



Blueprint II

*For the New Zealand Mental Health
and Addiction sector*

Consultation document

To inform the development of Blueprint II
for the Mental Health and Addiction sector

Mental Health Commission
February 2012





E tū ake nei tō tātou whare whakahirahira
Ko Ranginui e tū ake nei hei tuanui
Ko Papatūānuku e takoto nei hei whāriki
Ko te reo me ngā tikanga hei tāhuhu
Ko te iwi hei poutokomanawa
E tū e te whare e!
Hei whakairi i ō tātou wawata,
ō tātou tūmanako, ō tātou moemoeā!

There stands our house in all its grandeur
The sky is its roof
The earth is its carpet
Our language and culture is its ridge pole
And the people stand at its centre
Stand erect!
So that you may house our hope
and dreams within!

The purpose of this document

The Mental Health Commission (MHC) is developing a new Blueprint (Blueprint II) for the Mental Health and Addiction (MH&A) Sector. This work will update the 1998 'Blueprint for Mental Health Services in New Zealand: "How Things Need to Be". Blueprint II proposes a bold vision for the MH&A sector which will require innovation and changes in how we meet the MH&A needs of New Zealanders over the next 10 years. The purpose of this document is to enable you to provide feedback on the core propositions and help shape the practical pathways of change and development to realise this future.

How to have your say

The easiest way to make a submission on this consultation document is to visit www.mhc.govt.nz and complete the online form.

You can also download the feedback form, complete, and email it to info@mhc.govt.nz, or post to Blueprint II Submission, Mental Health Commission, PO Box 12479, Wellington 6144.

All submissions are due by 5pm, Friday 9th March 2012.

Note: Your submission may be requested under the Official Information Act 1982. If this happens, the Mental Health Commission will release your submission to the person who requested it.

Background, context and next steps

For the past decade, the original Blueprint has guided MH&A resourcing and service development. Much has changed since 1998; our service capability and capacity has improved greatly for those with the most severe problems, our understanding of the nature of population need and the impact of mental health and addiction has deepened, and a wider range of interventions and innovative service responses are available. There is also an awareness of significant levels of unmet need for MH&A services and significant disparities in MH&A outcomes.

We are working in a changing world. MH&A has benefited from a decade of investment but we are now in an environment that combines constrained funding, challenges in building workforce capacity and the demands of an increasingly ageing and ethnically diverse population. We need a step change in how we use existing resources to harness the capability across the wider health sector and work alongside intersectoral partners where MH&A also matters. Our challenge is to use the current financial constraints as a source of creativity, stimulating the investment of commitment, time, energy and resources to make change happen.

To respond to these drivers of change we believe that Blueprint II needs to support three interrelated changes in the way MH&A services work as a system, both on its own and alongside wider health and other agencies:

1. An outcomes oriented whole-of-population, life course approach that responds more effectively to the developmental pathway of MH&A issues and the needs of vulnerable populations
2. Development of systems of care that are people centred and delivering more timely, responsive and integrated approaches to recovery and building resiliency
3. A drive for a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money.

The seeds of the future envisaged by Blueprint II are already happening within the MH&A sector – but in isolated pockets. For Blueprint II we propose a change strategy that is informed by evidence from literature and research on change, feedback from consumers and family/whānau, knowledge of clinical leaders and providers and learning from current innovations and exemplar services.

To increase the pace of focused innovation and change will require leadership and effective supporting infrastructure. This includes better information on performance, change intelligence and aligned funding mechanisms that both protect the gains in MH&A achieved to date and provide greater flexibility in the use of resources to enable innovation, efficiencies and collaboration across multiple services and sectors.

The audience for Blueprint II is people who have an interest in, or can make a contribution to improving mental health and well being for New Zealanders. This includes the health sector, other government agencies, non-government organisations, private and voluntary sectors, communities and consumers and their families/whānau.

Over the past four months, the Mental Health Commission has worked closely with the MH&A sector to develop the concepts that can be found in this consultation document, and the working paper which accompanies it.



Blueprint II and Service Development Plan

Blueprint II covers a 10 year time horizon and represents an independent, sector informed view of how the MH&A system needs to evolve to meet future challenges and what is needed to enable change. It takes a broad view of MH&A and provides structured guidance on how the sector should position itself over the next 10 years to support the next wave of sector innovation and changes. This next wave includes intersectoral partners (i.e. health, social care, justice, education) along with communities and families/whānau.

The Ministry of Health is leading the development of its Service Development Plan which will articulate Government policy in relation to developments in health-funded services (primary and general healthcare and specialist mental health and addiction services) over the next three to five years. In order that it can be informed by Blueprint II, the Service Development Plan will be finalised after Blueprint II has been completed.

Next steps

Blueprint II is due to be completed in May 2012, and its development is the most important contribution the Mental Health Commission can provide before it is integrated into the Office of the Health and Disability Commissioner in July 2012.

During the consultation phase the Mental Health Commission will continue working with the sector to develop the detail underpinning this consultation document. This will be done via interviews, workshops and discussions. The accompanying Blueprint II Working Paper, available at www.mhc.govt.nz provides a work in progress summary of the development to date that supports this consultation document.

Why we need to change

No health without mental health

The argument to invest in mental health and wellbeing is strong and growing. Resilient mental health and freedom from the adverse impacts of addiction are important for the health of our population and the wellbeing and productivity of our society.

The need for investment in improving mental health and addiction outcomes is compelling:

- Mental health and addiction issues are more common than typically recognised. The personal impacts are higher than any other group of diseases, with societal impacts that go beyond the individual and the health sector.
- Mental health and substance use disorders are often identifiable and can be picked up early. But many mental health and addiction issues go unrecognised and untreated, as do many physical and biomedical conditions that have components of mental ill health.
- When patients do access services we can do much more to aid their recovery with growing evidence about what works and what doesn't.

To capture the value in MH&A investment, the World Health Organisation points to the need to widen our view of MH&A services and describes a new 'wave' or philosophy that moves beyond deinstitutionalisation and focuses on the interaction between MH&A, physical health and a person's social context.

We are embracing this next wave of development, and yet our resourcing framework for MH&A is more than a decade old and is constraining service delivery and development. It is time to develop a new direction and framework. One which maintains our position at the forefront of MH&A services internationally, building from today's strengths while improving whole-of-system MH&A outcomes.

We have made progress but we can do much better

Over the last decade the principles of 'recovery' have guided service development for those severely affected by mental illness; to empower consumers, assure their rights, to get the best outcomes through increasing their control over their own mental health and wellbeing and enable them to fully participate in society.

We have made substantial progress but we can do much better. We need to continue to work to engage people and their families, work with sector partners in building capability and support and ensure each response we make is directed towards recovery. There are access barriers and delays for many seeking support, while others have inadvertently become stuck inside our services. More service support could be provided closer to home, in the community and primary settings. We have made some progress towards addressing coexisting MH&A and physical health needs but again, we can do much better.

We believe Blueprint II should seek to strengthen the recovery approach while embedding it within a more broadly applicable principle of resiliency; the ability of people and their family or whānau to adapt, gain strengths and prosper despite the impacts of addiction or mental ill health.

Resiliency takes us a step further towards 'no health without mental health'. Resiliency demands a rapid, responsive approach which strengthens social inclusion as a means to supporting self care, and facilitates capacity in families, community and primary based care. Resiliency makes the best use of the limited resources of the health and MH&A system by seeking the most effective support in the least intensive setting.



The implication is that we will need to lift system performance, so that people experience a strengthening of recovery and a return to resiliency. The focus of our responses will need to keep shifting outwards, towards community based sources of social inclusion and individual/whānau strengths. We will need to drive for faster and earlier responses to minimise loss of resiliency. We will need responses that are more effective in meeting a balance of needs, whether social, mental, behavioural or physical.

Our environment is changing

The MH&A sector has benefited from a decade of investment. Today however we are in an environment that combines constrained funding and challenges in building workforce capacity with the demands of an increasingly ageing and ethnically diverse population.

The evidence of the costs of not addressing MH&A issues are increasingly clear; without lifting access to effective MH&A responses, we as society will bear the costs in terms of loss of employment, increased dependency on benefits and higher costs across the full spectrum of health, social and justice services.

Given the overall tight financial environment we cannot count on new investment, or expect any new money unless we have both used our current resources most effectively and can show the clear whole-of-government benefits of doing more.

Blueprint II is aiming to facilitate a breakthrough or step change in how effectively we use existing resources, to harness the capability across the wider health sector and work alongside intersectoral partners where MH&A also matters. Many, if not most, of the innovations in practice or service delivery needed to achieve this breakthrough are already evident across the sector, but not yet developed, integrated or scaled to the point where the new level of system performance could be consistently achieved.

Our challenge is to use the current financial constraints as a source of creativity, stimulating the investment of commitment, time, energy and resources to make change happen.

PART A: Future directions – How things need to be

From our dialogue with the sector we believe there is an emerging shared world view on the future shape of MH&A services. This is founded on a common understanding that mental wellbeing plays a critical role in creating a well-functioning and productive society. The emerging shared vision is of a future in which everyone plays their part in protecting and improving mental wellbeing.

- People, families/whānau and communities actively develop their own ability to weather adversity.
- Primary and other general healthcare services support resilience, recognise emerging issues early and enable people to recover rapidly.
- Focused MH&A treatment and support services further support and enable recovery and full participation in community living by people who have MH&A issues.
- Publicly-funded agencies work together to make best use of funds to enable people involved with multiple sectors to achieve the best possible outcomes.

To support this emerging vision, while responding to the pressing drivers of change, we believe that Blueprint II needs to support three interrelated developments in the way MH&A services work as a system, both in their own right and alongside wider health and intersectoral organisations and agencies.

1. An outcomes oriented whole-of-population, life course approach that responds more effectively to the developmental pathway of MH&A issues and the needs of vulnerable populations.
2. Development of systems of care that are people centred and delivering more timely, responsive and integrated approaches to recovery and building resiliency.
3. A drive for a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money.

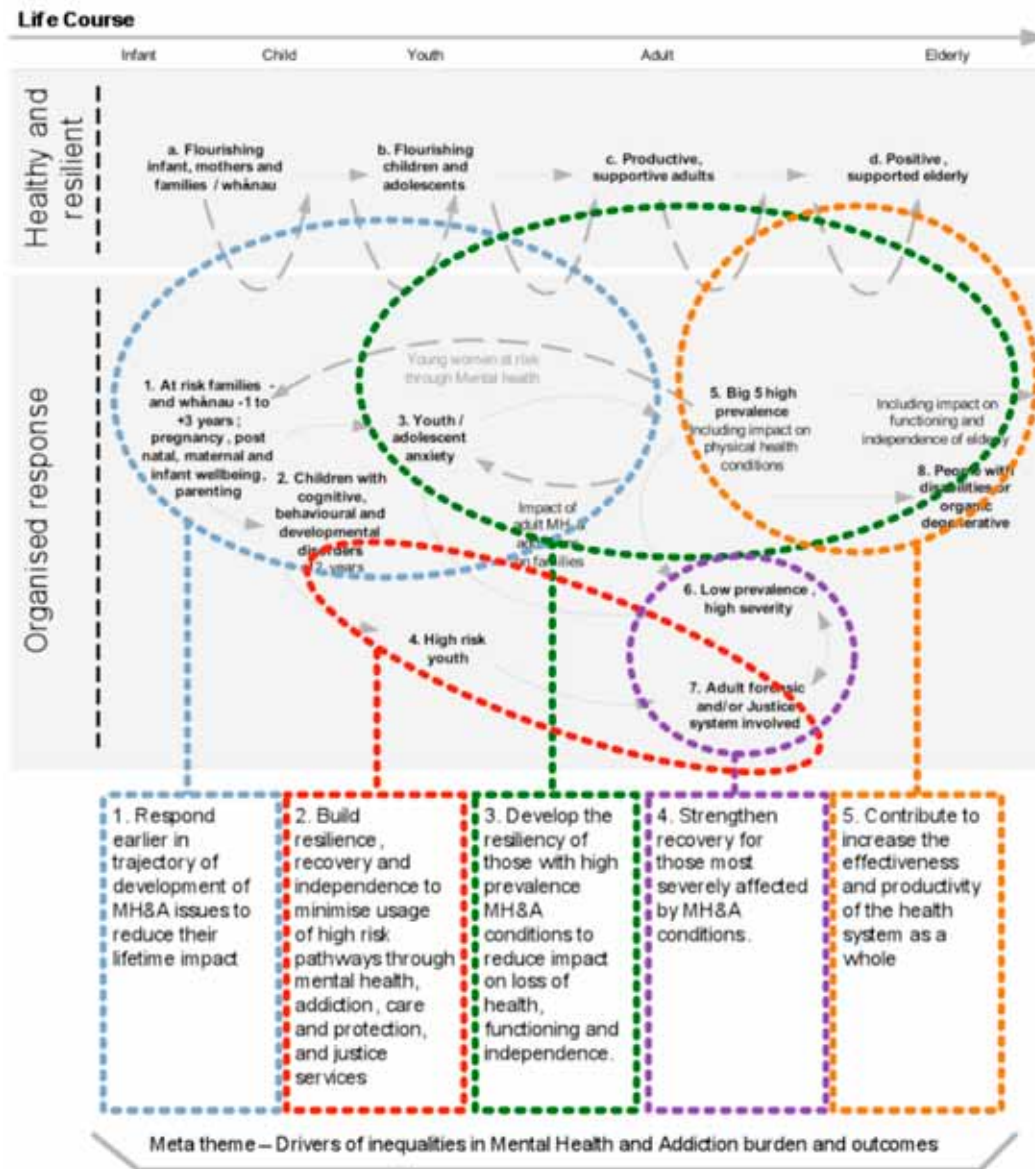
The following section (Part A) explores each of the three areas above in detail, highlighting what success would look like for New Zealanders. The final section (Part B) explores how we propose to make these changes happen. Each section includes specific consultation questions.

An outcomes oriented, whole-of-population, life course

We believe we must move to a population based, life course understanding of the development and prevalence of MH&A issues.

Using a population life course approach forces us to see the service and resource investments we make for different needs and populations as being connected within a service system and to look at how our responses impact on a consumer's journey through life.

These outcomes are not discrete but overlap and are directly connected to the population life course as depicted below. Achieving these outcomes requires effort across multiple population clusters and systems of care.



Across each of these outcomes we will need to drive for more equitable outcomes for vulnerable groups, including those with high needs, Māori, Pacific peoples, refugees and asylum seekers and people living under economic deprivation.

For example, for Māori and Pacific peoples, prevalence rates remain high across each of the eight populations. Māori and Pacific peoples' mental health and wellbeing clearly warrants continued focus as a health issue that concerns us all. Sustained efforts are required to focus on the outcomes, pathways, care environments and workforce that are effective for Māori and Pacific peoples mental health service users and their whānau.



In driving for these outcomes we will need to ensure that:

- There is recognition of Māori and Pasifika world views, issues and aspirations.
- We consider the broader social, health and mental needs of tangata whaiora in the context of their whānau.
- We support the capacity of whānau to help them achieve their full potential through positive health outcomes, educational attainment and social development.
- Cultural responsiveness is woven through our system of care because of the need to be able to reduce access barriers, communicate and engage effectively.

If we are successful across this area, New Zealanders will see:

- Improved outcomes for people with severe mental illness or Alcohol and Other Drug (AOD) issues and increased satisfaction with housing choices, employment opportunities, community connectedness/social inclusion, fewer hospital based contacts and a better quality of life.
- More equitable outcomes for vulnerable groups, including those with high needs, Māori, Pacific peoples, refugees and asylum seekers and people living under economic deprivation.
- Fewer relapses and less use of the more high intensity services because more people with high needs are staying well / dealing with their AOD issues.
- More people with mental health or AOD issues keeping their jobs or rapidly returning to work and fewer people needing welfare support because of mental health or addiction issues.

Consultation questions:

- Do you agree with the five outcomes that are proposed to shape how things need to be?
- If you disagree, please tell us why.
- Are there any other objectives we need to shape how things need to be?

A system of care that is people centred, responsive, timely and integrated, builds resiliency and is recovery focused

To achieve these outcomes we need to lift access and response rates and achieve a better mix of response across the life course. The Blueprint II working paper presents analysis from a range of data sources to identify a range of prevalence rates across the population life course, where a high impact on MH&A could be achieved through organised service responses; including primary, community and specialist services. Initial modelling in Towards Next Wave (2011) suggests that a substantial increase in access rate across the population is required in order to meet needs over the next decade.

We fully accept that our current service system will not be able to deliver a substantial lift in access and response rate today or tomorrow, but over the 10 year view of Blueprint II we expect this to be possible. To deliver, we will need to create improved, evidence based systems of care that deliver rapid and appropriate responses for people, family/whānau across the spectrum of services and responses.

Sector feedback has indicated that six areas of change in system response are required:

1. **Self care and resiliency support:** Increase support for consumer and family-centred services to respond most appropriately, to build capacity for self care and promote resiliency and wellbeing. We need to turn our current system of care into one that is people-centric and resiliency focused, and utilises tiers or layers of responses; from self care, primary and community through to more specialised and intensive services.

2. **Develop a responsive “no wait” system** to ensure prompt access to services, reduced escalation and loss of resiliency. The resiliency principle emphasises the value of strengthening the social context around people; family/whānau, activity with friends, the health benefits of workplaces and the role of peer support networks.
3. **Closer to home responses in less intensive settings**, to shorten the response pathway and reduce pressure on limited specialised resources. While episodic and intensive acute needs cannot always be anticipated, enhancing the planning and cross-system continuity of care for relapse response is important for supporting recovery and minimising loss of resiliency.
4. **Integrated responses across addiction, mental health and behavioural disorders**, to provide a more effective balance of response. Where longer duration of support is needed, our systems of care must retain the focus on pathways to recovery; minimising the risk of people becoming stuck and isolated by their engagement with ongoing MH&A care, ensuring good integration with medical care and supporting social inclusion, housing and employment where possible.
5. **Strengthened focus on the flows along pathways to resilience and recovery**; reduce coercion, reduce duration in services and frequency of relapse.
6. **Join up services across general health and the social sector** to gain greater impact and synergy from combined capability and resources.

If we are successful across this area, New Zealanders will see:

- Earlier responses when people begin to develop a MH&A issue to reduce lifetime impact.
- More people will receive primary and specialist interventions for MH&A issues.
- Care is better connected across the range of health services, enabling more specialist advice, shared care arrangements and access to effective therapies, in a range of settings alongside brief social/practical support for people experiencing difficulty.
- There is more support for self-management and more activities to promote wellbeing and resilience or intervene early.
- More services for people with multi-agency involvement are jointly funded and delivered.
- Consumers and their family/whānau are active partners in the delivery of MH&A responses.

Consultation questions:

- Do you agree with the six areas of change required in system response?
- If you disagree, please tell us why.
- Are there any other areas required in system response?

Creating a step change in performance that maximises the results we achieve from our limited resources of energy, time, capability and money

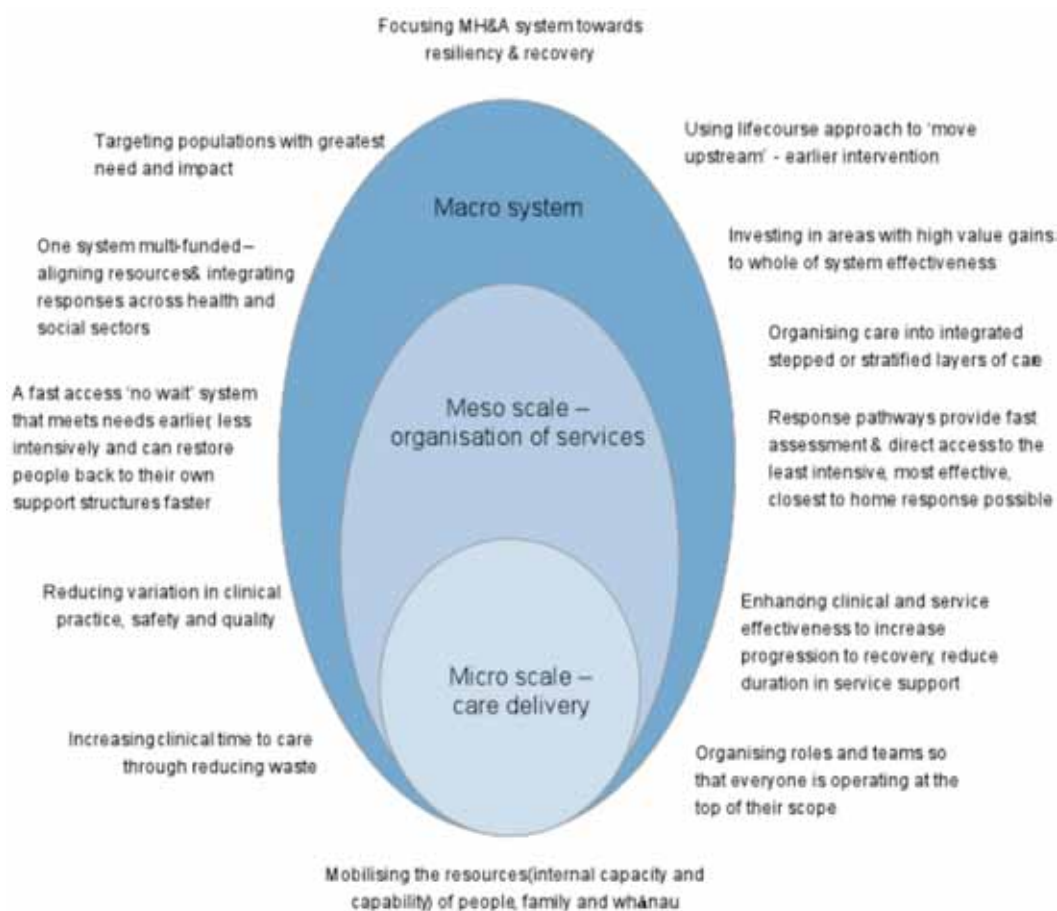
Blueprint II is aiming to facilitate a breakthrough or step change in how effectively we can use existing resources, to harness the capability across the wider health sector and work alongside intersectoral partners where MH&A also matters. Many, if not most, of the innovations in practice or service delivery needed to achieve this breakthrough are already evident across the sector, but not yet developed, integrated or scaled to the point where the new level of system performance can be consistently achieved.



The diagram below outlines proposed ideas for creating this step change across three layers of system performance: macro, meso and micro. Some of the core ideas include:

- **One system multi-funded** – aligning resources & integrating responses across health and social sectors.
- A fast access **'no wait' system** that meets needs earlier, less intensively and can restore people back to their own support structures faster.
- **Reducing variation** in clinical practice, safety and quality.
- Increasing **clinical time to care** through reducing waste.
- Organising roles and teams so that everyone is operating at the **top of their scope**.
- Response pathways provide fast assessment & direct access to the **least intensive, most effective**, closest to home response possible.
- Organising care into integrated **stepped or stratified layers of care**.

Supporting multi level system performance and effective use of resources



If we are successful across this area, New Zealanders will see:

- Increases in the non-regulated workforce, including peer support, supported by effective workforce development.
- Increasingly responsive services that are more culturally appropriate, engaging respectfully with people and their families.
- A responsive “no wait” system.
- Improved and increased access for all age groups.
- Increased confidence in recognising problems and acting in ways that help, right from the front line social sector agencies through primary care and specialist medical services to specialist AOD and MH services.

Consultation questions:

- Do you agree with the ideas proposed to create a change in performance?
- If you disagree, please tell us why.
- What do you think is needed for the MH&A sector to make these changes?

PART B: Making it happen

Most of the changes discussed in this paper are already happening within the MH&A sector – but in isolated pockets. Sector experience to date indicates that scaling and spreading innovation is a difficult and challenging task requiring alignment of thinking, motivation and practical action within a busy sector that has demanding business-as-usual priorities and limited time or capacity for change.

We need to be smarter about how we make change happen. We need to draw on the evidence base for effective change and use it to accelerate our rate of learning. With constrained resources we will need to create starting points that support self sustaining and self reinforcing change that rapidly, practically and safely frees up energy, time and resources to reinvest in the subsequent steps.

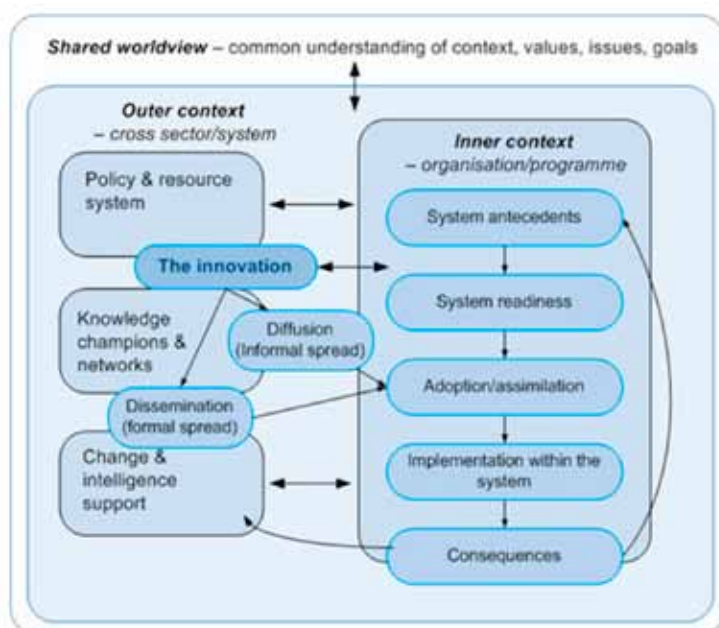
To increase the pace of focused innovation and achieve widespread adoption, adaptation and integration will require leadership and effective supporting infrastructure. This infrastructure must include ensuring that our planning, accountability and funding mechanisms support rather than hinder the developments needed.

Building an evidence informed system change capability

Although there are outstanding examples of effective change, our current processes of change are not up to the challenges of the future. We believe we need to aim for a breakthrough in our change performance if we are to achieve what is needed.

For Blueprint II we propose a change strategy that is informed by evidence from literature and research on change, feedback from consumers and family/whānau, knowledge of clinical leaders and providers and learning from current innovations and exemplar services.

A review of contemporary approaches to change management and innovation in health systems provides pointers to the effective change strategy required to successfully implement Blueprint II. One framework shown below comes from an extensive review of health services innovation, adoption and assimilation.



Adapted from Greenhalgh et al 2004/2005: Conceptual model for considering determinants of diffusion of innovation in the organisation and delivery of health services.

The evidence supporting the framework above clearly points to the nature of the change alignment needed across:

- The formal policy system, (e.g. the Ministry SDP) and resource accountability structures (e.g. the monitoring and funding mechanisms).
- The informal or semi-formal networks of knowledge champions and influence.
- A focused change and intelligence support (e.g. as seen within existing benchmarking processes).
- The more internal processes established or emerging within services, districts and regions.

We believe that as part of the next phase of Blueprint II development we need to:

1. Identify the small number of innovative system of care developments that can initiate the step change in performance needed.
2. Using these as our focus, work with the sector to apply the evidence base for effective change to identify the system antecedents, system readiness and adoption / assimilation capabilities needed.
3. Again drawing on the evidence base, make recommendations to Government and central agencies on change support infrastructure required that will align the formal policy, monitoring and resourcing frameworks with sector-led change networks and the change intelligence support needed.

Consultation questions:

- Do you agree with the move to a more evidence informed approach to system level change?
- If you disagree, please tell us why.
- Are there any other approaches to system level change you would recommend?

Developing effective sector leadership

To support and nurture the change and innovation envisaged in Blueprint II will require leadership that is connected and connects people and different parts of the system (agencies, services, resources) in creative ways to achieve common outcomes. Making it happen will require leadership operating at multiple levels across the system.

From dialogue with the sector we propose that Blueprint II should outline the need for:

1. **Stronger national and regional mental health and addiction networks:** Strengthened with a stronger role in enabling achievement of agreed local outcomes and performance goals. Networks are often the best way to enable and integrate leadership across a complex system with multiple organisations and groups. The networks should have the role of providing leadership on achieving the changes outlined in this document.
2. **Ministerial targets for MH&A:** These targets should be seen as an opportunity to enhance the profile of MH&A as an important contributor to the wider system of government in areas such as employment, transition to adulthood and at-risk youth.
3. **Continued advocacy and championing:** The Office of the Health and Disability Commissioner (which will include the Mental Health Commission from 1 July 2012) should have the role of championing the new Blueprint and monitoring its implementation.
4. **Aligned accountability and sector informed outcomes and performance development processes:** The National Health Board and Ministry of Health should lead the development and implementation of new national KPIs and accountabilities for District Health Boards that step beyond the current Blueprint access targets but are aligned with sector informed processes for service performance benchmarking and practice development.
5. **Aligned central agency support:** All central health agencies should work with their housing, education, justice and welfare partners to achieve a more supportive environment for recovery and resiliency.

Consultation questions:

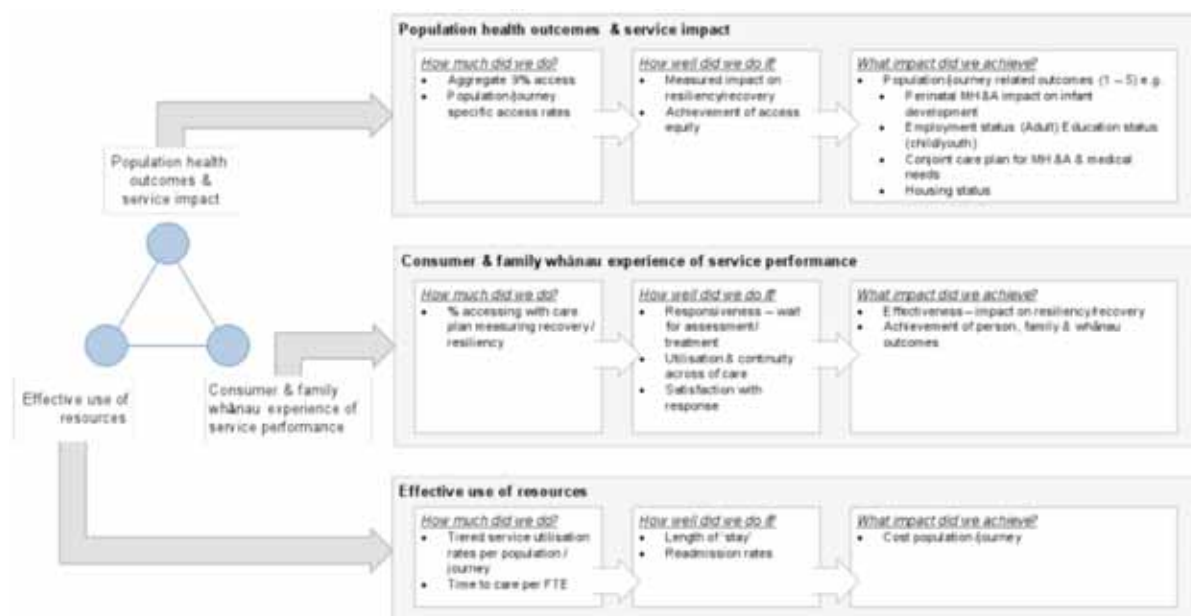
- Do you agree with the five proposed areas to develop sector leadership?
- If you disagree, please tell us why.
- Are there any other areas you would propose to develop sector leadership?

Guiding outcomes oriented development and resourcing decisions

Navigating through the shifts in response and breakthroughs in system performance required across the system to realise Blueprint II will require an intelligence capability that is able to guide outcomes oriented resourcing and service development decisions.

Over the last few years the sector has made a substantial investment in building a platform of measures and culture of benchmarking that is starting to deliver results. Blueprint II proposes in 'How things need to be' our collective challenge in shifting to a next level of care for critical population groups using integrated service models to lift system performance and effective use of resources.

Feedback from the sector shows strong interest in creating a framework to guide performance that combines approaches such as 'The Triple Aim', with its explicit linkage of (1) population health, (2) user experience of care and (3) efficient use of resources inside a quality improvement framework with a 'Results Based Accountability' approach, with its clarity of purpose, structure and application for collaborative performance development.



The diagram above offers an initial outline of how the 'Triple Aim' and results based accountability approaches can be linked to create a powerful outcomes aligned performance framework that can clearly support resourcing and service development decisions.

The direction of travel needs to be towards a broader approach that both protects the gains in MH&A achieved to date and provides greater flexibility in the use of resources to enable innovation, efficiencies and

collaboration across multiple services and sectors. To achieve the changes envisaged, we will need robust and accurate information that will be used to improve services delivered, guide investment decisions, and enhance accountability for use of public funding. This information will need to include information about people accessing services, the services they access (inputs and outputs) and the outcomes they achieve. This requires:

- **An evolution of existing KPIs:** Using the base of the existing national KPI programme develop and agree set of nationally consistent KPIs with a stronger output and outcome focus using the Triple Aim/ Results Based Accountability approach that is aligned with broader sector based direction.
- **Providing an integrated, benchmarked, outcomes oriented approach to performance:** Develop the emerging benchmarking capability in the KPI programme into a sector supported approach to whole-of-system development that supports change development and resourcing and contracting mechanisms.
- **Introduce nationally consistent resource allocation guidelines:** Develop a MH&A resource allocation decision support tool. This tool would provide a consistent systematic process for analysing need, performance and resourcing, to inform DHB MH&A resource allocation decisions (described in next section).
- **Annual process of review:** DHBs would be required to apply the decision support tool on at least an annual basis. The data from this process would inform a national database that would enable improved benchmarking, cross system learning and a national view of required forward investment levels in MH&A outcomes.

Consultation questions:

- Do you agree with the approach to supporting sector led performance improvement?
- If you disagree, please tell us why.
- Are there any other requirements for supporting sector led performance improvement?

Evolving how we organise funding

MH&A funding is currently organised by a complex structure of Population Based Funding Formula (PBFF), annual Blueprint funding increments and a ring-fence for specialist MH&A services. The sector has indicated that this is increasingly generating funding and resource conflicts constraining the ability of the system to adapt and innovate to the needs of people and future challenges.

Based on sector dialogue Blueprint II proposes working with stakeholders to review how MH&A funding and associated performance monitoring is organised. This could include taking a modified approach to mental health and addiction funding that:

- protects the gains in investment made to date, while allowing greater flexibility to promote innovation, efficiencies and collaboration across multiple services and sectors.
- drives for increased outputs and outcomes focus to maintain appropriate investment within the whole system view of MH&A.

Specific suggestions to achieve could include:

- A modified ring-fence (i.e. over time, ring-fenced funding could be better aligned with population mental health and addiction need and population-based health funding).
- Increase the accuracy and reliability of future PBFF funding.
- Improve the balance between inputs, outputs and outcomes in monitoring.



We propose working with stakeholders, including the MoH, during the consultation period (February and March) to develop ideas that can be tested with the sector before possible inclusion in Blueprint II.

Consultation questions:

- Do you agree we need to review how MH&A funding frameworks operate?
- If you disagree, please tell us why.
- Do you have any other suggestions for evolving MH&A funding frameworks?

Where do we start?

During the consultation phase the Mental Health Commission will continue working with the sector to develop a plan for 'where to start' with implementing the proposals in this consultation document and Blueprint II. While Blueprint II covers a 10 year horizon, however the sector has clearly indicated the need for a plan of where to start on this journey. This plan must be owned by the sector and provide the clarity and consensus required to get moving.

Once the consultation is complete, the submissions will be analysed. The issues and themes from this analysis along with outputs from the "where to start" work will form the basis for Blueprint II. Blueprint II will be available in June 2012.

Consultation questions:

- What are the top three issues the MHC needs to take into account to support sector led implementation of any changes?
- What are the top three issues the MHC needs to take into account to ensure better outcomes for vulnerable groups including Māori, Pacific peoples, refugees and people living under economic deprivation?