Annexure E

23/03/2024

To MNCLHD Board.

Thank you, Peter, for your recent email clarifying that I was welcome to continue to advocate to the Board regarding local health strategies. Previous correspondence in July and Sept 2023 had indicated that the Board felt responding was an unreasonable use of resources (see attached)

One of my reasons for advocating as I do, is doctors working within the LHD continue to expressed to me, the culture at the hospital is problematic and they report they feel is that it is not safe to speak up. My understanding is the culture of an organization is the legal responsibility of the Board.

I hope those on the Board are able to address systems and strategy to improve the care of mental health patients in our local area (my focus of advocacy since 2013) and to explore the question "is the culture at the CHHC problematic" and if so how can we improve the culture in the LHD to minimize burn out and psychological harm for its employees.

I would like to continue to focus my advocacy for improvement in tertiary mental health services for the local community and improved communication with general practitioners regarding mental health patients.

The following recent examples illustrate the difficulties facing general practice in accessing stepped up care for those with complex mental health needs. Regular experiences such as below create the belief in many local general practitioners that the LHD is unable to meet the needs of those with severe or complex mental illness in our community. This is the universal opinion of all GPs I have had detailed discussions with regarding this, approx. 30 in total. This in turn means patients are not referred to the LHD as is clinically indicated: as we balance the harm of referring patients versus the risk of not referring.

Strategically patients should be able to move between community and tertiary levels of care as their conditions require and not be influenced by general practitioner or patient negative experiences or expectations of LHD services. This in turn results in more ED presentations by patients in crisis and increased use of hospital resources resulting from poorly managed mental health patients.

Example 1:

October last year I requested the hospital's policy on management of psychosis and was advised it was under revision, I requested a copy when it had been revised.

That request was prompted by a patient with first presentation psychosis (severe presentation of mental illness that would usually receive admission) not receiving an admission in spite of significant delusions and bizarre behaviour (including threatening hospital dental staff with a knife and out of character aggression at the general practice surgery). Patient managed by myself in the community and was a near miss.

I have still not had a response, and would like to re request a copy of the recently revised hospital policy on management of first presentation psychosis.

I am at a loss for suggestions on how to get access to tertiary care for very unwell patients after discussions with external psychiatrists including Prof Pat McGorry and Dr Dubravka Jancovich. I

realize if they can not advocate for patient's they feel require stepped up care and get it at CHHC, then there is little hope for the GPs in the community, who would have less clinical leverage than that of a world renowned youth psychiatrist with a 90 page CV, past Australian of the year, who is the clinical director of Orygen in Melbourne!

Example 2:

A few weeks ago, a patient of mine was discharged after a 4-week mental health admission (on a legal community treatment order), still displaying symptoms of psychosis with delusions and out of character aggression. The Mission Australia case worker contacted the hospital multiple times after discharge, but could not get the patient reviewed. The patient then left abruptly 3 days after discharge, in a highly distressed state on a train south. He was apprehended in Haymarket a few days later by police for riding a train without a ticket, and eventually admitted a few days later to Concord hospital following an assault and persisting symptoms of psychosis. The registrar in Concord did phone me for collateral history (has only happened a couple of times in last 10 years in Coffs to me).

With regards to how to advocate for better clinical care for patients who are lucky enough to gain admission to the mental health department I am also at a loss, perhaps an exit interview with all rotating psychiatry registrars through our hospital would give you better insight in how to improve t s.

Example 3:

A patient in her 50s who had a 14-month mental health rehab admission had been reviewed in the hospital's clozapine clinic monthly since discharge in 2019. The staff did not order lithium levels (routine care and monitoring) for 4 years in spite of requests from myself as the GP for medication reviews since her discharge, due to ongoing side effects including offensive diarrhoea with faecal incontinence. I have written to clozapine clinic on 5 occasions from 25/7/2022 with specific questions regarding medication. I have received 5 letters back from the clozapine clinic in this time and not one of them responded to or addressed any of the questions I asked. I am not sure if this is a process issue (eg the ACS is not passing the letter onto the clinic) or the doctors in the clinic are not reading the patient's file.

This example highlights lack of communication. While we do receive discharge letters now (thank you for this improvement) GPs would hope for communication whenever their patient is assessed as an outpatient, by a psychiatrist, as in line with all other specialties who provide this written feedback to GPs involved in the patients care.

A suggestion for potential support the LHD could give to GPs in addition to the above points would be to provide a multidisciplinary team meeting via video link where GPs could communicate with a psychiatrist, psychologist, social worker regarding complex patients that have had or are likely to have mental health admissions. (This could operate in a similar way to the oncology MDT meetings and be funded similarly) This would generate money for LHD and GPs could also be renumerated and get advice without the patient needing to be present.

Another suggestion is that the patient stories the Board meeting opens with, are selected as those that provide learning opportunities for system review and improvement. If stories presented are all good news, pat on the back type stories, this is a significant missed opportunity and not in line with the purpose of the Ministry of Health directive. It would also indicate problems of culture with

overarching “nothing to see here” attitude and reluctance to accept feedback and provide ongoing system improvement.

Collaborating with the PHN to advertise to GPs they are welcome to provide these “patient stories” to the Board, to be considered for presentation, would be a way of engaging with primary care and improving hospital systems in the one process.

The following additional items are just for your information in your own strategic planning and your own legal responsibilities in considering if overarching culture is contributing to any of these issues. I do not need a response to any of the points below.

GPs are finding it increasingly difficult to get outpatient specialist opinions for patients who cannot pay significant out of pocket fees. A registrar recently observed to me how much easier it was in Ballarat to get specialists to collaborate with care, another GP previously from a remote indigenous community 300km from Darwin said he could access better specialist care for his patients in the NT than here in Coffs.

Paediatrics is no longer functioning for our local children:

Only 2 private paediatricians are accepting new referrals and have > 10 month wait to be seen. The one staff specialist paediatrician has similar wait times and does not assess behavioural conditions ASD and ADHD.

I was unable to get a 6-year-old with 2 non febrile seizures seen by any local paediatricians and had to refer to the Gold Coast for formal diagnosis of epilepsy and management. A 7-year-old patient with newly diagnosed insulin dependent diabetes had to go to Grafton to access a paediatrician.

GPs are disappointed to learn a final year paediatric registrar who was working in CHHC wanted to set up a public paediatric outpatient clinic here and work as a staff specialist in Coffs Harbour, but was blocked by the hospital and has taken up a position in Grafton Hospital instead.

Dr Naidoo and Dr Budd have retired having given 2 years notice for succession planning. I understand that Dr White is also ceasing work at LHD in June. This will likely result in loss of accreditation for paediatrics and subsequent loss of paediatric registrars. There will be subsequent cost of running a locum service. If a locum becomes unavailable (due to issues such as illness or flight cancellations, as happens in mental health) then the flow on consequences will be all obstetric patients will be unable to deliver in Coffs Harbour for the time there is no paediatric locum, and women in labour and planned elective caesarean sections will need to be transported to JHH. I am not sure if the Board is aware of this impending situation.

Gynaecology services are not far behind with Dr Budden and rumours of Dr Clarke withdrawing public services and the withdrawal of private services by Dr Ward.

GPs are deeply disappointed the proposed gynaecology outpatient clinic was blocked at a strategic level, in spite of a cost neutral proposal being put forward. This has denied local women access to cancer screening colposcopy, 5 year contraceptive IUD under sedation for those who have not had children or who have had sexual trauma, assessment for ovarian cancer, endometrial cancer etc without expensive gap payments. GPs locally are referring patients to Port and Newcastle for these basic services.

The previous excellent **sexual assault service** is still not fully operational such that vulnerable sexually assaulted patients have to either travel to Port Macquarie to receive a forensic examination, or present multiple times to the CHHC. We have been without a fully functioning service for approximately a year.

ENT patients are being sent out of area, as are **respiratory** patients due to unacceptably long wait times with the private specialists and prohibitive private fees.

There is still an 18 month wait for **denta**l extractions under GA (this has not changed with all my advocacy over the last 3 years) which increases opioid dependence in those waiting for treatment.

There is **still no collaboration between dental, mental health and drug and alcohol, sexual health departments** even though patients often have significant overlap needs between these services. I would like to quote from a discharge summary on a young man in his 20s. Discharged this year after 7 day admission for first presentation of drug induced psychosis. Discharge summary included the comment: "***patient requested a hepatitis screen due to his intravenous drug use. This was unable to be organized during his admission, GP to follow up in community***". Not sure why a doctor would document these words on paper? Are they asking for external GPs to rally and advocate to LHD that mental health patients should have access to blood tests? Do they believe Hepatitis screening is inappropriate for intravenous drug using mental health patients? Are they aware there is no capacity in the LDH to follow up mental health patients accurately and this would expose the hospital to legal risk of not following up significant results like a positive Hepatitis C? Whatever the intention of the author it is clear there is no collaboration between internal departments. Such collaboration would again save money as well as improving patient care.

On a positive note it is appreciated that after 8 years of advocacy we have had a neurologist appointed. Again no public outpatient services come with this appointment. Apparently such a clinic was discussed but not supported by the LHD : this is likely, again, due to lack of strategic goal at LHD level to provide accessible outpatient services to the local community. Similar issues seem to have closed down the short lived, GP and patient appreciated, general surgical outpatients' clinic.

Yours forever hopeful in advocacy

Dr Nicola Holmes