Using *On Track* to achieve system change: A case study of Whanganui DHB Mental health and addiction services

Te Pou o te Whakaaro Nui

Part of the Wise Group

PLATFORM

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Geoff Stone (Ripple Research Design and Evaluation) collected and transcribed all the information relating to the workshop.

Contents

Purpose

The purpose of this case study is to share Whanganui DHB's mental health and addiction services' story of their improvement journey to date. Whanganui DHB's initiatives are used to showcase how organisations can make changes to progress the action areas outlined in the *On Track: Knowing where we are going* road map (Platform and Te Pou o te Whakaaro Nui, 2015). Some key enablers of these changes are also identified and discussed. Finally, some next steps for the DHB to consider to progress *On Track* implementation and system redesign are identified.

The evidence presented is a snapshot of some the transformation work Whanganui DHB has done to ensure their mental health and addiction system better meets their population's needs. Recently the DHB signalled the next steps in the publication of a programme charter, *The Network Model of Care: A new approach for Specialist Mental Health and Addiction Services.* This document proposes a new model of care for the Adult Community Mental Health and Addictions Services, focussed on formalising and strengthening networks with primary care, NGO and iwi kaupapa providers, as well as government agencies and community resources. In addition to identifying the reasons change needs to occur, the *Network Model of Care* identifies key principles, values and enabling components that are considered critical to the change process.

Background

Whanganui DHB's mental health and addiction (MH&A) service describes themselves as undergoing transformative change. The DHB made a commitment to working towards ensuring the local mental health and addiction system was continuously improving and striving for excellence, reflecting the needs and values of the local community. The changes were prompted in response to a 2009 Ministerial review that found the services, particularly the inpatient unit, had serious issues which needed to be addressed. The Ministry's (2012) publication of *Rising to the Challenge* (RTTC) provided further direction for Whanganui. RTTC included priority areas for mental health and addiction service development, with the aim of improving outcomes for people who use primary and/or specialist mental health and addiction services, including their families and whānau.

To help implement RTTC the DHB developed *Whanganui Rising to the Challenge: The Mental Health and Addiction Service Development Framework* (2014). The framework positions the DHB as part of a broad community response to health issues. It has a dual focus on meeting current needs in practical ways, while also taking steps toward the aspirations outlined in the Ministry's RTTC. It is a broad document, outlining elements required for effective service provision and positive mental health outcomes, some mechanisms to achieve those elements, and general examples of what achieving that mechanism might look like. *Whanganui Rising to the Challenge* usefully outlined what the DHB needed; however, the document did not offer suggestions about actions to achieve these changes, nor did it offer case studies with specific examples. Table 1 provides a sample from the document.

Table 1: Sample element, mechanism and examples

Sample from *Whanganui Rising to the Challenge*		
Element	**Mechanism**	**Examples**
Whānau/family, person-centred care	Service user and whānau/family involvement is promoted and supported by, for example	• Consumer and family advisors • Peer support workers; peer advocated, educators and navigators • Whānau ora/whānau support workers
Whanganui Rising to the Challenge, 2014, p. 16-17		

WDHB mental health and addiction services' Nurse Manager, believed the services' adult community model was "focused too narrowly on secondary services", no longer met the increasingly complex needs of the population. They felt the model needed to be redesigned to meet the DHB's new direction in an integrated and socially cognisant way, understanding that no one provider or part of the sector could deliver what was required in isolation. Despite the challenges she identified that there was an emerging commitment across the DHB towards doing the "humanistic right thing by people".

She and the Consumer Advisor saw the opportunity to use *On Track* as part of a strategic approach to achieving the objectives outlined in *Whanganui Rising to the Challenge.* The consumer advisor provided input into the development of *On Track* and was in a good position to identify how the document could be used to support the services to make the necessary changes.

On Track was written as a road map to help inform the transformation of the mental health and addiction system. It outlines the wide range of issues that need to be addressed to improve health outcomes for individuals, whānau (families) and local communities. This case study links some of the changes in the WDHB model of service delivery to the seven priority action areas outlined in *On Track*. The hypothesis is that these seven inter-related action areas are critical to the mental health and addiction system's capacity for transformation and ongoing sustainability. They are as follows:

1. Support self-determination
2. Focus on system redesign
3. Improve workforce capability
4. Address investment and sustainability issues
5. Enhance community engagement
6. Use the evidence
7. Strengthen organisational infrastructure

Figure 1: Seven priority areas for action (*On Track*, p 33)

WDHB's Nurse Manager credited *On Track* as a primary influence for change in the MH&A sector in Whanganui, noting it provided the necessary background by addressing the context of New Zealand mental health systems, its history and future direction. She noted the document,

> *argued the imperative for change and the priority areas for focus as well as proposing emergent models for the future that could be best achieved through collective cross sector impact methods. The publication not only set 'a direction for travel' but also a comprehensive and understandable 'roadmap' of how to get there.*

The Nurse Manager believed the other important messages from *On Track* included the need for agencies to become relationally centred, working together to create a whole-of-system, person and whānau centred approach. The whole-of-system approach created through this relationship development inherently recognised that people have the personal strengths, resources and resilience to promote their own recovery. It also emphasised the need for the system to respond to people's mental health and addiction problems as part of a wider health and social sector contribution towards a state of improved wellbeing. This shift in perspective involves seeing people as being situated within a context that includes their life circumstances and the impact of social determinants on their wellbeing rather than just medicalising both their problems and their treatment.

> *For me, [On Track] provided a clear and accessible platform with which to change the direction of the current (albeit more than 20 years old) model of care in Whanganui.*

In July 2015, a group of Whanganui DHB stakeholders used the *On Track* illustrative theory of change (ToC), presented in Appendix 1, to complete an assessment of the Whanganui mental health and addiction system, presented in Appendix 2. The ToC is a visual representation of what success might look like in practice, using the seven action areas outlined in *On Track*. It was created to assist service providers to assess the

transformational capacity of their own organisation, as well as that of the local mental health and addiction system. The results of this assessment offer the DHB a useful baseline for monitoring progress across each action area over time.

The timeline in Table 2 describes the results of many of the key policy documents and events that influenced changes at the DHB.

Table 2: Timeline of changes at Whanganui DHB

Year	Event/policy document	Description	Result
2009	Ministry review	WDHB MH&A services reviewed, judged as poor and needing serious improvement.	*Achieving Excellence,* an internal WDHB document, was developed which identified action areas as a result of the review.
2012	*Rising to the Challenge*	MOH policy direction for MH&A services. DHBs required to report on actions identified in *Rising to the Challenge*.	
2014	*Whanganui Rising to the Challenge*	Policy document developed to guide WDHB MH&A services' future direction. Project management resource applied.	Included starting point for services to begin thinking about where improvements could occur and what services could look like in the future.
2015	*On Track: Knowing where we are going* published	July 2015 Whanganui *On Track* workshop	Identified themes from workshop which would be included into *Rising to the Challenge* implementation plan and process. Cross sector participation in collaborative workshop to identify readiness to undertake improvement. Included deliberate partnering with a number of key cross sector partners resulting in a number of collaborative initiatives: • Peer support employed to inpatient units from BALANCE • REINS programme with Jigsaw • Kaupapa Maori Drug Treatment Unit with Te Oranganui & PHO • Navigator programme WDHB & Supporting wellbeing (previously supporting families)
	Workshops, eg Ko Awatea,	DHB wide approach on co-design knowledge and skills. Ko Awatea delivered workshops.	Provided opportunity for improvement training based on co-design methods.

2016	Closing the Loop published	Increased understanding of the need to work more closely with primary care providers and redesign models of care.	Wellbeing modules and pathway developed collaboratively between specialist services and PHO. Creation of a new educator role from specialist services to provide primary care education. Conceptualising the adult community model of care to be a network model with hub teams service primary care and communities of practice in collaboration with PHO.
	On Track evaluation	Agreed to be a case study and contributed to initial development of approach for evaluation.	
2017	*On Track* evaluation workshop	Group of leaders across roles attended workshop and shared examples of change that has occurred.	Te Pou and Platform publish the evaluation results as a case study.
2018	Programme Charter, *The Network Model of Care: A new approach for Specialist Mental Health and Addiction Services* published	Document outlines a new model of care for Whanganui DHB Community Mental Health and Addiction Services. It is currently being implemented into adult community MH&A services.	

Method

Key stakeholders from Whanganui DHB MH&A services and community partners attended an *On Track* evaluation workshop on 1 February 2017. The workshop was facilitated by Geoff Stone (Ripple Research Design and Evaluation), Phillipa Gaines (Platform Trust), and Emma Wood (Te Pou). Participants shared stories demonstrating a variety of changes to the model of care. The discussion was recorded and transcribed. The transcription, along with key documents provided by Whanganui DHB, were analysed against the *On Track* action areas. The results of this analysis is presented in the next section.

Limitations

The workshop was undertaken as a group, and individuals briefly spoke and shared their short stories. As these were not in depth, some nuances might have been missed. Stories were taken as accurate representations of change and were not triangulated with other data (eg, metrics of system performance, interviews with other key stakeholders, etc).

Results

On Track action areas are used to showcase changes that occurred at Whanganui DHB MH&A services. The summaries presented in the results demonstrate practice and system change in a DHB environment. Many also demonstrate changes in how secondary staff work within the wider community. Several initiatives could be described under more than one action area. The issue of attribution is not explored as not all changes were directly in response to *On Track*. Evidence for an overall shift in Whanganui DHB's organisational culture is also explored.

1. Support service user self-determination

On Track identifies that a shift toward greater self-determination is a key part of system change. People who use services need to have the opportunity to exercise competence by being in control of their own health. They need to have autonomy to choose which services will work best for them and be supported by networks of people who care about them. The following examples demonstrate how the DHB has made changes to better support service user self-determination.

Supporting service user self-determination: co-production

A fundamental change in the DHB's MH&A service is demonstrated through the "trust and acceptance of my role" (consumer advisor). The DHB showed it valued the experience of people who experience mental health and/or addiction problems and use services. Developments supporting service user self-determination included:

- Utilising the consumer advisor's knowledge and skills to "test and challenge [the MH&A managers] thinking" and guide co-design and PDSA improvement cycles across a range of settings.
- Funding two full-time equivalent peer support workers in 2009 and an additional 1.9FTE in 2016/17.
- Giving support workers the freedom to make care decisions in the best interest of people with MH&A issues—decisions were previously controlled by clinicians.

- Changes to practice such as locating peer support in Acute and Forensic inpatient settings in February 2017.
- Partnering with people from the community to actively lead in creating systemic change across the MH&A and wider health sector.

The active overall acceptance of the consumer advisor and integration of the peer support roles demonstrate the system change toward supporting service user self-determination. By offering the opportunity for the consumer advisor to work closely to design and progress change, DHB MH&A management and clinicians, and staff demonstrate respect for his competence and acceptance of his expertise. The co-production of system changes by someone who has used them and has insights into aspects what might work or not, further increases the likelihood that services will better meet people's self-determination in the future.

2. Focus on system redesign

System redesign leads services to deeply analyse what parts of the system work well, what needs to be improved and how those improvements could be demonstrated in practice. *On Track* includes whole-of system approach, service integration, service delivery and early intervention as key focal areas of system redesign.

Using resources differently

One powerful example of changes to service delivery was told by a psychiatrist working in both the ICAMHAS and the Maternal Mental Health Team. A mother whom the psychiatrist had been working with for a long time under the Mental Health Act needed to be supported through another court appearance. The court hearing was scheduled at a time when the mother needed to pick up her three-year-old from kindy, a stressful situation as she did not have someone to care for her child.

The psychiatrist remembered there was a new flexible support person in the ICAMHAS team and arranged to borrow that resource to pick up the child. The mother was able to attend court because her child was looked after. "*That made that mum's life work...she knew that we cared about her and her kid*" (WDHB psychiatrist).

Whanganui DHB's movement to an ethos of "whatever it takes and it's ok" is demonstrated in this example. The smooth process made the psychiatrist confident that resources were used to provide the best care for the person, rather than protected in the allocated team as previously.

The psychiatrist identified that training each team, underpinned by strong professional relationships, created shared understanding and a momentum toward a person-focused system. Although the borrowed resource required only a small amount of time and is a small change, it demonstrates staff's willingness to be flexible, providing pragmatic solutions to reduce the mother's stress of being forced to manage the conflict of the court hearing and child care.

The youth worker who assisted the mother was one of two new roles established in early 2016 to help provide a link between the secondary MH&A services and the community. The worker was well integrated into a clinical team, enabling them to work well in a multi-disciplinary environment while understanding the boundaries of their role. The DHB infrastructure also provided clarity about who accesses support and how it is accessed. The deliberate development of roles designed to provide better community supports that deliver services responsive to the person's needs, particularly those outside the traditional scope of care, further demonstrates whole-of system thinking and change toward person-centred care.

3. Improving workforce capability

Improving workforce capability ensures the workforce is well-positioned to respond to needs in the sector, both current and in the future. Upskilling health professionals at all levels of the system, including primary care and community services, helps ensure people can access support early and provide a variety of supports. *On Track* emphasises the need to improve workforce capability planning, as well as the need to amplify the core values and attitudes required to work in MH&A and improve the cultural and linguistic competencies of the workforce (Platform and Te Pou, 2015).

Improving workforce capability through strengthening organisational infrastructure: The Wellbeing Modular Care pathway for primary practice

Whanganui DHB's new multi-purpose platform, The Wellbeing Approach, is a holistic, person centred model underpinned by the stepped-care approach. It contains a suite of tools designed to improve screening, clinical MH&A-related notetaking of the patient's "story", and decision pathways in primary care.

> *"[When talking to referring GPs] you could hear the [the patient's] story but it wasn't recorded and it wasn't actually being used in clinical decisions around what pathway to use."* (WRHN manager)

The platform's modules are fully integrated with MedTech and is expected to support changes in GP practice and achieve more consistency in the stepped care model. Targeted tools responsively guide the GP to consider support options, such as peer support, other than secondary care referrals, to best correspond assessed client needs. The platform has been developed in collaboration with GPs and Whanganui Regional Health Network, one of the region's two primary health organisations. This collaboration dually supported clinicians' deepened understanding of the practice model care options and helped ensure the tool would be useable in primary care.

Figure 2: Wellbeing modules

Features of The Wellbeing Modules include:

- Help for GPs to identify appropriate sources of support and manage referrals. The directory is searchable and updated in real-time.
- Encouragement for GPs and primary care teams to do whole-person assessments
- Identifying the right level of care in relation to need
- Language that is framed around the biopsychosocial model, encouraging GPs and primary care nurses to ask questions in a different way
- The addition of key messages and resources for use in the long term creatively modifies the otherwise linear Map of Medicine care pathway used by GPs and primary care teams in Whanganui.
- Suite of screening tools including screening for family violence in line with Supporting Parents, Healthy Children (COPMIA)
- Metabolic monitoring referral options
- Client self-management and using a shared care plan, with the ability to print out information during the consult
- Automatic transfer of information, eg medications, between forms
- An evaluation module which provides automatic feedback on using the tool

The development of the platform shows one of the PHOs, Wanganui Regional Health Network, was willing to invest in a technological programme that enhances workforce practice and may increase productivity. The co-design helped ensure the programme would be relevant, and its MedTech integration demonstrate the PHO wanted to increase the likelihood that it would support improvements in primary care capacity. In the long term, it is likely that the software will help primary care improve their community engagement. As practitioners assist patients by providing supports, such as self-help or helping the person utilise other MHA services, peer support services, for example, their knowledge of community services will increase. In addition to this increased knowledge, relationships with various community agencies will likely be formed and/or strengthened, which may lead the way to new and innovative partnerships at the primary care level.

4. Address investment and sustainability issues

Sustainability is a challenging area for MH&A services. Although funding has increased overall, there is evidence that this has not matched the cost of living nor the increased demand for services (Platform Trust & Te Pou o te Whakaaro Nui, 2015). It is also an area where providers have limited ability to influence or control. Despite these limitations, *On Track* gives examples of how providers can contribute through the use of organisational self-assessment tools and service activities. Supporting staff to work in more effective and efficient ways, such as through the use of mobile information technology, is another example of how organisations can address investment and sustainability issues. Additionally, organisations may be able to deepen funders' understanding by improved utilisation of outcomes and early impacts to better tell their story. Over time, investment in areas which are shown to have good outcomes leads to more sustainable services that are likely to produce lasting outcomes, resulting in healthier communities. Although Whanganui DHB stakeholders alluded to changes in this action area, they acknowledged it was a challenge to progress and it was not discussed in depth.

5. Enhancing community engagement

As outlined in *On Track*, enhancing community engagement requires MH&A services to adopt community development principles such as, shared local visions or goals that drive action and change, using existing community strengths and assets, having many people and groups working together, building diverse and collaborative local leadership and having adaptable planning and action informed by outcomes (Department of Internal Affairs, 2017). Other key aspects of enhanced community engagement in *On Track* include increasing connections with local communities to build organisational capacity and improving partnership between organisational staff and individuals and their whānau to ensure they maintain the power to shape their own lives. The following examples demonstrate ways in which Whanganui DHB improved their community engagement.

Enhancing community engagement through co-locating services at NGOs

WDHB MH&A services' initial step toward improving the level of community engagement was through extending an invitation for the DHB family advisor and a peer support worker to attend multidisciplinary team (MDT) meetings. Previously MH&A clinicians were risk-focussed and the environment did not encourage meeting, talking or collaborating with NGOs. NGOs were concerned about organisational competition and focussed on protecting client privacy over service cooperation to help achieve better health outcomes. NGOs are now encouraged to attend regular MDTs, which are described as 'whole-of-system' events and community gatherings.

The manager for Supporting Families in Mental Health Wanganui shared how the DHB mind set has changed and how the DHB clinical staff were now located onsite at the NGO. These changes have led to opportunities to share care and collaborate for both groups.

> *We've got clinicians using our rooms a couple of times a week. So they're seeing their clients at our rooms [and] they're bringing families with them. Their families are engaging with us at the same time and we're able to use them to see our clients if they're free. They also give us some supervision and training while they're there. It's a huge shift.*

In this example the services' co-location occurred through chance. The DHB was renovating and was struggling with space for staff. Due to their involvement at the MDTs, the Supporting Families manager had a strong relationship with MH&A services and offered to help house the clinicians. As illustrated, the presence of the clinicians onsite at the NGO further increased community engagement, as both services could more directly support families and the clinicians provided training and supervision opportunities to help upskill NGO staff.

Other examples of community engagement were intentional and strategic, such as placing a Child and Adolescent mental health registrar and SUPP[1], an adolescent alcohol and drug coexisting problem service at Youth Services Trust, a local NGO that provided providing holistic wrap-around health services to youth at a "one stop shop". The DHB's willingness to engage with NGOs and develop relationships was the first step in

[1] SUPP was suggested by local youth and is a nod to the commonly used expression 'what's up'. Youth believed it could also mean support your peers, see your progress and sort your problems.

enhancing community engagement. As relationships developed, leaders capitalised on opportunities to continue enhancing community engagement and strengthen relationships with NGOs.

Enhancing community engagement: a formal relationship group

Infant Child Adolescent Mental Health and Addictions (ICAMHAS) surveyed community agencies and the wider community about the aspects of their service that needed to change. As a result, a local data council where three working groups came together to improve inter-organisational relationships was formed. The relationship group's activities included reaching out to different agencies, holding teaching sessions, and seeking to identify what and how service could be improved. To ensure continuity staff took responsibility for specific stakeholder relationships. Importantly, the work has become routine, with staff setting aside one hour per week to do this liaison. After the scheduled liaison time, staff meet with all the groups to discuss what activities are being undertaken and consider what other things could be done.

As the group developed routine data collection about areas where MH&A services could be improved, they were able to make specific improvements including:

- employing a dedicated lead professional to be part of Whanganui Children's Team to help improve and form good relationships with key community groups.
- developing an important strategic relationship with Jigsaw Whanganui, which was previously critical of the DHB. As a result the DHB funded a support worker role to sit within Jigsaw to provide improved support for young people. They have further developed the partnership by contracting Jigsaw to provide the Riding Experiences Inspiring Next Successes (REINS) programme.
- appointing a coordinator who provides a navigator function. Rather than receiving a "referral declined" message without explanation, the coordinator now phones a referred family and discusses why the referral doesn't meet their criteria and offers to facilitate other help for the family. They also contact the referrer to discuss why it was declined and help them consider other options.
- redesigning the reception area of the ICAMHAS service so that people could more easily access it. Many people with young families had expressed that it was a difficult to find the service.

Being willing to listen and make changes in response to the community's identified needs is a critical part of improving community engagement. By asking professionals to set aside liaison time and time to meet as a group, management clearly signalled that organisational relationships were valuable. The group demonstrates the organisation is committed to community engagement as outlined in *On Track*. It supports, promotes and sustains inter-professional and interagency practice and workplace learning with the aim of providing better service responses to identified need.

6. Use of the evidence

The MH&A services are generally well-informed about the use of evidence-based practices and programmes likely to lead to good outcomes for people using services and their whānau. However, services are still learning about the need to implement a practice or programme as intended in order to achieve those positive effects. Training, coaching and peer review should be targeted to ensure project and programme uptake and successful implementation occurs. Organisational collection of

fidelity measures, which examine how well the programme or project is being implemented as expected, should be collected in addition to outcome measures. *On Track* identifies that there are similarities in implementation strategies and challenges across sectors closely aligned to mental health, such as justice. The document encourages the national workforce development organisations to work together to improve the science and practice of implementation.

Additionally, *On Track* identifies the need for both the sector and local levels need to invest in research and evaluation to examine and develop new and emerging practices in different contexts and for particular sub-populations. This ensures sound knowledge bases are developed and can be supported by appropriate levels of training and supervision. Whanganui DHB shared the story of how they used evidence and evaluation in the form of PDSA cycles to implement new practices at Stanford House.

Use of the evidence: Releasing Time to Care and PDSA cycles

One manager shared the results of introducing the initiative *Releasing Time to Care* into Stanford House, Whanganui DHB's Extended Secure Rehabilitation Regional Forensic Service. *Releasing Time to Care* is an NHS programme that has been shown to help staff increase the time they spend directly with people using services. Staff do this by changing their working environment and the way they carry out routine tasks (Doncaster and Bassetlaw Hospitals NHS Foundation Trust, 2011). The programme has been linked to increased hours spent on direct care, reduced medication error and increased staff satisfaction.

Stanford House staff, who were characterised as sceptical, took some time to come on board *Releasing Time to Care* after being introduced to it. However, once the staff understood the value, they ran with it. Staff found their most creative person, got her engaged in the initiative and convinced her to take the lead. They were encouraged by evidence that the managers trusted them to be experts in their own work, and to determine how the staff wanted changes to happen.

Some of this occurred when staff and people using the service developed their own vision statement, reducing it from a paragraph produced by management to a sentence, "Stanford House is a place where people can live, learn and grow in the wider community". Additionally, staff found they could embed the model and do most of their co-design work under the *Releasing Time to Care*. The manager commented, "*this is what we're aiming to do… releasing time to care from all the bureaucratic crap to actually take care of people*".

Stanford House staff were also taught PDSA (Plan, Do, Study, Act) cycles and learned to utilise them when they introduce new ways of working.

The staff tried some things and realised that some things didn't actually work the way they thought they would, but they've learned. They realised it's not just the same PDSA cycle [repeating]. It goes up and it goes around, then you've got to put something in behind it to stop it from rolling back down the hill [embed it], and it goes around again. They've really understood how that works and how each PDSA cycle will get them further on in their improvements. (Manager)

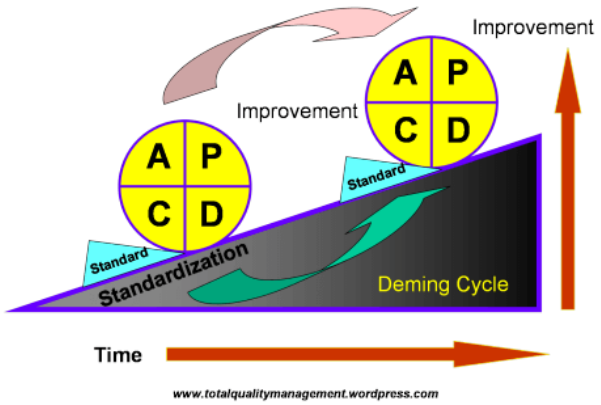

Figure 3: Deming cycle: Plan, Do, Check, Act (Kettering University Online, 2016)

Utilising evidence to drive practice at a local service level is shown in this example. Stanford House staff took advantage of PDSA cycles to determine the evidence that particular practice and system changes worked or not. Involving people who were currently using Stanford House services ensured that perspectives on this evidence were well-tested. The MH&As is committed to continuous improvement based on evidence from an emancipatory model where staff and service users are able to co design and produce improved service delivery and the experience of care.

7. Strengthen organisational infrastructure

Strengthening organisational infrastructure focuses on streamlining administrative functions and investing in technological developments. *On Track* discusses the need to invest in technological developments in terms of service delivery through the internet, mobile apps and text messaging services. It highlights the need to develop navigator roles as part of the MH&A workforce, ensure managers are able to use technology analyse information to inform decision-making, develop strategic plans and improve services. *On Track* also emphasises the need for MH&A services to continue to practice relational care and avoid substituting technology. The development of the *Smart Referral Directory*, discussed on p 12, demonstrates Whanganui DHB's work to strengthen the organisational infrastructure.

Change across all of the *On Track* action areas: providing support in a rural setting

The following example shows change in all seven *On Track* action areas, demonstrating how they are connected and the collaborative effect of changes begins to lead a whole-of-systems approach to delivering mental health care.

> *I went to visit a young mum in a very isolated location. I'd seen her once and was visiting her a second time. She was very much out there on her own and under the care of one of the GP practices we hadn't worked with much in the past. She hadn't slept for about 72 hours and was really unwell, very sleep deprived. I asked her if she wanted to stay in that situation or did she want to come into town and leave her children behind or any of those things. [She wanted to stay home].*

> *I was able to ring the GP practice and have a conversation with the practice nurse and a phone consult with the GP to organise some medication. Then I was able to ring through to Balance and arrange for a peer worker to come out and do some mindfulness in the mother's home. So all that kind of integrated service was arranged while I remained in the house for mum and the partner. So I was able to leave them knowing that they were going to be looked after. The GP had agreed to see her. I think that's something that our community needs to be proud of; that we're now starting to see more service integration and that we're able to work across sectors and with the community more.*

The improved engagement with primary care practices was a shift from previous years, when secondary care triage staff struggled to speak to GPs on the phone unless the GP had sent a referral about the person. The improved community engagement was a result of a project by the maternal mental health team that began in mid-2016 to further develop relationships with GPs in rural areas and lift the profile of the DHB.
The project was initiated due to the team's perception that they were underserving rural mothers and their whānau.

> *Although initially the project created a lot of [secondary service] referrals, including some inappropriate referrals, it also picked up some of those mums that really needed to access our services too."* (Maternal Mental Health Nurse)

The story shows **community engagement** by improved relationships between the mental health team, peer support service Balance and the primary care practice. All providers demonstrated **improved workforce capability** shown by their willingness to make time to coordinate care and make the reciprocal relationship work. Underpinning the engagement is **system redesign**—the coordination between the organisations meant they could provide the mother and her whānau with timely access to services. The nurse made effective use of local resources and worked efficiently to set up support while at the mother's home, showing how **investment and sustainability issues** can be addressed at the frontline.

Frontline work in the area of **strengthening organisational infrastructure** is demonstrated when the nurse exercised 'decision-power' and took responsibility to improve the mother's experience by offering choices, including option to access appropriate support in her home while staying with her children. **Evidence use** was also demonstrated—providing early intervention in line with the mother's preferences likely both improved her outcomes and had positive impacts on her children's emotional and cognitive development (Poobalan et al., 2007). Separating while she received treatment may have increased the family's stress and the complicated the mother/child attachment. Most importantly, the preferences of the mother and her whānau were taken into consideration and she was able to make decisions about her own health, **supporting self-determination**. This autonomy in choice reinforced the mother's personhood regardless of her current state of wellness and possibly prevented further negative stress for all family members. It seems likely that this whole-of-systems approach with work across all action areas led to a more positive experience for the mother and her whānau, compared to a potentially overwhelming experience of having to navigate the system by themselves, encountering barriers at the GP, and/or needing to leave her home to receive treatment.

Shifting WDHB's organisational culture

The examples shared by DHB staff showcase the concerted effort and time MH&A has spent changing organisational culture from a negative environment to a more positive environment focussed on meeting the community's needs. Stakeholders identified that a shared and common purpose was a critical aspect for the services and each department. It was important to know and articulate the kaupapa and values, while setting the standard and holding people to account. These approaches combined with the DHB's focus on quality improvement were key elements in supporting the organisational cultural change.

The focus and approach to change was deliberate but non-prescriptive. To support staff to achieve changes, the DHB funded training under *Whanganui Rising to the Challenge*, including the use of external expertise provided by *Ko Awatea*, the innovation arm from Counties Manukau DHB. They also invested in leadership development, including training in co-design for leaders across the sector.

Workshops and support provided by the *On Track* team were also highlighted as quality improvement enablers, with key leaders indicating the *On Track* workshop "challenged, refined and cemented" their thinking, prompting them to attend a collective impact workshop. Whanganui MH&A partners and the DHB also attended *Tahatū Rangi*, a national symposium hosted by Te Pou and Platform Trust, which reinforced the need to adapt and change across the system. Participants demonstrated understanding and willingness to work more closely together to provide services that better met community needs. Having the opportunity to receive *On Track* messages at the same time as the DHB offered all partners the opportunity to come together and go forward with an openness to new relationships and ways of working. Additionally, the Nurse Manager extended her use of *On Track* by integrating it into team planning days which were co-facilitated by them in conjunction with the consumer and family consultants.

The effects of these changes are becoming apparent, with the consumer advisor stating that clients have better experiences and really value the services in Whanganui. He also noted they have relatively easy access to DHB management if they have a problem with services. The Nurse Manager echoed this perception.

> *If someone's got a complaint they would ring me [Nurse Manager] and I will go to Supporting Families and meet with the family…that's accessible flat leadership. …It's kind of mutual ground. If someone's making a complaint they're not having to come in to the DHB.*

This is a shift from the previous negative culture.

One stakeholder commented that colleagues had become gentler with each other, which was flowing through to a new ethos of care. People were presented with a problem, then they were trusted to come up with possible solutions. They would try out new ideas and learn from the experience. They then extended this trust and learning to their colleagues. New ideas were explored, especially at the service user level, through developing and testing different options using PDSA cycles to see what worked best, for whom, and in what settings. The Nurse Manager indicated that a new understanding emerged,

> *We have to just stop thinking about change, but just keep thinking that we're just constantly evolving...it makes it so much easier if people believe that.*

Discussion

When the changes at Whanganui DHB are explored and mapped to *On Track*'s action areas, examples of progress are readily identifiable in most action areas. Interestingly, stakeholders discussed examples of change related to enhanced community engagement most often. This may be an indicator that change first happens in this action area. It may be relatively easy for services to identify how to develop and foster community relationship in order to make improvements in this action area. It may also be that enhanced community engagement is the visible result of work undertaken in other action areas as outlined previously. In contrast there was little discussion related to addressing the action area investment and sustainability issues as part of the whole-of-system change. As identified in *On Track,* this area can be challenging to change as funders typically control resource and providers have limited flexibility around how these resources are used.

Organisational culture change

In order for Whanganui DHB to make progress against the *On Track* action areas and work toward system changes, the MH&A service focussed on changing their organisational culture. Organisational culture is defined by the characteristics shared by people within an organisation, such as values, routines, sense-making and beliefs (Parmelli et al., 2011). The concept is often applied to help understand organisations. Organisational culture is linked with the quality of care provided and the overall responsiveness to a person's needs and preferences (Muls et al., 2015). Additionally, a negative organisational culture can cause high staff burnout, while staff working a culture they view as positive is linked to a sense of wellbeing (Watts, Robertson & Winter, 2013).

Learning organisations: systems thinking and leadership

Arguably becoming a learning organisation is a critical part of creating culture change. In order to change current culture, organisations need to learn why the current culture does not work, determine what type of culture they want to reflect going forward, and then actively work to make the changes to fill that gap. Learning organisations are characterised by people who are able to identify the results they desire and regularly upskill in order to achieve those results (Smith, 2001).

People in learning organisations are able to engage in systems thinking, seeing the whole picture, and engaging in continual reflection and learning to progress work toward a shared vision (Smith, 2001). While a number of factors can contribute to organisational culture change, leadership and the application of systems thinking appear to be critical factors affecting the shift at Whanganui DHB.

Leadership

Learning organisations provide leadership opportunities which are adaptive and distributive. Distributive leadership is shown when people at all levels of the organisation are supported to act as leaders. Leaders are adaptive when they are able to identify essential organisational elements and methods of working. They also need to identify things that do not add value and quickly reorient the organisation back to essentials. Senge

discusses how leaders in learning organisations are responsible for creating and fostering an environment that encourages learning (Smith, 2001). Behaviours of leaders who focus on collaboration and learning include: encouraging the process of goal, role and task clarification; promoting open communication to achieve team goals; developing collaborative team norms through less rules but very high standards; taking personal responsibility for team success; and employing energising strategies (Weiss, Tilin, & Morgan 2014). Elements of all the above leadership characteristics can be seen in Whanganui DHB's story of transformation.

The evolution of WDHB's leadership is a critical element in re-orienting MH&A services to a learning culture. Nearly all examples provided by workshop participants contained evidence of leadership. The leadership was shared and distributed across all levels, as demonstrated by staff exercising leadership qualities, in addition to the named leadership. Participants also identified the presence of an executive team who had "skin in the game and gave us permission to make changes" as being a critical component of leadership.

The notion of distributed leadership was fostered by line managers who encouraged diverse thinkers who were prepared to challenge them and encourage each other to consider new ideas. This led to a high-trust environment at the DHB where relationships between staff and the community improved. Staff identified the importance of working in "an environment of honesty without repercussions", which led them to feel as if they have the choice and the ability to influence things and to walk outside of the square and not be reprimanded. Colleagues were more likely to respectfully call each other out on less than optimal behaviour as well as praise one another for their successes. Additionally, staff felt encouraged to give things a try and to become involved in designing the services and that the role and responsibility for positive change sits with everyone.

Systems thinking

Systems thinking is demonstrated by the comprehension and ability to address the whole, while still noticing each of the parts and understanding how they relate to each other (Smith, 2001). Most people have a limited and partial perspective about what a system looks like and does, based on their viewpoint (Meadows, 2008). Yet, systems thinking can help people move beyond their limited viewpoint to understand the 'traps' or system structures that commonly cause problematic behaviour. People who understand these traps can get out of them or, better yet, avoid them in the first place. This way of thinking is a cornerstone to creating a learning organisation.

Meadows identified five traps that impede systems thinking. These are identified below, along with an explanation of how the DHB has responded to each one.

Response to trap 1- Policy resistance: Convince stakeholders to expend their energy in new ways to meet goals that transcend their individual interests.

Response to trap 2 – Tragedy of the commons: Increase the level of transparency so that more people have the same information about population need, service utilisation, pressure points, trends and the impact of service responses.

Response to trap 3 – Drift to low performance: Hold standards absolute. Encourage a process of continuous service improvement amongst staff that is based on those standards.

Response to trap 4: Escalation: Share the successes and the benefits of co-operation, rather than staff/providers continuing to compete with one another for a limited pool of resources.

The adoption of whole-of-systems thinking by Whanganui DHB has some interesting and potentially important lessons for the wider health and social system. Managers work within many complex systems, with intricate inter-relationships among the component elements, as well as multiple and sometimes conflicting goals. Whanganui DHB has shown their ability to engage in systems thinking with their publication of *The Network Model of Care* programme charter.

The implementation of the various service level changes outlined in the charter is due to conclude in December 2018. Successful implementation could help demonstrate to key stakeholders how new mental models of the MH&A system work in practice. It is also an opportunity for the DHB to demonstrate how their robust continuous improvement processes inform their change efforts as they scale their initiatives and roll out the Network Model across adult CMH&AS.

Conclusions

It is clear primary care capacity and capability is gradually improving, and that support from WDHB through the *Smart Referral Directory*, the community outreach model and the planned-for navigator role help foster these improvements. Small changes across the DHB, as reflected in community engagement by inviting the family advisor to MDTs, have led to greater opportunities to collaborate between organisations.

Whanganui DHB has encountered many challenges in working toward organisational change. Many people found the DHB's initial change project, *Achieving Excellence in Mental Health*, punitive in nature. Thus, the organisation was resistant to engage in change activities for several years. With hard work and an environment that is supportive of distributed leadership, with overt and resourced commitment to achieving changes and trust in staff to try, then learn from, new ways of working, changes to organisational culture are occurring. While challenges remain, people, including WDHB staff, primary care and NGOs, feel like they are being listened to, which leads to optimism and hope for the future.

Whanganui DHB mental health and addiction services are in the process of transforming themselves from being a secondary focused service to a wider whole-of systems approach that is focused on delivering services to people earlier, in the right way and in the best settings. A process of intentional co-production, combined with strategies to support changes in staff behaviour and practice plus organisational changes, have led to the design of a new system to deliver MH&A services. Sustainability remains a challenge as the DHB continues to work to consolidate these changes and make progress towards the system level outcomes outlined in *On Track*.

Next steps

This section includes some ideas for Whanganui DHB as they consider ways to continue progress toward *On Track* system level outcomes.

- Ensure any investment and sustainability issues are identified and addressed.
  - There was some evidence that staff considered programme sustainability; however, it is important to consider these issues to ensure gains are not lost.
  - The DHB may be able to use evidence the benefits of the system changes to explore more flexible funding models with the funder.
- Continue to upskill staff on data use and improve infrastructure to ensure relevant data is easily collected.
  - There is evidence this is beginning to occur, for example the relationship group is conducting a regular survey and using the results to drive change.
- Ensure successes are identified, celebrated and shared both internally and across partnerships as appropriate. Sharing successes provides further incentives for change and growth.
- Use the *On Track* theory of change (section 8.1, p 54) and the road map (section 8.2, p 55-58) to monitor progress toward the system level outcomes described in the action areas and develop plans to achieve WDHB system outcomes as required.
  - Identify what is being done under those action areas and how staff, organisation and system strategies are being utilised.
  - Re-assess themselves to identify whether services are *emerging, evolving, or partnering* according to the ToC, then decide what, if anything, is needed to progress toward WDHB MH&A system outcomes.

On Track action areas are a useful lens to examine WDHB's initiatives. The combination of leadership and systems thinking led to changes to the DHB's organisational culture and the beginnings of a whole-of-systems change approach that integrates co-design into a process of continuous improvement and targets communities' needs. The recent publication of a new Network Model of Care could begin to consolidate these gains and progress changes for WDHB's Community Mental Health and Addiction Services. Going forward WDHB has the opportunity to acknowledge and celebrate the achievements to date, as well as develop further plans to consolidate the current gains and continue to progress the whole-of-system change.

Appendix one: The *On Track* Road Map: An illustrative theory of change

Figure 4: *On Track roadmap*

Appendix two: Whanganui self-assessment

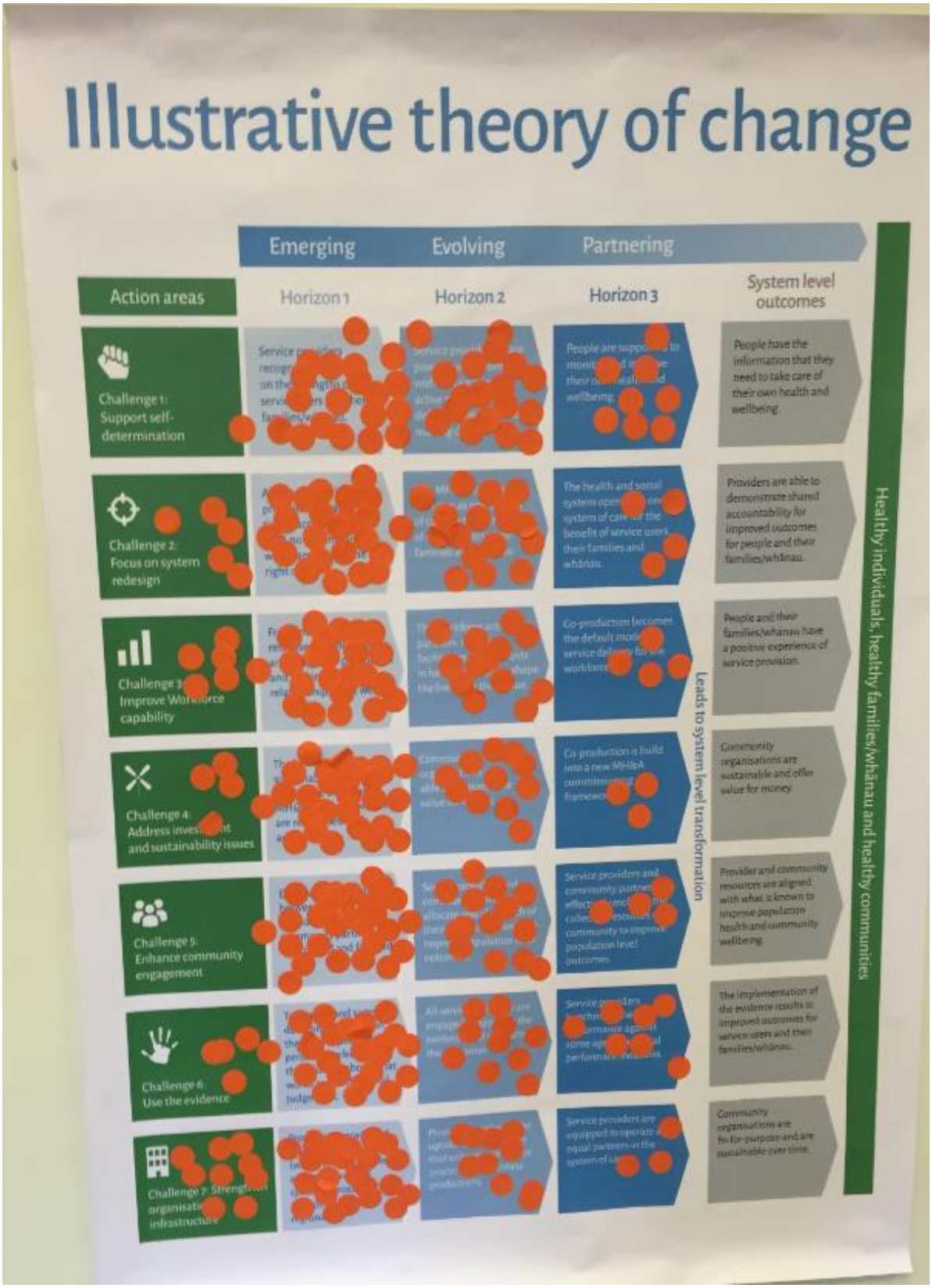

Figure 5: *On Track* roadmap—Whanganui DHB self-assessment July 2015

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