SERVICE PLAN:

CENTRAL GREAT SOUTHERN HEALTH DISTRICT (2011/12 – 2021/22)

Endorsed 26 September 2012

Working together for a healthier ***country WA***

Our Values: *Community | Compassion | Quality | Integrity | Justice*

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I certify that the *Service Plan* has been developed to my satisfaction, and proposed strategies are aligned with regional and Country Health Services strategic directions.	
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I certify that the *Service Plan* has been developed to my satisfaction, and proposed strategies are aligned with regional and Country Health Services strategic directions.	
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I certify that the *Service Plan* has been developed to my satisfaction, and proposed strategies are aligned with regional and Country Health Services strategic directions.	
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ACRONYMS

24/7	24 hours a day, 7 days a week
ACAT	Aged Care Assessment Team
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
COAG	Council of Australian Governments
CSF	Clinical Services Framework
CSSD	Central Sterilising Services Unit
DHAC	District Health Advisory Council
ED	Emergency Department
ENT	Ear Nose and Throat
ERP	Estimated Resident Population
ESRG	Expanded Service Related Group
FESA	Fire and Emergency Services
FTE	Full Time Equivalents
GP	General Practitioner
HACC	Home and Community Care
HIN	Health Information Network
ICT	Information Communication Technology
MPS	Multipurpose Service
RFDS	Royal Flying Doctor Service
SCHS	Southern Country Health Service
SEIFA	Socio-Economic Indexes for Areas
SIHI	Southern Inland Health Initiative
SWWAML	South West WA Medicare Local
WACHS	WA Country Health Service

KEY DEFINITIONS

Ambulatory health care is a broad term that generally refers to the planned services provided to patients who are able to 'walk in and walk out' on the same-day. Ambulatory care services can include primary health care services, day surgery and outpatients (e.g. wound care and management).

Primary health care is an aspect of ambulatory health care but is generally first level health care. The term is sometimes used interchangeably with the term primary care although primary care tends to refer to the clinical care provided by GPs. Primary health care gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes:

- Health promotion
- Illness prevention
- Clinical treatment and care of the sick
- Community development
- Advocacy and rehabilitation

Primary health care is provided by general practitioners; practice nurses; primary/community/child health nurses; pharmacists; dentists; allied health professionals; aged care workers, support workers; and many other providers across the local, state and federal government sectors, non-government organisations and the private sector.

Primary health care centre generally refers to a stand-alone health facility where primary health care services are provided. It would ideally be located in close proximity to emergency department and may be collocated with inpatient, outpatients, minor wound care and diagnostic services. A primary health care centre does not include day surgery services.

Nursing posts are generally located in small towns that do not have a hospital. Nursing posts are also a setting for primary health care services and visiting outpatient services and although they do not have an emergency department, they do provide low level emergency care and stabilisation to patients prior to transferring to a more specialised health service when required.

A full glossary is listed at the end of this service plan.

Important note:

On July 2012, WA Country Health Service (WACHS) consisted of two new health services - Southern Country Health Service and Northern and Remote Country Health Service. This enhancement to WACHS aligns with the plans put forward in to Council of Australian Government's (COAG) National Health Reform Agreement (2011).

1 EXECUTIVE SUMMARY

This service plan provides the strategic direction to strengthen the Southern Country Health Service's (SCHS) Central Great Southern health system over the next 10 years. The plan focuses on strategies that will enable the Central Great Southern Health District's integrated network of services to better meet the role delineations within WA Health's *Clinical Services Framework 2010 – 2020 (CSF, 2010a)*.

The district's health services include Katanning Hospital, Kojonup Hospital, Gnowangerup Hospital and Tambellup Nursing Post. These are supported by a range of public and private primary health care services, Albany Health Campus and metropolitan health services.

With the announcement of the State Government's $565 million *Southern Inland Health Initiative (SIHI)* and the redevelopment of Albany Health Campus, the recommendations of this plan will inform the development of a *SIHI Implementation Plan* which will detail the opportunities for investing the recurrent and capital funding available and work towards better integrating district and regional health services.

The service plan also provides baseline information for SCHS to monitor consumer demand and service activity as the Katanning SuperTown initiative is progressed.

The Service Plan was developed via a comprehensive planning process as detailed in *Appendix A.* Consultation revealed the strategic vision for health service delivery in the Central Great Southern is to integrate and boost primary health care services across the district and provide 24/7 efficient and effective medical service coverage which could be achieved by having sustainable complementary models of care across the continuum of care. Another key aspect of the vision is to better equip Katanning hospital to achieve its role delineations outlined in the CSF (2010a) within the context of workforce constraints.

Strengthening the integration of the local health systems from primary care to emergency care will have many benefits for the community. The Department of Health and Ageing (2009) acknowledge that health systems with strong, integrated primary health care systems are more efficient; have lower rates of hospitalisation; fewer health inequalities; and better health outcomes, than those that do not.

The way forward for SCHS to achieve this vision and more for the Central Great Southern is described in this service plan. It is essential that this service plan is reviewed as facility planning progresses, new policies are introduced and the needs of the community change.

Planning context

The Central Great Southern Health District is part of the larger Great Southern Health Region. The Great Southern Health Region incorporates two health districts: the Central Great Southern and Lower Great Southern, with Albany being the regional centre (Figure 1).

The Central Great Southern Health District includes the town sites and surrounding areas of Katanning, Kojonup, Gnowangerup, Broomehill/Tambellup, Woodanilling and Kent. The boundaries are defined by the Australian Bureau of Statistics (ABS) statistical local areas (SLA).

Figure 1: Central Great Southern Health District

Source: Department of Health Epidemiology Branch (2009).

Note: As of July 2012, Ravensthorpe (formerly part of the South East Coastal District) is part of the Great Southern Health Region. This is not illustrated in the image above.

Key catchment area features influencing service delivery

Rural location

The Central Great Southern Health District is located in a rural area of Western Australia (WA) with the district's major townsite of Katanning located approximately 250km south east of the Perth metropolitan area and 165km north of Albany.

The district experiences a level of isolation which can have a number of influences on health service delivery.

- Residents' access to health services, particular primary health care services, can be limited if mobile outreach services, e-health and telehealth modalities, or transport is not readily available.
- The level of isolation can adversely impact on workforce attraction and retention, reducing the ability to sustain service delivery. The lack of just one specialist or one highly trained individual can mean the difference between a service operating or not.
- Being a farming area and on the thoroughfare from Perth to the Great Southern, the district does experience major motor vehicle and farming accidents. This requires emergency services to remain responsive and equipped to manage highly acute trauma cases that may occur.
- Whilst the townsites have large populations, a significant proportion of the population resides on farming property outside the townsites which can challenge health service delivery and program reach.

Opportunities to invest the funding available through SIHI to boost service delivery, utilise telehealth technologies and deliver new workforce models for care will be required to overcome these challenges to sustain service delivery and provide care closer to home where possible.

Population growth

The current population of the Central Great Southern Health District is approximately 10,600, with Katanning shire being the largest population centre with 5,000 residents. According to the ABS Series B+ population projections, the population of the district is anticipated to grow by approximately 10% by 2021. If this growth is achieved, the Department of Health anticipates that demand for inpatient beds will increase slightly (refer to Section 6.3).

This growth however does not account for the population boom anticipated by the WA government's Regional Centres Development Program, known as the 'SuperTowns' initiative. Katanning is earmarked to become a SuperTown by the Department of Regional Development and Lands. This initiative has the vision to triple Katanning's population to 15,000 over the next 15 years which will exceed current planning forecasts and impact on health services. SCHS will need to monitor and adjust services and facilities accordingly to meet local needs and local industry if projections are realised (refer to Section 3.4.2 for more information).

Local industries

The main industries in the region are agriculture, fishing, forestry, meat processing, tourism and viticulture. There is also growth in mining exploration and operations involving gold, salt and magnetites. This emerging growth is the main instigator for Katanning to become a SuperTown.

Ageing community

The number of older people aged 70 years and over in the Central Great Southern is expected to increase by 45% by 2021. This is an increase from 1,100 individuals to 1,593. Health services will need to work in partnership with agencies to plan for this increase. Priority areas of need include sub-acute care to manage the transition from acute care; primary health and transitional models to keep people well in the community; and high-care residential aged care and dementia services, including services and facilities for those with dementia. Peripheral services such as transport options to access care and mobile service delivery models should also be explored.

Young families

Demographic data indicates that the Central Great Southern has a higher amount of individuals aged 0 to 14 when compared to WA. This indicates that a high proportion of the district includes young families. The Katanning SuperTown initiative and the commencement of mining operations in the district are expected to attract more young families to the Central Great Southern. SCHS will need to sustain primary health care and medical service delivery to meet future demand. This would include providing and sustaining child and school health services, allied health services, ante and post natal care, low risk obstetric services and visiting specialists such as a paediatrician and ear nose and throat (ENT) services.

Multicultural Community

The high representation of Aboriginal people reflected in mortality, preventable mortality, morbidity, hospitalisation and emergency department statistics indicates the importance of providing culturally secure services, particularly primary health care

programs specific to the conditions and risk factors pertinent for Aboriginal people (e.g. diabetes management and control).

During consultation, stakeholders reported that a high proportion of primary school aged children in the local area have English as a second language and there are at least 50 language groups present in the community. Health services will need to investigate ways to improve health literacy and ensure appropriate resources are available for the migrant population, ensuring care is provided at the right time, in the right setting and in a culturally secure manner.

Current service profile

The major hub for health services in the Central Great Southern is Katanning Hospital. Katanning Hospital is defined by the WA Health *Clinical Services Framework (CSF 2010a)* as an integrated district health service. The hospital is also recognised as a multipurpose service (MPS) site by the State and Commonwealth governments.[1]

Katanning Hospital works within an integrated network of district, regional and metropolitan health services. This includes the nearby MPS sites in Kojonup and Gnowangerup; the nursing post in Tambellup; the larger Albany Health Campus (regarded as the regional resource centre); the more specialised metropolitan hospitals and health services; ambulatory care services (Section 3.2) and health partners. Health partners include General Practitioners (GPs), government and non-government services, private providers and not-for-profit agencies (refer to Section 5).

The network of SCHS hospital and health services are highlighted in Figure 2. This network of services provides a continuum of care for the residents and visitors. Patients and consumers are treated and/or referred to the most appropriately resourced health service to meet their health care needs.

The level of care provided by health facilities across the State is defined within the WA Health *Clinical Services Framework 2010 - 2020*. This Framework also provides direction for the level of care required at regional resource centres and metropolitan hospitals until 2020/21. It excludes the role delineations of small hospitals which can be assumed to operate level one to two services.

1 Multi-purpose Services (MPS) are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities. For more information refer to: http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm

Figure 2: Current network of SCHS Central Great Southern health services

Services provided	Small Hospitals/ Multipurpose Services				
	Kojonup MPS (Level 1 -2)	Gnowangerup MPS (Level 1 -2)	Katanning MPS (Level 2 –3)	Albany RCC (Level 4 – 5)	Peth Metropolitan Hospitals
Emergency	✓	✓	✓	✓	
Elective Surgery	✗	✗	✓	✓	
Acute admissions	✓	✓	✓	✓	
Planned births	✗	✗	✓*	✓	
Antenatal & postnatal care	✗	✗	✓	✓	
Paediatrics (inpatient)	✗	✗	✓	✓	
Mental health inpatient (unauthorised/voluntary)	✓	✓	✓	✓	
Community aged care	✓	✓	✓	✓	
Residential aged care	✓	✓	✓	✗	
Hospice / palliative	✓	✓	✓	✓	
Outpatients	✓	✓	✓	✓	
Oncology / chemotherapy	✗	✗	✗	✓	
Renal dialysis	✗	✗	✗	✓	
Rehabilitation	✗	✗	✓	✓	
Population health	✓	✓	✓	✓	

Source: Myhospital.gov.au (accessed 26 January 2012) and SCHS – Great Southern. Developed by Aurora Projects.
**planned births at Katanning are currently temporarily suspended due to workforce constraints.*

Proposed Strategic Directions for Service Delivery

A review of the Government policies, planning initiatives, drivers for change and stakeholder expectations has identified the following strategic directions for Central Great Southern health services:

- Strengthen the integration of services across the continuum of care.
- Focus on primary health care and non-inpatient care.
- Enhance demand management strategies to reduce demand on acute and emergency services for primary health care.
- Deliver care closer to home and increase self-sufficiency.
- Improve Aboriginal health outcomes.
- Improve aged care services.

- Attract and retain a skilled workforce.
- Strengthen partnerships with primary care, private and not-for-profit providers.
- Utilise ICT advancements for better care.
- Create a safer environment for all.

The priorities for local health service reform include:

- Support the greater integration of services on the Katanning Health Campus by collocating primary health care services with outpatient care, adjacent to Emergency Department (ED) and mental health clinical services.
- Strengthen service integration across the continuum of care between Albany and Katanning as service reform and redevelopment are achieved at both sites.
- Boost primary health care service integration to better detect, assess and manage chronic health and mental health conditions. Suggestions include additional resources for allied health services; mental health prevention, promotion and counselling; dental care; transitional care; support in the home; early childhood services; youth and adolescent services; alcohol and other drug services; and multicultural and Aboriginal health liaison roles and associated workforce models.
- Increase resources for the management of mental health consumers with co-morbidities (alcohol and drug and chronic diseases).
- Ensure 24/7 "close on call" emergency and medical coverage.
- Provide greater access to visiting medical and surgical specialists. District priorities for visiting specialists which meet the identified need include securing the services of a General Physician, Ophthalmologist, General Surgeon, Psychiatrist, Rheumatologist, Gerontologist, Obstetrician, Gynaecologist, Paediatrician and Emergency Medicine specialist.
- Increase the capacity for planned elective surgery in Katanning through greater visiting surgeons from Albany Health Campus.
- Provide culturally secure services for the local Aboriginal and CALD communities.
- Utilise ehealth and telehealth technologies to enhance patient health outcomes (e.g. electronic medical records and video conferencing for patient care and staff support).
- Attract, retain and nurture a skilled workforce to increase and sustain service delivery.
- Upgrade infrastructure and ICT to contemporary standards to improve patient flow, reduce occupational health and safety risks and support best practice models of care.

Funding has already been allocated through SIHI to provide incentives to attract and retain GPs and an ED nurse practitioner to build a sustainable 24/7 emergency model for the district. Funding is also allocated to increase primary health care services in the district and to develop telehealth services, primarily in the emergency departments and for clinical consultations.

Translation of service requirements to service implementation and facility requirements

This service plan will assist in informing the development of future business cases for the potential redevelopment of sites and services in the Central Great Southern to support local service reform. The facility requirements to support reform are summarised in the Recommendations chapter of this service plan.

Capital funding has been notionally allocated through the SIHI project ($35.4 million) to redevelop the Katanning Health Campus to support the service reform priorities. The

redevelopment has a focus of building an integrated primary health care centre with upgrades to the ED, inpatient, pathology, medical imaging, theatres, non-clinical support services and site service infrastructure.

Furthermore, SIHI's Stream 3 (*Primary Health Care Demonstration Program*) and Stream 4 (*Small Hospital and Nursing Post Refurbishment Program*) have funding allocated to a number of health sites across the Wheatbelt, Midwest, Goldfields, South West and Great Southern regions. The implementation for these streams of activity to identify sites and prioritise capital works has commenced.

2 INTRODUCTION

This service plan, by the Southern Country Health Service (SCHS), sets the strategic vision for the delivery of emergency, acute, primary health care, aged care, mental health and associated clinical and non-clinical services to at least 10,600 residents and visitors of the Central Great Southern Health District.

The service plan will also inform the $565 million *Royalties for Region's Southern Inland Health Initiative's (SIHI) Implementation Plan.* The *SIHI Implementation Plan* will contain a number of service reform and capital works initiatives designed to enhance the sustainability, self-sufficiency and network of health services in the SCHS Great Southern, Wheatbelt, Mid West, Goldfields, and South West regions. This includes the network of services in the Central Great Southern.

The plan will also provide baseline information for SCHS to monitor service activity as the SuperTowns initiative is implemented and population projections are realised.

The planning process undertaken to develop this service plan is detailed in *Appendix A*. The recommendations for service reform developed as an outcome of this process will ensure that future service delivery in the Central Great Southern will:

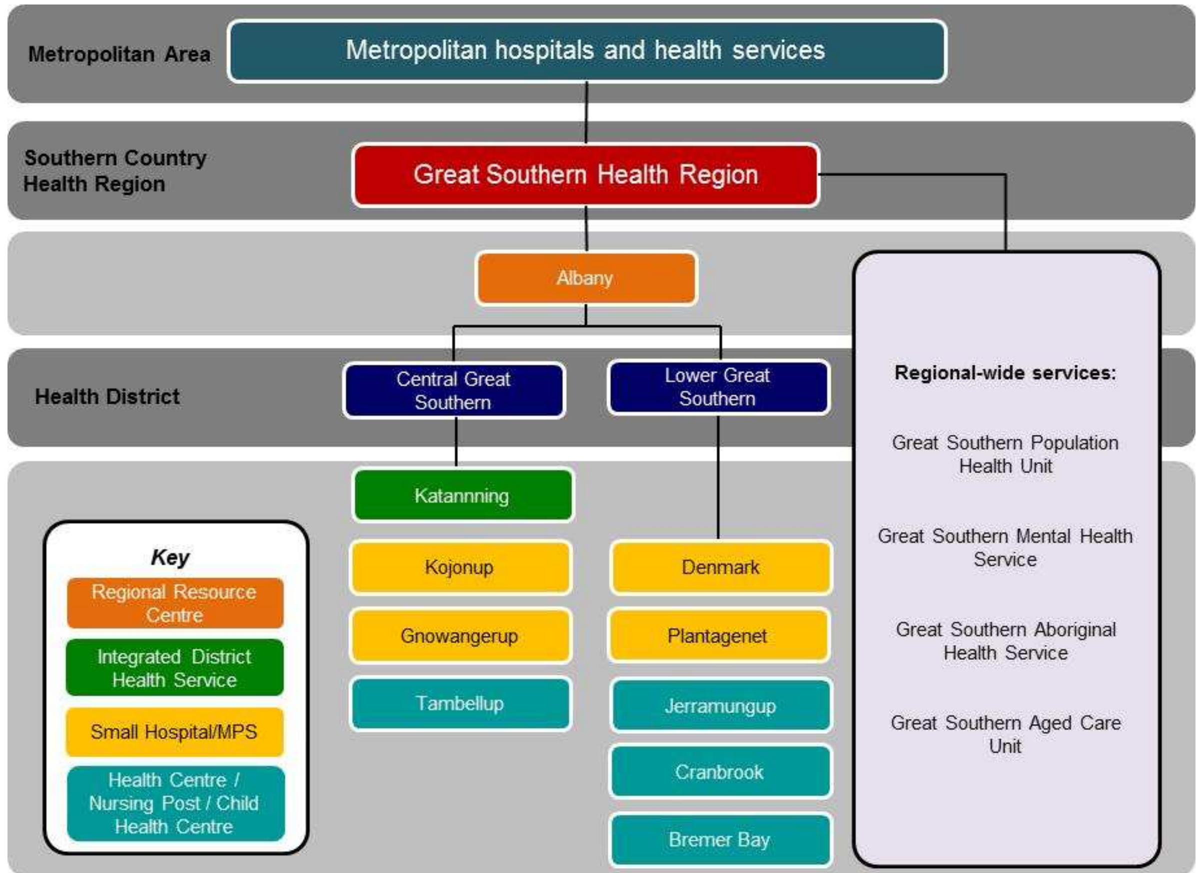
- Align with National and State policy and plans including the *WA Health Clinical Services Framework 2010 -2011* (CSF 2010a) and SIHI intentions.
- Address the demographic and health needs of the community.
- Meet the projected demand for health services.
- Implement modern and best practice models of care.
- Utilise contemporary health technologies including telehealth.
- Be supported by contemporary healthcare facilities.

3 PLANNING CONTEXT AND STRATEGIC DIRECTIONS

3.1 SCHS Great Southern current services

The operational network of SCHS and Department of Health clinical and primary health care services that residents and visitors can access in the Great Southern Region are described in the following section and are highlighted in Figure 3.

Figure 3: Great Southern: Current clinical and primary health care operational network of WA Health services



Katanning, Kojonup and Gnowangerup are MPS sites. Cranbrook is mainly used for HACC services with a visiting child health service. Image by Aurora Projects

3.2 Central Great Southern health service profile

3.2.1 Ambulatory health care services

Ambulatory health care services is a broad title that generally refers to the planned services provided to patients who are able to 'walk in and walk out' of a health service on the same-day. This includes:

- Primary health care services which incorporate GPs; nurses; allied health professionals; health workers, such as multicultural health workers and Aboriginal health workers; health education and community development workers; population health (e.g. child health, youth health, health promotion, Aboriginal health, chronic disease care and communicable disease control); community mental health; dental health; and community - based aged care services such as Home and Community Care (HACC).
- Same-day surgery and procedures.
- Visiting and permanent outpatient services.

Ambulatory health care services are provided adjacent to emergency and acute services as illustrated in Figure 4. In the Central Great Southern, the following ambulatory health care services are provided by SCHS in partnership with agencies listed in Section 5:

- ***Outpatient services*** are provided at all hospitals. The level and type of outpatient services available at each site depends on the availability of specialists.
- ***Same-day surgery*** is only provided at Katanning Hospital (planned only).
- ***Primary health care services*** include -
    - *Great Southern Population Health Unit* provide population health services to the Great Southern Health Region, with a team based in Katanning.
    - *Great Southern Mental Health Service* has a team based in Katanning that provides inpatient, emergency and some community-based services.
    - *Great Southern Aboriginal Health Service* has a team based in Katanning providing Aboriginal health programs and liaison support to the hospital and community.

The existing primary health care services in Katanning are currently spilt across multiple facilities on the Katanning Health Campus.

Figure 4: Illustration of ambulatory health care services

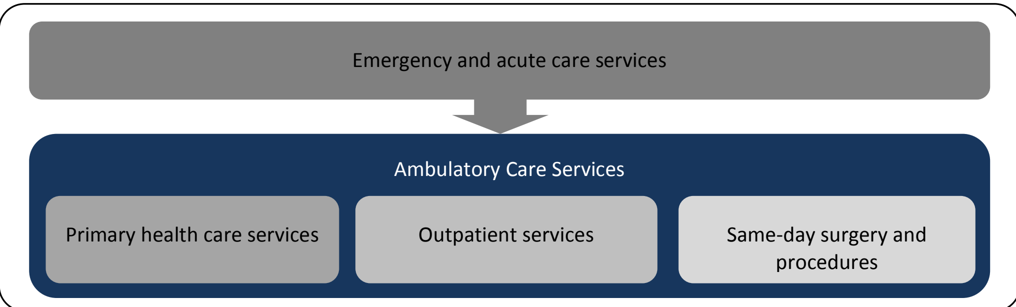


Image by Aurora Projects

3.2.2 Hospital services

Katanning Hospital

According to the *WA Health Clinical Services Framework* (CSF, 2010a), Katanning Hospital is an integrated district health service that networks with the larger Albany Hospital (the regional resource centre), Kojonup Hospital, Gnowangerup Hospital, Tambellup Nursing Post, ambulatory care services (as described in Section 3.2.1) and metropolitan health services. This level of integration attempts to provide a seamless continuum of care for residents and visitors of the Central Great Southern.

Katanning, Kojonup and Gnowangerup hospitals, along with Tambellup Nursing Post and HACC combined are regarded as the Central Great Southern MPS. As part of the Central Great Southern MPS, Katanning Hospital combines residential aged care and palliative care with acute and emergency care services on one site. The capacity of Katanning Hospital's emergency, acute, aged care, palliative care and primary health care services is summarised in Table 1 and detailed in Section 6.

Table 1: Katanning Hospital summary profile

Department	Features
Emergency Department	*24 hour / 7 day a week emergency services nurse-led with close on call GP support with 2 x treatment bays, 1 x consult space (no egress) and triage area. No procedure room. The resuscitation bay is currently based in theatres.*
Medical and surgical inpatient services	*30 bed capacity (includes up to 3 maternity beds), OF which 17 are active. Accepts admissions for surgical and medical, maternity, paediatrics, and acute mental health (no authorised beds onsite). No dedicated same-day beds.*
Residential aged care	*18 permanent high care beds and one respite bed.*
Palliative Care	*1 palliative care suite*
Theatres	*2 x theatres and a Central Sterilising Services Department (CSSD). Currently one theatre is operational.*
GP clinic	*Located on a site adjacent to Katanning Hospital.*
Outpatients/Extended Care	*1 consulting room, shared amongst visiting specialists.*
Aboriginal Health Service	*Co-located with Mental Health Services on campus but away from the main hospital building.*
Great Southern Mental Health Service	*Co-located with Aboriginal Health Services on campus but away from the main hospital building.*
Great Southern Population Health Service	*Located adjacent to allied health services and HACC within the main hospital building.*
HACC	*Located adjacent to population health and allied health within the main hospital building.*
Medical imaging	*Capacity for digital x-ray and ultrasound.*
Pathology	*Collection and laboratory testing facilities available.*
Pharmacy	*Small pharmacy store in the ward area.*

Source: SCHS Central Great Southern (November 2011)

Non-clinical support services including hotel and corporate services are described further in Section 6.6.

Kojonup Small Hospital

Kojonup Hospital, located 40km south west of Katanning Hospital, provides a two-treatment bay 24 hour nurse-led emergency service, six inpatient beds, six residential aged 'high care' beds and supports visiting primary health care and outpatient services. The hospital operates a 2:2:2 staffing roster, therefore only six inpatient beds are utilised at any one time.

Emergency and acute services are supported by a local GP who provides 24 hour close on call support during the weekdays. On the weekends, phone support is provided by the rostered GP on duty in Katanning. The current GP practice in Kojonup is located away from the hospital site.

Kojonup also has onsite: pathology collection (no laboratory services), administration and a cook fresh kitchen. Laundry, CSSD and other disposable supplies are provided from Katanning and/or Albany. Katanning also provides maintenance services to Kojonup.

Surgical, maternity and inpatient mental health services are not provided at Kojonup Hospital. Patients are referred to Katanning, Albany or metropolitan hospitals depending on their health care needs.

Gnowangerup Small Hospital

Gnowangerup Hospital, located 85km south east of Katanning Hospital, provides one-treatment bay 24 hour nurse-led emergency services, four inpatient beds, eight residential aged care beds and visiting primary health care and outpatient services. One bed is located in the decommissioned x-ray room to function as a second ED treatment bay when required. Emergency and acute services are supported by a local GP who is on close on call support during the weekdays. On the weekends, phone support is provided by the rostered GP on duty in Katanning.

Gnowangerup also has onsite: pathology collection (no laboratory services), administration, and cook fresh kitchen. Maintenance, laundry, CSSD and other disposable supplies are provided from Katanning and/or Albany.

Surgical, maternity and inpatient mental health services are not provided from Gnowangerup. As of late 2011, the medical imaging equipment at Gnowangerup was decommissioned due to insufficient demand. Patients are referred to Katanning, Albany or metropolitan hospitals for assessment and care depending on their health care needs.

Albany Health Campus

The Albany Health Campus is the regional resource centre for the Great Southern Health Region and is the base for many regional clinical, primary health care and non-clinical services that have a permanent or visiting presence in the Central Great Southern.

The Albany Health Campus is currently being redeveloped to modernise facilities and support modern models of care to meet future demand from residents and visitors of

the Great Southern Region. More information about the redevelopment project is provided in Section 3.4.3.

The Albany Health Campus Project Definition Plan (PDP) stated that prior to redevelopment, the site consisted of 24/7 emergency services; adult and paediatric medical and surgical services (elective and non-elective) (50 beds); day procedure unit (17 beds); mental health inpatient care (9 beds); maternity services (7 beds); intensive nursing (5 beds); sub-acute services (12 beds); renal services (6 chairs); and chemotherapy (4 chairs); along with non-clinical and clinical support services including regional pharmacy, maintenance and engineering and corporate services.

Central Great Southern health services will continue to transfer patients to Albany and Perth when escalation of care is required due to the expansion of services under the redevelopment project and the ability of the larger regional resource centre to attract specialists and staff.

3.3 Commonwealth and State government policies

The strategic direction for service delivery within this service plan considered the recommendations of Commonwealth and State government policies. The policies that have a direct impact on health services are highlighted in Table 2. Further background information regarding these policies can be found at: http://www.wacountry.health.wa.gov.au/index.php?id=445

From July 2012, the WA Country Health Service (WACHS) will for operational purposes be two new 'Health Services' - Southern Country Health Service and Northern and Remote Country Health Service. The former WACHS Central Office became the Country Health Services Central Office. This aligns with the plans put forward in to Council of Australian Government's (COAG) agreement detailed in the Table below.

Table 2: Major Commonwealth and State policy and strategic framework

Policy	Implications for services
Commonwealth Policy	
COAG National Health Reform Agreement (2011) including Local Health Networks and Medicare Locals	In August 2011, all states and territories agreed to the COAG National Health Reform Agreement which will deliver major reforms to the organisation, funding and delivery of health and aged care services. The Agreement sets out the shared intention of the Commonwealth, state and territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health care system. The reforms will achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for the health system into the future. Local Health Networks and Medicare Locals are being established to locally manage public hospital health services and primary health care services respectively. On 1 July 2012, the SCHS and Northern & Remote Country Health Service were formed with the Central Great Southern forming part of the SCHS. Furthermore, Ravensthorpe Shire became part of the SCHS catchment within the Great Southern region rather than being part of the Goldfields region. For more information: **Local Health Networks :** http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhn-report-toc#.TyhOisWO0sI

Policy	Implications for services
	Medicare Locals: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocals-lp-1#.TyhLMMWO0sI
National Partnership Agreement Closing the Gap in Indigenous Health Outcomes (2009)	Service planning enables key strategies within the Western Australian Implementation Plan to be achieved including strong collaboration of primary health care services for the Aboriginal community to address the rate of chronic diseases. For more information visit: http://www.health.gov.au/internet/main/Publishing.nsf/Content/closinggap-tacklingchronicdisease/$File/commonwealth_implementation_plan.pdf
Rural Cancer Units Plan (2010)	The Commonwealth have endorsed $22.3 million of infrastructure funding over three years (2010/11 – 2012/13) to develop rural cancer centres and patient accommodation in four country health regions of WA. Under this plan, by 2013/14 Albany will have a six chair, one bed chemotherapy unit and a six double/twin bedroom hostel. This means the level of oncology services at Katanning will remain as is with patients continuing to be transferred to Albany or Perth for chemotherapy and oncology services.
National Primary Health Reform Program	As part of the National Health and Hospitals Reform Agenda, the Commonwealth Department of Health and Ageing has outlined the national reform agenda for primary health care services in Australia which includes: • Better integration of services • Access to multiple primary health professionals at one site • Co-location of services to improve accessibility for small communities. SIHI provides the opportunity to implement this reform in the Central Great Southern. It will result in a strengthening of primary health services that integrate with GPs and other non SCHS primary care services. This will enhance early intervention, prevention and health promotion type services to better detect and manage chronic conditions in the community. Co-location of primary health services offers the opportunity for improved economies of scale and efficiencies, integrated systems and promotion of a 'working together' approach to address complex issues within the community.
State Government	**Policy**
WA Health Clinical Service Framework 2010-2020 (2010)	This Framework stipulates that Katanning Hospital remain as an integrated district health care service providing Level 2 – 3 health services (as per pp. 24-5 of the framework). Service planning utilises this State policy to understand the level of service delivery and the level of integration required with other Great Southern and metropolitan hospitals. Refer to: www.health.wa.gov.au/publications/documents/CLINICAL_SERVICES_FRAMEWORK_WEB.pdf
Mental Health 2020: Making it personal and everybody's business **(Strategic Policy)**	The WA Government's ten year strategic policy for mental health, *Mental Health 2020: Making it personal and everybody's business*, provides a whole of government and community approach and sets out three key directions: • person centred supports and services; • connected approaches; and • balanced investment.

Policy	Implications for services
	For more information go to: www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Mental_Health_Commission_strategic_plan_2020.sflb.ashx
Redundancy and Disaster Planning in Health's Capital Works Programs (2012)	Katanning Hospital will comply as a Level 3 facility for redundancy and disaster planning. Gnowangerup and Kojonup hospitals will comply as Level 2 facilities. The guidelines are available from the Disaster Preparedness and Management Unit, Department of Health.
WA Health Strategic Intent 2010-2015 (2010)	This document has a number of overarching goals for WA Health to build healthier, longer and better quality lives for all Western Australians. The intention of this Service Plan is to align with these overarching goals within this policy. Refer to: www.health.wa.gov.au/about/docs/WAHealth_Strategic_Intent_2010_2015.pdf
WA Health, Greening Health, Building and Renovations	Service reform provides an opportunity to maximise environmental safety and energy efficiencies which will address climate change issues and support actions to reduce WA health's environmental footprint.
WA Health Telehealth Strategic Direction (2012)	A major initiative of health service reform is to enhance telehealth facilities in health services to enable efficiencies to be gained in providing patient assessment and care; staff training; and patient-to-practitioner communication.
WA Health Network Models of Care (ongoing)	Service planning offers the opportunity to create facilities that best support the delivery of modern models of care as developed by the Network. The published models of care are found at: www.healthnetworks.health.wa.gov.au/modelsofcare
WACHS Policy	
WA Country Health Service Human Resources Strategic Directions Framework (2011)	Human Resources Priorities Plan for 2011/12 will be developed as an outcome of the former WACHS endorsing this framework. Workforce development initiatives as outlined in Section 7.1 should be considered in this process to improve the attraction and retention of a skilled workforce.
Aboriginal Employment Strategy 2010-2014	Since the Central Great Southern has a high proportion of Aboriginal people in the community, workforce planning efforts for the district should implement this strategy which advocates for more Aboriginal people to be employed in all levels of the organisation as a strategy to make services more culturally secure.
WACHS Renal Dialysis Plan (2010)	This plan identifies the need for renal satellite outreach dialysis or community supported dialysis services (small satellite services) to enable care closer to home. Six chairs will remain at Albany Health Campus with the potential to have more sessions operating per day. Four chairs are planned for the nearby Narrogin Hospital. There is no plan to establish renal chairs at Katanning in the near future.
WACHS ED Services Planning and Facility Design Principles	Calculation of the required number of treatment bays to manage future demand is based on the benchmarks published in this document.

3.4 Planning initiatives and commitments

The service reform and SIHI initiatives outlined in this service plan have considered previous planning initiatives and government commitments as follows.

3.4.1 Southern Inland Health Initiative

The $565 million *Royalties for Regions SIHI* project aims to work with the Commonwealth to reform and improve access to health care for all residents of the Southern Inland area of WA over the next five years. This area encompasses the Great Southern, Wheatbelt, Midwest, South West and Goldfields health regions.

This service plan and accompanying service planning processes is a direct outcome of the SIHI announcement by State Government. This service plan aims to inform the *SIHI Implementation Plan*, which will recommend the best strategy for investing funds from the State Government's *Royalties for Region Scheme* that includes:

- $240 million investment in health workforce and services over four years
- $325 million in capital works over five years

SIHI aims to dramatically improve medical resources and 24 hour emergency coverage, while boosting primary health care service delivery via the implementation of six streams of work. The streams are highlighted below with the allocations made for the Great Southern Health Region to achieve the intention of the Stream.

Table 3: SIHI overview and related plans for the Central Great Southern

Stream (Total Southern Inland Area)	Allocations: Central Great Southern
District Medical Workforce Investment Program ($182.9 million) to significantly improve medical resources and 24 hour emergency response across the districts.	*Allocation of recurrent funding to provide close on call 24/7 medical coverage at the Katanning Health Campus.*
District Hospital and Health Services Investment Program ($147.4 million) to provide major upgrades at Northam, Narrogin, Merredin, Katanning, Manjimup (Warren Hospital) and Collie. Recurrent funding of $26 million will also be provided under this program to boost primary and ambulatory health care services across the SIHI area.	*Allocation of $35.4 million (capital funding) towards the redevelopment of the Katanning Health Campus, This includes proposed construction of a new integrated primary health care centre and upgrades to engineering and site services, ED, inpatient areas, residential aged care, medical imaging, pathology, administration and non-clinical support services. Recurrent funding is also allocated to boost primary health care services.*
Primary Health Care Demonstration Program ($43.4 million) will provide communities with the opportunity to re-examine how health services are delivered. Funding will be available to boost primary health services for communities that opt in. This stream is in response to reducing inpatient activity and increasing demands for primary and ambulatory health care.	*The opportunity is available for small hospitals to be converted to primary health care centres with adjacent ED services (removing the inpatient functions).The scope of work for the district is yet to be determined.*

Stream (Total Southern Inland Area)	Allocations: Central Great Southern
Small Hospital and Nursing Post Refurbishment Program ($108.8 million) will provide a capital works program for small hospitals and nursing posts to be refurbished or, if required, rebuilt to enable delivery of health care services that will match the needs of their communities.	*The scope of work for the district is yet to be determined.*
Telehealth Investment ($36.5 million) will introduce innovative "e-technology" and increased use of telehealth technology across the region, including equipment upgrades.	*Allocation of funding for the procurement of equipment and FTE to enhance technology for patient care, staff supervision, training and consultation. Includes procurement of wireless practitioner carts and fixed telehealth units in EDs.*
Residential Aged Care and Dementia Investment Program ($20 million) will provide incentives for private providers to expand options for residential aged care and dementia care across the Southern Inland area.	*The scope of work for the district is yet to be determined.*

3.4.2 Regional Centres Development Program - SuperTowns

SuperTowns is a *Royalties for Regions* initiative to encourage regional communities in the southern half of the State to plan and prepare for the future so they can take advantage of opportunities created by WA's population growth. Katanning has been selected as a SuperTown based on their potential for population growth; economic expansion and diversification; strong local governance capabilities; and their potential to generate net benefits to WA.

Under the Katanning Growth Plan (endorsed by Shire of Katanning, January 2012) there are plans to establish new industry precincts for agri-food, mining and retail which will increase the number of jobs in the district driving up the number of permanent residents in the Shire of Katanning and surrounds.

The Shire of Katanning state, the first increase in the population is anticipated to be in late 2012 when construction of the Ausgold Goldmine commences. The commencement of works to open the mine is likely to attract 400 construction workers and contractors to Katanning. The opening of the mine in early 2014 is then anticipated to attract 200 workers. The impact of this, other industry developments and future industry growth on the local health, education and human services is currently being assessed.

3.4.3 Albany Health Campus Redevelopment Project

The Albany Health Campus is currently being redeveloped enabling SCHS to achieve health service reform locally and enhance the capacity of regional and district health services.

Once completed in 2013, the campus will provide the following:

- New medical, surgical and rehabilitation units including 134 beds -

- 60-bed medical, surgical, paediatric and maternity inpatient unit (includes eight beds for maternity and eight beds for paediatrics)
  - 16-bed mental health inpatient unit
  - 15-bed sub-acute unit
  - 18-bed same day unit
  - Expanded cancer care services (seven beds).
  - Upgraded renal dialysis services (six-chairs remain, with potentially more sessions operating a day).
  - Two-cot neonatal unit
  - An expanded six-bed high dependency unit and four-bed short stay/observations unit, collocate with the emergency department
- New dedicated surgical services centre which includes four operating theatres, scope room and CSSD.
- Consolidated ambulatory care services in one location (including chemotherapy).
- New telehealth facilities within many clinical areas and a new Learning and Development Centre which includes a seminar room, ICT training room, simulation room and meeting rooms.
- Expanded medical imaging facilities which will include: general X-ray, fluoroscopy, CT, ultrasound, orthopantomogram (OPG), mammography services and space for a future MRI.
- New pathology facilities.
- Expanded pharmacy facilities.
- Upgrade of critical engineering infrastructure.

The existing hospice building, dental clinic and hydrotherapy pool will be retained as part of the redevelopment of the campus. The current hospice will be used for other functions once the Community Hospice Association build their new facility attached to the new Albany Health Campus.

The upgrade of services, including additional capacity for chemotherapy and renal dialysis will enhance the Great Southern Region's capacity to provide care closer to home.

The WACHS promotes the WA government's vision of care provision via partnerships The new Albany Health Campus will provide an environment to support this direction.

3.5 Strategic directions for service delivery

The review of government policies, local planning initiatives, drivers for change and stakeholder priorities within the Central Great Southern has identified the following strategic directions for service delivery for district health services:

- Strengthen the integration of services across the continuum of care.
- Focus on primary health care and non-inpatient care.
- Enhance demand management strategies to reduce demand on acute and emergency services for primary health care.
- Deliver care closer to home and increase self-sufficiency.
- Improve Aboriginal health outcomes.

- Improve aged care services.
- Attract and retain a skilled workforce.
- Strengthen partnerships with primary care, private and not-for-profit providers.
- Utilise ICT advancements for better care.
- Create a safer environment for all.

3.6 Key drivers for change

The key drivers for change include the policies and planning initiatives above and the demography and health needs highlighted in Section 4. In addition to these drivers, are a number of issues and priorities that were highlighted by SCHS and stakeholders during service planning consultation.

In changing the way services are delivered, stakeholders also highlighted a number of existing strengths in service delivery that should be sustained or built upon in the future to build a stronger health system. The common issues and strengths highlighted by stakeholders are presented below with the priorities described thereafter.

Identified service strengths

- Significant service integration already exists between Katanning Hospital, Gnowangerup Hospital, Kojonup Hospital and Tambellup Nursing Post. There is support to continue this integrated model.
- Committed, experienced and passionate management and staff.
- Good teamwork evident within all areas.
- Good level of co-operation between GPs and Emergency Department (ED).
- Primary health care services strong on holistic approaches to care.
- Great opportunities to further integrate primary health care services.
- Recent move to co-locate Home and Community Care (HACC) with primary health care services showing benefits.
- Excellent local facility management support and hotel services leadership.
- Excellent knowledge of local issues impacting on health service delivery.
- High empathy for the pressures some teams experience in delivering primary health and emergency services.
- Willingness to look at how to deliver services more efficiently in an integrated way across the District from GPs services through to ED and primary health care services.

Identified service issues

Primary health care

- Population health services are split across facilities on the Katanning Health Campus. Mental health services are co-located with Aboriginal health in a detached building 100m away from the main hospital. The location of services adversely impacts on the opportunities to integrate primary health care services and conduct effective case management of chronic diseases. The facility for mental health and Aboriginal health is not an optimal environment for staff safety and security.

Aged care, Aboriginal health and chronic disease:

- Currently, there is a gap in providing primary health care support and transitional care to those who are discharged from the acute sector to the home.
- Less elderly people are presenting to ED due to HACC providing an effective level of care in the community.
- When older adults require residential aged care, increasingly they require high level rather than low level care. This may also directly relate to the HACC services providing care for people within the community who previously may have required low level residential care.
- HACC do charge a small fee for services. Whilst there is financial assistance available, stakeholders have reported that this fee at times can hinder access to HACC services for those on an old age pension.

Health Promotion, allied health and oral health:

- Stakeholders report staff shortages in the following primary health care areas: public podiatry, speech pathology, social work, diabetes education, dietetics, alcohol and other drug preventative and management, mental health and transitional care.
- The number of young families in the district is anticipated to grow with the implementation of the SuperTowns initiative.
- A reasonable amount of ED presentations are for acute episodes of dental pain and abscesses due to a lack of dental health services for adults in the district.

Community-based mental health / alcohol and drugs:

- Drug and alcohol problems correlating with mental health issues are increasing. There is a need for a locally based whole of community workforce and strategies to address drug and alcohol affected individuals as there is limited ongoing support for them locally.
- Mental health services are unable to access additional Commonwealth funding to increase primary mental health services due to challenges in maintaining viable GP services and private practitioners in the district.
- There are limited mental health psychosocial rehabilitation services available to assist those with chronic illnesses to maintain accommodation, employment and social connections.

Outpatients

- The key challenge for sustaining outpatient services is the ability to attract and retain visiting specialists to the district. There is currently a need to provide greater access to visiting medical specialties (including general medicine, cardiology, obstetrics, gynaecology, paediatrics, emergency medicine, pain management, psychiatry, rheumatology, urology, ophthalmology and gerontology) and surgical specialties (including general surgery and orthopaedics).

- There is one consult room which is shared between the extended care service and visiting specialist.

Emergency services

- Due to the lack of bulk billing and after-hours primary health care services in the district, a high proportion of ED presentations are for primary health care concerns which could potentially be seen by GPs and other primary health care services. This could also be evidenced by the higher number of presentations on the weekend rather than during the working week.
- There is strong support for an ED Nurse Practitioner to manage low acuity workloads, however the integration of the role with existing GP and nursing services will need to be determined.
- At times, additional demands are placed on nursing staff to manage acute mental health patients, particularly after-hours. There is a need to strengthen the model of care for after-hours mental health assessment and care. This model could consider the role of a nurse practitioner specialising in mental health care to manage the demand on existing staff.

Inpatient services

- There is a need to provide regular general physician, gerontology, pain management and rheumatology services.
- Only one of the two operating theatres is currently operational.
- Obstetric services are fragile, with staffing shortages impacting on the availability of sufficient numbers of GP obstetricians, anaesthetists, midwives and theatre staff to maintain the level three service. These shortages sometimes limit the hospital's ability to provide the full range of obstetric services. The hospital is not able to provide epidural anaesthesia.
- Many of the women who birth at Katanning have a CALD background whereby English is a second language. They are often unaware of antenatal services and may present to the ED in labour without antenatal care.
- Maternal obesity rates are increasing which means patients have to travel to Albany or Perth to give birth due to associated potential complications.
- Allied health reported that a lack of ENT services is the major issues for child health locally as 90-95% of children seen by speech therapy have an ear infection.
- The estimated demand for paediatric services is not increasing. The trend for paediatric patients to receive more complex inpatient care at Princess Margaret Hospital in Perth is expected to continue. However, where possible, skill levels should be improved in order to provide as much paediatric care locally as possible.
- The current mental health services are stretched to cover the acute and primary health care needs of the district.
- When patients present to ED they are allocated one code per presentation - this is usually for the 'injury', not the cause of the injury which may be a mental health issue. This leads to an underestimation of the true demand for more mental health services.
- Anecdotal reports suggest there is an increasing number of young people presenting with mental health issues largely due to social issues within the community and home.
- Many of the migrants experience post-traumatic stress disorders.
- Stakeholders report an increasing incidence of drug and alcohol induced mental health issues and need to access alcohol and other drug rehabilitation services (e.g. drying out facility).
- Mental health patient transfers are an issue for the health service and St John Ambulance as transport options are limited and when transport is available staff and

volunteers are away from the district for more than five hours. This removes expertise from the district.

- There are no private psychiatry services available to the district therefore opportunities to utilise telehealth technology to connect with psychiatrists should be explored.
- There is a need to review the model of care for mental health services to maximise the potential benefits from collocation with ED and primary health care services and the potential inclusion of a "safe room" in the inpatient area for patients awaiting transfer. This should also include a review of transfer strategies for patients with mental health issues (e.g. mental health retrieval team).
- There is limited training for staff in managing mental health patients.
- There is a need to review the after-hours model of care as the mental health team does not provide after-hours support.
- Silver Chain does not operate in the Central Great Southern for palliative care services.
- The existing palliative care unit has a low occupancy rate and could be expanded to support sub-acute care in the future.
- There is a need to develop the future model of care for sub-acute care across the Great Southern given the new Sub-acute Unit being built at Albany Health Campus.
- Data collection for sub-acute and rehabilitation patients is inconsistent and does not identify the real level of demand for these services.

Residential aged care

- Ageing population planning projections have not been realised in Katanning. Therefore the number of aged care beds in the hospital has not increased, nor is there a need to increase in the future as there is no demand for them. The reduction in demand is possibly due to effectiveness of HACC services.
- Consumers requiring aged care are more likely to require high-care beds and have more complex co-morbidities that require higher skilled staff (e.g. enrolled nurses rather than carers).
- GPs are often stretched and often unable to attend to the primary health care needs of residents in aged care facilities.
- Visiting geriatrician services are conducted on an ad-hoc basis to Katanning.
- Current facilities are not designed to care for residents with dementia.

Clinical support services

- Feedback from the District Health Advisory Council shows a level of community dissatisfaction regarding the lack of medical imaging services provided locally.
- Stakeholders report an increasing number of patient transfers for diagnostic services which is placing additional demands on St John volunteers (Refer to Section 7.2).
- The medical imaging services planned for the Albany Health Campus will be privatised. There is also a move to standardise diagnostic imaging across WA. Local planning should ensure that the systems between the private and public medical imaging sectors in the Great Southern Health Region are aligned and compatible with state-wide initiatives to maximise diagnostic support to district areas.
- To overcome some of these issues and challenges, staff felt that Katanning could adopted the 'Narrogin ultrasound model' whereby a private provider provides a service with mutual benefits to the hospital and service provider.
- The current pathology facility requires upgrades. The laboratory is no longer large enough for the service's processing and storage requirements and there is a need for two collection rooms instead of one. Security upgrades to maximise Pathology staff safety, particularly afterhours, are also required.

- With the plans to commence mining operations in the district, demands for workplace drug screening are likely to increase however the current toilet facilities are unsuitable for supervised drug testing.
- In 2006 the Federal Government introduced various reforms to the PBS Scheme. These reforms were designed to improve the continuum of care for patients moving between the hospital and community setting and to improve the way patients access their medication by making it easier and more convenient for patients to receive adequate medication. To implement the reforms hospitals may need to have increased capacity to dispense medication on discharge.
- Staff identified the need for staff training and education regarding pharmacy legislation and the *Poisons Act*.
- There is no Certificate III in CSSD Technician course delivered within the region or by distance education in WA.
- Current facilities generally are not designed for clinical telehealth service delivery in the ambulatory or acute care venues.
- Management is required to implement the necessary changes and reform for telehealth service provision for service users, consumers and staff.
- Bandwidth is limited at some health service sites in the Great Southern.

Non-clinical support services

- A risk assessment of laundry services at Katanning Hospital in 2010 identified the need to purchase new laundry equipment (e.g. washer and dryer), provide new furniture (e.g. trolleys and storage) and redesign the laundry. These changes would improve staff safety, ergonomics and infection control.
- Upgrades are required across the district to make facilities and site services more energy efficient.
- Upgrades and new equipment should be standardised to match those being developed at Albany Health Campus, where possible, to enable greater efficiencies and continuity for staffing across the region.
- Staff expressed a need for additional local resource support for ICT, human resource and medical records management at Katanning Hospital. The development of the Southern Country Health Service (SCHS) may give scope to review where corporate services are located.
- Demands are placed on line managers to conduct orientations and training.
- Medical records are paper-based which impacts on the ability to have a fully integrated service model across the continuum of care.

Key priorities identified by providers and stakeholders

A series of consultative workshops with internal and external stakeholders has identified a series of common priorities for strengthening the local health system. The top priorities identified during consultation (in no particular order) include:

- **Sustain a skilled permanent and visiting workforce**. All stakeholders highlighted the difficulty in attracting and retaining a skilled permanent and visiting workforce in rural areas. In many cases, the difference between a service operating or not was reliant on one person being available or adequately trained. Stakeholders reported that obstetrics, visiting medical and surgical specialties, allied health and medical imaging were services that may struggle to operate to full capacity due to staff shortages. There is an identified need to develop a comprehensive workforce strategy to attract and retain a skilled permanent and visiting workforce to support the health needs of the community. This would include investigating further opportunities to integrate service and staffing models to pool resources across the region and remove some of the existing barriers that reduce

the efficiency of appointing staff to positions. Recommended strategies to address this issue are presented in Section 7.1.

- **Co-locate primary health care services.** There was overwhelming support by stakeholders to co-locate primary health care services on the Katanning Health Campus in a dedicated primary health care centre (as per Stream 2 of SIHI). Furthermore, the preference would be to co-locate outpatient facilities and position the centre adjacent to the emergency department and mental health clinical services to better integrate services; pool physical and human resources; support an efficient model of care for the emergency department; and improve the patient experience by providing a 'one stop shop' for health services. Within the centre, a new dental clinic could be established to address the current lack of adult dental health services in the district. More information about this is presented in Section 6.1.1. Stakeholders also highlighted opportunities for collocation models to be adopted over the next 10 years in Kojonup and Tambellup with health and other human services to obtain similar benefits to the local health system and community (refer to Section 5.2).

- **Manage increasing demands on GP services.** Across the district there were concerns raised regarding the availability of local GPs now and into the future in supporting emergency, medical and primary health care delivery. GPs and staff were supportive of exploring new models of care to address this issue, including the placement of nurse practitioners in emergency, aged care, mental health and primary care to complement the work and reduce the demands on GPs to provide care, assessment and prescriptions where possible. Stakeholders were also keen to explore the role of a mobile nurse practitioner primary health care service that could visit more isolated rural areas for consumers who experienced difficulties in accessing health care. Identifying opportunities to develop greater after-hours support to meet the primary health care needs of the community was also a priority for stakeholders.

- **Build the capacity of local services to address mental health issues.** Stakeholders have observed an increasing incidence of mental health issues across the community. This includes the growing incidence of individuals with co-morbidities largely due to alcohol and other drug use, social isolation, depression and post-traumatic stress disorders in the migrant community. There is an identified need to build the capacity of local services to address mental health problems, from enhancing across sector partnerships to address the social determinants of mental health, to the enhancing initiatives to manage the acute presentations to emergency services.

- **Provide greater primary health care and transitional care services**. Stakeholders identified that there is a gap in service delivery between the acute setting to care in the home and community (and vice versa). The areas of greatest need for a transition model of care are aged care, mental health and Aboriginal health. Staff reported that demands from the emergency and acute services meant opportunities to support more preventative / transitional models of care were limited with the current staffing numbers. With the increasing incidence of mental health problems and the ageing population, stakeholders felt it was a priority to address this current gap in service delivery. More information regarding opportunities to boost primary health care services is presented in Section 6.1.1.

- **Re-assess patient transportation methods.** The number of patient transfers required for emergency care, medical care and diagnostic services (e.g. medical imaging) is a concern for health services, shires and St John Ambulance. Transfers to Albany or Perth can take vehicles, St John volunteers and health service staff out of the district for at least five hours at a time. This takes expertise away from the district health services and places demands on local volunteers who hold permanent positions in other fields within the community. Recommendations for addressing this issue are presented in Section 7.2.

- **Enhance telehealth technologies.** There were many opportunities identified by stakeholders where telehealth technologies would aid the delivery of health care and

diagnostic services, removing the need for patient transfers and independent travel. Stakeholders wish to explore opportunities to maximise the use of telehealth technology across all sites and provide suitable facilities to support fixed and mobile telehealth infrastructure. The recommendations from stakeholders are detailed in Section 6.5.5.

- **Provide culturally secure health services for the Aboriginal and cultural and linguistically diverse (CALD) communities.** With a high Aboriginal population and migrant community of at least 50 language groups, stakeholders identified the need to provide culturally secure services, facilities and information to ensure these communities are informed of the services available - aiding in providing care at the right time in the right setting.

- **Katanning as a SuperTown**. With Katanning identified as a future SuperTown, stakeholders consistently voiced the need to monitor the impact of this initiative on health and human services and the communities throughout the District. More information is presented in Section 3.4.2.

Priorities for local service reform

The priorities for local service reform include:

- Support the greater integration of services on the Katanning Health Campus by collocating primary health care services with outpatient care, adjacent to ED and mental health clinical services.
- Strengthen service integration across the continuum of care between Albany and Katanning as service reform and redevelopment are achieved at both sites.
- Boost primary health care service integration to better detect, assess and manage chronic health and mental health conditions. Suggestions include additional resources for allied health services; mental health prevention, promotion and counselling; dental care; transitional care; support in the home; early childhood services; youth and adolescent services; alcohol and other drug services; and multicultural and Aboriginal health liaison roles and associated workforce models.
- Increase resources for the management of mental health consumers with co-morbidities (alcohol and drug and chronic diseases).
- Ensure 24/7 “close on call” emergency and medical coverage, particularly obstetric care (e.g. provide access to anaesthetic services 24/7).
- Provide greater access to visiting medical and surgical specialists. District priorities for visiting specialists which meet the identified need include securing the services of a General Physician, Ophthalmologist, General Surgeon, Psychiatrist, Rheumatologist, Gerontologist, Obstetrician, Gynaecologist, Paediatrician and Emergency Medicine specialist.
- Increase the capacity for planned elective surgery in Katanning.
- Provide culturally secure services for the local Aboriginal and CALD communities.
- Utilise ehealth and telehealth technologies to enhance patient health outcomes (e.g. electronic medical records and video conferencing for patient care and staff support).
- Attract, retain and nurture a skilled workforce to increase and sustain service delivery.
- Upgrade infrastructure to contemporary standards to improve patient flow, reduce occupational health and safety risks and support best practice models of care.

4 DEMOGRAPHY AND HEALTH NEEDS

The future models of care delivered in the Central Great Southern will need to be responsive to the needs of the local catchment area and the social and economic realities within which services operate, including the availability of the resident or visiting workforce. This section provides an overview of the current catchment area, along with a description of the health status, demography and other factors that influence the health status of local residents. This information on the population's health needs informs the types and locations of services required in the Central Great Southern over the next 10 to 20 years.

Please note, Ravensthorpe Shire will become part of the Great Southern Region on 1 July 2012 rather than being part of the Goldfields region. The following data excludes Ravensthorpe.

4.1 Demography

The demography of the Central Great Southern will influence the type of services and the models of care delivered at health campuses across the region. This section highlights the population growth, gender, age distribution and cultural diversity of the district that will need to be considered in determining the future models of care, types and location of services.

4.1.1 Population growth

According to the Australian Bureau of Statistics (ABS) estimated resident population (ERP), approximately 18% of the Great Southern Health Region population reside in the Central Great Southern.

The estimated resident population of the Central Great Southern grew by 2% over the last five years, to 10,609 in 2010. This increase was markedly less than the 13% for the State (Australian Bureau of Statistics, 2010a).

The ABS Series B+ population projections[2] estimate the Central Great Southern's population will increase by 1,000 (10%) from 2011 to 2021. This is an increase from 10,851 residents in 2011 to 11,923 in 2021, as shown in the following table. This level of growth is much lower than the State's expected 20% growth rate for the same time period (Department of Health, 2010b).

Anecdotal feedback from the Shire of Katanning suggests the SuperTown initiative could triple the Shire of Katanning's catchment population from approximately 5,000 to 15,000 over the next 20 years. This anticipated increase is not included in the ABS Series B+ projections and therefore excluded from the next table.

2 WA Health has endorsed the use of the ABS series B+ population projections rebased to the 2009 estimated resident population. The projections by SLA are obtained by applying the distribution of Department of Planning and Infrastructure population projections by SLA, 5-year age group and sex to the ABS population projections.

Table 4: Great Southern Region: Estimated resident population (2011) and population projections (2011 to 2021)

Area	2010 ERP	Projections			Growth (2011-2021)	Average annual growth
		2011	2016	2021		
Central Great Southern	10,609	10,851	11,461	11,923	9.9%	0.9%
Lower Great Southern	48,803	49,693	53,349	56,882	14.5%	1.4%
Great Southern	**59,412**	**60,545**	**64,810**	**68,805**	**13.6%**	**1.3%**

Source: ABS ERP and ABS Series B+ projections

4.1.2 Gender distribution

The ABS estimated resident population (2010a) highlights there were slightly more males than females in the Central Great Southern (52% compared with 48%). According to ABS Series B+ population projections, this gender imbalance is projected to remain in the future, as shown in Table 5.

Table 5: Great Southern Region: Estimated resident population (2011) and population projections (2011 to 2021), by gender

Area	Gender	2010 ERP	Projections			Growth (2011-2021)	Average annual growth
			2011	2016	2021		
Central Great Southern	Female	5,085	5,179	5,477	5,696	10.0%	1.0%
	Male	5,524	5,672	5,983	6,227	9.8%	0.9%
Lower Great Southern	Female	23,836	24,556	26,356	28,124	14.5%	1.4%
	Male	24,967	25,137	26,994	28,758	14.4%	1.4%
Great Southern	**Female**	**28,921**	**29,735**	**31,833**	**33,820**	**13.7%**	**1.3%**
	Male	**30,491**	**30,809**	**32,977**	**34,985**	**13.6%**	**1.3%**

Source: ABS ERP and ABS Series B+ projections

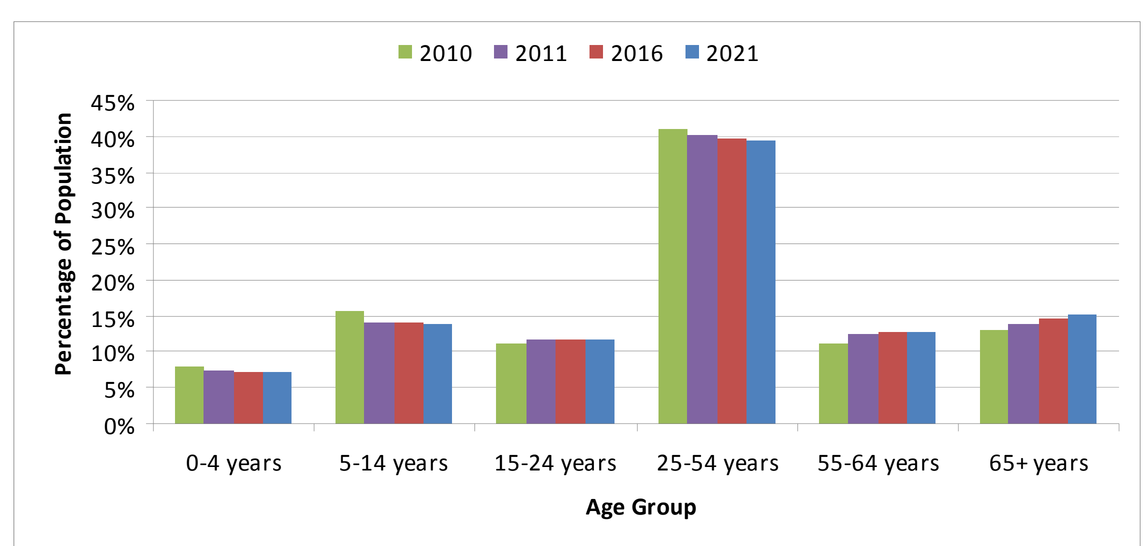
4.1.3 Age profile

Age distribution

The ABS estimated resident population (2010) indicates that the Central Great Southern had a greater proportion of residents aged 0 to 14 years (24%) and a similar proportion of older adults aged 65 years and over (12%) when compared to WA.

As shown in the following figure, the proportion of 25 to 54 year olds in the Central Great Southern is projected to decrease in the future, while the proportion of 55 year olds and over is projected to increase.

Figure 5: Central Great Southern Health District: Age distribution (2010 ERP to 2021)



Source: ABS ERP and ABS Series B+ projections

Dependency ratio

The dependency ratio is a ratio of those typically not in the labour force to those in the labour force and is calculated by dividing the number of people under 15 or over 64 years of age by the number of people aged 15 to 64 years.

The estimated resident population (2010) indicated the dependency ratio of the Central Great Southern was greater than that of WA (0.57 compared with 0.46). The ratio is anticipated to increase to 0.65 in 2021 according to the ABS Series B+ projections. This is largely due to an increase in the proportion of older adults aged over 65 years.

The proportion of Central Great Southern residents who are aged 65 years and over is anticipated to increase. With this increase there will be approximately an additional 500 older adults aged 70 years and over in the central Great Southern, as shown below.

Table 6: Great Southern Region: Older adult estimated resident population (2010) and population projections (2011 to 2021)

Area	Age	2010 ERP	Projections			Growth (2011-2021)	Average annual growth
			2011	2016	2021		
Central Great Southern	70-84 yrs	948	828	1,046	1,337	62%	5%
	85 yrs+	152	160	210	256	60%	5%
	Total	**1,100**	**988**	**1,256**	**1,593**	**61%**	***5%***
Great Southern	70-84 yrs	5,723	5,762	6,898	8,630	50%	4%
	85 yrs+	1,153	1,223	1,553	1,849	51%	4%
	Total	**6,876**	***6,985***	***8,451***	***10,479***	***50%***	***4%***

Source: ABS ERP and ABS Series B+ projections

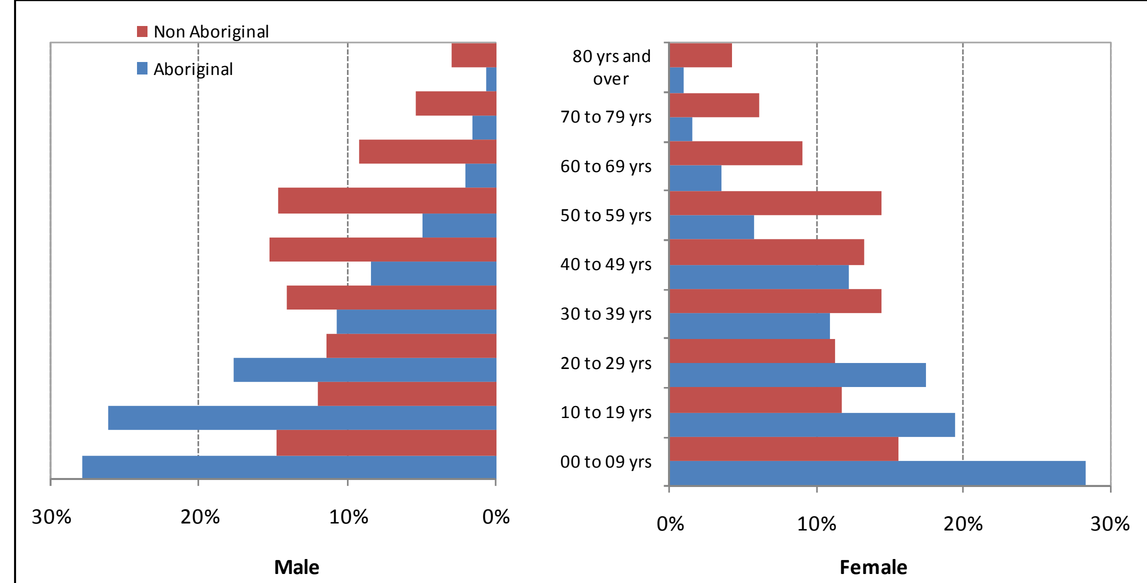
4.1.4 Cultural diversity

Aboriginal population

In the ABS 2006 Census, 7% of the Central Great Southern residents identified themselves as being of Aboriginal or Torres Strait Island descent. This is a higher proportion when compared to the State (3%) and the Lower Great Southern (2%). Approximately 11% of the Tambellup community identified as being of Aboriginal or Torres Strait Island descent, while Woodanilling had the lowest proportion of Aboriginal residents (1%) in the Central Great Southern District.

Based on figures derived by the Department of Health Epidemiology Branch (2009b), the Aboriginal population of the Central Great Southern has a much younger age structure, as shown in Figure 6.

Figure 6: Central Great Southern: Estimated resident population (2009), by Aboriginality



Source: ABS 2009 ERP

Culturally and linguistically diverse (CALD) communities

In the ABS 2006 Census, 12% of Central Great Southern residents reported being born overseas. This proportion was less than half that of the State (27%) and lower than the Lower Great Southern (18%). One in three of the Central Great Southern residents born overseas were born in the United Kingdom.

Despite these figures, feedback from stakeholders suggests that the Central Great Southern (particularly the Katanning area) has a high migrant population with at least 50 language groups residing in the area.

Previously, this community was largely Malay, migrating to Katanning to work at the local abattoirs. However, the migrant population is now shifting with more Sudanese and Burmese people settling in the community. A high proportion of the new migrants have post-traumatic stress disorders.

Anecdotal reports suggest that 60% of primary school students in Katanning have English as a second language which has implications for health, education and other human service providers.

Demography: Major implications for service planning

Population growth

Over the last five years the population of the Central Great Southern has grown at a slower pace than the population of the State and is projected to continue to grow at a slower pace than the State according to ABS Series B+ predictions. However, the framework was released prior to the announcement of the SuperTown initiative (see note below).

Age distribution

The ageing population will place added pressures on health services to manage health conditions commonly seen in older adults and indicates an increasing need to increase the capacity of local community-based services, sub-acute care, primary health care services for the management of chronic conditions and residential aged care services including dementia care.

Cultural diversity

The Aboriginal population of the Central Great Southern has a much younger age structure than the non-Aboriginal population. Half the Aboriginal population are aged under 20 years (a quarter of the non-Aboriginal population are aged under 25). This differing age structure, along with the well documented health inequalities of Aboriginal people, will need to be taken into account in the planning primary health care services and programs for young Aboriginal adults. This feature of the catchment may suggest the need for greater service capacity in the areas of antenatal and maternal care, chronic disease prevention and youth health and wellbeing.

With the changing profile of the migrant communities, SCHS will need to ensure access to CALD health resources and interpreter services. Furthermore the existing role of the Muslim Liaison Officer could be realigned to a CALD Liaison Officer to meet the broader needs of the migrant community. Other services will need to plan for greater cultural diversity and sustain current culturally secure services (e.g. food services currently serve halal food).

SuperTowns

Despite these findings, current population projections do not include assumptions regarding the impact of the SuperTown initiative on community demography.

The impact of the SuperTown initiative will require SCHS to engage in planning processes, monitor growth in the community and align service delivery and facilities where appropriate to meet the changing size and demographics of the community.

4.2 Health needs

There are many factors that influence a person's health, including genetics, lifestyle, environmental and social factors. These factors may have a positive or negative impact on the health and wellbeing of individuals and communities (Joyce and Daley, 2010). The following section describes the current health status of the region and summarises the factors (or determinants of health) that will influence the health status of residents now and into the future, including:

- Level of remoteness experience by the area (according to the Accessibility Remoteness Index of Australia)
- Level of disadvantage experienced in the community (according to the Socio-Economic Indexes for Areas)
- Modifiable risk factors that influence lifestyle behaviours

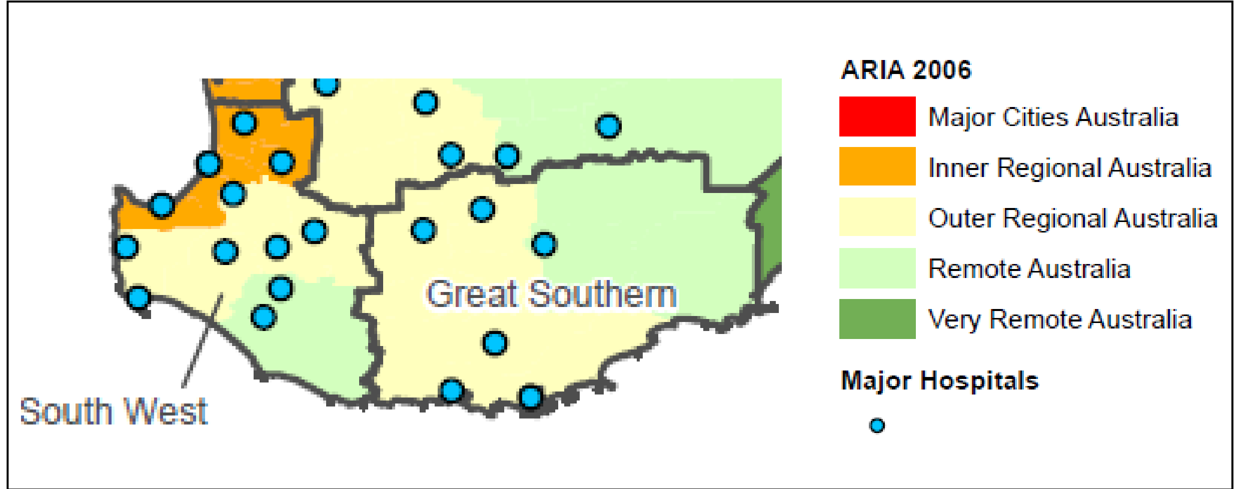
The factors highlighted influence the demand for health services and should be considered when designing the future models of care.

4.2.1 Remoteness

Remoteness is measured by the Department of Health and Ageing's (2001) *Accessibility Remoteness Index of Australia* (ARIA). Areas classified as remote have very restricted accessibility of goods, services and opportunities for social interaction.

Based on the 2006 ARIA the western part of the Central Great Southern is classified as outer regional (see Figure 7).

Figure 7: ARIA classification of the Great Southern



Source: Department of Health, Epidemiology Branch (2010)

The distances and approximate vehicle travel time between Perth and major Central Great Southern towns are shown in Table 7.

Table 7: Distance and approximate travel time from Perth

Town	Kilometers from Perth	Hours: minutes from Perth	Kilometers from Albany	Hours: minutes from Albany
Gnowangerup	376	4:15	138	1:40
Katanning	250	2:30	165	1:49
Kojonup	240	2:25	144	1:30
Tambellup	285	2:50	122	1:20

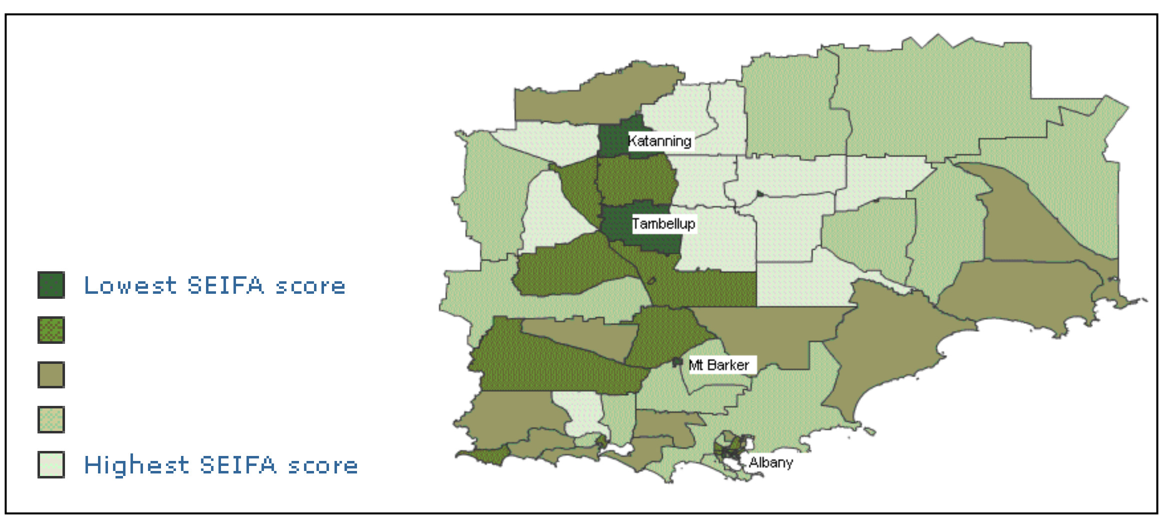
Source: Roadmap Australia

4.2.2 Socio-economic disadvantage

Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage scores are calculated by the ABS from responses to the Census. SEIFA calculates 17 different measures which include levels of education, income, rent, Aboriginality and more. The indexes do not take into account accumulated wealth, infrastructure of areas or differences in cost of living between areas. It has been shown that more disadvantaged areas have higher proportions of reported ill health or risk factors for ill health.

The mean SEIFA score for Australia is 1,000. Scores below 1,000 indicate areas of relative disadvantage, whereas scores above 1,000 shows areas of relative advantage. In the Central Great Southern the lowest score is 817 and the highest is 1106. Across the Great Southern Region, over 5,000 people (10%) live in collection districts with scores in the lowest 10% (darkest green) in Australia. An indication of the distribution can be seen in the map below.

Figure 8: Great Southern Health Region: Distribution of SEIFA Index of Relative Disadvantage scores



Source: Australian Early Development Index website

4.2.3 Self-reported modifiable risk factors

Lifestyle behaviours are particularly important because of their relationship with chronic conditions that are considered to be preventable (Joyce and Daley, 2010). Prevention and management of these modifiable risk factors can therefore have a substantial effect on these preventable chronic conditions.

The table below shows the relationship between these modifiable risk factors and the National Health Priority Areas.

Table 8: Chronic conditions and related modifiable risk factors

	Behavioural risk factors				Biomedical risk factors		
Chronic disease/ condition	Poor diet	Physical inactivity	Tobacco smoking	Excess alcohol use	Excess weight	High blood pressure	High blood cholesterol
Coronary heart disease	✓	✓	✓	✓	✓	✓	✓
Cerebrovascular disease	✓	✓	✓	✓	✓	✓	✓
Lung cancer			✓				
Colorectal cancer	✓	✓		✓	✓		
Depression				✓	✓		
Diabetes	✓	✓			✓		
Asthma			✓		✓		
COPD[a]			✓				
Chronic kidney disease	✓		✓		✓	✓	
Oral diseases	✓		✓	✓			
Osteoarthritis		✓			✓		
Osteoporosis	✓	✓	✓	✓			

(a) Chronic obstructive pulmonary disease
Source: AIHW 2002a.

Source: Reproduced from AIHW's (2006) chronic diseases and associated risk factors in Australia.

Risk factor information is usually collected by population based surveys, such as the WA Health and Wellbeing Surveillance System. The 2007 to 2010 System information has been analysed by the Department of Health Epidemiology Branch (2011a). For adults aged 16 years and over and children aged 15 years in the Central Great Southern:

- One in six adults (16%) smoke.
- More than four in five adults (85%) did not eat the recommended daily serves of vegetables.
- Half the adults (50%) did not eat the recommended daily serves of fruit.
- Two in five adults who drank alcohol drank at risk for long-term harm (42%).
- Half the adults (52%) did not do sufficient physical activity.
- Just over one in ten adults reported having high blood pressure (12%). This prevalence was significantly lower than the State (17%).
- One in five adults reported having high cholesterol (22%).
- One in three adults (28%) reported height and weight measurements that classified them as obese.
- Half the adults reported height and weight measurements that classified them as overweight, which was significantly higher than the State (26%).

Whilst there was no significant difference between the Central Great Southern and the State for most risk factors, all health services should attempt to reduce or prevent modifiable risk factors to prevent or manage chronic health conditions.

Lifestyle risk factor information is not available for Aboriginal Central Great Southern residents. At the national level Aboriginal people have been found to be twice as likely as non-Aboriginal people to be a current smoker (45% compared with 20%). Nearly a third (31%) of Aboriginal people have never smoked compared to half of non-Aboriginal people (52%). Furthermore, twice as many Aboriginal people report poor self-assessed health and higher levels of psychological stress as non-Aboriginal people (ABS, 2010b).

Health needs - Implications for service planning:

Remoteness

The level of remoteness in the Central Great Southern indicates that access to health services for residents could be limited at times, with resident and visitors required to travel outside the district for more specialised care. The level of remoteness supports the need for greater information and communication technologies (ICT) to bridge the gap in service delivery, enabling care and assessment to be provided closer to home where possible. The level of remoteness may also highlight the need for more mobile health services to reach those who have difficulty accessing health services close to home.

Socio-economic disadvantage

The SEIFA Index of Relative Socio-Economic Disadvantage shows that there are areas within the Great Southern with differing levels of disadvantage. Services and programs will need to be flexible to respond to the needs of these more 'disadvantaged' communities which are centred around the Tambellup and Katanning areas.

Modifiable risk factors

The modifiable risk factors and self-reported chronic conditions should continue to be monitored and used as a guide for developing and sustaining public health programs and interventions. Central Great Southern residents were twice as likely to report height and weight measurements that classified them as overweight when compared with the State, but there was no significant difference in the prevalence of obesity. Resident also reported high levels of insufficient physical activity. These behaviours are of particular interest as excess body weight and physical inactivity are linked with several chronic conditions, including coronary heart disease and some cancers. The increasing trend of obesity in the State may suggest an increase in these chronic conditions in the future. While specific information regarding the Central Great Southern Aboriginal population is not available, nationally Aboriginal people are more likely to smoke and to have poorer health than non-Aboriginal people. This demonstrates a need to continue culturally appropriate and targeted services for the Aboriginal community.

4.3 Health status

4.3.1 Self-reported chronic conditions

Chronic conditions refer to long-term conditions that last for six months or more (Joyce and Daley, 2010). Not all chronic conditions result in hospitalisations and so hospital data does not give the full picture of the level of chronic disease in the community. This type of information is usually collected by population based surveys, such as the WA Health and Wellbeing Surveillance System.

The most prevalent chronic conditions for adults in the Central Great Southern between 2007 and 2010 (ABS, 2010b) were:

- One in five adults reported arthritis (19%).
- One in ten adults reported a current mental health problem (11%).
- The prevalence of heart disease was significantly lower than the State (3% compared with 6%).

Nationally, Aboriginal people report a higher prevalence of most chronic conditions compared with non-Aboriginal people. For example, at a national level, after adjusting for age, Aboriginal people were 1.6 times more likely to report asthma, and three times more likely to report diabetes (ABS, 2006b). As the WA Health and Wellbeing Surveillance System may not be representative of the Aboriginal population, national levels of chronic disease among the Aboriginal population must be considered.

4.3.2 Self-reported service utilisation

According to the ABS (2010b), between 2007 and 2010 Central Great Southern residents reported their health service utilisation in the last year as:

- Eight in ten adults (83%) reported having used a primary health care service.
- Half the adults (51 %) reported having used a dental health care service. While there was no significant difference in the proportion of adults who had used the service in the last year compared with the State, Central Great Southern residents had a significantly lower mean number of visits (0.8 compared with 1.0)
- One in three adults (29%) reported having used a hospital based health care service.
- Only 4% of adults reported having used a mental health care service (e.g. a psychiatrist, psychologist or counsellor), which was significantly lower than the State (6%).

4.3.3 Mortality

Mortality rates

Mortality is an important indicator of the health of the population. Between 2003 and 2007 there were 286 deaths of Central Great Southern residents. There was no significant difference between the age standardised mortality rate (the number of deaths per 1,000 people) of Central Great Southern residents compared with the State or with the Lower Great Southern (Epidemiology Branch and Cooperative Research Centre for Spatial Information).

From 1998 to 2007, Wheatbelt, Great Southern and South West Aboriginal residents had a significantly higher mortality rate for cardiovascular disease compared with the State Aboriginal population (Carlose et al, 2009).

When compared with non-Aboriginal residents of the same area, Aboriginal residents in the Wheatbelt, Great Southern and South West Aboriginal had a significantly higher mortality rate for diabetes, cardiovascular disease, respiratory disease, injury and poisoning, alcohol-related conditions and tobacco-related conditions.

Leading cause of mortality

The leading cause of mortality is shown in the table below. Between 2003 and 2007, the leading cause of death of Great Southern residents was diseases of the circulatory system, followed by neoplasms and respiratory diseases. The leading causes of death were similar in each of the health districts and were similar to all WA residents.

Table 9: Leading cause of mortality by area of residence, 2003- 2007

Rank	Category	No.	% of total	State Rank
Central Great Southern				
1	Circulatory diseases	102	35.7%	1
2	Neoplasms	79	27.6%	2
3	Respiratory diseases	23	8.0%	3
4	Endocrine and nutritional diseases	18	6.3%	6
Lower Great Southern				
1	Circulatory diseases	578	37.2%	1
2	Neoplasms	471	30.3%	2
3	Respiratory diseases	96	6.2%	3
4	Injury and poisoning	90	5.8%	4
5	Endocrine and nutritional diseases	77	5.0%	6

Source: ABS Mortality data

Aboriginal people have a significantly lower life expectancy compared with their non-Aboriginal counterparts, with the gap at the national level estimated to be 11.5 years for males and 9.7 years for females (ABS, 2010b).

Avoidable mortality

Each year people die from diseases that have medical interventions and/or effective public health programs (Hocking et al, 2010). These deaths are referred to as avoidable mortality and are classified into three categories related to the type of intervention. Primary intervention includes deaths that could potentially have been avoided via effective public health measures. Secondary intervention includes deaths that could potentially have been avoided by early intervention through primary health care services or early detection through screening. Tertiary intervention includes deaths that could potentially have been avoided using medical or surgical techniques (Hocking et al, 2010).

Between 1998 and 2007, around two-thirds of Great Southern resident deaths under the age of 75 were classified as avoidable. Cancers and chronic conditions accounted for the majority of avoidable deaths. As shown in the next table ischaemic heart disease was responsible for one in five avoidable deaths (21%), followed by lung cancer (12%).

Table 10: Great Southern Health Region: Leading cause of avoidable mortality, residents aged 0-74 years (1998-2007)

Rank	Condition	No.	% of total
1	Ischaemic heart disease	189	21.2%
2	Lung cancer	105	11.8%
3	Cerebrovacular diseases	67	7.5%
4	Colorectal cancer	64	7.2%
5	Suicide and self inflicted injuries	54	6.1%

Source: ABS Mortality Data

The use of primary interventions could potentially have avoided more than half (53%) the avoidable deaths, while 22% could have potentially been avoided through the use of secondary interventions, such as primary health care services or early detection through screening. One-fifth of the avoidable deaths could potentially have been avoided through the use of tertiary interventions, such as medical or surgical techniques.

Between 1998 and 2007, Aboriginal Great Southern residents had a greater proportion of deaths classified as avoidable compared with non-Aboriginal Great Southern residents (74% compared with 64%). As shown in Table 11, ischaemic heart disease was the leading cause of avoidable death among both Aboriginal and non-Aboriginal residents.

Table 11: Great Southern Health Region: Leading causes of avoidable mortality for Aboriginal residents aged 0-74 years (1998-2007)

Condition	No.	% of total
Aboriginal		
Ischaemic heart disease	14	25.0%
Lung cancer	5	8.9%
Diabetes	5	8.9%
Cerebrovascular diseases	5	8.9%
Non-Aboriginal		
Ischaemic heart disease	174	21.1%
Lung cancer	97	11.7%
Colorectal cancer	62	7.5%
Cerebrovascular diseases	62	7.5%
Suicide and self inflicted injuries	51	6.2%

Source: ABS Mortality Data

4.3.4 Hospitalisations

Hospitalisations are an indicator of relatively severe conditions in the community and assist in targeting primary care resources to prevent hospitalisations. Central Great Southern residents may be admitted to a hospital in the district or region, or may choose to attend a hospital in the metropolitan area as a public or private patient.

Hospitalisation rate

Between 2005 and 2009, Central Great Southern residents had a significantly higher age standardised hospitalisation rate than that of the State, while Lower Central Great Southern residents had a significantly lower rate. The leading categories of hospitalisation are shown in the next table (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2011).

Aboriginal Great Southern residents had a significantly lower hospitalisation rate when compared with all Aboriginal WA residents. However, their hospitalisation rate was more than 1.5 times that of the non-Aboriginal Great Southern residents (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2011).

Leading cause of hospitalisation

Between 2005 and 2009, the leading category of hospitalisation of Great Southern residents was for factors influencing health status, followed by diseases of the digestive system. The leading causes of hospitalisation of Great Southern residents were similar to those of the State.

Table 12: Great Southern Health Region residents: Leading categories of hospitalisations (2005 - 2009)

Rank	Category	No.	% of total	State Rank
Central Great Southern				
1	Factors influencing health status	3,297	17.6%	1
2	Digestive diseases	1,979	10.6%	2
3	Injury and poisoning	1,761	9.4%	5
4	Pregnancy and childbirth	1,474	7.9%	6
5	Ill-defined conditions	1,412	7.5%	7
Lower Great Southern				
1	Factors influencing health status	16,199	21.0%	1
2	Digestive diseases	9,807	12.7%	2
3	Neoplasms	6,347	8.2%	3
4	Musculoskeletal diseases	5,443	7.0%	4
5	Injury and poisoning	5,199	6.7%	5

Source: WA Hospital Morbidity Data System

Between 2005 and 2009 the leading causes of hospitalisation differed between Aboriginal and non-Aboriginal Great Southern residents, as shown in the next table. Injury and poisoning, and mental disorders accounted for a greater proportion of hospitalisations of Aboriginal compared to non-Aboriginal Great Southern residents. Injury and poisoning is one of the leading causes of hospitalisation for both Aboriginal and non-Aboriginal residents and is also one of the leading causes of mortality.

Table 13: Great Southern Health Region residents: Leading category of hospitalisations for Aboriginal residents (2005 – 2009)

Rank	Category	No.	% of total
Aboriginal			
1	Factors influencing health status	1,366	17.2%
2	Respiratory diseases	991	12.5%
3	Injury and poisoning	883	11.1%
4	Mental disorders	864	10.9%
5	Pregnancy and childbirth	769	9.7%
Non-Aboriginal			
1	Factors influencing health status	18,738	20.4%
2	Digestive diseases	11,476	12.5%
3	Neoplasms	7,244	7.9%
4	Musculoskeletal diseases	6,703	7.3%
5	Injury and poisoning	6,529	7.1%

Source: WA Hospital Morbidity Data System

Potentially preventable hospitalisations

Many hospitalisations result from conditions where hospitalisations could potentially be prevented by the use of preventive care and early disease management. These hospitalisations are known as potentially preventable hospitalisations and are grouped into three major categories acute, chronic and vaccine preventable. Public health measures have the greatest influence on vaccine preventable and chronic conditions (Hocking et al, 2010).

Epidemiology Branch and Cooperative Research Centre for Spatial Information (2011) reported that between 2005 and 2009 potentially preventable hospitalisations accounted for 10% of hospitalisations of Central Great Southern residents, a similar proportion to that of the State. Of these, vaccine preventable conditions accounted for 3%, acute preventable accounted for 49% and chronic conditions accounted for 48%. As shown in Table 14, diabetes and its complications were the leading potentially preventable hospitalisations, accounting for nearly one in four hospitalisations.

Table 14: Central Great Southern residents: Leading potentially preventable cause of hospitalisations (2005 – 2009)

Category	No.	% of total
Diabetes complications	341	18.1%
Dental conditions	274	14.5%
ENT infections	216	11.5%
Asthma	194	10.3%
Convulsions and epilepsy	133	7.1%

Source: WA Hospital Morbidity Data System

Between 2005 and 2009, potentially preventable hospitalisations accounted for a similar proportion of hospitalisations of Aboriginal Central Great Southern residents compared with non-Aboriginal residents (9% for both). Acute conditions accounted for 59% of the Aboriginal potentially preventable hospitalisations. Dental conditions and diabetes and its complications were the leading potentially preventable hospitalisations for Aboriginal residents, each accounting for nearly one in five potentially preventable hospitalisations, as shown in Table 15 (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2011).

Table 15: Central Great Southern: Leading potentially preventable cause of hospitalisations for Aboriginal residents, 2005 to 2009

Category	No.	% of total
Aboriginal		
Dental conditions	57	17.9%
Diabetes complications	54	17.0%
ENT infections	51	16.0%
Convulsions and epilepsy	49	15.4%
Asthma	37	11.6%
Non Aboriginal		
Diabetes complications	287	18.3%
Dental conditions	217	13.9%
ENT infections	165	10.5%
Dehydration and gastroenteritis	119	7.6%
Congestive cardiac failure	119	7.6%

Source: WA Hospital Morbidity Data System

Health status: Implications for service planning

Access to health services

As the majority of Central Great Southern residents use primary health care this presents an opportunity for chronic conditions and modifiable risk factors to be assessed.

While 11% of Central Great Southern adults reported having a current mental health problem, only 4% reported having used mental health services in the past year, which was significantly lower than the State (6%). This indicates the importance of intervention at the time of assessment and the importance of improving access to mental health services.

Mortality

More than half the deaths of Great Southern residents under the age of 75 could potentially be avoided through the use of primary health programs.

Circulatory diseases were the leading cause of mortality for Great Southern residents, with ischaemic heart disease the leading cause of avoidable mortality. This highlights that many of these deaths could potentially be avoided with the use of health programs. In particular, physical activity and excess weight are both modifiable risk factors for ischaemic heart disease. With the increasing trend of obesity seen across the State, heart disease may also be likely to increase in the future, suggesting the need for primary health services targeted at this condition and its risk factors.

The primary health care streams of the SIHI will be integral to working towards reducing avoidable deaths of Great Southern residents.

Hospitalisations

The leading cause of hospitalisation of residents is for factors influencing health status, which includes a variety of diagnoses, such as health services for examination and investigation, communicable diseases and reproduction.

One in ten hospitalisations of all Central Great Southern residents could potentially be avoided through the use of preventative care and early disease management. The SIHI will move the focus from providing inpatient hospital services to the delivery of primary care, including the prevention and detection of chronic conditions, such as diabetes related conditions and dental conditions, which accounted for the greatest proportion of potentially preventable hospitalisations.

Central Great Southern Aboriginal residents have a greater need for health care services compared with their non-Aboriginal counterparts. Future service planning needs to ensure culturally appropriate services for the Aboriginal residents are incorporated in this planning.

5 HEALTH PARTNERS

The following services support SCHS to deliver services to the Central Great Southern to provide a continuum of care from primary health care to acute and emergency services in the regional and metropolitan area.

Summary:
Central Great Southern
Health District
Health Partners

State Government

Department of Child Protection (DCP)

Department for Communities (DfC)

Department of Education (DOE)

Disability Services Commission (DSC)

District Health Advisory Council (DHAC)

Fire and Emergency Services (FESA)

Mental Health Commission

PathWest

Regional Development and Lands (RDL)

RuralLink

WA Dental Health Services

WA Police Service (WAPS)

Other agencies

Residential Aged Care

Local government agencies

Relationships Australia

Royal Flying Doctors Service (RFDS)

South West WA Medicare Local

St John Ambulance (SJA)

Private Providers

Independent GPs

Private allied health providers

Private dentists

Community Pharmacy

Visiting Specialists

Commonwealth Government

Centrelink

Department of Veterans' Affairs (DVA)

Department of Health and Ageing (DOHA)

Home and Community Care (HACC)

Medical Specialist Outreach Assistance Program (MSOAP)

Medicare Locals

5.1 State Government

Department of Child Protection

Department of Child Protection provides a range of child safety and family support services to children and families assessed as 'at risk' in the Great Southern Region. SCHS has working relationships with Department of Child Protection to assess and monitor the health needs of 'at risk' children and families in the community.

The Department provides funding to a number of not-for-profit agencies to coordinate a range of programs that address social issues that can impact on health. The not-for-profit agencies include Anglicare WA, Southern Agcare, Albany Halfway House Association, Albany Youth Support Association, Jobs South West, Shire of Katanning (Katanning Youth Support Service) and Katanning Regional Emergency Accommodation Centre. The range of services delivered from these agencies includes:

- Counselling (for those at risk or experiencing domestic violence, abuse and homelessness)
- Financial counselling
- Case management
- Accommodation and transitional care
- Centre-based services, outreach, mobile services and drop-in centres for young people
- Support and outreach services (for those at risk or experiencing domestic violence and homelessness)

A full description of these services are listed by agency at: http://www.dcp.wa.gov.au/servicescommunity/Pages/Location%20of%20services.aspx

For more information: www.dcp.wa.gov.au

Department for Communities

The Department for Communities informs the development of social policy, advocating on behalf of WA children, parents and their families, young people, seniors, women, carers, volunteers and non-government organisations. As such, the Department offers a range of grant programs and incentives to enhance the health and wellbeing of communities and provides the Women's Information Service, Seniors Hotline and Parenting Line telephone support services. For more information: www.communities.wa.gov.au

Disability Services Commission

The Disability Services Commission, established in December 1993 under the Disability Services Act 1993 (WA), is the State Government agency responsible for advancing opportunities, community participation and quality of life for people with disabilities. The Commission provides a range of direct services and support and also funds non-government agencies to provide services to people with disabilities, their families and carers. For more information: www.dsc.wa.gov.au

District Health Advisory Council (DHAC)

District Health Advisory Councils (DHACs) have been established by the State Government to give country people a say in how their health services are delivered and provide the opportunity for continuously improving consumer and community participation at the local, district and State levels. The Council consists of a group of people - health consumers, carers, community members & service providers who actively seek to improve service planning, access, safety and quality.

The composition of Advisory Councils intends to reflect a cross-section of community health interests. Health service providers and agency representatives should comprise no more than 30 per cent of the total number of members.

In the Central Great Southern, the DHAC recently completed a survey to measure community satisfaction regarding health services. The results are currently being analysed by the District and will be made available by mid-2012.

WA Mental Health Commission

The WA Mental Health Commission was established in March 2010 with responsibility for policy, planning and the purchasing of mental health services in Western Australia.

The Commission's functions include development and provision of mental health policy and advice to the government and leading the implementation of the Mental Health Strategic Policy. Local mental health reform across the continuum of care will need to liaise closely with the Commission to ensure local planning aligns with Commission's intentions. For more information: www.mentalhealth.wa.gov.au

PathWest

PathWest provide collection and testing services as per Section 6.5.2.

Regional Development and Lands (RDL), Royalties for Regions

Regional Development and Lands aims to bring a stronger focus to regional development, Crown land administration and facilitates the development of sustainable regional communities in WA. The Department is responsible for initiatives such as Royalties for Regions which funds the SIHI and the SuperTown initiatives (refer to Section 3.4). For more information: www.rdl.wa.gov.au

RuralLink

RuralLink is an after-hours extension of local mental health services that provide a specialist after-hours mental health telephone service to experienced community mental health staff in rural communities and health services of WA. The confidential service also provides an after-hours contact point for information, advice, assessment and/or referral for new and existing clients, carers, other community members, health professionals and community and welfare services. RuralLink helps people deal with depression, suicide, anxiety, psychosis, mental health issues or mental health crisis and operates 4.30pm – 8:30am Monday to Friday and 24 hours Saturday, Sunday and public holidays. For more information: http://www.mentalhealth.wa.gov.au/getting_help/Emergency_help/emergency_rural.aspx

WA Police and Fire and Emergency Services (FESA)

WA Police and FESA are often the 'first responders' to incidents within the community. They work together with SCHS and St John Ambulance to coordinate emergency management responses for the Central Great Southern. This is largely coordinated through their roles on the Local Emergency Management Committee which includes local representatives from Department for Environment and Conservation, Department of Agriculture and Food, Volunteer Fire and Rescue Services, Community Women's Association, SES, Water Corporation, Western Power, local shires, and Red Cross.

WA Dental Health Services

WA Dental Health Services provide visiting public dental health services to school aged children in the Central Great Southern. The closest public adult dental clinic is located in Albany.

5.2 Commonwealth Government

Home and Community Care (HACC)

The existing HACC Program for the Central Great Southern District is coordinated from the Katanning Health Campus with outreach to neighbouring towns. The HACC Program is a joint Commonwealth, State and Territory initiative which funds basic maintenance and support services to help frail older people and younger people with disabilities to continue living in their community. There are eligibility criteria for accessing HACC services. For more information: http://www.health.gov.au/internet/main/publishing.nsf/content/hacc-index.htm

Medical Specialist Outreach Assistance Program

The Medical Specialist Outreach Assistance Program aims to improve access to medical specialists in rural and remote communities and reduce some of the financial disincentives incurred by medical specialists in providing outreach services. Funds are available for the costs of travel; meals and accommodation; facility fees; administrative support at outreach locations; lease and transport of equipment; telephone support; and up-skilling sessions for resident health professionals. For more information: http://www.health.gov.au/internet/main/publishing.nsf/content/ruralhealth-services-msoap

South West WA Medicare Local (SWWAML)

The *South West WA Medicare Local (SWWAML)* is one of the 19 Medicare Locals that commenced across Australia on the 1 July 2011. SWWAML was formed through an alliance of the following three GP Networks: GP Down South; Greater Bunbury Division of General Practice; and Great Southern GP Network. SWWAML covers the Wheatbelt, South West and Great Southern, with offices in Albany, Northam and Busselton. For further information visit: www.sw-medicarelocl.com.au

Department of Veterans' Affairs

The SCHS are supported by the Department of Veterans' Affairs to implement community nursing services and the Coordinated Veterans' Care Program. The Program aims to improve the wellbeing and quality of care for chronically ill Veterans' Affairs gold card holders. The program funds general practitioners and nursing providers to co-ordinate care for gold card holders who are at risk of hospitalisation. Services include health assessments, social assistance and other support designed to keep veterans and war widows / widowers well in their community, live independently and prevent hospitalisation. For more information visit: www.dva.gov.au

Department of Health and Ageing

The Department of Health and Ageing (DOHA) provide flexible funding to the MPS sites for the provision of residential and community aged care services.

5.3 Local Government

The Central Great Southern includes the shires of Katanning, Gnowangerup, Kent, Kojonup, Broomehill/Tambellup and Woodanilling. Generally, local governments provide a number of health and community services that address the social determinants of health and support the health and wellbeing of their communities. This can include environmental health, immunisation services, accommodation for child health clinics, aged care and accommodation, community care, recreational and sporting venues and welfare services. Local government are also at times the first point of contact for community complaints related to individuals with alcohol and drug problems and/or mental health problems. The level of support provided to health services by local governments in the Central Great Southern differ from shire to shire. For example:

- Shire of Kojonup provides a building for the local GP clinic in the centre of town and provide a house to attract and retain a GP. The shire also own and operate the 22-bed Spring Haven low care Residential Aged Care Unit and own and rent eight independent living units adjacent to Kojonup Hospital. The Shire is in the process of building a new GP clinic in town. However, there is a longer-term view to collocate GP services onsite with Kojonup Hospital and Spring Haven.
- To attract and retain local GPs, the Shire of Gnowangerup subsidise local GP services by providing the building for the local GP clinic, a car and house.
- Shire of Katanning is a lead agency in the implementation of the SuperTown initiative. The Shire has also received funding from the *National Partnership Agreement on Preventive Health - Healthy Communities Initiative* to implement the Shire of Katanning's *Healthy Communities Initiative*. This two-year project aims to increase the awareness of the benefits of a healthy lifestyle by enhancing knowledge and skills to develop healthier eating habits and patterns of physical activity in the community.
- Shires of Kent and Woodanilling have partnered with the surrounding Wheatbelt shires of West Arthur, Wagin, Dumbleyung and Lake Grace to build local 'well aged care units' to accommodate elderly citizens who are looking to downgrade from large houses to address the housing issues highlighted in Section 7.1. The units are designed to be the step between independent living and residential aged care. The housing initiative is funded through Royalties for Regions.

- Shire of Kent have limited visiting health services and a lack of health infrastructure to accommodate services, however with the increase in the local mining industry there is expected to be some growth in the population of Nyabing– the closest townsite to the mining operations (in the Shire of Kent).
- The Shire of Tambellup, whilst not directly involved in the delivery of health services, is involved in the project to build a new community resource centre adjacent to the existing Tambellup Nursing Post. Due to the resource centre's planned proximity to the nursing post, there maybe opportunities to create a community hub for health and human services in Tambellup in the future.

5.4 Other agencies

Aged care residential services

The aged care residential services are detailed in Section 6.4.

Palmerston

Palmerston provide a visiting service for individuals and their families with alcohol and other drug misuse issues. The service visits twice a week for young mums or court authorised clients. A range of services are provided to the Central Great Southern including counselling for groups, individuals and families; information about drugs and alcohol; and drug and alcohol withdrawal management. For more information: www.palmerston.org.au

Royal Flying Doctor Service (RFDS)

The RFDS provides a pivotal role throughout WA providing medical and nursing services to transfer patients to larger regional or metropolitan hospitals. The RFDS can fly into Katanning, Gnowangerup and Kojonup however due to the absence of an RFDS base in Albany patients are flown to Perth for care. Section 7.2 details the RFDS transfers for the district.

St John Ambulance

St John Ambulance in Katanning has a Community Paramedic who is responsible for training, auditing and retaining volunteer ambulance officers and drivers across the Great Southern. There are St John Ambulance bases in Katanning, Gnowangerup, Tambellup and Kojonup which have a combined pool of approximately 15 ambulances and 50 officers and volunteer drivers. St John coordinate patient transfers in partnership with SCHS and RFDS to district, regional and metropolitan health services. A Community Paramedic will also be based in Jerramungup in 2012. Statistics for patient transfers are shown in Section 7.2.

5.5 Private providers

As of July 2012, there were six GPs based in Katanning. Five of these GPs are credentialed to provide inpatient care and 24/7 emergency on call support to Katanning Hospital. There is one GP in Gnowangerup providing inpatient support and emergency close call to Gnowangerup Hospital during the week, as well as supporting a fortnightly *Closing the Gap Aboriginal Health* clinic at Tambellup. On weekends this GP participates in the Katanning Hospital on-call roster. There is one GP in Kojonup

providing inpatient support and emergency close call to Kojonup Hospital during the week. Kojonup and Gnowangerup Hospitals are both supported by Katanning Hospital's close call medical roster on weekends. A female GP from Albany undertakes regular Women's Health Clinics in Katanning and Kojonup.

An audit of private allied health providers in late 2010 shows that there were the following private practitioners available: psychiatry (Katanning only), psychology (Katanning and Tambellup), physiotherapy and podiatry (Katanning, Kojonup, Gnowangerup and Tambellup). There is also a visiting chiropractic service to Kojonup and private dentists available in Katanning and Kojonup.

6 CURRENT & FUTURE SERVICE DELIVERY

The following section details the current and projected demand for services in the Central Great Southern based on the demography and health status information in Section 4 and the activity of hospitals and health services. The information in this chapter will provide guidance for services in the District as they work towards consolidating improved models of care under the Southern Inland Health Initiative (SIHI).

This chapter provides an overview of current activity for the District; describes patient flows within the region and outflows to other regional and metropolitan healthcare facilities; profiles each major service area including current service model (as of April 2012); historical activity; demand projections (where available) and recommended service delivery strategies to:

- Better align health services to meet the role delineations of the *WA Health Clinical Services Framework 2010 -2020* (CSF 2010a).[3]
- Highlight opportunities to meet the intentions of SIHI and invest the allocated recurrent and capital funding available for Katanning Hospital and other facilities.
- Support sustainable models for medical, emergency, aged care and primary health care service delivery to meet the needs of the local catchment area.
- Improve safety and efficiencies in patient care.

Implementing the recommendations will be dependent on appropriate endorsement, local collaborations and partnerships with other providers, and the degree to which the staff, GPs and specialists can be attracted and retained to deliver the services.

6.1 Ambulatory health care services

Ambulatory health care services is a broad title that generally refers to the planned services provided to patients who are able to 'walk in and walk out' on the same day. Services include primary health care services, procedural day surgery and outpatient services. Ambulatory care services provided for Central Great Southern residents are outlined below.

3 The *Clinical Services Framework* does not include the role delineations for small hospitals, therefore the role delineations are presented for Katanning Hospital only.

6.1.1 Primary health care services

The preferred future model of primary health care in the Central Great Southern will support the Commonwealth's *National Primary Health Reform Program* (2011), align with the intentions of SIHI and link with Medicare Locals and Local Health Networks.

Integrated primary health care services offer the opportunity for improved economies of scale and efficiencies, integrated systems and promotion of a collaborative approach to patient and consumer health care and service improvement.

This service planning exercise for the Central Great Southern is an opportunity to reconsider the organisation of primary health care service in line with developments in acute, aged and emergency care. Integrated programs addressing issues such as chronic disease care coordination, community rehabilitation, maternal and child health, youth health, oral health and suicide prevention, will enhance the services delivered.

The current service model, key issues and challenges and proposed service model are described, by each primary health care service below.

Current service profile

SCHS Population Health Services

SCHS Population Health Services covering the age and care continuum are an essential element of the continuum of care for the Central Great Southern. Local population health services are part of a regional service delivery model coordinated from Albany. The focus locally is on community health, public health and Aboriginal health, with a focus on interventions directed at preventing, detecting or minimising the progression of disease. The current services are as follows:

- Community health including child health nursing services, school health, Muslim liaison services, chronic disease services and allied health services including physiotherapy, occupational therapy, speech pathology, social work, dietetics and audiology. Podiatry is a visiting service.
- Aboriginal health including access to GP clinical services, chronic disease coordination, sexual health, antenatal support, child health, health promotion, liaison and support to the hospital and community based services.
- Public health including research and evaluation, communicable disease control and health promotion to prevent the occurrence or further development of communicable and non-communicable diseases in the community.

There are several other not-for-profit and private providers in the district and region who provide primary health care services – refer chapter five health partners.

It is the intention that more service and funding partnership approaches will develop over time to address the health needs of the population identified in this plan.

In 2009/10, there were at least 4,910 community health occasions of service from Katanning (AOD pivot, extracted 22nd August 2011). This data should be used as a guide only, as there are often inconsistencies in recording community health. Around 13% of these community health occasions of service were for Aboriginal residents, which is higher than the overall proportion of Aboriginal people living in the Central Great Southern (7% as of 2006 Census).

Community Mental Health Services

The Mental Health Team based in Katanning is coordinated via the Great Southern Mental Health Service. The resources they have (2.8 FTE) are largely directed to supporting assessment, care and transportation of patients in the emergency and acute care settings (Refer to Section 6.3.5).

Although there is a small Commonwealth funded primary mental health service, there is limited capacity to provide more comprehensive preventative / health promotion community-based mental health services. The Commonwealth funded service provides mental health first aid, drumbeat, counselling and mental health promotion activities to Katanning and surrounding areas.

The community mental health activity provided by the Katanning Mental Health Team is outlined below. The data does show an increase in activity, however the data should be treated as a guide only due to limitations in data collection.

Table 16: Community Mental Health Data – Katanning, 2007/08 - 2009/10

Community Mental Health Team	Occasions of service		
	2007/08	2008/09	2009/10
Katanning	2,597	2,946	2,819

Source: MHIS

Community Aged Care

The Home and Community Care (HACC) Program is a joint Commonwealth, State and Territory initiative. It funds basic maintenance and support services to help frail older people, younger people with disabilities and their carers to continue living in their community.

HACC provides services to the Central Great Southern from the Katanning, Kojonup and Gnowangerup Hospitals. The HACC service recently moved to co-locate with community health on the Katanning Heath Campus; this has strengthened the interdisciplinary approach to the wellness model incorporated into the Central Great Southern's service delivery model. This coordinated approach to client centred care planning, reduces duplication of service and provides a coordinated and integrated service with key stakeholders (e.g. team meetings/joint case management).

The Senior Community Service Coordinator is based at the Katanning Hospital; however there are also local coordinators based in Kojonup and Gnowangerup.

HACC provides regular community activities for Aboriginal and non-Aboriginal community members. A transport service is also available for clients within the Central Great Southern. HACC is designed to assist people with the greatest need and aims to maximise people's independence; the HACC service provider (SCHS) will assess eligibility and identify level of need. An open referral system exists (this means anyone can refer to HACC for an assessment for eligibility). The HACC program has developed strong working partnerships with both government and non-government agencies in the region (i.e.: HACC and Anglicare liaise to provide disability support services).

The Stay on Your Feet program is also available to older adults in the community via population health physiotherapy services.

The Great Southern Aged Care Unit provides a visiting service to the Central Great Southern. The Aged Care Assessment Team plan site visits to provide assessment and care planning for Commonwealth funded programs and services. The Great Southern HACC Project Officer also makes regular site visits to ensure ongoing support and provide guidance with administering the HACC Program.

SCHS also receives support from the Department of Veterans' Affairs to implement community nursing services and the Coordinated Veterans' Care Program (refer to Section 5.2).

Public Oral Health Care

Public dental services for school aged children are available at dental therapy centres at a range of schools. However, there are currently no public adult dental health services in the District. The closest public adult dental clinic is located in Albany.

Recommendations for service reform - Primary health care services
General recommendations
• Co-locate primary health care services on the Katanning Health Campus as proposed by SIHI (Stream 2). Collocate with outpatients, ED services, mental health and feature primary health as part of the integrated service.
• Re-orient health services towards a primary care model across the continuum of care and provide an integrated model of care for consumers and the community.
• The new Service Integration Coordinator to work in partnership with GPs and staff to establish an integrated ED and primary health model of care including innovative funding partnership models. This includes determining the integration model between ED, mental health services, HACC, GPs, Aboriginal health, population health and other primary health care services such as non-government agencies.

Recommendations for service reform - Primary health care services
• Prioritise the resources available for boosting primary health care services as per SIHI (Stream 2). Suggestions based on identified need include additional resources for allied health services; mental health prevention and promotion; counselling; transitional care; support in the home; early childhood services; youth and adolescent services; alcohol and other drug services; diabetes education; and multicultural and Aboriginal health liaison roles and associated workforce models.
• Investigate the need for a mobile primary health care nurse practitioner service to monitor and treat the health care needs of families and individuals in outlying communities who have limited access to health services. A similar model has been recently established in the Eastern Wheatbelt.
• Continue to implement and explore new opportunities to realign services and resources to provide joint case management across disciplines and service providers.
• Review the role of administration / reception staff in directing patients and consumers to appropriate services.
• Advocate to Area Information Services and Health Information Network to provide an integrated medical records system to support primary health care across the continuum.
• Explore opportunities to collocate other Government departments (Commonwealth, State and local) and non-government service providers with primary health care services on the Katanning Health Campus to create a community hub for services and respite. Explore joint funding for such a venture (e.g. with LotteryWest).
• Explore opportunities to collocate health and human services on other small hospital sites.
Aged care, Aboriginal health and chronic disease
• Implement the nurse practitioner role in primary health (e.g. aged care, chronic disease management, urology, pain management).
• Realign services and resources to support high need individuals to transition from acute care to the community/home (e.g. mental health, Aboriginal health and aged care).
• Build the capacity of the local Aboriginal community to have greater community control for health services.
• Explore opportunities to provide greater after hours support and flexibility to manage peak demand and 'drop ins' for primary health care.

Recommendations for service reform - Primary health care services
• Investigate opportunities to strengthen access to federally funded medical and pharmaceutical programs for Aboriginal people.
Population health, allied health and oral health
• Explore the need to build up dental health services locally (e.g. two-chair dental clinic for preventative care and treatment).
• Develop generalist and interdisciplinary workforce with a strong primary health care focus.
• Provide services in partnership with Commonwealth, State and local government and non-government service providers with primary health care services to address and identify community needs and service gaps.
• Advocate across government action to address the social determinants of health in the community (e.g. social infrastructure, housing, education, alcohol and other drug issues, food security).
• Support an increase in non-State Government primary health care service delivery through non-government and private providers where the services can address community health needs in effective ways.
Community mental health and alcohol and other drug services
• Advocate for more integrated services in the management of alcohol and other drug issues and up skilling of staff to enable more holistic care for clients with multiple issues.

6.1.2 Day surgery

Refer to section 6.3.2.

6.1.3 Outpatient services

The following outpatient services are provided at Katanning through visiting medical and surgical specialists:

- General surgery
- General medicine
- Gynaecology
- Obstetrics
- Ophthalmology
- Orthopaedics

- Pain Management
- Psychiatry
- Palliative care
- A range of nursing outpatient services including extended care services, regional urology/continence/stoma services, palliative care and cancer care.

The majority of outpatient services are provided by specialists based in Albany. An orthopaedic specialist and one of the ophthalmologists travel from Perth to provide clinics.

There are currently no outpatient services in Katanning for cardiology, endocrinology, neurology, paediatrics, respiratory, gastroenterology, ENT, haematology and immunology. Rheumatology and urology outpatient services and visiting gerontology services are conducted on an ad-hoc basis to Katanning. The level of outpatient and medical care for renal dialysis and oncology is described Section 6.3.1.

Recommendations for service reform - Outpatient services
• Provide greater access to existing visiting medical specialties (including general medicine, ENT, cardiology, pain management, psychiatry, rheumatology, urology, ophthalmology and gerontology) and surgical specialties (including general surgery and orthopaedics).
• Refer also to recommended facility upgrades under Section 10.

6.2 Emergency services

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 emergency services should provide

- Local GPs rostered to provide 24 hour cover with services by a registered nurse
- Resuscitation and stabilisation
- Access to specialist services visiting or by telehealth

The ED at Katanning Hospital generally meets the role delineation above. The nurse led model of care has 'close on call' support from GPs, however at times there can be delays in GPs being able to respond efficiently 24 hours a day.

The ED currently provides two ED bays, with an additional resuscitation bay located in the decommission theatre nearby. The bays have the capacity for acute management and stabilisation of all forms of emergencies including life threatening illnesses requiring immediate resuscitation and management.

There are no district medical officers in the Central Great Southern. GPs who attend the hospital do so as visiting medical practitioners.

Gnowangerup and Kojonup hospitals generally have close on call support by a local GP during the weekdays. On the weekend Katanning and Gnowangerup GPs support a rotating roster system providing close on call support to Katanning and phone support to the smaller hospitals.

In 2012, a FACEM from Albany Hospital commenced monthly visits to Katanning Hospital to provide clinical governance and education support.

The hospital has the physical capacity for telehealth ED consultations. However, there are not yet any agreed processes for linking to other sites, other than RuralLink for mental health presentations.

Activity summary

Current and projected emergency department activity

- In 2010/11 80% of ED presentations at Katanning were for triage four and five (non-urgent) presentations.
- Aboriginal residents are over-represented in the ED figures across the district. At Katanning Hospital, 26% of presentations were by Aboriginal people. At Gnowangerup and Kojonup 15% and 11% of the presentations involved an Aboriginal person, respectively (despite 7% of the population identifying as being of Aboriginal descent in the 2006 Census).

- The projected data in Table 17 is estimated from 2010/11 actual activity. Katanning Hospital ED activity is predicted to increase by 15% between 2011/12 and 2021/22. This is an increase of 981 presentations.
- By 2021/22, the presentations for triage five categories at Katanning are projected to decrease, which is expected as a result of greater access to primary health care services as per the intentions of SIHI and State-wide initiatives.
- Current projections (based on the 2010/11 activity) suggests that at least five treatment bays will be required at Katanning and the current two bay capacity at Kojonup and Gnowangerup will be sufficient to meet future demand. However, a dedicated second bay in the Gnowangerup ED should be established, rather than have a bay in the decommissioned X-ray room.
- The estimated number of treatment bays required to meet actual and projected demand is calculated using the benchmarks in Table 18.

Table 17: Central Great Southern hospitals: current and projected emergency department presentations, by triage category

Hospital	Actual presentations			Projected presentations		
	2008/09	2009/10	2010/11	2011/12	2016/17	2021/22
Katanning Hospital						
Triage 1 & 2	172	216	402	430	701	1085
Triage 3	1,238	1,240	892	949	1,387	1,998
Triage 4 & 5	4,305	4,444	5,089	5,010	4,581	4,287
Total	**5,715**	**5,900**	**6,383**	**6,389**	**6,669**	**7,370**
ED bays	**2.9**	**2.9**	**3.0**	**3.5**	**4.3**	**5.6**
Other Central Great Southern hospitals						
Triage 1& 2	80	96	92	99	164	255
Triage 3	248	334	361	388	603	916
Triage 4 & 5	1,208	1,348	1,194	1,187	1,156	1,122
Total	**1,536**	**1,778**	**1,647**	**1,674**	**1,923**	**2,293**
ED bays	**0.7**	**0.9**	**0.9**	**1.0**	**1.3**	**1.7**

Source (historic): WACHS online ED pivot extracted January 2012;
Source (projections) WACHS ED Projections Pivot (Based on ABS Series B+)

Table 18: ED Planning Benchmarks

Measure	Treatment Space	Hospital Classification	Benchmark	Source
ED Attendances (all ages)	Fast Track	All SCHS hospitals	1/3000 yearly T4 and T5 attendances	Adapted from Emergency Demand Treatment Space Calculator, The Advisory Board Company, 2009. Revised in 2011 to incorporate combined triage 1 & 2 categories.
	General ED	All SCHS hospitals	1/1000 yearly T3 attendances	
	Trauma/ Critical Care	Regional Resource Centres	1/975 yearly T1 and T2 attendances	
		Integrated District Health Services	1/975 yearly T1 and T2 attendances	
		Small Hospitals	1/950 yearly T1 and T2 attendances	

Source: Country Health Services Central Office, Planning Team

Current activity, by age group

- Almost one third of presentations (32%) at Central Great Southern EDs in 2010/11 involved children aged 14 years and under.
- One in ten presentations (10%) at Central Great Southern EDs involved older adults aged over 65 years.

Table 19: Central Great Southern hospitals: ED activity 2010/11, by age category.

Hospital	0-14 yrs	15-44 yrs	45-64 yrs	65-84 yrs	85+ yrs	Total
Katanning	2,127	2,562	1,101	513	81	6,384
Gnowangerup	244	272	147	101	10	774
Kojonup	268	323	146	103	33	873
Total	**2,639**	**3,157**	**1,394**	**717**	**124**	**8,031**

Source: WACHS online ED pivot, extracted January 2012

Current activity, by weekday and time of day

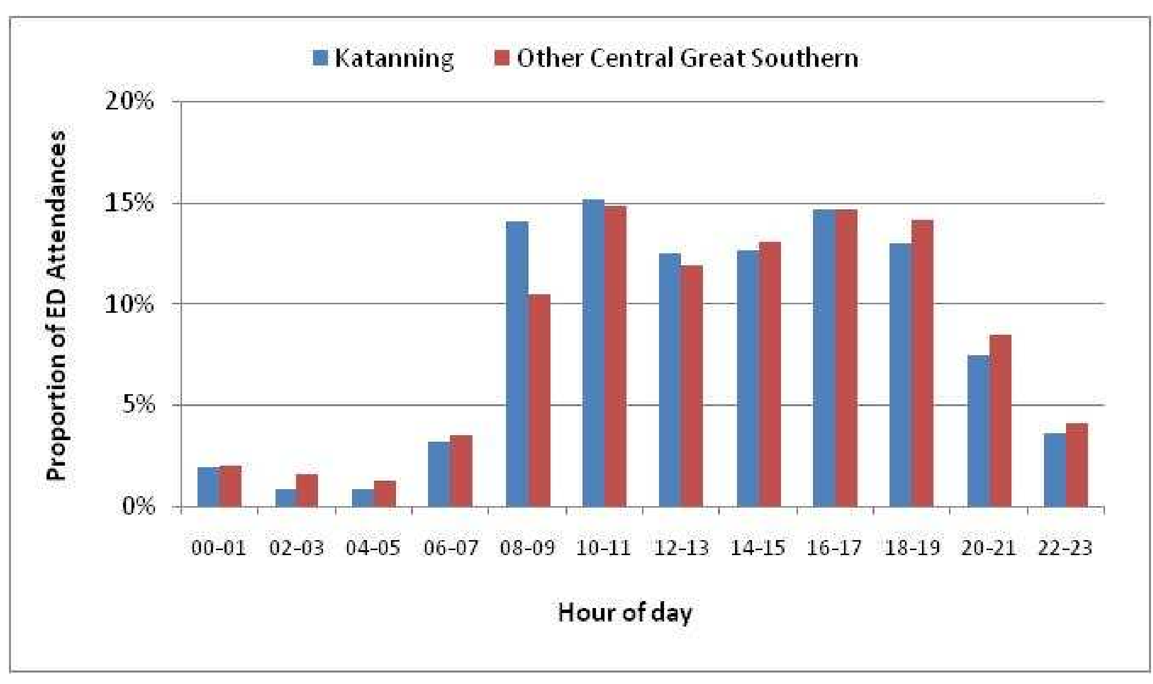
- Central Great Southern hospitals show similarities in regards to the weekday and time of day that people attend to ED:
  - A third (33%) of presentations occurs over the weekend as shown in the next figure.
  - Figure 10 shows peek activity is between 8am and 11am and 4pm and 7pm, 60% of presentations occur between 8am and 6pm.

Figure 9: Proportion of ED presentations, by day of week (2010/11)

Katanning
Other Central Great Southern
Proportion of ED Presentations
20%
15%
10%
5%
0%
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
Day of week

Source: WACHS online ED pivot, extracted September 2011

Figure 10: Proportion of ED presentations, by hour of day (2010/11)

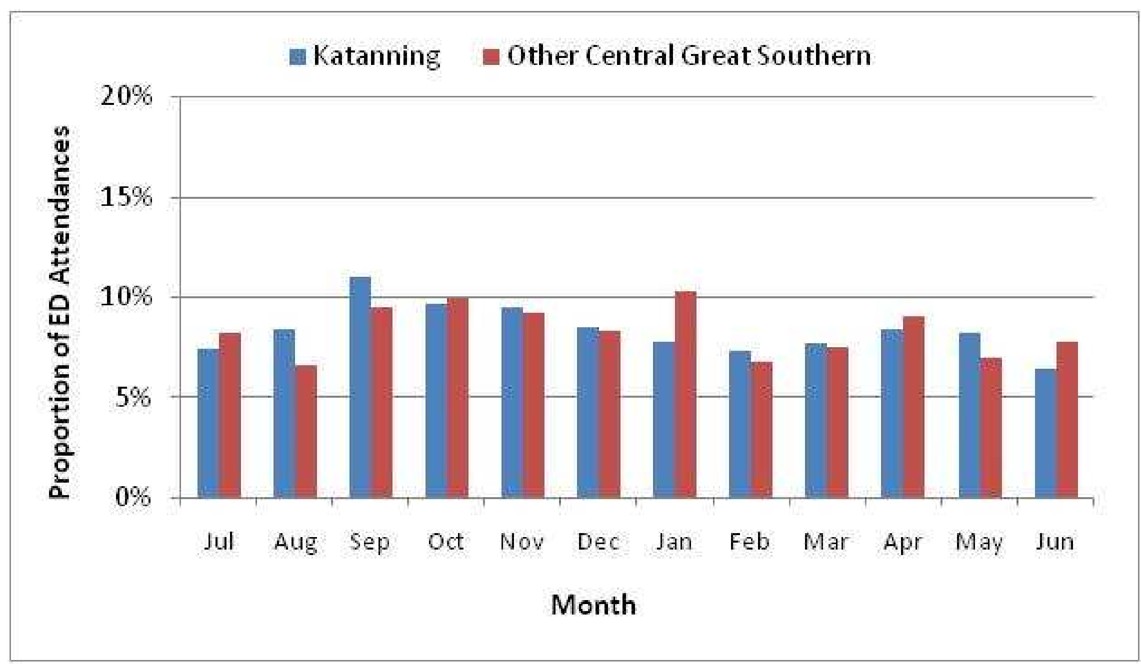


Source: WACHS online ED pivot, extracted September 2011

Current activity, by month

- As shown in Figure 11, there is little seasonal variation shown in the ED attendances at Central Great Southern hospitals. Katanning does have a spike in activity in September while January was the busiest month for Kojonup and Gnowangerup hospitals.

Figure 11: Proportion of ED attendances by month of year, 2010/11



Source: WACHS online ED pivot, extracted September 2011

Current activity involving mental health and alcohol and other drug issues

- As shown in Table 20, in 2010/11 at least 2% of all presentations to Katanning ED and 2% of presentations to Kojonup and Gnowangerup EDs were identified as involving a mental health or alcohol and other drug issue.
- In 2010/11, 'alcohol/drugs' accounted for around 23% of ED presentations at Katanning Hospital and 24% of presentations to Kojonup and Gnowangerup hospitals.
- Presentations involving mental health and alcohol/drug issues are likely to be underestimated as the principal diagnosis is often coded as a physical issue, such as injury or poisoning.

Table 20: Central Great Southern hospitals: Proportion of ED Attendances classified as Mental Health/Alcohol/Drug (2008/09 – 2010/11)

Hospital	Proportion of ED presentations		
	2008/09	2009/10	2010/11
Katanning	2%	2%	2%
Kojonup and Gnowangerup hospitals	2%	2%	2%

Source: WACHS online ED pivot, extracted January 2012

Recommendations for service reform - Emergency Services
• Attain a Level three ED service at Katanning Hospital by establishing the ED 24/7 'close on call' model of care (as per Stream 1 SIHI) in partnership with regional and district staff and GPs. Integrate the model with the co-located primary health care service model (Stream 2 SIHI).
• In providing the 24/7 'close on call' emergergency model of care and to boost primary health care services, decide on the best strategy to invest the human resource allocations available in Stream 1 and 2 of SIHI. Primary health priorities are listed in the *recommendations* of Section 6.1.
• Collocate with ED services with the co-located primary health care services on the Katanning Health Campus and other small hospitals sites as proposed by SIHI (Stream 2) where possible.
• Integrate the Older Person Initiative into ED screening practices. The Older Patient Initiative aims to reduce avoidable or premature admissions of older people to hospitals through early identification of people at risk, complex care coordination and provision of age friendly services.
• Increase ED bays to five in redevelopments - refer also to recommended facility upgrades under Section 10.

6.3 Acute inpatient services

The following section summarises the high level data for acute inpatient services across the district. The activity and recommendations for the various medical and surgical sub-specialties are summarised thereafter. This includes general medicine, general surgery, paediatric, mental health, maternity services and sub-acute services.

Prior to interpreting the data please read the assumptions below.

Assumptions for Future Patient Flows and Self Sufficiency

Future inpatient activity projections were remodelled in late 2011 by the Department of Health Clinical Modelling Unit, the Country Health Services Central Office Planning Team and the Region. The updated modelling was based on the following assumptions for the Central Great Southern (and Great Southern region):

- The public self-sufficiency of renal dialysis services will increase to 95%, in line with the *WACHS Renal Dialysis Plan* (2010). The increase in renal dialysis services in the Great Southern will be achieved with Albany Hospital increasing service capacity for renal services.
- The public self-sufficiency of select ESRGs[4] at Katanning Hospital is increasing due to anticipated workforce planning strategies to increase the retention of core specialists in line with the role delineation of the hospital.
- The public self-sufficiency of cancer services will increase, in line with the *WACHS Rural Cancer Units Plan* (2010). The increase in cancer services in the Great Southern will operate at Albany Hospital with the six chair, one bed chemotherapy unit.
- An increase in the public self-sufficiency of sub-acute care.

Current district activity profile

- The next table provides an overview of the current activity within the district and demonstrates that Katanning is the major hub for service delivery in the Central Great Southern.

4 Core specialists include general medical, general surgery, obstetrics and gynaecology, orthopaedics, drug and alcohol related conditions, psychiatry and medical paediatrics.

Table 21: Central Great Southern hospitals: Current activity profile (2009/10)

Category	Katanning	Gnowangerup	Kojonup
Number of active acute multi-day beds	**17 beds**	**4 beds**	**6 beds**
Total acute multi-day separations	1,144	66	103
Total acute multi-day bed-days	3,641 days	857 days	528 days
Average multi-day acute bed occupancy	10	2	1
Number of active same-day beds	**-**	**-**	**-**
Number of active residential beds	**19**	**8**	**6**
Total same-day separations	527	31	15
Total same-day bed-days	527	31	15
Average same-day bed occupancy	1	0	0
Total separations	**1,671**	**97**	**118**
Total bed-days	**4,168**	**888**	**543**
Average acute bed occupancy	**11**	**2**	**2**
Average acute multi-day length of stay	**3 days**	**13 days**	**5 days**

Inpatient data excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Katanning has capacity of 30 multi-day beds of which 17 are active (as of April 2012).
Source (inpatient): WA Hospital Morbidity Data System, via Clinical Modelling Unit.
Source (active beds): WACHS online bed pivot accessed 23 February 2012.
NOTE: The number of active beds is less than the physical capacity (total beds) of the hospital.

Current and projected inpatient activity

- As shown in the next table, the overall separations at Katanning Hospital increased by 14% between 2007/08 and 2009/10. For the same period, activity decreased slightly for the other Central Great Southern hospitals.
- Inpatient activity is projected to increase between 2009/10 and 2021/22, particularly in same-day activity at all sites.

Table 22: Central Great Southern hospitals: Historic and projected inpatient separations (2009/10 – 2021/22)

Hospital	Actual separations			Projected separations			% growth (2009/10 - 2021/22)
	2007/08	2008/09	2009/10	2012/13	2016/17	2021/22	
Katanning Hospital							
Same-day	517	598	527	602	754	929	76%
Multi-day	947	1,093	1,144	1,132	1,243	1,280	12%
Total	**1,464**	**1,691**	**1,671**	**1,734**	**1,997**	**2,209**	**32%**
Other Central Great Southern hospitals							
Same-day	44	32	46	53	63	76	65%
Multi-day	179	183	169	175	191	207	23%
Total	**223**	**215**	**215**	**227**	**253**	**283**	**32%**

Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling– based on ABS Series B+

Current activity, by age group

- As shown in the table below, 40% of separations at Katanning Hospital involved people aged between 15 to 44 years and 4% were aged 85 years and over.
- Gnowangerup and Kojonup have an older patient cohort, with 85 year olds and over accounting for 16% and 28% of separations respectively.
- Aboriginal people were over-represented in the Katanning separations, accounting for 18% of the 2009/10 separations but 7% of the Central Great Southern population.

Table 23: Central Great Southern Hospitals: Inpatient separations by age group (2009/10)

Hospital	Age Group					Total
	0-14 yrs	15-44 yrs	45-64 yrs	65-84 yrs	85+ yrs	
Katanning	260	667	381	296	67	1,671
Gnowangerup	10	35	12	25	16	98
Kojonup	5	16	20	44	33	118
Total	**275**	**718**	**413**	**365**	**116**	**1,887**

Source: WA Hospital Morbidity Data System, via Clinical Activity Modelling Unit. Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 days at separation.

Bed-days and bed projections

- As shown in Table 24, by 2021/22, the number of bed-days at Katanning Hospital will be approximately 6,000. This correlates to a requirement for approximately 22 beds. This indicates that the current number of active acute inpatient beds (17) will not be sufficient to meet future demand, but the total bed capacity of the hospital will be sufficient.

Table 24: Central Great Southern hospitals: Historic and projected inpatient bed-days (2009/10–2021/22)

Hospital	Actual		Projected					
	2009/10		2012/13		2016/17		2021/22	
	Bed-days	*Occupied Beds*	*Bed-days*	*Occupied Beds*	*Bed-days*	*Occupied Beds*	*Bed-days*	*Occupied Beds*
Katanning Hospital								
Same-day	527	1.9	602	2.2	754	2.8	929	3.4
Multi-day	3,641	13.3	4,300	15.7	4,921	18.0	5,061	18.5
Total	**4,168**	**15.2**	**4,902**	**17.9**	**5,674**	**20.8**	**5,990**	**21.9**
Other Central Great Southern hospitals								
Same-day	46	0.2	53	0.2	63	0.3	80	0.3
Multi-day	1,385	5.8	1,480	6.2	1,617	6.8	1,784	7.5
Total	**1,431**	**6.0**	**1,533**	**6.4**	**1,679**	**7.1**	**1,864**	**7.8**

Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling – based on ABS Series B+

Supply of inpatient services from Central Great Southern hospitals

- In 2009/10, 90% (1,730) of the 1,886 separations from SCHS Central Great Southern hospitals involved residents of the Central Great Southern.
- The majority of separations were from Katanning Hospital (89%).

Table 25: Central Great Southern Health District: Supply of inpatient services, by residential area (2009/10)

Hospital	Number of separations by residential area					% of total Separations
	Central Great Southern	Lower Great Southern	Southern Wheatbelt	Other	Total	
Katanning	1,540	12	73	46	**1,671**	89%
Gnowangerup	83	8	<5	<5	**97**	5%
Kojonup	107	<5	<5	7	**118**	6%
Total	**1,730**	**20**	**73**	**53**	**1,886**	**100%**

Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Source: WA Hospital Morbidity Data System, via Clinical Activity Modelling Unit

Demand for public and private inpatient health services by residents

- In 2009/10, 4,292 separations from all WA private and public hospitals involved residents of the Central Great Southern. Of these separations:
  - 40% (1,730) were from hospitals within the Central Great Southern;
  - 17% (721) were from Lower Great Southern hospitals (including Albany Hospital);
  - 20% (844) were from public metropolitan hospitals; and
  - 20% (852) were privately treated (1% were privately treated in rural facilities and 19% were privately treated in metropolitan facilities).

Table 26: Central Great Southern residents: Inpatient separations at all WA Health facilities (2009/10)

Region	Treating Hospital	Resident Separations 2009/10	% of Total Public & Private Separations	% of Total Public Separations only
SCHS Central Great Southern	Katanning	1,540	40%	45%
	Gnowangerup	83	2%	2%
	Kojonup	107	2%	3%
Sub-total (Central Great Southern)		**1,730**	**40%**	**50%**
Lower Great Southern	All	721	17%	21%
Other Country Regions	All	145	3%	4%
Sub-total (Country WA)		**2,596**	**60%**	**76%**
South Metropolitan Health Service	All	278	6%	8%
North Metropolitan Health Service	All	353	8%	10%
Child and Adolescent Health Service	All	64	2%	2%
Contracted Metro	All	149	4%	4%
Sub-total (metro)		**844**	**20%**	**24%**
Total Public*		**3,440**	**80%**	**100%**
Private	Metro	815	19%	0%
	Rural	37	1%	0%
Total (Private and Public)		**4,292**	**100%**	

Source: WA Hospital Morbidity Data System, via Clinical Modelling Unit
Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
**Includes public patients in private hospitals.*

Public self-sufficiency of SCHS Central Great Southern hospitals

- 'Self-sufficiency' is a calculation used to identify the proportion of resident public health separations that are managed by Central Great Southern hospitals - an indicator of the district's capacity to provide care closer to home.
- Due to the level of remoteness and availability of onsite specialists, a country health service will not achieve 100% self-sufficiency. Highly acute and complex patients will continue to be transferred to Perth or Albany where more specialised services and medical equipment are located.
- In 2009/10, 50% (1,730) of the Central Great Southern residents who required public health care received that care from a SCHS hospital in the Central Great Southern. This equates to a public self-sufficiency of 50% for Central Great Southern hospitals.
- The public self-sufficiency has ranged from 57% in 2007/08 to 50% in 2009/10.

Table 27: Central Great Southern hospital: Public self-sufficiency (2005/06 - 2009/10)

Category	Financial year				
	2005/06	2006/07	2007/08	2008/09	2009/10
Public self sufficiency	56%	55%	57%	50%	50%

Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Source: WA Hospital Morbidity Data System, via Clinical Activity Modelling Unit

Length of stay performance

WA Health is now using an activity based funding (ABM) and management (AMB) system. Within the ABF inpatient separations with a length of stay between one-third and three times the WA average length of stay (known as the central episode) for a DRG will be funded at the same price. This funding mechanism means that separations within the central episode that have a length of stay greater than the average will tend to cost the hospital more than the payment they receive.

Separations with a length of stay greater than three times the WA average are regarded as being over the high boundary of the central episode (outlier episodes of care) and in 2011/12 will be paid at a rate per day. These high boundary separations are of particular interest from a safety and quality perspective and in the ABF/M as they are more likely to have adverse events associated with them.

In 2009/10 there were 69 separations at Katanning Hospital that had a length of stay that was greater than three times the WA average. These 69 separations resulted in 609 bed-days (1.7 beds) of over boundary stay.

Within the service planning the models of care and hospital processes, such as admission and discharge, will also need to be considered within the context of how they impact on the average length of stay.

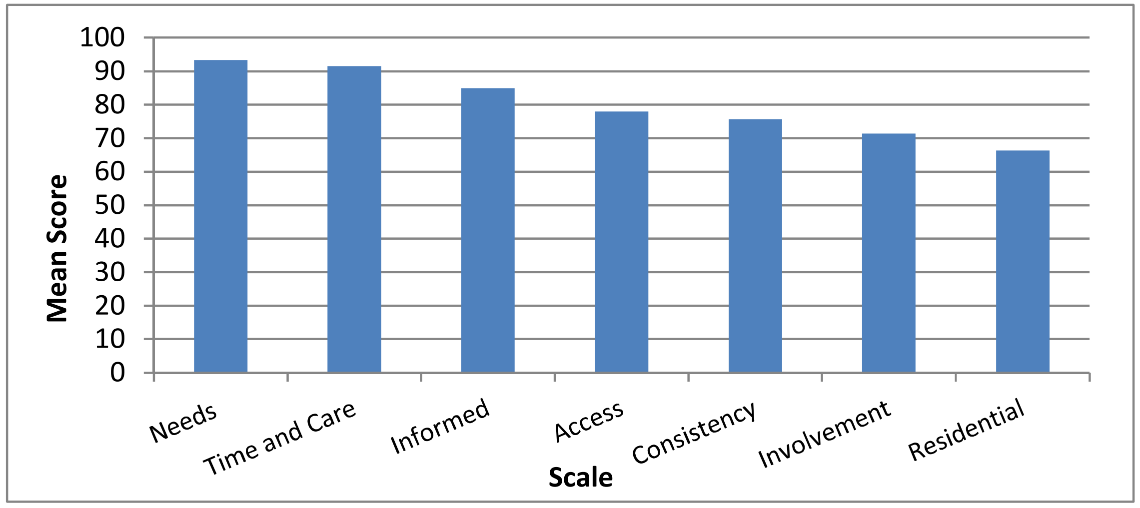
Patient satisfaction

In 2009/10 a sample of adult patients who had stayed less than 35 nights at Katanning Hospital completed a patient satisfaction survey. The answers to the survey have been grouped into themes (scales) that represent how the patients rated the hospital on a particular aspect of health service. The scales are:

- Needs Scale: Meeting personal as well as clinical needs
- Time and Care Scale: Time and attention paid to patient care
- Informed Scale: Information and communication
- Involvement Scale: Involved in decisions about your care and treatment
- Access Scale: Getting into hospital
- Residential Scale: Food and residential aspects
- Consistency Scale: Continuity of care

As shown in Figure 12, the *needs scale* was rated the highest (94), while the *residential scale* was rated the lowest (69). Overall patients were satisfied with their hospital stay and its outcome.

Figure 12: Katanning Hospital: Mean Scale Scores, (adults, 0-34 nights), 2009/10



Source: Patient Evaluation of Health Services (Epidemiology Branch)

Note: these scale score do not represent the percentage of patients satisfied with the service.

6.3.1 Medical Services (Adult - 15 year olds and over)

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 adult medical services should provide:

- 24/7 on-call by GP or visiting medical practitioner
- 24 hour cover by a Registered Nurse
- GP inpatient care
- Outpatient care by general physician or general medicine specialist visiting or via Telehealth
- Access to some allied health services

General

Katanning generally meets the role delineation above. However, there is a need to contract more permanent and visiting medical specialists and allied health staff to increase access to services available in the district and reduce the number of patient and consumer transfers for care.

There are no regular visiting or telehealth general physician services. These services are accessed from the Regional Resource Centre at Albany on an ad hoc basis.

Medical services to Katanning Hospital are provided by the local GPs and visiting medical specialists including:

- Orthopaedics: three monthly consulting and some surgery not involving joints.
- Pain Management: three monthly visiting service and ad hoc telephone consulting.
- Radiology: not provided on site. Films are sent to Telerad for reporting.

Outreach services are also provided from Albany including urology/continence/stoma, cancer and palliative care services.

Renal services - dialysis

Katanning CSF role delineation – Level 2

Level 2 renal dialysis services should provide:

- Community may support self-care dialysis inpatients (if adequate water supply)
- Services offered by a general health service/clinic
- Care under supervision of GP with or without a registered nurse
- Self-caring stable patients
- Outreach support for home dialysis, possibly under remote direction from a Level 5 or Level 6 dialysis facility
- May accommodate self-care dialysis inpatients within the facility

Katanning Hospital meets the *Clinical Services Framework* role delineation for renal dialysis services. Patients requiring renal dialysis services are referred to Albany or metropolitan services.

Renal dialysis in the Great Southern Health Region is an area of growth due to the ageing population, the increased use of hypertension medication, the increase prevalence of diabetes and the higher proportion of Aboriginal people who utilise renal dialysis services. The endorsed *WACHS Renal Dialysis Plan (2010)* identified the need to increase the self-sufficiency of renal services in the Great Southern, however there are no plans to provide additional services in the district in the future. Albany will continue to provide a six-chair renal satellite outreach service with the capacity to increase the number of sessions completed per day.

Oncology

Katanning CSF role delineation – Level 2

Level 2 oncology services should provide:

- Specialist registered nurse in region (Cancer Nurse Coordinator/Breast Care Nurse) who links with relevant tumour specific Cancer Nurse Coordinator and treating facility for care coordination
- No treatment facilities

Oncology services at Katanning Hospital meet the role delineation above. In line with the *Clinical Services Framework* there are no designated chemotherapy chairs/places at Katanning Hospital. Low level chemotherapy is sometimes given in accordance with chemotherapy guidelines. However, patients from the Central Great Southern who require oncology services are transferred to Albany or metropolitan facilities for care.

The outflows from Central Great Southern residents in 2009/10 for chemotherapy services are outlined in the next table.

Table 28: Central Great Southern residents: Chemotherapy separations (2009/10)

Category	Place of treatment (2009/10)			Total
	Country WA	Metro Public	Private	
Number of separations	79	98	42	219

Source: Hospital Morbidity Data System via Clinical activity modelling

Under the WA Health *Clinical Services Framework*, the role delineation for medical oncology services at Katanning Hospital will remain at level two. Demand projections for Great Southern residents requiring public chemotherapy services are provided below. Patients will continue to be transferred from the district for care. A Cancer Centre is being established at Albany Health Campus from Commonwealth funding. Albany will have a six chair, one bed chemotherapy unit and a six double/twin bedroom hostel by 2013/14.

Table 29: Central Great Southern residents: Projected public demand for chemotherapy (2012/13 – 2021/22)

Place of treatment	2012/13	2016/17	2021/22
Treated in Country WA	167	213	271
Treated in Metro	47	41	47
Total	**213**	**254**	**318**

Source (projections): Inpatient 2011 Modelling– based on ABS Series B+
NOTE: Excludes private patients in private hospitals.

Activity summary

Current and projected activity

- The activity for inpatient medical services in Katanning is outlined in the next table. The data excludes activity that is categorised as paediatrics, mental health, obstetrics and palliative care, as these service areas are presented in subsequent sections.
- There has been a 20% increase in adult medical service activity at Katanning Hospital between 2007/08 and 2009/10, which has been due to increases in both multi-day and same-day activity.
- Adult medical activity within the Kojonup and Gnowangerup hospitals has remained relatively stable over the same period.
- Adult medical activity is projected to increase by 36% at Katanning between 2009/10 and 2021/22. This includes a 93% increase in same-day services from 204 in 09/0 up to 394 same day separations by 21/22.

Table 30: Central Great Southern hospitals: Adult medical services activity (2007/08 – 2021/22)

Hospital	Historical			Projected		
	2007/08	2008/09	2009/10	2012/13	2016/17	2021/22
Katanning Hospital						
Same-day	166	194	204	241	312	394
Multi-day	526	585	623	639	685	727
Total	**692**	**779**	**827**	**880**	**997**	**1,121**
Other Central Great Southern hospitals						
Same-day	30	19	36	42	50	66
Multi-day	131	151	131	138	153	172
Total	**161**	**170**	**167**	**180**	**203**	**238**

Excludes boarders, unqualified neonates and residents. Also excludes Nursing Home Type patients with bed-days greater than 180 at separation.
Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling – based on ABS Series B+

Recommendations for adult medical services are described at the end of this chapter.

6.3.2 Surgical Services (Adult - 15 year olds and over)

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 adult surgical services should provide:

- Surgery by GPs, general surgeons and visiting sub-specialists
- Broad range of day and general surgery and some specialty surgery
- Emergency surgery
- Theatre trained nurses
- More than two theatres
- Access to designated allied health services
- Some allied health undergraduate education
- 24 hour cover by a Registered Nurse
- Outpatient care.

Katanning only partially meets the role delineation above. The hospital provides a limited range of day and general surgery, including some specialist surgery. The following surgical services are provided from Katanning:

- General surgery, including endoscopy
- Gynaecology
- Ophthalmology
- Orthopaedics
- Dental
- Anaesthetics provided by GP anaesthetists

Katanning is the only hospital in the Central Great Southern that provides elective surgical services. Because there is no general surgeon in Katanning, emergency surgery is available for obstetrics only. There is a need to contract more permanent and visiting surgical specialists and allied health staff to increase access to services available in the district and reduce the number of patient and consumer transfers for care.

Katanning has only one functioning operating theatre. A second theatre has been decommissioned for some time due to inadequate facilities and staffing limitations. The second theatre is currently used as a resuscitation room and could not be recommissioned without major refurbishment. There are no dedicated same-day beds. Same-day patients are managed within the general ward.

GPs also provide obstetric, “lumps and bumps” procedures and anaesthetic services.

Activity summary

Current and projected activity

- The multi-day and same-day surgical activity for adults (aged 15 years and over) at Katanning is outlined in the table below.
- Surgical activity has increased by 28% (31 separations) between 2007/08 and 2009/10, while procedural activity has decreased.
- Separations for adult surgical and procedural activity at Katanning are anticipated to increase by 54% between 2011/12 and 2021/21. Procedural activity is anticipated to more than double current activity.

Table 31: Central Great Southern hospitals: Adult surgical and procedural* services (2007/08 – 2021/22)

Hospital	Historical			Projected		
	2007/08	2008/09	2009/10	2011/12	2016/17	2021/22
Katanning Hospital						
Same-day surgical	68	95	75	82	100	109
Multi-day surgical	39	67	63	38	39	40
Total surgical	**107**	**162**	**138**	**119**	**139**	**149**
Same-day procedural	117	139	98	146	182	221
Multi-day procedural	6	10	5	<5	<5	<5
Total procedural	**123**	**149**	**103**	**146**	**182**	**221**
Other Central Great Southern hospitals						
Total surgical/procedural	<5	<5	<5	<5	<5	<5

** Procedural includes scopes and dental extractions and restorations*
Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling– based on ABS Series B+

Recommendations for adult surgical services are described at the end of this chapter.

6.3.3 Maternity Services

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 maternity services should provide:

- Elective and emergency caesarean capability
- 24 hour anaesthetic service
- Visiting obstetrician
- Access to some allied health services
- Service by GPs/GP obstetricians/district medical officers and midwives
- Access to 24 hour telephone support from obstetricians
- Access to e-health or telehealth
- Onsite level 1 neonatal facilities

Katanning Hospital is currently not able to meet this role delineation consistently.

Obstetric services, including emergency and elective caesarean section, could be provided by a GP obstetrician, however as of July 2012, this service is temporarily suspended. Currently specialist advice is provided by telephone contact with the regional obstetrician in Albany, or by phoning King Edward Memorial Hospital. A monthly visiting consultant obstetric/gynaecologist service commenced in 2012.

Obstetric services have been fragile for sometime, with staffing shortages impacting on the availability of sufficient numbers of GP obstetricians, anaesthetists, midwives and theatre staff to maintain the level three service. These shortages sometimes limit the hospital's ability to provide the full range of obstetric services. The hospital is not able to provide epidural anaesthesia.

As of July 2012, birthing services have been temporarily suspended mainly due to a lack of GP obstetricians to provide a safe and sustainable service. Arrangements have been made for women to deliver at alternative sites. The health service has focused on developing comprehensive antenatal and postnatal models of care.

Katanning Hospital is the only hospital within the Central Great Southern with the potential capacity to provide obstetric services including emergency caesareans. The hospital has a modern dedicated three-bed maternity ward. When obstetric services are operational, the hospital accepts low risk deliveries only. All planned medium and high risk deliveries are transferred to Albany or Perth metropolitan hospitals.

Activity summary

Current and projected activity

- Obstetric activity at Katanning Hospital increased by 25% between 2007/08 and 2009/10. This includes an 11% increase in deliveries and 51% increase in ante-natal and post-natal services.
- Regardless of the current cessation in service delivery, activity projections forecast that the number of deliveries at Katanning Hospital will remain relatively stable between 2012/13 and 2021/22. Ante-natal and post-natal separations will remain stable at 70 separations per year.

Table 32: Central Great Southern hospitals: Actual and projected maternity services at (2007/08 – 2021/22)

Hospital	Actual activity			Projected activity		
	2007/08	2008/09	2009/10	2012/13	2016/17	2021/22
Katanning Hospital						
Deliveries	102	109	113	114	126	128
Ante-natal/Post-natal	53	55	80	73	77	70
Total	**155**	**164**	**193**	**187**	**203**	**198**
Other Central Great Southern hospitals						
Other	<5	<5	<5	<5	<5	<5

Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling– based on ABS Series B+

Maternity patient flows

- The majority of Central Great Southern residents deliver in Katanning Hospital (74% of public activity).
- Of the 277 obstetric separations involving Central Great Southern residents in 2009/10, only 13% were from private facilities.
- All high risk deliveries are transferred to Perth metropolitan hospitals.

Table 33: Central Great Southern residents: Obstetric patient flow (2009/10)

Region	Treating hospital	Total resident separations (2009/10)	% of total public & private separations	% of total public separations
Central Great Southern	Katanning	179	65%	74%
Lower Great Southern	Albany	19	7%	8%
Other Country WA Regions	All	7	2%	3%
Sub-total (Country WA)		**205**	**74%**	**85%**
South Metropolitan Health Service	All	<5	n/a	n/a
North Metropolitan Health Service	All	31	11%	13%
Child and Adolescent Health Service	All	<5	n/a	n/a
Sub-total (Metropolitan area)		**36**	**13%**	**14%**
Total Public*		**241**	**87%**	**100%**
Private	All	36	13%	
Total (Private and Public)		**277**	**100.0%**	

**Includes public patients in private hospitals.*
Source: Hospital Morbidity Data System via Clinical activity modelling

Recommendations for obstetric services are described at the end of this chapter.

6.3.4 Paediatric services

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 paediatric services should provide:

- Designated paediatric ward, including short stay
- Inpatient medical care by GP or paediatrician
- On-call paediatric advice
- Outpatient care by visiting paediatrician
- Limited surgery by visiting paediatric surgeon or surgeon with paediatric skills
- Day surgery, uncomplicated elective surgery and emergency surgery
- Access to some allied health services

Katanning Hospital only partially meets the role delineation above. There are nominated paediatric beds in the general ward area which are used for paediatric medical and surgical patients, but these beds do not have designated paediatric-qualified staffing, and paediatric patients are managed within the hospital's overall bed numbers and staffing/skill mix. Medical care is provided by GPs and specialist advice is accessed by telephone from Princess Margaret Hospital.

The hospital does not have a visiting paediatrician or paediatric surgeon, although the dental surgeon and general surgeon do operate on older children. The hospital is unable to provide general anaesthesia to children under four years of age, as anaesthetics are provided by GP anaesthetists rather than specialist anaesthetists.

The hospital does not have emergency surgery capability for paediatrics.

Katanning, Kojonup and Gnowangerup EDs assess and treat minor paediatric health issues. Paediatric patients with more complex needs are transferred to Albany or Perth depending on their health care needs

Activity summary

Current and projected activity

- Paediatric inpatient activity (patients aged 0 – 14 years) across Katanning Hospital has remained relatively steady in recent years, as outlined in the next table.
- Paediatric separations are anticipated to reduce slightly from 2009/10 to 2021/22.
- The majority of current and projected paediatric activity at Katanning is for medical services. There is very little paediatric surgical and procedural activity now and in the future.

Table 34: Central Great Southern hospitals: Paediatric activity, 0-14 years (2007/08-2009/10)

Hospital	Actual separations			Projected separations		
	2007/08	2008/09	2009/10	2012/13	2016/17	2021/22
Katanning Hospital						
Medical	191	230	216	192	198	197
Surgical	35	25	23	22	24	26
Procedural	16	17	21	18	18	17
Total	**242**	**272**	**260**	**232**	**240**	**240**
Other central Great Southern hospitals						
All	33	22	15	14	14	14

Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling – based on ABS Series B+

Paediatric patient flows

- As shown in Table 35, 64% of the public paediatric activity of Central Great Southern residents is seen in the district, with only 25% seen within the metropolitan area. Approximately 14% of paediatric patients were treated in private facilities.

Table 35: Central Great Southern residents: Paediatric inpatient separations, 0-14 years (2009/10)

Region	Treating Hospital	Total resident separations (2009/10)	% of total public & private separations	% of total public separations
Central Great Southern	Katanning	244	52%	60%
	Gnowangerup	9	2%	2%
	Kojonup	5	1%	1%
Sub-total (Central Great Southern)		**258**	**54%**	**64%**
Lower Central Great Southern	All	39	8%	10%
Other Country WA Regions	All	11	2%	3%
Total (Country WA)		**308**	**65%**	**76%**
South Metropolitan Health Service	All	17	4%	4%
North Metropolitan Health Service	All	21	4%	5%
Child & Adolescent Health Service	All	59	12%	15%
Sub-total (Metropolitan area)		**97**	**20%**	**24%**
Total Public*		**405**	**86%**	**100%**
Private	All	68	14%	
Total (Private and Public)		473	100%	

*Includes public patients in private hospitals. Excludes unqualified neonates, boarders and obstetrics.
Source: Hospital Morbidity Data System via Clinical activity modelling

6.3.5 Adult mental health services, including alcohol and other drug services (15 years and over)

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 hospital-based (emergency and inpatient) adult and older adult mental health services should provide:

- Emergency assessment capacity
- Capacity for non-authorised mental health treatment only
- Admission and management by GP or other medical officers
- Capacity to cope with acutely unwell pending transfer

Level 3 services are not expected to provide specialist mental health professionals on site and only expected to provide:

- Limited assessment and treatment for severe and persistent mental health conditions
- Limited access to mental health multidisciplinary team

Child and adolescent emergency mental health services are also currently role delineated as a level three service, however the role delineation for child and adolescent inpatient mental health services is nil.

Mental health services at Katanning Hospital are currently meeting the role delineation of the *Clinical Services Framework*. The Mental Health Service of the Central Great Southern is managed by the Great Southern Region. A small team of mental health clinicians based in Katanning (2.8 FTE) provide community mental health triaging, hospital liaison, community treatment services and road transfers across the age spectrum.

The general wards at Katanning are used to manage mental health patients, although these are not purpose built to maximise patient and staff safety. A safe ward with good observation, dual egress and modification to reduce ligature points and reduce risk of patients leaving against medical advice would be required in the future to better manage patients awaiting transfer or requiring a short admission

Visiting services to Katanning include psychiatry services for adults and older adults; and specialist mental health services for children, adolescents, adults and older adults. These services support the clinical team within Katanning. Palmerston Association visits regularly to support mental health services in the case management of alcohol and other drug issues.

Highly acute patients are stabilised in district hospitals and transferred to Albany, Bunbury or Perth mental health facilities with the capacity for authorised admissions.

Activity summary

Current and projected activity

- Adult inpatient mental health activity has increased by 7% at Katanning Hospital between 2007/08 and 2009/10, driven by an increase in acute psychiatry activity. This includes schizophrenia, major affective disorders and other psychiatry (including anxiety disorders, eating & obsessive compulsive disorders).
- Adult mental health inpatient activity at Katanning Hospital is projected to increase by 16% between 2012/13 and 2021/22.
- There were very few paediatric mental health separations as district hospitals do not have the capacity to treat paediatric mental health patients (<5 at Katanning Hospital in 2009/10).

Table 36: Central Great Southern hospitals: Actual and projected adult mental health inpatient activity, 15 years and over (2007/08- 2009/10)

Hospital	Actual separations			Projected separations		
	2007/08	2008/09	2009/10	2012/13	2016/17	2021/22
Katanning Hospital						
Acute Psychiatry	68	82	78	76	86	85
Drug & Alcohol	67	66	66	69	76	82
Total	**135**	**148**	**144**	**145**	**162**	**167**
Other Central Great Southern hospitals						
Acute Psychiatry	15	10	12	12	12	13
Drug & Alcohol	5	<5	6	7	7	8
Total	**20**	**10**	**18**	**19**	**19**	**21**

Data includes acute mental health and drug and alcohol ESRGs.
Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling – based on ABS Series B+

Mental health patient flows

- In 2009/10 there were 253 adult mental health separations at all public and private WA health facilities involving Central Great Southern residents.
- Six in ten (150) of these residents received their public mental health care from a Central Great Southern hospital, giving the district's public adult mental health services a self-sufficiency of 63%. The majority of these patients (133) received their care at Katanning Hospital.
- Fourteen percent (14%) were transferred to Perth facilities and 6% were treated in private facilities.
- The number of bed-days suggests the average length of stay for adult mental health services at:
  - Katanning Hospital was 2.7 days
  - Albany Health Campus was 8.1 days
  - South Metropolitan Health Service facilities was 9.9 days
  - North Metropolitan Health Service facilities was 14.2 days
  - Private facilities was 9.5 days

- High bed-day counts in Albany and metropolitan facilities are indicative of authorised facilities, which accept involuntary admissions and are more likely to treat chronic mental health conditions.

Table 37: Central Great Southern hospitals: Adult mental health patient flow, 15 years and over (2009/10)

Region	Treating Hospital	Total Residents Separations	Bed-days	% of Total Public & Private Separations	% of Total Public Separations
Central Great Southern	Katanning	133	356	53%	56%
	Gnowangerup	8	30	3%	3.%
	Kojonup	9	33	4%	4%
Sub-total (Central Great Southern)		**150**	**419**	**59%**	**63%**
Lower Great Southern	Albany	46	371	18%	19%
Other Country WA Regions	All	10	51	4%	4%
Sub-total (Country WA)		**206**	**841**	**81%**	**86%**
South Metropolitan Health Service	All	10	99	4%	4%
North Metropolitan Health Service	All	23	327	9%	10%
Sub-total (metro)		**33**	**426**	**13%**	**14%**
Total Public*		**239**	**1,267**	**94%**	**100%**
Private	Metro	14	134	6%	
Total (Private and Public)		253	1,401	100%	

Includes acute mental health and drug and alcohol ESRGs.
**Includes public patients in private hospitals.*
Source: Hospital Morbidity Data System via Clinical activity modelling

Recommendations for mental health services are described at the end of this chapter.

6.3.6 Palliative care

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 palliative care services should provide:

- Inpatient care by accredited GP
- 24 hour cover clinical nurse with experience in palliative care services
- Outpatient care by visiting general physician and possible palliative care specialist by telehealth
- Access to some allied health services
- Consult liaison services for inpatients

Katanning Hospital partially meets this role delineation. GPs providing inpatient care are not specifically accredited in Palliative Care. They are able to access telephone support from the regional palliative care physician in Albany, but there is no regular visiting or telehealth outpatient palliative care service.

Only two nurses have palliative care qualification and experience, and these nurses are not available 24/7. Nursing staff have access to specialist advice by telephone from the regional palliative care nursing coordinator in Albany and the Cancer Foundation.

Katanning Hospital has a Palliative Care Suite attached to the residential aged care unit. The Extended Care Team provides home support to palliative care patients.

Activity summary

Current and projected activity

- The palliative care separations varied at all sites between 2007/08 and 2009/10, and are projected to remain steady in the future. Projections are based on actual 2009/10 historical data.

Table 38: Recent and projected palliative care activity at Katanning & Other Central Great Southern Hospitals, 15 years + (2007/08 – 2021/22)

Hospital	Actual separations			Projected separations		
	2007/08	**2008/09**	**2009/10**	**2012/13**	**2016/17**	**2021/22**
Katanning Hospital	10	17	6	6	6	6
Kojonup and Gnowangerup	<5	6	13	13	15	17

Source (historic): Hospital Morbidity Data System via Clinical activity modelling
Source (projections): WACHS Inpatient 2011 Modelling– based on ABS Series B+

Recommendations for palliative care services are described at the end of this chapter.

6.3.7 Sub-acute and rehabilitation services

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3/4

Level 3/4 rehabilitation services should provide:

- Regular visiting services provided by district/regional allied health staff
- Full time salaried physiotherapy, occupational therapy
- Speech and social work services
- Region referral role
- Limited day hospital program
- Rehab program for both inpatient and outpatient
- Links between regions and designated metropolitan hospitals
- Rehab Specialist service with experienced RN/PT/OT/SP/Dietitian

Katanning Hospital partially meets the role delineation above and there is currently limited capacity to provide sub-acute care. Sub-acute care is defined as interdisciplinary care in which the need for *care is driven primarily by the patient's functional status* and quality of life rather than the underlying medical diagnosis. It may include care for patients who have multiple diagnoses, none of which is a principal diagnosis. One of the planned deliverables outlined in the WACHS Operational Plan is to implement the *COAG Sub-acute Care National Partnership Agreement*.

The hospital has a range of on-site allied health staff, but they are not solely involved in provision of sub-acute care, and have to balance this work with acute and community/outpatient workload. There is no formal rehabilitation program for inpatients or outpatients. Complex patients are managed through a fairly effective multi-disciplinary team, but there are no dedicated staffing resources or facilities for sub-acute care.

There is no rehabilitation specialist service. There is no formalised regional referral pathway to or from Katanning Hospital. Patients returning to Katanning are assessed on a case by case basis. The hospital's ability to accept the patient is subject to the type and level of support required, and the resources currently available.

A 15-bed sub-acute unit will be established at Albany as part of the redevelopment of the Albany Health Campus.

Activity summary

- The Country Health Services Central Office Planning Team has undertaken sub-acute modelling using the 2009 projected inpatient activity within select ESRGs, including rehabilitation and neurology. This modelling considers multi-day separations of patients 15 years and over and considers how many sub-acute beds would be required by the projected activity of Katanning Hospital as well as transferring 25% of sub-acute activity from smaller hospitals, Gnowangerup and Kojonup.

- Based on an 80% bed occupancy an estimated three sub-acute beds would be required in Katanning Hospital by 2016/17. This assumes no NHT patients are transferred into sub-acute care.

Recommendations for service reform – Inpatient Services
• Review all models of care across the Great Southern to align service delivery with the new and expanded services available at the future redeveloped Albany Health Campus.
• Under the *Clinical Services Framework,* the role delineation at Katanning Hospital for: o Geriatric medical services will increase from level two to level three by 2014/15. o All other medical services (e.g. obstetrics, paediatrics) will remain at level three to 2020/21. o Surgical services will remain at a level three to 2020/21. o Renal services will remain as a level two service. o Oncology services to remain as a level two service. o The service description for each level is outlined in detail in the framework.
• Support the development of renal services in the Great Southern including Albany Hospital by implementing workforce development and service integration strategies as per the *WACHS Renal Dialysis Plan, 2010*.
• As a priority introduce visiting general medical services to the District.
• Develop a plan to provide greater access to medical specialties (i.e. priorities include obstetrics, ophthalmology, cardiology, pain management, psychiatry, rheumatology, urology and gerontology) and surgical specialties (i.e. priorities include general surgery and orthopaedics).
• Complementary to medical services, explore the role of the nurse practitioner in providing services for pain management, mental health, urology and gerontology.
• Increase access to GP proceduralists with obstetric and anaesthetic skills.
• Sustain level three maternity services at Katanning by maintaining a 24/7 GP obstetric & anaesthetic, nursing midwifery and theatre workforce.
• Introduce better facilities and models of care for the management of patients with behavioural issues (e.g. mental health, alcohol and other drugs).
• Explore the feasibility of utilising the existing Palliative Suite as a “Sub-Acute” living skills room to assist patients to transition from hospital type care in Perth, Albany and Katanning to self-care in the home.

6.4 Residential aged care

Current service profile

Katanning, Kojonup and Gnowangerup hospitals are all regarded as MPS sites providing high care beds for residential aged care. Low care beds are provided by Bethshan Lodge in Katanning and Spring Haven Lodge in Kojonup.

There are currently 19 residential aged high care beds provided at Katanning Hospital with no plan for additional residential aged care capacity in the future. The following residential aged care beds are provided in the Central Great Southern.

Table 39: Central Great Southern District: Residential Aged Care Facilities

Residential care facility	Location	High care beds	Low care beds	Respite beds	Total beds
Katanning MPS	Katanning	18	-	1	19
Gnowangerup MPS	Gnowangerup	8	-	-	8
Kojonup MPS	Kojonup	6	-	-	6
Bethshan Lodge (private)	Katanning	-	26	-	26
Spring Haven Lodge	Kojonup		22	1	23
Total beds		**34**	**48**	**1**	**83**

Source: http://www.agedcareguide.com.au/ *and WACHS online bed pivot*

Spring Haven is an aged care residential unit owned and operated by the Shire of Kojonup. The Lodge is located directly adjacent to Kojonup Hospital. Bethshan Lodge is located off the Katanning Health Campus.

Activity summary

- Activity recorded in 2009/10 relating to residential care activity at Central Great Southern hospitals is outlined in the next table.
- The occupancy rate at SCHS residential aged care facilities is high (at least 95%).
- Commonwealth aged care planning benchmarks for high and low care residential aged care places, applied to forecast populations (refer section 4.1), provide an indicator of demand. The current benchmarks are for the provision of 44 high beds and 44 low care beds for every 1,000 people, non-Aboriginal aged 70 years and over, and Aboriginal aged 50 years and over.
- There are currently no Aboriginal projections available for the Central Great Southern district. Based on the 2021 projected population of all Central Great Southern residents aged 70 years and over (1,593 persons) there will be a need for 140 residential care beds (70 high and 70 low). However, the trend is for people to be cared for in their own home with support via HACC and community aged care packages rather than enter low care facilities. Where sites are part of an MPS the "cashed out" funding for residential care places can be used based on the community needs and transferred into such community care packages.

Table 40: Central Great Southern hospitals: Residential aged care activity (2009/10)

Facility	Bed-days	No. of residential care beds	Occupancy Rate
Katanning	6,610	19	95%
Gnowangerup	3,159	8	99%
Kojonup	2,180	6	97%

Source: WACHS online Bed Numbers pivot, extracted January 2012.

Recommendations for service reform - Residential Aged Care Services
• Services and facilities to plan for high care residents with higher acuity throughout Central Great Southern District.
• Review the need and location for more frail and dementia aged care beds in the Central Great Southern to address current demand.
• As per Stream 6 of SIHI, explore opportunities for private providers to establish and manage aged care beds in the region.
• Introduce a nurse practitioner role to aged care services (e.g. wound management, urology, gerontology).

6.5 Clinical support services

The following section details the clinical support services available in the Central Great Southern District. Outreach services from Albany are also delivered in the Central Great Southern on occasions. For example patient safety and quality, clinical training and development and infection control.

6.5.1 Medical imaging

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3/4

Level 3 medical imaging services should provide:

- Mobile service and limited to x-ray of extremities, chest, abdomen
- Interpreted by onsite doctor/health professional or by electronic means
- On site designated room
- Radiographer in attendance who has regular access to radiological consultation
- Simple ultrasound capacity for foetal monitoring
- Tele-radiology facility available

Level 4 medical imaging services should provide

- Facilities for general and fluoroscopy, in addition to mobile CD for wards, operating theatres and ED
- Auto film processing capacity
- Mobile image intensifier in operating theatre
- Staff radiographer on-call 24 hours
- Visiting specialist radiological appointment
- Always has ultrasound
- May have CT scanner
- Registered nurse as required
- Tele-radiology facility available

Medical imaging services at Katanning currently do not meet the level three role delineation. Due to high plain X-ray demand, provision of ultrasound services in addition to X-ray is not possible within the current authorised 1.0 FTE. A proposal to relocate vacant ultrasonographer FTE from Albany to Katanning is currently under consideration.

Digital x-rays are provided at Katanning Hospital. Gnowangerup x-ray service has been decommissioned and as of July 2012, Kojonup medical imaging services are being re-aligned to Katanning. The medical imaging services available in the district

are supported by nurse operators and on-call radiologists. Katanning Hospital is also on the PACS network enabling sharing of medical imaging records with other sites on the network. Reporting is conducted off-site. Patients and consumers requiring a CT scan are referred to Narrogin or Albany.

6.5.2 Pathology

Current service profile

Katanning's Clinical Services Framework role delineation – Level 3

Level 3 pathology services should provide:

- Specimen collection by a registered nurse or GP
- Specimens transmittal to referral laboratory
- Specimen collection by pathology staff
- Able to perform a defined range urgent tests

PathWest are contracted to provide all pathology services for SCHS. Current services align with the role delineation above.

Katanning is the hub for pathology services in the Central Great Southern providing specimen collection (one room) and laboratory services at Katanning Hospital. Pathwest personnel are based only at Katanning Hospital, basic specimen collections are collected by nursing staff in Kojonup, Gnowangerup and Tambellup with visiting GP also collecting specimens at Tambellup. Pathwest provides a regular "courier" services to collect specimens from these sites. Consumers and patients from the Central Great Southern requiring more complex tests are referred to Katanning, Narrogin, Albany or Perth Pathwest facilities.

Katanning Hospital has limited processing on-site and therefore works with Albany and Narrogin to provide routine and urgent diagnostic services in haematology, transfusion medicine, biochemistry and microbiology, and refer more complex tests to the central PathWest laboratories in Perth. PathWest also process workplace drug testing.

Point of care testing (iSTAT) is conducted by nurses and medical staff at Katanning for a limited range of tests including electrolytes, blood glucose, drug use and cardiac markers. The technology is currently unavailable at Kojonup and Gnowangerup hospitals; however they are able to do basic cardiac enzymes for initial assessment of chest pain.

6.5.3 Pharmacy

Current service profile

Katanning's Clinical Services Framework role delineation – Level 2

Level 2 pharmacy services should provide:

- Service oversight by pharmacist located elsewhere
- Drugs supplied on individual prescription from community pharmacy
- Visiting pharmacist from regional hospital
- Minimal clinical service
- Staff education
- Drugs provided by regional hospital

Katanning Hospital aligns with the role delineations of the *Clinical Services Framework* for pharmacy services. Pharmacy services are managed via a regional model in Albany with a visiting service from a pharmacist half a day a month. There is a small pharmacy store on the general ward in Katanning with a courier service to small hospitals. Medications are supplied from Albany or sourced from community pharmacist if urgent. Community pharmacist services supply to the residential aged care unit.

6.5.4 Sterilising Services

Current service profile

The Central Sterilising Services Department (CSSD) is staffed by 0.8 FTE Advanced Skills Enrolled Nurse who has a formal CSSD qualifications (Certificate III). The nurse at Katanning Hospital and provides sterilising services for small hospitals, Tambellup Nursing Post and allied health (podiatrist and physiotherapy).

Some equipment and consumables are shared between Katanning and Albany. Supplies are transferred via well-established processes.

6.5.5 Telehealth and e-health

Current service profile

The Central Great Southern currently utilise telehealth for staff meetings; some outpatient services; staff education and to enable families to contact clients who have transferred out of the district for medical care.

The SIHI telehealth investment will provide the opportunity to standardise telehealth venues ensuring that these are clinically appropriate. This will assist with receiving additional services from specialists and other health professionals for patient assessment, follow up and care planning. Additionally it will allow telehealth service delivery to be developed within the region resulting in improved access to healthcare for health consumers.

Considerable work is being undertaken by the *Statewide Telehealth Service* to establish and deploy improved videoconferencing technologies and supporting systems in a consistent and scalable manner across WA Health Department sites.

The initial focus of telehealth will be:

- **Clinical telehealth service provision** – live, synchronous interaction between two or more locations conducted by videoconference.
- **Emergency telehealth** – enabling remote monitoring and triage of patients in the acute care setting.

These models will be developed to enable smaller regional sites to link into larger resource centres and / or metropolitan providers in order to access services and advice.

Telehealth can deliver:

- Efficient and cost effective services while improving service access, equity, safety and quality.
- Improved health outcomes through increased service access and support.
- Better education, training and support opportunities for local health care providers and consumers.
- Improved collaboration and communication between health care providers.

Recommendations for service reform – Clinical support services
• Sustain existing Medical Imaging modalities (including ultrasound services) at Katanning Health Campus.
• Through ongoing service planning, review the model for medical imaging services across the Great Southern Region to complement upgrades occurring at Albany Health Campus including the future need for CT at Katanning.
• Review the need to enhance clinical governance and capacity as extra demands are placed on clinical support services with the new models of care in primary health care and ED.
• Upgrade PathWest facilities to meet growing demands from the medical workforce and supervised drug screening from nearby mining operations. Upgrades include a larger laboratory, extra storage space, increased security and bathroom facilities for supervised drug screening.
• Review clinical needs and quality assurance requirements to determine what point of care testing should be available in small hospitals.

Recommendations for service reform – Clinical support services
• Introduce telehealth workforce and infrastructure initiatives as per SIHI (Stream 5) to support 1:1 consult, supervision, patient care and interpreter services across the district particularly for outpatient, ED, allied health and inpatient care.
• Introduce mobile ICT/Videoconferencing technology in small hospitals to have greater flexible in conducting patient assessments (where possible).
• Provide dedicated ICT technical support in Katanning and the District to coordinate and manage ICT and telehealth needs of staff and service delivery as per SIHI (Stream 5).
• Refer also to workforce development recommendations in Section 7.1.
• Refer also to recommended facility upgrades under Section 10.

6.6 Non-clinical support services

6.6.1 Hotel services

Food services

All Central Great Southern hospitals operate cook fresh kitchens that service their own patient, resident (aged care) and staff needs. All Central Great Southern hospitals provide meal on wheels services and Kojonup provides meals for their HACC day club.

Linen

Katanning has the central laundry that supplies linen to all Central Great Southern hospitals and associated aged care services.

Supplies

There is no local supply service in the district. A regional service is operated out of Albany, with hotel services staff in Katanning acting as the part-time storeperson.

Cleaning

Cleaning is an in-house service provided by SCHS employees with the responsibility to clean the hospital and residential care areas as well as staff housing and adjacent facilities including community health, Aboriginal health and mental health.

6.6.2 Engineering, Maintenance & Supply

There is an Engineering and Maintenance team based at Katanning Hospital that has responsibility for the continuity of essential and non-essential services and maintenance of buildings and equipment on all hospital sites in the district. The team also provides home care installations for patients. The team includes an electrician, plumber, three handymen and gardener and is line managed by Albany Hospital's Operations Manager and is supported by a regional service delivery model.

6.6.3 Corporate Services

The SCHS Great Southern Regional Corporate Services are coordinated from Albany. This includes the corporate governance and financial accountability structures and systems for the region.

Human resources and finance

Health Corporate Network (WA Health's shared services centre) was established more than five years ago and provides SCHS with centralised payroll services, and some employment related services. Human resource functions for the Great Southern

Region (including recruitment and selection) are coordinated on a regional level via the human resource staff based in Albany. Occupational Health and Safety is also a regional service coordinated from Albany. Whilst FTE for business support is available, district staff reported that there is currently limited FTE for human resource management in Katanning.

In addition, Health Corporate Network provides limited support to components of the finance function of SCHS. Preparation and analysis of financial and management reports, and all other finance department functions for the Great Southern region are dealt with in Albany. Senior finance department staff provide support to managers at all sites – either by visits to regional sites, or via telephone or videoconference links.

Information and communication technology

The Health Information Network (HIN) was established in 2005 as Health's shared information and communication technology (ICT) service. HIN provides SCHS with a range of ICT related services, but ICT staff remain managed through SCHS. A full range of ICT service functions and support are coordinated via SCHS Great Southern staff based in Albany. Key regional ICT equipment is monitored remotely from Albany, enabling prompt recognition and resolution of any potential or actual issues. Service planning, maintenance agreements and equipment replacement programs ensure minimal disruption to any regional ICT services.

Learning and development

Learning and development (including clinical training) is coordinated from Albany and the Central Office in Perth. All programs are designed to meet the needs of, and be delivered and applied in a standard way, across the entire Great Southern region.

6.6.4 Medical records management

Medical records are currently paper based throughout the district. Archived records are kept on site until an appropriate time when the records are moved to Albany and stored with Albany Records Management. Katanning patient records until 2012 have been archived with Iron Mountain, which is based in Perth. Local management of the acute record is by either the Business Manager or Senior Clerk with support from the Regional Health Information Manager based in Albany. Clinical coders based in Albany service the region with records being scanned at Kojonup and Gnowangerup limiting travel by the coder. Freedom of Information for Central Great Southern is coordinated by Albany.

Recommendations for service reform - Non-clinical support services
• Integrate local service reform for non-clinical support services with the redevelopment occurring at Albany Hospital (e.g. standardise equipment, processes and region wide services/specialists where possible to assist efficient operations across the Region).
• Undertake condition audits of existing site services and buildings to establish if the services's current capacity can meet reform as outlined in this service plan.
• Investigate existing reports of gaps in local administration needs (e.g. District-level FTE needed in human resource management, records management, business support and ICT support).
• Provide staff training and development in key areas of need (e.g. care of mental health patients, CSSD Certificate III, pharmaceutical education, cross-cultural training and food safety).
• Implement the ICT Strategic Plan which aims to establish electronic medical records and human resource systems.
• Review the impact that electronic medical records will have on models of care across the continuum of care.

7 OTHER SERVICE DELIVERY ENABLERS

7.1 Workforce attraction and retention

Regional and district level workforce planning to attract, retain and nurture the Great Southern workforce is the key priority for ensuring the successful implementation of this service plan. The district has an ageing workforce which is often stretched to adequately sustain service delivery. Staff report current workloads and patient needs are more complex (e.g. mental health) and there are shortages in GP services (obstetrics and anaesthetics), visiting and permanent medical and surgical specialists, allied health, health promotion and medical imaging.

Staff also reported that the complex needs of some patients and the on-call support expected of some positions is affecting the 'work life balance' of staff, placing staff at risk of 'burn-out.' These issues can have many adverse impacts on the availability, sustainability and safety of services in the district, particularly the efficiency and effectiveness of patient assessment and care.

Consultation undertaken with stakeholders expressed a need for a comprehensive review to develop and implement a workforce strategy for the Region to attract, retain and nurture visiting and permanent staff. This strategy could include:

- Succession planning to build career pathways for staff and graduates.
- Succession planning to ensure staff can work across the district and in areas that require back-filling for staff training or general staff absences.
- Enhanced orientation programs.
- Continuation of 'trans-disciplinary' types of interventions for high need groups of patients to share workloads and case management.
- Increased access to a range of professional supervision and mandatory / clinical training (e.g. face-to face and via telehealth technologies).
- Relocation of some FTE from Albany to Katanning to build up local expertise (e.g. human resource management, records management, business support and ICT support).
- More opportunities for permanency for casual staff.
- Better incentives for staff to remain in rural and remote areas rather than the metropolitan area (e.g. paid overtime and suitable modern housing for singles and families onsite and offsite).
- Short-term on-site self-contained accommodation for visiting specialists, locums and transient staff in Katanning.
- Access to mentoring.
- Partnerships with employment networks to extend the reach of recruitment efforts.
- Reduced delays in the current recruitment process.

Concurrent to this is the need to employ and nurture Aboriginal and CALD people through all levels of the health system. This would also include the development of traineeships and mentoring to increase recruitment of Aboriginal and CALD people.

Staff felt the Great Southern has the similar attraction and retention issues as the Pilbara or Goldfields. However, they felt there are no additional incentives to work in

rural areas when compared to the metropolitan area. With the commencement of the SuperTown initiative, staff suggested there may be opportunities to partner with mining companies to offer incentives or subsidise employment packages to attract health staff and specialists to rural communities.

Incentives such as providing modern housing and units for permanent and visiting staff would also assist in attracting and retaining a workforce in the district. The current housing stock is often not appropriate for couples or families or those who have pets.

More broadly, in the Central Great Southern community there is a shortage of suitable housing. Demand for larger houses for families is high. However, staff reported older people were living alone in large houses and willing to down grade to smaller units, but there were no units available to downgrade to. Therefore the large houses in the community are unavailable for families. Whilst local governments in the area are working to address this issue by providing independent living units for the elderly, a variety of staff accommodation options to enhance attraction and retention will need to be explored in the future.

Recommendations for service reform - Workforce attraction and retention
• Employ Aboriginal and CALD people in all levels of the organisation as per *Aboriginal Employment Strategy* and Department of Health's *Equity and Diversity Plan*.
• Job classifications for small hospitals to acknowledge the high level of responsibility for the leadership roles (e.g. Clincial nurse or senior registered nurse required).
• Provide staff training and development in key areas of need (e.g. care of mental health patients, central sterilising services (CSSD) Certificate III, pharmaceutical education, cross-cultural training, food safety).
• Recognise the work value of staff in rural areas (e.g. currently job classifications and overtime are the same or less than the metropolitan area).
• Introduce paid on-call services for registered nurses within emergency departments.
• Investigate adopting the Leonora incentives program whereby staff are provided with additional incentives to work in rural towns by mining companies. Incentives should be consistent across all disciplines and roles.
• Work with GROH to provide additional permanent and short-stay modern housing on and off hospital sites in the district as an incentive for staff attraction and retention.

7.2 Transport and retrieval

The need for efficient transport service options for patients and consumers is a high priority for SCHS and stakeholders. The transport and retrieval of acute patients and primary health care consumers within the Central Great Southern and to surrounding areas is undertaken by a mixture of services including St John Ambulance, Royal

Flying Doctors Service (RFDS), hospital vehicles, private vehicles and helicopter evacuations. The transfer activity is described below.

RFDS Inter-hospital patient transfers

- In 2009/10, nine in ten of the RFDS transfers were from Katanning Hospital.
- There has been a 38% increase in RFDS transfers from the Central Great Southern between 2007/08 to 2009/10.
- There is no RFDS base in Albany. Therefore all the RFDS transfers are to metropolitan facilities. In 2009/10, 36% and 30% of RFDS transfers from the Central Great Southern hospitals were to Royal Perth Hospital and Sir Charles Gairdner Hospital, respectively.

Table 41: RFDS transfers from Central Great Southern hospitals (2007/08 - 2009/10)

Hospital (transfer from)	Number of transfers		
	2007/08	2008/09	2009/10
Katanning	82	92	120
Gnowangerup	7	6	<5
Kojonup	8	10	14
Total	**97**	**108**	**134**

Table 42: RFDS transfers from Central Great Southern hospitals to other facilities (2009/10)

Hospital (transfer to)	Number of transfers
	2009/10
Fremantle Hospital	5
Royal Perth Hospital	49
Sir Charles Gairdner Hospital	41
King Edward Memorial Hospital	14
Princess Margaret Hospital	19
Other	10
Total	**138**

Data in Table 41 and Table 42 includes unqualified neonates and boarders. Excludes emergency evacuations funded by the Commonwealth.
Source: WACHS RFDS pivot, extracted 22nd August 2011.

Other inter-hospital patient transfers

- Table 43 outlines the number of inter-hospital patient transfers (non-RFDS) from the Central Great Southern via ambulance, health service owned transport or helicopter evacuation.
- In 2009/10, there were at least 171 non-RFDS transfers from Central Great Southern hospitals, with 52 of these being from Katanning Hospital.
- In 2009/10, 91% of the non-RFDS transfers from Central Great Southern hospitals were to Great Southern facilities (hospitals and nursing homes). Eighteen of the transfers were to metropolitan facilities.
- Note: there would also be ambulances associated with the RFDS transfers shown in Table 41 and 42 that are excluded from the following tables.

Table 43: Central Great Southern hospitals: Non-RFDS inter-hospital transfers (2009/10)

Hospital	Transport type	Number of transfers (2009/10)
Katanning	Ambulance	13
	Hospital Transport	<5
	Helicopter Evacuation	<5
	Other*	38
	Sub-total	**52**
Other (excludes nursing posts and aged care)	Ambulance	73
	Hospital Transport	5
	Helicopter Evacuation	0
	Other*	42
	Sub-total	**120**
Total non-RFDS transfers from Central Great Southern^		**171**

Data includes unqualified neonates and boarders. Includes transfers to acute hospitals, psychiatric hospitals and nursing homes. Excludes transfers from residential aged care facilities and nursing posts.
** Other includes private/public transport, police and other.*
^Total includes the small numbers suppressed in the table.
Source: WACHS online ED pivot and WACHS online ATS pivot, as at 22nd August 2011.
Note: Ambulances include volunteer, community or hospital owned ambulances, but exclude instances where an ambulance is used in conjunction with RFDS, other plane or helicopter.

Table 44: Central Great Southern hospitals: Destination of non-RFDS inter-hospital transfers (2009/10)

Region	Hospital (transfer to)	2009/10
Transferred from ED		
Great Southern	Katanning Hospital	64
	Albany Hospital	15
	Other Country WA Hospital	<5
Other^		8
Transferred from inpatient		
Great Southern	Katanning Hospital	10
	Albany Hospital	24
	Springhaven Frail Aged Hostel (Kojonup)	16
	Other Great Southern	5
Other Country WA		9
Metro	Other	18
Total		**171**

Data includes unqualified neonates and boarders. Includes transfers to acute hospitals, psychiatric hospitals and nursing homes. Excludes transfers from residential aged care facilities and nursing posts.
Source: WACHS online ED pivot and WACHS online ATS pivot, as at 22nd August 2011.

There are many challenges that exist with patient transportation between sites, including emergency, unplanned and non-urgent cases. At times, staff are required to escort patients during transportation which takes human resources and expertise out of the local health system for up to five or more hours. This is particularly difficult for teams that are stretched to meet demand (e.g. mental health services).

Furthermore, all St John transfers are conducted by volunteers within the community who are largely of working age with work and family commitments. In 2009/10 there were 220 transfers required from a pool of 50 volunteers who are a mix of drivers and patient attendants (not all trained in patient care). This equates on average to four transfers per week which is having a noticeable impact on volunteers.

Within the community, there is no public transport for consumers. Transport is available within particular programs. For example, transport is available for HACC eligible clients and the Patient Assisted Travel Scheme (PATS), funded by the State Government's Royalties for Regions Scheme is available. PATS provides an important role in linking specialist treatment to country residents who are required to travel more than 100 km (one way) to obtain medical specialist treatment not available locally, via telehealth or from a visiting service. There is a clerk based in Katanning who is responsible (0.5 FTE) for coordinating the PATS program locally. For more information: http://www.wacountry.health.wa.gov.au/index.php?id=487. However, despite these being available, HACC and PATS do not cover all consumers and their expenses due to eligibility criteria.

The limited public / private transport options for consumers without access to transport can mean consumers experience delays in accessing assessment and care or miss services entirely. This is particular pertinent to consumers requiring ongoing primary health care services. Often they do not engage with health services, leaving conditions undetected or unmanaged until acute or emergency care is required.

Recommendations for service reform – Transport and retrieval
• Review transport and staffing models for inpatients to access ongoing assessment and care (when their transport options are limited).
• Review transport and staffing models for the transfer of highly acute patients from ED to large regional facilities and tertiary hospitals (e.g. ensure back-fill, establish a mental health retrieval team).
• Establish transportation options for primary care consumers/patients to access specialist services outside the region.
• Develop partnerships (where possible) with other service providers/funders to establish a District transport shuttle service with dedicated drivers to enable greater access to health and human services by consumers.

7.3 Cultural security

Central Great Southern health services and facilities need to be culturally appropriate for the catchment area's Aboriginal and CALD population. This will work towards ensuring Aboriginal and CALD people receive appropriate care at the right time and in the right setting and would align with the intentions of Commonwealth and State Government policies.

Recommendations for service reform – Cultural security
• Ensure health services and facility designs are supportive of Aboriginal, multicultural and religious needs.
• Realign the existing Muslim Liaison Officer FTE to a Culturally and Linguistically Diverse (CALD) service (e.g. with access to male and female CALD advice and support).
• Identify options to treat and care for non-permanent residents in rural areas.
• Build the capacity of the local Aboriginal community to have greater community control for health services.
• Resource interpreter services to provide more patient support within the health service and community setting.
• Advocate across government action to address the social determinants of health in the community (e.g. Social infrastructure, housing, education, alcohol and other drug issues, food security)

7.4 Disaster preparedness and response

Katanning Hospital will comply as a Level 3 facility and Gnowangerup and Kojonup hospitals will comply as Level 2 facilities as per the *Redundancy and Disaster Planning in Health's Capital Works Program (January 2012)*. The guidelines are available from the Disaster Preparedness and Management Unit, Department of Health.

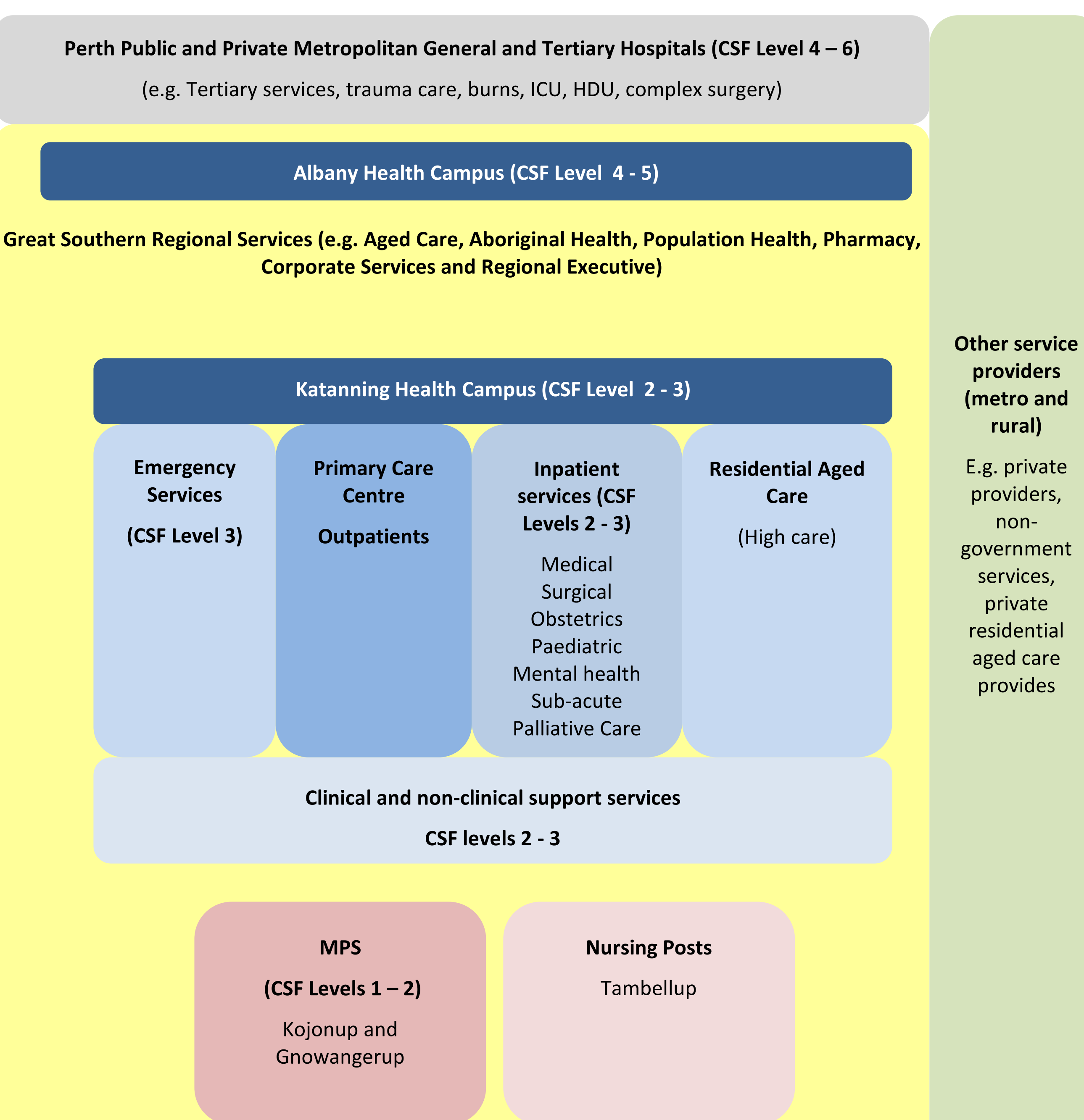
7.5 Contemporary facility design

Future redevelopment of the Central Great Southern sites should align with the *Australasian Health Facility Guidelines* (www.healthfacilityguidelines.com.au) and various building codes and guidelines of Australia to ensure the facilities are contemporary, safe and able to meet modern best practice models of care. The list of potential upgrades highlighted during service planning is detailed in Section 10.

8 PROPOSED FUNCTIONAL MODEL OF CARE

The following image provides a visual representation of the future functional external relationships for the Central Great Southern. The figure attempts to summarise the range of services available across the district and the role delineation. Patients will flow to and from any of the services listed. The levels provided are from *WA Health Clinical Services Framework* (2010a).

Figure 13: Central Great Southern: Future functional model of care



9 CONCLUSION

This service plan is the outcome of research and consultation with SCHS and their stakeholders to set the strategic directions for service delivery across the district for the next ten years.

The service plan will be invaluable to informing the Supertown initiative and the development of the *Implementation Plan* for the $565 million *Royalties for Region's Southern Inland Health Initiative (SIHI),* as well as forming the basis for other funding opportunities and business cases as they arise.

The recommendations contained within will inform the service reform and capital works initiatives designed to enhance the sustainability and self-sufficiency of the network of health services in the district over the next ten years. As such, the plan sets the baseline for the future evaluation of service reform and capital works projects. With time, one would expect the following outcomes:

- Modern and efficient models of care delivered across a continuum of care.
- Operational efficiencies gained with the collocation of services on site.
- Access to primary care improved.
- Care provided in the right setting.
- Care provided closer to home for selected services (increased self-sufficiency).
- Greater capacity to provide assessment and care with modern eHealth services.
- Engineering and site works compliant with statutory obligations and duty of care requirements.
- eHealth utilisation for staff training increased.
- Staff, patient and visitor safety improved.
- Attraction, recruitment and retention of health professionals improved.

It is essential that this service plan is reviewed as facility planning progresses, as National/State policies are introduced, as SuperTowns is progressed and as the needs of the community change.

An ongoing proactive approach to service planning will ensure that healthcare services remain responsive to the rapidly changing community, new policy developments and advances in medical care and technology.

10 RECOMMENDATIONS

The following recommendations should be undertaken over the next six to 12 months as planning progresses to Business Case development and beyond.

Service reform recommendations

- Develop an Implementation Plan to identify the key operational activity and tasks arising from the service delivery strategies outlined in this document. This will ensure all key issues arising from this service plan are considered to progress service reform and to enable full achievement of current and future *Clinical Services Framework* role delineations.
- Action service delivery recommendations as outlined throughout Section 6.0 to achieve the priorities within this service plan to ensure health services meet the needs of the catchment for the next 10 years.
- Action service delivery recommendations within this service plan that align with the funding intentions of the SIHI to ensure SIHI priorities are met, this includes:
  - Determine the investment of recurrent funding for medical, visiting specialist and emergency services (Stream 1).
  - Establish a one-stop shop by co-locating primary health care services on the Katanning Health Campus (Stream 2) by building a primary health care centre adjacent to outpatients, ED and mental health.
  - Utilise recurrent funding for primary health care services as per Stream 2.
  - Identify if Central Great Southern sites are suitable for the Stream 3: Primary Health Care Demonstration Program as informed by their historical and projected acute activity levels.
  - Conduct building condition audits of Kojonup MPS, Gnowangerup MPS and Tambellup Nursing Post to prioritise the redevelopment of facilities as per Stream 4.
  - Employ a Central Great Southern Telehealth Project Implementation Team and upgrade telehealth technology as it becomes available to the district (Stream 5).
  - Leverage partnerships with private aged care providers to establish residential aged care and respite beds (Stream 6).
- Implement the recommendations of the key Commonwealth and State Government policy, including:
  - Establish corporate and clinical governance to support the new Medicare Locals and Health Networks reform.
  - Establish electronic integrated medical records (as per the National Health Reform Agreement and WACHS ICT Strategy).
- Work with GPs and stakeholders to consolidate the future integrated model of care for emergency services and primary health care on the Katanning Health Campus to support Stream 1 and 2 of SIHI.
- Determine the workforce strategy and recurrent cost implications of new models of care.
- Determine the private and inter-governmental partnerships to be formed to enable the future models of care to be established.
- Continue the ‘community engagement’ model for service planning to ensure services are suitable, addressing the concerns of stakeholders and culturally secure for all residents.

Facility development

- Support the achievement of service reform above by redeveloping Central Great Southern District Health facilities. This includes utilising the funding allocation available from SIHI and other funding sources (as they become available) to:

  Katanning Hospital

  - Establish a dedicated primary heath care centre to co-locate primary health care services and enable consult space for outpatient services. Locate the centre in close proximity to the ED, GPs and mental health consult space.
  - Plan for a two-chair dental clinic within the new primary health care centre.
  - Provide multipurpose clinic rooms for allied health in the new primary health care centre.
  - Provide four treatment bays (including two resuscitation bays) and additional treatment consult rooms in the emergency department to meet future demand.
  - Ensure the ED resuscitation room is within the ED and not within theatre area (currently the minor theatre is being used as resuscitation room).
  - Establish a major theatre and scope room.
  - Address patient and service flow issues between and within the operating theatre, ED, CSSD and dirty utility.
  - Collocate a mental health clinic with ED with suitable community-based consult space within primary health care centre to allow better security, duress backup and more effective care coordination.
  - Include a “safe room” in the inpatient area for observation and management of mental health patients awaiting transfer (e.g. with dual egress).
  - Upgrade kitchen and laundry to improve staff safety and compliance with infection control.
  - Upgrade pathology facilities providing two collection bays, upgraded toilet facilities and a larger laboratory space to meet future demand for workplace drug testing and routine laboratory testing.
  - Katanning Hospital to comply as a Level 3 service for redundancy and disaster planning.
  - Consider needs of bariatric patients across the site.
  - Consider appropriate short term accommodation on-site (e.g. for on-call GPs, students, locums etc).

All sites

- Ensure telehealth facilities are located closer to the ward areas (e.g. mobile telehealth facilities and fixed facilities in ED, outpatient and inpatient areas. Include areas for viewing of medical imaging results where PACS is available).
- At Gnowangerup, establish a second dedicated treatment bay in ED, removing the need to use the decommissioned X-ray room as a treatment space.
- Provide multipurpose consult rooms with dual egress to accommodate visiting mental health and allied health staff. Ensure telehealth access.
- Provide capacity to lock down and secure areas at all sites.
- Ensure ICT bandwidth is upgraded to support telehealth.
- Gnowangerup and Kojonup hospitals to comply as Level 2 facilities for redundancy and disaster planning.

- Katanning Health Campus *Concept Development Master Plan* to map the space to expand and replace existing facilities to provide the capacity to meet the potential future demand in line with the aspirational intentions of *SuperTowns*.
- Any future facility planning must consider the *WACHS ICT Strategic Plan* and broader Health Information Network (HIN) requirements.

Table 45: Summary of preliminary proposed facility changes for Katanning Health Campus

The following needs are preliminary only and not a complete list of services. Future facility needs will be discussed and determined as planning continues.

Services	Current configuration	Proposed future configuration
Primary Health Care with outpatients	Primary health services split over several sites including: GP clinic in one detached building 200 meters from ED Mental health and Aboriginal health co-located in one detached building approximately 150m metres	Collocated Primary Health Care Centre with: GP / Nurse practitioner consult space 2 x chair public dental clinic Multipurpose consult space for outpatients Multipurpose consult rooms for allied health and mental health Administration and associated assessment space for population health, Aboriginal health, HACC, allied health and visiting staff Mental health services to be in close proximity to ED, with primary care consult space available in primary health
Acute Care Inpatient	30 bed capacity includes 3 maternity beds. No dedicated same day beds.	30 bed capacity to include 3 sub-acute beds.

Services	Current configuration	Proposed future configuration
Emergency Department	3 x treatment spaces (includes 1 resuscitation room currently in theatre)	4 x treatment spaces (includes 2 x resuscitation bays) Interview room with dual egress Procedure room Clinical accommodation for the mental health team
Theatres	2 x theatres (only 1 fully functional)	1 x theatre and 1 x scope room (fully functional)
Medical imaging	General X-ray room Ultrasound room	Located closer to ED.
Pathology	One collection bay Laboratory Standard toilet facilities	Two collection rooms Expanded laboratory Toilet facilities that enable supervised drug screening
Staff accommodation	Throughout community	Community-based housing to be more suitable for families On-site short stay units for visiting specialists and staff

11 GLOSSARY

Term	Meaning
Acute care	Care in which the need for treatment is driven primarily by the patient's principal medical diagnosis rather than their functional status.
Admitted patient	Is a person who has been assessed by the treating clinician as meeting at least one of the minimum criteria for admission to an inpatient area and who undergoes the hospital's formal or statistical admission process as either a same-day, overnight or multi-day patient.
Ambulatory care services	Is a broad term that generally refers to the planned services provided to patients who are able to 'walk in and walk out' on the same-day. Ambulatory care services can include primary health care services, day surgery and outpatients (e.g. wound care and management).
Authorised bed	Authorised under the *Western Australia Mental Health Act, 1996* to accept involuntary admission to a Mental Health Unit. Unauthorised facilities cannot accept involuntary admissions.
Catchment area	A catchment area refers to the geographical area that a health service will primarily provide services to. It is usually bound by one or more local statistical areas as defined by the Australian Bureau of Statistics.
Clinical support services	Includes services to support the operations of clinical services. Includes pharmacy, medical imaging, central sterilising services and pathology.
Co-located/ collocated	Co-located services are located together in the one facility. Collocated services are located adjacent to anther another or in close proximity to one another, generally in a separate buildings.
Community mental health services	Community mental health services support or treat people with mental health problems in a domiciliary setting, instead of in a psychiatric acute setting. The range of services can include outpatient care, supported housing, counselling, peer group support and other therapies in a community setting. The goal is to maintain positive mental health and wellbeing and manage and/or prevent acute mental health conditions.
Culturally secure	Services or facilities that are culturally appropriate and meet local cultural and religious needs.
Fluoroscopy	Is a type of medical imaging that shows a continuous x-ray image on a monitor, much like an x-ray movie. It is used to diagnose or treat patients by displaying the movement of a body part or of an instrument or dye (contrast agent) through the body.
Health consumer	A term utilised to refer to individuals who are likely to or are currently accessing SCHS services. Includes inpatients and clients.
Length of stay	The number of days spent in hospital by a patient for a single admission. Calculated as date of separation minus date of admission.
Model of care / service delivery model	A service delivery model is a framework that establishes how particular health care services will be delivered. The model stipulates the key features of a service such the key aim/focus of care provided; type of specialist and general services provided; the preferred strategy for patient management and flow; and the relationships required with other stakeholders to deliver care. One of the key features of the Service Plan is the future service delivery models. These form the foundation for workforce and master planning.
Multi-day patient	A patient that was admitted to, and then separated from, the hospital on different dates. Therefore, a booked same-day patient who is subsequently

Term	Meaning
	required to stay in hospital for one night or more is an overnight patient; a patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same-day patient even if the intention at admission was that they remain in hospital at least overnight.
Non-clinical support services	Includes corporate support, information and communication technology services, supply services, site maintenance, cleaning, kitchen services and laundry services. Services that are required to maintain the safety and comfort of staff, patients and visitors.
Orthopantomogram (OPG)	A special type of x-ray looking at the lower face that displays both the upper and lower teeth in a long flat line. It demonstrates the number, position and growth of all teeth including those that have not yet erupted.
Population Health Services	A combination of services that aim to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. Population health seeks to step beyond the individual-level focus of mainstream medicine and public health by addressing a broad range of factors that impact health on a population-level, such as environment, social structure, resource distribution, political factors etc.
Primary health care	Is an aspect of ambulatory health care but is generally first level health care. The term is sometimes used interchangeably with the term primary care although primary care tends to refer to the clinical care provided by GPs. Primary health care gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes: • Health promotion • Illness prevention • Clinical treatment and care of the sick • Community development • Advocacy and rehabilitation Primary health care is provided by general practitioners, practice nurses, primary/community/child health nurses, pharmacists, dentists, allied health professionals, aged care workers, support workers and many other providers across the local, state and federal government sectors, non-government organisations and the private sector.
Primary health care centre	Generally refers to a stand-alone health facility where primary health care services are provided. It would ideally be located in close proximity to emergency department and may be collocated with inpatient, outpatients, minor wound care and diagnostic services. A primary health care centre does not include day surgery services.
Role delineation	Indicates the type and level of services provided by a hospital, as outlined in the WA Health *Clinical Services Framework 2010 - 2020*.
Same-day patient	A same-day patient is a patient who is admitted and separated on the same day of inpatient admission. May be either a planned booked patient or an unplanned patient transferred from the emergency department. A patient cannot be both a same-day patient and an overnight or multi-day stay patient at the one hospital. The category of same-day is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Rather, a patients is deemed to have been a same-day patient, if in retrospect, it can be seen that the patient was admitted to, and separated from, the hospital on the same date. Therefore patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are included. Booked same-day patients who are subsequently required to stay in

Term	Meaning
	hospital for one night of more are excluded and regarded as a multi-day patient. Examples of same-day activity include renal dialysis, colonoscopy and chemotherapy.
Separation	Separation is the most commonly used measure to determine the utilisation of hospital services. A separation equates to a patient leaving a healthcare facility because of discharge, sign-out against medical advice, transfer to another facility/service or death. Separations, rather than admissions, are used because hospital data for inpatient care are based on information gathered at the time of discharge.
Service planning	Is a process of: 1. Documenting the demographics and health status of a health service's catchment area. 2. Recording the current status and projected future demands for the health service. 3. Evaluating the adequacy of the existing health service to meet the future demands. The process involves analysis of current and future population and service data and consultation with a range of internal and external stakeholders to develop the future service delivery models for the identified health campus or site. The key deliverable or outcome of service planning is a Service Plan.
Service plan	A Service Plan will outline the current and preferred future profile for services operating from an identified health campus or site. It will include the context for service delivery including the population profile, future demand, existing policies and strategies and the preferred future service delivery models.
Sub-acute care	Interdisciplinary or multidisciplinary care in which the need for care is driven primarily by the patient's functional status and quality of life rather than the underlying medical diagnosis. It may include care for patients who have multiple diagnoses, none of which can be specified as the principal diagnosis.

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APPENDIX A: DEVELOPING THE SERVICE PLAN

The following methodology was undertaken by Aurora Projects and SCHS to develop the Central Great Southern Health District Service Plan:

Project Plan (July 2011)

A Project Plan detailing the method, consultation process, timeframe, key milestones and budget for the planning process for developing the service plan was negotiated with and signed off by the former WACHS.

Literature Review (October 2011 – January 2012)

Key literature including Commonwealth, State and local policies were reviewed to provide direction for service reform as contained in Section 3.3 of this service plan.

Data Analysis (October 2011 – January 2012)

The Country Health Services Central Office's Clinical Planning Team provided the following data: Demographic data (population numbers) and Australia Bureau of Statistics Series B+ (population growth); health status activity data obtain from the WA Health and Wellbeing Survey (2009); various morbidity and mortality statistics from a variety of databases; and actual and projected health service activity from various Department of Health databases.

Consultation workshops (November 2011)

Round 1 of service planning consultation workshops were conducted with staff of the Central Great Southern hospitals to determine the District's strengths, emerging issues, areas for improving the existing model of care and opportunities to implement the intentions of SIHI. Workshops engaged representatives from emergency, acute, aged care, primary health care services and clinical and non-clinical support services. Representatives from the District Health Advisory Council were also in attendance.

Validation workshops (December 2011)

A thematic analysis was undertaken of the data collected in Round 1. Validation workshops were held with staff of Round 1 to confirm the outcomes and determine the strategic direction as detailed in this service plan. Some health partners attended these workshops.

External stakeholder consultation (from November 2012)

Consultation, via telephone and face-to-face meetings, with key external stakeholders including shires, WA Police, Fire and Emergency Services, PathWest and St John Ambulance has occurred to promote the objectives of SIHI, describe the intentions of the service plan and obtain stakeholder's views for local service reform.

Service Plan review processes (February – March 2012)

Several iterations of the draft plan were reviewed by central office, SCHS, district staff and other stakeholders to ensure accurate and realistic information and strategies are documented.