Briefing for decision

Mental health and addiction dashboard

Date due to MO:	31 October 2024	**Action required by:**	14 November 2024
Security level:	IN CONFIDENCE	**Reference:**	H2024053958
To:	Hon Matt Doocey, Minister for Mental Health		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		

Contact for telephone discussion

Name	Position	Telephone
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Minister's office to complete:

☐ Approved	☐ Decline	☐ Overtaken by events
☐ Needs change	☐ Seen	
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Briefing for decision

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Security level:	IN CONFIDENCE	**Date:**	31 October 2024
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Purpose

1. This briefing seeks your confirmation of mental health, addiction and suicide prevention measures to request for inclusion in quarterly dashboard reporting from Health New Zealand | Te Whatu Ora (Health New Zealand).

Background

2. The Ministry of Health (the Ministry) has provided you with previous advice outlining monitoring roles and responsibilities across the health system and current reporting mechanisms [H2024046096] as well as initial advice on a comprehensive range of both existing and developmental metrics that could be used to understand mental health and addiction system performance [13 September 2024 information request].
3. Health New Zealand has developed a mental health and addiction dashboard which forms part of its quarterly reporting to the Board/Commissioner, the Ministry and Ministers. Health New Zealand's dashboard for Quarter 4 of 2023/24 is attached as **Appendix 1** for reference.
4. Health New Zealand's dashboard includes many but not all metrics the Ministry would recommend for ongoing reporting. Your office has requested the Ministry's advice to enable to you to confirm the metrics you wish to see in ongoing quarterly dashboard reporting from Health New Zealand, taking into account data availability.

Proposed quarterly dashboard content

5. **Appendix 2** sets out the metrics the Ministry proposes are included in quarterly dashboard reporting, mapped to your four mental health and addiction system priorities. The metrics proposed:
   a. reflect advice from your office on specific metrics you have expressed an interest in
   b. build on the metrics in Health New Zealand's existing dashboard with additional metrics suggested to provide a fuller picture of system and service performance against your priority areas
   c. are limited to those with existing data sources that can be reported on in the short-term, noting that data completeness and quality will be a challenge across metrics (see below for further discussion on areas for further development)
   d. include the mental health and addiction targets and initial balancing measures, noting that final balancing measures will be confirmed through Health New Zealand's detailed implementation plans and there may be standalone reporting against the targets and balancing measures in future

e. aim to balance the need for a diverse set of metrics to understand system and service performance with feasibility and an intention to minimise reporting burden.

6. Where applicable, we recommend that measures include:

   a. both numbers and percentage of population

   b. timeseries data (preferably over at least 8 quarters)

   c. age, ethnicity and regional breakdowns, particularly where there are notable variances.

7. As the dashboard is developed, and as Health New Zealand's regional model embeds, it may be appropriate to request both national and regional dashboards from Health New Zealand, to understand variances between regions. We understand Health New Zealand is working to put in place more automated processes that would allow reporting at regional and district levels.

8. Alongside reporting against service performance metrics, we recommend Health New Zealand retains the section in the dashboard reporting on risks and mitigations, as well as reporting limitations and planned enhancements.

Areas for further development

9. There are constraints in the mental health, addiction and suicide prevention metrics available for short-term reporting due to data availability, as well as areas where we would expect to see increasing quality and granularity of reporting. These include:

   a. **Consumer and whānau experience measures**: there is not currently consistent national collection of data related to consumer and whānau experience of mental health and addiction services. This data gap was highlighted in a recent report by the Mental Health and Wellbeing Commission, which noted that filling this gap will require collaboration with the Health Quality and Safety Commission. There are also no current measures around complaints and processing times, or the implementation of lessons from complaints, which is required to understand a learning health system.

   b. **Workforce data**: There is variable quality and collection of regular mental health and addiction workforce data, including composition, vacancies and training. While Health New Zealand's current dashboard includes training numbers and vacancies for some professions, further work to capture a broader range of workforces is required (e.g., the consumer, peer support and lived experience workforce) as well as more regular capture of workforces outside of Health New Zealand-delivered specialist services (e.g., Te Pou collects data annually on non-government organisation workforces). In future, it would also be useful to have an aggregated view of data from exit interviews for workforces where there are shortages.

   c. **Mental health and addiction support in primary care**: Health New Zealand is working to bolster reporting across the Access and Choice programme to support reporting against the wait times target, noting that around 30% of Access and Choice activity data is not reported at an NHI level. We are also not able to capture mental health and addiction-related interactions within general practice more broadly.

d. **Financial reporting**: Reporting on expenditure against the ringfence is a manual process, which limits the granularity of information that Health New Zealand is able to provide. There are also limitations in Health New Zealand's ability to connect expenditure data with information on inputs, outputs and outcomes. The Ministry continues to work with Health New Zealand to bolster reporting against the ringfence and has reinforced that this is a priority for you.

10. As Health New Zealand's data improvement work progresses, additional information and breakdowns could be included in regular reporting. There will also need to be an ongoing focus on improving data quality and completeness of PRIMHD (the national data collection for specialist mental health services) as the source of many metrics, including the targets. We understand Health New Zealand has work underway to strengthen governance of PRIMHD to support this, and there is an opportunity to leverage the work of the sector-led Key Performance Indicator quality improvement programme.

Wider monitoring considerations

11. The Ministry continues to progress work to reset the wider Health New Zealand monitoring plan and will incorporate your expectations on service metrics once confirmed. We will also continue to provide advice in our system monitoring role, drawing from Health New Zealand's quarterly reporting and other sources to provide a critical lens on system and entity performance.

12. While this briefing focuses on mental health and addiction service performance and the Ministry's monitoring of Health New Zealand, the Mental Health and Wellbeing Commission also has a role to play in understanding system performance. The Commission is well-placed to do deeper analysis into systemic issues than quarterly dashboard reporting allows, but the dashboard could be shared with the Commission (and other interested agencies) for awareness and transparency. The Ministry also monitors the performance of the Commission as a Crown entity.

13. We have tested this advice with the Mental Health, Addiction and Suicide Prevention Assurance Group. The Group has reinforced the need for confidence in the timeliness and accuracy of data, and mitigations around gaming of service metrics. The Group also reinforced the need for clear leadership and accountability within Health New Zealand for targets delivery and performance reporting. The Ministry will continue to monitor the impacts of Health New Zealand's structural changes on mental health and addiction.

Equity

14. It is proposed that Health New Zealand's quarterly dashboard reporting includes breakdowns by age, ethnicity and region to maintain visibility of variances and track progress in addressing inequities in access and outcomes.

Next steps

15. Subject to your approval, we recommend your office commissions enhanced dashboard reporting including the suggested metrics from Health New Zealand, to be included in its quarterly reporting going forward. Reporting on Quarter 1 of 2024/25 is expected in December 2024.

16. It may take multiple quarterly reporting cycles for Health New Zealand to fully incorporate the additional information requested into its quality assurance and reporting processes. Specific timeframes for enhanced dashboard reporting will be confirmed in discussion with Health New Zealand.

Recommendations

We recommend that you:

a) **note** that Health New Zealand has developed a dashboard for quarterly reporting on mental health and addiction system performance (attached as Appendix 1)

b) **note** that the Ministry recommends inclusion of additional metrics to provide a fuller view of system performance (refer Appendix 2)

c) **agree** to the broader suite of metrics recommended in Appendix 2 and to request inclusion in future Health New Zealand quarterly dashboard reporting **Yes/No**

OR

provide feedback to officials on Appendix 2 and any additional information you would like to see included in quarterly reporting **Yes/No**

d) **note** that following your confirmation of additional metrics, we recommend your office commissions enhanced dashboard reporting from Health New Zealand to be included in its quarterly reporting, following which the Ministry will work with Health New Zealand to support this.

Geoff Short
Deputy Director-General
Clinical, Community and Mental Health | Te Pou Whakakaha
Date: 31 October 2024

Hon Matt Doocey
Minister for Mental Health
Date:

Appendix 1: Health New Zealand's Quarter 4 dashboard

Mental Health and Addictions Dashboard | page 1

Q4 2023/24 (April-June 2024)

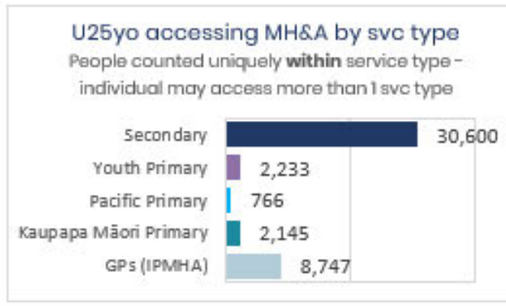
Health New Zealand
Te Whatu Ora

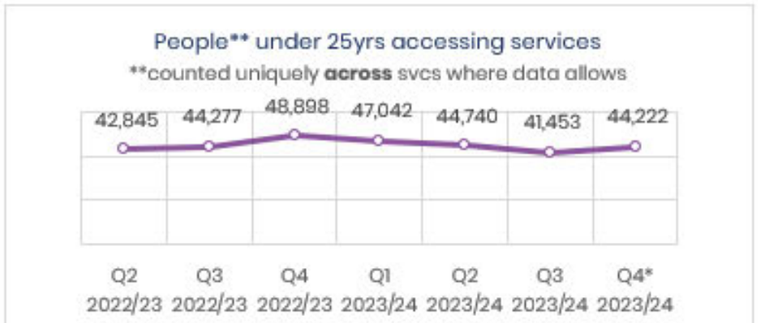
EARLY INTERVENTION

More people are seen earlier in life span

U25 yr olds seen Q4
44,222

People seen per 100,000 popn
Under 25: **2,726**
25 & over: **3,151**

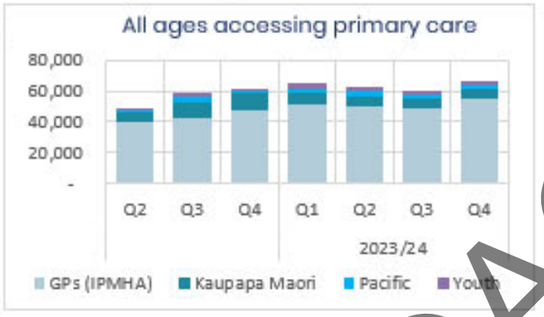




More people are seen in primary MH&A

People seen in primary
66,434

People seen in primary per 100,000 popn
1,272



These figures reflect only people seen by Access and Choice services and are therefore an under-statement of people seen in primary MH&A services. In this quarter, 42% of all people seen by MH&A services were seen in primary MH&A settings (up from 39% in the last quarter).

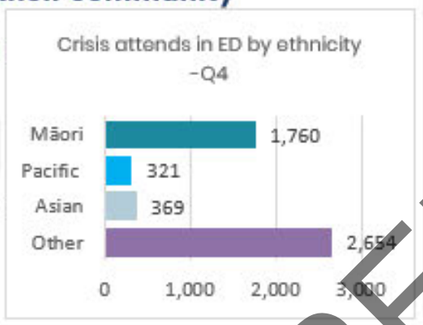
Note: In the absence of a recent epidemiology study regarding prevalence of MH issues it is difficult to ascertain the expected rates per 100,000 population for each age group.

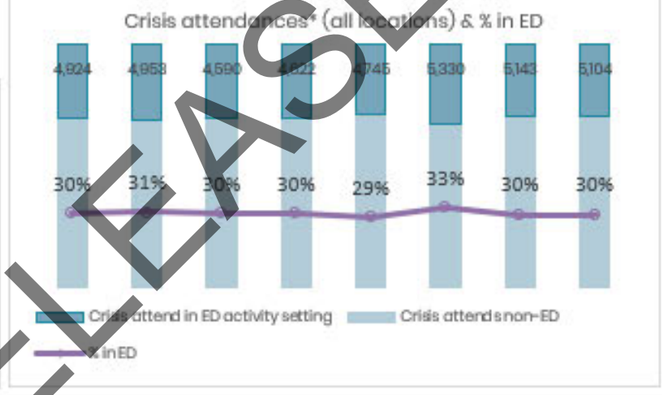
SERVICE RESPONSIVENESS AND ACCESS

People can access urgent care rapidly and in their community

MH ED stays < 6hrs
67.0%
TARGET: 95%

Crisis attendances in ED - Q4
5,104





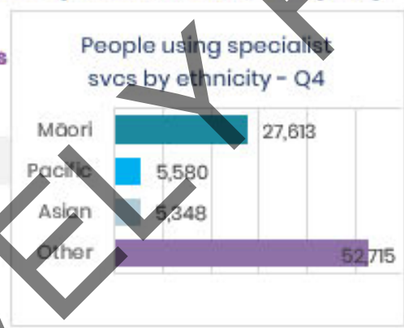
There is no discernible trend in either the number of people seen in crisis or the relative proportion of these seen in ED.
ED length of stay for people with mental health-related concerns is a new target with no established baseline. Work is under way to improve data and develop detailed implementation plans to improve performance

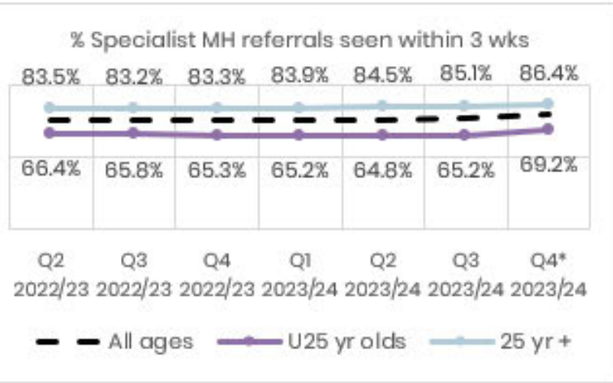
Note: incomplete data in total crisis attendances in Q2 is likely to overstate % in ED - missing data has been imputed to estimate value.

People can access specialist care & rapidly

Seen within 3 weeks
79.3%
TARGET: 80%

People seen per 100,000 popn Q4
1,747



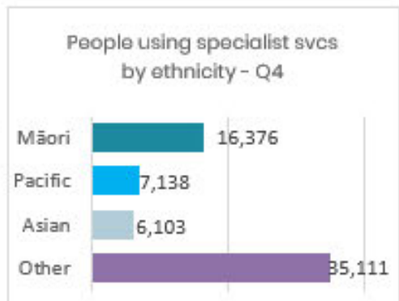


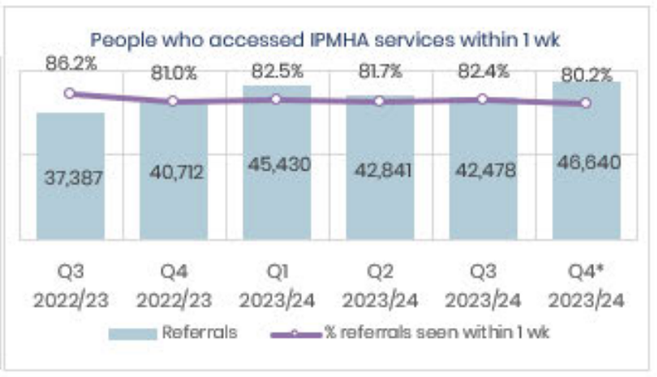
86% of people 25 and over are seen by MH&A services within three weeks, while 69% of under 25s are seen within this time frame.
There has been improvement over the past two quarters in both wait time measures. This will be monitored to identify whether this reflects increased effort to decrease wait times.

Note: incomplete data in total referrals in Q2 is likely to overstate % seen - Q1 result used instead.

People can access primary MH&A rapidly

Seen within 1 wk
80.2%
TARGET: 80%





There is no wait time data for youth, Māori or Pacific services. NHI-based reporting will be rolled out over the next two years to expand services included. This data is only provided by services in general practice, and referral date is not mandatory, so wait time data is highly unreliable. Commencing quarter 2 referral date will be made mandatory.

Note: only Access and Choice services are included in the primary care section at this stage.

Mental Health and Addictions Dashboard | page 2

Q4 2023/24 (Apr-Jun 2024)

Health New Zealand
Te Whatu Ora

RINGFENCE

We are fully committing funding to expectations

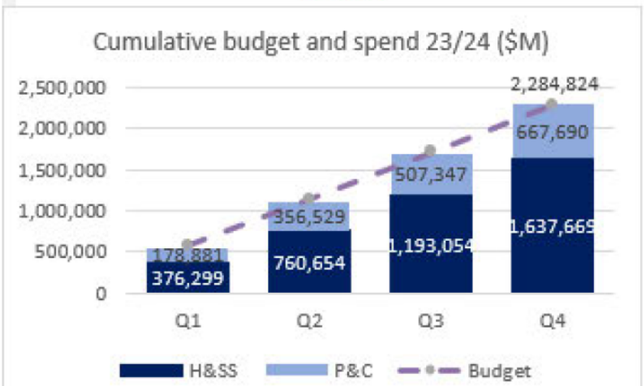
Investment in prevention and early intervention

▲23.9% OF RINGFENCE

TARGET: 25%

Spend to budget* year to Dec 2023

101%



s 9(2)(g)(i)

The report of professionals entering training currently excludes psychiatric registrars and is for semester 1 of 2024 only. Reporting for the full 2024 academic year (including semester 2) will be presented in the quarter 1 report for 2024/25. From quarter 3 2024/25 psychiatric registrars will be included.

Note: only Access and Choice services are included in funded and actual FTE for primary care section at this stage.

WORKFORCE

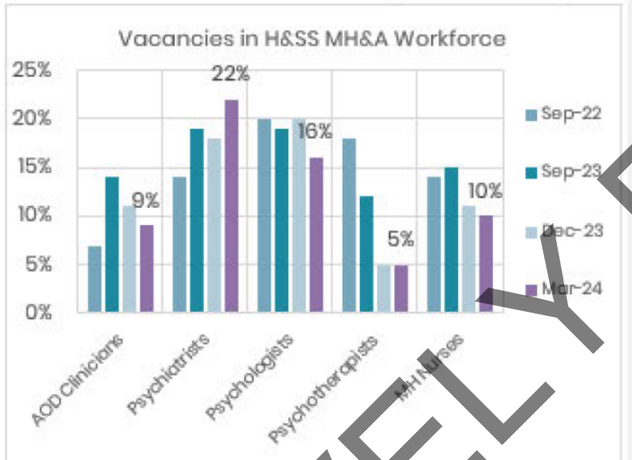
Our workforce is increasing toward funded levels

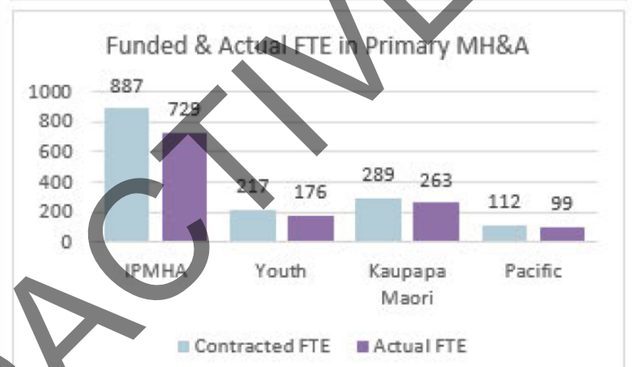
Professionals entering training in calendar year

430 SEMESTER 1

FULL YEAR

TARGET: 500





RISKS AND MITIGATIONS

Risk	Mitigation
Workforce shortages	a) Develop a MH&A specific section of the Te Whatu Ora workforce plan b) Have MH&A as a priority in the overarching workforce pipeline work c) Continue with a MH specific WF work programme within commissioning d) Targeted international recruitment
Increasing demand placing pressure across the system	a) Continued focus on developing and enhancing primary MH&A services b) Developing alternatives to address inpatient acute demand c) Ongoing recruitment to vacant clinical role sin H&SS d) Clinical Service Planning – bed capacity project
Poor state of infrastructure	a) Mental Health Infrastructure Programme with 14 inflight projects to refurbish or rebuild b) National anti-ligature remediation programme c) Infrastructure Investment Plan
Data Quality	a) Data and Digital data infrastructure improvement through the National Data Platform Programme b) Reinstate and strengthen the function of MH&A Data Governance Group

REPORTING LIMITATIONS AND PLANNED ENHANCEMENTS

There is a key focus on improving data reliability in order to be able to report against MHA targets. There are several risks to providing reliable, timely reporting of mental health & addictions health data. . Risks are due to 1) Incomplete/immature data sets, 2) Data quality and 3) Manual collection of data.

Approx. 30% of Access & Choice (A&C) activity is currently not reported at NHI-level.	D&D to bring in data for youth providers Jan 2025 and Māori & Pacific providers over the next two years.
A&C data pipeline is unnecessarily complex, introducing several points of failure.	Data Services to complete work underway to automate the ingestion and transformation of data onto a common national data platform.
Ongoing lag in receiving PRIMHD data.	D&D review PRIMHD data submission processes in districts & NGOs with issues to reduce delay.
Some Districts show poor data quality of SNOMED Clinical Terms coding	HS&S ED physicians to review completeness and compliance with accepted terms. D&D Quality check has been added to NNPAC app highlighting high use of non-specific codes
Financial reporting is manual , with many assumptions & estimates.	A programme of work driven by Finance is required to improve reliability & ease of reporting.

Note: Currently working towards an automated reporting pipeline that will allow reporting where applicable down to region and district

Appendix 2: Proposed quarterly dashboard content

The table below sets out the suite of metrics the Ministry recommends is included in future Health New Zealand quarterly dashboard reporting. These metrics are supported by existing data sources, so can be reported against in the short-term; however, there will be data completeness and quality issues underpinning many metrics which will need ongoing focus to address.

Note: It may take multiple quarterly reporting cycles for Health New Zealand to fully incorporate the additional information requested into its quality assurance and reporting processes. The Ministry can work with Health New Zealand to support this.

Key

** Metrics indicated by Minister for Mental Health's office as of particular interest

Mental health and addiction targets shown in italics

Blue – measure is not currently on Health New Zealand dashboard, recommended for inclusion in future dashboard reporting

Timely access	Workforce	Prevention and early intervention / Investment	Effectiveness
Access • Primary MH&A services: ○ Access and Choice: # people and % of population ** ○ Access and Choice: Referral numbers [if different from above] ** • Specialist MH&A services: ○ Specialist community MH services: # people and % of population ** ○ Specialist community AOD services: # people and % of population ** ○ Referral numbers to specialist MH and AOD services ** • Inpatient and residential services: ○ # people and % of population ○ Bed numbers ** [may require manual reporting] ○ Occupancy rates ** [may require manual reporting] • Emergency: # of MH-related ED presentations and % total presentations • Forensic MH services: ○ # people and % of population ○ Bed numbers ** [may require manual reporting] ○ Occupancy rates ** [may require manual reporting] • MH&A telehealth call volumes [relies on provider reporting] • Suicide prevention: Uptake of suicide prevention and postvention services [relies on provider reporting] **Timeliness** • *Access and Choice primary MH&A services: % seen within 1 week [MH&A target] *** • *Total, adult and child/youth (under 25) specialist MH&A service wait times: % seen within 3 weeks [MH&A target] *** • *ED wait times: % of MH&A-related ED presentations admitted, discharged, or transferred within 6 hours [MH&A target]* • Telehealth average call wait times [relies on provider reporting] • Prison waiting list for admission to forensic inpatient care [further data capture work is required and underway as part of the joint work programme with Corrections]	**Capacity** • Increased numbers across MH&A workforces ○ Growth across professions/disciplines: FTE by profession ** ○ *Growth in training pipelines: 500 professionals trained each year [MH&A target]* **Increased recruitment and retention** • Vacancies: # and % across professions and/or service types ** ○ Primary MH&A service vacancy # and rates (Access and Choice) ** ○ Specialist MH&A service vacancy # and rates **	**Access early in the life course** • Under 25s: # of people and % of population of under 25s accessing MH&A services by service type **Investment** • MH&A investment / expenditure across the continuum of care ** ○ *Investment in promotion, prevention and early intervention incl. suicide prevention/postvention [MH&A target]* ○ Expenditure against the ringfence by appropriation and/or service type ** • Expenditure against budget (and any forecast over/underspends)	**Quality** • % of acute inpatient discharges that have a face-to-face follow up in the community setting within the 7 days immediately following discharge from an acute inpatient stay • Proportion of specialist MH&A service users with a transition and wellbeing plan **Safety** • Compulsory care: # and rates of compulsory treatment orders • Seclusion: # people secluded and seclusion hours in adult and/or youth inpatient services [note: this would be unvalidated data, further work is required to establish measures for unintended consequences such as increasing use of other forms of restraint] ** **Experience** • Rate of family/whānau engagement in specialist MH&A services **Effectiveness and outcomes **** • Individual outcome measures (HONOS, SDQ, Hua Oranga, etc.) [from Te Pou reporting collation] **Efficiency** • Long-term inpatient stays: ○ Average length of stay in inpatient units ** ○ # of people over 3 months, 9 months • Percentage of acute inpatients that are readmitted to inpatient mental health services within 28 days of discharge **