Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Matthew Russell

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Occupation:	Director Mental Health, Nepean Blue Mountains Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

My role

2. I am the Director of Mental Health for the Nepean Blue Mountains Local Health District (**NBMLHD**). I have been in this role since March 2021. I am qualified as a registered nurse and previously worked as an Operations Manager in a Non-Government Organisation (**NGO**) and in child and adolescent mental health at Northern Sydney Local Health District.

3. As the Director of Mental Health, I am responsible for oversight of the operational, strategic and clinical work in the Mental Health Service. The Mental Health Service is comprised of a range of services - including specialised services for children, young people, families and older people, through our community-based services, community health centres and inpatient services at Nepean Hospital and Blue Mountains Hospital.

4. In this role I report to both the Chief Executive and Director of Community and Integration. I have 6 direct reports which include:

   a. Medical Director for Mental Health;

   b. Divisional Manager;

   c. Manager for Adult Mental Health;

   d. Manager for Child Youth Mental Health;

   e. Director of Nursing, and

   f. Manager for Allied Health and Specialty Teams.

5. The Mental Health Executive is comprised of myself and my direct reports.

Corporate Governance Framework

6. NBMLHD operates under the *Corporate Governance and Accountability Framework* for NSW Health.

7. The governance structure within the Mental Health Service includes the following:

   a. Monthly Executive Leadership Team meeting that oversees a number of key performance indicators (**KPIs**) within the service. I attend this meeting.

   b. Monthly Senior Managers meeting which oversees all senior managers in the service. I attend this meeting.

   c. Two Patient Safety Quality meetings which oversee patient safety and quality for inpatients and patients utilising community services. I do not attend these meetings.

   d. Regular Mental Health Performance Meeting with the district that oversees core KPIs. I attend and co-chair this meeting. This meeting includes the Director of Community Integration, the Director of Nursing, the Director of Clinical Governance, the Director of Finance, Director of Hospital Services and the Director of Allied Health. The CE is also invited to attend.

   e. Individual accountability meetings – I have a meeting with each of my direct reports on their performance, then each of my direct reports having a meeting with their direct reports and so on. I do not attend every meeting which a line manager has with a staff member.

   f. Fortnightly meetings with cost centre managers. I chair these meetings. All managers within the Mental Health Service are invited to join and ask questions. They are a mixture of open forums and set topics.

   g. All Staff Forum every 6 months. These meetings are a mixture of online and in person. Everybody who works across the mental health service are invited to attend.

   h. Informal meetings with the Executive Director for Mental Health at the MOH and Mental Health Directors from each LHD approximately every 6 weeks.

i. Formal meetings with the Executive Director for Mental Health at the MOH at Mental Health Directors from each LHD 4 times per year.

j. Mental Health Program Council meetings 4 times per year. This Council has a wider membership including a number of peak NGO bodies.

k. Producing Annual Operational Reports that feed into the district reporting.

8. The Mental Health Service also have engagement with the following board subcommittees:

a. Safe Care Committee, and

b. Work Health Safety (**WHS**) Committee.

9. The Mental Health Executive submits regular written reports to both committees and there is a rotational structure as to who provides verbal updates on their reports.

10. A due diligence report is to be completed for each quarterly Work Health Safety Committee meeting. This report identifies my responsibilities and must demonstrate that I have regularly fulfilled these functions.

11. A Quadrant report is also completed quarterly for both subcommittees which highlights main achievements, risks, areas that the Mental Health Service is working on and progress in relation to the security improvement action audit and WHS audit. These audits are completed regularly and progress is to be regularly reported on to this committee.

12. Corporate governance is mostly managed up through the WHS Committee. We nevertheless undertook consultation within the Mental Health Service to learn how clinicians would prefer WHS issues are fed into this committee. For example, we recently consulted with our services as to whether they wanted to have health safety representatives in each area of the service or whether they would prefer to progress WHS issues through their regular team meetings. The majority of services surveyed preferred that WHS issues be regularly noted in their team meeting, which feeds up to the Executive Leadership Team, with executive managers reporting work health and safety issues in their regular meeting. Where a service prefers to have a dedicated WHS committee that has been implemented.

13. Where the board, or one of its subcommittees, indicates actions to be undertaken, this flows down through circulation of the board minutes.

14. I do not have any role in budget setting for mental health services and receive a budget from finance. I am allocated a savings and revenue target for mental health services which is set by the MOH for the district. The current savings target is $1.1 million and the current revenue target is $2.4 million. Revenue can be recouped from private health insurance and Medicare billing through staff specialists.

15. The Mental Health Executive receives a target from the district as to what efficiency improvement plans need to be created. These plans are created and submitted to district finance for review before being submitted to the MOH. The only efficiencies that the Mental Health Executive are responsible for stem from the district's *Efficiency and Improvement Plan.*

Clinical Governance Framework

16. The Mental Health Executive develops an *Annual Operational Plan* for mental health services which aligns with the *Mental Health Strategic Plan* co-developed with the CCC.

17. There is also an *Aboriginal Mental Health Plan* developed specifically to address Aboriginal mental health.

18. There are professional leads for each health discipline within the Mental Health Service. The Medical Director holds clinical responsibility for medical decisions, the Director of Nursing holds clinical responsibility for nursing decisions, the Manager for Allied Health holds clinical responsibility for allied health and so on. These functions ultimately report up to my direct reports and myself as it is my overall responsibility to oversee work within the service.

19. The service works under a broad suite of NSW Health policies and district policies. The application of a policy will depend on the issue at hand. For example, there is a very detailed incident management process. Incidents are reviewed through 2 structures:

    a. Patient Safety Quality meetings (mentioned above), and

    b. Safety Review & Strategy Committee.

20. The Safety Review & Strategy Committee does not review specific incidents but takes a broader view by identifying trends and considering the interaction between staff wellbeing and clinical incidents. Reporting from these committees comes up to the Executive Leadership Team meeting.

21. Incidents must all be recorded in the Incident Management System (**IMS**). Whenever a worker becomes aware of an incident or near miss they are obliged to enter it into the IMS. They are required to describe the incident and allocate a risk assessment or harm score from 1 (being a catastrophic or significant outcome) to 4 (being a lower level incident or near miss). The harm score is determined by consulting a matrix. The initial rating is reviewed by the Clinical Governance Unit (**CGU**) who review all incidents. If an incident is significant, a preliminary risk assessment is undertaken by the CGU within 27 – 72 hours of the incident occurring. I attend this assessment for any incidents that occur within the mental health service. This assessment determines if the incident is escalated to the MOH.

22. An incident with a harm score 1 will automatically go to the MOH but there is discretion around other harm scores. These incidents are also reviewed at a quarterly meeting with the CGU. We also receive monthly reports from the CGU about the number and type of incidents reported and outstanding action items or open investigations which I then follow up with my direct reports. The Mental Health Service and CGU operate on a business partner model where the clinical governance unit are overall responsible for patient quality and safety within the mental health service, chair the Patient Safety Quality meetings and attend the Safety Review Committee meeting.

23. Consumer complaints are also received through multiple different pathways. Complaints typically come to me first. I review and allocate complaints to relevant stream managers for action. Feedback then comes back up to my office before I submit the information to the LHD Executive who, if necessary, submit it to the MOH.

24. The usual process for a Health Care Complaints Commission complaint is to accept it for local resolution unless there is a unique reason not to do so. I participate in the local resolution meeting on behalf of the LHD or delegate it to one of my direct reports.

25. The Mental Health Service also participates in open disclosure processes.

Community and Stakeholder Engagement

The Consumer and Carer Council

26. The Consumer and Carer Council (**CCC**) was established in April 2019. It is a 12 person body comprised of 6 mental health consumers and 6 carers who have either had lived experiences of mental illness or psychological distress or provided care to someone with a mental illness. This partnership ensures the lived experience, knowledge and skills of the community is utilised in all aspects of improving mental health care and operations. The CCC works in active and open collaboration with the Mental Health Service and develops its own priorities and projects aimed at identifying opportunities and solutions for service improvement.

27. As the Director of Mental Health, I am the Executive Sponsor of the CCC and take responsibility for overseeing the successful implementation of the *Mental Health Service Consumer and Carer Council Charter.*

28. On an organisational level, the CCC sits at the same level as the Mental Health Executive. This means that we have an equal decision-making role around strategy and oversight for the mental health service, although the Mental Health Service bears the ultimate responsibility for delivery.

29. Members of the CCC are selected via a competitive application and approval process.

30. The CCC has its own work plan and provides an annual report each calendar year outlining the activities, operations and achievements of the council.

31. As part of our Aboriginal Wellbeing Strategy, we have recently established a new Koori Council addressing Aboriginal mental health which follows a similar structure to the CCC and will similarly occupy the same level in the organisational structure as the Mental Health Executive.

Feedback from the Community

32. I frequently receive anecdotal reports and suggestions from members of the CCC which they have heard from talking to consumers, NGOs or other service providers directly.

33. The Mental Health Service receives direct feedback and data from consumers and carers through the Your Experience of Service and Carer's Experience of Service surveys. This is a consumer led and consumer designed 34 question survey which it is voluntary for users to complete either electronically or on paper. It is a national initiative but each LHD collects its own data and performs to a KPI which is that over 80% of users completing the survey should be reporting a 'good' or 'excellent' experience of service.

34. In order to obtain meaningful feedback and data we need to get at least 10 returns of the survey per team per quarter. The data is collected and analysed by the MOH and we receive quarterly reports. Once we understand the main themes arising from the data, we provide feedback to specific units and teams and ask them to develop action plans based on the feedback. It is a de-identified process which means we do not respond to individual users based on their feedback.

Relationship with Primary Health Network

35. In addition to programs involving NGO engagement, NBMLHD's connection with the Primary Health Network (**PHN**) is increasing. Bilateral funding agreements for a number of services which will be introduced over the next couple of years. Examples include:

    a. Aftercare Service – due to commence on 1 July. This is a peer led service which provides assistance and support from a peer worker for people leaving hospital after an attempt to end their own life.

    b. Youth Enhancement Scheme. This scheme involves embedding LHD staff into Headspace centres.

    c. Head to Health Kids Hubs. This hub will be located in Penrith and provide comprehensive, multi-disciplinary mental health and wellbeing care for children under 12 and their families.

36. The Mental Health Service has a positive relationship with the PHN. I co-chair a Joint Regional Suicide and Mental Health Prevention Committee alongside the Executive Manager Strategy & Integration in the PHN.