DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC) MEETING  
22 August 2018

Venue: Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Papatoetoe, Auckland 
Time: 1.00pm

Committee Members
Colleen Brown – Committee Chair
Catherine Abel-Pattinson – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Katrina Bungard – CMDHB Board Member
Dr Lyn Murphy– CMDHB Board Member
Reece Autagavaia – CMDHB Board Member

CMDHB Management
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dana Ralph-Smith – General Manager, ARHoP
Vicky Tafau - Secretariat

APOLOGIES

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

AGENDA

1.00pm  1. AGENDA ORDER AND TIMING  

2. CONFIRMATION OF MINUTES

1.05pm  2.1 Confirmation of Previous Minutes of the Disability Support Advisory Committee Meeting – 22 November 2017  
1.15pm  2.2 Action Items Register

3. FOR DISCUSSION

1.30pm  3.1 Disability Strategy Implementation Update (Jenny Parr)  
2.00pm  3.2 Overview of Long Term Support Chronic Health Conditions Services at Counties Manukau Health (Dana Ralph-Smith)  
3.2.1 Appendix 1: Long Term Support Chronic Health Conditions Services Utilisation Analysis
2.30pm  3.3 Dementia Care Monitoring Discussion

4. PRESENTATION

3.00pm  4.1 Update: Safe Patient Handling and Mobility Programme at CM Health (Dana Ralph-Smith)  
4.1.1 Presentation

Next meeting: Wednesday, 3 October 2018
# BOARD MEMBER ATTENDANCE SCHEDULE 2018 – DiSAC

<table>
<thead>
<tr>
<th>Name</th>
<th>22 Aug</th>
<th>Sept</th>
<th>3 Oct</th>
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<td>Catherine Abel-Pattinson</td>
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<td>Colleen Brown (Chair)</td>
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<td>Katrina Bungard</td>
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<td>Lyn Murphy</td>
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<td>Reece Autagavaia (Deputy Chair)</td>
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## DiSAC MEMBERS’ DISCLOSURE OF INTERESTS
22 August 2018

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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<tbody>
<tr>
<td>Colleen Brown</td>
<td>- Chair, Disability Connect (Auckland Metropolitan Area)</td>
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<td>- Member, Advisory Committee for Disability Programme Manukau Institute of Technology</td>
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<td></td>
<td>- Member, NZ Down Syndrome Association</td>
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<td></td>
<td>- Husband, Determination Referee for Department of Building and Housing</td>
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<td></td>
<td>- Director, Charlie Starling Production Ltd</td>
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<td></td>
<td>- Member, Auckland Council Disability Advisory Panel</td>
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<td></td>
<td>- Member, NZ Disability Strategy Reference Group</td>
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<td>- District Representative, Neighbourhood Support NZ Board</td>
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<td>- Chair, Rawiri Residents Association</td>
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<td>- Director and Shareholder, Travers Brown Trustee Limited</td>
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<td>Catherine Abel-Pattinson</td>
<td>- Board Member, Health Promotion Agency</td>
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<td>- National Party Policy Committee Northern Region</td>
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<td>- Member, NZNO</td>
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<td>- Member, Directors Institute</td>
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<td>- Husband (John Abel-Pattinson), Director, Blackstone Group Ltd</td>
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<td>- Husband, Blackstone Partners Ltd</td>
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<td>- Husband, Director, Bspoke Ltd</td>
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<td>- Husband, Director, 540 Great South Ltd</td>
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<td>- Husband, Director, Barclay Suites</td>
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<td>- Husband, Chairman, Lifetime Design</td>
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<td>- Husband, Director, various single purpose property owning companies</td>
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<td>- Co-Chair, National Party Health Policy Committee</td>
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<td>Dianne Glenn</td>
<td>- Member, NZ Institute of Directors</td>
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<td>- Life Member, Business and Professional Women Franklin</td>
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<td>- Member, UN Women Aotearoa/NZ</td>
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<td>- President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust</td>
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<td>- Life Member, Ambury Park Centre for Riding Therapy Inc.</td>
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<td>- Member, National Council of Women of New Zealand</td>
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<td>- Justice of the Peace</td>
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<td>- Member, Pacific Women’s Watch (NZ)</td>
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<td>- Member, Auckland Disabled Women’s Group</td>
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<td></td>
<td>- Life Member of Business and Professional Women NZ</td>
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</table>
| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party  |
| Dr Lyn Murphy | • Director and Shareholder, Bizness Synergy Training Ltd  
• Director and Shareholder, Synergex Holdings Ltd  
• Trustee, Synergex Trust  
• Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
• Member, New Zealand Association of Clinical Research (NZACRes)  
• Senior Lecturer, AUT University School of Inter professional Health Studies  
• Member, Public Health Association of New Zealand  |
| Reece Autagavaia | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board  
• Member, District Licensing Committee of Auckland Council  
• Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation |
### DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 22 November 2017

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tbody>
<tr>
<td>Colleen Brown</td>
<td>Item 3.1 – NZ Disability Strategy</td>
<td>Ms Brown is on the Strategy Reference Group for the NZ Disability Strategy.</td>
<td>16 August 2017</td>
<td>That Ms Brown’s specific interest be noted and that the Committee agreed that she may remain in the room and participate in any discussion, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td>Item 3.1 – NZ Disability Strategy</td>
<td>Lyn Murphy works on the Case Management Degree at AUT.</td>
<td>16 August 2017</td>
<td>That Ms Murphy’s specific interest be noted and that the Committee agreed that she may remain in the room and participate in any discussions, but be excluded from any voting.</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Disability Support Advisory Committee
Held on Wednesday, 22 November 2017 at 1.00pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dianne Glenn
Katrina Bungard
Dr Lyn Murphy

ALSO PRESENT

Jenny Parr (Director Patient Care, Chief Nurse & Allied Health Professions Officer)
Dana Ralph-Smith (General Manager, Adult Rehabilitation & Health of Older People)
Dinah Nicholas (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present.

APOLOGIES

Apologies were received and accepted from Gloria Johnson, Catherine Abel-Pattinson and Apulu Reece Autagavaia.

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

There were no Specific Interests to note with regard to the agenda for this meeting.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

   An amendment to the minutes was noted on page 2 – should read ‘400 NGO organisations’ not ‘40 different MSD funded organisations’.

2.1 **Confirmation of the Minutes of the Disability Support Advisory Committee meeting held on 16 August 2017.**

   **Resolution** (Moved: Dianne Glenn /Seconded: Katrina Bungard)

   That the minutes of the Disability Support Advisory Committee meeting held on 16 August 2017 be approved.

   **Carried**

2.2 **Action Items Register**

   **Aligned Regional DiSAC ToR** – Colleen Brown confirmed that she had created a merged ToR document which she sent to Jo Agnew who has advised that the Board Chair has given this to the CEs to work through. Colleen will investigate further through the Board Chair.

   **Disability Provider Stocktake** – Lyn Murphy to look into whether AUT could undertake the stocktake of who provides disability services generally within the health sector, starting with what DSS provide (list and scope).

   **Disability Friendly Hospital Maps** – Colleen Brown advised that she has spoken to Phillip Balmer who has agreed to undertake an accessibility audit of the MMH campus facilities. Jenny Parr to follow up with Phillip Balmer and Chester Buller in relation to see where to from here and come up with a brief for the audit.

   **HQSC/Mid Central** – Colleen Brown advised that she had been in contact with HQSC in relation to what they did in conjunction with Mid Central to make their campus accessible for disabled people. HQSC advised that they just in fact reported on it and had nothing to do with funding it.

   **DiSAC Dates for 2018** – still a lack of clarity around dates for 2018.

3. **FOR DISCUSSION**

3.1 **NZ Disability Strategy Implementation Update** (Annelize de Wet)

   At their meeting on 16 August 2017, the DiSAC Committee endorsed the recommendation to work with Waitemata and Auckland District Health Boards to contribute CM Health community engagement and perspectives into a metro-Auckland approach to implementation of the New Zealand Disability Strategy. Following that decision a small working team was formed to undertake the work plan. The Counties approach is to undertake two community engagements in 2017:

   Event 1: Thursday 23 November, Te Roopu Waiora, Manukau
   Event 2: Thursday 7 December, MIT Pasifika Community Centre, Otara
An additional opportunity to attend a collaboration workshop facilitated by Disability Connect has been offered for 16 November.

In addition to the two engagement events, an electronic survey has been circulated through the disability network to allow for those who are unable to attend the events. This has been adapted from the Waitemata and Auckland DHB survey that was carried out earlier this year.

**Next Steps** - the results of the two engagement events and the electronic survey results will be provided to the DiSAC committee at its next meeting after 20 December 2017 and to WDHB and ADHB for contribution to the metro Auckland strategy in early 2018. In the interim, Counties Manukau Health continues to liaise with Waitemata and Auckland DHB.

**Resolution** (Moved: Colleen Brown/Seconded: Lyn Murphy)

The Disability Support Advisory Group:

**Endorsed** the current work plan of community engagement around the NZ Disability Strategy Implementation.

**Support** Counties Manukau Health to work with Waitemata and Auckland District Health Boards to produce a Regional implementation plan by circulating the survey and invitations to the two events to their networks and attending these where possible.

**Agreed** that at the first DiSAC meeting in 2018 the Committee receive written feedback on the two meetings and what this is going to mean for CMDHB for endorsement and circulation to the participants.

**Carried**

### 3.2 Overview of Long Term Support Chronic Health Conditions Services at CM Health (Dana Ralph-Smith)

Long term support chronic health conditions (LTS-CHC) services are provided through CM Health funded contracts to support people who have chronic conditions such as, but not limited to, renal failure, respiratory disease, diabetes and obesity. To be eligible for LTS-CHC services at CM Health the person should be:

- Aged under 65 on first presenting to NASC.
- Not eligible for Ministry funded Disability Support Services (DSS) or other DHB funded long-term support services (may be joint funded if has disability plus chronic health condition).
- Have one or more chronic health condition(s) that is/are expected to continue for six months or more.
- Have high need for long-term support services, defined as requiring assistance with activities of daily living at least once a day for five days a week to remain safely in their own home or needing residential care. Some or most of it may be provided by family, Whanau or friends.
- The person’s wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent.
- Does not have an informal/or natural support system (family/Whanau) or the caregiver is under considerable pressure and their ability to support the person is compromised.

Natural (unfunded) support is provided by family/whanau/friends to enable the person to remain as independent as possible.
Funded supports includes DHB clinical programmes and DHB funded/contracted services. DHB clinical support can come in the form of clinical services such as home health care, reablement, specialist assessment and treatment. Funded contracted service support can come in the form of home based support, day care, respite and carer support services. While these services are needs assessed they are not asset tested/restricted.

3.3 Deaths of Intellectually Disabled People (Dr David Hughes)

At a previous meeting, the Committee discussed a Radio New Zealand article from 6 March 2017 that noted that ‘the deaths of intellectually disabled people are being incorrectly recorded in Australia, research has found, and the same problem is likely to exist in New Zealand’. A team from the University of NSW found some people with Downs syndrome who had died of pneumonia or heart failure would have Downs syndrome written on their death certificate though the condition did not directly cause their death.

The Committee asked that a small investigation be undertaken to see what that turns up. Dr David Hughes undertook such investigation and reported:

- Across the whole of New Zealand, during 2014 (latest stats available), according to MoH statistics, there were 45 primary cases of death related to a disability:
  - 25 attributable to Cerebral Palsy
  - 15 attributable to Down syndrome
  - 4 attributable to unspecified mental retardation
  - 1 attributable to chromosomal abnormalities
- These categories come from and are recognised in the ICD-10 coding system.
- We should be identifying the primary cause of death, followed by the antecedent cause of death and then thirdly, the underlying cause of death.
- Doctors do not get a lot of training around completing death certificates.
- The Coroner’s Office was not particularly interested.

Next Steps
- Dr Hughes, on behalf of the Di SAC Chair and the Committee, to provide some feedback to the MoH:
  1. To update their Guideline and Training Package and encourage them to provide some correct examples regarding disability.
  2. That this issue has been shared regionally with the Auckland/Waitemata DHB DiSAC Chair and Committee.
  3. That this does not give people with disabilities much dignity in death and this is something that the DHBs will be advocating for (ie) that they have accurate diagnosis and explanation in death.
- Dr Hughes to ask MoH when they will be publishing more up to date data, most recent data is from 2014.
- Dr Hughes to provide feedback to the Committee in the New Year.

3.4 Experience of People with a Disability Accessing Mental Health & Addiction Services (Tess Ahern, Peter Watson and Marlene Verhoeven)

It was confirmed that there has been no funding reduction for Whirinaki.

Health indicators for New Zealander’s with an intellectual disability:

- 3560 people in the Counties Manukau district.
- Males have an average life expectancy of 59.7 years, which is more than 18 years below the life expectancy for all New Zealand males (78.4 years).
• Females have an average life expectancy of 59.5 years, which is almost 23 years below the life expectancy for all New Zealand females (82.4 years).
• Adjusted for age, people with an intellectual disability were approximately 1.5 times more likely to receive treatment for a chronic health condition than people without intellectual disability (ie) 31.5% of all people with ID.
• Māori had the highest age-adjusted rates of treatment for chronic health conditions, followed by Pacific, Asian and Other/European people.
• Compared to people without ID, people with ID were:
  o Over 3 times more likely to receive care or treatment for any type of mental disorder
  o Twice as likely to receive care or treatment for a mood disorder
  o 17 times more likely to receive care or treatment for a psychotic mental disorder
  o 10 times more likely to receive care or treatment for dementia
• The average cost per person with an ID of both primary health care and total health care was almost 3 times higher than the average annual cost per person for people without ID.

The Chair thanked the presenters for attending and providing a lot of great information to the Committee.

The Chair asked that a special letter of thanks be sent to Tess Ahern for attending the meeting today when she was on annual leave.

4. GENERAL BUSINESS

There was no general business.

The meeting concluded at 3.25pm.


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Colleen Brown, Committee Chair
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

**Disability Support Advisory Committee Meeting – Action Items Register – 22 August 2018**

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<th>DATE</th>
<th>ITEM</th>
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<tr>
<td>16.11.2016</td>
<td>3.1</td>
<td><strong>Eastern Locality –</strong> come back with an update on the Minor Adaptations project and an agreed pathway for requests.</td>
<td>xxx 2018</td>
<td>Penny Magud</td>
<td>xxxx.2018 - the agreed pathway for this continues to be via the Community Health Team, the team complete an assessment of need and ensure the adaptations are installed. Each Community Health Team funds the minor adaptations directly from the equipment budget.</td>
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<td>16.8.2017</td>
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<td><strong>Deaths of Intellectually Disabled People</strong></td>
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<td>Provide some feedback to the MoH:</td>
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<td>• To update their Guideline and Training Package and encourage them to provide some correct examples regarding disability.</td>
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<td>• That this issue has been shared regionally with the Auckland/Waitemata DHB DiSAC Chair and Committee.</td>
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<td>• Provide feedback to the Committee in the New Year.</td>
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<td>David Hughes</td>
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<td>22.11.2017</td>
<td>3.1</td>
<td><strong>NZ Disability Strategy Implementation</strong></td>
<td>Date TBC</td>
<td>Jenny Parr/</td>
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<td>Annelize de Wet</td>
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<td>22.11.2017</td>
<td>2.2</td>
<td><strong>Aligned Regional DiSAC ToR –</strong> Colleen Brown confirmed that she had created a merged ToR document which she sent to Jo Agnew who has advised that the Board Chair has given this to the CEs to work through. Colleen will investigate</td>
<td>Date TBC</td>
<td>Colleen Brown</td>
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<td>further through the Board Chair.</td>
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<td>16.8.2017</td>
<td>2.3</td>
<td>Contact Jo Agnew/Samantha Dalwood to see if they have tried to map/scope what disability services are available.</td>
<td>Date TBC</td>
<td>Colleen Brown</td>
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<td>16.8.2017</td>
<td>3.2</td>
<td><strong>Improving NZ Disability Data</strong> Contact Office of Disability in Wellington to find out who is doing the national data collection for disability.</td>
<td>Date TBC</td>
<td>Colleen Brown</td>
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<td>16.8.2017</td>
<td>3.5</td>
<td><strong>Disability Friendly Hospital Maps</strong> Contact Phillip Balmer to advise that the Committee would like to undertake an accessibility audit of the MMH campus facilities. Work with Chester Buller to write the brief for the audit. Contact HQSC to see what they did with Mid Central DHB to make their campus accessible for disabled people and see whether they are interested in doing a joint project with CM Health.</td>
<td>Date TBC</td>
<td>Colleen Brown</td>
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<tr>
<td>31.7.2018</td>
<td>ELT</td>
<td><strong>NZ Disability Strategy – CM Health Implementation Update</strong> Suggest to the DiSAC Committee that they make</td>
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<td>Jenny Parr</td>
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<td>a strong submission in relation to the Health &amp; Disability System Review being chaired by Heather Simpson.</td>
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Counties Manukau District Health Board
Disability Support Advisory Committee
New Zealand Disability Strategy CM Health Implementation Update

Recommendation

It is recommended that the Disability Support Advisory Committee:

Receive CM Health’s New Zealand Disability Strategy CM Health Implementation update.

Note the findings of the 2017 engagement events.

Note Appendix 2 to confirm agreement of implementation of these goals at Counties Manukau District Health Board.

CM Health will work with Waitemata and Auckland District Health Boards to produce a regional implementation plan of the New Zealand Disability Strategy and local action plan.

Prepared and submitted by Wendy McKinstry, Acting Director of Allied Health and Renee Greaves, Patient and Whaanau Care advisor on behalf of Jenny Parr, Director of Patient Care Chief Nurse and Allied Health professions officer.

Executive Summary

Under the direction of the CM Health Disability Advisory Committee, community engagement on the New Zealand Disability Strategy 2016-2026 was undertaken. Community engagement took place in November/December 2017 with a representation of the disability community of Counties Manukau, and this paper summarises these findings.

Consideration is now required into how the findings of the community engagement events may be incorporated into a regional metro-Auckland Disability Strategy Implementation Plan, potentially under a regional Disability Advisory Committee. It is important that CM Health continues to honor and act on what is important to the people of Counties Manukau, whilst contributing to the regional plan. Consideration needs to be given to the resourcing of the work plan related to the metro-Auckland Disability Strategy Implementation Plan.

Purpose

The purpose of this paper is to provide an update on community engagement undertaken in November/December 2017 with the disability community of Counties Manukau, on behalf of the Counties Manukau Health (CM Health) Disability Advisory Committee. This engagement was the first step in the formulation of the CM Health implementation of the New Zealand Disability Strategy 2016-2026. It also followed a similar engagement approach taken by Auckland DHB (ADHB) and Waitemata DHB (WDHB) earlier in 2017 with the aim of developing a metro-Auckland Disability Strategy.

Background

The New Zealand Disability Strategy 2016-2026 has a vision of New Zealand as a non-disabling society, a place where disabled people have an opportunity to achieve their goals and aspirations and all of New Zealand works together to make this happen.
The vision, principles and approach of the NZ Disability Strategy 2016-2026, along with input from the disability sector and disability community, will shape a Disability Strategy Implementation Plan 2016-2026 moving forward.

**New Zealand Disability Strategy 2016-2026**

![Disability Strategy Framework Diagram](image)

All eight outcomes noted in the Disability Strategy Framework (Figure 1) are relevant to the work of District Health Boards and will inform the focus areas over the next ten years. The five key outcome areas that most closely align with the work of District Health Boards and that will be the focus on are outlined in Figure 2.

![Key Outcomes Table](image)

**Figure 2 | Key Outcomes**

<table>
<thead>
<tr>
<th>Outcome 2: employment &amp; economic security</th>
<th>Outcome 3: health &amp; wellbeing</th>
<th>Outcome 5: accessibility</th>
<th>Outcome 6: attitudes</th>
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</tr>
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</table>

**ACTIONS TO BE DEVELOPED IN PARTNERSHIP WITH DISABLED COMMUNITY**
Influences

There are a number of other principles, disability strategies and action plans that influence CM Health’s Implementation Plan. These include:

- Te Tiriti o Waitangi
- Disability Action Plan 2014-2018
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- Faiva Ora: National Pasifika Disability Plan 2016–2021
- Counties Manukau Health Annual Plans

Values

CM Health’s values of Kotahitanga (Together), Manaakitanga (Kind), Rangitiratanga (Excellent) and Whakawhanaungatanga (Valuing everyone) are at the core of everything we do and the services we provide. They reflect a shared vision for equity and inclusion of disabled people in our care.

ADHB/WDHB approach

Acknowledgment is given to the extensive work already done by colleagues at Waitemata and Auckland DHBs (in particular Disability Advisor Samantha Dalwood), which has informed the approach taken at CM Health in the engagement around the New Zealand Disability Strategy.

CM Health community engagement on the NZ Disability Strategy 2016-2026

At the August 2017 meeting of the CM Health Disability Advisory Committee, there was a request for community engagement to be undertaken on the NZ Disability strategy, with a focus on engaging with the Māori and Pacific disability community. The approach taken at ADHB/WDHB was replicated with support from WDHB staff. An electronic survey was circulated, and two face to face engagement events held. Two local organisations that work closely with the Māori and Pacific disability community partnered CM Health by hosting these events. WDHB staff assisted with the engagement events, to provide regional consistency and sharing of knowledge.

Invitations to the two community engagement events and a link to the electronic survey were circulated electronically through existing internal and external communication channels in November and December 2017. This included the networks of the CM Health Consumer Council, and the CM Health Disability Advisory committee members and through CM Health social media pages, and internally through the Daily Dose. The two partner organisations; Vaka Tautua and Te Roopu Waiora, also circulated the invitation through their extensive networks.

The first event was held at Te Roopu Waiora. This came at the suggestion and through the existing relationship with the previous GM Māori, who had left CM Health at the time of this event. Thirty-five participants attended representing a diverse range of consumers and agencies from the Māori disability sector in Counties Manukau. Summary findings are found in Table 1 and full details of the findings are in Appendix 2.

The second event was co-hosted with Vaka Tautua at Manukau Institute of Technology facilities. Thirteen participants attended representing a diverse range of consumers and fanau from a range of Pacific communities within the disability sector in Counties Manukau. Summary findings are found in Table 1 and full details of the findings are in Appendix 2.
Table 1: Findings from the engagement events held in November and December 2017

| Event 1: Thursday November 23rd, held at the facilities of Te Roopu Waiora, Manukau | Event 2: Thursday 7th December, MIT Pasifika Community Centre, Otara. |
| Findings from this event included themes around; | Finding from this event include themes around; |
| 1. A lack of access to appropriate information | 1. Accessibility |
| 2. Environmental access | 2. Equity |
| 3. Attitude | 3. Attitudes |
| 4. Hospital ‘systems’ not meeting their needs | 4. Support systems |
| 5. Frustration at ongoing engagement with little change | 5. Hearing the voice of the people |

There were five responses to the electronic survey. Findings from the surveys were limited due to the low response rate. They did reflect similar themes to the engagement events;

1) Attitudes
2) Environmental access
3) Employment opportunities for people with a disability
4) Staff training

Summary findings from engagement events and survey

A diverse group of consumers (n=53) representing members of the disability community in Counties Manukau participated in the engagement events and electronic survey, offering a perspective of issues important to them. There was limited NZ European and Asian representation through the CM Health engagement events and surveys. Regionally these ethnic groups were well represented at the ADHB and WDHB engagement events. There is an opportunity to broaden the engagement to include a wider representation in the formation of the draft strategy and to continue working with the community groups who identified an interest in an ongoing relationship. The overall themes combined from the different events were:

1. Environmental accessibility
2. Access to information
3. Attitudes
4. Gaps in the system
5. Equity
6. A lack of support systems
7. Ongoing community engagement

These themes support the five key outcome areas of the New Zealand Disability Strategy 2016-2026, that align with the work of District Health Boards; Employment and Economic security, Health and Wellbeing, Accessibility, Attitudes and Choice and Control. The issues raised at CM Health were similar to the two other DHBs and the disability community in general. This means that the three Auckland DHBs are trying to improve in the same areas, which allows for development of collaborative work. ADHB and WDHB have already drafted an implementation plan (appendix 2). Further work will be undertaken to understand detailed alignment between the three metro-Auckland DHB findings and priorities.

Resourcing

At present there is no dedicated resource to support this work and it needs to be absorbed within existing work as a priority at CM Health. The engagement events were undertaken by staff from various divisions, and consideration needs to be given to resourcing future work around disability, including development and implementation of the draft regional Disability Strategy and work plan. The Chief of Allied Health, Scientific and Technical will continue to lead the implementation of the strategy.
Discussion

The community engagement approach was designed to contribute to a single regional Disability Strategy Implementation Plan which aligns with discussions about the formation of a metro-Auckland Disability Advisory Board. Prior to contributing CM Health findings, this report will be provided to the next CM Health DiSAC committee scheduled for August 2018.

There was strong feedback around the need for a local plan from the CM Health Consumer Council, as well as further involvement of the disability community in development of this plan and specific actions points and measures. Comment has also been made by the CM Health Consumer Council that the ADHB/WDHB implementation plan (Appendix 2) does not provide the required detail to consider CM Health alignment and potential contributions and this is acknowledged. Members are asked to specifically note Appendix 2 to confirm agreement of implementation of these goals. The regional Disability Strategy Implementation Plan will therefore be further refined and where necessary local implementation actions alongside an overall regional framework may be developed to meet the needs of the Counties Manukau Health community.

**Additional Note:** A suggested action from the Executive Leadership Team was that the DiSAC committee make a submission in relation to the Health & Disability System Review being chaired by Heather Simpson.
Appendix 1: Findings from community engagement events – CM Health Disability Strategy Implementation

Event 1: Thursday November 23rd, held at the facilities of Te Roopu Waiora, Manukau

Findings:

Areas they identified as requiring further focus included;

1. **Access To information that is appropriate**;

   **Written information**
   - Consider the forms/font size use, format and accessibility for those with different needs, there is no point sending hard copy letters to visually impaired, how can I read the menu or the appointment letters? website and digital information, this isn’t necessarily user-friendly
   - My own personal health information – how can I access my notes if I can’t read? i.e. vision impairment

   **Environmental access**
   - Environmental access, way finding signs, access to building (access is more than just providing a ramp)
   - Inadequate management of disability needs when in hospital e.g. mattress, beds, she will often end up sleeping in a wheelchair as equipment not available. We need this sorted on day one.
   - When last in hospital, e.g. basic maintenance required on doors to allow wheelchair access easily (the magnetic stick on the door was broken)
   - Not enough disability parking
   - Ensure there are enough people to help physically move patients and provide the care needed

2. **Attitude**
   - Are health care staff trained around disability, why can’t they learn a few basic signs to communicate with the deaf community?
   - Why can’t staff be inducted into the basics of working with disability, a ‘disability competency’ they need to meet? Also, they need to be taught how to work with people? Is it included in their training?
   - Would appreciate access to somebody who knows how to look after them, and additionally with lived experiences to support with ‘disability’ expertise. They could also support the health care staff to provide the right support. A good current example is of asking for Maaori support through Kaumatua, which is readily arranged, yet for disability there is nothing.

3. **Hospital ‘systems’ (not meeting the need)**
   - A need for consistency across the system, experiences can vary a lot.
   - Struggles with being under the ‘right’ medical team, so the correct people know the information they need, also finding the ‘right nurse’ to be able to provide the appropriate care.
   - Consider the language used, often we don’t understand what hospital and health care staff are saying because they talk in another language, how about talking in our language so we understand? We won’t always say we don’t understand because then we might look dumb.
The information below is a record of discussions (these were emailed out to Vaka Tautua for review and comments were made).

**Findings from small group discussion:**

1. **Accessibility**
   - Accessible parking at the front of the hospital is often used inappropriately by the public, as patients are being met and picked up.
   - Need more accessible car parks particularly on Middlemore site.
   - Toilets – need to have coat hooks lower down for wheelchair users
   - Dignity – when on a drip, you can’t wheel your wheelchair and get around, makes you dependent on others for care
   - Not a concern for all participants, but for some housing modifications can be tricky and they know of many families who have just ‘given up’ as it’s too hard to commit to where they will be living and to fill out all the paperwork. They can feel like they are passed between services/agencies and are a nuisance. Suggestions to streamline this.
   - One of the participants was aware of someone with a spinal injury being discharged to a rest home, and this is no place for a young person.
   - Another example is getting letters sent out that they can’t read, if they have vision problems, this is a privacy concern as they then have to ask someone else to read it for them.
   - In health there is a need to use the interpreters more often, and translate documents and forms, not everything needs to be electronic, as Pacific people, particularly older Pacific people, don’t necessarily have access to electronic information.
   - Staff need to use fewer big words when explaining things, Pacific people will generally nod and agree even when they don’t understand. They will then ask family/friends if they aren’t sure, so things can get lost in translation.

2. **Equity**
   - Waiting times appear too long for their medical appointments, as they often have more complicated medical conditions compounded by their disability.
   - Employment – not being treated fairly due to disability and employer attitudes
   - Lack of awareness of employment options for people with disability in the healthcare sector – perception that they would need qualifications
   - They did talk about having Pacifica staff caring for them as being very important, one participant spoke very fondly of her Tongan GP

3. **Attitudes**
   - Overall, they would like increased awareness of disability in the health sector, maybe training sessions for staff so they can understand more about different disabilities e.g. wheelchair knowledge for wheelchair users, and around employment – often there applications are rejected citing health and safety concerns, or perceived extra costs.
   - One participant talked about always having had a great experience from staff in the health services, she says it is because she is very articulate and can understand what is said, and says that isn’t always the same for others who struggle more with language and comprehension.
   - Patients disability is not always acknowledged e.g. if they are at an appointment for something else, the disability isn’t considered
   - Community attitudes: There was talk about struggles with attitudes within their own Pacifica communities, not necessarily their immediate families, but the ‘wider village’. There can be perceptions that disability is a ‘curse’, and ‘you have done something to get this’. This is a misunderstanding that has its origins in folklore and appears to be changing over time, but was very real for two of our group participants who had experienced this within the last three years. They have had experiences of this in many settings, including at church, so much so that they no longer
attend church as they felt they were being judged and laughed at by their own people. They acknowledged that these perceptions can come from ignorance, and that these are often learnt from parents, need to increase disability awareness in schools, churches – educate our own people!

- Staff need to ask before they make assumptions around culture or needs, treat you as an individual and be flexible. Often staff will explain things to the carer rather than the person, there is an assumption of cognitive disability with all impairments, and this is not the case at all!
- One participant stated he “just wanted to be loved and accepted for who he is now he has a disability.”

4. **Support systems**
- It’s hard to know what supports are available, and what you are entitled to.
- GPs aren’t always well informed either
- There can be an expectation in the Pacifica community that families will provide care to the disabled for free. Reliance on family for care, who maybe ageing and this care is not sustainable
- Having Pacifica people providing home care makes a big difference
- Transition from kids to adult services is a significant issue for many, they lose access to equipment, resources, care facilities, and this doesn’t appear to be co-ordinated
- Referral for services/equipment and wait times can be up to 3-4 months, would like to be able to track some of these things online.
- Need counsellors when people are discharged from the spinal unit, and more outpatient support, ongoing support is needed especially that with lived experience of disability.
- A comment was made around social workers needing more passion and commitment to supporting people.

5. **Hear the voice of the people**
- Language is often a barrier for surveys, particularly for the older Pacific community, surveys and forms are almost always in English.
- No real differences between the different ethnic groups, except language.
- Often have to “tell their story” multiple times to many health professions.

6. **What’s going well?**
- Text reminders for appointments
- Working with the carer and the patient for the contact
- Cultural support and disability peer support – need more of this!
- IF Funding – having the freedom and independence to employ your own caregiver
- Fanau being able to stay overnight
- Healthline/Plunketline – people not a voice message
- Relationship with the keyworker with ACC – this is pivotal, particularly for patients with spinal cord injury

7. **Suggestions**
The participants in this group had an idea of having a home for younger people with disabilities and families (like a rest home but for younger people) with mental health supports and practical support and fun. They also suggested a Disability Connector – who can support people on their journey through the health system, and support the transition from child health to adult health if needed.

There was an overwhelming response from participants at the second workshop that their needs to be more opportunities for community engagement, particularly around changes in the community and events such as these ones to inform changes and development of services, and the connection of disability services across the sector.

In regards to the event with Te Roopu Waiora event, the participant group expressed frustration at continual engagement with little change. They are weary of feeding their input to advisory groups, and would like their message to go to where it will make a difference. They see a need at three levels;
1) Political  
2) Decision making (DHB board level)  
3) Operational (frontline staff)  

The first priority for the group is for CM Health to talk to the community, particularly the Maaori disabled community, then to get the young, skilled disabled into employment, and to grow the leadership in the disability community alongside the decision making, resulting in ACTION, that is monitored by the community.
Appendix 2: ADHB/WDHB Draft Disability Strategy Implementation Plan

Health Literacy

The three District Health Boards have made a commitment to improve health literacy across their organisations. Health Literacy means that “people can obtain, understand and use the health information and services they need to enable them to make the best decisions about their own health or the health of a dependant family member/friend”

This work focusses on two areas:
- improving health literacy of both organisations and their staff
- enabling communities to become more health literate

Patient Experience

There is a focus on Patient Experience and Community Engagement across the three DHBs. This has led to greater inclusion of disabled people in design and planning of both facilities and services. Examples of this are the Public Spaces work at Auckland DHB and the Waitemata 2025 commitment to universal design as a core design principle. At CM Health there is an emphasis on co-design being undertaken in quality improvement projects and programmes, including co-design of the signage around Middlemore Hospital.

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Outcome 2: employment & economic security

We have security in our economic situation and can achieve our potential

1. Increase the number of disabled people into paid employment.
2. Increase the confidence of Hiring Managers to recruit disabled people.
3. Record the number of staff with impairments working for the DHB.
Outcome 3: health & wellbeing

We have the highest attainable standards of health and wellbeing.

4. Improve the health outcomes of disabled people.
5. Robust data and evidence to inform decision making.
6. Barrier free and inclusive access to health services.
7. Increased understanding of the support needs of people with learning disabilities.
8. Better understanding of the needs of Deaf people. This includes access to interpreters, information available in NZSL and knowledge of Deaf culture.
9. Better support for young people moving from child to adult health.

Outcome 5: accessibility

We access all places, services and information with ease and dignity.

10. Barrier free access to health services.
11. The principles of universal design and the needs of disabled people are understood and taken into account.
12. Improve & increase accessible information across the DHB.
13. People able to access information in formats that they prefer, eg. Easy Read
14. Ensure physical access to DHB buildings and services, including signage and way finding.

Outcome 6: attitudes

We are treated with dignity and respect.

15. All health and well-being professionals treat disabled people with dignity and respect.
16. Provide a range of disability responsiveness training.
17. Promote the Disability Awareness e-learning module to all staff across the DHBs.
18. Disabled people are able to access supports that they need in hospital.
19. Disabled people and their families respected as the experts in themselves.
20. Increase cultural awareness of disability.
### Outcome 7: choice & control

*We have choice and control over our lives.*

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<tr>
<td>21.</td>
<td>Engage regularly with the disability sector and community.</td>
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<tr>
<td>22.</td>
<td>Ensure a diverse range of disabled people are identified as stake-holders.</td>
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<td>Ensure the voice of disabled people from the community is included.</td>
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<td>24.</td>
<td>Supported decision making and informed consent.</td>
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<td>25.</td>
<td>Ensure services are responsive to disabled people and provide choice and flexibility.</td>
</tr>
<tr>
<td>26.</td>
<td>Improve access to screening services for disabled people.</td>
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<tr>
<td>27.</td>
<td>Continue the implementation of the Health Passport across both DHBs.</td>
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Counties Manukau District Health Board
Disability Support Advisory Committee
Overview of Long Term Support Chronic Health Conditions Services at Counties Manukau Health

Recommendation

It is recommended that the Disability Support Advisory Committee:

Receive an overview of Long Term Support Chronic Health Conditions (LTS-CHC) Services at Counties Manukau Health specifically focusing on the population that accesses these funded services, length of time using the services, costs to CMH and any trends observed

Prepared and submitted by Dana Ralph-Smith, General Manager Adult Rehabilitation and Health of Older People on behalf of Jenny Parr, Chief Nurse and Director of Patient and Whaanau Experience
LTS-CHC Long Term Supports Chronic Health Conditions
DSS- Disability Support Services
NASC-Needs Assessment Service Coordination

Purpose

The purpose of this paper is to provide a brief overview of the LTS-CHC service provided at CMH and in particular the to clarify the population that uses the LTS-CHC funded services, the time they use the services and the costs to CMH and any trends observed

Background

Populations Served

LTS-CHC service are provided through CMH funded contracts to support people between 0 – 64 years old who have chronic conditions such as (but not limited to) renal failure, respiratory disease, diabetes and obesity. The service is also used for a specific group of very medically fragile children. To be eligible for LTS-CHC services at CMH the person should be:

- Aged under 65 on first presenting to NASC
- Not eligible for Ministry funded Disability Support Services (DSS) or other DHB funded long-term support services (may be joint funded if has disability plus chronic health condition)
- Have one or more chronic health condition(s) that is/are expected to continue for six months or more
- Have high need for long-term support services, defined as requiring assistance with activities of daily living at least once a day for five days a week to remain safely in their own home or needing residential care. Some or most of it may be provided by family, Whanau or friends
- The person’s wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent.
- Does not have an informal/or natural support system (family/Whanau) or the caregiver is under considerable pressure and their ability to support the person is compromised.
LTS-CHC funded contracted service support can come in the form of residential care, home based support, day care, respite and carer support services. These services are needs assessed and the following restrictions may apply:

- Residential care clients are income tested only and those on a benefit are required to make a contribution to their care.

- Home Based Support Personal Care supports are not asset tested/restricted however Household Management supports are allocated to Community Services Card holders only.

- Daycare, respite and carer support are not income or asset tested.

**Average length of time LTS-CHC funding used**

Once assessed and accepted as eligible the LTS-CHC funding can be accessed life long as long as the individual has the confirmed on-going assessed needs and continues to meet the eligibility criteria.

**Costs to CMH and Trends observed**

The 2018/19 budget for LTS-CHC is currently $7,642,250. The spend for LTS-CHC service can vary widely dependent on number of complex clients presenting with assessed needs in that year and is highly unpredictable as they included medically fragile children and can include very complex medical adults with very high needs including 24 hours and sleep over cares. The number of clients on LTS-CHC does not fluctuate very much. The overall number of clients and hours provided is summarised in Appendix 1.

**Appendix**

Appendix 1 LTS-CHC Utilisation Analysis 2016-2018
Data from NRA utilisation report - March 2018

### LTS-CHC spend

<table>
<thead>
<tr>
<th></th>
<th>Community Residential</th>
<th>Home Based Support</th>
<th>Rehab and Community</th>
<th>Total for all services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>Q4 $779,638</td>
<td>$205,330</td>
<td>$21,549</td>
<td>$1,141,729</td>
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<tr>
<td></td>
<td>Q1 $842,914</td>
<td>$188,335</td>
<td>$44,056</td>
<td>$1,216,518</td>
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<td></td>
<td>Q2 $866,024</td>
<td>$240,327</td>
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<td></td>
<td>Q3 $875,178</td>
<td>$257,020</td>
<td>$57,018</td>
<td>$1,310,340</td>
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<td></td>
<td>Q4 $895,937</td>
<td>$279,212</td>
<td>$96,357</td>
<td>$1,392,767</td>
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<td>2017/18</td>
<td>Q1 $1,010,161</td>
<td>$293,582</td>
<td>$98,697</td>
<td>$1,508,857</td>
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<tr>
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<td>Q2 $989,534</td>
<td>$282,681</td>
<td>$98,697</td>
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<td>Q3 $908,881</td>
<td>$295,714</td>
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LTS-CHC spend includes pay equity settlement price increase.

### LTS-CHC Units (Hours/Days)

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<tr>
<th></th>
<th>Community Residential (days)</th>
<th>Home Based Support (hours)</th>
<th>Rehab and Community (days)</th>
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<tr>
<td>2015/16</td>
<td>Q4 5,387</td>
<td>8,484</td>
<td>45</td>
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<td></td>
<td>Q1 5,688</td>
<td>7,739</td>
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<td></td>
<td>Q2 5,850</td>
<td>9,881</td>
<td>92</td>
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<td>Q3 5,808</td>
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<td>Q4 5,831</td>
<td>11,353</td>
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<td>2017/18</td>
<td>Q1 6,016</td>
<td>11,270</td>
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<td>Q2 5,815</td>
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<td>Q3 5,435</td>
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<td>Year</td>
<td>Quarter</td>
<td>Community Residential</td>
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CM Health LTS-CHC Spend

CM Health LTS-CHC Units (Hours/Days)
Fact sheet

Monitoring the treatment of people detained in private aged care facilities

26 July 2018

On 6 June 2018, Justice Minister Andrew Little gazetted new responsibilities for the Chief Ombudsman in monitoring and inspecting the treatment of people detained in privately run aged care facilities.

This is an extension to the Chief Ombudsman’s OPCAT (Optional Protocol to the Convention Against Torture) mandate to ensure decent and humane treatment of people held in detention. It addresses New Zealand’s international obligations to have independent inspections.

This is the first in a series of fact sheets about a new monitoring programme. More information will be made available as the programme is developed over the next 12 months.

Why we are monitoring privately run aged care facilities

New Zealand has made an international commitment to ensure the fair treatment of people in its detention facilities. This includes people detained in privately run aged care facilities.

The Chief Ombudsman already monitors the treatment of people detained in state-run health and disability places of detention, including those detained in dementia facilities, to ensure these residents are not subjected to cruel, inhuman, or degrading treatment.

Extending the Chief Ombudsman’s mandate to monitor the treatment of people detained in privately run aged care facilities will provide New Zealanders and the United Nations with a good, independent overview of how some of our most vulnerable people are treated and what, if any, improvements need to be made.

How our monitoring will differ from current audits and reviews

The Chief Ombudsman is an Officer of Parliament, not part of government. His OPCAT monitoring and inspections programme is fully independent of government, the health and disability sector, and private interests.

The focus is on inspecting, monitoring and reporting to Parliament to prevent possible mistreatment of detainees. This includes examining the ‘lived experience’ of these particular residents; looking at how systems and policies affect them in their daily lives.

Current audits and reviews of the health sector ensure that systems and standards meet the requirements set by New Zealand. The OPCAT inspections and monitoring programme will
assess the **conditions and treatment** in places of detention to ensure we meet international human rights obligations.

**When will we start inspections**

Not for at least 12 months. We’ll be working on understanding the scope of our role over the next 12 months. Our planning will include engaging widely across the sector and industry bodies, visiting facilities, as well as talking to Parliament about the resources we will need to carry out our role effectively.

**What will be involved**

We expect that the new monitoring programme will be along similar lines to how we currently monitor other places of detention. That is:

- Conduct physical inspections of the facilities; a proportion of these will be unannounced
- A review of paperwork, policies and procedures, and complaint records
- Interviews with staff, residents (where feasible) and their families and representatives.

These will be done by our experienced OPCAT team that assists the Chief Ombudsman by inspecting the relevant places of detention. The team includes inspectors with various expertise and backgrounds in mental health and disability, social work, and prison operation and management.

A report is prepared following the inspections. The Chief Ombudsman’s reports highlight good practice, identify areas for improvement, and make recommendations where necessary. These are shared with those in charge of the facility, and are often tabled in Parliament and published on our website.

In some cases, our OPCAT team may do a follow up visit to the facility to find out how the Chief Ombudsman’s recommendations are being addressed.

We will let you know what exactly is involved once we have completed our planning.

**Who will pay**

The current facilities inspected under OPCAT (prisons and health and disability residences) are not required to cover the cost of inspections, as these are funded by Parliament. As a result, we will not be charging dementia facilities as part of the Chief Ombudsman’s OPCAT inspection and monitoring regime.

**More information**

- For the latest news and updates, follow us on Facebook: [https://www.facebook.com/Ombudsman-NZ](https://www.facebook.com/Ombudsman-NZ)
Counties Manukau District Health Board
Disability Support Advisory Committee
Update: Safe Patient Handling and Mobility Programme at CM Health

**Recommendation**

It is recommended that the Disability Support Advisory Committee:

- **Receive** this update on the current state of the Safe Patient Handling and Mobility programme at CM Health.

- **Note** the expected benefits of this programme for people with a disability and older people populations at CM Health.

**Prepared and submitted by:** Dana Ralph-Smith, General Manager ARHOP, on behalf of Jenny Parr, Chief Nurse.

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**Glossary**

- MMH  Middlemore Hospital
- SPHM  Safe Patient Handling and Mobility
- TROPHI  Tools for Risks Outstanding in Patient Handling Interventions

**Purpose**

The purpose of this paper is to provide an update to the Disability Support Advisory Committee on the Safe Patient Handling and Mobility (SPHM) programme at CM Health, including how this programme will improve health outcomes for people with disabilities, and any further plans for the programme in 2018/19.

**Executive Summary**

The Patient Moving and Handling Subcommittee is a subcommittee of the Clinical Government Group, tasked with the implementation of an organisation wide SPHM program that is robust and sustainable. Since recommencement of the project to carry out this implementation, the validated Tool for Risks Outstanding in Patient Handling Interventions (TROPHI) has been used in 14 ward areas to get a baseline assessment of the wards who confirmed their interest in partaking in this audit. Initial results highlighted three key areas for focus:

1. Safety Culture & Organizational Systems
2. Equipment
3. Education & Training

On-going communication with subject matter experts Dr Susan Gallagher (Author – “Implementation Guide to Safe Patient Handling and Mobility”, USA) and Dr Mike Fray (TROPHI tool consultant from Loughborough University, UK) has continued, and their contributions have heavily informed the direction of this programme. It is anticipated that their involvement will continue throughout the duration of the early implementation period, especially seeing as this programme will require significant tailoring to the unique population serviced by CM Health, including its patients with disabilities. Early discussion with Lynne Maher and Renee Greaves on seeking patient experience was sought prior to that information being collected as part of the baseline assessment (TROPHI tool).
Background

The fundamental purpose of the SPHM programme is to implement an organisation wide strategic management system for patient handling and mobilisation that will prevent and minimise staff and patient related harm and injury in the workplace.

Following discussion with Consumer engagement and Patient Whanaau Centre Care Board members Dr Lynne Maher and Renee Greaves, and subject matter expert Dr Mike Fray, initial baseline assessments have been compiled and used to develop the next steps forward. Ongoing work in the three key focus areas has seen progress unfold, especially in 2018, with early programme implementation anticipated to ‘go-live’ in the 2018/19 financial year. Significant work has gone into ensuring this programme, adapted from the Waitmeta DHB organisation wide moving and handling training and education programme, is tailored to the unique CM Health population which is growing both in total numbers and in age.

Discussion

Current Programme State and Future Plans for 2018/19

After identification of the three key focus areas, the following progress has been made.

1. Safety Culture & Organizational Systems
   - A draft policy and procedure document regarding SPHM and the ‘right to refuse’ operational process is under development and will need to be sent to Human Resources to be signed off.
   - A teleconference with Dr Susan Gallagher (author of “Implementation Guide to Safe Patient Handling & Mobility”) in early August 2018, highlighted the importance of developing and building a safety culture that influences a change in behaviour by staff towards SPHM. This will be fundamental to the self-sustainability of the programme. Dr Gallagher will visit MMH in November 2018 to discuss how to best approach this.
   - A particular discussion that has been had with Dr Gallagher is around how to best communicate with patients around what they can expect from the SPHM programme. It is thought this requires further co-design and discussion from consumers and their families/whaanau.

   **Note:** Dr Mike Fray will also visit MMH in November 2018 to discuss the TROPHI tool further and explain how it can be used in the evaluation process of the programme.

2. Equipment
   - Stocktakes of equipment for the wards who took place in the baseline TROPHI assessment is continuing. The purpose of this stocktake is to take inventory of the equipment specifically related to patient moving and handling that each ward has, how often they use it, where/how it is stored, and the condition of it as per the SPHM programme. This stocktake also provides an opportunity for staff to identify and make suggestions for any equipment that they think is needed.
   - Equipment required for the training room has been compiled and team members of the programme are exploring the availability of said equipment. Securing equipment for the permanent training room is ongoing, although it is anticipated that this will line up with the date that a training room is secured.

3. Education & Training
   - Training with Waitemata DHB has been agreed upon
   - 12 CM Health nurses and allied health professionals who were trained in using the TROPHI tool and assessed the 14 ward units are attending SPHM training at the Waitakere Hospital Simulation Lab in August, 2018.
     - Once trained they will be competent Moving and Handling educators and will commence training CM Health clinical staff
     - Moving & handling educators are also undertaking 3 days of adult education training
   - Ongoing progress is being made towards securing a permanent training room for CM Health staff. Ideally, this will be on-site at MMH and before the 18th of September; first training date.
Proposal
Impact on Health Outcomes for People with a Disability

CM Health services a diverse population in a variety of settings including in the hospital, community, and residential care facilities. Each setting comprises a significant portion of people who are likely to be disproportionately affected by patient handling and mobilisation related injuries due to increase dependency on health care workers, including people with disabilities and older people. It is understood that CM Health consists of a population that is not only growing in total numbers, but is ageing, and we are seeing increasing numbers of complex patients with various comorbidities. Subsequently, this programme has been developed with all of these confounding factors in mind, and intends to ensure that all patients, including those with a disability or of an older age, equitably benefit from the proposed initiatives. The anticipated impact this programme will have on improving the health outcomes and care for people with a disability or of an older age at CM Health can be understood by analysing the following outcomes.

- Having staff that are trained to use the appropriate equipment and support a safety promoting culture will ensure that all patients will be mobilised and handled using the right equipment/techniques, for the right patient, at the right time. This will reduce the amount of avoidable patient and staff injuries.

- For the staff, this programme will lead to less turnover and increase retention of specialist staff in specialist areas to appropriately handle and mobilise their patients. This will have positive impacts on patient outcomes.

- Patients with a disability who have increased dependency on health care workers and require multiple lifts or mobilisations throughout the day. Further, the older people population at CM Health will also benefit from this programme as they generally have higher levels of dependency, requiring mobility and handling assistance daily. It is expected that with the implementation of this organization wide programme, these highlighted patient groups will be less likely to incur a handling or mobilisation related injury which may have otherwise:
  - Lengthened their stay in hospital as a result of inpatient falls, pressure injuries, or other hospital acquired infections including pneumonias
  - Reduced their physical function
  - Negatively impacted on their level of independence

Such significant benefits cannot be ignored when planning to improve health outcomes and provide equitable health care to patients serviced by CM Health.

Conclusion

Ultimately, the intention for this programme is to propagate a substantially different safety culture and eventually embed SPHM into staff work profiles and thought processes. The successful implementation of this programme will provide benefits for both staff and patients at CM Health, especially those people with a disability.

Appendices

Appendix 1
Safe Patient Moving – Data and Next Steps PowerPoint presentation
Safe Patient Moving and Early Mobilisation

Early Review of Data and Implementation

Plan

COUNTIES MANUKAU HEALTH

Dana Ralph-Smith, GM

9 May 2018
Using the TROPHI ¹

- TROPHI (The Tool for Risks Outstanding in Patient Handling Interventions) was chosen to be used as our assessment tool.
- Assesses performance of domains aligned to our strategic programme and was a validated tool.
- Designed for use by clinical staff or those with base knowledge of patient handling with small amount of training.
- Allows reassessment to measure improvement over time.

The TROPHI Tool Domains

- Safety Culture of the Organisation
- Musculoskeletal Health of Staff
- Staff compliance and competency in PH
- Sickness absence of staff due to PH injury
- General Quality of Care (Patient Experience Survey)
- Incident and Accident reporting system (and estimated under reporting)
- Staff general psychological wellbeing/support
- Patient Condition (space and equipment availability vs needs)
- Patient Perception of the observed PH
- Musculoskeletal exposure and risk (patient dependency equipment used and other patient risk factors – behaviour/weight)
- Patient Injury-over 12 months including pressure injuries
- Financial implications of PH injuries/staff injuries/absence
# Ward Performance data from TROPHI

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Discussion of the data

- Meet with each ward clinical and managerial team to discuss data and work through a quality improvement plan
- Identify resource person(s) in that ward/service that will be a key contact to develop the communication information and quality improvement safety system for the ward/service
- Areas that are common that we can standardise beyond training?
First areas of change implementation

- Safety Culture
  - Policy and Procedures
  - Incident reporting and corrective action plans
  - Patient Assessment and Algorithms of care plans
  - Core trainers and service key resource people

- Equipment assessment
  - Stocktake and gap analysis
  - Procurement
  - Storage and Ergonomics

- SPH Competency Training
  - Trainers trained
  - Staff trained
Other Considerations

- Measurement and alignment with FOC audits
- Evaluation and ROI
- Ensuring sustainability
- Frontline leadership and part of BAU
Welcome to our PH improvement...Any questions?