# Counties Manukau District Health Board

## Disability Support Advisory Committee Meeting Agenda

**Wednesday, 24 August 2016 at 1.30 – 4.00pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>1.30pm</td>
<td>1. Welcome</td>
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<td>1.30 – 1.40pm</td>
<td>2. Governance</td>
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<td>2.1 Attendance &amp; Apologies</td>
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<td>2.2 Disclosure of Interests/Specific Interests</td>
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<td>2.3 Confirmation of Previous Minutes (1 June 2016)</td>
<td>7-14</td>
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<td>2.4 Action Items Register</td>
<td>15-18</td>
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<td>1.40 – 2.15pm</td>
<td>3. Reports</td>
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<td>2.15 – 2.45pm</td>
<td>3.1 Te Roopuu Waiora (Riki Nia Nia/Tania Kingi)</td>
<td>19-20</td>
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<td></td>
<td>3.2 Inpatient Experience Report No. 6 (David Hughes)</td>
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<td><strong>Afternoon Tea Break</strong></td>
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<td>3.00 – 3.30pm</td>
<td>3. Reports (continued)</td>
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<td>3.3 Regional Data Collection Pertaining to the Disability Community (Martin Chadwick)</td>
<td>27-28</td>
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**Next Meeting: 16 November 2016**

Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau
# COUNTIES MANUKAU HEALTH – DISAC ATTENDANCE SCHEDULE 2016

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<tr>
<th>Name</th>
<th>Jan</th>
<th>Feb</th>
<th>9 Mar</th>
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<th>May</th>
<th>1 June</th>
<th>July</th>
<th>24 Aug</th>
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<td>Dianne Glenn</td>
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* resigned effective 20.7.16
## COMMITTEE MEMBERS’ DISCLOSURE OF INTERESTS
### 24 August 2016

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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<tbody>
<tr>
<td><strong>Dr Lee Mathias, Chair</strong></td>
<td>• Chair Health Promotion Agency</td>
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<td>• Chairman, Unitec</td>
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<td>• Deputy Chair, Auckland District Health Board</td>
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<td>• Acting Chair, New Zealand Health Innovation Hub</td>
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<td>• Director, healthAlliance NZ Ltd</td>
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<td>• Director, New Zealand Health Partners Ltd</td>
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<td>• External Advisor, National Health Committee</td>
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<td>• Director, Pictor Limited</td>
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<td>• Director, John Seabrook Holdings Limited</td>
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<td>• MD, Lee Mathias Limited</td>
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<td>• Trustee, Lee Mathias Family Trust</td>
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<td>• Trustee, Awamoana Family Trust</td>
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<td>• Trustee, Mathias Martin Family Trust</td>
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<td><strong>Colleen Brown</strong></td>
<td>• Chair, Disability Connect (Auckland Metropolitan Area)</td>
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<td>• Member of 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>• Husband, Determination Referee for Department of Building and Housing</td>
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<td>• Chair IIMuch Trust</td>
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<td>• Director, Charlie Starling Production Ltd</td>
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<td>• Member, Auckland Council Disability Advisory Panel</td>
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<td>• Member, NZ Disability Strategy Reference Group</td>
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<tr>
<td><strong>Sandra Alofivae</strong></td>
<td>• Member, Fonua Ola Board</td>
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<td>• Director, Housing New Zealand</td>
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<td>• Member, Ministerial Advisory Council for Pacific Island Affairs</td>
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<td>• Member, Social Housing Reference Group</td>
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<td>• Independent Chair, Social Investment Board</td>
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<td><strong>David Collings</strong></td>
<td>• Chair, Howick Local Board of Auckland Council</td>
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<td></td>
<td>• Member Auckland Council Southern Initiative</td>
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<tr>
<td><strong>George Ngatai</strong></td>
<td>• Chair Safer Aotearoa Family Violence Prevention Network</td>
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<td></td>
<td>• Director Transitioning Out Aotearoa</td>
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<td>• Director BDO Marketing</td>
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<td>• Board Member, Manurewa Marae</td>
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### Counties Manukau District Health Board – Disability Support Advisory Committee

**Date:** 24 August 2016

- **Conservation Volunteers New Zealand**
- **Maori Gout Action Group**
- **Nga Ngaru Rautahi o Aotearoa Board**
- **Transitioning Out Aotearoa (provides services & back office support to Huakina Development Trust and provides GP services to their people).**
- **Chair of Restorative Practices NZ.**

### Dianne Glenn
- **Member – NZ Institute of Directors**
- **Member – District Licensing Committee of Auckland Council**
- **Life Member – Business and Professional Women Franklin**
- **Member – UN Women Aotearoa/NZ**
- **President – Friends of Auckland Botanic Gardens and Chair of the Friends Trust**
- **Life Member – Ambury Park Centre for Riding Therapy Inc.**
- **Vice President, National Council of Women of New Zealand**
- **Member, Auckland Disabled Women’s Group**
- **Member, Pacific Women’s Watch (NZ)**
- **Justice of the Peace**

### Reece Autagavaia
- **Member, Pacific Lawyers’ Association**
- **Member, Labour Party**
- **Member, Auckland Council Pacific People’s Advisory Panel**
- **Member, Tangata o le Moana Steering Group**
- **Employed by Tamaki Legal**
- **Board Member, Governance Board, Fatugatiti Aoga Amata Preschool**
- **Trustee, Epiphany Pacific Trust**

### Sefita Hao’uli
- **Trustee Te Papapa Pre-school Trust Board**
- **Member Tonga Business Association & Tonga Business Council**
- **Member ASH Board**
- **Board member, Pacific Education Centre**

#### Advisory roles:
- **Tongan Community Suicide Prevention Project (MoH)**
- **Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control)**
- **Member Pacific People’s Advisory Panel, Auckland Council**

#### Consultant:
- **Government of Tonga: Manage RSE scheme in NZ**
- **NZ Translation Centre: Translates government and health provider documents.**
- **Promotus GSL on Rheumatic Fever campaign (HPA)**
- **Taulanga U Society Rheumatic Fever Innovation project (MoH).**
- **Member, Ministerial Advisory Council for Pacific**
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions and Roles</th>
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</thead>
<tbody>
<tr>
<td>Wendy Bremner</td>
<td>• CEO Age Concern Counties Manukau Inc</td>
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<td></td>
<td>• Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH)</td>
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<td></td>
<td>• Member Interagency Suicide Prevention Group</td>
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<tr>
<td>Ezekiel Robson</td>
<td>• Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee</td>
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<td></td>
<td>• Be.Institute/Be.Accessible ‘Be.Leadership 2011’ Alumni</td>
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<tr>
<td></td>
<td>• Member, CM Health Patient &amp; Whaanau Centred Care Consumer Council</td>
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<tr>
<td>John Wong</td>
<td>• Director, Asian Family Services at The Problem Gambling Foundation of New Zealand (PGF), also part of the PGF national management team</td>
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<tr>
<td></td>
<td>• Member, National Minimising Gambling Harm Advisory Group</td>
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<td>• Chairman and Trustee, Chinese Positive Ageing Charitable</td>
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<td>• Chairman, Chinese Social Workers Interest Group of the Aotearoa New Zealand Association of Social Workers</td>
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<td>• Chairman, Eastern Locality Asian Health Group</td>
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<td>• Founding member and council member, Asian Network Incorporation (TANI)</td>
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<td>• Board member, Auckland District Police Asian Advisory Board</td>
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<td></td>
<td>• Member, Auckland and Waitemata DHBs Suicide Prevention Advisory Group</td>
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<td>• Board member, Manukau Institute of Technology (MIT) Chinese Community Advisory Group</td>
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<td></td>
<td>• Member, CADS Asian Counselling Service Reference Group</td>
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<td>• Member, Waitemata DHB Asian Mental Health &amp; Addiction Governance Group</td>
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<td>• Member, Older People Advisory Group (ACC)</td>
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<td>• Member, University of Auckland Social Work Advisory Group</td>
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<td>• Member, Community Advisory Group of Health Care New Zealand</td>
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<td>• Member, Auckland Regional Public Health Service – Asian Public Health External Reference Group</td>
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<td></td>
<td>• Member of the Advisory Committee for the School of Social Sciences &amp;Public Policy at AUT University</td>
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### 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 24 August 2016

<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>Mr Ezekiel Robson</td>
<td>Be.Institute</td>
<td>Mr Robson had a past interest with the Be.Accessible Leadership Alumi.</td>
<td>18 June 2014</td>
<td>That Mr Robson’s specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations or decisions.</td>
</tr>
<tr>
<td>Mr Ezekiel Robson</td>
<td>Item 3.1</td>
<td>Mr Robson is a current member of the DHB Consumer Council</td>
<td>26 August 2015</td>
<td>That Mr Robson’s specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations or decisions.</td>
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Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 01 June 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

<table>
<thead>
<tr>
<th>Auckland and Waitemata DHB Committee Members Present</th>
<th>Auckland and Waitemata DHB Staff Present</th>
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<tbody>
<tr>
<td>Sandra Coney (Chair)</td>
<td>Ailsa Claire</td>
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<tr>
<td>Max Abbott</td>
<td>Samantha Dalwood</td>
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<td>Jo Agnew (Deputy Chair)</td>
<td>Dr Debbie Holdsworth</td>
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<tr>
<td>Judith Bassett</td>
<td>Briga Krismayanti</td>
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<tr>
<td>Marie Hull-Brown</td>
<td>Fiona Michel</td>
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<td>Dairne Kirton</td>
<td>Tony O’Connor</td>
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<td>Dr Lester Levy</td>
<td>Corina Paterson</td>
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<tr>
<td>Jan Moss</td>
<td>David Price</td>
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<tr>
<td>Robyn Northey</td>
<td>Marlene Skelton</td>
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<tr>
<td>Russell Vickery</td>
<td>Kate Sladden</td>
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<td>Sue Waters</td>
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(Other staff members who attend for a particular item are named at the start of the respective minute)

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<thead>
<tr>
<th>Counties Manukau DHB Committee Members Present</th>
<th>Counties Manukau DHB Staff Present</th>
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<tbody>
<tr>
<td>Dr Lee Mathias (Board Chair)</td>
<td>Martin Chadwick</td>
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<td>Colleen Brown (DiSAC Chair)</td>
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<tr>
<td>Dianne Glenn</td>
<td>Director Allied Health Counties Manukau</td>
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<td>Mr Sefita Hao’uli</td>
<td>Health (DSAC Liaison)</td>
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<td>Ms Wendy Bremner</td>
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<td>Mr Ezekiel Robson</td>
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<td>Mr John Wong</td>
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<td>Arthur Anae</td>
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(Other staff members who attend for a particular item are named at the start of the respective minute)

<table>
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<tr>
<th>Guests</th>
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<tr>
<td>Toni Atkinson</td>
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<td>Group Manager, Disability Support Services,</td>
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<td>Ministry of Health</td>
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(Other staff members who attend for a particular item are named at the start of the respective minute)
1. **ATTENDANCE AND APOLOGIES**

   The Chair welcomed everyone to the meeting and asked that since it had been quite some time since the last regional meeting, that everyone around the table introduced themselves to the meeting.

   Apologies were received from committee members Sandra Alofivae, Jade Farrar and Reese Autagaviaia. Apologies for late arrival were received from Marie Hull-Brown.

   The apologies of Dale Bramley, Waitemata DHB Chief Executive were received.

   **Resolution:** Moved Sandra Coney / Seconded Jan Moss

   That the apologies be received.

   **Carried**

2. **CONFLICTS OF INTEREST** (pages 6 to 11)

   Russell Vickery advised he was temporary Acting Chair of the Wilson Home Trust from 13 June 2016.

3. **PRESENTATIONS**

   **3.1 People First Review Recommendations Implementation**

   **Presenter:** Toni Atkinson, Group Manager – Disability Support Services, Ministry of Health (MOH). (Attachment 3.3.1)

   Toni provided the background to the review of performance and quality management services of MOH funded providers of disability support services.

   An independent review was commissioned in 2013 by Minister, Tony Ryall, to review client and family complaints received by the MOH and to consider how to deal with such complaints. The review and all recommendations were accepted by the Minister in November 2013. There were 36 recommendations which evolved into 86 action points to be implemented over a two year period.

   Three working groups were established which included support providers to disabled people, with governance being through a Ministry steering group (including a Disabled Persons’ Assembly (DPA) representative).

   Key points were:

   **Recommendation 1:**
   - Establish a process to streamline contracting with outcome measures rather than outputs.
   - An annual provider forum would be organised across the country to share new and good practices beneficial to other providers.
   - A special edition disability support newsletter would be published each year on International Day of People with Disabilities.

   **Recommendation 9:**
   - To support development of a new model of more flexible support options which would give individuals more choice and options for community living. This has proved to be successful in Auckland and Waikato with Hutt Valley and Christchurch the next regions to be rolled out.
   - The introduction of Flexible Disability Support (FDS) contracts to 11 providers to offer support options for employing staff.
   - Purchasing guidelines are currently being updated for enhanced individualised funding to make funding more beneficial to individuals.
**Recommendation 10:** The MOH has implemented a two year intern programme. So far, four interns have completed the programme with three being in employment (two fulltime, one in temporary work). The MOH encourages DHBs to employ disabled people and to look at the way they employ people and the barriers which stop people applying for roles, such as requiring a driver’s licence.

**Recommendation 13:** The MOH has adopted a policy of ‘no tolerance for abuse’. It has developed guidelines which will be published on its website shortly. It is a practical guide for providers and others in the disabled space.

**Recommendation 14:** A consumer consortium meets twice a year to ensure that those who cannot speak for themselves (and their families) are fairly represented at forums.

**Recommendation 15:** To ensure disabled people are safe after laying a complaint. MOH requires providers to have policies and guidelines in place, to report any complaints to the Police and to ensure the resident is kept safe while an investigation is underway.

**Recommendation 16:** The MOH has set up an expert panel to review complaints of allegations of abuse and can co-op other specialists to assist with a review as required. A trial was run in March with the process to be reviewed later this year.

**Recommendation 22:** The MOH has developed new incident reporting forms and will provide guidelines to providers as to what constitutes an incident and serious misconduct. More sophisticated tools are being investigated to capture this data.

**Recommendation 28:** All evaluation agencies are to place routine evaluation reports on their websites.

**Recommendation 29:** Conduct ‘No notice’ issues-based audits where the MOH appears on the provider’s doorstep unannounced. The MOH has established criteria for ‘no notice’ audits which include complaints of cleanliness, the state of the facility, or an issue that needs to be addressed. The MOH is seeking to establish stronger links with the Police, CYFs and Housing NZ. The first RBA (results based accountability) results will be available in July. There is further work required in refining the outcome measures to be more useable.

Discussion was then invited from the floor.

- In answer to a question of, “How do we give more voice and participation in communities – what tools are different to give flexible options to people?”; it was advised that a new model had been introduced to give ‘independent facilitation’ and navigation of the local area to assist disabled people outside the system to connect with the community and obtain the support they require. Individualised funding will allow a person to take allocated funding and make it work for them to buy services, choose staff, pay staff, give flexibility when staff come, etc.

- A comment was made in regard to the consumer consortium; it was felt that the Police had an issue with young people who are non-verbal. They are brushed off as unreliable witnesses and this is why they have yet to bring any successful cases in these situations.

- Concern was expressed about incident reporting and how it was determined who was at fault. Where an incident occurs between a disabled person and staff, sometimes this is due to the incompetency of staff. Young people have large lists of incident reports where there are no witnesses. They are often labelled as violent but this may be due to the poor management by or competency of staff. It was acknowledged that autistic teenagers have unpredictable behaviours and that often they can become aggressive through frustration due to their lack of communication skill.

- It was felt that “enabling a good life” was not possible in the Auckland region. There was very little choice for autistic people. Parents do not have the same choice when it came to respite care or additional services. There is a lack of training in this area and it tends to have the most poorly paid people providing these services. Opportunities for training young people were discussed. Free services to providers for training are available. The MOH provide backfill while staff are training.
In answer to a question; “Does there need to be a complaint before the MOH undertakes an audit or are there regular audits and if so, how regularly are they undertaken?” It was advised that a residential provider with 5+ patients is audited regularly; however, there is no statutory requirement to audit smaller providers. Due to insufficient resourcing, MOH performs an audit on average, every three years. Work is being undertaken to look at regulating the frequency of audits for residential and aged providers.

John Wong cited an incident where a migrant family whose mother was in a rest home was being abused. The mother had told the daughter who had complained to the Chinese Ageing Trust. The daughter was afraid that if she reported the abuse, her mother would be further abused. John asked how the Trust could further support the family. It was advised that nothing could be done unless the family laid a formal complaint.

It was acknowledged that there was a challenge in what an auditor should be looking for when conducting an audit. The things that an auditor would look at are not always the things that are important to a resident or their families.

It was commented that it was often what was heard from the GP and other support carers that provided some clarity and quality to data collected.

It was acknowledged that there was a distance between MOH and DHBs at the operational level. It was questioned whether the model of distant commissioning was the right one in this instance. It was noted that the disabled community itself for some time had wanted it to be this way and did not want that direct relationship with a DHB.

It was advised that the MOH has Contract Relationship Managers across the country who have the required links into local regions to reach the disabled community.

The Chair thanked Toni Atkinson for making the time to come and address the joint committee and for her report which had generated such a robust discussion.

4. DISCUSSION TOPICS (Pages 13 to 102)

4.1 Current and Future Areas of Focus for each DSAC (Pages 13 to 30)

Martin Chadwick, Director Allied Health Counties Manukau Health (DSAC Liaison) spoke to his report advising that he had been working with the Disabled Action Group as to what it wants as an organisation and what specific things need to be looked at.

Areas to be focussed on are:

- Clinician literacy to enable staff members to understand what it is like to work alongside or with someone with a disability.
- The establishment of localities and getting disabled people and older peoples communities to be part of localities projects was a challenge.

It was noted that one of the key issues was the lack of data on disabilities which inhibits specific planning.

An open discussion followed to determine what areas the DiSAC groups could focus on.

- It was noted that there was a lack of clinician health literacy which was especially challenging in the disability sector and especially for those disabled people who sit outside recognised disability groups. It was agreed that a truly regional collaboration was required to deal with this issue. Auckland and Waitemata DHBs were working together to complete the current three year Disability Strategy Implementation Plan which has been split into five main areas to focus on. Samantha Dalwood (WDHB) advised they are waiting for the government review of the New Zealand Disability Strategy to be completed and key areas identified for the DHBs to develop their implementation plan for the next three years.
Resolution: Moved Sandra Coney / Seconded Jo Agnew

That the Regional Disability Support Advisory Committee:

1. Receives the reports.
   Noting that the focus of the Counties Manukau Health DiSAC for 2016 onward is on:
   - Monitoring progress on the initiatives underway around clinician literacy.
   - Monitoring the maturation of the Localities and Local Boards to be able to ensure the voice of the disability community is heard.
   - Learning from social media campaigns that have been undertaken by CM Health and to determine if there are any lessons that can be applied to raising awareness around the disability community.
   - Continuing to engage with Health Point and Health Navigator to ensure there is adequate representation of material pertaining to the disability community.
   - Building the focus on data as it pertains to the disability community.

   Noting that the five main works areas Auckland and Waitemata DHB are focussing on to ensure both are fully inclusive (as outlined in the 2013 – 16 Disability Strategy Implementation Plan) are:
   - Communication and Access to Information
   - Physical Access
   - Disability Responsiveness
   - Community and Consumer Engagement
   - Employment Opportunities

   Notes that Auckland and Waitemata DHBs have commenced work to develop the 2016-2019 Disability Strategy Implementation Plan

2. Supports there being a regional approach with the required resource allocated to support increasing consumer health literacy across the region.
   Carried

4.2 Collection of Data for Patients with Disabilities (Pages 31 to 34)

Martin Chadwick, Director Allied Health Counties Manukau Health (DSAC Liaison) spoke to his report advising that coding was being conducted in its own right utilising a very crude tool. This does not address the innate difficulties at a granular level or to understand exactly what is occurring.

Dr Doone Winnard was invited to make a short presentation. (Attachment 4.4.2)

Discussion was then invited from the floor.

- A Disability Data and Evidence Working Group has been established to focus on the lack of data. Contact has been made with Statistics New Zealand in order to get questions into relevant surveys. It was advised that there had been talk that there may not be specific questions relating to disability in the survey after the next census.

- A stocktake has been carried out to determine what information is held on people with disabilities and highlights current limitations. It has also provided a good summary of just what information is available.

- Some key questions were posed; “what are the core enduring questions in the disabilities domain?” and “what information is required to do the right thing for people to feel involved?” It was acknowledged that there was a need to think very clearly about what data is required. Data in itself will not change a situation unless it is used wisely.
• It was noted that there is disability data available but it raises more questions than it answers. The DiSAC committees need to engage with the Disability Data and Evidence Working Group in a way to ensure a regional and connected voice is heard.

• It was advised that some well attended disability workshops had recently been held across Auckland and in Hamilton. What was highlighted was that Pacifica people have quite a limited voice in the community as do older people who tend to distance themselves from disability. While the voices are filtering freely there is a requirement for strong thematic principles regionally owned and driven.

• Dr Doone Winnard said consideration needed to be given to whether we really knew what data we needed for good decision-making? Are we comfortable the decisions we are already making don’t already include disabled people? The situation is a complex one. Disabilities are so wide ranging and varied. A high level strategic view is required along with deep dives that provide granular detail. There is also the need to understand the role of prevention and be aware that some issues are disease related, aging and childhood prevention of rheumatic fever for example.

A discussion was had as to what the next steps for this group should be.

It was agreed that there needs to be a consistent approach across the Auckland region in the way data is collected. There was not a lot known about the Auckland population or how accurate the data is. Information is currently only collected in an adult space and then only used for specific purposes. No detail is collected, for example if a baby is diagnosed with a disability.

It was acknowledged that Auckland DHB does not know the numbers of staff with disabilities it employs. It was unlikely that Waitemata or Counties Manukau DHBs have this information either. The need for caution due to privacy reasons was noted when collecting information pertaining to staff.

It was agreed that for the DHBs to be an organisation of choice for disabled people, support needed to be provided. As a group there is a need to be clear of the objectives then ask Human Resources how to implement this. It was suggested that a small number of metro DiSAC committee members formulate a working group to work in collaboration with Human Resources departments to this end.

Resolution: Moved Jo Agnew / Seconded Diane Glenn

1. That the reports be received.

2. That the Auckland Metro DiSAC groups:
   2.1 Actively engage with the disability data and evidence working group
   2.2 Seek to understand how the need for better disability population data will be reflected in the review of the disability strategy.

3. That the Auckland Metro DiSAC groups recommend to their Boards that:
   3.1 The same method of data collection be employed across the three regional DHBs
   3.2 They investigate processes for the collection of the identified data about staff with disabilities.
   3.3 A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.

Carried
4.3 **Auckland and Waitemata DHB Patient Experience Reports** (Pages 35 to 44)

Tony O’Connor – Director of Participation and Experience Auckland DHB spoke to his report

David Price - Director Patient Experience Waitemata DHB was present to answer any questions about Waitemata’s work.

The survey received 3,000 responses with between 40-45% of patients having a disability. Patients with sight impairment struggled to complete the survey so it was suggested that future surveys be made accessible through screen readers.

The responses showed there was not a great difference between those with or without a disability, although those with a disability gave slightly lower scores. Good communication and confident health professionals who understood their patient’s requirements rated highly followed by accessibility (beds with motors, wheelchairs, staff availability and helpfulness). What appeared to matter most was good discharge and connection plans.

**Discussion was then invited from the floor.**

- Jan Moss questioned how the experience of autistic, severely disabled or non-verbal patients would be captured. It was acknowledged it would be a challenge to collect this data which required good connections into the disabled community. She suggested consulting with families with autism or a severe disability on their experiences, especially those with experiences of the emergency department.

- Ezekiel Robson shared a positive patient experience where staff had been flexible in recording a patient complaint. If a complaint to a DHB could not put in writing, people were happy to simply verbalise their complaint over the telephone provided it was given the same weight as a written complaint. In the end, it was all about the patient getting what they required.

**Resolution:** Moved Sandra Coney / Seconded Lee Mathias

That the report be received.

Carried

4.4 **Environmental Accessibility at Auckland and Waitemata DHBs** (Pages 45 to 102)

Tony O’Connor – Director of Participation and Experience Auckland DHB spoke to his report.

The key roles of the project are to ensure welcoming public spaces and the safe and comfortable movement around the hospital. This is based on what patients and families have related that they want the spaces to do for them and what is international best practice.

Completed to date is improved entry to the hospital, wheelchair bays now placed at the entrances of the hospital, a taxi telephone installed on L4 with improved signage, (this was not previously accessible for people in wheelchairs) and confusing signage removed from Reception on level 5.

**Discussion was then invited from the floor.**

- There needs to be a consistent look and feel across all the DHBs not just Auckland Hospital so that a common experience is provided.

- The question was raised whether the recommendations in the Be.Accessible report meet NZ4121 standards? Martin advised that Counties DiSAC don’t want to be code compliant, they want to exceed that. They are 1% away from attaining Gold status. Counties Manukau cautioned that this was an expensive exercise.
• Jan Moss commented that there were no dedicated changing places for incontinent or disabled young people in the regional hospitals. Families were confined to being only able to leave home for very short periods. It would be good if hospitals would consider that sort of facility.

• The question was raised as to what our strategy is for making sure all facilities are accessible. There was a time when hospitals had their own staff doing this. Samantha Dalwood advised that Waitemata DHB had eight members of staff attending Barrier Free training in June.

Resolution: Moved Sandra Coney / Seconded Judith Bassett

1. That the reports be received.

2. That the approach by Counties Manukau Health to test using an external agency to review facility accessibility.

Carried

5 GENERAL BUSINESS

Ezekiel Robson tabled an open invitation received from the Blind Foundation, Chief Executive on its, ‘Why Accessibility Matters Research Day’ seminar. (Attachment 5) This was an opportunity for staff and board members, leaders, researchers and policymakers to attend.

6 CLOSING COMMENTS

The Chair, Sandra Coney, closed the meeting and thanked everyone for attending. Sandra acknowledged that it had been a very useful and valuable meeting where learning was shared and an opportunity provided to work together to get some consistency across the region. Colleen Brown, Counties Manukau DHB DiSAC Chair reiterated that by working together in a complementary fashion, it would provide patients a consistency in experience and be cost effective.

Both Chairs undertook to meet to discuss next steps in how to make the most of opportunities that promoted a regional approach to disability support.

The meeting closed at 3.35 pm.

Signed as a true and correct record of the Regional Disability Support Advisory Committee meeting held on Wednesday, 01 June 2016

Chair: ___________________________ Date: ___________________________
Sandra Coney
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 – 24 August 2016

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tbody>
<tr>
<td>3.6.2015</td>
<td>2.5</td>
<td>Manawhenua community representative for this Committee.</td>
<td>On Hold</td>
<td>Mr Chadwick</td>
<td>3.6.2015 - deferred to Board Chair for follow-up with Manawhenua. 18.11.2015 – Dr Mathias confirmed that Manawhenua have identified a disabled Maaori representative and that this needs to be followed up with them. 5.8.16 – Board Secretary advised appointment on hold due to the local elections taking place in October.</td>
<td>✓</td>
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<tr>
<td>3.6.2015</td>
<td>5.</td>
<td>Mr Hao’uli suggested that a Pacific community representative with a disability focus be appointed to the Committee and he would step down.</td>
<td>On Hold</td>
<td>Ms Brown</td>
<td>This position has been approved by the Board chair. Ms Brown to now finalise how to appoint to the position. 18.11.2015 – Ms Brown to follow up with Mr Sefita Hao’uli on his suggestion that he step down to allow a Pacific representative with a disability focus to be appointed. 5.8.16 – Board Secretary advised appointment on hold due to the local elections taking place in October.</td>
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</table>
| 26.8.2015 | 3.1  | Disability Strategy – Community Dialogue GM Localities to return to DISAC in one year for an update. For discussion:  
- Who has the resources to plan, fund & undertake a current state & gap analysis of community groups and services per locality from a disability perspective;  
- Who can resource disability stakeholder engagement per locality for sustainable service design and development. | 24 August/16 November | Mr Chadwick     |                                                                                                        |          |
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<tbody>
<tr>
<td>18.11.2015</td>
<td>3.1</td>
<td>Clinician Capability – Work-plan findings and actions to be reported back.</td>
<td>1 June/24 August/16 November</td>
<td>Mr Chadwick/ Ms Wiseman</td>
<td></td>
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<tr>
<td>9.3.2016</td>
<td>2.4</td>
<td>Maaori Health Quarterly report against current work programme in relation to engagement with Maaori on disability issues.</td>
<td>1 June/24 August/16 November</td>
<td>Riki Nia Nia</td>
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<td>9.3.2016</td>
<td>3.2</td>
<td>DiSAC 2016 Focus Investigate if any outreach programmes are currently operating in schools to raise awareness around disability (ie) TASK/Kaleidoscope and look at how we can understand and influence what they do. Clinician Literacy – look into what Te Roopu Waiora are currently doing in relation to training Maaori with disabilities to go into hospitals to assist Maaori patients have a better interaction with doctors, nurses etc.</td>
<td>24 August/16 November</td>
<td>Mr Chadwick</td>
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<tr>
<td>9.3.2016</td>
<td>4.1</td>
<td>General Business Look into what the district health board’s process is in situations where a disabled person, who is medically dependent on an uninterrupted power supply, has their power disconnected by a lines company who had not been made aware of their dependency by the power provider.</td>
<td>24 August/16 November</td>
<td>Mr Chadwick</td>
<td></td>
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<tr>
<td>1.6.2016</td>
<td>4.2</td>
<td>Collection of Data for Patients with Disabilities Akld metro DHBs to form a small working group to: • actively engage with the disability data and evidence working group.</td>
<td>24 August</td>
<td>Mr Chadwick</td>
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 Counties Manukau District Health Board – Disability Support Advisory Committee

24 August 2016
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<td>to understand how the need for better disability population data will</td>
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<td>be reflected in the review of the disability strategy.</td>
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**Resolutions**

9.3.2016 3.2 DiSAC 2016 Focus

Resolution

Endorsed a focus on the local DiSAC for 2016 on:

- Monitoring progress on the initiatives underway around clinician literacy.
- Monitoring the maturation of the Localities and Community Boards to be able to ensure the voice of the disability community is heard.
- Learning from social media campaigns that have been undertaken by CM Health (ie) SnapChat smoking cessation initiative, positive peer pressure to reduce smoking around the hospital, and to determine if there are any lessons that can be applied to raising awareness around the disability community.
- Continuing to engage with Health Point and Health Navigator to ensure there is adequate representation of material pertaining to the disability community.
- Celebrating disabled employees.

Moved: Ms Colleen Brown/Seconded: Dr Lee Mathias/Carried: Unanimously

Mr Chadwick
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</thead>
<tbody>
<tr>
<td>9.3.2016</td>
<td>4.2</td>
<td>Resolution</td>
<td></td>
<td></td>
<td>16.3.16 – Resolution passed to the Board Secretary. 24.8.2016 - A letter to Ms Jude Sprott has been sent by the Board Secretary.</td>
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<td>That the Board send a formal thank you to Ms Jude Sprott, Service Manager, Spinal Unit Bairds Road for taking the Board and DiSAC members on a tour of the spinal unit on 9 March. <strong>Moved:</strong> Ms Colleen Brown/ <strong>Seconded:</strong> Dr Lee Mathias/ <strong>Carried:</strong> Unanimously</td>
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Counties Manukau District Health Board
Disability Support Advisory Committee
Te Roopuu Waiora

**Recommendation**

It is recommended that the Disability Support Advisory Committee:

**Note** that Te Roopuu Waiora has initiated a training pilot entitled Te Tohu Whakawaiora aimed at lifting the capability of the health workforce to improve health outcomes for our population with a disability.

**Invite** Te Roopuu Waiora to present the evaluation findings of the training pilot entitled Te Tohu Whakawaiora

**Prepared and submitted by** Riki Nia Nia, General Manager, Maaori Health

**Executive Summary**

Strengthening the capability of our workforce to work effectively with whaanau haua (disability) must be a priority for our system if we are to achieve health equity for our population.

To enable this from a disability perspective, Te Roopuu Waiora has initiated a training pilot entitled Te Tohu Whakawaiora. The aim of Te Tohu Whakawaiora (Certificate in Healthcare Capability, Level 3) is to raise the capability of our workforce to improve Maaori health outcomes through a better understanding of Tikanga, Te Reo, Te Tiriti o Waitangi/the Treaty of Waitangi and cultural competence from a whaanau haua perspective.

The programme is delivered in three modules:

- **Module 1: The Treaty and Healthcare**
- **Module 2: Tikanga and Healthcare**
- **Module 3: Cultural Competence and Healthcare.**

**Purpose**

The purpose of this paper is to advise DiSAC of the Te Tohu Whakawaiora pilot being implemented by Te Roopuu Waiora between August 2016 – January 2017. The aim of the pilot is to test the effectiveness of the training and development approach being taken to raise the capability of our workforce to improve Māori health outcomes

**Background**

Te Roopuu Waiora is a consumer based, kaupapa Maaori organisation founded and governed by whaanau experiencing a range of disabilities – whaanau haua. In 2015, the endeavor to develop a staff training programme aimed at lifting cultural competency within the health system from a disability worldview commenced. With support from CM Health, Te Roopuu Waiora formed a working relationship with Skills Active Aotearoa (ITO) – an industry training organisation. Together these groups have developed the NZQA certified course in Capability in Healthcare from a Whaanau haua perspective.
Programme Overview

What makes this course unique is that it provides learning and intelligence associated with cultural competency from a whanau haua worldview and is offered by a team of whanau haua representatives from various disability groups.

The full course is delivered over four to six months (flexible). There is approximately 20 hours of self-directed study and one 4 hour workshop per module (3 in total), concluding with an overnight waananga (marae based learning and assessment). All workbook materials provided to course attendees, along with individual support from course facilitators if required. Web based and e-resources are available. The course learnings are assessed by trained assessors who are frequent users of health services and leaders in the Maori disability community. The programme is supported by Mana Whenua i Tamaki Makaurau. The NZQA Assessors are trained by Skills Active Aotearoa.

20 students from across the local health system have been accepted into the first training pilot. The pilot commenced on the 2nd of August, 2016. A comprehensive evaluation report will be available to DiSAC in the future.
Counties Manukau District Health Board
Disability Support Advisory Committee
Patient Experience Report

Recommendation

It is recommended that DiSAC:

*Receive* the Patient Experience Report with a focus on Disability.

**Prepared and submitted by:** Martin Chadwick, Director Allied Health

Purpose

To review the patient experience report with a disability focus.

Background

At the Regional DiSAC meeting it was noted that both Waitemata and Auckland DHBs have generated a patient experience report with a focus on people with disabilities. As we share the same provider of these reports there was the ability to make this a focus of a CM Health report.

Discussion

As an initial patient experience report with a disability focus, this now provides us with a baseline to compare future reports. The report itself should not be read in isolation, and until there are further reports to compare, it is difficult to draw definitive conclusions. That being said it is noted that the general experience of an individual in our facilities rated lower than a person without a disability, which does provide the impetus we have as an organisation to improve our clinician literacy around engaging with people living with a disability.

Appendix

Inpatient Experience Report No. 6
INPATIENT EXPERIENCE
SURVEY
Patients with disabilities

One in every two respondents to the Counties Manukau Health Patient Experience survey tell us they have a disability. For nearly three-quarters of these patients (73%), the disability is short term (less than six months) or only while they are in hospital. For one quarter (27%), the disability is long term.

Our inpatients with disabilities rate their overall care and treatment four percentage points lower than patients who do not have a disability. They also consistently rate us between two and six percentage points lower on the different dimensions of care that matter most to them. Most of these results are statistically significant.

The data in this report may help to provide an indication as to why patients with disabilities rate our care and treatment lower than other patients. While six out of 10 patients with disabilities say they are definitely given the support they are need whilst in hospital, the rest say they are only given support “to some extent” (33%) or not at all (10%). In addition to this, patients with disabilities say they are less likely to be talked to in ways they can understand, feel they have less time to discuss their health and treatment with clinical staff, are less likely to feel their views are taken into account and respected and are more likely to be given conflicting information by staff members.

Despite this, the majority of the patients who commented told us that, overall, we do a good job of caring for patients with disabilities. Many spoke very highly of their care and were very appreciative of the support and assistance they received. Having equipment available, particularly for those with mobility issues and arranging good follow up care and support were also singled out for appreciation.

The best information on how we can improve our service for patients with disabilities, however, comes from those who didn’t have such a good experience in hospital. These patients tell us that paying attention to the following things will improve the experience of those with disabilities whilst in our care:

- Offer support and help and when needed, particularly if assistance is required with personal cares such as toileting.
- Have equipment, such as wheelchairs, walking frames, shower seats, toilet seats, chairs, and specialised beds on hand and easily available, and ensure that patients know how to use them properly.
- Make sure there is a sound discharge plan in place and that good follow up care and support is available where needed.

David Hughes
Deputy Chief Medical Officer
Happened how the surgery went and what I would see a doctor and hear about think it was unrealistic of me to
because [a family member]."

"I really appreciate the notice on the wall to inform me where I was, what room and who my nurse was and how long her
shift was."

"All the people that took care of me ... blew me away. I did not for a moment feel unsafe ... Yo, the management need
to be proud of these truly caring people who took great pride in their profession and treated me like I was also someone
special ... "

"I particularly enjoyed the swift help by staff day and night. They were always on hand for any problem I may have been
experiencing."

**Rated overall care very good**

"Fantastic nurses in the kids’ surgical ward. The ward was warm and beds were comfortable. My child enjoyed the
playroom and liked how the doctors talked to her."

"The nurses ... were fantastic overall and worked very hard under trying circumstances..."

"Very friendly and professional staff. First class facilities. Provision of all dressings ... access to specialists, high standards of
hygiene etc.... NZ does not know how good they have it. Oh and all of this provided for free."

**Rated overall care good**

"The thing I found most useful is when you get staff that aren’t afraid to show you that they care as it makes you feel
human and understood. I liked it when they would joke with me and it was also nice when nurses were joking with each
other etc. as it makes for a way nicer environment to be in...."

**Rated overall care fair or poor**

"I did not see a doctor for over 24 hours after my surgery - and that was only because [a family member] chased one
down in the hall and demanded his attention. I had just had surgery - I do not think it was unrealistic of me to expect
that I would see a doctor and hear about how the surgery went and what happened."
**FOCUS ON DISABILITIES**

Our Patient Experience survey asks our patients to indicate if they have difficulty doing everyday activities because of a health condition or disability. One in every two (54%) tell us they have a long term (14%) or short term (40%) disability.

**PROFILE OF PATIENTS WITH DISABILITIES**

More than half of all patients (55%) with a disability have difficulty with mobility (walking, lifting or bending).

**TYPE OF HEALTH CONDITION OR DISABILITY EXPERIENCED BY PATIENTS WITH DISABILITIES (%)**

<table>
<thead>
<tr>
<th>Disability</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Mobility</td>
<td>55%</td>
</tr>
<tr>
<td>Using hands</td>
<td>15%</td>
</tr>
<tr>
<td>Intellectual</td>
<td>7%</td>
</tr>
<tr>
<td>Hearing</td>
<td>6%</td>
</tr>
<tr>
<td>Communicating</td>
<td>4%</td>
</tr>
<tr>
<td>Sight</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
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Four out of 10 patients with disabilities (43%) say they were not always given the support they needed in hospital.

**SUPPORTED WHILE IN HOSPITAL (%)**

- Always: 57%
- Yes to some extent: 67%
- Some: 67%
- No: 68%

**WHAT MATTERS MOST?**

The three things that matter most to patients with disabilities are communication (55%), being treated with compassion, dignity and respect (43%) and getting consistent and coordinated care (37%). This section looks at how we are performing on each of these dimensions for patients with disabilities.

**COMMUNICATION**

Communication ratings for patients with disabilities are, on average, three to four percent lower than for all patients. Statistically significant differences (p<0.05) are indicated with an asterisk (*).

**PERCENTAGE OF PATIENTS WHO SAY THE FOLLOWING STAFF TALKED TO THEM ABOUT THEIR CONDITION AND TREATMENT IN WAYS THAT MADE IT EASY FOR THEM TO UNDERSTAND**

- **Doctors**
  - Patients with disabilities: 69%
  - All patients: 73%
- **Nurses / Midwives**
  - Patients with disabilities: 68%
  - All patients: 71%
- **Administration**
  - Patients with disabilities: 63%
  - All patients: 67%
- **Allied health**
  - Patients with disabilities: 66%
  - All patients: 68%

**PERCENTAGE OF PATIENTS WHO SAY STAFF LISTENED TO WHAT THEY HAD TO SAY**

- **Doctors**
  - Patients with disabilities: 69%
  - All patients: 73%
- **Nurses / Midwives**
  - Patients with disabilities: 67%
  - All patients: 73%
- **Administration**
  - Patients with disabilities: 70%
  - All patients: 74%

**PERCENTAGE OF PATIENTS WHO SAY THEY HAD ENOUGH TIME TO DISCUSS THEIR HEALTH AND TREATMENT WITH CLINIC STAFF**

- **Doctors**
  - Patients with disabilities: 58%
  - All patients: 62%
- **Nurses / Midwives**
  - Patients with disabilities: 65%
  - All patients: 69%
- **Administration**
  - Patients with disabilities: 61%
  - All patients: 64%

**OVERALL RATING**

- **Very good**
  - Patients with disabilities: 12%
  - All patients: 65%
- **Moderate**
  - Patients with disabilities: 21%
  - All patients: 23%
- **Poor**
  - Patients with disabilities: 10%
  - All patients: 68%

65 per cent of inpatients with disabilities rate us “very good” on communication, compared with 68 per cent of all patients, however the difference is not significant.
COMPASSION, DIGNITY AND RESPECT

Patients with disabilities are less likely to feel that their views are taken into account, that they are treated with empathy, compassion, dignity or respect or that they have someone to talk to than all patients. Statistically significant differences (p<0.05) are indicated with an asterisk *.

PERCENTAGE OF PATIENTS WHO SAY THEIR VIEWS WERE TAKEN INTO ACCOUNT AND RESPECTED

Doctors* 74% 77%
Nurses / Midwives* 73% 77%
Allied health 78% 80%

Patients with disabilities: Doctors n=2050, Nurses/Midwives n=1722; Allied health n=1120
All patients: Doctors n=3714, Nurses/Midwives n=3159; Allied health n=1756

OVERALL RATING

78 per cent of inpatients with disabilities rate us "very good" on being treated with dignity and respect, compared with 80 per cent of all patients, however the difference is not significant.

EMPATHY AND COMPASSION

70% of patients with disabilities say they were definitely treated with empathy and compassion (compared with 74 percent of all patients). *

DIGNITY AND RESPECT

76% of patients with disabilities say they were always treated with DIGNITY AND RESPECT (compared with 79 percent of all patients). *

SOMEONE TO TALK TO

63% of patients with disabilities say they could talk to staff about any worries, fears or concerns they had about their condition or treatment (compared with 67 percent of all patients). *

CONSISTENT AND COORDINATED CARE

Patients with disabilities are more likely to say that they are given conflicting information by different staff members (when someone tells them one thing and another tells them something else), and do not score staff as highly on coordination as all patients. Statistically significant differences (p<0.05) are indicated with an asterisk *.

PATIENT RATINGS OF HOW WELL STAFF WORK TOGETHER

Doctors, nurses and midwives* Patients with disabilities 35 39 15 8 3
All patients 38 39 14 7 2

Allied health with healthcare team Patients with disabilities 35 38 17 7 3
All patients 37 38 16 6 2

Patients with disabilities: Doctors, nurses and midwives n=2213; Allied health n=1579
All patients: Doctors, nurses and midwives n=4121; Allied health n=2621

OVERALL RATING

69 per cent of inpatients with disabilities rate us "very good" on being treated with dignity and respect, compared with 71 per cent of all patients, however the difference is not significant.

PERCENTAGE OF PATIENTS WHO SAY THEY WERE GIVEN CONFLICTING INFORMATION BY DIFFERENT STAFF MEMBERS

Patients with disabilities 59 11
All patients 64 10

The differences are significant (p<0.05).
SUPPORT FOR PEOPLE WITH DISABILITIES

Overall, 857 patients with a disability commented on the support they were given whilst in hospital. More than half (69%) of the comments were positive, whilst 39 percent were negative (note that some respondents commented both positively and negatively, therefore the percentage adds up to more than 100%). The percentage of respondents who commented negatively or positively are in brackets.

STAFF AVAILABILITY AND HELPFULNESS

BEHAVIOUR WE WANT TO SEE (19%)

One in five patients with disabilities told us they appreciated the support and assistance they received from hospital staff, with most saying this was offered, rather than asked for, timely and helpful. For many it was the little things, such as being supported to walk to the bathroom or help to get in and out of bed that made the most difference. These patients also appreciated that staff made allowances for their disability, such as speaking slowly to people with hearing issues.

“When my son arrived the orderly noticed he was struggling to walk and brought over a wheelchair straight away.”

“They were aware I was deaf so spoke very clearly.”

BEHAVIOUR WE DON’T WANT TO SEE (11%)

The highest percentage of negative comments came from patients who felt staff made no allowance for their disability, or that help and assistance was not offered or available when they needed it. This was particularly problematic for patients who depended on staff help to use the toilet, shower or move around the hospital. A small number of these patients felt that staff were impatient, rude or disrespectful.

“That staff were careless with Dad’s hearing aids and many of them had no idea how to address someone with severe hearing loss. Didn’t place much importance on it in some instances.”

“(I called) the bell for assistance to get off bed to use the toilet and no-one came.”

EQUIPMENT

BEHAVIOUR WE WANT TO SEE (19%)

Many patients who commented positively on equipment said that it was suitable for their needs and available when they needed it, both in hospital and once they were discharged. Patients with mobility issues particularly appreciated access to wheelchairs, walkers and crutches. A number of patients commented that access to the right equipment made them feel more independent and expected it to aid their recovery.

“I got crutches, toilet, shower chair, chair and a hand rail for my bed. All of these things are badly needed when I returned home. If these weren’t supplied, I will probably experience more pain and longer recovery.”

BEHAVIOUR WE DON’T WANT TO SEE (8%)

Patients with disabilities commented negatively about the lack or unsuitability of equipment in hospital, such as hoists, shower chairs or crutches, or that they were not shown how to use equipment properly (e.g. bed controls).

“My son had surgery on his foot ... we have to carry him or he crawls... (I would have) thought they would offer crutches.”

Almost half of those who commented negatively about equipment did so because of the lack of wheelchairs, particularly on discharge.

“No wheelchair available when I was discharged, had to walk from ward to carpark with family.”

POST-DISCHARGE FOLLOW UP AND SUPPORT

BEHAVIOUR WE WANT TO SEE (8%)

Eight percent of patients commented that equipment was arranged and available for when they arrived home, they received prompt in-home or district nursing support and that they had good access to support staff such as physiotherapists and speech and occupational therapists or rehabilitation programmes.

“I received home visits from the district nurse and after day 2 it was arranged to have them visit at my place of work. This helped me to continue working and speed my recovery knowing I would not fall behind in my work. Not being able to be visited at work would have increased my stress levels. I am extremely grateful...”

“While in hospital I was visited by an OT who ensured that I had equipment needed when I returned home. The physiotherapist ensured that I was able to use crutches & she ensured that they were adjusted correctly for me.”

BEHAVIOUR WE DON’T WANT TO SEE (8%)

Patients commented negatively when they were unhappy with the follow up and support services after discharge. This included equipment being delivered late, or not at all and no or limited follow up from in-home support services. A number of patients commented that no one checked to see how they would cope at home and what support they might need. This was particularly an issue for people living on their own or those with family responsibilities (i.e. parents of small children).

“I live on my own, have two broken legs and was never asked how I would cope.”

“Home help was ordered they rang me twice but never turned up [and I had to get help myself].”

“I have a baby and basically have not been able to care for him as I simply can’t lift him [after my surgery, and] I wasn’t given any support or even advice.”
Counties Manukau District Health Board
Disability Support Advisory Committee
Regional Data Collection Pertaining to the Disability Community

Recommendation

It is recommended that the Disability Support Advisory Committee:

Recommend to the Board that:

• It notes that the Auckland metro DISAC committees will:
  1. Actively engage with the disability data and evidence working group
  2. Seek to understand how the need for better disability population data will be reflected in
     the review of the Disability Strategy.

• It notes that DISAC recognises that while there is the ability to collect and extrapolate population
  level data pertaining to the health needs of the disability community, there is not the same ability to
  collect and interpret this data at a granular level.

• It notes that any efforts to improve data collection around the disability community needs to be
  accomplished at a regional level for greatest applicability.

• A small regional working group be established to:
  1. Establish guidelines relating to the collection of data to support the DHBs to be good
     employers of people with disabilities.
  2. Quantify the meaningful data that would benefit from being collected pertaining to the
     disability community.
  3. Investigate processes for the collection of the identified data about staff with disabilities.
  4. Ensure the same method of data collection be employed across the three regional DHBs.
  5. Determine what information is currently being collected.
  6. Clarify what gaps exist between 1 and 2.
  7. Propose solutions to the prospective DHB Boards to improve the capture of data pertaining
     to the disability community.

• It requests CM Health Management to scope the resource needed by CM Health to contribute to such
  a working group.

Prepared and submitted by: Martin Chadwick, Director Allied Health

Purpose

To maintain a focus on the issue of limited specific data pertaining to the disability community within
CM Health.

Background

At the Regional DISAC meeting it was noted that there is an ability to use population level data to
extrapolate and make assumptions around the level of disability within our resident community. What
was further noted was that current systems and processes do not easily enable the collection of data
around disability issues.

Discussion

This lack of data around the disability community highlights the issue that should an individual present
to our facilities for either a disability related, or an unrelated complaint, the fact that they are living with
a disability is not necessarily captured within current systems and processes. As such it is unlikely that it
will be coded as such which is critical from a data capture standpoint. This then makes it near impossible to draw any correlation between common procedures and the outcome difference (if any) between someone living with, or not living with a disability. This in turn limits the ability to make informed decisions around how to align services to take into account the needs of the disability community.

This is an issue that is not unique to CM Health, and the Regional DiAC confirmed this issue exists across the region. As we have a large portion of the population that move across DHB boundaries, to approach this in an ad hoc fashion would be less than helpful. There is an opportunity arising out of the Regional DISAC to take a regional approach as to how this could be addressed.