Executive Summary

Background

The Charters Towers Community Mental Health Service (CTCMHS) provides community-based mental health care to consumers in Charters Towers as well as in Richmond and Hughenden. These consumers are supported in the community by the multidisciplinary CTCMHS team as well as general practitioners and other external service providers. Consumers experiencing serious episodes of mental illness who cannot be adequately supported in the community are cared for in the acute inpatient unit at The Townsville Hospital.

The goal of the CTCMHS is to provide individual support and treatment to consumers with a mental illness in the community. There is a long and proud history of quality mental health service delivery in Charters Towers. However, the provision of a broad scope of mental health care services across a large geographical footprint has inherent challenges. This has been compounded in recent years by staffing vacancies and a high turnover of team leadership.

The provision of safe, high-quality healthcare to consumers is the highest priority of the Townsville Hospital and Health Service (THHS). In 2017, THHS Chief Executive Dr Peter Bristow was made aware of clinical practice and workplace culture concerns within the CTCMHS. A number of reviews were subsequently commissioned.

Context

Ms S Wigan was appointed to review clinical matters at the CTCMHS in August 2017. This appointment was made in accordance with the legislation under Sections 124 (c) and 125 (2) of the *Hospital and Health Boards Act 2011*.

The review involved the comprehensive case-file analysis of the services provided to 105 CTCMHS consumers by one clinician between 1 February 2016 and 23 August 2017. All cases were reviewed against set criteria based upon clinical best practice, procedural compliance and documentation standards. The scope of this review excluded the assessment of patient outcomes and did not benchmark findings against the performance of other services.

This external clinical review occurred independently to a service-initiated internal review of 433 cases which covered a similar but shorter time period of 1 January 2016 to 30 November 2016. The results of the internal informed the final recommendations of the external review.

An external investigation into workplace bullying and harassment claims within the CTCMHS was also commissioned. This commenced in late 2017 and at the time of writing is ongoing.

Overview

The review has found that the actions of individual clinicians did not directly cause any adverse clinical incidents. The review has found, however, that systemic service delivery issues exist. These must be addressed to reduce risk, improve safety and increase consumer confidence in the service.

In all, this review makes 37 service improvement recommendations to address the issues identified and improve the care provided to consumers by the CTCMHS.

The clinical review involved comprehensive analysis of the care provided to individual consumers. A review of this nature would in any case be expected to identify opportunities for improvement.

Service Improvement Recommendations

The review recommendations fall into 14 categories of service improvement. These are classified as either immediate or ongoing.

Immediate Recommendations:

1. Resourcing

The review identified a shortfall in clinical resourcing both in the type and level of resourcing and has recommended an increase in psychiatrist time to facilitate their engagement and input into the early phases of care resulting in more comprehensive assessment and earlier initiation of treatment.

Further, the review recommends the addition of a further two senior clinicians within the service to support primary care providers and support service providers in delivery of comprehensive care. This includes GPs but is not limited to GPs. The second position will support other clinicians on the ground to engage with clients and deliver evidence based treatments.

2. Service Governance

The review has recommended an enhancement to service governance. The review found that Service Governance was weakened by constant changes to leadership over the review period and lack of valuable input from the medical/psychiatrist staff.

A new team leader commenced in January 2018 and that person will be supported by the psychiatrist in terms of service governance and monitoring and enhancing Clinical performance to achieve agreed performance targets.

Ongoing Recommendations:

3. Service Responsiveness

The review found that due to inadequate resource levels, further compromised by constant staff vacancies and difficulties in recruiting staff, clients were waiting a long time to be fully assessed and treatment initiated resulting in a number of people ceasing service and not receiving the service they requested. The suggested increase in resourcing along with implementation of other recommendations should reduce this wait time and engage clients earlier thus affording clients earlier intervention if required.

4. Community Linkage and Service Integration

There are a large and diverse number of specialist mental health services located in Townsville that could provide outreach services into the Charters Towers area including addiction services, forensic services, older persons mental health.

The review has recommended that these services develop protocols for their access, consultation and ongoing involvement and input into Charters Towers to enhance outcome for clients with complex needs and dual diagnosis.

Further linkages with community and community providers will be enhanced by the addition of the resource as identified in recommendation one. To get the best clinical outcome and assist people to recover it is essential that all inputs clinical and non-clinical are co-ordinated and directed towards client needs.

5. Procedures and Protocols

It has been recommended that all procedures and protocols that drive service excellence be reviewed to ensure currency and relevancy and that they reflect the most up-to-date quality and safety standards. This process is already underway.

The implementation of the procedures and protocols will be supported by regular and sustained staff experience and training staff along with regular evaluation of compliance. New procedures/practices will be developed to underpin outreach services and hand over of clients to other practitioners when required.

6. Staff Supervision

All clinical staff require regular practice supervision and clinical support, none less than the staff in rural and remote communities. Supervision and support are evidenced as critical to the delivery of safe quality service. The review has recommended that supervision be enhanced and monitored to ensure it is directed appropriately. The review further recommended the adoption and implementation of the National Practice Standards for Mental Health Practitioners as the single unifying standard for practitioners delivering service to complement discipline specific standards of practice.

7. Clinical Support

The review identified a lack of direct psychiatric clinical support and oversight into some clinical processes eg. referral, intake and assessment - critical front end processes that lay the foundation for appropriate management and treatment. It has been strongly recommended that this change with direct psychiatrist oversight and review and support for the ground clinical staff in applying comprehensive intake and assessment protocols.

8. Education/Training

Staff education and training was found to be lacking and not inclusive of critical elements both in clinical content and aspects of service delivery eg. carer engagement, client focussed care recovery as an approach to connecting with clients and co-ordinating care with other providers. To address

this it has been recommended that staff education and training be reinvigorated and targeted specifically to interventions and methodologies that suit the local communities.

9. Auditing, Review and Evaluation

It is essential that there be continuous monitoring of the clinical and procedural requirements that drive best practice. It has been recommended that a schedule of audits, reviews and evaluations be developed and carried out to ensure changes are being implemented and are having effect with a further review to occur at the twelve month mark.

10. Intake/Assessment

The review found that more than 50 per cent of the clinical activity within the service is directed to receiving referrals and conducting intake and initial assessment to inform management and intervention. It has been recommended that there be increased psychiatrist and senior clinician involvement, oversight and engagement in these processes and activities.

11. Documentation

It was found that documentation requirements and standards were not consistently met. Documentation on many occasions lacked completeness and rigour of detail. It has been recommended that a full and comprehensive retraining in documentation, both written and electronic, be undertaken by all staff focussing in particular on the changes that have come into play following the implementation of the *Mental Health Act 2016*, which has been in effect since March 2017.

12. Other Reviews

It has been recommended that with the results of the Review of Charters Towers in mind that either internal or external reviews of the other rural sites be carried out to proactively identify service improvements relevant to their area and their functioning.

13. Contingency Planning

The review identified that during times of high staff vacancies and turnover it is difficult to maintain service delivery to an acceptable level.

It has been recommended that the service develop a contingency plan for service management during these times by utilising additional resources both physical and electronic from Townsville to support local clients and staff.

14. Physical Work Environment

A further recommendation has been made that the work environment existing in Charters Towers be assessed with a view to creating staff amenities that foster good working relationships and conditions and improved areas for receiving and working with clients who present.

Clinical Reviewer

Ms S Wigan.

MBA , Graduate Dip P Health, B of S Wk, Dip Legal Studies.

40 years' experience at the operational and executive level of mental health service delivery overseeing innovative service development, service reform and service improvement.