



# **Disability Support Advisory Committee**

## **Meeting**

**Wednesday 15 June 2011**

**11:30am**

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

*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:	
<b>DAP</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>KPIs</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>RISKS</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
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

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



## ADHB DSAC INTERESTS REGISTER

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Jo AGNEW (Chair)</b>	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		
<b>Susan BUCKLAND</b>	1. Writing, editing and public relations services	Self-employed	Fees	Writer, editor and public relations services	7 August 2009
	2. Medical Council of NZ	Professional Conduct Committee member	Hourly fee	Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes	
	3. Occupational Therapy Board	Professional Conduct Committee member	Hourly fee	Lay member of PCC to assess complaints and determine outcomes	

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Maria HULL-BROWN</b>	1. Employee Mental Health Foundation 2. Member Auckland City Council Disability Issues Advisory Group 3. Board member HOPE Foundation for Research on Ageing 4. Council Member Age Concern Auckland.				13 May 2010
<b>Dairne KIRTON</b>	1. Nil				24 June 2008
<b>Robyn NORTHEY</b>	1. Self employed Contractor  2. Hope Foundation 3. Northern Region Ethics Committee	Project management, service review, planning etc.  Board member  Member	FEE  NIL  FEE	SOME CLIENTS ARE CONTRACTORS TO ADHB  RESEARCH AND EDUCATION INTO AGING IN NZ, DELIVER SEMINARS AND AWARDS SCHOLARSHIPS	<b>16 DECEMBER 2010</b>
<b>Susan SHERRARD</b>	1. Team Leader for CCS Disability Action 2. Trustee Ripple Trust				18 February 2010
<b>Nanar TAN</b>	1. Nil				16 July 2008

**CONFIRMATION OF MINUTES**  
**- WEDNESDAY 20 APRIL 2011**



# Disability Support Advisory Committee Minutes

<b>MEETING DETAILS</b>									
Date and Time	11:30 am, Wednesday 20 April 2011								
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom								
<b>1</b>	<b>WELCOME</b>								
	The Chair declared the meeting open 11:44 am and welcomed attendees and introductions were made.								
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>								
	<p><b>Committee Members</b></p> <table> <tr> <td>Jo Agnew (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Marie Hull-Brown</td> <td>Dairne Kirton</td> </tr> <tr> <td>Dr Lester Levy</td> <td>Robyn Northey</td> </tr> <tr> <td>Susan Sherrard</td> <td>Nanar Tan</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive  Dr Denis Jury – Chief Planning &amp; Funding Officer  Lisa Gestro – Manager Planning and Funding  Janice Mueller - Director Allied Health  Ian Bell – Board Administrator</p>	Jo Agnew (Chair)	Susan Buckland	Marie Hull-Brown	Dairne Kirton	Dr Lester Levy	Robyn Northey	Susan Sherrard	Nanar Tan
Jo Agnew (Chair)	Susan Buckland								
Marie Hull-Brown	Dairne Kirton								
Dr Lester Levy	Robyn Northey								
Susan Sherrard	Nanar Tan								
<b>3</b>	<b>CONFLICTS OF INTEREST</b>								
	There were no notifications of any conflicts of interest for any item on the agenda.								
<b>4</b>	<b>CONFIRMATION OF MINUTES 16 FEBRUARY 2011</b>								
	<p><u>Moved Robyn Northey; seconded Susan Buckland</u></p> <p><i>That the minutes of the Disability Support Advisory Committee meeting held on 16 February 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>It was noted that Lester Levy was an ex officio member of the Committee as Chair of the ADHB.</p>								
<b>6</b>	<b>CHAIRMAN'S REPORT</b>								
	<p>Be. Assessable was getting traction with strong leadership and a launch on 6 May 2011.</p> <p>There was a meeting on Thursday 28 April 2011 on the Positive Aging Strategy Way Forward for the Auckland Region which she would attend along with Robyn Northey.</p> <p>Marcia Reid of the Phobic Trust had written to the Chair and Denis Jury seeking to arrange a meeting with them and the Clinical Director Mental Health on their plans to build a regional in-patient centre. This needed to be discussed in the Mental Health Regional Planning and have a tender process. There was a difference between the Trust's and clinical views as to where it should sit and what the service should look like. It may not be a priority for Regional Mental Health. Mental Health should also report to CPHAC as it was not necessarily a disability. This request demonstrated the tension of a provider seeking to get preferential access. It was</p>								

	<p>suggested that the proposal be put in writing with the Chief Planning and Funding Officer to write a recommendation to the Board.</p> <p><u>Moved Susan Buckland; seconded Marie Hull-Brown</u></p> <p><i>That the Chairman's report be noted.</i></p> <p><u>Carried</u></p>
<b>7.1</b>	<b>DAP Report</b>
	There were no exceptions.
<b>8.1</b>	<b>Devolution of Interim Funding Pool Clients</b>
	<p>Through Order in Council this was on track to devolve on 1 July 2011. There were 512 people in the region and ADHB was well positioned to absorb these into existing services and to see that their needs are met. A group under 15 were managed through Starship services and while they were a small number they can be very expensive and over time evolve to special needs or disability services.</p> <p>There is an issue with the pool devolving into PBF from 1 July 2013 with, for the region, a \$2.9m gap between cost commitment and PBF share of which \$2m would be ADHB's gap. ADHB could not accept this risk so existing clients would be retained and funded through a regional funding pool and new clients would be absorbed into their DHB of residence. Counties Manukau wished to unilaterally withdraw from the regional pool so this issue is to be escalated to the regional governance group if necessary.</p> <p>A Steering Group had been established to determine what services were needed and to monitor services provided, with the biggest gap being for 16-25 year olds.</p>
<b>8.2</b>	<b>Accessibility Audit Review Update</b>
	<p>A project team was working through the recommendations to develop a recommendation to the Senior Leadership Team noting that no funding had been budgeted as yet. The question of a disability advisor was going through the steering group process as there is in other ways this could be done i.e. a shared resource between Waitemata and Auckland.</p> <p>The recommendation on wireless internet access had been reviewed, following a suggestion from a patient to the Chair, by the CIO noting that it was very expensive and not a regional priority. There may be some opportunities of sponsorship.</p> <p>There was disability awareness training on the orientation day with Moodle yet to be developed. There would be further updates from the project team at the next meeting.</p>
	<b>Mainstream</b>
	Mainstream provided joint funding for two years to promote disabled persons into the workforce. Nanar Tan advised that there needed to be very good communication and that the supervisors tended to have too many clients. ADHB was taking a cautious approach to have the organisation right to do this properly.
<b>9.1</b>	<b>DAP Reporting</b>
	<p>The paper detailed the DAP aims within the Annual Plan relating to disability. InteRAI was included for the 4 Home Based Support Services providers and specialist care but was yet to be implemented into rest homes and private hospitals. There were two main assessments, being short and long, with a need to monitor who can use the tools.</p> <p>With disability complaints there was a problem of definition and the Quality Department does not capture the information. There was a meeting to scope the project with, at present, just issues and barriers highlighted. Presently using a key word search there was only a couple of</p>

	<p>complaints. It was thought that for those with disabilities there may be an expectation of a low level of service so they did not complain.</p> <p>The Board Chair advised that the function of the Quality, Risk and Audit Committee would be migrated into the other committees of HAC, CPHAC, DSAC and Finance and Audit as appropriate.</p> <p>The Committee recommended that staff needed to understand the policies and view services from a patient point of view. Dairne Kirton recounted her recent experience and it was suggested that she write this as a case study.</p> <p>The Chief Planning and Funding Officer advised of another unsatisfactory complaint concerning a rest home who also wished to open a dementia unit without clinical approval. The Committee and Board would support strong action and suggested discussions with the Chair of the publicly listed holding company.</p> <p>The Liverpool Care Pathway was being rolled out in ACH and included doctors.</p>
<b>9.2</b>	<b>Report to the UN on Implementation of UN Convention of Rights</b>
	This was provided for information and had been a favourable report.
<b>9.3</b>	<b>Launch of the Be. Accessible Campaign</b>
	<p>ADHB was one of the founding partners. Be. Accessible was being funded to do an audit of all Rugby World Cup stadiums as well as being engaged by a bank and schools. A number of members and staff would be attending the launch and it would be taken to the Senior Leadership Team.</p> <p><u>Moved Jo Agnew; seconded Marie Hull-Brown</u></p> <p><i>That the Disability Support Advisory Committee supports the Be. Accessible Institute and programmes.</i></p> <p><u>Carried</u></p>
<b>10</b>	<b>GENERAL BUSINESS</b>
	<p><b>Disability Support Advisory Committee</b></p> <p>The Board Chair spoke on the collaboration between Auckland District Health Board and Waitemata District Health Board and the proposal to have a joint committee noting that the Chair, Rob Cooper and Gwen Tepania-Palmer were joint appointments to both Boards and that regionalisation was the direction being taken. Primary Care Planning and Funding were merging as were the Maori Health operational workforce. There were papers going to the Boards to form the joint committees of Community and Public Health Advisory Committee, Disability Support Advisory Committee and Maori Health Gain Advisory Committee.</p> <p>Membership proposed was Chair, Sandra Coney (WDHB); Deputy Chair, Jo Agnew (ADHB); Ex Officio, Chairman; ADHB members, Susan Buckland and Robyn Northey and WDHB members, Max Abbott and Pat Booth with up to 4 external appointments. While the external appointments across the two boards would be reduced there was a possibility of the Committee having a separate advisory committee. The existing externally appointed members were thanked for their contribution. It was also noted that there were regional clinical networks being established i.e. Health of Older People.</p>

	<b>NEXT MEETING</b>
	The meeting closed at 1:36pm The next meeting would be subject to the revised six-weekly joint meeting cycle to be approved by the ADHB and WDHB Boards.
<b>CONFIRMED</b>  <b>CHAIR:</b> <span style="float: right;"><b>DATE:</b></span>	

**ACTION POINTS**

- **WEDNESDAY 20 APRIL 2011**



**Disability Support Advisory Committee  
Action Points from the Meeting held on Thursday 20 April 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
6.	The Phobic Trust proposal to be put in writing with the Chief Planning and Funding Officer to write a recommendation to the Board.	Denis Jury	



## **CHAIRMAN'S REPORT**



# **IMPROVEMENT ACTIVITIES**

## **7.1 DAP Projects Report**



# Group Pack Report

Group/Committee: Disability Support Advisory Committee



## Goal Level Summary

DAP Projects - total projects: 8

Goal	Number	Started	Current Phase							On Time			On Budget			Expected Outcome			Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	7	7	2	0	1	2	2	0	4	3	0	7	0	0	7	0	0	0	0	0	0
2 Performance improvement	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total #</b>	<b>8</b>	<b>8</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>5</b>	<b>3</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>38%</b>	<b>0%</b>	<b>13%</b>	<b>25%</b>	<b>25%</b>	<b>0%</b>	<b>63%</b>	<b>38%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

### Review

No review entered for this committee report

## Goal: 1 Lift the Health of the people in Auckland City

### High Level Summary - total projects: 7

	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
<b>High Level Strategy</b>																					
1.1 Reduce inequalities in health status	2	2	0	0	0	1	1	0	2	0	0	2	0	0	2	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2b Improve outcomes for older people	4	4	2	0	1	1	0	0	2	2	0	4	0	0	4	0	0	0	0	0	
1.2c Improve outcomes for mental health and addictions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2d Improve outcomes for long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2e Improve outcomes for Palliative care	1	1	0	0	0	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	
<b>Total #</b>	<b>7</b>	<b>7</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>4</b>	<b>3</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>29%</b>	<b>0%</b>	<b>14%</b>	<b>29%</b>	<b>29%</b>	<b>0%</b>	<b>57%</b>	<b>43%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	

### Objectives

Objective	Objective Owner	Comment
1.1.4 Support disabled people and improve their access to health care and support services	<a href="#">Denis Jury (ADHB)</a>	Disability Responsiveness Audit recommendations currently being reviewed and prioritised and paper to SLT planned for June / July. Regional work underway to manage devolvement of the IFP by July 2011, and issues of regional processes and risk sharing to be considered by RFF in May.

### Exceptions

There are no projects that have been marked as an exception

## Goal: 2 Performance improvement

### High Level Summary - total projects: 1

	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits		
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure																
<b>High Level Strategy</b>																				
2.1a Efficient and effective Primary health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total #</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

### Objectives

No Objectives have been entered for this committee or group against this goal.

### Exceptions

There are no projects that have been marked as an exception



## PAPERS

- 8.1 Update on the Implementation of the Disability Audit**
- 8.2 Report from Health Workforce New Zealand**
- 8.3 Consumer and Community Engagement Framework**



**8.1 Update on the Implementation of the Disability Audit**





# Disability Support Advisory Committee Paper

<b>Date</b>	Wednesday 15 June 2011
<b>To</b>	Disability Support Advisory Committee
<b>From</b>	Janice Mueller Director Allied Health, Scientific & Technical Auckland DHB <a href="mailto:jmueller@adhb.govt.nz">jmueller@adhb.govt.nz</a>
<b>Author</b>	Lisa Gestro Planning and Funding Manager
<b>Functional Group</b>	Planning and Funding
<b>Subject</b>	Update – Implementation of the Disability Audit
1	<p><b>Purpose</b></p> <p>To update the committee on the progress of the prioritisation and implementation of the recommendations contained in the comprehensive Disability Responsiveness Report completed at the end of 2009/10.</p>
2	<p><b>Recommendations</b></p> <p>It is recommended that the Committee:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the recommendations and that work that is underway in respect of each of these key areas.</li> </ul>
3	<p><b>Background</b></p> <p>In 2007/08 the need for an audit to measure accessibility and service user experiences among the Disabled community became a priority for the ADHB. This objective was deferred a year due to competing priorities but was revisited following the launch of the Step Up Auckland report, which highlighted access as the single biggest issues for disabled people within Auckland City. Discussions began in mid 2009/10 with stakeholders and potential providers to agree the outcome that would be sought from the exercise, and to scope what such an audit might include.</p> <p>A small internal steering group was established in September 2009, and A1 Communications were confirmed as the agency to oversee the review. The process used to undertake the review was broad and encompassing – it involved a planning and design phase, a comprehensive literature review and a series of qualitative research streams including staff focus groups, key informant interviews and questionnaires for those that were not able to engage in person.</p> <p>What resulted is a significant précis of both the positive and negative aspects</p>

	<p>of our organisation's responsiveness to disability. This report was tabled at DSAC in November 2010, with the resulting action being that a small working group should be established to review the recommendations contained within the report, prioritise the recommendations within agreed DAP and budget constraints and then obtain SLT sign off for a staged implementation.</p>
4	<p><b>Update</b></p> <p>The project team have developed the following table, which summarises each of the recommendations from the report and assigns an accountable project team member. The table, which is appended to this report, provides an update on progress on each objective, with the purpose of further prioritisation to take place once a complete set of information has been collected to inform a robust discussion.</p>

## 8.2 Report from Health Workforce New Zealand





## Disability Support Advisory Committee Paper

Date	Wednesday 15 June 2011
To	Disability Support Advisory Committee
From	Janice Mueller Director of Allied Health, Scientific and Technical
Author	Lisa Gestro Ext 26097 lgestro@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Health Workforce New Zealand - findings of the first five national workforce reviews
	<p>The purpose of this item is to:</p> <ul style="list-style-type: none"> <li>• Provide DSAC with an update on the national HWNZ reports, which includes Health of Older People.</li> </ul> <p>A full report of the initial findings is appended to this report.</p>



### **8.3 Consumer & Community Engagement Framework**





# Disability Support Advisory Committee Paper

<b>Date</b>	Wednesday 15 June 2011
<b>To</b>	Disability Support Advisory Committee
<b>From</b>	Janice Mueller, Director Allied Health - Scientific & Technical <a href="mailto:JM Mueller@adhb.govt.nz">JM Mueller@adhb.govt.nz</a> Ext 23941
<b>Author</b>	Tony O'Connor ADHB Consultation Manager Ext 26765
<b>Functional Group</b>	Planning and Funding Management Group
<b>Subject</b>	Consumer and Community Engagement Framework
1	<p><b>Purpose</b></p> <p>The purpose of this paper is to provide an update on the development of an organisation-wide framework of mechanisms for engaging the ADHB population and health service consumers on both an on-going and ad-hoc basis.</p>
2	<p><b>Recommendations</b></p> <p><b>It is recommended that the Committee:</b></p> <ol style="list-style-type: none"> <li>1. <b>Note</b> the development of the Online Community and Consumer Representatives format</li> </ol>
3	<p><b>Description of Solution (Option)</b></p> <p>The Consumer and Community Engagement Framework will provide planners and service improvement managers across the DHB with a range of “tools” that can be used to source reliable and comprehensive knowledge about consumers’ views on service quality, planning and health matters. The Online Community will provide an on-going flexible communication channel across a large number of people and statistically reliable and demographically representative feedback. Trained consumer representatives will allow for on-going involvement of consumers in a project team. Taken together, the two options provide a comprehensive and accurate consumer engagement mechanisms about consumers’ views. Aligned to and enable greater</p>

	community and patient centeredness in decision-making as required by the Health Excellence Framework. Existing community engagement mechanisms (e.g.: HVAZ) will remain in place.
4	<p><b>Background</b></p> <p>An organization and environmental scan in mid-2009 showed that there were clear opportunities to improve the way Auckland DHB engages its community and patients. On 29 March 2010 the DHB's Quality, Risk and Audit Committee endorsed the development of a community and consumer engagement framework as described in more detail here. Completing the Framework's development and moving through to implementation over 2011-12 (as proposed in the draft Annual Plan) will help the DHB's journey toward Healthcare Excellence, which will involve keeping patients at the centre of our planning and service improvement activity.</p>
5	<p><b>Activity</b></p> <p>A Steering Group chaired by the Director of Allied Health, Scientific &amp; Technical and includes clinical, Maori, Pacific, Consumer and Planning and Funding members oversees the project. The Senior Leadership Team was introduced to project last year and will be briefed in detail about progress and proposed developments in April.</p> <p><b>Online Community:</b> An RFP process was issued to three respected local providers. The successful respondent progressed to contract negotiation and has subsequently signed-up for the delivery of on-line technology and research and engagement expertise. The online community is now live and being tested (via the Child Health Improvement Plan engagement) and it is expected that its functionality and usability will develop via internal, consumer and community feedback. The website will be demonstrated at the meeting of DSAC.</p> <p><b>Consumer Representatives:</b> Options for training consumers to serve as consumer reps are being considered. The project team is considering equity issues, for example how to accommodate those within our population who have high health needs, poorer health status and/or do not have the ability or resources to speak for themselves. Some solutions identified to date are:</p> <ol style="list-style-type: none"> <li>1) ensure the Consumer Council includes members with strong links throughout the Maori and Pacific communities;</li> <li>2) ensure that the provider of the technology underpinning the online community meets the highest accessibility standards;</li> <li>3) ensure one-off engagement activities consider the equity and accessibility issues particular to that activity and where appropriate engage with disadvantaged people on terms that suit them.</li> </ol>
6	<p><b>Issues and Risks</b></p> <p>Currently our understanding of consumer and stakeholder views (eg: consumer/interest groups) is partial and fragmented across the organisation and the input collected is not well coordinated in terms of flowing through to</p>

	<p>planning for the future, service improvement or the development of an in-depth and comprehensive knowledge-base about community and consumer views. These complications lead to a weakness in the organisation's ability to respond to growing focus on patient-centred quality improvement and service development.</p> <p>There is growing interest in and excitement about the potential of this framework. When it is launched, project staff will need to manage other staff's expectations about how much activity can be accommodated across the framework. In addition to internally managing expectations, the DHB will need to demonstrate responsiveness to (or valid, comprehensible reasons why it can not meet) consumers' demands for change.</p>
<b>7</b>	<p><b>Budget Implications</b></p> <p>Planning and Funding and Quality Department have budgeted funds to meet costs through to the end of 2010-11. The total cost of developing the Online Panel (\$22,000), the monthly hosting fee (\$5,000 for each of May and June) and running the first activity through it (the CHIP survey at \$11,000) will be approximately \$43,000. For 2011-12, the Quality Department is reallocating funds from the current patient satisfaction survey (which is to be discontinued) to meet the base costs of maintaining the online community. Costs of running one-off engagement activity through the online community will be met through project budgets (as is current practice). Budget to meet the costs of the training Consumer Representatives training Consumer Representatives has been budgeted within the Quality Department's proposed budget for 2011-12. Hosting Consumer Representatives on a project team will be met through project's engagement budget.</p>
<b>8</b>	<p><b>Regional / National Implications</b></p> <p>Counties Manukau DHB has a Community Panel which was formally evaluated during 2010 and found to have both strengths and weaknesses. Waitemata DHB has a formal relationship with "Health Links", which works well to distribute information from the DHB to community representatives across the district and feed information back to the DHB. Health Links also trains consumer representatives WDHB and it is an option that they be paid to train consumer representatives for ADHB too (but we may undertake to train consumer representatives so we are able to tailor the training package and save on costs). Both WDHB &amp; CMDHB are interested in developments at ADHB, particularly the online community and its potential to be expanded across the region once it gets up and running (the online community is scalable).</p>
<b>9</b>	<p><b>Appendices available on request</b></p> <p>Steering Group minutes and project team progress reports.</p>



## **FOR INFORMATION**

### **9.1 Residential Respite Care**





Denis Jory to  
action

18 April 2011

Mr Garry Smith  
Chief Executive Officer  
Auckland District Health Board  
P.O. Box 92 189, Greenlane  
AUCKLAND 1142

Dear Garry

**Increased Flexibility - Residential Respite Funding**

As you are aware funding was allocated in 2009 to increase the availability of residential respite care beds for older people on an ongoing basis. DHB's put some of this funding into action in the 2010 calendar year but a progress report to the Minister clearly showed varying levels of service delivery despite the funding being made available to each DHB.

On 12 April 2011 we updated the Joint Oversight Group (JOG) on the Minister of Health's decision following an assessment of the 2009 residential funding initiative.

We have taken DHB feedback into consideration and the Minister has decided to allow greater flexibility in the way funding is used to provide respite care for older people. In return for this greater flexibility we expect improved planning and an increase in the provision of respite care. You will need to clearly show how you intend to fully utilise the funding with specific target volumes for respite care options. For these targets to be meaningful we will also need your baseline figures for 2010/2011.

As an example, your respite care plans for older people in 2011/2012 could include the following:

- XXX occupied residential respite bed days
- XXX hours of in-home residential respite for older people with dementia
- XXX places for community day programmes targeted to older people with dementia
- Information and support provided to carers to ensure greater utilisation of allocated
- 90% of allocated respite care is utilised

In the coming weeks, as we work through the annual plans with you, we will discuss your respite care arrangements for older people.

Yours sincerely

Michael Hundleby  
Deputy National Director / Director - DHB Performance  
National Health Board

cc: DHB Funding & Planning Managers





# *10*

## **CONFIRM**

**10.1 Action Points for next DSAC Meeting**

**10.2 DSAC Feedback to Board**

**Use Forms at beginning of Meeting Pack**

# *11*

## **GENERAL BUSINESS**



# *12*

## **APPENDICES**

### **12.1 Report from Health Workforce New Zealand**





Level 2  
 1 The Terrace  
 Wellington 6011  
 New Zealand  
 PO Box 5013 Wellington 6145

**EMAIL** [info@healthworkforce.govt.nz](mailto:info@healthworkforce.govt.nz)

**FAX** +64-4-496 2191

**WEB** [www.healthworkforce.govt.nz](http://www.healthworkforce.govt.nz)

Dear colleague,

The first tranche of workforce service reviews have reported their findings and recommendations to the Health Workforce New Zealand (HWNZ) Board. These reviews, being overseen by HWNZ and driven and managed by clinicians across the country, have the potential to deliver some of the most significant shifts in how health services are delivered for decades. There is no alternative but for this series of reviews to achieve major change – with increased demand for health services expected to significantly outstrip projected increases in funding; the status quo is not an option.

The reviews, currently being undertaken in 12 service areas, were initiated when individual clinicians began to question the make up of the future workforce and to suggest some options for new ways of working. The leadership, commitment and trust shown by members of the review teams has fostered new and collaborative thinking about more effective delivery of patient-centred services.

HWNZ has provided the project support for the 12 review groups to describe their vision of the 2020 workforce. Operating as multi-disciplinary think tanks, over a 16-week period each group is preparing scenarios for how people will work and services will be delivered in an environment where resources are more limited but quality and outcomes are maintained or improved.

This work has required courageous and innovative thinking to construct options that can then be scoped further with colleagues and analysed, modelled and tested. The first five review groups – in eye health, palliative care, aged care, anaesthesia and muscular skeletal – are now setting out their thinking so that the projects can move to that next stage. A summary of their findings is attached.

The attached diagram outlines the review process, starting with small think-tanks generating scenarios which are then further developed and analysed by HWNZ, supported by clinicians and other sector experts. The scenarios are subject to financial modelling and scrutiny for alignment with health priorities and emerging models of care.

At this phase we are seeking the wider views of the sector as to how to progress the development and testing of the recommendations arising from the think tank stage. Contributions are invited from sector partners, such as those working in the specialties, professional bodies, regulators, education and consumers.

HWNZ is particularly interested in hearing from people in the sector who have experience in the types of innovations proposed by the reviews. Please contact us through [innovations@healthworkforce.govt.nz](mailto:innovations@healthworkforce.govt.nz).

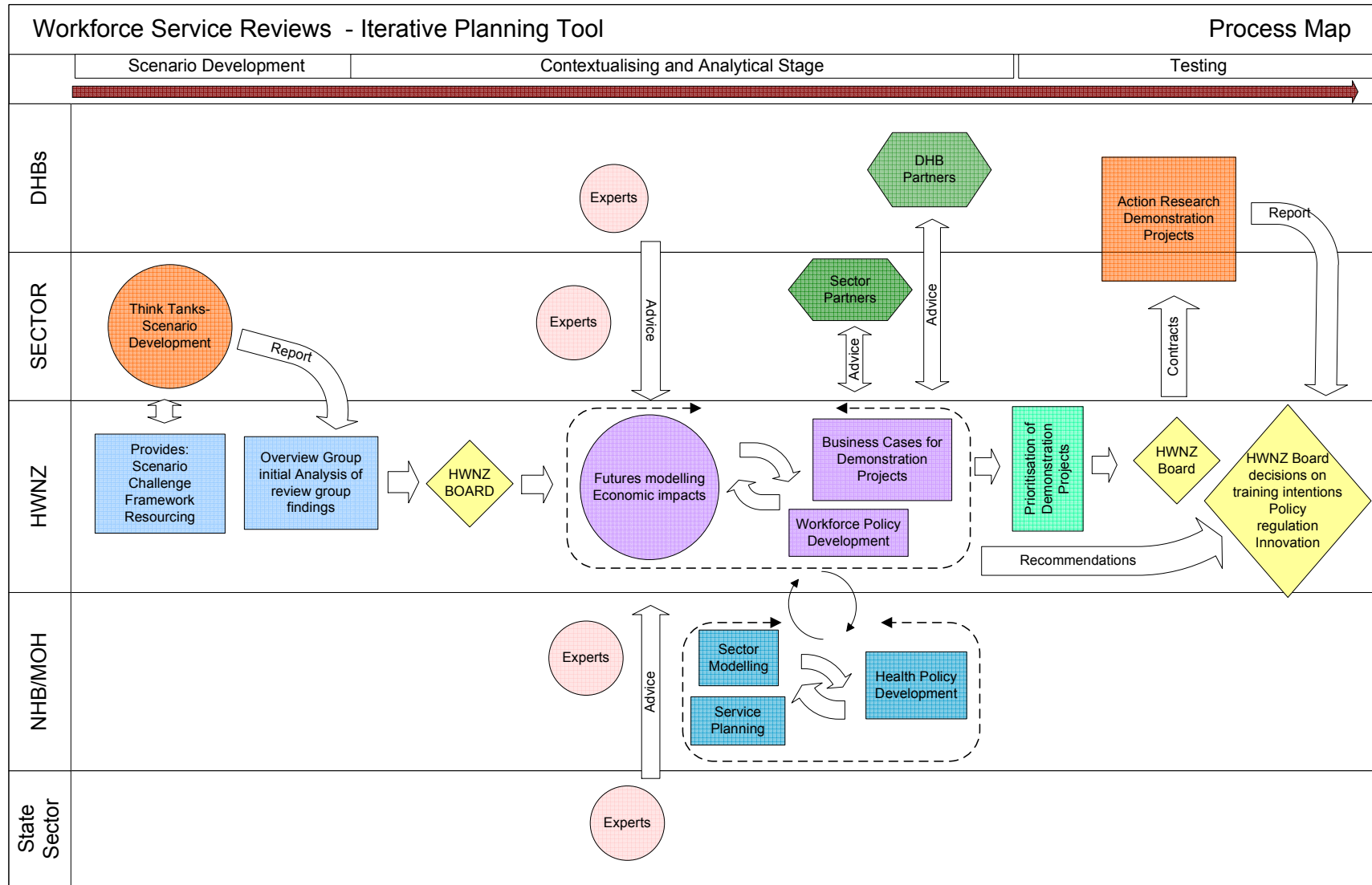
The subsequent phase involves the establishment of demonstrations of new scopes, roles and ways of working emerging from the reviews in sites across the sector. The ideas and recommendations will influence HWNZ's investment strategy, leading on to longer term changes in workforce training, development and skill mix. Their insights also provide an opportunity to shape National Health Board service planning. Some of the work arising from this stage will be policy issues for the Ministry to consider as part of its work programme.

It is an iterative process and unlikely to be a straightforward or easy one. The projects are ambitious and the pace to date has been challenging. Each think tank has done a remarkable job to develop a vision for the future that can be put to the sector and can provide a platform for change.

An independent evaluation by the Australian Health Workforce Institute is underway in parallel and will inform the process.

Professor Des Gorman  
 Executive Chairman  
 Health Workforce New Zealand







## Aged Care Workforce Service Review

### Lead: Dr Ray Naden

The review group adopted a 'whole of systems' approach to the health of older people, looking at the range of factors which impact on the health of older people and the relationships between them. These include the **needs** of older people themselves, the **services** which exist or are required to meet these needs, and the **workforce** which provides these services.

More of the same will not meet the challenge of increasing demand with finite services. It will be necessary to provide more of *some* existing services as *more* older people will require them. However, it will also be necessary to innovate to provide for some needs in ways that are significantly different to current services. The system of the future will have to be well-integrated, rather than a range of discrete or "siloed" services as they are currently.

A number of common themes were identified:

- It is vital to prevent or delay loss of function
- There needs to be more community-based responses to acute needs
- Rehabilitation for those people with significant potential for restoration of function must be active and rapid
- People should be supported in their homes where possible (through supporting self-care, informal carers, etc)
- Disruption of older people's normal routines and self-management should be avoided as far as possible (e.g., where possible bringing services to people rather than moving them to the service, and especially avoiding people being away from home overnight)

To have an aged care sector that is able to provide support services, to at least the current level and within a sustainable funding path, significant improvements will have to be made in preventive and rehabilitative care AND significant numbers of older adults will need to receive care in a community and primary care setting.

Shifts in the number of older people with acute care needs being treated in primary and community care settings can affect admissions to acute hospitals. Furthermore, when this scenario is combined with changing the nature and location of the service and/or the workforce providing the care, quite different future scenarios can be envisaged. However, this requires a large 'rethink' in what we currently consider to be community-based care facilities.

Shifts in the focus and deployment of skilled clinicians from DHBs to primary and community settings where they will support large numbers of formal and informal care providers will be a key strategy.

The funding and focus of residential care is currently on long-term care and support. Much more focus needs to be directed to preventative and rehabilitative care, with development of short-term service options.

Modelling indicates that it is possible to lower the rate of increase in older people accessing health services. For example, the improved preventative and rehabilitation care inherent within the 'healthier ageing' strategy could potentially reduce the number of older people needing long-term aged residential care.

The changes in the workforce required to support these changes include:



- More consistent focus on preventing and delaying loss of function and restoration of function where that potential exists (“caring for” cannot be simply “doing for”, which may be counter-productive if it leads to loss of potential capability).
- Focus on needs assessment and care planning (focusing on how to best meet the needs and optimise the potential of the individual rather than simply assessing their eligibility for available services)
- Co-ordination and active management of care plans with older people, so that the various and usually multiple components of their care plan are well-integrated (to be better sooner and more convenient for the consumer rather than for the provider). The role of care co-ordinator / health navigator needs to be developed.
- Building on the expertise of the small group of health practitioners (nurse practitioners, geriatricians, allied health professionals etc) with specialist expertise in care of older people, so that they focus increasingly on developing the capability of the wider health workforce, informal carers and older people themselves.

Several key enablers will be critical to the success of these models of care and workforce changes. They include:

- Enhanced information and communication technology (ICT) to ensure prompt and easy access to all of the information needed to provide quality care to older people. This includes access by older people themselves and anyone they choose to provide care for them.
- Flexible funding focused on supporting and promoting desired outcomes, models of care and innovations (for example, greater support for preservation and restoration of function rather than only long-term support for disability needs)

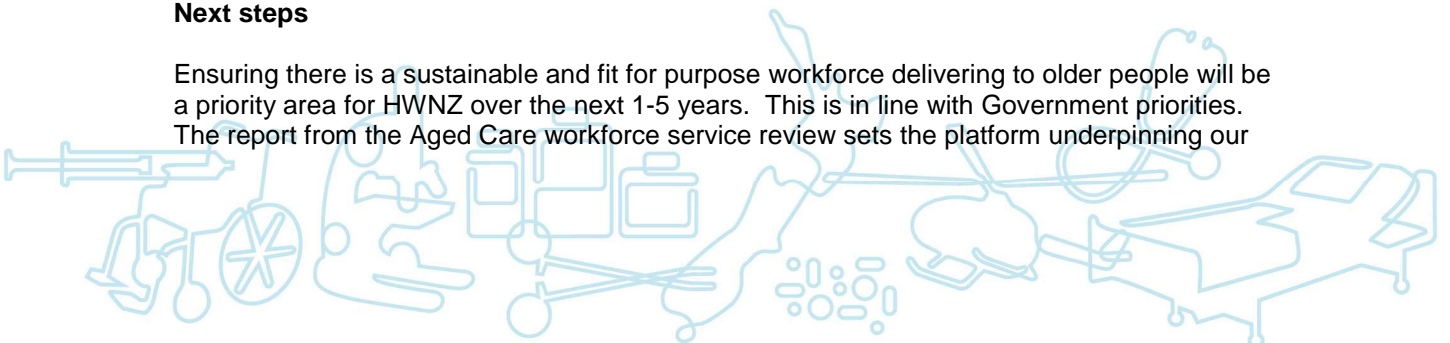
### Recommendations

It is recommended that:

- An increased focus is directed to home and community-based prevention and rehabilitative service options for older people, emphasising short-term interventions focused on maximising the potential for independence.
- More work is done to support formal and informal caregivers, especially in helping older people to maximise their own potential. It is recommended that specific training and development be provided to these groups with a ‘career path’ for formal caregivers who make up the bulk of the aged-care workforce.
- Clinical specialists in the needs of older people be seen as one of the major resources available and they need to focus on supporting increased knowledge and skills of other health and support workers in community and primary care. (“leveraging”) To do this the constraints that ‘tie’ people to a facility such as an acute hospital need to be looked at to facilitate the ‘transfer of expertise’ across different service locations.
- Service and facility design within acute care to be geared up to the needs of their major patient group i.e. people over the age of 65.
- Older people, because of their multiple needs, cut across many specialities and service locations. A key to enabling integrated care for older people will be to design and pilot a ‘network information strategy’ based on ensuring ready access to all data relevant to the individual person by anyone who needs this to provide optimal care.

### Next steps

Ensuring there is a sustainable and fit for purpose workforce delivering to older people will be a priority area for HWNZ over the next 1-5 years. This is in line with Government priorities. The report from the Aged Care workforce service review sets the platform underpinning our



next steps in this area. The strength of this report is its broad view of services provided to older people and the need to ensure these are working effectively to keep older people at a high level of functioning for as long as possible.

The next step for this review is to set up an internal HWNZ group with external advisors involved to assess what are our immediate and medium term priorities for action. This will involve working with other parts of the Ministry and with the DHBs to ensure we have joined up work programmes that deliver maximum benefit for the sector.

A report will be submitted to the HWNZ Board for consideration at its June meeting. Details on the aged care components of HWNZ's work programme will be released shortly after this.





# Disability Support Advisory Committee

## Agenda

<b>MEETING DETAILS</b>		
Time and Date	11:30 a.m. – 1:30 p.m. Wednesday 15 June 2011	
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre	
Members	Jo Agnew (Chair), Susan Buckland, Marie Hull-Brown, Dairne Kirton, Robyn Northey, Susan Sherrard, Nanar Tan.	
In Attendance		
Apologies		
In Attendance	Garry Smith, Dr Denis Jury, Janice Mueller, Ian Bell, Carolyn Simmons Carlsson.	
	<b>Item</b>	<b>Page No</b>
<b>1</b> 5m to 11:35 am	<b>Karakia</b>	<b>1</b>
<b>2</b> 5m to 11:40 am	<b>Attendance and Apologies</b>	<b>5</b>
<b>3</b> 5m to 11:45 am	<b>Conflicts of Interest</b>	<b>7</b>
<b>4</b> 5m to 11:50 am	<b>Confirmation of Minutes</b> - Wednesday 20 April 2011	<b>13</b>
<b>5</b> 5m to 11:55 am	<b>Action Points</b> - Wednesday 20 April 2011	<b>19</b>
<b>6</b> 10m to 12:05 am	<b>Chairman's Report</b>	<b>23</b>

<b>7</b> 10m to 12:15 am	<b>Improvement Activities</b> 7.1 DAP Projects Report	<b>25</b>
<b>8</b> 20m to 12:35 am	<b>Papers</b> 8.1 Update on the Implementation of the Disability Audit 8.2 Report from Health Workforce New Zealand 8.3 Consumer and Community Engagement Framework	<b>33</b> <b>37</b> <b>41</b>
<b>9</b> 15m to 13:05 am	<b>For Information</b> 9.1 Residential Respite Care	<b>47</b>
<b>10</b> 10m to 13:20 pm	<b>Confirm</b> 10.1 Action Points for next DSAC Meeting 10.2 DSAC Feedback to Board	<b>51</b>
<b>11</b> 10m to 13:30 pm	<b>General Business</b>	<b>53</b>
<b>12</b> 13:30 pm	<b>Appendices</b> 12.1 Report from Health Workforce New Zealand	<b>55</b>
<b>NEXT MEETING</b>		
<b>Date and Time: 2:00 p.m. – 4:00 p.m. Wednesday 21 September 2011</b>		
<b>Venue: Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre</b>		

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