The WA GP Shortage - the impact on our community and health sector
3 May 2013

October 2015: Update on activity relating to Clinical Senate recommendations
Update on activity against the Recommendations

Background

- The challenge for the May 2013 Clinical Senate, proposed by former Director General Mr Kim Snowball, was to consider the shortage of general practitioners (GPs) in Western Australia and the impact this may pose to communities and the health sector.
- The resulting Clinical Senate debate titled 'The WA GP Shortage – the impact on our community and health sector' was held on 3 May 2013.
- Experts from general practice, community nursing, residential aged care, aboriginal health, non-government organisations, universities, professional bodies, Medicare Locals and consumers contributed to the debate.
- The state’s role in ensuring an adequate primary care workforce was considered and, in addition to discussion around GP shortages, the debate identified the need for better integration and improvement of key services as well as communication between the Department, health sectors and consumers.
- Broad sector representation provided by clinical senators, presenters and expert witnesses enabled the identification of both gaps in primary health care delivery, and opportunities to meet those gaps.
- The Clinical Senate - WA GP Shortage debate resulted in nine recommendations (see Appendix 1). These recommendations were endorsed or, where dependent on collaboration with primary care or health organisations outside of WA Health, endorsed in principle by the State Health Executive Forum on 22 July 2013.

Update

- Since the Clinical Senate debate in 2013, significant restructure has occurred within the Commonwealth and State Health care environment. In particular, changes to the primary care service commissioning and delivery have been implemented, with the establishment in April 2015 of the three Western Australian Primary Health Networks - Perth North Metropolitan, Perth South Metropolitan and Country WA under the Commonwealth-funded Western Australian Primary Health Alliance (WAPHA), and the cessation of Medicare Locals from 30 June 2015.
- In addition, governance reforms have resulted in changes to Health Service operations within WA Health.
- In recognition of this restructure, a number of the Clinical Senate recommendations describe arrangements which are no longer operational.
- Nevertheless, under the new model of primary care service commissioning and delivery, activity generally described by the recommendations will still be pursued. In this key performance indicator (KPI) update, stakeholders have been encouraged to address the recommendations for related activity, both before and, where relevant, after the restructure.
- The following summary represents an overview of activity related to the nine Clinical Senate recommendations, as reported by key stakeholders both within and external to WA Health. Some activity is noted by more than one organisation, reflecting the collaborative nature of many of the outlined programs.

Executive Sponsor:

Professor Gary Geelhoed
Chief Medical Officer
Assistant Director General – Clinical Services and Research
Note: an important aspect for reporting activity addressing the recommendations is to identify the overall status (level of implementation) for activity. The table below broadly describes the criteria for each level of implementation of activity. The status levels in this report in general have been allocated by stakeholders. However, where no implementation level was provided, a level has been assigned based on activity described.

<table>
<thead>
<tr>
<th>Level of implementation</th>
<th>Outcomes that may have been achieved</th>
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<tbody>
<tr>
<td><strong>Discontinued</strong></td>
<td>The recommendation has been discontinued. Please provide further information in the ‘Comments’ section.</td>
</tr>
<tr>
<td><strong>Level 1:</strong></td>
<td>Outcomes include: Components to deliver recommendations may have commenced (e.g. the establishments of a governance structure and/or scoping of a plan) but the project has not progressed further.</td>
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<tr>
<td>No/little progress</td>
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<tr>
<td><strong>Level 2:</strong></td>
<td>Outcomes include: Governance has been established and formal plans have been endorsed. Change has commenced and/or resources have been allocated (recruitment or training of personnel, development of procurement procedures etc.)</td>
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<tr>
<td>Partial implementation</td>
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<tr>
<td><strong>Level 3:</strong></td>
<td>Outcomes include: Processes and/or procedures to deliver the recommendation have been established and the timetable for full implementation is almost complete and/or milestones have been achieved.</td>
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<tr>
<td>Substantial implementation</td>
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<tr>
<td><strong>Level 4:</strong></td>
<td>Outcome: The recommendation is fully implemented.</td>
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<tr>
<td>Full implementation</td>
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</table>
**Recommendation 1- Update on related activity**

**Recommendation 1:** Each Health Service through its governing council must have an agreement with its Medicare Local(s) to take a population health approach to service delivery through better use of data that is outcomes focused.  
Note: Key Performance Indicator (KPI) is that joint planning includes health services, Medicare Locals, and engages the community.

**Information provided by:** North Metropolitan Health Service - Public Health & Ambulatory Care (PHAC)  
**Overall implementation status:** Level 3

<table>
<thead>
<tr>
<th>Memoranda of Understanding between NMHS, NM Governing Council &amp; Perth North Medicare Local &amp; Perth Central and East Medicare Local</th>
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<tr>
<td>Start date: 29/11/12</td>
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<td>End date: 30/06/15</td>
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Memoranda of Understanding (MoU) – formal mechanism for all parties to commence working together with communities to provide more sustainable health outcomes including:

- Strengthening community governance and organisations
- Enhancing the participation of the MoU parties and partners
- Contributing to effective regional planning and its application

Included under the MoU, the Clinical Service Planning Framework between NMHS and the respective Medicare Locals outlined:

- a systematic planning process to address agreed outcomes proposed under the MoU.
- prioritising of population demand and need across the continuum of care
- methodologies to map availability and accessibility of primary care and community based services
- methodologies to determine equity, access and outcomes for individuals receiving services

MoU extended by all signatories to 30 June 2015 to coincide with the ceasing of NMHS Governing Council and establishment of Primary Health Networks on 1 July 2015 (replacing Medicare Locals)

<table>
<thead>
<tr>
<th>Establishment of Executive Partnership Group (EPG)</th>
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<tr>
<td>Start Date: 5/2/13</td>
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<td>End Date: 5/11/14</td>
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</table>

EPG inaugural meeting February 2013 with membership from NMHS, NM Governing Council, Perth North Medicare Local and Perth Central and East Medicare Local. The last meeting of EPG was 5/11/14 pending the outcome of the National Medicare Locals Review.

A major component of the work of EPG was the sharing of data to assist with NMHS Clinical Service Planning and Medicare Locals Comprehensive Needs Assessment. Disadvantages to communities and areas of priority were identified including City of Perth, Bassendean, Wanneroo and Stirling.

The Collaborative for Healthcare Analysis and Statistical Modelling (CHASM), funded by the Department of Health to supply high level research and evaluation services by PHAC NMHS, directly advised NMHS Executive Partnership Group with analysis and reporting on emergency department demand and accessibility to services to support coordinated care planning, particularly through interventions such as GP After Hours programs.

<table>
<thead>
<tr>
<th>Working Groups of the EPG</th>
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<tr>
<td>Start Date: Jun 2013</td>
</tr>
<tr>
<td>End Date: Mar 2015</td>
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Convened to support priority areas with membership from all EPG partners and others

- Mental Health Working Group
- Aged Care Working Group
- Sexual Health Working Group
- Aboriginal Health Working Group (Start Date: March 2014)
- Immunisation Working Group
  Key issues
  - Aboriginal overdue catch up program.
  - Creation of a new immunisation service in a low coverage area – Peppermint Grove clinic opened in January 2015.
  - Additional catch up immunisation clinics for newly arrived refugees at the Humanitarian Entrant Health Service (HEHS).
  - Immunisation education to Child Care Centre’s, Practice Nurses, Tertiary Health facilities and Derby Yerrigan Health Service.
  - Projects with Local Government in Bayswater and Bassendean to identify overdue children and link them to local immunisation providers.
  - Establishing pathways for children in care to access immunisations.

Start Date: May 2013
Ongoing

Information provided by: **North Metropolitan Health Service- Public Health & Ambulatory Care**

**Post- restructure activity**

**Statement of Intent – North Metro working in partnership with the future Perth North Primary Health Network**

Recognition that working in partnership with primary care is integral to achieving a systematic approach to achieving health outcomes for the community.

Start Date: Dec 2014

Partnership working between Department of Health and WA Primary Health Alliance (WAPHA) is yet to be determined; informal liaison between NMHS and Perth North Primary Health Network is ongoing to address the WAPHA priority areas: Mental Health; Aboriginal Health; Chronic Disease; Aged Care.

Executive Director Public Health & Ambulatory Care has delegated responsibility from Chief Executive NMHS for engagement.

Start Date: Aug 2015

**Data and support provided for the development of local government Health Plans**

- City of Wanneroo Public Health Plan 2014-2016
- Shire of Kalamunda Community Health & Wellbeing Plan 2013 – 2016
- City of Perth Public Health & Wellbeing Plan 2014-2016

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**Recommendation 1- Update on related activity**

Information provided by: **South Metropolitan Health Service**

Overall implementation status: **Level 4**

**Memoranda of Understanding between SMHS, SMHS Governing Council & Perth Central and East Metro Medicare Local, Fremantle Medicare Local, Perth South Coastal Medicare Local and Bentley-Armadale Medicare Local**

Start date: Jan 2013
End date: July 2015

Memoranda of Understanding (MoU) - a formal mechanism outlining the agreed principles of engagement, participation and working partnership between the SMHS, SMHS Governing Council, and Medicare Locals.

The MoU identifies a key function of Medicare Locals was to engage with community stakeholders, so to fully understand local primary health care issues and needs and reflect them in priorities and coordination. Appropriate community engagement was a key expectation of the federal Government.

No post-restructure activity was outlined.
### Recommendation 1- Update on related activity

<table>
<thead>
<tr>
<th>Information provided by: <strong>Western Australian General Practice Education and Training Limited (WAGPET)</strong></th>
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<tr>
<td><strong>Overall implementation status:</strong> <strong>Level 3</strong></td>
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<tr>
<td><strong>Comments:</strong> The Clinical Senate of GP Shortage was a very significant meeting for WAGPET and we took the verbal recommendations and passions of the Senate on the day very seriously. The below (responses to recommendations 1, 5, 7 and 8) have been informed directly by that day. WAGPET has been most active in building the workforce capacity of primary care and the integration of primary care with secondary and tertiary care through new workforce models since the Clinical Senate met.</td>
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<thead>
<tr>
<th>Research: WA GP number training requirement- predictive model development</th>
<th>End date: end 2015</th>
</tr>
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<tbody>
<tr>
<td>WAGPET commissioned academic research to determine exactly how many general practitioners this state should train. This research led to a predictive model that enables us to interpret the impact of many variables including the existing workforce, models of care, IMGs, increasing medical schools students, participation in the workforce. The team leading this work have already developed such a model for South Australia and shown it to be a valid and reliable predictor of workforce needs for the coming two decades. The results show that while the inner metro and much of rural appears well serviced, there are very significant shortages of primary care doctors in the outer metropolitan and remote areas of WA. We are undertaking a fine print review of the difference within Remoteness Area (RA) 2 and RA 3 as it appears RA 2 is oversupplied and RA 3 may be undersupplied, a status lost when RA 2 and RA 3 are analysed together. This research will be available from WAGPET shortly.</td>
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</table>
**Recommendation 2: Update on related activity**

**Recommendation 2:** Department of Health to work with Medicare Locals to identify gaps in primary care service delivery and work on collaborative solutions including linkages with local health care services to address the gaps and duplication.

**Information provided by:** North Metropolitan Health Service - Public Health & Ambulatory Care  
**Overall implementation status:** Level 3

<table>
<thead>
<tr>
<th>Establishment of Ambulatory Care Sensitive Conditions Collaborative (ACSCC)</th>
<th>Start Date: Jun 2013</th>
<th>End Date: Mar 2015</th>
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The ACSCC was established to facilitate a system-wide approach to address the population health needs for chronic conditions across the north metropolitan region, aiming to create a sustainable system to meet demand, which is equitable, client centred, accessible, coordinated and connected across the continuum of care.

Key principles of the group were to align to health reform priorities to manage demand and reduce avoidable Emergency Department presentations, unplanned hospital admissions and hospital length of stay. This group was accountable to the EPG (Recommendation 1) with formalised quarterly reporting timelines.

A formalised report “Reform Transition to Vision” was developed with the group implementing the 7 key recommendations; These included:

1. A service identifying frequent presenters to hospital and clients with complex conditions requiring care coordination and case management (a) hospital and (b) community based;
2. A multidisciplinary ED service targeting acute and frequently presenting clients, avoiding hospital admission by treating, redirecting and linking clients to health care services for ongoing management;
3. A community based sub-acute clinical service for the treatment and management of chronic conditions targeting demand management priorities;
4. A multidisciplinary allied health service providing sub-acute home visiting for admitted and non-admitted clients;
5. A community based sub-acute rehabilitation service for chronic conditions and selected high need client groups;
6. A community based Consultant providing medical treatment and management for complex clients with chronic conditions targeting demand management priorities;
7. A community based Podiatry service for the treatment and management of complex High Risk Foot (HRF) conditions targeting; Vascular disease, Neurological disease, Neurovascular disease, Complex wounds, Diabetes, Infection management, Renal Disease and Connective Tissue Disorders.

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**Recommendation 2: Update on related activity**

**Information provided by:** South Metropolitan Health Service  
**Overall implementation status:** Level 1

No further information provided
**Collaborative Complex Care in Diabetes Pilot - Level 2**

- WA Health, in conjunction with 360 Health and Community, South Metropolitan Health Service and WA Country Health Service are piloting the CCCDP program to improve community-based treatment for complex diabetes patients.
- This project is based on practice and research from Queensland which has shown that a community-based, integrated model of complex diabetes care, delivered by general practitioners with advanced skills supported by specialist Endocrinologists, produced clinical and process benefits compared with a tertiary diabetes outpatient clinic.
- Recruited GP’s will undertake a course in advanced diabetes management and be supported by an Endocrinologist and an allied health and project team for a set period of time.
- Patients will receive multidisciplinary care, helping them to manage their condition and reducing pressure on the public hospital system.
- The project is aiming to achieve reduced tertiary waiting times and demand, improved outcomes, improved care and access in the community and reduced fragmentation in diabetes services.

**Self-Management Programs**

WA Health has established a number of pilot programs with the Diabetes Association of Western Australia (Diabetes WA) to support people to self-manage their diabetes through the ‘Diabetes Education Self-Management for Ongoing and Newly Diagnosed’ (DESMOND) program:

**Grant 06378 - Diabetes WA - DESMOND** – Does it deliver for Aboriginal and Torres Strait Islander People? The aim of the project is to deliver quality diabetes education to Aboriginal people with type 2 diabetes living in the South West, Wheatbelt and Goldfields-Esperance regions of WA.

**Grant 06379 - Diabetes WA - Diabetes group education using an adapted delivery style.** The aim of the pilot project is to explore an alternative mode of DESMOND delivery by combined modes of face to face and Telehealth in the Wheatbelt and Great Southern Regions of WA, evaluating participant experience and outcomes compared with programs delivered in the conventional way.

**Grant 06380 - Diabetes WA - Helping Women with a history of gestational diabetes mellitus (GDM) to ‘Walk Away’ from diabetes.** The aim of the pilot project is to

- Adapt the Walking Away module of DESMOND and to deliver a quality diabetes prevention program to meet the needs of Australian postnatal women with a history of GDM.
- To train and support local allied health professionals to deliver the Walking Away program in their local communities and to assess the appropriateness of the Walking Away program for Aboriginal women in the pilot region.
WA Health has commenced procurement of the Healthy Lifestyle Program to provide a
- fully coordinated patient-centred lifestyle and risk modification for people at risk of, or newly diagnosed with a chronic disease
- support general practitioners in the referral process through improved integration, systems, resources and education
- increase capacity of services providers through improved integration, systems, resources and education

This program will replace the current Metropolitan Healthy Lifestyle Program which is delivered by the Medicare Locals and scheduled to cease 30 September 2015, due to the Commonwealth changes to the Medicare Locals and introduction of the Primary Health Networks (PHN).

### Partnership with Western Australian Primary Health Alliance (WAPHA)

- WA Health will work in partnership with the WAPHA to customise and localise HealthPathways for the WA community
- HealthPathways is an online manual that is targeted at clinicians (including general practitioners and other community based practitioners) to help make assessment, management and specialist request decisions for over 550 conditions

### painHEALTH

Evaluation and monitoring of a consumer oriented resource for the self-management of musculoskeletal pain.

The aim of the project is to support evaluation, monitoring and analysis of painHEALTH data with the potential for extending data capture capabilities and content relevant to other pain-related musculoskeletal conditions and health populations as agreed by the parties.

painHEALTH is a consumer-focused web resource that provides accessible, sustainable evidence-based information and practical skills for the (self) management of musculoskeletal pain. Data will be reported and used to inform health policy in relation to work of the Health Networks relevant to musculoskeletal pain.
Recommendation 3- Update on related activity

**Recommendation 3:** Ensure that there is a consistent, standardised, electronic platform for patient clinical records and secure two-way communication between hospital-based services and primary care within five years.

**Information provided by:** Department of Health, System Policy and Planning, Health System Improvement Unit

**Overall implementation status:** Level 3

<table>
<thead>
<tr>
<th>Statewide Discharge Summary Policy, and Notifications and Clinical Summaries</th>
<th>Start date: Oct 2014</th>
<th>End date: ongoing</th>
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- The Demand Management Steering Committee (DMSC), chaired by the then A/Director General, identified the need for a statewide discharge summary policy in October 2014.
- It had been identified that there was variation between hospital sites' discharge policies and practices in the communication of discharge summaries to GPs.
- A single statewide discharge summary policy for WA Health hospitals would assist with the standardisation of policy and practice.
- This draft policy has been developed by the Health System Improvement Unit with final feedback received now from Hospital Liaison General Practitioners, various hospital staff including medical records and clinical coders, junior medical doctors and DMSC members (hospital executives and General Practitioners).
- WA hospital sites are moving from faxed, emailed or posted transfer over time as the roll out of electronic platforms and secure two way communications by individual hospitals progresses.
- The implementation of the Notifications and Clinical Summaries (NaCS) web-based application shows good promise in addressing many of the issues relating to discharge summaries from WA Health hospitals to GPs (and other stakeholders).
- NaCS is an application that allows users to complete discharge summaries from patient details captured in the Patient Administration System (PAS); it talks to other current clinical systems used in WA Health including PAS, iPharmacy and iCM.
- When the recipient (e.g. GP) is registered for secure electronic delivery, these summaries are securely transmitted to compatible GP practice software via electronic means and to other health services such as psychiatric and aged care facilities as requested.
- NaCS is the only application in WA that is able to upload discharge summary documents to the national Personally Controlled Electronic Health Record (PCEHR), providing the patient is enrolled and has consented to upload.
- It is also the only current accessible platform for clinicians in WA Health country-wide to access a patient’s eHealth Record and view any uploaded documents, which will build a better picture of the patient’s medical history.
- NaCS is created by Health Information Network (HIN) and is consistent with the National E-Health Transition Authority (NEHTA) standards and created under guidance by users of current discharge summaries from sites.
- NaCs is in use in a number of metropolitan and regional sites including Royal Perth and Fiona Stanley Hospitals, a number of hospitals in the Great Southern and Kimberley areas and planning/scheduling the rollout is underway in a number of other sites including Princess Margaret and King Edward Memorial Hospitals.
**Recommendation 4- Update on related activity**

**Recommendation 4:** Strengthen consumer health literacy through an accessible multi layered approach.

- e.g. Beyond existing to new media
  - website
  - phone/tablet/apps
  - newspapers
  - tools for specific consumer groups such as the Association for the Blind

**Information provided by:** North Metropolitan Health Service, Public Health & Ambulatory Care

**Overall implementation status:** Level 3

| Building the capacity of Local Governments within the boundaries of the NMHS to afford healthier, safer, inclusive environments for all its community members. | Start date:  
End date: |
|---|---|
| Health literacy/information sessions to 15 elected Council members of the North Metropolitan Zone (City of Joondalup, Wanneroo and Stirling). Providing local community profiles, highlighting issues and trends affecting the health and wellbeing of their communities. | Held: Feb 2015  
Held: May 2015 |
| Health literacy/information sessions to East Metropolitan Zone elected Council members (Bassendean, Bayswater, Belmont, Kalamunda, Mundaring and Swan). Seminar for all 17 Local governments in the NMHS on the proposed Public Health Bill in partnership with Western Australian Local Government Association (WALGA). Partnership with Department of Sport and Recreation (DSR) and the Department of Transport (DoT) in the ‘Your Move’ programme, a physical activity and active transport behaviour change project. The program is delivered by the City of Wanneroo. | Start date: Jan 2015  
End date: Dec 2015 |

**Health literacy: Creating safer communities.**

**Targeted interventions with at-risk groups: Aboriginal and Culturally and Linguistically Diverse (CaLD) communities**

| Workshop in partnership with Drugs and Alcohol Office (DAO), Office of Multicultural Interest (OMI) and City of Stirling (CoS) targeting agencies and community leaders working with CaLD groups. 104 people attended. | Held: Sept 2014 |
| Delivery of food literacy and physical activity workshops | Start date: July 2013  
End date: June 2014 |
| The Moorditj lifestyles project actively engaged 194 Aboriginal people in a variety of settings. |  |
| Local food mapping audit developed | Start date: July 2013  
End date: June 2014 |
<p>| In collaboration with Epidemiology branch of WA DoH and the Joondalup, Stirling, and Wanneroo Councils a mapping reflecting food, alcohol and fast-food outlets per suburb within those three local councils |  |</p>
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Start date:</th>
<th>End date:</th>
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<tbody>
<tr>
<td>Production of a cookbook: the “More Deadly Tucker Cookbook”,</td>
<td>July 2013</td>
<td>Nov 2013</td>
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<tr>
<td>A pictorial, practical know-how resource for the Aboriginal community highlighting convenience, cost, and nutritional information. Edith Cowan University (School of Exercise and Health Science) contracted to support the production of the More Deadly Tucker cookbook worked with their students to reproduce, test and analyse up to three times, over 60 recipes provided by the community. To ensure each recipe met the nutritional content of the new Australian Dietary Guidelines, recipes were also modified and then taste-tested and approved by community members.</td>
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<tr>
<td>Aboriginal health: “Community champions’ video: An everyday role model</td>
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<td>Nov 2013</td>
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<tr>
<td>The Ngulluk Koolbaang DVD: “Healthy lifestyle community champions”, reflect the motivational journey of five inspiring community people towards the practice of healthy lifestyles. This resource use “real people” based on community feedback favouring the use of a regular person in any campaign as this breaks down the “someone like me can’t do” barrier.</td>
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<tr>
<td>Chronic Condition Self-Management (CCSM) Project: Website</td>
<td>July 2012</td>
<td>June 2015</td>
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</table>
| CCSM was implemented with the aim to embed self-management support principles and practice across NMHS services thereby assisting consumers to more actively participate in their own healthcare, improve their quality of life and health outcomes and reduce or optimise health service utilisation. This included:  
- Organisational-system level: To support NMHS system and practice changes to incorporate self-management across the continuum of care;  
- Practice level: To facilitate the delivery of self-management support resources to NMHS health care providers to support consumers with chronic conditions to actively self-manage their health;  
- Individual level: To facilitate the development, implementation and enhancement of quality services and resources incorporating CCSM for consumers across NMHS.  
As a result the following was completed:  
Development and implementation of ‘Embedding CCSM Support’ toolkits. Each toolkit included a suite of key CCSM resources, tools and references now available online on the WA Health Intranet Health Point alongside compilation of CCSM web content for the various WA Health web locations. | |

Clinical Senate Recommendations: The GP Shortage – The impact on our community and health sector

12 | Page
### Recommendation 4- Update on related activity

**Information provided by:** Department of Health, Public Health, Chronic Disease Prevention Directorate

**Overall implementation status:** Level 3

**Comment:** The following information relates to statewide population wide initiatives undertaken by the Chronic Disease Prevention Directorate, noting these were already planned or established before the Clinical Senate, as part of endorsed Public Health Division strategic directions and investment planning.

Note in order to give an accurate idea of the extent of this type of work across WA Health, further information is needed from other areas that run their own local and community initiatives that address health literacy e.g. metropolitan and regional public health units and Children and Adolescent Community Health.

### Public awareness/engagement programs and targeted interventions

- The Chronic Disease Prevention Directorate (Public Health Division) invests in a range of state-wide population wide public awareness/engagement programs and targeted interventions that promote healthy living through addressing the risk factors for chronic disease (including tobacco, physical activity, nutrition, overweight and obesity, child and water safety and falls prevention).

- These initiatives aim to provide accurate, accessible and actionable health information so the community is more informed and motivated to make positive decisions related to their health.

- These programs have been funded through a mix of dedicated state funding and under the National Partnership Agreement on Preventive Health (which ceased in June 2014).

- Programs use a range of strategies to provide reliable, high-quality health information including face-to-face community delivery, state-wide mass media (including television, radio and press, and unpaid media), websites and web-based tools and social media.

- In program design and delivery stages, contracted agencies have considered issues of accessibility and the needs of different groups including people living in low socioeconomic circumstances, Aboriginal people, people living in regional areas, Culturally and Linguistically Diverse (CALD) populations, people with low literacy levels and people with a disability.

### Ensuring equitable access to health services for Culturally and Linguistically Diverse groups

- The Cultural Diversity Unit (CDU), located in the Chronic Disease Prevention Directorate (Public Health Division), has stewardship of the WA Health Language Services Policy 2011, which is currently under review. This is a system wide policy that applies to all health service providers and staff employed within WA Health. The aim of the policy is to ensure there is effective communication between health professionals, consumers and carers who need language assistance in accessing WA Health services. There is a toolkit and cultural competency training offered to WA Health staff to support implementation of the policy. The CDU has also implemented several initiatives to strengthen CALD consumer literacy in health matters via ‘Multicultural Health Diversity Cafes’ and ‘Let’s Talk Culture Seminars’.
<table>
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<tr>
<th>Recommendation 4- Update on related activity</th>
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<tr>
<td>Information provided by: <strong>Department of Health, Office of the Director General, Communications Directorate</strong></td>
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<tr>
<td>Overall implementation status: <strong>Level 2</strong></td>
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| Specialist workforce capacity program worksheets | Start date: Feb 2015  
End date: June 2015 (ongoing updates) |
| Range of fact sheets developed with the Medical Workforce division of the Office of the Chief Medical Officer. These are published to the corporate website:  

| Careers section of website | Start date: Sept 2015  
End date: Dec 2015 |
| Changes to the careers section of the corporate website will be implemented to increase appeal and user-friendliness |

| Promotion of seminars and expos | Ongoing activity |
| Communications provides an account manager service to business units to assist in promotion of initiatives – such as various career expos and seminars. |

| Consumer website | Start live in late 2014  
End Date: ongoing |
| A consumer website has been developed and launched. The website is aimed at increasing consumer literacy around health conditions and the public health system. |
Recommendation 5- Update on related activity

Recommendation 5: Department of Health to explore reintegration of primary care clinicians with secondary and tertiary care through patient centred models with Key Performance Indicators (KPI). For example:

- GPs funded to upskill in tertiary hospitals
- Shared care of patients with complex/chronic conditions with general practitioners supported by consultants

Information provided by: Department of Health, System Policy and Planning, Health Networks
Overall implementation status: Level 2

Collaborative Complex Care in Diabetes Pilot (CCCDP)

- WA Health, in conjunction with 360 Health and Community, South Metropolitan Health Service and WA Country Health Service are piloting the CCCDP program to improve community-based treatment for complex diabetes patients
- This project is based on practice and research from Queensland which has shown that a community-based, integrated model of complex diabetes care, delivered by general practitioners with advanced skills supported by specialist Endocrinologists, produced clinical and process benefits compared with a tertiary diabetes outpatient clinic
- Recruited GP’s will undertake a course in advanced diabetes management and be supported by an Endocrinologist and an allied health and project team for a set period of time
- Patients will receive multidisciplinary care, helping them to manage their condition and reducing pressure on the public hospital system

The project is aiming to achieve reduced tertiary waiting times and demand, improved outcomes, improved care and access in the community and reduced fragmentation in diabetes services.
Recommendation 5 - Update on related activity

Information provided by: **Department of Health, Clinical Services and Research, Medical Workforce Branch (MW) and the Postgraduate Medical Council of WA (PMCWA)**

**Overall implementation status:** **Level 2**

**Comments:** Recommendation 5 is not yet complete, but progress has been made on the implementation of the following strategies:

- Planning the development of a centralised recruitment process for service and discipline specific vocational medical registrars.
- Identification of GPs and procedural GPs into system-wide medical workforce planning to support their integration into medical workforce training initiatives.
- Continued support, following withdrawal of Commonwealth support, of the Community Residency Program (CRP) to attract increased interest in primary care practice and to give primary care experience to those who will still enter subspecialty practice.

### PMCWA - Community Residency Program

<table>
<thead>
<tr>
<th>Description</th>
<th>Start date</th>
<th>End date</th>
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<tbody>
<tr>
<td>2015: Retained CRP to attract increased interest in primary care and to expose those aiming for specialist training to a primary care environment.</td>
<td>Jan 2015</td>
<td>Jan 2016</td>
</tr>
<tr>
<td>Ongoing: Further development of a sustainable and ongoing CRP that supports a general practice pathway involving community and hospital placements to build the skills required for general practice.</td>
<td>Jan 2016</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

### PMCWA - Centralised Resident Medical Officer recruitment process for 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides workforce data to identify GP training and procedural GP training and upskilling needs.</td>
<td>Jan 2015</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

### MW and PMCWA - Centralised registrar recruitment process for 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion of the centralised recruitment process to all inter-hospital rotation and discipline specific vocational registrars for 2017 is being progressed.</td>
<td>Jan 2015</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

### MW - Integration of GP and procedural GP training

<table>
<thead>
<tr>
<th>Description</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of GP and procedural GP training with better access to tertiary hospital rotations in anaesthetics, surgery, obstetrics, and emergency medicine.</td>
<td>Jan 2015</td>
<td>ongoing</td>
</tr>
</tbody>
</table>
**Recommendation 5- Update on related activity**

<table>
<thead>
<tr>
<th>Information provided by:</th>
<th>Western Australian General Practice Education and Training Limited (WAGPET)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall implementation status:</td>
<td>Level 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Residency program (on behalf of WA Health)</th>
<th>Start date: 2014</th>
<th>End date: 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In May 2014 the federal budget announced the funding for integrated training of prevocational doctors across primary and secondary care settings would cease at the end of year. The Director General of WA Health agreed to fund the program, known as the community residencies program, and WAGPET did so for 2015 on behalf of WA Health. However with no federal support for the primary care settings this was unlikely to be a sustainable model. Should a relabel contribution from the Federal Health Department be forthcoming this program could be easily re-established.</strong></td>
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</table>

**Rural Practice Pathway**

WAGPET coordinates the Rural Practice Pathway (RPP) in WA, a working collaboration between the Rural Clinical School of WA, WA Country Health Service, Rural Health West and WAGPET. This group is part of a larger cross sector rural health training group chaired by the CMO. The RPP delivers quality training posts for prevocational and vocational rural doctors, in particular integrated two year contracts that cross the primary and secondary health sectors. WA Country Health Service has been the major provider of significant new rural posts and careers for WA doctors since 2013.

**WAGPET Activity review and recommendations**

WAGPET commissioned a comprehensive review of its activity and achievements over the past decade, and there are recommendations to build a stronger rural procedural GP workforce, integrate services regionally with others such as the Rural Clinical School and the WA Country Health Service in these locations. There is a call for more long term training contracts and a streamlining of processes towards completion of training. Solo GPs and Aboriginal health training sites are identified as priorities for further consideration for integrated – vertically and horizontally – training.
### Recommendation 6- Update on related activity

#### Recommendation 6:
Department of Health to consider outsourcing more of the existing primary health care-type services (e.g. chronic disease management) to the non-government sector, including to GP-centred services. Funding linked to potentially preventable hospitalisations and accessibility.

**Information provided by:** North Metropolitan Health Service, Public Health & Ambulatory Care

**Overall implementation status:** Level 3

| Establishment of Ambulatory Care Sensitive Conditions Collaborative (ACSCC) | Start date: 2013  
End date: Mar 2015 |
|---|---|
| The ACSCC was established to facilitate a system-wide approach to address the population health needs for chronic conditions across the north metropolitan region, aiming to create a sustainable system to meet demand, which is equitable, client centred, accessible, coordinated and connected across the continuum of care.  
Key principles of the group were to align to health reform priorities to manage demand and reduce avoidable Emergency Department presentations, unplanned hospital admissions and hospital length of stay. This group was accountable to the EPG (see Recommendation 2) with formalised quarterly reporting timelines.  
A formalised report “Reform Transition to Vision” was developed including priority areas for long term system change. Recommendations linked to outsourcing more of the existing primary health care-type services included;  
• Transition of the NMHS Community Respiratory Linkage Service  
• Implementation of Care point  
• Review of Diabetes services across the care continuum. |

| Transition of the NMHS Community Respiratory Linkage Service (COPD: Congestive Obstructive Pulmonary Disease) | Start date: July 2013  
End date: under review |
|---|---|
| The NMHS transitioned the Community Respiratory Linkage Program to the Perth North Medicare Local (PNML now Black Swan).  
This service operated in Joondalup, employing a Respiratory Nurse Specialist for an initial period of one year, after which PNML were to review the service and its ongoing capacity to support the service in line with Primary Health Care Reform.  
Key deliverables for the service as agreed to in the endorsed letter of agreement was to;  
• Receive referrals for high acuity COPD clients in the NMHS catchment area.  
• Maintain service requirements targeting the treatment of high acuity clients.  
• Maintain and establish where necessary connected referral pathways for high acuity clients between providers. This was to include hospital sites, Community Physiotherapy Service and General Practice.  
• Consider any required service expansion to meet population needs.  
• Operate the service model in alignment with the NMHS Integrated Management Model.  
• To establish common clinical pathways in support of client transitioning, and will endeavour to meet to discuss any issues that arise. |

| Implementation of the Care Point Program | Start date: 2014  
End date: 2017 |
|---|---|
| WA Health, HBF and Medibank Health Solutions (MHS) partnered to implement a pilot project Care Point, to test the effectiveness of an integrated model of care for people with chronic conditions and complex needs. MHS is the project lead. This project will include a patient cohort of 1500 people. The breakdown of patients will comprise 500 participants from each private health insurance (Medibank, HBF) and 500 uninsured adults (NMHS public patients) who have multiple chronic and complex conditions.  
Referral into CarePoint aims to enable;  
• Patient access to healthcare professionals who can assist in the management of healthcare issues  
• Patient in conjunction with the GP to have tailored care plans specific to needs;  
• Coordination and referral to community health and social services as required;  
• Support in arrangement and attendance to healthcare appointments;  
• Support before and after a stay in hospital;  
• Education & support to assist patients regarding care conditions. |
Review of Diabetes services across the care continuum.

<table>
<thead>
<tr>
<th>Start date: 2013</th>
<th>Ongoing in line with Service Standards</th>
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</table>

Service mapping against the Diabetes Model of Care (MoC) identified regional gaps across the care continuum that included a review of existing client pathways to establish the development of case management & referral pathways within the region.

Ongoing work led to the development of the WA Framework for Action & Diabetes Service Standards 2014. The development of the standards provides a shared vision and resources to support the delivery of better services for people at risk of or living with diabetes. It demonstrates an effort by organisations to work in partnership with acute and primary health care sectors.

Recommendation 6- Update on related activity

<table>
<thead>
<tr>
<th>Start date: Apr 2015</th>
<th>End date: Feb 2018</th>
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</table>

Collaborative Complex Care in Diabetes Pilot (CCCDP) – Level 2

- WA Health, in conjunction with 360 Health and Community, South Metropolitan Health Service and WA Country Health Service are piloting the CCCDP program to improve community-based treatment for complex diabetes patients.
- This project is based on practice and research from Queensland which has shown that a community-based, integrated model of complex diabetes care, delivered by general practitioners with advanced skills supported by specialist Endocrinologists, produced clinical and process benefits compared with a tertiary diabetes outpatient clinic.
- Recruited GP’s will undertake a course in advanced diabetes management and be supported by an Endocrinologist and an allied health and project team for a set period of time.
- Patients will receive multidisciplinary care, helping them to manage their condition and reducing pressure on the public hospital system.
- The project is aiming to achieve reduced tertiary waiting times and demand, improved outcomes, improved care and access in the community and reduced fragmentation in diabetes services.

General Practitioner upskilling G06364 - Level 3

- Upskilling of General Practitioners (GP) using video vignettes to improve the management of patients with chronic heart failure (HF). GPs will be provided with six pairs of video vignettes of actor-patients depicting patients with HF. Continuing medical education points will be allocated for participation in the project.
- The vignettes are likely to give GPs greater skills and confidence in managing HF, which will directly improve patient care and is likely to reduce hospitalisations. The Service provider will evaluate the effectiveness of the vignettes by measuring the proportion of patients (scenarios) appropriately managed in each set of vignettes.
- A secondary outcome measure is the number and type of critical errors in the responses to each set of video vignettes. The demographic data on all participants will help to establish the baseline and determine identifiable subgroups of GPs who do not manage patients with HF as per expert opinion. This data will guide future GP support and upskilling strategies that the investigators plan to implement and evaluate.

The project will be completed in two phases and WA Health has provided one year of funding.
Recommendation 6- Update on related activity

Information provided by: South Metropolitan Health Service
Overall implementation status: Level 2
Comments: Some level of outsourcing had commenced. Please note that MCL’s have since ceased to exist. Some contracts have not been extended with no further funding source.

<table>
<thead>
<tr>
<th>Contracted services to Medicare Locals</th>
<th>Start date: 2013</th>
<th>End date: June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GP after hours services</td>
<td></td>
<td></td>
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<tr>
<td>• Street Doctor</td>
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<tr>
<td>• Maternity Group Practice (Aboriginal Antenatal Care)</td>
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<tr>
<td>• Heart beat program</td>
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Recommendation 7- Update on related activity

Recommendation 7: Department of Health to enable GPs and their teams access to remote consultation through mechanisms such as Skype/Scopia with appropriate facilities and authorisation for items such as: prescribing, referrals and consent.

Information provided by: Western Australian General Practice Education and Training Limited (WAGPET)
Overall implementation status: Level 3

Virtual presence project

WAGPET set up a virtual presence project and has now instated a heavily on-line approach to GP education. This has been of enormous benefit to rural doctors outside the regional centres. We have set up new models of remote supervision using video-conferencing equipment. We have developed models for virtual consolations that with funding WAGPET could train registrars to develop competency in this context.

Recommendation 7- Update on related activity

Information provided by: Rural Health West
Overall implementation status: Level 1
Comments: The Department of Health (WACHS) has made very good progress with the implementation of the Emergency Tele-health Service for rural communities, hospitals and GPs.
There has been no scalable progress to enable rural and remote private practice GPs, and their patients, access to Tele-health through video-consulting; e-prescribing; store and forward of imaging and diagnostics, etc
The WA GP Tele-health Advisory Group made requests to the Statewide Tele-health Advisory Group (now disbanded) for widespread access to Scopia for rural and remote private practice GPs, however this has not been enabled.
WACHS and the RACGP do not advocate the use of Skype for Tele-health services.
<table>
<thead>
<tr>
<th>Recommendation 8- Update on related activity</th>
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<tbody>
<tr>
<td><strong>Recommendation 8</strong>: Department of Health and Medicare Locals to identify why WA GP workforce participation is as low as 0.55 FTE and to explore innovative ways to better utilise their skills, e.g. Telehealth to rural communities.</td>
</tr>
</tbody>
</table>

**Information provided by**: Western Australian General Practice Education and Training Limited (WAGPET)

**Overall implementation status**: Level 2

**Comments**: This question is addressed in the very robust research discussed under recommendation 1 (WA GP number training requirement- predictive model development). Further, nationally the RACGP have established a post-fellowship education expert committee (REC) and asked me (WAGPET Chief Executive Officer, Dr Janice Bell) to chair it. The REC will develop models for revalidation, professional development for new fellows, return to work programs and base all of these on an agreed GP competency map. This should not encourage doctors back to the workforce, but ensure their quality practice.

<table>
<thead>
<tr>
<th>Recommendation 8- Update on related activity</th>
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<tbody>
<tr>
<td><strong>Information provided by</strong>: Rural Health West</td>
</tr>
</tbody>
</table>

**Overall implementation status**: Level 2

**Comments**: WACHS have been engaged in the ongoing work of the Rural Practice Pathway Committee which aims to improve rural/remote area distribution of GPs.

WACHS continue to support the GP Obstetrics and Anaesthetics Mentoring programs which aim to encourage, support and distribute GPs with procedural skills to rural locations.

The Medical and Dental Workforce Committee is a forum available to raise issues related to rural and remote GP workforce supply and distribution.

There has been minimal progress in exploring innovative models to better utilise the skills of the GP workforce.
**Recommendation 9- Update on related activity**

**Recommendation 9:** Department of Health and Medicare Locals to utilise a range of methods to directly engage consumers to identify their primary health care needs including:

- Public forums
- Electronic technology (apps etc)
- Hard copy surveys

Information provided by: Western Australia Primary Health Alliance (WAPHA)

Overall implementation status: Discontinued (see comments below)

Comments: As Medicare Locals ceased to operate on 30 June 2015, we have responded to this recommendation by speaking to individuals who worked with Medicare Locals (MLs) and have provided as much anecdotal feedback as we could.

In our response, we have highlighted WAPHA’s strategies to continue to engage directly with consumers to identify and find solutions to their primary health needs.

It should be noted that consumer engagement was embedded as a deliverable in every ML program. MLs held a number of stakeholder forums to engage GPs, health professionals, key stakeholders, local government and consumer (community) representatives. Outlined below are some examples of initiatives that were in place that address Recommendation 9.

### Consumer Engagement programs and activity

**Establishment of ‘Hubs’** (country locations). The purpose of the Hubs were to:

- provide recommendations to the key health forums and the ML local primary health care matters and potential solutions; and
- act as a conduit for information exchange and engagement.

**Establishment of Forums**

Structured formal meetings were held on a set schedule. The objectives of the Forum were to:

- improve the coordination in Primary Health Care service planning and delivery based on locally identified health needs;
- share information, knowledge and resources with the aim of improving access to services for those within the region; and
- work collectively to monitor, address and devise strategies that will assist all agencies and funders to plan and develop initiatives best suited to the region’s needs.

**Community Reference Groups**

Each ML had community reference groups with a broad range of representatives. Some examples of the representatives included the Heath Consumers’ Council, consumers, Aboriginal and Torres Strait Islanders and people with lived experience of mental health. The reference groups held formally scheduled meetings each year which focused on developing strategies to address key health issues eg diabetes.

**Program Advisory Committee**

Members included pharmacists, locum services, consumers, GPs and aged care members. The focus areas for this committee were after hour’s services and eHealth.

**Road Shows and Community events** – worked closely with local government authorities, attended community events to directly engage with health consumers to promote primary health care and provide general health education.

**Newsletters/emails** – prepared for community members to provide the latest news on initiatives, health concerns, and promote primary health care.

**Information booths** – based at local shopping centres and community events – used for promotions, information sharing and conducting surveys.

**Fact sheets** – provided to consumers.
**Surveys**

A number of MLs worked in collaboration with GPs and supported the GPs to conduct surveys with GPs and consumers. These included surveys specific to consumers’ awareness of primary health care services eg Afterhours GP services.

**Electronic Technology**

Two key ehealth programs that MLs worked with included:
- *Personally Controlled Electronic Health Record (PCEHR)* the MLs worked/engaged directly with the community to encourage sign ups and the use of the PCEHR.
- *Percy’s Practice* website – an online program to assist consumers to find after hours GP services and it also provides topical monthly health and well-being information.

**Post- restructure activity**

Implementation status: **Level 1-2**

Comments: WAPHA exists to facilitate a better health system, with improved patient outcomes at better ‘value’ to the community.

WAPHA is implementing a number of strategies, within the first 6 months of operations to directly engage with consumers. These strategies will be critical to capture the voice of the consumer and will help WAPHA to identify and understand the consumers’ primary health needs. These strategies include:

**Community Engagement Committees (CEC)**

We are establishing CECs for each Primary Health Network (PHN). The CECs are integral to assist the PHNs to understand health issues specific to patients, consumers and the community. The membership of the CECs is representative of carers, consumers, Aboriginal and Torres Strait Islander community and the broader community. The CECs Terms of Reference have been finalised and made available via WAPHA’s website.

Nominations are now open for the CECs with the first meetings scheduled to occur in November 2015.

In addition to the CECs, community engagement groups will be established to address specific issues/concerns, on an as needed basis.

**Community Forum**

The key objective of the forum is to seek the community’s feedback on WAPHA’s strategic direction, to ensure we are applying our capabilities, resources, policies and service commissioning design, in line with expectations. The community forum is scheduled to be held in November (2015).

**Technology – eHealth**

**Health Pathways**

One of WAPHA’s eHealth initiatives has been the development of Health Pathways WA, an online health information portal for General Practitioners and primary health clinicians. Health Pathways assists with managing and referring patients to appropriate services. Health Pathways is designed for use during patient consultations and will support patients to receive the right treatment or special care, with short waiting times.

Health Pathways will be launched in WA on Thursday 9 October.

**Personally Controlled Electronic Health Record (PCEHR) – My Health Record**

WAPHA continues to work with the Department of Health on the implementation of this initiative. This is an ongoing initiative.
### Recommendation 9- Update on related activity

| Information provided by: North Metropolitan Health Service, Public Health & Ambulatory Care |
| Overall implementation status: **Level 3** |

**Healthy neighbourhoods Symposiums: Building local social capital and interagency collaboration**

- 72 stakeholders attended The Healthy Neighbourhoods Symposium for the City of Joondalup (CoJ). Health Promotion collaborated with the CoJ, West Coast Institute and Panorama Health (Perth North Medicare Local)  
- 34 stakeholders attended The Healthy Neighbourhoods Symposium for the City of Bayswater and Town of Bassendean in collaboration with the City of Bayswater, Town of Bassendean, Perth Central & East Metro Medicare Local and the Department of Sport and Recreation.  
- A total of 158 participants from 113 organisations have now participated in one of the four Healthy Neighbourhood Symposiums conducted by the NMHS Health Promotion Unit. Over 60 people have registered interest to participate in one of the four working groups that have been established in each LGA.

| Held: Nov 2014 |
| Held: Mar 2015 |

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As executive sponsor, I would like to recognise the important work which supports primary health care delivery in the State, and thank all those who have contributed to this update on activity relating to the recommendations for the **WA GP shortage- the impact on our community and health sector** Clinical Senate.

![Signature](signature.jpg)

Professor Gary Geelhoed  
**Chief Medical Officer**  
**Assistant Director General – Clinical Services and Research**

28\textsuperscript{th} October 2015
Appendix 1:

Nine recommendations from the Clinical Senate: The WA GP Shortage - The impact on our community and health sector, 3 May 2013

1. Each Health Service through its governing council must have an agreement with its Medicare Local(s) to take a population health approach to service delivery through better use of data that is outcomes focused.
   Note: Key Performance Indicator (KPI) is that joint planning includes health services, Medicare Locals, and engages the community.

2. Department of Health to work with Medicare Locals to identify gaps in primary care service delivery and work on collaborative solutions including linkages with local health care services to address the gaps and duplication.

3. Ensure that there is a consistent, standardised, electronic platform for patient clinical records and secure two-way communication between hospital-based services and primary care within five years.

4. Strengthen consumer health literacy through an accessible multi layered approach. For example, beyond existing to new media:
   - website
   - phone/tablet/ apps
   - newspapers
   - tools for specific consumer groups such as the Association for the Blind

5. Department of Health to explore reintegration of primary care clinicians with secondary and tertiary care through patient centred models with Key Performance Indicators (KPI). For example:
   - GPs funded to upskill in tertiary hospitals
   - Shared care of patients with complex/chronic conditions with general practitioners supported by consultants

6. Department of Health to consider outsourcing more of the existing primary health care-type services (e.g. chronic disease management) to the non-government sector, including to GP-centred services. Funding linked to potentially preventable hospitalisations and accessibility.

7. Department of Health to enable GPs and their teams access to remote consultation through mechanisms such as Skype/Scopia with appropriate facilities and authorisation for items such as: prescribing, referrals and consent.

8. Department of Health and Medicare Locals to identify why WA GP workforce participation is as low as 0.55 FTE and to explore innovative ways to better utilise their skills e.g. Telehealth to rural communities

9. Department of Health and Medicare Locals to utilise a range of methods to directly engage consumers to identify their primary health care needs including:
   - Public forums
   - Electronic technology (apps etc)
   - Hard copy surveys