



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

Disability Liaison Officer Project Summary Report

Phase 1, 2 and 3

North Metropolitan Health Service
South Metropolitan Health Service

Contents

Executive summary and findings	2
1. Phase 1	3
1.1. Scope	3
1.2. Policy and planning context	3
1.3. Models of Care	3
1.4. Health and disability sector reform	3
1.5. Consultation themes	4
1.5.1. Theme one: no central point of patient information	4
1.5.2. Theme two: disability profile	4
1.5.3. Theme three: service integration	4
1.5.4. Theme four: resource limitations	5
1.5.5. Theme five: disability education	5
1.5.6. Theme six: disability service delivery models	6
1.6. Phase 1 recommendations	6
1.6.1. North Metropolitan Health Service	6
1.6.2. South Metropolitan Health Service	6
2. Phase 2	7
2.1. North Metropolitan Health Service	7
2.2. South Metropolitan Health Service	7
2.3. Phase 2 Recommendations	7
2.3.1. North Metropolitan Health Service	7
2.3.2. South Metropolitan Health Service	8
3. Phase 3	8
3.1. North Metropolitan Health Service	8
3.2. South Metropolitan Health Service	8
3.3. Phase 3 Recommendations	8
3.3.1. North Metropolitan Health Service	8
3.3.2. South Metropolitan Health Service	9
4. Conclusion	10

Executive summary and findings

At the 2011 Clinical Senate “Clinicians, do you see me?” a number of recommendations were made. The State Health Executive Forum endorsed Recommendation 2:

“The Department of Health introduces Disability Liaison Officers in all adult tertiary/secondary health services.”

The Disability Liaison Officer (DLO) Project was initiated based on this recommendation, and jointly funded by Department of Health and the Disability Services Commission (DSC). The project was managed by the Health Networks Directorate, with a Steering Group comprising of representatives from the Disability Health Network, DSC, North Metropolitan Health Service (NMHS) and South Metropolitan Health Services (SMHS). Consumers and carers were represented in the Working Groups for each Health Service Provider (HSP).¹

The project was piloted in Armadale, Fiona Stanley and Sir Charles Gairdner Hospitals, between April 2013 and June 2016 in three phases.

Conducted over three phases, the project involved extensive stakeholder consultation (via individual and group interviews, questionnaires, focus groups and open group consultations) and data analysis to provide a baseline to describe the current experience of people with disability using the hospital system. This was followed by piloting different approaches to address the identified service needs, including developing screening tools to record the disability cohort and assist in appropriately managing services including admissions and discharge planning. The final phase of the project focused on sustainable service goals, and promoted system and service delivery change, with a view to improving the journey for patients with complex need across the health service.

Both HSPs concluded that addressing system and process change would be more effective than a dedicated position. It was determined that the most sustainable solution is to embed this through existing infrastructure, particularly Disability Access and Inclusion Plans.

Funding from DSC ceased in 2016, however Department of Health provided an additional \$70,000 to NMHS for 2016/2017 to enable ongoing embedding of system change.

Detailed reports for each project phase in each HSP can be found on the DLO Project landing page: http://www.healthnetworks.health.wa.gov.au/network/disability_liaison_officer.cfm

The project has now concluded for SMHS and is nearing completion for NMHS, with the recommendations being embedded into the Disability Access and Inclusions Plans business practice to create sustainable system change and improvement.

¹ Please note: due to changes within the WA health system in relation to the Health Services Act 2016, Area Health Services are now known as Health Service Providers (HSPs).¹

1. Phase 1

1.1. Scope

Phase 1 was conducted over six months from April to August 2014. The aim was to scope the needs in North Metropolitan Health Service (NMHS) and South Metropolitan Health Service (SMHS), with a focus on inpatients with complexity of need, related to disability.

An extensive stakeholder consultation was undertaken via individual and group interviews, questionnaires, focus groups and open group consultations. Key issues raised were:

- No access to one central point of patient information.
- Poor awareness of and attitude towards people with disability.
- Fragmented and poorly coordinated disability services across NMHS, SMHS and the community.
- Resource limitations which impact on hospital service delivery.
- Lack of disability education and training.
- Absence of disability service delivery models.

Data was also obtained to analyse current service delivery, from the WA health system Epidemiology, Disability Services Commission (DSC), Community Aids and Equipment (through DSC) and Activity Based Funding (ABF) analysis, to provide a baseline to describe current experience of people with disability entering the hospital system.

1.2. Policy and planning context

The [Clinical Services Framework 2014–2024](#) provides a structured plan for clinical services, with a breakdown of clinical service levels across the state and projections of future service needs to guide service planning delivery.

1.3. Models of Care

Models of care provide an overarching framework to improve the care and flow of patients in the acute inpatient setting and throughout the patient journey. At the time, the WA health system did not have an overarching model of care for disability, however the Disability Health Network has now produced:

- [WA Disability Health Framework 2015-2025: Improving the health care of people with disability](#)
- [WA Disability Health Framework Companion Resource: Foundations for change](#)
- [WA Disability Health Framework 2015–2025 Snapshot](#)

Other models of care relevant to the disability cohort include:

- The *Stroke Model of Care*.
- Chronic lung conditions.
- Motor neurone disease.
- Morbid obesity.

1.4. Health and disability sector reform

The WA health system has been and continues to undergo change and significant reform. Reform initiatives encompassing growth, decommissioning, redevelopment and reconfiguration of services have influenced decisions and capacity to implement DLO positions in every adult tertiary/secondary health service.

The disability sector has also faced a number of challenges and reforms at a state and national level. Some of these changes include:

- *Disability Services Act* and regulation amendments.
- National Disability Insurance Scheme (NDIS) and self-directed service and supports.
- Procurement reform.
- NDIS/My Way trial sites.

1.5. Consultation themes

Engagement of key stakeholders across the health and disability sectors was considered vital to inform the DLO project. Consultation was considered in three broad groups:

- People with disability, their families, carers and support workers.
- Disability agencies/specialist disability agencies, for example DSC, Nulsen, The Centre for Cerebral Palsy and Ethnic Disability Advocacy Centre.
- The WA health system, including tertiary and secondary hospital clinicians and representatives from the Department of Health.

The consultation identified the following themes around current disability service challenges:

1.5.1. Theme one: no central point of patient information

- Limits timely access to patient information including next of kin, GP details, functional requirements and essential specialist equipment, leading to inefficiencies for hospital staff and frustration from a consumer and carer perspective due to the need to repeat information.
- Increases risk of incorrect clinical management. An example of this was a patient requiring thickened fluids for mealtimes who was at risk of aspiration was not given thickened fluids nor positioned in her wheelchair for mealtimes.

1.5.1.1. Theme one identified strategies

- The DLO considers developing a hardcopy template of a Profile Summary (Patient Passport) as a collation point of patient information, as an interim solution until an electronic option is available, in partnership with the Disability Health Network.
- The DLO considers creating a disability checklist (screening) to understand disability patient cohort complexity to better manage inpatient admission.

1.5.2. Theme two: disability profile

- Profile of people with disability remains low in the hospital system – awareness, attitudes towards people with disability and disability-specific education is limited.
- Service provision viewed as being focused on Key Performance Indicators and funding drivers, rather than being person or family centric.

1.5.2.1. Theme two identified strategies

- The DLO evaluates consumer satisfaction, via satisfaction surveys, interviews, incidence of complaints, receipt of qualitative positive feedback or other methods, to be reported informally bi-monthly or formally bi-annually.

1.5.3. Theme three: service integration

- Disability services throughout NMHS and SMHS were reported to be fragmented and poorly coordinated.
- Lack of early identification of patients with complex needs was identified as an ongoing gap in service provision.

- A range of other issues were identified, including:
 - Poor pre-admission planning for elective admissions.
 - Poor discharge planning for people with disability with complex needs.
 - Poor communication between hospital and community services.
 - Limited case management.
 - Lack of patient advocacy/patient-centric practice.
 - An identified gap for people with disability with no external agency involvement.
 - Lack of clinical pathways, processes and mechanisms for disability cohort/poor coordination of care.
 - Co-morbidities poorly assessed and managed.

1.5.3.1. Theme three identified strategies

- Develop an early identification ‘red flag’ system in Emergency Department (ED) to flag complex disability.
- Improved holistic health care for the complex disability cohort, including integrated medical and mental health care. This will be achieved by the DLO working in alignment with multidisciplinary teams, mental health and medical teams (i.e. complex health includes complex co-morbidity and the mental health of the patient).
- Develop a pre-admission pathway, discharge planning pathway and contribute to a multidisciplinary care plan for the disability cohort.

1.5.4. Theme four: resource limitations

- Lack of room on wards for patients with complex disability – equipment, family/carers etc.
- Some people with disability require a more time-intensive, slower paced, specialist model of service delivery.
- Poorly developed or limited resources available for people with vision or hearing impairment.
- Physical infrastructure and accessibility issues.

1.5.4.1. Theme four identified strategies

- The DLO will work collaboratively and in accordance with the Disability Access and Inclusion Plan (DAIP) goals and strategies, to identify hospital wards with the majority of the disability cohort. They will work with the multidisciplinary team to consider one room on each of these wards to be set-up to be as disability-friendly as possible. For example, ceiling hoist, sufficient room for wheelchair/essential equipment (this is a prime DAIP role that the DLO can assist with).
- The DLO will work with hospital ward staff to audit the wards with the higher number of patients with a disability and prioritise those wards with greatest area of urgency and need.

1.5.5. Theme five: disability education

- Lack of general disability awareness as well as specialist area education were consistently identified as major issues.

1.5.5.1. Theme five identified strategies

- The DLO will aim to provide education and training for health care professionals, consumers and families to raise awareness of people with disability and their special needs in the health care setting. This may include specialist disability education for staff, general disability awareness training, bed-side education for consumers/families, information pamphlets in accessible language and resource packages.

1.5.6. Theme six: disability service delivery models

- The absence of an over-arching Disability Model of Care, safety, quality and performance clinical governance framework, clinical pathways and policy were highlighted as a strong stakeholder issue, by consumers, hospital staff and the disability sector.
- No shared understanding or accountability of this patient cohort in the hospital sector, leading to the existence of fragmented services, silos, duplication, inefficiencies, poor patient flow and poor patient outcomes.

1.5.6.1. Theme six identified strategies

- The DLO will aim to develop a clinical pathway for the complex disability patient cohort within second quarter of DLO pilot project.
- Work in partnership with the Disability Health Network to contribute to developing an overarching 'Disability Model of Care' (or overarching framework with principles) and Clinical Governance Framework which will help support service delivery in the hospital system.
- Build strong working partnerships with DSC – particularly Hospital Eligibility Coordinator, MyWay Coordinators, DSC Hospital Eligibility and DSC Nursing. Aim to have bi-monthly or quarterly meetings.
- Build working partnerships with Specialist Disability Agencies and non-government organisations. Aim to have quarterly service-wide disability sector meetings which include Department of Health WA.
- Work in collaboration and partnership with the Disability Health Network and DAIP hospital staff to help the DLO guide strategic direction and service planning requirements, with bi-monthly meetings.

1.6. Phase 1 recommendations

The above findings and outcome measures were used to develop recommendations for Phase 2 of the DLO project.

1.6.1. North Metropolitan Health Service

The recommendation was to implement the DLO pilot position at Sir Charles Gairdner Hospital (SCGH) within the inpatient complex care team, Strategic Winter Allied Team (SWAT). This option was strongly supported by the Epidemiology data, with this tertiary hospital having the highest volumes of the disability patient cohort for NMHS. Furthermore it met the aims of the inpatient project scope and was endorsed by both NMHS clinicians and consumers alike.

This option was further supported by the draft NMHS Rehabilitation Plan which includes recommendations to improve and enhance the SWAT team for complex inpatients, including added medical governance to better support the team. Proposed governance for this option would include daily management by the SWAT team lead, with an Executive sponsor and an advisory team.

1.6.2. South Metropolitan Health Service

The recommendation was to implement the DLO pilot position at Armadale Health Service (AHS). This option met the aims of the project scope, was supported by Epidemiology data and stakeholder consultation, and was endorsed by AHS clinicians.

The DLO was to be supported by the Complex Needs Coordination Team (CoNeCT) team; however needed to have clearly defined boundaries to distinguish its role, aims and objectives from that of CoNeCT, which has a greater focus on supporting people in the community to prevent readmissions. Aligning with CoNeCT had the advantages of linking the DLO with an established multi-disciplinary team, and also creating stronger links between inpatient and community management of patients with complex disability.

Proposed governance for this option would include daily management by the CoNeCT team lead, with an executive sponsor and an advisory team. The governance that eventuated in SMHS Phase 2 involved overall governance by the DLO Steering Group at Department of Health, SMHS Area Executive Sponsor Kate Gatti, Director SMHS Population Health, metro-wide project oversight by DLO Pilot Coordinating Group. Daily management occurred through usual line management (CoNeCT and AHS Occupational Therapy with the SMHS Allied Health Advisor supporting and mediating where required).

2. Phase 2

Both North and South Metropolitan Health Services chose to focus on improving the patient journey at each pilot site.

2.1. North Metropolitan Health Service

North Metropolitan Health Service implemented Phase 2 of the project at SCGH over seven months in 2014.

Activities/project deliverables included:

- Development of a “disability checklist” – to record the disability cohort complexity and assist in appropriately managing the admission according to need.
- Development of an “Early Identification of the Complex Patient” system and “Pre-admission pathway” for “at risk” patients with complex need.
- Risk screen – identification of the Mayo Risk Screen as an effective tool to assist in admission process.
- Staff education sessions.

2.2. South Metropolitan Health Service

Armadale Health Service was identified as the preferred trial site within SMHS. The project was titled “Focus on Disability – Improving the patient journey at Armadale Health Service” and commenced in 2014 for a five month period.

Activities/project deliverables included:

- Patient Journey study – 15 patients with disability and their carers.
- Focus on Disability forum – half-day community information forum attended by 51 participants.
- Resource directory development - local services relevant to supporting patients with disability in the AHS area.
- Review of AHS patient intake and transfer documentation.
- National standards accreditation workbook review – with recommendations for:
 - Standard 2 – Partnering with Consumers
 - Standard 11 – Service Delivery
 - Standard 12 – Assessment and Care Planning.

2.3. Phase 2 Recommendations

2.3.1. North Metropolitan Health Service

The NMHS Project Team also made a number of recommendations, for AHS, SCGH, and the NMHS as a whole.

These recommendations built on the project deliverables above, with a focus on “embedding” disability screening processes into current systems, enabling sustainable changes in the long term.

2.3.2. South Metropolitan Health Service

The project team made a number of recommendations regarding service delivery and areas for improvement in processes for people with disability in the hospital system, at both AHS level, and SMHS level, as well as for the Disability Health Network.

Most notably however, the project team did not find sufficient evidence for a “DLO” role at AHS.

3. Phase 3

Both the NMHS and SMHS projects’ Phase 3 project scopes planned to utilise the DLO role to achieve goals that are self-sustainable, and promote system and service delivery change, with a view to improving the journey for patients with complex needs.

3.1. North Metropolitan Health Service

Activities/project deliverables included:

- Early identification of the complex patient, with focus on elective admission pathways, for the full disability cohort.
- Engagement and partnering with internal stakeholders and disability-related community agencies/service providers.
- Distribution of education resources for frontline hospital staff.
- Facilitated training and education sessions for frontline staff.
- Increased availability and awareness of disability e-learning package.

3.2. South Metropolitan Health Service

Activities/project deliverables included:

- A patient journey study, informed by in-depth interviews with patients and carers, covering a wide range of people with disability.
- Two process mapping workshops, the first with emergency department staff and the second with ward representatives. The emergency department workshop analysed the patient journey from emergency department presentation to ward admission. The ward representative workshop analysed the patient journey from arrival on the ward to discharge or inter hospital transfer.
- Hospital wide survey for Fiona Stanley Hospital (FSH) staff to assist the development of the hospital’s Disability Access and Inclusion Plan.

A thematic review was undertaken to identify common themes evident in these activities, and identify key recommendations. These are detailed in 3.3.2.

3.3. Phase 3 Recommendations

3.3.1. North Metropolitan Health Service

- To form partnerships and explore options to link with existing projects, tools and research.
- DAIP provides valuable opportunity for consideration of the *WA Disability Health Framework* in service planning.
- Include cross sector stakeholders from disability and hospital sectors to embed processes that support people with disability and complex health needs.
- Embed practice change into many roles rather than linking into one central role.

- Develop a communications strategy to ensure broad reach to influence change.
- Identify opportunities to capture specific data.

The Health Networks Directorate approached NMHS and SMHS to determine further outcomes or objectives that could be progressed with a time limited reduced funding amount of \$70,000. North Metropolitan Health Service were in a position to accept these funds to continue the system change process at SCGH, embed further change throughout NMHS and share processes and pathways with other HSPs.

3.3.2. South Metropolitan Health Service

- Commence the FSH DAIP Committee.
- Develop working relationships with FSH Consumer Advisory Council.
- Provide information to the Standard 2 – Partnering with Consumers Committee and develop plan to address various aspects of communication issues in collaboration with this committee.
- Determine education strategy with regards to the *Carers Recognition Act*.
- Determine a strategy to enhance hospital wide awareness of people with disability.
- Develop a “pre-admission planning pathway” to enable identification of people with disability at point of admission.
- Increase education of staff following implementation of changes to enable compliance and quality of risk screen tool in ED.
- Establish criteria on rating disability in the discharge risk rating scale.
- Provide re-education and training on referral process to allied health services.
- Review current clinical handover audits to determine identified gaps in clinical handover.
- Provide information to the Standard 6 – Clinical Handover Committee.
- Develop an education plan regarding incorporating the needs of the people with disability in clinical hand-overs.
- Collaborate with Mental Health Team at FSH to address mental health during admission and establish support networks with external organisations.
- Increase support to carers especially related to inpatient admissions.
- Investigate current transport options within FSH to aid with difficulty of access due to distances required to be travelled.

The responsibility for implementation of these recommendations is held by a range of people including the Director of Allied Health, Disability Access and Inclusion Committee and other FSH groups, and the Director Operations.

4. Conclusion

With the conclusion of Phases 1, 2 and 3 of the DLO Project across North and South Metropolitan Health Services, the findings demonstrate that the desired outcomes of the DLO position are most sustainably reached through embedding the principles within existing DAIP structures. Both HSPs have concluded that the position and time limited funding were more effectively utilised to promote system change and improvements in service delivery through changes to existing system and processes. Areas that can be influenced through these processes include the use of screening tools, admission and discharge planning, and early identification of patients with complex care needs.

Both HSPs found that the role of the DAIP Committees are best placed to hold overall governance and responsibility, including encouraging ongoing change in relation to the experience of people with disability and their carers in the hospital system.

As a requirement of the *Disability Services Act 1993*, all public authorities are required to develop and implement a DAIP. Many hospitals have a DAIP committee, consisting of people with experience in both the health and disability areas. Establishment and utilisation of DAIP Committees was identified as a high priority in improving the patient journey for people with disability.

Detailed reports for each Phase of the project in each HSP can be found on the Health Networks website: <http://www.healthnetworks.health.wa.gov.au/network/disability.cfm>

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

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