PUBLIC

Wairarapa DHB · Hutt Valley DHB · Capital & Coast District Health Board	**AGENDA** Held on 29 September 2021 Location: Zoom Time: 1.30pm Zoom meeting ID: 826 6127 3900

3DHB COMBINED DISABILITY SUPPORT ADVISORY COMMITTEE

	ITEM	ACTION	PRESENTER	PG
1	**PROCEDURAL BUSINESS**			
1.1	Karakia		All members	2
1.2	Apologies	**RECORD**	Chair	
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair	3
1.4	Confirmation of Draft Minutes from meeting dated 21 July 2021	**APPROVE**	Chair	6
1.5	Matters Arising	**NOTE**	Chair	13
1.6	Draft Work plan	**APPROVE**	Chair	14
2	**STRATEGIC PRIORITIES**			
2.1	Locality Community Mental Health Development (Strategic Priority: Community Mental Health Networks)	**NOTE**	Chief Executive 2DHB	15
3	**PERFORMANCE REPORTING**			
3.1	MHAIDS Service Performance Update	**NOTE**	Executive Director MHAIDS Executive Clinical Director MHAIDS	25
3.2	3DHB Sub Regional Disability Strategy 2017 – 2022 Update	**NOTE**	General Manager – Disability	42
4	**OTHER**			
4.1	COVID-19 Response	**NOTE***	Chief Executive – 2DHB Director Strategy, Planning and Performance - 2DHB Executive Leader, Planning and Performance - WrDHB	
4.2	General Business	**NOTE**	Chair	

DATE OF NEXT DSAC MEETING:
Wednesday 24 November 2021, 1:30pm-4pm, Level 11 Boardroom, Grace Neill Block

**** No paper at the meeting – presentation only***

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

3DHB Disability Services Advisory Committee

Interest Register

22/09/2021

Name	Interest
'Ana Coffe *Chair*	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Member - Te Hauora Runanga o Wairarapa • Member - Wairarapa Child and Youth Mortally Review Committee Member - He Kahui Wairarapa • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • 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) • Senior Research Fellow, University of Otago Wellington • Employee, University of Otago • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Sue Kedgley	• Member, Consumer New Zealand Board
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Jill Pettis	• Nil
Ryan Soriano	• Clinical Services Manager, Health Care New Zealand • Member, Board Trustee for Saint Patrick School Board, Masterton • Wife Employed as Senior Caregiver at Lansdowne Park Aged Care Facility
Jill Stringer	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee on Wellington Welfare Guardianship Trust
Jack Rikihana	• Chair Horo Te Pai Trust • Chair Horo Te Pai health service • Research Advisory Group – Māori • Kaumātua Advisory Group • Noose Monotony Committee • Chairman RGAM • Partner Secretary ICU Wellington • Daughter Managing Director Anaesthetists NZ
Sue Emirali	• Nil
Bernadette Jones	• Director, Foundation for Equity & Research New Zealand • Co-Chair, Tāngata Whakaha Roopu, Subregional Māori Disability Group • Co-Chair, 3DHB Sub-Regional Disability Advisory Group

	• Executive Committee member Muscular Dystrophy Central Region • Board member, My Life My Voice Charitable Trust • Member, Health Research Council NZ, College of Experts • Senior Research Fellow, University of Otago Wellington • Husband, Tristram Ingham, is a board member of CCDHB • Director, Miramar Enterprises Limited
Marama Eddie	• Board member Whaiora Whanui • Sister works for CCDHB • Sister works with the Aged Care at the Kandahar Dementia Unit in Masterton • Trustee of Ngati Kahungunu ki Wairarapa Tamaki Nui a Rua Treaty Settlement Trust • Member of Māori Women's Welfare League

3DHB DSAC MEETING **PUBLIC**

3DHB Disability Support Advisory Committee Meeting - PUBLIC

MINUTES

Held on Wednesday 21 July 2021
Boardroom, Pilmuir House, Hutt Hospital
Zoom link:
Time: 1pm-4pm

Members	Attendance	Membership
'Ana Coffey - Chair	Present	CCDHB
Sue Kedgley	Present	CCDHB
Yvette Grace	Apology	WrDHB & HVDHB
Prue Lamason	Present	HVDHB
Tristram Ingham	Present	CCDHB
John Ryall	Apology	HVDHB
Naomi Shaw	Present	HVDHB
Jill Pettis	Present	WrDHB
Jill Stringer	Present	WrDHB
Sue Emirali	Present	Sub Regional Disability Support Advisory Group Rep.
Marama Tuuta	Present	Co-Chair of Kaunihera Whaikaha
Bernadette Jones	Present	Sub Regional Disability Support Advisory Group Rep.
Jack Rikihana	Present	Te Upoko o te Ika a Maui Māori Council

District Health Board Staff Present		
Fionnagh Dougan	2DHB	Chief Executive
Dale Oliff	WrDHB	Chief Executive
Rachel Haggerty	2DHB	2DHB Director Strategy, Planning and Performance
Sandra Williams	WrDHB	Executive Leader Planning and Performance
Karla Bergquist	3DHB	Executive Director Mental Health, Addiction and Intellectual Disability Services
Paul Oxnam	3DHB	Clinical Director Mental Health, Addiction and Intellectual Disability Services
Sally Dossor	2DHB	Director of Office of the Chief Executive/Board Secretary
Rachel Noble	3DHB	General Manager Disability Strategy, Innovation and Performance
Christopher Nolan	3DHB	3DHB General Manager - Commissioning Mental Health & Addictions
Chris King	2DHB	Chief Allied Professions Officer
Meila Wilkins	2DHB	Board Liaison Officer

1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Committee opened the meeting with a karakia.

1.2 APOLOGIES

As noted above. And in addition David Smol and Vanessa Simpson (who are not members of the Committee)

1.3 CONTINUOUS DISCLOSURE

The interest register was **noted** as current and any changes would to be sent to the Board Liaison Officer via email. Jack Rikihana advised that he had an update to make and will notify the Board Liaison Officer.

1.4 MINUTES OF PREVIOUS CONCURRENT MEETING

The Committee **approved** the minutes of the previous 3DHB DSAC Meeting held on 28 April 2021.

Moved	**Seconded**	
'Ana Coffey	Jack Rikihana	**CARRIED**

1.5 MATTERS ARISING FROM PREVIOUS MEETINGS

Noted that a letter has been sent to the Ministry of Health raising funding delays and their impact on the 3DHB's contribution to He Ara Oranga.

Accessibility Charter:

- Naomi Shaw also updated the Committee that due to timing that it was not possible to pursue the LGNZ remit process for the LGNZ AGM.
- Other options were discussed regarding working with local councils in terms of their plans.
- Rachel Noble advised that in her role as co-Chair of the WCC Accessibility Advisory Group, she will soon be attending the Mayoral Forum and will be raising the Accessibility Charter.
- It was also noted that the LGWM programme includes projects that remove carparking from the City centre and it was questioned whether that programme is considering the impact on disabled people. Prue Lamason agreed to raise this.

Action: add this item on the action log. Members who also hold roles on our local councils to raise issues and see what other action can initiated.

2 ENGAGEMENT

2.1 3DHB SUB-REGIONAL DISABILITY ADVISORY GROUP

The Chairs of Sub-Regional Disability Advisory Group (SRDAG) presented.

Notes:

- The Chairs of SRDAG acknowledged and thanked staff and senior management for being accessible and easy to make the connections. Commented in the new structures for Health NZ and hope that once the reforms are in place (
- SRDAG thanked staff, particularly General Manager Disability - Rachel Noble, for work done on the COVID response.
- The Chairs invited members of the Committee and the Executive to attend their meetings.
- Feedback from the community that there is real need and that SRDAG gives voice to people in the disability communities.
- Feedback that disability voice on DSAC is appreciated but noted that there could be wider representation.
- Discussed the Sub-Regional Disability Strategy and whether the Strategy is still relevant and aligns with the work needing to be done. Recognition that the Strategy has its failings and that there is a need to move to a partnership model. Progress to review has been slow given Covid last year and the resource required for the vaccination programme. Rachel Noble noted the review that has been commissioned in preparation for a new strategy, and will be reported to the November 2021 meeting.

Action: Staff to follow up with SRDAG for an appropriate opportunity for DSAC members to attend a future SRDAG meeting.

3 SERVICE AND PLANNING

3.1 SUICIDE PREVENTION POSTVENTION ANNUAL ACTION PLAN 2021/2022

General Manager Commissioning, Mental Health and Addictions presented and responded to questions.

It is recommended the 3DHB Disability Support Advisory Committee endorse, for Board approval:

(a) 3DHB Suicide Prevention Postvention Annual Action Plan 2021/2022.

The 3DHB Disability Support Advisory Committee notes:

(a) The subregion's *Suicide Prevention and Postvention Action Plan* has been refreshed to align with the *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Action Plan 2019-2029.*

(b) *The Action Plan* aligns with the goals *Taurite Ora Māori Health Strategy 2019-2030 and Te Pae Amorangi Maori Health Strategy 2018 -2027.*

(c) The Action Plan also reflects the purpose of *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025* and the *Sub-Regional Disability Strategy 2017 – 2022 - Wairarapa, Hutt Valley and Capital & Coast District Health Boards*

(d) The Suicide Prevention and Postvention Action Plan governance group has endorsed the *Suicide Prevention and Postvention Action Plan.*

(e) The support of our *intersectoral partners* is being coordinated through our locality relationships.

(f) The implementation and progression of *The Suicide Prevention and Postvention Action Plan* and the related activities across the four domains of health promotion, prevention, intervention and postvention.

(g) That the timing of the DSAC meeting has meant the paper is yet to be presented to the Maori Partnership Board, and Subregional Disability Advisory Group and that their advice will be incorporated in the Action Plan.

3DHB Suicide Prevention and Post

Notes:

- The plan must be aligned with the National Strategy
- The plan has been developed in response to the National Strategy on suicide prevention
- Governance group has wide inter-sectorial representation.
- Experience and voice of lived experience vital and valued.
- The Committee commended the staff on the action plan.

Moved	**Seconded**	
Prue Lamason	Jill Pettis	**CARRIED**

3.2 DISABILITY COVID-19 VACCINE RESPONSE

General Manager - Commissioning Disability Responsiveness presented and responded to questions.

Creating an accessible and inclu

Notes:

- Disability guidelines produced for vaccination program
- Work on building equity for disabled people into the programme is being undertaken.

3.3 CREATING ENABLING MATERNITY CARE: DISMANTLING DISABILITY BARRIER - MUMS AND BABIES' EXPERIENCE AT THE 3DHB

The 3DHB General Manager – Disability spoke to the paper.

The 3DHB Disability Support Advisory Committee noted:

(a) the 3DHB review of disabling barriers to maternity care at 3DHB.

Notes:

- Noted the work is well timed and informed to feed into the strategic priority on Maternity and women's health.
- The report has been useful to understand equity and how we can changed current practises, before passing over to Health New Zealand.
- Maternal mental health is a priority for the government which should bring focus to this area and opportunities for funding.

3.4 3DHB FINAL DRAFT ANNUAL PLANS 2020/21

The 2DHB Director Strategy, Planning and Performance spoke to the paper and was available for questions.

The 3DHB Disability Support Advisory Committee noted:

(a) the CCDHB, HVDHB, and WrDHB final draft annual plans 2021/22

Notes:

- The Draft Annual Plans were included to ensure that DSAC sees the Mental Health and Disability sections in them.
- Draft Annual Plans have been submitted to the Minister but not yet signed off.

3.5 MENTAL HEALTH AND ADDICTION COMMISSIONING FORUM

The 2DHB Director Strategy, Planning and Performance spoke to the paper and was available for questions.

The 3DHB Disability Support Advisory Committee noted:

(a) The establishment of a Mental Health and Addiction Commissioning Forum to steer the design and implementation a whole of population, equitable, mental health and addiction system of care to support the wellbeing of the people in our subregion.

(b) The appointment of office holders and members to the Mental Health and Addiction Commissioning Forum from four groups: DHB system leaders; people with lived experience; Māori; and clinical/expert leaders.

(c) The Mental Health and Addiction Commissioning Forum's role to provide advice and recommendations to the Chief Executive, Hutt Valley and Capital & Coast DHBs.

(d) The Mental Health and Addiction Commissioning Forum will provide governance for our DHBs' delivery on the mental health and addiction strategic priority; driving system transformation as we transition to a new health and disability system.

(e) The plan to hold the first meeting of the Mental Health and Addiction Commissioning Forum in August 2021

Notes:

- This is a 2DHB forum to create a 'whole system' approach.
- Leadership forum rather than a representative forum – there are lots of groups which sit alongside it.
- This provides an opportunity to take a fresh look at the services and to ensure that people with disabilities (and all persons) can access.
- A pro-equity approach is being advanced.
- Representation on the forum will include the 2DHB Director Māori Health, Director Pacific People's Health and General Manager – Disability.

4 REPORTING

4.1 3DHB SUB-REGIONAL DISABILITY STRATEGY 2017-2022 UPDATE

The 2DHB Director Strategy, Planning and Performance and 3DHB General Manager – Disability was available for questions.

The 3DHB Disability Support Advisory Committee noted:

(a) the update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

(b) the disability question has been prototyped included in our regional booking processes and systems established to allow people to request reasonable accommodations if required.

(c) the Disability Equity e-learning modules are now available on Connect Me, Ko Awatea and Health On Line.

Notes:

- Highlighted importance of representation and enabling disabled people to participate in the health system
- Timeline was acknowledged, looking forward to the new strategy.
- Progress the Accessibility Charter

4.2 3DHB MHAIDS SERVICE PERFORMANCE UPDATE

The paper was taken as read. The Executive Director MHAIDS spoke to the paper and was available for questions.

The 3DHB Disability Services Advisory Committee notes:

(a) the attached data report from MHAIDS

Notes:

- The Executive Director MHAIDS noted increasing demand from young people for services.
- Noted there is a shortage of experienced clinical staff, which is a nationwide issue.
- Work is underway on how delivery options could improve waiting times.
- Ongoing therapy is difficult to resource
- The ratio of urgent to non-urgent has shifted and is increasing the challenge
- WrDHB acknowledged the 'on call' GP liaison service

5 OTHER

5.1 GENERAL BUSINESS & AGENDA ITEM 1.6 (DRAFT WORKPLAN)

The Committee discussed the work programme moving forward in light of health system reform.

6 NEXT MEETING

Wednesday 29 September 2021, 1:30pm-4pm, Boardroom, Pilmuir House, Hutt Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2021

'Ana Coffey
DSAC CHAIR

DSAC ACTION LOG - as at 23/09/2021

Action Number	Date of meeting	Due Date	Date Completed	Status	Assigned	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
DSAC2021-02	21-Jul-21	Next meeting for update		In progress	Committee members	1.5	Action items	Continue to raise the adoption of the Accessibility Charter (and more important- actions under it) with our local government partners. Important in the design work on new projects, for example the LGWM project and consideration of the impact on disabled	Members who also hold roles on our local councils to raise issues and see what action can initiated.
DSAC2021-03	21-Jul-21			In progress	General Manager - Disability	2	Engagement with SRDAG	SRDAG invited DSAC Chair (and members) to attend a future SRDAG meeting.	

DSAC DRAFT WORK PLAN 2021/22 AS AT 22/09/2021			
	24 November 2021 Capital & Coast 1:30pm-4pm	**16 March 2022 Hutt Valley 1pm-4pm**	**Placeholder meeting (TBC) 8 June 2022 Capital & Coast 1pm-4pm**
Strategy			
Sub Regional Disability Strategy 2017 - 2022	Review of Sub Regional Disability Strategy 2017 - 2022	To be confirmed following review	
3DHB Mental Health and Wellbeing Strategy • Sub Regional Living Life Well - a strategy for mental health and addiction 2019 – 2025 • 3DHB Suicide Prevention Postvention Annual Action Plan 2021/2022	3DHB Mental Health and Wellbeing Strategy Update	3DHB Mental Health and Wellbeing Strategy Update	
Strategic Priorities			
Mental Health and Addiction Services	Kaupapa Māori Mental Health Service Development	Child and Adolescent Mental Health	
Performance Reporting			
3DHB Disability Performance	3DHB Disability Performance	3DHB Disability Performance	
3DHB MHAIDS Performance Report	3DHB MHAIDS Performance report	3DHB MHAIDS Performance report	
3DHB Mental Health and Addictions Outcome Framework	3DHB Mental Health – Commissioning		
System and Service Planning			
Draft Annual Plans 2022/23 (Mental Health, Addiction and Disability Sections)	Planning process for 2022/2023 – subject to confirmation of process required for Health New Zealand.		
System Performance			
Mental Health – Provider (MHAIDS) and System (SPP)	Mental Health – Provider (MHAIDS)		
Other			
Update following any announcement on system transformation for disability support services.	TBC		

Disability Support Advisory Committee

29 September 2021

Locality Community Mental Health Development (Strategic Priority: Community Mental Health Networks)

Action Required

The Committee notes:

(a) the purpose of the Community Mental Health and Addiction (MHA) Change Programme (the Programme) is to design, and implement integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua that are operational by 30 June 2022.

(b) the Programme is part-funded by Ministry of Health investment and is one of three MHA strategic priorities for delivery in the 2021/2022 financial year, as our DHBs transition to a new health and disability system.

(c) the first stage of the Programme is the MHAIDs-led 3-month Te Haika/Crisis Response project to address immediate pressures in our 24 hour call centre and intake/triage services and will consider our community mental health teams' structure.

(d) Te Rangapū Ahikaaroa, our memorandum of understanding with Ngāti Toa Rangatira and Te Āti Awa ki te Upoko o te Ika a Māui, is our platform for partnering to design and develop community MHA services for Māori.

(e) the Mental Health and Addiction Commissioning Forum will provide Programme governance and the design process will implement the Pro-Equity, People-based Commissioning Policy to understand and address inequities for our priority populations.

(f) the enablers for the Programme design and implementation – our evolving partner, provider and stakeholder MHA networks, including the Lived Experience Advisory Group.

Strategic Alignment	*Health System Plan 2030* *Living Life Well A strategy for mental health and addiction 2019-2025* *Taurite Ora Māori Health Strategy 2019-2030 and Te Pae Amorangi Maori Health Strategy 2018 -2027* *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region* *Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services*
Author	Catherine Inder, Principal Advisor, Mental Health and Addiction, SPP
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Fionnagh Dougan, Chief Executive
Purpose	To introduce the strategic priority Community Mental Health and Addiction Change Programme to modernise community MHA services and improve equity
Contributors	Karla Bergquist, Executive Director, Mental Health, Addiction and Intellectual Disability Services (MHAIDS) Paul Oxnam, Clinical Director, MHAIDS Rachel Haggerty, Director, SPP Chris Nolan, General Manager Commissioning, Mental Health & Addiction, SPP
Consultation	N/A

Executive Summary

This paper describes our programme structure and progress establishing the strategic priority Community Mental Health and Addiction (MHA) Change Programme – a significant first step towards developing a whole-of-population, community/locality-based, networked MHA service system for the full continuum of care in our subregion.

The strategic priority Community MHA Change Programme, and three complementary projects, are designed to alleviate significant pressures on our MHA acute and crisis services by establishing integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua responsive to the people with MHA needs in those communities.

Our design process will implement the Equity Principles and the Pro-Equity, People-based Commissioning Policy. We will partner with mana whenua and work closely with our priority populations and people with lived experience of mental distress, illness and addiction to codevelop the case for change; the models of care and pathways; service delivery model options; and, a pro-equity service delivery investment case for the consideration of the MHA Commissioning Forum.

Our approach includes a focus on the culture and behaviour changes that must underpin the service changes and continuing to grow and develop our MHA networks – the enablers for both designing and implementing community MHA services in our localities.

Strategic Considerations

Service	Mental Health and Addiction services
People	The Director, People and Capability, is supporting service change management processes
Financial	The Community MHA Change Programme team and consultants are part-funded by the Ministry of Health investment in *Collaborative Design and Implementation Support*
Governance	The Mental Health and Addiction Commissioning Forum

Engagement/Consultation

Patient/Family	Lived Experience Advisory Group
Clinician/Staff	A wide range of clinicians will be engaged in developing models of care and service delivery models via our MHA networks and forums
Community	Community providers via the Partner, Provider and Stakeholder Collaborative Forum and the Alcohol and Other Drug Model of Care Collaborative Forum

Identified Risks

High level project risks will be identified in the programme and project documentation.

Attachments

Attachment 1 – Our evolving Mental Health and Addiction networks.

Community Mental Health and Addiction Networks

Purpose

1. This report describes our Hutt Valley DHB and Capital & Coast DHBs' (2DHB) strategic approach and progress towards implementing a Mental Health and Addiction (MHA) community/locality networked service delivery model that meets the needs of communities.

Introduction

2. Our 2DHBs have been implementing the Health System Plan 2030, and Living Life Well (2019), across our districts. The impetus has been to transform our health system to support the capabilities of our communities and to make our health system easier to navigate, more effective, and more affordable. Critical to this has been building strong partnerships with mana whenua, community leadership, and our wider network of health and social sector partners.
3. We recognise that there is an urgent need to alleviate the significant pressures on our MHA services, and to respond to *He Ara Oranga – the Report of the Government Inquiry into Mental Health and Addiction*, by designing a whole of system MHA system for the full continuum of care (inclusive of prevention and early intervention). *He Ara Oranga* calls for a transformed approach to MHA in New Zealand requiring significant investment over years and signals the need for a system of services that meets the full spectrum of need.
4. These recent reports to the Disability System Advisory Committee provide the background and context for this report. They describe the pressures on our MHA services; our current state; and the range of projects we have put in place to address these challenges:
    - Implementing Living Life Well (February 2019)
    - Acute Mental Health Integrated Service Response (18 December 2020)
    - Alcohol and Other Drug (AOD) Model of Care and Priority Investment (31 March 2021)
    - Our 3DHBs' Mental Health and Wellbeing Strategies Update (28 April 2021).
5. This report is focused on the work to stand-up the Community Mental Health and Addiction Change Programme (Community MHA Change Programme) which is a key part of the MHA Strategic Priorities Programme.

Community Mental Health and Addiction Change Programme

6. Our Living Life Well strategy recognises that "we can do a better job of providing earlier intervention when things start to go wrong, and focusing our attention on those with inequitable health outcomes."
7. Our 2DHBs are committed to modernising community MHA services to offer a joined-up approach that is more responsive to the diverse needs of people who are experiencing mental illness, mental distress and/or the issues related to the use of alcohol and other drugs.
8. The purpose of the Community MHA Change Programme is to design, develop and implement integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua that are operational by 30 June 2022 and are:
    - closely aligned with primary health care, social services and other third sector partners
    - physically situated in the community

- easy for people to access
- focused on reducing inequities in health access and outcomes
- delivering culturally safe, trauma-informed care
- contributing towards the health and well-being of the population in each locality.

Programme structure

9. This paper is primarily focused on the Community MHA Change Programme which is one of three MHA Strategic Priorities for delivery in the 2021/2022 financial year, as our DHBs transition to a new health and disability system.

10. The Community MHA Change Programme is co-led by the Mental Health, Addiction and Intellectual Disability Service (MHAIDs) and Strategy Planning and Performance (SPP) and is part-funded by the Ministry of Health investment in *Collaborative Design and Implementation Support*. Synergia, a leading Australasian analytics, consulting and evaluation group, is helping us scope and plan the programme of work. We have recruited a programme director, a communications expert and are in the process of employing additional project resources into both MHAIDs and SPP. The Director, People and Capability, will support the MHAIDs' change management processes.

11. The first stage of the Community MHA Change Programme is the Te Haika/Crisis Response project to address immediate pressures in our 24 hour call centre and intake/triage services and will consider our community mental health teams' structure. Synergia is developing an urgent, three-month project plan aligned to a community/locality networked service delivery model.

12. There are three projects that complement the Community MHA Change Programme, two of which are also MHA Strategic Priorities:

    - The Child and Adolescent Mental Health project which is in the discovery phase (a MHA Strategic Priority).
    - The Kaupapa Māori Mental Health Development project which includes the development of Kaupapa Māori Community Forensic Services and the redevelopment of the Kaupapa Maori service in the Hutt Valley (a MHA Strategic Priority).
    - The Health Infrastructure Unit in the Ministry of Health is leading the project to replace and expand the 24 bed Acute Inpatient Unit in the Hutt Valley with a new 34 bed unit. A benefactor is making a substantial contribution to the replacement and we understand that signing a deed with the benefactor is imminent. We will then commence the detailed design process in partnership with the Ministry of Health; the preferred architect; and the benefactor's team. We will codevelop the unit with our user group that includes mana whenua, lived experience, and clinicians supported by a project manager who has recent experience of the design and implementation process.

Governance

13. The MHA Commissioning Forum (the Commissioning Forum) has been established to provide advice and recommendations to the Chief Executive on the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. Chaired by the Chief Executive, the Commissioning Forum has ten members (including the Chair) from four groups:

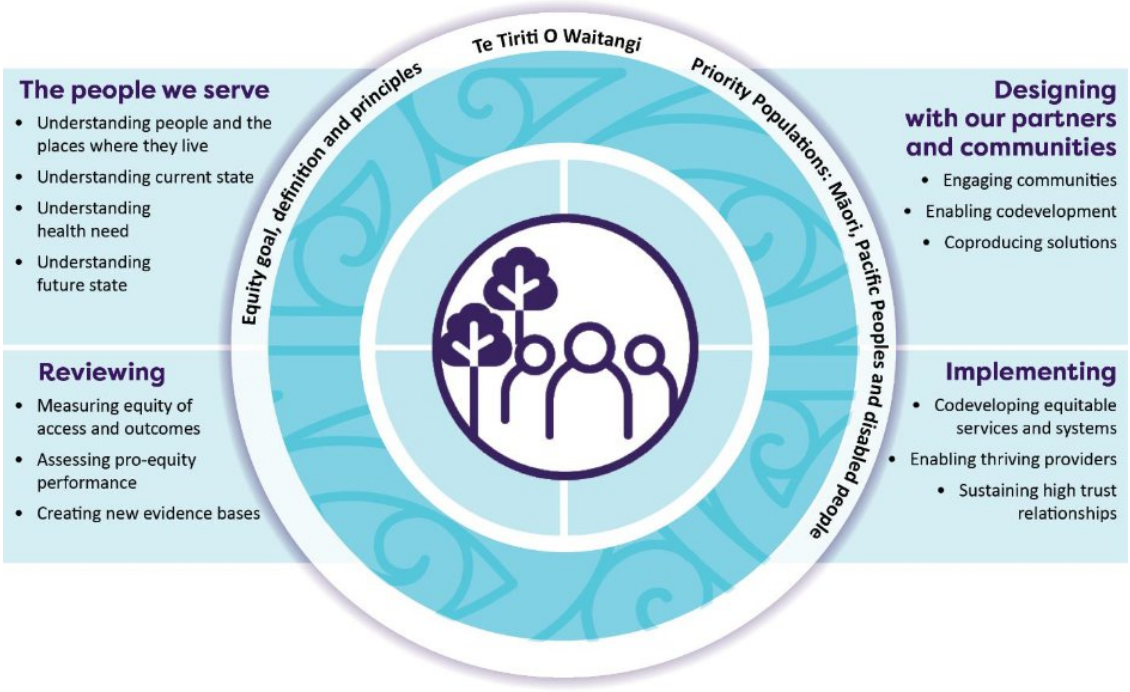
    - System leaders – DHB leaders focused on health system performance and equity
    - Lived experience leaders – people with experience of MHA issues contributing their perspectives and ideas

- Māori – partnering with Māori in fulfilment of our Te Tiriti obligations and to strengthen mātauranga Māori in our MHA services
- Clinical/Expert - contributing system, service, clinical and cultural knowledge and ways of knowing.

14. The Commissioning Forum's first meeting was on 13 September 2021. It agreed that its immediate focus is delivery of the Community MHA Change Programme.

Approach - Pro-Equity, People-based Commissioning Policy

15. The Commissioning Forum has responsibility for implementing our Pro-equity, People-based Commissioning Policy when we are commissioning MHA systems and services, including the Community MHA Change Programme.
16. The Pro-equity, People-based Commissioning Policy mandates processes and standards for all our 2DHB commissioning activities. The Policy requires our DHBs to ensure that those responsible for commissioning health services and supports:
    - uphold the principles of Te Tiriti o Waitangi, as they apply to the health and disability sector
    - incorporate our DHBs' Equity principles into all aspects of their commissioning practice
    - ensure the commissioning strategies and investment choices are proportionate and will address the equity gaps for Māori, Pacific peoples and Disabled people
    - ensure health services and supports are focused on improving equity.
17. The Policy introduces a bespoke 2DHB pro-equity, people-based commissioning cycle with four overlapping and non-sequential phases: The People we Serve, Designing with our Partners and Communities, Implementing, and Reviewing. The four phases define the approaches and activities that underpin commissioning to redress inequities. The Policy is supported by a complementary health intelligence operating model.



Community MHA Change Programme – our design process

Overview

18. We are initiating a codesign process for place-based, community MHA services. A good design process is both a means to an end and a goal in itself. The granularity inherent in designing place-based, community MHA services naturally drives a pro-equity approach. Designing place-based community MHA services will begin to attract and grow natural community resources that are essential for improving individual, family and whānau and community wellbeing.

19. The design process needs to grapple with the extent of the behaviour change needed in MHA services. Our lived experience voices tell us that people in mental distress often feel much worse after coming in contact with our services. A good design process will be conducive for culture and behaviour changes in the participants that can amplify across workforces and services.

20. The codesign process will incorporate multiple intersecting lenses including Māori and Pacific peoples' cultural perspectives; those of Disabled people; and people with lived experience of mental illness, distress, and addiction; and from other population groups for example, gender and sexual minorities and refugees. The design process needs to also include the perspectives of clinicians and providers and engage our health and other sector partners including criminal and youth justice, housing, and social services.

21. The goal of the design process is to ground multi-dimensional thinking into defining the full MHA continuum of care for each of our localities and, in doing so, create a shared understanding of the desired outcomes, what needs to change, and commitment for change.

Partnering with mana whenua

22. The ongoing processes of colonisation have traumatised generations of Māori whānau, and our Māori communities, compared to other population groups, experience significantly higher rates of mental distress. For example, Māori are legally mandated into MHA treatment more than any other groups. We must ensure that our investment in place-based community MHA services matches our commitments to upholding Te Tiriti o Waitangi and to addressing inequities.

23. In July 2021, our 2DHBs and Ngāti Toa Rangatira and Te Āti Awa ki te Upoko o te Ika a Māui signed Te Rangapū Ahikaaroa, a new memorandum of understanding. Te Rangapū Ahikaaroa differs from previous agreements because the two Iwis, facilitated by our 2DHBs, have put aside historical differences, strengthened their relationship, and are working together to improve health outcomes. Te Rangapū Ahikaaroa is our platform for partnering to commission community MHA services for Māori.

24. Developing strong and trusted relationships with mana whenua is key to designing accessible, mana-enhancing, trauma-informed MHA community services that can play their part in restoring wellbeing to Māori whānau and communities.

Developing the case for change

25. The first step is to bring together a comprehensive picture of the people we serve, MHA need, investment, and service provision in our communities. Locality commissioning allows us to pinpoint where we can make the greatest difference for Māori, for example, where there is deprivation and compulsory treatment orders are high.

26. Synergia analysts are augmenting our health analysis team and updating 2018 data prepared for Capital & Coast DHB's response to the Government Inquiry into Mental Health and Addiction.

Work is underway to develop 4 locality storyboards for Kāpiti, Porirua, Wellington and the Hutt Valley so that we understand:

- **Our population cohorts:** children, young people and their families and whānau; Pacific, Māori; episodic adults; complex illness; and, older people
- **Who our people are and where they live**: ethnicity; age; and, deprivation
- **Our continuum of services**: Public Health; community commissioning; primary care; specialist mental heath; and, hospital services
- **Our investment**: revenue received for MHA; where we invest; the cost of delivery; and, identification of patterns and under/over-servicing
- **Our unmet need**: in community; primary care; NGO; and, MHAIDs services.

27. The four locality storyboards will help us understand both the opportunity costs and the opportunities for change and summarise these in a case for change.

Determining our models of care and service delivery options

28. Once the case for change is sufficiently refined we will be able to codevelop models of care for each of our 4 localities and identify priority pathways for defined service user groups in those localities.
29. In an iterative process, the models of care and priority pathways will enable the codesign of locality-based service delivery options including workforce configurations and service delivery modes and settings.

Change management and implementation

30. The outcome of the above steps is a pro-equity service delivery investment case for the consideration of the MHA Commissioning Forum that covers:
    - our current investment and contracts
    - the design options identified
    - the investment choices proposed
    - how our obligations under Te Tiriti o Waitangi will be upheld
    - the service commissioning plan including proposed workforce and team structures; clinical pathways; and practice and culture changes.

Our evolving Mental Health and Addiction networks

Overview

31. Paralleling the Community MHA Change Programme, we will continue to invest in and grow our MHA collaborative networks and forums as the enablers for a whole-of-population, community/locality-based, networked MHA service system for the full continuum of care.
32. We have provided more information in the Appendix about our Lived Experience Advisory Group and two of our existing MHA networks – the Partner, Provider and Stakeholder Group (working name) and the AOD Model of Care Collaborative. We are developing these potentially system-level MHA networks to enable them to effectively contribute to both the discovery, design, and implementation phases of the Community MHA Change Programme.

Future networked service delivery

33. MHA collaborative service delivery networks (MHA networks) can foster the development of shared responsibility and care for individual, service and system outcomes and enable partners, providers and stakeholders (inclusive of lived experience) across the continuum of care to coordinate and improve services.

34. A high-functioning, self-sustaining MHA network offers participants a level playing field that nurtures the collective spirit and collaborative leadership necessary to deliver distributed, community services, and improve equity, access, quality and outcomes.

35. MHA network participants lead the network and health commissioners provide it with backbone support including advice, facilitation, coordination, project resource, and, if needed, a visible and responsive escalation pathway.

36. MHA networks connect naturally with other networks enabling both formal (for example, representation) and informal (at the project or client-level) contributions to each other's service delivery focus across both health service and other agency boundaries. We have identified these design principles associated with successful networks:

    - creating a 'level playing field' ensuring providers have equality of opportunity and visibility
    - at the decision-making level, ensuring service leaders across the continuum of care are represented
    - ensuring secretariat resource with defined functions including coordinating activity, quality improvement, and sharing network 'intelligence'
    - focusing on the need to address equity issues across the service system
    - supporting distributed service delivery, leadership and accountability
    - creating tools to facilitate collective understanding and the 'how-to' of service delivery.

Progress

37. At the system level, we are establishing an overarching partner, provider and stakeholder network that represents the full continuum of care responsible for implementing significant change programmes through connections to locality networks. At the local level, we plan to replicate the system level network with networks delivering connected core MHA services to a defined critical mass of approximately 50,000 people.

38. Our existing collaborative MHA networks and forums are developing the collaborative leadership and the effective partnerships necessary to implement our integrated models of care - the Acute Care Continuum Model of Care and the Alcohol and Other Drug (AOD) Model of Care and the Community MHA Change Programme.

39. These networks are at different stages of maturity and do not yet cover the full range of needed services. Our partners, providers and stakeholders are committed to collaborative service delivery but lack the tools and experience to do so successfully - especially when complexity conspires to defeat their good intent. We need to prioritise:

    - professional development that can build our workforces' skills for collaborative problem solving in real service contexts
    - developing a service mapping tool describing each MHA service's focus, position on the continuum of care, and alignment to other services.

Attachment 1: Evolving Mental Health and Addiction Networks

Lived Experience Advisory Group

1. The 3DHB Lived Experience Advisory Group (LEAG) was established in 2018 recognising the gap in lived experience leadership across the MHA system of care. SPP and LEAG work together to ensure that lived experience voices contribute to all MHA initiatives. LEAG's objectives are to:
    - guide and support the work of the 3DHB Strategy, Planning and Performance MHA teams
    - provide two-way feedback between the 3DHBs and people and whānau with a lived experience of MHA in the community
    - identify two individuals with specific expertise to provide advice on 3DHB projects
    - identify individuals with specific expertise to peer review 3DHB documents
    - identify needs and solutions, and present these to the 3DHB partners.
2. Two members of LEAG are represented on the Commissioning Forum (the MHAIDs Consumer Advisor representative on LEAG and another member voted by LEAG to represent it).
3. The need for lived experience voices to contribute to the Community MHA Change Programme will place increased demands on LEAG members. We are working with LEAG to build members' capacity and capability including through:
    - actively building the membership to ensure representation of our priority populations
    - facilitating learning and leadership development opportunities through linking to practiced lived experience national and regional leaders
    - supporting members to expand their constituencies of interest.

Partner, Provider & Stakeholder Collaborative Network

4. This tentatively named group is reforming following its previous incarnation as the Acute Care Continuum Collective Forum and the successful completion of a significant initiative to develop and implement the Acute Care Continuum Model of Care.
5. The Acute Care Continuum Collective Forum was collectively responsible for delivering a flexible, fully responsive acute system of care by supporting engagement to build trust; solving challenges to implement system change; coordinating project activities; and coproducing solutions. Its members are MHAIDS operational managers; whānau and lived experience representatives; managers from MHA Hutt Valley-based NGO acute care services; and 2DHB partners.
6. The Partner, Provider & Stakeholder Collaborative Network (the Network) has a broader membership incorporating primary care and broader health and community representation from across both the Hutt and Wellington regions. The Network's goals are to:
    - support distributed service delivery leadership and accountability
    - grow a whole of system approach to the provision of MHA services across the region

- support the development of enhanced cross health sector and intersectoral relationships
- support joined up, equitable and seamless service provision across the health and social sectors.

7. We are setting the Network up carefully and actively managing it recognising the opportunity for a high-functioning network across a broad continuum of care. Key challenges are:
    - size - the reconfigured group will be large so it will need to be carefully managed to ensure effectiveness
    - strengthening the representation of our priority populations
    - focusing on behaviours – managing tensions between specialist DHB services and community services.

Alcohol and Other Drug (AOD) Model of Care Collaborative

8. The collaboratively developed AOD Model of Care takes a whole-of-population approach to reducing substance-related harms by enabling early intervention in places that work for the people experiencing and exposed to the harms. The Model of Care identifies five priority pathways (for Māori, Pacific people, young people, people living rurally or remotely, people with severe problems).
9. The AOD Model of Care Collaborative has representatives from people with lived experience, PHO, Regional Public Health, NGO AOD providers, DHB mental health and addiction clinicians and operational managers, Kaupapa Māori AOD providers, and a Pacifica AOD provider. The AOD Collaborative also incorporates the Youth Coexisting Problems Collaborative - specialist providers who deliver services for youth.
10. The AOD Model of Care Collaborative is key to enabling a coordinated approach to the implementation of new AOD services. Its goal is to build the relationships that are needed to implement the priority pathways.

Disability Support Advisory Committee

29 September 2021

MHAIDS Service Performance Update	
Action Required **The Committee notes** the attached report from MHAIDS.	
Strategic Alignment	Service Access
Presented by	Karla Bergquist, Executive Director MHAIDS Paul Oxnam, Executive Clinical Director, MHAIDS
Purpose	To update DSAC on the MHAIDS Service Performance data
Contributors	Karla Bergquist, Executive Director MHAIDS Paul Oxnam, Executive Clinical Director, MHAIDS
Consultation	N/A

Executive Summary

People accessing services

- There are currently 7,141 Current Service Users in the Community.
- In the past 12 months MHAIDS received referrals for 14,665 individuals.
- The number of people that had contact with MHAIDS increased by 14.4% between 2014-15 and 2020-21. The rate of increase for Māori is significantly higher than that for Non-Māori.
- The patterns are similar across DHBs although the rate of Māori accessing services in Hutt has dropped slightly in recent years (7.2 to 6.5%).

Urgent referrals

- While overall referral numbers have returned to levels similar to previous years, there has been a marked increase in urgent referrals received since the end of the initial COVID-19 lockdown in April/May 2020. This pattern has continued over the last 12 months.
- The most significant demographic group for this increase in urgent referrals has been young people aged 24 and under.

Crisis Resolution Service

- The Crisis Resolution Service saw a significantly higher number of people in the months post COVID-19 lockdown last year than in previous years. The number of people presenting in crisis has remained high this year.
- Again the biggest increase has been in presentations by young people (aged 24 years and under) and the monthly total has remained at a higher level than pre-COVID.

Community Caseloads & Wait times

- In the past six years, community caseload totals have generally increased year on year. There are 384 more people on Younger Persons teams caseloads relative to 2014 (20.8% increase) and 267 more people on Adult teams caseloads (7.0% increase).
- The Ministry of Health targets for wait times are 80% of people to be seen within 3 weeks of referral and 95% of people to be seen within 8 weeks. The Younger Persons sector has struggled to meet these targets – the mean since Jan 2020 is 56% seen within 3 weeks and 83% seen within 8 weeks.
- The Adult Community & Addictions sector has slightly higher wait times results – the mean since Jan 2020 is 58% seen within 3 weeks and 87% seen within 8 weeks.

Acute Inpatient Services

- Bed occupancy in the two adult acute inpatient units remains a critical issue with Te Whare O Matairangi in particular regularly being at maximum or over capacity.

Strategic Considerations

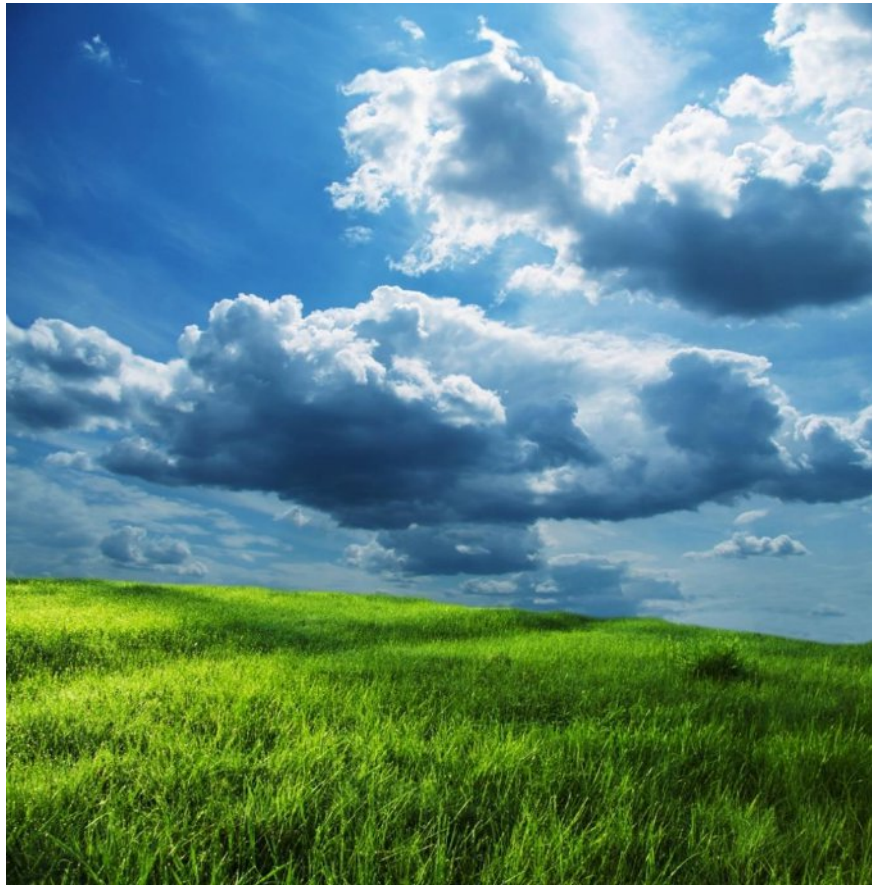
Service	All 2DHB services are committed to delivering safe, quality care to patients and whānau, and ensuring staff safety.
People	Increase understanding of patient safety, quality improvement patient / whānau experience and recognising opportunities for learning.
Financial	Poor patient outcomes and harm can have a direct financial impact on the performance of our DHBs.
Governance	We will strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across the health and disability system of the 2DHBs.

Attachment/s

1. MHAIDS Service Performance Report

Mental Health, Addiction and Intellectual Disability Service

Service Performance Update to DSAC September 2021



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

7,141 Current Service Users in the Community

1,585 Māori (22.2%)	429 Pacific Peoples (6.0%)	331 Asian (4.6%)	4,796 Other Ethnicity (67.2%)

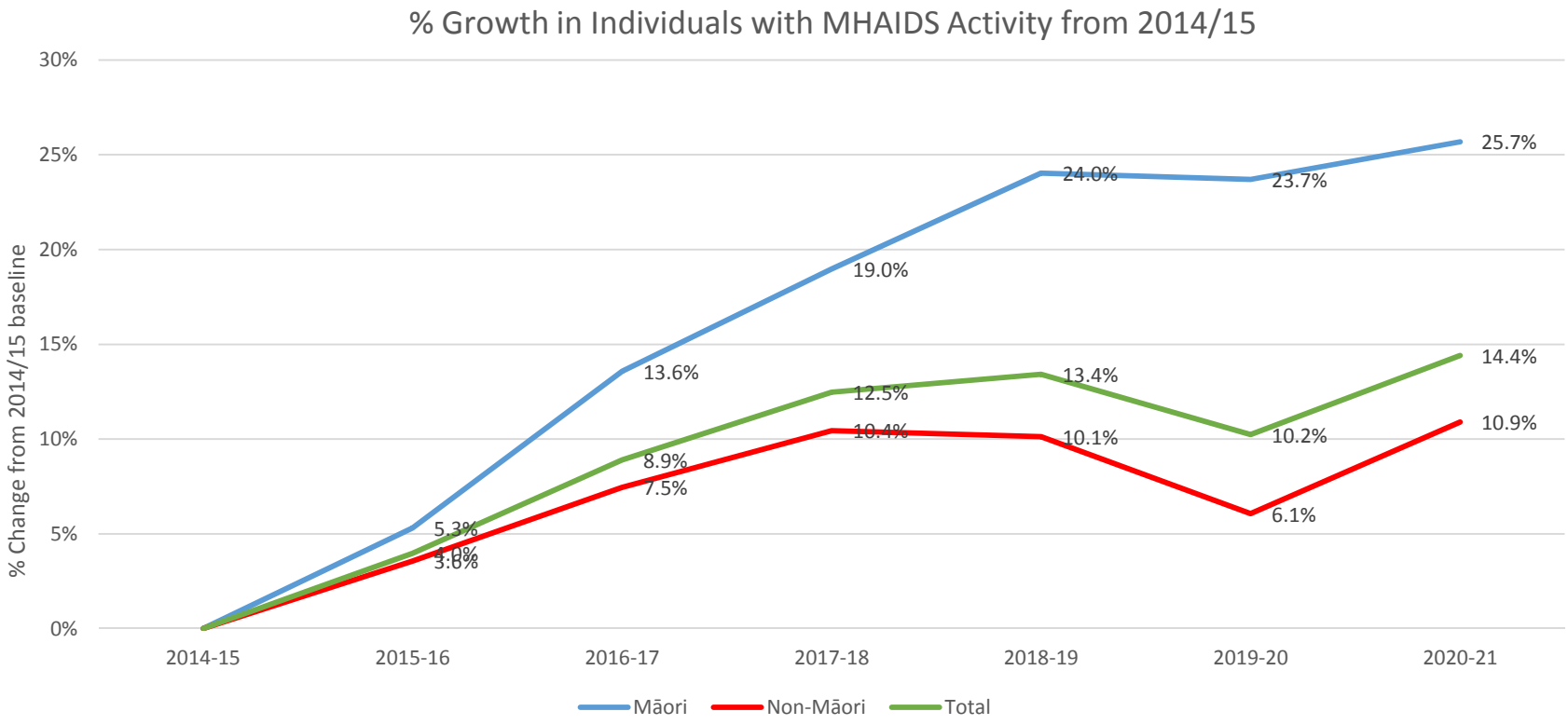
In the past 12 months MHAIDS received referrals for 14,665 individuals

3,604 Māori (24.6%)	781 Pacific Peoples (5.3%)	661 Asian (4.5%)	9,619 Other Ethnicity (65.7%)

HUTT VALLEY DHB
Capital & Coast District Health Board
Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

People accessing MHAIDS services

The number of people that had contact with MHAIDS increased by 14.4% between 2014-15 and 2020-21. The rate of increase for Māori is significantly higher than that for Non-Māori.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

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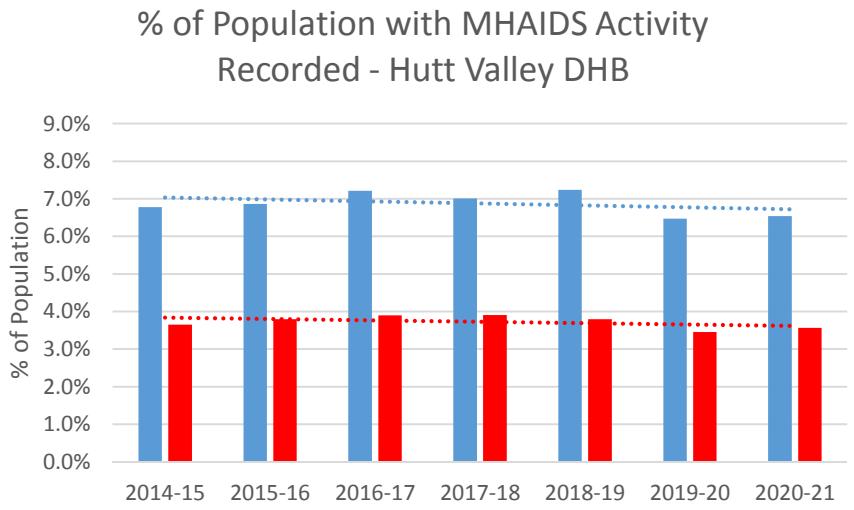
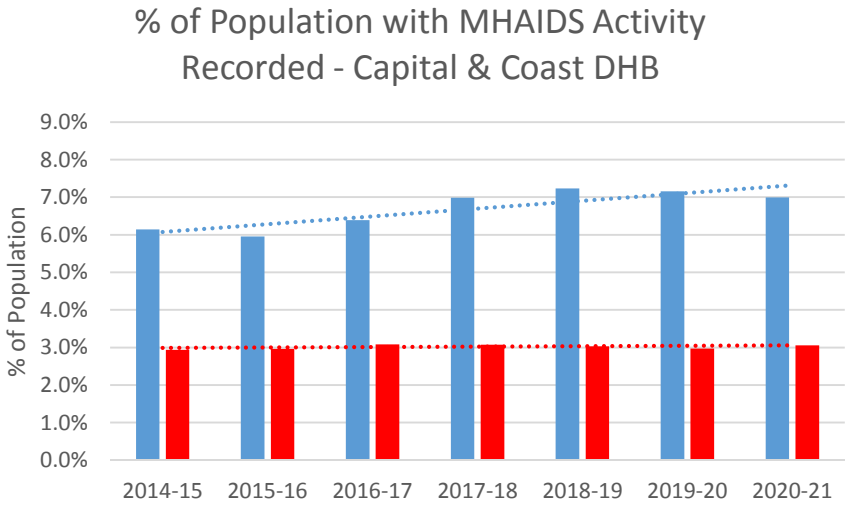
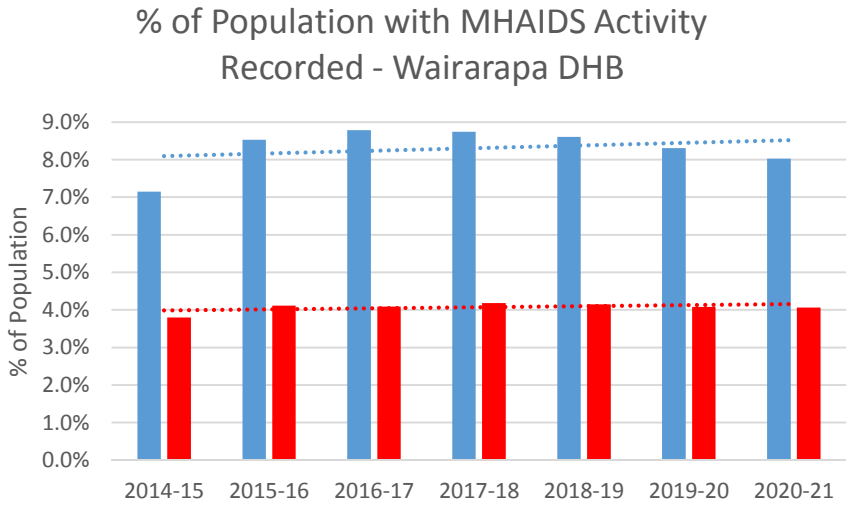




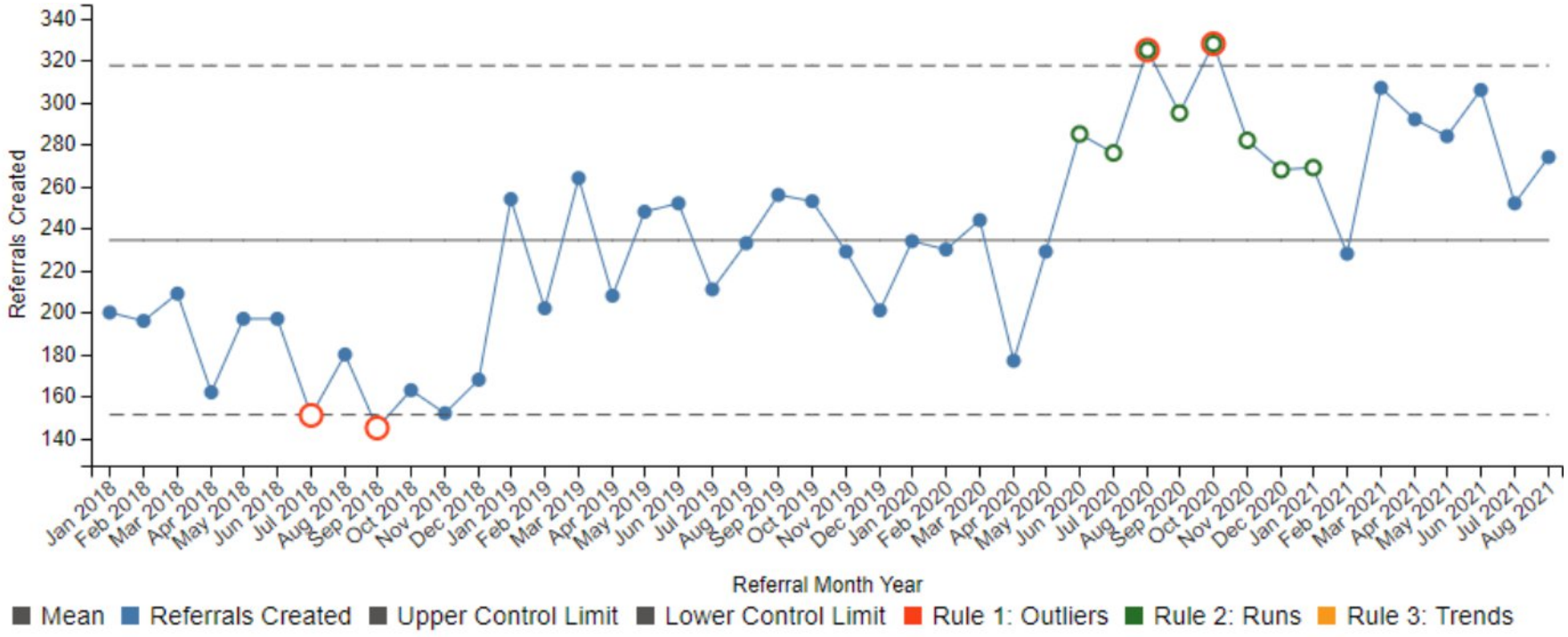


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Urgent Referrals to MHAIDS

While overall referral numbers have returned to levels similar to previous years, there has been a marked increase in urgent referrals received since the end of the initial COVID-19 lockdown in April/May 2020. This pattern has continued over the last 12 months.

Control Chart (I Chart) Showing Urgent Referrals Created



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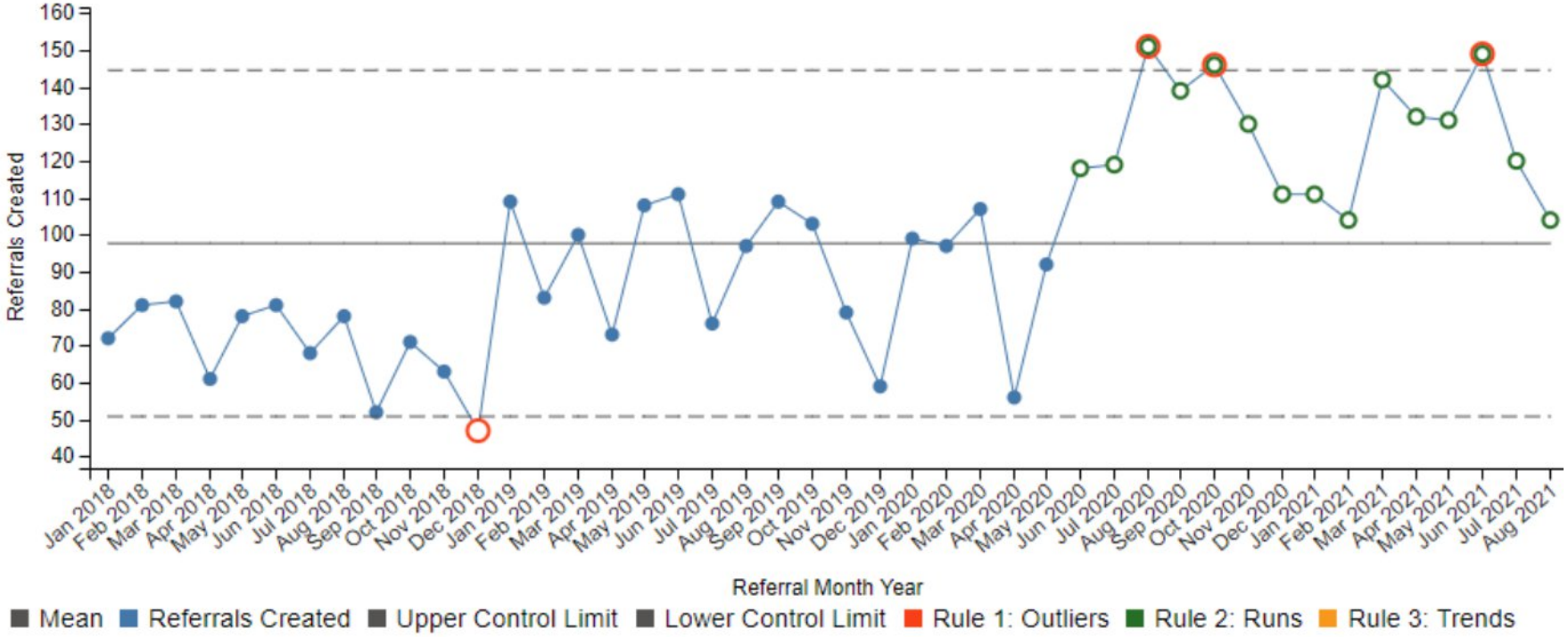
Mental Health, Addictions and Intellectual Disability Service

Urgent Referrals to MHAIDS

The most significant demographic group for this increase in urgent referrals has been young people aged 24 and under.

Control Chart (I Chart) Showing Urgent Referrals Created – Age 0-24 Years

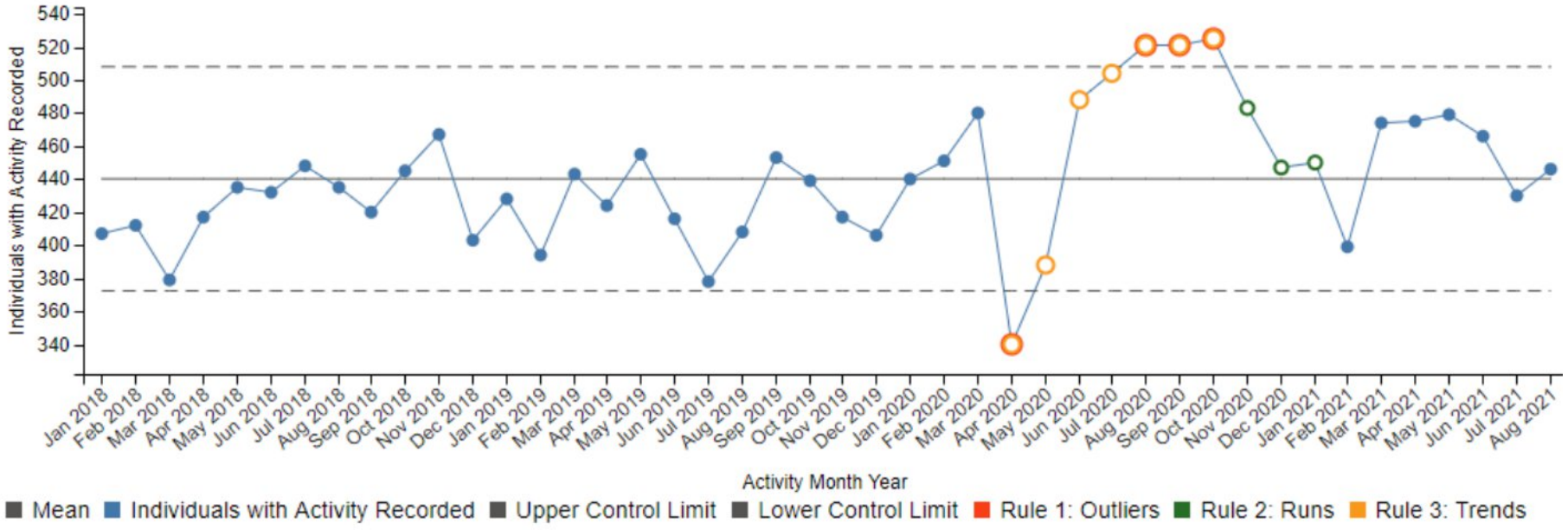


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Crisis Resolution Service

The Crisis Resolution Service saw a significantly higher number of people in the months post COVID-19 lockdown last year than in previous years. The number of people presenting in crisis has remained high this year.

Control Chart (I Chart) Showing Individuals seen by Crisis Resolution Service



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

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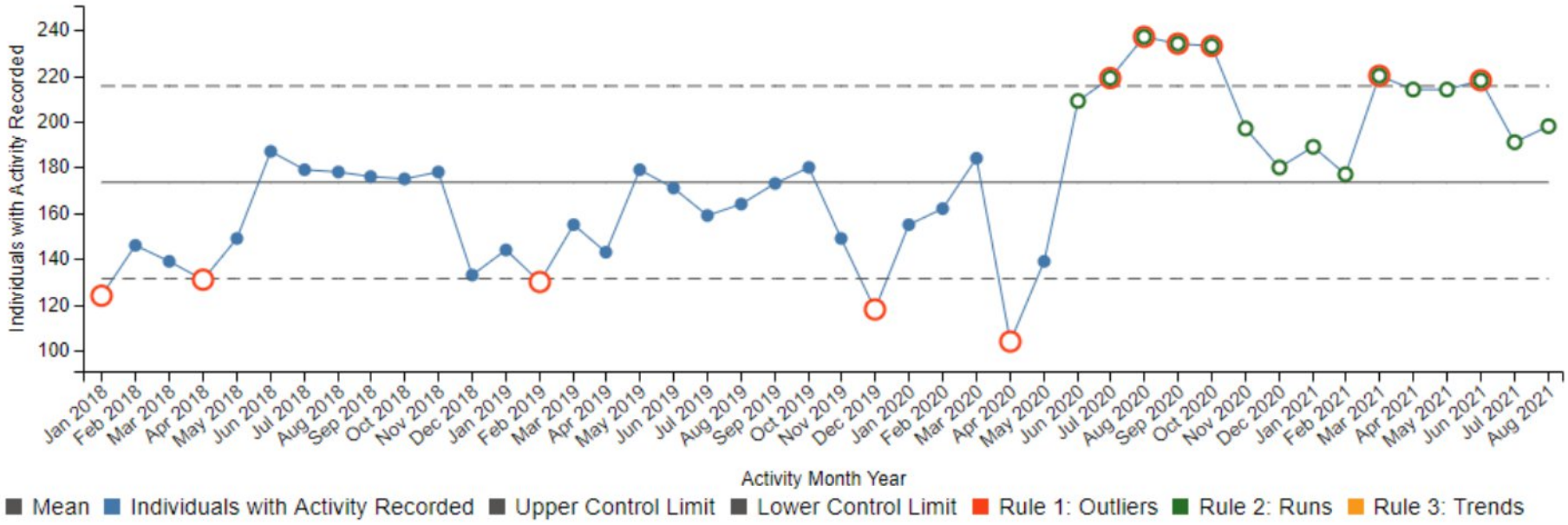

Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Community Caseloads

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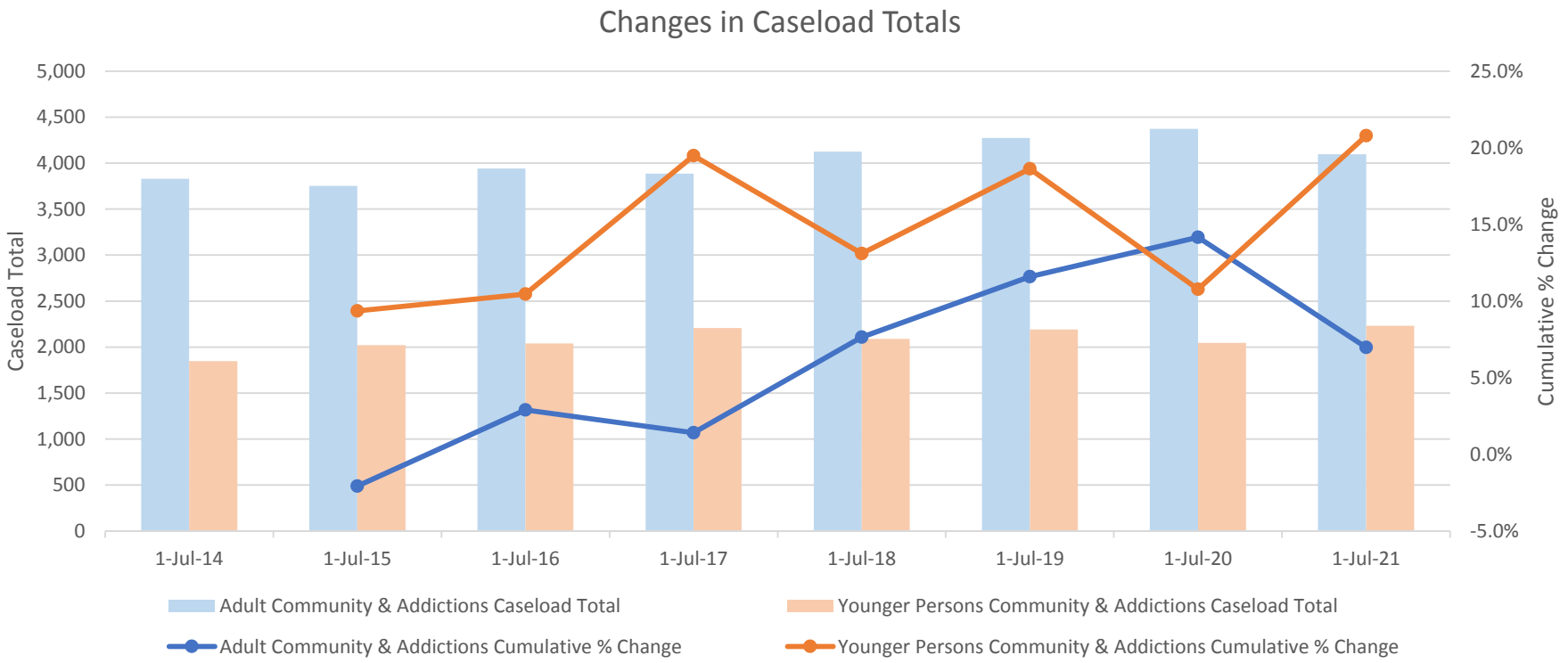
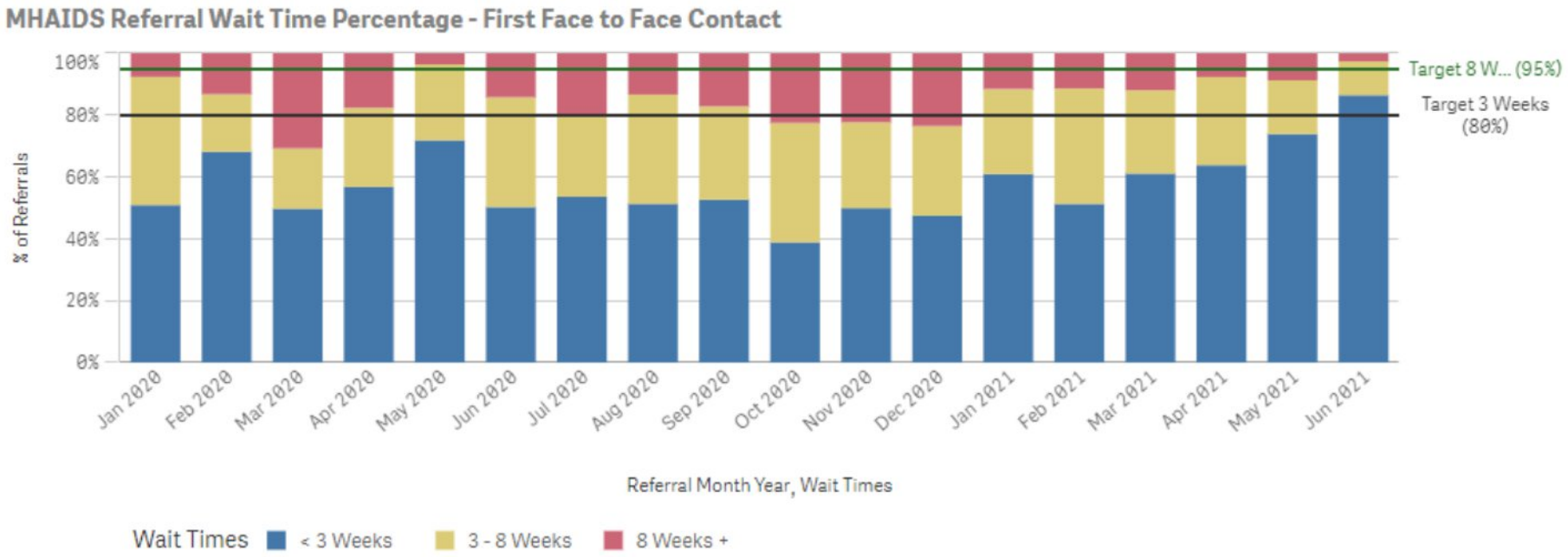


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Wait Times – Younger Persons Community & Addictions Sector

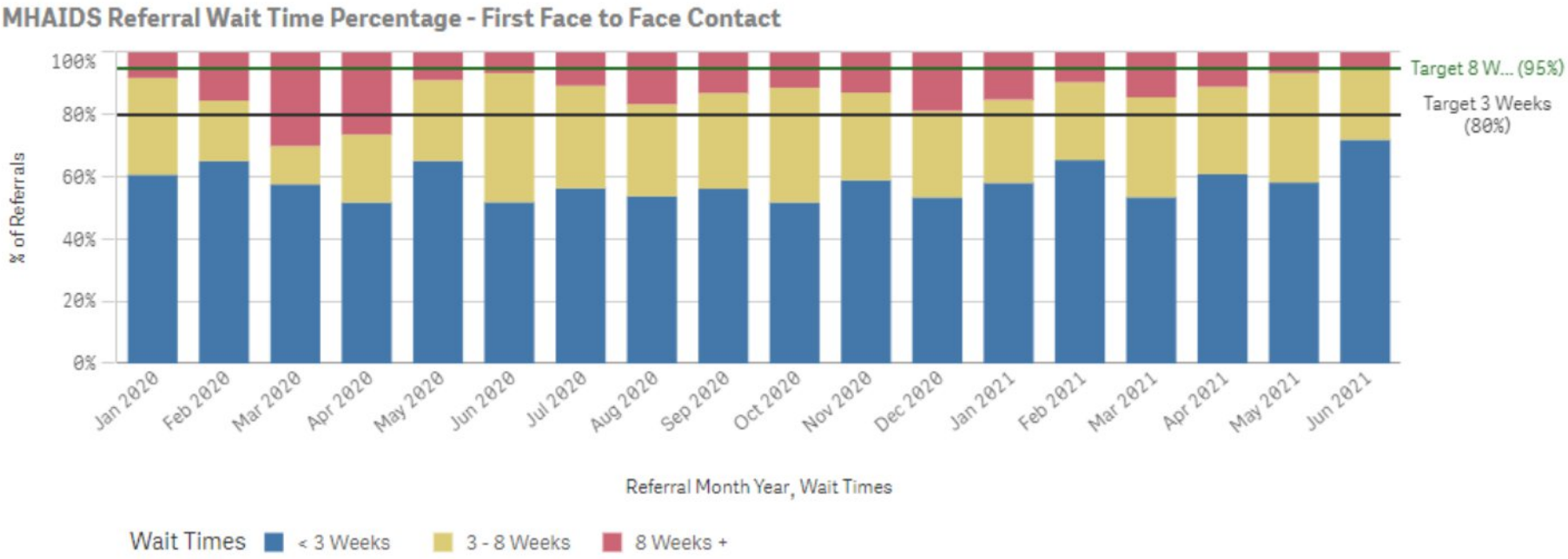
The Ministry of Health targets for wait times are 80% of people to be seen within 3 weeks of referral and 95% of people to be seen within 8 weeks. The Younger Persons sector has struggled to meet these targets – the mean since Jan 2020 is 56% seen within 3 weeks and 83% seen within 8 weeks.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Wait Times – Adult Community & Addictions Sector

The Adult Community & Addictions sector has slightly higher wait times results – the mean since Jan 2020 is 58% seen within 3 weeks and 87% seen within 8 weeks.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

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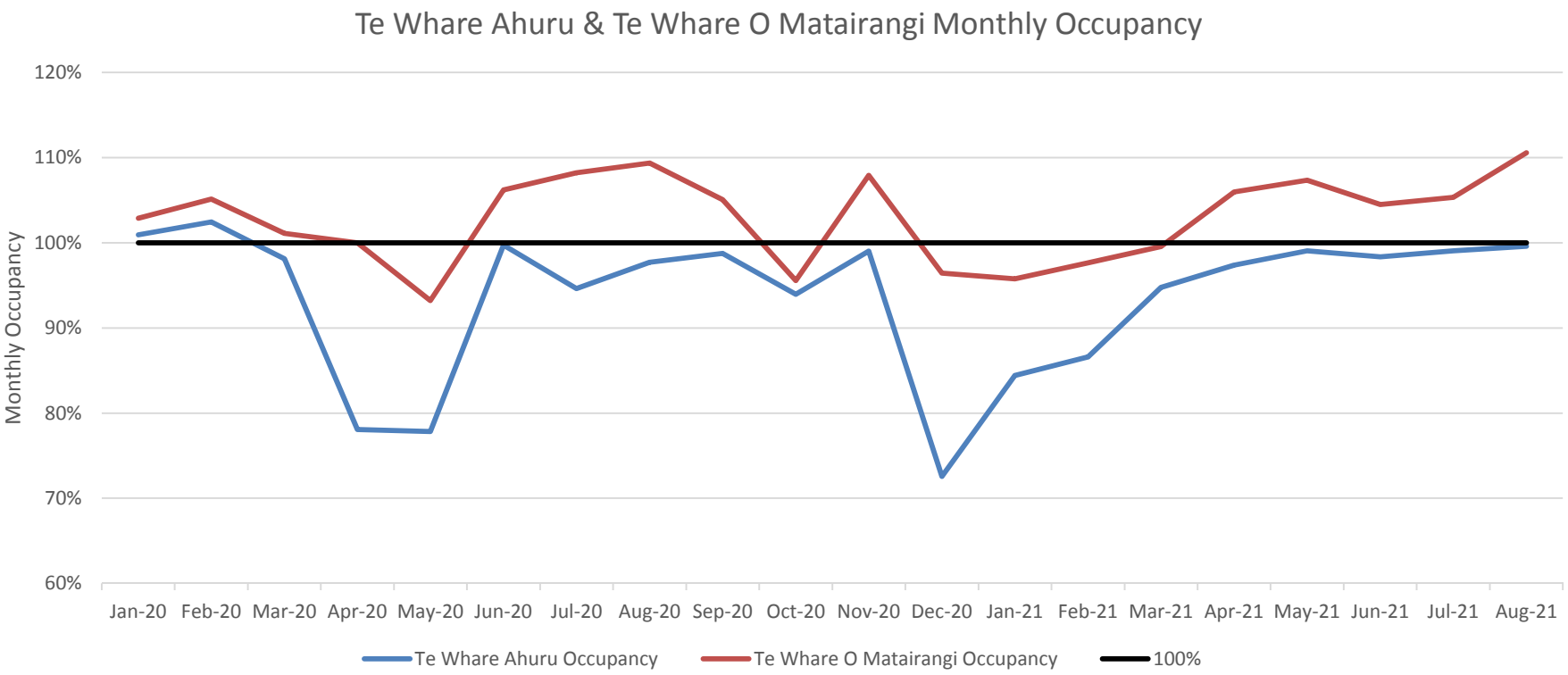

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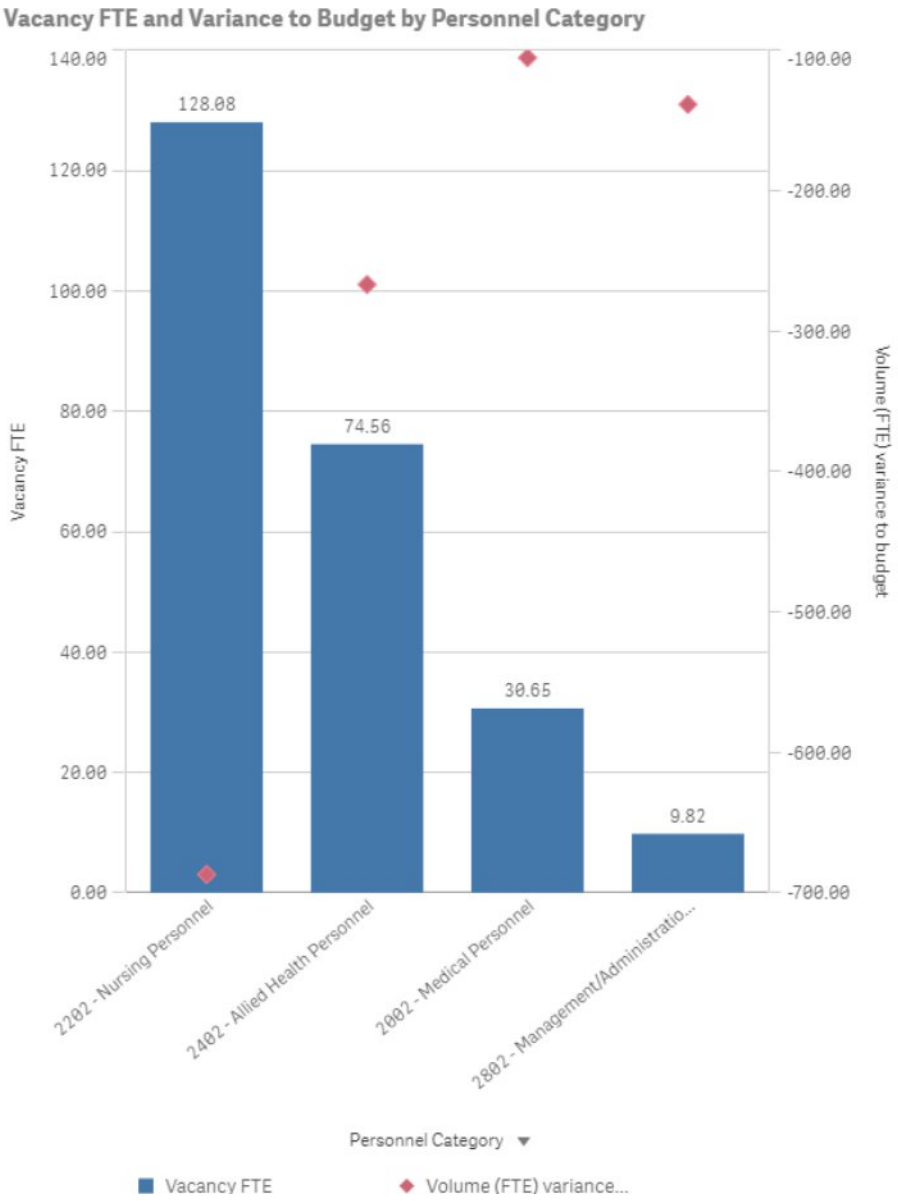
Mental Health, Addictions and Intellectual Disability Service

MHAIDS Vacancy FTE and Variance to Budget by Personnel Category



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Our Networks – whole of system

Future Direction

- Improving equity for Māori and Pacific
- Transformation of community mental health and addiction services
- Workforce development and planning
- Addressing challenges in delivery of acute care
- Upgrading facilities at Rātonga Rua o Porirua and Kenepuru Hospital
- Providing responsive Regional Services
- Rebuild of Acute Inpatient Unit HVDHB Te Whare Ahuru
- Structure changes for Senior Leadership Team

Disability Support Advisory Committee

29 September 2021

3DHB Sub Regional Disability Strategy 2017 – 2022 Update

Action Required

3DHB Disability Support Advisory Committee note:

(a) This report provides DSAC with an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

Strategic Alignment	Health System Plan 2030 Living Life Well A strategy for mental health and addiction 2019-2025 Taurite Ora Māori Health Strategy 2019-2030 Te Pae Amorangi Māori Health Strategy 2018 -2027 Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025
Authors	Rachel Noble, General Manager Disability
Endorsed by	Rachel Haggerty, Executive Director Strategy, Planning & Performance
Presented by	Rachel Noble, General Manager Disability
Purpose	This paper provides brief updates on the implementation of our Sub Regional Disability Strategy 2017 – 2022.
Contributors	The Disability Team
Consultation	N/A

Background

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

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

The key areas of activity are outlined the in the Sub Regional Disability Strategy 2017 – 2022 and includes our responses to the recommendations from the Sub Regional Disability Forum.

Focus Area One: Leadership

Disability Team

The COVID-19 Vaccination work continues to be the main focus for the Disability Team however several of us are now combining COVID-19 work with our regular work. We continue to enhance our COVID-19 resources and guidance material based on the feedback gained from the community and those providing services. We continue to be grateful for the pro-equity stance taken by the 2DHBs as part of the COVID-19 vaccination programme. It is worth noting that the disability related examples of good practice mentioned by Dr Ashley Bloomfield come from our region.

We are taking seriously our role in the implementation of the Pro-Equity Policy across the DHB Commissioning Programme and across all Strategy Projects. Part of this includes connecting with members of the community where possible. We also keep the Sub Regional Disability Advisory Group informed.

Regional Hui and Fono

The Sub Regional Disability Advisory Group is currently reviewing the recommendations made at the 2019 Silverstream Forum and to report on progress to date. The co-facilitator from the Forum, Grant Cleland, is conducting this review which will be ready for the November meeting.

The foundation of the next five year sub-regional disability strategy has been built by Kaunihera Whaikaha and their strategy work with an independent consultant Cathy Nesus.

COVID-19 has impacted our ability to connect with the Pacific Disability Forum. We will pick this up again as soon as possible.

Disabled Employees Network

The Disabled Employees Network in CCDHB was established late 2020. It was agreed to carry out a survey to find out how many CCDHB identify as disabled, and to start exploring the experiences of those disabled employees. The survey was put together by the Disabled Employees Network which is made up of disabled employees and allies. This work took place in December 2020.

Staff were asked a series of questions relating to having a disability, impairment, or long term condition.

From the 66 respondents 86% of respondents (57 people) stated that they do have a disability, impairment, or long term condition, but that only 28% (18) people believe they are recorded as such with CCDHB. Reasons for not sharing include:

- *It may impact on my work in the future*
- *Worried that I would be turned down for employment*

When it comes to thriving at work the answers reflect the importance of workplace culture. Having supportive managers and colleagues were most helpful for respondents. The importance of reasonable accommodations such as flexible working arrangements, adaptations to the work environment, and equipment such as laptops also has an impact.

- *Being trusted to do my work and take care of my own wellbeing*

- *I am very supported by my colleagues, I seldom need to ask for help, it just happens when I need it and I'm never made to feel like a burden*

The barriers that people encountered also focus on culture and reasonable accommodations. Unfortunately 40% of the responses noted a fear of bullying or discrimination and 52% noted that feeling unsupported was a barrier.

- *Fear I would be perceived as unreliable, and less worthy*
- *Discrimination may be too harsh a term – don't wish to be seen as different, don't wish to let team mates down or feel that they need to accommodate changes in their practice to meet my needs*

Based on the responses from staff, the Disability Network has highlighted three main recommendations for improvement.

1. Culture – This plays a huge part in how valued disabled employees feel. A large part of this is the way in which disability is perceived. The Disability Network advocates strongly for a social model of disability to be used and promoted so that all staff have an increased understanding of disability, and the value that disabled people bring to the workplace.

2. Occupational Health – It has been highlighted by some staff that they did not feel comfortable sharing their disabilities with occupational health. The Disability Network would like the opportunity to discuss this further with Occupational Health to help improve these conversations, and ensure that they leave staff feeling valued, trusted to manage their own health, and safe to share any disabilities or impairments.

3. Hiring and Management – Linked to culture and the above recommendation are the processes used for hiring and management. As noted in the comments, supportive managers can have a huge impact on all staff, but especially disabled staff. Hiring managers need to be confident in providing an inclusive recruitment process and when responding to requests for reasonable accommodation. The Disability Network recommend training and resources are provided to Hiring Managers to cover these two topics.

The Network will share the recommendations with the People & Culture Leadership Group soon.

Hutt Valley DHB has started a Disabled Employee Network, and the Wairarapa DHB has also had some sessions. All groups have been impacted by the COVID-19 Vaccination work.

Research Focus:

3DHB Localities: Disabled people's placed based experiences of local healthcare services.

Research consistently shows that disabled people have poorer health outcomes than non-disabled people and do not receive appropriate care. Barriers to access, including limited availability of services and transport options, inaccessible environments and communication, discriminatory attitudes, and inadequate skills and knowledge of healthcare workers, prevent disabled people from accessing health care across the spectrum of health services – promotion, prevention, and treatment. Any attempts to improve the coordination and provision of health care services within 3DHB localities

needs to include the experiences of disabled people. Finding out from disabled people what types of barriers prevent them from accessing local healthcare as well as what enables their access will help address health disparities experienced by disabled people in the 3DHB region.

Imagine Better has also been asked to create a research brief for a project on disabled people's experiences of accessing specialist services. Rather than conducting two separate projects, we propose a project that addresses access to specialist services as part of a focus on localities. As described in more detail below, focusing on different sites of healthcare – home, community, hospital – means disabled people's experiences of accessing specialist services can be captured. Combining the two projects helps mitigate the impacts of research fatigue by the disability community within the 3DHB region.

A reference group is being pulled together to oversee this project.

Focus Area Two: Inclusion and Support

Data and Alerts

We have not yet been able to process this work across the DHBs. We have however talked with a team in the Ministry of Health which is looking at the exchange of information between people and clinicians. We have explained our work and stressed the importance of disability leadership in the design and development of any tools. This includes translating our My Health Passport into an electronic form which is used by anybody transitioning between the health sector.

Enabling Good Lives

With support from the Directors of Allied Health we delivered five workshops as an Introduction to Enabling Good Lives Principles. The new health system has already indicated that the Enabling Good Lives (EGL) principles are to underpin disability related services. Imagine Better provided these workshops. Chris King and I are continuing to explore ways to follow up with the material produced from these workshops in order to identify what next.

The Kāpiti Health Network has provided us with a unique opportunity. We held one workshop there, and will hold more with staff members. We will also hold one or two for the disability community. Part of the workshop involves identifying what needs to change to make sure our processes reflect the EGL Principles. The final workshop will bring staff and disabled people to share their suggestions and perspectives to help identify steps to make health services in Kāpiti more inclusive and accessible.

We are also organising workshops for the Strategy Planning and Performance team so the principles can be applied across the Strategy Projects as part of the Pro-Equity process.

Child and Adult Transition

A review of the Child and Adult Transition project led by the Disability Responsiveness Team in 2014 – 2016 took place recently as the project came to a halt before it was completed.

This led to a recommendation to develop a targeted educational programme for using the revised My Health Passport to:

- families whose children will be transitioning into adult services
- All staff working with Children, both within DHB services and PHO and community services

It can be used across all health professionals in all settings. This tool seems well placed to meet the needs of this population of people transitioning from child to adult services. It would seem unnecessary to duplicate this with a similar transitioning tool.

The project developed the first draft of an electronic health pathway to support GPs in managing the issues faced by young people who have been discharged from child health and child development services. These children are known to face difficulties accessing adult services when and if they require them. The General Practice, as the main health care provider for the young person, needs to be knowledgeable about individual circumstances and understand the most appropriate referral pathways to secondary services or indeed to community services.

The Child Development Service in the Ministry of Health are keen for this work to be set up as a pilot with a view to a long term roll out.

Maternity Services

Following our Mums and Babies project we have engaged closely with the team developing services in this space to ensure the disability lens will be applied.

Focus Area Three: Access

Accessible Information

We continue to create COVID-19 Vaccination information in accessible formats. We also have a section in the Vaccinate Greater Wellington website for disability related information and accessible formats.

We continue to revise our existing resources and to develop new resources based on the feedback we receive from the community.

Built Environment

The main focus of this work has been around the accessibility of vaccination sites.

Easy Read Photo Project

An experienced photographer is taking photographs across the health sector environment to be used in Easy Read material which is a form of information that is clear and easy for people with low literacy to read and understand.

This project is progressing well. Here are some sample photos:

We are close to being able to produce some appointment letters in Easy Read format. This project will provide us with 500 – 750 local images alongside the British images for more generic subjects. We are only focusing on NZ based places, information, equipment and processes.

Focus Area Four: Health

Education

The COVID-19 work has provided us with an opportunity to engage directly with disability groups and organisations which has been very useful for raising our awareness and also for identifying critical points for inclusion in our education programme.

We have managed to maintain our core education programme throughout the COVID-19 Vaccination programme. We have also received more requests for education sessions so we are looking to offer more in 2022 and focusing on developing the course content and appropriate resources.

Another element that is increasing is the number of requests to our Education Advisor to actually assist with patients in hospital wards. The requests range from wanting advice on working with particular patients, assistance in communication and assistance in decision making processes. This is not the role of the Education Advisor however these requests illustrate a gap. We will start recording these requests.