Disability Support Advisory Committee Meeting

Wednesday 4 June 2014
1.30pm

Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare
Disability Support Advisory Committee
4 June 2014

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

Time: 1.30pm

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<thead>
<tr>
<th>ADHB and WDHB Members</th>
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<tr>
<td>Sandra Coney (Chair)</td>
<td>Dr Dale Bramley</td>
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<tr>
<td>Jan Moss</td>
<td>Chief Executive Officer Waitakere District Health Board</td>
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<td>Max Abbott</td>
<td>Ailsa Claire</td>
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<td>Jo Agnew</td>
<td>Chief Executive Auckland District Health Board</td>
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<td>Dr Marie Hull-Brown</td>
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<td>Daire Kirton</td>
<td>Director Funding – Auckland and Waitakere District Health Boards</td>
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<td>Dr Lester Levy</td>
<td>Katrina Lenzie-Smith</td>
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<td>Robyn Northey</td>
<td>Programme Manager, Health of Older People</td>
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<td>Russell Vickery</td>
<td>Marty Rogers</td>
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<td>Maori Health Gain Manager</td>
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<td>Kate Sladden</td>
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<td>Funding and Development Manager, Health of Older People</td>
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<td>Funding and Development Manager, Primary Care</td>
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<td>Marlene Skelton</td>
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<td>Corporate Business Manager</td>
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<td>Sue Waters</td>
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<td>Chief Health Professions Officer</td>
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</table>

Other staff members who attend for a particular item are named at the start of the minute for that item

Apologies Members: Max Abbot

Apologies Staff: Tim Wood, Dale Bramley, Marty Rogers

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

1.30pm 1 ATTENDANCE AND APOLOGIES
2 CONFLICTS OF INTEREST
1:40pm 3 CONFIRMATION OF MINUTES 12 MARCH 2014
1:45pm 4 ACTION POINTS 12 MARCH 2014
1:50pm 5 CHAIRPERSON’S REPORT
2:00pm 6 PRESENTATION
   6.1 Delivery of Respite Care – Estelle Muller
2:30pm 7 IMPROVEMENT ACTIVITIES

Auckland and Waitakere District Health Boards
Disability Support Advisory Committee 4 June 2014
7.1 Health of Older People – Quarterly Report on Activities in Auckland and Waitemata
7.2 Implementation of the New Zealand Disability Strategy 2013-2016

3:00pm 8 PAPERS
8.1 Auckland DHB Accessibility Report Update
8.2 Accessibility of Information for People with Disabilities

3:30pm 9 CONFIRM
9.1 Action Points for next DSAC Meeting
9.2 DSAC feedback to CPAC
9.3 DSAC feedback to Board

10 GENERAL BUSINESS

<table>
<thead>
<tr>
<th>Next Meeting</th>
<th>Wednesday 27 August 2014 at 1.00pm</th>
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<tbody>
<tr>
<td></td>
<td>Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland</td>
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Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare
## Attendance at Disability Support Advisory Committee

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<td>Sandra Coney (Chair) (WDHB)</td>
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<td>Jo Agnew (Deputy Chair) (ADHB)</td>
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<td>Max Abbott (WDHB)</td>
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<td>Judith Bassett (ADHB)</td>
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<td>Pat Booth (WDHB)</td>
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<td>Dr Marie Hull-Booth (Appointed)</td>
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<td>Dairne Kirton (Appointed)</td>
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<td>Lester Levy (Ex-officio) (ADHB/WDHB)</td>
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<td>Jan Moss (Appointed)</td>
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<td>Robyn Northey (ADHB)</td>
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<td>Russell Vickey (Appointed)</td>
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# leave of absence
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 – Disability Support Advisory Committee

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Organisation</th>
<th>Latest Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra CONEY (Chair)</td>
<td>Chair – Waitakere Ranges Local Board, Auckland Council</td>
<td>12 Dec 2013</td>
</tr>
</tbody>
</table>
| Jo AGNEW (Deputy Chair) | Professional Teaching Fellow - School of Nursing, Auckland University  
Appointed trustee Starship Foundation  
Casual Staff Nurse - ADHB | 1 Mar 2014       |
| Max ABBOTT           | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology  
Patron - Raeburn House  
Board Member - Health Workforce New Zealand  
Board Member - AUT Millennium Ownership Trust  
Chair - Social Services Online Trust  
Board Member - The Rotary National Science and Technology Trust | 28 Sept 2011 |
| Judith BASSETT       | Shareholder – Fisher and Paykel Healthcare  
Shareholder – Westpac Banking Corporation | 27 May 2014       |
| Pat BOOTH            | Consulting Editor - Fairfax Suburban Papers in Auckland                                           | 24 June 2009       |
| Lester LEVY (Ex-officio) | Chairman - Waitakere District Health Board  
Chairman - Auckland Transport  
Independent Chairman - Tonkin & Taylor  
Deputy Chairman – Health Benefits Ltd  
Chief Executive - New Zealand Leadership Institute  
Professor (Adjunct) of Leadership - University of Auckland Business School  
Trustee of the Well Foundation (ex-officio member as Waitakere DHB Chairman) | 25 Mar 2014 |
| Robyn NORTHEY        | Self-employed Contractor - Project management, service review, planning etc.  
Board Member - Hope Foundation  
Trustee - A+ Charitable Trust | 20 June 2012       |
| Maria HULL-BROWN     | Employee - Mental Health Foundation of NZ                                                        | 25 Mar 2014       |
| Dairne KIRTON        | Northern Regional Representative - CCS Disability Action National Board  
Grants Committee Member – Variety the Children’s Charity | 25 Mar 2014       |
| Jan MOSS             | Co-ordinator - Complex Carer Group  
Board Member YES Disability Centre, Albany  
Member - SSOAS Stakeholders Group, WDHB  
Reference Group Member - MOH Disability Workforce NZ & Choices in Community Living | 25 Mar 2014 |
| Russell VICKERY      | None declared                                                                                   | 12 Mar 2014       |
Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 12 March 2014 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak commencing at 1:00pm

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<td>Michele Cavanagh</td>
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<td>Russell Vickery</td>
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1 Attendance and Apologies

Apologies were received from Max Abbot and Dr Lester Levy and from staff, Dr Dale Bramley, Chief Executive Officer Waitemata District Health Board, Ailsa Claire, Chief Executive Auckland District Health Board, Dr Debbie Holdsworth, Director Funding – Auckland and Waitemata District Health Boards, Sue Waters, Chief Health Professions Officer and Tim Wood, Funding and Development Manager, Primary Care.

2 Conflicts of Interest

Jo Agnew advised that the register of interests should be amended to reflect her appointment to the Starship foundation.

There were no declarations of conflicts of interest for any other items on the agenda.

3 Confirmation of Minutes 20 November 2013 (Pages 3 – 8)

Resolution: Moved Sandra Coney/Seconded Marie Hull-Brown

That the minutes of the Disability Support Advisory Committee meeting held on 20 November 2013 be confirmed as a true and correct record.

Carried
4 **Action Points 20 November 2013 (Page 11)**

It was noted that in terms of a joint meeting with other regional Disability Groups that the Corporate Business Manager was arranging a joint meeting with Counties Manukau District Health Board and Auckland Council. A date has yet to be agreed but it was likely that it would not coincide with a scheduled meeting of this Committee.

5 **Chairman’s Report (Page 13)**

**External Appointments to the Committee**

Sandra Coney thanked the four external appointees for agreeing to sit for another term and welcomed them back. She advised that the fifth vacancy had yet to be filled and asked the Committee members to consider areas where they felt additional expertise was required. Initial suggestions put forward were for someone with experience with vision impairment or hearing disability, or an adult with experience or strong interest in, or with a child with a disability.

It was agreed that the Corporate Business Manager email members calling for suggestions, names of individuals or organisations that could be approached so that the Chair could make a recommendation to the Chair of the DHBs.

**Putting People First Report**

Jan Moss advised that this report had been released prior to Christmas, was available online and had an introduction that had a strong emphasis on those with disabilities. It was a good framework, however, it did not go so far as to discuss funding required to support that framework.

It was agreed that the Corporate Business Manager provide the link to all members and that members read the document with a view to determining if there were issues that the committee could practically pursue. Those issues and ideas are to be forwarded to Sandra Coney to inform a work plan for the new term.

**Proactivity of the Committee**

It was agreed that the Committee needed to be more proactive and take advantage of the mechanisms allowed it for reporting through to other Committees and the Boards. Reports to the Committee need to be crafted to allow for this to occur and should not be considered to be merely for information of Committee members.

**Outstanding Issues for Future Report**

A discussion was had in regard to accessibility provisions and it was noted that it was unclear what Auckland District Health Board had achieved in this area.

It was agreed that Sue Waters, Chief Health Professions Officer, be asked to report on the progress made in implementing the recommendations from the Accessibility Report completed in 2011.
Actions

1. That the Corporate Business Manager email members calling for suggestions, names of individuals or organisations that could be approached so that the Chair could make a recommendation to the Chair of the Boards to fill the fifth external appointee vacancy.

2. That the Corporate Business Manager provide the link to the report *Putting People First* to all Committee members.

3. That the Corporate Business Manager advise report writers of the necessity of ensuring issues are reported on in such a way that the Committee can make recommendations to other Committees and the Boards.

4. That Sue Waters, Chief Health Professions Officer, be asked to report to the June meeting on the progress made in implementing the recommendations from the Accessibility Report completed in 2011.

6 IMPROVEMENT ACTIVITIES (Pages 15 – 32)

6.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata (Pages 19 – 24)

Kate Sladden, Programme Manager Funding Team addressed this item and highlighted two key areas.

- A recent report from the Ministry of Health indicates 100% of ARRC providers in Auckland and Waitemata DHBs have signed an engagement agreement with the national interRAI Project Team. This is a significant outcome and now requires impetus to get nurses through training and using the tools.

- Good progress has been made with the Dementia Care Pathway work particularly at Waitemata DHB where the Cognitive Impairment Clinical Pathway is being piloted in GP practices. Action research meetings between secondary clinicians, and pilot GPs and their practice nurses are proving valuable in determining what is working and what needs to change.

Matters covered in discussion of the report and in response to questions included:

- Comment that all facilities should be reporting and monitoring progress with reducing falls. If falls programmes are not making a difference, then funding should be reapplied to where it can make a difference.

- A difference in the use of the HBSS budget 2013 additional funding between the two District Health Boards was noted. It was advised that this was quite a small amount of funding when considered in the light of what each District Health Board spent annually on home support services to assist older persons to stay in their own homes longer. The two Intensive Service Coordinators were required in the Waitemata District Health Board area as it has a list of overdue reassessment of current patients list along with a growing waiting list of new patients.
Resolution: Moved Robyn Northey/Seconded Marie Hull-Brown

That the report be received.

Carried

6.2 Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs (Pages 27 – 32)

Samantha Dalwood, Disability Strategy Coordinator, Waitemata District Health Board asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- Advice that the Patient Experience Manager had been recruited as part of the Quality team and worked in the Patient and Family Care Centre. Concern was expressed that Waitemata District Health Board had many initiatives that were being reported on but there was no corresponding information provided from Auckland District Health Board. It would be beneficial to be able to review pragmatically what was occurring across both District Health Boards.

- Noting that the Disability Strategy appeared to have no teeth and that members needed to be informed on the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). It was agreed that a picture of what the United Nations document contained and what New Zealand is doing within this framework is required. This was suggested for a presentation for a future meeting item. It is important to note that the Disability Strategy Coordinator role reports against the NZ Disability Strategy objectives.

- Drawing member’s attention to the Elective Surgery Centre signage and way finding, which won a Health Excellence Award for Excellence in Compassionate Patient Support, and which is now seen as the WDHB standard. This is being used for the new Community Renal service in Albany. As a visit to view was not practicable, it was asked that photographs be provided to the next committee meeting to illustrate what had been achieved.

- General discussion was had in regard to what was occurring in both District Health Boards around the incorporation of disability strategies into information and communications from the District Health Boards and the communication platforms that existed to support disabled people to access information. It was agreed that more clarity in this area would be beneficial to ensure access to information and inclusion for everyone.

Actions

1. That the Patient Experience Manager be invited to the August meeting to provide
an overview of his/her role and goals in the short to medium term.

2. That a presentation be provided to a future meeting on what the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) contains and how New Zealand Is meeting its obligations under the convention.

3. Photographs of the Elective Surgery Centre signage and way finding, which won a Health Excellence Award for Excellence in Compassionate Patient Support, be provided to the next committee meeting to illustrate what had been achieved.

4. That a report on how Communications Teams are making information accessible to disabled people. This includes paper and web based communication. The report will be made by both District Health Boards to the June meeting.

Resolution: Moved Jo Agnew/seconded Jan Moss

That Auckland District Health Board commence reporting, as do Waitemata District Health Board, on a regular basis, comparable action and progress, on the implementation of the New Zealand Disability Strategy 2013-2016, in the same manner and in the same template.

Carried

Resolution: Moved Sandra Coney/Seconded Russell Vickery

That the report be received.

Carried

7 INFORMATION PAPERS (Pages 33 – 50)

7.1 Funding Barriers for Support Services for Children (Pages 37 – 38)

Kate Sladden, Programme Manager Funding Team asked that the report be taken as read advising that:

There has historically been an issue of barriers to access to support services for children with both disability and personal health support needs. The Family Options service and Taikura Trust have worked together to develop a collaborative model for assessing these children. An issue remains in that the allocated services still need to be coordinated and funded separately by the respective agencies. The Northern Region District Health Boards (DHBs) are requesting that this issue is addressed by the new LTS-CHC and DSS National Resolutions Panel.

Matters covered in discussion of the report and in response to questions included:

- Advising that the pilot has become standard practise and that there is a skilled workforce in place to support this. However, an issue remains around the two funding streams which is why a regional paper is being written for the National Resolution Panel advocating for coordinated joint assessments and establishing a process for payments to be paid to a single provider by two funders on a single contract. The Committee considered that weight could be added to the case if the
Boards followed up with a letter in support to the National Resolutions Panel.

Action

That DSAC requests, if required; that the Boards follow up with a letter in regard to Support Services for Children, supporting coordinated joint assessments and the establishment of a process for payments to be paid to a single provider by two funders on a single contract to the National Resolutions Panel.

Resolution: Moved Sandra Coney/Seconded Dairne Kirton

That the report be received.

Carried

7.2 Funded Family Care (Pages 41 – 46)

Samantha Dalwood, Disability Strategy Coordinator Waitemata District Health Board asked that her report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- Acknowledgement that the issue is extremely complicated and complex and it appeared that you could only have one welfare guardian and in that case you cannot apply for individualised funding.

- Individualised funding was at a rate of $25 per hour and family funded care was at a rate of $16 per hour. It was seen that the Government was in an advantageous position in these cases. A cognitively impaired person could not be expected to be an employer or carer and this legislation just added another layer of bureaucracy to an already difficult situation.

- A cognitively impaired person did not always have the ability to comprehend their obligations as an employer. To expect as an alternative, an advocate to be able to explain and have this understood by that person is contradictory.

- Eligibility criteria to receive support services were also noted and in particular the exclusion of a spouse, civil union or de facto factor partner from caring for the disabled person if this funding were to be allocated.

Resolution: Moved Jan Moss/Seconded Dairne Kirton

That the report be received.

Carried

7.3 Current Policy for ACC Funding for Falls Programme (Pages 49 – 50)

Kate Sladden reporting in response to an action from the Committee requesting information
from ACC as to what had occurred with funding for the “Falls Programme”.

ACC want and are willing to work with District Health Boards in the area of falls. Currently they are involved with the Fracture Liaison Services at Waitemata District Health Board and the funding for “Community Integrated Falls Programme” at Auckland District Health Board. They are open to funding initiatives for short periods of time to assist in getting them up and running.

Matters covered in discussion of the report and in response to questions included:

- Comment that it would be good to see this funding extended to those with an existing impairment and focussing on “transferring”. An education programme is required as transferring technique does not grow with you as your body shape changes and as you age.

- General discussion ensued around the necessity for a “no fault” system associated with ACC claims. Those with disabilities were penalised as the likelihood of falls was greater for them than the general population. It had prevented many from fully engaging and enjoying activities or from living in places that carried a risk of falls.

That the report be received.

8 CONFIRM ACTIONS AND FEEDBACK TO COMMITTEES AND BOARD

8.1 Action Points for next DSAC Meeting (Pages 51)

1. That the Corporate Business Manager email members calling for suggestions, names of individuals or organisations that could be approached so that the Chair could make a recommendation to the Chair of the Boards to fill the fifth external appointee vacancy.

2. That the Corporate Business Manager provide the link to the report Putting People First to all Committee members.

3. That the Corporate Business Manager advise report writers of the necessity of ensuring issues are reported on in such a way that the Committee can make recommendation to other Committees and the Boards.

4. That Sue Waters, Chief Health Professions Officer be asked to report to the June meeting on the progress made in implementing the recommendations from the Accessibility Report completed in 2011.

5. That the Patient Experience Manager be invited to the August meeting to provide an overview of his or her role and goals in the short to medium term.

6. That a presentation be provided to a future meeting on what the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) contains and how New Zealand is meeting its obligations under the convention.
7. Photographs of the Elective Surgery Centre signage and way finding, which won a Health Excellence Award for Excellence in Compassionate Patient Support, be provided to the next committee meeting to illustrate what had been achieved.

8. That a report be provided on how Communications Teams are making information accessible to disabled people. This includes paper and web based communication. The report will be made by both District Health Boards to the June meeting.

9. That DSAC requests, if required; that the Boards follow up with a letter in regard to Support Services for Children, supporting coordinated joint assessments and the establishment of a process for payments to be paid to a single provider by two funders on a single contract to the National Resolutions Panel.

8.2 DSAC feedback to CPHAC (Pages 51)

There was none.

8.3 DSAC feedback to Board (Page 51)

There was none.

9 General Business (Page 53)

Toru and Seadrome

Michelle Cavanagh advised of an initiative that was occurring with regard to a local West Auckland rest home that had a number of Maori residents all of whom were korero Maori with differing levels of dementia. All the staff were non Maori. There was concern that these residents were marginalised and lonely. Kelston Girls High School have put forward interested Maori girls aged 12 to 13 years to be part of a programme working with these Kaumatua. The girls are to give 1 day a week spending time and caring for these Kaumatua and in return will learn language and culture in a practical sense. The girls will also gain a Health Academy qualification toward NCA and Seadrome Hospital will consider these girls candidates for future employment. The project went live on 1 March 2014.

The meeting closed at 3.15pm.

Next Meeting

The next ordinary scheduled meeting will be held:

1:00pm, Wednesday, 4 June 2014

Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 12 March 2014.
### Action Points from Previous DSAC meetings

As at Wednesday 12 March 2014

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail</th>
<th>Designated to</th>
<th>Action by</th>
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<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 full committee in place.</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>Deferred until full committee in place.</td>
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<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>June 2014</td>
</tr>
<tr>
<td>Item 5 12 March 2014</td>
<td>That the Corporate Business Manager email members calling for suggestions, names of individuals or organisations that could be approached so that the Chair could make a recommendation to the Chair of the Boards to fill the fifth external appointee vacancy.</td>
<td>Marlene Skelton</td>
<td>Completed</td>
</tr>
<tr>
<td>Item 5 12 March 2014</td>
<td>That the Corporate Business Manager provide the link to the report; Putting People First to all Committee members.</td>
<td>Marlene Skelton</td>
<td>Completed</td>
</tr>
<tr>
<td>Item 6.2 12 March 2014</td>
<td>That Sue Waters, Chief Health Professions Officer be asked to report to the June meeting on the progress made in implementing the recommendations from the Accessibility Report completed in 2011.</td>
<td>Sue Waters</td>
<td>Item 8.1 on this agenda</td>
</tr>
<tr>
<td>Item 6.2 12 March 2014</td>
<td>That the WDHB Patient Experience Manager be invited to the August meeting to provide an overview of his or her role and goals in the short to medium term.</td>
<td>Debbie Holdsworth</td>
<td>August 2014</td>
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<td>That a presentation be provided to a future meeting on what the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) contains and how New Zealand is meeting its obligations under the convention.</td>
<td>Samantha Dalwood (Linda Harun)</td>
<td>August 2014</td>
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<td>Item 6.2 12 March 2014</td>
<td>Photographs of the Elective Surgery Centre signage and way finding, which won a Health Excellence Award for Excellence in Compassionate Patient Support, be provided to the next committee meeting.</td>
<td>Samantha Dalwood</td>
<td>Completed. Email prior to 4 June meeting</td>
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<td>Item 6.2 12 March 2014</td>
<td>That a report on how Communications Teams are making information accessible to disabled people. This includes paper and web based communication. The report will be made by both District Health Boards to the June meeting.</td>
<td>Gilbert Wong, ADHB  Errol Kiong, WDHB</td>
<td>Item 8.2 on this agenda</td>
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<tr>
<td>Item 7.1 12 March 2014</td>
<td>That DSAC requests, if required; that the Boards follow up with a letter in regard to Support Services for Children, supporting coordinated joint assessments and the establishment of a process for payments to be paid to a single provider by two funders on a single contract to the National Resolutions Panel.</td>
<td>Leanne Catchpole</td>
<td>Item 7.1 on this agenda</td>
</tr>
</tbody>
</table>
CHAIRPERSON’S REPORT
Chair’s Report

An item for discussion will be:

- Appointment of external appointees (Terms of Reference for DiSAC are appended)
Establishment

The Disability Support Advisory Committees (DiSAC) are established by the boards of the Auckland District Health Board ("ADHB") and Waitemata District Health Board ("WDHB") under section 34 of the New Zealand Public Health and Disability Act 2000 ("Act"). The Boards may amend the terms of reference for the Committees from time to time. While constituted as each Board’s separate DiSAC they will meet and act as one committee.

Functions of Committee

The functions of the DiSACs of the ADHB and WDHB are to:

(a) Give the Boards advice on:
   - The disability support needs of the resident population of ADHB and WDHB
   - Priorities for use of disability support funding provided

(b) The aim of the Committees’ advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of disabled people within ADHB’s and WDHB’s resident populations:
   - The kinds of disability support services ADHB and WDHB have provided or funded or could provide or fund for those people
   - All policies ADHB and WDHB have adopted or could adopt, and how these policies could impact on persons or groups of people with a disability

(c) The Committees’ advice must not be inconsistent with the New Zealand Disability Strategy.

(d) The Committees are to ensure that disability support needs of the community are reflected in all ADHB and WDHB strategic planning processes, including the Northern Region’s Health Plan and Annual Plans, and to ensure that appropriate processes, including consultation, are followed in preparation of all documents.

(e) In carrying out their functions the Committees shall also have regard to the Health of Older People Strategy and the New Zealand Positive Ageing Strategy.
Responsibilities

Note 1  Health of Older People
Because it is difficult to distinguish between disability and personal health issues for older people, it is expected that DiSAC will deal with Health of Older People across the full range of issues and services for this age group.

Note 2  Mental Health Services
Mental Health services are dealt with by the Hospital Advisory Committees (DHB provider aspects) and the Community and Public Health Advisory Committees (funder aspects)

(a) To carry out its functions, the Committees will develop and operate under an explicit philosophy that values diversity and self-determination for people with disabilities.

(b) In particular, the Committees will review and advise the Boards on:

- the overall performance of disability support service delivered by or through ADHB and WDHB.
- the development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the districts having regard to the New Zealand Disability Strategy and the Health of Older People Strategy.
- assessment of the disability support services' performance against expectation set in the Annual Plans and other relevant accountability documents, documented standards and legislation.
- issues related to the delivery of mainstream health services accessed by disabled people.
- the ADHB and WDHB districts’ perspective to be contributed to the development and implementation of regional and national policies related to disability issues in the ADHB and WDHB districts.
- developing and maintaining relationships with disability stakeholders to develop district and regional inter-sectoral collaboration and co-ordination.
- focusing on the disability support needs of the population and developing principles on which to determine priorities for using disability support funding.
- ensuring that the Annual Plans demonstrate how disabled people will access health services and how ADHB and WDHB will ensure that the disability support services they provide are co-ordinated with services of other providers to meet the needs of disabled people.
advise the Boards on how they can effectively meet their responsibilities towards the government’s vision and strategies for people with disabilities.

in accordance with the functions of DHBs:
- establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement.
- continue to foster the development of Maori capacity for participating in the health and disability sector and providing for the needs of Maori.

in accordance with the functions of DHBs:
- establish and maintain processes to enable Pacific people to participate in, and contribute to, strategies for Pacific health improvement.
- continue to foster the development of Pacific capacity for participating in the health and disability sector and providing for the needs of Pacific people.

improving collaboration and coordination of services between the ADHB and WDHB to effectively and efficiently provide for the needs of the populations served.

Relationship with Boards and Management

(a) The Committees are established by and accountable to the Boards. The Committees’ role is advisory only, and unless specifically delegated by a Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committees.

(b) The Committees shall receive all material and information for review or consideration through the respective Chief Executive Officers.

(c) The Committees shall provide advice and make recommendations to the Boards only.

(d) The Committees are to comply with the standing orders of the ADHB and WDHB based on the model standard standing orders.

Membership

(a) The membership of the DiSACs will compromise of:

- Three Board members from ADHB
- Three Board members from WDHB
- Six appointed members

(b) The Chairperson(s) of both ADHB and WDHB will mutually agree upon the appointment of the Chairperson of the DiSACs.
(c) The Boards will endeavour to appoint, as members of the Committees, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committees to carry out their functions.

(d) The Boards will ensure that the Committee includes representation for Maori in accordance with section 34 of the Act and for Pacific people.

(e) The Boards will appoint any external appointees as members in accordance with the following process:
   - The Chair and Deputy Chair of each Board together with the respective Chief Executive Officer will evaluate potential members in accordance with the criteria determined by the Boards and make recommendations to the Boards as to the proposed appointments.
   - The Boards will make the final appointments (if any) to the Committees.

Meeting Procedure

(a) The Committees shall meet in a combined forum quarterly. Meetings shall be conducted in accordance with:
   - The requirements of the Act
   - The Standing Orders of the ADHB and WDHB based on the model standing orders.

(b) ADHB and WDHB CEOs will ensure adequate provision of management and administrative support to the DSACs’ function including attendance of the CEOs and Chief Planning and Funding Officers.

(c) The venue for the meeting will alternate between an agreed ADHB and WDHB site, with technology (e.g. video or teleconferencing) aiding from remote locations where appropriate.

(d) The quorum of each meeting shall be, if the total number of members of the Committees is an even number, half that number; but if the total number of members is an odd number, a majority of the members.
Delivery of Respite Care – Estelle Muller

Estelle Muller was newly appointed to her role as Contract Relationship Manager, National Health Board when she last addressed the Disability Advisory Committee in August 2013. It was suggested then that she attend the 4 June meeting when she would be in a better position to provide a more detailed update on the progress made with Respite Care.

Estelle will provide information about her service, what it does and how it interfaces with the community and DHBs. You have asked that Estelle touch on the following issues during her presentation to you:

**Case Workers**
What is the process to manage case workers and their loads?
Numbers of clients who take up this service in relation to numbers who could take up this service?

**Respite Care**
When will respite be able to be accessed through Individualised funding.
What provision is there for respite for young people with serious on-going medical conditions?

**Carer Support**
How is the review of Carer Support going?
What process and support exists to find suitable carers?

**Key Initiatives**
What are some of the key initiatives/projects that you are involved in that will, in your opinion, make a difference in respite care over the next two to five years?

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Aged Residential Care Health Utilisation Study (ARCHUS) – Professor Martin Connolly

Professor Martin Connolly presenting on the Age Residential Care Health Utilisation Study (ARCHUS) the first randomised controlled trial of multi-disciplinary intervention into residential aged care facilities with the aim of reducing avoidable hospital admissions.
HEALTH OF OLDER PEOPLE QUARTERLY REPORT ON ACTIVITIES IN AUCKLAND & WAITEMATA DHBS

Recommendation:

That the Disability Support Advisory Committee receives the Health of Older People quarterly report.

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

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ARRC – Age Related Residential Care
DHB – District Health Board
HBSS – Home Based Support Services
HCSS – Home and Community Support Services
HOP - Health of Older People
LTCF – Long Term Care Facility
LTS-CHC – Long Term Support for Chronic Health Conditions
NRHP - Northern Region Health Plan
PFC - Paid Family Carer

1. Purpose

The purpose of this report is to provide an update to DISAC on the progress and activities occurring across Auckland and Waitemata DHBs for Health Older People. The report includes material common to both DHBs and where appropriate material specific to an individual DHB.

2. Background

Health of Older People (HOP) services are directed by the Minister of Health, the Northern Region Health Plan (NRHP) and the Auckland and Waitmata DHB Annual Plans and Māori Health Plans. We are currently finalising our 2014/15 Annual Plans. Ministry of Health guidance for the planning process requires DHBs to continue working with community providers and primary care to deliver integrated services for older people to support safe and independent living at home. There is a focus on avoiding hospital admissions and ensuring appropriate provision of care after a hospital discharge. Following the development process, we now need to implement our dementia care pathways. We also need to support aged residential care in adopting interRAl Long Term Care Facility (LTCF) Assessment as their primary assessment tool.
3. The Northern Region Health Plan (NRHP)

The two major achievements for the Health of Older People Clinical Network since the last report, have been drafting the regional plan for 2014/15 and completion of the Northern Region Psycho-Geriatric (PG) service review.

Health of Older People has been identified as one of the three priorities in the NRHP for 2014/15. Consequently, the existing plan has been overhauled with a greater emphasis on: consistent assessment processes for people requiring long term support; dementia services e.g. regional diagnosis tools, management in primary care and alternative treatment options; targeted programmes in ARRC; supporting disease prevention e.g. Fracture Liaison Service; and information sharing e.g. interRAI.

The Northern Region Psycho-Geriatric (PG) service review was completed and submitted to the CEO/CMO Group who endorsed the findings and have offered support to implement the recommendations over coming months. The review was conducted over five months (on a part-time basis) and found variability around managing residents in PG beds across the four DHBs and opportunities for better use of PG beds in terms of sub-specialisation and consistent entry/discharge processes. Given regional variability and the lack of nationally agreed benchmarks for bed capacity, the emphasis is about making better use of existing resources in the short to medium term. There has been widespread support from DHB and ARRC stakeholders, following extensive consultation.

Other dementia related initiatives include:

- A regional dementia dynamic pathway that has been signed off by all four DHBs and is being developed with GAIHN and HealthPoint
- The HOP network co-hosted a talk by Professor Graham Stokes in partnership with Bupa; this was attended by a wide range of participants across community, ARRC and DHB sectors
- Participation in a national MOH project to develop education resources for people with dementia and their caregivers.

Comprehensive training and support for falls and pressure injury reduction initiatives in ARRC continues to be well led by First Do No Harm. There has been a slight increase in ARRC providers furnishing data in the last quarter and we are working with a large corporate provider to submit one aggregated file for all their facilities. Reporting against the KPI for participation in a falls reduction programme has been brought forward to quarter 3. This has meant surveying ARRC facilities to assess whether they meet all four criteria which constitute a ‘falls reduction programme’. Currently, 28% of ARRC providers meet the criteria.

4. Home Based Support Services (HBSS)

4.1 Auckland DHB

The ADHB HBSS model has had an increase in the proportion of clients classified as ‘complex’, from 27% in January 2013 to 37% in January 2014. There has also been a shift up the eight complex categories from what was originally modelled using client data in 2012. Both these shifts have funding implications.
There is no convincing reason for the shift in complexity of the client population to the extent that it has occurred, over such a short time period. At the same time there has been no indication from providers that the level of service they are being required to provide has taken a sudden or marked step increase.

However, some systems and processes have changed over the last year with an increased proportion of patients now being assessed (using the interRAI Home Care assessment) in hospital prior to their discharge rather than in their homes. The increase in hospital based assessments began in mid-2012 and potentially could be inflating a patient’s acuity.

A recent analysis of Auckland DHB interRAI data has shown that patients assessed in hospital have a significantly higher complexity rating than those assessed post discharge. An audit of all HBSS clients assessed in hospital started in May 2014. The audit will determine if there has been a reduction in a client’s complexity/acuity since they returned home.

Current priorities for HBSS are:

- to agree a bulk funding arrangement with providers for 2013/14 in order to remain within budget; currently three providers have agreed to this and we are awaiting feedback from the fourth provider
- in conjunction with the University of Auckland (who developed the original cost model) realign the cost model for 2014/15
- working with Gerontology Services to ensure consistency in triaging (non-complex vs complex) and assessment processes
- working with the four community providers and Gerontology Services to establish a mechanism for timely review of a client’s complexity rating.

The existing five year contract with the community HBSS providers expires on the 30 June 2014. The Audit and Finance Committee has recommended to the Board that the contract is extended for one year to 30 June 2015 and that the option of having a joint procurement process with Waitemata DHB is investigated.

4.2 Waitemata DHB

Waitemata DHB has seconded four experienced Needs Assessors to complete assessments of people on the NASC waiting list for HBSS. All individuals on the waiting list were screened as low risk when their referrals were received but due to the high inflow of more complex patients the low risk waiting list became too long. The Needs Assessors commenced this work on 31 March 2014 and it is progressing well. Despite the DHB making no change to the eligibility criteria for HBSS the Needs Assessors are finding a significant number of people on the waiting list do not require any HBSS at the time of assessment. When the needs assessment is completed both the individual and their GP are sent a letter to confirm the results; these are also discussed with the person at the time of the assessment.

4.3 Paid Family Carer Policy

In May 2013, as part of the Budget Legislation, Parliament enacted the New Zealand Public Health and Disability Amendment Act 2013, which inserted a new Part 4A in the Act called family care policies. This amendment Act was a response to Court decisions in Atkinsons and Others v Ministry of Health that the Ministry of Health’s blanket policy of not paying certain family members to provide disability support for their disabled family members amounted to unjustified discrimination, on the ground of family status, under the Human Rights Act 1993.
In May 2013 the Director-General of Health advised all DHBs that Part 4A in the Act requires any DHBs that are paying, or intending to pay, family carers to have an explicit and lawful Paid Family Carer (PFC) policy in place by 21 May 2014.

In December 2013 Cabinet decided that no payments should be made to spouses (including civil union partners and de facto partners) or parents of children under 18 years.

The Ministry of Health provided DHBs with a guidance document for developing PFC policies in April 2014. It recommended that PFC policies only enable DHBs to permit some family members to be paid, in exceptional circumstances, for providing home-based support services (HBSS) to disabled family members.

It was agreed that the three metro Auckland DHBs would develop a policy to be used across the region. The management arrangement decided upon was to pay family carers via contracted HBSS providers rather through a host agency or paying directly. This approach mitigates a number of risks and can be implemented quickly. It means that two independent bodies (DHB as funder and provider organisation as employer) have clearly defined responsibilities and already established processes for monitoring to ensure a family carer does not abuse or financially exploit the family member they are caring for. The DHB contract makes the HBSS provider responsible for ensuring statutory employee rights are not breached and working as a HBSS employee means family carers have more access to peer support from other non-family carers to ensure they are not exploited by the family member they are caring for.

Currently across the three metro Auckland DHBs there is a practice of HBSS providers employing family carers in extenuating circumstances. This has been happening for a number of years albeit with no formal policy in place. The number of family members employed by HBSS providers is unknown but thought to be small. Data is currently being collected to gain an accurate understanding of the situation. This will include ethnicity data as anecdotally it is thought that Paid Family Carers are used by Maori and Pacific providers.

The metro Auckland DHBs’ PFC policy has been reviewed by the Ministry of Health and is currently going through the DHBs’ formal document control sign off processes in order to meet the 21 May 2014 deadline.

5. Dementia Care Pathway

5.1 Auckland DHB
The following four workstreams for the Dementia Care Pathway continue to make progress:

1. Carer Workstream (support for carers)
2. Integration Workstream (integration between services and agencies, diagnostic processes)
3. Support Suite Workstream (support services e.g. respite care, day programmes, home based support)
4. Foundation Workstream (workforce competency and understanding roles and accountabilities)
Actions over the last quarter include:

- **Shared Care Record pilot commenced.** The Shared Care Record is a key mechanism for communication and information sharing between the care team. A small pilot has started involving specialists, GPs, and Alzheimer’s Auckland. The pilot will test processes and user acceptability prior to wider rollout.

- **Carer assessment and action plan developed.** As carers carry a large burden in caring for a person with dementia, the focus of this work has been on early identification of carer strain and implementation of interventions that provide support to enable carers to continue their role for longer.

- **Services Directory due for completion May 2014.** This will include a summary description of services available for people with dementia and carers in the Auckland DHB area, including contact information.

- **The Waitemtata DHB Cognitive Impairment Clinical Pathway has been presented to the ADHB stakeholders and there is agreement to adopt this pathway for use in primary care once it has been evaluated.**

### 5.2 Waitemata DHB

The Waitemata DHB Cognitive Impairment Clinical Pathway is tracking to plan. The third action research meeting was held with Geriatricians, Specialist Nurses, General Practitioners, Practice Nurses, PHO Clinical Leaders, and Alzheimer’s Auckland to discuss what is working / what is not / what will we change and test for the next six to eight week period of the Pilot. There continues to be high attendance at these interactive forums. The GPs have recruited 50 of the required 60 patient and carer pairs and they were all at varying stages on the pathway from diagnosis through to a management plan being in place.

One GP reported back on having had a ‘Living Well with Dementia Care Planning Meeting’ with a patient and carer that was facilitated by the Practice Nurse and an Alzheimer’s Auckland key worker. The GP came into the one hour meeting at the start and the end. The GP reported he was pleasantly surprised at how useful and successful this meeting was.

Two replacement GPs and Practice Nurses have been confirmed to replace the two who withdrew from the Pilot due to workload. The new GPs have had training with the Clinical Director of Geriatric Medicine and the Project Manager. Both these GPs will use the Regional Clinical Pathways Navigator Information Technology. These GPs have until 31 May 2014 to recruit three patients each with previously undiagnosed cognitive impairment, thus the original target of 60 patient and carer pairs (5 per GP) may be reduced to 56.

### 6. Aged Related Residential Care

#### 6.1 Auckland DHB

All ADHB ARRC facilities are now engaged with interRAI training as follows:

- 12 are fully competent (required number of nurses trained)
- 17 are competent (at least one nurse trained)
- 2 in training
- 39 have signed an engagement agreement (to commence training)

The specialist team had 303 consultations with aged residential care over the last quarter. Key reasons for these consults included: wound care, orthopaedic interim care case management, complex residents, complex discharges from Auckland City Hospital, care planning guidance,
advice on falls, pressure injury, behaviours of concern, change in level of care, interRAI, support for facility (manager/clinical manager), meetings with families.

A study day held for aged residential health care assistants had 115 attendees from 33 facilities. Topics covered were: stroke management; infection control; patient handling; heart failure management; and managing residents with COPD.

The ARRC cluster group model continues to make progress. There is a bimonthly Steering Group meeting with the cluster groups meeting in the alternate months. The focus has been on achieving the First Do No Harm targets to reduce pressure injuries and falls by 20%. Approximately 30% of facilities are providing data on falls and pressure injuries and they are now transitioning from sending the data via Excel to entering it themselves via the www.qualitycare4olderpeople.org.nz website. Work is also underway to determine what other topic areas would be most beneficial for facilities and could become a focus for the cluster group model.

6.2 Waitemata DHB

All Waitemata DHB ARRC facilities are now engaged with interRAI training as follows:

- 9 are fully competent (required number of nurses trained)
- 19 are competent (at least one nurse trained)
- 12 in training
- 20 have signed an engagement agreement (to commence training).

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, its members are: managers and clinicians from ARRC facilities, Gerontology Nurse Specialists (GNS), Funding and Planning Quality Nurse Leader and experts in the field e.g. Hospice, Dementia Nurse Specialist. The purpose of this group is networking, informing practice and developing clinical guidelines.

RACIP projects

- Development of a booklet for family members of people with advanced and end-stage dementia living in ARRC. This resource will support families to understand end stage dementia, advance care plans and appropriate and inappropriate intervention. The content is finalised and is with Waitemata DHB Design department before printing and launching. An electronic version will be freely downloadable from the RACIP website www.wdhb-agedcare.co.nz

- Development of two resources: one for end stage lung disease and one for end stage heart disease. These new resources will support staff in ARRC to help families understand disease trajectory and what end stage disease looks like. They will encourage appropriate symptom management, advance care planning and avoidance of preventable admission. Currently the RACIP work group is developing the content.

- Project Toru is the vision of Di MacGregor Maori GNS. It is a partnership between Seadrome residential care facility, Kelston Girls College and Waitemata DHB. It brings Maori Kaumatua in a dementia unit and year 13 Maori focused students into regular contact with each other using a Maori model based on traditional Kaumatua Mokapuna interaction. Objectives include use of Maoritanga for all (young-old interactions) teina
tuakana kawa, NCEA credits for student time with clients, encouraging the students into health related careers and potential employment opportunities.

- ARRC cluster groups 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 four cluster groups up and running with 20 represented facilities.

7. **Long-Term Supports for Chronic Health Conditions (LTS-CHC)**

The Regional LTS-CHC Group has assisted the development of the terms of reference for the now functioning National LTS-CHC and DSS Resolution Panel. We also raised the lack of consistent methodology to determine dual funding agreements and the need to reduce dual assessments of clients with the National Panel as an issue to be considered and addressed. The National Panel will be able to address issues and sanction national guidelines/policies as well as provide 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.

Ongoing regional support is provided by:

- Bimonthly LTS-CHC Regional Review Panel meetings that;
  - review and monitor clients with an annual service package of $80,000 or more. Five clients were reviewed and monitored by the Panel in the last quarter
  - review and consolidate regional support for all submissions to the National LTS-CHC and DSS Resolution Panel
- Monthly meetings with DSS NASC (Taikura Trust) to discuss clients with unclear eligibility and joint funding opportunities
- Ongoing peer review (including with Midland region) to compare assessment outcomes and service utilisation.

The financial model for 2013/14 transitions LTS-CHC from a regional risk share to a local utilisation and cost model for future years. The first six months maintained the risk share model excluding NDHB. The second six months sees each DHB managing their own risk and utilisation costs through their respective PBFF. A regional IDF process has been adopted similar to the HOP process.

The financial model for LTS CHC in 2014/15 and future years has been regionally agreed. DHBs will continue to manage their own risks and utilisation costs through their respective PBFF and adopt the national process for IDFs.
IMPLEMENTATION OF THE NZ DISABILITY STRATEGY IN AUCKLAND & WAITEMATA DHBS UPDATE REPORT

Recommendation:

That the Disability Support Advisory Committee receives the update report on the implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs.

Prepared by: Samantha Dalwood, Disability Strategy Coordinator, Waitemata DHB
Endorsed by: Dr Debbie Holdsworth (Director Funding), Sue Waters ADHB Executive Director Allied Health, Scientific & Technical

Glossary

DHB  -  District Health Board

1. Purpose

The purpose of this report is to provide an update to DiSAC on the joint Waitemata DHB/ADHB Implementation Plan 2013-2016 progress report which is attached.

A separate report providing an update on the accessibility work to date at Auckland DHB is provided elsewhere on the agenda.
Waitemata DHB and Auckland DHB
Implementation of the New Zealand Disability Strategy 2013-2016
Current Status at 1 May 2014
<table>
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<tr>
<th><strong>What</strong> we will do... actions</th>
<th><strong>Where</strong> we are now...current status</th>
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<tr>
<td>Accessible Communication guidelines developed.</td>
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<td>Review of Web content and presentation.</td>
<td><strong>May 2014</strong> – Communications Teams to report to DiSAC on how they are making web based content more accessible to all.</td>
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<td>Increase formats of key documents, e.g. Strategic Plans.</td>
<td><strong>April 2014</strong> – Given costs and process to the WDHB Web Content Editor for information to be translated by Seeflow into NZSL. These short videos can then be put onto the DHB websites.</td>
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<td>Review the automated telephone system with regard to access for people with disabilities.</td>
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<td>Review the possibility of improved text communication to patients.</td>
<td><strong>July 2013</strong> – Gave feedback around better support for disabled, particularly Deaf, people accessing information via the telephone into the Contact Centre consultation.</td>
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<td>Continue the implementation of the Health Passport across both DHBs.</td>
<td><strong>May 2014</strong> - Ongoing promotion of the Health Passport across the DHB, eg. Nutrition and Hydration improvement work currently being done.</td>
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<td>Work with the Deaf community to improve access to interpreters.</td>
<td><strong>May 2014</strong> – WATIS (WDHB Interpreting Service) have recommended improving wifi at the main hospital sites. Improved wifi will allow VRI (Video Remote Interpreting) to happen. VRI gives access to interpreters via an internet video connection.</td>
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<td>Encourage the use of interpreters for non-English speaking families.</td>
<td><strong>May 2014</strong> - WATIS have recommended improving wifi at the main hospital sites. This will allow interpreting to be done across the internet, including NZSL interpreting.</td>
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**Community and Engagement** Working within a family and patient centred framework  
**Current Status at 1 May 2014**

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<th><strong>What</strong> we will do... actions</th>
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<tr>
<td>Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.</td>
<td><strong>May 2014</strong> – The Patient Experience Manager has started at Waitemata DHB. The role looks at the improving the experience of all our patients, including disabled people.</td>
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<td>Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.</td>
<td>Ongoing.</td>
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<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><strong>May 2014</strong> – The Patient Experience Manager and Disability Strategy Coordinator have met and talked about how we can better include people who are often forgotten, particularly those with high and complex needs, labelled as having ‘challenging behaviour’ or who are unable to speak for themselves. For example, better waiting processes for people who find waiting difficult.</td>
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<td>Continue working with Health Links to increase health literacy through fully accessible patient information.</td>
<td>Ongoing.</td>
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**Employment Opportunities** Equal employment opportunities for people with impairments and carers  
**Current Status at 1 May 2014**

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<th><strong>Where</strong> we are now...current status</th>
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<tr>
<td>Encourage the use of supported employment agencies.</td>
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<td>Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.</td>
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<td>Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).</td>
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<td>Work with Hiring Managers to increase disability awareness.</td>
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| Working with HR to look at how the DHBs support staff with Carer responsibilities. | February 2014 – WDHB HR Workforce Development Team and Carers NZ are working on the following three work streams – 1. Carer Aware staff training, 2. a staff survey on caring responsibilities, and 3. Carer information being available on the staff intranet site.  
**April 2014** – reviewed Carers NZ staff awareness training module and made recommendations.  
**May 2014** – first Auckland area cluster meeting between Carers NZ and a small network of employers who want to support family carers in their workplaces. |
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<tr>
<td>Work with Dieticians to improve the nutritional outcomes for disabled patients.</td>
<td><strong>May 2014</strong> – Jocelyn Peach, Director of Nursing at Waitemata DHB, is leading a project to look improving the nutrition and hydration of in-patients. The work that the Disability Strategy Coordinator has done looking at nutrition issues specific to disabled people is included in this work.</td>
</tr>
<tr>
<td>Develop ‘Disability Champion’ roles across the DHBs.</td>
<td><strong>May 2014</strong> – ongoing work to develop the Disability Champion model.</td>
</tr>
<tr>
<td>Promote the Disability Awareness e-learning module to all staff across the DHBs.</td>
<td></td>
</tr>
<tr>
<td>Provide a range of disability awareness training, targeting specific services.</td>
<td><strong>May 2014</strong> – The Disability Awareness e-learning module has been reviewed and updated. The changes made are based on feedback from people who have completed the course.</td>
</tr>
<tr>
<td>Develop tools to increase staff skills for working with people with communication difficulties.</td>
<td></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><strong>April 2014</strong> – The Disability Strategy Coordinator is working with ADHB to look at possible way to improve the entrance to Auckland City Hospital and make them more accessible and consumer friendly.</td>
</tr>
</tbody>
</table>
### What we will do... actions

<table>
<thead>
<tr>
<th>What we will do... actions</th>
<th>Where we are now...current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the use of symbols and pictograms in signage and way finding.</td>
<td><strong>May 2014</strong> – Tātari Oranga O Te Raki, which means 'filtering for wellness – North', a new 18-station community dialysis opened on the North Shore. The Disability Strategy Coordinator has been involved to ensure accessible way finding.</td>
</tr>
<tr>
<td>ADHB Disability Champions will complete the 2-day Barrier Free Training.</td>
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</tr>
<tr>
<td>An accredited Barrier Free Advisor will be involved in all new Facilities work.</td>
<td></td>
</tr>
<tr>
<td>Adoption of Universal Design principles in all Facilities work.</td>
<td><strong>May 2014</strong> - The Disability Access review is a joint undertaking between the Ministry of Business, Innovation and Employment (MBIE) and the Office for Disability Issues (ODI). The review will look at whether the current building regulatory system meets the needs of people with disabilities. The review aims to gain a better understanding of how building access requirements are being implemented in new and older buildings and the extent to which the requirements provide for access to buildings for people with disabilities. Recommendations from the review are due mid-2014.</td>
</tr>
<tr>
<td>Building standards document developed in ADHB.</td>
<td></td>
</tr>
<tr>
<td>A review of accessible toilets in ADHB buildings to be completed.</td>
<td><strong>May 2014</strong> – Stage One of the review looking at leaks and plumbing is complete. Upgrades to toilets will be done on an individual project basis when funding becomes available.</td>
</tr>
<tr>
<td>Work with Auckland Transport to improve accessible transport between hospital sites.</td>
<td></td>
</tr>
<tr>
<td>Investigate the reported shortage of wheelchairs available - both numbers and sizes.</td>
<td><strong>Completed</strong> – 40 wheelchairs were delivered and are in use across the services.</td>
</tr>
</tbody>
</table>
ADHB Accessibility Report Update

Recommendation
That the report be received

and

That the Disability Support Advisory Committee (DSAC):

1. Note the continuation of the 2012 work plan tabled.

and

That the Committee considers the following issues:

1. Note and accept the progress of work in this update

Prepared by: Carolyn Simmons Carlsson (AH Director/Professional Leader) and Andrea Benoit (AH Professional Leader)
Approved/Endorsed by: Sue Waters (Chief Health professions Officer)

Glossary
ADHB – Auckland District Health Board
DAP – District Annual Plan
DSAC – Disability Advisory Support Committee

1. Executive Summary
This report provides an update on the accessibility work to date at Auckland DHB as requested by the Disability Support Advisory Committee (DSAC).

2. Introduction/Background
Auckland DHB commissioned an access review of its services and facilities from the perspective of people with disabilities with a view to enhancing engagement between people with disabilities. Eighteen recommendations were tabled in the review report. This work is on-going and incorporated into an ADHB whole of system approach. This report provides an update on the various work streams and activities to date.

3. Progress/Achievements/Activity

3.1 Disability Awareness:
- The Disability Responsiveness MOODLE is on-line and accessible for all staff.
- The Disability Responsiveness pamphlet is incorporated into the ADHB Welcome day for all staff.
- Work is being progressed to establish Disability Champions model across the ADHB services.
- Health Passport has been rolled out across ADHB.

3.2 Employment Opportunities:
- The Mainstream employment programme was set up by the Ministry of Social Development (MSD) and aims to place people with disabilities in State service organisations for two-year job placements. The intent of the programme is to give people with disabilities a stepping stone into independent and sustainable employment.
• The programme requires employers to create a job (outside the staffing allocation/not using an existing vacancy) and train the employee on the job. Mainstream provides a 100% salary subsidy for year one and 80% for year two.

• ADHB has been one of the participating organisations in the Mainstream Programme since 2012 with two Mainstream candidates (Jin Oh and Richard Richards) being recruited into positions for the duration of two year fixed term agreements each. Both roles are Team Administrators with one in the Occupational Health & Safety department under Human Resources, commencing the employment with ADHB 31 January 2012, and the other in Allied Health under Clinical Support, commencing 16 February 2012. These two departments contributed to the 20% of their respective mainstream employee’s salary towards the end of the placement.

• By now both Mainstream employees have completed their fixed term employment with ADHB and moved on. Both employees found their work experience at ADHB very pleasant, and felt their skills and work were valued by their respective departments. One of the employees indicated that if possible he would like to carry on working for ADHB in another form (e.g., permanent employment). Although there wasn’t any suitable permanent role internally for him to go to at the end of the placement, it is pleasing to see that he managed to get a new position at healthAlliance in March this year and has been working there since. The other candidate was thankful for the opportunity that the introduction of the Mainstream programme into ADHB has provided him with and decided to seek further employment in other organisations especially those engaging many people with disabilities (e.g., Deaf Foundation) and to apply his social skills gained from his ADHB experience there.

• Feedback from the managers in both departments is that the implementation of the Mainstream program was successful and that the employees were contributing well. Given the positive experience both departments have indicated their willingness to participate in the Mainstream programme again if any further opportunity arises in the future.

• The Mainstream programme was discontinued in October 2012 as the funding was not sufficient enough to cover high levels of demands at that time (i.e., number of mainstream cases). MSD resumed the programme in January 2014 introducing a new set of priorities to determine if candidates applying for Mainstream funding are eligible or not for a placement. The funding arrangement for the 2-year placement stays the same as before (100% for year one and 80% for year two). And ADHB is of course committed to continue participating in the Mainstream programme and making a positive and tangible commitment to people with disabilities.

3.4 Community & Consumer Engagement:
• Level 5 re-design project involves consultation with visitors, patients and staff to identify issues with the current Level 5 space. Various strategies including open workshops, surveys and interviews in the Level 5 space. These will ensure time is also provided to all major stakeholder groups in the ADHB to hear specific concerns through interviews or focus groups. ADHB Patient experience survey is sent to inpatients after discharge and outpatients and has a number of questions that are specific to Disability issues.

• There have been a number of Disability Themed Reports produced from this information and reported to the Board in the ADHB Patient Experience Report ( appendix 2.)

3.5 Communication & Informatics:
• A review of the 2D signage forms part of the wayfinding pilot on Wards 81 and 83 linked to the Releasing Time to care project. The live trial, co-design wayfinding process included Ms Vivian Naylor (Barrier Free Advisor and Educator, CCS Disability Action) and Ms Carol Groom. This
project will inform progress towards universal access across the Auckland DHB sites and facilities.

- **First Impressions**: an umbrella name for a range of projects to improve access and communications with the Auckland DHB. The major First Impression projects are: Patient 101, to review and ensure consistency for the written material provided to patients; plain English reviews of outpatient communications, a refresh of the Auckland DHB website and intranet to ensure these major communication channels meet e-Govt accessibility guidelines.
- Promotion of the Auckland DHB style guide and publication guidelines to assist staff incorporate accessibility principles in DHB text-based communications
- Scoping how core information can be made available in NZ Sign Language video to enhance accessibility to the Deaf communities

3.6 **Physical Access**:
- Co-design principles are built into projects to engage all necessary stakeholders fully in the discovery and resolution of issues.
- Incorporating regular use of established facility evaluation tools when redesigning facilities such as Environmental Audit Tool (EAT) (Fleming Forbes Bennett) and the EHE Environmental Assessment Tool 2nd edition The Kings Fund 2013.
- New build and refurbishments involve barrier free consultation to provide expert input to detailed design.
- Level 5 re-design project will evaluate access to and through the Auckland DHB’s main entrance. The projects includes: traffic flow evaluation, barrier free consultation input and evaluation using the abovementioned tools.
- Remodelling/re-design of single room toilets in OPH to meet accessibility standards is underway.

4. **Conclusion**
Auckland DHB continues its work towards achieving all 18 objectives of the 2010 accessibility review as laid out in the Schnackenberg, Bijoux, and Naylor report (2010)

5. **References**
### Appendix 1: Accessibility Audit Report\(^1\) Recommendations:

<table>
<thead>
<tr>
<th>That Auckland DHB:</th>
<th>Implementation Progress Report:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>Health Literacy assessment planned for 14/15</strong></td>
</tr>
<tr>
<td>a) Creates a patient <strong>information</strong> group to develop guidelines for letters, forms, pamphlets and handout material for appropriate vocabulary, presentation and format</td>
<td>a) Health Literacy assessment planned for 14/15</td>
</tr>
<tr>
<td>b) Enables all departments to send patient information to patients in their specified preferred formats (including emailing or text messaging of appointments)</td>
<td>b) First Impressions work stream to improve patient, family and visitor touch points will address physical and informational accessibility</td>
</tr>
<tr>
<td>c) Makes available on its <strong>website</strong> all its health information pamphlets, including consent forms: and</td>
<td>c) Planning underway to refresh website and enhance accessibility which includes the patient 101 project to review patient information</td>
</tr>
<tr>
<td>d) Reviews its <strong>website</strong> and takes any necessary steps to ensure that it complies with New Zealand Government Standards for Web Accessibility</td>
<td>d) Refreshed website plan will include need to comply with e-Govt standards for web accessibility</td>
</tr>
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</table>

| **2** |  |
| a) Explores ways of **improving access** by consumers with disabilities to ADHB departments and staff via the automated **telephone** system | The proposal was presented to the service manager to employ a permanent sign language interpreter in order to improve access for DEAF patients to health services, ADHB departments and staff |
| | The proposal should be presented for next financial year for the senior management’s assessment/approval. (proposal included as attachment) |
| | First impressions Workstream will address this point further in 14/15 |

| **3** |  |
| a) Engages with the deaf community to improve the availability of **NZSL interpreters** | a) Information on how to access interpreters is available on ADHB intranet for staff and on the Public web domain:  |
| b) Records and reports to government any instances where an NZSL interpreter is not available on time to meet the needs of a deaf patient or families of patients with deaf members | **Intranet - Staff:** [http://adhbintranet/Interpreters](http://adhbintranet/Interpreters)  |
| | • All requests for sign languages are made via an online booking system as for all other languages  |
| | • The Interpreter Service or the Contact Centre (after hours) will arrange sign interpreters as per bookings  |
| | • ADHB uses two providers: **Isign** and **Connect**  |
| | **Public web:** [http://www.adhb.govt.nz/sites-services/interpreting.htm](http://www.adhb.govt.nz/sites-services/interpreting.htm)  |
| | • States that whenever practically possible ADHB will endeavour to arrange an NZSL Interpreter  |

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through established sign language providers for ADHB clients where sign language is needed.

Statistics for NZSL in table below:

<table>
<thead>
<tr>
<th>Sign Language requests</th>
<th>Total Number of requests</th>
<th>confirmed</th>
<th>Unable to fill</th>
<th>Cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>360</td>
<td>328</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>2012</td>
<td>628</td>
<td>564</td>
<td>7</td>
<td>52</td>
</tr>
<tr>
<td>2013</td>
<td>672</td>
<td>598</td>
<td>1</td>
<td>72</td>
</tr>
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</table>

4 a) Arranges wireless access for patients and visitors across its sites

a) Public wireless access has been made available across the Grafton site as a pilot initiative for 1 hour per day.

5 a) Facilitates awareness-raising among staff with disabilities about available work-related equipment and sources of funding

a) Occupational Health & Safety: all new staff complete pre-employment screening. This includes a questionnaire that can identify and special needs that a new employee may have in relation to a disability. Each person who declares personal health issues that may require accommodation is the workplace is assessed by the occupational health medical team. The manager is then given recommendations on how the disability should be accommodated.

b) Vocational Rehabilitation advisor: OH&S provides a service where staff with personal health issues that are effecting their ability to work as assessed and advice is given to the manager on reasonable accommodation. Occupational Therapists are engaged to provide worksite assessments and recommendations regarding equipment needed. Funding for the equipment is either provided by the workplace or specialist disability agencies such as the Blind or Deaf Foundation.

c) Occupational Health and Safety provide advice specific to individual needs. OH&S forms provide details and further information is available on the website under personal health issues.

http://adhbintranet/OHS/All/HealthandWellbeing/wellbeing.htm

6 a) Increases the availability of its facilities maps and reviews the style and placement

a) Maps are accessible on-line – in 2D and 3D versions
<table>
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<tr>
<th>7</th>
<th><strong>a)</strong> Establishes and promulgates a <strong>policy</strong> concerning <strong>accessible car parking</strong> for its staff with disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>b)</strong></td>
<td>Staff are able to access accessible parking which is allocated on every floor of carpark A &amp; B close to lift access. Daily records are kept of disabled carpark usage. Where there is evidence of insufficient disabled staff carparking the carpark manager will investigate increasing the number of mobility parks.</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>There is a parking liaison person within facilities, Reg Prasad who deals with parking queries and works with the parking provider, DHB service and occupational health staff and the individual involved to find bespoke solutions if necessary for disabled staff members.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>8</th>
<th><strong>a)</strong> Publishes the eligibility criteria and process for obtaining refunds of the cost of car parking in all its communications channels with patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong></td>
<td>Through the patient 101 workstream information about parking eligibility and criteria will be included in all communication channels.</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>Project is currently auditing all information provided to patients and visitors with a view to standardising this across the DHB wherever possible.</td>
</tr>
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<tr>
<th>9</th>
<th><strong>a)</strong> Discusses with Auckland Transport a plan to improve accessible transport to and between the four ADHB site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong></td>
<td>ADHB has engaged with Auckland transport to improve traffic flow to and from the ACH site and around the site.</td>
</tr>
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</table>

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<thead>
<tr>
<th>10</th>
<th><strong>a)</strong> When choosing future fleet cars, considers the extent to which they have to carry equipment and the needs of staff with mobility impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
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<table>
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<tr>
<th>11</th>
<th><strong>a)</strong> Advises patients with disabilities to bring with their disability-related personal equipment during hospital stays</th>
</tr>
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<tbody>
<tr>
<td><strong>b)</strong></td>
<td>Investigates a cost effective system for maintaining security for such items</td>
</tr>
<tr>
<td><strong>a)</strong></td>
<td>Admitted patients with disabilities are advised to bring their own equipment in as it is likely that it will be specialist equipment. ADHB attach tags to this patient owned equipment so that it can be identified and not confused with the equipment loan pool.</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>Investigating system availability and costs</td>
</tr>
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<tr>
<th>12</th>
<th><strong>a)</strong> Investigates the reported shortage of wheelchairs, purchases sufficient wheelchairs to avoid unnecessary delays in patient service and that the costs of buying replacement wheelchairs are weighed</th>
</tr>
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<tbody>
<tr>
<td><strong>b)</strong></td>
<td>There is no reported shortage</td>
</tr>
<tr>
<td><strong>c)</strong></td>
<td>Wheelchairs are purchased via CAPEX and procurement process for each service</td>
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</table>
|13 | a) Adopts, following discussion with relevant staff, a consistent design of accessible and functional toilets and bathrooms for the wards; and  
   b) Reviews the location of all accessible toilets for patients and visitors, establishes whether there are sufficient numbers in accordance with best practice guidelines and develops a plan for upgrades to meet current standards  
   a) In any new build or upgrade facilities follows Barrier Free / design Standards  
   b) The Barrier Free advisor is engaged and this can be assessed as part of the Level 5 and Level 9 Redesign Projects |
|14 | a) We consult Barrier Free Advisors to ensure accessibility issues are addressed for any refurbishment, re-design project or new builds.  
   b) ADHB has introduced an equality impact assessment to identify diversity issues when making changes to policies, service design etc and this includes disability issues |
|15 | a) Considers how best to collect disability-related information from consumers who wish to give it and how best to provide such information to ADHB staff as needed  
   a) The ADHB patient experience survey asks specific questions related to disability and reports on these themes to the HAC.  
   ADHB’s Patient Experience Survey [http://adhbintranet/QualityDepartment/Patient_Experience/] |
|16 | a) Commissions modules of disability awareness training for including in MOODLE and systematically ensures all ADHB staff receive such training every one to two years  
   b) Designated Professional Leader attends the Welcome Day for new staff  
   c) A representative from the Independent Living Services also attends the Welcome Day  
   d) The staff MOODLE is in place and use on the intranet: ‘Disability Responsiveness’  
   o plan to make it a 2 year training  
   e) ‘Responding to Disability’ staff pamphlet has been developed and printed and is given out to staff at Welcome Day  
   f) Future plans:  
   • distribution pamphlet to each service area  
   • develop a poster for lifts – Med Photogoraphy  
   • Explore annual communications campaign every UN International Day of People with Disability (December 3) using social media platforms to link ODI and UN campaigns. |
|17 | a) Review the accessibility of content in MOODLE modules and makes adjustments to comply with online accessibility standards if required.  
   Ongoing |
|18 | a) Appoints a disability liaison officer to have oversight of disability awareness training  
   a) Work in progress – establishing disability champions across the Directorates |
for all ADHB staff and to provide disability related support to ADHB staff with disabilities

| • ADHB has chosen not to appoint a disability liaison officer. Leadership provided by the CHPO.  
| • Currently scoping implementation of disability champions across services  
| • Collaborating with Waitemata DHB disability liaison officer |
**TOP THREE**
Patients believe these things make the most difference to the quality of their care and treatment:

1. Communication (clear answers patients can understand) 51%
2. Feeling confident about the quality of their care and treatment 45%
3. Getting coordinated care 40%

**Rated Excellent**
Every bit of information, equipment and support we could ever have asked for was provided before we were discharged. Fantastic.

I needed a wheelchair and I had one the minute I got to the hospital.

**Rated Good**
If you’re on your own with a child that needs a wheelchair to get into the hospital, there was no help offered. I had to carry him everywhere and then had the added stress of having to move my car or have it towed! Not great at 11pm at night on my own.

**Rated Fair or poor**
I was forced to push myself to beyond the limits of my physical ability and then when this caused me great distress I was given anti-anxiety medication, which then made it impossible for me to communicate these problems.

Nobody seemed to care a damn about coping at home... A medical social worker made some grandiose statements about after care but to date I have not heard a whisper from her. A request for an additional shower stool took over a week to get a response on the excuse that the person was on a week’s leave - - in the meantime I have purchased another stool - - 3 1/2 weeks after discharge. A belated phone call was received from home help services some 11 days after discharge. By this stage I had managed to introduce a regime that enabled me to survive.

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**Difficulty with everyday activities and self-directed care**

Enabling people to maximise their own health and well being is a central part of self-directed care. Providing appropriate care and support for people with disabilities supports self-directed care, maintains dignity and demonstrates respect.

We are all responsible for the care of people within our services who experience difficulty doing everyday activities. You need to ask each person you see whether they have specific difficulties. Some disabilities are hidden. Ask what assistance may be needed to manage while in hospital. Be mindful of those who have short term difficulties due to their current medical condition, procedures or medication.

People with communication difficulties are at risk of serious harm during hospitalisation if their particular needs are not assessed accurately and provided (Death by Indifference, Mencap, 2007). Often the person themselves can tell you the best way to communicate with them, or their family will be able to. A Speech Language Therapist can help with suggestions of how to help the person communicate their needs to you, particularly if there are new communication difficulties.

Consumers may have a Health Passport to help their health providers understand their special needs. Look for it and ask for it. For more information, go to our intranet page: Health Passport - Information for ADHB Staff.

If a person has a disability, it may take you longer to do the assessment or give standard care. You may need to go away to do something urgent but communicate this and go back to the person who needs extra care or assistance. Communicate within your team and handover specific needs and management plans.

We have recently launched a new online Moodle course on Disability Responsiveness to assist staff to support consumers who live with disability. This course is aimed at all staff. (Log in to Moodle: http://adhb.moodle.co.nz/course/view.php?id=369, and sign up using the enrolment key “responsive”)

**Sue Waters**
Executive Director Allied Health
Scientific & Technical

“When I was in Hospital after my stroke I was left a bit too long from time to time I couldn’t talk so a couple of times I was left in wet hospital gown and bed for a bit too long... I realise that the nurses are very busy but this was very uncomfortable extra help for someone like me in that situation would have been really good. I couldn’t speak and didn’t remember about the buzzer so sometimes things weren’t seen too until my wife came in and went and got help.”

“Once up in the ward my left arm had had surgery, I was given a pillow to elevate the arm, I had no help to open containers or butter bread etc. Everything I needed I had to ring the bell. My husband had to dress me and as I left on the same day I even had to ask for a wheelchair because there was no way I could walk down to the car.”
Disability report

The report this month focuses on our patients who have disabilities. Some are permanently disabled; however many have short term disabilities as a result of an injury or condition. This month’s report is about providing the best care and treatment to those who have difficulty doing everyday activities, whether their disability is whilst they are in hospital, short term, longer term on permanent.

Over one-third of the patients who responded to the In-patient experience survey said that they had difficulty doing everyday things. One thousand commented on the support they received. It appears that their experiences, good and bad, are highly correlated with how they rate their overall care and treatment. Their insights can be used to help us improve our services.

Overall satisfaction

Each month patients are asked to rate their overall care and treatment.

In February there was a drop in the percentage of patients rating their overall care as very good or excellent. This fall was seen across all the Health Service Groups other than Cancer and Blood.

Overall care rated very good/excellent (%)

In the past 12 months most patients (82%) rated their care and treatment as very good or excellent. Around one per cent rate it as poor, with a further four per cent rating it as fair. There are small but significant differences between the Health Service Groups.

Overall care and treatment satisfaction by Health Service Group (%)

Over one per cent rate it as poor, with a further four per cent rating it as fair. There are small but significant differences between the Health Service Groups.

PATIENTS’ VOICES

Rated overall care as excellent:

I was advised of the difficulties I would experience along with tips on how to better assist me.

All staff spoke clearly and took into account my father’s age and ability to absorb information, however, I as a daughter was there as a back-up for any further advice or communication from them on his behalf.

Rated overall care as good:

No one ever asked me whether I had conditions that were disabling.

I was loaned a wheel chair to get back to the car. The nurse did finally heat my wheat bag for me to help with the pain, when she realised I could not make it to the family room myself. I think there is a lack of understanding about patients in pain and how best to manage it, and how it manifests in different people in different ways. I find it hard to communicate and comprehend when I am in severe pain.

I just didn’t have the strength to do everyday chores around the house. Like keeping my toilet clean, cooking meals, hoovering the house. I would have loved to have the help of a caregiver. The nurses I asked in the hospital had no information and I had no idea where to ask for it.

Had to borrow wheelchair from ward and then be left on own on pavement while chair was returned to ward.

Rated overall care as fair or poor:

I am partially disabled, Social Worker was to access and help me with certain things and didn’t follow through, AGAIN.

I have osteo arthritis in my shoulders which limits me in my movements and even though I asked for assistance once the 24 hour nursing care finished I was really left on my own to care for myself. Which I felt was very unfair.

I have had to ask, but the request has always been handled well, for a wheelchair, home help, assistance with transport to and from work. I was not aware of what I was entitled to, so people in my workplace advised me from their past experiences.
Disabilities

Difficulty doing everyday activities

It is noted that although some patients experience long term disabilities, many of ADHB patients have conditions that affect their ability to do everyday things in the short term. They too may require support. Hence ADHB patients were asked whether they had difficulty doing everyday activities because of a health condition or disability. Over one-third (1,872 or 39%) said they had. Twelve per cent indicated that they had longer term (6 months or more) or permanent difficulties, 18 per cent said that they had shorter term difficulties that were unlikely to be permanent and a further nine per cent had difficulties while in hospital.

<table>
<thead>
<tr>
<th>Difficulty doing every day activities (%) n=4760</th>
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<tbody>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>0%</td>
</tr>
<tr>
<td>20%</td>
</tr>
<tr>
<td>40%</td>
</tr>
<tr>
<td>60%</td>
</tr>
<tr>
<td>80%</td>
</tr>
<tr>
<td>100%</td>
</tr>
</tbody>
</table>

Of those that had difficulty doing everyday things, almost three-quarters (73%) said that they had difficulty walking, bending or lifting.

Type of difficulty (%)

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Walking/bending/lifting</th>
<th>Hands - grasping/holding</th>
<th>Hearing</th>
<th>Learning/concentrating/remembering</th>
<th>Communicating/socialising</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>73</td>
<td>17</td>
<td>8</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>20%</td>
<td>17</td>
<td>21</td>
<td>4</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>40%</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>60%</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>43</td>
<td>23</td>
</tr>
<tr>
<td>80%</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>43</td>
<td>22</td>
</tr>
<tr>
<td>100%</td>
<td>5</td>
<td>12</td>
<td>7</td>
<td>43</td>
<td>22</td>
</tr>
</tbody>
</table>

Note that as some patients had more than one difficulty the percentages exceed 100.

Patients were asked to think about their difficulties and if they felt that we gave them the support they needed. This included access to buildings and facilities, any technology or equipment that they needed, support from staff, caregivers, or interpreters.

One third (34%) did not feel that they got the support they needed, or only got it to some extent.

Were given the additional support they needed (%)

<table>
<thead>
<tr>
<th>Overall</th>
<th>Not needed</th>
<th>No</th>
<th>To some extent</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>8</td>
<td>26</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Women's Health</td>
<td>21</td>
<td>9</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td>Children's Health</td>
<td>21</td>
<td>9</td>
<td>29</td>
<td>42</td>
</tr>
<tr>
<td>Cardiac</td>
<td>25</td>
<td>5</td>
<td>16</td>
<td>53</td>
</tr>
<tr>
<td>Cancer &amp; Blood</td>
<td>28</td>
<td>2</td>
<td>23</td>
<td>46</td>
</tr>
<tr>
<td>Adult Health</td>
<td>29</td>
<td>9</td>
<td>26</td>
<td>41</td>
</tr>
</tbody>
</table>

The differences were significant p< .05.

Overall satisfaction

Patients who did not have difficulty doing everyday activities were much more likely to rate their overall experience with ADHB services positively than those who experienced difficulties.*

<table>
<thead>
<tr>
<th>Experience</th>
<th>Rated overall care as excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difficulty</td>
<td>45%</td>
</tr>
<tr>
<td>Difficulty in hospital</td>
<td>38%</td>
</tr>
<tr>
<td>Short term difficulty</td>
<td>42%</td>
</tr>
<tr>
<td>Long term difficulty</td>
<td>41%</td>
</tr>
</tbody>
</table>

There was a marked difference in overall satisfaction levels between those who felt that they got the support they needed and those who did not. Only 14% of those who did not feel they got the support they needed considered their care to be excellent.*

<table>
<thead>
<tr>
<th>Experience</th>
<th>Rated overall care as excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not need support</td>
<td>41%</td>
</tr>
<tr>
<td>Got the support needed</td>
<td>58%</td>
</tr>
<tr>
<td>Got some support they needed</td>
<td>21%</td>
</tr>
<tr>
<td>Did not get the support they needed</td>
<td>14%</td>
</tr>
</tbody>
</table>

There were also differences in satisfaction levels according to the types of disabilities experienced.*

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Rated excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>40%</td>
</tr>
<tr>
<td>Using hands</td>
<td>40%</td>
</tr>
<tr>
<td>Hearing</td>
<td>38%</td>
</tr>
<tr>
<td>Learning</td>
<td>39%</td>
</tr>
<tr>
<td>Seeing</td>
<td>37%</td>
</tr>
<tr>
<td>Communication</td>
<td>36%</td>
</tr>
</tbody>
</table>

*The differences were significant p< .05.
A closer look at: Disability

The survey invites patients to tell us what ADHB is doing well, and to give suggestions on anything we could do differently. Awareness of these issues can be used to help modify how we treat and care for our patients.

Almost 1000 (979) patients commented about the support they needed in dealing with the difficulties they were experiencing. Those who felt that they got the support they needed got good support from physiotherapists and OTs, were given clear instructions on how to use equipment and were given equipment in hospital and at home, and were treated with compassion. Staff offered support.

**Good care**

**Acknowledge needs respectfully**

Patients appreciated having their difficulties acknowledged and being treated with respect and compassion.

“I was very happy when asked what my needs were and asked what the nurse could do to help “just tell me what to do, you live with this everyday I am here to help you for just 2 days”

**Equipment**

Patients were supplied with the equipment they needed.

“I was provided with crutches by the physiotherapist which has vastly improved my mobility and independence, though advice on the best ways to move/maintain normal mobility was somewhat lacking.”

“The hospital supplied chair to sit on shower chair and a thing that help you to get out of bed plus a walker all delivered and picked up when finished with.”

**Clear information**

Patients were also given clear instructions on how to use equipment.

“Staff taught my son to walk with crutches and to do the stairs. Taught us how to bathe and toilet him supplied toilet chair and bath board which were a necessity at home.”

“The physio and also nursing staff taught me how to dress myself while temporarily disabled. The physio could have been more forthcoming for useful ideas about how to manage at home.”

**Proactive help**

Help was offered while in hospital and on discharge.

“I was asked more than once and from various staff, how I would cope at home, and if I would need any arranged help at home, to which I replied no, as I would be able to cope on my own. It was good that there were options and assistance available during hospitalization, for such help if needed.”

**Areas for improvement**

**Needs ignored**

Many of the patients dissatisfied with their care felt that staff lacked compassion and did not offer to help them.

“No one ever asked me whether I had conditions that were disabling.

“I had trouble following the surgery with getting out of bed and hygiene needs. at no time did a nurse or other offer to help. I relied heavily on my whānau for this support which was fine but no offer and I had to repeatedly ask for help in adjusting my bed and when a nurse could see I was struggling to sit up so she could do tests did not offer to help till I said I gave up and said I can’t move said oh do you need help.”

**Equipment**

Patients were not provided with equipment that they needed or felt would help them and keep them safe.

“There was no shower chair which would have made me feel safer and more comfortable while showering. I had a major operation and was not offered a wheelchair to get me to the car park upon discharge...I was in pain when I walked and had to rely heavily on my husband for support.”

“As I was still not walking well my husband asked about a wheelchair to take me to the front entrance where our daughter was picking us up. He was told they didn’t have any - try the entrance - they had none either, so I found it a real struggle to walk the distance even with the aid of my husband.”

**Clear information**

Patients were not given information on how to manage their condition.

“I was instructed by doctors not to lift, bend or exert my abdominal muscles. However the midwives did not offer counseling on how to work within these limitations - either within hospital or once home - until just before discharge, i.e. several days after being severely limited and/or being in pain.”

**How to make a difference**

Patients who experience difficulties doing every day activities are much more likely to feel that the care they receive at ADHB is excellent if they get the support they need.

To provide excellent care patients are telling us to:

- Focus on their strengths, and needs rather than their disability i.e. don’t assume they can or can’t do things – find out
- Ask if they have a disabling condition – many of the conditions are hidden
- Ask if they want or need support
- Be mindful of their disability and proactive in our support i.e. if they can’t hear well, speak clearly and slowly, if they can’t sit up, ask how you can assist them.
- Provide the equipment needed both in hospital and at home
- Provide good information on how they can manage their condition and care for themselves e.g. dress or shower themselves, lift things safely
- Provide instructions on how to use equipment safely – some have not used it before and are unfamiliar with how to use it
- Make sure that they are supported on discharge.

**In addition:**

Sign language interpreters are available through the Interpreting service

**Disability Responsiveness course** available to all staff - (Log in to Moodle: [http://adhb.moodle.co.nz/course/view.php?id=369](http://adhb.moodle.co.nz/course/view.php?id=369), and sign up using the enrolment key “responsive”)”

**Health Passport:**

Check on the intranet for information on Health passport for those with special needs. Health Passport - Information for ADHB Staff.
Noticeboard

Patient Feedback

“This is the first time I was asked to do a survey after we had experience in hospital. This is a really good opportunity to have our say, and also it is good for hospital to know what is good and what is bad. I suggest to keep it going, and follow this way I believe the hospital will definitely improve a lot. Good job, well done.”

Email addresses

The Patient Experience survey is currently sent to in-patients that provide us with current email addresses. This means we need up to date email addresses for our patients.

You can help by making sure that:

- Patient email addresses are collected and checked before discharge.
- Email addresses are recorded accurately.

Let us know about the changes you are making

We would like to hear how the Patient Experience reports are being used, and about any changes that are being made in response to this feedback.

We are particularly interested in hearing specific examples of changes you have made.

Please let us know at SarahD@adhb.govt.nz

“(The nurses) go above and beyond what is expected of them and they truly bring the compassion to nursing. I felt safe in their care and I felt supported and respected as a human being. You should be proud to call them your staff because they make painful, difficult and exhausting hospital stays bearable - so thank you.”

Executive Summary

The April Patient Experience Report focuses on disability. This is the administrative report that gives background details such as the method used, the response rate and information about the respondents.

Response Rate

- A total of 17,929 patients discharged between 1 September 2011 and 29 April 2013 were sent an email containing a link to the survey.
- One-quarter (27%) completed the survey, with 31 percent completing or partially completing the survey.

Requests for contact

- Up until 30 April, a total of 11 percent of the patients who participated in the survey requested ADHB contact them directly about their experience.

Complaints

- One per cent of the requests for contact were formal complaints.

Making the most difference

- Communication, having confidence in the quality of their care and treatment, and getting consistent and coordinated care while in hospital, are the three things patients say make the most difference to their hospital care and treatment.
- Overall, these percentages have remained largely stable over the last few months.

Overall ADHB Care and Treatment

- The percentage of patients rating their overall care and treatment as very good or excellent reached a high of 86 percent in January 2013. The differences, although small, are significant.
What makes a difference?

Communication, having confidence in the quality of their care and treatment, and getting consistent and coordinated care while in hospital, are the three things that patients say make the most difference to their hospital care and treatment. Getting good information and being treated with dignity and respect is important to patients. Overall, these percentages have remained largely stable over the last few months.

The three things that make the most difference to care and treatment

How patients rate their care and treatment

Rating ADHB’s care and treatment

Having identified the factors they consider make the most difference to their care and treatment, patients are then asked to rate ADHB’s performance on each of these dimensions, on an 11-point scale where 0 is ‘poor’ and 10 is ‘excellent’. The ratings have been grouped as Poor (0-4), Moderate (5-7) and Very Good (8-10)

Most patients rated ADHB’s performance as very good (between 8 and 10) on the dimensions they considered important to them. Most (80%) felt confident that they received good quality treatment and care, and indicated that they were treated with dignity and respect (80%). Similarly, most felt that whānau/family and friends were able to support them (77%), were involved in decisions about their health and care (73%) and that staff did everything they could to help manage their pain (73%).

Patients were most likely to give a poor rating to food (61%), the coordination of care between hospital, home, and other services (21%), the management of nausea (14%), and cleanliness (14%).

Rating ADHB’s performance
Administrative information

About the Patient Experience Survey

Patients and their whānau/families have unique perspectives on their care. When they share these perspectives and insights they can help those delivering health care services to identify ways of improving performance.

The ADHB In-Patient Experience Survey is online. An email containing a survey link is sent to patients between one and two weeks after they have been discharged from hospital. They are asked about their most recent experience in hospital. The survey is sent out weekly, kept open for three weeks, and the results are collated, analysed, and reported each month. Note, no reminders are sent.

Response rate

A total of 17,929 patients discharged between 1 September 2011 and 29 April 2013 were sent an email containing a link to the survey. To date, one-quarter (27%) have completed the survey, with just under one-third (31%) completing or partially completing the survey.

Requests for ADHB to contact respondents

Up until 30 April 2013, 11 percent of those who participated in the survey requested ADHB contact them directly about their experiences.

Complaints

One percent of the requests for contact were formal complaints. Some did not want to be contacted, but wanted to make suggestions to improve services, or let ADHB know of their experiences. Others just wanted to compliment ADHB.

"I would like to know that my compliments were passed on to the two staff members mentioned, so I know they received the praise they were due."

For more information contact:

Sarah Devine, Quality Projects Facilitator, ADHB, 09 3074949 x 27941 SarahD@adhb.govt.nz
Alex Woodley, Point & Associates, 09 215 9663, alex@pointresearch.co.nz

ADHB Patient Experience Admin Report no.17 April 2013: 3
What Matters, Matters

It sounds obvious doesn’t it; what matters most to patients is what matters most to each individual patient. Indeed it is obvious, but like the proverbial wood amongst the trees, it is perhaps so obvious that we fail to see it.

In our patient experience survey we ask people what three aspects of care make the most difference during their hospital stays. The top three have been consistent, month after month, and are:

- Communication (clear answers patients can understand)
- Feeling confident about the quality of care, and
- Getting consistent and coordinated care

This month’s report digs a little deeper and shows that, unsurprisingly, different people hold different views about what aspects of these dimensions are more or less important to them. So, although across the board the same three areas come up time and time again, we now can show that if say ‘pain management’ is most important to you and your pain is not well managed, then it doesn’t matter how well we do on communication etc, you will have a poor experience. What matters, matters.

What this suggests is that the greatest gains in improving the quality of our patients’ experiences will be made if we are aware of the individual needs of our patients and are able to customise care accordingly. It appears to be less about any specific dimension of care, than the approach we take – the provision of individualised care. Comments from both the in-patient and community surveys suggest that this approach, taking the time to understand the individual needs of our patients, has the potential to both support our population to identify their needs and for our patients to feel more in control of their health and health care. What matters, matters.

In response to this we will be looking at ways we can encourage staff to ask people what matters to them early on in an admission and would welcome any feedback on ways to do this.

The other aspect we look at this month is differences in experience by ethnicity. Auckland DHB’s role is to maximise the health and independence of people living in our district and to provide high-quality healthcare. These ethnicity specific views provide valuable insight into how we can improve care for these patients and although many of the themes are similar, there are some important differences. Again, what matters, matters. Of particular concern however is the theme that came through for both Pacific and Asian patients that there were occasions when they felt discriminated against because of their ethnicity. Thankfully these were not common but it is a timely reminder of the need to treat all patients with dignity and respect, and in a way that is culturally appropriate for them.

Finally, we hit a significant milestone this month. Not only have those rating their care as very good or excellent peaked at 88 per cent for the second time in three months but for the first time since the inception of the survey, no-one rated their care as poor. This is a tremendous result and a huge credit to the organisation, well done.

Dr Andrew Old
Chief of Strategy, Participation & Innovation

ADHB Patient Experience Report no. 26 March 2014: 1
Population groups

ADHB’s role is to provide high-quality healthcare services and support the population of Auckland to be fit, healthy and well.

This report is designed to look at different population groups, such as Maori, Pasifika and Asian peoples, and analyse the feedback to the in-patient experience survey to identify the areas of care that are important to them. Although different population groups of in-patients appear to value similar overall aspects of care, such as good communication, caring staff, being listened to, and the coordination of their care and treatment, there are important differences. For example, those from Pasifika cultures, along with Asian and Indian patients strongly value being treated with dignity and respect.

This report looks at the aspects of care that different population groups have identified as important to them, and where we can make improvements.

It is noted that every interaction is important. Sometimes an isolated interaction or incident, particularly if it is negative, can have a profound effect on a patient’s overall rating of their care and treatment.

Overall care and treatment

In the year to January 31st 2014, 83 per cent of patients rated their care as very good or excellent.

Overall care and treatment ratings by Health Service Group (%)

<table>
<thead>
<tr>
<th>Health Service Group</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>11%</td>
<td>39%</td>
<td>44%</td>
<td>39%</td>
<td>44%</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>9%</td>
<td>39%</td>
<td>44%</td>
<td>39%</td>
<td>44%</td>
</tr>
<tr>
<td>Children’s Health</td>
<td>7%</td>
<td>30%</td>
<td>41%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>7%</td>
<td>38%</td>
<td>40%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Cancer &amp; Blood</td>
<td>14%</td>
<td>20%</td>
<td>38%</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>Adult Health</td>
<td>2%</td>
<td>12%</td>
<td>40%</td>
<td>43%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Overall n=4101 (Women’s Health n=1001, Children’s Health n=904, Cardiac services n=235, Cancer and Blood n=138, Adult Health n=1823)

Overall

The ADHB target is to have 90% of patients rating their overall care and treatment as very good or excellent. Overall the ratings have been trending upwards. In November 2013 and January 2014, those rating their care as very good or excellent peaked at 88 per cent. Moreover for the first time since the inception of the survey, no-one rated their care as poor.

Overall care and treatment rated very good and excellent (%) n=7448

What makes the most difference to patients?

MĀORI IN-PATIENTS

Communication 53%
Feeling confident about the quality of care 42%
Getting consistent and coordinated care 36%
Getting good information 34%
Being treated with dignity and respect 34%
Total respondents 700

PASIFIKA IN-PATIENTS

Communication 52%
Being treated with dignity and respect 44%
Feeling confident about the quality of care 40%
Getting consistent and coordinated care 36%
Getting good information 33%
Total respondents 626

ASIAN IN-PATIENTS

Communication 45%
Being treated with dignity and respect 43%
Feeling confident about the quality of care 39%
Getting consistent and coordinated care 38%
Getting good information 34%
Total respondents 631
What matters overall

The three aspects of care that the ADHB population considered made the most difference during their hospital stays were:

- Communication
- Feeling confident about the quality of care, and
- Getting consistent and coordinated care

Other key factors included:

- Being treated with care and compassion
- Being treated as an individual
- Pro-active and attentive care
- Being treated with respect and dignity, and
- Feeling included in decisions about care.

It is noted however that people hold different views about what aspects of these dimensions are important to them.

Moreover, comments from the in-patient and community surveys suggest that the greatest gains in improving the quality of the delivery of services will be made if we are aware of the individual needs of their patients and are able to customise care accordingly. Hence, it appears to be less about any specific dimension of care, than the approach we take – the provision of individualised care. What matters most to patients is what matters most to each individual patient.

Comments from both the in-patient and community surveys suggest that this approach has the potential to support our population to identify their needs and feel more in control of their health care.

What are patients asking for?

Patients matter

The ADHB population, and in-patients in particular, want to feel as if they matter i.e. that they are treated respectfully, with care and compassion, they are made to feel welcome and reassured.

They want staff to show they matter by being proactive, checking on them, taking an interested in their well-being and understanding and delivering on what matters to them. They want individualised care. Some patients feel staff are discriminatory and rude and as if they do not matter or matter less than other patients.

Respect them, their views and support them (though good information and communication) to make decisions

They want staff to respect their views, beliefs and decisions, communicate with them, provide them with good information, and listen to them. For some this is to help them to have greater control over their health, well-being and decision making ie they want to know about their condition, services and how to navigate an unfamiliar health system. For this group it appears partnering with health professionals who can provide parts of the picture they are unfamiliar with is important. Not all appear to want greater control over their health – they want to have trust and confidence in health professionals and feel in ‘safe hands’. Good communication is reassuring that health professionals are doing all they can for them.

The desire for good two-way communication and information (including test results) is strong. It is interesting to note, for example, that only 51 of the 8,864 in-patients surveyed to date (or 0.6%) felt that they had been provided with too much information.

How are we doing on what matters to patients?

Average rating on an 11 point scale where 0 is very poor and 10 is excellent.

In-patients (all ethnicities)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>7.9</td>
</tr>
<tr>
<td>Being treated with dignity and respect</td>
<td>8.5</td>
</tr>
<tr>
<td>Feeling confident about the quality of care</td>
<td>8.5</td>
</tr>
<tr>
<td>Getting consistent and coordinated care</td>
<td>7.8</td>
</tr>
<tr>
<td>Getting good information</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Māori in-patients

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>8.1</td>
</tr>
<tr>
<td>Feeling confident about the quality of care</td>
<td>8.6</td>
</tr>
<tr>
<td>Getting consistent &amp; coordinated care</td>
<td>7.8</td>
</tr>
<tr>
<td>Getting good information</td>
<td>7.9</td>
</tr>
<tr>
<td>Being treated with dignity and respect</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Pasifika in-patients

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>7.9</td>
</tr>
<tr>
<td>Being treated with dignity and respect</td>
<td>8.7</td>
</tr>
<tr>
<td>Feeling confident about the quality of care</td>
<td>7.7</td>
</tr>
<tr>
<td>Getting consistent and coordinated care</td>
<td>8.7</td>
</tr>
<tr>
<td>Getting good information</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Asian in-patients

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>8.0</td>
</tr>
<tr>
<td>Being treated with dignity and respect</td>
<td>8.5</td>
</tr>
<tr>
<td>Feeling confident about the quality of care</td>
<td>8.3</td>
</tr>
<tr>
<td>Getting consistent and coordinated care</td>
<td>7.9</td>
</tr>
<tr>
<td>Getting good information</td>
<td>8.0</td>
</tr>
</tbody>
</table>
A closer look at care for Māori

Overall, Māori identified similar positive and negative aspects of their care compared with the other ADHB respondents. There were, however, two areas of particular emphasis for Māori patients:

- Accommodating whānau to visit and stay overnight whilst in hospital – they want to feel (welcome and to be able to support their whānau;
- Culturally appropriate care: some respondents felt that hospital staff and those providing services could benefit from more training in tikanga best practice, and resources could in some cases better cater for Māori.”

Positive aspects of care

Caring staff: Respondents found hospital experiences potentially scary and stressful, and they appreciated efforts from staff to reassure them. Parents of young children appreciated staff who helped them to manage distressed children; and adults (especially young adults) who were unaccompanied during their procedures appreciated efforts to make them feel calm and welcome.

Communication: Respondents from all age groups appreciated being kept up-to-date with regard to the timing and outcomes of procedures. This not only made them feel included in the process, but also allowed them to make plans around their medical procedures.

Listening to patients: Patients want staff to listen to their opinions, feelings, and expertise. Parents appreciated it when staff listened not only to their expertise as caregivers, but also to children’s requests. Adults similarly wanted staff to treat them with respect and to listen to their requests and feelings about their own conditions and treatment.

Accommodating whānau: This is about feeling welcome when supporting. Respondents from all age groups indicated that they appreciate accommodation for their support people when in hospital – parents, caregivers, whānau, and partners. Although many parents felt accommodated, fewer adults felt that their partners and whānau were welcomed and given room to stay.

Smooth coordination of care: Patients appreciated it when staff communicated with one another clearly to ensure that procedures, transfers, and discharges went smoothly.

Improvements

Miscommunication. Patients did not appreciate it when miscommunications between staff members, or between staff and patients, led to disruptions in their care, poor follow-up, and excessive wait times.

Feeling ignored. Some felt neglected or ignored. This usually came about when staff failed to keep patients updated on what was happening, or failed to consult them which potentially led to care that did not align with patients’ wishes.

Rude or judgmental staff. Respondents did not appreciate it when staff spoke to them rudely, were unfairly judgmental, or failed to consider their opinions and wishes.

Lack of accommodation for support people. Some parents felt that the accommodation provided was inadequate or uncomfortable. A number of adults found it problematic that they could not have partners or whānau stay with them.

Nutritious and appropriate food. There were comments on food quality, appropriateness, or scheduling. Some felt food was insufficiently nutritious, or that it did not meet their dietary requirements. Others found that they went for extended periods without food, which was a particular issue raised by parents of young children.

Facilities. Some felt that the facilities were cramped or uncomfortable. In particular, young adults, teens, and women giving birth placed a high value on privacy, and some parents reported that conditions were cramped in their children’s shared rooms. Some respondents were also concerned with cleanliness and hygiene.

Follow-up and discharge. Some felt that they were not given enough information or support upon discharge. A number of adults who were alone during their stays requested written instructions for their home care, since they were not always able to remember instructions given at discharge. A number of new mothers felt that they were discharged from hospital too quickly and were not given enough instruction and advice about caring for their babies.

High ratings


“[The nurse] was reassuring and made me feel at ease with some of the procedures she had to carry out.” (65 years +)

High rating but ...

“The blue pillow case slips should be used for the head wherever possible as Māori consider this to be a Tapu area. My wife who was present made sure that my pillow slips were changed from white to blue. We also consider that the white pillow case slips to be available for everyday use and therefore should not be used for the head.”

Moderate ratings

“The ward allowed continued access at all times for whānau members.”

“We need Māori TV Channel – being Māori myself, many whānau and people would be very happy.”

“Try not to cramp two patients into small rooms, especially young children who require their parents with them. There was no space, nowhere to sit, nowhere to put your personal things. My husband had to sleep on the floor […] It is not ideal with a young child who is sick and stressed parents to have to share such a confined space.” (Parent)

Poor ratings

“The [doctor] did not introduce himself to [my husband] or make him feel in any way part of a process (he was effectively ignored) and I felt this was deeply inappropriate.”

“Place for my partner to sleep as he was required to stay the night as a support person.”
A closer look at care for Pasifika

Overall, Pasifika respondents identified very similar positive and negative aspects of their care compared with the overall surveyed groups. There were, however, two areas of particular emphasis for Pasifika:

- Discrimination against Pasifika peoples on behalf of some staff members;
- Care for those travelling from out of Auckland, including from the Pacific.

Positive aspects of care

Caring, compassionate staff: Pasifika respondents of all ages appreciated staff who made them feel reassured and comforted, and who treated patients as individuals. Related to this, adult Pasifika emphasised respect and dignity as important aspects of good hospital care.

Communication: Pasifika respondents appreciated being kept up to date about the timing of procedures, and having diagnoses, outcomes, and procedures clearly explained to them in plain language. Some felt the need for an interpreter.

Listening to patients: Pasifika respondents also appreciated it when staff took into account their feelings, beliefs, and opinions in determining treatment options. Like care and compassion, this theme was closely tied to respect and dignity, which was an especially important theme for Pasifika.

Smooth coordination of care: Pasifika of all ages also appreciated it when staff communicated with one another clearly to ensure that procedures, transfers, and discharges went smoothly. This was once again especially important for those visiting Auckland from overseas for treatment. Furthermore, some respondents expressed their appreciation for having an unchanging group of staff members overseeing their care, as they were able to develop rapport with their carers and developed a good system of communication.

Pro-active care: Pasifika respondents from all age groups expressed their appreciation when staff members offered help without being asked, and checked in on them frequently.

Improvements

Rude or judgmental staff and discrimination: Some Pasifika patients said staff spoke to them rudely, failed to consider their opinions and wishes, or failed to treat them with respect and dignity. Furthermore, some respondents reported that they had experienced discrimination from some staff members.

Miscommunication and wait times: Like members of other ethnic groups, Pasifika respondents did not appreciate it when miscommunications between staff members, or between staff and patients, led to disruptions in their care, poor follow-up, and excessive wait times.

Feeling ignored: Some Pasifika described feeling neglected or ignored – with staff failing to keep them updated on what was happening, failing to consult them on a course of action, or being too overworked to offer patients full attention.

Follow-up and discharge: Some Pasifika—especially adults who had travelled from distant suburbs or from overseas—felt that they were not given enough information or support upon discharge. Some Pasifika adults suggested that making better use of email would improve their ability to access information easily after discharge. While many respondents indicated that their discharge was too slow, some indicated that they felt moved out of hospital too quickly.

Nutritious and appropriate food: Some Pasifika indicated that food was unappetising or of poor nutritional quality, not appropriate for their dietary or medical needs, or that they went for extended periods without food.

Facilities and parking: One particular issue that was unique to Pasifika women—and to senior citizens of all ethnicities—was discomfort with mixed-gender wards. Like respondents from other ethnic groups, Pasifika respondents were also concerned with cleanliness and hygiene, and with excessive parking fees and few other transport options.

Pasifika patients say...

High ratings
“Staff are efficient and attentive to our son’s needs and always maintain a good rapport with him [which] is a huge need and comfort for family who need that extra support and reassurance during what is quite a sensitive time for the patient.”

High rating but...
“I felt that we were being treated differently to Pākehās in the family room. [...] They walked in, and the receptionists would jump off their seats to greet them and show them where the tea, cups, etc. were, and if they were not new patients they would at least have conversations with them. But for us, receptionists hardly say hi [...] never started a conversation with us or said a nice goodbye when we left. One time we were just about to walk in when the receptionist quickly turned away and pretending to be busy.”

Moderate ratings
“Well, my diabetic sister took three buses to come visit me [...] She got tired, being diabetic, and lay down on the sofas in the whānau room, but was reprimanded by staff and told that she should go home.”

“I and my daughter prefer to attend to my personal hygiene every morning and this is welcome by staff who appreciate some assistance, whereas in the other ward this was rejected, to the point where my daughter was told, not requested, to wait in the waiting room, to which she replied, no she would rather attend to my personal needs. I don’t think you would ever overcome the obstacles to meeting cultural needs, as this is possibly achieved through accepting values of ethnicities.” (80 years +)

Poor ratings
“I feel that because I am of Pacific Island heritage, [the nurse] was not willing to engage with me about my own care.”
A closer look at care for Asian patients

Like respondents from other groups, people of Asian ethnicities valued respect, compassion, and communication, prompt and streamlined care, and adequate follow-up. There were, however, two concerns that were unique to this group:

- Cultural and language support for non-English speakers;
- Discrimination against people of Asian ethnicities.

Positive aspects of care

**Caring staff:** People of Asian ethnicities appreciated caring, respectful staff who took an interest them individually. A number of respondents emphasised the importance of feeling that their cultural values were respected.

“One nurse was really kind and always had a smile on her face and made me feel at ease from the pain. [...] if all the nurses were as polite and caring as her, patients’ recovery time would be halved.”

**Communication:** People of Asian ethnicities appreciated efforts from staff to clearly explain the nature of their conditions, treatment options, and scheduling. In addition, they felt included in the process when staff would take the time to listen to their opinions and wishes. Those respondents for whom English is a second language particularly appreciated it when staff would make an effort to communicate with them even if interpreters were not present.

**Prompt, well-coordinated, pro-active care:** Like respondents from other groups, people of Asian ethnicities expressed their gratitude when their care was prompt and streamlined, and when staff made an effort to offer assistance and support without needing to be asked.

**Comfortable and clean accommodation:** Like other respondents, people of Asian ethnicities expressed their appreciation when they found that their hospital accommodation was clean and comfortable.

“Experienced and friendly staff. Caring nurses. Felt like I was in the good hands when my daughter was sick and am grateful that I had a bed in her room to sleep on.”

Improvements

**Miscommunication and wait times:** Like respondents from other groups, people of Asian ethnicities did not appreciate it when miscommunications between staff members, or between staff and patients, led to disruptions in their care, poor follow-up, and excessive wait times.

**Rude, disrespectful staff and discrimination:** Some described how staff spoke to them rudely, or failed to consider their opinions and wishes. A number of respondents of Asian ethnicities described feeling like they were dealt with in a racist manner. This theme also arose among Pasifika peoples.

**Feeling ignored:** Some people of Asian ethnicities described feeling neglected or ignored.

**Follow-up and discharge:** Some felt that they were not given enough information or support upon discharge or that the discharge process was unnecessarily slow.

**Comfort and hygiene:** Some respondents from all age categories expressed concerns about the cleanliness of their accommodation, and some also indicated that they found shared rooms to be disruptive and uncomfortable.

**Food:** A number of respondents commented on food quality, appropriateness, or scheduling. Some indicated that they would like to see Halal meat options incorporated into hospital menus. Furthermore, parents of young children were especially concerned about the scheduling of food, in particular that their children had been required to fast for extended periods due to surgery delays.

**Facilities and parking:** A number of respondents felt that parking fees were excessive, especially if they had to stay for more than one day and had no other transport options. Others found that hospitals were under-resourced and did not carry equipment that they required for their care.

Asian patients say ...

High ratings

“They took care of our social and cultural needs. They provided me with religious support. It helped me out at the most difficult time.”

“The staff treated him with such respect and care, which made him feel secured and less anxious about being away from home.” Support person for 85 + year-old

“We requested that my child’s surgery is scheduled at a particular time of the year as we were having overseas family coming over (to help). And our requests were granted! Thank you! It helped our family so much!”

“Staff, nurses, anaesthetist and doctor were friendly and made me feel like I ‘belonged’, not like an item that they just finish their job/task and send me off quickly. They were cheerful and pleasant, making me feel comfortable and relaxed.”

Moderate ratings

“Doctors and nurses were friendly and showed empathy to our situation.”

“Pay more respect to the cultural needs of non-English-speaking ethnicities by both native and non-native English speakers.”

“Some [nurses/midwives] were terrible and not understanding, telling me off for things that I didn’t know I had to do and some showing reluctance to help when I needed it.”

Poor

“Brief patients properly post-surgery – do not bung all info on the patients coming out of anaesthesia. Brief their family members – common sense?”

“Had two doctors talking about me in a whispering manner after doing a test as they walked out and to me – this is disrespectful.

“I asked for an MRI scan before surgery. But she decided to do my surgery before MRI scan – a big, big mistake here. Maybe she thinks I am Chinese, so no need to take care?!”
Accessibility of information for people with disabilities

Recommendation

That the report be received.

Prepared by: Gilbert Wong, director of communications, Auckland District Health Board
Errol Kiong, senior advisor - external affairs, Waitemata District Health Board

1. Executive Summary

This report outlines the approach of the Auckland and Waitemata communications teams at making DHB information as accessible as possible to people with disabilities. It covers the approach that is adopted for both print and web-based communications, and has been prepared as a result of a request made at the March DSAC meeting for this information to be provided to committee members. It also outlines future plans at both DHBs to further improve accessibility of information for people with disabilities.

2. Communications approach

The Auckland DHB has embarked on an umbrella project First Impressions that encompasses a range of projects to improve access for patients, visitors and staff to the DHB services. The main First Impression projects are: plain English reviews of outpatient communications, a refresh of the Auckland DHB website and intranet to ensure the key communication channels meet e-Govt accessibility guidelines. The DHB has also completed a wayfinding trial based on co-design that has reviewed signage on Wards 81 and 83. The trial, co-design wayfinding process included Ms Vivian Naylor (Barrier Free Advisor and Educator, CCS Disability Action) and Ms Carol Groom. This project will inform progress towards universal access across the Auckland DHB sites and facilities.

The communications team continues to promote the value of plain English communications with tips highlighted in internal communications channels with links to the DHB writing and publication guidelines that outline how text produced by staff at the DHB can be made clearer, simpler and avoid jargon. The publication guidelines include format documents using consistent fonts and formats that enhance legibility.

The communications team has worked with the DHB’s corporate service team to promote simplicity and clarity for reports for meetings.

At Waitemata DHB, the development of any new print or web-based communications collateral is guided by a number of documents, including the Waitemata DHB Style Guide and the organisation’s internet accessibility strategy. A range of informational/educational material produced at the DHB is also reviewed by a health literacy group convened by the Health Links.

The Waitemata DHB Style Guide is the primary reference point for all new print-based communications material. Adopted in August last year, the Style Guide formally sets down the DHB’s approach to written communications for members of the public.

Along with extensive guidelines on the use of plain English, the document also identifies one standard typeface for all DHB printed communications material – Calibri 11 point – as well as the standard typeface for web-based communications – Verdana 10 to 12 point.
Calibri 11 point was chosen as the standard typeface for a number of reasons, including:

- **Easy readability on both screen and printed material**
  
  Calibri is part of a series of new fonts created to improve screen readability (as more people are reading documents on a screen rather than physically printing documents out). It also works well for printed documents, with larger spacing between lines, allowing for better readability. It is now the default font for the Microsoft office suite, replacing Times New Roman and Arial typefaces.

- **High legibility**
  
  Individual letters are easily identifiable in Calibri. The UK’s Royal National Institute for the Blind recommends a sizing of between 9 and 12 point type as the suggested minimum for text. Waitemata’s standard size is 11 point Calibri for body text.

- **Supports recommendations around fonts for people with dyslexia**
  
  Many dyslexic people find that the readability of a piece of text varies greatly depending on the font used. Calibri’s shape and style supports better readability for people with dyslexia, which is estimated to affect one in ten New Zealanders. [http://www.dyslexic.com/fonts](http://www.dyslexic.com/fonts)

- **Type personality and adaptability**
  
  Calibri is an adaptable typeface, making it suitable for both smaller sizes in body text as well as larger headline sizes (which some typefaces are not suited for). It is pleasant on the eye, with soft rounded corners that make for a smooth reading experience, hence its description as a ‘warm’ and ‘friendly’ typeface.

Web-based communications at Waitemata, meanwhile, is guided by the Style Guide – which identifies the standard typeface for web-based communications as Verdana 10 to 12 point – and the DHB’s internet accessibility strategy document, which was first presented to DSAC in 2009.

The Waitemata DHB corporate website was re-developed in 2010 based on the guiding principles contained in the internet accessibility strategy document, including:

- **Page organisation**
  
  - Minimising page size and the need for scrolling down. The former site had some very long pages and these were reviewed for relevance, and where appropriate, split into more than one page. Along with better design, this move benefits site users that rely on screen magnifiers, who already have to scroll many times to see one standard-sized screen of content.
  
  - Cascading menus or navigation bars are not used, as people using screen readers or people with motor skill impairment find it difficult to drag and hold the mouse and then click with precision on the correct option. (The former website navigation menu was a cascading one).

- **Images**
  
  - Crisp and clear images are used, ensuring that they are still visible when enlarged by a screen magnifier.
  
  - Use of ‘alternative text’ tags (ALT tags) which describe images for users who cannot see them. An ALT tag provides the text that you can sometimes see when you hold
your mouse over an image on a website, and is read by screen readers. These were not present in the former DHB website.

- Avoids the use of images as the only way to link to something. The former site had images that were used as the sole navigation method to other pages, which limited accessibility for those with vision impairment.

- **Links and buttons**
  - All links in the redesigned website are in a different colour to the main text, are underlined, and have ALT tags, ensuring easy distinction between links and body text.
  - The redesigned website also refrained from using ‘click here’ links, instead using a descriptive text that explains what the link is for (e.g. ‘download our Primary Health Care Plan’). Users with screen readers often scan pages for links – a ‘click here’ link does not convey information about the subject or the link.

- **Text**
  - Use of the 10 to 12 point Verdana font size across the DHB website ensures that users with screen magnifiers are able to increase the text size while still enabling the magnified text to be clear enough to read.
  - The option was also included for users to easily further increase the standard font size themselves through a button at the top of each page. While changing font size is possible by adjusting browser settings, some people may not know how to do this.
  - The redeveloped Waitemata website also continued to use a sans serif font, which is recommended as the easiest font for users with low vision to read.

In addition to this, the current website also features an Accessibility Assistance page [http://www.waitematadhb.govt.nz/Access.aspx](http://www.waitematadhb.govt.nz/Access.aspx) which describes how access can be made to the various web pages without a mouse. A list of shortcut key numbers is listed on this page, including a keyboard shortcut to a site map page, which makes it easier for the visitor to select their required page.

Newer documents on the Waitemata website also are also created using the more recent versions of Adobe Acrobat (versions 8.0 onwards). Documents created using these later versions of Adobe allow for full tagging of a document so accessibility software are able to read the entire file (something not possible for PDFs created using earlier versions of Adobe Acrobat).

Further refinements to the website from an accessibility perspective took place in 2012 following feedback from a visually impaired user who was asked to review the website by Waitemata DHB disability strategy coordinator Samantha Dalwood. Based on the user’s feedback, a number of changes were made, including making it easier for users to locate general information such as visiting hours.

### 3. Future plans to improve accessibility


- Accessible HTML
- Tagged PDF files, optimised for accessibility. Don’t use ordinary PDF files as the only communications tool. They cannot be read by screen readers and can be inaccessible to people with other impairments as well.
Specialist formats, like audio, New Zealand Sign Language videos, captioned videos, and transcripts, can be put online.

The first two have already been implemented with Waitemata’s website redesign in 2010. The third criterion, specialist formats, is being factored into a proposal currently being prepared to rebuild the website interface.

Mobile devices such as smartphones and digital tablets are increasingly being used as the primary means for accessing the web. Web browser technology has correspondingly responded to this trend, with abilities to display a site with a best fit for the device it is being displayed on (responsive design).

The redesign is a response to this trend, enabling Waitemata DHB’s website to be better displayed on mobile devices. But it should also improve accessibility, with the ability to zoom in to site content more easily than is possible currently.

Video and audio formats will also be increased under the rebuild, providing more options for information access for site visitors with disabilities. This has already been progressively added to the current Waitemata DHB website with videos for pre-operative patients, providing them with advice on preparing for surgery, the surgery process and post-operative recovery. There are plans to increase this type of video experience in the near future for some Waitemata clinical services.

The Auckland DHB broad communications approach will be informed by the key principles outlined in the UN Convention on the Rights of People with Disabilities. These are in summary: respect for inherent dignity of all people, non-discrimination, full and effective participation and inclusion, respect for difference, equality of opportunity and accessibility.

The Auckland DHB website has been due for a refresh and update for some years. The 2014/15 communications budget includes funding to embark on a major website refresh. The project brief will include the need to meet e-Govt guidelines for accessibility, and ensure that the three key criteria noted above are incorporated in the new website and intranet. The brief for the new website includes the need to ensure core Auckland DHB information is available in multiple and accessible formats, including audio, NZSL video and captioned video.