DISABILITY SERVICES ADVISORY COMMITTEE

PUBLIC
Agenda

10 September 2019, 10am to 12.30pm
Board Room, Level 11, Grace Neill Block, Capital & Coast DHB, Wellington

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia				10am	
1.2	Apologies	**RECORD**	Fran Wilde			
1.3	Continuous Disclosure - Register of Interest	**ACCEPT**	Fran Wilde			2
1.4	Confirmation of Draft Minutes from 4 February 2019	**APPROVE**	Fran Wilde			6
1.5	Matters Arising	**NOTE**	Fran Wilde			
1.6	Action List	**NOTE**	Fran Wilde			11
2 DISCUSSION						
2.1	Accessibility Charter – Disability Strategy		Rachel Noble			13
2.2	3DHB Mental Health & Addictions Strategy – Living Life Well 2019 – 2025: Population Outcomes Framework 2.2.1 Population Outcomes Framework 2.2.2 Population Indicators 2.2.3 Draft Performance Measurement Framework 2.2.4 Draft Commissioning Dashboard		Rachel Haggerty			18 23 24 29 30
2.3	Preventing Suicide and Suicidal Behaviour in our Communities Update 2.3.1 Analysis of Coroner's Provisional Suicide Deaths Data Released on 26 August 2019		Rachel Haggerty Rawinia Mariner			31 39
3 INFORMATION						
3.1	Update on the Annual Sub-Regional Disability Forum		Rachel Noble, Sue Emirali			40

DATE OF NEXT MEETING 18 NOVEMBER – CSSB LECTURE ROOM, GROUND FLOOR CLINICAL & SUPPORT SERVICES BUILDING, WAIRARAPA DHB, MASTERTON

3 DHB DISABILITY SUPPORT ADVISORY COMMITTEE

Conflicts & Declarations of Interest Register

UPDATED AS AT SEPTEMBER 2019

Name	Interest
Dame Fran Wilde *Chairperson*	• Deputy Chair, Capital & Coast District Health Board • Chair, CCDHB Health System Committee • Member CCDHB FRAC • Chair CCDHB 3DHB DSAC • Chair Remuneration Authority • Chair, Te Papa Tongarewa Museum of New Zealand • Chief Crown Negotiator Moriori and Ngati Mutunga Treaty of Waitangi Claims • Chair Kiwi Can Do Ltd • Chair Wellington Lifelines Group • Director Frequency Projects Ltd • Ambassador Cancer Society Hope Fellowship • Trustee, Asia New Zealand Foundation
Yvette Grace *Deputy Chair*	• Member, Hutt Valley District Health Board (includes HAC) • Deputy Chair, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Chair, Te Oranga O Te Iwi Kainga Māori Relationship Board to Wairarapa DHB • Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust • Manager, Compass Health Wairarapa • Member, 3DHB Youth SLA (Service Level Alliance) • Member, Te Whiti Ki Te Uru Central Regions Māori Relationship Board • Husband, Family Violence Intervention Coordinator and Child Protection Officer Wairarapa DHB • Husband, Community Council, Compass Health • Husband, Community member of Tihei Wairarapa Alliance Leadership Team • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt • Niece, Nurse at Hutt Hospital
Mr Andrew Blair *Member*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board • Chair, Hutt Valley DHB Hospital Advisory Committee • Chair, Queenstown Lakes Community Housing Trust • Member of the Governing Board for the Health Finance, Procurement and Information Management System business case • Member, Hutt Valley DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory

Name	Interest
	Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast Health Systems Committee • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Lisa Bridson *Member*	• Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB Combined CPHAC DSAC Committee • Hutt City Councillor • Chair, Kete Foodshare
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • 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 • Executive Committee Member of Healthcare Aotearoa • Executive Member of Health Benefits of Good Work • Nephew on temporary CCDHB ICT employment contract.
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council • Step son works in middle management of Fletcher Steel
Prue Lamason *Member*	• Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Deputy Chair, Hutt Mana Charitable Trust • 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
Mr Derek Milne *Member*	• Member, Wairarapa District Health Board • Member, WrDHB CPHAC/DSAC (30 March 2016)

Name	Interest
	• Brother-in-law is on the Board of Health Care Ltd • Daughter, GP in Masterton, Wairarapa
Jane Hopkirk *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (23 February 2016)
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board (includes HAC) • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • General surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Kim Smith *Member*	• Employee of Te Puni Kokiri • Trustee for Te Hauora Runanga o Wairarapa • Brother is Chair for Te Hauora Runanga o Wairarapa • Chair, Te Oranga o Te Iwi Kainga • Sister, Member of Parliament
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
Sue Driver *Member*	• 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 *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Sue Emirali *Member*	• Interim Chair, Sub Regional Disability Advisory Group 3DHB • Chair, KCDC Disability Advisory Group • President Retina NZ (Low Vision support organisation) • Member of Eye Health Coalition • Member Kapiti Health Advocacy Group • Board Member of Wellable (Wellington and Districts Disability Centres) • Chair Digital Seniors • Chair Wairarapa Healthy Homes
Fa'amatuainu Tino Pereira	• Managing Director Niu Vision Group Ltd (NVG)

Name	Interest
Member	• 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 *Member*	• 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

DRAFT Minutes of the 3DHB DSAC
Held on Monday 6 May 2019 at 10am
Boardroom, Pilmuir House, Hutt Valley District Health Board
PUBLIC SECTION

PRESENT:

BOARD Dame Fran Wilde (Chair)
Lisa Bridson
Eileen Brown
Roger Blakeley
Sue Kedgley
Derek Milne
Jane Hopkirk *(arrived 10.05am)*
Alan Shirley
'Ana Coffee
Sue Driver
Prue Lamason
Bob Francis
Dr Tristram Ingham
Pati Umaga (representing Sub-Regional Pacific Disability Advisory Group)

STAFF: Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB
Helene Carbonatto, General Manager, Strategy, Planning and Outcome, HVDHB
Sandra Williams, Acting Executive Leader, Planning and Performance, WrDHB
Rachel Noble, General Manger, 3DHB Disability Responsiveness
Nigel Fairley, General Manager, 3DHB Mental Health Addictions and Intellectual Disability Services
Rod Bartling, Mental Health Improvement Manager HVDHB
Arawhetu Gray, Director, Maori Health, CCDHB
Kerry McDougall, Director, Maori Health Services, HVDHB
Taima Fagaloa, Director, Pacific People's Health, CCDHB
Tofa Suafole Gush, Director, Pacific People's Health, HVDHB

PRESENTER: Rachel Noble, General Manager, 3DHB Disability Responsiveness (item 2.1)

GENERAL PUBLIC: Kathryn Adams, Capital & Coast District Board Member

1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

The Karakia was led by Tristram Ingham. Committee Chair, Fran Wilde, welcomed the members and DHB staff. Congratulated Dale on new appointment.

1.2 APOLOGIES

Apologies received from Andrew Blair, Yvette Grace, Sue Kedgley, John Terris and Fa'amatuinu Pereira

1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS

It was **noted** that Derek Milne is not a Board member of Masterton Medical.

Action:

1. Committee Secretary to amend the Register of Interests.

1.4 CONFIRMATION OF PREVIOUS MINUTES: 4 February 2019

It was **noted** that Prue Lamason attended the meeting on 4 February 2019.

1.5 MATTERS ARISING

1.6 ACTION LIST

The reporting timeframes on the other open action items were **noted**.

Note the agenda items are presented in the order that the Committee considered them.

3 FOR DECISION

3.1 3DHB Mental Health and Addictions Strategy – Living Life Well 2019 - 2025

The paper was taken as **read**.

The Committee:

a) **Received** and provided feedback on the draft Living Life Well 2019 – 2025 Implementation Plan

b) **Requested** that, subjected to incorporating DSAC feedback, the 3DHB Boards approve the implementation plan

c) **Noted** the proposed implementation principles

d) **Noted** the staged implementation approach

e) **Noted** that significant additional investment will need to be committed to by our 3DHBs to achieve the outcomes sought from this Plan

f) **Requested** that a Population Outcomes Framework be presented to DSAC for feedback in August 2019

g) **Requested** that a 5-year investment plan be presented to DSAC for feedback in December 2019

h) **Noted** that the strategy and implementation plan will be reviewed against the Government's response to the Mental Health and Addiction Inquiry Report once available

i) **Noted** that the strategy and implementation plan will be reviewed in December 2019 and annually thereafter.

Discussion:

1. The team is working closely with the 3DHB Māori Health managers in terms of the strategy but we need to work much closer with the Iwi Partnership Boards and other Māori groups to ensure better feedback into the strategy.
2. We are working with a Mental Health provider to support tāngata whaiora into housing accommodation options.
3. The Strategy considers the different ways of providing services to Māori consumers where the traditional model may not be what they want.

4. In the space of Maternal Mental Health, to ensure that mothers in particular single mothers are engaged. There were some upset feeling from the last Mental Health Inquiry around how the Māori voices were recorded and feedback through the official documents. We need to remain brave and unafraid of sharing the voices of dissent and not sanitise our documentation. If we do that, we run the risk of further undermining the process and the voices of the Māori and Pacific community.
5. Tristram raised the question on how do we maintain and enshrine the ongoing active voice of our co-design partners. As the implementation plan tightens up, it would be useful to get feedback from staff and the groups we work with.
6. We are committed to co design, we have experience advisory groups across all of our services but we need to work around how to involve them around the decision making process.
7. Sue Driver noted that we need to think carefully about outcomes and what we want to achieve from this strategy. Courage is an important part of us achieving this. The strategy needs to be talked about more publicly and engage with the communities.
8. The Chair thanked the team who worked on this strategy.

Recommendations to the Board

a) ***Requests*** *that the 3DHB Boards approve the implementation plan.*

Actions:

1. The Living Life Well presentation to be included to the Board.
2. Population Outcomes Framework to be presented to DSAC in August 2019
3. 5 year investment plan to be presented to DSAC for feedback in December 2019

2 PRESENTATION

2.1 3DHB DISABILITY RESPONSIVENESS – NEW DIRECTION

The presentation was **noted**.

Discussion:

1. The Committee agreed that the charter will help all communities.
2. A more detailed plan including the investment cost will be presented to DSAC in August.

Recommendation to the Board:

*a) To **note** the presentation.*

Actions:

1. Recommendations for The Accessibility Charter to be brought back to DSAC in August 2019.

4 FOR DISCUSSION

4.1 Acute Continuum Care Wairarapa DHB

The paper was taken as **read**.

The Committee:

a) **Noted** the updates for initiatives that directly or indirectly affect the Wairarapa Acute Care needs.

Recommendation to the Board:

a) *To **note** the paper.*

4.2 Mental Health Improvement Programme Update

The paper was taken as **read**.

The Committee:

a) **Noted** this update on the Mental Health and Addictions Improvement Programme

b) **Noted** the update on:

- The Digital Client Record Improvements and Enhancements
- Acute Demand Response
- Alcohol and Other Drug Model of Care
- Lived Experience Advisory Group (LEAG)
- Acute Care Continuum Project
- Te Whare Ahuru Reconfiguration Project
- Review of Health Responses to Suicide and Suicidal Behaviours
- Establishing a Lead DHB model, Living Life Well 2019 – 2025 Implementation Plan

Recommendation to the Board:

a) *To **note** the paper.*

5 FOR INFORMATION

5.1 Update on Annual Sub-Regional Disability Group Meeting

The Committee **noted** the verbal update.

Discussion:

1. Due to major transitions in the 3DHB Disability team, the Annual Sub-Regional Disability Group Forum is moved to 21 June 2019. Bob will provide Forum information to the Board and Committee members.
2. The team had a planning workshop last Friday. Theme was “Moving from Talking to Partnerships.”
3. There will be 4 focus for the forum – Leadership, Inclusion & Support, Access and Health.
4. There will be a report recognising the Disability Strategy with strong focus on Maori and Pacific.
5. We will be looking at health issues from Disability context and also applying the Treaty.
6. We will run a number of workshops picking up 4 strategies.
7. The team will report back to the DSAC in August on the outcome of the forum.

Recommendation to the Board:

a) *To **note** the update.*

Actions:

1. The forum invitations to be sent out before end of May 2019.
2. Team to report back on the Forum outcome in DSAC August 2019.

5.2 Update on Government's Response to the Mental Health Inquiry Report

The paper was taken as **read**.

Recommendation to the Board:

b) *To **note** the paper.*

The meeting closed at 11.35am.

3 DATE OF NEXT MEETING

26 August, 10am, Board Room, Level 13, Grace Neill Block, Wellington Regional Hospital.

SCHEDULE OF ACTION POINTS – DISABILITY SERVICES ADVISORY COMMITTEE (DSAC)

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 6 May 2019					
3.1	**3DHB Mental Health and Addictions Strategy – Living Life Well 2019 – 2025**	1. 5 Year investment plan to be presented to DSAC for feedback in December 2019	Rachel Haggerty Helene Carbonatto Sandra Williams		December

Closed since last meeting – 6 May 2019

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 6 May 2019					
3.1	**3DHB Mental Health and Addictions Strategy – Living Life Well 2019 – 2025**	1. The Living Life Well presentation to be included to the Board 2. Population Outcomes Framework to be presented to DSAC in August 2019	Rachel Haggerty Helene Carbonatto Sandra Williams	The Living Life Well paper discussed at the 3DHB Boards in July / August Population Outcomes Framework to be discussed in the August DSAC meeting.	Closed
2.1	**3DHB Disability Responsiveness – New Direction**	3. Recommendations for the Accessibility Charter to be discussed at DSAC in August 2019	Rachel Noble	On the August agenda.	Closed
5.1	**Update on Annual Sub-Regional Disability Group Meeting**	4. Forum invitations to be sent out before end of May 2019. 5. Team to report back on the Forum outcome at DSAC in August 2019.	Rachel Noble / Sue Emirali	On the August agenda.	Closed.
DSAC Public Meeting 4 February 2019					
1.5	**Terms of Reference**	1. A covering letter to advise the Boards that the 3DHB DSAC is seeking their endorsement of the Terms of Reference	Sandra Williams	3DHB Boards endorsed the Terms of Reference	Closed.

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Date 30 August 2019	**3DHB DISABILITY SERVICES ADVISORY COMMITTEE** **DISCUSSION**
Author	Rachel Noble, General Manager, Commissioning 3DHB Disability
Endorsed by	Rachel Haggerty, Director, Strategy Innovation and Performance
Subject	**Summary and Update of activities relating to the development of activities that support the inclusion of the Accessibility Charter into BAU of CCDHB**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Note** the range of accessible formats to be considered for the implementation of the Accessibility Charter;

(b) **Note** the commitment form the Disability team and the Disability community;

(c) **Endorse** a five year commitment to progressing the use of the Accessibility Charter across the three DHBs leveraging existing resources only in this 2019/20 financial year, and

(d) **Note** the progress in key activities.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs	**X**	**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities	**X**	**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	

1. INTRODUCTION

1.1 Purpose

This paper provides an update on the status of the Accessibility Charter within the 3DHBs and its subsidiaries. This update outlines the approach to ensuring the Accessibility Charter is incorporated into practice across the three District Health Boards using existing resources, in the first instance.

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The initial intent was to bring a fully scoped and costed proposal to DSAC. In scoping the work it is now clear that more detailed feasibility work is needed to understand cost, how implementation may be leveraged from existing DHB work and what can be completed within current resources.

It is recommended that a five year commitment is made by each DHB to adopt the Accessibility Charter with a commitment in this financial year (2019/20) to leverage existing resources only.

2. BACKGROUND

The Accessibility Charter was launched in 2018, and endorsed by public service Chief Executives' who are committed to the provision of accessible information and online tools to progress the development of equitable public services for disabled people by removing barriers.

The purpose of the accessibility Charter is to:

- improve access to information provided by government agencies to people who experience barriers in accessing information;
- provide affected people with a consistent experience when accessing information; and
- meet international obligations under the United Nations Convention on the Rights of Persons with Disabilities.

3. PROCESS

The DHB has made a commitment to working progressively over the next 5 years to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets their individual need and promotes their independence and dignity.

This includes meeting the government's web accessibility and usability standards, ensuring information is available in a range of accessible formats, compliance with accessibility standards, responding positively when customers make staff aware of instances of inaccessibility and adopting a flexible approach to interacting with the public, actively championing accessibility within the leadership team.

The outpatient department at CCDHB has been identified to lead development of a prototype including the Accessibility Charter in a business as usual manner. The department is primarily patient-facing with a high level of engagement with disabled people. This department is focused on developing patient engagement which includes letters and supplementary information for patients.

Two other areas are being considered as part of this work these are the provision of emergency alerts being issued by the DHBs and information/advice relating to medication.

CCDHB has a project underway to re-develop a group of letters for outpatients. Leveraging this existing project enables the prototyping of the Accessibility Charter approach being integrated. Those who we have spoken to about the translation of documents to other formats have praised this work and highlighted the way this will make the translation of the letters into multiple formats easier.

4. REQUIREMENTS

The first requirement is to confirm that formats used for information are accessible for disabled people who engage with health services. At this stage they are Plain Language, Easy Read, NZ Sign Language, Braille, Audio, and Large Print.

The second requirement is to source appropriate solutions for the design and implementation of the formats required by the people who access health services. This includes exploring in-house and outsourced options.

The third requirement is to identify the most appropriate platform for holding the information which is easy for health care service providers and agencies to access.

4.1 Plain Language

Plain Language is a method of presenting written English to make it more understandable for people with varying abilities. Typically, plain language uses sentences that should be no more than ten to fifteen words, and each sentence should have just one idea and one verb. Active sentences are used instead of passive sentences.

The starting point of the project is premised on plain language as the foundation of the other required formats. Having this in place allows for translation into other formats to be smoother and efficient.

4.2 Easy Read

This is a form of writing which uses representational, pictorial drawings, to share information, ask questions or to convey messages and ideas.

There has been an initial meeting with the service (People First – Make it Easy) who holds the license for Easy Read in New Zealand. It was a beneficial discussion which identified two potential outcomes: the first being where CCDHB will provide the information, and People First will retain the full responsibility to develop the resource; the second is where CCDHB will draft the resource applying People First's format, which they then will review and return back to CCDHB for quality assurance.

4.3 NZ Sign Language

Sign language is a combination of hand shapes, facial expressions and body movements used jointly to communicate information primarily in the deaf community.

New Zealand Sign Language (NZSL) is the natural language of the Deaf community in New Zealand; it reflects the country's culture by including signs for Māori concepts which cannot be found in other sign languages or countries.

Fortunately within the Disability Team we have people with expertise in translating and presenting information for the community. As the information is being translated from 2D to 3D, to a different

language it is important to ensure the information is provided using natural sign language, not sign language imposed on an English structure.

4.4 Braille

Braille is a tactile writing system used by people who are blind or low vision. It is traditionally written with embossed paper. Some Braille users can read computer screens and other electronic supports using refreshable braille displays.

Currently CCDHB does not have the capacity to produce letters or supplementary information in Braille format, and it is likely that this service will initially be outsourced.

We are identifying a local source which is skilled in translating written material to Braille format. Initial discussions the Blind Foundation highlighted the importance of accuracy in the process.

4.5 Audio

Providing audio files is an accessibility format that conveys information to people who are blind or have low vision by auditory means. Audio documents are essentially formatted and scripted to recreate the intent of a visual document. It is expected that the provision of information via audio means will benefit a wide range of members of the community.

Audio describing is an additional feature where information sighted people see is described verbally. Fortunately Wellington has a number of trained audio describers and it is possible to access training should we offer this in-house.

4.6 Large Print

Large Print refers to the formatting of a text document in which the typeface (or font), and sometimes the format, are considerably larger than usual, to accommodate people who find this format more legible. Firstly the standards for large-print is more than changing font size.

Aspects of colour blend and stylising of the information needs to be understood so that documents can be formatted correctly in a readable format. We will be working with experts in this area to clarify appropriate practice requirements. When these standards are understood it is envisaged that Large Print formatting can be completed within the DHB.

5. RESOURCE REQUIREMENTS

We are focusing on understanding business requirements. This is the process of discovering, analysing, defining, and documenting the requirements that are related to each format type. We are also identifying an appropriate platform for storing the information in a way that is accessible by the providers of services within the DHB community. The concept applied to the Health Navigator website is often mooted as a model for this work. www.healthnavigator.org.nz

In order to fully understand the resources required and the cost factor, each of the advisers we have spoken to say they are unable to provide a cost until they have had the opportunity to physically translate information. Therefore we intend to use draft letters from the Outpatients project which have already been converted into Plain English.

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6. THE DISABILITY COMMUNITY

Those we spoke to within the disability community praised the 3DHBs highly for this initiative. Each 'provider' expressed a keen willingness to engage with us to find a way to ensure the project can be cost effective and relevant to their community of interest. Co-design and the engagement of the wider disability community is being integrated into the process of design.

We are grateful as a team for the high level of encouragement and support for this initiative within the DHB and the disability community.

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Date: 27 August 2019	**3DHB DISABILITY SERVICES ADVISORY COMMITTEE**
Author	Sandra Murray, Project Manager, Strategy, Innovation & Performance Rawinia Mariner, General Manager Commissioning – Mental Health & Addictions
Endorsed by	Helene Carbonatto, General Manager – Strategy, Planning and Outcomes , HVDHB Rachel Haggerty, Director – Strategy, Innovation & Performance, CCDHB Sandra Williams, Acting Executive Leader, Planning and Performance, WrDHB
Subject	**Indicative Population Outcomes Framework - *Living Life Well* - Mental Health and Addictions Strategy**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Note** the intention to use a collective impact measurement system to bring together providers and other agencies to support outcomes for populations.

(b) **Note** the population outcome framework.

(c) **Endorse** the approach to outcome measurement using population indicators.

(d) **Endorse** the approach to service performance measurement and dashboards to be applied to all existing and new services.

(e) **Recommend** the endorsed approach to their respective Boards.

APPENDICES

1. **POPULATION OUTCOMES FRAMEWORK - *LIVING LIFE WELL***
2. **POPULATION INDICATORS - *LIVING LIFE WELL***
3. **DRAFT COMMISSIONING DASHBOARD (ADULTS)**
4. **PERFORMANCE MEASUREMENT FRAMEWORK (ADULTS)**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	✓	Quality & Safety Quality & safety of service delivery	✓
People Centred Make it easier for people to manage their own health needs	✓	Service Performance Report on service performance.	
Equity Support equal health outcomes for all communities	✓	Health System Performance Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		Planning Processes and Compliance Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health	✓	Government Priority Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	✓

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1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to present the population outcomes framework, population indicators and the approach to applying outcome based performance measurement to services and interventions.

The paper follows an earlier presentation on the *Living Life Well* Strategy at the May 2019 DSAC and Board meetings, where the Boards approved an initial implementation plan, and noted that the next steps are co-designing an outcomes framework and an investment plan.

The Living Life Well Strategy sets the direction for mental health and addiction care in the sub-region to improve the experience and outcomes for our people, whānau and our communities and is consistent with other national and regional strategies that have been developed in recent years.

2. CONTEXT

The outcome framework has been built using the population outcome framework approach developed by the Ministry of Health. It ensures the focus is on outcomes for people and recognises that the social determinants of health are a critical aspect of mental health and wellbeing.

2.1 Working Together to Collectively Achieve Outcomes

We need to work collaboratively to achieve the strategy and its underpinning outcomes. DHBs contribute partially to individual's mental health and wellbeing however collective impact[1] has emerged as a powerful and innovative approach to solving social problems and is a paradigm shift for how to create social change. Complex social problems are affected by large and interdependent systems that no single organization can change alone. For us to achieve outcomes we must work collaboratively with other organisations having a shared focus on outcomes that link efforts and outcomes across services, funders, accountabilities, and strategic and government priorities. Going forward we need to work more collectively with service providers and users of those services and we need an outcomes framework that will enable other agencies to see how they can contribute to outcomes.

2.2 Applying an outcomes framework and developing investment plans

This change is complex and requires careful thought and management of expectations. The initial focus is this development of a population outcomes framework that underpins *Living Life Well*. This will enable us to have a shared view of success and measurable shifts in population outcomes. The outcomes framework will help us develop priorities and options for staging transformational change and will result in an investment (transformation) plan. This Plan will enable CCDHB to leverage the funding being made available by the Ministry of Health to implement community mental health and addiction models that improve equity and outcomes.

The services models will be co-designed with those with lived experience and communities. They will be co-investment models across the Ministry of Health, the three DHBs, the PHOs and other social sector agencies who can contribute to collectively achieving our shared goals and outcomes and further refine those outcomes. The co-design process will also integrate with MHAIDS provided community mental health and addiction services.

[1] **Collective Impact** (CI) is the commitment of a group of actors from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration.

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3. OUR APPROACH TO DEVELOPING AN OUTCOMES FRAMEWORK

We have chosen a population based outcomes methodology to underpin *Living Life Well.* A population outcomes focus assists multiple agencies and their workforce to identify their contribution to outcomes. It emphasises positive changes in circumstances for people, rather than the inputs or outputs of services. When applying a population-based outcome approach all complex and co-existing problems can be considered and managed together to sustain positive outcomes. Working towards a shared outcome encourages collaboration by organisations and services.

It will ultimately ensure that we focus on services that are not only treating mental illness and addiction, but are supporting people to live good lives and thrive.

This collaborative response is most effective when it is;

- Focused on equity of outcome particularly for Māori and Pacific communities as well as those with enduring mental illness and addiction;
- Supports intervention being provided early in the life-course and the emergence of mental distress and misuse of substances being supportive at times of risk and need for everyone;
- The underpinning methodology is informed by complex system theory, collective impact and Results-Based Accountabilities (RBA);
- Is applicable at a local/community level, district and sub-regional level;
- Is used as a commissioning framework that can be used to create consistency and overall visibility of population outcomes whilst supporting local responsiveness.

The population outcome framework is a simple one page framework supported by a range of population performance indicators that underpin the outcomes framework. The indicators are based on the agreed key result areas identified in the one page population framework. The population indicators are attached as Appendix Two and can be sourced from existing measurement systems held by DHBs, MoH and other social agencies. The measures will be applied to different populations and show differences for Māori and non-Māori as well as by life course, other ethnicities and localities.

The performance measurement of services will use the outcomes based approach measuring structural activity measures (how *much* are we doing), process measures (how *well* are we doing it), and impact measures *(is anyone better off*). These will be developed for all population groups and applied to all existing and proposed services working with providers and communities. The concept attached as appendix three illustrates how the measurement will occur.

Finally, attached as appendix four is the draft Commission Dashboard that will map how services are making a contribution to population indicators. This will ensure that the services commissioned contribute to equity and the outcome.

4. THE POPULATION OUTCOME FRAMEWORK

The statements that construct the outcome framework are attached below. Importantly they provide a framework for collective activity to improve mental health and wellbeing.

4.1 The Collective Vision

"A journey of paths that promotes hope and choice, enhancing one's mauri (essence) within all our communities" - gifted from people with lived experience 2014.

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4.2 The Shared Outcome

"To contribute to all people thriving; to reduce the impact of mental distress, mental illness and addiction harm on people's life outcomes; to achieve equity and to collectively address social determinants of health".

4.3 The Shared Goals

For people and whānau - collectively we will reduce the impact of mental distress, illness and addiction on their life

For our communities - collectively we will support communities to thrive

For our populations - collectively we will achieve equity of outcome for our communities

4.4 Key Result Areas and Population Indicators

The population outcome is broken down into the components that matter the most for people, referred to as key result areas. These areas are informed by the evidence and research into what matters most to the target populations and the population outcome.

Achievement in key result areas is measured using population indicators: quantifiable characteristics of a population that reflect the key result area. The indicators help to understand the complexity of key result area for a specific target population and to focus on the variation between target populations. The approach supports comprehensive reporting designed to improve equity and outcomes alongside headline measures across the life course.

The key result areas are:

- Mauri Ora / Health Status
- Whanau Ora / Social Wellness
- Wai Ora / Healthy Living

4.5 Guiding Principles.

We have also included guiding principles in this population outcome framework. To further support clarity around working together to collectively achieve population outcomes. These are translated in to service maps that assist in intervention planning. An example is attached as appendix four.

5. CONCLUSIONS

The appendices attached include the Population Outcome Framework; the draft population indicators; the performance measurement framework and the commissioning dashboard. Collectively they form the outcome framework for implementation of Living Life Well.

The application of the framework will be completed with our Advisory Groups (Sub-regional Pacific Advisory Group, Sub-regional Disability Advisory Group, Citizens Health Council and Māori Partnership Board) communities and providers. It will inform all future reporting.

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6. APPENDIX ONE

Population Outcomes Framework

Shared purpose: *what we want to achieve by our own efforts and by working with others*

Vision

A journey of paths that promotes hope and choice, enhancing one's mauri (essence) within all our communities- gifted from people with lived experience 2014

Outcome

To contribute to all people thriving; to reduce the impact of mental distress, mental illness and addiction harm on people's life outcomes; to achieve equity and to collectively address social determinants of health

Goal

- For people and whānau - collectively we will reduce the impact of mental distress, illness and addiction on their life
- For our communities - collectively we will support communities to thrive
- For our populations - collectively we will achieve equity of outcome for our communities

Key Result Area

Key Result Areas: *what matters for people to live life well*

Mauri ora/ Health status

- Whānau experience less mental distress, illness and addiction
- Whānau do not suicide or experience the impact of suicide
- Whānau do not misuse alcohol or drugs
- Whānau have good health
- Whānau have healthy behaviours

Get well

Whānau ora/ Social wellness

- Whānau have security of accommodation
- Whānau live in healthy homes
- Whānau live in safe homes
- Whānau have financial security
- Whānau do not experience deprivation
- Whānau are participating in their communities
- Whānau are achieving in education
- Whānau are in quality employment

Stay well

Wai ora/ Healthy living

- Whānau have social equality
- Whānau report wellbeing
- Whānau do experience stigma, racism and discrimination
- Whānau have friends and social networks
- Whānau do not participate in criminal activity
- Whānau enjoy cultural participation

Live well

Achieving equity

- We will ensure equity by planning services and measuring outcomes for Maori, Pacific and other populations, as well as localities.

Principles

Principles: *we will be guided by these*

- We recognise Te Tiriti o Waitangi, and the principles of partnership, participation and protection that underpin the relationship between the Government and Māori;
- We will focus on achieving equity for Māori and Pacific people;
- We will improve outcomes for everyone especially those who need us most;
- We are community-focused, recognising that there are strengths and resources already available in the community;
- We will work with communities to make a collective impact that will enable people in their community to be well, stay well, be resilient and thrive;
- We will place people at the centre of our focus, with a culture of equity and teams made up of diverse people who can offer cultural responses that reflect the needs of the local communities;
- We will use holistic and social determinant-informed approaches to mental health and wellbeing recognising cultural identity, spirituality, material sufficiency, intellectual and emotional engagement, a safe place to call home and participation in communities;
- We will ensure our approaches include de-stigmatisation, prevention and early intervention;
- We will provide support across the life-course including new parents, infants, children, youth, and older people needing support for their wellbeing.

Population Outcomes Framework

Shared purpose: *what we want to achieve by our own efforts and by working with others*

Vision

A journey of paths that promotes hope and choice, enhancing one's mauri (essence) within all our communities- gifted from people with lived experience 2014

Outcome

To contribute to all people thriving; to reduce the impact of mental distress, mental illness and addiction harm on people's life outcomes; to achieve equity and to collectively address social determinants of health

Goal

- For people and whanau- collectively we will reduce the impact of mental distress, illness and addiction on their life
- For our communities-collectively we will support communities to thrive
- For our populations –Collectively we will change the trajectory of outcomes for our populations

Key Result Area

Key Result Areas: *what matters for people to live life well*

Mauri ora/ Health status

- Mental health and freedom from addictions
- Physical health

Get well

Whanau ora/ Social wellness

- Social and cultural connection
- Wellbeing and respect

Stay well

Wai ora/ Healthy living

- Healthy, safe and secure housing
- Financial security and living standards
- Participation, education and employment

Live well

Principles

Principles: *we will be guided by these*

- We actively reognise Te Tiriti o Waitangi, and the principles of partnership, participation and protection that underpin the relationship between the Government and Māori
- We are community-focused, recognising that there are strengths and resources already available in the community. For this reason, we will work with communities to make a collective impact that will enable people in their community to be well, stay well, be resilient and thrive
- We place people at the centre of our focus, with a culture of equity and teams made up of diverse people who can offer cultural responses that reflect the needs of the local community
- By moving from a medical-based model to a holistic, social determinants-informed and whole of government approach to mental health and wellbeing, we recognise that these areas encompass cultural identity, spirituality, material sufficiency, intellectual and emotional engagement, a safe place to call home and participation in communities.
- We need to make a true difference by focussing on de-stigmatisation, prevention, intervene early, provide more choice and options-including cultural models of care, to a wider range of people (including new parents, infants, children, youth, people needing support for their wellbeing and providing simple access for people who need more specialist support)
- We will make a significant difference for Māori and Pacific people, youth and people with addiction needs

Target Population

Target Populations: *who we are doing it for to achieve equity of outcome for populations and better lives for individuals*

Populations with risk factors

Due to Socioeconomic factors
- Low education and low income
- Insecure accommodation and homelessness

Due to adverse experience
- Interpersonal violence, family violence and abuse
- Misuse of drugs and alcohol
- Major disruptive events

Populations with greater incidence
- Institutional care
- Refugees
- People who are LGBTQIA
- People with poor physical health or disability

Tangata Whai Ora

- Mild experience of mental distress, illness and addiction
- Moderate experience of mental distress, mental illness and addiction
- Severe experience of mental distress, mental illness and addiction
- People under compulsory treatment orders
- People under compulsory treatment orders
- People Receiving mental health care in a forensic setting

Family, Friends and Whanau of tangata whai ora

- Whanau and friends supporting tangata whai ora
- Dependant children of parents who are tangata whai ora
- Adults supporting children or adults who are tangata whai ora

Life course, Maori, Pacific, Locality

Appendix 2

Population Indicators for the Key Result Areas

The purpose of this document is to show the range of population indicators that we would measure as means to know we were collectively making a population change and achieving the population outcome and goals.

The Population indicators relate to the three key result areas described in the population outcome framework (appendix 1). The result areas are Mauri ora (health status), Whanau ora (social wellness) and Wai ora (healthy living). This indicators are applied across the life course.

The following tables lists available measures and notes for whom data is not available.

Table 1: Mauri ora / Health status population indicators and their proposed application across the life course

Population indicators applied across the life course	Whānau with dependent children	Unborn children; from birth to 5 years	Tamariki aged 6 to 14	Rangatahi aged 15 to 24	Pākeke aged 25 to 64	Older adults aged 65 plus
Mental health and freedom from addiction problems						
Family experience less mental distress, mental illness and addiction						
Proportion of people in treatment <6 months	✓	✓	✓	✓	✓	✓
Proportion of people in treatment >6 months	✓	✓	✓	✓	✓	✓
Proportion of community treatment orders	n/a	n/a	✓	✓	✓	✓
Use of Seclusion in Services	n/a	n/a	✓	✓	✓	✓
Proportion of people in forensic care	n/a	n/a	✓	✓	✓	✓
Mental health distress calls to NZ Police (1m)	✓	✓	✓	✓	✓	✓
Infant attachment and developmental milestones	n/a	✓	✓	n/a	n/a	n/a
Family do not suicide or experience the impact of suicide						
Suicide rates	✓	n/a	✓	✓	✓	✓
Suicide behaviour rates	✓	n/a	✓	✓	✓	✓
Suicide ideation in young people	n/a	n/a	✓	✓	n/a	n/a
Suicide related distress calls to NZ Police (1X)	✓	n/a	✓	✓	✓	✓
Family do not misuse alcohol and drugs						
Drink driving / disorderly conduct rates	n/a	n/a	n/a	✓	✓	✓
Drinking frequency	n/a	n/a	n/a	✓	✓	✓
Misuse of substance	n/a	n/a	✓	✓	✓	✓
Substance misuse / conviction	n/a	n/a	n/a	✓	✓	✓

Population indicators applied across the life course	Whānau with dependent children	Unborn children; from birth to 5 years	Tamariki aged 6 to 14	Rangatahi aged 15 to 24	Pākeke aged 25 to 64	Older adults aged 65 plus
Physical health						
Whānau have good health						
Life expectancy	✓	✓	✓	✓	✓	✓
Incidence of long term health conditions	✓	✓	✓	✓	✓	✓
Long term disability by type	✓	✓	✓	✓	✓	✓
Older people living independently	n/a	n/a	n/a	n/a	n/a	✓
Supported living benefit	✓	✓	✓	✓	✓	✓
Whānau have healthy behaviours						
Healthy behaviour index	✓	✓	✓	✓	✓	✓
Dental health	n/a	✓	✓	✓	✓	✓
Obesity rates	n/a	✓	✓	✓	✓	✓
Self-reported personal health	n/a	n/a	n/a	✓	✓	✓
Smoking rates	n/a	n/a	✓	✓	✓	✓

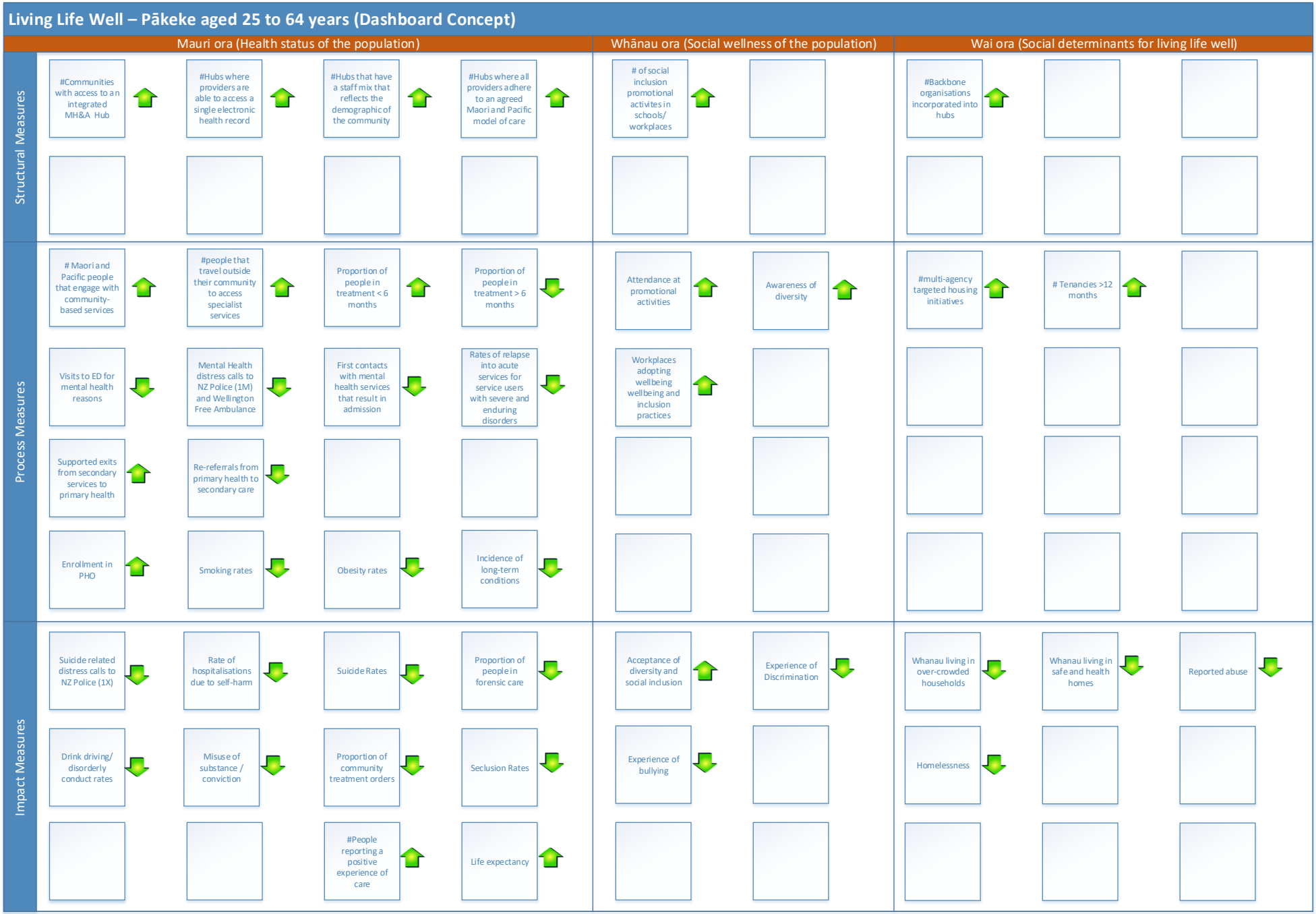
Table 2: Whanau ora / Social wellness population indicators

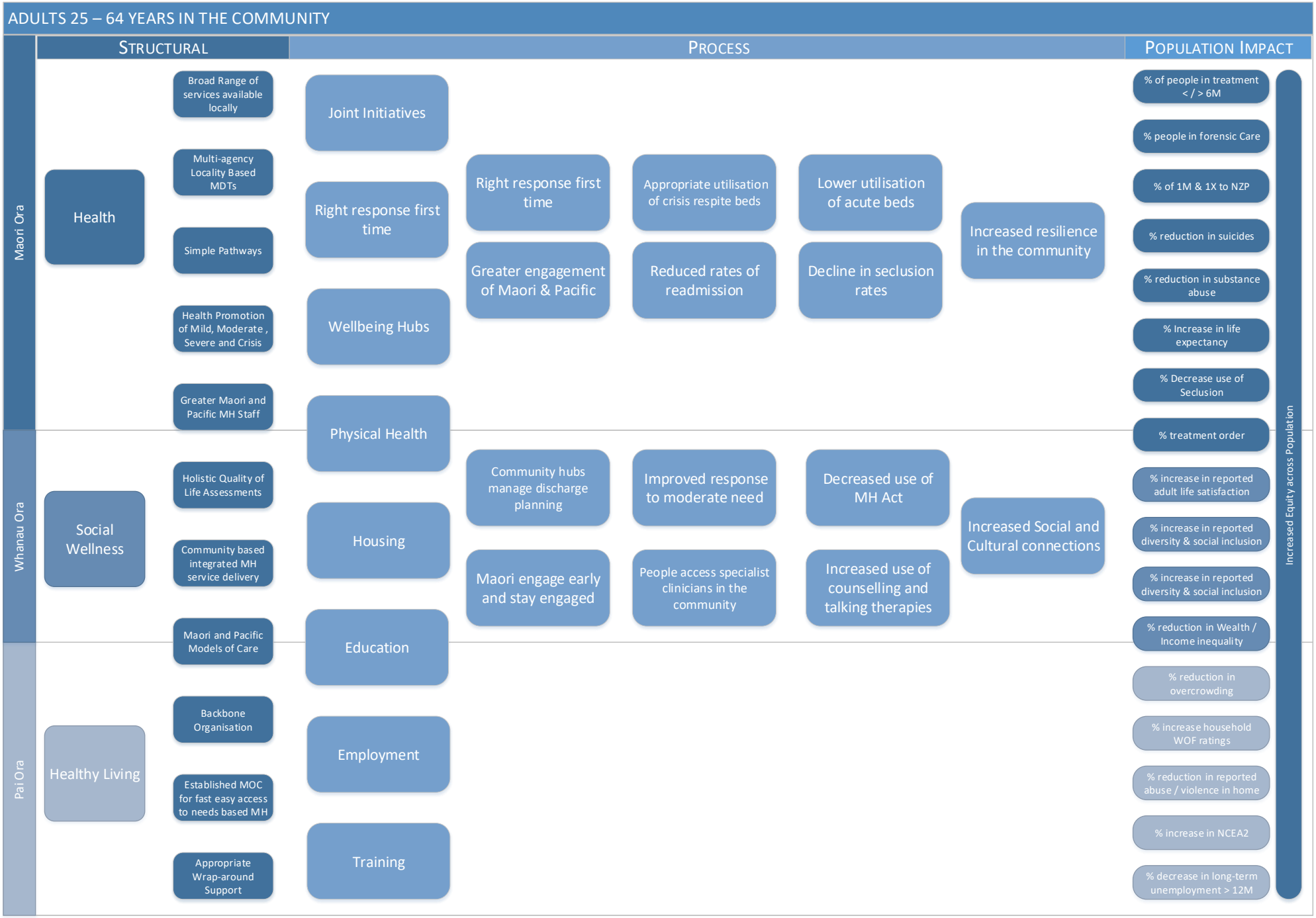
Population indicators applied across the life course	Whānau with dependent children	Unborn children; from birth to 5 years	Tamariki aged 6 to 14	Rangatahi aged 15 to 24	Pākeke aged 25 to 64	Older adults aged 65 plus
Wellbeing and respect						
Whānau have social equality						
Income inequality	✓	n/a	n/a	✓	✓	✓
Wealth inequality – derived	✓	n/a	n/a	✓	✓	✓
Self-reported wellbeing						
Adult life satisfaction / purpose	n/a	n/a	n/a	✓	✓	✓
Feeling lonely most of the time	n/a	n/a	n/a	✓	✓	✓
Stigma and discrimination						
Accepting of diversity and social inclusion	n/a	n/a	✓	✓	✓	✓
Experience of discrimination	n/a	n/a	✓	✓	✓	✓
Experience of bullying	n/a	n/a	✓	✓	✓	✓
Social and cultural connection						
Whānau, friends and social networks						
Strength of social network for support	✓	n/a	n/a	✓	✓	✓
ECE participation / Cultural segments	✓	✓	n/a	n/a	n/a	n/a
Yr9 feel connected to parents	✓	n/a	n/a	✓	n/a	n/a
Yr9 feel connected to school	✓	n/a	n/a	✓	n/a	n/a
Cultural participation						
Adult able to express identity	✓	n/a	n/a	✓	✓	✓
Voter participation	✓	n/a	n/a	✓	✓	✓

Table 3: Wai ora / Health living population indicators

Population indicators applied across the life course	Whānau with dependent children	Unborn children; from birth to 5 years	Tamariki aged 6 to 14	Rangatahi aged 15 to 24	Pākeke aged 25 to 64	Older adults aged 65 plus
Healthy, safe and secure homes						
Whānau have security of accommodation						
Home ownership rate	✓	n/a	n/a	n/a	✓	✓
Tenancy >12 months rate	✓	n/a	n/a	n/a	✓	✓
Accommodation supplement	✓	n/a	n/a	n/a	✓	✓
Homelessness rate	✓	✓	✓	✓	✓	✓
Whānau live in healthy homes						
Crowding of households	✓	n/a	n/a	✓	✓	✓
WOF Rating of homes	✓	n/a	n/a	✓	✓	✓
Whānau live in safe homes						
In dwelling assault rate	✓	n/a	✓	✓	✓	✓
Reported abuse	✓	✓	✓	✓	✓	✓
Child report to CYF with follow-up	✓	✓	✓	n/a	n/a	n/a
Witness reported violence at home	✓	✓	✓	✓	✓	✓
Financial security and living standards						
Whānau have financial security						
Individual income	n/a	n/a	n/a	✓	✓	✓
Household equivalised income after housing	✓	n/a	n/a	✓	✓	✓
More than three sources of debt	✓	n/a	n/a	✓	✓	✓
Sickness or invalid beneficiary	✓	n/a	n/a	✓	✓	n/a
Whānau do not experience deprivation						
Households experiencing deprivation (MW1)	✓	n/a	n/a	✓	✓	✓
Participation, education and employment						
Whānau are participating in their communities						
School exclusion rates	n/a	n/a	✓	✓	n/a	n/a
Literacy rates	✓	n/a		✓	✓	✓
Voluntary hours worked	n/a	n/a	n/a	✓	✓	✓
Not in employment, education or training (NEET)	n/a	n/a	n/a	✓	✓	n/a
Whānau are achieving in education						
ECE participation	✓	✓	n/a	n/a	n/a	n/a
Participation in alternative education	n/a	n/a	✓	✓	n/a	n/a
Levels of tertiary education	✓	n/a	n/a	✓	✓	✓
NCEA level 2 achievement	✓	n/a	n/a	✓	✓	✓
Whānau are in quality employment						
Long term unemployment >12 months	✓	n/a	n/a	✓	✓	n/a

Population indicators applied across the life course	Whānau with dependent children	Unborn children; from birth to 5 years	Tamariki aged 6 to 14	Rangatahi aged 15 to 24	Pākeke aged 25 to 64	Older adults aged 65 plus
Employment rate	✓	n/a	n/a	✓	✓	n/a


Living Life Well – Pākeke aged 25 to 64 years (Dashboard Concept)
Mauri ora (Health status of the population)
Whānau ora (Social wellness of the population)
Wai ora (Social determinants for living life well)
Structural Measures
Process Measures
Impact Measures
#Communities with access to an integrated MH&A Hub
#Hubs where providers are able to access a single electronic health record
#Hubs that have a staff mix that reflects the demographic of the community
#Hubs where all providers adhere to an agreed Maori and Pacific model of care
# of social inclusion promotional activites in schools/ workplaces
#Backbone organisations incorporated into hubs
Maori and Pacific people that engage with community-based services
#people that travel outside their community to access specialist services
Proportion of people in treatment < 6 months
Proportion of people in treatment > 6 months
Attendance at promotional activities
Awareness of diversity
#multi-agency targeted housing initiatives
Tenancies >12 months
Visits to ED for mental health reasons
Mental Health distress calls to NZ Police (1M) and Wellington Free Ambulance
First contacts with mental health services that result in admission
Rates of relapse into acute services for service users with severe and enduring disorders
Workplaces adopting wellbeing wellbeing and inclusion practices
Supported exits from secondary services to primary health
Re-referrals from primary health to secondary care
Enrollment in PHO
Smoking rates
Obesity rates
Incidence of long-term conditions
Suicide related distress calls to NZ Police (1X)
Rate of hospitalisations due to self-harm
Suicide Rates
Proportion of people in forensic care
Acceptance of diversity and social inclusion
Experience of Discrimination
Whanau living in over-crowded households
Whanau living in safe and health homes
Reported abuse
Drink driving/ disorderly conduct rates
Misuse of substance / conviction
Proportion of community treatment orders
Seclusion Rates
Experience of bullying
Homelessness
#People reporting a positive experience of care
Life expectancy


ADULTS 25 – 64 YEARS IN THE COMMUNITY
STRUCTURAL
PROCESS
POPULATION IMPACT
Maori Ora
Whanau Ora
Pai Ora
Health
Social Wellness
Healthy Living
Broad Range of services available locally
Multi-agency Locality Based MDTs
Simple Pathways
Health Promotion of Mild, Moderate , Severe and Crisis
Greater Maori and Pacific MH Staff
Holistic Quality of Life Assessments
Community based integrated MH service delivery
Maori and Pacific Models of Care
Backbone Organisation
Established MOC for fast easy access to needs based MH
Appropriate Wrap-around Support
Joint Initiatives
Right response first time
Wellbeing Hubs
Physical Health
Housing
Education
Employment
Training
Right response first time
Greater engagement of Maori & Pacific
Community hubs manage discharge planning
Maori engage early and stay engaged
Appropriate utilisation of crisis respite beds
Reduced rates of readmission
Improved response to moderate need
People access specialist clinicians in the community
Lower utilisation of acute beds
Decline in seclusion rates
Decreased use of MH Act
Increased use of counselling and talking therapies
Increased resilience in the community
Increased Social and Cultural connections
% of people in treatment < / > 6M
% people in forensic Care
% of 1M & 1X to NZP
% reduction in suicides
% reduction in substance abuse
% Increase in life expectancy
% Decrease use of Seclusion
% treatment order
% increase in reported adult life satisfaction
% increase in reported diversity & social inclusion
% increase in reported diversity & social inclusion
% reduction in Wealth / Income inequality
% reduction in overcrowding
% increase household WOF ratings
% reduction in reported abuse / violence in home
% increase in NCEA2
% decrease in long-term unemployment > 12M
Increased Equity across Population

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Date: 2 September 2019	**3DHB DISABILITY SERVICES ADVISORY COMMITTEE** **DISCUSSION**
Author	Trish Davis, Senior System Development Leader, Mental Health and Addictions, Strategy, Innovation and Performance Rawinia Mariner, General Manager, Commissioning Mental Health and Addictions, Strategy, Innovation and Performance
Endorsed by	Rachel Haggerty, Director, Strategy, Innovation and Performance
Subject	**PREVENTING SUICIDE AND SUICIDAL BEHAVIOUR IN OUR COMMUNITIES UPDATE**

RECOMMENDATIONS

It is **recommended** that the Disability Advisory Committee:

(a) **Note** that suicide continues to be a significant issue for our communities and the Coroner's data shows that deaths in Capital and Coast District Health Board (CCDHB) are increasing at a faster rate than the NZ total, and the gap between the national rate and CCDHB is getting smaller.

(a) **Note** that a review of health service responses to suicide and suicidal behaviour was completed to explore opportunities to improve suicide prevention activity across all health services.

(b) **Note** significant improvement in suicide prevention and postvention with increased postvention activity and greater engagement with community networks.

(c) **Note** the implementation of reporting and analysis of all suicides, once notified, to inform incident review in addition to informing activities to prevent suicide.

(d) **Note** that a revised 3DHB suicide prevention and postvention action plan is being developed and will align to the Ministry of Health's release of the new national strategy.

APPENDICES

1. **ANALYSIS OF CORONER'S PROVISIONAL SUICIDE DEATHS DATA RELEASED ON 26 AUGUST 2019**

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well	X	Quality & Safety Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs	X	Service Performance Report on service performance.	
Equity Support equal health outcomes for all communities	X	Health System Performance Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions	X	Planning Processes and Compliance Planning processes and compliance with legislation or policy.	X
Specialist Services Ensure expert specialist services are available to help improve people's health		Government Priority Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	X

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1. INTRODUCTION

1.1 Purpose

This paper provides an update to highlight that death by suicide continues to be a significant issue for CCDHB, particularly in light of the release of the annual provisional suicide statistics on 26 August 2019 by the Chief Coroner, Judge Deborah Marshall.

1.2 Previous Board Discussions/Decisions

The paper follows up on an earlier decision paper tabled at the 3DHB DSAC meeting on 10 September 2018. At this time Wairarapa, Hutt Valley and Capital and Coast District Health Boards (3DHB), adopted a 3DHB zero approach to suicide prevention that considers suicide and suicidal behaviour as a preventable event.

2. BACKGROUND

According to the annual provisional suicide statistics for deaths reported to the Chief Coroner between 1 July 2007 and 30 June 2019 the total number of suicide deaths in New Zealand for 2018/19 is 685 or 13.93 per 100,000 population. This is the highest number since records began and an increase of 23 deaths from the previous year.

For 2018/19 the total number of deaths for Capital and Coast District Health Board (CCDHB) was 41, up one from the previous year. For Hutt Valley District Health Board (HVDHB), the total number of deaths was 12, down one from the previous year. For Wairarapa District Health Board (WDHB), the total number of deaths was eight with no change from the previous year.

The recently released Coroner's provisional suicide data shows that deaths in CCDHB are increasing at a faster rate than the NZ total, and the gap between the national rate and CCDHB is getting smaller.

2.1 The CCDHB, HVDHB and WRDHB Approach to Suicide Prevention and Postvention?

While waiting for the Ministry of Health's national suicide prevention strategy to be completed and published, the 3DHBs have focused improving suicide prevention and postvention activity, implementing the interim suicide prevention and postvention (2018-2021) action plan and establishing the internal suicide prevention and postvention teams.

On 1 May 2019 the functions of suicide prevention and postvention ceased to be contracted with external providers (Lifeline Aotearoa and Regional Public Health). The rationale for this change was to provide a more joined up approach to planning and delivery of suicide prevention and postvention.

At this time the Wairarapa District Health Board (WRDHB) chose to deliver its suicide prevention and postvention service locally but remains aligned to the action plan and governance arrangements that are in place. CCDHB hosts the service to support both Capital & Coast and Hutt Valley communities.

3. UPDATE ON SUICIDE PREVENTION AND POSTVENTION ACTIVITY

3.1 What Is In Place for Suicide Prevention?

3.1.1 Reporting and Database of Suspected Suicides

Current reporting of suspected suicides is fragmented within the DHBs, mainly occurring in Mental Health Addiction and Intellectual Disability Services (MHAIDS) and in quality, serious adverse event and statutory reporting. The community suicide information was held by the Regional Public Health Unit, and the planning and funding teams held knowledge of community NGO service provider suicides.

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To ensure immediate DHB awareness, closer monitoring and more responsive improvement actions a single reporting system has been developed that takes effect from 1 October 2019. This report has two parts:

- an automated report on suspected suicides for internal use to increase the level of awareness and service response;
- a comprehensive suicide death database which analyses the service interactions of all people who die by suicide enabling the DHBs to improve service responses and inform future service planning to reduce suicides.

3.1.2 Suicide Prevention and Postvention Staffing Levels

Currently, there are two Suicide Prevention and Postvention Coordinators in place to cover CCDHB and HVDHB. Wairarapa DHB has advertised a 0.5 FTE position and have recently completed their recruitment process. A third leader for suicide prevention is pending appointment. The Suicide Prevention and Postvention Coordinators will work closely together as a team in regards to postvention and ensure the implementation of the best suicide prevention strategies.

3.1.3 Governance Structure

A Greater Wellington Governance Group for Suicide Prevention and Postvention has been established with a 3DHB focus. The Governance Group focuses on ensuring the interim suicide prevention action plan is being implemented. The group includes a wide range of stakeholders including people with lived experience, MHAIDS, NZ Police, Councils, Primary Health Organisations (PHOs), Victim Support, Māori, Pacific, Non-Government Organisations (NGOs) and youth.

3.1.4 Localities

The Suicide Prevention and Postvention Coordinators focus on building a strong understanding of each community's needs and providing tools and education. Every community is different, and their aim is to equip and empower groups to provide education and support in their area.

Community Initiatives	**Work Underway**
Porirua	The Porirua Community Suicide Prevention group is established and meeting on a 6-8 week basis. They have identified their training needs and are actively seeking funding from CCDHB to support their community champions in wellbeing and suicide prevention. Linkages are to be made with Te Whare Wānanga o Aotearoa.
Kāpiti	Linkages have been made with a range of groups including youth, Age Concern, Grey Power, Men's Shed, Whirlwind Men's Group, Council, secondary schools. A suicide working group for men in Kāpiti group has been established by CCDHB and will be meeting in September.
Wellington Central	Meetings have been held with Victoria University, Massey University, WelTec, and Whitireia tertiary institutions in regards to supports for students. Work is underway to bring together the tertiary providers in Wellington so they can share strategies and support each other in regards to suicide prevention.
Wainuiomata	Networks are being established in this area. The initial feedback from the community is they consider this work can dovetail into the existing "strengthening families" networks.

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Wairarapa	Interagency meetings continue with good representation and an appetite for outcomes. A localised Action Plan is in place, prioritising youth, Māori and Men. Work with Ministers and Funeral Directors around the development of safe messaging continues. Youth co-design groups are in place and, with the support of three youth representatives, the SPPC and volunteers from the interagency group are working to gain a better understanding of what works and what doesn't for youth support. A research project for Men has been drafted and is under consultation. Kaupapa Māori Motivational Interviewing training has been provided for local service staff. A partnership with local media has allowed for extensive promotional messaging with two double-page spreads being published in the free, all residential property circulated Midweek paper and radio advertising supports Suicide Prevention during September. Riders Against Teenage Suicide will ride through Wairarapa in a public event to highlight Suicide Prevention Awareness in October, supported by the DHB.
Hutt Valley	Meetings have been held with youth groups, Marae, the local PHO and DHB services. Resilience training has been implemented for Pacific church leaders.

2.1.1 Porirua Suicide Cluster

Between May and September 2018 there was a youth suicide cluster of five (aged between 14 and 24+) in Porirua. At the time of the suspected suicides CCDHB funded a local NGO to provide support, guidance and counselling for the four high schools in Porirua. In addition, Clinical Advisory Services Aotearoa, the Ministry of Health's response service facilitated the postvention response. Since then CCDHB has worked closely with the Porirua high schools, community groups and NGOs to support them in their direct work with whānau and students.

Despite the higher numbers of suicides nationally particularly for Māori, Pacific and young people, it is significant that there have been no further deaths of these most at-risk groups in Cannons Creek and its close localities. That being said, significant vulnerabilities still exist within these communities. Both the CCDHB, Mental Health and Addictions Commissioning Team and the Child, Youth, Localities Commissioning Team are working closely together to ensure alignment in regards to the establishment of an Integrated Youth Service in Porirua.

A response of this nature has been effective in Kāpiti with the Kāpiti Youth Service, in Wellington with Evolve and Vibe in Hutt Valley. However these services indicate demand continues that exceed capacity.

3.2 Postvention Support

Postvention is the process following notification of a suspected suicide by the Secure Coroner Notification Service. CCDHB works closely with the Police, Victim Support, health professionals, MHAIDs, schools and other NGOs as required. The main function is to ensure that supports are put into place for families and whānau and that a Register of Vulnerable Persons is collated and supports are put into place for everyone on the list. CCDHB has reviewed the postvention process and implemented a new practice of holding a postvention meeting for each suspected suicide. Prior to the transfer of the function back to CCDHB postvention meetings were only held for youth but are now held for all age groups.

Access to bereavement counselling is variable across the region, with some people accessing supports through churches, Marae, their employer, NGOs, PHOs or paying for counselling privately. In the May 2019 Budget, the Government announced that as part of the new $40 million for suicide prevention over four

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years that this includes a national fund to provide free counselling for those bereaved by suicide. CCDHB supports this initiative and is linking with the Ministry of Health about this.

CCDHB continues to support the WAVES programme that is offered by Te Awakairangi PHO in the Hutt. Waves is an eight week programme that aims to support adults aged 18 and older who have been bereaved by suicide. CCDHB is keen for the programme to be also available in other parts of the region.

3.3 Draft Systems Review Report of Health's Response to Suicide and Suicidal Behaviours

Every suicide is a tragedy for the person, their family or whānau, and the communities in which they live. As a collective, the 3DHBs are seeking to create positive change for people who live in their regions and who experience the distress of suicidal behaviours and reduce the rate at which people die by suicide.

We recognise a need to re-think the way in which suicide prevention is approached. Many of those who are dying by suicide are already known to the healthcare system. In addition evidence suggest that intimate partner violence (IPV) has been linked to a number of deaths by suicide and that fragmentation within health care systems can lead to delays and people falling through the cracks.

The Zero Suicide philosophy promotes that to improve outcomes and close gaps, a system-wide approach, which includes a holistic and comprehensive approach to patient safety and quality improvement, is critical. The 3DHBs are developing a whole-of-system 3DHB to enable them to respond in a way that makes a positive difference for people, families, whānau and communities living within the regions.

A review was conducted to provide a picture of the 3DHB's health service responses to suicide and suicidal behaviours and identify opportunities for improvement. The review was supported by a literature review, review of suicide prevention programmes, internal data analysis and interviews with 53 stakeholders across the 3 DHBs including primary health care, DHB services and community services.

The report provides an insight to some of challenges that exist within current health services. It also identifies significant opportunities. The summarised recommendations in the draft report are:

- 3DHBs prioritise the development of a formalised suicide prevention structure. (completed)
- A review of Te Haika is completed. (underway)
- Postvention inter-agency working groups are developed across the regions. (underway)
- Implement formalised support to people bereaved by suicide. (completed)
- The 3DHB Suicide Prevention and Postvention Action Plan is finalised.
- A resource is developed to outline the standard of care expected in the 3DHBs.
- 3DHBs seek opportunities for integrated responses across the system of care.
- 3DHBs engage people with lived experience and those bereaved by suicide. (underway)
- 3DHBs consider implementing programme initiatives which include involvement of peer support workers.
- Healthcare workforces are upskilled to better support people experiencing distress and who are at risk of suicide.
- The 3DHBs improve the identification and responses to people experiencing intimate partner violence (IPV).
- The 3DHBs improve responses for people who present to Emergency Departments with distress.
- The 3DHBs explore the possibility of implementing responses such as Living Room, Retreat models of care or development of a hub into service provision.

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This review will guide future systemic, process and/or service changes, with an aim to support them to respond in ways that make a positive difference to people affected by suicide and suicidal behaviour.

4. NEXT STEPS

The anticipated release of the Ministry of Health's new national suicide prevention strategy will enable the 3DHBs to finalise a revised suicide prevention and postvention action plan for release in early 2020.

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5. APPENDIX 1:

DHB ANALYSIS OF CORONER'S PROVISIONAL SUICIDE DEATH DATA RELEASED ON 26 AUGUST 2019

Table 1: Coroner's data shows deaths in CCDHB increasing at a faster than the NZ total, and the gap between the national rate and CCDHB getting smaller

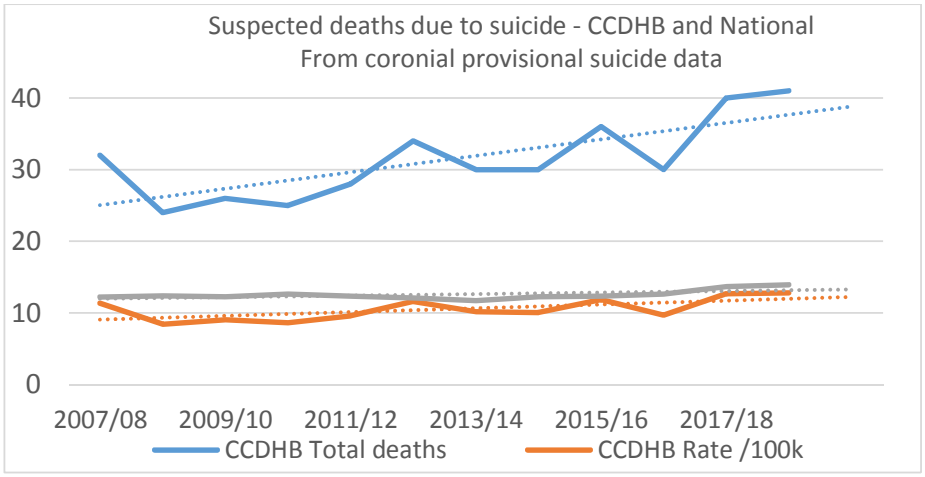

Table 2: Coroner's data shows a decreasing trend in deaths in HVDHB and the rate has fallen below the national rate

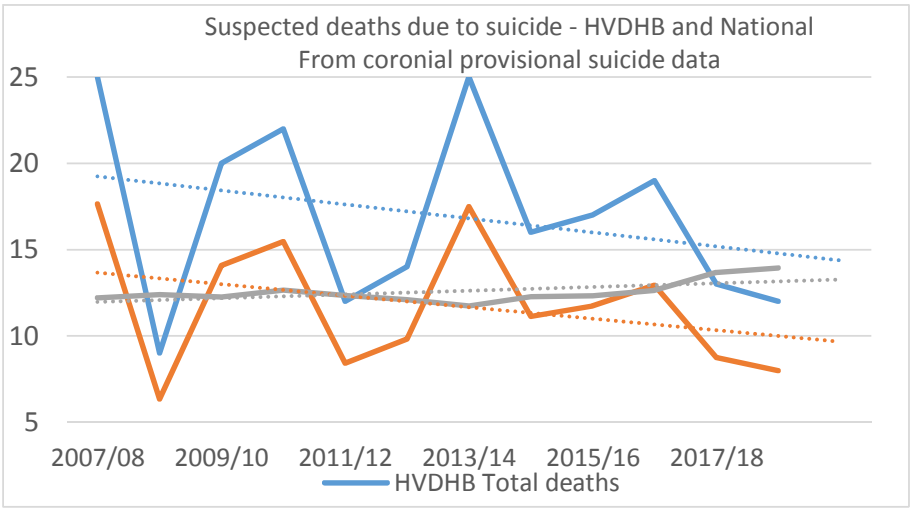

Table 3: Coroner's data shows a slight increasing trend in deaths in Wairarapa DHB and the rate remains above the national rate

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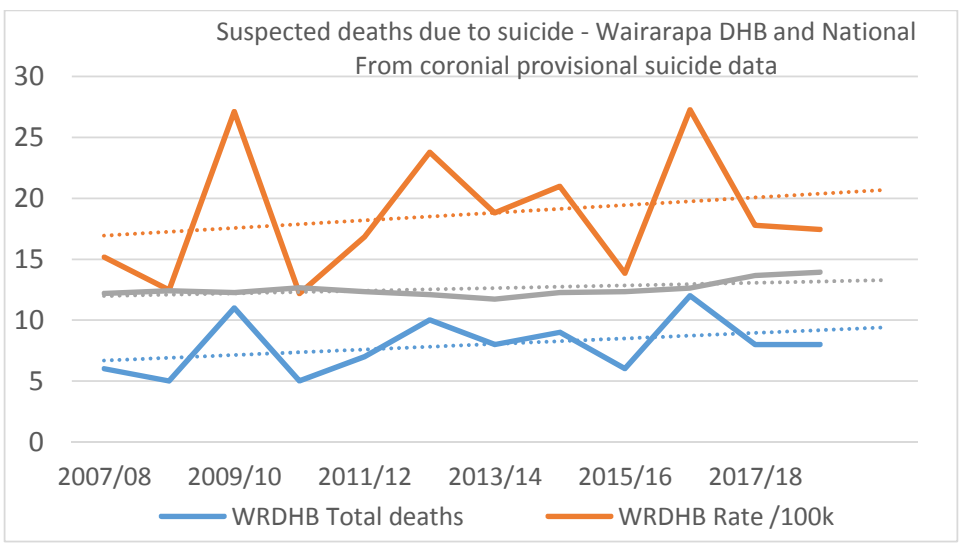
Suspected deaths due to suicide - Wairarapa DHB and National
From coronial provisional suicide data
30
25
20
15
10
5
0
2007/08
2009/10
2011/12
2013/14
2015/16
2017/18
WRDHB Total deaths
WRDHB Rate /100k

Review of Health Responses to Suicide and Suicidal Behaviours

v2

Context and Approach

Purpose

The purpose of the systems review was to provide a picture of the 3DHBs health service responses to suicide and suicidal behaviours and identify opportunities for improvement. The review also explored possible whole of system approaches. Recommendations for future suicide prevention and postvention planning across the 3DHB region were made.

40% of those in NZ who died by suicide accessed mental health services in the year before they died

In the 3DHB region, in the past two years the number of people who died by suicide that were known to MHAIDS has risen sharply from 25% each year to almost 50%

Background context

Every suicide is a tragedy for the person, their family or whānau, and the communities in which they live. As a collective, the 3DHBs are seeking to create positive change for people who live in their regions and who experience the distress of suicidal behaviours and reduce the rate at which people die by suicide. The 3DHBs have requested this review of their processes to guide future systemic, process and/or service changes, with an aim to support them to respond in ways that make a positive difference to people affected by suicide and suicidal behaviour.

The 3DHBs recognise a need to re-think the way in which suicide prevention is approached. Many of those who are dying by suicide are already known to the healthcare system. In addition evidence suggest that intimate partner violence (IPV) has been linked to a number of deaths by suicide. Fragmentation within health care systems can lead to delays and people falling through the cracks. The Zero Suicide philosophy suggests that to improve outcomes and close gaps, a system-wide approach, which includes a holistic and comprehensive approach to patient safety and quality improvement, is critical. The 3DHBs are seeking to develop a whole-of-system 3DHB to enable them to respond in a way that makes a positive difference for people, families, whānau and communities living within the regions.

The process

This review was supported by both quantitative and qualitative data. Engagement with stakeholders supported the literature review, providing a more rounded foundation for the recommendations for change.

External analysis

- Literature review
- Review of suicide prevention programmes
- *Domestic & international*

Internal analysis

- Stakeholder feedback
- DHB data
- Review of the use of Preventing Suicide: Guidance for Emergency Departments (2016)

22 meetings
53 stakeholders
+ written responses

Stakeholders came from DHB services, primary health care, and community services:

- Emergency Departments
- Mental Health, Addictions and Intellectual Disability Services (MHAIDS)
- Primary care including GPs and Primary Health Organisations
- Kaupapa Māori health providers
- Community Services
- Regional Public Health

Gaps and constraints

The breadth of response required in the area of suicide prevention goes well beyond health. It is recognised that all sectors including health must work together effectively to make any substantial and sustainable change.
The scope of this review has been limited by the short timeframe for completion. As such, it provides a broad overview and does not go into the depth that could be achieved by having more time.

No feedback was gathered from people who identified themselves as having lived experience of suicidal behaviours and so is very limited in this respect. Information from the recent Mental Health and Addiction Inquiry He Ara Oranga provides some voice from this population group.

The stakeholders who participated worked mainly in mainstream services. However, stakeholders from three Kaupapa Māori services provided feedback. The qualitative research findings are limited to the population groups interviewed and will not necessarily mirror the experience of other services or people from all cultures living in New Zealand. Stakeholders provided an extremely large volume of feedback. Due to the scope of the review not all feedback will be documented within the review. Instead, key themes were drawn from the conversations. Literature relating to these themes was drawn upon in a discussion section as part of the overall analysis.

Strategic alignment

- The contract with Lifeline Trust to deliver suicide prevention co-ordination for Capital and Coast and Hutt Valley and postvention for Wairarapa is drawing to an end and will soon be delivered through the DHBs
- 3DHBs postvention responses for Capital and Coast and Hutt Valley are being co-ordinated by the Regional Public Health Unit, but will soon be delivered through the DHBs
- The Ministry of Health's draft 2017 national suicide prevention and postvention
- The draft 3DHB Suicide Prevention and Postvention Action Plan 2018-2021
- 3DHB Mental Health Strategy (Living Life Well)
- Other things to go here?

Key Findings

The findings of this review have identified systemic, process, and services gaps and barriers to access for people experiencing distress, suicidal behaviours and bereavement by suicide across all 3DHBs.

Stakeholder feedback (and the wider Review) found that:

- We all have a part to play in doing better for those presenting with suicidal behaviours and those impacted by suicide
- A need to work together better. There is service fragmentation and some service delivery is poor. Service providers experience barriers to access and suggest a structure to achieve a more cohesive response
- Majority are stretched and under-resourced and all those needing to refer out to other services said that options were limited
- There is incongruence between the way in which Te Haika describes the service they provide and how others experience it. Feedback was often negative, with concerns around access, delays and quality of service
- When making referrals 'knowing' and 'trusting' the person making the referrals was said to improve access. Some shared that at present, they have to advocate, fight, and prove to services the concerns that they have for people are valid
- Screening for Intimate Partner Violence (IPV) is inconsistent across regions. There are unsuitable environmental settings, no suitably trained staff, limited training resources, data entry processes, and a lack of understanding
- Emergency Departments are stretched and under-resourced. The working environment creates general challenges and delays. The current referral system through Te Haika and limitations of other providers hinder the ability to meet response times
- Concerned for the 'missing middle': missing out on support in the early stages of distress. There are often no resources to provide the support needed to stop distress levels increasing
- High vulnerability groups were rarely mentioned. There was limited recognition and understanding of the impact of trauma, Pacific people were very seldom mentioned, and the Rainbow community not at all
- Suicide prevention is everyone's business, but when a person was presenting with suicidal behaviours, this was deemed a mental health trained and/or services issue. Community provider upskilling could facilitate a supporting role
- Integrated care responses are extremely limited in the 3DHB regions. Examples provided are in early stages and/or show room for improvement. No evaluation has occurred
- Postvention responses have been variable. Vast majority have been poorly coordinated reactive responses. Effective and quick responses are due to a pre-existing postvention group or network
- Access to timely, specialised, and culturally appropriate postvention support is currently scarce and often those affected are left to source this themselves

Concluding Remarks

This review highlights a need for the 3DHBs to significantly improve services to people who present with suicidal behaviours and people who are bereaved by suicide. The fragmented approach is impacting on service provision and as such will be impacting on the experience of tāngata whai ora. Service providers in the DHB are calling for change to improve responses to people in distress and presenting with suicidal behaviours. There is a consensus that this is everyone's business and it requires everyone to work well together.

The pathway through Te Haika needs to be addressed with urgency and changes made to reduce delays and barriers for both service providers and tāngata whai ora.

This review unearths a real need to improve engagement between the DHBs and community and primary care service providers. This is critical if the 3DHBs are hoping to improve suicide prevention and postvention responses to people in need. Better engagement and a whole-of-system response will support any future integrative programme initiatives.

Recommendations

Immediate priorities (A)

Urgent review of Te Haika ✓UNDERWAY
- Incorporate areas of concern from stakeholder feedback – delays, communication and response issues
- Use relevant and available data to provide accuracy in relation to delays

Improve responses for people who present to ED ✓UNDERWAY
- Reduce the impact of the busy environment on their distress levels
- Presence of peer support or health care assistants employed to wait with people; provision of food and drink; and any possible changes to the rooms in which tāngata whai ora wait
- Additional supportive changes identified by tāngata whai ora and their family or whānau
- Upskilling ED staff so they feel greater confidence in responding to distress and assessing risk
- Address delays between Te Haika and ED and the delays between request and crisis response team attendance

Develop alternatives to ED
- Effective alternatives to ED
- Use of existing space as a 'Living Room' response after hours
- Retreat model as a component of the Zero suicide approach
- Changes to environments to support emotional safety, and reduction of distress and escalation risk

Upskill staff in distress support
- Increase the chances that people at risk are identified earlier and provide people with timely, supportive, and appropriate responses
- Formalised training for providers
- Regular interaction with (and understanding of) secondary mental health providers

Consumer (B)

Seek feedback from people with lived experience and those bereaved by suicide
- Address the gap in the review, gaining feedback from those with lived experiences in suicide and suicidal behaviour
- Potential incorporation of 'What Matters to You?' to unearth opportunities for change

Ask people with lived experience and bereavement to support improvements
- People with lived experience and family representatives to have a presence in working groups for the prevention framework
- Input into the action plan, programme development, postvention response changes
- Better, sustainable outcomes

Framework (C)

Develop a suicide prevention framework
- As per the Suicide Prevention and Postvention Toolkit
- Key role for Suicide prevention coordinators and suicide postvention coordinators
- Prevention and postvention inter-agency groups
- Cohesive and coordinated across
- Environmental Scan of Capacity
- Ascertain the regions' capacity to respond

Finalise the 3DHB Suicide Prevention Action Plan
- Input from the new supporting suicide prevention structure
- Involvement of people with lived experience of suicidal behaviours and people bereaved by suicide
- Supported by Toolkit planning tools

Seek strategic opportunities for an integrated response
- Integration of secondary mental health care services into primary health care
- Early detection
- Immediate response for those at risk

Service development (D)

Place people at the centre of care
- Improved engagement and trust
- Better outcomes
- Consider implementing 'What Matters to You?' for person-centred care in key services
- Evaluate impact on stakeholder experience and outcomes
- Education and training on person-centred care

Develop system outlining the expected standard of care
- Key gaps in the 3 DHBs
- Developed for service provider reference
- Shared language and standard of care
- Similar to the Action Alliance document - Recommended Standard Care for People with Suicide Risk: Making health Care Suicide Safe

Improve engagement between services supporting people experiencing suicidal behaviours
- Seek additional ways to improve engagement across services (including outside of times of crisis)
- Shared language and shared goal in a systems approach
- Sharing stories of where engagement has made a difference in practice
- Knowing and trusting people

Service change (E)

Employ peer support workers
- Employ peer support workers as part of emergent approaches
- Service responses aimed at supporting tāngata whai ora affected by suicidal behaviours and suicide

Provide formal support for people bereaved by suicide
- Evidence based postvention responses that will best support families and whānau impacted by suicide (at high risk themselves)
- Specialised, easily accessible, preferably at no cost to this population group
- Feedback from people bereaved by suicide to shape effective service responses

Develop postvention groups across the regions
- Include stakeholders of relevance to that particular population group, including people bereaved by suicide
- Key role for Suicide Prevention Coordinators
- Anticipatory, cohesive and coordinated response

Review follow-up for people presenting with suicidal behaviours
- Recommend implementation of responses in services where they are lacking or require improvement
- Ascertaining what will work best for particular population groups and services

Improve the identification and responses to IPV
- Improve access to the Violence Intervention Programmes training and support services
- Remove existing barriers to IPV screening
- Include family violence specialists in the inter-agency working group membership

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Date 30 August 2019	**3DHB DISABILITY SERVICES ADVISORY COMMITTEE INFORMATION**
Author	Rachel Noble, General Manager, commissioning 3DHB Disability
Endorsed by	Rachel Haggerty, Director, Strategy Innovation and Performance
Subject	Summary and Update of activities supported by the Sub-Regional Disability Strategy February – July 2018

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Note** the recommendations from the Sub-Regional Disability Forum;

(b) **Note** the changes to the Disability Team including people with disability;

(c) **Note** the progress in activities related to the implementation of the Disability Strategy; and

(d) **Note** the commitment to strengthen links between the Sub-Regional Disability Advisory Group, the Maori Disability Roopu and the Pacific Disability Steering Group to enhance our ability to deliver on the recommendations from the Forum.

APPENDICES

1. **SUB-REGIONAL DISABILITY FORUM CONTENT SUMMARY**

1. INTRODUCTION

1.1 Purpose

This paper provides an update on the status of the 3DHB Disability Strategy 2019 – 2022 and highlights from the work programme for the Disability Team. This update intends to assure you that the objectives of the team remain in scope, and that the team remains committed to meeting the goals of the work programme.

2. BACKGROUND

The Disability Strategy and Performance team supports 3DHB initiatives to provide accessible and inclusive healthcare services to disabled people and their whanau by identifying and addressing inequalities within the DHBs.

The team provides advice across the 3 DHBs on polices, strategies and initiatives. It also promotes quality accessible services, reasonable accommodation measures, co-design while also raising awareness through a range of education initiatives. The team also promotes accountability through data and monitoring initiatives.

3. HIGHLIGHTS

These are outlined against the Sub-Regional Disability Strategy 2017 – 2022 and includes our response to the recommendations from the Sub Regional Disability Forum.

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3.1 Focus Area One: Leadership

3.1.1 Sub-Regional Disability Forum

The Sub-Regional Disability Forum was well attended in Silverstream on June 21. There was a strong presence of disabled people who resonated strongly with the co-facilitation team consisting of a disabled and non-disabled facilitator.

The Forum affirmed the intended Disability SIP 3DHB work programme with the following recommendations:

- The 3 DHBs sign, promote and implement the Accessibility Charter
- To improve Communication and Information Access, the 3 DHBs
- Develop staff guidelines and mandatory staff training for all departments for improving communication and information access for the Disability and Deaf community.
- Review across all departments the current systems for communicating with and providing information to disabled people and their families against these guidelines.

A summary of the workshop is attached as Appendix One.

3.1.2 Disability Team

Five new staff members, including Rachel Noble as the General Manager, joined the Disability Team over the past 5 months. We now in a commendable position in having 50% disabled/non-disabled staff members working across the 3 DHBs.

We are driven by the UN Convention on the Rights of People with Disabilities, Equity and Better Health Outcomes. We value the disability community and disability leadership and understand the importance of visibility and the vital role health plays in citizenship for Disabled people.

The Disability Educator/Adviser role in currently vacant within the Wairarapa DHB. It is hoped an appointment will be made shortly.

3.1.3 Mental Health

Contributions are being made to the MHAIDS initiatives with a focus on accessible mental health services for disabled and deaf people. Deaf and disabled people experience mental health issues at a greater rate than the regular population. The principles of the Convention on the Rights of Persons with Disabilities needs to be embedded as part of the way services are planned and delivered as it includes the rights of people with psycho social impairments as well as those with intellectual disabilities. We will focus on the delivery of services that are targeted specifically for deaf and disabled people (as we do for Maori communities) in a manner that is effective.

We are currently engaging with a disability research agency in developing a research scope to define the problem and to suggest how the DHBs may progress with a view to informing the MHAIDS development work.

3.1.4 Using information to support the disability strategy

Unlike ethnicity, data on disability is not widely collected, reported nor subject to Statistical New Zealand for standardisation. Furthermore, the ability to view disability data at a more granular level (e.g. by ethnicity or locality) is limited. In the 3DHB sub-region, the development and implementation of Disability Alerts (Capital & Coast DHB in 2013 and Hutt Valley DHB in 2014) was an attempt to capture information on people with disabilities across the sub-region, while also being a support solutions tool for disabled people.

A working group with members of the SIP analytical team and the disability team are working to improve the information we have available about the sub-regional population with a disability. The aim of the working group is to develop a 'spine' of disabled people's NHIs that can be used to match to NHI-level datasets we have access to. This will enable an understanding of disabled people experiences across the health system including equity of access and equity of outcomes; not just the disabled population accessing secondary/tertiary care services as currently achieved through Disability Alert. The scope of this project includes all data systems for services currently funded or delivered by the sub-regional DHBs.

We are piloting this approach in CCDHB where we have Bilateral Data Sharing Agreements in place with major health service providers and look to rapidly roll this approach out across the sub-regional DHBs. We will be working with the Ministry of Health and be guided by the frameworks and existing work undertaken by Statistics New Zealand, the Human Rights Commission and Office for Disability Issues.

Defining exactly what data is required and how it will be used within the DHBs is a priority. This is part of the paper being developed and progressed to keep this work moving with urgency.

3.2 Focus Area Two: Inclusion and Support

3.2.1 Alerts

Disability Alerts were developed in 2013. The aim was to enable disabled people to communicate their reasonable accommodation needs to staff working with them. This information forms part of their electronic health record.

Discussions with wider group of stakeholders has identified that the Alerts provides us with the opportunity to illustrate how diversity is valued and invited from everyone by asking *"what do you need us to know in order for you to have the best experience here".* This can encompass disability, mental health, cultural, rainbow identity and language needs.

A recent quality review suggests only 22 percent of disability alerts identify the support/access need of the patient. This analysis first assessed the 7630 Disability Alerts created between 02/10/2013 and 06/10/2017. These Alerts were then split into five specific categories; Physical, Psychiatric, Sensory, Intellectual and Other. A random sample of 100 was then taken from each of these categories, producing a data set of 500 Disability Alerts which were then manually reviewed to determine whether or not a support or access need was identified within the alert. The sampling process suggested information is not being sought from the disabled person as some of the language is confronting and not related to disability support needs.

It is not clear if the current alerts provide value to the disabled person's experience in accessing healthcare services. Disability Alert information should be gathered and entered by hospital staff using information provided by the person.

The review has identified that knowledge of the existence of Disability Alerts is sporadic, and if accessed the reputation of being value add is low. The mechanism by which the detail contained in the Disability Alert is accessed on the electronic health record is also cumbersome. The existence of an alert is identified by a wheelchair symbol on the electronic patient record, which some would deem inappropriate.

The disability team is working with the SIP analytical team to better develop the disability alert platform, so that it will deliver disability and demographic related information. This phase is at an early stage and we are currently identifying key players to support effective implementation.

The intended outcomes of this work are:

- The Disability Alert is entered and updated across all platforms simultaneously.
- The Alerts are readily available across all platforms used within the DHB's.

- The Alert can be seen by staff across all three DHB's following only one process of entering the information.

Having a designated ICT person connected with this work is a positive advancement. We will engage with this person shortly.

3.2.2 Electronic Health Passport

The Electronic Health Passport project did not progress as hoped as the external contractor to lead the development of the project plan became unavailable. We have now engaged an internal team to rejuvenate the project. The Health and Disability Commission continue to act as a partner for this work.

Because of the history surrounding the many reviews we are proposing a **final review and development** phase. The purpose of this phase is to use available information to:

- Review current content
- Make required changes
- Agree format and style of paper based versions of the Health Passport
- Support the development of an electronic version of the Health Passport, one that is transportable, easy to access while ownership of information is retained by the person the information pertains to.

Having a designated ICT person connected with this work is a positive advancement. We will engage with this person shortly.

3.2.3 Supported Decision Making

Workshops have been held on Supported Decision Making. Supported Decision Making processes ensure disabled people are positioned to make decisions about their own health, a shift from the commonly used substituted decision making process.

We are working on a partnership with Otago University and the Health Promotion Agency to be mentored through the process of introducing Supported Decision Making concepts and practices as recommended by He Ara Oranga (Mental Health and Addiction Inquiry). It is also particularly relevant to those with Learning (Intellectual) disabilities.

Together with MHAIDS (and other yet to be identified partners) a proposal is being developed for the implementation of the programme which includes training and guidance across clinical teams, NGOs, and community organisations to assist with the paradigm shift this brings. External mentoring will be provided at no cost to the DHB.

We now have access to all the resources for this project. We are due to meet with our mentor during the week October 22 with our proposal.

3.3 Focus Area Three: Access

3.3.1 Accessibility Charter

A proposal is being developed to demonstrate how we can ensure information is accessible to disabled people in ways that promote their independence and dignity. This would include signing the Accessibility Charter meaning that the DHB would be making a commitment to working progressively over the next 5 years to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets the individual need to promote their independence and dignity.

This includes meeting the government's web accessibility and usability standards, ensuring information is available in a range of accessible formats, compliance with accessibility standards, responding positively

when customers make staff aware of instances of inaccessibility and adopting a flexible approach to interacting with the public and actively championing accessibility within the leadership team.

See separate paper.

3.3.2 Outpatients

The Outpatients Department in Wellington Hospital invited a small group of disabled people to provide feedback on the accessibility and usability of the department. A report was prepared and will inform their plans for the area. The exercise will soon be repeated in Kenepuru Hospital.

3.4 Focus Area Four: Health

3.4.1 Education

The three Educators reviewed the E-Learning module, identified areas of improvement and are currently developing new resources. They are now leading a national project in conjunction with other DHBs nationally (through the Capability Development work programme) to develop nationwide resources.

A 3DHB education plan is now being developed by the Educators and the Disability Team as we now have data and information from both staff members and the disability community. The Forum sent a clear message on their expectation for the education programme to train providers to 'get the basics right' around engaging with disabled people. We have also sourced research conducted in New Zealand about access to health care services by Maori Disabled people which is also informing our work.

4. MĀORI PARTNERSHIP AND ADVISORY GROUPS

The composition of the Sub-Regional Disability Advisory Group (SRDAG) is adapting to one where half of the members are selected by the Maori Disability Community. This means there will be a greater representation of Maori disabled people informing the implementation of the strategy as we strive to recognise Tiriti o Waitangi in our work. The Roopu led this process at the time when we were recruiting new SRDAG members. We are yet to have our first SRDAG meeting as a new Roopu.

There will be a joint meeting between SRDAG, the Maori Disability Roopu, and the Pacific Disability Steering Group on August 30 to discuss how the three groups can work more closely together to oversee the implementation of the outcomes from the Forum.

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5. APPENDIX ONE

Sub Regional 2017-2022 Disability Strategy Forum: Moving from We Know Best to Partnering with the Disability Community

21 June 2019, Silverstream Conference Centre, Hutt Valley

97 people registered for the forum. We estimate that 85 to 90 attended for some or all of the forum. 169 were initially invited, 24 formally declined. Approximately 16 to 20 of those who attended were DHB staff or providers from across the 3 DHB's. Therefore the large majority who attended were disabled people and their whānau.

The forum aims were to:

- Report progress to date on the Sub Regional Disability Strategy 2017-2022.
- Understand the shifts and current experiences within the 3 DHB Health Services.
- Review the proposed actions for the next 24 months and identify any gaps.
- Develop approaches to advance the planned actions.

Proposed Actions for the Next 24 Months

Leadership

- Align the SRDAG, Maori and Pacific Disability Steering Groups.
- Establish a co-design process for planning services.
- Provide advice across the 3 DHBs.
- Promote employment of disabled people across the 3 DHBs.
- Promote disability inclusion in all aspects of the health service model.
- Explore Research Projects.

Inclusion and Support

- Education programmes and resources for staff and community.
- Complete work on Supported Decision Making.
- Mental health services for Deaf and Disabled people.
- Disability Alerts - information to meet a person's support needs.
- Health Passport completed including electronic version.

Access

- Implement Accessibility Charter.
- Complete checking website accessibility.
- Continue Accessibility Audits.

Health

- Education programmes and resources for staff and community.
- Continue to collect information to see if services are getting better and to check quality.

Some Actions go across more than one Focus Area.

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The Big Global Picture – Rachel Noble

We know disabled people:

- Are not targeted by strategies for health promotion and disease prevention.
- Do not receive the mental health care they may need and seek.
- Are more likely to experience poverty and social exclusion → ill health → barriers.
- 2 x more likely to be at risk of violence and abuse, than the general population.
- Children with disabilities are 6 x more likely to experience violence and abuse.

Barriers Disabled People Face in Health:

- Stigma and stereotypes.
- Medical model assessment tools and standards that are not strength-based.
- Rehabilitation that is more hospital focused than locally available.
- Lack of physical access to buildings, equipment and services.
- Distance to health services.
- Lack of supported decision making.
- Lack of family and community support.
- Lack of accessible information.
- Relatives and caregivers acting as gatekeepers.
- Low income vs the high cost of medical services.

Actions to Resolve these Barriers:

- Access to health promotion and prevention services.
- Financial, geographical, physical, information and communication access.
- Respectful medical ethics.
- Culturally appropriate, sensitive gender and life cycle requirements.
- Scientifically and medically appropriate services of good quality.
- Start as early as possible.
- Adopt multidisciplinary assessments.
- Training for professionals and staff.
- Promote availability, knowledge and use of assistive devices and technology.
- Uses indicators and benchmarks to monitor progress.

Partnership in Practice - Adri Isbister, Deputy Director-General Disability, MoH

Accessibility initiatives are underway:

- DHBs are reporting to the Ministry on how DHBs know a patient has a disability. Development and use of an e-learning module for staff about interacting with a disabled person.
- Your 3 DHBs have great actions in this area.
- Accessibility Charter and Tick important.

MSD will soon be approaching DHBs to sign the Accessibility Charter. The Ministry of Health is developing actions on:

- Seclusion and restraint
- Mental health legislative reform
- Improving access to health services and health outcomes of disabled people.

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Analysis of the Workshop Feedback

The 21st of June forum included six workshops to identify key actions for the next 24 months. Participants were able to choose the workshop they attended and there were a mixture of disabled people, whānau, providers and DHB staff in each group.

Four workshops discussed one of the Focus Areas in the Sub Regional Disability Strategy:

- Leadership.
- Inclusion and Support.
- Access including the Accessibility Charter.
- Health.
- Recent experiences of Maori, Pacific and other disabled people and their families when they received health and support services from the 3 DHBs.
- Systems Change: How we develop a co-design process for the Sub Regional Disability Strategy? How do we incorporate the Disability Transformation into this Strategy?

General Themes from Across the Workshops

- There was general support for the Proposed Actions that Rachel Noble outlined at the forum. There was also a strong correlation between these Actions, the Workshop Feedback and the Sub Regional 2017-2022 Disability Strategy. People now want to see 'the pockets of brilliance consistent across all 3 DHBs'.
- Across the workshops a number of people raised serious issues about the need for more accessible communication and information for and with disabled people and their families, when health staff contact them.
- Lack of accessible transport and/or lack of money are key issues preventing some disabled people and their families accessing health services. Families are becoming more isolated and this is increasing their health risk. People wanted more staff who are mobile, can visit people in their homes and local community and provide these services outside of normal work hours.
- Developing accessible communication, information and transport options and addressing the cost of and getting to health services should be a priority.
- There are disabled people and families who are not aware of what's available: Where to go for help, who to ask, how to self-manage health needs.
- It is important to implement different levels of co-design and build trust between staff and the disability community so this can be effective.
- At the Forum we heard that health services need to be more culturally responsive to Maori and Pacific people: More services, traditional health practices available from the outset, more time 'to talk face-to-face' when receiving services, specific forums, simplify processes for raising issues, more culturally appropriate Disability Alerts and Health Passports should be developed, increased awareness of available health services, co-design of health services with Maori and Pacific people, taking action and reporting progress back to these communities.
- This feedback highlights that for Maori the treaty partnership should be at the forefront of our minds and while Workshop 5 identified mostly general themes for both Maori and Pacific people where their needs are aligned, it will also be important to identify any specific issues for each group.
- People supported signing, promoting & implementing the Accessibility Charter across the 3 DHBs. The Access Workshop thought this must include consultation with the disability community, statistics to measure progress, be culturally appropriate, resolve language barriers & ensure people are not scared to complain.

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Key Actions Suggested in the Forum Workshop

Access to Health Services

- Important Health Services are Person/Whānau centred.
- Some disabled people want staff to be more mobile to visit people in their homes and local community and outside normal work hours.
- Developing accessible transport options and making hospital parking easier for disabled people and their families.
- Addressing the cost of and getting to health services.
- Signing, promoting and implementing the Accessibility Charter across the 3 DHBs.

Communication and Information Access

- Tailor communication and information that people receive about their health service to the specific access needs of individual disabled people. Without accessible information, people cannot understand things, communicate or make decisions.
- The Health Passport should be electronic and identify people's communication and information needs/preferences and staff should refer to this before making contact so that are aware of any specific access requirements.
- Having a contact point for clinics and other services that is either person to person, by phone, text or through an interpreter.
- Mandatory staff training so departments can provide more accessible communication and information and are aware of the impact of lack of accessible transport and/or lack of money for accessing health services.

Community Links

- Improving the links between health, councils, government, SRDAG, Maori and Pacific groups. The pockets of brilliance need to be consistent across all 3 DHBs.

Services for Maori and Pacific People

- Better Navigation and Access: Where to go for help, who to ask, how to self-manage health needs, more culturally appropriate Disability Alerts and Health Passports should be developed.
- Simplify processes that enable Maori and Pacific people to raise their issues and have their complaints addressed.
- More forums specifically for Maori and Pacific people.
- Co-design of health services with Maori and Pacific people - more services, traditional health practices, face-to-face, training required, health passport, etc.
- More ACTION taken to implement the 3 DHB Disability Strategy.
- Resolve issues and report progress back to the Maori and Pacific people.
- Home support providers more consistent, better resourcing and training for home support workers/carers.
- Housing forum to discuss housing for Maori and Pacific disabled people.

Systems Change (Co-design/Disability Transformation)

- It is important to implement different levels of co-design:
    - Small focus groups with disabled people and their families giving feedback about specific health services from a user perspective.

  - Using the SRDAG, Maori and Pacific Groups and regular forums to involve disabled people and their families at the strategic level.
  - Community-based forums for specific groups (e.g. Maori, Pacific people, younger people & their families, older people, at Marae, etc.). One size doesn't fit all.
  - SRDAG building an ongoing working relationship with the DHB staff on key projects and being included in developing the Disability SIP work programme.
  - More targeted discussions throughout the year on key initiatives e.g. Children, youth and older people, etc.
- In order for co-design and the disability transformation to be successful we need to develop solutions that build trust between the disability community and health staff at all levels - without this trust it is difficult for co-design to be effective. All parties need to value the contribution that each can make to the development of effective health services.
- DHBs making space for the voice of disabled people at all levels of the 3 DHBs: Governance (e.g. DHB), local community advisory groups (e.g. DSAC), increasing disabled staff employed at management and operational levels.
- Staying future focused - Co-design, Implementing the Treaty and UNCRPD.
- Sharing and collaborating across the 3 DHBs and improving communication with specific groups of disabled people is essential.
- Disability Data Collection is required to provide the evidence base that the changes that are being made are making a difference.

6. JANET ANDERSON-BIDOIS HAD THIS TO SAY ABOUT HUMAN RIGHTS AND HEALTH:

Goals:

- Meaningful and active participation of disabled people must be embedded in all stages of the health system. This includes involvement in legislative, policy and strategy development; governance and monitoring arrangements; implementation and delivery of services.
- The system must be equitable and inclusive and approaches and responses should fully reflect, involve, value and support all people regardless of sex, age, sexual orientation, disability, gender identity, race, colour or ethnicity.
- The human right to health is a fundamental human right for <u>all</u> people. Significant changes are required to ensure that disabled people have the same opportunities to attain the highest possible standard of health as others.
- We all have a role to play in making these changes happen.