TO	Healthy Communities Advisory Committee and Quality and Excellence Advisory Committee
FROM	Portfolio Manager Mental Health & Addictions and Service Director Mental Health and Addictions Clinical Services
DATE	15 March 2017
SUBJECT	**Joint Report Mental Health and Addictions & Annual Plan 2016/17 Update**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report is for information only. No decision is required.

2. SUMMARY

This report marks a further transition from reporting on detailed implementation of the external review of the mental health and addiction clinical services, to a focus on substantive goals and strategic imperatives that support transformational change across the district to implement our new Strategy.

During the reporting period, the mental health and addictions sector has accomplished many initiatives under the auspices of the Annual Plan focus areas, the Suicide Prevention Action Plan, and the Rising to the Challenge Plan. These initiatives have come via the Mental Health and Addictions District Group, the NGO Leadership Group and the specialist Mental Health Executive team. Achievements have included:

- the establishment of a single point of entry service for offenders requiring alcohol and drug assessments with Department of Corrections
- a 'fit for purpose' service configuration in Integrated Family Health Centres and promulgated across the sector
- a project that focused on service users whom have children
- co-designed the Suicide Prevention Action Plan (now reported separately to the Ministry of Health)
- a district wide evaluation of generic services being responsive to Māori, with feedback provided to Non-government Organisation (NGO) managers and governance boards
- a strengthened participation of service users has been achieved.

Education and training workshops have occurred across the mental health and non-mental health sector as part of the Suicide Prevention Action Plan, increasing awareness for those that work with people/youth in work places, school settings, education and social services. Education and training sessions have been held on managing challenging behaviour, understanding mental illness, working with families, hearing voices and Lesbian, Gay, Bisexual,

Transgender and Queer. Additionally, a scoping report has been completed with Youth One Stop Shop on the cyber-bullying of young people. A stock take and analysis of options for youth programmes for Māori has been completed and will inform the development of a youth friendly primary care model.

The acute inpatient unit has maintained significant gains in managing effective throughput and has managed within capped capacity. Reportedly all families of consumers are engaged through a range of mechanisms throughout the consumer's stay in the Ward.

A new model of care has been implemented across the district for clients with acute crisis; the service is now 24 hours a day, seven days a week. There are now regular liaison meetings with Police, the Director of Area Mental Health Services and other relevant stakeholders. An audit system and process has been established with the service wide rollout due in March 2017. Performance is being monitored and reported internally and nationally.

Help-seeking information for suicide prevention has been disseminated via social media, workshops, training programmes, seminars and forums. Examples of this include a mental health presentation for Kiwi Lumber staff, a memorial ceremony bringing together people to remember those lost to suicide and a seminar for funeral homes across the district on the provision of support for bereavement involving suicide.

The specialist Mental Health and Addictions service has implemented most of the recommendations arising from the external review. Remaining tasks continue as part of the wider transformational change project. The Dashboard report continues to map progress against targets and indicators for specialist mental health and addiction services. Notably there have been occasional peak demands within the Inpatient unit, and there are two clients with over a 12 month length of stay. Compliance has been reached for the Inpatient Unit for the Health of the Nation Outcome Scale (HONOS) and work is underway as part of the National Key Performance Indicators (KPI) Project, particularly to address reaching the target areas KPI 18 Pre-admission community care and KPI 19 Post discharge community care.

The specialist mental health and addictions services have led the development of several project work streams across the sector and held several stakeholder hui since mid-last year. Additionally, the Acute Care Team now manages all referrals and crises for services based in Palmerston North, Feilding, and Oranga Hinengaro. A consult and liaison hospital service has been established with a full time Clinical Nurse Specialist in place from January 2017.

There has been a delay to the implementation of a district-wide model of care for mental health specialist services for older persons due to changes in personnel and resources. The new model has been agreed upon and new referral pathways to match the model are in progress.

Improvement towards the equity of access and timeliness for all population groups through the increased capacity of mental health services (greater than 80 percent of non-urgent referrals are seen within 3 weeks and greater than 95 percent of non-urgent referrals are seen within 8 weeks) has been challenging to achieve this quarter. Data integrity issues have been discovered and work is underway to resolve them.

It is acknowledged that further system wide change is fundamental to make service provision more consistent and improve outcomes both for people who use primary, community and specialist services and for their families and whanau. The approach towards improving outcomes will need to be constructed as part of the service integration model of approach to commissioning services and planning.

Consideration will be given to the networks, project groups and various work plans within the context of supporting system level transformation, including the development of sharing data across the system to improve outcomes.

Attached to this report are details of progress against the various programmed activities:

Appendix 1 details initiatives in relation to Focus Areas 3, 4 and 5 of the Annual Plan 2016/2017

Appendix 2 details the specialist service dashboards

Appendix 3 provides specialist project work stream updates.

3. RECOMMENDATION

It is recommended:

That this report be received.

4. INTRODUCTION

This is the second report undertaken jointly by the Portfolio Manager and Service Director Mental Health and Addictions to the joint meeting of the Quality and Excellence and Healthy Communities committees.

The first report (November 2016) introduced the Ministry of Health's recently established Commissioning Framework. It is expected to underpin the next National plan for mental health and addictions and will also form the basis of our commissioning approach locally. The Commissioning Framework broadens planning for mental health and addiction services by including wider health determinants, such as access to housing and support from inter-sector agencies as key factors affecting health outcomes.

5. BACKGROUND

The primary focus of the national Rising to the Challenge Service Development Plan for mental health and addictions (2012-2017) is to assist health services across the spectrum, from health promotion through primary care and other general health services to specialist mental health and addiction services, to collectively take action to achieve four overarching goals and align to the vision that-*'whatever our age, gender or culture, when we need support to improve our mental health and addiction, we will be able to rapidly access the interventions we need from a range of effective, well-integrated services'.*

Currently there are a number of mental health and addictions advisory groups, project and reference groups aligned to the Rising to the Challenge Plan. They have been producing outputs and outcomes towards the vision and key goal areas of this Plan. We have been reporting our progress in implementing the 94 initiatives of the Plan through to the Ministry of Health. As the Rising to the Challenge Plan comes to the end of its intended term in 2017, it is timely that we acknowledge what has been achieved and the contribution made by our community partners.

The Ministry has indicated that Rising to the Challenge will be refreshed in some way, so we can anticipate that further planning will be required in the future.

5.1 Integrated Health Service System

The Portfolio Manager, the Service Director and the Clinical Director have been working together for the last five months as part of the organisational wide development of integrated service models. We have collaboratively worked on what this might look like in the mental health and addictions sector and who it might be implemented. Essentially it is proposed that the integrated system leadership team will be accountable for designing a framework of approach and ultimately leading the implementation across the mental health and addictions continuum of care.

The leadership team will have overall accountability for the commissioning process which will in turn be used to establish and support integrated and system-wide service delivery, supported by effective engagement with key stakeholders and partners.

The integrated approach to service planning design and delivery will create an investment approach that sets the direction for mental health and addiction service delivery across the health sector over the next five years.

We will need to ensure the MidCentral Strategy and its strategic imperatives are clearly articulated. Expectations about the changes needed to build on and enhance the gains made in the delivery of mental health and addiction services in recent years. We are focussed on continuing to work with our community and intersectoral colleagues from Police, Community Probation Services, Special Education Service, Ministry of Education, Child Youth and Family to support better health outcomes and health care for all.

Further system-wide change is necessary to make service provision more consistent and to improve outcomes both for people who use primary, community and specialist services and for their families and whanau. The approach to improving outcomes will be constructed as part of the service integration model and its approach to commissioning services and planning. It will be based on needs of the population.

6. STRATEGIC INTIATIVES UPDATES

6.1 Introduction

Strategic initiatives are reported on for local settings and goals, including the update of the external review implementation. The Mental Health and Addictions external review recommendations have all been implemented and some of these have been lifted to more high level goals as part of the on-going work plan in specialist services. An update of the Annual Plan initiatives is reported on (Appendix 1).

In future we will shift to align all the local initiatives more directly to the MidCentral Strategy and its strategic imperatives. This involves a significant planning task to identify what projects have been completed, to align ongoing projects, and to rationalise activity that may have some duplication. As an example the Hui work stream projects which have created more effective and immediate change, will be incorporated into on-going business. This is also true of some projects on quality activity, which will move from review based action plans to systematic auditing of change.

6.1.1 Connect Transform Primary, Community and Specialist Care

i. District Group Clinical Network Mental Health and Addictions

The Clinical Network work plan (2013-2017) is based on the Rising to the Challenge Plan and the District Group has lead and implemented many projects. An example is the establishment of services in response to need such as the single point of entry service for Community Probation Service offenders requiring alcohol and drug assessments. Other examples are a project group that commissioned a ‘fit for purpose service configurations in Integrated Family Health Centres discussion paper, a district gap analysis report on mental health and addiction service users who have children, developed the Suicide Prevention Postvention Action Plan (now reported separately to the Ministry of Health), a district wide evaluation of service

provision for Māori people and feedback provided to services, strengthened participation and leadership of service users, increased access for children and youth- increased coordination and investment in program delivery, project group established to enhance responsiveness and flexibility of specialist mental health services for older people.

ii. 'One Team' Collaborative network

The specialist clinical services take a strong clinical leadership role in the sector supporting the delivery of a comprehensive range of specialist clinical care and effective management of clinical risk in partnership with other community providers and intersectoral partners. In order to achieve the goals of more integrated approaches to care, the Executive has led the development of a provider collaborative network which continues to grow the ability of provider organisations to work together. Strengthening primary mental health and addictions care is a part of this collaborative approach and improvements in this part of the system will deliver better service access and treatment efficacy in the primary care sector as well as offer improved system integration.

Inaugural collaborative network forums have been held and the provider forum will continue the work of connecting up services in order to further strengthen the delivery system across our district. The collaborative network improves the capacity of providers to work together and as this ability to work together improves, it will create system wide capacity to implement planning which emerges from the integrated service model.

6.2.1 Achieve Quality and Excellence by Design

i. Transformational Change

The NGO Connected Workforce Leadership group was established in 2012 subsequent to MDHB commencing the implementation of a competency framework across all mental health and addictions NGOs and their workforce. The leadership group is to implement the recent On Track Co-Creating a Mental Health and Addiction System framework (Te Pou 2016) and workforce development plan.

The On Track framework is intended to serve as a road map for all mental health and addiction NGO Primary providers, as they work to achieve transformation. On Track is a framework of transformation actions, to address the wide range of challenges that are facing the mental health and addictions system. MidCentral NGOs are in a good position to lead this reform, based on their unique position in the community and existing relationships with other non-health community based services.

The leadership group is undertaking a strategic planning day next month to formulate a work plan 2017-2020 based on the On Track framework 'translating theory into action'. The framework essentially covers seven action areas:

1. **Support self-determination**- *build co-production into the commissioning framework*
2. **Focus on system redesign**-*system leaders enable all current professional groups working in MHA NGOs to work to full scope of practice*
3. **Improve workforce capability**- *NGOs evaluate current service provision and*

workforce skill mix with a view to better matching needs of underserved population

4. **Address investment and sustainability issues**- *NGOs widen their organizational horizon and invest in tomorrow through use of organisational self-assessment processes, strategic alliances*
5. **Enhance community engagement**- *system leaders support the development of shared vision and shared interest in good community outcomes and joint accountabilities*
6. **Use the evidence**- *NGOs benchmark their performance against agreed performance measures and take action to make improvements*
7. **Strengthen organizational infrastructure**- *NGOs foster the development of adaptive leadership skills throughout the organization. NGOs facilitate the uptake of technologies that enhance workforce practice and productivity.*

From a planning perspective, the work plan that is developed by this Group will be joined up across the other work programs and our Strategic Framework.

ii. Specialist Services Mental Health Executive Leadership

The specialist Mental Health and Addictions service has implemented most recommendations arising from the external review. Long term external review recommendations continue and implementation is part of a transformational change project.

The Mental Health Executive leadership team is tasked with this transformational change and in order to achieve this level of organisational change, the Executive works in an integrated co-design model, which includes the Clinical Director, Director Area Mental Health Services, kaumatua, Consumer Advisor, Family/Whanau Advisor, Allied Health and Nurse Director. This approach to executive leadership is very consistent with the proposed organisational integrated service model.

The remaining long term external review recommendations are focused on four core goals; Cultural Change, the Development of Models of Care
('One Team' approach/Integrated Service Development/rural focus) and Improved Infrastructure (facility development and financial viability). These are further outlined below:

Cultural Change - To change culture and improve specialist quality of service delivery, has been undertaken using a co-design approach to service and workforce development. Key achievements are completion of the 'let's get real' training, implementation of clinical governance across the service and implementation of the quality and risk framework.

'**One Team' Approach**-To develop a district wide provider collaborative, uniting all providers and stakeholders in one network in order to increase capacity to deliver and better coordinate services. Key achievements include the completion of two Hui, plans for a final third Hui, and the establishment of a collaborative network.

Models of Service- To further develop improved mental health and addiction models of service provision. Key achievements are the implementation of the Acute Care Team model of care, continued implementation of a focus on locality based planning for rural service delivery with

growth in rural teams, development of an older person's district wide service and focus on the development plan for Oranga Hinengaro kaupapa Māori Mental Health service.

Infrastructural Improvement- Include transport issues, Information Technology and facilities for example the Mental Health Inpatient Ward 21 re-design/rebuild project. Key achievements include the contracting of an external consultant to progress the development of a business case proposal for the Ward 21 re-design project. An initial briefing meeting was held in February 2017 and the Executive team is working towards the WebPas system implementation by August 2017.

Clinical and Financial sustainability- To achieve clinical and financially sustainable specialist District Health Board services. Annual planning is underway and planning to meet required sustainability in the 2018 budget year. Refer to Appendix 2 for the update report on specialist services Quality and Risk Dashboards.

External review
A workshop has been completed and further updated following the review visit from Dr Gloria Johnson last month. Dr Johnson again reinforced that the specialist services is moving solidly in the right direction, noting strong supportive observations at the workshop to the Quality Excellence Advisory Committee.

Dr Johnson made some recommendations about both reporting and actions to be taken. Amongst these was a recommendation to trend the caseload measurement of key workers in the community mental health teams, as well as the National Key Performance Indicators (PP18, PP19), which measure the time people are seen prior to and after inpatient admissions. Dr Johnson reinforced the need to progress plans for a new inpatient unit, and further work to connect community providers and stakeholders.

<u>External Review Action Plan Update:</u>

Consumer feedback
The 'Real Time Feedback' project implements electronic systems for consumer and family. Whanau feedback is underway and envisaged to be implemented in the second half of 2017.

Family/Whanau input
The Hume family continue to participate in the quality development as family representatives in the mental health and addictions Quality team. The detailed action plan has reached a point where more than eighty percent of the recommendations have been implemented. The recommendations from the action plan regarding referral management, assessment and formulation, treatment and interventions, have all been subject to a standardisation process which has improved these elements across all services. The focus on Student referrals and ensuring area of origin contact has been implemented.

The development of flexible models of care is now at a point of completion with full implementation of the acute care team model. Collaborative note writing, which is implemented through education and training is underway lead by the consumer and family advisor. All elements of the action plan are subject to implementation audits to be completed by the Quality team, which are made available to the Hume family.

6.3.1 Partner with People and Whanau to Support Health and Wellbeing

i. Mental Health and Addictions service Hui

The specialist mental health and addictions services have led the development of collaborative project workstreams agreed at a community provider, stakeholder and intersectoral Hui in April and in July 2016 projects agreed were to be completed and these have been underway since that date. Each group has a project brief, coordinating chair, and participation from a wide range of service and intersectoral agencies. The Hui work streams reported on progress in a November 2016 (Appendix 3). A final Hui is planned for May 2017, where providers will report back on completed developmental work across the district. The Hui workstreams include involvement by all intersectoral agencies and services.

The work involved is supported by the specialist services project team, whom also engage with services to promote family/whanau involvement, peer support and work with organisations such as Enable New Zealand to address issues related to disability and mental health.

6.4.1 Achieve Equity of Outcomes across Communities

i. Models of Care- Kaupapa Māori Service

The Māori Mental Health service development includes support to adopt a proposed leadership model based on the concept of Te Pae o Amorangi, within Oranga Hinengaro kaupapa Māori Mental Health Service. The strengthened leadership model in the Māori Mental Health service will also include the development of a broad partnership approach to all specialist mental health and addiction teams. The aim of this approach is to ensure culturally appropriate provision of care in working with Māori is achieved across all specialist care services, whilst retaining the capacity to deliver a kaupapa Māori programme of care.

Māori Mental Health service manager, kaumatua, Service Director, Clinical Director and Portfolio Manager are developing a model of care that provides a more effective integration of cultural and clinical components of care within the Service, Oranga Hinengaro. One aim of this development is to ensure strengthened relationships between the Māori Mental Health team and other kaupapa Maori NGO and iwi providers in our district, which will further assist with rural services development. The next step in this development is to hold further discussion involving Pae Ora and the Kaumatua Council.

ii. Older Adult Service

The Executive leadership team continues to implement a project to develop a comprehensive and integrated community-oriented older person's mental health and addiction service. This project has been expanded to include input from intersectoral, Aged Residential Care providers and Needs Assessment and Service Coordination Services. The expanded service will address inequities of access for older persons across our district related to lack of development in this part of our service. This planning includes specifically identifying the needs of Māori and developing improved plans to meet this need. Steering group meetings have been held in January and February 2017. Current activity includes completing an agreed vision, timeline, mapping a care pathway, with a second Psychogeratrician commencing May 2017.

iii. Acute Care Team (Mental Health Crisis)

This team continues to recruit to a full complement of staff. The Acute Care Team now manages all referrals and crises for services based in Palmerston North, including Palmerston North community team, Feilding, and Oranga Hinengaro. A consult and Liaison Hospital service has been established with a full time Clinical Nurse Specialist in place from January 2017.

This initiative reduces inequity of access and support to a full range of services from hospital based patients. The Acute Care team is also considering how improvements in culturally appropriate service delivery may be developed, and currently manage a joint referral triage process with Oranga Hinengaro for Māori referred to the service and follow up of crisis calls.

7. CONCLUSION

This report notes the final period of the previous five years of the national mental health strategic plan, Rising to the Challenge, and anticipates a move towards the Ministry of Health's commissioning framework for mental health and addictions, which has a welcome broader focus and will bring into scope the wider health determinants.

This change in the sector coincides with an organisational shift to an integrated service system structure which will match and support this approach to care planning and delivery. The report has also outlined the substantial move in the clinical specialist care towards integration with strategy, planning and performance and implementation of a more outward view into our community to deliver a connected approach to care.

The realisation of the vision towards integrated service system model requires a commitment to the transformation of the mental health and addiction sector over a long period of time, led by sector leaders and thinkers.

The development of the mental health and addiction service development for better health outcomes must now take place at a time of scarcer resources, increasing numbers of service users with complex mental illness and/or addiction and social issues. The complexity of this landscape means that our approach to understanding the population needs, must move away from traditional approaches and seek to construct different ways of obtaining information to develop mental health and addiction service becoming more malleable and transformative.

With this in mind, planning is required to identify next steps to encompass the Commissioning Approach, consolidating work plans, networks and projects, operationalising the DHB Strategy and working as an integrated service system model.

Appendix 1: Annual Plan 2016/2017 Mental Health and Addictions

FOCUS AREA 3: IMPROVING CRISIS RESPONSE SERVICES- ACUTE MENTAL HEALTH AND ADDICTION SERVICES					
Objective: Reduce unacceptably high occupancy levels and lengths of stay in acute inpatient unit					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Inpatient unit redesign project implementation commenced from October 2016	**G**	**G**			Project commenced with a contracted external consultant working on the better business case model proposal, following presentation to the board committees of the initial options paper. Estimated progress report to the Board committee in April with draft Business Case ready in June 2017.
Occupancy rate <100% of purchased acute bed days	**G**	**G**			The acute inpatient unit has maintained significant gains in managing effective throughput and has managed within capped capacity, with less than half a dozen short exceptional periods (weekends) for the past 12 months.
LOS for outliers <3/12	**G**	**G**			There are three consumers who due to their complex presenting issues have been in the Acute Inpatient Ward for more than 3 months. We have been working to find long term alternative solutions to ensure their transition is sustainable.
≥80% consumers discharged with family input to transfer of care plans	**G**	**G**			All families of consumers are engaged via a range of ways throughout the consumers stay in the inpatient Ward unless there are circumstances that negate this occurring.
≥95% consumers discharged from acute unit seen by community mental health service within 7 days of discharge	**A**	**A**			While we have not attained the 95% target we are achieving monthly incremental improvements. Processes implemented to ensure consumers being discharged from the Inpatient Ward are leaving with an appointment within 7 days-with their allocated Keyworker. Also collections of outliers to implement future strategies to ensure all consumers are followed through.
Objective: Improve access to consistent, coordinated services for assessment and follow up of clients in crisis and provide a better response to consumers presenting with acute need					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Review implementation progress and results end of October 2016	**G**	**G**			There are regular liaison meetings with Police, Director of Area Mental Health Services and other relevant stakeholders. Focus is persons of joint interest, joint plans and common approaches to care. However the focus of these meetings has predominately been clients who are under the Mental Health Act. Investigating data of all Police referrals to inform and broaden these liaison meetings. Preliminary discussions occurred with Police for data sharing to effectively identify known clients that will shape subsequent actions. As a learning exercise Police have placed a role for one shift on the Acute Care Team after hour's roster.
Increase proportion of Police referrals responded to with a direct contact by Acute Care Team within 3 hours of referral	**A**	**A**			Establishing data collection system to capture Acute team's response to Police referrals in real time. Previously did not have the ability to collect time of referral therefore not able to calculate actual response times. Instigated a change process in the last Quarter to rectify this and from January 2017 we will be able to capture relevant data for analysis and reporting for Q3 and 4.
Number of complaints received from referrers (including self-referred consumers) regarding inability to access acute team	**G**	**G**			There were no complaints specific to inability to access the Acute team this quarter and previous quarter.

within expected timeframes (no target)					
Objective: Implement district-wide model of care for mental health specialist services for older persons					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Agreed model and referral pathways in place by 30 October 2016	**A**	**A**			Delays in the project due to changes in personnel and resource. The new model has been agreed upon and new referral pathways to match the model are still in progress.
District-wide service implemented by 31 December 2016	**A**	**A**			Engagement occurred more widely than anticipated to create a more comprehensive model which has resulted in a delay, also compounded by the variables noted above. Implementation is now time lined for late 2017.
All admissions to STAR1 meet criteria for admission to inpatient specialist mental health service for older people	**G**	**G**			This piece of work has been completed.
Objective: **Improve equity of access and timeliness of service response for all population groups across the district through increased capacity of community based mental health services**					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Updated model of care implemented by February 2017	**G**	**G**			A new model of care has being implemented across the district for the response to acute crisis 24 hours a day seven days a week.
≥80% non-urgent referrals are seen within 3 weeks (all ages and all ethnicities)	**A**	**A**			Collation of data to report on the timeframes of referrals across all services. However data integrity issues have been discovered that are working to be resolved.
≥95% non-urgent referrals are seen within 8 weeks (all ages and all ethnicities)	**A**	**A**			
Percentage of the total population (all ages) seen by 30 June 2017 Māori >5% Non Māori >3% Total >3.8%	**G**	**G**			Total percentage of population for the 12 months ending the 30 Sept 2016 is slightly above the target due to the increased acuity and number of referrals into services Māori 5.87% Non Māori 3.69% Total 4.12%
Objective: Clients receive improved safe delivery of treatment options for opioid addiction per standard guidelines					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Analysis and review of service agreements completed by 31 July 2016		**G**			The external mental health review requirements were fully implemented by 31 July 2016. A follow up audit of the OST programme was completed in May 2016. All recommendations arising from this audit were implemented.
≤3% variance in contracted volume of clients (primary, secondary and shared care)	**G**	**G**			The established primary care purchased volume is 64 and current actual is 90. The services are in discussion with the PHO to better balance specialist and GP OST placements. The current specialist OST placement purchased volume is 260 and current actual is 325. The programme is oversubscribed by 65 clients. There is a plan in place with the lead clinical staff including consultant psychiatrist to reduce the OST volume to within contracted levels.
Recommendations implemented from 1 September 2016 (subject to any priority corrective action dates)	**G**	**G**			All recommendations of the external audit are implemented.

Objective: Support staff to better engage with consumers and family as valued partners in service delivery and service development opportunities across Mental Health services					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Workforce programme commenced by 1 October 2016	**G**	**G**			75% staff trained in 'Let's Get Real' Mental Health and Addictions values & attitudes workshops completed.
Consumer feedback surveys in place by 31 August 2016	**G**	**G**			Ministry of Health survey completed with results published. There was an improvement in our patient experience. Implementing the 'Marama Real Time' feedback process- go live date May 2017. Provide consumers and their family/whanau ability to give feedback at the time of their appointments.
Three surveys completed by 31 December 2016	**G**	**G**			Surveys completed. Forums across the region for service users and their family/whanau occurred. The numbers attending the forums were low but the level and quality of feedback was rich in information.
Objective: Reduce the number of Māori receiving mental health care under a Compulsory Treatment Order (CTO) Mental Health Act relative to non-Māori population					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Rate of Māori people per 100,000 population receiving treatment under a compulsory treatment order relative to non-Māori and New Zealand rates (No target). Baseline: 12 months to 30 September 2015 Māori / Non Māori New Zealand 294 / 100 MidCentral 143 (n.48) / 67 (n.93)	**G**	**G**			Despite our rates for both Maori and Non Maori showing an increase from the 30 Sept 2015 baseline we are still below the national baseline rate. MidCentral / Māori / Non Māori Q1 212 / 81 Q2 212 / 91 Work has been initiated by Pae Ora in conjunction with the DAMHS (Director of Area Mental Health Services) office and Oranga Hinengaro to examine the contributors to the disparity between our Māori and Non Māori population's rate for receiving treatment under a Compulsory Treatment Order.
Objective: Improve quality of care delivery system, reduce risks and enhance the consumer's experience of care					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Clinical governance arrangements fully implemented by August 2016	**G**	**G**			Clinical Governance arrangements have been fully implemented.
Performance monitoring and compliance auditing system and processes established across all services by October 2016	**A**	**A**			Audit system and process has been established with the service wide rollout due March 2017. Performance is being monitored and reported on internally and nationally.

FOCUS AREA 4: IMPROVE OUTCOMES FOR CHILDREN- RESPONSIVE CHILD, ADOLESCENT AND FAMILY MENTAL HEALTH AND ADDICTION SERVICES					
Objective: Increase options for young people with mild to moderate mental health and/or addiction issues to attend early intervention programmes (focused on specific age groups within the cohort) • **Maori youth programmes**					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Youth programme response framework for early intervention agreed and implemented by February 2017	—	**A**			While there has been some small delay around the holiday period, a framework is in development. Project Group yet to finalise framework for presentation to the sector. Exception report provided.
Stock take and analysis of options for kaupapa Māori youth	—	**G**			On track. Currently in correspondence with National Maori training provider Te Korowai Aroha. Stocktake

programmes completed by February 2017		G			of available programmes in district underway.
Increased number of individuals (from 2016 base) engaging in early intervention programmes from April 2017 (no target)	—	G			On track. Stocktake of youth participation in programmes to create baseline information underway.
Objective: Improve follow up in primary care of youth (aged 12-19 years) discharged from secondary mental health and addiction services through better transfer of care arrangements from CAMHS and Oranga Hinengaro • **Discharge planning audit** • **Process to monitor receipt and uptake of referrals (and care plans) to primary care providers**					
≥95% young people (0-19 years) discharged from the community Child and Adolescent Mental Health and Addictions Service have a transition (discharge) plan	A	A			Data indicates 78.76% of young people (0-19 years) were discharged from CAMHS with a transition (discharge) plan. Working through further analysis to determine contributory factors for not achieving the required 95% target of clients being discharged with a transition (discharge) plan along with actions to remedy.
≥90% of discharged clients from CAMHS are seen for follow up by primary health care practitioner within 3 weeks of referral	A	A			Currently there is no agreed report back mechanism with to collect data to ascertain clients are being followed up within 3 weeks of being discharged from CAMHS.
Objective: Reduce waiting times for young people referred to specialist child and adolescent mental health and addiction services • **Remove barriers to completing first specialist assessments on time using outcomes from review of CAPA** • **Multidisciplinary team intake reviews and ongoing caseload monitoring process**					
≥3.8% of population (0-19 yrs) seen on average per year	G	G			The total population (0-19yrs) seen for this quarter was 4.51% due to a steady rise in referrals throughout the year.
≥80% non-urgent referrals (0 – 19 year old) are seen within 3 weeks	G	G			Achieved 71.1% that is within 10% of the cumulative total target of 80% of 0-19 years olds seen within 3 weeks.
≥95% non-urgent referrals (0 – 19 year old) are seen within 8 weeks	G	G			Achieved 93.6% that is within 10% of the cumulative total target of 95% within 8 weeks for non-urgent mental health and addiction services.
Urgent (non-crisis) referrals are seen within 72 days	G	G			96.3% of clients were seen within 72 days. However there is no way from the data provided by the Ministry of Health to differentiate between urgent (non crisis) and non-urgent.

FOCUS AREA 5: INTEGRATED MENTAL HEALTH AND ADDICTION SERVICES					
Objective: Improve outcomes for offenders engaged with Alcohol and Other Drug (AOD) Services through the Community Probation Service					
Performance measures and milestones	**Progress status**				**Results and exception report**
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	
Agreed common outcomes for offenders identified by September 2016		G			On track. KPIs developed between health and Corrections and yet to be confirmed by MOH, as KPI development has now become national project.
% of total clients seen over the year by addictions service providers who were re-referred by CPS with alcohol/addiction related re-offending	—	G			41 repeat referrals. The total referrals processed were 106, meaning that 38% of referrals for this quarter had previously been through the Single Point of Entry system. Difficult to get an accurate account of whether those who have been listed have reoffended, or simply been re-referred. Currently no code or process in place for re-offenders coming through the Probation system. Offender details are kept in a spread sheet which is regularly updated with each month's referrals.
Protocols for sharing information across Department of Corrections and DHB developed by December 2016	—	G			Completed. Shared pathway for information sharing developed.

First reports available for review from July 2017	—	—			
Objective: Increase support for children of parents with mental illness and/or addiction (Supporting parents, healthy children)					
Performance measures and milestones	**Progress status Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Results and exception report**
Complete survey and report of results by 30 September 2016	—	G			Completed.
Commence roll out of toolkit resource pack from 01 October 2016 Number of referrals received by NGO Supporting Families Manawatu for children of parents with a mental illness reported 6 monthly	—	A			Behind planned milestone. Secondary representation now on project group and discussion across care continuum occurring on implementation of toolkit. On track.
Objective: Ensure local and regional capacity to respond to potential requirements from the new Substance Addiction (Compulsory Assessment and Treatment) Bill ‡					
Performance measures and milestones	**Progress status Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Results and exception report**
Subject to regional decisions, commence from October 2016		A			Awaiting regional portfolio manager to develop central regions approach, in alignment with Alcohol & Drug Regional Residential services review.
Two local sector workshops for AOD teams completed by August 2016		G			Completed.
Objective: Maintain an accessible and cost effective primary health care service for people with a long term mental illness through redesign of the Shared Care Programme					
Performance measures and milestones	**Progress status Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Results and exception report**
Proportion of service users under the Shared Care Program who have a Comprehensive Health Assessment Review (including physical health status) Completed	—	D			Yet to occur. Primary Mental Health Project Manager recruited in December and will work with secondary services and combined project group on model design.
≥50% of service users on Shared Care Programme are reviewed at least three monthly by a designated clinician	—	D			Yet to occur.
Objective: Consider requirements to support the shift to an outcome focused approach					
Performance measures and milestones	**Progress status Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Results and exception report**
Undertake educational workshop with the NGO primary care providers, by September 2016	—	G			Completed. Workshop with Ministry of Business Innovation & Employment undertaken.

Progress Status Legend:	**G**	Objectives/actions, performance measures and milestones all on track, progressing as planned
	A	Behind planned milestones or performance measures off track; there are minor risks/issues associated with achieving objectives and/or performance measures but there is a satisfactory remedial action plan in place to return to plan (exception report required outlining remedial action)
	R	Behind planned milestones or performance measures off track and there are major risks/issues associated with achieving objectives and performance measures (exception report required outlining risk mitigations, remedial action and revised timeframe/scope or milestone)
	D	Not completed as planned – approved closure or deferral with alternate scope/milestones

Appendix 2: Specialist MHA service Project Updates

ITEM	STATUS UPDATE
HUI III	Planned for May 2017 at the Manawatu Golf Club. This Hui will be the final forum to report back on completed workstreams.
One Team Approach	The 'One Team' network has been established, using a co design process with consumer advisor. Representatives are in place from all sectors and mental health and addictions providers, and stakeholders. The group have met twice. A mapping document which records all linked services and including funded resources for all providers is underway. The mapping process creates a level playing field amongst all providers by making all information commonly available. A competition has commenced for a name and network logo. This group has very good momentum.
Primary Care Mental Health & Addictions Model	Project group established with Central PHO committing dedicated Project Manager resource partnering with specialist services project team. A Model of Care has been developed 'Te Ara Rau' that proposes bringing all of primary mental health and addictions under a single service delivery model. The supporting operational detail to still be determined. Data sharing pathways being developed. The Ministry of Health recently circulated a definitive paper on models of care which is closely aligned to the proposed model.
Older Persons MHS	The project team has met, confirmed a vision, key goals and is supporting current progress with the OAMHS service and team.
Housing & Recovery	The group last met in 2016, with further progress awaiting outcomes from other work streams.
Whanau Ora	Seminar series on Whanau Ora. Ted Talks style series has been completed.
Data Matching	This project has found that there are significant data matching challenges which require are scoping of the focus of this project. At present data sharing is occurring with police and justice. It is hoped that data sharing with primary care and NGO providers will follow.
Police Custody	Proposal from the working group to support a roll-out in MidCentral of the Canterbury region work is accepted and a plan is agreed with police addressing the wait times for urgent assessment in police cells and working group activity with police has produced a significantly improved relationship with police. Data is being produced to measure the success of this project through monitoring police contacts and assessments.
Prison Release	This group is about to re group for 2017. Most work has been completed.
Employment & Vocational	Working group developing resource pack and considering the implications for providing the information in an electronic application. This work stream is completed
Tertiary Education	Working group meeting regularly. Initial discussions have focused on understanding what is already in place, what resources have been developed that could be shared and be applicable for other institutions. Some Workforce development opportunities e.g. education to teaching staff on signs/symptoms and first responses Needs update. Next meeting is scheduled March 2017.

Appendix 3: Mental Health and Addiction Specialist Services Quality and Risk Dashboards

Mental Health and Addiction Secondary Specialist Services Quality and Risk Dashboard Summary

January 2017

Mid Central District Health Board Area Population Map

The MCDHB responsibility is for the populations in a defined geographic catchment. The defined area is based on territorial authority and ward boundaries, and includes Manawatu, Tararua, Horowhenua, Kapiti districts (Otaki Ward) and Palmerston North City. The map of the district is below.

Four Iwi have manawhenua status within the district: Muaupoko; Ngati Raukawa; Ngati Kahungunu and Rangitaane (manawhenua status means that the Iwi is recognised as having tribal authority within a region)
Muaupoko and Ngati Raukawa Iwi are located on the western side of the mountain ranges, and Ngati Kahungunu Iwi is located on the eastern side. Rangitaane Iwi covers both sides of the ranges for the Manawatu district (including Palmerston North) across to Pahiatua and Dannevirke areas. The groups of people who experience health status disadvantage in Mid Central are Maori, Pacific peoples, and people experiencing socio economic disadvantage. Horowhenua residents are highly representative of people who experience health status disadvantage.

Break down of DHB District by Population and area

	P.N City	Manawatu	Tararua	Horowhenua	Otaki
Total Population	**81231**	**27156**	**16635**	**29787**	**5745**
Male	38979	13434	8136	14118	2598
Female	42249	13722	8499	15669	3147
<15yrs old	19.7%	21.2%	21.9%	19.4%	20.8%
>65yrs old	13.3%	15.8%	17.2%	23.6%	25.1%
Maori	**12546**	**3924**	**3378**	**6486**	**1803**
Male	6183	1923	1581	3045	813
Female	6363	2001	1797	3441	990
<15yrs old	34.6%	35.3%	35.5%	35.0%	34.6%
>65yrs old	3.8%	4.8%	5.2%	6.7%	7.8%

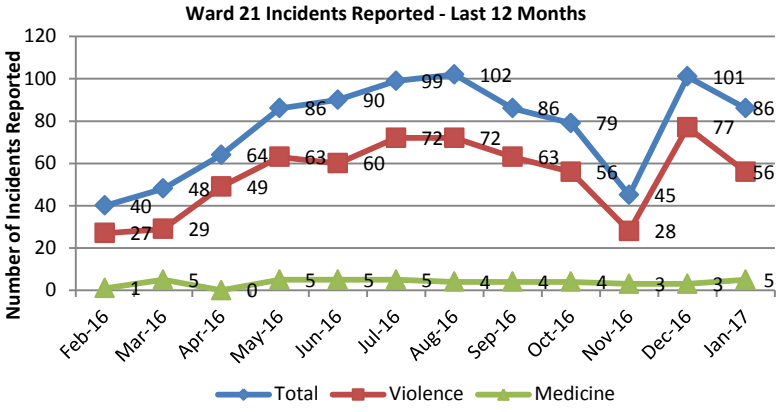
**Data Source 2013 Cen*

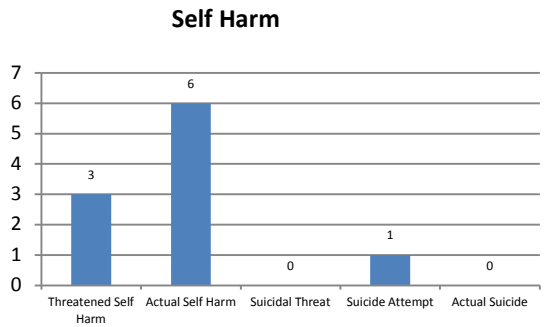
Risk and Incident Summary for January 2017 – MHAS Service-wide

Complaints and Compliments	From previous months	Opened this month	Closed same month	Others closed this month	Carried to next month	
Direct	1	3	0	3	1	-
HDC Open	2	0	0	0	2	-
HDC awaiting feedback for closure	2	0	0	0	2	-
Compliments	0	1				↑
Queries	1	2	2	1	0	↓
MHAS SAERG	**Last Month**	**This month**				
SAC1	0	0				-
SAC2	1	2				↑
SAC3 (These are included as part of the total incidents ward 21 for example self-harm, violence, medication categories)	45	49				↑
Total	46	51				↑

Quality & Risk –
Complaints for the service are managed within acceptable timeframes and managed through the leadership group. The Serious Adverse Event Review Group (SAERG) continues to monitor and address systems/processes for continuous improvement. A slight increase in SAC 3 incidents were reported for Ward 21, the top groupings related to conduct and behaviour/violence (56 incidents).

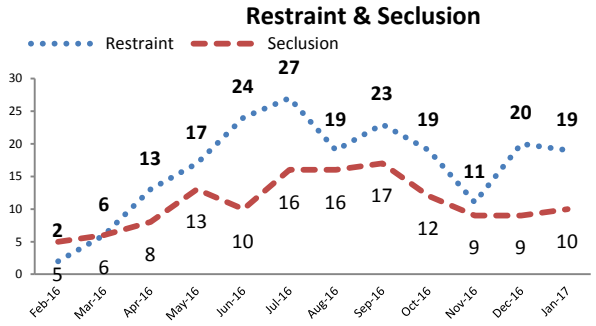
Ward 21 Risk and Incident Graphs:



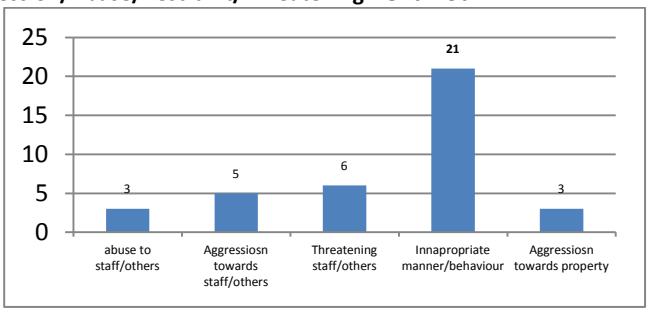


Ward 21 Total Incidents – Includes SAC4
Total incidents for Ward 21 was 86, this has reduced slightly from the previous month. The majority of events are related to incidents such as violence and inappropriate manner towards staff and others, damage to property, contraband such as weapons and cannabis found on the ward, smoking on ward. Six Occupational Health and Safety incidents were reported, due

to assaults on staff members, and a needle stick injury. Four incidents were reported for patient falls within the High Needs Unit (HNU). There is a reduction in self harm and suicidal behaviour but the report still highlights the level of demand and risk management in Ward 21 during this month.



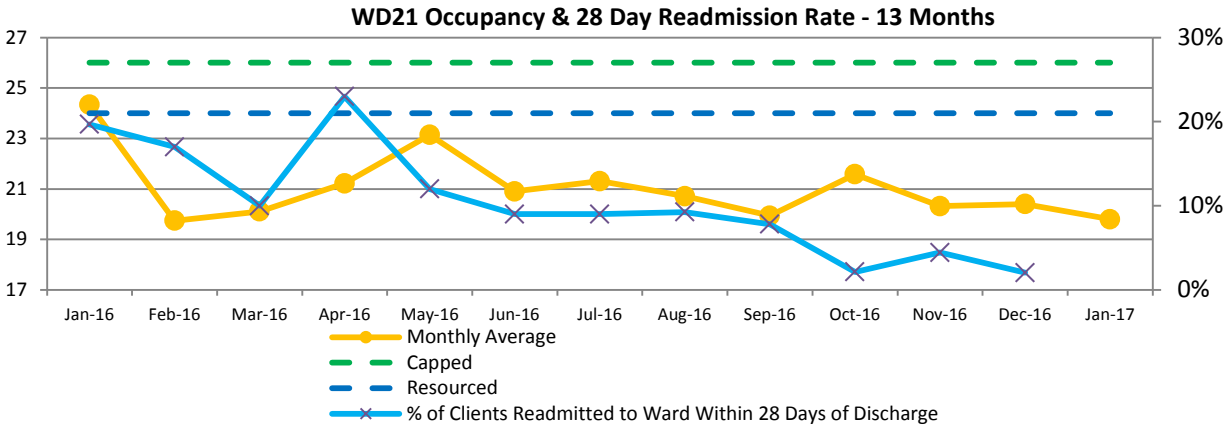
Aggression/Abuse/Restraint/Threatening Behaviour

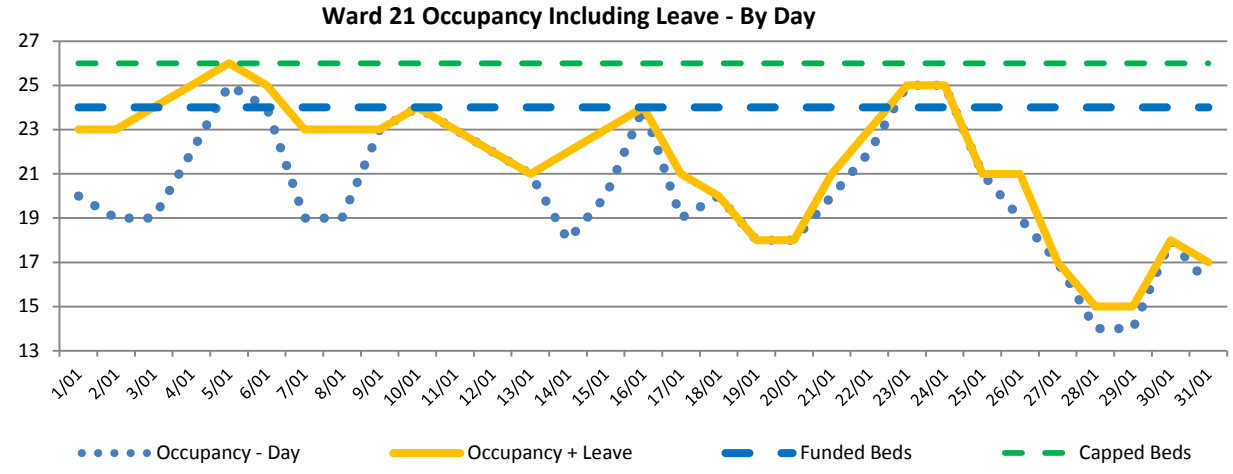


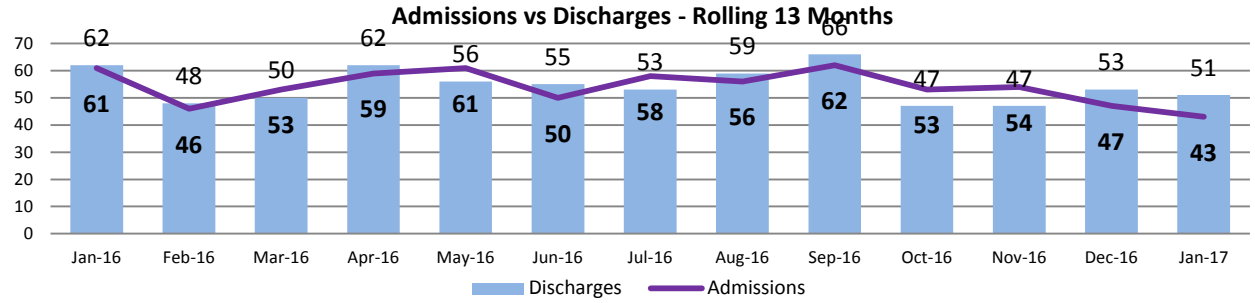
Actual Self Harm/ threatened Self Harm/Suicide/Threatened suicide & Restraint/Seclusion

Seclusion numbers have remained down from the Mid-Year point. Four seclusion events occurred following assault on staff and the remainder involved significant verbal threats towards staff. Seclusion events were for seven individuals. Restraint events are related to administration of medication, self-harm events (6) threats of self-harm (3) and 1 attempted suicide. One person was responsible for 10 of 19 events.

Ward 21





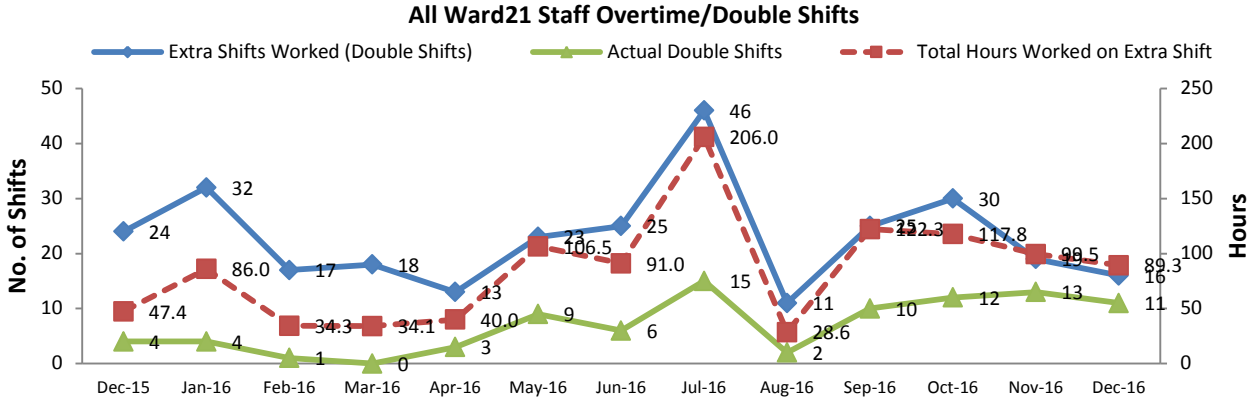


Narrative

Discharges are lower than is desirable with some individuals remaining on the ward longer than necessary due to lack of availability of accommodation options, within both MHAS NGO providers and the wider community. This contributes to the disparity between admission and discharge rate. Note the high occupancy level late January and remaining high admission rate for this population. The high occupancy rate, challenges in finding appropriate placement for individuals (two patients with over a one year LOS) contribute to the level of aggression and incidents in January.

Ward 21 Staffing

Regrettably, double shift data was not available for January 2017

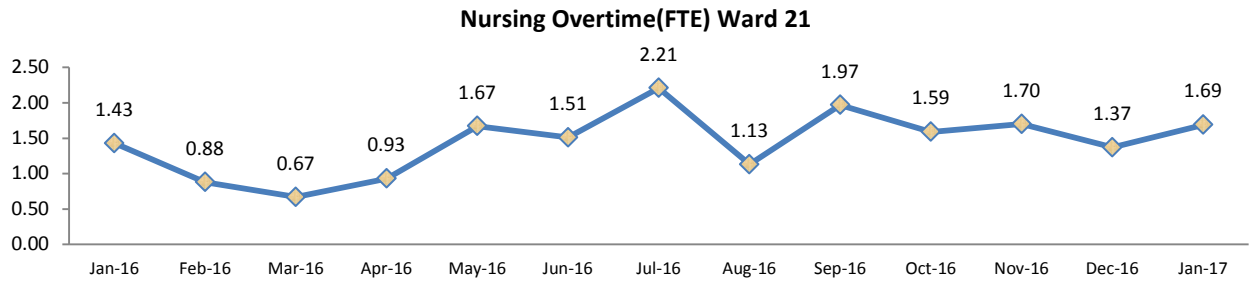


Extra Shifts are any shift precluding or concluding a normal shift. The graphed line is the number of shifts, not total hours

Total Hours worked on Extra Shift

Shifts >= 15 hours are shifts where the total hours (first shift + second shift) are greater than 15 hours

The above graph includes all Ward21 staff, where the graph below only includes nursing staff.



Resourcing

January overtime related to cover for Safe Practice Effective Communication (SPEC) training & out of area escorts to Hawkes Bay, Wellington, and Hamilton. There was no capacity to roster casual staff for unplanned (sick) leave. High levels of hospital sick leave reduced Bureau access.

Mental Health Scorecard

Mental Health KPI (National Benchmarking)	Monthly	Target	Change
KPI 2: 28 day acute inpatient readmission rate (for December)*	2.04%	0-10%	↓
KPI 8: Average length of acute inpatient stay (days)	12.8	14-21 days	↑
KPI 18: Pre-admission community care (Seen in 7 days before ward admission)	55.0%	75-100%	↑
KPI 19: Post-discharge community care (Seen in 7 days following ward discharge)	67.0%	90-100%	↓
KPI 33: Percentage of contact time with client participation	84.1%	80-90%	↑
KPI 34: Community service-user-related time	Not avail	35-40%	---
% Current clients in a service for more than 90 days with no diagnosis‡	7.0%	0%	↑
% HoNOS/CA/65+ Compliant Admissions and Discharges - Community Teams (excl. A&OD)	52.0%	80%	↑
% HoNOS/CA/65+ Compliant Admissions and Discharges - Inpatient Team	82.0%	80%	↑

* 28-day readmission rate is for the previous month to allow the full 28 days to pass. ‡ "No diagnosis" includes DSM-IV 7999 ("deferred diagnosis"), DSM-IV V7109 ("no diagnosis") and no diagnosis entered at all. FTE information was not available for January 2017, therefore KPI 34 could not be calculated

Warning signs (Alerts) are defined by the Ministry of Health as follows:

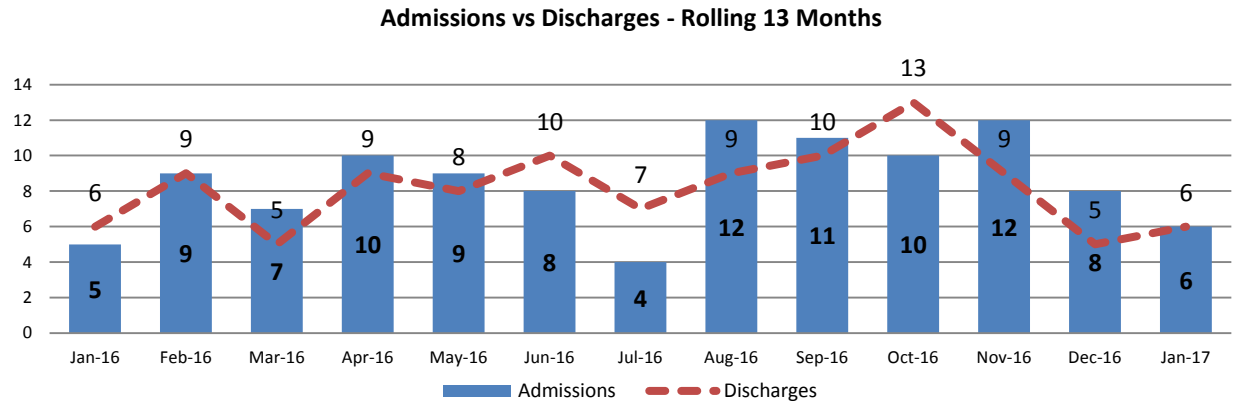
- 28-Day Readmission Rate (KPI 2) exceeds 20%
- Average Length of Acute Inpatient Stay (KPI 8) exceeds 30 days
- Percentage of Contact Time with Client Participation (KPI 33) exceeds 90%
- Pre-admission Community Care (KPI 18) is less than 50%
- Post-discharge Community Care (KPI 19) is less than 80%

Source: *Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services (2015)*

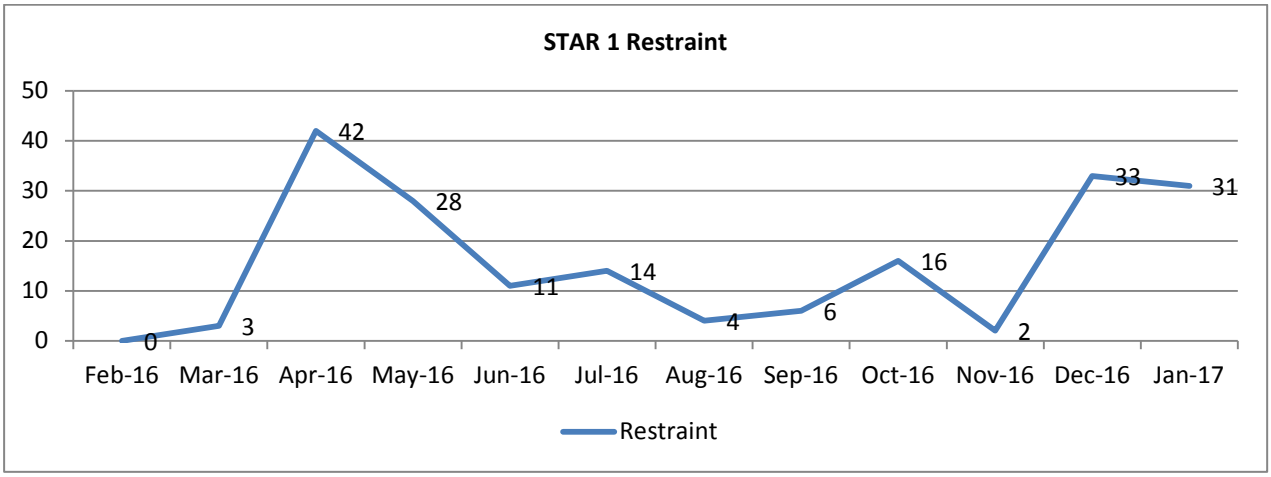
Narrative

KPIs 18 and 19 are still subject to review and analysis to improve performance. It should be acknowledged that the MHAS sits nationally in the middle range of achievement with these KPIs. Some factors include transfers to other services, not attending arranged appointments and reporting rules. (Clients seen on the same day as discharge not counted) A system to improve confirmation is being established. Note the continued very good performance on readmission rate, which is an indication of some effectiveness in follow up even if not meeting KPI goals.

STAR1 Older Adult Inpatient unit 15 beds



STAR1 admissions and discharges



Restraint

Personal restraint remains reasonably unchanged in the unit on the basis of heightened levels of aggression towards staff during provision of personal cares with 2-3 patients with an advanced dementia and for who have an inability to process what is happening around them. We are continuing to investigate our strategies for restraint minimisation which includes the purchasing of more sensory modulation tools and potential for setting up a sensory modulation room. There are five patients on Star One awaiting processing applications under the PPPR act and for Enduring Power of Attorney in order to place them appropriately in rest home care.

Community Mental Health Teams

- Mental Health & Addiction Services (MHAS) Acute Care Team (ACT)
- Palmerston North Community Mental Health Team(Includes Maternal Mental Health)
- Feilding Community Mental Health Team (Manawatu District)
- Tararua Community Mental Health Team – Dannevirke
- Pahiatua Community Mental Health Team
- Horowhenua Community Mental Health Team
- Older Adult Specialist Community Mental Health Team
- Oranga Hinengaro (Māori Mental Health Team)
- Alcohol and Drug Service
- Opioid Substitution Treatment (OST) Team
- Early Intervention Team
- Intensive Treatment and Rehabilitation Team
- Child Adolescent and Family Community Mental Health

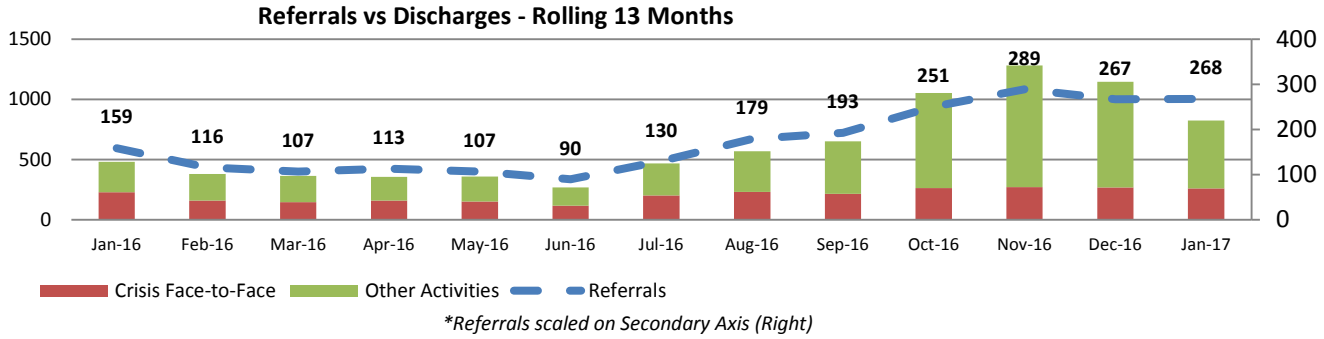
Overview

Each Community Team listed below has its own section including: Active Episodes of Care (as at the last day of the reporting month), Referral vs. Discharges and Average Length of stay (ALOS), and a breakdown of current client age ranges. Also included is population data for each area.
The Mental Health Emergency Team page shows Crisis Face-to-Face attendances, Other Activities and Referrals. Warning signs are indicated as planned in the recent HAC workshop. The community teams current 'warning signs' are defined as referral volume variance over 20%. In the inpatient unit the warning sign is defined as sustained over-utilization, over 105% occupancy > two days. **Due to lack of FTE data for January 2017, *all* following FTEs are those for December 2016.**

Mental Health & Addiction Services Acute Care Team

Area	Population				
Palmerston North City	80,079	**Total Population**	162,561	**Target Population**	All
Horowhenua Region	38,172				
Tararua Region	16,854				
Manawatu District	27,456				
Total Clinical FTE:	16.78	**Opened Episodes this month:**	267		
Productive Clinical FTE:	15.02				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Episodes	39	70	151	7	267
% of Total Episodes	14.6%	26.2%	56.6%	2.6%	



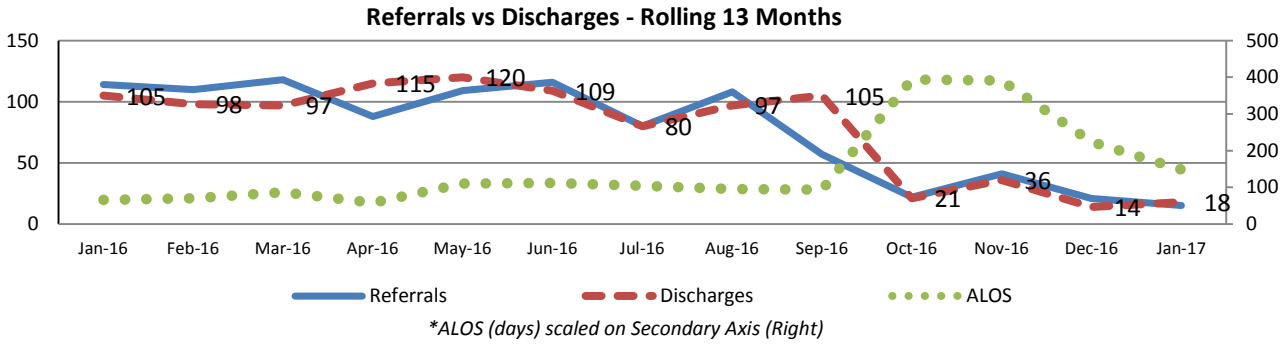
Narrative

ACT Managed referral pathways and procedure continue to be refined for PN, Feilding and Oranga Hinengaro. The referral rate is being benchmarked with other jurisdictions as it has remained high for this area. Over 90% of referrals are generated from primary care, which is similar across the country but Initial comparisons appear to reflect up to a 30% + variance in referral rate. Our current review indicates that some factors may be related to 1) a higher rate of referrals misdirected to specialist care, 2) lack of earlier access to service e.g. primary care.

Palmerston North Community Mental Health Team

Area	Population				
Palmerston North City	80,079	**Total Population**	80,079	**Target Population**	All
Total Clinical FTE:	22.55	**Active Episodes of Care:**	417		
Productive Clinical FTE:	20.50				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	2	50	329	36	417
% of Current Clients	.5%	12.0%	78.9%	8.6%	



ALOS (days) scaled on Secondary Axis (Right)

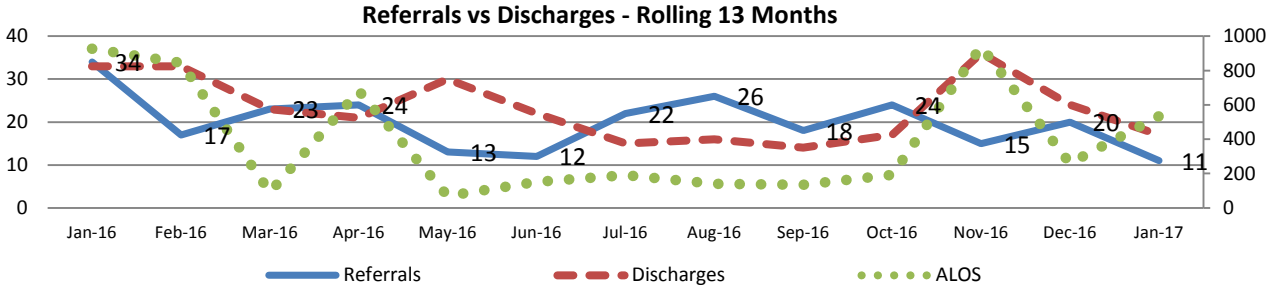
Narrative

Referrals and discharges are consistent with the lower level of December and the ALOS is continuing to trend down. However the referral rate remains high. The graphed referrals require updating to better reflect the number of clients taken up by the Palmerston North team, as the current internal reports of total referrals is reported through the Acute Care team, which in the new model triages all referrals.

Feilding Community Mental Health Team (Manawatu District)

Area	Population				
Manawatu District	27,456	**Total Population**	27,456	**Target Population**	All
Total Clinical FTE:	4.06			**Active Episodes of Care:**	74
Productive Clinical FTE:	3.78				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	3	9	56	6	74
% of Current Clients	4.1%	12.2%	75.7%	8.1%	



ALOS (days) scaled on Secondary Axis (Right)

Narrative

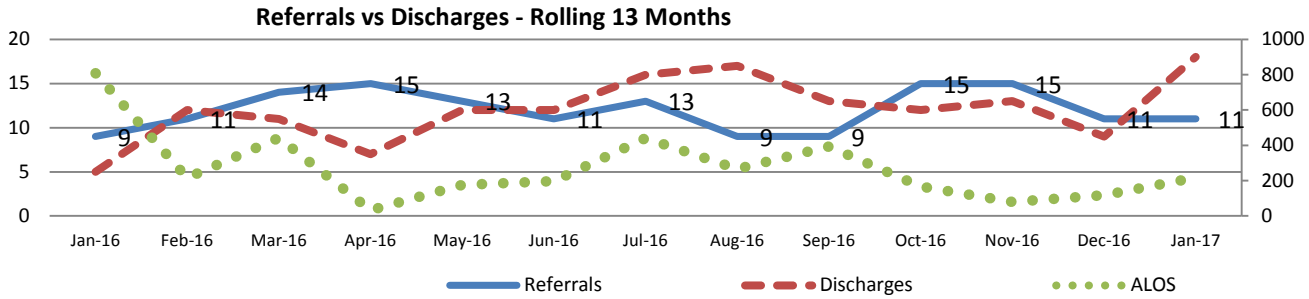
Referrals and discharges follow a similar trajectory down for the month of January however the average length of stay has increased due to a reduction in discharges as a result of complexity of clinical presentation.

Dannevirke Community Mental Health Team

Area	Population				
Dannevirke	5,043	**Total Population**	9,525	**Target Population**	All
Rural Areas*	4,482				
Total Clinical FTE:	3.83			**Active Episodes of Care:**	97
Productive Clinical FTE:	U/A				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	1	14	78	4	97
% of Current Clients	1.0%	14.4%	80.4%	4.1%	

** "Rural Areas" include Norsewood and Papatawa.*



**ALOS (days) scaled on Secondary Axis (Right)*

Narrative

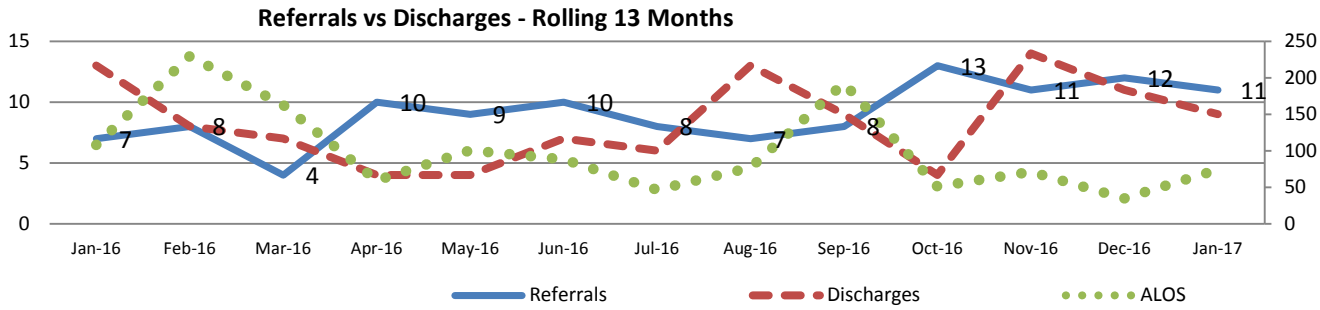
Referrals reduced in December and January over the Christmas break. Discharges for Tararua increased over this period, this was a key priority area for the Psychiatrist prior to his departure and the commencement of a new psychiatrist.

Pahiatua Community Mental Health Team

Area	Population				
Pahiatua*	4,251	**Total Population**	7,332	**Target Population**	All
Rural Areas*	3,081				
Total Clinical FTE:	4.00			**Active Episodes of Care:**	48
Productive Clinical FTE:	U/A				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	0	8	39	1	48
% of Current Clients	.0%	16.7%	81.3%	2.1%	

**Pahiatua includes Woodville & Eketahuna. "Rural Areas" include Mangatainoka and Tiraumea*



**ALOS (days) scaled on Secondary Axis (Right)*

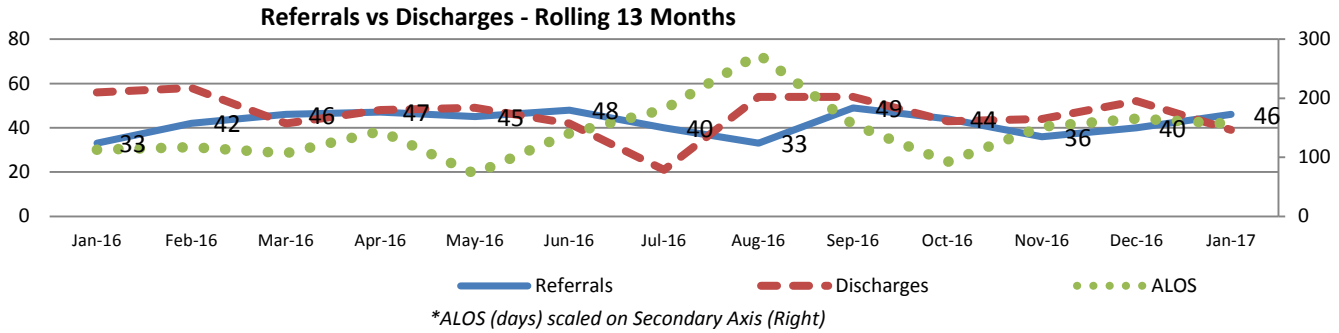
Narrative

In Pahiatau the work remains constant but capacity was reduced through staff leaves, and support provided from Palmerston North, and the inpatient unit to cover.

Horowhenua Community Mental Health Team

Area	Population				
Horowhenua	30,096	**Total Population**	38,172	**Target Population**	All
Otaki Ward	8,076				
Total Clinical FTE:	13.48			**Active Episodes of Care:**	220
Productive Clinical FTE:	11.93				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	2	22	182	14	220
% of Current Clients	.9%	10.0%	82.7%	6.4%	



**ALOS (days) scaled on Secondary Axis (Right)*

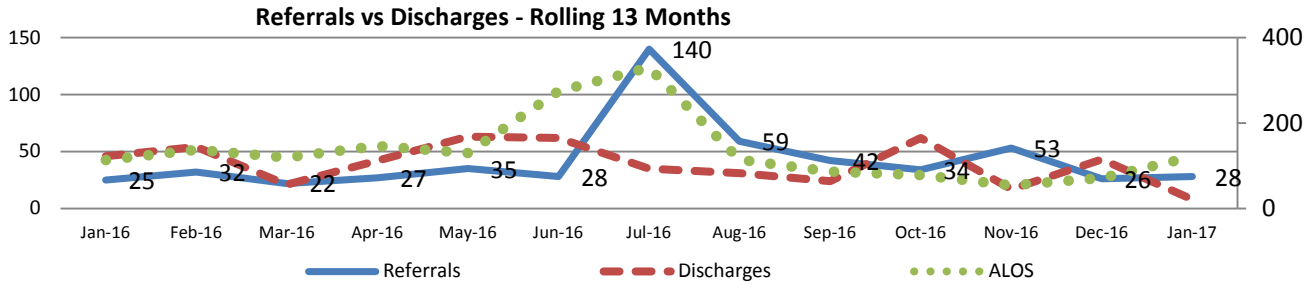
Narrative

The referrals remain constant at two per day and are being assessed and managed in a timely manner by the duty team. Discharges are also consistently maintained due to an effective MDT process.

Older Adult Specialist Community Mental Health Team

Area	Population				
Palmerston North City	10,611	**Total Population**	26,886	**Target Population**	65+ years
Horowhenua Region	9,072				
Tararua Region	2,871				
Manawatu District	4,332				
Total Clinical FTE:	3.70			**Active Episodes of Care:**	187
Productive Clinical FTE:	3.70				

Age Bracket	<65 years	65+ years			Total
Current Clients		187			187
% of Current Clients		100%			



**ALOS (days) scaled on Secondary Axis (Right)*

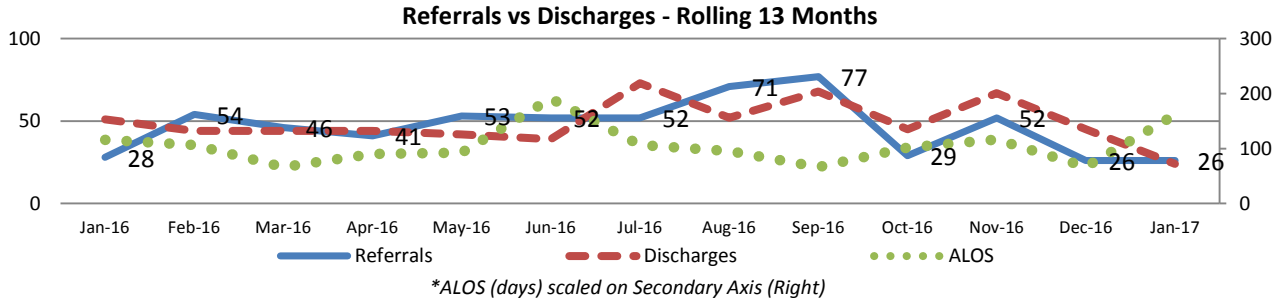
Narrative

Referrals remain similar to December with minimum discharges. The ALOS is still slowly trending up.

Oranga Hinengaro (Māori Mental Health Team)

Area	Population				
Palmerston North City	15,942	Total Population	34,107	Target Population	Māori and Pasifika
Horowhenua Region	10,194				
Tararua Region	3,627				
Manawatu District	4,344				
Total Clinical FTE:	12.00	Active Episodes of Care:	183		
Productive Clinical FTE:	9.79				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	45	25	110	3	183
% of Current Clients	24.6%	13.7%	60.1%	1.6%	



ALOS (days) scaled on Secondary Axis (Right)

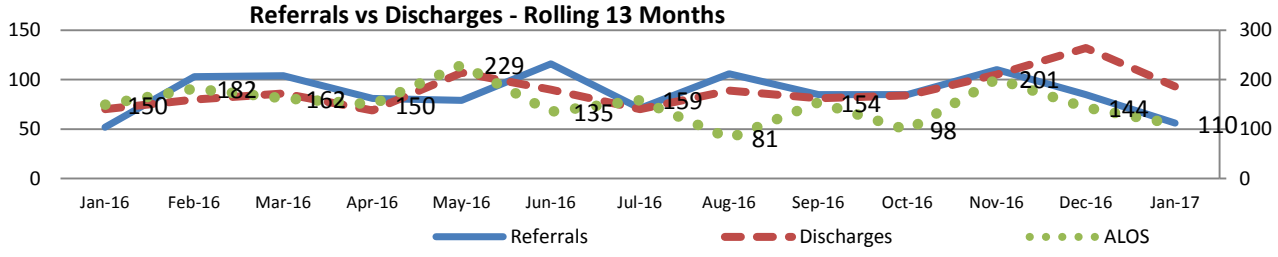
Narrative

Referrals have plateaued which is in part reflective of the new referral pathway commenced in December. The average length of stay has increased due to holding a number of cases longer for increased monitoring.

Child Adolescent & Family Community Mental Health Team

Area	Population				
Palmerston North City	20,961	Total Population	42,252	Target Population	<19 years
Horowhenua Region	9,279				
Tararua Region	4,599				
Manawatu District	7,413				
Total Clinical FTE:	25.07	Active Episodes of Care:	398		
Productive Clinical FTE:	22.14				

Age Bracket	<19 years	19-24 years			Total
Current Clients	396	2			398
% of Current Clients	99.5%	.5%			



ALOS (days) scaled on Secondary Axis (Right)

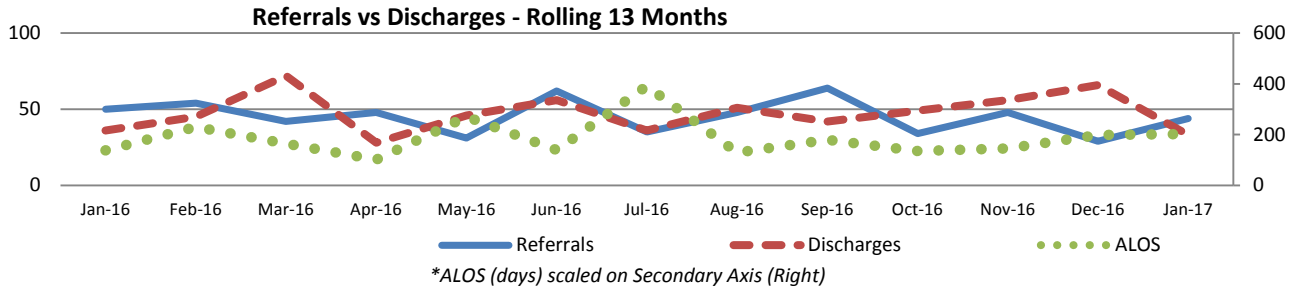
Narrative

January is always a quieter time for CAFS with referrals reducing due to families focusing on holidays, schools being closed and usual referrers to the service not open during January. The service is currently managing referrals within requirements, despite ongoing high demand. The CAFs service is supporting the Oranga Hinengaro key workers with oversight in Horowhenua, and better and more refined allocation of resource (dedicated key worker time in Horowhenua) to need (referrals and ongoing need for consistent key worker input).

Alcohol and Other Drug Service

Area	Population				
Palmerston North City	80,079	**Total Population**	162,561	**Target Population**	All
Horowhenua Region	38,172				
Tararua Region	16,854				
Manawatu District	27,456				
Total Clinical FTE:	12.31			**Active Episodes of Care:**	270
Productive Clinical FTE:	U/A				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	2	19	242	7	270
% of Current Clients	.7%	7.0%	89.6%	2.6%	



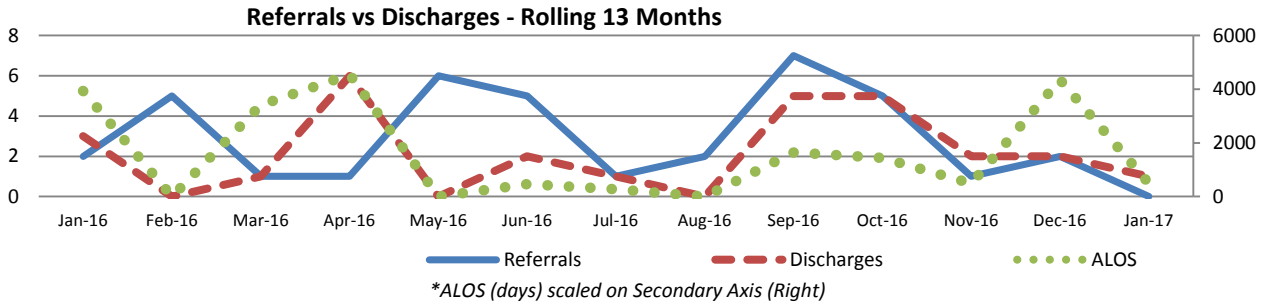
Narrative

We have recently separated out the data for AoD and OST. The total number of episodes for General AOD is inconsistent, and we are refining the data collections and reporting to rectify this. The cause of the data inconsistency appears to be that the cohort of GP authorised OST clients has been included in this data set rather than in the following OST graph. Methamphetamine and Alcohol continue to be the substances involved in presenting high need.

Opioid Substitution Treatment (OST) Team

Area	Population				
Palmerston North City	80,079	**Total Population**	162,561	**Target Population**	All
Horowhenua Region	38,172				
Tararua Region	16,854				
Manawatu District	27,456				
Total Clinical FTE:	8.00			**Active Episodes of Care:**	334
Productive Clinical FTE:	U/A				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	0	6	325	3	334
% of Current Clients	.0%	1.8%	97.3%	.9%	



**ALOS (days) scaled on Secondary Axis (Right)*

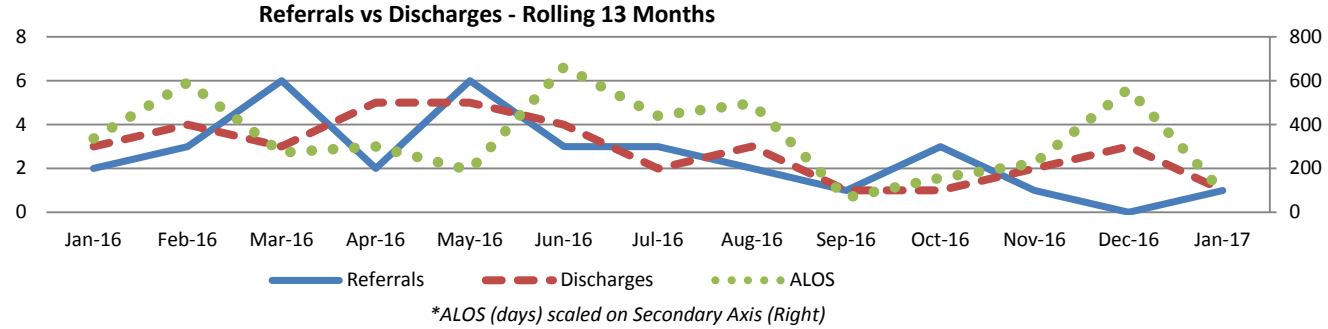
Narrative

The total Active Episodes of Care for OST should include the 90 clients on the GP Authorised list and therefore is currently at 424. Anecdotally, Methamphetamine appears to have a noticeable negative impact on the acuity of OST clients leading to more abusive behaviour, less compliance with appointments and increased diversion of medication.

Early Intervention Team

Area	Population				
Palmerston North City	80,079	**Total Population**	162,561	**Target Population**	All
Horowhenua Region	38,172				
Tararua Region	16,854				
Manawatu District	27,456				
Total Clinical FTE:	4.22			**Active Episodes of Care:**	33
Productive Clinical FTE:	3.89				

Age Bracket	<19 years	19-24 years	25-64 years		Total
Current Clients	9	23	1		33
% of Current Clients	27.3%	69.7%	3.0%		



**ALOS (days) scaled on Secondary Axis (Right)*

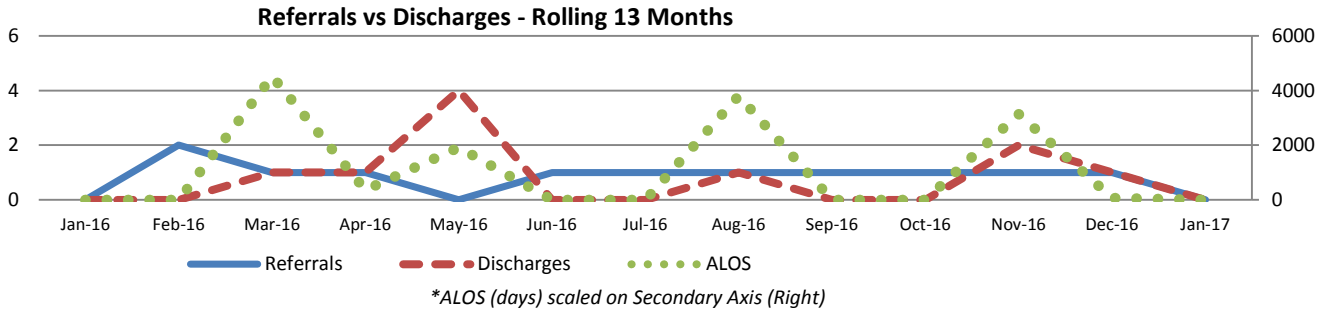
Narrative

Referral rate has been steadily declining, allowing for opportunity for pre-emptive insight building exercises to reduce relapse risk for service users already in the team.

Intensive Treatment and Rehabilitation Team

Area	Population				
Palmerston North City	80,079	**Total Population**	162,561	**Target Population**	All
Horowhenua Region	38,172				
Tararua Region	16,854				
Manawatu District	27,456				
Total Clinical FTE:	4.87			**Active Episodes of Care:**	45
Productive Clinical FTE:	4.57				

Age Bracket	<19 years	19-24 years	25-64 years	65+ years	Total
Current Clients	0	2	41	2	45
% of Current Clients	.0%	4.4%	91.1%	4.4%	



Narrative

No new referrals/ discharges for this month. The focus of the service has been on preparing long-stay service-users for transition to other settings. Complex care planning remains a priority via engaging multiple Non-Government Organisations (NGO's) partners to reduce inpatient admission length of stay. Accommodation options are becoming an issue for this population.

Dashboard reporting: Other service coverage

The need to report more comprehensively on connected service linkages and utilisation has been highlighted by the specialist mental health and addiction workshops with HCAC and QEAC. This inclusion of these areas of reporting in our dashboard are an initial attempt to report on both support service capacity and to provide a fuller and more accurate picture of activity in each of these areas.

Non-Government Organisation Providers

Provider	No funded	No utilised	Available Beds	Clients waiting ward 21
CCDHB Regional Rehab inpatient beds	2	2	2	
MASH Trust				
Level 4 high support	16	16	0	**2**
Level 3 medium support	21	21	0	
Supported living (visiting flat)	22	21	1	
Dalcam (St Dominics)				
Level 4 high support	**6**	6	0	**3**

Level 4 flexible placements (Called package of care (POC) used for higher shorter term needs)	**4**	4	0	
Level 4 High support Transition beds (Temp Funding April 2015 ceased December 2016)	**2**	2	0	
Level 3 medium support	**21**	21	0	**1**
Crisis Respite (located in Feilding)	**6**	4	2	
Total places				
Regional	**2**			**1 (NASC)**
Level 4 (including POC)	**26**			
Transition (note not currently funded**)**	**2**			
Level 3	**42**			
Crisis Respite	**6**			
Supported living	**22**			
Total waiting ward 21 (note 1 LOS 18mths placement Enable NZ)				**6**