Government of **Western Australia**
Department of **Health**

Destination: Sustainability

Clinical Senate of Western Australia
20 November 2017

Report for the Sustainable Health Review Panel

better health ▪ better care ▪ better value

Executive Summary

“Destination: Sustainability”.

Following an offer and acceptance to the Chair of the Sustainable Health Review (SHR) by the Clinical Senate (CS), a debate on the sustainability of health care using a reflective model around what had gone before i.e. “A Healthy Future for Western Australians – Report of the Health Reform Committee here-after to be known as “the Reid Report”, and what would measure success going forward was held on 20 November 2017.

In March 2004, A Healthy Future for Western Australians - Report of the Health Reform Committee (the Reid Report) identified strategic directions for the WA health system. The recommendations endorsed by the State Government, included a number of major infrastructure projects and other initiatives that mapped out health reform for the following decade.

In 2017, the WA health system is the largest single source of expenditure in the WA State Budget, representing 30 percent of expenditure in 2016-17 compared to 24.9 percent in 2008-09. (Cook, R. 2017)

The growth in the cost of healthcare has not been accompanied by an equivalent increase in services to the community or improvement in health outcomes. WA’s health system continues to face challenges associated with an increasing ageing population, increased rates of chronic disease and health inequity as reflected in the Reid Report but recommendations addressing these issues have not been fully implemented. Within the constrained budgetary environment, new solutions must be sought to meet the future health needs for all West Australians. In June 2017 the Government of Western Australia announced the Sustainable Health Review (SHR) with an independent Chair, Ms Robyn Kruk AM to consider how the WA health system can continue to provide patient-first, innovative and sustainable care for years to come.

This Clinical Senate debate, with Ms Kruk as sponsor represents a significant engagement with clinicians to inform the review.

The debate first focussed on key learnings from the 2004 Reid Report, before considering priorities for the system going forward and metrics to drive system change. A pre-debate survey issued to Clinical Senators and Alumni provided opinions on the progress from the Reid Report, as an opportunity to learn from previous reform.

Present at the debate were a range of experts from across the health services, health service boards, universities and community and primary care. Participants also included members of both the clinician and consumer and carer SHR reference groups and the WA High Value Healthcare Collaborative.

The full program and list of presenters and expert witnesses is listed in Appendix 1 and Appendix 2. Presentations from the day can be found on the Clinical Senate website: http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia

Consultation on the recommendations from the Reid Report

A range of the Reid recommendations where successfully implemented over the past decade. To address what was outstanding and understand the "why" senators used group map technology to log their answers and provide feedback on the following focus question:

What blocked implementation of the Reid Report that might have changed models of care?

What follows is a range of the key messages:

- No funding models carrying the patient from the community to a tertiary or secondary health service and back into a primary care setting;
- Poor linkage from rural into metro services;
- Continued focus on the acute sector and diminishing funds for population health and effective prevention;
- Organisational culture;
- Need for early and sustained staff engagement in change;
- Identification of change champions;
- Leadership is a balance of keeping people engaged and budgets in line;
- Lack of transparency of data to drive change;
- Lack of incentive for IT hardware and software providers to provide an integrated service;
- Political will was lacking;
- Lack of shared electronic records across systems, unable to link hospitals with mental health, Aboriginal Medical Services and private providers for primary care coordination and referral;
- Too many recommendations and projects. This cluttered the line of sight necessary for reform, compromising clear monitoring, accountability and communication of recommendation implementation;
- Health literacy is lacking. Community understanding of the structure, functions and inefficiencies of the health systems is insufficient. Poor understanding means that the public as an ally in reform didn't hold those responsible for implementation to account. There was not enough transparency and education;
- There is no consistent workforce strategy;
- Poor communication following the Reid Report to front line staff and no feedback loop on the recommendation for implementation and its progress;
- Focus on infrastructure rather than service;
- Linkages with primary care as a system largely funded by the Commonwealth Government were truly not established;
- Generalism vs subspecialties. Aging population - need more generalists as there is no evidence of improved outcomes if they only have specialists. Leads to other problems (e.g. rostering and staffing of hospitals);
- Lack of strategy to support development and integration of new models of care and to ensure focus was not just hospital investment;
- Lack of timeframes for action of the recommendations (i.e. not SMART); and
- Failure to drive change around State and Commonwealth investment in primary/ preventative care. Lack of consistency and attention to the outcome and driving it regardless of political agenda, by both Health and Treasury. Need to invest more in skillful negotiation at executive level in Health and Treasury and staying with it until the best outcomes are obtained for the people of WA.

On the basis of this analysis, advice to the SHR from the CS of WA with regard to the Reid Report outcomes is not unexpected. As in any reform process, there needs to be a clear statement of purpose and continuous communication across the system with all stakeholders including consumers, clinicians, managers and other government departments including the Commonwealth Department of Health. There must also be better management of expectations. In addition timeliness proved important, as did the need to underpin reform within WA health system with alignment of funding so that the needs of the patient drove improvements in the system (where treatment occurs). An absence of clear outcome statements with which stakeholders could support and evaluate implementation in partnership with the WA Department of Health left a legacy of perceived confusion. Nonetheless, successes are evident.

Key metrics for system change

To inform metrics for system change senators were posed the following statement:

We will know we have a sustainable health system when…

Senators used Group Map technology to complete this statement and, after doing so, discussed and applied measures of success. Their discussions were organised into the six SHR themes:

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

Senators developed 85 outcomes and in excess of 250 metrics to validate success in achieving a sustainable health system through reform.

Completed statements under these themes and the diversity of recommended metrics can be found with the full list at Appendix 3.

The Clinical Senate of WA strongly recommends the SHR consider all metrics developed.

What follows are examples of the key outcomes and metrics. (Appendix 3 Full list)

Theme	**Outcomes** and Metrics
Patients, Pathways and Experience	**When patients are empowered to access and contribute to their own health information.** Goals of Care or Advanced Health Directives (AHD) for every patient (number or percentage) EHR accessed by patients and all providers (primary, public, private hospital, aged care) (%)
	When the patient experience is acknowledged, measured and the outcomes are available in the public domain. Proportion of feedback (complaints) that results in change in area health service practices
	When the impact of chronic disease reduces and is demonstrated by a reduction in Disability Adjusted Life Years (DALY) attributable to i.) ischaemic heart disease, ii) chronic pulmonary disease, iii) diabetes

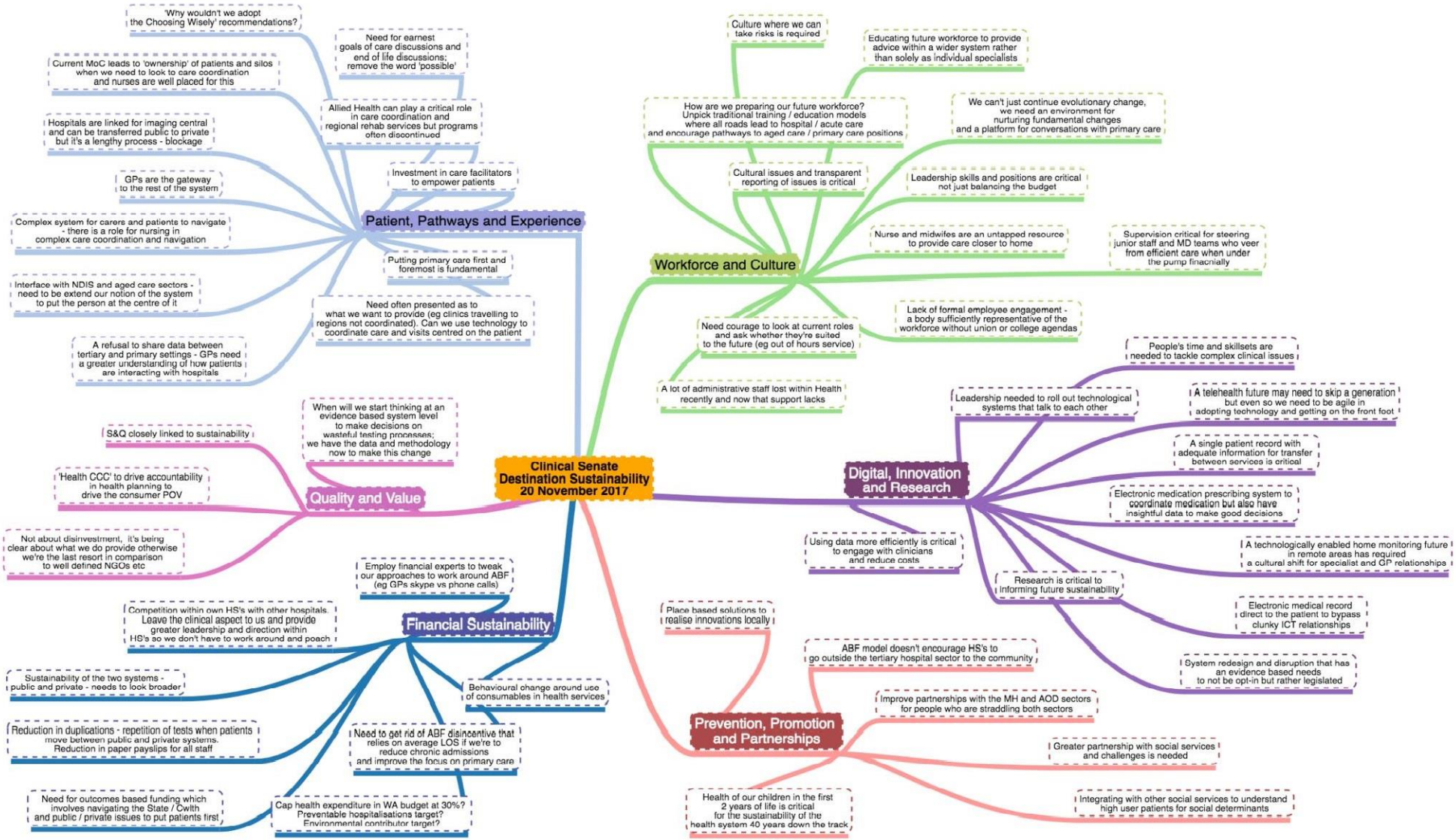
	When primary care is first and foremost WA and measured by GP satisfaction with hospital communication 100% Discharge summary completion rates and receipted Rates of ED presentations in triage 4 and 5 are reduced to 5% total presentations
	When hospital in the home beds are greater than traditional hospital beds. Number, percentage and occupancy of Hospital in The Home (HITH) beds
Prevention, Promotion and Partnerships	**When the acute sector and primary care work together to improve patient pathways and health outcomes.** Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home)
	When Aboriginal people enjoy the same health as the mainstream population. Aboriginal people have the same life expectancy and health outcomes as the non- Aboriginal community
Quality and Value	**When interventions not endorsed by Choosing Wisely are disinvested.** Expenditure on non-endorsed interventions Percentage of compliance with Choosing Wisely strategies
	When unwarranted duplication has been eliminated. Re-order rates/percentages across private and public
	When there is zero healthcare associated harm to patients. Classification of Hospital Acquired Diagnoses (CHADx)
	When there is seamless transition from acute to primary healthcare. Proportion of handover to GP GP satisfaction with hospital communication Proportion of patients with discharge summaries GP review of discharge summaries within timeframe Measure of patient satisfaction with transition
Workforce and Culture	**When WA Health is the employer of choice for healthcare workers as rated *by healthcare workers.*** All positions filled Reduced OSH stress and absenteeism Staff satisfaction is >70% Access to teaching and training Timely recruiting processes and practices within 4 weeks Leading staff engagement scores on benchmarked tools

	When WA Health is the employer of choice for healthcare workers as rated *by the system.* Vacancy rate across all areas of care delivery – professional and non-professional staff is low Low staff turnover Research output is high Peer comparisons rank WA Health as a system leader
	When WA Health is an employer of choice by *International reputation.* World leading in clinical care Percentage of research papers published Uptake Nationally and Internationally of innovative change State, National and International compliance with accreditation standards and measures of safety
	When there is evidence of effective working partnerships between consumer, GP, Primary Health Networks (PHN) and tertiary services. Memorandum of Understanding (MOU) in place between Health Service Providers (HSPs) and Aboriginal Health Council of Western Australia (AHCWA) MOU in place between HSPs and WA Primary Health Alliance (WAPHA)
	When society has confidence that all health care does not have to be provided in an acute care setting. Percentage of care delivered outside a hospital setting Investment in non-hospital centres health care delivery services and locations by government When consumers can identify a transparent link between GPs and specialists
Financial Sustainability	**When healthcare costs are related to clinical and patient reported outcome measures.** Costs of testing/treatment are displayed in the public domain Report the amount of spend on unnecessary duplication of services and reduce it by X percentage Transparency of costs over the full cycle of care is identified
	When healthcare costs are transparent to both consumers and clinicians. Patient Reported Outcome Measures (PROMs) at head of service level Budgets at head of service level Consumer Advisory Councils are aware of the financial status of health

	When consumers understand waste in healthcare. Reduction in consumer requests for futile care or non-evidence based services
	When the proportion of waste to the total health spend is reduced by at least X% per year. Compliance reporting against “on tender” purchasing Compliance reporting against the use of “off tender” request processes Contract managers in every Health Service Provider (HSP)
Digital, Innovation and Research	**When we have real-time prescribing.** Clinician access to real-time prescribing (including decision support). Percentage
	When ‘inpatients’ can be monitored at home. Reduction in Length of Stay (LOS) Cap on hospital beds

Plenary – The Critical conversations

Mind Map (MM) technology was used in order to organise and support the robust discussion during the plenary session. The MM also created the mechanisms to validate whether the themes for sustainability from a clinician’s perspective were similar to or different from those identified by the SHR. This map provided key feedback drawn from the Senate process of front loading senators prior to the debate, the use of expert opinion using keynote speakers and the facilitated plenary. This identified what was needed to ensure success and what was to be measured to ensure success. A copy of the MM is included here:


Clinical Senate
Destination Sustainability
20 November 2017
Patient, Pathways and Experience
'Why wouldn't we adopt the Choosing Wisely' recommendations?
Need for earnest goals of care discussions and end of life discussions; remove the word 'possible'
Current MoC leads to 'ownership' of patients and silos when we need to look to care coordination and nurses are well placed for this
Allied Health can play a critical role in care coordination and regional rehab services but programs often discontinued
Hospitals are linked for imaging central and can be transferred public to private but it's a lengthy process - blockage
Investment in care facilitators to empower patients
GPs are the gateway to the rest of the system
Complex system for carers and patients to navigate - there is a role for nursing in complex care coordination and navigation
Putting primary care first and foremost is fundamental
Interface with NDIS and aged care sectors - need to be extend our notion of the system to put the person at the centre of it
Need often presented as to what we want to provide (eg clinics travelling to regions not coordinated). Can we use technology to coordinate care and visits centred on the patient
A refusal to share data between tertiary and primary settings - GPs need a greater understanding of how patients are interacting with hospitals
Workforce and Culture
Culture where we can take risks is required
Educating future workforce to provide advice within a wider system rather than solely as individual specialists
How are we preparing our future workforce? Unpick traditional training / education models where all roads lead to hospital / acute care and encourage pathways to aged care / primary care positions
We can't just continue evolutionary change, we need an environment for nurturing fundamental changes and a platform for conversations with primary care
Cultural issues and transparent reporting of issues is critical
Leadership skills and positions are critical not just balancing the budget
Nurse and midwifes are an untapped resource to provide care closer to home
Supervision critical for steering junior staff and MD teams who veer from efficient care when under the pump financially
Need courage to look at current roles and ask whether they're suited to the future (eg out of hours service)
Lack of formal employee engagement - a body sufficiently representative of the workforce without union or college agendas
A lot of administrative staff lost within Health recently and now that support lacks
Digital, Innovation and Research
People's time and skillsets are needed to tackle complex clinical issues
Leadership needed to roll out technological systems that talk to each other
A telehealth future may need to skip a generation but even so we need to be agile in adopting technology and getting on the front foot
A single patient record with adequate information for transfer between services is critical
Electronic medication prescribing system to coordinate medication but also have insightful data to make good decisions
Using data more efficiently is critical to engage with clinicians and reduce costs
A technologically enabled home monitoring future in remote areas has required a cultural shift for specialist and GP relationships
Research is critical to informing future sustainability
Electronic medical record direct to the patient to bypass clunky ICT relationships
System redesign and disruption that has an evidence based needs to not be opt-in but rather legislated
Quality and Value
When will we start thinking at an evidence based system level to make decisions on wasteful testing processes; we have the data and methodology now to make this change
S&Q closely linked to sustainability
'Health CCC' to drive accountability in health planning to drive the consumer POV
Not about disinvestment, it's being clear about what we do provide otherwise we're the last resort in comparison to well defined NGOs etc
Financial Sustainability
Employ financial experts to tweak our approaches to work around ABF (eg GPs skype vs phone calls)
Competition within own HS's with other hospitals. Leave the clinical aspect to us and provide greater leadership and direction within HS's so we don't have to work around and poach
Sustainability of the two systems - public and private - needs to look broader
Behavioural change around use of consumables in health services
Reduction in duplications - repetition of tests when patients move between public and private systems. Reduction in paper payslips for all staff
Need to get rid of ABF disincentive that relies on average LOS if we're to reduce chronic admissions and improve the focus on primary care
Need for outcomes based funding which involves navigating the State / Cwlth and public / private issues to put patients first
Cap health expenditure in WA budget at 30%? Preventable hospitalisations target? Environmental contributor target?
Prevention, Promotion and Partnerships
Place based solutions to realise innovations locally
ABF model doesn't encourage HS's to go outside the tertiary hospital sector to the community
Improve partnerships with the MH and AOD sectors for people who are straddling both sectors
Greater partnership with social services and challenges is needed
Health of our children in the first 2 years of life is critical for the sustainability of the health system 40 years down the track
Integrating with other social services to understand high user patients for social determinants

Chair's Reflection

It was refreshing and reassuring that through this process the clinician-dominated forum did not identify any major variation in themes to those chosen by the SHR and those used in the wider community consultation processes.

We do not have to justify what needs to be considered to embed change. We do not need to argue why the change is necessary. We all recognise the success of a sustainable health system requires a multi-pronged approach around the themes identified.

To ensure success it will require strong leadership with reported outcomes. We must reduce waste by creating a safe, quality driven system and we must engage with our consumers and our partners to maximise efficiency.

The unique experiences gained from the implementation of Reid, the overlap of what has been reported in the Professor Hugo Mascie-Taylor report coupled with the SHR is fundamental to delivering Western Australians with a safe, sustainable health system for the future.

The Clinical Senate outcomes will inform the Sustainable Health Review Panel and have clearly identified the metrics for success.

Sincerely

Ms Tanya Basile RN, BSc, FACN
Chair
Clinical Senate of Western Australia

Appendices

Appendix 1: Full Program

Destination: Sustainability

Monday 20 November 2017

Fraser's Function Centre, 60 Fraser Avenue
Kings Park, Western Australia

7:45am – 8:30am	**Registration**	**Tea & coffee**

8:30am – 9:35am Presentations

Executive sponsor:	**Ms Robyn Kruk AM, Chair, Sustainable Health Review**	
Facilitators:	**Clinical Adjunct Associate Professor Kim Gibson and Mr Will Bessen**	
8:30am	Welcome to Country	Ms Marie Taylor
8:35am	Welcome and senate update	Ms Tanya Basile
8:45am	Director General's response to clinical indicators and introduction of Ms Robyn Kruk AM	Dr David Russell-Weisz
8.55am	Setting the scene for debate	Ms Robyn Kruk AM
9:15am	The clinician perspective	Dr Hannah Seymour
9:25am	The consumer perspective	Ms Pip Brennan
9:35am-10:10am	**Group map session**	Mr Will Bessen

10:10am- 10:35am	**Morning tea**

10:35am – 12:15pm – Plenary – Destination: Sustainability - The critical conversations

Additional Expert Witnesses	Dr Simon Towler, Clinical Associate Professor Susan Benson, Dr Jodi Graham, Dr Joel Tate, Mr James Aitken, Professor Fiona Lake, Dr Phil Montgomery, Dr Audrey Koay, Dr Susan Slatyer, Dr Greg Sweetman, Ms Linda Sinclair, Ms Monica Taylor, Ms Trish Morrell, Ms Rebecca Brown, Ms Kerry Fitzsimons and Mr Ryan Sengara.
Invited Guests	Dr Neale Fong, Professor Geoff Dobb and Clinical Professor Mark Khangure.

12:15pm – 1:00 pm	**Lunch**

2:50pm- 3:30pm Final Session

2:50pm	Feedback, discussion and summary of outcomes	Clinical Adjunct Associate Professor Kim Gibson Mr Will Bessen
3:10pm	Closing remarks	Ms Robyn Kruk AM
3:25pm	Deputy Chair's summary	Dr Jeanette Ward
3:30pm	Close	

Appendix 2: Presenters and Expert Witnesses

- Ms Marie Taylor, Nyungar Aboriginal Elder
- Ms Tanya Basile, Chair, Clinical Senate of Western Australia
- Dr David Russell-Weisz, Director General , Department of Health, WA
- Ms Robyn Kruk AM, Independent Chair, Sustainable Health Review
- Dr Hannah Seymour, Chair, Clinical Reference Group, Sustainable Health Review
- Ms Pip Brennan, Chair, Consumer and Carer Reference Group, Sustainable Health Review
- Adjunct Associate Professor Simon Towler, Clinical Services, Fiona Stanley Hospital
- Clinical Associate Professor Sue Benson, Consultant Clinical Microbiologist, Infectious Diseases Physician, PathWest, Fiona Stanley Hospital
- Dr Jodi Graham, Medical Advisor, Sustainable Health Review
- Dr Joel Tate, Geriatrician, Armadale Health Service
- Mr James Aitken, Consultant General Surgeon, Sir Charles Gairdner Hospital
- Professor Fiona Lake, Eric Saint Professor of Medicine and Respiratory Physician, Sir Charles Gairdner Hospital
- Dr Phil Montgomery, Regional Medical Director, WA Country Health Service - Pilbara
- Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, Department of Health, WA
- Dr Susan Slatyer, Research Fellow, School of Nursing, Midwifery and Paramedicine, Curtin University
- Dr Greg Sweetman, Director of Medical Education, Fiona Stanley Hospital
- Ms Linda Sinclair, Acting Coordinator of Nursing, WA Country Health Service
- Ms Monica Taylor, Service Director, Mental Health, Armadale Kalamunda Group
- Ms Trish Morrell, A/Director, Business Performance, Department of Health, WA
- Ms Rebecca Brown, Deputy Director General, Department of Health, WA
- Ms Kerry Fitzsimons, Medication Safety Pharmacist, Pharmacy Department, Fiona Stanley Hospital
- Mr Ryan Sengara, Director of Strategy, Department of Health WA
- Professor Geoff Dobb, Deputy Chair, Child and Adolescent Health Service Board
- Clinical Professor Mark Khangure, Board Member, South Metropolitan Health Service Board
- Dr Neale Fong, Chair, WA Country Health Service Board

Appendix 3: Outcomes and Metrics

We will know we have a sustainable health system when …

	Outcomes	Metrics
	Patients, Pathways and Experience	
1.	When patients are empowered to access and contribute to their own health information.	– Electronic Health Record (EHR) accessed by patients and all providers (primary, public, private hospital, aged care) (%) – Goals of Care or Advanced Health Directives (AHD) for every patient (number or percentage) – Every admission form to include a prompt to consider whether a patient requires an Advanced Health Directive
2.	When a person enters the healthcare system an EHR with a unique identifier is established.	– Percent of contact with a health service and percent of EHRs established. Target = 100 %
3.	When the patient experience is acknowledged, measured and the outcomes are available in the public domain.	– Patient experience data is reported publically – Consistent feedback on the patient experience is implemented across all health facilities – Patient Opinion® is promoted to at least 80% of patients across all health facilities – All comments on Patient Opinion® are responded to. – 100% compliance by Health Services (HS)/Health Service Providers (HPSs) with implementation of the WA Carers recognition Act 2004 policy – Proportion of feedback (complaints) that results in change in area health service practices – There is evidence of the use of culturally appropriate feedback systems
4.	When diverse patient groups are catered for.	– Life expectancy of Aboriginal populations equals that of non-Indigenous – 50% of aboriginal people are cared for by an aboriginal strong health workforce with 10 years – All health specialities and disciplines have Telehealth capability – All health facilities are 100% compliant with the WA Health System Language Services Policy – Percent measure
5.	When culturally appropriate methods of measuring patient experience and feedback systems are available in all health facilities.	– Percentage of feedback from marginalised groups
6.	When the role of the carer is seen as a partner in the delivery of health care.	– 100% compliance by HS/HSPs with implementation of the WA Carers recognition Act 2004 policy
7.	When the consumer voice is recognised and is part of service planning and service review at every level of health delivery.	– Compliance reporting of consumer engagement at the decision making tables – All HS/HSPs demonstrate active consumer engagement programs/strategies – Consumer representation is present at all levels of service planning and service reviews

8a.	When the patient experiences a holistic and seamless delivery of health care.	– Timeliness of information exchange (e.g. discharge summary completion rates, timeliness of outpatient letters/correspondence) – Access to investigation results Investigation results are reported in 100% of inpatient discharge summaries and 100% of outpatient correspondence letters. – Percentage of complex care patients having a care coordinator
8b.	When patients transfer or travel is seamless and timely, and patient transport providers are seen as integrated within the overall health service.	– Integrated and state-wide Patient Assisted Travel Scheme (PATS) program Centralisation of the PATS
9.	When the impact of chronic disease reduces.	– A reduction in Disability Adjusted Life Years (DALY) attributable to i) Ischaemic heart disease, ii) chronic pulmonary disease, iii) diabetes – All HS/HSPs, in conjunction with the primary health and non-government organisation (NGO) sector, have a chronic disease self-management program in their health facilities – All HS/HSPs implement a chronic disease coordination program for patients with 2 or more conditions listed by WA Health as being amenable to preventative measures – There is an integrated care pathway for every patient with chronic disease with clearly articulated tiers of care needs
10.	When primary care is put first and foremost.	– GP satisfaction with hospital communication – 100% Discharge summary completion rates and receipted – 100% of GP referrals to outpatients have documented communication back to the GP – Immediate access to specialist advice for clinicians in primary health care is available in all health services. This will mean the patient does not require admission and the clinician is upskilling and building capacity – Transition of care to and from primary to secondary / tertiary systems is seamless as reported by the patient or family – Funding follows the patient pathway – Rates of ED presentations in triage 4 and 5 are reduced to 5% of total presentations
11.	When hospital in the home beds are greater than traditional hospital beds.	– Number, percentage and occupancy of Hospital in The Home (HITH) beds
12.	When the acute sector and primary care work together to improve patient pathways and health outcomes.	– Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home) – MOU in place between HSPs and Aboriginal Health Council of WA (AHCWA) – MOU in place between HSPs and WA Primary Health Alliance (WAPHA) – Reduction in Waiting times for individuals with substance abuse disorders
13.	When the variations to achievable health outcomes across regions are made clear and transparent to consumers.	– Clinical variation mapping and reporting in the public domain
14.	When consumers have increased health literacy.	– Demonstrated increase in the uptake of AHDs and Goals of Care – Demonstrated increase in the use of Patient Opinion®

15.	When all patients admitted to aged care have an AHD in place and linkages back into tertiary and primary health networks.	– Record counting compliance rates
16.	When WA Health prioritises Investment in infant, child health and youth.	– Decrease in waiting periods for outpatient appointments and intervention for children and adolescent patients – Decrease wait between diagnosis and intervention – When all HS/HSPs quarantine funding for early intervention for the 0-2 year old age cohort
17.	When the incidence of risk factors attributable to chronic disease decreases.	– Decrease prevalence of harmful alcohol use by 20% based on public sales following Public Health campaign – Increase the prevalence of WA persons who meet the Australian Dietary Guidelines recommendations for daily fruit and vegetable intake – Increase the prevalence of WA persons who meet sufficient levels of physical activity
18.	When we can ensure birthing practices are appropriate and evidence based.	– Benchmark Caesarean rate with other states – Increase access to continuity of midwifery carer model (number of health services offering the model, number of women and percentage receiving care in the model)
19.	When vaccine preventable conditions decrease.	– Percent of fully immunised children reaches >95 in all age groups – Health care worker influenza vaccination rates reaches 70% – Adolescent vaccination rates reaches 90% – Pneumococcal and influenza vaccination status is recorded for All at risk patients on admission
20.	When Area Health Services have partnerships with local councils.	– Health focused MOU – public support for health education, harm minimisation and fitness programs – Number of programs – Percentage of working parties with consumer/ carer representation
21.	When there is a process/system for development of state-wide evidence based clinical guidelines with clinical content experts/specialists drawn from health service.	– Measure across site Professional Development (PD) Opportunities – Measure across site patient outcomes for specific health conditions e.g. asthma
22.	When an increased percentage of health dollars are allocated to research and education at a rate of 5 to 8%.	– Proportion of budget allocated to research and education by each health service

	Prevention, Promotion and Partnerships	
1.	When the acute sector and primary care work together to improve patient pathways and health outcomes.	– Number of programs and partnerships delivering collaborative care with agreed health outcomes (health quicker, cheaper, closer to home) – MOU in place between HSPs and AHCWA – MOU in place between HSPs and WAPHA – Increased number of GP clinics co-located near ED Departments – Measure of integrated care pathways for every patient with chronic disease that articulates care needs
2.	When Aboriginal persons enjoy the same health as the mainstream population.	– Aboriginal populations have the same life expectancy and health outcomes as the non-Aboriginal community
3.	When consumers have increased health literacy.	– Demonstrated increase in the uptake of AHDs and Goals of Care – Demonstrated increase in the use of Patient Opinion – Active participation in setting Goals of Care
4.	When we work with communities to better meet their health care needs.	– All HS/HSPs demonstrate active consumer engagement programs/strategies – Consumer representation is present at all levels of service planning and service reviews – The engagement of GPs in care partnership
5.	When Hepatitis C is eliminated within 10 years.	– Increase in uptake of Hepatitis C treatment – Decrease in waiting time for hepatology outpatient appointments for Hepatitis C treatment – Decrease in hepatitis failure caused by hepatitis C
6.	When the incidence of risk factors attributable to chronic disease decreases.	– Decrease the prevalence of smoking rates – Decrease the prevalence of obesity in children and adults – Decrease in drug and alcohol related conditions – Decrease alcohol sales as a measure – Decrease prevalence of harmful alcohol use – Increase the prevalence of WA persons who meet the Australian Dietary Guidelines recommendations for daily fruit and vegetable intake – Increase the prevalence of WA persons who meet sufficient levels of physical activity
7.	When vaccine preventable conditions decreases.	– Percentage of fully immunised children reaches >95 in all age groups – Health care worker influenza vaccination rates reaches 70% – Adolescent vaccination rates reaches 90% – Pneumococcal and influenza vaccination status is recorded for All at risk patients on admission
8.	When there is a strong partnership with local councils, education, housing, justice to address the social determinants of health.	– Regular round table meetings between agencies to identify and address local issues with accountability to Parliament – Improved health literacy – Number of Health promotion community run programs – Presence of interagency committees
9.	When there is evidence of effective working partnerships between consumer, GP, Primary Health Networks (PHN) and tertiary services.	– E health record in place and owned by the patient – 100% discharge summary on discharge – Reduction in unnecessary readmission to tertiary healthcare – Decease in presentations of Triage score 4 and 5 in tertiary Emergency Departments (EDs)
10.	When we can improve care for individuals with substance abuse disorders.	– Reduced waiting time for programs supporting individuals with substance abuse disorders

11.	When all patients admitted to aged care have an AHD in place and linkages back into tertiary and primary health networks	– Audit of admission records demonstrates 100% compliance with AHD recording
12.	When Patient experience is valued.	– Patient experience is measured across the whole patient journey and care centres
13.	When an increased percentage of health dollars needs to be allocated to research and education at a rate of 5 to 8%.	– Percentage of budget – Proportion of budget allocated to research and education by each health service

	Quality and Value	
1.	When there is zero healthcare associated harm to patients.	– Measure and outcome reporting of all Severity Assessment Codes (SAC) 1s at HSPs – Classification of Hospital Acquired Diagnoses (CHADx)
2.	When unwarranted duplication has been eliminated.	– Re-order rates/percentage across private and public – Periodic audits of elective surgery admissions to assess co-ordination of pathology / x-rays and corroborate reduction of duplication – Standardisation of protocols and policies across services including public / private services – Accessing results is faster than reordering tests
3.	When interventions not endorsed by Choosing Wisely are disinvested.	– Expenditure on non-endorsed interventions – Percentage of compliance with Choosing Wisely strategies.
4.	When patient services are efficiently used.	– Proportion of patients who need to return for test results – Percentage that come back multiple times for the same referral
5.	When there is a transparent process involved with high cost “low value” interventions.	– Reportable costs with overseeing panel for each site – Percentage of decisions which have appropriate authorisation – Patient understanding of health care decisions – Public reporting on waste
6.	When there is seamless transition from acute to primary healthcare.	– Proportion of handover to GP – GP satisfaction with hospital communication – Proportion of patients with discharge summaries – GP review of discharge summaries within timeframe – Measure of patient satisfaction with transition.
7.	When all patients have Goals of Care / Advanced Health Directive.	– Percentage of patients who have documentation of Goals of Care
8.	When both clinicians and consumers agree on the measure of safety and access to services .	– Agreed indicators across WA health for each specialty with consumer endorsement – Agreed wait times for elective procedures, clinical referral, access to a specialist
9.	When clinical staff are adequately supported in administrative duties.	– Percentage of administrative support provided to clinician managers/Heads of Departments (HoDs) – Clinicians’ satisfaction with administrative support provided to their teams to support patient care – Time in motion studies for clinician management to review time spent of duties that could be performed by clerical/administrative business/HR staff
10.	When staff engagement is effective.	– Staff retention – Sick leave – Staff feedback – WA Health policies for dealing with bullying and disrespectful behaviour at senior level are contemporary and implemented – Culture surveys demonstrate consensus regarding ‘above’ and ‘below’ the line behaviours with mandatory consequences
11.	When staff are working to their scope of practice (i.e. cutting out lower value tasks, able to divulge tasks to the most appropriately skilled person, not sending patients back to GP for specialist referral/ imaging, removing the barriers e.g. advanced scope roles).	– Reduced wait times for services – Reduced point of contact for an episode of care – Improved staff satisfaction.

12.	When WA Health has a suite of endorsed indicators to benchmark and measure quality of services.	– MyHospitals indicators – WA Emergency Access Target (WEAT) >80% – >90% children aged 5 are fully vaccinated – Preventable admissions are <5%
13.	When clinicians are given real time data on their performance and benchmarked against their peers, and made publicly available.	– Atlas of Variation
14.	When WA Health is meeting the National Efficient Price (NEP).	– Measure against the Independent Hospital Pricing Authority (IHPA) and track reason for variation

	Workforce and Culture	
1.	When WA Health is the employer of choice for healthcare workers as *rated by the system*	– Vacancy rate across all areas of care delivery – professional and non- professional staff is low – Low staff turnover – Research output is high – Peer comparisons rank WA Health as a system leader
2.	When WA Health is the employer of choice *by healthcare workers*	– Increased retention rate – Leading staff engagement scores on benchmarked tools – All positions filled – Reduced OSH stress and absenteeism – Increase in substantively filled roles and reduction in acting percentages for staff – Staff satisfaction is >70% – Sick leave rates – Lost time to injury rates – Proportion of vacancies, permanent, acting – Access to teaching and training – Increased access to flexible working hours – Timely recruiting processes and practices within 4 weeks
3.	When WA Health is an employer of choice *by International reputation*	– World leading in clinical care – Percentage of research papers published – Uptake Nationally and Internationally of innovative change – State, National and International compliance with accreditation standards and measures of safety
4.	When staff wellbeing programs are embedded into the Heath service.	– Presence of staff welfare programs and number of staff accessing them – Increased rates of reporting incidents and hazards – Access to further development programs
5.	When managers and leaders have leadership training.	– When 80% of managers have management training (20 hours) – Leadership training completion rates (% of all in leadership positions)
6.	When Leadership programs are linked with performance development processes / plans	– Percentage of staff that have undertaken leadership development plans
7.	When we have the right people, providing the right care in the right place	– Baseline workforce metrics: demographics and skill mix measures – Benchmark cost of episodes of care – Agreed acceptable low volume service delivery locations
8.	When innovation is integral to culture.	– Establishment of innovations department – Innovations are shared system wide and state wide – When innovation becomes a Health Service Provider Report (HSPR) Key Performance Indicator (KPI) – Incentives for IT software and hardware solutions from a university level
9.	When all members of the health workforce feel valued equally.	– Investment in leadership and development programs – Investment in career development pathways – Development of assistant models to relieve the non-clinical workload – Representation of all health professionals on key decision making committees – Salary scales for leadership roles should be the same regardless of awards (AMA, HSU or ANF or professional background)

10.	When skill mix is appropriate for patient demand.	– Continue targets to increase percentage of Aboriginal workforce – Increased advance practice roles for non-medical staff
11.	When we are able to appropriately manage poor performance.	– All employees have appropriate performance planning and self -directed appraisal – Number of employees being performance managed – Evidence of managing substandard performance is a recruitment criteria for managerial positions – HR support is available in 100% of substandard performance management processes. – Establishment of WA Health 'above' and 'below' the line behaviours with mandated consequences – Recruitment and dismissal processes are values based 100% of the time
12.	When society has confidence that all health care does not have to be provided in an acute care setting.	– Percentage of care delivered outside a hospital setting – Investment in non-hospital centres health care delivery services and locations by government – When consumers can identify a transparent link between GPs and specialists.
13.	When undergraduate training for all clinicians commences with a common base unit(s) and shared training. Individuals then take on further training (i.e. Nursing, Medicine)	– Number of units that provide Inter Professional Learning (IPL)

	Financial Sustainability	
1.	When healthcare expenditure does not grow beyond Consumer Price Index (CPI).	– Expenditure as a percentage of state budget – Expenditure as a percentage of Gross domestic product (GDP)
2.a	When healthcare costs are transparent to both consumers and clinicians.	– Patient Reported Outcome Measures (PROMs) at head of service level – Budgets at head of service level – Consumer Advisory Councils are aware of the financial status of health
2.b	When healthcare costs are related to clinical and patient reported outcome measures.	– Costs of testing/treatment are displayed in the public domain – Report the amount of spend on unnecessary duplication of services and reduce it by X percentage – Transparency of costs over the full cycle of care is identified
2.c	When consumers understand waste in healthcare.	– Reduction in consumer requests for futile care or non-evidence based services
3.	When there are bundled payments for GPs over the whole cycle of care.	– Number of (chronic disease) Diagnosis Related Groups (DRGs) with bundled payments – Number of DRGs with bundled payments – Number of GPs receiving bundled payments for patients with chronic diseases
4.	When the Head of Service is a recognised position and those in these roles are adequately educated to be accountable for these budgets	– All allocated budgets will be with 5% of expenditure to forecast – All Head of Departments have completed financial education within 12 months of assuming the role
5.	When population health funding is quarantined and separated from hospital budgets for each area rather than a hospital budget.	– Improvements in access to care – Rates of sentinel complications related to number of DRG funded patients – Reductions in Potentially Preventable Hospitalisations (PPH) – Percentage of the health budget allocated to preventative activities
6.	When WA Health has a clear understanding of its finances.	– Robust tools – Robust metrics – Connected finance reporting systems
7.	When the proportion of waste to the total health spend is reduced by at least X% per year.	– Compliance reporting against “on tender” purchasing. – Compliance reporting against the use of “off tender” request processes. – Contract managers in every HSP
8.	When costs of care are transparent to both consumers and clinicians, and are related to clinical and patient reported outcomes.	– Cost related to the National Efficient Price (NEP) target – Unplanned readmission at 30 days or within 24 hours – Standardised adverse events measures per discipline – Patient reported outcomes per discipline (e.g. International Consortium for Health Outcomes Measurement (ICHOM) scores per discipline) – When the amount of spending on treatments are <u>not</u> endorsed by Choosing Wisely

9.	When the consumers lead the decisions on where the budget for health care is spent.	– Each HSP Board engages consumer members on financial decisions – Number of citizens juries held to discuss health spending – Community Advisory Councils or similar in every health service – Audit the consumer understanding of “informed consent” annually and n=200
10.	When clinicians have timely access to specialist advice that reduce unnecessary tests and/or hospitalisation.	– Reduction in Length of Stay (LOS)

	Digital, Innovation and Research	
1.	When 'inpatients' can be monitored at home.	– Reduction in Length of Stay (LOS) – Cap on hospital beds – No increase in tertiary/ general hospital beds. An absolute cap on available hospital beds
2.	When home monitoring with a system that includes patient GP, nurse specialist working collaboratively with real time data to maximise patient outcomes is embedded everywhere.	– 60% of homes of people with chronic complex conditions have home monitoring connected to their health care team within 2 years
3.	When we have real-time prescribing.	– Reduction in inappropriate prescriptions S4 and S8 medications – Clinician access to real-time prescribing (including decision support) % – Scripts filled through real-time prescribing % – Contemporary decision support systems are promoted – Accreditation affirms high-quality decision support leading the country
4.	When research is integral, funded and demonstrates improvement in health outcomes.	– The data is linked to the performance of the health service – A percentage of HSP budgets be quarantined for research activity – Metrics are developed to corroborate translational research relevant to health facility priorities – Promote evidence-based decision-making throughout the system by developing 'markers' of evidence-based treatment and monitoring its delivery – Statewide clinical guidelines – A measure of health funded research
5.	When we have effective research transfer.	– Variation outside evidence based guidelines diminishes over time
6.	When innovation incubation occurring throughout the health system and is visible, valued and when demonstrated to be effective, has a pathway to scaling up and embedding.	– 1.5% of HSP budgets are quarantined for innovation and embedding
7.	When HSP policies and procedures enable uptake of new social technology for patient benefit and fully imbedded in day to day business (metro and rural)	– When all specialist first follow up assessments are done by telehealth/ percentage of subsequent visits. Reduction in PATS expenditure/ usage
8.	In regions of aboriginal population density, Aboriginal Health Practitioners use all available IT to serve their communities.	– 100% Aboriginal Health Practitioners report they are enabled to use all IT available in their context to the benefit of Aboriginal people
9.	When there are consistent digital systems across all HSPs.	– All health services use same patient administration system, pathology system, imaging system etc. – Staff satisfaction increase – Implementation of a centralised and common patient management system across all health services

10.	When there is a fully functioning e-health record utilised by all health care providers with ready access to all results, investigations, history, medications etc.	– Percentage of health care providers using e-health record – Number of patient records being used health care providers – Reduction in investigation duplication shown by reducing costs – Includes primary health care, public hospital and private hospital care, specialist care – A patient controlled health record – Number of patients using e health record – Data breaches are monitored and sanctions for behaviour outside of policy are implemented by managers
11.	When we have digital systems that allow rapid transfer of information.	– 95% discharge summaries received by GP within 24hrs of discharge
12.	When patients can use existing digital technology to navigate health service sites.	– Patient experience reporting – Number of hits on the App

This document can be made available in alternative formats on request for a person with a disability.

© Department of Health 2018

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.