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Mental health: Effectiveness of the planning to discharge people from hospital



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Mental health: Effectiveness of the planning to discharge people from hospital

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Overview

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata.

Mental health problems affect New Zealanders from all walks of life, with one in five people affected each year. Many people with serious mental illnesses also suffer chronic physical health conditions and many live shorter lives. Mental illnesses can also impact families, friends and care-givers, and communities. The personal, societal, and economic costs are high.

In November 2016, the Ministry of Health’s Director of Mental Health reported that specialist mental health and addiction services are experiencing increasing pressure. Numbers have been increasing every year since at least 2003. In 2015, a record number of people, more than 160,000 or 3.5% of the population, used these services.

Of these, about 15,000 people needed to stay in an inpatient unit during 2015. District health boards spent more than \$200 million providing care to mental health patients in hospitals. People who are admitted to a hospital-based inpatient unit for mental health problems are in greatest need of support. Supporting them is difficult and demanding, especially for those directly involved in delivering services, and requires the co-ordination of a wide range of health and broader social services. If the system fails in effectively supporting these people, there are huge implications for them, their families, and the health and other sectors. Getting it right is an investment with significant payback.

International evidence shows that good planning before a person is discharged from hospital to community support services is critical in effectively supporting people with mental health problems. When done well, “discharge planning” brings together a person’s health and broader social needs and enables those needs to be met.

This report considers whether discharge planning is completed as intended, whether the needs identified are met after people leave hospital, and whether discharge planning is helping to improve outcomes for people. My staff analysed data for all district health boards, closely inspected practices at three district health boards, and considered the views of a broad range of people directly involved in delivering services.

We focused on people experiencing mental health problems acute enough that they were admitted to hospital. Although they are a relatively small group, their acute and often complex health problems mean that they can need a large amount of care and support from the country’s health services.

Overall, the timeliness, quality, and effectiveness of discharge planning (and the associated follow-up work) are impaired by pressures on inpatient and community services and other factors. The extent of these pressures and how well discharge planning is done varies.

Some inpatient units have high occupancy rates – sometimes beyond their capacity – and in some places there is limited availability of community services, such as suitable accommodation, to discharge people to. In these circumstances, discharge planning can be late or incomplete, and may not involve everyone who needs to be included for it to be effective.

This means that people with mental health problems can be discharged from hospital without a plan for their broader needs, such as getting help with housing, their finances, or support from their employer or family.

In my view, improvements are urgently needed for discharge planning to be more effective in enabling better outcomes for people with mental health problems. The pressures on inpatient units and community services need to be addressed.

Most district health boards use a collaborative approach to discharge planning – they seek to involve the inpatient unit and community mental health teams, the person with the mental health problems, and that person's family. However, the extent to which different teams, the individual concerned, and their family are involved is variable and sometimes limited.

Follow-up with people after they had been discharged was also not as timely as expected. Nationally, district health boards follow up with only two-thirds of people within seven days. Their target is to follow up within seven days with at least 90% of people discharged after staying in hospital because of acute mental health problems. There are also barriers to discharge plans being implemented. People, especially those with complex needs, do not always have access to the services they require, including services outside the control of the health sector.

The mental health sector has made progress in recent years in using information to understand service performance and how to make improvements. However, there is more for the Ministry of Health and district health boards to do to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and make service improvements. For example, more work is needed to systematically gather and use feedback from people using mental health services and those supporting them.

The mental health sector has started to take a more people-centred view in how it uses information to understand how well services are delivered. In my view,

it can do more. My staff have been sharing the insights they gained from using the Ministry's data to map when and how people have been in contact with a range of acute mental health and other health care services. We took the concept, developed by people working in the health sector, and refined it to highlight its potential uses, which we have shared with people in the sector.

During the audit, my staff met with many people who are doing the best they can to provide the best mental health support services they can, despite obstacles and hurdles. These people are well aware that the consequences for people with acute mental health problems, their family, communities, and other agencies can be significant if discharge planning is not done well or discharge plans are not acted on.

The increasing demand for acute mental health services and the problems with co-ordinated support in the community are not new. In my view, the Ministry and district health boards need to urgently make demonstrable improvements to deliver better results for people with acute mental health problems.

Since we completed our fieldwork, the Ministry and district health boards have been working on changes to improve mental health service delivery, including to better support people in moving from inpatient units to community mental health services. The effectiveness of these changes is yet to be determined. On this occasion, I have decided to include, as an Appendix to my report, a letter from the Ministry of Health that outlines these changes. This is to provide an update and a reference point to help Parliament and the public hold the Ministry and district health boards accountable for delivering better results for people with acute mental health problems.

I thank the many people in the mental health sector who shared their views, information, and expertise with my staff as they carried out their work.

Nāku noa, nā



Greg Schollum
Deputy Controller and Auditor-General

25 May 2017

Our recommendations

There are clearly pressures on parts of the mental health system and support services that demand urgent attention and, potentially, innovative solutions. In this challenging context, the planning for discharging people dealing with acute mental health problems from hospital needs to be done to a high standard.

We recommend that district health boards:

1. urgently find ways for inpatient and community mental health teams to work together more effectively to prepare and implement discharge plans, ensuring that all those who need to be – the person to be discharged, family, other carers, and all service providers – are appropriately involved and informed;
2. help staff by improving the guidance and tools to support discharge planning (including information systems) so that the information needed for discharge planning can be accessed and brought together easily and efficiently; and
3. regularly review the standard of discharge planning and follow-up work to identify and make improvements.

We recommend that the Ministry of Health and district health boards:

4. quickly make improvements to how they use information to monitor and report on outcomes for people using mental health services; and
5. use the information from this monitoring to identify and make service improvements.

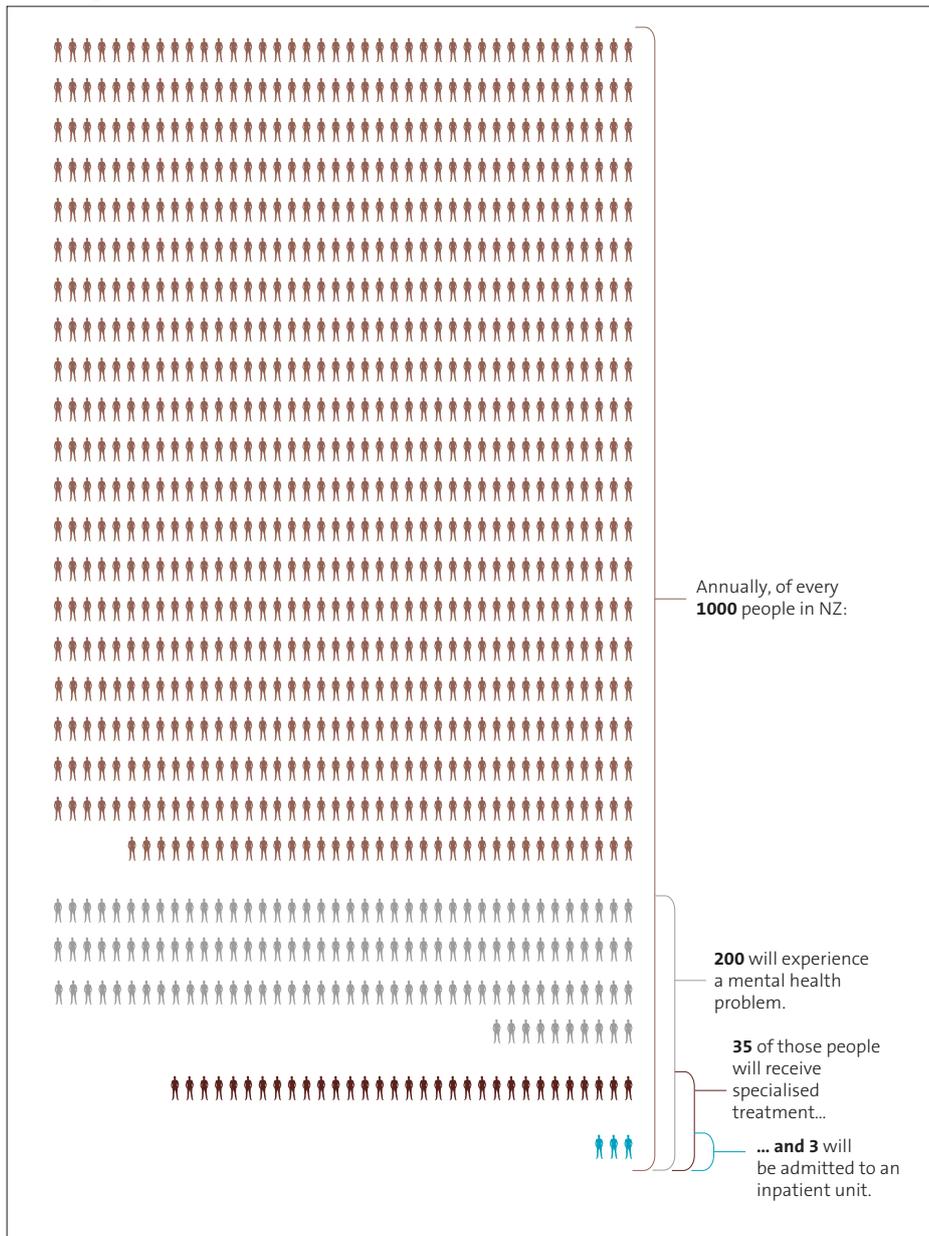
Introduction

- 1.1 In this Part, we discuss:
- the purpose of our audit;
 - what we audited;
 - what we did not audit;
 - how we carried out our audit; and
 - the structure of this report.

The purpose of our audit

- 1.2 Mental health problems affect New Zealanders from all walks of life, with one in five people affected each year. The number of people accessing specialist mental health services has been increasing steadily since at least 2003.
- 1.3 We carried out a performance audit that focused on the relatively few people who are most unwell with mental health problems and require a high level of care, including care in a hospital-based inpatient unit. We looked at whether:
- planning for these people's discharge from an inpatient unit to community care was completed as intended;
 - the needs identified by discharge planning were followed up after discharge; and
 - discharge planning was helping to improve outcomes for people with acute mental health problems.
- 1.4 Figure 1 shows the proportion of the total population that experience mental health problems and that access services at different levels. Most people receive mental health care services in primary health care settings, usually with their general practitioner (GP). However, more than 160,000 New Zealanders (3.5% of the population) accessed specialist mental health and addiction services in 2015. About 15,000 (9%) of these people were admitted to an inpatient unit. These 15,000 people required a high level of care. When they were admitted, many were considered to pose a serious danger to themselves or others as a result of their mental illness. Some of them were admitted under a compulsory treatment order.
- 1.5 Providing inpatient care is expensive. District health boards (DHBs) spend a significant amount of their specialist mental health funding on inpatient units. Sometimes DHBs offer alternatives to inpatient treatment that support people to stay in the community. These can help to reduce the pressure on inpatient units.
- 1.6 It is important that people receive good planning and appropriate follow-up for their discharge from hospital care and transition back to the community. International evidence shows that good planning for the transition from inpatient units to the community is critical in effectively supporting people with mental health problems.

Figure 1
Proportion of New Zealanders who experience mental health problems and access specialist mental health services



Source: Our analysis of available data.

- 1.7 People who need to stay in an inpatient unit often have a broad range of other needs. These can include help with accommodation or finances, or support for their employer or family.
- 1.8 Once a person's needs are identified, prompt access to suitable support is critical. Without this, any benefits gained from treatment during an inpatient stay are more likely to be lost, and there is a risk that the person might suffer a relapse while waiting for help to meet their other needs.

What we audited

- 1.9 Our audit looked at whether:
- discharge planning for people who were leaving an inpatient unit was done in a way that made sure all their relevant needs were identified; and
 - people received support to make sure their mental health and broader needs were met after they left an inpatient unit.

What we did not audit

- 1.10 We did not audit:
- the delivery of primary mental health services;
 - the experiences of people who accessed only specialist community mental health services;
 - services for children and young people or adults aged 65 years or older;
 - forensic mental health services;
 - the experiences of people who accessed only addiction services; or
 - equity of service delivery across ethnic groups or culturally appropriate services.

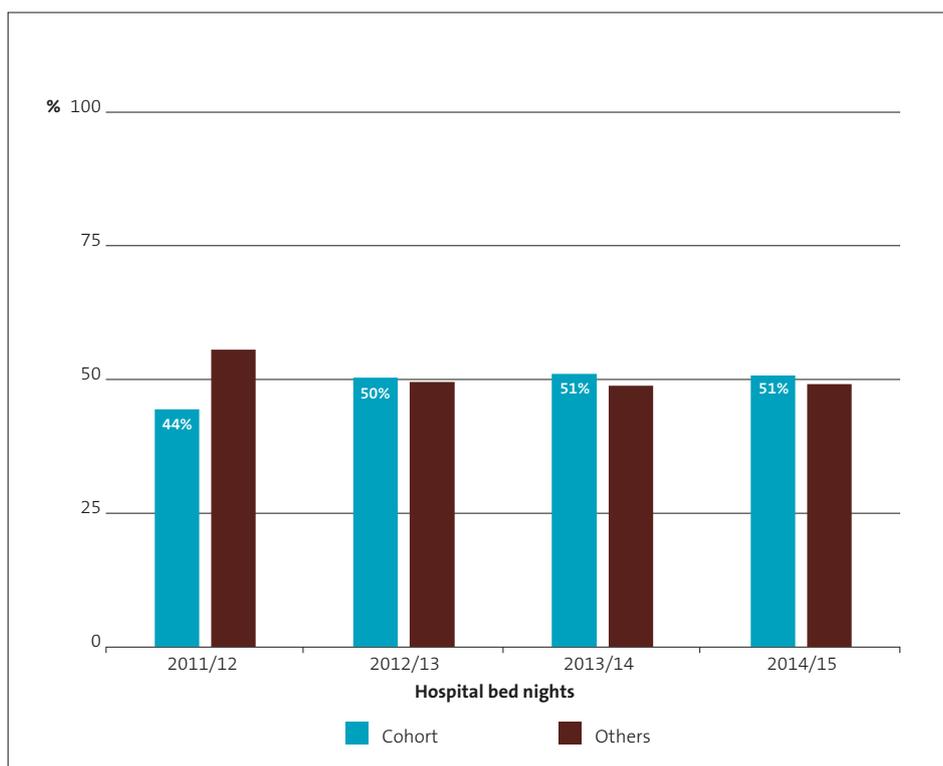
How we carried out our audit

- 1.11 Some parts of our audit looked at national information from all 20 DHBs. We also selected three DHBs to visit and audit in more depth. These visits took place between December 2015 and March 2016. We chose DHBs of different sizes, in different regions, with different demographics.
- 1.12 We also collected data from the Ministry of Health (the Ministry) about people who had used mental health services in 2011/12, 2012/13, 2013/14, and 2014/15. The data did not include people's identities.
- 1.13 About 375,000 individuals received specialist mental health services during those four years. Of these, about 20,000 were aged 20-64 years and had at least one

acute mental health admission to a hospital during the four years. We analysed data for this cohort of 20,000 people.

- 1.14 Although they made up a small proportion of all those receiving specialist mental health services, these 20,000 people accounted for almost half of all mental health bed nights¹ (see Figure 2) and about 30% of all community contact activities² (see Figure 3).

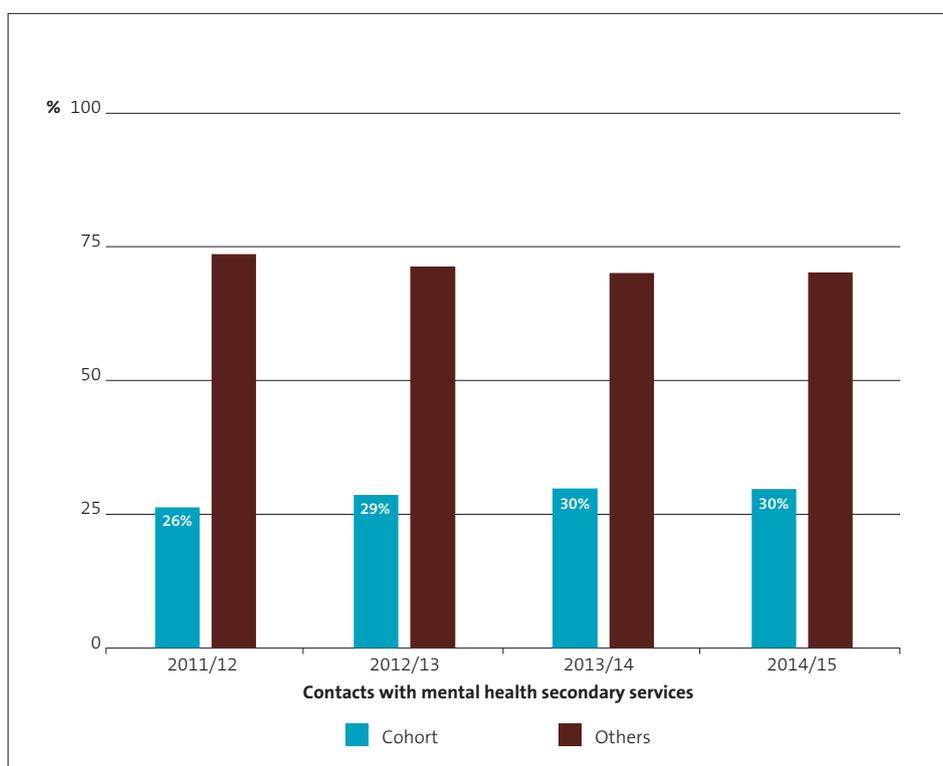
Figure 2
Percentage of bed nights for the cohort as a proportion of all mental health bed nights in all district health boards



Source: Our analysis of Ministry of Health data.

1 Total bed nights includes all types of mental health inpatient and residential care (such as acute, crisis, forensic, and residential) and also includes beds used by people aged 65 years or older.
2 Community contacts include any contact with community mental health services that is recorded in the data we received from the Ministry of Health.

Figure 3
Percentage of community contact activities for the cohort as a proportion of all mental health community contact activities



Source: Our analysis of Ministry of Health data.

- 1.15 We analysed data about the contact the 20,000 people had with mental health services from 2011/12 to 2014/15.
- 1.16 We completed in-depth reviews of case files and clinical notes for 110 people treated in the three DHBs we visited and who were part of our national cohort of 20,000 people. Usually, we looked at the period from the person's admission to hospital to 90 days after leaving. If the person had a pattern of repeat admissions, then we looked at a wider time frame.
- 1.17 We interviewed more than 100 people in about 50 semi-structured interviews. These interviews included a mix of clinical and non-clinical staff, such as independent family, cultural, and patient advisers; staff from inpatient mental health teams; staff from community mental health teams; and staff in non-governmental organisations. Most of these people work for the three DHBs we visited. We also interviewed senior staff at the Ministry. We did not interview

patients directly because we did not wish to potentially cause unnecessary distress.

- 1.18 We structured the interviews around our criteria, with a particular focus on matters raised by our case file reviews and early data findings.
- 1.19 We conducted a survey of just over 900 DHB staff, and achieved a response rate of just over 20%. We received responses from staff in 15 of the 20 DHBs.
- 1.20 We reviewed and analysed documentation and data, including financial information, from all 20 DHBs.
- 1.21 We held one workshop at Canterbury DHB, which was attended by about 16 clinical and non-clinical staff.
- 1.22 We reviewed some of the 500 stories that people submitted to the *People's Mental Health Review*.³ These stories gave us an insight into the views of people with a personal experience of mental health services in New Zealand. This helped us to understand and validate our findings.
- 1.23 We set up an external reference group to provide specialist advice to our audit team. Most of the group were clinicians (psychiatrists and registered mental health nurses) but we also included a patient representative and a Ministry data expert. The representatives on the group came from four different DHBs to the three that we visited.
- 1.24 We have also liaised with the relevant teams in the offices of the Ombudsman and of the Health and Disability Commissioner.

The structure of this report

- 1.25 In Part 2, we provide background information about the provision of acute mental health care, patterns of contact with mental health services, and mental health funding.
- 1.26 In Part 3, we consider how well planning was done before a person was discharged from an inpatient unit.
- 1.27 In Part 4, we discuss whether people received the support and follow-up they needed after they were discharged from an inpatient unit.
- 1.28 In Part 5, we examine the data and information that is currently available about acute mental health services. We explore opportunities for using that information to better understand how people with acute mental health problems are interacting with health services.

³ These stories were analysed to identify key themes that are explored in the *People's Mental Health Report*, which was published by Action Station on 19 April 2017. See www.peoplesmentalhealthreport.com.

Acute mental health care

- 2.1 In this Part, we describe:
- the organisations with a role in providing mental health care;
 - patterns of contact with mental health services; and
 - mental health funding.

Organisations with a role in providing mental health care

The Ministry of Health

- 2.2 The Ministry sets the overall strategy for mental health, including outcome frameworks, high-level standards, and performance expectations. The Ministry also allocates funding to DHBs and monitors their performance.
- 2.3 The Ministry told us that it is working with other government agencies to consider how government can better respond to mental health needs and support well-being for a range of population groups. This work will have a broad focus and is expected to lead to improvements to a person's mental health and well-being after they are discharged from an inpatient unit.

District health boards

- 2.4 DHBs provide specialist mental health services. They provide some services directly, such as hospitals' inpatient facilities, and some community-based services. DHBs also contract some services to non-governmental organisations and private providers.
- 2.5 When people are discharged from an inpatient unit, most are discharged to a community-based mental health service. Each person will receive a different combination of services and care to meet their individual needs. A few people are discharged to another type of service, such as their GP. Occasionally, people do not have any type of follow-on service after their stay in an inpatient unit, based on assessment or by their own choice.

Non-governmental organisations

- 2.6 Non-governmental organisations also provide community-based services on behalf of DHBs. These services can include respite or residential facilities and day programmes, as well as therapies and other types of support for people living in their own homes.

General practitioners and other primary care providers

- 2.7 A GP is often the first contact with a medical professional for someone with a mental health problem. Most people will need to receive care only from their GP, but if required a GP will refer someone to more specialised services. A person

can also be returned to a GP's care when they are discharged after a hospital stay. Primary mental health care is also sometimes provided by other types of practitioner such as mental health co-ordinators and nurse practitioners.

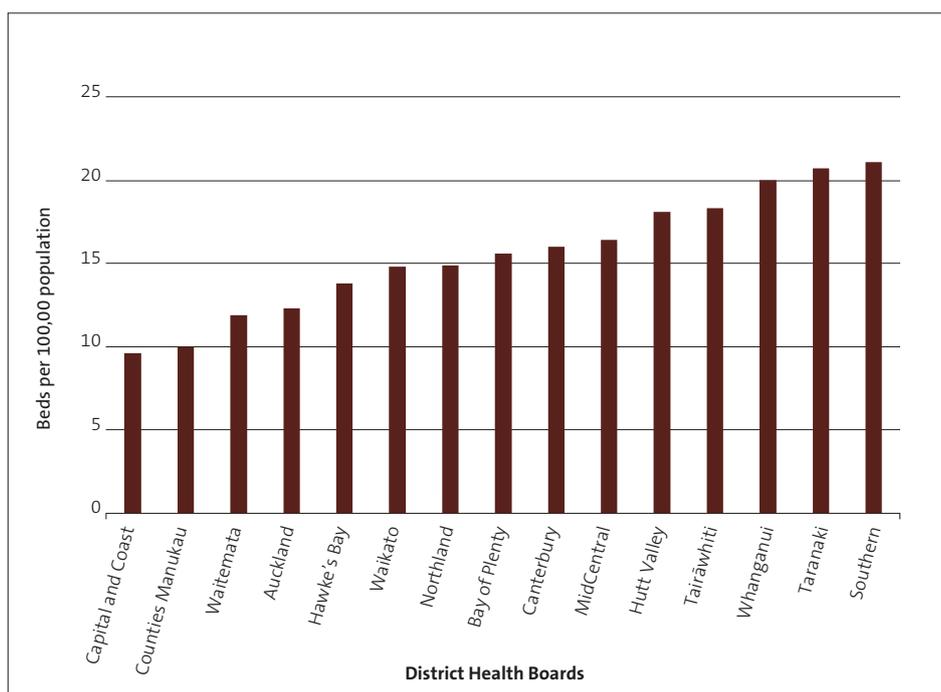
Private providers

- 2.8 Private providers include specialist practitioners, such as psychiatrists, and facilities such as rehabilitation clinics. These are outside the scope of our audit.

Patterns of contact with mental health services

- 2.9 Our audit focused on a relatively small group of people with high and complex needs. Each individual in this group had a unique combination of mental health conditions, general health conditions, and personal circumstances. This means that each person had a unique set of needs and corresponding service requirements.
- 2.10 Each DHB provides mental health services differently, too. We explain these differences in the next few paragraphs. Together, this means that each person had a different pattern of contact with mental health services – we did not expect to see everyone receiving the same services in the same way. Instead, we expected DHBs to deliver services in a way that met the needs of each person with acute mental health problems.
- 2.11 An example of differences in how DHBs organise mental health services is the provision of acute care. All DHBs have a hospital-based inpatient unit for people needing acute care,⁴ but each DHB structures its inpatient unit in a different way. For example, as shown in Figure 4, there is considerable variation in the number of beds in inpatient units compared to population size. There will also be different numbers of secure, intensive care, and non-secure beds in each inpatient unit.

Figure 4
Number of beds in inpatient units for every 100,000 of population, by district health board



Note: Data were available for 15 of the 20 DHBs. Wairarapa DHB does not have an inpatient unit. Data from the other four DHBs were not available.

Source: Our analysis of DHB Key Performance Indicator Programme data.

- 2.12 Beyond inpatient units, DHBs provide different types of services. For example, some DHBs provide a sub-acute unit as a step between the inpatient unit and community-based care.
- 2.13 Each DHB also serves a different population. Some DHBs have a large, ethnically diverse, high-density, urban population. Others have a smaller population spread over large rural areas. This affects the types of services that DHBs need to provide and the best way of structuring their services.

Mental health funding

- 2.14 The total “ring-fenced” funding for the Ministry and DHBs to spend on mental health and addiction services for the last three years was:
- \$1.296 billion in 2013/14;
 - \$1.372 billion in 2014/15; and
 - \$1.407 billion in 2015/16.
- 2.15 This represents around 9% of the total Vote Health budget.

Planning for discharge from an inpatient unit

- 3.1 In this Part, we cover discharge planning and:
- the effect of a high demand for beds;
 - taking people’s broader needs into account;
 - involving all appropriate people; and
 - systems and tools to support the process.

Summary of our findings

- 3.2 The Ministry and DHBs expect discharge planning to start between one and seven days after a person’s admission to an inpatient unit. This does not always happen. Sometimes people are considered too unwell to start planning in the first few days. High demand for beds also sometimes delays discharge planning.
- 3.3 Most people have at least a partial plan when they are discharged from an inpatient unit. However, many people are discharged without a plan to meet all their needs, including:
- suitable accommodation – in practice, some people are discharged to unsuitable accommodation;
 - finances and support for their employer and/or family; and
 - what to do when arrangements break down.
- 3.4 Some people are discharged at short notice and before they are ready (on a “least unwell” basis, to make space for a “more unwell” person) and before the DHB has had time to set up support in the community. People can also discharge themselves if they are not subject to, or are no longer subject to, the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- 3.5 When there are high occupancy rates in inpatient units, contact and meetings with people outside the inpatient unit (such as community mental health teams, families, and other health professionals) suffer. People can be discharged with no formal handover to the community mental health team.
- 3.6 Families are sometimes unable to attend and contribute when care planning or discharge meetings are called or changed at short notice, or are held at inconvenient times. When the patient and their family are involved, they do not always feel listened to.
- 3.7 The person being discharged and, where appropriate, their family are rarely given copies of discharge plans. Sometimes families are not told, when they should have been, that their family member has been discharged.

- 3.8 Discharge planning is not well supported by tools and systems. Information about a patient is fragmented between different systems, which makes it hard for mental health staff to gain a clear picture of a person and their needs.

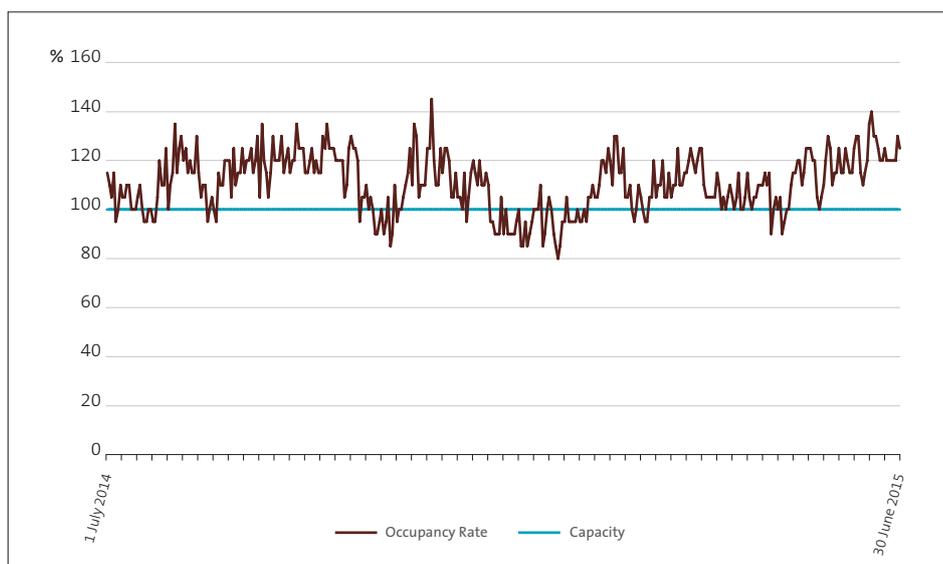
Discharge planning is adversely affected by high demand

- 3.9 Discharge planning does not always start as early as it should and many people leave the inpatient unit without a plan to address their broader needs, such as getting help with a housing situation or their finances, or support for their employer or family.
- 3.10 In line with expectations, most DHBs aim to start discharge planning within the first seven days after someone is admitted to the inpatient unit. Two-thirds of respondents to our survey indicated that planning should start 1-3 days after admission. In practice, this does not always happen.

High demand for beds

- 3.11 Discharge decisions were affected by occupancy pressures on inpatient units at two of the DHBs we visited. One of the DHBs was providing inpatient services for significantly more people than it had beds for (see Figure 5). The inpatient unit occupancy rate for this DHB was particularly high, but our analysis showed that several other DHBs also had high occupancy rates in their inpatient units.
- 3.12 High occupancy rates in inpatient units mean that sometimes people have to be discharged on a “least unwell” basis to create a space for a “more unwell” person. People are sometimes discharged at short notice, and sometimes without the knowledge of community mental health teams or the person’s family.
- 3.13 Demand for beds can also affect the quality of discharge planning. Short-notice discharges can lead to incomplete assessments, which increases the risk that people who are still unwell are leaving the inpatient unit without adequate support in place. We were told that staff had a backlog of paperwork when occupancy rates were high, including preparing discharge plans before people were discharged. Liaison with others outside of the inpatient unit, for example co-ordinating with the community mental health team, also suffered.
- 3.14 The short-notice discharges can also put pressure on other parts of the health service. For example, in one DHB, a sub-acute unit was having to treat people who were acutely unwell when it was not set up for this.

Figure 5
 Inpatient unit occupancy rate per day for a DHB with a high level of bed pressure, year ended 30 June 2015



Source: Our analysis of Ministry of Health data.

- 3.15 We also found that some people could not be discharged because there was nowhere suitable to discharge them to. This reduces the number of beds available for other people. Our data analysis identified about 80 people nationally who have extremely long lengths of stay, which number months or years rather than days.
- 3.16 We looked at whether occupancy rates were lower for DHBs where there were more beds for every 100,000 people in the local population, and did not find a strong indication that this was the case. This suggests that occupancy pressures are about more than the availability of beds.

Discharge planning often fails to cover broader needs

- 3.17 Most people have at least a partial plan to meet their mental health needs when they are discharged from an inpatient unit. However, many people are discharged without a plan to meet their broader needs. Sometimes the planning for broader needs does not happen until after a person has been discharged.
- 3.18 Most DHBs expected a person's broader needs, including needs for services that are not provided by the health sector, to be considered as part of discharge planning. We found a lack of consensus about which needs should be included, and variability in how DHBs assess a person's needs.

- 3.19 In our case file review, we found that broader needs that were identified were not always included in any formal plan. We also found gaps in planning for early intervention and crisis management. Some staff told us that plans did not cover what to do when arrangements broke down.
- 3.20 Accommodation needs were more likely to be assessed than anything else, and we saw from case notes that hospital-based social workers were proactive in this aspect. Staff told us they are not supposed to discharge people who have nowhere to stay. In practice, some people were discharged to tenuous or unsustainable accommodation.

There is scope for better collaboration in discharge planning

- 3.21 All DHBs seek to promote a collaborative approach to discharge planning, involving staff from different disciplines from both the inpatient unit and community mental health teams. Most patients and, where appropriate, their family make some contribution to discharge planning. However, we were told that they could be more and better involved.
- 3.22 In our view, more could be done to involve all relevant people in discharge planning, even when the demands on inpatient units are high. In particular, we found that communication could be improved:
- between health professionals who are part of a multi-disciplinary team in inpatient units;
 - between health professionals and the patient and, where appropriate, their family;
 - between inpatient unit staff and community mental health teams; and
 - in giving copies of discharge plans to the patient and, where appropriate, their family.

Multi-disciplinary approaches

- 3.23 Most respondents in our survey agreed that a range of hospital-based mental health staff, including clinical and allied health staff, should be involved in identifying needs. But there are practical difficulties and tensions that can impede this approach. For example:
- although most inpatient units held weekly multi-disciplinary team meetings where a patient's progress is discussed, not all people who should have been at the meetings could attend;
 - inpatient unit staff in one DHB told us there was a lack of formal process

around multi-disciplinary team meetings;

- notes from the multi-disciplinary team meetings were often not entered into clinical notes; and
- other staff, such as psychologists and occupational therapists, have limited input into a patient's care plan and treatment.

Involving patients and their family

- 3.24 It is generally considered good practice to involve the patient's family in treatment, including forming a discharge plan, but this is sometimes not appropriate – such as when the patient does not want the family involved, the patient is not in contact with their family, or family involvement is considered detrimental to the patient's well-being.
- 3.25 Community mental health teams and families were concerned with inpatient unit staff calling, or changing the timing of, care planning or discharge meetings at short notice. Both groups told us that this affected their ability to contribute and be informed. Both groups also told us that sometimes patients had been discharged without their knowledge. Family members who worked during the day were often unable to attend meetings because these were held during office hours. People who work as advocates or advisors for patients reported that when patients and their family were involved, they did not always feel listened to.

Handing over care to the community mental health team

- 3.26 People were frequently discharged from an inpatient unit without a clearly identified "keyworker" – the person who is responsible for co-ordinating care and support in the community – and without a formal handover to the community mental health team. This increases the risk that people might not receive the support they need after they leave the inpatient unit. In our review of case files, only one-half to two-thirds of people had a clearly identified keyworker. There was no evidence of a formal handover between the hospital and community psychiatrists in one-half to two-thirds of the files we reviewed.
- 3.27 In the three DHBs we visited, keyworkers could be allocated at short notice or after a person was discharged, or not assigned at all. Late allocation of keyworkers means they may not have met the patient before they were discharged, or may not have been at the discharge planning meeting.

Copies of discharge plans

- 3.28 Most DHBs expect that patients receive a copy of their discharge plan. This is in keeping with good practice and a patients' rights under the Health and Disability Act 1994 to be informed and involved in their own care. However, we

heard that plans were not often shared with patients and sometimes not with community mental health teams. The sharing of discharge plans with patients and community mental health teams by inpatient units is generally poor.

- 3.29 In most of the case files from the three DHBs we reviewed, neither patients nor their families received a copy of the discharge plan. Responses to our survey indicated that only about one-half of patients, GPs, community psychiatrists, and social workers, and only one-third of families, received copies of discharge plans.
- 3.30 Some of the reasons we were given for not providing copies of discharge plans to patients and their families included:
- patients would need to make a formal request;
 - it is illegal;
 - it would upset/distress them (patients) to read it; and
 - they (patients) would leave it laying around.
- 3.31 There was uncertainty among staff in one DHB we visited about what information they could and should share with patients, and some reluctance to share discharge plans. We were told that discharge plans are not generally shared with patients and that discharge documentation is often not prepared until after the person has been discharged, partly because of workload.

Systems and tools do not support effective and efficient discharge planning

- 3.32 DHBs have a range of tools (such as forms and checklists) and guidance available to help discharge planning. We focused on:
- processes and forms to support needs assessment;
 - tools to help refer people to the right services; and
 - information systems.

Processes and forms to support needs assessment

- 3.33 Over half of DHBs have a formal process/checklist to help staff complete needs assessments. These include mental health, physical health, education, employment, and addiction issues. However, during our case file review, we found that there were many forms in use, mostly poorly completed, and often duplicating information. One DHB had three different types of risk assessment forms. None of these forms focused systematically on identifying broader needs.

- 3.34 In the three DHBs we visited, forms were not always completed properly. There was also no monitoring of whether and how well risk assessments and other forms were completed.
- 3.35 In our view, forms and checklists for supporting needs assessments could be streamlined and better used. This could help to reduce the pressure on staff and avoid the late or partial completion of discharge plans when occupancy rates are high.

Tools to help refer people to the right services

- 3.36 All DHBs have documented “pathways” for people entering and exiting the mental health service. These pathways describe the requirements for discharge and admission and explain different treatment and care options depending on what each person needs.
- 3.37 Some DHBs had good tools to aid referrals to other services. One DHB uses a central list of all services available in that DHB and how to access them. This was a good example of clear documentation to help staff decide where and how to refer people. In our view, there is an opportunity for DHBs to share these good practices and learn from each other.
- 3.38 Only a few DHBs had tools to help staff refer people to the right services after discharge from the inpatient unit. Few DHBs provided good information about the services available and how to match people to them, based on need.
- 3.39 Some DHB staff told us that they would like better information about service providers and their performance in improving outcomes. This would help them refer people with acute mental health problems to the most appropriate services available.
- 3.40 Without formal processes in place, DHB staff use a range of informal processes to connect people to the services they need. In our survey, most respondents indicated that although they draw on a wide range of resources to help them decide which services to refer a person to, the primary source was local and/or previous knowledge. Care pathways was the second most frequently named source of information.

Information systems

- 3.41 In some DHBs, information about patients was fragmented across different systems, and those systems did not support co-ordinated discharge planning between inpatient units and community mental health teams. For our case file review, we looked at electronic and paper records. On average, we had to look in at least six places to build up a holistic picture of a patient and their needs. A senior

manager told us that having a shared care record is fundamental to seamless service delivery.

- 3.42 One DHB we visited had an integrated computer system that helped the sharing of information between different parts of the mental health service. This DHB was also seeking to improve communication with non-governmental organisations by allowing them access to the DHB's main information technology system.
- 3.43 Systems at another DHB were not as good at sharing information with non-governmental organisations and primary care services. This hampered assessment and referrals. The DHB did have a system that was integrated with two neighbouring DHBs. This helped keep the records for people who move around, and might enter and re-enter the system in different parts of the region, up to date. However, this system was not integrated with some of that DHB's other systems (for example, its electronic medication system).
- 3.44 Some DHBs have found practical ways to help support communication between different parts of the mental health service. Some teams in our fieldwork sites had been co-located, such as the acute and community mental health teams, which helped with integration and continuity of care. One DHB also used video conferencing to facilitate communication between services located in different areas.

Recommendation 1

We recommend that district health boards urgently find ways for inpatient and community mental health teams to work together more effectively to prepare and implement discharge plans, ensuring that all those who need to be – the person to be discharged, family, other carers, and all service providers – are appropriately involved and informed.

Recommendation 2

We recommend that district health boards help staff by improving the guidance and tools to support discharge planning (including information systems) so that the information needed for discharge planning can be accessed and brought together easily and efficiently.

Recommendation 3

We recommend that district health boards regularly review the standard of discharge planning and follow-up work to identify and make improvements.

Supporting people after they leave an inpatient unit

- 4.1 In this Part, we cover:
- expectations for following up with people after discharge; and
 - barriers to getting support after being discharged.

Summary of our findings

- 4.2 All DHBs consistently failed to meet the target to follow up with people within seven days of discharging that person from an inpatient unit. The target is for at least 90% of people to receive a follow-up contact but, on average, DHBs manage to follow up with only two-thirds of people within seven days. This is sometimes because of high caseloads for community mental health teams.
- 4.3 Even when follow-up contact is made, there can be barriers that prevent people accessing the services they need, including services that are outside the control of the health sector. Poor availability of suitable accommodation, especially for people with complex needs, is the largest barrier people face, and this can prevent some mental health patients from being discharged.
- 4.4 Some services are not available in all locations. Where they are available, long waiting lists can prevent people from getting timely access to those services.

Follow-up rates are well below expectations

- 4.5 DHBs are not meeting their own expectations that discharge plans will be actioned and followed up. The target that 90% of people are followed up with an initial contact from the community mental health team within seven days of discharge has not been met by any DHBs for at least the last three years. Many DHBs fall well short of the target. Nationally, only around two-thirds of people are followed up within seven days, and we found evidence that some people are not followed up at all.
- 4.6 Expectations for follow-up vary from within two days after discharge to no specified time frame. In our survey, there was clear consensus that the first contact should occur within the first seven days after someone leaves the inpatient unit. However, a few respondents said lack of staff capacity can interfere with this. In one DHB, we were told there is a lack of staff capacity in community mental health teams because of high caseloads.
- 4.7 We found in our case file review at three DHBs that between two-thirds and four-fifths of people with a plan for their mental health needs had a follow-up contact within seven days of discharge. However, we could not see any evidence of follow-up for the other people discharged.

- 4.8 Some of the people who were not followed up may have voluntarily decided not to engage with mental health services. Others may have been followed up by a different DHB. Most DHBs, including the three we visited, have policies and guidance about what to do when people do not show up for appointments or cannot be contacted. However, responses to our survey indicate that there are very few mechanisms for tracking individuals once they have left acute mental health care. The exception to this is those receiving secondary mental health support who have been allocated a keyworker.
- 4.9 Many of our survey respondents and staff we spoke to who work in inpatient units did not know whether people who had left their unit were receiving support. Overall, respondents indicated that there are no particular systems in place to ensure that people received follow-up care.

Barriers make it hard for people to get support after being discharged

- 4.10 We identified several barriers that prevent people accessing the services they need, when they need them. Many of these services are provided by agencies outside the health sector. The most significant of these barriers is a lack of suitable accommodation. There is also limited accessibility for some services in some areas of the country.
- 4.11 Many of these barriers are not within DHBs' control, so improving mental health services is not a challenge for just the health sector. Other agencies also need to be involved in meeting the needs of people with mental health problems. The Ministry recognises this and told us that it is working with other agencies to consider how the Government can better respond to mental health needs.

Accommodation

- 4.12 The most frequently reported service barrier we identified was finding suitable accommodation for people leaving an inpatient unit. The cost of accommodation is particularly a problem in some regions, and there is a shortage of accommodation options for people with complex needs. Workarounds are sometimes put in place, such as discharging people to caravan parks.
- 4.13 In all three DHBs that we visited, staff told us that people are kept in inpatient units when no accommodation can be found for them in the community or their families refuse to take them.
- 4.14 Some people stay in an inpatient unit for long periods (for example, two years) because of problems with access to suitable accommodation, rehabilitation, and other services in the community.

- 4.15 Keeping people in the inpatient unit longer than they need to be there takes up beds so that others cannot be admitted, or are discharged early to make room. As a result, there is a risk that accommodation issues rather than clinical need are influencing some discharge decisions.
- 4.16 The lack of suitable accommodation can mean that vulnerable people are living in loosely regulated and unsupported environments, and sometimes living with several unwell or dependent people.

Accessibility

- 4.17 What services are available can be different depending on where people live. Some services, such as detoxification, are not available everywhere and people have to travel to access them. We were told that, even within a DHB's district, access to services in the community was better in some places than others.
- 4.18 One DHB we visited had a shared care arrangement with neighbouring DHBs, which helped in providing a continuum of care for people moving around the region.
- 4.19 Despite this, that DHB still had some difficulty in arranging drug and alcohol services for people. It also did not have any services available to treat people with both acute mental health problems and other severe health conditions, such as diabetes. Mental health clinicians do not have the expertise to treat all of a person's medical conditions.

Other barriers

- 4.20 Other significant barriers include waiting lists, funding, and eligibility. For two of the DHBs we visited, access to services was problematic in about a third of cases we reviewed, either because of waiting times or entry requirements. In the other DHB, we were told that staff did not have information about waiting times to help them make decisions about referrals.
- 4.21 We were provided with examples of how inpatient unit teams in some DHBs were seeking to work together more closely and share information with other teams providing mental health services, such as with non-governmental organisations and community mental health teams, to be more co-ordinated and provide better continuity of care.
- 4.22 Failing to connect people with the services they need within an appropriate time frame after they have been discharged can make life more difficult for people. This can mean they are re-admitted to hospital sooner than might otherwise have been the case, or increase the demand on other health services.

5

Using information to assess outcomes

- 5.1 In this Part, we cover:
- the information that the Ministry and DHBs hold and how they use it;
 - efforts under way to improve how information is used; and
 - how information can be used better to understand people's experiences and improve services.

Summary of our findings

- 5.2 The Ministry and DHBs have a lot of data about mental health services. The Ministry uses the data to report mainly on what services are provided and who is providing them. DHBs and other providers use the data to understand service performance through a set of indicators that they have been developing since 2006.
- 5.3 Both the Ministry and DHBs are seeking to improve how they use information. The Ministry has started to collect information about outcomes for people, and is intending to collect data and improve reporting on the use and quality of discharge planning from 2017/18. DHBs are working to use indicators more effectively to inform improvements to services and outcomes for people.
- 5.4 There is more for the Ministry and DHBs to do to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and improve their services. More work is needed to:
- establish and use solid outcomes measures;
 - systematically gather and use feedback from people using mental health services and those supporting them;
 - build capability to use data and information; and
 - address some lack of trust and confidence in the quality of the available data.
- 5.5 In our view, the Ministry and DHBs can gain a greater understanding of how to improve services for people by understanding the patterns and trends in people's experience of services. We show some examples in this Part. We also introduce the concept of viewing a person's contact with mental health services as a timeline of interactions. This is a concept developed by people working in the health sector, which we refined to highlight its potential uses. We have shared this with people working in the health sector.

Using data about mental health services to report on and understand service performance

- 5.6 The Ministry collects mental health data from DHBs and non-governmental organisations providing mental health services. Information about consumer satisfaction with mental health services is also collected by the Ministry and DHBs.

Collection and use of data about provision of mental health services

- 5.7 Data about specialist mental health services are collected by the Ministry in the Programme for the Integration of Mental Health Data (PRIMHD) system. The Ministry uses PRIMHD to report mainly on what services are provided and who is providing them.
- 5.8 The Ministry also collects information through the DHB non-financial monitoring framework. For 2016/17, the Ministry's DHB non-financial reporting framework has three performance measures about mental health services. One of them, *Improving mental health services using transition (discharge) planning and employment*, is about discharge planning.
- 5.9 DHBs and other providers use PRIMHD data to understand service performance through the New Zealand Mental Health and Addiction Services Key Performance Indicator Programme (the KPI Programme). The KPI Programme is a provider-led initiative that began in 2006. It is primarily a benchmarking forum whose purpose is to systematically analyse and use service and outcome data to inform service development and improve the outcomes for people using mental health and addiction services and their families.
- 5.10 Through the KPI Programme, DHBs have designed a framework of key performance indicators and associated stretch targets for adult mental health and addiction services⁵ that represent good performance. The framework includes just over 60 indicators. Results were published in May 2016, covering the three years from 2012/13 to 2014/15. Selected results are also available on the KPI Programme website⁶ for 2015/16 and 2016/17 (year to date).
- 5.11 DHBs also have access to an interactive web-based tool that allows them to examine their own KPI Programme results. Currently 12 of the 60 indicators can be examined using the tool.

5 The KPI Programme also has indicators for children and forensic mental health service users. These are outside the scope of our audit.

6 See www.mhakpi.health.nz.

5.12 Figure 6 shows the results of six of the KPI Programme indicators relating to the discharge of people with mental health problems from acute inpatient units and follow-up contact with them by community mental health services. For each KPI we show, for the three years from 2012/13 to 2014/15, the weighted average value and the highest and lowest value for all DHBs. Our observations from these results are that:

- the average performance of DHBs against the indicators has remained reasonably static in the three years, and the performance of DHBs has varied; and
- the average performance of DHBs did not meet the targets for four of the indicators (see the darker shading in Figure 6), and is well below the targets for percentage of people followed up within seven days of a discharge and the percentage of discharges with qualifying Health of the Nation Outcome Score (HoNOS) assessments (see paragraphs 5.23-5.24).

5.13 Participants from DHBs, NGOs, and their “strategic partners” are involved in benchmarking forums twice a year with the aim of understanding variations in performance, and learning from each other about service improvements and practices to improve outcomes for people using mental health services. For the last 12 months, the KPI Programme has changed its approach to focus on one indicator for all DHBs (and two indicators at a sub-national level, focusing on northern and southern priorities). This approach is intended to increase collective learning on how to improve performance.

5.14 At the DHBs we visited, we heard examples of how information, such as some of the indicators from the KPI Programme and case files of people admitted to an inpatient unit, was analysed to identify trends and service improvements. We also heard examples of how people’s progress, such as length of stay as an inpatient and contact with community mental health services, was monitored.

Satisfaction of people using mental health services

5.15 The Ministry collects and publishes consumer satisfaction information. Since 2006/07, DHBs have been carrying out an annual national mental health consumer satisfaction survey. Survey participants have all received specialist mental health services. In 2014/15, 14 of the 20 DHBs participated in the survey. The Office of the Director of Mental Health reported that 82% of respondents either agreed or agreed strongly with the statement “*overall I am satisfied with the services I received*”.

5.16 In our view, the results that are published do not contain enough information to give a reliable indication of the satisfaction levels of people using mental health services. The response rate for the survey was not provided and there was no breakdown by DHB.

Figure 6
Summary of district health boards' results against six key performance indicators, 2012/13-2014/15

	Year	Weighted average (all DHBs)	Lowest (all DHBs)	Highest (all DHBs)
Average length of acute inpatient stay (Target: 14-21 days)	2012/13	18.2	12.1	29.6
	2013/14	18.1	11.4	27.9
	2014/15	17.4	12.7	28.3
	Average	17.9	-	-
Percentage of discharges with qualifying Health of the Nation Outcome Score assessments (Target: 75-100%)	2012/13	57.9	12.2	90.4
	2013/14	58.1	12.8	94.3
	2014/15	59.0	28.9	94.3
	Average	58.3	-	-
Percentage of discharges for which community mental health contact is recorded in the seven days after discharge (Target: 90-100%)	2012/13	65.6	50.8	85.5
	2013/14	62.5	38.4	80.1
	2014/15	64.1	39.5	80.8
	Average	64.1	-	-
Percentage of discharges re-admitted to acute inpatient unit within 28 days of discharge (Target: 0-10%)	2012/13	15.6	6.3	28.4
	2013/14	14.7	6.4	21.4
	2014/15	15.9	8.7	32.4
	Average	15.4	-	-
Number of community treatment days provided for each person each quarter (Target: 10-20 days)	2012/13	8.5	6.0	11.2
	2013/14	8.3	6.0	10.6
	2014/15	8.1	5.6	12.2
	Average	8.3	-	-
Percentage of community service-user related time with client participation (telephone or face-to-face) (Target: 80-90 %)	2012/13	86.2	72.9	96.8
	2013/14	89.0	73.5	97.9
	2014/15	89.7	68.7	98.6
	Average	88.3	-	-

Source: www.mhakpi.health.nz.

Notes: We have not included data from Lakes DHB because we were told these were incorrect.

One person can have multiple discharges, because each time they are discharged is counted separately.

Efforts to improve how information is used

- 5.17 In our view, the Ministry is starting to collect and report more useful information. DHBs and other service providers, supported through the KPI Programme, have been looking at how they can improve their use of information over time. There is more for the Ministry and DHBs to do to understand what influences outcomes for people, including the effectiveness of discharge planning so that they can improve their services.

The Ministry is starting to collect and report more useful information

- 5.18 From 1 July 2016, the Ministry has started to collect data from some DHBs, in a Supplementary Consumer Records Collection to PRIMHD, on selected social outcomes indicators for people receiving services for mental health and whether they have a wellness plan in place. The social outcome indicators are accommodation status, employment status, and education and training status.
- 5.19 For 2017/18, the Ministry is modifying the discharge planning measure in the DHB non-financial reporting framework to include all age groups and with an expectation that 95% of people have a transition plan⁷ at discharge and 95% of those who have been in the service for a year or more will have a wellness plan.⁸ The measure will also expect DHBs to carry out file audits to determine the quality of the plans and report the results. The Ministry is introducing file audits in response to some of our findings from this audit. We support changing performance measures when doing so makes them more meaningful.

Making better use of information is an ongoing focus for the KPI Programme

- 5.20 In our view, the mental health sector has made progress in using information to improve service performance through the KPI Programme. The *KPI Programme Strategic Plan 2015-2020* outlines how developing how the indicators are used is expected to better inform improvements to services and outcomes for people. The strategic plan focuses on three priorities:
- governance and leadership in the use of information to drive improvement, including through advocating for sector-wide improvement and engaging people using mental health services and their families;
 - collaborative learning and performance improvement, including through focusing on improving a person's experience and sharing lessons and experiences across all those involved in a person's continuum of care; and

7 A transition plan is equivalent to a discharge plan.

8 A wellness plan is another term for a relapse prevention plan.

- increasing data capability to help the sector in improving the range and quality of data and information available for decision-making.

There is more to do to make better use of information

- 5.21 In our view, the Ministry and DHBs need to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and make service improvements. More work is needed to:
- establish and use solid outcomes measures;
 - systematically gather and use feedback from people using mental health services and those supporting them;
 - build capability to use data and information; and
 - address some lack of trust and confidence in the quality of the available data.

Solid outcomes measures need to be established and used

- 5.22 We acknowledge that data for some social outcome indicators have started to be collected recently, but in our view further work is needed to establish and use solid outcome measures and create a framework to demonstrate how activities such as discharge planning contribute to outcomes.
- 5.23 The sector uses the HoNOS outcomes tool,⁹ completed by clinicians, to assess the health and social functioning of adults with severe mental health problems. HoNOS improvements after admission to an acute inpatient unit are used as one of the qualifying criteria for discharging a person from the unit.
- 5.24 HoNOS has supporters and detractors. At one of the DHBs we visited, we were told that HoNOS did not contribute useful information to service improvements. We were told that it was not used consistently and was seen as a “tick box exercise”, with poor reliability and a lack of training in how to use it. Some staff said they would like to use it better and that steps were being taken to improve its use. Others said they would like to have it scrapped. At another DHB, some staff were not committed to using HoNOS because it was not seen as an accurate representation of the treatment provided.
- 5.25 The Ministry told us that it is moving to outcomes-based commissioning for mental health services. The Mental Health and Addiction Commissioning Framework published in August 2016 provides guidance and direction for those who are responsible for commissioning care to improve outcomes for people with mental health and addiction issues. We support an outcomes-based approach to improving mental health initiatives.

9 Developed in the United Kingdom by the Royal College of Psychiatrists' Research Unit between 1993 and 1996.

Better collection and use of feedback is needed

- 5.26 DHBs seek feedback from people in different ways, but make limited use of this feedback to improve services. In particular, the views of people who have used mental health services and those supporting them, such as their family and GP, about their experiences of discharge planning and its effects are not systematically collected and considered. This means that the Ministry and DHBs do not have a good understanding of how people are involved in discharge planning and how well discharge planning is supporting better outcomes.
- 5.27 Those DHBs that provided us with information about how they seek feedback said that they used means such as surveys and “service user” forums. At one of the DHBs we visited, we heard from advocates that a Whānau hui gave families the opportunity to provide feedback about inpatient unit services. At another, we heard of opportunities for people who had used mental health services to provide feedback and saw an example of a change made as a result of feedback.
- 5.28 However, generally we found that systems to collect and use feedback were underdeveloped. Most DHBs relied on complaints, or the absence of complaints, as a measure of satisfaction.
- 5.29 Because people receiving treatment can be reluctant to complain about the staff treating them, some DHBs have begun to use anonymised real-time feedback by giving people access to an electronic tablet running a feedback application.
- 5.30 We also heard from patient advisors and family advisors that DHBs did not make the best use of them as a resource to bring a user perspective. Nearly every advisor we spoke to or who responded to our survey felt that their involvement was tokenistic. One DHB had not had a patient advisor for nearly two years.

Barriers to using data and information to improve services

- 5.31 Increasing the capability to use data and information is one of the priorities identified in the *KPI Programme Strategic Plan 2015-2020*. For staff in the DHBs we visited, capacity and systems make the effective use of information difficult.
- 5.32 Overall, there was limited use of data and information to inform service improvements at the three DHBs we visited. At one DHB we visited, we were told that there was limited evaluation of what mental health interventions work well because staff lacked the tools, time, and expertise. We also heard that cross-sector evaluation of what works was weak. At another DHB, we were told that there was a lack of capacity to use data to effectively monitor service delivery and make changes.

- 5.33 During our visit to one DHB, staff said that information systems did not support accurate data collection and that information was held in different places, making it hard for staff to gather data and get a complete picture of outcomes for people using services. Staff said that there was no way of tracking a person's care between services. At another DHB, we were told that information was hard to find. At another, we were told that there was no one place to check whether discharge plans were working.

Addressing a lack of trust and confidence in the quality of the available data

- 5.34 We heard a range of frustrations – and varying degrees of confidence or mistrust – about the reliability of the available data from the people throughout the sector that we talked to about how information could be used.
- 5.35 The Ministry and DHBs use data definitions and data quality checking to control the quality of the data in PRIMHD. However, these do not prevent discrepancies occurring. We also heard that some people felt what the KPI Programme indicators showed was disconnected from the reality they experienced.
- 5.36 For some, these issues devalued the data and indicators, and how they could be used.

Using information better to improve services and understanding

- 5.37 In our view, looking at the patterns and trends in people's experience of services will provide a greater understanding of how to improve services. In the remainder of this Part, we show this by looking at the data for two of the indicators from the KPI Programme and what these reveal. We also introduce work we have shared with the health sector on viewing a person's contact with mental health services as a timeline of interactions. Our work was based on the innovative thinking of an individual working in the mental health sector.

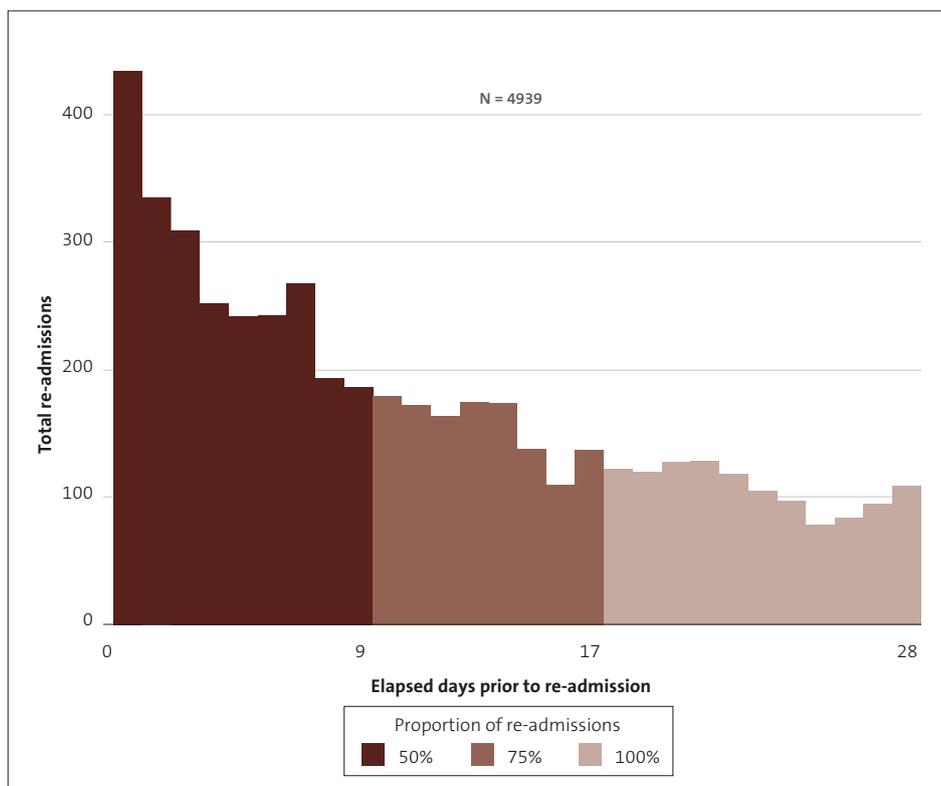
Patterns and trends in people's experiences

- 5.38 We looked at two indicators from the KPI Programme and analysed the data. The indicators related to:
- follow-up contact with people after their discharge from inpatient units; and
 - people's re-admission to inpatient units.
- 5.39 In our view, the patterns and trends we highlight could be useful for the Ministry and DHBs in considering how to improve services.

Patterns and trends in people’s experiences of re-admission to inpatient units

- 5.40 The indicator for re-admission shows the overall percentage of re-admissions to acute inpatient units within 28 days of discharge. We looked at the distribution of all re-admissions that occurred within 28 days of discharge from an inpatient unit, for the period 2011/12-2014/15. Figure 7 shows that almost half of all re-admissions occurred within nine days of discharge, and three-quarters within 17 days. In other words, most re-admissions occurred well before 28 days had passed.
- 5.41 Figure 7 excludes people who were re-admitted on the same day that they were discharged. This often happens when people given day leave from the inpatient unit get counted as a discharge and re-admission on the same day.

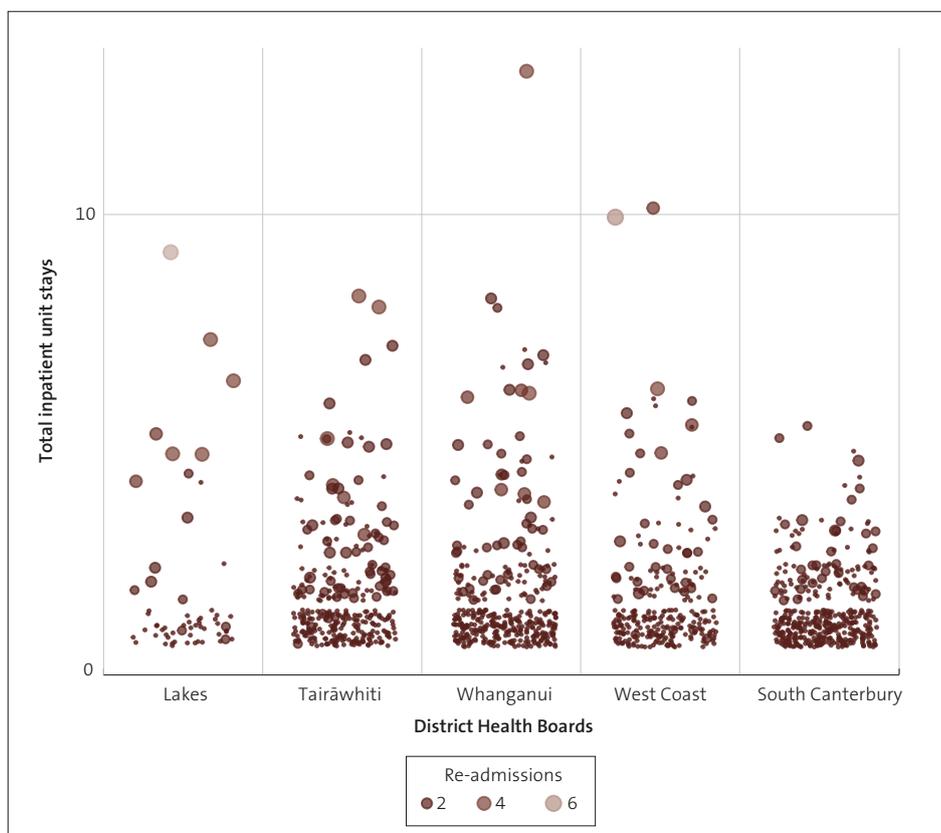
Figure 7
Profile of when re-admissions occurred for re-admissions between 1 and 28 days after discharge, 2011/12-2014/15



Source: Our analysis of Ministry of Health data.

- 5.42 We also looked at the profile of re-admissions by three-month periods for small, medium, and large DHBs and found that:
- the spread of rates is erratic from one quarter to the next;
 - the rates for some DHBs (outliers) is as high as 100% in a particular quarter (meaning every single inpatient stay in that quarter would have been a re-admission); and
 - there is no clear pattern of an ongoing decrease (or increase) in re-admission rates.
- 5.43 Small DHBs (which have the lowest numbers of people using acute inpatient services) are more prone to erratic swings in their re-admission rates than medium or large DHBs. Medium and large DHBs display progressively tighter distributions of re-admission rates from one quarter to the next, with less wide-ranging outliers.
- 5.44 Focusing in on the cohort of people described in paragraph 1.13 and needing acute mental health services, we looked at re-admissions for each person. Figure 8 shows re-admissions for each person treated in five small DHBs.

Figure 8
Distribution of re-admissions and all inpatient unit stays for people at five small district health boards



Source: Our analysis of Ministry of Health data.

- 5.45 The larger bubbles in the top three-quarters of Figure 8 represent people who have experienced many re-admissions during their inpatient stays. There is a relatively small number of these people. Most people have had fewer inpatient stays and no re-admissions.¹⁰ These are represented by the smaller bubbles at the bottom. We found a similar distribution pattern for all DHBs.

Patterns and trends in people's experiences of follow-up contact

- 5.46 The indicator for follow-up activity looks at the percentage of people who were contacted by the community mental health team within seven days of their discharge from an inpatient unit. The contact does not need to be in person, but some forms of social media contact are excluded.

¹⁰ An inpatient stay counts as a re-admission when it occurs within 28 days after the most recent discharge and within the same inpatient unit. This means that, for example, a person can have more than one inpatient stay but no re-admissions.

- 5.47 Our analysis showed that follow-up rates for small DHBs display a similar picture to that of re-admission rates: movement is erratic and highly variable over time. Similar to the 28-day re-admission rates, the follow-up KPI displays a tighter distribution as we move from small to medium to large DHB groups. However, there is no clear observable trend for all three DHB groups.

Viewing a person's contact with mental health services as a timeline of interactions

- 5.48 Building on innovative thinking already happening in the sector, we used the data for the cohort of people described in paragraph 1.13 to construct timelines of people's contact with mental health services. We constructed these timelines for individuals and for groups of people. We took the concept of using visual timelines to understand people's interactions with mental health services, which was developed by people working in the health sector, and refined it to highlight its potential uses.
- 5.49 Currently, it is not always easy for clinicians to form a quick impression of a person's contact history (the details of which might be bundled together as part of various case notes). Timelines show a single picture of a person's contact history, providing clinicians with an intuitive mechanism for rapidly understanding patterns of contact, and can be adapted to focus on different types of contact, groups of people, or areas of the health service.
- 5.50 Viewing data from a person's perspective can also:
- help DHB clinicians and administrators to understand who is using their services and plan to meet their needs, including identifying service gaps; and
 - enable identification and sharing of good practice between DHBs, and enable services between DHBs to be co-ordinated when a person moves, to help with their continuity of care.
- 5.51 Alongside this report, we have made more information available on our website (oag.govt.nz) about the concept of people's timelines showing their different types of contact with mental health services, and potential uses of it.

Recommendation 4

We recommend that the Ministry of Health and district health boards quickly make improvements to how they use information to monitor and report on outcomes for people using mental health services.

Recommendation 5

We recommend that the Ministry of Health and district health boards use the information from this monitoring to identify and make service improvements.

Appendix

Letter from the Ministry of Health



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5 May 2017

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Dear Mr Matthews

Mental health: effectiveness of planning to discharge people from hospital

I appreciate the opportunity to comment on the issues raised in your report into discharge planning for people in inpatient mental health services. We welcome the report of your audit of the effectiveness of planning to discharge people from inpatient mental health services. It will be a valuable source of information to assist district health boards (DHBs) and the Ministry of Health (the Ministry) in our efforts to continually improve mental health service delivery. As you note in your report, discharge planning is not a separate component of service delivery; rather, it is an integral aspect of good care.

In the period since you commenced your investigation, there are several areas in which considerable work has been done to enhance service delivery across district health board (DHB) mental health services. Some of that work was outlined in a recent address by Hon. Dr Jonathan Coleman, at the launch of the Health Quality and Safety Commission's (HQSC) mental health quality improvement initiative.

Some of the work already in progress is being led from the Ministry and others (including the KPI project referred to in your report) are driven by the sector. We recognise that mental health services are under considerable pressure as a result of increased demand. As a result, the Ministry is considering how best to support mental health system pressures and address broader social needs, such as housing. Some of the key actions already under way are outlined below.

Mental health as a priority

The Minister of Health made it very clear that although there are challenges in meeting the demand for mental health services, both the mental health system and the wider social sector is responding. The Minister has included mental health in his recent 2017/18 Letter of Expectation to all DHBs and it is also further reflected in DHBs' Annual Plans. Greater visibility of the ways in which DHBs meet their obligations for discharge planning will also be assisted by including a section on the discharge planning KPI as part of the Annual Report of the Office of the Director of Mental Health.

Mental health strategy and supporting resources

To help guide continued transformation of mental health and addiction services, the Government is adopting a new approach. The Minister of Health has announced his intention to take a paper to Cabinet in the near future, outlining the Government's approach to a new mental health and addiction strategy. This approach recognises that mental health and addiction issues are not simply 'health' problems and that there are significant gains to be made from taking a social investment approach. The development of a new strategy will be informed by other work, including early feedback arising from public consultation on the draft suicide prevention strategy (currently underway) and work being undertaken by the Social Investment Unit. I anticipate that the new mental health and addiction strategy will have an increased focus on prevention and early intervention, as well as building on the gains already made under 'Rising to the Challenge'.

The He Tangata Framework is an analytical tool that identifies critical factors impacting mental health and allows us to identify populations experiencing inequity of mental health and addictions outcomes from the total NZ population. I expect the tool will usefully inform both the national strategy, and DHBs' own annual planning, within the context of the Mental Health Commissioning Framework.

The Ministry's recently-published Mental Health and Addiction Workforce Action Plan 2017–2021 states that New Zealand's health workforce is highly skilled and professional, and acknowledges that the workforce faces staff shortages, as well as that Māori and Pacific health professionals are under-represented in the ethnic distribution of this workforce.

National quality improvement programme

The Minister has recently launch a national quality improvement programme for mental health. This programme has been developed by the HQSC as a result of meetings with the Chief Executive Officers of DHBs and the Minister of Health, and:

- has DHB mandate and ownership and is supported by the sector
- serves as a repository for evidence and best practice for service quality improvement
- establishes standardised, evidence-based processes and practices within MHA services
- begins to generalise best practice across all MHA services and monitors impacts and effectiveness
- employs proven methodologies for service quality improvement
- actively rejuvenates leadership in the sector.

The proposal is endorsed by DHB Chief Executives, and is designed to complement and augment other initiatives in the sector. The programme will focus on a small number of nationally agreed priorities and use the collaborative methodology similar to the Scottish Patient Safety Programme and the Institute for Healthcare Improvement. Assistance and leadership for the programme will also be sought from those services and agencies that have implemented and/or supported successful improvement initiatives, including DHBs, NGOs, PHOs and MHA workforce centres. It will be run for the next five years at a cost of around \$7.5 million, with a review after the first three years.

Proposed priority areas for improvement include a focus on improving service transitions (including from inpatient to community services). Initial steps are in place to implement the programme, with a national leadership group and clinical lead currently being appointed and the programme commencing from July this year. The programme also supports training for quality improvement facilitation, to support DHBs in building their own capability in quality improvement.

Conclusion

In conclusion, there are always opportunities to do better and this includes improvement in the ways in which mental health services support people in moving from inpatient to community mental health services. I am confident that audit report's findings, alongside the processes and activities outlined in this letter, will lead to sustained improvement in the ways in which mental health services support people in need of their care.

Yours sincerely



Chai Chuah
Director-General of Health

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