Section 99 Inspection
of Waikato District Health Board Mental
Health and Addiction Services

April 2016

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1.   Introduction

In early 2015, there were a number of serious events at the Waikato District Health Board mental health and addiction services. Following these events, Dr John Crawshaw, Director of Mental Health, decided to use his statutory powers under section 99[1] of the Mental Health (Compulsory Assessment and Treatment Act) 1992 to inspect the services to ensure they are providing a good quality of care to people in the Waikato region.

Dr Crawshaw, alongside colleagues from the Ministry of Health and a consumer leader from Te Kupenga Net Trust, carried out this inspection in August 2015.

This document is the final report from that inspection.

1.1.   Terms of reference[2]

Set out below are the original terms of reference for this Inspection.

Purpose

The purpose of this review is for the Director of Mental Health to inspect the service so he can examine how the services are functioning. This will enable him to determine whether there are any systemic issues, and if there are none, to assure the public on how the services are being run.

Background

Waikato DHB Mental Health Services have had number of incidents raised in the media over the past 6 months. The final issue was the charging of an overseas doctor, who was believed to not have the qualifications he claimed, with fraud on 25 July 2015.

There has been intense media and other public comment around the various incidents and the services offered by the Waikato DHB Mental Health Services. This has given rise to a perception and concern in some about the quality and functioning of these services.

As a result the Director of Mental Health has decided to use his statutory powers under s99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to inspect the Waikato DHB Mental Health Services so he can examine how the services are functioning. This will enable him to determine whether there are any systemic issues and if there are none to assure the public on how the services are being run.

Review process

The Director will be taking a small team with him to ensure there is a comprehensive look at not just the operational and clinical governance and functioning of the service but also how that operational and clinical governance is overseen by the wider DHB processes.

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[1] Section 99 of the Mental Health Act reads:

Powers of inspection of Director: In relation to any hospital, or any ward, unit, or other part of a hospital, in which psychiatric treatment is given, the Director shall have all the powers of the Director-General of Health under section 148 of the Hospitals Act 1957, and the provisions of that section shall extend and apply accordingly.

[2] The terms of reference set out here replicate those issued by the Director of Mental Health on 30 July 2015.

While any individual incidents are important they are not the subject of this inspection as there are separate processes (criminal, quality and statutory) to look at those incidents. There will be careful analysis of the DHB recruitment, credentialing and supervision of new staff and in particular overseas trained staff, with particular reference to the recent allegations leading to an overseas doctor being charged with fraud.

1.2. The Inspection Team

The Inspection Team consisted of the following people.

Dr John Crawshaw   Director of Mental Health, Chief Advisor
                                                Ministry of Health

Dr Jane O'Malley   Chief Nurse
                                                Ministry of Health

Wi Keelan   Chief Advisor, Māori Health
                                                Ministry of Health

Mike Elliott   Principle Advisor, People and Capability
                                                Ministry of Health

Chloe Fergusson-Tibble   Consumer Leader
                                                Te Kupenga Net Trust, Tairawhiti

1.3. Process of the inspection

The process of the inspection consisted of the following.

1. Meeting with district health board leadership

    The reviewers met with the leadership of the Waikato District Health Board (DHB) Mental Health and Addiction Service (MHAS) to receive an overview of the service and the issues as seen by the leadership team. They received extensive documentation of the service.[3]

2. Meeting with wider staff and community, including non-governmental organisations and whānau

    The Inspection Team then met with a wide range of staff both within the MHAS and in the wider DHB, and with key non-governmental organisations (NGOs), and consumer and whānau groups. The Team consulted key unions, seeking perspectives from their membership. Please note, this report identifies no individuals or individual comments: the people the Team spoke with did so on the understanding that their interview comments would be kept confidential.

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[3] This included a range of formal documents relating to service planning and funding, strategic plans, recruitment, training, financials, performance reports, projects and initiatives (eg, on suicide prevention), serious incident reports, meeting agendas and minutes, provider contracts and audit reports.

3. Inspection of facilities

The Inspection Team physically inspected the buildings, taking into account an independent review of the main adult mental health inpatient facilities that the DHB had previously commissioned.[4]

4. Recruitment process review

The Team's human relations advisor undertook an audit of the recruitment of the psychiatrist who allegedly obtained employment and registration by fraudulent means.

During each stage of the inspection the Team was particularly keen to understand the model of care and the clinical governance of the MHAS. They listened to perspectives of how the MHAS delivers care, and the impact it has on individuals and their whānau. Because a number of service users in Waikato DHB are Māori, the Team paid particular attention to the cultural appropriateness of care, and the MHAS' links with local iwi.

At the time of the inspection, police were actively undertaking a criminal investigation into the events surrounding the death of a patient. To ensure the Team's inspection did not interfere with the police investigation, the Director met with the police (including their legal advisor), the Chief Executive of the Waikato DHB and the DHB's legal advisor. Some constraints were agreed upon: for instance, the Inspection Team agreed that they would not interview key police witnesses. The Team feels that this did not have a material effect on the conduct of the inspection.

1.4. Handling of allegations currently before the court

This report only briefly summarises findings concerning employment of the doctor facing charges of dishonesty and using a document for a pecuniary advantage due to the fact that, at the time of writing, the matters were still before the court. The publication of detailed findings would be prejudicial to the court proceedings.

1.5. Preparation of this report

The inspection process was complex. In addition to those in leadership and management positions, the Team met with over 200 front-line staff. In addition, the consumer leader on the Team heard directly from over 105 people using the services and their whānau.

Preparation of this report required analysis of a large amount of information, including interviews. Due to challenges this entailed, and other competing priorities, there were some delays in its finalisation. The Team initially provided a draft report to the DHB for comment. The DHB's response required a further visit by Dr Crawshaw and Dr O'Malley to clarify certain aspects.

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[4] Fjeldsoe K, Meehan T, Kingswell I. 2015. *Henry Rongomau Bennett Centre Models of Care and Facility Infrastructure Review: Planning for the Continuing Development of Adult Acute Inpatient Services.* Hamilton: Waikato District Health Board.

2. Overview of the district and its services

2.1. The district

Waikato DHB serves a population of 391,770 and covers 21,220 square kilometres. It stretches from northern Coromandel to close to Mt Ruapehu in the south, and from Raglan on the west coast to Waihi on the east. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngāruawāhia, Te Kuiti, Tokoroa and Taumarunui.

There are 10 territorial local authorities within Waikato DHB boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames Coromandel, Waikato, Waipa and Waitomo (see Figure 1.)
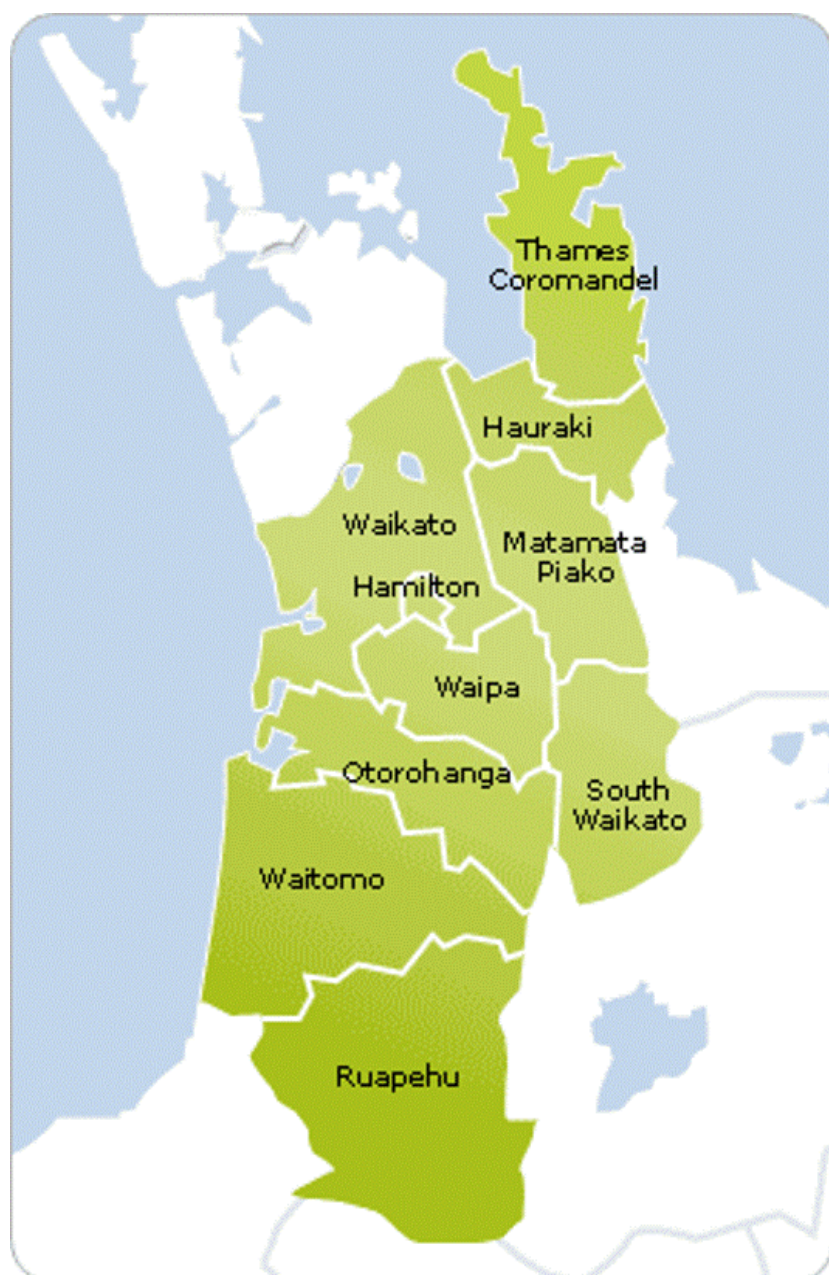
Population – 391,770

8.2% of New Zealand population (4,572,206 as at 13 March 2015)

Area – 21,220 km^2

7.9% of New Zealand land area

Population across the Midland region: 848,311(2013–14)

Midland region includes the following district health boards: Waikato, Lakes, Bay of Plenty, Taranaki and Tairāwhiti

Figure 1: Waikato District Health Board area (source: Waikato District Health Board Mental Health and Addiction Service Orientation Pack)

Waikato DHB has a larger proportion of people living in high-deprivation areas than in low deprivation areas. Within the region, Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in high-deprivation areas.

The Waikato population is getting proportionately older: the 65-plus age group is projected to increase by more than 78 percent by 2026.

The Māori population in Waikato is 22.5 percent, and is growing more rapidly than in other parts of New Zealand.

The Pacific population is 2.9 percent.

2.2. The services

Waikato DHB directly provides a full range of mental health and addiction clinical services. Its inpatient services are concentrated at Waikato Hospital in Hamilton. The majority of inpatient services are provided from the Henry Rongomau Bennett Centre (HRBC) and its associated regional forensic services (combined providing a total of 102 beds – 49 of which are forensic beds). The Mental Health for Older Persons 15-bed inpatient unit is in a separate building co-located with other assessment, treatment and rehabilitation services. In addition, Hauora Waikato, an NGO runs a separate 15-bed forensic unit at Tamahere. A range of facilities provide community-based services in Hamilton. Rural services are based in Thames Hospital and a community base in Te Awamutu. There are outreach bases in Whitianga, Coromandel, Whangamata, Paeroa, Waihi, Te Aroha, Te Kuiti, Tokoroa and Taumarunui.

The DHB provides the Midland Regional Forensic Psychiatric Service (Puawai) in partnership with Hauora Waikato under a one-service, two-provider model. Puawai provides services to courts and prisons, community follow-up and inpatient services.

The DHB purchases a significant extent of NGO services (approximately 40% of its mental health and addiction service spend) – this includes the contract with Hauora Waikato. Non-governmental organisation contracts also include community residential facilities. In addition, the DHB refers child and adolescent inpatients to Starship Hospital in Auckland.

The inspection concentrated on the adult service provision of the MHAS. To a lesser extent, it looked at how the community components of the Infant Child and Adolescent Mental Health Services (ICAMHS) and Mental Health for Older Persons Services were functioning. The Inspection Team looked at NGO service provision only in so far as it aided their understanding of the relationships with the DHB provider-arm services.

3. Governance, leadership and management

3.1. Service development

Mental health services in Waikato DHB – particularly adult mental health services – have been going through a major change process since 2008/9. A major review of adult mental health and addiction services was commissioned in 2009 – resulting in the report *A Time for Change*.[5] This review and the subsequent strategic plan covering 2009–2014 have governed the services' agenda for improvement over the last five years.

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[5] Fjeldsoe K, Aimer M, Meehan T, et al. 2009. *A Time for Change: Evaluation of Health Waikato Adult Mental Health and Addictions Service*.

Essentially *A Time for Change* identified problems in the following broad areas:

- culture
- clinical governance and leadership
- structural elements (service configuration issues)
- facilities
- quality and safety.

Appendices 1, 2 and 3 to this report reproduce the executive summary and the recommendations of *A Time for Change*, and the resulting strategic plan.

3.2. Mental Health and Addiction Services within the wider district health board[6]

As part of changes to the wider Waikato DHB executive structure in 2015, the role of Executive Director of the MHAS changed, to report directly to the Chief Executive. The Executive Director's position was vacant at the time of the Inspection visits; Dr Rees Tapsell was occupying both this role and his extant role as Director of Clinical Services.

A professional reporting line exists from the Director of Clinical Services to the Chief Medical Officer, and from the MHAS Nurse Director to the DHB Director of Nursing and Midwifery (DON/M). This latter position was being filled at the time of the Inspection. Under the new Waikato DHB executive structure, the DHB envisages that the Director of Quality and Patient Safety, the Director of Allied Health and the Clinical Director of Primary and Integrated Care will also have improved linkages with governance of the MHAS.

3.3. Operational and clinical governance, leadership and service direction

The DHB saw the programme of change outlined in *A Time for Change* as a phased process, with the following major components:

1. functional service orientation (model of care, etc)
2. realignment of structure to function (including the integrated care pathway)
3. practice improvement.

The programme of change also focused on clarifying the accountability pathway. All disciplines working in the MHAS report via one point of accountability through the operational management line. The service saw this accountability pathway as enabling a focus on managing across the boundaries to ensure good integration of care.

It is worth noting that a review of Waikato DHB in 2014 produced for the use of the incoming chief executive[7] commented favourably on the clinical governance of the MHAS, observing that:

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[6] The Waikato DHB executive leadership structure and governance processes had been undergoing significant change prior to and during the Inspection. For clarity, this report will provide an historical as well as a contemporary commentary.

[7] The 2014 review was commissioned by the Waikato DHB Board Chair and supported by the Ministry of Health. The purpose of the review was to understand the performance, strengths, weaknesses and any significant issues facing the DHB to help set the agenda for an incoming Chief Executive (*Waikato District Health Board: Review of opportunities for the incoming Chief Executive. May 2014).*

Waikato's Mental Health service provides a useful model for developing a true clinical governance structure where the manager, medical, nursing and allied health teams have engaged in collective decision making, robust debate and shared accountability.

The documentation the MHAS provided to the Inspection Team (supported by individual interviews) demonstrated a robust strategic, operational and clinical governance structure.

The Executive Director, with support from two assistant group managers, three operational managers, the Director of Clinical Services, the Nurse Director and the professional leads for social work, psychology and occupational therapy.

Around the time of the review in August 2015, there was a realignment of the roles of the operations managers: the DHB extended the role of operations manager for forensics across all of the HRBC inpatient units (that is, adult and forensic inpatient services). This was to ensure that the management of the combined inpatient units (HRBC) came under one manager. The person holding this role must have a detailed knowledge of inpatient care, the ability to work with clinical nurse managers, and a clear understanding of nursing care.[8]

Individual services (for Older Persons, Adult, Forensics, Alcohol and Other Drugs, and Child and Adolescent) replicate the clinical/operational governance structure: clinical directors and clinical nurse managers/team leaders report operationally to operations managers and professionally to their respective clinical leads.

At the MHAS there is a clear focus on the use of data and information to understand how the service is functioning. The documentation shows attention to detail with respect to the service work plan and the development of policies and procedures. There is a clear process for signing off formal documents. The service clearly documents its reviews of issues, signs off decisions and follows through where necessary.

From the interviews it was clear that, prior to the departure of the Group Manager (later replaced by a new role, the Executive Director of Mental Health Services), the Director of Clinical Services and Group Manager had enjoyed an effective working relationship that had enabled them to drive service changes. Together, they provided effective leadership to the senior team through the early change process.

The two associate group managers (AGMs) were clearly across their portfolios and knew what changes were necessary in their areas. They demonstrated how they worked effectively with their clinical leaders.

The operational managers were focused on the operational management of their areas. Their direct reports were the team leaders and charge nurse managers. They reported to the AGMs and Group Manager (now the Executive Director). Like the AGMs, operational managers demonstrated a significant understanding of the challenges faced by the services they were responsible for.

A number of staff commented that the Director of Clinical Services had a clear and effective strategic vision for the service. Furthermore, they observed that this vision was well supported by the other clinical directors at the DHB.

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[8] For further commentary on this restructuring, see section 3.4.

The goals of the service and the steps it has documented to achieve these goals are consistent with contemporary mental health service development. There seems to be appropriate engagement with external parties, and innovative developments involving cross-agency linkages and linkages to in the wider community (examples include The People's Project,[9] a 'frequent presenters' trial with police and ambulance[10] and joint work with Child, Youth and Family services).

The documentation and interview comments supported a significant increase in the MHAS' engagement with people using the service and their whānau since the report *A Time for Change*. The service was an early user of the Real Time Feedback Tool developed by the Mental Health Commission (for more detail see section 7) However, senior leaders noted that, while there had been progress, they were still in the implementation phase of the plan to improve consumer engagement.

3.4. Nursing and allied health leadership

The Inspection Team received conflicting information about the area of nursing and allied health leadership, and sought further clarification from the DHB. The Team saw this as particularly important in view of the level of practice change inherent within the service transformation occurring within the MHAS and the importance of solid clinical leadership across all disciplines to support effective change.

The senior leadership team acknowledged that professional practice leadership in the nursing and allied health area may have been initially underplayed, and that they were seeking to strengthen this. The Inspection Team heard evidence of this relative under-recognition from a number of nursing and allied health staff.

The magnitude of the clinical practice changes left some clinical staff with a view that the service required more discipline-specific professional practice leadership. Given the extent of the front-line practice changes that need to occur as a result of its current change programme, the service may need to explore how this area may be further strengthened.

Nursing leadership within the service and its relationship to the professional nursing direction across the DHB has been an evolving area. At the time of the initial inspection visits, a new Nurse Director for the MHAS had just been appointed. As she was on leave for part of the duration of the inspection, it was difficult for the Team to clarify the overall direction of travel of the nursing leadership within the service. Further, the number of people who were in acting roles at the time of the inspection no doubt contributed to a perception among a number of staff of a lack of front-line discipline-specific leadership.

The Nurse Director for the MHAS reports to the Executive Director, and, professionally, to the DHB's DON/M (this is in line with similar nursing directors within the DHB.)

As part of the restructuring within the service, the DHB has appointed professional allied health clinical leads (0.2 full-time equivalent (FTE)) in the subservice areas.

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[9] The People's Project is a multiagency project based in Hamilton that has been operating since August 2014. It has a unique collaborative commitment to the vision to end homelessness in the city by 2016. The focus is on ending homelessness rather than managing it. The MHAS has been involved since the beginning of the project.
[10] This is a trial looking at improving response to a small number of people who present frequently to police and ambulance services.

In the months since the commencement of the inspection, professional nursing leadership within the MHAS has strengthened.

The DHB DON/M has been working to improve the effectiveness of linkages with the newly appointed Nurse Director for the MHAS and supporting the strengthening of professional practice.

It is noteworthy that six months on from the inspection, the Nurse Director has instituted a formal structure of professional reporting across the service and within each subservice area, and strengthened the link between the clinical nurse managers/team leaders and front-line staff to standardise good clinical practice. All clinical nurse specialists have formal professional reporting lines to, and now attend regular meetings with, the Nurse Director.

There is now a robust process of appointments to senior roles, and a recognition that the person in charge of inpatient units needs to have a detailed knowledge of acute inpatient clinical care.

Opportunities exist to further drive practice change by using nurse educators more effectively. The reporting line for nurse educator in the MHAS was moved to the wider DHB Nursing and Midwifery Professional Development Unit following a restructure lead by the DON/M, and the reporting line is now through the Clinical Nurse Director/Professional Development to the DON/M. The Inspection Team agrees with the DHB that it is essential that nurse educators work closely with the service to ensure that the service delivers the objectives of the MHAS' Workforce Development Strategy. The Team would support a continued strengthening of the linkage to the MHAS leadership to achieve this.

Currently the nurse educators' focus is on the DHB-wide Professional Development and Recognition Programme (PDRP) as a means to grow professional development. However, given that the MHAS is undergoing transformational change, it is the Team's view that the nurse educators' focus for the MHAS should first be on the managers of front-line clinical staff; they should ensure that managers know how to support best practice, how to identify unacceptable practice and how to guide their staff by setting standards for consistent high-quality care. The focus should be on roles, responsibilities, accountabilities and the essentials of care.

The leadership team spoke about the need for a specific focus on workforce capability, especially in management and leadership. At the time of the inspection they were looking to identify and develop emerging leaders and focus on building leaders across the service. They were also developing a new workforce plan, to clarify expectations and required competencies.

3.5. Clinical and operational leadership: summary

The Team were observing the service at a time of intense external pressure, which clearly had had a serious impact on morale. This was particularly evident to the Director of Mental Health, who on previous visits had observed that morale and support for change had been much higher. The rapid change forced on the service in response to the external scrutiny had clearly had an impact on the capacity of the service to embed the level of practice change required by their model of care and strategic direction. Given the comments made by a number of staff to the Inspection Team regarding the need for discipline-specific and clinical leadership in the area of practice change, the service should consider regularly evaluating the effectiveness of recent changes to strengthen this area.

3.6. Consumer and whānau leadership and engagement

The service has defined expectations for consumer engagement at all levels, and the consumer lead sits on the governance committees. The service contracts provision of a family/ whānau facilitator to an NGO, to avoid potential conflicts of interest. The service charges a family/whānau steering group with looking at the responsiveness of the service to family/whānau. Two NGOs provide dedicated support for families: Supporting Families (SF) and People Relying on People (PROP). There has been a clear focus on rolling out recovery and peer support modules, to ensure effective engagement with people who use services and their and families/whānau.

The Inspection Team's consumer leader met with a peer support worker from the MHAS, the consumer development advisor, and a team leader from Progress to Health[11], who spends time in the adult inpatient wards regularly. This group informed her that peer support and recovery modules are seen as a valuable part of service delivery in the inpatient wards and in forensic services, and that the MHAS is committed to ensuring that people are involved in service development across all levels. The group acknowledged that there is bad with good but said that the services were on track overall.

The Team's consumer leader believes the different consumer roles within the service appear connected and seem to be working well together. Together, people in these roles have confidence that the system is working hard to realise the visions of people accessing the services, and feel that people accessing the services are included. There is potential for further improvement, by connecting with the wider consumer movement and people outside the system. This will help improve alignment between public expectations and the MHAS' ability to deliver.

3.7. Governance of implementation of *A Time for Change*

One of the recommendations from *A Time for Change* was:

> … that a committee structure be developed which establishes new or revised terms of reference for each committee to ensure clear lines of authority and effective decision making capacity.

The documentation provided to the Inspection Team relating to governance of implementation of the change programme, and the Team's interviews with staff, clearly demonstrated that in the initial phase the DHB followed a standard change management approach. There was good documentation of desired outcomes, and good engagement of key stakeholders.

The DHB set up nine working groups to implement *A Time for Change*. There appeared to be a good process for engaging people in the project, and a good methodology for the shift in practice. In addition, the DHB designated a specific external 'change team' to assist the service in the transition.

The initial post-implementation review showed significant improvements.

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[11] An NGO that offers support services to those living with mental health issues, including facilitators, advocates, and transitional coordinations.

3.8.   A change in the implementation process

Around 2013, there was a shift in the implementation process for *A Time for Change*. The service told the Inspection Team that this followed a significant demand for fiscal savings and efficiencies across the DHB (see section 9.2). As well as an annually reducing budget, the external change team which had been assisting in the change programme came to a planned end.

A Time for Change and the service's strategic plan had called for transformational change. Change on this magnitude required a concerted effort, not just by the MHAS but the wider DHB. The support and resourcing for this type of change is significant and there are significant risks if it is only partially supported and if the resources are removed prematurely. The Inspection Team believes that the resources for change were not sufficient to effectively manage the change and created undue risk.

3.9.   External factors

Waikato DHB has been faced with increasing demands on its MHAS, at a time when significant fiscal pressures across the DHB over the last two to three years have meant that all services have had to have savings plans. Addressing these demand pressures has been challenging.

In addition, early in 2015 some serious incidents within the DHB led to significant and sustained criticism of its services, external pressure and intense media coverage. The Inspection Team saw clear evidence that this had adversely impacted on services, particularly in terms of lowered morale among staff, the development of defensive and more restrictive practices (see section 5.5), and a negative perception of the MHAS among people using the services.

The Inspection Team was particularly concerned that individual staff (some quite junior) reported being personally harassed by the public. Provision of good mental health care is challenging even under ideal circumstances. Personal harassment of staff already under significant pressure can only be expected to result in even further reduction of morale, increased staff turnover and the development of defensive practice. The Inspection Team heard evidence that this had occurred.

To be seen to be decisively addressing the perceived issues, the service has had to undertake rapid improvement, which has compounded what was already a challenging transformational change process.

During interviews with staff, the Inspection Team gained an impression that articulation of high-level direction did not readily reconcile with staff experience of changes on the ground, particularly given reported work pressures. Staff noted that the speed of change (particularly in response to external scrutiny of the services) and the top-down driving of the implementation process was damaging to morale. Staff also described the senior management and leadership as more distant than it used to be, particularly over the past year (2014/15). This appeared to be linked to the focus required by senior management to manage intense media and external scrutiny.

4.   Impact of change on front-line clinical staff

The mission of the MHAS is to provide a safe and high-quality service for those who seek care when experiencing mental health needs. One of the most important factors (if not the most important factor) determining quality of care is staff.

The Inspection Team made it a priority to speak with staff, gauge their morale and seek an understanding of how they were managing with work pressures, implementing the change programme and looking after those in their care.

The Inspection Team were particularly keen to gather the views of a cross-section of front-line clinical staff. While time constraints limited the number of staff the Team could talk to, up to 200 clinical staff had an opportunity to meet with one or other of the Inspection Team members.[12] Staff groupings the Team talked to included senior medical officers, junior medical officers, clinical nurse managers, clinical nurse specialists, clinical nurse educators, staff nurses, allied health staff and psychiatric assistants. In addition, representatives of the various community teams and specialist teams spoke with the Team.

4.1.   Morale

Front-line clinical staff appeared to be disheartened and concerned. They commented that, in their opinion, morale was as low as it had ever been. Other sections document some of the themes that emerged from interviews and group meetings.

Some staff told the Team they were afraid to speak up about their concerns; some felt they would be punished if they did.

In the main, the specialised teams and subservices appeared to have greater morale and team cohesion. While staff in all teams spoke about demand pressures and the challenges of service changes, these issues were most noticeable in the adult services. Staff involved in the acute end of community services (crisis and community teams) appeared to be particularly under pressure, and noticeably demoralised.

The adult inpatient staff appeared especially affected by the recent changes of structure and process.

4.2.   Workload pressures

From the staff interviews the Inspection Team developed a sense of significant demand and workload pressure. This was evident across all staff groups and disciplines. In some meetings there was discussion about how the additional pressures brought to bear on staff by service and role changes had compounded the effect. The increased documentation and the fact that a mix of electronic and paper-based documentation were required also added to staff stress, and fostered a perception of increased risk among staff who were working remotely and could not immediately access electronic records. The need for these staff to return back to base to document assessments added to their workload pressures.

Staff expressed particular concerns about the situation for staff working in adult community teams. The Inspection Team received reports of individual caseloads of 53 and upwards. There were also high vacancy rates in some teams. Staff reported a rapid turnover of key

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[12] Because the Team wished to encourage a free exchange of information and were concerned that identifying individuals would inhibit this, it did not keep a record of attendance.

staff, including team leaders, and said that some staff were not covered while on leave. There was a sense in some meetings of job dissatisfaction among front-line community services staff: if they were given the opportunity to change roles, they would take it.

Community staff reported that in the past eight months they had experienced a range of pressures, including having to care for acutely unwell people without being allowed the time for long-term care planning, and a sense of having no time for the basics. They reported that community caseloads had risen, while the standard of quality service remained high. For key workers, maintaining that standard included carrying out tasks such as completing comprehensive assessments and monitoring the duty phone.

Staff were concerned about the impacts on people using the service. They were aware that people using the service noticed they were busy. Staff reported that people using the service had expressed significant frustration due to frequent changes of key workers. There were comments about changes of psychiatrist impacting on changes of treatment. Staff were concerned that this was not only frustrating but potentially unsafe.

While staff noted that cover for leave and vacancies was provided by bureau nurses (in the wards and, to a lesser extent, in the community), they noted that this was not ideal in terms of continuity of care.

4.3.   Meetings with unions[13]

A number of the observations the Inspection Team heard from the unions it consulted with were similar to those it heard from other interviews and group meetings. This section covers some further specific observations from unions.

In general, the Team developed the impression that health unions and staff would welcome a more collaborative, more respectful, relationship with the DHB and service . On a positive note, more recently, there appeared to have been a collaborative approach between the DHB and the unions towards staff assaults; this has been positive from the unions' viewpoint. A ninety-day plan is in place. Union representatives gave some other examples of some innovative joint practice developments that were in the early days.

The unions reported challenging relationships with the DHB as a whole. Specific issues raised included the influenza policy and negotiations concerning the 4 on 2 off roster. However, the Inspection Team was particularly concerned with more general sense of a difficult engagement process with delays in response to issues raised, was of concern.

Union representatives told the Team that staff had reported that they had been told by senior DHB staff not to take concerns to their unions. The union representatives felt that the DHB culture either passively or actively discouraged feedback. In their opinion, this resulted in innovative ideas not being encouraged.

The RDA reported issues concerning the culture within the service, the difficulty of attracting and retaining registrars and the difficulty of attracting junior doctors into psychiatry. It is worth noting that the junior doctors the Inspection Team spoke to had a more positive view of the support they received from their consultants and of the training programme. The RDA's view was that the DHB needed to rethink its employment relations/human resources approach.

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[13] The Inspection Team met with the New Zealand Nurses Organisation (NZNO), the New Zealand Public Service Association (PSA) and the New Zealand Resident Doctors' Association (RDA).

5. Quality and safety

5.1. Clinical governance and oversight

As noted in section 3.2, the service has focused on ensuring there is appropriate clinical governance in place. This extends to ensuring incidents are dealt with in an appropriate and timely fashion. The service provided the Inspection Team with documentation proving that its policies and procedures were appropriate. Documentation from clinical governance meetings at the whole-of-service and subservice level illustrated an appropriate focus on service quality, including the monitoring of key quality indicators (KPIs) (including national KPIs). Interviews confirmed this. The Team's analysis of reporting shows the service has been making good progress on KPIs.

5.2. Serious and sentinel events

The service's documentation and the Inspection Team's discussions with key staff indicate that the service's handling of serious and sentinel events is appropriate and consistent with best practice.

The service's Serious and Sentinel Events Committee has responsibility for the oversight of management of these events. Its membership consists of the Director of Clinical Services (chair), the Senior Consumer Advisor, the Clinical Nurse Director, an administration person who records minutes, professional advisors, service managers, the Service Quality Coordinator, the Clinical Director(s), the Group Manager and the Clinical Director of the DHB's major partner, Hauora Waikato. The Chief Medical Advisor or a delegate and the Manager Quality and Risk may attend meetings on request. The committee requests attendance by specialist advisors when required. The minutes of this committee's meetings demonstrated to the Inspection Team that the service addresses serious and sentinel events and follows up its recommendations appropriately.

The Inspection Team reviewed the details of how the committee handled specific incidents, and discussed them at interview. There is a standard triage process that commences once an incident form is received (or a serious incident is notified). If possible (depending on the committee's meeting schedule), the whole committee examine the incident. If not, a subcommittee consisting of the Director of Clinical Services, the Clinical Nurse Director and the Senior Consumer Advisor examines it. The committee makes a decision on whether to change or confirm the Severity Assessment Code[14] (SAC) rating, and on the type of review it will undertake.

The service has several levels of review:

- informal review: file review and engagement with person concerned and their whānau

- formal review:

    o   includes involvement of a clinical director or other role external to the subservice or

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[14] The Severity Assessment Code is a numerical rating which defines the severity of an adverse event and as a consequence the level of reporting and investigation to be undertaken following the event. A rating of 1 is given to events of the highest severity. For more information on the SAC scoring system, visit the Health Quality & Safety Commission's website, www.hqsc.govt.nz.

o   is led by an external MHAS but involves Hauora Waikato

- formal review completely external to MHAS and Hauora Waikato.

The service encourages the use of the London Protocol[15] for its formal reviews.

The committee monitors reviews, and can ask for further details. It can also decide to increase the formality of a particular review.

The subservice Clinical Governance Forum reviews SAC3 events. Until recently, there was no monitoring at the executive level. Since the end of 2014 there has been an expectation of a six-monthly review of all SAC3 events.

The Serious and Sentinel Events Committee centrally monitors SAC1 and SAC2 events, through to completion of the review (including ensuring that families/whānau have had an opportunity to engage in the review process). There is a process for ensuring that learning from a serious event is fed back to the team involved and to the person using the service and their family/whānau. As for the SAC3 events there is an analysis every six months that can be accessed by staff (on a shared drive).

5.3.   Quality and risk – wider DHB engagement

As noted earlier, there have been changes in wider Waikato DHB leadership and governance processes. These changes have resulted in an increased integration of the MHAS with the the wider DHB with regard to quality and risk management. The DHB is implementing a regional quality and risk management tool (Datex) that should assist with broader staff engagement. The DHB sees the risk register for MHAS. In addition, the MHAS is now using the the wider DHB Risk Register, Clinical Audit and Complaint Management systems. The DHB wishes to ensure that all SAC1 events undergo review by a clinician external to the MHAS.

5.4.   Compulsory care, seclusion and restrictive care

Waikato DHB's quarterly reporting to the Office of the Director of Mental Health indicates similar performance to comparable DHBs across a range of indicators such as seclusion, family/whānau consultation and use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). As in most DHBs, there are areas for improvement (for instance, in the ratio of Māori versus non-Māori compulsory treatment orders).

Over the last few years the DHB has made a concerted effort across all levels to reduce the use of seclusion in adult inpatient units, with significant success, according to trend data. This is particularly remarkable given the problematic layout of the adult acute unit.

5.5.   Defensive practice and restrictive care

In response to recent serious incidents and subsequent external criticism and intense media attention, the service has felt pressured to make reactive changes towards more defensive, risk-based care. In practice, this has meant increased use of the Mental Health Act, greater reliance on locked facilities and more restrictions on leave.

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[15] The London Protocol is a tool for conducting a comprehensive analysis of a clinical incident. For more information, visit the Institute for Healthcare Improvement's website, www.ihi.org.

Senior leaders and staff at all levels expressed concern about this shift in practice due to the perceived need to control risk and reduce criticism. For instance, senior medical staff noted the development of increased defensive use of the Mental Health Act, where previously they would have adopted a more pragmatic and positive management of risk. Other staff described feeling pressured by senior staff to change decisions perceived as risky to more conservative and risk-averse options. Staff felt this limited the use of their professional judgement and experience and discouraged patient's self-management.

The increased steps in signing out of patient leave from the inpatient unit and a limitation on leaves had resulted in a substantial reduction in inpatient leaves. People using the service made significantly adverse comments on this aspect, and staff described the new protocols as 'micromanagement'.

While these changes are perhaps understandable in view of recent serious incidents and subsequent scrutiny and criticism; however, they are contrary to good clinical practice. Further, they are inconsistent with the intent of legislation that prioritises the least restrictive care (particularly when the Mental Health Act is read in conjunction with the New Zealand Bill of Rights Act 1990).

Leaders of the MHAS said that they had felt compelled to take some action to protect staff and to reassure members of the public who might need to access the services. They faced an environment where they were under increasing pressure from media, families of patients and, to an extent, judicial officers such as coroners. They noted that the new measures were introduced to reassure patients and their families, and to provide a greater degree of guidance for staff (some of whom were being named and criticised personally in social media). They considered the steps taken were necessary to encourage those with mental illness to continue to seek care and to support staff who were feeling personally exposed and attacked.

Mental health services must manage the risks arising in the context of acute psychiatric illness on a daily basis. In order to do this effectively and to have the best likelihood of improving patients' condition and avoiding adverse outcomes, clinicians must positively manage risk in the context of the individual's life and their wider whānau context. Further, with increasing knowledge of trauma-informed care, clinicians need to do so in such a way that minimises risk of re-traumatisation. Defensive practice and attempts to control (rather than manage) risk work against this. In some circumstances these practices can result in increased risk. It is therefore particularly concerning that the service has felt it had to take the steps it has.

Delivering mental health services is always a balance between least restrictive care and public and patient safety. How this balance is struck is important in terms of maintaining good outcomes for those who use the services and their whānau. It is also important for maintaining confidence in mental health services.

5.6.   Wider DHB engagement

The Inspection Team found a perception among staff that during the time the service was dealing with the implementation of *A Time for Change*, it became more inward-looking. This meant that it was slower to engage with the DHB Board of Clinical Governance. As an example, oversight of serious incidents and their follow-up tended to stop at the MHAS;

formal reports to the Board of Clinical Governance were more focused on progress to improve clinical quality, as opposed to the dilemmas and issues facing the service.

Relationships between MHAS nursing leaders and the wider DHB leadership network were not fostered at this time, meaning that professional nursing input into clinical care and service design decisions became challenging. The importance of mental health nurse leaders' connections with the wider DHB nursing structure has been reconstituted and strengthened in the six months since the Inspection commenced.

6. Service planning, care planning and pathways

6.1. Integrated care pathway

The service has been implementing an integrated care pathway (ICP). This originated out of *A Time for Change*, and is central to the transformation into a more integrated service. The service advised the Inspection Team that there had been good initial consultation over the ICP development.

The approach set out in the ICP document appears consistent with contemporary practice. It was designed to reduce clinical variation and improve the movement through the system of people accessing the services. Staff raised some issues about the ICP with the Inspection Team, but these were more about implementation than underlying principles.

The service has continued to develop documentation of the ICP. At the time of the inspection, it had started to establish the role various disciplines would play in the ICP. Some staff thought the approach was too generic and rigid: a production-line approach that was not flexible enough for individuals and their whānau. Some expressed a view that the ICP needed to be refined to better represent specific client groups and issues.

6.2. Circle of care

Central to the roll-out of the ICP has been the concept of a circle of care, especially within the inpatient environment. A circle of care is in essence a full meeting of the relevant multidisciplinary team (MDT) involved in a person's care with the person and their whānau.

The service's documentation describes it thus: 'The Circle of Care is the term that refers to the various people involved in the community/ inpatient intervention cycle, inclusive of service user, family/whānau, community agencies, and clinical and non-clinical staff.' Staff the Inspection Team spoke to described the concept as a good one: it formalises the involvement of the family/whānau and service-user.

However, the implementation has been challenged by logistics and other problems, including the speed of implementation. However, at the time of the inspection the service was still embedding the concept in its practice, and was subject to pressure to do so speedily, due to external pressures. The Inspection Team's analysis needs to be seen in this context.

The team involved in the implementation of the circle of care explained that management had asked them to align it with key transition points in care. The model requires three meetings during an inpatient stay, the first to be set up within 24 hours and occur within 72 hours. These tight timeframes placed burdens on ward and community staff. Key workers and families faced problems in terms of the need to travel large distances to attend

meetings. Videoconferencing, which might have allowed more options, was not always available.

Staff told the Inspection Team that there had been instances in which people had been acutely unwell at the time the first meeting was required, and had not wanted family involvement.

The responsibility for initial implementation of the circle of care seemed to fall on social workers and, where there were staff vacancies, occupational therapists. Some staff asked why nurses were not encouraged to attend the circle of care training programs.

6.3.   Change programme and process

In general, staff told the Inspection Team that the direction set out in *A Time for Change* was appropriate. Staff spoke about the early involvement and engagement in the process as positive. They reported: 'lots of focus groups', a direction that went 'back to our roots', lots of energy and good consumer and family support. Some felt that a key issue with *A Time for Change* was that staff were involved in its design but not in how it was managed.

Staff made similar comments about the ICP. The consensus was that the direction of streamlining of the IPC for consistency, quality and safety was good, but that there was an issue with how it was being embedded and implemented.

It should be noted that the service was still rolling out the full ICP at the time of the inspection. Certain aspects of the roll-out (particularly in the context of the inpatient environment) occurred more quickly than ideal, at a time when the service was under pressure to respond to sustained external adverse attention. This no doubt contributed to some of the comments staff made to the Inspection Team.

Some staff thought the implementation of the ICP had been rushed and under-resourced in already stretched high-volume service areas (eg, adult community teams).

Staff spoke to the Inspection Team about the sequencing of change, and the need to workshop implementation issues with front-line staff to ensure that challenges were worked through. Many staff felt that the changes had been imposed without the option of staff involvement or the opportunity to make suggestions. A fine balance needs to be struck between maintaining the momentum necessary to effectively implement change and working at a pace that allows effective uptake. Some staff commented that the pace of change had been too fast.

It seemed to the Inspection Team that many staff did not understand or had failed to grasp the rationale behind certain changes: they did not buy into concepts such as generic case management and standardisation of practice. Conversations with staff revealed differing understandings of the purpose of the ICP. This points to implementation issues, including the need to engage front-line staff.

Staff suggested that the change needed to be slower so people could have time to process and understand. They said that managers and clinical leaders needed to understand resistance, making comments like 'don't take it as always just about difficult people; resistance sometimes happens for a good reason'.

Some groups raised concerns about the generic case management approach, while others raised issues about deployment of profession-specific roles and training. The concern about generic case management was by no means universal. It was clear from the documentation

the Team received that the intention of the ICP was to develop commonalities of approach while enhancing discipline-specific contributions. Some staff noted that for the ICP to work all staff would need to adopt a bio-psycho-social approach, which would require training and support.

Some community nurses felt the burden of case management had fallen disproportionately on them, at a time when they were expected to conduct more face-to-face assessments. Social workers and occupational therapists noted that they were expected to provide functional and social work assessments for clients other than those on their caseloads, which added extra pressure.

Rural teams were concerned about how the ICP would be rolled out in more remote areas with less staff resource. Staffing was seen as a problem in a more general sense for rural teams, not just in terms of the ICP.

The Inspection Team notes that the roll-out of the ICP was at different stages in different areas, which could account for staff uncertainty. However, some staff noted that there had been a wave of changes (particularly after the adverse media attention) at a pace that was difficult to cope with.

One staff member commented: 'We barely had time to adjust to *A Time for Change* when restructuring the adult services, the wards, the areas in which doctors worked came on us.' The latter was perceived as meaning no continuity of care for medical staff.

6.4. Relationship with primary care

The service has been working on improved integration with primary care services. A clinical management forum is currently driving change in this regard. The DHB has a clinical director for primary care (Dr Damian Tomic), whose role has been to facilitate conversations between primary and secondary care services, to forge better outcomes for patients. There have been four to five meetings over six months looking at mental health pathways and how mental health services can improve their engagement with primary care. Staff the Inspection Team talked to felt people were on the same page, but that the challenge was to match capacity and resources to desired changes.

A DHB primary/secondary clinical governance group consists of representatives from the three primary health organisations (PHOs), secondary mental health services and the primary care strategic liaison position. This group oversees and sets the direction for the Integrated Care Co-ordination Team (ICCT) and the primary health working group.

There were work streams in place for shared care and discharge. However, staff told the Inspection Team there was inadequate communication between secondary care and primary care (eg, not receiving discharge letters and lack of consistent support for primary care by secondary care services). Primary care clinicians expressed confidence in psychiatrists over other members of the crisis team, but reported difficulty accessing them. They wanted assurance their patients could be seen by a psychiatrist in the secondary service. Primary care clinicians believed that only psychiatrists had the knowledge and skills to provide urgent and ongoing advice that would give people who used services the confidence to manage in the community.

The ICCT, established in 2014, provides an example of innovative practice within the DHB. It supports primary and secondary integration. The team facilitates a process whereby adults

within the secondary mental and addiction services whose illness is now stable, and who do not have high and/or complex needs, can receive care within a primary health setting. The team has four clinical FTE roles (including dedicated psychiatrist time). To support its work, and to reduce the barriers to accessing GP care, the ICCT has access to Packages of Care (POC) flexible funding for GP consultation co-payments and to fund intra-muscular injection administration by primary care practice nurses.

Waikato PHOs run brief intervention services, but not all adults who experience moderately severe illness are able to access such services, due to limited access to resources.

The Inspection Team heard some examples of positive collaboration between primary and secondary service providers. For example, ICAMHS referrals were all seen with a 20 percent uptake after the first appointment.

6.5.   Relationship with major non-governmental organisation partners

The Inspection Team spoke to the service's three major NGO partners: Wise Group, Emerge Aotearoa and Hauora Waikato. Overall, the Team found that there were effective working relationships between the service and these NGOs.

Perhaps the strongest of these working relationships was that between Hauora Waikato and the Midland Regional Forensic Psychiatric Service, which work to a one-service, two-provider model. It was evident that over the years these two agencies had worked effectively under good operational and clinical governance. They had worked through specific issues identified as barriers; the partnership approach was very evident. A number of examples were given of how the relationship has developed over the years. Comment was made that since recent pressures had been placed on the service, there seemed to be some fragmentation among senior managers attempting to deal with the issues.

Wise Group and Emerge Aotearoa clearly enjoyed good working relationships with the DHB provider arm, but that their staff felt there were grounds for improvement. In particular, they made suggestions for enhancing integration across the provider arm and NGO services if in the current direction of travel. They suggested that NGO partners might better be able to provide some elements of service. As noted above, there were some interesting examples of how joint working together had resulted in improvements (eg, *The People's Project*).

6.6.   Infant Child and Adolescent Mental Health Service

The current ICAMHS delivery structure was set up following a major review of services in 2006 by the Werry Centre. ICAMHS provider arm services now work in collaboration with NGO providers in a three cluster approach.This approach splits the Waikato region into three geographic areas; a formalised combination of provider arm and NGO services provides coverage to each. The ICAMHS team described the Werry Centre's review as their equivalent of *A Time for Change*. Staff noted there had been no post-implementation review of the service delivery changes, and felt that the cluster approach had had the unintended consequence of allowing three different models to develop, with the result that the Clinical Director faced challenges in ensuring consistent clinical governance. In addition to the clusters operating differently there were also challenges in terms of the interoperability of computer systems and other systems between ICAMHS and their NGO partners.

Despite these challenges, overall staff in the ICAMHS team felt they provided a high-quality service, although they noted that they were seeing increasing demand pressures, in terms of increased referrals, and increased complexity of issues on referral. In the more rural areas, inability to recruit suitable staff has led to an increased focus on crisis work and less longer-term therapeutic work. Some staff expressed concerns about the potential adverse impact of these pressures on patient care and staff retention.

6.7. Older Person Mental Health Service

Like the MHAS, the Older Person Mental Health (OPMHS) subservice provides coverage across the district: there are two nursing and 0.5 social worker FTE roles in Thames, and the rest of the staff are based in Hamilton. The OPMHS uses an integrated model of care: the same team is involved in the inpatient unit and in the community. Inpatient care is focused around a recovery model, but the service is experiencing challenges in ensuring alignment of the required paperwork and actual practice.

The OPMHS has recently moved into new facilities. While the new facilities are clean and well-lit, they have posed a particular challenge. as two distinct patient groups are managed with the one ward; patients with functional psychiatric illness (70%) and those with behavioural problems arising from their dementia or organic illnesses (30%). The needs of and treatment approach to these groups are different. Staff have made some adaptations to the ward environment to manage these groups. It was evident to the Inspection Team that the staff provided a high standard of care.

There is an increasing elderly population within the Waikato DHB district. This is reflected in an increased demand for the OPMHS. Staff working within the community reported relatively high caseloads: 30–35 clients per key worker. This had led to increased staff stress and increased use of nursing bureau staff, resulting in issues related to differences in skill sets.

The OPMHS subservice has multiple entry points. The service is in the process of developing one for cognitive disorders.

The OPMHS has not yet adopted the ICP. Staff are apprehensive about its introduction given the issues that have arisen with its implementation elsewhere. The Inspection Team believes that the DHB should give some thought to how it could adapt the ICP to this area of the service.

6.8. Acute Care Coordination and Integration Service and Crisis and Home Treatment services

The Acute Care Coordination and Integration Service (ACCIS) and the Crisis and Home Treatment (CAHT) services operate from a single point of entry that includes transfers of care. The ACCIS has undergone significant change recently; it has essentially rebuilt itself over the last two years. Its staff have embraced the change.

The issues the service reported to the Inspection Team appeared to be mainly in association with the community teams. Staff noted that stability is lacking in this area, and that there are significant resourcing challenges, including a high rate of staff turnover. Staff felt the resourcing pressures on the adult teams had resulted in them 'picking up the pieces'.

Staff expressed some frustrations with referrals coming from general practice, considering some of them inappropriate.

Staff expressed concern about what had been happening since the external pressures had become an issue. They said they felt less supported in their risk management work (especially in terms of supporting people accessing the service to self-manage). They felt that a more punitive model of care, involving restrictive care and micromanagement, was entering the culture of the service. This had left them feeling disempowered.

6.9.   Other subspecialty teams

The service comprises a number of other subspecialty teams: Alcohol and Other Drugs, Intellectual Disability-Dual Diagnosis, Integrated Recovery, Assertive Community Service, Residential Coordination, Specialist Eating Disorder, Dialectical Behavioural Therapy, Consult Liaison and Perinatal Mental Health. The Inspection Team spoke to representatives of these teams, but they were not the major focus of the inspection. Staff from these teams reported some pressure on resources, but seemed not to have the same concerns as the community and crisis teams.

Similarly, the Regional Forensic Psychiatric Service was not inspected in detail, however the Inspection Team did take into account comments from people using the forensic service.

7.   People using the services and their whānau

The Inspection Team's consumer leader inspected the Waikato DHB's mental health services from the perspective of people using the services and their whānau. She met with 105 people accessing the services either as tangata whaiora or whānau. Where possible, the Inspection Team has incorporated comments from these people into the wider body of this report.

As noted earlier (section 3.8) the MHAS has made considerable progress in the areas of consumer and whānau engagement since the *A Time for Change* report. As part of the process of significant change, the service has defined expectations for consumer engagement at all levels, including at all levels of governance. Further, there has been a clear focus on rolling out recovery and peer support modules for this purpose.

The commentary received by the Team's consumer leader was valuable and demonstrated a willingness by people using the service to provide feedback. This feedback is invaluable when services are undergoing transformation. There were both positive and negative experiences and the challenge for the service will be to find mechanisms to build a culture within the service (at all levels) to incorporate those experiences as a driver for further change and improvement.

The service has recently started using the Real Time Feedback Tool,[16] which gathers system-level feedback, and is valuable for service development. Service user networks regionally and nationally are applauding the use of this tool. However, people interviewed reported being most interested in their personal treatment plan and this tool does not account for that. Unfortunately, there is not one system that will work for everything.

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[16] The Mental Health Commissioner developed the Real Time Feedback Tool in association with CBG Health Research Limited. It electronically records feedback from people interacting with mental health and addiction services. The tool aims to ensure that the voices of consumers and their family/whānau are heard and contribute to quality improvement.

Other services, both within New Zealand and internationally, have explored using tools that enable people using a service to provide feedback about their personal treatment and care. To be effective, a feedback tool needs to ensure that receiving and responding to feedback makes a positive difference to the outcome for an individual person and their whānau. Nationally and internationally there is still some debate as to what tools work best in this regard. Scott Miller's evidence-based, pan-theoretical, Feedback Informed Treatment[17] outcome tool is one contender.

In many cases, service users' experience of staff seemed to predict their experience of their care generally: those who rated their experience of staff as 'good' also tended to rate their overall care as 'good'. The Inspection Team recommends exploring this dynamic, with the aim of maintaining consistency of practice change at the front line. Feedback tools could assist this process.

The MHAS should also explore whether the feedback process should be more multi-faceted. For example, it could include not just people directly accessing services, but those outside the system who have an interest in or are potential users of the services. A broadened base could further enhance knowledge of the effectiveness of a service from a service user perspective. It could in turn drive further transformation and improve public understanding of the service.

Some strengthening could occur in the area of whānau engagement within the MHAS. There have been significant system developments since *A Time for Change*, including the introduction of the Family Facilitator role, survey options for family/whānau and the Real Time Feedback Tool. However, the Inspection Team notes that family/whānau engagement is everyone's business. Currently, there appears to be a small group of people responsible for championing such engagement, within a system that is still largely designed for individuals.

Mental health services around the country often find difficulties in balancing the rights and responsibilities to the individuals using the service and those of the whānau. On occasions these can be in conflict and staff will need to be supported through this. In Waikato DHB's MHAS, as part of the cultural change already taken place, there needs to be a more consistent commitment to equally engage individuals accessing services and their whānau. Such a commitment is likely to assist the MHAS to obtain wider community support for its work.

There are opportunities to further strengthen transition planning between the MHAS and external service providers, and to look at providing services closer to home.

Like front-line staff, some people using the service perceived that the services were under pressure, and that more resources in certain areas would assist. This appeared more evident in the more rural areas.

Service users made some favourable comments about forensic and older persons' services, but raised concerns over the adult inpatient environment. (See further section 9.4.)

Service users also noticed an increasing reliance on defensive practice and restrictive care which was reported to be related to external criticism of the MHAS and this was experienced negatively (see section 5.5).

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[17] For more information on this tool, and academic articles supporting its efficacy, see www.scottdmiller.com.

8.   Cultural responsiveness

This section has been compiled by the Chief Advisor Māori Health.

The report *A Time for a Change* identified two main quality issues for Māori who use mental health services in Waikato DHB: that 'there was little evidence of Māori participation in service planning' and that 'whānau were concerned they were not sufficiently involved in decision making with respect to the care of tangata whaiora'.

As part of the Implementation of *A Time for Change*, Te Pou o Te Whakaaronui (Te Pou), agreed to assist the DHB to strengthen its responsiveness to Māori. The Te Pou consultants identified a number of areas of work within which to improve cultural responsiveness to Māori, the main focus being that the DHB develop an implementation/action plan based on their report *Building Cultural Responsiveness*.[18] The MHAS is currently implementing a ninety-day cultural responsiveness action plan.

The cultural inspection was not extended to the community mental health teams (CMHTs). This is because the DHB's kaitakawaenga services, who provide cultural services to the MHAS, do not yet have sufficient resources to provide this service to CMHTs.

The inspection found that the MHAS has improved its cultural responsiveness. It should be commended for the actions it has taken since *A Time for a Change* and the Te Pou review. However, there is room for improvement, particularly in terms of the need to appy a consistent process to ensure cultural responsiveness for all Māori across all units of the MHAS. The Inspection Team recommends that:

- the MHAS incorporate the recommendations of this inspection into its ninety-day cultural responsiveness action plan, and continue to implement that plan

- the MHAS and Te Puna Oranga (Waikato DHB Māori Health) review and update their collective governance and operational policies and procedures in relation to Māori participation in DHB services with a view to improving coordination and alignment

- the MHAS provide its staff with the opportunity to attend in-service training and learn about the kaupapa Māori model, its fit within the ICP and when and how to refer tangata whaiora to kaitakawaenga

- MHAS staff receive appropriate cultural competence and health literacy workforce development training, so that they may better support kaitakawaenga and tangata whaiora and whānau

- the MHAS review its processes for ensuring that tangata whaiora receive supportive written and verbal statements of their rights while a patient in the MHAS, at their earliest convenience

- a policy and procedure for the involvement of whānau in the planning and development of MHAS in an advisory capacity is established and contained in the manuals of the Te Puna Oranga Māori unit

- the MHAS ensures that it appropriately involves whānau in the care planning, treatment and care monitoring of tangata whaiora (with their informed consent),

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[18] Milne M. (nd). *Building Cultural Responsiveness at Waikato DHB Mental Health and Addiction Service*. Hamilton: Te Pou o te Whakaaronui.

and that kaitiaki and kaitakawaenga services be made available throughout all units of the MHAS, including the CMHTs.

9. Planning, funding, facilities, financials and IT supports

9.1. Planning and funding

The MHAS delivers provider arm services in the context of the broader services contracted and provided by the DHB. Up to 40 percent of the Waikato DHB mental health and addiction spend goes to non-provider arm services (eg, NGOs). This is significant in terms of the planning and delivery of care across the continuum. The Inspection Team therefore examined coordination across the full continuum of care.

The DHB planning and funding area hashave the task of purchasing and coordination of various services, including in the mental health and addition sector.

Planning and funding staff explained to the Inspection Team that, in part, the current diversity of NGO providers is a result of the historical structure, in the Regional Health Authority and Health Funding Authority period. When the devolution to the DHB occurred, there were a large number of NGO contracts. In the child and youth area, 17 NGOs were providing services (see section 6.6 for information on the current situation). The contracts in the adult area were more confined to traditional services such as residential and community support services. As noted above, key NGO partners are now the Wise Group, Emerge Aotearoa (previously Richmond and Recovery Solutions) and Hauora Waikato.

The Inspection Team received documentation on reviews of NGO service provision in certain areas (eg, for services for people with high and complex needs).

From a planning and funding point of view, the relative sizes of Waikato's three PHOs in terms of enrolled populations (one large, one medium-size and one small) has posed difficulties in terms of the DHB's ability to develop a coherent approach across the primary care–secondary care continuum.

The DHB developed an the ICCT and packages of care to ease consumers' transition out of the MHAS and back into primary care and other service providers. However, it is still developing a clear process for how different services coordinate the continuum of care and transitions. The main tool for this appeared to the Inspection Team to be the Map of Medicine (focused at the current time on continuing care and dementia).

The Inspection Team found that, while mechanisms for integration between NGO and provider arm services were evident across all services, they were much more apparent in the youth and forensic space. While there were clearly clinical and other relationships between NGOs and provider arm services for adults, quality and reporting relationships worked differently in those services. Non-governmental organisation services reported to the DHB's planning and funding function, and provider arm services reported to the Board of Clinical Governance. The exception was Hauora Waikato, which had much better linkages with the provider arm, and used a common overarching clinical governance approach.

9.2. Financials

The DHB funds both the provider arm services (MHAS) and NGO services. The provider arm receives internal revenue through the Price Volume Schedule. This is funded on the basis of community FTE, bed days and programmes and packages of care linked to specific

programmes. The community FTEs are funded on a fully absorbed costs basis. NGO services are contracted.

There is alignment between the human resources and financial systems. While there appeared to be some mechanisms to enable the shifting of resources to accommodate pressure points and changing demands, the overall rigidity of the systems appeared to the Inspection Team to have limited the ability of managers to flexibly respond to demand pressures and service changes.

In recent years there has been a particular focus on meeting savings targets, and senior management has become preoccupied with financial pressures. The Inspection Team notes that the MHAS has managed effectively within its budget, although it seems there have been some challenges in balancing finances with service quality.

During the inspection visit, and in its response to a preliminary version of this report, the DHB acknowledged funding pressures on the MHAS. It reported that these were a result of:

- a Price Volume Schedule that did not reflect national pricing levels of inpatient services

- internal provider arm budgeting that did not adequately provide for the mandated rostering system (the budget was for a 5 on 2 off roster, but the service was required to run a 4 on 2 off roster)

- a provider arm requirement to meet organisational savings targets that involved a budget that assumed a FTE vacancy factor of approximately 25 FTE per year.

The DHB reported that 'whilst the MHAS have historically had difficulties in recruitment of staff, this led to significant staff vacancies across the services which were accentuated by internal recruitment processes that caused further vacancies (approximately 10–15 FTE) as a result of "churn"'.

9.3.   IT and Technology Support

The DHB acknowledged to the Inspection Team that its population is highly dispersed, and that its rural population in particular has high needs. As such, one of the key elements of its future strategy is to develop a focus on virtual health care, and to plan how to meet the needs of a dispersed population. It has appointed a Clinical Director of Virtual Health Care.

The DHB has a clear strategy for implementing an electronic record and electronic supports for staff working outside Hamilton. However, it has faced various challenges from a technological point of view. The project of implementing a comprehensive electronic record draws on regional and national work. In this regard, the DHB still needs to address some system implementation issues.

The roll-out of wireless and remote access is still in its early stages for some of the more rural teams. The DHB aims to implement videoconferencing in all rural hospitals, but so far only one of the CMHTs appears to be using this successfully.

9.4.   Henry Rongomau Bennett Centre facilities

One of the conclusions of *A Time for Change* was that 'the capital infrastructure does not meet contemporary standards'. It specifically recommended that the DHB redevelop the HRBC to provide an environment which meets contemporary standards.

The service has made some changes to the HRBC to give effect to this recommendation, but the structure of the building poses fundamental limitations on redevelopment. The service produced a business case for redevelopment in 2013. The documentation on proposed changes to the unit (following the AWOLs and other issues in May 2015) summarised the following key drivers and risks:

1. Significant deficiencies have been identified by external bodies and originally documented within 'A Time for Change'. These deficiencies include; lack of space, lighting, congestion, lack of privacy and lack of areas for therapeutic interventions. They can be summarised as providing an environment which is institutional, dark and depressing and does not meet contemporary standards.

2. The organisation is attempting to mitigate an increasing number of AWOL incidents with associated significant risk of self harm, harm to others and reputational risk. The current environment constrains the ability to manage the tension of providing services in the least restrictive environment, whilst ensuring those most unwell do not abscond. With limited options for separate indoor and outdoor spaces to manage varying levels of acuity at any one time the ability to manage this dichotomy is severely constrained.

3. The national imperative and drive to eliminate[19] the practice of seclusion nationally. Nationally seclusion is considered evidence of a failure in treatment. Rates of seclusion are nationally benchmarked. Waikato's performance is of concern. A clear strategy is in place to improve performance in this area, however the current inability to de-escalate service users in their current environment, with staff they know, in a safe, private and therapeutic space inevitably results in otherwise avoidable use of seclusion and restraint.

4. The service, organisation and region has identified and articulated the need to have access to suitable intensive rehabilitation beds for service users with high and complex needs. Currently these service users are spending extended time in acute wards, forensic mental health beds or in the criminal justice system. The increased rates of incarceration for those with multiple and complex needs is directly related to gaps in the system of care required for those with severe mental illness. Waikato District Health Board is one of the only larger DHB districts without this core component of the care continuum.

5. The fulfilment of the service goal 'To earn the reputation as a service people trust with their loved ones' care'. An environment which is unable to support safe and quality focused care is not an environment in which any DHB employee would comfortably entrust the care of their loved ones.[20]

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[19] The national direction set by the Ministry of Health and evident in the Health and Disability Services Standards is towards progressive reduction (and eventual elimination) of the use of seclusion and restraint. At present the focus is on reducing seclusion as more work needs to be done in this space to ensure effective alternatives are put in place.

[20] Mental Health and Addictions Service. 2015. *Henry Rongomau Bennett Centre Improvement Plan (Facilities/Environment)*. Hamilton: Mental Health and Addictions Service.

The Inspection Team understands that the DHB accepted the business case 'in principle subject to the ability of the organisation to realise the necessary capital funding'.[21]

Following the presentation of the business case, the service made some alterations to the security and fencing at HRBC. It also changed its use of the wards in the light of considerations relating to risk and acuity. One ward became an intensive care/low-stimulus locked unit; a second became a locked unit (for people under compulsory care) with access to the courtyard with its improved fencing; and a third became more open, with a focus on rehabilitative activities geared towards discharge.

While the changes in utilisation of the facility are understandable given the facility's serious limitations, these changes have had unintended consequences. For instance, significant risks to continuity of care emerge when a person is moved to a less restrictive environment and their care team is changed; these risks need to be carefully managed. The MHAS has put policies and processes in place to mitigate such risks. However, given some of the concerns raised with Inpection Team, further consideration needs to be given to how to maintain the therapeutic alliance and continuity of care between key staff and the people using the service.

Overall, the findings of the Inspection Team were in line with conclusions in the 2013 business case: the current facilities do not meet contemporary standards, and have therefore posed challenges to the teams providing care to acutely unwell patients. The confusing layout and lack of good sight-lines will continue to pose safety risks. It was hard to see how the service could effectively address these issues given the structure of the unit. (For instance, the narrowness of the corridors and the placement of bedroom doors lead to real possibility of the effective barricading of corridors, and the potential for a disturbed individual to harm themselves or another person out of sight.)

The Inspection Team did not undertake a detailed analysis of the facilities, because the DHB had already commissioned a full review of its adult mental health facilities in 2015[22]. This report was completed during the inspection; it makes similar findings.

The DHB commissioned this review in part because of concerns following the significant adverse incidents that occurred in early 2015. The review team was headed by Kevin Fjeldsoe, who was also the head of the review team that developed *A Time for Change*. The review made the following findings.

> … despite considerable effort to improve the HRBC environment, [the facility] did not meet a significant number of basic contemporary standards. Further, it was the view of the review team that the capacity of the service to develop new and potentially more efficient and effective models of service was being constrained by the need to deliver services in the existing facility.

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[21] Mental Health and Addictions Service. 2015. *Henry Rongomau Bennett Centre Improvement Plan (Facilities/Environment)*. Hamilton: Mental Health and Addictions Service.
[22] Fjeldsoe K , Meehan T, Kingswell I. 2015. *Henry Rongomau Bennett Centre Models of Care and Facility Infrastructure Review: Planning for the Continuing Development of Adult Acute Inpatient Services*.

The review team believes that a contemporary service model involving the construction of new purpose built hospital and community facilities should be considered. This should provide a more efficient use of recurrent funds and provide a greater array of inpatient treatment options for consumers with increasingly complex and diverse needs.

10. Recruitment of doctor who allegedly dishonestly gained employment

The Inspection Team carefully examined the recruitment process for the overseas doctor who allegedly used documents belonging to another person to gain employment as a psychiatrist at Waikato DHB. It looked at his supervision and the subsequent events up until he left Waikato DHB's employment.

As noted earlier, this doctor is currently before the court on charges of dishonesty and using a document for a pecuniary advantage. For this reason, the Inspection Team can provide only a limited overview, to ensure court processes are not compromised. Appendix 5 provides fuller information, but will be redacted in the public release of this document.

In recruiting the doctor concerned, Waikato DHB followed what the Inspection Team considers to be a best-practice process. During this process there were no obvious red flags that would have alerted the human relations team to identity fraud. No fault can be accorded to any person within the DHB in respect to this recruitment process. To the contrary, the DHB was quick to recognise concerns with the competence of the individual concerned. It was also diligent in taking action to mitigate further risk to patients and the wider service.

The Inspection Team has identified some strategies to assist Waikato DHB and other DHBs to enhance the way they recruit employees from other jurisdictions: see Appendix 5.

11. Conclusion

11.1. Summary

The MHAS and its leadership team has made significant improvements to the service since 2009. The direction of travel of the change is appropriate, and shows good strategic thought as to contemporary models of practice. The shift in models of care through this time have been significant, and it needs to be acknowledged that the transformational change is yet to be completed.

Overall, the MHAS are well managed and led. They provide a good standard of care. Staff, despite the problems of morale and increased pressure, are dedicated to doing their best for people accessing the services. People accessing the services and their families/whānau can be assured that they can expect to receive good care.

Like all mental health and addiction services, Waikato DHB's MHAS faces significant pressures as it changes its models of care and responds to increased community expectations. In some respects, pressures on the services are to be expected as the MHAS moves towards more accessible and timely care.

However, there are some obvious issues that the MHAS and the DHB need to address immediately, within the current programme of change.

- The MHAS needs to secure adequate resources to meet staffing gaps, and support a redefined change timeline.

- The MHAS needs to further strengthen leadership to support clinical change capability and capacity.

- The wider DHB needs to provide increased oversight and support to the MHAS leadership team driving the transformational change.

Supporting change

A Time for Change and the subsequent strategic plan was the first step toward reform. There was good initial engagement, and a recognition that significant change was necessary. The culture prior to this was described by some as 'toxic', and one of the areas that needed addressing. The desired goals of *A Time for Change* were consistent with contemporary mental health service development. In particular, the Inspection Team sees The plan for change was good and the service's intention to increase service user/ family/whānau engagement is appropriate. However, in the Inspection Team's view, me further work.

The initial implementation of *A Time for Change* was done well and was appropriate. As the implementation service transformation arising from *A Time for Change* progressed, other factors intervened that have adversely impacted on the service. The removal of the original external change team at the critical point of embedding shifts in practice undermined the roll-out. Furthermore, the roll-out was compromised by the spilt in focus between implementing the change programme and making required fiscal savings. A triple set of competing goals ensued: 1) maintaining effective clinical and operational oversight in an area of potential high risk; 2) driving effective transformational change; and 3) making financial savings.

The MHAS developed a solid and appropriate strategic plan to guide the implementation of its transformation to a more contemporary service. It developed an appropriate governance structure, and sound policies and procedures. However, there was an underestimation of the need for clinical leadership across all disciplines. In particular, the service underestimated the need for support for practice change.

More recently, the pressure to make rapid change and control risk in the face of serious incidents and resulting external pressures has compounded the issues. Further, there has been a lack of capital and fiscal support for all these necessary changes. This has led to a 'perfect storm' of pressures and impacts on the service.

Leadership for the support of quality clinical care

In recent times, staff have perceived changes as being driven from the top down. They report not being listened to. Managers and leaders have assumed responsibility to ensure no further risks emerge, leading to a staff perception that managers are directing them to control risk, rather than exercise appropriate clinical decision-making and plan clinical risk taking. Of particular concern has been the emergence of defensive practice, associated with an increased use of restrictive care.

The recent pressures on the MHAS has had a particularly significant impact on its leadership and management. Senior leadership presence at the front-line diminished as those leaders focused on managing what had become a very challenging external and internal space. This

led to communication issues. During interviews, some staff observed that their immediate managers had become overwhelmed by competing pressures.

To front-line staff and people using the service, the increase in the speed and intensity of change has created a sense of 'change on change', leading to staff demoralisation and an adverse experience of care by the people using the service. It should be emphasised that all staff need to take responsibility for supporting change processes, and for consistency and quality of care. It would be useful for the DHB to undertake more work on understanding the role of individuals in supporting change.

The wider District Health Board and the Mental Health and Addiction Service

The Inspection Team considers that the leadership group and the wider DHB need to more deliberately develop a split-screen approach: a focus on the transformational change alongside day-to-day management. This requires specific resourcing and support.

While the MHAS certainly recognised that it was undertaking a major change programme, it is not clear that the rest of the DHB recognised that it needed to support the service's leadership team to achieve transformational change. The existing strength and coherence of the leadership team enabled them to continue to drive change even when the resources were diminished. However, it seemed to the Inspection Team that this had the unintended consequence of the service becoming an island within the DHB. It also made vertical communication within the MHAS more challenging.

There is a need for greater engagement and support from the wider DHB – especially given the magnitude of the transformational change the service has embarked on and the associated risks.

12. Recommendations

When commenting on the initial draft, the DHB indicated that they have commenced actions in regard to a number of the recommendations below. Their responses are presented in italics under relevant recommendations below.

The Inspection Team emphasises that some of these recommendations support the direction of travel that the DHB has already been taking in its service transformation; to a greater or lesser extent, the DHB may have already addressed them.

12.1. Immediate

1. There needs to be an immediate appointment to the role of Executive Director, to enable the Director of Clinical Services to concentrate on leading clinical changes. The DHB needs to give careful consideration to appointing someone who is the right fit for this service given its transformational change and operational challenges.

    Mr Derek Wright commenced work in his new role as Executive Director of Mental Health and Addictions on 15 February 2016. He is a very experienced manager with a long history of involvement in the mental health and addictions sector. He has managed large services in both New Zealand and Australia and has overseen a number of significant change processes.

2. There needs to be a clear strategy on positive clinical risk management that ensures appropriate human rights while at the same time educating and assuring the public.

Many of the more restrictive practices (eg, regarding leave management, etc) have been amended and the service is moving its training and approach to management to a model of 'positive risk taking'.

In addition, the organisation had already begun the development of a communications strategy, addressing both internal and external stakeholders to improve the understanding of the media and the wider Waikato community about its MHAS and the challenges it faces.

3. The DHB needs to devote attention to some immediate staffing relief in critical areas (especially in some of the community teams) to reduce staff burn-out and churn, fill vacancies and improve staff retention.

   The organisation has moved to bring immediate staffing relief to critical areas within MHASs. Particularly:

   - *The service has increased the number of Acute inpatient registered nursing staff by 6 FTE.*

   - *Mechanisms have been put in place to maximise the efficiency and effectiveness of recruitment (and retention) of staff to key areas. These involve more flexibility in the placement of staff, increased efficiency of internal HR processes to minimise the 'churn' factor.*

   - *Planning and Funding have agreed to an increase of approximately $3.5M into the Price Volume Schedule (PVS). Business cases will need to be developed in order to define how these funds might be best used. In addition, funding and planning have agreed to review the current PVS in terms of community FTE to better respond to current demands.*

4. Because of the magnitude of the change agenda, the MHAS needs strong engagement and support from the wider DHB at all levels.

   The MHAS has increased its engagement with, and involvement in, wider DHB organisational processes (eg, at executive level, within quality and risk, finance, savings and sustainability forums, the Board of Clinical Governance, performance and operations etc).

   Further, the DHB executive accepts that as MHASs continue to undergo major transformational change (accentuated by the proposals for a review of the wider MHA sector and rebuilding of the HRBC) there is a need for additional change management capacity and capability. There are papers proposing these changes (and the need for commensurate change management resource) about to go to the wider WDHB board for consideration.

5. The strategic direction is one of system change in the district; therefore, a systems-wide change process is needed that includes the MHAS, its strategic NGO partners, primary care services, iwi, consumers and family/whānau.

   Planning and Funding are about to propose a wider alcohol and other drug and MHAS needs assessment service planning and purchasing plan to address the MHA needs of the Waikato population through to 2026. A paper prosing this initiative is currently being worked up, sponsored by the new Executive Director and Clinical Director of the Strategy and Funding team of the DHB.

6. Integrated clinical and operational governance that includes planning and funding is necessary across this continuum.

   An integral part of the process noted in 5 above will be the development of an operational governance structure across all elements of the MHA sector with clear reporting through to the CEO and Board.

7. The service should report progress to the DHB Board and the Director of Mental Health.

   Evidence of the initiatives set out above and regular reports on their progress will be provided to the Director of Mental Health

12.2. Longer term

8. The current direction of travel is appropriate and necessary. The agenda for transformational change cannot be discarded. However, to give effect to change of this magnitude, the following are required.

   a. There needs to be appropriate shared leadership, supported by a change team with experience in embedding transformational change.

   b. There needs to be adequate resourcing for the change (including fiscal resources and staffing resources).

   c. There needs to be support for embedding practice change at the front line/consumer level, with effective feedback loops.

   d. Industrial relationships need resetting to ensure partnership in change.

   e. Professional leads need time to participate in and develop support for change (including service and clinical leads).

   f. The renewed strengthened nursing and allied leadership model needs ongoing monitoring and support.

   g. The MHAS needs to build up a sufficient group of 'in-service leads and champions' to support change within teams.

   h. There needs to be a clear and detailed communication and engagement strategy at all levels. The strategy needs to include the DHB's strategic partners, the people using the service and the community. The strategy should have a clearly articulated narrative that supports the transformational change agenda.

   The DHB accepts that there is a need for the development of a change team to ensure robust methodology (and adequate resources) are available for the implementation of change and this change process is closely monitored by the MHAS and by the DHB executive.

   Additional change management resource will become available as a result of both MHA sector review and the proposal for the HRBC (and associated model of care), once agreed by the board.

   There are a number of projects currently under way within the service to further develop and implement the ICP and to define and implement diagnostic-specific ICPs (identifying discipline-specific interventions and the case management role and resultant competencies). This work will better define the service's needs for its workforce (and their specific competencies) and will better inform the educational

and training needs. This work is led by the Director of Clinical Services with close involvement of all of the disciplinary heads and with project management support from within MHAS service improvement team.

The MHAS has in its change processes used service leads and champions and intends to continue to use them.

A draft communications strategy (orientated to internal and external stakeholders) has been developed

9. The ICP, while appropriate as a high-level organising principle, needs to be customised to fit local circumstances. This would effectively complement the existing level of co-design and increase future levels of acceptance among service users.

    This is already part of the implementation process for the ICP.

10. Good cultural practice must be embedded, effective and consistent (see the suggestions in section 8).

    This is already part of the cultural responsiveness plan.

11. Planning must incorporate realistic timeframes, based on best practice and how to embed change.

12. The service needs to galvanise community relationships to support and protect the change.

APPENDICES

Appendix 1: *A Time for Change* – Summary

This appendix is a summary of the March 2009 Waikato DHB report *A Time for Change: Evaluation of Health Waikato Adult Mental Health and Addictions Service.*[23]

In *A Time for Change*, external reviewers presented the results of their review into the provision of care in the acute adult mental health services of the Waikato DHB. The purpose and process of this investigation is set out below.

Purpose:

- Review the standard of acute adult inpatient care compared with expected recovery standards

- Review the standard of clinical leadership and management of acute adult inpatient care

- Produce practical recommendations that may be used to take action to significantly improve the mental health care provided by Health Waikato Adult Mental Health and Addictions Service over the medium to long term to achieve the recovery standards set out in Te Kokiri: The Mental Health and Addictions Action Plan (Ministry of Health, 2006) and the Blueprint (Mental Health Commission, 1998).

Process:

- Undertake a review of all relevant documentation provided by Waikato DHB

- Undertake a site visit to Waikato DHB, visiting all identified business units and services of adult mental health services and those of other areas identified by Waikato DHB to be pertinent to the review

- Undertake interviews with any or all staff identified by Waikato DHB as being pertinent to the review

1. EXECUTIVE SUMMARY

The focus of this evaluation is the acute adult inpatient service. The team found that there are significant problems with the current operation of this service:

- Inpatient units operate with unacceptably high occupancy rates

- The capital infrastructure does not meet contemporary standards

- Staff report low levels of commitment to the organisation

- The capacity to recruit and retain staff seems to be impaired

- There is little evidence of Māori participation in service planning and provision

- There is little evidence that service users and tangata whaiora are sufficiently involved in planning for their care

- Whānau and families are concerned that they are not sufficiently involved in decision making.

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[23] Fjeldsoe K, Aimer M, Meehan T, et al. 2009. *A Time for Change: Evaluation of Health Waikato Adult Mental Health and Addictions Service*.

It is the opinion of the evaluation team that these problems are not in the main related to resources but rather to the systems currently in place to deliver services. By any measure the quantum of resources provided should be sufficient to provide a high standard of care. While plans for the development of home based intensive care services and alternatives to admission for service users with complex needs are supported strongly they should not be seen as the sole answer to the challenges which currently confront the service.

Although staff may report significant dissatisfaction with the service, there is a clear desire for change and commitment to improve the services provided. Despite this expressed desire, there seems to be an organisational inertia where staff no longer can identify or have little faith in the processes currently available to make decisions and effect change. There is a distinct lack of a shared direction or vision for the future.

The evaluation team believes that a number of major systemic changes are required. They include:

- Realignment of the service as an active public partner with Māori, and with the other government and non-government providers

- Restructuring to provide an improved level of integrated, continuous care where the focus of service is located in the community

- Serious investment to plan for the establishment of the recovery approach as the foundation for redesigning care planning and delivery across inpatient and community services

- Restructuring the current leadership and management systems to support the establishment of more effective delivery of clinical leadership and governance.

This report provides more than 70 recommendations (Appendix 4) aimed at supporting these fundamental changes in the systems and processes in place.

It may be that organisational inertia referred to earlier relates to previous unsuccessful attempts to introduce change. Changes of this magnitude require a consolidated commitment which should not be underestimated.

Meaningful, effective change of this scale will require persistent and consistent investment over an extended period of years rather than months.

Appendix 2: *A Time for Change* – Recommendations

This appendix is an excerpt of the recommendations from the March 2009 Waikato DHB report *A Time for Change: Evaluation of Health Waikato Adult Mental Health and Addictions Service*.24

Organisational Development

1. Initiate the development of a multi-agency Waikato District Mental Health Services Plan which engages all relevant agencies in planning and continuing commitment to a shared vision for the future. The recovery approach should underpin this planning process.

2. Should the service decide to adopt the recommendations provided in this report, it is recommended that Health Waikato Mental Health and Addictions Service engage in collaboration with local iwi and key stakeholders to develop a plan for the new service which provides a clear and unambiguous vision for the future. This plan will provide the foundation for a change management strategy.

3. Review the current organisational structure to clarify lines of communication, decision making and reporting processes, and professional, clinical and managerial supervision. It is further recommended that a committee structure be developed which establishes new or revised terms of reference for each committee to ensure clear lines of authority and effective decision making capacity.

4. Expedite as a matter of urgency, the excellent work currently under way to establish a framework for improved clinical governance. The development of an implementation plan should also be considered.

Safety

5. Redevelop the Henry Rongomau Bennett Centre to provide an environment which meets contemporary standards.

6. Consider the process of and actions arising from risk assessment as a matter of priority during the development of the clinical governance model.

7. Take immediate action to complete the training of staff in the use of the new Risk Assessment Tool to enable the tool to be applied consistently across the service.

8. Initiate planning for the development and utilisation of a minimum data set which includes a strong focus on standardised outcome measures as part of the work being undertaken to establish a framework for clinical governance.

9. Consult and work more closely with the Quality Unit located at Waikato Hospital.

10. Rigorously examine the processes for undertaking root cause analysis and for managing recommended actions arising from reviews in order to:

    a. improve the quality of the root cause analysis process;

    b. increase capacity to respond to critical incidents in a timely manner; and

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[24] Fjeldsoe K, Aimer M, Meehan T, et al. 2009. *A Time for Change: Evaluation of Health Waikato Adult Mental Health and Addictions Service*.

c. as a consequence, improve confidence in the system.

Recovery Approach and Application

11. Develop an implementation strategy for recovery, accompanied by strong demonstration of organisational leadership and understanding of the process of change.

12. Develop a workforce pathway for service user and family/whānau workers and representatives within the service which will:

   d. Distinguish between different 'lived experience' roles (e.g. peer support worker, representative, organisational advisor)

   e. Detail the functional relationships between the different roles

   f. Clearly articulate the purpose of 'lived experience' positions, and

   g. Demonstrate embedded partnership and influence at all levels of the service as per Health and Disability Sector Standards.

   h. Provide position descriptions for all roles, with skills, tasks and expected results which are congruent both with the recovery approach and with roles operating at similar levels.

13. Prioritise tangata whaiora development as an area for development in order to demonstrate embedded partnership and influence of Māori service users at all levels of the service.

14. Prioritise the 'Action Plan from a Tangata Whaiora Perspective' document for completion, and implement.

15. Adopt a recognised and clearly articulated model of intentional peer support for peer support workers within the service.

16. Make provision for peer support workers to receive adequate training in the chosen model of intentional peer support.

17. Develop position descriptions for peer support workers which outline the model of intentional peer support used, the tasks peer support workers will undertake, and the expected results.

18. Provide formal peer supervision consistent with the service's chosen model of intentional peer support for peer support workers.

19. Redraft the current Multidisciplinary Team Treatment Plan to enable information concerning accommodation and discharge planning to be considered.

20. Ensure greater involvement from all disciplines in the development and utility of Multidisciplinary Team Treatment Plans for service users. The Multidisciplinary Team Treatment Plan should be viewed as a key document in providing direction for treatment interventions across all disciplines.

21. Give a higher priority to service user involvement in the development of their care plans, in keeping with recovery principles. Use of an evaluation tool such as the Scottish Recovery Indicator could be considered for measuring service user involvement.

22. Implement a standardised framework for discharge planning that considers the conditions of discharge, risk factors and any supports required for service users being discharged from the inpatient units.

23. Develop and implement a strategy for effective engagement of community based organisations including the NGO sector in the planning and provision of services.

24. Consider the co-location of mental health and NGO workers as a first step in developing partnerships between these groups, especially in rural areas.

25. Permanently engage a service user in service evaluation. This individual would work closely with the quality coordinator so as to ensure service user and tangata whaiora input in quality and benchmarking activities.

Integration and Continuity of Care

26. Review and realign all adult community teams, including rural teams, to better reflect an appropriate and clearly defined geographical district.

27. Enhance relationships with NGO providers to develop clear and timely pathways out of acute services using NGO provided mobile and residential support services.

28. Invest in a range of community based acute care options e.g.: crisis resolution models, home based treatment, acute respite care, community acute alternatives etc. These could be supported by NGO providers as joint ventures.

29. Implement an integrated service model through the application of a comprehensive change management strategy. This will need to include aligning the Henry Rongomau Bennett Centre wards to the community teams, paying considerable attention to the roles, responsibilities and leadership structure of nursing staff, and redefining the structure and function of the multidisciplinary team within the inpatient unit. The change management strategy should establish clear key performance indicators, and will need to appreciate the complexity of organisational change associated with the implementation of the service model.

30. Develop and implement strategies for primary care engagement. Actively support community teams to discharge clients back to primary care or encourage shared care approaches.

31. Expand local capacity for early psychosis identification and response by realigning existing services to focus more precisely on the target group, using national guidelines to advise and direct service development.

32. Develop and implement an integrated approach to crisis services. This should include the following steps:

    a. Reassign crisis staff to align with community teams

    b. Develop and implement protocols for engagement, shared care and referral from within the integrated crisis/community team

    c. Redefine crisis staff to be the single point of entry to acute services, including inpatient services, requiring close liaison with emergency department, consultation-liaison services and community services

d. Develop and implement protocols that engage crisis staff in actively supporting discharge from Henry Rongomau Bennett Centre with clear responsibilities described.

33. Reconsider the model for multidisciplinary team function with specific focus on redefining generic competencies, discipline specific competencies, and the role of the keyworker/case manager.

34. Develop and implement an assertive assessment to evaluate the need for ongoing care within mental health services and to engage with the discharge process, utilising standardised assessment tools.

35. Integrate alcohol and other drug services into adult community teams.

36. Integrate the intellectual disability team across community and inpatient services, and include allied health input.

37. Consult with and consider the Consultation-Liaison team in the service restructure, particularly regarding the interface with adult mental health teams and the crisis function as a single point of entry to inpatient services.

38. Explore opportunities to assertively build relationships with the primary care sector in rural areas.

39. Explore technological solutions to minimise long distance travel such as telemedicine, peer support via videoconferencing, email, texting etc.

40. Enhance or provide supported beds in local areas with local capacity to manage those who are acutely unwell.

Treatment and Therapy

41. Gather data to better understand current prescribing practices, and use this to benchmark against best practice guidelines.

42. Support consistent implementation of metabolic monitoring guidelines, including addressing any barriers and using regular audit.

43. Undertake a specific project, using a recovery approach and in partnership with service users, that:

    a. identifies evidence based interventions that should be available in inpatient and community settings

    b. audits to measure current delivery of these therapies

    c. uses the gap analysis to inform service development, training needs and service delivery across all members of the multidisciplinary team.

44. Undertake a specific project, liaising with Te Puna Oranga, Māori mental health service providers, tangata whaiora and mana whenua to quantify and resolve this gap in service delivery across the Waikato district. This project will firstly inform and then fit within the recommended multi-agency Waikato District Mental Health Services Plan.

45. Provide a greater focus on the provision of vocational rehabilitation services, where possible integrating vocational rehabilitation and mental health services.

46. Evaluate the current Integrated Recovery Service to determine its ability to meet stated goals. Future directions for the service (expansion or otherwise) should be based on findings from the evaluation.

47. Review the current accommodation options that are available to determine what is available and to whom; undertake a stocktake and a gap analysis; and identify a range of options for individuals with a varying range of assessed needs and disability.

48. Consider the service's relationship with the NGO sector more broadly, for example NGO agencies could be embedded within and as part of clinical teams, rather than just co-located.

Seclusion, Restraint and Involuntary Detention

49. Restructure the current Seclusion and Restraint Committee:

    a. Include broader representation from clinical, management and service user groups

    b. Change the name of the committee to Safe Practice and Effective Communication Committee to reflect a focus on the broader issues around seclusion and restraint

    c. Revisit the Seclusion Reduction Framework and Action Plan and have the committee provide a coordinated approach/plan for the development and implementation of future seclusion reduction strategies

    d. Engage the assistance of agencies such as Te Pou for this work, as well as local service user and cultural representatives.

50. Develop a mechanism for monitoring seclusion and restraint use within each multidisciplinary team:

    a. Carry out this monitoring activity on a monthly basis with clear actions implemented to address identified concerns

    b. Include a strategy for ensuring that all staff have access to reports and opportunity to engage in the process.

51. Consider changing the policy to have secluded individuals reviewed by a senior medical officer every four hours (rather than the current eight hours).

52. Explore opportunities for greater service user involvement in the planning and monitoring of strategies aimed at reducing seclusion and restraint. Address immediately the lack of service user involvement in Safe Practice and Effective Communication training.

53. Implement a proactive approach to reducing seclusion and restraint by engaging with Kaitakawaenga for tangata whaiora earlier and in a more meaningful way. This may include embedding Kaitakawaenga in the clinical teams.

54. Take immediate action to reduce the flow of traffic through the seclusion area so as to provide greater privacy for those using seclusion.

55. If a redevelopment of the HRBC is delayed for some years, a significant upgrade of the existing seclusion area is required to provide a more therapeutic environment in the interim.

56. Identify a space in each of the acute units that could be converted to a comfort room along the lines described above. Any redevelopment of the HRBC should include provision of comfort rooms or sensory modulation rooms to support efforts in reducing seclusion.

57. Review the current documentation associated with seclusion and restraint with the aim of reducing duplication.

58. Recommence Safe Practice and Effective Communication refresher training to ensure that staff have adequate skills to identify and be proactive in the management of aggressive patient behaviour.

59. Identify another venue for the delivery of Safe Practice and Effective Communication training, especially during the warmer months.

Workforce

60. Ensure that any change management strategy assertively supports and directs the workforce through the change process, including resources for rapidly developing and then maintaining effective team function over at least a two year timeframe.

61. Clearly define the team structure and expected roles of team leaders across the service, with organisational support for team leaders to achieve the required change:

    a. Implement a supporting structure of second-in-charge roles, separate from the professional leadership roles

    b. Consider implementing clinical governance at team level.

62. Review professional leadership structures across the service to align with core service provision within each discipline, and embed multidisciplinary relationships in the professional structure of the service.

63. Investigate communication within the service:

    a. Implement a communication audit to track information flow from Group Manager to service delivery levels

    b. develop a plan for improving communication uptake across the service as part of the change management plan.

64. Consider using the proposed restructuring as an opportunity to rebrand the Health Waikato mental health service as innovative and people-focused.

65. Establish a dedicated recruiter to specialise in mental health recruitment, taking timely action to initiate recruitment especially in relation to vacancies that are expected, and communicating progress and strategy with clinical areas.

66. Develop and implement a standard multidisciplinary comprehensive induction programme, with a goal of delivery prior to first day of work.

67. Develop a cultural induction programme in partnership with tangata whenua, which is delivered to all international staff prior to their first day of work.

68. Review the Education, Training and Development Committee:

a. Align its purpose and process with the integrated organisational structure, with an emphasis on the multidisciplinary recovery approach and the change management process at a strategic level

b. Further develop the Education, Training and Development strategy through consultation with staff as a part of the change process

c. Review the mandatory training requirements, align them with the Education, Training and Development strategy, and report as a key performance indicator

d. Use the Committee to monitor the quality and uptake of multidisciplinary education and training.

69. Align decisions about individual professional development with the Education, Training and Development strategy and annual performance reviews:

a. Use succession planning for the service to inform decisions

b. Make decisions at Team Leader level in consultation with the appropriate Professional Advisor/Clinical Director/Clinical Nurse Director.

70. Review the role of the Nurse Educator to align with the integrated care model and the Education, Training and Development strategy, and engage the Nurse Educators with the Professional Development Unit.

71.

a. Develop and formalise a multidisciplinary preceptorship and mentoring process across the service to ensure quality teaching and learning experiences for undergraduate, new graduate and junior staff

b. Assign a quality overview of all staff in need of preceptorship and all preceptors to one role within the service, and report on this.

72. Consider the role and position of Kaitakawaenga in light of the proposed structural changes in mental health services, and recent role changes in Te Puna Oranga.

73. Reconsider the 'psychiatric assistant' role:

a. Rename this workforce in line with the recovery approach and the engaged nature of their work

b. Establish the need for the role and create permanent vacancies accordingly

c. Review and report on the delegated authority for this workforce.

74. Within service planning for clinical supervision:

a. Clarify the meaning and process of 'clinical supervision'

b. Explore options for increasing initial training and refreshers for supervisors

c. Embed clinical supervision in position descriptions, and service and team function

d. Measure compliance across all disciplines.

Appendix 3: Health Waikato Mental Health and Addiction Service Strategic Plan 2009–2014

This appendix is an excerpt from the Health Waikato Mental Health and Addiction Service Strategic Plan 2009—2014.

1. Purpose

This plan will guide the direction for Health Waikato Mental Health and Addictions Service's development through to 2014. The plan aligns Health Waikato Mental Health and Addictions Service's strategic development with current Waikato DHB plans, Ministry of Health policy documents, sector standards and regional plans.

2. Service Values

During service development and in every interaction Health Waikato Mental Health and Addictions Service will:

- provide hope for recovery and compassion
- be safe
- be effective and evidence based
- be culturally responsive
- provide care in partnership with service users and their whānau
- encourage and foster staff development
- support service users to make sure their rights are upheld
- be trustworthy and accountable
- assist service users to achieve their personal aspirations
- cultivate a seamless service user journey across the 'sector' continuum (primary/secondary/NGO/inter-agency/within Mental Health and Addictions Service).

3. Actions

Action 1: Health Waikato Mental Health and Addictions Service will implement a recovery approach in practice.

Recovery is often defined in terms of the internal conditions experienced by a person's healing, empowerment and connection or people living without mental illness. But recovery in this plan is also defined as the culture of service development.

How

Health Waikato Mental Health and Addictions Service development is guided by the recovery approach via:

- alignment of policies and procedures with recovery definitions in the NZ Health and Disability Services Standards 2008
- management and clinical leaders taking responsibility for annual tasks to implement all the actions in this plan

- a clinical governance structure that will monitor and develop operational actions to ensure this plan is implemented

- management structure to enable the meaningful professional, clinical, service user and family participation

- supervision to ensure all staff communication with service users and families promotes hope that people can actually recover rather than being in a constant state of recovery

- implementing a seclusion reduction plan and using mental health and addictions reports to monitor progress

- the provision or availability of a range of social, cultural medical, occupational and psychological supports

- the continued focus on developing services and supports in the community to prevent unnecessary admissions to hospital.

Outcome

Health Waikato Mental Health and Addictions Service will ensure that:

- all policies, procedures and guidelines reflect the recovery approach

- an effective clinical governance structure is in place

- leaders demonstrate a recovery approach

- all staff are engaged in peer support or supervision

- seclusion is reduced and eliminated by 2014

- there is evidence in all files that service users (consistent with where they are in their journey) have participated in the development of their recovery/treatment plan

- all long-term service users will have an up-to-date effective relapse prevention plan.

Action 2: Health Waikato Mental Health and Addictions Service will be safe and effective.

The key measure of performance will be a demonstration of how the service improves outcomes for service users. An outcome is defined as a measurable change in the health of an individual, which is attributable to interventions or services. The service will be safe and effective.

How

Health Waikato Mental Health and Addictions Service will:

- develop clear and measurable annual operational plans which ensure the actions in this strategic plan are implemented

- develop meaningful key performance indicators

- measure service performance on service user outcomes

- engage all clinical staff in peer-support/supervision and training on the most up-to-date evidence informed clinical treatments/therapies that support service user recovery

- develop and monitor clear safety guidelines based on international best practice

- improve the financial control, reporting and monitoring system

- implement service-wide systems to reduce the likelihood of harm to service users and the community (e.g. learnings from serious incidents) via annual risk plans

- use service-wide systems and processes which enable seamless service delivery for users within Health Waikato Mental Health and Addiction Service

- build effective relationships with primary mental health providers (figure 1).

Outcomes

- The service will be driven by meaningful key performance indicators.

- Annual objectives implemented.

- Managers and team leaders receive and understand regular reports that enable them to monitor performance.

- Service performance will reflect an overall improvement in service user outcomes.

- All staff are aware and use the most up-to-date evidence informed clinical treatments/therapies to support service user recovery.

- There will be an effective financial control, reporting and monitoring system.

- There will be a formal prioritisation of resource requirements based on the service performance.

- The implementation of learnings from serious incidents across the whole service reduces risk.

- Primary mental health will be the hub of service delivery (figure 1).
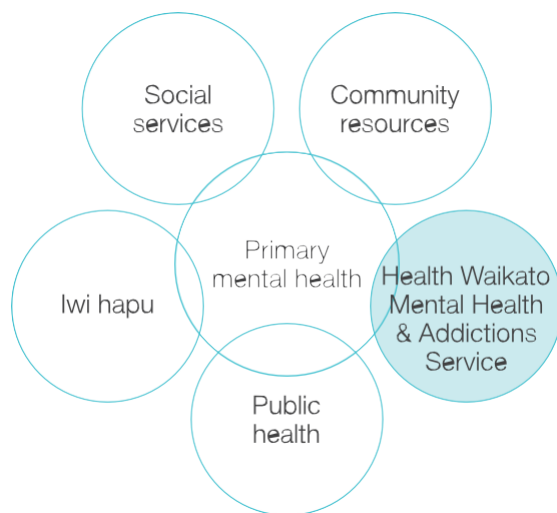
- *Figure 1: The overlapping circles illustrate that Health Waikato Mental Health and Addictions Service will build closer relationships with other sectors to ensure service users are not captured within secondary services and can smoothly navigate to other services if required.*

Action 3: Health Waikato Mental Health and Addictions Service will be transparent and trustworthy.

There will be a focus on service accountability and trustworthiness through open communication with staff and stakeholders of audit reports, decision making, and

understandable key performance indicators. This will ensure service-wide quality improvement aligned with contemporary best practice.

How

Health Waikato Mental Health and Addictions Service will:

- use external certification auditing of systems and service delivery against the national health and disability sector standards
- develop a clear communication and a transparent decision making pathway
- ensure decision making (administrative and clinical) is transparent to staff
- ensure all staff have a shared understanding of all the service terms and language by developing a Health Waikato Mental Health and Addictions Service glossary
- develop and communicate clear lines of accountability.

Outcomes

Health Waikato Mental Health and Addictions Service will ensure:

- regular annual service performance reports on progress are communicated to stakeholders
- service gains a 90 per cent pass rate from external certification audits
- a clear written communication pathway is available for all staff
- an up-to-date Health Waikato Mental Health and Addictions Service glossary is made available for all staff
- the implementation of learnings from serious incidents across the whole service
- reporting of serious incidents aligned with Waikato DHB and national incident reporting requirements
- all staff have a clear understanding of who is accountable and how decisions are made.

Action 4: Health Waikato Mental Health and Addictions Service will provide culturally responsive services.

The service will work with tangata whaiora (Māori service users) to implement He Ara Ki Te Ao Marama. The focus will be on activities that will improve tangata whaiora mental health outcomes.

How

- Include tangata whaiora in implementation.
- Develop working groups that have clear and detailed activities.
- Raise the awareness within provider arm and the community of Kaitakawaenga services.
- Increase the numbers of Mental Health and Addictions staff completing Waikato DHB Māori health training and education (Te Ara Tika) by 50 per cent.

Outcomes

Health Waikato Mental Health and Addictions Service will ensure:

- meaningful tangata whaiora participation in service planning and treatment
- the connection of tangata whaiora with a range of options (spiritual, psychological, sociological, occupational, cultural and biological therapies) that help Māori and whānau lead their own recovery
- all staff respect Māori values/ beliefs and practices
- all staff understand that Māori health is everyone's responsibility (Kotahitanga).

Action 5: Health Waikato Mental Health and Addictions Service will build leadership, recruit and retain a skilled workforce.

Recruitment and retention of a skilled workforce is one of the key challenges over the next five years. The implementation of this plan depends on effective leadership and sophisticated understandings among clinicians about why and how they can assist managers.

How

Health Waikato Mental Health and Addictions Service will:

- develop a local Mental Health and Addictions Service recruitment and retention plan within the context of national mental health workforce development
- grow recovery orientated leadership by fostering leaders and encouraging leadership development: leaders at all levels will model recovery principles with staff and reward effective performance
- ensure leaders focus on a supported effort to build a coordinated clinical governance structure
- promote pride of working in Health Waikato Mental Health and Addiction Service
- support employing service users
- support recovery training and development
- promote and utilise research and evaluation findings in practice.

Outcomes

Health Waikato Mental Health and Addictions Service will:

- plan and coordinate recruitment and retention
- ensure leadership decisions and interaction reflect a recovery approach
- increase the number of service users employed
- have a recovery focused workforce
- use research and evaluation findings in practice.

4. Measuring progress

- Recovery plans and treatment plans reflect service users/tangata whaiora's own recovery outcomes and goals.

- Relapse prevention plans demonstrate that service users/tangata whaiora are encouraged to be drivers of their own care.

- Service user outcome measures indicate that there is measurable change in the long-term recovery of individuals, which is attributable to interventions or services.

- Reduction in numbers of people using the service for more than three years.

- An increase in the range of psychosocial interventions.

- Service users and family feedback informs operational plans.

- 20 percent annual reduction in the use of seclusion, and elimination by 2014.

Appendix 4: Henry Rongomau Bennett Centre Models of Care and Facility Infrastructure Review

This appendix contains excerpts from the August 2015 Waikato DHB review of the Henry Rongomau Bennett Centre Models of Care and facility infrastructure.[25] This review arose in part because of concerns around the appropriateness of the facilities following some significant incidents. The review team was headed by Kevin Fjeldsoe, who was also the head of the review team that developed *A Time for Change*.

Background

The primary focus of this review was the assessment of the Henry Rongomau Bennett Centre's (HRBC) capital infrastructure. The assessment aimed to determine its suitability for redevelopment and its capacity to respond effectively and efficiently to existing and emerging models of service delivery for adults requiring acute inpatient care. The review process involved an assessment of documentation related to the proposed model of service delivery and the proposed plans for redevelopment. This was followed by a site visit to the HRBC by the review team in July 2015 to consider the observations of staff, service users and their families. A structured framework for information collection and analysis was drawn from available standards and guidelines. This review is primarily a test of the facilities' clinical utility rather than a purely technical assessment.

In recent years there has been increasing interest in models of care which most effectively and efficiently target the needs of those admitted to acute inpatient units. This has resulted in an increasing level of specialisation which has often been associated with a need to consider redevelopment or replacement of existing facilities. Major advances are commonly impeded as the ability to meet the changing needs of those admitted becomes increasingly difficult in faculties which were not designed for their current purpose. It is almost 20 years since the HRBC was designed and built. The characteristics needs and expectations of those who use the service have changed significantly since that time.

At the HRBC there is evidence of ongoing work over a number of years to improve the facility and to refine service models. This review found that the service models which have been evolving are based on a contemporary set of principles and clinical evidence. Work has continued over an extensive period to improve the process of service delivery and integrated care planning to more effectively target the needs of those referred for treatment. More recently, work has been undertaken to define the expected range of therapeutic interventions provided on the units and to improve the process of communicating and managing the care planning process. These are important initiatives which should contribute significantly to the continuous improvement of the service and inform the redevelopment of the HRBC. A major redevelopment plan aimed at improving the facilities capacity to respond to the changing needs and expectations of service users.

Findings

This review found that despite considerable effort to improve the HRBC environment, it did not meet a significant number of basic contemporary standards. Further, it was the view of the review team that the capacity of the service to develop new and potentially more efficient and effective models of service was being constrained by the need to deliver services in the existing facility. Essentially, the service has been, until recent times, trying to make the service model fit the facility. The planning work undertaken in 2013 clearly articulates the extent of the problem. The review team is of the belief that the planned redevelopment will not address a number of fundamental problems. Fundamental problems with layout and insufficient space mean that associated problems with privacy, safety and security will remain. A contemporary expectation of an acute mental health unit is the provision of single rooms with ensuites. These should be designed to restrict access to hanging point and to improve client privacy and personal safety. The redeveloped unit would not meet this expectation and would be unlikely to achieve significant improvements to the safe and

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[25] Fjeldsoe K , Meehan T, Kingswell I. 2015. *Henry Rongomau Bennett Centre Models of Care and Facility Infrastructure Review: Planning for the Continuing Development of Adult Acute Inpatient Services*.

effective treatment of those with the highest and most complex needs. The basic layout would still provide an institutional ambience and restrict the delivery of new and potentially more effective and efficient service options.

The review analysed the options available and came up with a preferred option.

The review team believes that a contemporary service model involving the construction of new purpose built hospital and community facilities should be considered. This should provide a more efficient use of recurrent funds and provide a greater array of inpatient treatment options for consumers with increasingly complex and diverse needs (Table 1). This option has been developed on the premise that even with substantial investment, the continued use of the HRBC to deliver contemporary models of acute inpatient service will be problematic and the facility might be better used for other purposes. A provisional attempt to test the recurrent impact of a new service model is provided. It indicates that the recurrent cost of the new service model would not be greater than the anticipated cost of the existing service as it expands over time.

Hospital Based	
Acute Adult Inpatient	36 beds (2x18 bed units)
Intensive Care (Each collocated with an 18 bed unit)	8 beds (2x4 bed units)
High and Complex needs (Secure – Hospital based)	14 beds (Includes 2 detox beds)
Community Based	
High and Complex Needs	15 beds
Sub-Acute – Step up/Step down	6 beds
<u>Total</u>	<u>79 beds</u>

Table 1 Provisional Mental Health Adult Bed Program Structure

The new model provides a mix of hospital and community based alternatives with services designed to meet the needs of three groups identified during the course of the review. The programs would target those with high and complex needs who require intensive care in a secure environment as well those with high and complex needs for clinical treatment and psycho-social rehabilitation which can be provided most effectively in the community rather in hospital. In addition the model provides for a small step up/step down subacute unit in the community to support transition from hospital and to prevent admission for those who can be safely and effectively managed with higher levels of support than is currently available in the community.

The proposed service model supports the construction of new purpose build units which could be designed to more effectively meet the gender and cultural needs of those who use the service. As well, spaces to more effectively meet the needs of young people (18–24 years) including those with early psychosis could be provided.

This model would introduce a number of new treatment options for service users with varying levels of complexity. The need for integrated care planning and service delivery aimed at ensuring continuity of care would be paramount as would the need for a workforce supported to deliver more targeted and specialised services than those that are currently available.

Option 1 – Summary[26]

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[26] Option 1 is the preferred option. Option 2 is to continue with the current redevelopment.

As outlined, Option 1 promotes the development a new and expanded range of services in the community and on the hospital campus (to provide a total of 79 beds). While the option has a number of advantages, there are some disadvantages to be considered (Table 2).

Advantages	Disadvantages
- No need for decanting during construction - Highly likely to produce improved clinical outcomes - Opportunity to substantially reduce clinical risk factors - More cost effective over time (79 beds for the same price as 64) - Services provided at nationally benchmarked rate - Opportunity to achieve savings and efficiencies by relocating community teams - Improved consumer satisfaction - Better, more productive environments for staff	- Significant capital investment - Need to identify site and use valuable space on hospital campus - Possible community resistance to community based units - Work needs to be undertaken to locate the plans in a new multi-agency strategic plan

Table 2 Advantages and disadvantages of new service model (Option 1)

Appendix 5: Report into investigation into the recruitment of Dr Mohamed Siddiqui[27] (REDACTED)

This appendix has been redacted for the public release in April 2016 so as to not compromise current legal proceedings.

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[27] Mike Elliott, Principal Advisor, People and Capability, undertook this investigation and prepared this report. He would like to acknowledge the hospitality and helpfulness of Gregory Peploe, who provided all of the documentation necessary to support the findings of this report.