Response to the RECOMMENDATIONS form the MH&A Directorate Review

Based on the findings, the review team developed the following recommendations. Each recommendation (and associated rationale and supportive information) appears in the left text box. Management have been asked to comment (in the right box) as to whether they agree or disagree with this recommendation. Where they agree, an action plan is requested (to understand how it will be implemented and the associated timeline). Where there is disagreement, the rationale for this has been requested.
The recommendations have been identified as '**Yes**' Y = to be implemented; '**No**' N = disagree with the recommendation; '**Further Clarification Required**" F = not fully understanding of recommendation or believe the recommendation needs further challenging, the reviewer will be approached to discuss these items more fully before determining direction.; '**Partial'** P = where there is some of the recommendation is supported

Timeframes are generally stated as a duration from when **approval** is given to proceed and is subject to discussion and approval. Cross-reference is made to the Service Integration proposal submitted September 2015

	Recommendation from Review Team	Y/ N/P/F	Timing	MH&A management comment & rationale
	The Stepped Model of Care:			
	1. Acute care continuum:			
1.	• The review team endorses the current plan to close the Tipahi subacute unit, and instead devolve those resources into bolstering the continuum of acute care alternatives to inpatient care. A range of potential models exist across NZ which could serve as models for this development of a more robust continuum of acute care options.	Y	3 months for down-sizing	• While we agree with this as a long term plan it will need to be staged as service models develop and alternative sustainable solutions in the community are identified.
2.	• Beyond this, it is also recommended that the number of acute unit beds is reduced to a maximum of 22 in the relatively short term (noting that a 20 bed unit would at current admission rates mean average occupancy of 85%, which is the generally accepted ideal).	P	June 2017 Benchmark every 3 months for 9 months then plan actions	Bed numbers should be benchmarked against best practice rather than sizing based on current average occupancy. This should be done on a periodic basis as demand for inpatient beds should change as community based services mature and any alternatives developed.
3.	• However, the Wairau adult team do not utilise their "share" of beds. It is thus recommended that in a staged way, the resource currently used to fund beds for the Marlborough	F	6 months	The team believes that we should be focusing any capacity in Wairau within the community and not an "inpatient alternative" on the Wairau site. Need to discuss rationale with

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	population, is devolved to develop an extended range of local acute care options, including ideally an inpatient-alternative facility co-located with the adult community team on the Wairau site. Implementing this recommendation will require formation of a dedicated project group, review of relevant data re current utilisation and costs/funding, and review of relevant inpatient alternative models in use in other small NZ communities (e.g., Wairarapa DHB) as well as internationally (e.g., Trieste, Italy).			the reviewer and have further engagement on differing views.
4.	• Resource freed up should also be used to develop CAMHS alternative to inpatient care capacity locally, in both Nelson and Marlborough, with a goal that young people are never admitted to the adult IPU.	P	3mths to look at options if so directed	• We do not believe this is viable due to the numbers of child and youth patients. Presently we utilise the Paediatric Unit for young children (often with eating disorders) and this is a more viable solution to a stand alone CAMHS inpatient unit. There is a challenge more for adolescents transitioning child stages into adult stages. With the upcoming redevelopment of Nelson Hospital it may be possible to consider a remodelled Paediatric Unit which would consider this age group through a more flexible design.
5.	• Nursing leadership in the IPU needs to be strengthened to improve care and implement eg, the reducing restraint and seclusion initiative. Equivalent sized units in other DHBs will have a Charge Nurse/Manager, a Clinical Nurse Specialist, and a Nurse Educator role.	Y	linked to 1 and 2 above. 4 mths	• This will need to be balanced through the models of care project and how we prioritise savings and further investments.
	2. Intensive community support:			
6.	• The review team endorses the findings of the "residential review", and the plan to work with the NGO sector to move from a predominance of residential "beds" to a predominance of "supported housing" services.	Y	Linked to contract renewal – end of June 2016 but may be some negotiation required beyond that.	

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7.	• As part of this, effort will need to be put into improving access to affordable housing for people with MH&A needs. Options include developing a close working relationship with Housing NZ, developing an umbrella trust to purchase and manage a stock of housing for people with MH&A needs, etc.	Y	Ongoing	• Need to strengthen intersectoral activity across the Nelson Marlborough Health System. This is a particular need for Mental Health and Addictions but also for other services such as Paediatrics, Maori Health etc
8.	• It is also recommended that some of the funding freed up by reducing the number of acute/sub-acute beds, is used to boost the current flexifund pool, to fund intensive support and "wrap-around care" locally for people with high and complex needs.	Y	linked to DHB budget status and prioritisation process	We support this in principle, however increases in any flexifund will need to be considered through the savings and reinvestment process underway.
	3. Alcohol and Drug Services:			
9.	• NMDHB needs a full continuum of AoD services available locally. It is recommended that a trade-off with the rest of the region is negotiated, whereby the regional funding to St Marks is "swapped" for the NMDHB funding going to regional services. This will then increase the resource available to develop a collaboration of the clinical and NGO AoD services, to develop a full continuum of local AoD services.	P	Dec 2016 Regional Detox Review – due mid 2016;	Agree and are working with St Marks, Specialist Services and the SI Alliance on the review of the continuum – changing the model of care and closer collaboration. Any trade-off with regional services would have to be negotiated with the regional providers. We also note that it is not correct to assume we would "swap" St Marks Regional Funding as this infers that the other DHBs would not want to utilise St Marks Services and they do. Of the regional services, whilst many aren't utilised by NMDHB, the Addictions services are and need to remain accessible. (e.g. Nova, The Bridge). Locally we wouldn't have the expertise or economy of scale for similar residential services to these. MH&A are also working with the region on the detox services review and this may create opportunities, e.g. one option being explored is to reduce beds at Kennedy with some funding returned to NMDHB which could be used as extension of what already occurs in the local MH Inpatient continuum and Medical Unit. Another possibility is to engage a specialist detox nurse in Wairau who can work across inpatient, community, short term residential such as exists in Nelson (and used to exist in Wairau).

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	4. The model of community mental health and addictions care:			
10.	• The review team would, based on feedback from consumers and family/whanau in particular, like to propose that services locally, as part of moving to function as one integrated continuum of care, remove all "referral criteria", and instead operate from a principle that need is consumer/family determined (people who do not need services in general do not want them!). The role of services is then is to ensure the appropriate response matched to level of assessed need. The fact that there is an effective highly regarded local SPOE function, will substantially enable this change.	F	Awaiting discussion with Panel	We need to discuss this further with the reviewer. We have a Single Point of Entry for which there is no referral criteria, however there is a threshold for who can access the services based on the Ministry of Health Service Specifications. We are somewhat perplexed that the recommendation infers that we should simply take al comers on the basis that people who do not need services in general do not want them. This is not our experience, some people clearly want to keep receiving our services when they have no further clinical need, some do not want our services when clearly they need them under the Mental Health (CAT) Act and there are people who wish to access services through MH&A who do not meet the thresholds espoused in the service specifications.
11.	• As part of the move to integrate MH&A clinical services more closely with NGO support services (see below), it is recommended that there is a shift to having for all consumers a single agreed point of care co-ordination, and a single integrated care plan.	Y	5 months	•
12.	• For people with high and complex needs the model of care should be one of so-called "assertive community treatment" intensive, low-caseload, multi-disciplinary case management.	Y	Nov 2016 dependent on Budget prioritisation	•
13.	• For all other consumers, it is recommended that the single point of care coordination should in most instances be either their GP (for people whose need for specialist MH&A services care is episodic), or their community/peer support worker (for people whose needs are enduring). While concerns can very reasonably be raised regarding the capability of GPs and NGO support staff to undertake this function, it is expected that the shift of role for community MH clinicians will allow for a far greater focus on up-skilling their primary care and	P	Ongoing. Links to Service integration as in 1. Above June 2016	• We agree in principle however there are workforce isssues associated with preparedness of both GPs and the community / peer support worker. This will have to be worked on to ensure there is consistency across the District over time.

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	NGO colleagues within an integrated model, providing supervision and support, phone and face-to-face consultation, and also ensuring appropriate response to any escalation of acuity or risk.			
14.	• In freeing up community mental health clinician time from generic case management, there will thus be capacity to provide better MH&A clinical support to NGO support services and primary care; and to increase access to evidence-based talking therapies, family therapies, improved COPMIA support/services etc. Improving clinical support for Te Piki Oranga (and in particular the single CAMHS clinician there) could be an early focus of this shift.	P	Linked to time in 1 and 13 above	• Agreed however this relates to the item above so will be something that will take time to achieve
	5. Primary Mental Health Initiatives:			
15.	• The purchase of packages of care (POC) within the PMHI should be reviewed, including the threshold for accessing a POC, so as to ensure that people with moderate to severe needs are able to access a POC of higher expertise, and greater duration (4-6 sessions, extended by exception following an agreed case review process). While it is recognised that the PMHI budget is small compared to the level of need/demand, over time the realignment of community mental health clinician roles in particular, and community MH&A services in general, towards primary care, will greatly increase access to more extended POC for people with more moderate to severe needs.	Yes	Dec 2016	Yes – useful to review the PoC within the PMHI. There were no national specification, frameworks or consistency established when PMHI was introduced, so each DHB has its own model. Very limited funding in PMHI (0.25% of the entire DHB budget; 3.04% of MH&A budget), so limited places available to each practice (6 per practice each quarter). Therefore each practice has to carefully ration/prioritise. Fewer other options for counselling in the community now with reductions in services over time, e.g. Family Court counselling; Relationships Aotearoa. At the same time, higher demand is presenting in the community. _____ This should be part of below There is potential for counsellors and clinical psychologists to work in primary care, particularly joint groups (psycho-education, and management for disorders such as anxiety and depression of moderate range).

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16.	• While extending POC to some consumers will under current arrangements/funding, result in lack of access for others, this can be readily addressed via i) Co-running of group programmes between primary and secondary MH&A services; and ii) Diverting some of the community MH clinician time "liberated" from generic case management, into working in primary care settings.	Y	6mths	Agree with co-running of groups – with referrals from both Primary and Specialist Services, where there is a need. AOD and CAMHS do some co-running of groups with NGOs currently. •
17.	• The process for credentialing of POC providers was not accessed in the process of this review, but it is recommended that this credentialing process is reviewed to ensure it has clear criteria which ensure only sufficiently qualified/skilled providers are contracted to provide POC.	Yes	4mths	
18.	• The current barriers to NGO support services both continuing for a period following discharge from MH&A services to primary care, and being accessed from primary care, must be removed.	P	May 2016	• This requires robust pathways to be developed so that access can be opened up in a sustainable manner
19.	• PMHI outcome data reporting needs to be improved to include pre and post measures and not just change. Further to this, using PHQ-9 as a reporting tool is also not ideal as it measures depression only. At a minimum given the PHQ-9 is already in use, the GAD-7 (a measure of anxiety) should be added. Ideally a brief measure of function or quality of life (eg, WHOQOL) should also be used. For children and youth a measure such as the Strengths and Difficulties Questionnaire (SDQ) should be routinely used	Y	June 2016	Currently the PHQ-9 is used as noted. But as outcomes tools involves GP consult time, they have to be very quick to complete & there may be a cost to adding further tools. Will need to be linked to pathway work and prioritisation of resourcing.
	Interfaces Across the Wider Health System:			
	1. Integration of MH&A Services:			
20.	• Continued support of the Directorate Reference Group should be provided, and over time negotiated devolved authority be negotiated to enable true "whole of sector" leadership and planning of further service development.	Y	Immed post approval	

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21.	• To enable this, as part of a move to a modern IT platform, ensuring the Reference Group has access to the data it needs to over-view quality of services will be key.	y		Modern it platform is essential for all services, will require prioritisation of resources.
22.	• It is also recommended that the Reference Group lead and sponsor use of co-design principles as the means by which services plan and implement new developments and improvement – including the service development and improvement recommendations of this report. There is abundant evidence in the wider health sector, regarding the key role of a sustained focus on understanding and measuring "patient experience", and use of co-design principles, in improving healthcare services.	Y	12 mths Ongoing	• Reference group will be a key player in co-design principles however the imperative for change has a degree of urgency which will require wider sponsorship.
23.	• SPOE is a model of successful innovation, and as such the review team were clear that it's function should be extended to include CAMHS and older people referrals, and also the Wairau locality. We understand that since the review visit, the planned extension to cover CAMHS and the Wairau district has been completed.	Y	Ongoing	Presently Older Persons access is via a separate point of entry. Careful planning will be required to make the changes into a SPOE.
24.	• The project to integrate adult community services into two locality focussed teams, is a key priority to improve safety and effectiveness of care, along with reducing the service boundaries issue. It is recommended that within these locality teams, subspecialty expertise is maintained where this reflects evidence-based models of care (eg, early psychosis service, provision of talking therapies/CBT) via subspecialty "sub-teams" within the locality team. However the locality team must function as a single coherent entity via having a single manager, having shared referral intake and case review processes etc. The current subspecialty teams have been an important vehicle for building subspecialty expertise, and continuing a "virtual" subspecialty team structure (eg subspecialty groups coming together across	Y	March 2017	As in the Service Integration proposal, Early Intervention, addictions, Maori and Forensic teams are to be maintained as subspecialties participating in the community modules. There will be 'virtual' teams across sub-specialities, e.g. counselling, psychology, professional disciplines. These are key to supporting the clinical expertise and professions.

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	locality team boundaries for shared training/peer review) will be key to continuing to maintain subspecialty expertise.			
25.	• Given the example of collaboration between Adult MH and AoD on the Wairau site, and the offer to co-locate/integrate made by the Nelson AoD team, consideration should be given to how to operationalise this as a part of implementing the integration project. This will go a long way to addressing the issue of better meeting the needs of people with CEP.	Y	Dec 2016 Long term	
26.	• Given the much improved collaboration between clinical and NGO management that the Directorate Reference Group has achieved, it is recommended that this group now takes an active role and leadership in promoting integration of Clinical and NGO services (and also Clinical and Primary Care services), at the level of service managers, and clinicians/NGO workforce. Minimum targets for referrals to support services should be set and maintained.	P	Ongoing	An active role has always been taken promoting integration across all services in the continuum. Need to have further discussion with reviewers to understand the focus of minimum targets to ensure that perverse incentives are not created.
27.	• Increased knowledge of the range of services available, and how to access them, needs to be achieved across the sector. This should be via both shared educational activities, and development and maintenance of an accurate "resource directory".	Y	March 2016	
28.	• It would also be helpful for the Reference Group to play a role in promoting the roles of the NGO's, profiling the services they provide, implementing processes to improve NGO visibility and foster stronger working relationships, and to also promote a vision of potential future development of NGO roles (eg, peer lead admission alternatives integrating a clinical service). As part of this, identifying the NGO which in feedback to the draft report indicated they did not have issues with low referral rates and enjoyed good working relationships with clinical services, and clarifying what the differences are that allowed the functional relationship to	Y	ongoing	•

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	develop, will help inform efforts to make this the norm across the sector.			
	2. Transition between primary and secondary services:			
29.	• As recommended above, enabling/allowing NGO support access from primary care, and continuing for an agreed period (eg, 2 years) following discharge from MH&A services; and aligning mental health nursing expertise more closely with primary care, are recommendations to improve the transitions from primary care to MH&A services, and back.	Y	Nov 2016	• Agreed subject to both prioritisation of resources as well as pathway development
	3. Intersectoral Collaboration:			
30.	• A second area of focus for the Directorate Reference Group should be to lead the process of establishing better relationships in the NMDHB area communities with cross sectoral partners – in particular Police, Housing NZ, CYFS, WINZ/MSD. Some models of this are in evidence – eg, the Wairau Police Liaison role. The forums between cross-sector partners currently in existence are clearly not achieving the collaboration and integration required so will need to be reviewed in terms of how to achieve improved collaboration as a service-provision level.	Y	Ongoing	• Good intersectoral relationships exist however they can always be further strengthened •
	Organisational Culture Within the Services:			
	1. MH&A – Hospital Services Relationship:			
31.	• Given the difficult relationship between MH&A and Nelson Hospital being manifest from ELT level down, the review team is of the opinion that a facilitated process to support ELT to reach a point of greater trust and collaboration is required.	Y		
32.	• It will then be important for ELT members to model greater openness and collaboration, and to make a commitment to taking up issues directly with each other rather than going "around" each other and/or going directly to the CEO.	Y		
33.	• As a follow-on from this, it will then be key that ELT model a culture of cooperation and provide leadership to ensure all	Y		

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	staff follow this model of specialist services operating as one coherent entity and continuum of care.			
	2. MH&A Services Culture:			
34.	• The review team recommends that service clinical leadership roles are created, to be joint clinician - leadership roles with depending on the size of the service, 2-4 tenths dedicated to the leadership role.	P		Many already exist. Questions the suggestion of 2 to 4 tenths dedicated to leadership role need to consider within construct of wider organisation.
35.	• Each service manager will thus have a clinical leader "partner" to work with, and to provide clinical leadership to the service.	Y		•
36.	• Creation of these roles will also create a "team" to work with the Clinical Director/DAMHS, and create a structure for service-wide clinical governance.	Y		•
	Cost Structure including the Quality of the Spend, and Opportunities for Efficiencies:			
	• **Acute Services:**			
37.	• Contracted volumes and funding should be adjusted to reflect actual occupancy levels; and	Y	June 2016 Next contract round	Review the Production Plan for greater alignment
38.	• The Mental Health Admissions Unit and Tipahi nursing models should be reviewed as part of NMDHB nursing roster project.	Y	Dependent on NMDHB project	
	• **Provider Arm:**			
39.	• There is an urgent need for investment in a modern enabling IT infrastructure and PMS, and to ensure clinicians have "tools for the job", to enable a sustained focus on improving efficiency.	Y	ASAP	
40.	• As part of carrying out the nursing roster reviews and looking at new models of care through the integration model staffing mix and the level of penal, overtime and allowances should be reviewed to identify if there are opportunities to	Y	Ongoing	Agree. Have had two external roster reviews – for inpatient services and Service Integration. MH&A is part of the DHB-wide roster review, i.e. the multi-partite 'Best Practice Standards for Rostering Nursing and

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	reduce unnecessary costs and ensure that roster patterns better fit service demand. Leave, overtime, penal and allowance costs should be monitored on an ongoing basis by the Directorate.	N		Midwifery'. Although, MH&A does not have the same issues in that we have a set roster rotating on a 6-weekly cycle, which only needs adjusted according to annual leave and illness. Also, community teams work Monday to Friday. Leave, overtime, penal and allowance costs are monitored by the Unit Managers.
41.	• The MH&A Directorate has a flat and lean management structure. We recommend that consideration is given to strengthening management support roles to help enable implementation of these recommendations.	Y	Resource dependent June 2016	• Agree in principle, however need to consider alongside wider investment and savings opportunity.
42.	• In determining the 2016/17 PVS schedule consideration should be given to reallocating the funding of those areas that are contributing more than 17% towards overheads to those services where funding is currently insufficient to cover costs &/or costs plus 17% e.g. medical personnel & Nikau House.	Y	in time for Jan 2017	
	• **NGOs:**			
43.	• All NGO contracts require clearly defined output expectations and for these to be reported. Output targets for each type of service regardless of who is providing the service (e.g. Provider Arm, NGO) should be reviewed and the target measure (e.g. bed utilisation) and where possible the target metric (e.g. 85% bed utilisation) should be standardised. If targets are not being met the NGOs and the DHB need to determine whether this is due to the NGOs not receiving the referrals or a permanent change in need for that service. If it is a change in need then the contracted volumes and funding needs to be adjusted accordingly. This adjustment should also include consideration of what areas of support need may currently be underfunded.	Y	for June 2016	
44.	• Consideration should be given to funding the NGOs on a fixed price basis for the agreed service delivery rather than a	P	MoH & resource	Dont agree with fixed price, but do agree with concept of moving away from FTE contracting to focus on output and

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	price per FTE to ensure that the total price paid covers: the cost of delivery; plus a fair allocation of the NGOs overheads costs associated with delivering that service; and provides some allowance for some flexi-funding. All of the services provided by the NGO to the DHB should be considered as part of the pricing in order to ensure that the allowance for overheads is appropriate. Once this mechanism is in place and the DHB is contracting for additional services then the increase in total funding should represent the additional costs of providing that service only.		dependent	outcome contracts
45.	• Improving linkages and integration with clinical services, increasing referral rates, allowing referrals from primary care (say 10%) and allowing NGOs to support consumers for up to two years after discharge from primary care will also assist in ensuring that the use of these services is maximised.	y		• Links to earlier recommendations
	• **IDFs:**			
46.	• NMDHB needs to re-negotiate its share of cost of CAMHS regional services to better reflect the actual need for and use of these services.	Y	Long term	Agree need to re-negotiate our share of all regional services that are underutilised, mostly due to access issues (not all are CAMHS services), including Mothers & Baby services and Child & Youth inpatients; this would not include Eating Disorders. Support from CE and then South Island ALT will be required. Forensic Services are 'top-sliced' although utilisation is an issue.
47.	• There are also a number of AoD funding lines which should be reviewed as part of developing a full continuum of AOD services locally., as recommended in the Stepped Model of Care section above.	Y	June 2016	Follows with current review of AOD services. Cross reference: • Rec 9 above
	• **High Cost Packages of Care:**			
48.	• MH&A have two consumers currently one being supported by Capital & Coast and one in the MHAU who are high need consumers for which the cost of care is significant. Alternative options for high needs and high cost consumers need to be developed and considered as part of the review	Y	Budget prioritisation dependent for DHB-wide	Agree

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	of IDF services and NGO bulk funding/NASC flexifund.		High and Complex Service	
	Other Recommendations:			
49.	**1. Hospital Liaison Roles:** • The two hospital liaison roles which were identified as savings targets due to concerns that they did not fall within the ring fence framework are seen as adding value and the preference from the hospital and mental health service is to retain the services if possible. It is also noted that there are no hospital liaison roles on the Wairau site – support is provided from the general community team – but we recommend consideration is given to creating a dedicated liaison role for that site also. Whilst MH&A is not contracted to provide these services currently through the PVS there are specific MOH funding lines for the provision of hospital liaison services. We recommend that these roles with appropriate funding are formally incorporated into the MH&A PVS for 2016/17 from funding made available from adjusting acute services to reflect actual demand.	P	Budget dependent June 2016	Agree Subject to budget prioritisation
50.	**2. Restraint/Seclusion Reduction:** The nationally applied and proven methodology for reducing rates of restraint and seclusion must be adopted. A project to do so has been under way for some time, but without organisational mandate and commitment it has not succeeded. With increasing nursing leadership to the IPU team (see recommendation above) this will help, but implementing this proven methodology locally must be a key priority for the MH&A Directorate. It is heartening to be told that since the review team visit, this project has been "rejuvenated".	Y	Immediate	Further actions are underway.
51.	**3. Family/whanau advocacy and advisory Service:** A family advisor role should be re-established – noting that	Y	Immediate – resource	Subject to prioritisation

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	such a role can be an employed FTE, or a contracted role from an external organisation.		dependent	
52.	**4. Cultural responsiveness:** In keeping with what is considered "best practise" nationally, MH&A services should consider integrating specific roles to lead clinical service delivery to the Maori, Pacific, and Asian communities it serves. There are a range of models nationally for achieving this; the key issue will be what model best serves the local community.	Y (not E)	Ongoing	Have Kaupapa Maori services as well as 4 dedicated clinical staff for Maori provision in the Specialist Services (1 unfilled for 3 years in Wairau). These also incorporate Pasifika. MH&A Spec Services have psychologists who have developed appropriate skills for working with refugees. MH&A utilise the Multi-Ethnic Council and interpreters for support with other ethnicities (e.g. Bhutanese) and there are Regional Services to contact. There is a new development for accessing telephone consultation &/or therapy support for different ethnic groups.
53.	**5. Maori responsiveness and participation:** The review panel did not incorporate any dedicated expertise with respect to Maori Mental Health services. A number of recommendations were made in feedback to the draft report, which fit with the team's understanding of "best practice" in meeting MH&A needs of Maori communities. We recommend that a further piece of work subsequent to this review is commissioned from someone with dedicated Maori MH&A expertise, to develop specific recommendations regarding how to improve Maori participation in decision-making processes and governance, and in ensuring optimal pathways to care and cultural appropriateness of care for Maori locally.	Y	Immediate - resource dependent June 2016	The Specialist Service is performing well in access rates and treatment modalities for Maori (admission, CTO,) (e.g. HSP page109; 110) Agree, always room for improvement, so further work is supported. MH&A would welcome a dedicated resource attached to the Directorate, particularly for the Specialist Service. The new TPO contract was a 2 year collaboration to develop the service. TPO are part of the Reference Group and are a presence in the Directorate. MH&A initiated He Taura Tieke, the DHB-wide self audit tool for the DHB and continues to utilise this. An Alliance Support Manager is shared with the Maori Health Directorate which facilitates information and planning. The Specialist Service actively supports and invests in individual management training and cultural professional development for both Maori and non-Maori staff requesting this, in addition to service-wide training.

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54.	6. **Management Support for the Wairau MH&A Teams:** The review panel recommends that the current service management structure is reconfigured, to create a Wairau locality MH&A manager role. This role will obviously retain strong links to Nelson-based services and management team, but should also forge strong links to other services on the Wairau site and the related management structure. As recommended above, this service manager should have a locality clinical leader to work with. Having good local clinical leadership and management will be key to over-seeing local service development to implement the recommendations of this review for the Wairau services.	Y	Feb 2017	This has been considered as part of Service Integration and will be investigated further.
55.	7. **Dual Disability Funding:** The current situation regarding inability to readily agree co-funding for people with high and complex needs as a result of dual disability is resulting in substantial harm, and must be addressed. Primarily this requires the 2 relevant members of the ELT to be able to agree reasonable compromises re shared funding, but ideally backed up by an agreed and equitable process for establishing a fair sharing of funding. If necessary, CEO intervention may be required to achieve this recommendation.	Y	Ongoing 12-18 mths IDF discussion/ resource dependent	There is a current pathway: MH&A will assess and where mental illness exists, the pathway is clear. However, for behavioural and learning difficulties and/or challenging behaviour in the absence of mental illness it is more problematic. Whilst there has been progress subsequent to the review, and although dual disability remains on the agenda for further service development (within resource constraints), it would be beneficial to have a project approach to explore the ongoing level of need, the type of service required and the interface of all relevant services (DSS, MH, HOP). Currently there is a South Island Alliance project initiated by the GM, looking at a stocktake and resources for dual disability. The intention is to disinvest in regional services less utilised to reinvest in dual disability consultation, when the pathway is unclear. Discussion in the past has identified that ideally a sub-speciality position with access to external specialist consultation and clinical psychology with dual disability expertise would be established.

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			June 2017	Support Works were trained to use a screening tool for this, but the current status of this is uncertain. However, disagree that it be the '2 relevant members of ELT' as neither manage the funding resource as it rests with Support Works and MH-NASC and they meet two-weekly to discuss consumers. This is a clinical/behavioural discussion of needs/relevant services not a management discussion.