Waitematā
District Health Board

Best Care for Everyone

SPECIALIST MENTAL HEALTH AND ADDICTION SERVICES
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14 March 2022

[redacted]

Via email: [redacted]

Dear [redacted]

Re: OIA request – Mental health vacancies over past three years and COVID-19 impacts

Thank you for your Official Information Act request, received 27 January 2022, seeking information from Waitematā District Health Board (DHB) about Specialist Mental Health and Addictions Service (SMHAS) vacancies and the impact of COVID-19 on the service.

On 18 February, we contacted you to advise that as our clinicians, managers and staff were concentrating on measures to manage the current COVID-19 outbreak in the region, we had limited capacity to respond to some OIA requests and needed to extend the timeframe for providing a response to your request until 10 March.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In response to your request, we are able to provide the following information:

1. **Data showing the total population covered by the DHB's mental health and addiction services at the end of December 2021.**

Waitematā DHB's SMHAS provide care to the people in our district, across the Waitakere, North Shore and Rodney areas.

In addition, Waitematā DHB is responsible for delivering two services on behalf of other DHBs:

i. Community Alcohol and Drug Services (CADS) provide addiction services across the populations of the three metropolitan Auckland DHBs (Counties Manukau, Waitematā and Auckland) – serving a total population of approximately 1,739,790 people.
ii. Regional Forensic Psychiatry Services that delivers services to the five prisons within the Northern Region DHBs' districts (Northland, Counties Manukau, Waitematā and Auckland) and to the Courts within the northern region, as well as eight inpatient villas and a regional medium secure intellectual disability unit and liaison service – serving a total population of 1,937,720 people.

2. Data showing the total number of full-time staff employed by the DHB's mental health services in each of the last three years to the end of December 2021, particularly the number of psychiatrists, psychologists and nurses.

Please note that the figures provided below are the number of permanent roles for both part-time and full-time staff. A full-time staff member is defined as someone who works 40 hours per week. A number of staff employed by the service work part-time (less than 40 hours per week). Given this, for completeness, information on the number of full-time and part-time staff employed by the service has been provided.

Discipline	Staff employed in general mental health, CADS and Forensic Psychiatry (n)								
	2019			2020			2021		
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total
Nurses	389	94	483	409	108	517	432	100	532
Psychology	26	44	70	27	41	68	26	41	67
Psychiatry	47	46	93	49	54	103	50	55	105
Other[1]	508	166	674	525	169	694	515	168	683

[1] Other includes allied health staff (i.e. occupational therapists and social workers), administrators and support roles.

3. A breakdown for each of the past three years to December 2021 showing the number of full-time psychiatrists, psychologists and nurses employed in each of your mental health and addiction services (e.g. alcohol and drug, child and youth, community, inpatient units etc).

The attached table details the number of psychiatrists, psychologists and nurses employed by the DHB's Specialist Mental Health and Addiction services by service type.

Again, for completeness, information on the number of full-time and part-time staff has been provided – please see **Appendix 1**.

4. Data showing the number of vacancies for psychiatrists, psychologists and nurses in each of those three years to December 2021, broken down by teams.

Waitematā DHB provides the largest mental health and addiction service in New Zealand, employing over 1,300 staff. Like any large service, at any given time, despite a proactive recruitment programme, there will be vacancies due to usual (projected) turnover.

However, there are challenges with recruiting some disciplines (e.g. clinical psychologists) and some staff with specific clinical experience and expertise (e.g. in child and adolescent mental health). These challenges are not unique to Waitematā DHB and are experienced by DHBs across the country.

The table below shows the number of vacancies for psychiatrists, psychologists and nurses broken down by service. Please note, the vacancy data is provided by full-time equivalent[2], so includes both full-time and part-time vacancies.

Of further note, in some areas, there has been additional investment (e.g. adult acute mental health inpatient units). As a result, although it appears that the number of vacancies has increased, this is because new roles have been created, which are currently being recruited to.

[2] 1.00 full time equivalent = 40 hours per week

Number of vacancies for psychiatrists, psychologists and nurses from 2019 to December 2021 broken down by teams				
Service	**Discipline**	**Vacancies (n)**		
		2019	**2020**	**2021**
Adult Community Services	Nurses	12.30	5.30	24.00
	Psychologists	3.70	2.40	1.10
	Psychiatrists	3.90	3.00	1.50
Acute Adult Inpatient Units	Nurses	4.40	0.00	6.90
	Psychologists	0.90	2.00	0
	Psychiatrists	1.00	3.60	1.00
Child and Youth Services	Nurses	5.40	3.60	9.40
	Psychologists	2.20	0	3.00
	Psychiatrists	3.10	3.50	1.50
CADS (Alcohol and Drug Service)	Nurses	2.20	2.00	5.80
	Psychologists	0.80	0	1.10
	Psychiatrists	1.50	0	0.20
Forensics (Mason Clinic)	Nurses	9.80	17.30	3.90
	Psychologists	0.30	1.00	1.00
	Psychiatrists	1.00	2.00	2.80
Whitiki Maurea	Nurses	0.20	1.00	3.80
	Psychologists	0	0	0
	Psychiatrists	0.40	0	0.40
Takanga A Fohe	Nurses	1.00	1.00	0
	Psychologists	0	0	0
	Psychiatrists	0	0	0
Mental Health Management	Nurses	0	0	2.00
	Psychologists	0	0	0
	Psychiatrists	0	0	0

5. Data showing the number of psychiatrists, psychologists, and nurses who left the DHB's mental health and addiction services in each of those three years to December 2021, broken down by teams.

Like any large organisation, Waitematā DHB experiences and anticipates staff turnover each year. Staff may resign from their role for a number of reasons, including: retirement; family/personal reasons; new work opportunities or moving out of Auckland.

Average turnover for staff working in Specialist Mental Health and Addiction Services over the last 12 months was 9.5% (this excludes staff who retired or moved internally within the service). This is consistent with the organisation's expectation of a 10% turnover rate.

The table below shows the number of psychiatrists, psychologists and nurses who left Specialist Mental Health and Addiction Services in the past three years, broken down by service. Please note, the information provided is by head count, not full-time equivalent staff member, so staff may have worked part-time or full-time.

Staff resignations in general mental health, CADS and Forensic Psychiatry (n)				
Service	**Discipline**	**Resignations (n)**		
		2019	**2020**	**2021**
Adult Community Services	Nurses	13	12	13
	Psychologists	4	5	3
	Psychiatrists	4	1	1
Acute Adult Inpatient Units	Nurses	10	5	12
	Psychologists			1
	Psychiatrists			1
Child and Youth Services	Nurses	6	2	5
	Psychologists	3	4	6
	Psychiatrists	2		
CADS (alcohol and drug service)	Nurses	2	4	9
	Psychologists		1	
	Psychiatrists		3	
Forensics (Mason Clinic)	Nurses	16	8	14
	Psychologists	1	3	1
	Psychiatrists	1	1	1
Whitiki Maurea	Nurses			3
	Psychologists			
	Psychiatrists			
Takanga A Fohe	Nurses			
	Psychologists			
	Psychiatrists			
Mental Health Management	Nurses	1	3	2
	Psychologists	1		
	Psychiatrists	1		

6. **Details of what regular updates are received by the mental health and addiction service's senior leadership on workforce and/or recruitment (for example, do they have access to a dashboard of key metrics that provides data in real time; do they receive weekly or monthly written reports; which key metrics do they track). If applicable, please provide copies of the three most-recent updates**.

Leaders and managers at Waitematā DHB have access to a human resources reporting system, which provides monthly information (at an organisational, divisional, service and team level). Metrics include:

- Current employ
- Headcount
- New starts
- Leavers
- Vacancies
- Turnover
- Length of service
- Annual leave
- Overtime
- Sick leave
- Certifications and registrations
- Mandatory training.

More detailed reporting is available on recruitment, allowances paid, leave management and vacancies. Analytical support is also available for specific information requests.

Real-time data is available in a reporting application (QlikSense), which provides access to data across multiple datasets and systems (i.e. payroll).

Waitematā DHB has a range of human resources-related key performance indicators (KPIs), which are reported against regularly. At a service level, Specialist Mental Health and Addiction Services has reported to the DHB's Community and Public Health Advisory Committee (CPHAC) and provides information on any KPIs that are not achieved or are off-track from the DHB's target. KPIs currently tracked are on the Specialist Mental Health and Addictions scorecard are:

1. Sick leave rate
2. Turnover rate – external
3. Vacancies (%).

From the Specialist Mental Health and Addictions' last three reports to CPHAC, the relevant updates relating to leadership on workforce and/or recruitment is from the May 2021 report as follows:

> ***Staffing***
> There continues to be challenges in recruiting registered nurses to the Adult North Community Acute team. The core function of this part of the service is to provide crisis and acute care for people. At present, there are five full time equivalent (FTE) vacancies. The service is using casual staff and overtime to fill service gaps. A plan has been developed, in partnership with staff and the union, to ensure staff are supported and service delivery is maintained. This includes the provision of increased operational support for the team, enhanced coaching for new clinicians and the introduction of mental health care assistants. An active recruitment strategy is also in place. The plan is being closely monitored to ensure that it is addressing the key issues and weekly updates are being provided to the leadership team on progress.

7. Copies of key documents held by senior management created in the last two years that were substantially about the challenges in recruitment and/or the impact of staffing pressures on services.

The term "key documents" has been interpreted as being any documentation that was presented to the DHB's Executive Leadership Team or to the Board and its sub-committees. "Substantially about" has been interpreted as being one of the key topics or the sole topic of the paper or report.

The following key documents contained information on the challenges in recruitment and/or the impact of staffing pressures on the services and are attached for your reference:

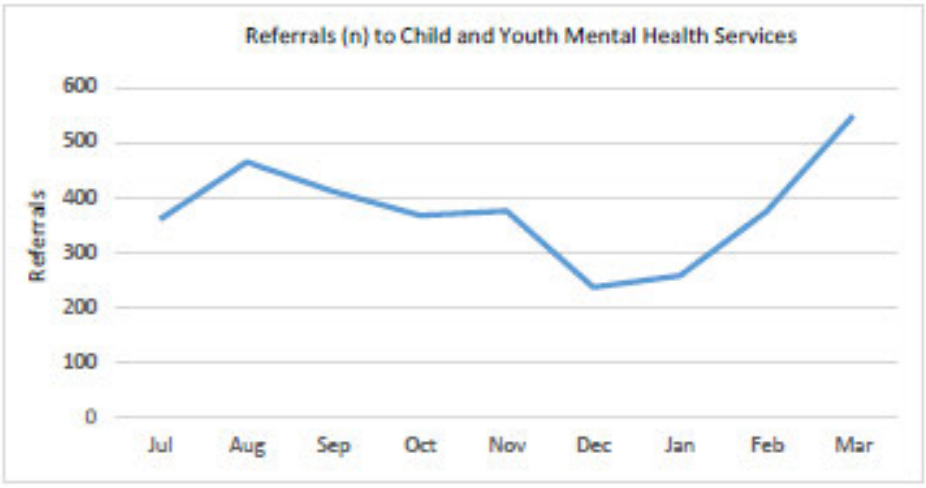
Year	Prepared for	Name of paper
2020	DHB Board	▪ Extracts from: Recommendation paper to Board, publicly excluded, September 2020 **- Appendix 2**
	Hospital Advisory Committee (HAC)	▪ Specialist Mental Health and Addiction HAC Report July 2020 – published online at https://www.waitematadhb.govt.nz/assets/Documents/board/2020/HAC-July-2020-Open-Agenda.pdf
2021	DHB Board	▪ Extracts from: Improving Adult Acute Mental Health Patient Flow, Outcomes and Experience, publicly excluded, April 2021 - **Appendix 3** ▪ Extracts from: Update on Adult Mental Health Inpatient Unit Improvement Activities, publicly excluded, July 2021 - **Appendix 4**
	Waitematā DHB Executive Leadership Team	▪ **Appendix 3** – see above. ▪ Extract from: Executive Leadership Team (ELT) Mental Health and Addictions Strategic Workshop Presentation, October 2021 - **Appendix 5** ▪ Extracts from: Follow Up from the Executive Leadership Team Mental Health and Addictions Strategic Workshop, November 2021 - **Appendix 6** ▪ Extracts from: Adult Acute Psychiatric Inpatient Units: A Seven-Day a Week Resilient Service, December 2021 - **Appendix 7** ▪ Extracts from: Provision of Acute Mental Health Care within the Emergency Unit, December 2021 - **Appendix 8**

8. Copies of key documents held by senior management created in the last two years that were substantially about the state of or challenges in CAMHS services.

Challenges recruiting into the Child and Adolescent Mental Health services were detailed in the Specialist Mental Health and Addictions report to CPHAC in May 2021 as follows:

Increased demand for Child and Youth Mental Health Services

The Child and Youth Mental Health Services continue to see an increase in referral numbers. Data over the last four years indicates growth year-on-year from approximately 4,200 referrals in 2016 to 5,200 in 2020 (a 24% increase in the referral rate). This increase in demand is demonstrated in the graph below, which details the number of referrals received by the service this calendar year.



Graph 1. Referrals received per month by Child and Youth Mental Health Services, July 2021 – March 2021

The service is currently undertaking a detailed review of referral trends, with the initial analysis indicating that since the outbreak of COVID-19 in 2020, there has been an increase in young people presenting with anxiety and school refusal. In addition, higher levels of acuity and complexity are anecdotally reported by clinicians with young people seen with psychosis, as well as serious self-harm and suicidal ideation.

The service is refining referral processes and the entry pathway to ensure the most efficient approaches are being used. Consultation across the region, indicates that other child and youth services are experiencing a similar increases in referrals and are also struggling to respond to demand.

9. Copies of key documents held by senior management created in the last two years that were substantially about the impact of the Covid-19 pandemic on your mental health and addiction services.

Key documents that detail the impact of the COVID-19 pandemic on mental health and addiction service are detailed in the division's report to the DHB's Community and Public Health Advisory Committee in November 2021 as follows (see next page):

Key Issue
Impact of COVID-19 on mental health and wellbeing
There is growing international evidence that the pandemic, and measures to contain it, are negatively impacting on people's mental health and wellbeing. There is also considerable risk that these impacts are on-going and enduring, even when restrictions are lifted.

This will increase demand for mental health and addiction services, including from those who would not usually require support from specialist services.

Over the last few months, services have also seen an increase in acuity and complexity of people presenting for care. Some of the factors thought to be contributing to this are: social isolation, reduced ability of services (including community and primary care services) to provide face-to-face care, the quality of illicit substances, and delayed presentation for care.

People with severe mental illness (such as Schizophrenia) are at increased risk of infection and more severe complications, including higher mortality. This may partially be in relation to a higher rate of vaccine hesitancy for people with serious mental illness. Historically, the uptake of similar vaccines, such as the influenza vaccine, in tāngata whai i te ora can be as low as 25%. As of the start of November, the rates of adults who are fully vaccinated across the various components of SMHAS range from around 50% to 70%, with just one or two outlier teams with much lower or higher rates.

SMHAS are monitoring demand for service to identify any particular trends and/or themes and a number of initiatives have been instituted to improve efficiency across the Division and reduce barriers to care. The service is also working closely with the other Metro Auckland DHBs and participating in the development of the Metro Auckland psychosocial response programme.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

[redacted]

Director Specialist Mental Health & Addictions Services
Waitematā District Health Board

Appendix 1

Number of psychiatrists, psychologists, and nurses employed in Specialist Mental Health and Addiction Services by team, for the past three years to December 2021										
Service	**Discipline**	**2019**			**2020**			**2021**		
		Full-time	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**
Adult Community Services	Nurses	85	25	110	85	28	113	84	33	117
	Psychologists	3	20	23	5	18	23	7	17	24
	Psychiatrists	11	17	28	15	18	33	14	18	32
Adult Inpatient Units (He Puna Waiora /Waiatarau)	Nurses	59	24	83	69	22	91	78	18	86
	Psychologists	0	2	2	0	1	1	2	2	4
	Psychiatrists	6	0	6	6	0	6	6	1	7
Child and Youth Services	Nurses	18	8	26	16	10	26	17	9	26
	Psychologists	11	9	20	9	9	18	8	8	16
	Psychiatrists	2	9	11	2	9	11	4	9	13
CADS (Alcohol and Drug Service)	Nurses	24	14	38	28	16	44	29	14	43
	Psychologists	2	3	5	2	5	7	1	4	5
	Psychiatrists	9	9	18	9	10	19	9	9	18
Forensics (Mason Clinic)	Nurses	180	14	194	190	18	208	206	15	221
	Psychologists	8	7	15	9	6	15	7	6	13
	Psychiatrists	13	7	20	12	8	20	12	8	20
Whitiki Maurea	Nurses	8	2	10	8	2	10	4	3	7
	Psychologists	1	0	1	1	0	1	1	0	1
	Psychiatrists	2	1	3	1	3	4	2	2	4
Takanga A Fohe	Nurses	4	0	4	4	1	5	6	0	6
	Psychologists	1	0	1	1	1	2	0	2	2
	Psychiatrists	2	1	3	2	1	3	2	1	3
Mental Health Management	Nurses	12	4	16	12	5	17	10	3	13
	Psychologists	0	0	0	0	1	1	0	1	1
	Psychiatrists	2	2	2	2	5	7	1	7	8
Total:		***463***	***178***	***641***	***488***	***197***	***685***	***510***	***190***	***700***

Appendix 2

Extracts from: Recommendation paper to Board, publicly excluded, September 2020

Project group	Recommendation and source (AE number or other source)	Activities	Status
Model of care workstream	**250349** - Bed demand and bed capacity management process to be reviewed.	• Established new role for 1FTE bed coordinator, this role started in the service in early 2020.	• Completed
		• Develop proposal for peer support to go to Funding and Planning	• Planning • This will be the subject of a Business Case in the first quarter of 2021
	258333 - Ensure the availability of Peer Support Workers 7/7 in the Inpatient Unit so that it is possible to offer this resource to each service user on or soon after admission **250349** - Create capacity to have Peer Support Workers available 7 days a week to assist with the orientation of Service Users during admission **250349** - Peer Support Workers are in an ideal position to offer narrative interventions and PSW should be available 7 days a week on the inpatient unit		• Planning • Component of the point above
Cover model working group	**258333** - Service Clinical Director to job size SMO roles in the Inpatient Unit based on expected roles and responsibilities as defined by the Model of Care	• Job size • Liaise with finance re any identified shortfalls	• Job sizing completed • Small shortfall at HPW to be reviewed with Finance • This will require a Business Case to ELT early in 20201
	253830 - Review FTE volumes in inpatient unit	• Complete cover model and write required business cases for up to 10 FTE Registered Nurses and Mental Health Care Assistants and 1FTE SMO	• One final meeting pending with unions, then

			business case can be submitted • This is part of the Business Case which the Board are reviewing today. But the cost of the Cover Model will be a separate Business Case.
Model of care - Length of stay working group		• Business Case planned for 12-24 months for a Specialist Rehabilitation Coordinator for long stay in-patients with complex needs	• n/a at this stage
Psychology review	**253830** - Review of current specialist provision for people with identified personality disorders across the Waitematā DHB services **258333** - Ensure there is adequate Psychology FTE in Waiatarau to enable all Service Users to have an initial Psychology assessment to generate a full psychosocial formulation, to identify and provide therapeutic interventions as indicated, and to provide in-house support and up-skilling for other clinicians **250349** - Ensure there is adequate	• Review international recommendations relating to Psychology FTE in IPUs and job sizing	• Complete
		• Review psychology model of care and international literature for psychology models in inpatient units	• In progress • Completion by November 2020
		• Review of current psychology structure across IPU and community to address the issue of recruitment, retention and specialty skills and write business	• In progress • Business Case will be developed first quarter

Project group	Recommendation and source (AE number or other source)	Activities	Status
	Psychology FTE in HPW to enable all Service Users to have an initial diagnostic Psychology assessment to identify and provide appropriate interventions as indicated, and to provide in-house support and up-skilling for other clinicians	case to increase Psychology resources	of 2021
		• Business case to Increase psychology FTE	• Awaiting completion of review
		• Undertake a review of current psychology functions in the IPUs and identify any functions to improve or increase	• Completed
Adult mental health leadership	**250349** Staff to work shifts at Piri Pono as in-service opportunities	• Plan in-service and staff swaps as able	• At this stage unable to complete due to limited availability of staff to cover shifts

Appendix 1 - Planned business cases for Adult Mental Health Services as at July 2020

Business cases to be submitted:
Imminent (within 3 months): • Capex business case for works to eliminate or mitigate residual ligature risk points **Short term (3-6 months):** • Cover model - up to 10FTE RN and mental health care assistants • SMO - 1FTE - to support job sizing • Clinical Psychologists - 2 FTE - for inpatient units • Clinical specialist - 1 FTE - to provide coordination for people with comorbid neurological disorders **Medium Term (6-12 months):** • Clinical coordinators - 6FTE - to provide clinical leadership in community mental health teams • Coordinator for talking therapies provision - 1FTE • Inpatient Clinical Nurse Educators - 2FTE • Inpatient family/whānau liaison role (person with lived experience) - 1FTE • Inpatient Social Workers - 2FTE • Increase in beds for IPU (x5 over the next 12-24 months) • Alarm systems in IPU **Long term (12-24 months):** • Specialist Rehabilitation Coordinator for long stay inpatients and complex needs community recovery team clients - 1FTE Adult Mental Health expects to collaborate on business cases for: • Peer support within Inpatient Unit – if initiated by Funding and Planning • Acute alternative to admission in west Auckland (Peer Led and/or Kaupapa Māori) – if initiated by Funding and Planning • Mobile technology, equipment and infrastructure for NZEWS and electronic Therapeutic Observations implementation – with health Alliance and i3

Appendix 3

Extracts from: Improving Adult Acute Mental Health Patient Flow, Outcomes and Experience (publicly excluded, April 2021)

Recommendations:

That the Board:

(a) Notes demand for acute mental health care has grown significantly over the lastfive years, which is consistent with both national and international experience.

(b) Notes there is insufficient acute mental health bed capacity and a lack of dedicated mental health staff within the North Shore Emergency Department, which is impacting on patient flow, outcomes and experience.

(c) Notes work has commenced on developing a model of psychiatric care within the Emergency Department, to ensure flow through the department. This includes the provision of 24-hour per day, seven days a week dedicated nursing support in the Departments.

(d) Notes the complementary aspects with respect to the previous approval for investment in both a regional 10 bed facility and Packages of Care at the 10th March 2021 Board meeting to help address demand on the inpatient units.

(e) Approves the allocation of $ per annum to commission four 'step down'intensive care beds at He Puna Waiora.

(f) Approves, in principle, an indicative allocation of $ to implement an expanded Emergency Department mental health staffing model across both Hospitals. Noting, confirmation of the total investment required will be determined once the model of care has been completed.

(g) Notes this investment if approved would the first call on the 'ring fence' uplift for2021/22.

(h) Notes these investments form closely linked components of a programme of work that is currently underway to improve adult acute mental health flow, outcomes and experience

(i) Notes the Specialist Mental Health and Addictions Service and Funder are working collaboratively to develop a staged plan to grow the bed-based capacity of the adult mental health services through to 2030.

Prepared by: Stephanie Doe (General Manager, Specialist Mental Health and Addiction Services) and Dr Murray Patton (Director, Specialist Mental Health and Addiction Services)
Endorsed by: Tim Wood (Interim Executive Director, Tier One Community Services)

1.Glossary

DHB District Health Board
ED Emergency Department
FTE Full time equivalent
He Puna Waiora Acute adult inpatient mental health unit (North Shore Hospital campus) ICU Intensive Care Unit

NSH North Shore Hospital

Special observations Increased oversight of people during the process of assessment and treatment (commonly, in the ED setting, being a 'watch' – a staff member assigned to sit with a person for the purpose of maintaining safety)

Step down ICU bed Beds for patients who require continued close support and observation by staff, but do not require the restrictiveness of a locked intensive care environment.
Waiatarau Acute adult inpatient mental health unit (Waitakere Hospital campus)

2. Executive Summary

This paper outlines two proposals that will support the acute adult mental health patient flow, outcomes and experience.
Over the last five years, there has been a more than 60% growth in the number of patients presenting to the North Shore Hospital (NSH) Emergency Department (ED) with acute mental health concerns. This has placed pressure on existing resources and has created issues with patient flow, outcomes and experience.
There are several programmes of work looking at management of demand on the IPU. This paper covers two of these. Other elements include the business case, approved by the Board on March 10th, on intensive community solution for high user of inpatient units. This case was for a mix of community residential beds and packages of care to improve flow, for some of the long stay patients in particular, from the inpatient unit to a community setting. This case compliments these initiatives by improving capacity in the inpatient units and improving flow form the high need wards to usual care wards and addressing inappropriately long wait times of people presenting to the emergency department in need of an inpatient placement. These initiatives are all designed to improve the experience of patients needing a stay in the inpatient unit and to move them in to community settings in a clinically appropriate manner.

Based on its current population, Waitematā District Health Board (DHB) has a shortfall of 37 acute mental health beds. The greatest area of pressure is for beds within the Intensive Care Unit (ICU). The inability to admit an acutely unwell patient to an appropriate environment creates clinical risk and is suboptimal for both the patient and staff. Furthermore, it is resulting in the need to discharge patients back to the community before they are clinically ready. As a result, the 28-day readmission rate across the DHB is much higher than the national target.
At present there are different models operating for the provision of acute mental health assessments and support across the two ED's. In contrast to Waitakere Hospital, NSH does not have 24-hour, seven-day a week dedicated mental health nursing for the ED. Mental health assessment and treatment commencement at NSH ED is provided either by the Mental Health Liaison team (who provide mental health support across the entire hospital site) or by the Community Mental Health team (who also provide assessments and follow-up care to acutely unwell patients in the community). This creates delays for patients to be assessed within the ED, which compromises patient care and staff safety.
It is proposed that investment is provided to operationalise two key initiatives:
1. Commissioning of four 'step down' intensive care beds at He Puna Waiora; and
2. Expansion of the Mental Health Liaison team to enable provision of 24-hour per day, seven-day a week dedicated support to the North Shore Hospital (NSH) ED.

These proposals will improve the provision of timely mental health assessments to people who present acutely to the NSH ED and reduce the wait times associated with making an acute inpatient mental health bed available. Together, the enhancements will improve patient flow, reduce pressure on the ED and increase capacity within the acute inpatient mental health service.
A project group has been convened, with representatives from the ED, Mental Health Services and the Institute of Innovation and Improvement, to review and define the model of psychiatric care within the ED. The investment required to implement proposed changes will be determined at the completion of the project. A further paper will be submitted for the Board's consideration at this time.
Of note, these initiatives are two components of a programme of work that is currently underway to improve patient flow, outcomes and experience.

3. Strategic Alignment

Community, whanau and patient centred model of care	Initiatives place additional resource in areas that will improve timeliness of care and improve patient experience and outcomes.
Emphasis and investment on both treatment and keeping people healthy	Initiatives aim to improve the provision of timely mental health assessments of people presenting to the NSH ED and reduce the wait times for an acute inpatient mental health bed.
Evidence informed decision making and practice	Proposed expansion of Mental Health Liaison team is based on experience and success of a similar service within the Waitakere Hospital ED.
Operational and financial sustainability	Reducing the length of stay in the ED and ensuring timely admission to an appropriate inpatient environment will reduce the need to provide 1:1 staff support.

4. Introduction/Background

As demonstrated in the table (Figure 1) below, over the last five years there has been significant growth in the number of patients presenting to the North Shore Emergency Department (ED) with acute mental health concerns[1].

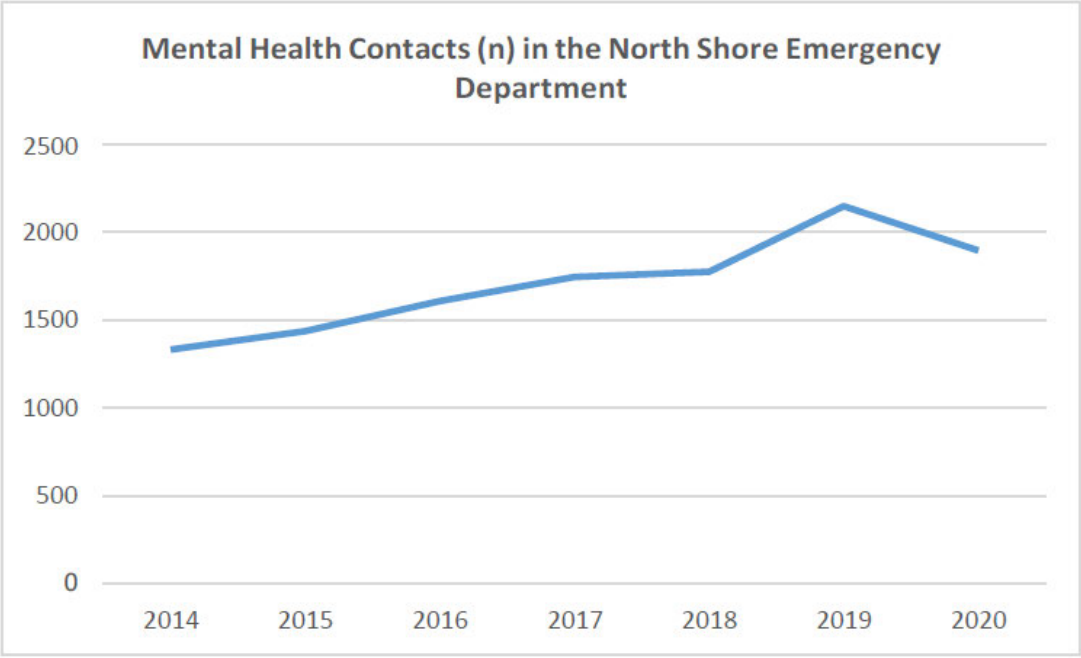


Figure 1. Mental Health ED contacts by calendar year at NSH

Complexity and acuity have also increased. This has placed pressure on the resources in place and has created issues with patient flow, in that there can be delays in patients receiving acute mental health assessments and extended wait times (up to three days), before those who require an acute mental health bed are transferred out of the ED. The ED is not an appropriate environment to provide care to people who are acutely unwell; so extended stays can delay the commencement of treatment, compromise patient and staff safety and lead to poor patient and whānau experience, as well as place undue stress on staff working within the department.
There are two primary constraints that have been identified that are impacting on patient flow. These are:

2. The availability of dedicated mental health staff in the NSH ED

Availability of dedicated mental health staff in the NSH ED
At present there are different models operating for the provision of acute mental health assessment and support in each of the ED's. At North Shore ED, an in-reach mental health service is provided by the Mental Health Liaison team and the community mental health services. Assessments are decided based on the patient's presentation:

- Liaison sees patients who present with self-harm or a primary medical presentation, along with secondary mental health concerns.
- The Community team sees patients presenting with acute primary mental health concerns. The Liaison team provides mental health support to all inpatient areas across the hospital and does not have dedicated staff for ED.

The community teams are based off the NSH site and cover a large geographical area, stretching across the entire North Shore and Rodney catchment. Staff need to prioritise attendance at the ED against other work priorities, including assessing acutely unwell patients in their homes and providing follow-up acute community care. Assessments can also be delayed if staff are required to travel onto the hospital site from more rural areas within the catchment.

In contrast, due to the increasing demand for mental health services at Waitakere Hospital, in 2015 additional resourcing was approved to provide dedicated mental health nurses in the ED which provides cover from 0800am to 1130pm, seven days a week. An additional psychiatric registrar was also provided, which enabled the nurses to immediately access medical intervention and treatment when required.

As demonstrated in the graph (Figure 3) below, there is greater demand for acute mental health assessments in the NSH ED than at Waitakere. The lack of dedicated mental health staff within the department appears to be a significant contributor to longer stays in the ED. These delays also prevent timely assessment and treatment commencement, thus compromising patient care.

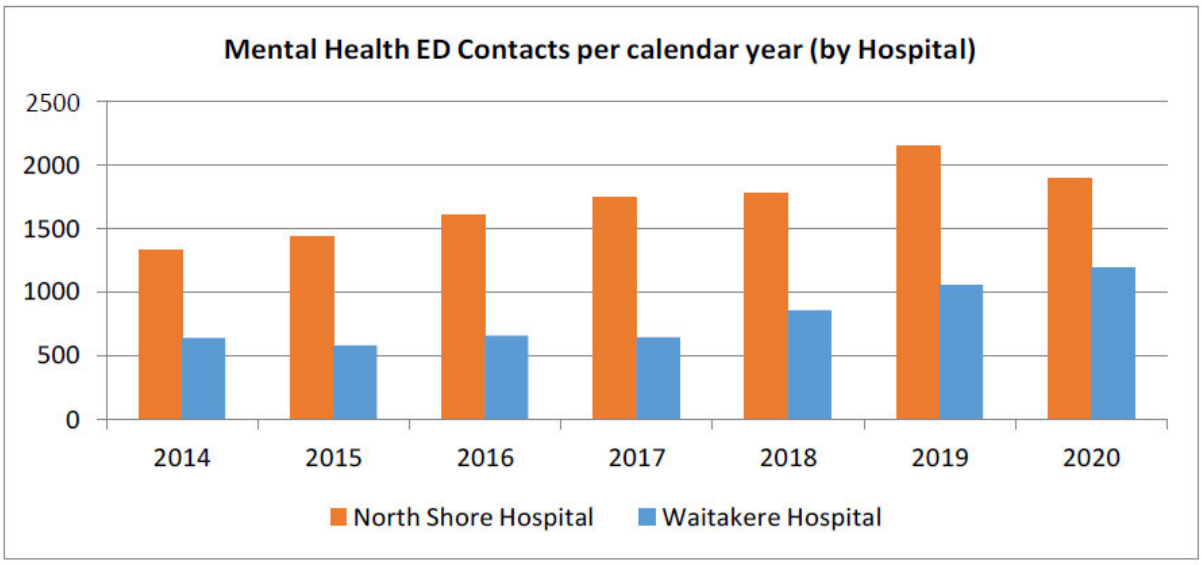


Figure 3. Mental Health ED contacts by calendar year, by Hospital

The service has explored options to redeploy existing community to staff to work from the ED, but this would lead to a reduction of acute and crisis work occurring in the community and increase the number of presentations to the ED. As a result, this has been discounted.

5. Risks/Issues

The risks and issues are identified in the table below:

Risk/Issue	Mitigation
Unable to recruit staff to operationalise initiatives.	Develop and implement targeted recruitment strategy. Continue work on initiatives that aim to improve staff experience (thus aiding retention).
Reduced incentive to provide more timely disposition as a result of having more staff to provide care within an ED setting.	Work has started to design the pathway to ensure flow through ED, into an expanded number of inpatient places.

6. Approach

It is proposed that investment in two key initiatives is made to address the issue of patients being in ED unduly and to improve 28-day readmission rates. These are:

1. **Commission four 'step down' intensive care beds in He Puna Waiora**

It is proposed that the staffing ratios in place within the step down ICU area are aligned with those in the ICU. Specifically, there will be one registered nurse and one mental health care assistant for four patients. This level of staffing is required to ensure that appropriate oversight and support can be provided within a less restrictive (unlocked) environment.
The identified benefits of the initiative include:

- Potential to reduce the use and cost of one-to-one special observations, both in the inpatient and ED settings. At present, patients awaiting assessment or for an acute mental health bed can require one-to-one observation to maintain their (or others) safety within the ED environment. Reducing wait times for assessment and transfer to an acute bed will reduce the need for additional staff to undertake special observations.

2. Expansion of the mental health liaison team at NSH.
Work is currently underway, in partnership with the ED leadership team, to review and define the model of psychiatric care within the Emergency Department, to ensure flow is maintained and patient outcomes and experience is maximised. The intention is to ensure that both EDs have dedicated mental health support 24-hours a day, seven days a week. This will improve the timeliness of the provision of mental health assessment and decision making, thereby enhancing the quality and experience of people presenting to acutely to the ED.
The functions to be carried out by the mental health staff include: clinical leadership of the ED Mental Health Team, provision of supervision, advice and oversight to other staff and initiation of early prescribing[3].

7. Costs/Resources/Funding

The indicative cost of commissioning four 'step down' intensive care beds is detailed in the table below:

Component Personnel	FTE
Registered nurses	5.78
Mental health care assistants	5.72
Medical officer	0.40
Social worker	0.25
Occupational therapist	0.25

Appendix 4

Extracts from: Update on Adult Mental Health Inpatient Unit Improvement Activities, publicly excluded, July 2021

Change Management Programme

Given the size of the programme of work, a senior staff member has been seconded into a full-time programme management role. Priority work within the scope of the role includes the development of:

Development of a 'resilient 7-day acute service'. This aims to describe the components (including increased senior nursing and allied health staffing) and systems of care to enable provision of acute care and improve flow through the unit across the full week.

Current staffing numbers of just two full time equivalent staff across both inpatient settings are insufficient to ensure that the role of these staff in facilitating other cultural processes for Maori within the inpatient settings (including morning karakia, whanau hui, contributing to individual and group programmes, and liaison with wider community) is able to be performed as well as being available to assist with welcomes across day and evening hours, seven days per week. A proposal for the additional staffing required for these activities for Maori is currently near completion.

Leadership

Work has commenced on strengthening the leadership structure across the inpatient services. A Lead clinician role for the services has been developed. The person appointed is a SMO, whose role spans both units, to assist with medical leadership and consistency of practice across both settings. This role has been developed using reconfigured existing funding.

A new permanent Charge Nurse Manager (CNM) [paragraph redacted]
Additional funding has been allocated to enable both units to have an associate clinical charge nurse (ACCN) on shift, 0700 – 2300hrs, seven days a week and the overnight shift coordinators are now supernumerary. These ACCN roles provide an important function in providing clinical leadership and guidance to the inpatient nursing team at times of peak activity in these units, during daytime and afternoon shifts. The night shift coordinators provide a similar leadership role date has been constrained by the requirement that they are part of the core staffing numbers on each shift whilst also responding to calls from referrers and the wider community and coordinating responses to these calls.

Resourcing

A number of additional staffing positions have been agreed and funded, including:

- Clinical psychology – an additional 2.00fte have been allocated to each unit
- Senior nursing – as stated above, ACCNs will now be available to provide nursing leadership and co-ordination across all day and afternoon shifts, seven days per week (an additional 3.14fte approved)

- Supernumerary shift coordinators are being rostered on overnight in order to support as 'on the floor' rostered staff (an additional 3.88fte approved)
- Medical leadership – a 0.60fte medical lead role has been allocated to provide oversight and leadership across the two inpatient units
- In-principle support to increase dedicated mental health staffing in the Emergency Departments at North Shore and Waitakere hospitals (subject to the ED Model of care work) has been provided by the Board. A business case is being developed for this.

A review of the base nursing staff required to reliably meet roster demands (when annual leave, sick leave and mandatory training is taken into account) has been completed, in partnership with staff and the union, for both units. This demonstrated that there was insufficient staff in the budget to meet the roster requirements. This has been addressed by redistributing existing resource and both units now have sufficient staff budgeted. However, this increase has resulted in a vacancy gap in staffing pending recruitment to these additional positions.

Work is also underway with progressing the Care Capacity Demand Management (CCDM) framework. This will ensure that the base staffing is sufficient to meet acuity demands. It will also provide a standardised mechanism and criteria for escalating concerns with staffing and/or acuity.

7. Conclusion

All of the recommendations highlight issues with meeting the demand and complexity of presenting issues and the quality and continuity of care. The service is consistently working towards the completion of the recommendations. Robust mechanisms are in place to oversee implementation and evaluate the impact of the improvements made.

Performance area	Recommendation	Source + (Recommendation number)	Responsible Group	Activities	Progress June 2021/ Next Steps
Staffing levels					
	Review FTE volumes in inpatient unit	AE 253830 (Rec 932)		Whilst the cover model was completed in 2015 for He Puna Waiora, the staffing model has since changed. Therefore, a revised cover model has been developed for He Puna Waiora and Waiatarau Complete cover model and write required business cases for up to 10 FTE Registered Nurses and Mental Health Care Assistants and 1FTE SMO	Complete.
	A model of primary nursing or at least team nursing should be implemented on the unit. Evidence shows this would provide improved consistent relationships, enhance individual personalised planning and support, and strengthen the MDT collaboration.	HPW Review (Rec 1180)		Primary nursing is the preferred model for nursing identified in the model of care for He Puna Waiora. An options review has identified primary nursing is possible within an expanded FTE and split rosters or an adapted team nursing model is able to function within existing staff levels. In this model tāngata whai I te ora who have stays of longer durations or who have complex needs would be allocated a primary nurse and other tāngata whai I te ora would be allocated to team nursing.	Cover model is complete. Recruitment is underway.
Staff recruitm induction supervisi	The Unit takes action to rebuild staff morale and address the high turnover rate.			Clinical educator appointed and providing training and coaching; second ACCN appointed; increased number of PSA delegates supporting staff; nursing model of care under review. Unit fully recruited as of March 2021	In progress

Recruitment and Retention

Service	Recruitment Cap (FTE)	Current Employ (FTE)	Vacancies	
			FTE	%
Adult Mental Health	421.10	383.80	37.30	8.9%
CADS	208.60	174.80	33.80	16.2%
Forensics	472.40	455.90	16.50	3.5%
SMHAS General Management	72.90	62.50	10.40	14.3%
Whitiki Maurea	52.30	43.10	9.20	17.6%
Takanga A Fohe	39.50	34.90	4.60	11.6%
Child and Youth Mental Health	131.20	112.10	19.10	14.6%
TOTAL	**1,397.90**	**1255.70**	**130.90**	**9.4%**

- Particularly challenging to recruit AOD workers, clinical psychologists, child psychiatrists
- Attracting appropriate skilled and experienced staff also challenging
- Increasingly difficult with the introduction of primary mental health services

Appendix 6

Extracts from: Follow Up from the Executive Leadership Team Mental Health and Addictions Strategic Workshop, November 2021

Follow Up from the Executive Leadership Team Mental Health and Addictions Strategic Workshop

Date: *10 November 2021*

Recommendations:

The recommendations are that the Executive Leadership team:

a) **Approve** the exploration of advanced allied health and nursing roles across the Division to support recruitment and retention and reorienting the service to provision of specialist care — Yes/No

b) **Approve** the over-recruitment of new graduate staff where possible and increase the clinical coaching FTE required to support them accordingly (using vacancy underspend) — Yes/No

d) **Approve** the commencement of a review into the configuration and span of control of team manager across the Division, as well as the configuration and FTE associated with clinical leadership positions. — Yes/No

Glossary

DHB District Health Board
NRA Northern Regional Alliance
SMHAS Specialist Mental Health and Addiction Services
Tāngata whai i te ora People seeking wellness

Key Issues

- *The Division is experiencing significant workforce challenges and has an approximate vacancy rate of 9.5% at any one point of time. There are several factors that are felt to impacting on this, including: the cost of living in Auckland and the growth of community and primary care delivered mental health services.*

Introduction

On 26 October 2021 the Executive Leadership Team participated in a Mental Health and Addiction strategic session. Following this, the Specialist Mental Health and Addictions Service (SMHAS) were

asked to provide a briefing paper, which made recommendations on how best to support SMHAS and address the key issues discussed during the workshop.
This paper outlines the Division's suggested way forward, as well as commenting (as requested) on considerations with the transition of mental health and addiction services and forensic services to Health New Zealand.

Workforce Development

It is proposed that four initiatives are progressed to address workforce development issues across the Division. These are:

1. **Career progression** – explore the introduction of advanced practice roles (both nursing and allied health) across the Division. This will assist with recruitment and retention challenges, in part, by ensuring career pathways are more accessible and visible. It will also assist with reorienting the service to the provision of specialist care, as we reduce more 'generic' case management activity, and support staff to work at 'top of scope'.

2. **Supporting new graduates** – SMHAS has a small number of designation new graduate positions for both nurses and allied health staff. This year there have been more applicants than positions available.

Given the current level of vacancy, it is proposed that the Division over-recruits new graduate staff, and to ensure they are appropriately supported, the FTE allocated to clinical coaching roles is increased proportionately (using vacancy underspend).

3. **Leadership development** - an initial conversation has been held with Te Pou (the national workforce centre for mental health, addiction and disability). They have advised they do not have a specific programme on offer, but would be interested in partnering with the DHB to develop a bespoke leadership programme.

It is noted that the Francis Group is currently leading the development a national leadership programme for the health sector. At this point in time, it is unclear the target audience and/or whether there is a specific mental health and addictions component to the programme.

It is proposed that SMHAS investigates the scope of the work being undertaken by the Francis Group and the intended implementation timeframe. Alongside this, discussions continue with Te Pou to look at the possibility of the development of a bespoke Mental Health and Addictions leadership development programme (either separately or in partnership with the Francis Group).

Any potential funding required to develop and/or implement a programme could be obtained through the re-allocation of the funds put aside for the High Performance High Engagement (HPHE) initiative (which has been deferred).

4. **Review of leadership capacity and infrastructure** – there are a number of roles across the Division that have a significant number of direct reports (for example, the Adult Mental Health Services West team manager has 80.30fte direct reports and the Adult North team manager 72.10fte direct reports). The size of these roles do not enable the provision of adequate support and development

of the clinical teams.

It is proposed that the configuration and span of control of team managers across the Division is reviewed and a proposed future structure developed that supports the delivery of high quality and effective clinical services. It is also proposed that configuration and FTE associated with clinical leadership positions is also reviewed to ensure these are well aligned with the operational structure.

Summary of Recommendations

1. Explore the introduction of advanced allied health and nursing roles across the Division to support recruitment and retention and reorienting the service to provision of specialist care.
2. Over-recruit new graduate staff where possible and increase the clinical coaching FTE required to support them accordingly.
3. Continue to explore opportunities to a bespoke Mental Health and Addictions leadership development programme.
4. Review the configuration and span of control of team manager across the Division, as well as the configuration and FTE associated with clinical leadership positions.

Appendix 7

Extracts from: Adult Acute Psychiatric Inpatient Units: A Seven-Day a Week Resilient Service

Although providing acute care 24-hours a day, seven days a week, the current inpatient staffing at He Puna Waiora and Waiatarau is heavily weighted toward Monday to Friday, 0800-1630hrs. There has been some expansion of associate allied health staff (unregistered) into evenings and weekends although that has been associated with some issues regarding responsibilities for the oversight of these staff. Cultural staff availability outside of usual working hours is limited. However, most admissions take place in evenings and weekends.

Work has been completed on the development of an acute inpatient model of care. Within existing budgets implementation has seen the introduction of clinical charge nurse positions, a CNE, SMO job sizing, an increase in psychology FTE and a cover model developed for nursing across the inpatient units (IPUs).

There remains unmet need in the area of allied health leadership and coverage. Expanded leadership and availability, in evenings and weekends, will allow for:

- Improved whanau participation
- Improved therapeutic programmes
- Improved discharged planning and timeliness thereof.

This will lead to improved whānau and tāngata whai i te ora experience and more timely discharge. Additionally, this will relieve some of the capacity pressure in the two IPUs.

Cultural welcoming and wellbeing of tāngata whai I te ora is currently less than desirable. Cultural staff currently come from Whītiki Maurea (the Maori community mental health service) and is only routinely available during day time hours. IPU specific Taurawhiri will allow an improved cultural welcome and experience.

The table below, details the proposed expanded allied health and Taurawhiri leadership and availability requirements. This is a priority budget bid for SMHAS for the 2022-23 financial year.

Role	Description	Total FTE Required	$ (per annum)
Social worker	2.00fte – senior social workers (one for each unit to provide leadership and oversight of social work practice and support discharge planning for tāngata whai i te ora with high and complex needs. 1.00fte – additional social worker to enable weekend service provision in both units.	3.00	$[redacted]
Occupational therapy	1.50fte – senior occupational therapists (0.50fte HPW; 1.00fte WAI) to provide leadership and oversight of practice and support discharge planning for tāngata whai i te ora with high and complex needs. *NOTE: the reason for requesting differing FTE for the two units is that He Puna Waiora have a pre-existing larger number of FTE for OT and only require 0.5FTE,*	1.50	$[redacted]

	whereas Waiatarau have fewer FTE.		
Taurawhiri	4.40fte for each unit - to provide daily access to cultural interventions (including welcomes). FTE allocation would provide cover 1100 – 2300hrs, seven days a week.	8.80	$[redacted]
[redacted]			$[redacted]
TOTAL		**13.30**	**$[redacted]**

Extracts from: Provision of Acute Mental Health Care within the Emergency Departments

Date: 06 December 2021

Recommendation:

The recommendations are that ELT:

a) **Note** since 2015 there have been mental health clinicians based within the Emergency Department at Waitakere Hospital, although there is insufficient FTE allocated to provide 24-hour, seven day a week cover.

b) **Note** in April 2021 the Waitematā DHB Board approved *"....in principle, an indicative allocation of $[redacted] to implement an expanded Emergency Department mental health staffing model across both Hospitals. Noting, confirmation of the total investment required will be determined once the model of care has been completed."*

c) **Note** the model of care for acute mental health care within the Emergency Departments has been developed, with oversight from both Specialist Mental Health and Addiction Services and Acute and Emergency Medicine.

d) Note the model of care will ensure there are dedicated acute mental health clinicians working in both the North Shore and Waitakere Hospital Emergency Departments 24 hours per day, seven days per week (including leave cover).

e) **Approve** the allocation of $[redacted] to implement the first phase of the agreed model of care and the recommended staffing model. Yes/No

Key Issues

- Both Emergency Departments have experienced an increase in presentations of people requiring acute psychiatric care. There has been a concurrent increase in acute psychiatric assessments in the community.
-
- Waitakere Hospital has some dedicated acute mental health clinicians based within the Emergency Department. This has improved the ability of the service to respond to people who are psychiatrically unwell or acutely distressed and supports patient flow. However, the model is not fully realised, as it is insufficiently resourced to provide cover 24 hours per day, seven days per week.
- The physical environments within the Emergency Departments have not been designed to meet the needs of people who present with acute psychiatric concerns or other serious mental health issues. This impacts on patient experience and staff safety.

Contact for telephone discussion

Name	Position	Telephone
Stephanie Doe	General Manager, Specialist Mental Health and Addiction Services	[redacted]
Dr Murray Patton	Director, Specialist Mental Health and Addiction Services	[redacted]

Glossary

24/7	24 hours per day, seven days per week
ED	Emergency Department
EM	Emergency Medicine
FTE	Full Time Equivalent
ICU	Intensive Care Unit
NRA	Northern Regional Alliance
NSH	North Shore Hospital
RN	Registered nurse
SMHAS	Specialist Mental Health & Addiction Services
SMO	Senior Medical Officer
Tāngata whai i te ora	Common term used for mental health patients (people in search of wellness)
WTH	Waitakere Hospital

Executive Summary

In early 2021 Specialist Mental Health and Addiction Services (SMHAS) presented a proposal to the Executive Leadership Team for additional staffing to increase the availability of acute mental health clinicians in the Emergency Department (ED) at North Shore Hospital (NSH). Whilst there was in principle support for the proposal, the Division was requested to work collaboratively with Emergency Medicine (EM) to articulate the model of care required to meet the needs of tāngata whai i te ora presenting with acute mental health concerns.

Subsequently, senior clinical and operational representatives from Acute and Emergency Medicine and SMHAS have worked collaboratively to review the current state of acute psychiatric care in the EDs and develop a new model, which addresses the issues identified at both hospitals.

The proposed model of care aims to provide timely acute mental health assessment and treatment, improve patient flow and enhance the quality of care and experience of tāngata whai i te ora and whānau. The detailed document for the Model of Care has been finalised and will be reviewed within 6 months of the service delivery commencing. The Model of Care offers dedicated acute mental health resources in the NSH ED, 24/7 and increase the acute mental health coverage at the Waitakere Hospital ED to ensure there is a dedicated mental health clinician available for all shifts (including provision of leave cover).

The model of care will provide the same level of support to both hospitals, with staff located in and dedicated to each ED and some staff available to work across both sites. However, the number of staff per shift differs between the two sites. This reflects the number of acute mental health presentations to each ED and also ensures there is sufficient staffing cover at peak times. As a result, the recommended FTE for each site differs.

Background

At present, the NSH ED is supported by the Liaison Psychiatry Service and two community based mental health teams. Depending on the time of day, on-call staff may also be required to attend. It is a complex arrangement, where the team responsible is determined by the nature of the presentation, whether the person is already to known to service and their domicile.

time. The lack of onsite staff to prioritise early assessment can mean that assessments and interventions are delayed;

There is a different model operating in the Waitakere Hospital (WTH) ED. In 2015, additional resource was approved to respond to population growth and increased mental health presentations. Specifically, the investment enabled the provision of a dedicated mental health nurse to the ED two shifts per day. An additional registrar position was also funded, which enabled the nurse to have immediate access to medical intervention and treatment when required.
It is apparent that the model at Waitakere Hospital initially resulted in an improvement in the service's ability to respond to people with acute mental health needs. However, as demonstrated in graph above, since July 2020 these improvements have not been maintained. This is due to staffing gaps (including extended sick leave) and increased demand for inpatient beds, which has caused delays in admission and subsequently longer waits in the ED

There are other areas that need to be addressed at WTH. These include: increased FTE allocation in order to provide 24/7 care; and extending care to children and adolescents presenting with acute mental health concerns.

A review of the data shows that there has been rapid growth in the number of tāngata whai i te ora presenting to the EDs with serious mental health problems.

been seen in the ED. Although successful in reducing demand on the ED, the urgent care centres are not sustainable within existing FTE and facility configuration.

The primary issues with the current provision of acute psychiatric care within the ED are:

- Neither of the EDs have 24/7 mental health cover.
-

In order to successfully provide acute psychiatric care within the EDs, without compromising the ability to respond to acute pressures in other settings, resource and provisions to the EDs must be enhanced. Relocating existing staff to the ED would result in a reduction of acute community service provision, therefore this option has been discounted. It could also result in many more tāngata whai i te ora presenting to the ED for solely a mental health assessment if community staff were unavailable.

Model of Care

The proposed model of care aims to provide timely acute mental health assessment and treatment, improve patient flow and enhance the quality of care and experience of tāngata whai i te ora and whānau presenting to the ED with acute mental health concerns.

It will provide:

1. Dedicated acute mental health staffing resource in the NSH and WTH ED, 24/7
2. Dedicated medical and senior nursing staff to support early decision making and commencement of treatment
3. Leave cover across both sites.

Two staffing options have been investigated to implement the model of care. These are described below.

Option One:
Dedicated team mental health ED team of registered nurses, senior medical officers (SMOs) and nurse practitioners at NSH ED and increase the FTE allocated to WTH ED to enable provision of consistent 24/7 cover. No reliance on community teams for staffing support.

In summary, at NSH ED:

- **Mon – Fri:** there would be a minimum of 1.00fte registered nurse (RN) rostered on 0700 – 1530hrs (with the ability to have 2.00fte allocated at peak times, e.g. Monday mornings). This would increase to 2.00fte for the afternoon shift (1530 – 2300hrs), and reduce again to 1.00fte overnight (2300 – 0700hrs).
- **Sat – Sun:** there would be 2.00fte RNs rostered on 0700 – 1530hrs, 1.00fte RN for the mid-shift (1200 - 2000hrs) and then 2.00fte 1530 – 0700 hours.
- **Mon – Fri**: there would be a 1.00fte RMO rostered 0830 – 1630hrs based in NSH but with availability to attend WTH and an SMO rostered 1pm-9pm in North Shore Hospital
- **Mon – Fri:** 1.12fte Nurse Practitioner would work between NSH and WTH with options to extend shifts to Saturday and Sunday

In summary, at WTH ED:

- **Mon – Sun:** there would be 1.00fte registered nurse (RN) rostered on 24/7.

Both EDs would be supported by a dedicated 1.00fte SMO (1300 – 2100hrs). It is expected that this role, alongside the nurse practitioner and RMO, would work flexibly across the EDs in response to demand and clinical need. Overnight the acute mental health team in the EDs would continue to be supported by the on-call registrars and on call SMO.

This option would provide a full and comprehensive acute psychiatric service in the ED, which had the ability to ensure the provision of timely assessment, initiation of treatment and discharge planning.

The team would stand alone and not require support or cover from the Community Mental Health teams. This would also increase the capacity of the acute community teams to respond to emergent concerns in the community caseload, which will help reduce the number of acute psychiatric presentations to the ED.

As demonstrated in the table below, implementation of this option would require an additional 16.10fte at an incremental cost of $[redacted] excluding any overhead charges, $[redacted] inclusive of a 20% overhead allocation.

Discipline	Additional FTE budget required		
	NSH	WTH	Total
Registered nurses	8.62	2.62	11.24
Clinical nurse specialist	1.74	-	1.74
Nurse practitioner	0.56	0.56	1.12
RMO	1.00	-	1.00
SMO	1.00	-	1.00
TOTAL	***12.92***	***3.18***	***16.10***

Option Two (Recommended):
Dedicated team mental health ED team of registered nurses, RMO and nurse practitioner at NSH ED and increase the FTE allocated to WTH ED to enable provision of consistent 24/7 cover. **But** reliance

on community teams to manage periods of increased demand and provide leave cover and SMO support to be provided by existing Psychiatric Liaison and on-call medical staff.

In summary, at NSH ED:

- **Mon – Fri:** there would be 1.00fte registered nurse (RN) rostered on 0700 – 1530hrs. This would increase to 2.00fte for the afternoon shift (1530 – 2300hrs), and reduce again to 1.00fte overnight (2300 – 0700hrs).
- **Sat – Sun:** there would be 1.00fte RNs rostered on 0700 – 1530hrs and 1530 – 2300hrs, this would increase to 2.00fte overnight.
- **Mon – Sun**: there would be a 1.00fte RMO rostered 0830 – 1630hrs, based on site in the ED.
- **Mon – Fri:** 1.00fte Nurse Practitioner would work between NSH and WTH with option to extend shifts to Saturday and Sunday

In summary, at WTH ED:

- **Mon – Sun:** there would be 1.00fte RN rostered on 24/7.

There is a reduced FTE requirement for this option, as there is no dedicated SMO FTE for the ED. SMO support and cover would be provided by the existing Psychiatric Liaison medical staff with further cover from Community teams when required.

This option recognises the fluctuating demand for acute psychiatric care in the ED and would require the community mental health teams to provide support during periods of high demand. This would ensure that there are strong connections between the acute community teams and acute ED team. Furthermore, it is anticipated that it would be less likely that community teams would recommend tāngata whai I te ora go to ED for an acute assessment if they continue to have responsibility to provide cover to ED.

As demonstrated in the table below, implementation of this option would require an additional 16.80fte at an incremental cost of $[redacted] excluding any overhead charges, $[redacted] inclusive of 20% overhead allocation.

Discipline	Additional FTE budget Required		
	NSH	WTH	Total
Registered nurses	7.75	2.01	9.76
Clinical nurse specialist	1.74	-	1.74
Nurse practitioner	1.12	-	1.12
RMO	1.00	-	1.00
TOTAL	***11.61***	***2.01***	***13.62***

Options analysis

Option	Advantages	Disadvantages
Option One Dedicated 24/7 acute psychiatric team in EDs, including SMO. Minimal support requirements from community teams and/or Liaison Psychiatry	▪ Full complement of FTE offers responsive service to the EDs, including to periods of peak demand. ▪ FTE allocation enables cover for planned and short notice leave ▪ Improved experience for tāngata whai i te ora. ▪ Increased timeliness of assessment, decision making and commencement of treatment.	▪ Expectations from community teams may result in their reluctance to support when required ▪ Potential for community teams to direct tāngata whai I te ora to ED for assessment.
Option Two Dedicated 24/7 acute psychiatric team in EDs. SMO oversight and support provided by Liaison Psychiatry. Community teams and Liaison Psychiatry to provide support to manage periods of peak demand.	▪ Tāngata whai i te ora receive timely and appropriate interventions in ED ▪ Improved experience for tāngata whai i te ora. ▪ Provides comprehensive, yet fully integrated, service across the acute ED and community continuum. ▪ Reduces risk of increasing acute mental health presentations to the ED (people not requiring EM input). ▪ Increased flexibility in staffing (across acute continuum).	▪ Reliant on continued in-reach by community teams.

Option two is the preferred option, as it enables the provision of 24/7 acute psychiatric care in both EDs and will support the provision of timely, appropriate assessment and intervention. It will ensure that the acute community-ED continuum is well integrated, and there is the flexibility across the system to respond to peaks in demand. It will also limit the risk of increasing the number of people presenting to the EDs who do not require EM assessment and intervention.

Costing

The costs associated with the preferred option are detailed below.

Discipline	Additional FTE Required	Incremental cost per annum
Registered nurses	9.76	
Clinical Nurse Specialist	1.74	
Nurse practitioners	1.12	
RMO	1	
TOTAL	13.62	
TOTAL (incl. of 20% overhead allocation)		

The anticipated costs for the remainder of the 2021-22 financial year are $[redacted].

Next Steps

Next steps include:

- Recruit to new positions.
- Work with the NRA to establish the new RMO position.
- Establish joint service KPIs to monitor effectiveness of new model of care and identify opportunities for further improvement.

Conclusion

In conclusion, there has been an increase in the number of people presenting to the EDs with acute mental health concerns. This has resulted in extended wait times and concerns about tāngata whai i te ora experience and outcomes. Consequently, a collaborative review of the acute psychiatric model of care in the ED has been completed and a new model has been articulated.

The proposed model of care will result in dedicated mental health clinicians being located in both EDs, 24/7. There is evidence and support for an in-house model, which offers comprehensive mental health input with the ED and operates as part of the ED team. There is evidence that on-site dedicated mental health clinicians in the ED are able to provide more responsive assessment, can initiate treatment more quickly and provide support to both tāngata whai i te ora and the ED team. Furthermore, it is anticipated that this model will improve patient flow and tāngata whai i te ora and whanau experience.