Evaluation of the NZGG Self-Harm and Suicide Prevention Collaborative

Whakawhanaungatanga (Phase 2) Evaluation Final Report
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Executive summary

This report presents findings from a process and impact evaluation of phase 2 of the New Zealand Guidelines Group’s (NZGG) Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga. The collaborative is designed to improve crisis care in emergency departments, Māori health, Māori mental health and mental health services in a way that recognises local situations, people and resources, and builds on the 2003 guideline, Assessment and Management of People at Risk of Suicide.

The objectives of the evaluation were to:

- review the quality of project implementation at a national level, against the NZGG’s declared methodology
- review local implementation progress and impacts against targets for change
- evaluate stakeholder satisfaction with the collaborative.

The evaluation focused on the performance of the collaborative overall. While the experiences and context of individual district health boards (DHBs) were taken into account, findings were analysed and presented at a whole-of-collaborative level and do not identify individual DHBs or participants.

The evaluation involved interviews with project members (including project coordinators from all of the DHBs, all key project team members at six DHBs, and members of the NZGG implementation team), as well as a review of the target data collated by the NZGG. In seeking to describe how the project has made a difference to people at risk of self-harm and suicide, the evaluation report encompasses findings on the impacts of the collaborative, the sustainability of the changes made, the quality of implementation, and stakeholder satisfaction. It also highlights opportunities for improvements and makes recommendations for the future.

Quality of implementation

Overall, the collaborative had made significant progress by the end of phase 2. Project coordinators and their teams were generally positive about being part of the collaborative, and about the guidance, support and encouragement they were receiving from the NZGG implementation team.

The collaborative was implemented in accordance with the NZGG’s intended methodology. Feedback from DHB stakeholders and the NZGG indicated that implementation was consistent with the quality features known, or thought to be, important for the success of the collaborative (as set out in the evaluation framework – Appendix A). For example, the NZGG implementation team included an appropriate mix of skills and disciplines, the DHB teams generally included representatives from key departments, support from the NZGG implementation team was effective, and the plan–do–study–act methodology was used by project coordinators when implementing changes.
Impacts of the collaborative

Targets for change were a core component of the collaborative methodology in phase 2 and these are described in detail in Section 1.6. The targets incorporate process or systemic elements that require change strategies. Following on from the progress made in phase 1, DHB project teams in phase 2 made substantial progress towards achieving all four targets.

Almost all DHBs had implemented changes to meet the Access Target (aimed at reducing emergency department waiting times for people at risk of self-harm or suicide), and most had made progress in meeting the target timeframe. In general, stakeholder feedback indicated that initial mental health assessment was conducted by emergency department staff with more confidence and consistency.

All DHBs were addressing the Assessment Target (aimed at ensuring psychosocial assessment, mental illness and risk screening, and cultural assessment are carried out for patients at risk of self-harm or suicide), through increasing communication between emergency department and mental health staff, and developing processes for sharing patient records and including both medical and mental health information. The closer working relationship enabled mental health assessments to be carried out more promptly and thoroughly.

While most DHBs were not able to introduce cultural assessment per se within the timeframe of the collaborative, stakeholders said that participating in the collaborative had prompted dialogue about the meaning and practice of being culturally responsive, and brought more of a cultural lens into emergency department practice in most DHBs.

Progress was also being made in meeting the Discharge Target (aimed at providing the patient and their family/whānau or significant other, as well as others involved in the person’s care, with a written copy of their discharge plan). Most DHBs had improved their formal discharge processes, resulting in more patients and their family/whānau receiving discharge summaries in clear language, and in electronic copies of the summaries being sent to patients’ general practitioners (GPs).

In regard to the Follow-up Target (aimed at providing people who remain at risk of self-harm or suicide with a follow-up appointment, and contacting those who do not attend that follow-up appointment), DHBs were developing processes (e.g. automatic referrals) for ensuring follow-up appointments were made. However, developing processes for follow-up of non-attendances by patients that had been referred to primary or community care providers was not a focus for many DHBs, as they lacked resources to engage outside of the DHB.

All stakeholders reported that the collaborative had resulted in improved communication between and within the different departments of the DHBs, particularly the emergency and mental health departments, and a better understanding of each other’s roles. These improvements in turn contributed to tangible improvements in the quality of assessment and treatment of people at risk of suicide.
Sustainability of the changes

The degree to which system improvements had been embedded into DHBs’ standard procedures varied. However, in most DHBs, assessment tools, education packages for emergency department staff, and effective documentation (such as patient discharge forms) had become part of standard practice. As such, many stakeholders were confident that these changes would be sustained.

Other changes were still in their early days, e.g. determining appropriate circumstances, settings and processes for offering cultural assessments, and the development of processes for dealing with community service providers. Some DHBs were faced with poor or sporadic management support, insufficient time, or lack of champions in important departmental areas, which hindered the development and embedding of new, more effective processes.

Despite these challenges, efforts were being made by individual DHB teams, the NZGG implementation team and the advisory group to improve the sustainability of impacts and changes.

Stakeholder satisfaction

General satisfaction with the collaborative was high amongst all stakeholders. This was particularly true with regard to the NZGG implementation team’s support, the more effective relationships developed between DHB departments and the flexibility allowed to find local solutions to any issues that were encountered.

Stakeholders widely held the view that the Ministry of Health needed to better coordinate (at a national policy level) the various suicide and self-harm initiatives happening in DHBs and other work on national priorities.

Opportunities to enhance effectiveness and sustainability

With the decision by the Ministry of Health to continue the collaborative for another 12 months, from April 2010 until March 2011, the focus of the project is expected to shift from national facilitation and guidance to building local sustainability. This community of practice model will be less resource intensive in terms of the national implementation team and will require greater leadership from DHBs themselves. Many of the project coordinator positions have been disestablished from March 2010, creating a challenge for DHBs to keep up momentum.

In this context, the findings of this evaluation will be useful in identifying opportunities for the NZGG to consider in moving forward.
The NZGG and DHBs have identified opportunities to strengthen buy-in and ownership of future collaboratives, and improve the stability and profile of the current project. These opportunities are for DHBs, the Ministry of Health and other stakeholders to consider, and include:

- providing more support for project coordination, especially in larger DHBs
- developing key performance indicators around the project targets, and auditing these
- including the requirements for achieving the targets in DHBs’ policies, procedures and district annual plans
- involving high-level clinical champions more closely in the project.

In the next phase of the project, the NZGG intends to support the sustainability of the approach by:

- enhancing the website, e.g. by providing checklists for DHBs to achieve, tick off and compare
- publishing improvements achieved by DHBs as case studies on the website
- offering support with improving processes for cultural assessment (if wanted)
- engaging the support of medical colleges (e.g. emergency physicians, emergency department nurses, psychiatrists, GPs), the Mental Health Commission, and (possibly) the Alcohol Advisory Council
- developing, or supporting the development of, key performance indicators
- enabling advisory group members to provide high-level advocacy to senior DHB management
- positioning the collaborative as a way to assist DHBs in reducing the emergency department waiting times
- enabling project coordinators and project teams to support each other through an email network
- better aligning the collaborative and other mental health or self-harm and suicide initiatives in DHBs, e.g. by establishing an overall steering group across all initiatives to give strategic advice and capitalise on reductions in duplicated efforts.

Evaluation of the next phase of the project should focus on the sustainability of the methodology within the DHBs, and would also provide the opportunity to update the analysis of the project’s impacts.
Contents

Acknowledgements ................................................................. iii
Executive summary ................................................................. iv
  Quality of implementation .................................................... iv
  Impacts of the collaborative .................................................. v
  Sustainability of the changes .................................................. vi
  Stakeholder satisfaction ......................................................... vi
  Opportunities to enhance effectiveness and sustainability .......... vii

Contents ................................................................................. viii
  List of figures ........................................................................ ix
  List of tables ......................................................................... ix

1 Introduction ........................................................................ 1
  1.1 Background ........................................................................ 1
  1.2 The guideline ....................................................................... 1
  1.3 Collaborative phase 1 (2005–2007) ...................................... 3
  1.4 Collaborative phase 2 (2008–2010) ...................................... 7
  1.5 Whakawhanaungatanga ..................................................... 8
  1.6 Targets for change ............................................................ 8

2 Evaluation objectives and methodology ................................ 10

3 Findings .............................................................................. 12
  3.1 Impacts of the collaborative ............................................... 12
  3.2 Sustainability of improvements and impacts achieved .......... 24
  3.3 Quality of implementation at the national level ................... 26
  3.4 Satisfaction amongst project members ................................. 30

4 Conclusion and recommendations ........................................ 35
  4.1 Quality of project implementation at a national level .......... 35
  4.2 Local implementation progress and impacts achieved .......... 36
  4.3 Stakeholder satisfaction with the collaborative ................... 38
  4.4 Sustainability of the impacts and changes achieved ............ 38
  4.5 Opportunities to enhance effectiveness and sustainability .... 39

Appendix A: Overview of the evaluation framework ............... 41
  A.1 Logic model ................................................................. 41
  A.2 Framework of indicators ................................................. 42
Appendix B: Overview of improvement methodology ............................... 50
Appendix C: Overview of DHB target data ............................................. 52
References .......................................................................................... 58

List of figures

Figure 1: Logic model ................................................................................................. 42
Figure 1B: The clinical process improvement model .................................................. 50
Figure 2B: The improvement process ........................................................................ 51
Figure 1C: Target 1 (Access) .................................................................................... 54
Figure 2C: Target 2a (Comprehensive Assessment) .................................................. 54
Figure 3C: Target 2b (Cultural Assessment) ............................................................... 55
Figure 4C: Target 3 (Discharge) ................................................................................ 56
Figure 5C: Target 4a (Follow-up) ............................................................................. 57
Figure 6C: Target 4b (Did Not Attend) ..................................................................... 57

List of tables

Table 1: Matrix of evaluation objectives, questions, indicators and data sources ......................................................................................... 43
Table 1C: Summary of DHB target data ................................................................. 53
1 Introduction

Te Pou engaged Health Outcomes International Pty Ltd to conduct an evaluation of phase 2 of the New Zealand Guidelines Group’s (NZGG) Self-Harm and Suicide Prevention Collaborative – Whakawhanaungatanga. This document is a draft final report on that evaluation.

1.1 Background

Suicide and deliberate self-harm are identified as priority areas in the New Zealand health strategy (Ministry of Health, 2000) and the New Zealand injury prevention strategy (Ministry of Health, 2003). More recently, five goals have been identified in the New Zealand suicide prevention strategy 2006–2016 (Ministry of Health, 2006), of:

- promoting mental health and well-being and preventing mental health problems
- improving the care of people who are experiencing mental disorders associated with suicidal behaviour
- improving the care of people who make non-fatal suicide attempts
- supporting families/whānau, friends and others affected by suicide or a suicide attempt
- expanding the evidence about rates, causes and effective interventions.

In 2007, 483 New Zealanders died by suicide, there were 2,679 admissions to hospital for intentional self-harm, and a further 2,426 patients who presented with self-harm, but who were not included in hospital admissions1. Māori have higher rates of suicide and hospitalisation for intentional self-harm, than other ethnic groups. Suicide rates are also significantly higher among people living in the most deprived areas, than those living in the least deprived areas (Ministry of Health, 2009). People who make one suicide attempt are at high risk of making a further, possibly fatal attempt, and there is good evidence that improving the care of these people may reduce the risk (NZGG and Ministry of Health, 2003).

The NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga is designed to improve crisis care in emergency departments, Māori health, Māori mental health and mental health services in a way that recognises local situations, people and resources, and builds on the 2003 guideline The Assessment and Management of People at Risk of Suicide (NZGG and Ministry of Health).

1.2 The guideline

The NZGG developed the guideline The Assessment and Management of People at Risk of Suicide (NZGG and Ministry of Health, 2003) as a best-practice, evidence-based resource for emergency staff and mental health workers caring for people who are at risk of taking their own lives, or who have made a suicide attempt.

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1 This includes patients who were discharged from emergency departments and stayed less than 48 hours, and patients who were re-admitted within two days of a previous admission for an intentional self-harm episode.
In essence, the guideline spawned from evidence that suggests that a key strategy for assisting those who are suicidal is to seek supervision and the input of a multidisciplinary team, as these factors are likely to assist in the assessment of risk, diagnosis, treatment and management plans of suicidal individuals.

Implementation of the guideline first began in 2003 with the direct dissemination of recommendations to emergency departments and mental health services, as well as presentations at conferences for key health workers. By providing explicit and practical advice for the appropriate care and management of suicidal individuals, it was hoped that improved services would translate into better patient outcomes and a reduction in the psychosocial and economic burden of suicide in New Zealand.

The guideline discusses implementation issues, including gaps and barriers to implementation as identified in the Mental Health Commission’s report *Open all hours: A review of crisis mental health services* (2001). These issues included, among other things:

- integration of the delivery of crisis services, including poor coordination and a lack of cooperation between crisis services, emergency departments and other mental health services, and breakdowns in liaison between services
- access to services (particularly for people in rural settings, Māori and Pacific people wanting culturally specific crisis services, services for children, youth and older people) and general issues in relation to access to crisis management resources
- gaps in best practice, including a lack of crisis training opportunities, a lack of widely agreed and implemented competencies for crisis workers, a lack of systems and processes for supervision and external clinical review, and (in some areas) a lack of access to medical backup and no routine review of crisis work with medical staff.

The guideline notes that, “a key effort in any implementation process must be to target clinician knowledge and attitudinal change, particularly promoting staff members’ confidence in assessing and managing risk, so fewer people at risk are overlooked due to fears about asking about suicide” (NZGG and Ministry of Health, 2003, p. 42).

It also notes that a key focus in implementing the guideline should be on, “upskilling the workforce to better assess and manage suicidal risk and reviewing work force configuration to better respond to risk, in accordance with the evidence based guidelines” (Ibid, p. 42), and identifies four key elements to implementing the guideline:

- targeting implementation strategies to affect individual clinicians’ practice
- targeting implementation strategies to address clinical process issues
- targeting implementation strategies at a service configuration level
- ensuring that the above three components are done in accordance with the key recommendations in the guideline and evidence for effective practice.

With regard to service configuration and integration issues, the guideline identifies a number of key players including crisis assessment and treatment teams, community mental health teams, psychiatric inpatient units, consult-liaison psychiatry teams, emergency departments and the interface between these services.
It notes that, “This is a specific challenge for the implementation process as they target a number of clinicians with quite disparate backgrounds, training levels, modes of working and theoretical stances” (Ibid, p. 43).

Other strategies to promote the use and application of the guideline are also identified, including:

- developing memoranda of understanding between services to enhance response times and transfer between services
- developing workforce competencies in mental health and emergency department settings to increase staffs’ ability to recognise and effectively care for people at risk of suicide
- adopting tools such as the RAPID assessment tool to support appropriate clinical decision-making
- using summaries of the guideline resource for the relevant health services, consumers and their families.

1.3 Collaborative phase 1 (2005-2007)

Building on the 2003 guideline, *The assessment and management of people at risk of suicide* (NZGG and Ministry of Health), the Ministry of Health engaged the NZGG to develop and lead the Self-Harm and Suicide Prevention Collaborative, a project aimed at ensuring that people at risk of self-harm and suicide receive timely and appropriate care.

A collaborative is a network of people who share information, build on existing knowledge, develop expertise and solve problems for a common purpose, driven by the interest of the community involved. Participation in a collaborative is voluntary and varies depending on the motivation and level of interest of the individual members. Collaborative models have demonstrated the potential to achieve a rapid spread of knowledge and innovation across diverse sectors, from IT, manufacturing and research, to education. Examples of settings in which collaboratives have been developed to support practice change, include the World Bank (for community development), and multinational companies.

The NZGG developed its collaborative methodology in 2005 and 2006. Initial development work was undertaken in partnership with Skylight and Auckland Uniservices, drawing on the assistance and sector expertise of an advisory group. Following this initial work, the NZGG developed the whakawhanaungatanga model that underpins the collaborative.

In developing its collaborative methodology, the consortium drew on the already tested methodology of Australia’s National Institute of Clinical Studies (NICS) in its “communities of practice” work (NICS 2004a; NICS 2004b). This methodology was pioneered in the United States by the Institute of Healthcare Improvement. It also underpins much of the work conducted by the National Institute for Mental Health in England. In New Zealand, the methodology had been adapted by the Mental Health Workforce Development Project in its work on implementing risk assessments (particularly for violence) in emergency departments. Canterbury DHB had also participated in a collaborative with Australian hospitals.
It was recognised that many DHBs already provided training in suicide assessment and management, and that significant resources already existed nationally and internationally to support this. The collaborative approach was seen as being preferable to a “train the trainer” methodology because:

- it did not duplicate these existing materials and approaches
- it provided an explicit focus on systemic and practice change, rather than the transfer of information
- it aimed to embed changes in organisational culture and practice that would be sustainable and would not be lost through staff turnover.

The NZGG developed its collaborative model in consultation with the NICS, adapting it to the specific structural and cultural features within the New Zealand health system and society. The project became known as the Self-Harm and Suicide Prevention Collaborative – Whakawhanaungatanga.

Ten DHBs (Counties Manukau, Hutt Valley, Lakes, Mid-Central, Northland, Southland, Taranaki, Waikato, Waitemata and West Coast) participated in phase 1.

The following key steps were included in the implementation of phase 1 of the collaborative.

- **Consultation**: consultation with stakeholders was identified as an important initial step. NZGG and Advisory Group members consulted with the sector to raise the profile of the project and generate buy-in from DHBs to participate in the collaborative. At the same time, Implementation Team members attended key conferences and meetings to present and discuss the project.

- **Recruitment**: all DHB emergency departments, mental health services and Māori health services were invited to form a project team and apply to participate in the collaborative. Applicant DHBs had to demonstrate their readiness to participate, by meeting criteria relating to the composition of their team, commitment of a project manager and executive sponsor, and commitment of adequate resources. These factors had previously been found by the NICS and the Institute of Healthcare Improvement to be characteristics of project teams that work successfully in a collaborative.

- **Demonstration project**: the demonstration project commenced at one DHB, four months prior to the general roll-out, with the aim of piloting the formation and initial activities of a project team. This included the use of key tools, such as pathway mapping, as well as providing the opportunity to develop, test and refine the initial preparation, training and resources that would be provided to participants, and the quantum and nature of support that would also be provided.

- **Targets for change**: four targets for change were developed in consultation with key stakeholders. These targets were a core component of the collaborative methodology. They represented macro-level changes, which DHBs participating in the collaborative would develop local solutions to achieve. The targets incorporated best practice, process and systemic elements that required change strategies in the areas of access, assessment, discharge, and follow-up.
• **Training workshop**: a two-day workshop was held in Wellington in March 2006 and marked the commencement of the full roll-out of the collaborative. The workshop involved all DHB project teams and provided training in relevant concepts and tools. It also facilitated the development of a national network of collaborative teams.

• **Local implementation processes**: collaborative teams undertook pathway mapping to analyse consumers’ journeys through emergency departments, mental health services and Māori health services, in order to identify any gaps, bottlenecks, duplications or other problems in the system. The teams then applied a plan–do–study–act approach to modifying local structures and procedures, with the aim of addressing the issues identified, and measured their progress by collecting and reporting monthly data against the targets for change.

• **Ongoing support**: the NZGG implementation team provided ongoing advice and support to the collaborative project teams including web-based support, mentoring, monthly teleconferences (with a focus on maintaining motivation and momentum and sharing success stories), workshops for project coordinators and consumers, and periodic site visits. The process concluded with a wrap-up workshop in June 2007.

1.3.1 Evaluation of phase 1

The phase 1 evaluation examined the effectiveness of the collaborative as a method of guideline implementation, and described critical success factors and barriers to success that may be relevant to other projects to implement guidelines in the health sector. The evaluation followed a multi-method approach, which included review of documentation and a scan of background literature, observation of collaborative processes through attendance at key meetings and teleconferences, consultation with a range of national and local stakeholders, and analysis of local project data collated by the NZGG.

The final report on the evaluation observed that the project had been “ambitious in setting four targets for change that involved addressing entrenched issues of fragmented care across disparate hospital departments in the relatively short timeframe of 12 months”. Moreover, the project had been:

- facilitated at national level by a small team of people who worked part-time, were separated geographically for the majority of their working time, and who were learning the methodology at the same time as they were implementing it
- implemented within each DHB by a project team comprised of clinical staff and consumers, who typically started out with fundamentally different experiences and world views about crisis care for people at risk of suicide and who (either predominantly or completely) undertook the project in addition to their regular work.

Despite these challenges, improvements were reported in the following areas:

- improved relationships and communication between emergency departments and mental health teams, leading to more effective and timely transfer of patients and information
- improved relationships and communication between hospital clinicians and consumers, with improved awareness and knowledge about suicide, reduced stigma, and greater appreciation of consumers’ experiences of the health services
• the participating emergency departments, mental health, Māori health and Māori mental health teams gained a greater awareness of the guideline and improved understanding of gaps in best practice
• the collection of data on self-harm and suicidality presentations improved, leading to raised awareness of health inequalities in relation to suicide risk
• people presenting at DHBs with self-harm were more likely to be recognised as potentially having an elevated risk of suicide and to be assessed for suicide risk in the emergency department, and the results were more likely to be communicated to community assessment and treatment teams in terms that were mutually understood by both departments
• waiting times for these patients in emergency departments were reduced
• process improvements meant that the assessment of people at risk of suicide could be started by mental health staff before the patient had been medically cleared by the emergency department, significantly improving access to timely mental health assessment and treatment for these patients
• some DHBs had started conducting cultural assessments as a routine component of their mental health assessments (while other DHBs were taking steps toward this), and documentation of mental health assessments had improved;
• some DHBs had successfully implemented written discharge plans for people at risk of suicide, while other DHBs were continuing to work toward this. In some cases, electronic discharge summaries had also been introduced, facilitating more consistent and reliable communication with the consumer, their family/whānau, significant others and other people involved in their care
• some DHBs had begun overhauling their discharge processes to improve communication with primary care and other community-based providers aimed at ensuring people at risk of suicide receive timely and appropriate follow-up.

A number of success factors were identified. These are in accord with success factors identified in evaluations of collaboratives overseas and include factors related to:

• the composition, functioning, resourcing and motivation of local project teams and the national implementation team
• a consumer-centred approach to identifying issues and gaps in care
• the collection and monitoring of data to provide an objective measure of progress
• the flexibility for project teams to develop local solutions to address issues and gaps
• a focus on embedding new processes into work practices in ways that are readily acceptable to staff and that can be incorporated into work practices without being unduly onerous (i.e. making business-as-usual better)
• a high-quality and up-to-date evidence base as a central point of reference
• the provision of overall facilitation and support from a national implementation team, including a mix of support strategies ranging from individual contact with project coordinators and teams to national teleconferences and hui.
1.4 Collaborative phase 2 (2008-2010)

In 2007, the government committed funding for a further four years to continue to support participating DHBs to reinforce the changes, and to expand the collaborative to further DHBs.

A total of 14 DHBs participated in phase 2, including nine that were involved in phase 1. The DHBs participating in phase 2 were: Bay of Plenty, Capital and Coast\(^2\), Counties Manukau, Hawkes Bay, Hutt Valley, Lakes, Mid-Central, Northland, Southland, Tairawhiti, Taranaki, Waikato, Wairarapa and Waitemata.

The methodology that was followed in phase 2 was essentially similar to that used in phase 1, with some refinements. Key project elements included:

- four targets for change (with the target areas remaining the same, but some refinements being made to data collection in order to collect record-level data, rather than aggregate data as in phase 1)
- a training workshop for project teams (reduced from two days to one, and held in two regions – Auckland and Wellington)
- a strengthened focus on pre-workshop orientation, with the NZGG visiting each DHB prior to the training workshops to ensure project team members had a basic understanding of the collaborative and had met each other before they attended the workshop
- the implementation of local improvement processes, including pathway mapping, testing small changes and collecting data, supported throughout by the NZGG implementation team, as in phase 1.

Membership of the NZGG implementation team changed at the outset of phase 2, with the appointment of new project leaders. A new Māori advisor was also appointed, but subsequently vacated the position. More recently, the NZGG has contracted a Māori health consultant to work with Māori stakeholders and DHBs to implement an action plan to address cultural aspects of the collaborative.

A new consumer advisor position (0.2 FTE) was also established, and a consumer advisor appointed. The role was subsequently discontinued and instead a consumer panel\(^3\) was established in May 2009. The emergency department advisor from phase 1 remained in her role for phase 2.

Similarly, there had been turnover in the DHB project teams, with new project coordinators being appointed in many cases, as well as significant changes in the medical, nursing, consumer and technical members of the project teams.

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\(^2\) Capital and Coast DHB joined the collaborative after the commencement of the phase 2 evaluation. As a result, it has not been included in the evaluation.

\(^3\) A consumer panel was established in May 2009 to provide a consumer perspective to the NZGG team and to offer support to consumer advisors in DHB project teams (e.g. sharing information and updates, offering advice). The panel replaced a sole consumer advisor role on the NZGG team.
1.5 Whakawhanaungatanga

In applying the term whakawhanaungatanga to the implementation of the collaborative, it was acknowledged that suicide or self-harm were not just problems of the individual, but of the community at large. Actions to address these issues must be initiated at multiple levels of the community.

In essence, whakawhanaungatanga is a community of practice, but is based on a more holistic approach. Principles for this approach include the creation and maintenance of:

- a group connected like kin or whānau
- shared responsibility for one another
- common understanding
- cheerful cooperation
- corporate responsibility.

In bringing these principles to life, whakawhanaungatanga is thought to work through forces of aroha (love), awhi (support), manāki (hospitality), and ti aki (guidance). These forces and principles are at the core of whakawhanaungatanga, and it is these that provide a vessel for the structural relationships that are considered key for a successful collaborative aimed at the prevention of suicide in New Zealand.

1.6 Targets for change

Targets for change were a core component of the collaborative methodology. The targets represented macro-level changes, which project teams developed local solutions to achieve, and which they monitored progress against through data collation and reporting. The targets incorporated best practice, and process or systemic elements that required change strategies.

Four global targets were developed in phase 1 and these were further developed at the outset of phase 2 to improve consistency and integrity in data recording\(^4\). The targets used in phase 2 were:

- **Target 1 – Access:** 90 per cent of presentations, to any of the services, of people at risk of self-harm or suicide should be seen within one hour of arrival by a clinician skilled in conducting mental health and risk assessments

- **Target 2a – Comprehensive Assessment:** 100 per cent of presentations, to any of the services, of people at risk of self-harm or suicide will have a documented assessment that incorporates an assessment of psychosocial stressors, a screen for mental illness and risk assessment within 72 hours

- **Target 2b – Cultural Assessment:** 100 per cent of Māori presentations, to any of the services, of people at risk of self-harm or suicide will have a cultural assessment within 72 hours.

- **Target 3 – Discharge:** A person discharged and their family/whānau or significant others (if appropriate) should be provided with a written copy of their discharge plan, which should also be sent to all others involved in the person’s care

\(^4\) For example, in phase 1, attempts were made to track every presentation, even if the patient was admitted to the ward. In phase 2, only those who were discharged from an emergency department were tracked (as they were the people with less systematic support).
- **Target 4a – Follow-up**: 90 per cent of emergency department presentations of people who are at risk of self-harm or suicide will have a follow-up appointment [made] with a continuing care provider within 48 hours of discharge.

- **Target 4b – Follow up of those who did not attend**: 90 per cent of those who do not attend that follow-up appointment (or their significant other) will be contacted by the appropriate service within 48 hours.
2 Evaluation objectives and methodology

The objectives of the evaluation were to:

- review the quality of project implementation at a national level, against the NZGG’s declared methodology
- review local implementation progress and the impacts achieved against targets for change
- evaluate stakeholder satisfaction with the collaborative.

The evaluation focused on the performance of the collaborative as an overall approach. While the experiences and context of individual DHBs were taken into account, findings were analysed and presented at whole-of-collaborative level and did not identify individual DHBs or participants.

A multi-method evaluation was undertaken, drawing on the following sources of information:

- telephone interviews with project coordinators at all DHBs in April and May 2009, and November and December 2009
- semi-structured face-to-face or telephone interviews with the NZGG implementation team
- semi-structured group or individual interviews with project teams in six of the DHBs in October to December 2009
- descriptive analysis of impact data against targets for change, accessed from the NZGG in January 2010.

A detailed evaluation framework was developed, and was finalised in April 2009. The evaluation framework included a logic model, evaluation questions and indicators (including evaluative criteria to address the evaluation questions). Evaluative criteria permit a systematic approach to the evaluation of qualitative factors that cannot readily be measured using available data. The logic model, evaluation questions and indicators are summarised in Appendix A.

A formative evaluation report (King et al, 2009) was presented in September 2009, covering implementation progress and the quality of the project’s implementation, based on interviews conducted during April to June 2009.

Qualitative feedback from stakeholders was the primary data source for the evaluation. DHB project coordinators were asked to report on, and give a rating for, the progress their DHB had made in relation to each of the collaborative’s targets. They described the process changes that their project teams had tested and implemented, and the impacts these changes had had on improving services for people at risk of suicide and self-harm in emergency departments, mental health services and Māori health services. They also provided ratings and commentary on the quality of implementation against a framework of core features from the NZGG’s declared methodology.
Evaluative criteria reflect key success factors for the collaborative, which are in turn reflected in the NZGG's declared methodology. These success factors have been drawn from findings from the phase 1 evaluation and other evidence used by the NZGG in formulating the methodology. Evaluative criteria were grouped into a series of checklists, which were reflected in the interview schedules set out in the evaluation framework document.

Further depth was obtained through visits to six DHBs. These DHBs represented a range of characteristics, including small and large DHBs, some that were making strong progress in the collaborative and others that were facing significant challenges, and DHBs with high Māori populations. At each DHB visit, interviews were conducted with consumer/tangata whaiora advisors, family/whānau advisors, medical and nursing staff from emergency departments, mental health services, Māori health and Māori mental health services, and managers and executive sponsors.

Interviews were also conducted with the NZGG implementation team and nominated advisory group members.

Quantitative data against the targets has been used as a secondary data source. Participating DHBs collected data against each of the targets and this data was uploaded onto the NZGG website. The NZGG analysed the data reported by DHBs and provided feedback, enabling each DHB to see how well it was performing against the targets and against DHBs’ national averages. It is important to note that the primary purpose of the data was to assist project teams to monitor their own progress. During the collaborative, project teams were expected to improve data collection processes, and most achieved this.

DHBs were asked to collect data for 26 weeks over the life of the collaborative. However, some DHBs collected data for longer periods (e.g. over 40 weeks) and there were instances where data was incomplete for some periods. The NZGG handled asynchronous data collection by presenting data in terms of elapsed weeks of data collection since the commencement of data collection at each DHB.

Due to small numbers, statistical analysis of this data would be inappropriate. However, descriptive analysis of the data is of some value to the extent that findings corroborate (or otherwise) the qualitative feedback received. Appendix C gives more detail about how data was collected, presents aggregated data for each target, and discusses the data's limitations in terms of informing the evaluation of the collaborative's impacts.
3 Findings

The following findings are structured around the key groups of processes and outcomes set out in the logic model (Appendix A, Figure 1). Section 3.1 presents impacts of the collaborative. Section 3.2 examines the sustainability of the changes implemented. Section 3.3 discusses the quality of implementation. Section 3.4 summarises stakeholder satisfaction with the collaborative from the perspective of DHB project team members, including project coordinators, clinical staff, and consumer and family advisors.

3.1 Impacts of the collaborative

Early findings from the formative evaluation of phase 2 of the NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga suggested that local implementation was progressing well (King et al, 2009). DHB project teams were implementing changes and reported feeling comfortable with using the collaborative methodology. There was some variability in the extent to which DHBs (and departments within DHBs) had adopted the methodology and achieved changes. Challenges that contributed to this variability included the extent of support from sponsors, staff turnover, technical difficulties and the different contexts in which DHBs were working.

Summative findings presented in this report suggest that although similar challenges are still being faced by DHBs, impacts have been achieved as further progress has been made. Stakeholder feedback indicated that the collaborative had resulted in a substantial number and range of changes to the way that people at risk of suicide, who present at the participating emergency departments, are assessed and managed. For DHB project team members, the impact of the collaborative that stood out most was the opportunity it provided for departments to collaborate.

The good thing is that we are now talking about integration and breaking down silos. [Participating DHB departments] have common points of engagement and [they’re] client focused. The collaborative has offered a platform on which to discuss these types of things. (DHB suicide prevention coordinator)

3.1.1 Impacts of the project in the four target areas

This section outlines:

- the changes implemented by project teams around the four collaborative targets
- the impacts of these changes for people at risk of self-harm and suicide
- the extent to which these impacts are reflected in the data reported by DHBs to the NZGG website
- the barriers to achieving the impacts identified by project teams
- the ways DHBs were addressing these barriers.
Overall, through working to achieve the four targets for change, participating DHBs had increased knowledge and understanding of issues for people at risk of self-harm and suicide amongst their emergency department staff. From the training received (in many cases regular and ongoing), as well as discussion about the collaborative as a running agenda item in staff meetings, it was reported that emergency department staff were now more aware, confident and competent to deal with issues of suicide and self-harm, and with mental health issues in general.

**Target 1: Access Target**

In phase 2 of the collaborative, all but three DHBs\(^5\) had implemented process changes aimed at reducing waiting times for people at risk of suicide as encapsulated in Target 1.

| Target 1: 90 per cent of presentations, to any of the services, of people at risk of self-harm or suicide should be seen within one hour of arrival by a clinician skilled in conducting mental health and risk assessments. |

The process changes made included:

- adapting the rapid assessment tool developed by the NZGG, or other similar templates (e.g., the SAD Person’s Scale\(^6\) or pre-existing tools in DHBs) to suit their needs and/or avoid requiring ED staff to complete more than one form
- trialling the assessment tools (e.g. asking structured questions and prompts with patients, such as, “Are you feeling safe?”) to establish how well they worked in practice
- implementing the tools once trialling them had demonstrated their value
- training (e.g. in how to respond to self-harm and suicide presentations, how to ask open-ended questions, and how to complete the new tools) for emergency department staff, including doctors, around initial assessment. The format for these training sessions differed (e.g. ambulance and primary care staff were included in one DHB, and in another DHB training was provided by the consumer advisor).

Incentives to embed these process changes into everyday practice also varied between DHBs, and included:

- displaying graphs from the NZGG website, which showed progress on the Access Target, in a prominent place to encourage emergency department staff to sustain or improve their progress (e.g. by undergoing further training)

\(^5\) In one DHB, the emergency department had stopped participating in the collaborative, in one the target was on hold due to turnover of team members (including the project coordinator), and in one the target was already met prior to joining the collaborative.

\(^6\) Appendix 7 of the Guideline provides a mnemonic “Sad Person’s Escape” which can act as an aide memoir to assist the clinician to cover the key factors in assessing for suicide risk (Sex, Age, Depression, Previous attempt, Ethanol and drug abuse, etc). Evaluation of a similar tool involving a semi-structured interview based on the acronym ”SAD PERSONAS” (Patterson WM et al. 1983. The SAD PERSON Scale. Psychosomatics. 1983;24(4):343-349) has been found to encourage the systematic gathering of patient data and relevant psychosocial history, and improve the evaluation of suicide risk (Juhnke G. 1994. SAD PERSONS Scale review. Measurement and Evaluation in Counselling and Development. 1994;27(1):325-327).
• creating a reward system (e.g. one DHB created a poster for its emergency department called the “Three Ps”: fill in pink form; contact PET (psychiatric emergency team); show that you’ve filled in a crisis form; and then you get a Pinky bar.)

Initially, some emergency departments found it difficult to adjust to the increased workload that accompanied the process changes. However, the benefits of implementing the changes had been realised over time.

*Initially it was burdensome, but it is now seen as not just another form [but] time-saving.* (Project coordinator)

The impacts of the above changes, as reported by both the NZGG and DHB project team members, centred around improved processes (e.g. standardised forms), improved knowledge about self-harm and suicide amongst emergency department staff, increased skills and confidence to ask relevant questions of people at risk, and prompter detection of and action on mental health issues. This included faster access to triage and initial assessment (sometimes sequentially, sometimes both at the same time).

The comment made by one emergency department nurse manager exemplified the views of many:

*There is increased confidence of emergency department staff because of training and the tools. People used to be left just sitting there...there were no key processes...nurses felt uncomfortable and didn't know how to talk about self-harm and suicide. And they didn't know how to ask open-ended questions. Most emergency department staff have the confidence to deal with this client group now, which they didn't have before.* (Emergency department nurse manager)

However, despite the stated improvements, feedback from project coordinators, as well as from the NZGG implementation team members, indicated that the target was not being achieved consistently for all patients at risk of suicide. Of the 10 project coordinators in DHBs that had implemented process changes around Target 1:

• seven said that their DHB had significantly reduced waiting times (as a result of more efficient processes)
• three said that they were working towards meeting the 1 hour maximum waiting time.

The data reported to the NZGG by the DHB project teams (summarised in Appendix C) reinforced stakeholder feedback that the DHBs struggled to meet Target 1 consistently. The highest performing DHB against Target 1 met the target in more than three-quarters of the weeks they reported data. However, the majority of DHBs had met the target less than half of the time. Collectively, DHB data fluctuated widely throughout the period, but was suggestive of a possible slow upward trend (see Target 1 graph, Appendix C).

According to the project coordinators, barriers to achieving Target 1 centred around the time and resources available in emergency departments. For example:

• due to high staff turnover and the nature of shift work, it was difficult to achieve consistent compliance with aspects of this target
• the large number of competing projects that were being implemented simultaneously in emergency departments limited staffs’ capacity to be fully involved.

Examples of how DHB project teams were continuing their ongoing efforts towards meeting the target included:

• checking all assessment forms, and contacting the relevant clinician if anything was missing to explain why the form needed to be completed
• hand-picking champions in emergency departments, e.g. triage nurses or charge nurses, to ensure forms were completed
• attending emergency department staff meetings to keep the project profile constantly to the fore
• working in collaboration with other initiatives (e.g. having a representative from the Suicide Prevention Coordinators Project on the DHB project team)
• developing a memorandum of understanding between the mental health and emergency departments.

**Target 2: Assessment Target**

Stakeholder feedback indicated that all of the DHBs had implemented changes aimed at meeting Target 2. This target was divided into two parts for data reporting purposes: mental health, and cultural assessment. These are discussed separately below.

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**Target 2a:** 100 per cent of presentations, to any of the services, of people at risk of self-harm or suicide will have a documented assessment that incorporates an assessment of psychosocial stressors, a screen for mental illness and risk assessment within 72 hours.

Examples of changes introduced to meet the comprehensive mental health Assessment Target were:

• alerting mental health services immediately of their need to become engaged (having met Target 1, emergency department staff were in a position to do this)
• developing communication channels between emergency departments and mental health services, which provided the opportunity to ascertain urgency and carry out comprehensive assessments of patients out of hours, rather than waiting until morning
• allowing mental health assessment to take place prior to medical clearance
• providing an increased presence of mental health staff in emergency departments
• introducing improved electronic records that could be shared between departments (e.g. including both medical information and mental health notes, which in many instances had been completely separate in the past).

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Stakeholder feedback suggested that impacts occurring, as a result of the changes to meet this target, centred around improved communication and relationships between emergency departments and mental health services, and more prompt and thorough comprehensive assessment (e.g. where it was appropriate, there was no need to wait for medical clearance).

*There is more open discussion of what needs to be done. The emergency department can raise issues and there is more open communication.* (Project coordinator)

*The relationship between the emergency department and mental health is more open. The emergency department can now say to mental health that they need to get to the emergency department to do assessment quicker.* (Service manager, mental health and addiction services)

The data reported to the NZGG by the DHB project teams confirmed stakeholder feedback about the collaborative contributing to improved mental health assessments, indicating that all DHBs were meeting Target 2a most or all of the time. In fact, the data suggests that six DHBs had fully met the target during the period of reported data (see Appendix C).

The particular mental health staff and teams with responsibility for providing the comprehensive assessment differed amongst participating DHBs. The main barrier reported was limited access to those staff after hours, particularly over weekends. As a means to address this barrier, DHBs were using other appropriate staff within mental health services, such as community assessment and treatment team members or mental health registrars.

The second part of this target focuses on cultural assessment.

**Target 2b**: 100 per cent of Māori presentations, to any of the services, of people at risk of self-harm or suicide will have a cultural assessment within 72 hours.

As discussed in the interim evaluation report, and elsewhere in the current report, the nature of cultural assessment varied between DHBs and tended more towards cultural input, than assessment per se.

Examples of changes introduced to meet this target were therefore not always aimed at providing assessment, but rather at providing cultural input or being more culturally responsive. These changes included:

- collaboration between departments to develop strategies for better cultural responsiveness
- Māori staff increasing their responsiveness, e.g. in one DHB, half of the mental health crisis team was Māori and these people were offering cultural input to Māori patients
- emergency department staff asking culturally specific questions as part of the initial assessment, such as, “Would you like cultural input” and “Do you want whānau support?”
- one Māori health unit changing its working hours to provide 24-hour cultural assessment
- appropriate space being made available in emergency departments for cultural assessments to take place in private.
What seemed to be a common approach across the DHBs was the use of staff within either the Māori health or Māori mental health units, or kaumatua advisory services, to provide the required input with respect to cultural assessment and cultural responsiveness. This was not always possible, or where it was, was not able to be sustained.

This was due to a combination of a lack of capacity for ongoing involvement, and simply not having the time to have the conversations, agree on a common pathway, do the necessary education and demonstrate Māori responsiveness in action.

_There’s no resourcing for Māori within mainstream services, so this has made it difficult to resource cultural assessors. There is also variation in what cultural assessment is._ (Quality and risk mental health manager)

_Getting Māori health buy-in has been difficult. It has been challenging for them fitting this in with what they do._ (Psychiatric liaison manager)

Although working towards the Cultural Assessment Target has been challenging, the collaborative has created debate within participating DHBs around this important issue, and provided the opportunity for more professional and whānau cultural support in emergency departments.

Feedback suggested that impacts experienced so far included:

- better collaboration with Māori health and other departments to engage culturally appropriate services for those who want them
- dialogue taking place about how things could change for the future
- connections being made with Māori providers in the community
- exploring possibilities for collaboration with cultural-specific projects.

Even if full cultural assessment may not have happened yet, models were appearing, often as a result of a wider DHB approach to the issue. There was one particularly positive example of Māori responsiveness, whereby the Māori mental health team had brought in kaumatua to look at how an emergency department operates and could operate in the future from a marae-based model.

_We put together the model based on Te Whare Tapa Whā [holistic service delivery], where we considered that when people present at emergency department, emergency department becomes the tangata whenua [home people] in the sense that it is their job to manaaki manuhiri [look after those who come within their space]...this concept is about using marae tikanga [rituals and principles] to ensure patients are cared for._ (Service manager, Māori mental health)

These impacts were reinforced in feedback from the NZGG implementation team, who talked about DHBs bringing more of a “cultural lens” into emergency departments, than had occurred prior to the collaborative, so that in cases where the ethnicity question was asked and the patient identified as Māori,
more cultural support (e.g. rituals of welcome, such as karakia, and whānau support) was being offered. However, not everybody who should, was necessarily getting access to these services.

The challenges DHBs were facing were reflected in the data. In most cases there were very small numbers of patients recorded. However, the reported data was consistent with stakeholder advice in suggesting that despite the positive changes occurring in this area, the Cultural Assessment Target (as originally conceived) was not being met, for the reasons discussed above. Specifically:

- one DHB had fully met the target
- five DHBs had met the target, less than a quarter of reported weeks
- five DHBs had not met the target for any of reported weeks.

The dominant problem affecting DHBs’ ability to achieve this target was limited resourcing of Māori health units. Specific barriers included:

- lack of appropriate kaumatua, kuia or Māori staff to carry out cultural assessments, and non-availability of appropriate people after hours
- lack of a coordinated DHB response to the issue, including not providing links to cultural support people, e.g. takawaenga, kaumatua and kuia, to provide tautoko
- models of care that separate Māori and mainstream services (e.g. if a person is not referred to a kaupapa Māori service, it is unlikely that there are sufficient resources within the mainstream setting to meet the needs of Māori)
- different understandings about what cultural assessment means, as well as the appropriate time and place to do it, i.e. not within the target timeframe or having no private space in an emergency department
- non-Māori staff failing to appreciate the value of cultural input to a person’s health and well-being, making assumptions about a person’s ethnicity (i.e. that they are not Māori), making decisions about whether or not a person needs cultural input, rather than asking them (e.g. Māori health unit staff in one DHB considered it unhelpful to attempt to determine “how Māori someone was”), and deciding what is needed instead of making contact with Māori health
- lack of time, or DHB support, for emergency department staff to develop their cultural competency (e.g. improve understanding of Māori world views and rituals of first engagement etc)
- low engagement by Māori health services in some DHBs (often as a result of lack of time and resources).
Nonetheless, DHBs were continuing their ongoing efforts towards providing cultural input or assessment, by:

- consulting with key local Māori individuals, organisations and communities
- making a referral for cultural assessment to be done at a later stage
- integrating kaupapa Māori service delivery within emergency departments, i.e. having Māori staff on the team or available there at all times.

In general, the importance of developing wider strategies for increasing cultural awareness amongst all DHB staff, such as the provision of staff training in holistic health or whānau ora as part of the treatment plan for Māori patients, was emphasised:

*It all comes back to training...all staff at the DHB have to have a certain level of understanding of what needs to happen till people are handed over.* (Māori health director)

The challenges related to this particular target had been recognised by the NZGG implementation team, who have recently contracted a Māori health consultant to implement an action plan to address some of the above issues. Work has commenced with seven DHBs that initially expressed willingness to work more on the issue of providing appropriate cultural input. Discussions have focused on the existence of cultural assessment processes, key issues and resources (e.g. audit tools, policies and procedures). It has been found that most of these DHBs have existing policy, but do not have the resources to provide adequate staff in emergency departments, as required by the target. DHBs have also questioned the validity of this target and have explained the difficulties inherent in achieving cultural assessment, rather than cultural engagement, which is a term many prefer. Five of the seven DHBs have advised that they no longer wish to focus any more work in this area.

**Target 3: Discharge Target**

Although there was some variability amongst DHBs in meeting the Discharge Target, the overall findings suggested that good progress was being made to improve discharge processes for people at risk of suicide and self-harm.

*Target 3: A person discharged and their family/whānau and significant others (if appropriate) should be provided with a written copy of their discharge plan, which should also be sent to all others involved in the person’s care.*

Overall, this was a challenging target to meet, as DHBs were required to provide not only the consumer with a discharge plan, but also their family/whānau. Eight DHBs reported either achieving, or making significant improvements towards achieving the target. Two indicated that good discharge processes were already in place before the collaborative, and one DHB was about to implement changes in discharge processes.
Examples of changes that had occurred around the development, trialling and introduction of discharge plans included:

- development and implementation of discharge forms for the patient, with information about their follow-up appointment, who would contact them and what additional support was available
- inclusion of mental health notes, as well as emergency department notes, in discharge plans
- development of further resources, such as a booklet for family members, so that they also went away with supportive information
- the design of a consumer satisfaction survey to measure the effectiveness of discharge and follow-up procedures, as well as consumer satisfaction with their experiences in the emergency department
- use of layperson’s language, rather than clinical terminology, in discharge plans, in order to make it easier for patients and family/whānau to understand them
- sending fax or electronic copies of the discharge form to GPs and other care providers.

Impacts, brought about by the changes implemented by DHBs in order to meet the Discharge Target, were reported by project members. These included:

- more people at risk of suicide and self-harm who were discharged from the emergency department now received a written discharge summary
- discharge plans now contained more useful, and clearer, information (including on suicide and self-harm, as well as the person’s plan for the next 48 hours, who would contact them and when, follow-up appointment details, and important contact telephone numbers if further support was needed)
- more family/whānau also received a copy of the discharge plan
- better engagement with primary care (e.g. copies of patients’ discharge summaries being provided to GPs).

Aggregated data for Target 3 suggested an improvement over time. The data also suggested variability in DHBs’ achieving Target 3 as noted above. Specifically:

- two DHBs were meeting the target most or all of the time
- four DHBs had met the target between half and three-quarters of the time
- two DHBs had met the target in a quarter to a half of reported weeks
- three DHBs had met the target in less than a quarter of reported weeks
- two DHBs did not meet the target for any of the time.
Barriers to achieving this target centred around:

- agreeing to a common form that could be used by all teams, e.g. emergency department, psychiatric liaison, crisis team
- emails or faxes not getting through to the GP, or GPs not reading the discharge summary before the patient attended the follow-up appointment (and thus not having an understanding of what the appointment was about)
- getting information to family, if no family member was present at discharge
- staff not documenting that discharge plans had been given.

DHB teams were continuing to strengthen and embed processes aimed to meet this target. For example, one team was using pathway mapping as a means to develop agreement on format for discharge summaries. Another DHB phoned GPs or other service providers to provide verbal discharge. GPs would then write discharge notes directly on the system and be aware that the appointment was related to self-harm. Others were developing electronic discharge summaries that would automatically go to the GP and patient, as well as the family.

**Follow-up Target**
The Follow-up Target was broken into two parts.

| Target 4a: 90 per cent of emergency department presentations of people who are at risk of self-harm or suicide will have a follow-up appointment with a continuing care provider within 48 hours of discharge. |

The changes DHBs had implemented, or planned to implement, to improve discharge processes included:

- automatically referring people at further risk of suicide to mental health services
- improving IT infrastructure, so that patient notes could be accessed by both mental health services and the emergency department
- developing processes for people referred to mental health services to be contacted by that service prior to their follow-up appointment
- developing policy that all current mental health unit clients should be seen by that service after discharge from the emergency department
- improving communication between the DHB and services in the community.

Feedback from the NZGG implementation team reflected these positive changes, reporting that although DHBs were at varying stages, all were working towards meeting the Follow-up Target and were showing a distinct improvement from where they were at the start of the project. Smaller DHBs could follow-up more easily, whereas larger DHBs with more patients found it harder to manage.

Impacts reported by stakeholders included improved referral processes and continuity of care (e.g. as a result of note sharing, the emergency department could see what had happened after a patient had been discharged). These changes and impacts suggested that follow-up procedures for people at risk of self-harm and suicide were increasingly becoming embedded as standard practice in many of these DHBs.
Follow-up is better. Before, the emergency department usually had no idea what happened once a patient went to Mental Health. Now all info can be found in the notes. (Emergency department nurse manager)

Reported data showed that:

- four of the DHBs had met the target between half and three-quarters of the time
- six DHBs had met the target in a quarter to a half of reported weeks.

In aggregate, the data suggested an improvement in performance over time.

Barriers to achieving this target centred on practical difficulties around establishing systems and protocols to ensure follow-up happened, and documenting this. This was particularly challenging when a follow-up appointment fell outside of the DHB mental health unit, e.g. it was with a GP or other community providers. However, some commented that any patients referred out to the community would not be considered at risk anyway, and they therefore questioned the necessity to follow-up on these clients.

Ongoing efforts towards meeting the target included developing better relationships with GPs and other community providers, and plans to provide follow-up for up to 12 months for people at further risk of suicide and self-harm.

| Target 4b: 90 per cent of those who do not attend that follow-up appointment (or their significant other) will be contacted by the appropriate service, within 48 hours. |

Not all DHBs focused on this second part of the Follow-up Target. Many DHBs indicated that follow-up of non-attendances would automatically happen if the follow-up appointment was with the mental health unit. At the same time, there were expectations on GPs to follow-up on appointments that were meant to occur in the community. As such, these DHBs considered they could only work with this target in relation to mental health unit referrals. Other DHBs argued that this aspect of Target 4 was redundant if 4a had already been achieved.

The NZGG implementation team indicated that this was a difficult target, as it follows Australian clinical practice, which may not be the choice of New Zealand DHB mental health clinicians.

Data reported against Target 4b suggested that the seven DHBs that were reporting data were generally performing well against the target.

Barriers to achieving this target centred around practical difficulties involved in providing ongoing follow-up (i.e. inadequate time and resources), if people failed to attend. It was difficult for DHB staff to know whether the patient had made the follow-up appointment or not, when referred to GPs and community providers. Issues were raised by DHB project teams about how time consuming it was to phone people, and whether it was appropriate for a non-clinical person to do this.
Ongoing efforts toward meeting the target involved:

- putting in place staffing and systems to make follow-up calls to patients
- putting “did not attend” processes in place and acting on these
- improving engagement with primary care providers.

3.1.2 Other impacts

Feedback from DHB project team stakeholders highlighted many positive changes, which represent important shifts in culture and practice that can be expected to impact positively on patient outcomes. These improvements are notable in that they were identified by a range of stakeholders (medical, nursing, consumers and management) across the participating DHBs, and relate to aspects of practice where culture change has traditionally been difficult to achieve. These improvements are summarised below.

Improved communication between and within departments

Stakeholders reported that the collaborative had had a considerable impact on communication between and within different departments of all DHBs, particularly emergency departments and mental health services and, to a lesser extent, Māori health and Māori mental health services.

*The relationship between emergency department and crisis mental health staff is 100 per cent better on the floor.* (Mental health manager)

*Mental health is more responsive to emergency department. It’s not them and us anymore.*

(Emergency department charge nurse)

*It’s because of the conversation that takes place now. We used to be different services…even secret services, but now it’s our business!* (Mental health nurse)

The collaborative was seen to have provided the opportunity to foster awareness of, respect for, and collaboration with each other. In the words of a project sponsor, the project was “a vehicle for strengthening the working relationships between emergency department and mental health”. Different departments were reported to have a better understanding of each other’s role and the “busyness” that each other’s staff faced.

Improved relationships between DHBs

Several project coordinators commented on the helpful relationships between participating DHBs that had developed for them through the collaborative, from peer support and sharing learning, tools and other resources. For example, one DHB was using another’s SAD scale and risk assessment form.

Emergency department staff using learnt skills in other presentations

As a result of the collaborative, emergency department staff had “learnt to ask more questions in general” and therefore enabled identification of other critical situations. For example, one emergency department clinical nurse manager identified a domestic violence situation because she was more interested in finding
out the context around the presentation. She said that, “Before, I would have just stitched up the person and sent him off”.

**Improved awareness and implementation of the guideline**

Generally, project coordinators and other members of DHB project teams reported that key departments were more aware of and were using the guideline, as a result of the collaborative. This had contributed to staff taking more appropriate steps to manage at-risk patients.

**Reduction in repeat self-harm presentations in emergency departments**

A few DHBs indicated that their involvement in the collaborative had been accompanied by a reduction in repeat self-harm presentations in the emergency department. This was attributed to improved communication between mental health services and the emergency department, and action plans being put in place, as well as more rigour in follow-up procedures. One DHB had included police and ambulance staff in some of the project work leading to a more extensive approach to self-harm and suicide issues. A mental health representative on the team commented:

> From a Mental Health perspective, the collaborative has helped with [repeat self-harmers] rather than the “not known” because there is an across the board response now, it’s more consistent. This means you get a better response from the client. (Mental health nurse).

In two other DHBs a “green card” system had been put in place, which allowed some repeat self-harming patients to bypass the emergency department and go straight to inpatients for a structured admission. This was empowering for the patients, as they knew they always had the option to use the green card “if things get bad”. Staff reported that patients often used the card several times initially, but over time, appeared to present less frequently.

**Increased awareness of DHB performance**

Because of the need to collect and collate accurate data, the collaborative helped project teams to identify and pinpoint presentations that are not dealt with appropriately, and which can be addressed to improve their services.

> We know numbers now of people presenting. This enables us to quantify and also identify problems and assess them. (General manager Māori health)

A number of people interviewed reported that being part of the collaborative “acts as an audit” and “helps identify loopholes” in the services that they provide.

**3.2 Sustainability of improvements and impacts achieved**

It is important to highlight that at the end of phase 2, for some DHB project teams, it was too early to attest whether the impacts they had achieved were actually sustainable. Nonetheless, there was strong commitment among DHB project team members to sustain the changes and impacts achieved.

> We expect the project to stay and become normal practice. (Project coordinator)
We will incorporate the project into business as usual. (Project sponsor)

I have a fantasy that this project will become standard practice and that the training will become part of the emergency department’s orientation. (Project coordinator)

There hasn’t been one meeting without us discussing sustainability. (Suicide prevention coordinator)

The extent to which changes were embedded varied, with some changes taking more time to implement (e.g. following up on DNAs) than others. Examples of what DHBs were doing to embed the changes into standard procedure, and sustain the impacts achieved, included:

- developing education packages. (The format and extent to which this was taking place varied between DHBs. For example, one DHB envisioned developing a self-learning package with video vignettes, supported by an online tool, to raise mental health awareness as part of DHB competencies, whereas another anticipated developing an education package as part of the emergency department’s orientation to raise awareness of self-harm among emergency department staff and to support decision-making around self-harm and suicide presentations)

- educating emergency department staff about issues for people at risk of suicide and self-harm, e.g. providing a CD-ROM for emergency department staff to easily access mental health information, and thereby “get competent and up to date” (DHB project team member)

- building changes into competencies and policy

- concentrating on small, achievable things (e.g. using yellow paper to make it easier for emergency department staff to recognise their documents)

- applying for funding for a dedicated position to support ongoing integration and sustainability of project outcomes, and to enable further improvements to take place as new research emerges.

Similarly, while some DHBs were further ahead with, and felt confident about, embedding their changes, others felt they were “not quite there yet”. Project coordinators at five DHBs felt confident that most of their changes were already embedded and that they would be sustained. Others were not as confident and did not consider the majority of changes to be embedded into standard practice at the time of the interviews.

The following barriers to sustainability were identified:

- lack of management or sponsor support (e.g. not participating in the planning and implementation of the collaborative, not attending meetings)

- IT systems that do not allow for file sharing

- inadequate time

- lack of champions in all areas, but in the emergency department in particular (“this project has really highlighted that if you don’t have champions in all the areas, that’s when you don’t get sustained change”)
lack of primary care or community involvement
lack of performance indicators.

A number of implementation measures, required to ensure that the project impacts would be sustained over time, were identified. For example, continued communication between departments, annual audits, adequate time and resources, and addressing gaps in policies and procedures.

Towards the end of phase 2 of the collaborative, ongoing discussion was occurring between the NZGG and DHBs about how to move to a “community of practice” model, whereby DHBs could be more self-sustaining, and require less external support. Ideas for achieving this, some of which address the barriers noted above, included:

- ensuring the project featuring in DHBs’ ongoing district annual plans
- continuing the education for emergency department staff around issues of self-harm and suicide
- having an emergency department champion take over after the project ended
- encouraging more active use, and further development, of the NZGG website (e.g. adding a checklist so DHBs can tick off when certain aspects have been achieved)
- providing peer support by means of an e-group (i.e. an email group where clinicians can access support from their peers)
- providing survey tools to assess consumer satisfaction
- developing other templates and audit tools, such as mental health assessments and staff self-assessment tools.

Increasingly, the collaborative’s efforts have focused on strategies for embedding changes within DHB practice. These strategies go beyond the participating DHBs’ collaborative project teams to address systemic issues and opportunities. For example, building on the government’s interest in reducing emergency department waiting times, the advisory group approached the College of Emergency Medicine to link the guideline for the Assessment and Management of People at Risk of Suicide with the six-hour emergency department waiting time target.

### 3.3 Quality of implementation at the national level

One of the evaluation objectives was to review the quality of project implementation at a national level against the NZGG’s declared methodology. This section focuses on the extent to which the NZGG implementation team and DHB project teams were effective in implementing the collaborative methodology. It summarises and updates findings that were presented in the formative evaluation (King et al, 2009) drawing on the later round of consultations.
3.3.1 Team composition*

NZGG project team

The criteria used in the evaluation to indicate a successful composition of the NZGG project team included:

- credibility to engage with clinicians and managers form relevant departments
- members cover a useful mix of skills and disciplines
- leadership style is consistent with the collaborative
- team is effective in generating excitement for the project.

There was general agreement amongst project coordinators and other DHB team members that the NZGG implementation team conformed to these criteria. Project coordinators consistently reported that the team had credibility, and the qualities amongst the NZGG team members that were commented on included:

- possessing a mix of skills and knowledge
- having real commitment and passion for the project
- showing respect for the needs of DHBs
- demonstrating a collaborative approach, which mirrored the whakawhanaungatanga expected to occur within DHB teams.

For example, project coordinators attested that:

_They (NZGG team) have a good cross-section of experience and expertise._

_They are very keen, passionate and have drive._

Throughout phase 2 of the collaborative, the NZGG have encountered issues affecting the involvement of Māori and consumer advisors on the implementation team (e.g. staff turnover in the Māori advisor position). Early on in the collaborative, DHB project team members commented that they would like to see further and more consistent involvement by these advisors. In response, the NZGG established a consumer advisor panel and, more recently, has begun collaboration with a Māori health consultant to implement an action plan for supporting project teams (as detailed in section 3.1.1, Target 2b).

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* See section 1.4 for details of the NZGG team’s composition.
DHB project team
The NZGG declared methodology calls for DHB project teams to comprise representatives from all relevant departments (emergency, mental health, Māori health, Māori mental health), as well as consumer/tangata whaiora and family/whânau advisors, and a mix of innovators, leaders and technical experts. The team’s members are also expected to demonstrate strong whakawhanaungatanga and whole-team ownership.

Overall, the project coordinators reported that they had a good range of skills within their teams, including clinicians (in some cases senior), administrators and IT staff. Representation by all departments was generally good, with some having more than one staff member from each department. Most teams had representation from both consumer advocates and family/whânau advisors. Feedback also suggests that all teams had the intention to work collaboratively and to appreciate each other’s perspectives.

Project coordinators came from a wide range of backgrounds. Most were from mental health, particularly managers or team leaders, clinicians (e.g. nurses or psychologists) and community mental health. Others were nurses outside of mental health (e.g. registered nurses and emergency department nurses).

Challenges to DHB team composition centred on maintaining consumer or family/whânau advisor involvement, gaining technical (IT) advice and assistance, and having committed emergency department representation. The satisfaction with involvement by key departments is discussed below.

3.3.2 NZGG project team support
The support expected to be provided by the NZGG project team included training workshops, teleconferences, a website and one-on-one support (e.g. phone, face-to-face, email). According to project coordinators, all these expectations were fulfilled. Feedback also suggests that the quality of this support was high, as:

- coordinators thought the workshops were informative, well-presented, practical and provided a good opportunity to reflect on the collaborative’s philosophy and processes, which in turn gave coordinators better understanding and direction
- teleconferences were seen to be facilitated in a professional and effective manner, and as a useful tool for providing learning opportunities from the implementation team and each other
- face-to-face support was seen as particularly effective, and many project coordinators would have liked to have seen more of this type of support, as it allowed for more in-depth assistance with local specific issues
- feedback suggests that the website was perhaps not used as much as had been anticipated, due to lack of time to access and read the resources. However, one DHB team had found it useful and referred their emergency department staff to it if they had any questions or queries.
Project coordinators considered that the NZGG team, in providing support:

- was readily available and accessible, e.g. contactable by telephone and email
- was responsive and prompt in providing information and advice when requested
- provided structure for collegial support from other project coordinators and DHBs
- provided useful research, guidelines and documentation
- allowed flexibility for individual DHB teams to adapt processes to suit local conditions.

Opportunities for improving the quality of support included:

- making information less academic or formal, so that the target audience would find it more accessible and easier to relate to
- providing greater clarity around how to interpret the collaborative methodology in the local DHB context
- tailoring training workshops to better suit the needs of both phase 1 and 2 DHBs
- providing more guidance about how to approach cultural assessment, e.g. provide a framework or set of guidelines for DHB project teams to follow, while still taking account of each region’s unique situation (note this type of support has recently begun, as described in section 3.1.1).

Adding to this, some felt that there could have been more clarity around what was expected to happen at the end of phase 2 (e.g. would there be a third phase and if so, what support would be provided and what would be expected from DHB project teams?).

### 3.3.3 Implementing the collaborative methodology

The collaborative methodology includes pathway mapping (i.e. mapping out the client journey), ground rules (e.g. respecting the diversity of the group and differences of opinion), a consumer-centred approach (e.g. effectively involving consumer and family advisors), breakthrough methods (e.g., defining the problem, clarifying and agreeing aims, goals and measures, testing changes using the plan–do–study–act approach, and monitoring improvement prior to implementation), and collecting and monitoring data.

Feedback suggested that the methodology was implemented to the following extent:

- most project coordinators reported having used pathway mapping, with some reportedly carrying out the approach in other DHB areas as a result of the collaborative
- overall, ground rules appeared to have been followed, and were seen as an effective way of keeping team members on task, and keeping the consumer at the centre of the process
- the majority of project coordinators had very close working relationships with their consumer advisors and acknowledged that their perspectives were very useful for applying a consumer-centred approach. Similarly, most consumers were satisfied with the way they were involved in the collaborative (discussed further below)
- project coordinators indicated that they found the breakthrough methods concept helpful and were either applying it or working towards this
- data collection and monitoring by DHBs increased towards the end of phase 2. Throughout, there had been some variability in the quality and consistency of the recording and provision of data.

Adding to this, the methodology was considered a good tool for quality improvement. In particular, process mapping and a plan–do–study–act approach helped DHB teams to identify gaps and respond quickly, and had subsequently been used elsewhere in a few DHBs.

A number of project coordinators, as well as other DHB team members, commented that the methodology at times had been unclear to them, or seemed too complex. Project members at one DHB reported that “the methodology gets too complex at times”, but “we try and keep it simple. It’s better that way: we get more done”. Two other project coordinators found that they were unclear about specific aspects of the methodology, such as testing small changes. Data collection and entry was considered extremely time consuming and, as such, a source of dissatisfaction for several project coordinators.

### 3.4 Satisfaction amongst project members

Overall, project stakeholders spoke positively about their experience with the collaborative. For example, DHB project coordinators commented that they now have an approach they can use for implementing changes and making improvements. If it hadn’t been for the collaborative, they “wouldn’t have known what needed to be done”. Many felt that the project had made a difference to the people they serve. One project coordinator exemplified the views of many:

> Increased awareness, better care and understanding of patients, having a tool to do risk assessment with, knowing what questions to ask, good buy-in – staff have embraced the project and want it to continue. (Emergency department charge nurse)

On the other hand, a few project coordinators felt frustrated at times with the pace of progress they had been able to achieve, noting that “the project was not as complete as it might have been”, or that more could have been achieved with more “drive and enthusiasm” and “the right people on the [DHB project] team”.

The paragraphs below cover aspects of satisfaction that have not already been covered in the sections above. For example, satisfaction with the support provided by the NZGG implementation team has already been discussed in section 3.3.

#### 3.4.1 Engagement from key departments

Feedback in general suggests that DHB project teams were fairly satisfied with engagement by key departments. However, when this engagement was lacking it was considered a significant problem and a barrier to the sustainability of the project.
Overall, across the DHBs, the extent to which Māori stakeholders were actively involved in the initiative varied. Reflecting DHBs’ resourcing issues for cultural input more broadly, it was clear that Māori health service units within DHBs are, as one person said “thinly spread” and not always resourced at a level to enable the level of required input that this initiative needed.

Similarly, emergency departments often lacked the resources to be fully engaged and, with a range of other projects competing for emergency department staff attention, this particular project may not have been their first priority.

Maintaining consistent engagement of team members, and having to “chase people up”, was mentioned by several project coordinators as one of the most difficult aspects of their role. It was accepted, however, that patchy attendance at meetings was due to people being busy with shift work and competing priorities. Project members who did not have the capacity to participate fully acknowledged and expressed regret at their lack of involvement, which they attributed to limited capacity and resources.

Smaller numbers at meetings was not always seen as negative, as long as the core group remained effective and focused.

3.4.2 Engagement from consumer and family advisors

Most project coordinators were very satisfied with the involvement of consumer advocates/tangata whaiaora and family/whānau advisors on their project teams, commenting on their consistent attendance and good input. In one DHB, for example, the consumer advisor was considered to be “totally involved and passionate” to the extent of actively providing education to emergency department staff from a consumer perspective.

Some DHBs, however, had experienced some continuity issues when consumer or family advisors changed, and two DHBs reported that their consumer and family advisors were too busy to be fully engaged.

Four of the five interviewed consumer advisors from DHB project teams were generally satisfied with the nature and extent of their involvement in the collaborative. Conversely, one consumer advisor felt dissatisfied with her own engagement and would have liked to have been more involved, but other commitments had made this difficult. Some project coordinators also acknowledged that they could probably “make better use” of their consumer and family advisors.

Consumer panel members were of the view that the NZGG implementation team was supportive of consumer participation and strong in their advocacy for consumer involvement within DHBs. However, it was suggested in the interviews for the formative evaluation, that some DHBs needed more guidance about how to involve consumers.
3.4.3 DHB management support and resourcing

Overall, project coordinators were satisfied with the support and resourcing that their DHB managers were providing. However, some inconsistency to this support was highlighted, including that:

- support and active engagement was not consistent across departments (e.g. a Māori health manager may have been supportive, but emergency department and mental health managers were not)
- only some aspects of managers’ engagement were satisfactory, e.g. that they allocated resources (e.g. FTE staff), and some were unsatisfactory, (e.g. not showing up to meetings)
- one or more managers or sponsors might “just pay lip service” to the project.

The variability in satisfaction is exemplified by one project coordinator:

*The CEO is brilliant and emergency department and Mental Health managers are great too, but the way is lost in the middle at times.*

More than one coordinator struggled to gain management support, as expressed by one:

*It’s an uphill battle...I have to go over stuff again and again playing catch up.*

3.4.4 Flexibility to develop local solutions

Almost all project coordinators were very satisfied that the collaborative allowed them to tailor project implementation to suit local issues and priorities, which was important in order for the project to be workable in the DHB context. For example, one DHB project team was involving local services, such as the police, in the collaborative.

The following comments from project coordinators reflect overall views:

*We can come up with our own solutions to local problems.*

*NZGG gave us the guideline and allowed us to adapt it.*

One project coordinator, on the other hand, commented that the ability within the collaborative to develop flexible solutions sometimes went too far, believing instead that having a template, which all DHBs had to implement (with room for local adaptation), would have been more appropriate.
3.4.5 Cultural responsiveness

All people interviewed as part of this evaluation believed that increasing cultural awareness amongst DHB staff was important. As summarised in the interim report (King et al, 2009) Project Coordinators expressed satisfaction with the opportunity that the collaborative provided to:

- improve cultural responsiveness to Māori in a range of ways
- acknowledge that Māori are over-represented in self-harm and suicide
- identify specific needs of Māori patients
- provide support for both patients and their whānau
- use Māori-specific processes
- work with Māori colleagues to find a common philosophy.

It was suggested that these opportunities could also be applied to working with people from other cultures.

As described elsewhere, DHBs participating in the collaborative were generally making slow progress around the Cultural Assessment Target, but were making headway in offering cultural input, increasing discussion about the issue and getting departments to work together.

The slow progress on the target stems from the wider debate that has been created around what cultural assessment is, and the appropriateness of assessment per se in the context of the collaborative. What was common also was an overall lack of understanding, alongside genuine attempts to understand and work alongside Māori health services in this regard.

> It has taken me a long time to get my head around the workings of Māori health, but I now have a better understanding of what would happen. (Project coordinator)

Stakeholders commented that cultural responsiveness is something that should be dealt with across the board within the DHBs, and not as part of one particular project. One Māori mental health director summarised the views of many:

> Staff need to incorporate culturally appropriate responses in the whole organisation. They need to understand Māori world views and concepts. This is absolutely necessary before talk of cultural assessment can even begin. (Māori mental health director)

The debate around cultural assessment, responsiveness and awareness is occurring within project teams, between DHB departments and across DHB regions. On the one hand, this has been a source of dissatisfaction with the collaborative for some people, as it has delayed progress. However, others are positive about the debate taking place at all, as it has created dialogue, moving the issue of cultural responsiveness to the fore in some of the DHBs. As one community mental health worker puts it, “Conversations are happening between staff. Actually, cultural assessment is a collaborative effort now!”
3.4.6 Coordination of initiatives taking place in emergency departments

All but one of the DHB project coordinators expressed frustration with the apparent lack of coordination and alignment between the collaborative and other, related national initiatives taking place in the same DHBs (including other self-harm and suicide projects, such as the suicide prevention coordinators initiatives, and the six-hour length of stay national target).

- This is a stand-alone project: isolated and not integrated with other projects. (Project sponsor)

- For people outside mental health, all these programmes appear the same. The initiatives are watered down. (Project coordinator)

- There are suicide projects from all directions; it’s incredibly frustrating. There’s a lack of coordination at ministry level. It’s like everyone has jumped on the bandwagon but they haven’t spoken to each other. (Mental health clinical director)

Many felt that better coordination from the Ministry of Health would enable these initiatives to complement each other, rather than making project teams compete for emergency department involvement. This was particularly so for the ones that are related to self-harm and suicide. For its part, the NZGG made sure to link with suicide prevention coordinators in DHBs participating in both projects, including the running of a training session for participants in the Suicide Prevention Project.

On the flipside, one DHB project team was satisfied with the ways in which different initiatives supported and complemented each other. The suicide prevention coordinator was part of the project team at this DHB, and he had provided extensive training and awareness-raising of self-harm and suicide issues within the DHB and the community. A culturally specific project was also taking place within this DHB, which was seen to complement the cultural aspects of the collaborative.
4 Conclusion and recommendations

The aim of the Self-Harm and Suicide Prevention Collaborative was to ensure that people at risk of self-harm and suicide received timely and appropriate care based on the guideline. The project methodology and its four targets for change were intended to address entrenched issues of fragmented care across disparate DHB departments. Participating DHBs were supported to achieve the project objectives by a small national implementation team. Each DHB project team comprised clinical and nursing staff, as well as consumers, who for the most part undertook the project on top of their regular workloads.

Findings indicate that the collaborative has had important effects on the ways in which people at risk of self-harm and suicide, who present at the participating emergency departments, are assessed and managed. An overarching observation from the evaluation is that the collaborative has increased awareness of self-harm and suicide amongst DHB staff, many of whom previously may have lacked an understanding about these issues, as well as the confidence to deal with them. The apparent newly gained motivation to approach self-harm and suicide issues differently, and more appropriately, suggests that the collaborative has had a positive effect on people’s perceptions and values.

The extent of the outcomes achieved during the two-year period of the collaborative is a result of the ongoing commitment and effective collaboration of project leaders and participants.

4.1 Quality of project implementation at a national level

Overall, evaluation findings indicate that the quality of project implementation at a national level conformed with the NZGG’s intended methodology (as encapsulated in the evaluative criteria – Table 1, Appendix A). This is exemplified by:

- the NZGG implementation team, whose members brought an appropriate mix of skills and knowledge, were accessible and responsive to DHB project teams, and offered a range of supports (of which, project coordinators found face-to-face meetings and workshops to be particularly effective)

- DHB project teams, which generally had good representation from the key DHB departments and which found effective ways to make ongoing progress between team meetings in the context of shift work and competing priorities (although maintaining or gaining involvement from some departments was a challenge for some)

- effective learning and application of the collaborative methodology by DHB project teams, e.g. pathway mapping, consumer involvement and use of the breakthrough methods.
4.2 Local implementation progress and impacts achieved

Although DHB project teams were implementing changes and reported feeling comfortable with using the collaborative methodology, there was some variability in the extent to which DHBs (and departments within DHBs) had adopted the methodology and achieved changes. Changes were implemented in relation to all four targets (i.e. Access, Assessment, Discharge and Follow-up), while some aspects of some targets (e.g. follow-up on non-attendances as part of Target 4) had received less attention, because of delays associated with IT infrastructure issues and dealing with providers outside of the DHB (e.g. GPs).

Despite this variability, findings suggest that the collaborative has resulted in a substantial number and range of improvements. In regard to the four targets for change, the following were reported:

- DHBs had adapted or developed templates for initial assessment, and had provided emergency department staff with training in their use, as well as in issues pertaining to self-harm and suicide in general
- with respect to comprehensive mental health assessments, DHBs had: strengthened or developed new processes for communication and collaboration between emergency departments and mental health departments; made provisions for assessments to take place prior to medical clearance if appropriate; provided an increased presence of mental health staff in emergency departments; and introduced shared and electronic records
- with respect to cultural assessment or input, DHBs had: initiated collaboration between the relevant departments; Māori staff had increased their responsiveness in emergency departments; emergency department staff had made provision for culturally specific questions to patients; increased Māori specific-resources; and made available appropriate space for cultural assessment to take place
- to achieve the Discharge Target, DHBs had: developed and implemented discharge forms that included more useful information for patients as well as family/whānau; included mental health notes, as well as emergency department notes, in discharge plans; used more accessible language that is easy for patients and whānau to read and understand; and developed consumer satisfaction surveys and family/whānau information resources
- for the Follow-up Target, DHBs had: implemented automatic referral processes; improved IT infrastructure; made changes to follow-up procedures and policy; and improved communication with community providers.

The overarching impacts of implementing these changes is improved assessment and management of people at risk of self-harm and suicide. This is evident in stakeholder feedback that:

- mental health issues are being detected and acted on more promptly, as a result of improved processes (e.g. standardised forms that are responsive to issues of mental health, self-harm and suicide risk), improved knowledge about self-harm and suicide among emergency department staff, and increased confidence to ask relevant questions of people at risk
• patient care is more effective, due to improved relationships and communication between emergency department and mental health teams

• assessments for people who present with self-harm and suicide are more timely and thorough, because, for example, comprehensive mental health assessments can be carried out prior to medical clearance, when it is appropriate to do so

• measures are being introduced to increase cultural input and awareness within emergency departments, while dialogue and collaboration to plan for the future is taking place between Māori health and other departments, as well as between Māori community providers and DHBs

• more effective discharge processes are in place for clients at risk of suicide, including written discharge plans and information (e.g. leaflets for patients and their family/whānau) about support that is available post-discharge, as well as processes for engaging with GPs and other community services involved in the patient’s care

• follow up is more timely and appropriate in some DHBs as a result of improved referral processes.

In addition, participating in the collaborative has led to:

• emergency department staff using learnt skills in other situations and with other presentations

• improved awareness and implementation of the guideline

• a reduction in repeat self-harm presentations in emergency departments

• increased awareness of DHB performance in working with patients at risk of suicide.

Although DHBs identified these positive results, they faced a range of barriers to fully meeting the targets. These centred around: staff turnover in emergency departments; competing projects being implemented simultaneously in emergency departments; limited access to resources (e.g. FTE staff for project managers, and access to Māori staff); lack of a coordinated DHB response to certain issues (e.g. cultural input and responsiveness); different understandings around the meaning and necessity of certain targets, or aspects of targets (e.g. follow-up of non-attendances that were referred outside the DHB); and lack of time to implement the methodology fully and achieve the targets. However, ongoing efforts were being undertaken by all of the DHBs to address or minimise the impacts of these barriers.
4.3 Stakeholder satisfaction with the collaborative

Stakeholders overall spoke positively about their experiences in the collaborative. In particular:

- stakeholders were satisfied with the support provided by the NZGG implementation team
- stakeholders were generally satisfied with engagement from key departments, as well as from consumer and family advisors. However, maintaining consistent engagement appeared to be a challenge for some. Stakeholders also noted that guidance for DHBs on how to involve consumer and family advisors would have been beneficial
- most project coordinators expressed satisfaction with the support and resourcing they were receiving from DHB management. However, support often appeared to be inconsistent in that only one manager was engaged, or managers would only engage to a certain degree, e.g. by attending meetings but not allocating the necessary resources
- project coordinators were satisfied that the collaborative allowed them to tailor implementation to suit local issues and priorities
- stakeholders were satisfied, on the whole, with the opportunities that the collaborative provided for improving responsiveness to Māori, as well as to other cultures. However, some were frustrated with the slow progress on cultural assessment.

Stakeholders widely held the view that the various suicide and self-harm initiatives happening in DHBs, and other work on national priorities, needed to be better coordinated by the Ministry of Health at a national policy level.

4.4 Sustainability of the impacts and changes achieved

There was strong commitment amongst DHB project team members to sustain the changes and impacts achieved. This report has identified that the extent to which changes were embedded varied, with some changes taking more time to implement than others. However, DHBs were embedding changes into standard practice by developing education packages, building changes into competencies and policy, and applying for funding for continued dedicated FTE staff for the project.

In addition, the NZGG implementation team and the advisory group were increasing their efforts with respect to issues of sustainability.

Five DHBs reported feeling confident that their changes were already embedded and that they would be sustained. Others were facing challenges, such as a lack of management or sponsor support, out-dated IT systems, inadequate time, a lack of champions in all areas, and a lack of performance indicators.
4.5 Opportunities to enhance effectiveness and sustainability

With the decision by the Ministry of Health to continue the collaborative for another 12 months, from April 2010 until March 2011, the focus of the project is expected to shift from national facilitation and guidance to building local sustainability. This “community of practice” model will be less resource intensive with regards to the national implementation team and will require increased leadership from the DHBs themselves. Many of the project coordinator positions have been disestablished as from March 2010, which will create a challenge for DHBs to keep up the project’s momentum.

In this context, the findings of this evaluation will be useful for identifying opportunities for the NZGG to consider in moving forward.

The NZGG and the DHBs have identified opportunities to strengthen buy-in and ownership of future collaboratives, and to improve the stability and profile of the current project, for DHBs, the Ministry of Health and other stakeholders to consider. These include:

- Providing more FTE support for project coordination, especially in the larger DHBs
- Developing key performance indicators around the project targets, and auditing these
- Including the requirement to achieve the project’s targets in DHBs’ policies, procedures and district annual plans
- Involving high-level clinical champions more closely in the project.

In the next phase of the project, the NZGG intends to support the sustainability of the approach by:

- Enhancing the project’s website, e.g. by providing checklists for DHBs to achieve, tick off and compare
- Publishing improvements achieved by DHBs on the website as case studies
- Offering support with improving processes for cultural assessment (if wanted)
- Engaging the support of various medical colleges (e.g. for emergency physicians, emergency department nurses, psychiatrists, GPs), the Mental Health Commission and (potentially) the Alcohol Advisory Council
- Developing, or supporting the development of, key performance indicators
- Enabling advisory group members to provide high-level advocacy to senior DHB management
- Positioning the collaborative as a way of assisting DHBs to reduce emergency department waiting times
- Enabling project coordinators and teams to support each other through an email network
• better aligning the collaborative and other mental health and self-harm and suicide initiatives in DHBs, e.g. by establishing an overall steering group across all of the initiatives to give strategic advice and reduce duplicated efforts.

Evaluation of the next phase of the project should focus on the sustainability of the methodology within the DHBs, and should also provide the opportunity to update the analysis of impacts.
Appendix A: Overview of the evaluation framework

The evaluation logic model, and the framework of indicators and evaluative criteria are presented below. Further details, including stakeholder analysis and interview schedules, are presented in the evaluation framework document (King et al, 2009).

A.1 Logic model

A logic model is a systematic and reasoned way of describing the presumed relationships between a project’s processes and its outcomes. It describes the activities that are thought to bring about change, and links these activities to the results the project is expected to achieve. Logic models can be used to support the definition of a project and its formulation in operational terms, as well as its implementation, monitoring and evaluation (European Union, 2004).

A logic model was developed for this evaluation in consultation with the NZGG, and is set out in Figure 1. It provides a representation of the key overarching process components embedded within the NZGG’s declared methodology, and the intended intermediate and long-term outcomes of the collaborative. This logic model provided an overarching structure for defining the evaluation framework.

Process elements identify the main factors involved in implementing the collaborative (the NZGG, DHB project teams and DHB management), and four groups of processes (e.g. support project teams, learn methodology, etc). Within each group of people and processes, ingredients for project success have been identified, drawing on the findings from the evaluation of phase 1, as well as the success factors identified in the wider literature on collaborative and change management methods. These success factors are reflected in the evaluation criteria discussed below.

The “apply methodology” group of activities includes a symbol of circular arrows, drawing attention to the cyclical nature of the plan–do–study–act practice improvement methodology, which involves a continuous process of improvement (see Appendix B).

The logic model also makes explicit which aspects of the collaborative are and are not included within the scope of the evaluation. The evaluation is not attempting to measure long-term health outcomes (e.g. decreased incidence of self-harm and suicide), as measurable impacts are not expected within the timeframe of the evaluation. Accordingly, long-term outcomes are unshaded in the logic model.

Underpinning the whole logic model are the whakawhanaungatanga concept and the principles of cultural responsiveness and local flexibility, which are all integral parts of the NZGG’s collaborative approach.
A.2 Framework of indicators

Table 1 summarises the evaluation questions and links these back to the project components set out in the logic model. Note that the evaluation questions set out in the framework are the questions that the evaluators were required to address in the final report in order to fulfil the objectives of the evaluation. Stakeholders were not asked these questions verbatim. Interview schedules were developed expanding on each evaluation question as set out in the evaluation framework.

The evaluation methodology involved the use of evaluative criteria, permitting a systematic approach to the evaluation of qualitative factors that could not readily be measured using available data. This approach provided a framework for transparently and systematically gauging stakeholders’ assessments of how effectively the project was operating.

Evaluative criteria represent key success factors for the collaborative, which were reflected in the NZGG’s declared methodology. These success factors were drawn from findings of the phase 1 evaluation and other evidence used by NZGG in formulating the methodology. Evaluative criteria were grouped into a series of checklists as summarised in Table 1.
Table 1: Matrix of evaluation objectives, questions, indicators and data sources

<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
</table>
| Review quality of project implementation at a national level, against the NZGG's declared methodology | Did the NZGG project team composition conform to key criteria and success factors? | Extent to which:  
  - team has credibility to engage with clinicians and managers from relevant departments  
  - NZGG project leadership covers a useful mix of skills and disciplines to meet the support needs of DHBs (including project management, clinical, Māori Health and mental health, mental health and consumer)  
  - leadership style is consistent with the collaborative (e.g. facilitates and models whakawhanaungatanga and whole-team ownership)  
  - team is effective in generating excitement for the project (including with DHB management, clinical (emergency department, Māori health and mental health, and mental health), consumer/tangata whaiora and family/whānau advisors).  

Supplemented by commentary on key strengths/weaknesses and context.                                                                 |
| Did the DHB project team composition conform to key criteria and success factors? | Was there meaningful engagement and commitment from all departments? | Extent to which:  
  - project team includes representatives from all departments (emergency department, mental health, Māori health and mental health)  
  - project team includes consumer/tangata whaiora and family/whānau advisors  
  - team includes a mix of innovators, leaders and technical experts  
  - team demonstrates strong whakawhanaungatanga and whole-team ownership of goals and commitment to make change happen  
  - there are effective mechanisms in place for sharing information between team members and maintaining team cohesion (e.g. email, team meetings, phone, one-on-one)  

<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Was there support from DHB management? Did the DHB project team have access to the necessary resources?</td>
<td>• between team meetings, ongoing progress is made in project activities. Supplemented by commentary on key strengths and weaknesses, and context.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extent to which:</td>
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<tr>
<td></td>
<td></td>
<td>• DHBs applying to take part in the collaborative demonstrated executive support for the project, including support from the chief operating officer and the general managers of the involved departments (Māori health and mental health, mental health, emergency)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• DHBs applying to take part in the collaborative were able to identify nominated emergency and mental health clinical leaders, and a project facilitator</td>
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<td></td>
<td></td>
<td>• DHBs provided staff release time and resources for the project</td>
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<td></td>
<td></td>
<td>• the project coordinator and the NZGG are satisfied with the executive sponsor’s understanding of the collaborative, championing of the collaborative at management level, and modelling of best practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• the project coordinator and the NZGG are satisfied with the level of financial and technological resources allocated to the collaborative by the DHB.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supplemented by commentary on key strengths and weaknesses, and context.</td>
</tr>
<tr>
<td></td>
<td>Did the NZGG provide effective support</td>
<td>Extent to which:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Evaluation objectives</td>
<td>Evaluation questions</td>
<td>Indicators and evaluative criteria</td>
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</table>
|                       | for DHB project teams? | • DHB project coordinators and project teams found that the initial training workshop (or in-house training by the NZGG) provided a good foundation for their subsequent collaborative project work  
• DHB project coordinators and project teams were satisfied with the frequency of teleconferences, meetings and workshops  
• DHB project coordinators and project teams found teleconferences, meetings, workshops relevant and useful  
• DHB coordinators and project teams saw the NZGG as accessible, supportive and effective  
• DHB project coordinators and project teams saw the timeframes as achievable.  
Supplemented by commentary on key strengths and weaknesses, and context. |

<p>| Did the DHBs learn the methodology | Extent to which: |</p>
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
</table>
|                        | effectively?         | • DHB project teams completed pre-workshop orientation and planning effectively (including involvement from the emergency department, mental health, Māori health and mental health, consumer/tangata whaiora and family/whānau advisors)  
• DHB project teams sent a strong contingent to the initial training workshop (or in-house training by the NZGG)  
• after completing the initial training workshop (or in-house training by the NZGG), project teams were familiar enough with the methodology to initiate an action plan  
• team members felt they understood the concept of whakawhanaungatanga, as applied in the collaborative (i.e. commitment from the different services to work together with respect, aroha and shared responsibility for one another)  
• team members felt they understood the pathway mapping element of the collaborative  
• team members felt they understood the concept of “testing small changes” and how to apply the change methodologies  
• team members felt they understood how to access support or expertise when needed.  
Supplemented by commentary on key strengths and weaknesses, and context. |
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
</table>
|                       | Did the DHBs apply the methodology effectively? | Extent to which:  
• project teams applied pathway mapping, together with guideline evidence, to identify gaps, barriers and opportunities for improvement  
• project teams followed ground rules for pathway mapping, e.g. respected the diversity of the group and differences of opinion, the five minute rule  
• project teams applied a consumer-centred approach, with effective involvement of consumer/tangata whaiora and family/whānau advisors from the outset  
• project teams applied breakthrough methods, e.g. defining the problem, clear and agreed aims or goals, measures, test changes and monitor improvement prior to implementation  
• project teams collected and monitored data to support targets and reported the data monthly to the NZGG, using the data as a change management (not accountability) tool.  
Supplemented by commentary on key strengths and weaknesses, and context. |
| Review local implementation progress and impacts achieved against targets for change | What were the key issues and gaps identified through the process mapping?  
What improvements did the project team agree?  
What changes were tested?  
Which changes were found to be effective, and implemented?  
Within what timeframes were the above steps undertaken? | Qualitative description. |
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
</table>
|                       | What impacts were achieved against the targets for change? | Target indicators.  
Supplemented by commentary on context and issues. |
|                       | What wider impacts were achieved? | Extent to which the collaborative contributed to:  
- improved understanding of self-harm and suicide issues amongst emergency and mental health departments (including culturally specific understanding)  
- improved cultural responsiveness, e.g. services accessible and acceptable for Māori, Pacific and other patients and their families/whānau  
- improved communication between and within departments  
- improved relationships and communications between hospital clinicians and consumers (including Māori, Pacific, others)  
- reduced waiting times for people at risk of suicide  
- more thorough assessment of risk of suicide  
- improved processes for timely and appropriate follow-up  
- improved awareness and implementation of guideline.  
Extent to which the project has made a difference to the person at risk of self-harm or suicide who presents to the emergency department. |
| Evaluate stakeholder satisfaction with the collaborative | How satisfied were project teams overall with the collaborative?  
How satisfied were consumer/ tangata whaiora and family/whānau advisors | Qualitative feedback including consideration of:  
- support provided by the NZGG  
- the level of engagement and participation by key clinical departments, consumers/ tangata whaiora and family/whānau advisors |
<table>
<thead>
<tr>
<th>Evaluation objectives</th>
<th>Evaluation questions</th>
<th>Indicators and evaluative criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>with the collaborative?</td>
<td>• the collaborative methodologies</td>
</tr>
<tr>
<td></td>
<td>What were the key areas of satisfaction or dissatisfaction?</td>
<td>• DHB management support</td>
</tr>
<tr>
<td></td>
<td>What did stakeholders see as the key success factors?</td>
<td>• level of DHB resourcing for the collaborative</td>
</tr>
<tr>
<td></td>
<td>What opportunities are there for improving the collaborative?</td>
<td>• local flexibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• cultural responsiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• outcomes achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• sustainability of processes and outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• any other issues of importance to the participants.</td>
</tr>
</tbody>
</table>
Appendix B: Overview of improvement methodology


A summary of steps

The model described below for improving processes of care and service delivery has much in common with the process of clinical care. It involves the identification and diagnosis of a problem, measurement of the scope and size of the problem, identification of a number of interventions that may reduce the problem, implementation of the intervention(s) and re-measurement to ascertain whether the interventions have been effective.

Figure 1B: The clinical process improvement model

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

Systematic improvement in quality requires recognition of the systems and processes of the service being provided.
The five recognised steps in this improvement process are as follows.

1. Project phase: identify what you are trying to accomplish and who should be involved.
2. Diagnostic phase: establish the full extent of the problem, what changes can be made that will result in an improvement, and how to measure any resulting improvement.
3. Interventions phase: implement the changes identified in the diagnostic phase.
4. Impact and implementation phase: measure and record the effect of the changes.
5. Sustaining improvement phase: continue monitoring and planning for future improvement.

The following diagram represents these five recognised stages in the improvement process and illustrates that the cycle is ongoing. It identifies the essential steps to be taken when using the model and provides an indicative timeframe for successfully improving a significant clinical process.

Figure 2B: The improvement process
Appendix C: Overview of DHB target data

All DHBs participating in the collaborative were to collect data (on patients at risk of suicide or self-harm presenting at emergency departments) in terms of the four targets. This data was reported via upload to the NZGG collaborative website.

The primary purpose of the targets was to lend a focus to improvement work, in terms of four important areas of service quality, allowing DHBs to compare their own individual performance with national average performance across the participating DHBs. Clear definitions were provided to the DHBs on the data items they were to collect, to ensure all DHBs were collecting the same things. In contrast to phase 1 of the project, where aggregate data only was collected, in this phase individual record-level data has been collected. This has substantially improved data quality and interpretability.

The collaborative improvement methodology allowed flexibility for DHBs to choose their own local focuses for improvement work. The NZGG’s workshops for DHBs at the commencement of the project included training on measuring impacts, and the teams subsequently monitored the impacts of their improvement work in ways other than just the targets. The methodology also emphasises that data should be collected even if at first it is not perfect, as that will improve as work progresses. This proved to be the case. As project coordinators began to understand their own patient information systems for data collection (even if this meant clinical audit), data quality improved.

The creation of some new, national or sub-national formal dataset was not within the remit of the collaborative. The targets provided a pragmatic means of data collection, intended for use and interpretation by the DHBs themselves. Appropriately, DHBs collected data at different times and for different durations throughout the project. The minimum period for collecting data was 26 weeks. In addition, data volumes were sometimes very small, especially in smaller DHBs, and for subgroups of presenters, such as Māori or those patients still considered to be at risk at discharge.

Some DHBs struggled with clinical processes and systems that did not facilitate easy data collection. In these instances, data quality was sometimes poor, or the period for which data could feasibly be collected was short. No baseline comparison data were available.

For all these reasons, it is important not to over-interpret the data and formal statistical analysis of the data would be inappropriate. Nonetheless, review of the data, in combination with knowledge of the other impacts documented in this report, allows some useful and reasonably sound description about the impacts of the improvement work.

As at January 2010, data had been collected for a total of 1,834 presentations.

Table 1 summarises the targets against which the DHBs reported particularly small numbers of presentations, and the spread of DHBs with regard to performance against the targets.
For example, against Target 1 (Access):

- 12 DHBs reported data against this target
- one DHB reported data that had 10 or fewer data points (weeks) on the graph, and six DHBs were reporting on five or fewer patients in the majority of weeks in which they reported data
- the majority of the DHBs (9) met the 90 per cent target in less than half their reported weeks, while two DHBs met the target between half and three-quarters of the time, and one DHB met the target over three-quarters of the time.

Table 1C: Summary of DHB target data

<table>
<thead>
<tr>
<th>Target</th>
<th>Number of DHBs (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Number of DHBs that reported data against the target</td>
<td>12</td>
</tr>
<tr>
<td>Small numbers</td>
<td></td>
</tr>
<tr>
<td>Ten or fewer data points on graph</td>
<td>1</td>
</tr>
<tr>
<td>Five or fewer patients reported for most weeks</td>
<td>6</td>
</tr>
<tr>
<td>Percentage of weeks in which individual DHBs met the targets</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>75–99%</td>
<td>1</td>
</tr>
<tr>
<td>50–74%</td>
<td>2</td>
</tr>
<tr>
<td>25–49%</td>
<td>2</td>
</tr>
<tr>
<td>1–24%</td>
<td>5</td>
</tr>
<tr>
<td>0%</td>
<td>2</td>
</tr>
</tbody>
</table>

The following graphs provide snapshots of the DHBs’ aggregate performance (i.e. all of the DHBs together) against each target. In each graph, the green line indicates the target (%) and the yellow line shows the DHBs’ aggregate performance each week. The graphs only show those presentations where the target was completely met. So for instance, if a presentation was only 1 minute over the target timeframe this will not be seen in the relevant graph. For 10 of the DHBs, some of the work towards some of the targets may have already begun in phase 1. For all of these reasons, the results should be interpreted cautiously.

**Target 1**

A total of 746 presentations were recorded for which data was complete for assessment against Target 1\(^{10}\). The graph suggests a slow trend upward towards the target of 90 per cent. However, wide fluctuations mean the apparent trend is uncertain. Three DHBs did not collect Target 1 data and two of these were large DHBs.

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\(^9\) A total of 14 DHBs participated in phase 2 of the collaborative. However, data from one DHB was excluded from the evaluation as the DHB joined after the evaluation had commenced.

\(^{10}\) This figure does not include those responses that were “No” or those that were “N/A” or “Refused.”
Target 2a
A total of 1,550 presentations were recorded, for which data was completed for assessment against Target 2a. As shown in Table 2 (above), six DHBs were achieving a comprehensive assessment 100 per cent of the time, and seven DHBs were doing so in at least three-quarters of the reported weeks. The graph shows the aggregate result, suggesting the seven DHBs were achieving a slight improvement over time.

Figure 2C: Target 2a (Comprehensive Assessment)
Target 2b
As noted in the body of the report, achieving Target 2b (as originally conceived) was challenging for most DHBs. Although many DHBs were making positive changes in this area, these changes revolved around cultural input (rather than assessment) or longer-term work toward cultural assessments, and therefore did not show up in target data.

Two DHBs with high Māori populations achieved the target very well. The NZGG reported that a count of the number of presentations that “probably” had a cultural assessment (i.e. they might have one or two pieces of data missing, but it looks from the current data that the person probably did have one) suggested that 26 per cent of Māori had a cultural assessment overall.

Figure 3C: Target 2b (Cultural Assessment)

Target 3
This target was a challenge for DHBs as it required discharge plans to be provided for consumers and their family/whānau or significant others, and ongoing support where required. The graph below suggests improvements were achieved overall. In aggregate, 1,267 discharges were made from emergency departments. Of these:

- 780 (62 per cent) involved a discharge plan to the consumer;
- 423 (33 per cent) involved a discharge plan to family/whānau
- 1,153 (91 per cent) involved a discharge plan to the discharge destination.
Figure 4C: Target 3 (Discharge)

**Target 4a**
DHBs worked hard on establishing processes for improving follow-up and for collecting the relevant data. The graph suggests that some improvements have been achieved. The data showed a total of 866 follow-ups arranged.
Figure 5C: Target 4a (Follow-up)

Target 4b

Patients were to be followed up again if they did not attend their first appointment. There were very low numbers of people who did not attend the first appointment and required follow-up. As shown in Table 2 (above), seven DHBs reported data against this target, and all of these reported data for a 10-week period or less. Four DHBs met the target in 100 per cent of their reported weeks, and three DHBs met the target in more than three-quarters of their reported weeks. The aggregate result, shown below, must be interpreted with caution due to the small numbers involved.

Figure 6C: Target 4b Follow up of patients who did not attend their first appointment
References


