Disability Support Advisory Committee Meeting

Wednesday 20 November 2013
1.00pm

Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare
Agenda
Meeting of the Disability Support Advisory Committee
20 November 2013

Venue: Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak
Time: 1.00pm

<table>
<thead>
<tr>
<th>ADHB and WDHB Members</th>
<th>ADHB and WDHB Staff</th>
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</thead>
<tbody>
<tr>
<td>Sandra Coney (Chair)</td>
<td>Dr Dale Bramley</td>
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<tr>
<td>Dairne Kirton</td>
<td>Leanne Catchpole</td>
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<tr>
<td>Jan Moss</td>
<td>Michele Cavanagh</td>
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<tr>
<td>Jo Agnew,</td>
<td>Dr Debbie Holdsworth</td>
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<tr>
<td>Dr Marie Hull-Brown</td>
<td>Ronnelle Baker</td>
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<tr>
<td>Max Abbot</td>
<td>Linda Harun</td>
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<td>Pat Booth</td>
<td>Katrina Lenzie-Smith</td>
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<td>Robyn Northey</td>
<td>Tim Woods</td>
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<td>Susan Buckland,</td>
<td>Sue Waters</td>
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<td>Susan Sherrard</td>
<td>Marlene Skelton</td>
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<td>Russell Vickery</td>
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</tbody>
</table>

Apologies: Max Abbot, Ailsa Claire, Debbie Holdsworth

Register of Interests
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Agenda
Please note that agenda item times are estimates only

<table>
<thead>
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<th>Time</th>
<th>Item</th>
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<tr>
<td>1.00pm</td>
<td><strong>1</strong> Introductions</td>
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<td></td>
<td><strong>2</strong> Attendance and Apologies</td>
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<tr>
<td>5min</td>
<td><strong>3</strong> Conflicts of Interest</td>
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<td></td>
<td><strong>4</strong> Confirmation of Minutes 28 August 2013</td>
</tr>
<tr>
<td>5min</td>
<td><strong>5</strong> Action Points 28 August 2013</td>
</tr>
<tr>
<td>5min</td>
<td><strong>6</strong> Chairperson’s Report (verbal)</td>
</tr>
<tr>
<td>30min</td>
<td><strong>7</strong> Presentation – Health Passport &amp; Residential Facility Taupaki Gables – Linda Venables, Regional Manager, Radius Care</td>
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<tr>
<td>30min</td>
<td><strong>8</strong> Papers</td>
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<td></td>
<td><strong>8.1</strong> Review of Key Objectives and Areas of Focus for the Disability Support Advisory Committee (2011-2013)</td>
</tr>
<tr>
<td>9</td>
<td><strong>9</strong> Improvement Activities</td>
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<tr>
<td>20min</td>
<td><strong>9.1</strong> Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs</td>
</tr>
<tr>
<td>20min</td>
<td><strong>9.2</strong> Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs</td>
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<td>Confirm</td>
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<tr>
<td>10</td>
<td>Action Points for next DSAC Meeting</td>
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<td></td>
<td>DSAC Feedback to Board</td>
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<td></td>
<td>General Business</td>
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</tbody>
</table>

**Next Meeting**

**Wednesday 12 March 2014 at 1.00pm**
Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland

*Hei Oranga Tika Mo Te Iti Me Te Rahi*

*Healthy Communities, Quality Healthcare*
Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full nature of the interest is disclosed, not just the existence of the interest.

## Register of Interests

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Organisation</th>
<th>Latest Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sandra CONEY (Chair)</strong></td>
<td>Councillor – Auckland Council&lt;br&gt;Chair – Parks Committee, Auckland Council</td>
<td>2 May 2011</td>
</tr>
<tr>
<td><strong>Jo AGNEW (Deputy Chair)</strong></td>
<td>Professional Teaching Fellow - School of Nursing, Auckland University&lt;br&gt;Casual Staff Nurse - ADHB</td>
<td>9 Sept 2011</td>
</tr>
<tr>
<td><strong>Max ABBOTT</strong></td>
<td>Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology&lt;br&gt;Patron - Raeburn House&lt;br&gt;Board Member - Health Workforce New Zealand&lt;br&gt;Board Member - AUT Ownership Trust&lt;br&gt;Chair - Social Services Online Trust&lt;br&gt;Board Member - The Rotary National Science and Technology Trust</td>
<td>28 Sept 2011</td>
</tr>
<tr>
<td><strong>Pat BOOTH</strong></td>
<td>Consulting Editor - Fairfax Suburban Papers in Auckland</td>
<td>24 June 2009</td>
</tr>
<tr>
<td><strong>Susan BUCKLAND</strong></td>
<td>Self-employed - Writer and editor&lt;br&gt;Professional Conduct Committee member - Medical Council of NZ&lt;br&gt;Member - Occupational Therapy Board&lt;br&gt;Member - Northern Region Ethics Committee&lt;br&gt;Trustee - Starship Foundation</td>
<td>12 Sept 2012</td>
</tr>
<tr>
<td><strong>Lester LEVY</strong></td>
<td>Professor (Adjunct) of Leadership - University of Auckland Business School&lt;br&gt;Co-Director - New Zealand Leadership Institute&lt;br&gt;Deputy Chair - Health Benefits Limited&lt;br&gt;Independent Chairman - Tonkin &amp; Taylor&lt;br&gt;Chairman - Waitemata District Health Board&lt;br&gt;Chairman - Auckland Transport</td>
<td>1 Nov 2012</td>
</tr>
<tr>
<td><strong>Robyn NORTHEY</strong></td>
<td>Self-employed Contractor - Project management, service review, planning etc.&lt;br&gt;Board Member - Hope Foundation&lt;br&gt;Trustee - A+ Charitable Trust</td>
<td>20 June 2012</td>
</tr>
<tr>
<td><strong>Michelle CAVANAGH</strong></td>
<td>Involvement - Te Taurahere O Ngati Porou Ki Tamaki&lt;br&gt;Part time employee - HWF NZ Hauora Maori Coordinator, WDHB&lt;br&gt;Contractor - Kai Ora Hauora Northern Regional Coordinator – Northland DHB</td>
<td>7 Mar 2012</td>
</tr>
<tr>
<td><strong>Maria HULL-BROWN</strong></td>
<td>Employee - Mental Health Foundation&lt;br&gt;Board member - HOPE Foundation for Research on Ageing&lt;br&gt;Council - Member Age Concern, Auckland.</td>
<td>1 Nov 2012</td>
</tr>
<tr>
<td><strong>Daine KIRTON</strong></td>
<td>Northern Regional Representative - CCS Disability Action National Board</td>
<td>23 Nov 2011</td>
</tr>
<tr>
<td><strong>Jan MOSS</strong></td>
<td>Co-ordinator - Complex Carer Group&lt;br&gt;Member - SSOAS Stakeholders Group, WDHB&lt;br&gt;Board Member - Operational Trust YES Centre&lt;br&gt;Member - MOH Disability Workforce Reference Group</td>
<td>30 Sept 2011</td>
</tr>
<tr>
<td><strong>Susan SHERRARD</strong></td>
<td>Contractor - CCS Disability Action&lt;br&gt;Trustee - Ripple Trust&lt;br&gt;Member - Strategic Advisory Group, Auckland Council</td>
<td>7 Mar 2012</td>
</tr>
<tr>
<td><strong>Russell VICKERY</strong></td>
<td>Member - Ripple Trust&lt;br&gt;Life Member - CCS Disability Action, Auckland&lt;br&gt;Trustee - TalkLink Trust&lt;br&gt;Member, Steering Committee, Auckland Disability Law&lt;br&gt;Committee Member - Waitakere Community Law&lt;br&gt;Self-employed - Disability Consultant&lt;br&gt;CCS Disability Action Nominee - Wilson Home Trust Management Committee&lt;br&gt;Disability Consultant - Care Managers Research, Auckland University Nursing School</td>
<td>14 Nov 2012</td>
</tr>
</tbody>
</table>
CONFIRMATION OF MINUTES

WEDNESDAY 28 AUGUST 2013
Auckland District Health Board and Waitemata District Health Board
Disability Support Advisory Committee
Minutes

Minutes of the Auckland District Health Board and Waitemata District Health Board, Disability Support Advisory Committee meeting held on Wednesday, 28 August 2013 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1:00pm

2 ATTENDANCE AND APOLOGIES

The Chair declared the meeting open at 1.00pm.

Committee Members

Jo Agnew (ADHB) (Acting Chair)   Pat Booth (WDHB)
Susan Buckland (ADHB)    Jan Moss
Robyn Northey (ADHB)    Marie Hull-Brown
Russell Vickery    Susan Sherrard

Management in Attendance

ADHB
Alison Paulin – Professional Leader Allied Health for Sue Waters – Chief Health Professionals Officer
Kate Sladden, Planning and Funding Manager
Marlene Skelton, Corporate Business Manager
Noelene Carey – Personal Assistant

WDHB
Leanne Catchpole – Programme Manager Health of Older People
Samantha Dalwood - Disability Strategy Coordinator

Apologies

Apologies had been received from Sandra Coney, Max Abbot, Ailsa Clair, Dairne Kirton, and Sue Waters

Moved Jo Agnew/Seconded Robyn Northey
That the apologies be received.
Carried

3 CONFLICTS OF INTEREST

There were no declarations of conflicts of interest for any item on the agenda.
CONFIRMATION OF MINUTES 5 JUNE 2013

Moved by Robyn Northey /Seconded Marie Hull-Brown

That the minutes of the Auckland District Health Board and Waitemata District Health Board Disability Support Advisory Committee meeting held on 5 June 2013 be confirmed as a true and correct record.

ACTION POINTS 5 JUNE 2013

<table>
<thead>
<tr>
<th>Item</th>
<th>Detail</th>
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<th>Action</th>
</tr>
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<tbody>
<tr>
<td>Carried forward</td>
<td>The Secretary was to follow up with Colleen Brown on organising a meeting with the Auckland Council Disability Group.</td>
<td>Sandra Coney</td>
<td>Deferred until after the election</td>
</tr>
<tr>
<td>Carried forward</td>
<td>The Committee asked for information on remuneration and reimbursement and the Terms of Reference of the Regional HOP Consumer Representatives Group.</td>
<td>Katrina Lenzie-Smith Tony O'Connor</td>
<td>Item 9.1 on this agenda</td>
</tr>
<tr>
<td>Carried forward</td>
<td>Some estimate of what the costs would be to implement the Caring Counts report recommendations (after their report is available)</td>
<td>Debbie Holdsworth Tim Wood</td>
<td>To go to full Board of each DHB</td>
</tr>
<tr>
<td>Carried forward</td>
<td>Management to bring forward options to reduce funding barriers and while the problem is defined it was better to approach the MoH with solutions and options for a way forward. A pilot for 0-1 years was suggested as a way forward.</td>
<td>Debbie Holdsworth</td>
<td>November</td>
</tr>
<tr>
<td>Carried forward</td>
<td>A letter under Sandra Coney’s name is to be drafted to ACC concerning funding boundary issues that impact on clients and patients. (Item 9.1 14 November 2012)</td>
<td>Tim Wood</td>
<td>To be advised. Marlene to request that Tim provide a copy of the letter</td>
</tr>
<tr>
<td>Item 8.1.1 5 June 2013</td>
<td>That this Committee invite the Ministry of Health to brief the committee and discuss concerns of people under 65 in the Auckland region about receiving respite and residential care.</td>
<td>Katrina Lenzie-Smith</td>
<td>Item 7 on this agenda</td>
</tr>
<tr>
<td>Item 7.2 5 June 2013</td>
<td>A brief presentation be made to both ADHB and WDHB Boards on the “Yellow Envelope” system and process and how it works.</td>
<td>Marlene Skelton to arrange</td>
<td>Trialled for a few months before reviewing and a report to DSAC after that post launch review</td>
</tr>
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</table>

Chairperson’s Report

Jo Agnew on behalf of the Committee Chair, Sandra Coney, thanked the Committee Members for their contribution and attendance throughout the term. The Board Chair, Lester Levy reiterated this. Members seeking re-election were wished the best of luck.

Robyn Northey commented that she had attended meetings of a newly created Autism Network and Addiction Network at the medical school and found the experience very beneficial. There were changes to the WINZ Benefits System in July. The Committee, at its November meeting, needed to consider how this is impacting on the ADHB/WDHB population.
Bryan Agnew and Estelle Muller from the Ministry of Health appeared to address the Committee.

Residential Care

Bryan commented that they had no formal presentation to make and were happy to address the members concerns and questions about the service.

The Acting Chair clarified that the Committee would like to know:

- what facilities and services were available for those under 65 in respite and residential care
- What plans were currently being worked on to develop and extend this service?

The Acting Chair commented that there appeared to be a lack of facilities and there had been negative reports in the Media.

Matters covered in discussion and in response to questions included:

- The explanation being given of the Community Care and the Group Care philosophy with four to five people in a house. 24/7 care is provided. There are 1500 people in residential care in the Auckland area with 30 providers.

- Access to this care is evaluated using the STAR rating system with those being eligible requiring a result of high to very high. Although there is a decline in people needing residential care, the costs have increased. This is due to the higher complex needs patients moving into residential community based care.

- A question was asked in regard to the the number of people in rest homes designed primarily for the elderly. It was advised that there were 700 nationally funded in this position but that 500 of those were under 65. There is a strategy in place to gain a better understanding of this group of people. There is a need to apply a definition to “elderly” as it cannot be considered in the context that it was 20 years ago.

- A further question was asked in regard to information publically available for those under 65 and whether a list of providers was freely available. It was advised that information is available and that there were currently 30 providers.

- The Wilson Home was discussed and it was identified that there was a lack of respite services available for families of young people once they reached the age of 21. It was acknowledged that the transition period was an important step and should be started when they were around 16 or 17 years old.

- Bryan commented that they were working with young people from the Wilson Home and specific services had been set up and were on-going. The young people had complex needs and they had to be evaluated and addressed on a case by case basis.

Respite Care

- The lack of housing suitable for respite care was considered an issue by Committee Members. The MOH was working with Housing NZ to find a solution. Bryan indicated that there were also big changes ahead for Housing New Zealand which could impact on any decisions. There was a clear need for a consistent joint response to the issue.

- It was commented that some people want to re-enter the community but have to contend with the problem of availability of affordable housing. If that choice is made are there services and facilities available to support them? It was advised that quality of residential homes is an issue with the MoH. Residential care waiting lists have been implemented. There are set criteria to get on to the waiting list, however, they are only for non-urgent cases, urgent cases get dealt with straight away.

- Currently there are around 50 families on the waiting lists. A high percentage of that number is
due to the choice of the family itself, as provider and home compatibility can be an issue.

- There was a real concern that there was a lack of facilities available for respite care. Bryan acknowledged that allocation of beds was a real challenge with the demand for beds higher on weekends and over holiday periods. Providers could not operate with empty beds all week and full beds on the weekend as it was not financially viable.

- There has been a change in the funding mechanism with caps being lifted. This is expected to make services more sustainable.

- A pilot study for enhanced individualised funding is underway in the Bay of Plenty and is set to be rolled out in other centres after it has been evaluated at the end of 2013. This entails an individual receiving a package with the ability to spend it on the services that best suite them. eg. Some may only require three hours per week, where-as others may require full days or overnight stays.

- An explanation of the differences between institutionalised living and community living was requested. It was advised that institutionalised living was an “agreed home” concept. It had disadvantages in that one high needs person could draw a large share of the allocated funding to that home, leaving little for the other inhabitants. Community living allowed an individual to take the allocated funding and make personal choices.

- The Committee asked Bryan and Estelle what the greatest pressure was when delivering services they were involved with. They replied that it was the required time to get things completed. Finding the right balance of time between projects to keep things moving.

**Actions**

1. That Estelle Muller be invited to address the DSAC meeting in May 2014 to give a more detailed update on progress made in delivery of respite care.

2. That both Bryan Agnew and Estelle Muller from the Ministry of Health be thanked for attending the meeting and answering member’s questions.

8.1 DISAC Update Report on the Implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs

Samantha Dalwood - Disability Strategy Coordinator asked that her report be taken as read and addressed questions related to it. Matters covered in discussion being:

- The role of the Disabled Champions. It was clarified that these were to be existing frontline members of staff across the DHB. There were people who did this now but it wasn’t recognised. The DHB’s were looking to formalise the role, although it was stressed that there would be no allowance or adjustment in salary for the extra responsibilities. They were looking to recruit and potentially train and empower them to spread information and answer questions, Committee Members noted that although there was a need to find individuals with passion and interest, more importantly, the DHB’s needed structure around the implementation of this project, to ensure the same message was communicated and there were formal job descriptions.

- It was noted that there was an issue that had been raised at previous meetings in regard to the refurbished 6th floor of the Starship Hospital and the disabled toilet facilities. The specifications were not met and it was agreed that it was the responsibility of both DHB’s to ensure that they employed the use of “universal design” in such instances.

**Actions**

That a letter be written to both CEO’s requesting an assurance that “accessibility” issues be taken into account for all facilities being designed or refurbished and that they provide confirmation to DSAC that this has been done.
## 8.2 Engagement & Consultation Financial Recognition (Public Participation Reimbursement)

This item was taken as read and the information received.

## 9.1 Health of Older People Quarterly Report on Activities in Auckland & Waitemata DHBs

The report was taken as read. Discussion and comment covered:

### First Do No HARM (FDNH)
- The focus has been on Hospital and Aged Residential Care. There is now a move to look at community and home based support services.

- A change in facility was identified as an increased risk for older people having falls. It was suggested that there needs to be liaison with the providers running these services with training and education being offered.

- Initiatives such as Tai Chi; the funding of which has been scrapped by ACC, had a major impact on reducing the number of injuries in the elderly as it increased strength and balance. It was suggested that this could be revisited.

### Yellow Envelope
- This was reported as working well within the ADHB. It was designed for the transfer of essential resident documentation between the Hospital and the ARRC facility. A post launch review is planned to evaluate whether the implementation has been successful and when completed a report will come back to this committee.

### InterRAI
- Positive progress is starting to occur across the Northern region. All DHB’s have agreed to share their data and report regionally. There has been an issue that needed resolution where one DHB was outside the regional data warehouse.

- Disappointment was expressed with regard to the number of initiatives that were still in project stage and yet to be fully rolled out.

- It was queried what Auckland was going to do in regard to the Health and Dementia Passports. Members also asked when the Disabled were going to learn about the Health Passport. It was reported that it was a difficult area as a personal explanation to the patient was required. There has been an attempt to get PHO’s to assist with this via their GP’s. It is hard to find appropriate avenues and the time to roll this out effectively.

### Discharge Procedures for the Elderly
- There were concerns expressed about how DHB’s dealt with discharging the elderly. The Board Chair commented that the WDHB was developing a plan for the vulnerable, when and to whom were they discharged, which ideally was to families. Auckland is going to have to adopt the same policy, however it was more about a culture change where staff thought about the individual patients and the conditions on discharge, critical thinking was not valued enough, the context needs to be assessed and taken into account. Education was key for critical thinking.

### Action

**That a report come to the November meeting updating DSAC members on what is occurring in relation to the Health and Dementia Passports.**
CONFIRMATION

Action Points for Next DSAC Meeting

1. That Estelle Muller be invited to address the DSAC meeting in May 2014 to give a more detailed update on progress made in delivery of respite care.

2. There were changes to the WINZ Benefits System in July. The Committee, at its November meeting, requested an update detailing how this is impacting on the ADHB/WDHB population.

3. That a letter be written to both CEO’s requesting an assurance that “accessibility” issues be taken into account for all facilities being designed or refurbished and that they provide confirmation to DSAC that this has been done.

4. That a report come to the November meeting updating DSAC members on what is occurring in relation to the Health and Dementia Passports.

NEXT MEETING

There being no further business the meeting closed at 2:30pm

The next scheduled meeting is:
1:00pm, Wednesday, 20 November 2013
Training Room, CCS Disability Action
14 Erson Avenue
Royal Oak
Auckland

CONFIRMED

CHAIR: DATE:
ACTION POINTS

WEDNESDAY 28 AUGUST 2013
### Action Points from Previous DSAC meetings

As at Wednesday 28 August 2013

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail</th>
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<td>Sandra Coney</td>
<td>Deferred until after the election March 2014</td>
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<tr>
<td>Carried forward</td>
<td>Management to bring forward options to reduce funding barriers and while the problem is defined it was better to approach the MoH with solutions and options for a way forward. A pilot for 0-1 years was suggested as a way forward. <em>(The Chair to discuss with the Committee to clarify what is required given the Committee have had the Ministry of Health presentation which touched on this issue)</em></td>
<td>Debbie Holdsworth</td>
<td>TBA</td>
</tr>
<tr>
<td>Item 7 28 Aug 2013</td>
<td>That Estelle Muller of the Ministry of Health be invited to address the DSAC meeting in June 2014 to give a more detailed update on progress made in delivery of respite care.</td>
<td>Marlene Skelton</td>
<td>June 2014</td>
</tr>
<tr>
<td>Item 9.1 28 Aug 2013</td>
<td>That a report come to the November meeting updating DSAC members on what is occurring in relation to the Health and Dementia Passports.</td>
<td>Katrina Lenzies-Smith</td>
<td>November 2013 <em>(This agenda - Presentation on Health Passport)</em></td>
</tr>
<tr>
<td>Item 9.1 28 Aug 2013</td>
<td>There were changes to the WINZ Benefits System in July an update detailing how this is impacting on the ADHB/WDHB population is requested.</td>
<td>Katrina Lenzies-Smith</td>
<td>March 2014</td>
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CHAIRPERSON’S REPORT
PRESENTATION

Health Passport & Residential Facility Taupaki

Gables
8

PAPERS

8.1 Review of Key Objectives and Areas of Focus for the Disability Support Advisory Committee (2011-2013)
8.1 Review of Key Objectives and Areas of Focus for the Disability Support Advisory Committee (2011-2013)
Review of Key Objectives and Areas of Focus for the Disability Support Advisory Committee (2011-2013)

Recommendation

That the report be received.

Prepared by: Marlene Skelton (Corporate Business Manager) for Sandra Coney (Chair of Disability Support Advisory Committee)

1. Executive Summary

Reporting, appending the minutes of the agreement made by the Committee at its workshop held on 21 September 2011 to determine key objectives and areas of focus for the Committee to take for the remainder of the term.

The Chair is requesting that a review of progress against what was agreed take place.
# DISABILITY SUPPORT ADVISORY COMMITTEE Paper

<table>
<thead>
<tr>
<th>Date</th>
<th>Wednesday 21 September 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>To</td>
<td>Disability Support Advisory Committees</td>
</tr>
<tr>
<td>From</td>
<td>Denis Jury and Tim Wood</td>
</tr>
<tr>
<td>Author</td>
<td>Lisa Gestro Ext 26097 <a href="mailto:lgestro@adhb.govt.nz">lgestro@adhb.govt.nz</a></td>
</tr>
<tr>
<td>Functional Group</td>
<td>Planning and Funding Functional Group</td>
</tr>
<tr>
<td>Subject</td>
<td>Proposed Approach to the Combined Auckland and Waitemata DHB Disability Support Advisory Committee Meetings</td>
</tr>
</tbody>
</table>

## 1 Purpose

This paper serves to provide some context and guidance into the management and process relating to the new combined committee, and has been prepared to inform discussion at the inaugural combined committee meeting in September about the aims, objectives and purpose of the committee.

## 2 Recommendation

It is recommended that the Committee *note* the paper; and

That the proposed approach to the management of the combined Disability Support Advisory Committee Meetings is *supported*.

## 3 Background

The Boards of Auckland District Health Board and Waitemata District Health Board have sought approval from the Minister of Health to combine the functions and memberships of the Disability Support Advisory Committee, as well as several other key statutory committees of the DHB’s.

The Minister of Health supports this collaborative initiative, noting that to remain compliant with the New Zealand Public Health and Disability Act, the
committees must be separately identifiable.

The move to combine the DSAC meetings for Auckland and Waitemata DHBs provides a unique opportunity to consider the role of the committees and the most beneficial way to ensure the committees are well informed and supported in their decision-making. An overview of the benefits and a proposed approached to the management of these committees is described to assist the committees and determine how best to provide advice to their respective Boards under this new model.

**Benefits of a joint approach**

The joint approach to these committees enables greater opportunity for collaboration at a governance level where there are issues in common, particularly:

- Ensuring that we are responsive to the needs of residents within our population who are living with a disability
- Subscribing to a vision which is inclusive, accommodating and reflects the needs of all residents within our population
- Providing oversight to the development and implementation to a new Rehabilitation Strategy for our collective DHB areas
- Ensuring that we follow best practice in all issues relating to our built environments and infrastructure, particularly when new capital projects are undertaken
- Advocating for clients that have experienced barriers in accessing service within either of the DHB boundaries
- Achieving common board priorities
- Advancing the concerns of frail elderly
- Collectively supporting local, regional and national initiatives that promote our common goals, such as Be. Accessible
- Promoting equity of access through involvement in activities around prioritisation, including principles and framework
- Promoting the interests of Maori and ensuring that Disability features strongly in DHB Maori health plan/s
- Promoting Community / patient views and preferences
- Improving collaboration between the two DHBs
- Improving the use of resources across boundaries and reducing bureaucracy.

While the committees will share the same agenda and information, they will still need to report back to their respective Boards with their recommendations and advice in order to meet the legislative requirements within the Act.
Proposed Approach

In order to progress this initiative, the overall approach and management of these committees needs to be agreed by both organisations. The agreed process should also be subject to regular ongoing review by the Chair and Deputy Chair to ensure that the initial objectives remain current and that the process is enabling these objectives to be delivered.

Development of the Agenda

A schedule of future papers will be agreed by the Committee Chair in conjunction with the Deputy Chair to enable preparation of more substantive papers. This will assist the committees to discuss complex issues more thoroughly. A draft schedule for further discussion has been attached as appendix one.

It is also proposed that the committees’ agenda be split into key sections, and that this format becomes the standard format for each meeting. These sections include:

- Joint Summary Report – a high level summary of all current and ongoing issues, consolidated across both DHB’s, including DAP KPI’s.

- Specialist Hospital Services for Health of Older People (currently WDHB only as this is a priority area for them). This is presented bi-monthly so consideration should be given to whether this is replicated across both DHB’s.

- Substantive update papers, designed to provide more in depth background on topical or current issues as per the schedule to provide information to members and inform discussion at meetings.

- Individual papers from each of the DHB’s as appropriate, for issues that are specific to each of the DHB’s, as appropriate. These should also follow the pre-agreed schedule with the exception of new business of unforeseen issues.

Decision papers should consider the implications for both DHBs, even where the recommendation has been initiated and involves only one DHB.

Secretariat

As previously agreed, the host DHB of the combined committees will prepare the agenda documentation, including the format. Therefore, for DSAC, Auckland DHB will undertake this role.

In order to get the agenda papers to members in a timely way, the agenda for each meeting will be agreed with the Chair and Deputy Chair a minimum of three weeks prior to the meeting, enabling two weeks for the papers to be written with one week for collation and distribution.

It is also expected that the writers of the papers will be available at meetings as required, to respond to questions. The Designated lead Senior Management Team members, as well as appropriate Planning and Funding
and clinical representatives from each DHB will be required to attend these meetings.

**Workshop**

To work through the role of the newly conjoined committee, and ensure that the committee takes an active rather than passive role in the governing of key DHB activity, it has been proposed that a workshop of all DSAC members as well as invited DHB personnel takes place at a suitable time following the initial committee meeting in September.

This will be discussed in further detail at the first meeting.

<table>
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<tr>
<th>5</th>
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<tbody>
<tr>
<td><strong>Risks/Issues</strong></td>
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<tr>
<td>There are a number of risks and issues which have been identified while considering the combined approach to the management of the combined DSACs. These include:</td>
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<tr>
<td>• Managing the logistics of preparing papers across two organisations</td>
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<td>• Ensuring the implications of decisions for both DHBs are considered</td>
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<tr>
<td>• Managing the scope of the committee</td>
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<tr>
<td>• Managing stakeholder expectations</td>
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<tr>
<td>• Aligning the focus of the committees with the relevant Board to ensure the same approach to decisions, functions or activities is implemented</td>
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<tr>
<td>Much of these can be successfully managed through good communication between the DSAC Chair and the lead management team representatives who support the committees.</td>
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</table>

**Conclusion**

The joint approach to these committees enables greater collaboration where there are issues in common. The proposed approach attempts to support this goal with increased collaboration in advice provided to the committees and greater opportunity for more detailed discussion on the complex issues within the key functions of the committees.
### Appendix One: Planning Table for Combined DSAC Meetings

<table>
<thead>
<tr>
<th>Common Topics /Combined Papers</th>
<th>WDHB Specific Papers</th>
<th>ADHB Specific Papers</th>
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</table>
| **1** Home Based Support Services – Update from each DHB condensed into one overarching paper  
(September and then briefer update ongoing) | | |
| **2** Aged Residential Care  
- Quality  
- Contractual issues  
- Strategic Developments  
Update from each DHB condensed into one overarching paper  
(November and then briefer updates ongoing) | | |
| **3** Interim Funding Pool -  
(September and then activity data reports ongoing) | | |
| **5** Northern Regional Health Plan  
- HOP  
- First do no harm  
(September and then ongoing) | | |
| **7** InterRAI Rollout into Aged residential Care  
(September) | | |
| **8** Core (5-6) KPIs  
Will need a draft set (Julie Harris to assist here) | Specific KPIs as well as common ones | Specific KPIs as well as common ones |
| **9** Rehabilitation strategy | | |
- Adults
- Children’s
(November and then regular updates – to be agreed if single DHB or consolidated)

| 10 | Disability Strategy – adoption of collective vision |
| 11 | Disability Coordinator - Regular Report to the Committee (Every month) |
| 12 | Accessibility Audit – action plan (for November) |
| 13 | Mainstream Project Update (for September) |
Auckland District Health Board and Waitemata District Health Board
Disability Support Advisory Committee
Workshop Notes

MEETING DETAILS
Date and Time 12 Noon, Wednesday, 21 September 2011
Venue Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom

ATTENDANCE AND APOLOGIES
Committee Members
Sandra Coney (WDHB) (Chair) Jo Agnew (ADHB) (Deputy Chair)
Pat Booth (WDHB) Robyn Northey (ADHB)
Michelle Cavanagh Marie Hull-Brown
Dairne Kirton Jan Moss
Susan Sherrard Russell Vickery

Management in Attendance
ADHB
Denis Jury – Chief Planning and Funding Officer
Lisa Gestro – Manager Planning and Funding

WDHB
Linda Harun – General Manager Child, Women and Family Services
Katrina Lenzie-Smith – Health of Older People Programme Manager

Secretary
Ian Bell – Board Administrator

Apologies
Apologies had been received from Dr Lester Levy and Susan Buckland.

Introduction
Sandra Coney introduced the workshop and restated the purpose, which was to identify and prioritise key objectives and areas of focus for the committee during its term. It was proposed that this be managed in three sections:

1. Strategic Priorities: Identification of Strategic priorities – this would include areas that needed to be prioritised for closer focus by the Committee included where there was a clear need for identified service improvements
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. <strong>Access:</strong></td>
<td>How we improve access to all services for people with a disability, including communication, access to information and checking that our services and facilities are fit for purpose.</td>
</tr>
<tr>
<td>3. <strong>Reports:</strong></td>
<td>Reports coming to the Committee showed differences in approach by each DHB. Would coming together ensure better services can be provided by a coordinated approach?</td>
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<tr>
<td></td>
<td>Background papers had been prepared to inform the discussion, and these included:</td>
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<tr>
<td></td>
<td>- The Terms of Reference for the Committee</td>
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<td></td>
<td>- Briefing paper 1: Responding to the NZ Disability Strategy</td>
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<td></td>
<td>- Briefing paper 2: Services for Health of Older People; and;</td>
</tr>
<tr>
<td></td>
<td>- Briefing paper 3: Disability Support Services for people aged under 65</td>
</tr>
<tr>
<td>1. <strong>Identification of Strategic Priorities for the Committee</strong></td>
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<tr>
<td></td>
<td>- <strong>Mental Health of Older people</strong></td>
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<tr>
<td></td>
<td>Mental Health was thought to be an important issue impacting Older People, and was considered to be an area that was often overlooked. It was agreed that this should be a new area of focus.</td>
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<tr>
<td></td>
<td>- <strong>Dementia pathway</strong></td>
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<td></td>
<td>The development of a regional dementia pathway was a key output of the Northern regional health plan, and because of the increasing prevalence of dementia in our population, it was agreed that this should be monitored by the Committee</td>
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<td></td>
<td>- <strong>Home Based Support Services</strong></td>
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<td></td>
<td>There is significant national and local activity currently in this area, with differing approaches currently being offered by ADHB and WDHB. The Committee are very interested in understanding more about the differences with a view to advocating for a more common approach where appropriate.</td>
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<tr>
<td></td>
<td>- <strong>Aged Residential Care, monitoring of quality of facilities and the associated audit and compliance programme.</strong></td>
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<td></td>
<td>The very public nature of the quality concerns surrounding Aged Residential Care makes this a key area of ongoing monitoring and focus for the committee. Specifically it was requested that more information is provided in regards to the type and level of audit and quality assurance that currently goes on across the sector by the various agencies involved.</td>
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<tr>
<td></td>
<td>- <strong>Implementation of the Northern Region Health Plan</strong></td>
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<td></td>
<td>Progress relating to the development and implementation of this should be a standing item on the agenda given the priority for closer regional working and the Committee’s role across both ADHB and WDHB</td>
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<td></td>
<td>- <strong>Disability related aspects of the DHB Annual Plans</strong></td>
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<td>Ongoing monitoring of key deliverables in the form of regular reports to the committee</td>
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<tr>
<td>2. <strong>Improving Access for the Disabled Community</strong></td>
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<td></td>
<td>- <strong>ADHB Accessibility Review</strong></td>
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<td></td>
<td>A regular report on the prioritisation and implementation of the recommendations within this report will be provided to the Committee, and as part of this key areas for conjoint work across both DHB’s will be identified</td>
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<tr>
<td></td>
<td>- <strong>Universal accessibility for carers</strong></td>
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<td></td>
<td>Currently there are significant issues for carers of both children and adults with impairments, and this Committee has a key role in continuing to advocate for improvements in this area</td>
</tr>
</tbody>
</table>
- **Funding boundaries**
  Funding boundaries continues to be an issue for both DHB’s with the majority of Disability funding being maintained by the Ministry of Health, with inequitable access to services for this group than those who are funding by District health Boards. There is currently a piece meal approach to devolution of funds and responsibility, with the Long Term Chronic Health Conditions group recently being devolved. This is continuing to provide significant challenges for both boards in terms of service delivery and financial exposure.

- **Cultural and attitudinal shifts required**
  This is a key role of the committee in terms of advocating for change

- **Physical infrastructure environment.**
  As well as attitudinal shift, the committee will continue to be updated on any environmental design when it comes to capital expenditure and new developments across both sites, such as the new car parks and the major capital development currently planned at North Shore Hospital

- **Respite and transitional care for disabled youth**
  This is a historical access issue where the Committee will support Management to negotiate a more acceptable level of access for children and youth

### 3. Reports
- Similarities and differences between the DHBs
- Aligned format.
- Tables and illustrations
- Case studies
- More interpretation and analysis
- Highlighting of the differences in the DHBs' approaches and performances
- Unmet need
IMPROVEMENT ACTIVITIES

9.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs

9.2 Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs
9.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs
HEALTH OF OLDER PEOPLE QUARTERLY REPORT ON ACTIVITIES IN AUCKLAND & WAITEMATA DHBS

Recommendation:

That the report is received.

Prepared by: Katrina Lenzie-Smith (Programme Manager Health of Older People) and Kate Sladden (Funding and Development Manager Health of Older People)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

DHB – District Health Board
HCSS – Home and Community Support Services
LTS-CHC – Long Term Support for Chronic Health Conditions
VfM - Value for Money

1. Purpose

The purpose of this report is to provide an update to DISAC on the progress and activities occurring across both DHBs. Material is provided across both Boards where appropriate, and for specific Boards as outlined.

2. Background

Health of Older People (HOP) services are directed by the Minister of Health, the 2013/14 Northern Region Health Plan, (NRHP), Waitemata and Auckland District Annual Plans, and the Māori Health Plan. The 2013/14 Annual Plans were approved by the Ministry of Health and are now being implemented to ensure that we address the key service development needs of the over 65 age group. This includes planning for growth in demand for dementia and acute services; strengthening coordination and delivery of whole of system care by enhancing cooperation with primary, community and Age Related Residential Care (ARRC) sectors, and providing informed choice for older people in their care to minimise dependence.

3. The Northern Region Health Plan (NRHP)

The HOP Clinical Network has commenced the new financial year with the review and subsequent updating of their Terms of Reference, and successful recruitment to the new membership roles for Consumer and Maori Representatives.

The Transfer of Clinical Information (aka Yellow Envelope) Project has closed out following a very positive post-implementation evaluation conducted by First, Do No Harm (FDNH). A debrief session and small celebration was held with key DHB stakeholders. This initiative can be regarded as an example of successful regional collaboration, not only across all four DHBs but also with the Aged Residential Care sector and St John Ambulance Service.
Development and piloting of Dementia Care Pathways continues in all the DHBs. CMDHB now has approximately 40 people enrolled in their pilot. The other three DHBs are taking slightly different but complementary approaches to pathway development. Waitemata DHB is the next cab off the rank to trial their pathway with primary care in November.

The Northern Region Psycho-Geriatric (PG) Bed Review kicked off three weeks ago. The Terms of Reference and project plan have been agreed. A communiqué has been prepared and distributed to key leaders in the DHBs (Mental Health/HOP) and the two ARRC providers of PG beds (Bupa & Radius). A census of beds has been undertaken, individual DHB policies examined, and 10 cases per DHB are now being analysed. The review is due for completion in February.

Focus is being applied to increase the number of ARRC providers participating in the Northern Region falls and pressure injury reduction initiatives led by First, Do No Harm and the Health Quality & Safety Commission. Feedback is that provision of an electronic means for data submission and automatic reporting, could be a key incentive for ARRC providers to participate.

A Northern Region “data warehouse” has now been set up which will enable reporting on interRAI – this is a major step forward. Meanwhile, clinical and business reporting specifications are still being developed at regional and DHB level.

An initiative which has not been explicitly identified in the project plan but which will provide benefits over a number of workstreams, is the e-Referral Project. This is being rolled out across the metropolitan DHBs. Northland DHB has been operating this process for several years and the other DHBs have been keen to learn from their experience and keep the primary care interface simple and standard across boundaries where possible.

A baseline of 12.9% has been established for the new KPI, “Reduction in patients aged 75+ readmitted within 28 days”. Reporting will commence next quarter.

4. **Home and Community Sector Services (HCSS)**

**Home and Community Support Sector Standards**

All DHB contracted providers were required to achieve compliance against NZS8158:2012 by 1 September 2013. All providers have achieved this except for one very small provider in ADHB area that the DHB is working with. The new standards include enhanced requirements for staff training as per standard 3.2 “Consumers receive services from service providers who are trained and assessed as competent to provide services”. To meet these standards providers have training programmes to increase the percentage of staff that has achieved level 2 and 3 qualifications.

4.1 **Auckland DHB**

Auckland DHB has Home and Community Sector Services based on the restorative model of care. A case mix model is used to cluster client need and associated payment for client need on this basis. Over the last year there has been a significant shift in the complexity of clients from when the original complex classifications were undertaken in 2012. The table below illustrates this shift (C1 patients are low complex and C8 are high complex).
## HCSS Complex Clients

<table>
<thead>
<tr>
<th>Client Clusters</th>
<th>August 2013</th>
<th>May 2012</th>
<th>May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>18%</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>C2</td>
<td>6%</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>C3</td>
<td>1%</td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>C4</td>
<td>3%</td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>C5</td>
<td>3%</td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>C6</td>
<td>27%</td>
<td>70%</td>
<td>17%</td>
</tr>
<tr>
<td>C7</td>
<td>20%</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>C8</td>
<td>23%</td>
<td></td>
<td>13%</td>
</tr>
</tbody>
</table>

In May 2012, 55% of clients were classified C6-C8 and this shifted to 70% in August 2013. The shift in complexity has funding implications due to the higher daily rates applied to categories C6-C8. Auckland DHB is embarking on a process to review its cost model to support the increasing complexity of clients but remain within the budgeted funding for HCSS. However, this shift could be considered an indication that the model is being successful in enabling older people to remain living in their own homes rather than entering residential care particularly for rest home level care.

### 4.2 Waitemata DHB

**Re-Design of Home Based Support Services**

During May 2013 Waitemata DHB undertook a consultation process whereby it signalled to its population and the range of health and social service providers that the DHB was planning to review its purchase and provision of Home Based Support Services (HBSS). The feedback from the May 2013 consultation identified general support for the proposed home based support shift from ‘doing things for patients’ to ‘assisting patients to maximise their independence and prevent or slow deterioration’. It was acknowledged that making these changes to a model of care that has been largely unchanged for 10 years will need to be phased and include open communication with all stakeholders, and most especially the patients and their carers.

An update of progress will be provided at the meeting.

### Changes to Home Based Support Service Providers

Te Whanau O Waipareira Trust decided to exit their contract for providing HBSS in October 2013. Their 16 current clients had their needs and service allocation reassessed / reviewed by NASC prior to transferring to a new provider. The transfer process went smoothly and all clients choose to transfer to Te Rununga O Ngati Whatua.

Northlink Health was purchased by Geneva in October and is now known as Geneva Northlink Health. All existing staff and service provision has transferred to the new company.

Howick Baptist Healthcare is being purchased by Access HomeHealth in November. All existing staff and service provision will transfer to the new company.
5. **Dementia Care Pathway**

5.1 **Auckland DHB**
A co-design methodology comprising workshops and interviews with people with dementia, carers and services providers have been undertaken. The project team now has a comprehensive view of the issues, barriers and potential solutions required to develop a person centered model of care.

Through the consultation phase the areas that were identified as most important to people with dementia and their carers were:

- Diagnosis and early intervention - delays to diagnosis are very distressing and disorientating.
- Information and communication – information is variable and difficult to access.
- Integration of services – lack of coordination and integration between and within services. People with dementia and their carers want to know that there is a plan in place and that everybody involved is on the same page.
- Support - people with dementia and their carers want to be able to keep doing the simple things that they enjoy. People with dementia feel like a burden and struggle to find ways to give their life meaning, they often feel locked into a world that they dislike. Carers often want to provide care but recognise that they need a break from time to time; their stress levels can be very high.
- Infrastructure/enablers - currently information is collected and stored in disparate systems. There are significant opportunities to improve efficiency by having a ‘once only’ approach to assessment and storage of information into systems that interface.

Using the information gained through the consultation phase the project team have identified five workstreams, which are currently being established:

- Peer support, carer assessment and carer information - this workstream will focus on the day to day information and support needs that people with dementia and carers require and on proactively identifying the support needs of carers who are critical to enabling ongoing home based care.
- Diagnostic process, shared care, information services and integration of agencies - this workstream will focus on the integration and alignment of all of the various agencies and services involved.
- Comprehensive suite of support services - this workstream will focus on the identification and development of community based services to ensure they meet the needs of people with dementia and carers e.g. respite care, day programmes, home based support etc.
- Worker competencies - this workstream will focus on the base competency requirements of all staff involved with clear accountabilities for each so that care is provided efficiently and effectively by those with the appropriate skills.

5.2 **Waitemata DHB**
The Waitemata DHB Cognitive Impairment Clinical Pathway went live on 4 November 2013 as planned. The 12 GPS (6 per PHO) and their Practice Nurses participated in two pre-pilot training evenings facilitated by secondary care clinicians in October.

Each GP is to case-find 3 patients with undiagnosed dementia and 2 with undiagnosed mild cognitive impairment and with the consent of the patient and their carer / partner trial the Pathway. There will be action research meetings every 6 - 8 weeks, across the duration of the
9 month pilot, between the secondary care clinicians and pilot GPs and practice nurses to identify what’s working / what is not working / what will be changed and trialled for the next 6 - 8 week period. The aim is by the end of the 9 month pilot we will have developed a pathway that is appropriate for all key stakeholder groups and is sustainable to be rolled out to the 300 GPs of Waitemata DHB district. The University of Auckland, Department of Geriatric Medicine is evaluating the pilot.

6. **Aged Related Residential Care**

From November, the Ministry of Health will trial a new system giving people access to full rest home audit reports, in addition to the audit summaries already available on its website.

People will be able to see if a rest home has any current problems and what is being done to fix them. Historical audit summaries going back to 2009 will also be published so people can see what progress has been made and if there are any ongoing issues.

The Herald is running a week long feature to coincide with the release of the audits and this is likely to feature facilities from both DHBs.

6.1 **Auckland DHB**

Auckland DHB terminated its contract with Rossmore Rest Home on 30 September 2013. The DHB took this action as the facility was an old villa requiring a high level of maintenance work and resident numbers had declined making the facility no longer viable. Meetings were held with all residents and their families and the transfer to new facilities was a smooth process.

The specialist team had 450 consultations with aged residential care over the last quarter. Key reasons for these consults included: interim care case management; care planning follow up; skin care guidance; pressure injury advice; complex discharge from Auckland Hospital check ups; assessments from rest home to private hospital level of care.

A study day was attended by 159 health care assistants from ARRC. Topics covered were: medication management; diabetes update; infection prevention and management; safer handling and moving; and seeing the person i.e. including the person not talking and working around them.

Thirty (44%) of Auckland DHB ARRC facilities are engaged with interRAI training as follows: eight are fully competent (required number of nurses trained)
- 14 are competent (at least one nurse trained)
- eight have signed an engagement agreement(to commence training before December 2014).

6.2 **Waitemata DHB**

The 60 ARRC facilities have the opportunity to meet in two forums (the quality forum for managers and owners) and the Residential Aged Care Integration Programme (RACIP) work group.

The RACIP work group meets bi-monthly, it’s members are: managers and clinicians from aged care facilities, Gerontology Nurse Specialists (GNS), Funding and Planning Quality Nurse Leader and experts in the field: Alzheimer’s society, Hospice. The purpose of this group is networking, informing practice and developing clinical guidelines.
**Current project:** development of booklet for family members of people with advanced and end-stage dementia living in residential care. The resource will support families to understand end stage dementia, advance care plans, appropriate and inappropriate interventions etc. It has been sent out for review to consumer groups including individuals from the public who have cared for parents with advanced dementia.

**Quarterly off site education:** August: Wound Care Products and Appropriate Use: 156 attendees.

**Onsite educations:** Topics are offered bimonthly. Facilities can choose to have an alternative or an extra topic according to need. Depression (Jun/Jul): Communication and Person-Centred Care (Aug/Sept): Other topics including male catheterisation: A total of 1114 RNs and Caregivers received education.

**Cluster groups:** These have been formed in response to the targets set by First Do No Harm to reduce Pressure Injuries and Falls by 20%. Facilities are encouraged to group together to support each other with quality improvements and data collection. There are three cluster groups up and running covering 19 facilities. Two more cluster groups are in the planning stage. A GNS supports each group as they start and is available when required.

**Onsite education:** Topics are offered bimonthly. Facilities can choose to have an alternative or an extra topic according to need.

Thirty (50%) of Waitemata DHB ARRC facilities are engaged with interRAI training as follows:
- one is fully competent (required number of nurses trained)
- 12 are competent (at least one nurse trained)
- 17 have signed an engagement agreement (to commence training before December 2014).

7. **New Provider Regulation and Monitoring System**

Health Cert manages the regulatory mechanisms within the Ministry of Health to ensure hospitals, rest homes dementia and psycho-geriatric facilities provide safe and reasonable levels of care. In November 2013, HealthCert will be introducing a new information management system called the Provider Regulation and Monitoring System (PRMS).

The PRMS will:
- replace an outdated set of systems
- simplify and connect business processes
- allow for more certification audit data to be analysed and monitored to:
- identify how audit effectiveness and efficiencies can be improved
- Provide feedback to ARRC providers to encourage continuous improvement in the quality of care for residents.
8. **Long-Term Supports for Chronic Health Conditions**

Devolution of Long-Term Supports for Chronic Health Conditions (LTS CHC) from the MoH to DHBs occurred over two years ago in 2011. The Northern Region has put in place arrangements regionally to oversee and report on LTS CHC.

**Key achievements in the first quarter of 2013/14 include:**

- Ongoing work in developing and implementing the LTS CHC model of care for the following service groups:
  - children
  - mental health support services
  - dementia and other significant cognitive impairments
  - age generational appropriate service options
  - rehabilitation.

- Ongoing work to establish regionally consistent assessments, standard tools and regionally practiced principals and policies includes:
  - bimonthly LTS CHC Regional Review Panel meetings to review and monitor clients with an annual service package of $80k or more.
  - monthly meeting with Taikura Trust to discuss clients with unclear eligibility and joint funding opportunities.
  - ongoing peer review with Midland region to compare assessment outcomes and service utilisation
  - LTS CHC and HoP have obtained an agreement with InterRAI to download the region’s data to Health Alliance so NRA can access the data to develop LTS CHC KPI reports to profile client base and utilisation.

- A procurement strategy for LTS CHC has been developed based that:
  - identifies LTS CHC service gaps requiring an Expression of Interest (EOI).
  - supports negotiations with MoH DSS to enable contract variations for LTS CHC similar clients to access contracts that are not available/ viable with LTS CHC.
  - With the region’s support DHB Shared Services is in the process of implementing a National LTS CHC and DSS Resolution Panel. A resolution panel will provide better clarity between LTS CHC and DSS criteria, review funding stream eligibility for unclear complex high cost clients and conduct robust decision making that will establish national precedents.
  - A high cost client (approximately $1m per annum service package) has been accepted by ACC and LTS CHC has received reimbursement of all reasonable costs incurred by LTS CHC.

**Key issues for LTS-CHC:**

- Based on actual utilisation the region’s LTS CHC deficit has been determined to be $1.01 million for 2012/13 based on the MoH’s historical funding model. The risk share model has calculated apportionment based on each DHB’s population based funding formula (PBFF) share. The deficit is expected to be higher in 2013/14 as the MoH funding envelope transitions to PBFF.
9.2 Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs
Date | 20 November 2013
---|---
To | Auckland and Waitemata DHBs - DiSAC Committee
From | Debbie Holdsworth, Director of Funding, WDHB & ADHB
| Sue Waters, ADHB Executive Director Allied Health, Scientific & Technical
Author | Samantha Dalwood, Disability Strategy Coordinator, WDHB
Functional Group | Auckland and Waitemata DHB Funding and Planning Managers
Subject | DiSAC Update Report on the implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs

**Purpose**

The purpose of this report is to provide an update to DiSAC on the progress and activities occurring across both DHBs to implement the NZ Disability Strategy. Material is provided across both Boards where appropriate, and for specific Boards as outlined.

**Recommendation**

*That the report be received by DiSAC.*

**NZ Disability Strategy Implementation Plan 2013-2016**

The joint Waitemata DHB/ADHB Implementation Plan 2013-2016 progress report is attached in Appendix I.

**2013-2016 Disability Strategy Implementation Plan**

**Facilities Work**

Since the August DiSAC Meeting, the Disability Coordinator has met with the ADHB Facilities Team to discuss access. A review of the toilet on Level 6 at Starship Hospital has been completed and changes are being made to ensure accessibility. The audit of all ADHB toilets has started and changes will be made once this has been completed. At the meeting with the ADHB Facilities Team we discussed universal design principles, Barrier Free standards and the New Zealand Standard 4121. A review of 4121 has just started and should mean better access for everyone. The ADHB Facilities Team has agreed to involve the Disability Coordinator in all their projects.

**Presentation at Dietitian Conference**

The Disability Strategy Coordinator presented at the NZ Dietitians Conference held in Auckland in September. The paper was entitled ‘For Want of a Straw: Nutrition and Hydration for People with Disabilities’ in a health setting. The paper was well received and some good discussion followed.

The presentation is attached in Appendix II.
Waitemata Health Excellence Awards
As mentioned in the August DiSAC paper, the Disability Coordinator has entered this piece of work for the Waitemata Health Excellence Awards as an example of inclusion. It is titled ‘Finding Your Way in Elective Surgery Unit’. The Health Excellence Awards take place on 7 November and we will know then how the poster was received by our peers.

With collaboration, good will and the inclusion of consumers in the process we ended up with consistent, accessible signage throughout the building. We had clear guidelines around which signs should be translated into Maori and have promoted the use of international symbols where possible. Having a consumer voice built into the process does not cost more money or take any more time but adds so much value. The Elective Surgery Centre signage is ‘by the people, for the people’ and embraces the Waitemata DHB values of Connected and Everyone Matters.

Attached in Appendix III.

Disability Champions
ADHB and Waitemata DHB will have slightly different role descriptions depending on how the role fits within each DHB; these role descriptions are currently being developed. Both DHBs will continue to promote the role and attract interest across the DHBs. The aim is that the Champions will be from a diverse range of services and experience. The Waitemata DHB Disability Coordinator is currently talking to Waitemata DHB ward staff about how they see the role and what would be useful to them.

Contact Centre Consultation
The Contact Centre consultation generated a huge amount of feedback, including a number of submissions about the challenges of an AVR (automatic voice recognition) system. A separate work stream has been set up to review this.

Appendix I: Joint Waitemata DHB/ADHB Disability Strategy Implementation Plan 2013-2016 progress report
Appendix II: For Want of a Straw – presentation at the Dietitians NZ Conference
Appendix III: Poster entered for the Waitemata Health Excellence Awards
Waitemata DHB and Auckland DHB
Implementation of the New Zealand Disability Strategy 2013-2016
Current Status at 1 November 2013
<table>
<thead>
<tr>
<th><strong>What</strong> we will do... actions</th>
<th><strong>Where</strong> we are now...current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible Communication guidelines developed.</td>
<td>July 2013 - Communications Teams have received the Office for Disability Accessible Communications Guidelines for information.</td>
</tr>
<tr>
<td>Review of Web content and presentation.</td>
<td>Oct 2013 – Met with WDHB Communication Manager to look at specific access issues to the website and overall look.</td>
</tr>
<tr>
<td>Increase formats of key documents, e.g. Strategic Plans.</td>
<td>Oct 2013 – Met with WDHB Communication Manager to discuss the importance of other formats being considered and included where possible.</td>
</tr>
<tr>
<td>Review the automated telephone system with regard to access for people with disabilities.</td>
<td>Oct 2013 – Contact Centre consultation generated a huge amount of feedback, including a number of submissions about the challenges of an AVR (automatic voice recognition) system. A separate work stream has been set up to review this.</td>
</tr>
<tr>
<td>Review the possibility of improved text communication to patients.</td>
<td>July 2013 – Gave feedback around better support for disabled, particularly deaf, people accessing information via the telephone into the Contact Centre consultation.</td>
</tr>
<tr>
<td>Continue the implementation of the Health Passport across both DHBs.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Work with the Deaf community to improve access to interpreters.</td>
<td></td>
</tr>
<tr>
<td>Encourage the use of interpreters for non-English speaking families.</td>
<td>Working with Asian Health to look at the use of interpreters for disabled people and their families.</td>
</tr>
<tr>
<td><strong>What</strong> we will do... actions</td>
<td><strong>Where</strong> we are now...current status</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.</td>
<td>Sept/Oct 2013 - CCS Disability Action have set up a Health &amp; Wellness Group for disabled people to discuss issues around the health system, but also about keeping well. The Disability Coordinator is part of this group.</td>
</tr>
<tr>
<td>Ensure the voice of people with learning/intellectual disabilities, particularly people with high/complex needs, is included in consumer reviews of service planning and development.</td>
<td>Oct 2013 – Review of Waitakere ED. Review agreed to consider a suitable waiting area for people that prefer somewhere quieter to wait.</td>
</tr>
<tr>
<td>Continue working with Health Links to increase health literacy through fully accessible patient information.</td>
<td>Ongoing work. Cancer and Blood Service in ADHB has begun a 'Patient Engagement and Information' working group to increase health literacy among their patients and ensure person-centred patient engagement and education. One of the ADHB Disability Champions is on the steering group.</td>
</tr>
<tr>
<td><strong>What</strong> we will do... actions</td>
<td><strong>Where</strong> we are now...current status</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Encourage the use of supported employment agencies.</td>
<td></td>
</tr>
<tr>
<td>Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.</td>
<td></td>
</tr>
<tr>
<td>Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).</td>
<td>In the staff management system, staff can now tick a box to say that they identify as having an impairment and can add information about this impairment. This means that we are starting to collect data on the number of staff with impairments.</td>
</tr>
<tr>
<td>Work with Hiring Managers to increase disability awareness.</td>
<td>August 2013 - Reviewing the current Recruitment and Retention of Staff with Disabilities / Impairments Guidelines.</td>
</tr>
<tr>
<td>Working with HR to look at how the DHBs support staff with Carer responsibilities.</td>
<td>Working with HR and Carers NZ to develop initiatives to become a CareAware workplace. CareAware is a national initiative from Australia to support organizations to become carer friendly workplaces.</td>
</tr>
<tr>
<td><strong>What</strong> we will do... actions</td>
<td><strong>Where</strong> we are now...current status</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Work with Dieticians to improve the nutritional outcomes for disabled patients.</td>
<td>Sept 2013 - Disability Coordinator presented a paper at the NZ Dietitians Conference called ‘For want of a straw: Nutrition and Hydration for People with Disabilities in a Health Setting’ (attached).</td>
</tr>
<tr>
<td>Develop ‘Disability Champion’ roles across the DHBs.</td>
<td>Oct 2013 - ADHB and WDHB will have slightly different role descriptions depending on how the role fits within each DHB. These role descriptions are currently being developed. Both DHBs will continue to promote the role and attract interest across the DHBs. The aim is that the Champions will be from a diverse range of services and experience. The WDHB Disability Coordinator is currently talking to WDHB ward staff about how they see the role and what would be useful to them.</td>
</tr>
<tr>
<td>Promote the Disability Awareness e-learning module to all staff across the DHBs.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Develop tools to increase staff skills for working with people with communication difficulties.</td>
<td>Oct 2013 – Working with the WDHB SLTs to get information around accessible communication across the DHBs.</td>
</tr>
<tr>
<td>Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.</td>
<td>Sept 2013 - ADHB Oncology Reception Oct 2013 – Review of Waitakere ED. Met with project manager and discussed the need to include a waiting area that supports people with ASD.</td>
</tr>
</tbody>
</table>
**What** we will do... actions

| Where we are now...current status                                                                                                                                                                                                 |
|---|---|
| **Encourage the use of symbols and pictograms in signage and way finding.** | Oct 2013 - Elective Surgery Centre inclusive signage work entered as part of the Waitemata Health Excellence Awards. This showcases the work that has been done and how successful collaborative working can be. |
| **ADHB Disability Champions will complete the 2-day Barrier Free Training.** | Oct 2013 – Disability Strategy Coordinator is being included in all ADHB Facilities projects. |
| **An accredited Barrier Free Advisor will be involved in all new Facilities work.** | Oct 2013 – met with Allan Johns, ADHB Facilities Manager. And the ADHB Facilities Team to discuss what this means and what my expectations are. |
| **Adoption of Universal Design principles in all Facilities work.** | Oct 2013 – met with Allan Johns, ADHB Facilities Manager, and the ADHB Facilities Team to discuss this. Government Standard 4121 is currently being reviewed so this may have some impact. |
| **Building standards document developed in ADHB.** | Oct 2013 – this work has been started by the ADHB Facilities Team. They are reviewing all toilets across the DHB and ranking them using clear criteria. This will influence the order the work is done. |
| **A review of accessible toilets in ADHB buildings to be completed.** | Oct 2013 – 40 wheelchairs have been delivered to Waitemata DHB. Hospital Operations are clarifying how many have gone to which areas of the hospitals. |
| **Work with Auckland Transport to improve accessible transport between hospital sites.** |  |
| **Investigate the reported shortage of wheelchairs available - both numbers and sizes.** |  |
For Want of a Straw
Nutrition and Disabled People in Hospital

Samantha Dalwood
Disability Advisor
For Want of a Nail

For want of a nail the shoe was lost.
For want of a shoe the horse was lost.
For want of a horse the rider was lost.
For want of a rider the message was lost.
For want of a message the battle was lost.
For want of a battle the kingdom was lost.
And all for the want of a horseshoe nail.
Real Experiences

“Support staff bring in meals and put the meal on the patient’s table but do not wake the patient or tell the patient who cannot move or see that their meal has arrived.”

Real Experiences

“Sometimes I didn’t even know the menu had been put near the end of my bed ...... so I ended up getting what someone else chose for my meals. I was really angry about this......”

Real Experiences

“Nurses would leave food, but did not seem to realise that without help she couldn’t eat it.”

From HDC summary report of an independent review, commentary and recommendations, 2009.
Human Rights

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was signed by New Zealand on 30 March 2007, and ratified on 26 September 2008.

Article 10 - Right to life
States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.
Human Rights

Article 25: Right to Health

• Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

• Section f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.
Breach of Human Rights

If someone is not receiving food and/or fluids as a direct result of their disability, their human rights are being breached.
Patient Focused Nutrition & Hydration Audit

- July 2013
- 257 in Waitemata DHB – 122 M, 135 F
- Dieticians interviewed inpatients after a meal
- Breakfast 85, Lunch 84, Supper 88
- 72 people had a cognitive and/or physical impairment, 50 people had a sensory impairment.
## Patient Focused Nutrition & Hydration Audit

### Key findings –

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the patient prepared for a meal?</td>
<td>162</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Are protected meal times observed on the ward?</td>
<td>31</td>
<td>221</td>
<td></td>
</tr>
<tr>
<td>Was the patient interrupted during the meal time?</td>
<td>102</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>Was the patient able to eat the meal unassisted?</td>
<td>216</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>If patient required help, did they receive it?</td>
<td>33</td>
<td>9</td>
<td>210</td>
</tr>
<tr>
<td>Did the patient require support in opening lids, portion pack items etc?</td>
<td>48</td>
<td>156</td>
<td>48</td>
</tr>
</tbody>
</table>

### Patient comments

- Difficult to open milk and soups. Cutlery and tray placed too far away
- Milk lids too hard to open, you have to stab it with a fork
- Butter and milk containers too hard to open, I always need assistance
### Patient Focused Nutrition & Hydration Audit

#### Key findings (cont.)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>If patient required help in opening lids etc did they receive it?</td>
<td>40</td>
<td>12</td>
<td>199</td>
</tr>
<tr>
<td>Did the patient require adaptive equipment for eating &amp; drinking?</td>
<td>6</td>
<td>188</td>
<td>58</td>
</tr>
<tr>
<td>If required, was it available?</td>
<td>3</td>
<td>4</td>
<td>245</td>
</tr>
<tr>
<td>If available, was it used?</td>
<td>3</td>
<td>1</td>
<td>248</td>
</tr>
</tbody>
</table>

“Sandwiches seem to be very large and difficult to eat.”

“I would prefer cut up fruit. One whole item is difficult to eat.”

“Cutlery and tray placed too far away.”

“Meal placed on tray table out of reach of partially sighted patient.”

Patient comments
What can make a difference?

• Health Passport
• Positive Eating Environment
• Practical Support
• Staff Training
Health Passport

• The Health Passport is a patient owned communication tool.

• Page 9 - Eating and Drinking for patient to list supports needed.

• “B relies on staff to supply all food and fluid. He currently has a quite good appetite. Staff sit with B when he is eating or drinking. He will often push food away if he is not interested, but if left beside him sometimes he eventually eats it.”
Positive Eating Environment

Protected Mealtimes Initiative

Key aspects:

• Making sure people are ready to eat
• Making sure the environment encourages eating
• Providing assistance
• Observation
• Monitoring/Assessment
Practical Support

- specialist crockery, cutlery
- presentation
- the eating environment
- physical position
- availability (snacks)
- company
- choice
- dignity and respect
- support and encouragement
- oral health
Staff Training

• Disability Awareness training
• Waitemata DHB, Auckland DHB and Northland DHB have an e-learning training.
• The training focuses on attitude to and communication with people with disabilities.
Key Points when working with disabled people

• Be aware of any negative attitudes you may have.
• Ensure access for people with all types of impairment.
• Ask people if they need assistance and the best way to help.
• Make sure that you communicate in the best possible way.
• Remember that different cultures have different perspectives on disability.
• Always treat people disabled people with dignity and respect.
• If in doubt, ask the person.
Contact Details

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Disability Advisor
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(09) 442 3289
021 221 7810
samantha.dalwood@waitematadhb.govt.nz
WHAT WE DID:

→ We used international symbols where possible
→ Translated key consumer touch points into Maori
→ Worked through the plans, to draft positioning and need for signs at decision points
→ Identified the wording and symbol for each sign
→ Reviewed the positioning, visibility and wording on proposed signs
→ Visited the site to walk through proposal on each floor
→ Once the signs where in place, we walked through with key staff and consumers

LAST WORD:

Most importantly, good way finding design promotes healing because being able to understand their environment provides visitors with a sense of control and empowerment, key factors in reducing stress, anxiety and fear – feelings that undermine the body’s ability to heal.

(Passini and Arthur, 1992)
10

CONFIRM

10.1 Action Points for next DSAC Meeting

10.2 DSAC Feedback to Board
GENERAL BUSINESS