CANTERBURY DISTRICT HEALTH BOARD REVIEW OF TE AWAKURA 2008

EXECUTIVE SUMMARY

Reviewing the Adult Inpatient Service, Te Awakura, has been an important undertaking to ensure that the consumers of Canterbury's Specialist Mental Health Service and their families are provided safe, responsive and effective care. The Canterbury District Health Board in collaboration with the Ministry of Health commissioned this systemic external service review. The end result provides a comprehensive review of the service and focuses on two overarching recommendations,(1) integration of planning ,funding and purchasing of services and integrated service delivery and (2) bed resources

Subsequent to the death of three inpatients, the purpose of this review was to identify any underlying key contributing factors in practice and policy, provide recommendations for the improvement of service provision, ensure service governance supports service delivery, identify audit and monitoring processes for evaluation and provide a platform for service generated solutions. Admission, assessment, treatment and discharge planning processes and the interface relationships with the Adult Community Service, including the Psychiatric Emergency Service and the Single Point of Entry was a focus of the review team.

The two recommendations (Appendix 1) are further divided into the (macro) strategic level and (micro) unit specific level each with possible short and medium term implementation solutions. The larger (macro) issues could be addressed in the first instance with the (micro) unit level recommendations in part emanating concurrently as a result of planning and implementation. The overarching principles for making decisions should be assessed for effectiveness, efficiency, continuous improvement capability and context. We acknowledge that the planning, implementation and evaluation of the accepted recommendations will require much effort and commitment from all staff across the service.

Recurring themes from participants interviewed included over occupancy in units, and the subsequent sleepover transfers to other units, a fragmentation of service delivery with subsequent disruption to the continuity of care, hurried discharge planning, delayed needs assessments, the purpose and management of respite, unit culture and design being, the casualisation of the workforce, and the service reliance on clinical staff working simultaneous double shifts.

The first overarching recommendation described as 'integration" identifies three macro recommendations. These are planning, funding and purchasing of mental health services to facilitate integration, a (whole of) sector stakeholder group responsible for planning service provision which models clinical governance, and which provides for integrated service delivery with the primary service being the defined community mental health team and including the NGO provider and Needs Assessment and Service Coordination (NASC) as partners in service delivery.

The second overarching recommendation, reconfiguration and, or rebuilding of bed resources advocates an increase the Adult Inpatient Service bed capacity and a decrease in the Rehabilitation Service bed capacity albeit not resulting in an overall increase in the current total. Purchasing of services by bed/population and community FTE/population ratios is currently somewhat indistinct. The number of adult acute inpatient beds appears to be at the lower end of the

levels generally recommended internationally, although there is no current national benchmark in New Zealand of the number of beds per hundred thousand population. Like most acute adult psychiatric units across the country the average bed occupancy in the Adult Inpatient Service remains high and to enable an effective efficient service, a lower average occupancy of 85% would, it is proposed, allow for flexibility of responses and preserve an environment which is conducive to consumer recovery and staff effectiveness.

A number of clinical practice matters were raised as requiring ongoing attention including risk assessment and risk management standards, subsequent recordings in clinical records and the participation of relevant staff in the development of the consumer recovery plan (treatment plan).

This review points a way forward for acute psychiatric services in Canterbury. It describes improvements to service delivery that can be enacted in the near future as well as the medium term and we look forward to continuous improvements in the service while acknowledging that it is the staff who will be instrumental in effecting change.

We are committed to provide the very best mental health services we can, delivered safely effectively and efficiently to the people of Canterbury. As such we will encourage the planning, implementation and evaluation of the recommendations in this report as soon as practicable, while promoting, enhancing and facilitating the wellbeing of consumers and their families and whanau.

Assoc. Prof. Phil Brinded
Chief of Psychiatry

Vince Barry
General Manager

APPENDIX 1

RECOMMENDATIONS

Our major recommendations are all consistent with the views of the majority of the stakeholders. Each, however, is likely to provoke resistance from (different for each) small but significant groups.

Section A, Macro

1. INTEGRATION

a. Planning, Funding and Purchasing for Integration

Develop planning, funding and purchasing of mental health services to facilitate integration rather than fragmentation, to improve effectiveness and efficiency.

- A sector stakeholder group would be a key advisor to the planning and funding team. Minimising the "management'/clinician capacity for different views on resource allocation needs to start at this level. See b., below, for details on who this group would comprise and how it would differ from a Local Advisory Group.

  This group would also oversee the development of the District Annual Plan.

b. Sector Stakeholder Group

Implement a system for the overall Canterbury district adult mental health service provision, which also models Clinical Governance at all levels of the sector.

- A sector stakeholder group to be established; this group of eight to twelve people meeting, for example, every two months, to ensure that planning, funding, and purchasing were delivered on the principles of Best Practice.
- The views of consumers, whanau, tangata whenua, management, and multidisciplinary clinicians (attempts should be made to have these representatives from within a variety of service levels) should be represented. Management representatives should include one each from DHB and NGO providers.
- Group could be chaired by the Chief of Psychiatry, or other suitably senior and broadly based senior position holder, and managed by Planning and Funding.
- Simple and transparent feedback structures and processes would need to be developed to enable representation from the various stakeholder groups and to maintain the integrity of that representation.

c. Integrated Service Delivery

Within the DHB provider arm, plan for greater levels of continuity of care by taking every opportunity to increase the integration of the services. Ideally this would commence with adoption of a vision that the primary service structure was the sector-defined community team, which always carried ultimate responsibility for the CRP (Consumer Recovery Plan).

- The services or functions delivered in the community, and ideally also the inpatient responsibilities, would be conceptualised as services interfaced in a matrix structure with the dominant, geographically based, sector teams.
- NGO and NASC services should be partners within this matrix.
- Develop and articulate a model of care and a workforce development plan that reflects that model of care.

2. BED RESOURCES RECONFIGURED AND/OR REBUILT

The inpatient component of an integrated adult mental health service will not approach best practice or optimal effectiveness and efficiency without a reconfiguration of the beds. The reviewers recommend that the adult acute inpatient bed numbers be increased and the rehabilitation bed numbers be decreased.

The end total bed numbers are unlikely to need to be increased over the present total of 130 (64+51+15).

The review team further recommends that:

- Adult acute inpatient services are developed on two sites, to minimise the "ghettoisation" and therefore reduce the stigma of the Hillmorton site, as well as to allow for manageable unit sizes; for example, one adult acute inpatient service at an alternative hospital site in Christchurch and another at Hillmorton.
- The sites be configured, for example, to service the inpatient components of two urban sectors at an alternative hospital site and the balance at Hillmorton (e.g. two urban, rural and Hereford).
- Wards be (re)designed to optimise service user dignity, safety, comfort and staff ability to deliver on those same issues.

Section B, Micro and Relatively Independent Recommendations

Recommendations in this section have been organised under the headings of the macro recommendations from Section A. Taking each macro recommendation heading, the micro recommendations have been further organised into (i) recommendations implementable in the near future; and (ii) those requiring more medium-term implementation.

Rationalisation of beds/dollars could be applied to support new pilot roles and PDSA (PlanDoStudyAct cycle) to enable sustainable new initiatives to acute care.

1. <u>INTEGRATION</u>

(i) Implementable in the near future

1.1 <u>Clinical Governance</u>: Develop a method for ensuring the vertical integration of Clinical Governance throughout all levels of the DHB provider arm services. While clinical governance has multiple, sometimes confusing, interpretations, it is always about the need to incorporate clinician perspectives adequately into resource allocation decisions. The current Clinical Governance Directorate incorporates membership with a divisional overview; similar groups with functional relationships to each

other could be created at the other levels of the provider arm (akin to a matrix model, with ideas and information flowing both up and down, as well as horizontally and diagonally e.g. between services and/or units). Alternatively, representative staff from all other levels of the provider arm could be included in the Directorate's membership; or in regular divisional Clinical Governance meetings with the Directorate.

1.2 Model of Care, including Consumer Recovery Plan (CRP) that follows the consumer:

1.2.1 Develop and articulate a model of care for adult services overall, and a workforce development plan that reflects that model of care *[see also 1.10 below]*

1.2.2 The community team involved with the consumer should be part of the CRP as early as possible in an admission

1.2.3 NASC services involved as soon as it is indicated that a change in accommodation or community supports may be required. *[see also 1.4 Discharge Planning and Partnerships, below]*

1.2.4 For all new patients a full psychosocial assessment and plan should be completed as soon as is clinically practicable by a social worker. The plan should inform the CRP and the engagement of NGO and NASC.

1.2.5 An integrated process mapping and quality improvement trial to inform the development of this could be undertaken and piloted by one team in the first instance, eg PDSA cycles. This team would then be instrumental in the implementation throughout the services. It should be a key informant to a sector stakeholder group's planning and development activities. *[See Macro recommendation 1.b). Sector Stakeholder Group]*

1.2.6 IT development and support will be required to allow one set of electronic patient notes, rather than new "case" opened per "admission" or transfer

1.2.7 Single set of electronic patient notes *[see 1.2.6. above]* would be facilitated by continuity of responsible clinician and/or key worker.

1.3 MDT functioning:

1.3.1 Implement an MDT approach to risk assessment and risk management. Risk assessment and risk management planning becomes part of the evolving CRP, and is reflected in the electronic record.

1.3.2 This in turn will require the SMHS division to resolve its stated model of clinical responsibility to come into line with the HPC Act and recent Coronial rulings

1.3.3 Require inpatient MDTs to function in general in a more integrated, multi-disciplinary way and with the patient's journey (within and without the sector) at the centre of their practice; ensuring that the evolving CRP is always comprehensive.

1.4 Discharge Planning and Partnerships:

1.4.1 The patient admission-discharge pathway is collaborative and begins on admission. The community team involved with the consumer should be part of the CRP as early as possible in an admission and NASC services involved as soon as it is indicated that a change in accommodation or community supports may be

required. *[see also 1.2 Model of care, including Consumer Recovery Plan (CRP) that follows the consumer, above]*

1.4.2 Explore and pilot Clinical/NGO partnership intensive community living services for a targeted number of those who have multiple admissions. Learning and success from this pilot would also inform a sector stakeholder group's planning and funding activities. This pilot team would also take a lead in implementing new community initiatives.

1.5 Cultural and attitudinal change: Staff's focus on "the least restrictive environment" as part of a recovery approach to be reframed to include a focus on "the most socially inclusive environment". Social inclusion mechanisms available include courteous, helpful and welcoming relationships between all staff and consumers, family and visitors; support for consumers to access existing networks e.g. NGO services, family, whanau and friends; and support for NGOs to establish services for consumers, family and whanau which will aid their transition back to the community.

(ii) For medium-term implementation

1.6 Crisis resolution mechanisms:

1.6.1 Respite access to be managed via CMHTs

1.6.2 Develop home based treatment and/or alternatives to acute inpatient admission

1.7 Discharge Planning and Partnerships:

1.7.1 CMHTs to manage their own acute inpatient beds – "one in, one out"

1.7.2 Consider returning needs assessment function to SMHS; or otherwise significantly streamlining process*. [see also 1.2.3 and 1.4.1 above]*

1.8 CMHT boundaries: Realigned boundaries for sector bases to reflect population growth and align with other major boundaries e.g. census mesh blocks, to enable better use of data in identifying trends and predicting needs

1.9 Consumer Recovery Plan (CRP) that follows the consumer: Make an unambiguous organisational commitment to one format for the consumer record, which is designed to meet all CRP and all compliance requirements. *[see 1.12 Resource commitment, below]*

1.10 Workforce development:

1.10.1 Fully involve workforce in the development of services

1.10.2 Workforce development that reflects developing needs for staff

1.11 Monitoring and evaluation: Use KPIs for which the desired direction of change or benchmark level is clearly indicated.

1.12 Resource commitment: All initiatives to be resourced adequately and for as long as necessary

1.13 Planning for patient journey: Planning and process mapping to follow the patient journey, not restricted to siloed services (sector-wide)

2. BED RESOURCES RECONFIGURED AND/OR REBUILT

(i) Implementable in the near future

2.1 Security for ICU: While Pipiri B remains an intensive care unit, secure fence to be an immediate priority.

(ii) For medium-term implementation

2.2 Intensive care beds integrated to acute units: Continuity of care, and continuity of the responsibility for the CRP including the key clinician/consumer relationship, should be modelled at the unit level. Any adult acute inpatient unit should therefore incorporate their own intensive care bed capacity.

2.3 Lines of sight in Pipiri unit: Observation could be significantly improved by the removal of one wall in Pipiri to improve lines of sight.

2.4 Address size of Takahe unit: Takahe unit to be split into two smaller units

2.5 CMHT boundaries: Realigned boundaries for sector bases *[see 1.8 CHMT boundaries, above]*