TO	Hospital Advisory Committee
FROM	Operations Director, Specialist Community & Regional Services Clinical Director, Mental Health & Addiction Services Director of Nursing
DATE	26 August 2015
SUBJECT	Mental Health Report

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

To report on the development of the Mental Health and Addictions services (MHAS) and continued implementation of the mental health external review recommendations. The recommendations focussed on the need to improve culture, leadership, and responsiveness. The completed mental health review actions and proposed further development is summarised in the 'phase one' summary report added to this document as an appendix.

2. SUMMARY

This report outlines the key activities in the Mental Health and Addictions services which create sustainable service development, quality improvement, including a change of culture and clinical leadership and governance. As noted above this is the 'phase two' of the work related to the implementation of the MHAS review recommendations.

Completed 'phase one' activities arising from implementation of the MHAS Review recommendations, are recorded in a summary document attached to this report as 'Appendix one completed.'

Phase two of the MHAS Review proposes the expansion of the review recommendations to create a sector wide vision, including development of a network of providers across our sector. The provider network will become the vehicle for development o both quality and improved service delivery across our sector. These goals are overseen by the Mental Health and Addictions Advisory Group.

Good progress has been made with scoping the options analysis for the redesign of Ward 21. However further work is required to further test the feasibility of the options and confirm the recommended next steps. This needs to consider both local DHB and wider capital expenditure planning and approval requirements in the light of the Master Health Service Plan. The fully developed options paper will be presented to ELT for consideration and endorsement before inclusion in the next full MH report to November 2015 HAC.

This report also has attached the plan for implementation of recommendations arising from the longitudinal clinical review of the care of Erica Hume. These two reports are attached as appendix two and three.

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 and move on to include quality and risk as well as large project management. 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 & Addictions Service Structure and management

Strengthening Clinical Governance and change of culture

The restructuring of the Mental Health and Addictions Services management continues to progress, with appointments to seven of the eight new clinical manager positions. The latest appointment, to the Alcohol and Other Drugs Service (AOD) clinical manager role will take effect in six weeks time. An interim manager has been seconded as the interim Clinical Manager until the new appointment has commenced and he will stay in this position until the new appointee has completed a comprehensive orientation to the service.

The Acute Care Team advertisement recruitment process did not attract any applicants and the position is being re advertised. In the interim, the very experienced Horowhenua Clinical Manager is managing this service and is more than capable of leading the ongoing development of the new model of care.

The development of the mental health leadership has continued with the Service Director, in partnership with the Clinical Director, facilitating three team workshops in the past month. Two Executive Leadership team half day workshops were held, to consider and plan to meet current challenges and set broader service direction. These workshops have enabled the team to set determine the next six months service priorities.

The executive leadership forums were followed by a full day workshop with the new clinical managers. This workshop included team building lead by a HR consultant, Vivienne Laurenson. The clinical manager team forum also addressed broad planning goals and determined operational priorities for the next six months. Both teams are very new and valued the opportunity to spend time developing emergent and increasingly effective working relationships.

Clinical governance of the Mental Health service is becoming well established through a mix of strong professional discipline, statutory representation and leadership in the executive leadership team. The leadership team includes the Nursing Director, Allied Health representative, Clinical Director, two Medical Heads and the Director of Area Mental Health Services. The forum is chaired by the Service Director and lead by the Service Director in partnership with the Clinical Director.

The management team, including the leadership team is now focused on the development of a quality and risk framework which will include monitoring and reporting on key performance indicators which measure service improvement. These indicators form the basis for this report on quality and risk to the Hospital Advisory Committee. The outcome of this direct monitoring and reporting both informs the service and the board about developmental priorities and establishes greater accountability across the service. This monitoring of current performance and required improvements will also improve service culture. The report on clinical governance and leadership includes sections from the Nurse Director, Allied Heath representatives and the Director Area Mental Health Services.

Nurse Director

The Nurse Director is working as part of the Mental Health Executive to progress priorities in service development. Key for this is work towards the nursing component of the workforce development plan and further developing multidisciplinary function, particularly in Ward 21. Good progress is reflected in the overall resilience and effectiveness of the Ward 21 nursing team in the context of recent high patient numbers and complexity of care.

Allied Health Representative

The allied health representative role has led the recent psychology review, and allied health plan. Both of these papers were developed in response to the Mental Health Review. Implementation of the recommendations from these reviews will form a key priority for the next six months for allied health.

The Director of Area Mental Health Services (DAMHS)

The Director of Area Mental Health has continued the development of the DAMHS office, 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.

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. The 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 it together with the Hume family who have provided input and it will now be monitored and reported on. The next step for this plan is to table the report and action plan at the Serious Adverse Event Review Group meeting (SAERG) which oversights the implementation of all action plans arising from clinical reviews.

The plan is attached to this report in Appendix 2. In future the report on implementation of the actions arising from the longitudinal clinical review will appear in the clinical review report section of this quality and risk part of the mental health report.

This is in line with our recommendation that the monitoring and reporting on implementation be separate from the mental health review. A progress report will continue for 12 months. A review of full implementation based on audit results will be completed in 12 months time.

Longitudinal Clinical Review: Shaun Gray

The final longitudinal clinical review into the care of Shaun Gray was received on the 13th August 2015. The findings and recommendations have been accepted in full and they will be incorporated into our service development planning.

Review Project Phase one Final Report

A Mental Health Review summary report on 'Phase one' of the mental health review project, and proposal to move to the broader 'Phase two' planning for a sector wide vision is attached to this HAC report. The summary report identifies the proposed transition from the initial phase one processes as identified in the external review to a longer term sustainable sector wide vision for the Mental Health and Addiction Services within the Mid Central region. The activities associated with the development of a vision and strategic development includes the 'phase two' ongoing recommendations of the Mental Health Review. The phase one summary report has been developed in partnership with the newly expanded review project advisory group. This expanded group now has input from our primary care and NGO partners. The Report is attached as Appendix one.

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. The explanatory comment is added in order 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 which will provide the context in which the later detailed quality indicators can be understood. It is useful to understand the total activity in ward 21 before looking at the accompanying reports on incidents and staff utilisation. Ward 21 and management of demand in this part of the service remains a challenging area and still require close management. Key areas that the service is monitoring are:

Ward 21

Activity data for ward 21 in representational graphs are attached at Appendix A.

Occupancy

The Executive Leadership team has focused strongly in the past three months on managing the acute demand placed on ward 21. The team has reviewed and updated reporting on unit activity in order to ensure an ongoing and more accurate understanding of the drivers of over utilisation. The team has maintained the rolling 12 month graph and update this to include when inpatients are on leave. There is an accompanying graph which focuses in on the month's activities which is aimed to provide more detail about occupancy and demand. The two graphs illustrate four key drivers that are being activity monitored.

Occupancy including leave management

Leave management is now included in the presenting data in order to provide a more complete picture of not only patients in the unit, but those on leave or returning from leave. Patients on leave remain the clinical responsibility of the inpatient unit and the inclusion of leaves provides a more accurate picture of the total demand on the unit. Patients on leave can return at any time to the unit.

Monitoring against funded and non funded capacity

The line graphs also now show utilisation in a rolling 12 month utilisation for both 24 (funded) and 26 beds, two unfunded).

Throughput or total activity

The overall utilisation of the unit is portrayed in accurate 'total patient movement' figures which indicate overall levels of activity. At times if the average length of stay is shorter the occupancy results can be lower but they do not alone indicate the unit demand as patient movement can still be very high. It is also important to monitor national KPIs which focus on numbers seen seven days prior to admission, post discharge and the readmission rate. We are consistently failing to meet the national KPIs in each of these areas. These KPIs are indicative measures of factors which lead to over utilisation. These KPIs are attached as the National KPI report at Appendix A.

Ward 21 Smoke free

Progress continues to be made in embedding a smoke free culture in Ward 21. Established guidelines are generally being followed well and supported by Multi Disciplinary Team (MDT) decision making. We see the smoke free policy on Ward 21 as moving to a 'business as normal' approach.

Consumer Engagement/Participation

Consumer and family input is a fundamental part of our further development of quality improvement. The leadership team is reviewing our current consumer and family input in order to strengthen the representational 'voice' from each part of our sector. The development of a partnership with Supporting Families, Mana o Te Tangata and other family / whanau and consumer groups and persons in our community is part of our consumer engagement project.

With the new members on the Consumer Engagement/Participation group, this will bring an NGO voice to the project. The Terms of Reference/Project Scope is being reviewed to better reflect a more district-wide perspective. It is expected the ToR/Project Scope will be finalised by 24 August 2015. A consultative forum is being held with the support of the consumer organisation partners-Mana o te Tangata in September.

MONITORING AND AUDITING

Serious Adverse Events Review Group (SAERG)

The Mental Heath SAERG oversights all reviews of serious adverse events. The SAERG also monitors all implementation plans arising from clinical reviews to the point of completion. Currently the SAERG is monitoring the implementation of eight review plans at present. The SAERG is also completing an audit of the past 12 month's implementation of review action plans. Ten review plans have been audited to date.

The SAERG is proposing a review of all completed suicides across our district as reported through the coroner's office as a midyear review project. This work will inform the suicide prevention strategy. The SAERG also oversights audits of implemented recommendations.

Quality Representatives

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.

Quality and Risk

ACTION/ITEM **Quality and Risk**	MILESTONE	COMMENTARY	RISK R **At Risk;** A **On track;** G **Complete.**
-longitudinal review (Erica Hume)	Action plan complete	Final action plan endorsed with a short list of clarifications	A
-longitudinal review (Shaun Gray)	Draft Action plan complete	Longitudinal clinical review received	A
-Phase One Review Project	Report complete	Report Complete	G
-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.	R
-Ward 21 smoke free	Ward 21 100% smoke free	Compliance with smoke free policy continues to be monitored.	A
- Consumer Engagement/Participation	Increased consumer/family engagement and participation	Review of current consumer and family input is being completed by the leadership group in order to strengthen representation from these groups.	A
-SAERG	All serious adverse events are reviewed with action plans completed	SAERG is completing an audit of the past 12 month's implementation of review actions.	A

4.2 Workforce Development

The service is embarking on the completion of a Workforce development plan. The plan is being supported by Central TAS. The workforce plan will include compliance with basic standards of practice, by discipline and monitoring competencies including registration and updated practice attainment. The plan will also include all education and training initiatives planned for a 12 month period, as well as goals associated with cultural change and maintenance of skill base for delivery of critical clinical programmes including Dialectical Behavioural therapy (DBT), Cognitive Behavioural Therapy (CBT) and motivational therapies. The final draft of a plan is expected to be completed by the end of September.

The workforce plan 'change of culture' activity stream is continuing in line with the MH recommendations. In this respect the previously reported plan to hold three TePou values based workshops before the end of the year are on track. The roll out is to three initial individual teams. These are Community Mental Health (CMH), Oranga Hinengaro (O.H) and Alcohol and Other Drugs (AOD). The focus of each workshop will be around values, attitudes and the role of supervision in supporting reflective practice.

4.3 Infrastructure development

Ward 21 Environment

Good progress has been made with scoping the options analysis for the redesign of Ward 21. However further work is required to further test the feasibility of the options and confirm the recommended next steps. This needs to consider both local DHB and wider capital expenditure planning and approval requirements in the light of the Master Health Service Plan. The fully developed options paper will be presented to ELT for consideration and endorsement before inclusion in the next full MH report to November 2015 HAC.

WebPAS

The MHAS is engaged in the scoping exercise that is the beginning of our WebPAS project. The service has identified key staff, who have been working with the Business Analyst within the WebPAS project team to demonstrate current practices and processes.

Clinical Portal

The clinical portal has commenced uploading of the historical clinical information from January 2015; this will take some weeks to complete.

4.4 Major Projects

The Acute Care Team (A.C.T)

Work on development of the new service model continues to be progressed with the current plan to roll out the service model by end of September. The project team are mindful of the need to keep all stakeholders informed and updated. Whilst there has been no change to the way in which referrers access the service, to date, it is still key to remind all of the current processes.

The Older Adult Mental Health Service (OAMHS)

A timeline is to be confirmed for Mental Health Services to take over direct management of OAMH. An implementation plan has been developed and integrated with a consulting process which will be released in early September.

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 at 'St Dominics' which houses up to 12 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. A review of their needs and more appropriate placement with aged care services which will better meet these needs is ongoing. The provider arm is providing support to expedite what has become a long process of multiple assessments. Until a more appropriate placement is found for individuals in this unit, access to high support accommodation for complex mental health clients is reduced.

Profile of needs of clients in the NGO sector

Both NGO partners are engaged 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 mental health. With better placement in age appropriate settings, capacity for current mental health clients improves.

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 these placements be continued for a further six months in order to build on this effective start to placing complex clients, and assisting with management of the ward 21 demand. Planning and funding portfolio manager has extended the contract for six

weeks in order that a proposal is submitted before the end of August prior to approving a longer trial.

Horowhenua

We have flagged that there is a need to extend access to supported accommodation and crisis respite to the Horowhenua region.

5.0 NEXT STEPS

Older Persons Specialist Mental Health Service

The need to strengthen specialist services for older persons is central to our range of required services. Following progress with the Star One development, the MHAS plans to further develop our specialist community mental health service for older persons. Taking this step will create a full range of services across the complete age range of need for our community.

Social Housing- Review of supported accommodation

The MHAS will continue to work with our NGO partners to develop improved access to support packages of care and accommodation in the community with an agreed 'whatever it takes' approach to providing support and accommodation for clients of the Mental Health Service.

Develop and implement a quality and risk framework including reporting, monitoring and auditing activity

The MHAS aims to have a standardised monitoring, reporting and auditing system which will focus on service improvement and ongoing implementation of Mental Health Review recommendations by 30 September 2015.

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.

Stakeholder input
The MHAS will have a secure and stable system of consumer, family / whanau input which will incorporate a co design approach to service development by December 2015.

Options paper and mental health unit redesign

A background options paper has been completed. This paper assesses and analyses the design issues with the current inpatient unit and benchmarks against contemporary projects for inpatient design, as well as reference design standards for mental health inpatient units.

However, further work is required to further test feasibility of the options that have been identified and consider both local DHB and wider capital expenditure planning and approval requirements in light of the Master Health Service Plan. It will also consider what can be undertaken in the short/medium term to improve the Ward 21 environment. The fully developed options paper will be presented to ELT for consideration and endorsement before inclusion in the next full MH report to November 2015 HAC.

Nicholas Glubb
Operations Director Specialist Community & Regional Services

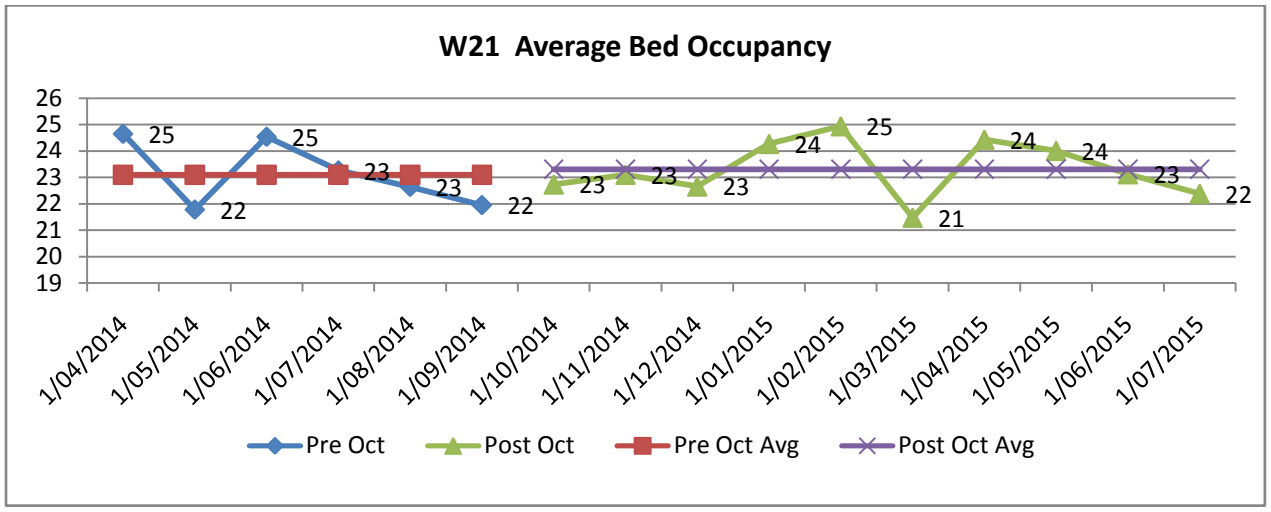
Dr Syed Ahmer
Clinical Director Mental Health

Michele Coghlan
Director of Nursing

APPENDIX: A

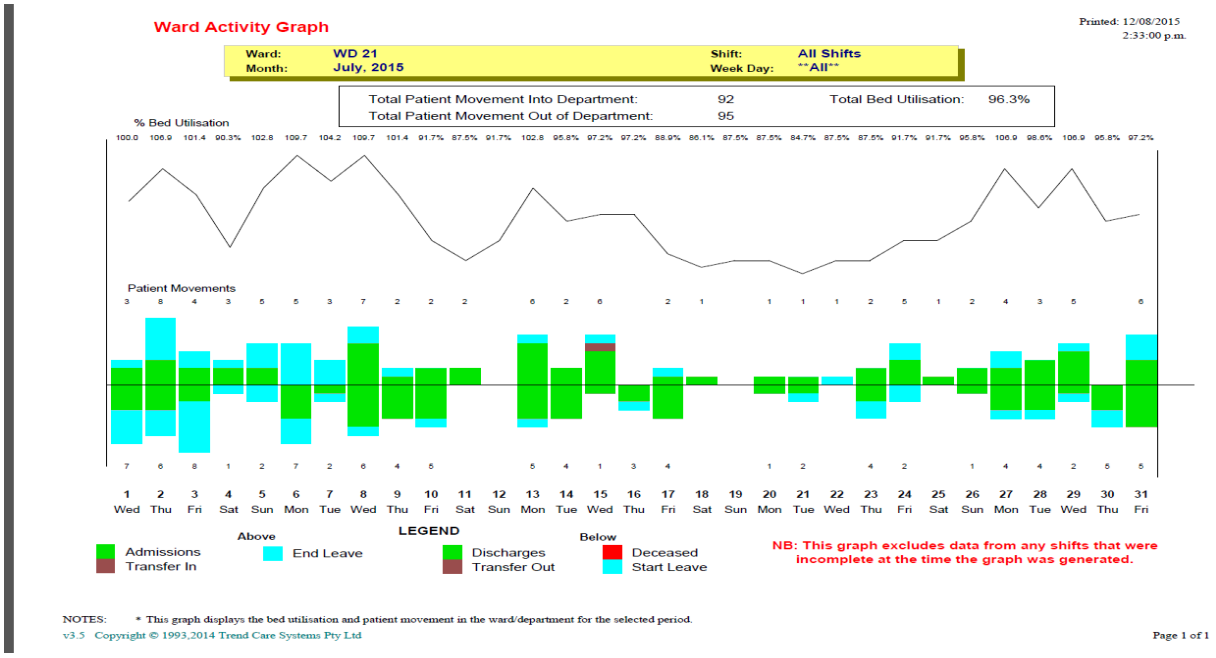
Mental Health & Addiction Services Performance Report

Table One: Ward 21 Average bed occupancy



Total admissions for July: 56, which is higher than previous months.

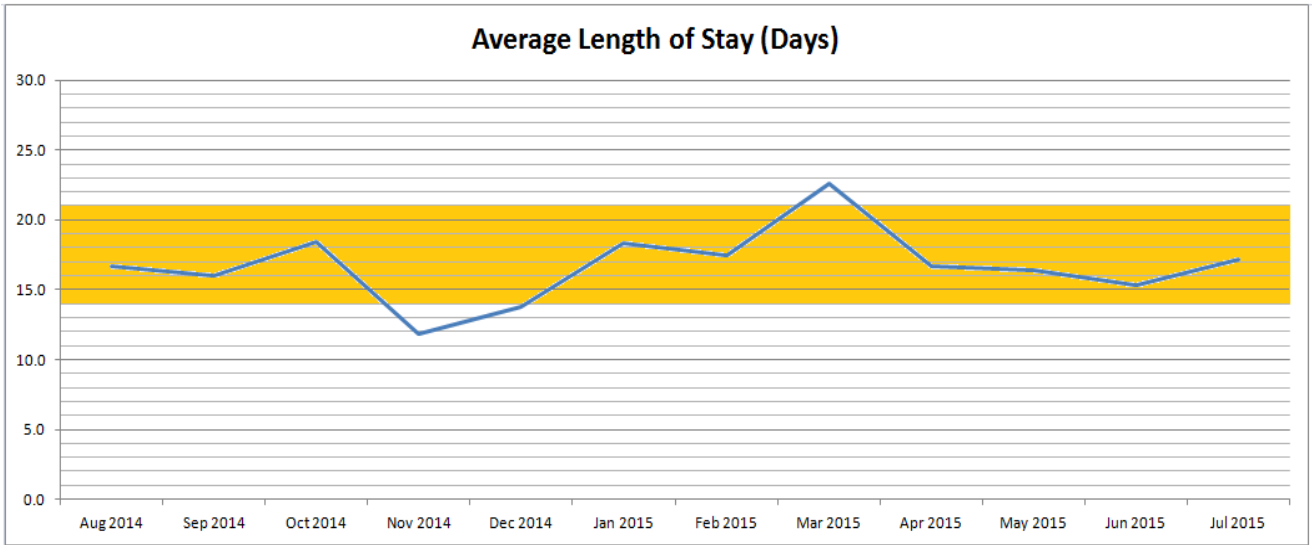
Table Two: Trendcare Activity for Ward 21 (Occupancy/Utilisation/patient movement)



The above graph indicates the Occupancy and utilisation for Ward 21 in July which is based on 24 resourced beds. Patients movement out of and into the department includes admissions/discharges/transfers and patients 'on leave' or return from 'on leave'.

A key point to note in this report is that the over utilisation of inpatient beds peaks at regular times during the month. These figures which can reach 109% do not include those patients on leave. Capturing the leave figures and noting the higher peaks of utilisation is a more informative report on demand placed on the inpatient unit rather than the traditional average occupancy.

Table Three: Ward 21 average length of stay

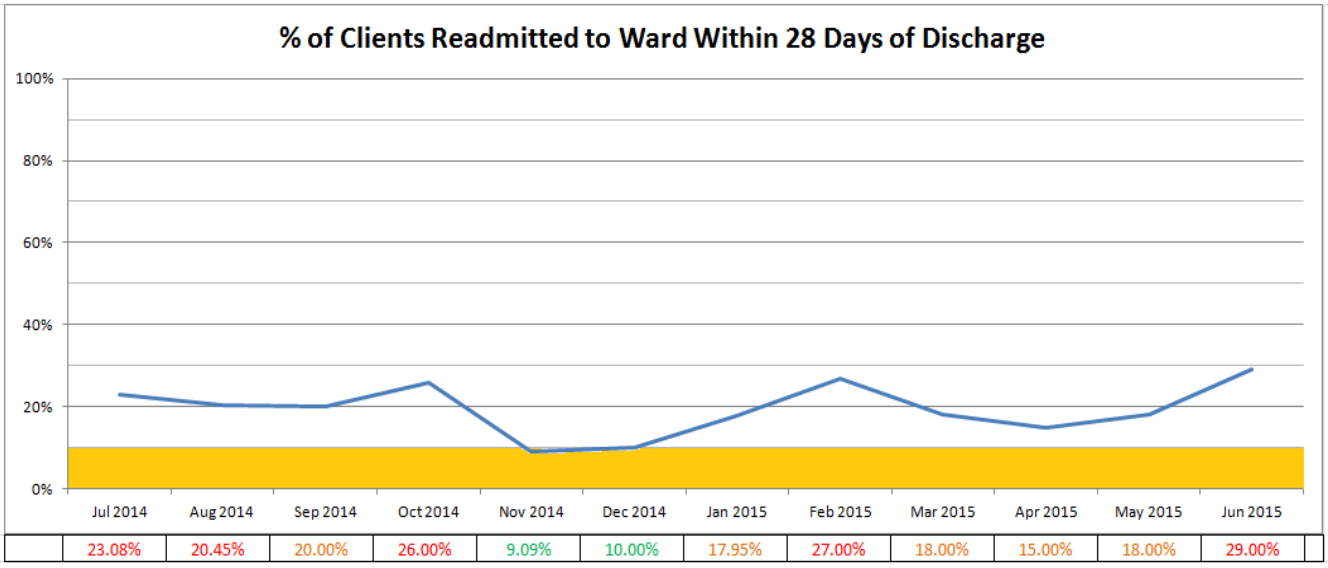


	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015
Days	16.7	16.0	18.4	11.8	13.8	18.3	17.5	22.6	16.7	16.4	15.3	17.2

Ministry of Health Target: 14 - 21 days

The ALOS remains within the Ministry of Health target range; this has been achieved through multi disciplinary discharge planning meetings and the ability to use community beds.

Table Four: Percentage of clients who are readmitted within 28 days of Discharge



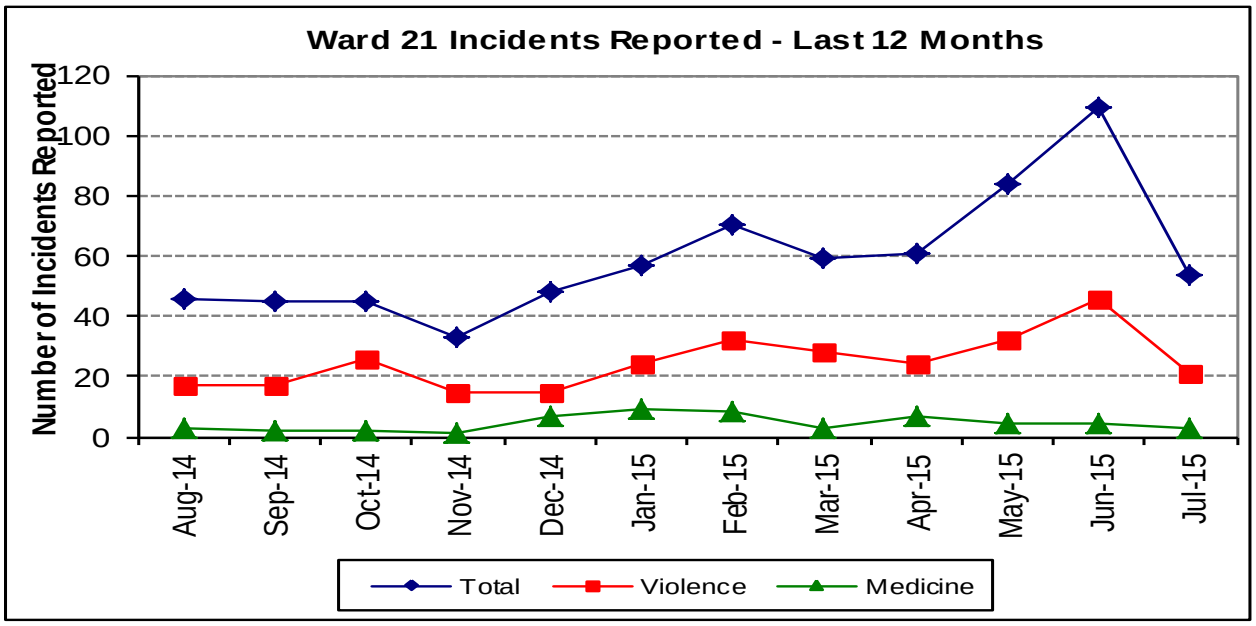
	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
	23.08%	20.45%	20.00%	26.00%	9.09%	10.00%	17.95%	27.00%	18.00%	15.00%	18.00%	29.00%

Ministry of Health Target: 0-10%

As noted in the narrative above, the KPI for readmissions has not been met. This KPI is under close monitoring by the service. Close monitoring is needed in order to improve the quality and effectiveness of discharge planning.

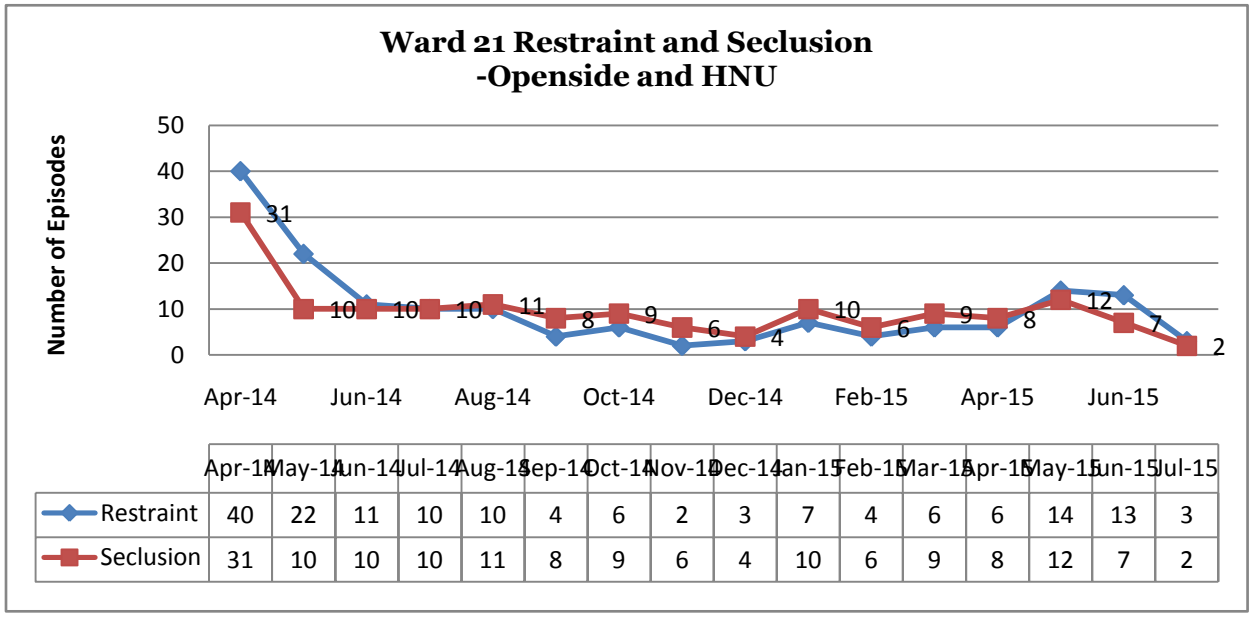
However, our current audit reveals that closer scrutiny and analysis of the data is required, as it appears some contact data has not been included in the report to the MOH. This will mean that once data is corrected the actual achievement for this KPI will improve.

Table Five: Ward 21 Total Incidents Reported



The above graph represents total incidents including- total self harm, conduct/behaviour/abuse and threatened self harm. More detailed individual graphs are included later in this report.

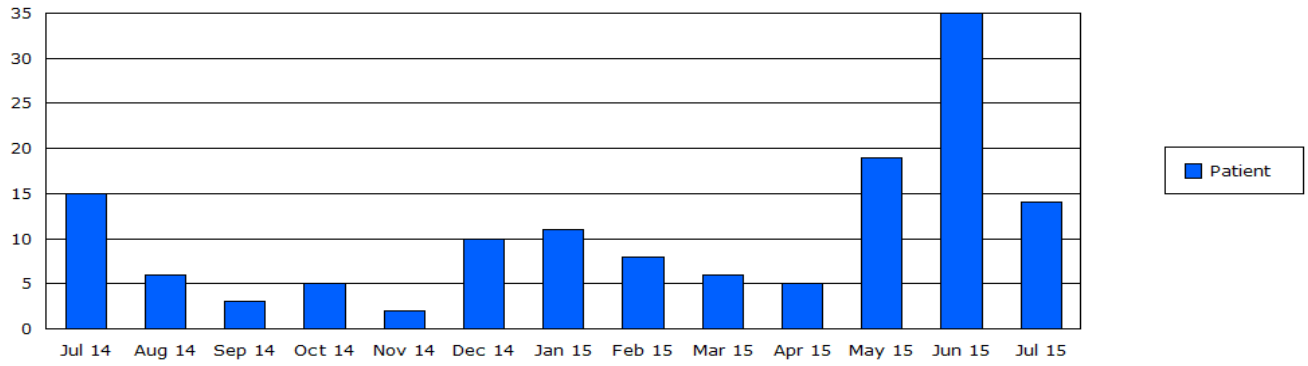
Table Six: Ward 21 Restraint and Seclusion Open side and HNU



	Apr-14	May-14	Jun-14	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
Restraint	40	22	11	10	10	4	6	2	3	7	4	6	6	14	13	3
Seclusion	31	10	10	10	11	8	9	6	4	10	6	9	8	12	7	2

Seclusions and Restraint Note the continuing decline and overall low utilisation of seclusion and restraint despite high occupancy and activity. This is a good outcome from the team in ward 21 under difficult circumstances.

Table Seven: Ward 21 Self Harm – Actual and Threatened July 14 – July 15



Note the lower report for July despite increase in activity.

Table: Eight: Ward 21 Threatened Self Harm only July 14 – July 15

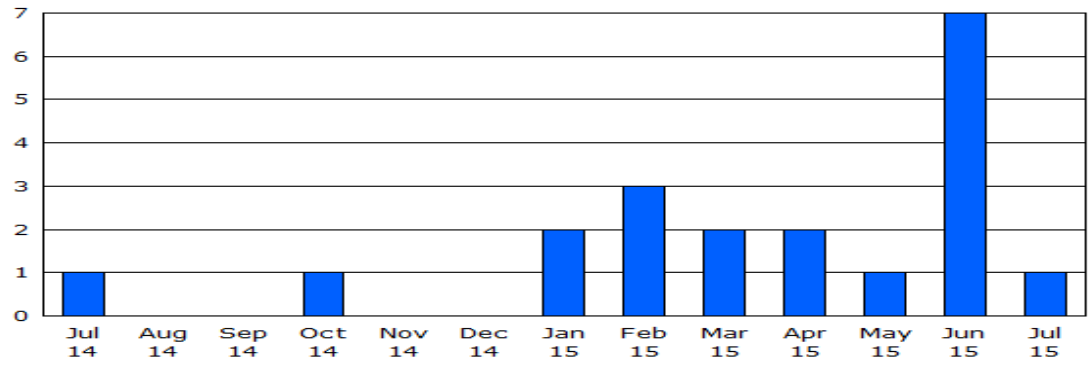
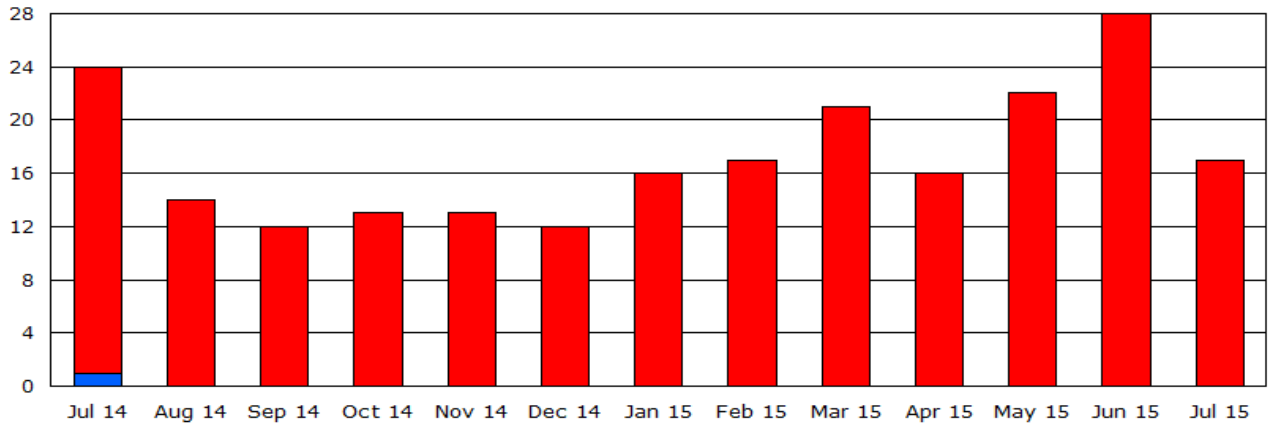


Table Nine: Ward 21 Conduct/Behaviour/Abuse towards Staff (Violence) July 14 –July 15



Self Harm/ threats and actual, and behavioural challenges.

The graphed results are linked to the overall level of activity in the unit. High periods of admission and occupancy occurred in June and July. In June two patients were the cause of a significant number of incidents.

Table 10: Ward 21 staff average double shifts April 2014 – July 2015

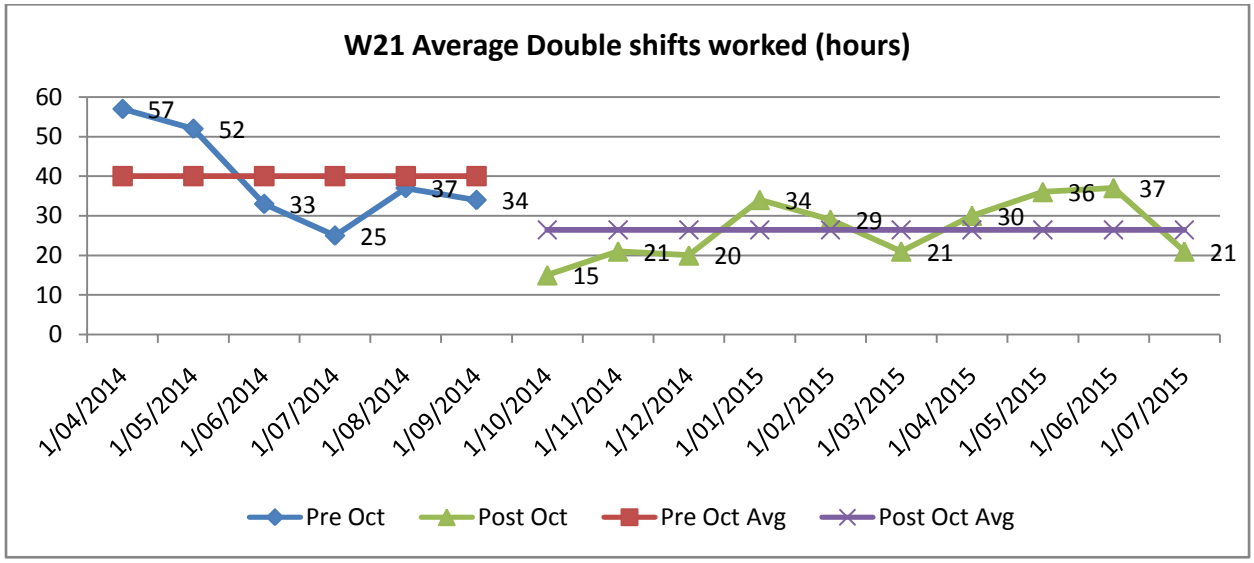
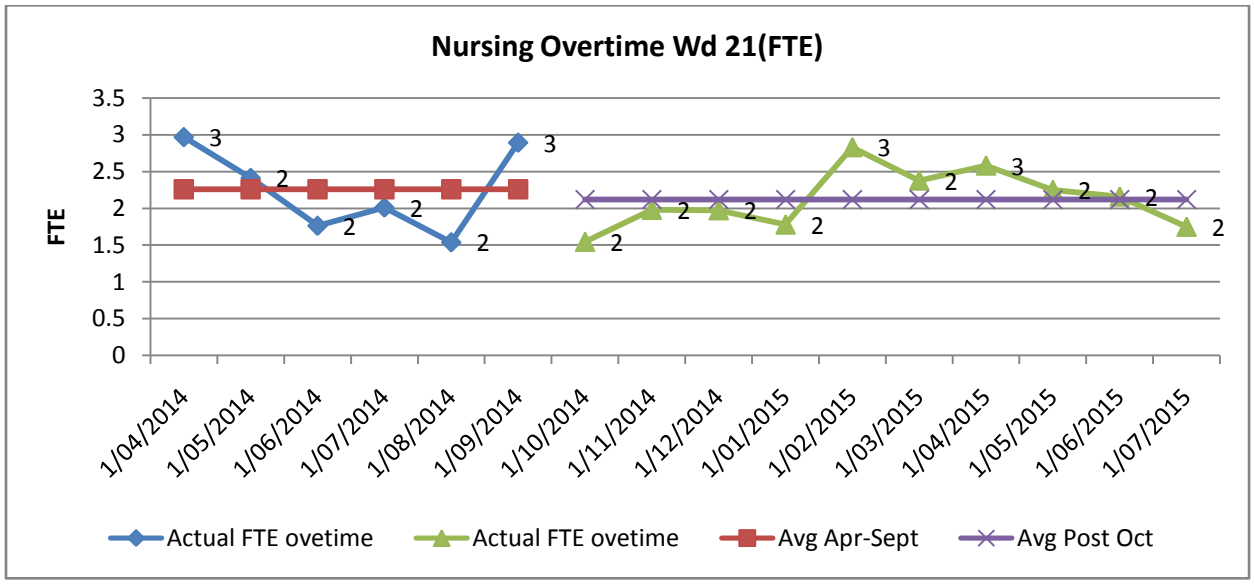


Table 11: Ward 21 Staff Over time April 2014 – July 2015



Staffing

The graphs above indicate staffing fluctuation including overtime and double shifts over the past month. There were periods in June, and end of July and early August which resulted in very high occupancy and demand on the unit. The inpatient team worked very hard to manage demand during this period. In June the unit managed a cohort of young people who needed of inpatient care. In late July and early August the unit experienced very high demand and over occupancy in the unit. The executive team held an afternoon tea in recognition of the effort made by the inpatient team at this time.

Mental Health KPI July 2015 (National Benchmarking)	Monthly	Target
28 day acute inpatient readmission rate (**for June**)*	**29%**	0-10 %
Average length of acute inpatient stay	**17.2**	14-21 days
Pre-admission community care (Seen in 7 days before ward admission)	**80%**	75-100 %
Post-discharge community care (Seen in 7 days afterward discharge)	**69%**	90-100 %
% current clients with deferred diagnosis (DSM IV 7999)	**18.00%**	
% HoNOS/CA/65+ Compliant Admissions and Discharged - Community Teams	**64%**	70%
% HoNOS/CA/65+ Compliant Admissions and Discharged - Inpatient Team	**79%**	80%

The national Key Performance Indicators are reliable and relevant measures of overall service activity and responsiveness. Key indicators which require improvement are the readmission rate, 29% and pre-and post admission targets. The preadmission target has improved significantly -80% but post transfer of care has remained low 69%. These three indicators are a combined useful measure of how well the community services are doing in regard to acute care. Post transfer of care pick up of clients within seven days is an improvement target for our community mental health teams. The readmission rate is affected by pick up rates post transfer of care.

Data Validity

We are currently auditing the data entry and reporting for these KPIs. These KPIs are a focus for the new Clinical Managers in the community, particularly the Palmerston North Clinical Manager. On an initial audit it appears that the data is not fully taken up in our systems and both the post transfer of care and readmission rate data may improve with better data entry. A full audit and improvement in data validity is expected to be confirmed in the following HAC report.

APPENDIX 1: Phase One Review Report

TO THE MENTAL HEALTH AND ADDICTION SERVICES REVIEW PROJECT ADVISORY BOARD

PROGRESS REPORT ON MENTAL HEALTH AND ADDICTION SERVICES REVIEW PROJECTS

18 AUGUST 2015

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EXECUTIVE SUMMARY

This report provides a reference point for the Mental Health Review eighteen months following the initial completed suicide events which lead to a service wide external review, and twelve months after the receipt of the final review report and recommendations.

The report records the progress of work to address the External Review recommendations following the two serious adverse events in April/May 2014. It sets out progress with the Phase One programme of work, maps ongoing work from Phase One that is transitioned into Phase Two, and highlights the next steps for the work that will take a planned whole of system approach for the redevelopment of mental health and addiction services across the MidCentral DHB district.

The mental health review project grouped the review recommendations under seven general headings as a means of organizing aligned work streams which were derived from the recommendations. This organization of the review work streams under seven grouped headings is continued in the layout of this summary document. All recommendations are listed under the grouped headings and each grouping is followed by a summary description of actions taken to implement all of the recommendations, to end July 2015.

Ongoing work that needs to be carried through in the service planning process is identified and carried over to be completed as part of 'Phase Two'. Phase Two relates to longer term planned development approach, builds on the work to date and looks to the future to sustain the momentum of improvement for consumers, families and staff.

Completed work under each of the recommendation headings includes:

Governance

- a change management process was developed and a review of clinical governance structure undertaken
- a Clinical Director and medical heads were appointed
- review of clinical audits arrangements undertaken
- a service executive was established that reflects the principles of clinical governance
- Managerial and CEPD roles were disestablished and a Service Director and Clinical Managers appointed
- A consumer engagement/participation project was initiated which will continue into Phase Two.

Structure

- a restructure of the mental health leadership was undertaken and a new Service Director appointed with clear single point of accountability and responsibility for the services overall
- Agreement was reached for a new 24 hours emergency service – now called the Acute Care Team – based in the Palmerston North Community Service and additional staff resources appointed. This team will manage the single point of entry (SPoE) and in future manage people

in crisis under a home based treatment model when appropriate. Progressing this team will be carried into Phase Two.

- A proposal to re-align the Older Adult Mental Health (OAMH) Service with Mental Health Services – including a proposed restructure of nursing leadership across Ward 21 and Star 1 - has been completed, along with an operational plan on the reconfiguration of and interface between OAMH, Mental Health and Elder Health Services.

Culture

- we have engaged Te Pou, the national workforce centre, to run a workshop on its *Let's Get Real – Values and Attitudes* programme and these workshops will continue into Phase Two
- formal weekly Executive and Operational meetings with new Clinical Managers have been implemented to identify barriers to decision making and address them
- There is now an established partnership between the Clinical Managers and Consultant Psychiatrists in a multidisciplinary team context to provide clinical governance and oversight. Care plans and clinical decisions are documented as an outcome MDT forums
- Improved linkages with consumer and family organisations are being developed. In addition, there is a MoU with the Student Health Service of Massey University in place.

Clinical Leadership and Partnership

- internal and external mentoring and support is now provided for the Clinical Director who also engaged with other DHBs for shared learning
- each MDT has a Consultant Psychiatrist whose role, in partnership with the clinical Manager, is to provide clinical leadership
- the Executive Forum has an established partnership of Allied Health, Nursing, Medical and managerial roles providing clinical governance, whilst the Service Executive Team monitors incidents, complaints and national KPIs set for the sector and the Service Forums include cultural, family and consumer representatives.

Quality and Safety

- A review by the Serious Adverse Event Review Group (SAERG) of all reported adverse events for the past year was undertaken. All recommendations arising from these were reviewed and monitored for implementation
- the Mental Health Mortality and Morbidity Forum was established
- weekly self harm reports are generated from Ward 21
- an Open Disclosure plan was developed and an educational workshop was held
- the service has now integrated the London Protocol with the Taproot process for RCA investigations
- regular environmental audits in Ward 21 are now undertaken by the Health and Safety representatives and reports are presented to the Mental Health and Addiction Services Review Project Advisory Board, with issues highlighted and actions taken
- Transitioning to Phase Two, the SAERG is developing an audit system for all ongoing recommendations. The SAERG has expanded its terms of reference to include reporting on 'near misses' and will continue to monitor related incidents to provide opportunities for service improvements.

Staffing

- a mental health training plan and schedule was updated
- Advanced Suicide Assessment and Risk Management training has continued with attendance of 154 front line staff at completion of the last workshop in April this year, including almost 100 percent of Ward 21 staff
- the DBT capacity was increased by four roles (from foundation to intensively trained) and therapy groups are now operating
- in Ward 21 a reorganization of staff skill mix/roster for staff-to-patient ratio and allocation was established to support and improve practice
- Associate Charge Nurses for morning and afternoon shifts were also put in place to support nursing leadership
- the position of Director of Nursing for mental health and addiction services has been temporarily seconded from the general hospital until a permanent role is appointed
- the consumer and family representative roles ensure linkages between their roles and the constituency they represent are improved and strengthened
- Further work to support professional development will continue through to Phase Two, including a new training and development calendar.

Ward 21 Facility and Environment

- environmental safety changes have been made to the ward including removal or replacement of key identified ligature points, shower heads and coat hooks
- changes were made to strengthen nursing leadership - two Clinical Nurse Specialists were seconded to provide mental health nursing leadership as well as support for the temporary appointment of the Charge Nurse, seconded from within the general hospital
- A cap on bed numbers was implemented to maintain a safe level of care and daily Dashboard reports are provided on bed status. The Clinical Director now reinforces stringent admission classification. Ongoing and intensive oversight is maintained.
- The use of CCTV enables staff to clearly identify people entering the ward and what is occurring in the open side communal area. It is not used as a clinical tool
- a systematic approach for responding to incidents has been developed and changes made to incident review processes to manage complex and high need patients
- formal procedures for staff injuries are now reinstated under the Riskman process
- a debriefing policy is in place and further work to put in place debriefing processes will be included in the workforce development plan in Phase Two
- A business case is being developed to address the design and upgrade of the facility. This work will be carried over into Phase Two under Infrastructure.

RECOMMENDATIONS:

It is recommended that:

1. The Review Project Advisory Board accepts this report.

2. The Review Project Advisory Board endorses this report for submission to the September Health Advisory Committee meeting.

SIGNED:

DATED:

1. INTRODUCTION

Following two serious adverse events in April/May 2014 an external systemic review of MidCentral secondary Mental Health and Addiction Services was commissioned. The review terms of reference aimed to ensure that any underlying issues in relation to the structure, resourcing or culture of the service was identified and addressed.

The Review was completed in August 2014 and 50 recommendations were made (six of these recommendations were subsumed into other review project areas, including implementation of clinical electronic records, and root cause analysis of the two deaths undertaken by the RCA teams).

To implement these recommendations, a work programme was developed and a project team put in place to help drive the changes. The project team received guidance from the Mental Health and Addiction Services Review Project Board (now called the Mental Health and Addiction Services Review Project Advisory Board). The review project team continue to submit regular reports to MDHB Hospital Advisory Committee.

Purpose

The purpose of this report is to provide the Mental Health and Addiction Services Review Project Advisory Board with a summary of the state of completion for 'phase one' tasks of the Review Work Programme: Phase One is completed work, arising from the Review recommendations. Phase Two is about taking the remaining recommendations which relates to longer term development, or larger projects and ensuring these are captured in the broader service plan. Incorporation of these recommendations in the broader service plan will link them to related developmental plans, and embed the Review recommendation goals into our core service development planning.

An example of a Phase One goal which has been completed is establishing Dialectical behaviour therapy training and service delivery. An example of the Phase Two component attached to this recommendation and incorporated into the future plan will be completing a workforce plan which will address all training needs, including ongoing sustainable training for DBT. Another example of a completed phase one actions but continuation of phase two development relates to the recommendation about inpatient unit redesign. Immediate Phase One goals to complete some refurbishment are met, but our longer term planning needs to include re-design which may include consideration of new build options.

This report will serve as a reference document which sets out the achievements made against Phase One actions to meet the External Review recommendations, record how these are embedded into 'business as usual' and also provide a clear link to our service planning goals for those recommendations which have commenced but require longer term implementation.

The report indicates a planned approach to transition to Phase Two and looks to the future to build on this review project work to sustain the momentum of improvement for our service.

2. PHASE ONE

Introduction

The review recommendations are numerous. For the purpose of coordinating effort when implementing recommendations, they were grouped under seven general headings. These headings were used to guide the project action plan completed by the Mental Health Review project implementation team.

The actions were also viewed in stages. Phase one being the initial implementation of tasks that required urgency, and commencement of implementation of larger projects which were planned for completion over a longer period of time. Phase one is now completed (see Appendix I: Phase One Status Report). This now marks the end of the first stage of the External Review recommendations.

The headings used to group together or aggregate the review recommendations were:

- Support for strengthening clinical governance
- Reviewing the structure and reporting arrangements
- Re-establishing the MHAS vision, values and embedding a change in culture
- Ensuring strong clinical leadership and clear partnerships established
- Reviewing quality and safety processes
- Staff actively supported to develop professionally, including team training
- Improving the acute admission Ward 21 environment, including a cap on bed numbers, and debriefing processes in place and upgrading the ward facility design and layout.

The following update lists the recommendations under each grouped heading and is referenced in the narrative report, evidencing actions taken to date. The narrative report is also linked to an updated action plan report in the Hospital Advisory Committee action plan report format, for consistent detailed reference.

SUMMARY OF PROGRESS

The following outlines the actions taken to address each of the recommendations under Phase One.

1. Support for Strengthening Clinical Governance

The Reviewers noted that clinical governance, '…has a key role in ensuring availability, quality and standardisation of evidence-based practice…' They observed there were unclear roles and fit between roles across services, the quality of partnerships was variable and the interface between services was ad hoc.

Review Recommendations:

The organisation needs to provide clear leadership and support for strengthening clinical governance in the mental health and addiction services through:

1. Articulating the vision, values and expected behaviors for MidCentral Health leadership and clinical governance.
2. Role modeling effective clinical governance at the executive level.
3. Giving ownership and accountability back to services, with clear points of accountability.
4. Clarifying expectations of accountability but also delegated authority to act.
5. Establishing consistent forums at all levels, with structures, processes and reporting based on the commonly agreed pillars of clinical governance.
6. Improving governance partnerships across the clinical governance leadership group with effective teamwork and clearly valued opportunities for wider contributions, from clinical and professional leaders of all disciplines, managers, consumer and family leads, quality and risk experts and business analysts.
7. Clarifying roles, especially the clinical manager roles and CEPD roles, and reporting lines.

Summary of Implementation

Implementation of a change management process was developed and a review of the clinical governance structure was undertaken in consultation with mental health and addiction services staff.

In the service, a Clinical Director was appointed and medical head roles established to support the new Clinical Director - reviews of clinical audit arrangements undertaken (with a process for regular reviews now in place), and clinical delegations and expectations established. Following appointment of a Service Director, the mental health and addiction service has established a service executive, with membership that reflects the principles of clinical governance. In addition, all of the prior managerial and CEPD roles were disestablished and new Clinical Managers were appointed with clear reporting lines. There is a functioning operational forum driven by the newly appointed Clinical Managers.

These changes have provided for clear points of accountability and clarifying expectations, improving governance partnerships and clarifying roles and reporting lines (see below: Structure and Reporting Arrangements).

In line with the recommendation on improving partnerships and engaging consumers in the clinical governance and leadership process, a consumer engagement/participation project has been initiated. The aim of this project is to be managed as part of Phase Two and with the goal of developing and embedding a vision of consumer, family and whanau engagement and participation within a model of co-design – a partnership between staff and consumers to work together for service improvements. The project group has met five times. The Terms of Reference/Project Scope is rewritten to include a district-wide view of the purpose and goal.

Transition to Phase Two:

The consumer engagement/participation project will continue into Phase Two.

As of June 2015 the Mental Health and Addictions Services Review Project Advisory Board has an extended membership and Terms of Reference which supports the development of a whole-of-sector vision and strategy for mental health and addiction services. The Board will continue to oversee work on progress of Phase Two.

2. Reviewing the Structure and Reporting Arrangements

The Reviewers noted the management and leadership structure appeared inconsistent, with confusing roles and reporting lines. There was also concern on the way the acute emergency mental health service was structured with inadequate resourcing to cover the DHB catchment area after hours, and lack of a formal psychiatric consultation-liaison role.

They also highlighted the need to support a medical/clinical manager partnership.

Review Recommendations:

1. Consider having a clear single point of accountability and leadership for mental health and addiction services that sits at service level and reports to the Operations Director and is responsible for decision-making in conjunction with clinical partners.
2. Review the effectiveness of the Service Development portfolio and where it sits in the structure; consider how the CEPD roles, if they are needed, might add more value to improving quality and effectiveness of the services.
3. The separation of daytime and out of hour's acute responses needs to be reviewed, given the dissatisfaction with the current model. The evaluation of the model needs to be undertaken in terms of capacity to meet crisis and urgent response needs for communities, the emergency department, primary care and other secondary clinical services; location; effectiveness; and medical staff roles in the service. An opportunity may also arise to formalize the psychiatric consultation-liaison service and strengthen the linkages across clinical services.
4. Medical staff in particular should have designated leadership roles at the clinical team level and should function as clinical partners for the Clinical Managers at that level.

Summary of Implementation

A review of the services structure, key leadership roles, reporting arrangements, accountability, and key partnerships at every level was undertaken. A restructure of the mental health leadership was completed and a new Service Director was appointed (May 2015) in which the position has a clear single point of accountability with responsibility for the services overall, and reporting to the Operations Director. In addition, the Clinical Education Practice Development roles were disestablished and Clinical Managers appointed for each of the specialty areas, reporting to the Service Director.

A review of the out-of-hours acute response service was undertaken in consultation with staff, consumers and families. Agreement made to put in place a new 24 hours emergency service – the Acute Care Team, relocated to the Palmerston North Community Service and additional staff resources appointed. This team will take the responsibility of managing the single point of entry approach across the mental health and addiction services and in the future will respond to people in crisis under a home based treatment model of care, when that is appropriate.

Transition to Phase Two

Progressing the Acute Care team establishment with the development of a new model of care that encompasses all aspects of acute care in the community and hospital settings.

3. Re-establishing the MHAS vision, values and embedding a change in culture

The External Review team made the observation there was a passive, complacent and powerless culture within the services. There were issues related to habitual, shaped beliefs and behaviours that have not been questioned; complacency; avoidance of action and learning; no clear sense of vision and direction for the service or how each service area 'fits' as part of a whole; and key people did not appear to have authority to make decisions and act on these. The Review team recommended that a programme of action be developed to re-establish vision, values and culture, and engage clinical teams and consumers in the process. In addition, standards of behaviour and standards of clinical practice are clearly articulated and addressed and the appropriate levels of authority to decide, act and review are delegated.

Review Recommendations:

1. MidCentral Health needs to undertake a programme of action that re-establishes its vision, values and culture and which clearly articulates that in practical terms.
2. Mental Health Services need to be more effectively connected to wider DHB structures through clinical and quality activities and professional group activities.
3. Clinical governance and stronger leadership need to be visible to clinical teams and to proactively engage clinical teams and consumers in the above process.
4. Senior leadership need to work with service users, families and staff to make some clear action-orientated commitment to change and agree where to start – breaking that down into practical achievable steps.
5. Innovation and initiative need to be modeled and encouraged by managers and clinical leaders, to create a sense that change for the better is possible and will happen.
6. Leadership and governance teams need to ensure that the appropriate level of authority to decide, act and review are delegated, so that when ideas and service improvements are generated, decisions are made and things happen.
7. Clinical Directors need to determine professional/clinical issues and actions required; expectations and responsibilities of line managers to act need to be clearly documented.
8. Standards of behavior and standards of clinical practice need to be clearly articulated and addressed, with positive examples acknowledged and problems acted upon appropriately and effectively.
9. Encouragement should be provided to all disciplines to work in different clinical areas by offering staff rotations or secondments either within the DHB or external to the DHB. Staff and managers need to collaborate on policy development and implementation with clear buy-in. This should not be a top down process.
10. Links should be established with clinical leaders in mental health and addiction services at other DHBs, and staff, particularly from Ward 21, should be sent to visit facilities and to meet with their counterparts at other DHBs, to seek new ideas and resources, which can support quality improvement (the external reviewers could provide contacts if required).

Summary of Implementation

The Project Board visited Whanganui and Waikato DHBs mental health services, to engage and learn regarding the challenges that those services had faced and the approach that they had taken to respond. A focus was identifying key factors that strengthened the culture of the service, predominantly through stronger clinical and managerial leadership, and clinical governance.

Te Pou was engaged to run a workshop on its *Let's Get Real* competency programme - *Values and Attitudes* for senior staff to help focus on improving clinical practice and working more therapeutically with consumers. The Te Pou workshops are value based, address expectations about standards of interpersonal behaviour and support improved clinical decision-making.

Whilst the Mental Health and Addiction Services Review Project Advisory Board is developing a sector-wide vision, the goal is to build a vision with a more engaged and 'ground up' approach, allowing time for a well supported vision to be developed in partnership with community stakeholder groups, including NGO providers, and aligning with the DHB overall planning process and timing.

Formal weekly Executive and Operational meetings with new Clinical Managers has been implemented to identify barriers to decision making and address them. The Service Director is establishing cost centre based financial management strategies to support competent service level decision-making about allocation and distribution of resources, as well as ownership of allocated budgets.

There is an established partnership between the new Clinical Managers and Consultant Psychiatrists in a multidisciplinary team context that provides clinical governance and oversight to individual care planning and engagement with consumers and families. Care plans and clinical decisions are documented as an outcome of the MDT forums, including tasks delegated to individual clinicians.

Visits to other services are encouraged and some Clinical Managers, Ward 21 Charge Nurse and nursing staff, and review project team members have visited other DHB services. Staff movement between services has been a feature of this year and this movement has been accommodated within the current budget allocation to each service.

Improved linkages with consumer and family organisations are being developed with individual visits to these organisations completed by the Service Director in the first three months of commencement. Linkages also include the development of a Memorandum of Understanding with the student health service of Massey University.

Further workshops with the teams on Te Pou's *Let's Get Real* values and attitudes training will assist in improvement to people's behaviour and cultural enhancement.

Transition to Phase Two

- Further work to embed vision and values, aligned with the sector view will be followed up in Phase Two under workforce development.
- Establishing a quality and risk framework which will include ongoing monitoring and auditing of implementation of recommendations.
- Management team development and training: ongoing service team development processes with the new Clinical Managers will be part of Phase Two, once these newly appointed Managers are embedded into their roles and there is stability within the teams. A team planning day is being organized for the new Clinical Managers on the 6th August 2015.

4. Ensuring Strong Clinical Leadership and Partnerships

Some of the issues observed by the Review team have been noted above. They also commented that strong clinical leadership, in particular medical leadership, was lacking. The Review team did acknowledge the challenge for provincial DHBs in New Zealand to attract and retain experienced clinical leaders, particularly in psychiatry which has a scarce national workforce. They also noted from interviews with staff clinical leadership and partnership was seen as a critical issue.

Review Recommendations:

1. The incoming Clinical Director should be actively supported by the DHB to undergo leadership and management training and to receive mentoring, both from other clinical leaders within the DHB and from Clinical Directors in Mental Health services at other DHBs in the region.
2. Additional clinical leadership roles should be established within the Mental Health service and in particular there should be a medical leader for each large clinical team or group of teams, with clear responsibilities and partners, and encouragement to use Continuing Medical Education (CME) resources for development of leadership skills.
3. Clear partnerships should be established between medical, nursing allied health and management leaders at each level of the service; it should be clear who the Clinical Director's partners are and what the forums and processes are for joint decision-making and leadership.
4. The Clinical Director should be expected to develop clear goals for their own role and also with their partners to develop clear goals for the leadership team, to enhance the quality and safety of the service and to strengthen its relationships with other clinical services.
5. The leadership team for the Mental Health and Addictions service at Capital and Coast DHB, as the large regional neighbor, should be asked to consider how they might support the team at MCDHB to develop their expertise in leadership and management, for example by means of a mentoring programme, bilateral site visits and staff exchanges.
6. DHB delegations and structure should be reflective of effective clinical governance principles.

Summary of Implementation

A stock take of opportunities for intra-hospital connections was completed and gaps in mental health representation have been identified. Engagement with other DHBs (Waikato, Whanganui and Capital and Coast DHBs) for shared learning was undertaken. Internal and external mentoring and support is now provided for the Clinical Director.

The service restructure has confirmed the clinical/management partnerships at every level of the service.

Each of the multidisciplinary teams (MDT) has a Consultant Psychiatrist whose role functions as the overall leader for the service in partnership with the Clinical Manager. The Executive team has an established partnership of Allied Health, Nursing, Medical and managerial roles and this provides clinical governance to the service. The Executive team directly monitors incidents, complaints and national KPIs set for the sector. The service forums include cultural, family and consumer representative input, and clinical partnerships are created at this forum through representation of all disciplines. Consumers and families are represented in key processes such as recruitment to senior roles and staff in clinical teams.

Transition to Phase Two

The Executive team will progress the development of a quality and risk report with identified key performance indicators.

5. Reviewing Quality and Safety Processes

The Review team found that open disclosure of incidents was not a well established custom or practice and there was insufficient engagement and transparency in review of incidents, especially from the families and consumers perspectives. In addition, they found that the quality and safety culture was not clearly established and visible as it should be, and the Root Cause Analysis (RCA) processes followed at MidCentral Health appeared to lack expert clinical input from the relevant clinical specialties, thus the potential to not recognise specific clinical issues to inform recommendations.

Review Recommendations:

1. The executive team should provide clear expectations and leadership not only around the open disclosure of adverse incidents to those affected but also for routine consumer engagement in review processes and provision of reports to affected patients and families.
2. Leaders of the Mental Health and Addictions service and the Quality and Risk team should develop together, and implement and lead jointly, a plan for clear governance of quality and risk in the Mental Health and Addictions Services, including ongoing training in safety and quality principles and practice, regular review of incidents and recommendations arising from their investigation and development of open disclosure and active learning from incidents.
3. The Quality and Risk team should consider inclusion of a clinical expert advisor from relevant clinical specialties and/or professional groups on each RCA team, to ensure that specific clinical issues are not missed.
4. The Quality and Risk team should also seek advice from other DHBs on additional approaches to the reporting, classification, and investigation of incidents, for example use of the London Protocol, which might be of particular value in the investigation of Mental Health incidents.

Summary of Implementation

A number of actions were undertaken from these recommendations. Included was a review by the Serious Adverse Event Review Group (SAERG) of all reported adverse events for the past year. All recommendations arising from reviews were reviewed and monitored for implementation.

The Mental Health Mortality and Morbidity Forum were established. An action plan for patient safety and clinical effectiveness was developed and implemented for each case reviewed.

An Open Disclosure plan was developed and a workshop on this completed through the quality and clinical risk department. The workshop took into account the MidCentral DHB Open Disclosure Policy (MDHB6623) which is based on the Health and Disability Commissioner's guidance. The service has now integrated the London Protocol with the Taproot process for RCA investigations.

Regular environmental audits in Ward 21 are now undertaken by the Health and Safety representatives and Riskman reports are presented to the Mental Health and Addiction Services Review Project Governance Board, with issues highlighted and actions taken.

Mental Health and Addiction Services has engaged with quality and clinical risk at a corporate level and improved monitoring and auditing processes for implementation of review recommendations. The MHAS is negotiating additional resources to provide further quality and clinical risk input to the services.

Transition to Phase Two

The SAERG is developing an audit system to ensure all recommendations are implemented and to measure the effectiveness of these. The SAERG has expanded its terms of reference to include reporting on 'near misses' and will continue to monitor related incidents to provide opportunities for service improvements.

Further Open Disclosure workshops have been scheduled for 30 September and I October 2015 following positive feedback at the workshop held in February 2015 for mental health and addiction Services.

6. Staff Actively Supported

The Review team noted the serious, recurrent and persistent issue with medical vacancies and the amount of pressure doctors worked under because of this. Vacancies also existed for psychologists. Whilst low morale, frustration and demoralization was expressed by some staff to the Reviewers, staff in specialized teams expressed much more job satisfaction. In addition, consumer advisors felt undervalued and under-resourced and the Reviewers noted the need for active ongoing support to develop these roles.

Review Recommendations:

1. Currently employed staff should be actively supported to develop professionally and given responsibilities and opportunities which ensure they feel highly valued by the DHB.
2. Planned team training, which we understand is to be rolled out throughout the DHB, should focus particular attention on staff in the large inpatient and adult community teams, which present particular challenges because of their size and roles. It should also include an emphasis on clarifying and enhancing the roles of consumers as members of the healthcare team.
3. Discussions should be held with the clinical leaders for Mental Health and Addictions services at the other DHBs in the region to look at how neighbouring DHBs might assist one another to cover gaps, provide additional supervision, arrange secondments or visits to other teams to share and increase clinical experience and explore the use of videoconferencing for clinical consultations and education both within and between DHBs.

Summary of Implementation

A mental health training plan and schedule was updated. Advanced Suicide Assessment and Risk Management training, facilitated by QPR New Zealand has continued to be implemented. At completion of the last workshop in April 2015, 154 front line staff had attended including almost 100% of Registered Nurses from Ward 21. The response to this training has been highly favourable with evaluations indicating increased confidence in managing risk associated with suicidality. The new training schedule will become part of the workforce development plan under Phase Two.

To sustain the Dialectic Therapy (DBT) training a data base was developed to capture quarterly reports on the demand for this training and the available staff resources. The DBT capacity was increased and therapy groups are now operating. All of the eight DBT clinicians practicing DBT with the PN DBT program are intensively trained. Of the two DBT clinicians in the Horowhenua, one is intensively trained and the other foundation trained.

To support and improve practice for the staff working in Ward 21, a plan was established to reorganize staff skill mix/roster through a staff to patient ratio and allocation, improving the rostering process by appointing Associate Charge Nurses for morning and afternoon shifts and secondment of two Clinical Nurse Specialists Monday to Friday to support the experienced Charge Nurse (seconded from the

general hospital) to provide nursing leadership and embed professional practice processes, starting with putting in place professional dress standards.

The consumer and family representative roles have been enhanced by ensuring that linkages between these roles and the constituency that they represent are improved and strengthened. The family advisor is committed to more time with the non-government organisation Supporting Families and whanau representatives in Kaupapa Māori organisations. The Operational Forum which is the general management forum for the service has consumer and family representation and these roles have full input to the decision making about service management.

While permanent recruitment to vacant SMO positions continues, a rolling programme of locum recruitment has been undertaken, with locums now engaged through to the commencement of permanent staff. This has brought SMMO staffing up to established levels.

Transition to Phase Two

Further work to support professional development will continue into Phase Two under Workforce Development.

A new Training and Development calendar will become part of the workforce development plan under Phase Two.

SMO recruitment and improved medical coverage will remain a priority in phase two.

7. Improving the Acute Admission Ward 21 Environment and Facility.

The Review team noted Ward 21 would not meet current standards for acute mental health units in New Zealand or Australia, although acknowledged a review of the ward design features had been undertaken since the recent incidents.

Their observation was of a ward that is not set up with the needs of mental health service users, family and staff in mind: with a sterile and overly 'clinical' look; limited space for 24 – 30 patients experiencing acute symptoms; little capacity to provide separate spaces for patients of varying ages and needs; limited appropriate communal space; a layout with many blind spots; a pressure cooker environment, not conducive to the type of recovery environment people need to heal in. However, they did acknowledge staff have tried to make some areas more recovery focused and environmentally more appropriate.

Review Recommendations:

1. Design, layout and ligature points need to be attended to as a matter of priority.
2. The focus on security and containment needs to be balanced with care, compassion and recovery.
3. Serious consideration needs to be given to the separate environment review and recommendations outlined in *Appendix 5*. Actions that can be implemented quickly should be implemented quickly.
4. A decision is needed and should be firmly implemented on the bed numbers for the unit. Community services staff need to be part of the bed management plan alongside in-patient unit staff.
5. Debriefing of service users and staff after a significant event on the ward should happen within 48 hours and with appropriately trained, experienced staff external to the unit, to identify and start implementing processes to care for those affected and to form part of the process of learning from the incident and implementing change as a result.
6. A joint union and staff management group should review all staff injuries, with feedback to staff, ensuring that the investigation and review process includes immediate and 1 week follow up of injured staff, review of the environment (inclusive of staffing adequacy) and consideration of patient care issues.
7. Regular maintenance of the unit should occur, to ensure that it is and looks like a place where the people using it feel cared for and valued.
8. The use of CCTV in the unit should be reviewed: technology of this nature does not replace skilled nursing care and there may be excessive reliance on it as a form of security.
9. Clinical leaders and occupational therapy staff should contact their counterparts at inpatient units in other DHBs to find out how sensory rooms may be used more fully (the external reviewers could provide contacts if required).
10. The location of the Mental Health Emergency Team should be reviewed, in consultation with that team and the Emergency Department. This needs to be considered in conjunction with a rethink of the clinical model, as noted previously under Structure, and provision of better access

to clinical information for this team to operate safely and to provide services in a timely manner, as noted under Resourcing below.

Summary of Implementation

Immediate environmental safety improvements made to the ward such as the removal of ligature points; including shower heads, coat hooks etc, with ongoing work to change door handles and hinges. Changes were made to strengthen nursing leadership with an experienced Charge Nurse seconded as interim Charge Nurse and two mental health Clinical Nurse Specialists seconded to support that role, with a focus on improving mental health nursing practice, patient care and staff and patient safety.

To maintain a safe level of care and manage patient flow within capacity, a cap on bed numbers was implemented. This requires close monitoring and management and this will continue into Phase Two. Dashboard reports are provided twice daily to the entire hospital informing on the bed status. The Clinical Director now reinforces stringent admission classification. A Security report was undertaken on the use of CCTV in the Ward and it was noted that the current system and use of CCTV complies with all relevant regulations and Code of Practice. It reinforced the use of CCTV to enable staff to clearly identify people entering the facility and what is occurring in the open side communal area. It is not used as a clinical tool. Regular maintenance is ongoing.

A systematic approach for responding to incidents has been developed and changes made to incident review processes to manage complex and high need patients, including an update on the policy and procedures. This will link with work on 'Resilience' under the SAERG. Formal procedures for reporting and management of staff injuries have been strengthened. A debriefing policy is in place.

Transition to Phase Two

Further work to put in place debriefing processes will be included in the workforce development plan in Phase Two.

An options paper is being developed to address design issues and make recommendations about an upgrade of the facility. This work will continue to Phase Two under Infrastructure.

4. Mental Health Emergency Team

This team has now been renamed the Acute Care Team to better fit with the type of service to be delivered. Appointments have been made to resource this team, with an interim Clinical Manager until this role has been filled. A project team is in place to plan and develop the acute model of care that will operate over a 24/7 period.

Relocation of the team to the Ruahine building on the Palmerston North Hospital campus from Ward 21 was completed in May 2015. This means the team is able to access clinical information faster and it provides a safer environment at night. Further work on this will carry over into Phase Two.

5. CLINICAL REVIEW INTO THE CARE AND TREATMENT PROVIDED TO ERICA HUME

As part of the Phase One recommendations an independent clinical review into the care and treatment of Erica Hume was undertaken. The Service Director and Clinical Director have been actively engaged with her family to develop an action plan to address the clinical review recommendations.

There is a separate implementation plan for the recommendations arising from the longitudinal review of the care of this client and it is intended that this remain a separate project, until implementation of the recommendations is assured. It is envisaged that this will take 12 months. The final action plan has been worked on it together with the Hume family who have provided input and it will now be monitored and reported on. During this period, the plan will be reported against in a separate report in the MHAS Report to the MHAS Executive. Following this, if sufficient progress has been demonstrated then a 'phase two' approach will be taken to incorporate these actions into the MHAS service plan.

A clinical review into the care of Shaun Gray has been finalised. Actions required to address the recommendations from this clinical review work will come under the Phase Two work-plan. Both of these clinical review implementation plans will have a separate reporting line, independent of the Mental Health Review reporting in phase two.

6. TRANSITION TO PHASE TWO

Introduction

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 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 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.

Work in Phase Two is planned to be organized into three main areas in the service plan: a service development plan, quality and risk, workforce development and infrastructure development. An action plan for each of the specific areas is attached – Appendix II.

i. Service Development Plan

The development and implementation of a Service Development Plan will provide a strategic framework to inform planning and delivery of mental health and addiction services to ensure our resources are configured to meet the mental health needs of our population. It will be developed in partnership between consumers, family/whanau, NGOs, Iwi and other Māori providers, and Central PHO. It will be a foundation document that clearly demonstrates the partnerships that will be integral to ensure the mental health and addiction services needs of our population across the district are met. The focus will be a seamless integration between services ensuring there are no barriers, a sector wide vision, and development of a network of providers across our sector to ensure better outcomes for our population.

Included in the plan will be an organizational chart that outlines the reporting and accountability lines. A draft outline of our plan is listed below. Areas where we will be locating the objectives continuing from the Review are noted below, with a short narrative about the link and focus, consistent with the Phase One summary. The service plan will have the following outline and areas of focus that will guide our planning for development across the district.

The service plan structure is:

- Introduction
- Organisational Management
- Key Strategies
- Service delivery and development
- Quality and Risk
- Workforce Development
- Infrastructure Development
- Projects.

ii. Organisational Management

- ***Clinical Governance***

The new Service Director has put in place an Operational Leadership group made up of the Clinical Managers, Nursing leadership, HR, Quality and Risk, Allied Health and Consumer and Family representatives. In addition there is also a new Mental Health Executive group in place Chaired by the Service Director and includes the Clinical Director, Nursing Director of Mental Health and Addictions, the clinical Manager/DAHMS, a representative of Allied Health. These groups provide the overarching leadership that goes towards strengthening clinical governance in the services. As these group members become embedded in their roles, they will help to articulate the vision, values and expected behaviours of the service.

iii. Service Delivery and Development

- ***Acute Care Service***

A new mental health model of acute care will replace the current Mental Health Emergency Team. As noted above, a working group has been established and a Steering Group made up of representatives from across the services. The MHET is now resourced 24 hours, as from June 30th 2015 with emergency cover provided during the day. The new Acute Care team will be responsible for all people accessing mental health and addiction services through a single point of entry (SPoE).

The working group will develop a standard operating manual incorporating the Choice and Partnership Approach (CAPA), designing the single point of entry process and defining and aligning the consultation-liaison role. Development of documentation (including a standard operating model of service manual is expected to be completed by September 2015) and training will be undertaken on the agreed model of care. In future, the team will look to support people in crisis within a home based treatment model.

- ***Older Adult Mental Health***

This is a work in progress with agreement on future direction for this service combining Older Adult Mental Health Services and Star 1 Ward, criteria agreed and a timeline in place, incorporating management of the change process. A plan is being developed to provide a framework for change.

- ***Admission/Discharge processes***

A more streamlined approach will be taken for people requiring admission, treatment and follow-up after discharge/transition back into the community. A greater focus will be on assessment, recovery planning and placement into the most appropriate treatment situation from the various referral pathways. Much of this will be through the Acute Care Team using the Choice and Partnership Approach, and involving the community key worker where appropriate. We will be looking to develop criteria integral to the Acute Care Team in partnership between primary and secondary care services. Included in this will be a project to work with NGOs who provide supported accommodation, to create more options for those people being transitioned out from the acute admission ward.

An evaluation will be carried out on this service after six months of operation.

iv. Quality and Risk

- ***Quality and Risk***

As noted above, discussions are underway with the quality and clinical risk department to improve monitoring and auditing of quality indicators. A quality and risk framework is being developed, and additional quality and clinical risk resource/input for the service is being negotiated. The service will develop a quality and risk framework as part of its quality and risk plan.

- ***Consumer Engagement/Participation***

Critical to establishing collaborative partnerships and meaningful engagement with consumers and their families was the establishment of project working group to develop a framework for partnership between consumers, families and clinical staff for designing and evaluating services. The group includes representatives from NGOs and the PHO to ensure we have a district-wide lens on the project, as well as mental health and addiction services consumer and family representatives and senior nursing staff.

Links with Mana o te Tangata (Peer Support services) and Supporting Families (Family representative group) and Kaupapa Maori Groups (representing Whanau) are being strengthened as our consulting partners in this project. It is anticipated the project will continue through to the end of 2015

v. Workforce Development

- ***Workforce plan***

The development of a workforce plan will be designed to support a workforce that is competent and capable to meet the needs of our population. The plan will build on the national workforce priorities as set out in *Rising to the Challenge* to ensure we have the workforce with the right skills, in the right place and at the right time. Using the Triple Aims Quality and Improvement Framework we want a workforce that is 'willing and able to learn; being consumer and community focused; getting it right; and being up to the job'.

Work continues to build a profile of our services workforce, as does the coordination of various reports to support intelligent use of data to inform workforce development. The Central Region Technical Advisory Service (TAS) will provide support to develop a workforce plan that takes into account:

- A stocktake of all staff competencies
- An analysis of the gaps and training needs to improve practice
- Development of a plan for ongoing training and development, including debrief training and ongoing training for DBT
- Incorporation of peer support workers into services.

- ***Culture Change:*** Part of the required cultural change within Mental Health and Addiction Services is to create an environment that is more flexible and accountable to consumers; more

recovery focused and promoting a culture of hope, autonomy and self determination. To address this and help support practice improvement a schedule of further *Let's Get Real* workshops from Te Pou will be undertaken – this includes training and development initiatives inclusive of *Let's Get Real* modules for Ward staff. Te Pou will provide three workshops by the end of 2015 with a focus on values, attitudes, and the role of supervision in supporting reflective practice.

- ***Team Development Process:*** The focus is for Clinical Managers is to develop, consult on and implement a team development plan for orientation, and a management training programme that includes professional development. Once the Clinical Mangers are well embedded into their roles further work will focus on developing a vision and look at how the use of the values and attitudes of "Let's Get Real" can be utilized into the teams. Clinical Managers will also develop a plan for performance management processes (including professional development). Performance management processes will then be undertaken by Clinical Managers over a 12 month period.

- ***Professional Development***

  We need to ensure the professional groups are meeting their professional standards to continue to work at the top of their scope. A training and development calendar will identify what is required. This will describe what ongoing is compulsory – such as compliance to the Health and Safety regulations, and what is mandatory organizational training such as CPR.

vi. Projects

- ***Ward 21 Re design***

  An initial business case summary for alternate options (redesign or new build) has been prepared by the Service Director and is awaiting approval from HAC. The proposal identifies a preferred option with contextual reference information about the service's capacity to provide a quality clinical programme from the existing/redesigned environment.

- ***WebPAS***

  MHAS is engaged in the scoping exercise that is the beginning of our WebPAS project. The service has identified key staff, who have been working with the Business Analyst within the WebPAS project team to demonstrate current practices and processes.

vii. Infrastructure

Whilst a number of changes have been made to the Acute Inpatient Ward 21 following the External Review recommendation, there is further work to ensure a more improved therapeutic environment that is and safe for both patients and staff. Part of the changes required is to the redesign of the facility itself. A business case is being developed to address the design and upgrade of the facility.

- ***Seclusion Reduction***

  Reducing the use of seclusion and minimizing the use of restraint is a national priority. A group of nursing representative from the ward is developing a policy and set of procedures on the use of seclusion and restraint. With assistance from Te Pou, further work to implement the full set of seclusion reduction six core strategies will be actioned.

- ***Intensive care pathway***

  One of the current projects is to establish clinical pathways which reflect best practice treatment standards. A clinical pathway serves as a reference point for standards and guides clinical service delivery. The service is embarking on the development of an Intensive Care Clinical Pathway which will support improved practice when providing care to those patients who are at most risk, and most acutely ill.

- ***Electronic records***

  Future planning is in place for progression to electronic records. This will be done once the project developing WebPAS completed and is implemented in August 2016.

7. SUMMARY

This report has provided an outline of the progress made on completing the Phase One External Review work programme. It signals further ongoing work from Phase One that will be transitioned into Phase Two (July 2015 – 2017). A conceptual framework provides an illustration of the activities in Phase Two against each of the recommendation headings, including future MHAS business as usual (Appendix III).

Much has been achieved in addressing the External Reviewers recommendations. Phase Two gives a new sense of direction to build on the achievements from Phase One and takes a longer term development approach incorporating a new service development plan, a workforce development plan and a more improved therapeutic environment within MidCentral Health's acute mental health inpatient unit, Ward 21.

In undertaking the many changes and challenges that were required to address the issues identified by the external reviewers, there is now a planned approach to sustain the momentum of improvement for our services and for those we care for. Achieving this will require effective partnerships at all levels within our services and across our district with everyone having the opportunity to have input and achieve the vision ahead.

Appendix 1: Phase One Status Report

Mental Health & Addictions Review Work Status Programme
Project Status Report – Phase 1

Phase 1- Completed Key Tasks		Responsible	Action	Due Date	Completed
Governance					
1.Support Clinical Director – internal milestones established		Chief Medical Officer (CMO)	Milestones met for support of clinical director	15.8.14	September 2014
2.Medical Heads appointed – positions developed and job descriptions prepared		Clinical Director (CD)	Medical Heads appointed and positions filled	29.8.14	September 2014
3.Clinical Governance specialties, include clinical leads for all services	Review the clinical governance structure and forums within the Mental Health Service and sub-specialties (Incorporated into proposal being finalised (as per Action 4 below).	C.D/Director of Nursing(DON), Director of Allied Health (DAH)	Proposal completed and presented	15.9.14	September 2014
	Incorporate proposed clinical governance structure into mental health service structure review proposal (See 4. below) and consult with staff.		First Proposal completed		December 2014
			Second proposal completed		March 2015
	Review and confirm the clinical governance framework in conjunction with the service structure review (see 4. below)		Implementation of change management process, appointment of new clinical managers underway May and due for completion July 2015.		July 2015 (with the exception of 2 positions which are temporarily filled whilst positions are re advertised.

Phase 1- Completed Key Tasks	Responsible	Action	Due Date	Completed
Structure				
4. Review structure and reporting arrangements Meetings with unions held; structure reviewed with agreement that changes are required • Service Management - proposal developed and finalised for consultation with unions and staff 24/7 Mental Health Emergency Team (MHET). Clarify reporting lines/Service Manager/Clinical Educator Practice Development (CEPD)/Integration of Older Adult Mental Health Service with Mental Health Ward 21 leadership. • Clinical leadership - feedback closed • Medical - feedback considered • clerical • Nursing - partial re-issue of proposal considered • Allied Health - consider feedback • Phase 1 decision determined	Manager Human Resources(M.H.R)/ C.D/O.D DON/DAH (others as appropriate)	All actions completed for phase 1 and 1b proposal document to CEO. All affected staff advised as per plan.	19.9.14	October 2014
			26.9.14	October 2014
			24.10.14	October 2014
			7.11.14 28.11.14 28.11.14 5.12.14	November 2014
• Finalise Phase 1 proposal and submit to CEO and CMO • Advise all affected staff that a further leadership proposal will be issued for consultation setting out a leadership structure, roles and responsibilities. • Phase 1b decision determined		Staff advised New Service Director appointed and commenced in April.	5.12.14 10.12.14	April 2015
5. Daytime and out of hours acute response (including location) Review separation of daytime and out of hours acute responses, including use of new community-based acute respite service; determine proposed model of care and incorporate into Service Structure Review proposal as per(4) above and undertake consultation process • 24 hour emergency service • Physical location agreed and arrangements for move has been made	C.D/DON/OD	Review of separate out of hours completed. Consultation process completed.	19.9.14	September 2014
		24/7 model agreed. New appointments pending.		December 2015
		Relocation completed		May 2015

Phase 1- Completed Key Tasks	Responsible	Action	Due Date	Completed
Culture				
6. **Culture Change Programme** • Reaffirm mental health vision • Reaffirm mental health values • Embed into team development programme (refer 8 below)	D/C. D/N. D/CN	Te Pou LGR workshop held in April 2015. Follow-up meetings held. Further workshops on values & attitudes planned.	19.9.14 15.3.15	December 2015
7. Support timely decision making - establish Mental Health Team meeting and determine decision making process. 1) Ensure barriers to decision-making during project implementation identified and remedied 2) Currently the project board is addressing any identified barriers to decision making via bi-weekly meetings. 3) Weekly meetings with Service Leaders identifying any barriers 4) Weekly walkabouts within the service by (O.D ,CD & DON) 5) Six weekly meetings with Sponsor and Project Board 6) Bi-Weekly meetings with Project Lead	C.D/DON/O.D	1). Mental Health Team meetings have been established within the inpatient ward.	30.9.14- 31.10.14	September 2014
		2). Bi-weekly project board meetings continue		September 2014
		3). Operation leaders meeting has been re-established with Service Director.		May 2015
		4). Weekly walk about was established immediately with O.D/DON.CD, now ongoing with Service Director/Nurse director and clinical director.		May 2015
		5). Six weekly meeting continues.		February 2015
		6).Bi weekly meetings established and continue with project lead		February 2015
8. Team Development process 1) Hospital Advisory Committee: Review staff safety in Mental Health Services. Results to inform Mental Health Review work programme 2) Determine time line with Human Resources for Mental Health Inpatient Service to undertake team development	M.H.R C.D/DON/DAH/OD/HR	1). Second Organisational Staff safety survey was completed in February/March , the results due July/August 2015 2). To be re –	1.3.15	March 2015

		looked at once all new positions established (*as part of phase 2) Will be scheduled again for new clinical managers later in 2015 as part of phase 2*		
Phase 1- Completed Key Tasks	Responsible	Action	Due Date	Completed
Clinical Leadership & Partnership				
9. Establish Connections with other services 1) Complete stock take of opportunities for intra-hospital connections and do gap analysis in respect of Mental Health Service 2) Encourage and support mental health service participation on intra hospital committees 3) Hospital Advisory Committee request : Engage with Whanganui and Waikato DHBs for shared learnings with regard to Mental Health and Addiction Service review	Director Patient Safety & Clinical Effectiveness (DPSCE)	1).Stock take completed and report circulated	31.10.14	November 2014
		2).To be implemented in phase 2* as part of new leadership focus. 3).Members visited both sites and engaged with the two DHBs and also CCDHB in March 2015. Ongoing engagement continues.	28.11.14	November 2014
Quality & Safety Process				
10. Review quality and safety 1) Hospital Advisory Committee request: Serious and Sentinel Event Group to review all reported adverse events as an opportunity for service improvement. This procedure has been implemented as mandatory requirement for all serious events 2) Hospital Advisory Committee: Patients and families are routinely informed of adverse events which affect their care. This procedure has been implemented as a mandatory requirement for all serious events 3) Formally request Patient Safety and Clinical effectiveness to consider review team's findings and to develop a plan of action 4) Action plan developed for implementation of recommendations Root Cause Analysis (RCA155) - to provide 6 weekly updates and report on Action Plan to Project Board synchronised with every Hospital Advisory Committee meeting 5) Action plan developed for implementation of recommendations (RCA156) - to provide 6	DPSCE Nurse Director Mental Health (N.D M.H) N.D M.H	1a).Serious and Sentinel Event Review Group (SAER) review completed. SAER group continues to monitor the related incidents 1b).Mental Health Mortality and Morbidity forum has been established 2).Regular updates to the 2 affected families occurs. 3,4,5).Action plan developed-6 weekly updates of RCA provided 6).Consumer/Family engagement	28.8.14 30.10.14 30.9.14 30.9.14	January 2015 March 2015 March 2014 April 2015

weekly updates and report on Action Plan to Project Board synchronised with every Hospital Advisory Committee meeting. 6) Consumer/family engagement – plan of action developed 7) RCA process & membership - Clinical Board advised 8) Open disclosure - Plan of Action considered by Clinical Board 9) RCA communication – Plan endorsed 10) Mental Health Service ownership and awareness re: RCA- Implementation Plan developed		and participation group has been established, TOR written. 8). An Open disclosure workshop provided and attended by a range of clinicians and senior managers. 7,9,10). RCA processes and implementation plan developed		
Staffing				
11. Professional Development • Mental Health Workforce Training Plan, Suicide Prevention, Suicide Triage & Risk Management Training commenced • Update Mental Health Workforce Training Plan and implemented	Project Team Project team DON,CD, DAH	Training plan updated and completed Training schedule updated.	31.12.14 31.12.14	February 2015 January 2015 .
11a Dialectic Behaviour Therapy (DBT) • Set up database for quarterly reports on demand, waiting list (if any) and available staff resource.	Project Team	Data base developed for DBT. DBT team capacity increased and therapy groups are now operating into future months.	1.4.15	March 2015
11b. Workforce (ward21) • Staff to pt ratio • Pt allocation • Rostering process • Embedding MHB professional practice culture	N.D/C.N/CNS	Staff skill mix/roster reorganisation plan established Professional practice culture process commenced with professional dress standards first. Plans to improve professional culture is ongoing		March 2015 & Ongoing

Ward 21 Facilities & Environment				
12. Upgrade facilities • Commission independent assessment by Waitemata DHB staff • Review recommendations and identify immediate action items • Arrange and implement immediate action items • Reiterate with staff process for requesting maintenance work • Develop timed and prioritised Action Plan	O.D O.D/DON/CD OD Project team	Independent assessment completed. Majority of immediate actions completed, others are awaiting contractors and CAPEX approval. Processes reinforced Action plan developed	14.8.14 5.9.14 14.9.14 10.9.14 31.3.15	August 2014 October 2014 December 2014 September 2014 April 2015
13 Beds • Develop structured plan to manage patient flow within capacity, including discharge planning, length of stay, complex case management for long stay patients, management of non-clinical patients, early identification of barriers to discharge • Plan considered and endorsed by Mental health leadership group	ND/CN/CNS	Ward 21 patient flow dashboard developed. Daily MDT meetings established to manage pt flow and discharge planning.	31.1.15 28.2.15 31.3.15	February 2015 February 2015 February 2015
14 CCTV • Project Team to meet with Ward 21 leadership to discuss any matters related to CCTV activity	OD/CD.DON Project team	Recommendation document circulated. Completed.	11.12.14 28.2.15	January 2015 March 2015
16. Staff Injuries • Meet with unions regarding review findings, action plan and process for staff injury reporting	Human Resource (HR)	Formal procedure for staff injury incidents now re instated in ward 21 (Riskman process)	12.9.14	March 2015
18. Location of Mental Health Emergency Team agreed	OD/CD/DON	Location agreed and date for move set		March 2015
19. Electronic Records 1) Stock take completed. Arrangements are underway for the Clinical Portal to be opened for inclusion of Mental Health and Addiction Service clinical notes by end June 2015. This is subject		1)Clinical portal working group established	31.12.14	January 2015

to 'Break the glass' security of access system being applied for first 12 months then reviewed. 2) Post stock take of M.H Clinical records , report findings to mental health leadership 3) Implement findings 4) Ensure mental health service represented on WebPAS steering group (as WebPAS is the organisation's long term solution)	C.D & Project Team	2).Report completed and presented to M.H project Board 3).Mental health Clinical portal 'go live' on 11th May for all Drs letters/MHET emergency assessments/mental health Act assessments. 4).Key personnel are represented on the WebPAS	31.1.15 30.9.14	February 2015 May 2015 February 2015
Additional Comments				
Key Tasks	**Responsible**	**Action**	**Due Date**	**Completed**
20. Independent Clinical review Approach suitably qualified senior clinician • Identify reviewer • Establish TOR • Inform families & seek feedback • Finalise TOR • Provide information to reviewer • Arrange site visit, access to staff, family as required • Report provided • Work programme developed as required • Report copied to families	CMO/OD OD/CD/DON/PL	Arrangements agreed for the Independent Review to proceed. Clinician identified and commenced review	22.8.14 5.9.14 5.9.14 12.9.14 17.9.14 19.9.14 19.9.14	February 2015
		The review has been completed (May 15) findings are to be discussed with families underway. Work program revisited to reflect report findings	31.10,14 14.11.14 14.11.14	May 2015
21. Incident Reviews 1) Action plan recommendations from both RCA reviews implemented 2) Common factors from the RCA review findings Action Plans are implemented 3) RCA findings and independent review findings have been reviewed to determine policy and other process changes required 4) Policy and procedure changes have been implemented	DON/CD	1,2).Action plans implemented 3,4).Policy and procedure changes have commenced further work will continue as part of the phase 2*ongoing	30.11.14 17.10.14 17.10.14 30.11.14	November 2014 October 2014 October 2014 November 2014

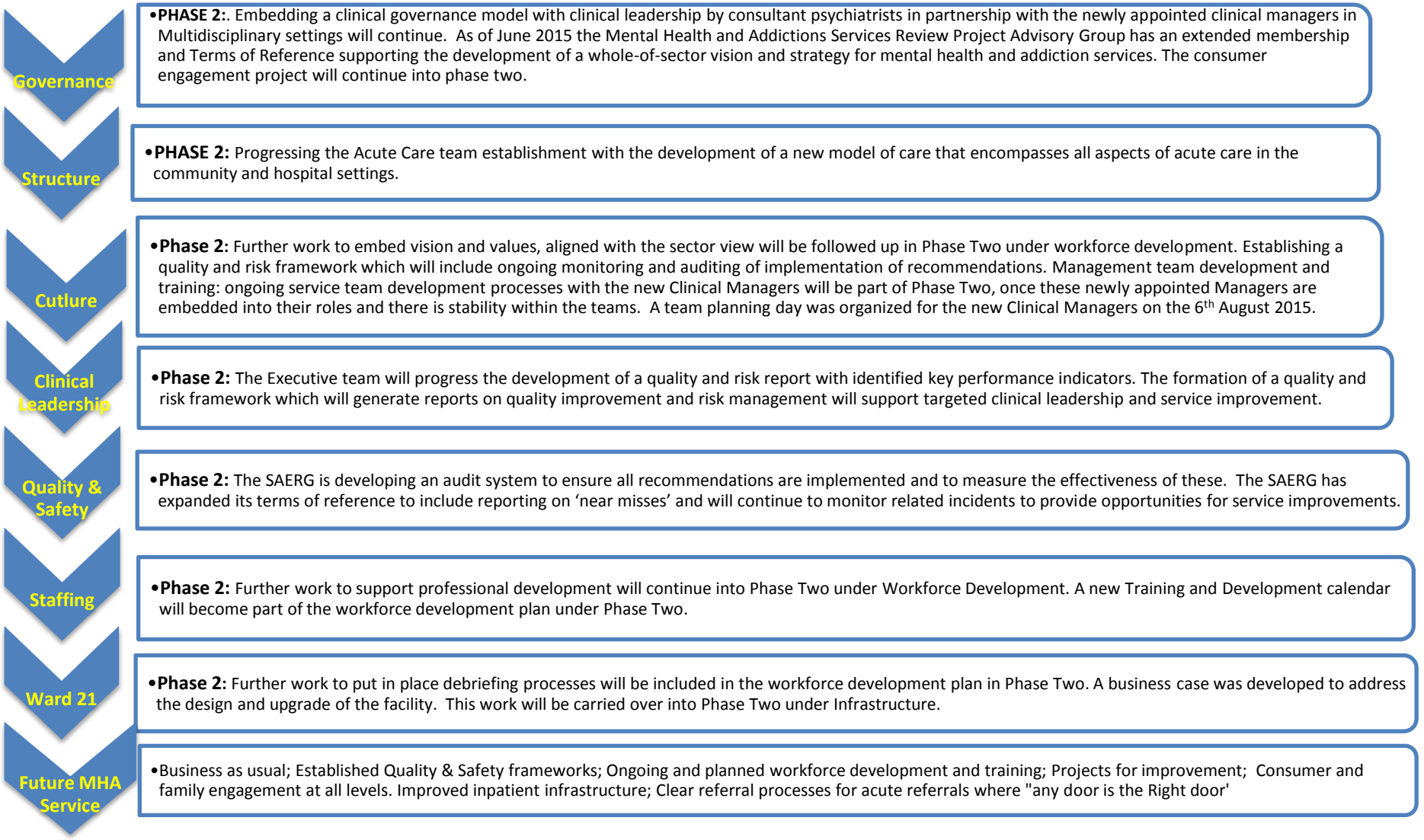
		processes.		
Project Approach & Review				
24. Resourcing • Appointment of Project Lead	OD	lead Appointed	29.8.14	September 14

Appendix 2: - Phase Two Action Plan

Service Development Plan	Description	Actions	Due Date for Completion
	Acute Care Service	• Develop a standard operating manual which includes integration with SPoE and CAPA processes and a daily MDT meeting. • Develop documentation and training for staff working in the Acute Care team on the 24/7 model of care • Define and implement a Consult/liaison role • Develop and undertake an evaluation plan after 6 months of operation.	September 2015 June 2016
	Clinical Governance	• Review audit arrangements, including clinical delegations and expectations	
	Quality and Safety,	Development of a quality risk plan will be a new project that will become a 'business as usual' component of the MHAS quality processes.	
	Admission/discharge processes	Develop criteria for both admission and discharge process.	October 2015
Infrastructure	Ward 21 – Environment improvements and upgrade of facility,	• Undertake environmental improvements to the ward décor and furnishings as well the courtyard • Complete a business case to upgrade the ward facility • Evaluate plan to manage patient flow within capacity • Provide staff training for complex and high needs patients including debriefing	Ongoing 31 July 2015 August 2015 Ongoing
	Electronic records	Future planning for progression to electronic records will occur after the WebPAS implementation in August 2016.	2016/17

Workforce Development	Culture change	• Development of the MHAS vision and values will rest with the Review Project Governance Board as per the terms of reference. • Ongoing discussions and workshops planned with Te Pou for staff training on the Let's Get Real values and attitudes.	Ongoing
	Team development process	New Clinical Managers to undertake team development exercises including financial and management training.	July/August 2015 and ongoing
	Professional development	• Review all clinical staff core competencies • Develop a plan for ongoing training • Work with Clinical Managers to develop, consult on and implement a team development plan. Evaluate plan six monthly • Performance management processes undertaken by Clinical Manager over a 12 month period • Develop a plan to sustain DBT long term • Work with Te Pou to develop a plan to increase staff capability to work with people with co-existing disorders (MHAS).	June 2016

Appendix 3: Conceptual Framework: Progressing to Phase Two



Appendix 4: Summary of External Review Recommendations

GOVERNANCE

The organisation needs to provide clear leadership and support for strengthening clinical governance in the mental health and addiction services through:

- Articulating the vision, values and expected behaviours for MidCentral Health leadership and clinical governance.
- Role modeling effective clinical governance at the executive level.
- Giving ownership and accountability back to services, with clear points of accountability.
- Clarifying expectations of accountability but also delegated authority to act.
- Establishing consistent forums at all levels, with structures, processes and reporting based on the commonly agreed pillars of clinical governance.
- Improving governance partnerships across the clinical governance leadership group with effective teamwork and clearly valued opportunities for wider contributions, from clinical and professional leaders of all disciplines, managers, consumer and family leads, quality and risk experts and business analysts.
- Clarifying roles, especially the clinical manager roles and CEPD roles, and reporting lines.

STRUCTURE

- Consider having a clear single point of accountability and leadership for mental health and addiction services that sits at service level and reports to the Operations Director and is responsible for decision-making in conjunction with clinical partners.
- Review the effectiveness of the Service Development portfolio and where it sits in the structure; consider how the CEPD roles, if they are needed, might add more value to improving quality and effectiveness of the services.
- The separation of daytime and out of hours acute responses needs to be reviewed, given the dissatisfaction with the current model. The evaluation of the model needs to be undertaken in terms of capacity to meet crisis and urgent response needs for communities, the emergency department, primary care and other secondary clinical services; location; effectiveness; and medical staff roles in the service. An opportunity may also arise to formalize the psychiatric consultation-liaison service and strengthen the linkages across clinical services.
- Medical staff in particular should have designated leadership roles at the clinical team level and should function as clinical partners for the Clinical Managers at that level.

CULTURE

- MidCentral Health needs to undertake a programme of action that re-establishes its vision, values and culture and which clearly articulates that in practical terms.
- Mental Health Services need to be more effectively connected to wider DHB structures through clinical and quality activities and professional group activities.
- Clinical governance and stronger leadership need to be visible to clinical teams and to proactively engage clinical teams and consumers in the above process.
- Senior leadership need to work with service users, families and staff to make some clear action-orientated commitment to change and agree where to start – breaking that down into practical achievable steps.
- Innovation and initiative need to be modeled and encouraged by managers and clinical leaders, to create a sense that change for the better is possible and will happen.

- Leadership and governance teams need to ensure that the appropriate level of authority to decide, act and review are delegated, so that when ideas and service improvements are generated, decisions are made and things happen.
- Clinical Directors need to determine professional/clinical issues and actions required; expectations and responsibilities of line managers to act need to be clearly documented.
- Standards of behaviour and standards of clinical practice need to be clearly articulated and addressed, with positive examples acknowledged and problems acted upon appropriately and effectively.
- Encouragement should be provided to all disciplines to work in different clinical areas by offering staff rotations or secondments either within the DHB or external to the DHB. Staff and managers need to collaborate on policy development and implementation with clear buy-in. This should not be a top down process.
- Links should be established with clinical leaders in mental health and addiction services at other DHBs, and staff, particularly from Ward 21, should be sent to visit facilities and to meet with their counterparts at other DHBs, to seek new ideas and resources, which can support quality improvement (the external reviewers could provide contacts if required).

CLINICAL LEADERSHIP AND PARTNERSHIP

- The incoming Clinical Director should be actively supported by the DHB to undergo leadership and management training and to receive mentoring, both from other clinical leaders within the DHB and from Clinical Directors in Mental Health services at other DHBs in the region.
- Additional clinical leadership roles should be established within the Mental Health service and in particular there should be a medical leader for each large clinical team or group of teams, with clear responsibilities and partners, and encouragement to use Continuing Medical Education (CME) resources for development of leadership skills.
- Clear partnerships should be established between medical, nursing allied health and management leaders at each level of the service; it should be clear who the Clinical Director's partners are and what the forums and processes are for joint decision-making and leadership.
- The Clinical Director should be expected to develop clear goals for their own role and also with their partners to develop clear goals for the leadership team, to enhance the quality and safety of the service and to strengthen its relationships with other clinical services.
- The leadership team for the Mental Health and Addictions service at Capital and Coast DHB, as the large regional neighbour, should be asked to consider how they might support the team at MCDHB to develop their expertise in leadership and management, for example by means of a mentoring programme, bilateral site visits and staff exchanges.
- DHB delegations and structure should be reflective of effective clinical governance principles.

QUALITY AND SAFETY

- The executive team should provide clear expectations and leadership not only around the open disclosure of adverse incidents to those affected but also for routine consumer engagement in review processes and provision of reports to affected patients and families.
- Leaders of the Mental Health and Addictions service and the Quality and Risk team should develop together, and implement and lead jointly, a plan for clear governance of quality and risk in the Mental Health and Addictions Services, including ongoing training in safety and quality principles and practice, regular review of incidents and recommendations arising

from their investigation and development of open disclosure and active learning from incidents.

- The Quality and Risk team should consider inclusion of a clinical expert advisor from relevant clinical specialties and/or professional groups on each RCA team, to ensure that specific clinical issues are not missed.
- The Quality and Risk team should also seek advice from other DHBs on additional approaches to the reporting, classification, and investigation of incidents, for example use of the London Protocol, which might be of particular value in the investigation of Mental Health incidents.

STAFF

- Currently employed staff should be actively supported to develop professionally and given responsibilities and opportunities which ensure they feel highly valued by the DHB.
- Planned team training, which we understand is to be rolled out throughout the DHB, should focus particular attention on staff in the large inpatient and adult community teams, which present particular challenges because of their size and roles. It should also include an emphasis on clarifying and enhancing the roles of consumers as members of the healthcare team.
- Discussions should be held with the clinical leaders for Mental Health and Addictions services at the other DHBs in the region to look at how neighbouring DHBs might assist one another to cover gaps, provide additional supervision, arrange secondments or visits to other teams to share and increase clinical experience and explore the use of videoconferencing for clinical consultations and education both within and between DHBs.

WARD 21 – Environment and Facility

- Design, layout and ligature points need to be attended to as a matter of priority.
- The focus on security and containment needs to be balanced with care, compassion and recovery.
- Serious consideration needs to be given to the separate environment review and recommendations outlined in *Appendix 5*. Actions that can be implemented quickly should be implemented quickly.
- A decision is needed and should be firmly implemented on the bed numbers for the unit. Community services staff need to be part of the bed management plan alongside in-patient unit staff.
- Debriefing of service users and staff after a significant event on the ward should happen within 48 hours and with appropriately trained, experienced staff external to the unit, to identify and start implementing processes to care for those affected and to form part of the process of learning from the incident and implementing change as a result.
- A joint union and staff management group should review all staff injuries, with feedback to staff, ensuring that the investigation and review process includes immediate and 1 week follow up of injured staff, review of the environment (inclusive of staffing adequacy) and consideration of patient care issues.
- Regular maintenance of the unit should occur, to ensure that it is and looks like a place where the people using it feel cared for and valued.
- The use of CCTV in the unit should be reviewed: technology of this nature does not replace skilled nursing care and there may be excessive reliance on it as a form of security.

- Clinical leaders and occupational therapy staff should contact their counterparts at inpatient units in other DHBs to find out how sensory rooms may be used more fully (the external reviewers could provide contacts if required).

- The location of the Mental Health Emergency Team should be reviewed, in consultation with that team and the Emergency Department. This needs to be considered in conjunction with a rethink of the clinical model, as noted previously under Structure, and provision of better access to clinical information for this team to operate safely and to provide services in a timely manner, as noted under Resourcing below.

APPENDIX 2: Longitudinal Clinical Review Erica Hume

Clinical Review into the Care and Treatment provided to Erica Hume by MidCentral District Health Board.

Recommendations and action plan

16.08.15

Clinical Review into the Care and Treatment provided to Erica Hume by MidCentral District Health Board.

Recommendations and action plan

21.05.15

1 **Referral*:***

Recommendation

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.

Action Plan one:

Key points:

- Ensure consideration of longitudinal history as part of the assessment criteria
- Have a low threshold for direct contact with referrer regarding referred concerns
- MDT process to be used for declines and referrals
- Question framed as "What does this person need (what matters to them) and where and by whom is that best delivered"
- Ensure they are truly set up to help the person seeking help and not centered on the needs of the service.

Description	Responsible Role	Action Required and Monitoring	By when
Review acute responses including proposed model of care to ensure that referrals of existing DHBs are reviewed by a psychiatrist for service follow up.	Clinical Director Service Director	To review the MCH referral policy to ensure psychiatrist oversight, in an MDT setting of referrals. Circulate current policy for feedback, and review with quality staff. Feedback to include NGO partner and PHO and stakeholder input.	30 May 2015 30 June 30 July 2015
Review of referrals includes longitudinal history as part of the assessment criteria		Finalise policy review (quality and risk team and Mental Health Services Clinical Director and Service Director). Include specific note of consideration of longitudinal history.	30 July 2015 30 August 2015

To establish a system of highlighting referrals from other DHBs and ensure direct contact with the identified referrer as part of the MDT review of referrals.	October 2015
Update the mental health referral policy to ensure psychiatrist oversight of all referrals and outcome of referral.	
Confirm psychiatrist oversight of all referrals with a sample audit of one month's referrals, and three month intervals for one year.	

2 & 3 **Assessment and formulation**

Recommendation

2. Ensure the MDT Case Review Policy which has psychiatrist oversight of reviews, is fully implemented

3. Build and sustain a culture of critical thinking, and a relentless focus on what matters to the Person and family. This will require developing and activating leaders and improvement champions across all parts of the service.

2-Key points are:

- Implement existing MDT review policy

3-Key points are: The development of

- A culture of critical thinking,
- a relentless focus on what matters to the patient and family,
- an investment in developing and activating leaders across all parts of the service
- Driving the culture and process changes needed, which include a workplace culture of empathy, team collaboration and quality improvement.

Description	Responsible Role	Action Required	Monitoring
Implement existing MDT review policy	Service Director Clinical Director	MDT policy is implemented by directive from CD	By 30 May 2015 30 September 2015
MDT processes are reviewed updated and implemented		MDT forums are sample audited from 01 July to 30 August and report on compliance with review standards and recommendations available by 30 September 2015.	December 2015
A culture of critical thinking, An investment in developing and activating leaders across all parts of the service		Implementation of recommendations planned and monitored until end of 2015. The clinical review and this action plan will be made available to the auditing team in the upcoming certification interim audit in November 2015. Complex case conferences calendarised Establish new clinical manager positions with a focus on clinical service delivery for all services	Quarterly monitoring of forums to end 2015 30 May 2015 June 30 2015 July / August 2015 December 2015
Driving the culture and process		• Clinical Manager appointment and selection processes finalised • Appoint to the new positions and to review and re advertise to any	December 2015

changes		unfilled clinical manager position	
		• Workforce development and educational forums completed Let's Get Real – Te Pou workshops x 2 by end of 2015	December 2015
		• Central TAS workforce plan including a family focus developed by end of 2015	
		• Supporting Families presentation and staff education sessions x 2 by end of 2015	

4&5 **Treatment and Interventions**

Recommendations

4. Take action to develop and sustain an appropriate range of psychological therapies, Especially adequate DBT services.

5. 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.

4 Key points

- Develop a sustained resource of staff able to deliver DBT
- Develop other complementary psychological therapy options, including CBT training
- To use other psychological therapy options as interventions with eating disorders-

5 Key points

- Ensure active MDT case review for clients receiving DBT, CBT, and other psychological therapies including referral, treatment and discharge processes.
- Ensure that MDT reviews (including pharmacy input) incorporate reviews of medication and co morbidity, including eating disorders

Description	Responsible Role	Action Required	Monitoring
Review and update of specialist programmes including updated service descriptions Professional Development Mental Health Workforce Training Plan and core competencies.	Mental Health Service Project Team	Review of Specialist Services Programme description, and update operational guidelines by December 2015. This update will include a 'sustainability' plan for DBT. This part of the workforce plan will address how the critical mass of DBT resource is maintained, as well as	Workforce Plan (WP) completed by 30 Oct 2015 WP commence implementation Dec 30 2015 Quarterly monitoring to July 2016 monitor as per WP from May

	allied training which will create a sustainable resource base. E.g. CBT training.	2015 September 30 2015
Update Mental Health Workforce Training Plan and monitor implementation over a 12 month period.	Create a new MH workforce training plan including prioritised core competencies and access to training for all staff, relevant to service needs. Involve external support and expertise in developing a workforce training plan. Approach Te Pou, and Central Region Technical Advisory Services (Central TAS)	September 30 2015 September 30 2015
Dialectic Behaviour Therapy (DBT) set up a database for quarterly reports on demand, waiting list (if any) and available staff resource	Monitor the implementation of the workforce training and education plan with quarterly reports on achievement to the Service Director and Clinical Director DBT database and quarterly reports on staffing and waiting list.	
Ensure MDT case reviews for clients receiving DBT , CBT and pharmacy input	Set targets for training access to DBT in the MH workforce training and education plan for the following 12 months. Implement active MDT case review for all clients, and audit for review of clients receiving DBT, CBT and psychological therapies. E.g. for clients with Eating Disorders. Ensure pharmacy input to MDT processes, over sighting prescribing regimes, and polypharmacy.	

6. Student focus

Recommendation

Actively support students in a way that minimises transitions of care and handovers to other services and that deliberately factors in their requirements as a student into care plans.

Key points

- Build relationships with student health and develop joint care planning
- Use a joint approach to ensure seamless transition from holidays into services
- Include contact with families from out of area as part of joint care planning
- MDHB should work with University Counseling and other student support services, including academic support to identify and action ways to jointly support students with mental health needs.

Description	Person responsible	Action Required	Monitoring
Build relationships with student health and develop joint care planning	Service Director Clinical Director	Approach student health to establish a Memorandum of Understanding (MOU) about joint care planning.	By end of July 2015- By September 30 2015
Use a joint approach to ensure seamless transition from holidays into services		The MOU will include clarified points of contact for both clinical and organizational relationship. The MOU will reference academic support systems and links and map out access pathways to support for students, including around times of stress such as at exam times.	By September 30 2015 October 2015 By November 30 2015
Include contact with families from out of area as part of joint care planning			By October 30 2015
		Stocktake all current clients with shared care arrangements with Massey University as well as all other Palmerston North	Explore use of Skype for relevant services e.g. CAFs and EIS as well as CMHT December 2015

Tertiary Institutes and Organisations

Develop shared care individual plans which incorporate presentation arrangements and care which covers absences due to holidays in other areas. Key worker handover to be incorporated into both MDT and individual care plan processes. The plan to note positive confirmation of contact by agreement that the individual can re contact the service of origin if other service contact is not made.

Develop shared care individual plans for students receiving joint care which incorporate contact by the lead carer with families during holiday periods. Audit a sample of shared care plans and report by end of October 2015.Ensure patient has telephone access to their family & support network whilst admitted to Ward.

Develop shared care individual plans for students receiving joint care which incorporate a full handover to services of origin where students

are not expected to return to Palmerston North. Contact to include ‘out of the box’ thinking, using modern technology, such as Skype / video conferencing / text and facebook.

7. Service Configuration

Recommendation

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.

Key points-

to develop

- An enhanced crisis response service
- A more home focused / home based treatment focus
- Improve community respite service access / capacity
- To develop peer support service options

Description	Person responsible	Action Required	Monitoring
Review acute responses including proposed model of care	Service Director Clinical Director	Progress the establishment of a 24 hour acute care team.	By end of August 2015-
Improve community respite service access / capacity	Service Director Clinical Director DHB Mental Health Planning and Funding Portfolio role (DHB P+F role)	Establish additional 4 places / beds in the community in support of alternative care and support for people in the community / who are ready for discharge from the inpatient unit	By June 30 2015 30 Dec 2015
An enhanced crisis response service A more home focused / home based treatment focus		Explore establishment of a home based treatment service and recommend service configuration to provide improved cover. The model of care is strengths and recovery focused. Using Co-Design principles that will help find solutions that are effective for DHB service development.	30 September 2015 workforce development plan Monitor Te Pou workshops Dec 2015 30 September 2015
To develop peer support service options		Workforce development plan with work stream on cultural change, and engagement with consumers Support the Palmerston North consumer advisory group to develop a peer support service.	30 November 2015 30 February 2015-05-22 December 2015

		• Engage with Planning and funding portfolio role • Map existing services • Develop a service level agreement with the consumer representative group	
		Audit report on completed workshops- completed within two months of the workshop completions. Audit report on utilisation of additional capacity completed end 2015.	

8 & 9 **Documentation**

Recommendation

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

Key points

- Training in collaborative note writing
- Improving the quality of clinical file documentation
- Work towards an electronic clinical record
- The focus on patients (and family) must remain clearly at the centre (of the service delivery and documentation)

Description	Person responsible	Action Required	Monitoring
Training in Collaborative note writing Implement a clinical file audit programme	Service Director Clinical Director	Workforce training to be completed in collaborative note writing Training to use the principles of 'co design' and include a focus on patient rights as outlined in the sector standards. (The Code of Health and Disability Services Consumers' Rights, and 'Health and Disability Core Standards, NZS 91344.1:2008). Rights include patient rights to edit and update notes. The training to highlight	By 30 November 2015 Update by December 2015

	individual right to request a change of responsible clinician or key worker.	
Develop a clinical electronic record	Update of the policy on collaborative care plan development, and review of file documentation and notes by consumers to be completed. Update the policy governing request for change of responsible clinician	Audit plan to be completed by 30 June 2015 December 2015
	Plan a clinical file audit programme as part of the quality assurance activity for the MHS	Audits commenced by 30 July 2015-July 2016 with quarterly auditing report
	WebPAS project (electronic system) to be implemented to establish a clinical electronic record	WebPAS to have quarterly report phase one completed end January 2015
	To engage with the project team managing the WebPAS project and for MHJ be represented on the project group	
	To commence reporting on this project by July 2015	