



Making a healthy difference to the community

Disability Support Advisory Committee Meeting

Wednesday 21 September 2011

**Marie Hosking Room
Level 7, Building 14
Greenlane Clinical Centre
Greenlane**

2:00pm

*Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare*



Disability Support Advisory Committee

For discussion with Board

DSAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	

KARAKIA AND INTRODUCTIONS

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

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.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

ADHB WDHB DSAC INTERESTS REGISTER

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Sandra CONEY (Chair)	Councillor Auckland Council	Chair Parks Committee			2 May 2011
Jo AGNEW (Deputy Chair)	Professional Teaching Fellow, School of Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		7 September 2011
Max ABBOTT	Auckland University of Technology Raeburn House Health Workforce New Zealand	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences Patron Board Member			14 July 2010
Pat BOOTH	Fairfax Suburban Papers in Auckland	Consulting Editor			24 June 2009
Susan BUCKLAND	Writing, editing and public relations services Medical Council of NZ Occupational Therapy Board Northern Regional Ethics Committee	Self-employed Professional Conduct Committee member Professional Conduct Committee member Member	Fees Fee Fee Fee		7 September 2011

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 2011
Robyn NORTHEY	Self employed Contractor Hope Foundation Northern Region Ethics Committee	Project management, service review, planning etc. Board member Member			16 December 2010
Michelle CAVANAGH	Nil				9 September 2011
Maria HULL-BROWN	Employee Mental Health Foundation Member Auckland City Council Disability Issues Advisory Group Board member HOPE Foundation for Research on Ageing Council Member Age Concern Auckland.				13 May 2010
Dairne KIRTON	Nil				24 June 2008
Jan MOSS	Nil				16 August 2011
Susan SHERRARD	CCS Disability Action Ripple Trust	Contract Tustee			9 September 2011

CONFIRMATION OF MINUTES

- **4.1 ADHB MINUTES – 15 JUNE 2011**
- **4.2 WDHB MINUTES – 22 JUNE 2011**

4.1

CONFIRMATION OF MINUTES

ADHB – WEDNESDAY 15 JUNE 2011

Disability Support Advisory Committee Minutes

MEETING DETAILS							
Date and Time	11:30 am, Wednesday, 15 June 2011						
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom						
1	WELCOME						
	The Chair declared the meeting open 11:38 am.						
2	ATTENDANCE AND APOLOGIES						
	<p>Committee Members</p> <table> <tr> <td>Jo Agnew (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Marie Hull-Brown</td> <td>Robyn Northey</td> </tr> <tr> <td>Susan Sherrard</td> <td>Nanar Tan</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning and Funding Officer Lisa Gestro – Manager Planning and Funding Alison Paulin – Allied Health Professional Leader Ian Bell – Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Lester Levy, Dairne Kirton and Janice Mueller.</p> <p>The Chair noted that this was the final meeting before the merged committee with Waitemata District Health Board.</p>	Jo Agnew (Chair)	Susan Buckland	Marie Hull-Brown	Robyn Northey	Susan Sherrard	Nanar Tan
Jo Agnew (Chair)	Susan Buckland						
Marie Hull-Brown	Robyn Northey						
Susan Sherrard	Nanar Tan						
3	CONFLICTS OF INTEREST						
	There were no notifications of any conflicts of interest for any item on the agenda. Susan Sherrard advised that she had been appointed to the Auckland Council's Committee on Disability.						
4	CONFIRMATION OF MINUTES 20 APRIL 2011						
	<p><u>Moved Marie Hull-Brown: seconded Robyn Northey</u></p> <p><i>That the minutes of the Disability Support Advisory Committee meeting held on 20 April 2011 with the amendments to Be.Accessible and noting the proposed membership of the merged committee being included in the minutes for clarification, be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>						
5	ACTION POINTS 20 APRIL 2011						
	The Chief Planning and Funding Officer had managed the Phobic Trust proposal.						

6	CHAIRMAN'S REPORT
	<p>The Chair and Lisa Gestro had attended the Be.Accessible launch noting that the Government had provided funding of \$4m. She expressed disappointment at the number of ADHB attending as they were a founding partner and ADHB had provided support and commitment over time to making it work. It was suggested in the future that there be prior agreement as to who would be representing ADHB. The Committee is to be kept informed on the initiative and it would be raised with the combined meeting.</p> <p>The new committee was proposing to have 4 co-opted members between the 2 DHBs noting that Waitemata had previously had 8 and Auckland 4. Representation was yet to be decided but there would be a yearly rotational policy to maintain continuity. The Chair thanked everyone for their support.</p> <p><u>Moved Robyn Northey; seconded Susan Buckland</u></p> <p><i>That the Chairman's report be received.</i></p> <p><u>Carried</u></p>
7	DAP Projects Report
	<p>Interim Funding Pool</p> <p>The DHBs were prepared to accept the interim funding pool on 1 July 2011 with Counties Manukau now agreeing to the regional risk sharing approach so the pool will be managed regionally with NDSA doing quarterly wash-ups. In year 3 funding would revert to each DHB. Funding for children will be top sliced from the pool and they would be managed through Starship. The group of people involved were being reviewed with a view to seeing how services could be clustered to provide for their needs. There would still be use of rest homes as it would take six months to understand the needs and up to twelve months to go to the market to get better solutions.</p> <p>The Committee asked to be regularly informed on the interim funding pool and the clients once devolved. Management was asked to check with MoH as to what complaints or issues they were dealing with prior to devolution.</p> <p>Issues Based Audit</p> <p>The Chief Planning and Funding Officer had met with the CEO of the owner of the facility explaining that there was a management issue at the facility and had required them to produce KPIs at short notice. A report was being developed and 2 gerontologists had assessed all in the facility. There was more visibility now and it was on intensive monitoring to the KPIs with involvement of the Health and Disability Commissioner.</p>
8.1	Update on the Implementation of the Disability Audit
	<p>An update from the Steering Committee was distributed with that group having met twice and taking a staged approach of familiarising themselves with the recommendations, assessing the current state, looking at options and then prioritising. The Steering Group was made up of people at a high level from across the organisation. The recommendation on a Disability Liaison Officer was being discussed with Waitemata and with the formation of a combined committee it may be strategic to look at one position across both DHBs noting that the roles between Waitemata and Counties Manukau were quite different with one being representative of disability whereas the other was charged with implementing the Disability Strategy at a governance level. While there needed to be a champion for disability what the position looked like needed to be clarified. The discussion on the orientation programme on disability, prior to the meeting, had been fruitful.</p>

4.2

CONFIRMATION OF MINUTES

WDHB – WEDNESDAY 22 JUNE 2011

Minutes of the meeting of the Waitemata DHB

Disability Support Advisory Committee

Wednesday 22 June 2011

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
commencing at 10.00am

COMMITTEE MEMBERS:

Sandra Coney (Committee Chair)
Lester Levy (Board Chair)
Max Abbott (Deputy Board Chair)
Natalie Brunzel (Co-opted Member)
Tina French (Co-opted Member)
Karl Gatoloia (Co-opted Member)
Jan Moss (Co-opted Member)
Russell Vickery (Co-opted Member)

ALSO PRESENT:

Dave Davies (Chief Executive)
Debbie Holdsworth (Acting Chief Planning and Funding Officer)
Michelle Wilson (Acting GM, Child Women and Family Services)
Sue Skipper (Operations Manager, Older Adults & Home Health)
Samantha Dalwood (Disability Strategy Co-ordinator)
Tim Wood (Acting Group Funding and Primary Care Manager)
Katrina Lenzie-Smith (Programme Manager, Health of Older People)
Stephanie Doe (Operations Manager, Child Health Services)
Tanya Bish (Quality and Prof. Development, Primary Health Care)
Paul Garbett (Board Secretary)

PUBLIC AND MEDIA REPRESENTATIVES

Margaret Willoughby, Rodney Health Link

APOLOGIES:

Resolution (Moved Sandra Coney / Seconded Jan Moss)

That the apologies from Pat Booth, Michele Cavanagh, Dale Bramley and Linda Harun be accepted.

Carried

DISCLOSURE OF INTERESTS

There were no notifications of additions or amendments to interests that had been previously advised.

With regard to this agenda, Russell Vickery declared an interest in Item 4.1 in relation to the Disability Awareness e-learning training module, in that he had applied for funding relating to e-learning. He advised that he would take no part in the consideration of that part of the agenda report.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda.

Presentation – Residential Aged Care Integration Programme

Tanya Bish (Quality and Professional Development, Primary Health Care) advised that she was making the presentation on behalf of Michael Boyd and Janice Parker, the nurse practitioners who had initiated and led the programme. She then provided a power point presentation, a copy of which has been included with the Board agenda for 29 June 2011.

In answer to questions, Tanya Bish advised:

- A key factor in the success of the programme had been mutual respect, with the gerontologists accepting that their role is to support the nurses providing the residential care. By taking that approach they had developed an understanding of the problems faced by those working in residential care.
- With regard to concerns about the quality of the discharge process, the RACIP Working Group has designed a transfer form for all transfers of residents between aged care facilities and the hospitals (whether in or out of the hospital). The form has to come with the transfer and there is a requirement for a good hand over by telephone before the resident arrives back in the facility. Tanya noted that the process could be “a little hit and miss” and more work needed to be done on improving that situation. There was a move to describe the process as “transfer of care” rather than “hospital discharge” and it was hoped that would assist with a change of outlook.
- Assistance is available from Board staff with the relevant language skills to assist Pacific residents in aged care with understanding and accessibility issues.

There was a discussion around the problems experienced when disabled people under the age of 65 get placed in aged care facilities because of a lack of other suitable facilities. While they might have similar medical and nursing needs, it is questionable whether their social and psychological needs can be met in aged care facilities. Tanya Bish noted that the training supplied to residential aged care facilities would have spin off benefits for any residents of those facilities, but she did consider there was a gap and would like to see all in residential care, regardless of age, supported in the same way. Tim Wood advised that Auckland DHB is currently looking at options for appropriate residential care for the disabled.

The Committee Chair raised the question of the need for a similar type of programme to the Residential Aged Care Integration Programme to work on psychological well being in aged residential care, around acknowledging the degree of independence that people have retained, their integrity and their personal preferences. Tanya Bish said that she thought the behaviour shown by Board staff in the RACIP Programme, by always showing that respect, could have a positive impact on residential care staff. The Board Chair noted an issue with the national contracts covering aged residential care, where there was not enough specificity around accountability. He saw a huge difference between best and worst not only in residential aged care, but in many other areas.

There was a discussion around the future of initiatives such as this in the context of the anticipated future requirement to prove actual savings – for example in the number of hospital beds not required as a result of a programme. Points made in that discussion included:

- The challenges of an ageing population, increasing rates of dementia etc.
- The importance of prevention at general practitioner level to avoid more serious problems developing – and the difficulty posed by the fact that primary care is funded to be reactive and not proactive, and the huge gaps that occur in support for many of those discharged from secondary care.
- The need to actually close down beds as a result of successful initiatives that reduce hospital admissions – so that further such initiatives can be funded.

In answer to questions, Tanya Bish advised that she thought that the increase in medication prescribed in aged residential care related to preventative medicine and improvements in medication available. She also noted the changed nature of rest home residents over the past 20-30 years. Residents now were on average much frailer and had more medical problems than in the past. In the past many of these people might have been found in private hospitals rather than in aged residential care. Yet the model had not changed. This had created huge challenges for residential care facilities as it is very expensive to support people with very high needs. In her view these facilities needed to be provided with more support. If financial support was not possible, then she suggested more programmes of this type.

There was a further discussion around negative attitudinal and cultural issues often associated with aged care residential facilities. A wide range of viewpoints were expressed as to the underlying causes of this, including the importance of leadership and culture within the individual facilities, negative perceptions in society arising from media highlighting particular cases, workforce issues, a lack of understanding of different cultures, and problems with national contracts not specifying accountability around consistent standards.

Presentation – Medication Care Guides for Residential Aged Care

Tanya Bish (Quality and Professional Development, Primary Health Care) provided this power point presentation, a copy of which has been included with the Board agenda for 29 June.

In answer to a question, Samantha Dalwood (NZ Disability Strategy Co-ordinator) advised that part of the work she was undertaking with the Communications Department involved looking at making information available in accessible formats to those with disabilities. A separate group was developing a policy around translation into different languages. The Committee Chair suggested that there should also be a policy around accessible resources.

In answer to a question, Tim Wood advised that the District Health Board had a clinical pharmacist looking at pharmaceutical utilisation in aged residential care and at how prescribing could be improved in that area. Regionally more specificity is being sought as to what pharmacy can deliver into aged care.

Sue Skipper noted that three launches of the Guides would take place in the district during July (details available from the Board Secretary if members wish to attend).

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of Disability Support Advisory Committee (DiSAC) Meeting of 23 March 2011 (agenda pages 1-10)

Resolution (Moved Tina French / Seconded Russell Vickery)

That the minutes of the DiSAC meeting held on 23 March 2011 be approved.

Carried

3 ITEMS FOR RECOMMENDATION TO BOARD

There were no items listed on the agenda requiring recommendation to the Board.

4 ITEMS FOR INFORMATION

4.1 NZ Disability Strategy Project Update (agenda pages 11-20)

There was no discussion of Disability Awareness Training – e-learning module, which Russell Vickery had disclosed an interest in.

Samantha Dalwood updated her report relating to the Health Passport. She advised that she had met with Michele Cavanagh regarding her concern that some of the images in the Passport should have more of a New Zealand flavour, and had agreed to support changes to three of the images. These suggestions had been forwarded to the Health and Disabilities Commission to be included in feedback to the pilot.

With regard to changes taking place with car parking at Waitakere and North Shore Hospitals, concerns were expressed at the impact of the new unmanned barrier arms on people with disabilities, and also accessibility of pay stations. Samantha Dalwood advised that with regard to barrier arms she had received an assurance from Facilities that if people had difficulties and pressed the help button, they would quickly receive assistance from a Traffic staff member. Samantha offered to take a look at the Pay Stations at Waitakere Hospital. She had understood that they were to be height accessible and the location near the entry to the Hospital is to facilitate assistance at reception. She also advised that there is a number on the Waitemata DHB website that people can ring to say that they will be arriving and will need support to park.

Russell Vickery commented that he still had concerns that disabled people who previously had been able to park without assistance would now require assistance. Other options were possible, for example in some locations Auckland City Council had ramps leading up to pay machines.

In response to a suggestion from the Board Chair, Samantha Dalwood offered to contact Auckland and Counties Manukau District Health Boards to see how they had managed issues relating to the disabled access to unmanned barrier arms and to pay machines.

The Committee noted the importance of Facilities involving the Disability Strategy Co-ordinator in projects from an early stage and Samantha Dalwood advised that there had been a significant improvement in that.

4.2 Specialised Services for Older Adults Activities (agenda pages 21-32)

Katrina Lenzie-Smith (Programme Manger, Health of Older People) and Sue Skipper (Operations Manager, Older Adults and Home Health) were present for this item.

The Committee was advised that with regard to the Ted and Molly Carr – Returning Home Project (page 31 of the agenda) all eight therapists for the pilot had now been identified and a brief is being developed for a training programme for health care assistants that will support that.

On the facilities needs for SSOA at North Shore Hospital, Lester Levy referred to the very limited capital expected to be available for the next few years and the need to start early with thinking long term about SSOA facilities development, and at alternative ways of funding and what else might be done. In further discussion on this topic it was noted that Ward 12 refurbishment was in the current capital prioritisation process for 2011/12 and if confirmed would be covered by existing available capital funding. It was also noted that it was generally difficult for health boards to attract funding from foundations and trusts, as they tended to either have rules excluding funding the state sector or an expectation that this was a government responsibility.

4.3 Child Disability Services Report (pages 33 - 35)

Stephanie Doe (Operations Manager, Child Health Services) presented the report. She updated the report by noting that the Ministry of Health had advised that additional funding from the Ministry of Health to cover an increase in Out of Area bed days at the Wilson Centre had not been approved for Quarter 1 2011/12, but from informal discussions there might still be a possibility of that for Quarter 2.

There was a discussion about the priorities for respite services, and a concern that additional funding for bed hours might not address the respite needs of families of young adults with high and complex needs. One possibility suggested was extending the respite contract to apply from age 15 to 21 or when the person leaves school.

Resolution (Moved Jan Moss / Seconded Sandra Coney)

- (a) That a report be provided to the next meeting of the Disabilities Advisory Committee on the respite needs of those families with young adults who have high and complex needs leaving the care of the Wilson Centre, including funding issues related to meeting those needs.**
- (b) That contact be made with the Ministry of Health about this issue and related funding matters.**

Carried

Resolution (Moved Sandra Coney / Seconded Karl Gatoloia)

That the reports comprising items 4.1 - 4.3 of the agenda be received.

Carried

CLOSING COMMENTS

The Committee Chair noted that this was the last meeting of the Disability Advisory Committee in its current form specific to Waitemata District Health Board. She said that she was new to the role and on a fast learning curve, but it had been good to work with Committee members around the table. She wished to thank all members for their contribution to the Committee, it had been really important to have that input and it had been much appreciated. She noted that members would have received a letter about the two DiSAC Committees of Auckland and Waitemata DHB being brought together. Recommendations on appointments to the newly structured Committees would be brought to the Waitemata and Auckland DHB Board meetings shortly and all members would be contacted about the outcome.

The Board Chair said that he would like to reinforce the gratitude and appreciation of the Board to Committee members. Hopefully this move to a sub-regional approach would create great opportunities to do more than could be done alone.

The meeting concluded at 11.35a.m.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATA DHB
DISABILITY SUPPORT ADVISORY COMMITTEE OF 22 JUNE 2011

_____ CHAIR

5

ACTION POINTS

5.1 ADHB ACTION POINTS 15 JUNE 2011

5.2 WDHB ACTION POINTS 22 JUNE 2011

5. 1 ADHB ACTION POINTS 15 JUNE 2011

**Disability Support Advisory Committee
Action Points from the Meeting held on Thursday 15 June 2011**

Item	Detail	Designated	Action
6	The Committee is to be kept informed on the Be.Accessible initiative and it would be raised with the combined meeting	Lisa Gestro	Item 8.1
7	The Committee asked to be regularly informed on the interim funding pool and the clients once devolved. Management was asked to check with MoH as to what complaints or issues they were dealing with prior to devolution.	Lisa Gestro	Verbal Update

5. 2 WDHB ACTION POINTS 22 JUNE 2011

**Matters Arising and Carried Forward from
Meetings of the Disability Support Advisory Committee
As at 24 June 2011**

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Action/ Comment
DiSAC 22/6/11	4.1	<u>Carparking Changes at Waitakere and North Shore Hospitals – Disabled Access</u> Samantha Dalwood will: - check pay stations at Waitakere Hospital - discuss with ADHB and CMDHB how they have managed issues relating to disabled access to unmanned barrier arms and to pay machines.	Samantha Dalwood	DiSAC 21/9/11	Item 8.8
DiSAC 22/6/11	4.3	<u>Child Disability Services – Respite Needs</u> - a report to be provided to the next meeting of DiSAC on the respite needs of those families with young adults who have high and complex needs leaving the Wilson Centre, including funding issues related to those needs. - contact to be made with the Ministry of Health about this issue and related funding matters.	Linda Harun, Stephanie Doe, with assistance from Tim Wood	DiSAC 21/9/11	

6

CHAIRPERSON'S REPORT

DISABILITY SUPPORT PERFORMANCE

7.1 DAP Report

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Auckland and Waitemata DHB - DiSAC Committee
From	Tim Wood, Funding & Planning Manager, Denis Jury, CPFO
Author	Katrina Lenzie-Smith, Health of Older People, Programme Manager, WDHB Lisa Gestro, Planning and Funding Manager, ADHB
Functional Group	Auckland and Waitemata DHB Funding and Planning Managers
Subject	DiSAC Quarterly Report on activities in Auckland & Waitemata DHBs
<p>Purpose</p> <p>The purpose of this report is to provide an update to DiSAC on the progress and activities occurring across both DHB's. Material is provided across both Boards where appropriate, and for specific boards as outlined.</p>	
<p>Recommendation:</p> <p>That the report be received by DiSAC.</p>	
<p>Background</p> <p>Health of Older People services are directed by the Minister of Health, the 2011/12 Regional Annual Plan and Waitemata and Auckland District Annual Plans. For Waitemata DHB, the implementation of Specialised Services for Older Adults (SSOA) is a Board priority for 2011/12.</p>	
<p>Long Term Supports – Chronic Health Conditions (LTS-CHC)</p> <p>The management of Long Term Support Services for people under the age of 65 years with chronic health conditions (LTS CHC) has recently been devolved from the Ministry of Health to District Health Boards:</p>	

- As of 1 July 2011 the funding for these services (\$27.155m nationally) has transferred to DHBs, initially on a cost estimate basis, to be amended when actual costs for the 2010/11 year for each DHB are known, plus a Population Based Funding (PBF) share of any under spend. Funding will be at this level for two years (i.e. 1 July 2011 to 30 June 2013). From 1 July 2013 funding will be on a PBF basis.
- From 29 August 2011 the contracts associated with the support services will transfer to DHBs through the provisions of an Order in Council. In this interim period, from 1 July 2011 to 29 August 2011, DHBs will take responsibility for assessing clients but the Ministry will continue to meet all other obligations.
- From 29 August the DHBs will take full responsibility for the devolved funds, and financial reporting will be provided to the Ministry via Northern DHB Support Agency (NDSA) on a quarterly basis via the Regional Service Plan. This is likely to be high level information i.e. client numbers, value of spend and within region cross subsidisation as provided by the individual DHBs. Further in depth financial analysis and reporting will be undertaken by NDSA so as to provide details of risk pool spend and each DHB savings against agreed targets in order to progress to PBFF within the two year time frame.

The Northern Region DHBs are proposing to put the following arrangements in place to manage the service regionally and deliver the service locally:

- **Service Delivery** – where possible clients will be assessed by individual DHBs and receive services locally. An exception to this is assessment services for children where, because of the small number of children and their complex needs, Family Options shall undertake all assessments for the Northern Region.
- **Service Management and Oversight** – the intent is to ensure that there is consistency in assessment and access to services, noting that the DHBs will set this alongside similar clients aged over 65 years and will as time progresses integrate service prioritisation in to wider DHB processes.
- **Financial Risk Sharing** –as required by the Ministry, a regional approach has been agreed for managing and sharing the financial risk associated with the delivery of services for LTS-CHC clients in the Northern Region
- **Service Development** – The region faces a number of risks in terms of managing the transition and putting in place sustainable and affordable services for this client group in the long term. The region will work collaboratively around agreed service development initiatives to ensure this occurs smoothly and ongoing care arrangements are appropriate and affordable for LTS-CHC clients

Aged Residential Care (ARC)

InterRAI and Age Related Residential Care(ARRC) Quality

The Minister of Health expects the national roll out of interRAI into ARRC facilities

to take place over the next four years with the associated implementation costs to be borne by individual DHBs. This is being presented in a separate paper to the DiSAC Board.

Age Related Residential Care (ARRC) Utilisation

The Grant Thornton Review (2010) of Aged Residential Care predicted an increase in bed utilisation in line with rising dependency levels. Waitemata DHB is starting to see this with growth in private hospital level services over the last three quarters, while entry into Rest Home level care remains steady. A similar pattern is being experienced in ADHB, although the HBSS initiatives described above have impacted on demand for Rest Home Level care in line with expectations. In time, within both districts, there is potential that there may be a demand and supply issue of private hospital bed availability. Although ADHB continues to have a greater level of capacity to absorb growing demand so the impact is not expected

InterRAI

The national roll out of interRAI into residential facilities over the next four years is one of the Minister of Health expectations. The implementation plan includes a national governance structure that will include residential care, National Health Sector, and DHB representation. This data will inform all future local, regional, and national funding and planning of this population. Currently expressions of interest are being sought from ARC providers who wish to be early adopters of the tool. Although not mandatory, the Minister has an expectation that 90% of providers will be using the tool at the end of the four year implementation period. A more substantive paper outlining the details of this project is attached.

Aged Residential Care Healthcare Utilisation Study (ARCHUS)

In February 2011, the Aged Residential Care Healthcare Utilisation Study (ARCHUS) commenced across the Northern Region. The Randomised Control Study (RCT) will recruit approximately 6800 Age Related Residential Care (ARRC) residents prospectively and follow them for 2 years. The study employs statistical modelling of Ambulatory Sensitive Hospitalisations (ASH) to determine predictors of ASH. This data will produce both resident level and facility level data. This work will be reported on at this forum on a regular basis.

Certification

Under the Health and Disability Service (Safety) Act 2001 all Age Related Residential Care (ARRC) facilities are required to provide safe and reasonable levels of service for consumers, and as such must have current Certification as the Health and Disability Standards. The Ministry of Health administers the certification, and an ARRC facility may be given a certification period of between 6 months and 4 years. Three year certification should be the norm. Waitemata DHB has been tracking this for a couple of years. Waitemata DHB currently has 67% of ARRC facilities on 3 or more year certification periods. For ADHB this is currently 64%. It should be noted that some of the decline in 3 year certification is due to a high number of (12 out of 61) ARRC facilities that have had a change of ownership over the last couple of years. On change of ownership the facility must undergo a Provisional Audit and can

only receive 12 month certification.

Home Based Support Services (HBSS)

In June 2011, the Office of the Auditor General (OAG) published the HBSS national audit findings. This has been closely followed by a national review of the HBSS service specifications; both of which have informed activity at both a local and regional level, with the establishment of the Regional Health of Older People Clinical Network which is the subject of a more substantive paper this month.

The total Waitemata DHB expenditure for HBSS for FY 11/12 is estimated to increase by 2-3% compared to a 20-30% increase in expenditure between FY06-10. This reduction has been largely attributed to the short and medium term interventions of the HBSS taskforce.

In February 2011, a HBSS discussion paper was presented to the Waitemata DHB Audit and Finance Committee who endorsed the proposed recommendations:

- continuing with the current work being undertaken by the HBSS taskforce;
- commissioning a feasibility study and pilot of alternative service for older people in the community;
- scoping and commencing a Home Based Support Services project.

In October 2011, an exploration of existing HBSS will be reviewed with the recipient population of HBSS to discover more about the relationship between HBSS, the patient experience, and the associated health gains. This deliberate and inclusive strategy will inform the next stage of the redesigning process of alternative community services which aim to improve the health of this population.

In ADHB, a major reformation of the service model for the delivery of HBSS is in the final stages of implementation. This has seen a significant level of value added to the service, such as the availability of clinical case managers for each client, standard assessment undertaken in the community using InterRAI, and a more responsive and individual package of care tailored to meet the goals of individuals. This service is now funded according to a case mix methodology, which funds each client according to their clinical complexity and level of anticipated support need, which has provided a level of transparency around the process which was previously not understood.

The model is currently being evaluated by the University of Auckland, with the initial draft findings being presented on the 21st of September.

Expenditure for HBSS is tracking to budget, with no further volume growth expected in the 11/12 year.

interRAI Minimum Data Set – Home Care (HC) and Contact Assessment (CA)

The implementation of interRAI Minimum Data Set-Home Care (HC) and Contact Assessment (CA) is a Ministry of Health nationally led project primarily to provide an evidence based standardised needs assessments of the older population (65+) living in the community or in hospital about to be discharged into the community. A national implementation of interRAI (MDS-HC and CA) is aimed at improving health

and support services for older people by:

- Enabling systematic, consistent and comparable assessment processes and
- Improving risk identification which is intended to result in more timely and effective care.

This is currently being implemented across both DHB's on time and within budget.

For ADHB, who have led the roll out within the region, there has been added dimensions to consider with the devolution of a large percentage of the Needs Assessment function to external HBSS agencies as outlined above. ADHB has now completed all aspects of the InterRAI rollout pending release of the INterRAI Community Health Assessment tool in 2012, which will streamline the assessment process further.

Advanced Care Planning (ACP)

The regional annual plan includes the activity of Advanced Care Planning (ACP). Auckland DHB co-ordinated this activity by creating an ACP cooperative which has taken a national approach to raising awareness about ACP and an integrated approach to bring ACP into every DHB throughout New Zealand. Waitemata DHB is committed to engaging in this process and has a number of employees contributing to the ACP cooperative activities for FY 2011/12.

All Aged Residential Care facilities within the ADHB area are active members of the cooperative.

Disability Awareness Training – e-learning module

WDHB: The first draft of the e-learning module in Moodle has been completed and has been reviewed. Karina Campbell, Waitemata DHB e-learning Designer is making these changes and it will then be ready to pilot across Waitemata and Northland DHBs. Lyn Rostern, Population Health Strategist at Northland DHB, and Samantha have worked closely to keep the training objectives aligned with our organisation's values.

Once the changes have been made the training will go to the Northland DHB Disability Steering Group and the Waitemata DHB Disability Steering Group for feedback.

ADHB: A new set of training material sourced via the Health and Disability Commission and DiversityWorks, has now been purchased and is being reformatted to load onto our MOODLE site as part of the ongoing Disability Training and responsiveness module for staff.

Disability Access Review, ADHB

As part of its Disability Access Review (substantive report to be provided to the November meeting), ADHB has identified several key initiatives that need to be prioritised and addressed as part of our response to the National Disability Strategy.

The implementation of the findings has been designated to a steering group, who will report through to the combined DSAC via the ADHB Senior Management Team. The

key areas being looked at by the committee are:

- Communication, including access to information
- Physical Access, including way finding, signage and car parking
- Facilities Management and Procurement
- Staff Training
- Disability Advocacy

Health Passport

The Health Passport is currently being piloted at Capital & Coast and Hutt Valley DHB's. The pilot is due to finish at the end of August. There has been activity across both DHB's to progress the roll out of the initiative across each respective DHB, and Samantha met with the Operations Managers to discuss the implementation of the Passport and the response was very positive. Samantha has met with the Health & Disability Commission to discuss the learning from the pilot, issues that arose and suggestions for improvements. Samantha is also working with the Communications Team to create a marketing and communication plan for the Health Passport. There have been two articles in Healthlines already, but this will be a targeted campaign. Once this has been put in place, the Community will be encouraged to start bringing their Health Passports with them. There have been a number of enquiries from people with disabilities, people who use English as a second language and families of older adults.

Facilities Planning – Car Park, WDHB

Further to a complaint by a member of the public and discussion at the previous DiSAC meeting on 22 June, a paper has been written for members of the DiSAC to consider. This paper, being presented at the meeting on 21 September, outlines the impact the changes to car parking at North Shore and Waitakere hospitals have on some people with disabilities and how the DHB is managing these issues.

Signage Policy Review, WDHB

Further to discussion about signage during recent building work, the current Signage Policy will be reviewed in September. Samantha is part of the group to promote the use of pictures and symbols in addition to text and to use colour as part of way finding.

Translation Policy, WDHB

The DHB is currently working on a policy looking at when and how documents should be translated into other languages. This has been a good opportunity to raise the issue of accessible formats and how information is being presented in an inclusive way.

Recruitment and Retention of Staff with Impairments policy

Sam Bartrum, GM HR, has approved this policy and it is now available on the

intranet for all managers. The updated policy gives advice on making recruitment an equal opportunity for applicants, advice on reasonable accommodations and information on supporting staff with disabilities.

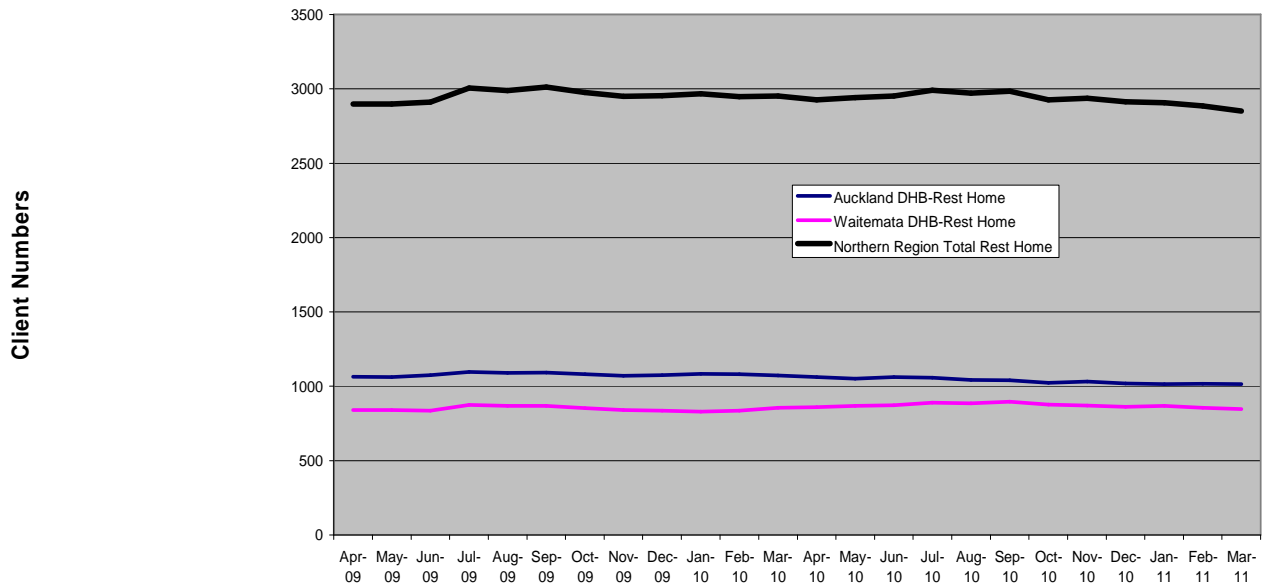
ADHB is currently underway with its Mainstream recruitment project, which is the subject of a separate paper for presentation at this meeting.

Appendices : Combined KPI Report

WDHB Disability Advisor Report

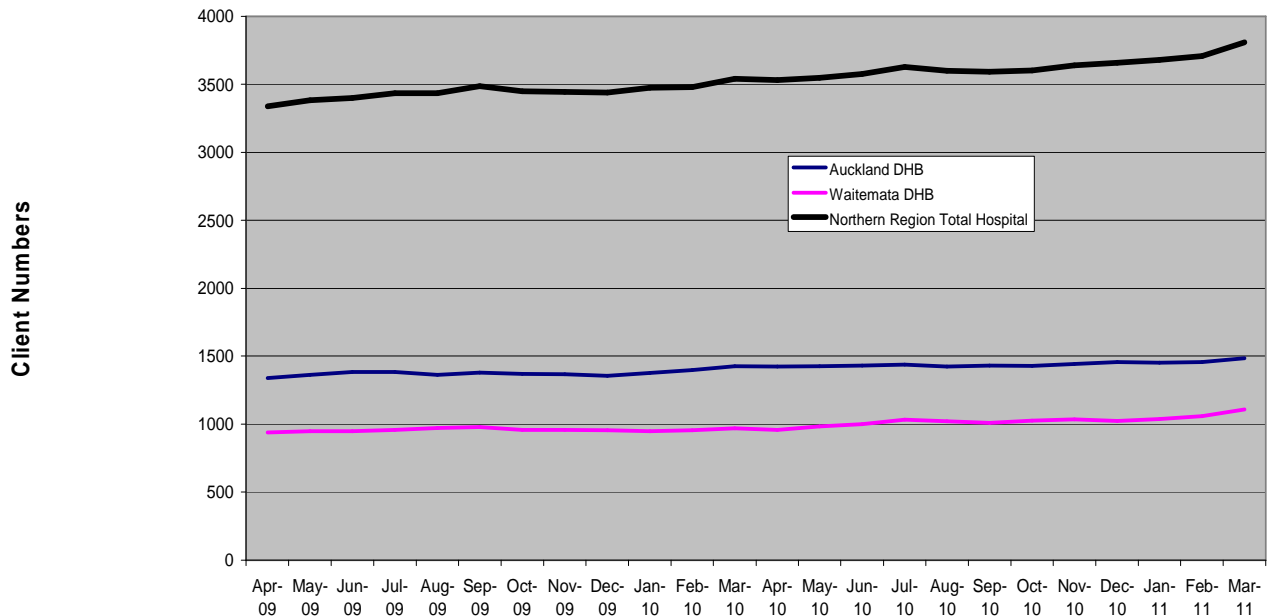
Appendix 1 - Combined KPI Report

Client ARRC Numbers - Rest Home



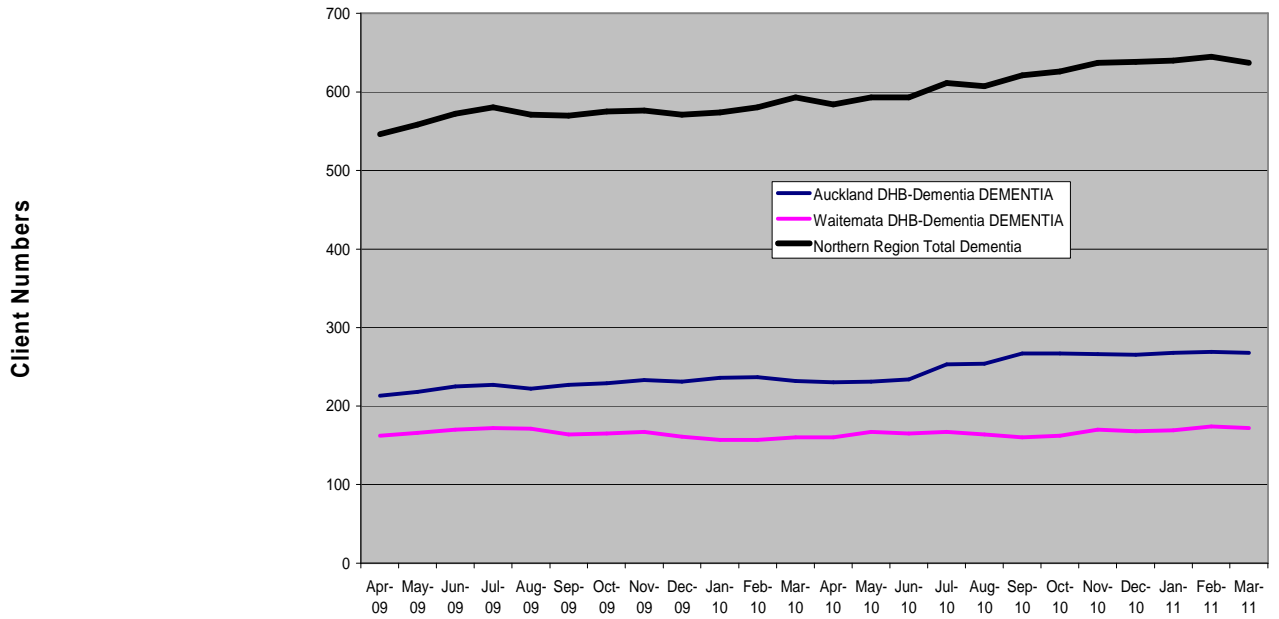
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Auckland DHB-Rest Home	1064	1062	1074	1095	1089	1092	1081	1070	1075	1083	1081	1072	1061	1052	1061	1058	1042	1040	1022	1032	1019	1014	1016	1014
Waitemata DHB-Rest Home	839	839	835	875	868	869	853	840	834	830	836	854	859	869	872	889	885	897	876	870	861	867	855	845
Northern Region Total Rest Home	2897	2896	2911	3005	2989	3011	2975	2949	2954	2966	2947	2952	2926	2942	2952	2992	2971	2984	2926	2936	2913	2906	2885	2851

Client ARRC Numbers - Hospital



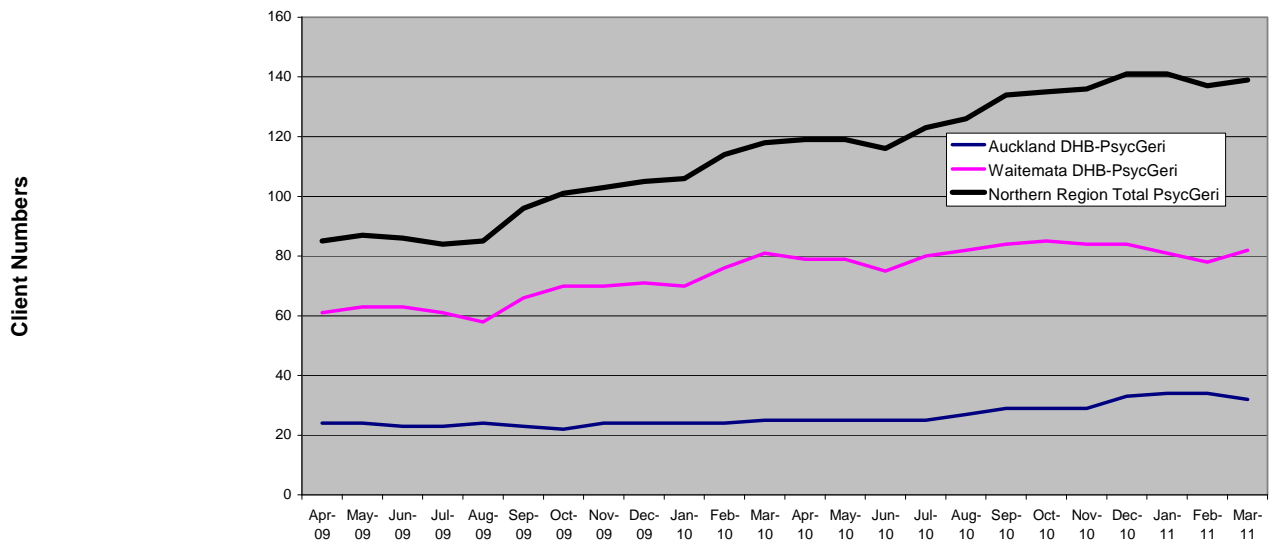
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Auckland DHB	1338	1362	1383	1382	1364	1380	1369	1366	1355	1376	1396	1426	1423	1427	1432	1437	1424	1431	1428	1442	1457	1451	1457	1485
Waitemata DHB	938	949	948	958	972	979	958	958	954	949	955	968	958	982	1000	1034	1022	1010	1025	1036	1023	1038	1059	1108
Northern Region Total Hospital	3337	3381	3397	3435	3434	3486	3449	3443	3438	3475	3479	3541	3529	3547	3576	3627	3598	3591	3601	3639	3657	3678	3708	3808

Client Numbers - Dementia



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Auckland DHB-Dementia DEMENTIA	213	218	225	227	222	227	229	233	231	236	237	232	230	231	234	253	254	267	267	266	265	268	269	268
Waitemata DHB-Dementia DEMENTIA	162	166	170	172	171	164	165	167	161	157	157	160	160	167	165	167	164	160	162	170	168	169	174	172
Northern Region Total Dementia	546	558	572	580	571	570	575	576	571	574	580	593	584	593	593	611	607	621	626	637	638	640	645	637

Client ARRC Numbers - Psychogeriatric



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Auckland DHB-PsycGeri	24	24	23	23	24	23	22	24	24	24	24	25	25	25	25	25	27	29	29	29	33	34	34	32
Waitemata DHB-PsycGeri	61	63	63	61	58	66	70	70	71	70	76	81	79	79	75	80	82	84	85	84	84	81	78	82
Northern Region Total PsycGeri	85	87	86	84	85	96	101	103	105	106	114	118	119	119	116	123	126	134	135	136	141	141	137	139

Appendix 2 - WDHB Disability Advisor Report



Implementation of the New Zealand Disability Strategy 2010-13
Current Status at 1 September 2011

Disability Awareness *Educating staff and challenging stereotypes & assumptions* **Current Status at 1 September 2011**

What we will do... actions	Who will work on this... Partners / Collaborators	When will actions take place... in what order	What is the current status?
Provide a range of disability awareness training, targeting specific services.	Head of Departments GMs and key leaders DiSAC Committee Learning & Development	Ongoing	Collaborative work with Northland DHB to develop a Disability Awareness e-learning module for health settings. Northland DHB Disability Advisory Group is overseeing the project. The proposed 'go-live' date is September 2011. COMPLETED Working with the Child Disability CALD Project to develop an e-learning module for working with CALD families with children with disabilities. Ongoing work to promote the Disability Training and looking at creative ways of delivery.
Write article for Healthlines on Disability Coordinator	Communications	Q1 2010/2011 COMPLETED	Article on the role of Disability

role.			Coordinator was in Healthlines in August 2010. Article on Health Passport in Healthlines April 2011.
Target team meetings to introduce Disability Coordinator role.	Head of Departments GMs and key leaders	Ongoing	Taking the Health Passport to Team Meetings.
Develop clearer policies and procedures for working with patients with disabilities.	Quality Community Organisations	Q1-Q4 2010-2012	Policy started. Draft will go out for input and comment from clinical staff.
Develop 'Disability Champions' across WDHB.	GMs Operations Managers Charge Nurse Managers	Q1-Q4 2010-2012	Work not started.



Physical Access *Overcoming a disability society*
Current Status at 1 September 2011

What we will do... actions	Who will work on this... Partners / Collaborators	When will actions take place... in what order	What is the current status?
Review current Mobility/accessible car parking.	Traffic Services Facilities Dept Communications Dept	By Q2 2010/2011	Have met with new Traffic Manager to discuss issues. New parking building being developed. May 11 - met with Traffic Manager to discuss impact of new unmanned barrier arms on people with disabilities.
Increase knowledge of Mobility/accessible parking by security staff and ward clerks.	Traffic Services Charge Nurse Managers	Ongoing	
Create maps of accessible car parking. Include maps in appointment letters and have them available on website.	Traffic Services Communications Dept Outpatient Departments	Ongoing	New Sustainability Officer in post who is looking at transport. Have met with new Traffic Manager to discuss issues. May 11 - working to develop and Outpatients leaflet with Healthlinks. This would have maps on the back for patients.
Walk through 'patient journey' to look at accessibility issues.	Community Groups - IHC, Age Concern, Foundation for the Blind. Facilities	From Q1 - Q4 2010-2012	

	Department		
Complete barrier free audits of all leased buildings.	Barrier Free Advisor Facilities Department	From Q1 - Q4 2010-2012	Have completed one audit and made recommendations to the landlord. Met with Leasing Manager to discuss accessibility issues. Disability Coordinator to complete Barrier Free training in October 2011.
Develop accessibility audit policy and process for all new facilities.	GM Facilities Facilities Team	By Q4 2010-2011	Met with Facilities Dept who agreed that the Disability Strategy Coordinator would be involved in new build works. Currently reviewing the 'Disability Compliance Guidelines' policy.
Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including autistic spectrum disorders.	Facilities Team Outpatients Team	Ongoing	Work being done with Project Team for new ED that includes looking at waiting areas and signage.
The Disability Reference Group will work to raise and improve access issues.	Disability Reference Group	Ongoing	Working with Imelda Quilty-King, Community Engagement Coordinator, to look how to link input from people with disabilities into larger Community Engagement work.



Communication and Access to Information

Empowering people through knowledge and understanding

Current progress at 1 September 2011

What we will do... actions	Who will work on this... Partners / Collaborators	When will actions take place... in what order	What is the current status?
Participate in development of Health Passport and work with HDC to plan roll out.	Health & Disability Commission (HDC) Quality Team, HOD Nursing	Draft passport out for consultation July 2010 Implementation during 2010/2011	The pilot and initial evaluation for the Health Passport will be done at Hutt Valley DHB. It will be available in the community and on HDC website. Waitemata DHB and Capital and Coast DHB will also start to use it. Positive feedback from Operations Managers on its introduction. Health Passport being implemented across Waitemata DHB from October 2012. Targeted internal marketing campaign.
Ensure WdHB website is accessible – both internet and intranet.	Communications Team	2010/2011 Ongoing	New website is now live. Overall looks good. It is being reviewed later this year.
Ensure patient information is in plain language with clear	Communications Team	Ongoing	Quality Team linked into process being

layout and good visuals.	Waitakere & Rodney Health links & North Shore Community Health Voice Literacy Reference Group		led by Corporate Quality Manager. New consumer information being checked for Health Literacy by Waitakere and Rodney Health Links and consumers.
Increase formats of key documents, e.g. District Strategic Plan.	Communications Team	Ongoing	Needs commitment from DHB and Communications Team.



Community and Consumer Engagement

Building relationships and being responsive to needs

Current Progress at 1 September 2011

<u>What</u> we will do... actions	<u>Who</u> will work on this... Partners / Collaborators	<u>When</u> will actions take place... in what order	<u>What</u> is the current status?
Set up Disability Reference Group.	-Waitakere & Rodney Health links & North Shore Community Health Voice. -Community Engagement Team. -General Managers. -Quality Team. -Community Groups working with traditionally 'silent' groups, eg. People with intellectual disabilities, people with Alzheimer's disease.	Ongoing	Working with Imelda Quilty-King, Community Engagement Coordinator to look how to link input from people with disabilities into larger Community Engagement work. Have had positive response from IHC to my request for feedback from service users at their Self Advocacy forums. Attended 'Health Service Co-design' workshop.
Ensure people with disabilities are identified as stakeholders in planning projects.	General Managers DiSAC and Board members (to request reports)	Ongoing	A policy for community engagement is being developed and will include involving people with disabilities in planning.
Improve the complaints process and make it more transparent.	Quality Team	COMPLETED	There is a dedicated person in the Quality Team to respond to complaints. The whole

			complaints process is being reviewed and the aim is to make a clearer, more transparent process accessible to all.
Develop group of self-advocates with intellectual disabilities.	IHC –Self Advocacy Team & Health Advisor. Spectrum Care People First.	Ongoing	Had positive initial response from IHC. Dec 2010 – meeting with IHC Health Advisor to look at issues for their client group.



Employment Opportunities

Providing employment opportunities for people with impairments and carers

Current Progress at 1 September 2011

What we will do... actions	Who will work on this... Partners / Collaborators	When will actions take place... in what order	What is the current status?
Review all recruitment and employment policies and make recommendations as required.	HR Group Manager Recruitment Manager Workforce Planning	Q1-Q4 2010-2011 COMPLETED	Reviewed and rewritten the 2006 "HR Guide for Recruitment and Retention of People with Impairments" with HR. Involved in review of HR policies.
Review support given to Hiring Managers during the recruitment process.	HR Group Manager Recruitment Manager Occupational Health General Managers	Q1-Q4 2010-2011 COMPLETED	Working with HR to review the 'Impairments at Work' Policy.
Encourage the use of 'Mainstream' and other supported employment agencies.	HR Group Manager Recruitment Manager Workforce Planning Hiring Managers	Ongoing	Met with Workforce Development Consultant to discuss finding suitable roles and suitable teams to employ using 'Mainstream'. Nov 2010 - ARDS (Auckland Regional Dental Service) were awarded the Mainstream Runner Up Employer of the Year. This award acknowledges employers who have a record in creating successful job

			placements for disabled people. We can use this to encourage other managers in the DHB to offer jobs through supported employment agencies.
Review the process for the recruitment of staff with disabilities.	Occupational Health HR Group Manager Recruitment Manager Hiring Managers	Q1-Q4 2010-2011 COMPLETED	Have reviewed the process. Met with Occupational Health to discuss their role. There is work to be done to support Hiring Managers, but centralised budgets are very positive.
Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	HR Group Manager Workforce Planning GM, Decision Support Systems	Ongoing	It is not mandatory for the organization to collect this data. The new HRMS that is due in 2011 should mean that it is possible to collect this data. There are some issues about the accuracy of the data that will be collected.

PAPERS

- 8.1 Presentation – Minnie Baragwanth, CEO – Be.Accessible**
- 8.2 Proposed Approach to the combined ADHB-WDHB DSAC**
- 8.3 Northern Region Health Plan – Update**
- 8.4 Implementation of interRAI Long Term Care Facility (iLTCF) Assessment in residential Care**
- 8.5 Child Rehabilitation Service**
- 8.6 Mainstream Positions at ADHB**
- 8.7 Waitemata DHB Specialised Services for Older Adults (SSOA) Project Charter**
- 8.8 Disability Access to Car Parking at North Shore and Waitakere Hospital**

8.1 PRESENTATION – MINNIE BARAGWANTH, CEO – BE.ACCESSIBLE

**8.2 PROPOSED APPROACH TO THE COMBINED ADHB-WDHB
DSAC**

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committees
From	Denis Jury and Tim Wood
Author	Lisa Gestro Ext 26097 lgestro@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Proposed Approach to the Combined Auckland and Waitemata DHB Disability Support Advisory Committee Meetings
1	<p>Purpose</p> <p>This paper serves to provide some context and guidance into the management and process relating to the new combined committee, and has been prepared to inform discussion at the inaugural combined committee meeting in September about the aims, objectives and purpose if of the committee.</p>
2	<p>Recommendation</p> <p>It is recommended that the Committee <i>note</i> the paper; and</p> <p>That the proposed approach to the management of the combined Disability Support Advisory Committee Meetings is <i>supported</i>.</p>
3	<p>Background</p> <p>The Boards of Auckland District Health Board and Waitemata District Health Board have sought approval from the Minister of Health to combine the functions and memberships of the Disability Support Advisory Committee, as well as several other key statutory committees of the DHB's.</p> <p>The Minister of Health supports this collaborative initiative, noting that to remain compliant with the New Zealand Public Health and Disability Act, the</p>

committees must be separately identifiable.

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

Benefits of a joint approach

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

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

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

4

Proposed Approach

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

Development of the Agenda

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

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

- Joint Summary Report – a high level summary of all current and ongoing issues, consolidated across both DHB's, including DAP KPI's.
- Specialist Hospital Services for Health of Older People (currently WDHB only as this is a priority area for them). This is presented bi-monthly so consideration should be given to whether this is replicated across both DHB's.
- Substantive update papers, designed to provide more in depth background on topical or current issues as per the schedule to provide information to members and inform discussion at meetings.
- Individual papers from each of the DHB's as appropriate, for issues that are specific to each of the DHB's, as appropriate. These should also follow the pre-agreed schedule with the exception of new business of unforeseen issues.

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

Secretariat

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

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

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

	<p>and clinical representatives from each DHB will be required to attend these meetings.</p> <p>Workshop</p> <p>To work through the role of the newly conjoined committee, and ensure that the committee takes an active rather than passive role in the governing of key DHB activity, it has been proposed that a workshop of all DSAC members as well as invited DHB personnel takes place at a suitable time following the initial committee meeting in September.</p> <p>This will be discussed in further detail at the first meeting.</p>
5	<p>Risks/Issues</p> <p>There are a number of risks and issues which have been identified while considering the combined approach to the management of the combined DSACs These include:</p> <ul style="list-style-type: none"> • Managing the logistics of preparing papers across two organisations • Ensuring the implications of decisions for both DHBs are considered • Managing the scope of the committee • Managing stakeholder expectations • Aligning the focus of the committees with the relevant Board to ensure the same approach to decisions, functions or activities is implemented <p>Much of these can be successfully managed through good communication between the DSAC Chair and the lead management team representatives who support the committees.</p> <p>Conclusion</p> <p>The joint approach to these committees enables greater collaboration where there are issues in common. The proposed approach attempts to support this goal with increased collaboration in advice provided to the committees and greater opportunity for more detailed discussion on the complex issues within the key functions of the committees.</p>

Appendix One: Planning Table for Combined DSAC Meetings

	Common Topics /Combined Papers	WDHB Specific Papers	ADHB Specific Papers
1	Home Based Support Services – Update from each DHB condensed into one overarching paper (September and then briefer update ongoing)		
2	Aged Residential Care <ul style="list-style-type: none"> - Quality - Contractual issues - Strategic Developments Update from each DHB condensed into one overarching paper (November and then briefer updates ongoing)		
3	Interim Funding Pool - (September and then activity data reports ongoing)		
5	Northern Regional Health Plan <ul style="list-style-type: none"> - HOP - First do no harm (September and then ongoing)		
7	InterRAI Rollout into Aged residential Care (September)		
8	Core (5-6) KPIs Will need a draft set (Julie Harris to assist here)	Specific KPIs as well as common ones	Specific KPIs as well as common ones
9	Rehabilitation strategy		

	<ul style="list-style-type: none"> - Adults - Children's <p>(November and then regular updates – to be agreed if single DHB or consolidated)</p>		
10	Disability Strategy – adoption of collective vision		
11		Disability Coordinator - Regular Report to the Committee (Every month)	
12			Accessibility Audit – action plan (for November)
13			Mainstream Project Update (for September)

8.3 NORTHERN REGION HEALTH PLAN – UPDATE

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committee (DSAC)
From	Janice Mueller, Director Allied Health, Scientific & Technical Extension 23941 JM Mueller@adhb.govt.nz
Author	Janice Mueller
	Northern Region Health Plan - Update

Purpose

The purpose of this paper is to provide an update to the Disability Support Advisory Committee (DSAC) on the progress of two major initiatives identified in the Northern Region Health Plan; Health of Older People and First, Do No Harm.

Background

The Northern Region is facing significant pressures which require substantive change in the way we work in the future because:

- Over the next 20 years the total population in the Northern Region will grow by around 500,000 which will exceed the current population of any other DHB.
- The Northern Region population is getting older and the burden of chronic diseases is increasing.
- Our projections show that continuing to deliver health services as we do now is not sustainable. Each year we will need an additional 75 -100 beds just to accommodate demographic growth. We will add \$30-40 million to our cost base, and need around \$300 million of capital.

In response, the four Northern Region District Health Boards (DHBs) and their primary care partners, The Greater Auckland Integrated Health Network, The National Hauora Coalition and Alliance Health+ have led the health sector in developing one whole of system regional health plan. The Northern Region Health Plan (NRHP) is a core strategic document which has been clinically led and sets our direction for 2011/2012 and out-years, and will inform DHBs and PHOs annual operational plans. This foundation will now enable us to progressively deliver

services in a fundamentally different way over the next five years.

Three strategic priorities for regional action have been established; First, Do No Harm, Life and Years and The Informed Patient. Within these priority goals, a number of work programmes have been identified, and of particular relevance to DSAC are; First, Do No Harm (a programme in it's own right) and Health of Older People (Life & Years). A third programme, Advanced Care Planning (The Informed Patient) has also been included in this report, for DSAC interest.

A leadership group, representing the four DHBs and consisting of multi-disciplinary stakeholders, is charged with managing the implementation using their expertise and experience for each programme. The Terms of Reference for the Health of Older People (HOP) Clinical Network Group is appended, as an example.

Progress To Date

The 2011/2012 Northern Region Health Plan was recently approved by the Minister of Health for the four District Health Boards, and the first set of targets is currently being progressed.

1. Health of Older People (HOP)

- The Implementation Plan has been concluded, with the major targets being; a 20% reduction in Falls (resulting in significant harm), 20% reduction in Pressure Injuries, development of a Dementia Care Pathway, capacity planning for Respite Care, and roll-out of InteRAI. It should be noted that the targets are applicable across the northern region incorporating non-DHB providers e.g. aged residential care providers. Progress to plan is on track.
- Terms of Reference for the HOP Clinical Network Group (CNG) have been finalised with recruitment of members to the CNG well in hand. Membership includes approximately 20% of representation being drawn from the non-DHB aged residential and home care sector, and comprised predominantly of clinicians and health professionals.
- The Programme Manager for HOP has been appointed and already commenced the role.

2. First, Do No Harm (FDNH)

- The Implementation Plan has also been concluded, with the major initiatives; addressing medication safety, crossover strategies of falls and pressure injury reductions with HOP, the 40% reduction in central line acquired bacteraemia, and review of 50 recent deaths. The overall plan is slightly behind schedule due to the delay in recruiting to the Clinical Leader and Programme Manager roles. On the other hand, good progress has been made between First, Do No Harm and the Health of Older People Workstream, in agreeing methodologies and approaches to the reducing falls and pressure injuries.
- Underpinning all the FDNH initiatives is a major training agenda to be conducted by the Institute for Healthcare Improvement (an independent not-for-profit organization based in the USA that works with health care providers and leaders throughout the world to achieve safe and effective health care).

The four DHBs are presently nominating individuals to attend training in October.

- Recruitment to the Clinical Director and Programme/Campaign Manager roles is up to interview stage.

3. Advance Care Planning

- The Implementation Plan is primarily comprised of a major training initiative for front line health professionals. A business case for the training Pilot has been approved by the NRHP Steering Group and with the intention of starting in December.

Next Steps

The next steps at a high level include:

1. Health of Older People (HOP)

- Finalise CNG membership.

2. First, Do No Harm (FDNH)

- Appoint the Clinical Director and Programme/Campaign Manager.
- Finalise IHI Training Participants.

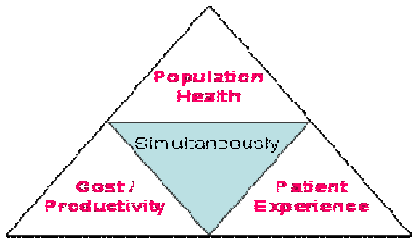
Appendices (attached)

1. Terms of Reference – Health of Older People Clinical Network

NORTHERN REGION

HEALTH OF OLDER PEOPLE CLINICAL NETWORK

Terms of Reference

Name	The group shall be known as the Northern Region Health of Older People (HOP) Clinical Network.
Purpose	<p>The principle purpose of the HOP Clinical Network is to provide strong clinical leadership across the continuum of care that optimises health outcomes, including the reduction of health disparities, within the resource available.</p> <p>Specifically:</p> <ul style="list-style-type: none"> • To provide effective regional Health of Older People strategic planning advice and recommendations to the Northern Region Health Plan Steering Group • To promote effective and appropriate sharing of information that supports a regional perspective on Health of Older People services. • To develop, prioritise, implement and monitor regional activities which contain prioritised goals and allocated resources for each financial year, that deliver outputs which will have an overall strategic aim for regional development.
Principles	<p>The Network will be guided by the following principles from the Regional Governance Group.</p> <div style="text-align: center;">  </div> <p>All services have a Triple Aim which must be considered simultaneously.</p> <p>The Regional Governance Group has agreed to this planning framework and principles as a foundation for regional planning, and to support key decisions and proposals for changes to service delivery.</p>
Objectives	Provide a regular forum that promotes discussion and development of collective strategic and operational priority

actions, and best practice service design of services for older people (+ 65 years), inclusive of mental health services for older people

Strategic Development and Planning

The deliverables for Year one have been finalised in the NRHP. Once established, the HOP Clinical Network is expected to develop the next stage of Strategic Plan for the Northern Region i.e. years two +, including specific, measureable outcomes by determining:

- Where improvements in patient outcomes are indicated, and prioritise initiatives to achieve these improvements, based on evidenced based leading practice.
- The appropriate services and structures required.
- The workforce to provide sustainable services by planning and overseeing implementation of regional workforce development initiatives.
- The priorities for further initiatives for older people
- Determining value for money for current and planned initiatives
- Appropriate access to prioritised services
- Incorporate advice for specific Māori, Pacific and consumer health issues into planning.
- Quality and service level match with affordability.
- Areas where joint procurement across multiple organisations may result in cost-savings.
- Joint asset management planning to ensure sustainability and cost effectiveness of service delivery.

Performance: Monitoring and Support

The HOP Clinical Network is also expected to:

- Oversee implementation of HOP Plan
- Monitor progress against HOP Implementation Plan
- Work with the NDSA Team to bridge information gaps by ensuring an Outcomes Based Framework is in place with appropriate processes to enable quality reporting

Reporting

The HOP Clinical Network will provide:

- A regular report to the Northern Region Health Plan Steering Group
- A quarterly update and submit an annual report to the Regional Chief Executive / Chief Medical Officer Group. (CEO/CMO Group)

Risk Management

- Identify potential risks and recommend mitigations to Northern Region Health Plan Steering Group

Clinical practice

- Provide guidance as to standards, best practice, new practice, reduction in variation.
- Develop quality improvement cycles through a standardised pathway of care
- Ensure the long term clinical sustainability of services.
- Direct the development and implementation of common, evidence-based, clinical policy standards and protocols.
- Advise on clinical practice audits and reviews to promote the use and application of best practice.
- Establish collaborative research projects across the continuum to improve clinical practice.
- Collaborate with the academic sector, vocational education sector, and with other relevant organisations (as appropriate).
- Collaborate with the Aged Residential Care (ARC) sector, Home Based Support Services (HBSS) sector, and with other relevant organisations (as appropriate).
- Identify potential areas where there are core groups of clinicians working in multidisciplinary teams to establish hubs of clinical excellence, research and innovation.

Collaboration

- Provide peer support, access to information and a learning group for those actively involved in Health of Older People planning and funding.
- Actively collaborate with other Networks across the Region to deliver outcomes, for example, First, Do No Harm to improve patient safety, The Informed Patient to implement Advance Care Planning.
- Convene regional forums on sector specific topics as

Objectives, cont.	<p>needed.</p> <ul style="list-style-type: none"> • Co-ordinate, contribute to and manage the interface with national or regional developments and projects. • Develop an effective relationship with the Aged Residential Care Sector, Home Based Support Sector and other appropriate agencies. • Develop an effective relationship with the Ministry of Health.
Accountability	<p>The HOP Clinical Network is accountable to the Regional CEO/CMO Group, through the Northern Region Health Plan Steering Group.</p> <p>In addition each member is accountable to their Board and management and shall inform their own organisation of the activities of the HOP Clinical Network that may be significant for their DHB.</p>
Clinical Leader	<ul style="list-style-type: none"> • The Clinical Leader will Chair the HOP Clinical Network. • The Clinical Leader will be interviewed and appointed by the Regional Clinical Leaders' Group including primary care. • The permanent position will be appointed for a fixed term of two years with renewal dependent on performance (determined by Regional CEO/CMO Group).
Membership	<ul style="list-style-type: none"> • The Network will have representation from all four DHBs, Aged Residential Care sector, Home Based Support Sector, community and primary care partners to ensure a mix of clinical (community services, primary and secondary care backgrounds e.g. nursing, medical and allied health), operational, management and funding e.g. planning & funding and general manager representation. • Members will be nominated by the Clinical Leader in consultation with existing fora/groups and endorsed by the Northern Region Health Plan Steering Group. • It is each member's responsibility to canvas views and provide feedback to their constituency as appropriate and as directed by the HOP Clinical Network. • Existing members will be reviewed annually, coinciding with year end NRHP monitoring and reporting, and development of deliverables for the forthcoming year. Renewal will be dependent on performance (determined by the Clinical Leader and endorsed by the Regional Clinical Leaders' Group).

	<p>Conduct and working ethos</p> <p>The following attributes are expected for members of the HOP Clinical Network</p> <ul style="list-style-type: none"> • Members are appointed for their personal skills and knowledge and are required to exercise these for the benefit of the HOP Clinical Network as a whole. • Appointment to the HOP Clinical Network assumes a position of trust and members are expected to act ethically and in the best interest of the Network at all times. Members will conduct themselves in a manner which promotes confidence in the integrity of the work being undertaken in the Network. • Members will comply with the decisions of the Network and will not participate in dissent outside of the Network meetings. • All network members will be expected to work collaboratively, and will be required to canvas views and provide feedback to their constituency as appropriate. • The chairperson reserves the right to review the membership of any member who acts contrary to the above. <p>The HOP Clinical Network will adhere to the following;</p> <ul style="list-style-type: none"> • Feedback and/or review of documentation responses are to be provided within requested timeframes. • Some discussion and decisions made by the HOP Clinical Network may need to be kept confidential. When this arises the Chair will ensure the confidential aspects are made explicit. • If a declaration of conflict of interest is required (competing professional or personal interest such as services that can only be provided by a member), the member will, on advice of the Clinical Leader either refrain from voting/participation in consensus decision making or absent themselves from the room at that point. • Work groups may also be established that include other stakeholders and expert advice. Work groups will report back to the HOP Clinical Network and will be dissolved once their fundamental task is completed.
<p>Operating procedures</p>	<p>Meeting frequency</p> <ul style="list-style-type: none"> • Meetings will be held approximately every six to seven

	<p>weeks except over December and January.</p> <ul style="list-style-type: none"> • A video conferencing link will be available for all meetings. • Agenda and papers will be circulated at least four days before the next meeting. Items for the agenda must be with the Clinical Leader at least five days before the next meeting. • Meeting minutes will be approved by the Clinical Leader and circulated to members. <p>Quorum</p> <p>A quorum will be eight members or more and to include;</p> <ul style="list-style-type: none"> • Preferably one representative from each DHB. • One secondary care clinician. • One primary care clinician. <p>The Clinical Leader reserves the right to consult further on any issues that may have been considered with the absence of specific HOP Clinical Network members.</p> <p>Decision-making</p> <p>Decisions for ratification by the Northern Region Health Plan Steering Group will be made by consensus. If it is not possible then areas of disagreement will be identified by the Clinical Leader and escalated to the Northern Region Health Plan Steering Group and if necessary, to the Regional CEO/CMO Group.</p>
<p>Support for the network</p>	<ul style="list-style-type: none"> • The HOP Clinical Network, through or at the direction of the Clinical Leader, is able to seek further advice as required. • Project management and business analyst resource will be sourced by the DHBs or NDSA as required. • Secretariat support will be provided by NDSA.
<p>Linkages</p>	<p>HOP specific linkages</p> <ul style="list-style-type: none"> • The Clinical Leader or his/her delegate will represent the Northern Region at National Forums. • The Clinical Leader will correspond and work with the other Regional Networks and international Networks as required. •

	<p>Other linkages</p> <ul style="list-style-type: none">• Other regional clinical networks and services• GAIHN Alliance and relevant workstreams• Alliance Health +• National Hauora Coalition• Northland PHOs• Aged Residential Care Sector• Home Based Support Sector• Unions <p>The Network will develop other linkages as appropriate.</p>
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**8.4 IMPLEMENTATION OF INTERRAI LONG TERM CARE FACILITY
(ILTCF) ASSESSMENT IN RESIDENTIAL CARE**

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

HEALTH OF OLDER PEOPLE, DISABILITY AND CHILD REHABILITATION ACTIVITIES FOR AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS

Date	Wednesday 21 September 2011
To	Auckland and Waitemata DHB - DiSAC Committee
From	Health Of Older People
Author	Bryan Agnew : Programme Manager HoP WDHB
Functional Group	Auckland DHB & Waitemata DHB Funding and Planning Managers
Subject	Implementation of interRAI Long Term Care Facility (iLTCF) Assessment in Residential Care
1	<p>Purpose</p> <p>The purpose of this report is to provide an update to DiSAC on the implementation of iLTCF into Aged Related Residential Care Facilities.</p>
2	<p>Recommendations</p> <p>That the report be received by the DiSAC.</p>
3	<p>Background</p> <p>The Minister of Health recently announced that new technology will be rolled out across Aged Related Residential Care (ARRC) facilities, over the next 4 years, to support regular, uniform, and comprehensive clinical assessment of all residents.</p> <p>This is the implementation of interRAI Long Term Care Facility (iLTCF) Assessment. It is proposed that this be a nationally managed implementation, with the 20 DHBs funding the implementation costs over the next 4 years. The total cost of the implementation is expected to be \$10.8m.</p> <p>The implementation of interRAI iLTCF into residential facilities will address two current critical issues in the residential sector:</p>

- Delivering high quality care to individual residents, and
- Developing systems for measuring, monitoring and improving quality of care across the whole sector over time

The interRAI Long Term Care Facility (iLTCF) is proposed as the tool of choice. It is comprised of:

- A detailed assessment of all aspects of functional, physical and psychological domains;
- Validated scales and indices that can be used to evaluate an individual's current clinical status e.g. Activities of Daily Living (ADLs) Hierarchy, Cognitive Performance Scale, Depression Rating Scale.
- Algorithms for clinical decision support and for comprehensive care planning;
- Standardised, validated quality indicators that provide a basis for benchmarking care across time and between settings.
- A case-mix system that can be used for reimbursement and policy and planning purposes.

International studies and trials of the tool within New Zealand confirm that the following benefits can be realised with a software based implementation of the iLTCF:

- At a clinical level - to access a status report about the client immediately upon or before entry, to access a list of risk issues for the clients, to be able to compare assessments of individual residents and to view progress and issues consistently across time. This process improves care planning and facilitates care plan updates.
- At a management level – to base staffing decisions on resident care requirements.
- At a facility level - to review Quality Indicators for a facility or a company e.g. number of falls; to review aggregated risk issues for clients and early responses to avoid unnecessary admissions to ED, for example; to review changing levels of complexity of clients over time.
- At a DHB level - to provide consistent case mix assessment for level of care determination to identify facilities that require proactive support; to identify systemic issues to prompt future planning such as numbers of clients with early dementia, or to identify issues that may require district resource such as incidence of pressure ulcers.
- At a national level - the aged care sector can use the Quality Indicators (QIs) for bench marking or other aggregated data for planning purposes. Establishing a repository of anonymous data will also facilitate local research.
- At an international level - using a well researched and comprehensive

	assessment tool will give extra validity to future NZ research and allow comparison with international quality outcome data.						
4	<p>Options Considered</p> <p>The business case which has been endorsed by the 20 DHB CEOs highlighted that other alternative options in improving quality of care in aged residential care were piecemeal and fragmented, and offered limited return for effort.</p>						
5	<p>Issues and Risks for Chosen Option</p> <p>Both Waitemata DHB and Auckland DHB have highlighted some risks with the implementation of interRAI iLTCF, and these have been raised with DHBNZ and the Implementation Project Manager. These identified risks and issues include:</p> <p>For many DHB this would now be an unbudgeted cost that needs to be priced</p> <ul style="list-style-type: none"> • InterRAI (iLTCF) benefits all parties within the older people sector, including at a National level, but there is no MoH investment being provided for the InterRAI (iLTCF) implementation, nor any rationale why they should not be party to this implementation. • It is noted that after 4 years it is expected that ongoing costs will be picked up by the providers. While the paper suggests this will be offset by efficiency gains DHBs would anticipate that it will be difficult to determine who receives these gains and as such the providers will want InterRAI recognised in the pricing for their services. • The extra Registered Nurse staff resources required within the ARRC facility to ensure that interRAI iLTCF is being undertaken correctly. This would be an extra cost to ARRC facilities, and may not be sustainable for some ARRC providers. 						
6	<p>Budget Implications</p> <p>The total implementation cost is approximately \$11m nationally. The 20 DHBs will fund the implementation over a 4 year period. The approximate cost (based on a PBF) for both ADHB and Waitemata DHB is:</p> <table border="1" data-bbox="293 1532 756 1722"> <tr> <td data-bbox="293 1532 517 1597">ADHB</td> <td data-bbox="517 1532 756 1597">\$0.9m</td> </tr> <tr> <td data-bbox="293 1597 517 1662">WDHB</td> <td data-bbox="517 1597 756 1662">\$1.2m</td> </tr> <tr> <td data-bbox="293 1662 517 1722"></td> <td data-bbox="517 1662 756 1722">\$2.2m</td> </tr> </table>	ADHB	\$0.9m	WDHB	\$1.2m		\$2.2m
ADHB	\$0.9m						
WDHB	\$1.2m						
	\$2.2m						
7	Appendix 1 – What is interRAI iLTCF						

APPENDIX ONE – WHAT IS interRAI iLTCF ?

The interRAI collaboration

interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

A suite of assessment instruments make up the interRAI family of tools and applications, each having been developed for a particular population. They are designed to work together to form an integrated health information system. The interRAI instruments all share a common language; that is, they refer to the same clinical concept in the same way across instruments. Data from this suite of tools forms an integrated health information system that supports a continuum of care, linking home and community based care, long term care, acute care and mental health services. All staff can be trained with the same set of tools, improving data integrity and enabling service information to be shared readily between services. The consistency of information promotes integration of services and allows health professionals and planners to monitor and case manage the flow of specific types of patients through the entire health care system.

The RAI has had extensive development and testing for validity and reliability, including review by hundreds of geriatricians, nurses, clinicians, and other practitioners. The authors of the instruments provide definitions and training materials. Many commercial vendors supply computer software that supports the RAI. Because the Minimum Data Set (MDS) is used in every nursing home in the United States, there is considerable experience with the use of aggregate data for various purposes. InterRAI has also devised parallel assessment systems for home care, post-acute care, palliative care, assisted living, acute care, and mental health. InterRAI works to balance the goals of making these systems specific to their applications yet compatible, so that individuals can be compared across types of care.

iLTCF

The interRAI Long Term Care Facility (iLTCF) is a comprehensive, standardized instrument specifically designed for evaluating the needs, strengths, and preferences of those in chronic care and nursing home institutional settings. The iLTCF consists of an assessment form, item-by-item instructions, outcome scales for decision support and a series of care planning protocols. The assessment form enables a health care provider to assess key domains of function, mental and physical health, social support, and service use.

Domains of assessment

The assessment tool provides resident assessment data across sixteen elder care domains.

Table 3.1 InterRAI MDS-LTCF domains

• Identification information	• Health condition
• Intake and initial history	• Oral and nutrition status
• Cognition	• Skin condition
• Communication and vision	• Activity pursuit
• Mood and behaviour	• Medications
• Psychosocial well-being	• Treatment and procedures
• Functional status	• Responsibility and directives
• Continence	• Discharge potential
• Disease diagnoses	• Discharge and sign off

Clinical Assessment Protocols

The assessment data is fed into an information system that uses algorithms to identify areas of concern, known as Clinical Assessment Protocols or ‘CAPs’. A new set of CAPs was released in 2008 for use with both community and long term care assessments.

Table 3.2 Clinical Assessment Protocols (CAPs)

Functional performance	Physical activities promotion Instrumental activities of daily living Activities of daily living Home environment optimisation Institutional risk Physical restraints
Cognition/mental health	Cognitive Loss Delirium Communication Mood Behaviour Abusive Relationships
Social life	Activities Informal Support Social Relationships
Clinical issues	Falls Pain Pressure Ulcer Cardiorespiratory Conditions Under-nutrition Dehydration Feeding Tube Prevention Appropriate Medications Tobacco and Alcohol Use Urinary Incontinence Bowel Conditions

CAPs are designed to assist the assessor to interpret systematically all the information recorded on an instrument. They are not intended to automate care planning; rather, they help the clinician focus on key issues identified during the assessment process, so that decisions as to whether and how to intervene can be explored with the individual. Each Clinical Assessment Protocol has been developed by a group of experts and validated through clinical focus groups and on-going research.

Functional sub-scales

The following Functional sub scales can also be calculated from the iLTCF assessment information:

Table 3.3 Functional sub-scales

Activities of Daily Living Hierarchy	Groups activities of daily living according to the stage of the disablement process in which they occur. Early loss ADL's such as showering are assigned lower scores than late loss ADL's such as eating.
RUG-III Activities of Daily Living Index	A summary measure of ADL that combines scores for bed mobility, toileting, transferring and eating.
CHESS Scale	The Changes in Health, End-stage disease and Signs and Symptoms scale identifies individuals at serious risk of decline. In the residential care population higher CHESS scores are predictive of adverse outcomes such as mortality, hospitalisation, and pain.
Cognitive Performance Scale	Combines information on memory impairment, level of consciousness and executive function to provide a measure of overall cognitive function. The CPS has been found to correlate with the Mini Mental Status Exam (Morris et al 1994).
Depression Rating Scale	The DRS has been found to adequately detect depression (Martin, et al, 2008).
IADL Involvement Scale	The IADL scale measure the degree of difficulty an individual has in performing instrumental activities such as managing finances, medications, phone use and transportation.
Index of Social Engagement	Describes the individual's sense of initiative and involvement in social activities. The scale was validated in a nursing home population by comparing its scores with actual time spent in activity programmes.
Pain Scale	Using a score from 0-3 this scale is highly predictive of pain in nursing home residents (Fries, et al., 2001, Wu, et al. 2005).

Resource Utilisation Groups

The interRAI-MDS has been further developed to provide a case mix classification system for reimbursement. The iLTCF is used to classify residents into Resource Utilisation Groups (RUGs). These RUGs were determined by investigation into the resources required to care for individuals in each group. The case mix is based on functional ability as determined by the iLTCF and the amount of caregiver in-pat needed. This case mix classification system has subsequently been used for care planning, bench marking for best practice and measuring quality, along with resource allocation.

Table 3.4 Factors that determine Resource Utilization Groups in the RUGS III Case Mix classification system.

<p>Resources paid for include:</p> <ul style="list-style-type: none"> • Time <ul style="list-style-type: none"> – Nursing (RN, LPN [Licensed Practical Nurse], aide) – Rehab (OT, PT, SLP [speech language pathologist], assistant, aide) • Non-rehab ancillaries <ul style="list-style-type: none"> – Medical supplies – Medications – Lab – Respiratory therapy – Radiology • General Services <ul style="list-style-type: none"> – Building and grounds maintenance – Dietary – Laundry – Activities • Capital <ul style="list-style-type: none"> – Buildings – Equipment 	<p>Utilisation is how much resource is used to care for residents. This was determined by the following measures:</p> <ul style="list-style-type: none"> • Time: Staff Time Measurement studies <ul style="list-style-type: none"> • direct time staff spent with residents • time spent on behalf of residents • other time associated with the operation of the nursing facility. • Cost reports of labour and services. • Claims for non-rehab ancillary costs.
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Quality Indicators

One of the original intended uses of the Minimum Data Set (MDS) in the U.S. was monitoring of nursing home quality of care and quality indicators are currently used for many different purposes e.g., by care providers for improving care, by governments to monitor care, and for public reporting. Nursing home outcomes-based Quality Indicators (QIs) are defined in terms of clinical characteristics collected by the iLTCF. Quality Indicators use MDS elements to establish a measure that can be translated into a statistical summary. While QIs are defined in terms of individual characteristics, they only take on meaning when expressed as averages at the facility or agency level. QIs are defined at the individual level and aggregated to the facility or agency level to produce summary measures reflecting presumed quality of care. Each QI has an explicit definition and inclusion/exclusion criteria.

Research has evaluated the reliability of the data on which these indicators are based and assessed the validity of the indicators themselves. There is strong evidence that the quality indicators do capture meaningful aspects of nursing home performance (Morris et al 2003).

Nursing facility quality is multidimensional, encompassing clinical, functional, psychosocial and other aspects of resident health and well being. No single QI is likely to capture overall facility quality. Facilities may perform extremely well on one type of QI, but may not perform nearly as well on another. It is therefore important to present different indicators across multiple domains for a full view of facility quality performance. (Morris et al, 2003).

There is a significant and obvious advantage of iLTCF based quality indicators. They are derived directly from the assessment instrument, so they can be calculated without the need for additional data collection. With no additional effort on the part of the assessor or the client information for the whole quality system is collected.

Quality indicators have been shown to influence the performance of care providers in improving quality of care; of governments in monitoring care; and of the sector in reporting to the public. In the U.S. in 1999, the interRAI-MDS was used as a quality indicator in the government survey and audit processes (Mor, 2003; Mor, et al., 2005). An extension of this quality initiative is a web-based consumer information system that compares outcome data for all facilities nationally. The 'OSCAR' (Online Survey, Certification and Reporting) database is freely available to the public. Additionally, the *Nursing Home Quality Initiative* began in 2002 and utilizes interRAI-MDS data for ongoing clinical research and policy development (Brown, 2001; Zhang, et al., 2009; Poss, et al., 2008).

Table 3.5 Quality Indicators

1a.	Prevalence of any injury
1b.	Incidence of new fractures
2.	Prevalence of falls
3.	Prevalence of behavioural symptoms affecting others
3H.	Prevalence of behavioural symptoms affecting others - High Risk
3L.	Prevalence of behavioural symptoms affecting others - Low Risk
4.	Prevalence of symptoms of depression
5.	Prevalence of symptoms of depression without antidepressant therapy
6.	Use of 9 or more different medications
7.	Incidence of cognitive impairment
8.	Prevalence of Bladder or Bowel Incontinence
8H.	Prevalence of Bladder or Bowel Incontinence - High Risk
8L.	Prevalence of Bladder or Bowel Incontinence - Low Risk
9.	Prevalence of occasional or frequent Bladder or Bowel Incontinence without a Toileting Plan
10.	Prevalence of Indwelling Catheters
10H.	Prevalence of Indwelling Catheters - High Risk
10L.	Prevalence of Indwelling Catheters - Low Risk
11.	Prevalence of Faecal Impaction
12.	Prevalence of urinary tract infections
14.	Prevalence of weight loss

15. Prevalence of tube feeding
16. Prevalence of dehydration
17. Prevalence of bedfast residents
18. Incidence of decline in late loss ADLs
- 18H. Incidence of decline in late loss ADLs - High Risk
- 18L. Incidence of decline in late loss ADLs - Low Risk
19. Incidence of decline in ROM
- 19H. Incidence of decline in ROM - High Risk
- 19L. Incidence of decline in ROM - Low Risk
20. Prevalence of limited range of motion without training/skill practice
21. Prevalence of antipsychotic use, in the absence of psychotic and related conditions
- 21H. Prevalence of antipsychotic use, in the absence of psychotic and related conditions - High Risk
- 21L. Prevalence of antipsychotic use, in the absence of psychotic and related conditions - Low Risk
23. Prevalence of antianxiety/hypnotic use
24. Prevalence of hypnotic use more than two times in last week
26. Prevalence of daily physical restraints
27. Prevalence of little or no activity
29. Prevalence of Stage 1-4 pressure ulcers
- 29H. Prevalence of Stage 1-4 pressure ulcers - High Risk
- 29L. Prevalence of Stage 1-4 pressure ulcers - Low Risk
30. Incidence of new pressure ulcers

8.5 CHILD REHABILITATION SERVICE

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committee
From	Linda Harun, General Manager - Child, Women and Family Service Phone: 6266/4609 Email: Linda.harun@waitematadhb.govt.nz
Authors	Linda Harun, GM, Child, Women & Family Services, Waitemata DHB Stephanie Doe, Operations Manager, Child Health, Waitemata DHB Danah Cadman, Service Manager, Surgical Services Starship Children's Health Dr. Tim Jelleyman, Head of Division Medicine, Child Women & Family Services
Functional Group	Child Women and Family Services, WDHB
Subject	Child Rehabilitation Service: Management of bed day usage for out of area patients

1 Purpose

The Child Rehabilitation Service (CRS) has exceeded its capped contract volumes for children domiciled outside of the Auckland metropolitan area for each of the last 6-years. The MoH approved additional funding in the 2010-11 financial year to meet some of the over delivery. However, there has been no increase in the capped volumes or additional funding for 2011-12.

Refusing service, once contracted bed days have been reached, would result in markedly poorer outcomes for children referred and likely additional costs to the health system in the long term.

Possible funding options are presented. The preferred option seeks funding from DHB of domicile when capped volumes are exceeded. While this disadvantages DHBs who require service in the later part of the financial year, it

	is more attractive than the provision of expensive secondary inpatient services either locally or at Starship Hospital.
2	<p>Recommendations</p> <p>That the Committee endorse the recommendation that Waitemata DHB invoice the Out of Area DHB of Domicile at the National rate for Children's rehabilitation Service for bed days above contract volumes (option C).</p>
3	<p>Description of Solution (Option)</p> <p>Endorse DHB's of domicile paying the national rate for Child Rehabilitation Service bed days if contract volumes are exceeded. This solution poses the least risks to the DHB and minimizes risk to children's health outcomes. Whilst it poses an increase in bureaucracy in terms of contract negotiation with individual DHBs, there is an agreed national price for the service and the process is transparent. This option was used successfully in 2009/10 but due to additional funded volumes was not used in 2010/11 year.</p>
4	<p>Background</p> <p>CRS is a national, specialist paediatric rehabilitation service that provides comprehensive and intensive rehabilitation for children aged 0-16 years or for older children who are still at school. The Service provides intensive post acute rehabilitation following acquired brain injury and complex orthopaedic interventions. This includes assessment of functional abilities and interventions to maximise a child's potential to ensure a successful return to community living and school.</p> <p>Waitemata DHB holds a capped contract with the MoH for 500 bed days per annum for children requiring rehabilitation who are domiciled outside the Auckland region¹. In 2010-11 the Ministry of Health funded an additional 250 out of area bed days and Waitemata DHB applied to MOH to have the cap increased. The MOH have advised that due to funding constraints this additional funding may not be available in 2011-12 or future years.</p>
5	<p>Options Considered</p> <p>A. Continue to provide paediatric rehabilitation services for Out of Area children in excess of contracted volumes</p> <p><u>Benefits:</u></p> <ul style="list-style-type: none"> ▪ Children receive appropriate and timely rehabilitation and good health outcomes are achieved. ▪ Bed blockage is minimised at Starship and acute capacity is maintained <p><u>Risks:</u></p> <ul style="list-style-type: none"> ▪ Activity is delivered that is not paid for

¹ Outside the Auckland region refers to children from all DHB's except Counties Manukau, Auckland and Waitemata

- May impact on the amount of other fee for service work the service is able to carry out (e.g., ACC referrals may not be able to be accepted if the service is busy with out of area patients).

B. Do not accept children into service once the MoH out of area bed day cap is exceeded

Benefits:

- Waitemata DHB provides the care it is paid to deliver

Risks:

- If children require care early in the financial year, they are likely to receive care under contract; if children require care later in the financial year, they may not
- Children may not receive any rehabilitation (or inappropriate or delayed rehabilitation due to lack of resources) - may be detrimental in the short or long term and end up costing the health system more.
- Children may remain in Starship for longer periods following their acute episode - this creates bed block and reduced capacity for acute care, which may lead to delays in accessing surgery. May be detrimental to the child and in the short or long term and end up costing the health system more
- Surgery may be delayed if rehabilitation is unavailable. This impacts both the child being able to access services at a clinically appropriate time as well as have a negative impact on the Elective Service Performance Indicator (ESPI) for the Orthopaedic Service
- May affect reputation of Waitemata DHB and the CRS

C. DHB of domicile pays for any period of inactive rehab and/or convalescence

Benefits:

- Children receive appropriate and timely rehabilitation and good health outcomes are achieved

Risks:

- DHB refuses to pay
- Convalescence period often requires (or is improved by) specialist rehabilitation input
- Length of the convalescing period is unknown - costs unknown for DHB of domicile ahead of episode.
- Increased bureaucracy, as each child convalescing will require a separate contract.
- Disadvantages DHBs farther away where returning home is not an

	<p>option.</p> <ul style="list-style-type: none"> ▪ There is no agreed national price for this type of service. ▪ May affect reputation of Waitemata DHB and the CRS
6	<p>Issues and Risks for Chosen Option</p> <ul style="list-style-type: none"> ▪ Lottery approach for DHBs, as if children require care early in the financial year, they are likely to receive care under contract; if children require care later in the financial year, they may miss out ▪ DHB refuses to pay - child does not receive required (or appropriate) rehabilitation. This may be detrimental to them in the short or long term and end up costing the health system more. ▪ Children may remain in Starship for longer periods following their acute episode - this creates bed block and reduced capacity for acute care, which may lead to delays in accessing surgery. This may be detrimental to the child and in the short or long term and end up costing the health system more ▪ Increased bureaucracy, as each child over the contract volume will require a separate contract. ▪ May affect reputation of Waitemata DHB and the Child Rehabilitation Service.
7	<p>Budget Implications</p> <p>Child Women and Family Services has included anticipated additional revenue from MOH of \$130,000 within budget and savings plan based on indications from MOH following a proposal document submitted to MOH in March 2011. Following the Christchurch earthquake MOH indicated the funding was unlikely to be available.</p> <p>Demand in 2011/12 is anticipated to be at least 250 bed days over contract leaving a \$130,000 shortfall in revenue.</p>
8	<p>Regional / National Implications</p> <p>If CRS deliver only contracted volumes then children may remain in Starship for longer periods following their acute episode - this creates bed block and reduced capacity for acute care, which may lead to delays in accessing surgery. May also have a negative impact on the ESPI for the Starship Orthopaedic Service</p>
9	<p>Appendices available on request</p> <p>Submission to MOH for additional funding for Out of Area Rehabilitation volumes (March 2011).</p>

The Child Rehabilitation Service – Background Information

1 Background

Rehabilitation for children has been provided from the Wilson Centre on the North Shore in Auckland for some decades but the current service model was established in July 1997. The Child Rehabilitation Service (CRS) is a national, specialist paediatric rehabilitation service that provides comprehensive and intensive rehabilitation for children aged 0-16 years or for older children who are still at school.

The CRS provides intensive post acute rehabilitation following acquired brain injury and complex orthopaedic interventions. This includes assessment of functional abilities and interventions to maximise a child's potential to ensure a successful return to community living and school.

2 What does the Child Rehabilitation Service provide?

The CRS provides rehabilitation by a skilled interdisciplinary team based on rehabilitation goals that are functionally based, regularly reviewed, client focused and have effective outcomes. It includes the following:

- Two Specialist Rehabilitation Paediatricians
- A Specialist Allied Health team
- A Paediatric Neuropsychologist
- A Specialist nursing team. The current nursing team is continually developing advanced practice skills to effectively manage children with increasingly complex technology requirements
- Specialist orthopaedic and neurological services in collaboration with Starship Children's Health
- An Orthotics clinic on-site
- Technology enablers such as a Gait Laboratory (contract with Auckland University of Technology)
- Schooling on-site provided by Northern Hospital Schools
- Education and research base and collaborations with Universities (part of Waitemata DHB's 'Centre of Excellence' plan for the Wilson Centre)
- Surveillance programmes and registers- the Cerebral Palsy Register is under development and related hip surveillance will be possible once this is complete
- Outcome Measures Framework based on the Paediatric Evaluation of Disability Inventory (PEDI) and Functional Independence Measure (FIM). Work is occurring with Australian Rehabilitation Outcomes Centre (AROC) on the development of the paediatric rehabilitation outcome measures. This will allow benchmarking across Australasia

- An environment that is conducive to healing and increased family resilience. The Wilson Centre is situated on the Wilson Home Trust site in Auckland. The site is frequently identified by families as a key factor in the recovery process. CRS is set in the grounds of the old Wilson family homestead overlooking the Hauraki Gulf and Rangitoto Island. Families describe the environment as restorative.

3 Children who require tertiary level rehabilitation services

The following groups of children require tertiary level rehabilitation services:

3.1 Traumatic and acquired brain injury and other traumatic injuries, for example:

- Motor vehicle accidents
- Near drowning
- Meningitis/encephalitis
- Guillain-Barre syndrome
- Stroke
- Non-accidental injuries
- Transverse myelitis
- Post-treatment effects of cancer
- Spinal cord injury
- Limb amputations

3.2 Other types of congenital or acquired deficiency leading to significant loss of function +/- neurological deficit, for example:

- Rare syndromes and congenital defects
- Spina bifida and other spinal conditions
- Chronic fatigue and pain syndromes

3.3 Neuromuscular conditions including cerebral palsy.

4 Drivers for Change

The development of the Child Rehabilitation Service is being guided by the following factors:

- Increased population growth in New Zealand
- Maximising the primary relationship between the child and their family with their local providers with intermittent support from a specialist unit
- Providing new ways of delivering services that are effective, efficient and based on evidence-based best practice

- Specialised technologies that require critical mass for safe and effective outcomes to be achieved
- A cost effective and sustainable model for a small number of complex cases per annum, achieved by a network of services, and a complete package of care
- A centrally managed Cerebral Palsy database and hip surveillance, which is essential in predicting and planning surgical services and gait analysis. This achieves long term economic benefits for both individuals and communities
- The identified need from communities for the development of outreach services e.g. Paediatric Rehabilitation Orthopaedic Combined Service support in Whangarei is currently being investigated. Spasticity management programmes e.g. Botulinum toxin 'A', acquired brain injury, spinal care, casting and splinting are all areas that have been identified to explore as future tertiary outreach services
- Advances in communication technology such as videoconferencing (Telepaeds), enhancing communication with local and international communities.

5 **Contracts and Volumes**

The Child Rehabilitation Services holds a number of contracts with MOH and Accident Compensation Corporation (ACC). The MOH Bed Day 'In Area' contract covers Auckland, Counties Manukau and Waitemata DHBs, and the Bed Day 'Out of Area' contract covers the remainder of New Zealand. Waitemata DHB also holds a number of other contracts with ACC, such as Active Rehabilitation, Training for Independence Services, Non Acute Rehabilitation, Social Rehabilitation, Serious Injury Support Needs Assessment and Education Based Rehabilitation Assessment.

Contract volumes are as follows:

	Volume
MOH 'In Area' Bed Days	1332
MOH 'Out of Area' Bed Days	500
ACC Bed Days	Nil – fee for service

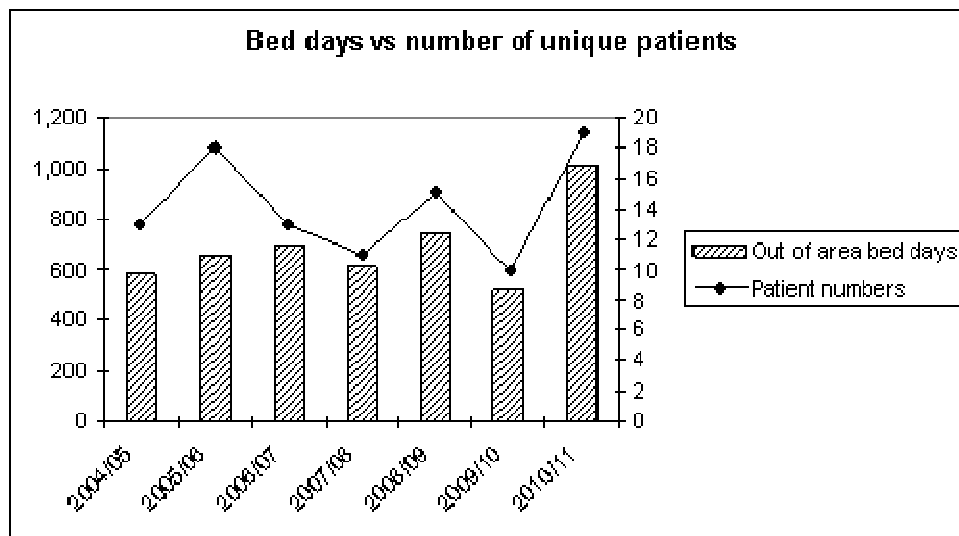
Actual bed day volumes delivered by CRS are as follows:

	2004/ 05	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	2010/ 11
MOH 'In Area' Bed Days	1,715	1,529	1,316	1,045	1,729	842	1,452
MOH 'Out of Area' Bed Days	582	658	701	613	748	521 ²	1,011
ACC Bed Days	701	785	1,076	767	1,071	1,179	569

² Number does not include 135 un-contracted bed days financed by other DHBs in 2009/10.

For the past seven years, the contract cap for MOH out of area bed days has been exceeded. Waitemata DHB has received ad hoc funding from MOH or other DHBs to cover some of the additional activity. In 2010-11, WDHB received MOH funding for an additional 250 bed days. However, this still left a shortage of 261 bed days and the MOH have advised Waitemata DHB that this additional funding may not be available in 2011-12 or future years.

Bed day volumes are generally matched by an increase in the number of children accessing the service, suggesting that bed day volumes are linked to more children accessing the service rather than an increase in complexity or length of stay.



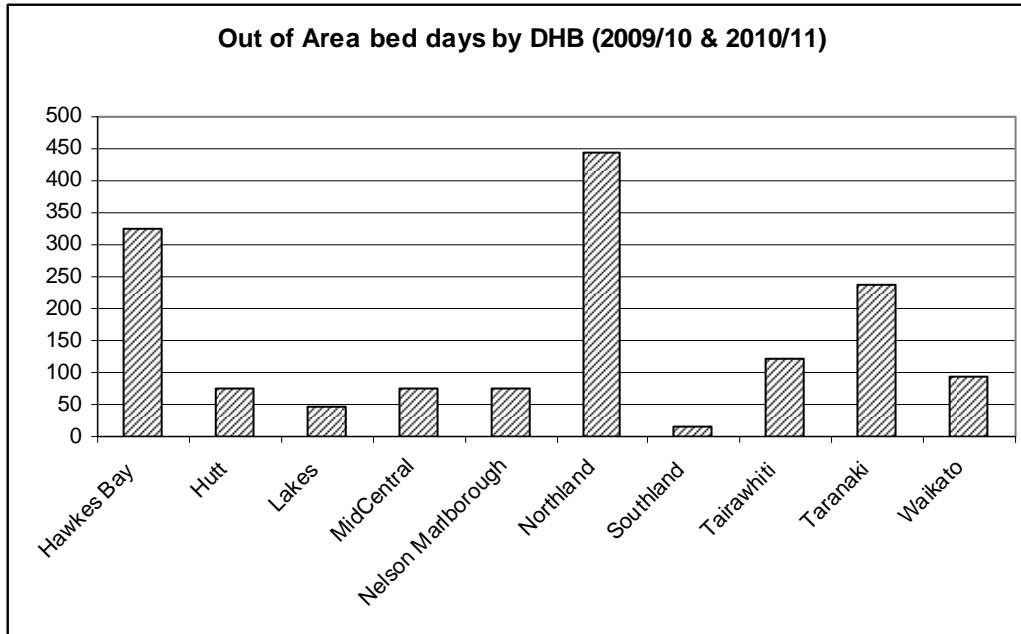
Case mix

Approximately 50% of children accessing the service are orthopaedic children requiring rehabilitation services after complex hip surgery and/or multi-level surgery. The remaining 50% of children fall under the neurological banner and are often previously well children who have succumbed to a severe neurological illness that requires rehabilitation. This volume is more unpredictable than orthopaedic volumes in its occurrence.

6 Other New Zealand-based Paediatric Rehabilitation Options

Whilst there are no other specialist tertiary paediatric rehabilitation services of this type in New Zealand, there is not an even spread of children accessing the service from across the country. Some children are potentially able to be managed locally by their community service, although this depends on complexity of the child's condition and the availability of local resources. The number of children who would benefit from the Waitemata DHB CRS but undergo local rehabilitation is unknown.

The graph below shows a breakdown of activity by DHB for the past two years.



7 Effectively Managing Bed Days

Approximately 50% of service volume is a result of planned surgical intervention and this activity is generally known of 1-2 months prior to the child requiring rehabilitation. However, actual bed days for this group can be difficult to estimate until a child has commenced their rehabilitation episode and the health and social factors affecting the child are known. The remaining 50% of service volume is unplanned and unable to be estimated until a child is well into their rehabilitation episode.

Ideally, children should be ready for active rehabilitation when they arrive at the Wilson Centre. If not, then children may be able to return to their 'home' DHB for a period of time to convalesce. However, being able to return home depends on a number of factors e.g., whether the child can transfer safely by ambulance (not possible if South Island-based) or if the child can be looked after appropriately at home (this depends on home environment, family supports and the type and amount of care required). Returning home is often not the most appropriate option for children and their families and could be detrimental to any upcoming rehabilitation. Currently, every effort is made to ensure that that the most appropriate option for the child is chosen when they are ready to leave Starship.

8.6 MAINSTREAM POSITIONS AT ADHB

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committee (DSAC)
From	Kelsey Price, HR Development & Project Manager Extension 23945 kelseyp@adhb.govt.nz
Author	Kelsey Price
Subject	Mainstream Positions at the Auckland District Health Board

Purpose

The purpose of this paper is to provide an update to the Disability Support Advisory Committee (DSAC) on the progress of creating up to two positions for people with disabilities under the Mainstream Programme. Additionally, this paper advises of the next steps relating to the matching of participants to the ADHB Services that have expressed interest in hosting a position.

Background

The Mainstream employment programme was set up by the Ministry of Social Development and aims to place people with disabilities in State service organisations for two-year job placements. The programme has a four-way partnership model between Mainstream, Placement Specialists (disability employment experts), people with disabilities, and employers.

The programme requires employers to create a job (outside the staffing allocation/not using an existing vacancy) and train the employee on the job. Mainstream provides a 100% salary subsidy for year one and 80% for year two and provides training funding for each year of the placement for both the participant and the participant's supervisor. Note that the initial year two subsidy was 50% however as part of recent updates to the programme this has been increased to 80%.

The ADHB's Senior Leadership Team has signed off on the implementation of the Mainstream programme at the ADHB and DSAC has endorsed this. Vivienne

Rawlings and Janice Mueller are the project sponsors.

Progress To Date

The following mediums have been or are currently being used to communicate the Mainstream concept to the DHB and request services interested in hosting a position contact the project manager. They include:

Discussion by the GM Human Resources at the Level 2 Management Integration Meeting.

A Memo from the GM Human Resources to the Level 2 management team to be cascaded through their management levels. The Memo also included an Information Sheet (see Appendix 1) and a link to a list of Frequently Asked Questions (see Appendix 2).

An introduction to the Mainstream project at the ADHB is being run throughout August in the weekly E-Nova.

The same introduction in the E-Nova was in the July hard copy Nova.

Around 40 posters have been put in lifts and on notice boards at both Greenlane and Auckland City sites (see Appendix 3 for an example).

Information relating to the Mainstream programme is on the ADHB main intranet and the HR intranet sites with additional links to the abovementioned Information Sheet and FAQs.

The Employment Specialists have previously sent through a dozen potential candidates, and one candidate has applied direct when seeing the advertisement in the hard copy Nova while waiting to attend surgery. We have asked for an updated list for the end of August.

Eight departments at the ADHB have made contact advising they are potentially interested in creating a position for a two year placement.

Next Steps

The next steps at a high level include:

- Completing the planned communications throughout August.
- Meeting with the various departments to help them document their potential position (initially just a general position purpose and bullet pointed activities).
- A team meeting in the first week of September to agree the matching process of participants to positions (including criteria).
- Conduct the matching process and identify potential barriers and modifications that might be required (such as adjustments to physical environments etc.).
- Run a recruitment process adjusted slightly for the individual participants involved.

- Select.
- Make any adjustments required.
- Induction and orientation including training for supervisors and potentially their teams.

Appendices (attached)

1. Mainstream Employment Programme Information Sheet
2. Frequently Asked Questions
3. Example Poster

Appendix 1: Mainstream Employment Programme Information Sheet

ADHB is participating in the Mainstream Employment Programme providing an introduction to employment for people with disabilities. Read on to find out more and how you can help.

What is the Mainstream Employment Programme?

People with disabilities can often have difficulty finding employment in New Zealand. The Mainstream Employment Programme has been introduced to give people with disabilities a stepping stone into independent and sustainable employment. The programme was set up by the Ministry of Social Development to help employers feel confident about giving work opportunities to people with disabilities. It provides people with disabilities and little work experience the chance to show they are an asset to the workforce.

The Mainstream Employment Programme provides training, support, and subsidies to organisations that will employ people with significant disabilities for two years.

Why is ADHB involved in the Mainstream Employment Programme?

The ADHB is committed to participating in this programme and making a positive and tangible commitment to people with disabilities. We are aiming to place two Mainstream Employment participants for a two year fixed term position. We have partnered with disability employment placement specialists to help find a match, and to provide ongoing support.

Key facts about Mainstream Employment programme

- The Mainstream Employment positions must be outside of the normal staffing allocation, so not filling an existing vacancy.
- Mainstream Employment will provide a 100% of the salary for year one and 80% of the salary for year two. Health Service Groups will need to pay for 20% of the salary for year two.
- Mainstream also provides training funding for both years of the placement for the employee and their supervisor, and the ADHB will provide on the job training for the employee.
- The role of the participants will be to do necessary but non-priority tasks, while freeing up existing staff to focus on tasks that require greater experience.
- The hours of work may initially start off quite small and increase over time.
- The participant will not be getting the position based on merit and may not be job ready; therefore, the supervisor is expected to provide training over and above the usual amount and support opportunities for the employee to skill up.
- The supervisor and participant will take part in a one day induction course.
- Mainstream Employment provides an opportunity for supervising staff to gain greater skills in coaching, mentoring and performance management.
- Mainstream at the ADHB is supported by the Senior Leadership Team and the Disability Support Advisory Committee.

To find out more visit the HR intranet and look at the [Frequently Asked Questions](#)

If you think your team or department could provide employment to someone with disabilities and you want to find out more please contact Kelsey Price from Human Resources (kelseyp@adhb.govt.nz; extension 23945).

APPENDIX 2: FREQUENTLY ASKED QUESTIONS – MAINSTREAM PROGRAMME

Question	Response
What sorts of positions are suitable for Mainstream participants?	<i>The Mainstream Employment positions must be outside of the normal staffing allocation, so not filling an existing vacancy. The type of work performed depends on ADHB's need and the participant's skill, and could include basic clerical duties to information technology, tutoring at tertiary level and customer service.</i>
How long does a mainstream position last?	<i>Placements are for two years. Research suggests that a two-year period is needed to enable the participant to become fully competent to compete on the open job market.</i>
Does the contract have to be extended once the two years is finished?	<i>No, but the Mainstream participant should be encouraged and assisted to apply for advertised positions within the organisation before the two year placement is complete</i>
What is the rate of pay for Mainstream participants?	<i>The rate of pay is expected to be the same as anyone else performing similar duties.</i>
Who pays the Mainstream participant's salary?	<i>The ADHB will pay the participant's salary, and will then invoice Mainstream for reimbursement. Mainstream will reimburse 100% of the salary for the first year, and 80% of the salary for the second year. The employing ADHB department pays 20% of the participant's salary for the second year.</i>
What is the required working hours for Mainstream participants?	<i>Working hours for employees in the Mainstream programme can be anything from a minimum of five hours per week up to full-time. Often people begin their Mainstream placement on a small number of hours and increase this over time.</i>
Are there any training requirements before a Mainstream participant can begin?	<i>There is one day induction training for the participant and their supervisor (paid for by Mainstream). The induction training is mandatory as placement success often depends on the ability of the supervisor to be a coach and a mentor.</i>
What training allowances are available for direct supervisors of mainstream participants?	<i>A training allowance of \$3,000 (including GST) is provided for the direct supervisor of Mainstream participants. Training must cover issues related to staff supervision, and/or be related to disability equity or performance management that will either enhance the participant's employment prospects or increase the supervisor's awareness of the capabilities of people with disabilities.</i>
What allowances are available for the participant to gain additional training outside of the workplace?	<i>Mainstream offers the participant up to \$4,000 (including GST) for external training over the two year placement. Training does not necessarily have to relate to the position that the participant is working in.</i>

<p>What level of on-the-job training is expected to be provided to the participants and who will pay for it?</p>	<p><i>The supervisor is expected to provide on-the-job training to the Mainstream participant. As the person is not employed as 'job ready' this may be over and above the usual amount and support opportunities for the participant to up-skill. Funding for on-the-job training is the responsibility of the ADHB.</i></p>
<p>What level of performance can be expected from new participants?</p>	<p><i>People placed into employment through the Mainstream Employment Programme are not 'job ready' in the conventional sense. It is expected that they will require some external training and some on-the-job training to perform certain duties. Knowledge and skills are expected to be built up over time, with the support and goodwill of co-workers. However, if any disciplinary issues arise they should be dealt with in line with the ADHB's HR practices.</i></p>
<p>Who will fund any adaptations necessary to the workplace?</p>	<p><i>The ADHB is expected to provide any resources that would normally be provided for employees including reasonable adjustments to accommodate their disability. Mainstream will fund up to \$16,900 (including GST) per year for each of the two years of the programme for adaptive equipment that make the participant's workplace more accessible, such as interpreter service, adaptive software and hardware, or other assistance considered reasonable by Mainstream. This funding is applied for by the ADHB to Mainstream.</i></p>
<p>How does a Mainstream Programme Participant get recruited?</p>	<p><i>Reasonably in-depth information is available on the process, however the higher level steps include:</i></p> <ul style="list-style-type: none"> ▪ <i>The employer (consisting of the employing ADHB department and the Mainstream Project Team, which has representation from a number of occupations across ADHB) creates a position for a two-year period outside the current staffing allocation.</i> ▪ <i>The employer draws up a job proposal.</i> ▪ <i>The employer contacts the disability placement specialist to discuss possible candidates.</i> ▪ <i>The employer undertakes a recruitment process and selects an appropriate participant.</i> ▪ <i>Pre-employment screening is completed.</i> ▪ <i>The employer provides the appropriate Mainstream participant with a fixed term Employment Agreement that sets out their terms and conditions of employment.</i> ▪ <i>The employer sets out a training plan.</i> ▪ <i>Any required workplace adjustments are made, including supervisor training.</i> ▪ <i>The participant begins work.</i> ▪ <i>Ongoing support is maintained.</i>

<p>How will the progress of the participant be monitored?</p>	<p><i>The Placement Specialist meets with the participant and supervisor regularly to complete placement progress reviews. Placement specialists also provide ongoing general support and assist participants and supervisors to apply for training and any workplace adjustment funding. Mainstream will phone the participant regularly to ensure that the placement is going well. They also act as an additional confidant for the participant if they are not confident discussing issues during placement progress reviews.</i></p>
<p>What will be required from me as a supervisor?</p>	<ul style="list-style-type: none"> ▪ <i>Be able to commit to be the participant's supervisor for the two-year duration of the placement to the best of your knowledge.</i> ▪ <i>Attend the initial one-day orientation/training session with the participant.</i> ▪ <i>Provide support and most of the on-the-job training that the participant requires. You will have the role of both a mentor and a supervisor of their work.</i> ▪ <i>Initiate regular catch-ups and one-on-ones with the participant.</i> ▪ <i>Actively attend on-going monitoring and placement reviews with the participant and their placement specialist.</i> ▪ <i>Help the participant with finding training opportunities if required.</i> ▪ <i>Check that Mainstream is regularly catching up with the participant as expected.</i> ▪ <i>Provide an open trusting relationship, in which you are approachable for the participant to ask for help when they need it.</i> ▪ <i>Contact HR or members of the project team if any additional support is required or if issues are arising. Keep HR informed.</i> ▪ <i>Work with HR and the placement specialists to encourage the individual to seek out a number of employment opportunities well before the placement draws to a close.</i> ▪ <i>Be passionate about the ethos behind the NZ Disability Strategy (inclusion, enhancing participation).</i>
<p>What will be required from the team of which the participant will be a part?</p>	<ul style="list-style-type: none"> ▪ <i>Create an inclusive environment, where the participant feels welcome and free to ask for help.</i> ▪ <i>Be willing to pick up extra tasks that perhaps the supervisor or the participant cannot perform, particularly in the initial phases of the programme. Be willing to offer on-the-job training as the participant needs it.</i> ▪ <i>If the participant has a physical disability that means they need particular help with specific tasks, a willingness to provide that would be helpful.</i>

Who do I contact for more information?

If you have any queries, are potentially interested in supervising a Mainstream participant, or think the department you work in/manage might like to host a Mainstream candidate then contact Human Resources:

- Kelsey Price kelseyp@adhb.govt.nz extension 23945 or
- Meng Lin MLin@adhb.govt.nz extension 23517.

ADHB getting people with disabilities into work



Could you create a two year work placement for someone with disabilities as a stepping stone into employment?

The placements must be outside of the normal staffing allocation. The posts are 100% funded by the Ministry of Social Development in the first year and 80% in the second year along with support and funding towards training (with the hiring service paying 20% of the salary costs in the second year).

To find out more contact Kelsey Price ext 23945 or kelseyp@adhb.govt.nz

**8.7 WAITEMATA DHB SPECIALISED SERVICES FOR OLDER
ADULTS (SSOA) PROJECT CHARTER**

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committee
From	Tim Wood, Funding Manager 15 Shea Tce, Takapuna AUCKLAND CITY 0740 Phone: (09) 486 8920 ext 3601 Mobile: 021 784 472 e-mail: tim.wood@waitematadhb.govt.nz
Author	Diana Spratt Casas
Functional Group	Older Adults and Home Health (OAHH)
Subject	Waitemata DHB Specialised Services for Older Adults (SSOA) Project Charter
1	Purpose To appraise DiSAC of the development of a Project Charter as a framework for the Waitemata DHB SSOA programme of work; and provide an update of the programme of work.
2	Recommendations That DiSAC note this report and that there will be a quarterly report on progress to DiSAC in future.
3	Description 1. SSOA is a priority for Waitemata DHB. In 2009 a Model of Care in which older people see “the right clinician, at the right time, in the right place, with the right competencies and supported by the right structures” was endorsed by the DHB. 2. SSOA includes all services for adults 65 years and older, from Mental Health Services for Older Adults, District Nursing, Assessment, Treatment and Rehabilitation, Advanced Nursing, System Administration Support,

	<p>Needs Assessment and Service Coordination, Allied Health, Clinics, Funding and Planning, NGO services to Primary Care.</p> <ol style="list-style-type: none"> 3. In 2010 DHB services included within SSOA were restructured to better achieve the agreed model. 4. A SSOA Governance Group was established to set key priorities and oversee various working groups. 5. A SSOA Stakeholder's Network was formed to provide broader advice and consultation opportunities. 6. In July 2011 the Charter was developed as a framework for a programme of work and endorsed by both Governance and Stakeholder groups. 7. Project Plans for the 5 agreed priority work stream areas below have been developed for the programme of work under this Charter and endorsed by both groups: <ol style="list-style-type: none"> a. <i>Delirium</i> - raising staff awareness of delirium and improving patient outcomes b. <i>Dementia</i> - planning and developing a whole of continuum dementia clinical pathway c. <i>Facilities</i> – ensuring SSOA facilities are fit for purpose in the short and longer term d. <i>Single point of entry</i> - determining the feasibility of bringing together SSOA referrals, screening and triage into one system; and planning and implementing agreed changes e. <i>Workforce</i> - ensuring managers and staff have appropriate training and workforce development opportunities to meet service and individual needs for people over 65 years with complex needs. Emphasis will be on progressing the SSOA Model of Care.
4	<p>Background</p> <p>The Charter will provide the framework for:</p> <ul style="list-style-type: none"> • Structured and concise advice to the Board on the direction and priorities of SSOA over the next 2-3 years. • Monitoring (summary of the project plan milestones) and reporting progress on the five SSOA work streams to the Board. • Monitoring progress as a coherent whole across the five SSOA work streams and inform its reports to the Board. • Ensuring the principles and objectives of the SSOA Governance Group Terms of Reference are met. • Supporting progress towards achieving the vision and benefits of the SSOA Model of Care.

<p>5</p>	<p>Options Considered</p> <p>Doing nothing. This is not an option for the following reasons:</p> <ul style="list-style-type: none"> • Very limited progress with District Plan’s strategic objectives, particularly in providing better support to older adults with dementia, mental ill-health and delirium. • Delayed progress on development and implementation of the SSOA Model of Care and related benefits will not accrue. • Reduced stakeholder satisfaction and negative impact on reputation.
<p>6</p>	<p>Issues and Risks for Chosen Option</p> <p>Risks involved in the current option relate to inability to put the District Plan into effect due to:</p> <ul style="list-style-type: none"> • Staff resistance to change or working in a more integrated manner • Insufficient budget to allow key service development • Limited clinical leader and clinical team availability for work stream project teams. <p>Mitigation of this risk involves:</p> <ul style="list-style-type: none"> • High priority given to projects and monitoring and review of resource requirements • Thoughtful use of representation to optimise use of subject matter expertise, work group time and decision-making.
<p>7</p>	<p>Regional / National Implications</p> <p>The Charter provides a framework and alignment with both Waitemata DHB’s Annual District Plan and the Northern Region Health Plan in relation to services to older people.</p>
<p>9</p>	<p>Appendices</p> <ul style="list-style-type: none"> a. SSOA Project Charter b. Programme of Work Update

SPECIALISED SERVICES FOR OLDER ADULTS (SSOA) PROGRAMME OF WORK UPDATE

Prepared for DiSAC Meeting 16 September 2011

Glossary

DHB – District Health Board

NGO – Non-Government Organisation

SSOA – Specialised Services for Older Adults

CMDHB – Counties Manukau District Health Board

Background

The SSOA programme of work has been developed from the District Annual Plan 2011/12 and includes a series of individual project plans for five priority work streams. It operates within the framework of a Project Charter and is guided by a Governance Group and a Stakeholder network. A Project Manager was appointed for 0.5 FTE mid-July to manage implementation of the 5 work streams. Hours were increased to 0.8 FTE from 29/8/11 to improve speed of change/implementation.

1. Delirium

Overall goal of this project is to increase Waitemata DHB hospital staff awareness and improve appropriate response where delirium arises and therefore improving patient outcomes (e.g. less in patient falls, better management of behaviours arising from delirium, less family/patient complaints related to delirium, etc).

- 1.1. Phases completed include preparation of resources, roll out schedule, ward champions and actual roll out with 10 days education on each ward
- 1.2. 6-month roll out to all in-patient areas between June and December on schedule.
- 1.3. Still to be completed, teaching for Champions, audit of compliance with expectations, communication, education for wider team, psych Liaison referrals.

2. Dementia

Dementia is a national priority. The overall goal of this project is to plan and commence development of a whole of continuum dementia clinical pathway consistent with regional and national dementia service development focusing on early diagnosis and better integration of DHB, primary care and Non-Government Organisation (NGO) services.

- 2.1. A regional review and pathway development has been called for by Government, although work has not commenced formally yet.
- 2.2. SMOs, Gavin Pilkington and John Scott, have led development of care pathway for the district with input from stakeholders and subject matter experts. For endorsement by executive, stakeholders and governance

groups in September. Once endorsed, the pathway will be the basis for developing dementia services.

- 2.3. Discussions with the Counties Manukau District Health Board (CMDHB) dementia team indicate desire to collaborate.
- 2.4. The Dementia Work Stream working group will resume meetings weekly again as soon as the model is endorsed.
- 2.5. Membership of a working group is being discussed.

3. Facilities

Overall goal of the project: to ensure Specialised Services for Older Adults facilities are made fit for purpose in the short and longer term.

- 3.1. Areas included are general in-patient facilities and intensive care area.
- 3.2. Range of Services include:
 - 3.2.1. Acute psycho geriatric admissions
 - 3.2.2. Assessment, treatment and management of older people who have severe behavioural disturbances including dementia and delirium or acute mental health issues
 - 3.2.3. Ability to practice isolation models of care and segregation of diagnostic groups.
- 3.3. A first draft of the design brief for refurbishment of the Kingsley Mortimer acute mental health unit been developed and circulated for comment from relevant parties, including Clinical Director Mental Health for input in respect of statutory requirements for environmental design.
- 3.4. Proposals for CAPEX for refit of Wards 14 and 15 will be developed by November 2011 for 20012/13 financial year.

4. Single Point of Entry

Overall goals of the project are:

- a) to determine the feasibility of bringing together Mental Health Services for Older Adults and Older Adults and Home Health referrals into one system; and
- b) to plan and implement agreed changes to Specialised Services for Older Adults (SSOA) referrals, screening and triage, including the establishment of a streamlined interdisciplinary assessment process.

- 4.1. This is very challenging work stream given the numerous groups affected - integration of two distinct cultures, physical and mental health, and the inevitable changes in work processes.
- 4.2. An initial meeting was held with key internal stakeholders and established a tight working group committed to results and true representation to/with their colleagues. A communication strategy for this project is in draft form.
- 4.3. The working group is meeting weekly from 16th August to:
 - 4.3.1. Analyse and document current situation in detail
 - 4.3.2. Compare processes and identify commonalities and differences
 - 4.3.3. Examine differences to find root cause
 - 4.3.4. Find and agree shared approach
 - 4.3.5. Document complete process.
- 4.4. The second phase is to pilot and evaluate the result; and the third is implementation.

5. Workforce

Overall goal of the project is to ensure managers and staff have access to appropriate training and workforce development opportunities to meet service

and individual needs for people over 65 years with complex needs. Emphasis will be on progressing the Specialised Services for Older Adults Model of Care rather than generic training and workforce development.

- 5.1. This project involves coordinating workforce development training opportunities currently in place, identifying workforce development training needs across Older Adults and Home Health Services and developing an integrated workforce development programme.
- 5.2. More specifically, it involves rolling out to both mental and physical health staff:
 - 5.2.1. Let's Get Real training, an e-learning tool of essential knowledge, skills and attitudes required to deliver effective mental health and addiction services
 - 5.2.2. Complete Interventions training in communication, de-escalation and handling
 - 5.2.3. Matua Raki training, the National Addiction Treatment Sector Workforce Development Programme for alcohol and drug/dual diagnosis or other related co-existing / dual diagnosis
 - 5.2.4. Delirium Work Stream project
- 5.3. It also involves establishing:
 - 5.3.1. a combined human resource/training database
 - 5.3.2. a SSOA integrated shared training module
- 5.4. Where resources allow, training will be developed and provided for NGO, Primary Care and Aged Residential Care services.
- 5.5. This project is impacted by and has an impact on all of the other work streams.
- 5.6. Discussion currently being held with key internal stakeholders to establish status of the above programmes and to establish a work group.

8.8 DISABILITY ACCESS TO CAR PARKING AT NORTH SHORE AND WAITAKERE HOSPITALS

DISABILITY SUPPORT ADVISORY COMMITTEE Paper

Date	Wednesday 21 September 2011
To	Disability Support Advisory Committee
From	Alan Wilson Chief Operating Officer Waitemata District Health Board Level 1 15 Shea Tce Takapuna Phone (09) 442 7223 Email : alan.wilson@waitematadhb.govt.nz
Prepared by:	Samantha Dalwood, Disability Strategy Coordinator, WDHB Louise Ward, Group Manager, Facilities & Development, WDHB
Endorsed by:	Alan Wilson, Chief Operating Officer, WDHB
Functional Group	Facilities & Development, Provider Group, Waitemata DHB
Subject	Disability Access to Car Parking at North Shore Hospital and Waitakere Hospital

1. Glossary

DHB	District Health Board
DiSAC	Disability Advisory Committee
NSH	North Shore Hospital
Barrier Free Advisor	Accredited Barrier Free Advisor from the Barrier Free Trust who undertake on request reports on accessibility of facilities
WDHB	Waitemata District Health Board
WTH	Waitakere Hospital

2. Executive Summary

This paper outlines the impact that changes to car parking at both Waitakere and North Shore Hospitals have on some people with disabilities and how the DHB is managing these issues.

The car parking changes that were introduced at both hospitals in June 2011 mean that there are unstaffed barrier arms and pay machines at North Shore Hospital and there are unstaffed barrier arms at Waitakere Hospital. This may have an impact on some disabled people accessing the hospital sites.

The paper outlines car parking arrangements at other hospitals. Access is varied, but the majority have either staffed traffic offices or can offer some mobility parking outside the barrier arms. There is no mobility parking available outside the barrier arms at either North Shore or Waitakere Hospitals as both hospitals are on major arterial routes and this would impede entry and exit of the route.

Feedback from people with disabilities who drive independently, but may have issues with the unstaffed barrier arm is that they see their access as compromised and that they have been disadvantaged by the changes. People with a disability, who are concerned they may not be able to operate the barrier arm, can phone ahead for parking assistance and a member of Traffic Services will meet them at the barrier arm.

Traffic Services have stated that they are confident that Traffic Services and Security would be able to respond to calls coming through from the barrier arms and people phoning ahead to say they were coming to the hospital and are unable to operate the barrier arms.

Some alternative solutions have been suggested, including moving the barrier arm, installing more cameras, or giving some people access to the pre-paid card scheme that is being introduced for staff. These are explored further in the paper.

It is important to note that this is not a compliance issue for the DHB, but an access one, as there are no specific regulations around barrier arms.

In conclusion, the ideal solution would be to have barrier arms staffed at each site, at least at the busiest times of the day. This would come at considerable additional cost (\$325k p.a.) that would need to come from further savings or reductions of clinical services in other areas.

Overall, the measures that have been put in place will support the provision of access for the very small number of people with some disabilities who will be affected by car parking barriers. Waitakere Hospital is already substantially above code for the number of disability car parks. North Shore Hospital is already at code for required disability car parks on-site and will increase by 18 covered car parks in the new car park building.

3. Introduction/Background

This report for information outlines the issues and possible solutions for people with disabilities using North Shore and Waitakere Hospitals where there are unstaffed

barrier arms in place. Advice is provided on actions already in place to manage the situation.

From June 2011, a number of changes occurred in parking management at NSH and WTH associated with changes to paid parking. At NSH existing traffic booths became unstaffed as part of the development of the new multi-storey parking facility at North Shore Hospital, the movement to paid parking becoming 24/7 (rather than 12 hours Monday to Friday), and there was preparation for staff paid parking to be introduced later in the year.

On 13 June ticket machines and barrier arms were installed at Waitakere Hospital and paid parking for the public was introduced for the first time. Paid parking for staff will be introduced later in the year concurrently with North Shore Hospital.

On entry to either hospital campus, a ticket is produced by the ticket machine when the vehicle is stopped at the barrier arms during the hours of 0600-2200. The driver is required to take the ticket from the machine to allow the barrier arm to rise. The driver passes the barrier arm and finds a car park in the visitor/patient parking areas. Prior to the visitor/patient leaving the hospital campus, the entry ticket is to be inserted into the pay machine as indicated on the pay machine.

The automated parking management system has been installed and there are traffic staff located at North Shore Hospital Traffic Office. The traffic staff at NSH are able to view the pay machines and barrier arms via cameras at WTH and NSH and they can assist with issues as they arise through an intercom system. However, as we are implementing a new pay for parking system, as a temporary measure there will be one traffic person available at both NSH and WTH to assist either at the pay station or the barrier arms. There is also the opportunity to push the “call for assistance” button (telephone icon) at the entry/exit points and at the pay machines that connect with the NSH Traffic Office. In the late evening and overnight, the traffic office of operating the barrier arms is transferred to the Security team to assist with issues as they arise with the Security office having remote access to the Traffic Management System.

As at June 2011, the pay machines at WTH are located at the Front of House with one at the Visitor/Patient car park and a further pay machine at Entrance F. As at July 2011, the pay machines are located at NSH by the Main Entry to the Front of House and one pay machine is in front of the temporary Traffic Office by the Public Parking area. From November an additional pay machine will be located between Entrance 3 and Entrance 4.

From November 2011, pay machines at NSH are intended to be located at the Main Entry to the Front of House (one), the Entrance 3 and Entrance 4 (one) as above, and two pay machines on the Ground Floor of the new car park building. These locations will be monitored for six months to establish that they are correctly positioned for the flow of patients and visitors. At the completion of the multi-storey car park an approved finalised site map with pay machine locations will be formatted and included in the Intranet.

The visitor/patient is able to pay for parking by inserting NZ currency (bank notes and coins), EFTPOS, Mastercard or Visa credit card. A receipt can also be requested. The entry ticket is removed from the pay machine after payment in full is made and

the visitor/patient returns to their vehicle and drives to one of the exit points. The entry ticket is inserted into the ticket machine in the exit lane. The barrier arm will lift and the visitor/patient is able to leave the hospital campus.

Arrangements have been put in place for people with disabilities to ring the direct number (09 442 7999) prior to arriving on site. This telephone number connects them with the NSH Traffic Office, and they can advise of their intended arrival time. Outpatients and waiting list information has been re-printed with this new information included. At the time of writing, we are only aware of disability assistance being provided on two occasions at WTH, with an average of 386,000 car movements per month.

The ticket machines at the points of entry/exit include a 'call for assistance' button (telephone icon) which the public can use. Waitemata DHB traffic/security staff will be available to assist disabled people through the process. Pay machines also have the 'call for assistance' button (telephone icon).

Earlier this year concerns were raised by a member of the community, with subsequent media attention, in relation to reduced access for patients with a disability who are unable to operate the barrier arm system i.e. taking a ticket from the machine, pressing a call assist button or accessing the pay machine prior to exit. The concerns of people with disability accessing parking at these two hospitals was subsequently discussed at WDHB DiSAC in June 2011 with management requested to look again at the issues.

Many people with impairment, particularly people with intellectual disabilities and visual impairments, will come to the hospitals with support. However, a number of people, with conditions such as Cerebral Palsy, Spina Bifida and Multiple Sclerosis, are likely to be driving independently, but may still have difficulty taking a parking ticket, pressing the call assist button, or using the pay machine on exit. Feedback from people with disabilities, from the Barrier Free Advisor, and from experience to date, indicate that this will affect a very small number of people.

There is no specific reference to barrier arms in building regulations and this should be seen as an access issue rather than a compliance issue.

The new parking system was progressively implemented from June 2011. Issues for people had not been anticipated as the system parallels that used in car parking buildings/sites around both New Zealand and overseas. The issues raised have improved the profile of disability access across WDHB facilities and this will have a number of benefits for promoting disability access. All new buildings under development will now be subject to Barrier Free audits and the WDHB Disability Strategy Coordinator is undertaking Barrier Free Auditor training so Barrier Free Audits can be incorporated into the early design phases of new facilities.

Car-Parking arrangements at other hospitals

A sample of other hospital sites around New Zealand was considered in relation to parking arrangements for people with disability:

Auckland City Hospitals parking is managed by Wilson Parking. There are 17 mobility parking spaces near the entrance to the main hospital building which are free and do not involve accessing via a barrier arm. This is achievable due to the location of the main hospital buildings near the external perimeter of the campus site and being located on a standard road.

Green Lane Clinical Centre has staffed barrier arms to support people entering and exiting the car park. Currently this site is predominantly a Monday-Friday facility operating extended office hours only - rather than a 24/hour acute care facility.

Middlemore Hospital has only unstaffed barrier arms and the same access issues as at North Shore Hospital and Waitakere Hospital.

Waikato Hospital has dedicated free mobility parking outside the barrier arms. This hospital is also sited on the external perimeter of the hospital so the proximity for patients with disability parking in these areas is not an issue.

Palmerston North is operated by Wilson Parking with staffed barrier arms and advertises helpful parking staff on their website.

Wellington Hospital has no staffed barrier arms, but patients can phone traffic services in advance to get a ticket to park in a pool parking area. They receive very few requests for this and there are also a few mobility parking spaces that do not have to go through the barrier arm.

Feedback from People with Disabilities

WDHB Disability Strategy Coordinator contacted people with disabilities who drive independently, but who may need support to access parking through a barrier arm, to explore any options to improve disability access following the car parking changes at WDHB that have reduced access for a small number of people with disabilities as described in this paper .

In general issues raised are as follows:

- Concerns about out of hours access for people with disability (Response: WDHB provides out of hours access support by contacting traffic/security staff, by phone, at both sites but individuals need to be able to access the telephone icon or use a phone prior to presenting)
- People with impairments may be disadvantaged by the unstaffed barrier arm and may feel that they can no longer come to hospital independently. There is often no choice about coming to hospital as a patient.
- Concerns that the phone numbers need to be widely publicized for all who need it. (Response: this is stated on the ticket machines, and has been advised through the Auckland disability networks].
- It can be challenging trying to control a hand-control car and get a ticket at the same time.
- Some patients may not be confident that they can get in and/or out, especially out of hours

- Could there be parking outside the barrier arms that is easily accessible to the hospital entrances? (A response to this has been investigated as is further outlined in this paper).

Current car parking arrangements North Shore and Waitakere Hospitals

A meeting was held on 16 May 2011 between the Chief Operating Officer, Facility and Development traffic staff, and WDHB Disability Strategy Coordinator to discuss the current disability access issues. The following arrangements have been implemented:

- Parking or Security staff (after hours) at North Shore or Waitakere Hospital are available to assist any people with disabilities who are unable to operate the barrier arm ticket machine or who are not accompanied by someone who can support them.
- People with a disability, who are concerned they may not be able to operate the barrier arm, can phone ahead for parking assistance (09 442 7999 – this number is for North Shore and Waitakere Hospitals) and they will be met at the barrier arm and assisted to obtain a ticket. They are also advised of assistance available to assist them to use the pay machine prior to exiting the site.
- The contact phone number for parking assistance has been put on the barrier arm and on the WDHB website. This means that people who are unable to take a ticket will be able to summon assistance by using the call button.
- Information on access arrangements for patients with disabilities has been provided through the disability networks, will be included on Outpatient Information letters as part of updating letters, and is on the website.

Alternative Solutions Considered

A number of alternative solutions have been raised/considered

- Vivien Naylor (Barrier-Free Advisor) suggested that the only real solution to create equality and take away the need for a separate system for people with disabilities is to have the barrier arms staffed. Her suggestion is that they are staffed in the day and left up after hours and the DHB has to accept that they will not get revenue during those times. If the DHB will not staff the barrier arms then there will need to be a system in place to support people. Visitors entering during periods when the barriers are raised, and hence do not take a ticket, have difficulty leaving the site as they do not have a validated ticket for exit.
- We have investigated placing mobility car parks in an existing car park near the Lincoln Road entrance to Waitakere Hospital. The advice from Flow Transportation Specialists (a Traffic Consultation company) acknowledges that while some disabled drivers may have difficulties obtaining/validating a ticket upon entry and exit to the parking areas, the additional access would allow vehicles to enter the parking area without travelling through a barrier. They reported that exiting through the same entrance (close to Lincoln Road) is not an option as this would obstruct traffic flow onto the site. To exit the site, a patient entering through this route would be expected to drive through the main hospital car park. The median strip and potential for obstructing entry of Lincoln Road,

would not allow the patient to exit the site directly without going through an exit barrier arm. For this arrangement to function, the patient would have to be able to collect a ticket on arrival (perhaps at hospital reception) and then to arrange prior to exiting, for security to assist them with the barrier arm. Such a new barrier route is likely to compromise revenue processes for the site as patients (disabled and non-disabled) could collect a ticket when they are leaving the site to minimise payment. Further issues are that non-disabled persons would use this new entrance as an entry, or would use this entrance as an exit – posing considerable risk to safe traffic flows for others. This option could be explored further if required.

- No suitable options for North Shore Hospital have been identified due to the location of the main building being too far from the barrier arms gate to be “disability accessible”. In the event that there are one or two patients, with genuine issues, and who are unable to use the ticketing machine, there is one option that could be considered on a case by case basis. There are a number of disability car parks at the new Renal Unit on Shakespeare Road and these could be made available on a case-by-case basis to such patients. These car parks however are not particularly disability-friendly as they are located a considerable distance way from the main building – however this would be an opportunity in extenuating circumstances.
- Install cameras on the barrier arms monitored by Traffic Services: There are already CCTV cameras viewing the barrier arms, but this would not be reliable in itself as Security staff are not continually observing only the barrier arms, but are viewing all security cameras on a rotating cycle.
- A pre-paid card (similar to staff access card) that could be used to swipe in and out for people with disability who are unable to operate the barrier arm and present regularly. This would mean that the person would not need to pay at the machine or take a ticket. This can be explored further for the small number of people for whom taking a ticket at the barrier arm is impossible and who present regularly.

Besam NZ, an Auckland based ‘entrance solution’ company, said they would be concerned about the high costs involved in a technological solution. A remote control system could be provided to identified patients as they came through the barrier arms but this would open both the incoming and outgoing barrier arms at the same time, or may open the wrong one. The cost of windscreen vehicle ID tags that the barrier arms can recognise and then open would be very expensive to create technology to identify certain vehicles, particularly as there would only be a few vehicles a year that would have the ID tags.

Implementing a system like the Northern Gateway Toll Road where the barrier arm would automatically open and the registration number of the car would be recorded. The fee could be paid on the day or online. This is likely to be very costly to set up and would involve retrospective cost recovery and associated costs.

The car park building at North Shore Hospital on completion will accommodate the parking management system that incorporates cameras, barrier arm controls, intercom, programme access cards, customer liaison, vehicle permits for Waitemata

DHB staff. This management system requires a person to man the station 0600-2200H, thereafter the system is transferred to the remote security control room. As a person is required in the traffic office at all times, we are not able to provide a stationery person at the barrier arms or pay machines during these hours.

The parking administration, compliance and supervision roles will operate from 0600-2200 (2 shifts) per day 365 days per year. Each shift will allow a person in the Traffic Office, one person at WTH and one person at NSH in the field and supervision. The incremental cost associated with one staffed traffic booth at each site would be \$325K per annum for one staffed booth at each site, and an additional one-off cost for re-installing staffed booths. It is likely that at NSH, a second booth would be required at further annual operating cost of \$162k per annum and a one-off capital cost of \$40k.

Risks/Issues

Reduced access to people with disability adversely affects public confidence and results in adverse media attention. WDHB has already put in place a number of strategies to reduce the implications of paid car parking.

Progress/Achievements/Activity

A number of solutions have been put in place (as above) to reduce access issues for people with disability.

The Traffic Services and Security will be able to respond to calls coming through from the barrier arms and people phoning ahead to say they were coming to the hospital and are unable to operate the barrier arms.

Since introduction of the system we have had only two written complaints regarding access through the barrier arms.

Conclusion

Supports have been put in place to lessen disability access issues at North Shore and Waitakere Hospitals. Should further measures be required by the Board then additional cost will need to be incurred. Further options include:

Staffing an additional person at each site would cost \$319k per annum with capital costs of \$40,000 per booth.

Additional work could be done on further exploring a free-access park at Waitakere but at North Shore there is no similar potential solution available.

Additional guidance is sought from the Committee on the matter.

CONFIRM

9.1 Action Points for next DSAC Meeting

9.2 DSAC Feedback to CPHAC

9.3 DSAC Feedback to Board

Use Forms at beginning of Meeting Pack

10

GENERAL BUSINESS

10.1 Agreement on date and purpose for DSAC Member's Workshop

10.1 Agreement on date and purpose for DSAC Member's Workshop



Making a healthy difference to the community

AUCKLAND and WAITEMATA DISTRICT HEALTH BOARD COMBINED DISABILITY SUPPORT ADVISORY COMMITTEE

MEETING DETAILS		
Time and Date	2:00 pm – 4:00 pm, Wednesday, 21 September 2011	
Venue	Marie Hosking Room, Level 7 Building 14, Greenlane Clinical Centre	
Members	Sandra Coney (Chair) WDHB, Jo Agnew ADHB, Max Abbot WDHB, Pat Booth WDHB, Susan Buckland ADHB, Dr Lester Levy, Robyn Northey ADHB, Michelle Cavanagh, Marie Hull-Brown, Dairne Kirton, Jan Moss, Susan Sherrard, Russell Vickery.	
Apologies		
In Attendance	ADHB: Garry Smith, Dr Denis Jury, Lisa Gestro, Janice Mueller. WDHB: Dr Dale Bramley, Debbie Holdsworth, Samantha Dalwood, Brian Agnew. Secretary: Nicky Caunter	
	Item	Page No
1 5m to 2:05 pm	Karakia and Introductions	001
2 3m to 2:08 pm	Attendance and Apologies	009
3 2m to 2:10 pm	Conflicts of Interest	011
4 2m 3m to 2:15 pm	Confirmation of Minutes ADHB Wednesday 15 June 2011 WDHB Wednesday 22 June 2011	017 021 027
5 3m 2m to 2:20 pm	Action Points ADHB Wednesday 15 June 2011 WDHB Wednesday 22 June 2011	033 037 041

6 5 m to 2:25 pm	Chairperson's Report	043
7 15m to 2:40pm	Improvement Activities 7.1 Quarterly Report on Activities in ADHB and WDHB	045 047
8 20m 10m 5m 10m 5m 5m 5m 10m to 3:50 pm	Papers 8.1 Presentation - Minnie Baragwanth, CEO Be.Accessible 8.2 Proposed Approach to the combined ADHB- WDHB DSAC 8.3 Northern Region Health Plan – Update 8.4 Implementation of interRAI Long Term Care Facility (iLTCF) Assessment in Residential Care 8.5 Child Rehabilitation Service 8.6 Mainstream Positions at ADHB 8.7 Waitemata DHB Specialised Services for Older Adults (SSOA) Project Charter 8.8 Disability Access to Car Parking at North Shore Hospital and Waitakere Hospital	067 069 073 081 093 105 117 129 137
9 5m to 3:55 pm	Confirm 9.1 Action Points for next DSAC Meeting 9.2 DSAC Feedback to CPHAC 9.3 DSAC Feedback to Board	145
10 5m to 4:00 pm	General Business 10.1 Agreement on date and purpose for DSAC Members Workshop	147 149
NEXT MEETING		
Time and Date:	2:00 pm – 4:00 pm, Wednesday, 16 November 2011	
Venue:	Marie Hosking Room, Level 7 Building 14, Greenlane Clinical Centre	

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare