Submission No 205

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Organisation: Community Care Northern Beaches

Date Received: 30 July 2019

15th July 2019

NORTHERN BEACHES HOSPITAL INQUIRY

A Submission from the local, independent community care service provider.

Introduction

CCNB aims to ensure that everyone gets the most out of life.

CCNB is a local, not-for-profit, community-based organisation. We provide impartial information, advice and guidance to support people to access health and community services. Our focus is to support people, their families and carers to navigate the health and social care systems to access the services they require, when they require them.

Established in 1994, and governed by local, community leaders, CCNB supports over 2000 people and their families at any one time. CCNB clients present with any need but are most likely to be people who are:

- older, requiring support to live well in their chosen community
- carers
- living with a mental health problem
- living with disability
- young people at risk
- recovering or affected by suicide

Strengthening the hospital community care interface is our key focus and our Care Navigation Service aims to provide continuity of care to people at their point of need.

CCNB Interface with Northern Beaches Hospital

The CCNB team including Care Navigators and Care Coordinators, usually interface with the hospital team on an almost daily basis. Our interface is usually patient specific and includes:

- discussing and accepting a referral for community care;
- feedback about a client and their wellbeing in the community and;
- supporting a patient whilst they are in hospital and planning safe discharge.

In addition, CCNB facilitates service improvements and social innovation activities, and hosts Communities of Practice, community campaign events (such as the End Loneliness Campaign, Compassionate Communities, and living with Hoarding Disorder). Hospital staff are invited to participate in building better responses and integrated care outcomes for people in the community.

Prior to the official opening, CCNB reached out to the hospital through the LHD to build referral pathways with community service providers. Since that time we continue to identify opportunities to improve the hospital interface with community.

Our Experience

There has been very little response from the hospital senior management team to our requests to raise challenges and present solutions. Despite best endeavours, opportunities to meet and discuss better hospital community pathways have been ignored, or shifted to the Brookvale Community Care Team (a service managed by the Local Health District).

The CCNB team turned our attention to the Social Workers and Allied Health teams on each ward to build better referral pathways, increase understanding of the community offer in the local area, and increase choices for people and their families.

The lack of formal support and communication protocols means that client/patient outcomes are dependent on the personal relationships between individual hospital staff and CCNB. When key hospital staff leave (and they do), integrated discharge planning experiences a significant decline.

Perhaps the most vulnerable situations arise when local police transport a suicidal person to hospital. That person is usually always referred to CCNB. Our Care Coordinator connects with the hospital team and where a person is identified as being at significant risk, the hospital contact agrees on a plan of action, that involves not discharging prior to CCNB meeting the patient and organising community care. There are too many occasions where this simply does not happen. When asked why, the staff often say that they have KPI's to meet or there was nothing the hospital could do for the patient.

Client/Patient Experience

CCNB works with a range of people across the community. Their reported experiences with the Northern Beaches Hospital are mixed but fall into five key areas:

- The hospital is new and amenity is very pleasing;
- The staff were friendly but looked very busy;
- They couldn't keep me in as there was nothing they could do for me;
- No-one told me I could get care in the community and;
- I was discharged home with a letter for my doctor.

We asked CCNB clients about their hospital experiences to better inform this submission. The names of clients below have been changed.

Bill

A recent suicide attempt led to Bill's referral to CCNB's Seasons Program. His GP referred to the Program. After 8 weeks of working with Bill, the CCNB Care Coordinator noticed unsual behaviour, repeating words, confusion. With no family or friends, the CCNB Care Coordinator took Bill to NBH. After several hours wait, he was assessed and it was determined that there was nothing wrong. The Care

Coordinator advocated and insisted he be assessed and undergo a CT scan or MRI. This was refused. The Care Coordinator then took Bill to RNS hospital and explained her concerns and Bill's experience at the NBH. The RNS staff said *".we are sick of taking all their patients. Take the patient back to NBH.."* The Care Coordinator did that and demanded to speak to a senior staff member. The senior staff member explained that there was no evidence of anything wrong and determined that Bill's behaviour was because he wanted to extend his visa. The CCNB Care Coordinator presented counter-evidence to support further examination. At 5pm the hospital relented and a CT scan of the brain indicated a very large tumour - the most likely cause of behavioural changes.

Bronwyn
Bronwyn is her mother's primary carer. Her mum is a 101 year old woman who presented to the hospital following her collapse at home. The daughter claims her mum was admitted but no tests were undertaken. She appeared to deteriorate on day 2 and was left in her bed to "sleep". She was tired but the daughter fed her. On day 3 the mother was shaking, appeared to be unconscious/unresponsive. Bronwyn demanded attention and 2 doctors assessed, ordered head and chest scans, blood tests etc., and antibiotics started. She was then diagnosed with Influenza Type A.

Jodie
Jodie presented to NBH following a suicide attempt. Four hours later she was discharged with no referral to Seasons Program. Her GP referred Jodie to Seasons three days after she presented to hospital.

Harry
Harry was admitted to NBH. A history of drug and alcohol addiction and depression, Harry was admitted to hospital following a suicide attempt. The hospital Social Worker referred to CCNB's Seasons Program and was told Harry would be in hospital for the week. Harry was discharged the following day (weekend) and died by suicide a day later.

Annetta
Annetta is 79 years old and has complex care needs. She has memory loss, anaemia and lives with hoarding disorder. There is a history of violence in the family. She was admitted to NB Hospital and the CCNB team made contact with the hospital who confirmed that Annetta would be admitted and likely to stay in hospital for a few days. Annetta was discharged back home to a violent situation and with no further referrals or linkages. She was allegedly assaulted by a family member.

Summary and Recommendation

The effectiveness of the hospital/community interface can determine health and wellbeing outcomes for people and their families.

CCNB's experience shows that referral pathways and in-hospital discharge planning is lacking – primarily due to the lack of internal resources. This means that patients do not get referred **and** linked into community care to avoid future hospital admissions or, at worse, early death. This is particularly the case for those people with a mental illness and or those experiencing suicidality.

Often the hospital staff display a lack of awareness of the existing community supports available for people and their families and the knowledge and time to link people to the right care following a hospital admission or presentation.

The community care sector is complex and continuously reforming, with new players entering the system and old players exiting. It can be difficult to understand what is available and the eligibility criteria for people at risk.

The discharge process does need to start at admission and integrated care planning needs to include informal supports (family, friends) and community care resources early on in a patient's journey.

CCNB recommends that:

1. The NBH works with CCNB (the independent and impartial provider of information, advice and guidance) and trials a Care Navigation* model that provides a seamless interface, and immediate access to community care and support for people who are at risk following a hospital admission or presentation.

2. The NBH participates in a Joint Care Planning** process that involves key community care providers in discharge planning for people who have high and complex care needs.

3. The NBH takes up information and training opportunities provided by CCNB regarding the eligibility criteria of a range of community services and support.

*CCNB's Care Navigation model is an evidence-based, peer-to-peer model of information, advice and guidance.

** CCNB's Joint Care Planning model is an evidence-based care coordination model specifically for people with high and complex care needs.

Dr. Gary Jacobson
CEO, CCNB