Office of the Chief Psychiatrist Delayed Transfer of Care Report: Summary of Feedback and Response to Recommendations 1st September 2020

Government of South Australia

SA Health

In 2019 a review of delayed transfer of care (also known as ambulance ramping) was requested by the Chief Psychiatrist (CP) to address concerns expressed by a Senior Staff member of the impact of delayed transfer of care of people with mental illness.

Under Section 90 (4) (a) and (b) of the *Mental Health Act 2009* (the Act), the Chief Psychiatrist has '*the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the Health Care Act 2008; and be taken to be an inspector under Part 10 of the Health Care Act 2008.'*

Under Section 91 (1), (2) and (3) of the Act, the Chief Psychiatrist may delegate a power or function of the Chief Psychiatrist to another person. In accordance with this power Dr Shane Gill was delegated as an inspection for the purpose of undertaking this review, assisted by Mr Graham Deakin of this Office.

A draft of the review was circulated for comment to Local Health Networks. It was initially intended to incorporate these comments into the report earlier this year. The arrival of COVID-19 delayed this work, with key mental health staff in our Office taking on roles supporting the COVID-19 mental health response and the Command Centre.

On reflection, I have decided to release the report as originally prepared. There was no disagreement from the earlier consultations with the major observations related to delayed transfer of care, although there was some differences in opinion regarding details. These vary from hospital to hospital, and practices change with time, so some of the small details are not critical. In releasing this report we can be confident that the reviewers faithfully recorded information given to them, and reviewed practices at that time, which has led to this informative report.

Findings and Recommendation of this Report

The statistical analysis demonstrated significant delays for many mental health consumers. The 2018 data as reported by the reviewers recorded 3,762 presentations of mental health consumers recording delays of more than 30 minutes. This represented 34.2% ambulance arrivals. Different patterns of response were described in different hospitals when ED cubicles are full, with both external delayed transfer where a consumer remains on a barouche in an ambulance and internal delayed transfer where a person may be taken to a wide corridor inside the department, and waits with a South Australian Ambulance Service (SAAS) officer. The report describes the impact of these practices on consumers, on staff and service delivery.

The factors leading to delayed transfer are described including access block for emergency departments, the lack of alternatives in SA to hospital EDs for emergency mental health assessment and intervention, the lack of non-hospital based acute mental health care options, and a lack of alternative pathways to admission to hospital rather than ED, a lack of coordination of mental health beds across the whole SA mental health system, physical space limitations in SA emergency departments, and the impact of methamphetamine intoxication on EDs.

Dr Gill and Mr Deakin made 24 recommendations. A number of these involve solutions requiring input from different agencies, and will need consideration in relevant committees including the Trauma Informed Practice Working Group and a Steering Group which oversees a memorandum of understanding between emergency services related to mental health care.

Recommendation from the Independent Reviewers	Comment from the Office of the Chief Psychiatrist
Interventions already implemented that could be expanded	
Priority Care Centres. These are available for consumers presenting to ED with relatively minor physical health problems. Currently they do not have mental health staff available and are not used for mental health presentations. There seems no reason why MH nurses could not be based in these PCCs and for MH consumers to have access to assessments there.	The Department has tendered for a specialist Urgent Mental Health Care Centre which will provide a community alternative to the ED in the CBD. Priority Care Centres, which are primary care based, are at times treating mental health consumers. This role will be explored further as the system for responding to people in crisis is reviewed as part of implementing the Mental Health Services Plan.
Mental Health Core Pilot Trial. This trial early in 2019 consisted of a MH clinician from CALHN being co-located with a paramedic at one ambulance station for a six-week period. This pilot trial found that 53% of consumers who were seen were diverted away from an ED attendance. Consideration should be given to extending and expanding this trial.	This 2019 trial which was a partnership between the Central Adelaide Local Health Network (CALHN) and SAAS, was considered successful and has been extended. Consideration is being given by the operators of this trial as to how this service can be expanded.
Recommendations for immediate action	
Whilst the reports indicate that in the vast majority of cases, consumers who have been restrained in the ambulance are allocated a triage category or 1 or 2, it should be made clear to all ED triage staff that these categories must be allocated for every MH consumer for whom restraint has been applied at any point during ambulance transport.	Supported in principle, however more work is needed to consider the impact of this change on other consumers – in particular comparing the use of this suggested rule to a decision based on current clinical assessment While the outcome of the decision is likely to be the same for persons restrained on arrival, it may be different for people who have been restrained at an earlier point in the journey) .This reflects a concern about potential unintended consequences (eg if a consumer who was restrained but is now settled is given priority over other consumers). This recommendation will be referred to the Trauma Informed Care Working Group for further advice on implementation.

Recommendation from the Independent Reviewers	Comment from the Office of the Chief Psychiatrist
When a consumer presents to a hospital on Code White, the default expectation should be that triage clinicians will personally speak to the consumer as part of the triage assessment. The process of external triage, where the consumer waits in the ambulance and is not reviewed by a triage clinician, should be the *exception* rather than the rule. Any OH&S barriers to this must be addressed as a matter of urgency.	Supported in principle. This topic will be raised at the Mental Health and Emergency Services Memorandum of Understanding (MoU) Steering Committee for assessment. This is attended by mental health, ED staff, SAAS, SAPOL and RFDS.
Hospitals and SAAS should provide collaborative care for all consumers whilst being ramped, regardless of whether or not this is external or internal ramping. This is consistent with SA Health Policy.	Supported in principle. For discussion at the MoU Steering Committee
Consumers, and SAAS officers, must be given appropriate access to food, water, and toilet facilities whilst being ramped, either externally or internally.	Supported. For discussion at the MoU Steering Committee
Explore the feasibility of providing electric power sockets in ambulance bays for ambulances to connect to, enabling diesel engines to be turned off.	Supported in principle. This is a technical matter related to ambulance design, that has not been explored further by OCP. OCP will discuss with SAAS.
Better reporting/notification of delayed TOC. The reviewers found that SLS notifications were not made for a large number of consumers experiencing delayed Transfer of Care for extended periods. Notifications should be made for all delayed TOC over 30 minutes where there is a direct clinical incident or adverse event, all delayed TOC over 60 minutes regardless of whether any additional adverse event occurs, and all external ramping over 30 minutes.	Supported For referral to the Strategic Mental Health Quality Improvement Committee to oversee implementation and review of statistics.
All incidents of use of restraint during ambulance transport, including during a period of ramping, must be documented and reported.	Supported This requirement has been incorporated in the draft Chief Psychiatrist standard that seeks to reduce and eliminate where possible the use of restraint and seclusion.
There needs to be consistent and uniform recording of TOC times between hospital services and SAAS. Consideration should be given to uniformly adopting the ACEM's recommendation of "ED Notification Time" as the start point for TOC.	Supported by OCP. For discussion at the MoU Steering Committee.

Recommendation from the Independent Reviewers	Comment from the Office of the Chief Psychiatrist
Hospital ED clinicians, including mental health clinicians, should commence some form of assessment (e.g. a limited risk assessment) whilst the consumer is being ramped, acknowledging the limitations of what can be achieved whilst the consumer remains within the ambulance, or in an open space such as an ED corridor or waiting room. This should be done collaboratively between SAAS and ED clinicians and would require additional MH staff resources, which should be a priority for funding.	Supported by OCP. For discussion at the MoU Steering Committee.
Every effort should be undertaken to reduce the practice of external ramping. Whilst internal ramping is still delayed TOC, and would also not occur in a well- functioning system, it is inherently preferable, from a consumer perspective, to external ramping. This may be challenging in those hospitals with limited physical space, but should not prevent attempts to find solutions to reduce external ramping.	Supported by OCP. To be raised at the Mental Health Leadership Group (which has representatives from the MH Leads of the LHNs), and the MoU Steering Committee.
Services should establish ED avoidance pathways. Inpatient MH Units need to develop an increased capacity for direct admissions of known consumers referred by their community team. Consumers who have absconded and return after a period of unapproved leave should be readmitted directly rather than re-routed through an ED.	Supported. To be referred to the Mental Health Leadership Group.
SA Health, SAAS and Mental Health Services should review the policy that consumers brought in by ambulance under s56 have the bill charged to the receiving LHN. This creates an incentive for more restrictive care, and the policy should be amended to ensure that it does not discourage the least restrictive care option for MH consumers at all times.	Supported in principle. To be raised by OCP with SAAS and DHW Finance.
A targeted risk assessment at the time of triage, or soon thereafter, should be undertaken to determine level of observation required for consumers brought in under s56, rather than a default assumption that assumes 1:1 observation by clinical or security staff is required.	Supported in principle. For referral to the Strategic Mental Health Quality Improvement Committee to consider the nature of the risk assessment and safe implementation.
Hospital EDs should ensure that sufficient authorised officers are available to receive handover of care and control for consumers brought in under s56 of the MHA, especially in smaller EDs, where the number is currently restricted. This may require increased training resources.	Supported For referral to the Strategic Mental Health Quality Improvement Committee and to the OCP training officer.
Mental Health Services should develop community-based options for delivering acute mental health assessment and intervention.	Supported This is incorporated into the Mental Health Services Plan

Recommendation from the Independent Reviewers	Comment from the Office of the Chief Psychiatrist
The capacity for community teams to provide acute assessment and crisis intervention, in a similar manner to the previous ACIS Teams, must be increased. This will probably necessitate the establishment of separate acute teams instead of an acute assessment role within an integrated team model.	Supported in principle The requirement to have an effective acute response is currently being incorporated into LHN re-designs of community service structures. Ultimately structure is determined by LHNs and their Boards, but the expectation of an effective community acute response to people in crisis is part of commissioning expectations. This will be referred to the DHW Mental Health Commissioning Committee for oversight.
Hospital at Home Teams should be established in each LHN and adequately funded to provide acute care for consumers who would otherwise be admitted to an inpatient unit. This is likely to require new funding and should be a priority.	Supported in principle. At least two LHNs are considering hospital in the home teams. Community based acute care as an alternative to hospital should be available. It is acknowledged that some providers may do this through Acute Community Teams, and others may prefer a Hospital in the Home team.
Community-based, acute assessment "Walk-in Clinics," which were previously successful at Salisbury, should also be considered for funding.	Supported in principle See the earlier reference to the Urgent Mental Health Care Centre. Although initially it will receive SAAS, SAPOL and telephone triage service referrals, it will then expand to receiving walk in consumers.
Mental Health Short-Stay Units have been successful in improving bed access capacity for mental health consumers and consideration should be given to expanding these where possible.	Supported in principle Work is underway to build a new Short Stay Unit at Lyell McEwin Hospitals, and similar units have a role in other metropolitan hospitals. Expanding this to country needs consideration. The MH Services Plan also recommends Acute Behavioural Assessment Units which provides a short stay response in a collaborative model between mental health, drug and alcohol services and ED toxicology..

Recommendation from the Independent Reviewers	Comment from the Office of the Chief Psychiatrist
The capacity for a rapid response, post-discharge brief intervention service within community teams should be expanded. This could be used for consumers discharged from inpatient units and ED.	Supported in principle. See earlier comments about community redesign. For referral to the Mental Health Leadership Group.
Recommendations for Medium to Longer Term Action	
SA Health should ensure that hospital ED infrastructure matches ED demand, now and into the future. Any capacity to increase the physical capacity to assess and treat the volume of consumers presenting should be explored.	Supported in principle – noting the intention to improve the Crisis system to deliver ED alternatives as above.
SA Health should review mental health policies to ensure they are in the best interest of SA mental health consumers *as a whole*, and that LHNs actively collaborate rather than acting in silos. This should include a review of the appropriateness of the policy of Local Bed Management, which appears to have directly worsened ED access block problems at the RAH as well as fostering a culture of non-cooperation rather than mutual collaboration among LHNs.	A review of the Localised Bed Management Policy is in place led by the Director of Mental Health Policy, Planning and Safety in the OCP. An actuarial review of previous data analyses used for the Localised Bed Management policy, confirms that these analyses were of a high standard, but has recommended that simulation modelling occur that can consider the day to day volatility in demand across services, and how this is affected by catchment size and policy changes.

<u>Feedback to the Report</u>

A concern was expressed that potential recommendations as well as a number of the statements in the report and could have unintended consequences. There were some statements that that have a level of factual accuracy but we were noted to have a number of complexities and the report does not completely address the root of the problem.

Dr Gill acknowledged that there will be a number of complex reasons why things are the way they are, which are not immediately evident unless you have worked at a centre for many years and know all of this background. This is one of the disadvantages of using external reviewers, but this is counteracted by the advantage of external review, around independence, objectivity and a lack of conflict of interest.

Another organisation reviewed the draft report and developed an action plan template to respond to its recommendations.

It was also noted that the review had a focus on adults.

There was also some disagreement about the authors' use of statistics that was used in the report to question Localised Bed Management, the definition of outliers and whether the Royal Adelaide Hospital was left to take extra demand because of the policy settings...

Dr Gill noted that the data the reviewers considered was based on a particular period of time (2018) and that there may have been change in data since then (esp. during covid-19). There are also concerns about the definition of "outliers", which reflect how boundaries are drawn. He was also complimentary about the data analysis noting that while raising issues, he had considered literature articles written by the Local Bed Management developers.

I have noted in my comments above that the overall data analysis has been independently endorsed and considered to be of high quality. There has however been policy feedback in 2017 that while the rigid application of Localised Bed Management may have been necessary at one point of time, it could become more flexible now particularly at periods of high demand, and that a broad Mental Health Services Plan is needed for responses across the community services as well as hospital. Such a plan now exists. The Localised Bed Management Policy review will also consider catchment area boundaries which vary between general health services and mental health services.

As part of this work it is expected that a range of different LHN and hospital boundaries for responses to mental health, older persons mental health and general health will be reviewed and possibly aligned, with mental health matching general health catchment areas where possible.

Next steps

The action table will be updated over coming months in response to follow-up of the recommendations of this review.

John Brayley

Chief Psychiatrist

For more information

Office of the Chief Psychiatrist
11 Hindmarsh Square, Adelaide 5000
Telephone: 8226 5985
www.sahealth.sa.gov.au