

Digestive Health Network Stakeholders Workshop

2 February 2007

Workshop Report

Prepared by the Clinical Network Support Unit
Health Policy and Clinical Reform Division



Table of Contents

Overview	2
1.0 Health Networks In Western Australia	2
2.0 The Digestive Health Network	2
3.0 Digestive Health Network Stakeholders Workshop.....	2
3.1 Executive Advisory Group	3
3.2 Workshop Invitations And Attendance.....	3
3.3 Workshop Aim.....	4
3.4 Workshop Objectives	4
3.5 Workshop Approach.....	4
4.0 Outcomes From The Workshop	5
4.1 Brainstorming Priorities For The Digestive Health Network	5
4.2 Network Priorities	9
4.3 Expansion Of Priority Areas	10
4.4 Barriers To Achieving Top 3 Priorities	16
4.5 Activity 4: Individual Reflection	21
5.0 Evaluation Of Workshop.....	23
Where To From Here?	24
Contact	24



Overview

A Health Network is a group of interested people representing health professionals, carers, consumers and others, coming together as advisory partners to plan and develop health policy and services across the State.

In September 2006, Dr Neale Fong, Director General, announced Dr Andre Chong as the Clinical Lead for the Digestive Health Network. Dr Andre Chong, members of the Digestive Health Network Executive Advisory group and the Clinical Networks Support Unit held a half-day stakeholders workshop on 2 February 2007. The purpose of the workshop was to provide an opportunity for key stakeholders to shape the direction and priorities of the Network and to unofficially launch the full operational status of the Network.

The information gathered from the workshop is documented in this report.

The workshop report will be considered a key resource in informing the Digestive Health Network Executive Advisory Group, who will be responsible for identifying the present and future priorities and projects for digestive care.

1.0 Health Networks in Western Australia

Health Networks are being established as part of the reform of WA Health and will cover major areas of health and illness. Health Networks are a means of providing a new collaborative focus across disciplines towards the prevention of illness and maintenance of health for all Western Australians.

By forging working relationships between a broad range of people, Health Networks will:

- plan better policy;
- ensure better co-ordination and integration of services; and
- increase participation, partnerships, communication and accountability across WA Health.

2.0 The Digestive Health Network

The Digestive Health Network will drive the development and facilitate the delivery of patient-centred, sustainable and effective clinical services for all those with digestive health conditions. It will forge effective and productive working relationships between a broader range of people and organisations. This will promote a more direct and holistic focus on priorities for patients and carers.

3.0 Digestive Health Network Stakeholders Workshop

Dr Andre Chong, Clinical Lead, members of the Executive Advisory Group and the Clinical Networks Support Unit held a half-day workshop to launch the Digestive Health Network. The purpose of the workshop was to provide an opportunity for stakeholders to shape the direction and priorities of the Network.

The workshop was held on 2nd February 2007 at the City West Function Centre from 1.00pm to 4.35pm.



This report is a summary of the workshop and includes the outcomes and information from the workshop activities.

3.1 Executive Advisory Group

The members of the Executive Advisory Group include:

Dr André Chong	Digestive Health Clinical Lead; Fremantle Hospital - Gastroenterology
Ms Samantha Boggs	Joondalup Health Campus - Dietetics
Dr Wendy Cheng	Royal Perth Hospital – Gastroenterology and Hepatology
Dr Hooi Ee	Sir Charles Gairdner Hospital - Gastroenterology
Professor David Fletcher	Fremantle Hospital/University of WA - Clinical Director of Surgery
Ms Iren Hunyadi	Consumer Representative
Dr Ian Lawrance	Fremantle Hospital / University of WA - Gastroenterology
Professor John Olynyk	Fremantle Hospital / University of WA – Gastroenterology and Hepatology
Ms Amanda McKnight	Sir Charles Gairdner Hospital - Nursing
WA Country Health Services (WACHS)	Dr John Lindsey – Albany physician
GP representative	To be engaged

3.2 Workshop Invitations and Attendance

Information about the workshop was circulated across the public health sector and to those that had formally registered their interest in the Digestive Health Network. More specifically, this included:

- statewide global email invitation sent to the public health sector;
- electronic and hard copy invitations to over 200 stakeholders; and
- release of the NetNews Health Network Newsletter, which contained workshop details. This was posted on the Clinical Networks website and the circulated to all acknowledged stakeholders and persons registered on the database.

More than 50 stakeholders attended the workshop, from a range of professional disciplines and organisations including gastroenterology, nursing, general practice, consumers, population health, nutrition and dietetics, Aboriginal health, patient support groups, research, academia, clinical governance, and non-government organisations.



3.3 Workshop Aim

To provide an opportunity for stakeholders in the area of digestive health to come together to discuss and contribute to the development of the Digestive Health Network and work priorities

3.4 Workshop Objectives

It was intended that by the completion of the workshop, participants would:

- Have provided input on the work priorities of the Digestive Health Network
- Have provided input on key measures of success for the Digestive Health Network
- Be more informed on the rationale behind the establishment of health networks and their contribution to health planning and service delivery

3.5 Workshop Approach

Dr Simon Towler, Executive Director, Health Policy and Clinical Reform, opened the workshop with a presentation of Health Networks in Western Australia. This included a definition of Health Networks and outline of network outcomes, targets and applications of health networks in other jurisdictions. Dr Andre Chong, Clinical Lead of the Digestive Health Network, then provided an overview of the aims of the Network, introduced members of the Executive Advisory Group and provided some introductory comments on digestive health priorities.

Following the presentations, a facilitated workshop session was conducted. Participants were split into working groups across 6 tables, with approximately 9 participants at each table with an officer from the Clinical Networks Support Unit acting as table facilitator. In addition, members of the Digestive Health Network Executive Advisory Group were allocated to separate table as table spokesperson. A mix of professional expertise and different organizations were also allocated to each table. Ms Karina Moore, Senior Development Officer, from the Clinical Network Support Unit provided overall workshop facilitation.

The workshop activities focused on the priorities and barriers in digestive healthcare:

- Activity 1a: **Brainstorm:** Tables were asked to identify the priorities for the Digestive Health Network.
- Activity 1b: **Top 3 priorities:** From the brainstorm list tables decide their top 3 priorities.
- Activity 1c: **Discuss/expand on top 3 priorities:** Table groups discussed and expanded on the top 3 priorities for their table, listing key points/issues against the following two major areas:
 - Prevention
 - Clinical care services
- Activity 2: **Table feedback.** Each table spokesperson briefly presented the top 3 priorities from the brainstorm to the room. Priorities were listed on whiteboard and projected.



- Activity 3: **Barriers to achieving top 3 priorities** – table groups discussed barriers to achieving priorities, listing barriers for each priority against the following two major areas:
 - Prevention
 - Clinical care services
- Activity 4: Individual Reflection: Participants individually considered and were asked to provide a written response to the following question: “What are **two** key measures that will indicate to you that the Digestive Health Network has been successful?”
- Activity 5: **Table feedback.** Each table spokesperson presented a summary of group discussion on priorities and barriers to the room.

4.0 Outcomes From The Workshop

The recorded responses from the table discussion are presented below. Where original material may have been written in note form, it has been reworded for readability.

4.1 Brainstorming priorities for the Digestive Health Network

The question considered by the group was “What are the priorities for the Digestive Health Network?”

Table 1.

Post Diagnosis Care

- Public Health/Paramedical services/Referral Process
 - GP
 - Dietetic educator and Counselling
 - Podiatry
 - Dietitian
 - Social worker
 - Pharmacist – home medicine review

IBS

- Bowel movements
- Stress
- Psychosocial/medical management
- Different treatment

Endoscope Services/Colonoscopy

1. Quality – Quality assurance
 - Prevention of colorectal cancer/diseases
2. Equipment
 - For diagnosis
 - Quality of scopes



3. Personnel

- Performance of procedures (Quality)
- Transparency of guidelines and ongoing credentialing

Hepatitis B & C

- Prevention and Education
- Management
- Prison
- Aboriginal Health
- Isolated nursing

Rural Health

Table 2.

- Access to services for Indigenous people
- Access to Hepatitis C treatment in all areas but especially rural areas
- Many people don't know where to go for particular digestive services
- Education – public and primary care providers e.g. pharmacies
- Lack of community dietetic services – many gaps in the services
- Education (Public) on risks for digestive health problems e.g. NAFLD, Colorectal cancer
- Access to preventative measure e.g. Vaccine for Hepatitis A & B
- Lack of positions in dietetic services
- Wait list for Endoscopic procedure – excessive waiting times in the public system
- Equitable access to treatment e.g. Bariatric surgery

Table 3.

- Communication – awareness issues – health professionals and community
- Access to services (Disability Services)
- Education
- Breakdown between tertiary and community
- Long wait lists
- Rural and remote – lack of services, PATS issues
- Inappropriate referrals
- Fatty Liver/hepatitis – Dietetics (prevention and early diagnosis)
- Nurse training/education
- CRC Screening issues – staffing, wait lists
- Focus on prevention for youth and Indigenous and access to treatments
- Data management



Table 4.

- Referral pathways relevant to outcome
- Quality data/access to data/central data
- Collaboration between networks
- Centralised service for digestive
- Screening pathway → diagnosis → treatment
- Management standard of patients
- Planning – utilise data
- Regional health
- Prevention/Diet
 - Gastro/Reflux disease/Coeliac
 - Education re diet in schools
 - Misinformation regarding food
 - Men's health access
 - Constipation
 - Obesity and related surgery

Table 5.

- Conditions
 - Coeliac
 - Hepatitis
 - Inflammatory bowel disease
 - Colonic Cancer
 - Liver Cancer
 - Irritable Bowel
- Access to services and equity – choice of referrals
 - Rural
 - Socioeconomic and Disadvantaged
 - GPs
- Workforce (medium and long term)
- Prevention
 - Individual
 - Within medical profession
 - Integrated services
 - Emotional
- Holistic care/multidisciplinary



Table 5 continued.

- GP Education/Awareness
 - No judgements/sensitivities
 - Prevention
 - Getting correct diagnosis
 - GP knowledge/awareness of appropriate treatments
 - Protocols/guidelines for individual conditions
 - Consistent information throughout the process, for patients explaining symptoms/treatments

Table 6.

- Education (GPs, patients, public, other staff, nurses, Drs)
- Minimisation of waste (primary, secondary and tertiary levels)
- Priorities, but some ideas/things miss out or funding
- Growing partnerships
- Integration/partnerships
- Public health
- Evidence based practice/Best practice applied
- Informatics – streamlining
- Integration/Breaking down barriers
- Health promotion
- Incorporation of NGOs - Protocols
- Standardisation (Models of care, IT, Care plans)
- Consumer information



4.2 Network Priorities

Tables identified the Top 3 priorities for the Digestive Health Network and presented these to the group via the table spokesperson. The major theme was education, followed by workforce, access issues, colorectal cancer screening, Viral Hepatitis, Post Diagnostic care and evidence based practice.

Table 1

Priority 1: Colorectal Cancer Screening
Priority 2: Hepatitis C
Priority 3: Post Diagnostic Care

Table 2

Priority 1: Access to Services – Indigenous, Rural and other disadvantaged groups EG: CALD and children
Priority 2: Education for the public and health service providers
Priority 3: Identification of areas of need for health service providers

Table 3

Priority 1: CRC Screening (Bowel Cancer)
Priority 2: Education
Priority 3: Viral Hepatitis

Table 4

Priority 1: Access and use of quality data to develop best practice guidelines/pathways
Priority 2: Education regarding diet. EG: Reflux, constipation, NAFLD, Obesity
Priority 3: Workforce/collaboration across the health system and networks

Table 5

Priority 1: Education and Training
Priority 2: Holistic/Multidisciplinary Care
Priority 3: Access /Equity to services

Table 6

Priority 1: Education – for medical and health staff and consumers
Priority 2: Integration/Partnerships
Priority 3: Evidence based practice



4.3 Expansion of Priority Areas (Activity 1c)

Each table developed and broke down their 3 top priorities into two categories; either prevention or clinical care services.

Priority 1:

Table 1. Colorectal Cancer Screening

Key Points and Issues	
Concerns for the current program	Guidelines - Inappropriate referrals
Referral process	Credentialing
State/Commonwealth - Blurred responsibilities - Funding problems	Equipment
Tender to standardise equipment	IT problems
Funding for replacement equipment	Results can not be transferred (hospital to hospital)
Politically motivated decision making	Health Dept integration of information – legal reasons???
Referral process – lack of clinical pathway	RURAL - Lack of health professionals - Dep in GPs - Accredited process makes it harder to gain access to specialists
Credentialing – re-accreditation procedures	
No IT program/support	

Table 2: Access to Services – Indigenous, Rural and Other Disadvantaged Groups e.g. CALD and children

Key Points and Issues	
Prevention	Clinical Care Services
Improving awareness	Availability of interpreter services especially out of hours
Appropriate message for health promotion	Transport for patients
Improved communication and collaboration	Provision of appropriate information
Targeting high risk groups e.g. injecting drug users	Availability of medical and ancillary services e.g. rural clinics



Table 3: Bowel Cancer Screening

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Education in Diet and Lifestyle for health care providers	Access to referral/procedures
Improving access to healthy diet	Self management of disease
Improving access to screening	Increase GP knowledge (appropriate referrals)
ID symptoms	Follow up processes – not relying on patients to do
Know how to access information	Decrease line of communication between hospitals and community
Resources	Discharge letters
Staff – rural and remote	IT incompatibility

Table 4: Access and use of quality data to develop best practice guidelines/pathways

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Access to demographic/disease load to plan Primary – Tertiary. Processing data	Access to meaningful clinical data – lots of data collected but not used/integrity issues/outcomes). Long term linkages – standardized approach to manage data.
Nutrition surveys/prospect in data	
Data linkages/software/definitions – who pays/ access issues?	
Support system, quality	

Table 5: Education and Training

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Professionals <ul style="list-style-type: none"> - Knowledge of sources of information - Appropriate testing - Multidisciplinary training 	Need for GPs and specialists skilled in treatment of Hepatitis
Consumer <ul style="list-style-type: none"> - General health promotion campaigns re healthy lifestyles - Understanding sources of information - General awareness campaigns around symptoms 	Attitudinal change
	Register of GPs using specialist interest



Table 6: Education – for medical and health staff and consumers

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Alcohol	GP education
Diet	Resource utilisation
Smoking	Training at schools, tertiary institutions
Exercise	Best practice guidelines
Obesity (Adult/Child)	Changing technology/continuous improvement
Entire continuum (Schools, public, hospitals)	Clinical practice guidelines for consumers and patients
GI Disease education	
Community awareness	
Advertising/Government regulations	

Priority 2:

Table 1: Hepatitis C

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Access to clean equipment (needles) – high risk groups e.g. Prisoners and Aboriginal Groups	Adequately trained GPs in shared care
Prison – Independent risk factor	IT support – transfer of patients into Liver clinic
Funding/trained staff	See Infectious Diseases Network
Difficult patients to deal with! – Nurse led care	“Prevention ISN’T SEXY!” Earlier decrease when times are tough
Willingness of GPs to get involved and be trained	Corporatisation of GP decrease time of consultations
Resource Issues – Rural and trained nurses (access of care)	
Holistic care through nurse practitioner – prescribing	
Attitudinal problems - Community - Health professionals Requires increased education and awareness	



Table 2: Education for the public and health service providers

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
More information through pharmacies and community facilities	Guidelines for referrals from GPs
Appropriate media communication	Referral pathway
Education in schools e.g. Hepatitis prevention, Obesity and NAFLD	

Table 3: Education

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
How to educate?? - Media - Cultural awareness	GPs
Mental health	Consumers/carers
Drug and alcohol	Allied Health
Patient: - Ownership of care - Empowerment - Guidance	Nursing etc

Table 4: Education regarding diet. EG: Reflux, constipation, NAFLD, Obesity

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Do it! Need (more) health promotion	Surgery on obese patients
More qualified people to give education – appropriate to culture e.g. children	Complications/risk
Influencing purchase of Health promotion/health education services – across health sector	Diet → disease
	Standard/surgery
	Anti obesity drugs/education

Table 5: Holistic/Multidisciplinary Care

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Professionals - Knowledge of/openness to other professionals to bring in - Development of clear holistic protocol - Development of multidisciplinary model of care - Clinical network system wide	Workforce provision
	Multidisciplinary training



Table 6: Integration/Partnerships

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
NGO's – WA Aids Council	Commonwealth /State
Primary care / GPs	Public/Private – public system, limited resources
Engagement of all relevant parties (consultants etc)	Viral hepatitis
Raise awareness	Information sharing – timelines
NGO – people not accessing standard health streams therefore need appropriate information	

Priority 3:

Table 1: Post Diagnostic Care

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Funding	Paramedical services
Staff	Staff training
Collaboration between health professionals	Specialist clinic
Limitation of staff – Need increase FTE (Metro and Rural)	CDM Team
Clinical pathways - Guidelines to follow - Assessment of	Digestive health team
Resources – best practice based pamphlets, video, dvd, educators	
Counselling services – patient or carer or family	
Annual health check	
Access to self help groups EG: Colios Society	

Table 2: Identification of areas of need for health service providers

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Survey areas of need (geographical need)	Lack of home visit services by health professionals
Identification of Gaps	Lack of nurses
	Identification of gaps in services



Table 3: Viral Hepatitis

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Enhancement of needle and syringe programs	Access to treatment especially indigenous population
Increase/expansion of above	Support and treatment rural and remote areas
Awareness of risk factors	Linking tertiary and community, support groups
State-wide awareness campaign → prevention	ADA partnerships and mental health
Self management	
Support groups	

Table 4. Workforce/collaboration across the health system and networks

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Communication across sectors	No's/measurement of performance – credentialed/accreditation
Need competent workforce. Retain recruit etc e.g. Colonoscopy	Measure of the standard. Greater acceptance of multidisciplinary teams
Expand specialties – professional ownership	Need time to be a team. Specialized units

Table 5: Access /Equity to services

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Availability/Access to multidisciplinary workforce in rural locations – Improving access	Use of enhanced PC resources

Table 6: Evidence based practice

Key Points and Issues	
<i>Prevention</i>	<i>Clinical Care Services</i>
Research based	Multidisciplinary health and consumer teams - Development - Application
Screening programs	
Continuity of community	
Consistent sustained support	
Sustainability	
Remove politics	
Bipartisan buy in	



4.4 Barriers to achieving top 3 priorities (Activity 3)

Barriers to achieving the top 3 priorities, with a focus on prevention and clinical care, were discussed by the table groups.

Priority 1:

Table 1. Colorectal Cancer Screening

Political decision making	Information dissemination
Blurred state/commonwealth responsibility and funding	Sharing information
Patient referral – lack clinical pathway	Dependant on Gastroenterologist access
Re credentialing	
Equipment – replacement funding	
IT support – state-wide refunding	
Rural – lack of specialist services	

Table 2: Access to Services – Indigenous, Rural and Other Disadvantaged Groups e.g. CALD and children

Prevention	Clinical Care Services
Language	Language
Culture	Culture
Remoteness	Remoteness
Workforce – retention	Not enough recognition
Workforce – lack of incentives for health care professionals to work in rural and remote areas	Cooperation and collaboration between different health service providers
	Resources

Table 3: Bowel Cancer Screening

Prevention	Clinical Care Services
Access	Decrease specialist services – rural and remote – have to come to Perth (cultural barriers)
- Social determinants	Skilled workforces need training
- Professionals	Resources both funding and workforce
- Support groups	
- Transport	
- Language	
Style of communication	Interstate partnerships e.g. Darwin with Perth
Cultural issues	“Silo System” between professionals
	Physical constraints on existing services



Table 4: Access and use of quality data to develop best practice guidelines/pathways

Prevention	Clinical Care Services
Measuring outcomes difficult due to lack of access and quality (retrospective) data	Lack of decision – support systems. General practice – decision support needed on pathway and referral practice
Money	Existing support not relevant. e.g. hospital system/outdated/inaccurate/not validated. Commonwealth to State.
	Language. Bureaucracy
	Audit needs to speak same language. Integrated a line medical support

Table 5: Education and Training

Prevention	Clinical Care Services
Engaging professionals/consumers in the information campaign	Time/workload/Funding
Time/ workload	Length of training
Funding to employ workforce	Development of a multidisciplinary protocol
Breaking down professional “Barriers IE: Between GPs	
Openness to change	
Continuity of message	
Ongoing support to patient to continue their self management/treatment	
Need to recognise importance of non clinical professions	
Multidisciplinary training	

Table 6: Education – for medical and health staff and consumers

Prevention	Clinical Care Services
Not glamorous	Workforce training issues
Low profile of this area	System resistance
Language/cultural barrier	Funding and resources scarce
Priorities of consumer → Hep C vs HIV	Respect
Government priorities need to be well researched and appropriate	Cultural shift
	Lack of involvement of junior staff



Priority 2:

Table 1: Hepatitis C

Shared care – nurse practitioners	IT Support – information transfer
High risk populations – prison/Aboriginal - harm reduction Attitude of community and health professionals	GP Willingness to take on access IUOU
Resources – training staff	

Table 2: Education for the public and health service providers

Prevention	Clinical Care Services
Impact of media messages on unhealthy lifestyles – especially children	Funding for workforce training and resources
Current health messages are not reaching target groups especially pre schoolers and the elderly	Inadequate staffing especially nurses
	Staff shortages
	Prevent staff education and development (not enough staff for backfilling)

Table 3: Education

Prevention	Clinical Care Services
Lack of empowerment by patient	To busy
Auditing effectiveness/lack of?	Lack of interest
Don't question information given - Generational - Intimidation - Cultural acceptance	Lack of resources - Interpreters - Appropriately skilled educators
Accommodating intellectual capacity - Providing appropriate education - Targeted and shaped to age, language etc	Funding cycles → money dries up before work is completed
“One size doesn't fit all”	Recruitment and retention (Housing, bonuses)
Needs to start early	Transient workforce especially rural and remote



Table 4: Education regarding diet. e.g. Reflux, constipation, NAFLD, Obesity

Prevention	Clinical Care Services
Measurement of outcomes – take time to prove – need time and money. Lack of education for some specialties. Socioeconomic issues for people	Seen as boring/based/ EG: advertising
Making health promotion as part of everyone’s role. Education needs to be integrated. Engagement of media – get media to support	Whose priority – competency priorities/hospital beds vs prevention programs

Table 5: Holistic/Multidisciplinary Care

Prevention	Clinical Care Services
Breaking down barriers	

Table 6: Integration/Partnerships

Prevention	Clinical Care Services
Competing for resources	Private/Public – competition (economic interests)
Protectionism	Privacy issues (data issues)
Conflict between sectors	Lack of enabling mechanisms
Lack of consultation	
Loss site of greater goal	

Priority 3:

Table 1: Post Diagnostic Care

Staff – integrated services	Communication → awareness – video/pamphlets
Self management – education and responsibility	Clinical pathway – auditor
Access – rural GP – Physio/OT/Dietician/Counselling	

Table 2: Identification of areas of need for health service providers

Prevention	Clinical Care Services
	Apathy
	Poor response to surveys



Table 3: Viral Hepatitis

Prevention	Clinical Care Services
Competing health agendas → many health issues and lack of knowledge → risk behaviours	Access to treatment – wellness issues
Morality re needle and syringe programs	Rural and remote access especially difficult
Entrenched discrimination against IVDU	
Lack of needle and syringe services in prison (Lack of acknowledgement of the problem)	

Table 4: Workforce/collaboration across the health system and networks

Prevention	Clinical Care Services
Professional ownership/turf issues, Translation	Recruitment problems – getting and keeping staff - Retention
Assumption on roles. Failure of multidisciplinary team	Lack of communication
Need surgery training. Expansion of medical student numbers who's paying to team them	Need credentialing – develop standard
	Private/public sector issues and remuneration issues/incentives

Table 5: Access /Equity to services

No breakdown

Table 6: Evidence based practice

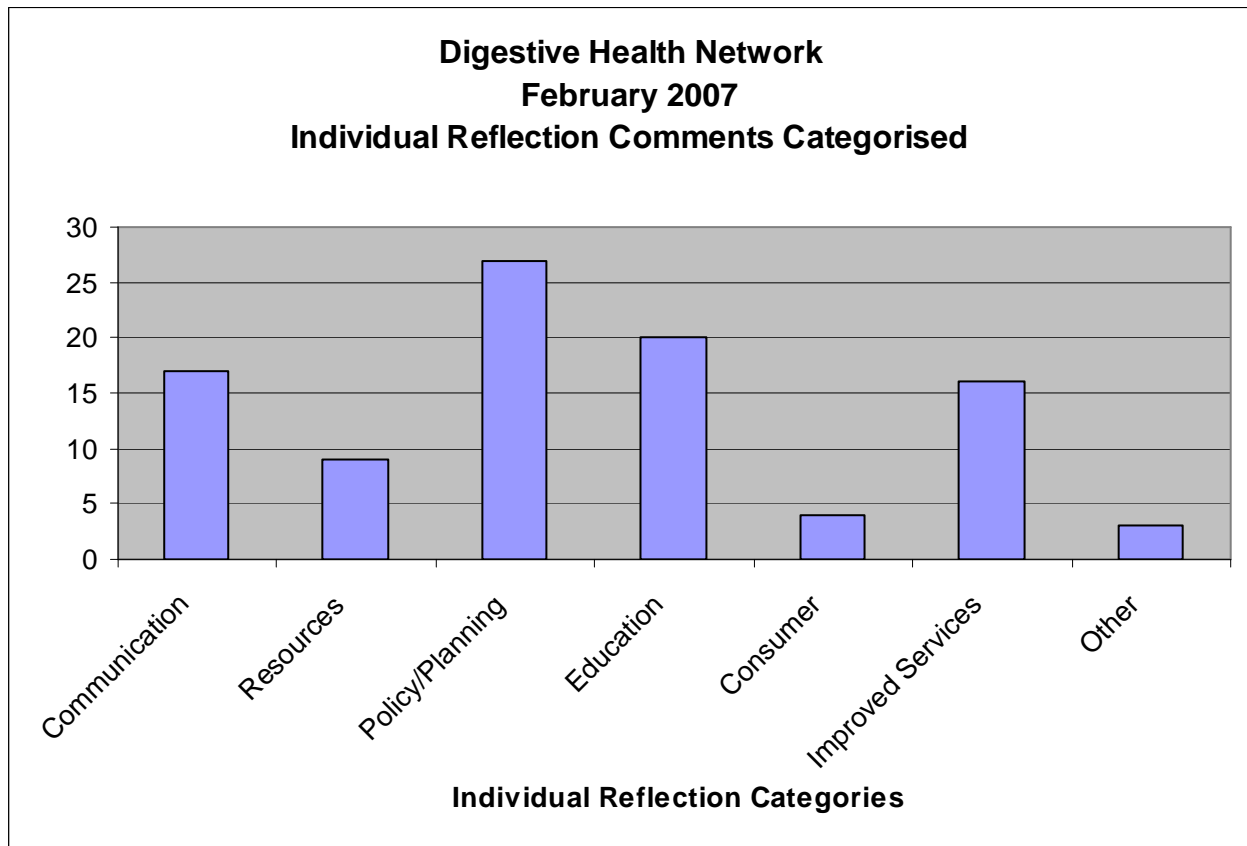
Prevention	Clinical Care Services
Dissemination of information	"Turf wars"
Lack of agreement	Personal preferences rather than evidence
Relevant research (ie local/Aust) is not funded	May have research and policy but no recurrent funding for implementation
	Lack of planning/needs assessment for research



4.5 Activity 4: Individual Reflection

Participants were to consider the following question: “What are **two** key measures that will indicate to you that the Digestive Health Network has been successful?”

This question yielded a wide range of written responses that indicated their vision for the Digestive Health Network and its potential. These were grouped under the following broad headings and some responses, identifying the background of the responder are provided below:



1. Communication.

“Increased communication (about activities related to digestive health in WA) between HEALTH sectors - NGO 1st, Community 2nd, Hospitals 3rd; between PRIVATE/PUBLIC; between disciplines within health leading to increase awareness of what others are doing as a step towards standardisation of practice. Increase debate - Ongoing work towards outcomes.” - Dietitian

“Information access to all health care providers for consistent management of health issues.”
Representative - Nurse Manager

“Open communication and cooperation between gastroenterological surgery and physicians, in Endoscope training and establishment of pathways and shared management where appropriate” - Endoscopist and Trainer



2. Resources.

“Acceptance of need for resources to progress some, if not all the priorities. Pathways across rural and metro great idea.” – not identified

“Ability to identify appropriate providers from stakeholders and implementation of solutions suggested” - Clinician

“Allocation of resources to achieve better outcomes in the most cost effective manner and publications of these values” – General Practitioner

3. Policy and Planning.

“Standardised best practice guidelines are developed and implemented across the state. Supported by appropriate policy” – Health Professional (Policy)

“Percentage of those screened needing ongoing therapy reduces over time - this will measure long term success of Health and Healthy lifestyle promotion programs/activities” – Office of Aboriginal Health

“That the major issues will have agreed protocols and pathways (Primary to Tertiary and outcomes) established across multiple integrated sites” – Gastroenterologist Surgeon/Academic

4. Education.

“Changes to tertiary training courses preparing practitioners for collaborative treatment - number of referrals from medical practitioners to allied health practitioners and multidisciplinary teams” - Behavioural Medicine/Clinical Psychologist

“Local awareness through education, access to support groups and in home care is markedly improved” – Community Nurse (Silver Chain)

“Awareness raising (instead of “education”). GPs explain to patient the consequences of a particular behaviour and if the patient is agreeable discuss a “care plan” to reduce or minimise harm from a particular risky behaviour e.g. IV use and Hepatitis” - Consumer

5. Consumer.

“Streamlined medical services with consumer involvement and empowerment. I.e: Consumers will receive care plans once diagnosed with a lifelong disease and know they are receiving consistent and up to date care” - Consumer

“Consumer satisfaction feedback” – Non Government Organisation

“Seeing an improvement in the next generations health - this will obviously take 10-15 years” – WA Coordinator for the Irritable Bowel Support Assoc.



6. Improved Services.

“Ability to access quality data at other hospital sites, to enable patients to continue their treatment/consultation in a timely manner” – Clinical Nurse, Endoscopy

“That all of the Western Australian population will be offered screening colonoscopy at age 50 years” – Private Hospital Administrator

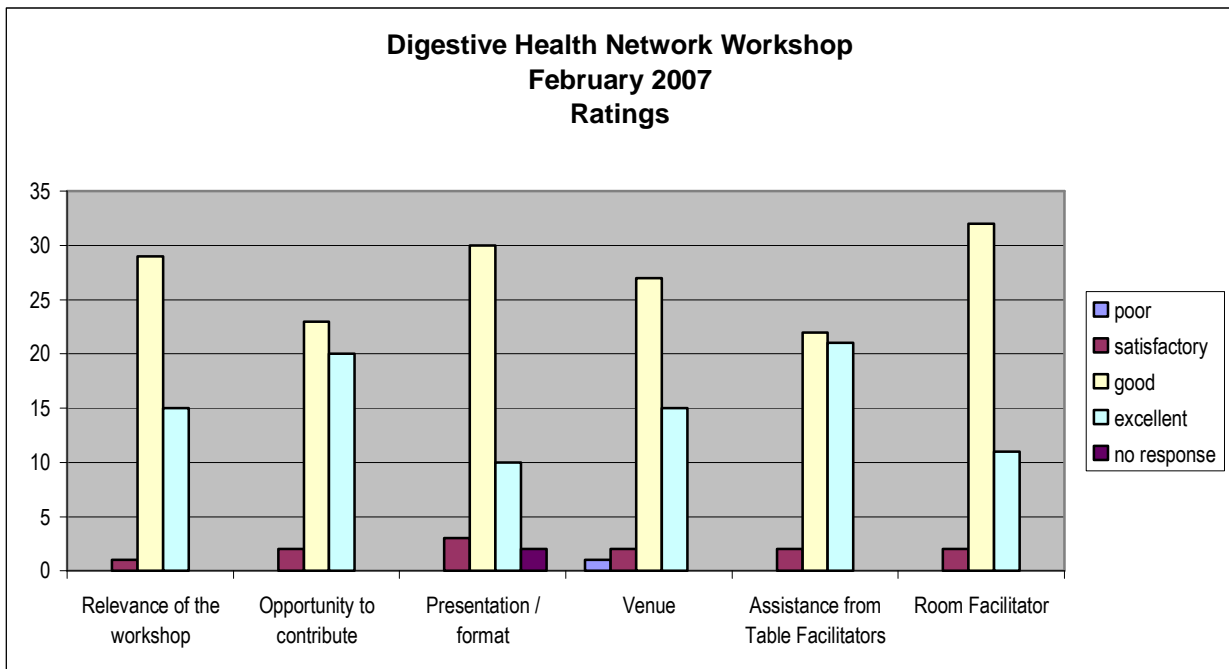
“Improved access to Hepatitis C treatment services in general, but in particular for those in rural areas, Aboriginal people and people from CALD backgrounds” – Policy Officer

7. Other.

“The discussions that took place were totally interesting” – GP

5.0 Evaluation of Workshop

Participants were asked to complete an evaluation form on the workshop. This included the provision a single word or short phrase to summarise their experience in the workshop as well as rating various program and organisational aspects. Overall the responses were very positive and optimistic.





Word and phrase responses included:

- Very professional, great learning curve
- Good collaborative and consultative process
- Worthwhile
- A great start
- Promising
- Good
- Interesting, useful and educational
- Enlightening
- Metro centric
- Inclusive
- The brainstorming activity is very valuable for all to contribute information and ideas
- Informative
- Encouraging
- Optimistic
- Thought provoking
- Well done
- Excellent
- Constructive and productive

Where to from here?

The next stage in establishing the Digestive Health Network will be the recruitment of members to various working groups to further develop priority areas. The groups will be responsible for projects within digestive health care.

The information coming out of the major stakeholders workshop will be considered a key resource in informing the Digestive Health Network Executive Advisory Group and in the establishment of working groups.

Contact

To provide comment on this report and for all queries relating to the Digestive Health Network please contact the Clinical Networks Support Unit:

Postal Address:

PO Box 8172
Perth Business Centre
PERTH WA 6849

Phone: (08) 9489 2800

Fax: (08) 9489 2833

Email: HealthPolicy@health.wa.gov.au

Website: www.clinicalnetworks.health.wa.gov.au