REPORT OF A VISIT TO ONTARIO, CANADA by JAN FILOCHOWSKI, UNIT GENERAL MANAGER, COMMUNITY CARE UNIT, SOUTHEND HEALTH AUTHORITY.

DATE AND PURPOSE OF THE VISIT

The visit to Ontario took place between 22 September and 4 October 1987. The aim was to investigate the feasibility of setting up an exchange arrangement between Health Service Organisations in Ontario and the U.K.

1. PURPOSE OF THIS REPORT

1.1 The trip to Canada was funded mainly by a grant from the King's Fund, and supplemented by Trust Funds from Southend Health Authority, which allowed the extension of the visit.

1.2 This report is submitted to the King's Fund in fulfilment of a condition attached to their funding. It also serves to set down my assessment of the scope for an exchange, and the right way of pursuing it, and it therefore concludes with a series of recommendations addressed to the District General Manager of Southend Health Authority.

2. BACKGROUND

2.1 I have for some time felt that it would be valuable both for staff morale and education to set up an exchange arrangement with Health Services in another country whereby all grades of staff - particularly staff directly involved in patient care, not just managers - who have something to learn and something to offer can observe how the services they are responsible for are provided in another environment. My initial inclination was to choose somewhere on the other side of the Atlantic, namely Canada or the USA, as a possible location for an exchange for three reasons:-

(i) We speak the same language.
(ii) The above countries have well developed Health Services from which we have a great deal to learn.
(iii) Both countries are very attractive places to visit.
The chance of a trip and of such a scheme might be a significant incentive to many staff.

2.2. I made a number of initial enquiries about possible locations for such an exchange, with two basic guiding principles:-

(i) I was keen that any exchange should start from the matching of the "non-acute" or "community" services which are the responsibility of my Unit. It seemed to me that unless a conscious choice was made to explore a suitable match for these services, we were likely to end up with a

twinning of two acute hospitals, and little of interest for the services in my Unit. On the other hand, if we were successful in setting up an exchange arrangement geared towards non-acute services, it seemed to me it would be relatively easy to extend this to cover the remaining (acute) services in, say, Southend.

(ii) It also seemed to me important to look for a location or locations that bore some correspondence with our situation in Southend. These might be summarised as a town large enough to be largely self sufficient in its Health Services, not a suburb of a large city but close enough to it to be within its orbit, and also substantially influenced by its role as a resort/retirement area.

2.3 I made various exploratory investigations and received particular help from John Smith and Laurie McMahon at The Kings Fund, and Kim Fleming then of North East Thames Region, now Director of Planning at Enfield Health Authority who visited the U.S. in May.

2.4 By the end of May two clear candidates were emerging: one based in Ontario in Canada, the other in Wilmington, North Carolina. There were also a couple of interesting possibilities in New York but, as explained above, I was keen that we should set up an exchange with a place that bore some obvious relationship to Southend and its surrounding areas and I therefore wished to avoid the middle of a very large city. The main interest of Wilmington appeared to be an excellently run General Hospital in a community with obvious characteristics in common with Southend. Its possible interest for non-acute services was much more speculative.

2.5 Ontario on the other hand offered the prospect of a wide range of acute and non-acute services and a visitor to England on the King's Fund Programme, who Laurie McMahon put me in touch with, was more than willing to help me set up the trip and explore the possibilitiy of some continuing interchange. This person was Tony Vines, Chief Executive of North Bay Civic Hospital in North Bay a town of 50 or 60 thousand people about two hundred miles north of Toronto. In discussing options with Tony it became clear that there was much greater likelihood of finding the right match if I explored the Ontario possibility.

2.6 I had by then taken matters to such a stage that it seemed to me essential to take them forward and to see whether an exchange really could be effected. I had to visit North America and see their services on the ground. Ontario seemed, all considered a more fruitful possibility than North Carolina and I felt that on a single visit I could not do justice to both. I therefore decided to explore as thoroughly as I could the Ontario option and only if it proved disappointing look again at North Carolina.

2.7 Once I had made my mind up to visit Ontario, I approached Tony Vines to see if he would help me to arrange matters. Tony kindly,if slightly foolhardily agreed to be my host overall and programme co-ordinator. At this point I approached the King's Fund with a request for a bursary and this was speedily agreed. I also sought the support of the Chairman of Southend Health Authority, Mr. Ron Williams, and of my District General Manager, Malcolm Jefferies, who both expressed themselves strongly in favour of the exchange idea and keen that I should pursue it via a visit. I would like to record my appreciation and thanks to both the Chairman and General Manager for their enthusiastic support as without this the visit could not have gone ahead and would indeed have had little point. I know they both remain keen to take the exchange idea forward and I am convinced that is of fundamental importance.

2.8 The position was shortly after this complicated by the fact that I was successful in securing a new post as Unit General Manager of St. Bartholomew's and St. Mark's Hospitals in London. I then had to make the choice as to whether to drop the whole idea or to take it a reasonable distance forward before I left for Bart's toward the end of 1987. I felt that if I did drop the idea it was unlikely that anyone would have the background, time or interest to pursue it in the short term and that it would then sink without trace when I left. As I remained fully committed to the idea, I pressed forward with arrangements for a visit, making clear what my position was to the King's Fund.

3. VISIT ITINERARY

3.1 The visit itinerary arranged by Tony Vines was geared to enable me to see a wide range of non-acute services in particular, in Ontario. Tony and I both felt that in the limited time available it was advisable that I concentrate on one particular care group and to this end a strong bias towards Mental Health Services was built into my programme. We also arranged a programme that was not dominated by visits in Toronto, by far the largest city in the province and now the biggest city in Canada, because of my desire to look at places whose population size bore more relationship to Southend. After all, Southend is a medium sized provincial town and from the point of view of Southend Health Authority it seemed better to examine a range of facilities away from as well as in the largest city, even though Toronto is relatively more of a magnet in Ontario terms than is London in British terms. This did not mean excluding Toronto visits altogether because there are so many things of interest in health service terms in that large city which must account for something like 40% of Ontario's population.

3.2 Tony and I also felt that on balance and given that this was a fact finding tour, it would be best for me to get a feel for as wide a range of places and services as possible so that I could make a reasonably

widely based judgement about what was most interesting to us and who might benefit from seeing things in England. A good degree of flexibility was built into the programme and indeed on my arrival there a number of significant changes were made when it appeared that time could be better spent by going to different places. The visit in the event had the following aspects:-

(i) A context setting visit to the Ontario Ministry of Health because of their key role in shaping Mental Health Services throughout the province (Mental Health Services are directly run by the Ontario Ministry).

(ii) A three day visit to North Bay, Ontario during which I was able to see and hear about acute, psychiatric and some community facilities, so obtaining a reasonably rounded picture of the total health services available in one locality.

(iii) Visits to Owen Sound and Barrie. Barrie is about 50 miles north of Toronto and Owen Sound is about 150 miles north west and both are medium size provincial towns (with populations I would guess of about 50 thousand), like North Bay providing a full range of health services. I visited them in particular to see the Community Mental Health Services they provided as these had been recommended to me as examples of good, progressive care.

(iv) Visits in Toronto to Sunnybrook Hospital, a large acute teaching hospital but with a large long stay component and to the Bay Crest Centre devoted exclusively to a range of elderly care. Both Hospitals had forward looking programmes for the elderly and elderly mental infirm. I also visited a hospital in Hamilton (Chedoke-McMaster) I saw their services for the elderly (in addition to which of course I saw some services for the elderly in North Bay, see (iii) above).

(v) At all these places, and also at Ottawa Civic Hospital, I explored organisational and financial issues with management. Two things recurred in these discussions namely quality assurance and fund raising. Indeed, my reason for choosing to visit Ottawa Civic Hospital was that it had an outstanding record of fund raising and fund raising ideas.

(vi) Finally, the visit also included a meeting with the Administrator of the Clarke Institute, a leading psychiatric teaching facility in Toronto and a session with the Psychiatrist and Administrator who were involved in the run down of a major

psychiatric hospital near Toronto at a place called Whitby.

4. IMPRESSIONS OF THE VISIT AND ASSESSMENT OF THE USEFULNESS OF INDIVIDUAL SESSIONS

4.1 In retrospect, it is clear that my subject was a punishing one and it had all but exhausted my learning capacity after two weeks in Canada. Overall, though, the spread was as reasonable a one as I could have settled on with the knowledge I had and including the substantial help I had from Tony Vines. A number of visits matched prior expectations, a few exceeded them and one or two were in varying degrees disappointing. On two or three occasions I came across material or even services which I had not expected and which proved of enormous interest. I am not attempting in this report to give a detailed account of the services I saw. Given my own managerial background and the brevity of my contact with various services I think this would be inappropriate. I have however, collected a great deal of detailed material on very many of the services I visited and I have organised this into a series of folders which I hope may be of assistance to potential visitors in the future who have particular interests and expertise in the field in question. The material is described in an appendix to this report and is being sent with the master copy to the District General Manager should anyone else care to obtain it.

4.2 What I can usefully do in this report is to give some broad general observations and pick out the most important threads in my visit because I think they offer useful clues as to how to take the whole exchange project forward. Given my background and the short time I spent at each place, what I say will of necessity often be superficial and subjective and I am conscious that deeper knowledge and familiarity might lead me to revise some of my observations. Nonetheless, for what they are worth, my comments follow broadly the categories set out above though with some obvious amendments:-

(i) Mental Health Services Generally

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Mental Health Services in England I believe have something to learn from and something to show Mental Health Services in Ontario. As in England, the development of services is patchy, and observation of the best and most helpful practices means casting one's net quite widely. (See my more detailed comments on North Bay in the next section). Simple twinning with an individual location such as North Bay in relation to Mental Health Services would therefore not be advisable even if it were achievable.

(ii) A Wider Exchange

A key positive feature of the visit, all the more welcome because I hadn't anticipated it, was the interest, enthusiasm and forward looking approach of the two key officials I met at the Ontario Ministry of Health. This Ministry performs a role which corresponds reasonably closely to that of a Regional Health Authority in England. During discussion it became clear that the Ministry is pursuing objectives in relation to Mental Health Services of de-institutionalisation and the build up of the Community Health Services, which correspond in broad terms to the objectives of health services in England in general and in North East Thames Region in particular. The key document in Ontario terms is the 1983 Heseltine report, a copy of which I obtained while in Canada and which is enclosed with the master copy of this report. With the help of the two officials, whose names are Debbie Mouro and Theresa Firestone, I was able to schedule at a late stage two very useful visits (to Owen Sound and Barrie) and a stimulating discussion about de-institutionalisation and Community Care (with Ms. Diana McFarland and Dr. Don Waslynki, who have been key figures in the run down of Whitby Psychiatric Hospital). I also found some enthusiasm from Debbie and Theresa for the idea of sending a group to England to look at the best of our services.

(iii) Community Mental Health Services: Owen Sound, Barrie and North Bay

Broadly speaking, the interesting mental health services to me as a visitor were those that arose from either the total or initial application of a community based Mental Health Service. In this respect the most exciting visit was to Owen Sound where a reasonably full range of community based services is now in place, though still being extended, and where Mental Health Services are being provided without a psychiatric hospital for backup. The former psychiatric hospital in Owen Sound has been closed and acute services are provided at the General Hospital there. There are also a spread of services away from Owen Sound itself in other centres in the surrounding area which look administratively to Owen Sound.

In Barrie I really only had the opportunity to see the community extended treatment centre, documentation in relation to which I also brought back. In summary the purpose of this is to integrate and re-integrate people into the community and give them support in the community when they need it by offering such things as a structured life skills programme, accessible out patient services, and other sorts of individual

tailored help, plus a varied range of group activities such as goal setting, communication skills, art therapy etc etc. The only personal observations I would offer on the centre is that the environment in which the service was provided was excellent; and that staff not only showed commitment but convinced me of the appropriateness of the objectives they were pursuing and the way in which they were doing that.

Thirdly, in North Bay I saw a new and (from my very brief visit there) good community mental health centre, as yet operating in quite a modest way but showing substantial promise, and what struck me as a really excellent community Rehabilitation Unit which was a sort of sheltered work shop/factory/occupational therapy department, reasonably resourced and imaginatively run. Most significantly it felt like a work place in the community not an institution in isolation from it.

(iv) Psychiatric Institutions:

What was less cheering was the initial impression I at least got from looking at psychiatric institutions. I feel that there would be little merit in learning a great deal about the way these organisations are run in Ontario compared to England. In both cases such institutions are in retreat and I saw little sense of the Canadians having a "better" way of running them. Indeed from my limited observations, they seem on the whole more inward looking because they are not directly concerned with the development of community care as ours are.

(v) North Bay:

North Bay is somewhat smaller and more remote than Southend but it is a full blown town with a full range of services and in the summer in particular expands to serve a large added tourist community. In my view it has much in common with Southend despite the manifest differences. It has two acute hospitals (plus a small third one run by an order of nuns). The larger of the two is North Bay Civic which has about 200 beds, a budget of well over 20 million Canadian dollars and over 400 staff. It also has a psychiatric hospital, well out of town, a little smaller than Runwell and set in similarly large grounds, I have to say that I was depressed by North Bay Psychiatric Hospital and on my superficial acquaintance, although it was rather better resourced than Runwell, it struck me as a place without that lively sense of purpose and commitment that is so evident at Runwell. I may simply be wrong in this impression and it is clearly not a measured judgement but from what I've seen I would not see any benefit in us linking up with that hospital. On the other hand, I could see some real benefits in people at

that hospital looking at the way we provide services in Southend.

My impression of the acute services was positive. North Bay Civic Hospital is a medium sized, well run, and if I may use the term, lively hospital with forward looking and active management. The plans to amalgamate the two hospitals and also to provide acute psychiatric services from the new single hospital, with the concomitant closure of North Bay Psychiatric Hospital, provides a fascinating and quite close parallel with the situation in Southend. This is because of Southend's current consideration of the rationalization of services between Rochford and Southend Hospitals, leading to the likely concentration of acute services on a single site, and the possible rundown and eventual closure of Runwell.

One area which I know Tony Vines was keen that North Bay Civic should move forward and improve on was in care of the chronically ill and the elderly. This is very much a concern of ours in Southend. We have a number of exciting developments which over the next 3 or 4 years will change the shape of the service we are providing to the elderly and indeed the much smaller group of chronically ill people, and give the whole service a much stronger community orientation. It is my feeling that people at North Bay might find our ideas and our developments in these areas of great interest, as I think they would some of the other developments in the care of the elderly going on elsewhere in this part of England.

One very interesting aspect of the culture of the hospital which struck me as an English visitor was the ready acceptance and implementation of quality assurance procedures relating to the way patients are cared for on the wards. This was both an internal mechanism for staff to explicitly examine their own procedures but it was also dovetailed into a hospital wide reporting mechanism which meant that hospital management had an up to date and clear sense of the activity and in certain respects the quality of activity going on in the institution.

(vi) Services For The Elderly:

Services for the elderly in Canada seem more institutionally based than in England. Hospitals appear to be used much more as holding places for the elderly in reasonably equipped but I would assume inappropriate and unduly costly circumstances. Generally therefore, my belief is that Ontario has something to learn from our integrated planning of services for the elderly and our strong emphasis towards community based care. A number of people to whom I put this

proposition concerned with these services readily concurred.

The one obvious exception to this was the magnificent facility at Baycrest in Toronto. This is in effect one of the most lavishly equipped hospitals imaginable, devoted to services for the elderly, attached to which are a wide range of day and community facilities plus independent and semi-independent accommodation for the elderly. The whole scheme is highly impressive both in terms of the imaginative mix of services and the way in which services are constantly extended and improved.

The other striking thing about Baycrest is its public image. In no sense is it a second class citizen compared to an acute hospital. It has a high and enormously positive public profile, a large and dedicated band of volunteers who work in and with the hospital and raise funds for it, and it has been consistently and enormously successful in raising new funds and in finding imaginative new ways of doing that. Attached to this report is a folder exclusively devoted to documentation received at Baycrest relating both to the programmes at the centre and the fund raising activities there.

(vii) Management Issues, particularly Quality Assurance

Since the introduction of Griffiths-style-management in England, the organisational arrangements in Ontario no longer look very different from those in England and there are clear and obvious correspondences in terms of managerial roles and managerial tasks. The strongest impression to come through the whole visit was the consistently higher level of resourcing of Health Services in Canada, particularly the acute hospitals, such that the institutions were in a very obvious way, a pleasure to walk through and made one envious. There also seemed to be a greater supply of management resource devoted to looking after these institutions and those I saw gave the impression of being well managed.

I was particularly struck by the work that is being done to develop quality assurance throughout Canada. In my view the hospital service there is 4 or 5 years ahead of us in England so we have obviously much to learn from what is going on there. Canada has the advantage of an accreditation system whereby hospitals are inspected in detail and reported on year by year. This tends to be a detailed , nuts and bolts - although nonetheless important - exercise. Quality assurance initiatives have gone much further than this and looked at the way people operate and how that can be monitored and

evaluated to produce better patient care. It is interesting that during my visit I came across another English visitor, Nigel Weever, the District General Manager of Barnet, who was looking at quality assurance.

Apart from North Bay Civic, where I got a sense of a good range of quality assurance work going on, I would pick out McMaster as a place with some very exciting quality assurance initiatives. The nursing quality assurance initiative was far advanced and impressive; but the hospital was also starting to move down the road of physician peer review, and I was lucky to be able to talk to the doctor who has done much of the exploratory work on this, Dr. William Barnes.

In a seperate folder attached to the master copy report I have included Dr. Barnes' report on peer review which is the basis of the work going on at McMaster and in the quality assurance folder some information about quality assurance in relation to nursing.

(viii) Fund Raising:

Fund raising plays a much greater part in the life of Canadian Hospitals than it does in that of our own, and funds raised from the general public provide larger contribution to the hospital's total resource, in capital terms at least, than they do in England. Despite their, in our terms, lavish resourcing, Canadians are much better at raising extra funds from the general public and from private industry to supplement their own resources than are we. Again and again I was struck by the fact that this was part of the culture of hospital funding, that the general public were encouraged to and were willing to contribute, and that management devoted priority, time and resource to fund raising effort. Not surprisingly all sorts of imaginative schemes were to be seen, resulting in the raising of, by English standards, quite extraordinary sums. I am convinced that we in England can learn an enormous amount from the Canadian experience here.

Apart from Baycrest, which I have already referred to in the section on Services for Elderly, I would pick out Ottawa Civic Hospital which has been enormously successful in raising additional funds and which has now recruited a director of marketing, Grant Walsh, who is adopting a very commercially orientated approach to locating sources of extra funding and realising them. It was evident from the short time I was able to spend with him that this approach is paying enormous dividends already.

(ix) Taking Services to Patients: Hospital in the Home

At Sunnybrook Hospital in Toronto, more or less by chance, I came across an idea there called "hospital in the home" which as I understand it means taking the full services of a hospital to fairly acutely ill people in their homes. It is thought to be highly cost effective and convenient to patients. The information I was given indicated that the idea of taking services to patients in their homes in this way had been turned into two successful schemes elsewhere in Canada: one in Montreal, which was likely to be expanded to cover locations in Quebec, and one, somewhat different in its approach, in New Brunswick. The paper I obtained from Sunnybrook on this development is included in one of the folders attached to this report.

The Chairman of Southend Health Authority, Councillor Williams, has for a long time been an advocate of the idea of a health pantechnicon taking services to people in the community wherever possible. We have never within England found any instance of this working except over single limited services and a small experimental scheme in Peterborough called "Hospital at Home". Therefore the Sunnybrook idea of going from a large high-tech hospital in the middle of Toronto, together with the Montreal and New Brunswick varients, would be just the sort of thing we ought to explore to see if anything remotely like it could be started in Southend.

(x) Interesting Developments in Mental Health Elsewhere in Canada

I discovered that there are a number of interesting experiments in Mental Health Services in parts of Canada other than Ontario. In particular the experience in British Columbia in running down large psychiatric institutions was sited to me by ministry officials as one from which there were substantial and positive lessons to be learnt. Also, I was told by Sandy Stockman at Owen Sound about the well developed community based services in Saskatchewan. Saskatchewan was I think in the forefront in Canada in the rundown of large institutions and in the setting up of community based programmes. They therefore have a long and valuable experience in this field. They have also developed some very advanced programmes such as the Faskatoon Crisis Management Programme which on the psychiatric side takes services to people as, when and where they need them. Documentation on this programme is included in one of the folders attached to the District General Manager's copy of this report.

(xi) An Innovative Approach To Funding Certain Non-Acute Services In Alberta

I came across an idea which may have a real interest for Roy Griffiths in his review of Community Care which was said to be operating in Alberta. This was the scheme whereby money for services was notionaly allocated to clients rather than to the funding authority and the client was then in a position, with whatever help, to decide what package of care to spend that on. This meant that where there were options in terms of different blends of care the patient would have a key role in deciding what was most important for him or her.

5. CONCLUSIONS

5.1 Health Services in Ontario are well developed and well resourced. There is much to learn from the way they are provided.

5.2 In many areas, English health services have much to show our Ontario counterparts. In Mental Health Services we have much to learn from each other and in terms of the range of services for the elderly England seems to me to have a much wider, better balanced spread of services generally, though fewer resources. The other general area in which we have a substantial advantage which may be of interest to others is the way in which we are set up to look at and plan comprehensively the services for the whole population not just in an institution or just in the community or just one aspect of the service they need.

5.3 It is dubious whether there is scope for an exchange based solely on one location even one with various interesting aspect like North Bay.

5.4 Even from my visit, it was evident that there were a number of individuals who would be interested and could gain substantial benefit from a visit to England. The comments I made about the benefits of visiting Ontario apply in the reverse direction. It seems to me that one location, even as progressive and interesting a place as Southend (!), is unlikely to contain all those matters likely to be of interest to someone wishing to learn about the best of the Health Service in England. If we are to take our part in fixing up an exchange, therefore, we must be prepared to act as agents in fixing up visits as well as hosts. This is exactly what Tony Vines did for me and did so ably, aided very helpfully by Debbie Mouro and Theresa Firestone at the Ontario Health Ministry. The key question which needs to be brought out into the open from the Canadian side is how they will convert the enthusiasm which I trust they will feel for visiting us and setting up an exchange into the resource actually to make that happen.

5.5 In terms of Mental Health Services, it would appear that the greatest benefit in an exchange would be one between a fairly wide spread of services. It may therefore be that the way forward is to try and arrange some exchange of personnel covering a wider area than Southend, perhaps the whole of the North East Thames Region, and matching this with the province of Ontario, which although somewhat larger in population contains a similarly comprehensive range of services and is dealing with a full range of mental health problems.

5.6 My visit was both very wide ranging and relatively superficial. I think this was right for a fact finding tour but I believe the greatest benefit will accrue if we set up a continuing series of exchanges if the majority of people involved in these actually have an opportunity to immerse themselves in a particular service and spend at the least a number of days with counterparts or near counterparts. In that way experience can be exchanged and experienced enriched, not simply about principles and organisation but actually about the services delivered on the ground. This leads me on to the related point that I feel it is vital that the staff involved in the exchange come from all parts of the organisation.

5.7 What I have said above does not mean the idea of an exchange centred on a particular place needs to be jettisoned. I think there was much interest in North Bay and hopefully there might be people from there who would like to come over and see our services. I certainly think we could benefit by going and looking at some of theirs. This may mean that the way forward is a combination of the specific and the more general with a particular twinning of North Bay and Southend but with a much wider field of exchange on both sides.

6. RECOMMENDATIONS

It will be evident from my report that a great deal of work is needed to take forward the initiative I have started, more work I must confess than I had frankly anticipated when starting down this road. However, I also believe that there were sufficient interesting services and practices and a sufficient number of interested people to make it worth while sustaining the momentum and trying to effect a long term exchange. To ensure this happens I recommend the following:-

6.1 The success of a scheme such as the one proposed in this paper will be crucially dependant upon the whole hearted and as appropriate public support of the Chairman and his District General Manager. That support has been a key factor in getting so far down the road. It is now essential that the Chairman and District General Manager assess my report and proposals and satisfy themselves that they are the right and a viable way forward. Their active support will be the corner stone of what is subsequently built.

6.2 The District General Manager as the Chief Executive Officer of the Health Authority should show a close personal involvement in the furtherance of this scheme and in any contacts with Canada should make clear his direct personal commitment and specific interest. This may very well mean that at an early stage he too should visit Ontario. From what I have said above I believe that there would be enormous value to him and to the Authority in such a visit, not least because of what could be learnt about quality assurance, which is a key topic on his and Southend Health Authority's agenda, and on a very much more specific topic, "The Hospital in the Home" initiative.

6.3 If as seems likely, the demands upon the District General Manager's time make it impossible for him personally to pursue the various avenues that need to be explored in firming up an exchange, it is essential that he designate a senior officer of Southend Health Authority to work closely with him and on his behalf and to take personal responsibility for taking matters forward. The person in question should be committed to the scheme and of some standing within the organisisation, in my opinion at least Assistant General Manager level. Because I feel it very important to continue the orientation towards exchange of staff actually providing services and not solely on principally senior managerial staff, I feel it highly desirable that this person should be in one or other of the Units.

6.4 Simultaneously with this report I am writing to all the people I visited in Canada and who made a significant contribution to my visit either by giving me time or making arrangements for me to see others. The next step seems to me to be for the District General Manager to invite those in that group who might be interested in a return visit to undertake something halfway between the first fact finding visit on their part and the first exchange visit.

6.5 Assuming a reasonably positive response to this, and perhaps foreshadowed in the invitation, we should be thinking about sending a first group to Canada in 1988. In my view we should aim at a group of about four people, one of whom should be a senior manager, perhaps the District General Manager himself or the Mental Health Services Manager given the orientation of my own visit and the promising possibilities it revealed. (But see paragraph 6.6 below). It will be necessary to indicate to the Canadian side that we are hoping to do this and asking them if they are prepared to play hosts on this basis. In my view the key enablers here would be North Bay Civic Hospital if they are prepared to tie themselves into such an arrangement and the Ontario Ministry of Health.

6.6 As can be seen from my observations and conclusions, I believe that any exchange we set up must have a wider dimension taking it beyond Southend. North East Thames Region is the obvious and logical extra dimension and I recommend that the Region be approached to see if they would be willing to take a partial share in the development of this scheme alongside Southend. My hope would be that they would be prepared to provide something like a third of the funding for what is after all a very modest scheme, provide an expert help and involvement in setting up visits on this side, and as the exchange is built up play a part along with Southend in making up a visiting group from the English side so that people in the Region outside Southend may have a chance to visit Ontario. Given that out Mental Health Services Manager, Joe Dorado, is also a Regional advisor on Mental Health Services, it seems to me we have someone who is ideally placed to bring together District and Regional interest and to pursue them. I would strongly hope that in sending out a first teem in 1988 the Region will be prepared to fund at least one member, probably Joe Dorado, to explore all this. They will need to consider whether their interest in an exchange should be related to a particular client group, namely the mentally ill, or should extend more widely. At the outset at least, I think there would be much sense in concentrating on that client group for the wider exchange.

6.7 An approach should formally be made to the King's Fund to see if they will help facilitate this exchange by way of part funding of the scheme. I think the appropriate contribution if the King's Fund wished to be associated with the project would be to offer a third of the cost and become equal sharers with Southend and North East Thames Regional Health Authority. It is very difficult to estimate what the overall costs of this scheme might be, but I suspect we are talking about £1,000 per person for up to a fortnights visit. Clearly if visits are longer the costs will be higher. This suggests that each of the funding organisations (if there are three) would only need to contribute a figure of between £1,000 and £2,000 per year which for the benefits that would accrue seems extraordinarily modest.

October 1987

APPENDIX

MATERIAL COLLECTED IN CANADA

FOLDER 1: Material relating to run down of a Psychiatric Hospital

Item 1 - Whitby Psychiatric Hospital redevelopment plan and the community care component.

FOLDER 2: Material relating to community psychiatric care in Ontario

Item 1 - Plan for mental health in the Gray-Bruce district July 1983 (this is the area around Owen Sound)

Item 2 - Various publicity material relating to community mental health programmes in Gray-Bruce district.

Item 3 - Folder giving details of Sunnybrook community psychiatric services for the community.

Item 4 - Sasktoon Prices Management programme annual actvitiy summary 1.4.86 to 30.3.87.

Item 5 - Material relating to the community extended treatment at Barrie.

FOLDER 3

Item 1 - Material relating to quality assurance programmes at McMaster Hospital with various key articles attached not necessarily based on McMasters.

Item 2 - Details of Sunnybrook's Hospital quality assurance programme and its system of monitoring quality assurance.

FOLDER 4

Item 1 - Information from Sunnybrook about the "hospital in the home scheme"

FOLDER 5: Physician peer review

Item 1 - Study report by Dr. Barns of McMaster University

FOLDER 6: Material relating to Ottawa Civic Hospital

Item 1 - Mission statement

Item 2 - Publicity handout

Item 3 - Employee opinion survey

Item 4 - Material on suggestion scheme

Item 5 - Details of invention made at Ottawa and marketed by the hospital to the benefit of the hospital called computerised DSM 3 diagnosis.

Item 6 - 1987 review of Ottawa Civic Hospital department by department.

FOLDER 7: Material relating to Baycrest Centre for the Elderly

Item 1 - Articles about progressive geriatric care relating particularly to Baycrest.

Item 2 - Publicity material relating to Baycrest.

Item 3 - Material relating to the objectives of Baycrest and service programmes there.

FOLDER 8: Information relating to North Bay psychiatric hospital.

Item 1 - 1987 annual report.

Item 2 - Outpatient clinic information.

Item 3 - Employee assistance programme information.

Item 4 - Social adaptation programme.

Item 5 - Handout on understanding schizophrenia.

Item 6 - Description of programmes and information summary for North Bay Psychiatric Hospital.

FOLDER 9: Key Ontario wide policy document.

Item 1 - Heseltine report, "towards a blue print for change: a mental health policy and programme perspective" (1983).

Item 2 - Ontario Government Mental Health Act (July 1987 update).