

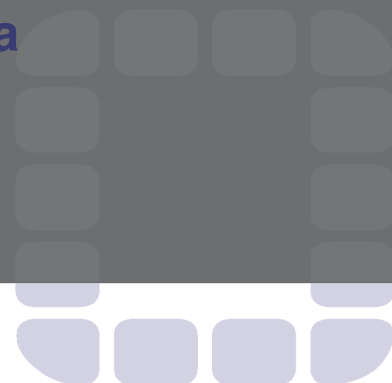
## Service Plan:

### Onslow Health Service, West Pilbara Health District

### WA Country Health Service - Pilbara

Final Version 3.0

4<sup>th</sup> May 2010



Government of **Western Australia**  
Department of **Health**  
WA Country Health Service



**ROYALTIES**  
FOR REGIONS

## Version Control

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### Corporate Details

#### Project Leader

David Naughton

#### Principal Author

Marnie Butson



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# 1. Executive Summary

The purpose of this high level Service Plan is to establish the health service delivery strategy for Onslow Health Service, part of the West Pilbara Health District within the WA Country Health Service - Pilbara Region.

## Planning Context

Onslow is located within the Shire of Ashburton, one of two shires making up the West Pilbara District. This region has experienced a mineral and energy resources boom that has triggered rapid population growth and a significant transient population due to the fly in/fly out (FIFO) workforce. Services at Onslow will need to align with regional wide directions for healthcare delivery, whilst also being responsive to the unique local issues of the area.

## Key Features of the Catchment Area influencing Delivery of Services

The proposal to develop Liquefied Natural Gas (LNG) facilities in the vicinity of Onslow, along with the recent construction of a solar salt field, indicates that the town's population is likely to undergo considerable expansion in future years. A report by Heuris Partners (March 2010), commissioned by the Pilbara Industry's Community Council, forecasts the population of Onslow to grow from approximately 600 residents at the time of the 2006 Census to more than 2,000 residents by 2015. Other projects under development that are still to be formally announced may lead to an even higher number of resident and FIFO population.

A review of the demography and epidemiology of Onslow reveals the following additional considerations in the planning for healthcare services:

- 33 percent of the Onslow population identify as being of Aboriginal or Torres Strait Islander descent but account for 60percent of admissions at Onslow hospital and 48 percent of emergency admissions. Aboriginal people in the Pilbara region have poorer health and lower life expectancy than the non Aboriginal residents.
- Onslow has a higher proportion of people aged 0-4 years and 25-54 years; and lower proportion of people aged 55 years and over when compared with WA. Based on the future industry plans for Onslow it is anticipated that the number of working aged males and young families will continue to grow at a faster rate than the elderly age groups.
- There are a significant seasonal influx of visitors between April and September.
- A new FIFO roster, currently being developed, will potentially result in two weekends per month where there will be a large volume of workers in town. It is anticipated that this will have a significant impact on health services, particularly emergency services, as well as drug and alcohol and counselling services.
- Despite the level of wealth in the community there are pockets of disadvantage whereby residents have difficulty accessing mainstream services, either due to living in remote areas, lack of transport or financial difficulties.
- There are considerable environmental health challenges in the region as a result of the extreme geographical remoteness and climatic conditions, including regular cyclones.

- Onslow is geographically isolated on the coast, 80 kilometres from the highway and a four hour drive from Karratha.
- There are no commercial flights into or out of Onslow and minimal public transport options.

### **Current Service Profile**

WACHS healthcare services available to the local community are delivered through the Onslow Hospital and Community Health Centre.

Under the WA Clinical Services Framework 2010-2020, Onslow Hospital is designated as a 'small hospital' and forms part of the WACHS Pilbara integrated network of services. Onslow is supported by the Nickol Bay Hospital (NBH) in Karratha, as the network 'hub' for hospitals in the West Pilbara and Hedland Health Campus, the regional resource centre for the Pilbara region.

There are no local resident GPs in Onslow. Medical cover for inpatients and emergency presentations are provided through telephone support from District Medical Officers (DMOs) based at NBH. In addition, fly in DMOs from NBH operate clinics three times a week.

Onslow Hospital provides a six bed inpatient service, along with a 24 hour nurse led emergency service. A review of historical activity reveals that:

- in 2009/10 approximately six to seven patients per day presented to the Onslow emergency service; and
- recent inpatient occupancy rates have been approximately 18-25 percent i.e. on average one to two of the six inpatient beds are occupied at any one time. Beds are mainly utilised for non subspecialty medical patients and the majority of patients requiring specialised acute care are transferred to NBH or elsewhere.

The Onslow Community Health Centre is located adjacent to the hospital and accommodates a community health nurse and Aboriginal health worker who provide a range of population health services for the local community. In addition, a number of ambulatory care services are provided through visiting medical specialists and allied health practitioners, many of who are based out of Karratha. A Community Mental Health Nurse visits Onslow on a fortnightly basis, driving the three and half hours from Exmouth (Midwest Region). All visiting services, including the fly in DMOs from NBH, are dependent on staffing and environmental issues, such as cyclones.

Given the forecast population growth will be driven by LNG plant workers and their families it is assumed that the resulting increase in healthcare demand will be focussed on primary healthcare and emergency services. In addition, the high proportion of Aboriginal residents in the area and identified issues around remoteness, lack of public transport and environmental conditions reflects the need to provide a continuum of care that offers a range of accessible healthcare services that are responsive to the age, ethnicity and health needs of the local community.

## **Proposed Service Reform Strategies**

The issues identified in this Service Plan, along with consultation processes that have occurred to date between WACHS Pilbara staff and the local community have informed the development of the following key service delivery strategies:

- Establish a commitment to integrate Onslow Hospital and Community Health Service into a single Onslow Health Service. Services will include the hospital; acute, aged care and emergency departments; resident GP service; facilities for all visiting service providers and community health clinics; Home and Community Care; other human services agencies and other support facilities.
- Increase and enhance access to a range of primary health services including dental care.
- Ensure culturally appropriate services are provided for the community with a particular focus on Aboriginal people's needs.
- Develop partnerships with external stakeholders to address the social determinants of health.
- Focus on ensuring workforce sustainability. Workforce modelling and a review of the future recurrent funding, as well as the introduction of innovative roles such as Nurse Practitioners, will be essential to address the future healthcare needs of the rapidly growing population.
- Address facility issues, including improved ED capacity, layout and appropriate ambulance access, development of contemporary ward areas; provision of a digitised imaging system; appropriate staff and patient accommodation and improved hospital security. Any new facility should be developed to meet a category 5 cyclone rating.
- Recognising the significant issues with the remote location of Onslow, difficulty accessing other services, the reliance on RFDS for patient evacuation, and the potential growth in demand for emergency services, the need to use Information and Communication Technology (ICT) and innovative Telehealth strategies to improve and link service providers working across large geographical distances is a critical enabler for the future Onslow Health Service. Critical is the provision of the necessary Telehealth equipment (e.g. practitioner carts), communication networks, staff training and ongoing ICT help desk and maintenance support.

## 2. Introduction & Purpose

This high-level Service Planning Report has been prepared by Aurora Projects for the WA Country Health Service – Pilbara Region. It summarises the key service planning issues for health services in the Onslow area.

The key objectives of the Service Plan are to:

- outline the planning context for the development of this document;
- provide an overview of the catchment population and their health need, including the demography and epidemiology of the catchment area and demand for services;
- describe the current status of healthcare service delivery in Onslow and the anticipated future needs of the catchment area;
- identify the key issues/shortcomings of the current service; and
- propose strategies for improving health service delivery for the local residents of Onslow and surrounding areas.



### 3. Planning Context

The mineral and energy resources boom in the West Pilbara and the anticipated growth in population have triggered the need to assess the current capacity of WACHS West Pilbara services and facilities to meet the future needs of the community.

The development of this Service Plan, for health services in Onslow, has been guided by a number of National, State and Local Government policies and service planning frameworks, as well as the overall future outlook for the Pilbara region.

#### 3.1. National and State Government Policies

National and State Government policies relevant to the *Onslow Service Plan* include:

Commonwealth Government Policy
A National Health and Hospitals Network for Australia's Future - Delivering the Reforms Council of Australian Governments (COAG) National Indigenous Reform Agreement National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
WA Health Policies
Health Activity Purchasing Intentions 2010-2011 WA Health's Clinical Services Framework, 2010 – 2020 (2009) WA Health Networks and Models of Care WA Health, Greening Health, Building and Renovations (2010) WA Health Telehealth Strategic Directions (under development)
WACHS Policies
WACHS Strategic Plan, Revitalising WA Country Health Service, 2009-2012 (2009) WACHS Operational Plan 2010/11 (2010) Primary Health Reform in Country WA 2010-2012 Aboriginal Employment Strategy 2010-2014 WACHS Mental Health Strategic Directions (2010) WACHS ICT Strategy (awaiting endorsement)

The healthcare reform policies outlined in these documents acknowledge that meeting future demand is not purely about increasing the capacity of facilities. Meeting demand is more reliant on reconfiguring service delivery to ensure patients are managed more efficiently and safely.

A summary of these policies is provided in Appendix 9.6

#### 3.2. Local service planning frameworks

The following WACHS planning frameworks provide specific reference to health services in Onslow and have been considered in developing this Service Plan:

- WACHS Pilbara Clinical Services Plan (2009); and
- WACHS Karratha Health Campus, West Pilbara Health District Service Plan (2010).

### 3.2.1 WACHS Pilbara Clinical Services Plan, March 2009

A comprehensive service planning process was undertaken for the development of this overarching strategic document, which sets out the vision and strategic approach for the development of health services in the Pilbara Region.

The document identifies key drivers for changing the delivery of health services. These include:

- The major direction for the development of services is based on a population health approach which supports services across the continuum of care with an increased focus on ambulatory care.
- Rapid population growth and an increase in local heavy industry activity is a major driver for change.
- Health data demonstrates significant growth in chronic disease (including diabetes and renal disease) and lifestyle risk behaviours including alcohol and other drug misuse, smoking and obesity.
- The proportion of the Pilbara region's population who are Aboriginal and Torres Strait Islander (ATSI) people is significant (13.5 percent) and the burden of disease incurred in the Indigenous community remains significantly higher than for the non-Indigenous community.
- Growth in demand for emergency services is expected to accelerate.
- The lack of access to primary health care services is impacting on the demand for emergency services.
- Significant health staff attraction and retention issues exist in the Pilbara.
- Poor patient transport systems and the challenges patients face to access necessary services are key health issues.

The WACHS – Pilbara CSP 2009 acknowledges that significant levels of service reform are required for the Region to continue to safely and effectively manage the current and future health needs of the population.

### 3.2.2 WACHS Karratha Health Campus, West Pilbara Health District, Service Plan, 2010.

The Karratha Health Campus, *West Pilbara Health District Service Plan* (2010) was endorsed in 2010.

This document sets out the health service delivery strategy for the Karratha Health Campus and surrounding services in the West Pilbara Health District to 2020. The Service Plan reinforces the role of the Karratha Health Campus (the site of the Nickol Bay Hospital) as the 'hub' health service for the West Pilbara region. A range of regional and district services are coordinated from Karratha to support the smaller facilities in the region including Onslow Hospital and Community Health Centre.

A number of key service delivery strategies for the West Pilbara region are identified within this document and relate to a focus on the patient across the continuum of care, Aboriginal health, non-inpatient care, demand management strategies, workforce, developing partnerships with primary care and the private sector and the essential role of information communication technology (ICT).

### 3.3. Pilbara Region – Future Outlook & Key Considerations

#### 3.3.1 Pilbara Industry's Community Council (PICC), Planning for Resources Growth in the Pilbara: revised employment & population projections to 2020, March 2010 (report prepared by Heuris Partners)

This report, commissioned by the Pilbara Industry's Community Council (PICC), was developed to provide a framework for understanding the implications of the planned growth in the resource sector for the wider Pilbara community, in particular the need for infrastructure provision.

The paper identifies that the traditional population measure for service planning (ABS recorded place of residence) does not provide a complete picture for areas such as the Pilbara, with a significant proportion of the population being fly in-fly out (FIFO). This factor, combined with the planned and real rapid expansion of heavy industry, has an impact on population and accordingly demand for infrastructure, such as hospitals. The report identifies that there will be significant increases in the Pilbara population by the year 2015, to approximately 57,000-60,000. This is a significant variance from the 2006 ABS population projections which proposed a population of 41,000 by the same year.

#### 3.3.2 State Government Royalties for Regions Scheme – Pilbara Cities initiative

The State Government has committed significant funding from the Royalties for Regions Scheme to the Pilbara Health Region. Through Royalties for Regions, the equivalent of 25 percent of the State's mining and onshore petroleum royalties will be returned to the State's regional areas each year as additional investment in projects, infrastructure and community services.

Specific to Onslow is the inclusion in the Royalties for Regions scheme of \$7million for the Onslow Sporting and Multipurpose Complex. The complex will include a full size sports gymnasium and a community emergency evacuation centre for use during extreme weather conditions such as cyclones.

##### **Pilbara Cities Initiative**

One of the key initiatives under the Royalties for Regions scheme is the **Pilbara Cities** blueprint, announced in November 2009, which aims to transform the region by creating modern higher density centres, supported by all the services and facilities enjoyed in other Australian cities.

Under the Pilbara Cities vision Karratha and Port Hedland would become major cities of the future. In addition there would be major revitalisation of Newman, Dampier, Tom Price and Onslow town centres, together with plans to create new marinas and improved waterfronts at Port Hedland, Dampier and possibly Onslow<sup>1</sup>.

The Pilbara Cities initiative also includes \$150million for a new Karratha Health Campus, as well as \$310million to partner with the Federal Government and private sector on major infrastructure projects such as power and water supply.

For additional information please refer to the Pilbara Cities website: <http://www.pilbaracities.com/>

### 3.3.3 Draft Pilbara Planning & Infrastructure Framework, February 2011

The draft Pilbara Planning and Infrastructure Framework defines a strategic direction for the future development of the Pilbara region, over the next 25 years. In summary, the Framework:

- Addresses the scale and distribution of future population growth (based on the Pilbara Industry's Community Council's projections – see Section 3.3.1) and housing development, as well as identifying strategies for economic growth, environmental issues, transport, infrastructure, water resources, tourism and the emerging impacts of climate change.
- Sets out regional planning principles, together with goals, objectives and actions to achieve these. The Framework represents an agreed 'whole of government' position on the broad future planning direction for the Pilbara, and will guide the preparation of local planning strategies.
- Informs government on infrastructure priorities, including Health infrastructure, across the Pilbara.

The draft Pilbara Planning and Infrastructure Framework is being publicly advertised for a period of 60 days, finishing on 9 May 2011. Consultation sessions will take place during this period prior to finalisation of the document in late 2011.

The document can be accessed at:

<http://www.planning.wa.gov.au/Plans+and+policies/Regional+planning/Pilbara/Pilbara+Planning+and+Infrastructure+Framework/default.aspx>

### 3.3.4 Draft Onslow Townsite Strategy

The ***Draft Onslow Townsite Strategy*** was released by the Shire of Ashburton in January 2010. The key drivers for development of this Strategy include the significant residential population expansion anticipated for Onslow as a result of the recent proposal to locate LNG facilities at the nearby Ashburton North Strategic Industrial Area (SIA) and the construction of a solar salt field, 'Onslow Salt', which will be capable of producing 2.5 million tonnes of sodium chloride per annum.

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<http://www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=132847&search=&admin=&minister=&portfolio=&region=Pilbara>

The townsite strategy seeks to balance pressure for the establishment of new living areas with the need to revitalise and restructure the existing residential precincts. The Department of State Development is currently working with LandCorp to determine that future land development needs for Onslow, in line with the planned industry expansion. This work is due for completion by June 2011.

## 4. Demographics & Epidemiology

### 4.1. Overview of the Catchment Area

#### Pilbara Region

Onslow Hospital is located within WA Country Health Service's Pilbara region. The location of Onslow in relation to other major towns in the region is presented in Figure 1.

**Figure 1: WACHS Pilbara**



Source: WACHS Website

The demand for the Pilbara region's minerals and energy resources has resulted in an economic and population boom, including a significant transient population due to the fly-in/fly out workforce. Despite the resource industry bringing a degree of wealth to the region, pockets of significant socio-economic disadvantage exist in Indigenous communities across the Pilbara.

Access to remote communities within the Pilbara region is an issue with long distances, and road and weather conditions changing seasonally. The dry, tropical climate can result in extreme temperatures both in summer and winter and the region is also subject to tropical cyclones and storms. These can produce torrential rainfall and potential health impacts relating to morbidity and trauma; the risk of post-cyclone disease outbreaks; and damage to health facilities.

#### Shire of Ashburton

The WACHS Pilbara region is divided operationally into East, West and Inland Pilbara Health Districts. Onslow is located within the Shire of Ashburton, which is one of two shires making up the West Pilbara District. Other WACHS services located within the Shire of Ashburton are located at Tom Price and Paraburdoo. The second shire comprising the West Pilbara Health District is the Shire of Roebourne, which includes the town of Karratha, the location of the Nickol Bay Hospital (NBH).

The Shire of Ashburton, at nearly half the size of Victoria (105,647 square km), boasts some of the world's largest open cut mines, largest pastoral leases and cattle stations and a thriving fishing industry. The majority of the population resides in the four towns of Onslow, Pannawonica, Paraburdoo and Tom Price. Tom Price, located in the eastern sector, is the largest town and the Shire's Administration Centre.

The Shire's 6000 residents are employed in a variety of industries including oil, gas, mining, cattle, fishing and tourism. The supporting infrastructure also provides employment and career opportunities.

### Town of Onslow

The original town of Onslow was gazetted as a townsite in 1885 and supported the nearby stations that had been established along the Ashburton River and the gold mines that had developed in the hinterland.

Today, the town is in a strategic location of interest for resource companies due to factors such as its location, deep-water access and proximity to off-shore gas reserves. A number of industry feasibility studies have identified the Onslow area in their assessments.

Onslow has a population of approximately 600, depending on the time of the year, with an influx of visitors occurring April through to September.

## 4.2. Demographics

A summary of the demographics of Ashburton Shire and the town of Onslow, as taken from the 2006 ABS Census, is provided in Table 1.

The Australian Bureau of Statistics (ABS) Census collects both the number of residents of an area and also the number of people in the area on the Census night (August). In August 2006 (peak tourist season in Onslow) there was an additional 63 percent of people in Onslow on Census night than are usually resident (934 compared with 573).

**Table 1: Summary of Demographics**

Population Characteristic	Ashburton (Shire)	Onslow (Town)	Western Australia
Estimated Resident Population (2006)	6,078	573	1.96M
Total Census Night Count (2006) – place of enumeration	8,139	934	1.99M
% Male Residents	56%	54%	50%
Median Age	31	37	37
% Unemployed	2.3%	9.8%	3.8%
% Identifying as Aboriginal/Torres Strait Islander*	9.6%	33%	3%

\* '% Unemployed' reflects the number of people unemployed and looking for work.

Source: Australian Bureau of Statistics, 2006 Census

A recent report by Heuris Partners<sup>2</sup>, commissioned by the Pilbara Industry's Community Council (March 2010) projects significant population growth in Onslow to more than 2,000 residents by 2015. The forecast growth is a result of the proposed development of LNG facilities nearby and the resulting influx of LNG plant workers and their families.

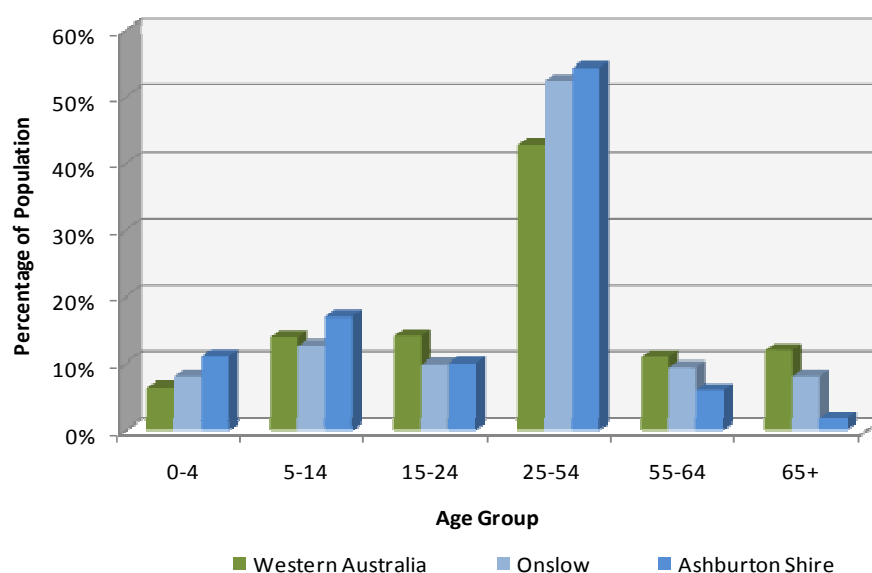
The Council of the Shire of Ashburton support 'fly- in, fly-out' (FIFO) operations where it is directly related to the construction of the respective industry. However, there is an expectation that operational staff associated with the proposed LNG precinct and Onslow Salt will be located within the Onslow townsite<sup>3</sup>.

A new FIFO roster currently being developed will potentially result in two weekends per month where there will be a large volume of workers in town. It is anticipated that this will have a significant impact on health services, particularly emergency services, as well as drug and alcohol and counselling services.

The age distribution within Onslow Town and Ashburton Shire, presented in Figure 2, shows that the areas pertinent to this Service Plan have a higher proportion of people aged 0-4 years and 25-54 years, and lower proportion of people aged 55 years and over, when compared to WA. It is acknowledged that the low proportion of residents in the older age groups may reflect the shorter life expectancy within the Aboriginal population.

Based on the future industry plans for Onslow it is anticipated that the number of young-middle aged males and young families will continue to grow at a faster rate than the elderly age groups. This feature of the catchment area highlights the need to focus services across all age groups with a particular focus on meeting the needs of adults and young families.

**Figure 2: Comparative Age Distributions, Onslow, Ashburton Shire & WA**



<sup>3</sup> Draft Onslow Townsite Strategy, January 2010, Shire of Ashburton



### 4.3. Factors Influencing Health Status

The following Section describes the current health status of the community and summarises the factors (or determinants of health) that will influence the health status of residents and visitors now and into the future. These influences include:

- Level of disadvantage experienced in the community (according to the Socio-Economic Indexes for Areas)
- Australian Early Development Index
- Level of remoteness experienced by the catchment area
- Climate
- Access to housing and transport
- Lifestyle behaviours

#### 4.3.1 SEIFA

The ABS produces the Socio-Economic Indexes for Areas (SEIFA) which measures the level of social and economic well-being of Australian geographical areas. According to the SEIFA Index of Relative Socio-Economic Disadvantage,<sup>4</sup> the shire of Ashburton, with a SEIFA score of 1023 and a State ranking of 9, reflects a higher socio-economic status when compared to WA. This would be largely influenced by the incomes of residents derived from the local mining and energy sector.

A high SEIFA score would indicate fewer households with low incomes and fewer people with no qualifications or in low skilled occupations. However, WACHS staff have indicated that despite the level of wealth in the community there are pockets of disadvantage whereby residents have limited resources and access to suitable health and human services. This includes Aboriginal communities, the elderly and those living with a disability.

The SEIFA score for Onslow is 895, significantly lower than the average for the Pilbara. The minimum score for a collection district (CD) in Onslow is 530, with the maximum being 952, reflecting the fact there are very disadvantaged communities in the catchment area pertaining to this Service Plan.

#### 4.3.2 Australian Early Development Index

The Australian Early Development Index (AEDI) is a population measure of children's development as they enter school. Based on the scores from a teacher-completed checklist, the AEDI measures five areas, or domains, of early childhood development: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills (school-based) and communication skills and general knowledge.

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<sup>4</sup> Includes the variables of low-income, low educational attainment, high unemployment, and people with low skilled occupations. The baseline for the Index of Disadvantage is 1,000. A score above 1,000 indicates an area of socio-economic advantage, and a score below 1,000 indicates an area of disadvantage. The further the deviation away from 1,000, the greater the level of advantage or disadvantage.

AEDI results are reported as average scores (0 is the lowest score; 10 is the highest score) on each of the five domains. AEDI results are also reported as proportions of children on each domain who are considered to be:

- **‘on track’**: children who score above the 25th percentile of the national AEDI population are classified as ‘on track’;
- **‘developmentally at risk’**: children who score between the 10th and 25th percentile of the national AEDI population are classified as ‘developmentally at risk’; or
- **‘developmentally vulnerable’**: children who score below the 10th percentile (in the lowest 10 per cent) of the national AEDI population are classified as ‘developmentally vulnerable’.

For Onslow, 11.1 percent of children were assessed as being developmentally vulnerable for the domain of emotional maturity, which includes the following sub-domains of pro-social and helping behavior; anxious and fearful behavior; aggressive behaviour and hyperactivity and inattention. For all other domains, zero percent of children were assessed as being developmentally vulnerable.

For further information please refer to the AEDI Community Profile – March 2011 Ashburton, WA ([www.aedi.org.au](http://www.aedi.org.au)).

### 4.3.3 Accessibility/Remoteness Index of Australia

According to the Accessibility/Remoteness Index of Australia (ARIA), the Shire of Ashburton is categorised as very remote, with very little access to goods and services and opportunities for social interaction.

The distances and approximate travel times between Perth, Karratha, Onslow, Tom Price and Paraburdoo are highlighted below.

**Table 2: Distances and Travel Times: Perth, Karratha, Onslow, Tom Price and Paraburdoo**

Approx. Travel Time					
Distance (Km)	Perth	3 hrs (RFDS)	17 hours	17 hours	18 hours
	1,538	Karratha	4 hours	5 hours	5 hours
	1,389	311	Onslow	5 hours	4.5 hours
	1,458	336	380	Tom Price	1 hour
	1518	336	360	80	Paraburdoo

Source: [www.westernaustralia.com.au](http://www.westernaustralia.com.au)

This ARIA Index and table above reinforce the level of isolation and remoteness experienced by local services and residents. Therefore, one of the underlying aims for the future will be to ensure services continue to be integrated within an efficient 'hub and spoke' model that provides adequate coverage within the resources provided. Furthermore, to meet the needs of the community, services need to be supported by modern ICT, Telehealth and other support services which enable staff and services to operate in a range of settings across the region.

#### **4.3.4 Climate**

As outlined above, the dry, tropical climate can result in extreme temperatures in both summer and winter which results in a number of presentations relating to heat stress. It is also expected that there is longer-term morbidity such as renal disease as a result of inadequate water intake and frequent dehydration associated with gastroenteritis, particularly in the Indigenous population.

In addition to the heat, the Bureau of Meteorology (2009) has estimated that the Pilbara region experiences at least one cyclone every two years which can impact on health service delivery, supply routes, and the health of the community.

It is reported by locals, that Onslow experiences a higher number of cyclones than any other town in Western Australia.

#### **4.3.5 Access to housing and transport**

A number of issues relating to transport in the region have been identified including:

- There is minimal public transport in the area. The only option is a public bus that is available from the highway (80km from town) which operates four times per week. This service is reported to be currently under threat of closure.
- Health consumers without access to vehicles are often unable to access health services. This is a pertinent issue for some Aboriginal people, young mothers, elderly and those living with a disability who are often isolated and unable to access transport readily.
- It was reported during consultations that the private rental homes in town are expensive and there is a lack of Homes West housing available.
- Overcrowding in the nearby Indigenous community of Bindi Bindi often occurs.
- There are no commercial flights in or out of Onslow and the air strip is not rated to land jet planes.

### 4.3.6 Lifestyle behaviors

The WA Health and Wellbeing Surveillance System surveys around 6,000 West Australians regularly. The System examines health and wellbeing indicators including health risk behaviours, prevalence of chronic diseases, health service utilisation and the level of psychological distress. The results of the 2007 analysis for the West Pilbara Health District are attached at Appendix 9.2. These results demonstrate that residents of the West Pilbara were less likely to access primary health care services, dental services and were more likely to access hospital-based services when compared to WA.

In addition, recent health surveys<sup>5</sup> indicate that the Pilbara non-indigenous and indigenous populations experience:

- relatively higher levels of smoking;
- relatively higher levels of obesity;
- poor dietary intake of fresh fruit and vegetables which is exacerbated in the remote indigenous populations; and
- relatively higher levels of drinking at risk for harm.

## 4.4. Health Status

Unless otherwise indicated, the following information is extracted from the Rural Health West paper Pilbara Region – The Population & Health Status (June 2009).

### 4.4.1 Mortality

For males living in the Pilbara region, the major cause of death is ischaemic heart disease. Compared to the State mortality rate, the number of male deaths due to transport related accidents and chronic obstructive pulmonary disease was greater than expected.

For females, other cancers were the leading cause of death. The number of deaths due to diabetes, transport related accidents and liver disease was greater than expected relative to the State mortality rate.

Over the period 1997 to 2006, the leading causes of mortality among Aboriginal people from the Pilbara region were cancer, ischaemic heart disease and diabetes.

From 1998 to 2007 the mortality rates for the Pilbara Aboriginal population were significantly higher for mental health conditions and alcohol-related conditions compared with the State Aboriginal population. Mortality rates for diabetes, cardiovascular disease, respiratory disease, injury and poisoning, mental health conditions, kidney disease, alcohol-related conditions and tobacco-related conditions were all higher within the Pilbara Aboriginal population compared with the non-Aboriginal population.

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<sup>5</sup> Rural Health West, June 2009. *Pilbara Region – The Population & Health Status*

Between 1997 and 2007 around two-thirds of Pilbara resident deaths under the age of 75 were classified as avoidable. Ischaemic heart disease was the leading cause of avoidable death for both Aboriginal and non-Aboriginal people, accounting for one in five of all deaths.

#### 4.4.2 Hospitalisation Rates & Potentially Preventable Hospitalisations

While 33 percent of the Onslow town populations identify as being Aboriginal (ABS 2006 Census), in recent years Aboriginal people have accounted for approximately 60 percent of hospital separations at Onslow hospital and 48 percent of emergency admissions.

From 2004 to 2008 the hospitalisation rates for the Pilbara Aboriginal population were significantly higher than the State Aboriginal population for diabetes, cardiovascular disease, respiratory disease, injury and poisonings, kidney disease, alcohol-related conditions and tobacco-related conditions. Hospitalisation rates for diabetes, cardiovascular disease, respiratory disease, injury and poisonings, kidney disease, alcohol-related conditions, tobacco-related conditions and other drug-related conditions were significantly higher within the Pilbara Aboriginal population compared with the non-Aboriginal population<sup>6</sup>.

Many hospitalisations result from conditions where hospitalisations could potentially be avoided using preventive care and early disease management<sup>7</sup>. These hospitalisations are known as Potentially Preventable Hospitalisations (PPH) and are grouped into three major categories acute, chronic and vaccine preventable.

In the West Pilbara in 2008/09 there were 611 potentially preventable hospitalisations:

- 130 (21 percent) of these related to children.
- 253 (41 percent) were Aboriginal residents.
- 18 were vaccine preventable (three percent), 321 (53 percent) were acute preventable and 277 (45 percent) were chronic preventable.

Among Pilbara residents, diabetes and its complications (including renal dialysis) was the most common potentially preventable condition (accounting for 43 percent), especially for Aboriginal residents. Dental conditions were the next most common (ten percent), followed by asthma (eight percent) and ear, nose and throat.

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<sup>6</sup> Carlose, N., Crouchley, K., Dawson, S., Draper, G., Hocking, S., Newton, B. and Somerford, P. 2009. *Pilbara Aboriginal Health Planning Forum*

<sup>7</sup> Hocking, S., Draper, G., Somerford, P., Xiao, J. and Weeramanthri, T. 2010 *The Western Australian Chief Health Officer's Report 2010*. Perth: Department of Health WA. [http://intranet.health.wa.gov.au/epidemiology/docs/Chief\\_Health\\_Officer's\\_Report.pdf](http://intranet.health.wa.gov.au/epidemiology/docs/Chief_Health_Officer's_Report.pdf)

#### 4.4.3 Chronic Disease

65 percent of Aboriginal people report at least one long term health condition and approximately 27 percent of Aboriginal children have one or more long-term health conditions. The high burden of disease is also reflected in a comparison of Aboriginal admission rates compared to the non-Aboriginal population:

- 12 times greater for renal dialysis;
- 8 times greater for diabetes;
- 5.62 times greater for cellulitis; and
- 6.64 times greater due to respiratory infections/inflammations.

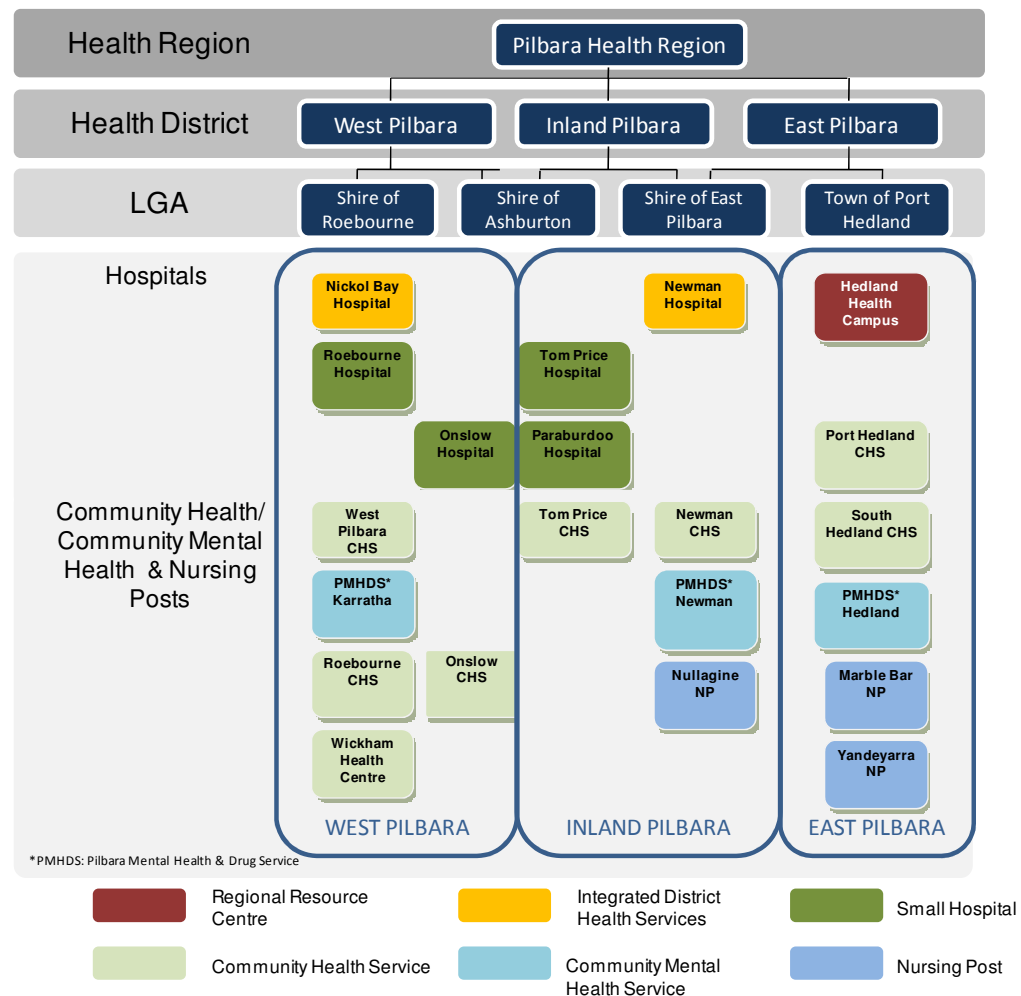
#### KEY ISSUES: DEMOGRAPHY & EPIDEMIOLOGY

- A significant expansion in population is forecast for Onslow due to the proposal to develop LNG facilities nearby and the recently constructed solar salt field. Population projections undertaken by Heuris Partners forecasts population growth in Onslow from approximately 600 residents at the time of the 2006 Census to over 2,000 residents by 2015.
- 33 percent of the population of Onslow identify as being of Aboriginal or Torres Strait Islander descent but account for 60 percent of admissions at Onslow hospital and 48 percent of emergency admissions.
- Onslow has a higher proportion of people aged 0-4 years and 25-54 years; and lower proportion of people aged 55 years and over when compared to WA. Based on the future industry plans for Onslow it is anticipated that the number of working aged males and young families will continue to grow at a faster rate than the elderly age groups.
- Onslow has a seasonal influx of visitors between April and September.
- There are environmental health challenges as a result of the extreme geographical remoteness and climatic conditions.
- Despite the level of wealth in the community there are pockets of disadvantage whereby residents have difficulty accessing mainstream services, either due to living in remote areas, lack of transport or financial difficulties.
- The level of remoteness reinforces the need for an efficient integrated 'hub and spoke' service delivery model. In addition ICT, Telehealth and other support services will enable staff and services to operate in a range of settings across the region.
- The Pilbara region has higher rates of avoidable hospitalisation than State and National averages for a range of chronic conditions including diabetes complications, congestive heart failure and chronic obstructive pulmonary disease.
- There is a high burden of disease within the Pilbara Aboriginal population with significantly higher mortality and hospitalisation rates than the non-Aboriginal population for a range of conditions.

## 5. Current & Future Service Delivery Profile

Onslow Health Service forms part of the WACHS Pilbara Health Region's integrated network of services.

**Figure 3: WACHS Pilbara: Location of clinical services, by district and LGA**



Nickol Bay Hospital in Karratha is the 'hub' for hospitals in the West Pilbara Health District and is recognised as an Integrated District Health Service under the *WA Clinical Services Framework*. A range of regional and district services are coordinated from NBH to support the smaller health services including Onslow Hospital and Community Health Centre. Planning is currently underway to transform the existing NBH into the Karratha Health Campus, a larger facility with all public sector health services collocated on the one site.

## Onslow Hospital

Onslow Hospital, designated as a small hospital under the *WA Clinical Services Framework*, was opened in 1965. Located close to town on a large block of land, the hospital is an attractive looking Northwest style old veranda clad building.

Although a structural survey of the building is pending, the staff have reported that the facility is no longer fit for purpose. In particular, the emergency department (no emergency wait area, no triage area, no ICT, no point of care testing, no piped oxygen or suction, no safe mental health room) and the ward areas require updating. There is a sink in one ward bed room only and there is no piped oxygen or suction. There is limited ICT hardware, only one Telehealth unit in a shared consulting room, and no digital imaging equipment. Access to the ambulance bay is poor with a steep sloping ramp. There is no staff education area; no designated Telehealth zone and no designated consulting rooms. The layout of the hospital makes it difficult to staff the emergency area and the wards when busy and there is limited capacity to manage any unplanned surge in emergency activity.

There are several well maintained accommodation units located on the grounds of the hospital and one hospital house located in town. A summary of the current staff accommodation is provided in Appendix 9.3.

The catchment area for the hospital is largely unpopulated with the exception of Onslow town. It includes the nearby Indigenous community of Bindi Bindi, five stations and the Mackeral islands. In the tourist season, between April and October, the township expands with the local caravan park fully occupied. During this period there are also resident campers on the Ashburton River, approximately 20km from town.

The hospital managed 223 inpatient separations in 2009/10, 6 percent of the total separations managed within the West Pilbara region. 88 percent of the activity met by Onslow Hospital, in the same year, related to West Pilbara residents.

Onslow Hospital operates under a Visiting Medical Practitioner (VMP) based medical model.

## Onslow Community Health Centre

The Onslow Community Health Centre was also built in 1965 and was originally the nurses' quarters adjacent to the hospital. The community health nurse and Aboriginal health worker are based in this facility. Whilst operational, this facility is well past its functional use and not fit for purpose.

## 5.1. Community Based Services

Although not specific to Onslow, the volume of potentially preventable hospitalisations in the West Pilbara district, as outlined in Section 4.4.2, is an important consideration in determining the quantum and range of ambulatory/community based services required.

For the local catchment area of Onslow, a range of community based services are currently provided.



## **Ambulatory Care**

Ambulatory care services provided at Onslow include the following:

- Medical Outpatients/Visiting Medical Practitioners:
  - physician visits every six months;
  - paediatrician visits monthly;
  - psychiatrist visits every three months;
  - obstetrician visiting monthly;
  - palliative care specialist visits approximately every four months (from July 2011 all palliative care consultations will be via videoconference from Perth);
  - visiting retinal imaging for diabetic clients visits every six months; and
  - optometrist, every six months.
- Medical services:
  - fly in DMOs from NBH operate clinics three times a week (there are no local GP's in Onslow), however this is dependent on staffing and environmental issues, e.g. cyclones; and
- Allied Health
  - physiotherapist visits fortnightly;
  - OT visits monthly;
  - speech pathologist visits every three months;
  - diabetes educator visits every three months;
  - dietician visits every one to three months;
  - audiologist visits every three to six months; and
  - breast screening mobile van every two years.

A Regional Cancer Nurse Coordinator and Palliative Care Coordinator also attend Onslow on a visiting basis.

Patients are currently required to travel to Port Hedland or Perth for haemodialysis, which is frequently problematic during the cyclone season. There is an identified need for more training for managing home based haemodialysis in Onslow.

Continuous ambulatory peritoneal dialysis (CAPD) has previously been supported in the community by the Community Health Nurse and Hospital where necessary; along with support by Fresenius Medical Care (a Perth based service offering 24 hour support for CAPD patients).

## **Population Health Services**

Population health services for the Onslow catchment area, are based at the Onslow Community Health Centre, and include:

- Weekly Indigenous growth and development group
- Child Health Services
- Preschool vision and hearing screening
- Ear health program run at the local school
- Immunisation Clinic (adults and children)

- Women's Health and STD screening

### **Mental Health and Drug & Alcohol Services**

Mental health and drug services for the Onslow community include the following:

- Pilbara Mental Health & Drug Services (PMHDS) provide drug and alcohol counselling every one to three months.
- The WACHS Midwest Mental Health Nurse provides outpatient support to Onslow Hospital.
- An Aboriginal mental health worker from the Midwest region visits monthly.
- A psychiatrist from PMHDS visits every three months. Psychiatric assessment can also be undertaken via telehealth facilities.
- Rurallink, a specialist after-hours mental health telephone service for rural communities, is utilised for after hours and weekend patient support. This service provides direct patient support and advises clinicians and carers on mental health management strategies.

### **Pilbara Community Aged Care Services**

There are no residential aged care beds in Onslow. There are nine pensioner units operated by the Shire.

Pilbara Community Aged Care Services (PCACS) provide a range of programs including ACAT, Community Aged Care Packages (CACP), Home and Community Care (HACC), Respite and Carelink services that provide assessment, information and resources to the ageing population. In addition they provide access to visiting Geriatrician and Psych-geriatrician services.

**Onslow HACC services** provide support to aged clients through a range of services including centre based day care, meals on wheels, home maintenance, and respite care transport, shopping and cleaning services.

The **Aged Care Assessment Team**, based in South Hedland, provide comprehensive assessments to determine the eligibility and level of care for residents above 65 years of age and ATSI residents above 45 years of age to access Commonwealth community programs and/or admission to a residential aged care facility for respite of permanent care.

## **5.2. Inpatient Services**

### **5.2.1 Patient Flow – demand for health services by Asburton residents**

Specific patient flow data for Onslow residents is not available, however the following table outlines the volume of activity, by treatment region, attributed to Ashburton Shire residents

In 2009/10, there were 1,908 separations from all WA private and public hospitals involving residents of the Shire of Ashburton. 40 percent of this activity was managed by hospitals within the West Pilbara district.

**Table 3: Ashburton residents by treatment region (2009/10)**

Treatment region	Seps	Percentage of Total
West Pilbara	755	40%
East Pilbara	177	9%
Other WACHS	32	2%
Metro (Public)	387	20%
Private	557	29%
Total	1,908	100%

*Excludes boarders and unqualified neonates.*

*Data Source: HMDS, via Clinical Modelling Unit*

## 5.2.2 Current Service Profile

### Overview of Inpatient Activity

Table 4 demonstrates that the total number of separations at the six bed Onslow Hospital has remained relatively static between 2007/08 and 2009/10. However, the number of multiday separations has decreased by 14 percent, while the number of same-day separations has increased by 43 percent over this time period.

The recent occupancy rates at Onslow Hospital have been low. An occupancy rate of 18-25 percent reflects that, on average, only one or two of the six inpatient beds are being utilised at any one time.

**Table 4: Onslow Hospital - Clinical activity (2007/08 – 2009/10)**

Activity	2007/08	2008/09	2009/10
<b>Multiday Separations</b>	160	160	137
<b>Same-day Separations</b>	60	78	86
<b>Total Separations</b>	220	238	223
<b>% Same-day</b>	27%	33%	39%
<b>Bed-days (multiday only)</b>	454	392	331
<b>Total Beddays</b>	514	470	417
<b>Average LOS (multiday)</b>	2.8	2.5	2.4
<b>Occupancy Rate</b>	23%	21%	19%

*Excludes boarders and unqualified neonates.*

*Source: HCARE: online ATS pivot, extracted 8<sup>th</sup> Feb 2011*

### Inpatient Activity by SRG

A breakdown of activity by SRG is provided in Appendix 9.4. A significant proportion of the activity is attributable to medical admissions, in particular 'non subspecialty medicine' and respiratory medicine (includes a substantial number of patients with chronic disease).

Surgery within the West Pilbara is undertaken at NBH (or if the condition warrants Hedland or Perth) and therefore surgical related admissions to Onslow are minimal. Onslow Hospital does not have planned deliveries. Obstetrics and gynaecology services, including emergency caesareans are provided at NBH. All pregnancies are transferred to Hedland or Perth at 36 weeks gestation, or earlier if required.

Drug and alcohol and mental health admissions are also low. There are no authorised inpatient mental health beds on-site at Onslow. People requiring authorised (involuntary) or unauthorised (or voluntary) admission for acute mental health and substance abuse issues may be admitted to the ward area for stabilisation or stabilised in ED. Patients are then transferred to NBH for assessment prior to RFDS transfer to Perth.

Boarders account for the second highest number of admissions to Onslow hospital. This is due to an established and effective model of care that ensures patients who are booked for a medical procedure or outpatient appointment in Karratha, are admitted as a boarder to Onslow Hospital the day before the appointment. This ensures they are appropriately prepared and on the daily courier/taxi service to Karratha at 0430hrs. This service takes patients directly to NBH.

A summary of the Onslow inpatient activity attributed to boarders between 2007/08 and 2009/10 is outlined below:

**Table 5: Onslow Hospital: boarders (2007/08 – 2009/10)**

Activity	2007/08	2008/09	2009/10
Separations	35	31	17

Source: HCARE: online ATS pivot, extracted 8<sup>th</sup> Feb 2011

### Inpatient Activity by Age Group

The inpatient activity by age group is outlined below. The 15-44 and 45-64 year old age groups have recorded the highest activity in recent years which is reflective of the fact that residents within this age range make up a high proportion of the local population (see Figure 2).

**Table 6: Onslow Hospital: Clinical activity By Age Group (2007/08 – 2009/10)**

Onslow	Seps		
Age Group	2007/08	2008/09	2009/10
0-14	25	32	66
15-44	88	90	70
45-64	53	68	72
65+	54	48	15

Source: HCARE: online ATS pivot, extracted 8<sup>th</sup> Feb 2011

### Indigenous Population Inpatient Activity

The breakdown of activity relating to Aboriginal and non-Aboriginal people is presented below. In recent years Aboriginal people accounted for approximately 60 percent of admissions at Onslow Hospital but accounted for only 33 percent of the population.

**Table 7: Onslow Hospital: Clinical activity: ATSI population (2007/08 – 2009/10)**

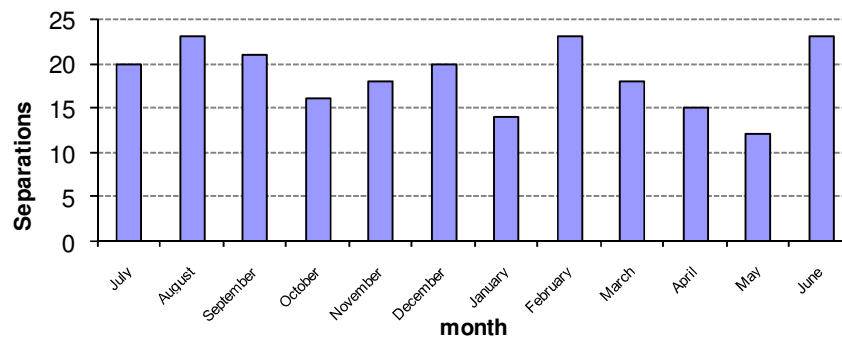
Activity	2007/08	2008/09	2009/10
ATSI	125	127	126
Non ATSI	95	111	97

Source: HCARE: online ATS pivot, extracted 8<sup>th</sup> Feb 2011

## Seasonal Variations in Demand

Inpatient activity at Onslow, by month of the year, is presented in the figure below. Peaks in activity were seen in June, August and February.

**Figure 4: Onslow inpatient separations by month, 2009/10**



Source: ATS online pivot

### 5.2.3 Future Service Profile

Given the forecast population growth will be driven by LNG plant workers and their families it is assumed that the resulting increase in healthcare demand will be focussed on primary healthcare and emergency services rather than significant increases in demand for inpatient care.

The recent Onslow Hospital occupancy rates demonstrate that the current inpatient bed capacity will be more than sufficient to meet current and future demand. Any future planning processes involving the redevelopment or relocation of inpatient facilities at Onslow will need to investigate and confirm the appropriate number of beds required. This will be dependent on whether the various scenarios/strategies for Onslow, as proposed in Section 7 of this document, will be implemented.

There is also a need to explore the future requirement for residential aged care beds in Onslow. Current Commonwealth aged care planning benchmarks for high and low care residential aged care places, applied to forecast populations, 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. As population projections by age group, are undertaken at an SLA level, rather than town level the anticipated number of elderly residents in Onslow is uncertain. However, it is assumed that this age group will be largely unaffected by the forecast growth relating to industry expansion.

The total number of residents aged 65 years and over recorded during the 2006 ABS Census, was 65 (44 of these were not ATSI, 15 ATSI and 6 not stated). In addition there were 85 ATSI residents aged 45 years and over. Therefore, the Commonwealth benchmarks support a requirement for a number of high care beds in Onslow. It is anticipated that the requirement for low care beds will continue to be met through the provision of Community Aged Care Packages.

## 5.3. Emergency Services

### 5.3.1 Current Service Profile

There is a 24 hour nurse led emergency service at Onslow Hospital with telephone back up from DMOs at Nickol Bay Hospital. There are currently two ED bays at Onslow, including one resuscitation bay.

Appropriate emergency management services in Onslow are essential as, due to Onslow's location, there are frequently incidents relating to motor vehicle accidents on the Coastal Highway, along with incidents associated with offshore rigs and water vessels. As Onslow is very isolated by road, the emergency service at the hospital need to be appropriately resourced and equipped to manage and stabilise patients until the RFDS is able to attend. RFDS are able to provide medical consultation or, if required, will transport patients to a more appropriate healthcare facility for definitive care.

As demonstrated in Table 8, the total presentations to Onslow Hospital's Emergency Department are increasing. The total activity in 2009/10 reflects an average of six to seven patients presenting to Onslow ED per day.

**Table 8: Onslow Hospital: Emergency Department activity, by triage category (2007/08 – 2009/10)**

	Number of presentations			% change 2007/08 – 2009/10
	2007/08	2008/09	2009/10	
<b>Triage 1&amp;2</b>	75	87	84	12%
<b>Triage 3</b>	217	288	303	40%
<b>Triage 4</b>	1,097	1,646	1,705	55%
<b>Triage 5</b>	833	470	324	-61%
<b>Total</b>	<b>2,222</b>	<b>2,491</b>	<b>2,416</b>	<b>9%</b>

*Note: In 2008 there was an audit of ED presentations at WACHS hospitals that found that some presentations were under triaged. This may account for the differences in triage 4 and 5 categories between 2007/08 and 2008/09.*

*Source: WACHS online ED pivot*

### Ambulatory Other Domiciliary (AOD) Presentations

It is acknowledged that a significant number of ED presentations are for outpatient type presentations, including those relating to nursing and allied health management. These presentations are categorised as AOD (Ambulatory Other Domiciliary) and are not included in ED statistics.

The total number of AOD presentations in 2009/10 was 1,753 occasions of service. It is proposed that in the future **some of** these patients will be managed in an ambulatory care setting rather than the Emergency Department. This activity will also be addressed through workforce reform strategies, including the use of AHW's, community and ED based Nurse Practitioners and allied health therapists.

## Indigenous Population ED Activity

The breakdown of ED activity relating to Aboriginal and non-Aboriginal people are presented below. In recent years Aboriginal people accounted for approximately 48 percent of ED presentations.

**Table 9: Onslow ED OOS by Aboriginal Status (2009/10)**

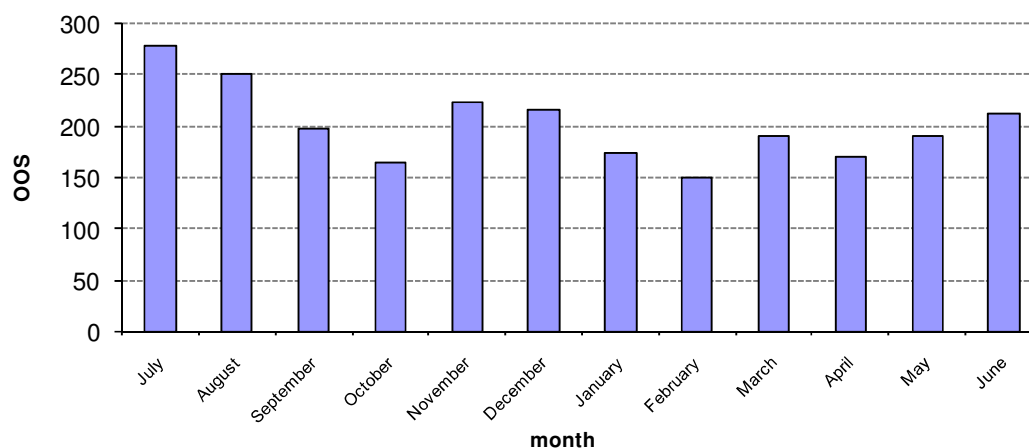
Activity	2009/10 OOS	Percentage of Total
ATSI	1155	48%
Non ATSI	1261	52%
<b>Total</b>	<b>2416</b>	<b>100%</b>

Source: WACHS online ED pivot

## Seasonal Variations in Demand

Onslow ED activity, by month of the year, is presented in the figure below. The peak tourist season from June – August is reflected in the increase in activity over this period.

**Figure 5: Onslow ED OOS by month, 2009/10**



Source: WACHS online ED pivot

### 5.3.2 Future Service Profile

The WACHS Area Office modeling for projected ED activity at Onslow is outlined in the following table:

**Table 10: Projected demand for Emergency Department Services, Onslow (2011/12 - 2020/21)**

	Number of presentations			% change 2009/10 – 2021/21
	2011/12	2016/17	2020/21	
<b>Triage 1</b>	8	9	11	na
<b>Triage 2</b>	133	177	244	194%
<b>Triage 3</b>	462	577	742	145%
<b>Triage 4</b>	2,766	3,620	4,715	177%
<b>Triage 5</b>	675	511	382	18%
<b>Total</b>	<b>4,044</b>	<b>4,894</b>	<b>6,095</b>	<b>152%</b>

Source: WACHS ED Projections pivot (based on ABS series B+).

This data is based on historical activity, projected to reflect forecast population growth and demographic trends (as based on the updated projections developed by Heuris Partners in March 2010). It is acknowledged that these activity projections do not take into account future changes to the model of service delivery, including the potential to reduce demand on acute care services through community based preventative health programs, such as Healthy Ageing.

#### Based on the activity projections outlined in

Table 10, it is proposed that additional ED capacity will be required, with a minimum of three ED bays (including one resuscitation bay). The total number of bays required will require confirmation as the projected growth in local industry, and associated population forecasts, becomes clearer.

## 5.4. Clinical Support Services

Clinical Support Services for Onslow are outlined below.

Service	Current Service Model
Medical Imaging	X-ray service available however this is limited to single views only as performed by nursing staff. Films are flown to NBH for digitising and reporting. Patients are referred to NBH for CT and ultrasound; to Perth for MRI and PET scans and to the mobile BreastScreen WA service or Perth medical imaging services for mammography.
Pharmacy	Pharmacy supplies at Onslow are managed by on-site nursing staff. Prescriptions are faxed to Exmouth pharmacy and delivered by courier the next day to Onslow Post Office for collection. There are no private pharmacists in Onslow (Karratha only).
Pathology	Specimen collection at Onslow by nursing staff– sent to PathWest laboratories at NBH for testing,



## 5.5. Non- Clinical Services

Corporate services including human resources, finance, ICT, supply, engineering and maintenance are coordinated within a regional model from Hedland.

Service	Current Service Model
Engineering & Maintenance	Facility Maintenance is undertaken 'in-house' through WACHS staff based in Exmouth or through locally employed handypersons
Medical Records	Onslow store and manage their medical records. Archived medical records are stored in Perth.
Catering	Onslow has a fresh cook kitchen on site. Meals are usually cooked, frozen and reheated when required.
Linen	Onslow operates an in-house laundry service which supplies Onslow Hospital only.

## 5.6. Health Partners

### Emergency Services

Police, St John Ambulance (SJA) and Fire and Emergency Services (FESA) are first responders to emergency situations. SJA and FESA are run by volunteers with basic training. A lack of volunteers in town is an ongoing problem with currently only six volunteers on the SJA roster.

On average, there are approximately one to two 'fly-out' transfers per week from Onslow. SJA provide transport to the airstrip for these patients. The ambulance services does not provide patient transfers by road out of town, however they do attend motor vehicle accidents on the highway. The total number of SJA, Onslow responses is approximately 60-70 per annum.

### RFDS

The RFDS provide a visiting female GP service, through the federally funded 'Royal Women's GP Service'. This service occurs four times per year for five days per session.

### Pilbara Health Network

The Pilbara Health Network (formerly the Pilbara Division of GP) has a number of partnerships with WACHS West Pilbara to complement the work of local GPs. The Pilbara Health Network provides access to allied health services, chronic disease management programs and community health initiatives. Services provided at Onslow include audiology, diabetes education, occupational therapy, physiotherapy, StandBy (suicide bereavement) Response Service, and social work (via video conference from Hedland). Service provision is on an outreach basis, usually delivered by allied health professionals travelling from Perth or Karratha.

### WACHS Midwest

Mental Health outpatient services are provided through the WACHS Midwest Mental Health Nurse.

### Aboriginal Medical Service (AMS)

There is no Aboriginal Medical Service (AMS) in town, however, the AMS from Roebourne has recently commenced a visiting service to Onslow.

**Private Practitioners**

A private chiropractor visits Onslow fortnightly from Exmouth. An optometrist from Perth visits every six months.

**Dental Services**

A dental clinic (one chair) is provided within the hospital.

**KEY ISSUES: SERVICE DELIVERY PROFILE**

- Under the WA Clinical Services Framework 2010-2020, Onslow Hospital is designated as a 'small hospital' and forms part of the WACHS Pilbara integrated network of services. Onslow is supported by the Nickol Bay Hospital (NBH) in Karratha, as the 'hub' for hospitals in the West Pilbara and the Hedland Health Campus, the regional resource centre for the Pilbara Region.
- There are no local resident GPs in Onslow. Medical cover for inpatients and emergency presentations are provided through telephone support from DMOs based at NBH. In addition, fly in DMOs from NBH operate clinics three times a week.
- A community health nurse and Aboriginal health worker are based at the Community Health Centre in Onslow and provide a range of population health services for the local community. In addition, a range of ambulatory care services are provided through visiting medical specialists and allied health practitioners.
- There is a 24 hour nurse led emergency service at Onslow Hospital. The number of presentations to Onslow ED is projected to increase from approximately 2,500 in 2008/09 to over 5,000 by 2016/17. This is reflective of the significant population growth anticipated for the area.
- Onslow Hospital has six inpatient beds. On average only one to two of the six beds are occupied at any one time. Beds are mainly utilised for non subspecialty medical patients and the majority of patients requiring specialised acute care are transferred to Nickol Bay Hospital in Karratha or elsewhere.
- Given the forecast population growth will be driven by LNG plant workers and their families it is assumed that the resulting increase in healthcare demand will be focussed on primary healthcare and emergency services rather than significant increases in demand for inpatient care.
- An X-Ray service is available at Onslow Hospital however this is limited to single views only as performed by nursing staff.
- Onslow Hospital has its own fresh cook kitchen and in-house laundry service.

## **6. Identified Strengths & Shortcomings Relating to the Current Service Delivery Model**

Based on an analysis of the planning context for health service development, the catchment population and activity data, the following strengths and shortcomings relating to the delivery of healthcare services in Onslow have been identified.

### **6.1. Strengths of the Current Service Delivery Model**

The service planning workshop conducted in March 2011 identified the following strengths relating to the health service delivery model:

- Committed hospital staff who work well together to provide a quality, culturally appropriate health service, based on client need.
- Experienced nurses providing a 24/7 service which is available to the entire community.
- Hospital is in an appropriate location, providing ease of access for the local community
- Health service staff reported an excellent working relationship with RFDS who are the only means of emergency patient evacuation.
- Service and follow-up provided by NBH is working well.
- Positive working relationship with visiting specialists.
- Video conferencing available for staff development.
- Current staff accommodation is of high quality with some excellent on site housing – see Appendix 9.3 (however access to staff accommodation by locums and visiting practitioners is limited).
- Well maintained hospital and grounds.
- Hospital swimming pool is well utilised.

### **6.2. Current Shortcomings/Constraints in Service Delivery**

#### **6.2.1 Increasing demand - forecast population expansion for Onslow**

The projected population for the Onslow catchment is difficult to quantify. However, it is acknowledged that the population will significantly spike or increase in the short term (during construction phases) and that there will be a sustained but smaller growth in the current population in the longer term (after the construction phase). Accordingly, there is a need to plan to manage the spike in population and the subsequent public health demands of this population.

Given the forecast population growth in Onslow will be driven by mining workers and their families from outside the region, it is assumed that the resulting increase in healthcare demand will be focussed on primary healthcare and emergency services rather than significant increases in demand for inpatient care. It is anticipated that there will be increased demand for the assessment, management and planned evacuation of emergency presentations. In addition, there will be the need to increase the range and quantum of ambulatory care services provided by an integrated multidisciplinary team.

In line with recent trends, it is anticipated that significant growth in the FIFO workforce will result in increased demand for mental health services, particularly for counselling and drug and alcohol services. WACHS staff have reported the need for improved awareness of the impact of social isolation on both the FIFO workers and their families.

It is also acknowledged that the increase in industry activity and population will have an effect on broader town infrastructure and demand for rental accommodation.

It is expected that industry will be finalising its decisions regarding future projects by the third quarter of 2011. Health service planning will need to be reviewed at this time, following greater definition around future population growth.

#### **6.2.2 Demand for inpatient beds at Onslow**

Only patients with very low acuity are admitted to Onslow hospital with an average of one to two individual patients being admitted at any one time. One of the contributing factors to the low level of inpatient activity at Onslow is the lack of a resident GP.

It is acknowledged that staffing for such low patient numbers is extremely inefficient, associated with high risk from a clinical incident point of view and detrimental to staff recruitment and retention due to the lack of professional support.

The majority of activity at Onslow Hospital is attributable to medical and respiratory admissions, with Aboriginal people accounting for 60 percent of total separations. It is assumed that a significant proportion of admissions could be avoided with improved community management of these patients through initiatives such as environmental health and chronic disease management programs.

Boarders also account for a high proportion of the inpatient activity at Onslow, with many of these relating to patients requiring accommodation to facilitate their access to transport to Karratha for planned procedural / outpatient appointments. It is proposed that these patients could be better managed in short term hostel style accommodation.

### **6.2.3 Access to Primary Health Services including Dental Care**

It was reported during staff consultation workshops, as part of the development of this service plan, that there is an inadequate number of allied health and community nursing staff based in the catchment area, impacting on the functionality of the multidisciplinary team. This is particularly problematic given the high prevalence of chronic disease in the population.

There is a one dental chair clinic under the main roof of the hospital, however staff have expressed the requirement for improved access to dental services in Onslow. Ideally the dental service would be located on a future Onslow Health Campus in the ambulatory care centre.

There is an identified need for improved access to appropriate antenatal services. Despite arranging travel to Karratha, local staff in Onslow report that there has been poor patient compliance to attending antenatal care at NBH. With the commencement of a more regular visiting obstetric service to Onslow, it is proposed that local antenatal services are enhanced.

The lack of a retail pharmacy in town is also identified as a key issue for Onslow as it is more expensive and takes longer for residents to have their prescriptions filled.

### **6.2.4 Aboriginal Health**

There is local acknowledgement that the existing model of healthcare delivery in Onslow is not adequately addressing Aboriginal health issues. This is despite the fact that 33 percent of the catchment population identifies as being Aboriginal and in recent years Aboriginal people accounted for almost 60 percent of the total hospital admissions.

The Aboriginal population presents with a range of health issues for the health service to manage. These include the management of patients who have waited until they are very ill to present and often have a number of co-morbidities, injury/trauma post intoxication and the short and long term effects of solvent abuse. The other most common presentations result from acute or chronic diseases including diabetes and renal disease.

The health service staff at Onslow are focused on providing a culturally appropriate health service and there is one Aboriginal Liaison Officer based at the hospital. There is no Aboriginal Medical Service (AMS) in town, however, the AMS from Roebourne has recently commenced a visiting service to Onslow. Recent challenges have been identified relating to the need for services provided by WACHS and the AMS to work more closely together to minimise patient confusion regarding their treatments and to clarify the roles of various health practitioners caring for Aboriginal patients.

Additional health service issues for the local Aboriginal people include:

- there is a need to improve the focus on chronic disease management and strategies to reduce the demand on acute services;
- an improved level of access by Aboriginal people to mental health services is required – currently there is a visiting mental health team only.

- there is a need to improve renal health services; and
- improved access to Environmental Health Services is required, in particular at Bindi Bindi, the local Aboriginal community.

For Aboriginal people living in surrounding communities, the lack of public transport is an additional barrier to accessing health services.

#### **6.2.5 Significant social issues impacting on the health status of local residents**

The key health issues in the community are directly related to a range of social problems that include drug and alcohol abuse, domestic violence, child neglect and high levels of chronic diseases, such as renal disease and diabetes.

#### **6.2.6 Regional transport issues impacting on the accessibility of health services**

Onslow is located in a very remote location, being a four hour drive from Karratha. The road is subject to flooding, straying livestock and kangaroos. Health service staff are not permitted to drive on the open roads on health related business after sunset and before sunrise. Due to the distances, patient road transport to Karratha using St John Ambulance is not available.

The town based public transport is non-existent and there are no taxis. There is a regular transport service available to Karratha that departs at 0430 and there is also an infrequent commercial bus service available from the highway (80kms drive from town). The only way to fly to Onslow is by charter.

The lack of public transport options is a pertinent issue for many Aboriginal people, young mothers, elderly and those living with a disability who are often isolated and unable to access transport readily. This impacts on their ability to access appropriate healthcare services.

#### **6.2.7 Aged Care Services**

Whilst the demand for aged care services is not high in Onslow at present, hospital staff have expressed the need to explore future demand for aged care services across the entire spectrum of service provision. This includes the requirement for residential aged care beds, as well as home based support services. An estimate of the projected requirements for residential aged care beds is provided in Section 0.

Hospital staff have also reported that HACC services in Onslow are currently hampered by staff shortages and ongoing difficulties with recruitment.

#### **6.2.8 Workforce recruitment and retention issues**

During the service planning consultation workshop, participants identified that the existing relatively stable health service workforce at Onslow was a major enabler to good practice, and that this needs to be maintained. There is, however, a concern that due to the relatively small size of the workforce, a few small staff changes have the potential to create a major change in the dynamic and effectiveness of the health service.

Current workforce issues identified for Onslow are:

- Lack of permanent medical staff in the community – Onslow does not have a resident GP (DMO services are provided by the WACHS-Pilbara health service on a visiting basis).
- Not having a resident doctor means acute inpatients cannot be admitted overnight and must be transferred to NBH.
- The rotating DMO services provided from NBH impacts on the continuity of care, which is particularly problematic for those patients with chronic disease or co-morbidities.
- A nurse practitioner role and the need for additional nursing staff for the implementation of the current triage policy are essential considerations in future workforce planning for Onslow.
- There is a need for improved and ongoing patient support services training, e.g. kitchen and cleaning standards.
- Staff shortages in HACC means that limited programs are provided.

There are also a range of challenges facing the staff of the Onslow Health Service that relate directly to working in such a remote location.

### 6.2.9 Facility shortcomings

The current acute facilities at Onslow were officially opened in 1965. Whilst a formal assessment of the state of the healthcare facilities has not been undertaken, it is reported that the facilities have been maintained but are not fit for the provision of contemporary models of care. For example, the inpatient wards have bottled oxygen and suction only.

Key facility shortcomings identified for Onslow hospital include:

- The facility is cyclone rated to a category 3 cyclone, which means that the hospital needs to be evacuated when category 4 and 5 cyclones are predicted. As Onslow is located in an area with a high prevalence of cyclones, any new facility would need to be built to cope with category 5.
- The ward areas are old fashioned and not fit for purpose with no piped oxygen or suction and limited bathroom facilities.
- The two bay ED (one treatment and one resuscitation room) has no space for patient triage or patient wait, has no capacity to manage surge activity, is poorly linked to the ward area, has no ICT or Telehealth connectivity, no point of care testing and no place to safely manage a disturbed mental health patient..
- The nurse led ED sees a large proportion of patients for follow up activity, such as dressings and medication. This is core business for the health service (given there is no resident GP) and would be more appropriately provided in an ambulatory care setting. This will require consideration during any future planning process for the potential redevelopment of Onslow hospital.
- The health service staff accommodation is of good quality with some excellent on site housing and some older houses that require refurbishment. There is also a health services house located in the town (see Appendix 9.3). However, there is an identified need for motel style staff accommodation for locum staff and any visiting WACHS – Pilbara staff who travel regularly to Onslow to provide visiting clinical services, as well



as additional houses/units to assist with the attraction and retention of permanent nursing staff;

- While demand for palliative care at Onslow is not high, there are specific facility requirements for this patient group that are not met by the current health facility. This includes the need to access outdoor areas and large waiting areas/courtyards for family members.
- It is recognised that as the population and demand for health services grow, there will be a need to improve the level of security provided at the hospital through an afterhours security presence and/or an appropriate facility solution.
- There is no digital imaging equipment or the capacity to transmit or receive digital images.
- The pathology collection centre is not fit for purpose.
- There are no designated Telehealth consulting room facilities
- There are no designated consulting room facilities
- There are no staff meeting or education areas.
- The facility is poorly networked with limited computer hardware and no wireless connectivity
- The ambulance bay requires transversing up a steep ramp to get under the hospital main roof

#### **6.2.10 ICT Shortcomings**

There is a clear need to improve acute clinical service assessment, diagnosis and management of patients presenting to Onslow Hospital, using technology that will facilitate enhanced linkages with clinicians in Karratha. The following shortcomings have been identified:

- Currently a basic X-Ray service (chest and extremities only) is provided by two nurse X-Ray operators. There is no digital transfer of images available and as such X-Ray films are flown to NBH for digitising and reporting. This means that urgent reporting to support the rapid diagnosis of patients is not possible, which could result in inappropriate patient evacuations. Approximately 30 to 40 percent of the images taken in Onslow are not suitable for digitizing when received at Karratha.
- The lack of a shared electronic record between all service providers is particularly problematic for managing patients who present to a range of clinicians and are often unable to provide updates on their progress, including changes to medication and the outcome of recent medical tests.
- There is an identified need for improved diagnostic equipment (such as point of care testing) in Onslow to facilitate diagnosis and decision making regarding the need to transfer patients to Karratha or elsewhere.
- There is currently no Telehealth videoconferencing service in the Onslow ED. A new Practitioner Cart has been purchased for the site to assist nurses to link up in real time with medical staff at NBH for patient assessment and improved clinical decision making regarding the need for patient transfer. However, at the time of writing this Service Plan, the Practitioner Cart was not yet wireless enabled.
- There is no designated Telehealth consulting room.



## **7. Proposed Service Reform Strategies**

The issues outlined in Section 6 and consultation processes that have occurred to date between WACHS Pilbara staff and the local community have informed the development of a number of key service delivery strategies for the Onslow area.

These strategies acknowledge that the focus of healthcare delivery at Onslow needs to be on primary health care and emergency services with an emphasis on the provision of health promotion, chronic disease management and prevention, and population health services to address local priorities.

### **7.1. Establish a commitment to integrate Onslow Hospital and Community Health Service into a single Onslow Health Service**

There is support for the concept of creating a single Onslow Health Service ('one stop shop'). The integrated Service will include the hospital; acute, aged care and emergency departments; resident GP service; facilities for all visiting service providers and community health clinics; Home and Community Care; other human services agencies and other support facilities. The precinct should have a primary health care focus where all health and related human service staff can either work from or be based when they provide visiting services.

An improved level of integration between the various health programmes will assist in improving communication between service providers, minimise service duplication, improve the ease of access for local residents to health services and enhance the local community's knowledge around the range of services available.

### **7.2. Increase and enhance access to a range of primary health services including dental care**

Improved access to range of primary health services is essential to assist in addressing the high rates of avoidable hospitalisations for a range of chronic diseases and the high burden of disease within the Aboriginal population.

It is proposed that a purpose built dental clinic and sustainable provision of public dental services in Onslow in the future would be a positive initiative.

Workforce recruitment strategies are required to target the shortage of allied health staff. It is proposed that opportunities to work with the local mining companies to facilitate joint clinical appointments be explored. In addition, there is support for encouraging industry to contribute to the funding for after hours services. This contribution should align with the anticipated increase in healthcare demand related to the growth in planned FIFO activity, and is particularly relevant given the impact of the new FIFO roster and the large number of workers that will be in town on weekends.

It is expected that demand for Mental Health, Alcohol and Other Drug counseling type services will increase as the town grows. In line with other primary health care type services it is likely that there will be a need to provide improved multidisciplinary (including resident) services, with a focus on Aboriginal mental health need.

As outlined in Section 6.2.3, there is a need for enhanced antenatal services in Onslow, to complement the increased frequency of the visiting obstetrics service and to improve patient compliance to accessing appropriate antenatal care. To facilitate this, a portable ultrasound machine is proposed.

There is an identified need to review the model for delivery of pharmacy services in Onslow due to the remote location and the lack of retail or on site health service pharmacy. The health service should explore alternate methods for service delivery, including the use of innovative, electronic ordering, supply and delivery systems.

### **7.3. Ensure culturally appropriate services are provided for the community with a particular focus on Aboriginal people's need**

There is a high proportion of Indigenous persons in Onslow and surrounding areas. One of the key directions for assisting in improving the health status of the Aboriginal community is to promote Indigenous focused early intervention and preventative community and outreach services as culturally sensitive alternatives to hospital based care. Key elements of the approach to managing Aboriginal peoples' needs include respect, recognition of the need to value the local sense of place, appropriate staff training (orientation and ongoing), appropriate range of health workers (male and female) creating a welcoming environment, and the provision of appropriate, cultural signage and way finding.

This approach must extend across the Pilbara region with a focus on healthcare and human services provided by St John's Ambulance Service, the Department of Housing, Centre Care and the Police.

It is suggested that cultural awareness training for staff should be evaluated for both effectiveness in raising non-Aboriginal peoples' awareness of Aboriginal peoples' culture and history, and also any long term impact on the health status of the local Aboriginal population.

### **7.4. Develop partnerships with external stakeholders to address the social determinants of health**

It is acknowledged that significant social issues in the Onslow area are impacting on the health status of the local residents. It is essential that WACHS work with external agencies with the aim of improving current issues relating to drug and alcohol abuse, domestic violence, child neglect, and poor regional transport. One of the key opportunities for WACHS is to assist in addressing some of the major determinants of ill health through illness prevention programs, health promotion and improved management of chronic disease.

As outlined in Section 6.2.4, the AMS in Roebourne has recently commenced a visiting service to Onslow. Improved working relationships between the AMS and local hospital staff will be essential to ensure the provision of appropriate healthcare services for the local Aboriginal population across the continuum of care, and to minimise the duplication of services.

The integration of all health care providers in the one area, as proposed above, will enable the provision of a multidisciplinary model of health care with a continuum of integrated services, through nursing, medical, allied health and community providers working collaboratively to meet the patient's needs. The integrated team needs to focus on delivering a proactive approach to improving the overall health of the individual and the broader community. In particular, it is proposed that child health services would benefit from being linked even more to the local school, the Department for Child Protection (DCP) and any other relevant agencies.

## **7.5. Focus on ensuring Workforce Sustainability**

As with other remote health settings there is a need for ongoing maximising of the existing staff attraction and retention strategies. Strategies being developed in other areas such as the 'grow your own' model (attracting young local people and Aboriginal people into the health business across all sectors), and the need for increased access to a range of professional supervision via Telehealth, are key enablers requiring consideration.

Workforce planning for the area is part of the overall WACHS Pilbara workforce planning process. Some of the specific strategies identified for the region to address this critical issue include:

- Ensure a range of staff accommodation is available for permanent, temporary and transient staff.
- Build the capacity of Aboriginal health initiatives in the West Pilbara Health District by attracting and retaining positions and leadership roles for Aboriginal people.
- Develop employment arrangements that support the introduction of flexible service models such as mobile clinical teams.
- Extend the use of Telehealth to increase remote access to specialist services for staff support and education.
- A commitment to redesign workflows and change skill mix as needed to better align available staff skills with patient needs.
- Develop a workforce culture and environment that supports innovation and continuous improvement.

As outlined in Section 6.2.1, it is acknowledged that the considerable population growth forecast for Onslow will result in significantly greater demand for primary healthcare and emergency services. This will include the need to increase the range and quantum of ambulatory care services, including mental health services and the requirement for a residential GP/DMO and nurse practitioner. Workforce modelling and a review of the future recurrent funding requirements will be essential to address the future healthcare needs of the rapidly growing population.

## 7.6. Address facility issues

The following facility improvements, as identified in section 6.2.9, are identified as high priorities for Onslow and will require consideration within any future planning process for the potential redevelopment of Onslow hospital:

- Provision of a single Onslow Health Campus precinct ('one stop shop') with a primary health care focus.
- Any new facility to be developed to meet a category 5 cyclone rating.
- Improved capacity within the ED to meet forecast demand, including surges in activity and to provide appropriate space for patient triage. There is also a need to improve the linkage between ED and the ward area.
- Develop a digitized imaging system.
- Contemporary ward and bathroom areas.
- Ambulance entrance.
- Provision of motel style staff accommodation for transient and locum staff and any visiting WACHS Pilbara staff who travel regularly to Onslow, along with additional units/houses to assist with the attraction and retention of permanent nursing staff. It is estimated that two additional houses/units will be required.
- Provision of short term patient motel style units for Onslow patients who are booked in for planned outpatient or short stay procedural work in Karratha and who require health service support to access the available road transport system. It is proposed that two units will be required to allow for some redundancy (e.g. cleaning, maintenance etc).
- Provision of appropriate facilities to manage palliative care patients.
- Improved security of the hospital, along with consideration of the need for an afterhours security presence.

## 7.7. Utilise ICT and Telehealth strategies to link service providers working across large geographical distances

### Proposed ICT Strategies

The use of ICT to improve the communication interface between healthcare services (including private and non-government sectors) is particularly relevant to Onslow where large geographical distances exist between hospitals and service providers are often working remotely within the community. The provision for the development of electronic medical records advanced networking capabilities; wireless messaging; and system integration will greatly assist in improving access to information and communication between providers. In addition to this, the ICT strategy is viewed as a method of attracting and retaining staff to a safe and appealing work environment.

In response to the issues identified in Section 6.2.10, the following strategies are suggested for Onslow:

- To expedite patient assessment and diagnosis, it is highly desirable that Onslow has access to a higher resolution X-Ray machine with the capability of digitally transmitting images to a radiologist for urgent reporting. There are plans for Onslow to obtain a Computed Radiography (CR) system, however at the time of writing this service plan, the set-up of the system was awaiting installation of appropriate network points and

power outlets. The CR equipment will be accommodated within the existing dark room at Onslow hospital.

- In order to facilitate diagnosis and decision making regarding the need to transfer patients out of Onslow, there is an identified need for improved diagnostic equipment, such as a bladder scanner in ambulatory care and point of care testing equipment in ED.
- The use of a portable ultra-sound for obstetrics care is proposed to assist with the enhancement of local antenatal services.
- The use of a shared electronic medical record between all service providers is also highly desirable.

### **Proposed Telehealth Strategies**

As outlined in Appendix 9.6, WACHS is currently finalising the strategic directions for a Statewide Telehealth service. One of the key aims of this Statewide strategy is to ensure 24/7 critical medical/clinical advice and support is provided to small rural and remote settings when it is needed in real time. In addition a 'state of the art' Telehealth service will enable significant improvements in staff training and professional supervision.

One of the key Telehealth strategies for Onslow is to enable the wireless operation of practitioner carts. The practitioner cart may include a high definition Telehealth video system, digital stethoscope, electronic sphygmomanometer and image sharing. A range of peripheral medical devices such as scopes can be added if/as required. This technology will be used to conduct a 'ward round' moving from patient to patient. It can also provide long distance patient monitoring for critically ill patients, with a specialist providing support and guidance via Telehealth technology to the clinician at the bedside.

In addition to this, fixed videoconference machines, providing high definition two way audio and video transmission, are required. Videoconferencing technology will be used for conducting multidisciplinary clinical case reviews, involving professional groups across multiple sites, and for staff education and training sessions.

### SUMMARY OF KEY SERVICE DELIVERY STRATEGIES

- Establish a commitment to integrate Onslow Hospital and Community Health Service into a single Onslow Health Service ('one stop shop'). Services will include the hospital; acute, aged care and emergency departments; resident GP service; facilities for all visiting service providers and community health clinics; Home and Community Care; other human services agencies and other support facilities.
- Increase and enhance access to a range of primary health care services including dental care.
- Ensure culturally appropriate services are provided for the community with a particular focus on Aboriginal people's needs.
- Develop partnerships with external stakeholders to address the social determinants of health.
- Focus on ensuring workforce sustainability. Workforce modelling and a review of the future recurrent funding requirements will be essential to address the future healthcare needs of the rapidly growing population.
- Address facility issues, including improved ED capacity, layout and appropriate ambulance access, development of contemporary ward areas; provision of a digitised imaging system; appropriate staff and patient accommodation and improved hospital security. Any new facility should be developed to meet a category 5 cyclone rating.
- Utilise ICT and Telehealth strategies to link service providers working across large geographical distances

## 8. Functional Model of Care

Figure 6: WACHS Pilbara – Onslow: Current Model of Care

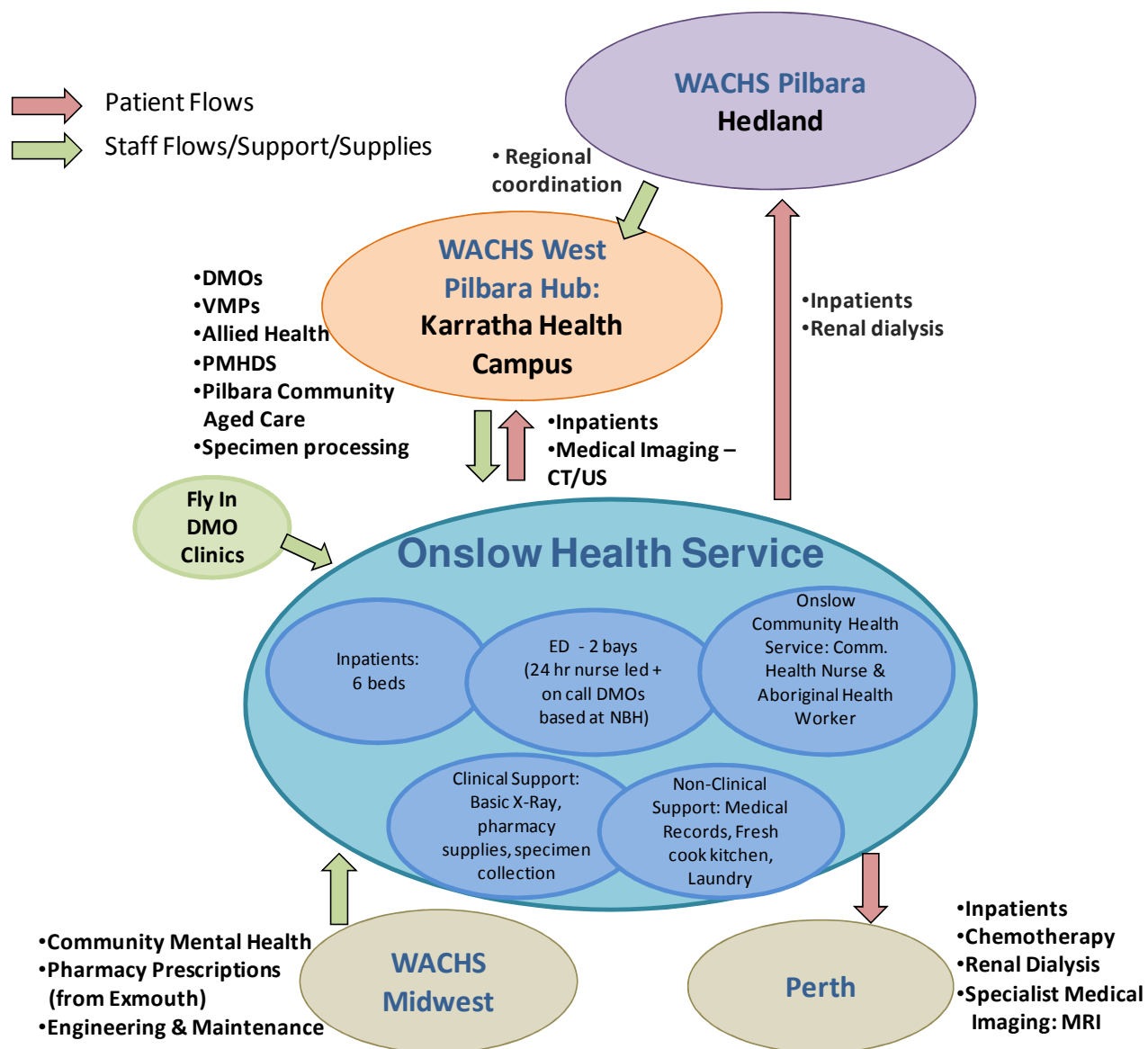
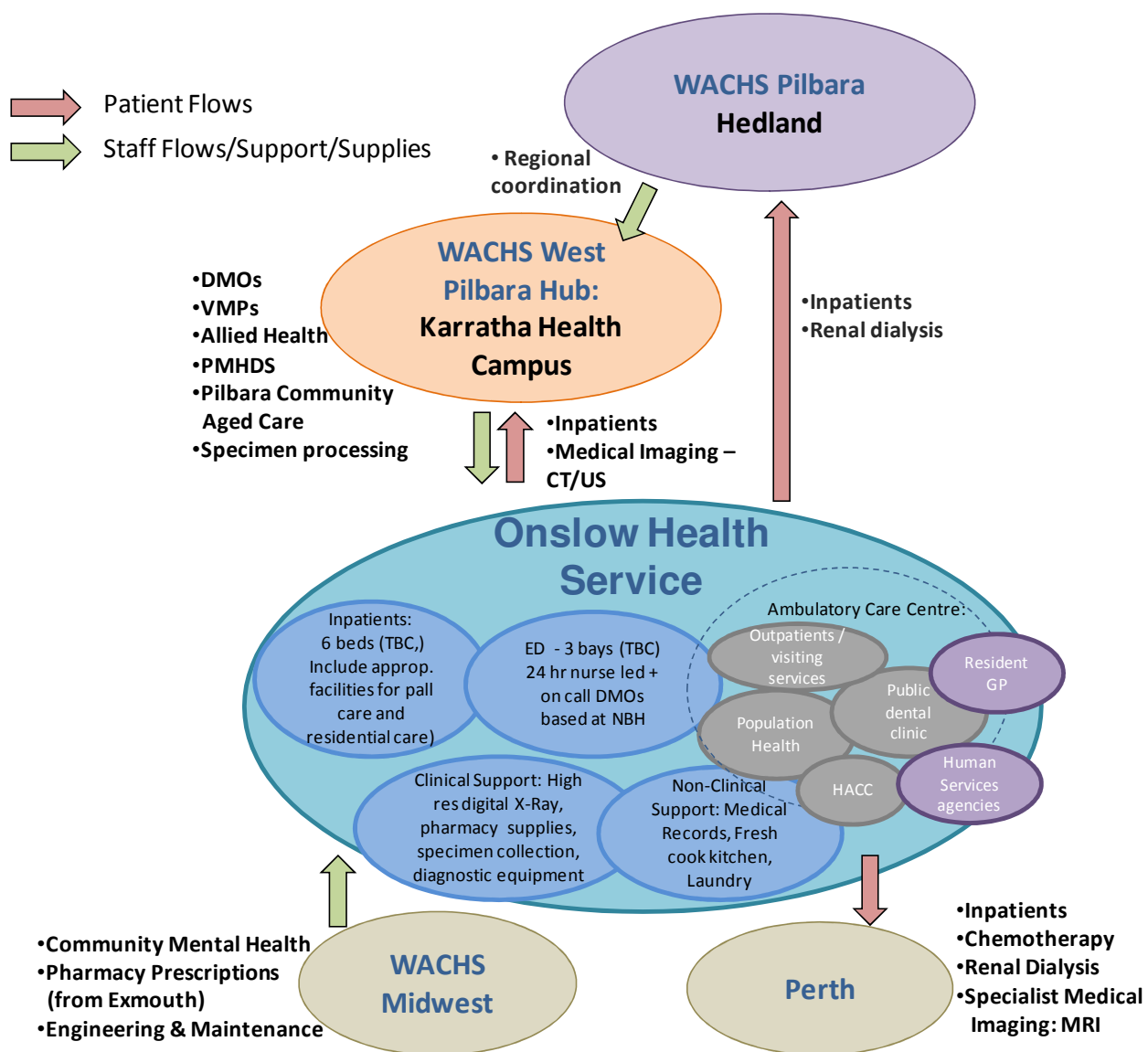


Figure 7: WACHS Pilbara – Onslow: Proposed Model of Care





## 9. Appendices

### 9.1. Staffing Profile for Onslow Hospital

	Budgeted FTE	Actual FTE
<b>Nursing</b>	9.74	7.60
<b>Administration</b>	2.27	1.8
<b>Hotel Services</b>	5.43	3.4

*Source: CNM, Onslow Hospital*

## 9.2. Health and Wellbeing Surveillance System West Pilbara Health District (adults aged 16 years and over), Jan 2005 to Sept 2007

	West Pilbara				Western Australia			Significant differences from Western Australia		
	Prevalence Estimate (%)			Estimated Pop'n (no.)	Prevalence Estimate (%)					
	Female	Male	Persons	Persons^	Female	Male	Persons	Female	Male	Persons
<b>Health Enhancing Behaviours - adults 16 years and over</b>										
Currently smokes	23.3	27.1	25.5	4477	15.6	18.3	16.9	Higher	Higher	Higher
Does not eat two or more serves of fruit daily	51.1	57.3	54.6	9601	43.9	53.1	48.5	Higher	-	Higher
Does not eat five or more serves of vegetables daily	85.6	87.1	86.4	15201	81.0	84.5	82.8	-	-	Higher
Drinks at risky/high risk levels for long-term harm (a)	10.9	12.7	11.9	2101	5.8	7.6	6.8	Higher	Higher	Higher
Drinks at risky/high risk levels for short-term harm (b)	22.9	25.0	24.1	4247	13.4	14.2	13.8	Higher	Higher	Higher
Insufficient physical activity (c) (16 to 64 years)	48.4	56.9	53.1	9109	53.8	51.3	52.5	-	-	-
<b>Risk Factors - adults 16 years and over</b>										
Current high blood pressure (25 years and over)	9.8	17.4	14.2	2087	18.6	18.4	18.5	Lower	-	Lower
Current high cholesterol (25 years and over)	13.0	13.4	13.3	1955	18.0	20.2	19.1	-	Lower	Lower
Overweight	27.0	48.4	39.1	6881	26.1	43.1	34.7	-	-	-
Obese	15.7	24.1	20.5	3599	17.4	16.6	17.0	-	Higher	-
High or very high psychological distress	11.2	3.9	7.1	1253	9.7	6.7	8.2	-	-	-
Lack of control over life in general (d)	4.5	2.6	3.4	600	4.2	3.6	3.9	-	-	-
<b>Prevalence of National Health Priority Area Health Conditions and Injury</b>										
Diabetes (16 years and over)	3.5	3.4	3.4	603	5.7	5.6	5.7	-	-	Lower
Heart disease (25 years and over)	1.8	3.4	2.7	401	5.6	8.8	7.2	Lower	Lower	Lower
Cancer (25 years and over)	3.5	2.5	3.0	438	7.1	6.0	6.6	Lower	Lower	Lower
Current Asthma (16 years and over)	10.6	7.3	8.8	1540	12.1	8.0	10.1	-	-	-
Current respiratory problem (e) (16 years and over)	1.4	1.5	1.5	255	1.8	2.4	2.1	-	-	-
Stroke (25 years and over)	0.8	1.8	1.4	203	1.7	2.4	2.1	-	-	-
Arthritis (25 years and over)	16.1	14.3	15.1	2226	28.5	21.0	24.8	Lower	Lower	Lower
Osteoporosis (25 years and over)	6.1	1.4	3.4	496	8.5	2.7	5.6	-	-	Lower
Injury (f) (16 years and over)	22.7	33.4	28.7	5055	17.7	27.7	22.7	Higher	-	Higher
Current mental health problem (g) (16 years and over)	16.9	4.2	9.8	1717	14.8	8.0	11.4	-	Lower	-

	West Pilbara				Western Australia			Significant differences from Western Australia		
	Prevalence Estimate (%)			Estimated Pop'n (no.)	Prevalence Estimate (%)					
	Female	Male	Persons		Persons^	Female	Male	Persons	Female	Male
Health Service Utilisation in the last 12 months - adults 16 years and over										
Used a primary health care service (h)	88.7	81.2	84.5	14865	91.4	85.6	88.5	-	-	Lower
Used a dental health care service	46.5	39.4	42.5	7477	53.0	47.6	50.3	Lower	Lower	Lower
Used a mental health care service (i)	8.2	4.3	6.0	1054	6.6	3.9	5.2	-	-	-
Used an allied health care service (j)	49.9	47.9	48.8	8577	51.7	44.5	48.1	-	-	-
Used a hospital based health care service (k)	31.1	29.3	30.1	5292	26.1	24.4	25.2	-	-	Higher
Used an alternative health care service (l)	10.1	6.0	7.8	1375	12.3	6.5	9.4	-	-	-
Mean visits to primary health care service (h)	4.9	3.0	3.8	N/A	5.3	3.7	4.5	-	Lower	Lower
Mean visits to dental health care service	1.0	0.8	0.9	N/A	1.1	0.9	1.0	-	-	Lower
Mean visits to mental health care service (i)	0.5	0.3	0.4	N/A	0.4	0.2	0.3	-	-	-
Mean visits to allied health care service (j)	2.2	2.2	2.2	N/A	3.3	2.1	2.7	Lower	-	-
Mean visits to hospital based health care service (k)	0.7	0.7	0.7	N/A	0.5	0.5	0.5	-	-	-
Mean visits to alternative health care service (l)	0.5	0.2	0.4	N/A	0.7	0.4	0.5	-	-	-

^ Estimated population refers to the estimated number of people with the particular risk factor/condition. It is derived by multiplying the Estimated Resident Population by the persons prevalence estimate.

(a) As a proportion of respondents who reported drinking alcohol. Drinks more than 4 standard drinks per day for males (29 or more per week) and more than 2 standard drinks per day for females (15 or more per week).

(b) As a proportion of respondents who reported drinking alcohol. Drinks 7 or more standard drinks per day for males and 5 or more standard drinks per day for females.

(c) Did not do 150 minutes or more of moderate activity over five or more sessions.

(d) Often or always feels a lack of control over life in general.

(e) Respiratory problem other than asthma that has lasted 6 months or more.

(f) Injury in the last 12 months requiring treatment from a health professional.

(g) Diagnosed with depression, anxiety, stress-related or other mental health problem in the past 12 months.

(h) e.g. medical specialist, general practitioner, community health centre, community or district nurses.

(i) e.g. psychiatrist, psychologist or counsellor.

(j) e.g. optician, physiotherapist, chiropractor, podiatrist, dietitian, nutritionist, occupational therapist, diabetes/other health educator.

(k) e.g. overnight stay, accident and emergency department or outpatients.

(l) e.g. acupuncturist, naturopath, homeopath or any other alternative health service.

Source: Epidemiology Branch and WACHS (2008, p. 7-8).

### 9.3. Current staff accommodation

Accommodation	No. of bedrooms	Construction date	Current status
1 x Nurses home	3	1970	<ul style="list-style-type: none"> <li>Older style house.</li> <li>Currently occupied by agency, often used as transit house for visitors.</li> </ul>
1 x sisters flat	1	1965	<ul style="list-style-type: none"> <li>In need of painting and repair.</li> <li>Currently occupied by agency nurse.</li> </ul>
2 x units	2	1980s	<ul style="list-style-type: none"> <li>1 unit (recently refurbished) occupied by HACC co-ordinator.</li> <li>Second unit in need of refurbishment - currently used as transit house and "on hold" for Community Health Nurse.</li> </ul>
4 x Houses	3 x 2 bedrooms 1 x 3 bedrooms	2002	<ul style="list-style-type: none"> <li>All in good condition, minor repairs and re-painting required.</li> <li>Occupied by permanent/contract staff and families.</li> </ul>
1 x Beach House	4	2002	<ul style="list-style-type: none"> <li>In good condition, minor repairs and re-painting required.</li> <li>Occupied by CNM and family.</li> </ul>

Source: Onslow CNM, March 2011

## 9.4. Inpatient Activity by SRG – Onslow Hospital

**Table: Onslow Hospital: Clinical activity By SRG (2007/08 – 2009/10)**

Onslow Hospital	Seps		
SRG_Name	2007/08	2008/09	2009/10
43, Non-acute	<5	6	43
16, Non Subspecialty Medicine	28	38	26
14, Respiratory Medicine	36	33	23
30, Non Subspecialty Surgery	29	24	22
01, Cardiology	23	22	16
08, Immunology & Infections	24	22	11
38, Drug & Alcohol	<5	9	10
05, Gastroenterology	<5	12	9
25, Orthopaedics	11	5	9
20, Upper GIT Surgery	6	<5	8
11, Neurology	6	6	7
35, Obstetrics	6	5	7
04, Endocrinology	5	9	6
22, Neurosurgery	6	6	5
Other SRG	31	39	21
<b>Total</b>	<b>220</b>	<b>236</b>	<b>223</b>

*Unqualified neonates and boarders excluded*

*Source: ATS pivot sep detail 2006\_07 to current as at extract 4-2-2011,*

*Data Source: HCARE & TOPAS via Data Warehouse*

## 9.5. Proposed Future Functional Model for Onslow

It is proposed that the future Onslow Health Service will provide a 'one stop shop' for healthcare services, and will include the hospital; acute, aged care and emergency departments; GP service; facilities for all visiting service providers and community health clinics; Home and Community Care; and other support facilities.

Key areas proposed for the Onslow Health Service are outlined below:

Functional Area	Proposed Key Features
<b>Clinical Services</b>	
Inpatient Beds	6 flexible use acute / residential care beds (TBC). Appropriate facilities for palliative care patients required.
Accident & Emergency Clinic	1 resuscitation bay, 2 ED bays (TBC). Improved layout / capacity of ED to provide appropriate triage area and improved linkage with ward area.
<b>Ambulatory Care Services</b>	
Ambulatory, Community Health & Community Mental Health	Integrated 'Ambulatory Health Care Centre collocating all community, mental health and primary health care services, and facilities for visiting services.
HACC	Inclusion of a day centre area
Dental Clinic	Purpose built public dental clinic
<b>Clinical Support Services</b>	
Medical Imaging	1 x General XRay (with Computerised Radiography – CR)
Pathology	Specimen collection area
Pharmacy	Nil
<b>Non-clinical Support Services</b>	
Medical Records	On-site records storage
Catering	Cook-fresh kitchen
Linen	On-site laundry
Staff Accommodation	Motel style staff accommodation for transient and visiting staff (locums, students, agency, regional): 2 additional houses/units for permanent nursing staff
Patient Accommodation	2 x motel type units for visitors/boarders

## **9.6. Summary: Commonwealth and Western Australian State Government Policies for WA Country Health Service Planning**

# Summary: Commonwealth and Western Australian State Government Policies for WA Country Health Service Planning

April 2011



Government of **Western Australia**  
Department of **Health**  
WA Country Health Service





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## **Corporate Details**

### **Project Leader**

David Naughton



### **Co-authors and Contributors**

Leeann Murphy

Marnie Butson

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# 1 OVERVIEW

The purpose of this document is to summarise the key Commonwealth Government and Western Australian State Government policies which should inform the way the WA Country Health Service (WACHS) delivers services to rural and remote areas of Western Australia.

These policies aim to reform health services to meet future demands and provide the strategic direction for service development at a local level. Overall, the policies acknowledge that meeting future demand is not purely about increasing staff numbers and bed capacity of health facilities. Meeting demand also requires reconfiguring service delivery across the continuum of care with consideration to population demographics, epidemiology, technology and medical advancements.

The policies highlighted in this document include:

- National Health Reform Agreement;
- Council of Australian Governments (COAG) National Indigenous Reform Agreement;
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013;
- WA Health Clinical Service Framework 2010 – 2020;
- Health Activity Purchasing Intentions 2010 - 2011;
- WA Health Strategic Intent 2010-2015;
- Strategic Policy and Key Directions for Mental Health in Western Australia 2011-2020 (yet to be published)
- WA Health Network Policies and Models of Care (various);
- WA Health, Greening Health, Building and Renovations;
- WA Health Telehealth Strategic Direction (yet to be published);
- WACHS Strategic Plan, Revitalising Country Health Service 2009-2012;
- Operational Plan 2010/11 WA Country Health Service;
- Primary Health Reform in Country WA 2010 - 2012;
- Aboriginal Employment Strategy 2010 – 2014;
- WACHS Mental Health Strategic Directions (2010); and
- WACHS ICT Strategy (yet to be published).

A description of each of these policies is provided in the following pages.

## 2 COMMONWEALTH GOVERNMENT POLICY

### 2.1 National Health Reform Agreement

In April 2010, the Council of Australian Governments (COAG), with the exception of Western Australia, agreed to a range of health reform initiatives to be implemented under the National Health and Hospitals Network (NHHN). In February 2011, COAG agreed to a revised range of initiatives to be implemented under the National Health Reform Agreement.

The revised range of initiatives, as documented in the paper 'Heads of Agreement – National Health Reform' were agreed to by all parties and will form the basis of negotiations leading to a new National Health Reform Agreement to be developed and signed by the parties by 1 July 2011.

The key aim of the National Health Reform Agreement is to deliver a nationally unified and locally controlled health system that will ensure future generations of Australians enjoy world class, universally accessible health care through:

- introducing new financial arrangements for the Commonwealth and States to share equally the costs of growth in the public health system;
- confirming the State's role as system managers for public hospital services including:
  - system-wide public hospital service planning and performance,
  - purchasing of public hospital services,
  - planning, funding and delivering capital, and
  - planning, funding (with the Commonwealth) and delivering teaching, research and training;
- confirming the State's lead role in public health;
- acknowledging the Commonwealth's lead role in delivering primary health care reform to enable patients to receive the care they need when and where they need it – and in doing so, take pressure off public hospitals; and
- affirming the Medicare principles, high level service delivery principles and objectives, outcomes, outputs and measures agreed by COAG in 2008.

The following key principles underpinning the implementation of the reform are supported in delivering WACHS services to rural and remote areas:

- an effective health system that meets the health needs of the community requires coordination between hospital care, GP and primary health care and aged care to minimise service duplication and fragmentation;
- Australians should be able to access transparent and nationally comparable performance data and information on hospitals, GPs and primary care, aged care services and other health services;
- governments should continue to support diversity and innovation in the health system, as a crucial mechanism to achieve better outcomes;

- these reforms should be delivered with no net increase in bureaucracy across Commonwealth and state and territory governments, as a proportion of the ongoing health workforce;
- all Australians should have equitable access to high quality health care, including those living in regional and remote areas; and
- Australia's health system should promote social inclusion and reduce disadvantage, especially for Aboriginal Australians.

The 'Heads of Agreement – National Health Reform can be viewed at: [http://www.coag.gov.au/coag\\_meeting\\_outcomes/2011-02-13/index.cfm?CFID=1346501&CFTOKEN=10935147](http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/index.cfm?CFID=1346501&CFTOKEN=10935147)

## 2.2

### Council of Australian Governments (COAG) National Indigenous Reform Agreement

In 2008 the Council of Australian Governments (COAG) agreed to a National Indigenous Reform Agreement, focussing on six key targets, as outlined in the figure below. In order to meet these targets, Federal and State governments have developed a number of National Partnership Agreements to provide joint funding for specific programs.

Figure: Council of Australian Governments National Indigenous Reform Agreement



Source: Department of Indigenous Affairs

## **2.3 National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013**

In 2003 the Commonwealth Government released a strategic framework for Indigenous health to 2013 with the following three aims:

- increase life expectancy to a level comparable with non-Indigenous Australians;
- decrease mortality rates in the first year of life and decrease infant morbidity; and
- strengthen the service infrastructure essential to improving access by Aboriginal and Torres Strait Islander peoples to health services.

Following a 2006 progress report, the Commonwealth Department of Health and Ageing, developed the 'Australian Government Implementation Plan (2007-2013)' which identified the following priority areas of focus:

- smoking, nutrition, alcohol, physical activity, overweight and obesity;
- chronic disease management (including uptake of Medicare health checks);
- access to primary health care (including mainstream GPs) and secondary/tertiary care;
- sexually transmissible infections (including HIV) and blood borne viruses;
- oral health;
- social and emotional well-being (including substance use and mental health);
- urban areas (accessibility, appropriateness and affordability of health services); and
- health determinants – education, employment, economic development, housing and environmental conditions

## **3 WA HEALTH POLICIES**

### **3.1 Health Activity Purchasing Intentions 2010-2011**

WA Health has embarked on an Activity Based Funding (ABF) and Activity Based Management (ABM) reform agenda. This programme will be implemented over the next three years.

ABF means that health services will be funded based on expected activity

ABF is the approach that WA Health and WACHS will use to link planning, budgeting and funding allocations, plus manage future activity and the provision of financial resources to meet future real health need.

### 3.2 WA Health Clinical Services Framework 2010-2020

Service and facility planning should align with the new *WA Health Clinical Services Framework 2010-2020* and the latest demand modelling that underpins and informs the Framework which projects future demand based on ABS Series B+ population projections. The framework:

- describes the role delineation for metropolitan and WACHS hospitals (excluding WACHS small hospitals);
- defines the projected bed numbers for metropolitan and WACHS hospitals to 2021 (excluding WACHS small hospitals); and
- outlines additional National, State and bi-lateral policies pertinent to service and facility planning in WA.

The Framework clearly defines the role delineation of services to be delivered at WACHS regional resource centres and integrated district hospitals. The services to be delivered at small hospitals are not included in the Framework.

### 3.3 WA Health Networks

Health Networks in WA were established after a major review of health services in 2003 with the aim of enabling a new focus across all clinical disciplines towards prevention of illness and injury and maintenance of health.

The major functions of Health Networks are to plan and develop:

- Models of Care;
- evidence based policy and practice;
- statewide clinical governance;
- transformational leadership and engagement; and
- strategic partnerships.

The Models of Care provide the potential to bring about vast improvements in the support available to clinicians and specialists and in the coordination of patient treatment across the State and within regional areas.

Network membership is drawn from key stakeholders and clinical experts from within Western Australia. WACHS, including the representatives from the regional areas, is actively involved in the establishment of these clinical networks (refer to <http://www.healthnetworks.health.wa.gov.au/home/> for an outline of the key networks and current models of care).

### 3.4 WA Health Strategic Intent 2010-2015

The WA Health Strategic Intent document outlines the vision, mission and values for WA Health and WACHS. The Strategic Intent aims to improve, promote and protect the health of Western Australians by:

- Caring for individuals and the community;
- Caring for those who need it most;
- Making best use of funds and resources; and
- Supporting our team.

Refer to: <http://www.health.wa.gov.au/about/strategicintent.cfm>



### 3.5 Strategic Policy and Key Directions for Mental Health in Western Australia 2011-2020 (under development)

The WA Mental Health Commission was established in March 2010 as a separate department of State reporting to the Minister for Mental Health. This model, the first of its kind in Australia, enables the Commission to have both the mandate and the resources to lead reforms of the mental health system throughout the State.

In 2011, the Mental Health Commission will be launching its first strategic document, '*Strategic Policy and Key Directions for Mental Health in Western Australia 2011-2020*'. This document, which will outline the future intentions for mental health reform in WA, is based on a process of consultation with the community and key stakeholders, along with feedback received on the draft WA mental health policy '*WA Mental Health Towards 2020*' (distributed for feedback in July 2010).

This draft policy outlines nine key reform areas which are matched to 25 actions that will drive the reform of mental health service delivery and lead to better mental health outcomes in WA. The key reform areas are:

- Consumer focused;
- Recovery focused and holistic;
- Appropriate and accessible;
- Integrated and continuous;
- Prevention and early intervention focused;
- Mental health workforce;
- Leadership and governance;
- Building resilient communities; and
- Social inclusion and equality for people with mental illness.

### 3.6 WA Health, Greening Health, Building and Renovations, (2010)

WA Health is committed to developing health services and capital projects in the most environmentally safe and energy efficient way to assist to address climate change issues and support actions to reduce health's environmental footprint. This includes a focus on how hospital waste is managed, general recycling, strategies for sustainable procurement and using best practice research to develop 'healthy hospitals, health planet and healthy people'.

WA health employees can view additional information on the WA Health Intranet site: [http://greeninghealth/1/31/2/building\\_and\\_renovations.pm](http://greeninghealth/1/31/2/building_and_renovations.pm)

The World Health Organisation (WHO) website contains more information. Refer to:

[http://www.who.int/globalchange/publications/healthcare\\_settings/en/index.html](http://www.who.int/globalchange/publications/healthcare_settings/en/index.html)



WACHS is finalising the strategic directions for a Statewide Telehealth service. The aim is to provide patient care that links smaller hospitals, health services, Integrated District Health Campuses and Regional Health Campuses (or 'hub' hospitals) across the regions/districts and to other health services. This would include electronic linkages to tertiary hospital outpatient and emergency departments, pre-admission clinics and other service providers, such as the Royal Flying Doctor Service or the St John Ambulance service.

The fully operational Telehealth service will improve patient access to care, reduce patient waiting times for treatment, reduce the costs of providing treatment, dramatically reduce patient travel times for outpatient care, reduce rural and remote health service staff 'road' travelling time and optimally provide the enabling technology to ensure 24/7 critical medical/clinical advice and support is provided to small rural and remote settings when it is needed in real time.

A Telehealth service will also be used for staff training, professional supervision and to reduce staff road travel time to attend a range of corporate and administrative meetings.

A key component of a Telehealth service will include supporting health service staff through the workplace and workforce changes required to introduce the new technology/systems.

Any Telehealth service will include 'state of the art' Telehealth equipment and expertise including electronic booking systems and patient to clinician linkage/communication systems. Examples of equipment could include:

- mobile telehealth units designed and purpose built to be used at the patient bedside, known as practitioner carts. They can include a high definition telehealth video system, digital stethoscope, electronic sphygmomanometer and image sharing. A range of peripheral medical devices such as scopes can be added if/as required. This 'practitioner cart' technology will be used to conduct a 'ward round' moving from patient to patient. It can also provide long distance patient monitoring for critically ill patients, with a specialist providing support and guidance via telehealth technology to the clinician at the bedside.
- Videoconference technology for 1:1 clinical consultations between clinicians and patients in Ambulatory Health Care facilities. Specialists from tertiary facilities or in other parts of the region will be able to provide support and guidance via telehealth technology to the clinician with the patient.
- Videoconference machines, that are fixed units, will provide high definition two way audio and video transmission. This will mean that multiple sites can be connected together or multiple sites could present and transmit to up to 30 multiple venues at one time. Multidisciplinary clinical case reviews will be conducted using this videoconference technology allowing for professional groups across multiple sites to participate in clinical review.
- Education and training sessions will be delivered to rural sites using videoconference technology. These will be delivered from specialist or tertiary facilities to training rooms and lecture theatres in the remote rural settings. By use of data projection in these facilities, in the rural

setting, interactive real time large screen presentations and education sessions will be conducted.

- Telehealth technology may be used to provide electronic patient monitoring direct from the patients home to the health service.

## 4 WACHS POLICIES

### 4.1 Revitalising WA Country Health Service (2009-2012)

The Strategic Plan outlines four revitalising directions that will underpin how WACHS will seek to improve the health of country Western Australians over the next three years. The revitalising directions include:

1. **A fair share for country health.** Securing a fair share of resources and being accountable for their use.
2. **Service delivery according to need.** Improving service access based on need and improving health outcomes.
3. **'Closing the Gap' to improve Aboriginal health.** Improving the health of Aboriginal people.
4. **Workforce Stability and Excellence.** Building a skilled workforce and a safe and supportive workplace.

The initiatives proposed in WACHS regional and district service plans align with these proposed these four directions. The strategic plan can be viewed at:

<http://www.wacountry.health.wa.gov.au/uploaddocs/booklet%20final.pdf>

### 4.2 Operational Plan 2010/11 WA Country Health Service

Building on the *Revitalising WA Country Health Service 2009-2012* and other WACHS strategic planning documents, this operational plan provides a summary of the 13 Revitalising prioritised actions/projects, plus five additional organisational priorities.

The Operational plan identifies the project sponsor and support for each action.

#### Operational Plan Revitalising Prioritised Actions

1. Improve services to Aboriginal communities and boost Aboriginal employment opportunities.
2. Strengthen and improve access to ED services.
3. Revitalise community and stakeholder partnerships and communication.
4. Introduce new models of care that improve services and the health and well being of country people.
5. Link alcohol , drug and mental health services and strengthen prevention and mental health promotion.
6. Work with communities so that health and hospital services match health needs.
7. Improve access of communities in rural and remote WA to primary health care services.
8. Improve country aged care services.

Operational Plan Revitalising Prioritised Actions
9. Develop a financial resource model to improve funding of country health services. 10. Develop a secure electronic clinical information system, Telehealth and e-health. 11. Stabilise and skill the workforce , and provide a safe and supportive workplace. 12. Establish the WA Centre for Country Health Service Research and Education. 13. Develop the WACHS permanent employees housing accommodation strategy.
Additional Organisational Priorities
1. Implement pharmacy reform. 2. Improve patient safety and quality. 3. Strengthen financial management, information and reporting. 4. Develop and implement a WACHS strategic information management plan. 5. Progress priority capital developments and the service plans that inform them, and capital transition plans.

### 4.3 Primary Health Reform in Country WA 2010-2012

The draft document, *Primary Health Reform in Country WA 2010-2012*, outlines a proposal to reform the way in which primary health care services are funded and delivered in rural and remote WA.

The paper reports that the current models of funding and delivering primary health care services are failing rural and remote communities, leading to poorer health outcomes, extensive service inefficiency and fragmentation, ineffective use of public hospitals and inadequate funding for primary health care. New approaches are therefore required that address the barriers of multiple funders and providers and increase primary health care resources in communities where they are most needed.

A six-point Country Primary Health Plan, consistent with the intentions outlined in the National Health and Hospital Reform Commission, has been developed. The Plan, outlined below, is based on joint funding, evidence based regional planning, multi-disciplinary teams providing coordinated services across the care continuum and improved community to hospital linkage and care.

Six Point Country Primary Health Plan:

- Two different regional funding models for the north and south of the State.
- A strong governance and engagement framework.
- Workforce development and reform.
- Integrated service models suited to regional needs.
- Better use of technology and E-health.
- Addressing six key health priorities through primary health care. The six health priorities are maternal and child health; chronic disease primary mental health; communicable disease; environmental health; dental health and aged care.

#### 4.4 Aboriginal Employment Strategy 2010-2014

Developed to deliver the vision for Aboriginal health in the WACHS, the *Aboriginal Employment Strategy 2010 – 2014* works to ‘improve health outcomes for Aboriginal people by providing culturally respectful and competent services throughout the WACHS’.

Employment of Aboriginal people in the health sector is seen as a key way to deliver this vision, providing not just work for Aboriginal people, but also other benefits that include improvements in individual’s and the broader Aboriginal communities sense of self esteem and worth, plus improve Aboriginal peoples access to health services by assisting to bridge the cultural differences between Aboriginal people and the mainstream health service.

Five priority areas for action have been identified.

1. Increase employment opportunities to attract and retain Aboriginal staff, including the shaping of an Aboriginal health workforce profile across all professions, occupations and regions to one that better matches that of the Aboriginal client group.
2. Focus on workforce skill development to include a variety of skill level entry points for Aboriginal employees and opportunity for Aboriginal employees to develop new skills through professional training and leadership development.
3. Develop a workforce culture and environment that supports the employment and retention of Aboriginal people by developing a workplace culture that is culturally respectful and secure for Aboriginal employees.
4. Redesign the workforce to enable employment and new work roles by developing new roles and workplace design.
5. Plan for workforce needs and evaluation of initiatives by ensuring all workforce strategies are evidence based and best practice.

To measure the effectiveness of this strategy WACHS will:

- see an increase in the number of Aboriginal people employed by 2014;
- see an increase in the number of Aboriginal people employed across all occupational groups;
- see an increase in the tenure of employment of Aboriginal people within WACHS;
- have an Aboriginal employment and career development strategy in all regions; and
- implement a WA Health Aboriginal and Midwifery Strategy across WA.

#### 4.5 WACHS Mental Health Strategic Directions (2010)

This paper is seen as an initial stage in the alignment of the State and National mental health services planning across the WACHS, projecting strategies to be developed out to 2020. The paper identifies the key priorities areas for service development, focussing on the continuum of care. Key priorities have been developed for immediate, short term and longer term actions and include:

### **Immediate (2010 - 2011)**

- commence development of comprehensive mental health service regional planning that aligns with the 4<sup>th</sup> National Mental Health Plan;
- commence planning for Statewide Clinical Services Enhancement Programme (SCSEP) to support service development;
- establish an Aboriginal mental health service;
- develop a policy direction for dual diagnosis patients; and
- commence mental health workforce planning for the Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS).

### **Intermediate (2011- 2013)**

- development of a comprehensive mental health workforce plan;
- evaluate older adult sub-acute programme to inform the development of older adult mental health programme to 2020;
- implement service models for emergency mental health services
- develop service models for rehabilitation and early intervention services
- improve the utilisation of mental health data in planning

### **Long Term (2013 onwards)**

- implement previously developed MH Strategic plans for ICAYMHS, older adult mental health services, rehabilitation, early intervention and SCSE; and
- implement WACHS specific mental health research.

## **4.6 WACHS ICT Strategy (awaiting endorsement)**

WACHS has developed its ICT strategy following extensive consultation with users of information and communications technology systems. Future service delivery models and facility design will need to take into account the emerging technologies and the strategic ICT directions as these are a key enabler of service delivery.

The key objectives of the ICT strategy are:


1. Align ICT systems and infrastructure with WACHS clinical and business needs
2. To improve the ICT function with regional health care at their base

In general WACHS is planning for wireless and Local Area Network (LAN) systems connected to new fibre optic communications systems. The ICT system across WACHS will be capable of transmitting CT scans and other test results to a tertiary ICU 'hub' facility and maintain the integrity of the high quality images.

Video conferencing facilities will be provided and require ISDN lines and connection to the LAN.

Dual flat screen computers will be provided in the acute clinical areas to access Picture Archiving and Communication System (PACS) images.





Personal Computers (PCs) will continue to be provided in ergonomically designed office areas. Efforts will be made to maximise both flexible work options and maximum capacity for desk top cabling. Over time, all offices will have flat screens for computers.

#### Data Linkage

Outcome data and statistical data will need to be exported to tertiary 'hub' facilities and regional centres using the WA Health Morbidity System as well as other State registers and data collection systems.

#### Health Information Network

The WA Health Department's Health Information Network (HIN) must be involved in all ICT planning for any capital planning project across WACHS. This will include HIN preparing a project needs analysis that will be considered as part of the facility planning for any project.

## **5 SERVICE PLANNING IMPLICATIONS**

All WACHS regional and district service plans will need to assess the implications of the above policies to local planning. Specifically, service planning should:

- Determine the overall service delivery models for clinical services at each site in line with their role delineation as described in the *WA Health Clinical Services Framework 2010 - 2020*.
- Consider the development of Activity Based Funding management strategies.
- Align service planning and facility planning with the four directions of the *WACHS Revitalising Country Health Service (2009 – 2012)* Strategic Plan (2009) and other strategic policies outlined in this document.
- Promote the development of culturally appropriate service delivery models.
- Promote coordination between hospital care, GP, primary health care, mental health care and aged care to facilitate the provision of a seamless continuum of care where service duplication and fragmentation are avoided.
- Develop and facilitate strategic and service delivery partnerships.
- Considers the development of ambulatory care services, illness prevention and health promotion strategies to address local health needs and issues.
- Focus on workforce development and reform, including strategies for increasing Aboriginal workforce participation.
- Focus on improving the health status and access to services for local Aboriginal people and disadvantaged groups.
- Consider the use of Telehealth and e-health technologies for service delivery, specialist consultation and advice, and education and peer support.
- Ensure planning considers the directions highlighted in the WACHS ICT Strategy.