TO	Hospital Advisory Committee
FROM	Operations Director, Specialist Community & Regional Services Clinical Director, Mental Health & Addiction Services Director of Nursing
DATE	10th November 2015
SUBJECT	Mental Health Report

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

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1. PURPOSE

To report on the development of the Mental Health and Addiction Services (MHAS) and continued implementation of the mental health external review recommendations.

2. SUMMARY

This report outlines the key activities in the Mental Health and Addiction Services, which create sustainable service development and quality improvement, re-establishing clinical leadership and governance and a change of culture. These improvements are at the core of the 'phase two' work related to the implementation of the MHAS review recommendations.

Tangible outcomes of the Mental Health Review 'phase two' includes the expansion of the review recommendations to create a sector wide vision, and development of a collaborative network of providers across our sector. Review recommendations continuing into phase two include a change in culture, redesign of the inpatient unit, and improved quality of care across all of our services. These goals are overseen by the MHAS Executive Leadership group and are reported on to the MHAS Advisory Group.

Cultural changes are being lead through workforce development with Te Pou workshops planned for completion by the end of the year.

The options paper for the redesign of Ward 21 is undergoing a costing exercise with a local quantity surveyor firm with recommendations about the next steps.
Next steps, need to consider both local DHB and wider capital expenditure planning and approval requirements in the light of the Master Health Service Plan.

This report also includes the first update on progress with implementation of recommendations arising from the longitudinal clinical review of the care of Erica Hume.

The format of this report is intended to reflect a standard approach to service reports by using service plan headings to report on developmental progress in an embedded 'business as usual' manner.

Headings used commence with organisational management focusing on quality and risk efforts, and then move on to service development projects. This report incorporates all of the phase two activities arising from recommendations for ongoing development from the Mental Health review.

3. RECOMMENDATION

It is recommended:

That this report be received.

4 Executive Summary: Clinical Director and Service Director

Mental Health & Addiction Services Structure and management

Strengthening Clinical Governance and change of culture

The restructuring of the Mental Health and Addictions Services management continues to progress, with the completion of the last appointment to the new clinical manager positions. The latest appointment, to the Acute Care team (ACT) clinical manager role will take effect in December. An existing manager has been seconded as the interim Clinical Manager for 12 months. This change will assist to manage the redevelopment of the service with experienced management.

The development of the mental health leadership has continued with a further clinical team manager workshop planned for December and executive half day planning to be completed in November.

Clinical governance of the MHAS continues to be well established through a mix of strong professional discipline, statutory representation and leadership in the executive leadership and clinical manager teams.

Quality improvement processes are continuing to develop with increased monitoring of clinical review implementation plans by the Serious Adverse Event Review Group (SAERG) and ongoing clinical reviews. An additional part of our process is direct feedback sessions to teams, including the Senior Medical Officer (SMO) group of psychiatrists, of review outcomes lead by the Clinical Director.

The management team, including the executive leadership team continues to focus on the development of a quality and risk framework which will include monitoring and reporting on key performance indicators which measure service improvement. Two projects on performance improvement facilitated by an external project management company BECCA, are aimed to assist our service to develop a performance management framework to improve both monitoring and reporting and service improvement.

This monitoring of current performance and required improvements will also improve service culture. The Mental Health Executive Leadership team report represents an integrated approach to clinical governance and includes input and reports from all members of the team.

Recruitment of permanent SMOs remains a major challenge despite extensive efforts. Out of 20 approved medical FTE posts only 10 are occupied by permanent doctors which pose huge challenges for development of service and continuity of care.

Nurse Director

Following a period of months where we have seen improved management of the occupancy rate in Ward 21 we have been faced the challenges of managing the higher than usual occupancy and the impact on nursing staff. However efforts continue in manage capacity against demand. For example a project to strengthen transition of care processes including MDT decision making is demonstrating improvements in patient flow. This includes plans for a pathway for acute admissions where escalating behavior is a risk. New guidelines have also been implemented to ensure that the Duty Nurse Managers are part of the decision making process for admissions, given that they manage both staffing and a patient flow hospital wide after hours. We have seen a closer working relationship between Star 1 and Ward 21 that has enabled Star 1 to take some pressure off Ward 21 in terms of occupation. The new Acute Care Team, formerly the Crisis Team, operating manual is now in final draft and plans are in place to move to the new model. Recruitment to the roster continues to

be a challenge although some of the fruits of our efforts in increasing the number of entry to practice nurses (NESPs) last year are bearing fruit. So far four NESPs have found permanent positions in the service with opportunities for four more over the next few months.

Allied Health Representative

Allied health representation on the Executive and within the Operational Leadership group has been established over recent months and will continue to be developed and strengthened. Embedding positive cultural change and ensuring quality service delivery through effective partnerships across the mental health service is a shared focus of all members of the management teams. The Allied Health Plan, (AHP) aimed at developing the allied health workforce, details key priorities for allied health. This is part of the Mental Health Review recommendations. The AHP incorporates the implementation of the psychology review,

The Director of Area Mental Health Services

The Director of Area Mental Health (DAMHS) has continued with the re development of the DAMHS office over the past six months, in order to ensure compliance with the regulatory requirements of the Mental Health Act.

The DAMHS office has developed improved systems to monitor and evaluate the use of the Mental Health Act. The DAMHS has improved tracking and monitoring the act status of people under the Mental Health Act and to coordinate with the courts to ensure that hearings are planned, and that clients whose status requires review have appropriate reports prepared and submitted according to the required timeline.

Statistical data reporting to the Ministry of Health (MOH) continues on a quarterly basis from the DAMHS office. Whilst the data is being collected, the MOH has been notified of challenges with collating data due to the need to improve local report writing tools. Seclusion and ECT data have to date found to be reliable. The planned move from CHIPS to WebPAS will hopefully address issues surrounding the long term difficulties experienced with the CHIPS programme.

Ward 21 occupancy rate remains high, the pressure experienced in this area is reflections of the pressure the Community Mental health teams are also experiencing with acute presentations and limited options to effectively manage demand in the community. The available community options such as crisis respite whilst being utilised need to develop. Work is being completed with our NGO partners to improve access to services.

Youth admissions to the adult acute in patient Ward 21 are reported to the MOH as part of the compliance with UNROC article 37(c) non age-mixing provisions. For the period April to September 2015 there were 116 bed days recorded. These present as significant resource intensive admissions as current protocol requires an additional staff member to accompany / chaperone the youth during their stay in an adult facility. The options of admission to Rangitahi unit a regional facility or Starship Hospital is not possible out of normal work hours Monday to Friday and existing waiting lists also delay potential transfers. The ongoing difficulties in accessing the Regional Rangitahi service have been notified to the MOH.

4.1 Quality and Risk

This section of the mental health report is proposed to contain all current quality and risk issues including the clinical reviews and associated implementation plans. The quality and risk part of the HAC report incorporates the phase two recommendations of the Mental Health Review. For instance, improved systems and processes. (Appendix D Table Two) has a diagram which demonstrates linkages between the various quality and monitoring forums overseen by the executive leadership team. An outline of the MHAS meeting structure and also the Organisation structure are shown as diagrams included in Appendix D tables two and three.

This report commences with an update on progress with the longitudinal clinical reviews.

Longitudinal Clinical Review and Action Plan Erica Hume

The organisation received the final copy of the clinical review report into the care of Erica Hume on 20th April 2015. The final action plan has been worked on together with the Hume family who have provided input and this will now be monitored and reported on.

Progress of the key Actions is listed in (Appendix E).

Review Project Phase Two Reports

The transition to Phase Two takes into account where mental health and addiction services have moved from a focus on the external review of secondary services and remedial action to secure patient safety particularly in Ward 21, to moving into a planned developmental approach across the continuum of care.

Phase Two review project takes a whole of system approach over time for the redevelopment of mental health and addiction services. This includes the development of contemporary models of care to support a service development plan for secondary specialist mental health and addiction services. Phase Two will be based on a district-wide approach developing strong and enduring networks between and across all elements of the system, with strong engagement with staff, consumers, families/whānau and the wider community. The following actions arising from the Mental Health Review recommendations are progressing:

- The consumer engagement/participation project (see update below);
- Progressing the Acute Care team (included in projects update);
- Further work to embed vision and values, aligned with the sector view; (advisory group planning) is underway
- Establishment of a quality and risk framework
- Ongoing service team development processes with the new Clinical Managers;
- Further Open Disclosure workshops occurred on 30th September and 1st October 2015;
- Further work to support professional development, as part of the Workforce plan.
- The workforce development plan includes a new Training and Development calendar
- SMO recruitment and improved medical coverage remain a priority;
- Debriefing processes are updated through the creation of debrief policy
- The redesign ‘options’ paper to address ward 21 issues is with an external consultant for a cost estimate

Mental Health and Addiction Services Key Quality Indicators

The report on key quality indicators is designed to provide a more informative report by including graphed information along with explanatory comment to provide context to the graphed activities and quality and risk indicators. The indicators associated with the inpatient unit (Ward 21) start with a graph of total occupancy (appendix B) which will provide the context in which the later detailed quality indicators can be understood.

Ward 21

Activity data for Ward 21 in representational graphs are attached at (Appendix B). Improvements in incident management and reporting are outlined in the graphs and associated commentary. Key points of improvement are listed below.

Incidents

A proposal to improve Riskman incident reporting has been accepted by the safety and clinical effectiveness unit. An update to reporting categories will more clearly differentiate between incidents of self harm, attempted suicide, aggression threats and actual events. Clearer analysis and reporting will also reduce errors in total incident reporting such as the mixing of non self harm related reporting in the total incidents of self harm.

Match of Resource to Demand

The inpatient unit continues to experience increased risk of adverse events related to over utilisation of resources. The over utilisation of Ward 21 occurs when there is ongoing higher than funded and resourced levels of occupancy.

Substantial work is being completed on reviewing all factors related to matching resource to demand, including improved rostering to ensure that staff on shifts is rostered to planned and budgeted levels and increased staffing is available when the unit is over funded capacity. Double shifts are under close scrutiny and a memorandum containing directives about management of staffing and more stringent approvals for double shifts to replace gaps has been circulated. Appendix C represents the number of double shifts and overtime for September.
Additional service capacity to support improved management of the bed state includes maintenance of additional capacity for longer stay patients in the community, through use of the 'transitional beds' created in April of this year.

Additional work is being completed to improve clinical standards of service delivery, through the development of a Psychiatric Intensive Care Programme and associated clinical pathway. This development will improve standards of clinical care and safety.

The accompanying graph of activity focuses on the month's level of occupancy (Appendix B). This graph is aimed at providing more detail about periods of over occupancy and demand in order to ensure appropriate levels of oversight and monitoring. The graphs on inpatient activity illustrate four key drivers that are activity monitored. The four key drivers are:

- numbers of admissions
- occupancy
- patients on leave
- outlier patients in other units but who remains the responsibility of the inpatient unit.

Continuum of Care

It is also important to monitor national KPIs which focus on patients seen seven days prior to admission, post discharge and the readmission rate. We continue to monitor these national KPIs. There are recent improvements in KPIs for patients seen prior to admission and after admission. Our readmission rates remain at a higher level than expected. The service is completing analysis work on the readmission numbers and will report to the executive on recommendations to address readmission rates.

Ward 21 Smoke free
Smoke free has moved to a 'business as normal' approach.

Consumer Engagement/Participation

The managerial team has been strengthened by confirming a replacement consumer advisor role and collegial regional consumer advisor input to ensure that development of consumer engagement continues. A forum for consumer engagement is planned for the 13th November in partnership with Mana o Te Tangata Trust, (previously Journeys to Wellbeing, a consumer run and representative organisation). The workshop is facilitated by the Director of Partners in Care for the Health Quality and Safety Commission. An additional element included in the consumer and family engagement project is the development of a co-design model, again in partnership with consumer and NGO organisations in the community.

4.2 MONITORING AND AUDITING

Serious Adverse Events Review Group (SAERG)

The SAERG group monitors all implementation plans arising from clinical reviews to the point of completion. Key achievements in the past two months are:

- Completed implementation audits for eight of 12 review plans created in the past 12 months
- Completed terms of reference for review of suicides across our district
- Updated review report formats to improved standards of service level review reporting

Quality Representatives and quality forum

The ARQ (Area Representative Quality) group manages ongoing auditing processes and the response to certification audit required actions. This forum has all services represented with roles in each service taking responsibility for quality audits and activity. The forum is currently responsible for preparing for the upcoming certification interim audit. Key gains in this forum over sighted by the project and quality forum are:

- Updating of policies, procedures, and forms from an outstanding 11 of 19 policies and 30 procedures to one outstanding policy and to date 7 procedures updated with a further 6 to be completed prior to the audit. The remainder of the procedures will be updated by the end of the year.

- Preparation for the upcoming interim certification audit includes a completed self audit, mock audit visits, and updating of key policies in the inpatient unit including seclusion, incident reporting and ECT provision.

Quality and Risk

Traffic Lights: RISK	**at Risk;** 	**On track;** 	**Complete.** 
ACTION/ITEM	**MILESTONE**	**COMMENTARY**	
longitudinal review (Erica Hume)	Action plan complete	Final action plan implementation and commencement of reporting	
-longitudinal review (Shaun Gray)	Draft Action plan complete	Action plan in development	
-Ward 21	Occupancy matched to resourced beds	Occupancy, at times still exceeds resourced beds, daily bed meetings and discharge planning is occurring to address this.	
-Ward 21 smoke free	Ward 21 100% smoke free	Compliance with smoke free policy continues to be monitored.	
- Consumer Engagement/Participation	Increased consumer/family engagement and participation	Interim engagement with consumer representatives to strengthen consumer input	
-SAERG	All serious adverse events are reviewed with action plans completed	SAERG has completed an audit of the past 12 month's implementation of review actions.	

4. 3 Workforce Development

The service is completing a draft workforce development plan. Key achievements in recent workforce development are:

- Attendance at the DBT conference (Auckland) for all available DBT team members
- Attendance at the annual national conference in Wellington of the complete early intervention team
- All MHAS Staff are supported to attend /national courses/conferences.
- Nine nurses completing the NESP programme
- Plans for three TePou values based workshops in October, November and December.

4.4 Infrastructure development

Ward 21 Environment

The options paper for the redesign of Ward 21 is undergoing a costing exercise with a local quantity surveyor firm with recommendations about the next steps. Next steps are to consider both local DHB and wider capital expenditure planning and approval requirements in the light of the Master Health Service Plan.

WebPAS

Representatives from MHAS visited CCDHB to view the live web PAS system along with mental health representatives from HBDHB and Hutt. This gave the representatives an understanding of the application and also the implications for data collection within the MHAS specialty. A recent bed flow workshop was provided to all services and also another MHAS specific workshop was facilitated at Mid Central DHB. Test environments have allowed identified people the opportunity to familiarise themselves with the program and to identify areas in which to inform the WebPAS project team include/improve or change.

4.5 Major Projects

The Acute Care Team (A.C.T)

Ongoing development of the new Acute Care Service is progressing well. There has been considerable input from a large number of people to develop an operations manual that describes the new model of service, functionality and roles within this service. Working in parallel with the development of the new service has been a concentrated effort to support the acute service through active recruitment and stabilising the roster and prioritising the greatest need to ensure safe and effective care for service users. In order to achieve this, there has been a definite need to take things slow; this has led to a delay in the implementation of this project. The project group focussed on completing the Acute Care Team Operating Manual and consultation paper which are both due to go out to the stakeholders by Monday 16th November.

The Older Adult Mental Health Service (OAMHS)

The service has now taken over responsibility for reporting for the OAMHS. Meetings are being held with staff in Star One, (04.11.15) and a working group (meeting 06.11.15) is being established which will plan for a transition period of up to six weeks to ensure appropriate assessment of need and placement of patients into appropriate treatment settings. The forum is being lead by the Nurse Director Mental Health in partnership with the Clinical Director, OAMHS and Medical and Rehabilitation Clinical Director. Members of the working party include allied health representation, the Star One charge nurse, representation from the geriatric services and clinical nurse specialist. Following management of this transition period, further planning will take place including our community partners to plan out district wide development of a specialist mental health service for older persons.

Social Housing

There are four main projects which aim to improve access to social housing and to effectively better meet the needs of the local community. These projects are outlined below.

Review of Yaxley

Yaxley is a 12 bed unit in Feilding provided by DALCAM HealthCare Management Group situated at 'St Dominic's' which houses mental health clients with complex needs. Of these beds 8 had recently been reserved for older clients with mental health issues and four for more complex clients. Currently most residents in this unit no longer have predominantly mental health but age related issues. The project to review for the most appropriate placement for these clients has made slow progress with one bed being available in November. A review of progress will be completed by the project facilitator role in the New Year.

Profile of needs of clients in the NGO sector

Both residential accommodation NGO partners, MASH Trust and DALCAM, are engaged with the provider Needs Assessment and Service Coordination service in a needs profiling exercise of current clients. Initial feedback is that the main presenting needs for a significant percentage of the clients in these services are age related, and not related to mental health issues. With better placement in age appropriate settings, capacity for current mental health clients improves. This project is also to be reviewed to identify how it may progress more quickly in order to free up capacity for patients who need a longer and better supported recovery period.

Four additional residential placements

Four temporary additional placements were created in May to assist with over demand in the inpatient unit. This additional capacity was instrumental in supporting the unit to manage high demand over the past three months. The initial programme report has evidenced a highly successful placement of this small group of clients in sustainable community supports. The MHAS are recommending that this programme continues at least for another 12 months.

Horowhenua support services including local Crisis Respite services

We have flagged that there is a need to extend access to supported accommodation and crisis respite to the Horowhenua region. Planning for this initiative will commence in the New Year.

Collaborative Provider Network

The MHAS will, together with NGO and primary care partners, develop a sector wide provider network. The goals of this network will be improved efficiency of service delivery, better connectedness and the creation of a level playing field for all providers. It is expected that a provider network will be in place by December 2016.

Christopher Nolan
Service Director
MHAS

Dr Syed Ahmer
Clinical Director
MHAS

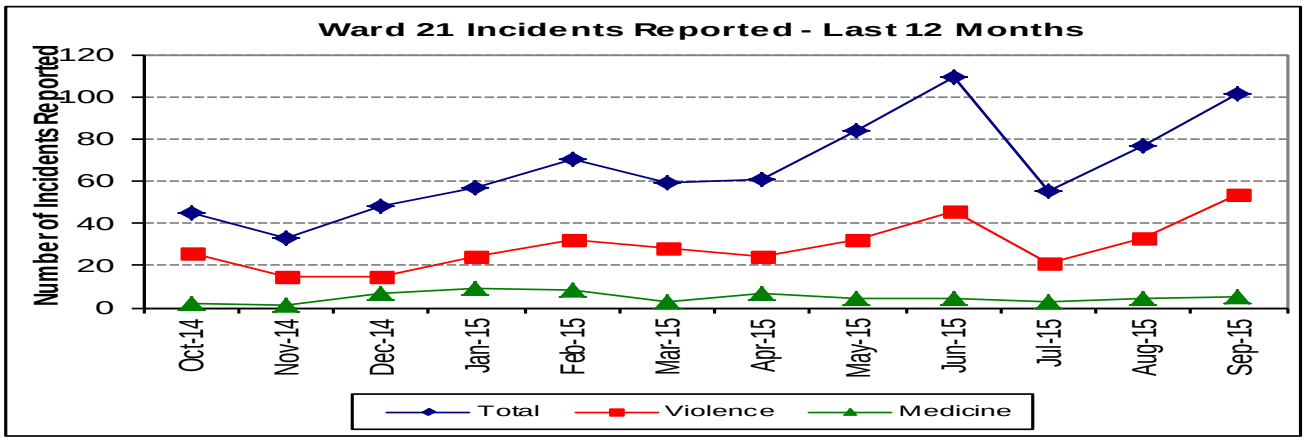
Barry Keane
Director of Nursing
MHAS

APPENDIX A: Quality and Risk

Table one: Mental Health & Addiction Services Performance Report

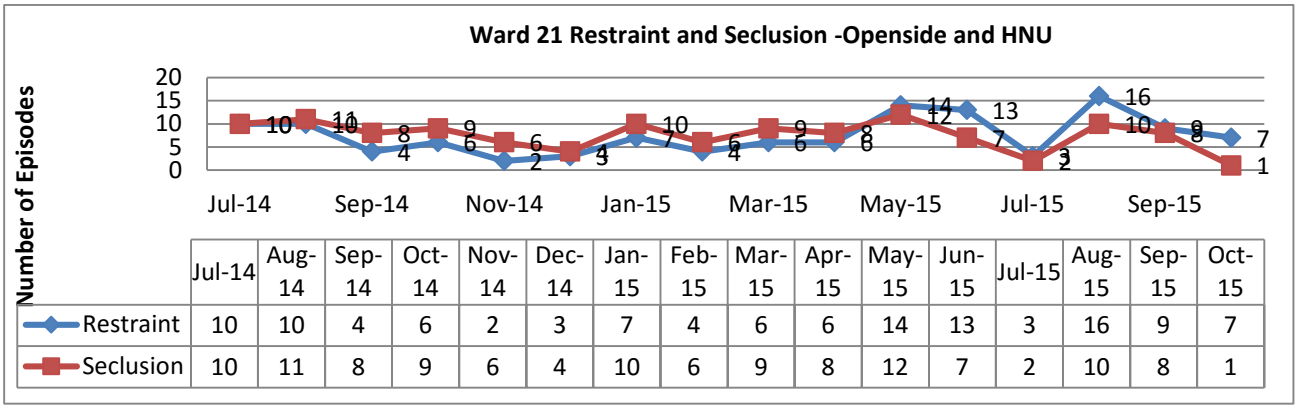
Serious Adverse Event Reviews: October	No		Complaints/Compliments (Completed = response within 30 days from receipt)	No/ Month (Oct)	Last Month (Sept)
Total with Review Committee	8		Complaints (current)	4	4
Total at final draft report stage	7		HDC Complaints (open)	4	0
Total Completed	1		Outstanding Complaints (open)	1 (this is an ongoing complaint	2
Total yet to be SAC rated	0		Compliments	1	0

Table two: Ward 21 Total Incidents Reported



The above graph represents total incidents for ward 21. More detailed individual graphs are included later in this report. Two patients in the unit over the past two months account for the increase in incidents and with adjusted figures and improved reporting, the incident rate is not increasing.

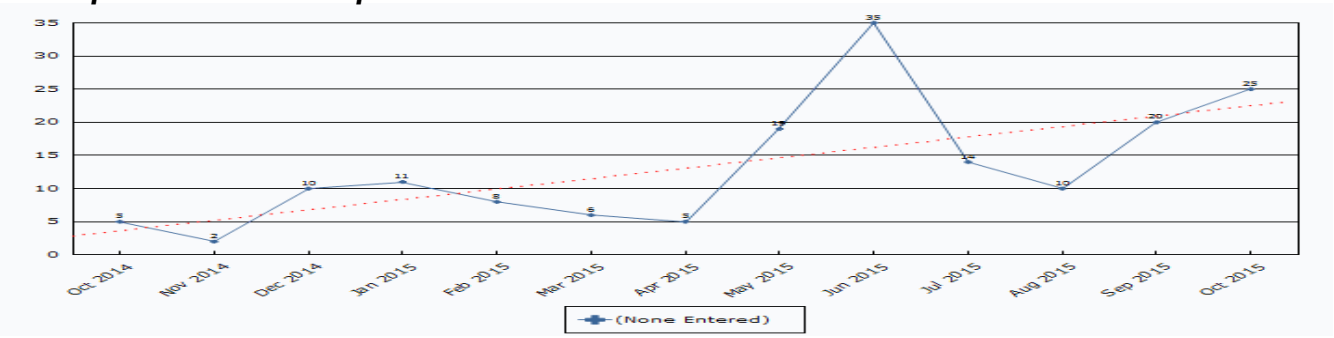
Table three: Ward 21 Restraint and Seclusion Open side and HNU



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Restraint	10	10	4	6	2	3	7	4	6	6	14	13	3	16	9	7
Seclusion	10	11	8	9	6	4	10	6	9	8	12	7	2	10	8	1

***Seclusions and Restraint*:** For September there was a total of nine episodes of Restraint, six of these related to one particular individual within the HNU who was restrained due to self harm (but not suicide) attempts. Eight seclusion episodes related to one patient requiring seclusion twice.

Table four: Ward 21 Self Harm –Total Actual and Threatened Oct 14 – Oct15

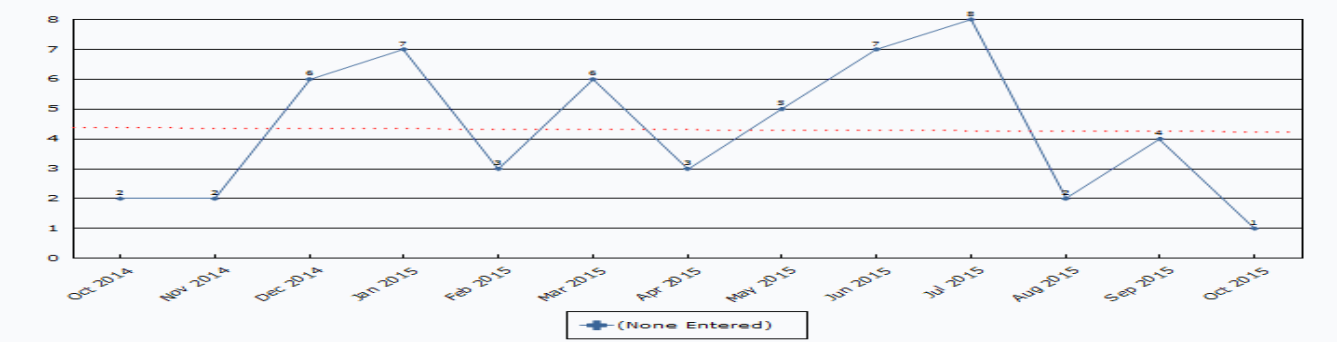


Self Harm/ threats and actual, and behavioural challenges.

The trend regarding incident and monthly totals portray a general increase in incidents but this is due to a small number of individual patients creating a large number of incidents. There were a total of 20 self harm incidents (total) generated by five patients during September. Nine incidents were from one specific patient within the HNU, this individual also required restraining on six occasions.

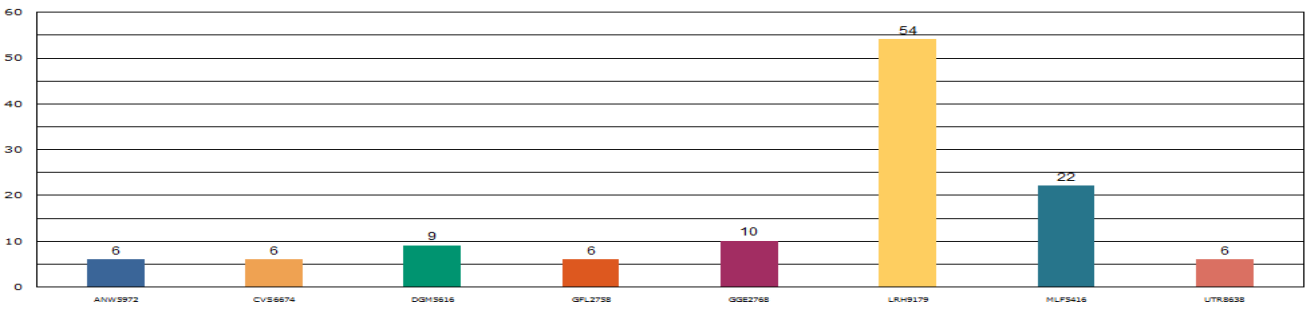
October showed an increase in self harm incidents from previous months to a total of 25 incidents, however 22 of these incidents were generated by one individual within the HNU. This left the number of incidents in this category excluding an individual patient for the month at one, which is an overall reduction as in the graph below. Some patients clinical presentations are characterised by multiple incidents, which may not be directly linked to suicidal behaviour. While concerning, this does not mean that there is a general increase in overall levels of incidents or risk in the general inpatient population.

Table five: Ward 21 Self Harm – Total and Threatened minus outliers Oct14-Oct15



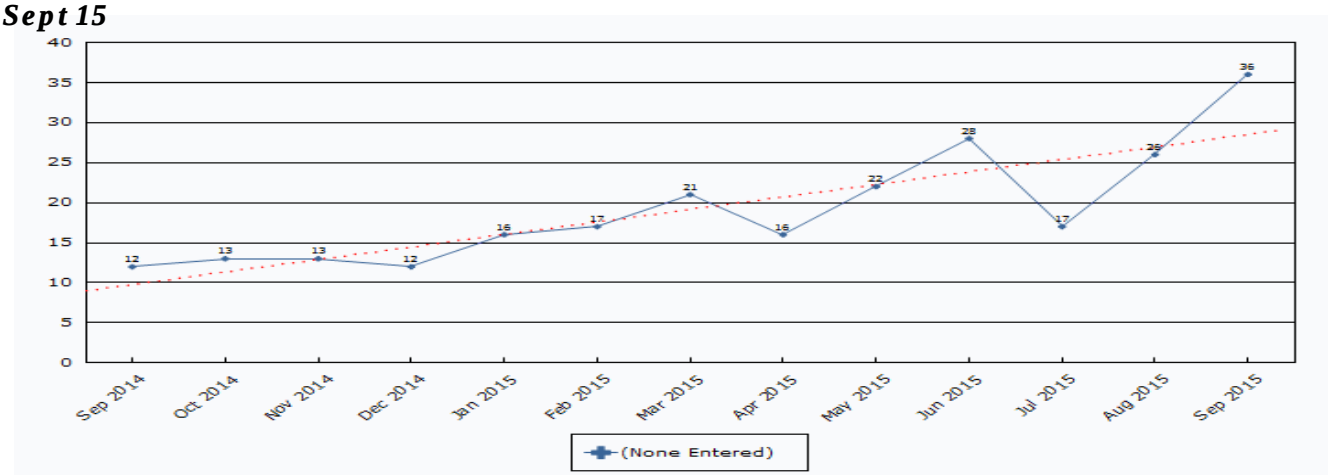
The above graph shows the actual number of self harm incidents taking out individual patients (outliers) who trigger multiple individual self harm incidents at during each admission.

Table: Six: Ward 21 Self Harm Actual and Threatened individual Outliers Oct 14 – Oct 15



The above graph shows the individuals (outliers) number of self harm incidents triggered during their admission. The eight individuals identified by the through the number of times they presented to the unit and also by the number of incidents, all individuals had triggered and minimum of 4 self harm incidents during and admission.

Table Seven: Ward 21 Conduct/Behaviour/Abuse towards Staff (Violence) Sept 14 – Sept 15



APPENDIX B: ***Ward 21 Occupancy, Utilisation Admission/Discharge***

Whilst the average bed occupancy may indicate that the inpatient unit is meeting the resourced beds, it is important to see the entire picture which includes the number of patients who are placed on leave. Whilst the patients may not physically remain in the hospital, it is still important to understand that they remain under the care of the acute unit and thus can return at any time. This can and does create significant fluctuations in bed status. Close management of the bed state is a current focus of the executive leadership team, lead by the Clinical Director. The tables below show the average occupancy; occupancy including leave; admissions and discharges.

Table one: Ward 21 Average bed occupancy for October 2015

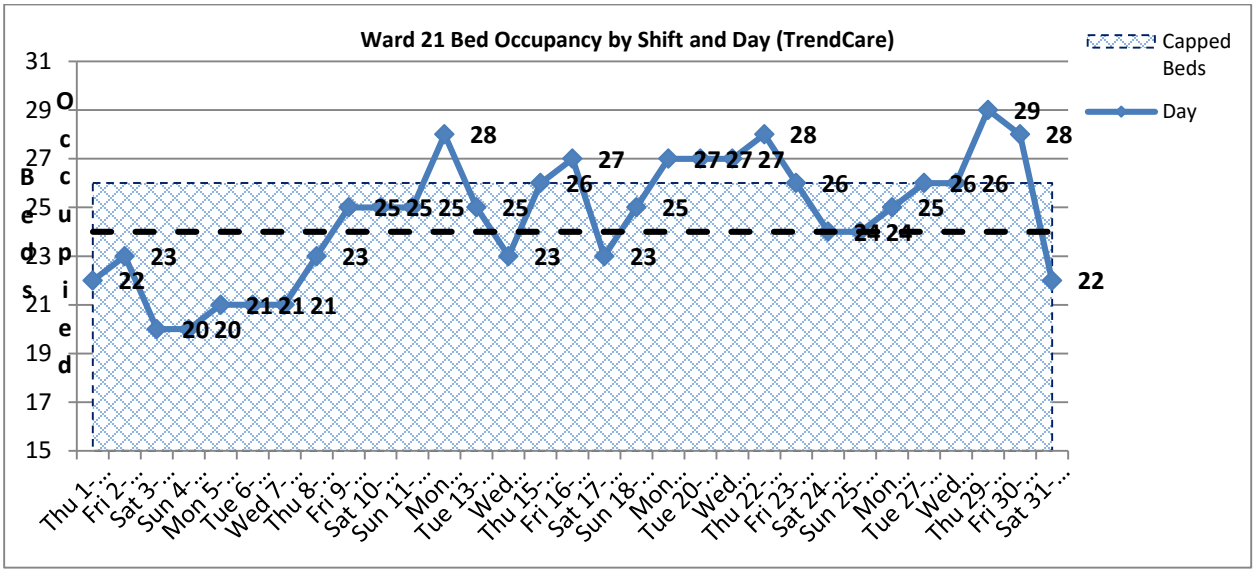


Table two: Ward 21 Occupancy per day including patient leave for October 2015.

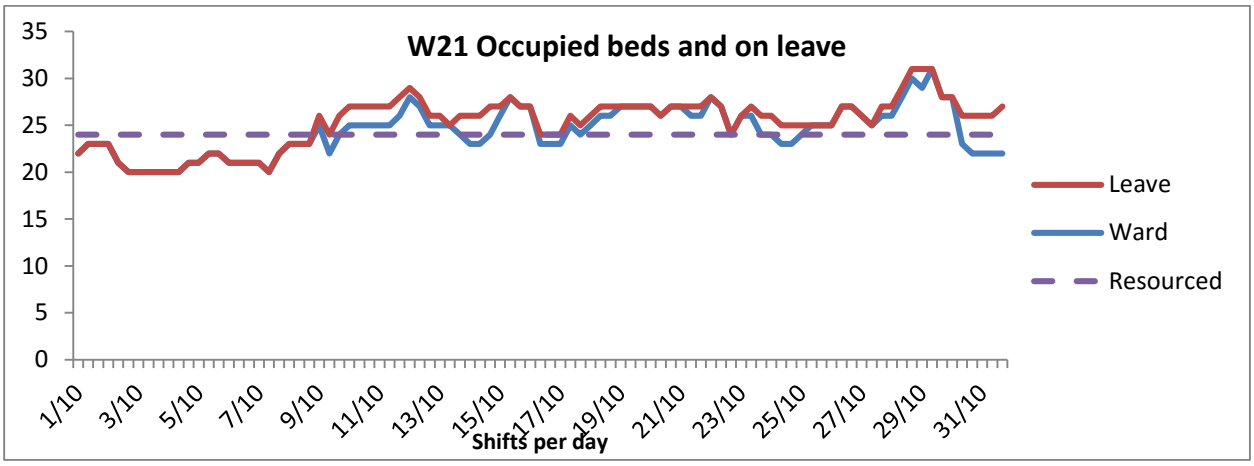


Table three: Ward 21 Total number of Admissions/Discharges per day October 2015

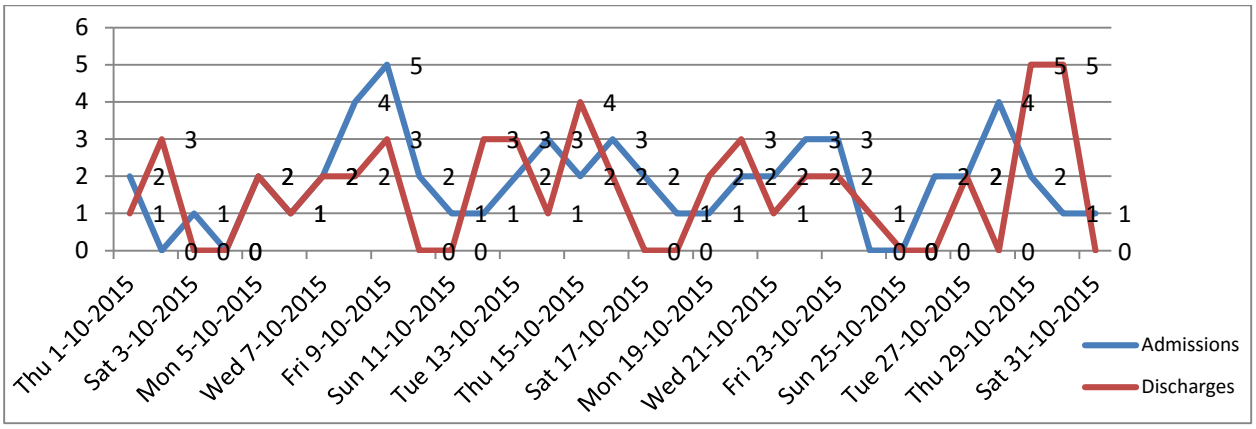
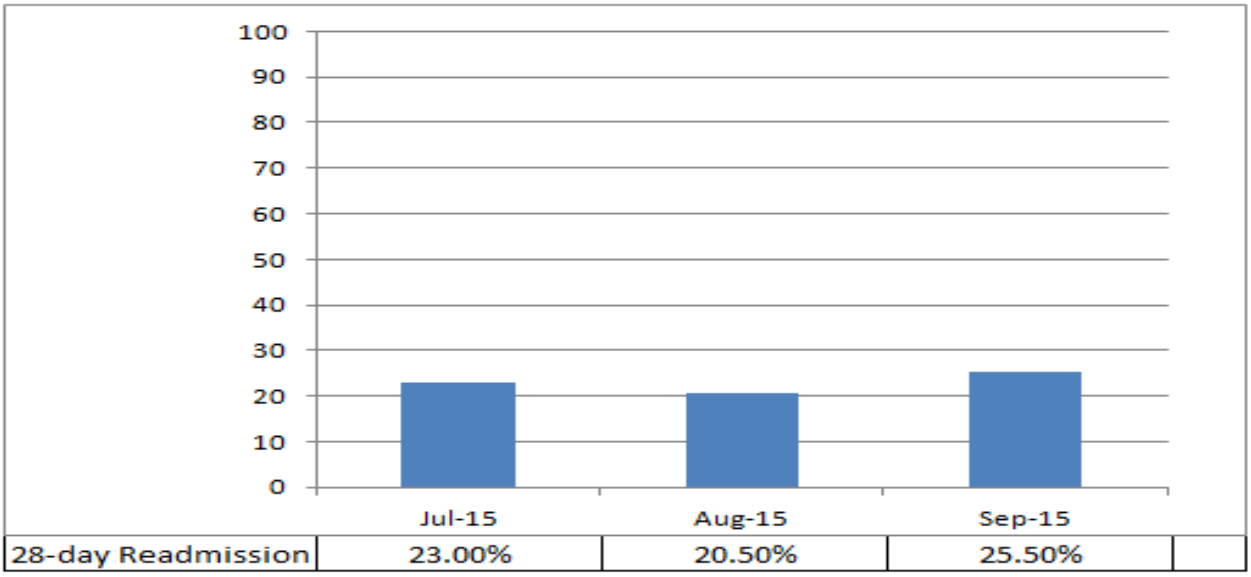


Table four: Readmissions within 28 days



The 28 day readmission rate remains well above the MOH key performance indicator of 0-10%, a working group has been established to monitor the readmissions on a weekly basis to identify any key causes that can be changed/improved in order to reduce the readmissions which will aid good transitions for patients and family from the acute unit to the community.

APPENDIX C: Ward 21 Staffing

Staffing

Ward 21 double shifts remain to be a concern for the service, which has led to an analysis of the drivers for this.
Some of the drivers identified are – high utilisation, occupancy and acuity of patients within the ward, along with available staff resource to cover gaps. The unit remains consistently above the resourced bed numbers, which leads to an increased need for staff resource. Whilst August showed a lower occupancy, this was counterbalanced by an increase in staff sick leave. Active recruitment is occurring and there have been successful appointments from the recent NESP positions.
September and October have continued to see ongoing use of double shifts with a slight reduction in September. Actions taken by the service to address the drivers for double shift activity are listed in the narrative in the main part of the report. It is expected that with improved consistency of staffing and better oversight of drivers for double shifts that a reduction will occur in November.

Table one: Ward 21 staff average double shifts April 2014 – October 2015

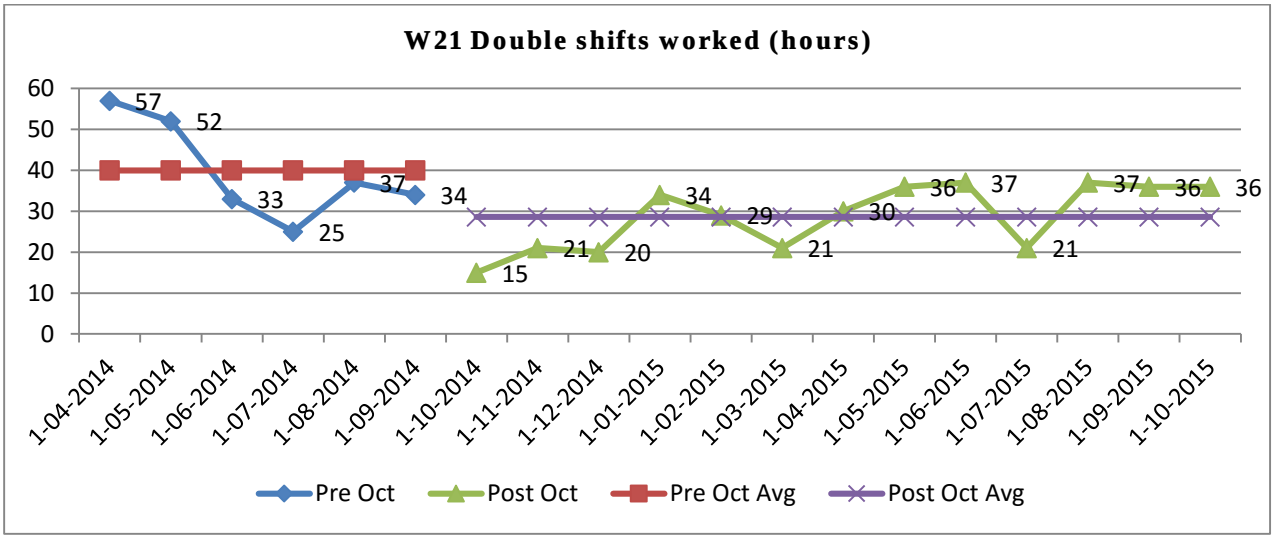
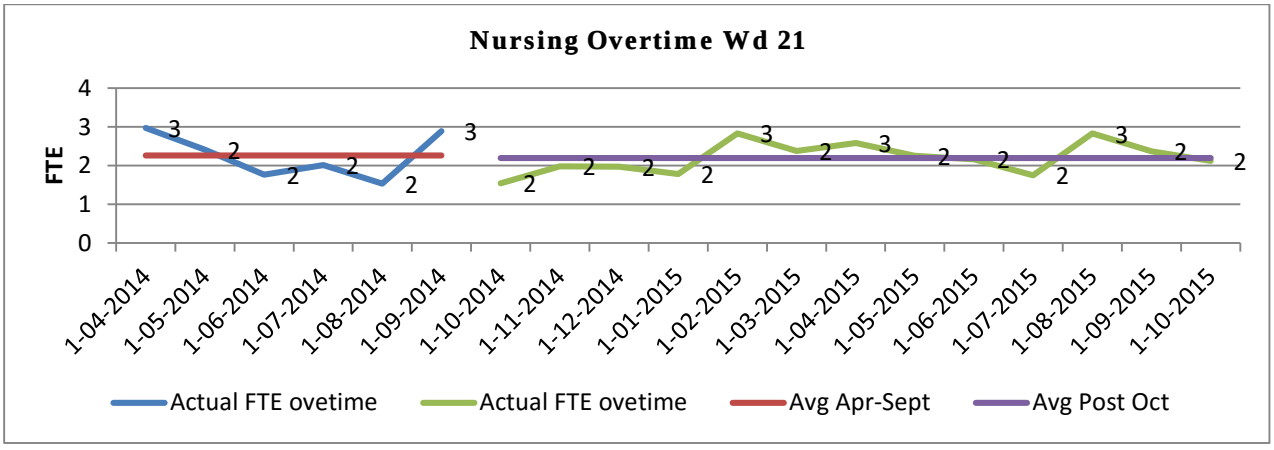


Table two: Ward 21 Staff over time April 2014 – October 2015



APPENDIX D: Organizational, Quality & Meeting Structure

Table One: (Meeting Structure)

Mental Health, OAMH & Addiction Services
Service Meeting Structure

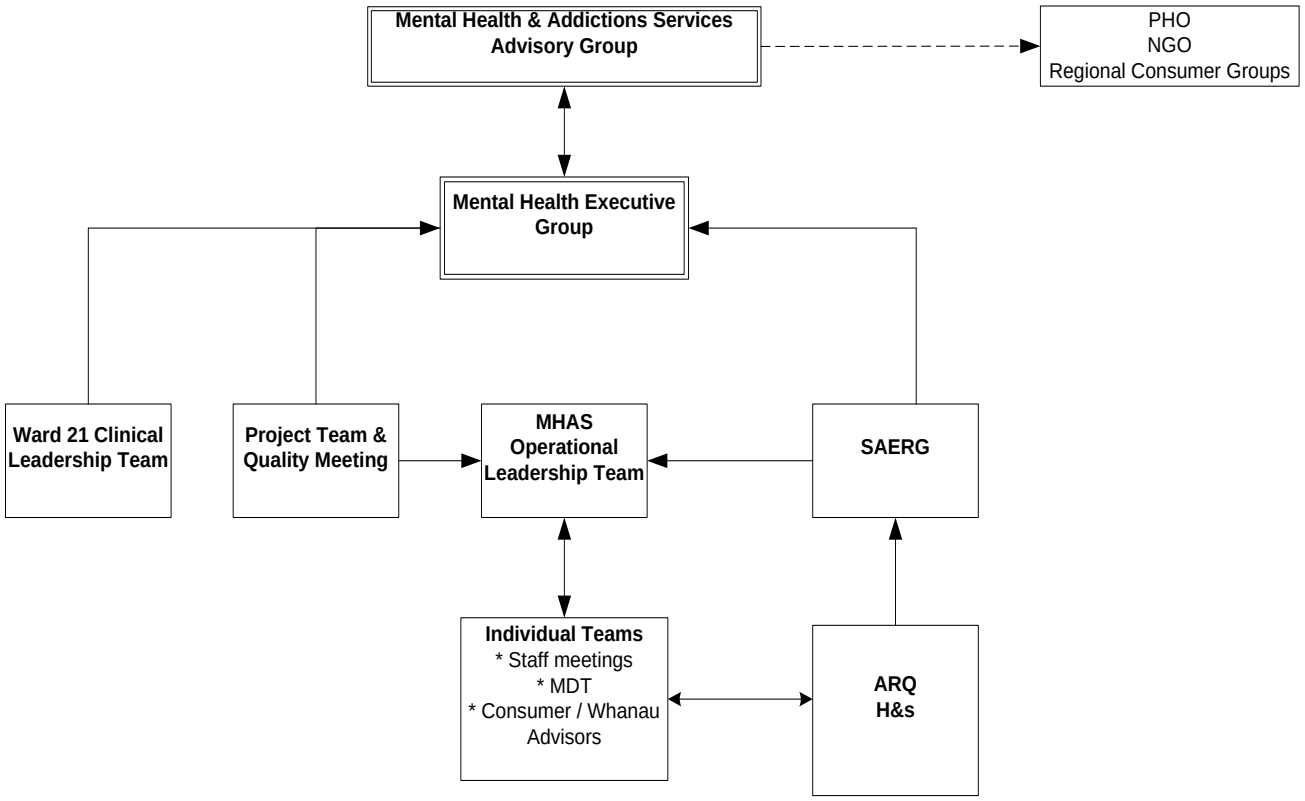


Table Two: (*MHAS Quality Structure)*

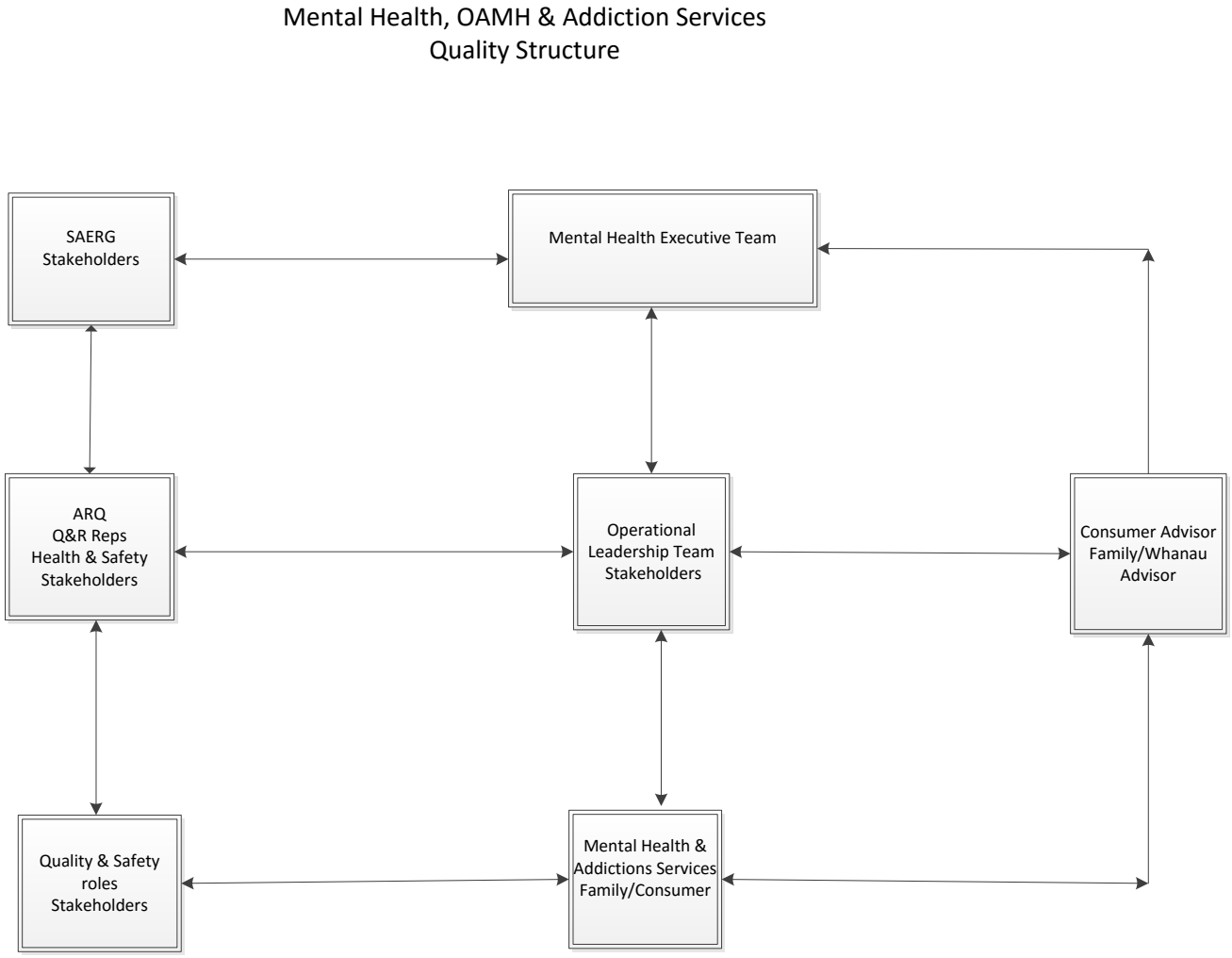
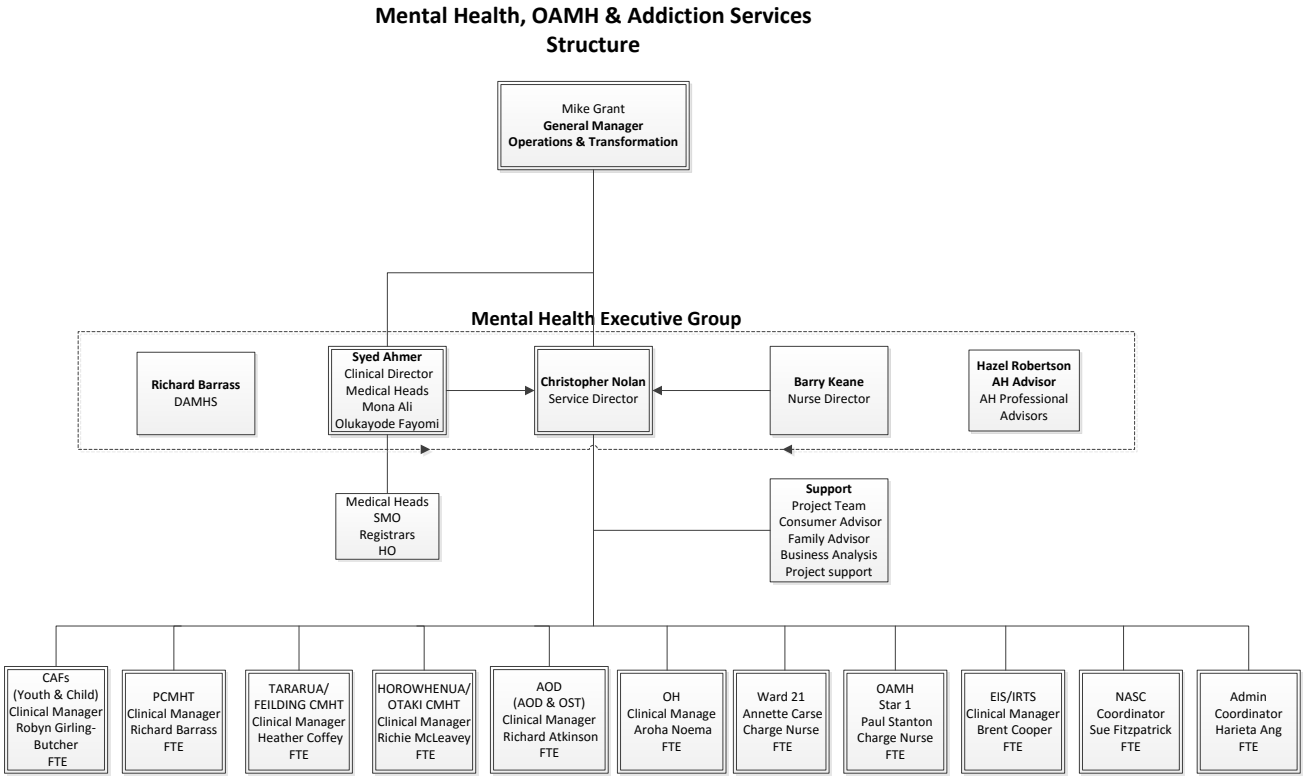


Table Three: (Organization Structure)



APPENDIX E: Key Actions Progressed from Erica Hume Recommendations

The following key actions arising from the recommendations have been progressed.

Key Actions

Recommendation 1 and 2: Review the processes that occur when a person is referred into the service and modify existing practice and policies to reflect a person-centred and responsive approach. Ensure the MDT Case Review Policy which has psychiatrist oversight, is fully implemented.

- Review of the MCH referral policy has occurred and a MEMO has been sent by the Clinical Director MHAS to medical staff highlighting the requirement of psychiatrist oversight of referrals to the service.
- All Palmerston North Adult Community Mental Health referrals are triaged and then reviewed at the Multi Disciplinary Meeting (MDT).
- All Rural referrals are reviewed by the Psychiatrist.
- Scheduled weekly MDT forums within Ward 21
- MDT forums in the community/rural areas occur as scheduled

Recommendation 3: Build and sustain a culture of critical thinking and a relentless focus on what matters to the person and family. Developing and activating leaders and improvement champions across all parts of the service.

- Appointments have been completed for the new clinical managers
- Re-establishing the operations meeting, has allowed for a shared forum to represent each area and how they are functioning, this also allows opportunity to discuss and work together to improve service delivery across MHAS.

Recommendation 4 &5: Develop and sustain an appropriate range of psychological therapies especially adequate Dialectical behaviour therapies (DBT); Implement and standardise a process for a person to be rapidly engaged in appropriate Psychological therapy and for the efficacy of this therapy to be regularly reviewed.

- DBT database and quarterly report are implemented.

- *External Training*
  All DBT clinicians have been supported to register with Practice Ground again for this year. The Palmerston North team have a scheduled education slot in their Consultation Group, which they have been dedicating to Practice Ground.

- A world-renowned DBT trainer is scheduled to visit New Zealand on 12-13 November 2015 to provide a workshop. The entire DBT team has been approved to attend this training event.

- *Internal Training*
  The DBT team are providing some internal training on DBT this year as well. This is in the form of a four-hour 'Introduction to DBT' workshop. The first of these was held on 22/04/15 and the second was held on 10/06/15. One more is scheduled for 04/11/15.
  The Palmerston North DBT Programme is currently providing the 'Distress Tolerance' module of their DBT Skills Group. Dates have been confirmed for 2015 and yet to be finalised for 2016.

- *Regional Personality Disorder Service*
  The Regional Personality Disorder Service (RPDS) continue to visit MCH on the third Tuesday of every month to provide consultation for clinicians working with clients diagnosed with personality disorders.

- Pharmacy input into MDT processes is established within Ward 21.

Recommendation 6: Actively support students in a way that minimises transitions of care and handovers to other services, including academic support and action ways to jointly support students with mental health needs.

- A memorandum of Understanding (MOU) has been established with Massey University, a further MOU is to be completed in consultation with UCOL.

Recommendation 7: Design and implement models of service delivery that support consumers in a variety of settings and that have the flexibility to adapt intensity of support when and where it is needed.

- Progressing of the 24/7 Acute Care Team (please see as part of the Major Projects item, 4.4)
- Established four beds in the community.
- Workforce Development plan with regards to culture change, three Let's Get real workshops facilitated by Te Pou have been scheduled for three specialties within MHAS.

Recommendation 8 and 9: Introduce and support collaborative note writing or similar tools, in order to keep the documented records accurate and meaningful to both consumers (and family) and to staff. Provide clear guidance to staff about how to share information with families

- Web Pas project has been established for the organisation which will have a link with the current clinical portal system which is progressing to include identified patient information which will inform and update health professionals on the patient. Representatives from mental health are members on both the clinical portal working group and also the WebPAS project. Not sure if there is a consumer/family rep on these groups