Disability Support Advisory Committee Meeting

Wednesday, 11 March 2015

1.30pm

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

He Oranga Tika Mo Te Iti Te Rahi

Healthy Communities, Quality Healthcare

Published 04 March 2015

Agenda
Disability Support Advisory Committee
11 March 2015

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

Time: 1.30pm

Committee Members	**ADHB and WDHB Staff**	
Sandra Coney (Chair)	Dr Dale Bramley	Chief Executive Officer Waitemata DHB
Max Abbott	Ailsa Claire	Chief Executive Officer Auckland DHB
Jo Agnew (Deputy Chair)	Samantha Dalwood	Disability Strategy Coordinator WDHB
Judith Bassett	Aroha Haggie	Acting Māori Health Gain Manager
Pat Booth	Dr Debbie Holdsworth	Director of Funding – Auckland & Waitemata DHB
Marie Hull-Brown	Katrina Lenzie-Smith	Programme Manager, Health of Older People
Dairne Kirton	Kate Sladden	Funding and Development Manager, Health of Older People
Dr Lester Levy		
Jan Moss	Marlene Skelton	Corporate Business Manager
Robyn Northey	Jesse Taylor	Corporate Committee Administrator
Russell Vickery	Vanessa Waldron	Executive Officer, Planning, Funding and Outcomes
	Sue Waters	Chief Health Professions Officer
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members: None

Apologies Staff: Sue Waters

Agenda

Please note that agenda times are estimates only

1.30pm **1. Attendance and Apologies**

2. Conflicts of Interest

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?

3. Confirmation of Minutes 27 August 2014

4. Action Points

1.40pm **5. Chair's Report**

1.45pm	**6.**	**Presentations**
	6.1	Suicide and the older person – Dr Gary Cheung
	6.2	Putting People First Quality Review – Mark Johansson
2.45pm	**7.**	**Improvement Activities**
	7.1	Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs
	7.2	Implementation of the Auckland and Waitemata DHBs NZ Disability Strategy
3.10pm	**8.**	**Papers**
	8.1	Collation of Statistics that Identify People with Impairments
	8.2	DiSAC Terms of Reference
3.30pm	**9.**	**Confirm**
	9.1	Action Points for next DiSAC meeting
	9.2	DiSAC feedback to CPHAC
	9.3	DiSAC feedback to Board
3.45pm	**10**	**Resolution to exclude the public**

Next Meeting:	Wednesday, 03 June 2015 at 1.30pm Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare

Attendance at Disability Support Advisory Committee Meetings

Members	12 Mar. 14	04 Jun. 14	27 Aug. 14	19 Nov. 14	28 Jan. 15	22 Apr. 15	15 Jul. 15	07 Oct. 15
Sandra Coney (Chair)	1	1	1	c				
Max Abbott	x	x	1	c				
Jo Agnew (Deputy Chair)	1	1	1	c				
Judith Bassett	1	1	x	c				
Pat Booth	1	1	1	c				
Marie Hull-Brown	1	1	1	c				
Dairne Kirton	1	1	1	c				
Lester Levy	x	1	x	c				
Jan Moss	1	1	1	c				
Robyn Northey	1	1	1	c				
Russell Vickery	1	1	1	c				
Key: x = absent, # = leave of absence, c = meeting cancelled								

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.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Register of Interests – Disability Support Advisory Committee

Member	Interest	Latest Disclosure
Sandra CONEY (Chair)	Chair – Waitakere Ranges Local Board, Auckland Council	12.12.2013
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	28.09.2011
Jo AGNEW	Professional Teaching Fellow - School of Nursing, Auckland University Appointed trustee Starship Foundation Casual Staff Nurse - ADHB	01.03.2014
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation	14.05.2014
Pat BOOTH	Consulting Editor – Fairfax Suburban Papers in Auckland	24.06.2009
Marie HULL-BROWN	Employee – Mental Health Foundation of NZ	25.03.2014
Dairne KIRTON	Vice President – CCS Disability Action National Board Grants Committee Member – Variety the Children's Charity	27.08.2014
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Director - Orion Health (includes Director – Orion Health Corporate Trustee Ltd) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Member – State Services Commission Performance Improvement Framework Review Panel Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	19.02.2015
Jan MOSS	Coordinator – 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	25.03.2014

Robyn NORTHEY	Self-employed Contractor - Project management, service review, planning etc. Board Member - Hope Foundation Trustee - A+ Charitable Trust	20.06.2012
Russell VICKERY	CCS Disability Action nominee to the Committee of Management for the Wilson Home Trust Member Talklink Trust Member Auckland Disability Law Member Waitemata Community Law Independent Disability Consultant Life Member Auckland Branch of CCS Disability Action	27.08.2014

Minutes
Disability Support Advisory Committee
27 August 2014

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 27 August 2014 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak commencing at 1:30pm

ADHB and WDHB Members	**ADHB and WDHB Staff**	
Sandra Coney (Chair)	Carolyn Simmons Carlsson	Allied Health Director, Adult Medical/Cancer and Blood
Jan Moss	Sue Copas	Community Engagement Manager
Max Abbot	Samantha Dalwood	Disability Strategy Coordinator Waitemata District Health Board
Jo Agnew	Dr Debbie Holdsworth	Director Funding – Auckland and Waitemata District Health Boards
Pat Booth	Kery McIlroy	Professional Leader Dieticians and Nutritionists
Marie Hull-Brown	Kate Sladden	Funding and Development Manager, Health of Older People
Dairne Kirton	Marlene Skelton	Corporate Business Manager
Robyn Northey	Gilbert Wong	Director Communications
Russell Vickery	Other staff members who attend for a particular item are named at the start of the minute for that item	

1 ATTENDANCE AND APOLOGIES

Apologies were received from Committee Members Dr Lester Levy and Judith Bassett. An apology was received from Max Abbott for lateness.

Apologies were received from staff members, Dr Dale Bramley, Chief Executive Officer Waitemata District Health Board, Ailsa Claire, Chief Executive Auckland District Health Board, Tim Wood, Funding and Development Manager, Primary Care, Sue Waters, Chief Health Professions Officer, Leanne Catchpole, Programme Manager Funding Team, Fionnagh Dougan, Director Provider Services and Judith Catherwood, Director of Community and Long Term Conditions.

2 CONFLICTS OF INTEREST

There were no conflict of interests advised for any item on the agenda.

Dairne Kirton advised that her register of interests should be updated to reflect that she had been appointed Vice President of the National Board of the CCS.

Russell Vickery advised that the following should be added to his register of interests:

- CCS Disability Action nominee to the Committee of Management for the Wilson

Home Trust

- Member Talklink Trust
- Member Auckland Disability Law
- Member Waitemata Community Law
- Independent Disability Consultant
- Life Member Auckland Branch of CCS Disability Action.

3 CONFIRMATION OF MINUTES 4 JUNE 2014 (Pages 7-15)

Resolution: Moved Jo Agnew/Seconded Pat Booth

That the minutes of the Disability Support Advisory Committee meeting held on 4 June 2014 be confirmed as a true and correct record.

Carried

4 ACTION POINTS 4 JUNE 2014 (Pages 16-17)

Severe Autism and/or Cognitive Impairment

At the last Disability Support Advisory Committee meeting Auckland District Health Board staff updated the committee on the progress made against the Accessibility Audit carried out in 2011. A query arose regarding facilities that were available for people with autism or similar disorders. A verbal update in response to this was given by Carolyn Simmons-Carlsson at this meeting relating what was in place in key services.

Phlebotomy Service

There is no specific protocol in place for severe autism or cognitive impairment. All patients are assessed as they present in Outpatients. With co-operation and advice from caregivers and patients the blood collection process is adapted to accommodate most disabilities.

Familiarisation packs are sent to families who have made contact when an autistic person needs a blood test. These packs contain samples of the equipment used, (no sharps) and information leaflets on blood tests in young persons for the caregiver. The patient can handle and smell the swabs and wipes so they are not new or foreign when they come to the hospital

Caregivers and patients are invited to visit the collection rooms as often as they like before any test is done. When the patient and caregivers are familiar and confident with the situation the blood test is proceeded with.

Some patients can become particularly distressed during the collection even with caregiver help. The collection in these cases is abandoned. Some patients need sedation before any intervention, this is a clinical decision and not in the phlebotomists' scope of practice.

There are regular blind, deaf and wheelchair patients; although not every treatment room can fit a wheelchair, there is a room at each of the Auckland and Greenlane sites that is

accessible. At Starship hospital the treatment rooms for blood collection are quite small allowing only child size wheelchairs.

No patient ever has blood collected in a public area such as waiting rooms or corridors. Patient privacy and dignity are paramount.

General Surgery, Trauma, Orthopaedics, Urology, ORL Neurosurery, Intra-abdo, Transplant, Ophthalmology and Pre Admit and Clinics

There is not anything specific in place for people with dementia or autism. However, if there were behaviours of concern related to a patient then the pathway would be put in place.

Orthopaedics does have an AOU which accommodates patients with dementia when required through a Behaviours of Concern pathway.

Starship Children's Hospital

As a result of concern about the process for managing severely behaviourally challenging adolescents with ID +/- ASD, an ad hoc working group have produced a report which has been discussed by child health and mental health management staff from the three Auckland Metro District Health Board's with representatives of the ad hoc group, Taikura Trust and MoH DSS personnel.

For child in-patients, the play specialists and consult liaison psychiatry team provide support to patients and their families as well as advice to staff about how to manage this group of patients.

In out-patients there is nothing specific in place, patients are managed on a case by case basis. The play room at Starship is very helpful for children who struggle with remaining in a small room throughout a consultation.

Older Peoples Health

A person centred, comprehensive assessment and needs based approach is taken for each individual rather than a single disease focus. It is rare that this service deals with people with autism or similar disorders. There may be some in residential care who have "graduated" from other services.

Adult Community and Long Term Conditions

Reliance is placed on the 'Health Passport' which is used by all patients who have difficulty expressing their needs, interests and preferences so that issues are clearly documented by family/carers. It is then brought with them when they come to hospital.

Rehabilitation Medicine Rehab Plus

Patients with a "secondary" diagnosis of Autism/related disorders, as well as intellectual disability are not admitted. Necessary interventions are delivered as part of a holistic approach to managing primary diagnosis and other Bio-Psycho-Social issues. However, Rehab Plus is not a service that specialises in addressing difficulties arising from those conditions.

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

- Advice that Allied Health staff received training in the management of patients with autism and cognitive impairment but that a definitive answer could not be provided in regard to other medical personnel.
- Jan Moss commented that there is a need for all staff to be compassionate toward families with a child with autism or a cognitive impairment coming into the hospital environment.

Appointed Members Vacancies

It was advised that the Corporate Business Manager was working with the Board Chair in regard to following the correct process for securing interest for Maori representation on the Committee. It had been thought that the remaining vacancy could be picked up as part of the process currently being managed by Waitemata District Health Board for obtaining a Pacific Island appointed member to CPHAC.

The Chair was clear that advertising for the latter vacancy was not to have been aimed particularly at securing a Pacific Island representative but was to have solicited candidates from the wider community.

Action

Dr Debbie Holdsworth, Director Funding – Auckland and Waitemata District Health Boards to ensure that an advertisement is drafted that would encourage candidates from the wider community with an interest in disability to apply. The advertisement to be circulated to the committee prior to being placed.

Both vacancies are to be filled prior to the November Committee meeting.

5 CHAIRMANS REPORT

Sandra Coney advised that the Auckland Council is advertising for membership for its Disability Committee. The applications close on 31 August 2014. This is seen as an opportunity to exercise a voice and influence and she encouraged anyone interested to apply.

6 PRESENTATIONS

6.1 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.

Ezekiel Robson, Disabled Persons Assembly NZ, presented to the Committee.

Ezekiel advised that his role was predominantly to inform and educate the community about this convention.

The convention is a treaty about the human rights of people with disabilities. It does not create new, special or different human rights for people with disabilities. The convention helps countries understand how to act to assure that people with disabilities are guaranteed human rights. It ensures people are treated equally and included in all areas of life.

It basically says that people are free to have:

- choice
- the same rights to be included in society
- equal opportunities for work and living.

The requirement is that there is equal access to places and activities. Countries are to include people with disabilities in decisions that affect their lives and it recognises the vital role of Disabled People's Organisations.

The UN CRPD was passed in 2006, with the promise of a paradigm shift in the human rights of people with disabilities. People with disabilities were to become full and participating members of society, able to make their own choices and live their own lives. The problems related to disability were articulated as flowing from social responses and not intrinsic to the person with the disability.

However, meaningful change on the ground cannot be introduced by administrative decree. The new approaches must be 'owned' by the people who implement them on the ground if they are to be successful. That means a shift in attitude by the bulk of the population, rather than by a legal process, so this will take time.

The convention works on the premise that "reasonable accommodation must be made for persons with disabilities".

It states that, "Necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms"

Therefore, a limitation on resource is not a valid reason to delay implementation – all that is required is reasonable, objective prioritisation of funds.

Key aspects in the convention are:

Article 9. To enable persons with disabilities to live independently and participate fully in all aspects of life. Appropriate measures are to be taken to ensure persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including:

- To provide training for stakeholders on accessibility issues facing persons with disabilities
- To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understood forms

- To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public.

Article 25. Recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.

- Persons with disabilities must be provided with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

- Health professionals are required to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.

Article 26. Effective and appropriate measures are to be taken, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

To that end, it is necessary to organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths

- Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

Once a government has signed up to this convention it must:

- Make laws which give people with disabilities rights and change laws that aren't fair

- Ensure no one discriminates against people with disabilities

- Ensure technology, equipment and information is accessible so people can take charge of their life

- Make sure government follows the UN CRPD and educates people about the requirements.

What this means for the District Health Boards is that they must set and implement a vision and strategy for disability. Including things such as:

- Preventative focus on population health issues - Diabetes, smoking, rheumatic fever,

asthma, stroke, arthritis, violence causing illness or further disability

- Address health disparities between disabled and non-disabled who have a "narrower margin of health because of poverty and other social determinants, and / or secondary health conditions such as pressure sores"
- Effective 'accessible journey' to services/facilities
- Systems for communicating, sending / receiving information in accessible, preferred formats / languages
- Staff Disability Awareness / Responsiveness Training
- Pro-active HR policies e.g. positive recruitment targets, guaranteed interview 'tick' scheme
- Facilitate consumer / stakeholder engagement in service planning and implementation, and feedback on service quality and reviews
- Reflect aspirations of disabled Maori and Pacific peoples
- Strategic collaboration e.g. hA, NDSA, PHOs, CMDHB (DISAC, and Funding and Planning)
- Dedicated staff resource – e.g. Disability Advisors at senior management level.

Ezekiel sited some ideas for improvement that District Health Boards have and should be involved with:

- Piloting of the Health Passport, and other methods of medical records being available in accessible formats
- Awareness training to address mis-attribution of illness, unnecessary admissions
- Health promotion campaigns including disabled people with information in accessible formats
- Equitable access to mainstream health initiatives such as vaccination programmes
- Physical accessibility of mobile services to address lower rates of preventative screenings
- Review of systems to minimise overruling of advanced directives or families being advised to terminate life support for people with intellectual impairments who had serious but still treatable illnesses, e.g. pneumonia
- Training in disability rights, supported decision making, advanced directives.

Ezekiel noted that the forming of partnerships was critical to allow disabled people to define, measure and improve the quality of healthcare that they receive. He posed questions for consideration:

> How can consumers be best informed about and have a say in what choices of treatment, support and rehabilitation methods are available or what alternative methods or community facility linkages might be possible?
>
> How can the person be aware and able to control whether treatment and rehabilitation methods being used reflect their own values and goals or whether such approaches are simply imitating often flawed, somewhat materialistic, and stereotyped societal values?
>
> He made the point that empowerment means not just a system handing back power to

service users, but educating them on how to exercise new choices.

In closing Ezekiel suggested that the Committee take a stand and make a resolution to the effect:

"That DISAC requests a summary report on any sentinel events involving disabled people at our District Health Board within the last 5 years, and an overview of any subsequent actions taken to address attitudinal and systemic issues highlighted by any such incidents seemingly compounded by / related to people with impairments.

That DISAC requests a summary report on current and/or further potential mechanisms for collation of robust statistics on people with disabilities engaging with our District Health Board as staff or consumers."

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

- Ezekiel advising that individual disability groups and sectors must divest themselves of the "divide and conquer" attitude toward having a voice and obtaining funding. Groups must begin to understand each other's issues better and learn to speak for each other.
- Pat Booth commented that a careful balance was required when protecting the rights of those placed in seclusion and on preventative detention.
- Russell Vickery commented that end of life was mentioned but not much was said about the beginning of life which contained emotive and sensitive issues. Sandra Coney added that routine tests were carried out on women for birth defects and little choice was given if something was found to be amiss. There is a need to introduce an ethical debate to address this.

In relation to the request by Ezekiel to make a resolution such as that recorded above, the Committee felt that sentinel events were reported now, however the data on disability was not collected and that it would in all probability not be possible to pass such a resolution.

Sandra Coney thanked Ezekiel Robson for his presentation.

Action

That senior staff report back on the feasibility of the two proposed recommendations and of obtaining the data that would be required to give effect to them.

6.2 Patient Experience Manager – Providing an overview of short to medium term goals for service

Jay O'Brien, Patient Experience Manager introduced himself to the Committee and provided an outline of what is occurring and being concentrated on in key areas within his service currently.

Understanding Patient Experience

- The Friends and Family Test has been redeveloped
- Patient reported outcome measures have been introduced
- Patient stories are being collected for use.

Improving as a result of Feedback

Local level improvements being sought through:

- Quality plans have been developed informing governance issues
- Robust transparent incident and complaint management process in place
- Use of quality boards throughout the hospital
- Continued implementation of patient smart quality improvement methodologies
- Continued implementation of the Advanced Care Planning training programme.

Engaging Consumers

- There is now a Waitemata Community Engagement Manager responsible for promoting health links groups
- Development and implementation of the Patient and Family Centred Care Programme
- Promoting family/whanau as care partners and supporting open visitation for family/whanau
- Continued implementation of the End of Life Bereavement project.

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

- Advice that a tool from the Clinical Excellence Commission is being used to assist with Patient and Family Centred Care. It is in the form of a survey and actions are taken from the survey information to be prioritised and reviewed annually.
- Advice that the Patient Based Challenge is a Waitemata District Health Board pilot programme. The information gathered from this is being shared with Dr Andrew Old at Auckland District Health Board.
- Sandra Coney commented that ancillary services need to be included in the education programme. She was assured that this would be addressed and that patient stories were to be utilised to identify issues in this area for addressing.

Sandra Coney thanked Jay O'Brien for his presentation.

7 IMPROVEMENT ACTIVITIES

7.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs (Pages 18-96)

Kate Sladden, Funding and Development Manager, asked that the report be taken as read and drew members attention in particular to the publication of, "Dementia and Driving Safely" a resource for clinicians and 'Dementia Decision – making journey' a resource for family members of people with end stage dementia.

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

- Comment that when an older person lost their drivers licence, a lot of independence was removed creating a new set of problems to be dealt with. It can often lead the individual to question the support that they receive not only from the medical fraternity but from family. There is a need to begin working with people much earlier to encourage them to think about what care they require as they age.
- Sandra Coney commented that the dementia booklet was particularly useful as it provided practical solutions to common issues.
- It was advised that the dementia booklet had been passed through the Health Literacy Group to test the language used and how easy it was to understand content. Committee members felt that there was still language within it that was technical and some terminology needed to be corrected.

The Committee congratulated the team that developed the dementia booklet and was pleased to see a carefully constructed publication developed for families on this issue.

Resolution: Moved Pat Booth/Seconded Marie Hull-Brown

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

Carried

7.2 Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs Update Report (Pages 97-105)

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:

- Noting that a collaboration was to occur around reviewing of web content and its presentation. It was felt that this was a particularly important project in order to enable information to be more widely shared.

- Russell Vickery commented that he was pleased to see that Auckland District Health Board had reviewed the placement of some of their disability parking spaces and had improved the usability of them.

- Way finding was generally thought to be extremely difficult at all three metropolitan District Health Boards and in need of attention.

- It was advised that during "Discovery week" at Auckland District Health Board, 800 people had been interviewed. A large number of disability issues were revealed which have been recorded and an action plan is being developed to address these. Jo Agnew commented that it is only through this sort of patient experience data that the real issues for a disabled patient visiting a hospital can be effectively identified and then dealt with.

Resolution: Moved Max Abbott/Carried Robyn Northey

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

Carried

8 CONFIRM

8.1 Action Points for next DSAC Meeting

Appointed Member Vacancies

Dr Debbie Holdsworth Director Funding – Auckland and Waitemata District Health Boards to ensure that an advertisement is drafted that would encourage candidates from the wider community with an interest in disability to apply. The advertisement to be circulated to the committee prior to being placed.

Both vacancies are to be filled prior to the November Committee meeting.

Statistics on Patients with Disabilities

That senior staff report back on the feasibility of the two proposed recommendations;

"That DISAC requests a summary report on any sentinel events involving disabled people at our District Health Board within the last 5 years, and an overview of any subsequent actions taken to address attitudinal and systemic issues highlighted by any such incidents seemingly compounded by / related to people with impairments.

That DISAC requests a summary report on current and/or further potential mechanisms for collation of robust statistics on people with disabilities engaging with our District Health Board as staff or consumers"

and of obtaining the data that would be required to give effect to them.

Suicide

1. **That Gilbert Wong, Director Communications provide to the Corporate Business Manager for distribution to the Committee, figures on suicide for older persons broken down by District Health Board area.**

2. **That Marlene Skelton, Corporate Business Manager arrange for a presentation from Dr Jane Casey on suicide and the older person.**

8.2 DSAC feedback to CPAC

There was none.

9 GENERAL BUSINESS

Suicide

Marie Hull-Brown commented that she had recently read an article about the increasingly larger number of older persons committing suicide. She particularly wanted to know whether there were figures that gave a more in depth picture of the situation by region.

It was advised that figures were broken down by District Health Board area and could be provided.

Comment was made that figures for older persons was just as high as those for youth. This is a big issue that has long gone unnoticed.

It was agreed that should any report be released from the Ministry or the Government that it be drawn to the attention of this Committee. Members were interested in knowing what the factors were that led older persons to committing suicide and what signs should be watched for.

Action

That the Marlene Skelton, Corporate Business Manager arrange for a presentation from Dr Jane Casey on suicide and the older person.

The meeting closed at 3.40pm.

Next Meeting

The next ordinary scheduled meeting will be held:
1:30pm, Wednesday, 19 November 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, 27 August 2014.

_____ Chair _____ Date

Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 04 March 2015

Meeting and Item	Detail of Action	Designated to	Action by
Carried forward	The Secretary was to follow up with Colleen Brown on organising a meeting with the Auckland Council Disability Group.	S Coney	Deferred until Committee carries full membership
Item 10 4 Jun 2014	**Putting People First** That the Corporate Business Manager arrange for Pam McNeil from the Ministry of Health to attend the next meeting of the Committee to address how recommendations from the "Putting People First" report are to be implemented	M Skelton/ D Holdsworth	Complete – see agenda item
Item 5 4 Jun 2014	**Appointed Member Vacancy** That the Marlene Skelton, Corporate Business Manager follows the prescribed process for requesting Maori representation on the Committee and proceed with the advertising required for the remaining vacant position.	M Skelton	Nov 2014 (with Lester Levy who is currently discussing appointment process with Naida Glavish)
27 Aug 2014	Dr Debbie Holdsworth to ensure that an advertisement is drafted that would encourage candidates from the wider community with an interest in disability to apply. The advertisement to be circulated to the committee prior to being placed. Both vacancies are to be filled prior to the November Committee meeting.	D Holdsworth	Partially complete – proposed appointment on confidential agenda
Item 5 4 Jun 2014	**Terms of Reference** That a review of the Terms of Reference be undertaken to ensure a more positive reference is included to the New Zealand Disability Strategy and other relevant strategies.	D Holdsworth	Complete - see agenda item

Item 6.1 27 Aug 2014	**Statistics on Patients with Disabilities** That senior staff report back on the feasibility of the two proposed recommendations; *"That DISAC requests a summary report on any sentinel events involving disabled people at our District Health Board within the last 5 years, and an overview of any subsequent actions taken to address attitudinal and systemic issues highlighted by any such incidents seemingly compounded by / related to people with impairments.* *That DISAC requests a summary report on current and/or further potential mechanisms for collation of robust statistics on people with disabilities engaging with our District Health Board as staff or consumers";* and of obtaining the data that would be required to give effect to them.	D Holdsworth	Complete - see agenda item
Item 9 27 Aug 2014	**Suicide** That Gilbert Wong, Director Communications provide to the Corporate Business Manager for distribution to the Committee, figures on suicide for older persons broken down by District Health Board area. That the Marlene Skelton, Corporate Business Manager arrange for a presentation from Dr Jane Casey on suicide and the older person.	G Wong (via email) M Skelton	Complete Complete – see agenda item

Suicide in Older People:

What We Know, and, is it Preventable?

Gary Cheung
Department of Psychological Medicine

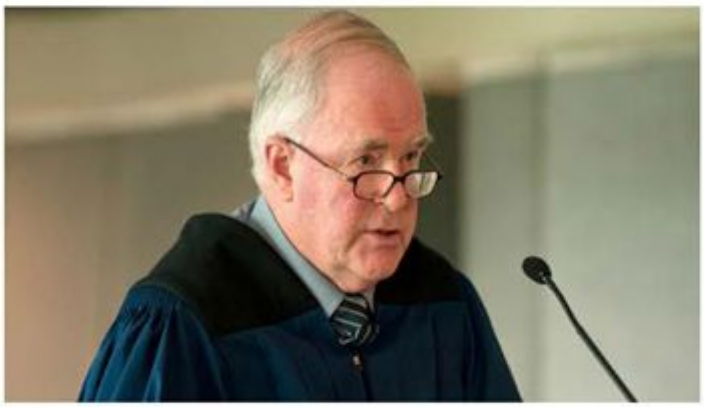
THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

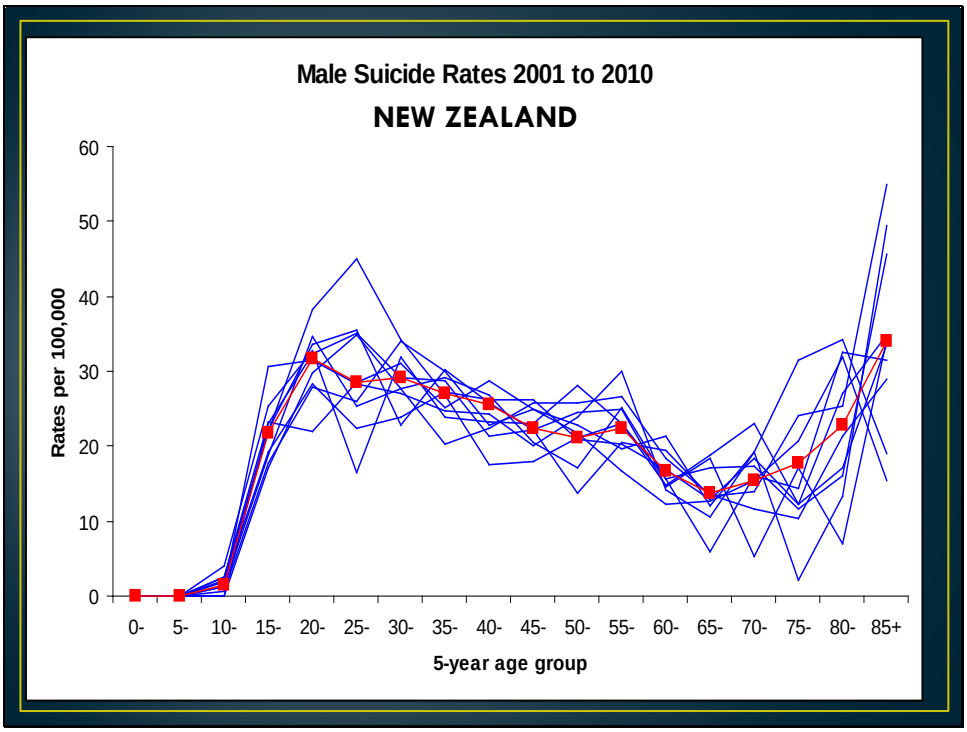
Simon Collins Simon Collins is the Herald's social issues reporter.

Youth suicide rate falls by a quarter, but elderly rate rises

11:36 AM Wednesday Aug 20, 2014

Health | Mental Health





Risk factors for Late-life suicide (international literature)

- Older Age
- Male gender
- Living alone
- Bereavement (especially in men)
- Psychiatric illness (depression, previous suicide attempt)
- Physical illness (pain)
- Social disconnectedness

Previous NZ study on late-life suicide

Increase risk with

- current mood disorders
- psychiatric hospital admission within the previous year
- limited social network

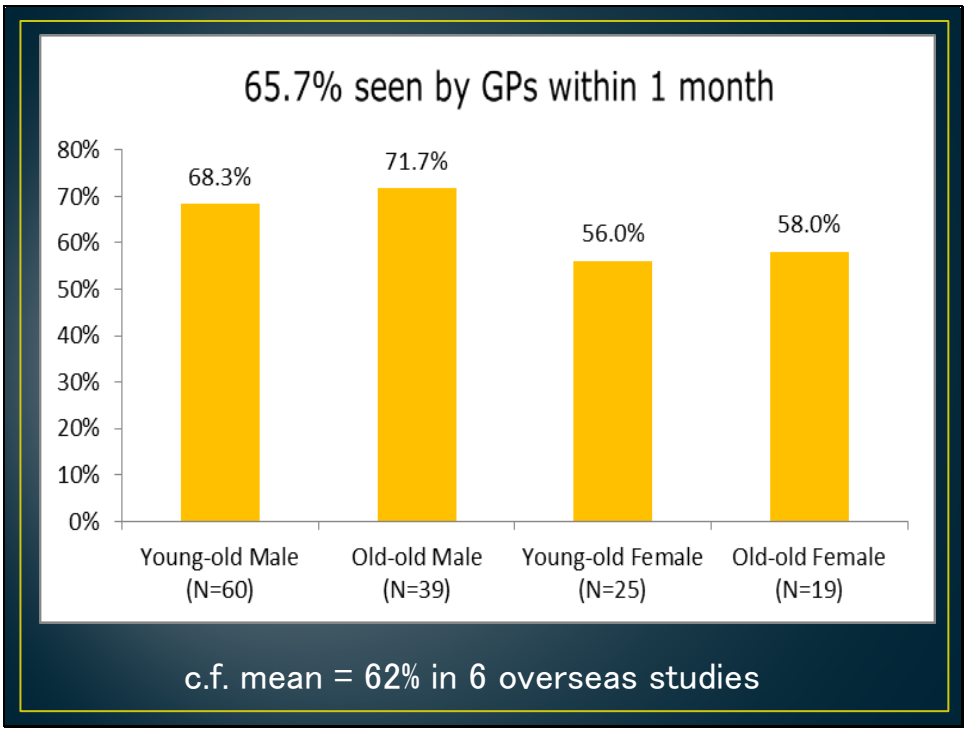
(Beautrais 2002)

Outline

1. What We Know
   i. Completed suicides from NZ coroner records
   ii. Suicide attempt presentations to emergency departments
   iii. Death wishes reported in interRAI assessment

2. Is it Preventable?
   i. Evidence based programmes
   ii. Physical illness and suicidal behaviour

		Coroners' Cohort N=225 (2007 – 2012)	2006 Census	2013 Census
Age	mean	76.6		
	SD	7.8		
	Range	65-96		
Gender	Male	74.2%	44.6%	45.9%
Ethnicity	European	90.7%	79.8%	83.8%
	Maori	1.3%	4.7%	5.3%
	Pacific Islander	0%	2.0%	2.3%
	Asian	6.7%	3.2%	4.5%



	Male N=167	Female N=58	Total N=225	p-value
Depression	58 (34.7%)	35(60.3%)	93 (41.3%)	0.001
Previous Suicide Attempt	33 (19.8%)	22 (37.9%)	55 (24.4%)	0.009

Suicide and Suicide Attempts

	General Population	**Older People**
Death	1	**1**
Hospitalisation	5	**2**
Emergency Department Visit	30	**4**

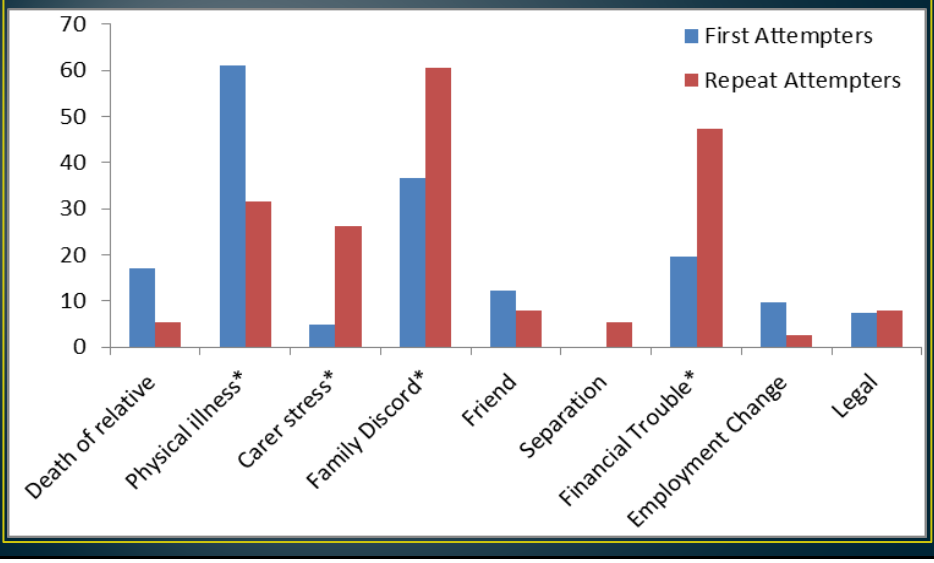
9 to 18% of older people who had made a suicide attempt would make further attempt(s) within 12 months

(Draper, 1996)

Suicide attempt presentation to Emergency Departments in NZ

- Auckland City Hospital, Middlemore Hospital, North Shore Hospital, Waitakere Hospital, Waikato Hospital, Wellington Hospital, Christchurch Hospital
- 3 years period
- 65+

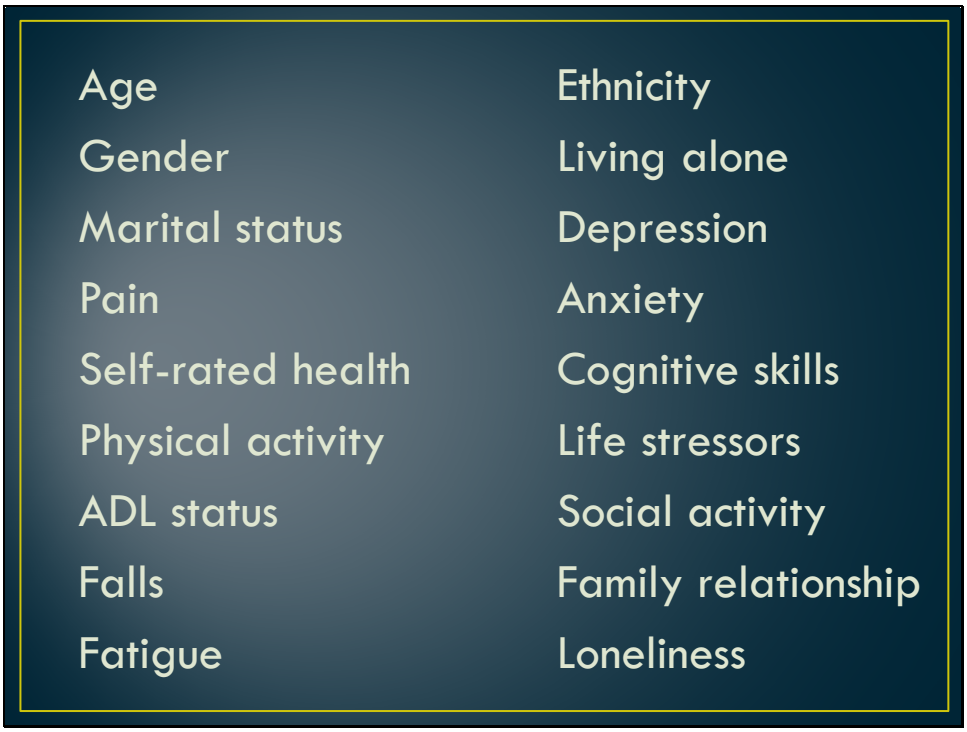
Stressors associated with suicide attempt

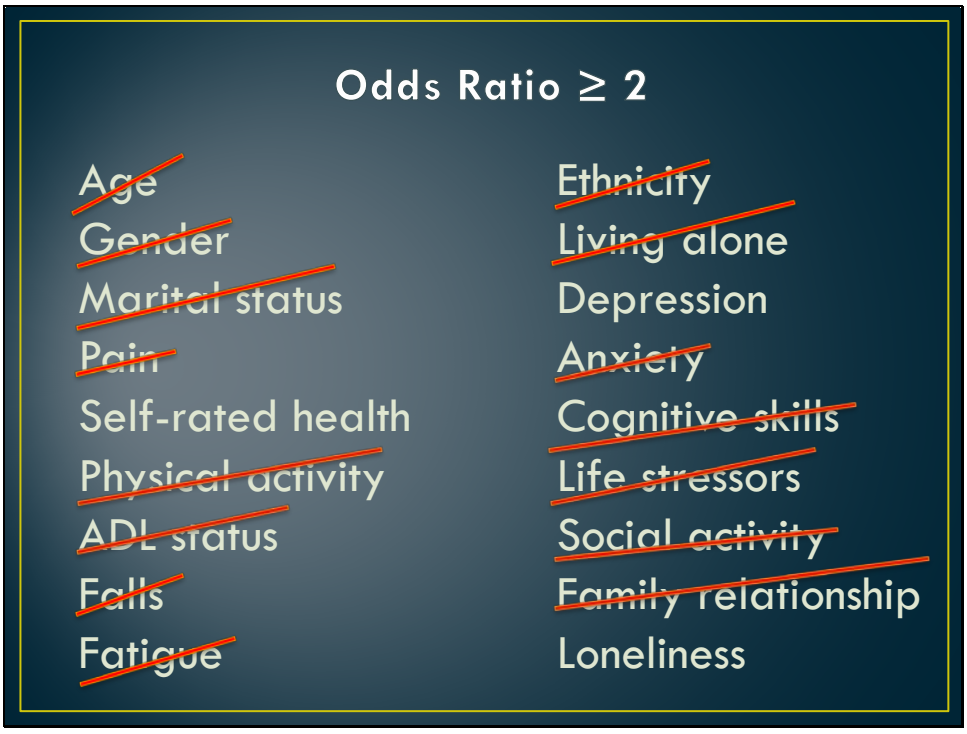


Negative statements reported in interRAI

- The 'International Resident Assessment Instrument' (interRAI) was developed by a network of health researchers in over 30 countries.
- Since 2012 the 'Home Care' version has been implemented nation-wide
- In the past 3 days,
  - "Nothing matters"; "Would rather be dead"; "what's the use"; "Let me die"

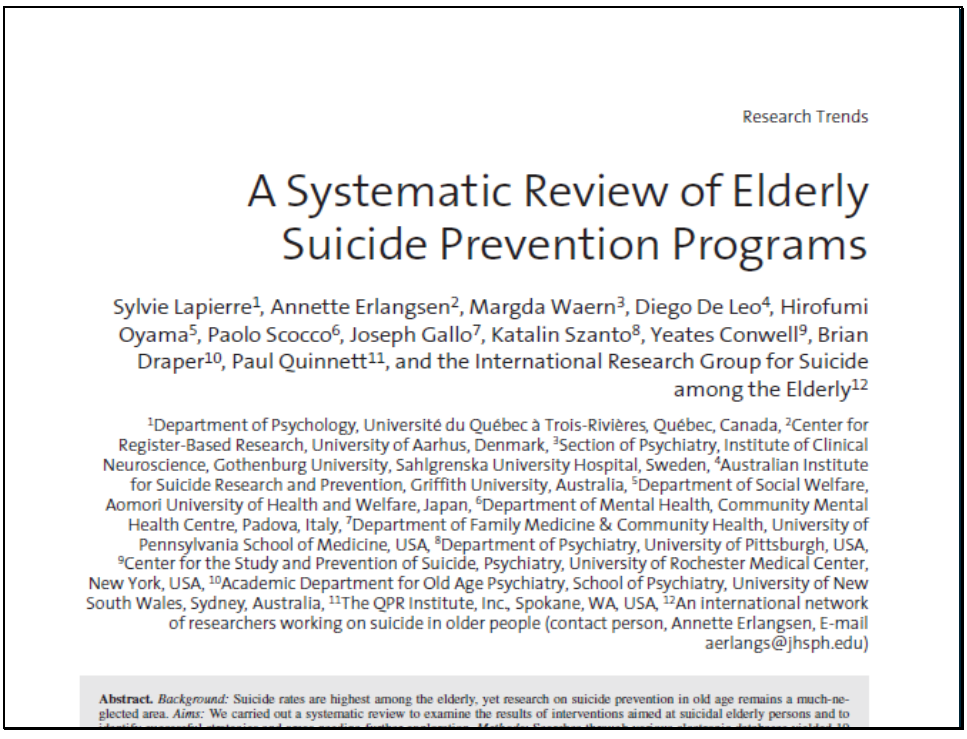
9.5%


Age
Gender
Marital status
Pain
Self-rated health
Physical activity
ADL status
Falls
Fatigue
Ethnicity
Living alone
Depression
Anxiety
Cognitive skills
Life stressors
Social activity
Family relationship
Loneliness


Odds Ratio ≥ 2
Age
Gender
Marital status
Pain
Self-rated health
Physical activity
ADL status
Falls
Fatigue
Ethnicity
Living alone
Depression
Anxiety
Cognitive skills
Life stressors
Social activity
Family relationship
Loneliness

Summary

1. An over-representation of males, Europeans and Asians
2. Rates of diagnosed depression and past suicide attempt higher in females
3. Older people were more likely to have consulted their general practitioners (primarily for non-mental health issues) than psychiatric services within one month of the suicide.
4. Role of physical illness, self-rated health and perceived loneliness



Research Trends

A Systematic Review of Elderly Suicide Prevention Programs

Sylvie Lapierre[1], Annette Erlangsen[2], Margda Waern[3], Diego De Leo[4], Hirofumi Oyama[5], Paolo Scocco[6], Joseph Gallo[7], Katalin Szanto[8], Yeates Conwell[9], Brian Draper[10], Paul Quinnett[11], and the International Research Group for Suicide among the Elderly[12]

[1]Department of Psychology, Université du Québec à Trois-Rivières, Québec, Canada, [2]Center for Register-Based Research, University of Aarhus, Denmark, [3]Section of Psychiatry, Institute of Clinical Neuroscience, Gothenburg University, Sahlgrenska University Hospital, Sweden, [4]Australian Institute for Suicide Research and Prevention, Griffith University, Australia, [5]Department of Social Welfare, Aomori University of Health and Welfare, Japan, [6]Department of Mental Health, Community Mental Health Centre, Padova, Italy, [7]Department of Family Medicine & Community Health, University of Pennsylvania School of Medicine, USA, [8]Department of Psychiatry, University of Pittsburgh, USA, [9]Center for the Study and Prevention of Suicide, Psychiatry, University of Rochester Medical Center, New York, USA, [10]Academic Department for Old Age Psychiatry, School of Psychiatry, University of New South Wales, Sydney, Australia, [11]The QPR Institute, Inc., Spokane, WA, USA, [12]An international network of researchers working on suicide in older people (contact person, Annette Erlangsen, E-mail aerlangs@jhsph.edu)

Abstract. *Background:* Suicide rates are highest among the elderly, yet research on suicide prevention in old age remains a much-neglected area. *Aims:* We carried out a systematic review to examine the results of interventions aimed at suicidal elderly persons and to

Potential Late-life Suicide Prevention Strategies in NZ

1. Public health awareness and mental health literacy programmes on depression and suicide targeting older males, Europeans and Asians

2. Collaboration between primary care and mental health services for assertive screening and management of late-life depression

3. Primary care to offer support services similar to the Telehelp/Telecheck service for individuals with a higher risk of suicide.

PROSPECT study (PRevention of Suicide in Primary Care Elderly: Collaborative Trial) (Bruce et al. 2004)

1. algorithm-driven antidepressant treatment
2. Interpersonal psychotherapy when indicated
3. physician, patient and family education;
4. care management by a depression specialist

- Results – Rates of suicide ideation declined faster in intervention vs. controls

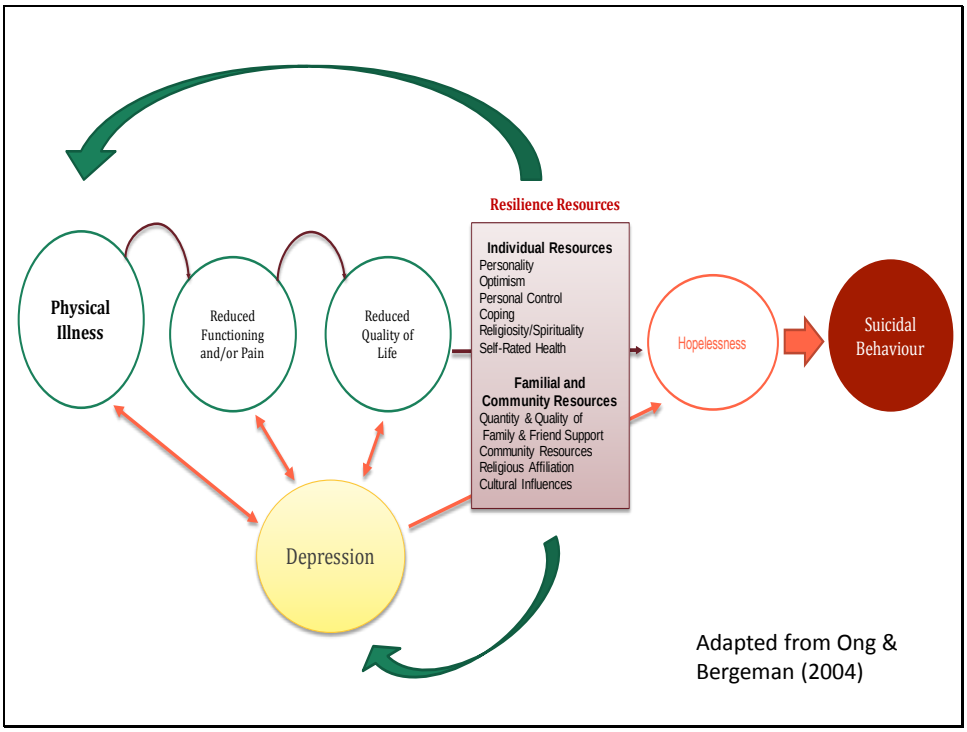
Telephone Counseling: Tele-help/Tele-check
(De Leo et al., 2002)

Tele-help - 24 hr emergency service for older people to call for help

Tele-check – 2x per week telephone support

- After 11 yrs
  - Suicide rate lower than expected
  - Reduced depression scores, hosp admissions, requests for GP home visits.
  - Impact for females only

Physical illness and Suicidal behaviour



Acknowledgements:

Judge MacLean, NZ Chief Coroner

Supervisors: Sally Merry, Fred Sundram

Collaborators: Wayne de Beer, April Clugston, Susan Gee, Matthew Croucher, Adam Sims, Sally Rimkeit, Owen Martin

Psychiatric Registrars: Joanna Wang, Yu Mwee Tan

Medical students: Kody Shaw, Amy Lockwood, Siobhan Edwards, Jenny Yoon

g.cheung@auckland.ac.nz

Putting People First Quality Review

Q&A – provided by the Ministry of Health

What is Putting People First?

Putting People First – a review of Disability Support Services performance and quality management processes for purchased provider services, is the work of an independent panel who assessed how well the Ministry's monitoring and management processes support the safety and wellbeing of disabled people. It was publicly released in December 2013.

What was the review commissioned?

The disability sector has signalled to the Ministry that there needs to be greater transparency relating to all aspects of performance and quality management of Ministry-funded provider services. Disabled people want a voice in decisions made about services that impact on them, their families and providers, and people want to feel safe when they have something to say about the quality of services they receive.

What did the review recommend?

The review made 36 recommendations, based on keeping the disabled person at the centre of everything DSS does, to give each disabled person a voice in decisions made, and to ensure their voice is listened to when they have something to say. For a full list of recommendations, see the review document on the Ministry's website.

What is the Ministry doing to implement the review's recommendations?

The Ministry has appointed Pam MacNeill as Quality Improvement Lead to oversee the implementation of the recommendations. A governance group monitors progress.

Three working groups have been established, with recommendations assigned to each under the headings:

- support providers to put disabled people at the centre of their service
- give disabled people a voice
- improve performance management.

Good progress has been made on implementation, including:

- increased collaboration with the sector
- the establishment of a governance group, which includes representation of disabled people, to lead the discussion on future improvements
- refocused provider reporting requirements
- service specifications becoming performance improvement tools
- simplified complaints processes.

How will the Ministry measure success?

Each of the Working Groups is responsible for a series of PPF recommendations and each recommendation has a number of linked activities. Once all activities under each recommendation are completed success will be achieved.

What do any changes mean for disabled people?

Disabled people and their families/whanau should see more engagement from providers and more ways to have a say in the issues that affect them.

What do any changes mean for providers?

Providers will be encouraged to try new approaches and to work differently. They will be required to consult more with disabled people. They should ultimately see less administrative burden.

When will all recommendations be implemented?

The implementation project has an initial two-year timeframe to 2016 but some recommendations or activities may take longer. Regular updates will be provided on progress in the Disability Support Services (DSS) newsletter and on our website.

- A visual representation, showing all work areas and interdependencies, will be available on our website shortly. This will be updated regularly.

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

Recommendation

That the Disability Support Advisory Committee:

1. **Receives the report.**

Prepared by: Kate Sladden (Funding and Development Manager Health of Older People)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata District Health Boards)

Glossary

ARRC	Age Related Residential Care
DHB	District Health Board
HBSS	Home Based Support Services
HOP	Health of Older People
LTS-CHC	Long Term Support for Chronic Health Conditions
NASC	Needs Assessment Service Coordination

1. Purpose

The purpose of this report is to provide an update to the Disability Support Advisory Committee 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. Home Bases Support Services (HBSS)

2.1 HBSS Review

A joint working group of Waitemata and Auckland DHB clinical leads (geriatric, medicine, nursing, allied health and NASC) and service managers, along with the Funder are working on a revised model of HBSS that can assist over 65 year olds to regain as much function and independence as appropriate within their respective conditions to enable them to live at home safely. The DHBs are due to discuss the proposed model with the range of home based service providers at workshops in March to determine feasibility from their perspective. Comparisons have also been made with other DHB models particularly around the NASC function and the funding model. The redesigned model will be presented to both Boards for approval prior to procurement in 2015/16.

A report on values based contracting and applicability to HBSS is being prepared by consultants Francis Group International (FGI). The report is due at the end of February and will feed into the revised HBSS model.

2.2 In-between Travel Time

The Settlement Agreement for In-between Travel Time, that is, paying support workers for their time travelling between clients has been ratified by all DHBs and will become effective 1 July 2015. We are awaiting implementation detail from the Ministry of Health.

2.3 interRAI – standardised clinical assessments

There has been an increase in the proportion of Waitemata DHB HBSS clients with an interRAI assessment. The most recent report (one quarter in arrears) shows:

- 67.7% of Waitemata HBSS clients have an interRAI assessment (previous quarter – 56.2%)
- 94.6% 0f ADHB HBSS clients have an interRAI assessment (previous quarter – 95.1%).

3. Dementia Care Pathway

3.1 Northern Region

The Northern Region Cognitive Impairment Pathway (for Primary Care) has been converted into a dynamic pathway and is currently being trialed in 10 GP practices prior to a roll-out to pilot.

A draft policy for secure dementia unit design is being reviewed by the Regional Dementia Working Group. There is growing evidence of the impact of environmental design on the day to day living experience of people with dementia and considerable literature to support dementia-friendly facility design. The purpose of the policy is to provide consistency and transparency on how the Northern Region DHBs will review and approve dementia units to ensure they are designed to benefit the health and wellbeing of residents.

A sub-committee for dementia education in primary care has participated in discussions with the other three regions resulting in consensus to pool some funding to develop nationally consistent resources.

Two dementia education symposia were held in November and attended by approximately 100 health professionals. The opportunity to have Professor Iliffe (the first professor of primary care in the UK and a world authority on dementia in the community) as the keynote speaker was opportune as he was attending the NZ Alzheimers Conference.

3.2 Auckland DHB

A hospital dementia project will link with the regional cognitive impairment clinical pathway. A dementia specialist role (nurse or allied health) has been advertised for a 12 month appointment. This role will work with key stakeholders to improve the pathway of care for patients with dementia across the hospital.

3.3 Waitemata DHB

The University Of Auckland Department Of Geriatric Medicine has provided a draft evaluation report on the Waitemata DHB Cognitive Impairment Clinical Pathway Pilot that ran from 4 November 2013 to 31 July 2014. The report is currently being critiqued by the pilot participants (GPs, practice nurses, and DHB community and HOP secondary care services) and the HOP Clinical Directors. The final report will be taken through the formal approval processes at both Waitemata and Auckland DHBs before being presented to both Boards for approval to rollout to GPs.

4. Aged Related Residential Care

4.1 Auckland DHB

All Auckland DHB aged residential care facilities are engaged in interRAI (standardised clinical assessment) training as follows:

- 40% (26) are fully competent (required number of nurses trained)
- 32% (21) are competent (at least one nurse trained)
- 8% (5) are currently training
- 12% (8) are scheduled for training
- 8% (5) have signed an engagement agreement.

The ARRC cluster group model continues to make progress. There is a bimonthly Steering Group meeting with the geographic cluster groups meetings in the alternate months. The focus has been on working collaboratively to achieve the First Do No Harm targets to reduce pressure injuries and falls by 20%. However, a range of other initiatives have also been implemented through the model. Gerontology Nurse Specialists attend meetings and provide advice and support.

Auckland DHB Gerontology Services will continue to deliver quarterly ARRC study days to registered nurses and health care assistants during 2015.

4.2 Waitemata DHB

All Waitemata DHB ARRC facilities are now engaged with interRAI (standardised clinical assessment) training as follows:

- 40% (24) fully competent (required number of nurses trained)
- 49% (30) competent (at least one nurse trained)
- 5% (3) in training
- 3% (2) booked in training
- 3% (2) signed an engagement agreement.

ARRC facilities continue to meet bi-monthly as part of the Residential Aged Care Integration Programme (RACIP) work group. Current RACIP projects included developing resources for end stage lung disease and end stage heart disease to provide information to residents and families to support decision making. The following onsite education topics will be offered to ARRC facilities during 2015: falls; medication management; delirium; and pain management. Falls is the February topic. The quarterly off-site education topic for February/March is assessments and care planning for registered nurses.

4.3 Asian ARRC Support Group

An initial meeting to scope a forum for Asian owned and operated ARRC facilities has been scheduled for February. The aim of the Group is better understand the issues faced by these providers so appropriate support can be provided and to increase their engagement in DHB ARRC programmes e.g. cluster groups, education sessions, study days etc.

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

There have been a number of complex clients requiring NHI level contracts over recent months. A Request for Proposal was undertaken for one client due to the complexity of the package of care required.

Regional support continues to be provided through the Regional Review Panel, which reviews and monitors clients with an annual service package of $80k or more. Terms of reference for this Panel are currently being updated.

6. Quality and Safety

6.1 Regional Falls and Pressure Injury Programme

The proportion of ARRC providers fully participating in the regional Falls and Pressure Injury Programme remains low for ADHB and Waitemata DHB at 24% and 30% respectively. This compares unfavourably with Northland DHB, which has achieved 75%. The programme has the following elements:

- a relevant assessment tool to identify residents at risk
- intervention guides/plans for use with residents who are identified as being at risk
- participation in approved training e.g. First, Do No Harm, NZACA, DHB/CNS training etc
- data capture and reporting of falls and pressure injuries.

It is acknowledged that there are facilities engaged in falls and pressure injury programmes at a facility or a provider level that may not have participated in the regional programme or submitted data. Notwithstanding this, work is underway to see how we can better support all providers to submit falls and pressure injury data so we can monitor progress in this area. It is important to note that this is not a contractual requirement but rather an example of quality improvement where we need to work in partnership with providers to achieve better outcomes for residents.

7. Older Adults and Vulnerable Adults

7.1 Waitemata DHB

The Waitemata DHB Older Adults and Vulnerable Adults Abuse and Neglect Policy has been finalised and is available on-line. The Policy has been shared with Auckland DHB. Current work areas include:

- developing an e-learning tool for Waitemata DHB staff to heighten awareness of the indicators of abuse and the effect of ageist attitudes
- establishing a forum where practitioners can consult and gain guidance from Age Concern coordinators, the Police Abuse Prevention Officer, District Inspectors and legal advisors when they are working with cases of alleged abuse.

7.2 Auckland DHB

The Auckland DHB Older and Vulnerable Adult Safeguarding Policy is in draft and being consulted on during a first round. Auckland DHB is also planning to establish a multidisciplinary/multiagency practice forum. There is a focus on aligning the policy and practice with Waitemata DHB.

Implementation of the Auckland and Waitemata District Health Boards' NZ Disability Strategy 2013-2016 – Update Report

Recommendation

That the Committee:

1. **Receives the report, which is an update on the implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs, as at 18 February 2015.**

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata District Health Boards) and Sue Waters (Chief Health Professions Officer, Auckland District Health Board)

Glossary

DHB	District Health Board

1. Purpose

The purpose of this report is to provide an update to the Disability Support Advisory Committee on the implementation of the joint Auckland and Waitemata District Health Boards' New Zealand Disability Strategy 2013-2016. The update is current to 18 February 2015.

Waitemata District Health Board

Best Care for Everyone

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitemata DHB and Auckland DHB

Implementation of the New Zealand Disability Strategy 2013-2016

Current Status at 18 February 2015

Communication and Information Empowering people through knowledge and understanding
Current Status at 18 February 2015

What we will do… actions	**Where** we are now…current status
Accessible Communication guidelines developed.	**February 2015** – this work is part of the proposal that both DHBs become 'Health Literate' healthcare organisations.
Review of Web content and presentation.	**February 2015** – ADHB & WDHB are developing their new websites. Both will have consumer input, which will include evaluation by the Blind Foundation to ensure that information is accessible to screen readers. Feedback from consumers also indicated that it would be useful to be able to complete forms available on the DHBs websites. This is also being looked at.
Increase formats of key documents, e.g. Strategic Plans.	November 2014 – the Joint ADHB/WDHB Health Literacy Steering Group has proposed that both DHBs adopt The Institute of Medicine (2012) recommended set of ten attributes that identify a 'Health Literate' healthcare organisation. These principles are the building blocks for developing a health literacy framework and include leadership, inclusion of consumers, easy access and preparation of workforce to be health literate.
Review the automated telephone system with regard to access for people with disabilities.	November 2014 – It has been agreed that a joint service will be established to deliver Contact Centre services to both DHBs. Issues raised in consultation feedback relating to comprehension and general dissatisfaction with ADHB's Interactive Voice Response (IVR) have been investigated. As originally planned, a review and final decision regarding a possible change to ADHB's IVR, and consideration of IVR technology for WDHB, will be undertaken as a parallel work-stream of activity, alongside the design and implementation phases for a new technology solution. It is hoped new technology will be in place by April 2015.

Review the possibility of improved text communication to patients.	**February 2015** – this work is part of the proposal that both DHBs become 'Health Literate' healthcare organisations. It is also reflected in work to look at how the DHBs engage with patients and families and the best way to communicate. November 2014 – Text communication is another area that may be looked at as part of the Contact Centre collaboration project.
Continue the implementation of the Health Passport across both DHBs.	**February 2015 -** The Health Quality & Safety Commission is seeking feedback from people who have used the Health Passport. The Health Passport has been used for a few years now and the HQSC consumer network is interested to hear from people who have used it, and to understand how effective it was in assisting staff to understand their needs. If you would like to give feedback on the Health Passport, please send your comments to info@hqsc.govt.nz by Friday 30 April 2015 with 'Health passport' in the subject line. The WDHB Disability Advisor and the Health & Disability Commission Disability Advisor will work with HQSC to review the feedback and make recommendations.
Work with the Deaf community to improve access to interpreters.	**February 2015** – WI-FI is now available for patients at North Shore Hospital. This means that staff and patients are able to access VRI (Video Remote Interpreting) through handheld devices. There is still a booking period required, but it is another option for people who use interpreters.
Encourage the use of interpreters for non-English speaking families.	**February 2015** - WI-FI is now available for patients at North Shore Hospital. This will allow interpreting to be done across the internet, including NZSL interpreting.

Community and Engagement Working within a family and patient centred framework
Current Status at 18 February 2015

What we will do… actions	**Where** we are now…current status
Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.	**February 2015** – WDHB have employed a new Community Engagement Manager, Carol Hayward. Carol has come from Auckland Council where she led the community engagement for strategic plans such as the Auckland Plan and the Unitary Plan and developed a new Significance and Engagement Policy during 2014. Her UK and New Zealand local government experience includes introducing a range of online tools and approaches for engagement, and she was instrumental in setting up the council's People's Panel. Part of her role is to ensure the inclusion of a diverse range of stakeholders in DHB projects and services.
Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.	**February 2015** – Ongoing. CCS Disability Health & Wellness group – regular meeting between members of the disability sector and DHBs to discuss issues and opportunities.
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.	**February 2015** – The ADHB Public Spaces project have been very mindful to include people with cognitive impairments in their work. This includes people with learning disabilities, dementia, Alzheimer's, Parkinson's and other cognitive and physical impairments.
Continue working with Health Links to increase health literacy through fully accessible patient information.	November 2014 – Health Literacy Steering Group includes the voice of the Health Links. Health Links are leading the work to 'translate' patient information leaflets.

Employment Opportunities Equal employment opportunities for people with impairments and carers
Current Status at 18 February 2015

What we will do… actions	**Where** we are now…current status
Encourage the use of supported employment agencies.	
Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.	November 2014 – reviewing the 'Recruitment & Retention of Staff with Disabilities/Impairments' guidelines to reflect changes in strategic documents and government guidance.
Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	
Work with Hiring Managers to increase disability awareness.	November 2014 – reviewing the 'Recruitment & Retention of Staff with Disabilities/Impairments' guidelines to reflect changes in strategic documents and government guidance.
Working with HR to look at how the DHBs support staff with Carer responsibilities.	November 2014 – • Carers NZ have completed their Carer Aware staff training – a 20 minute learning resource to be launched at WDHB early 2015. • WDHB are a foundation member of the Carers NZ Employer cluster group. This is a group of employers who are committed to support staff with carer commitments.

Disability Responsiveness Educating staff and challenging stereotypes & assumptions
Current Status at 18 February 2015

What we will do… actions	**Where** we are now…current status
Work with Dieticians to improve the nutritional outcomes for disabled patients.	**February 2015** – Ongoing rollout of Protected Mealtimes initiative. November 2014 **–** this work has moved from project phase into a component of WDHBs Essentials of Care programme. • All frontline staff to receive training in nutrition and hydration. • Red trays to be used to indicate that a patient requires assistance. • Protected mealtimes – rolling out across all wards • Do people have the right equipment to eat with? • Patients assessed on admission and regularly
Develop 'Disability Champion' roles across the DHBs.	
Promote the Disability Awareness e-learning module to all staff across the DHBs.	**February 2015** – This training module is being reviewed and updated in September 2015.
Provide a range of disability awareness training, targeting specific services.	**February 2015** – During Patient Experience Week (23-27 March) there will be a number of training opportunities for staff. Yes Disability is running two interactive sessions focusing on communication with people with impairments. Deaf Aotearoa, Blind Foundation and Mental Health Foundation are also involved.
Develop tools to increase staff skills for working with people with communication difficulties.	
Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.	**February 2015** – The Disability Advisor, with five AUT design students, has completed an access audit as Auckland City Hospital as part of the Public Spaces project. The findings from the audit will add to the consumer feedback to the project. There is also a focus on access for older adults, for example, those with dementia, confusion and other cognitive or physical impairments.

Physical Access Overcoming a disabling society
Current Status at 18 February 2015

What we will do… actions	**Where** we are now…current status
Encourage the use of symbols and pictograms in signage and way finding.	**February 2015** – Ongoing work. Also encouraging project teams to look at the way colour can be used to assist in way finding, both wall colours and colour on signs. August 2014 – the merger of Auckland & Waitemata DHB Facilities teams is a great opportunity to improve the way finding and signage at the hospital sites. Waitemata have done some good work to improve signage in new facilities.
ADHB Disability Champions will complete the 2-day Barrier Free Training.	
An accredited Barrier Free Advisor will be involved in all new Facilities work.	August 2014 - the merger of the two Facilities teams is a great opportunities to standardise ways of working across all sites.
Adoption of Universal Design principles in all Facilities work.	November 2014 - 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 purpose of this review is to gain a better understanding of how the requirements contained in the Building Act and the Building Code providing access for people with disabilities are being implemented in new buildings, as well as in buildings being altered, and the extent to which these requirements do in fact provide an accessible built environment for people with disabilities. The review report is now available and concludes that 'ensuring access into buildings for people with disabilities is complex. Providing regulations to ensure adequate access is not as simple as specifying the width of a doorway or the dimensions of an accessible toilet. It is about understanding how to integrate access into the design of the building as a whole to ensure the

	building is approachable, accessible and usable. The building regulations are tools to achieve accessible buildings. Although regulations will not achieve change on their own, they are important in defining standards and providing guidance to building owners, designers and regulators. However, there has been a lack of progression in updating and developing the regulations governing accessibility.' The full report has been provided to MBIE and ODI who will generate conclusions about next steps and make recommendations to senior officials. The full report can be found at http://www.dbh.govt.nz/disability-access-review
Building standards document developed in ADHB.	August 2014 - Waitemata currently has a standardization document. The merger of the two Facilities teams will mean both DHBs can use the same document.
A review of accessible toilets in ADHB buildings to be completed.	Ongoing – Upgrades to toilets will be done on an individual project basis when funding becomes available.
Work with Auckland Transport to improve accessible transport between hospital sites.	**February 2015** – The trial between Waitakere and North Shore Hospitals will be evaluated. August 2014 - a six month trial has commenced for visitors to travel between Waitakere & North Shore Hospitals.
Investigate the reported shortage of wheelchairs available - both numbers and sizes.	**Completed** – 40 wheelchairs were delivered and are in use across the services.

Collation of Statistics that Identify People with Impairments

Recommendation

That the Disability Support Advisory Committee:

1. **Receive this report.**
2. **Note that both Auckland and Waitemata District Health Boards currently collect information and report on sentinel events. However, neither District Health Board captures whether the information relates to a patient, visitor or staff member who identifies as being disabled or having an impaired function.**
3. **Note both District Health Boards need to develop a consistent process that enables disability and impairment information to be collected and reported on.**
4. **Provide management with guidance on how information on disability and impairment should best be captured.**
5. **Endorse the requirement of any future changes to reporting systems enable the reporting of this data.**

Prepared by: Samantha Dalwood (Disability Advisory, Waitemata District Health Board)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata District Health Boards)

Glossary

CCS Group	CCS Disability Action Health & Wellness Group
DHB	District Health Board

1. Executive Summary

At its meeting on 27 August 2014, the Disability Support Advisory Committee (DiSAC) requested a report back on the feasibility of providing data on sentinel events that have occurred over the last five years and involved people who identify themselves as impaired or disabled.

Currently, when a person engages with Auckland or Waitemata District Health Board (DHB), neither DHB captures information that relates to that person's *functioning* or *disability*.

While current systems are limited in their ability to capture functioning and disability information, it is envisaged that in the future, both Auckland DHB and Waitemata DHB will implement a new administration and reporting systems which will have this capacity.

The issue becomes what standard language or framework should be used to classify a person's functioning, or disability.

This paper recommends that DiSAC endorse the importance of this reporting change and provide guidance on a standard language or framework Waitemata and Auckland DHBs might use when engaging with a person to capture information that relates to that person's functioning or disability.

2. CCS Disability Action Health & Wellness Group Discussion

The CCS Disability Action Health & Wellness Group (CCS Group) meets monthly. At its most recent meeting, Samatha Dalwood – Disability Advisor, Waitemata DHB facilitated a discussion on what standard language or framework could be used to classify a person's functioning, or disability when Waitemata and Auckland DHB collect and report on information relating to patients, visitors and staff members. The following paragraphs illustrate some of the issues the Group identified when considering how to define a standard language or framework for disability.

2.1 "Disability" versus "Impairment"

To create a standard language, a clear understanding of the difference between the term "disability" and the term "impairment" is necessary. Feedback from the CCS Group was mixed on how to define these terms. One participant said that she would answer "no" if asked if she had a disability, but "yes" if asked if she had an impairment. Some participants said that it is important that in a health setting, where the medical model[i] (which focuses on the individual as disabled) is often applied to disability, that social model[ii] (which focuses on the individual as impaired and society as the disabler) language is used. Other participants did not know about the models of disability or had no opinion on the debate. This issue of confusion regarding terms is more complex than choosing whether to use one term or another in the standard language or framework, as disability is always an interaction between features of the person and features of the overall context in which the person lives, and accordingly is different for everyone.

2.2 The language for the framework must be plain

The CCS Group agreed that however the terms "disability" and "impairment" are defined, what is more important is that the language that is used is plain and understandable.

2.3 "Labelling" versus the value of having reliable data

The CCS Group considered whether information on functioning and disability should even be collected at all. Some participants in the CCS Group reasoned that each engagement between the Waitemata and Auckland DHB and a patient, visitor or staff member should be treated on its face, despite disability or functioning. However, other participants recognised that in order to achieve service change, reliable data is necessary. These participants also acknowledged the importance of individual stories.

2.4 Inaccuracies will be prevalent

The CCS Group noted that because collecting information on functioning and disability is reliant on patients, visitors and staff members "self-identifying" it may not be an accurate reflection of the population. In particular, the way the question is asked may make a difference to the way people respond. However, most participants agreed that some data is better than the status quo of no data at all.

3. Strategic Context and Impact on Reducing Inequalities

The Disability Action Plan 2014-2018 sets out strategic priorities to advance the implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD) and the New Zealand Disability Strategy. Priority 11 of the Action Plan is to increase government services' responsiveness to disabled people. Ensuring any changes to reporting or administration systems in the future have the capacity to capture functioning and disability information, will likely result in better service design and delivery. This will in turn increase access to health services and improve health outcomes for disabled people, including Māori.

[i] Two major conceptual models of disability exist. The *medical model* views disability as a feature of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals or intervention, to 'correct' the problem with the individual.

[ii] The *social model* of disability, on the other hand, sees disability as a socially created problem and not at all an attribute of an individual. On the social model, disability demands a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment.

Disability Support Advisory Committees' Terms of Reference

Recommendation

That the Disability Support Advisory Committee recommend that the Auckland DHB Board and Waitemata DHB Board:

1. **Approve the suggested amendments to the Disability Support Advisory Committees' Terms of Reference to better reflect the importance of the New Zealand Disability Strategy and other guiding strategies.**

Prepared by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata District Health Boards.)

Glossary

DHB	District Health Board
NZPHD Act	New Zealand Public Health and Disability Act (2000)

1. Introduction/Background

The Disability Support Advisory Committees are established under the New Zealand Public Health and Disability Act (2000) ("NZPHD Act"). The functions of these committees as described in the NZPHD Act and the current Auckland and Waitemata DHB's terms of reference are:

Functions of disability support advisory committees

(1) The functions of the disability support advisory committee of the board of a DHB are to give the board advice on:

  (a) the disability support needs of the resident population of the DHB; and

  (b) priorities for use of the disability support funding provided.

(2) The aim of a disability support advisory committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

  (a) the kinds of disability support services the DHB has provided or funded or could provide or fund for those people:

  (b) all policies the DHB has adopted or could adopt for those people.

(3) A disability support advisory committee's advice may not be inconsistent with the New Zealand disability strategy.

At the June 2014 Disability Support Advisory Committees' meeting the Committees requested:

"That a review of the Terms of Reference be undertaken to ensure a more positive reference is included to the New Zealand Disability Strategy and other relevant strategies."

2. Proposed Amendments

The terms of reference for the Auckland and Waitemata DHBs' Disability Support Advisory Committees have been reviewed and the following amendments are proposed to better reflect the importance of the New Zealand Disability Strategy and other guiding strategies.

Functions of Committee

(c) The Committees' advice must ~~not be inconsistent with~~ *consider and be aligned with* the New Zealand Disability Strategy. *This strategy provides the framework for the Government's overall direction of the disability sector in improving disability support service, and therefore the Committees' advice.*

(d) The Committees are to ensure that the 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' *advice must also consider and be aligned with* ~~shall also have regard to~~ the Health of Older People Strategy and the New Zealand Positive Ageing Strategy.

3. Responsibilities

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

- The development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the districts. *All strategies and policies must consider and be aligned with* ~~having regard to~~ the New Zealand Disability Strategy*, and when considering older people with the* ~~and the~~ Health of Older People Strategy *and the New Zealand Positive Ageing Strategy. The Committee must also consider other relevant national strategies.*

In addition to the above changes, some minor amendments have also been made to reference the correct section of the NZPHD Act and changes to job titles to reflect the implementation of the Joint Planning, Funding and Outcomes Unit across both Auckland and Waitemata DHBs'.

3. Conclusion

The Auckland and Waitemata DHB's Disability Support Advisory Committees' terms of reference are aligned with the NZPHD Act. The proposed amendments reflect the Committees' advice to include more positive references to the New Zealand Disability Strategy and other relevant strategies.

AUCKLAND and WAITEMATA DISTRICT HEALTH BOARDS'

Disability Support Advisory Committees
Terms of Reference

Establishment

The Disability Support Advisory Committees (DiSAC) are established by the boards of the Auckland District Health Board ("Auckland DHB") and Waitemata District Health Board ("Waitemata DHB") under section ~~34~~ 35 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~~Auckland and Waitemata DHBs' are to:

(a) Give the Boards advice on:

- The disability support needs of the resident population of both DHBs~~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 Auckland and Waitemata DHBs'~~ADHB's and WDHB's~~ resident populations:

- The kinds of disability support services Auckland and Waitemata DHBs' ~~and WDHB~~ have provided or funded or could provide or fund for those people
- All policies Auckland and Waitemata DHBs' ~~and WDHB h~~ 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~~ consider and be aligned with the New Zealand Disability Strategy. This strategy provides the framework for the Government's overall direction of the disability sector in improving disability support service, and therefore the Committees' advice.

(d) The Committees are to ensure that disability support needs of the community are reflected in all Auckland and Waitemata DHBs' ~~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~~ advice must also consider and be aligned with 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 Auckland ~~DHB~~ and Waitemata DHBs'
- the development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the districts. All strategies and policies must consider and be aligned with ~~having regard to~~ the New Zealand Disability Strategy and when considering older people with the Health of Older People Strategy and the New Zealand Positive Ageing Strategy. The Committee must also consider other relevant national strategies.
- 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 Auckland and Waitemata DHB ~~ADHB and WDHB~~ districts' perspective to be contributed to the development and implementation of regional and national policies related to disability issues in the Auckland and Waitemata DHBs' ~~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 Auckland and Waitemata DHBs~~DHB and WDHB~~ will ensure 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~~Auckland and Waitemata DHBs ~~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~~Auckland and Waitemata DHBs based on the model standard standing orders.

Membership

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

(i) Three Board members from Auckland DHB

(ii) Three Board members from Waitemata DHB

(iii) Six appointed members

(b) The Chairperson(s) of both Auckland and Waitemata DHBs ~~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~~ 35 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 Auckland and Waitemata DHBs ~~and WDHB~~ based on the model standing orders.

(b) Auckland and Waitemata DHB ~~and WDHB~~ CEOs will ensure adequate provision of management and administrative support to the DSACs' function including attendance of the CEOs and Directors of Funding and Health Outcomes.~~Chief Planning and Funding Officers.~~

(c) The venue for the meeting will alternate between an agreed Auckland and Waitemata DHB ~~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.

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 34 for the passing of this resolution
Proposed appointment to the Disability Support Advisory Committee	To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act 1982 s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]