DISABILITY SERVICES ADVISORY COMMITTEE

PUBLIC
Agenda

10 September 2018, 10.00am to 12.30pm
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia				10am	
1.2	Apologies	**RECORD**	F Wilde			
1.3	Continuous Disclosure - Register of Interest	**ACCEPT**	F Wilde			
1.4	Confirmation of Draft Minutes from 18 June 2018	**APPROVE**	F Wilde			
1.5	Terms of Reference	**APPROVE**	F Wilde			
1.6	Matters Arising	**NOTE**	F Wilde			
1.7	Action List	**NOTE**	F Wilde			
2 UPDATE						
	Verbal Update on key issues including: • Memorandum of Understanding • Integration of MHAIDS		Rachel Haggerty Julie Patterson		10.15am	
3 DECISION						
3.1	Regional Alcohol and Other Drugs Request for Proposal Update Report		Rachel Haggerty Rawinia Mariner		10.30am	
3.2	Suicide Prevention Project across 3DHBs		Rachel Haggerty Rawinia Mariner Rod Bartling		10.45am	
3.3	Rolleston Street Development Project 3.3.1 Memorandum of Understanding		Te Pare Meihana		11.15am	
4 DISCUSSION						
4.1	Whole of Life Needs Assessment Service Coordination Approach		Emma Hickson		11.30am	
4.2	Update on the Implementation of Disability Strategy		Bob Francis Emma Hickson		11.45am	

DATE OF NEXT MEETING 3 DECEMBER – CSSB LECTURE ROOM, CSSB BUILDING WAIRARAPA HOSPITAL, MASTERTON

DISABILITY SERVICE ADVISORY COMMITTEE

Conflicts & Declarations of Interest Register

UPDATED AS AT 18 JUNE 2018

Name	Interest
Dame Fran Wilde *Chairperson*	• Deputy Chair, Capital & Coast District Health Board (includes HAC) • Chair, Remuneration Authority • Deputy Chair NZ Transport Agency • Chair Wellington Lifelines Group • Director Museum of NZ Te Papa Tongarewa • Member Whitireia-Weltec Council • Director Business Mentors NZ Ltd • Director Frequency Projects Ltd • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair Wellington Culinary Events Trust • Chair National Military Heritage Trust
Yvette Grace *Deputy Chair*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Deputy Chair, 3DHB combined Disability Support Advisory Committee • Chair, Hutt Valley District Health Board Community and Public Health Advisory Committee • Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust • Husband, Family Violence Intervention Coordinator Wairarapa DHB • Husband, Community member of Tihei Wairarapa Alliance Leadership Team • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt
Mr Andrew Blair *Member*	• Chair, Capital & Coast DHB • Chair, Hutt Valley District Health Board • Chair, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Owner and Director of Andrew Blair Consulting • Advisor to the Board, Forte Health Ltd Christchurch • Former member of the Hawke's Bay DHB (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO, Acurity Health Group Limited
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board

Name	Interest
	• 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.
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board (includes HAC) • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Shareholder in Green Cross Health • Step son works in middle management of Fletcher Steel • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Jane Hopkirk *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB, Community Public Health Advisory Committees & Disability Support Advisory Committees (30 March 2016) • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (23 February 2016)
Kim Smith *Member*	• Employee of Te Puni Kokiri • Trustee, Te rūnanga Hauora o Rangitāne
Lisa Bridson *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Hutt City Councillor • Chair, Kete Foodshare
Prue Lamason *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Deputy Chair, Hutt Mana Charitable Trust • Deputy Chair, Britannia House – residence for the Elderly • Councillor, Greater Wellington Regional Council • Deputy Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB Hospital Advisory Committees • Surgeon at Wairarapa Hospital

Name	Interest
	• Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (*15 September 2016)*
Mr Derek Milne *Member*	• Member of 3DHB CPHAC/DSAC • Brother-in-law is Chairman of Health Care NZ • Daughter GP in Green Cross Health Onehunga, Auckland
Fa'amatuainu Tino Pereira *Member*	• Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Councillor at Large – National Council of the Muscular Dystrophy Association • Member, Executive Committee Wellington Branch MDA NZ, Inc. • 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) • Wife, Research Fellow, University of Otago Wellington
Sue Driver *Member*	• Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (base isolators, Wgtn Hospital) • Advisor to various NGOs
'Ana Coffey *Member*	• Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Councillor, Porirua City Council

Name	Interest
	• Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation
Bob Francis *Member*	• Chair, Masterton Medical Limited • Chair, Bromedical Services New Zealand Limited • Chair, Sub-Regional Disability Advisory Group • Chair, Pukata Mount Bruce • Chair, Wings over Wairarapa • Chair, Te Kauru Upper Ruamahanga River Management Plan

DRAFT Minutes of the 3DHB DSAC
Held on Monday 18 June 2018 at 10am
Board Room, Pilmuir House, Hutt Valley District Health Board

PUBLIC SECTION

PRESENT:

BOARD	Dame Fran Wilde (Chair) Ms Lisa Bridson Ms Eileen Brown Ms Prue Lamason Mr Derek Milne *via video conference* Ms Jane Hopkirk Mr Alan Shirley *via video conference* Ms Sue Driver Ms 'Ana Coffey *(arrived 10.45am)* Mr Bob Francis Dr Tristram Ingham
STAFF:	Ms Julie Patterson, Interim Chief Executive, Capital and Coast DHB (CCDHB) Ms Dale Oliff, Interim Chief Executive, Hutt Valley DHB (HVDHB) Ms Adri Isbister, Chief Executive, Wairarapa DHB (WrDHB) *via video conference* Ms Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB Mr Nigel Broom, Executive Leader, Planning and Performance Ms Catherine Khoo (Minute Secretary)
PRESENTERS:	Emma Hickson, Director, Nursing for Primary & Community (Item 2.2) Rod Bartling, Service Improvement Director, Mental Health & Addictions (Item 3.1)
GENERAL PUBLIC:	One members of the public was present. The member of public left the meeting at 11.13am.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

The Karakia was led by Tristram Ingham. Committee Chair, Dame Fran Wilde, welcomed the public, members and the DHB staff.

1.2 APOLOGIES

Apologies received from Andrew Blair, Yvette Grace, Sue Kedgeley, John Terris, Kim Smith, Tino Pereira, and Helene Carbonatto

1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS

No changes were registered.

1.4 CONFIRMATION OF PREVIOUS MINUTES

It was **noted** that Adri Isbister was present at the previous meeting and not an apology.
Derek – community circles. (8:40)

1.5 MATTERS ARISING

1.6 ACTION LIST

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

1.7 TERMS OF REFERENCE

Quorum to be amended to include at least 2 members from the three subcommittees – Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board(s) (MPB).

Discussion was held that this is a key strategic issue that all the Boards should know about.

Action:

1. Committee Secretary to amend the Terms of Reference.

2 FOR INFORMATION

2.1 MENTAL HEALTH INQUIRY SUBMISSIONS ONE AND TWO

The paper was taken as **read**.

The Committee:

(a) **Noted** the Inquiry consultation process and feedback from the Pacific attendees;

(b) **Noted** the feedback for the Mental Health Inquiry from the MHAIDS workforce; and

(c) **Noted** the final submission made to the Inquiry by Wairarapa, Hutt Valley and Capital and Coast District Health Boards

2.2 DISABILITY STRATEGY UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the review of education planning and the training in the United Nations Convention of the Rights of the Disabled Person;

(b) **Noted** progress on the New Zealand Sign Language (NZSL) Plan;

(c) **Noted** the strategic issues arising: Interim Clinical Governance Group (ICG), CCDHB and HVDHB; and

(d) **Noted** the update on Annual Planning priorities.

Bob Francis, the Chair of SRDAG advised of further activities:

I. Planning is underway for the 4th November Forum. The major focus is Disabilities with Maori and Pacific. Consumer groups, the Minister, CEs and the Chairs were invited to the Forum. The invitation will be extended to the 3DHBs DSAC members as well.
II. The June Sub Regional Disability Advisory Group meeting has been postponed to July.
III. Health passport is being prepared for an 18/19 relaunched.

2.3 Strategic issues arising: Clinical Governance Group (ICG), CCDHB and HVDHB

It was recommended that the CEs with their alliance leaderships and the ELT ensure that the whole patient journey (either in the community or in hospital) should be the focus instead of focussing on a specific issue at a time. The 3CEs agreed.

3.2 Dashboard of indicators

Dashboards will be available shortly and will incorporate the 3DHBs together and separately. There are four domains – infrastructure, system performance, experience and outcome.

5. Review of Work Plan and Prioritisation of Activities for 2018/19 against the Disability Strategy

Work plan to come to DSAC after the subcommittees. The strategy remains unchanged, but we need to make sure that we have a sustainable plan for the allocated resources within the identified time period. There is no change in financial allocation for the 3DHBs.

Action:

1. Forum organiser to send an invite to the 3DHB DSAC members.
2. Committee Secretary to organise a letter of appreciation and a get well card for Pauline Boyles.
3. On 2.3, a detailed update/report on the patient journey work to be provided at a future meeting.
4. The Disability Dashboard is to be presented at a future DSAC meeting.

3 FOR DISCUSSION

3.1 REPORTING PROGRESS OVER THE LAST YEAR ON THE MENTAL HEALTH AND ADDICTION WORK PROGRAMME AT HUTT VALLEY DHB

The paper was taken as **read**.

The Committee:

a) **Noted** that a mental health and addiction programme of work was established in early 2017 after a stocktake of current activity was undertaken;

b) **Noted** that two additional staff were employed to support this programme of work and to manage the commissioning activity related to functions undertaken by Capital & Coast DHB being transferred to Hutt Valley DHB;

c) **Noted** that in June 2017 the Board approved ongoing annual funding of $1,394,000 to help address service gaps that become obvious as the work programme advanced;

d) **Noted** the considerable progress made across the breadth of the work programme; and

e) **Noted** the areas of the work programme that did not advance as well as possible or planned.

General Discussion

Members noted that the 3DHB MHAIDS services as a huge help because it is cross-boundary, providing an underlying system to ensure a joined-up service across the three districts. Each DHB has its own challenges and all are working to raise their baseline performance, so we can move strongly and collectively. The Mental Health Inquiry could result in significant changes from July 2019.

4.1 Community Team Caseload Review

Members noted the importance of caseload monitoring, that people do not feel pressured to change and that primary care and community services can provide support. It was noted that the DHBs are working with both RPH and Corrections.

6.3 Mental Health and Addictions Strategy

There was discussion regarding the consultation process for the Mental Health strategy. There had been community consultation over two years and the strategy reflects its findings.

3.2 WAIRARAPA DHB MENTAL HEALTH AND ADDICTION SERVICES REVIEW

The paper was taken as **read**.

The Committee:

a) **Noted** that in February 2018 the Wairarapa DHB Board approved the Wairarapa Mental Health and Addiction Services Review; and

b) **Noted** the progress to date on the Review as per this report.

The WrDHB Mental Health and Addiction review report will be presented at the July Board Meeting. The importance of Pacifica stakeholder engagement was noted.

Action:

1. Nigel B to confirm what Pacifica individual feedback was received.

3.3 PROGRESSING A 3DHB ADDICTIONS MODEL OF CARE IN THE 2018/19 FINANCIAL YEAR

The paper was taken as **read**.

The Committee:

a) **Noted** the proposed project to develop a 3DHB Addictions' Model of Care; and

b) **Endorsed** the inclusion of this project on the 2018/19 Annual Plan.

Moved: Lisa Bridson **Seconded:** Roger Blakely **Carried:**

Members discussed the importance of a whole of system approach (including whānau), and understanding of international and national trends and evidence. It was noted there are budget provisions and it is part of our 3DHB health planning. It was also noted that additional funding may be required.

3.4 SUPPORTED HOUSING INITIATIVE CCDHB

The paper was taken as **read**.

The Committee:

a) **Noted** the update on the multi-agency initiative to create a supported housing initiative;

b) **Endorsed** the direction of the multiple agencies working together, especially Housing New Zealand as they go through their public consultation process;

c) **Endorsed** CCDHB services providing support to this initiative; and

d) **Noted** the additional funding maybe required for additional staff in the intensive outreach programme (Te Roopu Wahroaroa) but at this time this is unclear.

Moved: **Bob Francis** **Seconded:** **Eileen Brown** **Carried:**

Members noted the importance of housing, including the needs of people with mental illness and addictions, and those with disabilities who are unable to live independently because of limited social housing options. The Lead Agency is the Wellington City Council with Housing NZ. It was noted that 2020 is a long time-frame and the model of care is an important part of what we need to do as a system.

4 OTHER

4.1 RESOLUTION TO EXCLUDE THE PUBLIC

The Committee **noted** and **resolved** to:

(a) **Agree** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers.	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers.	
Mental Health Inquiry Submissions One and Two	Protect the privacy of natural persons, including that of deceased natural persons.	9 (2) (a)

The meeting closed at 12.30pm.

5 DATE OF NEXT MEETING

10 September 2018, 10am, Level 11 Board Room, Grace Neill Block, Wellington Regional Hospital.

Terms of Reference

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

September 2018

Compliance	In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Boards shall establish a Disability Support Advisory Committee (hereinafter called "The Committee") whose members and chairperson shall be as determined by the Boards from time to time. The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy. The Committee shall comply with the Boards' Standing Orders for Statutory Committees. These Terms of Reference: • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Terms of Reference dated 30 July 2017; • are effective from March 2018.
Functions of the Committee	The functions of this Committee are to give the advice to the full Board of each DHB on: • the needs, and the factors that may affect the mental health and addiction, and disability status, of the residents of the DHB; • the mental health and addiction, and disability support needs of the resident population of the DHB; • priorities for the use of mental health and addiction, and disability support funding. The aim of the Committee's advice is to ensure that each DHB maximise the independence of the people with mental health and addiction, and disability support needs within the DHBs resident population through: • the range of disability support and mental health and addiction, services the DHB has provided or funded or could provide or fund for those people; • the service interventions the DHB has provided or funded or could provide or fund for the population; • policies the DHB has adopted or could adopt for those people. The Committee's advice will be consistent with the New Zealand Health Strategy. The Committee shall present its findings and recommendations to the Boards for their consideration.
Objectives and Accountability	The Committee shall: • monitor the disability support and mental health and addiction, needs of each DHB resident population providing advice to each Board; • provide advice to each Board on the implications of mental health and addiction, and disability related needs and status for planning and funding of nation-wide and sector-wide system improvement goals ; • provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and wellbeing outcomes for the target population in each district;

	• provide advice to each Board on priorities for improvement and independence of people experiencing mental health and addiction, and disability as part of the strategic and annual planning process to improve wellness outcomes and independence within each district; • provide advice to each Board on strategies to achieve equity in modifiable mental health and addiction, and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction, and addiction conditions and people with disabilities; • monitor and advise each Board on the impact and effectiveness of disability support and mental health and addiction services being provided for the resident population of each DHB; • provide advice to each Board on the delivery of health services accessed by people with mental health and addiction, and disabilities including how it can effectively meet its responsibilities towards the government's vision and strategies for both populations; • identify issues and opportunities in relation to the provision of mental health and addiction, and disability services that the Committee considers may warrant further investigation and advise the Board accordingly; • ensure that this Committee is appropriately engaged with, and informed by, the other advisory groups of each DHB; • identify when 'expert' assistance will be required in order for the Committee to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • report regularly to each Board on the Committee's findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	The following authorities are delegated to the Committee to: • require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • interface with any other Committee(s) that may be formed from time to time.
Meetings	The Committee shall hold no less than four meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Boards.
Quorum	A quorum is a majority of Committee members, and must include at least one member from each Board and two members from the subcommittees: Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board (MPB).
Membership	Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.
Procedure	Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 18 June 2018					
2.2	**Disability Strategy Update**	1. Forum organizer to send an invite to the 3DHB DSAC members. 2. Item 2.3 Strategic issues arising: Clinical Governance Group (ICG), CCDHB & HVDHB – a detailed updated/report on the patient journey to be provided at a future meeting.	Bob Francis Rachel Haggerty	1. Forum has been postpone to March/April 2019. Invitations will be sent to DSAC members. 2. The Whole of Life NASC Report is included in the September 2018 DSAC Agenda.	Closed
3.2	**Wairarapa DHB Mental Health & Addiction Services Review**	1. Nigel Broom to confirm what Pasifika individual feedback was received.	Nigel Broom	This is confirmed.	Closed
DSAC Public Meeting 18 March 2018					
2.2	**Mental Health and Addiction: Joint Work Programme Update**	Sharing the Consumer Leadership presentation with the 3DHB Consumer Advisory Groups and Citizens Health Council (CHC) and obtain their feedback on how it fits with CHC's framework and recommendations.	SIP	On the CHC Agenda October 2018.	Closed
3.1	**Report on UK Research Trip: Citizen Led Social Care and NHS Transformation**	The Executive to develop proposals to identify how each DHB can implement the Community Circles approach.	SIP	CCDHB is leading a trial on Community Circles with a specific focus on disability and ageing in 2018/19. The findings will be shared across the DHBs.	Closed

Closed since last meeting – 18 June 2018

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 18 June 2018					
1.7	**Terms of Reference**	Quorum to be amended to include at least 2 members from the three subcommittees – Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board (MPB).	Committee Secretary	Updated TOR for Committee's approval on September Agenda.	September
2.2	**Disability Strategy Update**	The Disability Dashboard to be presented at a future DSAC meeting	SIP	Disability Dashboard is on September Agenda.	September

	DSAC **DISCUSSION PAPER**
	DATE: 25 August 2018

Author	Jeremy Tumoana, Regional Portfolio Manager MH&A
Endorsed by	Rawinia Mariner, General Manager Mental Health and Addictions. SIP
Subject	Regional AOD RFP Update Report

RECOMMENDATION

It is recommended that the Committee:

a) **Notes** the outcome of the Regional AOD RFP and endorse the recommendation to proceed to contract with Salvation Army NZ

b) **Endorses** to their Board that the service proceed through the normal delegations for their DHB.

1. PURPOSE

The purpose of this paper is to update the Committee on the progress for the Regional AOD RFP to contract residential treatment services, and the intended outcomes for our populations.

2. BACKGROUND

The number of residential beds and the types of community services provided for Alcohol and Other Drug (AOD) treatment (including intensive residential treatment) in the Central Region have been in place for over a decade, with limited service developmental change since service agreements were first established.

Over the past decade, local DHBs have improved their capability and capacity at a local level, by developing specialist local teams and services. However, the regional community-based (NGO provided) intensive residential treatment services have not evolved in line with these developments.

The current regional AOD service delivery model contains several significant inconsistencies in the area of pricing, service provision, configurations and sustainability. This can be largely attributed to the organic evolution of the NGO AOD service model which has been primarily based on a wide spectrum of peoples changing needs over time.

2.1. Development process

The Central Region undertook a wide-ranging engagement process to seek information to inform the development of the Alcohol and Other Drug (AOD) Service Model (see Figure 1.). This included mental health and addiction providers, people who use the service and their whanau, clinical inpatient and community teams, and other stakeholders. It also involved Māori specific Hui, and Pacific forums.

2.2. Our Service Expectations from the RFP

The key objective of this RFP was to commission intensive residential addiction services collectively, across the five DHB's. Of particular importance was the need to ensure equity of access and outcomes for Maori who are the highest users of AOD residential treatment services.

The centralised tender process sought the following outcomes:

- The delivery of cost effective, quality AOD services within the Central Region.
- Encouraging organisations to be innovative and demonstrate system thinking.
- Improving the selection of suppliers to provide suitable flexible services for maximising benefits to people using the services.

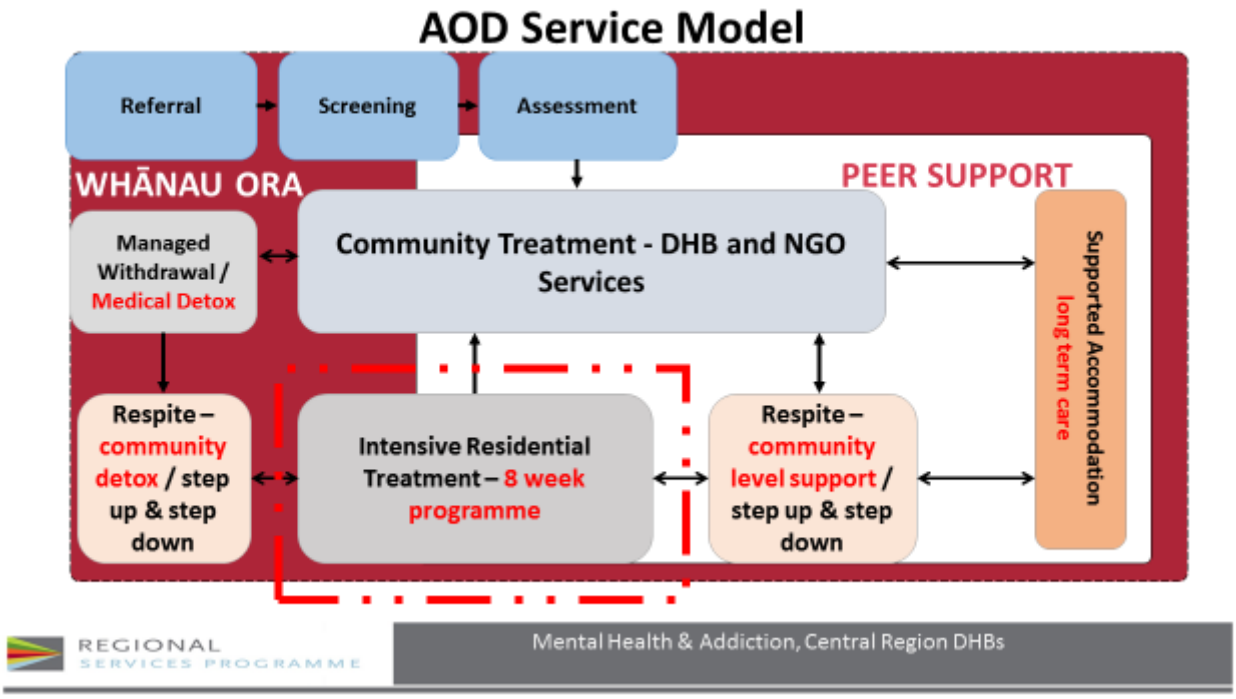
- Strengthening the association between the use of cost plus contracts and the negotiation procedure.
- The mix of AOD residential and community services is supported with an appropriate funding model across the central region.
- Resources are rationalised to deliver a sustainable range of AOD residential and community services in-line with best practice approaches.

2.3. Central Region AOD Service Model

A Service Specification for this RFP was developed, based on our regional Service Model and model of care approach, using a co-design process with AOD stakeholders, clinicians, and consumers. This regional model was initially developed in 14/15 by the regional leadership group and was endorsed by Central Region DHBs in 2015 (see Figure 1. Below).

This RFP focused solely on the intensive residential treatment 8 week programme outlined (in red) in the following diagram.

Figure 1. Central Region AOD Service Model (2015)



2.4. Referral Pathway

There is an agreed referral pathway. It has the following attributes:

- Access into the 8 week programme is via self-referral or referral from a community level AOD Service.
- Shared care planning starts from the initial referral and includes assessment for eligibility or preparedness for treatment
- Discharge planning is a collaborative process between the Service and DHB of Domicile Services
- Whanau engagement is core to the care planning for each individual

After the period of residential treatment is completed, the person would return to the care of a community service provider within their respective region, and the ongoing care would be a shared collaboration between The Salvation Army NZ and community services. Therefore, engagement with the community provider would occur before and after residential treatment.

2.5. Outcomes we are seeking from the Service

In addition to reducing alcohol and drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. Individual outcomes for people depend on the extent and nature of the person's problems, the appropriateness of the treatment and related services used to address those problems. Key outcomes from this change include:

- The right care at the right time in the right place.
- Reducing inequalities:
    - Tackling inequalities by also working with community partners to reduce health inequalities
- Effective management of resources at a local level:
    - Making the best use of shared resources to deliver high quality, integrated and personalised services, that improve the health and wellbeing of people whilst providing value for money.

Services are meeting the DHB population needs by providing the right care, in the right place at the right time for each individual, so that people:

- Have better access and availability to services for people and their whanau who need AOD help as a result of the AOD issue
- Are assessed, treated and supported at home and within the community wherever possible and are admitted to intensive AOD treatment facility only when clinically necessary
- Are transitioned from intensive AOD treatment facility as soon as possible with support to recover and regain their independence at home and in the community
- Experience a smooth transition between services
- Have their care and support reviewed regularly to ensure these remain appropriate
- Are safe and protected

3. PROCUREMENT APPROACH

A Regional Procurement Plan (28 Nov 2017) was approved by the 5 District Health Boards for the purchase of Alcohol and Other Drugs (AOD) Residential and Community Services for five (5) of the six (6) DHB's in the Central Region – Capital & Coast, MidCentral, Hutt Valley, Whanganui and Wairarapa DHBs'.

Hawkes Bay DHB excluded themselves from the Request for Proposal (RFP) process for the Central Region preferring to fund the adult intensive residential treatment beds from within in their Provider Arm Facility (Springhill), for their population, in preference to any other provider from 1st November 2018.

3.1. CCDHB lead facilitator of RFP process

CCDHB as lead DHB undertook a Request for Proposal (RFP) process in Feb 2018 via a nationally notified tender via GETS (Government Electronic Tendering Service). The evaluation process concluded in June 2018.

3.2. The Selection Process and Outcome

A total of seven (7) proposals were received in response to the regional residential treatment RFP. All seven proposals were evaluated according to the MBIE Procurement Guidelines.

A Probity Assurance Partner guided any issues that arose in terms of potential bias or conflict of interest during the process of moderation and interviews.

As a result of the evaluation process, a preferred provider has been selected.

3.3. Contract outline

A series of co-design meetings have been held with the provider with the final preparation of contract documents almost complete.

The funding for this service is met by the five participating DHBs from across the central region. The commitments are made within the delegation of each DHB. For our three DHBs the commitment is within funding budgets for each DHB. The process has reinvested from existing services to this redeveloped service, making better use of resources.

3.4. Summary of components within the contract

Service Specification: This was co-designed with The Salvation Army NZ and core Service components agreed in negotiations were included.

Evaluation: The service will be formally evaluated over the 3 year period of the contract.

Utilisation and Wait times: We agreed to monitor utilisation rates by DHB of Domicile on a regular monthly basis to ensure the Service remains on track to meet the agreed annual volumes of 7300 occupied bed nights for an average of 130 clients per annum. This will ensure each DHB is maximising its relative spend for Service and agreed outcomes for the total annual volumes. We will also monitor wait times that are longer than 4 weeks, and rates of referrals by DHB on a case-by-case basis to ensure access to service is maintained at an agreed level.

Regional Reference Group: In collaboration with the Regional Portfolio Manager and the 6 DHB's the Salvation Army will establish a regional reference group to monitor the quality and outcomes of the service, especially during the first 12 months.

4. Next Steps

The new service will commence on 1 November 2018. There are arrangements in place for Central Region clients still in treatment in other AOD residential facilities after 1 Nov 2018, in order to support the completion of care for these clients without them needing to change providers

The development of regional model of care for addiction services is in the priority work programme over 2018/19.

	DSAC **DECISION PAPER**
	28 August 2018

Author	Trish Davis, (National Operations Manager Intellectual Disability-on secondment to Mental Health and Addictions, SIP) Rawinia Mariner, General Manager, Mental Health and Addictions, Strategy Innovation and Performance Rod Bartling, Director of Mental Health Service Improvement
Endorsed by	Rachel Haggerty, Director Strategy, Innovation and Performance
Subject	**PREVENTING SUICIDE AND SUICIDAL BEHAVIOUR IN OUR COMMUNITIES**

RECOMMENDATIONS

It is recommended that the Disability Advisory Committee:

a) **Notes** that suicide and suicidal behaviour is a significant issue for our community but it is our Maori community who carry the greatest burden experiencing suicide at a rate of 18.9 compared to 10.3 per 100,000.

b) **Notes** there is funding to support the development of a suicide prevention work programme in 2018/19.

c) **Recommends** to their respective Boards the development of a whole-of-system approach to suicide prevention that extends beyond the current commitment to community based suicide prevention and postvention activity and focuses on the touch points of health services in the lives of those most at risk.

d) **Recommends** to their respective Boards to endorse the development of a response that has a zero-tolerance for suicide, seeing suicide as a preventable event in people's lives.

1. PURPOSE

The purpose of this paper is to seek the support of the Disability Support Advisory Committee for the development of a whole-of-system 3DHB approach to suicide prevention that considers suicide and suicidal behaviour as a preventable event.

This work will be led by Capital and Coast District Health Board (CCDHB) as part of the 3DHB work programme.

2. BACKGROUND

Every suicide is a tragedy, for their families and the communities of Aotearoa/New Zealand. Suicide, self-harm and distress calls to New Zealand Police for suicide risk are all indicators of distress in our community. Coronial Services (NZ) provisional suicide numbers are published quarterly. These provisional numbers are validated by the findings of coroner court proceedings. The validated numbers are used by the Ministry of Health statistics resulting in a three year delay in published statistics.

3. SUICIDE AND SELF-HARM IN NEW ZEALAND

Provisional figures published by the Coronial Services show NZ has had the highest number of people ever (668) died by suicide in 2017/18. Sadly, it is also the highest rate ever at 13.67 per 100,000 of population.

In addition to this over 2,500 will be hospitalised after seriously harming themselves[1], and tens of thousands will call the NZ Police in distress for themselves or their friends or families.

It is Māori who carry the greatest burden are most over represented in our suicide numbers. In 2014, Māori had a suicide rate of 18.9, compared to our Pākeha population at 10.3 and Pacific at 9.9 per 100,000. Furthermore it is our youth who are most adversely affected. New Zealand has one of the highest youth suicide rates in the developed world[2]. Our Māori and Pacific youth having higher rates relative to Pākeha youth.

Consistent with international patterns, there is also a significant gender disparity in suicides. Overall men are 2.8 times more likely to die by suicide than women[3]. For men, suicide mortality (17.0) is almost double that of motor vehicle accidents (9.8) per 100,000 of population.[4] This difference is declining as a greater number of women are dying by suicide with the difference having fallen from 3.4 times the rate five years ago.

Other communities significantly at risk are victims of intimate partner violence, child abuse and neglect, mothers of newborn children, the prison population, those who have been in Oranga Tamariki care and our LGBTQI[5] communities particularly those who are excluded from their families and communities.

But it is mental health service users who account for 46%[6] of all suicide deaths in 2014[7], the largest population by number, though they only make up 2.6% of the total population. This reflects not only their mental health status but also their increased vulnerability to the risk factors associated with suicide, including unemployment and social exclusion.

The communities at greater risk of suicide and suicidal behaviour are communities that we deliver a range of health services to, in their homes, in their communities, primary care settings, youth clinics and specialist services. These all present significant opportunities to consider how we strengthen our focus on suicide prevention and postvention approaches across the health system.

3.1 The link with intimate partner violence and child abuse and neglect

There is also ongoing concern about the link between intimate partner violence and child abuse and neglect to suicide and suicidal behaviour. This is especially evident for young Māori who have experienced and witnessed family violence[8]. The Australian Institute of Family Studies report 'Effects of child abuse and neglect for children and adolescents sums up the evidence thus:

- 'Research suggests that abuse and neglect doubles the risk of attempted suicide for young people (Brodsky & Stanley, 2008; Brown et al., 1999; Evans, Hawton, & Rodham, 2005). The systematic review by Evans and colleagues found a strong link between physical/sexual abuse and attempted suicide/suicidal thoughts occurring during adolescence.
- Perkins and Jones (2004) found that 31% of a physically abused group of adolescents had suicidal thoughts compared to 10% of a non-abused group.
- Brodksy and Stanley (2008) found that risks of repeated suicide attempts were eight times greater for youths with a sexual abuse history.'

Our DHBs support and treat the victims of intimate partner violence and child abuse and neglect including the DHB Violence Intervention Programmes which advocates for early intervention and recognises that victims of abuse are high users of health services. This is a further touch point for those who are at risk of suicide and suicidal behaviour.

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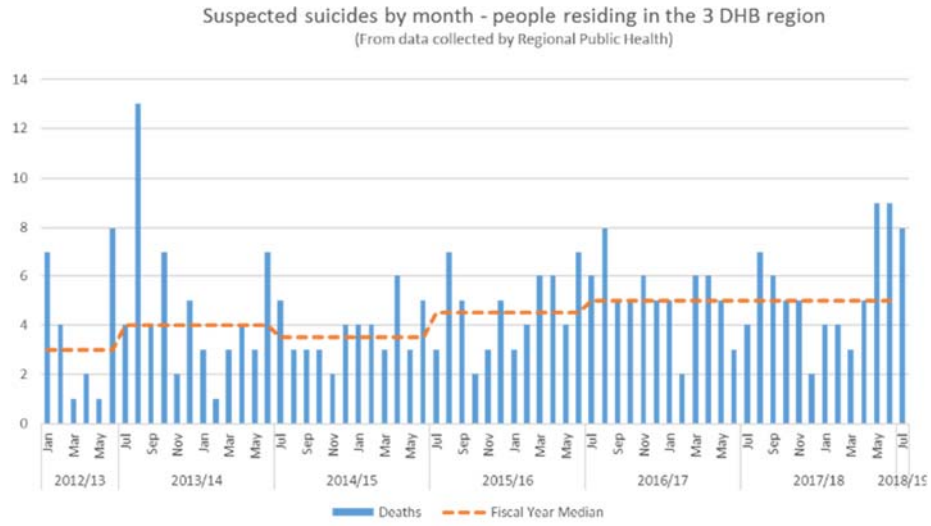
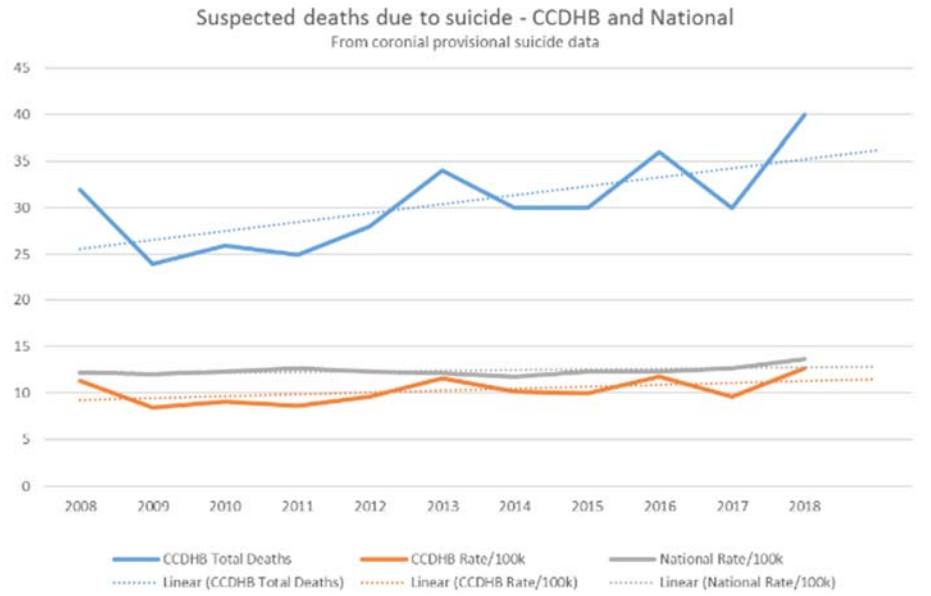
[1] Ministry of Health. (2014) Suicide Facts: Deaths and intentional self-harm hospitalisations 2011. Wellington: Ministry of Health. pp iii.
[2] Ministry of Health. (2013) New Zealand Suicide Prevention Action Plan 2013–2016. Wellington: Ministry of Health. pp iii
[3] Ministry of Health (2014) *Suicide Facts 2011.* pp3
[4] Ministry of Health. (2014) Mortality and Demographic Data 2011. Pp 5.
[5] Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
[6] This number includes 8 undetermined deaths of Mental Health Services Users in the total of 285.
[7] Ministry of Health. (2017) *Office of the Director of Mental Health. Annual Report 2013.* Wellington: Ministry of Health. pp 50.
[8] Suicide Mortality Review Committee (2016). *Ngā Rāhui Hau Kura: Suicide Mortality Review Committee Feasibility Study 2014–15*. Report to the Ministry of Health, 31 May 2016. Wellington: Suicide Mortality Review Committee.

3.2 Death by suicide and suicidal behaviour is a significant issue across the 3DHBs

From July 2017-30 June 2018 the coroner identified 61 deaths by suicide across the three DHBs. Of the 61, 40 were from the CCDHB region, 13 from HVDHB and 8 was from WRDHB. There is variability in suicide death numbers but there has been an increase over the last three years.

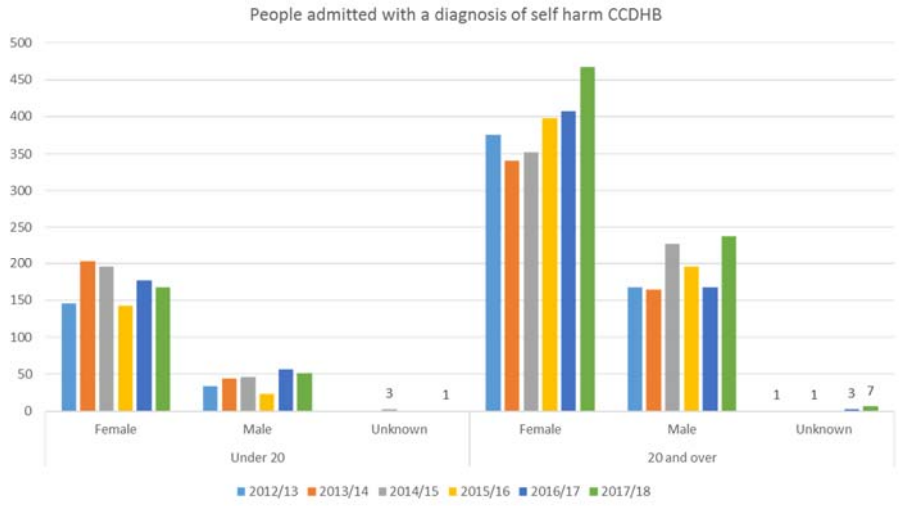


What we also know the rate of suicide in CCDHB is greater than the national trend.

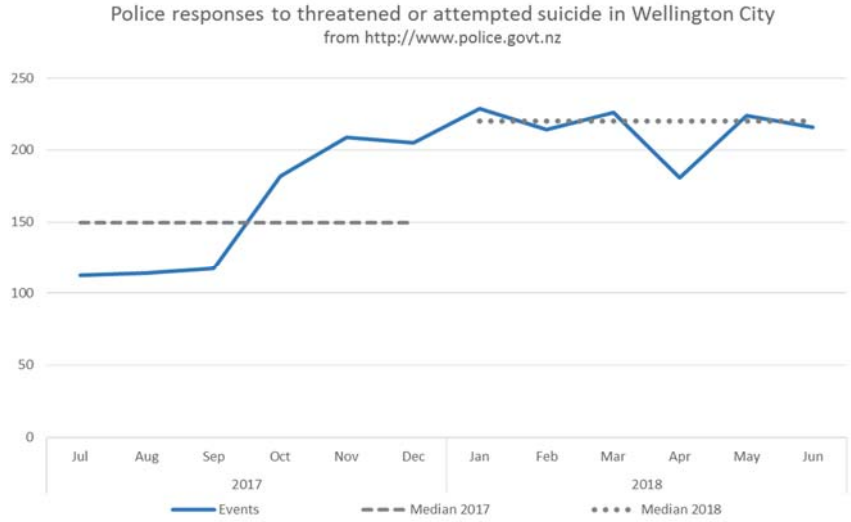


We have not only seen an increase in suicide. We also have a rise in suicidal behaviour and suicide distress calls to NZ Police.

There are almost 900 people admitted to Wellington regional Hospital after a self-harm attempt (suicidal behaviour). This number has climbed in 2017/18 – particularly in the over 20 age group. Those making suicide attempts requiring hospital admission (non-mental health) are at high risk of further hospitalization for suicide attempt and of death from suicide.



What we also know is that the number of police calls related to threatened or attempted suicide have increased by 47% in the past 12 months in Wellington.



3.3 More people who die by suicide or self-harm are known to 3DHB services

Between 2010 and 2015, 25% of people who suicided were known to MHAIDS each year. However, in the two years between 2016/17 and 2017/18 has risen sharply to almost 50% of people who suicided, higher than the national rate.

Furthermore, not only do we see these people in mental health services they also use primary care, community mental health services, emergency department services and hospital services. All of these points of contact are opportunities to make a difference to the experience of distress in our community and change the result.

3.1 Current suicide prevention and postvention plans

Since July 2014, all DHBs have been responsible for the development and implementation of suicide prevention and postvention plans that facilitate integrated cross-agency and community responses to suicide in their areas[9]. In 2015, WRDHB, HVDHB and CCDHB and a wide range of stakeholders developed a 3DHB Suicide Prevention and Postvention Action Plan (3DHB Action Plan) 2015-2017. Services are contracted to Lifeline Trust and postvention is delivered by the Regional Public Health Unit.

[9] Ministry of Health (2015). *Suicide Prevention Toolkit for District Health Boards*. Wellington: Ministry of Health

The draft Ministry of Health's 2017 national suicide prevention and postvention strategy.[10] This strategy has not been finalised and remains in draft.

In January 2018 a new 3DHB Action Plan 2018 -2021 was prepared and remains in draft. Challenges in delivery and the effectiveness of our approaches has created an opportunity for a re-think of our approach.

4. DISCUSSION

The reality is that we are not reducing the number of suicides, or the rate of suicide and suicidal behaviour in our communities. This is requiring a significant re-think of the way we approach suicide prevention across the 3DHBs.

Across New Zealand, and the world, there is developing thinking regarding how to successfully approach suicide prevention by thinking more carefully about who suicides, who engage in suicidal behaviour and why they do suicide.

We know that most of those who are dying by suicide are known to the healthcare system, not only to our MHAIDS services but across the health system. We also know that those people who we identify as experiencing violence, child abuse and neglect, who are seeking support when they are LGBTQI, having babies, and those who are in prison and engaged in forensic services and also users of health services we provide.

The type of programmes and approaches that are being considered nationally include:

4.1 Zero Suicide

The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioural health systems are often preventable. It presents both a bold goal and an aspirational challenge. It is important to note this is an aspirational goals and not a target in itself.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. A systematic approach to quality improvement in these settings is both available and necessary. The challenge and implementation of Zero Suicide cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical staff, who do the demanding work of supporting those with distress

4.2 Tu Kotahi and Mana Ake

Tu Kotahi supports the active participation and input from young New Zealanders into the prevention of suicide. The focus is in secondary schools and promoting positive conversations amongst young people. Mana Ake is a primary school based programme focusing on NGOs and schools working together with the support of community workers to improve mental health of young people. There are trials across New Zealand of these programmes supporting our young people.

5. APPROACH

Our approach to this project is to both analyse where and how people present to our health system who are experiencing distress, and understand the current way in which our health system responds to people presenting with distress suicidal behaviour.

We will also be looking at the programmes and evidence nationally and internationally that could work to make a difference to people who are at risk of distress and suicidal behaviour. This could include service responses, changes in models of care in how services respond to suicidal behaviour, how we work with our

[10] http://www.health.govt.nz/publication/strategy-prevent-suicide-new-zealand-draft-public-consultation

partners including Corrections and NZ Police, and importantly how we engage our communities.

The data report from the first phase will inform the scope for the second deliverable, a research document which will analyse the data, seek to understand what the key issues are and where these lie within the health system including community, non- government organisations (NGOs), and primary and secondary care and what our overall response should look like.

As a result of the findings the report will provide recommendations on what changes (systemic, processes or services) need to be implemented internally within the 3 DHBs as well as across the rest of the health system.

This work will be completed by experienced consultants who will be supported by the planning and funding teams at CCDHB, HVDHB and WrDHB. They will deliver a draft approach in December 2018, and a developed approach in February 2018. The value of this work is budgeted in 2018/19.

The final phase will be the development of the commissioning and change programme that implements the recommendations.

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**DSAC** **DECISION PAPER**
	Date: 20 August 2018

Author	Jane Presto, Localities Manager, Strategy, Innovation & Performance. Te Pare Meihana, GM Child, Youth and Localities, Strategy, Innovation & Performance.
Endorsed by	Rachel Haggerty, Director Strategy, Innovation and Performance, CCDHB
Subject	**Rolleston Street Social Housing Re-development Project**

RECOMMENDATION

It is recommended that DSAC:

a) **Note** the cross sectoral project with our partners (MSD, HNZ, WCC) in the development of an intensive supported living service for people with complex health and addiction needs who are homeless.

b) **Recommend to** the Board of CCDHB that they endorse the multi-agency initiative to provide support for vulnerable people with significant need in the Wellington region and become party to the final memorandum of understanding between the key parties.

APPENDICES

1. **MOU (DRAFT, IN DEVELOPMENT)**

1. PURPOSE

This paper gives the Disability Support Advisory Committee (DSAC) an overview of progress in the development of this specialist service, proposed to open in 2020.

2. BACKGROUND

In 2009 there was consideration of establishing a wet house, Te Whare Okioki, in Wellington. CCDHB was a lead in this work at that time, however this project did not progress for a variety of reasons, including concern from the community regarding the model of care.

The need for an intensive supported living service in Wellington for long term homeless people with complex health and addiction needs was again raised in 2017. In 2018, CCDHB joined MSD, Housing NZ and Wellington City Council in a multi-agency partnership to develop this initiative.

This group of people are currently living in very vulnerable situations and have high impact on health and other social service resource as a result of their complex needs. Within CCDHB, this is seen across several MHAID services as well as ED and primary health.

This project is the initial priority focus for the DHBs Localities approach in the Wellington area.

3. MULTI-AGENCY ROLES AND RESPONSIBILITIES TO THIS PROJECT

Housing New Zealand (HNZ) are re-developing their social housing complex at Rolleston St, Mount Cook, and are proposing to build a housing solution for this identified population as part of that re-design. The

supported living service is proposed to be for a maximum of 20 people, with a mix of communal and bedsit space available for both male and female tenancy. HNZ will be the landlord and the people living in the service would be tenants, with all usual rights under the Residential Tenancy Act. Plans for the full development include social housing apartments and a community space that will be open for use across the wider Mount Cook and Newtown community.

The Ministry of Social development (MSD), under their Housing First Model, will procure/contract a Housing First provider to deliver a 24 hour supported living service to the people living within the intensive supported living service. The Housing First model is an internationally proven response that recognises that it is much easier for people to address complex health and addiction issues once they are housed. This is a key point of difference to the earlier concept of Te Whare Okioki. The supported living provider would meet day to day support needs as well as provide for the safety and security of the people living there.

Wellington City Council will support the development and on-going resource for the community centre space. Their support of the tenants in the supported living service would be in conjunction with their overall aims to support the homeless population in Wellington.

CCDHB will provide a health and wellbeing response for people living within the supported living complex. CCDHB's model of care will include a range of supports to meet physical, mental and addiction related health needs. There will be a multidisciplinary approach to this work and services will range across community, primary and secondary health teams. It is intended that CCDHB funded services will provide visiting supports alongside improved access to community and hospital based services. In partnership with the individual, assessment and strengths based treatment planning will be undertaken. Appropriate health related supports will be available based on the outcome of this and these will be reviewed as and when the person's needs change. Services will have an underlying philosophy that is holistic and which reflects people's cultural and social needs and aspirations. CCDHB funded services will provide specialist advice to the Housing First contracted staff providing 24 hour care to the people residing at the supported living complex.

4. PROGRESS TO DATE

- Key stakeholders to this project meet fortnightly
- Concept plans have been developed by HNZ and are being readied for resource consent
- Public consultation in the Mount Cook community is in progress and CCDHB have attended a community drop in session to speak with people about our role in this proposed development
- A MOU is under development for the project phase and initial service model planning is in progress for the on-going provision of service
- Within CCDHB, discussion has commenced across SIPD and MHAIDS services in regard to a model of care. This discussion will be widened in September to include primary health, community and other secondary services (e.g. ED) who will need to be included in the development of an integrated service model for the people living at Rolleston St.

5. CCDHB KEY MESSAGING

- CCDHB is working in partnership with MSD, HNZ and WCC in regard to the Rolleston St re-development project
- This project gives us an opportunity to look at how we provide services to vulnerable people and how we can work alongside other organisations in offering a wraparound community service
- Our focus is the health and wellbeing of vulnerable people in the wider Newtown area
- People have a right to appropriate healthcare and our involvement in this project is a health response
- Vulnerable people have often not been well served by traditional mainstream health services

- A new approach is required to assist people to access the health and wellbeing services they need in order to be well
- CCDHB recognise that people need social and emotional support before they can be ready to address long-standing issues such as addiction
- Having a home is an essential 1st step to health and wellbeing
- CCDHB will be taking some time to consider a model of care, which will include a range of physical, mental health and addiction needs
- We envisage a multi-disciplinary approach to this work
- Services may be across community, primary and secondary health teams
- We hope this work will inform how we can work with wider community in the future

6. NEXT STEPS

CCDHB will work to develop a model of care for future provision of health and wellbeing services. This will be across a spectrum of primary, community and secondary services and holds the potential to widen to be a model of care for the wider Mount Cook and Newtown community. Although people will not be living at the supported living service until 2020, determination of a model of care holds significance for our commitment to our partners, to the reassurance of the wider community and to determine future investment implications, should that be required.

7. RESOURCE IMPLICATIONS

Resource implications are unknown at this stage. The project is being led as part of the Localities work and no additional project management is currently identified as being required. Future clinical or other resource need will be determined through work on the model of care. If required, an investment bid will be developed for the 19/20 financial year.

[*Insert WCC, MSD, CCDHB and HNZC logos*]

Memorandum of Understanding

relating to

21 Rolleston Street Development Project

Wellington City Council

WCC

and

Ministry of Social Development

MSD

and

Capital and Coast District Health Board

CCDHB

and

Housing New Zealand Corporation

HNZC

Date

This **Memorandum of Understanding** is made on 2018

between (1) **Wellington City Council** (**WCC**)

and (2) **Ministry of Social Development** (**MSD**)

and (3) **Capital and Coast District Health Board** (**CCDHB**)

and (4) **Housing New Zealand Corporation** (**HNZC**)

Introduction

A. The parties propose to develop an Intensively Supported Accommodation Project (ISAP) and community space as part of the **21 Rolleston Street Development Project**.

B. The 20 ISAP units will be targeted at men and women with long histories of homelessness and high and complex unmet needs, most often with co-existing disorders including substance use.

C. The ISAP will be aligned to Housing First principles in having no 'housing readiness' requirements. A harm reduction approach will support residents with substance use/alcohol dependence to achieve improved health outcomes including a reduction in consumption rates and greater wellbeing. The ISAP will be staffed 24 hours a day.

D. While having a high rating on the Social Housing Register will be an entry requirement, placement into the house will need to be through referral from a panel including CCDHB partners (or they are invited to design a referral criteria/process) to ensure that those with the highest unmet needs are targeted and housed. This clearly distinguishes the tenants from those who could be housed independently and supported through Housing First.

E. The ISAP will support the work of the Te Mahana/ Housing First Senior Leadership Group (SLG).

F. Tenants will have the usual legal rights under the Residential Tenancy Act.

G. There will be a funded formative and outcome evaluation of this project – to ensure it is optimally designed and delivered, and to determine the outcomes being met by this more intensively supported accommodation model.

H. While currently using the name ISAP, WCC would appreciate the use of Te Whare Okioki when the accommodation is opened, as the name was gifted for this development.

I. Development of a separate community space within the complex will be available to deliver programmes and services that meet the needs of HNZC tenants and other members of the local Mt Cook community.

J. Enable and support the delivery of wrap around services offered by the CC DHB and other providers to support the residents of the ISAP.

K. The parties are committed to working together on the **21 Rolleston Street Development Project** to provide supported living options for high dependency people.

L. This Memorandum sets out:

a. the shared commitment of the parties to the **21 Rolleston Street Development Project** in accordance with the agreed Principles; and

b. the approach the parties will follow in respect of managing the **21 Rolleston Street Development Project**.

It is agreed

1. Definitions and Interpretation

1.1 **Definitions**

In this Memorandum (including the Introduction), unless the context otherwise requires:

Business Day means any day that registered banks are open for general banking business in Wellington (other than a Saturday, Sunday or public holiday in Wellington);

Dispute means any dispute arising out of, or relating to, this Memorandum;

Memorandum means this Memorandum of Understanding;

Principles means the principles set out in clause 3.1;

Steering Group means the committee to be established pursuant to clause 5;

21 Rolleston Street Development Project has the meaning given to that term in paragraph A of the Introduction; and

Term shall have the meaning given to that term in clause 9.1.

1.2 **Interpretation**

In this Memorandum (including the Introduction), unless the context otherwise requires:

(a) headings are for ease of reference only and shall not affect this Memorandum's interpretation;

(b) references to a "party" means a party to this Memorandum and includes its successors and permitted assigns;

(c) references to a "clause" are to a clause of this Memorandum;

(d) references to the singular include the plural and vice versa;

(e) any references to the term "includes" or any similar derivatives shall not imply any limitations; and

(f) the interpretation of a provision of this Memorandum shall not be affected or influenced by the party who drafted or proposed it.

2. Purpose

As highlighted in Introduction, this Memorandum sets out:

(a) the overall principles which apply to the parties' relationship in relation to the **21 Rolleston Street Development Project**;

(b) the roles and responsibilities of each party in relation to the **21 Rolleston Street Development Project**;

3. Principles

3.1 Relationship principles

(a) In their engagement with each other in relation to the Project, the parties acknowledge and agree that they must abide by the following relationship principles:

(i) it is the parties' shared intention, in relation to the **21 Rolleston Street Development Project**, to:

(A) develop and implement an intensively supported permanent accommodation project which provides 24 hour a day support to some of the most vulnerable men and women in Wellington; and

(B) adopt and implement a "Housing First" approach for the funding and operation of the Intensively Supported Accommodation Project;

(C) develop a community space within the 21 Rolleston Street Complex that responds to and supports the needs of the tenants and local community;

(ii) the parties will be open, prompt, consistent, and fair in:

(A) all dealings and communications between each other; and

(B) the notification and resolution between the parties of any differences or Disputes which may arise or be apprehended; and

(iii) the parties will be non-adversarial in their dealings with each other and will take constructive steps to avoid differences and to identify solutions to issues.

(b) The parties agree to abide by the relationship principles in their day-to-day interaction and in performing their obligations under this Memorandum.

3.2 Further assurances and capacity

(a) Subject to clause 3.2(b), each party must carry out and fulfil all obligations imposed on them by this Memorandum and must do all acts and things, including the execution of all relevant documents, as may be required to implement and carry out its obligations under, and contemplated by, this Memorandum.

(b) Each party acknowledges and agrees that each of the other parties have a range of statutory and regulatory powers and functions which it may exercise or must fulfil and nothing in this Memorandum will be construed as:

(i) limiting any party, or fettering the discretion of any party, in the exercise of its statutory and regulatory powers and functions; or

(ii) requiring any party to exercise its statutory and regulatory powers and functions in a particular way.

4. Roles and Responsibilities

4.1 The parties each agree to be subject to the following overarching obligations:

(a) **WCC**:

(i) [to support the development, as part of the **21 Rolleston Street Development Project**, of a community space;] and

(ii) Develop a model and funding options for the operation of the community space

(iii) Provide governance support for the Working Group

(iv) [anything else]

(b) **MSD:**

(i) MSD will be the primary funder of the Intensively Supported Accommodation Project which will be managed by a Wellington Housing First Collective

(ii) [•]Point re working through funding and operating model

(c) **CCDHB**

(i) CCDHB will develop a model for provision and funding of healthcare services for people living within the intensive supported accommodation service.

(ii) Contribute to the development/determination of referral criteria for access to the intensive supported accommodation service.

(d) **HNZ:**

(i) To fund, manage and lead the build programme

(ii) To be responsible for the ongoing management and upkeep of the facilities

(iii) To be a member of the governance group responsible for the community centre management

(iv)

5. Working Group

5.1 **Establishment and composition**

(a) The parties will establish the Steering Group as soon as practicable following the date of this Memorandum.

(b) The Steering Group will include appointees of each of WCC, MSD and HNZC. Any party may replace its members on the Steering Group from time to time by giving written notice to the other parties.

(c) The Chair of the Steering Group will be one of the members of the Steering Group, appointed as Chair by a decision of the Steering Group made in accordance with clause 5.4.

5.2 **Purposes**

The purposes of the Steering Group will be:

(a) to oversee the implementation of this Memorandum;

(b) to work collaboratively together to agree the scope, nature, design, service model and costing of the **21 Rolleston Street Development Project**;

(c) to oversee the management of the **21 Rolleston Street Development Project**;

(d) oversee the implementation of the intensive Supported Accommodation Project and the Community Space and

(e) to generally operate in a manner that enables the parties to receive the benefits of this Memorandum, in a manner consistent with the Principles set out in clause 3.

5.3 **Meetings**

(a) The Steering Group is to meet ……. during the Term, or more or less frequently as the Steering Group may agree from time to time.

(b) Meetings of the Steering Group will be conducted in person or via telephone conference.

5.4 **Decisions**

(a) Decisions of the Steering Group must be made by simple majority of the members of the Steering Group.

(b) The members present appointed by one party will have [two] votes in the aggregate, irrespective of how many of that party's members are in attendance.

(c) If the Steering Group cannot make a decision under this clause 5.4, any party may refer the matter to be resolved under clause 6.

(d) Decisions of the Steering Group are not intended to be binding on the parties when they exercise any of their individual statutory / regulatory obligations.

6. Dispute Resolution

6.1 **Application**

Any Dispute must be determined in accordance with the procedure set out in this clause 6.

6.2 **Senior representatives**

(a) If a party believes that there is a Dispute, then:

(i) it will first notify the other parties in writing giving details of the Dispute;

(ii) the Dispute will then be promptly referred to the Chief Executive Officer of each party for resolution; and

(iii) if the Chief Executive Officers do not resolve the Dispute within 10 Business Days, any party may submit the dispute to mediation (to be conducted in accordance with clause 6.3).

(b) Nothing in this clause 6 limits the ability of any party to seek urgent interim or preliminary relief from a court of competent jurisdiction.

6.3 **Mediation**

(a) Where clause 6.2(a)(iii) applies, a Dispute may be submitted to mediation by a party giving notice to the other parties:

(i) setting out the subject matter and details of the Dispute and requiring that the Dispute be referred to mediation; and

(ii) stating the name of the person whom the party giving the notice nominates as a mediator.

(b) Where a matter is submitted to mediation in accordance with clause 6.2(a)(iii) above:

(i) if the parties fail to agree on the identity of the mediator within 10 Business Days of the date of receipt of the notice referring the Dispute to mediation, the parties will procure that the mediator is chosen by the President of the New Zealand Law Society (or her or his nominee) within a further 10 Business Days of referral of the matter to such President;

(ii) the mediation will be held in Wellington;

(iii) the mediator shall be deemed not to be acting as an expert or as an arbitrator;

(iv) the mediator shall determine the procedure and the timetable for the mediation;

(v) the cost of the mediation shall be shared equally between the parties (unless the mediator determines otherwise); and

(vi) if the parties fail to settle the Dispute by mediation within 40 Business Days of the matter being referred to mediation (or within such other period as the parties agree in writing), any party may commence court proceedings in respect of the Dispute.

6.4 **Court proceedings**

Subject to clauses 6.2(b) and 6.3(b)(vi), no party will bring any court proceedings relating to the Dispute or any part of it.

7. Communications and notices

7.1 **Communication Protocol**

Each party must comply with the Communication Protocol, as defined in Schedule 1, in respect of any third party communications to be made in relation to, or in connection with, the **21 Rolleston Street Development Project** or this Memorandum.

7.2 **Form of notice**

Each notice or communication under this Memorandum is to be in writing and is to be made by email, prepaid post or personal delivery to the addressee at (as applicable) the email address or physical address notified by each party, provided that any notice must expressly state it is a notice given pursuant to this clause 7. Any such notice or communication is to be marked for the attention of the person or office holder from time to time designated for the purpose by the addressee. The initial email address, physical address and relevant person or office holder of each party is set out below:

Wellington City Council

Address: [●]
Attention: [●]
Email: [●]

Ministry of Social Development

Address: [●]
Attention: [●]
Email: [●]

Housing New Zealand Corporation

Address: [●]
Attention: [●]
Email: [●]

Capital & Coast District Health Board

Address: [●]
Attention: [●]
Email: [●]

7.3 **Notice effective**

No notice or other communication is to be effective until received. A notice or other communication will be deemed to be received:

(a) in the case of personal delivery, on receipt;

(b) in the case of delivery by post, two Business Days after the date of posting; and

(c) in the case of email, at the time the email leaves the communications system of the sender, provided that:

(i) the sender does not receive any error message relating to the sending of the email at the time of sending; and

(ii) if the email is dispatched after 5.00pm or on a day that is not a Business Day, then it will be deemed to be received on the next Business Day after the date of dispatch.

8. Confidentiality

Each party must keep the existence of this Memorandum and its terms, and any confidential information about any other party which was obtained in relation to this Memorandum, confidential and no party is to make any public disclosure or announcement of the existence of this Memorandum or its terms, without the prior written consent of the other parties, except:

(a) to the extent expressly permitted by the Communication Protocol;

(b) to the extent required by law; or

(c) to its professional advisors, provided they are subject to a corresponding obligation of confidentiality.

9. General provisions

9.1 **Term**: The term of this Memorandum is [project phase of the initiative only – i.e. will be superseded by formal agreements] (the **Term**). The Term may be extended by the written agreement of the parties.

9.2 **Legal effect**: This Memorandum is not intended to be legally binding and shall not create a binding contract between the parties except for Clause 6 Dispute Resolution and Clause 8 Confidentiality.. [and possibly the communication protocol]

9.3 **Entire agreement**: This Memorandum constitutes the entire understanding and agreement of the parties with respect to the subject matter of this Memorandum, and supersedes all prior discussions and negotiations between the parties in relation to that subject matter.

9.4 **Counterparts**: This Memorandum may be signed in any number of counterparts (including any PDF copy) all of which, when taken together, will constitute one and the same instrument. A party may enter into this Memorandum by executing any counterpart.

9.5 **Amendments**: No amendment or variation to this Memorandum is effective unless it is in writing and signed by all parties.

9.6 **Validity**: If any provision or part-provision of this Memorandum is or becomes invalid, illegal or unenforceable, it shall be deemed to be modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision will be deemed deleted. Any modification to or deletion of a provision or part-provision under this clause will not affect the validity and enforceability of the rest of this Memorandum.

9.7 **Third party rights**: Nothing in this Memorandum is intended to confer a benefit upon or be enforceable by any third party under the Contract and Commercial Law Act 2017.

9.8 **New Zealand Law**: This Memorandum is governed by and is to be construed in accordance with New Zealand law. Each party submits to the exclusive jurisdiction of the New Zealand courts in respect of any dispute arising between the parties in respect of this Memorandum. Each party waives any right it has to object to an action being brought in those courts including, without limitation, by claiming that the action has been brought in an inconvenient forum or that those courts do not have jurisdiction.

Execution

Executed as an agreement by:

Wellington City Council by and in the presence of

Authorised Signatory

Print Name

Witness Signature

Print Name

Occupation

Address

Ministry of Social Development by and in the presence of

Authorised Signatory

Print Name

Witness Signature

Print Name

Occupation

Address

Housing New Zealand Corporation by and in the presence of

Authorised Signatory

Print Name

Witness Signature

Print Name

Occupation

Capital & Coast DHB by and in the presence of

Authorised Signatory

Print Name

Witness Signature

Print Name

Occupation

Address

Schedule 1: Communication Protocol

[*Note: this should include meeting schedule/reporting if any.*]

Wording previously provided by HNZ:

Communications and engagement approach

HNZ will lead the communications and engagement on the development of the Rolleston site, specifically on the master planning and design for the new homes and the social spaces that are planned there.

As the supported living service model at Rolleston will involve multiple agencies all communications and engagement on this proposed service will be jointly developed by HNZ, MSD, CCDHB and WCC.

HNZC will work closely with WCC and other agencies to support the proposed community centre.

The communications and engagement plan will outlines the roles and responsibilities of each agency for the service and the timeline for the related activities.

[include protocol/process for agreement]

Schedule 2: Service Model for the Intensively Supported Accommodation Project

Schedule 3: Service Model for the community space

	DISABILITY SERVICES ADVISORY COMMITTEE DISCUSSION PAPER
	DATE: 25 August 2018
From:	Emma Hickson, Acting Disability Strategy and Performance Directorate (DSPD), Capital and Coast DHB (CCDHB)
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, CCDHB
Subject	**Update on the Whole-of-Life NASC Project**

RECOMMENDATION

It is recommended that the Disability Services Advisory Committee:

- **Note** progress on the Whole-of-life Needs Assessment and Service Coordination (NASC) project occurring at CCDHB to develop options to improve whole-of-life approaches.
- **Notes** that the current system of NASC does not deliver the best use of resources, or the best levels of support for those clients who have complex needs over the course of their lives.
- **Notes** the proposed model of care and investment will be presented to the December DSAC with recommendations.

1. PURPOSE

This paper is to provide a brief update to DSAC members on progress on the Whole-of-life NASC project that is linked to the following 3DHB Sub-Regional Disability Strategy Actions

Action 2.8: Promote a whole-of-life approach to needs assessment and service coordination.

Action 2.8.1: Establish a whole-of-life approach to NASC which encompasses knowledge from the DHB, Ministry of Health, primary care and providers towards an integrated NASC.

This was requested at the DSAC meeting in June 2018.

2. NEEDS ASSESSMENT AND SERVICE COORDINATION (NASC)

When people in our community have long term support needs they are provided and funded by the healthcare system. Access to long term support is coordinated by a needs assessment and coordination service known as NASC. The concept was developed over 15 years ago and is now used to manage access to long-term support services across New Zealand. Short term needs are assessed by our district nursing services for the first six weeks post discharge or an urgent event.

These services can include everything from support to take medication, personal cares in your home and long-term residential care. Through our consumers and advocates we know that for some of those people have complex needs that extend over the course of their lives they can receive services that don't meet their needs.

2.1. Needs Assessment and Service Coordination services in CCDHB

People in in our community can access five different types of NASC services:

- A service for those with mental health need managed by Te Haika and provided as part of MHAIDS.
- A service for older people (including those with disability) accessing home care support and all forms of age residential care. CCDHB commissions this service from Nurse Maude.

- The national intellectual disability and/or mental health (NIDCA) for those with very complex needs. MHAIDS provide this on behalf of New Zealand.
- The service for those who are under 65 years accessing disability support services is known as Capital Support and is part of HHS.
- There is a national provider for those who have complex disability needs. This is commissioned from a group of Trusts by the Ministry of Health.

Each of these services manages resources for both the Ministry of Health and Capital & Coast DHB. They operate to a set of eligibility criteria that can access different services and supports. Some of these criteria can leave members of our community unable to access what they need to live independently. It can also result in a single person and/or household having multiple assessments, and multiple providers in their home, who may change over the course of their lives. This does not make best use of resources or provide our families with the optimal level of support.

3. DEVELOPING A WHOLE-OF-LIFE NASC

Capital and Coast District Health Board (CCDHB) has committed to taking an integrated approach to assessment and organisation of support that takes account of a full range and continuum of a person's needs during their life.

A strategic whole-of-life approach signals a significant change of approach, moving away from age or diagnosis-based categories (older people, people with disabilities and people with mental health issues) approach to taking a person and whānau wellness focused approach in assessing their health and social care needs.

It takes a view that regardless of age, diagnoses and eligibilities, systems must support the person to attain or retain self-management where this is possible, respond to risks where this is predictable and provide care and support where this is required.

3.1. This Whole-of-Life NASC Project

A Strategic Group for whole-of-life NASC, has membership across CCDHB and primary care. It was established to:

- Develop an integrated model for needs assessment that considers the full range and continuum of a person's needs informed by a whole-of-life approach that is based on national and international research on good practice evidence.
- Recommend the strategic direction for an integrated NASC that is supportive of organisational priorities including Health Care Home and Capital and Coast Health System Plan implementation.

3.2. Key Principles of this Development

The Strategic group agreed that the following key principles will guide the development of a whole-of-life approach to needs assessment and service coordination:

- Person-centered: Person and family, whānau centered services that sees people as equal partners in planning, developing and monitoring care and support to ensure it meets their individual needs and goals taking a whole-of-life approach rather than being split across programmes. This requires an approach that considers the full range and continuum of a person's needs.
- Social Investment: Invest early in supporting a person and families/whānau who are most at risk, avoiding crisis response with a proactive plan.
- Easy to navigate: Creation of an enabling and more accessible environment that people can navigate and seek support where needed and make well informed decisions.
- Community partnerships: Connect the person and families and whānau with their communities, building and strengthening relationships through community health and locality networks.

- Achieving equity: Achieve equity in health between groups that may require an unequal distribution of healthcare provision. Further, that those actions aimed at achieving equity 'do so in a way that benefits all members of society but with preferential benefits to those who experience more suffering. This is known as proportionate universalism'.
- Supporting interdependence: People having the right to be leaders and owners of their health, independence and autonomy utilising their natural support.
- Best Value: Using resources well to deliver the best outcomes for people and support them to achieve their health and wellbeing goals.
- Development of places and people: We use the terms 'localities' and 'communities' and we are clear that we mean both.
- Equity: Ensure the models reflect different cultural paradigms, ensure equity of access and equity of outcome amongst our communities.

4. PROGRESS AGAINST WHOLE-OF-LIFE APPROACH TO NASC

4.1. The concept

The whole-of-life concept has been developed with good support for the concept to evolve into service design guided by the key principles. The Strategic Group agreed to formulate an analytics work stream to inform the next steps.

The group also identified that the issues relating to funding, contracts and eligibilities are operational functions that can be managed through agreed business rules which the Needs Assessment Service Coordination (NASC) implement. There are some aspects to NASC services that are governed by the Ministry of Health. The MoH is aware of this project and is open to receiving advice on policies or processes that the implement could be improved to support this concept.

4.2. Analytics

The Strategic Group agreed that analytics would tell a story or narrative with data and evidence to answer the following key questions.

- Who is accessing what NASC services, for what purposes?
- Who is currently unable to access NASC services or have barriers in accessing NASC services despite their needs?
- Who can benefit the most from an integrated NASC approach?

Referral and outcome of referral data from all four NASCs covering nearly four years from 01 July 2014 to 30 April 2018 was collected along with data from Compass Health for enrolled population with high or very high-risk profile.

Highlights from this analysis are;

- 12,490 individuals accessed a NASC between July 2014 and April 2018 with 96% accessing just one NASC and 4% accessing multiple NASC
- This means that 490 people access multiple NASCs over the four years period. Some of this would have been age related progression and some would be people with multiple needs.
- 68% of the 12,490 who accessed NASC were identified by Compass Health as having a high or very high-risk profile and therefore already known to primary care.
- Primary care is often identified as the place that will hold the greatest knowledge of the health needs of people receiving NASC services/
- 63% of the 12,490 who accessed NASC had also accessed District Nursing or ORA services identifying a pathway from short term to long term support.

- Equity analysis is still progressing and as yet we do not have a view. Work to date suggests that levels of access will be lower than the presenting need for our more vulnerable families.

5. NEXT STEPS

The development of a working concept for implementation will be presented to the November DSAC. The focus is on completing more detailed analytics to test the problem definitions and assumptions, considering the role of technology in options developments and working with our consumers. This will enable us to present feasible options in November.

The analytics work continues to provide data and evidence to inform service design to answer the key questions; 'What would it take to create an integrated NASC? ; Who is it for? ; What do we integrate?' The aim is to present patient journeys over the four years for identified scenarios with a particular focus on people with health, disability and social needs.

In addition to the NASCs and Compass Health data, the aim is to look at wider hospital and DHB community health services that a person has accessed during the same selected period. This will give us a wider picture of resource use.

The project has also recently commenced work with Information Technology team to explore how the use of technologies can simplify access and support. This group is also looking to establish a minimum data set for NASC so there is consistency of data collection and reporting across all four NASCs.

The development of options for models of care and service delivery that improve the experience for people, and their families who require support will be considered at a series of workshops in September and October. This will include engaging our sub regional disability advisory groups (including Maori and Pacific advisory groups), engaging with older consumers and our mental health consumers.

The financial risks and options associated with NASC models will be considered as part of the development process. At this stage no significant financial risks have been identified. It has been identified that existing resources may be able to be better used to support people and their families. The issue of unmet need has been raised. This is difficult to quantify but will be assessed as part of the financial analysis of options.

	DISABILITY SERVICES ADVISORY COMMITTEE **DISCUSSION PAPER**
	DATE: 24 August 2018
From:	Emma Hickson, Acting Manager Disability Strategy and Performance Directorate (DSPD), Capital and Coast DHB (CCDHB)
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, Capital and Coast DHB (CCDHB) Helene Carbonatto, General Manager, Strategy, Planning and Outcomes, Hutt Valley DHB (HVDHB) Nigel Broom, Executive Leader, Planning and Performance, Wairarapa DHB (WRDHB)
Subject	Update on the implementation of the 3DHB Sub-Regional Disability Strategy

Recommendation

It is recommended that the Disability Services Advisory Committee:

- **Note** the 3DHB Disability, Strategy and Performance Directorate (DSPD) team has reviewed its 2018/2019 work plan, and identified priorities consistent with 3DHB Sub-Regional Disability Strategy
- **Note** progress on the New Zealand Sign Language (NZSL) Plan and use of Disability Alerts.
- **Endorse** the disability performance dashboard measures.

APPENDICES

1. DISABILITY ALERTS MEASUREMENT

1. PURPOSE

This paper seeks DSAC's **endorsement** of the:

- Disability performance monitoring approach

It also **updates** DSAC members on:

- The 2018/2019 work plan for the 3DHB DSPD team and its alignment with the 3DHB Sub-Regional Disability Strategy
- Updating of the terms of reference (TOR) for the Sub-Regional Disability Advisory Group (SRDAG) and progressing the TORs for the new Māori and Pacific sub-regional advisory groups
- Progress on the New Zealand Sign Language (NZSL) Plan.

2. WORK PLAN FOR 2018/2019 UPDATE AGAINST THE 3DHB SUB-REGIONAL DISABILITY STRATEGY (2017-22)

The 3DHB Disability, Strategy and Performance Directorate (DSPD) team has reviewed its 2018/19 work programme in relation to the disability strategy. The key priorities for the coming year include:

Sub-regional disability planning workshop and 2019 Forum: Preparation for the planning workshop on 2 November is well underway. A draft programme has been completed and members from the three sub-

regional disability committees will attend. A Disability Forum is planned for April 2019. The Forum will engage sector leaders and members of parliament.

Māori and Pacific peoples' needs and responses: Developing a work plan and priorities will be progressed, in addition to continuing to develop effective working relationships and project linkages between the 3DHB DSPD team, the Māori and Pacific disability committees and teams across respective work programmes.

Improved information for and about people with disabilities: Developing a database of information about the characteristics (including ethnicity and age) and service needs of people with disabilities within the 3 DHBs. The data base will inform the 3DHB DSPD team's development of interventions, the measurement of programme results and the reporting of performance, outcomes and the presenting of information in the "dashboard" of disability indicators.

Disability Education and Information: Improving understanding and attitude change among the health workforce and community groups working with people with disabilities through resource distribution and face to face training. A 3DHB disability education plan is a priority for the year and will include an e-learning review. The employment of a disability educator based at CCDHB is underway.

Information for service providers about people with disabilities: Enabling disabled people to provide accurate and accessible information about their characteristics and health needs to health professionals, in order to improve their health outcomes. This includes Disability Alerts, Health Passport, and an e Health Passport. Further work to raise the quality of Disability Alert information is required, together with identifying other mechanisms for providing information to health professionals (including in primary care), and enquiry into the feasibility of progressing the e Health Passport.

Whole of life NASC Promoting and further exploring a Whole of Life approach to needs assessment and service co-ordination.

Support for people accessing health services: Improving access to New Zealand Sign Language (NZSL) interpreters and access to and quality of care for the Deaf community.

3. SUB-REGIONAL DISABILITY ADVISORY GROUP (SRDAG)

The 3DHB DSPD team have mapped the committees within the 3DHB's governance structures, to ensure the newly developed Sub-Regional Māori Disability Rōpū and the Sub-Regional Pacific Disability Advisory group align with SRDAG. This has led to a review of the TOR for the SRDAG.

SRDAG discussed a revised draft at its most recent meeting on 17 August. Additional consultation with members is being carried out, and this will also inform the TOR for both the Māori Disability Rōpū and the Pacific Disabilities group.

The 3DHB DSPD team is proposing SRDAG meet to progress all three TORs, which will then be submitted to the next meeting of DSAC for endorsement.

4. PROGRESS ON THE NEW ZEALAND SIGN LANGUAGE (NZSL) PLAN

4.1. Mental Health and Wellbeing

The 3DHB DSPD team was successful in receiving $30,000 from the NZSL Board. (The NZSL Board is administered by the Office for Disability Issues who is tasked with distributing funding annually to ensure the development, preservation and acquisition of NZSL). This money will be used to facilitate a 'Deaf Wellbeing Group'. This group will be a place where members of the greater Wellington Deaf community can come together in a community setting on a weekly basis. The goal is wellbeing via connection with others, and will be set up and facilitated by members of the local Deaf community with oversight from the NZSL in Health Task Force (DHB advisory group to the NZSL in Health work program).

Discussions have begun with the Strategy, Innovation and Performance (SIP) Mental Health team and Mental Health, Addictions and Intellectual Disabilities Service (MHAIDS) leadership around accessibility

for the Deaf community to mental health services with the view to developing a work program to improve access.

4.2. Health Literacy

Local and international research suggests the Deaf community in NZ have a greater need for health information and poorer access to it (Witko et al., 2017). A report commissioned by the 3DHB DSPD team during 2017/2018 and funded by the NZSL Board looked into the sustainable production of health information in NZSL. This scoping report has led to the Health Navigator New Zealand website promoting the information and resources developed by CCDHB, and the Health Promotion Agency seeking advice about translating more heath information into NZSL.

In addition, the 3DHB DSPD team has been working in partnership with Deaf Aotearoa New Zealand (DANZ) to run a series of health-related workshops for the Deaf community. The majority of funding comes from Adult Community Education (ACE) funding received by DANZ. A series of 8 workshops will be held during 2018. To date the workshops, fully accessible in NZSL, have been well attended, with over 20 community members attending each workshop. For many Deaf community members this is the first opportunity they have had to access health information in NZSL in a two way exchange.

4.3. Health E-Passport

The development of the E-Passport continues. Meetings have been held with ICT to consider possible approaches that are linked to the disability alert in patient management systems of both hospitals and primary care. This integration is seen as essential for the passports to be successful. Once technical solutions are identified the options for investment in the E-Passports will be presented to the Boards.

5. PERFORMANCE MONITORING

In 2016 a dashboard of indicators based on the Disability Alerts at CCDHB was co-designed with SRDAG (Appendix 1). This dashboard was designed to assist the monitoring of key measures in the Annual Plan and the Equity Report. These were:

- The total number of people with a Disability Alert
- The inpatient average length of stay of people with a Disability Alert
- The outpatient DNA (did not attend) rates of people with a Disability Alert
- The inpatient readmission rates of people with a Disability Alert

The comparison of this performance against the general population is still being developed. This graphs attached show that:

- That over 8,500 people have disability alerts registered in our system.
- That people who have disability alerts are regular users of the healthcare system attending the emergency department and being admitted to our hospitals.
- That an average of 350 people a months are admitted to our hospital who have a disability alert.
- That on average 200 people a month attend the emergency department who have a disability alert.
- That 5% of our outpatients attendances are for people with disability alerts
- That disability alerts are greatest in number for our older population particularly those over 85 years.
- The number of alerts for children is disproportionately high and possibly reflects the high levels of parental engagement in the disability alert process.

5.1. Proposed Approach

The current dashboard of indicators is based on people with Disability Alerts and the performance of the services we provide to those people in one setting of care. The disability dashboard to assist the DHBs to improve understanding of the effectiveness of services for people with disabilities across a range of settings of care is has completed a set of proposed indicators. Below are the proposed indicators for 2018/19. They are intended to tell a story of the experiences of people with disability and compare this to those who don't have disabilities.

The reporting and analysis of these measures will be reported to the December DSAC.

The measures include:

Structural measures What is required to deliver the services?

System level performance How do we know we are delivering quality services?

Impact measures What is the expected change or experience?

5.2. Potential ideas for indicators of disability dashboard

Structural Measures	**Population**	Number of people with an impairment
		Number of New Zealand Sign Language users
	Support Services	Number of Disability Alerts
		Number of people receiving Disability Support Services
		Number of people with NASC funding
	Disability Education	Number of information requests from landline
		Number of accesses to Disability website
System Level Performance	**Quality**	Percentage of support needs found in Disability Alert sample
		Percentage of times a patient's Alert page was accessed near admission
		Percentage of staff who have completed eLearning
	Effectiveness	Percentage of 2+ NASC referrals
		Average length of stay
Impact Measures	**System Impact**	ED presentation rate
		Inpatient admission rate
		Readmission rate
	Patient experience	Patient experience in primary care
		Patient experience in hospital

5.3. Development of future indicators

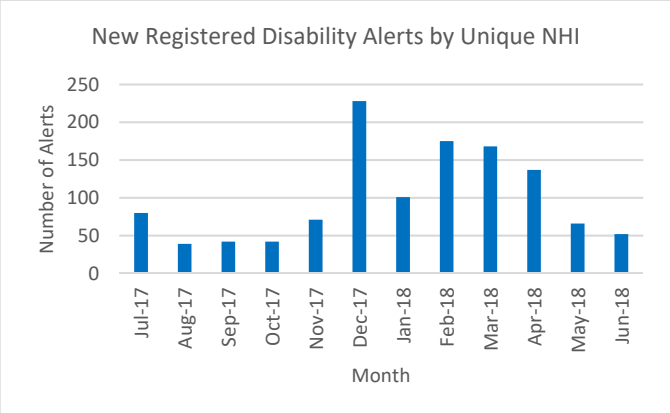
The DHBs will work with the SRDAG to improve understanding of how people use services and identify opportunities to continue to improve the effectiveness of services for people with disability. As understanding matures, additional impact measures will be developed and added to the dashboard to increase the scope of the system overview provided. These measures will include equity measures.

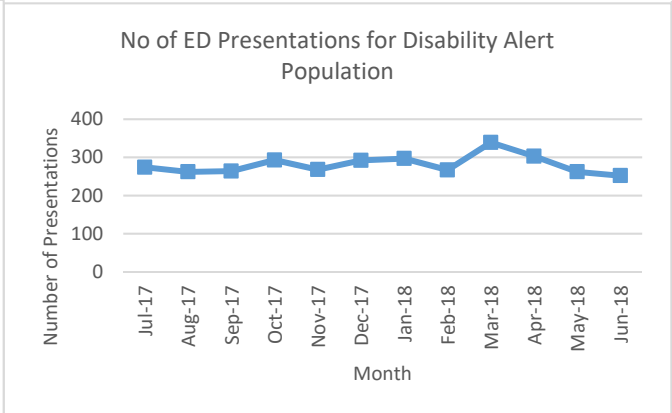
5.4. Presenting the dashboard to DSAC

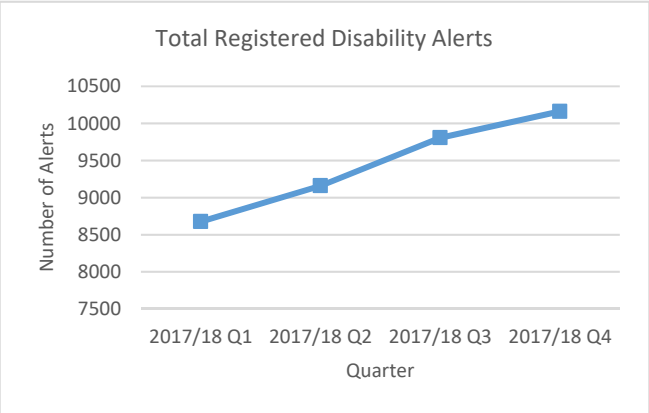
The first completed dashboard will be presented to DSAC in December 2018 with a short narrative report describing:

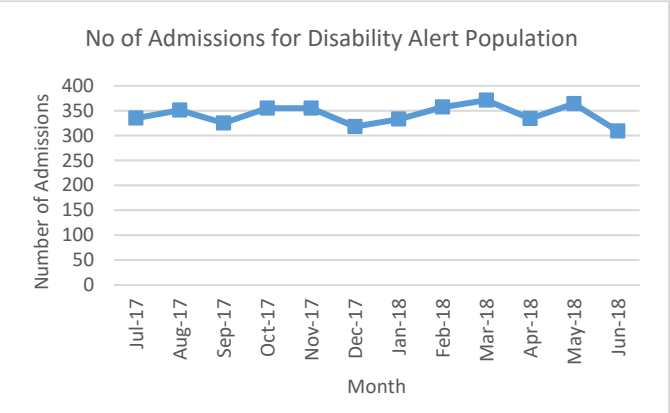
1) outcomes of improvement initiatives for the previous six months
2) performance issues for the current six months

- action plan of improvement initiatives for the coming six months


New Registered Disability Alerts by Unique NHI
Number of Alerts
250
200
150
100
50
0
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month


No of ED Presentations for Disability Alert Population
Number of Presentations
400
300
200
100
0
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month


Total Registered Disability Alerts
Number of Alerts
10500
10000
9500
9000
8500
8000
7500
2017/18 Q1
2017/18 Q2
2017/18 Q3
2017/18 Q4
Quarter


No of Admissions for Disability Alert Population
Number of Admissions
400
350
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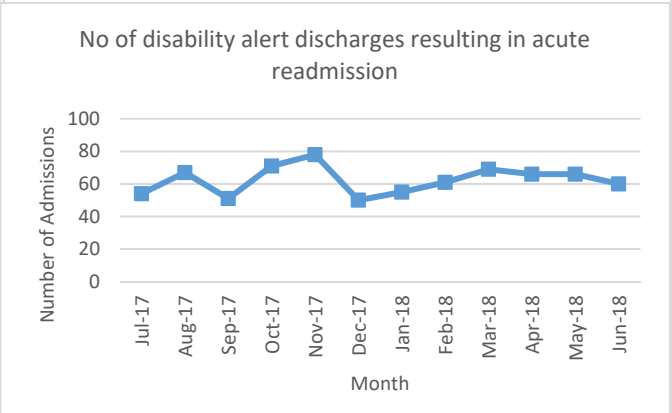
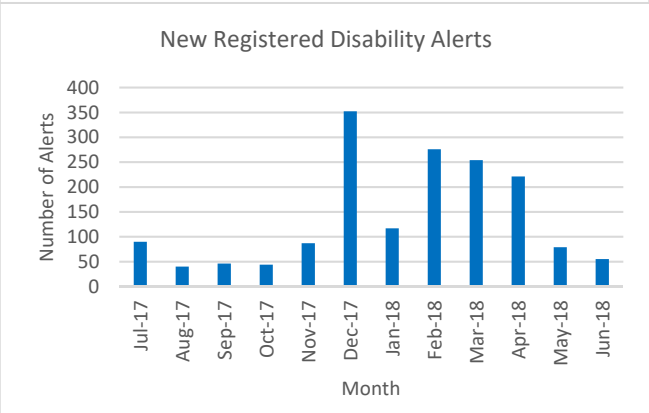
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month


No of disability alert discharges resulting in acute readmission
Number of Admissions
100
80
60
40
20
0
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month


New Registered Disability Alerts
Number of Alerts
400
350
300
250
200
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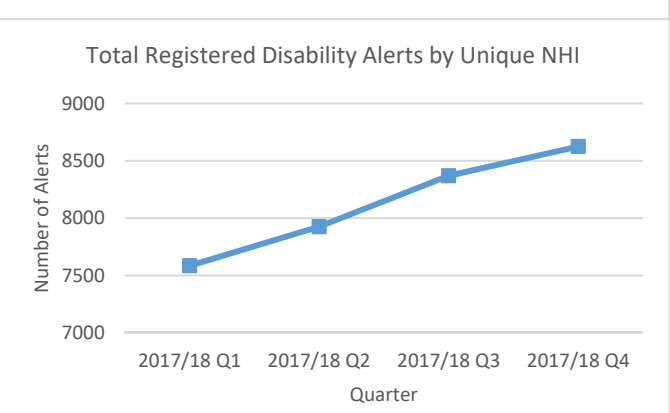
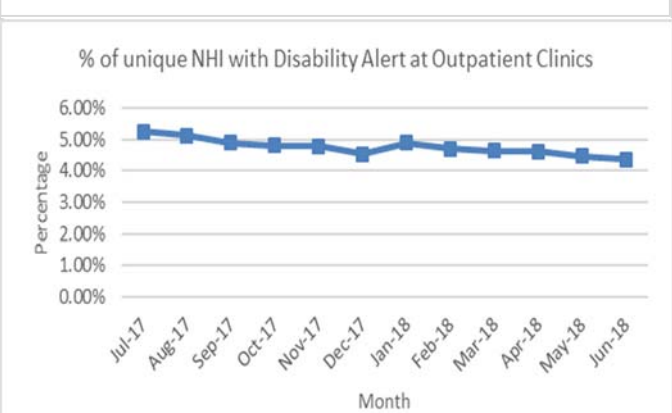
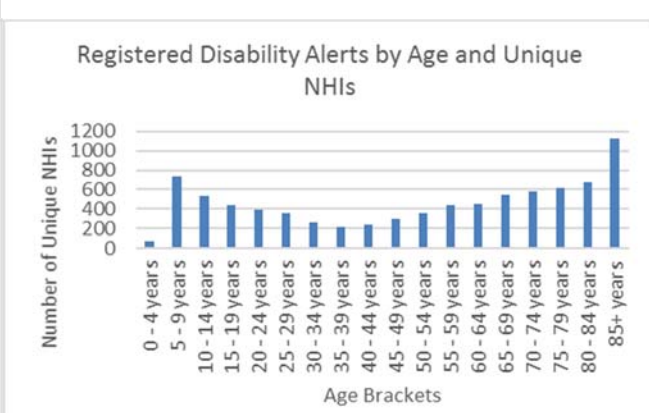
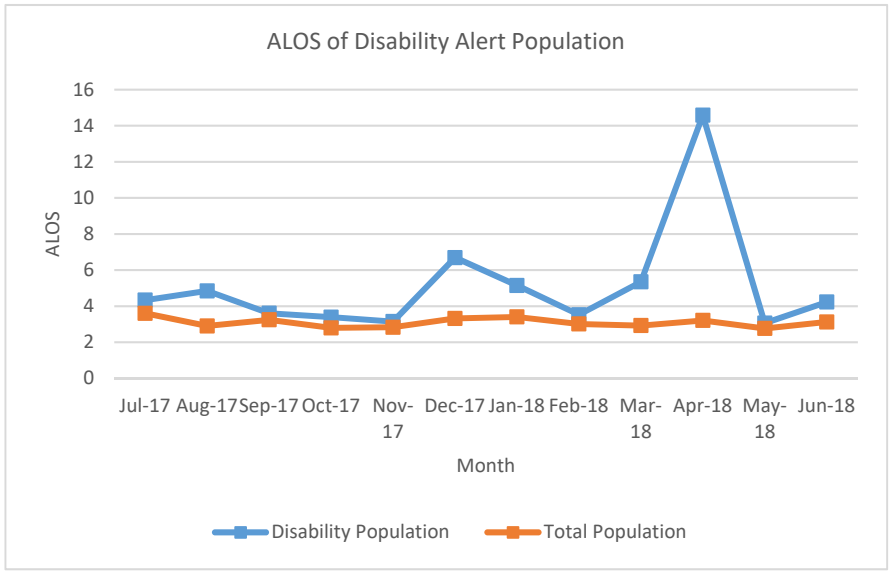
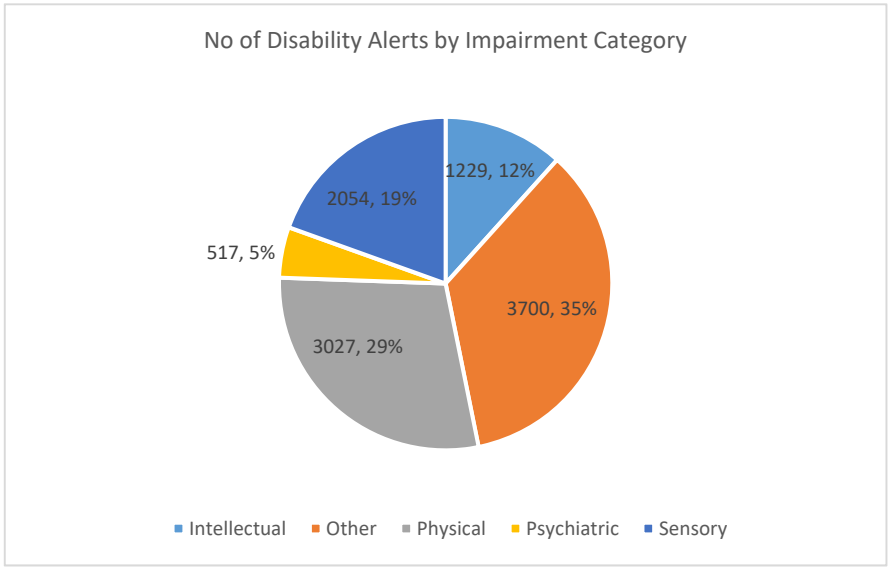
100
50
0
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month

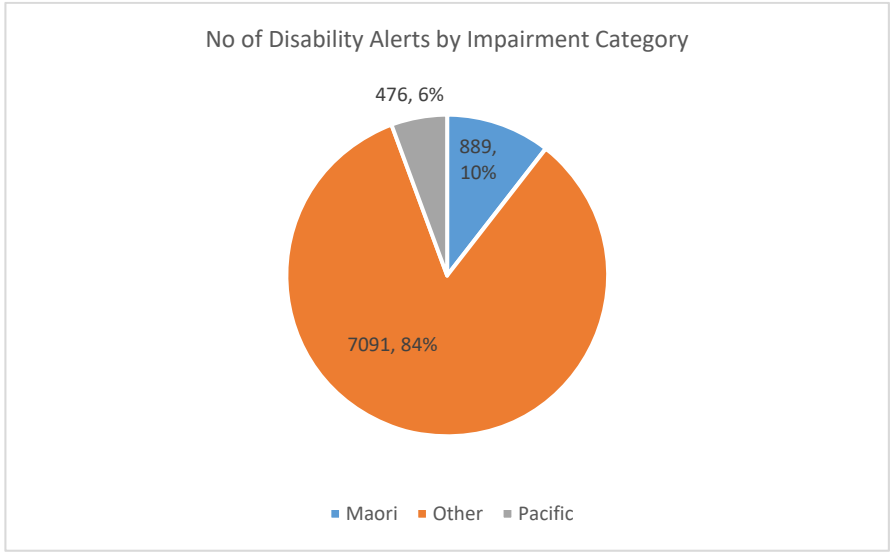

Total Registered Disability Alerts by Unique NHI
Number of Alerts
9000
8500
8000
7500
7000
2017/18 Q1
2017/18 Q2
2017/18 Q3
2017/18 Q4
Quarter


% of unique NHI with Disability Alert at Outpatient Clinics
Percentage
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month


Registered Disability Alerts by Age and Unique NHIs
Number of Unique NHIs
1200
1000
800
600
400
200
0
0 - 4 years
5 - 9 years
10 - 14 years
15 - 19 years
20 - 24 years
25 - 29 years
30 - 34 years
35 - 39 years
40 - 44 years
45 - 49 years
50 - 54 years
55 - 59 years
60 - 64 years
65 - 69 years
70 - 74 years
75 - 79 years
80 - 84 years
85+ years
Age Brackets


ALOS of Disability Alert Population
16
14
12
10
8
6
4
2
0
ALOS
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Month
Disability Population
Total Population


No of Disability Alerts by Impairment Category
1229, 12%
2054, 19%
517, 5%
3700, 35%
3027, 29%
Intellectual
Other
Physical
Psychiatric
Sensory


No of Disability Alerts by Impairment Category
476, 6%
889, 10%
7091, 84%
Maori
Other
Pacific