Non-admitted mental health services evaluation

Executive summary report

Mental Health Commission, Western Australia

July 2020

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Inherent limitations

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To comply with the Western Australian Government's accessibility requirements, this Executive Summary Microsoft Word version has been provided. The KPMG-branded PDF version of our Final Report, submitted to the Mental Health Commission, remains the definitive version of our Report.

1. Evaluation overview

The Mental Health Commission (MHC) purchases mental health, alcohol and other drug services for Western Australia from a range of providers including the public Health Service Providers (HSPs), non-government organisations and private service providers. Each financial year, the West Australian Government allocates funding through the State Budget to the MHC for the commissioning of mental health services. With this funding, the MHC commissions inpatient, non-admitted and teaching, training and research (TTR) services, as specified in Commission Service Agreements (CSA) with each HSP.

Mental Health Commission expenditure on core non-admitted mental health services delivered by WA's five HSPs was $322.0 million during 2017-18 and $325.8 million in 2018-19. Non-admitted mental health services encompass community and ambulatory specialised mental health programs provided by the HSPs.

Core non-admitted mental health services – being community and ambulatory specialised mental health programs – are purchased by the MHC purchases from HSPs under the following service streams:

- Prevention and promotion
- Community support services
- Community treatment services
- Community bed based services
- Specialised state-wide services
- Forensic services
- Hospital bed based services.[1]

These services are purchased on a block funded basis, calculated using a base year, an agreed cost escalation and the Age Weighted Population Growth Rate (AWPGR). An activity based funding framework for non-admitted services is currently unavailable.

In addition to the core non-admitted mental health services, the MHC also purchased some services, projects and initiatives under the 'targeted purchasing', 'specific projects' or 'system improvement and supporting change services' funding constructs.

Specific projects, purchased through a separate WA Department of Treasury process, added further funding of $19.0m in 2017-18 and $19.6m in 2018-19. In total (with core and specific project funding combined), expenditure on non-admitted mental health services in WA was $341.0m in 2017-18 and $345.4m in 2018-19. Specific projects are generally targeted, time limited and include an evaluation component.

The MHC engaged KPMG to help improve its understanding of the non-admitted mental health services it commissions, by developing a services inventory, evaluating the effectiveness and efficiency of the non-admitted mental health services it commissions, and providing recommendations regarding future commissioning and performance measurement.

[1] Hospital bed based services included the following funding allocations: East Metropolitan Health Service "John Milne Centre Post Discharge Adult' (2017-18); North Metropolitan Health Service 'Assertive Patient Flow' (2017-18 and 2018-19); and South Metropolitan Health Service 'Consultation Liaison' (2017-18).

1.1. Evaluation objectives

The evaluation considered the commissioning and delivery of non-admitted mental health services by HSPs during 2017-18 and 2018-19. Its objectives were to:

- Document and provide an **inventory** of all non-admitted mental health services delivered by HSPs under their MHC Commission Service Agreement, and identify / define the scope, eligibility criteria and objectives of these services
- Investigate and report on the **effectiveness** and **efficiency** of MHC funded non-admitted mental health services in terms of both patient outcomes and value for money
- Document the **similarities**, **differences** and **overlaps** in regards to non-admitted mental health services provision (including patient and referral pathways and examples of good practice) within and across HSPs
- Provide recommendations on ways to improve the purchasing, delivery and patient outcomes of non-admitted mental health services
- Provide recommendations on the best way to measure non-admitted mental health services performance.

2. Approach

The evaluation involved a multi-stage methodology that included:

- Development of an evaluation plan to establish the evaluation questions, considerations, indicators and methodology
- Collection and analysis of a range of information and data, including data recorded in the Psychiatric Services On Line Information System (PSOLIS), National Outcomes Casemix Collection (NOCC), Your Experience of Service (YES) survey and CAHS Experience of Service Questionnaire (ESQ), and Datix Clinical Incident Management System
- Consultation with HSP management, health service management and clinicians, as well as consumer and carer advisory groups through semi-structured interviews
- Synthesis and analysis of the data sources
- Development of the services inventory and validation of initial findings with the HSPs
- Reporting and validation with the Evaluation Steering Committee (ESC).

The evaluation was undertaken between May and November 2019.

2.1. Evaluation limitations

Although wide ranging, the evaluation had some scope limitations that impacted on approach and findings. The evaluation focussed on the delivery of non-admitted mental health services by HSPs during 2017-18 and 2018-19 only. The focus on two financial years meant that the evaluation has not been able to detect or consider trends in demand, service provision, funding or outcomes.

The evaluation was implemented with tight timeframes, requiring tasks such as stakeholder interviews, data analysis and development of the services inventory to be undertaken concurrently.

In addition, the evaluation scope did not include detailed consideration of consumer access to other parts of the mental health system, such as primary health care, non-government organisations (NGOs), emergency departments and inpatient units, as well as interactions and transitions to community mental health settings. The evaluation did not review data relating to activity, funding or performance in these sectors, nor consulted with relevant stakeholders from these sectors.

As is common for large, complex and dynamic service systems, issues relating to data quality and consistency were encountered during the evaluation. This included under-recording of service contacts and events, use of a variety of patient outcome tools, variations in programs and funding allocations, and a lack of information about actual expenditure at the program level. These issues, discussed in detail in the report, impacted the evaluation's analysis of service activity, outcomes, commissioning practices and reporting. Given these constraints, it was recognised that the evaluation would not be able to provide reliable analysis of good practice examples and value for money within the existing scope.

Noting the above limitations, the evaluation provides a point in time analysis or 'snapshot' of the non-admitted mental health system. In this regard, it also provides a baseline for ongoing performance monitoring and evaluation. Members of the Evaluation Steering Committee (ESC) convened to oversee the evaluation advised that in light of the various limitations, the evaluation findings are most useful for informing future quality improvement and performance monitoring efforts. ESC members raised concerns about basing commissioning decisions on evaluation findings alone and cautioned that these should be made collaboratively between the MHC and responsible HSP to ensure the full program context can be considered.

Evaluation Steering Committee members also noted that it is important that the recommendations provided in this evaluation report are implemented collaboratively, and in accordance with the roles and responsibilities articulated in the WA Health Governance model. It is recognised that some recommendations address issues that were also identified through the *Sustainable Health Review* and the Office of Auditor General's Office 2019 review, *Access to State-Managed Adult Mental Health Services*, that are being progressed by the MHC and WA Health.

3. Findings

3.1. Services inventory

Evaluation objectives included the development of an inventory of all non-admitted mental health services delivered by HSPs under their MHC Commission Service Agreement, and identify / define the scope, eligibility criteria and objectives of these services. A detailed services inventory has been submitted to the MHC as part of the evaluation outputs. An abridged version of the services inventory is provided at Appendix A of this report.

3.1.1. Service structures

Western Australia's non-admitted mental health services are broad and varied, reflecting the diverse needs of people with mental illness, carers and family members as well as local communities. During

2017-18 and 2018-19 the MHC funded a total of 139 programs and services[2] mainly focussed on the provision of community treatment and support. In addition, the MHC funded a range of projects and initiatives aimed at improving mental health services (e.g. through the delivery of training, development of strategies or resources) and provided funding for service enhancements, staffing and corporate overheads. At the service level, there are almost 450 programs recorded in the Psychiatric Services On Line Information System (PSOLIS), further highlighting the breadth of service types covered by this funding.

Programs / services are designated an age cohort within PSOLIS, being either Children and Adolescents (0-17), Adult (18-64) or Older Adult (65+). Youth programs are recorded as being either Children and Adolescents or Adult. However, a large number of programs have more discreet eligibility criteria, as highlighted by the Service Inventory. In addition, while consumers who are diagnosed with mental illness at age 65 years or older (or Aboriginal and Torres Strait Islander consumers aged 45 years or older) will most likely access Older Adult mental health services, those who commenced services prior to these ages will often remain with Adult mental health services (unless they have ageing related mental health or cognitive needs such as dementia).

Non-admitted mental health services provide a range of services to assess, diagnose and treat people with mental illness across clinical and community settings. The services are block funded and may involve brief interventions (e.g. triage and assessment) as well as more intensive programs and services to the patients admitted into the community based mental health programs. Non-admitted mental health services operate as part of the wider mental health and health systems that include emergency departments, inpatient services, private primary health care and specialist services, and non-government community support services.

There were differences in the structuring of services across each of the five HSPs. While there were broad similarities in the structuring of the metropolitan services (East Metropolitan Health Service (EMHS), North Metropolitan Health Service (NMHS) and South Metropolitan Health Service (SMHS)), the Child and Adolescent Health Service (CAHS) and WA Country Health Service (WACHS) operate with different structures. Inconsistencies in the allocation of funded programs to the service streams during 2017-18 and 2018-19 also created analytical challenges across the two financial years. For example, some programs changed service stream between the years, similar programs in separate HSPs were allocated to different service streams, and it was difficult to establish clear service stream definitions.

Subsequently, KPMG's evaluation team considered the funded programs and services[3] on the following basis:

- **General mental health services** for consumers with severe, complex and enduring mental illness who reside within the service catchment. General mental health services consisted of programs that were accessed by people with a variety of mental health conditions and provided in each catchment such as:
    - Assessment and treatment teams (ATT)
    - Clinical / community treatment teams (CTT)

[2] MHC funded a total of 139 programs during 2017-18 and 139 programs during 2018-19 across the five HSPs. 112 of these programs were delivered over both financial years.

[3] The services inventory lists of all funded programs as well as the corresponding HSP, plan stream, funding categorisation allocated by the evaluation, PSOLIS programs, location, operating hours and eligibility criteria.

- Intensive / early psychosis / clinical outreach programs
- Therapy, rehabilitation, psycho-education and wellness programs
- Older adult services
- Youth services

- **Specialised mental health services** for consumers with specific mental health conditions requiring a higher level of specialisation or targeted response. These services were either delivered on a state-wide or metropolitan-wide basis. Examples included:
  - Condition specific programs such as the Complex Attention and Hyperactivity Disorders Service, Eating Disorders Program, Gender Diversity Service, Neurosciences (Huntington's Disease, Predictive Testing, Early Onset Dementia (25-64 years))
  - Forensic mental health services
  - Perinatal mental health services
  - Telephone triage and referral services[4]
  - Mental health co-response teams[5]
- **Community bed based services** at Jacaranda House and Hampton Road, for consumers with severe, complex and enduring mental illness who require support to live within the community but have challenges accessing a non-government service.

[4] While these services do not require specialist expertise, when compared to general mental health services, telephone triage and referral services differ in terms of providing brief, non-recurrent interventions. These were therefore grouped with specialist services to enable clearer analysis of general mental health services.

[5] As above.

3.1.2. Service activity

Analysis of PSOLIS data indicates that the total number of consumers[6] treated in non-admitted settings grew from 60,967 in 2017-18 to 63,878 in 2018-19, an increase of 2,911 consumers or 5%. During the same period, total service contacts[7] increased from 937,448 to 966,487 (3%); and total service events[8] increased from 935,071[9] to 970,597 (4%). However the total service duration recorded decreased by almost 35,000 hours from 618,574 to 584,208 hours (-6%).

Analysis at the HSP level shows that changes in activity levels varied by provider, with CAHS, NMHS, EMHS and WACHS recording increases in patient numbers (15%, 2%, 8% and 6%) respectively, while SMHS experienced a very small decrease (-0.4%). Only EMHS recorded a decrease in service contacts (-5%) while only WACHS recorded an increase in total service hours (5%). Furthermore, NMHS, EMHS and SMHS all recorded substantial decreases in service duration, with decreases of 13,723 (-7%), 13,752 (-12%) and 11,878
(-9%) hours respectively. Feedback from service providers indicated that services are seeing increasing numbers of consumers, but providing fewer hours of direct care or less frequent care per consumer. However, under-recording of service activity was also reported by service managers as common, as service providers struggle with demand related pressure as well as administrative burden and the reported functionality limitations of the clinical information system.

Non-admitted mental health services are mainly delivered within business hours (Monday to Friday, between 8:30 am and 5:00 pm). The most common types of care were assessment, consultation liaison, counselling and therapy, and advocacy and assistance. Across the workforce, mental health professionals such as registered mental health nurses, social workers, psychologists, psychiatrists and occupational therapists provided the majority of care. The characteristics of consumers in terms of age, gender and ethnicity generally aligns to the focus and eligibility criteria for the different programs.

Service providers described two main referral models in effect for non-admitted mental health services, with general mental health services accepting referrals from all sources and directing them through the Assessment and Treatment Teams (ATTs) for assessment, while specialist services mainly require referral from a clinician or service partner. Notably, service providers reported that the ATT referral model has led to substantial increases in referrals and consequently workload, and that they are struggling to keep up with this pressure.

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[6] The total number of patients presents the unique individuals (counted using a unique patient identifier) who received NAMHS during 2017-18 and 2018-19. As many patients received services under more than one NAMHS program and / or HSP, the total number of patients at the HSP level is less than the sum of patients seen by funded program, and the total number of patients at the state level is less than the sum of patients seen by each HSP.

[7] Service Contacts are clinically significant services provided to clients by specialised Mental Health Services, where the nature of the service would normally warrant a dated entry in the clinical record of the client in question. Source: Department of Health. *Psychiatric Services Online Information System (PSOLIS) Service events User Guide v4.0*, 19 February 2019.

[8] Service Event describes the service activities or intervention(s) delivered during a service contact. Source: Department of Health. *Psychiatric Services Online Information System (PSOLIS) Service events User Guide v4.0*, 19 February 2019.

[9] While every Service Contact consists of one or more Service Events, there was a higher number of total number of Service Contacts than Service Events recorded during 2017-18. This was due to practices for recording group sessions (i.e. services involving more than one consumers), whereby each group session is recorded using a single Service Event identification number (which has been used by the Evaluation Team to count Service Events) but each consumer participant at the sessions is recorded as a separate Service Contact.

3.2. Effectiveness analysis

3.2.1. Capacity to respond to demand

The non-admitted mental health service providers consulted during the evaluation consistently reported that they are under significant pressure from increasing demand, a lack of alternative community treatment options, and a lack of discharge support options. This was an issue common to a wide range of services, but particularly impacted on the ATTs. Services are responding to this demand by prioritising early triage and assessment, but delaying access to care and providing this less frequently. The evaluation has been unable to fully substantiate the extent of this demand, noting it has not examined trends and has not had access to any demand assumptions that underpinned funding allocations. Nonetheless, there is some evidence of this growth in terms of rising patient and service contact numbers, particularly in catchments around Rockingham-Kwinana, Peel, Fremantle, Subiaco, Bentley and Armadale.

PSOLIS data shows a notable decrease in total service duration by almost 35,000 hours from 2017-18 to 2018-19. However, there is a possibility this is due to under-recording of service activity rather than a decrease in demand. HSP representatives indicated that often clinicians do not record the full extent of care delivered during a service contact[10], and hence the recorded service duration likely under-estimates the amount of care being provided. One service manager identified the functionality of PSOLIS as a barrier to accurate recording of service activity, describing the system as complicated, not intuitive, prone to errors and poorly integrated with other HSP information systems.

Service providers identified a range of additional issues impacting on service delivery, including funding limitations (and for some programs funding reductions), referral quality, increased workload relating to National Disability Insurance Scheme (NDIS) applications, and workforce vacancies (again more common concerns for outer metropolitan and regional services, but also many metropolitan services).

Workload relating to NDIS funding applications was an issue of particular concern reported by a large number of providers in both metropolitan and regional services. Mental health services are being asked to support consumers' NDIS funding applications through assessments and provision of paperwork. Multiple service providers and consumers across different settings identified examples of NDIS funding applications being refused by the NDIS Local Area Coordinator without explanation, requiring further work to clarify and revise relevant documentation as well as increased workload in providing case management and psychosocial services to consumers unable to access NDIS funding. Stakeholders also linked delays or inability to access NDIS funding to difficulties in securing NGO services as well as extended inpatient admissions due to a lack of community support and / or housing. For example, a senior leader at a major metropolitan mental health service estimated that each NDIS application is resulting in approximately 40 hours of work for their service.

[10] Examples of under-recording may include a failure to record all service types, all the time required for the activity, administrative activities and / or travel time. It is noted that under-recording of travel time is likely to particularly impact regional, outer metropolitan and metropolitan / state-wide services.

#	Recommendation
R.1	MHC, in consultation with the Department of Health and HSPs, to investigate the impacts of NDIS funding applications on non-admitted mental health services and identify strategies to respond to related workload, especially while the NDIS is implemented across WA.

Stakeholders reported that increasing consumer acuity and complexity is adding to workload, as more assistance is required and these consumers are less likely to be discharged to a non-government service provider. Reasons for complexity varied by locations; for example some stakeholders in outer metropolitan and regional areas noted that drug and alcohol use was an issue in their areas, while services at an inner city location treat a large number of refugees and migrants with trauma related mental illness. Several CAMHS services identified multi-generational trauma and attachment difficulties as common issues. WACHS stakeholders in regions with large Aboriginal populations also noted that support for many Aboriginal consumers was resource intensive due to the need for both culturally appropriate service responses and more intensive engagement efforts.

Metropolitan service providers were particularly concerned about the impacts of growing demand and referral quality on the ATTs. Given the important role of these programs as the gateway to other non-admitted mental health services, there is a need to review ATT demand, funding allocations and service models to ensure these services are able to respond to community need. It is recognised the ATTs perform an essential role in ensuring consumers receive timely access to care; however, there may be value in reviewing this service model (including operation of walk in clinics) to ensure its sustainability; if so, it will be important to consider the whole of system benefits ATTs provide.

Other considerations include demand management strategies and referral quality. Views amongst the HSPs about how to address referral quality varied, indicating that further investigation and localised responses are required. Examples of solutions suggested by the service providers included investment in GP liaison roles or community development officers, work to strengthen shared care models with NGOs that reflect varying risk appetites, and collocation of services. It is important to recognise that while there are no quick fixes, local engagement and relationships require ongoing attention.

#	Recommendation
R.2	HSPs, in consultation with the Department of Health and MHC, to identify strategies to improve referral quality, working with HSPs, NGOs and representatives of the primary health care sector. As noted by HSP representatives, these require local solutions aligned to the local service profile.
R.3	MHC, in consultation with the EMHS, NMHS, SMHS and Department of Health, to review demand, funding allocations and service models for Assessment and Treatment Teams to ensure these services are able to respond to community need and there is a consistent approach to funding ATTs across service locations. This should include consideration of the ATT objectives, demand, resourcing, eligibility criteria, service models and alternative treatment options, as well as their essential role in the wider mental health system.

3.2.2. Quality of care

Despite the increasing pressure on services, analysis of service activity, consumer outcomes data and quality indicators together with feedback from service managers, consumers and carers suggests

care is generally of high quality and services operated with structured and well established service models and procedures. Analysis of service duration data suggests also that activities such as post discharge follow up, assessment, consultation liaison, therapy, client education and advocacy reduced from 2017-18 to 2018-19 for many programs. Noting that funding and hence capacity was reduced for some programs, some HSPs suggested the decreases in service duration is also due to under-recording of activity. This indicates that ongoing attention to accurate data capture is important for demonstrating workload and demand.

Outcomes measurement and clinical review were described as routine practices, although the data reviewed indicates that these were not completed for all eligible patient episodes of care. Feedback from consumer and carer advisory groups as well as responses to YES[11] and ESQ survey show high levels of satisfaction for the majority of respondents, while compliments are received at higher rates than complaints and clinical incidents.

Consultations with the consumer and carer advisory groups supported the view that mental health services are generally of a high standard and provide a positive experience of care. In particular, the advisory groups consistently acknowledged that the majority of mental health service staff are doing their best to provide quality care. Nonetheless, the consumers and carers consulted identified a number of issues that are impacting on their experience of care, and several also identified isolated negative instances of care.

Many consumers spoke of extended waiting periods for services such as counselling, therapy and psycho-education services, and a sense of pressure and uncertainty relating to services' focus on discharge. This concern was exacerbated by the challenges in accessing NDIS funding experienced by some. Many of the groups also referenced frequent changes in treating staff and expressed frustration at the need to regularly "retell their story". Regional consumers in particular raised concerns about workforce turnover and vacancies, a reliance on telehealth services, a lack of transport options and a lack of mental health expertise among general health services.

Several stakeholders identified examples of poor communication by mental health services, such as attending appointments only to be told the clinician was unavailable, or not being notified of changes to their case manager or psychiatrist. Some consumers spoke of instances when poor communication between GPs and mental health services impacted on their care. One participant also flagged concerns about care plans, stating that in their experience they were not individualised and were not signed off by the consumer or their carer.

3.3. Efficiency analysis

From 2017-18 to 2018-19, core non-admitted mental health services funding increased by 1.2%, specific project funding increased by 3.1%, and total non-admitted mental health services funding increased by 1.3% (i.e. below the rate of inflation). This followed an increase in funding from 2016-17 to 2017-18 of 5.6% for core non-admitted mental health services, a decrease of 11.4% for specific projects, and an increase of 4.5% in total funding.

[11] Note: Caution is required in interpreting YES 'snapshot' survey results as the response rate was very low, with approximately 800 NAMHS consumers across WA completing the survey in 2018. See section 2.2.4 for further information.

In 2018-19, CAHS, NMHS, SMHS and WACHS received a net increase in total non-admitted mental health services funding[12] (1.7%, 0.7%, 0.2% and 4.2% respectively), while EMHS received a net decrease in funding (-0.5%).

The brief evaluation period limits the ability of this review to detect changes in service delivery costs, but does provide figures that can be used as a baseline for future measurement. Analysis of service delivery costs were complicated by differing approaches to the allocation of corporate overheads across the HSPs, meaning that comparison of service delivery costs between programs is not possible. It is further noted that CSAs also allow for up to 20% of a program funding allocation to be redirected to an alternative program without prior approval by the MHC. As program level expenditure reporting is not provided, it is important to recognise that actual expenditure may have differed from the allocated amounts. Finally, the current CSAs do not include a mechanism to capture expenditure in excess of the Special Purpose Accounts (SPAs). The MHC advised that some HSPs have identified this in previous reports; however a consistent approach to reporting expenditure in excess of the funding allocations has not been applied. The MHC has also advised it is investigating a potential mechanism to better capture the expenditure on public mental health services, but this was not in place during the evaluation period.

Service delivery costs, expressed in terms of costs per patient and per hour, vary by program and need to be considered in conjunction with factors such as service intensity, workforce profile, corporate, travel and infrastructure costs, and clinical efficacy. Further review or evaluation of high cost programs may be warranted, particularly where information about clinical efficacy, cost drivers and longer term cost-benefits is not available, or where service activity information is recorded in information systems other than PSOLIS. Relevant programs should be jointly identified by the MHC and HSPs.

#	Recommendation
R.4	MHC, in collaboration with the HSPs, to review high cost programs (where not already done) to establish a better understanding of clinical efficacy, long term costs benefits, cost drivers (including non-clinical costs) and potential service model, infrastructure or efficiency improvements.

3.4. Commissioning analysis

The evaluation has highlighted inconsistencies during 2017-18 and 2018-19 in relation to categorisation of programs under the Plan Streams and allocation of corporate costs. Addressing these will require ongoing collaboration between the MHC, HSPs and Department of Health.

The WA Mental Health, Alcohol and Other Drug Services Plan provides the overarching framework for the state's mental health system and defines the core Plan Streams. However, as noted, each HSP structures services differently and some programs were allocated to different Plan Streams in 2017-18 and 2018-19. There was a lack of clear distinction between Plan Streams such as Community Treatment Services, Community Support Services and Prevention and Promotion in particular, and there were around 50 funding allocations provided for various quality improvement initiatives under different streams, including Specific Projects, System Improvement and Support Change Services,

[12] i.e. Inclusive of core funding and specific project funding.

Targeted Purchasing and Corporate Costs. As some of these streams (e.g. Specific Projects and Targeted Purchasing) also funded the delivery of services, it has not been possible to make comparisons between the streams over the two financial years. There were also differing approaches to the funding and reporting of Corporate Costs across the HSPs and the two financial years.

Consistent use of the Plan Streams and allocation of funding to programs on the basis of the program type (as opposed to other funding characteristics or contractual conditions) will better enable the measurement of service performance. Likewise, adoption of a consistent approach to the allocation and reporting of corporate overheads across the five HSPs will improve transparency and measurement of these costs. This requires discussions between the MHC, Department of Health and HSPs to clarify the application of existing overhead policy, as specified in the CSAs and the WA Health Financial Management Manual.

The evaluation has encountered considerable difficulties in measuring both non-admitted mental health services activity and performance, needing to first determine the alignment of funding allocations to PSOLIS programs, and then calculate data indicators based on integration and / or interrogation of multiple datasets. HSP stakeholders have identified a range of differences in data recording practices as well as under-recording of care, which further complicates performance measurement. Service providers also consistently identified the PSOLIS clinical information system as challenging to use and inefficient, especially for services where staff were required to also enter data into other systems such as BOSSnet.[13] A key step to improving measurement is therefore improving compliance with the PSOLIS business rules released by the Department of Health during early February 2019.[14]

#	Recommendation
R.5	Department of Health, in collaboration with the HSPs, to strength strategies to improve accurate data recording and overall capacity to monitor demand and service activity. These may include further information and training to improve workforce awareness about the PSOLIS data business rules (including the PSOLIS Service Events User Guide), and increased compliance activities such as data auditing.

The HSPs were also consistent in calling for a better alignment of funding to the programs being commissioned and their level of demand, and a more collaborative approach to identifying priorities. While it is important to recognise the value of flexibility to respond to changing needs, this must be balanced with the need for accountability. It is recommended MHC and the HSPs adopt a defined suite of programs that can be made available to services[15], with:

- Common objectives, eligibility criteria and performance measures
- Flexibility in terms of where they are implemented and their resourcing
- Defined tolerances that provide flexibility to reallocate resources in response to changes in demand

[13] BOSSnet is a digital medical record (DMR) system implemented at a number of WA Health hospitals.

[14] Department of Health. *Psychiatric Services Online Information System (PSOLIS) Service Events User Guide v4.0*, 19 February 2019.

[15] The evaluation team notes that CAHS already have a consistent service model across its CAMHS clinics as well as defined models of care for its specialised programs.

- Key performance indicators.

The suite of programs could be aligned to the current service offering that includes assessment and treatment teams, community treatment teams, intensive / clinical outreach teams, therapy and wellness, older adult and youth programs. Further consultation with WACHS is required to consider suitability for regional services, given the workforce constraints faced by these communities.

#	Recommendation
R.6	MHC, in collaboration with the HSPs, to adopt a consistent framework and approach to allocating funding to the metropolitan HSPs that is better aligned to the type and structuring of non-admitted mental health services. The revised service structure should: a. Align to the Plan Streams used by the WA Mental Health, Alcohol and Other Drug Services Plan while also considering service structures within each Plan Stream b. Establish a suite of consistently defined programs with clear objectives, eligibility criteria, targets and performance measures that can be implemented according to local demand c. Ensure that quality improvement initiatives and corporate overheads are allocated using a consistent approach.
R.7	MHC, in collaboration with the HSPs, to ensure funding allocations are aligned to agreed service structures and demand, with transparency regarding demand assumptions, performance measures and the method used for determining funding.

Routine HSP performance indicators reported to the MHC cover service contacts, client numbers, service contacts per client and average HoNOS outcome scores and completion rates. This information, presented at the service level, provide a limited view of the performance of the non-admitted mental health services system, and do not provide a view of performance at the program level.

It is recognised that performance measurement needs to be practical, relatively easy to calculate and consistently available. The evaluation team considers that performance measurement at the program level is also desirable. Although this evaluation considered a wide range of data items and indicators, those considered by the evaluation team to best enable performance measurement have been:

- Number of consumers
- Number of service contacts
- Service duration (hours) – by total hours and service type[16]
- Proportion of clinical staff time spent on consumer related activities, with and without the consumer present[17]

[16] Although the evaluation team has identified potential inaccuracies relating to service duration, it is anticipated that ongoing monitoring of this metric as a KPI will increase attention on accurate data recording at the service level.

[17] Development of this indicator would require both program level FTE measures to be developed, definition of which client related activities (e.g. as recorded service event types) are considered 'productive', and definition of which client related activities require the consumer (and / or an associate) to be present.

- Average number of service contacts per consumer
- Average number of service hours per consumer – by total hours and service type
- Average cost per consumer
- Average cost per hour
- Care planning and clinical review completion rates (for eligible consumers)
- Referral outcomes and timing[18]
- Proportion of eligible consumer episodes of care with completed outcome measures
- Proportion of eligible consumer episodes of care with a significant improvement, no significant change, and significant deterioration between activation and deactivation.

As per Recommendation 6, work to establish a more consistent suite of programs would include establishing performance benchmarks, targets and measures. It could be expected that a more consistent suite of programs would results in program level performance monitoring becoming more feasible. In order to support improvements to performance monitoring, there would also be value in investing in a performance dashboard that enables KPIs to be viewed a different levels, such as the program, service, region, HSP and whole of mental health system; supports trend analysis; and supports objective comparison. Such a dashboard should be available to mental health services, as well as the HSPs, Department of Health and MHC.

Continued measurement of patient outcomes through tools such as the HoNOS suite and indicators of care quality (e.g. completion of clinical reviews and outcomes measurement, referral status, waiting times) is also desirable. While outcomes measurement can be useful at the program level, it is important to recognise that the HoNOS tools are not appropriate to all patient episodes of care or all programs, and there is a level of variation across services in how the requisite data is collected. Given differences in community demographics as well as service types, availability and access, HSP to HSP comparisons are not meaningful, and hence the value of the measures at the system level is primarily limited to measuring completion of outcome measures, and changes in actual outcomes over time.

In order to improve the value of patient outcome measurement as a system KPI, there would be value in a body of work to:

- Assess the suite of outcomes tools used across the non-admitted mental health service programs, giving consideration to identify programs are appropriate for system level outcomes measurement, and which outcomes tools are appropriate for system level monitoring of outcomes
- Establish and promote clear business rules for outcomes measurement and record keeping
- Establish appropriate targets and define tolerances.

[18] A number of issues impacting on the accuracy and reliability of referral data were identified during the evaluation. These are discussed in detailed in the evaluation final report. Work underway by the Department of Health to address referral data quality will need to be completed before this information can be used for performance measurement.

Outcomes indicators may be considered for more in-depth reviews, such as future system-level evaluations – particularly if improvements in data capture enable more reliable performance measurements. In this regard, the data collected for this evaluation has value in establishing benchmarks for future reference.

It is also recommended that financial acquittal reporting includes a mechanism for actual expenditure so that an accurate understanding of service delivery costs can be obtained. The MHC has indicated that it is investigating a potential mechanism to enable this to occur.[19]

#	Recommendation
R.8	MHC, in collaboration with the Department of Health and HSPs, to establish a set of key performance indicators that use existing systems to provide program, service, region, HSP and system level data to support performance monitoring and reporting. This should be aligned to the revised suite of mental health service programs, and involve the setting of performance benchmarks, targets and measures. It should also align with the work undertaken in the Sustainable Health Review and the mandatory Safety and Quality and National Benchmarks. Development of a performance dashboard available to mental health services, HSPs, the Department of Health and the MHC would support ongoing performance monitoring efforts.

[19] MHC email correspondence, May 2020.

Abbreviations

Abbreviation	Full term
ATT	Assessment and Treatment Team
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CSA	Commission Service Agreement
CTT	Community Treatment Team
EMHS	East Metropolitan Health Service
ESC	Evaluation Steering Committee
ESQ	Experience of Service Questionnaire
GP	General practitioner
HoNOS	Health of the Nation Outcome Scales (HoNOS)
HSP	Health Service Provider
MHC	Mental Health Commission
NAMHS	Non-admitted mental health services
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NMHS	North Metropolitan Health Service
NOCC	National Outcomes Casemix Collection
PSOLIS	Psychiatric Services On Line Information System
SMHS	South Metropolitan Health Service
WA	Western Australia
WACHS	WA Country Health Service
YES	Your Experience of Service

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