CENTRAL COAST LOCAL HEALTH DISTRICT: Acute Care Mental Health Services External Review

September 2023

EXECUTIVE SUMMARY

Referral/Intake/Triage/Allocation Processes

All mental health services are experiencing challenges in meeting demand, whether it is due to increased numbers or complexity of referrals, staff recruitment and retention challenges, or a lack of private sector or community-based treatment alternatives. Important principles when addressing these challenges include ensuring that priority is given to those most in need, minimising the number of transfers of care for any consumer, and ensuring consumers receive timely access to the most appropriate specialist care available. It is also important to ensure an equitable distribution of workloads across all teams, and to ensure that Community Mental Health (CMH) teams work collaboratively and always in the best interests of consumers.

The intake/triage/allocation process in Central Coast Local Health District (CCLHD) places an unreasonable burden on the Acute Care Teams (ACT) to hold and manage all referrals. This provides a lower standard of care to those consumers who were referred to other teams and undermines the effectiveness of the ACT model of care.

It should be noted that Community Mental Health Acute Care Teams provide a specialist service and have been shown to play a vital role in reducing suicide risk, and in suicide prevention. The changes recommended will allow the Acute Care Team to focus on their core business.

Recommendation 1

Revise referral/intake/triage processes for all community mental health teams, (Acute Care, Continuing Care, Assertive Outreach, Child and Adolescent, and Older Persons) so that all referrals are assigned to the appropriate team from the outset and all clinical handovers occur with the clinical teams responsible for their care.

Recommendation 2

Cease the use of the workload tool by the Acute Care Team and caps on caseloads by the Continuing Care Team, and engage teams and managers in a consumer-centred process of prioritising and managing demand individually for each team.

Recommendation 3

Review the Position Description of the patient flow coordinator position, inclusive of but not limited to reallocating the responsibility for clinical handover between teams back to the clinicians directly involved in a patient's care.

Team-based Clinical Governance Resources and Processes

The existing team-based discussions and meetings allow insufficient time for in-depth case-based discussions, and there is no opportunity for joint meetings that include all CMH teams.

There has been a loss of community-based CNC positions, and a reduction in hours for the CNE, currently vacant for a number of months.

Both teams have been making efforts to tailor the discussion at handover meetings to those consumers most in need, but the time pressure greatly reduces opportunity for meaningful discussion of challenging cases

Recommendation 4

Review existing mental health nursing leadership structure to ensure recruitment to Clinical Nurse Educator and reintroduction of Community Mental Health Clinical Nurse Consultant 3. Consider opportunities to share training and education across the mental health service more equitably.

Recommendation 5

Implement a professional development education and training program to support existing and newly appointed mental health staff.

Recommendation 6

Review the coverage and accountability of the medical staffing (junior and senior) to the acute care teams, and build more reliable multidisciplinary case review processes.

Recommendation 7

Introduce a 'Safety Huddle' to allow discussion of challenging or contentious referrals as per the Central Coast Local Health District Nursing and Midwifery Standards of Practice Framework.

Recommendation 8

Introduce dynamic management of the agenda for handover meetings to allow opportunity for discussion of new or challenging cases, and ensure alternative opportunities for case review/supervision.

Recommendation 9

Reinstate Morbidity and Mortality meetings in accordance with the District Morbidity and Mortality Memo February 2023 and M&M toolkit.

Safety and Quality Resources and Processes

There are potential benefits to the mental health service if the Mental Health Patient Safety Team become integrated with the broader clinical governance structures as part of the district wide Clinical Governance and Patient Safety Team. These include: enhanced governance processes; access to a greater pool of independent expertise; the ability to apply improvement science from a broader perspective, and facilitated participation in education and communities of practice directly related to clinical governance.

Recommendation 10

Integrate the Mental Health Quality and Safety Team with the District Clinical Governance Team to ensure a centralised governance model, shared learning, and responsibilities for mental health governance inclusive of incident management, risk management, complaints handling, policy and procedure development, and accreditation.

Recommendation 11

Review policy and procedure development and implementation processes in line with the Central Coast Local Health District Corporate Governance Policy and Procedure Development processes and the Nursing and Midwifery Standards of Practice Framework

ORGANISATIONAL STRUCTURE

There is at times minimal interaction between each of the community based streams leading to relatively isolated function at a team level. Each stream has their own senior manager reporting directly to the MH Director which minimises discussion and collaboration across the Community Mental Health Teams and creates a disconnect between clinical teams leading to a loss of a consumer-centred care.

To achieve a more flexible collaborative environment there is a need to reassess the organisational structure, ensuring it supports the strategic goals of the organisation and promotes flexibility and interdisciplinary collaboration across the Community Mental Health service as a whole.

Recommendation 12

Review the Mental Health organisation structure to address the isolation and siloing of community mental health teams.

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ACROYNMS

ACT – Acute Care Team

AOD – Alcohol and Other Drugs

CAMHS – Child and Adolescent Mental Health Service

CCLHD – Central Coast Local Health District

CCLHD MHS – Central Coast Mental Health Service

CCT – Continuing Care Team

CMH- Community Mental Health

CMO – Community Managed Organisation

CNC – Clinical Nurse Consultant

CNE – Clinical Nurse Educator

CTO – Community Treatment Order

FTE – Full Time Employee

GACT – Gosford Acute Care Team

GP – General Practitioner

IIMS- Incident Information Management System

LHD- Local Health District

LHD CGU- Local Health District Clinical Governance Unit

M&M – Mortality and Morbidity

MH- Mental Health

MH Q&S- Mental Health Quality and Safety

MNCLHD- Mid North Coast Local Health District

NSW – New South Wales

OPMHS – Older People's Mental Health Services

PACER – Police, Ambulance, Clinical, Early Response

SAER – Serious Adverse Event Review

SAFEGUARDS – Safeguards Teams are dedicated child and adolescent mental health services designed to provide care to young people aged 0-17 years experiencing acute mental distress, and their support network.

SOP – Standard Operation Procedure

WACT – Wyong Acute Care Team

INTRODUCTION

The Review Team would like to acknowledge the assistance received from many CCLHD staff during the course of this review. Everyone we met was generous in giving their time to speak with us, and to speak honestly and openly about the service and the challenges they faced. Likewise, those staff who took the trouble to write to the Reviewers. The overwhelming impression was that the staff we engaged with wanted to contribute to improving the quality and safety of this service.

Mental Health Services in New South Wales offer a range of care types aiming for the least restrictive form of care for any individual consumer. This translates to a large number of consumers being supported in ambulatory settings, either by publicly funded or private mental health services alone or by a combination of public, private and primary care services.

The publicly funded state-run services offer secondary and tertiary level inpatient, community and emergency care. Public sector ambulatory services for mental health consumers generally include acute care teams, continuing care teams and assertive outreach teams. Other specialist community based mental health teams include Police, Ambulance, Clinical, Early Response (PACER), Alcohol and Other Drugs (AOD), Child and Adolescent Mental Health Services (CAMHS) (and SAFEGUARDS), and Older People's Mental Health Services (OPMHS).

These teams accept referrals following discharge from inpatient care, and from Emergency Departments, telephone based Mental Health triage services, Primary Health and General Practice (GP) services, Police and Ambulance, the private sector, Community Managed Organisations (CMOs), and individual referrals from consumers and/or their families.

Community based services provide care to consumers with significant levels of mental illness, a high degree of complexity, and consequently significant levels of risk. A significant number are subject to treatment conditions determined by a Community Treatment Order (CTO), approved by the Mental Health Review Tribunal.

Community Mental Health Acute Care Teams provide a specialist service and have been shown to play a vital role in reducing suicide risk, and in suicide prevention.

Reliable and safe service delivery is dependent on the availability of highly skilled staff, good management and infrastructure resources, robust operational and clinical governance arrangements, and a clear and contemporary model of care, supported by policy and procedural clarity.

There are particular challenges around the transfer of care for mental health consumers, due to the complexity of some presenting complaints and the levels of acuity, and the potentially complex array of organisations and individuals involved in care.

The Central Coast Local Health District covers a population of approximately 350,000, in which 4.9% identify as Aboriginal or Torres Strait Islander, 21% were born overseas; and there is an increasing population of people aged 70-84 and over 85.[1]

[1] CCLHD Clinical Services Plan

The community mental health services in 2021-22 engaged in 431,772 occasions of service.

SCOPE

The Chief Executive, CCLHD commissioned the Review into the referral processes, caseload management, clinical decision making, risk assessment and care planning, transfer of care and organisational governance of the acute care mental health services.

The purpose of the Review was to identify any governance and system improvements that could enhance the safety, quality, and experience of care for patients, carers, staff, and providers who access this service. (The Terms of Reference are at Appendix 1)

The Review is not intended to investigate the care provided by any individual, nor was it a review of any individual case.

REVIEW TEAM

1. Dr Murray Wright, NSW Chief Psychiatrist, Mental Health Branch, NSW Ministry of Health
2. Ms Helen McFarlane, A/Director of Nursing and Manager of Innovation and Performance, MHDA, Western New South Wales Local Health District
3. Dr Nicholas Babidge, District Clinical Director, Mental Health, South Eastern Sydney Local Health District
4. Ms Katrina Hasleton, Principal Policy Officer, NSW Chief Psychiatrist team, Mental Health Branch, NSW Ministry of Health

METHODOLOGY

The Review Team had access to Incident Information Management System (IIMS) Root Cause Analysis Reports (RCA) and Serious Adverse Event Reports (SAER) (Appendix 2), Policy, Procedures and Standard Operating Procedures (SOP) the CCLHD Mental Health service organisation chart (Appendix 3), staffing profiles – Acute Services Staffing (Non Inpatient) (Appendix 4); Community Services Staffing (Appendix 5) and clinical governance documents (Appendix 6). The Review Team met with the CCLHD Executive Team, Mental Health Executive Team, community managers, and clinicians from Acute Care Teams in Gosford and Wyong.

Following an email invitation, the Review Team also received 14 written submissions.

CAVEATS/ LIMITATIONS

Although this Review was focused on the clinical governance processes relating to the Acute Care Teams (ACT) in CCLHD, the operational and governance challenges for ACT are strongly influenced by the other community based mental health teams and how they manage demand for their services.

Many of the issues impacting ACT are relevant for other teams, and our recommendations will impact CMH services beyond the Acute Care Teams.

The Review Team had the opportunity to meet with CMH Team Managers and the Acute Care Teams, but did not have the opportunity to consult with all staff working in CMH. However, the information provided to the Review Team in the form of interviews, written submissions, documents, and data has been remarkably consistent, providing the Review Team some confidence in the validity of our observations and recommendations.

FINDINGS

There are a range of processes, positions, functions and data at all levels of a complex health system that contribute to reliable and comprehensive clinical governance, and in the instance of reviewing how effectively clinical governance is working in a community based Mental Health system it suits the purposes of this review to start at the clinical team, looking at regular team-based processes which contribute to and maintain safety and quality.

Intake/Triage/Allocation

All mental health services are experiencing challenges in meeting demand, whether it is due to increased numbers or complexity of referrals, staff recruitment and retention challenges, or a lack of private sector or community-based alternatives. Important principles when addressing these challenges include ensuring that priority is given to those most in need, minimising the number of transfers of care for any consumer, and ensuring consumers receive timely access to the most appropriate specialist care available. It is also important to ensure an equitable distribution of workloads across all teams, and to ensure that CMH teams work collaboratively and always in the best interests of consumers.

The Review Team heard repeated concerns about increased referral numbers since the intake/triage service was outsourced to a private provider, having previously been an 'in house' service delivered jointly by CCLHD and Mid North Coast Local Health District. The Reviewers understand that there have been some challenges implementing the service with this provider but were reassured that there is an active and robust regular governance meeting between LHD and provider representatives, and a reliable escalation and dispute management process.

The CMH services based in Gosford and Wyong have very similar resources, and the same configuration of individual teams. The service demand, and hence the challenges, are very similar in each sector. (Appendix 7)

It was noted in discussions with both ACT teams and their managers that the referrals and caseloads were excessive, and the sheer numbers of consumers created 'overloaded' handover meetings, reducing the opportunity to discuss new, deteriorating, problematic or worrying cases as a team, an important source of 'on the run' supervision and peer support, contributing to safety and quality.

The excessive numbers of cases were partly due to increased referrals but were exacerbated by some local practices which effectively left the ACT responsible for the interim management

of consumers who had (appropriately) been referred to CCT, CAMHS/Safeguards or OPMH. This anomalous local practice in both sectors represents a potential safety risk for those consumers and will be the subject of a recommendation.

It appeared to the Review Team that there was an inequitable workload distribution between ACT, CCT, OPMH, and CAMHS, with evidence of arbitrary and non-negotiable decisions limiting acceptance of cases by CCT (caps), CAMHS, and OPMH, and an automatic referral back to ACT of cases from other teams in the event of possible deterioration. This 'defaulting' leads to excessive caseloads, and to a number of cases being inappropriately managed by the ACT. This is reported to cause confusion and frustration to consumers and their families, frustration to the ACT clinicians and managers, creates discontinuities and multiple handovers (increasing safety risks), and in the view of the Review Team is an unnecessary and unsafe practice.

Recommendation 1

Revise referral/intake/triage processes for all community mental health teams, (Acute Care, Continuing Care, Assertive Outreach, Child and Adolescent, and Older Persons) so that all referrals are assigned to the appropriate team from the outset and all clinical handovers occur with the clinical teams responsible for their care.

The CAMHS team should accept all referrals under 18, the OPMH team accept all referrals over 65, and the CCT should no longer require ACT to 'hold' CCT referrals until a 'vacancy' arises. This shares the burden of service demand across all teams and requires all teams to prioritise their services to those most in need and is more consistent with a consumer focus. This will require more meaningful communication and case flow management between the teams, and active engagement of managers and directors in the process and establishing more equitable case allocations between the teams.

The current practice of the ACT 'holding' consumers with CTOs designated for CCT for prolonged periods is confusing and frustrating for the consumers and their families, represents inadequate care, and may be inconsistent with the requirements of the NSW MH Act.

The current practice of the ACT 'holding' acute CAMHS referrals for up to two weeks is inadequate, may be unsafe, and should cease. The specialist CAMHS team should be responsible for all consumers under 18, no matter what their triage category.

Recommendation 2

Cease the use of the workload tool by the Acute Care Team and caps on caseloads by the Continuing Care Team, and engage teams and managers in a consumer-centred process of prioritising and managing demand individually for each team.

The Review Team were concerned to see the authority given to a locally produced 'Workload Tool' to determine work practices at the GACT and arbitrary 'caps' on CCT caseloads. It is

important to monitor workload and case numbers, but this should never occur at the expense of consumers' clinical needs, and it appears that in the ACT in Gosford the tool is used to limit clinical activity. Noting earlier comments about the practice of ACT 'holding' consumers who were referred to other teams, it is understandable that the team would look for ways to manage such a challenging workload, but the solution adopted is not delivering consumer-focused care and should cease.

Recommendation 3

Review the Position Description of the patient flow coordinator position, inclusive of but not limited to reallocating the responsibility for clinical handover between teams back to the clinicians directly involved in a patient's care.

The Review Team met the Patient Flow Coordinator, and believe this position to be a positive initiative, but recommend that the position be reviewed. One of the roles of this position is to manage all clinical handovers between teams, a role that we were told was added to improve efficiency of handover, but we heard also that most clinicians want to be directly involved in handover of their cases (which represents good clinical practice and minimises the number of people involved in handover)

Recommendation 4

Review existing mental health nursing leadership structure to ensure recruitment to Clinical Nurse Educator and reintroduction of Community Mental Health Clinical Nurse Consultant 3. Consider opportunities to share training and education across the mental health service more equitably.

Recommendation 5

Implement a professional development education and training program to support existing and newly appointed mental health staff.

The Review Team were told by both acute care teams of the key roles played by the CNE, including nurse education/orientation/clinical governance. We were told of the extensive orientation and shadowing/supervision available to new team members when that position was filled, contrasted with a desultory orientation in place now that seems largely self-directed.

The Review Team were told that the availability and participation of medical staff in handover meetings was inconsistent, diminishing their contribution to safety and quality, and reducing multidisciplinary team processes. Quality and Safety is covered in monthly team meetings, along with policy updates, but there is insufficient time in these meetings to cover these matters sufficiently.

The Review Team were told that over the last few years there had been a loss of community-based CNC positions, and a reduction in hours for the CNE, currently vacant for several months.

The Review Team were told that policy implementation is left largely to individual team members, with little opportunity for discussion/education. This had been more effectively managed when there was a Clinical Nurse Educator in place.

Recommendation 6

Review the coverage and accountability of the medical staffing (junior and senior) to the acute care teams, and build more reliable multidisciplinary case review processes.

There is unreliable access to medical staff for the Community Mental Health Teams, for a range of reasons, including night duty commitments for registrars, staffing shortages, and individual medical practices. It is noted that the Clinical Director was formerly a fulltime Staff Specialist position and is now covered by a part time Visiting Medical Officer who also has clinical responsibilities. It seems to the Reviewers that the reduction in medical leadership time makes it more difficult to ensure consistency of medical staffing and clinical practice across the LHD, and to contribute consistently to a range of clinical governance processes including incident reviews, M&Ms, policy review, supervision, and performance reviews. Increasing the time available for the duties of the Clinical Director would assist in addressing a number of the clinical governance challenges identified in this Review.

Recommendation 7

Introduce a 'Safety Huddle' to allow discussion of challenging or contentious referrals as per the Central Coast Local Health District Nursing and Midwifery Standards of Practice Framework

The introduction of a formalised and consistent safety huddle at shift handovers would also assist in addressing the concern raised by several clinicians that there are presently insufficient opportunities to discuss complex, new or deteriorating cases.

Recommendation 8

Introduce dynamic management of the agenda for handover meetings to allow opportunity for discussion of new or challenging cases, and ensure alternative opportunities for case review/supervision.

Quality and Safety items are discussed in monthly team meetings, along with policy updates, but the Review Team formed the general impression that there was insufficient time for in-depth discussions, and no opportunity for joint meetings that included all CMH teams.

The Review Team were told that the availability and participation of medical staff in handover meetings was inconsistent, diminishing potential opportunistic contribution to safety and quality, and reducing multidisciplinary team processes.

Both teams were making efforts to tailor the discussion at handover meetings to those consumers most in need, but the time pressure greatly reduced opportunity for meaningful discussion of challenging cases.

Recommendation 9

Reinstate Morbidity and Mortality meetings in accordance with the District Morbidity and Mortality Memo February 2023 and M&M toolkit.

Safety and Quality Resources and Processes

Effective clinical governance requires the collection and monitoring of a range of clinical data reflecting service demand, activity, and resources, and reliable and thorough investigation of incidents and complaints, and taking action to improve the safe delivery of care when indicated. Other important aspects of clinical governance are embedded in team-based care, and include safety huddles, handover meetings, clinical case conferences, and various forms of individual and team-based supervision and teaching.

There are two FTE roles dedicated to all aspects of safety and quality in CCLHD MHS, including incident investigation and report writing, complaints management, policy review and development, and accreditation preparation. All clinical staff and managers consulted during the review acknowledged the importance of these roles, and their expertise in mental health, but there were contrasting perspectives on whether or not these staff should work under the direction of the mental health service management or become more closely aligned with and supported by the LHD Clinical Governance team.

The Reviewers heard that the retention of these individuals within the MH Service ensured that they were available to respond to demands within the service (at the direction of the MH leadership team) and to retain and apply their expertise in the unique aspects of mental health services, which would ensure high quality investigations and outcomes.

On the other hand, the Reviewers were also advised that the MH Q&S team operated in relative isolation from the District Clinical Governance team and could benefit in terms of professional development and sharing of workload if they were more fully integrated into the LHD services.

The concerns about the risks of siloed mental health safety and quality roles included the risk that a small team of two people being solely responsible for all incident investigations and management of complaints could lead to a relative desensitisation to the importance of raising and addressing common, recurring, and important problems or vulnerabilities in the system of care. This desensitisation can lead to the introduction of human errors into the process, particularly anchoring bias, and confirmation bias. The benefit of a larger pool of safety and quality staff helps to ensure that each incident or complaint is approached with ‘fresh eyes’, to fully represent the care and the systems within which it occurred, including any recurring systemic challenges.

SAERs arising from the Gosford and Wyong ACMH teams were reviewed by the team. The relevant SAERs have been included in Appendix 2. These cases provide a snapshot of the complex and vulnerable patients cared for by the CMHTs and the associated acuity and risks.

In reviewing the clinical care detailed in the SAERs it was noted that potential opportunities for service improvement may have been overlooked or partially addressed in the report and associated recommendations. As mentioned above, desensitisation to common recurring but important vulnerabilities in the system is an understandable phenomenon, however the role of such vulnerabilities in each clinical scenario warrants consideration. The importance of expertise in Mental Health to the clinical governance processes of Mental Health Units is undeniable. Isolation of this expertise from the broader systems of clinical governance however is associated with risks to the quality of the governance process. Based on the analysis of the sample of SAERs provided, the Review team has formed the view that there is room for further improvement in the quality of the Mental Health SAERs, and that the professional development and support opportunities available if the mental health quality and safety team joined the district-wide team would assist in further improving the standard and utility of the SAERs.

Integration of the MH Q&S team within the broader governance structure would allow optimisation of the governance process and provide access to a greater pool of independent expertise. It would also allow the application of improvement science from a broader perspective and facilitate participation in education and communities of practice directly related to clinical governance. It would also improve access to collegiate support and professional development opportunities.

The Reviewers heard that the policy development process had become disengaged from the community based clinical teams. It was reported that the teams were not always consulted about policies and procedures that were central to their work, and that there was little or no opportunity to discuss implementation of newly developed policies.

There was a concern expressed that the threshold to reach for Policy, Procedure or Standard Operating Procedure (SOP) solutions to clinical problems was too low, resulting in a crowded and at times confusing policy, procedure and SOP set for the mental health service.

Recommendation 10

Integrate the Mental Health Quality and Safety Team with the District Clinical Governance Team to ensure a centralised governance model, shared learning, and responsibilities for mental health governance inclusive of incident management, risk management, complaints handling, policy and procedure development, and accreditation.

Recommendation 11

Review policy and procedure development and implementation processes in line with the Central Coast Local Health District Corporate Governance Policy and Procedure Development processes and the Nursing and Midwifery Standards of Practice Framework.

The principle of selective and parsimonious policy development is not apparent.

Jeffrey Braithwaite, the current chair of the Institute for Healthcare Improvement (IHI) points out that a complex adaptive system will reject change where; 1) the change is mandated without consultation or is not supported by parties with the power to resist (ie the clinicians doing the work) and 2) where more policies and procedures are issued on top of a multiplicity of existing policies and procedures.

The IHI have developed a Safety Tool Kit Action hierarchy which outlines **strong (require less reliance on humans to remember to perform the task correctly)**, intermediate and **weak (require more reliance on humans to remember to perform the task correctly) actions arising**, from serious incident review. Policy/procedure development as a recommendation from serious incidents is recognised as a weak action to support change or improvement.

In the link below, Braithwaite also touches on the very important concept of 'work as imagined' as opposed to 'work as done'. https://www.bmj.com/content/361/bmj.k2014

The Reviewers would suggest the service should invest in trying to understand the dichotomy of their clinicians work as done vs work as imagined (policy/procedures) through improvement science, rather than continuing to layer unnecessary procedures, which serve only to confuse and erode the adaptive capacity of staff to function within a complex system.

If a procedure is to be developed then this should be done collaboratively with clinicians, consumers and carers, to ensure a strong and effective outcome for change, and there needs to be strong governance links to the clinical governance unit for sign off and support to ensure a robust implementation plan and procedure owner and version control are in place to monitor outcome.

The Central Coast Local Health District Corporate Governance Policy and Procedure Development Processes can be found at Appendix 8. The Nursing and Midwifery Standards of Practice Framework and be found at Appendix 9

Recommendation 12

Review the Mental Health organisation structure to address the isolation and siloing of community mental health teams.

It was made evident to the interviewers that there is minimal interaction between each of the community mental health streams. Each stream has its own senior manager that reports to the MH Director. This largely prevents discussion and collaboration across the Community Mental

Health Teams and creates a disconnect between clinical teams leading to a loss of a consumer centred care.

The structure at Wyong and Gosford CMH is based on a hierarchical organisational structure which doesn't promote efficient communication between teams or assist in managing increasing service demands. To achieve a more flexible collaborative environment there should be a reassessment of the organisational structure, ensuring it supports the strategic goals of the organisation, promotes flexibility and interdisciplinary collaboration, and shifts towards greater collaboration across the CMH service as a whole rather than working in silos.