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Our reference: **FOI19/58**

[redacted]

Dear [redacted]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on 27 August 2019 and rescoped on 17 September 2019.

This application requested access to:

> *"Internal correspondence between executive level staff and correspondence between executive staff and clinical directors of departments regarding:*
> - *capacity issues/bed availability in the geriatric ward*
> - *capacity issues/bed availability for maternity services at Centenary Hospital for Women and Children*
> - *capacity issues/bed availability at the adult mental health unit.*
> - *capacity issues/bed availability/use of corridor beds in the emergency department."*

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Wednesday 6 November 2019**.

I have identified nine documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to:

- grant full access to 7 documents; and
- grant partial access to 2 documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004.*

Full Access

I have decided to grant full access to seven documents relevant to your request. These documents are at folios 1 – 2 and 4 - 8.

Partial Access

I have decided to grant partial access to two documents relevant to your scope. These documents are at folios 3 and 9 containing deletions to information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the FOI Act. The information contained in folio 3 is personal contact details, there is no public interest in disclosing this information. The redacted information in folio 9 is trade secrets, business affairs or research of an identifiable third party.

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2.1 (a) (viii) reveal the reason for a government decision and any background or contextual information that informed the decision.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2.2 (a) (xi) prejudice trade secrets, business affairs or research of an agency or person.

On balance, the information identified could reasonably be expected to prejudice the trade secrets, business affairs or research of Healthcare Reform Consulting. The public interest would not be advantaged by the release of this information and could have an adverse effect to the Consulting firm. Canberra Health Services could be affected in the ability to engage contractors if an external consultant's trade secrets or business affairs is not respected.

Charges

Processing charges are not applicable to this request.

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Disclosure Log

Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published. https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au.

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9829 or email HealthFOI@act.gov.au.

Yours sincerely

E. A. Chatham

Elizabeth Chatham
Chief Operating Officer
Canberra Health Services

6 November 2019

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FREEDOM OF INFORMATION REQUEST SCHEDULE

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	File No
[redacted]	*"Internal correspondence between executive level staff and correspondence between executive staff and clinical directors of departments regarding: (1 January – 17 September 2019)* *- capacity issues/bed availability in the geriatric ward* *- capacity issues/bed availability for maternity services at Centenary Hospital for Women and Children* *- capacity issues/bed availability at the adult mental health unit.* *- capacity issues/bed availability/use of corridor beds in the emergency department."*	**FOI19/58**

Ref No	No of Folios	Description	Date	Status	Reason for non-release or deferral	Open Access release status
Capacity issues/bed availability at the adult mental health unit						
1.	**1 - 2**	Email – AMHU ongoing crisis	5 February 2019	Full Release		YES
2.	**3**	Email – Beds and movement	11 February 2019	Full Release		YES
3.	**4 - 5**	Email – MH bed capacity and SUSD	30 March 2019	Partial Release	Schedule 2.2 (a) (ii)	YES

4.	**6 - 12**	Email and attachments – Draft Brief on ED gazettal from AHD for consultation.	24 June 2019	Full Release		YES
5.	**13 - 21**	CHS19/1084 – Request to repurpose four beds on Ward 7B for temporary surge capacity for Adult Acute Mental Health Services	19 July 2019	Full Release		YES
6.	**22 - 30**	Email and attachment – Performance Review – AMHU	8 October 2019	Full Release		YES
7.	**31**	Email – Psych referrals in ED	8 October 2019	Full Release		YES
8.	**32 - 34**	Email – Meeting today	8 October 2019	Full Release		YES
Capacity issues/bed availability/use of corridor beds in the emergency department						
9.	**35 - 139**	Email and in-scope attachments – Ministers Meeting	10 February 2019	Partial Release	Schedule 2.2 (a) (xi)	YES
Total No of Docs						
9						

Daly, Kelly (Health)

From: Aloisi, Bruno (Health)
Sent: Tuesday, 5 February 2019 5:32 PM
To: McDonald, Bernadette (Health); Bone, Chris (Health)
Subject: RE: AMHU ongoing crisis

Hi Bernadette
Yes will do. Chris organised meeting this morning to discuss and we are currently working on this brief.
Thank you
Bruno

-----Original Message-----
From: McDonald, Bernadette (Health)
Sent: Monday, 4 February 2019 6:28 PM
To: Bone, Chris (Health) <Chris.Bone@act.gov.au>; Aloisi, Bruno (Health) <Bruno.Aloisi@act.gov.au>
Subject: FW: AMHU ongoing crisis

UNCLASSIFIED

Chris, can we please put together a brief for the Minister on our mental health strategies that we have in place and also our planning processes for the future.

I would like to discuss with him on Friday. Bruno can you please assist Chris.
Thanks
Bernadette

Bernadette McDonald
Chief Executive Officer
Canberra Health Services

Phone: 02 5124 2728 | Email: bernadette.Mcdonald@act.gov.au
Building 24, Level 2, Canberra Hospital, Yamba Drive, Garran ACT 2605

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-----Original Message-----
From: Rattenbury, Shane
Sent: Monday, 4 February 2019 3:58 PM
To: McDonald, Bernadette (Health) <Bernadette.McDonald@act.gov.au>
Subject: FW: AMHU ongoing crisis

Hi Bernadette

Hope you had a good weekend? I know this is on your radar, but thought I would forward you this take from one of our Official Visitors. It reinforces our concerns about capacity in AMHU and mental health

generally. Would be useful to discuss again when you have had a chance to think more about possible responses.

Regards
Shane

Shane Rattenbury MLA

Minister for Climate Change and Sustainability; Minister for Justice, Consumer Affairs and Road Safety; Minister for Corrections and Justice Health; Minister for Mental Health ACT Greens Member for Kurrajong
t: 620 50005 | f: 620 50007 | rattenbury@act.gov.au |

Follow me on Facebook and Twitter

I acknowledge the Traditional Custodians of the Australian Capital Territory and across Australia, and pay respects to their Elders, past, present and future.

-----Original Message-----
From: Pickles, Shannon
Sent: Monday, 4 February 2019 3:29 PM
To: Gelbart, Lisa <Lisa.Gelbart@act.gov.au>
Cc: Robbins, Jarrah <Jarrah.Robbins@act.gov.au>
Subject: AMHU ongoing crisis

Hey Lisa,

I am sure you are aware but the crisis in bed pressure at AMHU is continuing. When I was there in the last week there was 40 of 37 beds booked with another 13 persons in ED waiting for a bed. MHSSU has in essence become an AMHU staging area and the team leader and clinical nurse educator of AMHU have both recently moved on (citing the stress of the unit to me as a factor in those decisions).

I spoke with the Allied Health Manager recently and she shared some of the data in terms of in the last 12 months demand has moved from 40 to over 100 movements a month, with 5+ persons coming in/out each day. This gives me concerns that whilst more exit options is obviously part of the problem, an issue that is potentially not being looked at (because it is not a pleasant thought) is that 40 crisis beds is just not enough to meet the systems current demand.

Happy to discuss.

regards,

Shannon Pickles
Official Visitor, Corrections
Official Visitor, Mental Health

Daly, Kelly (Health)

From: Aloisi, Bruno (Health)
Sent: Monday, 11 February 2019 11:15 AM
To: Calvin, Sam (Health); Lewis, Llew (Health); Glanville, Emma (Health); McMahon, Rachael (Health)
Cc: Riordan, Denise (Health); Miller, Alex (Health); Braun, Helen (Health)
Subject: RE: Beds and movement [SEC=UNCLASSIFIED]

Thanks Sam for update and work of team in dealing with this high demand.

Also Rachael/Cathy, FYI also and if you can please check if we have any SUSD options if we have suitable discharge options from AMHU/Calvary or ED. In the past we have expedited SUSD discharges for people who havent completed program but are ok to go home
Cheers
Bruno

From: Calvin, Sam (Health)
Sent: Monday, 11 February 2019 10:39 AM
To: Lewis, Llew (Health) <Llew.Lewis@act.gov.au>; Glanville, Emma (Health) <Emma.Glanville@act.gov.au>
Cc: Riordan, Denise (Health) <Denise.Riordan@act.gov.au>; Aloisi, Bruno (Health) <Bruno.Aloisi@act.gov.au>; Miller, Alex (Health) <Alex.Miller@act.gov.au>; Braun, Helen (Health) <Helen.Braun@act.gov.au>
Subject: Beds and movement [SEC=UNCLASSIFIED]
Importance: High

Dear Colleagues,

I am writing to seek assistance from your areas to make capacity for some of our patients. We have started another week with high demand for psychiatric beds. This is in the background of 17 discharges last week.

There have been 8 admissions to AMHU over the weekend and another 11 waiting in Emergency this morning.

May I kindly request

a) Emma to kindly assist by increasing capacity at 2N/OPMH and AMHRU if possible.
b) Llew to kindly check if HAART can take a few patients from our ward/ED.

Thank you all for your kind assistance.

Kind regards,

Sam

Dr Sam Calvin
M.B.B.S, M.D *(Psychiatry)*, MHlthMedLaw *(Melb)*, FRANZCP
Clinical Director of Adult Acute Mental Health Services
Mental Health, Justice Health and Alcohol & Drug Services

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Daly, Kelly (Health)

From: Aloisi, Bruno (Health)
Sent: Saturday, 30 March 2019 1:25 PM
To: Bracher, Katrina (Health); Bone, Chris (Health)
Cc: Mooney, Colm (Health)
Subject: RE: MH bed capacity and SUSD [SEC=UNCLASSIFIED]

Thanks Tina for generating this idea and I'm happy to follow up Chris. I also agree that this merits further consideration as could provide a more timely and financially viable option to address current acute bed demand and assist with ED Diversion. Whilst SUSD units should not be regarded as a direct substitute for an acute inpatient admission, additional SUSD beds would most definitely assist with those less acute presentations that generate long stays in ED or unnecessary inpatient admissions where insufficient community support options exist.
Cheers
Bruno

From: Bracher, Katrina (Health)
Sent: Friday, 29 March 2019 6:18 PM
To: Bone, Chris (Health) <Chris.Bone@act.gov.au>
Cc: Mooney, Colm (Health) <Colm.Mooney@act.gov.au>; Aloisi, Bruno (Health) <Bruno.Aloisi@act.gov.au>
Subject: RE: MH bed capacity and SUSD [SEC=UNCLASSIFIED]

Hi all
I will step back from this now that I am moving to another role, but do seriously think this is worth consideration.

Cheers Tina

From: Bracher, Katrina (Health)
Sent: Wednesday, 20 March 2019 1:10 PM
To: Bone, Chris (Health) <Chris.Bone@act.gov.au>
Cc: Mooney, Colm (Health) <Colm.Mooney@act.gov.au>; Aloisi, Bruno (Health) <Bruno.Aloisi@act.gov.au>
Subject: MH bed capacity and SUSD [SEC=UNCLASSIFIED]

Hi Chris,
After our discussion yesterday, I had a brief chat with Bruno about options for increasing our bed capacity.

While there may be more options, can I ask that we consider the SUSD unit about to be constructed on Gaunt Place with the MoC that aims to both prevent presentations to the ED and/or quickly move people out of the ED.

Currently the design is for 10 beds. The Business case is to construct and commission 6 of those beds, leaving 4 for a future business case and future construction.

Given:

- the design has been done for 10 beds,
- construction is about to commence, it would be available by the end of this year or early next year (significantly earlier than the timeframe noted yesterday in Exec of over 3 years),
- it would be cheaper to construct the 10 beds now – rather than do an extension etc. in the future, and
- we have significant demand that this MoC would help alleviate.....

I'm not sure which PCG this needs to go to, but could I ask that we formally consider a variation to this project to construct the entire 10 bed SUSD now, rather than in 2 stages?

Cheers Tina

Katrina Bracher
Executive Director
Mental Health, Justice Health and Alcohol & Drug Services

Level 3
1 Moore Street
Canberra City
Phone: 02 62051313
Mob: [redacted]
E-mail: katrina.bracher@act.gov.au

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Daly, Kelly (Health)

From: Grace, Karen (Health)
Sent: Monday, 24 June 2019 6:25 PM
To: George, Jacinta (Health)
Cc: McDonald, Bernadette (Health)
Subject: FW: Brief on ED gazettal [SEC=UNCLASSIFIED]
Attachments: Brief 24Jun2.docx

Hi Jacinta

As discussed I'm very comfortable with this version of the brief with my only comment being in relation to paragraph 14. I think we need to be careful about making assumptions about the level of service required to be provided at CPHB if the ED is gazetted (eg. An HDU). At a system level if a person assessed in CPHB as requiring HDU care they would be transferred to AMHU as they are now, or if they are assessed as requiring low level care they could be admitted to 2N. I think we would find it hard within our jurisdiction, given its size, to quantify the need to duplicate our HDU functions.

Thanks
Karen

From: George, Jacinta (Health)
Sent: Monday, 24 June 2019 5:08 PM
To: Grace, Karen (Health) <Karen.Grace@act.gov.au>
Subject: Brief on ED gazettal

UNCLASSIFIED

Karen

I will contact you about this shortly

Jacinta

Jacinta George
Executive Group Manager
Health System Planning and Evaluation
ACT Health Directorate
Email: Jacinta.george@act.gov.au
Ph: (02) 5124 9908

ACT Government

MINISTERIAL BRIEF

ACT Health Directorate

UNCLASSIFIED

To:	Minister for Health and Wellbeing	**Tracking No.:** Click here to enter text.
Date:	24 June 2019	
CC:	Minister for Mental Health Ms Bernadette McDonald, Chief Executive, Canberra Health Services Mr Mark Dykgraaf, General Manager, Calvary Public Hospital Bruce	
From:	Michael De'Ath, Director-General, ACT Health Directorate	
Subject:	Acute Adult Mental Health Emergency Department Capacity	
Critical Date:	Not Applicable	
Critical Reason:	Not Applicable	

- DG .../.../...
- DDG .../.../...

Recommendations
That you:

1. Note the information contained in this brief;

Noted / Please Discuss

2. Agree to the establishment of a working group to deliver, by the end of July 2019, costing of capital works and identification of investments needed in human resources to gazette the Emergency Department at Calvary Public Hospital Bruce.

Agreed / Not Agreed / Please Discuss

3. Note the ACT Health Directorate will provide project management resources to support development of strategies and actions to expand bed capacity within mental health services and emergency departments. This work will be overseen by the Territory-Wide Mental Health Management Committee.

Noted / Please Discuss

UNCLASSIFIED

Shane Rattenbury MLA ..../...../.....

Minister's Office Feedback

Background

Service consideration

1. Demand for acute mental health services, including acute hospital beds is increasing in the ACT.
2. Gazettal of the Emergency Department (ED) at Calvary Public Hospital Bruce (CPHB), together with other initiatives to increase the capacity of CPHB will provide options for increasing the acuity of mental health presentations at the facility.
3. An appropriation was made in the 2018-19 Budget to expand the ED at CPHB. The tender period for the works is currently open.

Governance consideration

4. The Territory-wide Mental Health Management Committee (TWMHMC) was established in May 2019. It is led by ACT Health Directorate and chaired by the Chief Psychiatrist. Priorities of the TWMHMC include:
    a. obtaining better clarity of data and bed usage;
    b. infrastructures to support patient flow across the whole of the Territory;
    c. clarification of governance mechanisms; and
    d. the establishment of shared training and education for staff to ensure consistency of care across the service.

Issues

5. Demand for acute mental health services comes from a range of sources including:
    a. Self-referral to the Emergency Department (ED);
    b. People brought to ED by the police and ambulances, including those detained under a Section 81 (Emergency Action) of the *Mental Health Act*

2015. This also includes people who may be drug affected and need a mental health assessment as part of their care;

c. People referred by the courts under Section 309 of the *Crimes Act 1900*. Section 309 requires that where there are concerns regarding mental health, an accused person be conveyed to an approved mental health facility for a clinical examination, for the sole purpose of deciding whether they need immediate treatment or care because of mental impairment; and

d. People receiving care as clinically managed clients in the community who relapse and need more intensive treatment.

6. The Adult Mental Health Unit (AMHU) at the Canberra Hospital can facilitate planned admissions, but generally does not accept direct urgent presentations. CHS has a model of care that manages these presentations through the ED to support safe clinical stabilisation prior to admission to AMHU, or the Mental Health Short Stay Unit, if required.
7. Calvary Public Hospital Bruce (CPHB) also delivers acute care through a low care non-secure unit. The ED at CPHB is not an approved (gazetted) facility for emergency detention or correctional patients.
8. Given the pressures on the existing system, and the opportunity provided by the current ED capital works at CPHB, we recommend a working group be established to rapidly deliver, by the end of July 2019, costing of capital works and an assessment of investments needed in human resources to support gazetting the ED at CPHB.
9. The working group would be facilitated by the ACT Health Directorate, with membership from CPHB and Canberra Health Services.
10. If agreed by Ministers (including funding considerations), additional capital works required could be delivered through a variation to the contract (for the current procurement process).
11. The proposed investigation of requirements for gazettal of the ED would include identification of any additional investment required to enable any changes in the infrastructure in the adult acute unit to support a gazetted ED.

Potential impacts of the proposal – increasing patient acuity at CPHB

12. Increasing the acuity of the inpatient unit at CPHB will necessitate a number of changes.

13. Apart from gazetting the ED, the working group will look at other steps necessary to provide for clients to be transferred in and out, including those clients who may be acutely unwell. This includes those experiencing a level of emotional distress that results in a range of challenging behaviours, including both verbal

and physical aggression. For people admitted, there would need to be a mechanism to transfer them safely to a designated in-patient facility at CPHB.

14. Changes at the in-patient facility to support admitting acutely unwell people will also be worked through. This could include adding a designated high-dependency suite and de-escalation suite to the existing capital works program.

Commented [GK(1]: I still think that gazetting the ED does not necessarily lead to the requirement for HDU care at CPHB if we are looking across the system. We already transfer patients between facilities and this could continue in a new model following assessment and a determination that HDU care is required.

15. The working group will also explore the necessary training to support gazettal, to ensure staff have the skills to manage clients who would be far more acutely unwell than those they currently treat.

16. Staffing ratios will also be considered, with a particular focus on out of hours cover. People being brought to the ED especially if detained on an Emergency Action under the *Mental Health Act 2015* are required by the legislation to be seen within 4 hours. Currently these clients are seen at The Canberra Hospital, which has psychiatry staff on site 24 hours per day.

Territory-Wide Mental Health Management Committee (TWMHMC)

17. The TWMHMC includes representation from Canberra Health Services, Calvary Health Services and ACT Health Directorate, as well as the Office of the Chief Psychatrist and the Office for Mental Health and Wellbeing.

18. To date an initial meeting has been held to clarify Terms of Reference. This was followed by a workshop to identify a work plan. Its workplan includes a number of short and medium term actions, which are summarised below.

19. The TWMHMC is undertaking a service mapping exercise to better understand demand drivers across the system. In particular, a clearer appreciation of the types of beds that are in demand; at present demand appears to be for high-acuity beds, but this has not been fully analysed.

20. Design and implementation of a robust governance framework to assess, review and manage capacity across the system are also being considered. Integral to such an approach would be the appointment of a Territory Wide Clinical Director for acute mental health services. The clinical director would work with operational directors and senior clinicians across both EDs and acute wards to ensure the people most in need of an inpatient facility are admitted and provided the appropriate level of care. The Director would also work with facilities to ensure active discharge planning is a priority across the service. Assisting in this role would be a patient flow manager supported by a clear set of policies and guidelines. There would be a centralised bed register, and clear transparency about bed utilisation. These developments would need to be underpinned by a clearly articulated and robust clinical governance structure.

21. Demand in the ED could be reduced by addressing the significant increase in patients brought in under an Emergency Action of the *Mental Health Act 2015*.

Clients are brought in under the Act even if they are agreeable to coming to the ED. Being brought in under the Act has implications for patients, who may be distressed to discover they are subject to the Act even when they have indicated that they wish to seek help. It also results in an increased administrative burden on staff, and triaging that is led by legislative requirements rather than clinical need. An amendment to the Mental Health Act to clarify this may be required. This is being reviewed in the current review of the Mental Health Act.

22. Development of a more clinically responsive service for those people requiring assessment under s309 of the *Crimes Act 1900* by having an approved facility located other than at a public hospital, as occurs in other Australian jurisdictions. A designated area in the courts for example, could provide the appropriate facility and lead to a timelier assessment which would enhance patient care. This requires legislative changes – the *Crimes Act 1900* sits under the Attorney General /JACS portfolio.

23. A Specialty Services Plan for Mental Health services will be developed in addition to the current regional planning exercise, to identify current and future capacity needs and models of care and service delivery and, specifically the future role for a Northside hospital in the mental health service system.

Financial Implications

24. The recommendation is to undertake costing of additional infrastructure required to gazette the ED as well as to plan and cost staffing and training in order to safely deliver a service to people requiring a higher level of care.

25. At this stage no further resources are required.

Consultation

Internal

26. Dr Denise Riordan, Chief Psychiatrist, 6205 0687, 17-24 June 2019.

27. Amber Shuhyta, Executive Branch Manager, Mental Health Policy, 5124 9737, 17-24 June 2019.

28. Jon Ord, Senior Manager, Mental Health Policy, 5124 9733, 17-24 June 2019.

29. Sarah Galton, Senior Manager, Health System Strategies and Program Support, 5124 9877, 17-24 June 2019.

Cross Directorate

30. Karen Grace, Executive Director, Mental Health, Justice Health and Alcohol & Drug Division, Canberra Health Services, 5125 1577, 17-24 June 2019.

External

31. Mark Dykgraaf, General Manager, Calvary Public Hospital Bruce, 17-24 June 2019.
32. Carmel Ronning, Manager, Public Mental Health Services, Calvary Public Hospital Bruce, 17-24 June 2019.

Benefits/Sensitivities

33. The working group to oversee planning for and costing of capital works and human resources required to gazette the ED at Calvary Public Hospital Bruce will include representation from Canberra Health Services, Calvary Public Hospital Bruce and the ACT Health Directorate.

34. The TWMHMC will play an integral role in supporting the delivery of territory wide services. The first step would be to identify the drivers of demand as well as the barriers to flow. This would lead to the development of a Territory wide plan, described within a robust governance framework for all acute and community mental health services in ACT. Management of all acute beds should sit within a single framework, where utilisation is transparent and managed through a single point of entry.

35. The TWMHMC will work with Canberra Health Services and CPHB to prioritise actions for service development, and the implementation of strategies to improve models of care and capacity within Mental Health services.

36. ACTHD would provide project management resources to ensure that the proposals identified by TWMHMC are actioned, and that support is provided to develop business cases for additional resources and implement priority projects.

Signatory Name:	Dave Peffer	Phone: 5124 9180
Action Officer:	Jacinta George	Phone: 5124 9699

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CORRESPONDENCE COVER SHEET

Correspondent:

Record Number: CHS19/1084

Date Due: .....

Topic: **PATIENT SERVICES ADMINISTRATION - Planning - Request to repurpose six beds on Ward 7B for temporary surge capacity for Adult Acute Mental Health Services.**

Action Required:	No	Reply Directly	No	Draft Response
	No	Brief to D-G	No	
		Action by Group	No	Info Only
	No	Action as Necessary	No	For Discussion
	No	Advice	No	Comments to D-G
	No		No	Full Speech
		Media	No	Ministerial Response

Assignee: Whittall, Christine since 26/07/2019 at 5:51 PM

Comments for Cover Sheet:

1 August 2019 - Complete - with comments
- returned to DDG clinical.

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CORRESPONDENCE CLEARANCE

Subject: **Request to repurpose four beds on Ward 7B for temporary surge capacity for Adult Acute Mental Health Services.**

Number: **COR19/16565** Date Due: .....

Chief Executive Officer - Canberra Health Services: BmO Date: 31/7/19

Chief Operating Officer - Clinical Services: E A. Chesterton Date: 24/7/19

Executive Group Manager - Infrastructure & Health Support Services: _____ Date: .....

Executive Group Manager - People and Culture: _____ Date: .....

Executive Group Manager - Quality, Safety, Innovation & Improvement: _____ Date: .....

Executive Group Manager - Finance & Business Intelligence: _____ Date: .....

General Manager - Canberra Hospital Foundation: _____ Date: .....

Contextually Correct ☐ Grammatically Correct ☐ Spell Checked ☐

Position: Executive Director Area name: MHSHADS

Signature: cleared via email Date: 8/7/19

Executive Director - Area name: _____ Date: .....

Director - Area name: _____ Date: .....

Manager - Area name: _____ Date: .....

Government Relations - Canberra Health Services: _____ Date: .....

Other: _____ Date: .....

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MINUTE

SUBJECT: Request to repurpose six beds on Ward 7B for temporary surge capacity for Adult Acute Mental Health Services.

To: Bernadette McDonald, Chief Executive Officer, Canberra Health Services

From: Karen Grace, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services

Date: 2 July 2019

Purpose

To request approval for re-purposing of six beds on Ward 7B for surge capacity for Adult Acute Mental Health Services and to request approval of minor remediation works to minimise ligature points within the identified area.

Background

The Adult Mental Health Unit (AHMU) has 40 beds which consistently experience occupancy levels of 100 per cent. The ligature minimisation works are scheduled to commence on 15 July 2019 and may have an impact on this capacity for a period of up to 12 weeks.

In recent times, the Acute Surgical Unit (ASU) has been utilised as surge space for the Acute Adult Mental Health Service (AAMHS). However, this has resulted in a 25 per cent reduction in capacity for the ASU patient cohort, significantly impacting the service.

In response to this impact, alternate spaces were considered. An area of Ward 7B which will allow for up to six surge beds has been identified as the preferred option. These beds are currently not in use and are not included within the winter plan.

A risk assessment of the area has been undertaken Attachment A, and several minor remediation works have been identified in order to make the area fit for purpose for AAMHS patients that have been assessed as suitable for admission to these beds.

The scope of the works is estimated to be no higher than $20,000 and includes:

- removal of cupboard doors and hinges, pin boards, curtain tracks above the windows, fixed hooks and holders on the bedroom walls;
- capping/modifications to medical gas panel to restrict tampering with gas outlets;
- removal of grab rail in bathroom and replacement of fittings (e.g. taps, shower head) and cover up exposed drain from the sink to the floor waste; and
- remove other fixed items on bathrooms walls, including shelf, toilet roll holder. Retain paper towel and auto hand wash dispensers.

Issues

The risk assessment has concluded that some ligature points will remain within the space. These are standard curtain tracks and ceiling mounted televisions. The risk of self-harm by a patient in relation to these will be mitigated by a staffing profile of one RN1 and one AIN on each shift for four patients. A higher nurse to patient ratio will enable the necessary level of observation and engagement with patients to ensure a safe environment.

A clinical procedure has been developed to ensure that patients are carefully assessed for suitability for admission to these beds, as is currently the case when ASU beds are used.

Mathew Daniels from the Australian Nursing Midwifery Federation (ANMF) has been advised of the need to open four additional AAMHS beds for surge capacity. The ACT Mental Health Consumer Network and Carer ACT are well aware of our capacity issues and the potential impact of the ligature minimisation works on our operational bed base. Once the proposal is approved to progress, formal consultation with these bodies will progress as a matter of urgency.

Nursing recruitment strategies are currently underway, including active recruitment and utilisation of agency nurses. A number of casual Assistants in Nursing are being offered temporary contracts and will be on-boarded as soon as possible for orientation and training.

MHJHADS has explored the possibility of purchasing beds at Calvary Public Hospital Bruce, however advice has been received that this option would be limited to persons over the age of 60 and therefore unlikely to meet the needs of Canberra Health Services.

Recommendations
That you:

- Note the above information;

(NOTED)/PLEASE DISCUSS

- Note the risk rating of the risk assessment for surge beds on Ward 7B, see Attachment A;

(NOTED)/PLEASE DISCUSS

- Agree to approve the use of Ward 7B for AAMHS surge capacity; and

(AGREED)/NOT AGREED/PLEASE DISCUSS

- Agree to approve the progress of procurement for minor remediation works.

(AGREED)/NOT AGREED/PLEASE DISCUSS

Once consultation has been completed.

.....

Bernadette McDonald
Chief Executive Officer
Canberra Health Services

July 2019

I would like this presented at HTSEC to get full support.

Also we need to brief the HD + Minister / chief psyche to have their full support.

Karen Grace
Executive Director
MHJHADS

19 July 2019

Action Officer: Helen Braun
Branch: Adult Acute Mental Health Services
Extension: x41623

RISK ASSESSMENT

ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

Notified by	Helen Braun	**Contact Details**	0434 686 106
Division/Group	MHJHADS	**Program/Service/Unit**	Adult Acute Mental Health Services
Date	19/6/19		

STEP 1 - ESTABLISH THE CONTEXT: Establishing the context takes into consideration the circumstances in which the team, division, group or organisation as a whole is operating. Things to consider may be:

- What objectives are to be achieved & how do they influence your team / project / program?
- How are you planning to achieve the objective & at what tier?
- When should it be finished, what resources are available & what other limitations exist?
- Who may be influenced; how and why?
- How do the objectives influence the division, the group, ACT Health, the public and other stakeholders?

The Acute Mental Health Service has been under demand pressures for some time, with occupancy rates consistently above 100%. Existing capacity on the Canberra Hospital Campus consists of a 10 bed High Dependency Unit (HDU), 30 bed Low Dependency Unit (LDU) and a 6 bed Mental Health Short Stay Unit (MHSSU). A number of operational strategies have been put in place to ensure that flow is optimised, however despite this there are regular periods where demand for acute inpatient beds outstrips existing capacity. It is planned to undertake a comprehensive review of acute MH services however in the interim there is an urgent requirement for access to additional beds.
Currently patients admitted with a Diagnosis relating to both a a physical health problem and a Mental Illness or Disorder are admitted to ward 7b. Once they are medically cleared, they will be transferred to the Adult Mental Health Unit (AMHU) if there is a bed available.
There is a 6 bedded area on ward 7b which is currently not operational for medical patients and available for use by MH for surge capacity. However, remediation works are necessary to minimise the ligature risk in this space. 7b is a Gazetted MH space, like all of Canberra Hospital.
All inpatient areas for MH at Canberra Hospital are locked units, however it is noted that ward 2N at Calvary Public Hospital Bruce is part of the acute service and is an unlocked unit.
This risk assessment is establishing any risks identified with utilising the available 6 beds on 7b for a select cohort of Mental Health patients whose Primary Diagnosis is a Mental Illness or Disorder.

Risk Category	**PEOPLE (Staff, patients, Clients, contractors and Work Health and Safety)**
STEP 2 - RISK IDENTIFICATION	
Title (What is the risk?)	Injury/Self-harm, harm to others, misadventure, absconding
Cause (Why is it a risk? Why can something go wrong? How does it happen?	General inpatient units are not designed to minimise ligature risk with multiple ligature points present. The area is also part of an unlocked ward where people are able to freely move in and out of the unit.

A

RISK ASSESSMENT TEMPLATE

Consequence (What could happen if this risk eventuated?)	Injury/Self-harm, harm to others, misadventure, absconding		
STEP 3 - RISK ANALYSIS			
Current controls (What is currently in place to reduce/mitigate the risk?) **For example education, processes, investigation/data analysis, interventions**	Careful consideration of patient allocation to the beds under the direction of a Consultant Psychiatrist and supported by a clinical protocol The MHSSU CNC will provide operational support and oversight to the Ward 7B beds. Any deterioration in mental state of the patients will be immediately addressed through medical review, and if appropriate immediate transfer to Adult Mental Health Unit (AMHU). Additional infrastructure/minor works will occur to address some of the immediate ligature risks within the identified space. Staff within 7b are currently providing care for patients with a Mental Illness or Disorder		
Current Level of Risk - **The current level of risk with all existing controls taken into consideration but before any treatment or management.** (Refer to Risk Matrix & apply objective measures when possible)	Likelihood= possible	Consequence= Major	Risk Rating= High
Target Level of Risk - **The level of risk that ACT Health would ideally and realistically like to reduce the rating to, for the risk to become acceptable.** (Refer to Risk Matrix, What would the risk rating have to be for the risk to be deemed acceptable?)	Likelihood= Unlikely	Consequence= Moderate	Risk Rating= **Medium**
STEP 4 – RISK EVALUATION			
This risk is	**ACCEPTABLE** – with identified risk treatments, staffing levels and clinical procedures followed.		
STEP 5 – RISK TREATMENT			

RISK TREATMENT ACTION PLAN

Possible Risk Treatment Actions (Should be listed in order of priority)	Advantages of this action	Disadvantages of this action	Action Accepted (Yes/No)	Position responsible for completing action	Estimated completion date	Other comments

RISK ASSESSMENT

ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

Minor remediation work will be undertaken including: removal of cupboard doors and hinges, pinboards, capping gas ports, removal of fixed hooks and holders, removal of grab rail in bathroom or replacement with suicidal anti-ligature option. Change out fixtures and fittings in the bathroom and metal sheath over the hinges.	Reduces the risk of self ham for patient admitted to these beds	Time and expense, further delay of works.	Yes	Operational Director, Acute Mental Health Services		
Increase staffing level per 4 beds: 1 RN and 1 AIN	Provides close observation and engagement of admitted persons providing early response and de-escalation of agitation, distress etc.	In daytime, MHSSU can cover back fill for break allocation. In night time, backfill will require formal agreement with ward 7B to ensure 2 nurses are present	Yes	Operational Director, Acute Mental Health Services		
Mobile Duress	Provides a systematic response, escalation and identification when an instance of occupational violence and or an emergency issues relating to a consumer occurs	This is not currently in place and will need to form part of the remedial works scope. This may add minor delays and additional costs	Yes	Operational Director, Acute Mental Health Services		
Education & Training	Provision of education and training for 7b staff who may not be Mental Health trained to improved understanding of what to expect from mental Health consumers, how to support their care to ensure the ward environment is safe for all patients, staff and carers.	Will need to be an ongoing responsibility for the MH team to provide the additional orientation, education and training support to 7b staff	Yes	Operational Director, Acute Mental Health Services		
Effective Communication	Ensure the MH staff supporting the 6 MH consumers on 7b are also included in handover and patient journey board / multidisciplinary ward rounds.	Will require 7b staff may at times be required to support the AIN whilst handover/multidisciplinary patient ward rounds are occurring.	Yes	Operational Director, Acute Mental Health Services		

Risk Management resources; including the Action and Response Timeframe, Risk Matrix and Consequence Definition and Likelihood Definition tables can be found on the Intranet Policy Register.

Daly, Kelly (Health)

From: Grace, Karen (Health)
Sent: Tuesday, 8 October 2019 5:25 PM
To: Daly, Kelly (Health)
Subject: FW: Performance Review/Improvements/Developments-AMHU (May 2018-August 2019) [SEC=UNCLASSIFIED]
Attachments: Performance Review- AMHU.docx

UNCLASSIFIED

From: Pullela, Ananth (Health) <Ananth.Pullela@act.gov.au>
Sent: Wednesday, 14 August 2019 8:28 AM
To: Riordan, Denise (Health) <Denise.Riordan@act.gov.au>
Cc: Grace, Karen (Health) <Karen.Grace@act.gov.au>; Roberts, Charmain (Health) <Charmain.Roberts@act.gov.au>
Subject: Performance Review/Improvements/Developments-AMHU (May 2018-August 2019) [SEC=UNCLASSIFIED]

Dear Denise,
Greetings and best wishes. Enclosed is the Performance Review of Adult Acute MHS, TCH, Canberra from May 2018-August 2019, since I have been working as a Clinical Director. It would be nice if the Minister for MH could have a glance at it and hopefully he will pay attention to the limitations and drawbacks in the service still. Credit to all for the improvements made so far in developing the service with the limited resources available.
I would be more than happy if you wish to clarify anything in particular.

Regards,
Dr Ananth Pullela
Adult General & Forensic Psychiatrist
Interim Clinical Director, Adult Acute MHS, TCH
ACT Health, Canberra

Performance Review/Improvements/Developments of Adult Acute MHS, TCH, ACT Health, Canberra (AMHU, MHSSU, ED/7B) (From May 2018 to August 2019)

Special tribute: At the outset, as the Interim Clinical Director from May 2018 till today (August 2019), I respectfully pay my gratitude and special thanks to Dr Denise Riordan, Chief Psychiatrist and Ms Karen Grace, ED, ACT MHS for some identifiable and noticeable improvements and developments, occurred in Adult Acute MHS, The Canberra Hospital. Without their vision, assistance and guidance, we would have not achieved any of the improvements or developments made in Adult Acute MHS in Canberra this year.

The mental health services from the Adult Acute (LDU/HDU), Short Stay Unit and ED have improved, both in quality of care and prompt and timely service delivery in the state. The statistics from ARCs, the reduction in number of violent/ assaultive incidents in the Unit and the Riskman System Records and notifications in general, reveal the progress being made in some aspects of patient care and to the satisfaction of both consumers and carers, to a great extent.

.There have been relatively early and quick assessments and discharges from the unit.
. Quick proactive and aggressive treatment strategies for transfer of patients from HDU to LDU to the community.
. Reduction in the number of violent/assaultive incidents in the Unit due to pro-active and aggressive treatments.
. Improved staff morale due to clinical direction, stability, support and reassurance
. Improved patient and staff safety and better quality of care.

The key performance indicators, as I have noted where improvements and developments occurred are in the areas at:

Strategic Level
Clinical Level
Professional Level
Supervision & Training
Teaching Modules
Service Level
Carers, Guardians & Consumers
Management of Alcohol & Illegal Drugs in the Unit
Clinical Audit of the In-Patient Services
Accreditation Standards
Limitations/Drawbacks in the Service
Pending Projects

Strategic Level:
Efficient delivery of quality MH Services have been streamlined and getting delivered by reviewing/revisiting the existing Clinical Services Polices & Protocols.

Over the past 6-8 months, the existing policies and protocols have been revisited and amendments were done to ensure Quality Assurance and Clinical Governance measures are constantly met in the service delivery.

Admission process/protocols/procedures:
The Unit is providing the care plans, based on a comprehensive bio, psychosocial, cultural and behavioral assessment, which includes a comprehensive risk and strengths assessment. A comprehensive assessment by the allied health staff-MDT and their close involvement and participation in the patient's management & discharge planning has been getting implemented and getting identified the possible barriers for discharge.

Other developments include consumers & careers are involved and notified of the following, at the time of admission and what expect:
- a clear description of the aims of the acute ward;
- the current programme and modes of treatment;
- a clear description of what is expected and rights and responsibilities;
- a simple description of the ward's philosophy, principles and their rationale, and the ward team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse;
- visiting arrangements;
- personal safety on the ward;
- ward facilities;
- ward programme of activities;
- what practical items patients need in hospital and what should be brought in?

The identified unit guidelines are fully implemented during the process of admission:
On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures.

On the day of their admission or as soon as they are well enough, informal patients are given written information on their rights, rights to advocacy and second opinion, right of access to interpreting services, professional roles and responsibilities and the complaints procedure.

On the day of their admission or as soon as they are well enough, the patient is told the name(s) of their Primary Nurse/care team and how to arrange to meet with them and the patient receives a basic structured standard medical assessment.A full physical examination is done within 24 hours.

Further targeted examinations and investigations are undertaken if the physical history or physical symptoms demand, and a named individual is responsible for follow-up.

Where the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint this is:
- clearly documented in their records;
- regularly reviewed;
- communicated to all MDT members;
- evaluated with them and, where appropriate, their carer/advocate.

The patient is involved in the decisions (wherever possible) about when, where and with whom information about them is going to be shared and used.

The patient is able to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessment.

The immediate risk assessment of the patient is carried out including
- identification of whether they may be predatory or likely to abuse or offend;
- potential physical, psychological and social risks to themselves and/or others;
- risk of self-harm;
- level of substance use;
- absconding risk;
- consent or refusal of consent to treatment;
- sexual vulnerability;
- financial vulnerability

Discharge Planning
Discharge planning is getting initiated soon after admission with an estimated date of discharge/ likely number of days of stay in the unit.
Comprehensive discharge summaries are being done timely and promptly and the discharge summaries are signed by the respective Consultants within 48 hours.

Close involvement of the allied health staff-MDT in management & discharge planning has been encouraged.

Prescribed discharge medications from the pharmacy are obtained 48 hours prior to planned discharge date, in order to prevent any delays in patients leaving the hospital.

Managers and practitioners have agreed standards for discharge planning:
The patient is actively involved in developing their discharge plan.
The patient and carer (if requested by the patient) are actively involved in who takes part in discharge planning.
The patient is given timely notification of transfer or discharge and this is documented in their notes.

The patient is given a copy of a written aftercare plan, agreed on discharge, which sets out:
- the care and rehabilitation to be provided;
- the name of their care co-ordinator (if they require further care);
- the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment;
- specific action to take in the first week.

Prior to discharge, the date of the next CPA review or other review date is recorded in the notes and communicated to the patient and members of the allied health staff MDT.

Written copies of discharge plans are sent out within seven days of discharge to the patient, carer(s) where relevant, social workers, community mental health services, GPs, other community, residential and day-care staff.

It's ensured that the procedure for informal patients who discharge themselves against medical advice is also followed.

All staff possess knowledge of local resources to support the patient/carer on discharge.

The Unit and the treating teams are able to liaise with CMHS closely for:
.Post-discharge transfer of care
.Special needs to be addressed
.If possible, for allocation of a CMHT care co-ordinator/CPN after their internal intake process
.To visit the patient on the ward if indicated or preferred by the CMHS during the week prior to discharge.
.To follow the ward's referral process for outpatient psychology, CMHT-based Services or any specific identified specialist services.

Delayed discharges are routinely reviewed and action is taken to review any identified problems/ barriers

Clinical Level:
. Regular Consultants Meetings have been established fortnightly for 1 hour in AMHU on Tuesdays
. Meetings for Long stay patients have been regularized on Thursdays.
. ECT meetings have been scheduled for Fridays 10.00am to 11.00am
. Individual MDT meetings occur from Tuesdays to Fridays.
. Weekly clinical audit of the treatment strategies with individual teams, with a focus on pro-active/ aggressive strategies for clients in HDU.

Professional Level:
I ensure with my colleague Consultants to maintain
.Professionalism & Accountability
.To stick to Work Ethics
.To maintain Professional ethos
.To encourage participation in CME activities and Peer Review Groups, for self development.

Supervision & training:
In my role as the Clinical Director, I provide supervision and training to the junior medical staff and Registrars, when individual cases are discussed. They are encouraged to allocate time for reading, studies and to attend their allotted supervision times and teaching sessions.

Service Level:
Proposed coverage of ED Psychiatric Services by a full time Consultant with. Registrar.

I have streamlined the process of:

.Transfer of patients from ED to MHSSU and to AMHU
.Transfer of patients from ED to MHSSU after hours
.Transfer of Adolescent patients (under 18) either to MHSSU or to AMHU
(to revisit/ review the existing policy in conjunction with the Director of CAMS)

Close liaison with
ED Service Consultants
CMHT
AMHRU

Liaison with Calvary MHS
A&D Services
Forensic Services
Retention of staff

ECT services have been established thrice a week within TCH, until the ECT suite is up and running in mid 2020.

Occupational Violence:
At-Risk management issues/Incidents of assaultive/Violent behavior in the unit are getting identified, recorded and communicated:
.Incident recording in Riskman
.Incident reporting to the CD of the Unit
.Psychological postmartam of the incident
.Measures to be addressed from the incident
.Debriefing of the staff
.Treatment compliance issues
. Proactive/aggressive treatment of the patients in general, in HDU.

Guidelines for management of Violence in Acute Inpatient Settings:
(From the Royal College perspective, there is a recommended operational policy on searching of the patients, based on legal advice, which complies with the NICE Guidelines)

.There is a written mutual code of conduct for ward behaviour of which, patients are advised.

.Adherence to the code of conduct for ward behaviour is monitored.

. The agreed protocols in place are met with the local police to ensure effective and sensitive liaison regarding incidents of criminal activity/harassment/ violence.

. Further, the local protocols are met with that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies.

. The policies are set out and met with, what constitutes an emergency requiring police intervention.

. The staff are made aware of the written policies on the use of restraints and seclusion.

. The policies are in place to ensure that the provision for review of each incident of restraint, and its application is audited and reported to the hospital managers/ operational directors.

. To ensure any incident requiring rapid tranquillisation, physical intervention or seclusion is recorded contemporaneously, using a local template, which records the use of these interventions and the procedures taken during these interventions, and any adverse outcomes.

. To ensure the ward has mechanisms to document and monitor all incidents of violence

and aggression.

. To ensure that the systems are in place and to ensure that post-incident support and review are available and take place.

. To ensure a collective response to alarm calls is followed for any type of incident occurs and consistently rehearsed and applied.

. To ensure that all staff carry their duress alarms prior to seeing/ interacting with any consumer at all times.

.To follow where risk assessment indicates, there is an established, reliable and effective means of communication during escorted leave etc. such as two-way radios or mobile phones, should be strictly followed.

Continuous Assessment:
If needs are identified that cannot be met by the ward team, then a referral is made to a service that can. The referral should be made within a specified time period after identifying the need, and the date of the referral recorded in the patient's notes.

Where an unmet need is identified there is a clear mechanism for reporting it.

There is evidence within the notes of regular assessment of mental capacity using a formal document/standardised assessment tool.

To ensure Risk assessments are done weekly, updated, documented and communicated. Risk management plans are reviewed at a minimum frequency of once a month and updated accordingly in collaboration with the patient (wherever possible) and their carer (where appropriate).

Patients have a comprehensive, ongoing assessment of risk to self and to others with the full involvement of the patient and their carer (if the patient gives consent).

Carers, Guardians & Consumers:
Close involvement & participation of the carers' in consumers' assessment, management and in consumers' discharge planning at all levels.

.The patient's main carers are identified and contact details are recorded.

.The principal carer is advised how to obtain an assessment of their own needs.

.The principal carer is offered a meeting with a named professional, in the earliest possible working days of admission, during which:

- the carer's views about ongoing and future involvement are recorded
- the carer is given an explanation and information sheet about ward procedures etc.;
- the carer is offered information on carer advocacy, welfare rights and about mental health services.
- The identified guardians were notified at every step of patient's progress, investigations needed and a discharge plan.

Management of Alcohol and Illegal Drugs in the Unit:

The ward has a strategy for the comprehensive care of patients with dual diagnosis that includes:

- liaison between mental health and substance misuse services;
- regular drug/alcohol screening to support decisions about care/treatment options;
- liaison between mental health and statutory and voluntary agencies;
- staff training (which includes input from the police);
- the appointment of key staff who will lead clinical developments;
- clear protocols, agreed with the police;
- consideration as to the impact on other patients of adverse behaviors due to alcohol/drug abuse.

.To ensure that there are clear and comprehensive policies and procedures regarding positive risk-taking by the consumers, including self-harm, risk of harm to others, property damage and illicit drug use within the inpatient unit.

Clinical Audit of the inpatient services:
In my current role as the Clinical Director, I have streamlined and ensure that

.There is a handover between the nursing staff, doctors and other relevant members of the allied health staff-MDT on a daily basis in full attendance (as happening now)

.Each handover contains a discussion of risk factors and patient needs resulting in an MDT action plan for the shift, with individual and group responsibilities.

.Actions from reviews/ward rounds are fed back to the patient and this is documented.

.Reviews/ward rounds are facilitated to allow carers to express their views.

.Patients have the opportunity to meet their consultant on a weekly basis outside of reviews/ward rounds, time permitting

.Managers and practitioners have agreed standards for reviews/ward rounds.

.A full allied health (multi-disciplinary) MDT meetings occurs once a week, by the individual teams.

.Patients to be made aware of the standards for reviews/ward rounds.

.A CMHT/crisis team representative will be invited to attend the MDT review meetings of the individual teams at any stage if indicated.

.To invite the individual patients to attend the weekly MDT team reviews, if indicated

Accreditation Standards:
To ensure that accreditation standards are met at all times, and highlighted the fact that, as

. failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
. standards that an accredited ward would be expected to meet;
. standards that an excellent ward should meet or standards that are not the direct

responsibility of the ward.
. standards are met in close liaison with the allied health staff-MDT

I ensure that the standards cover the following areas and reviewed annually:
Issues of Quality Assurance
Clinical Governance
Clinical Audit

- General admission/ discharge standards
- Timely and Purposeful Admission
- Safety of the consumers and Staff
- Environment and Facilities
- MD Therapies and Activities in the unit

Limitations/Drawbacks in the service:
.No pharmacist cover for well over six months.
.Barriers to discharge still persist from
-Forensics cause of their strict model of care and stringent criteria,
lack of support from NDIS and withdrawn services for some clients,
delays in transferring patients to AMHRU, once again due to their admission criteria.
-homelessness.
.Lack of an ECT Nurse Coordinator.

Pending Projects:
.Clinical Risk Assessment Tool for In-Patient Assessments
.Risk Assessment & Predictors for Reduction of violent Incidents in Acute In-Patient Settings

Final Comment:
Overall I must say, everyone who has contributed for the development of the service in this very difficult, demanding and a complex sector of mental health should be proud for their contributions, for whatever we have achieved and still aiming to work towards improving the identified limitations/ drawbacks in the service.

Yours Sincerely,
Dr Ananth S Pullela
Interim Clinical Director
Adult Acute MHS, ACT Health, Canberra

Daly, Kelly (Health)

From: Grace, Karen (Health)
Sent: Tuesday, 8 October 2019 5:16 PM
To: Daly, Kelly (Health)
Subject: FW: Psych referrals in ED [SEC=UNCLASSIFIED]

UNCLASSIFIED

From: Pullela, Ananth (Health) <Ananth.Pullela@act.gov.au>
Sent: Friday, 16 August 2019 11:06 AM
To: Grace, Karen (Health) <Karen.Grace@act.gov.au>; Riordan, Denise (Health) <Denise.Riordan@act.gov.au>
Cc: Braun, Helen (Health) <Helen.Braun@act.gov.au>; Hoyle, Philip (Health) <Philip.A.Hoyle@act.gov.au>
Subject: Psych referrals in ED [SEC=UNCLASSIFIED]

Dear Karen and Denise,
What I have proposed is, as much as possible, any psych referral presenting to ED between 8.30am and 5.00pm should be seen by our fulltime ED Consultant Dr Finlay or at least be discussed with him, so that he could triage and discharge a few, not requiring admission.
Some of the patients bed booked after hours in ED, can also be discharged but unfortunately this can't happen, unless they come to short stay or AMHU in the night or next day, due to the 4 hour clause. Last night I was reported that there were difficulties in accepting all the bed booked patients, merely due to the number arrived! One patient arrived with very little information, and I will address this issue with the attended ED/CL Clinician and the Registrar on call. Happy to discuss this further.

Regards,
Dr Ananth Pullela
Adult General & Forensic Psychiatrist
Interim Clinical Director, Adult Acute MHS, TCH
ACT Health, Canberra

Daly, Kelly (Health)

From: Grace, Karen (Health)
Sent: Tuesday, 8 October 2019 5:26 PM
To: Daly, Kelly (Health)
Subject: FW: Meeting today [SEC=UNCLASSIFIED]

UNCLASSIFIED

From: Pullela, Ananth (Health) <Ananth.Pullela@act.gov.au>
Sent: Wednesday, 28 August 2019 3:37 PM
To: Scanlan, Samuel (Health) <Samuel.Scanlan@act.gov.au>
Cc: Grace, Karen (Health) <Karen.Grace@act.gov.au>; Finlay, Russell (Health) <Russell.Finlay@act.gov.au>; Rakov, Jacqueline (Health) <Jacqueline.Rakov@act.gov.au>
Subject: RE: Meeting today [SEC=UNCLASSIFIED]

Hi Sam,
Many thanks for your prompt reply. I fully understand the issues you have clarified and agree but what I like to discuss with you is the process of bed booking itself means how it's been done now, who should be doing , when, timing, etc and secondly the medical clearance before any bed is booked. I will discuss these issues with you on my return from leave.

Regards,
Dr Ananth Pullela
Adult General & Forensic Psychiatrist
Interim Clinical Director, Adult Acute MHS, TCH
ACT Health, Canberra

From: Scanlan, Samuel (Health)
Sent: Wednesday, 28 August 2019 2:18 PM
To: Pullela, Ananth (Health) <Ananth.Pullela@act.gov.au>
Cc: Grace, Karen (Health) <Karen.Grace@act.gov.au>
Subject: RE: Meeting today [SEC=UNCLASSIFIED]

Hi Ananth,

Sounds good, hope you enjoy your leave.

We did briefly discuss admitted patients. It is important that you and your team are aware that once a patient is accepted for admission (ie Bed Booked) then the clinical responsibility for that patient lies with the admitting team. ED nursing staff will continue to provide nursing care. ED medical staff will respond to significant clinical deterioration. Outside of this, the treating team are responsible for all other aspects of care. This means that teams need to have resources in place to provide this care.

Cheers

Sam

From: Pullela, Ananth (Health)
Sent: Wednesday, 28 August 2019 1:32 PM
To: Scanlan, Samuel (Health) <Samuel.Scanlan@act.gov.au>; Finlay, Russell (Health) <Russell.Finlay@act.gov.au>; Rakov, Jacqueline (Health) <Jacqueline.Rakov@act.gov.au>
Subject: RE: Meeting today [SEC=UNCLASSIFIED]

Hi Sam,
Many thanks for accommodating Russell and Jackie in your meeting. Very useful and glad some decisions are made. I was talking to Karen grace yesterday. I have suggested we must have a meeting with your staff and ours to look at this BB process, which would clarify some of the clinical responsibilities/actions etc for both sides. I have some some ideas and suggestions. The second issue is medical clearance before they see the psych clinicians. I will be on leave from 7th September for 5 weeks and back in mid October. I am planning this meeting after my return. Finally, I have forwarded the Jackie's message to all the Registrars on on call roster.

Regards,
Dr Ananth Pullela
Adult General & Forensic Psychiatrist
Interim Clinical Director, Adult Acute MHS, TCH
ACT Health, Canberra

From: Scanlan, Samuel (Health)
Sent: Wednesday, 28 August 2019 12:40 PM
To: Finlay, Russell (Health) <Russell.Finlay@act.gov.au>; Rakov, Jacqueline (Health) <Jacqueline.Rakov@act.gov.au>
Cc: Pullela, Ananth (Health) <Ananth.Pullela@act.gov.au>
Subject: Meeting today

Dear Russell and Jacqui,

Thank you both for the time today.

Summary of today's meeting and Action Items;

1. Utility of BAL
    a. Discussed concerns that staff are telling you that it is 'Policy' not to perform BALs on Mental Health patients. This is absolutely NOT the case. I suspect this has come from years ago where we wre being requested to perform a BAL on ALL mental health patients.
    b. Agreed position is that if a decision is made that BAL is clinically ndicated, then that request will be accommodated.
    c. ACTION Item (SS): I will communicate to senior medical and nursing staff regarding this.
2. EA Notification process
    a. Discussed timing of EA notification and the confusion around this being a mental health referral.
    b. Agreed position is that the EA notification is usually NOT the referral (though on occasion may be – ie patient BIB community team on EA for psych assessment with no acute medical issues).
    c. ACTION Item (SS): I will communicate with senior medical and nursing regarding notification of arrival of EA to MHC for all patients. This will prpobably come from Nav, but I need to confirm.
3. Mental Health Referral process
    a. Discussed that at times ED staff feel the patient will need Psych reg review, rather than MHC first.
    b. Agreed position is that all referrals will still go through the MHC, so they can track work load. However, at time of referral the MHC will be informed as to whether the patient needs to be seen directly by psych reg. Psych registrars need tobe aware that the MHC does not need to see all patients before them.
    c. ACTION Item (JR): Jackie will ask Ananth to communicate this to the psych registrar group. (complete)

   d. ACTION Item (SS): Need to inform MHC. I will ask Peter Dexter to pass this on.
4. Physical exam and triage screening tool
   a. Discussed that the triage screening tool is used to identify patients that have an acute medical issue that needs to be addressed by ED medical staff. This does not havce a purpose for chronic illness. Agreed that identification and some management/ntervention for chronic illnesses for this group of patients is important, it is beyond the scope and resources of the ED.
   b. Also discussed concerns that does a negative screening tooll mean that ED medical staff will not re-engage with patient. This Should not be the case.
   c. ACTION Item (ALL): any future cases in which this is occurring will be referred back to me.
5. Interactions between ED Mental Health Staff and ED Medical/Nursing staff
   a. Discussed problems of role delineation, clinical responsibility, nursing reaction to requests made by ED mental health staff. The discussion was largely around complacency and inadvertent acceptance of a higher than acceptable risk of aggression from patients.
   b. Agreed position was that during business hours, when a patient goes to DES, then a senior ED medical and Senior ED Mental health discuss ongoing management, decide who will take lead in clinical decision making and ongoing care (may need to be shared care).
      i. Out of hours, the posych reg should attend as soon as is practical, noting competing concerns.
      ii. Aim of early senior input is to ensure that adequate early sedation (regular rather than PRN) occurs.
   c. ACTION Item (SS): I will discuss this approach with ED consultant group and ED senior nursing. If no major impediment, then aim to start this ASAP. I will then communicate with Ananth to get the messaging out to the after hours registrars.
   d. ACTION Item (RF): We have agreed that it would be useful for Russell to present a case (or several vignettes) to ED QA meeting. This will allow discussion of many common issues and raise awareness of profile and role in the ED. Russell will let me know in the next 1-2 weeks which Wednesday he would be ready/available to do this.
   e. ACTION Item (SS): Russell and Jacqui to be added to the Occupation Violence Steering committee meetings to provide useful input.
   f. ACTION Item (SS): Not discussed. However, I have though that having Jacqui and Russell added to EDIS, so they can be listed as treating Senior doctor, it would add to helping with role delineation and boosting your profiles in the department. Please advise if you would be OK with this.
6. BB Process
   a. Discussed that once a patient has been assessed and accepted for admission (ie Bed Booked), then that patient is considered to be the responsibility of the admitting team.
   b. These patients should be considered essentially as ward outliers. The Psychiatric team is responsible for ensuring that regular meds and other treatments are being documented (ED Nurses will provide ED care).
   c. ACTION Item: Nil, just for noting

Please let me know if there are significant ommissions or errors in above.

I think it would be useful to catch up again in the next 3-4 weeks and see where we are up to.

Cheers

Sam

Sam Scanlan, B Med, FACEM
Senior Staff Specialist - Emergency Medicine
A/g Director ED
Canberra Hospital & Health Services

Stevenson, Nicole (Health)

From: Hollis, Gregory (Health)
Sent: Sunday, 10 February 2019 3:09 PM
To: McDonald, Bernadette (Health)
Subject: RE: Ministers Meeting [SEC=UNCLASSIFIED]

Understood. Look forward to catching up in person during the week.

-----Original Message-----
From: McDonald, Bernadette (Health)
Sent: Sunday, 10 February 2019 8:07 AM
To: Hollis, Gregory (Health) <Gregory.Hollis@act.gov.au>
Subject: Re: Ministers Meeting [SEC=UNCLASSIFIED]

Greg, thanks for your analysis, I have been looking at the NEAT daily and that's where we sometimes see fluctuations eg one day it can be 48 then the next 69. This is what the Minister sees so we need to be able to bring the discussion back to the average for the month and our plans to improve our performance overall. She also focuses on time to be seen.

In our discussion we will need to have a goal of improving and some predicted timelines to match. A strong commitment from all of our leaders will reassure the minister.

Please be assured however that my focus is timely care for our patients and easier processes for our staff not just political targets.

Thanks Bernadette

Sent from my iPhone

> On 9 Feb 2019, at 1:35 pm, Hollis, Gregory (Health) <Gregory.Hollis@act.gov.au> wrote:
>
> No worries.
>
> In regard to fluctuation, I'm not sure what figures we're looking at - can you provide whatever that information from the data unit?
>
> I've had a look at Portal just now, and there don't seem to have been big fluctuations, unless we're talking re individual days, which will have variations.
>
> Looking month by month on the portal from July-Jan, the NEATs in order were: 52,55,59,59,55,61,56, so not much in the way of big variations.
> Looking week by week on the portal from beginning of Dec to end of Jan: 61,58,56,69,55,55,60,59, again not much variation with the exception of the Xmas week (69) which had low presentations(221/day average) and minimal access block.
>
> If there's more detailed data that the team need to look at before Wednesday, please send.

>
> Greg
>
> _____
> From: McDonald, Bernadette (Health)
> Sent: Saturday 9 February 2019 10:19
> To: Hollis, Gregory (Health)
> Cc: Boyd, Narelle (Health); Bone, Chris (Health); Stevenson, Nicole
> (Health); Alexander, Tonia (Health)
> Subject: Re: Ministers Meeting [SEC=UNCLASSIFIED]
>
> Dear Greg, thanks so much for your email and thoughts. I have read many reports, Narelle provided them to me when I commenced at CHS.
>
> I think for next weeks meeting let's not involve Calvary but a good idea for future discussions.
>
> Your review of previous strategies is very helpful and I will chat with Tonia about using this as the basis of a document for the minister and our discussion.
>
> The Minister will be interested to know why our NEAT performance has fluctuated so much through December and January. We will need to have a discussion on this prior to our Mi islets meeting.
>
> I look forward to working on improving our whole of organisation performance with you.
>
> Kind Regards Bernadette
>
> Sent from my iPhone
>
>> On 8 Feb 2019, at 6:31 pm, Hollis, Gregory (Health) <Gregory.Hollis@act.gov.au> wrote:
>>
>> Dear Bernadette,
>>
>> Of course; very happy to attend.
>>
>> I've included a bit of information below and attached in case you have time to peruse prior to Wednesday and to make the best use of the available in-person time.
>>
>> You may have already reviewed all the attached information, as I presume others have probably passed it on. If not, there is plenty of meat in there to consider for the CHS timely care strategy I suspect.
>>
>> Narelle and I discussed some of these issues in a meeting with Chris yesterday afternoon.
>>
>> I have also just spoken with Tonia Alexander, who is collating some further information, which I believe she/Chris will provide you by Tuesday.
>>
>> Question – Would it be useful to involved Calvary ED in next Wednesday's discussions, or would you prefer just CHS ED?
>>
>> Comments in advance that may aid preparation/maximising the use of
>> whatever time is available
>>
>> In regard to your comment about what was working two years ago:
>>
>> o I agree wholeheartedly that the successes of 2016-2017 need to be reviewed and the successful interventions re-invigorated; the organisation CAN get there again.
>>

>> o There will be plenty of organisational memory, documentation and data in regard to those, that I'm sure various non-ED parties can provide you with.
>>
>> § strongly suggest you speak personally with Mark Dykgraaf. He will have wise insights into what worked/what didn't, & what the issues are throughout the organisation.
>>
>> § Many current executive and other staff will be able to provide input, including Narelle and Chris of course.
>>
>>
>>
>> o The massive improvements through 2016 and into early 2017 arose from the interventions post-the external review of 2015, and intense, continued focus on those at all levels.
>>
>>
>>
>> o I've attached the Diagnostic report, and the 24 recommendations. Effective Implementation of a decent proportion of them was what those successes were based on.
>>
>>
>> a) GOOD, STILL GOING, Maybe need some work
>>
>> i.e. Recommendations that were implemented, successful, continuing to various extents & my opinions:
>>
>> § ED Navigator role (recommendation 2):
>>
>> · Successful, continues
>>
>> · modified with the successful Clinical coordinator and pod leader roles – these continue and should be maintained
>>
>> § ED admission to ward procedure (recommendation 3)
>>
>> · In place, only moderately successful
>>
>> · Lack of culture of compliance cross-hospital within all inpatient teams.
>>
>> · Requires leadership and embedding of that cultural change beyond ED.
>>
>> · Would greatly benefit by the implementation of AAU (recommendation 7)
>>
>> § Patient Flow Unit (recommendation 5)
>>
>> · Successful, continues. Great current leadership in Lyn O'Connell.
>>
>> § Team based care in the ED (recommendation 10)
>>
>> · Reasonably successful, continues, could have some amendments
>>
>> § Medical Imaging (recommendation 15):
>>
>> · There was really dramatic improvement in timeliness of imaging – both test and report, for xray, CT, U/S.
>>
>> · Big differences in ability to make timely decisions in the ED. Good data produced by medical imaging showed this.
>>
>> · Last 6 months – unfortunately a major drop off in timeliness, particularly in regard to CT report availability.

>>
>> o So, this one could do with re-fixing to achieve the highs of where we were at perhaps 12-18 month ago.
>>
>>
>>
>> b) NOT GOOD, Consider implementation actions ASAP for some of these
>>
>> i.e. Some of these were never done, some were successful to some degree but drifted off/ceased to be enforced/were actively removed:
>>
>> · Acute Admissions Unit(recommendation 7)
>>
>> 1. The organisation has failed to implement. I believe could make a big difference to performance, culture, and further breakdown silos.
>>
>> 2. See my email to Chris of 3 days ago, which highlights an AAU – attached, entitled "Medicine-YES!
>>
>> ii. Long LOS Committee (recommendation 4):
>>
>> 1. The long LOS issue appears to have deteriorated from the highs of 2016, although admittedly I can't see all the data today.
>>
>> 2. Really important notes that should NOT be lost:
>>
>> a. Note recommendation 4 in the 2015 report
>>
>> b. Target and achievement in the period of success was <250.
>>
>> c. Note the graph in today's long stay report attached. That appears to have deteriorated – todays graph shows 260-325 is the current number of LOS patients (past 60 days).
>>
>> d. That there were successes, with significant reductions in long-stayers across the hospital.
>>
>> e. Whatever those interventions were should be re-introduced and concentrated on. I'm not sure the organisation is focussing on this
>>
>> f. Note in succinct "Patient Flow Plan" in the "Documents and Actions" attachment – a target of <250 long stay patients.
>>
>> i. This clearly affects available inpatient beds.
>>
>> ii. Great potential for good if success on this can be achieved again.
>>
>> iii. Side note – the long stay report used to have a 6 month graph; when the numbers started to go up again a year or two ago, it was reduced to a 2 month graph.
>> (The LOS item I do note that the data should be reviewed before
>> actioning this one)
>>
>> iii. MET – remove all inpatient MET responsibilities from the ED (i.e. focus on ED-patient care, rather than diverting key ED human resources to attend inpatient wards.
>>
>> iv. Internal Review of Mental Health (recommendation 17)
>>

>> 1. While there has been significant change within the ED, which is good,
>>
>> 2. The inpatient Mental Health aspects within the wider organisation need significant work.
>>
>> 3. Two separate current briefs are also relevant (one from B.Aloisi to yourself, the other MIN19/85 through you to the Ministers).
>>
>> v. Predictive Bed Management (recommendation 20)
>>
>> 1. Has not progressed
>>
>> 2. Some indication just this week (!) that a new M.Phipps-led tool might get some legs, but early days.
>>
>> vi. Discharge planning focus (recommendation 11)
>>
>> 1. Medical buy-in, action, ownership cross-hospital requires further attention
>>
>> vii. Medical engagement strategy (recommendation 14)
>>
>> 1. Really needs some serious attention
>>
>> viii. Director of Operations position (recommendation 1)
>>
>> 1. Organisation has chosen to remove.
>>
>> 2. Was a key intervention. Suggest –review the details/justification under that recommendation and ensure that current governance arrangements maintain that function, even if the position no longer exists.
>>
>>
>> c) NEW, adverse changes since 2016 that would benefit from remediation in order for future success to be achieved:
>>
>>
>> · Mental health access block – Dramatic deterioration in access block for mental health patients.
>>
>> o Much less long stayers in 2016-17. Now a HUGE issue for ED performance overall.
>>
>> · EMU capacity
>>
>> o Not too bad in 2016.
>>
>> o Presentation rises 2016-2019 have now resulted in a capacity issue, ie 12 beds not sufficient to be able to admit EMU-appropriate patients; resultant impact on NEAT
>>
>> · Continued major flows of Northside patients to Canberra ED, bypassing Calvary ED (see recommendation 24)
>>
>> o This one is not new, but is continuing/worsening
>>
>> o Detailed post-code Modelling work by ACT Health planning during 2018 clearly demonstrates that even in the new northside suburbs there are major % flows to Canberra ED
>>
>> o Needs effective action re reputation/knowledge of Calvary ED's capacities/expertise/roles.
>>
>> · ED Senior medical recruitment:
>>

>> o currently under-recruited, current ad closes 21st Feb. Working on it. Happy to discuss detail
>>
>> o No additional funding required this financial year. Do need additional funding yearly for next 2-3 years to address growth and safe supervision/clinical care.
>>
>> · ED nursing:
>>
>> o Do need additional funding. Approved additional Fast-track/DES nursing staffing was implemented, but has not yet been funded. Resus 4 & Resus 5 – no nursing funding.
>>
>> o NIP, NIX commenced. Good for patient care, but not expected to have any/minimal effect on NEAT.
>>
>> · Note on "Discharge stream"
>>
>> o NOT independent of other factors, and in my opinion will not be possible to make significant improvements here without:
>>
>> § Removing the very large mental health-type patients impact on this
>> areas
>>
>> § Removing the worsening access block (large numbers of admitted
>> patients affect space, impact on staff time, reduce physical and
>> human resources to address the "discharge stream")
>>
>> · Pharmacy:
>>
>> o Huge. Affecting discharge timing from wards throughout the hospital, and thus delay in bed allocations for ED patients, patient flow, NEAT.
>>
>>
>> Sorry that's a bit long, but hopefully there is some useful information in there somewhere that will aid efforts to improve CHS performance, including ED performance.
>>
>> I look forward to discussing & thank you for the invitation.
>>
>> Greg
>>
>>
>> Greg Hollis
>> Clinical Director, Emergency Medicine, Senior Specialist, Capital
>> Region Retrieval Service Canberra Hospital
>>
>> Phone: 02 62443309
>> E-mail: gregory.hollis@act.gov.au
>> Care | Excellence | Collaboration | Integrity
>>
>>
>>
>> From: McDonald, Bernadette (Health)
>> Sent: Friday, 8 February 2019 11:37 AM
>> To: Hollis, Gregory (Health) <Gregory.Hollis@act.gov.au>
>> Cc: Boyd, Narelle (Health) <Narelle.Boyd@act.gov.au>; Bone, Chris
>> (Health) <Chris.Bone@act.gov.au>; Stevenson, Nicole (Health)
>> <Nicole.Stevenson@act.gov.au>
>> Subject: Ministers Meeting
>>

>>
>> UNCLASSIFIED
>>
>>
>> Dear Greg,
>>
>> I have weekly meetings with the Minister for Health and next week she is very keen to understand what we are doing and can do to improve ED performance. I have talked to her in recent times about a whole of health service approach to timely care, which she understands however she is also keen to have an understanding of what can be improved specifically in the ED.
>>
>> We are putting together a list of strategies and focus areas which are aimed at improving timely care across the health service which will also aid in improving the flow of patients through the ED.
>>
>> I would like you to join me at the Ministers meeting to discuss from an ED perspective what the opportunities are within the ED to support improved performance. I think it would be valuable for the Minister to get an insight into the pressures in ED, what we can focus on externally to the ED and also what we can focus on improving within the ED.
>>
>> We have had a higher level of performance in our ED indicators around 2 years ago and it would be good to understand how we can focus on returning to this level of performance.
>>
>> Please let me know if you would like to attend the meeting, it will be next Wednesday around 10ish, we can confirm the time.
>>
>> Regards
>> Bernadette
>>
>>
>> Bernadette McDonald
>> Chief Executive Officer
>> Canberra Health Services
>>
>>
>> Phone: 02 5124 2728 | Email:
>> bernadette.Mcdonald@act.gov.au<mailto:bernadette.Mcdonald@act.gov.au>
>> Building 24, Level 2, Canberra Hospital, Yamba Drive, Garran ACT 2605
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>> 2015 Final..pdf> <Documents and Actions
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>> [DLM=For-Official-Use-Only].eml> <Medicine - YES!
>> [SEC=UNCLASSIFIED].eml>

CANBERRA HOSPITAL AND HEALTH SERVICES

HEALTHCARE REFORM CONSULTING

Diagnostic Report for Canberra Hospital and Health Services

Note: this report should be read in conjunction with HRC's Recommendations Report for Canberra Hospital and Health Services

Kate Brockman, Director
Mark Walmsley, Senior Manager
[redacted]

Table of Contents

1. Introduction and background

1.1. Introduction and report outline

This report was commissioned to baseline the high level 'Whole of Hospital' performance of the Canberra Hospital (CH) as the centre-piece of the Canberra Hospital and Health Service (CHHS). The methodology used was based on the successful diagnostic approaches used in WA and NSW reform programs from 2008 to 2013. The baseline activity looked into five areas as follows:

- High level data on emergency department presentation and discharge profiles, and length of stay.
- High level data on ward admissions and discharge profiles, and length of stay.

- Generic hospital and overarching structures review.

This report should be read in conjunction with the accompanying report *HRC's Recommendations Report for Canberra Hospital and Health Service*. The purpose of each report is as follows:

- **Diagnostic Report for CHHS.** To outline the analysis completed on the Canberra Hospital and summarise the findings.
- **Recommendations Report for CHHS.** To outline the recommendations for the Canberra Hospital based on the findings of the diagnostic investigation undertaken.

1.2. Background

The CH has undertaken significant focus on project work and redesign since 2011 beginning with the "Care Around the Clock" analysis report. Whilst this project work has delivered some change it has been siloed and driven by a collective few. This is most notable with the Project Venturi work which has delivered significant improvements in medicine around flow and improved discharge practices. A different approach will be required to support the outcomes required for hospital wide performance improvement that can build on the positive outcomes thus far achieved.

The authors recommend a whole of hospital approach to improving patient flow that looks at the ED, inpatient interface, back of hospital and overarching structures that support patient flow in and out of the hospital.

1.3. Overview of Whole of Hospital Approach

Reforming a hospital with a view to decreasing ED and hospital overcrowding requires a whole of hospital approach to identifying bottlenecks and selecting the focus areas and projects that will bring biggest success. An overcrowded ED is the result of both inefficient processes within the ED and the rest of the hospital.

A whole of hospital approach incorporates looking at the time and process delays across the entire patient journey from presentation at triage to departure from the wards. These delays are a result of people, process, governance, models of care and often patient factors. Achieving transformational change and maintaining a high performing organisation requires strong executive focus and sponsorship, medical engagement, detailed understanding of the problem and widespread communication. This is most successfully supported by a focus on implementation and data measurement.

2. Details of diagnostic activities

2.1. Engagement scope

The scope for this diagnostic activity is shown below:

- Areas to review:
  - Emergency department
  - Patient flow management and ED interface
  - Ward length of stay management
- Methods of review:
  - Process (manual collection)
  - Activity levels

Out of scope for these diagnostic activities are:

- Areas to review:
  - Out-patients, elective surgery, theatres, and imaging
  - Allied health services, and ACT ambulance service
  - Staffing levels across the hospital
- Method of review:
  - Budget and facilities review
  - Voice of patient and voice of staff

2.2. Approach to diagnostic activity

2.3. Report nomenclature

This report should be read with the following considerations in mind:

- All time data is shown in the format hh:mm unless the time in discussion is less than 60 mins, in which case it is shown as mm mins. So 2:33 equates to 2 hours 33 minutes, rather than 2 mins, 33 seconds; and 55 minutes is shown as 55 mins.

- Data sources for each study or data review are listed at the beginning of the applicable section.

2.4. Final site visits and schedule

HRC visits to sites in support of the studies are detailed below.

- 22-24 July 2015. Kate Brockman, [redacted]
- 28 July – 1 August 2015 Kate Brockman, Mark Walmsley.
- 11-14 August 2015. Kate Brockman.
- 6-13 September 2015. Kate Brockman, Mark Walmsley, [redacted]

2.5. Studies and analysis conducted

2.5.1. *High level business of the hospital – emergency department*

We undertook a high level business of hospital (BOH) review into ward activity including:

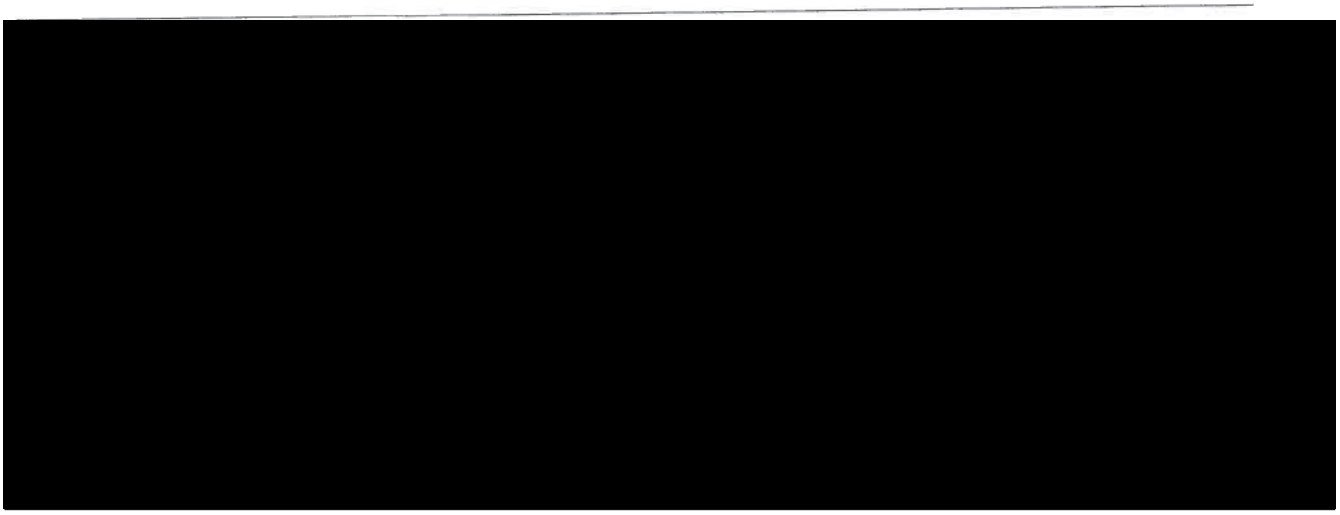
- [redacted]
- ED presentation profile.
- [redacted]
- ED length of stay overall and by specialty.
- [redacted]

2.5.2. *High level business of the hospital – wards*

We undertook a high level business of hospital (BOH) review into ward activity including:

- [redacted]
- Ward admission profile.
- Ward discharge profile.
- Net separations and separations before 10am.

[redacted]



2.5.6. *High level business of the hospital – stakeholder interviews*

We undertook stakeholder interviews with over 25 staff from all disciplines and divisions including Imaging, Surgery, Medicine, Critical Care, Mental Health, Drug and alcohol, Access Unit, Executive team, and the Business Intelligence Unit.

3. Business of the hospital – emergency department

3.1. Study details

A high level review of hospital data was conducted using information provided covering 73,950 ED presentations from 1/9/14 to 31/8/15. The review sought to summarise key ED activity profiles and performance metrics.

3.2. ED volume, length of stay and NEAT summary

The following table summarises overall volume and volume by triage category with the corresponding NEAT performance.

Triage	Volume	Volume %	NEAT %
Triage cat 1	375	0.5%	61.6%
Triage cat 2	8303	11.2%	48.3%
Triage cat 3	24648	33.3%	42.4%
Triage cat 4	30890	41.8%	61.1%
Triage cat 5	9734	13.2%	82.2%
Total	**73950**	**100.0%**	**56.2%**
Admit stream	24,652	33.3%	32.6%
Discharge stream	49,298	66.7%	68.03%

Key findings – analysis

- The data indicated that the admit stream represents one third of ED presentations and has a NEAT performance of 32.6%.
- The data indicated that the discharge stream represents two thirds of ED presentations and has a NEAT performance of 68.03%.

Key findings – observations

- CH NEAT of 56.2% compares with the 2013Q4 national average for major metropolitan hospitals of 66%[1].
- The top 5 major metropolitan hospitals in 2013Q4 averaged approximately 84% (Mater Adult QLD, Ipswich QLD, Dandenong VIC, The Alfred VIC, The Tweed NSW).

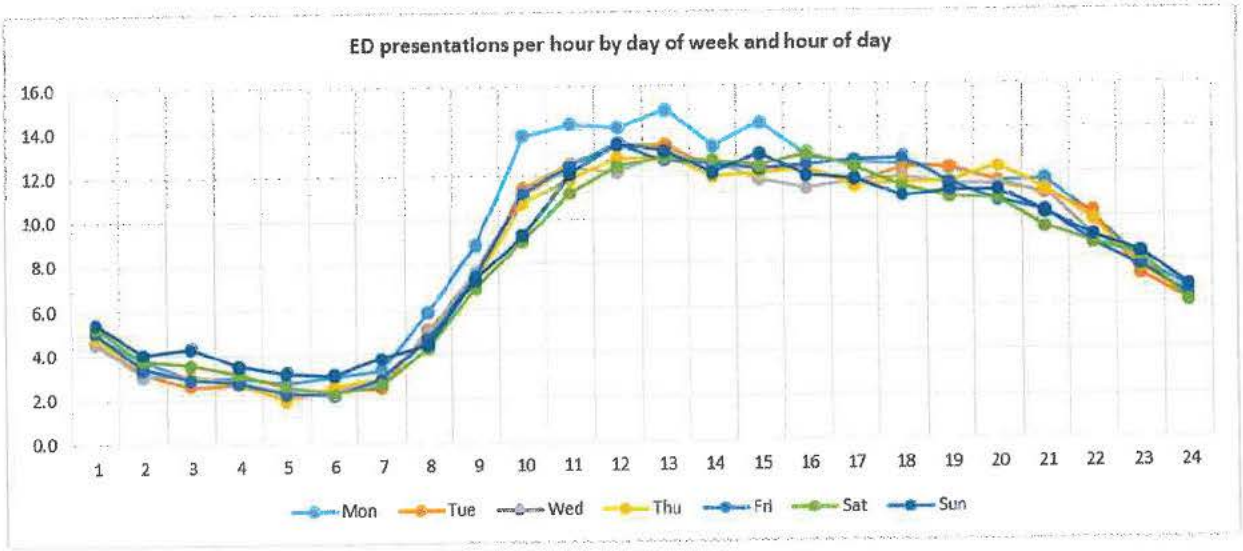
Conclusions

- There is opportunity to improve both admit and discharge NEAT streams to further improve overall NEAT.

[1] http://www.myhospitals.gov.au/docs/default-source/our-report-pdfs/HP-U_TimeInEmergencyDepartments_2012-13_RPT.pdf

3.3. ED presentation profile

The ED presentation profile was investigated by day of week (Monday to Sunday) and hour of day (0 to 23) to ascertain key volumes and trends.



Key findings – analysis

- The data indicated a predictable pattern for ED presentations per hour across the week ranging from a low of 2.0 patients per hour on average at 5am, to a high of approximately 15 per hour at midday.
- The data indicated a high presentation rate plateau of more than 10 patients per hour (1 per 6 mins) from 10am to approximately 9pm.
- The data indicated a low presentation rate trough of less than 4 patients per hour (1 per 15 mins) from 2am to approximately 7:30am.

Key findings – observations

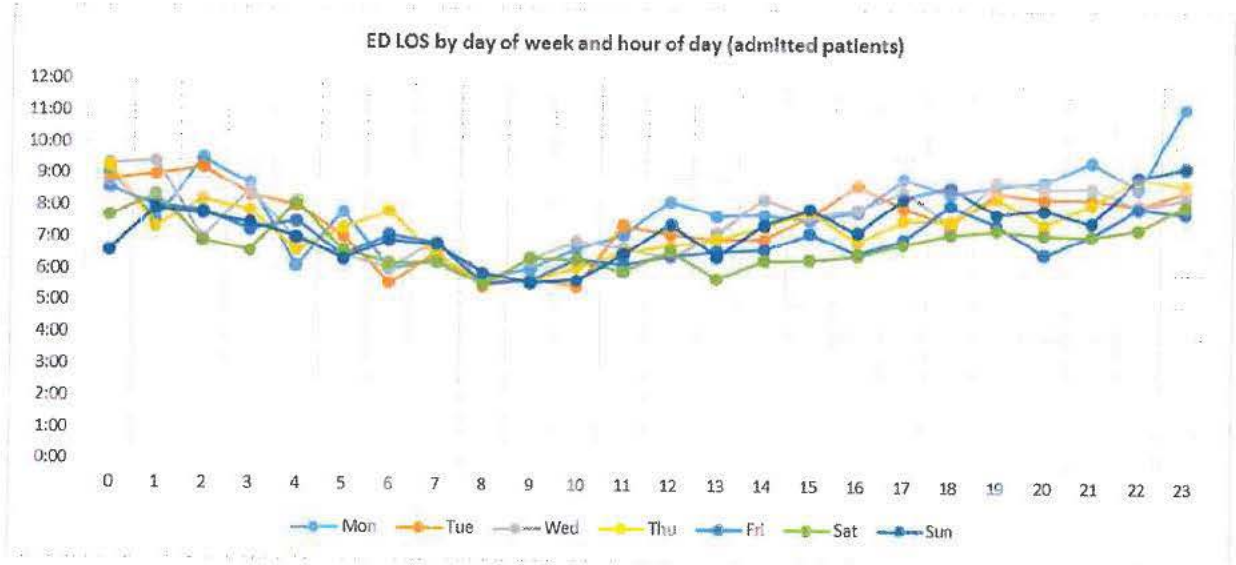
- The above ED presentations profile is similar by day of week and hour of day to numerous hospitals across Australia.
- The expected presentation profile can be analysed with other metrics such as admitted percentage and patient DRG, to determine the estimated demand across impacted areas of the hospital.

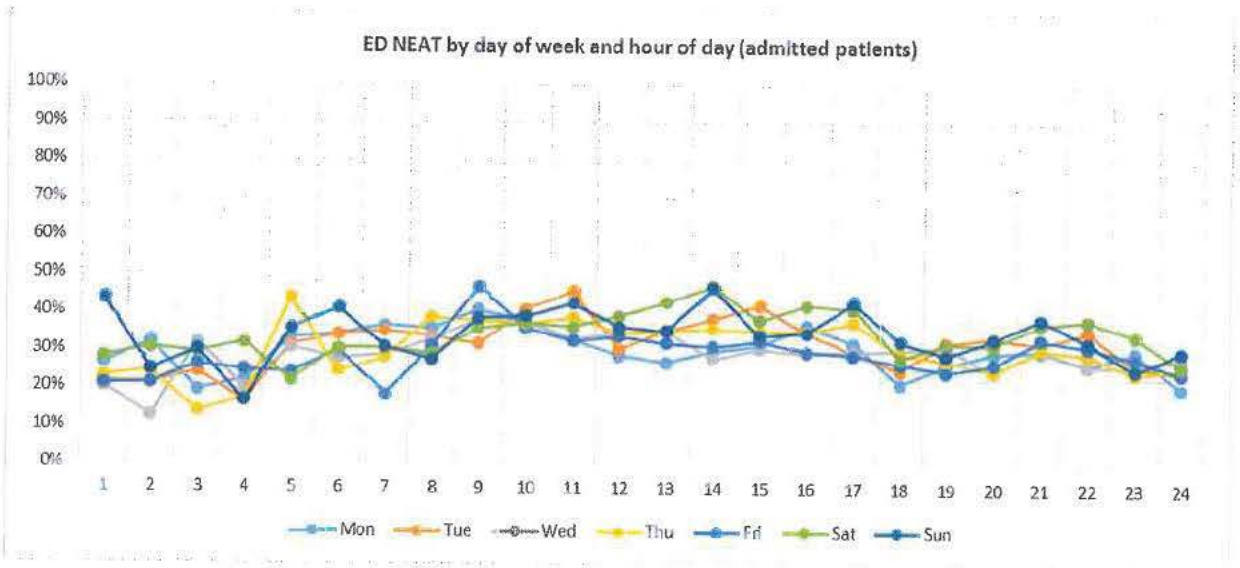
Conclusions

- The predictable presentation patterns of patients to the ED should be used to optimise ED clinical and administrative staffing levels.

3.4. Admit stream profile

The admit stream profile was investigated in relation to ED length of stay (ED LOS) and corresponding NEAT performance by day of week and hour of day with the results in the graphs below. Each chart has 168 data points (7 days x 24 hours per day) with N for each point between 32 and 295, average 146.





Key findings – analysis

- The data indicated variation in average admit stream ED LOS from a low of 5:32 (Tuesday 8-9am, N=119), to a high of 11:16 (Monday 11pm-12am, N=111).
- The data indicated variation in average admit stream NEAT performance from a low of 13% (Wednesday 1-2am, N=47), to a high of 47.3% (Saturday 1-2pm, N=207).

Key findings – observations

- Nil[2].

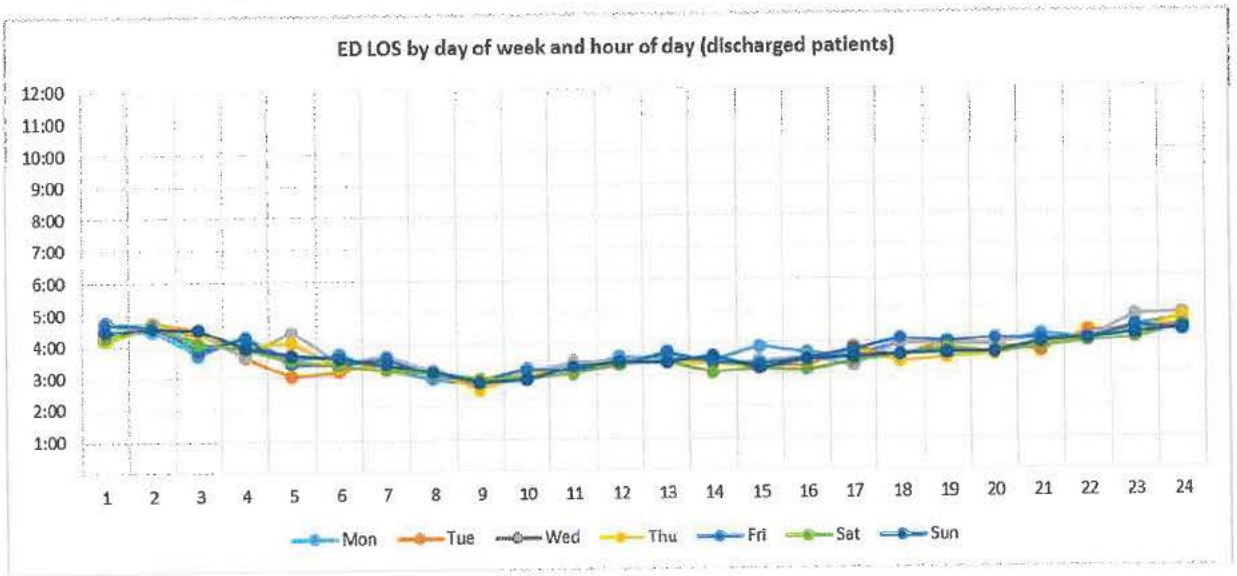
[redacted]

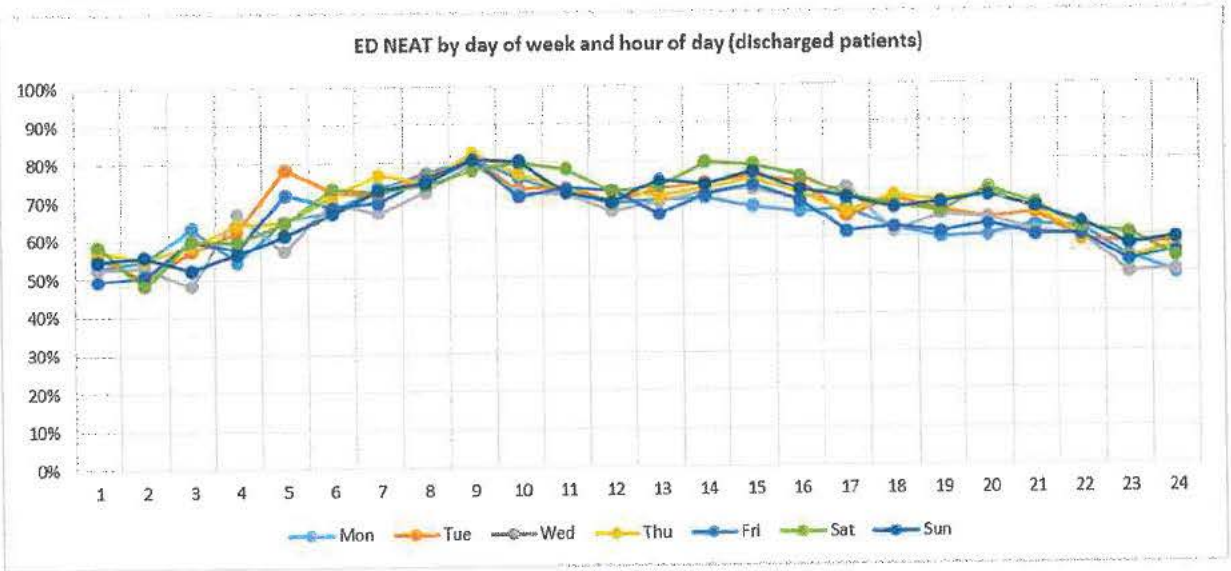
Conclusions

- Nil.

3.5. Discharge stream profile

The discharge stream profile was investigated in relation to ED length of stay (ED LOS) and corresponding NEAT performance by day of week and hour of day with the results in the graphs below. Each chart has 168 data points (7 days x 24 hours per day) with N for each point between 65 and 509, average 293.





Key findings – analysis

- The data indicated variation in average discharge stream ED LOS from a low of 2:35 (Thursday 8-9am, N=405), to a high of 4:50 (Wednesday 11pm-12am, N=226).
- The data indicated variation in average discharge stream NEAT performance from a low of 48% (Wednesday 2-3am, N=108), to a high of 83% (Thursday 8-9am, N=259).
- There is less variation in the discharge data between days of the week (indicated by the lines being closer together) than was observed in the admit data.

Key findings – observations

- Nil.

Conclusions

- Nil.

[redacted]

Key findings – observations

- Nil.

[redacted]

[redacted]

3.7. ED length of stay overall and by specialty

The average ED LOS by specialty was investigated using the data provided. The table below shows the ED LOS for individual specialties. Note calculations of average ED LOS and NEAT performance should be considered informative when the corresponding N is more than 30 and caution is warranted with N less than 30. A heat map colour code is added to the ED LOS field to assist in understanding high versus low LOS[4].

Admitting specialty	Patient N	Admit LOS	Admit NEAT	Admitting specialty	Patient N	Admit LOS	Admit NEAT
Acute Surgical Unit	308	7:12	21%	Oncology	458	11:28	5%
Cardiac Surgery	6	7:26	17%	Ophthalmology	61	5:08	48%
Cardiology	2165	4:57	56%	Oral Medicine	1	1:01	100%
Dermatology	18	9:35	22%	Oral-Maxillofacial Surgery	72	6:00	39%
Ear, Nose and Throat	262	6:14	35%	Orthopaedic Surgery	1487	6:53	27%
Emergency Medicine	7472	4:35	54%	Paediatric Surgery	596	5:12	39%
Endocrinology	119	9:31	10%	Paediatrics	1998	5:48	32%
Gastroenterology	998	10:38	12%	Plastic Surgery	281	5:48	34%
General Medical Unit	15	11:47	7%	Psychiatry	701	20:41	7%
General Surgery	1481	7:29	19%	Radiation Oncology	67	10:56	9%
Geriatric Medicine	671	13:53	1%	Rehabilitation	2	8:59	0%
Gynaecology	324	7:51	13%	Renal	297	10:04	17%
Haematology	240	11:19	9%	Respiratory	971	11:20	9%
Immunology	48	9:49	19%	Rheumatology	96	11:58	5%
Infectious Diseases	403	11:20	8%	Shock Trauma Service	236	7:16	24%
MAPU	928	9:59	8%	Thoracic Surgery	58	7:24	21%
Neonatology	10	5:12	20%	Unknown	1	2:52	100%
Neurology	704	10:12	11%	Urology	455	7:33	20%
Neurosurgery	327	7:51	27%	Vascular	228	8:24	21%
Obstetrics	62	7:32	18%				

Key findings – analysis

- Considering only specialties with more than 10 patient admissions, the data indicated that the four specialties with the highest average ED admit NEAT performance were:
    - Cardiology (N=2165, 4:57, 56%)
    - Emergency medicine/EMU (N=7472, 4:35, 54%)
    - Ophthalmology (N=61, 5:08, 48%)
    - Paediatric surgery (N=596, 5:12, 39%)
- Considering only specialties with more than 10 patient admissions, the data indicated that the four specialties with the lowest average ED admit performance were:
    - Geriatric medicine (N=671, 13:53, 1%)
    - Rheumatology (N=96, 11:58, 5%)

[4] Note the table provides for average performance with N as shown, with each data set having a unique standard deviation/distribution. For this reason there is not a direct relationship between ED LOS and NEAT and some variation is evident.

- Oncology (N=458, 11:28, 5%)
- Psychiatry (N=701, 20:41, 7%)

Key findings -- observations

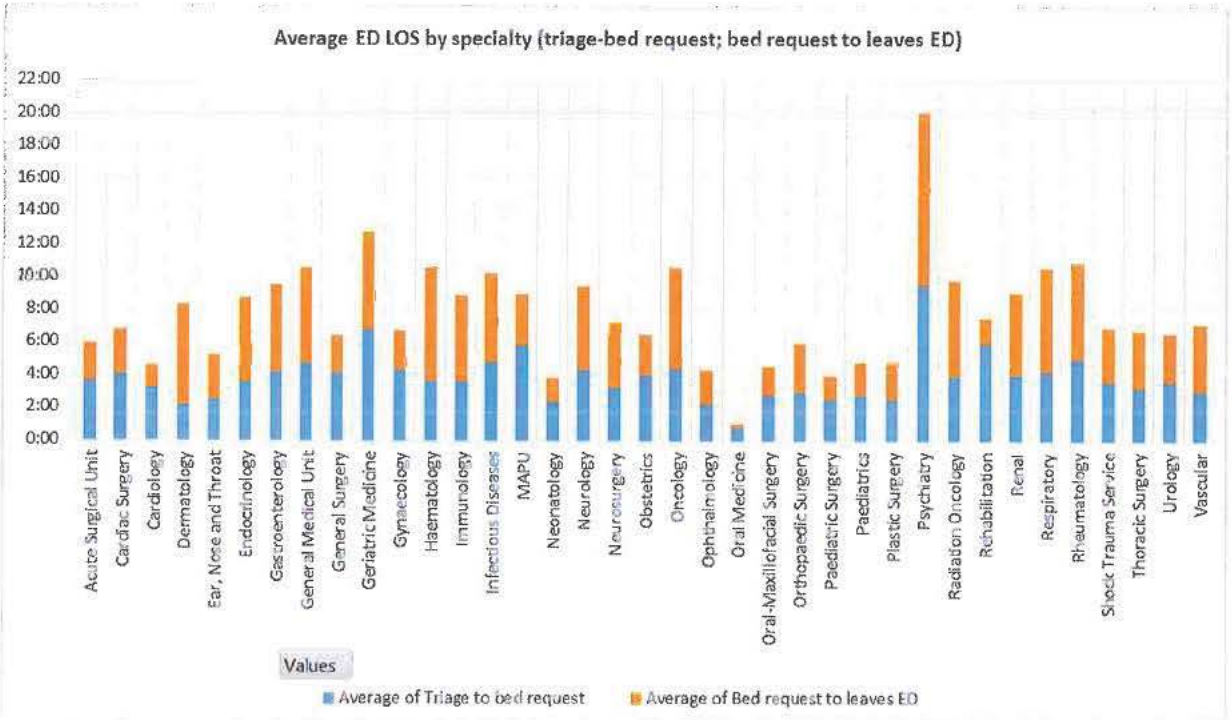
- Nil.

Conclusions

- Nil.

3.8. ED admit performance by specialty and stage

The ED admit performance by specialty was investigated to determine the proportion of time taken from [redacted] Note the stored time for 'departure ready' was used for the bed request date/time on the advice of the Business Intelligence Unit. The results are shown in the graph below with N as per the table in the section immediately above.



Key findings – analysis

- The data indicated there is considerable variation in both the duration and distribution of time taken from triage-be request; and from bed request-patient leaves ED.

Key findings – observations

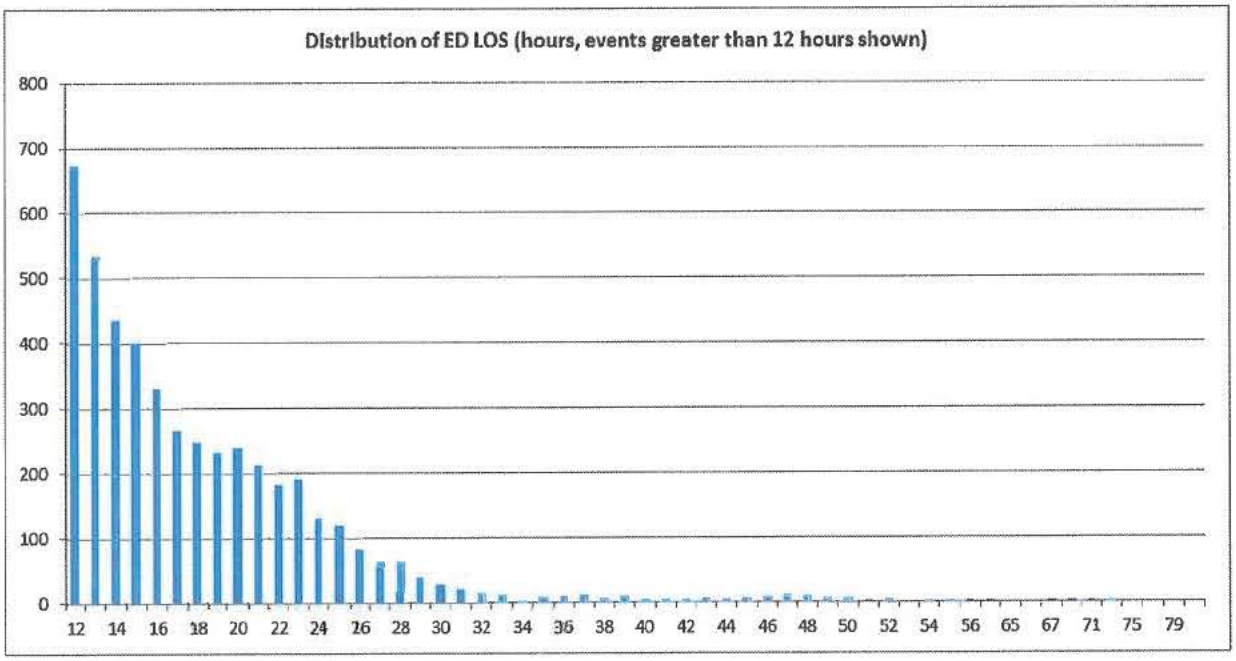
- Nil.

Conclusions

- Nil.

3.9. ED long length of stay

The distribution of ED long LOS patients was investigated to determine the distribution of patients staying longer than 12 hours with the results shown in the chart below. Note the data analysed the 73,950 events between 1/9/14 and 31/8/15.



Key findings – analysis

- The data indicated there is a considerable 'tail' of patients staying longer than 12 hours in the ED.
    - 4,692 patients/year or 13/day stayed longer than 12 hours in the ED
    - 737 patients/year or 14/week stayed longer than 24 hours in the ED
    - 145 patients/year or 12/month stayed longer than 36 hours in the ED
    - 56 patients/year or 14/quarter stayed longer than 48 hours in the ED
    - 17 patients/year stayed longer than 60 hours in the ED

Key findings – observations

- Nil.

Conclusions

- Increased LOS in the ED is associated with increased mortality[5], decreasing this LOS should be a priority for the CH.

[5] The association between hospital overcrowding and mortality among patients admitted via West Australian emergency departments. Peter C Sprivulus et al. MJA 2006.

4. Business of the hospital – wards

4.1. Study details

A high level review of hospital data was conducted using information provided covering 52,025 hospital ward discharges from 1/9/14 to 31/8/15. The data set excluded internal-to-hospital care type changes so that each entry reflected the total journey length from initial entry to final departure from the hospital. Note; to investigate long-length-of-stay the data set was based on 12 months of discharges, with the admission date for each entry in a limited number of instances occurring prior to 1/9/14.

4.2. Patient summary by admitting specialty

The table below shows the number of patients by admission specialty as same day (admission date = separation date) and multiple day stays.

Admitting specialty	Same day	Multiple day	Total admissions	Admitting specialty	Same day	Multiple day	Total admissions
REN	15201	270	**15471**	ADPBLU	12	365	**377**
OBS	723	6412	**7135**	REH	318	18	**336**
EME	4020	1935	**5955**	GER	15	315	**330**
ORT	885	1779	**2664**	HAE	9	293	**302**
PLA	1738	491	**2229**	INF	8	239	**247**
PAE	896	1099	**1995**	NEO	5	222	**227**
CAR	876	1046	**1922**	OPH	83	141	**224**
G/S	226	1351	**1577**	ASU	9	191	**200**
GAS	593	630	**1223**	THO	17	143	**160**
URO	364	596	**960**	STS	8	112	**120**
GYN	475	436	**911**	ROC	5	99	**104**
PDS	361	528	**889**	END	26	77	**103**
NEU	351	386	**737**	CTS	2	65	**67**
ENT	213	521	**734**	DEN	48	2	**50**
VAS	175	549	**724**	DER	28	21	**49**
PSY	4	627	**631**	GYNO	11	15	**26**
MAPU	15	558	**573**	GMU	6	13	**19**
RES	11	546	**557**	ANA	13	0	**13**
RHE	469	58	**527**	RAD	2	1	**3**
NUS	71	365	**436**	FET	1	0	**1**
ONC	11	415	**426**	ORA	0	1	**1**
IMM	367	31	**398**	Grand Total	28883	23142	52025
ORS	212	180	**392**	Allocation	56%	44%	100%

Key findings – analysis

- The data indicated 56% of patient admissions were for same day events, 44% for multi-day stays.
- The data indicated the highest volume same day specialties are REN (15201), EME (4020), and PLA (1738).
- The data indicated the highest volume multi-day specialties are OBS (6412), EME (1935), and ORT (1779).

Key findings – observations

- Nil.

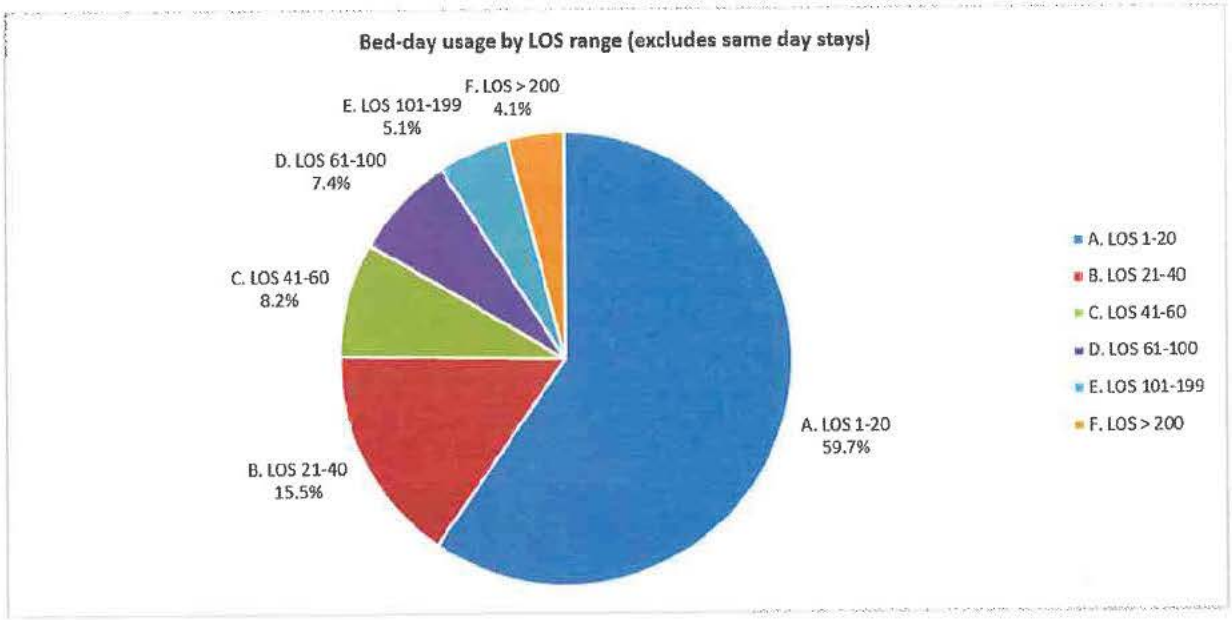
Conclusions

- Nil.

4.3. Long length of stay summary

An investigation into long length of stay (L-LOS) patients was investigated by reviewing the total hospital length of stay (including any care-type changes) for all patients discharged between 1/9/14 and 31/8/15. Only multiple day stays were considered (same day stays defined as admission date the same as discharge date). The table below groups patient LOS by duration into 6 categories.

Hospital LOS	Patient count	Average LOS	Bed days	Bed day %
A. LOS 1-20 days	21,966	3.6	78,802	59.7%
B. LOS 21-40 days	759	27.0	20,510	15.5%
C. LOS 41-60 days	233	48.4	10,799	8.2%
D. LOS 61-100 days	127	76.4	9,705	7.4%
E. LOS 101-199 days	52	130.7	6,796	5.1%
F. LOS > 200 days	15	357.3	5,360	4.1%



The 15 individual patients L-LOS events that were greater that 200 days LOS in the above analysis were individual patients staying for:

1. 843 days (GER),
2. 632 days (G/M),
3. 476 days (G/S),
4. 430 days (G/S),
5. 408 days (REN),
6. 400 days (INF),
7. 311 days (END),
8. 285 days (GER),
9. 262 days (REN),
10. 238 days (NEU),
11. 226 days (END),
12. 217 days (VAS),
13. 216 days (PSY),
14. 210 days (EME), and
15. 208 days (VAS).

Key findings – analysis

- The data indicated there were considerable L-LOS events in CH.
    - 4.1% of bed days associated with multiple-day patient separations are for patients who have been in the hospital for longer than 200 days (N=15 patients).
    - 9.2% of bed days associated with multiple-day patient separations are for patients who have been in the hospital for longer than 100 days (N=67 patients).
    - 16.6% of bed days associated with multiple-day patient separations are for patients who have been in the hospital for longer than 60 days (N=194 patients).

Key findings – observations

- The long length of stay profile for CH represents significant opportunity for improvement.

Conclusions

- A high number of bed days are attributable to a specific cohort of long stay patients; management of these patients will yield a high number of beds for other patients and this should be a priority focus area.

4.4. Long length of stay review by discharge specialty

An investigation into long length of stay (L-LOS) patients by ward was investigated by reviewing the total hospital length of stay (including any care-type changes) for all patients discharged between 1/9/14 and 31/8/15. Only multiple day stays were considered (same day stays defined as admission date the same as discharge date). The table below groups patient LOS by duration into 6 categories with each entry representing one patient event, and highest multiple-stay volume specialties at the top of the table. The rightmost column shows the percentage of patient events with LOS greater than 60 days. Note specialties with N <50 were excluded.

Specialties	A. LOS 1-20	B. LOS 21-40	C. LOS 41-60	D. LOS 61-100	E. LOS 101-199	F. LOS > 200	Grand Total	% events 60+ days
OBS	5,594	10	4	1			5,609	0.0%
ORT	1,702	87	32	15	4		1,840	1.0%
EME	1,398						1,398	0.0%
G/S	1,340	34	8	3	2	2	1,389	0.5%
PAE	1,093	14	3	2	1		1,113	0.3%
CAR	1,008	15	6	2	1	1	1,033	0.4%
NEO	937	56	9	16	5		1,023	2.1%

Specialties	A. LOS 1-20	B. LOS 21-40	C. LOS 41-60	D. LOS 61-100	E. LOS 101-199	F. LOS > 200	Grand Total	% events 60+ days
PSY	490	111	39	20	4	1	665	3.8%
URO	640	9	2		1		652	0.2%
GAS	600	28	2	2	2		634	0.6%
RES	528	30	5	2			565	0.4%
VAS	513	26	4	3		1	547	0.7%
ENT	521	8		1			530	0.2%
PDS	525	1			1		527	0.2%
PLA	493	14	4	2	1		514	0.6%
MAPU	464	2					466	0.0%
GYN	464						464	0.0%
ONC	389	38	15	2	4		448	1.3%
NEU	378	16	4	3	1	1	403	1.2%
GER	297	53	13	14	1	2	380	4.5%
ADPBL	365						365	0.0%
NUS	322	26	11	3	1		363	1.1%
HAE	264	35	10	2	1		312	1.0%
REN	242	25	9	6	4	2	288	4.2%
INF	222	20	8	4	2	1	257	2.7%
ORS	184	1					185	0.0%
THO	155	5	2				162	0.0%
ASU	141	6		1			148	0.7%
OPH	141	2					143	0.0%
GMU	94	16	7	3	2		122	4.1%
ROC	81	22	5	1	1		110	1.8%
STS	90	5	1				96	0.0%
RHE	72	10	1				83	0.0%
CTS	68	8	1	1			78	1.3%
REH	6	20	17	18	12	2	75	42.7%
END	71	3				1	75	1.3%
Grand Total	**21892**	**756**	**222**	**127**	**51**	**14**	**23,062**	

Key findings – analysis

- The data indicated the five wards with the highest percentage volume of patients staying longer than 60 days were REH (42.7%), GER (4.2%), REN (4.2%), GMU (4.1%), and PSY (3.8%).

Key findings – observations

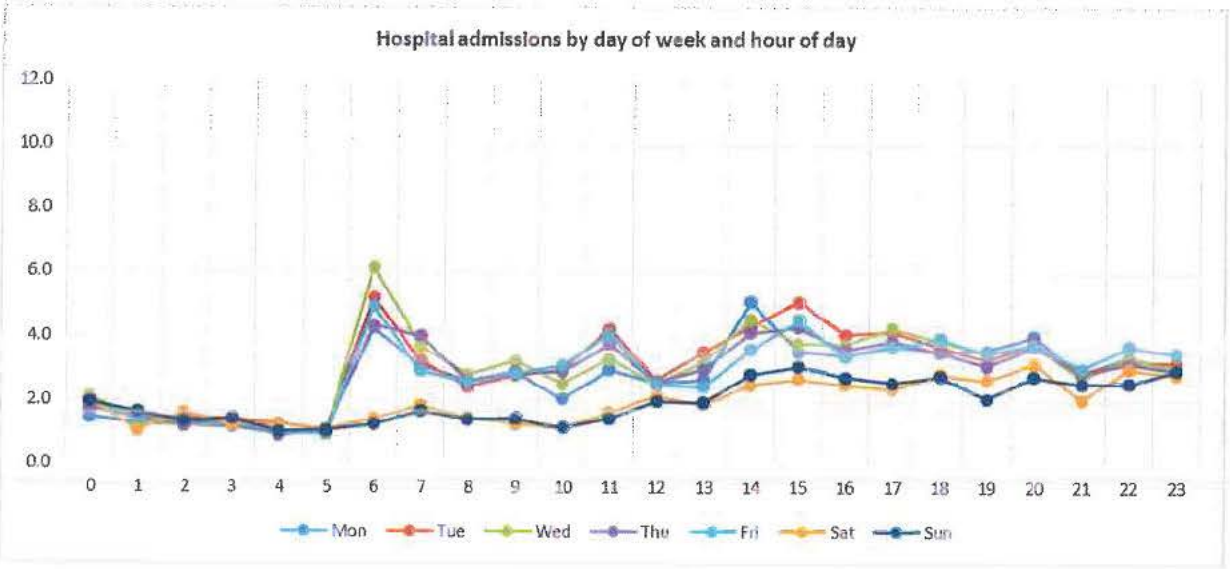
- The long length of stay profile for CH represents significant opportunity for improvement.

Conclusions

- Operational management processes at CH should be reviewed to avoid excessive long length of stay events.

4.5. Ward admission profile

The ward admissions profile was investigated by day of week (Monday to Sunday) and hour of day (0 to 23) to ascertain key volumes and trends with the results summarised in the chart below. The data shows average admissions for each day/hour combination. Only multiple day stays (N=23,142) are considered below.



Key findings – analysis

- The data indicated a different profile for admissions on weekends, compared to business days.
- The data indicated a peak average rate of admissions of 6.2 on Wednesday at 6-7 am.
- The data indicated that 31% of daily average admissions take place by 9am.
- The data indicated there was a lower level of admissions on Saturday and Sundays.

Key findings – observations

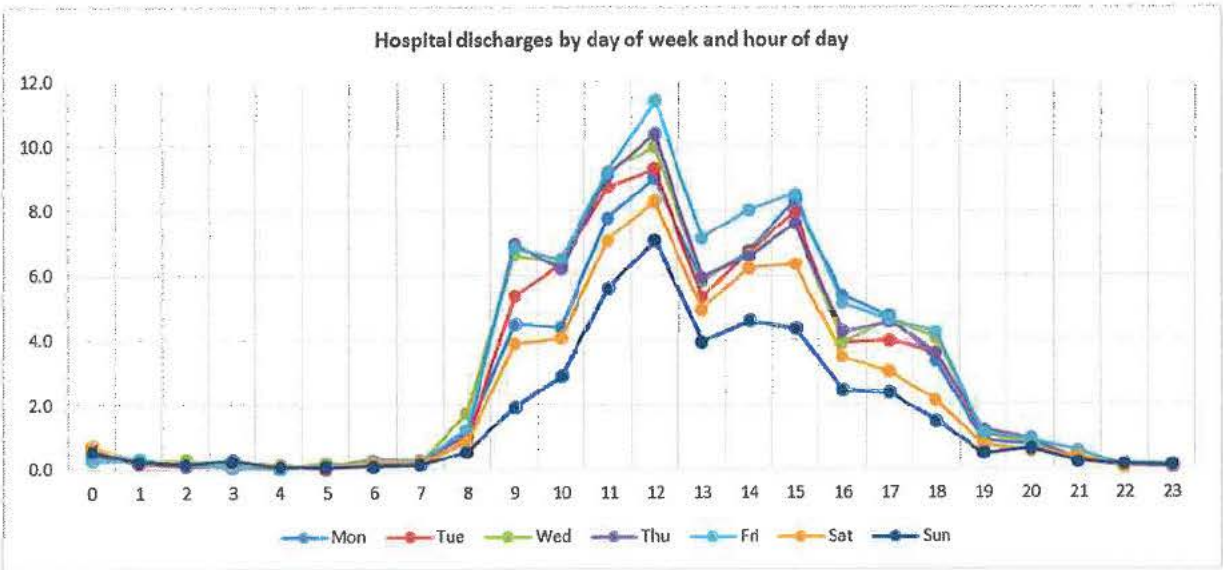
- Nil.

Conclusions

- Nil.

4.6. Ward discharge profile

The ward discharges profile was investigated by day of week (Monday to Sunday) and hour of day (0 to 23) to ascertain key volumes and trends with the results summarised in the chart below. The data shows average admissions for each day/hour combination. Only multiple day stays (N=23,142) are considered below.



Key findings – analysis

- The data indicated a different profile for admissions on weekends, compared to business days.
- The data indicated a peak average rate of discharges of 11.4 on Friday at 12-1pm.
- The data indicated that 12%% of daily average admissions take place by 10am.
- The data indicated a high level of discharges on Saturday and Sundays.

Key findings – observations

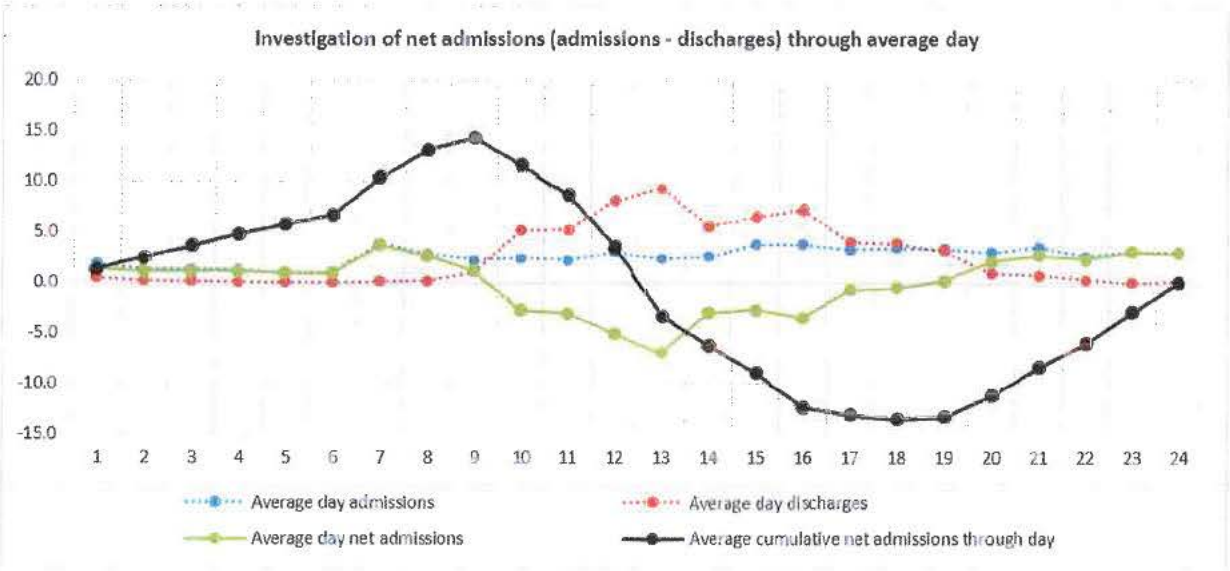
- The weekend discharge patterns are relatively high compared to comparable peer sites.

Conclusions

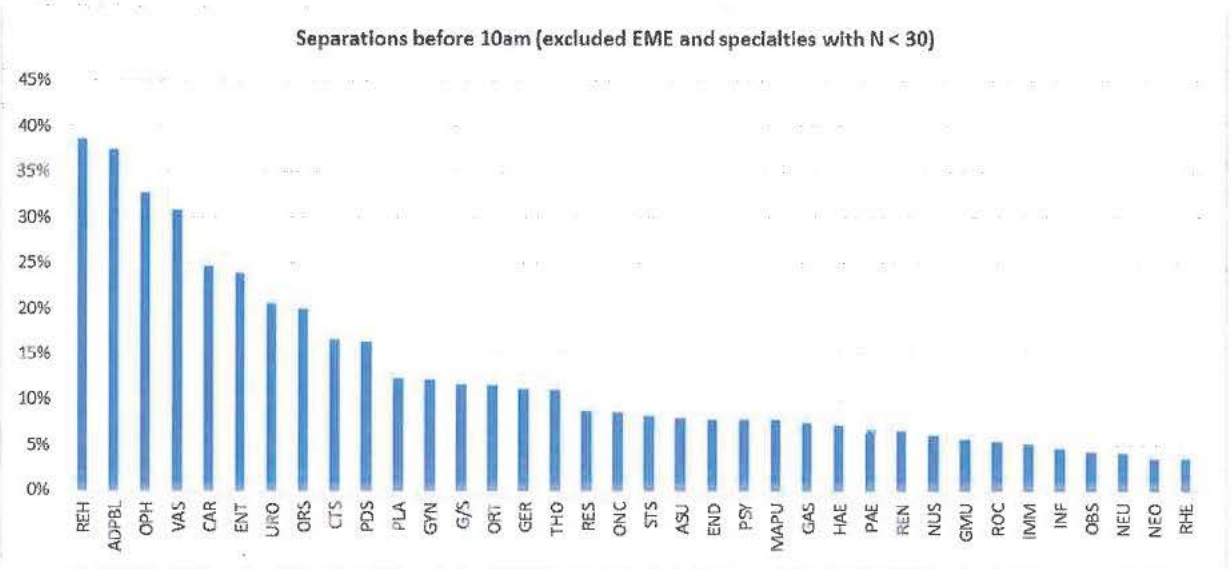
- Nil.

4.7. Net separations and separations before 10am

An investigation into the impact of net separations on bed requirements was conducted using the multiple day stay admissions and separations data by day of week and hour of day. A daily average net separation was calculated and then shown as a cumulative result across an average day in the chart below.



An investigation into discharge patterns was completed by reviewing discharge before 10am performance by ward. Only multiple day stays were considered and excluded from the analysis were EME and specialties with N < 30.



Key findings – analysis

- The data indicated that on average, the mismatch between admissions and separations (admissions occurring earlier) places a requirement for 15 additional beds[6].
- The data indicated that an average of 13% patients separate before 10 am.
- The data indicated the specialties with the highest separations before 10am are REH (39%), ADPBL (38%), and OPH (33%).
- The data indicated the specialties with the lowest separations before 10am are RHE (4%), NEO (4%), and NEU (4%).

Key findings – observations

- In our experience the discharge before 10am profile represents a significant opportunity for improvement.

Conclusions

- Discharge practices at CH should be reviewed to improve the discharge before 10am performance to reduce the demand on CH beds that the current net discharge profile imposes.

[6] Note we are not requesting 15 extra beds, rather noting that the cumulative net admissions place a requirement for at least 15 additional beds each day. Increasing discharges before 10am and reducing LOS will assist in this regard.

Summary by primary stream

The overall NEAT performance based on collected and analysed data for the study is shown in the table below.

Patient stream	NEAT %	N (5 of total)
Discharge stream	69%	220 (53%)
Admit stream	35%	188 (46%)
Did not wait	75%	4 (1%)
Total	53%	412 (100%)

Summary by triage category

The overall NEAT performance from the recorded data based on triage category is shown in the table below.

Triage category	NEAT %	N ... (% of total)
Category 1	50%	2 (0.5%)
Category 2	40%	52 (13%)
Category 3	42%	174 (42%)
Category 4	65%	155 (38%)
Category 5	83%	29 (7%)

Key findings – analysis

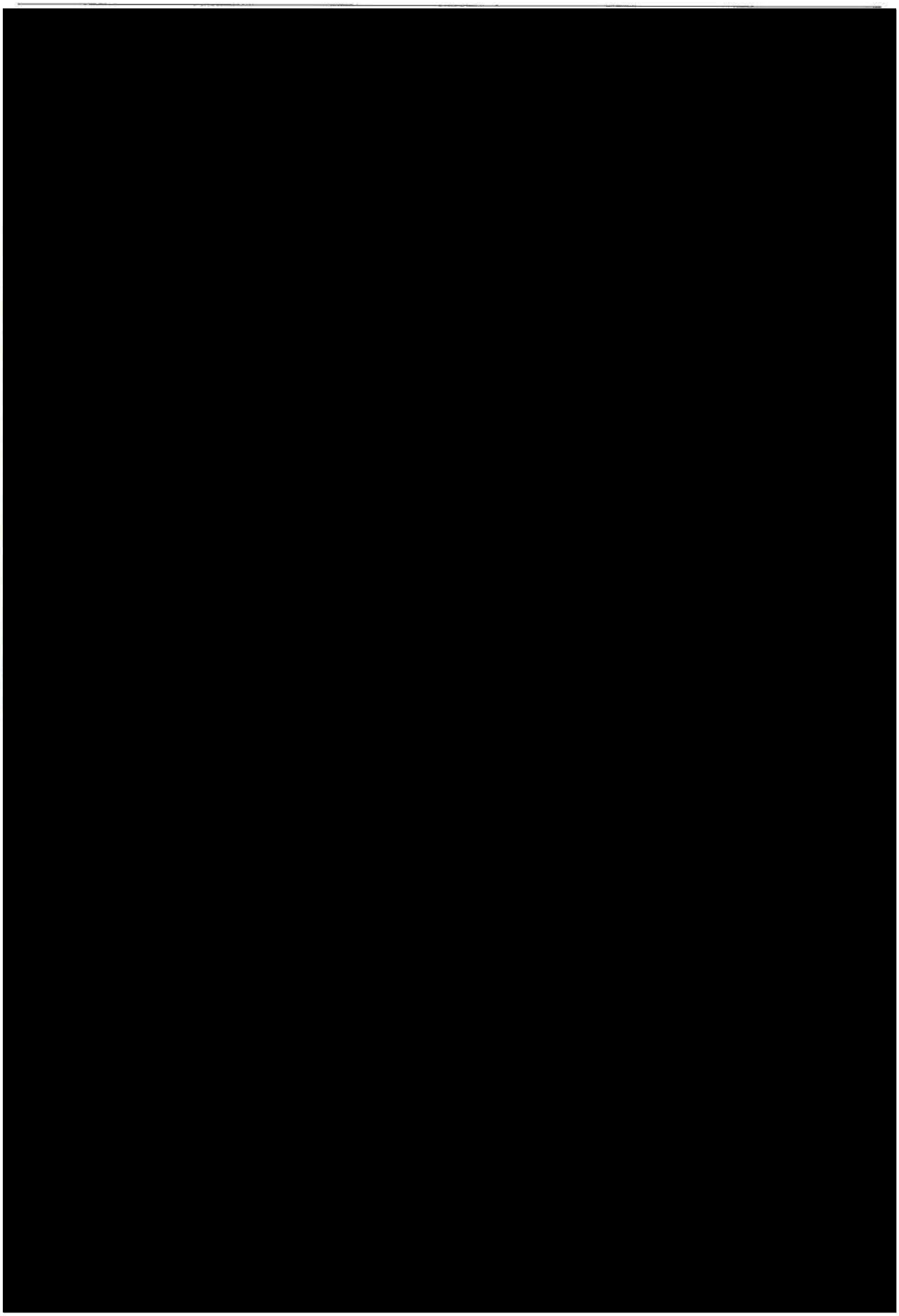
- The data indicated that the NEAT performance for admit stream, discharge stream and overall ED for the [redacted] study was largely consistent with that achieved during the 12 month period from 1/9/14 to 31/8/15.

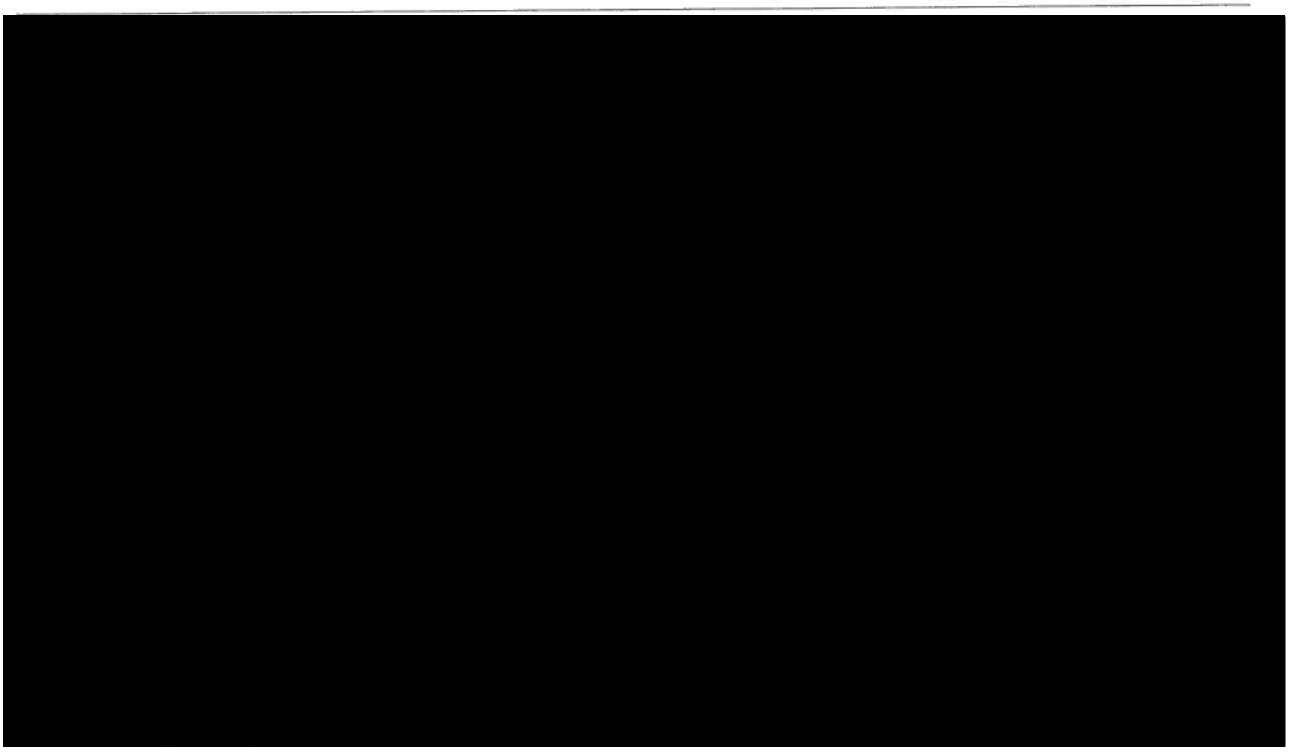
Key findings – observations

- We observed a culture within the ED that is one of team work with positive communication and a can do attitude. It is commendable that the staff work effectively in such a logistically constrained environment.
- Our observations pertaining to process delays are similar to those observed in similar ED's around Australia.
- The did not wait rate is exemplar compared to similar peer hospitals.

Conclusions

- There is significant opportunity to improve flow as measured by the NEAT.





Key findings – observations

- The triage process was highly variable and observed to be person dependant.
- The practice of the triage nurse having to take notes and patients into the ED was observed to be time consuming and inefficient, the triage nurse also at times escorted relatives into the department.
- There was great variability in how many patients were seen in a shift by the medical staff. We observed a resident pick up 2 patients for the whole shift during one of the data collection days.
- The logistics of the ED are fractured, inefficient, crowded and presented a challenge when trying to manage the internal flow within the department.
- The X-ray chairs lacked an environment of privacy when examining patients and taking a history. It was common to have more than 12 patients sitting together on the chairs and presented a challenge for confidentiality.
- There was great variability within the Nurse Coordinator role and it appeared to be person dependant. We observed a Nurse Coordinator absent from the Nurse Coordinator computer for > 2 hours during one of the data collection days.
- Some Nurse Coordinators were unable to pay the requisite attention to patient flow through the ED.
- There was passiveness towards flow management and a general lack of sense of urgency with some medical staff who undertook the medical team leader role.
- There was a high level of variation in how EDIS data was entered and a high level of discrepancy between real time and data entry.
- There was little control over how the real estate within the ED was used. For example it was noted on one of the study days that a patient had an EEG in the ED.
- There were long and frequent delays to bed requests.

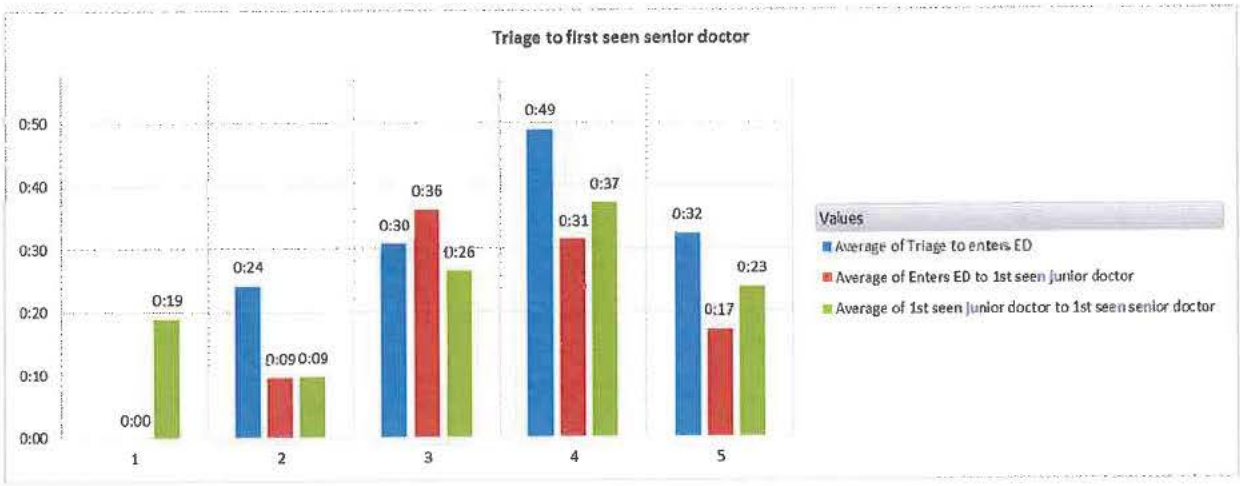
- There was a lack of clear escalation in times of overcrowding and need for beds within the ED.
- The role of the Chest Pain Evaluation Unit (CPEU) nurse in pulling patient to the CPEU was variable.
- It was not clear who was overall "in charge" of the ED.
- Transparency around when beds were going to be allocated by the Access Unit was not clear.
- The process around calling a wards-person for transfer was variable and not transparent, the data collection was also not transparent and was limited.

Conclusions

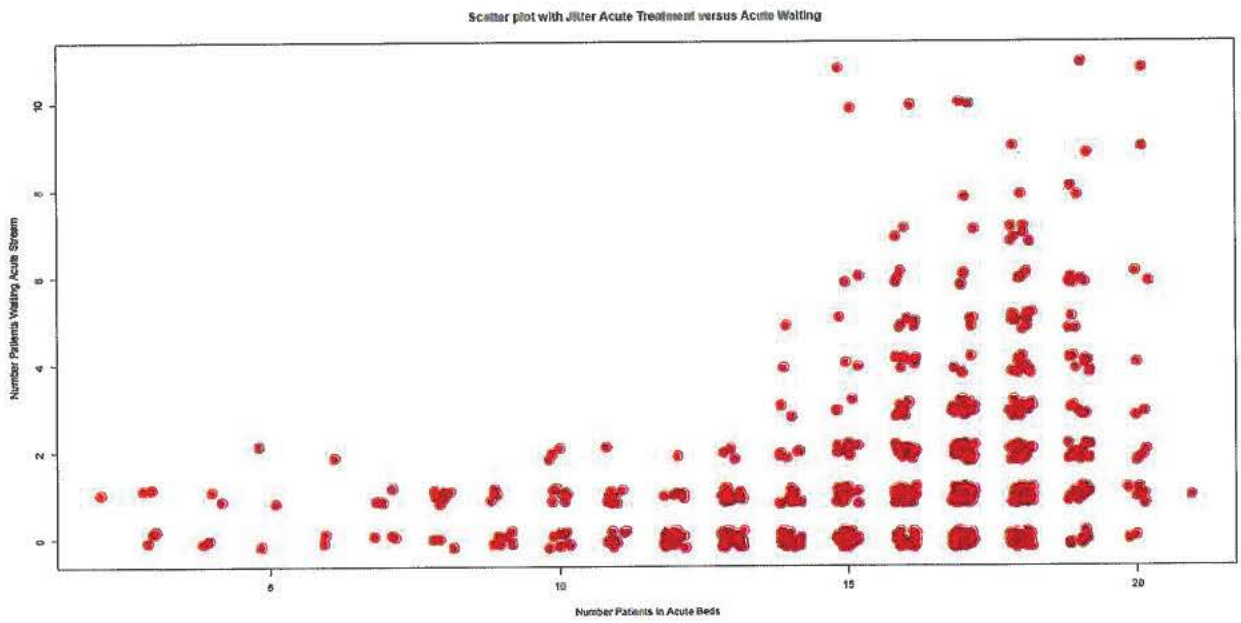
- There was great variability and lack of clarity as to who was "in charge" in the ED on a shift by shift basis. This requires a solution to prevent person dependant flow management.
- The timely and accurate entry of data into EDIS requires a focus of attention, this is likely having a significant effect on reported performance figures.
- ED processes should be reviewed to ensure patients are pulled (or pushed) into the ED in a more timely manner.
- The internal and external escalation processes should be clearly defined and communicated within the ED and broader hospital. This will require widespread consultation and clarity of roles and responsibilities regards who is ultimately responsible to respond to escalation.
- The role of the NC and medical team leader should be reviewed with regards to how flow is managed and how timeliness of decision making will be best supported.
- [redacted]
- The triage process should be reviewed.
- The logistics of the department are a high contributor to the lack of smooth flow within the ED. Solutions for this are limited at time of report due to the current new ED build.
- ED processes should be reviewed to ensure patients are pulled (or pushed) into the ED in a timely manner. A solution will need to be defined that enables a helicopter view of the department and oversight of all empty beds.
- Patient flow processes should be reviewed to ensure that bed allocation is conducted in a more timely manner. This should also be inclusive of more robust communication processes between bed management and the ED.
- The time pairs outlining the time delays for the wards man were < 30. The impact of the wards - person was observed to be negligible.
- [redacted]
- [redacted]

5.4. Triage to 1st seen decision/senior doctor

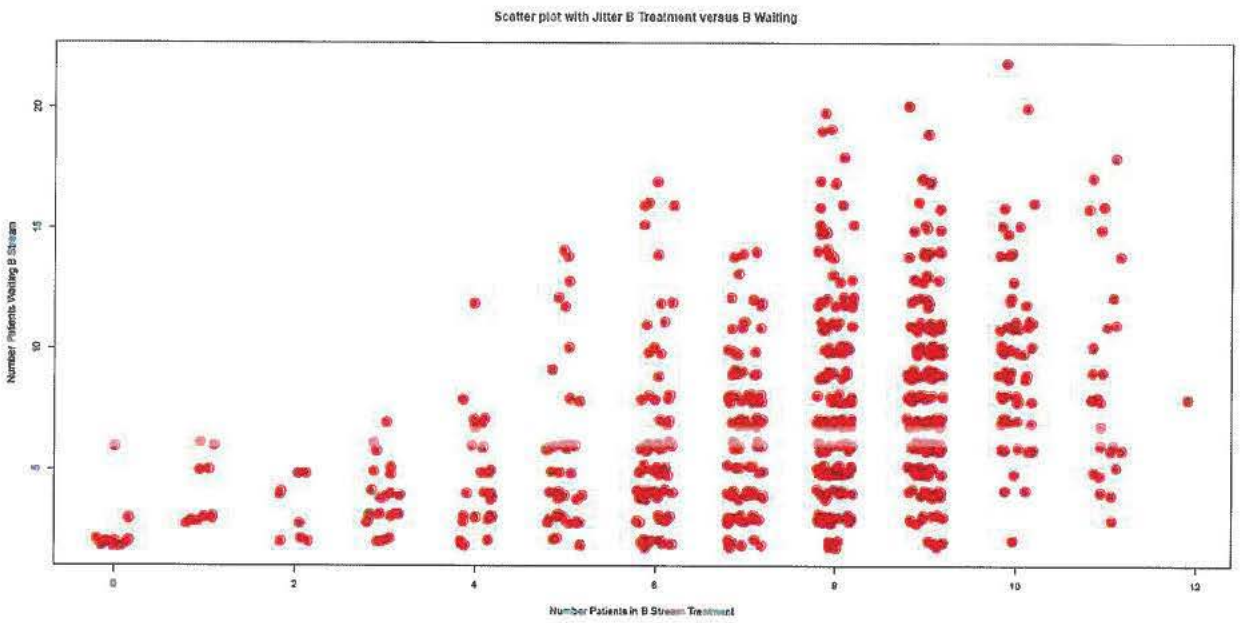
The process from triage to first seen decision/senior doctor was investigated by triage category with the results shown below.



An investigation into the timeliness of patients entering the ED was conducted by reviewing the location of patients in A and B ED streams. The data was provided by ACT BIU on our request. The scatter plots for A stream (patients in A WAIT and patients in acute beds in the ED) is shown in the graph below.



The scatter plot for B stream (patients in B WAIT and patients in B stream treatment) is shown in the graph below.



Key findings – analysis

- [redacted]
- The data indicated that there have been multiple instances of up to 2 patients waiting in the A stream wait with A stream acute beds not at full occupancy.
- The data indicated that there have been multiple instances of up to 16 patients waiting in B stream wait with the B stream treatment not at full occupancy.

Key findings – observations

- Junior Dr's often saw patients first then went looking for senior Dr's for a discussion or a review of the patient.
- There was cherry picking of patients by medical staff, particularly towards the end of a shift.
- There were delays in patients being pulled into the ED, with patients waiting in A/B stream wait, and empty beds in the ED.
- We observed evidence of patients entering the ED in batches of up to 4 patients at a time, with the beds they were allocated not becoming available all at once.
- The B stream NC covers triage for breaks and stops managing flow at that point.
- There are a high number of interns working and rostered in the ED.

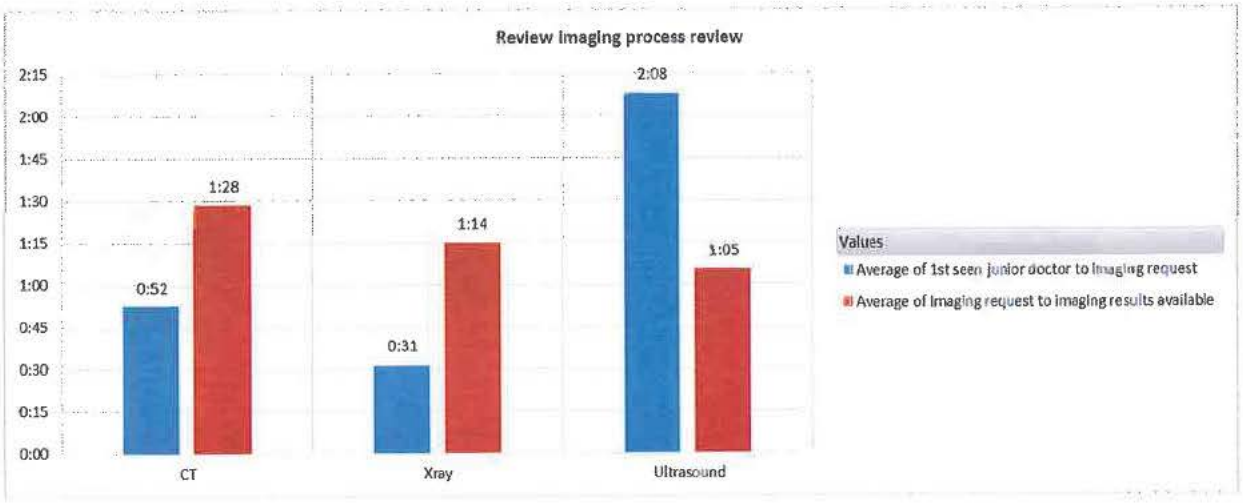
Conclusions

- Junior Dr's saw patients first then went looking for a senior Dr to discuss/request review, this increased the ED LOS for patients.

- The junior/senior Dr processes for assessing patients would benefit from more rigour around communication and supervision.
- The high number of interns rostered in the ED presents a significant teaching and supervision workload for the senior Dr's, this needs review.
- ED processes should be reviewed to ensure patients are pulled (or pushed) into the ED in a more timely manner.
- The role of the NC should be reviewed and a role developed with a focus on timeline and patient journey management. This should be separate from a clinical role and developed within current FTE.

5.5. Imaging process investigation

The imaging process was investigated by averaging time pairs for seen junior doctor to imaging request, and imaging request to imaging results available. This investigation was conducted for Xray (N=83), CT (N=12), and Ultrasound (N=5) with the results in the graph below.



Key findings – analysis

- The data indicated the average cycle time from CT request to results available is 1:28, with test request occurring 52 mins after first seen junior doctor.
- The data indicated the average cycle time from X-ray request to results available is 1:14, with test request occurring 25 mins after first seen junior doctor.
- The data indicated the average cycle time from ultrasound request to results available is 1:05, with test request occurring 2:08 mins after first seen junior doctor.

Key findings – observations

- There was general widespread anecdote within the ED regarding delays to imaging. This was also reflected in hospital wide anecdote regarding delays to imaging.

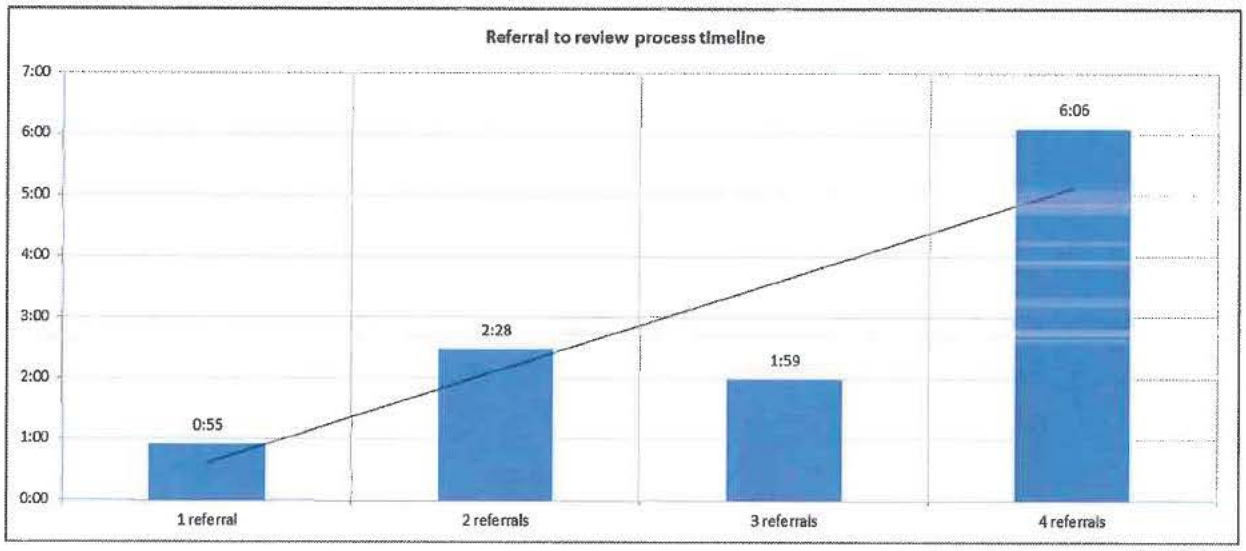
Conclusions

- The processes management CT imaging activities in the ED should be reviewed to enable faster CT cycle times.

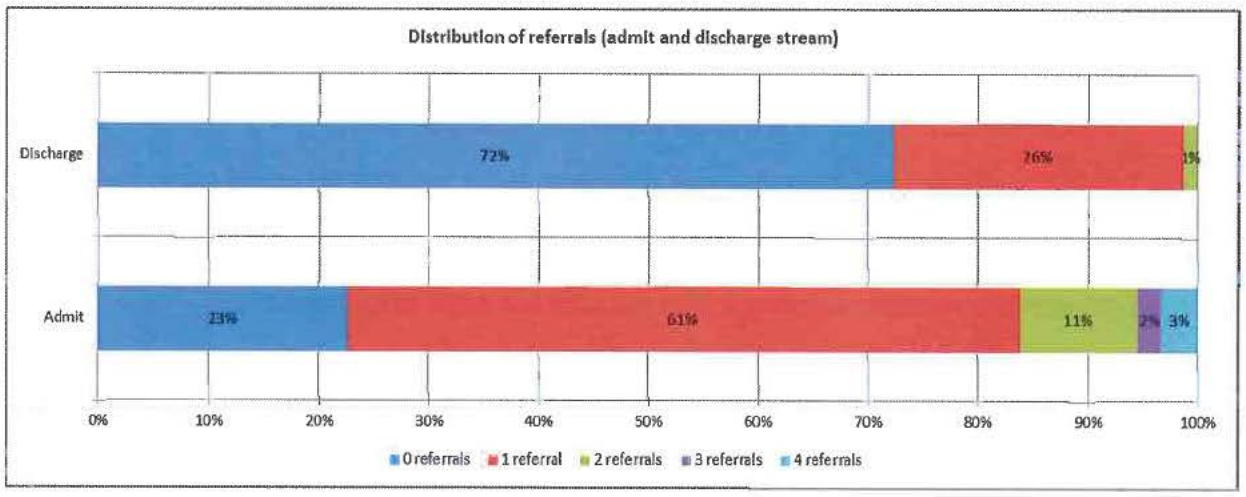
- Further imaging data is required to support or refute the strong anecdote of imaging delays inclusive of defining exactly where the problem is (process, resources, reporting etc.). This data was requested but not supplied.

5.6. Multiple referrals process investigation

The impact of multiple referrals was investigated by reviewing events of multiple referrals and considering the average time from first referral to final review with the results shown in the graph below. Note N for 1, 2, 3, and 4 referrals was 172, 24, 4 and 6 respectively. Note with N for 3 and 4 referrals less than 20 the data should be viewed as indicative only and subject to further investigation.



The distribution of referrals was investigated by reviewing the number of referrals that occurred for admit and discharge patients (between 0 and 4 referrals) with the results shown in the chart below.



Key findings – analysis

- The data indicated that the average time from referral to review varies with the number of referrals from 55 mins for 1 referral, to 6:06 for 4 referrals. Note for 3 and 4 referrals the number of data points is < 10.
- The data indicated that 77% of admitted patients had one or more referrals.
- The data indicated that 28% of discharged patients had one or more referrals.

Key findings – observations

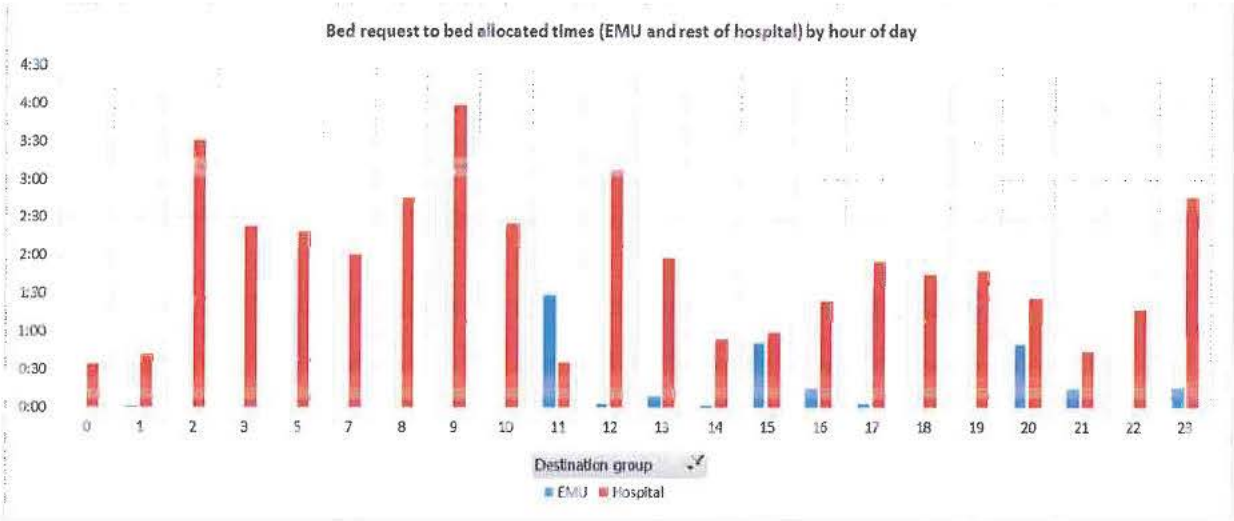
- There were extensive delays associated with multiple referrals.
- High levels of referrals to inpatient teams were made by the by the ED medical staff.
- The percentage of patients that had a referral to an inpatient team in the discharge stream was high.
- Refusal by the inpatient team by phone request for review and admission was common.
- Lack of arbitration for refusal to accept admissions by the inpatient team was observed on a number of occasions.
- Patients received multiple reviews by the same team that the patient was originally referred to and "bounced" between these inpatient teams (general surgery, obs/gyn).
- The ED staff spent significant time trying to find an accepting team and this was observed to be the responsibility of the ED staff, not the inpatient teams.
- Inpatient teams frequently came to the ED, reviewed patients and left without communicating decisions.
- The ED staff were frequently unaware of when the inpatient teams would be attending the ED to review patients.
- Frequent batching of patients occurred as part of the process for ARM review.

Conclusions

- There were extensive delays in the patient journey and a subsequent increased ED LOS with 2 or 4 referrals to inpatient teams.
- ED processes governing referrals and multiple referrals for ED patients must be reviewed to minimise the impact of multiple referrals on patient progress through the ED.
- A process for one way referrals should be investigated and an arbitration process at the hospital wide level agreed.
- The root causes for the high number of inpatient referrals for the discharge stream patients will require defining.
- The Admitting Registrar for Medicine (ARM) role should be reviewed. Batching of patients contributes to an increased LOS for those patients requiring an ARM review prior to referral to an admitting inpatient team.

5.7. Bed allocation process investigation

The variation in bed request to bed allocation process was investigated by looking at the average time from request to allocation by hour of day at time of request. The results for EMU and hospital bed requests are shown in the graph below.



Key findings – analysis

- The data indicated that the average time from bed request to allocate for hospital beds varies considerably by time of day with a range of 34 mins to 3:59.
- The data indicated that the average time from bed request to allocate for EMU beds varies considerably by time of day with a range of 0 mins to 1:29.

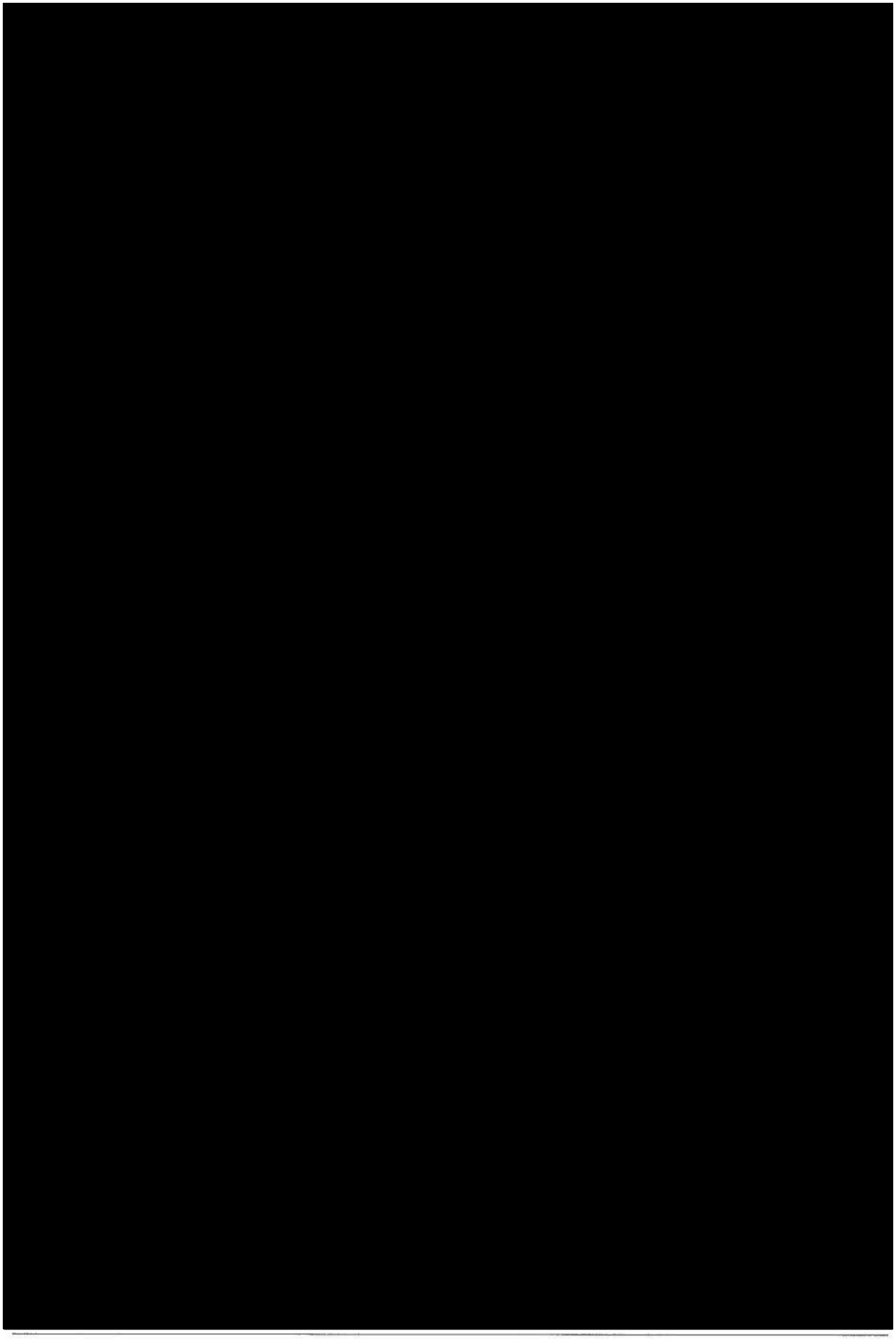
Key findings – observations

- There was considerable variation in the time taken to allocate beds.
- Batching in bed allocation associated with patient flow rounding was common (i.e. delays were incurred for individual patients as part of this process).
- The internal processes within the Access Unit for bed allocation were highly variable.
- At times the Access Unit staff were aware of bed requests from the ED and had knowledge of a corresponding suitable bed.
- The Access Unit staff only allocate beds that are ready and not virtual.
- There was a lack of a clearly defined escalation process both within the ED and Access Unit for patients with increasing ED LOS.
- There was minimal executive or Access Unit presence in the ED during times of overcrowding noted during the study period.

Conclusions

- Bed allocation processes should be reviewed to minimise and standardise the time taken to allocate a bed following bed request. These processes should be standardized.

- The practice of allocating a bed that is ready should remain as this is a sound practice. Allocating "virtual" beds creates confusion in the ED and impacts the ability to plan and manage flow within the ED.
- The Access Unit should be reviewed in terms of core business, governance, roles and responsibilities, communication pathways, escalations, reporting and KPI's. This should take in to account the findings of the current internal Access Unit Review.
- The hospital wide and internal ED escalation processes should be reviewed and defined.
- There was no overarching "helicopter" view of the hospital that linked the ED and inpatient wards together that was readily evident, nor one source of truth for information regards which patient was going to be allocated which bed. A solution should be developed to ensure hospital wide oversight of patient flow.



6.2. High level [redacted] data summary

The overall occupancy status of hospital beds was assessed using the [redacted] is shown in the two tables below (all ward data, and all wards excluding MH and Paediatrics).

Bed groups – all wards	Beds	% allocation
[redacted]	3,759	66.7%
	1,541	27.4%
	333	5.9%
	1,874	**33.3%**
Outliers	319	5.7% of beds

Bed groups – all wards excluding MH/Paeds	Beds	% allocation
[redacted]	3,292	67.9%%
	1308	27.0%
	247	5.1%
	1,555	**32.1%**
Outliers	309	6.4% of beds

Key findings – analysis (all beds)

- The data indicated that [redacted] bed usage and empty beds totalled 1,874 or 33.3%.
- The data indicated that [redacted] totalled 333 or 5.9%.
- The data indicated that [redacted] totalled 1,874 or 33.3% of beds reviewed.
- The data indicated that excluding MH and Paediatric beds made only a minor impact on the overall distribution of [redacted] beds.

Key findings – observations

- The % of empty beds noted in this study is high comparative to other reviewed sites.
- There were frequently empty beds on wards with patients waiting in ED.
- There was evidence of empty beds across the hospital which ward staff did not know which patient was coming in next or where from.
- The use of the patient journey boards was variable and in some cases the information was not up to date.

- There was a cohort of patients who were occupying beds for [redacted]

Conclusions

- There is [redacted] capacity within the organisation that represents beds that could be used for incoming patients.
- There is an overall lack of discharge and patient journey planning at the ward level across a high number of wards.

6.3. Summary by review category – all wards

The occupancy status of hospital beds by [redacted] was assessed using the [redacted] tool is shown in the table and graphic below.

[redacted]

Beds	% total
3,759	66.7%
689	12.2%
439	7.8%
279	5.0%
260	4.6%
95	1.7%
58	1.0%
54	1.0%

[redacted]

Key findings – analysis

- The data indicated the main [redacted] delays were:

[redacted]

Key findings – observations

- Discharge destination as a reason for [redacted] is high comparative to other reviewed sites.
- Overall there was not a culture of "pull" rather the wards wait for "push" from the patient flow team.
- There was variability of the active management of patient flow at the ward level, evident during and after hours within the CNC and in-charge group.
- There was a general passive approach to LOS, EDDs, patient flow and resource management of beds at the ward level from both medicine and nursing. One patient was found to have a LOS > than 365 days however the ward nursing staff were not aware that the patient had been in hospital for this long.
- There was a general acceptance that the hospital provides a 5 day "in hrs" service rather than a 24/7, as evidenced by the weekend discharge patterns and comments such as "no one goes home today as it is Sunday".
- It was common practice for some wards to hold a bed "just in case", this was noted on CCU predominantly.
- The Chest Pain Evaluation Unit was commonly underutilised; this is also reflected in the quantitative data.
- Rehab processes were of particular note, anecdotally we were advised that patients have a trial of rehab for an assessment of suitability for rehabilitation prior to being accepted for rehabilitation.
- Level 7B has a very confusing model in terms of managing LOS and patient flow. This was particularly evident in trying to ascertain which patients are short stay, which are surgical, which are for the assessment unit and which are long stay.
- Patients were commonly waiting in the ICU for a ward bed; this was noted during the study to be as high as 6 patients.
- Multiple intra-ward bed moves took place to accommodate booked admissions, electives and the ED patients.
- Beds were held for extended periods for patients coming from theatre, direct admits, inter-ward transfers, inter-hospital transfers, this could account for a large number of occupied bed days.

- Out of hospital services such as residential care packages, ACAT and ASSET appeared to be lengthy in terms of communications and process.
- Medical staff rounding and decision making was variable and impacted on the ability of nursing staff to predict discharges and therefore manage the ward.
- There was a lack of awareness by ward staff of ED workload levels and therefore responses in a manner that alleviated ED overcrowding.
- There appeared to be a significant disconnect between the published hospital escalation policy and the hospital wide and executive response to ED over-crowding.

Conclusions

- The processes governing discharge planning, destination, requirements, and transfer of care should be improved to create additional ward capacity.
- There was a general lack of sense of urgency at the ward level regards patient flow, discharge times, filling empty beds and escalations and this impacted on the timeliness of ward level flow. Focus should be given in this area to educate and empower the ward leaders to have a higher level of patient flow ownership.
- There was unclear ownership of the ED overcrowding issue within the hospital and a lack of transparency of this problem across the hospital, this requires review.
- There was an unclear executive response to ED overcrowding, this requires review.
- There was an unclear process for LOS and L-LOS at a ward and hospital level, this is contributing to wasted bed days and requires review.
- The current approach to managing patient flow and filling empty beds is fractured and siloed.
- There were empty beds in the hospital whilst patients are waiting in the ED or ICU, capacity in the first instance is not a problem at the CH.
- The model of care on L7B should be reviewed with view to establishing a medical model that provides greater clarity of process and purpose. This should also include review of the ARM role.
- There is a large opportunity for improving patient flow and the management of beds at an executive, hospital wide and ward level.

6.4. High level summary by ward

The summary occupancy status of wards was assessed using the [redacted] is shown in the table and graphic below.

[redacted]

Key findings - analysis

- The data indicated that the top five wards in terms of [redacted] were ICU (99.5%), 14B (87.1%), Antenatal (78.7%), 10A (75.9%), and 12B (73.0%).
- The data indicated that the bottom five wards in terms of [redacted] were MHAU (31.7%), 11B (35.0%), EMU (43.3%), CCU (50.3%), and 8B (53.8%).

Key findings – observations

- The processes for patient flow management within the MHAU were not clear. There were multiple methods for logging patients in and out of the MHAU.
- CCU manage their own beds internally. It was observed that the CCU frequently kept an empty bed "just in case" and that the CPEU frequently had a low occupancy.
- Paediatrics manage their own beds internally. It was observed that the Paediatric wards frequently ran at low occupancy.
- EMU beds are managed by the ED, a high number of patients that were refused by the inpatient teams were observed to be admitted to the EMU.
- The spread of empty beds crosses the majority of wards and units in the hospital.

Conclusions

- There is a large opportunity for improving patient flow and the management of beds at an executive, hospital wide and ward level. This is inclusive of all inpatient areas in the hospital. Paediatrics, CCU and Mental Health should be included in this improvement opportunity.

6.5. Summary of review category by ward

The detailed [redacted] requirements for each ward were investigated with the results shown in the table below. The left table below shows the percentage of [redacted] at audit, with the right table below showing the relative ranking of each category (red = highest and most important).

Ward	Sum of Clinical bed	Sum of D/C destination	Sum of D/C require'ts	Sum of Empty registered	Sum of D/C planning	Sum of Transfer care	Sum of Delay other	Sum of Empty not-registered
10A	76%	6%	9%	2%	4%	0%	3%	0%
11A	67%	19%	3%	3%	1%	3%	2%	2%
11B	35%	48%	6%	1%	1%	8%	2%	0%
11C	61%	25%	5%	3%	5%	0%	1%	0%
12B	73%	18%	2%	1%	2%	3%	2%	0%
14B	87%	5%	1%	6%	0%	0%	0%	0%
5A	70%	16%	7%	0%	4%	3%	1%	0%
5B	65%	12%	13%	1%	7%	1%	2%	0%
6A	66%	11%	13%	4%	4%	0%	0%	1%
6B	65%	14%	13%	2%	2%	1%	1%	1%
7A	63%	18%	9%	3%	5%	1%	1%	0%
7B	64%	8%	11%	10%	6%	1%	0%	0%
8B	54%	18%	12%	6%	7%	1%	2%	0%
9A	73%	7%	10%	3%	4%	1%	1%	0%
9B	61%	20%	7%	5%	2%	2%	0%	2%
AAHMU + HDU	68%	16%	2%	0%	9%	3%	2%	0%
Antenatal	79%	4%	5%	6%	3%	3%	1%	0%
ASU	71%	1%	10%	8%	7%	1%	0%	1%
CCU	48%	5%	13%	23%	6%	0%	0%	4%
EDSU	63%	3%	18%	10%	4%	0%	1%	1%
EMU	43%	2%	21%	6%	16%	6%	2%	4%
ICU	100%	0%	0%	0%	0%	0%	0%	0%
MHAU	32%	17%	2%	23%	23%	2%	2%	0%
Paed Adol	45%	13%	4%	19%	9%	6%	0%	4%
Paed HDU	67%	2%	1%	10%	12%	3%	1%	5%
Paed MED	70%	0%	5%	11%	7%	2%	0%	6%

Ward	Sum of D/C destination	Sum of D/C require'ts	Sum of Empty registered	Sum of D/C planning	Sum of Transfer care	Sum of Delay other	Sum of Empty not-registered
10A	2	1	5	3	6	4	7
11A	1	2	3	7	3	6	5
11B	1	3	5	5	2	4	7
11C	1	2	4	2	6	5	6
12B	1	3	6	3	2	5	7
14B	2	3	1	4	6	6	4
5A	1	2	6	3	4	5	7
5B	2	1	5	3	5	4	7
6A	2	1	4	3	6	6	5
6B	1	2	3	4	7	5	5
7A	1	2	4	3	5	6	7
7B	3	1	2	4	5	6	6
8B	1	2	4	3	6	5	7
9A	2	1	4	3	5	5	7
9B	1	2	3	4	5	7	5
AAHMU + HDU	1	5	6	2	3	4	6
Antenatal	3	2	1	5	4	6	7
ASU	4	1	2	3	4	7	4
CCU	4	2	1	3	6	6	5
EDSU	4	1	2	3	7	6	5
EMU	6	1	3	2	3	6	5
ICU	2	2	1	2	2	2	2
MHAU	3	4	1	1	4	4	7
Paed Adol	2	5	1	3	4	7	5
Paed HDU	5	6	2	1	4	6	3
Paed MED	6	4	1	2	5	6	3

Key findings – analysis

- The above graphic can be read as follows:
  - The data indicated ward 10A had 76% [redacted] 9% [redacted] for [redacted] (priority #1), 6% [redacted] for [redacted] (priority #2), 4% [redacted] for discharge planning (priority #3), and so on.
  - The data indicated that CCU and the MHAU had the highest % of [redacted] beds at 23% for each.
  - The data indicated that 11B had the highest % of [redacted] at 48%.
  - The data indicated that EMU had the highest % of [redacted] at 21%.

Key findings – observations

- We observed great variation in how the beds and discharge planning were managed across the wards.
- CCU commonly held a bed empty in reserve.
- A large number of patients were waiting in EMU for the Discharge Liaison Nurse (DLN) prior to being able to leave the hospital.

Conclusions

- Individual wards should review the above information to help prioritise their improvement activities to reduce ward length of stay.
- The [redacted] study should become business as usual and used frequently to identify the [redacted] at the ward level.
- There are 35 specialised DLN roles within the CH that directly or indirectly affect the discharge process. The DLN role should be reviewed and take into consideration the findings of the current internal DLN review.

6.6. Summary by individual [redacted] review

An investigation into the hospital-wide drivers of [redacted] (27.4%) and [redacted] (5.9%) was conducted by analysing the [redacted] data collected. The results are presented in Pareto form with the criteria item % shown on the left axis (blue line), and cumulative percent contribution on the right axis (red line) below. Note the percentage figures are based on beds assessed as [redacted] (total 33.3% of audited beds).

Key findings – analysis

- The data indicated that the top five [redacted] accounted for ~41% of all [redacted] bed-days and were (note % values below indicate percentage of all [redacted] [redacted] [aged care]. 9.3%

- [redacted] - unknown. 9.2%
- [redacted] [rehab]. 8.0%
- [redacted] 7.8%
- [redacted] [other]. 6.8%

Key findings – observations

- Overall there was not a culture of "pull" rather the wards wait for "push" from the patient flow team.

Conclusions

- Whilst the top 5 [redacted] are not all within direct control of the CH there is significant opportunity to identify and directly manage improvements in [redacted] and [redacted] Solutions are required for greater control and management over [redacted] and [redacted]

[redacted]

"The data is for the period 1/9/2014 to 31/8/2015 and excludes admissions directly to theatre, hospital in the home, renal services. This data shows wards at the Canberra hospital where [redacted] *I have removed patients who went to EMU from this list. Please note that there are wards like "MID' that are Medical Imaging beds that are used sometime for emergency overflow. Other wards that fit this criteria are 'DIS' = Discharge lounge, GAS = 'Gastro Procedure Room'.*

7.2. High level [redacted]

An investigation into the frequency and size of the incidences of delays in transferring a patient from the [redacted] was conducted reviewing the [redacted] and BoH – ED data sets.

After further excluding ANG, BS, DIA, DSU, NIC, and SCN as ED inaccessible beds the analysis found 10,083 instances of [redacted] The average time from bed request to patient leaves the ED was 154.5 mins or 2:34:30. This represented 41% of the 24,652 ED admissions in the period.

Key findings – analysis

- The data indicated that 41% of all ED admissions are to [redacted]
- The data indicated that the time to get a patient from the ED (bed request) to a known [redacted] takes an average of 2:35 mins.

Key findings – observations

- We observed numerous instances of patients waiting in the ED (for admission) with [redacted] on the ward.

Conclusions

- Processes, roles and responsibilities and systems governing patient flow and ward management of [redacted] beds must be reviewed to ensure that patients can be allocated and transferred to [redacted] beds in the hospital in a more timely manner.

7.3. Summary by ward

An investigation into the delays in getting patients from the ED to wards with [redacted] was conducted by reviewing the BIU dataset for all wards with N>10. The results are shown in the graph below.

[redacted]

Key findings – analysis

- The data indicated that the wards with the fastest average time to move a patient from the ED to the ward are CPE (7 mins, N=613), CLD (24 mins, N=83), and AN (1:18, N=156).
- The data indicated that the wards with the slowest average time to move a patient from the ED (bed request) to the ward are PHD (6:30, N=138), PLD (5:43, N=202), and L7A (2:58, N=87).

Key findings – observations

- We observed great variation in the sense of urgency at the ward level to take the next incoming patient. Commonly the ward staff were just waiting to be told by the Access Unit about the next incoming patient.
- We commonly observed [redacted] in the hospital with patients waiting in the ED.

Conclusions

- There is a disconnect in the management across the system between the empty bed and the next patient waiting for that bed.
- There are [redacted] in the hospital and patients waiting in the ED and ICU for those beds. Capacity at this point does not appear to be an issue for the CH.

8. Stakeholder interviews

8.1. Study details

Interviews with over 25 stakeholders were undertaken. These were inclusive of stakeholders within the disciplines and divisions of Imaging, Surgery, Medicine, Critical Care, Mental Health, Drug and Alcohol, Access Unit, Executive team, and Business Intelligence Unit. The interviews were open discussions about current issues relating to patient flow within the individual units and areas and more broadly across the hospital. The issues can be supported by soft, presumed or hard evidence and were themed against categories. The categories were [redacted]

The authors are grateful for the time given by all stakeholders and found all staff to be willing and open in the conversations across the board about the challenges with flow within the CHHS.

8.2. Key findings from interviews

The general themes from the interviews were found to be related to [redacted]

In the whole the key themes were as follows:

- People:
  - Medical engagement (particularly VMO engagement) is a challenge
- Process:
  - Mental Health flow management of the patient journey and overall flow is unclear
  - The process for escalation is unclear
- Hospital wide flow and operations:
  - There is no one role that has the "helicopter view" of hospital wide operations
  - Siloed approach to managing patient flow across the divisions
  - Patient flow should be managed under one central unit that sits separately from any one division
  - Management of flow and reform happens by committee and consensus or is left to a few key individuals
  - Executives on call are frequently aware of the number of empty beds through the shift reports. There is an inherent level of frustration in knowing that there are empty beds in the hospital and overcrowding in the ED
- Governance:
  - Well-resourced hospital with top heavy management layers, current governance structure is not best fit
- External factors:
  - Flow out of the hospital within ACT Health and to other states is a major challenge, a large number of patients reside in NSW and transfer back to NSW is difficult
  - Queanbeyan Hospital presents a particular challenge in terms of the flow on impact to the CH. Opening hours for the ED are variable

  - Calvary Hospital refers a large number of patients to the CH that could otherwise have been treated at the Calvary Hospital
  - ACT Health sub-acute and rehab beds are difficult to access
  - GP support for and the processes around hospital avoidance are variable
  - There is a high level of scrutiny and involvement from ACT Health regards the performance and overall management of the hospital
  - The external and community services for Mental Health are not adequate to support the current requirements for patients, particularly the adolescent cohort
- Strategic reform:
  - There are multiple projects being run concurrently within the organisation supported by a high resource load
  - Reform is siloed and there are multiple projects
  - The strategic direction and vision of the hospital is not clear to many of the staff
  - CH has previously been a smaller hospital; challenges are how to transition to a major tertiary hospital and change attitudes and culture to reflect this

Conclusions

- Human resourcing within the CH is largely not an impediment to hospital wide patient flow.
- Patient flow is siloed and it is unclear who has the hospital wide "helicopter" view to operations and flow, this requires defining.
- Reform is siloed, divisional and person dependant and not aligned to a predefined strategy. The method and process for strategic reform across the organisation needs defining and articulating to the executive and rest of hospital.
- The governance structures of the hospital are top heavy with many layers of executive and middle management. This requires review in the long term however should not be a focus in the short term.
- Medical engagement is seen as a significant challenge across the hospital. A dedicated medical engagement strategy is needed.
- Patient flow out of the hospital to sub-acute areas within ACT Health and to NSW sites needs review. The magnitude of the problem should be quantified to support/refute the high level of comments about this issue.
- The flow of Mental Health patients within the CH and within the community needs review.
- The organisation generally has a support and positive view towards the need for reform, the gap is the overarching plan and strategy to achieve this.

9. Other information and findings

9.1. Project review

Project management controls and alignment to strategy within the organisation are loose. There are over 22 patient flow projects and an unknown amount of other projects being run con-currently within the organisation with many resources. These should be reviewed and rationalised.

9.2. Document review

28 documents pertaining to patient flow, projects, previous work and hospital wide structures were reviewed. Some of these documents are confidential, in draft and being reviewed; therefore we have not listed the documents in detail. We are grateful for the transparency of information shared across the CH and ACT Health as this has greatly informed this report.

9.3. [redacted] findings

The following findings related to hospital operations were not immediately apparent in the quantitative data analysis, however they were observed by the team and discussed during the stakeholder interviews during the diagnostic phase:

- The key findings and conclusions for hospital operations point to gaps at the executive and management level.
- There is no one role that has the overarching "helicopter view" for day to day and strategic operations management with respect to flow.
- There is great opportunity to improve performance improvement in this area.

9.4. [redacted] findings

The following findings related to strategy, culture, and leadership were not immediately apparent in the quantitative data analysis, however they were observed by the team during the diagnostic phase:

- The key findings and conclusions for strategy, culture and leadership are not a reflection of people but rather of process, governance, accountabilities and expectations.
- The culture of the hospital is overall very positive in terms of team work and shared recognition of the need for change.
- The plan for how change will be enabled, effected and sustained is fractured and unclear. This is a relatively quick win for the organisation in terms of a starting point for engagement and outcome.
- There is a gap in how strategy is developed and deployed across the organisation in terms of flow and performance improvement.
- Bringing the executive together and breaking down the siloed approach to how and which solutions and projects are implemented will bring a significant improvement and a resource credit to the implementation arm of flow success.
- The leadership of the organisation is viewed as very positive but siloed and fractured. This will likely entail a review and possible restructure of the current governance structure in the long term however will not yield the biggest improvements in performance at this point.

CANBERRA HOSPITAL AND HEALTH SERVICES

HEALTHCARE REFORM CONSULTING

Recommendations Report

The Canberra Hospital

Kate Brockman, Director
Mark Walmsley, Senior Manager
[redacted]

This document provides the key recommendations following the diagnostic analysis of the Canberra Hospital conducted by HRC in August and September. This recommendations report is being provided on request to facilitate the immediate term planning needs of CHHS. This recommendations report should be read in conjunction with the Diagnostic Report for Canberra Hospital and Health Services and the diagnostic report references read accordingly.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
1	Director of Operations or equivalent (Business as Usual)	• The DOPS role is a single point of accountability for system operational performance and performance improvement. • The DOPS role works in partnership with other senior executives who provide clinical governance, HR, IT, infrastructure, financial, and departmental support. • It is recommended that this role report directly to the Deputy Director General Canberra Hospital and Health Services. [redacted]	• There is currently a siloed approach to patient flow across the hospital at all levels. Patient flow is managed by consensus across the divisions and not integrated, there is a lack of arbitration and final decision making around how beds are allocated and managed. • There is lack of clarity of overall controls as to how and when beds are opened and closed, particularly on L7B, ICU, AMHU and Paediatric wards. • The current Access Unit staff do not have the authority to make final decisions about bed management. • There is a practice of holding a CCU bed "just in case", this contributes to beds that are underutilized. • The 4th Paediatric ward is opened only when needed, the process for this is unclear. • There is a lack of executive accountability and awareness to understand the hospital from a systems perspective and being able to readily identify bottlenecks. • There is no one point of escalation for times of crisis related to patient flow. • There is an uncoordinated approach to managing improvement activities through the divisions. • The current system provides no incentive for any executive to map/view the hospital as a system and therefore investigate system constraints or bottlenecks.	• Document review, DRG Z64A, Access Unit Review. • Ref 3.9, 4.3, 5.6, 5.7, 6.3, 7.2, 8.2.
2	ED Navigator (Project with full implementation)	• A role is developed that focuses purely on internal patient flow through the ED starting from triage to leaving ED. This role has oversight of the department, is non-clinical and is developed within existing FTE. [redacted]	• Patient's sit in the waiting room whilst there are empty beds in the main department. • The current Nurse Coordinator role is person dependant and the roles and responsibilities are not clear. • There is not a focus on the patient journey timeline nor a sense of urgency regarding flow with some incumbents in the current role. • Bed requests are not timely in a large majority of cases. • EDIS data is inaccurately entered or retrospective in a large number of cases, this is likely having a significant effect on reported performance figures.	• Ref 5.3, 5.4.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
3	Hospital Admissions Policy (Business as usual with implementation support)	• Admission rights for ED with Consultant to Consultant referral and review. [redacted]	• Within the ED there are currently numerous processes to finding an admitting team for patients presenting to the ED who require an admission under an inpatient team. This process can be quite lengthy with multiple referrals a common scenario. This increases the ED LOS for the admitted patient cohort. • There is no obvious arbitration process for the final decision of admitting team in a high number of cases, patients "bounce" between inpatient teams.	• Ref 5.3, 5.6.
4	Long LOS committee (Business as usual JDI)	• Establish a weekly LOS committee chaired by DOPs comprised of senior representation across the organisation and with a nominated Clinical Lead.	• The Canberra Hospital currently has a number of long LOS patients. The most significant cohort has a LOS of > 200 days. • There are no mechanisms in place to identify and manage the long LOS cohort of patients and nil clear ownership of this issue.	• Document review DRG Z64A • Ref 4.3, 6.3.
5	Patient Flow Unit review and establish a hospital wide patient flow unit (Project with full implementation)	• Clearly defined whole of hospital unit with responsibility for all beds (including greater oversight of Cardiology, Mental Health and Womans, Youth and Children). • Governance of the unit sitting under the Director of Operations. [redacted]	• Patient flow management in the hospital is currently siloed and inconsistent. The Demand Management Unit consists of 7B, Discharge Lounge, Medi-hotel, Acute Surgical Unit and the Access Unit. The Access Unit is primarily responsible for bed management however has little authority and control over the remaining areas of the hospital. • Patients ready for transfer to a ward bed commonly wait in the ICU for beds to be allocated, these are often batched. • Bed allocations are commonly batched, beds held over before being allocated. • The bed allocation and management team is comprised of junior staff and doesn't always have the authority to challenge some of the hospital wide practices. • There is blurring of roles and responsibilities of staff within the current Access Unit. • There are a number of patients stranded in the hospital.	• Document review DRG Z64A, Access unit Review • Ref 4.3, 4.4, 5.3, 5.7, 6.2, 6.5, 8.1.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
6	Strategic oversight of reform (Business as usual)	• The DDG develops a clear reform program including: o Understanding of current state performance relative to peers. o Agreed operational performance targets for 1, 2, 3, and 5 years. o Agreed programs of work to achieve future operational targets. o Significant executive commitment to reform. [redacted]	• There are currently 22+ projects across the organisation that are individually or collectively (within divisions) being managed with a siloed approach. There is a very large resource pool associated with the combination of these projects. • Key personnel are driving reform through different divisions, however this is largely person dependent and reliant on being able to build successful relationships and influence peers. As this is person dependant there is a high level of risk. • Whilst this approach has driven some change it is unlikely to enact the transformational outcomes required in a short timeframe. • There are currently multiple reform and service improvement teams within CHHS without an overarching strategic reform plan.	• Document review: Health Care Improvement Division, Research and Service Development Team, Territory Wide Surgical Services, Care Around the Clock. • Ref 3.2, 8.1, 9. • Further data requested.
7	Acute Admissions Unit (AAU) or equivalent Project with full implementation	• This unit is a short stay unit designed to accommodate the cohort of patients with a LOS less than 48 hours, the large majority will be discharged and a smaller cohort will be transferred to a general or sub-specialty ward. [redacted] around existing and successful models of care.	• The current model on L7B is a mixed model and made up of General Medicine, Surgical Short Stay Unit, Medical Assessment and Planning Unit, and Medical Short Stay Unit. This is a confusing model and the opening and closing of beds appears ad hoc. • Evidence based practice suggests that acute medical models reduce inpatient mortality, reduce ED LOS and overcrowding and increase patient satisfaction[1].	• Ref 4.3, 6.3, 6.5.

[1] Effectiveness of acute medical units in hospitals: a systematic review. Ian Scott et al, 2009.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
8	Review Hospital footprint (Business as usual with implementation support)	[redacted]	• There is commonly low occupancy for CPEU and Paediatric wards. • Level 7B is a very confusing model with variable LOS cohorts, medical and surgical mix and mental health cohorts as required. This has obvious LOS and budget management implications. • 8 beds are opened in the Medical Imaging Department in times of crisis and overcrowding, patients are transferred to this area from the ED to stay overnight and wait for a ward bed. • There are currently 2 surgical short stay models of care, the Acute Surgical Unit (ASU) and the Surgical Short Stay Unit (SSSU). These units could effectively take the same cohort of patients however are located in separate areas of the hospital.	• Document review, 2 x surgical short stay models and units. • Ref 6.2, 6.3, 6.5.
9	Develop Operational KPI's and Operational Dashboards (Business as usual)	• Review the current performance metrics used in the ED to measure and track performance. [redacted]	• Some of the currently reviewed operational KPI's are not accurate (e.g. seen by Dr times are not an accurate measure of ED performance due to EDIS errors from delays to entering data). • There are currently limited operational KPI's that are used broadly in the hospital to drive performance improvement, these largely sit with the executive team. • Overall operational performance is measured however is not an indicator for how individual wards and units and individual clinicians are performing.	• Ref 3.2, 3.9, 4.3, 5.3, 7.2, 8.2, 9.
10	Team Based Care ED (Project with full implementation)	• Review the high number of interns currently rostered in the ED. • Review supply and demand in line with ED medical staffing roster.	• There is currently cherry picking of patients and variation in how many patients are seen per shift. • This solution supports a sense of urgency, flow focus, improved teaching, training and supervision. • The current number of interns rostered in the ED is high.	• Ref 5.3, 5.4, 5.6.
11	Discharge planning focus (Projects - can be managed internally)	• Roll out Project Venturi to all wards. • Continue review of the Discharge Liaison position. • Incorporate a discharge planning focus into the Medical Engagement Strategy. • Incorporate a discharge planning focus into the Ward Leadership strategy.	• It was observed on a number of occasions that patients were waiting for the discharge liaison nurse prior to being able to leave the hospital, this created a bottleneck. • Discharge patterns reflect need for improvement.	• Document review, Discharge Liaison Nurse. • Ref 4.3, 4.7, 6.3.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
12	Patient Journey Boards (Project with full implementation – can be managed internally with BIU support)	• Implement patient journey boards from the Performance Improvement Portal to all relevant areas and wards.	• The current ward journey boards are underutilized, out of date and display limited information (L7B is the exception). • The current bed management tools are out of date and require a high degree of manual entry. • The data for both is not real time.	• Document review Project Venturi. • Ref 4.3, 6.2.
13	Ward leadership (Project with full implementation)	• Defined education and training program for nursing staff to create understanding, ownership and sense of urgency about patient flow. • Clarity of roles and responsibilities for ward patient flow. • Defined escalation pathway for managing bottlenecks (tests, destination).	• There was variable knowledge of patient and discharge plans by the nursing staff at a ward level. • Estimated day of discharge and general LOS focus was largely absent. • The in-charge nursing staff largely deferred to the Access Unit staff for all patient movement.	• Ref 4.3, 6.2, 6.3, 6.5.
14	Medical engagement strategy (Project, short term)	• Define and document a medical engagement strategy.	• Clinical engagement is a key tenant for successful reform and improved operational performance.	• Ref 5.6, 6.3. • Literature, Kings Fund NHS.
15	Internal review of Imaging Department (Clinical redesign review)	• Undertake a review of the current governance, processes, KPI's and service delivery of the imaging department to the ED and broader organisation.	• Significant stakeholder feedback regards the delivery of timely service for imaging. • Requires data collection and root cause analysis for definition of the real problem and the appropriate solutions.	• Ref 5.5, 8.1. • Further data requested.
16	Review of governance structure and middle management layers (External review)	• Review current roles at senior and middle management with view to defining how the current roles contribute to operational and flow management within the hospital.	• The current structure of staffing is top heavy. • There are many layers of middle and senior management but it is unclear who has ultimate authority and accountability for day to day operations and service integration. • A common theme from the interviews was a lack of executive focus on flow and unclear	• Document review Key Senior Positions as at 1 August 2015. • Ref 8.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
17	Internal review of Mental Health (Clinical redesign review)	[redacted]	• Unclear processes around patient pathways into the MHAU. • Patient flow journey as reflected in EDIS is inaccurate, patients are allocated to the MHAU but not logged as seen by Dr, this reflects a longer LOS in ED than is reality. • There is great variation in internal management of patients LOS and location within the MHAU from a clerical perspective, this includes use of various patient registers. • LOS is not managed with long LOS in the MHAU. • AMHU patient flow management is unclear, sometime patients on gate leave are counted in the numbers, sometimes not. This has implications for costing activity, budget management and patient flow.	• Ref 3.8, 4.3, 5.7, 6.5. • EDIS data and LOS for MH.
18	Implementation Plan (Deliverable for HRC)	• Define a strict implementation plan inclusive of change management, risk management and communication strategies. Identify timeframes with defined executive sponsorship. • Document a clear Medical Engagement Strategy to support the reform. [redacted]	• This review is the 3rd attempt at strategic reform since 2011 and it is the authors opinion based on previous experience that robust hospital wide implementation has been a challenge for the previous reform attempts. • Of the 60+ hospitals that have been reviewed or supported by HRC those that have been successful have had a strong focus on implementation.	• Not applicable
19	ED Triage Process (Clinical redesign review – can be managed internally)	• Review the current triage process. • Review the current practice of the triage nurses.	• The current process is convoluted, can be lengthy and person dependant. • The triage nurse commonly undertakes tasks that are not directly related to triage.	• Ref 5.4.
20	Predictive bed management (Project with full implementation)	• Develop a framework for predictive bed management [redacted]	• Patient presentations to an ED are highly predictable as are admission patterns. It is feasible to plan for this demand in advance and ensure the appropriate processes are in place to accept and manage patients. • This supports the hospital footprint review in looking at demand patterns, particularly around seasonality.	• Ref 3.3, 3.4.
21	Review rehabilitation pathways (Clinical redesign review)	• Review the current processes and systems for rehab.	• The long LOS rehab patients count for a high number of occupied bed days.	• Ref 4.4.

Ref	Title	Recommendation details	Recommendation justification	Diagnostic report reference
22	GP education and agreed referral pathways (Project with full implementation)	• Strengthen links with GP's, provide regular education on alternatives for patient treatments. • Investigate alternative models for triage and treatment of this cohort of patients based on the opinions of the ED staff and GP's. • Define agreed referral pathways.	• Large numbers of patients are sent to the ED by GP's with little admissions for this cohort. • Presents a high demand on the ED which might not be necessary.	• Expects data to be confirmed.
23	ED and Inpatient Pathways (Clinical redesign review)	• Define pathways for Obs Gyn, Orthopaedics, Plastics. • Review root cause drivers being review before referral to clinic appointments etc.	• Multiple referrals take place for patients in the admit stream. • A large number of patients who are ultimately discharged have a prior referral to certain inpatient team specialties.	• Ref 5.6.
24	Queanbeyan and Calvary Hospitals (Clinical redesign review)	• Review the current agreements of flow and transfers from both sites into the Canberra Hospital.	• Opening hours of Queanbeyan ED and hours of medical coverage are dynamic, a high number of patients present to CH as a result. • Calvary Hospital refers a high number of patients to CH that could (?) be treated at Calvary Hospital.	• TBA data from BIU. • Ref 9.

Stevenson, Nicole (Health)

From: Dykgraaf, Mark (Health)
Sent: Wednesday, 9 August 2017 6:46 PM
To: Feely, Nicole
Cc: Bone, Chris (Health); Boyd, Narelle (Health); Hollis, Gregory (Health)
Subject: Documents and Actions [DLM=For-Official-Use-Only]
Attachments: Moderating ED Demand CHHS - Final - 30 March17.pdf; Patient Flow Plan - 17-18 - v3-August2017-Final.pdf; Chief of Clinical Operations -After Hours Pharmacy - August2017.pdf; Chief of Clinical Operations Memo - Medical Imaging Support - 9August 17.pdf; A Safe Hospital - A Shared Challenge - Senior Medical Officers - 3Aug 17.pptx; Moderating ED Demand CHHS - Final - 30 March17.pdf; Moderating ED Demand CHHS - Final - 30 March17.pdf

Hi Nicole,

As discussed at today's meeting:

- ***ED Diversion Strategy*** – March 2017;
- ***Patient Flow Action Plan*** – July/ August 2017 this is what I am using for my team;
- **Communications**
  - 2 examples of the Memo process I have instituted to deal with organisation wide issues. As issues arise i am seeking to resolve them as promptly as possible working with relevant individuals and teams. We maintain an action log on all issues so we can track if they have been resolved;
  - ***Safe Hospital Presentation*** – example attached was given to Senior Medical officers (surgical M and M tonight). I have given this presentation at a range of forums across the organisation over the last 3 weeks. Presentation has been provided to all Divisions
  - ***Chief of Clinical Operations Bulletin*** – first edition of this will go out this week
- ***Targets*** – I have set/ utilised 3 key organisational targets:
  - 1 discharge from every ward by 10 am/ further 2 discharges by midday – this is starting to improve
  - 150 discharges every weekend
  - Long Length of Stay report – hospital target below 250 patients

I have as part of a longer email to EDs last night I set the following expectation:

> *As mentioned previously I am now seeking a formal position from each Division on:*
>
> - *the process and actions that will be undertaken for this coming weekend (and ongoing) to achieve improved level of weekend discharges; and*
> - *the weekly process and actions that will be (are being) used in each Division to review long length of stay patients. This process must engage the medical teams in a process of active review. Our hospital target is to maintain the number of long stay patients below 250 and I note that today we were over 275. I understand a regular weekly report on long stay patients is provided by each Division to Chris Bone, could I be copied in on these reports please.*
>
> *Could each Divisions formal position/ actions be with me by **12 midday on Friday** please.*

Trust this assists,

Regards,

Mark

Mark Dykgraaf

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Moderating ED Demand at Canberra Hospital and Health Services

A Brief Discussion Paper – March 2017

The Issue

Demand for ED services at CHHS continues to rise significantly representing a significant operational challenge. Over the course of financial year 2016-17 demand has risen by 11.9% compared to the same period in the previous financial year. The presentation rate YTD (as at 20 February 2017) at the CHHS Emergency Department is 54,463 compared to 48,670 for the same period last financial year. This represents an additional 5793 presentations at CHHS this financial year.

	Jan 2016	Feb 16 MTD	2015-16 FYD	Jan 2017	Feb 17 MTD	2016 -17 FYD
4 hour rule	62.8%	53.6%	55.5%	76.2%	64.4%	71.7%
Presentation/ day	197	220	207	229	238	232
Average Did not wait	7	14	11	4	9	6
Did not wait %	3.4%	6.5%	5.5%	1.8%	3.8%	2.6%
Average admissions	71	80	73	85	90	89
Average Waiting time	59 minutes	82 minutes	72 minutes	40 minutes	64 minutes	49minutes
Average treating time	166 minutes	168 minutes	174 minutes	127 minutes	144 minutes	135 minutes
Average bed block	109 minutes	96 minutes	187minutes	166 minutes	158minutes	144 minutes

A brief analysis of the above table shows:

- The increase in presentation rate also contributes to a 23.2% increase in admission rate year on year. The admission rate is being driven by acuity and also the expanded EMU bed numbers which are being heavily utilised
- Despite this increase in presentation rate the ED team are maintaining significant improvements in:
    - 4 hour performance – 16.2% points year on year;

- DNW – this has been improved by over 50%
- Waiting times – improved by 31.9% or 24 minutes on average
- Treatment times – improved by 22.4% or 39 minutes per patient on average
- Bed block – improved by 22.9% or 43 minutes on average.

This growth in presentation rate is an operational challenge now, and will become an increasingly problematic issue within 12 – 24 months in terms of being able to manage the growth rate. This means a wider approach is required to managing demand.

In the broad the strategy for dealing with the increased demand for ED services should be dealt with in 3 ways:

1. **ED performance** - By improving ED operational performance. Improvement in this area has been significant over the past 12 months and work continues within that team to bed down and drive further improvement. As an aside it has been suggested that this improved operational performance is driving some of the increased demand for services.

2. **Patient Flow** - Continued work within the wider CHHS to improve patient flow so that the movement of patients from ED to the wider hospital improves significantly. There have been improvements in this regard, as witnessed by the improvement in average bed block time, but further work is required. This work is being represented by:

    a. The Early Discharge Programme – underway since April 2016;
    b. The "How can I Help You Programme" – commencing May 2017; and
    c. The Nursing Ward Leadership Programme – this is currently commencing across the hospital

    Further, in detail, patient flow improvement work across the hospital will commence from 1 May 2017 in order to prepare for the increase in demand in the coming winter season. It is important to note that more work is required in relation to overall patient flow management strategy, particularly in regard to the medical engagement, team engagement and ensuring business processes are sharp in terms of patient movement.

3. **Demand Moderation Programme** – the subject of this paper.

Discussion

This paper seeks to canvas a range of approaches aimed at demand moderation and then make formal recommendation for the way forward. The discussion is broken down into the following sections:

1. Frequently Presenting Patients
2. CHHS Units and Changes to Current Practices
3. General Practice
4. Walk in Centres

5. Community Communications
6. Residential Aged Care
7. Researching the Challenge and Learning from other Jurisdictions
8. More controversial Ideas
9. Next Steps and Recommendations for Action

1. Frequently Presenting Patients

Data indicates that around 22% of all presentations at CHHS are driven by approximately 6% of all patients that present to the ED. Clearly this represents an opportunity to moderate demand through more effective:

- Case management of patients who present frequently; and
- The establishment of algorithms that would assist in identifying patients at risk of multiple presentations.

A recently developed programme that could usefully be deployed in the short to medium term to tackle this issue ***Transitions to Care Programme.*** It is important to note that this work is in the very early stages of development.

The primary objective of the pilot programme, to be run in collaboration with the Capital Health Network, is to 'improve patient focused transitions of care between hospital and primary health care and community settings. This will be achieved by:

- Identification through risk stratification of a targeted in-patient population
- Effective patient-centred discharge planning
- Immediate post hospital follow-up
- Self-management support
- Care coordination
- Multi-disciplinary team support
- Effective communication and information exchange
- Accessible community and social care support

In the context of rising ED demand the question to be asked is whether a close focus of this programme on the ED will assist in moderating the demand of patients that present to the ED on repeated occasions. This concept should be explored in detail with a view, if appropriate, of implementing the strategy in June 2017. The fundamental idea is that we use existing programmes and resources to try and impact on demand on ED services.

As part of this approach consideration should be given to developing a series of algorithms that will:

- Identify patients at risk of being multiple presenters on the first occasion they present to the ED;
- Contacting these patients post discharge from the ED to direct them into appropriate support services. This would be a post ED discharge care model that would seek to intervene before further multiple presentations occurred.

In considering this particular cohort of patients, there should be clear consideration given to Improve advanced care planning practices. This is a cohort of patients for whom advanced care

planning can be achieved with a focused approach. Patients with multiple presentations, or who are identified as being at risk of multiple presentations, should have an advanced care plan as part of a wider diversion strategy. Again this should be addressed in the post care follow up with the patient.

2. CHHS Units and Changes to Current Practice

There are clearly a number of internal service issues that could usefully be addressed to assist in moderating demand in the ED. These initiatives would largely be within current resources and would require the work of a focussed team to assist in addressing the issues of ED demand.

a. **Mental Health** – the management of MH patients in the ED has improved significantly as a result of a joint initiative between MHJHDA and Critical Care over the past 18 months. There remain a number of critical work practice and flow issues that significantly impact on the ability of the ED to manage high demand:
   - **Access to inpatient mental health beds** – remains poor, with prolonged stays in the ED for patients with complex needs occupying critical ED acute bed spaces. This does impact on the ED ability to manage flow during period of peak demand. The MHJHDA executive team acknowledge that further work is required which will commence shortly and focus on patient management in the Adult Mental Health Unit, this is a critical piece of work.
   - **Timely review & disposition decisions** in regard to mental health patients in the ED. There have been improvements in regard to the MH team decision making in the ED, however a significant further piece of work is required with the psychiatrists in terms of timely decision making and responsibilities for attending the ED when on-call. This is already the subject of discussion and planning between the MHJHDA and Critical Care Executive teams
   - **The management of children and adolescents** with mental health issues presenting to ED remains a key organisational challenge particularly outside the Monday - Fri day period. The issue arises in part as a result of the lack of discrete inpatient adolescent MH beds. Until these beds are available a more formal process for managing this small but complex group of patients is required. Such a formalisation of approach will require a formal team approach between the 3 affected Divisions – MHJHDA, WYC and Critical Care. Some informal work has already occurred on a case by case basis but further strengthening of approach is required.
   - **Gazetting of Calvary ED under the Mental Health Act** would assist in managing MH demand at CHHS. Such an approach would stop the transfers of psychiatric patients on EA/ED3 from Calvary to CHHS ED. This group of patents is labour intensive both in terms of staff time and ED real-estate terms. It would also help to send the message to the community that Calvary ED is appropriate for mental health presentations.

b. **Urgent Outpatient Clinics for GP referrals** – require each subspecialty to reserve a number of appointments for urgent review or alternatively ask key specialties to establish genuinely urgent outpatient clinics. A not insignificant number of patients that require urgent review are sent directly to the ED because GPs cannot access urgent appointments. This creates