HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Connecting Care National Collaborative

Northland DHB

NORTHLAND DISTRICT HEALTH BOARD

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Project selected

Transition from primary care into DHB specialist community services

Aim

A 26% reduction in the wait times for assessment for non-urgent referrals from Primary into Secondary services from 18.9 to 14.0 days by June 2019

Achieving the about target will:

- Deliver a timely and effective triage and intake service that provides client-centred best outcomes, minimises risk and employs tools, processes and pathways acceptable to clients, referrers and the adult community teams.

In addition success will be evidenced through:

- Agreed and documented pathway processes between triage and CMHS
- Qualitative survey's of client, referrer and staff interviews as the project progresses

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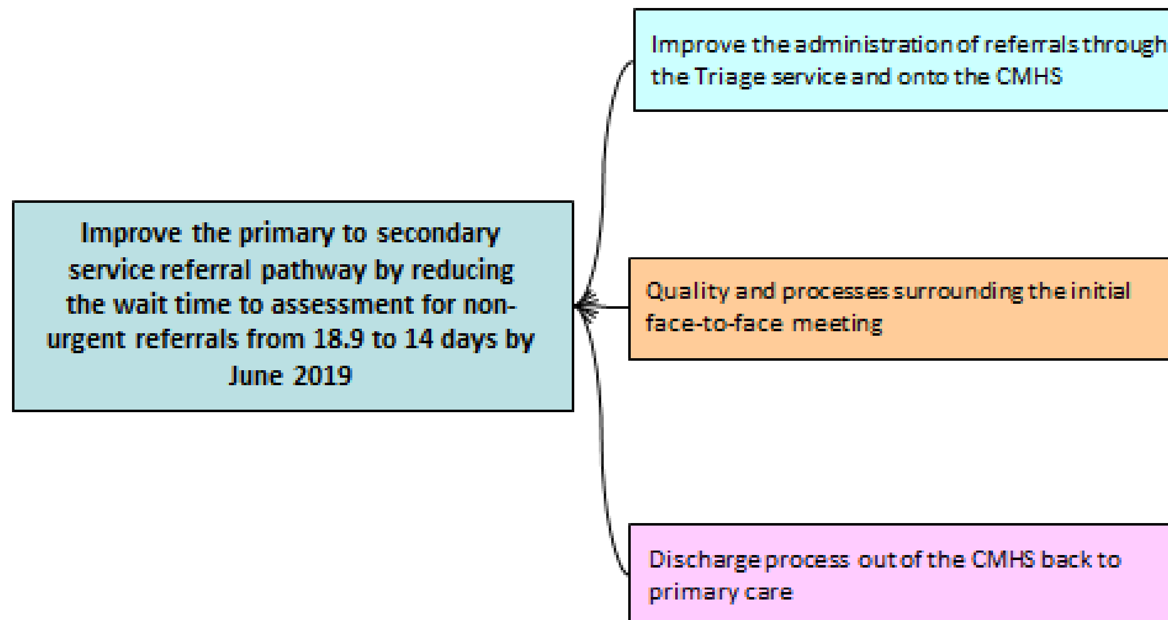
High Level Driver Diagram



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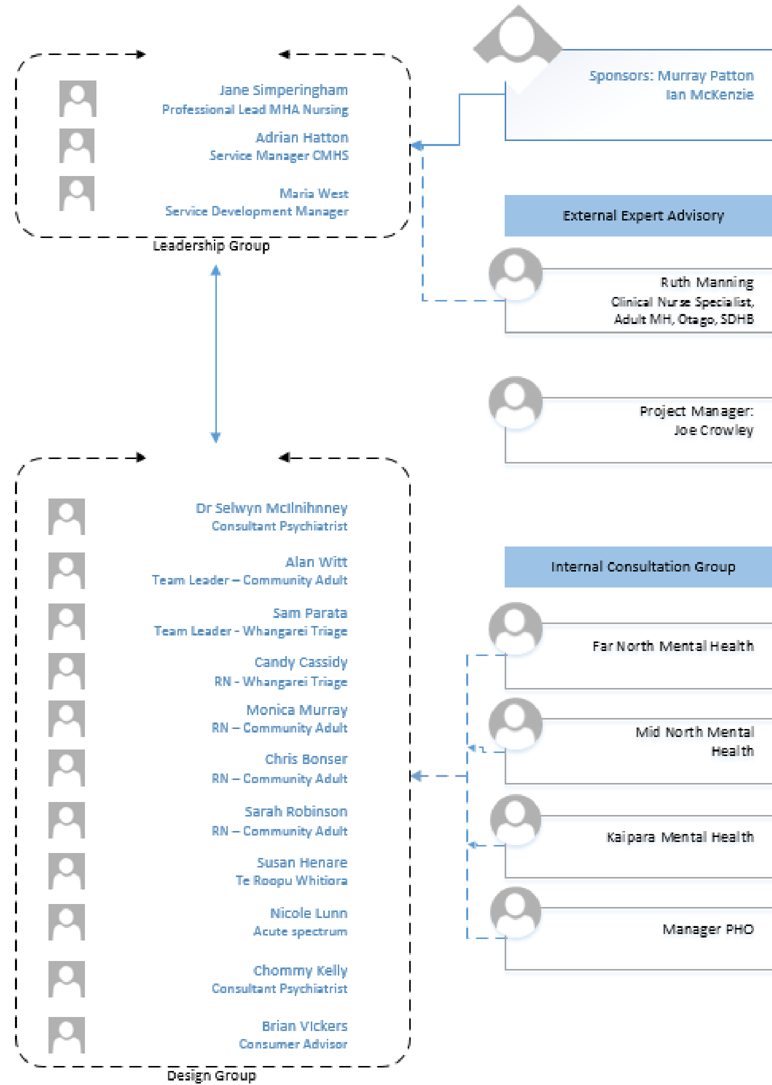
Project Team



Project timeline to date

- TOR initially drafted in November 2017
- Meetings involving selected group of internal stakeholders occurred prior to March 2018
- Analysis of client journey's Feb and March 2018

Beginning of Continuing Carte / Transitions Initiative

- Options and ideas moved into testing phase late Oct 18

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Client Journey analysis

Client 1

Date	What occurred	What resulted
31/03/2017	GP referral	Response to GP 18/4/17 with a recommended change to meds. Case closed.
20/04/2017	Self-referral. Commented that they were "losing it".	Doctor appointment made for 26/04/17. Medications were adjusted and client referred to anxiety support.
21/04/2017	GP referral for CMH input, supporting self-referral previous day.	
27/07/2017	Surgical procedure.	
15/09/2017	GP referral for CMH support.	AOD appointment made for 13/10. Referral to anxiety group same day.
02/10/2017	CATT contact.	Given category E triage. FYI sent onto AOD team.
17/10/2017	GP referral (urgent) wanting CMH support in addition to AOD.	Discussed with CATT. Client advised to present to ED but did not present. CATT handover to AOD.
31/10/2017	Attends anxiety group.	Attends once but does not attend again. Discussion at MDT about discharging client but MDT does not agree to discharge.
03/11/2017	GP referral (advice only)	MDT discussion on 07/11. Dr. response on 13/11 with appointment made for 18/01/18.
15/12/2018	GP referral (advice on meds)	MDT discussion 20/12. Case accepted by GA North team.
16/01/2018	GP referral (worsening symptoms). Advises that clients partner now under significant stress and is also being referred to CMH services.	
18/01/2017	Doctor appointment	

Observation:
Length of time MH service to engage. This is an example of how another factor, surgery in this case and suspected addiction, can possibly complicate things and influence intake although triage has determined that the client met MH service eligibility.

Client 2

Date	What occurred	What resulted
20/11/2017	GP referral	Triage referral to GA MDT (plan to discuss referral 29/11/17)
02/12/2017	Suicide attempt	CATT engaged. Handover to Triage 4/12/17
04/12/2017	Triage presentation to MDT.	No action.
18/12/2017	Triage remind GA that case needs attention.	
19/12/2017	GA team attempts to make contact with client.	Unsuccessful - no contact made. Case discussed again at MDT.
20/12/2017	GA team makes contact with clients mother.	Appointment offered for 05/01/18.
05/01/2018	Appointment with doctor.	Client attended. Follow-up appointment offered for 24/01/18.

Observation:
GP time to contact with clients mother: 21 days. Triage engaged for entire period.

Client 3

Date	What occurred	What resulted
22/11/2017	GP referral.	Discussed at MDT - Triage requested to provide more information.
29/11/2017	Triage presented again at MDT.	MDT denied again requesting more information.
Triage send email to team leads with triage summary.		
07/12/2017	GA manager intervenes and presents case at MDT.	GA team engages and makes appointment for 10/01/18.

Observation:
Triage presented case twice to MDT although Triage determined eligibility for intake.
Triage service responsible for client for 15 days.
No record of what the missing information was.
Informal use of an escalation process.

Client 4

Date	What occurred	What resulted
05/11/2017	ED presentation (not previously known to service).	CATT engaged and follow up including doctor input. Referred to CMH via Triage.
14/12/2017	Referral from Triage to CMH.	
20/12/2017	Appointment set with doctor for 04/01/18	
28/12/2017	Case manager allocated to client.	Triage formally handed over at this point.

Observation:
Caseworker not allocated until 28/12 extending Triage responsibility from 5 days (9-14/12) to 19 days.

Client 5

Date	What occurred	What resulted
13/12/2017	GP referral. Triage allocated client a D (semi-urgent requiring 72 hour response).	MDT denied entry to service but did not provide reasons why that could be fed back to the GP.
20/12/2017	GP re-referrs	Presented to MDT and appointment made for 28/12/17.

Observation:
Quality of information coming back from MDT on the initial denial of service was not in depth enough to be supportive to the referring GP.

Client 6

Date	What occurred	What resulted
21/02/2018	Referral from Dept. of Corrections probation officer. Client had a suicide attempt in Dec 2017. History of substance abuse.	Triaged a 'D' with a recommendation for discussion at next MDT.
22/02/2018	Case discussed at MDT	Referral declined.
26/02/2018	Email sent to referrer providing outcome of MDT decision.	

Observation:
No clinical reason for the referral being declined in Jade.

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Documenting key variables

What might be the key features of an effective triage process?

Mind map below is a summary of ideas from Design Group meetings and discussions with other key stakeholders.

What might a successful Triage process look like?

Referral:
- Reliable, comprehensive referral information
- Non-urgent. I.e. GP's are supported to help managing clients and prevent escalation into crisis
- Referral information is standardised to help reduce inconsistency

Triage
- Process anchored in agreed scale
- Quick and timely
- Assessment of eligibility for service entry is consistently accurate
- GA service has full confidence in the Triage service (i.e. trust in system)

User Experience
- Good information at all contact points
- Eliminate multiple assessments where possible (don't have to repeat their story)
- Prompt, transparent service

Service engagement
- Clients already in acute services are transferred with priority
- Initial assessment completed by community teams
- All clients are accepted by community teams
- Open, transparent process keeping client and GP fully informed

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Mapping the process: current

RMS Lite | CATT – IPU Transfers of Care into Community

Referral

Referral from GP via RMS lite

Case opened in JADE triage team are alerted via email

CATT intake

IPU

Triage

Triage reads referral, collates information and makes eligibility criteria decision

Not eligible

If not eligible for service, inform GP (1/3 of referrals approx)

Eligible

If eligible for service (2/3's of referrals approx) prepare documentation for handover to appropriate team

If urgency high refer onto CATT

Service engagement

Acceptance by team

No

Require more information. Sent back to triage.

Ineligible for intake. Refer back to triage with instruction to inform the referrer

Yes

Community team MDT for allocation

Mapping the process: trial option Nov18

Referral

GP providing care

Referral for secondary services via RMS-lite

Case opened in JADE, triage team are alerted via email

Clearly urgent

GP marks referral as 'urgent' - referred onto CATT for clinical appraisal of risk.

Urgent/high risk

CATT engagement

Clearly non-urgent

'Advice only' referral forwarded based on complexity of question(s).

Clearly defined query

Response provided by a doctor.

More complex query

Non-urgent

Triage

Triage decision about need for Specialist Comprehensive Assessment (SCA)

Advice provided through RMs lite back to referrer

Risk or urgency increases

Referral to CATT

SCA not required - Advice only

CMHS provide support / advice on intake suitability

Triage prepares assessment documentation for handover to CMHS

The Triage service holds the responsibility to assess clients for eligibility for service intake or if the response needs to be advice and brief support only.

GP holding clinical responsibility

CMHS Holding Clinical Responsibility

Adult Services

Eligible for intake

CMHS allocation process

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Capture – theme's emerging

- Client 'repeating their story'
- Length of time triage team engaged with client
- Multiple times client presented to MDT
- Inconsistent feedback process to referring GP
- Inconsistent use of outcome scale from triage to CMHS
- Use of informal escalation process when triage and CMHS don't agree
- Pathway unclear when AOD also factor in referral
- Line of clinical responsibility between triage and CMHS can be blurred creating risk for client
- Software solution required to monitor clients referred into DHB service

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Ideas generation

Decisions from Design Group meeting 26 October 2018:

A number of change ideas were suggested and these are as follows:

1. Trial to provide senior clinical support/oversight of the Triage team. One month trial November 2018
2. Standardise advice-only responses back to GP's through RMS-lite.
3. Standardising the inclusion of the triage-outcome scale in the referral documentation
4. Mapping the current process flow through the referral-Triage-Kamo pathway showing critical timelines.
5. Audit of timescales of clients moving through the pathway (reviewing and updating of the analysis work done earlier in the year).
6. Deep dive into the data looking at client presentations where the assessment at triage looks very different to the presentation at the following face-to-face meeting with the GA clinician
7. Development of dashboard to monitor clients through referral pathway

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Improvement in monitoring information

Mental Health - Whangarei Triage Dashboard

			TRIAGE				COMMUNITY				
NHI	Client Surname	CaseStart	Clinician	Referral Date	First Triage Contact	Days to Contact	Team Change Date	Key Worker	Days to Change	Case Outcome	Case ID
	-	02/07/2018 12:03		02/07/2018 12:03							238790
		25/10/2018 08:01		25/10/2018 08:00	02/11/2018 11:30	8					246450
		30/10/2018 08:49		30/10/2018 08:49							246759
		01/11/2018 09:21		01/11/2018 09:07	01/11/2018 01:30	0					246927
		01/11/2018 09:10		01/11/2018 09:00							246929
		12/11/2018 12:01		09/11/2018 04:16	13/11/2018 08:28	4					247708
		12/11/2018 04:00		12/11/2018 03:58							247711
		13/11/2018 11:55		13/11/2018 11:54							247752
		13/11/2018 03:19		13/11/2018 03:18	14/11/2018 03:30	1					247785
		13/11/2018 04:01		13/11/2018 04:00							247814
		15/11/2018 08:07		15/11/2018 08:06							247915
		01/11/2018 08:00									246920
	s	16/11/2018 10:02		16/11/2018 10:01							248016
	n	19/11/2018 08:51		19/11/2018 08:51							248085
		19/11/2018 09:01		19/11/2018 09:01							248087
		09/11/2018 04:35		09/11/2018 04:34			13/11/2018				247604
		09/11/2018 10:05		09/11/2018 10:04	12/11/2018 11:30	3	13/11/2018		1		247530
		09/11/2018 12:42		09/11/2018 12:41	12/11/2018 09:00	3	13/11/2018		1	Discharged to another Healthcare Org	247557
		13/11/2018 03:29		13/11/2018 03:27	14/11/2018 12:30	1	15/11/2018		1		247791
		01/11/2018 09:42		06/11/2018 09:32	13/11/2018 09:30	7	15/11/2018		2		246931
		12/11/2018 03:09		12/11/2018 03:08	13/11/2018 09:00	1	15/11/2018		2		247699
		07/11/2018 09:26		07/11/2018 09:17	07/11/2018 10:00	0	13/11/2018		6		247342
		06/11/2018 09:48		06/11/2018 09:48	06/11/2018 11:00	0	13/11/2018		7		247251
		01/11/2018 10:06		01/11/2018 10:06	01/11/2018 10:10	0	13/11/2018		12		246935
		01/11/2018 04:03								DNA following Referral	247003
		06/11/2018 01:01		06/11/2018 01:00	06/11/2018 01:02	0				DNA following Referral	247312
		06/11/2018 10:14		06/11/2018 10:09						Ended routinely / Goals complete	247257
		08/11/2018 01:12		08/11/2018 01:11						Ended routinely / Goals complete	247466
		08/11/2018 09:04		08/11/2018 09:03						Ended routinely / Goals complete	247427
		13/11/2018 03:41		13/11/2018 03:41						Client Terminated Services	247797
		13/11/2018 08:27		13/11/2018 08:26	13/11/2018 10:45	0				Ended routinely / Goals complete	247723

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Measures (non-urgent referrals)

CMHS Referrals: Days Wait to Assessment c Chart

Days Wait to Assessment

160
140
120
100
80
60
40
20
0

UCL 31.972
CL 18.922
LCL 5.872

06/03/2018, 22/03/2018, 27/03/2018, 13/04/2018, 19/04/2018, 08/05/2018, 09/05/2018, 15/05/2018, 24/05/2018, 29/05/2018, 01/06/2018, 07/06/2018, 14/06/2018, 19/06/2018, 26/06/2018, 29/06/2018, 04/07/2018, 12/07/2018, 17/07/2018, 20/07/2018, 01/08/2018, 06/08/2018, 17/08/2018, 20/08/2018, 27/08/2018, 29/08/2018, 11/09/2018, 13/09/2018, 17/09/2018, 26/09/2018, 11/10/2018, 09/11/2018

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Measures (non-urgent referrals)

CMHS Referrals: Days Wait to 2nd Contact c Chart

Days Wait to 2nd Contact

250
200
150
100
50
0

UCL 58.703
CL 39.781
LCL 20.860

06/03/2018, 22/03/2018, 27/03/2018, 13/04/2018, 19/04/2018, 08/05/2018, 09/05/2018, 15/05/2018, 24/05/2018, 29/05/2018, 01/06/2018, 07/06/2018, 14/06/2018, 19/06/2018, 26/06/2018, 29/06/2018, 04/07/2018, 12/07/2018, 17/07/2018, 20/07/2018, 01/08/2018, 06/08/2018, 17/08/2018, 20/08/2018, 27/08/2018, 29/08/2018, 11/09/2018, 13/09/2018, 17/09/2018, 26/09/2018, 11/10/2018, 09/11/2018

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Elevator Pitch

The current primary care referral to CMHS pathway is not consistent across all CMHS teams.   Delays in client care have occurred due to responsibilities for clients sometimes being unclear, with these delays creating clinical risk.

The Aim of the project is to reduce the time a client waits from referral to face-to-face meeting with the CMHS clinician.

Achieving the about target will:

•Deliver a timely and effective triage and intake service that provides client-centred best outcomes, minimises risk and employs tools, processes and pathways acceptable to clients, referrers and the adult community teams.