

Endocrine Health Network Stakeholders Forum

5 December 2006

Forum Report

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



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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 August 2006, Dr Neale Fong, Director General, announced Dr David Hurley as the Clinical Lead for the Endocrine Health Network. On 5 December 2006 Dr Hurley and the Clinical Networks Support Unit held a Stakeholder Forum to provide an opportunity for key stakeholders to discuss the priorities of the Network.

The information gathered from the Stakeholder Forum is documented in this report.

The workshop report will be considered a key resource in informing the objectives and workplan of the Endocrine Health Network Executive Advisory Group, who are responsible for addressing identified network priorities.



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 Endocrine Health Network

The Endocrine Health Network will drive the development and facilitate the delivery of sustainable and effective prevention programs and clinical services relating to endocrine conditions. It will also forge effective and productive partnerships between a broader range of people and organisations that will promote a coordinated approach across the continuum of care.

The Endocrine Health Network will focus on the following primary conditions

- Type 2 diabetes
- Type 1 diabetes;
- Gestational diabetes;
- Osteoporosis; and
- General Endocrinology

3.0 Endocrine Health Stakeholders Forum

Dr David Hurley and the Clinical Networks Support Unit held a three-hour Stakeholder Forum on 5 December 2006 at the City West Function Centre, West Perth.

The purpose of the Stakeholder Forum was to provide an opportunity for stakeholders to discuss the priorities of the Network and to also unofficially launch the network.

This report is a summary of the Forum and includes the outcomes and information from the Forum discussion and associated activities.



3.1 Forum Invitations and Attendance

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

- State-wide global email invitation sent to the public health sector;
- Electronic and hard copy invitations to 270 stakeholders and others registered on the Endocrine Clinical Networks database; and
- Coverage in the Clinical Networks Newsletter *Netnews*, which contained workshop details and registration information.

More than 50 stakeholders attended the workshop from various sectors and disciplines including: endocrinology and diabetes, nephrology, physiotherapy, telehealth, primary care, consumers, population health, health promotion/physical activity, Pharmaceutical Council, podiatry, country health services, non-government organisations, nursing, geriatrics, cardiology, chronic disease management teams, diabetes education, Aboriginal health, Aboriginal advocacy, child health, Commonwealth Department of Health and Ageing, research, oral health, epidemiology, critical care, academia, general practice, nursing, dietetics, clinical governance, information technology, and non-government organizations.

3.2 Forum Aim

The aim of the Forum was to bring key stakeholders together to discuss and contribute to the development of the priorities for the Endocrine Health Network.

3.3 Forum Objectives

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

- have a greater understanding of clinical/health networks and the aims and objectives of the Endocrine Health Network;
- define some measures that will indicate that the Endocrine Health Network has been successful;
- have an opportunity to discuss and consider priorities and barriers for the delivery of effective endocrine prevention activities and clinical services; and
- have an understanding of the future directions of the Endocrine Network.



3.4 Forum Program

Ms Kylie Mayo, A/Director, Clinical Network Development Unit, provided an opening presentation on Health Networks in Western Australia. This included a definition of health networks, an outline of network outcomes, and applications of clinical networks in other Australian jurisdictions. Following this, Dr David Hurley provided an overview of the aims, focus areas, scope and some key questions to be addressed by the network.

Following the presentations, a facilitated table group workshop session was conducted. Participants were seated across 7 tables, with approximately 8 - 10 participants at each table. Officers from the Clinical Networks Support Unit acted as table facilitators. Ms Marea Gent, Senior Development Officer from the Clinical Networks Support Unit, was responsible for overall room facilitation.

The table group session was divided into two components:

1. *Individual Reflection*: Participants considered the following question: "What are two measures that will indicate to you that the Endocrine Health Network has been successful?"
2. *Table group discussion questions*: The Forum discussion questions focused on the priorities and barriers relating to endocrine and diabetes prevention activities and health care services.

4.0 Outcomes From the Table Discussion

The information is presented below. Where original material may have been documented in note form, it has been reworded for readability.



4.1 Individual Reflection

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

This question yielded a wide range of the responses that indicated their vision for the Network and its potential. These were collated and grouped under the following broad headings and some responses are provided below:

1. Improved integration and coordination of diabetes and endocrine service providers.

“Coordinated/integrated approach to community diabetes services with single point of referral.”

“Coordination of diabetes services between acute hospital, community, GP with defined processes for follow up referral and feedback.”

“Achieve better integration of service providers of community based diabetes education/Allied Health initiatives in diabetes care.”

“Integrated service, primary to tertiary including prevention => optimum management of clinical pathways regarding access/equity/prioritization.”

“Clear plan/strategy across the various health services for endocrine services for the future, enabling seamless integration between the community and secondary and tertiary services.”

“ Development of a coherent multidisciplinary, coordinated whole of state approach to the prevention, diagnosis and management of the major endocrine disorders that is evidence based and integrates a strong backbone of research behaviour”

2. Reduction or slowing of the incidence of obesity, diabetes and its complications.

“A reduction of diabetes over a realistic period of time, especially for the Indigenous population of Western Australia.”

“Reduction in the incidence of diabetes and obesity.”

“Reduced rate of diabetes and complications.”

“Reduced morbidity and mortality from endocrine disorders, especially diabetes”



3. Increased health promotion/prevention programs including risk reduction within Aboriginal communities

“Public aware of early intervention and prevention methods they should be considering in their personal lives.”

“There will be more awareness of obesity and diabetes in the community resulting in our patients/clients/consumers increasing their daily exercise routine and a more healthy way of eating.”

“Increased health promotion/prevention programs and awareness within Aboriginal communities regarding the importance of nutrition and exercise (healthy lifestyles)”

“Increase in dieticians, nutritionists, accessing Aboriginal communities, liaising with community stores etc”

“Public awareness of preventative measures which are both successful and accepted by the majority of people with the problem.”

4. Health workforce training and role of Allied Health services providers

“Comprehensive coverage of training of the health workforce, includes primary health care through to tertiary healthcare, about prevention, diagnosis and treatment of all types of diabetes.”

“Increase the proportion of subjects with diabetes accessing diabetes Allied Health services in a timely manner.”

“Initiation of research that demonstrates the effectiveness, or otherwise, of Allied Health practitioners in health care outcome measures.”

“Increase in dieticians, nutritionists, accessing Aboriginal communities, liaising with the community stores etc.”

5. Policy development

“An effective forward policy with good resourcing has been developed.”

“This policy has been developed with input from all the major stakeholders.”

“Equal contribution to Network policy from prevention, detection and clinical areas.”



4.2 Discussion Questions – top three responses for each table group

Question 1: What are the priorities for improving current endocrine and diabetes PREVENTION programs and activities?

Table 1

1. Culturally appropriate Education materials and programs addressing healthy eating, physical activity, weight, diabetes awareness with emphasis on high risk groups eg: Aboriginal, Immigrant
2. Accessible web-based data-base of programs, protocols, outcomes measures etc
3. Protocols for screening for Vitamin D deficiency and supplementation

Table 2:

1. Primary prevention of type 2 DM
 - Identify existing programs
 - Consider current evidence based for point of intervention and/or specific sub groups
 - Assess cost effectiveness of current programs and prospective programs
2. Primary prevention of osteoporosis – expand current programs
3. Primary prevention of Type 1 DM – encourage active research

Table 3:

1. Funding
 - reduce duplication
 - maximise limited resources
 - work together (not territorial mindset)
 - use best practice
2. Community involvement and engagement
 - Next generation
 - At risk groups
 - How to deliver and tailor programs to each group (not one size fits all)
3. Linkages/Style of delivery
 - Knowing what is already out there
 - Integration (holistic integrated approach with multi disciplinary teams to identify and address risk factors)

Table 4: (Diabetes)

1. Targeting with evidence based programs for children and families in the area of healthy lifestyle.
2. Targeting high risk groups especially ATSI
3. Addressing community cultural issues to enable individual self management

Table 5:

1. DoH, DoE, Local community – collaboration on early prevention at school level – physical education daily/exercise programs, healthy food choices education.



2. Availability and cost for better access to exercise programs – “working age”, “elderly”.
3. Single point of contact to access availability/local services – IT, resources, phone, Advertisement.

Table 6:

1. Healthy food choices offered in Indigenous communities
2. P/N Diabetes in pregnancy – family education commencement of lifestyle issues to decrease Type 2 diabetes or improve management of pre-existing.
3. Access to education on a local level rather than travel to Perth

Table 7:

1. Government – commitment to policy, resourcing, regulation, legislation and infrastructure to support healthy active lifestyles.
2. Strategies to help people assess risk and make informed easy choices about reducing risk.
3. Strategies that address development of personal skills in nutrition, personal activity, weight management and disease management available both in the diagnosed and undiagnosed.

Question 2: What are the priorities for improving current endocrine and diabetes HEALTH CARE SERVICES?

Table 1:

1. Upskilling and capacity building of workforce (GPs, Diabetes Educators) in Type 2 and gestational diabetes particularly in regions including workforce communications, information sharing and mentoring.
2. Better use of IT for self-management e.g. telephones, electronic media
3. Screening guidelines and protocols.

Table 2:

1. Examine current workforce and roles to improve integrations (T2 and Osteoporosis)
2. Address management of inpatients with diabetes as a co morbidity.
3. Transition in T, diabetes.
4. Empower patients

Table 3:

1. Funding/Funding/Funding
2. Audit current services
 - identify gaps
 - understand what already exists, who is delivering
 - access and uptake of services (services out in the community and not run by tertiary hospitals)
3. Best practice
 - understanding best practice (journey of care)



- need to ask/survey the consumer
4. The right people at the right place
 - addressing true relevant community needs
 - social determinants (holistic health care)
 - workplace development through mentoring, experience, allocate/identify champions
 5. Allow opportunistic advice by HP

Table 4:

1. Establish and implement clinical guidelines spanning continuum of care enabling multidisciplinary care.
2. Equitable access to services especially rural and remote
3. Appropriate community care

Table 5:

1. Identify gaps in existing service
 - what is currently available?
 - where are they?
 - what do they offer?
2. Multidisciplinary teams
 - working from newly diagnosed – death within the community
 - remote and rural teams
3. Integration of services from community - tertiary - community

Table 6:

1. Medication supply
 - legislation for remote areas
 - nurse practitioners
 - pharmacist access
 - education: tracking dispensed
2. PATS
 - access to services
 - inequality
 - cultural
3. Cultural security
 - environment of health services
 - workforce
 - activities

Table 7:

1. Increase essential service resourcing so more on the ground staff to work within self-management and disease management models
2. Better access to these services by decreasing barriers for GPs to refer to self-management services
3. Increase communication of these services to GPs and other providers.



Question 3a – What are the top 3 barriers to implementing PREVENTION priorities?

Table 1:

1. Lack of culturally appropriate workforce, programs and resources
2. Lack of evidence
3. Lack of a coordinated approach and long-term funding and commitment

Table 2:

1. Lack of knowledge/evidence/difficulty in disseminating evidence
 - Research
2. Paternalistic attitude plus lack of system to support self-management/resources.
3. Inability to access long-term efficiency of interventions.
4. Difficulty of implementing lifestyle interventions.

Table 3:

1. Funding – cycle vs sustainability
2. Cultural shift
 - Engage mass media in a positive way
 - Mind set of community attitudes of wellness vs sickness/apathy
 - Recognise one size doesn't fit all
 - Patient focus vs institutional/department focus
 - Community education on risk for 18-24 yrs, school and younger
 - Weight reduction vs exercise
3. Territorialism (linkages)
 - Lack of communication
 - Reduce duplication
 - Stop fighting for the funding

Table 4:

1. Lack of human and financial resources at community level especially rural and remote.
2. Lack of evidence
3. Lack of political commitment.

Table 5:

1. Funding; power → who controls decision making: Government department/communication
2. Cultural barrier/access

Table 6:

1. Internal motivation
 - Sense of worth
 - Provide opportunities
2. Workforce issues
 - Access



- Availability
 - Communication
 - Non-health professionals e.g. teachers, store managers, lifesavers.
3. Funding sources
 - Time frame
 - Conflict (Commonwealth – State)

Table 7:

1. Lack of ownership and responsibility
2. Funding and resources (long term)
3. Unwillingness to take a long-term planning cycle and commitment

Question 3b – What are the top 3 barriers to implementing HEALTH CARE SERVICE priorities?

Table 1:

1. Poor IT, database and agreement on requirements
2. Lack of skilled workforce – multidisciplinary teams
3. Distance

Table 2:

1. Workforce
2. Resources
 - Integration
 - Efficiency
 - Accountability
3. Training
4. Structures/Cultural/Location/Information → barriers to integrated services (e.g. between hospitals, GP – Hospitals, hospitals – community/consumers.)
5. Research application, evidence base application.

Table 3:

1. Funding
 - Sustainable
 - Cost of services to patient
 - Lack of funding for independent research for better treatment/services
2. Access
 - Lack of knowledge of services who/where available
 - Transport
 - No provision of information to carer
 - Location of services (currently in tertiary hospitals; not in the community where needed.)
 - Patient involvement focussed services.



3. Workforce
 - No clearly defined career path
 - No structural support
 - Getting the right people to where they are needed

Table 4:

1. Lack of human and financial resources
2. Lack of consensus among clinicians and failure to accept alternative service providers and models of care
3. Multiple funders of health care

Table 5:

1. Communication
 - Current services
 - Gaps in service
2. Workforce
 - Funding
3. Resistance to change/inappropriate use of services

Table 6:

1. Access to service
 - Travel/PATS
 - Accommodation (Metro.)
 - Unable to bring partners/ support person
 - Local and Metro.
 - Availability of HP's/AHW's
2. Medication → legislative change
3. Models of Care
 - Cultural issues
 - Communication (Primary → Tertiary)

Table 7:

1. Time taken to train and recruit workforce
2. Dual funded health care system
3. GP practice oriented around occasions of service rather than outcomes (increased red tape)



5.0 Word or Phrase to Summarise the Workshop

As a part of the evaluation, participants were asked to provide a single word or short phrase to summarise their experience in the workshop. Overall the responses were positive.

Some responses included:

- Positive mindset from all
- Communication between professionals
- Great opportunity to contribute to WA Health
- Learning experience
- Discussed useful issues
- Interactive
- Interesting
- Shared vision
- Good participation and input
- Valuable
- Much needed workshop
- More questions raised than answers provided
- Informative and comprehensive
- Talkfest – format certainly allowed maximum participation.
- Well organised
- I hope things change before I get diabetes or other chronic conditions.



6.0 Where to from here?

The responses from the Endocrine Health Network Stakeholders Forum will be collated by the Clinical Network Support Unit and used by the Network Executive Advisory Group to determine the top priorities for action. A number of working groups will be formed to develop detailed plans for each priority area. Wherever possible, plans will be implemented directly using existing resources. Proposals requiring higher-level support will be presented as recommended policy to the State Health Executive Forum.

Development of strong partnerships between general practice, community services, non-government organisations, consumer groups, medical specialists, general hospitals and tertiary hospitals will be critical for success in each priority area. Wherever possible, efforts will focus on building upon models of care which are already working well in general practice, developing flexible, 'joined up' solutions which optimise 'the patient journey'.

Communication, information technology support and e-health will be essential components of most plans. In many cases, it will be necessary to develop innovative WA solutions in the absence of national systems. Obtaining accurate baseline information and establishing relevant and useful performance indicators will be early priorities.

Contact

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

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