Mental Health and Addictions Integration Programme

"When you hold hands it is difficult to point fingers."

Nelson Marlborough Health

Priority Improvement Ambitions	What we will do to improve - To achieve a system-wide integrated service: Foundations	Improvements	Integration	Agile and Adaptive	How we will know change is improvement
Equity	* Build on Single Point of Entry (SPOE): district-wide, all ages, all services. * Strengthen and integrate Maori workforce with co-location * Whakapapa described for the recovery journey	* Implement a universal triage tool for all services across primary and secondary care * Cultural model of care (Poutama) * Intervention and support is responsive for diverse communties, such as refugee communities	* Develop a Maori Model of Care and Action Plan. * Access to primary care * Screening for all in supported accomodation and in specialsit services	* Deliver the Equally Well outcomes - improved physical and mental health. * Deliver Maori Model of care * Cultural assessment and intervention tool utilised across system	* Universal use of triage tool – audit * Increased number of people on metabolic monitoring * Set milestones for implementation of Maori Model of Care * Improve ethnicity capture all people who access services * Data are used to inform service development * Implement cultural assessment and intervention tool and measure utilisation * CTO rate by ethnicity (A KPI) * Community DNA rate (A & C&Y KPI) * Population receiving care (A KPI) - compare Nel:Tas:Marl * Access to services (C&Y KPI)
Participation	* Person held care plan developed and signed. * Real time feedback systems * Peer-led respite service available	* One wellness plan that is shared and available to team members aross the system * Consumer involvement / contribution to Multi-Disciplinary Team meetings * Establish peer-led respite across district * Record of participation in discharge plan development	* Accessible Advanced Directives included in the one plan * Collaborative note taking * Referred peer-led respite * Range of flexible respite services	* Holistic recovery oriented plans that aim to achieve a person's aspirations and goals * Open access peer-led respite - a range of flexible in reach and outreach service	* Utilisation of shared recovery plan * Recovery plans reflect goal identification * Implementation of Real-time feedback and reporting. * Mental Health and Addictions is included in IT strategic initiatives * Consumers involved in development of care plans * Satisfaction survey - treatment plan collaboration (A KPI) * Service user, family whānau participation (C&Y KPI) * Community service user related time with service user participation (A & C&Y KPI)
Networked	* Health pathways which are evidence based and articulate team member' roles and responsibilities * Develop a MH specific IT strategy to enable integration programme	* Timely info sharing with General Practice. * Use Health One to improve information sharing with primary and community care. * Medication management and prescribing practices improved and monitored * Improved continuous assessment process	* Collaborative responses. * Increased capacity and capability in primary care. * Liaison roles based in primary care. * Communication of DNAs with GPs. * Service transitions are seamless	* Mobile, effective, real time, on line communication between team members, supported by IT systems	* Utilisation of established health pathways. * Increased number of discharge summaries completed prior to discharge from inpatients. * Implementation and use of HCS and HealthOne * Increased investment into primary and community care * Service user registration with a PHO (A KPI) * Wait times (C&Y KPI)
One Team	* Strengthen community response by co-location of Marlborough, Nelson and Tasman * Psychologist based in primary care. * Community Assessment & Treatment based in Emergency department in after hours	* Metabolic monitoring. * Rapid re-access to specialist services if required. * Integrated community care pathways * Capability building in primary care nursing workforce * Primary Care Liaison and interface roles * Housing and acommodaiton coordination	* Stepped care model supporting acute response and early intervention for mild, moderate & severe presentations. * Assertive primary care engagement with clients discharged from specialist services * Workforce training and education programme to include the peer support workforce * Community based group work e.g. Refugee support, yoga classes * Have an effective housing and employment response	* Integrated team - whole of system, whole of workforce * Strong cross-sector partnership support one team * Housing and employment options to suit need * Access to budgeting support * First contact with services takes a wellness approach	* Improved system for people on metabolic monitoring * Number of referrals for individuals from Primary Care following access to PMHI * MH inclusion in organisation-wide projects/programmes e.g. Hospital re-development * Pre-admission rate community care (A KPI) * Post-discharge community care (A KPI) * NGO services investment - (C&Y and A KPI) * Employment status (A KPI) * Housing status (A KPI)
Culture	* Implement least restrictive practices, positive behaviour support and trauma informed care. * Recognise importance of employment as a essential aspect to recovery * Clients with High and Complex Needs are a DHB responsibility	* Focus on recovery and independence. * Increasing access to respite * Recognise Mental health in priamry care within the broader model of care and resources for people with Chronic Conditions * Ensure employment support is identified and within care plan * High and Complex Needs Specialty Nurse in place	*Family/whānau involvement and engagement. *Develop a unified Wellness Plan shared across all team members - Te Whare Tapa Wha * Implementation and support for mental health consumer reference group * Employment support services strongly engaged with clinical teams * High and complex Care - Multi service team pathway	*Support independence in housing, training and employment. * Integrated model for employment support	* Reporting set for seclusion, restraint and safe injury. * Increased levels of planned respite * Reduced level of crisis respite * Seclusion rate (A KPI) * Total staff turn over (KPI - A & C&Y) * Total hones score (KPI) * 28 day acute inpatient re-admission rate (A KPI) * Community 90 day re-referral rate (C&Y KPI)
Quality	* Workforce training and education - mandatory and service specific core competencies delivered. * Key Performance Indicators * Co-design of integration solutions * Minimised workplace aggression * Health and safety compliance	*Quality framework articulated. * Safety training and procedures implemented across system. * Relevant data collected and fed back to clinical teams. * Guidelines for sharing information developed across team members * Recognise and support risk identification and management strategies	* Embedding and mentoring post training and learning * Key Quality Indicators developed and used across all services and organisations KQI = KPI (Key Performance Indicator)+ KOI (Key Outcome Indicator). * Pharmacists role embraced to support high quality prescribing and medication reviews	* Quality focus on the person and whānau. * System improvements result from serious and adverse events and consumer experience * Top of scope working * High functioning system for complaints and incident reviews in line with Clinical Governacne Group (CGG) processes * Pharmacy embraced within Multidisciplinary Team (MDT)	* Align with HQSC MH & A Quality Framework * Data is used to inform service development * Mandatory training and core skills for specific services determined * Time to first face to face contact (C&Y KPI) * Av length of acute inpatient stay (A KPI) * Av length residential rehabilitation facility stay (A KPI) * Residential occupancy (A KPI)