New South Wales Auditor-General's Report
Performance Audit

Mental health post-discharge care

NSW Health

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In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled **Mental health post-discharge care: NSW Health.**

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Acting Auditor-General
17 December 2015

Contents

Executive summary

The audit assessed how well NSW Health and Local Health Districts provide follow-up care for mental health consumers within seven days of being discharged from public mental health units.

To frame our analysis, the audit used NSW Health's policy directive on the 'transfer' of consumers from mental health inpatient units to the community. This policy directive includes a Key Performance Indicator (KPI) on post-discharge follow-up. This KPI measures the proportion of consumers receiving follow-up contact from public community mental health services within seven days of discharge from acute mental health units.

We visited five Local Health Districts, interviewing key staff, as well as reviewing files, policies, internal audit reports and other reviews.

Conclusion

Overall, mental health consumers receive good follow-up in the first seven days after their discharge from mental health units. However, there is opportunity for further improvement.

Improvements over the past five years in the rate of consumers receiving follow-up care have been driven by a range of different practices across Local Health Districts, as well as by the strong commitment of clinicians and management.

There is strong understanding and awareness of the general intent of NSW Health's transfer of care policy directive for mental health consumers, with clinicians and managers displaying commitment to ensuring that consumers receive post-discharge follow-up. However, there could be better adherence to some aspects of the policy.

There has been a strong improvement in the proportion of consumers receiving post-discharge follow-up, albeit with further scope for improvement. Whether this follow-up by itself leads to better outcomes for consumers is harder to measure, as post-discharge follow-up is just activity along a continuum of care.

Significant effort devoted to improving the rate of follow-up care for mental health consumers

Local Health Districts have improved rates of post-discharge follow-up by public community mental health services over the past 5 years. Models of follow-up vary between Local Health Districts, with responsibility for local policy implementation devolved to each district and NSW Health adopting a 'hands off' approach that is consistent with the devolution of responsibility.

Local Health Districts also vary in how they follow-up consumers who are transferred to types of care such as private psychiatrists, residential aged care, GPs, or to other public community mental health services in other districts. The audit found that many clinicians go to great lengths to ensure some form of follow-up care in these circumstances, though there is a need for better follow-up practices for consumers referred to other districts.

A performance culture has emerged around the Key Performance Indicator for post-discharge follow-up

In each Local Health District we visited, there was a consistent theme in our discussions that performance reporting of the post-discharge follow-up KPI had created a performance culture. This was seen as a good outcome. As one clinician noted, "This is how to get KPIs to work in health; make them about good care". Another clinician agreed that the KPI was consistent with good clinical practice, noting "It is not just a stat".

In each Local Health District, down to ward level, clinicians and managers were aware of their performance, and were often aware of the performance of like wards or units. Through these comparisons, successful practices were reinforced and unsuccessful practices were revised. In addition, interest was spurred in more actively and routinely exchanging good practice ideas across Local Health Districts.

Implementation of the policy directive can be improved

While awareness of the general intent of the policy directive is high, and performance has improved, there are still aspects of the policy directive that are not uniformly done well:

- There was little evidence that transfer of care plans are developed with and provided to the consumer and their carers, an important step to ensuring that consumers, their carers and families are at the centre of care and are partners in care.
- Two Local Health Districts were still developing local adaptations of the policy, almost three years after the directive was issued.
- Only a handful of inpatient units estimate a date of discharge within the first 72 hours of a patient being admitted — one internal audit of a major inpatient unit found only 7 per cent of audited records included an estimated discharge date.
- Most Local Health Districts did not provide evidence of how clinical staff were educated in the principles and procedures required by the policy, nor evidence of how these principles and procedures were incorporated into orientation programs for new staff.

Good discharge practices support follow-up care

In each of the five Local Health Districts, clinicians highlighted activities that, when done well, supported continuity of care after transfer to community mental health services. Among the most consistent themes were:

- Planning for discharge and follow-up should begin at, or close to, the time of admission. This helps to ensure that sufficient time is available to understand the consumer's needs (both clinical and psychosocial) and avoids rushed or ill planned discharge.
- Early engagement with community mental health services — as well as other service providers, like drug and alcohol services and NGOs — in discharge planning helps to ensure a seamless transition from inpatient to community care. Some Local Health Districts were demonstrably better at this than others. Implicit to this is good communication between inpatient and community-based clinicians, something that was raised as a problem in many of the discussions we held.
- Discharge summaries need to be prepared in timely way — incomplete and, especially, delayed discharge summaries was raised as an issue by clinicians in each Local Health District we visited, as well as in internal audit reports. One clinician described delayed discharge summaries as the '…greatest barrier to ensuring continuity of care'.

It is difficult to 'prove' that follow-up is leading to better outcomes

An aim of this audit was to determine whether follow-up care is supporting mental health consumers' transition to the community. This is difficult to determine.

There is research to show that post-discharge follow-up leads to better outcomes for consumers, especially for those at high-risk.

However, better outcomes are difficult to prove at local level. The policy directive sets-out that readmission rates within 28 days of discharge is a measure of the effectiveness of post-discharge follow-up, though many people we interviewed were not persuaded by this.

Post-discharge follow-up is not a standalone intervention. It is part of a continuum of care beginning at admission (or even earlier for consumers known to the mental health system) and can continue well after the consumer leaves hospital. Outcomes for the consumer will reflect the quality of care received along this continuum, and not just at a single point.

Various alternative quality outcomes measures were proposed by clinicians and managers. While it was beyond the scope of the audit to evaluate their adequacy, these alternative proposals did tend to reflect longer time frames and more holistic outcomes.

Anecdotal and qualitative evidence points to failures in individual cases

While our overall assessment on post-discharge follow-up is positive, this view is not consistently shared by other consumer and oversight bodies, some of which cite evidence of poor outcomes in individual cases.

This is not inconsistent with the audit finding that while performance has improved, most Local Health Districts need further progress to achieve the 70 per cent benchmark. There are still individuals, many of whom may be very unwell, who do not receive post-discharge follow-up care. It is also an important reminder that individuals sit behind these statistics.

Recommendations

The NSW Ministry of Health should:

1. Reinforce to Local Health Districts that the policy directive on the transfer of care from mental health units to the community:
    1.1. is intended to ensure that the consumer and their family, carer, or guardian are at the centre of care and are partners in care
    1.2. requires that Transfer of Care plans be developed, the components of which should be tailored to the recipient's needs
    1.3. requires that estimated discharge dates be allocated within 72 hours of admission
    1.4. requires the education of existing staff about the principles and procedures for transfer of care planning
    1.5. requires that the principles and procedures for transfer of care planning are incorporated into orientation programs for new clinical staff.
2. Include in its review of the policy directive due for completion by 14 November 2017 consideration of the follow matters:
    2.1. whether there are circumstances where an estimated discharge date need not be allocated within 72 hours of admission
    2.2. whether there are circumstances where the consumer need not always be present for follow-up contact to be valid for measuring its performance
    2.3. whether the policy directive adequately addresses possible role for other parties, in particular peer support workers and NGOs that provide services as part of a consumer's transition from inpatient care.
3. Clarify with Local Health Districts the scope of the policy directive, particularly with reference to consumers who are transferred to public community mental health services out of the area.
4. Facilitate Local Health Districts to:
    4.1. review processes around the handling of discharge summaries to ensure that they are a timely component of the transfer of care process
    4.2. implement mechanisms to share information and experiences about models of post-discharge follow-up
    4.3. review the quality of communication that occurs between mental health inpatient unit staff and community mental health staff, and develop action plans to address any deficiencies
    4.4. review how community mental health services interact with admitted inpatients, particularly with regard to discharge planning, and compare to good practice models across NSW.

Introduction

1. Public mental health services

1.1 Inpatient and community mental health care settings

The NSW Government funds Local Health Districts to deliver public mental health services, which provide specialist care for consumers with severe mental illness. These services include:

- Specialised mental health care delivered in public acute hospitals and standalone psychiatric hospitals.
- Specialised community mental health care services.
- Specialised residential mental health care services.
- Other mental health-specific services in community settings, such as the Housing and Accommodation Support Initiative (HASI), which provides people with mental health problems access to stable housing linked to clinical and psychosocial rehabilitation services.[1]

Mental health services can also be provided in a range of other care settings, such as by GPs or specialist private psychiatrists. Other care settings include private psychiatric hospitals or residential facilities, or NGO-based services, including services funded by the Australian or State Governments.

This audit focused on two care settings:

- Admitted care provided in mental health inpatient units in public hospitals
- Care provided out-of-hospital by public community mental health services.

There is great diversity in the service models for these care settings, not just between Local Health Districts, but even within districts. This includes matters such as how a consumer is referred to care.

These services are run by Local Health Districts, though they are subject to policy settings determined by the NSW Ministry of Health.

Care provided in public mental health units

Depending on the hospital, a non-exhaustive list of services provided by public mental health inpatient units includes the following:

- Acute Adult units provide care to consumers experiencing serious episodes of mental illness and who cannot be adequately supported in the community environment.
- Specialist Child & Adolescent Mental Health Services (CAMHS) provide specialist mental health services for children and adolescents up to the age of 18 years. Depending on the adolescent's needs, care can be provided in inpatient, outpatient (day programs), or community settings. Not all Local Health Districts have a CAMHS inpatient unit. Where there are no specialist CAMHS inpatient units, young people are admitted to paediatric hospital or wards in general hospitals, adult acute wards under special conditions, and PECCS (psychiatric emergency care centres).
- Specialist Mental Health Services for Older People (SMHSOP) provide a range of services to people over 65 years, including acute inpatient, though also rehabilitative care and community care.
- Non-Acute Rehabilitation units support consumers through their recovery from mental illness and promote social inclusion.

Care provided by public community mental health services

Community mental health services are provided through teams. In the Local Health Districts we visited, community mental health teams were usually located in general community health centres, or in their own dedicated centre. Community mental health teams can also be

[1] HASI is a joint program between NSW Health, Housing NSW and various non-government organisations (NGOs).

co-located with inpatient services, though this is not common.

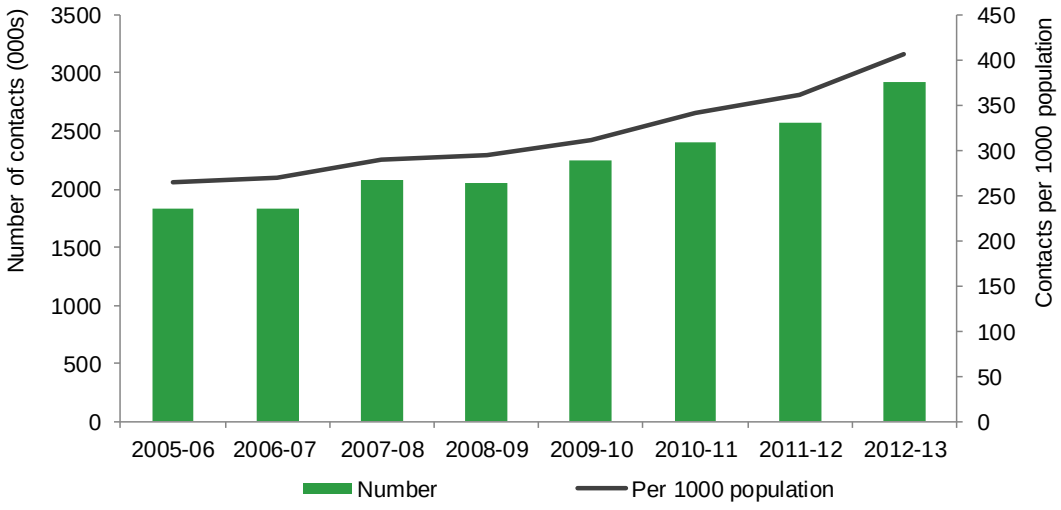
As with the hospital inpatient units, there are a range of community mental health teams, including:

- Acute Care Teams (ACT) provide 'face to face' assessments for people experiencing acute symptoms of mental illness, including those at risk of suicide. They are the teams most likely to provide post-discharge follow-up care within seven days of discharge, though clinicians from Case Management teams may sometimes provide this care if the consumer was already known to them prior to their most recent admission.
- Specialist CAMHS and SMHSOP teams.
- Case Management teams provide assessment and individual recovery orientated treatment for people living in the community.
- Assertive Outreach Teams (AOT) provide medium to long term care to consumers who are seriously affected by mental illness to enable them to live as independently as possible in their own home.

There can also be mixed teams, where community mental health workers spend part of their time providing acute care, and still have a case management load. In this audit, mixed teams were uncommon in the Local Health Districts we visited. Some Local Health Districts may also have dedicated Aboriginal Mental Health Teams and other specialist teams, such as Early Psychosis Intervention Teams.

From 2005-06 to 2012-13, there were substantial increases in community mental health service contacts in NSW, both in terms of volume and the rate per 100,000 population. This is shown in Exhibit 1.1 below.

Exhibit 1.1 Community mental health service contacts, by number and rate per 1000 population, 2005-06 to 2012-13



Source: Steering Committee for the Review of Government Service Provision (2015), *Review of Government Services*, data table 12A.24

1.2 Reform to mental health service delivery in NSW

In December 2014, the NSW Government announced reforms to mental health care service delivery. These reforms responded to a 10-year strategic plan prepared by the NSW Mental Health Commission, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*. Chief among these reforms is a commitment over the next 10 years for:

> More support for staying well and at home as community mental health services are enhanced, and unnecessary hospital stays reduced.

1.3 Post-discharge follow-up from inpatient units

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have a

heightened level of vulnerability and, without adequate follow-up, may relapse or be readmitted.

Continuity of care includes prompt community follow-up in the vulnerable period following discharge from hospital (within seven days is the common benchmark). The effectiveness of continuity of care is usually measured by the rate at which discharged patients are readmitted to hospital within 28 days.

The term 'transfer of care' is sometimes used in the health system as a substitute for 'discharge'. This is intended to reflect that care for the individual does not end when they leave hospital, but is made the responsibility of someone else, such as a GP, specialist, community health services, the individual themselves or their carer and family. The policy directive focuses on the concept of 'transfer of care', though for brevity this report will sometimes use 'discharge'. Transfer of care is described in the policy directive as:

> A structured, standardised process for ensuring the safe, efficient and effective transition of people with a mental illness between inpatient settings and from hospital to the community. Transfer of care is part of the continuum of care that starts with the person's admission to hospital.

A person under the care of a mental health service in NSW is referred to as a 'consumer'. This is the term used in the policy directive, and adopted in this report. The term 'patient' is only used when discussing a person with regard to their legal status — for example, when discussing someone's status under the *Mental Health Act (2007)*, which refers to voluntary or involuntary 'patients'.

Key elements to the transfer of care policy directive

The audit assessed how well NSW Health and Local Health Districts provide follow-up care for mental health consumers within seven days of being discharged from public mental health units.

Follow-up is governed by a policy directive issued by the NSW Ministry of Health (*Transfer of Care from Mental Health Inpatient Services PD2012_060*).

Along with a range of other matters, this policy directive specifies that there must be 'assertive follow-up' within the timeframe indicated in a transfer of care plan or within no more than seven days. The aim of follow-up is to ensure adequate care and support in the community and to reduce readmissions to hospital.

The policy directive is mandatory in NSW Health and sets out roles and responsibilities at all levels from the Ministry to Local health Districts, hospital management and clinical staff in mental health units. The policy directive includes two key performance indicators:

- increase the rate of community follow-up within seven days (following discharge) from a NSW public mental health unit — this KPI is measured by reference to acute inpatient units only.
- reduce readmissions within 28 days to any facility.

1.4 A cross-section of Local Health Districts were visited for this audit

This audit visited five selected Local Health Districts: Central Coast; Murrumbidgee; Northern NSW; Sydney; and Western Sydney.

These districts were chosen in consultation with the NSW Ministry of Health and because they reflected a reasonable cross-section of Local Health Districts in NSW, including regional and rural locations.

They also had a range of services and different service delivery models:

- All five Local Health Districts had acute and non-acute inpatient units.
- A number had specialist CAMHS (for example, Western Sydney and Northern NSW Local Health Districts) or SMHSOP inpatient units (Western Sydney, Sydney, and Central Coast Local Health Districts), though all had specialist community teams.
- One Local Health District had a Psychiatric Emergency Care Centre (PECC) attached to the emergency department of a general acute hospital (Wyong Hospital in the Central Coast Local Health District).

- There was Assertive Outreach community teams (such as at Central Coast Local Health District).

Exhibit 1.2 shows the population of each Local Health District, as well as key performance measures. Results for the two KPIs included in the policy directive are shaded in blue.

Exhibit 1.2 Population and select performance measures for the five Local Health Districts visited by this audit

	Central Coast	Murrumbidgee	Northern NSW	Sydney	Western Sydney	NSW
LHD Population	333,486	289,498	296,664	614,556	916,543	7,561,749
Acute post-discharge community care within 7 days[1] (per cent)	**72**	**73**	**60**	**58**	**70**	**63**
Acute readmissions within 28 days[2] (per cent)	**15**	**10**	**14**	**17**	**17**	**15**
Number of acute inpatient separations[3]	814	343	771	1,487	1,697	17,090
Number of acute inpatient separations per 100,000 people[3]	244.1	118.5	259.9	242.0	187.2	226.0
Average length of stay[4]	15	12	14	18	15	14

Source: InforMH, Mental Health Performance Report July-December 2014 and other data supplied by InforMH. Rates of acute post-discharge community care and acute readmissions within 28 days are for the period January to June 2015.

Notes

1. Measured as the percentage of people discharged from acute inpatient mental health units who receive follow up from a specialist mental health team within 7 days.
2. Measures the percentage of people who are readmitted to acute mental health care settings within 28 days of discharge from acute mental health. Includes readmission to other facility and other LHD
3. Excludes same day separations.
4. Acute inpatient average length of stay for admissions to acute mental health inpatient units for people of all ages and excludes day-only admission.

Key findings

2. Are the roles and responsibilities for providing follow-up care understood and met?

There is a strong understanding and awareness of the general intent of NSW Health's transfer of care policy directive for mental health consumers, with clinicians and managers displaying commitment to ensuring that consumers receive post-discharge follow-up. However, there could be better adherence with some aspects of the policy.

Responsibility for developing models of care has been devolved to each Local Health District, with the Ministry of Health adopting a relatively 'hands off' approach that is consistent with this devolution of responsibility.

Clinicians and managers in Local Health Districts displayed a strong understand of the policy directive and a strong commitment to its principles. Key matters that were not as clearly evidenced in how the policy directive was implemented included:

- education for both existing and new staff
- involvement of consumers, their carers and families in their care, including the scant use of transfer of care plans.

Recommendations

The NSW Ministry of Health should:

1. Reinforce to Local Health Districts that the policy directive on the transfer of care from mental health units to the community:
    - 1.1. is intended to ensure that the consumer and their family, carer, or guardian are at the centre of care and are partners in care
    - 1.2. requires that Transfer of Care plans be developed, the components of which should be tailored to the recipient's needs
    - 1.3. requires that estimated discharge dates be allocated within 72 hours of admission
    - 1.4. requires the education of existing staff about the principles and procedures for transfer of care planning
    - 1.5. requires that the principles and procedures for transfer of care planning are incorporated into orientation programs for new clinical staff
2. Include in its review of the policy directive due for completion by 14 November 2017 consideration of the follow matters:
    - 2.1. Whether there are circumstances where an estimated discharge date need not be allocated within 72 hours of admission
    - 2.2. Whether there are circumstances where the consumer need not always be present for follow-up contact to be valid for measuring its performance
    - 2.3. Whether the policy directive adequately addresses possible role for other parties, in particular peer support workers and NGOs that provide services as part of a consumer's transition from inpatient care.

2.1 Roles and responsibilities are mostly understood

The policy directive sets out roles and responsibilities for the NSW Ministry of Health, Local Health Districts Chief Executives, directors of mental health, hospital managers and clinicians and community mental health service clinicians. The full scheme of roles and responsibilities is shown in Appendix 3.

The Ministry of Health affords Local Health Districts autonomy in implementing the policy directive

The policy sets out roles for the Ministry of Health in providing assistance to implement the policy, to monitor and review implementation, and to receive annual reports on implementation from Local Health Districts. Local Health Districts are given the autonomy to adapt the policy to local circumstances and develop their own solutions for implementation. Consistent with this devolved responsibility, the Ministry takes a relatively 'hands-off' approach to how Local Health Districts implement the policy directive.

In discussion with Local Health District staff, we came across only isolated instances where advice or assistance had been sought from the Ministry. While the policy directive envisages that the Ministry will monitor implementation of the policy, Local Health Districts were advised in 2013 that it would not be seeking annual reports on implementation in the future.

The Ministry's engagement with Local Health Districts about the policy directive is now focused on holding the districts accountable for performance outcomes. One example of this is a regular schedule of performance forums, where Local Health Districts are expected to attend and discuss their performance under agreed KPIs, including the KPI on post-discharge follow-up. Depending on whether a district is performing well or poorly, its attendance at performance forums may be quarterly or, where more regular monitoring is necessary, monthly.

InforMH provides Local Health Districts with performance reporting and benchmarking

InforMH is a specialist mental health data and information resource for NSW Health.[2] Feedback from Local Health Districts indicated that it, more so than the Ministry, was often contacted regarded technical issues with the performance reporting on the KPI. Its advice was usually considered valuable and timely.

InforMH provides performance benchmarking for Local Health Districts, allowing clinicians and managers to compare performance and discuss good practice. In our discussions with clinicians in Local Health Districts, it was apparent that there was a keen appetite for greater sharing of good practice between Local Health Districts. Managers and clinicians in Local Health Districts reflected positively on being able to benchmark their performance against other Local Health Districts, as well as being able to monitor change over time in their own performance.

While Local Health Districts compile their own performance data, InforMH is tasked with collating the definitive performance data for all KPIs. InforMH is best placed to do this task as it is able to collate data across Local Health District borders. While this results in more accurate data than Local Health Districts can produce themselves, the process is slower than what some clinicians and managers would like. This frustration is compounded where performance data from InforMH vary materially from the Local Health District's own computations.

Roles and responsibilities are generally understood at Local Health District level

Staff in both hospital and community settings, across general adult acute and specialist services, were aware of the policy directive and its principles and key elements. In particular,

[2] InforMH is a devolved unit of the NSW Ministry of Health (MoH) operating within Northern Sydney Local Health District (NSLHD) under a Service Level Agreement (SLA) between the MoH and NSLHD. Its primary purpose is to provide data and information needed by the NSW Ministry of Health for developing and implementing policy and monitoring the performance of NSW Mental Health and Drug and Alcohol Services.

there was a high level of awareness of KPIs and related benchmarks, including transfer from emergency departments to acute units, monitoring average length of stay, and the need for follow-up within seven days.

All five Local Health Districts we visited provided evidence of local policies and practices for discharge planning and transfer of care to the community. However, two years on from the issue of the policy directive, some Local Health Districts had still not finalised the local adaptations of the policy directive across their whole districts. Some cited restructuring of community teams and service models, as well as changes to area or district boundaries as significant factors in the relative slowness to implement.

Most Local Health Districts did not appear to have formal approaches to educating clinical staff in the principles and policies for transfer of care planning. Similarly, there was relatively scant evidence that these principles and policies were included in orientation programs for new staff.

2.2 Planning for follow-up occurs for most consumers as part of transfer of care planning

Overall, planning for follow-up occurs for the majority of consumers discharged from acute units and, of these, most are receiving some form of follow-up. This was evident from both the local policies and practices reviewed during the audit, the actual practices outlined by clinicians, and our review of clinical files.

There are differences between Local Health Districts in local policies for categories of clients that do not require or do not receive follow-up. These decisions are generally linked to views about appropriate clinical practice and, to a lesser extent, resource management. The policy directive itself requires mandatory follow-up for consumers transferred to the care of community mental health services, but it also allows for clinicians' discretion.

A benchmark of 70 per cent has been set by the Ministry, although this is not specified in the policy directive. That fewer than 100 per cent of consumers are expected to receive follow-up indicates that the policy envisages some consumers will not require follow-up by NSW public mental health services or may not desire it. In almost all Local Health Districts, clinicians expressed a strong desire for clear guidance on the types of consumers that are not expected to receive follow-up care.

The KPI on post-discharge follow-up is accompanied by a technical paper issued by InforMH. This paper sets out the details of the construction of the KPI — both numerator and denominator — and the categories of discharges which 'do not count'.

2.3 Building a performance culture that supports continuous improvement

Performance reporting and accountability

A consistent theme across all Local Health Districts was that a performance culture has grown from the establishment of performance reporting and accountability. This performance culture is centred on a single, simple KPI, with reporting from hospital unit performance to Director, service performance to Chief Executives, and district performance to the Ministry of Health.

Much of this reporting is done comparatively within districts, showing how each inpatient unit and each community team performed, including their progress over time. This sort of reporting was described as contributing to building performance cultures in Local Health Districts. The audit was provided with examples of comprehensive reporting and accountability at all levels within the mental health service.

Internal audits driving better performance

Clinical audits are also important contributors to continuous improvement. Some of these audits and related internal reviews are mandatory to meet four-year accreditation requirements under the National Safety and Quality Health Service standards. All Local Health Districts we visited provided documentation of clinical audits, which included clinical

decision making around discharge planning in acute units, clinical assessment and risk assessment.

Non-clinical internal audits are also conducted extensively across Local Health Districts. These audits examine areas such as improving the documentation trail and serve as a reminder of the stages and steps within the policy. These include assessments of documentation to ensure care planning and review is done, and that consumers and carers are involved in care.

Some audits are done frequently. For example, Sydney Local Health District has scheduled fortnightly audits of inpatient clinical documentation and weekly audits of follow-up within seven days of discharge.

Most audits found improvements in documentation and practice were necessary and performance was variable across months of the year. Sustained effort is required to maintain high levels of compliance in documentation.

Initiatives and trial projects exploring better performance

Various initiatives have been trialled — mainly within existing resources — to improve performance in the follow-up within seven days of discharge. Some initiatives are improvements in clinical care and coordination, while others address data and system issues.

In a number of Local Health Districts, staff have been assigned to actively chase down cases where the seven day follow-up period is due to expire and a follow-up contact has not been recorded. This can be either an administrative task (follow-up reminders and early warnings to responsible clinicians) or direct contact with a client by clinicians assigned to this task who have no ongoing role in care for the client.

Other strategies reported on included:

- intensive interrogation of demographic details to ensure patient identification and therefore client matching between hospital and community were optimised — this was associated with very strong post-discharge follow-up rates in Murrumbidgee Local Health District.
- active reviews of cases where follow-up did not occur and analysis of causes
- triple checking of contact numbers for community clients prior to discharge.

2.4 Involvement of the consumer, family or carer is the main failure in implementation

There are some weaknesses in the involvement of consumer, family or carer in discharge planning and therefore effective follow-up. This was evident from our discussions with clinicians, our review of local policies and practices, and clinical files.

The overall principle of client-led recovery is compromised if basic steps of consumer involvement are not taken. For example, we noted:

- no, or poorly constructed, discharge summaries, including with no information about follow-up care
- ‘verbal’ transfer of care, where discharge summaries had been delayed
- discharge summaries not routinely given to patients at discharge, under the guise of risk management
- carers not involved or advised of discharge
- little use of wellness plans or safety plans, which are consumer-directed tools to gain ownership of the recovery plan.

There was evidence that Local Health Districts recognised these practices were less than optimal and efforts were being made to address them, including by escalation to and intervention by senior executives.

At the same time, we noted high levels of compliance in informing GPs or other doctors of discharge, and generally concerted efforts to inform and provide relevant information to the

community mental health service at, or before, the point of discharge. Building collaborative care between mental health services and GPs was a specific focus of projects in two Local Health Districts. Unfortunately, this same level of collaboration with consumers and their carers was often not apparent.

2.5 Areas of uncertainty in how Local Health Districts apply the policy directive

There are a number of matters in the policy directive that Local Health Districts sometimes struggled to implement or which seemed to cause uncertainty.

Transfer of care plans are missing

As mentioned above, the policy directive envisages a package of documents — the Transfer of Care Plan — which is a comprehensive set of information for the consumer, family/carers, community mental health staff, and other service providers involved in ongoing care and support of the person.

The discharge summary is listed as one element of this package. In practice, the discharge summary was nearly universally used for all purposes, and was prepared by a doctor (usually by the psychiatric registrar and then counter-signed by the consultant psychiatrist).[3]

There seemed to be a reluctance to develop forms or letters that could be customised for different recipients — that is, different model transfer of care plans for a consumer or carer, compared to what might be prepared for a GP or psychiatrist. The role of the doctor as the sole preparer of discharge summaries was seen as a barrier to more customisable forms of written communication.

The imminent full implementation of the integrated patient record system will allow for automated drafting of discharge summaries from various fields of the record and should improve performance around discharge summary preparation. However, further guidance is required to ensure consumers receive relevant tailored information that is useful to them at time of discharge.

Exclusion of same day discharge from the technical definition of the KPI

Under the nationally agreed specifications for the data, the post-discharge follow-up KPI does not count contacts made on the day of discharge. Many of the clinicians with whom we spoke did not understand the reason for this exclusion.

Some Local Health Districts had a local practice to contact patients on the day of discharge to schedule a home visit. If the home visit is scheduled or delayed beyond day 7, then a second phone call is required to satisfy the KPI. Some clinicians felt that this encouraged duplication of effort and was an unnecessary contact.

Requirement for the client to be present in all cases

The nationally agreed specifications for counting follow-up contacts requires that consumers be ‘present’ for the follow-up contact, whether it is over the phone or face-to-face.

Clinicians making contact with family or carers in follow-up phone calls considered this constituted follow-up for particular consumers, such as reluctant participants, people from non-English speaking backgrounds, and residents of nursing homes. This included when the consumer was not present at the other end of the call. These clinicians felt that the policy lacked discretion on this requirement. As most local polices favoured face-to-face contact as the form of follow-up, this problem was highly relevant for performance reporting when the centre or home visit could not be scheduled within seven days.

Requirement for an estimated date of discharge (EDD) within 72 hours of admission

This was the most frequently omitted item in patient records. Clinicians on the whole were unconvinced of the value of an EDD so soon in care, except Psychiatric Emergency Care

[3] A psychiatric registrar is a medical officer who is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. A consultant psychiatrist has already completed their training and is registered to practice psychiatry.

Centres (PECCs)[4] and other time-limited units.[5] Its purpose in providing a signpost for staff and consumers to ensure timely discharge planning was not universally accepted. This is discussed further in section 3.4.

[4] PECCs are short stay mental health units co-located with Emergency Departments in 13 major hospitals around the state. PECCs generally have 4 to 6 beds and have maximum 48 hour lengths of stay. PECCs are specifically declared inpatient mental health facilities under the *Mental Health Act 2007* http://nswiop.nsw.edu.au/images/departments/special/mha/declared_mh_fac_gazettals_with_ward_2013-10-31.pdf

[5] Other time limited units include the Short Stay Unit at the Professor Marie Bashir Centre http://www.slhd.nsw.gov.au/MentalHealth/services_mb.html

3. Do mental health consumers receive follow-up care after discharge that ensures care and support in the community and reduces the need for hospital readmission?

There have been strong improvements in the proportion of consumers receiving post-discharge follow-up, albeit with further scope for improvement. Whether this follow-up by itself leads to better outcomes for consumers is harder to establish, as the episode of post-discharge follow-up is part of a continuum of care. It is not a standalone intervention.

Rates of post-discharge follow-up have improved in NSW over the past five years. However, the 70 per cent benchmark has not yet been reached either across the State or by most Local Health Districts. Rates of follow-up for consumers who leave hospital and discharge out of area are considerably lower than rates for consumers who remain in the same Local Health District.

We found that timely and comprehensive discharge summaries are an important tool for ensuring continuity of care and effective follow-up, though timeliness of their provision was a problem in all Local Health Districts visited.

Quality engagement between inpatient units and community mental health services was important to good discharge planning and, in turn, to good follow-up. A number of Local Health Districts have conducted initiatives to improve how the two care settings interact.

Recommendations

The NSW Ministry of Health should:

3. Clarify with Local Health Districts the scope of the policy directive, particularly with reference to consumers who are transferred to public community mental health services out of the area.

4. Facilitate Local Health Districts to:

    4.1. review processes around the handling of discharge summaries to ensure that they are a timely component of the transfer of care process

    4.2. consider mechanisms to share information and experiences about models of post-discharge follow-up

    4.3. review the quality of communication that occurs between mental health inpatient unit staff and community mental health staff, and develop action plans to address any deficiencies.

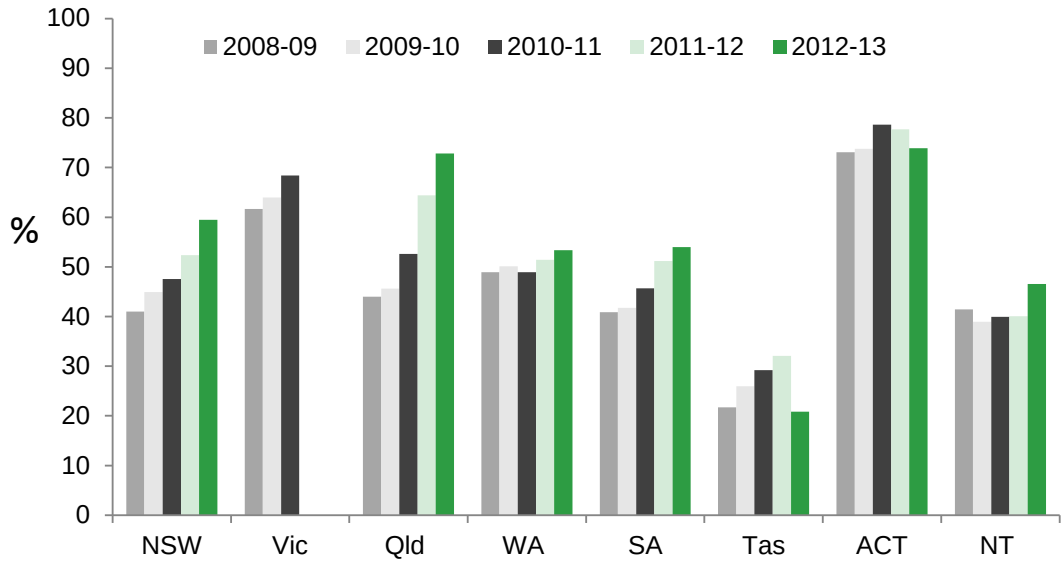
    4.4. review how community mental health services interact with admitted inpatients, particularly with regard to discharge planning, and compare to good practice models across NSW

3.1 The proportion of mental health consumers receiving follow-up has increased

As well as being a KPI in NSW Health's policy directive, the proportion of mental health consumers who receive follow-up care in the community within seven days of discharge is also a nationally reported performance measure. Annual reporting of this performance indicator is also done by agencies such as the Australian Institute of Health and Welfare and the Productivity Commission. This allows for relatively comparable reporting across States and Territories, as well as over time.

From 2010 to 2014, the rate of post-discharge follow-up from acute mental health units increased in NSW from 43.0 per cent to 59.9 per cent (Exhibit 3.1 below).

Exhibit 3.1 **Rate of post-discharge public community care provided out of the Local Health District within seven days of discharge, by State and Territory, 2008-09 to 2012-13**



Source: Steering Committee for the Review of Government Service Provision (2015), *Review of Government Services*, data table 12A.53.
Note
1. Victorian data are unavailable for 2011-12 and 2012-13 due to service level collection gaps resulting from protected industrial action during this period.

While rates of follow-up are improving at State and Local Health District level, and some individual facilities are achieving rates well above the 70 per cent benchmark, there is variation.

The most recent data for the period from January to June 2015 show that of the five Local Health Districts we visited:

- Four of the five improved their rates over the last five years — the rate has only fallen in Northern NSW, though this was from a relatively high base that was already at the benchmark.
- Three achieved the 70 per cent benchmark — Murrumbidgee (73 per cent), Central Coast (72 per cent), and Western Sydney (70 per cent).
- The remaining two districts achieved rates below the State benchmark — Northern NSW (60 per cent) and Sydney (58 per cent).

In some Local Health Districts, improvements are not sustained month to month and may depend on certain staff rather then embedded practices being in place.

For example, in one of the five Local Health Districts we visited, performance against the KPI dropped dramatically when a single staff member took annual leave. A consumer representative expressed the view that performance should not have been so dependent on an individual staff member taking leave: "…it wasn't a surprise she went on leave, other arrangements should have made".

Follow-up for consumers who go from hospital to out of area remains a challenge

Providing follow-up care to consumers who left the Local Health District after their discharge was raised as a recurring challenge across the five Local Health Districts we visited. Routinely, as many as a quarter of consumers may leave acute inpatient units for destinations in other Local Health Districts, or even other States and Territories. It can be difficult for Local Health Districts to ensure follow-up to these "out of area" (OOA) transfers.

Data shows that follow-up rates are considerably lower for consumers who are referred outside of the Local Health District compared to those who are referred to community mental health services within the same district.

From 2010 to 2014, of the five Local Health Districts we visited:

- all had follow-up contact rates as low as 30 per cent in at least one 6-month period — one district had rates as low as 13 per cent.
- none were able to ensure that consumers were followed-up by community MHS at the overall benchmark rates of 70 per cent.

There appears ample scope for Local Health Districts to improve how well they ensure that consumers receive follow-up when they are transferred to community mental health services in other areas.

Some clinicians did not view it as their responsibility to ensure follow-up for consumers who are discharged out of area and few policies address the issue. A number of clinicians go to considerable lengths to provide some form of follow-up, this is often characterised as a 'courtesy' or as a sense of professional obligation rather than a necessary measure to meet NSW Health's policy directive. It is not surprising in these circumstances that follow-up rates for OOA consumers are much poorer than in-district consumers. There were also examples of unit record data being collated that treated discharges to other teams in the district as being "out of area."

In these circumstances, follow-up contact within seven days, if any, will often fall on a community mental health service in another Local Health District. However, it remains the responsibility of the district from which the consumer is being discharged to effectively plan the discharge and to transfer care to the community team. OOA transfers count toward meeting the KPI for the Local Health District that provided the inpatient care. In one Local Health District, staff were allocated to make contact with OOA consumers, though there seemed confusion within the Local Health District about whether the contacts were counting toward achieving the KPI.

3.2 There was confusion in Local Health Districts regarding what gets measured

While the definitive KPI performance data collated by InforMH are likely to be robust, there was confusion evident in what some Local Health Districts understood was being measured. This becomes more problematic where the districts attempt to calculate their own results in advance of InforMH's data.

We became aware of differing practices across Local Health Districts in regard to:

- The inclusion of discharges from sub-acute units, when the KPI only includes acute units.
- Follow-up contact for clients being wholly managed in the private sector and where there seemed minimal need for publicly funded follow-up.
- The use of a 'proxy' for the person to get around KPI specification that consumer be present for the contact.
- Follow-up contact by two community teams when a consumer is being transferred out of district resulting in duplication.

Out of area transfers are the category most subject to variation in clinical care and in counting for the KPI reporting. This requires addressing with guidance and training, particularly in regard to the technical paper already prepared by NSW Health. This technical paper sets out the indicator specifications for measuring acute post-discharge follow-up care. These specifications reflect those agreed nationally, and which are publicly available from the Australian Institute of Health and Welfare.[6]

3.3 Different models of follow-up contact

There is great variety in follow-up practices

In general, follow-up practices are governed by detailed local policies and procedures. For the majority of consumers discharged from an acute inpatient unit, follow-up will be specifically planned as part of discharge planning while in hospital, will be arranged by a

[6] http://meteor.aihw.gov.au/content/index.phtml/itemId/559016

community clinician shortly after discharge (often within 24 hours), and will occur face-to-face either at a community health centre or in the home.

There is great variety in the models of follow-up used between Local Health Districts. There is also variety within districts. For example, follow-up may vary for specialist child and adolescent community mental health teams, compared to how it is done for acute adult care teams. Models may also vary depending on whether the consumer is already known to the service. If they are known, they may go immediately to a case manager as opposed to being followed-up by an acute care team. Acute care teams are more likely to provide only short-term, crisis-type intervention.

Other models may vary according to when the face-to-face contact is scheduled, as well as when the community mental health service becomes involved. In a few locations, inpatient staff may also make a follow-up contact shortly after discharge. As discussed above, where consumers are being transferred out of district, inpatient staff will usually plan and manage the transfer of care, including some form of follow-up with the consumer.

Short term projects initiated to improve performance in follow-up may also have staff who directly contact a consumer, but efforts are made to reduce duplication and multiple contacts with consumers. In one Local Health District with a dedicated follow-up team, there seemed uncertainty around when the dedicated team would follow-up a consumer, and when community staff would contact the same consumer.

Many clinicians made a distinction between consumers who are already known to mental health services and those who are new to mental health care,

The first group are those already engaged with community mental health services and perhaps an NGO provider. They may need inpatient care for a period of extreme unwellness. This person will be supported during that inpatient stay and transfer back to community care will be done. Follow-up is not such an issue for these consumers as continuity of care is more easily established.

The second group are consumers new to mental health care. The inpatient stay may be their first episode of intervention with a health service. Discharge planning will involve assessing the care needs of a consumer from scratch and gaining trust between service providers and consumer. The need for consumer and family information and care may be greater. Resettlement options may need greater research and coordination with community providers. There may be no established community for the person to return to. All these issues place discharge planning and follow-up at the centre of effective care for that person.

The ‘gold standard’ of follow-up practice, as advised by consumers and clinicians, seems to involve the following elements:

- face-to-face contact, especially for patients at greater risk of harm
- looking at what was agreed in the discharge plan
- asking did it happen
- was it made clear to the consumer and carer at the time
- was it written down
- was it within 7 days, not at 7 days
- did it result in agreed further actions between the consumer and the worker to make an effective care plan in the community.

It was also advised by clinicians in some Local Health Districts that connection to a GP would be the most basic form of safety net discharge process.

Follow-up contact is thoroughly planned and structured

While data shows that the rate of post-discharge follow-up has increased, this does not reveal whether the substance of that follow-up is of high quality. While it is difficult to measure the quality of these contacts, the audit did explore whether these encounters are well-planned and structured.

Follow-up contact is mostly done by face-to-face meetings, and usually in the consumer's home. A number of clinicians explained that meeting at the consumer's home allows them to review their domestic circumstances and whether the consumer appeared to be coping. Two community mental health teams expected consumers, where possible, to come to the community mental health centre. This was preferred by those clinicians, as it required consumers to display commitment to their own care.

The content of the follow-up meeting is prepared and structured. For home visits, a home visit assessment form is required to be completed. For all contacts, community mental health workers review discharge summaries, as well as related documents like consumer risk assessments.

While the content of follow-up meetings is not scripted, clinicians explained that there were standard matters that were discussed. These matters were detailed in checklists prepared by Local Health Districts. Our review of community mental health service files found evidence that these discussions were reflected in consumer records.

In many instances, considerable resources are devoted to seeking follow-up contact. Across Local Health Districts, we were told of practices where multiple phone calls would be made to attempt to schedule face-to-face contact, followed by two or three home visits. If contact could still not be made after these efforts, a letter would be sent to the consumer explaining that attempts had been made to contact them, and providing information on what the consumer can do next. Our review of files also noted examples where numerous attempts were made to contact individual consumers.

Accordingly, the audit did not find reason to believe that follow-up contacts are cursory, unplanned or insubstantial.

3.4 Discharge planning supports good follow-up

The audit has identified several areas where adherence to the policy and the underlying quality clinical practice may lead to improvements in care and better performance against the KPI. Perhaps chief among these areas is discharge planning.

The policy promotes integrated, collaborative continuity of care between health settings, involving safe and quality follow-up as a key element in the continuum of care. It particularly focuses on the needs of consumers returning to the community after an episode of inpatient care.

Within our audit's scope are the provisions concerning follow-up and associated processes. Follow-up is viewed as part of a transition process from hospital to home, and cannot really be examined without understanding discharge practices. These discharge practices are themselves supposed to start at the point of admission (or even before admission when the consumer is already known to the mental health service and the admission is planned).

The policy refers to "transfer of care plans", "discharge summaries" and "discharge plans". In practice, there is nearly universal use of the terms discharge plan and discharge summary to cover these concepts. The discharge plan is often included as part of an inpatient's clinical progress notes and as part of the discharge summary, rather than as standalone documents.

From those interviewed and an examination of local policies and protocols, the 'gold standard' for quality discharge planning includes the following key steps:

- commencement of discharge planning on admission
- early involvement of the specific community caseworker who will provide care in the community (ideal) or at least community mental health team representative
- carer and consumer involvement
- holistic assessments and plans
- allocated worker in inpatient setting to coordinate all aspects of discharge plan
- excellent documentation and communication
- a recommendation on nature and timing of initial follow up.

While it is expressly required by the policy directive, the recording of an estimated date of discharge within the first 72 hours of admission was seen as less relevant by most clinicians, and certainly the 72 hours was viewed as "just a guess". In one mental health unit where discharge dates were routinely estimated, clinicians noted that this was done by consulting psychiatrists and was more likely to err on the side of longer stays.

Internal audit reports prepared by one Local Health District noted that very few records contained estimated discharge dates. However, it was also noted that this information may be on handover sheets maintained on the ward, which are never incorporated into individual patient records. This was recognised as bad practice. In another Local Health District, local policy specified that the date must recorded on the patient's individual record, but it was not apparent that this was being done.

3.5 Weaknesses in discharge planning that are affecting post-discharge follow-up

Other than the estimated date of discharge, the elements set out above largely accord with the policy 'essential actions', but are being variably implemented by the Local Health Districts. In particular, discussions with clinicians and managers, internal documentation audits and our own file reviews showed weaknesses in:

- timely preparation of discharge summaries
- communication problems between hospital and community staff, sometimes related to availability of community staff to attend inpatient meetings
- overreliance on discharge summary as the primary communication vehicle
- reliance on fax as technology for passing written information and documents
- lack of involvement of the consumer and often lack of information tailored and provided to the consumer.

Discharge summaries are delayed by doctors' workloads

Clinicians in each Local Health District we visited spoke about delays in the preparation and distribution of discharge summaries from inpatient units to community mental health teams and other care providers. These are commonly prepared, in full, by psychiatric registrars (a doctor undergoing training to become a specialist psychiatrist), then approved by consultant psychiatrists.

We were provided with examples where units were complying with a benchmark of provision of the discharge summary to client and referral points, at time of discharge or on day of discharge, though these examples were exceptions.

More common were delays of around 48 hours, with one Local Health District reporting routine delays of up to two-weeks. Two Local Health Districts were attempting to send discharge summaries to community mental health teams within 12 hours, though performance was very poor. An internal audit found that even where discharge summaries were prepared in a timely manner, they were not sent in a timely manner that supported good transition of care.

'Verbal' transfers of care were seen as acceptable practice by one unit, if done by a psychiatrist, though this was not universally accepted. A more widely preferred model was that verbal clinical handover should accompany a written discharge summary, rather than be an interim substitute for an incomplete discharge summary.

There was a single Local Health District using an electronic medical record and associated software to pre-populate the discharge summary for a designated doctor to confirm/update at point of discharge, having particular regard to the medication management, and entering it as 'signed'.

In contrast, there was one facility where the discharge summary was completely handwritten by a registrar, repeating basic diagnostic and admission assessments through to a discharge plan. This is considered inefficient and has led to delays in discharge and in provision of discharge summaries to referral points.

The proposal that a nurse or other clinician, better placed at the centre of discharge planning, prepare the discharge plan/summary, had not been considered by most clinicians and managers interviewed. One noted that this had occurred 'in the old days'. The rationale for doctor approval was unknown or usually understood to have some relationship with medico-legal requirements.

Misunderstandings about privacy provisions affect information sharing

We were told many times that discharge summaries could not be supplied to non-approved recipients due to privacy considerations. This was sometimes the NGO involved in their non-hospital care, private health workers other than doctors, carers and families if not formal guardians. Only one Local Health District had developed the bespoke discharge plan envisaged by the policy directive. Such plans would include different information for different audiences — the consumer, the family, the NGO or others.

When discharge summaries were not provided to the consumer themselves, the reasons given were mainly related to risk management — the information would 'upset them', they would not understand the medications list, they would 'Google their diagnosis' etc.

Clear guidelines and training is needed to clarify this widespread confusion, which has led to less than optimal involvement of consumers and those involved in their community-based care. This should include the use of tailored discharge plans (as opposed to a one size fits all discharge summary), as envisaged in the policy on transfer of care.

The slow migration from fax to secure email as the mode of communication

There is an overreliance on fax to transfer client documents, particularly the discharge summary. Fax machines are often unreliable, are unmonitored, and many government and non-government organisations have moved on from faxing as a form of telecommunication. An internal audit report found that the lack of secure messaging between service providers, including GPs, was a key cause of inefficient and poor communication.

More generally, there was considerable uncertainty and inconsistency across Local Health Districts regarding whether, and in what circumstances, clinicians may use various technologies to contact consumers.

For example, there were some clinicians who believed faxing was the only permitted means due to security issues with email, though at least one other Local Health District routinely uses secure email and has systems in place to ensure security of information and safety for the individual. Another has implemented automated transfer of discharge summaries to nominated GPs who have subscribed to the system.

Similarly text messages, as part of securing a follow-up contact, were also considered forbidden as insecure privacy–wise and potentially unsafe for the worker if personal contact phone numbers are revealed.

3.6 Roles in discharge planning and follow-up

Involvement of community mental health services

The involvement of community mental health clinicians in discharge planning is considered critical to quality post-discharge follow-up and ongoing care. This involvement can be cursory or comprehensive, depending on the inpatient unit polices and practices, the community team's inclusion/exclusion practices and resource constraints, and the target group — specialist or general acute adult.

There is a range of practices, varying in timing and nature, and some are considered more effective than others. The most proactive example of this practice was the Murrumbidgee Local Health District where all admissions are allocated a community caseworker on admission or within 24 hours. This is possible within this defined network of services and many clients are already known and managed in the community when hospitalisation occurs. (Murrumbidgee Local Health District's approach to coordinating across inpatient units and community teams is discussed further in Exhibit 3.2).

At the very least, a community mental health worker from the local team attending discharge planning meetings or reviews (handover, clinical reviews, and daily meetings) is critical for effective follow-up.

At best, this in-hospital contact involves the actual future case worker/ case manager, any NGO providing significant levels of support such as accommodation, the family and/or carer and a peer worker supporting the transition to community living and care if needed.

Exhibit 3.2 Murrumbidgee Local Health District — Coordinating Mental Health Transfer of Care Project

Murrumbidgee Local Health District had low rates of community mental health team involvement in discharge planning or admissions. Internal audits found that clinical handover issues were a recurring feature in clinical incident investigations.

A range of reasons were identified to explain this low level of engagement between the inpatient unit and community team, including:

- No clear processes
- No one responsible for communicating with the community team
- Unclear role definitions for care plan – who leads between the inpatient unit and community mental health staff?
- Coordination of Doctor's list was often too late to allow case managers to attend
- Lack of recognition of importance of communication in establishing a good discharge plan.

A range of strategies and solutions have been trialled to address these issues, with results suggesting success in establishing better communication between the inpatient unit and community mental health team, as well as very good performance under the seven day follow-up KPI.

The project has clarified specific roles and responsibilities for both key inpatient unit clinicians and the community mental health clinicians. It makes clear that engagement with the consumers is expected, with face to face meeting preferable where a consumer has a length of stay greater than one week or is identified as being either high risk or having complex needs by either the inpatient unit or community team. The approach explains that:

> Familiarity of the consumer and their carer with the clinicians involved will support coordinated transfer of care and the effective, early engagement of the consumer in the community post-discharge.

Improving communication between inpatient units and community mental health services

Effective communication between inpatient and community mental health staff is crucial to community mental health services involvement in planning for quality discharge and follow-up. Throughout the audit, there was evidence of poor communication, and even low levels of trust, between these two care settings. For example:

- A community mental health clinician stated that there was '…still room to improve how we connect with inpatient units' and that this disconnect could be '…confusing for patients because they don't know what's going on between inpatient and community, especially new patients.'
- In another Local Health District, community-based clinicians expressed the view that inpatient staff often did not trust them to make decisions and would not 'let go' of 'their patients' to the care and judgement of the community mental health team.
- In yet another district, inpatient staff made the observation that they knew little about what the community-based teams did: '…they come to review meetings, with 20 or 30 people around a big room, but they sit at the back and don't say much.'

- Community-based clinicians in one Local Health District felt that inpatient staff '…just think we sit around having coffee all day'.

More commonly, communication was perceived to be limited by geography and workload, with community mental health workers being physically separate from inpatient units, and staff from neither care setting having the time to meet regularly.

We witnessed first hand in a weekly case review meeting how the use of videoconferencing was helping to overcome these challenges, as well as hearing positive experiences from clinicians in other Local Health Districts about how improved communication technologies were overcoming distance-based barriers.

A number of the Local Health Districts had recent or current initiatives to address perceived communication problems between inpatient and community care settings. Exhibit 3.3 describes proposals considered or implemented in two Local Health Districts.

Exhibit 3.3 Building better engagement between inpatient units and community mental health services

In Western Sydney Local Health District, ideas that were considered to improve communication between inpatient and community-based mental health clinicians included:

- Using work shadowing across professions or services to develop understanding
- Staff rotation between services
- Joint assessments of inpatient between community and inpatient teams
- Clear guidance and concise protocols on confidentiality and information sharing.

Northern NSW Local Health District identified the need for better communication to lift its performance against the KPI above the 50 per cent it was achieving two years ago.

In this case, the large size of the district made communication between care settings inherently challenging. A regular Friday morning discharge planning meeting has been established that provides a forum for inpatient and community based staff to discuss upcoming discharge needs for consumers. Clinicians from both inpatient and community care settings reflected positively on the structure of this meeting, which includes:

- Formal terms of reference with clearly articulated meeting purpose and standing agenda items
- Formal minutes to keep record of what was discussed and agreed
- Chairing by an experienced social worker, rather than a doctor, which was felt to contribute to more holistic planning
- The use of videoconferencing enabling staff in locations other than Lismore to easily participate.
- Including local NGO service provider representatives.

This meeting was seen as being a significant contributor to better interactions between care settings, as well as improving performance against the KPI from high-40 per cent figures in 2012 to results from 60% to above 70%.

Involvement of peer workers in discharge planning and transition to community care

Peer support workers are people with lived experience of mental illness who are employed to support consumers or their carers.

The audit team met with peer support workers and community advocates, and their managers, as part of our interviews. Development of the role of peer workers in effective discharge planning is in its infancy. Working with people with lived experience has demonstrated benefits for both consumers and service delivery. According to the NSW Mental Health Commission:

> Peer workers know what it is like to experience mental illness and can share experiences of personal recovery with consumers. People who are living well with mental illness represent hope that is often missing in people's lives.[7]

Some were working wholly within the inpatient setting and providing a valued service, particularly in advocating for individual patients and supporting them through processes, such as tribunal hearings.

One model, which was aimed at supporting consumers in a community setting, placed the peer support workers in community teams and their support was focussed on the transition to community and maintaining wellness in the community. This seemed an innovative model in keeping with principles of recovery-oriented practice and worth resourcing. It was highly valued by co-workers.

Involvement of NGOs in discharge planning and transition to community care

Involvement of NGOs in discharge planning is haphazard and uncommon. We noted examples of NGO workers visiting while the client was still an inpatient. One consumer representative expressed the view that: "Where the NGO worker visits while the person is in acute care in hospital, the coordination and follow-up is better."

However, this was not common and clinicians did not generally speak much about the role of NGOs. Consumer and community workers noted that, in general, clinicians were more likely to only have awareness of specialist mental health services, and not of crucial general services such housing, job placement and domestic violence.

However, clinicians were highly supportive of programs such as Housing and Support Intervention (HASI) type packages, which provide coordination of care addressing the basic needs of a person for successful community living, that health cannot.

Clinicians also supported the collaborative care models being developed and implemented by the Ministry, such as LikeMind[8], and in two Local Health Districts — Western Sydney and Murrumbidgee — care models were being explored that established closer links with NGOs. The important role of NGOs was particularly highlighted for children and adolescents.

NGO service providers themselves felt the policy directive itself did not support or reflect these models and that it had been "written from another age".

Links with drug and alcohol services

Some clinicians and consumer groups report that the bulk of inpatients are dual diagnosis — mental health and substance abuse issues. There is evidence from our file audit of the prevalence of substance abuse issues among mental health consumers.

Although this is the case, there were largely undeveloped policies and initiatives to ensure collaboration and coordination between drug and alcohol services and mental health services. There were instances of fairly passive referral responses, such as an information brochure on drug use and where to get help. There was also a general lack of knowledge of treatment interventions and options.

There were exceptions to this across each Local Health District that offer better practice models, if adopted consistently and more comprehensively:

- In Sydney Local Health District, the new short stay unit at the Professor Marie Bashir Centre provides mental health assessment and treatment integrated with emergency medicine, drug health and toxicology for patients able to be managed within a 72 hour stay.

[7] NSW Mental Health Commission (2014) *Living well: A strategic plan for mental health in NSW 2014-2024,* p100.

[8] The LikeMind initiative has seen integrated mental health service pilot sites for adults established by Uniting Care Mental Health in Seven Hills and Penrith. Supported by funding from the NSW Government, these sites are designed to co-locate a comprehensive range of mental health services, as well as other services, such as vocational and employment services, general health and wellbeing programs, education, housing, family planning and drug and alcohol services.

- In Murrumbidgee, community teams have an allocated drug and alcohol counsellor.
- In Western Sydney and Northern NSW Local Health Districts, co-location of community drug and alcohol services is used more frequently and supports collaboration.
- In the Central Coast Local Health District, some inpatient services make use of a clinical nurse consultant in a liaison role while the person is in hospital.

The Mental Health Review Tribunal

The Tribunal has a range of responsibilities for people detained in mental health facilities and people in the community on Community Treatment Orders. The proposed treatment plan and discharge plan are very important processes and documents for the Tribunal to consider when considering if it safe and appropriate for a person to be discharged from hospital on a Community Treatment Order.

Tribunal officers advised us that they regularly experience problems with the quality of documentation presented to the Tribunal. In terms of the scope of the audit, these problems often related to poor discharge planning and no, or minimal, arrangements for follow-up at the time of the tribunal hearing or mental health inquiry.

The Tribunal holds no data on the number or frequency of these issues. It conducts over 17,000 hearings per year, including more than 5,000 Community Treatment Order hearings and says the problem is not isolated.

The Tribunal has formulated practice directions and checklists to assist facilities in ensuring that health services have the correct documents ready for a mental health inquiry and other Tribunal hearings. The Tribunal encourages facilities to use these resources.

3.7 Link to other KPIs or better KPIs not established

While the policy directive includes a KPI on inpatient readmission rates within 28 days of discharge, there was not great confidence that this is an adequate KPI for measuring the effectiveness of follow-up within 7 days. Various clinicians noted that 28 days is a period more relevant to general medicine, and that readmissions may be caused by a range of factors that have nothing to do with follow-up care (such as whether the consumer could access other programs and services, such as housing or drug and alcohol programs).

The reliance on the two KPIs to provide performance information and accountability was seen as limiting. Various managers and clinicians suggested exploring the use of alternative or additional KPIs. Suggestions included:

- pre-admission community care and the relationship to follow-up rates
- suicide prevention measures
- 28 day representations at emergency departments
- presentations at ED of registered community services clients
- continuing engagement with community services (MHS and NGOs).

The audit was not in a position to assess the feasibility of these indicators or source their technical components.

Research and clinical experience supports the strong likelihood that follow-up contact within seven days is crucial to effective continuity of care and transition out of hospital. However, follow-up contact is not a standalone intervention, but is part of a continuum of care starting at admission. While it is possible to identify those activities that may support quality follow-up care, it is difficult to attribute consumer outcomes specifically to the follow up.

Appendices

Appendix 1: Response from Agency

NSW GOVERNMENT | Health

Trim Ref: S15/668

Mr A T Whitfield PSM
Acting Auditor-General
Audit Office of NSW
GPO Box 12
SYDNEY NSW 2001

Dear Mr Whitfield

Performance Audit: Follow-up care for mental health consumers after transfer from hospital to the community

I refer to the Assistant Auditor-General's letter of 13 November 2015 inviting NSW Health to provide a formal response on the final performance audit report: *Follow-up care for mental health consumers after transfer from hospital to the community.*

NSW Health welcomes the audit's finding that overall, mental health consumers receive good follow-up in the first seven days after their discharge from mental health units. It is pleasing to note that this is as a result of improvements to a range of different practices across Local Health Districts and the strong commitment of clinicians and management.

NSW Health supports the report's four (4) recommendations which provide valuable guidance on how we can further improve patient follow up after discharge from hospital. The recommendations will be progressed in the context of NSW Health's role in implementing the Government's mental health reforms which are directed to providing effective care and support in the community

I would like to thank you and your team for working with the Ministry of Health and Local Health Districts to make this audit a worthwhile and constructive exercise.

Yours sincerely

Dr Mary Foley
Secretary, NSW Health

11.12.15

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73 Miller St North Sydney NSW 2060
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Appendix 2: About the Audit

Audit objective

The objective of this audit was to examine how well NSW Health and Local Health Districts manage follow-up from acute mental health units after transfer to the community to ensure adequate care and reduce hospital re-admissions.

Audit scope and focus

This audit focused on the NSW Ministry of Health, particularly the Mental Health, Drug and Alcohol Office, and Mental Health Services provided by Local Health Districts. Five Local Health Districts were visited for this audit. This audit included mental health consumers who are returning to the community following an episode of inpatient care in a mental health unit.

Audit Exclusions

The audit did not include follow-up for mental health consumers on approved leave from an inpatient unit.

Justice Health and other specialist health networks were excluded from this audit.

While only required to comply with the policy directive 'where practicable', Psychiatric Emergency Care Centres (PECCs) were included the scope of this audit. However, mental health presentations to emergency departments are not covered by the policy directive and do not fall within scope (though any subsequent transfer to a PECC or admission to a mental health unit would fall within scope).

Other activities that contribute to effective transfer of care/discharge to the community are not directly included in this audit, though may be discussed to the extent that they affect follow-up policies and procedures.

Audit Criteria

Our two audit criteria are:

- Are the roles and responsibilities for providing follow-up care understood and met?
- Are mental health consumers receiving follow-up that supports their transition to the community?

Audit approach

The audit team acquired subject matter expertise through:

- interviews with relevant staff in NSW Health and Local Health Districts, as well as InforMH
- examination of relevant documents, including legislation, policies, strategies, guidelines, procedures, reports, reviews, business cases and plans
- consultations with representatives of key stakeholders
- research into better practices.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Audit Standards ASAE 3500 on performance auditing. The Standard requires the audit team to comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance and draw a conclusion on the audit objective. Our processes have also been designed to comply with the auditing requirements specified in the *Public Finance and Audit Act 1983*.

Acknowledgements

We gratefully acknowledge the co-operation and assistance provided by the Mental Health Drug and Alcohol Office of the NSW Ministry of Health. We also thank the staff of InforMH for their expert technical assistance and advice.

We also thank staff and management from stakeholder bodies who provided background advice and assistance on this audit, including the NSW Mental Health Commission, the Mental Health Review Tribunal, Official Visitors Program, NSW Mental Health Coordinating Council, and BEING.

Finally, we particularly thank our liaison officers and staff from the Mental Health Services in the five Local Health Districts we visited. This includes the many clinicians, managers, senior executives, consumer and carer representatives, and data custodians who generously gave their time and expertise.

Audit team

This audit was conducted by Andrew Hayne (Principal Performance Analyst) and Michelle Wheeler of Michelle Wheeler Consulting. Support was also provided by Jason Appleby (Performance Analyst). Kathrina Lo (Assistant Auditor-General) provided direction and quality assurance.

Audit cost

Including staff costs, travel and overheads, the estimated cost of the audit is $160,000.

Appendix 3: Roles and responsibilities for the transfer of care from mental health units to the community

Roles and responsibilities of the Ministry of Health

- Provide advice and assistance in the implementation of the policy
- Monitor and review the implementation of the policy

Roles and responsibilities of Local Health District Chief Executives

- Assign responsibility, personnel and resources to implement the principles and procedures for mental health service settings
- Report annually on the implementation of transfer of care principles and procedures to the NSW Ministry of Health

Roles and responsibilities of Local Health District Directors of Mental Health

- Facilitate development of District-wide transfer of care and leave policy and protocols
- Facilitate development of District-wide transfer of care and leave policy and protocols that
    - Are consistent with the state-wide policy directive's principles and procedures; and
    - Include protocols for managing a consumer's transfer of care to the community outside of usual working hours, at weekends and during holiday periods.
- Develop a transfer of care checklist to ensure that all steps of the procedure are carried out.
- Educate clinical staff in the engagement of the principles and procedures for transfer of care planning.
- Ensure the principles and procedures for transfer of care planning are incorporated into orientation programs for new clinical staff.
- Ensure transfer of care practices are regularly monitored across their services and feedback on results is provided to staff.
- Report annually to the Ministry on implementation of the policy directive's requirements through the Chief Executive.

Roles and responsibilities of Hospital, facility, clinical stream, unit managers and heads of departments:

- Implement the local policy for mental health transfer of care.
- Ensure that the Primary Carer, and/or family, other health care providers and community support services participate in the process of planning for transfer of care as appropriate (see Procedures).
- Evaluate compliance with the principles and procedures for transfer of care planning.
- Annually monitor and evaluate local transfer processes in line with the principles and procedures for transfer of care and report to Local Health Districts /Network Director of Mental Health.

Roles and responsibilities of all clinicians:

- Ensure their work practices are consistent with the principles and procedures for safe and effective transfer of care processes.

Source: NSW Health (2012) *Transfer of Care from Mental Health Inpatient Services*, policy directive PD2012_060

Performance auditing

What are performance audits?

Performance audits determine whether an agency is carrying out its activities effectively, and doing so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of a government agency or consider particular issues which affect the whole public sector. They cannot question the merits of government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in the *Public Finance and Audit Act 1983*.

Why do we conduct performance audits?

Performance audits provide independent assurance to parliament and the public.

Through their recommendations, performance audits seek to improve the efficiency and effectiveness of government agencies so that the community receives value for money from government services.

Performance audits also focus on assisting accountability processes by holding managers to account for agency performance.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, the public, agencies and Audit Office research.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing. They can take up to nine months to complete, depending on the audit's scope.

During the planning phase the audit team develops an understanding of agency activities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the agency or program activities are assessed. Criteria may be based on best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork the audit team meets with agency management to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with agency management to check that facts presented in the draft report are accurate and that recommendations are practical and appropriate.

A final report is then provided to the CEO for comment. The relevant minister and the Treasurer are also provided with a copy of the final report. The report tabled in parliament includes a response from the CEO on the report's conclusion and recommendations. In multiple agency performance audits there may be responses from more than one agency or from a nominated coordinating agency.

Do we check to see if recommendations have been implemented?

Following the tabling of the report in parliament, agencies are requested to advise the Audit Office on action taken, or proposed, against each of the report's recommendations. It is usual for agency audit committees to monitor progress with the implementation of recommendations.

In addition, it is the practice of Parliament's Public Accounts Committee (PAC) to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report is tabled. These reports are available on the parliamentary website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

Internal quality control review of each audit ensures compliance with Australian assurance standards. Periodic review by other Audit Offices tests our activities against best practice.

The PAC is also responsible for overseeing the performance of the Audit Office and conducts a review of our operations every four years. The review's report is tabled in parliament and available on its website.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

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People – we trust and respect others and have a balanced approach to work.

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