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21 February 2022

[redacted]

Dear [redacted]

Re: Official Information Act

I am responding on behalf of the Taranaki District Health Board (DHB) to your request of 27 January 2022. You have requested the following information:

Q1 Data showing the total population covered by the DHB's mental health and addiction services at the end of December 2021.

The total projected population supported by Taranaki DHB for the 2021/2022 period is 125,840.

Q2 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 see Table 1 and 2 in the *Appendix*.

Q3 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 teams (eg alcohol and drug, child and youth, community, inpatient units etc).

Please see Table 3 in the *Appendix*.

Q4 Data showing the number of vacancies for psychiatrists, psychologists, and nurses in each of those years to December 2021, broken down by teams.

Please see Table 4 in the *Appendix*.

Q5 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

Please see Table 5 in the *Appendix*.

Continued…

Q6 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.

MHAS does not have a workforce dashboard.

Q7 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.

Please see Memo 1 in the *Appendix*.

Q8 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.

There are no key documents in regards this matter

Q9 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.

There are no key documents in regards this matter.

I trust the above information answers your OIA request.

Yours sincerely

Gillian Campbell
Chief Operating Officer

Enc.

Appendix

Table 1

Year	Dec-19	Dec-20	Dec-21
Total number of Mental Health Employees	165	169	158

Table 2

Year	Dec-19	Dec-20	Dec-21
Psychologists	10	12	11
Psychiatrists	12	13	11
Nurses	100	100	98

Please note: Casuals and Fixed Terms are not included in the analysis. The nursing numbers include Psych assistants.

Table 3

Units	Dec-19		Dec-20		Dec-21	
	Psychologist	Nurses	Psychologist	Nurses	Psychologist	Nurses
Alcohol & Drug Services		3		2		2
Child/Youth Mental Health	4	5	5	5	4	5
Mental Health Management		1		2		2
MH Acute Intervention Service		17		17		
MH – Assessment & Brief Care Team						14
North Comm Mental Health Team	3	13	3	11	5	11
South Comm Mental Health Team		6		6		6
MH – Psychogeriatric Community	2	4	2	4	1	4
Te Puna Waiora Ward	1	51	2	53	1	54

Please note: Casuals and Fixed Terms are not included in the analysis. The Psychiatrists in Taranaki DHB work across multiple teams within the department and are not appointed to a specific team. The nursing numbers include Psych assistants.

Table 4

Occupation	Team	2019	2020	2021
Nursing	Te Puna Waiora	9	5	12
	Psycho-Geriatrics			2
	South Taranaki	3		2
	Community		2	6
	CAMHS		2	3
	MH Acute Intervention	7	4	2
	Clinical Management			
Psychologist	Te Puna Waiora			
	Psycho-Geriatrics			1
	South Taranaki	1		
	Community	4		
	CAMHS	1	1	
	MH Acute Intervention		1	
	Clinical Management		1	3
Psychiatrists	General Adult	1	1	3
	Psycho-Geriatrics		2	1
	CAMHS			
	Addiction	1		

Table 5

Units	Dec-19		Dec-20		Dec-21
	Psychiatrist	Nurses	Psychiatrist	Nurses	Nurses
Alcohol & Drug Services				1	1
Child/Youth Mental Health				1	
Mental Health Management					1
MH Acute Intervention Service		1			4
North Comm Mental Health Team					3
Psychiatric Service	2		2		
South Comm Mental Health Team		1		1	
Te Puna Waiora Ward		1		4	6

Please note: Fixed Terms are not included in the analysis. There was no turnover in Psychologists for past 3 years in TDHB. The nursing numbers include Psych assistants.

Memo 1

TARANAKI DISTRICT HEALTH BOARD

Memorandum

DATE: **21 October 2020**

TO: [redacted], Chief Operating Officer

FROM: [redacted], Interim Mental Health Lead

COPIES: [redacted] Clinical Director
[redacted] Quality and Risk Advisor
[redacted] Operations Manager

SUBJECT: RISK AND RECOVERY PLAN TPW

Dear [redacted]

From our recent discussion underpinned by the Health and Safety at Work Act 2015 and TDHBs obligations under this I am formally alerting you as the interim lead of MHAS to the high risk situation pertaining to sustained difficulties across a number of areas in the. Since stepping into this role over the last couple of months coupled with my knowledge and experience of specialist mental health services I am very concerned about the state of play in this area taking on the interim lead role. Following discussion with a range of staff these difficulties include , held vacancies with limited backfill provisions, a number of poor clinical , HR and leadership processes, confusion around roles and delegation of functions and lastly capacity to meet ongoing service demand accumulating to create of perfect storm.

These concerns have been raised through various channels and delegations, the most recent from [redacted] NZNO Organiser informing me of her intention to make a work safe notification. I spoke to [redacted] as a priority to; a) acknowledge the concerns and b) request some time to look into the issues in more detail and the actions being taken to date. I can confirm that the Mental Health and Addiction Leadership team (SD, CD, OPs Manager, ADON, and CNM) have implemented or are working through the following actions to minimise and mitigate current risks;

- The use of 3:1 staffing ratio to nurse and manage an identified high and complex patient. This equates to an additional 9 shifts per day; 63 shifts per week and in FTE terms, 12.6 FTE.
- Intensified Inpatient Clinical Nurse Specialist supervision of the above patient involving daily management review and twice daily safety huddle with staff.
- Additional Security Guard based in Rimu for evenings from 3pm-3am commencing Saturday 11 May for a six-week period to provide an additional presence and enhance security during what is often termed an unsettled period.
- Prioritised recruitment into Relief Staffing FTE package equating to 4 FTE inclusive of PM and weekend Clinical Nurse positions, an additional Swing Shift RN, extension of Older Person's area Psychiatric Assistant and additional general Psychiatric Assistant FTE. Active recruitment is in progress.

- Additional recruitment of casual Psychiatric Assistant positions (8 new casual staff recruited to date with additional interviews occurring). Specific induction training to the area will be prioritised
- Heightened presence of Acute Service Operations Manager and ADON MHAS in Te Puna Waiora, providing assistance as required.
- Staff wellbeing sessions with a MHAS Psychologist have been made available to staff.
- Notification x 2 to the Director of Mental Health [redacted] highlighting challenges involved in management and care of the high and complex patient with a directive to keep him informed as appropriate. [redacted] and myself are responsible for updating as appropriate.
- Acceptance by Waikato this week to undertake a forensic psychiatrist and forensic nurse review of this patient management and care plan. [redacted] and myself will be providing oversight to expedite this happening as soon as possible.

Other Contributory Actions to Address MHAS Work Pressures:

- Implementation of a 7 day per week Consult Liaison nurse model as of 8 May between the hours of 0800-1630hrs (previously 5 days per week). The aim of this is to prevent avoidable admission and speed up our response time for assessments being seen in the ED.
- The introduction of Circulating Nurse Role PMs and Nights in the Assessment and Brief Care Team, with the ability to provide support to Te Puna Waiora. To date we have had difficulty recruiting to these positions.
- Implementation of the MHAS Nursing Workforce succession and retention plan. This plan is based on the recruitment of 4 x 0.8 FTE Second Year of Practice (Y2P) RNs, who have generally been our New Entry to Specialist Practice RNs in TPW, to permanent positions with an initial Y2P placement in either Community MH or TPW. On completion of Y2P year these RNs will 'graduate' onto a MHAS Nursing Pool. Under this plan the first 'graduation' of Y2P onto the MHAS Nursing Pool is due in June 2020 however with the approval of the Service Director the 2018 Y2P has secured the first MHAS Nursing Pool position with commencement in June 2019.

In progress

- Review of bed management process is expected to be completed to final draft in a fortnight. This plan outlines key steps in patient flow management, including alternatives to admissions and consideration of transfer to neighbouring DHBs to decongest as appropriate or able.
- Urgent recruitment to budget base RN FTE continues with interviews scheduled
- TPW Operations Meeting to commence 0830 and 1445hrs daily with CNM/ACNM/CNS/Ops Manager/ADON. Meeting @ 1445 to include afternoon RN rostered as Coordinator.
- Operations Manager to distribute a daily TPW situational update to Duty Managers and HLT
- Dedicated Senior Manager on call for MHAS

Despite these actions, there are ongoing challenges:

- Te Puna Waiora consists of three distinct individual areas – Nikau (12 beds); Kowhai (4 beds); Rimu 7 beds. These areas are staffed independent of each other to ensure service users are safe guarded and wellbeing maintained. The staff have to be based in the area with the service users due to safety concerns so whilst one area may be lower occupancy and/or acuity if another is higher then this may still result in additional staffing resource being required. At times it may be permissible to move service users from one area into another to manage staffing resource but for much of the time this is not appropriate.
- The addition of the Rimu suites (Kea and Tui suites) where a service user can be cared for in an
- individualised environment has been an excellent quality improvement for the unit and enables staff to tailor care specifically for the individual. These suites have supported TPW staff to achieve a heavily reduced seclusion rate as well as adopt whanau inclusive/friendly practices to support service users. This being said the suites have also added to our staffing resource demand due in part to an Ombudsmen inspection whereby they ruled that the suite was being used as 'quasi seclusion' and forced our hand to have one staff member in or available for each suite if in use. This was not factored in at the time the concept idea of the suites were developed and has had a significant impact on staffing requirements for the unit.

- Sustained difficulties to find enough staff with experience to match patient acuity and bed numbers has resulted in an almost daily requirement for a staff member/s to work overtime or double shifts (16 hours) and is neither healthy nor safe for either patients or staff and has become untenable.
- Staff are experiencing high levels of fatigue; sick leave appears to have spiralled and morale has plummeted. Staff resilience is at an all time low. The CNM, ACNM, CNS and DMs are to be commended for managing this daily situation and clinical risk in the best way that they can. However even they are exhausted by the constant staffing and patient acuity and numbers issues.

Proposed Recovery Plan Moving Forward

Immediate Resource Injection to the MHAS Nursing Pool

MHAS Leadership recommends an RN pool staffing of 7 FTE which equates to 2 RNs AM, 2 RNs PM and 1 RN overnight. Keeping in mind the 4 x 0.8 (3.2) FTE Y2P RNs who will graduate into Pool next year we recommend that immediate recruitment occurs for 3.8 FTE of RNs for Pool. This resource can be used across MHAS but with the demands currently and likely to continue, this resource will be prioritised for orientation to TPW with Community Mental Health orientation occurring once the inpatient unit has stabilised.

Anticipated benefits:

- Immediate staffing relief and reduced reliance on doubles to cover shifts
- Relief for staff allowing work/life balance for personal wellbeing
- Reduce clinical risk resulting from staff working double/extra overtime shifts

Unbundling of Associate Director of Nursing MHAS Responsibilities

The function and coverage area for the ADON MHAS was expanded in the past 12+ months to include (among other things) District Nursing, Specialist Nurse Educators and Postgraduate study funding coordination. This has come at the cost of dedicated Nursing leadership and development within the MHAS. We recommend an immediate release of these additional functions with the aim of the ADON providing enhanced support to the MHAS Nursing Leadership, both inpatient and community.

Anticipated benefits:

- Implementation of evidenced based practice
- Addressing skill-development, critical thinking and decision-making needs in collaboration with CNMs/Team Leaders
- Revitalise Education programme for MHAS

Reconfiguration of the TPW Receptionist Role

Extend Ward Administration to cover the hours 0800 to 2000 when a position becomes vacant.

Currently TPW has two administrative roles, a Ward Administrator (Clerk) who works 0800-1630hrs and a Receptionist/Medical Typist role. Greater admin/reception support is required after hours for TPW to monitor entry and exit of the unit, take phone calls as well as provides IT administration support such as clerking new admissions or discharges, creating referrals etc. Currently this is all performed by the TPW RNs with no admin support afterhours and the main phone line to TPW is diverted to the afternoon coordinator Wi-Fi phone.

Anticipated benefits:

- Reduce IT admin burden on RN staff
- Provide greater observation of service user movements in and out of TPW
- Reduce unnecessary phone calls to the afternoon coordinator
- Increase RN clinical time and time spent on the floor engaging, assessing and intervening with service users

Introduction of Peer Support Workers for TPW with a Focus on After Hour's Availability. These positions are held by individuals who have lived experience and have or are working towards a Peer Support worker qualification. These roles are able to work alongside Service Users using a recovery and trauma informed

focus to assist in discharge planning and support, looking at strengths-based interventions and a champion of hope for the service users.

Anticipated benefits:

- Provide activities after hours
- Support service users to use sensory modulation activities, supplementing clinical staff interventions to prevent escalation of presentation.
- Work with service users to engage meaningfully in completing recovery plans and advance directives
- Supporting service users to address social needs such as accommodation, income
- Linking service users with NGO and other community support services
- Support effective and successful discharge processes and reintegration for the service user in their community.

Finally the following are areas of focus that we also recommend as priorities moving forward from a planning cycle perspective.

- A local high and complex step down unit (a Brixton house model)
- Bulk-funded respite availability both in North and South.
- Review the current model of multidisciplinary operation in MHAS, including efficient use of Allied Health resource and the role of the Psychologists.
- Increased key worker/peer support resources based on increasing demand for service.

Thank you. We welcome further discussion.