The Southland Story

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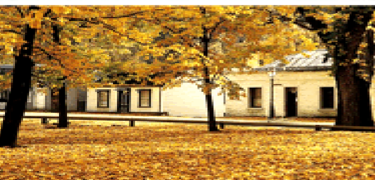
Quality and Humanity in Health

Southland Mental Health in 2001

- Just emerged from 1990s
- Poor resources & facilities
- Low morale
- Part time workforce (including the unit manager)
- Locum psychiatrist workforce
- High occupancy
- High community caseloads

Southland Mental Health in 2001

- Community services emerging, developing and Invercargill services spread across three sites
- Small teams in Gore and Wakatipu
- Isolation from Personal Health and other DHB services
- Isolation from Regional Services
- **Limited investment in workforce development**
- Cluster of inpatient suicides and serious attempts
- Limited advocacy for mental health
- Naivety



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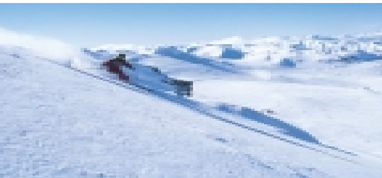
THE Event

- Blame and shame
- Self recrimination
- Audits, audits and more audits
- Murder investigation
- Coroners investigation
- HDC investigation
- Medical Council



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All this left the Service:

- Fragmented
- Vulnerable
- Isolated
- Really at a crisis point
- A feeling of failure

But……….

There was also a willingness, desire and motivation…

- To learn from this
- To move on and improve our service
- To make the most of any opportunities
- To change the culture to one that listened to clinical staff

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Quality & Risk Management became critical

- Focus on systems and improving
- Keeping track of recommendations
- Certification & Accreditation
- Service Development
- Associate Director of Nursing/Service Manager & Inpatient Coordinator positions
- Facilities improvement

But…

- The culture of the service was still not right, things just didn’t feel right
- Disconnect between management and the workforce

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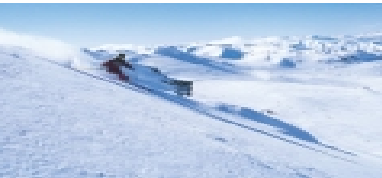
About 2005 - Cross Roads

- Workforce Development Plan
- Build staff resource - assertive recruitment
- Preference for full time employees
- Move from reliance on locums
- Access to national opportunities
- Presentation at conferences
- Reward and recognition



2006 -07 ~ Crisis Point for Inpatient Unit

- Inpatient unit positioned as the centre of the service
- Large vacancy factor & limited clinical leadership
- Fragmentation with community services
- Had ‘bled’ experienced staff to support development of community services
- Enrolled nurses
- Still reliant on locum psychiatrists

- Clinical Leadership - Clinical Nurse Specialists
- Appointment of ADON
- Appointment of Service Manager
- Secondments from community teams
- Requested support from other regions
- Active recruitment
- Positive feedback and support for the team
- <u>Took a long hard look at our model of service delivery</u>

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Model of Treatment

Identified a need to move to a model that integrated inpatient treatment into a wider continuum/context

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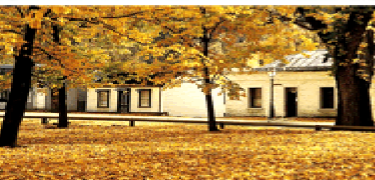
Building Blocks for Change

- Review of current workload, model and size, culture
- Line up resources to clinical need
- Principle for every patient to have a designated key worker
- Focus on core business
- Increase FTE in adult community, CAFS and rural areas
- Identify and address gaps eg. Primary Mental Health, Older Persons



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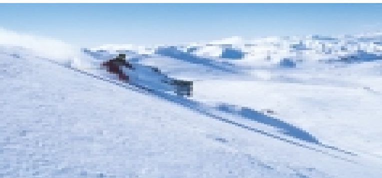
Keeping an eye on risk

- Refining quality and risk programme
- Annual CQI plan
- Quarterly monitoring of CQI activity
- Managing and learning from complaints
- Managing the media, good news stories
- Move to an Integrated Model & Service Provision Framework



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FUTURE DIRECTIONS
The Southland Mental Health Network - *Weaving Wellness into our future*

Mental Health Network
Established 2005

- Led and enabled integration and connection within the sector
- Was resourced to enable it to do its work
- Planning
- Mapping Document
- Open Forums
- Memorandums of Understanding
- Quality Awards

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Clinical Governance

- Developed a strong model within Mental Health
- Strong clinical leadership
- New model within the provider arm based on this
- Stronger links with Personal Health
- Getting the good news out

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Outcomes - where we are now?

- Inpatient Occupancy between 50% and 80%
- KPP improvement from <50% to 94%
- 80% of <u>all</u> patients have current crisis plans
- Community case load for a nurse is 20-25
- Average case load for a psychiatrist is 50
- Close links and access to regional specialist services
- Reduced vacancy factor
- Full complement of psychiatrists, most are permanent, almost all vocationally registered
- Much improved integration with sector, NGOs

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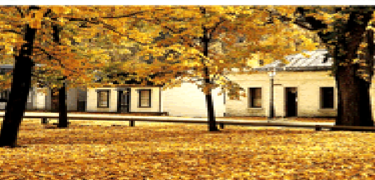
What patients and families say….

"This is great. It means I don't have to tell my story to a different doc every couple of months because in the past they have changed so many times. It is very upsetting to have to do this as it stirs up things that I really would rather not have to think about too often. Long may it last."



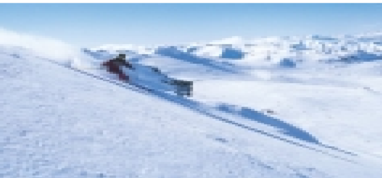
Morale has improved - people say they like working here

Culture of expectation of professional standards

Increased national and international inquiry for positions

Succession planning

Building resilience and confidence



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Challenges going Forward

- Living within our means
- Facilities
- Completion and implementation of SPFs
- Watching for gaps and addressing them
- Managing risk
- Increasing compliance with HONOS
- Data Validity
- Implementation of Clinical Governance within SDHB
- Closer regional relationships

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