COUNTIES MANUKAU HEALTH

8 July 2016

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Dear Chris, Ahmer and Barry

Please find attached a brief report from me regarding observations during the follow-up visit I made to MidCentral DHB on 1 July 2016.

Please don't hesitate to contact me if you have any questions.

Yours sincerely

Dr Gloria Johnson
Chief Medical Officer

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Report from follow-up visit on 1 July 2016 regarding progress on implementing recommendations of the 2014 MidCentral District Health Board Mental Health and Addictions Service external review.

I was invited by the Service Director, Clinical Director and Nurse Director of the MidCentral DHB Mental Health and Addictions Services (MHAS) to visit the service on 1 July 2016. Over the course of the day, I met with the MHAS executive team, some Ward 21 senior staff (the acting charge nurse, a clinical nurse educator, a family and consumer adviser and a consultant psychiatrist), leaders of the Palmerston North adult community team, the Quality Team, a subgroup of Clinical Managers and the General Manager. I also toured the Ward 21 facility. This visit did not expose me to the array of front-line staff met with by the review team in 2014, and so did not provide a first-hand perspective from front-line staff, but did enable me to gain a clear impression of the current senior leadership structure, various changes which have occurred since 2014 and the current developmental direction of the service. I was also provided with a dossier of documents, including minutes of the MHAS Executive team, Quality team, Clinical Managers' team, Serious and Adverse Events Review Forum meetings, recent MHAS reports to HAC and the progress summary for the November 2015 certification audit Corrective Action Report. This enabled me to see tangible evidence of the reporting and monitoring processes and associated actions which have been implemented.

My overall impression is that there has been substantial and relatively rapid progress in implementing the principal recommendations of the external review over the past two years and that this progress has accelerated over the last year. There has been a marked improvement in the leadership structure, leadership skills and engagement by leaders with the rest of the service, particularly over the past year. Quality assurance processes and transparency with both staff and consumers have also undergone considerable development. It seems likely then that a real culture change is underway and that the service is now able to operate much more effectively, despite an ongoing rise in referrals and the challenges of providing a high quality service with resource and geographic constraints. There is a high but realistic level of optimism and confidence within the service leaders that challenges can be dealt with constructively.

Positive changes since 2014 review

- The new MHAS executive team appears cohesive and with members who are mutually supportive. Individually and collectively they have excellent leadership skills and knowledge which makes them confident in dealing with ongoing pressures.

- The new organisational structure is clear, simple and has reporting lines which support accountability and service development.

- Frequent and regular meetings of the MHAS executive team and the clinical managers group enable information-sharing, collective problem-solving and establishment of professional standards.

- Clinical-managerial partnerships are much more evident and valued. The partnership between the Clinical Director and the Service Manager is particularly strong and helpful and although it has not been possible to implement other medical leadership roles so far, the partnership between senior medical staff and clinical managers within services is more valued and effective.

- The quality team has developed a set of meaningful reports which enables them to identify problems and trends and to plan relevant quality improvement activities.

- The involvement of the Hume family in the quality team is viewed very positively and the value of family and consumer input in service planning and quality assurance is clearly acknowledged, so consumer and family advisers see their roles as having a meaningful influence.

- Transparency is valued by the leaders and reports on service quality and adverse event investigations are routinely and widely shared with staff and consumers.

- Ongoing demand pressures, for example the rise in referrals to community teams and high bed occupancy on Ward 21 with periodic surges, are now responded to constructively, confidently and effectively. The Clinical Director and Service Director no longer receive phone calls for advice on managing these pressures as staff have established plans and implement them.

- The focus of team meetings is now quality, rather than finances.

- Medical recruitment has filled vacancies and stabilised the medical workforce so other staff are more confident in the clinical skills and leadership of the medical staff.

- Readmissions within 28 days to Ward 21 have declined, despite the ongoing demand pressures on beds and thus on preparation for discharge – this suggests that treatment during admissions, the transitions from inpatient to community care and/or follow-up in the community, are becoming more effective.

- Ward 21 has well-organised MDT meetings to underpin proactive care planning; junior nursing staff are actively supported by senior staff to develop their professional skills and to contribute to service improvements; union concerns appear to have subsided; there has been some refurbishment so the ward now appears much better maintained and furnished, and there has been attention to safety hazards such as ligature points, for example by installation of safer door handles.

Cautions and concerns

- The design of Ward 21 remains very unsuitable – the vast central nursing station remains intrusive and a waste of space, the intensive care unit still looks and feels intimidating and imprisoning rather than therapeutic, and the design overall limits both observation and therapeutic engagement. It should also be noted that it took a very long time for the required safe door handles to be acquired and installed, which I was told was in part due to cumbersome DHB procurement processes.

- There is a need for quality improvement (QI) and change management skills to be more readily available, so that QI projects are implemented and evaluated well – this ideally requires a combination of training for MHAS staff and access to a central DHB QI/change management team of experts to support projects.

- There are nursing leadership gaps, so it has been difficult for example to fill the Charge Nurse role in Ward 21. The use of nurse leaders from outside MHAS has proven successful to date, providing fresh ideas and skills, and it would seem sensible to continue this model for hard to fill roles, as the leadership skills are probably more useful and important than mental health nursing experience if the number of people with the required leadership skills and experience in the MHAS nursing group is limited.

- Concerns have been raised about the clinical skills and overall functioning of the kaupapa Maori team, which is now subject to a review following an adverse event. This team would ideally be attracting the most highly skilled clinicians, given the vulnerability of the community it serves and the potential for this type of service to provide superior holistic care combining cultural and clinical skills. The kaupapa must support best clinical practice, not be seen as an alternative or detractor. There is a risk that the review process will have the perverse effect of demoralising staff and consumers by creating an impression that

the kaupapa is a weakness rather than a strength, and that the service can only be improved by becoming more "mainstream". It may be useful to engage expert advisers from successful kaupapa Maori teams elsewhere to clarify what it is possible to achieve in this model and what would be required to deliver that.

- The relationship with primary care seems weak and the potential for more integrated community care delivery not developed. Given the demand pressures, it is urgent and important that the relationship is strengthened and opportunities for collaboration on innovative service delivery explored. This could be particularly useful in the rural areas where it is difficult for both primary care and secondary care to have sufficient resources available for efficient safe and sustainable care delivery.

- The relationship between the service and the funder is reported to be strained at times and not as collaborative as it should be. This may result in inadequately informed decision-making about how resources are allocated and what types of clinical services are most appropriate for funding.

- The required budget to maintain adequate service provision on an ongoing basis has not yet been determined, as additional funds have been provided over the agreed budget to support the service developments required as a result of the identified risks and deficiencies. The budget needs to be established and agreed to allow ongoing planning for a sustainable service.

Opportunities

- The proposed implementation of the "cluster model" as a new approach to service funding and planning led by the service providers sounds like an opportunity to engage in more innovative and integrated care delivery and to further develop care partnerships with other providers.

- The progress to date is sufficiently impressive and substantial to warrant presentation at meetings and conferences, which could provide an opportunity to gain additional ideas for consolidation and extension by the changes so far.

- The revitalised leadership and engagement with staff should enable further coordination of how services could be extended and improved by changing work patterns, for example by extending clinic opening hours to provide more care without needing additional facilities and to provide more flexible access for consumers and their families.

- The Clinical Director is very talented and successful in that role. He should be supported to continue developing his leadership and management skills and experience, which could be of value not only to the MHAS but also to the wider DHB organisation. The appointment of a Deputy Clinical Director would be a useful step to provide him with additional support and to extend the depth of medical leadership within the service. It may be necessary to seek an external applicant for this role if there is nobody suitable and interested within the current MHAS medical workforce.

Concluding comments

It was suggested that it might be useful for me to meet with the Hume family to gain their perspective on how the service is evolving and on the impact of their own participation in the Quality Team. I would be very interested and pleased to do this if the Humes would like to meet and if it can be arranged. I am also happy to meet again with the CEO and Board at some stage if that is thought useful.

Overall, I would like to congratulate the DHB and especially the MHAS team on the great strides they have made in response to the adverse events and identified issues. The willingness to learn from failure and to put quality first is impressive and a great example for other services to follow.

I am grateful for the opportunity to observe and learn myself and for the generous and positive spirit in which my visit have been received.

I hope these comments are of some use to the team.

Gloria Johnson
Chief Medical Officer
Counties Manukau Health
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