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

Midwest Health District Services Plan

2013 - 2023

To be completed by the Regional Director
I certify that the Service Plan has been developed to my satisfaction, and that all project deliverables/requirements have been stated within the document.
Signed M Denton Date: 04/06/2014
Print Name: Margaret Denton
Position: Regional Director, WACHS - Midwest Health Region

To be completed by the Chief Operations Officer - WACHS Northern
I certify that the Service Plan has been developed to my satisfaction, and that all project deliverables/requirements have been stated within the document.
Signed Date: 06/08/2014
Print Name: Shane Matthews
Position: Chief Operating Officer - Northern, WACHS

To be completed by the Chief Executive Officer, WACHS
I certify that the Service Plan has been developed to my satisfaction, and that all project deliverables/requirements have been stated within the document.
Signed Date: 19/1/15.
Print Name: Jeffrey Moffet
Position: Chief Executive Officer, WACHS

CONTENTS

Executive Summary

This Service Plan provides the strategic direction for service delivery for the Western Australian Country Health Service's (WACHS) Midwest Health District for the next five to ten years. It also informs the implementation plan for the State Government's $565 million Southern Inland Health Initiative (SIHI). The Service Plan was developed via a comprehensive planning process as detailed in Appendix A.

The service planning process in the Midwest Health District has identified a number of opportunities to strengthen service delivery to meet the future needs of its population. It is essential that this service plan is reviewed if facility planning progresses, new policies are introduced and the needs of the community change, for example in response to the Morawa SuperTown growth plan.

1.1 Strategic context

All planning in the WA Country Health Service (WACHS) occurs within a national and state policy context and in a multifaceted funding context.

The Australian health system encompasses public, non government and private service providers including medical practitioners, nurses, allied health and other health professionals, and services within hospitals, clinics, and government and non-government agencies. 'Health' is a complex system supported by a range of legislative, regulatory and funding arrangements, which involves three levels of government, non-government organisations, health insurers and individual Australians (refer to Diagram 1).

Diagram 1: Australian health care funding and responsibilities

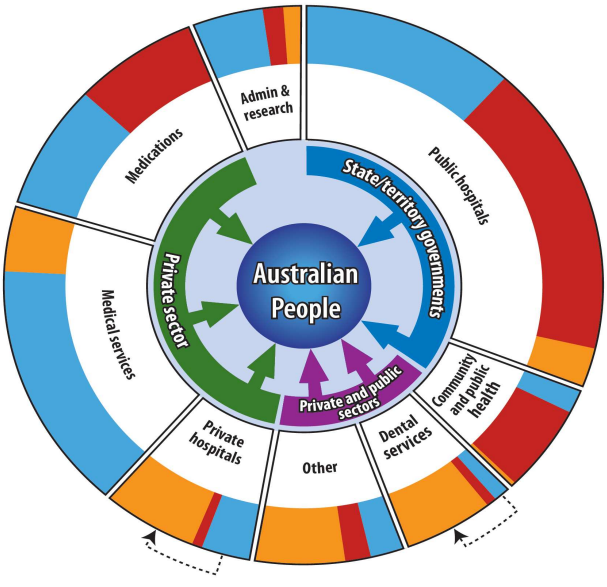


Figure 1.4: Health services—funding and responsibility

Source: Australia's Health 2012, Australian Institute of Health and Welfare (AIHW)
Note: Excludes the Aged Care Sector which is categorised 'welfare' by AIHW.
Community and Residential aged care services are funded primarily by the Commonwealth and provided by either the public system (e.g. WACHS) or private or non government providers.

The Commonwealth Government is the largest contributor to health funding primarily through the two national subsidy schemes, the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). The Australian Government and state and territory governments also jointly fund public hospital services through the National Health Care Agreement.

Individual community members fund 17 per cent of the total funding (in 2009–10), with private health insurers contributing eight per cent, and accident compensation schemes contributing further five per cent toward health funding.

The formal 'aged care system' (Residential aged care and Home and Community Care services) are funded and regulated by the Australian Commonwealth Government.

Aged care delivery (both community and residential) is provided by a range of not-for-profit (religious, charitable and community groups), private sector operators as well as state, territory and local governments (Caring for Older Australians, 2011). The not-for-profit sector delivers approximately 65% of the county's residential aged care services, with the balance provided by the private sector and governments (Health Directory Australia). There is also significant capital investment by both private, local government and not-for-profit sectors.

Additionally the contribution by family members, carers and community organisations in caring for older people cannot be overlooked.

1.2 Local planning context

The WACHS Midwest Health Region has historically been split into four operational health districts, the Gascoyne, Murchison, Midwest and Greater Geraldton Health Districts. For Health Service Planning purposes the Midwest Health District refers to the Shires of Northampton, Irwin, Coorow, Perenjori, Morawa, Three Springs, Carnamah, Chapman Valley, Murchison and Mingenew, and Mullewa (which is now included as part of the City of Greater Geraldton). The plan also considers the services located in Geraldton that support the Midwest Health District catchment.

1.3 Key catchment area features influencing service delivery

Population growth

The Midwest Health District had a resident population of 12,984 people according to the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) 2012 compared with 12,385 in 2006, a growth of 4 percent over this period. Note this population does not include Mullewa which is now classed as part of Greater Geraldton. Its population decreased from 982 in 2006 to 729 in 2011. The greatest growth occurred within the Shire of Perenjori (928 people, 64 percent growth from 2006 - ERP 2012). By 2026 the Midwest Health District population is estimated to grow to 15,786 people (WA State Government population projection 2014) with the majority of the growth expected in Irwin, followed by Northampton. Additionally, within the Morawa Shire, Morawa's designation and future development as a 'SuperTown' under the Department of Regional Development and Lands funded through 'Royalties for Regions' will need to be monitored to determine impact on population growth.

Health status

Data from the WA Health and Wellbeing Surveillance System has highlighted a number of modifiable risk factors within the Midwest that impact on health status. The Midwest Health District area has a significantly higher prevalence of smoking, high blood pressure and high cholesterol than the State (Department of Health WA 2012). While other risk factors may not be significantly different to the State these are still important given they are modifiable risk factors for chronic conditions. The Midwest Health District has a significantly lower level of reported psychological distress than the State.

Mortality

Mortality data for the Midwest Health District and region highlights:

- Between 2006 and 2010, the leading cause of death in the Midwest Health District was cancer, followed by diseases of the circulatory system and injury and poisoning.
- Between 2006 and 2010, 51% of Midwest resident deaths under the age of 75 were classified as avoidable. Cancers and chronic conditions accounted for the majority of avoidable deaths including ischaemic heart disease, lung cancer and diabetes.

Hospitalisations

Hospitalisation data for the Midwest Health District and region highlights that between 2007 and 2011:

- Midwest Health District residents had a significantly lower hospitalisation rate when compared to all WA residents.
- The leading cause of hospitalisation of Midwest Health District residents was for renal dialysis followed by diseases of the digestive system.
- Many hospitalisations result from conditions where hospitalisations could potentially be prevented by the use of preventive care and early disease management. Overall, Midwest Health District residents had a significantly lower rate of potentially preventable hospitalisations compared with the State (Department of Health WA 2014). These differences may highlight differences in health need, but also disparities in access to hospitals. However, Non Aboriginal hospitalisations for chronic obstructive pulmonary disease, heart failure and dental conditions were significantly higher than the state rate.

Primary Health Care

Research shows that health systems with strong primary health care services are more efficient; have lower rates of hospitalisation; fewer health inequalities; and better health outcomes including lower mortality, than those that do not. For this reason, a key feature of this service plan is to boost primary health care services.

Almost nine in ten Midwest residents utilise primary health care services each year. This provides opportunities for both health promotion and early intervention initiatives. The focus should be on reducing the modifiable risk factors and responding to the range of identified priority needs of the people in the district: chronic disease, mental health, health care for older people, maternal, child and youth health, Aboriginal health, and oral/dental health.

Rural location

Given the rural location of the Midwest Health District, there are opportunities to utilise Telehealth technologies and new workforce models for care provision, professional supervision and to provide care closer to home.

Ageing population

The proportion and numbers of people in the Midwest Health District that are ageing are increasing, which will place added pressures on public, private and non government sectors to provide primary health care services to manage chronic health conditions and co-morbidities. Demand for specialised dementia and high care aged care community packages and residential services are also likely to increase.

Aboriginal people

Aboriginal people are over represented in both death and hospitalisation statistics. This indicates the importance of providing culturally secure health care specific to the conditions and risk factors experienced by Aboriginal people.

1.4 Current Midwest Health District Health Service Profile

The population health, inpatient, residential aged care and 24/7 emergency response services in the Midwest Health District are provided by WACHS via the multi-purpose service sites (MPSs), at Dongara, Morawa, Three Springs, Mullewa, Northampton and Kalbarri (WACHS small hospitals). The Morawa MPS also takes in Perenjori where a health centre is located.

The WACHS services are supported by local private General Practitioners (GPs), government and not for profit agencies, and other private providers (refer to Appendix G for more detail on health partners).

There is a network of health providers servicing the Midwest Health District who provide health services for the residents of and visitors to the Midwest Health District, delivering services throughout the catchment area, and referring patients where necessary to larger hospitals primarily in Perth and Geraldton.

1.5 Strategic directions for service delivery

A review of current government policies, quality standards, state government commitments, drivers for change and stakeholder expectations within the Midwest Health District has identified the following strategic directions for service delivery for the Midwest Health District.

Collectively these will improve the consumer experience of quality health care and services:

- strengthen partnerships between WACHS and primary care, private and not-for-profit providers
- engage consumers in service planning and implementation of service improvements and reforms
- improve the integration of services and providers across the care continuum
- implement coordinated case management for people with complex health needs

- improve access to primary health care, chronic disease prevention and self-management
- increase access to mental health and drug and alcohol services
- deliver care closer to home where safe and viable
- improve Aboriginal service access, cultural security of services and health outcomes
- improve services to older people, particularly in the community
- attract and retain a skilled workforce and enhance workforce capacity
- utilise ICT advancements for better care, including Telehealth; and
- create a safer environment for all.

1.6 Service Reform priorities for the WACHS Midwest Health District

Workforce

The challenges of recruiting and retaining appropriate health staff within the Midwest Health District are ongoing and recognised throughout this service plan. Workforce planning, staff recruitment, retention, training and ongoing development is therefore a significant priority for reform in the area. Specific reform priorities are detailed below.

- Consider opportunities to encourage a public/private mix of health service providers and to have funding, service and resource partnerships; supporting the establishment of services may be required (e.g. provision of free low cost facilities from which to provide services, provision of low cost housing options, shared training opportunities, use of technology etc)
- Support a sustainable and safe GP led 24/7 emergency model and roster across the district and increase access to out of hours medical on call models.
- Where practical, expand the call out roster to a larger group of GPs.
- The Midwest Region and district to work with in partnership with GP practices and SIHI to maximise the incentives under SIHI Stream One, thereby enhancing GP primary care and improving medical coverage.
- Progress implementation of the Emergency Telehealth Service at all small hospitals subject to funding.
- Implement Scopia into specialist rooms at Geraldton Hospital
- Explore potential to employ an ED Nurse Practitioner for the Midwest and Murchison Health Districts located in Geraldton to provide advanced emergency nursing care and clinical up-skilling to nursing staff across the districts.
- Continue online options such as e-training or using Telehealth/Scopia for workforce training to maintain staff competencies while reducing travel.
- Investigate opportunities to share training opportunities between local health providers, which could also improve cross-agency partnerships,

but may need to address some concerns around differences in clinical governance between agencies.

- Implement a system of professional supervision, mentoring and online training.
- Engage in a leadership development program.
- Introduce staff development portfolio roles at each district site.
- Implement succession planning to build career pathways for staff and graduates.
- Develop partnerships with shires to improve accommodation options.
- Explore opportunities for utilising semi-retired health professionals, particularly for Telehealth consultations, which may reduce waiting times and workload for the limited number of GPs available in the area.

Community Awareness of Services

- Use of a wide variety of media to promote awareness and efficacy of services for both providers and the community by:
    - enhancing communication between service providers
    - ensuring accurate information is available through a range of media; and
    - increasing interagency communication and exchange of information, including liaison with the GMML who are contributing local information to the production of a National directory of health services

Service Partnerships

- Work with the metropolitan area hospitals, outpatient clinics and Geraldton Hospital to improve case management, care coordination, appointment and discharge planning for Midwest Health District residents, particularly those with complex needs and who are elderly or more vulnerable and who are receiving inpatient care in the metropolitan area or at the Regional Resource Centre. This should include:
    - improving communication,
    - documentation,
    - electronic medical record sharing,
    - boundary issues; and
    - day of discharge decisions.
- Increase case management and care coordination, particularly focusing on people with complex and co-morbid mental health and alcohol and drug or other chronic physical health issues. This can be achieved by developing agreements between the NGO sector and coordinators of the WACHS chronic conditions projects. For example accessing the Commonwealth Better Health Improvement Program funds to support service improvement initiatives for people with chronic conditions and their carers.

- Establish a Midwest Health District interagency forum similar to the Murchison District interagency forum that meets in rotating locations across the District. This group could enable more partnerships and coordination and confirm which group is responsible for different aspects of health and related service provision (e.g. State health, local government authorities, private GP's, other service agencies and /or the community).
- Work with the Goldfields Midwest Medicare Local (GMML) to address limitations in service provision for domiciliary post-acute care and primary health care.

Explore opportunities to provide greater access to Ambulatory, Population and Primary Health

- The demographics and review of current service levels across the Midwest Health District indicates that Mullewa is a priority location for re orientation of the health service site from acute to primary care. This will enhance access to health promotion, primary health, child, maternal and community health, and mental health and drug and alcohol services over the next few years to help close the gap in health outcomes for the local Aboriginal population.
- SIHI stream one will enhance primary care (GP) services to better support the emergency models and increase primary care access for communities.
- Explore medical governance models and admitting rights to the MPS sites via Geraldton ED doctors using Telehealth or the WACHS Emergency Telehealth Service or via a proposed District wide Nurse Practitioner and Telehealth.
- There will be a steadily growing need to increase access to primary health services across the district, aligned with local needs and population growth. The priority primary health services include:
    - chronic disease self management,
    - revision of the model of care for chronic disease monitoring including the potential use of I pad/pod apps for chronic disease management
    - additional allied health to enhance home visiting capacity for elderly clients
    - mental health and drug and alcohol health promotion and general health promotion; and
    - antenatal and postnatal care, including mothers groups.

Priority localities are Dongara, Mullewa and Morawa Perenjori

- There is an opportunity to better coordinate targeted immunisation for vulnerable groups, older people, workers, health workers in discussion with the Goldfields-Midwest Medicare Local (GMML) and Geraldton Regional Aboriginal Medical Service (GRAMS). For example, the Medicare Local may focus on the 'mainstream' population, while

population health and GRAMS may focus on engaging vulnerable groups.

- Explore opportunities to increase allied health and domiciliary post-acute care services, given the limited existing services and projected growth in the number and proportion of older people. Potential avenues for increasing services include funding new and existing service providers in the private/NGO sectors (such as Medicare Local funding and other Commonwealth funding opportunities).
- Advocate for increased access to public and private dental services. This should be considered from a WACHS and Midwest regional perspective in conjunction with the public Dental Health Services (DHS), targeting low income groups, Aboriginal people and the elderly.

Care for Older People

- Advocate for:
    - equitable access to extended community aged care packages and high care beds based on population need with incentives to encourage local non government and private residential and community aged care package providers
    - increased access to respite care either through MWCRCC in home respite, or private aged care provider
    - implement the Midwest Aged Care Action Plan; and
    - regional or Midwest/Murchison/Geraldton model/network of Aged Care ('Ageing in Place') in collaboration with the Midwest Development Commission.
- Increase access to Geriatrician and Psycho-geriatrician, through visiting or Telehealth consultations, particularly for Irwin and Northampton Shires.
- Support local Shires to explore independent living options for older people in the area. 'Independent living options' includes both ageing in place within the home, and moving to supported well aged housing.
- Continue with provision of HACC services.
- Ensure older residents and HACC eligible clients are supported to access regular physical health, podiatry and oral health reviews as part of care planning.

Mental Health and Drug and Alcohol Services

- In alignment with the WACHS '*Mental Health Service Plan 2013-2015*' and '*Towards Healthier Country Communities 2013-2015*' explore collaborative arrangements to improve integration of mental health and drug and alcohol services (including collocations, mergers, shared care protocols and case management) particularly for younger, older, and Aboriginal people.
- Increase access to and awareness of mental health services provided by WACHS and non-government providers, including older mental health services (e.g. services for those experiencing, dementia, depression,

grief and loss), by using a variety of health promotion measures including media.

- Improve case management and integration of care for clients with mental health conditions including drug and alcohol issues, with particular focus on supporting the Aboriginal population in Mullewa.
- Review access and referral and discharge processes to community mental health services for the Midwest Health District to ensure those in most need have access to care and for continuity of care.
- Continue to liaise and advocate with metropolitan services to improve communication flows to the community mental health team so they can provide follow-up and support locally.
- Continue the weekly VC for clients receiving treatment and pending discharge at Graylands Hospital between the Graylands clinical team and the adult team in Geraldton.
- Implement primary mental health services, including child, adolescent and youth mental health promotion.
- Increase access to psychiatrists and psycho-geriatrician consults (including through the use of Telehealth consultation).
- Develop service linkages with the proposed Geraldton APU; this will assist in improving access to acute care and discharge planning for mental health patients.

Services for Aboriginal People

- Ensure all health and hospital services across the continuum of care are welcoming, culturally aware, secure and sensitive to the needs of clients from Aboriginal families. This would be enhanced by:
    - Coordination of services with GMML
    - Improving the Aboriginal workforce via increased opportunities for employment & traineeships, advertisements, and lower level entry as per the WACHS Aboriginal Employment Strategy 2010-2014,
    - Improving Aboriginal community engagement
    - Improving Aboriginal client transport
    - Mandatory comprehensive cultural security training
- Develop additional engagement strategies to support Aboriginal clients to access health services, for example use of community development approaches address the social determinants of health.

Telehealth

- Telehealth needs to be better promoted and used.
- Increase telehealth resources and training for both specialists and the local staff who meet the patient and prepare them for their consultation.
- The priority services for increased Telehealth for Midwest Health District residents include:

        - emergency services (including access to the new ETS for all MPS sites)
        - mental health and alcohol and drug services
        - psycho-geriatrics and geriatrics
        - pain management, cancer care and palliative care
        - general physicians
    - Increasing opportunities to access ambulatory / primary health care type services via Telehealth should be raised and promoted at all Midwest Health District sites.
    - Seek funding for home based Scopia for patients
    - Consider the use of Telehealth for remote monitoring. Liaise with Silver Chain regarding their remote monitoring systems.
    - Increase the number of clinically appropriate Telehealth rooms.
    - Encourage the community to enquire about Telehealth consultation as an alternative to travelling to the metropolitan area.
    - Conduct an example Telehealth session so people can understand how Telehealth will work (e.g. with community groups such as Lions, CWA).
    - Ensure local GPs are aware of Telehealth including the Medicare incentives to claim for equipment and undertaking consultations using Telehealth.
    - Support WACHS wide initiatives to introduce e-health records, I Pads and Apps.

Information and Communication Technology (ICT)

- Sharing of information via the national roll out of the electronic health record between WA Country Health Services facilities/regions, and into metro and other providers would/will be of great benefit to consumers and professionals.
- Monitor the impact of electronic medical records and human resource systems as these systems are established.

Patient Transport

- Negotiate with Goldfield-Midwest Medicare Local to potentially fund transport
- Support the SJAA to lead the Midwest Development Commission, Gascoyne Development Commission and Local Government Authorities in the development of:
    - Volunteer patient transport across the Midwest District (referring to the successful Community Assisted Patient Transport model in Narrogin).
    - Funding options (Shire, Lotterywest, Bendigo Bank) for a ‘community car’ or local buses that could possibly be used with volunteer drivers.
    - Advocating for inclusion of dental services within PATS eligibility criteria

        - Dongara and Northampton non urgent patient transport as these sites are both outside of PATS eligibility criteria (exception Cancer and Dialysis patients)
        - Advocate SJAA to provide a salaried paramedic
        - Advocate for public transport services to Geraldton
    - Promote awareness of the pensioner $500 fuel card entitlement.
    - Also refer to Telehealth strategies detailed earlier, which can impact on the need for patient travel.

Facilities

The Service Plan will assist in informing the development of future business cases for the potential redevelopment of sites and services.

Funding has been allocated through Southern Inland Health Initiative (SIHI) to attract and retain Primary Health GP services in the district. Sustainable general practices in local towns then support sustainable on-call and medical coverage for emergency departments and MPS sites.

Future redevelopment of the Midwest Health District sites should align with the *Australasian Health Facility Guidelines* and various building codes and guidelines of Australia to ensure the facilities are contemporary and able to meet modern best practice models of care.

Specific priorities for reform are listed below. The facility requirements are more fully detailed in Section 6.

- Mullewa, Three Springs and Northampton are particularly older style small hospital sites. Mullewa is currently undertaking some remedial work within its residential and palliative care rooms. These small hospitals were designed to deliver acute inpatient care, however over time there is a growing need to change focus toward Primary Health Care service delivery. This would include provision of residential aged care, ambulatory care services and limited emergency care to align more closely with local needs.
- Few sites have dedicated clinical rooms outside of ED for Telehealth clinical outpatient consults. Most sites use a multipurpose meeting room for Telehealth consults which may have carpeted floors and no access to water and sinks resulting in possible infection control issues and lack of privacy for patients. See specific locations for site specific details.
- When funding becomes available for infrastructure development, facilities should be upgraded to contemporary standards to reduce occupational health and safety risks, to enable co-location of services and providers, support best practice models of care for rural health, and transitioned towards a Primary Health Care service model as outlined above.
- Suitable residential accommodation for health staff across the Midwest Health District.

The contents of this Service Plan detail how these priorities were established.

2 Introduction

This Service Plan focuses on the Midwest Health District catchment and is the outcome of extensive research and consultation with stakeholders by the Midwest Health District of the WACHS Midwest region.

It sets the strategic vision for health reform and service improvements over the next five to ten years and proposes strategies in relation to the delivery of emergency, acute, primary health and aged care and associated clinical and non-clinical services to residents of and visitors to the Midwest Health District area.

The directions and proposed strategies outlined in this Service Plan will enable the Midwest Health District to meet the needs of the local catchment area, improve efficiencies and effectiveness of patient care and ensure alignment with existing strategic directions and policies.

It is essential that this Service Plan is reviewed if and when facility planning progresses, National/State policies are introduced and the needs of the community change, for example if the planned increase in the Morawa population transpires as a result of its SuperTown growth plan.

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

The planning process undertaken to develop this Service Plan and the subsequent proposed strategies for service reform and improvements ensure that future service delivery to the Midwest Health District will:

- align with National and State policy and plans
- address the demographic and health needs of the community
- meet the projected demand for health services of local residents and visitors
- strengthen primary health care services
- deliver modern and best practice models of care
- utilise contemporary health technologies; and
- be supported by contemporary healthcare facilities.

The service planning process undertaken to develop this Service Plan is detailed in Appendix A.

3 Planning Context and Strategic Directions

This section provides an overview of the catchment area of the district, along with a description of the health status, demography and other factors that influence the health status of local residents. This information on the population's health needs informs the types and locations of services required in the area over the next ten years. Refer to Appendix B for a detailed health needs analysis of the district.

3.1 Overview of the Midwest Health Region

The Midwest region has a diverse geographic profile ranging from pristine beaches to vast agricultural and desert landscapes. The Midwest health region covers 603,449 square kilometres. The economy is based around agriculture, fishing, mining/gas, tourism and manufacturing, which are supported by the high availability of infrastructure such as water, transport and energy.

The Midwest Health Region extends from the west coast at Greenhead, to Exmouth in the north to 800 kilometres inland to Wiluna in the Gibson Desert (see Figure 1).

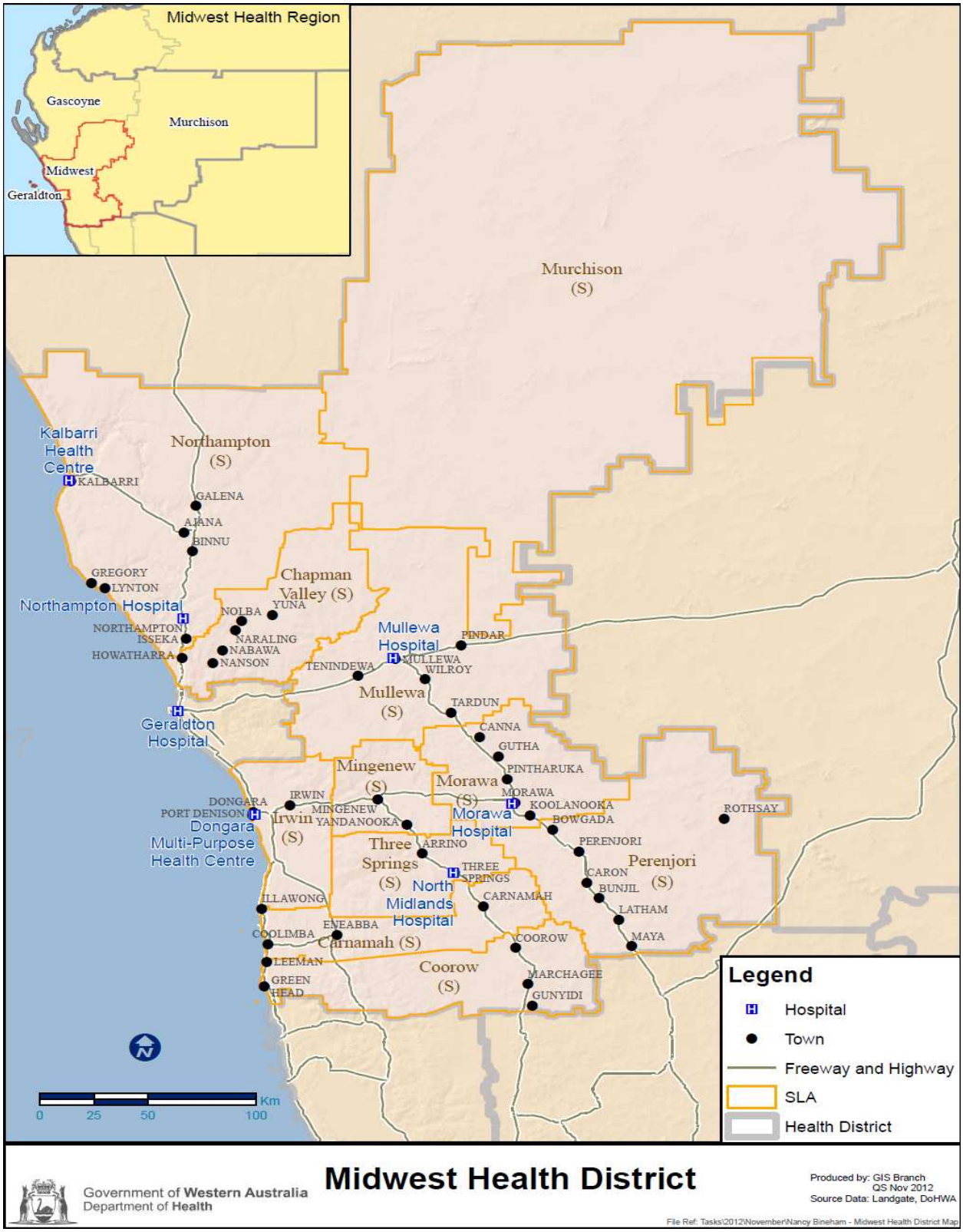
A characteristic of the Midwest Health Region is its scattered population dispersion. There is one regional centre at Geraldton and the smaller northern regional centre of Carnarvon in the Gascoyne health district.

The Midwest Health region has historically been split into four health districts defined by the ABS Statistical Local Areas (SLA) as follows:

- **Midwest Health District:** Northampton, Irwin, Coorow, Perenjori, Morawa, Three Springs, Carnamah, Chapman Valley, Murchison and Mingenew and Mullewa (now considered part of the City of Greater Geraldton)
- **Murchison Health District**: Yalgoo, Cue, Mount Magnet, Meekatharra, Sandstone and Wiluna
- **Gascoyne Health District**: Carnarvon, Exmouth, Shark Bay and Upper Gascoyne
- **Greater Geraldton Health District**: Geraldton, Greenough Part A and Greenough Part B (refer note regarding Mullewa above).

The future models of care delivered in the Midwest Health District must be responsive to the needs of the local catchment area and the social and economic realities within which services operate, including the availability of resident or visiting workforce.

Figure 1: WACHS Midwest Region and Midwest Health District

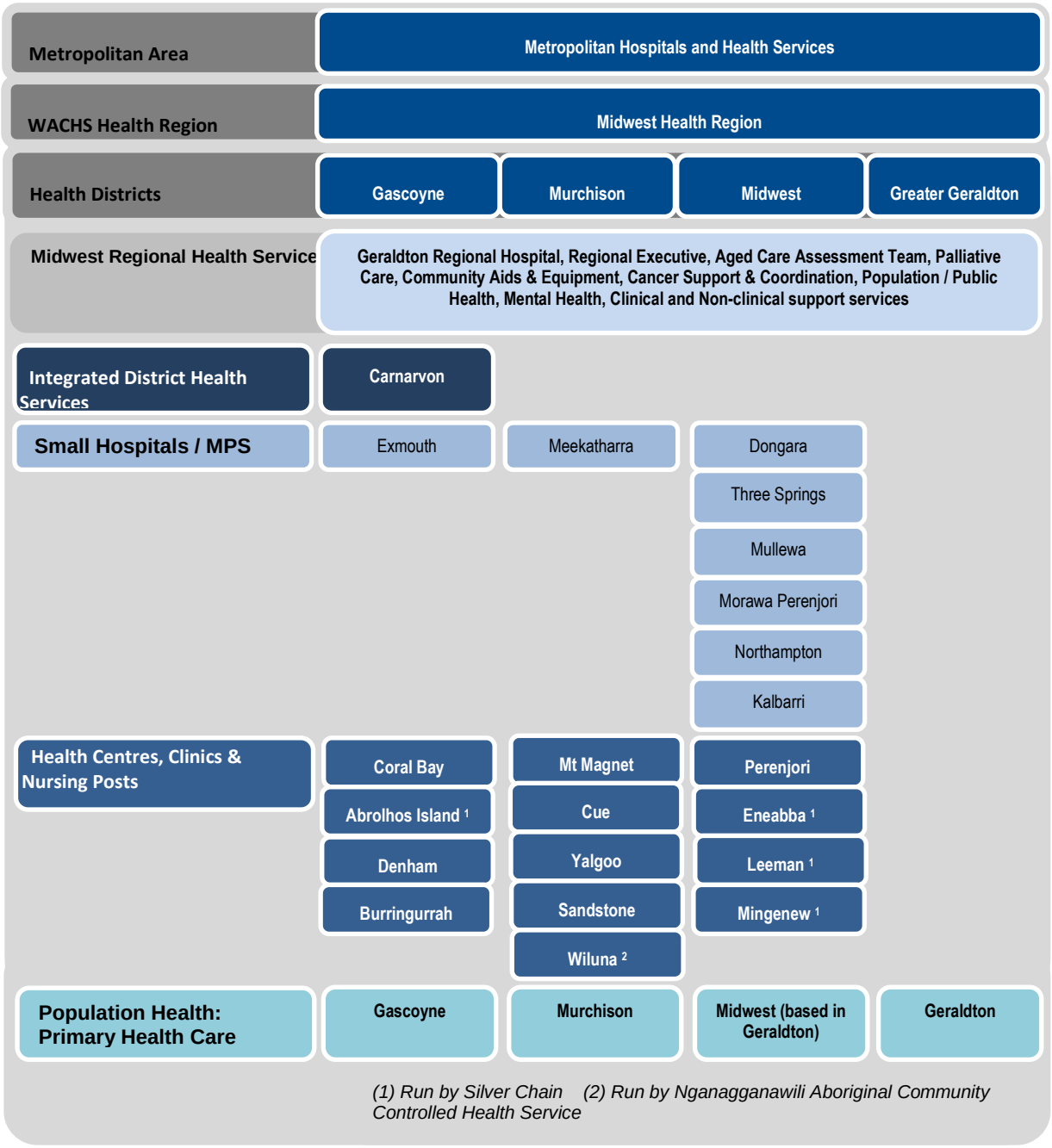


Source: Department of Health, Epidemiology Branch, 2012

3.2 WACHS Midwest Health District current services

The operational network WACHS hospitals and health services that residents and visitors of the Midwest Health Region can access are highlighted in Figure 2.

Figure 2: WACHS Midwest Region Health Services



3.3 Organisational Governance

The Organisational Governance structure for the Midwest Health District is detailed in Appendix C. In summary there are five structures for the District:

- Operational structure for acute, emergency, clinical support, non-clinical support and associated corporate functions (managed through the Operations Manager, Midwest Health District). With a Health Service Manager (HSM/DON) for Dongara/Northampton/Kalbarri and a HSM/DON for Mullewa/ Morawa Perenjori /Three Springs.
- Corporate Services structure (managed through the Director of Corporate Services, WACHS Midwest region).
- Mental Health Services structure (managed through the Regional Manager of WACHS Midwest Mental Health Services).
- Aged and Community Care Services (managed through the Regional Manager of Midwest Aged and Community Care)
- Population Health (managed through the Director of WACHS Midwest Population Health) consisting of:
    - Midwest Population Health (Regional) servicing the four districts Greater Geraldton, Gascoyne, Murchison and Midwest.
    - Midwest Community Drug Service Team (CDST)

3.4 Community Engagement in Health Services

3.4.1 Northern and Remote Country Governing Council

On 1 July 2012, Western Australia officially launched five new Health Service Governing Councils made up of community members and clinicians selected by the Minister for Health. These high-level governing councils have an important role to play in planning, monitoring and reporting on our public health services, and engaging with clinical and community stakeholders.

3.4.2 District Health Advisory Council

The Midwest Health District DHAC enables Midwest Health District community members to have input into local health service planning, access, safety and quality.

The Northern and Remote Country Governing Council and DHACs provide a voice for the community and consumers to WACHS Executive and senior managers, the Minister for Health and Director General of Health about country health needs, priorities and services.

3.5 National, State and Local Health Policy Context

The strategic direction for Midwest Health District service delivery described within this Service Plan has considered the recommendations of National, State and local government policies (including the WA Health Strategic Intent, WA Clinical Service Framework and WACHS Strategic Directions) as outlined in Appendix B. Additional detail can be found on the WACHS internet at:

www.wacountry.health.wa.gov.au/fileadmin/sections/publications/WACHS_-_Summary_National_and_State_Government_Policy_-_March_2014.pdf

3.6 Local planning initiatives

The service reform initiatives outlined in this Service Plan have evolved from the previous planning initiatives for the Midwest Region.

The *WACHS – Midwest Clinical Services Plan, 2009* recommended implementation of an Ambulatory Care model to reduce inpatient demand and strengthening primary health care along with increasing the capacity of integrated district health services.

The *Yamatji Regional Aboriginal Health Plan 2013 - 2017* identified the following priority health service delivery issues for the Council of Australian Government's (COAG) 'Close the Gap' funding:

- cultural security
- aboriginal employment
- tackling smoking, alcohol and substance abuse
- adolescence and transition from school years
- men's health
- prison health
- chronic disease management and coordination
- liaison; and
- maternal and child health.

Proposed additional priorities included collaborative approaches to environmental health, housing for staff and visiting health professionals in the Murchison district, IT infrastructure, the need for a wheel chair accessible vehicle and outdoor resting and activity area at Geraldton Hospital, an Aboriginal GP after hours clinic via Geraldton Aboriginal Medical Service, Hospital admission risk prevention programs and food security in the Gascoyne for Aboriginal people.

3.7 Existing Federal and State Government Commitments

3.7.1 National Health Reform

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 and governance arrangements for the Australian public hospital system and new governance arrangements for primary health care and aged care
- recognising the State as system managers of the public hospital system
- confirming the scope of the State's role in public health
- recognising the Commonwealth has full funding and program responsibility for aged care (except where otherwise agreed) and has lead responsibility for general practitioners (GP) and primary health care; and

- building on and affirming the Medicare principles, and high level service delivery principles and objectives, outcomes, outputs and measures agreed by COAG in 2008 and amended in July 2011.

3.7.2 National Reform Agenda for Aged Care

The Commonwealth is taking full responsibility for aged care in most States, resulting in a nationally consistent and better integrated aged care system. This system will have strong links to health and hospital services. It will be easier for older Australians, their families and carers to access information, assessment and service linkage for aged care. The introduction of a national information line in July 2011 was the first step to make it easier for people to access information about aged care.

3.7.3 Southern Inland Health Initiative (SIHI)

The $565 million *SIHI* project aims to work with the Commonwealth to reform and improve access to health care for all residents of the Southern Inland area of Western Australia over the next five years. The SIHI will impact on selected communities within the Midwest, South West, Great Southern and Goldfields health regions, but excludes the regional resource centres (hospitals) and South West coastal areas.

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

The Service Plan will inform the SIHI Implementation for the Midwest Health District.

Table 1: Overview of SIHI within the Midwest Health District

Stream (Total Southern Inland Area)	Allocations for Midwest Health District to achieve the Stream
1. District Medical Workforce Investment Program ($182.9 million) to significantly improve medical resources and 24 hour emergency response across the districts.	*Allocation of recurrent funding available through SIHI to achieve the intentions of Stream 1 including **Midwest Health District**.*
3. Primary Health Care Demonstration Program ($43.4 million)	*A nominal allocation of capital funding to increase ambulatory health care at two sites in the **Midwest** (yet to be determined)*
5. Telehealth Investment ($36.5 million) will introduce innovative "e-technology" and increased use of Telehealth technology across the region, including equipment upgrades.	*Allocation of funding for procurement of equipment and FTE (including admin support, technical support, medical staff) to enhance technology for patient care, staff supervision, training and consultation. Includes procurement of Telehealth units in Emergency Departments to enable connection to the Emergency Telehealth Service (ETS). Including **Midwest Health District**.*
6. Residential Aged Care and Dementia Investment Program ($20 million) will provide incentive for private providers to expand options across the Southern Inland area.	*Scope of work for **Midwest Health District** to be determined.*

3.7.4 'SuperTowns'

SuperTowns is a *Royalties for Regions* initiative to encourage regional communities in the southern half of the State to plan and prepare for the future so they can take advantage of opportunities created by population growth in WA. Morawa Perenjori has been selected as a SuperTown based on its potential for population growth; economic expansion and diversification; strong local governance capabilities; and potential to generate net benefits to WA. The Morawa SuperTown planning process commenced in September 2011. The *Morawa SuperTown Growth Plan* provides an overall framework for the future growth of Morawa Perenjori over the next 30 to 40 years.

3.8 Strategic directions for service delivery in the Midwest Health District

A review of current government policies, quality standards, state government commitments, drivers for change and stakeholder expectations within the Midwest Health District has identified the following strategic directions for service delivery for the Midwest Health District. Collectively these will improve the consumer experience of quality health care and services:

- strengthen partnerships between WACHS and primary care, private and not-for-profit providers
- engage consumers in service planning and implementation of service improvements and reforms
- improve the integration of services and providers across the care continuum
- implement coordinated case management for people with complex health needs
- improve access to primary health care, chronic disease prevention and self management,
- increase access to mental health and drug and alcohol services
- deliver care closer to home where safe and viable to do so
- improve Aboriginal service access, cultural security of services and health outcomes
- improve services to older people, particularly in the community
- attract and retain a skilled workforce and enhance workforce capacity
- utilise ICT advancements for better care, including Telehealth; and
- create a safer environment for all.

3.9 Key drivers for change

The catchment population, current and projected activity data, and qualitative information have been analysed along with information gained from a series of consultative workshops with service providers and external stakeholders. This analysis has identified current service strengths within the Midwest Health District as well as a series of specific issues which are driving the development of future models of care and service reform priorities for Midwest District. These strengths and issues inform the proposed strategies for service improvements and reforms presented in Sections 4.0 and 5.0.

4 District Wide Current and Future Services

The following section details the current services and service models and future service reform and improvement strategies for the whole Midwest Health District. The strategies are based on the drivers, issues and priorities highlighted in the service planning process and Section 3, the demography and health status information in Appendix B: and the overview of current and future inpatient demand and supply activity for the district including patient flows in Appendix E:.

The information in this chapter will provide guidance for services in the district as they work towards improving primary health care models of care, aged care and acute care services throughout the District.

4.1 An Overview

WACHS health services within the Midwest Health District catchment include emergency response, primary health, population health and other ambulatory care services, and residential and community aged care and inpatient acute services.

The Geraldton Health Campus provides a variety of acute and sub acute medical, surgical and investigative procedures for all Midwest region residents and visitors. Geraldton Health Campus services are designated in the *WA Health Clinical Services Framework, 2010 - 2020* as primarily Level 4 services. More specialist and complex inpatient treatment is provided for Midwest region residents in Perth when required.

WACHS and other agencies have primary health, population health and community mental health teams and services based in Geraldton, some of which provide visiting services to the Midwest Health District. Geraldton ED clinicians provide some (limited) phone support and advice to the six small hospital/MPS sites throughout the Midwest Health District. Telehealth videoconferencing services are also available if required and this modality of service provision is increasing.

The Midwest region's Executive and corporate services are based in Geraldton.

4.2 Inpatient activity

While Midwest Health District health facilities primarily deliver primary health type services, residential aged care, palliative care and emergency stabilisation for their communities, and a small level of inpatient (acute) activity is also delivered at sites across the district.

In 2011/12 there were 5,377 private and public acute inpatient separations from all WA hospitals (private and public) involving residents of the Midwest Health District. Of these separations:

- 7% (375) were from MPS sites/ small hospitals within the Midwest Health District
- 39% (2,081) were from Geraldton hospital; and
- 16% (857) were from public metropolitan hospitals.

Of the Midwest Health District residents who required only public inpatient care in 2011/12 only 11 percent received that care within a Midwest Health District facility, a decrease from 15 percent in 2007/08. This low rate demonstrates that very little of the local resident inpatient demand for public inpatient health care is met by local

services. This is due to the close proximity of Geraldton, the limited availability of medical staff in the district and the high acuity and complexity of patients.

The current number of inpatient acute beds and residential beds at each hospital is shown in the table below. The current total acute bed activity level is around seven beds. The existing acute beds (24) will be more than sufficient to meet future bed demand which is forecast to only be five acute beds by 2021.

Table 2. Midwest Health District: Acute (Same Day and Multiday) and Residential Beds

Hospital	Total Active Available Beds	Sum of Active Available Multiday Acute Beds	Total Active Available Residential Beds	2021/22 Forecast Acute beds
Dongara	10	3	7	0
Kalbarri	4	4	0	1
Morawa	16	5	11	1
Mullewa	10	3	7	0
North Midlands	14	5	9	1
Northampton	15	4	11	1
Total	**69**	**24**	**45**	**5**

Source: Current beds from WACHS online bed pivot & Midwest Aged Care manager, Forecast beds from Department of Health 2009/10 activity forecast modelling.

4.3 Emergency Services

The Midwest Health District MPS services and sites provide a nurse led 24/7 emergency model with medical support provided through Visiting Medical Practitioners (GPs) when a Medical Service Agreement is in place between WACHS and a private GP practice or from Geraldton telephone and or Telehealth support. Out of hours support via GPs is not always possible as the GPs may not be within close on call to the MPS sites.

The actual and projected emergency activity within the Midwest Health District (see also Table 3 and further detail is available in Appendix E):

- is projected to increase by 32% between 2011/12 and 2021/22
- is projected to decrease in attendances for triage 5 categories (non urgent primary care type presentations), in line with trends occurring at the State level.

Emergency activity projections will be re-modelled in late 2013/14.

At Mullewa Hospital, 58% of ED attendances involved an Aboriginal person while in Dongara they accounted for only 1% (in 2011 39.0% of Mullewa residents were identified as being Aboriginal or Torres Strait Islander and 2.1% of Irwin residents).

Table 3. Midwest Health District: Actual and projected emergency department presentations and bays

		historic			forecast		
hospital	Triage	2009/10	2010/11	2011/12	2013/14	2016/17	2021/22
Dongara							
	total OOS	3,792	2,563	2,886	2,692	2,892	3,402
	Bays	1.7	1.2	1.4	1.4	1.6	2.1
Kalbarri							
	total OOS	2,592	2,564	2,146	2,679	2,832	3,184
	Bays	1.0	1.1	1.1	1.2	1.3	1.6
Morawa							
	total OOS	1,255	1,516	1,470	1,597	1,707	1,986
	Bays	0.6	0.8	0.9	0.9	1.0	1.3
Mullewa							
	total OOS	937	889	870	907	932	1,009
	Bays	0.4	0.4	0.4	0.5	0.5	0.6
North Midlands							
	total OOS	855	890	845	917	965	1,101
	Bays	0.4	0.4	0.5	0.5	0.5	0.7
Northampton							
	total OOS	857	901	862	962	1,048	1,261
	Bays	0.4	0.5	0.5	0.5	0.6	0.8

4.4 Medical, Acute Inpatient and Emergency Issues

- There are challenges accessing medical services across several locations within the Midwest. While most locations have access to a general practitioner during regular office hours (Mullewa has a half-time GP), several communities lack on-call and after hours medical coverage.
- Lack of on-call and after hours medical coverage currently impacts on ability to admit acute inpatients to MPS sites, and these patients must then be transferred to Geraldton for treatment.
- Acute beds are underutilised in the Midwest Health District but demand for residential aged care beds is high – with 100% or more occupancy of designated aged care beds (ie acute beds are sometimes used to accommodate aged care residents).
- Strategies to increase medical services within Midwest Health District communities, which could lead to increased acute inpatient activity, will also potentially impact on bed availability for aged care.
- Emergency specialist consultation is limited and adhoc. Geraldton hospital emergency staff offer phone support but the use of Telehealth is limited. One reason given for lack of use is poor location in the Geraldton ED, even though the location was originally chosen by Geraldton ED Medical staff.

Proposed service reform and improvement strategies – Acute Inpatient and Emergency Services

- Support a sustainable and safe GP led 24/7 emergency model and roster across the District and increase access to out of hours medical on call models.
- Where practical, spread the call out roster to a larger group of GPs
- The Midwest Region and district to work with in partnership with GP practices and SIHI to maximise the incentives under SIHI Stream One, thereby enhancing GP primary care and improving medical coverage.
- Progress implementation of the Emergency Telehealth Service at all small hospitals subject to funding.
- Implement Scopia into specialist rooms at Geraldton Hospital
- Explore potential to employ an ED Nurse Practitioner for the Midwest and Murchison Health Districts located in Geraldton to provide advanced emergency nursing care and clinical up-skilling to nursing staff across the districts.

4.5 Primary, population health, mental health and ambulatory care

These terms tend to be used somewhat interchangeably but the following attempts to build on the definitions provided at the front of this document to help clarify the terms and services.

4.5.1 Definitions:

Primary Health Care

Primary health care services provide first level community based health care, across the life continuum. Primary health care encompasses medical (general practice), nursing and allied health services. It also covers the scope of services delivered by WACHS and other providers of child and maternal health services, Aboriginal health services, school and youth health, community mental health, oral health, community aged care and chronic disease care coordination and other health workers, such as multicultural health workers, health education, health promotion and community development workers.

As part of the *National Health and Hospitals Reform Agenda*, the Commonwealth Department of Health and Ageing has outlined the national reform agenda for primary health care services in Australia which includes:

- better integration of services
- access to multiple primary health professionals at one site
- co-location of services to improve accessibility for small communities

The proposed future models of primary health care in Midwest Health District should support the Commonwealth reform agenda, the WACHS strategic priorities and link with the Goldfields and Midwest Medicare Local.

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

Integrated programs addressing issues such as chronic disease care coordination, community rehabilitation, maternal and child health, youth health, oral health and suicide prevention, will enhance the services delivered.

Population Health

Population Health Services cover public, child and community health services across the age and care continuum. The focus is on health promotion and primary prevention plus interventions directed at preventing or minimising the progression of chronic disease (secondary and tertiary prevention) where possible. These services can be provided by both public and non government providers.

Ambulatory Care

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

- primary health care services, particularly those services focused on management of chronic diseases and mental health
- population health services
- same-day surgery and procedures; and
- visiting and nursing outpatient services.

4.5.2 Population and Primary Health Care Services

Within country WA primary and population health services are delivered by a range of service providers, including both WACHS primary and secondary level services. Services are often delivered in partnership with other not-for-profit and private providers in the district and region described in the Appendix G: Health Partners.

The WACHS Midwest Population Health Services team is managed by the Midwest Region's Director of Population Health. The team is based in Geraldton and visit the Midwest Health District area. Referral to the service can be via a health professional or self-referral. The team includes:

- Aboriginal Health Workers
- Liaison Officers
- Community Health Nurses – Aboriginal health and antenatal programs
- Community Health Nurses – child health, school health & immunisation
- Continence Nurse – visits MPS sites approximately once every six weeks
- Dietitian – visiting on referral / request
- Diabetes Educator – visits sites twice per month and also home visits
- Health Promotion Officer
- Occupational Therapists – visit on referral
- Physiotherapists – visit on referral

- Social Worker – visits on referral
- Speech Pathologists – visit on referral
- Therapy assistants; and
- Drug, alcohol and mental health promotion workers.

The Midwest Child Development Team (comprised of some of the professionals listed above) visits the Midwest Health District for assessment, treatment and case management of children with developmental delay or complex disabilities.

The Midwest Community Drug Service Team (CDST) is part of the Population Health service and provides drug and alcohol services to the whole of the Midwest region. It has a team of 22 staff, including qualified nursing staff, a mental health nurse, and also an Aboriginal Community Development worker who primarily focuses on the Mullewa area, and Murchison and Morawa Perenjori shires. It has the highest number of employed Aboriginal staff for any West Australian CDST. The service is involved in a wide variety of treatment and community development programs.

The community aids and equipment program (CAEP) is a regional service and provides eligible people (aged and disability) with equipment and home modifications following assessment by local allied health service providers. The CAEP service is managed centrally from Geraldton.

Please note quantitative activity data for Primary and Population health services is presented in Appendix D: Demography and Health Needs and Appendix E: Service and Activity where available.

4.5.3 Outpatient and Domiciliary / Extended (outpatient) Nursing Care

Ambulatory (same day) surgery is only provided at Geraldton Hospital.

Outpatient specialist services (visiting or via Telehealth) are available throughout the Midwest Health District although limited in specialty and availability of the specialists.

Outpatient nursing services (extended care nurses) are provided at all Midwest Health District hospitals/MPS sites via nursing staff. Service Provision includes domiciliary / extended care nursing available 3-4 days per week, who provide outpatient nursing care consultations on a regular basis.

When domiciliary / extended care nurses are unavailable, staff at the six Midwest small hospital / MPS sites provide post-acute outpatient services (e.g. wound care). Elderly HACC clients are encouraged to access available outpatient services (not HACC specific) when transport is available to them.

4.5.4 Aboriginal Health

In 2011, 7% of Midwest Health District residents (965), 2.1% of Irwin and 39.0 % of Mullewa residents were identified as being Aboriginal or Torres Strait Islander compared to the State (3.0%) (ABS Estimated Resident Population, 2011).

WACHS-Midwest has a positive relationship with Geraldton Regional Aboriginal Medical Services (GRAMS) Aboriginal staff, which is reported to have improved service access for Aboriginal people. The Yamatji Aboriginal Health planning forum occurs bi-monthly and consists of GRAMS, WACHS, RFDS, GMML and other key stakeholders.

Partnerships between GRAMS, WACHS, RFDS and GMML have enabled improvements in chronic disease self management, especially diabetes. The partnership creates opportunities to provide education on healthy lifestyle choices, and more opportunity to undertake clinical early interventions (blood tests). Aboriginal targeted early intervention chronic disease management, and immunisation services are delivered across Midwest and Murchison health districts.

4.5.5 Oral Health Care

The National Health Reform Agreement 2011[1] reiterates the Commonwealth's role as the system manager and funder for Primary Health Care, General Practitioner Services and Aged Care Services. This range of services includes dental care.

In August 2012 several Dental Health Reform initiatives were announced including:

- the *Child Dental Benefits Schedule* for children between 2 and 17 years (replacing the Medicare Teen Dental Plan and with a total benefit entitlement capped at $1,000 per child over a 2 year period).
- the National Partnership Agreement (NPA) for adult public dental services to commence 1 July 2014. $1.3billion will be provided to states and territories to expand low income adult public dental health services
- a total of $225 million will be provided for infrastructure (workforce and capital) to assist in "reducing access barriers," and to target gaps in service delivery. Public and private sector agencies will be able to apply.

Within the wider Midwest region there are limited oral and dental health services available to local residents.

4.5.5.1 Public and Private Dental Services

Dental care for school children in WA is available via Dental Therapy Centres (fixed centres) and Mobile Units.

The closest public dental services for eligible adults in the Midwest Health District are offered in Geraldton. Alternatively residents can access one of the 11 private dental clinics in Geraldton. There are also private dentists in Dongara and Three Springs.

School dental services available in the Midwest Health District area include those available through the 'Geraldton' mobile unit which includes the towns of Dongara, Kalbarri, Northampton, Morawa Perenjori, Mullewa, Mingenew, Three Springs and Perenjori within its circuit and 'Jurien' mobile unit which includes the towns of Eneabba and Leeman within its circuit.

As part of WACHS Primary Health Care (PHC) planning, oral and dental health is considered a core PHC service area. Dental Health Services (DHS) and WACHS are meeting with the aim to better integrate dental health and WACHS, thereby increasing access to services.

4.5.6 Cancer and Palliative Care

The WA Cancer and Palliative Care Network in collaboration in WACHS appointed a Midwest Regional Rural Cancer Nurse Co-coordinator (RCNC) in January 2007 and a regional Palliative Care Coordinator in 2008 (RPNC). The RCNC and RPNC

[1] Commonwealth and Western Australian Government National Health Reform Agreement 2011

facilitate coordinated regional approach to cancer services and palliative care for patients in the Midwest.

Chemotherapy services are primarily provided through the Geraldton Hospital and funding has been secured for an expanded rural cancer unit on the Geraldton Health Campus through Commonwealth funding. Around 30 percent of people will always need to travel to Perth for more complex chemotherapy and cancer treatments though this may improve through the implementation of regional cancer networks, advances in medical technologies and use of Telehealth.

The Rural Palliative Care Model in Western Australia has the purpose of addressing the specific palliative care needs in rural and remote WA and supplements the WA Palliative Care Model of Care.

The Midwest palliative care services are nurse led with a palliative care nurse coordinator who coordinates care of patients in the community, at Geraldton Hospital, SJOG Hospital Geraldton, aged care facilities and provides support throughout the region. Medical care is usually provided via the local GP or local medical officer where available, with additional medical supports available. Each small hospital (MPS site) has one palliative care bed and most provide a home like environment. Additional supports are available via the Regional Palliative Care Nurse Coordinator through the Medical Outreach Indigenous Chronic Disease Program (MOICDP) palliative care program.

4.5.7 Primary Health / Population Health Issues Identified

Six service planning workshops were conducted across the Midwest Health District at Kalbarri, Northampton, Dongara, Mullewa, Morawa Perenjori and Three Springs. Several related issues were raised at all these locations by community and stakeholders attendees.

These common issues will be discussed in more detail below and later in this chapter:

- health promotion and access to primary care
- chronic disease management support including mental health promotion and alcohol and drug services
- Aboriginal health and Aboriginal access to services
- partnerships, collaboration, case management and communication
- prison health
- oral health
- workforce attraction and retention including staff accommodation (refer to sub section – enablers)

Health promotion, access to primary care

- Access to GPs was a particular community concern and medical cover for some sites was of concern as some sites do not have contracts in place between WACHS and local GPs to provide medical governance of the MPS/small hospital.
- Access to paediatric consultation and treatment was identified as a serious issue and to a lesser extent the provision of antenatal/postnatal and early childhood care.

- Community members across several Midwest Health District areas expressed a desire for increased health promotion.

Chronic disease management

- There is an identified need for chronic disease prevention and management resources and programs, with a focus on building self-management capacity within the community, and for self-management support from providers.
- Enabling support for self-management for people with chronic conditions, their families and carers is a challenge that requires positive engagement with consumers, health service staff and providers in other organisations involved in supporting people to manage better at home. It is recognised that there is a need for raising community awareness on the concept of 'self-management' for seniors. Identifying local level/regional referral pathways for the management of priority chronic conditions and between primary health, acute and community based services to establish areas of improvement and interagency collaboration and to identify what will make a difference.
- It was deemed important to address chronic disease across the continuum of care from risk factors such as overweight and obesity to long term sequelae such as renal disease.
- Several Midwest Health District communities expressed a desire for increased mental health promotion within the community, particularly regarding improved recognition of mental health and drug and alcohol issues.

Aboriginal health and Aboriginal people's access to services

- With a particular focus on Aboriginal people, some of the key service delivery barriers are:
    - financial barriers such as limited bulk billing, cost of treatment/disease management
    - service and cultural issues including inadequate cultural safety, lack of 'walk in' clinics, difficulty attending appointments and reluctance to identify Aboriginality
    - remoteness issues such as staff retention, recruitment, (often exacerbated by lack of accommodation) lack of female GPs, high proportion of locum/overseas staff, long waiting lists and community responsiveness towards health promotion
    - GRAMS (Geraldton Regional Aboriginal Medical Service) provide extensive services in the Geraldton area and outreach to the Murchison district, but have limited capacity in the Midwest district.
    - access, provision of outreach services, access to transport
    - complex health and social care needs and co-morbidities
    - community perception and expectations of services

- apathy with difficulty in engaging communities in regards to education and health promotion
- lack of mental health inpatient unit in Geraldton
- recruitment and retention of Aboriginal staff
- management of cardiovascular issues.
- need for increased oral and dental care
- greater access to chronic disease prevention and management services; and
- culturally appropriate youth sexual health programs.

Partnerships, collaboration, case management and communication

- There is acknowledgement that while agencies have varied roles, linkages and the development of service and resource partnerships between providers will be increasingly important in the future to maximise the limited health dollar and create efficiencies.
- There were good indications of 'on the ground' cooperative service provider relationships in many areas that could be further strengthened and built upon to maximise the health dollar and to enhance workforce attraction and retention.
- Unlike the Murchison, the Midwest Health District does not have an active 'human services' group that meets regularly.
- Case management and coordination of care and general communication between metropolitan and local health services was reported to be challenging. This is also the case between Geraldton based services, smaller sites and primary care services. Discharge planning from Geraldton Hospital or the metropolitan area back to the Midwest Health District is viewed as an issue.

  For example: information is not always shared with local health professionals and GPs in a timely manner and there is no seven day discharge coordination in the region. Patients may be discharged on a Friday afternoon when there is limited, if any, post-acute care available locally or 'step down' care in local small hospitals prior to returning home.

Prison health

- The Greenough Prison can only support a small number of prisoners leaving the compound for specialist services in any one day. For prisoners with chronic or low acuity conditions there may be delays in accessing diagnostic services or specialist appointments. The challenge of managing chronic illnesses is that any treatment must involve patient self-management, including prisoners with chronic conditions at Greenough Prison. The rate of compliance varies within prison, as it does in all communities. All attempts are made to stabilise chronic conditions whilst in prison, educating the prisoner with strategies for future management, and providing care plans to manage the condition.
- Health and human service staff of Greenough Prison attend the Yamatji Aboriginal Health Forum.

Oral Health

- Lack of access to public dental services is a widespread issue across the whole Midwest region including the Midwest Health District area. Given that Dental conditions are higher in the Midwest when compared to the State rate this is of particular concern.

4.5.8 Proposed Strategies for Service Reform

The following strategies are common to all Midwest Health District communities and MPS services.

Proposed service reform and service improvements – Ambulatory, Population and Primary health

The demographics and review of current service levels across the Midwest Health District indicates that Mullewa is a priority location for re orientation of the health service site from acute to primary care. This will enhance access to health promotion, primary health, child, maternal and community health, and mental health and drug and alcohol services over the next few years to help close the gap in health outcomes for the local Aboriginal population.

If the population in Morawa Perenjori increases as per the Morawa SuperTown growth plan then primary health/ population health resources will need to be reviewed to this community to meet the needs of the growing population, especially families with younger children.

Note specific strategies for each site are listed in Section 6.

Primary Health Care / Population Health/Chronic Disease

- SIHI stream one will enhance primary care (GP) services to better support the emergency models and increase primary care access for communities.
- Explore medical governance models and admitting rights to the MPS sites via Geraldton ED doctors using Telehealth or the WACHS Emergency Telehealth Service or via a proposed District wide Nurse Practitioner and Telehealth.
- There will be a steadily growing need to increase access to primary health services across the district, aligned with local needs and population growth. The priority primary health services include:
    - chronic disease self-management,
    - Revise the model of care for chronic disease monitoring including the potential use of I pad/pod apps for chronic disease management
    - additional allied health to enhance home visiting capacity for elderly clients,
    - mental health and drug and alcohol health promotion and general health promotion,
    - antenatal and postnatal care, including mothers groups.

Proposed service reform and service improvements – Ambulatory, Population and Primary health

Priority localities are Dongara, Mullewa and Morawa Perenjori

- There is an opportunity to better coordinate targeted immunisation for vulnerable groups, older people, workers and health workers in discussion with the GMML and GRAMS. For example, the Medicare Local may focus on the 'mainstream' population, while population health and GRAMS may focus on engaging vulnerable groups.
- Explore opportunities to increase allied health and domiciliary post-acute care services, given the limited existing services and projected growth in the number and proportion of older people. Potential avenues for increasing services include funding new and existing service providers in the private/NGO sectors (such as Medicare Local funding and other Commonwealth funding opportunities).

Aboriginal Health

For Aboriginal people, some of the key service reform strategies are:

- Coordination of services with GMML
- Improve the Aboriginal workforce via increased opportunities for employment & traineeships, advertisements, and lower level entry
- Improve Aboriginal community engagement
- Improve Aboriginal client transport
- Comprehensive cultural security training

This should help to improve service delivery issues in the following areas:

- access to oral health and primary dental care,
- chronic disease preventive and management services
- culturally appropriate sexually transmitted infection (STI) programs for the 13-25 age group across the whole region
- bulk billing by GPs
- re-investment in Statewide Specialist Aboriginal Mental Health Service funding programs that address the social determinants of health (e.g. education, employment, housing costs in the communities, improved transport links). These programs may be outside of WACHS service scope, but are within the scope of our service partners.
- housing for Aboriginal staff
- increasing use of telehealth
- private and NGO sector service and resource partnerships

Partnerships and Collaboration

- Work with the metropolitan area hospitals, outpatient clinics and Geraldton Hospital to improve case management, care coordination, appointment and discharge planning for Midwest Health District residents, particularly those with complex needs and who are elderly or more vulnerable and who are receiving inpatient care in the

metropolitan area. This should include:

- improving communication,
- documentation,
- electronic medical record sharing,
- boundary issues; and
- day of discharge decisions.

- There are opportunities for increased case management and care coordination, particularly focusing on people with complex and co-morbid mental health and alcohol and drug or other chronic physical health issues. This can be achieved by developing agreements between the NGO sector and coordinators of the WACHS chronic conditions projects. For example accessing the Commonwealth Better Health Improvement Program funds to support service improvement initiatives for people with chronic conditions and their carers.
- Establish a Midwest Health District interagency forum similar to the Murchison District interagency forum that meets in rotating locations across the District. This group could enable more partnerships and coordination and confirm which group is responsible for different aspects of health and related service provision (e.g. State health, local government authorities, private GP's, other service agencies and /or the community).
- The current limitations in service provision for domiciliary post-acute care and primary health care need to be discussed with the GMML. It may be possible to provide education /support via Telehealth for staff in other centres or too pool resources to fund services.
- In addition, for mental health patients advocate that metropolitan units improve the communication flow to the Midwest community mental health team so they can provide follow-up and support locally.
- Within some service areas attracting new providers may be challenging, particularly when demand for services has not yet reached levels where private services are viable (e.g. aged care providers).

Prison Health

- While the health care of prisoners remains a Department of Justice responsibility, health and human service staff of Greenough Prison could be included in training and service provider forums.

Oral Health

- Increasing access to public and private dental services should be considered from a WACHS and Midwest regional perspective in conjunction with the public Dental Health Services (DHS), targeting low income groups, Aboriginal people and the elderly.

Proposed service reform and service improvements – Ambulatory, Population and Primary health

- WACHS and DHS are currently working toward better integration of dental health with Primary Health Care planning processes and WACHS will ensure the needs of the Midwest are considered in this planning.
- Access supports available through the National Dental Reform initiatives (for workforce, services funding and infrastructure funding) to increase local private dental service availability.

4.6 Mental Health Services

Specialist Adult Mental Health Services in WACHS are purchased through the WA Mental Health Commission. The Commission's role is briefly described under Appendix G – Stakeholders and Health Partners.

Delivery of public mental health services to the rural communities of Western Australia is a significant challenge. The 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities and services in WA* (the Stokes Review) recognised the need for consistent, quality mental health care to be available to all Western Australians.

The Review's first priority was the development of a Mental Health Clinical Services Plan for WA to be progressed jointly between the WA Mental Health Commission and the Department of Health. The Plan will embrace the key elements of clinical care, rehabilitation, living accommodation, geographical location and infrastructure build and support.

WACHS prepared a two year Mental Health Services Plan in December 2012 to inform the WA Mental Health Clinical Services Plan. It outlines rural and remote clinical service and corporate reform priorities for specialist mental health services that support people with severe, persistent and enduring mental health issues including co-existing drug and alcohol issues. These priorities and principles will address needs and gaps identified in the Stokes Review and inform WACHS service planning.

4.6.1 Inpatient Mental Health Services

There are no authorised involuntary mental health beds within the Midwest Region so patients receive voluntary inpatient care in medical beds within the region or involuntary acute and complex mental health inpatient care outside the region (primarily Perth).

Patients requiring voluntary but less complex inpatient care predominantly access this care from Geraldton Hospital rather than Perth. Geraldton Hospital has two specialist voluntary mental health beds in line with the WA Health Clinical Services Framework and the December 2012 WACHS Mental Health Plan. There is supported residential accommodation in Geraldton.

In 2011/12 Geraldton Hospital provided 42 mental health and drug and alcohol inpatient separations for Midwest District residents and the Midwest District MPS sites collectively provided 27 separations.

From 2007/08 to 2011/12 the proportion of mental health and drug and alcohol separations for Midwest District residents occurring in the Midwest region fell from 79% to 65%. The proportion occurring in Perth increased from 13% to 21%.

4.6.2 Community Mental Health

The specialist WACHS Midwest community mental health service falls under the Regional Manager of Mental health. Workers visit the following Midwest Health District communities, usually monthly:

- Dongara-Port Denison
- Morawa
- Eneabba
- Coorow
- Mingenew
- Perenjori
- Three Springs
- Mullewa
- Kalbarri
- Northampton
- Leeman
- Yalgoo
- Carnamah

The community mental health team is part of the WACHS regional mental health services program. The team servicing the Midwest Health District consists of eight staff (eight FTE). This includes four senior nurses, one senior community mental health professional and two Aboriginal community mental health professionals and one Psychiatrist) who deliver services to the Midwest Health District area. In addition a psycho-geriatrician and a CAMHS Psychiatrist are funded to visit Geraldton eight times a year.

Elements of the mental health service include:

- the Community Mental Health Team which has a case management role with triaging (initial assessment) performed centrally via the phone and based in Geraldton. The services cover child and adolescent, as well as adult and older adult services and Aboriginal mental health.
- Rural Link is available for after-hours mental health issues. Rural Link has access to mental health plans so they can obtain such information when needed. During the day the Rural Link phone number diverts to community mental health, ensuring people are linked with the locally based service.
- funding was received under a COAG agreement for Aboriginal mental health to enable four people to undertake training to provide community development for better mental health across the Midwest; and
- extensive use of video conferencing, and also Telehealth for limited mental health clinic and outpatient consults; and
- drug and alcohol staff attend the weekly intake meeting at Mental Health in Geraldton and Carnarvon

Health Tracks data shows that between 2007 and 2011 there were 7,531 mental health occasions of service to Midwest Health District residents. This was significantly less, and less than half the rate of occasions of service per head of population across the state.

4.6.3 Mental health and drug and alcohol issues

- The 2012 ‘Stokes Review’ of public mental health facilities and services in WA recognised the need for consistent, quality mental health care to be available for all Western Australians. The Stokes review recommendations require WACHS to respond.

- Patients within the Midwest Region requiring inpatient care for involuntary acute and complex mental health issues must be seen in the metropolitan area. This can result in communication breakdowns when the patient is transferred or returns home.
- There is supported residential accommodation in Geraldton, but not for people in Midwest Health District rural communities who cannot go home (i.e. no step down facilities or hostels).
- There is a general lack of awareness of mental health services in the Midwest District and in Geraldton. This is the case for both potential clients of the service and staff within the health service who are potential referrers into the mental health service.
- There is also a lack of Mental health promotion services including a lack of suicide prevention strategies
- Several Midwest Health District communities noted the need for increased community Mental Health Services for older people.
- More collaborative models to assess and support/treat people with mental illness anda co-existing drug and alcohol issue are required.

Proposed service reform and service improvements – Mental Health

- In alignment with the WACHS '*Mental Health Service Plan 2013-2015*' and '*Foundations for Country Health Services 2007-2010*' explore collaborative arrangements to improve integration of mental health and drug and alcohol services (including collocations, mergers, shared care protocols and case management).
- Increase access to and awareness of mental health services provided by WACHS and non-government providers, including older mental health services (e.g. services for those experiencing, dementia, depression, grief and loss), by using a variety of health promotion measures including media
- Improve case management and integration of care for clients with mental health conditions including drug and alcohol issues, with particular focus on supporting the Aboriginal population in Mullewa.
- Review access and referral and discharge processes to community mental health services for the Midwest Health District to ensure those in most need have access to care and for continuity of care.
- Continue to liaise and advocate with metropolitan services to improve communication flows to the community mental health team so they can provide follow-up and support locally.
- Continue the weekly VC for clients receiving treatment and pending discharge at Graylands between the Graylands clinical team and the adult team in Geraldton.
- Implement primary mental health services, including child, adolescent and youth mental health promotion.
- Increase access to psychiatrists and psycho-geriatrician consults (including through the use of Telehealth consultation).

4.7 Aged Care

4.7.1 National Aged Care Reforms

The Australian Government released a report "Living Longer, Living Better" in 2012 which identifies a range of Aged care Reforms which include:

- Greater emphasis on community care and increased numbers and levels of home support programs. It is uncertain how this will relate to MPS community package funding as the details have not been released. However with the ability of MPS' to remain as an MPS without a community service component there may be opportunities for increased private provider service provision. Similarly there is an opportunity to review occupancy of dedicated low residential care beds with a view of funds transfer from residential to community care in line with reforms.
- Increase in carer respite care. This could be possible in the Midwest district with the potential attrition of low care permanent care beds
- Creation of centralised information and assessment centres. In WA this is being delivered through Regional Assessment Services which removes the role of assessment from the individual HACC projects. The Midwest Aged and Community Care Unit will implement an independent assessment service for HACC as per Kimberley and South West by early 2014.
- Focus on dementia including primary and hospital care. The Midwest district will participate in a State Health dementia project including training for staff to identify signs of dementia at the point of admission and the implementation of appropriate protocols.

4.7.2 Community Aged and Respite Care

The Midwest regional Aged Care Assessment Team (ACAT) is available as required as a visiting service from Geraldton. This service assesses and recommends access to community or residential aged care for older people.

The Midwest Commonwealth Respite and Carelink Centre (MWCRCCC) based at the Geraldton Health Campus is responsible for regional coordination of Midwest respite services.

MWCRCCC support carers via education, wellness activities, support groups, access / referral to alternative services, and broker respite services across the Midwest Region. MWCRCCC has a collaborative approach for additional activities with WACHS health sites and services and its staff visits each district within the region at least quarterly.

Direct residential respite is available through each of the MPS sites. In home respite support is available through the Mobile Respite Worker who will stay within the Care Recipients home, providing day to day support for periods up to 10 days. Residential respite is also available in Geraldton Residential Aged Care Facilities (Hillcrest and Geraldton Nursing Home) and/or cottage respite facilities (RSL).

Indirect respite is available to be brokered via local community care services, when staff availability allows. Indirect respite might include meal preparation, personal care or domestic assistance. Equipment which assists with independence (e.g.

personal alarms) or which reduces Carer stress may also be purchased where alternatives are not available.

Eligible carers are those who support persons who may be frail aged, palliative, and/or have a chronic disease, mental illness or disability, including young carers whose caring role is impacting on their education.

4.7.3 Residential Aged Care

Commonwealth aged care planning benchmarks for high and low care residential aged and community care places, applied to forecast populations, provide an indicator of demand. The current benchmarks are for the provision of 49 high care beds, 58 low care beds and 25 places for community care (with 4 for high level community care and 21 for low level community care) for every 1,000 people that are aged 70 years and over (non-Aboriginal) and aged 50 years and over (Aboriginal). The Commonwealth aged care reform agenda will see these benchmarks changing from July 2014 when there will be no distinction between high and low care approvals and the approval being based on need.

Within the Midwest Health District area:

- currently residential aged care services within the area are provided in Dongara, Morawa-Perenjori, Mullewa, Northampton and Three Springs (see Section 6 and Appendix D)
- while provision of residential aged care is the responsibility of the Australian Government, the MPS provides 'flexible care places', where private aged care facilities are not viable, under an MPS funding agreement. Allocations of aged care places across the Midwest are detailed in Appendix E.
- dementia specific beds are not available within the Midwest Health District Sites, but are available in Geraldton (e.g. Nazareth Care includes 40 secure dementia specific beds, Hillcrest includes 20 secure dementia specific beds).
- SIHI includes a residential aged care and dementia investment program that will provide incentives for private providers to expand residential aged and dementia care across the Southern Inland area.

4.7.4 Aged Care Issues

Population projections indicate the greatest change to the age structure for the Midwest Health District is for the older population with an increase from 9.5% to 14% of the population – the greatest proportion of those over 70 will be in the Northampton and Irwin shires (both 16%) (refer to Appendix E). This increase will place greater demand on health and community services for older people, both from the increased numbers of people and the fact that older people experience greater levels of ill health through chronic disease and cancers.

Community Aged Care

- Across the Midwest there is a focus on supporting older people to 'age in place' meaning that can receive high level care without relocating. For older residents, there are flexible services available and HACC services are well regarded, but if people require higher level care due to lack of extended community aged care packages, specialist dementia care and

residential aged care, they may need to relocate. The community report that some community members choose to stay at home without the care they need so that they can remain within their community.

- There is limited access to allied health home visiting services and community aged care packages and services across the whole Midwest region including the Midwest Health District area.

Respite Care

- There is limited access to home based respite care.

Supporting older people with high care needs

- There is a perceived gap across the Midwest Health District in specialised and privately provided dementia and high care residential aged care and intensive community aged care packages which support people with multiple and complex needs to stay at home.
- There are intermittent pressures on existing residential aged care beds, particularly in Northampton and Dongara and limited ability to provide extended aged care packages due to both limitations in funding and availability of service providers.
- National Residential Aged Care Standards indicate that medical and other assessments should occur as appropriate to the needs of the patient, these should be clearly identified within the patient care plan and that the care plans should be regularly reviewed. This is potentially challenging to achieve, given limitation on both medical and other health providers in many areas of the Midwest.
- There are no private aged care providers throughout the Midwest Health District, and it will be difficult to attract private providers given the challenges to business viability (with existing residential aged care models providers requiring at least 40 beds to be viable). Within the rural setting differing models of aged care provision will need to be considered, such as decentralised services (where smaller numbers of beds in several locations are grouped to comprise one service).
- For older residents, HACC services are well regarded, but eventually people must relocate when they require higher care (often residential aged care).
- Some community members choose to stay at home without the care they need, as there is a lack of support such as respite and carer support services for independent living elderly, so that they can remain within their community.

Proposed service reforms and service improvements –Aged Care

Meeting the needs of the older population is an increasing priority with the greatest numbers and proportion of older people in the Northampton and Irwin shires. Strategies to address this demand and need include:

- Advocate to the Commonwealth for increased access to extended community aged care packages and high care beds based on population need with incentives to encourage local non government

Proposed service reforms and service improvements –Aged Care
and private residential and community aged care package providers. ▪ Increase access to Geriatrician and Psycho-geriatrician, through visiting or Telehealth consultations, particularly for Irwin and Northampton Shires. ▪ Advocate for increased access to respite care either through MWCRCC in home respite, or private aged care provider. ▪ Advocate for the Midwest Aged Care Plan ▪ Advocate for a regional or Midwest/Murchison/Geraldton Model/Network of Aged Care (Ageing in Place) in collaboration with the Midwest Regional Development Commission. This would investigate innovative models of aged care provision including consideration of needs of people with dementia (similar to the Wheatbelt Aged Care Planning Strategy underway through the Wheatbelt Development Commission). ▪ Support local shires to explore independent living options for older people in the area. 'Independent living options' includes both ageing in place within the home, and moving to supported well aged housing. ▪ Continue with HACC home monitoring ▪ Ensure older residents and HACC eligible clients are supported to access regular physical health, podiatry and oral health reviews as part of care planning. ▪ The needs and living arrangements of partners and carers of people requiring high care aged care needs to be considered in residential and community aged care services planning and funding.

4.8 Midwest Health District Clinical Support Services

4.8.1 Medical Imaging

Residents of the Midwest Health District generally travel to Geraldton or Perth for imaging services. Currently Kalbarri and Morawa Perenjori provide emergency imaging services (x-rays of injured extremities and chest) by nurse x-ray operators. The images are sent electronically to Geraldton and interpreted by the radiographer and a report back is provided by the radiologist. There is no provision of ultrasound at any centre within the Midwest Health District.

Most imaging services in the district occur at Kalbarri and Morawa Perenjori. In 2011/12 there were 254 services recorded in the district, of these, 109 services were recorded at Kalbarri and 138 at Morawa Perenjori. *Source: HCARe (AOD)*

4.8.2 Pharmacy

The Midwest region's pharmacy service is located in Geraldton. The pharmacy department at Geraldton supplies the Midwest region with both clinical pharmaceutical and supply services to the six Midwest Health District Hospitals/MPS sites and supplies are ordered by the iPharmacy (Iproc) system and imprest based (daily).

There are nine private pharmacies in Geraldton and others in Dongara, Mullewa (through the local GP practice), Morawa Perenjori, Three Springs, Northampton and Kalbarri. Most are open 6 days per week. Most private pharmacies were noted to provide the community methadone program.

No issues were raised during the planning process and it is anticipated the centralised regional WACHS- Midwest pharmacy service model will continue.

4.8.3 Pathology

PathWest are contracted to provide all pathology services for WACHS. Pathology tests are regularly transported from the sites to Geraldton (Monday to Friday) and results are returned in a timely manner. All MPS/ small hospital sites provide limited point of care testing which can provide results immediately.

4.8.4 Sterilising Services

WACHS – Midwest region has a central sterilising services department (CSSD) that provides sterilising services for all Midwest hospitals and doctors' surgeries, including Midwest MPS sites. No issues were raised and it is anticipated this centralised WACHS- Midwest CSSD service model will continue.

4.8.5 Telehealth

The WACHS - Midwest region currently utilises Telehealth for staff meetings, staff education, and the receiving of outpatient appointments provided by the metropolitan health services.

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

The initial focus of Telehealth will be:

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

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

- efficient and cost effective services while improving service access, equity, safety and quality
- improved health outcomes through increased service access and patient support, and potential to reduce the amount of travel required
- better education, training and support opportunities for local health care providers and consumers
- improved collaboration and communication between health care providers.

4.8.5.1 Issues Identified

- Existing Telehealth equipment is reported to be cumbersome to use despite its simplicity. This may be due to lack of familiarity or infrequency

of use. It is usually located in places that are inconvenient to use particularly for clinical consultations (multi-purpose rooms or staff offices e.g. Mullewa).

- While Telehealth equipment is available to all Midwest ED units, there is reported reluctance by the ED medical staff at Geraldton Hospital to fully utilise the existing linkages. The implementation of the ETS will need to ensure staff engagement in the service.
- Lack of a Telehealth coordinated, streamlined outpatients and Telehealth booking system.
- At present there are only limited Geraldton based specialists who use Telehealth regularly to provide consultations.
- There are currently limited opportunities for remote health monitoring in peoples own homes, due both to lack of available technology and also the cost to clients to participate in home monitoring.
- The community is largely unaware of the advantages of using Telehealth to improve access to health care, and minimise the need to travel to attend appointments.
- Currently Telehealth uses the MMEx booking system across DoH WA, but this mechanism is under review and a search for a new system is underway. Greater access to and education is required re whichever booking system becomes the mechanism.
- There are difficulties in interfacing between private providers (e.g. GPs, Specialists) and WACHS services and some GPs prefer to use SKYPE for personal computer videoconferencing and not the WA Health Department approved Scopia.

Proposed strategies for service improvements and reforms – Telehealth

- Telehealth needs to be better promoted and used. The future NGO model will provide one platform for telemedicine type services that could be accessed by subscription by all providers (private, public and not for profit). Plan a 2-3 year timeframe that will save money and improve access to care.
- The SIHI Telehealth streams will increase access to emergency and outpatient specialists. This will enable metropolitan or Geraldton based services to be increasingly accessed locally from the Midwest Health District sites including GP practices and may also reduce the need to transfer patients to the metropolitan area.
- SIHI will assist working with metropolitan doctors to develop Telehealth consultation models which would lead to effective Telehealth consultation for both patient and health professionals. May need to resolve the need for a clinical nurse to be in the room for many consultations.
- Increase telehealth resources and training for both specialists and the local staff who meet the patient and prepare them for their consultation.
- The priority services for increased Telehealth for Midwest Health District residents include:

Proposed strategies for service improvements and reforms – Telehealth

- emergency services (including access to ETS for all MPS sites)
- mental health and alcohol and drug services
- psycho-geriatrics and geriatrics
- pain management, palliative care and cancer care
- general physicians

- Promote and increase opportunities to access ambulatory / primary health care type services via Telehealth at all Midwest Health District sites (e.g. assemble a group of patients in a district site with an OT in Geraldton). This will enhance patient care, bring care closer to home, reduce travel for people in these communities and decrease impact on PATS budgets (where eligible).
- Seek funding for home based Scopia
- Consider the use of Telehealth for remote monitoring. Liaise with Silver Chain regarding their remote monitoring systems across areas they service, for those clients with chronic disease.
- Increase the number of clinically appropriate Telehealth rooms
- Encourage the community to enquire about Telehealth consultation as an alternative to travelling to the metropolitan area.
- Conduct an example Telehealth session so people can understand how Telehealth will work (e.g. with community groups such as Lions, CWA).
- Ensure local GPs' awareness of Telehealth including Medicare incentives to claim for equipment and undertaking consultations
- Support WACHS initiatives for e-health records, iPads and 'Apps'

4.9 Midwest Health District Non-Clinical Support Services

4.9.1 Engineering, Facilities Maintenance, Cleaning, Gardening and Supply

There is an Engineering and Maintenance team based at Geraldton Hospital with responsibility for the continuity of essential services on all hospital sites and buildings in Midwest Health District. Cleaning and gardening services are provided by locally employed WACHS staff or local volunteers.

A regional service model for supply provides a 'just in time' service. Ordering is completed electronically and then sent to smaller sites. Ordering is usually completed two to three times per week. Oracle is used for stores ordering with the catalogue being managed by Health Corporate Network (HCN).

4.9.2 Corporate Services

The WACHS–Midwest Regional Corporate Services are coordinated from Geraldton. This includes the administration, ICT, corporate governance, human resource, medical records management and financial accountability structures and systems.

HCN is WA Health's shared services centre and provides WACHS with centralised Employment and Payroll Services. In addition, HCN provides support to components of the finance and procurement function.

4.9.3 ICT

WACHS has an ICT Strategic Plan that will guide developments for the next five years, including equipment investment and application development. The implications for services and workforce from the establishment electronic medical records and human resource systems will need to be monitored.

Health Information Network (HIN) was established in 2005 as WA Health's shared ICT service. HIN provides WACHS with a range of ICT related services.

The ICT helpdesk service is centralised in WACHS. It is provided from 24 hours per day, 7 days per week with a mobile phone on call service outside business hours via Bunbury with support from local regional ICT staff for more complex issues and user provisioning. The regional ICT team has 1 FTE allocated for the Midwest and Murchison Districts and that officer attempts to visit the smaller sites in the Districts every 6 – 12 weeks and provide remote assistance in between visits.

Computer, ICT and telecommunications hardware replacement and maintenance with some software, antivirus support and updates are also managed by the regional ICT team.

Proposed strategies for service improvements and reform – ICT

- Sharing of information via the national roll out of the electronic health record between WA Country Health Services facilities/regions, and into metro and other providers would/will be of great benefit to consumers and professionals.
- Monitor the impact of electronic medical records and human resource systems as these systems are established.

4.9.4 Human Resources

Human Resources (HR) in Geraldton provide services to the whole of the Midwest including Occupational Safety and Health (OSH) services for the region. The team provide recruitment support and advice, manage grievances, misconduct/disciplinary issues, classification and establishment queries, workers compensation claims, and provides day to day HR/OSH advice, employee support and HR training.

4.9.5 Learning and Development

The Learning and Development team within the Midwest is based at Geraldton hospital and the team is responsible for the coordination of clinical and non-clinical training and development across the Midwest region. Each Midwest Health District site had staff development nurses funded for two years (to end of 2012/13 through the Commonwealth's 'Health Workforce Australia' program.

4.9.6 Issues

No significant issues were raised with existing clinical and non-clinical support services. It is anticipated that all the current centralised service models will continue.

4.10 Other Service Enablers

The six service planning workshops identified the following service enabler issues across all areas. The strategies proposed here could apply across the whole Midwest region:

- community awareness of services
- workforce attraction and retention including staff accommodation
- cultural security; and
- patient transport, particularly for non urgent transport or attendance at health appointments.

4.10.1 Community awareness of services

Consultation across the Midwest Health District indicated a lack of awareness by both community members and health providers of the services that are currently available for community members to access, and for professionals and GPs to refer. Not only will this impact on people accessing services, it may lead to under-utilised/unviable services. The planning workshops revealed that more information about services is required as it can be hard to source information about services and providers.

At present within some Midwest locations WACHS places information about WACHS, St John Ambulance and GP services within community newsletters/newspapers. It is also understood that GMML are compiling a central repository of health and wellbeing services for the Midwest Region.

Local government authorities send out resident awareness packs containing health and community service contacts, although it is acknowledged that residents who rent may not receive this information.

Proposed strategies to increase awareness of services - information sharing

Use of a wide variety of media to promote awareness and efficacy of services for both providers and the community by:

- enhanced communication between service providers
- ensuring accurate information is available through a range of mechanisms such as:
  - local government websites
  - resident awareness packs
  - social media
  - local media and radio
  - in booklets and flyers
  - rural shows/expos and community notice boards
  - in GP practices; and
  - pharmacies, main street shops, cafés and hotels
- Increase interagency communication and exchange of information, including liaison with the GMML who are contributing local information to the production of a National directory of health services.
- Review and enhance the existing regular multidisciplinary and inter-agency Midwest Health District service provider meetings (or inland and coastal Midwest Health District meetings), such as the human services group that meets for the Murchison health district.

4.10.2 Workforce

There is a moderately high turnover of staff in the Midwest and recruitment and retention is also an issue within the region. Visiting models of clinical and support services currently work well overall (though more access to mental health and drug and alcohol staff remain a priority). Visiting models allow staff to be based where greatest demand for services exist with options to provide visiting services where required. However with the population growth projected to be greatest in the Irwin and Northampton shires and the ageing population, the effectiveness of visiting models will need to be monitored.

Identified 'workforce' issues are detailed below.

- Attracting suitably experienced new providers (particularly, but not limited to nursing) may be challenging, particularly in the Midwest inland areas and where demand for services has not yet reached service viability levels (e.g. particularly residential aged care providers).
- Staff reported limited access to accommodation and incentives as well as child care to support staff with children.
- Many areas across the Midwest Health District indicated that even if skilled staff could be recruited, existing staff accommodation is largely unavailable or of poor standard. Limited short term and long term staff housing throughout the Midwest Health District is often unattractive particularly for couples, families and staff with pets.
- A workforce related issue linked to provision of emergency services is that several WACHS employees are also employees / volunteers with SJAA. This can result in issues of employee fatigue.
- Existing staff are ageing and there is more reliance on drive in drive out staff; both of these scenarios present OHS&W risks.
- There are issues re professional supervision, mentoring and professional development.
- There is high community expectation about maintaining services
- Exploration of new workforce types and models is required such as introduction of Nurse and Allied Health practitioners, increasing community development workers to better engage with the Aboriginal community, increased use of allied health and nursing assistants.

Proposed strategies for Workforce reform and improvements

Service planning consultation undertaken with stakeholders in all locations across the Midwest Health District indicated the need for a review of the regional workforce to develop and implement a strategy to attract, retain and nurture the workforce and implement new workforce models. This strategy would include:

- Implementing professional supervision, mentoring and online training
- Engage in a leadership development program
- Ongoing staff development positions in all sites
- Succession planning to build career pathways for staff and graduates
- Considering opportunities to encourage a public/private mix of health service providers and to have funding, service and resource

Proposed strategies for Workforce reform and improvements

partnerships; supporting the establishment of services may be required (e.g. provision of free low cost facilities from which to provide services, provision of low cost housing options, shared training opportunities, use of technology etc)

- Exploring new workforce models and types
- Continuing online options such as e-training or using Telehealth/Scopia for workforce training, to maintain staff competencies, to reduce the need for travel
- Developing partnerships with shires to improve accommodation options
- Exploring opportunities for utilising semi-retired health professionals, particularly for Telehealth consultations, which may reduce waiting times and workload for the limited number of GPs available in the area
- Investigating opportunities to share training between local health providers (which could also improve cross-agency partnerships) but concerns about clinical governance will need to be addressed
- Developing recruitment strategies that target 457 visa holders who are overseas trained, plus local scholarships

4.10.3 Cultural security

Whilst WACHS – Midwest provides an Aboriginal Health Service, the need to provide culturally appropriate health services and facilities for the area's Aboriginal population is well recognised, including the recruitment of more Aboriginal staff as both health workers and across the workforce more generally. For example, there is limited uptake of Home and Community Care (HACC) Services by Aboriginal families and no Aboriginal Community Controlled Health Organisation (ACCHO) providing GP and other primary health care services in the Midwest District.

Strengthening the cultural security of services will work towards ensuring Aboriginal people receive appropriate care at the right time in the right setting and would align with the intentions of Commonwealth and State Government policies.

Feedback from a recent survey by Midwest Health District Aboriginal Health Workers of the local Aboriginal community confirms workshop participant views of the need to continually ensure all health and hospital services across the continuum of care are welcoming and culturally aware and sensitive to the needs of clients from Aboriginal families and to develop engagement strategies to support Aboriginal clients access services.

Proposed strategies improving Cultural Security

- As per the WACHS Aboriginal Employment Strategy 2010-2014, increase recruitment of Aboriginal staff, both within Aboriginal specific positions and across the workforce more generally.
- Ensure all staff attend mandatory cultural security training
- Increase aboriginal community engagement

4.10.4 Patient transport

Difficulties for patients who must travel to and from Geraldton and Perth health services were raised in all locations across the Midwest. There is a current lack of voluntary patient/consumer transport services, difficulty in accessing suitable, reliable vehicles and in most locations, no public transport options.

Some transport support is currently available through HACC (for HACC clients) and via PATS where eligible. Other options for patient transport rely on volunteer ambulance, WACHS staff (inland staff particularly) and family and friends volunteering to transport patients. Volunteer SJAA services are often called on to transport non acute and non-urgent patients at a significant cost to WACHS. There are a range of transport issues including:

- non urgent, non-acute inter-hospital transfers (by road) to Geraldton and repatriation back to home communities or hospital when an ambulance transfer has occurred to take them to Geraldton
- some people require multiple appointments each week but are unable to travel to services
- transport of people with a mental health issue or in an altered mental state due to alcohol or drug use, who are a risk to themselves or others
- private/public/community transport to outpatient specialists or coming in for local appointments from outlying farms or communities
- need for more support for the volunteer SJAA services, 5-7 hour turn around for ambulance call out are not uncommon
- shared training opportunities and Telehealth supports for SJAA volunteers could be considered
- low availability and/or numbers of SJAA volunteers across the District
- WACHS transport issues such as lack of appropriate vehicles to enable home visit patients and transport equipment
- unwell, frail and/or aged patients, single parents and young mothers who are unable to drive or access transport to appointments within the region or in the metropolitan area are reported to sometimes forego appointments which could potentially compromise their health
- within the Midwest Health District – inland area, it has been reported that health staff drive patients to appointments in Geraldton resulting in a shortage of staff at the inland MPS sites, this is exacerbated when transporting a mental health patient as two staff must accompany the patient
- similarly where patients require non urgent inter-hospital transport from smaller sites to Geraldton Hospital, ambulance transport is often used putting pressure on SJAA volunteers and leaving the community without ambulance services; and
- when SJAA volunteers transport to Geraldton there is limited support available for the volunteers whilst they are in Geraldton (e.g. no overnight accommodation).

The statistics for inter hospital patient transfers in the Midwest Health District are shown below in Table 4.

4.10.4.1 Inter-hospital patient transfers

In 2010/11 there were 1054 inter hospital patient transfers from all Midwest Health District hospitals via ambulance, health service owned transport, and RFDS. Ambulances associated with the RFDS transfers shown above are excluded from this information. There were1204 transfers in 2012/13 an increase of 14%.

The hospitals with the biggest increases were Dongara (36%), and Kalbarri (59%). The type of transport with the biggest actual and percentage increase was Private transport which increased by 106 (29%) from 2010/11 to 2012/13. This highlights the increased pressure on transport over the last two years. In Dongara alone, private transport increased by 93 (50%).

Table 4: Midwest Health District: inter-hospital transfers (2010/11 – 2012/13)

HOSPITAL	TRANSFER MODE	2010/11	2011/12	2012/13
DONGARA	(blank)	4	12	15
	Hospital Transport		2	1
	Private Transport	188	280	281
	Other	1	1	5
	Ambulance Emergency	182	138	225
	Private/Pub Transport	7		1
	Ambulance Non-Emergency	5	70	12
	Ambulance	10		
TOTAL		**397**	**503**	**540**
KALBARRI	TRANSFER MODE	2010/11	2011/12	2012/13
	(blank)	4	1	5
	Hospital Transport	1	1	5
	Private Transport	16	25	21
	Other	3	1	
	Ambulance Emergency	47	60	90
	Police		1	1
	Interhospital RFDS	1	1	4
	Priv/Pub Transport	1		2
	Ambulance Non-Emergency	10	8	4
	Repatriation RFDS	0	2	4
	Ambulance	2		
	Emergency RFDS (Evac)	1		1
TOTAL		**86**	**107**	**137**
MORAWA	TRANSFER MODE	2010/11	2011/12	2012/13
	(blank)	2	2	5
	Hospital Transport	6	8	2
	Private Transport	30	50	41
	Other	9	4	1
	Ambulance Emergency	81	55	38
	Police	2	1	0
	Interhospital RFDS	11	20	27

	Private/Pub Transport	2		2
	Emergency RFDS (Evac)	2		5
	Ambulance Non-Emergency	4	10	0
	Royal Flying Doctor	2	0	2
	Ambulance	3		
TOTAL		**154**	**150**	**123**
MULLEWA	TRANSFER MODE	2010/11	2011/12	2012/13
	(blank)	9	4	0
	Hospital Transport	13	7	21
	Private Transport	43	48	53
	Other		2	
	Self	1		
	Ambulance Emergency	41	51	56
	Police		1	
	Interhospital RFDS		1	1
	Emergency RFDS (Evac)	1	2	1
	Ambulance Non-Emergency	10	26	12
	Ambulance	3		
TOTAL		**121**	**142**	**144**
NORTH MIDLANDS	TRANSFER MODE	2010/11	2011/12	2012/13
	(blank)	3	1	3
	Hospital Transport	5	13	8
	Private Transport	35	57	36
	Ambulance Emergency	26	31	16
	Police		1	2
	Interhospital RFDS	3	1	7
	Private/Pub Transport	8	0	9
	Emergency RFDS (Evac)	13	21	17
	Ambulance Non-Emergency	3		
	Royal Flying Doctor	3	0	4
TOTAL		**99**	**125**	**102**
NORTHAMPTON	TRANSFER MODE	2010/11	2011/12	2012/13
	(blank)	15	19	19
	Hospital Transport		3	5
	Private Transport	57	57	43
	Other	3	0	
	Ambulance Emergency	107	70	78
	Ambulance Non-Emergency	11	27	13
	Ambulance	4		
TOTAL		**197**	**176**	**158**
MIDWEST HEALTH DISTRICT TOTAL		**1054**	**1203**	**1204**

Source: WACHS online ED pivot and WACHS online ATS pivot, as at 24th Feb 2014.
Data includes unqualified neonates and boarders.
Includes transfers to acute hospitals, psychiatric hospitals and nursing homes.
** Other includes commercial airline and other.*
Note: Ambulances include volunteer, community or hospital owned ambulances, but exclude instances where an ambulance is used in conjunction with RFDS, other plane or helicopter.

As shown in

Table 5, from 2010/11 to 2012/13 the majority of the Midwest Health District hospitals patient transfers were to Geraldton.

Table 5: Destination of inter-hospital transfers from Midwest Health District Inpatient and Emergency Departments and (2010/11 - 2012/13)

Hospital	Separated to	2010/11	2011/12	2012/13
Dongara	Geraldton	393	482	529
	Metro	2	0	1
	other MW	0	2	0
	other/blank	3	19	10
Dongara Total		**398**	**503**	**540**
Kalbarri	Geraldton	80	104	119
	Metro	3	3	10
	other MW	2	0	1
	other/blank	2	0	7
Kalbarri Total		**87**	**107**	**137**
Morawa	Geraldton	120	115	75
	Metro	16	25	37
	other MW	4	1	6
	other/blank	13	7	5
Morawa Total		**153**	**148**	**123**
Mullewa	Geraldton	120	136	142
	Metro	1	1	2
	other MW	0	0	0
	other/blank	0	5	0
Mullewa Total		**121**	**142**	**144**
North Midlands	Geraldton	74	103	68
	Metro	20	26	30
	other MW	6	1	1
	other/blank	3	6	2
North Midlands Total		**103**	**136**	**102**
Northampton	Geraldton	181	162	145
	Metro	1	1	1
	other MW	3	1	0
	other/blank	2	1	12
Northampton Total		**187**	**165**	**158**

Data includes unqualified neonates and boarders.
Includes transfers to acute hospitals, psychiatric hospitals and nursing homes. Excludes transfers from residential aged care facilities and nursing posts.
^Includes not stated. Source: WACHS online ED pivot and WACHS online ATS pivot, as at February 2014.

4.10.5 Patient's Assisted Travel Scheme (PATS)

The Patient Assisted Travel Scheme (PATS) provides an important role in linking specialist treatment to country Western Australians. Assistance is offered to eligible residents of a WACHS region and their approved escorts who are required to travel more than 100km (one way) to access the nearest PATS eligible medical specialist services not available locally, via telehealth or from a visiting service.

Assistance is provided in the form of a travel and accommodation (where applicable) subsidy. It is not intended to meet the full costs of travel and accommodation, or to provide assistance with other costs associated with access to specialist appointments. Patients who are required to travel between 70-100km to access the nearest eligible medical specialist service for cancer treatment or dialysis are also eligible for limited PATS assistance.

Most specialist medical services covered by Medicare are eligible under PATS. However, referrals to other health professionals are not covered by PATS.

Local hospitals and health services can provide help with organising travel and accommodation if required. Fuel and accommodation subsidies can also be provided prior to travel if necessary. Taxi vouchers are not routinely provided but in limited and exceptional circumstances will be considered.

Some locations in the Midwest Health District (including Northampton, Dongara) are less than this distance from Geraldton and therefore residents do not qualify for PATS if going to Geraldton, but do if needing treatment in Perth. Mullewa is 98.5 km from Geraldton, but the community does qualify for PATS support.

Proposed strategies improvements in Patient Transfers / Transport Issues

- Negotiate with GMML to potentially fund transport
- Given these issues are experienced across the Midwest Health Region, it is proposed the region supports the SJAA to lead the development of a Midwest Development Commission, Gascoyne Development Commission and Shires with consideration of:
  - Volunteer patient transport across the Midwest District (referring to the successful Community Assisted Patient Transport model in Narrogin).
  - Funding options (shire, Lotterywest, Bendigo Bank) for a 'community car' or local buses that could possibly be used with volunteer drivers.
  - Advocating for inclusion of dental services within PATS criteria
  - Dongara and Northampton non urgent patient transports as these sites are both outside of PATS eligibility criteria (exception Cancer and Dialysis patients)
  - Advocate SJAA to provide a salaried paramedic
  - Advocate for public transport services to Geraldton
- at the local level health providers can promote awareness of the pensioner $500 fuel card entitlement(applications available from Australia Post), which may assist with transport expenses.
- Also refer to Telehealth strategies detailed earlier, which can impact on the need for patient travel.

5 Site Specific – Current and Future Services

All WACHS - Midwest Health District sites and local health services are part of the Multi-purpose service (MPS) program. The design of the MPS program allows rural communities to pool Commonwealth and State health and aged care funds within a designated geographical area, creating opportunities to coordinate and appropriately target community health and aged care needs.

Flexible aged care funding allows services to be provided either in a residential setting (currently primarily the hospital or a hostel) or in the community in people's own home. The major objective of a MPS is to improve the range of health and aged care services being offered in the community, to dispense with inflexible funding arrangements, to encourage community participation in service planning, and to improve quality of care.

The Commonwealth is changing its policy focus to enable people to remain in their own homes for as long as possible in line with national and international trends.

For WACHS the health service management of the six MPS sites in the WACHS Midwest Health District is split into the coastal sites (Dongara, Northampton and Kalbarri) and the inland sites (Morawa Perenjori, Mullewa and Three Springs (refer to the operational structures in Appendix C).

5.1 Dongara/Eneabba/Mingenew MPS

In addition to the district wide WACHS health services and those of the health partners that service the WACHS - Midwest Health District, the following services are based in Dongara and serve the catchment population of the Dongara / Eneabba / Mingenew MPS.

Table 6: Summary of the Dongara / Eneabba / Mingenew MPS Health Services

Services	Features
Emergency Services	Dongara provides 24 hour/ 7 day a week nurse-led emergency response and stabilisation. It has three ED bays including one resuscitation bay, Telehealth and ECG capability. Medical cover is provided by Geraldton doctors and ED. The current Department of Health ED activity forecast indicates Dongara will need no more than the current ED bays in around ten years' time as the population is not forecast to increase significantly.
Medical acute inpatient services	Two acute bed multi-day beds at Dongara There is one respite and one palliative bed. The current Department of Health activity forecast indicates Dongara will require no more than the current three acute beds bed in ten years (2021/22).
Medical cover	Currently via Geraldton hospital doctors for ED and acute admissions(admissions to Geraldton)
Residential Aged Care	Six residential aged care beds (single rooms) at

Services	Features
	Dongara with Aging in Place
Nursing Outpatients/ Extended Care	Provided by Dongara MPS nurses
Home Visiting	If available a Midwife may provide newborn early discharge home visits
X rays	Not at present
Pathology	Are provided a private laboratory and regularly transported to Geraldton (Mon to Fri).
Pharmacy	Prescription via fax from Geraldton ED doctors.
Non Clinical Support	Laundry and Patient Care Assistants on site and local handyman/gardener and volunteers.
Patient Assisted Travel Scheme (PATS)	Health Service Admin provide PATS processing support on site at Dongara
Day Centre	Two days per week at Dongara and includes residents and aged community members
Respite	Overnight booked Respite as well as weekly Day and Emergency in house Respite available. Carer support groups are held on site bi-monthly
Home and Community Care (HACC)	ACAT visit once a month There are 41 Aged Care Packages. Services include home support services including for Veterans, meals on wheels, patient transfers and visits to specialist appointments
Child and School Health	0.9 FTE child health and 0.6 school health nurses based at Dongara MPS
Physiotherapy	Visiting - two clinics are held per week at the MPS and 'fit to live' at the recreation centre for older residents and Stay on your feet activities.
Diabetes Educator	Visiting – two clinics are held per month at MPS and home visits
Continence Advice	A nurse provides for Midwest East (Three Springs, Morawa Perenjori and Mullewa) and Dongara.
Therapy assistant	Provides limited services for children with special needs including autism.
Social work	Visiting once per fortnight
Community Mental Health	Midwest Regional Child, Adult and Older Adult services visit twice per week
Community Alcohol and Drug	Visiting monthly
Public School Dental Health Services	Visit schools from Geraldton

5.1.1 General Practitioners

Medical Services in Dongara are provided by a Geraldton based private GP practice (Batavia Health) with two visiting Nominated Medical Practitioners (NMPs) co-located on the Dongara MPS site. In addition a Royal Flying Doctors Service (RFDS) female GP visits one week every 2 months.

According to the MSA between WACHS and the Principal GP at Batavia Health:

- both ED medical coverage and acute medical coverage can be provided by the NMPs in Dongara
- at present one NMP is credentialed for ED medical coverage, but both NMPs have admitting rights at both Dongara MPS and Geraldton health campus
- the MSA does not including on-call or after hours medical coverage
- a recent SIHI variation to the MSA notes that the two NMPs will provide 'network primary care services' up to a maximum of 10 days per week (i.e. 5 days each NMP).

Due to the lack of close on-call after hours medical coverage, currently any patient in Dongara requiring an acute hospital admission is transferred to Geraldton.

The MPS aged residential care and palliative care clients receive their medical cover, as per usual arrangements, via the Dongara GP practice.

5.1.2 Ambulance Services

Dongara SJAA has approximately 50 volunteers and is the busiest sub-centre in the Midwest region. SJAA attend acute and non acute transfers. Trauma cases are transferred directly to Geraldton.

5.1.3 Additional Community, Health and Aged Care Services

Private practitioners

- Dentist – visiting, rents rooms, no orthodontist
- Pharmacy opens five and half days per week
- Private physiotherapy services provide a visiting service
- A psychologist from Goldfields-Midwest Medicare Local (GMML) visits five days per fortnight.

Other community based, health and wellbeing services

- Dental Health Service from Geraldton (Leeman and Eneabba receive mobile dental service from Jurien Bay
- Dongara Men's Shed
- Community Volunteers – Health Service, homes, activities assistants, meals on wheels
- Recreation opportunities - Zumba, Zumba gold (seniors), Badminton/tennis/volleyball, "Stroller Striders " walking and social group, Building Better Bones" activity group

- Service Groups - Country Women's Association (CWA), Lions Club, Surf Lifesavers, Local Church Breakfast Club, Charities Association and the local Catholic Church provide food vouchers for those in urgent financial need, "My time" disability service for children with special needs - run by a local church
- Irwin Shire operate environmental health, Better Beginnings, Dongara Library, Children Services – Toddler time, music time, toy library, story time and playgroup (3 times each week for 2 hours and utilise nature play and other themes)
- Irwin Shire also operates 39 independent living units for older people.
- Dongara Community Resource Centre (formerly Telecentre).

5.1.4 Service and Community Strengths

- The health services at the Dongara MPS are highly regarded by both the community and providers. Health service patients generally feel safe and well cared for. There is open disclosure and complaints are dealt with well.
- There is a reasonably wide range of primary health care type services (public and private) currently available to the Dongara community although additional resources would be welcomed across all areas as the demand increases.
- Flexibility and responsiveness of community nursing (outpatient home visits, palliative care and wound care) is recognised and appreciated.
- Dongara MPS has good linkages and combined aged care activities with Three Springs and Morawa Perenjori communities.
- HACC services are reported as being excellent at supporting older people to remain in their homes for as long as possible.
- Dongara Community Resource Centre is considered to provide a valued and useful service.
- Telehealth is used for some specialist appointments, although this is still a limited service.
- Irwin Shire has good sporting and recreational facilities in the area. Shire facilities can be used by community groups to run activities. It also has developed its strategic planning strategy which is available.
- The Dongara community has a strong sense of community spirit. The community are generous with donations to the MPS (e.g. chook pen and raised vegetable beds). The volunteer base for SJAA and other services is strong. There are a variety of activities run throughout the week largely run by volunteers.
- The Irwin (Dongara, Port Denison and surrounding area) population was estimated at approximately 3700 in 2012 of which 350 people (approx 9%) are volunteers in some capacity. It is acknowledged that volunteers are ageing and it is anticipated this volunteer base may reduce over time.

- Dongara has natural assets such as the beach which provide opportunity to be active. These assets and the townscape are being enhanced through the Irwin Shire's new strategic plan.

5.1.5 Key Service Issues and Needs Highlighted

In addition to the District wide issues raised at all planning workshops the following are issues specific to Dongara.

Medical and Emergency Services

- There can be a wait of up to three weeks for appointments with the GP. The GPs are not available out of hours or at weekends people and people therefore tend to access primary care services via Dongara's emergency department (ED) at these times.
- The GPs manage their appointment schedule and reserve a few spots for following up patients from the health service. However, this does not meet the current level of demand.
- The GP practice does bulk bill for aged pensioners only, with other concession card holders refunded their Medicare rebate on the day of consultation.
- Dongara's medical services are also used by Eneabba and Leeman residents (approximately 90 kilometres or one hour's drive away) even though Leeman is only around half an hour from Jurien Bay. Historically the Dongara GP travelled to Mingenew and Leeman weekly but this no longer occurs.
- The current MSA between the GPs and WACHS does not include on-call or after hours medical cover at Dongara health centre and ED. Patients therefore are not admitted into the Dongara health centre, they are transferred to Geraldton Hospital.

Service Access and Telehealth

- There is a notable increase in visitors to the area in summer and holiday periods. This is reflected in ED presentations at Dongara (where higher numbers of presentations are seen to occur in line with the summer, autumn and spring school holiday periods) and needs to continue to be managed operationally – potentially by increasing staff in peak periods as the population increases.
- The existing ambulance services run through a substantial volunteer base but non urgent Inter-hospital patient transport falls back to SJAA due to lack of alternative patient transport options.
- While there is good access for emergency care at the Dongara Health Centre access is limited for more complex care. For example older people must travel to Geraldton or Perth for neurological and/or a falls assessment or Exercise Stress Tests which can limit service access. However numbers requiring such assessments are unlikely to be sufficient to warrant a visiting service in the next few years.
- There is limited use of Telehealth for ED and clinical consults at present.

- Dongara MPS reports that it often fills the gap between acute discharge and recovery but resources for extended care /domiciliary care nursing are limited.
- There was community concern regarding the length of the waitlist for haemodialysis patients. Further investigation has identified that there has already been considerable reduction of this wait list through efforts at Geraldton Hospital.
- There are no hydrotherapy services available locally, but the consultation discussion noted these services are unlikely to be viable in Dongara itself as a hydrotherapy facility is very costly to operate, maintain and staff for relatively small numbers of people who would require the service. Hydrotherapy services are available in Geraldton at the aquatic centre and via private physiotherapists.

Care for Older People

- The community expressed a need for more options to 'age in place' in Dongara and there is a growing elderly population.
- There are six aged care beds at Dongara MPS which is not meeting the current level of demand for Dongara hospital which averaged 6.7 occupied residential beds in 2012/13 (calculated by dividing the occupied beddays (2433) by 365). This indicates that acute beds are being used to meet the overflow of residential aged care type clients. The acute beds in Dongara are not being used for acute patients due to the lack of close on call medical coverage available in Dongara.
- There is one respite bed available.
- The Irwin Shire has earmarked land for an ageing in place precinct based on the York model, and are continuing to explore options.
- Older community representatives at the planning workshops expressed concern about social isolation of elderly people in the community, particularly if their partner has passed away.
- There is a visiting Geriatrician and Psycho-geriatrician to Geraldton.
- The community considered that the eligibility criteria for Home and Community Care Services (HACC) are unclear and lack transparency.
- There are bi-monthly carer support groups (six times each year)

Mental Health

- The community perceived there to be limited access to the Geraldton based community mental health team services prior to and post crisis.
- The community felt that Dongara could be a more youth friendly town, with more age appropriate activities for young people. It was acknowledged that currently many young people leave town for education and employment opportunities.

Patient Transport

- As well as the patient transport issues discussed under district wide issues Dongara only has a public transport bus that operates daily to Geraldton. It does not leave until 2pm and does not return until 2pm the following day, and therefore cannot readily be used for patient transport unless patients stay overnight.

Health Promotion, Primary Health Care and Chronic Disease Services

- There is currently no local health promotion officer based in/or visiting Dongara.
- The community report difficulty accessing health and or exercise programs after hours.
- The community indicated that there are limited cheap fresh fruit and vegetables in Dongara town stores which can impact on food choices.

5.1.6 Proposed Service Strategies

These strategies for the Dongara health services are in addition to the District wide strategies proposed in chapter four.

Proposed Service Improvement and Reform Strategies - Dongara

Medical and Emergency Services

- Midwest Region and District to work in partnership with the GP practice and SIHI to maximise service potential by way of identifying incentives under SIHI Stream One, with a focus on the development of sustainable GP services in Dongara.
- Ensure that all stakeholders are fully aware of the details of the MSA between WACHS and Batavia Health to deliver medical services in Dongara.

Service Access and Telehealth

- Advocate to SJAA to investigate the need for a salaried paramedic during times of anticipated higher volumes (e.g. holiday periods). The paramedic would provide additional local emergency support in Dongara during times of greater need.

Care for Older People

- The 2012/13 MPS planning should use the most current occupied beddays data to monitor the need in Dongara for residential aged care beds which currently slightly exceeds available aged care beds, and to plan for more extended care community aged care packages to enable people to remain at home for as long as possible in consultation with the Commonwealth Department of Health and Ageing (DOHA).
- In partnership with other residential care providers (such as Global Care Inc), work with the Irwin Shire to explore options for more independent living, respite care, carer support facilities or HACC supported residential aged/frail aged units.

Proposed Service Improvement and Reform Strategies - Dongara

- Promote the existing respite and support services available including the bi-monthly carer support group run by MWCRCCC
- Investigate opportunities to increase the amount of care support and respite available, and review coordination of support to ensure optimal access by carers.
- The national reform agenda for aged care should assist country residents by increasing flexibility around respite care, increasing knowledge of and access to HACC services and potentially supports for non HACC users.
- Explore ways to provide support and care to recently bereaved older people: (e.g. a follow up call by the MPS staff or link up with a group or helpline for grief counselling/support).

Mental Health

- Need to increase awareness of and access to existing WACHS and GMML (Medicare Local) community mental health and alcohol and drug services in Dongara.
- Increase community education and understanding of Mental Health and Alcohol and Drug issues for both the local community and providers.
- Explore whether the volume of patients is sufficient for the GP practice to employ a mental health nurse via Medicare incentives.
- Work in partnership with other providers of mental health services to explore options to increase availability of mental health services for the Dongara community including increased locally available services, use of Telehealth services and increased use of Rural Link.
- Ensure that all staff have access to mental health training.

Patient Transport

- The Shire to advocate to the bus transport company for a return of a daily service to and from Geraldton to Dongara that leaves in the morning and returns in the afternoon.

Telehealth

- Need to increase access to and use of Telehealth at Dongara MPS for ED, mental health consultations and clinical care for residents and outpatients. This will lessen the impact of not having access to the PATS subsidy for Dongara residents.

Health Promotion, Primary Health Care and Chronic Disease Services

- Advocate to the Shire, Police and other agencies for greater options for youth in the area (e.g. YMCA, Police and Citizens youth club).
- WACHS and GMML to develop an integrated model of care that increases the capacity of both agencies to deliver primary health care and chronic disease services.

Proposed Service Improvement and Reform Strategies - Dongara
Awareness and Coordination of services ▪ Use local media and other established communication mechanisms to actively promote health services available in Dongara, including advertising phone help lines – Health Direct and Rural Link (for mental health counselling and crisis care). ▪ Promote the Medi-alert and also the $500 fuel card for seniors at both GP and Dongara MPS. Encourage people to nominate neighbours or relatives to be the Medi-alert contact rather than Dongara ED. ▪ Establishing a Midwest Health District interagency forum that meets in rotating locations across the District could enable more partnerships and better coordination between agencies. The group could work toward confirming the responsibilities of each partner (WACHS, Shire, other agency and also community). Additionally the group could explore the establishment of a community development resource (funded across agencies/shire) to support development of community networking (e.g. single parents group, adopt a nanna/pop, singles day). ▪ Farm safety was raised as an issue to be further investigated to ascertain the need for health promotion programs for farmers, their families and workers.

5.2 Northampton and Kalbarri MPS

In addition to the district wide WACHS health services and those of the health partners that service the WACHS - Midwest Health District, the following services are based in Northampton and Kalbarri serving the catchment population of the joint Northampton – Kalbarri MPS.

Table 7: Summary of the Northampton – Kalbarri MPS Health Services

Services	Features
Emergency Services	24 hour/ 7 day a week nurse-led emergency response and stabilisation at both Northampton and Kalbarri Northampton - three ED bays including one resuscitation bay. Kalbarri – three ED bays including one resuscitation bay. Both have Telehealth capability. The current Department of Health ED activity forecast indicates Kalbarri will need no more than the current ED bays in around ten years.
Medical inpatient services	Northampton - two acute bed multi-day beds, two care awaiting placement beds. Kalbarri – 4 acute multi day beds (one 3 bed room & one single room – shared bathrooms)

Services	Features
	The current Department of Health inpatient activity forecasting indicates neither site will require more than their current acute beds within the next ten years (to 2021/22).
Residential care	Northampton – 10 residential aged care beds including two respite and one palliative care bed (single rooms with ensuites) Kalbarri – No residential or respite beds.
Medical cover	GP practice provides 24/7 on-call cover to the Health Centre. Occasional no on-call medical cover available - back up provided through WACHS i.e. RFDS and GRH.
Outpatients/Extended Care	Provided by MPS nurses – can provide home visits.
X rays	Kalbarri - Seven nurse x-ray operators provide emergency imaging of chests and extremities. Northampton – no imaging
Pathology	Collection facilities available and pathology/blood test transported to Geraldton.
Pharmacy	Prescription via fax from Geraldton ED doctors. GP service provides prescriptions for patients attending KHC ED / OP department.
Non Clinical Support	Laundry on site and local handyman/gardener. Patient Care Assistants (PCAs) on site, general handyman services and gardening services are provided by locally employed WACHS staff and volunteers.
Patient Assisted Travel Scheme (PATS)	PATS Clerk on site at Kalbarri and Northampton.
Day Centre/Falls Prevention	Kalbarri – Falls prevention group weekly Northampton - one day per week includes residents and aged community members. Also a 'mums and bubs' playgroup once per week.
Visiting respite Midwest Central Respite Care Coordination (MWCRCCC)	Kalbarri – visits six times per year Northampton – carer support group is held six times a year and additionally MWCRCC funds carer self-management and morning tea group
Home and Community Care (HACC)	Located at both Kalbarri and Northampton. Services include home support services including for Veterans, meals on wheels, patient transfers and visits to specialist appointments and Aged Care Assessment (see below)
Aged Care Assessments	Visiting Northampton monthly and Kalbarri as required from Geraldton

Services	Features
Child and School Health	Kalbarri & Northampton have child health and school health nursing
Diabetic and Asthma Educators	Visiting Northampton and Kalbarri. Asthma education also provided by Asthma education RN.
Allied Health	WACHS physiotherapist visits 1x per week from Geraldton Dietitian, OT and Speech Pathologist – visit from Geraldton every 4-6 weeks. Social worker – onsite: works between Kalbarri & Northampton. Therapy Assistant – 0.6 FTE Health Promotion Officer Commonwealth Rehabilitation service periodically when clients booked for appointments.
Community Mental Health	Northampton - Visit on required depending on referrals and case management requirements. Kalbarri – visit on request
Midwest Community Alcohol and Drug service	Visit on request and periodically
Public School Dental Health Services	Visit schools from Geraldton

5.2.1 General Practitioners

Medical Services in Northampton are provided by a GP practice with two GPs (1 works 0.9 and one works 0.2). During opening hours people can usually be seen on the day, urgent patients are seen straight away. The practice is well regarded by the community. The GP is located close to the MPS site but there is no local 'on-call' medical support on the weekends or after hours to the MPS or to the Northampton community.

Medical services in Kalbarri are provided by a GP practice with three GPs. This practice also provides GP services in Mullewa and Northampton. During opening hours people can usually be seen on the day, urgent patients are seen straight away. The GP practice provides 24/7 on-call cover to the Health Centre. Occasionally no on-call medical cover is available so back up is provided via WACHS' 'contacting a general practitioner to attend an emergency department or inpatient' algorithm i.e. RFDS and GRH.

5.2.2 Ambulance Services

SJAA has volunteer bases in Kalbarri and Northampton. SJAA attend acute and non acute transfers. Trauma cases are transferred directly to Geraldton.

5.2.3 Additional Community, Health and Aged Care Services

Private practitioners

- Pharmacies which open five and half days per week are available in both Northampton and Kalbarri.
- Psychologist from Goldfields-Midwest Medicare Local (GMML) visits Northampton five days per fortnight.
- Private Optician – visits Northampton every three months and Kalbarri every two months or as needed.
- Chiropractor visits Kalbarri every six weeks at the GP practice.
- Massage therapist is based in Kalbarri.

Other community based, health and wellbeing services

Northampton

- Independent Living Centre visits Kalbarri three times a year.
- Mother's Group Weekly
- Centacare visits from Geraldton and provides financial and general counselling services
- Mental Health Emergency Response Line (MERHL) – Appointments every 3 weeks for Aboriginal people, provides links and transport
- A group for aboriginal mums and bubs meets at the old school building and provides some transport
- Recreation facilities – many available e.g. sporting teams, boot camp except swimming pool.
- Volunteer walking and light exercise group.
- Volunteer boot camp classes.
- Volunteer patient transport – shopping and trips to Geraldton.
- Volunteer Meals on Wheels.
- Eight independent living units and eight frail aged accommodation units.

Kalbarri

- Centacare financial and general counselling service visit from Geraldton
- Chrysalis Counselling visits from Geraldton
- Alcoholics Anonymous visit from Geraldton
- Recreation activities available include, golf, bowls, tai chi, football and cricket.

5.2.4 Service and Community Strengths

- The health services provided by the Northampton - Kalbarri MPS are highly regarded by the community.

- There is a reasonably wide range of primary health care type services (public and private) currently available to the local communities.
- There is flexibility and responsiveness by community nursing in delivering outpatient home visits, palliative care, and wound care.
- There is access to a range of community volunteers in Northampton although SJAA volunteers are limited.
- The Northampton Shire supports health service delivery including contributing significant funds towards health facility developments and services ($1 million over the last 18 months – 1.6% of all rate income in collaboration with Rural Health West).
- Kalbarri particularly has natural assets such as the beach which provide opportunities to be active.
-

5.2.5 Key Service Issues and Needs Highlighted

In addition to the District wide issues raised at all planning workshops the following are issues specific to Kalbarri and Northampton

Medical and Emergency Services

- The local GP services cover the three surgeries at Northampton, Kalbarri and also Mullewa (currently four GPs to cover the three surgeries). This results in extensive, unproductive travel time and reduced capacity to provide on call after hours support to the MPS sites (particularly Mullewa).
- At Northampton the GP is only available on call to the MPS four nights per week and every third weekend to admit patients. When the GP is unavailable patients have to be transferred to Geraldton unless it is for respite care.
- There is a high transient tourist population in Kalbarri which increases demands on health services and ED during holiday periods. The effect can be seen within the ED data where increased activity aligns to the summer, spring and autumn school holiday periods.

Service Access and Telehealth

- Limited local access to specialists, pathology, diagnostics and allied health in Northampton due to close proximity to Geraldton and long waiting time – up to three months – for Specialists in Geraldton.
- Telehealth can work well but increased education of both staff and the community is needed to increase familiarity and therefore the use of this valuable mode of service which increases local access to services.
- Limited access to services and facilities for the disabled and rehabilitation services.

Care for Older People

- The proportion of older people (70+ years) in the Northampton community is growing faster than other age groups. It was 12.5% (405

people) in 2011 and increased to 13.1% (439 people) in 2012. (ABS 2012 Estimated resident population figures) The WA Department of Planning projections forecast the proportion to increase to 16% by 2026 (or 784).

- There are ten aged care beds at Northampton MPS which is meeting the current level of demand for Northampton hospital which averaged 9.7 occupied residential beds in 2012/13, calculated by dividing the occupied beddays (3535) by 365
- The need for additional aged high care aged care options is perceived by the community to be both a current and future issue for Northampton.
- HACC services currently provide cover from Northampton to Port Gregory which requires significant travel by staff. HACC services has over 30 clients, and provides six community aged care packages which exceeds current resources and reduces the capacity to take on more clients.
- In Kalbarri it is perceived that older people feel Telehealth is confronting / confusing**.** It is more feasible for it to be implemented at Northampton although there may be ICT issues
- The facility at Northampton is run down and requires an upgrade
- There are limited respite services available. At Northampton MPS there is one respite bed, but any additional respite type patients are accommodated by flexible bed allocation. The community members report there is a lack of information available to the local community regarding accessing respite beds or in home respite care.
- The community raised a wish for a hydro tub or pool for people with physical limitations and disabilities, however viability is unlikely given the high cost to build, maintain and staff for relatively low volumes of people.

Mental Health

- The community report limited awareness of and how to access specialist community mental health and drug and alcohol services in Northampton
- There are no local private counsellors or GP based primary mental health nurses.

  Kalbarri staff stated they have no access to Mental health and The GP stopped referring people as there was no one to see them.

Patient Transport

- In addition to the patient transport issues highlighted under district wide issues, chapter four, there is virtually no public transport or taxi service in Northampton – just a monthly bus to and from Kalbarri via Northampton to Geraldton.
- Transport to outpatient appointments relies on relatives, community members and ambulance volunteers unless people are HACC eligible.
- Northampton does not have a large pool of SJAA volunteers and there are difficulties in attracting and retaining community volunteers.

- Northampton residents incur extra costs to access many health services as they do not receive PATS subsidy for travel costs.
- At Kalbarri some SJAA drivers are difficult to engage, so more support is needed for them
- Kalbarri – transport is a major issue: particularly to Geraldton – only three volunteers at present, and have to pay for O/N accommodation, not just the elderly but for a range of groups,

Health Promotion, Primary Care and Chronic Disease Services

- There is a community perception of limited education and preventative or health promotion groups to tackle mental health and drug and alcohol issues, particularly for younger people.
- No facilities for service provision to 0-10 year olds and early years initiatives
- Limited awareness of or access to health and wellbeing services for young adults
- A query was raised in the planning sessions about re-establishing a Men's Shed and / or a Men's health program.
- Limited access to early discharge midwife follow up particularly in Kalbarri.
- There is no hydrotherapy pool and service available locally, but noted as unlikely to be viable as very costly to operate, maintain and staff for relatively small numbers of people.

Care Coordination

- Similar issues to those expressed in planning workshops to all other Midwest Health District communities (refer chapter four).
- Kalbarri: It's important that the information going back from St Johns to the health service is timely and accurate.

Aboriginal Health

- Given the district wide roles there is limited access to the WACHS or GRAMS Aboriginal Health Worker (AHW) and Aboriginal Liaison Officers (ALO) resources and no access in Kalbarri or Northampton at present.

5.2.6 Proposed Service Strategies

These strategies for the Northampton and Kalbarri MPS and other health services are in addition to the District wide strategies proposed in chapter four.

Proposed Service Strategies – Northampton- Kalbarri MPS
Medical and Emergency Services ▪ Midwest Region and District to partner with the GP practice and SIHI to maximise service potential by identifying incentives under SIHI Stream One, with a focus on developing sustainable GP services in Northampton and Kalbarri, which will enhance GP primary care and improve medical coverage available for on call support to the MPS.

Proposed Service Strategies – Northampton- Kalbarri MPS

Service Access and Telehealth

- Increased education and support for staff, community and the GP practice to utilise Telehealth for outpatient and follow up appointments with medical, nursing and allied health to reduce the need to travel to Geraldton or Perth.
- Implementation of the ETS
- Refer Chapter four also

Care for Older People

- Increase Aged Care places in Northampton
- Upgrade the facility in Northampton
- In partnership with other providers, work with the Shire to explore options for more independent living, carer support facilities or HACC supported residential aged/frail aged units.
- Investigate apparent demand for an increase in Aged Care Places in Kalbarri and Northampton Promote the existing services available including the bi-monthly carer support group run by MWCRCC
- The national reform agenda for aged care should assist country residents by increasing flexibility around respite care, increasing knowledge of and access to HACC services and potentially supports for non HACC users.
- Investigate opportunities to increase the amount of care support and respite available, and review coordination of support to ensure optimal access by carers.
- Advocate with the Shire, Country Women's Association, Rotary and GMML for increased opportunities for more social connectedness and health and wellbeing activities for older people (e.g. expansion of the day centre services at both Kalbarri and Northampton to include more older community members, bowls, bridge, outings, 'Strong Bones' keep fit, and other age appropriate activities).

Mental Health

- Increase awareness of and access to existing WACHS and GMML (Medicare Local) community mental health and alcohol and drug services in Northampton and Kalbarri.
- Increase community education and understanding of Mental Health and Alcohol and Drug issues for both the local community and providers.
- Explore whether the volume of patients is sufficient for the GP practice to employ a mental health nurse via Medicare incentives.
- Work in partnership with other providers of mental health services to explore options to increase availability of mental health and alcohol and

drug services for the Northampton and Kalbarri communities, including increased locally available services, use of Telehealth services and increased use of Rural Link.

- Ensure that all staff have access to mental health training.

Patient Transport

- In addition to the District and Region wide patient transport strategies proposed under Chapter four, advocate for daily public transport service to and from Northampton and Kalbarri to Geraldton.
- Work with the Shire to explore the use of Shire buses for non urgent patient transfer using volunteer drivers.
- Improve coordination of HACC transport to Geraldton so clients can undertake multiple health appointments on one day.
- Overarching Telehealth strategies for the Midwest (Outpatients, ETS, e-health records) should positively impact on the need for patient travel.

Health Promotion, Primary Care and Chronic Disease Services

- Increase access to education and mental health and alcohol and drug health promotion groups and information particularly for younger people.
- Increase access to Women's health services and Well Women's checks.
- Explore further the need and feasibility for re-establishing a Men's Shed and / or a Men's health program in Northampton.
- Refer chapter four, District wide proposed strategies also.
- Promote a partnership with a private or public dentist to utilise the dental chair at Kalbarri Health Centre (refer chapter four also).

Care Coordination

- Refer chapter four District wide proposed strategies also.
- Improve the information going back with people (DC Planning) to the health service (Kalbarri)

Aboriginal Health

- GMML is exploring an Aboriginal Liaison role for the area to help people access services and appointments.

Awareness and Coordination of services

- Building on the local newsletter that is distributed only in Kalbarri at present, the joint Kalbarri and Northampton MPS could put a one page advert in the local papers outlining all Health and Wellbeing Services across the joint MPS service area. This could include advertising phone help lines – Health Direct and Rural Link (for mental health counselling and crisis care).
- Promote the Medi-alert and $500 fuel card for seniors at both GP and MPS sites. Encourage people to nominate neighbours or relatives to be the Medi-alert contact rather than Northampton or Kalbarri ED.

5.3 Morawa - Perenjori MPS

In addition to the district wide WACHS health services and those of the health partners that service the WACHS - Midwest Health District, the following services are based in Morawa and Perenjori serving the catchment population of the joint Morawa - Perenjori MPS.

Table 8: Summary of the Morawa - Perenjori MPS Health Services

Services	Features
Emergency Services	24 hour/ 7 day a week nurse-led emergency response and stabilisation at Morawa Two ED bays The current Department of Health ED activity forecast indicates Morawa will need two ED bays in 2021/22.
Medical inpatient services	Four acute multi day beds (including a palliative care bed and one respite bed) The current Department of Health inpatient activity forecasting indicates they won't require more than their current acute beds within the next ten years (to 2021/22).
Residential care	Ten residential aged care beds (single rooms with shared bathrooms)
Medical cover	Currently provided by one part time GP via a Medical Service Agreement with WACHS. This GP performs a limited on call after hours roster. A second GP will commence in 2013 After hours / weekend medical on call provided by RFDS (Triage 1 and 2) and Geraldton Hospital ED (Triage 3-5)
Outpatients/Extended Care	Provided by MPS nurses – can provide home visits
X rays	Limited imaging available in Morawa (chest and extremity only: no elective) taken by nurse x-ray operators. Images are transferred to Geraldton and report provided to GP
Pathology	Collection facilities available and pathology/blood test transported to Geraldton
Pharmacy	There is no public pharmacy service available from hospital Private pharmacy available week days and Saturday morning but does not open on Sunday
Non Clinical Support	Laundry on site and local handyman/gardener. Patient Care Assistants (PCAs) on site, general handyman services and gardening services are provided by locally employed WACHS staff. Volunteers provide transport and activities.

Services	Features
Patient Assisted Travel Scheme (PATS)	PATS part of the overall administration assistant role
Visiting respite MWCRCC	Respite services visiting five times each year
Home and Community Care (HACC)	Services include home and social support services including for Veterans, community nursing service, meals on wheels, patient transfers and visits to specialist appointments and Aged Care Assessment bi-monthly. There are centre based, individualised and outing activity programs for HACC clients
Aged Care Assessments	Visiting bi-monthly (or as required) from Geraldton
Child and School Health	Visiting paediatrician once per month. Child health (including newborn early discharge home visits) and school health nursing
Diabetic and Asthma Educators	Visiting Diabetes Educator from North Midlands (Three Springs) Asthma Educator available
Continence Advisory Nurse	A nurse provides for Midwest East (Three Springs, Morawa Perenjori and Mullewa) and Dongara.
Allied Health	WACHS physiotherapist 0.8 FTE OT (adult) can visit from Geraldton OT (paediatric) and Speech pathologist – visit twice every school term Dietitian – visiting every three months from Geraldton Social worker – weekly visit from Geraldton Health promotion officer commenced in 2013 Aboriginal liaison officer - monthly visit from Geraldton
Community Mental Health	Visit on request
Community Alcohol and Drug service	Visit on request Limited alcohol detoxification is available at Morawa Perenjori
Public School Dental Health Services	Visit schools from Geraldton
Dentist in Three Springs	Community members from Morawa Perenjori access this service

5.3.1 General Practitioners

Medical Services are provided by a GP practice with one fulltime GP (a second GP working 0.6 FTE is due to commence in the near future). The GP is located close to the MPS site and supplies after-hours access four night a week and every third

weekend. At other times, after hours medical services are provided through Geraldton Hospital or RFDS.

5.3.2 Ambulance Services

SJAA has a volunteer base in Morawa. SJAA attend acute and non acute transfers. Trauma cases are transferred directly to Geraldton. The turnaround time to Geraldton is generally four hours but may be as long as six hours.

5.3.3 Additional Community, Health and Aged Care Services

Private practitioners

- Private chiropractor is available one evening (contracted by Karara mines)
- Private pharmacist open Monday to Friday, and Saturday

Other community based, health and wellbeing services

- Recreation facilities and opportunities including squash, gliding, golf, swimming pool and aqua aerobic, football, cricket, lawn bowls are well attended
- A gymnasium (unsupervised) is available in Perenjori
- A health promotion officer has recently been recruited
- Breast screen WA bus visits every two years
- Morawa Perenjori Shire provides environmental health services and enforcement
- Karara mining and RFDS exploring opportunities to increase dental services across three local government areas

5.3.4 Service and Community Strengths

Health services for Aboriginal people are viewed as a particular strength within Morawa Perenjori, and one which has improved health outcomes and reduced the frequency of attendances at the Morawa ED. A local Aboriginal Health Worker was recently nominated for an award in recognition of her achievements in the community.

5.3.5 Key Service Issues and Needs Highlighted

In addition to the District wide issues raised at all planning workshops the following are issues specific to Morawa and Perenjori

Medical and Emergency Services

- Within Morawa Perenjori there is only one GP, and therefore medical services are not available 24/7. There is currently a one week wait to see a Doctor, with even longer waiting times experienced by Perenjori residents.
- Workforce attraction and retention issues reflect those experienced across the Midwest Health District (refer to chapter 4), particularly regarding locums.

- Not enough support for staff who want to stay. There is a lack of after hours facilities, and the staff lack confidence.

Service Access and Telehealth

- There are difficulties accessing specialised services in the local area (E.g. Audiology, Geriatrician, Psycho-geriatrician, Dialysis)
- There are limitations (lack of WIFI or mobile phone coverage) in some areas which may impact on ability to implement Telehealth and or remote monitoring systems.
- Morawa Perenjori staff are strong users of Telehealth and require regular up skilling and encouragement.
- There are barriers for Medical staff in Geraldton Hospital to access Telehealth for ED. Telehealth is used by Midwest Mental Health and Palliative Care teams, PMH outpatient clinics (e.g. burns), and SCGH and RPH outpatient clinics.

Care for Older People

- The proportion of older people (70+ years) in the Morawa and surrounding areas (Perenjori) is growing faster than other age groups. It was 6.4% (118 people) in 2011 (ABS 2011 Estimated resident population figures), and rose to 6.9% (126 people) in 2012. The WA Treasury endorsed population projections 2014 forecast the proportion to increase to 12% by 2026 (or 167 people).
- There are eleven aged care beds at Morawa Perenjori MPS which is meeting the current level of demand for Morawa hospital which averaged 10.4 occupied residential beds in 2012/13, calculated by dividing the occupied beddays (3785) by 365.
- There are very limited extended community aged care packages and supports to enable people to remain in their own homes to reduce the demand on residential aged care beds.
- Of particular note consultation identified a need for greater occupational therapy services for adults and older people.

Mental Health

- Child and adolescent, adult and older mental health services are reportedly under resourced in Morawa and Perenjori
- The Department of Education School Psychologist has indicated the need for additional mental health resources
- There is limited capacity to undertake community development action to enhance trust and increase access to CDST team.
- The Local Drug Action Group is reliant on support by the Health Promotion Officer position, which was vacant in late 2012 (position was due to recommence in January 2013).

Patient Transport

- In addition to the patient transport issues highlighted under district wide issues, chapter four, there is virtually no public transport in Morawa - Perenjori
- Transport to outpatient appointments relies on relatives, community and ambulance volunteers unless people are HACC eligible.
- Morawa Perenjori does not have a large pool of SJAA volunteers and there are difficulties experienced in attracting and retaining community volunteers. The six hour turnaround time to and from Geraldton can deter would be volunteers.
- Aboriginal people have difficulty accessing services in Geraldton: transport is the main issue.

Health Promotion, Primary Care and Chronic Disease Services

- Similar to other areas there is a community perception of limited education and preventative or health promotion strategies to address mental and general health issues.
- The increasing number of overweight/obese people in the population was noted, as was the lack of services to respond to this issue.
- Limited facilities for service provision to 0 -10 year olds and early years initiatives.
- Limited awareness of or access to health and wellbeing services for young adults.

Care Coordination

- Similar issues were noted for Morawa Perenjori, as those expressed in planning workshops for all other Midwest Health District communities (refer chapter four).
- Services continuity and coordination between the multiple providers both local and regionally based can be difficult (e.g. timely communication of changes to care plans and medications)

5.3.6 Proposed Service Strategies

These strategies for the Morawa - Perenjori MPS and other health services are in addition to the District wide strategies proposed in chapter four.

Proposed Service Strategies – Morawa - Perenjori MPS

Medical and Emergency Services

- Midwest Region and District to work in partnership with the GP practice and SIHI to maximise service potential by way of identifying incentives under SIHI Stream One, with a focus on the development of sustainable GP services in Morawa and Perenjori, which will enhance GP primary care and improve medical coverage available for on call support to the MPS.

Staff Attraction and Retention issues

Retention and recruitment are significant barriers to consistent high quality service provision.

Proposed Service Strategies – Morawa - Perenjori MPS

Service Access and Telehealth

- Investigate parameters of current health service provision in relation to health needs
- Explore opportunities to increase access to specialised services where feasible and where sufficient demand for service exists. This should include the adoption of Telehealth consultations where appropriate.
- Increase the range of health services to address the health needs of the population particularly for older people, Aboriginal people and families with young children.
- Increased education and support for staff and the GP practice to utilise Telehealth for outpatient and follow up appointments with medical, nursing and allied health to reduce the need to travel to Geraldton or Perth.
- Implementation of the Emergency Telehealth Service.
- Encourage Geraldton Hospital staff and the community to increase use of Telehealth to support Morawa – Perenjori ED
- Refer also to Chapter four

Care for Older People

- The 2012/13 MPS planning should use the most current occupied bed days data to monitor the need for residential aged care beds which currently exceeds available aged care beds in Morawa Perenjori, and to plan for more extended care community aged care packages to enable people to remain at home for as long as possible.
- The national reform agenda for aged care should assist country residents by increasing flexibility around respite care, increasing knowledge of and access to HACC services and potentially supports for non HACC users. However there are significant issues around recruiting appropriate local people for HACC service
- Include consideration of additional respite / palliative care requirements within any future enhancement of the Morawa-Perenjori MPS
- Consider accommodation of older couples requiring shared care

Mental Health

- Increase awareness of and access to existing WACHS and GMML (Medicare Local) community mental health and alcohol and drug services in Morawa Perenjori.
- Increase community education and understanding of Mental Health and Alcohol and Drug issues for both the local community and providers.
- Explore whether the volume of patients is sufficient for the GP practice to employ a mental health nurse via Medicare incentives.

Proposed Service Strategies – Morawa - Perenjori MPS

- Work in partnership with other providers of mental health services (including the Department of Education) to explore options to increase availability of mental health and alcohol and drug services for the Morawa Perenjori community, including increased locally available services, use of Telehealth services and increased use of Rural Link.
- Ensure that all staff have access to mental health training.

Patient Transport

- In addition to the District and Region wide patient transport strategies proposed under Chapter four, work with the Shire to explore the use of Shire buses for non urgent patient transfer using volunteer drivers.
- Improve coordination of HACC transport to Geraldton so clients can undertake multiple health appointments on one day.
- Continue to promote the $500 fuel card for seniors at both GP and MPS sites, which may assist with some transport costs.

Health Promotion, Primary Care and Chronic Disease Services

- Increase access to education, preventative and/or health promotion strategies to address general health, mental health and alcohol and drug needs across the community.
- Work in partnership (e.g. with GMML) to increase access to services specifically addressing overweight/obese people in the population.
- Work in partnership (e.g. with the Morawa Perenjori Shire) to address the need for local facilities for support and service provision to 0 -10 year olds
- Promote and encourage the Karara Mining – RFDS proposal to increase dental services in the area: (The Karara dental van was launched at the Mingenew Expo in September 2013).
- Refer also to chapter four, District wide proposed strategies.
- GMML is exploring an Aboriginal Liaison role for the area to help people access services and appointments

Care Coordination

- Refer also to chapter four, District wide proposed strategies.
- Increase collaboration between providers (e.g. establish an interagency group, hold health forums, develop memorandums of agreement)
- Continue to participate in the Local Emergency Management Group for Morawa-Perenjori/Mingenew/Three Springs, coordinated by the Police
- Continue communication strategies to increase awareness of key health messages and service availability (e.g. using local media, social media, letter drops, rural shows/expos and community notice boards and with the workplace)

Proposed Service Strategies – Morawa - Perenjori MPS
▪ Provide information on accessing Health Direct and Rural Link (for mental health counselling and crisis care). ▪ Enhance the current directory of local services, in partnership with the Shire and GMML. The directory is complete and in distribution: (Helen Webb) ▪ Promote the Medi-alert for seniors at both GP and MPS sites. Continue to encourage people to nominate neighbours or relatives to be the Medi-alert contact rather than Morawa-Perenjori MPS ED. ▪ Monitor the impact of the Morawa Supertown plan and liaise with service partners where appropriate.

5.4 Mullewa MPS

In addition to the district wide WACHS health services and those of the health partners that service the WACHS - Midwest Health District, the following services are based in Mullewa serving the catchment population of the area.

Table 9: Summary of the Mullewa MPS Health Services

Services	Features
Emergency Services	24 hour/ 7 day a week nurse-led emergency response and stabilisation Two ED bays including one resuscitation bay. The ED was upgraded in 2011 (and has Telehealth capability but this is used infrequently). The current Department of Health ED activity forecast indicates Mullewa will need no more than the current ED bays in around ten years.
Medical inpatient services	One acute multi day bed, however there is no GP based in Mullewa so no admissions (facility has three bed room & 1 single room – shared bathrooms) The current Department of Health inpatient activity forecasting indicates the site will not require more than their current acute beds within the next ten years (to 2021/22).
Residential care	Seven residential aged care beds (single rooms with shared bathrooms). There is also one palliative and one respite bed
Medical cover	Via Medical Service Agreements with WACHS, there is currently one GP (0.5FTE) in Mullewa providing medical cover to the MPS. After hours / weekend medical on call RFDS (Triage 1 and 2) Geraldton Hospital ED (Triage 3-5)

Services	Features
Outpatients/Extended Care	Provided by MPS nurses, including a weekly extended care clinic by an Advanced Skill Enrolled Nurse (ASEN) who assists with appointments, medications and therapies
X rays	No imaging in Mullewa
Pathology	Collection facilities available and pathology/blood test transported to Geraldton.
Pharmacy	Mullewa MPS provides pharmaceutical starter packs. Prescriptions are also completed via GP to Geraldton Pharmacy and couriered to Mullewa. GP dispenses at surgery when open.
Non Clinical Support	Facilities management is via the Regional model. Laundry and kitchen are on site Patient Care Assistants (PCAs) on site, general handyman services and gardening services are provided by locally employed WACHS staff.
Patient Assisted Travel Scheme (PATS)	PATS undertaken as part of the administration role
Day Centre	Centre based activity centre is available weekly for aged care residents and aged community members.
Visiting respite MWCRCC	Respite services visit and support carer support groups five times each year
Home and Community Care (HACC)	Services include home and social support services including for Veterans, day centre, meals on wheels, patient transfers and fortnightly bus for visits to specialist appointments and ACAT as required. Centre based activities for individuals and groups
Aged Care Assessments	Visiting as required from Geraldton
Child and School Health	Child health nursing including newborn early discharge home visits, Aboriginal child health and school health nursing
Diabetic Educator	No service (visiting or based in Mullewa)
Continence Advice	A nurse provides for Midwest East (Three Springs, Morawa Perenjori and Mullewa) and Dongara.
Allied Health	Physiotherapist visits weekly from Geraldton Podiatrist visits monthly from Geraldton OT visits every two months or as required from Geraldton Speech pathologist visits as required from Geraldton Dietitian visits as required from Geraldton Social worker visits weekly from Geraldton

Services	Features
	Aboriginal Liaison Officer 0.7 FTE Audiology visits 3 monthly for child health services Therapy Assistant support child development (mainly speech and occupational therapies Health promotion officer focussed on health eating and schools programs
Community Mental Health	Child, adolescent and adult services visit on request
Community Alcohol and Drug service	Midwest CDST visit on request
Public School Dental Health Services	Visit schools from Geraldton

5.4.1 General Practitioners

Medical Services are provided by one GP (0.5 FTE, 2 days first week, 3 days second week). The practice also provides services to Kalbarri and Northampton communities. The practice is highly valued and well regarded by the community. There is no local 'on-call' medical support on the weekends or after hours to the MPS or community.

5.4.2 Ambulance Services

SJAA has volunteer bases in Mullewa. SJAA attend acute and non acute transfers. Trauma cases are transferred directly to Geraldton. The service is highly regarded by the community and other service providers.

5.4.3 Additional Community, Health and Aged Care Services

Private practitioners

- Private pharmacy is provided through the GP practice

Other community based, health and wellbeing services

- Local interagency meetings are held monthly
- Disability Services provide a local area coordinator
- GRAMS provide both men's and women's health programs in Mullewa
- Centacare provides a visiting counsellor once a week
- Several recreation and leisure opportunities are available including the swimming pool ('no school, no pool'), Zumba classes, walking group, lawn bowls, golf, basketball, football, women's art group and craft groups. Of particular note is the new football coach who is building team pride and commitment (club involvement in youth behaviour programs).
- The Youth Centre is focussed on supporting youth to participate in activities and positive behaviour programs
- Church and pastoral care is available in the community
- An Aboriginal 'Men's Shed' is running in town
- A Strong Aboriginal Girls/Women's group is run through Department of Child Protection.
- Mullewa Shire provide environmental health services and enforcement

5.4.4 Service and Community Strengths

Medical and Emergency Services

- The GP is highly valued by the community and other service providers
  The SJAA and its volunteer group are highly regarded by the community and other service providers

Service Access and Telehealth

- The MPS and WACHS staff are well regarded by the community and other service providers. Positive feedback was received regarding treatment received within the ED, the Midwives clinic and via home visits by the community nurses and child health services.
- The health service manages any complaints well and addresses issues raised through personal contact, both formally and informally.
- Transport to Geraldton that can be provided via the HACC Coordinator Nurse is seen as a strength of the current service
- Telehealth services while limited were seen to be positive
- The Shire operated sporting complex was seen to provide a good range of services, program and activities for the community

Mental Health and Wellbeing

- Mental Health and other published information is available at the Health Centre, Community Resource Centre and through the Women's Group.
- Mental health care planning was noted as a strength within Mullewa
- Good support available via Rural Link for both mental health and alcohol and drug issues
- A range of mental health promotion initiatives such as Kids Matter Program and Gatekeeper Training (Suicide Prevention) are available
- The 'Drug and Alcohol Recovery Model' has been a positive development
- The allocation of liquor restricted housing in Mullewa supports improved community safety

Collaboration and Partnership

- Health Partner agencies work closely and effectively to deliver community responsive services (regular interagency meetings are held between the Police Service and Department of Child Protection (DCP), Violence Action Group, Patrol bus for Aboriginal people coordinated by the local Shire.

5.4.5 Key Service Issues and Needs Highlighted

In addition to the District wide issues raised at all planning workshops the following are issues specific to Mullewa

Medical and Emergency Services

- At present only Mullewa hospital provides a 24/7 health service within Mullewa. There is a great reliance on visiting services from Geraldton and other areas, including the visiting GP service.
- There is a need to increase the availability of GP services (currently only 0.5FTE, five days each fortnight). It can be difficult to get a timely appointment with the GP and other health services, particularly during the winter months.

- Limited access to specialist services
- There are insufficient numbers of volunteers to sustain the SJAA service in Mullewa. This was noted as a significant issue for the area.

Staff attraction and retention issues

- Issues of professional stagnation and lack of education are a problem
- High level staff education program, staff development nurse on site 0.2FTE, high level emergency training program for RN staff. Rotation of staff to GRH for ED experience, airways management in OR

Service Access and Telehealth

- The Mullewa MPS provides pharmaceutical starter packs, (currently limited pharmacy dispensing operates at the GP practice, when open)
- The increasing rates of chronic diseases and conditions (obesity, renal disease) require services that are unavailable within Mullewa (e.g. dialysis)
- There is an increase child health and dietetic service availability.
- As noted across the Midwest Health District, it was reported that there were poor levels of community awareness about what services are available in the Mullewa area.
- Workshop participants also reported other challenges to service access (e.g. low awareness of health risks and the need for early identification of problems; men not accessing services for prevention or when sick).
- There are limits to what health services can provide via face to face contact in Mullewa, and other options (e.g. Telehealth) need to be better utilised.

Care for Older People

- The proportion of older people (70+ years) in the Mullewa and surrounding areas was 7.1 percent (52 people) in 2011 (ABS 2011 Estimated resident population figures). The WA Department of Planning projections are unavailable for Mullewa town specifically.

- There are seven aged care beds at Mullewa MPS which is meeting the current level of demand for Mullewa hospital which averaged 6.1 occupied residential beds in 2012/13, calculated by dividing the occupied beddays (2431) by 365. The use of beds at the MPS is flexible and can be used as required by community members. The acute bed is not is use due to lack of medical coverage in Mullewa, and the palliative bed can be used for respite if required. WACHS staff reported that there have been no transfers of older people requiring an aged care bed in the past three years

  During the consultation, a lack of respite services was noted for Mullewa. However renovation of a room has increased capacity, so that all recent requests for respite have been met. Beds are flexible and the MPS manipulates all beds as required for community need.

  There has been a recent reported increase in local demand for respite services. Respite services are available at Mullewa MPS, or with Geraldton Residential Aged Care facilities. Mullewa MPS (as per other

sites) is unable to provide respite for high level dementia clients due to the limited security of the unit.

- Access to home monitoring for older people would be of great benefit and reduce some of the patient transport issues. However there are costs to the clients using home monitoring (which increase as pensions increase) and therefore many opt not to use the available HACC service.

Mental Health

- Mental health, and alcohol and other drugs are significant issues within Mullewa. Mullewa MPS report a high level mental health client case load that is very difficult to manage given the lack of available and appropriate medical advice within Mullewa, especially after hours when most presentations occur.
- Police service officers indicated that mental health, and alcohol and other drugs issues are their prime concern and account for a large proportion of police work and resources.
- Accessing alcohol and drug services is very difficult, and when community members experienced major mental health issues it was reportedly difficult to contact the appropriate case manager for assistance.

Patient Transport

- As per other Midwest Health district areas, transport issues are experienced by Mullewa residents
- There is no public transport to Geraldton, and this is very much needed to support community access to services
- There are some concerns regarding the PATS process, which as per standard practice must be booked through the Mullewa GP. This is felt to be restrictive given the limited hours the practice is open, however Mullewa MPS indicated that PATS is available to community members via the MPS on most days.
- Mullewa police officers are often called to assist with patient transport for those with mental health issues.

Health Promotion, Primary Care and Chronic Disease Services

- The Mullewa health promotion program has a high level of engagement with and is well accepted by the community. A high level of success has been achieved particularly with youth and 'early years' health promotion programs.
- Early years programs include the 'best start' program for aboriginal children and their mothers twice a week, a transitional day care twice a week and also a playgroup for all families. Challenges for the delivery of these programs can arise from lack of qualified crèche/child care staff.
- While there is good recognition of key health messages from both local and mass media social marketing campaigns, there is a need for additional resources to facilitate primary and secondary prevention and support community members toward actual behaviour change
- Mullewa needs a greater focus on sexual health and protective behaviour programs particularly for young women/girls

Care Coordination

- In addition to the issues to those expressed in planning workshops to all other Midwest Health District communities (refer chapter four) issues pertaining to discharge planning were noted as a particular concern for Mullewa. Improved interagency collaboration could assist.

Aboriginal Health

- Engagement between services and Aboriginal people was noted as an area requiring action to improve service accessibility.
- Some feedback was received which indicated division and conflict between various families within Mullewa, is also of concern.

Other

- Access to quality and supply of fresh food is limited in Mullewa. This can result in poor food choices (e.g. reliance on fast food).

5.4.6 Proposed Service Strategies

These strategies for the Mullewa MPS and other health services are in addition to the District wide strategies proposed in chapter four.

Proposed Service Strategies – Mullewa MPS

Medical and Emergency Services

- Midwest Region and District to work in partnership with the GP practice and SIHI to maximise service potential by way of identifying incentives under SIHI Stream One, with a focus on the development of sustainable GP services in Mullewa (linked to the practice in Kalbarri and Northampton), which will to enhance GP primary care and improve medical coverage available for on call support to the MPS.

Re orientate the hospital from acute to primary care (see under *Health Promotion, Primary Care and Chronic Disease Services section below)*

- Lack of GPs may be overcome by a nurse practitioner
- Where possible support SJAA to identify ways to attract and retain new ambulance volunteers.
- Training is available to keep staff up skilled, but should be the personal responsibility of each staff member.

Attraction and retention

- Aim to recruit Australian residents who understand the geography and demographics of the area so their expectations aren't inflated

Service Access and Telehealth

- Explore strategies for increasing resources for nursing, allied health (dietitian of particular note), mental health and child health services.
- Utilise Telehealth for outpatient and follow up appointments with specialist medical, nursing and allied health to reduce the need to travel to Geraldton or Perth.
- Increased education and support via Telehealth for staff and the GP

Proposed Service Strategies – Mullewa MPS

practice (including education and support about Telehealth).
- Investigate the introduction of electronic health records and home monitoring systems when and if available
- Implementation of the Emergency Telehealth Service as it is rolled out.
- Refer also to chapter four

Care for Older People

- The 2012/13 MPS planning should use the most current occupied beddays data to monitor the need for residential aged care beds and to plan for more extended care community aged care packages to enable people to remain at home for as long as possible.
- The national reform agenda for aged care should assist country residents by increasing flexibility around respite care, increasing knowledge of and access to HACC services and potential supports for non HACC users.
- Any service reform or improvement for the care of older people must consider how best to deliver services for Aboriginal people and their families (Aboriginal people comprise 39 percent of the Mullewa population).
- Continue to explore opportunities to increase access to respite services within Mullewa

Mental Health

- Increase awareness of and access to existing WACHS and GMML (Medicare Local) community mental health and alcohol and drug services in Mullewa, particularly for vulnerable community groups
- Support the current programs of alcohol restrictions, 'liquor restricted housing' and the Recovery Model
- Increase community education and understanding of Mental Health and Alcohol and Drug issues for both the local community and providers.
- Explore whether the volume of patients is sufficient for the GP practice to employ a mental health nurse via Medicare incentives.
- Work in partnership with other providers of mental health services to explore options to increase availability of mental health and alcohol and drug services for the Mullewa community.
- Increase locally available services by providing regular overnight visits from a Mental Health Nurse
- Ensure that all staff have access to mental health training, and facilitate particular staff to be dual trained in both mental health and drug & alcohol
- Increase use of Telehealth services and Rural Link.
- Explore the need for a dedicated drug and alcohol prevention officer and increased after hours support (via Rural Link).

Proposed Service Strategies – Mullewa MPS

Patient Transport

- In addition to the District and Region wide patient transport strategies proposed under Chapter four, advocate for daily public transport between Mullewa and Geraldton to increase access to services, fresh food and shopping.
- Work with the Shire to explore non urgent patient transfers using volunteer drivers.
- Improve service coordination so clients can undertake multiple health appointments on one day.
- Promote the Medi-alert and also the $500 fuel card for seniors at both GP and MPS sites. Encourage people to nominate neighbours or relatives to be the Medi-alert contact rather than Mullewa ED.

Health Promotion, Primary Care and Chronic Disease Services

- Explore the potential of re orientating the health service from acute to primary care: this will offer a new way of providing care which will have a positive flow on effect by:
    - Increasing health promotion, prevention and chronic disease management programs,
    - Including promotion of chronic disease self-management within the community (e.g. Healthy Lifestyle programs, PIT Stop, Schools programs; LIFE) in various formats (e.g. individual and groups, online and via Telehealth).
    - Redistributing staff to where they can be of optimal benefit
- Increase access to education and mental health and alcohol and drug health promotion groups and information particularly for younger people.
- Explore further the need and feasibility for re-establishing the Men's Shed and / or a Men's health program (with a paid coordinator).
- Partner with the GMML Medicare Locals to provide resources and services within Mullewa.
- Continue to partner with GRAMS (Geraldton Regional Aboriginal Medical Service) to deliver culturally safe population health programs and services.
- Support community development initiatives: building strength, skills and commitment in the community (e.g. Football club)
- Utilise all avenues to promote key and consistent health messages throughout the community
- Promote the use of Health Link and Health Direct
- Refer also to chapter four, District wide proposed strategies.

Proposed Service Strategies – Mullewa MPS

Care Coordination

- In addition to the issues to the District wide proposed strategies (refer chapter four) improved coordination of discharge planning is indicated in Mullewa.
- Improved interagency collaboration across service agencies in Mullewa
- Improve accessibility to care and care coordination for high needs individuals and families

Aboriginal Health

- Explore the establishment of culturally specific services for Aboriginal clients.
- Support where possible the Strong Girls/Women group, and family mediation services run by DCP
- GMML is exploring an Aboriginal liaison role for Mullewa to assist people access services and appointments.
- Improve coordination with Geraldton Hospital so people can go at particular times.

Awareness and Coordination of services

- An interagency group is coordinated by the Shire. In partnership with the interagency group members explore way to recognise and reward positive examples of community initiatives and services.
- In partnership with the interagency group, develop and promote a list of local and visiting services. This should include advertising phone help lines (Health Direct and Rural Link for mental health counselling and crisis care) and also promote the availability of Telehealth as a mechanism for receiving services.

Other

- Advocate for the Shire and Midwest Development Commission to explore ways to increase business opportunities within Mullewa.

5.5 North Midlands MPS

In addition to the district wide WACHS health services and those of the health partners that service the WACHS - Midwest Health District, the following North Midlands health services are based in Three Springs serving the catchment population of the area (Three Springs, Carnamah and Coorow).

Table 10: Summary of the North Midlands (Three Springs) MPS Health Services

Services	Features
Emergency Services	24 hour/ 7 day a week nurse-led emergency response and stabilisation

Services	Features
	Two ED bays (including one resuscitation bay) with Telehealth capability. The current Department of Health ED activity forecast indicates Three Springs will need two ED bays in 2021/22.
Medical inpatient services	Three acute multi day beds. The GP admits and manages inpatient care. There are on average five overnight admissions per month. Observation bay next to nurse station. The current Department of Health inpatient activity forecasting indicates North Midlands won't require more than their current acute beds within the next ten years (to 2021/22).
Residential care	Nine residential aged care beds including one respite/palliative care bed (single rooms, shared bathrooms)
Medical cover	Currently via the local GP with no local on call medical support in the weekends. The GP is usually available after hours
Outpatients/Extended Care	Provided by MPS nurses – wound care, dressings and home oxygen nursing support. Telehealth is used by Midwest Mental Health and Palliative Care teams, PMH outpatient clinics (e.g. burns), and SCGH and RPH outpatient clinics (e.g. dressings).
X rays	No imaging service
Pathology	Collection facilities available and pathology/blood test transported to Geraldton.
Pharmacy	There is a local pharmacy in Three Springs.
Non Clinical Support	Facilities management is provided by a Regional model Laundry and kitchen on site (cook fresh / cook chill) Patient Care Assistants (PCAs) on site, general handyman services and gardening services are provided by locally employed WACHS staff.
Patient Assisted Travel Scheme (PATS)	PATS undertaken as part of the administration role
Day Centre	Runs weekly (first week at hospital, second week an outing) and includes residents and aged community members. The frequency of outings can alter seasonally (reduced outings in the hotter months)
Respite	Respite services visits five times each year (combined with Morawa/Perenjori visits)

Services	Features
Home and Community Care (HACC)	Services include home support services (including for Veterans), meals on wheels, patient transfers and visits to specialist appointments and Aged Care Assessments. Activities Coordinator for the residential aged care HACC bus goes to Geraldton monthly, as does the HACC bus service for Aboriginal patients to attend appointments at GRAMS (organised by the GMML ALO) Hospital volunteers can provide additional transport options
Aged Care Assessments	Visit six times each year from Geraldton
Community Nurse	Child health nursing including newborn early discharge home visits, school health service, immunisation.
Diabetic and Asthma Educators	Diabetes education available onsite (and visiting Morawa Perenjori 0.1 FTE) Asthma education available onsite
Continence Advisory Nurse	A nurse provides for Midwest East (**Three Springs**, Morawa Perenjori and Mullewa) and Dongara.
Allied Health	Physiotherapist visits weekly from Geraldton, and private group Geraldton Physiotherapy provide a service from Dongara Health Service twice a week. Public Podiatrist visits six weekly from Geraldton, and a private podiatrist runs a weekly Foot and Ankle Health group. OT visits every 3 months or as required Speech pathologist visits as required from Geraldton Dietitian visits as required from Geraldton Social worker visits weekly from Geraldton Aboriginal liaison officer visits monthly (based in Morawa Perenjori) Therapy Assistant supports child development and seniors fitness programs
Community Mental Health	Midwest Mental Health Team used Telehealth for some consultations Until recently there was a child mental health service visiting once a week. There is no adolescent mental health services and a rarely visit from the older mental health service.
Community Alcohol and Drug service	Community Drug service team: visit from Geraldton on occasional basis on request
Public School Dental Health Services	Visit schools from Geraldton

5.5.1 General Practitioners

Medical Services are provided by one full time General Practitioner (GP), plus a visiting female GP from RFDS every 6 weeks. There is no local 'on-call' medical support or support on weekends when the local GP is away from Three Springs, but weekday after hours medical coverage is usually available. The GP practice is reportedly treating increasing numbers of people from outside Three Springs due to difficulties accessing medical attention in other communities.

5.5.2 Ambulance Services

Three Springs is part of the North Midlands St John Ambulance service and there is a sub-centre in Three Springs staffed by volunteers. SJAA attend acute and non acute transfers. Trauma cases are transferred directly to Geraldton. Other supporting services include: Carnamah, Coorow, Mingenew and Perenjori.

5.5.3 Additional Community, Health and Aged Care Services

Private practitioners

- Psychologist is available monthly via the GMML (Medicare Local)
- Private optometrist operates from the GP practice/medical centre on a quarterly basis.

Other community based, health and wellbeing services

- Recreation facilities (e.g. golf, swimming pool, football, cricket, lawn bowls, indoor bowls, seniors fitness classes, craft group) are well attended
- Pastoral care is available in the community
- Retired Serviceman's League (RSL) hold meetings and support local members
- Shire of Three Springs provides environmental health investigation and enforcement action
- Silver Chain operate the health centre in Mingenew (approximately 50 kms from Three Springs, 50 kms from Dongara, 60 kms to Morawa)
- Men's Shed previously ran, however currently no volunteer coordinator

5.5.4 Service and Community Strengths

- There is a wide range of activities and a strong social network for older people within Three Springs
- The PATS program was felt to be a strength, for the support it provides for patients who require travel to Perth for treatment.

5.5.5 Key Service Issues and Needs Highlighted

In addition to the District wide issues raised at all planning workshops the following are issues specific to Three Springs:

Medical and Emergency Services

- North Midlands (Three Springs) MPS ED treatment space is very small and cramped, and multiple people are often treated within the one room, impacting negatively on confidentiality and ability to appropriately assess and treat patients.

- There is only one fulltime GP based in Three Springs. Increasingly people are attending the GP from other locations, limiting the availability of 'same day' appointments for local residents (e.g. for prescription and blood pressure checks etc)
- There is a lack of local ambulance volunteers, which places added pressure on the existing ambulance volunteers.
- There is a private Dental service Monday – Friday.

Service Access and Telehealth

- Increased dietetic and diabetes education services are required in the community, particularly with the high incidence of chronic disease, poor dietary intake and the availability of healthy food choices.
- There is no medical imaging service at North Midlands (Three Springs) MPS.
- There is a lack of paediatric consultation and treatment within the area (Telehealth may be able to address)
- The existing continence advice service is in high demand by the aged, disabled and also childbearing aged women. The service is currently unfunded and delivered by a Continence qualified nurse at North Midlands (Three Springs). The lack of funding for this service could impact on ongoing service sustainability.
- There is a lack space in the existing North Midlands (Three Springs) ED for Telehealth. There is a need for more Telehealth education particularly for Geraldton ED medical staff to ensure it is utilised to its full potential. Internet access also has limitations. A review of Telehealth and ICT services is required to determine the level of investment in infrastructure and services required to build a robust system.
- As noted above currently Telehealth is used by Midwest Mental Health and Palliative Care teams, PMH outpatient clinics (e.g. burns), and SCGH and RPH outpatient clinics (e.g. dressings).

Staff Attraction and Retention

- **Residential accommodation** for health staff is an issue across the Midwest, particularly significant in some areas. The standard of existing accommodation is generally poor, much is still shared space with other staff and therefore not private nor contemporary. This can impact on staff recruitment. In Three Springs there is accommodation but the rent is a deterrent. The move to GROH (Government Residential Officers Housing) rental rates increased costs by 80%. Local private rental provides appropriate accommodation at reasonable rates and is now being used
- At Three Springs there is a lack of family supporting facilities e.g. to meet children's education needs
- The focus on Aged Care deters recruitment

Care for Older People

- The proportion of older people (70+ years) in the Three Springs and surrounding areas (Coorow, Mingenew, Carnamah) is not growing faster than other age groups. It is currently 10.1 percent (279 people) in 2012 (ABS 2012 Estimated resident population figures). The WA Department of Planning projections forecast the proportion to decrease to 7.9 percent by 2026 (or 189 people)
- There is concern from the community and local government (Three Springs, Carnamah and Coorow) that there are insufficient aged residential beds for the area.
- There are nine aged care beds at North Midlands MPS which are meeting the current level of demand for North Midlands hospital (Three Springs) which averaged 8.8 occupied residential beds in 2012/13, calculated by dividing the occupied beddays (3222) by 365
- The renovation at Three Springs did not consider enough growth in the future, and is not to contemporary Aged Care standards. They still have a waiting list, old facilities, small rooms, and sparse furniture.
- While there were community concerns regarding the need for Geriatrician assessment and GP referrals to access HACC / ACAT services, it has been confirmed that WACHS staff can perform both HACC and ACAT assessment thereby avoiding delays in accessing support services. As of 31/3/2014 the Regional Assessment Service (RAS) conduct all HACC assessments in the region without the need for a GP referral.
- Respite services are available but limited. The community has requested increased access to respite to support carers and patients; however WACHS confirmed that the respite booking system works well and people rarely have to wait for a respite bed.
- The community raised the issue of social isolation of older people, particularly those who choose not to access HACC services.

Mental Health

- North Midlands health staff and community members indicated during consultation that access to ongoing mental health services is limited in Three Springs.
- The Mental Health Nurse (MHN) provides services throughout the Midwest Health District and Geraldton which limits availability to clients and the staff members. The extensive travel requirement may make the position untenable in the long term.
- The Geraldton based Older Adult MHN visits infrequently.
- Ad hoc visiting service leaves clients at disadvantage; there is no communication when a practitioner resigns and large gap with no fill-in staff member to address client ongoing needs. There is a lack of continuity, a lack of communication and a lack of after hours access.

Patient Transport

- As per other Midwest Health district areas, transport issues are experienced by Three Springs' residents, particularly Aboriginal patients.
- There is no public transport to Geraldton and therefore a reliance on volunteer models for transport is unsustainable.
- There is a reported expectation by community members that the hospital will transfer people for services at no cost to the patient, to any location to access health services. On being advised that they must make their own travel arrangements many community members have become aggressive toward staff.
- The HACC bus is very limited in application – it is not available for general community access but consideration should be given to support health service activity on a cost recovery basis.
- As noted previously PATS provides some assistance with expenses. .
- The community indicated that people were often required to travel to Geraldton to access services, particularly children and older people.

Health Promotion, Primary Care and Chronic Disease Services

- Service providers indicated that there is information out there and that patients are aware of what health behaviour change is required, but there is a lack of services to support behaviour change.
- The issue of 'work safety' was raised, however it is unclear whether this related to farm safety, health service staff safety and or security issues.
- There is a high incidence of chronic disease, poor dietary intake and the availability of healthy food choices. While people are aware of risk factors and healthy lifestyle choices, the community could benefit from programs that build self- management of chronic disease and facilitate behaviour change.

Care Coordination

- There were similar issues expressed in the Three Springs planning workshops as all other Midwest Health District communities (refer chapter four for further details).
- There is a perceived lack of or ad hoc communication between providers and a lack of knowledge about what particular services exist for the Three Springs community to access. Improvements in the last few months include large service directories having been placed at Post Offices for all residents to deliver information for service availability and access. These have been well received and include service visiting days, contact information and appointment details
- At present there is no interagency human services group
- Of particular note in Three Springs, there can be delays in completing discharge summaries, and on occasion these summaries do not get sent on to the GP.

Other related concerns

- There are some concerns regarding succession planning to support the family farm given the next generation are reluctant to take over the farms. This could impact on future population growth, but is considered more within the scope of the Midwest Development Commission or Three Springs Shire.
- The Three Springs Shire currently underwrites salaries for the local private GP practice and feels this is an additional cost to the community. Many local government authorities across regional WA support GPs, whether via monetary payments, accommodation and/or providing professional facilities.

  GP services are private business funded by the Commonwealth Medicare scheme. Through SIHI the State government can fund some GP incentives to 'top up' the Commonwealth Medicare funding. WACHS generally provides accommodation support and incentives to recruit and retain WACHS staff, rather than supporting private GPs or other providers.

5.5.6 Proposed Service Strategies

These strategies for the Three Springs MPS and other health services are in addition to the District wide strategies proposed in chapter four.

Proposed Service Strategies – Three Springs MPS

Medical and Emergency Services

- Midwest Region and District to work in partnership with the GP practice and SIHI to maximise service potential by way of identifying incentives under SIHI Stream One, with a focus on the development of sustainable GP services in Three Springs, which will to enhance GP primary care and improve medical coverage available for on call support to the MPS.
- Invest in training to assist with upskilling of GPs
- An extensive ED upgrade (with the inclusion of Telehealth equipment) should be investigated. Ideally Telehealth needs to be ceiling mounted. (Recently purchased equipment remains on a cumbersome trolley and uses a large amount of room in a small space).

  Investigate the role and recruitment of a Nurse Practitioner to support the community to access timely health care as relevant

Service Access and Telehealth

- Increased education and support for staff and the GP practice to utilise Telehealth for outpatient and follow up appointments with medical, nursing and allied health, to reduce the need to travel to Geraldton/Perth.
- The use of Telehealth within the Three Springs MPS site and local GP Practice could be enhanced / extended to increase availability of services in the local area, including the roll out of the Emergency Telehealth Service (ETS).

Proposed Service Strategies – Three Springs MPS

- Secure funding to provide a comprehensive weekly (3 days a week) Continence service to Dongara, Three Springs, Morawa–Perenjori, Mullewa and surrounding locations. This will meet the current and expected future demand.
- More access to allied health professionals (diabetes education, dietitian, health promotion) to be able to provide nutrition and behaviour change advice. This could potentially be provided by Telehealth.
- Improved access to Cardiologist and Paediatric consultation and treatment and other specialists (visiting or via Telehealth)
- Increased access to mental health professionals/services (In particular a regularly visiting psychologist/counsellor specialising in child and adolescent behavioural issues). WACHS should liaise with Three Springs Primary School principal to determine extent of need.
- Explore opportunities to collaborate with other agencies to develop health services in partnership (such as the proposed partnership between Karara and RFDS to provide dental services).
- Staff accommodation needs to be reviewed / monitored to encourage recruitment and retention. It should be considered as part of an overarching Midwest strategy.
- Refer also to Chapter four

Care for Older People

- The 2012/13 MPS planning should use the most current occupied beddays data to monitor the need for residential aged care beds and to plan for more extended care community aged care packages to enable people to remain at home for as long as possible. Currently the aged care bed numbers for Three Springs are meeting the demand.
- Explore funding options to review staffing levels relative to activity and service demand.
- The national reform agenda for aged care should assist country residents by increasing flexibility around respite care, increasing knowledge of and access to HACC services and potential supports for non HACC users.
- Increase opportunities with the Shire, Country Women's Association, Rotary and GMML for more social connectedness and health and wellbeing activities for older people (e.g. expansion of the day centre. This should include appropriate funding of a day centre activities coordinator).
- The provision of aged care may benefit from coordination by an Interagency Group or a partnership developed with GMML and / or other provider.
- Increased aged independent living options are required to accommodate growing need to house elderly. This would be an area for consideration by the Shire, Midwest Development Commission and private providers.

Proposed Service Strategies – Three Springs MPS

Mental Health

- Increase awareness of and access to existing WACHS and GMML community mental health and alcohol and drug services in Three Springs.
- Increase community education and understanding of Mental Health and Alcohol and Drug issues for both the local community and providers.
- Explore whether the volume of patients is sufficient for the GP practice to employ a mental health nurse via Medicare incentives.
- Work in partnership with other providers of mental health services to explore options to increase availability of mental health and alcohol and drug services for the Three Springs community, including increased locally available services, use of Telehealth services and increased use of Rural Link.
- Ensure that all staff have access to mental health training.

Patient Transport

- In addition to the District and Region wide patient transport strategies proposed under Chapter four, advocate for daily public transport service to and from Geraldton.
- Work with the Shire to explore possible use of Shire buses for non urgent patient transfer using volunteer drivers.
- Explore increased use of the HACC bus for transport to and from appointments and / or activities for eligible clients.
- Review the coordination of appointment scheduling so that multiple health appointments can occur on the days people travel to Geraldton.
- Continue to promote the $500 fuel card for seniors at GP and MPS sites.

Health Promotion, Primary Care and Chronic Disease Services

- Refer chapter four, District wide proposed strategies also.
- Increase access to education and mental health and alcohol and drug health promotion groups and information particularly for younger people.
- Provide programs and services which help to facilitate behaviour change in people with or at risk of chronic disease (e.g. self-management training/courses) and also establish and nurture self-management support groups.
- Explore the establishment of a Health Promotion Officer position based in Three Springs
- With community partners, explore the feasibility for re-establishing the Men's Shed

Proposed Service Strategies – Three Springs MPS

- Work in partnership with providers and community to enable self-monitoring and management of chronic conditions (e.g. ensure blood pressure equipment available with education on the use and awareness of when to contact a doctor).

Care Coordination

- Refer chapter four District wide proposed strategies also.
- Discharge summaries prepared and made available as soon as possible to encourage ongoing care and support for the patient and maintaining current treatment information to staff.

Aboriginal Health

- Population Health has a part time Aboriginal Liaison position who visits.
- GMML is exploring an Aboriginal Liaison role for the area to help people access services and appointments.
- For Aboriginal community members, provide a safe and secure environment for yarning and other activities.

Awareness of services

- Continue to improve the methods and sustainability of communication of key health messages by using available local media (e.g. 'Yakabout', letter drop, rural shows/expos, and community notice boards and the workplace) to increase visibility of information. Information to be available in a number of different forms and forums, combined with increased programs and services. This could include advertising phone help lines – Health Direct and Rural Link (for mental health counselling and crisis care).
- Continue to promote the Medi-alert at both GP and MPS sites. Encourage people to nominate neighbours or relatives to be the Medi-alert contact rather than Three Springs MPS

6 Priorities for service reform

The proposed service reform priorities for the Midwest Health District health services are:

6.1 Service Reform priorities for Midwest Health District

Workforce

The challenges of recruiting and retaining appropriate health staff within the Midwest Health District are ongoing and recognised throughout this service plan. Workforce planning, staff recruitment, retention, training and ongoing development is therefore a significant priority for reform in the area. Specific reform priorities are detailed below.

- Consider opportunities to encourage a public/private mix of health service providers and to have funding, service and resource partnerships; supporting the establishment of services may be required (e.g. provision of free low cost facilities from which to provide services, provision of low cost housing options, shared training opportunities, use of technology etc)
- Support a sustainable and safe GP led 24/7 emergency model and roster across the District and increase access to out of hours medical on call models.
- Where practical, spread the call out roster to a larger group of GPs
- The Midwest Region and district to work with in partnership with GP practices and SIHI to maximise the incentives under SIHI Stream One, thereby enhancing GP primary care and improving medical coverage.
- Progress implementation of the Emergency Telehealth Service at all small hospitals subject to funding.
- Implement Scopia into specialist rooms at Geraldton Hospital
- Explore potential to employ an ED Nurse Practitioner for the Midwest and Murchison and Gascoyne Health Districts located in Geraldton to provide advanced emergency nursing care and clinical up-skilling to nursing staff across the districts.
- Continuing online options such as e-training or using Telehealth/Scopia for workforce training, to maintain staff competencies, to reduce the need for travel
- Investigate opportunities to share training opportunities between local health providers, which could also improve cross-agency partnerships, but may need to address some concerns around differences in clinical governance between agencies.
- Implement a system of professional supervision, mentoring and Online training
- Engage in a leadership development program
- Lobby for ongoing staff development positions in all sites
- Implement succession planning to build career pathways for staff and graduates

- Develop partnerships with shires to improve accommodation options
- Explore opportunities for utilising semi-retired health professionals, particularly for Telehealth consultations, which may reduce waiting times and workload for the limited number of GPs available in the area

Community Awareness of Services

- Use of a wide variety of media to promote awareness and efficacy of services for both providers and the community by:
  - Enhanced communication between service providers
  - Ensuring accurate information is available through a range of media
  - Increasing interagency communication and exchange of information, including liaison with the GMML who are contributing local information to the production of a National directory of health services.

Service Partnerships

- Work with the metropolitan area hospitals and outpatient clinics and Geraldton Hospital to improve case management, care coordination, appointment and discharge planning for Midwest Health District residents, particularly those with complex needs and who are elderly or more vulnerable and who are receiving inpatient care in the metropolitan area. This should include:
  - improving communication,
  - documentation,
  - electronic medical record sharing,
  - boundary issues and
  - day of discharge decisions.
- Increase case management and care coordination, particularly focusing on people with complex and co-morbid mental health and alcohol and drug or other chronic physical health issues. This can be achieved by developing agreements between the NGO sector and coordinators of the WACHS chronic conditions projects. For example accessing the Commonwealth Better Health Improvement Program funds to support service improvement initiatives for people with chronic conditions and their carers.
- Establish a Midwest Health District interagency forum similar to the Murchison District interagency forum that meets in rotating locations across the District. This group could enable more partnerships and coordination and confirm which group is responsible for different aspects of health and related service provision (e.g. State health, local government authorities, private GP's, other service agencies and /or the community).
- Work with the Goldfields Midwest Medicare Local (GMML) to address limitations in service provision for domiciliary post-acute care and primary health care.

Explore opportunities to provide greater access to Ambulatory, Population and Primary health

- The demographics and review of current service levels across the Midwest Health District indicates that Mullewa is a priority location for re orientation of the health service site from acute to primary care. This will enhance access to health promotion, primary health, child, maternal and community health, and mental health and drug and alcohol services over the next few years to help close the gap in health outcomes for the local Aboriginal population.
- SIHI stream one will enhance primary care (GP) services to better support the emergency models and increase primary care access for communities.
- Explore medical governance models and admitting rights to the MPS sites via Geraldton ED doctors using Telehealth or the WACHS Emergency Telehealth Service or via a proposed District wide Nurse Practitioner and Telehealth.
- There will be a steadily growing need to increase access to primary health services across the district, aligned with local needs and population growth. The priority primary health services include:
    - chronic disease self-management,
    - Revising the model of care for chronic disease monitoring including the potential use of I pad/pod apps for chronic disease management
    - additional allied health to enhance home visiting capacity for elderly clients,
    - mental health and drug and alcohol health promotion and general health promotion,
    - antenatal and postnatal care, including mothers groups.

Priority localities are Dongara, Mullewa and Morawa Perenjori

- There is an opportunity to better coordinate targeted immunisation for vulnerable groups, older people, workers, health workers in discussion with the GMML and GRAMS. For example, the Medicare Local may focus on the 'mainstream' population, while population health and GRAMS may focus on engaging vulnerable groups.
- Explore opportunities to increase allied health and domiciliary post-acute care services, given the limited existing services and projected growth in the number and proportion of older people. Potential avenues for increasing services include funding new and existing service providers in the private/NGO sectors (such as Medicare Local funding and other Commonwealth funding opportunities).
- Advocate for increased access to public and private dental services should be considered from a WACHS and Midwest regional perspective in conjunction with the public Dental Health Services (DHS), targeting low income groups, Aboriginal people and the elderly.

Care for Older People

- Advocate for:
  - Increased access to extended community aged care packages and high care beds based on population need with incentives to encourage local non-government and private residential and community aged care package providers.
  - Increased access to respite care either through ACAT in home respite, or private aged care provider.
  - The Midwest Aged Care Plan.
  - A regional or Midwest/Murchison/Geraldton Model/Network of Aged Care (Ageing in Place) in collaboration with the Midwest Regional Development Commission
- Increase access to Geriatrician and Psycho-geriatrician, through visiting or Telehealth consultations, particularly for Irwin and Northampton Shires.
- Support local Shires to explore independent living options for older people in the area. 'Independent living options' includes both ageing in place within the home, and moving to supported well aged housing.
- Continue with provision of HACC services
- Ensure older residents and HACC eligible clients are supported to access regular physical health, podiatry and oral health reviews as part of care planning.

Mental Health and Drug and Alcohol Services

- In alignment with the WACHS '*Mental Health Service Plan 2013-2015*' and '*Foundations for Country Health Services 2007-2010*' explore collaborative arrangements to improve integration of mental health and drug and alcohol services (including collocations, mergers, shared care protocols and case management).
- Increase access to and awareness of mental health services provided by WACHS and non-government providers, including older mental health services (e.g. services for those experiencing, dementia, depression, grief and loss), by using a variety of health promotion measures including media.
- Improve case management and integration of care for clients with mental health conditions including drug and alcohol issues, with particular focus on supporting the Aboriginal population in Mullewa.
- Review access and referral and discharge processes to community mental health services for the Midwest Health District to ensure those in most need have access to care and for continuity of care.
- Continue to liaise and advocate with metropolitan services to improve communication flows to the community mental health team so they can provide follow-up and support locally.

- Continue the weekly VC for clients receiving treatment and pending discharge at Graylands between the Graylands clinical team and the adult team in Geraldton.
- Implement primary mental health services, including child, adolescent and youth mental health promotion.
- Increase access to psychiatrists and psycho-geriatrician consults (including via Telehealth consultation).

Services for Aboriginal People

- Ensure all health and hospital services across the continuum of care are welcoming, culturally aware, secure and sensitive to the needs of clients from Aboriginal families. This would be enhanced by:
  - Coordination of services with GMML
  - Improving the Aboriginal workforce via increased opportunities for employment & traineeships, advertisements, and lower level entry as per the WACHS Aboriginal Employment Strategy 2010-2014,
  - Improving Aboriginal community engagement
  - Improving Aboriginal client transport
  - Mandatory comprehensive cultural security training
- Develop additional engagement strategies to support Aboriginal clients to access health services, for example use of community development approaches to address the social determinants of health.

Telehealth

- Telehealth needs to be better promoted and used. The future NGO model will provide one platform for telemedicine type services that could be accessed by subscription by all providers.
- Increase telehealth resources and training for both specialists and the local staff who meet the patient and prepare them for their consultation.
- The priority services for increased Telehealth for Midwest Health District residents include:
  - emergency services (including access to the new ETS for all MPS sites)
  - mental health and alcohol and drug services
  - psycho-geriatrics and geriatrics
  - pain management, palliative care and cancer care
  - general physicians
- Increasing opportunities to access ambulatory / primary health care type services via Telehealth should be raised and promoted at all Midwest Health District sites.
- Seek funding for home based Scopia

- Consider the use of Telehealth for remote monitoring. Liaise with Silver Chain regarding their remote monitoring systems.
- Increase the number of clinically appropriate Telehealth rooms.
- Encourage the community to enquire about Telehealth consultation as an alternative to travelling to the metropolitan area.
- Conduct an example Telehealth session so people can understand how Telehealth will work (e.g. with community groups such as Lions, CWA).
- Ensure local GPs are aware of Telehealth including the Medicare incentives to claim for equipment and undertaking consultations using Telehealth.
- Support WACHS wide initiatives to introduce e-health records, I Pads and Apps.

Information and Communication Technology (ICT)

- Sharing of information via the national roll out of the electronic health record between WA Country Health Services facilities/regions, and into metro and other providers would/will be of great benefit to consumers and professionals.
- Monitor the impact of electronic medical records and human resource systems as these systems are established.

Patient Transport

- Negotiate with GMML to potentially fund transport
- Advocating for inclusion of dental services within PATS eligibility criteria
- Funding options (shire, Lotterywest, Bendigo Bank) for a 'community car' or local buses that could possibly be used with volunteer drivers.
- Following identification at the planning consultations of patient transport as an issue, Geraldton SJA has commenced a patient transport service using drivers based in Geraldton. This service can be extended to district MPS sites based on availability of staff.
- Support the SJA in further development of patient transport services in the Midwest District. This could include seeking potential funding support from key agencies such as the Midwest Development Commission, Gascoyne Development Commission and Local Government Authorities
- Promote awareness of the pensioner $500 fuel card entitlement.
- Also refer to Telehealth strategies detailed earlier, which can impact on the need for patient travel.

6.2 Facilities and Infrastructure Priorities

The Service Plan will assist in informing the development of future business cases for the potential redevelopment of sites and services.

Funding has been allocated through Southern Inland Health Initiative (SIHI) to attract and retain Primary Health GP services in the district. Sustainable general practices in

local towns then support sustainable on-call and medical coverage for emergency departments and MPS sites. Additionally a nominal allocation of SIHI capital funding has been made to increase ambulatory health care at two sites in the Midwest district.

Future redevelopment of the Midwest Health District sites should align with the *Australasian Health Facility Guidelines* and various building codes and guidelines of Australia to ensure the facilities are contemporary and able to meet modern best practice models of care.

6.2.1.1 Issues Identified

- Mullewa, Three Springs and Northampton are particularly older style small hospital sites. Mullewa is currently undertaking some remedial works within its residential and palliative care rooms.
- Few sites have dedicated clinical rooms outside of ED for Telehealth clinical outpatient consults. Most sites use a multipurpose meeting room for such consults which may have carpeted floors and no access to water and sinks – i.e. infection control issues and lack of privacy for patients. See specific locations for site specific details.
- Suitable residential accommodation for health staff is a significant issue across the Midwest Health District. Issues include poor standard of some existing accommodation, much of the available accommodation is shared space with other staff and therefore not private nor contemporary. This can impact on staff recruitment and retention.

Proposed strategies for Facilities

The facility development priorities in Midwest Health District are:

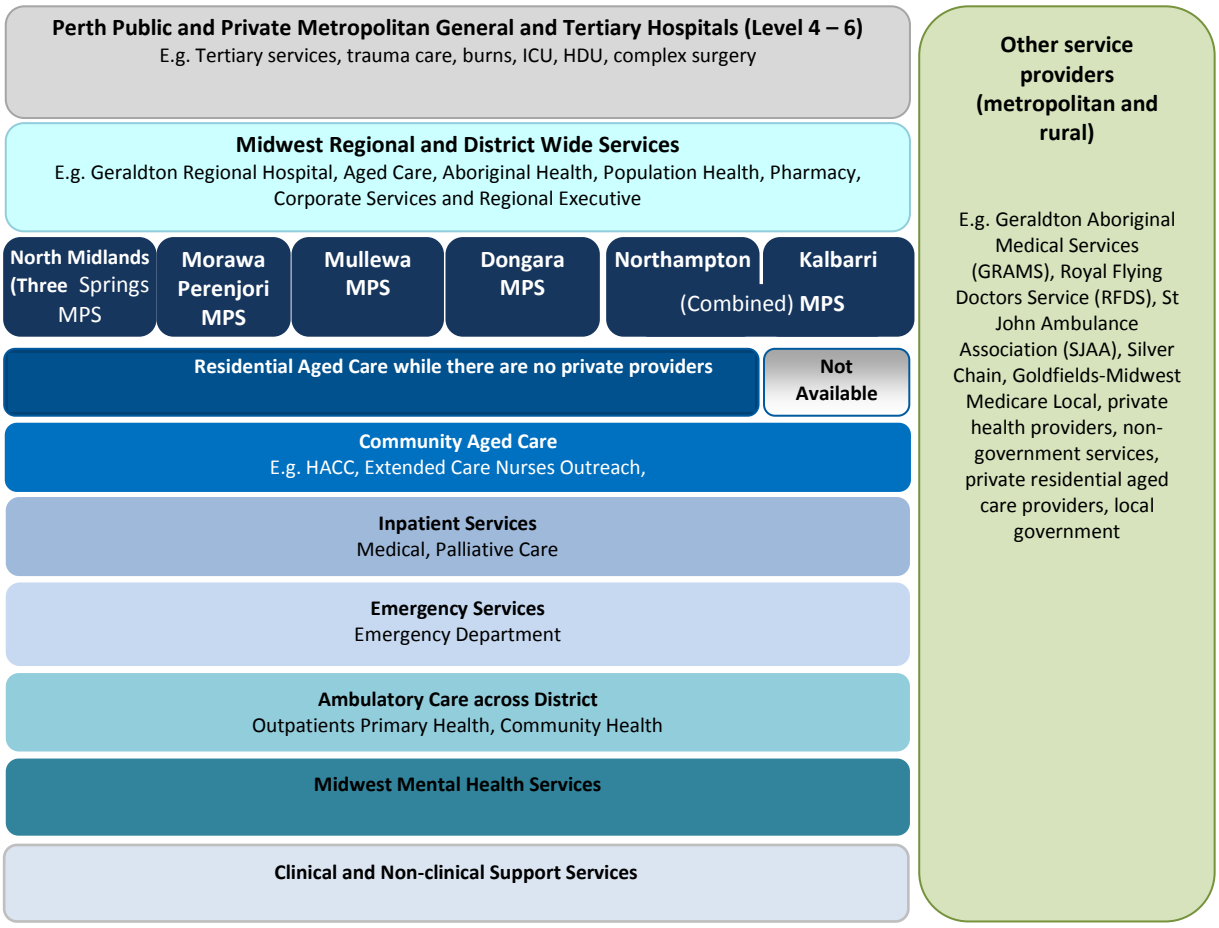
- To develop a facilities plan that prioritises upgrades of facilities across the region and within each district. The facilities plan should include identification of the appropriate locations for increased ambulatory health care services via SIHI funding.
- When funding becomes available for infrastructure development, facilities should be upgraded to contemporary standards to reduce occupational health and safety risks, to enable co-location of services and providers, and support best practice models of care for rural health
- Explore options for improved health facilities at Northampton and Three Springs and Mullewa in partnership where possible with other providers
- At Three Springs an extensive ED upgrade (with the inclusion of Telehealth equipment) should be investigated
- Staff accommodation needs to be reviewed / monitored to encourage recruitment and retention. It should be considered as part of an overarching Midwest strategy.
- Ensure telehealth and e-health technology is available and accessible at all sites in the Midwest Health District to enhance emergency services, primary health care service delivery and specialist outpatient access.

7 Functional Model of Care

The following section provides a visual representation of the functional external relationships for the Midwest Health District area. The figure attempts to summarise the range of services available across the district and the role delineation. Patients will flow to and from any of the services listed.

The future Model of Care, while reflecting the existing service delivery models, will focus on strengthening existing services particularly in the primary health care, complex care coordination and partnerships.

Figure 2: Future Functional Model of Care for Midwest Health District – levels where provided are from the CSF 2010 – 2020



8 Next Steps

Develop an Implementation Plan to identify the key operational and facility implications arising from the service delivery strategies outlined in this document. This will ensure all key issues arising from the Service Plan are considered to progress service reforms and to enable full achievement of current and future CSF role delineations. This includes determining priorities within the Service Plan for the Midwest Health District and Midwest Region that align with the funding intentions of the SIHI to ensure priorities are met, including but not limited to:

  - Utilise recurrent funding for medical and emergency services (SIHI Stream 1)
  - Maximise the SIHI Stream 3 (small hospital upgrades at two Midwest sites) contribution to the development of improved health facilities as per the established SIHI capital works prioritisation processes
  - Leverage partnerships with private aged care providers to establish residential aged care and respite beds (SIHI Stream 6).

- Determine the higher level strategic directions for the Midwest region and prioritise the service reforms required across the Region (e.g. workforce development, patient transport, sub-acute rehabilitation services and increasing nursing outpatients and chronic disease prevention and management services in collaboration with other providers).
- Determine the workforce strategy and recurrent cost implications (workforce model to include a focus on education and training for GPs, medical, nursing and allied health staff).
- Determine the private and inter-governmental partnerships to be formed to enable the future models of care to be established.
- Continue the 'community engagement' model for service planning and implementation to ensure services are suitable and culturally secure services for all residents.
- Develop the future functional models of care for emergency services and primary health care within the Midwest Health District.
- Work with the Department of Health's Health Information Network branch to establish electronic shared and integrated medical records (as per the National Health Reform Agreement).

9 Appendix A: Method for Developing the Service Plan

Developing the Midwest Health District Service Plan included CHS undertaking the following methods:

Project Plan (July 2012)

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

Literature Review (August – December 2011)

Key literature including Commonwealth, State and local policies were reviewed to provide direction for service reform as contained Section 3.5 in this Service Plan.

Data Analysis (August 2011, updated August 2012)

WACHS Planning Team provided the following data:

Demographic data analysis of Estimated Resident Population (population numbers) and population projections (population growth).

Health status activity data obtained from the WA Health and Wellbeing Survey (2009) and various morbidity and mortality databases.

Actual and projected inpatient and ED health service activity using endorsed 2011 modeling and other Department of Health data sources.

Consultation workshops (October 2012)

Round 1 of Service Planning Consultation workshops were conducted with staff of the Midwest Health District and external stakeholders to determine the District's strengths, emerging issues, areas for improving the existing model of care and opportunities to implement the intentions of the Southern Inland Health Initiative. Workshops engaged representatives from emergency, acute, aged care, primary health care services and clinical and non-clinical support services.

Online Validation survey (December, 2012)

A thematic analysis was undertaken of the data collected in Round 1. Validation surveys with health service staff and community members were undertaken to confirm and prioritise the issues and strategies and determine the strategic direction as detailed in this Service Plan.

Validation Workshop (August 2013)

Senior health service staff prioritised the issues and strategies based on perceived need and the potential ability to deliver the intended outcome.

10 Appendix B: Major Commonwealth and State policies

More detail on Commonwealth and State Government policies that inform services planning can be accessed by the WACHS Planning team or on the WACHS internet.

Policy	Policy implications for the Midwest Health District
Commonwealth Policy	
Council of Australian Governments (COAG) National Health Reform Agreement (2011) including Local Health Networks and Medicare Locals	In August 2011, all States and Territories agreed to the *COAG National Health Reform Agreement* which will deliver major reforms to the organisation, funding and delivery of health and aged care. The Agreement sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. The reforms will achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future. Local Health Networks and Medicare Locals are being established to locally manage public hospital health services and primary health care services respectively. www.coag.gov.au/docs/national_health_reform_agreement.pdf
National Partnership Agreement Closing the Gap in Indigenous Health Outcomes (2009)	Service planning enables key strategies within the *Western Australian Implementation Plan* to be achieved including strong collaboration of ambulatory care services.
State Government Policy	
WA Health Strategic Intent 2010-2015 (2010)	This document has a number of overarching goals for WA Health to build *healthier, longer and better quality lives for all Western Australians*. The intention of this Service Plan is to align with these overarching goals within this policy. Refer to: www.health.wa.gov.au/about/docs/WAHealth_Strategic_Intent_2010_2015.pdf
WA Health Clinical Service Framework 2014-2024 (WA CSF 2014 awaiting endorsement)	The WA CSF identifies the core services available in a facility with each clinical service level meeting a set of definitions for clinical specialties with Level 1 being the least complex and Level 6 being the most complex service model, generally consistent with a tertiary metropolitan hospital. The WA CSF 2024-2024 details role delineations for Regional Resources Centre, Integrated District Health Service and for the first time Small Hospitals in WACHS. It also delineates community-based services at the district level. Service planning utilises this State policy to understand the level of service delivery at WACHS facilities and the level of integration required with other Midwest and metropolitan hospitals. See Appendix C for Midwest Role delineations
WA Health, Greening Health, Building and Renovations	Service reform provides an opportunity to maximise environmental safety and energy efficiencies which will address climate change issues and support actions to reduce WA health's environmental footprint. The full implications of this policy are available on the WA Health Intranet site.
WA Health Telehealth Strategic Direction	A major initiative of health service reform is to enhance Telehealth facilities in health services to enable efficiencies to be gained in providing patient assessment and care; staff training; and patient-to-practitioner communication.
WA Health Network Models of Care (ongoing)	Service planning offers the opportunity to create facilities that best support the delivery of modern models of care as developed by the Network. The published models of care are found at www.healthnetworks.health.wa.gov.au/modelsofcare

Policy	Policy implications for the Midwest Health District
***Mental Health 2020: Making it personal and everybody's business* (Strategic Policy)**	The WA Government's ten year strategic policy for mental health, *Mental Health 2020: Making it personal and everybody's business*, provides a whole of government and community approach and sets out three key directions: • person centred supports and services; • connected approaches; and • balanced investment. For more information go to: www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Mental_Health_Commission_strategic_plan_2020.sflb.ashx
Western Australian Health Promotion Strategic Framework 2012 - 2016	*The Health Promotion Strategic Framework 2012–2016* outlines WA Health's priorities for meeting its obligations under the National Partnership Agreement on Preventive Health (NPAPH) and its plan to lower the incidence of avoidable chronic disease and injury by facilitating improvements in health behaviours and environments over the next five years.
WA Health Redundancy and Disaster Planning Guidelines (2008)	Midwest Hospitals will comply as a Group 3 facility for Redundancy and Disaster Planning as per these Guidelines: www.public.health.wa.gov.au/cproot/2540/2/Redudancy%20and%20Disaster%20Planning.pdf
Southern CHS Policy	
WACHS Towards Healthier Country Communities 2013-2015	Service reform enables WACHS to achieve many of the key action areas within this strategic plan for the Midwest community. Refer to: www.wacountry.health.wa.gov.au
Operational Plan 2011/12 WA Country Health Service	This *Operational Plan* actions the *Strategic Plan*, providing practical direction for WACHS operations across the State.
WA Country Health Services Human Resources Strategic Directions Framework (2011)	Human Resources Priorities Plan for 2011/12 will be developed as an outcome of WACHS endorsing this framework. Workforce development within the Midwest should engage in this process to improve the attraction and retention of a skilled workforce.
Aboriginal Employment Strategy 2010-2014	This strategy advocates for more Aboriginal people to be employed in all levels of the organisation as a strategy to make services more culturally secure.
WACHS Renal Dialysis Plan	This plan identifies the need for renal satellite outreach dialysis or community supported dialysis services (small satellite services) in the Midwest to enable care closer to home.
WACHS ED Services Planning and Facility Design Principles and Benchmarks	Calculation of the required number of treatment bays to manage future demand is based on the benchmarks published in this document.

11 Appendix C: WA Clinical Services Framework 2014-2024

Service Role Delineations for Midwest Health District Services

The WA Clinical Services Framework 2010 – 2020 (CSF 2010) has been revised to the Clinical Services Framework 2014 - 2024 and services going forward will align with the CSF 2014. The CSF identifies the core services available in a facility with each clinical service level meeting a set of definitions for clinical specialties with Level 1 being the least complex and Level 6 being the most complex service model, generally consistent with a tertiary metropolitan hospital. The CSF 2024-2024 for community-based services will be role delineated at the district level.

The current and expected role levels for Midwest District Hospitals are summarised below in Tables 11, 12, 13 and 14 against the expanded clinical service lines for hospital and community services and the new role delineation for outpatient services. The CSF 2014 includes role delineation for services for all hospitals and will be expanded with descriptions under each of the subsequent sections discussing these functional areas.

The Service Matrices for the Midwest District Hospitals and community services is interpreted as follows:

- Hospital Based Services Level 1- 6; the service levels are cumulative (denotes no inpatient care for the clinical specialty)
- Hospital Based Services Outpatients I-VI; the service levels are cumulative (denotes no outpatient care for that clinical specialty)
- Community and Integrated Services A – F; the service levels may or may not be cumulative role descriptions.

The Draft Clinical Services Framework 2014-2024 is in the approval process. When endorsed and published, service, infrastructure and implementations plans may need to be reviewed against the CSF 2014.

Table 11: Draft WA Clinical Services Framework 2014-2024 Hospital Medical Services Role Levels Midwest District Health Services

Note: Clinical specialities for hospital services where the role delineates no inpatient or outpatient care for all the facilities in the district has been excluded from this table for the Midwest District Services

Medical Services	Facility																	
	Dongara			Kalbarri			Morawa - Perenjori			Mullewa			North Midlands (Three Springs)			Northampton		
	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025
General	3	3	3	3	3	3	3	3	3	2	2	2	2	2	2	2	2	2
Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Geriatric	3	3	3	3	3	3	3	3	3	2	2	2	2	2	2	2	2	2
Outpatients	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Palliative Care	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II

Source: Draft WA Health Clinical Services Framework 2014-2024.

Table 12: Draft WA Clinical Services Framework 2014-2024 Hospital Surgical, Obstetrics and Neonatal and Paediatric Services Role Levels Midwest District Health Services

Surgical Obstetrics & Neonatal Paediatric Services	Facility																	
	Dongara			Kalbarri			Morawa - Perenjori			Mullewa			North Midlands (Three Springs)			Northampton		
	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025
Burns	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Trauma	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Vascular	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Emergency Services	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Obstetrics and Neonatal Services																		
Obstetrics	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Neonatology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Paediatric Services																		
Emergency Services	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
General Medicine	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Trauma	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

Table 13: Draft WA Clinical Services Framework 2014-2024 Hospital Rehabilitation, Mental Health, Disaster Preparedness and Clinical Support Services Role Levels Midwest District Health Services

Rehabilitation Mental Health Disaster Preparedness Clinical Support	Facility																	
	Dongara			Kalbarri			Morawa - Perenjori			Mullewa			North Midlands (Three Springs)			Northampton		
	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025	2013-2014	2018-2019	2024-2025
Rehabilitation	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Child & Adolescent Mental Health Services																		
Emergency Services	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Inpatient Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Adult Mental Health Services																		
Emergency Services	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Inpatient Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Older Persons Mental Health Services																		
Emergency Services	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Inpatient Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Disaster Preparedness and Response																		
Disaster Preparedness	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Clinical Support Services																		
Infection Control	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Pain Medicine	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Outpatients	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II	II
Pathology	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Pharmacy	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Radiology	2	2	2	2	2	2	2	2	2	2	-	-	-	-	-	-	-	-

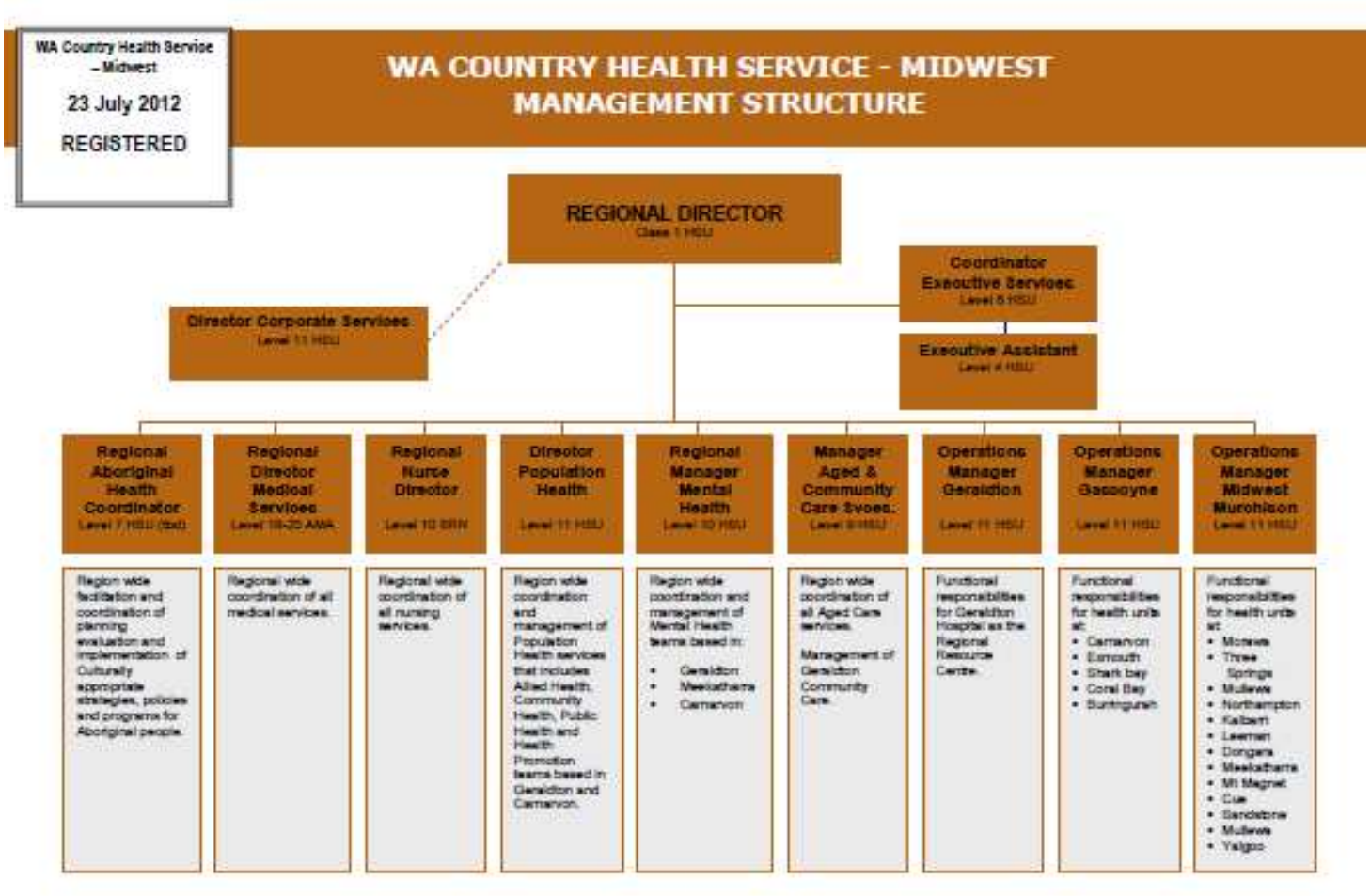
Table 14: Draft WA Clinical Services Framework 2014-2024 Community and Integrated Services Warren Black Health District

	Midwest Health District						
Service Description	**2013-2014**	**2018-2019**	**2024-2025**	**Service Description**	**2013-2014**	**2018-2019**	**2024-2025**
Public Health and Prevention Services aimed at promoting health in the community, preventing disease before it occurs, and managing risk. Includes a mix of publicly and privately funded services				**Primary Care** First point of care services for prevention, diagnosis and treatment of ill-health accessible to people in their local communities. Includes a mix of publicly and privately funded services			
BreastScreen WA	A	A	A	Child Health and Immunisation Programs	C	C	C
Communicable Diseases Control Programs	A	A	A	Maternity Services	A	A	A
Drug and Alcohol Prevention Programs	B	B	B	Primary Health Care Services	BC	BC	BC
Environmental Health Protection Services	B	B	B	Sexual Health Services	B	B	B
Health Promotion Programs	C	C	C	Targeted Aboriginal Health Services	A	B	C
Complex and Long Term Care Integrated and coordinated service delivery for people living with one or more chronic health conditions. Includes a mix of publicly and privately funded services							
Ageing and Aged Care – Services that support National Programs	A	A	B	Drug and Alcohol Treatment and Support Services	A	A	A
Ageing and Aged Care – Continuing Care for the Older Person	A	A	A	Neurological Services	A	A	A
Arthritis and other Musculoskeletal Services	B	B	B	Overweight and Obesity Services	B	B	B
Asthma Services	A	A	A	Paediatric Complex Care Coordination	A	A	A
Cancer Services	B	B	B	Paediatric Developmental Allied Health Services	A	A	A
Cardiovascular Services	B	B	B	Pain Management Services	A	A	A
Chronic Respiratory Services	A	A	B	Palliative Care	B	B	B
Diabetes Services	B	B	B	Rehabilitation Services	A	A	A
Digestive Services	A	A	A	Renal Dialysis	A	A	A
Mental Health Services				**Dental Health Services** includes publicly funded services provided through government funded dental clinics, itinerant services and private dentist participating in subsidy schemes			
Mental Health – Child and Adolescent	B	B	B	Dental Services for Infants 1-4 years	A	A	A
Mental Health - Adult	B	B	B	Dental – School Aged (5-16 yrs.)	A	A	A
Mental Health – Older Person	B	B	B	Dental Adult Services	A	A	A

Note: Specialty Dental Services are not role delineated for the Midwest District

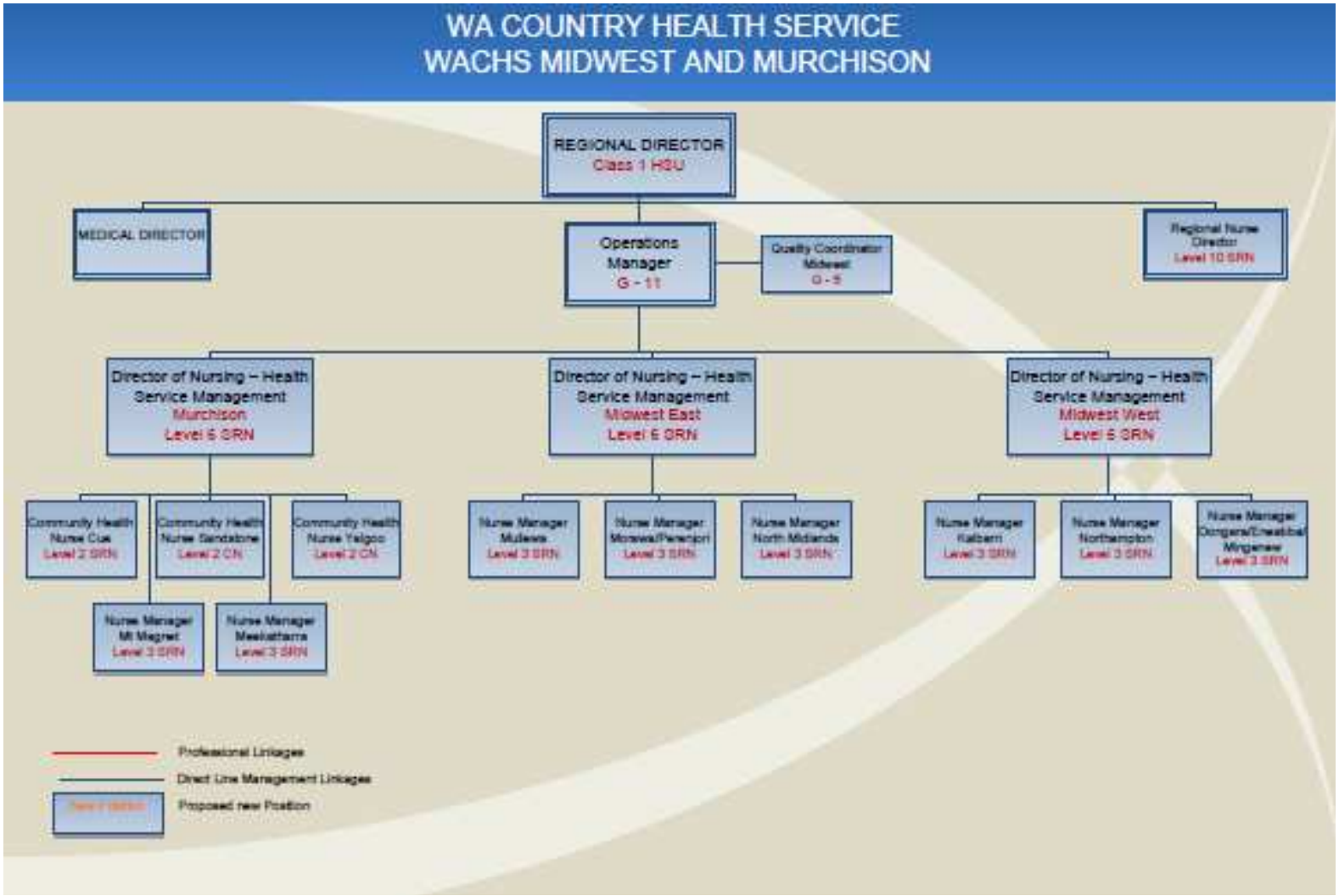
12 Appendix C: Organisational structures

Figure 3: WACHS Midwest Region Governance Structure



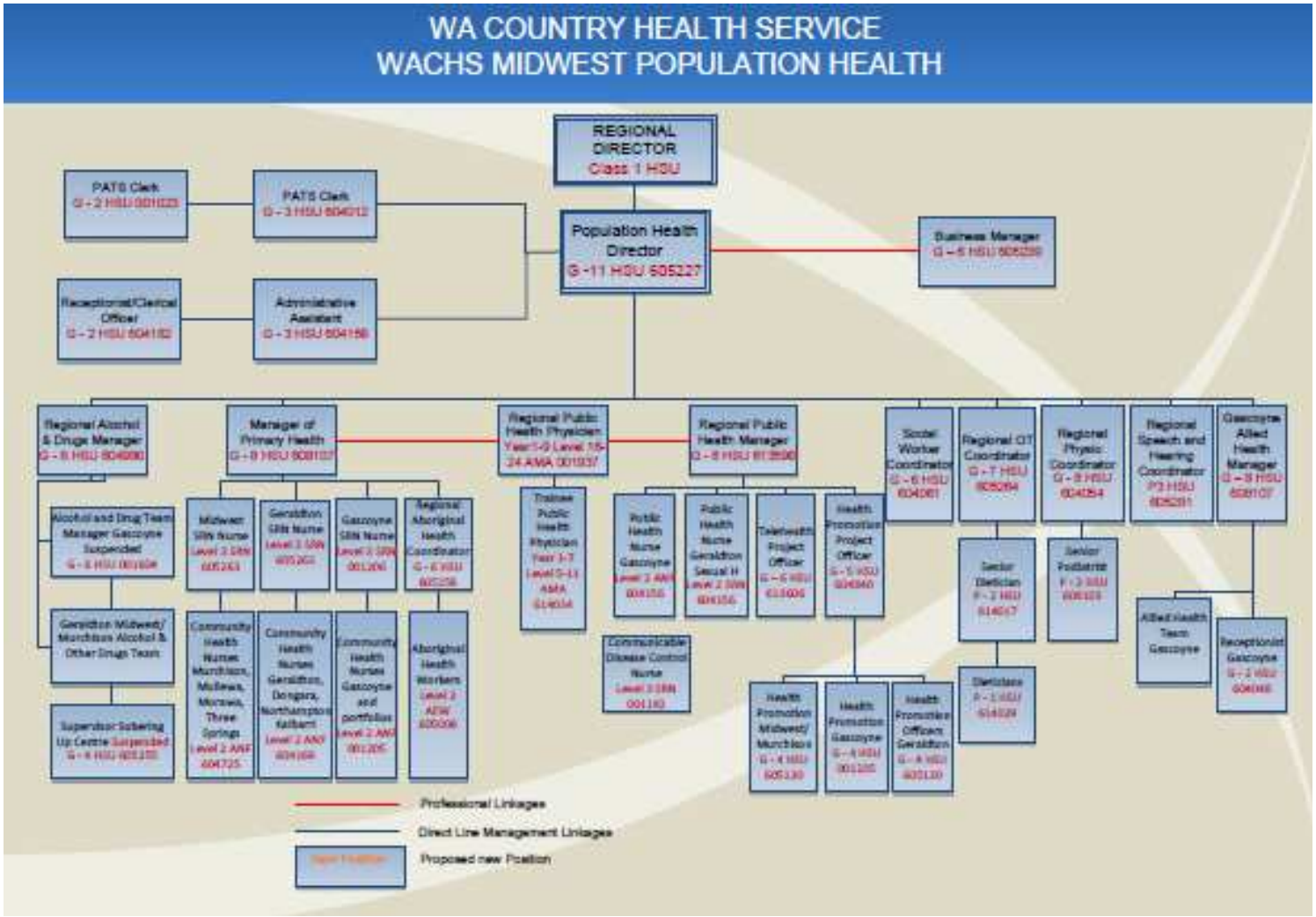
Source: WACHS Midwest Intranet accessed 17 January 2013-01-17

Figure 4: WACHS Midwest and Murchison District Governance Structure



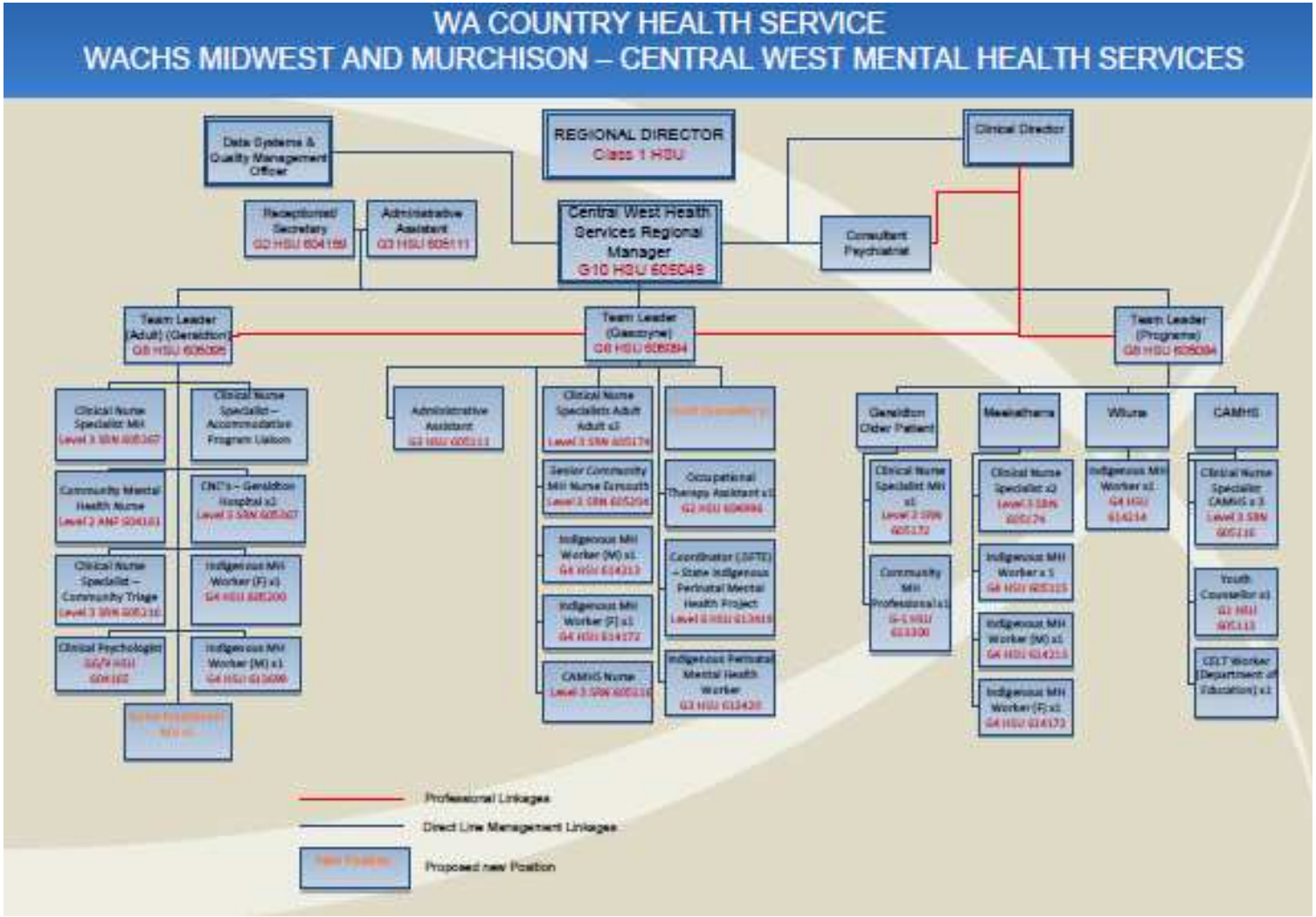
Source: Midwest Intranet accessed January 17th 2013

Figure 5: Midwest Population/ Health Structure



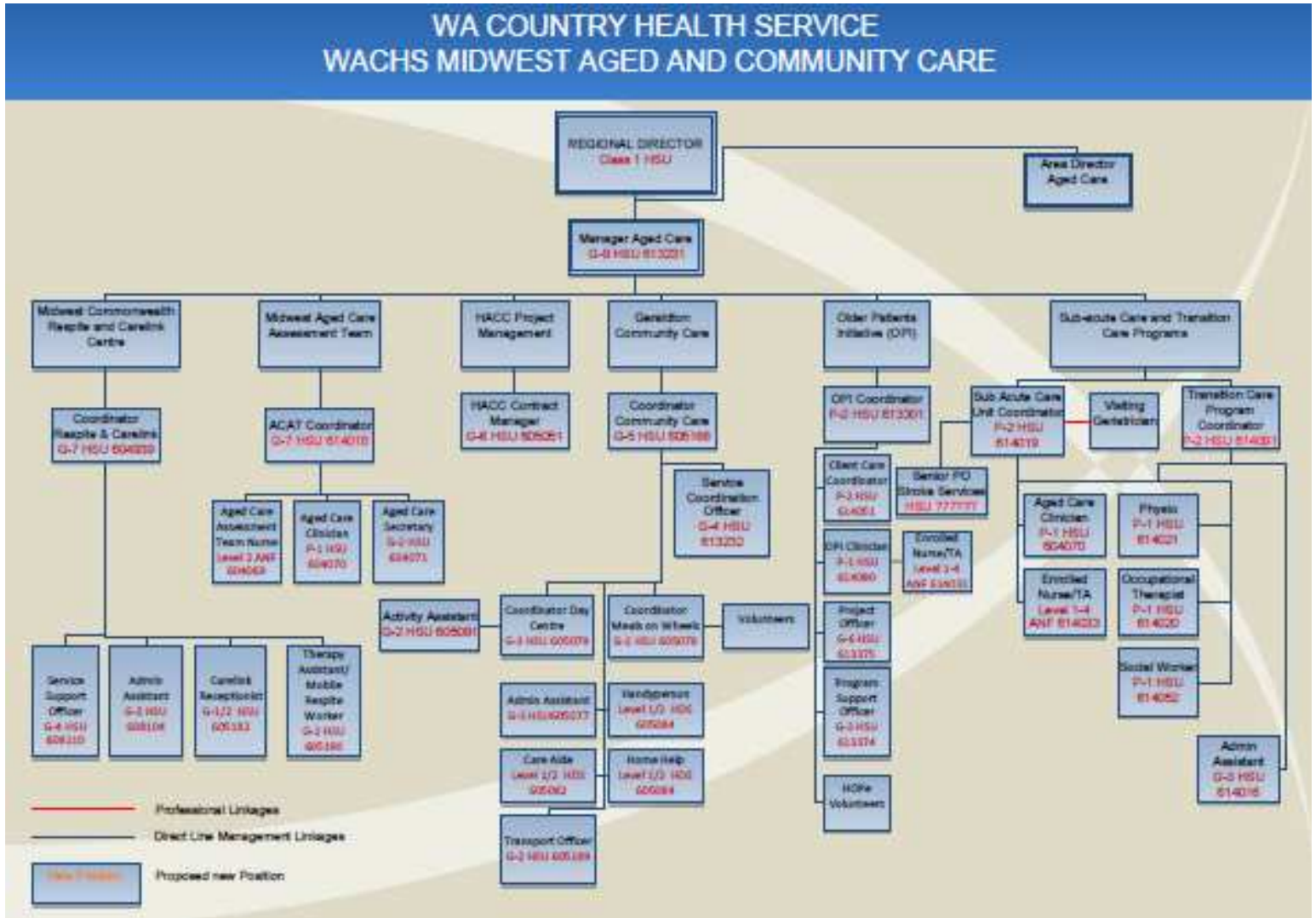
Source: Midwest Intranet accessed January 17th 2013

Figure 6: WACHS- Midwest Mental Health Service structure



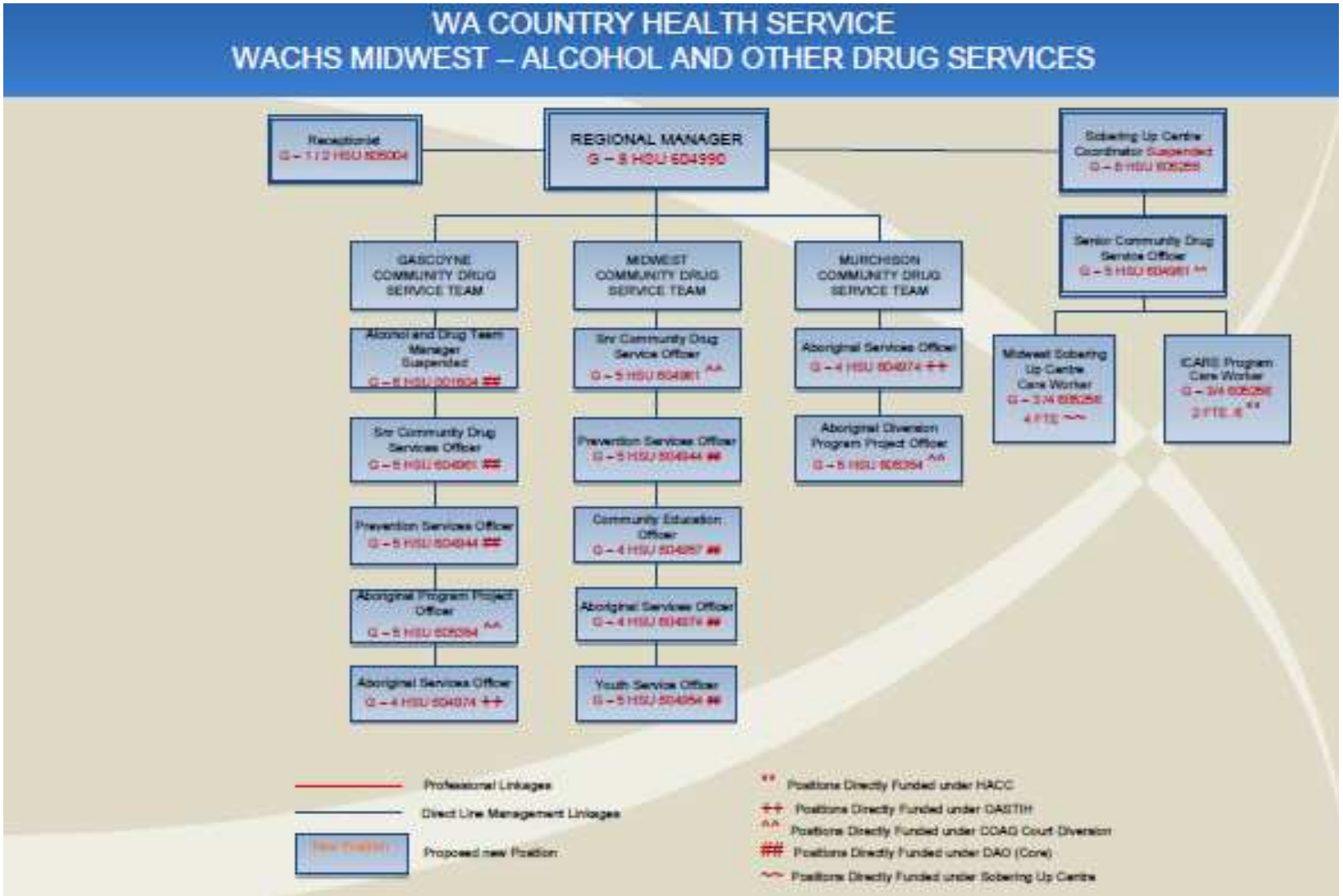
Source: Midwest Intranet accessed January 17th 2013

Figure 7: Midwest Aged Care Structure



Source: Midwest Intranet accessed January 17th 2013

Figure 8: Midwest Alcohol and Drug Structure



Source: Midwest Intranet accessed January 17th 2013

13 Appendix D: Demography and Health Needs

13.1 Demography

The demography of the Midwest Health District, as well as the broader Midwest health region will influence the type of services and the models of care delivered to residents and visitors. This section highlights the population growth, gender, age distribution and cultural diversity of the Midwest Health District that will need to be considered in determining the future models of care, types and location of services.

13.1.1 Population and population growth

The Australian Bureau of Statistics (ABS, 2012) Estimated Resident Population (ERP) of the Midwest Health District region grew by five percent over the previous five years, to 12,984 in 2012. This increase was less than the 14 percent for the State.

The WA Department of Health publishes population projections based on historic trends in the components of population growth (fertility, mortality and migration). These projections are used across Government to plan for infrastructure and service provision and by private sector organisations to plan for changing demand. The current endorsed projections come from Treasury in February 2014 and are based on the 2011 census series B with low migration. There may be errors at LGA level as projections are calculated based on proportions of people in each LGA in each age group from previous projections. If there has been a change in the proportion of a particular age group it will be missed in the projections (i.e. the 45-69 age group in Perenjori has grown significantly in the last five years but this is not reflected in the Perenjori projections).

WA population projections estimate the district's population to increase by 2319 (17percent), from 13,467 in 2012 to 15,786 in 2026, as shown in the Table below. This level of growth is lower than the expected 33 percent growth of the State for the same time period.

The Midwest Health District is expected to have growth of 17 percent between 2012 and 2026. This growth is around one percent per year.

Table 15: Midwest Health District : 2012 ERP and 2012 to 2026 population projections

LGA	ERP 2012	2016	2021	2026	growth 2012-2026	av. Annual
Carnamah (S)	553	821	794	798	44.3%	2.7%
Chapman Valley (S)	1212	1,222	1,378	1,519	25.4%	1.6%
Coorow (S)	1088	903	714	632	-41.9%	-3.8%
Irwin (S)	3703	4,354	4,921	5,495	48.4%	2.9%
Mingenew (S)	487	374	339	305	-37.3%	-3.3%
Morawa (S)	908	897	945	972	7.0%	0.5%
Murchison (S)	121	117	128	132	8.8%	0.6%
Northampton (S)	3353	4,144	4,492	4,836	44.2%	2.6%
Perenjori (S)	928	480	448	431	-53.5%	-5.3%
Three Springs (S)	631	686	673	666	5.6%	0.4%
Total	**12,984**	**13,998**	**14,832**	**15,786**	**21.6%**	**1.4%**

Note: Mullewa's population is now linked with Greater Geraldton and Perenjori's appears to be a gross underestimate.

Source: WA Treasury 2014 population projections, ERP 2012

Implications for service planning:

The population of the Midwest Health District has grown at a slower pace than the population of the State There was strong growth in Chapman Valley, Irwin and Perenjori and decline in other locations. The main future growth appears to be in the coastal shires.

13.1.2 Gender distribution

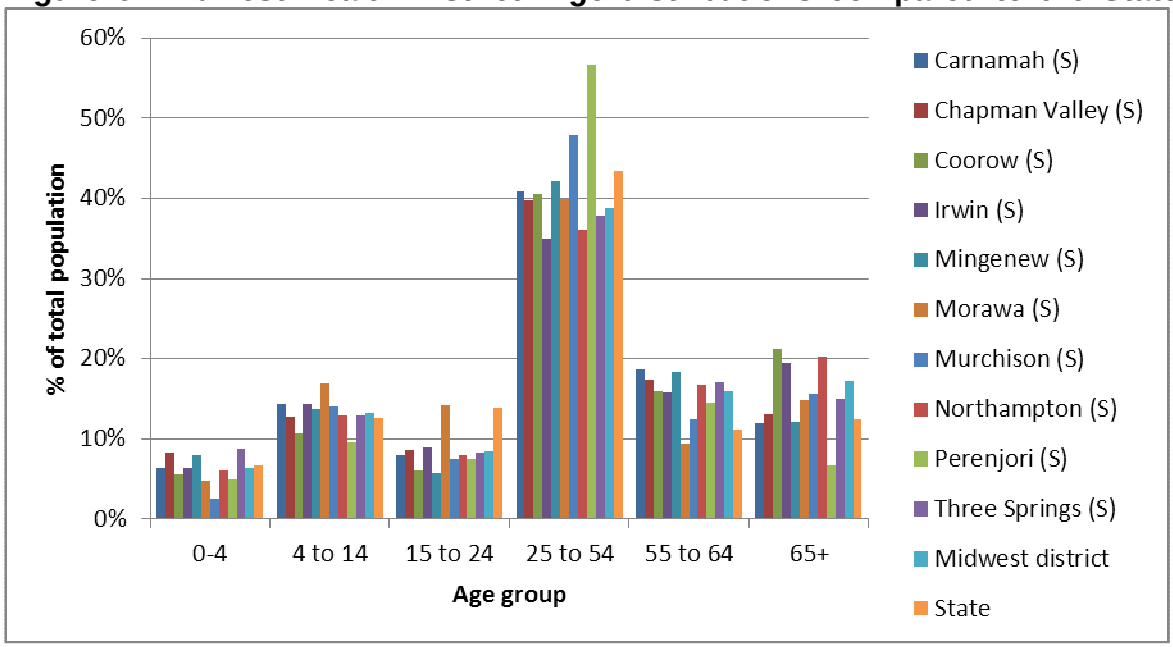
The 2012 ERP shows there were slightly more males than females in the Midwest Health District (53 percent compared with 47 percent) and this gender imbalance is projected to remain in the future.

13.1.3 Age distribution

In the 2012 ERP the Midwest region had an older age distribution compared with the State, as shown in Figure 9. In the Midwest Health District 17 percent of the population are aged 65 years and over, compared with 12 percent in the State.

The dependency ratio is a ratio of those typically not in the labour force to those in the labour force and is calculated by dividing the number of people under 15 or over 64 years of age by the number of people aged 15 to 64 years. In 2011 the dependency ratio of the Midwest Health District was greater than that of the State (0.69 compared with 0.61) and is anticipated to increase to 0.7 in 2026.

Figure 9: Midwest Health District: Age distributions compared to the State (2012 ERP)



Source: ABS 2012 ERP

The proportion of residents who are aged 85 years and over was 1.1% in 2011, 1.4% in 2012 and is anticipated to increase to 1.6 percent in 2026 (WA Treasury 2014 endorsed projections) reflecting an increasing longevity. With this increase there will be an additional 107 older adults aged 85 years and over between 2012 and 2026, including 32 in Irwin and 37 in Northampton.

Implications for service planning: The ageing population will place added pressures on health services to manage health conditions commonly seen in older adults and indicates an increasing need for community, primary health (chronic conditions) and residential aged care services.

With the Midwest's older population the residential aged care and dementia investment program of the SIHI will be particularly important for providing the residential aged care and dementia services that will be required in the region in the future.

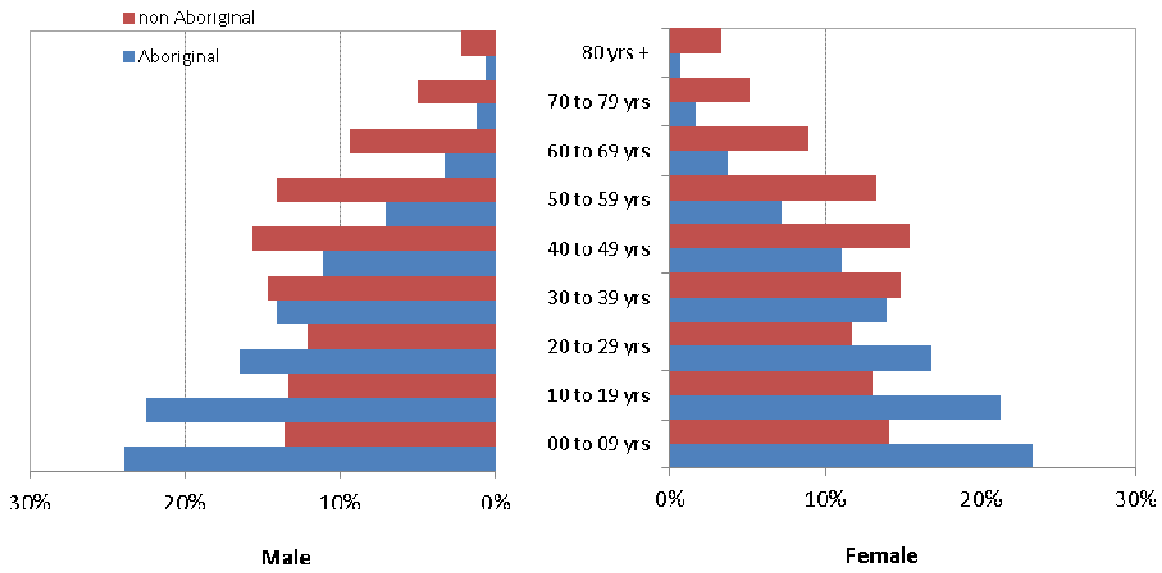
13.1.4 Cultural diversity

13.1.4.1 Aboriginal people

In the 2011 Estimated Resident Population seven percent of Midwest residents (965), 2.1 percent of Irwin and 39 percent of Mullewa residents are identified as being Aboriginal or Torres Strait Islander (ABS ERP via Rates Calculator), compared to the State (three percent).

The Aboriginal Midwest Health District population has a greater proportion of females than the non-Aboriginal population does (56 percent compared with 47percent) and a much younger age structure, as shown in the next figure.

Figure11: Midwest Health District region by Aboriginality, 2011



Source: Estimated by the Epidemiology Branch, Public Health Division, Department of Health WA.

Implications for service planning:

The Aboriginal population of the Midwest health district has a much younger age structure than the non-Aboriginal population. Nearly half the Aboriginal population is under 20 years of age compared with a quarter for the non-Aboriginal population. This differing age structure will need to be taken into account in the planning of primary health services and programs.

13.1.4.2 Ethnicity

In the 2011 Census, 14% of the Midwest Health District residents reported being born overseas. This proportion was less than that of the State (35 percent). Most Midwest residents born overseas were born in the United Kingdom.

13.2 Health status and health service needs

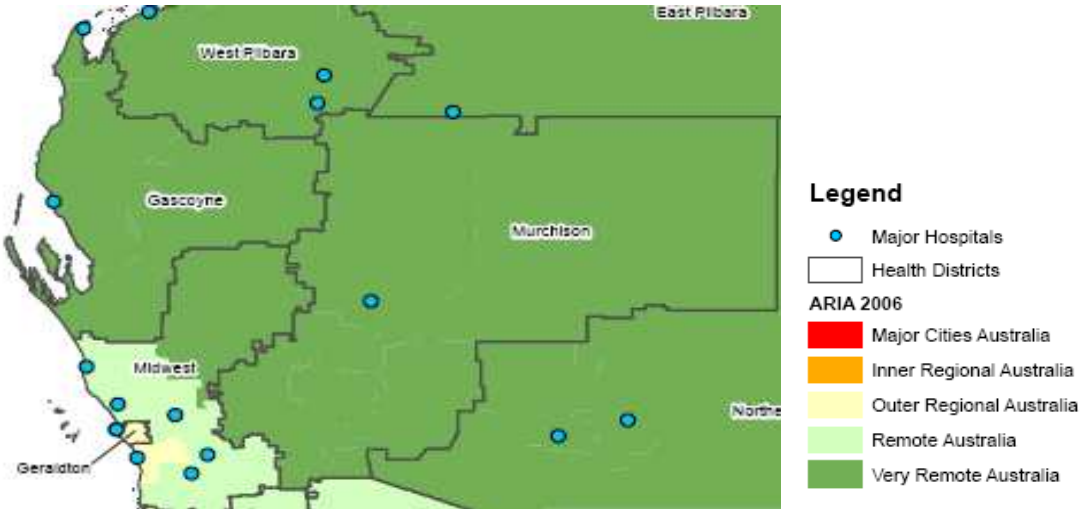
13.2.1 Determinants of Health

There are many factors that influence a person's health, including genetics, lifestyle and environmental and social factors. These factors may have a positive or a negative impact (Joyce and Daly, 2010). The following section describes the current health status of the region and summarises the factors (or determinants of health) that will influence the health status of residents now and into the future. The factors highlighted influence the demand for health services and should be considered when designing the future models of care for the Midwest.

13.2.2 Remoteness

Remoteness is measured by the Accessibility Remoteness Index of Australia (ARIA), ARIA is a systematic approach to the classification of areas of Australia according to level of remoteness where areas classified as remote have very restricted accessibility of goods, services and opportunities for social interaction (Department of Health and Ageing, 2001).Within this classification system there are 5 categories ranging from Major Cities to Very Remote.

Figure 10: Accessibility/Remoteness Index of Australia (ARIA) classification of the Midwest



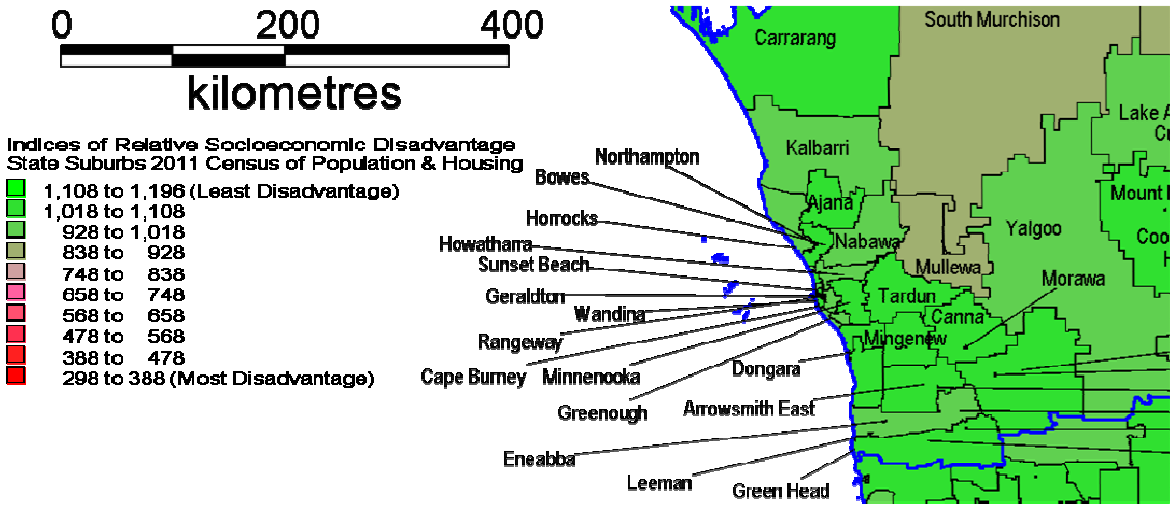
Source: DoH Epidemiology Branch

Based on the 2006 ARIA the Midwest health district is mainly remote with the north east portion of Murchison LGA classed as very remote. However it is classed by the Independent Hospital Pricing Authority (IPHA) as Outer Regional.

13.2.3 Socio-Economic Disadvantage

The ABS (2011) SEIFA reveals that Midwest Health District LGA scores were average to low ranging from 883 in Murchison to 1,031 in Perenjori. Murchison was in the lowest 10% of scores in Australia, but only represents a population of 115. Mullewa, Murchison, Coorow and Three Springs are in the lowest 40 percent and Perenjori is in the top 20 percent of scores.. There were pockets of need within LGAs. For example suburbs of Morawa (pop 245), Mullewa (pop 360), and Northampton (pop 309) had scores of 826, 850, and 852 respectively, placing all these suburbs in the bottom 10% of scores in Australia

Figure 13: SEIFA classification of the Midwest Health District



Source: Health Tracks

Implications for service planning:

The SEIFA Index of Relative Socio-Economic Disadvantage shows that there are areas within the Midwest health district with differing levels of disadvantage. Services and programs will need to be flexible to respond to the needs of these disadvantaged communities.

13.2.4 Australian Early Childhood Development Index

The results for Midwest Health District communities are shown in Table 16. The cells shaded green indicate towns with significantly lower than average levels of vulnerable children across developmental domain, while red cells indicate towns with significantly higher levels.

Table 16 : Proportion of children vulnerable on one or more domain, 2009

Community	Number children surveyed	% Developmentally vulnerable on one or more domains	% Developmentally vulnerable on two or more domains
Carnamah (S)	17	24%	12%
Coorow (S)	26	38%	27%
Irwin (S)	79	10%	5%
Mullewa (S)	19	42%	11%
Northampton (S)	50	28%	12%
Perenjori (S)	32	25%	16%
Three Springs (S)	26	23%	15%
Australia	**261,203 (4.8% ATSI)**	**24%**	**12%**

Data Source: Australian Early Development Index

13.2.5 Local risks and climate

The Midwest Health District has proximity to major highways and all traffic to the north of the state from Perth and so is at a higher risk of receiving high trauma cases from motor vehicle accidents.

The Midwest Health District due to its location north of Perth has a similar but warmer climate than the metropolitan area and is at higher risk of cyclone threat, therefore health services should also be responsive to extreme conditions such as storms and flooding and natural disasters like fire.

Implications for service planning:

Midwest will need to maintain effective emergency management plans for receiving, stabilising and transferring patients to tertiary hospitals in the future and be responsive to climate risks such as storms, flooding and fires.

13.2.6 Self-reported measures of health and wellbeing

Risk factor information is usually collected by population based surveys, such as the WA Health and Wellbeing Surveillance System (HWSS). Since 2002, the WA HWSS has captured information from over 6,000 Western Australians annually. This comprehensive survey collects information health and wellbeing indicators including health risk behaviours, chronic diseases, health service utilisation and the level of psychological distress.

All information provided by the HWSS reports is based on self-reported data. Testing has shown that the responses on the HWSS survey are reliable but in a very few cases, may not be completely accurate. For example, people are likely to underestimate their weight and alcohol consumption, but they do so consistently. This means that although the estimates for these are

likely to be less than the 'true' estimate in the population, the estimates reliably show patterns of change over time. Therefore the information provided in this report is representative of the WA population as a whole but it is unlikely to be reliably representative of small minority groups within the population such as Aboriginal people, the homeless or those without telephones

The Epidemiology Branch and Cooperative Research Centre for Spatial Information (2009) reported the results in the following chart for adults aged 16 years and over in the Midwest Health District between 2007 and 2010.

Table 17: Self Reported Risk Factors Midwest Health District Residents 16 years and over, 2007-10

Lifestyle & Psychosocial Risk Factors (16 years & over) 2007-2010	Prevalence Estimate		
	MW District	MW region	State
Currently smokes (%)	22.3	19.7	15.9
Doesn't eat two or more serves of fruit daily	47.3	45.7	47
Doesn't eat five or more serves of vegetables daily	83.9	87	86.4
Drinks at risky levels for long-term harm	51.9	51.7	49
Drinks at risky levels for short-term harm	23.4	23.4	22.8
Insufficient physical activity	49.2	48.4	46.9
Current high blood pressure	22.5	20.7	16.7
Current high cholesterol	24.4	21.4	18.7
Overweight	44.4	43.1	39.3
Obese	29.2	26.9	26.2
High or very high psychological distress	7.1	7	8.3
Lack of control over life	1.8	4	3.9

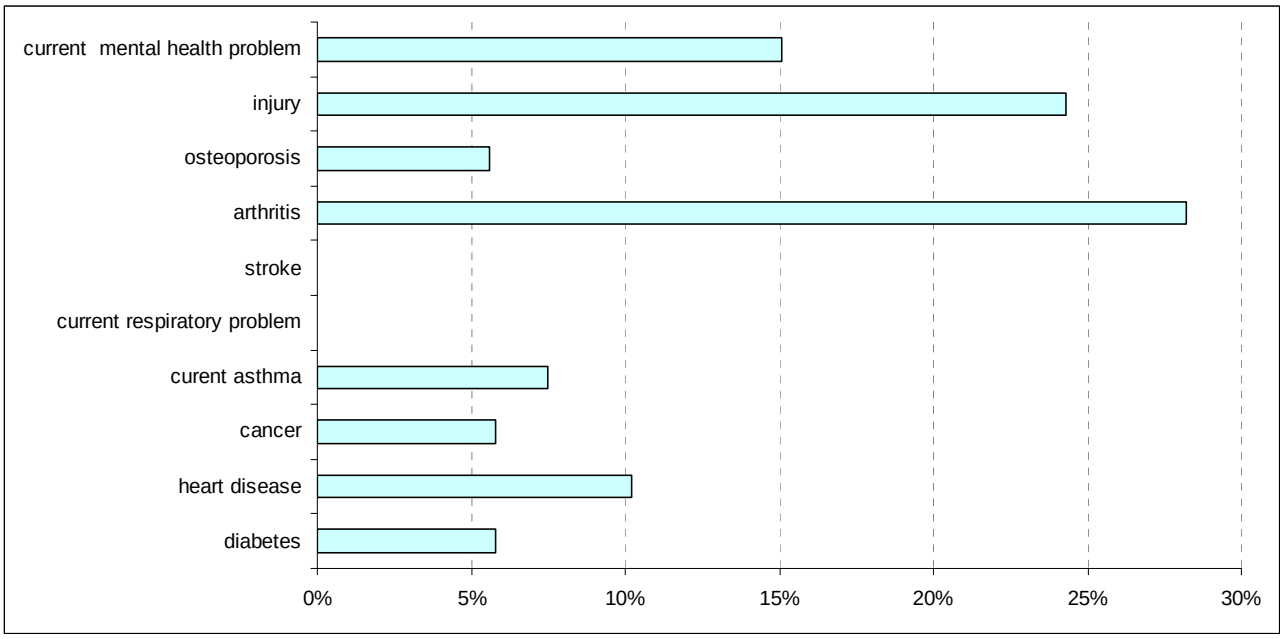
Note: The red shading indicates that this is significantly higher than the State; Green is significantly lower than the state rate. Includes information from 502 adult (16 years and over) residents in the Midwest Health district 2007-2010 (total WA sample 27,877 adult residents)
Source: HWSS, via Health Tracks

13.2.7 Health Status, all Midwest residents

13.2.7.1 Self-reported chronic conditions

According to the Epidemiology Branch and Cooperative Research Centre for Spatial Information (2009a), the most prevalent chronic conditions for adults in the Midwest Health District are shown in the chart below.

Figure 14: Self Reported Chronic Conditions Midwest Health District Residents 16 yrs and over, 2007 - 2010



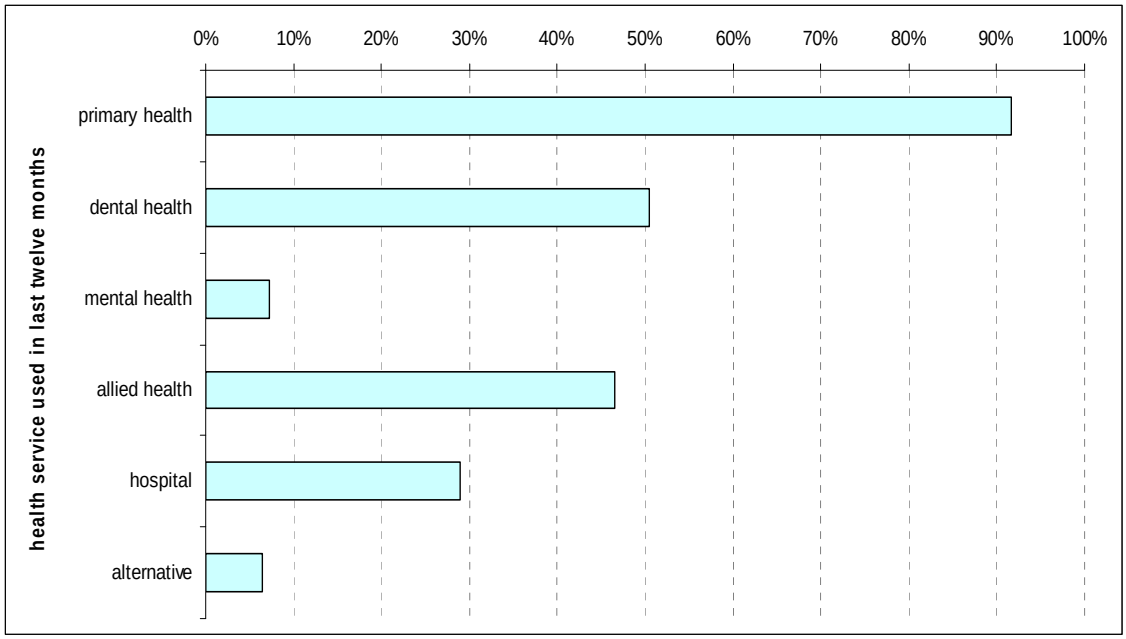
Note: Missing bars are where respondent numbers were too small to make a prevalence estimate. There were no significant differences to prevalence estimates compared with the state
Source: HWSS, via Health Tracks

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

13.2.7.2 Self-reported service utilisation

The Epidemiology Branch and Cooperative Research Centre for Spatial Information (2009) reported between 2007 and 2010 there were no significant differences in the reported health service utilisation of Midwest Health District residents compared to the State.

Figure 15: Self Reported Service Utilisation Midwest Health District Residents 16 yrs and over, 2007 - 2010



Source: HWSS, via Health Tracks

Implications for service planning:

As the majority of Midwest residents use primary health care, this presents an opportunity for chronic conditions and modifiable risk factors to be assessed. While 10% of Midwest adults reported having a current mental health problem, only 6% reported having used mental health services in the past year. This indicates the importance of:

- Implementing health promotion programs, population health level interventions, awareness raising and de-stigmatising initiatives and intervention at the time of assessment to improve access to mental health services.
- Enhancing the continuum care, service integration and coordinated care planning between emergency, inpatient and primary health care services within the acute and community sector to enable more effective assessment, management and follow-up as patients transition from acute care to the community (and vice versa) particularly for chronic disease management and mental health care.

13.2.7.3 Mortality

Mortality is an important indicator of the health of the population. Aboriginal people have a significantly lower life expectancy compared with their non-Aboriginal counterparts, with the gap at the national level is estimated to be 11.5 years for males and 9.7 years for females (ABS, 2006b).

Between 2006 and 2010 more than 65 Midwest Health District residents died each year. After removing the impact of the different age structures in the populations there was a significantly lower mortality rate (the number of deaths per 1,000 people) for all Midwest Health District residents compared with the State (Epidemiology Branch and Cooperative Research Centre for Spatial Information 2009).

The leading cause of death of Midwest Health District residents in that period was neoplasm, followed by diseases of the circulatory system and injury and poisoning. The Midwest district mortality rate for Injury and poisoning was significantly higher than the state rate. The major cause of male death was ischaemic heart disease which resulted in 36 deaths (15.5%). Compared to the State male mortality rate, the number of male deaths due to other forms of heart disease and transport accidents was significantly greater.

From 2001 to 2010, Midwest Aboriginal males had a significantly higher rate of death due to neoplasm compared to male Aboriginals across the whole state, and Midwest Aboriginal females had a significantly lower overall mortality rate than state female Aboriginals, although the numbers are too low to draw any strong conclusions. (Health tracks 2014) Aboriginal residents in the Midwest had a significantly higher mortality rate for diabetes, cardiovascular disease, respiratory disease, injury and poisoning, alcohol-related conditions and tobacco-related conditions compared with non-Aboriginal residents of the same area (Hocking, Draper, Somerford, Xiao, and Weeramanthri, 2010).

13.2.7.4 Avoidable mortality

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

Between 2006 and 2010, 50% of Midwest resident deaths under the age of 75 were classified as avoidable. Cancers and chronic conditions accounted for the majority of avoidable deaths. Lung cancer was responsible for 24 (26%) avoidable deaths, followed by ischaemic heart disease (22 deaths) and diabetes in Aboriginal residents.

The use of primary interventions could potentially have avoided more than half (54 percent) the avoidable deaths, while 24 percent could have potentially been avoided through the use of secondary interventions, such as primary health care services or early detection through screening. One-fifth of the avoidable deaths could potentially have been avoided through the use of tertiary interventions, such as medical or surgical techniques.

Between 2001 and 2010 Aboriginal Midwest District residents had a significantly greater proportion of deaths classified as avoidable compared with non-Aboriginal Midwest residents:

the age adjusted rate was six (6) times higher for Aboriginal residents. As shown in Table 18, ischaemic heart disease and diabetes accounted for a greater proportion of Aboriginal than non-Aboriginal deaths.

Table 18: Midwest Health Region residents: Leading causes of avoidable mortality, by Aboriginality, aged 0-74 years

Condition	No.	% of total
Aboriginal 2001-2010		
Ischaemic heart disease	62	26%
Diabetes	38	16%
Lung cancer	20	8%
Selected invasive bacterial and protozoal infection	16	7%
Alcohol related disease	9	4%
Non aboriginal 2006-2010		
Lung cancer	89	22%
Ischaemic heart disease	88	22%
Breast cancer (females only)	29	7%
COPD (45-74 years only)	21	5%
Colorectal cancer	18	4%
Diabetes	16	4%

Source: Health Tracks note Midwest region data is used in the table to protect confidentiality as there were too few deaths in some categories in the Midwest district to publish.

13.2.7.5 Hospitalisations

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

Between 2007 and 2011 Midwest Health District residents had a significantly lower hospitalisation rate than that of the State. The leading categories of hospitalisation are shown in the next table. Between 2007 and 2011 the leading category of hospitalisation of Midwest Health District residents was renal dialysis followed by diseases of the digestive system. The leading causes of hospitalisation were similar to those of the State.

Between 2002 and 2011 Aboriginal Midwest residents had a significantly lower hospitalisation rate when compared with all Aboriginal WA residents. However, their hospitalisation rate was significantly greater than (double) that of the non-Aboriginal Midwest residents (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2014).

Between 2002 and 2011 the leading causes of hospitalisation differed markedly between Aboriginal and non-Aboriginal Midwest Health District residents, as shown in Table 19. Injury and poisoning, and mental and behavioural disorders accounted for a greater proportion of hospitalisations of Aboriginal compared to non-Aboriginal Midwest Health District residents. Injury and poisoning is one of the leading causes of hospitalisation for both Aboriginal and non-Aboriginal residents and is also one of the leading causes of mortality.

Table 19: Leading category of hospitalisations by Aboriginality Midwest Health District Residents.

Condition	No.	%of total
Aboriginal 2002-2011		
Dialysis	375	11%
Acute respiratory infections	143	4%
Maternal care related to the fetus & amniotic cavity & possible delivery problems	113	3%
Influenza and pneumonia	113	3%
Infections of the skin and subcutaneous tissue	100	3%
Non aboriginal 2007-2011		
Chemotherapy	1884	9%
Diseases of the eye and adnexa	1071	5%
Dialysis	955	4%
Persons encountering health services for other specific procedures & care	946	4%
Arthropathies	900	4%
Diseases of oral cavity, salivary glands and jaws	576	3%

Source: WA Hospital Morbidity Data System. Green shading denotes less than the state rate, orange represents 0-50% above the state rate

13.2.7.6 Potentially preventable hospitalisations

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

Between 2007and 2011, potentially preventable hospitalisations accounted for eight percent of hospitalisations of Midwest district residents. Of these, vaccine preventable conditions accounted for two percent, acute preventable accounted for 44 percent and chronic conditions accounted for 54 percent of potentially preventable hospitalisations in the Midwest district (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2014). As shown in the following Table, diabetes and its complications was the highest cause of potentially preventable hospitalisations, accounting for 394 (20% of PPH).

Between 2005 and 2009 potentially preventable hospitalisations accounted for a greater proportion of hospitalisations of Aboriginal Midwest residents compared with non-Aboriginal Midwest residents (21 percent compared with nine percent) (Epidemiology Branch and Cooperative Research Centre for Spatial Information, 2009).

Chronic conditions accounted for 59 percent of the Aboriginal potentially preventable hospitalisations. While diabetes and its complications was the leading potentially preventable hospitalisations for both Aboriginal and non-Aboriginal Midwest residents, it accounted for a greater proportion of hospitalisations of Aboriginal residents, as shown in the next table (Epidemiology Branch and Cooperative Research Centre for Spatial Information 2009).

Table 20: Leading potentially preventable hospitalisations by Aboriginality, Midwest District residents

Condition	No.	% of total
Aboriginal 2005-2011		
diabetes complications	92	27%
asthma	42	13%
ENT infections	31	9%
convulsions and epilepsy	28	8%
pyelonephritis	25	7%
Total	**336**	**1**
Non aboriginal 2007-2011		
diabetes complications	335	20%
dental conditions	282	17%
chronic obstructive pulmonary disease	200	12%
congestive cardiac failure	162	10%
pyelonephritis	113	7%
ENT infections	111	7%
Total	**1671**	**1**

Source: Health Tracks: green shading denotes less than the state rate, orange represents 0-50% above the state rate

Implications for service planning:

Midwest residents had a significantly lower hospitalisation rate compared with the State.

The leading cause of hospitalisation of Midwest residents is for factors influencing health status, which includes renal dialysis and chemotherapy.

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

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

14 Appendix E: Services and Activity

14.1 Acute inpatient flow of Midwest Health District residents

In 2011/12 5377 separations from all WA private and public hospitals involved residents of the Midwest Health District. Of these separations:

- 11 percent (375) were supplied by hospitals within the Midwest Health District (2,598 across WACHS)
- 39 percent (2,081) were supplied by Geraldton hospital
- 16 percent (857) were separated from public metropolitan hospitals; and
- 36 percent (1,919) were privately treated (15% were privately treated in rural facilities, almost all of these were at SJOG Geraldton, and 21 percent were privately treated in metropolitan facilities).

Self-sufficiency is a calculation used to identify the proportion of resident acute separations that are managed by a local region/district. It is an indicator of the district's capacity to provide acute care closer to home. Due to remoteness and availability of onsite specialists, a country health service will not achieve 100 percent self-sufficiency. Highly acute and complex patients will continue to be transferred to Perth where more specialised services and medical equipment are located.

The public self sufficiency of the Midwest Health District was determined as the proportion of Midwest Health District resident public separations that occurred in the Midwest Health District. In 2011/12 this was eleven per cent. This means eleven percent of Midwest residents who required Inpatient public health care received that care from a Midwest district facility. This shows just how little of resident demand is met by local services primarily due to the direct road transport routes and relative proximity to Geraldton. The self sufficiency for Midwest residents across the whole Midwest region was 72 percent.

14.2 Emergency Services

Actual and projected activity

It is projected that the number of ED attendances to Midwest district hospitals will increase by between 14 percent in Mullewa and 40 percent in Northampton for an overall increase of 28% between 2010/11 and 2021/22.

The attendances for triage 4 and 5 categories are projected to decrease by two (2) percent in line with what has been happening at a State level, which is consistent with the expected decrease as a result of the SIHI.

In 2012/13 13% of presentations were for Aboriginal people. This ranged from 2% at Dongara to 59% at Mullewa.

Table 21: Midwest Health District: Actual and projected emergency department presentations and bays, by triage

		historic			forecast		
hospital	Triage	2008/09	2009/10	2010/11	2013/14	2016/17	2021/22
Dongara	Triage 1&2	124	118	129	167	223	340
	Triage 3	503	463	450	566	724	1,095
	Triage 4&5	3,486	3,211	1,984	1,960	1,945	1,968
	total OOS	**4,113**	**3,792**	**2,563**	**2,692**	**2,892**	**3,402**
	Bays	**2**	**2**	**1**	**1**	**2**	**2**
Kalbarri	Triage 1&2	23	58	72	89	115	173
	Triage 3	168	137	277	346	438	645
	Triage 4&5	2,007	2,397	2,215	2,243	2,279	2,366
	total OOS	**2,198**	**2,592**	**2,564**	**2,679**	**2,832**	**3,184**
	Bays	**1**	**1**	**1**	**1**	**1**	**2**
Morawa	Triage 1&2	57	38	93	123	166	262
	Triage 3	235	174	296	374	475	701
	Triage 4&5	793	1,043	1,127	1,100	1,066	1,022
	total OOS	**1,085**	**1,255**	**1,516**	**1,597**	**1,707**	**1,986**
	Bays	**1**	**1**	**1**	**1**	**1**	**1**
Mullewa	Triage 1&2	4	27	23	30	41	63
	Triage 3	176	104	168	205	251	349
	Triage 4&5	715	806	698	671	640	597
	total OOS	**895**	**937**	**889**	**907**	**932**	**1,009**
	Bays	**0**	**0**	**0**	**0**	**1**	**1**
North Midlands	Triage 1&2	23	55	49	63	84	132
(Three Springs)	Triage 3	76	104	143	174	216	315
	Triage 4&5	533	696	698	680	665	654
	total OOS	**632**	**855**	**890**	**917**	**965**	**1,101**
	Bays	**0**	**0**	**0**	**0**	**1**	**1**
Northampton	Triage 1&2	45	46	65	87	117	183
	Triage 3	149	174	176	222	284	429
	Triage 4&5	477	637	660	654	647	649
	total OOS	**671**	**857**	**901**	**962**	**1,048**	**1,261**
	Bays	**0**	**0**	**0**	**1**	**1**	**1**

Source: WACHS ED Projections Pivot, via Modeling 2012 (Based on ABS Series B+);
See Appendix C for benchmarks used to calculate bays.

14.3 Inpatient Services Profile

14.3.1 District Current Activity Overview

Table 22: Midwest Hospitals: Health Activity Summary

EMERGENCY DEPARTMENT	2012/13
Number of hospitals	6
Emergency Department Attendances	8,136
RESIDENTIAL AGED CARE AS AT 20/02/2014	
Number of residential beds (low and high care)	41
ACUTE INPATIENT CARE (2010/11)	**2012/13**
Number of active acute beds	24
Total separations	485
Total bed-days	1303
Average multi day Bed Occupancy	3.23
Public Acute Self Sufficiency (within districts)	11%
Public Acute Self Sufficiency (within regions)	72%

Acute inpatient data excludes boarders, unqualified neonates and residents.
Includes public patients in private hospitals. Average bed occupancy is derived by beddays/365.
Source: WA Hospital Morbidity Data System, via Clinical Activity Modeling Unit, WACHS online bed pivot

Inpatient activity by age group

Patients aged 70 years and over accounted for 278 (57%) separations.

Inpatient separations, by Aboriginality

Aboriginal and Torres Strait Islander people accounted for seven (7) percent of the 2012/13 separations at Midwest Hospitals.

Midwest Assumptions for Projected Activity, 2011
Future inpatient activity projections were remodelled in late 2011 by the Department of Health Clinical Modelling Unit, the WACHS Planning Team and the region. The updated modelling for the Midwest was based on the following assumptions:

- An increase in the relative utilization of renal dialysis to account for people moving to receive their dialysis care.
- An increase in the public self-sufficiency of renal dialysis (to 95 percent), in line with the WACHS Renal Plan. In the Western Midwest the renal dialysis service will operate at Northam Hospital with four chairs.
- An increase in the public self-sufficiency for chemotherapy (to 75 percent), in line with the WACHS Cancer Plan.
- An increase in the public self-sufficiency of select ESRGs, in line with the role delineation of the hospitals.

14.3.2 Mental Health IP service profile (inc. Alcohol and Other Drugs)

There is no dedicated inpatient mental health facility in the Midwest Health District and local mental health professionals are not on call for out of hours emergency services. This service is provided by Rural Link.

Videoconferencing is used for assessment, treatment, education and meetings and there is VC through Rural Link for out of hour's services.

There has been a slight increase in mental health separations involving people aged 15 years and over in hospitals in the Midwest Health District between 2008/09 and 2010/11.

Mental health inpatient activity of those aged 15 years and over is projected to increase at Midwest Health District Hospital, as outlined in the table below.

Most Midwest Health District residents would be admitted in Geraldton Hospital.

Table 23: Historic and Projected Midwest Health District Inpatient Mental Health Separations, 15 years and over

srg	2008/09	2009/10	2010/11	2013/14	2016/17	2021/22	projected growth 10/11 to 21/22
38, Drug a	10	13	10	29	35	44	341%
39, Psychi	20	14	14	49	55	63	353%
Total	**30**	**27**	**24**	**78**	**89**	**108**	**348%**

Excludes unqualified neonates and boarders.

Source (historic): WA Hospital Morbidity Data System, via Clinical Activity Modelling UnitSource (projections): WACHS Inpatient 2011 Modelling– based on ABS Series B+

Table 24: Mental Health Inpatient Flows (inc drug and alcohol)

hosp area	2007/08	2008/09	2009/10	2010/11	2011/12
Midwest District	17	23	24	18	27
Geraldton	38	32	39	46	42
Other WACHS	<5	<5	<5	<5	5
Rural Private	<5	<5	<5	<5	<5
Public Metro	9	10	15	16	22
Private Metro	<5	10	11	7	10
Total	**70**	**81**	**96**	**90**	n/a

Source: WA Hospital Morbidity Data System, via Clinical Activity Modelling Unit

In 2011/12 there were over 100 mental health separations of residents aged 15 years and over from the Midwest Health District at all private and public facilities of WA. The total has increased over the last few years

Less than ten of these separations were in private facilities.

The majority (42) of these residents received their public health care from Geraldton Hospital.

14.3.3 Sub-Acute and Rehabilitation Inpatient Care

Subacute care is defined as interdisciplinary care in which the need for *care is driven primarily by the patient's functional status* and quality of life rather than the underlying medical diagnosis. It may include care for patients who have multiple diagnoses, none of which is a principal diagnosis.

14.4 Residential Aged Care Services Profile

The residential aged care beds and 'places' within the Midwest Health District are shown below in Table 25 and Table 26.

Table25: Residential Aged Care Facilities in Midwest Health District (beds as at 2012/13)

Location	High Care Beds	Low Care Beds	Respite Beds	Beddays*	Occupancy Rate*
Dongara	2	4	1	2433	95%
Morawa	4	6	1	3785	94%
Mullewa	4	2	1	2231	87%
Three Springs	4	5	0	3,222	98%
Northampton	1	9	1	3,535	88%
TOTALS	**15**	**26**	**4**	**15206**	

*Source: Midwest Aged Care Manager, *WACHS online bed pivot, accessed 20 Febru***ary 2014.**

Table26: Residential Aged Care Places across the Midwest (as at Feb 2014)

Multi-Purpose Site	Flexible high care	Flexible low care	Flexible community care	Total
Dongara Eneabba Mingenew	15	18	8	41
Northampton Kalbarri	16	19	8	43
Mullewa	4	5	2	11
Morawa Perenjori	5	6	3	14
North Midlands	9	10	4	23
TOTALS	**49**	**58**	**25**	**132**

Source: Midwest Aged Care Manager, 20 February 2014.

14.5 Ambulatory Care Services Profile

Occasions of service for Ambulatory Care are shown in the table below. The increase in OOS for 2012/13 is likely due to improved data entry rather than a doubling of services.

Table 27: Occasions of service for Ambulatory Care

Site	2011/12	2012/13
Dongara	2000	5830
Kalbarri	1721	3229
Morawa	811	1699
Mullewa	679	612
Northhampton	1088	1783
Three Springs	1215	2126
Total	**7514**	**15279**

Source: AOD pivot, 2014

The proportion of Ambulatory Care occasions of service (OOS) for Aboriginal residents in 2012/13 is shown below and is similar to the overall proportion of Aboriginal people living in the areas.

Table 28: Proportion of Ambulatory Care OOS for Aboriginal residents

Site	Aboriginal	Other	Total	% Aboriginal
Dongara	118	5712	5830	2.0%
Kalbarri	11	3218	3229	0.3%
Morawa	291	1408	1699	17.1%
Mullewa	350	262	612	57.2%
Northhampton	214	1569	1783	12.0%
Three Springs	86	2040	2126	4.0%
total	**1070**	**14209**	**15279**	**7.0%**

Source: AOD pivot, 2014

15 Appendix F: Planning Benchmarks and Assumptions

15.1.1 Inpatient Activity Forecast Benchmarks

Table 29: Occupancy rates

Category	Occupancy Rate
Renal Dialysis	2 per day, 6 days per wk, 52 wks a year
Chemotherapy	100%
Sameday	100%
Paediatric - Sameday	100%
Paediatrics - Medical/Surgical Paediatric Mental Health	75%
Obstetrics	75%
Neonatology	75%
Medical/Surgical	85% in Bunbury RRC
Mental Health	80% in other RRCs
Rehabilitation	75% in IHDs
Palliative Nursing Home Type	65% in Small Hospitals
Excess beddays 90	100%

Beds Calculation

Sameday & Multiday: Number of beddays/365/occupancy rate

15.1.2 ED Activity Projections Benchmarks

ED Projections are unavailable for Nursing Posts/Health Centres. The estimated number of treatment bays is calculated from the attendances for each triage category using the benchmarks in Table 30. These benchmarks have also been applied to historic activity to give an indication of the current number of ED bays required to meet demand.

Table30: ED Planning Benchmarks

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

Source: Adapted from Emergency Demand Treatment Space Calculator, The Advisory Board Company, 2009. Revised in 2011 to incorporate combined triage 1 & 2 categories

15.1.3 Activity Modelling Assumptions

The assumptions listed below are those of most relevance to the Midwest Health District area, however consideration should also be given to the regional models being strengthened within the Midwest .

15.1.3.1 Emergency Assumptions for Midwest Health District activity modelling 2011

- Midwest will use new population projections Source: Australian Bureau of Statistics Cat. No. 3222.0 - Population Projections, Series B: Australia, 2012 (base) to 2101,. modified using WA Tomorrow, 2012 band proportions; Modified further by Treasury incorporating medium fertility, declining improvement in life expectancy, low migration February 2014
- Increase ED presentations for Triage 4 and 5 due to decreased GP numbers
- In future, SIHI will increase GP availability and this will need to be considered.

15.1.3.2 Inpatient Assumptions for Midwest Health District activity modelling 2011

- Some marginal increases in self-sufficiency in adult general medicine

16 Appendix G: Planning Working Group & Health Partners

Name	Role	WACHS
Andrew Klein	Operations Manager	Chair WACHS – Midwest Health District
David Richardson	Regional Population Health Director	WACHS – Midwest
Ken Thompson	Regional Mental Health Manager	WACHS – Midwest
Di Franklin	Regional Aged and Community Care Manager	WACHS – Midwest
Alex McIntosh	A/Regional Aboriginal Coordinator	WACHS – Midwest
Paul Artis	Health Service Manager	WACHS- Midwest
Helen Webb	Health Service Manager	WACHS- Midwest
Nancy Bineham	Manager, Planning	WACHS – Central Office
Campbell Anderson	Senior Planning Analyst	WACHS – Central Office
Sonia Bray	Senior Health Planner – until Nov 2012	WACHS – Central Office
Tia Lockwood	Senior Health Planner – from Nov 2012	WACHS – Central Office

16.1 Governance, Community Engagement and Health Partners

16.1.1.1 Governing Councils and District Health Advisory Councils

Northern Country Health Service Governing Council

The Northern & Remote and Southern Country Health Service Governing Councils came into effect on 1 July 2012.

The formation of the Governing Councils aligned with commitments made by Western Australia under the National Health Reform Agreement to change governance arrangements for our public hospitals

Governing councils bring high–level community and clinician input and control into the planning and monitoring of public health services in WA.

Council members represent a broad cross-section of skills, experience and interests and bring these to bear in ensuring health services are responsive to the needs of their communities.

Council members have a specific responsibility for ensuring effective engagement with community and clinical stakeholders and ensuring their interests are reflected in health service planning and reporting.

Midwest is under the auspice of the Northern Country Health Service Governing Council

Further information on the role and membership can be found at:

http://www.health.wa.gov.au/governingcouncils/faqs/about.cfm#a

District Health Advisory Council (DHAC)

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

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

16.2 Health Partners

The following services support or fund the delivery of services to the Midwest Health District area and provide a continuum of care from primary health care to acute and emergency services in the regional and metropolitan area.

Midwest Health District

Health and related providers or funding partners

Private Providers

Community Pharmacies

GPs

Private allied health providers

St John of God Health Care

Visiting Specialists

State and Local Governments

Health Governing Councils

District Health Advisory Council (DHAC)

Department of Child Protection

Department for Communities

Department of Education

Disability Services Commission (DSC)

Fire and Emergency Services (FESA)

Local governments

Metropolitan Health Services

Midwest Development Commission

PathWest

Patient Assisted Travel Scheme (PATS)

Prison Health Services

Regional Development and Lands (RDL)

Rural Link

WA Dental Health Services

WA Mental Health Commission

WA Police

Commonwealth Government

Goldfields Midwest Medicare Local (GMML) - (purchaser and provider of primary health care services)

Centrelink

Commonwealth Rehabilitation Service

Department of Health and Ageing (purchaser of Aged Care, Rural Health, Primary Health, Aboriginal Health Services, the Medical Specialist Outreach Assistance Program and Home and Community Care programs)

Department of Veterans Affairs (DVA)

Not-for-profit organisations

Centacare

Chrysalis Support Services

Geraldton Regional Aboriginal Medical Service

Midwest Resource Unit for Children with Special Needs (RUCSN)

Royal Flying Doctors Service (RFDS)

Silver Chain

16.2.1 State and Local Government

A number of government departments provide services and programs to provide support and social needs of the community as follows:

16.2.1.1 Department of Child Protection

Department of Child Protection focuses on working with children and families assessed as 'at risk'. WACHS has working relationships Department of Child Protection to assess and monitor the health needs of 'at risk' children in the community.

16.2.1.2 Department for Communities (recently amalgamated with the Department for Local Government)

The Department for Communities informs the development of social policy, advocating on behalf of Western Australian children, parents and their families, young people, seniors, women, carers, volunteers and non-government organisations. Department for Communities is also responsible for the delivery of programs and services to support and strengthen WA's diverse communities. This includes administering WA's child care regulatory framework and, through the Child Care Licensing and Standards Unit, managing the licensing and compliance of some 1 500 child care services throughout WA.

DFC also offers the *Best Start* program for Aboriginal families, which provide activities for children aged 0 to 5 years old, and their families "to enhance the children's social, educational, cultural and physical development." This includes mentoring, support and role modeling by mothers with older children.

16.2.1.3 Disability Services Commission

Disability Services Commission work with people with disabilities and their families to access support in the community, access funding, and work across the community in collaboration with other agencies in the community.

16.2.1.4 Regional Development and Lands, Royalties for Regions

Regional Development and Lands is responsible for initiatives such as SIHI and SuperTowns and enables opportunities to develop partnerships with State, Local, Commonwealth and non-government agencies and private providers in the Region.

16.2.1.5 Local government authorities

The Midwest Health District consists of eleven shires: Northampton, Irwin, Coorow, Perenjori, Morawa, Three Springs, Carnamah, Chapman Valley, Murchison and Mingenew, with Mullewa now part of the Greater Geraldton Shire.

Local governments provide a number of health and community services that support the health and wellbeing of their communities. These include environmental health, immunisation services, aged care and accommodation, community care, recreational and sporting venues and welfare services. In some cases local governments will provide financial, accommodation, vehicles and other incentives to attract GPs to the district.

16.2.1.6 Midwest Development Commission

The Midwest Development Commission is a State Government statutory authority that strives to encourage the sustainable development of Western Australia's Midwest region. It is one of nine regional development commissions in Western Australia. The Commission manages and assists with the management of a number of economic and community based projects. The Commission also actively promotes and assists eligible groups to access State and Federal Government funding programs including our own funding program the Royalties for Regions Mid West Regional Grants Scheme.

For more information visit: http://www.mwdc.wa.gov.au/PathWest

PathWest provide collection and testing services as per Section 6.6.

16.2.1.7 Department of Corrective Services - Prison Health Services

The Greenough Regional Prison Health Service is staffed by clinical nurses seven days a week, with GP sessions Monday to Friday and an on-call doctor. There is no after-hours medical service within the prison, so community services are utilised if a need arises.

A pharmacy service supplies medication to all Department of Corrective services sites. Prisoners who are admitted to prison with drug and/or alcohol dependencies are provided with detoxification and rehabilitation programs and arrangements are made for the continuation of care once released. The health service also provides mental health assessment and treatment programs. Prisoners with mental health issues receive appropriate care whilst in prison and then discharge planning and implementation of services in the community once released.

WACHS –Midwest partners with GRAMS in a prison discharge planning and re-entry (into society) program. This program provides planned follow-up appointments with health professionals in the nominated location of the prisoners' release destination.

16.2.1.8 WA Police and Fire and Emergency Services (FESA)

WA Police and FESA work together with WACHS and St John Ambulance to coordinate emergency management responses for the Midwest. This is largely coordinated through the Local Emergency Management Committee.

WA Police also provide patient escorts as required by the Mental Health Act for acute mental health patients requiring admission to metropolitan health facilities.

16.2.1.9 WA Dental Health Services

Dental health Service (DHS) provide visiting dental health services to eligible adults and school aged children in the Midwest Health District.

16.2.1.10 WA Mental Health Commission

The Mental Health Commission is responsible for the development of mental health policy and leading the implementation of State and Federal Mental Health Strategic Plans. Additional information regarding the functions and role of the Commission can be accessed at:

http://www.mentalhealth.wa.gov.au/Homepage.aspx

16.2.1.11 WoundsWest

WoundsWest is an innovative project that aims to improve wound prevention and management throughout Western Australia. The project implemented in partnership between WA Health, Silver Chain and Curtin University.

16.2.2 Commonwealth Government

16.2.2.1 Department of Veterans' Affairs (DVA)

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

16.2.2.2 Department of Health and Ageing (DOHA)

The Department of Health and Ageing (DOHA) is a funder of Aged Care, Rural Health, Primary Health & Aboriginal Health programs and Medical Specialist Outreach Assistance Program (MSOAP and Home and Community Care (HACC). DOHA provides flexible funding to the MPS sites for the provision of residential and community aged care services.

Home and Community Care (HACC)

The HACC Program is a joint Commonwealth, State and Territory initiative which funds basic maintenance and support services to help frail older people and younger people with disabilities to continue living in their community.

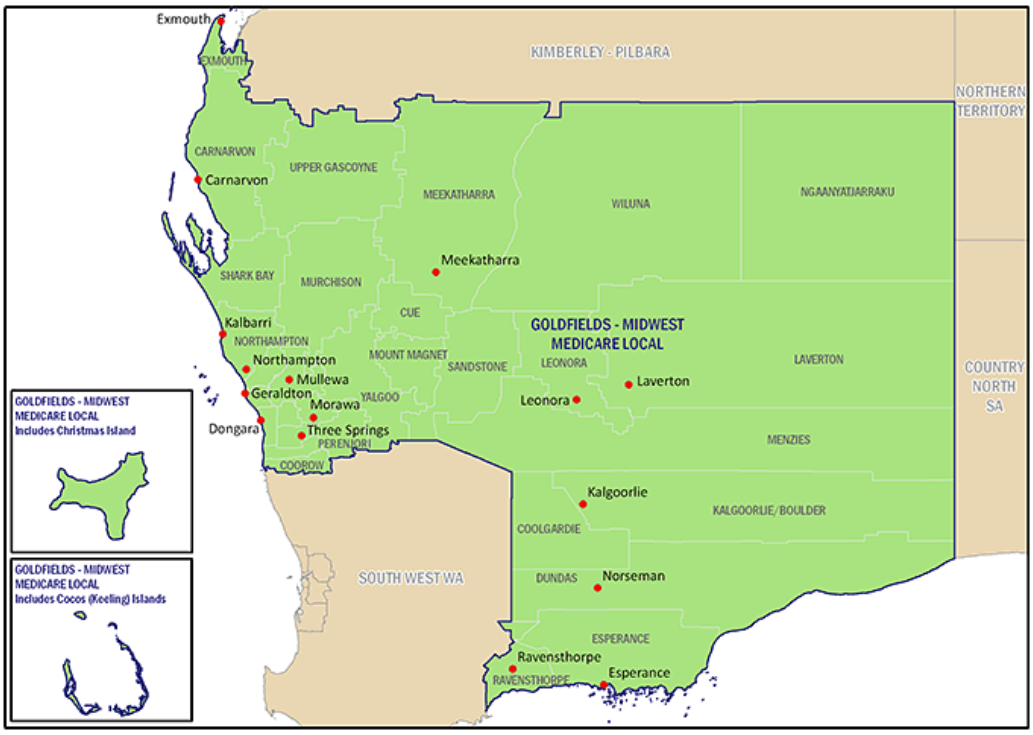
Medical Specialist Outreach Assistance Program (MSOAP)

The MSOAP aims to improve access to medical specialists in rural and remote communities and reduce some of the financial disincentives incurred by medical specialists in providing outreach services. Funds are available for the costs of travel, meals and accommodation, facility fees, administrative support at the outreach location, lease and transport of equipment, telephone support and up-skilling sessions for resident health professionals.

Goldfields and Midwest Medicare Local

The Goldfields and Midwest Medicare Local (GMML) commenced operation on the 1st January 2012 with head office located in Geraldton and regional offices in Kalgoorlie, Esperance and Laverton. The GMML boundary includes the Gascoyne, Midwest and Goldfields Esperance regions of WA. For further information visit: http://www.gmml.org.au

Figure 17: Goldfields and Midwest Medicare Local



Source: http://www.gmml.org.au

16.2.3 Non-government and private agencies

16.2.3.1 Aged care residential services

The aged care residential services are detailed in Section 5.

16.2.3.2 Centacare

Centacare is based in Geraldton and provides family and relationship counselling; emergency and other support services; and financial advice services. Other Midwest Centacare services are located in Kalbarri and Mullewa.

16.2.3.3 Chrysalis Support Services

Chrysalis provides crisis accommodation and free confidential counselling and support programs to people who are being impacted by domestic violence or sexual assault/abuse issues.

16.2.3.4 Geraldton Regional Aboriginal Medical Service (GRAMS)

GRAMS provides a range of health care, counseling and support services to Aboriginal and Torres Strait Islander people in the Geraldton and surrounding areas.

16.2.3.5 Midwest Resource Unit for Children with Special Needs (RUCSN)

RUCSN provides assistance for children with disabilities to integrate into childcare or school. RUCSN's operating hours are 9-3pm Monday, Wednesday and Thursday.

16.2.3.6 Royal Flying Doctor Service (RFDS)

The RFDS provides a pivotal role throughout country Western Australia providing medical and nursing services to transfer patients to larger regional or metropolitan hospitals. There are no

RFDS bases located in the Midwest, but they do transfer patients from the Midwest to the metropolitan area. This is due to the relative closeness of the Midwest to Perth metropolitan.

16.2.3.7 Silver Chain

Silver Chain is one of the largest providers of community and health services to the Western Australian community. Silver Chain provide a diverse range of services, including home care, palliative care, emergency care, family health care and other care services to residents living in metropolitan and rural Western Australia. Within the Midwest Health District, Silver Chain provides palliative care and rehabilitation services in the home and support the WoundsWest Program.

16.2.3.8 St John Ambulance Association (SJAA)

St John Ambulance Australia (SJAA) is contracted by the WA Health to provide emergency pre-hospital care and transport. SJAA also provides an interhospital transfers service, which is paid for directly by health services. SJAA is largely a volunteer led service in country areas, but selected centres do have professional paramedics who have an ongoing training and coordination role

16.2.3.9 St John of God Health Care Geraldton

St John of God Health Care provides private inpatient and outpatient health care at its Geraldton Health Campus. WACHS funds St John of God to provide public elective care. The role and linkages between Geraldton Health Campus and St John of God Geraldton is currently being explored and may result in some changes to the current purchasing arrangements. St John of God provides an after-hours GP service which provides access for communities across the Midwest Health District without a local after hours GP.

17 Appendix H: Glossary and Acronyms

ACAT	Aged Care Assessment Team
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ALOS	Average Length of Stay
CAMHS	Child and Adolescent Mental Health Service
CDST	Community Drug Service team
CHS	Country Health Services
COAG	Council of Australian Governments
CSF	Clinical Services Framework
CSSD	Central Sterilising Services Department
DGPP	Divisions of General Practice Program
DHAC	District Health Advisory Committee
ED	Emergency Department
ENT	Ear Nose and Throat
ERP	Estimated Resident Population
ESRG	Expanded Service Related Group
FESA	Fire and Emergency Services
FTE	Full Time Equivalents
GP	General Practitioner
GMML	Goldfields-Midwest Medicare Local
HACC	Home and Community Care
HCN	Health Corporate Network
HIN	Health Information Network
HWSS	WA Health and Wellbeing Surveillance System
ICT	Information Communication Technology
IDHS	Integrated District Health Service
KEEDAC	Kaata-Koorliny Employment and Enterprise Development Aboriginal Corporation
MHERL	Mental Health Emergency Response Line
MOU	Memorandum of Understanding
MWCRCC	Midwest COMMONWEALTH Respite and Carelink Centre
MPS	Multipurpose Service
NMP	Nominated Medical Practitioner
RFDS	Royal Flying Doctor Service
SEIFA	Socio-Economic Indexes for Areas
SIHI	Southern Inland Health Initiative
SWWAML	South West WA Medicare Local
WGPN	Midwest General Practitioner Network
WACHS	WA Country Health Service

17.1 Key Definitions

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

Ambulatory health care centre refers to a health facility where ambulatory health care services are provided in close proximity to emergency department care and overnight inpatient admissions.

Primary care is often used interchangeably with primary medical care as its focus is on clinical services provided predominantly by general practitioners, as well as by practice nurses, primary/community health care nurses, early childhood nurses and community pharmacists.

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

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

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

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

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

Table 31: Definitions of key terms

Term	Meaning
Acute care	Care in which the need for treatment is driven primarily by the patient's principal medical diagnosis rather than their functional status.
Admitted patient	Is a person who has been assessed by the treating clinician as meeting at least one of the minimum criteria for admission to an inpatient area and who undergoes the hospital's formal or statistical admission process as either a same-day, overnight or multi-day patient.
Ambulatory health care centre	Is a health facility where ambulatory health care services are provided along with emergency department care and overnight inpatient admissions.
Ambulatory care services	Is a broad term that generally refers to the planned services provided to patients who are able to 'walk in and walk out' on the same-day. Ambulatory care services can include primary health care services, day surgery and outpatients (e.g. wound care and management).
Authorised bed	Authorised under the *Western Australia Mental Health Act, 1996* to accept involuntary admission to a Mental Health Unit. Unauthorised facilities cannot accept involuntary admissions.
Catchment area	A catchment area refers to the geographical area that a health service will primarily provide services to. It is usually bound by one or more local statistical areas as defined by the Australian Bureau of Statistics.
Clinical support services	Includes services to support the operations of clinical services. Includes pharmacy, medical imaging, central sterilising services and pathology.
Co-located/ Collocated	*Co-located* services are located together in the one facility. *Collocated* services are located adjacent to anther another or in close proximity to one another, generally in a separate buildings.
Culturally secure	Services or facilities that are culturally appropriate and meet local cultural and religious needs.
Fluoroscopy	Is a type of medical imaging that shows a continuous x-ray image on a monitor, much like an x-ray movie. It is used to diagnose or treat patients by displaying the movement of a body part or of an instrument or dye (contrast agent) through the body.
Health consumer	A term utilised to refer to individuals who are likely to or are currently accessing WACHS services. Includes inpatients and clients.
Length of stay	The number of days spent in hospital by a patient for a single admission. Calculated as date of separation minus date of admission.
Model of care / service delivery model	A service delivery model is a framework that establishes how particular health care services will be delivered. The model stipulates the key features of a service such the key aim/focus of care provided; type of specialist and general services provided; the preferred strategy for patient management and flow; and the relationships required with other stakeholders to deliver care. One of the key features of the Service Plan is the future service delivery models. These form the foundation for workforce and master planning.
Multi-day patient	Is a patient that was admitted to, and separated from, the hospital on different dates. Therefore, a booked same-day patient who is subsequently required to stay in hospital for one night or more is an overnight patient; a patient who dies, is transferred to another hospital or leaves of their own accord on their first day in the hospital is a same-day patient even if the intention at admission was that they remain in hospital at least overnight.
Non-clinical support services	Includes corporate support, information and communication technology services, supply services, site maintenance, cleaning, kitchen services and laundry services. Services that are required to maintain the safety and comfort of staff, patients and visitors.
Palliative Care	The World Health Organisation definition of palliative care is used for this rural model of care The World Health Organisation (2006) has in recent years refined the definition of palliative care to reflect the reality that people with life threatening illness may have palliative care needs throughout their illness trajectory: Palliative care is an approach that aims to improve the quality of life of patients and their families facing the problems associated with life-threatening illness. This is achieved through the prevention and relief of suffering by means of the early identification, impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems.

Term	Meaning
Primary health care	Is an aspect of ambulatory health care but is generally first level health care. The term is sometimes used interchangeably with the term primary care although primary care tends to refer to the clinical care provided by GPs. Primary health care gives priority to those most in need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes: • Health promotion • Illness prevention • Clinical treatment and care of the sick • Community development • Advocacy and rehabilitation Primary health care is provided by general practitioners, practice nurses, primary/community/child health nurses, pharmacists, dentists, allied health professionals, aged care workers, support workers and many other providers across the local, state and federal government sectors, non-government organisations and the private sector.
Primary health care centre	Refers to a stand-alone health facility where primary health care services are provided. It would ideally be located in close proximity to emergency department and may be collocated with inpatient, outpatients, minor wound care and diagnostic services. A primary health care centre does not include day surgery services.
Role delineation	Indicates the type and level of services provided by a hospital, as outlined in the WA Health *Clinical Services Framework 2010 - 2020*.
Same-day patient	A same-day patient is a patient who is admitted and separated on the same day of inpatient admission. May be either a planned booked patient or an unplanned patient transferred from the emergency department. A patient cannot be both a same-day patient and an overnight or multi-day stay patient at the one hospital. The category of same-day is determined retrospectively; that is, it is not based on the intention to admit and separate on the same date. Rather, a patients is deemed to have been a same-day patient, if in retrospect, it can be seen that the patient was admitted to, and separated from, the hospital on the same date. Therefore patients who die, transfer to another hospital or leave of their own accord on their first day in the hospital are included. Booked same-day patients who subsequently stay in hospital for one night of more are excluded and regarded as a multi-day patient. Examples of same-day activity include renal dialysis, colonoscopy and chemotherapy.
Separation	Separation is the most commonly used measure to determine the utilisation of hospital services. A separation equates to a patient leaving a healthcare facility because of discharge, sign-out against medical advice, transfer to another facility/service or death. Separations, rather than admissions, are used as hospital inpatient care are based on information gathered at time of discharge.
Service planning	A process of: 1. Documenting the demographics and health status of a health service's catchment area. 2. Recording the current status and projected future demands for the health service. 3. Evaluating the adequacy of the existing health service to meet the future demands. The process involves analysis of current and future population and service data and consultation with a range of internal and external stakeholders to develop the future service delivery models for the identified health campus or site. The key deliverable or outcome of service planning is a Service Plan.
Service plan	A Service Plan will outline the current and preferred future profile for services operating from an identified health campus or site. It will include the context for service delivery including the population profile, future demand, existing policies and strategies and the preferred future service delivery models.
Sub-acute care	Interdisciplinary or multidisciplinary care in which the need for care is driven primarily by the patient's functional status and quality of life rather than the underlying medical diagnosis. It may include care for patients who have multiple diagnoses, none of which can be specified as the principal diagnosis.

18 Appendix I: Bibliography

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