A Summary Report 2013/2014
Mental Health
Provider Arm Services
Counties Manukau Health

We set an ambitious work plan for 2013 /14 in order to address the many competing priorities at service, organisational, regional and national levels. The purpose of this report is to summarise the progress and achievements made against actions documented in the work plan during the 2013/14 financial year.

Our work plan was Year One of our 5 Year Service Plan 2013/14 – 2017/18 which set the direction for the delivery of mental health and addiction services[1] for the next five years in the Counties Manukau Health (CMH) district. It acknowledges the sector informed vision articulated in the former Mental Health Commission's Blueprint II. This vision builds on the understanding that the physical, mental, cultural and spiritual needs of service users and their whaanau are central. A philosophy of recovery and resilience is the focus.

The Government's strategic imperatives as outlined in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* call for change. System wide change is necessary to achieve greater consistency in service provision and improve outcomes for service users and their whaanau in order for services to:

- Respond earlier and more effectively
- Be more accessible
- Make better use of resources
- Focus on improving equity of outcomes for different populations
- Raise system performance
- Strengthen partnerships across the whole of government.

The Health Quality and Safety Commission (HQSC) supports the application of the Triple Aim: *better population health, improved patient experience and provide value for money*. This has also been adopted by CMH at organisational level and for the Mental Health division.

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[1] Although most addiction services are provided by a regional provider (Waitemata DHB) we acknowledge the role we have in addiction in the way we work particularly given the high prevalence of co-existing disorders – mental health and addiction.

In preparing the 5 year service plan information was collated to reflect the current position of the Mental Health division and respond to critical questions. What services are being provided and to whom? What is the future service demand and the likely volumes services might expect? What are the types of issues that are likely to be more prevalent and require intervention?

This information supported the development of key strategic objectives and actions to achieve the expected outcomes are described in detail in the appendices of the Service Plan.
Overall key outcomes known as 'big dots' for the Mental Health division include:
- 50% of community FTE working alongside primary care in 5 years
- 30% reduction in inpatient readmissions and community re-referrals in 3 years
- 25% reduction in counties Manukau suicide rate in 5 years
- 75% assessments demonstrate cultural capability in 3 years

The Mental Health division will participate in the following CMH organisational developments:
- Locality Partnerships
- Living Within Our Means
- Developing Patient and Family Centred Care

Furthermore the Mental Health division will lead specific initiatives in cultural capability to enhance the service delivery provided to service users and their whaanau of all cultures. Cultural capability will be demonstrated from initial engagement with the service to point of discharge.

The Mental Health workforce will be better supported to meet the needs of service users and their whaanau with a range of initiatives focused on recruitment, retention, training and credentialing. The aim being to recruit, create and retain a workforce that is resilient, competent and effective.

Measuring Improvement Over time

The following metrics are captured and shown in the tables and graphs below at baseline and in the following two financial years, demonstrating progress over time.

2013/14 was a year of learning for us as we worked to demonstrate baseline measures and looked to demonstrate improvement in our big dot outcomes. However it proved more challenging than anticipated for some measures! We will continue to refine the measures we can use to demonstrate progress over the 2014/15 year.

Big dots

Overall key outcomes known as 'big dots' for the Mental Health division include:

50% of community FTE working alongside primary care in 5 years

We have not had a baseline for this measure however we do have 4 designated primary nurse liaison roles and 4 GP liaison staff. The focus for 13/14 was to progress opportunities for staff to be working more closely with primary care providers and there have been a range of different initiatives undertaken. 14/15 will see us work to quantify roles that are designated to work alongside primary care.

30% reduction in inpatient readmissions and community re-referrals in 3 years

	11/12	12/13	13/14
Re-referrals within 90 days-community(C&Y)	9.02%	9.54%	8.80%
Re-referrals within 90 days-community Adult	16.43%	16.58%	17.27%
28 Day readmission rate	12.90%	12.55%	12.59%

This is the first year we have focused on and reported Re-referrals for both child and youth and adult community services. Our contribution to the child and youth national KPI project has provided some insight into some of the reasons for referrals which we plan to learn from for the adult services to look at how we can reduce re-referrals.
There has been a change in how we record 28 day readmissions to align with the national KPI definition. There seems to be little change to this rate over the past three years.

25% reduction in Counties Manukau suicide rate in 5 years

Official suicide data is released from the Ministry of Health after determination and aggregation by the Coroner's office in annual reports typically 3 years retrospectively. The latest annual data available in 2014 is from 2011. The implementation of a systematic multisectorial postvention response lead by the DHB to suspected suicide deaths in collaboration with the Coroner's office has enable the determination of the number of suicide deaths of people who were open to MH services or had been open to our services within the year prior to their death. This indicates a larger proportion of suicide deaths are amongst people accessing specialist MH services and gives the opportunity to focus on care delivery issues identified through the systematic review of these serious incidents. In addition it appears that young people and Maori are the least likely to have had contact with our services and provides useful direction to what groups may be the focus of efforts to enhance access to MH services.

The baseline suicide data for the 12/13 year based on suspected suicides known to service is not available as the data was not reported in that way. In 13/14 we have focused on being able to report this information and have a baseline of 18 suspected suicides known to the service within the last year.

75% assessments demonstrate cultural capability in 3 years

This measure was identified as an aspirational goal to focus our work on prioritizing cultural capability of staff within the service. We have utilized the Community organizing methodology as a way to progress this big dot. In 14/15 we will aim to achieve a 10% increase in cultural contacts/assessments via HCC as one measure as well as identifying the percentage of Maaori, Pacific and Asian staff employed by designation.

Overall in this first year we have learnt a great deal about how challenging it might be to achieve these targets including what data we don't collect. This coming year we need to stretch ourselves to make early identifiable progress towards the big dot targets.

MoH Accountability Measures

The Ministry of Health has three accountability measures that they use to monitor the performance of DHB Mental Health Services. These are:

Measure 1.

PP6: Improving the health status of people with severe mental illness through improved access

	11/12	12/13	13/14
Access rate			
Adult(age 20-64)	3.69%	3.83%	3.8%
MHSOP(age 65+)	2.77%	2.66%	2.62%
C&Y(age 0-19)	2.82%	3.02%	2.99%
Total	3.32%	3.45%	3.42%
No. of unique CMH domiciled clients seen by PRIMHD reporting services over 12 months	16693	17456	17,550

While overall numbers of people who live in the CMH district seen by PRMIHD reporting mental health and addiction services (in provider services, regional service and NGOs) is increasing the access rates to specialist mental health and addiction services for the CM population have slightly reduced from what they were the previous year. This is in contrast to the steady gains in access rates of the preceding 5 years. This is most likely contributed to from a number of factors including the move to integration with primary care in alignment with Blueprint II. The access rate to specialist services does not currently include those who obtain specialist MH&A input through consultation and liaison work from specialist community services to primary care and other sectors. A pilot project recording Consult-Liaison by CMH CAMHS team in this 3 months of this time period recorded 410 consultation events by clinicians. This is a significant growth area of expanding clinical work and regional efforts are in progress at developing data collection on this activity to supplement the individual access data collected in in PRIMHD.

Additionally the reduction in adult service users seen in AOD services (these are mostly delivered by other DHBs provider services and NGO services) accounts for nearly all the reduction in the access rate in the last year.

A positive aspect of the access rates is that the number of service users seen in both DHB and NGO services has increased from 17.6% to 21.1% reflecting greater integration of provider arm and NGO services.

Measure 2.

PP7: Improving mental health services using relapse prevention planning

Relapse Prevention plans	11/12	12/13	13/14
C&Y	85%	97%	95.4%
Adult	94.9%	96.6%	92%

This shows there has been a 10.4% increase in completion of relapse prevention plans in Child & Youth services over the past three years following concerted efforts by the teams to exceed the MoH target of 95%. The adult service has shown a reduction and not achieved the MoH target.

Measure 3.

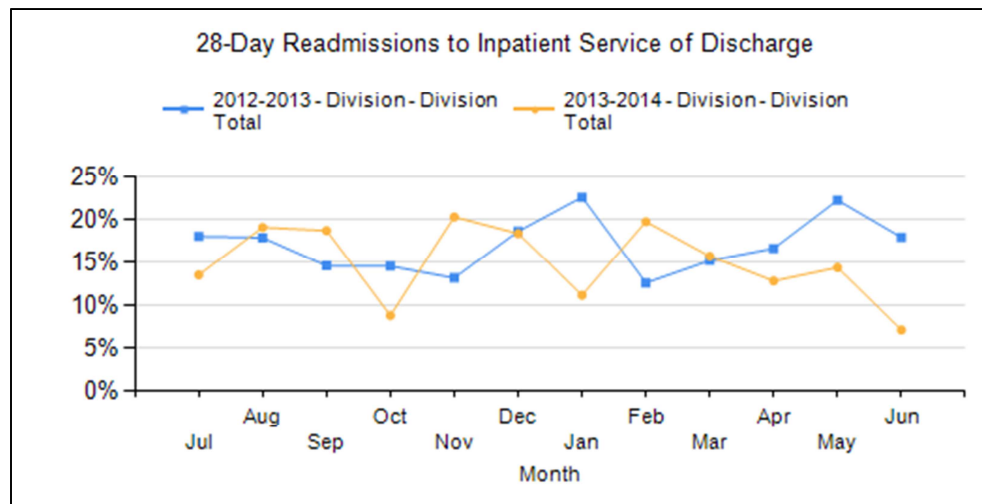PP8: Shorter waits for non-urgent mental health and addiction services

Wait Time(<= 3 weeks)	11/12	12/13	13/14
Adult(age 20-64)	89.81%	89.50%	87.81%
MHSOP(age 65+)	91.15%	89.47%	89.25%
C&Y(age 0-19)	70.75%	75.43%	69.69%

Wait times in adult and old age remains very stable and exceed the target of 80% seen with 3 weeks. The child and youth wait time has increased. In the Adult and Child and Youth services in the 14/15 year new intake and assessment systems and pathways are being implemented to ensure that people are provided with easily accessible and appropriate clinical services that meet their needs.
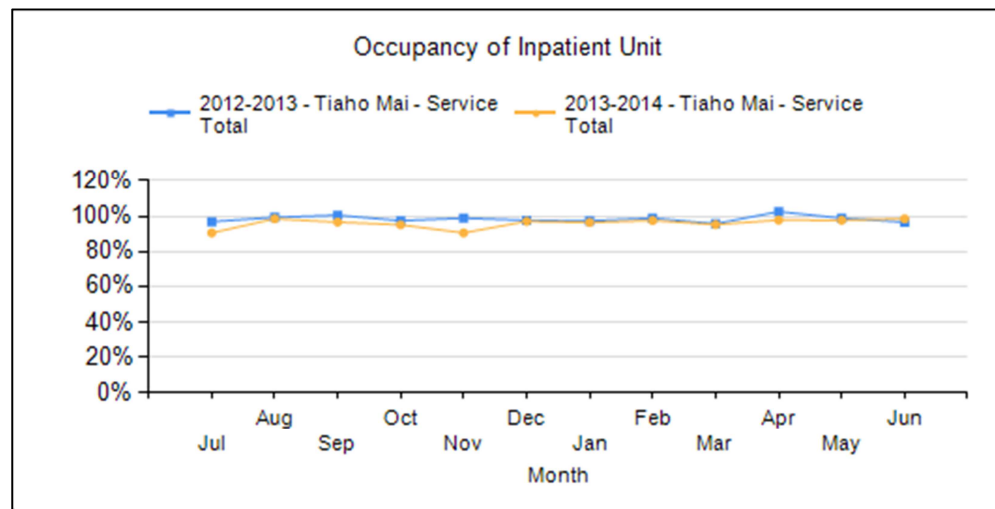
National KPI's

The following section outlines CMH performance and commentary in relation to some of the National KPI's
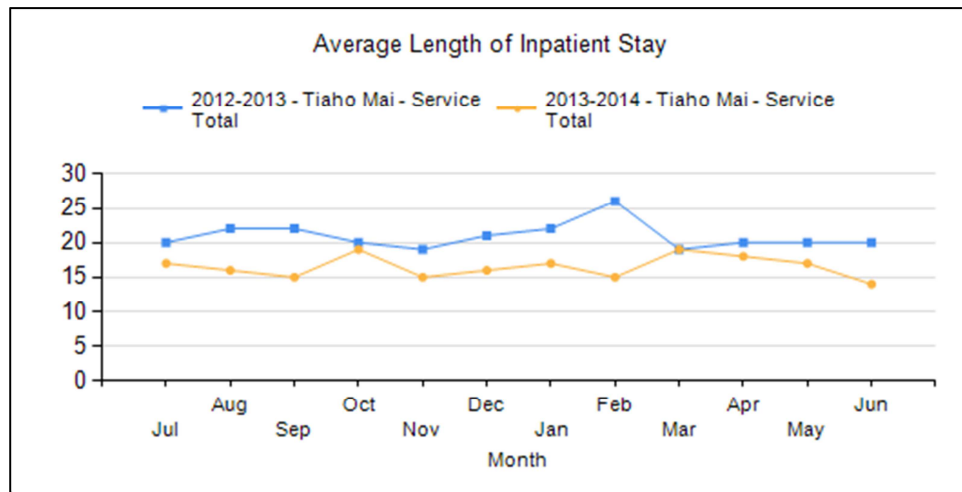
Mental Health Acute 28 Day Readmission rate: Overall readmission rates have trended down over the financial year. In September 2013 the Supported Discharge service started in Tiaho Mai. These clinicians provide a "wrap around" support package for clients who have been assessed as requiring a high level of support after they leave hospital. This has seen an improvement in the rate of readmissions and is particularly pleasing in an environment that has a high daily demand and that frequently operates at over capacity.
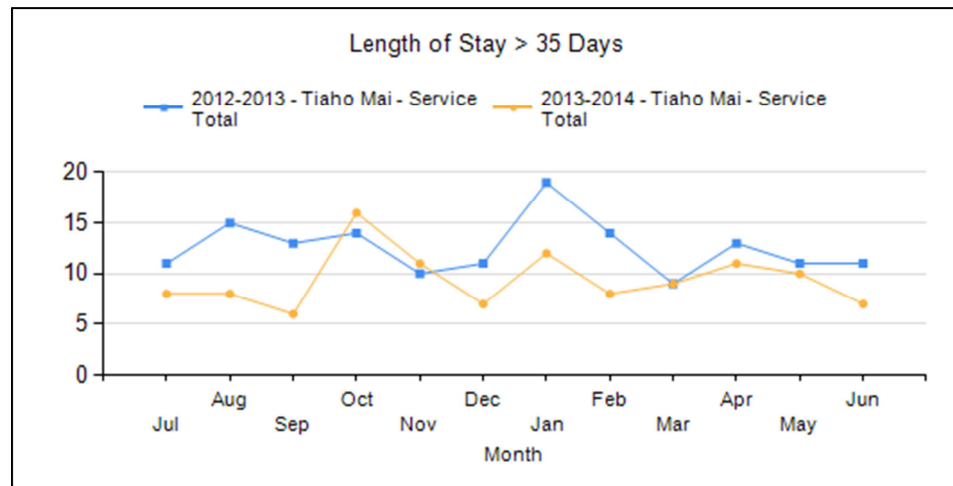

28-Day Readmissions to Inpatient Service of Discharge

Tiaho Mai- Occupancy has remained consistently high for the past 2 years at close to 96% .This is far in excess of the recommended maximum occupancy level of 85% and remains an organisational risk. This graph does not demonstrate the extent to which the inpatient unit was over census which occurs on many occasions with clients waiting for admission creating a cycle of unplanned discharge events. Over the year the unit has been under a lot of pressure in having to manage over census clients complicated by the issue of overcrowding and risk of premature discharges to "make" beds. The Supported Discharge service has assisted in providing a comprehensive support package and it is anticipated that the implementation of the Home Based Treatment service and Intake and Assessment service will rationalise the admission process. A detailed business case is being prepared that seeks Government approval for a new acute inpatient unit with an increase in be numbers and a new model of care.
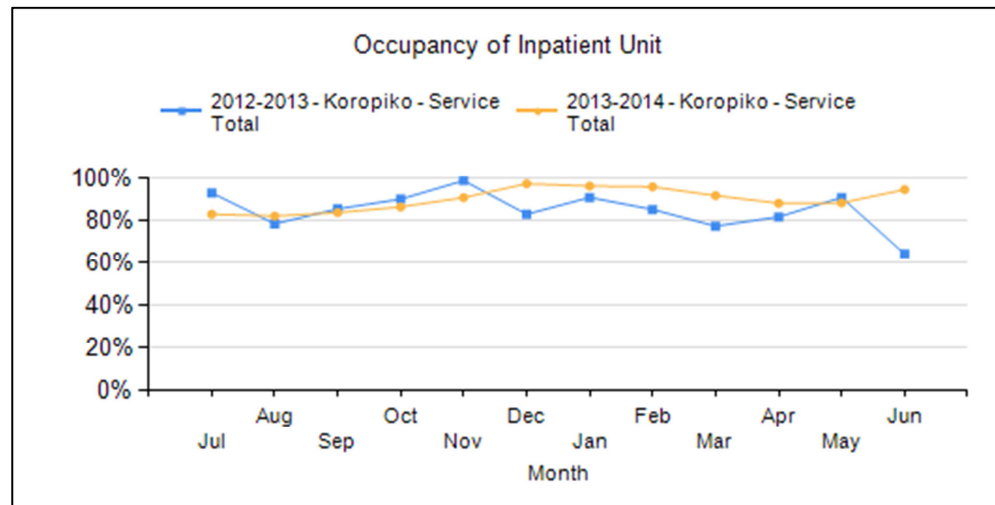
Length of Stay - The average length of Tiaho Mai inpatient stay has been trending downwards which, in conjunction with the decrease in readmission rates, points to the efficacy of the Supported Discharge service. However, this is not the only explanation for a decrease in length of stay. The number of clients with a length of stay of 7 days or less has been increasing and it appears that some have been admitted for assessment purposes. The development of the Mental Health Short Stay option may have an impact in reducing the number of admissions for the purpose of assessment. This will be measured as the first MH Short Stay PDSA test.
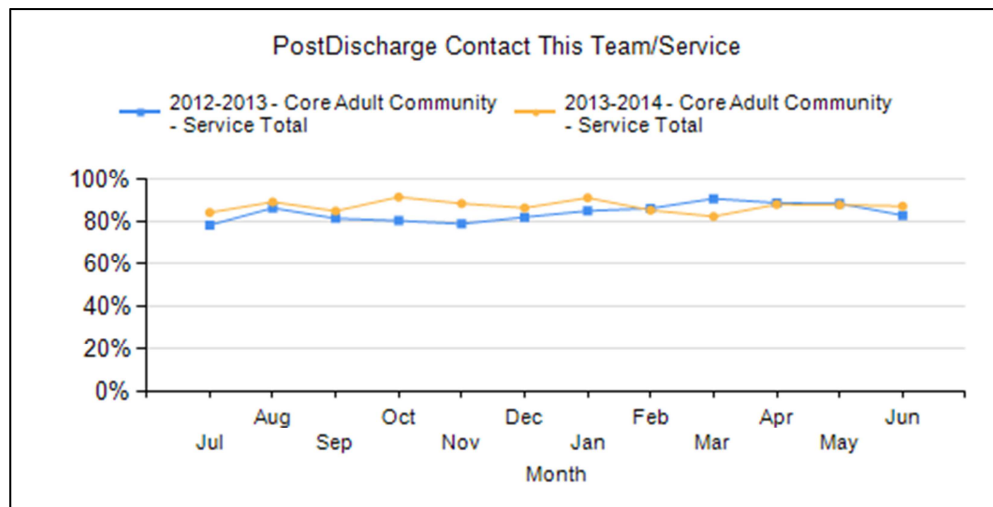
Length of Stay > 35 days Tiaho Mai: The average length of stay greater than 35 days has also been trending downwards. The development of the Length of Stay meeting in Tiaho Mai each Friday has had an impact. This meeting has the focus of identifying what the issues are related to the client's stay with the view to overcoming those issues. Where complex funding arrangements are identified as the issue another forum has been developed this year called the Funding Interface Meeting. All funding agencies attend this meeting and solutions are agreed. Both of these initiatives have had a positive impact on this KPI, however there is still room to improve further.
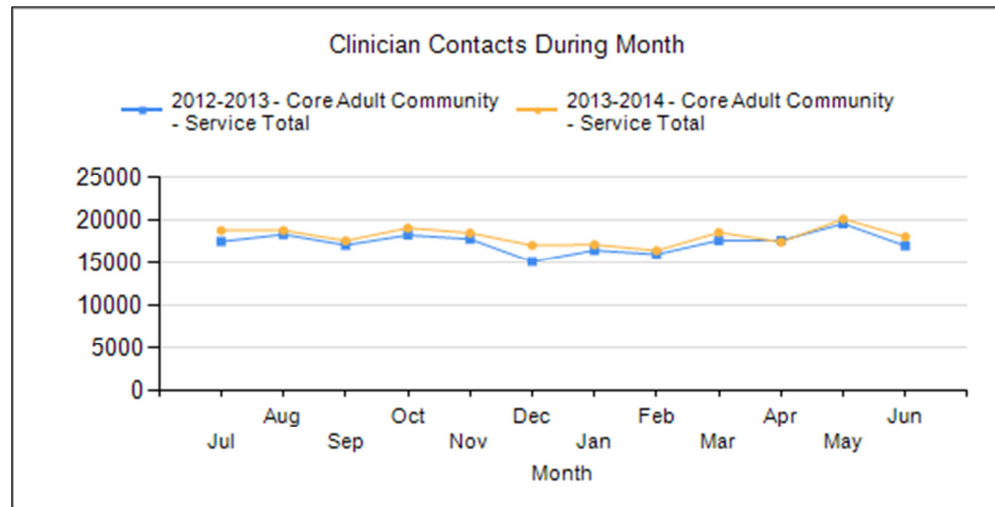
Mental Health Services for Older People (MHSOP): The trend for increasing occupancy has continued this year. Average occupancy for this year is 90.1% compared to 85% last year. There is no clear pattern to predict when demand is likely to be higher throughout the year which makes forward planning challenging. Occupancy in June has continued to increase to 95%. This increasing trend could be indicative of the growth in the aging population. In addition to the increase in numbers there is an increase in complexity in that there are increasing numbers admitted with a diagnosis of dementia with challenging behaviours before they can move to a community support option.
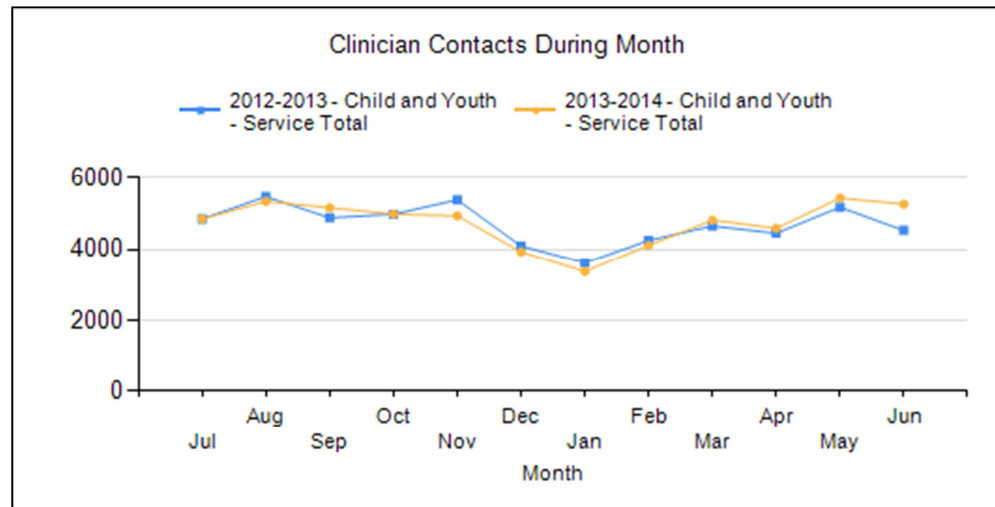

Occupancy of Inpatient Unit

Adult services 7 Day Post Discharge Contact: The overall average for clients to be seen within seven days of discharge from the Tiaho Mai was 87.64% during 2013/14. This is slightly below the national target which is set at 90%; however the National KPI data shows Counties is the best performer in the country for this indicator. The service believes the actual number of clients seen within that period is above 90% as the reported percentage includes clients who are discharged to another DHB or to the general hospital for physical health issues and who then return back to the inpatient unit (and would therefore be reported as not see by community clinicians).

PostDischarge Contact This Team/Service

2012-2013 - Core Adult Community - Service Total

2013-2014 - Core Adult Community - Service Total

Adult Community Service: Clinician Contacts: Throughout this past year, the clinician contacts have remained fairly steady, with only slight variations which can be attributed to the holiday periods. Overall there has been an increase from 2012/13, with an average of 18,215 contacts per month in 2013/14. Of note, the average caseload for 2013/14 was 3427 clients.
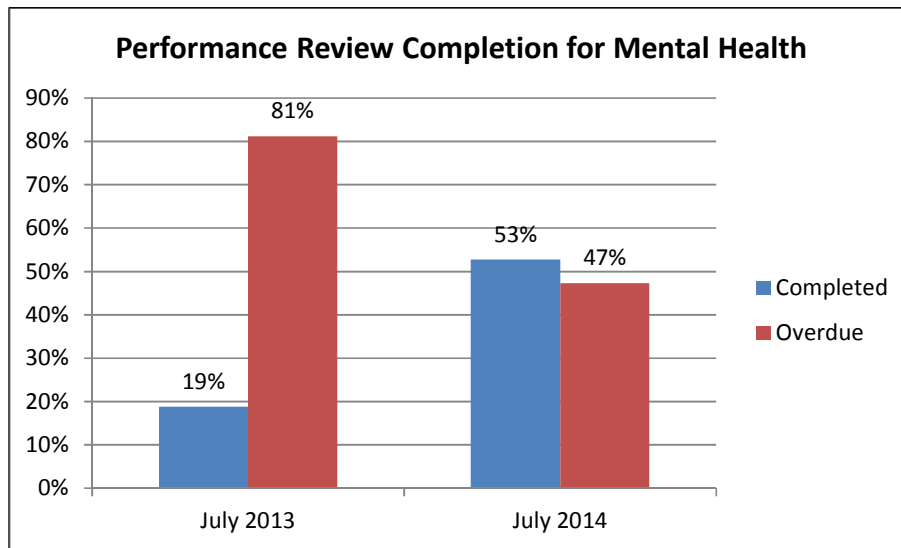
Child and Youth Service: Clinician Contacts: 2013-14 year has followed the peaks and troughs of the previous year these reflect the school terms as schools are one of our largest referral source. Productivity appears higher in the second half of this year than the previous year. June and July have been particularly busy; this could be attributed to the mobilization of suicide post-vention involving clinical teams within in some of our communities.
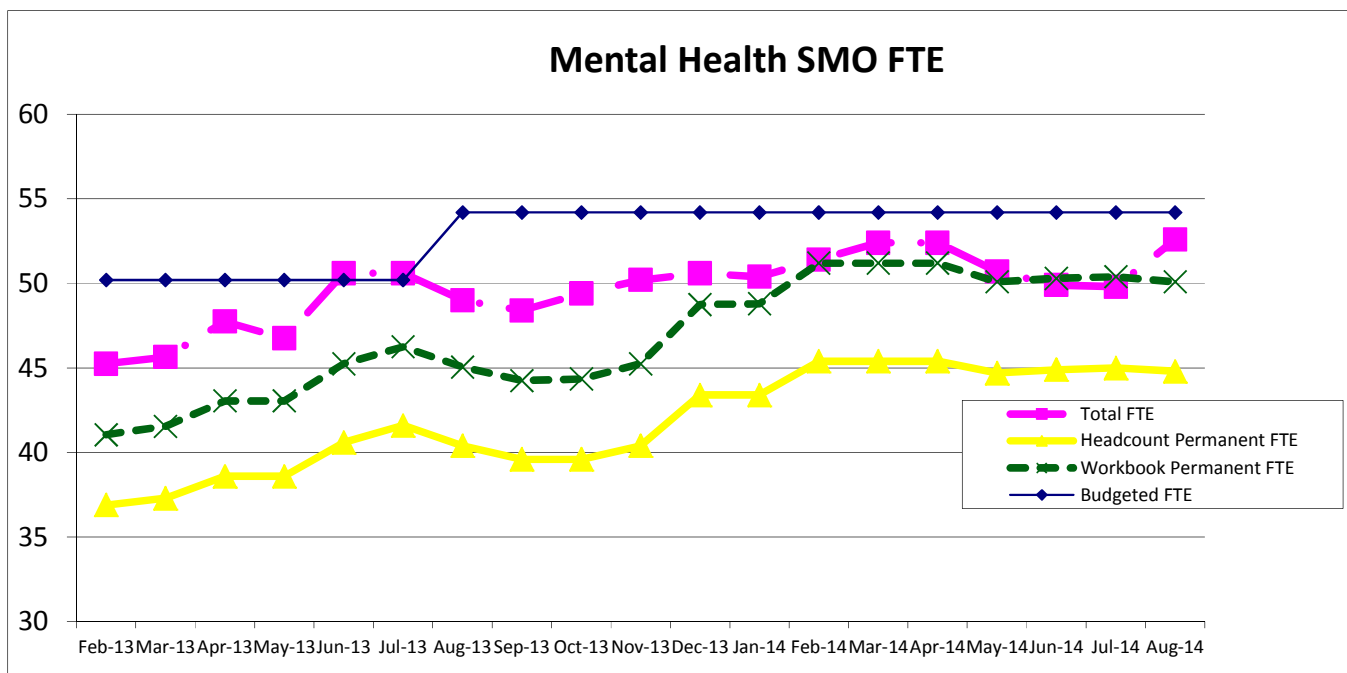

Clinician Contacts During Month

Human resources

The following section provides information on staffing

Performance Development Review is one of the ways managers demonstrate commitment to supporting staff through identify areas of strength and areas for improvement through an individual development plan. Managers have been working to increase the percentage of annual Performance reviews completed. The table demonstrates a 34% improvement in the 13/14 year

Performance Review Completion for Mental Health

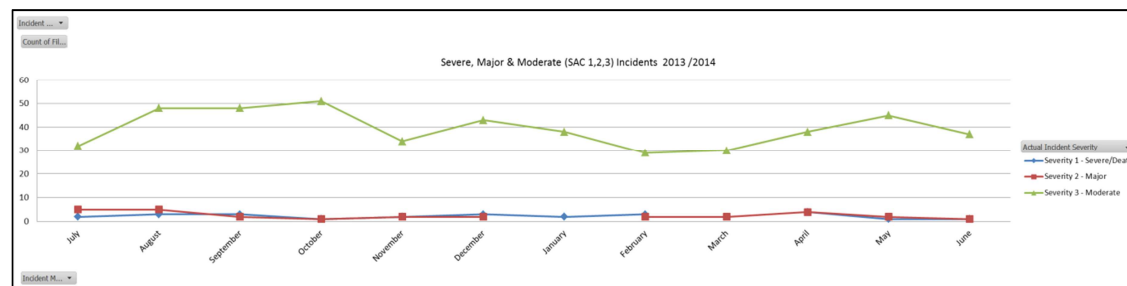|	Completed	Overdue
July 2013	19%	81%
July 2014	53%	47%

Mental Health SMO FTE

We are pleased to report the Division continues to slowly increase our overall SMO FTE and importantly our permanent FTE (with a corresponding reduction on locum FTE). However in the short term we have resignations from a number of Consultant Psychiatrists which again will reduce our specialist workforce capacity.

	AL > 2 Years			Sick Leave		
DIVISION	Jun-13	Jun-14	Change	Jun-13	Jun-14	Change
Mental Health Total	11.5%	8.8%	-2.8%	3.7%	4.4%	0.7%

Staff are encouraged to take regular annual leave. An indicator that reflects how we are managing this is the percentage of staff with greater than two year's accumulated annual leave. There is an organisational target of <5% accumulated leave. Over all the service has achieved a reduction of 2.8%.

Quality

Figure 1: Serious Incidents 2013/2014

Serious Incident Review (SIR) Triage Team meets fortnightly and comprises of the Clinical Director MH Services, Service Managers, Clinical Heads and Quality Coordinators from each of Mental Health Service groupings, the MH Act Coordinator, the Peer Support Specialist Professional Leader / Manager for consumer and family advisors and the Clinical Quality and Risk Manager. A departmental review is undertaken locally in the team where the incident occurred. Preliminary findings and recommendations are recorded. These reports are then presented to the SIR Triage Team. The SIR Triage team ratifies the findings and recommendations for those where "No further investigation" is required. For those that require further investigation the responsibility for determining the actions lies with the investigation team. (SIRP / Case Review / London Protocol)

SIR Outcomes 2013/2014

Of the 70 Serious and major incidents reviewed at the SIR Triage, it was determined that 19 required Serious Incident Review panels to be convened to review in depth any systems issues that were highlighted in the initial departmental reports. Highlighted by the reviews are many areas for improvement but two of particular note are we need to be more effective in engaging and communicating with families as well as improving how we transfer service user's care between teams and services.

Complaints

Over the period 1 July 2013 – 30 June 2014 there have been a total of 86 complaints logged; 10 Compliments logged, 4 Enquiries logged.

Table 3: Finance

	11/12	12/13	13/14	
Overtime	1,828,992	1,764,453	1,093,881	There has been a focus on reducing Medical staff overtime costs which has been effective
Locum costs	598,279	1,818,356	1,878,768	The increase from 11/12 to 12/13 reflects a high level of vacancies with subsequent recruitment of locums to alleviate clinical risk whilst permanent staff are recruited
Vacancy rates	5.2%	4.7%	4.3%	There has been a gradual reduction in vacancies as we strive to employ permanent staff
Net results	$634	$1,314	$449	The higher surplus in 12/13 than 13/14 is due to; 1)delay in the implementation of the newly funded contract (HBT) 2)higher level of medical staff vacancies in 12/13 3) budgetary increase for cost pressures (0.0613%) being less than the salary and step increases per the collective agreements

Progress against initiatives in 5 year plan and Achievements

Clearly statistics are not the only way we know we are making a positive difference. Some other significant achievements in the past year have included:

Strengthened Clinical Governance across the Division

- Serious Incident Triage and Review process embedded
- Mortality and Morbidity meetings established
- Quality framework developed
- Research and Audit group established

Improvement Science methodology has been embedded across all services so PDSA testing is the way we approach change ideas matched to change concepts in quality improvement.

Framework for Change - Phase 1

Staff were engaged in a significant change programme to redesign the adult acute pathway. Using improvement science methodology over 100 participants made up of staff, NGO staff, service users and family members, in developmental work streams, reviewed current processes and pathways and explored opportunities for improvement. They were introduced to subject matter experts and literature reviews before creating change ideas. These ideas were matched with change concepts and prepared for testing.

PDSA testing was undertaken of the modified triage tool, the triage environment in a centralised location, and of the functions of Intake and Acute Assessment, and Home Based Treatment Teams.

FFC programme achievements in 2013/14 include: the establishment of the Supported Discharge Team, secondment of 2 FTE of mental health nurses to Emergency Department in readiness for a mental health short stay and the developed acute and non-acute pathways with the formation of the centralised Intake and Acute Assessment Team and the two cluster Home based Treatment Teams, for implementation.

An 0800 number has been allocated (0800 080091) in readiness for implementation in order for services to be more accessible for Mental Health service users, family and referrers. Processes for implementation have been developed in collaboration with Health Alliance and will be tested with a sample of referrers before the 0800 number goes live. Additional functions such as recording and call centre metrics are being purchased.

Addressing Inpatient Bed Shortage

Indicative Business case for acute inpatient unit has been completed and approved.   A detailed Business case as per national requirements is in progress. Service users and Family/whaanau were engaged in co-design approaches to inform the business case development.

Responding to local and national need- Best Practice ECT

This nationally recognised programme was established and delivered 2 block sessions. It has become very popular and is oversubscribed. Subsequently there is a waiting list for a third block session proposed for November 2014.

Contributing to National Child & Youth KPI project

Whirinaki is actively involved in testing the Child and Youth phase of the national KPI project including significant contributions to the development of family/whanau involvement and consultation-liaison indicators

Leading the region with the development of acute behavioural guidelines

Acute behavioural Guidelines implemented and informing regional processes, potentially a resource adopted for the region.

Real Time Feedback

We have participated in the Real time feedback pilot led nationally by the Mental Health Commissioner.

Global Trigger Tool

MHSOP staff have led the way introducing the global trigger tool to identify potential medication harms in inpatient care. This has involved key senior staff being trained to audit patient files post discharge. The findings are used to inform quality improvement initiatives. The global trigger tool is widely used in other services but this in the first time it has been used in a mental health service in New Zealand.

Technology developments

Increased utilisation of Videoconferencing equipment has been reported in the adult services.

Successful Upgrade of HCC

Wider availability and use of laptops

Smoke Free

We exceeded our Inpatient Smokefree target of 95% of smokers offered advice to quit by achieving 100%

Increased staff uptake of flu vaccination from 48 to 57% of our staff