DHB Office
Braemar Campus

Private Bag 18
Nelson, New Zealand

8 June 2021

[redacted]
Via Email: [redacted]

Response to a request for official information

Dear [redacted]

Thank you for your request for official information received 16 March 2021 by Nelson Marlborough Health (NMH)[1], followed by the necessary extension of time 15 April 2021 and notice of decision 14 May 2021, where you seek the following information.

1. ***Copies of documents created since the start of 2019 that relate to the condition, performance and adequacy of specialist mental health facilities managed by the DHB. If it helps to refine my request, I am particularly interested in documents such as reports, briefings and letters that provide an overview of deficiencies in the ability of mental health units to provide adequate treatment for patients with serious mental illness, including factors such as funding, demand, staffing, overcrowding, patient safety and comfort, readmission rates, and the physical state of the facilities.***

NMH response: The service reports quarterly to the Advisory Committee, a statutory committee of NMH. This report is part of the publicly available agenda for that Committee published on our website. See: https://www.nmdhb.govt.nz/quicklinks/news-and-publications/published-documents/board-and-committee-agendas/

2. ***Copies of business cases for repairs or upgrades of existing specialist mental health facilities.***

NMH response: We do not have any reports subsequent to 2019 on the inpatient mental health facility.

3. ***Copies of business cases for the building of new specialist mental health facilities.***

NMH response: Please see attached NMH *Wahi Oranga Upgrade Business Case*.

Please also provide data for the last five years, broken down by month if possible, on the following metrics:

4. ***Bed occupancy rates in specialist mental health and addiction facilities (broken down by facility if possible and applicable).***

NMH response: Table One shows occupancy rates, by month, for our Mental Health (MH) Inpatient Units. Data prior to June 2018 is not held in a centrally retrievable central data system and, as such, NMH declines to respond for this aspect of your request under section 18(f) as *'the information requested cannot be made available without substantial collation and research'*.

[1] Nelson Marlborough District Health Board

- Wahi Oranga Mental Health Inpatient Unit: 94%
- Older persons Mental Health Inpatient Unit: 89%

TABLE ONE

Year Month	Wahi Oranga MH Inpatient Unit	Older Persons MH Inpatient Unit
2018 06	26	11
2018 07	29	10
2018 08	26	8
2018 09	26	7
2018 10	29	7
2018 11	28	9
2018 12	31	8
2019 01	30	9
2019 02	31	10
2019 03	30	8
2019 04	31	7
2019 05	31	9
2019 06	32	10
2019 07	30	10
2019 08	29	8
2019 09	28	7
2019 10	30	9
2019 11	31	9
2019 12	28	10
2020 01	30	11
2020 02	28	9
2020 03	25	7
2020 04	24	8
2020 05	25	8
2020 06	28	10
2020 07	24	10
2020 08	27	8
2020 09	27	9
2020 10	28	10
2020 11	24	10
2020 12	26	10

5. ***Bed numbers in specialist mental health and addiction facilities (broken down by facility if possible and applicable).***

NMH response: Please see table Two.

TABLE TWO

Facility	Beds
Wahi Oranga Mental Health Inpatient Unit	30 beds
Older Persons Mental Health Inpatient Unit	10 beds

6. ***Unplanned readmission rates in specialist mental health and addiction facilities (broken down by facility if possible and applicable).***

NMH response: Table Three shows 28 Day Readmissions, by month, to either the same or the other Mental Health Inpatient Unit. Data prior to June 2018 is not held in a centrally retrievable central data system and, as such, NMH declines to respond for this aspect of your request under section 18(f) as *'the information requested cannot be made available without substantial collation and research'*.

***Caveat:**
Work is underway to redefine and improve this data collection. Numbers for Older Persons Mental Health (MH) Inpatient Unit fluctuate dramatically due to low numbers of discharges each month.

TABLE THREE

Month	Wahi Oranga MH Inpatient Unit	Older Persons MH Inpatient Unit
2018 06	11%	0%
2018 07	14%	0%
2018 08	8%	0%
2018 09	4%	0%
2018 10	4%	0%
2018 11	6%	100%
2018 12	12%	0%
2019 01	3%	0%
2019 02	8%	0%
2019 03	15%	20%
2019 04	12%	
2019 05	12%	
2019 06	15%	0%
2019 07	7%	0%
2019 08	26%	0%
2019 09	29%	0%
2019 10	12%	25%
2019 11	20%	0%
2019 12	11%	100%
2020 01	20%	0%
2020 02	8%	0%
2020 03	9%	0%
2020 04	19%	0%
2020 05	5%	0%
2020 06	29%	0%
2020 07	16%	33%
2020 08	7%	0%
2020 09	16%	0%
2020 10	13%	0%
2020 11	25%	0%
2020 12	22%	100%

7. ***Funding for specialist mental health and addiction facilities.***

NMH response: Table Four shows total funding allocated and the amount spent on Mental Health services (Inpatient and Community) over the last five financial years. This spend covers all mental health services as we do not separate out adult funding/costs from that allocated to infant, child or youth. The costs include workforce, clinical and non-clinical supplies, and payments made to Non-Government Organisations and other District Health Boards.

TABLE FOUR

$M	2015/16	2016/17	2017/18	2018/19	2019/20
Funding	$40.28	$41.13	$41.69	$43.44	$44.43
Costs	$39.93	$40.25	$42.30	$43.60	$46.54

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602.

If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz I trust that this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely

Lexie O'Shea
Chief Executive

Encl: NMH *Wahi Oranga Upgrade Business Case* 14 September 2020 V1.1 Final (21 pages)

Nelson Marlborough Health

Wāhi Oranga Upgrade
Business Case

Prepared by:	Mental Health Services
Prepared for:	Capital Investment Committee
Date:	14 September 2020
Version:	V1.1
Status:	Final

Document Control

Document sign-off

Role	Name	Sign-Off Date
Project Manager	Stewart Lawson	
Senior Responsible Owner / Project Executive	Jane Kinsey	
General Manager	Jane Kinsey	
GM Finance, Performance & Facilities	Eric Sinclair	
Chief Executive	Peter Bramley	
Board [if applicable]		

Document history

Version	Issue Date	Changes
0.1	2 July	Initial Draft GM MHA&DSS
0.2		Additions from Service Manager facilities
0.3		Review by GMFPF and number of edits
0.4	21 July	Consolidated version by GM MHA
1.0	21 August	Review GMFPF/CEO
1.1	14 September	Addendum completed following MOH review

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1 Purpose

1.1 Summary of the investment

To upgrade grade the Mental Health Inpatient Unit – Wāhi Oranga. This inpatient unit services our Nelson, Tasman and Wairau areas, a population of approximately 150,000 people.

This would be a collaborative project that will use co-design processes and optimise the skills, knowledge and expertise of internal and external parties inclusive of our clients, whānau, operational teams, contractors, property management, financial and funders.

This upgrade will look specifically at the more acute care end of the building including seclusion rooms, addition of a sally port to support acute admissions, IPC area, nursing station and entrance to the unit.

This investment is not only in bricks and mortar (asset portfolio) but also in supporting the aspects of improving safety and support for our teams and our clients, as appropriately designed facilities do have a role in supporting our implementation of improved models of care.

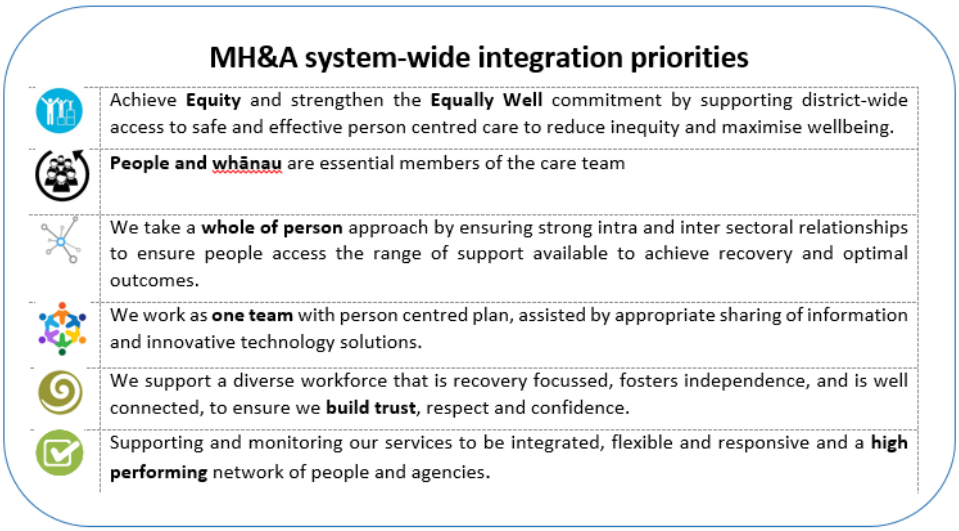
1.2 Recommendation

It is recommended that the funding of $ 2.5 million be approved to allow this valuable project to proceed. In the first instances from approval of funding NMH will proceed to enhance the initial design work already undertaken to produce a detailed design followed by an approach to the market for a fixed price construction contract

2 Strategic Case

2.1 Problem definition

Mental Health services are actively working to ensure continued alignment to the Te Ara Oranga report and the governments recommendations form this and we continue to work towards our aim of *"working with people in our community to promote, encourage and enable their health, wellbeing and independence by providing flexible, responsive, integrated mental health and addictions services"*. The following diagram depicts the high level strategy for our Mental Health Services:



To better contribute to the achievement of this strategy and priorities an upgrade is required to the Mental Health Inpatient Unit, known as Wahi Oranga. Wahi Oranga was built in the mid-1990s on the Nelson Hospital site. It has also had some modifications in the 2000's to the acute (IPC and seclusion) areas.

Recent reviews of the service have highlighted possible modifications and/or extensions to this facility as outlined below. They have been developed through workshops with staff and architects. There are several factors leading to the need to scope possible modifications and/or extensions to this facility outlined below:

2.1.1 Team safety

Workplace violence and aggression is one of mental health services critical safety risk. Re-design of the IPC and seclusion area to provide greater flexibility for de-escalation spaces, seclusion lounge, access to outdoor area and an area for welcome/arrival.

The principal risks to staff safety are:

a) Design weaknesses around the main entry where triaging is unreliable, and patients and visitors are admitted directly into the ward without a transition space and safety risks to main reception staff.

b) Patient reception and admission spaces, that do not:

- Allow staff to feel safe, be safe, and be able to withdraw to a place of safety and security within a staff area.
- Allow staff to safely and fully carryout a full medical triage, clinical triage and security triage in order to determine risk levels and informed care plans.
- Provide for people who accompany, visit or otherwise support patients in a safe and secure manner without risk and disruption.
- Allow patients to be welcomed, deescalated, made comfortable, and informed so as to experience a suitable transition before going into the unit. This helps minimise potential 'admission shock' which is a recognised 'flash point' for conflict.
- Require visitors to necessarily transit through patient areas.
- Require staff to transit through patient areas to access or to safely withdraw from entry/reception/admission spaces.

c) Interview / consult rooms: Unsafe design without a safe egress path for staff to exit to a secured staff area to protect themselves and others

- A lack of interview / consult rooms causing offices and other spaces which are risky and not designed for this purpose to be used instead.
- The conference room is multipurpose, used by several parties and is currently not designed with safety in mind – let alone for interviews and consults.

d) Nursing stations (main and IPC): Configured for good visibility but not a 'hub' for all the spokes which are disconnected from IPC and the main entry which,

- Can drive patients elsewhere to seek privacy, and
- Staff to seek respite from patients when not actually supervising them.
- Does not feel secure and would benefit from security-for-safety enhancements and review of amenities'

- Parts of the wards (and therefore other staff and patients) are out of direct sight from the nursing station(s).

e) Staff safety issues around IPC include:

- Nursing station is isolated, cramped, has poor natural visibility, and lacks a safe exit path direct to a staff area. Lack of amenities compromises continuity of patient supervision.
- The meeting/interview room has no privacy and unsafe on account of the blocked exit door.
- The lounge, external courtyard and bedrooms have blind spots.
- No satisfactory triage / interview / consult / transition space as part of the admission to IPC – particularly for the rear entrance to the wing.
- Security and safety risks arising when staff need to take clients outside of the IPC unit to other areas for meetings and consults;
- No ability to segregate acute clients without transferring them to the Secure Care Unit;
- Needing to enter bedrooms alone at night for patient-watch due to poor room lighting.

f) Secure Care Unit and Seclusion: safety risks are similar to the IPC unit, but also include:

- Narrow corridors and doors make it less safe when multiple staff are needed to manage acute clients.
- No safe local consult space.
- The technical security systems, electronic access control systems are rudimentary, CCTV has limited and poor coverage, and the duress alarm system is being revised.
- There are residual risks around managing clients who act out and become threatening, aggressive and violent. Added safety risk comes from having limited numbers of SPEC trained staff (the NMH security staff are trained in both MAPA and SPEC and use the appropriate techniques based on the situation and location they are in) on site to manage an incident for as long as is needed for additional resources to arrive from the main hospital or the Police. As is evident in ED and Mental Health facilities in all DHBs, the need to be safely self-reliant until suitable additional resources arrive, is paramount.
- Environmental design factors[1] that affect clients adversely and that can result in flashpoints or escalating behaviours ranging from unpleasantness to violence against staff.

[1] the Safewards Model moves beyond a simplistic recommendation of quality improvement and to a more precise description of the physical features of wards and their relationship to staff and patient safety. Prompt requests for repairs, attention to décor, supervision of and attention to cleaning services, and keeping the ward tidy can all contribute to a better-quality environment that enhances patients' self-esteem, expresses respect and can reduce absconding. If the ward is locked, staff could increase alternative choices for patients, or act in ways that enhance self-esteem or minimize the impact of the locked door. (Bowers. 2014).

2.1.2 Patient safety and support needs affected by environment factors:

Environmental factors at Wāhi Oranga which can influence safety risk to, and by clients, and consequently transferable to staff.

We need to remove our current fishbowl nursing station and redesign a space which supports team's workflow and increases engagement opportunities with clients. Our entry to the unit will also be made more warm, friendly and welcoming as well as a better designed entry of emergency vehicles with the addition of a sally port.

The main conclusions that can be drawn from a recent review of security-for-safety matters from the environmental / building perspective are summarised below. Underpinning these conclusions and the discussion is the important role of the environment of the building for security for safety, both directly and indirectly – for which there is a well-known track record.

Moreover, there is an opportunity to follow the principles of Wai Ora which encapsulate the importance of the environments in which we live and that have a significant impact on the health and wellbeing of individuals, whānau and communities.

Staff have engaged seriously in reducing our levels of seclusion and have made a significant difference in our utilisation of these rooms. There is however, feedback from staff and recommendations form Te Pou that there are aspects of the facility that do not support best practice nursing and allied support and ideally are addressed. If they were to be addressed, then this will further support our efforts to reduce the utilisation of seclusion rooms.

Some examples of where improvements can be made include:

- Unwelcoming, institutional, potentially foreign (and thus feared) entry at the main reception, bordering on that of a prison at the rear entry.
- Admission shock due to the lack of or poor admission and transition spaces, particularly the rear entrances into IPC and Seclusion.
- Lack of space to have family, whānau and support people to visit and if necessary stay a while.
- Nowhere to find privacy outside of the bedroom. However, a degree of situational awareness, if not direct supervision, does need to be maintained through careful design
- Limited features that are culturally familiar and comforting or able to be personalised (except for chalk boards).
- Poor use of colour for comfort, normalcy, homeliness and therapy.
- A prison like sensory environment failing in terms of excessive and unwanted stimulus, equally as lacking desirable stimulus, e.g.: bedrooms, mattresses, robust toilet fittings, locks and hardware, and finishes, that are tough, sterile, austere and modelled on prisons and confinement spaces
- Patient lounges that have few of the attributes of a lounge with respect to decoration, comfort, and entertainment.
- An acoustic environment with overly-loud and unpleasant noises (e.g. door slamming - being jarring, and a reminder of an angry gesture, or of being locked away), reverberation, unwanted noise transfer indicative of others being angry or stressed.
- Cage-like courtyard spaces outside for IPC and none for Secure Care; whilst the prison-like environment is harsh in part because of the need to protect against damage and self-harm, innovative design over the last decade or so has demonstrated that these performance

requirements do not necessarily mean that robust, minimalist and aggressive features cannot be mitigated

- Patients are required to be escorted throughout other parts of the ward because meeting facilities are unavailable in the unit.
- Except for the "Sensory Room' which has a different purpose, not all patients have access to facilities that allow them to vent

2.2 Benefits of the investment

As well as updating an older facility closer to the level expected by service users one of the main benefits is improved safety for staff and clients. By providing more appropriate spaces there is a reduced likelihood of escalation and, in the event that there is, the building elements and layout will assist with improved safety and less potential for harm to the client and staff members. This aligns with the improved model of care that will be undertaken in the Wahi Oranga.

More efficient staffing is also seen as an opportunity with the current configuration more segregated enhancements will allow reduce the segregation and allow an improved coverage by staff.

- Improve safety for staff and clients.
- Increase ability to de-escalate situations by design of facility and increased sensory modulation experience throughout the unit; therefore, resulting on an impact on reducing seclusion levels, reducing workplace aggression and staff assaults resulting from high acuity clients
- Improve the pathway for admission to the inpatient's unit by emergency services and the CAT team
- Improve the experience for people and whanau visiting clients in the inpatient unit by making a warm friendlier environment
- Increase ability for our team to genuinely engage with clients by modifying the environment to assist with this.

Wāhi Oranga does not meet many of the current best design practices and the mandates for staff safety. There are significant opportunities for improvements that will result in better staff safety and likely patient care.

Seclusion levels: Staff have engaged seriously in reducing our levels of seclusion and have made a significant difference in our utilisation of these rooms. There is however, feedback from staff and recommendations from Te Pou that there are aspects of the facility that do not support best practice nursing and allied support and ideally are addressed. If they were to be addressed, then this will further support our efforts to reduce the utilisation of seclusion rooms.

Team safety: Workplace violence and aggression is one of mental health services critical safety risk. Re-design of the IPC and seclusion area to provide greater flexibility for de-escalation spaces, seclusion lounge, access to outdoor area and an area for welcome/arrival. It will be necessary to co-design any plans with consumers, whānau, Maori, police and community mental health workers

Engagement with clients: remove our current fishbowl nursing station and redesign a space which supports team's workflow and increases engagement opportunities with clients. Our entry to the unit will also be made more warm, friendly and welcoming as well as a better designed entry of emergency vehicles with the addition of a sally port

3 Economic Case

3.1 Investment proposed

This proposed investment will serve as a significant improvement to our services. We recognise that a re-build and design of a new acute ward is not reasonably, practically or economically possible whilst we are undergoing a detailed process to redevelop the hospital, and therefore our best option is to make adaptations to the existing unit.

Main entrance:

- Improve the entry as a familiar, normal, caring and welcoming place with suitable cultural identifiers embedded.
- Improve direct visibility of the entrance approach and inner lobby for staff and reception.
- Upgrade the main reception kiosk to be more welcoming and have a better view of, and engagement with the entrance.
- Provide a direct link to the Acute wards [via transition spaces] from the main entrance to improve afterhours access and supervision.

Reception:

- Upgrade the main reception kiosk to be more welcoming and safer.
- Create a separate acute entrance at or adjoining the main entrance that can more readily be supported by acute staff, especially afterhours.
- Provide a waiting space suitable for acute patients [not mixed with other patients and visitors].
- Create a welcome lobby for acute patients – The space also needs to be suitable for gathering and adjourning of whanau and visitors with access to toilets and refreshments.

Nursing station:

- Redesign the nurse station so as to be: more secure [screens and doors], but, achievably] perceptually more accessible to patients; whilst, providing a good balance of supervision and ability for staff who are not actively supervising at the moment to withdraw better set up for monitoring secure doors and CCTV.
- Review staff amenities for main nurse station.

IPC:

- A complete redesign of the IPC nurses station is required to achieve client and staff safety objectives.
- For efficiency of access to patient entry points, transition lounge [Atea Oranga], safe interview spaces, and staff situational awareness, the IPC unit should ideally be part of the overall hub and spoke configuration of the AMHS ward – and preferably not an isolated outlier.
- To make safe for an interview room, change the inward opening door into the courtyard to a secured safe egress path. [e.g. slam lock enabled by the duress alarm].
- With specialist professional input, upgrade the IPC courtyard by the application of human factors with respect to type and location of seating, recreational activity, improved planting to be visible from the courtyard but located outside and through the fence [like a reinforced hedge], places with shelter from wind, rain and sun, places to be in the sun.
- Provide an interlocked lobby into the rear entry of IPC.
- Vehicle assisted admissions should enter the building via a securable drop off space – a 'sally port' - to discourage absconding and reduce admission shock by eliminating the need for close handling

- Provide the ability to segregate bedrooms in the Secure Unit and be able to convert to IPC bedrooms as needed.

Main lounge:

- Clients should not feel forced to stay in their bedrooms because the lounge(s) are unsuitable. Lounges should be designed so clients can avoid interacting with others when they don't want to – and not feel that other desirable spaces within the ward outside of their bedrooms are unavailable and inaccessible.
- The main lounge should allow for diverse activities, interests and recreational opportunities. It should support client's needs to be able to regulate their personal space, be alone or mingle in small groups
- The lounge should resemble a series of interconnectable identifiable smaller scale spaces with the ability to annex each other as a bigger space for flexibility of use.
- The lounge should have a close relationship with the external courtyard - not via one offset set of doors, but via a wide controllable opening to a veranda which provides a useful, occupiable, transition space of its own –neither indoors nor outdoors, but perfectly annexing the [upgraded model] courtyard.

Courtyard:

- Tidy up the main courtyard.
- Upgrade the integrity and security of the perimeter fence to a reasonable degree to deter AWOLs.

3.2 Options analysis

A more significant upgrade of the Wahi Oranga facility was proposed within the Nelson Hospital Redevelopment Indicative Business Case submitted in 2019 to the Capital Investment Committee however this was 'descoped' in the Addendum that was submitted in May 2020. This descoping occurred to reduce the overall cost of the Nelson Hospital Redevelopment and recognised that the refurbishment proposed within this Business Case would be sufficient to meet the ongoing needs for a number of years until a more complete redevelopment of mental health inpatient services would be required in 15-20 years.

Given this only the refurbishment option to address the range of fundamental issues identified earlier in this Case has been identified. It is expected that some variation will occur when the detailed design has been completed but this will be managed within the capital envelope provided.

4 Commercial Case

4.1 Procurement plan

The DHB has a range of preferred suppliers for various building/construction services, including architectural, engineering and quantity surveying, that were put in place to support the Nelson Hospital Redevelopment programme however a main development contractor would require completion of a Request for Proposal (RFP) and submitted to the open market as it is expected a number of potential contractors would be suitable to complete this work. The NMH normal procurement procedures would be followed that align to the Government procurement rules.

Initial market research has identified that commercial building companies from the local market will have capacity and be interested in tendering for this work. More market analysis will be undertaken during the formation of the formal procurement plan.

4.2 Commercial risks

For a medium sized project ordinary commercial risks exist with this project however it has been considered that, given the short duration of the build and having a fixed price contract the risk is low. Some of these risks have been identified as:

- Delays in securing a suitably qualified company to undertake the construction work which in turn will impact the completion dates of the project. This could result in potential price (CPI) escalation, although we suspect construction prices will soften due to COVID's impact on the economy.
- Risk main building contractor or subcontractors goes into liquidation and delays construction completion date.
- Cost escalation and over run due to unforeseen issues and resulting variations with the construction work and unforeseen items.
- Internal funding risk to cover additional unforeseen costs during construction.
- Poor construction work and resulting remedial work.
- Impact on service delivery (Mental Health Acute Inpatient care) during construction work from delays.

NMH will monitor these factors during the construction phase however they are considered a low risk. Other risks like a similar Covid outbreak occurring could vary considerably in severity and are beyond our ability to predict.

5 Financial Case

5.1 Capital cost

The total estimated capital cost for the upgrade is $2,500, 000. The construction cost is based on preliminary options estimate completed by Rider Levett Bucknall, the DHB's quantity surveyor, in July 2020.

Contingency and decanting costs has been allowed for within the total capital cost. The capital project will span three financial years (with the construction process likely over two financial years) being FY22 to FY23 depending on the available resources which could impact the start date.

The estimated construction commencement date is 1 October 2021 (with professional fees to be incurred in 2020/21) while the completion date is estimated by 1 August 2022 (subject to resource, procurement and other consenting processes required).

The following table summarises the capital costs for the project:

Capital Cost ($000)	**2020/21**	**2021/22**	**2022/23**	**Total**
Service Entry / SalleyPort/ Admission	$30	$391	$54	$475
IPC Refurbishment	$12	$151	$21	$184
Acute Day Space	$41	$535	$74	$650
Access for Tipahi Street	$26	$336	$46	$408
Decorate Existing Facility	$17	$216	$30	$263
Electronic Security			$130	$130
Sub-total	**$126**	**$1,629**	**$355**	**$2,110**
Contingency	$25	$271	$44	$340

Decanting*		$50		$50
Total Capital required	**$151**	**$1,950**	**$400**	**$2,500**
External funding requested				
Internal funding requested				

5.2 Operating cost impact

The following table summarises the impact on the net operating costs of the project:

Operating Cost ($000)	2022/23	2023/24	2024/25	Total
Additional facilities, utilities and cleaning	$12	$13	$13	$38
Depreciation	$121	$132	$132	$385
Capital charge	$138	$150	$150	$438
Total operating costs	**$271**	**$295**	**$295**	**$861**
Additional revenue	$0	$0	$0	$0
Savings	$160	$174	$174	$508
Net impact	**($111)**	**($121)**	**($121)**	**($353)**

The upgrade will increase operational costs for NMH, namely an increase in depreciation expense and capital charge been the largest, followed by an increase facility operating costs such as electricity (heating systems inadequate and will be upgraded), cleaning and general maintenance for wear and tear. To offset some of the cost increase, we anticipate nurse FTE time savings resulting from a more efficient building layout, largely in the IPC space.

6 Management Case

6.1 Project management and governance

NMH has commenced the engagement of a project manager to take responsibility for a range of facilities projects including the various "shovel ready" projects. This project manager reports to the GM Finance, Performance & Facilities who will have overall responsibility for the delivery of the various facility related projects.

A steering group for the broader Ki Te Pae Ora programme within the DHB is made up of members of the executive leadership team which will maintain the executive oversight of all the facility projects. In addition a specific steering group for the Respite Blenheim project comprising expertise from the Mental Health Services team will be established to provide the day-to-day direction required for this project.

The project will encompass normal building & construction practise. Complexity will be encountered in project staging and when more complex building systems are encountered. The work will require specialist engineering advice and guidance from Australasian Hospital design standards.

This project requires staging including decamping of areas to allow works to be undertaken without unduly affecting the operation of the service and maintaining staff and client security.

A Project Control Group consisting of the Project Sponsor, Project Owner and Project Manager as well as key stakeholders will provide high level project guidance. Project financials will be overseen

by the Business units Financial Advisor and managed through NMH's financial system TechnologyOne.

The Project Control Group will consider major project decision points; with the Project Manager undertaking most of the day to day control. Critical assistance will be provided by NMH's Procurement, Finance, Facilities and Audit teams

NMH has capacity to complete projects of this size and complexity however, recognising that a busy schedule of work is likely over the next two years, NMH is in the process of appointing an Interim Development Specialist Project Manager who will take over Project Management of this project.

Construction contract is proposed to be NZS 3910:2013

6.2 Project risk

As a more complex build inside an existing and operational facility some risks have been identified being:

Risk Description	Risk Assessment (H / M / L)	Risk Mitigations
Interruption to the service	M	Work with Facility management to ensure appropriate precautions are in place
Unforeseen costs/finite funding	L	Detailed design and qualified consultancies
Governance	L	NMH has established processes.

7 Next Steps

At the completion of the Business Case and when confidence allows the project will proceed to:

1. Engage a contracted supplier for architectural services to complete detailed design and specification. With some initial design work already completed this is expected to take less 6 months to the point of building consent and tender readiness
2. Complete the procurement plan and begin procurement process that is likely to be a lump sum RFP advertised via GETS and, in parallel application made for necessary consents.
3. Value engineering if required
4. Engage the preferred supplier construction company with NZS 3910 with a negotiated start and completion timeframe where completion is expected to be 5 – 7 months from contract execution.

8 Appendices / Attachments

Nil

9 Addendum

The following information is provided is response to the questions raised by the MOH review of this Business Case.

9.1 Improve patient and team experience

NMH is focused on ensuring our Mental Health and Addictions inpatient settings are safe for our clients, whanau and staff team. Reducing seclusion is a focus for us and we recognise that it is multifaceted and complex. The factors recognised by research to reduce seclusion include family and cultural input, early recognition of flashpoints and constructive ways to deal with these, de-escalation, therapeutic relationships, sensory modulation, medication, distress tolerance coping mechanisms, exercise, activities and meaningful engagement and a calm, welcoming environment.

Improving the psychiatric intensive care environment is one of many initiatives at NMDHB to reduce seclusion. The area used for the admission assessment, de-escalation and seclusion of high-risk clients must primarily remain a safe environment. This limits the number of furnishings and comforts that can be provided for consumers and has resulted in a very clinical, sterile, cold and unwelcoming space that does little to soothe distress and anxiety for clients. This area is often the first part of the ward that higher risk clients enter and spend time in and is key for setting initial expectations of both care and behaviour during an admission.

A client who has been assessed as high risk to others may come to the ward escorted by police, they may be handcuffed and will need to be checked by staff to ensure they do not have dangerous items on themselves. They are often extremely agitated and can be very frightened, they will have been admitted under the Mental Health Act, against their will and frequently describe feeling like they are losing control of their basic human rights. They are often experiencing paranoia, grief, loss, visual and/or auditory hallucinations and delusions and commonly lack of sleep. Admission is a high-risk time for use of seclusion and restrictive practice due to both the described factors and the need to ensure safety.

The staff at Wāhi Oranga respond at these times by being welcoming, de-escalating, reassuring and beginning to build relationships, and safely managing any risks and containing the client within the unit. There is no special equipment, staff use their own skills, training and experience to do this well, and in the least restrictive and supportive way possible. Currently the physical environment Is not supportive to best practice. The purpose of this application is to secure funds to use directly in improving the Psychiatric Intensive Care environment to make it more welcoming, calming and reassuring for clients.

Safe ways to improve the physical environment are limited, materials such as doors and bathroom facilities need to be indestructible, glass and windows must safety proof to highest standards and no fittings that can be used as ligature points are acceptable. Furniture has been limited to a built-in concrete plinth with a specially manufactured mattress and blankets. These safety requirements unfortunately have resulted in an environment that is more prison like than appropriate for an acute health setting.

We are currently working on some ideas for improving the environment for consumers in a simple way and see the opportunity for modifications to further enhance what we are trying to do to improve the environment. The following photo images are examples of some images we are looking to seek fundraised funding for as well as purchasing specially made challenging behaviour soft furniture.

9.2 Supporting people with high and complex issues

Our health system is working to focus on improving how we support people and whanau with complex needs by better identification of holistic needs, responding in a timely way, with targeting early identification and having a coordinated planning approach.

Currently we have a model which takes an approach of identifying services that best meet clients/whanau needs. We understand that in some situations needs cannot be met by one or two services working closely together. Instead; as complexity increases on our client and whanau involved in services, we have identified the need to take a more integrated approach across multiple services and agencies is required for sustainable improvement in outcomes to be achieved.

The clients who are envisaged to benefit from our system taking a more integrated approach are people who have presentations which cannot be adequately addressed by any one or more services working within traditional boundaries. The people likely to benefit from this approach often have multiple co-existing issues such as intellectual disability, behaviour issues, mental health, addictions, frailty, physical health concerns, social complexity and current of history of abuse and

neglect. For these people often a 'primary need' focus leads to other needs not being met, or even exacerbated, these 'fit them into a box' solutions, frequently and rapidly fail.

We accept and support that Wāhi Oranga is not an appropriate environment for our long stay clients. Unfortunately, this issue has built up over several years. We have an opportunity to invest in some dedicated SMO time, alongside a multidisciplinary team to work with long term clients in Wāhi Oranga, for a trial period. We will focus on improving our specialist input into clients who have intellectual disability, developmental disorder, forensic, or other complex cognitive needs.

We are establishing an identified MDT team to improve our response and input into clients presenting with complex needs across the mental health, addictions, physical health and disability support systems to prevent avoidable admissions for people with these complex needs. The MDT team will identify ways we can better respond as a system to prevent the need for an admission, as well as facilitate smoother discharge processes.

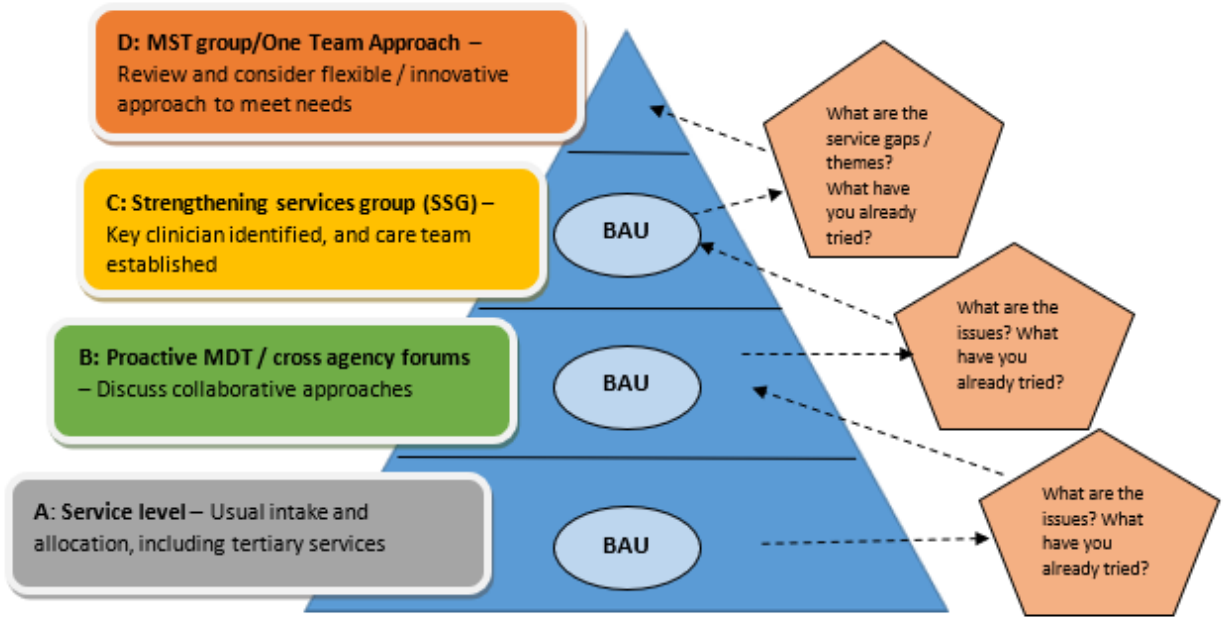
High and Complex needs – Our Model of Care:

Aim: A model which guides a timely escalation pathway for individuals whose needs are complex and cross multiple services and agencies.

Objective: To provide support for clinical teams with integrated care and discharge planning for patients with complex needs – e.g. multiple comorbidities & chronic conditions (including psychiatric) & welfare issues

Outcome: To have a collaborative and coordinated approach to care and support planning to ensure sustainable and timely community support and residential plans are in place for people whanau.

Scope: This model is designed to provide support for individual with complex needs district-wide and across the continuum of the health system.



A. Service level

All services are encouraged to develop and document service responses to meeting the needs of client's and whanau. This is ideally reinforced and supported by utilising Health Pathways.

The documentation of usual referral pathways and processes supports consistency and enables the services to review, refine and improve as processes and systems evolve.

When there are occasions where usual service options and referral pathways have been explored then what has been tried should be documented and escalated to the next level, proactive MDT process.

B. Pro-active MDT / cross agency planning:

We are working to support all services to have an established MDT and/or cross agency forum to discuss complex clients. The purpose is to proactively identify patients that do or have potential to experience complexities. By being pro-active the services can facilitate early access to appropriate service responses as required to prevent a crisis or urgent situations from arising. Identifying and acting early is designed to manage the need and prevent further exacerbation of complexity.

C. Strengthening Services Group (SSG)

This group aims to improve our service's ability to better coordinate between each other. The purpose is to align with the system wide mode of care initiatives, cover the continuum of care and discuss complex care management issues that arise and develop a plan to support and address the needs.

D. Multi Service Team (MST) / One Team

The role of this group is to consider all referrals received, district-wide, where people who have complex support needs who have not been able to be adequately supported by current service provision or been solved at Strengthening Service Group. This group is to identify service gaps and offer solutions from within DHB resource but also by collaboration with external agencies such as other government departments or at Ministry of Health level.

9.3 Concept floor plans

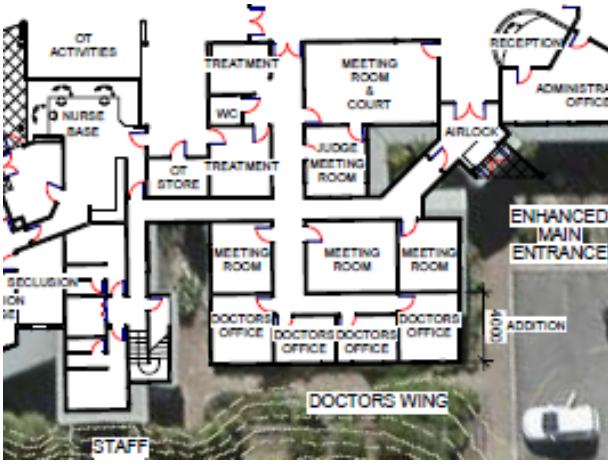
We have received some early drafts of some ideas for how we can modify our Wāhi Oranga.

The current floor plan of Wāhi Oranga is attached to this addendum.

The formal floor plan design for the proposal in this business case is not yet finalised however the following provide a guide to the changes that will be formally drawn into the plans:

Proposed Plan for Acute Area

Proposed Plan for Nursing Area



9.4 Impact on Wāhi Oranga Statistics

9.4.1 Bed Day Occupancy

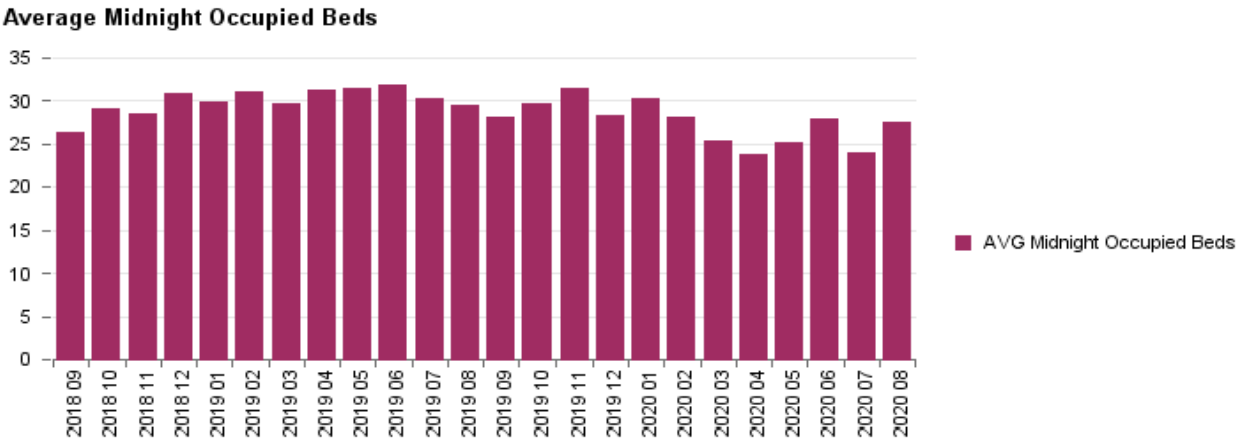
The funded beds for Wāhi Oranga is 25 beds and Tipahi Mental Health (sub-acute) is 5 beds, total funded beds = 30, the number of physical beds is greater than the funded bed days. Bed day occupancy has been high for the last 2 years, at times greater than the number of funded beds.

High bed day occupancy and client acuity within Wāhi Oranga creates extra pressure on staffing resources within the current facility due to its layout inefficiencies resulting in notably more nursing hours worked and it also increases the likelihood of assaults occurring.

Improvement expected: An improved facility design and layout as per this business case will help reduce the pressure on staffing resources during times of high occupancy.

Wahi Oranga Inpatient Unit

	Referrals - 2020 08			Midnight Occupied Beds - 2020 08			2020 07
	Caseload 03/09/20	Received	DX'd	AVG Occupied	Funded Beds	% Occupied	% Clinically Coded
Wahi Oranga Inpatient Unit	26	25	27	27.5	30	92%	100%



9.4.2 Seclusion

The facility redesign allows for increased sensory modulation input which reduces seclusion and restrictive practice e.g. less sensory deprivation with flexible spaces and enhanced sensory input and more opportunity for physical activity as well as ability to provide low stimulus environments to meet other clients' needs.

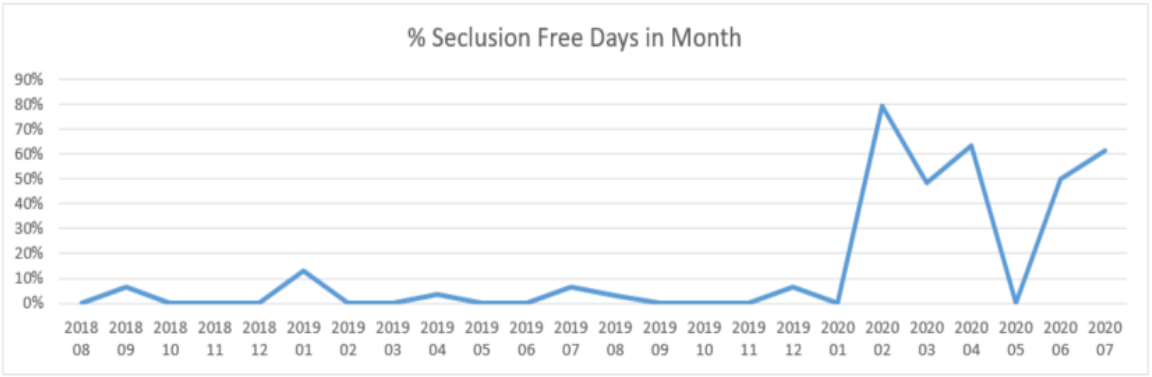
Improvement expected: The total number of seclusion events projected to be reduced due to the improved environment and increased options of care for clients safely with greater flexible. In addition:

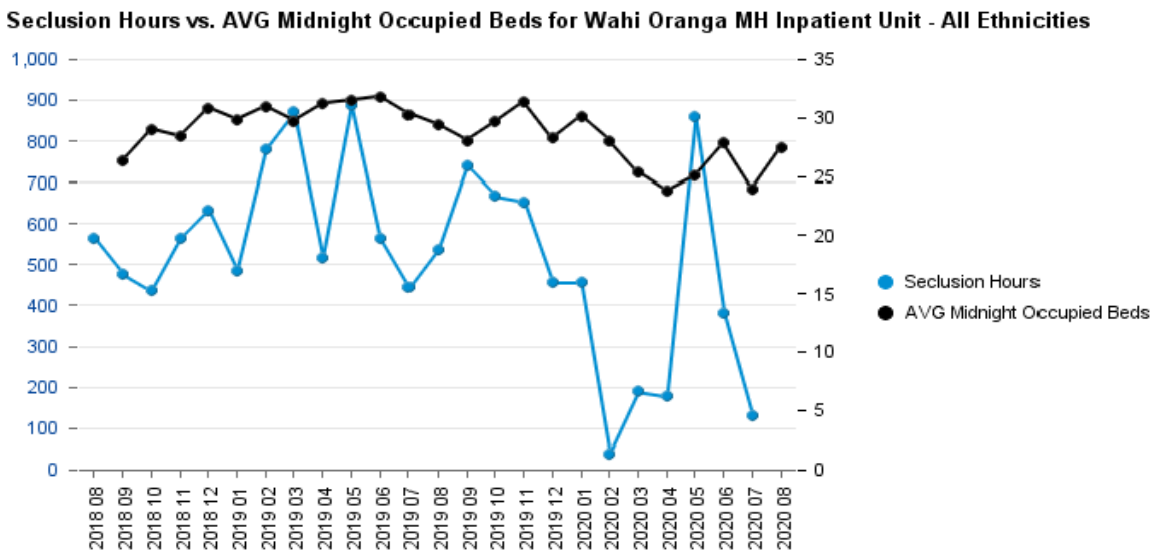
- The length of seclusion is expected to reduce as staff confidence increases when they have other safe options apart from the open ward.
- Restraint and assaults should be reduced, currently seclusion and IPC are separated by a long corridor that is a significant safety hazard to move clients from one secure area to another.

9.4.3 Impact on MHKPI programme data:

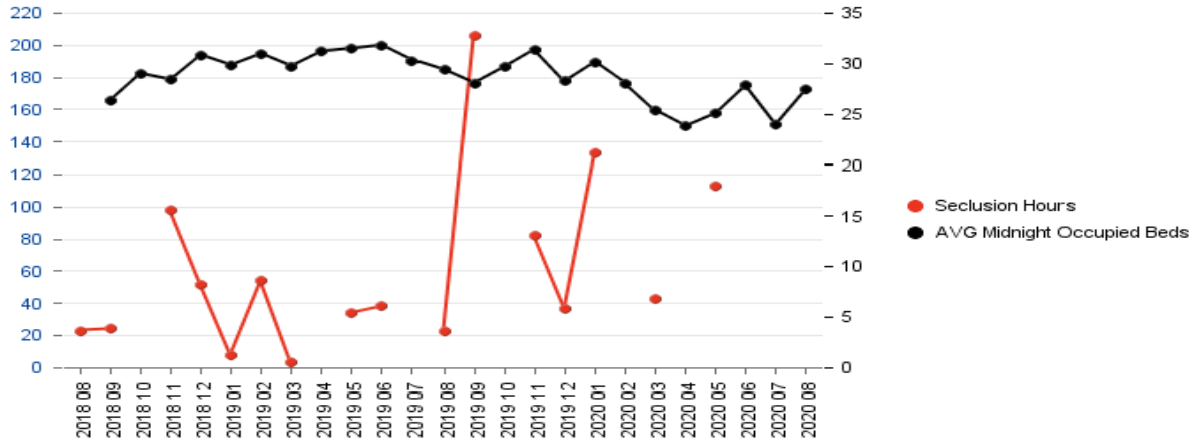
Seclusion

	Seclusion - 2020 07				Seclusion - Last 12 Months			
	Hours	Events	Consumers Secluded	AVG Hours per Event	Hours	Events	Consumers Secluded	AVG Hours per Event
Total	130	9	4	14	12,524	756	99	17
Maori Ethnicity					971	37	27	26
Female					1,750	109	40	16
Male	130	9	4	14	10,774	647	59	17

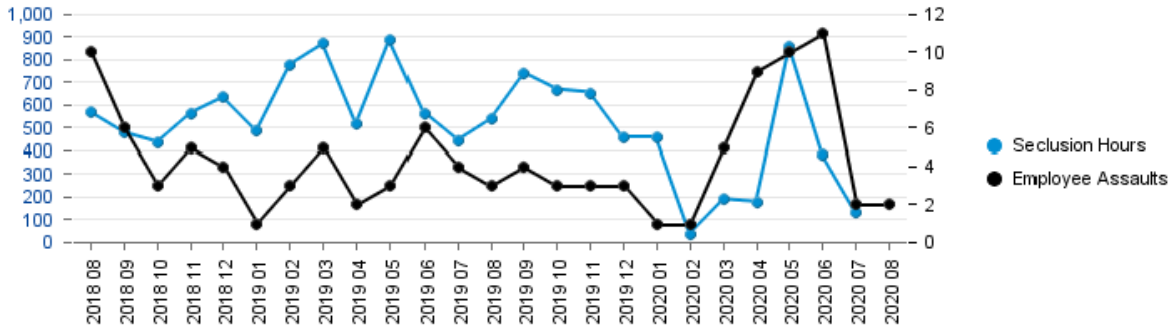




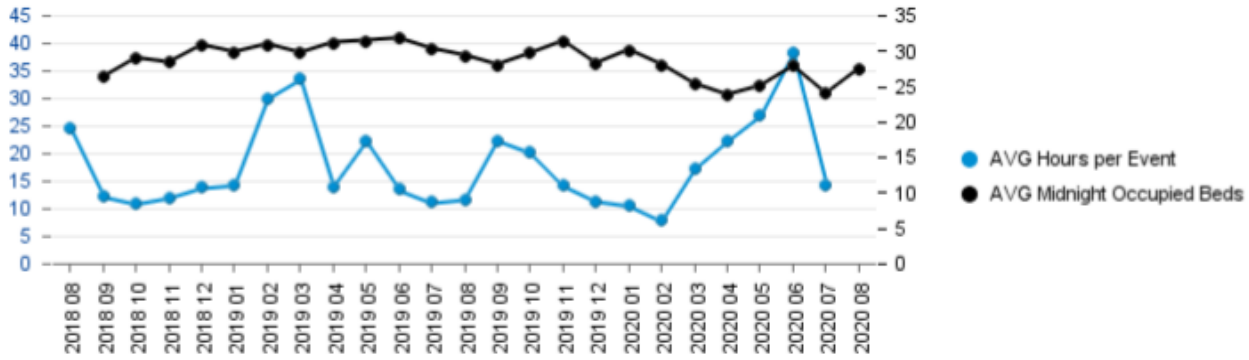
Seclusion Hours vs. AVG Midnight Occupied Beds for Wahi Oranga MH Inpatient Unit - Maori Ethnicity



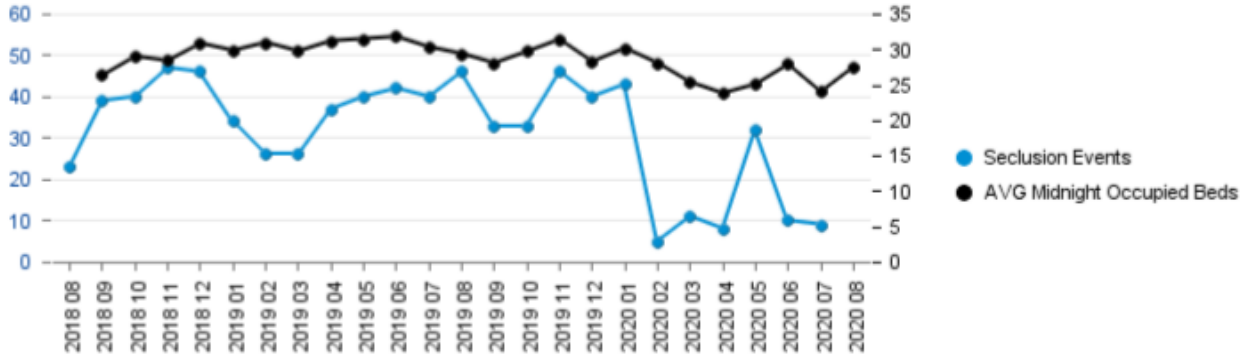
Seclusion Hours vs. Employee Assaults



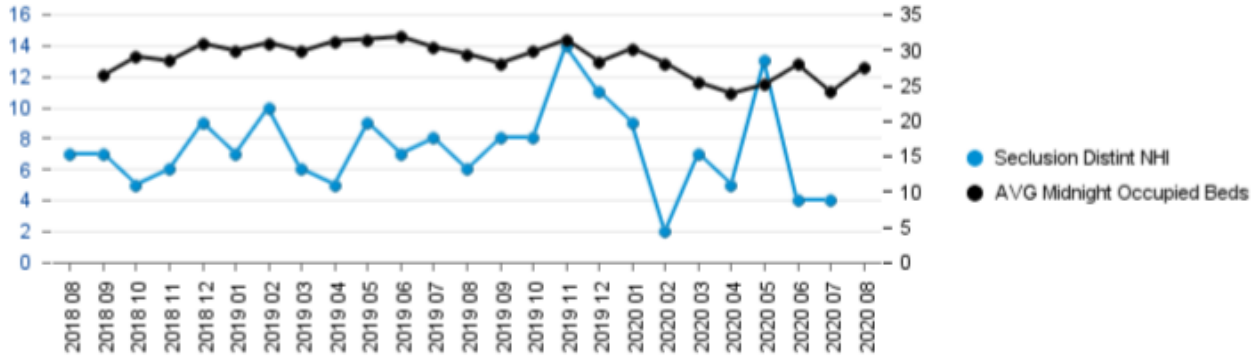
Average Hours per Event vs. AVG Midnight Occupied Beds for Wahi Oranga MH Inpatient Unit



Seclusion Events vs. AVG Midnight Occupied Beds for Wahi Oranga MH Inpatient Unit



Seclusion Distinct Consumers vs. AVG Midnight Occupied Beds for Wahi Oranga MH Inpatient Unit



9.4.4 Average Length of Stay

The facility redesign will improve the admission experience significantly which will lead to shorter stays. Increased ability for family involvement and support of clients in the acute part of their stay improves outcomes and recues admission length.

Improvement expected: There is the opportunity for much improved whanau involvement reduces restrictive practice and length of stay as well as meet cultural needs of clients.

Average Length of Stay (ALOS) Days of Referral