

DISABILITY SERVICES ADVISORY COMMITTEES

Agenda



19 March 2018, 10.00am to 12.30pm

Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia			15min	10am	
1.2	Apologies	RECORD				
1.3	Continuous Disclosure - Conflict of Interest	ACCEPT				2
1.4	Confirmation of Minutes 17 November 2017	APPROVE				6
1.5	Matters Arising	NOTE				
1.6	Terms of Reference	APPROVE				12
2 PRESENTATIONS						
2.1	Approach to DSAC	Discussion	Fran Wilde Rachel Haggerty Helene Carbonatto Nigel Broom	20 min	10.15am	14
2.2	Mental Health and Addiction – Joint Work Programme Update	NOTE	Arawhetu Gray	45 mins	10.35am	21
3 DECISION						
3.1	Report on UK Research Trip: Citizen Led Social Care and NHS Transformation	ENDORSE	Pauline Boyles	30 min	11.20am	34
4 DISCUSSION						
4.1	Update on implementation of Disability Strategy	NOTE	Pauline Boyles	30 min	11.50am	42
APPENDICES						
2.2.1	Mental Health and Addiction Inquiry					45
2.2.2	Update from the Inquiry Chair					48
2.2.3	Establishment of Government Inquiry into Mental Health and Addiction					51
3.1.1	Citizen Led Health & Social Care Transformation – Study Trip Presentation					56
3.1.2	Community Circles Research Summary					77
4.1.1	Supported Decision Making					79



DISABILITY SERVICE ADVISORY COMMITTEE

Conflicts & Declarations of Interest Register

UPDATED AS AT 14 MARCH 2018

Name	Interest
Dame Fran Wilde <i>Chairperson</i>	<ul style="list-style-type: none"> Deputy Chair, Capital & Coast District Health Board (includes HAC) Chair, Remuneration Authority Deputy Chair NZ Transport Agency Chair Wellington Lifelines Group Director Museum of NZ Te Papa Tongarewa Member Whitireia-Weltec Council Director Business Mentors NZ Ltd Director Frequency Projects Ltd Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims Chair Wellington Culinary Events Trust Chair National Military Heritage Trust
Yvette Grace <i>Deputy Chair</i>	<ul style="list-style-type: none"> Member, Hutt Valley District Health Board Member, Hutt Valley District Health Board Hospital Advisory Committee Deputy Chair, 3DHB combined Disability Support Advisory Committee Chair, Hutt Valley District Health Board Community and Public Health Advisory Committee Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust Husband, Family Violence Intervention Coordinator Wairarapa DHB Husband, Community member of Tihei Wairarapa Alliance Leadership Team Sister in law, Nurse at Hutt Hospital Sister in Law, Private Physiotherapist in Upper Hutt
Mr Andrew Blair <i>Member</i>	<ul style="list-style-type: none"> Chair, Capital & Coast DHB Chair, Hutt Valley District Health Board Chair, Hutt Valley District Health Board Hospital Advisory Committee Member, Hutt Valley District Health Board Finance, Risk and Audit Committee Member, 3DHB combined Disability Support Advisory Committee Member, Hutt Valley District Health Board Community and Public Health Advisory Committee Owner and Director of Andrew Blair Consulting Advisor to the Board, Forte Health Ltd Christchurch Former member of the Hawke's Bay DHB (2013-2016) Former Chair, Cancer Control (2014-2015) Former CEO, Acurity Health Group Limited
Ms Eileen Brown <i>Member</i>	<ul style="list-style-type: none"> Member of Capital & Coast District Health Board Board member (until Feb. 2017), Newtown Union Health Service Board

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Name	Interest
	<ul style="list-style-type: none"> Employee of New Zealand Council of Trade Unions Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union. God daughter/family friend employed as a solicitor at specialist health law firm, Claro.
Ms Sue Kedgley <i>Member</i>	<ul style="list-style-type: none"> Member, Capital & Coast District Health Board (includes HAC) Member, Greater Wellington Regional Council Member, Consumer New Zealand Board Shareholder in Green Cross Health Step son works in middle management of Fletcher Steel Deputy Chair, Consumer New Zealand Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Jane Hopkirk <i>Member</i>	<ul style="list-style-type: none"> Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committees & Disability Support Advisory Committees (30 March 2016) Member, Wairarapa Te Iwi Kainga Committee Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora Member, Occupational Therapy Board of New Zealand (23 February 2016)
Kim Smith <i>Member</i>	<ul style="list-style-type: none"> Employee of Te Puni Kokiri Trustee, Te rūnanga Hauora o Rangitāne
Lisa Bridson <i>Member</i>	<ul style="list-style-type: none"> Member, Hutt Valley District Health Board Member, Hutt Valley District Health Board Hospital Advisory Committee Member, 3DHB combined Disability Support Advisory Committee Member, Hutt Valley District Health Board Community and Public Health Advisory Committee Hutt City Councillor Chair, Kete Foodshare
Prue Lamason <i>Member</i>	<ul style="list-style-type: none"> Member, Hutt Valley District Health Board Member, Hutt Valley District Health Board Hospital Advisory Committee Member, 3DHB combined Disability Support Advisory Committee Member, Hutt Valley District Health Board Community and Public Health Advisory Committee Deputy Chair, Hutt Mana Charitable Trust Deputy Chair, Britannia House – residence for the Elderly Councillor, Greater Wellington Regional Council Deputy Chair, Greater Wellington Regional Council Holdings Company Trustee, She Trust Daughter is a Lead Maternity Carer in the Hutt
John Terris <i>Member</i>	<ul style="list-style-type: none"> Member, Hutt Valley District Health Board Member, Hutt Valley District Health Board Hospital Advisory Committee Member, 3DHB combined Disability Support Advisory Committee Member, Hutt Valley District Health Board Community and Public Health Advisory Committee
Mr Alan Shirley <i>Member</i>	<ul style="list-style-type: none"> Member, Wairarapa District Health Board Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees

Name	Interest
	<ul style="list-style-type: none"> • Surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Mr Derek Milne <i>Member</i>	<ul style="list-style-type: none"> • Member of 3DHB CPHAC/DSAC • Brother-in-law is Chairman of Health Care NZ • Daughter GP in Green Cross Health Onehunga, Auckland
Fa'amatuainu Tino Pereira <i>Member</i>	<ul style="list-style-type: none"> • Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham <i>Member</i>	<ul style="list-style-type: none"> • Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Clinical Scientific Advisor & Chair Scientific Advisory Board – Asthma Foundation of NZ • Trustee, Wellhealth Trust PHO • Councillor at Large – National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Daughter, Employee of Hutt Valley based Māori provider (Tu Kotahi Māori Asthma Trust) • Wife, Research Fellow, University of Otago Wellington
Sue Driver <i>Member</i>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (base isolators, Wgtn Hospital) • Advisor to various NGOs
'Ana Coffey <i>Member</i>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability

Name	Interest
	Support Advisory Committees <ul style="list-style-type: none"> • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation
Bob Francis <i>Member</i>	<ul style="list-style-type: none"> • Chair, Masterton Medical Limited • Chair, Bromedical Services New Zealand Limited • Chair, Sub-Regional Disability Advisory Group • Chair, Pukata Mount Bruce • Chair, Wings over Wairarapa • Chair, Te Kauru Upper Ruamahanga River Management Plan



3DHB CPHAC/DSAC Meeting Minutes

DATE:	17 November 2017	TIME:	10am – 1pm
VENUE:	CSSB Lecture Room, Ground Floor Clinical & Support Services Building, Blair Street, Masterton		
PRESENT:	Dame Fran Wilde (Chair), Bob Francis, Derek Milne, Lisa Bridson, Prue Lamason, Ana Coffey, Yvette Grace, Sue Kedgley, Andrew Blair (from 11.30am), John Terris, Yvette Grace		
APOLOGIES:	Tino Pereira, Kim Smith, Sue Driver, Andrew Blair, Debbie Chin, Dr Tristram Ingram, Jane Hopkirk, Wayne Guppy, Alan Shirley,		
IN ATTENDANCE:	Ashley Bloomfield, Adri Isbister, Rachel Haggerty, Helene Carbonatto, Nigel Broom,		
PUBLIC	No members of public present.		
PRESENTERS	<p>Regional Child Oral Health: Nicky Smith, Manager HVDHB Dr Nicky Fuge, Clinical Director HVDHB</p> <p>Wairarapa Child Oral Health: Lynette Field, Manager WDHB</p> <p>Regional Public Health: Peter Gush, Manager HVDHB</p> <p>Regional Screening Update: Lindsay Wilde, Manager HVDHB</p> <p>Hutt Valley Wellbeing Approach: Dr Peter Murray, Public Health Registrar HVDHB</p>		



	Agenda Item	Discussion	Action Required And by Whom
1	PROCEDURAL BUSINESS		
1.1	KARAKIA	Yvette Grace led Karakia, Committee Chair, Dame Fran Wilde, welcomed members and DHB staff	
1.2	APOLOGIES	Received from Tino Pereira, Kim Smith, Sue Driver, Andrew Blair, Debbie Chin, Dr Tristram Ingram, Jane Hopkirk, Wayne Guppy, Alan Shirley,	
1.3	INTEREST REGISTER	Board members would note further conflicts	
1.4	Confirmation of previous minutes	Otherwise, minutes were accepted as true and correct. Moved Derek Milne seconded by Lisa Bridson	
1.5	Matters arising	No matters arising	
1.6	Action points	Note action point 2.3 – Equity Monitoring Indicators are transferred to local CPHACs in 2018 Note action 2.5 – Regional Public Health Updates are transferred to local CPHACs in 2018 Note 2.1 – Advanced Care Planning item is closed Note action 2.5 – Regional Public Health Updates is transferred to local CPHACs in 2018 Note action 2.3 – Aged Care Services Update are transferred to local CPHACs in 2018	



		Note 4.1 – Structure of CPHAC DSAC item is closed	
1.7	Dissolution of 3DHB CPHAC/DSAC	Noted that the 3DHBs have agreed the importance of meeting to discuss strategic issues and work together. Moved Prue Lamason and seconded Lisa Bridson	
1.8	DSAC Meeting Schedule 2018	Confirmed there will be a minimum of four meetings and they will consider Mental Health and Disability. CEs to ensure these meetings are resourced and supported to be effective.	Two meetings in Hutt Valley, one in Wellington and the December meeting in Wairarapa. Director SIP
2	DISCUSSION		
2.1	Regional Child Oral Health Nicky Smith, Manager HVDHB Dr Nicky Fuge, Clinical Director HVDHB	This services is for Hutt Valley and Capital & Coast communities. There was a highly informative briefing and presentation on oral health. The importance of data and ensuring that the data tables are read as opportunities for improvement. The discussion on oral health, programmes to support children and their families and fluoridation were widely discussed. It was identified that this information need to be discussed by the Boards of each DHB. It was identified that this would be the role of the District CPHACs. The Committee NOTED the approach to oral health.	
2.1a	Wairarapa Child Oral Health Lynette Field, Manager WDHB	The presentation and paper were well received. Discussion on tooth brushing pilots which were resource intensive for schools but had merit in improving oral health. There was also discussion on fluoridation and amalgam use. The Committee NOTED the approach to oral health.	Transferred to local CPHACs and Boards



		The Committee to RECOMMEND to all three Boards that they write to the Minister of Health regarding introducing a tax on sugar-sweetened beverages.	
2.2	Regional Public Health Update Peter Gush	<p>The presentation and paper were well received. There was extensive discussion regarding the importance of these population health approaches particularly with the recent change in government.</p> <p>This included discussion on:</p> <ul style="list-style-type: none"> • The impact of the environment on health and consideration of the impacts of climate change and diesel emissions. • The opportunities to target very poor quality housing to improve insulation, curtains and family understanding of how to keep their home healthy. These initiatives are supported through the Well Homes activity. Committee members noted other activities being supported in Porirua. • That there should be reconsideration of School Food Guidelines by this government and the importance of healthy eating for a wide range of reasons including oral health and obesity. • Consideration of the recommendations of the Lan Commission report on alcohol as an authoritative source for the CEs in considering the activities of Regional Public Health. • The role of the Health Promotion Agency in promoting messages regarding alcohol and population health messages was acknowledged. <p>The importance of outcome data in understanding the impact of these population and public health initiatives.</p> <p>A communication is to be drafted for the new government. This would be developed by management across the three DHBs with expert input. It should reinforce the importance of health as an investment.</p> <p>This resolution will focus on:</p> <ul style="list-style-type: none"> • The importance of housing insulation and quality homes 	This is now transferred to local CPHACs.



		<ul style="list-style-type: none"> Government approach to sugar tax/soft drinks 	
2.2a	Hutt Valley Wellbeing Approach Dr Peter Murray, Public Health Registrar HVDHB	<p>The Hutt Valley Wellbeing approach was presented by Dr Peter Murray. There was detailed discussion on the benefits of a wellbeing approach as the entry point to health.</p> <p>The discussion regarding the analysis of ambulatory sensitive hospital admissions (ASH) rates and matching data with other services had identified that these children were mostly immunised and frequently engaged with primary care. This strongly suggested that social determinants were major drivers in avoidable hospital use by children.</p> <p>It was noted that all of the DHBs should be taking a wellbeing approach, and it was noted by management that CCDHB and WDHB have their own wellbeing approaches.</p> <p>The Committee received the presentation.</p>	
2.3	Regional Screening Update Lindsay Wilde, Manager HVDHB	<p>The regional screening update was well received and included the breast and cervical screening programme. There was discussion regarding national and local results and the critical importance of equity. This included being more flexible and responsive to the ways in which our Maori and Pasifika communities prefer to receive services.</p> <p>The Committee NOTED the approach to screening services.</p>	
3	INFORMATION		
3.1	Bowel Cancer Screening Update	<p>The bowel screening update was well received with a particular focus on the approach to inequalities. The programme has been 'go live' since July 2017. Hutt Valley has seen 53 positive results from the tests returned with one with cancer and one with suspected cancer. It is too early for Wairarapa results to be reported. Capital & Coast has not been advised when bowel screening will be implemented.</p> <p>The Committee NOTED the update.</p>	



3.2	Disability Strategy Implementation First Quarter Report Bob Francis	<p>Update on implementation of the 3DHB Disability Strategy was well received. There was particular interest in the Review of Footpath Accessibility at Masterton Hospital.</p> <p>Good progress being made on the co-design of an electronic Health Passport with the support of MoH and PWC consulting.</p> <p>It was also noted that it is International Day of Disabled People of 3 December 2017. Derek Milne was specifically delighted to see the Health Passport reach fruition.</p> <p>The Committee NOTED the update and quarterly report.</p>	
4.0	OTHER		
4.1	Healthy Ageing Strategy	<p>The Ministry of Health published 'Healthy Ageing Strategy' was attached for information for members as it was discussed at the September meeting. Members noted that it was an excellent strategy. There was considerable discussion on the activities of each DHB in responding to the strategy; the level of support from government and how policy makers are responding to the strategy. Committed members wanted to ensure that each Board monitored the strategy through their district CPHAC.</p>	
This is the final combined 3DHB meeting of CPHAC DSAC. The next 3DHB DSAC meeting is Monday 19 March.			



Terms of Reference

Wairarapa, Hutt Valley and Capital & Coast District Health Boards Disability Services Advisory Committee

March 2018

Compliance	<p>In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Boards shall establish a Disability Support Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Boards from time to time.</p> <p>The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.</p> <p>The Committee shall comply with the Boards’ Standing Orders for Statutory Committees.</p> <p>These Terms of Reference:</p> <ul style="list-style-type: none"> • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Terms of Reference dated 30 July 2017; • are effective from March 2018.
Functions of the Committee	<p>The functions of this Committee are to give the advice to the full Board of each DHB on:</p> <ul style="list-style-type: none"> • the needs, and the factors that may affect the mental health and disability status, of the residents of the DHB; • the mental health and disability support needs of the resident population of the DHB; • priorities for use of mental health and disability support funding. <p>The aim of the Committee’s advice is to ensure that each DHB maximize the independence of the people with mental health and disability support needs within the DHB’s resident population through:</p> <ul style="list-style-type: none"> • the range of disability support and mental health services the DHB has provided or funded or could provide or fund for those people; • the service interventions the DHB has provided or funded or could provide or fund for the population; • policies the DHB has adopted or could adopt for those people. <p>The Committee’s advice will be consistent with the New Zealand Health Strategy.</p> <p>The Committee shall present its findings and recommendations to the Boards for their consideration.</p>
Objectives and Accountability	<p>The Committee shall:</p> <ul style="list-style-type: none"> • monitor the disability support and mental health needs of each DHB resident population providing advice to each Board; • provide advice to each Board on the implications of mental health and disability related needs and status for planning and funding of nation-wide and sector-wide system improvement goals ; • provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and wellbeing outcomes for the target population in each district;

	<ul style="list-style-type: none"> • provide advice to each Board on priorities for improvement and independence of people experiencing mental health distress and disability as part of the strategic and annual planning process to improve wellness outcomes and independence within each district; • provide advice to each Board on strategies to achieve equity in modifiable mental health and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction conditions and people with disabilities; • monitor and advise each Board on the impact and effectiveness of disability support and mental health services being provided for the resident population of each DHB; • provide advice to each Board on the delivery of health services accessed by people with mental health distress and disabilities including how it can effectively meet its responsibilities towards the government's vision and strategies for both populations • identify issues and opportunities in relation to the provision of mental health and disability services that the Committee considers may warrant further investigation and advise the Board accordingly; • identify when 'expert' assistance will be required in order for the Committee to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • report regularly to each Board on the Committee's findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	<p>The following authorities are delegated to the Committee to:</p> <ul style="list-style-type: none"> • require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • interface with any other Committee(s) that may be formed from time to time.
Meetings	The Committee shall hold no less than four meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Boards.
Quorum	A quorum is a majority of Committee members, and must include at least one member from each Board and at least one co-opted member from the Sub-regional Disability Advisory Group, Sub-regional Pacific Advisory Group and Māori Partnership Board(s).
Membership	Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.
Procedure	Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.

Creating our DSAC

Disability Advisory Committee
3DHB Disability & Mental Health & Addiction

Our legislative obligations

- a) improve, promote, and protect the health of people and communities:
- b) promote the integration of health services, especially primary and secondary health services:
 - a) to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs:
- c) promote effective care or support for those in need of personal health services or disability support services:
- d) promote the inclusion and participation in society and independence of people with disabilities:
- e) reduce health disparities by improving health outcomes for Maori and other population groups:
- f) reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:
- g) exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:
- h) foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:
- i) uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:
- j) exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:
- k) be a good employer in accordance with section 118 of the Crown Entities Act 2004.

Our legislative obligations

- Hospital advisory committee
 - to advise on matters relating to hospitals, called the hospital advisory committee, and must provide for Maori representation on the committee.
- Community and public health advisory committee
 - to advise on health improvement measures, called the community and public health advisory committee, and must provide for Maori representation on the committee.
- Disability support advisory committees
 - to advise on disability issues, called the disability support advisory committee, and must provide for Maori representation on the committee.

PROVIDING ADVICE TO OUR BOARDS

The purpose of a 3DHB Disability Advisory Committee

Planning and monitoring the mental health, addiction and disability
strategy & system

Monitoring performance and implementation

3DHB DSAC Scope

- The functions of this Committee are to give the advice to the Board of each DHB on:
 - the needs, and the factors that may affect the mental health and disability status, of the residents of the DHB;
 - the mental health and disability support needs of the resident population of the DHB;
 - priorities for use of mental health and disability support funding.
- The Committee's advice is to ensure each DHB maximize the independence of people with mental health and disability support needs:
 - the range of disability support and mental health services the DHB has provided or funded or could provide or fund for those people;
 - the service interventions the DHB has provided or funded or could provide or fund for the population;
 - policies the DHB has adopted or could adopt for those people.

Planning our health system

- Planning the health system:
 - **To support those who experience mental illness, addiction and disability**
 - **To fulfil our obligations to government and their priorities**
- Health system development
 - Mental Health and Addiction investment plans for outcomes for our populations
 - Integration and locality plans for outcomes for our communities
 - Social and health sector integration for these populations
 - Mental Health & Addiction & Disability Strategy development and implementation
- Health system performance
 - Quality and effectiveness of services available to our communities
 - Achieving equity amongst our populations
 - System performance and impacts on health gain
 - Health outcomes for our mental health, addictions and disability communities

What's important in our papers?

- We are clear what is across the three DHBs, and what is local DHB activity
- We reflect a whole of system approach
 - Community to specialist services
 - How the needs of these populations are met by the services delivered
- Consistent performance measurement:
 - Structural measures
 - System level performance
 - Impact Measures
- Focus on health outcomes and equity for these communities
- Checklist:
 - Alignment to:
 - each DHBs strategies and plans
 - government priorities
 - Who is served and impact for communities and populations
 - Is it working?
 - What is the evidence of impact?
 - What is the experience of our communities?
 - What is the impact on:
 - Equity
 - Quality
 - Safety
 - Clinical sustainability
 - Financial sustainability



Mental health and addiction

Presentation for Discussion

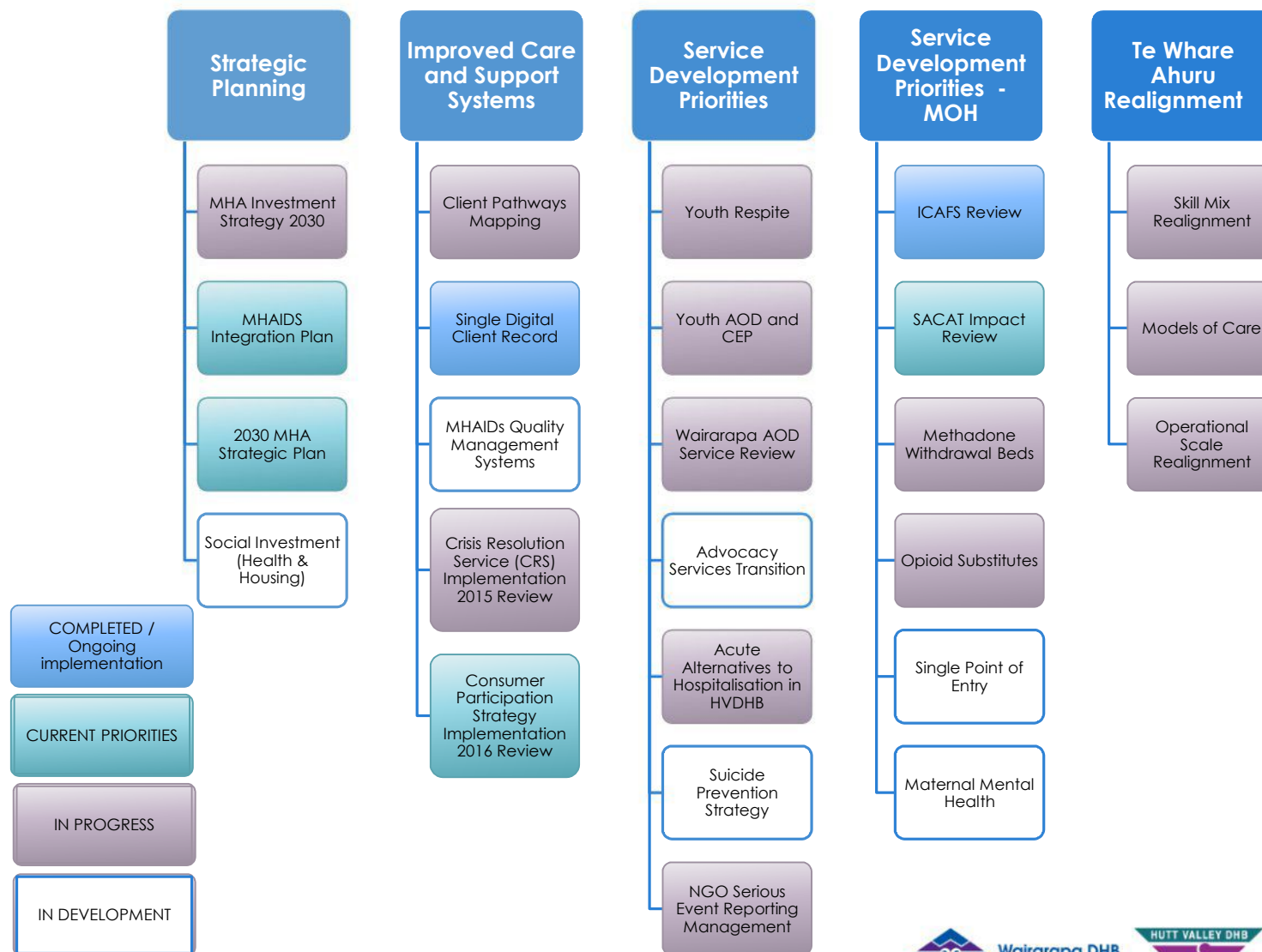


How we work across the 3DHBs

- The Joint work programme was developed to ensure that our activity to improve mental health and wellbeing outcomes across the 3DHBs are connected and makes good use of resources.
- The work programme is ongoing and a governance group meets monthly to review project process, and plan the next key priorities.
- The current work programme is on the next page.
- The current key priorities are:
 - MHAIDS Integration Plan
 - 2030 MHA Strategic (Localities Integration) Plan
 - Consumer Leadership
 - SACAT Information Review
- The developing key priorities for 2018/19:
 - Acute mental health demand management
 - Suicide prevention and responsiveness
 - Addiction prevention and management



The Joint 3DHB Work Programme



MHAIDS Integration

- A 3DHB sub-board working group reviewing mental health made recommendations in April 2017 following their review of DHB mental health services.
- A key recommendation was to consider how to improve the management integration across the 3DHBs to enable delivery that is more seamless, higher quality and more cost effective.
- The programme of work is focused on an approach that will:
 - Improve outcomes and reduce inequality
 - Strong services and coordination within communities
 - Sustainable workforce and specialist skills
 - Clear funding, contracting and financial systems
 - Effective governance and accountability



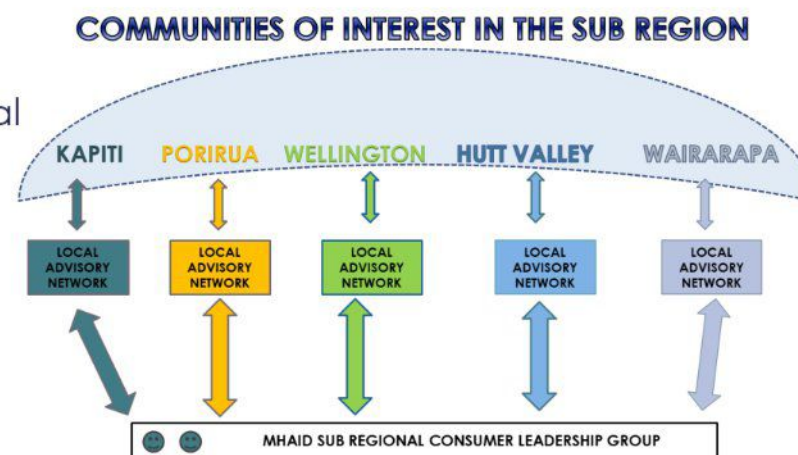
Consumer Leadership

- The structure and process proposed are grounded in the principles and values developed by consumers during the sub regional strategic development process also linked to *community development*. These values were adopted as part of 3DHB CPHAC:
 - **Empowerment**, which, in this context, means supporting individuals and groups to influence issues that affect them and their communities
 - **Participation**: which, in this context, means supporting individuals and groups to directly participate as equal partners in decision-making processes which affect them and their communities;
 - **Self-determination**: which, in this context, means communities coming to their own conclusions, and defining their own positions on issues, which they then bring to the decision-making process;
 - **Inclusion**: defined in this context as “the inclusion of all communities which have a vulnerability to, or significant experience of, mental ill health”.
 - **Mana Motuhake**: defined in this context as “ensuring equitable empowerment, participation, self-determination and inclusion of whānau, hapū and iwi Maori”.
- Implementation and use of these values in the workplace has been supported by the following developments:
 - The appointment of a Consumer Director to MHAIDS. This position reports to the GM, MHAIDS and sits at the leadership table.
 - The development of a draft Localities Network approach to consumer participation in service delivery and planning & funding of mental health and addiction services.



Consideration of a Consumer Leadership Group

- A Consumer Leadership Group and Locality Network may:
 - support a consistent, credible and locality-receptive approach to service user participation throughout the sub-region
 - maintain an oversight of the sub-regional and locality-based development of consumer leadership
 - support the local consumer voice to be heard in service development
 - ensure that the service user values are honoured
 - represent the Local Advisory Networks to both the MHAIDS and planning/funding of the 3DHBs



Client pathway

- A new single MHAIDS client pathway and digital client record to enhance and support safe clinical practice was identified through reviews of mental health as critical to:
 - Improve continuity of care
 - Ensure consumers received care matched to their needs
 - Improve communication between professional groups
- The selected solution:
 - The pathway and record will let all staff view and update client information at any time and place
 - GP/primary care and NGO access to the this digital client record is part of phase two
- Implementation is underway:
 - It is live across mental health, addictions and intellectual disability services (MHAIDS)
 - From 12 March, all client pathway documentation for new clients are being entered into the digital client record.
 - Existing client records will be updated over time
 - More than 110 training sessions delivered to the client pathway implementation leaders
- The second stage development of the digital client record looking at enhancements will get underway at the end of March 2018

Infant, Child, Adolescent and Family Service (ICAFS)

- Improving access to the ICAF services at Hutt Valley DHB to reduce waiting times and improve outcomes.
- Independent review resulting in staff consultation also completed
 - A new team structure is agreed
 - Additional resources agreed to support service access
- Decision document released and implementation well advanced
 - Currently recruiting team leader positions
 - Staff being redeployed to the two new teams in the new structure
 - New structure to be in place by June 2018
- Phase two to improve service connectivity and client outcomes
 - Other related service improvement initiatives underway including the role of Te Haika in triaging all new clients

Te Whare Ahuru

- The refurbishment of the inpatient unit to better serve the needs of adult clients of MHAIDS in the Hutt Valley
 - Develop the best model of care for the consumer
 - Design a facility to support this model of care
- Reconfiguration of inpatient unit based on the development of a new model of care
 - Consumer centred
 - Consistent across the 3DHBs
- Several workshops with staff and key stakeholders are underway
 - Final report end of May 2018
 - Recommendations will then be made to the Hutt Valley DHB Board to advance to next stage including building design



SACAT

- The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACAT) replaced the Alcoholism and Drug Addiction Act on 21 February 2018.
 - SACAT Act provides for the compulsory assessment and treatment of people who are considered to have a severe substance addiction. It is a last resort and can only be used after all other options have been tried without success.
- Implementation has been well managed across the 3DHBs:
 - DHB clinical governance arrangements for ongoing monitoring, review, quality improvement, risk management are being developed and are incorporated into current clinical governance.
 - The Ministry of Health is developing sector wide clinical governance arrangements.
 - Key staff are in place including Area Director, Authorised Officer(s) and Approved Specialists and Responsible Clinicians across the three DHBs.
 - Internal orientation/ training day was held on 20 February 18 and regional mana enhancing training is planned for mid- March.
 - A localised pathway has been developed to ensure appropriate clients receive the service and referrals to available family and whanau support, cultural support and peer support.
 - Two medical detox beds are available in CCDHB.
 - National travel assistance fund covers the cost of transporting people and their whanau to assessments and to treatment.
 - Ministry of Health are implementing the Court process, the inpatient beds for the Central Region and the appeal process for clients.
 - Data, information and reporting process are implemented alongside the process



Wairarapa Mental Health & Addiction Service Development

- Tihei Wairarapa was implemented in 2010. Now preparing for the next ten years:
- Reviewing Wairarapa DHBs existing mental health and addiction services and programmes.
 - Wairarapa DHB Provider Arm, Non-government Organisations (NGO), Primary Mental Health and any services provided by other DHBs.
- Facilitating discussion with people using mental health and/or addiction services, their family/whānau and the Wairarapa community.
 - Improve understanding of what is happening in Mental Health and Addiction services
 - Create a sustainable service model pathway, and improved approach within existing services
- Deliver results that:
 - Service user, population outcomes and value for money improved
 - Culturally appropriate services
 - Enhanced collaboration between clinical services, community support services and the people
- Report due to the Wairarapa DHB Board May 2018



MHA integrated care collaborative and networks

- Both HVDHB and CCDHB are implementing Mental Health and Addiction Integrated Care Collaborative/Networks to improve outcomes:
 - Lead the strategic development of integrated primary and secondary mental health services
 - Review the data on all aspects of the delivery of mental health services
 - Develop a work plan to develop new approaches to improve effectiveness and quality across the system as well as how such improvements would best be implemented.
 - Develop an integrated monitoring framework to meet the agreed purpose and objectives of the group
- There will be joint working and resulting joint initiatives between the MHA ICC/ Networks across the three DHBs including the use of the shared dataset/
- Membership includes:
 - Specialist mental health and addiction, general practice, primary mental health, NGOs, Maori & Pacifica leadership and consumers





Mental Health Inquiry

Engaging our providers and sharing our approach



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  		DSAC DECISION PAPER
		Date: 5 March 2018
From:	Dr Pauline Boyles, Director, Disability Strategy and Performance (SIPD), Capital and Coast DHB (CCDHB)	
Endorsed By:	Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB Helene Carbonatto, General Manager, Strategy Planning and Outcomes, Hutt Valley DHB (HVDHB) Nigel Broom, Executive Leader, Planning and Performance, Wairarapa DHB (WDHB)	
Subject:	Report on UK research trip: Citizen led social care and NHS transformation.	
Recommendations	It is recommended that the Committee: 1. Notes: that Social Care Partnerships in Greater Manchester have led to: a. Citizen led transformation through a commitment to citizen leadership and joint commissioning b. Key features of good practice 2. Notes: that there are numerous examples of successful citizen led initiatives and examples are outlined in this paper: 3. Notes: Community Circles can be a mechanism for building community assets (which is supported by evidence): 4. Notes: that there is potential for Community Circles learning for implementation in the sub region 5. Endorses: Further development work on Community Circles with a view to trialling Community Circles during 2018/19, subject to the outcomes of the 2018/19 prioritisation and budgeting process.	
APPENDIX ONE: POWER POINT OF CONTENT OVERVIEW OF UK RESEARCH TRIP		
APPENDIX TWO: PAULINE BOYLES TRIP ITINERARY		
APPENDIX TWO: COMMUNITY CIRCLES RESEARCH SUMMARY LONDON SCHOOL OF ECONOMICS (

1 PURPOSE

This paper is to provide information on a recent research trip to the UK to examine the value of citizen led initiatives to strengthen health and social wellbeing. It includes the key learnings from the research trip for Disability Strategy implementation and system transformation within the Wellington sub region.

2 KEY LEARNINGS IN SUMMARY APPLIED TO A NEW ZEALAND CONTEXT

The key findings of this work are:

- Citizen led leadership is proven to add value.
- Person centred change can be successful on a small and large scale.
- Health Care Home could be a key enabler, using community connectors that could start small and be scaled.
- Proactive citizen leadership could be built into all contracts as an expectation.

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- Proactive citizen leadership and connection could be built into all contracts as in UK to begin a process of culture change.
- Wellington sub region has several communities with similar opportunities to build alongside councils or health services.
- The social value framework can be developed according to the issues and problems of each community e.g. reduced loneliness, social enterprise leading to more employment; volunteer work force and improved neighbourhood connections responsive to emergency.
- Small investment from social care funding has led to tangible change as could small investments of health funding (similar responsibility).
- General practice in certain areas where there is high need and/or older communities could work well with citizen champions irrespective of business model.

3 BACKGROUND (SEE APPENDIX ONE)

I was honoured to be hosted by senior NHS staff involved in system transformation to learn about their high level strategies and core principles. They were generous with their time and passion for people powered change.

Everyone I met at NHS England had experience of implementing initiatives on the ground. I was welcomed equally by those working on the ground in Primary Care, citizen champions working in partnership and others who have campaigned for many years for citizen driven and person centred change.

Highlighted below are some key findings and analysis that we, as a DHB, can consider from the practice and learning that has taken place in local communities and NHS England.

Health services in the UK, as other countries internationally are facing a “tipping point” where the demand for health care into old age exceeds resourcing. Transformational change has been in process for several years but austerity has impacted on people most vulnerable to change. In fact disabled people have experienced six times more cuts in services including benefits than any other group¹. In 2011, regions were given the opportunity to take social care in a different direction and more powers were delegated to local councils to work with communities and NHS services. Within commissioning the concept of “commissioning for social value” has become a desired prominent outcome as opposed to more quantifiable outputs characteristic of health service planning over 20 years. This emerged with the recognition of the following:

- Social value outcomes are now sought consistently in the first instance as opposed to service widgets or costs;
- Procurement of large providers has broken down the fabric of society in the UK in a measurable way re social and economic outcomes;
- Often low financial cost can be spread across multiple small suppliers who use a mixed model of workforce to deliver specific community based citizen led services; and
- Many examples of community regeneration due to this approach.

I chose the particular areas of research to visit to learn from the strategy, the vision, the impact on the ground and to see examples of citizen led initiatives changing health and wellbeing outcomes in a

¹ Dr Simon Duffy Director Centre of Welfare Reform cited 5th March 2018

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measurable way. The key areas described below are those with the most relevance and learning in the implementation of the Disability Strategy within Wellington Health System Transformation.

4 FINDINGS:**Social Care Partnerships:**

Greater Manchester has a population greater by 2 million than New Zealand. The commitment to citizen leadership and joint commissioning with other bodies has led to examples of good practice and change in specific areas.

Key features are as follows:

- Person and community centred approaches are a key part of “Taking Charge” and the “Population Health Plan”, as well as all ten Locality Plans within ten local council areas²;
- Formal and informal networks collaborate and are strengthened for individuals and communities;
- Recognition that when there has been more funding available a co-dependence and reduced autonomy has occurred for health and social wellbeing. Individuals and communities were “done to” rather than “partnered with”;
- Populations with the highest users of services have been targeted (see slide four). New Zealand faces identical challenges;
- NHS GM agreed and endorsed a primary care strategy with partners, setting out how more effective integrated care will be delivered;
- Facilitated development of plans for Local Care Organisations and Integrated Commissioning arrangements in all ten districts (See Figure 1); and
- Figure 2 indicates the intent for a shift of funding to preventive proactive care in the hands of citizens.

Transformation funds have been awarded to stimulate communities to partner with health services in development of improved social care. Of particular impact was the learning identified by the writers of a report on the process and outcomes of commissioning of community based activity:

‘Fundamental lessons were learnt through the commissioning process. Chief of these was that without relationships and building trust and alignment around a common vision, change won’t happen.

Strategic relationship building, flexibility and finding new ways of working is vital. It is inevitable and necessary for significant disruption to the system to take place. For the process to be efficient and successful, there is an essential role for change agents with the skills to manage positive change and ensure that an appropriate level of disruption is achieved without significant imbalances’.³

The above statement is a significant learning for the design and implementation of any system change where the chaos and disruption can lead to fear and tightening of controls or if well managed to significant growth and more collaborative and involved communities

² In the UK councils hold the majority of social care funding across all age groups and health holds only funding related to clinical care. Joint commissioning is now a more accepted way of operating

³ People powered commissioning for social action in Stockport (Nick Dixon for Stockport council et al) October 2016 (available on request)

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Figure 1 Bottom up approach to strengthening integrated care partnerships

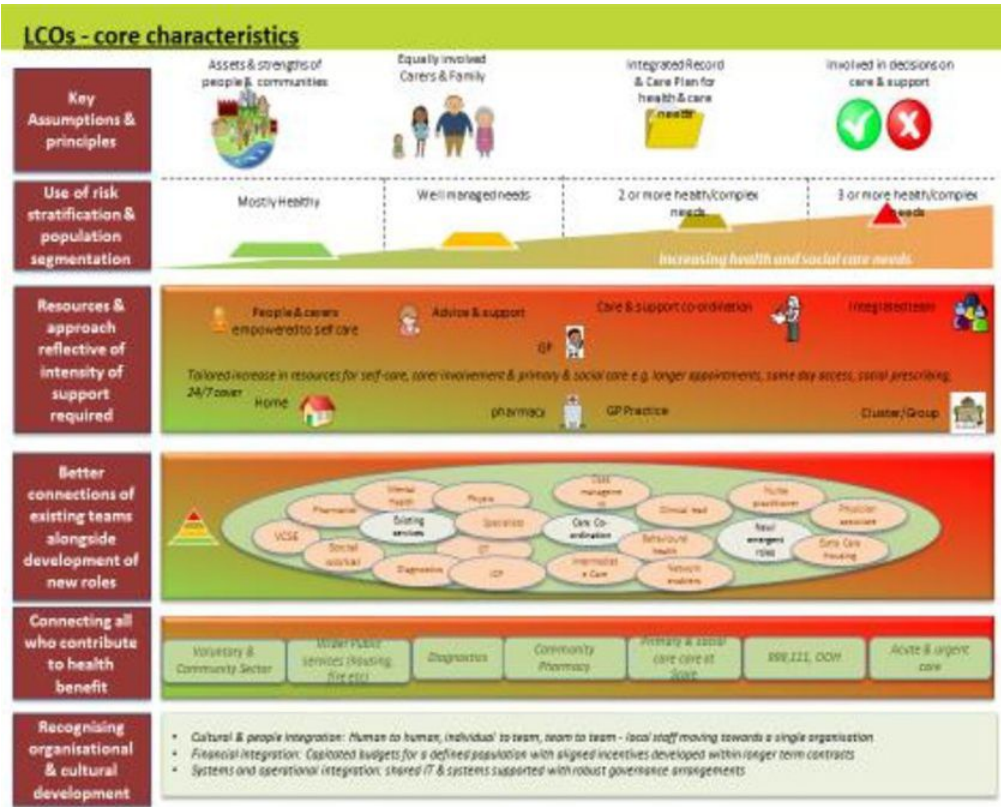
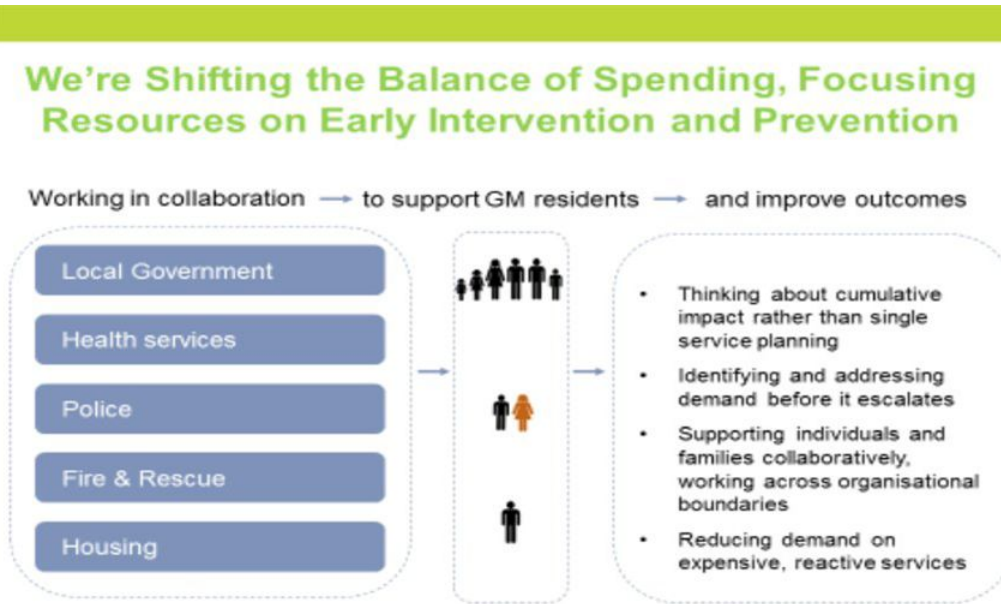


Figure 2: Local Integration



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The next section identifies some of the “on the ground” initiatives, either unfunded or funded, with relatively small amounts in the first instance.

5 SUCCESSFUL CITIZEN LED INITIATIVES

Multiple examples of citizen led initiatives in the North of England were explored during the research trip. These are outlined below.

Altogether Better: Bringing Citizens and Services Together

This NHS network is mentioned in point 3.0 and the evaluation of the initiative is referenced in footnote 5. “Altogether Better” has developed an evidenced based approach, working with General Practice, which delivers this vision and provides an offer to reduce the pressure in General Practice. The work has been developed in over 70 GP practices in 18 CCG areas, involving over 1000 citizens who gift their time as champions and have the ability to touch the lives of half a million people. By 2018 the network of early adopters continues to grow.

Key principles and goals of approach of Altogether Better:

- Goal to improve social physical and mental health and wellbeing
- Citizens work together to achieve a bottom up approach to deliver wellbeing
- Citizens no longer seen as users or choosers of services but as shapers and makers of innovative new services
- People are enabled to adapt to self- manage in the face of social and emotional challenges
- Evidence that people use services differently

The network evolved to move to a more sustainable model of general practice. Early findings replicated country wide could achieve:

- **The resilience** of general practice is transformed so that it can cope with the reducing number of GPs in the system, in particular the reduction in the number of single handed GPs, the increasing numbers of GPs retiring or leaving the system, and the decreasing numbers of GP trainees;
- Prevention becomes the norm - an integrated part of the system, reducing the future prevalence and incidence of socially determined disease by creating the conditions where people are supported to prevent, manage and live well with long term conditions and improve their mental, social and physical health and wellbeing;

The introduction of Practice Health Champions brought about health improvements for both the Champions themselves and wider participants. The approach also brought about long term and embedded system change, by involving the Champions in service design and delivery.

As a result of the work:

- 87% (488) of Champions and 94% (286) of participants reported having gained new knowledge/awareness related to health and wellbeing; and
- 86% (482) of Champions and 94% (286) of participants reported increased levels of confidence and wellbeing following their involvement in the project.

Alvanley Family Practice (AFP Hyde Stockport)

Alvanley is seen as the leading practice exemplar and I was fortunate to spend two days with staff and champions.

The Change Agents at this practice were the Practice Manager and one a GP practice partner. Altogether Better (NHS) encouraged and supported the change but the dedication and commitment of the change agents were the critical elements of success. Over a relatively short period of time a number of changes were able to be realised including the recruitment of over 20 practice champions across age groups and

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ethnicity. I was fortunate to meet and spend time with all involved and was able to learn from the sharing of different perspectives. A change to the practice name called Alvanley Family Practice reflecting a more people and family centred approach made a public statement about the intent. Within a short period of time the practice enrolment raised by 2000 people who were attracted to a different style of clinical leadership and collaboration.

Both patients and champions described their own improvement in wellbeing through the involvement with peers, a trusting relationship with the practice and a sense of responsibility for themselves and others.

The Wellbeing Prescription

The champions of AFP developed their own wellbeing prescription as an exemplar of how other practices can implement and prevent avoidable impact of living with long term conditions. It is often recognized within health services that people with enduring long term conditions and/or other impairments, have needs not easily met by clinical staff. Patients often consult GPs for example when anxious or lonely and related exacerbations of their conditions.

These are recognized as potentially avoidable requiring some resolution. The development of prescriptions for social wellbeing is akin to green prescriptions in New Zealand. These were implemented to address health benefits of exercise for people with certain conditions, usually related to some level of obesity. Wellbeing prescriptions are intended for a wider group

The wellbeing prescription (shown on power point Appendix One) is designed specifically around the skills and availability of practice champions is being used in communications with many other general practices in Greater Manchester. It is being distributed by GPs to the high number of patients with long term conditions who are then connected in with the appropriate champion/s and group/s.

Unique to this local practice is also a community café that hosts a free computer training course and a weekly singing group. These are well attended and provide a natural social circle of support for many people. The participation and presence of the lead GP partner and the practice manager cement the sense that there is a real commitment and interest in the lives of local people.

6 COMMUNITY CIRCLES

Community Circles can be a positive mechanism for building community assets. Community Circles New Zealand was established in 2016/17 based on the UK model driven by Helen Sanderson Associates (HSA). Circles of support as a concept is not new and has been used extensively within the learning disability field based on a Canadian model of inclusion⁴ since the 1980s. However within the UK HSA and a team of change agents have targeted a wider population, initially older people in rest homes using Community Circles and specific organising principles. Community Circles NZ have now developed circles within disability services in Palmerston North and are training connectors and facilitators around the country to develop circles with people in most need.

The pressures and isolation of older people, people with long term conditions and disability related to life-long impairments including mental distress are enduring challenges for people, family/whānau and services. Community Circles is therefore seen as a solution to many of the health and social wellbeing issues so difficult to separate within existing funding silos.

A prioritisation bid for the establishment of Community Circles in the Wellington area was submitted in January 2018 for consideration. It noted that CCDHB is keen to develop capacity and capability of local service providers, NGOs and community volunteers to deliver Community Circles.

A London School of Economics Research report Appendix Three) identified positive outcomes including:

- Circles can offer a very powerful, effective and personalised way of supporting a young person with disabilities to have a good quality of life.

⁴ Martha Rioux Centre for Inclusion Toronto

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- Circles have potential to develop and harness community resources to promote greater social inclusion and improved wellbeing for young people and family.
- The young person was seen to be much better integrated into the local community and able to be involved in the same activities as people of a similar age would.

The Wigan Example

The visit to Wigan revealed an excellent example of successful change agency working within a person centred model of change. Wigan has a diverse population of a similar size to CCDHB and a similar proportion of older people. Within the UK it appears people are choosing rest homes at an earlier stage than in New Zealand, partly due to isolation from natural supports and difficult to access appropriate social care.

Wigan Council have commissioned a three year initial project to develop circles in rest homes in Wigan. The issue of high hospital acute rates for this population has led to a more social wellbeing approach based on relief of isolation, early preventative care and a number of people sharing responsibility for the wellbeing of each individual.

Early results are excellent and there are three community connectors working with several volunteer facilitators within the first year.

Key features of the Wigan Community Circle include:

- The circle is driven by the person and based on their needs and wishes;
- It often includes family members but other volunteers according to the interests of the person;
- A monthly meeting is called by the facilitator to ensure the circle is working based on feedback from the circle owner;
- It is as formal or informal as appropriate;
- The daily needs of a person may still be met by services. Other tasks include shopping, social outings, creation of friendship networks, learning to use the smart phone or computer. These are all shared between a numbers of people chosen by the person but no individual including family members feels they are carrying all the responsibility and the outcomes are better than more random natural supports;
- One connector can oversee a large number of circles;
- Facilitators can oversee several circles; and
- A circle can stop or gradually reduce where a person no longer requires such support.

Key Benefits of Community Circles and underlying principles:

- Good for a range of people at risk of isolation for many reasons including the inability to meet funding criteria;
- A three year plan would be proposed in initial areas where there are isolated older people such as Kapiti and Wairarapa;
- This may be linked to a choice for people with long term conditions and home care to receive individualised funding;
- People employed as connectors must be trained by those experienced in building circles and be part of and known to their local community;
- Commissioning body should allow limited bureaucracy and work on a high degree of trust; and
- Outcomes should be defined clearly as those based on social value principles co- produced with interested citizens.

7 CONCLUSION

Two key projects stand out where a joint commissioning approach between health and social care could be replicated in local areas of the sub region.

These are the Primary Care movement for change with the Alvanley example and Community Circles. This direction is contained within the Sub Regional Disability Strategy Leadership module; *including 1.2 Practice Positive Partnerships to enhance collaboration and co-production* and the access module *3.1 community resilience is promoted in the sub region*. These also fit with health system planning priorities to ensure care is closer to home and to health services work with communities to develop solutions.

Key Learnings for Sub regional system transformation:




- This approach can be applied in other settings in a New Zealand context (e.g.(Wairarapa and Kāpiti);
- The model operates with minimal costs by identifying change agents within workforces or communities;
- People participate by invitation and cross all age groups (linked with disability plan);
- Sub Regional Disability Advisory Group also has a role in this space (leading within local areas); and
- People value what they have built themselves.

Support is requested to:

- Develop the concept of community circles in at least one demonstration site in any local area depending on need and buy in from communities, subject to the outcome of the prioritisation and budget process; and/or
- Support trial change agency or champions in any local General practice or PHO interested in building health and social wellbeing for patients identified as in need.

Endorsement is requested for a Community Circles approach for local areas based on small projects that can be scaled up over time based on citizen led principles and defined social value outcomes.

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<div><div>Wairarapa DHB Wairarapa District Health Board Te Pouti Hauora o Wairarapa</div></div> <div><div>HUTT VALLEY DHB</div></div> <div><div>Capital & Coast District Health Board Ōpoko ki te Uru Hauora</div></div>		DSAC DISCUSSION PAPER
		Date: 5 March 2018
From:	Dr Pauline Boyles, Director, Disability Strategy and Performance (SIPD), Capital and Coast DHB (CCDHB)	
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, CCDHB Helene Carbonatto, General Manager, Strategy, Planning and Outcomes, Hutt Valley DHB (HVDHB) Nigel Broom, Executive Leader, Planning and Performance, Wairarapa DHB (WRDHB)	
Subject	Update on implementation of Disability Strategy	
<p>It is recommended that the Committee:</p> <ol style="list-style-type: none">Notes: the Review of Disability Education at CCDHB which recommends that the position is part of People and Capability and is focused on disability literacy within a rights-based context;Notes: the research on Informed Consent for people with learning disabilities with a focus on developing resources;Notes: the progress on the New Zealand Sign Language (NZSL) Plan with the development of resources to support the deaf community when using health services; andNotes: the strategic issues identified by the CCDHB/HVDHB (joint needs assessment services (NASC) and clinicians Interim Clinical Governance Group (ICG) identifying the need for greater support for those who are homeless and those who are experiencing obesity related disability.		
APPENDIX ONE: SUPPORTED DECISION-MAKING AUCKLAND LAW CENTRE (EASY READ)		

1 PURPOSE

This paper is to update to DSAC members on progress against the Disability Strategy on four specific areas of work to meet the goals of the 17/18 Annual Plan;

- Review of Disability Education at CCDHB
- Informed Consent and People with Learning Disabilities
- Progress on the New Zealand Sign Language (NZSL) Plan
- Strategic issues arising: Interim Clinical Governance Group (CCDHB and HVDHB).

2 UPDATE ON PROGRESS AGAINST THE DISABILITY STRATEGY (2017-22) AND THE 3DHB ANNUAL PLANS (2017/18)

2.1 Review of Education

The sub-regional Disability Strategy “Enabling Participation” (sections 1.6 and 4.4) gives clear strategic guidance on what is required for the next five years. An assessment of the training needs related to improving disability literacy of CCDHB staff has been completed.

A more strategically focused disability responsiveness education programme at CCDHB is planned. This includes incorporation of disability literacy within a rights-based context.¹ A dialogue that includes rights, responsibilities and solutions is a critical component in the Disability Strategy and performance led

¹ Within most health and disability planning needs are prominent leaving definition of needs in the hands of health professionals. Under the UN Convention on the rights of disabled people health services are obliged to consider rights to equal treatment. This also enables disabled people to more easily provide solutions as partners in care.

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improvements to disabled peoples' health outcomes, access, inclusion and leadership in CCDHB and across the sub region.²

A Disability Responsiveness Educator role will be line managed from within Capability and Development, with professional oversight from the Disability Strategy and Performance Team where the content expertise lies. This will strengthen the education partnerships and connection with the other sub-regional disability educators whose work on the ground in Hutt and Wairarapa is yielding tangible changes in staff responsiveness.

People with lived experience of disability will be proactively targeted for recruitment to demonstrate commitment to embedding a more representative work force. There is a preference to increase the role to fulltime. This will be considered as part of the budget process for 2018/19.

2.2 Informed Consent and People with Learning Disabilities

A draft report on scoping policy guidance and resources required for disabled people, families, clinicians and people with learning disabilities (formerly referred to as "intellectual disability")³ across the sub region on informed consent is near completion. In parallel with this, the CCDHB Informed Consent policy is currently being reviewed and will soon be open for internal consultation and development for approximately a year. There is much community interest in this policy.

Clinician feedback on the current informed consent policy across the sub region is that it is long, not well used or user friendly to clinicians. It currently aligns with the Protection of Personal and Property Rights Act but does not ensure or facilitate the progressive rights-based approach of the Convention on the Rights of Persons with Disabilities (CRPD).⁴

The CRPD requires supported decision making with safeguards. This means, regardless of level of impairment, ensuring an understanding, or at least "best guess" of the disabled person's will and preferences are respected, and enacted within similar reasonable safeguarding parameters to non-disabled people. It does not allow substitute decision making, decisions made with best interest intent, or presence or not of conflict of interest by the substitute decision maker.

Extensive consultation in NZ, and internationally has led to adaptable resources, such as representation agreements. Such representatives would be people who know the person with a learning disability well, usually family. However where there is no appropriate family member the ideal person would be of the same gender, generation, ethnicity, and where possible have similar experience of disability. It is expected they have understood a person's choices and preferences and can represent them within a mutually agreed process for communicating decisions.

The cutting edge of progress would be a representation agreement expressed through video via a health passport held on a computer application or similar device. This includes information introducing the person, others close to them, their consenting information and a suggested process accessible to, but not amendable by, the health system. This will be consider as part of the Health Passport project.

Auckland Disability Law, the Human Rights Commission, Office of Disability Issues, and People First NZ have developed a nationally available plain language resource for supported decision making (see Appendix One). All resources will be shared sub regionally and distributed to all community members and groups with an interest in developing the tools for their own use.

2.3 Progress on the New Zealand Sign Language (NZSL) Plan

The 'NZSL in health' programme of work is led by the 'NZSL in Health Task Force'. This group is made up of eight members of the local deaf community including an NZSL interpreter, a parent of a Deaf child and representation from Deaf Aotearoa of New Zealand, and the video Interpreting Service (NZVIS). This group

² Leadership access inclusion and health are the four cornerstones of the strategic plan

³ "People First NZ., the national advocacy movement for people who experience a range of intellectual impairments have asked that all documents refer to learning disability rather than ID. The latter is still used for diagnostics to establish levels of impairment usually at an early age)

⁴ Hutt Valley and Wairarapa have also expressed concern about informed consent and any tools developed will be shared including the proactive use of the supported decision-making document (appendix one)

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meets quarterly, advises on the work programme and is involved in our projects that received external funding from the NZSL board.

The current work programme has focused on the production of two short videos, one for the deaf community about useful information to know when coming to hospital and another for DHB staff about working with deaf people. These videos highlight the importance of access to full information and communication including the ease and availability of the video interpreting service currently available in New Zealand. To improve access to interpreters, five iPads have been costed to cover key departments across all hospital locations sub regionally which will allow access to an interpreter online from 8am – 8pm. This work is funded by the NZSL Board.

This group is currently setting the work program for the coming year based on the 5 year strategy. Two more applications to the NZSL Board have been made: 1) for the development of health information videos into NZSL; and 2) to support and provide access for deaf people who struggle with mental health difficulties and isolation.

2.4 Strategic issues arising: Interim Clinical Governance Group (CCDHB and HVDHB)

The Interim Clinical Governance Group was established January 2017 to address the needs of people using hospital services who are unable to achieve independence or discharge. Since 2015, an increasing number of people in this category have come to the attention of clinicians and funders. The main referrals are people who are “hard to place” and/or discharge from acute services and/or for whom the appropriate funding stream is difficult to identify.

The Group is chaired by the HVDHB or the CCDHB Chief Medical Officer and the Director of Disability Strategy and Performance and has been largely successful in helping staff and people using services achieve a resolution in a shorter time period.

There are some themes emerging which require a more strategic approach. A shared work programme to address these key issues, now the specific details are understood, is now being developed.

One example concerns the issues with people who are homeless and disabled and/or experiencing some other long term physical or mental health condition.

While solutions have been found, there is often difficulty in achieving a physically accessible or generally safe and dry home. It is intended to work with both the Ministry of Social Development and the Ministry of Health to design short, medium and long-term solutions.

A second example is that concerning bariatric clients and their access to health care. The most significant issue is that of appropriately scaled equipment. Enable⁵ in the past has been reluctant to provide equipment due to cost, but increasingly as people become more disabled, it is provided once a funding stream has been identified.

Clinicians have asked whether access to bariatric surgery is adequate in New Zealand and whether the increasing number of people in the “at risk” category might require some national discussion. People who are obese are considered at risk of discrimination in all aspects of society including health services.

Data analysis is planned as well as a meeting with the fund holder within the Ministry of Health regarding this issue. Clinicians have requested that the whole picture is addressed: This includes surgery, equipment and wrap around intensive support to prevent disabling obesity.

⁵ Enable Palmerston North provide equipment for a large percentage of the population in New Zealand and are funded by the MOH.

MENTAL HEALTH AND ADDICTION INQUIRY

The six panel members:

- Professor Ron Paterson (Chair)
- Dr Barbara Disley
- Sir Mason Durie
- Dean Rangihuna
- Dr Jemaima Tiatia-Seath
- Josiah Tualamali'i

Below are bios for each member

Professor Ron Paterson (Chair)

Professor Paterson has been a leading voice for health and disability consumers for many years, notably as Health and Disability Commissioner (2000–2010). He is a Professor of Law at the University of Auckland. Ron is recognised internationally for his expertise in consumers' rights, regulation of health practitioners and healthcare quality improvement. He has chaired several major health system reviews in Australia, including the Review of National Aged Care Quality Regulatory Processes (2017). He chaired the Counties Manukau Maternity Care Review (2012) and recently reviewed the Veterans' Support Act for the Chief of the Defence Force.



Dr Barbara Disley

Dr Disley has filled a number of leadership roles in the mental health sector since the 1990s and has an in-depth understanding of mental health and addiction services. She is a former Director of the Mental Health Foundation (1991-1996), and a former Executive Chair of the Mental Health Commission (1996-2002) and is currently Chief Executive of Emerge Aotearoa, which works in the mental health sector.



Sir Mason Durie

Sir Mason is a member of the Ngāti Kauwhata, Ngāti Raukawa and Rangitane Iwi. He has had a lifelong commitment to public health, including mental health and addiction, with a particular expertise in Māori health and culture. He has served on range of health-related committees, councils and advisory groups, including the Mental Health Foundation (1976-1980), Royal Commission on Social Policy (1986-88), The National Health Committee (1998-2000) and was a Families Commissioner (2003-2007). Since 2002 he has been a leader in Te Rau Matatini, Māori Mental Health Workforce Development. He is currently an Emeritus Professor at Massey University.



Dean Rangihuna

Dean Rangihuna is of Ngati Porou and Ngati Hei descent. Dean worked for 14 years in the community prior to his appointment as a Māori Consumer Advisor. He has also worked as a Pukenga Atawhai/Māori health worker for the Canterbury DHB's specialist mental health service since 2005, alongside the community mental health team, crisis resolution, adult and forensic inpatient units, Police, Courts, and whānau/families. Dean is also active advising from a cultural perspective at the national level and was recently part of an expert advisory group set up by the Ministry of Health to look at the Mental Health Act and Human Rights. He has also been invited to be a member of the Ngā Rōpū Kaitiaki Advisory Panel for Te Rau Matatini for Maori workforce development. In November 2016 Dean was appointed to the National Training Governance Committee for Safe Practice and Effective Communication, which is the national training programme to reduce the use of seclusion and restraint in mental health facilities.



Dr Jemaima Tiatia-Seath

Dr Tiatia-Seath has particular expertise and experience in Pacific mental health, and suicide prevention and postvention. She is a member of the Health Research Council's Public Health Research Committee, the Mental Health Foundation's Suicide Bereavement Service Advisory Group and a former member of the Health Quality and Safety Commission's Suicide Mortality Review Committee (2014-2016). Jemaima is currently Co-Head of the School of Māori Studies and Pacific Studies, and Head of Pacific Studies at the University of Auckland.



Josiah Tualamali'i

Josiah Tualamali'i brings a youth perspective to the Inquiry. In 2016, he received the Prime Minister's Pacific Youth Award for Leadership and Inspiration. He is currently the Chair of the Pacific Youth Leadership and Transformation Trust which assists Pacific Young people to participate in all worlds, and a Director on the board of Le Va, the Pacific Mental Health, Suicide Prevention and Addictions lead.



Update from the Inquiry Chair

23 February 2018

Tena koutou katoa, Talofa lava and warm Pacific greetings

Welcome to the first update on the work of the Government Inquiry into Mental Health and Addiction.

This Inquiry is a once in a generation opportunity. Many people called for the Inquiry and will be keenly watching our work and anticipating our final report.

The Inquiry panel met together for the first time on 14 February. It was a good meeting. We bring a wide range of skills and backgrounds, and a shared sense of the importance of the task ahead of us.

The focus of our meeting was on developing a common understanding of the scope of the Inquiry, what we each individually and collectively bring to the Inquiry, the values and approaches that will guide our work, and identifying ways to ensure engagement with the broad range of stakeholders. Our values (**attached**) will underpin how we undertake work together, how we engage with people, and how we develop our recommendations.

We know we have a big, complex job ahead of us. Our terms of reference are very broad. However, a lot of work and thinking has already been done nationally and internationally. We are determined to tap into this – to learn what's working well, what isn't, where the gaps and the opportunities (especially in prevention and early access) are and, probably most importantly, how can we do things differently and put health and wellbeing back into mental health?

We're keen for the Inquiry to listen widely, build a strong evidence base, and deliver a report with some fresh thinking that is clear, pragmatic and implementable – with a focus on solutions at the national and local level.

We want the Inquiry to generate hope and set a clear direction for the future – for our whānau and families, for users of mental health and addiction services, for people working in mental health and addiction, and for the Government.

We want people to be able to see how their ideas and the evidence have been used in developing our recommendations.

We ask you, as individuals or groups, to:

- 1) help us by sharing your experiences and ideas, particularly focussing on recommendations for how things can be done better and who is best placed to deliver on suggested improvements; and
- 2) continue to implement changes that are already underway – we don't want things to be on hold until October!

I will aim to provide an update every month, so you can follow the progress of the Inquiry and know when and how you can be involved.

We aim to release a consultation document by the end of March and to have public hearings and hui in May/June. However, we will not wait until then to engage with our communities across Aotearoa,

nor should people wait. If you have something to say, we want to hear it. Feel free to contact us (email: mentalhealthinquiry@dia.govt.nz) and share your views.

We look forward to hearing from you!

Mahi Ngātahi he oranga mō tatou.

Ron Paterson

Inquiry Chair

Mental Health and Addiction Inquiry Panel

Our values are:

- Aroha – love, compassion, empathy
- Whanaungatanga – relationship, kinship, sense of connection
- Kotahitanga – unity, togetherness, solidarity, collective action
- Whakamana – respect for everyone’s mana/connections
- Mahitahi – collaboration, cooperation
- Tumanako pai – hope, positiveness
- Korowai – a cloak of care over the Inquiry

NEW ZEALAND GAZETTE

Establishment of the Government Inquiry into Mental Health and Addiction

Pursuant to section 6(3) of the Inquiries Act 2013, I, The Honourable Dr David Clark, Minister of Health, hereby establish the Government Inquiry into Mental Health and Addiction ("Inquiry").

Membership

The following persons are appointed to be members of the Inquiry:

- Professor Ron Paterson, ONZM (Chair);
- Dr Barbara Disley, ONZM;
- Sir Mason Durie, KNZM, CNZM;
- Dr Jemaima Tiatia-Seath;
- Josiah Tualamali'i; and
- Dean Rangihuna.

Terms of Reference**Background and Matter of Importance**

The Government has committed to setting up an inquiry into mental health as part of its first 100 days' work programme. The catalyst for the inquiry has been widespread concern about mental health services, within the mental health sector and the broader community. Service users, their families and whānau, people affected by suicide, people working in health, media, iwi and advocacy groups have called for a wide-ranging inquiry.

The *People's Mental Health Report* (2017) highlighted a range of problems, including: access to services and wait times, limited treatment options in primary and community care, compulsory treatment and seclusion practices, ineffective responses to crisis situations and underfunding of mental health and addiction services in the face of rising demand. There have been calls for a transformation in New Zealand's response to mental health and addiction problems. Major concerns are stubbornly high suicide rates, growing substance abuse and poorer mental health outcomes for Māori.

People can experience a broad range of mental health problems on a spectrum from mental distress to enduring psychiatric illness requiring ongoing interventions. Substance abuse often occurs together with mental health problems. Poor mental health increases the likelihood of suicidal behaviour. However, not everyone who plans, thinks about, attempts or dies by suicide has a diagnosable mental disorder, and factors that contribute to suicide differ markedly across age groups.

Mental health and addiction problems are relatively common (approximately 20 percent of New Zealanders are predicted to meet the criteria for a diagnosable mental disorder each year) and prevalence is increasing. Unmet need is substantial, with at least 50 percent of people with a mental health problem receiving no treatment. This situation reflects both people not recognising their own needs for mental health support and a lack of capacity to meet those needs. Families and whānau of service users, and of New Zealanders lost to suicide, report little or no support or treatment.

Risk factors include ease of access and cultural attitudes to alcohol (which is implicated in over 50 percent of cases of youth suicide) and continued dislocation of Māori from their whānau, communities and iwi. There is also increasing dislocation within our ethnic migrant and refugee communities. Many other risk factors associated with poor mental health sit across a range of social determinants such as poverty, inequality, inadequate parenting, lack of affordable housing, low-paid work, exposure to abuse, neglect, family violence or other trauma, social isolation (particularly in the elderly and rural populations) and discrimination.

Risks are higher where deprivation persists across generations. These risk factors can contribute to a wide range of other poor life outcomes including low levels of educational achievement, poor employment outcomes, inadequate housing and criminal offending. On the positive side, many resilience and mental health-enhancing factors can be found even in difficult and deprived social settings.

There is strong evidence that prevention and early intervention is most beneficial and cost-effective. Often mental disorders are recognised only after they become severe and consequently harder to treat. Half of all lifetime cases of mental disorder begin by age 14 and three-quarters by age 24. New Zealand's current approach to mental health is not geared towards prevention and early intervention.

Across the spectrum of poor mental health are inequalities in mental health and addiction outcomes. In addition to Māori, disproportionately poorer mental health is experienced by Pacific and youth, people with disabilities, the rainbow/LGBTIQ community, the prison population and refugees.

Many interventions, particularly in relation to preventing mental health and addiction problems and suicide, lie outside the health system. There needs to be better coordination and a more integrated approach to promoting

NEW ZEALAND GAZETTE

mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing mental health and addiction problems. Models of care such as Whānau Ora and whānau focussed initiatives offer significant potential benefit. New approaches will have implications beyond the health system, for example, for education, welfare, housing, justice, disability support, accident compensation and emergency response systems.

Some actions cannot wait until the inquiry is completed. Alongside the inquiry, the Government is already taking steps to address some immediate service gaps and pressures, including increasing funding for alcohol and drug addiction services, increasing resources for frontline health workers, putting more nurses into schools, extending free doctors' visits for all under 14 year olds, providing teen health checks for all year 9 students and providing free counselling for those under 25 years of age.

Purpose and objectives

The purpose of this inquiry is to:

1. hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction, and what needs to change;
2. report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems; and
3. recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

To do this the inquiry will:

1. identify unmet needs in mental health and addiction (encompassing the full spectrum of mental health problems from mental distress to enduring psychiatric illness);
2. identify those groups of people (including those not currently accessing services) for whom there is the greatest opportunity to prevent, or respond more effectively to, mental health and addiction problems;
3. recommend specific changes to create an integrated approach to promoting mental well-being, preventing mental health and addiction problems, and identifying and responding to the needs of people experiencing mental health and addiction problems; and
4. specify which entities should progress the inquiry's recommendations, including relevant ministries and a re-established Mental Health Commission.

The recommendations of the inquiry will help inform the Government's decisions on future arrangements for the mental health and addiction system, including:

1. roles and responsibilities of agencies in the health sector, including a re-established Mental Health Commission;
2. improved coordination between the health system and other systems such as education, welfare, housing, justice, disability support, accident compensation and emergency response;
3. the design and delivery of services (for example, kaupapa Māori approaches to mental health) and effective engagement with all relevant stakeholders including mental health service providers, and consumers and their communities and whānau;
4. governance, leadership and accountability levers to ensure access to an appropriate standard of mental health services across the country;
5. fiscal approaches, models and funding arrangements;
6. data collection, programme evaluation and information flows;
7. the suite of relevant regulatory frameworks, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Abuse (Compulsory Assessment and Treatment) Act 2017; and
8. workforce planning, training, support and management.

Scope

NEW ZEALAND GAZETTE

In identifying the issues, opportunities, and recommendations the inquiry will consider the following:

1. mental health problems across the full spectrum from mental distress to enduring psychiatric illness;
2. mental health and addiction needs from the perspective of both:
 - a. identifying and responding to people with mental health and addiction problems; and
 - b. preventing mental health problems and promoting mental well-being;
3. prevention of suicide;
4. activities directly related to mental health and addiction undertaken within the broader health and disability sector (in community, primary and secondary care), as well as the education, justice and social sectors and through the accident compensation and wider workplace relations and safety systems; and
5. opportunities to build on the efforts of whānau, communities, employers, people working in mental health and others to promote mental health.

The inquiry will need to understand and acknowledge the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and cultural factors, in particular the historical and contemporary differences in outcomes for Māori, and consider the implications of these determinants and factors for the design and delivery of mental health and addiction services. Commentary on these matters is welcome to help inform the Government's work programmes in these areas.

The inquiry may signal changes to be considered in subsequent regulatory reviews. It will not undertake these reviews itself.

The following matter is outside the scope of the inquiry:

1. individual incidents or cases within current services. The inquiry panel will refer these to the appropriate pathway, for example, the Health and Disability Commissioner or relevant authorities.

Principles

The inquiry will take an approach that:

1. enables consumers, carers, family and whānau to be included and heard, and ensures acknowledgement and consideration of input from previous consultations and specific consultation with Māori communities and whānau/hapū/iwi;
2. attempts to build consensus between consumers, potential consumers, carers, family, whānau and providers about what government needs to do to transform the mental health and addiction system;
3. recognises the particular mental health and addiction inequalities for Māori, reflects the special relationship between Māori and the Crown under the Treaty of Waitangi, and the value of the work done by Māori experts and practitioners to design and deliver services that are more relevant and effective for Māori;
4. recognises and respect the needs of people with disabilities, and takes into account New Zealand's obligations under the UN Convention on the Rights of Persons with Disabilities;
5. recognises and respects the needs of different population groups, including Pacific people, refugees, migrants, LGBTIQ, prison inmates, youth, the elderly, and rural populations;
6. is person-centred, appreciating the impact of changes on individuals;
7. takes account of the whole system, including all relevant sectors and services and how they can work better together to improve mental health and addiction outcomes;
8. focuses on opportunities for early intervention; and
9. is based on the best research, ongoing evaluation and available evidence, in New Zealand and overseas.

Report back

The inquiry is to report its findings and opinions, together with recommendations, to the Minister of Health in writing no later than 31 October 2018. In order to ensure the Minister is kept appropriately informed as to progress, the Chair will provide regular updates to the Minister on the inquiry's progress throughout the course of the inquiry.

Related work

NEW ZEALAND GAZETTE

The inquiry will consider previous investigations, reviews, reports and consultation processes relating to mental health and addiction, including:

1. the *Peoples' Mental Health Report*;
2. *Blueprint II: Improving mental health and wellbeing for all New Zealanders*;
3. reports from the Government's Chief Science Advisors into mental health and suicide;
4. report of the Director of Mental Health on the consistency of New Zealand mental health laws with the UN Convention on the Rights of Persons with Disabilities;
5. various workforce reviews including *Mental Health and Addictions Workforce Action Plan 2016-2020*;
6. consultation on *A Strategy to Prevent Suicide in New Zealand: Draft for public consultation*;
7. consultation on *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*;
8. *Mentally Healthy Rural Communities. RHANZ Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand* (2016);
9. *Puahau: Five Point Plan* (1998);
10. *Fit for the Future - Summary of Stakeholder Feedback* (2017);
11. *Understanding whānau-centred approaches: Analysis of Phase One Whānau Ora research and monitoring results* (2015); and
12. relevant Waitangi Tribunal inquiry reports (including *Ko Aotearoa Tenei*).

The inquiry will also consider and interface with other relevant inquiries and reviews currently underway, including:

1. the Wai 2575 Health Services and Outcomes Kaupapa Inquiry;
2. the inquiry into the abuse of children in state care; and
3. Disability Support Transformation.

Authority

The inquiry is established as a government inquiry under the Inquiries Act 2013, with the Minister of Health as the appointing Minister.

Consideration of Evidence

The Inquiry may begin considering evidence on and from **31 January 2018**.

Dated at Wellington this 25th day of January 2018.

HON DR DAVID CLARK, Minister of Health.

2018-go318

30-01-2018 10:00

UK Health Citizen Led Health and Social Care Transformation

Research Trip January 2018



NHS Social Care partnership

System Transformation



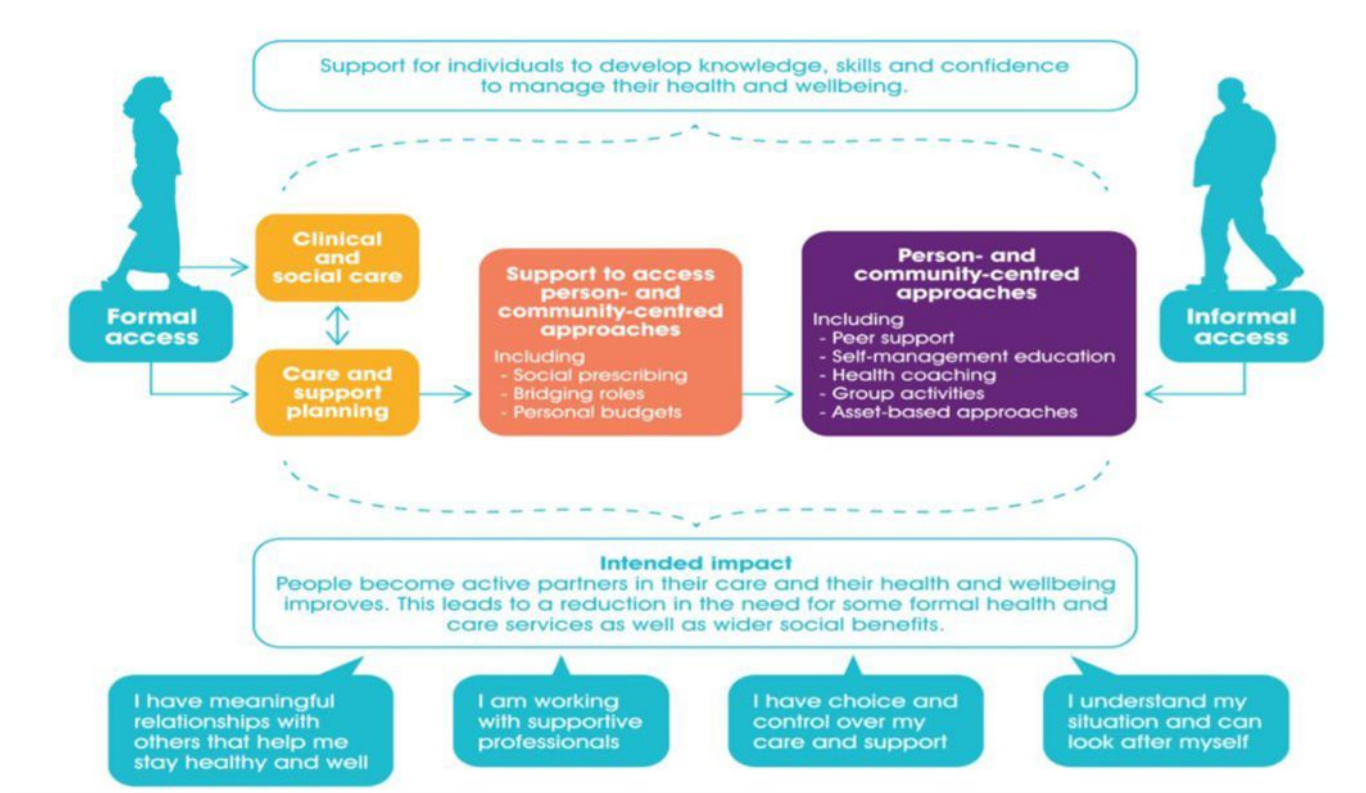
National & Greater Manchester

- Five Year Forward View on a new relationship with Patients & Communities

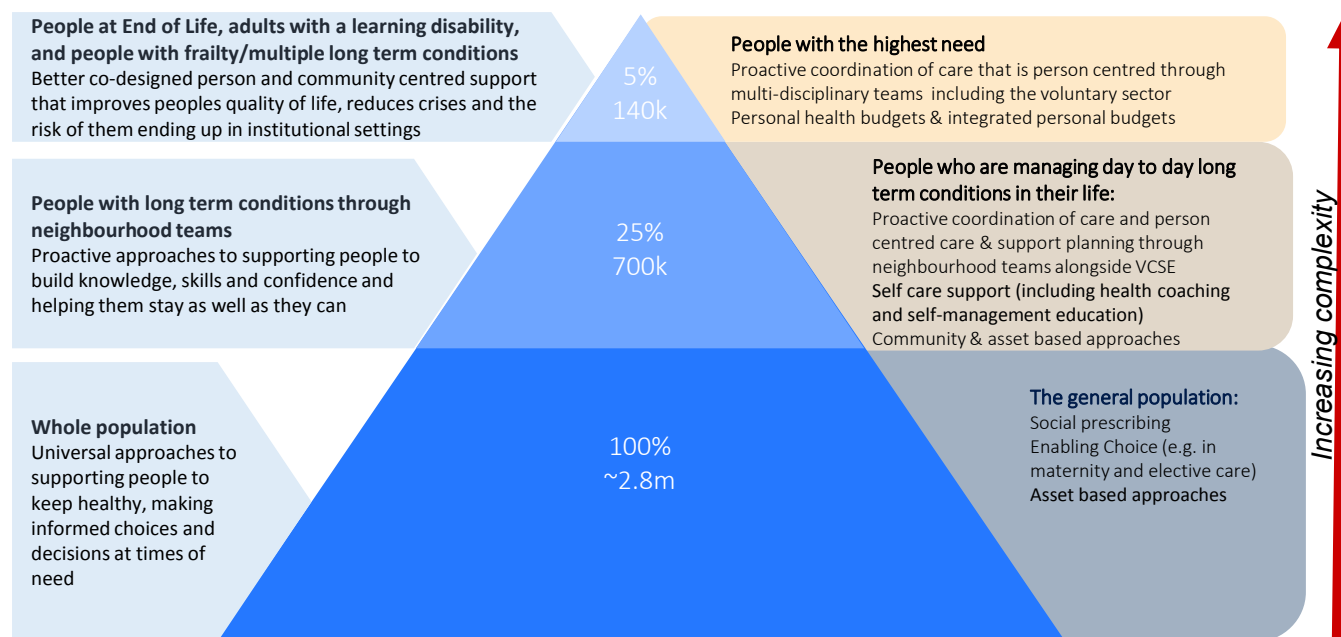


- Person and community centred approaches are a key part of “Taking Charge” and the “Population Health Plan”, as well as all ten Locality Plans

How will people experience this support?



Who is it for and what kind of things will they get?



Commissioning for Social Value and Community Sourcing

- Procurement of large providers has broken down the fabric of society in the UK in a measurable way re social and economic outcomes
- Social value outcomes are now sought consistently in the first instance as opposed service widgets or costs.
- Often low financial cost spread across multiple small suppliers who use a mixed model of workforce to deliver specific community based citizen led services
- Many examples of community regeneration due to this approach



On the Ground: Citizen led initiatives

Stockport Wigan Leeds



Altogether Better

Bringing Citizens and Services together in new conversations



Creating a sustainable future for General Practice

- **If early findings from the evaluation were to be replicated across the country we would see a future where:**
- **The resilience of general practice is transformed** so that it can cope with the reducing number of GPs in the system, in particular the reduction in the number of single handed GPs, the increasing numbers of GPs retiring or leaving the system, and the decreasing numbers of GP trainees;
- **Prevention becomes the norm - an integrated part of the system,** reducing the future prevalence and incidence of socially determined disease by creating the conditions where people are supported to prevent, manage and live well with long term conditions and improve their mental, social and physical health and wellbeing;

Practice Champions

- Participant/community impacts and sustainability
- The introduction of Practice Health Champions brought about health improvements for both the Champions themselves and wider participants. The approach also brought about long term and embedded system change, by involving the Champions in service design and delivery.
- **As a result of the work:**
 - 87% (488) of Champions and 94% (286) of participants reported having gained new knowledge/awareness related to health and wellbeing.
 - 86% (482) of Champions and 94% (286) of participants reported increased levels of confidence and wellbeing following their involvement in the project.



People powered commissioning Stockport

Represents a preventative approach.

The approach in Stockport was based on a set of principles...

- **A health and social care system that mobilises people** and recognises their assets, strengths and abilities, not just their needs
- **An ability to live well with long-term conditions powered by a partnership** between individuals, carers and practitioners
- **A system that organises care around the individual** in ways that blur the boundaries between health, public health, social care, and community and voluntary organisations



CITIZEN LED CHANGE: ALVANLEY FAMILY PRACTICE

- Goal to improve social physical and mental health and wellbeing
- Citizens work together to achieve a bottom up approach to deliver wellbeing
- Citizens no longer seen as users or choosers of services but as shapers and makers of innovative new services
- People are enabled to adapt to self manage in the face of social and emotional challenges
- Evidence that people use services differently

Person & Community-Centred Approaches

WELLBEING PRESCRIPTION

NOTE Did you know that Alavanley Family Practice can offer so much more than you think. Check out the list below to see if any of the activities may be of interest to you. Just put a tick in the box of those you like the look of, complete your name and contact details and pop it in to reception. Alternatively you can email us with your inquiry and details to stoccg.healthchampions@nhs.net

PART 1 I am interested in receiving more information about the following:

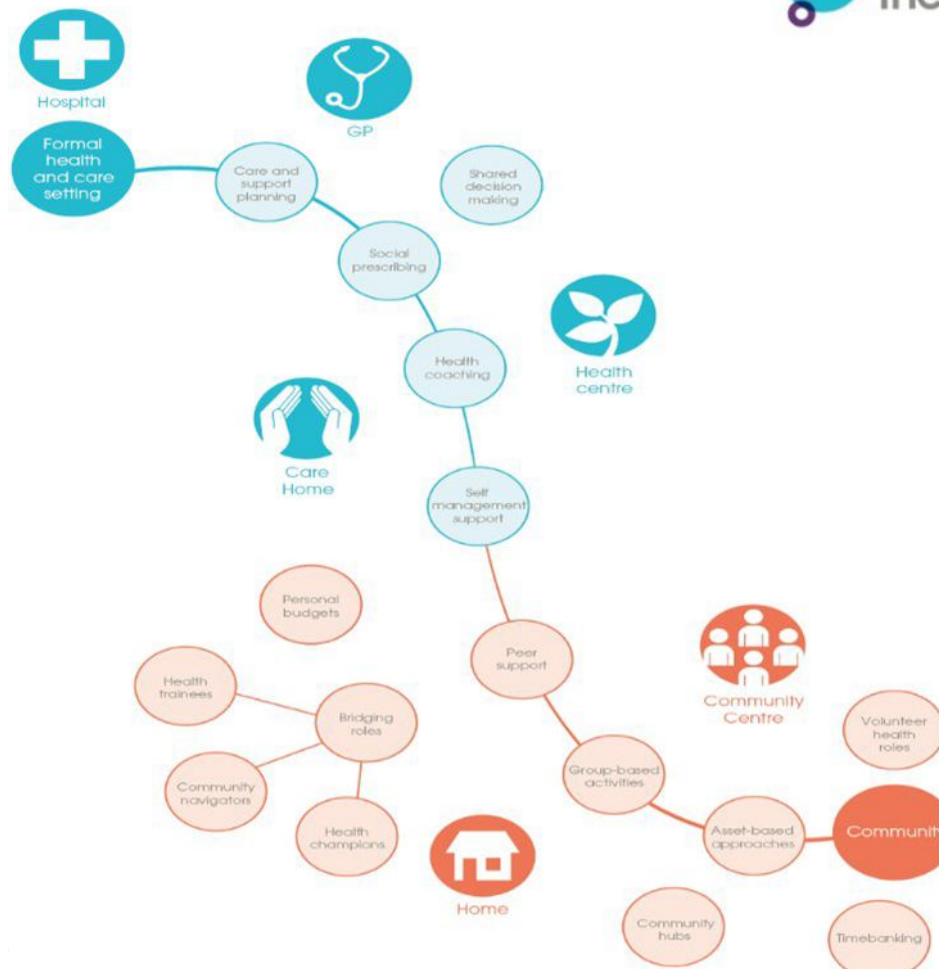
- ☐ Veg on prescription - Grow your own, cook your own !!
- ☐ Weekly Health Walks - Every Wednesday
- ☐ Coffee and Conversation - Feeling alone, fancy a chat?
- ☐ Social Events for New Mums - Don't feel alone
- ☐ Pram Pushers Walk - Bring along baby for a friendly walk
- ☐ Singing for Health - Singalong with the Champions
- ☐ Knit and Natter - Friendly banter with like minds
- ☐ Cook and Taste - Let us show you how to cook it
- ☐ IT Skills - Let's get you started with the basics
- ☐ Telephone Support - A friendly voice on the end of the line
- ☐ Practice Allotment - Come and help with our allotment
- ☐ Money Advice - Advice and guidance
- ☐ Evening Get Togethers - A friendly group gathering

PART 2 I understand that the details I give will be passed on to the Practice Health Champions who will contact me with the information I have requested

PART 3 Signed:

Name:

Contact Number/Email address:







Learning for change and the theme of co - production

- This approach can be applied in other settings
- The model operates with minimal costs
- People participate by invitation and cross all age groups
- SRDAG also has a role in this space
- People value what they have built themselves

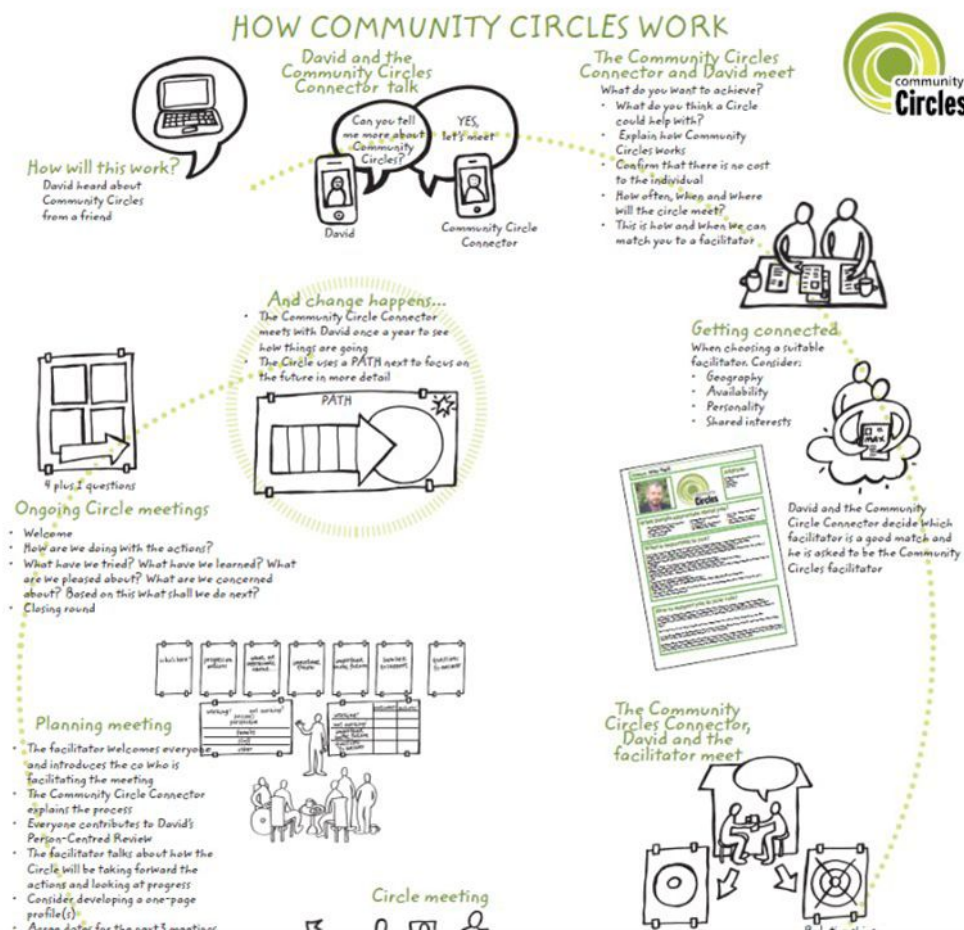


Asset based rather than
deficit based



Building resilience

- Helen Sanderson Associates: Community Transformation via citizen led initiatives
- Community circles are being built in the UK and have traction in a number of areas
- Wigan North Manchester now has 20 rest homes using a community based connector
- Community Circles New Zealand based on the HSA model monitors and mentors for quality and training.
- Benefits for community resilience as well improved individual health and social wellbeing for individuals and populations.



What can community circles do for an individual?

- The daily needs of a person may still be met by services. Other tasks such as shopping, social outings, making new friends, learning to use the smart phone or computer are all shared between a number of people chosen by the person. No person feels they are carrying all the responsibility and the outcomes are better than more random natural supports.
- One connector can oversee a large number of circles
- Facilitators can oversee several circles
- A circle can stop or gradually reduce where a person no longer requires such support



So how will we use this knowledge

- Good for all people at risk of isolation for a range of reasons
- A three year plan will be developed and an area like Kapiti will be considered
- This may be linked to a choice for people with long term conditions and home care to receive individualised funding
- More investment in local arms length initiatives to build community





Community Circles

Summary of Research: *Community Circles Building Resilience and Saves Money*

This was a small research study undertaken by PSSRU (London School of Economics) using quantitative and qualitative data. It was funded by North West TLAP and looked at Circles of Support for young people with complex disabilities. The research looked at the potential to harness local community resources to meet social care needs, promote social inclusion and improve wellbeing. This was a small but important research project at a time of fiscal austerity and a shrinking state offer.

The study

Based on five families, each of them with a young person with complex disabilities with a Circle of support already in place. The young people's age range was 19 to 49 years.

Background to Circles of Support

Circles of Support were developed in Canada, rooted in the Inclusion movement and Circles of support began to be set up in the UK in the mid-1980s (Circles Network). They have been described as a group of people selected by an individual that meets regularly to help plan, design and support ways for that person to achieve goals. This is important as many people with disability cannot achieve independence goals on their own and without proactive support risk institutionalization.

ASCOT data

ASCOT data show (based on the opinion of the primary informant) that the Circle had impacted positively on the young person's quality of life. The mean change of 0.61 suggests a substantial increase in this sample's (SCRQoL) through having the Circle.

Client Service Receipt Inventory data (CSRI)

The CSRI data indicated that recent service use (over the previous 6 months) was very low for three of the five young people involved. The oldest young person had used specialist health services more frequently while another reported a small use of specialist hospital services over that time. *The highest estimate of service costs was £751 while the lowest was £29. The mean cost was £275.* These costs are in addition to the cost of the care packages (mean cost of £50k per package). This low level of service use might seem surprising given the level of needs of some of the young people and their service use described in their earlier years. It is difficult to say categorically that the Circle had helped avoid specialist input but informants suggested this was the case.

Conclusions

This was a small study and the results cannot be generalised to all Circles. There was no comparison group so it did not compare potential outcomes of traditional support.

- Circles can offer a very powerful, effective and personalised way of supporting a young person with disabilities to have a good quality of life.
- The young person was seen to be much better integrated into the local community and able to be involved in activities as people of similar age would.
- Circles were described as 'natural', using the important people in the young person's life and the networks that Circle members have.
- Circles have potential to develop and harness community resources to promote greater social inclusion and improved wellbeing for young person and family.
- Circles may delay or prevent need for specialist health and social care support.
- The cost of the various packages of care, while high in some cases, was notably less than if young people had been placed into a specialised residential setting.
- The Circles were argued to have prevented admission to residential care.
- Circles potentially reduced the need for mental health services by primary carers as they reported that their mental health was improved.
- There still appeared to be a gap in the understanding of this personalised approach to meeting the needs of the young person within local authorities.
- The possibility of facilitators being paid from Personal Budgets and being drawn from a wide base of user led or advocacy organisations should be considered.

Potential limitations

A number of factors emerged in this study which may impact on wider roll out of Circles. This included a high level of personal and professional knowledge and credibility of those involved in supporting the circle along with a clear vision for developing personalised support. If these are key factors for a Circle to work as successfully as the ones in the study clearly did, then much wider roll-out may be difficult, but not necessarily impossible.

References

- <http://Circles-of-support.co.uk/>)
- http://www.Circlesnetwork.org.uk/index.asp?slevel=0z114z115&parent_id=115.
- <http://www.helensandersonassociates.co.uk/media/75948/Circlesofsupportandpersonalisation.pdf>

Please connect and stay in touch

helen@community-circles.co.uk

Find us on twitter • @C_Circles

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Follow our blog • www.communitycirclesblog.wordpress.com

www.community-circles.co.uk

www.communitycircles.groupsie.com



Supported Decision Making



**Easy
Read**

What is Supported Decision Making?



Everyone has the right to make their own decisions.

Sometimes you might need support to make your decisions.



Supported decision making means that people assist you to make your own decisions.

This way you have control and choice over your life.

Why is Supported Decision Making important?



Supported decision making is a human right.

This means that everyone has this right.

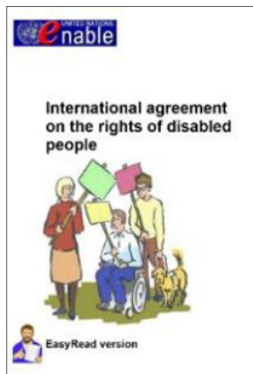


You should have the same control over your life as other people have over their own lives.



Supported decision making is a **right** in the **United Nations Convention on the Rights of Persons with Disabilities**.

The **United Nations Convention on the Rights of Persons with Disabilities** is an agreement.



It is also called the **Disability Convention**.

This agreement says what countries have to do to make sure that disabled people have the same rights as everybody else.



The **Disability Convention** says that:

- everyone has the right to make decisions about their own lives
- everyone should have the support they need to make decisions.



Supported decision making is a way to make sure disabled people have equal rights with other people.

Communication support



It is important you are given the support you need when you communicate.

Communicate means how you tell other people what you think or feel.



Everyone communicates in different ways.

Some people:

- use body language
- use sign language
- speak
- use communication tools, like computers.



Kinds of support



There are lots of different kinds of support that you can use to assist you to make decisions.

You can choose which kinds of support are right for you.



1 kind of support you can choose is:

Having a team of people who know you well that can assist you.

Teams like this are sometimes called:



- circles of support
- support networks
- effective communication partners.



Another kind of support you can choose is:



Having the time you need to:

- **talk about the different choices**
- **make your own decision.**

Another kind of support you can choose is:



Using a communication tool.

These are sometimes called **augmentative** or **alternative communicators**.

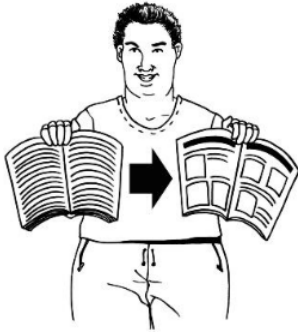
Sometimes they are called **AAC**.

Augmentative or **alternative communicators** are tools which assist people to communicate.

These can include:

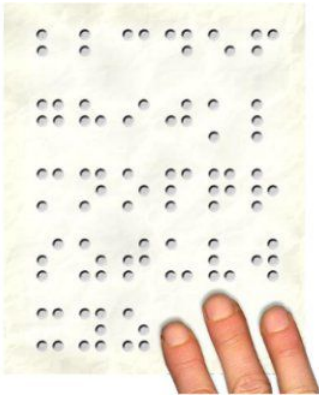
- electronic speech devices like tablets
- electronic speech Apps
- talking mats
- other visual aids.





Another kind of support you can choose is:

Having information in easy to use formats.



This can include:

- Easy Read
- braille
- large print
- sign language.



Getting the right support



Most people have whānau / family or support people who know what they usually want and need.



You can choose who the best people to support you are.

You might choose to have more than one support person.



When someone is supporting you to make a decision it is important that they know some things about you:

- they need to know what is important to you
- they need to know what kinds of decisions and choices you usually make.



What if people do not listen to you?



Sometimes people might think that you cannot make decisions for yourself.

This might be:

- your whānau / family
- your support staff.



Some people might need to change their thinking about whether you can make your own decisions.



You might need to speak up for yourself and show people that you can make your own decisions.

You have the right to make your own decisions about your life.

An example of Supported Decision Making



Here is a story about someone using supported decision making.

We changed the names of the people in the story to protect their privacy.



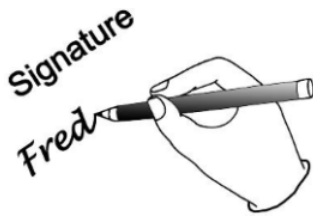
Jake and his mum Mary went to a dentist appointment at the hospital.



When the dentist looked at Jake's teeth she decided that Jake needed surgery on his teeth.



The dentist wanted Mary to sign a form for Jake to have surgery.



She said that the form had to be signed that day so they could book the surgery.



Mary said that Jake needed to make his own decision.

Jake needed time to make a decision.



Mary said that she and Jake could talk while the dentist met with other patients.



This would give Jake some time to make his decision.



The dentist said this was okay.



Jake and Mary talked about the form.

They also talked about the surgery.



Mary asked Jake if he wanted to talk to his stepbrother Rob about it.

Jake said he did.



Mary rang Rob on her mobile phone.
Jake and Rob talked about what
would happen if Jake had the surgery.



They also talked about what would
happen if Jake **did not** have the
surgery.



Rob reminded Jake of the last time he had surgery on his teeth.

After talking to Rob Jake said "I say yes."



After this Mary and Jake went back to talk to the dentist.



Mary said that Jake was ready to sign the form.

The dentist checked with Jake that he wanted the surgery.



Jake said "I say yes"



This story shows that Mary was not allowed to make a decision about surgery for Jake.

This is because the law says that Jake should make his own decision.



The dentist could have let Mary and Jake take the form away.



This would have meant Jake and Mary would have had lots of time to talk about the decision.



But the dentist did let Mary and Jake have some time to talk.



The dentist also checked that Jake had made his own decision.



This meant that Jake was able to make a supported decision.

Mary supported Jake to make his own decision.

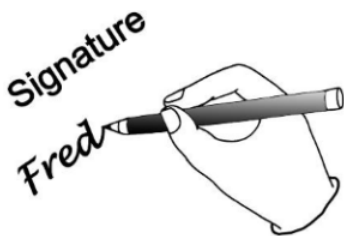


This is how she supported him:

- Mary supported Jake with his communication.



Mary was able to talk to Jake about the surgery in a way that Jake could understand.



Mary also talked about what signing the form meant.



- Mary supported Jake to talk to another person in his support network.



- Jake was supported to understand what the surgery meant.



Rob reminded Jake of a surgery he had had before.

This helped Jake to understand what this surgery would be like.



Jake was able to make his own decision about surgery.



ADL would like to thank our Conversation Partners:



For more information see our website:
www.aucklanddisabilitylaw.org.nz



**This information has been translated into Easy Read
by People First New Zealand Inc. Ngā Tāngata Tuatahi**

