alignment and interoperability across their own local systems. Their service agreements with the System Manager should establish approval requirements for local ICT strategies. HSPs should report on local ICT priorities and initiatives in performance management discussions with the System Manager to assure adherence to systemwide policies, standards and architectures and enable sharing of ideas and insights about business needs.

Figure 9 summarises the ICT and digital enablement responsibilities of the System Manager, HSS and HSPs.

Figure 9: Summary of ICT and digital enablement responsibilities



Systemwide governance

WA health system's ICT Executive Board should be chaired by the System Manager and comprise of members with suitable technical expertise or project experience. The ICT Executive Board is to manage an annual process of prioritising projects for inclusion in HSS' workplan, communicate these priorities to HSPs and oversee the delivery of major ICT projects. This executive board should also receive reports about local ICT and digital health initiatives from HSS to monitor alignment with systemwide strategies and enable decisions on scaling of local innovations.

Through this executive board and its relationships with HSPs, HSS should also provide intelligence to the System Manager on factors to consider in designing statewide system implementation to manage localised risks and leverage capital developments.

The HSS CIO should convene a digital health reference group, inclusive of relevant leads from the Digital Health Directorate within the System Manager, the CCIO and HSP CIOs. This forum should share information about digital health priorities, collect feedback on technical issues in the roll out of digital initiatives and facilitate consistent interpretation of the ICT strategy, including ICT principles, standards and architecture.

Integrating digital enablement into major projects and health system development

The Panel notes that there are a number of significant infrastructure projects underway including the Women and Newborns Hospital. The Panel recommends that digital enablement be integrated into the development of these projects and incorporate early implementation of enhanced clinical systems, including an integrated electronic medical record system. This will prevent the logical need for physical and technological re-implementation and duplicative change management for staff early in a hospital's operating life.

Clearer governance over digital enablement will substantially support the delivery of ICT as a critical stream of infrastructure and transformational project delivery under the leadership of the Major Health Projects Directorate within the System Manager.

Recommendations

45. That the Act is amended to formalise how Health Support Services guides HSPs procurement activity and engages their customers in strategic decision making by:
    a. empowering Health Support Services to set mandated requirements in the form of procurement and ICT policy frameworks and monitor adherence to whole of government legislative and policy requirements
    b. requiring the Health Support Services Board to establish a Customer Advisory Committee, with an independent chair representation from the System Manager and each HSP
    c. mandating customer representation on the Health Support Services Board from the Chair of the Customer Advisory Committee.
46. That Health Support Services is formally recognised as the central point for goods and services tendering and contracting in the WA public health system drives value for money and customer experience by:
    a. progressively assuming responsibility for statewide contracts currently managed by other Health Service Providers (excluding pathology services)
    b. working with the System Manager and HSPs through the Strategic Leadership Forum to agree on the criteria for statewide and localised purchasing and conduct a rapid review of existing local contracts
    c. recommending to the Strategic Leadership Forum findings from this review on:
        i. contracts that would clearly benefit from statewide purchasing
        ii. contracts where there are possible benefits from statewide purchasing
        iii. contracts that clearly benefit from localised purchasing
    d. assume responsibility for renegotiating local contracts that would clearly benefit from a statewide approach
    e. undertaking a more comprehensive assessment of local contracts which may benefit from statewide purchasing to agree with the Strategic Leadership Group whether any of these should be migrated to statewide contracts.
47. That a systemwide ICT strategy is developed to support implementation of the long-term health and rolling digital strategies by:
    a. defining ICT standards, architectural models and a portfolio implementation framework
    b. supporting ongoing maturation of the ICT operating model.
48. That the System Manager retains accountability for ICT and digital strategy, including agreeing annual priorities for ICT and digital enablement.
49. That Health Support Services is confirmed as the lead agency for systemwide ICT projects and ICT development, with responsibilities outlined in their service agreement including:
    a. leading the development of ICT principles and standards infrastructure, data and application architecture
    b. managing procurement of ICT solutions
    c. supporting deployment of solutions
    d. reporting on all ICT programs at a portfolio level, allowing the ICT Executive Board to understand the ICT risk, cost, timing, resourcing and scope resourcing profile.

50. That the WA health system's ICT Executive Board, chaired by the System Manager, oversees:
    a. an annual process of prioritising projects for inclusion in Health Support Services workplan
    b. the delivery of major ICT projects.
51. That Health Support Services work closely with the Data Linkage Unit within the System Manager, WA Primary Health Alliance and Aboriginal Health Council to advance linkage of clinical and public health data and establish:
    a. clear governance processes for prioritising and authorising the development, access and use of linked data sets
    b. appropriate cyber-security and privacy protections
    c. clearly defined data custodianship.
52. That the Health Support Service Chief Information Officer is recognised as the Chief Information Officer for the WA health system and convene a digital health reference group inclusive of relevant leads from the Digital Health Directorate within the System Manager, the Chief Clinical Information Officer and HSP Chief Information Officers to facilitate:
    a. sharing of information about digital health priorities
    b. feedback on technical issues in the roll out of digital initiatives
    c. consistent interpretation of ICT principles and standards.
53. That Health Support Services ensure that a Chief Technology Officer and experienced staff in ICT portfolio management and delivery support the CIO in fulfilling Health Support Services ICT responsibilities.
54. That HSPs are expected to adhere to the ICT strategy components of standards and architecture to ensure alignment and interoperability, with digital and ICT enablement forming part of performance management dialogues with the System Manager.

Preparedness for future emergencies

The COVID-19 pandemic continues to stretch staffing and management of health service delivery around the world.

Responding to the rapid pace of the pandemic's spread has required a rapid learning system capable of capturing, organising, sharing, and analysing large amounts of data digitally across public health, research, and clinical systems.

The WA health system has demonstrated its capacity to be agile and develop swift responses to a complex, enduring emergency. HSPs are working together, and with the System Manager and HSS, to rapidly mobilise and adapt to changing knowledge and circumstances. New service and supervision models were adopted early in the pandemic and HSPs have continued to deliver critical health services across the State. Examples of successful rapid action include procurement of PPE and provisioning remote desktop access to enable more WA health system employees to work remotely.

The consolidation of public health response capability has enabled peer support to specialist infection disease physicians and timely access to data to inform pandemic planning and responses.

Industrial partners and participants in the health system reflected on the benefits of forums that were created that supported flows of information, rapid mobilisation of new service models, and collaboration across the WA health system. This feedback has informed recommendations about enduring governance mechanisms to support clear strategic directions, strategic alignment and joint problem-solving (see recommendations 6–8, 19, 20, 22, 23, 25a)

> 'The response to the pandemic is an example of where DoH [Department of Health] and the HSPs effectively operated in their respective roles whilst working together to benefit the community.'
>
> HSP submission

Managing the health response has required diversion of significant management and staff resources and the load on particular individuals was significant – consistent with the experience of other jurisdictions.

The COVID-19 experience has demonstrated the need for the system's response practices to concurrently address immediate issues and anticipate and plan for the next issues it expects to encounter. This practice would help the system commence planning earlier on items that have a longer lead time.

The ability to respond can also be strengthened by building the system's business continuity planning and testing in readiness for future emergencies (e.g., cyber-attacks or health emergencies triggered by climate change). Planning for surge capacity should be a feature of all emergency and pandemic preparedness.

Looking forward, there are also opportunities to leverage technology developed for the COVID-19 pandemic for the management of less complex public health incidents. Digital enablement and access to integrated public health and clinical data are critical capabilities for any future pandemic (see recommendation 55).

A decision will be required on whether to maintain centralised incident management capability or devolve responsibilities for functions such as contact tracing back to HSPs.

The Panel heard the rest of government and other sectors impacted by complex emergencies would value as much forward planning and proactive communication as possible.

Earlier in this report we have canvassed opportunities to enhance consumer and clinician engagement – which would enhance the ability of WA to respond quickly and effectively to future emergencies and pandemics (see recommendations 1, 8, 10, 14c, 16, 28). Consumers and Aboriginal health services should be engaged in the design of emergency responses, including any rapid design and mobilisation of new service models. This engagement is particularly important in ensuring responses meet the needs of regional and remote communities.

Further consideration should also be given to how the Chief Health Officer best supports community engagement broadly – including through leadership on health promotion. Community-led and culturally appropriate approaches to health promotion, underpinned by systemwide directions and strategic leadership, contributes substantively to population health outcomes. Local partnerships also build the community knowledge and relationships that matter in targeting communication and responding to complex emergencies.

Importantly the COVID-19 pandemic has demonstrated the capacity of the public sector to work collectively to protect its citizens and economy. Department of Health has maintained a critical role, working with WA Police and the DPC, to drive the State response. Consultations emphasised that the State Health Incident Coordination Centre (SHICC) and State Welfare Incident Coordination Centre (SWICC) have fulfilled critical co-ordinating roles.

A multitude of other organisations including public, private and the not-for-profit sector are working collaboratively with these lead agencies to ensure that the health, social and economic consequences of the COVID-19 pandemic are understood and successfully managed.

Given the range of agencies involved and the intersecting legislative instruments, the Panel would recommend a whole of government review of the COVID-19 pandemic management to capture lessons on what worked well, and what could be improved, to enhance WA's preparedness and response to any future pandemic or complex emergency.

Recommendation

55. That a whole of government review of the management of the COVID-19 pandemic is undertaken to capture lessons on what worked well and what could be improved to enhance WA's preparedness and response to any future pandemic or complex emergency.

Appendix 1: Overview of recommendations

Engaged system leadership – strategy and risk management

1. That the Act is amended to require the Minister for Health to prepare:
    a. a long-term health strategy with a minimum 10-year horizon, which will:
        i. guide health service providers (HSPs) in protecting and promoting people's physical and mental health and wellbeing against clearly defined outcomes
        ii. explicitly address how the health portfolio will contribute to whole of government priorities to tackle social determinants of health and improve health outcomes for priority cohorts
    b. a code of expectations for consumer engagement in the health sector
    c. a code of expectations for clinical workforce engagement in health system development and improvement.
2. That the Department of Health publish rolling capital, digital and workforce strategies and clinical service plans – including for mental health and Aboriginal health – to support delivery of the long-term health strategy, in consultation with a system leadership forum and other key stakeholders.
3. Given disruptions caused by the COVID-19 pandemic and the importance of progressing system priorities:
    a. an interim health strategy should reflect existing priorities from the 2019 Sustainable Health Review and emerging whole of government priorities, especially in Aboriginal affairs
    b. a program logic for the interim health strategy should be developed which includes:
        i. an outcomes performance framework to measure the impact of the interim health strategy, Sustainable Health Review and the delivery of reform initiatives, with specific outcome indicators for priority population groups including Aboriginal people
        ii. mapping how reform initiatives will help establish the necessary conditions to meet outcome indicators (with an aggregate assessment of the contribution of strategic initiatives to each outcome indicator)
        iii. performance dashboards to provide the Minister, System Manager, HSP boards, central agencies and system leadership forums with insights on how well outputs are being delivered and whether they are achieving outcomes
    c. the first long term health strategy should be completed within two years of the gazetting of the legislative amendments.
4. That the delivery of health strategies is supported by existing legislative requirements for:
    a. the System Manager to produce an operational plan setting out actions the department will take to support delivery of health strategies – with the operational plan subject to a full review every 3 years and an annual update
    b. HSPs to produce an operational plan outlining key initiatives to implement systemwide priorities, while responding to local needs – with the operational plan subject to the same review cycle as the System Manager (full review every 3 years and an annual update).

5. That the System Manager improve the maturity of risk management by:
    a. establishing a Health Chief Risk Officer, carrying a mandate to build a risk strategy and framework and build risk analysis capability
    b. developing a systemwide risk profile, which accumulates operational, project and program, strategic, infrastructural and occupational health and safety risks into a single risk overview.

Stronger collective responsibility for outcomes

6. That the Act is amended to recognise HSP obligations to the system as a whole, and to one another, including:
    a. ensuring the effective and efficient use of public health system resources and the best interests of patients and other users of public health services throughout the state
    b. delivery of services in partnership with primary and community care to address barriers to access and maximise community health and wellbeing
    c. planning and provision of health services that address the health needs of the people who live or work in regional WA
    d. committing to achieve health equity for Aboriginal people including through partnering with Aboriginal health organisations to deliver culturally competent health care.
7. That systemwide collaboration is driven through:
    a. the System Manager and all HSPs entering into an Alliance Agreement detailing how these whole-of-system obligations will be met
    b. the Health Minister's annual statement of expectations reinforcing the collective leadership priorities
    c. opportunities for the Minister and Director General to meet with board chairs as a collective (this could precede new system leadership forums).
8. That the System Manager facilitate stewardship of the WA's public health system, through:
    a. a System Leadership Forum chaired by the Director General of the Department of Health and including HSP board chairs and Chief Executives and the Chair of the Clinical Senate
    b. a System Leadership Advisory Council, enabling strategic engagement of WA Primary Health Alliance, Aboriginal Health Council of Western Australia, private hospital and ambulance operators, National Disability Insurance Agency, the residential aged care sector and consumer representatives
    c. maintaining the Mental Health Leadership Advisory Council, Community Mental Health Alcohol and Other Drug Council and Aboriginal Advisory Group enabling strategic engagement of public and community based mental health and AOD sectors, as well as lived experience leadership and culturally secure consultation and advice
    d. maintaining the Ministerial Advisory Panel to support strategic workforce planning and development and consistent application of workforce policies
    e. revitalising the Clinical Senate and clinical networks to facilitate clinician and consumer engagement in statewide policy and planning development and priorities for quality improvement.

Clear expectations and support for HSP board accountabilities

9. That the Act is amended to strengthen corporate governance and accountability so that HSP CEs are employed by their HSP board, with appointment and termination decisions requiring the concurrence of the Department of Health Director General.
10. That the Act is amended to mandate consumer representation on board quality and safety committees and representation on HSP boards by:
    a. the Chair of the board's Consumer Advisory Committee
    b. a member with mental health expertise
    c. a member who is an Aboriginal person nominated by the Aboriginal Health Council of WA.
11. That the System Manager develop a governance framework for HSP boards and provide support for its implementation, including through:
    a. a comprehensive board member skills matrix and induction program and providing ongoing development support including through an annual forum, tools and resources and a learning and development program
    b. providing guidance on board evaluations
    c. guidance on the levels and permitted applications of retained earnings, developed in consultation with the Department of Treasury
    d. commissioning the WA Public Sector Commission to review board chair and member remuneration.
12. That HSP board chairs recommit to 2 communities of practice to facilitate collaboration and sharing of information, noting that these forums are not decision-making forums:
    a. a Council of Board Chairs
    b. Quality and Safety Chairs community of practice.

Realigning responsibilities for statewide policy and services

13. That the System Manager review responsibilities for statewide services and health responses to vulnerable groups and prioritise:
    a. rapid identification of options to reduce the breadth and scale of North Metropolitan Health Services scope of services
    b. clarification of responsibilities for policy leadership, commissioning and operational responses to child safety and family violence
    c. finalisation of a MOU with the Department of Communities and an operational model for information sharing to promote wellbeing and protections for children and victim survivors of family violence.

Mental health commissioning and oversight

14. That the Act is amended to:
    a. shift responsibilities for policy, planning, commissioning, performance management, workforce development and clinical assurance of public mental health services to the System Manager
    b. establish primary prevention and oversight functions for the Mental Health Commission, including for example:
        i. reporting on the performance of the WA public health system and progress in delivering against committed system reforms
        ii. undertaking inquiries into matters that support its objectives and public reports containing its findings, on the request of the Minister
        iii. supporting people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system
        iv. addressing stigma related to mental health

c. establish an advisory board to provide strategic advice to the Mental Health Commission in exercising its functions, with membership that provides a suitable mix of knowledge, skills and experience, including lived experience and expertise in mental health promotion, service delivery and data analytics

d. enable the Mental Health Commission to access performance information and administrative data necessary to fulfil its functions.

15. That the System Manager:

a. create a new Mental Health Directorate to provide a central point of accountability for alcohol and other drugs, and the public mental health system, with responsibility for:

i. setting strategic direction, mandatory policy frameworks, system planning and commissioning, funding and performance management

ii. updating of performance measures to provide public information about the experience and outcomes of alcohol and other drugs and the public mental health system, in consultation with the Patient Safety and Clinical Quality Directorate

iii. collaborating with other units within the System Manager on capital planning and development and strategic workforce planning

b. create a dedicated Mental Health Improvement Unit in the Clinical Excellence Division to lead clinical safety and quality monitoring and improvement

c. work with the Mental Health Commissioner and the Director General of the DPC to establish an appropriate interdepartmental committee chaired by the Director General of DPC to drive whole of government leadership on mental health and wellbeing.

16. That more opportunities are created for people with lived experience to participate in the WA health system, including:

a. the employee cohort within the Mental Health Directorate and the Mental Health Commission include people with lived experience of mental illness, addiction or psychological distress and people with lived experience of caring for someone living with mental illness

b. The Mental Health Commission establishing a Lived Experience Leadership Group to provide peer support and professional development to people with lived experience and provide a source of expertise into the range of systemwide leadership forums.

17. That each HSP employ a senior mental health executive position, reporting directly to the Chief Executive.

Establishing clear guardrails for the WA public health system

18. That the Department of Health cease to draw a distinction between 'System Manager' and 'Department of State' functions, so that all functions are directed toward improving the performance of the public health system and health outcomes for the people of Western Australia.

19. That the System Manager provide clear guidance on the level of consistency and discretion available to HSPs by progressively determining whether decisions and activities fall into one of 3 categories:

a. prescribed requirements: mandatory activities, standards and processes to standardise practice (to enable comparability, or to reflect evidence of best practice)

b. permitted adaptation with guard rails: providing guidance on desired outcomes and evidence, while permitting HSPs to adapt to local conditions

c. wider discretion: activities and strategic outcomes where freedom to act locally within the unique contexts of each HSP are essential, and the inability to do so would reduce operational effectiveness and agility.

20. That the System Manager prioritise the updating and consolidation of 9 policy frameworks prescribing mandatory requirements for:
    a. patient flow between HSPs, based on need
    b. record keeping and movement of health records between HSPs
    c. performance, risk and financial reporting, providing a consistent format and data standards for output and outcome measures
    d. clinical incident management and notification requirements
    e. integrity requirements
    f. workforce data collection and reporting, providing a consistent format and data standards
    g. capturing consumer, carer and family feedback about the experience of care through endorsed patient experience tools
    h. employment conditions, processes and practices, including whole of government requirements
    i. clinical teaching and training placement obligations.
21. That the System Manager publish prescribed requirements in a consolidated online repository of policy frameworks, with alerts provided to HSPs on any updates.

Simpler and more strategic service agreements

22. That the System Manager continue to implement the recommendations from the 2020 Review of the Service Agreement Framework, including:
    a. increasing the strategic focus of the Service Agreement, by better co-ordinating strategic prioritisation, planning, purchasing and performance functions within the System Manager and within a new model service agreement
    b. clarifying and streamlining the processes involved in the service agreement negotiation and administration cycle, enabled through:
        i. documenting the negotiation and administration cycle and opportunities for HSPs to input into priority setting
        ii. creating more space for long-term planning by shifting to 3-year agreements with annual update to funding and purchasing schedules
        iii. integrating physical and mental health service expectations into a single agreement
    c. redesigning the resource allocation model to increase transparency and drive performance.
23. That the System Manager develop a plain English model service agreement that includes:
    a. identification of a small number of high-impact government priorities and outcomes for the system, including key actions required to advance Sustainable Health Review priorities as implementation planning matures
    b. performance targets for the highest priority KPIs, aligned to strategic priorities and outcomes – with an assessment framework against each of these targets (aligned with the 4-scale escalation process).

24. That a single Service Agreement is provided to HSPs which covers all State funding, including:
    a. activity based funding for physical and mental health services
    b. any specific program funding
    c. any financial incentives for HSP innovation, improvement and capability development.

Joint stewardship and performance management

25. That the System Manager lead a change process to embed accountability for adherence to prescribed requirements and strategic outcomes, including through:
    a. an enhanced relationship and positive performance management system and annual performance cycle for HSPs, focused on joint problem-solving
    b. further developing a health outcomes performance framework with clear outcomes and output performance indicators aligned to health strategies and capturing consumer, supporter and workforce experiences
    c. performance dashboards that provide standardised reporting against a health outcomes performance framework including reporting on specific Aboriginal health metrics
    d. clearly defined graduated performance interventions
    e. engagement of the Department of Treasury in an annual performance review meeting with each HSP.
26. That the performance metrics included in the health outcomes performance framework and associated performance dashboards demonstrate:
    a. alignment with legislative obligations, delivery of government commitments and alignment with the system strategic plan
    b. a balance between qualitative (outcome focused) and quantitative (output focused) performance
    c. clarity on agreed unacceptable deviations and identified 'never events'
    d. a clear and positive bias for higher performance outcomes benefitting Aboriginal people.

More support for innovation and improvement

27. That the System Manager develop shared risk incentive funding within service agreements to support HSPs to prioritise contemporary models of care and high value care initiatives.
28. That the System Manager support sharing of innovation and systemwide collaboration for improvement through:
    a. revitalising the role and influence of the Clinical Senate and clinical networks in designing and leading improvement projects
    b. strengthening clinical engagement, including engaging emerging clinical leaders in system improvement processes.

Local collaborative commissioning

29. That local commissioning authorities are created to support planning, resourcing and performance management of mental health and targeted chronic disease management services with:
    a. the System Manager retaining responsibility for funding and policy parameters for collaborative commissioning and oversee the performance of local commissioning authorities
    b. three skills based local commissioning authorities servicing the north, south and east of the State and given responsibility to join up key pathways of care
    c. structured consultation processes established to include Aboriginal health, primary health and aged and disability services.
30. That devolution of planning, resourcing and performance management of mental health services and a targeted chronic disease stream is staged, with:
    a. local commissioning authorities initially taking responsibility for local assessment of the needs of their populations, and in designing at scale trials for new service and funding models for mental health and wellbeing services and for a targeted chronic disease stream
    b. these authorities progressively assuming additional responsibilities, starting with at least one authority leading a co-commissioning trial with Commonwealth commissioning authorities to test and track:
        i. alignment and co-ordination of funding incentives and potentially innovative payment models
        ii. improved information-sharing and cross-sectoral collaboration in the design and delivery of services
        iii. shared use of workforce capabilities
        iv. co-ordinated monitoring of performance by holding services providers to account for outcomes, monitoring the strength of provider partnerships, assessing quality and safety through data collection including consumer perspectives and provide leadership and support on improvement, innovation and integration.
31. That the System Manager lead a program of sustained development of commissioning capabilities within the System Manager and with the 3 new local commissioning authorities to drive ongoing collaboration and sharing of good practice.

Data access and information flows

32. That HSPs are accountable for more streamlined, open and transparent sharing of data with the System Manager, while maintaining appropriate protections for privacy and confidentiality.
33. That the System Manager facilitate a single source of truth for performance data in a consistent format to reduce duplicative reporting, ensure consistency of access and interpretation, and support timely benchmarking.
34. That the System Manager develop performance dashboards and take responsibility for sharing performance information with the Minister, central agencies and the community.
35. That the System Manager continue to mature measurement and evaluation of health outcomes and expenditure, including through:
    a. collaborating with the Australian Government Department of Health and WA Primary Health Alliance to measure the impact of total health expenditure on health outcomes and hospital demand

b. working with the Office of Digital Government to incorporate adult population health statistics into the existing whole of government linked child population health data sets to inform and track the impact of preventative and population health initiatives.

Real time data to optimise system capacity and flow

36. That the proposed State Health Operations Centre be prioritised and activities informed by real time data on acute hospital capacity and patient flow, enabling tactical coordination of capacity load share across the system.
37. That the System Manager utilise HSP planned care demand and capacity data to:
    a. improve equity of access to services across WA
    b. enable predictive modelling
    c. inform service delivery capacity investment decisions.

A system approach to workforce strategy development and management

38. That a Strategic Workforce Development Unit be established within the System Manager, with responsibility for monitoring systemwide workforce capacity and working with the health workforce, professional leads, local commissioning authorities, HSPs and professional and industrial partners to:
    a. ensure standard employment policies, practices and processes are implemented across HSPs
    b. develop new roles, expand scopes of practice, support the training of the future workforce and deploy competencies to meet system demand and deliver new models of care
    c. support career pathways for generalist roles, such as career medical officer and procedural GPs
    d. develop patient-oriented lay roles to work alongside clinical roles and support consumer engagement and system navigation.
    e. provide advice to the Director General on health executive roles and classifications.
39. That the implementation of Human Resources Management Information System be fast tracked to ensure mobility across the system and consistent reporting of workforce data in order that workforce planning and issue identification can be implemented as a priority.
40. That as part of the Human Resources Management Information System implementation, a single employee number is assigned to a staff member and continues with them if they move between HSPs.
41. That the consistency of experience for the health workforce is improved through:
    a. mandatory policies on specific issues including compliance with awards and agreements, state government legislative and policy requirements with clear accountabilities for the implementation
    b. an ongoing collaborative process on systemwide issues for industrial relations, mandatory training competency requirements and human resources policy development
    c. the creation of a dedicated unit for industrial relations and human resources expertise and advice within the System Manager to ensure a consistent application of award and agreement entitlements and policies across HSPs.

42. That timeliness of recruitment of staff and mobility throughout the system is increased by maintaining and enhancing process and practices in recruitment adopted during the COVID-19 pandemic, including through:
    a. creating a position number (PN) for each ongoing position and limiting the employment of additional staff against a single PN for backfilling arrangements in clearly defined circumstances and for specific periods of time
    b. only requiring an application to the central reclassification committee where a new job definition form is required
    c. the further centralisation of the recruitment processes to Health Support Services with mandatory streamlined processes around advertising and onboarding employees but with the final selection decision remaining with the HSP
    d. the implementation of pool recruitment processes by Health Support Services for identified occupational groups with the final selection decision remaining with the HSP.
43. That strategies be implemented to support the future workforce needs of the WA health system including:
    a. continuing to advocate to the Australian Government to open up Commonwealth supported places to support a sustainable pipeline of medical practitioners
    b. the facilitation of training and development opportunities for existing staff across all occupational groups and the rotation of employees between HSPs to support professional development and good clinical practice
    c. that an Aboriginal health practitioner classification structure be created
    d. that a centralised placement program and unit be established to manage placements with an obligation for the HSPs to participate in the program detailed in their service agreements and in a Clinical Teaching and Training mandatory policy
    e. define structured support for new graduates and systemwide pathways to employment and career progression through the 10-year workforce strategy
    f. work with educational institutions to increase the opportunities to train regional and remote citizens to become the local workforce
    g. developed structured arrangements to support metropolitan staff to work in regional and remote locations (fly in fly out and drive-in drive-out).

Central major projects capability

44. That the role of the Major Health Projects and Infrastructure Directorate in the department be expanded and strengthened with responsibility to oversee the planning, development and delivery of major projects and capital works supported by project-based leadership groups and a whole of portfolio skills-based steering group.

A stronger mandate for HSS in procurement and digital enablement

45. That the Act is amended to formalise how Health Support Services guides HSP procurement activity and engages their customers in strategic decision making by:
    a. empowering Health Support Services to set mandated requirements in the form of procurement and ICT policy frameworks and monitor adherence to whole of government legislative and policy requirements
    b. requiring the Health Support Services Board to establish a Customer Advisory Committee, with an independent chair and representation from the System Manager and each HSP
    c. mandating customer representation on the Health Support Services Board from the Chair of the Customer Advisory Committee.
46. That Health Support Services is formally recognised as the central point for goods and services tendering and contracting in the WA public health system drives value for money and customer experience by:
    a. progressively assuming responsibility for statewide contracts currently managed by other HSPs (excluding pathology services)
    b. working with the System Manager and HSPs through the Strategic Leadership Forum to agree the criteria for statewide and localised purchasing and conduct a rapid review of existing local contracts
    c. recommending to the Strategic Leadership Forum findings from this review on:
        i. contracts that would clearly benefit from statewide purchasing
        ii. contracts where there are possible benefits from statewide purchasing
        iii. contracts that clearly benefit from localised purchasing
    d. assume responsibility for renegotiating local contracts that would clearly benefit from a statewide approach
    e. undertaking a more comprehensive assessment of local contracts which may benefit from statewide purchasing to agree with the Strategic Leadership Group whether any of these should be migrated to statewide contracts.
47. That a systemwide ICT strategy is developed to support implementation of the long-term health and rolling digital strategies by:
    a. defining ICT standards, architectural models and a portfolio implementation framework
    b. supporting ongoing maturation of the ICT operating model.
48. That the System Manager retains accountability for ICT and digital strategy, including agreeing annual priorities for ICT and digital enablement.
49. That Health Support Services is confirmed as the lead agency for systemwide ICT projects and ICT development, with responsibilities outlined in their service agreement including:
    a. leading the development of ICT principles and standards, data infrastructure and application architecture
    b. managing procurement of ICT solutions
    c. supporting deployment of solutions
    d. reporting on all ICT programs at a portfolio level, allowing the ICT Executive Board to understand the ICT risk, cost, timing, resourcing and scope resourcing profile.

50. That the WA health system's ICT Executive Board, chaired by the System Manager, oversees:
    a. an annual process of prioritising projects for inclusion in Health Support Services workplan
    b. the delivery of major ICT projects.
51. That Health Support Services work closely with the Data Linkage Unit within the System Manager, WA Primary Health Alliance and Aboriginal Health Council to advance linkage of clinical and public health data and establish:
    a. clear governance processes for prioritising and authorising the development, access and use of linked data sets
    b. appropriate cyber-security and privacy protections
    c. clearly defined data custodianship.
52. That the Health Support Service Chief Information Officer is recognised as the Chief Information Officer for the WA health system and convene a digital health reference group including relevant leads from the Digital Health Branch within the System Manager, the Clinical Chief Information Officer and HSP Chief Information Officers to facilitate:
    a. sharing of information about digital health priorities
    b. feedback on technical issues in the roll out of digital initiatives
    c. consistent interpretation of ICT principles and standards.
53. That Health Support Services ensure that a Chief Technology Officer and experienced staff in ICT portfolio management and delivery, support the CIO in fulfilling Health Support Services ICT responsibilities.
54. That HSPs are expected to adhere to the ICT strategy components of standards and architecture to ensure alignment and interoperability, with digital and ICT enablement forming part of performance management dialogues with the System Manager.

Preparedness for future emergencies

55. That a whole of government review of the management of the COVID-19 pandemic is undertaken to capture lessons on what worked well and what could be improved to enhance WA's preparedness and response to any future pandemic or complex emergency.

Appendix 2: Summary of consultations

2.1 Public consultation survey response analysis

Background

The Independent Governance Review public consultation survey (the survey) opened on 28 March 2022.

The survey sought feedback regarding the operational and practical effectiveness of the governance structures (relationships, responsibilities, processes and systems) within the WA health system, including their impact on the health workforce and patient outcomes.

A total of 58 respondents answered the survey with over 80 per cent of respondents responding to each question.

Question 1:

Are roles, responsibilities and accountabilities for performance clear under the current governance model?

59 per cent of respondents stated that the roles, responsibilities and accountabilities for performance are not clear under the current governance model.

The common themes from the responses include:

- confusion and lack of clarity in the governance roles, specifically the role of the System Manager
- lack of collaboration between HSPs on statewide issues
- HSPs working in silos resulting in a duplication of processes across the system
- lack of clear direction regarding the allocation of responsibility
- lack of clarity regarding the role of boards
- the governance processes lack maturity and consistency
- improved accountability in relation to performance and compliance
- clarification required regarding the system level risk and the department risk appetite.

Question 2

Is the Department of Health, as System Manager, empowered to, and accountable for, setting systemwide direction and priorities and managing systemwide risks?

37 per cent of respondents provided a negative response to this question.

The common themes from the responses include:

- the System Manager is legally empowered; however, improved accountability is required to ensure appropriate systemwide direction in key areas
- siloed working approaches resulting in lack of collaboration and consultation resulting in misguided systemwide direction
- Ineffective risk management practices across the system and an inherent lack of engagement and understanding of system risk
- greater focus on corporate risk with a poor understanding of clinical risk and a lack of clarity on risk management at the HSP level.

Question 3

Does the current devolved governance model encourage collective responsibility for the performance of Western Australia's health system and management of complex emergencies?

62 per cent of respondents stated that the current devolved governance model does not encourage collective responsibility for the performance of the WA health system and management of complex emergencies.

Some respondents supported the devolved governance model stating that it has empowered HSPs to be responsible for their performance and governance.

The common themes from the responses include:

- the current devolved model in practice lacks the leadership as there is ambiguity in relation to accountability for governance
- competition and siloed working approach amongst HSPs rather than collectively to achieve shared objectives
- additional layers of bureaucracy when dealing with service delivery issues delaying resolution
- support for a coordinated approach with consistent processes
- incorporation of primary health care into state and regional emergency preparedness plans with clear responsibilities.

Question 4

Are health service boards empowered to, and accountable for, implementing Western Australian Government policies and priorities?

24 per cent of respondents answered 'no', whilst 30 per cent of respondents provided a positive response. Several respondents were unsure or assumed that health service boards are empowered to, and accountable for, implementing WA Government policies and priorities.

The common themes from the responses include:

- lack of accountability from the boards, with some respondents claiming that the boards lacked the power to enable changes
- limited collaboration between the boards, the Chief Executives and the System Manager
- consultation with front-line workers, other HSPs and stakeholders required
- support for a consistent and standardised approach across HSP boards
- Boards require a better understanding of their HSP's operations
- weak policy compliance monitoring mechanisms to ensure HSP policy implementation and compliance.

Question 5

Do current responsibilities and relationships enable effective workforce planning and support a consistent and positive experience of working in the WA health system?

61 per cent of respondents answered 'no' to this question.

The common themes from the responses include:

- siloed working approach resulted in lack of collaboration to enable workforce planning
- centralised management systems are required
- strong reliance on international recruitment, particularly for rural recruitment
- inconsistent workforce practices and lengthy recruitment processes
- competition amongst HSPs for resources and funding

- barrier between the metropolitan HSPs and WACHS which impedes the flow of resources to rural areas
- improved understanding required regarding rural workforce issues
- heavy reliance on contractual staff.

Overall, the survey responses indicated that workforce was a significant weakness of the health system and the current responsibilities and relationships are ineffective in enabling workforce planning and supporting a consistent and positive working experience in the WA health system.

Question 6

Has devolved governance led to improved patient satisfaction with health care delivery and outcomes?

38 per cent of respondents responded negatively whilst 25 per cent were unsure in relation to this question.

The common themes from the responses include:

- a lack of reliable mechanism to effectively measure patient outcomes
- workforce shortages
- lack of collaboration
- patient satisfaction is a low priority to HSPs as it does not generate funding
- inequitable access to services between HSPs
- underutilisation of regional sites and huge costs to regional patients due to reliance on metro centric care.

Question 7

Are consumers and carers supported to participate in HSP and systemwide governance and decision-making?

22 per cent of respondents answered no to this question.

The common themes from the responses include:

- little emphasis on or appetite for consumer or carer engagement across the system
- engagement of consumers and carers is limited and occurs inconsistently across the system
- when consumers and carers are engaged, it is tokenistic and passive.

Question 8

Do current relationships and decision-making processes encourage sharing of resources across the system to enable responsive management of demand and patient flows?

65 per cent of respondents stated that the current relationships and decision-making processes do not encourage the sharing of resources across the system to enable responsive management of demand and patient flows.

The common themes from the responses include:

- HSPs work in silos which hinders collaboration or sharing of resources
- competition between HSPs for resources does not support the sharing of information or resources
- existence of barriers
- current funding model does not promote the sharing of information
- reliance on personal relationships rather than systems or processes.

Question 9

Is mental health well integrated into the governance responsibilities of Health Service boards and systemwide policy development and service planning?

49 per cent of respondents provided a negative response.

The common themes from the responses include:

- lack of clarity regarding mental health governance and responsibility
- mental health is integrated into policy but not reflected in practice
- lack of resources to integrate mental health
- lack of emphasis or concern regarding staff mental health
- lack of support from the System Manager or Mental Health Commission.

Question 10

Does the current devolved governance model provide clear accountability for increasing health prevention and shifting delivery of care to home and community settings?

44 per cent of respondents answered no to this question.

The common themes from the responses include:

- a strong focus on acute care with little emphasis on primary prevention or promoting primary models of care
- better collaboration and accountability are required
- weak governance affecting decision-making
- lack of funding.

Question 11

Is there any other element of the current governance model that you feel the Panel should consider?

Recurring issues for consideration included:

- removal of statewide services from HSPs
- examination of HR and classification processes including the standardisation of processes and system
- review the role of MHC for improved co-ordinated provision of services
- board and executive leadership to be examined and improved
- removal of layers of bureaucracy
- review of processes to ensure consistency and reduce duplication
- examination of the policy frameworks to be more robust with greater emphasis on compliance
- focus on innovation and research.

2.2 Workforce consultation response analysis

Background

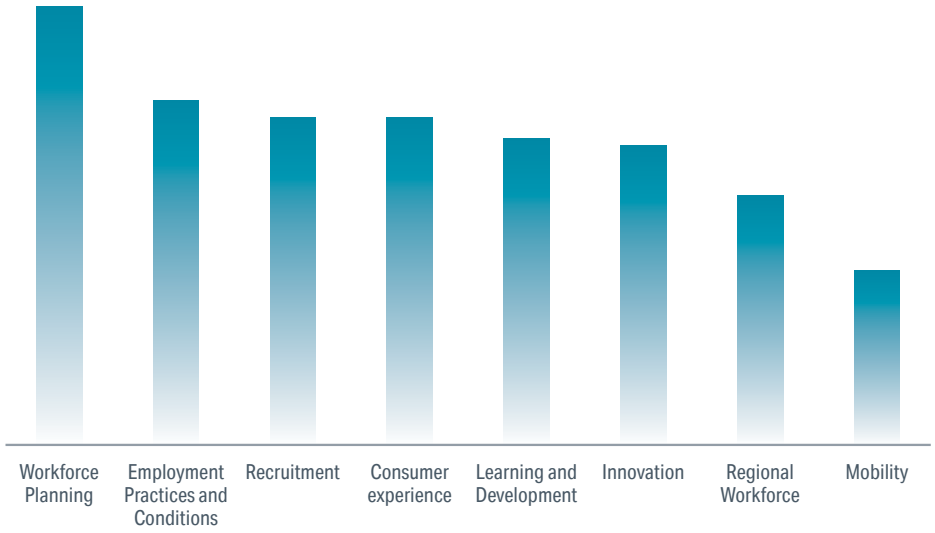
The Independent Governance Review Panel hosted 3 virtual sessions to engage the WA health system workforce to obtain their views regarding the impact of governance structures and processes on staff, patients and other stakeholders.

The consultation was open to all WA health system staff members with 237 staff members participating in these sessions (with 217 using the mentimeter feedback tool). The distribution of participants is stated below.

Health service provider	Attendees	% of attendees
System Manager	52	21.94%
WA Country Health Service	50	21.10%
North Metropolitan Health Service	45	19.99%
South Metropolitan Health Service	30	12.66%
East Metropolitan Health Service	22	9.28%
Child and Adolescent Health Service	18	7.59%
Health Support Services	14	5.91%
PathWest	6	2.53%
Total	**237**	

The sessions focused on a number of governance areas and asked participants for their views to improve these areas. The analysis of responses is outlined below.

Participant ranking of priority areas



Topic	Common themes
Recruitment	• Timely processing resulting in quicker onboarding • Streamlined processes including simpler forms • Reduce bureaucracy • Standardisation of levels/ job descriptions • Consistent processes across the system • 360° survey requirement for leadership positions • Transferrable employee conditions • Appointing long-term acting/contract staff where substantive occupant resigns or where the position becomes permanent, depending on performance • Remove duplication of processes • Improve and update job advertising and selection criteria • Improved HSS support during recruitment • Shared resourcing between HSPs for similar roles • Improve and modernise recruitment practices • Greater focus on retention including the provision of incentives
Mobility	• Provide incentives to encourage mobility • Maintain staff entitlements • Centralised credentialing processes • Consistent and streamlined process

Topic	Common themes
	• Support for rural and remote placements i.e., accommodation • Centralised pools across all HSPs for staff willing to complete short to medium term roles in other areas • Recognising transferrable skills • Collaboration across HSPs • Increased support of and access to secondments • Identical mandatory training that is recognised at all sites
Employment practices and conditions improvements	• Improved and integrated HR system and processes • Flexible working arrangements such as working from home, rostered days off, flex hours. • Staff recognition • Availability of longer-term contracts and permanent positions to provide job security • Access to leave entitlements • Administrative support for clinical roles • Appropriate leave coverage • Improve use of and access to technology • Consistent onboarding processes to remove duplication when transferring between HSPs • Better performance management processes and assistance

Topic	Common themes
	• Conversion of fixed term/acting staff to permanent without the lengthy recruitment process • Wage increases • Improve funding and support for learning and development opportunities
Learning and development improvements	• Equitable access to learning and development opportunities across the system • Improve support for learning such as study leave, study allowance, protected time, backfill • Collaboration between HSPs to provide joint training opportunities and recognition of training between HSPs (training passport) • Expand virtual/online learning opportunities • Appropriate budget allocation for learning and development • Improve systemwide learning management system • Mentorship programs • Leadership training
Regional workforce	• Training and recruiting people from regional WA • Consideration for fly-in fly-out or drive-in drive-out arrangements • Short term engagements/secondments particularly for interested metropolitan staff
	• Incentives for regional deployments i.e., accommodation, relocation assistance and subsidies • Suitable and safe accommodation and housing support • Staff rotational programs • Improved and expanded access to telehealth • Partnerships with universities and TAFEs to offer regional placements as part of graduate programs • Induction, orientation and cultural bias competencies
Workforce planning	• Partnering with education providers (universities and TAFEs) to meet future requirements • Staff retention • Professional development and training of staff • Improve and invest in succession planning • Improve and better integrate technology • Additional support and investment to increase the number of Aboriginal people in the health workforce • Alternative and modern models of care
Innovation	• Technology and system improvements such as electronic medical record, data automation, data sharing, central HR system • Streamlined and contemporary processes

Topic	Common themes
	• Flexible working arrangements • Collaboration with HSPs and the community to share knowledge • Improve focus on research • Data sharing across sites
Consumer experience	• Improve communication to be simple and transparent • Reduce waiting times • Improve integration of technology, for example, electronic medical record, electronic prescriptions, digital patient interaction during stay, electronic booking and appointment reminder systems • Improve parking and facilities • Better support and integration of primary care • Better consumer engagement in planning and delivery of services • Collaboration between services • Reduce staff workload to allow better patient experience • Improved cultural awareness support and training • Care closer to home for example, community care

Topic	Common themes
Other areas for improvement	• Inconsistencies and duplication across the system to be addressed • Improve collaboration across the system to remove the existing siloed approaches • Clarity regarding System Manager functions i.e. oversight, assurance • Improving leadership across the system • Management of statewide services • Equitable processes • Mental health governance

2.3 Consumer carer consultation analysis summary

Background

The Independent Governance Review Panel commissioned the Health Consumer Council (HCC) to engage with consumers, carers and families regarding the operational and practical effectiveness of the governance structures (relationships, responsibilities, processes and systems) within the WA health system.

The HCC hosted and facilitated 2 consultation workshops with a total of 31 attendees for both workshops.

Consultation responses are summarised below.

Consumer involvement

- Many felt that consumer involvement had been sidelined during COVID-19 in 2020 and hadn't really regained momentum.
- There are pockets of good practice of consumer involvement across the system but it is not brought together. The absence of consumer voice at System Manager level is a concern – governance is definitely consumer business.
- A change in culture is needed: consumer involvement is not always valued – it is undertaken as something that 'has to be done' rather than an essential activity that drives patient safety and a person-centred health system.
- Education, briefings and mentoring are required for all parties – health staff and consumers – to continue to embed effective consumer involvement. This needs to go beyond the acquisition of technical knowledge about ways to engage, and move into building people's experience – through 'learning by doing' – so that people have the opportunity to learn how and why involving consumers adds value to activities.
- Consultation that doesn't result in change is a concerning trend noted in health and mental health sectors.
- Addressing the power imbalance is key - what gets prioritised is usually not what's important to consumers.
- Inclusion and diversity need time and commitment to build relationships.

Patient experience and culture

- Patient experience and being able to navigate the system go hand in hand. Access to services is also key – there needs to be something to navigate to.
- There can be a stark difference in patient experience, highlighting inequities.
- Care opinion has been a game-changer in seeing feedback turn into quality improvements but is inconsistently implemented across the system.

Emergency management

- Consumer involvement was minimal in emergency management planning and having an expert consumer panel for future emergencies is a key opportunity.
- Communication and involvement with consumers would support more consumer-centred approaches, e.g., minimising the need to cancel elective surgery, a compassionate approach to visitor numbers, messaging that works for communities.
- Technology has been important in emergency response but consideration of those on the other side of the digital divide is important.

Preventative health

- Both emergency management and public health initiatives require those well-established relationships with communities.
- Consumer involvement in prevention supports more effective campaigns and greater community uptake.
- Preventative health requires resources.
- Thinking more creatively is important – parenting classes and support can prevent more complex problems, peer supporters can assist people post a serious diagnosis or significant operation to stay well in the community.

Appendix 3: Terms of reference

In carrying out the review, the Panel considered the governance of the WA health system in relation to:

- the efficiency and effectiveness of the devolved governance structure, the System Manager and Board-led Health Service Providers (HSPs)
- the impact of the current governance structure on the culture of HSPs from the perspective of consumers and carers, staff and the community
- whether the System Manager's role in planning and commissioning services and ensuring accountability is adequately enabled through existing mechanisms, such as mandatory policies, directions and Service Agreements
- whether the System Manager and the HSPs are fulfilling their respective roles as originally envisaged, including whether the System Manager is exercising available authority under the existing structure and the HSPs are responding accordingly
- the system's ability to manage, plan and implement key health reforms and workforce requirements
- the system's ability to respond to emergency situations
- any other related matters.

This document can be made available in alternative formats.

Produced by the Independent Governance Review Panel

GSS-014247 OCT'22