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- ❑ Mike Grant, General Manager, Planning & Support
- ❑ Heather Browning, General Manager, Enable NZ
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Next Meeting Date: 13 March 2012
Closing Date for Agenda Items: 21 February 2012

MidCentral District Health Board

Agenda

Disability Support Advisory Committee

Part 1

Date: Tuesday, 4 October 2011

Time: 4.00 pm

Place: MidCentral DHB Offices
Board Room
Gate 2
Heretaunga Street
Palmerston North

MIDCENTRAL DISTRICT HEALTH BOARD

Disability Support Advisory Committee Meeting

4 October 2011

Part 1

Order

1. APOLOGIES

Lindsay Burnell, Chair

2. LATE ITEMS

3. CONFLICT OF INTEREST/REGISTER OF INTEREST UPDATE

3.1 Amendments to the Register of Interests

3.2 Declaration of Conflicts in Relation to Today's Business

4. MINUTES

4.1 Minutes

Pages:	4.1 – 4.7
Documentation:	minutes of the previous meeting held on 5 July 2011
Recommendation:	that the minutes of the previous meeting held on 5 July 2011 be confirmed as a true and correct record.

4.2 Recommendations to Board

To note that all recommendations contained in the minutes were approved by the Board.

4.3 Matters Arising

5. STRATEGIC ISSUES

5.1 Implementation of Disability Stocktake

Pages:	5.1 – 5.6
Documentation:	CEO's report dated 23 September 2011
Recommendation:	that the report be received.

5.2 New Zealand Disability Support Network Update

Pages: 5.7
Documentation: General Manager, Enable New Zealand's report dated 19 September 2011
Recommendation: that the report be received.

5.3 Portfolio update 2011 - NZ Disability Stocktake

Pages: 5.8
Documentation: Director, Patient Safety and Clinical Effectiveness report dated 7 September 2011
Recommendation: this report is received.

5.4 Disability Consumer Feedback January – June 2011 (inclusive)

Pages: 5.9 – 5.16
Documentation: Director, Patient Safety and Clinical Effectiveness report dated 9 September 2011
Recommendation: this report be received.

5.5 National Policy Update

Pages: 5.17 – 5.18
Documentation: CEO's report dated 19 September 2011
Recommendation: that the report be received.

5.6 Health Passport Update

Pages: 5.19
Documentation: Director, Patient Safety and Clinical Effectiveness report dated 5 September 2011
Recommendation: this report be received.

5.7 Health Indicators for NZers with Intellectual Disability

Pages: 5.20 – 5.33
Documentation: CEO's report dated 23 September 2011
Recommendation: that the report be received.

6. GOVERNANCE ISSUES

6.1 Terms of Reference Review

Pages: 6.1 – 6.6
Documentation: CEO's report dated 23 September 2011
Recommendation: that the Disability Support Advisory Committee's terms of reference be noted and reviewed in 36 month's time.

6.2 Committee's Work Programme, 2011/12

Pages: 6.7 – 6.8
Documentation: CEO's report dated 26 September 2011
Recommendation: that the updated work programme for 2011/12 be noted.

7. LATE ITEMS

To discuss any such items as identified under item 2 above.

8. DATE OF NEXT MEETING

Tuesday 13 March at 4pm, MidCentral DHB Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North.

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Disability Support Advisory Committee held on Tuesday 5 July 2011 at 4.00 pm in Board Room, Board Office, Gate 2, Heretaunga Street, Palmerston North.

PRESENT

Lindsay Burnell (Chair)
Ann Chapman
Jonathan Godfrey
Tawhiti Kunaiti
Kevin Miles
Phil Sunderland

IN ATTENDANCE

Murray Georgel, Chief Executive Officer
Craig Johnston, Acting General Manager, Funding Division
Muriel Hanratty, Director, Patient Safety and Clinical Effectiveness
Anne Amoore, Manager, Human Resources
Jill Matthews, Manager, Administration and Communications
Jeff Small, Group Manager, Commercial Support Services
Brad Grimmer, Portfolio Manager, Health of Older Persons
Karen Nisbet, Committee Secretary

Media (0)
Public (0)

In opening the meeting the Chair welcomed Kevin Miles.

1. APOLOGIES

Mavis Mullins, Committee Member
Pat Kelly, Committee Member
Heather Browning, General Manager, Enable New Zealand

2. LATE ITEMS

There were no late items.

3 CONFLICT OF INTEREST/REGISTER OF INTEREST UPDATE

3.1 Amendments to the Register of Interests

There were no amendments to the Register of Interest.

3.2 Declaration of Conflicts in Relation to Today's Business

No interests were declared.

4. MINUTES

4.1 Minutes

that the minutes of the previous meeting held on 1 March 2011 be confirmed as a true and correct record.

4.2 Recommendations to Board

The Committee noted that all recommendations contained in the minutes had been approved by the Board.

4.3 Matters Arising

There were no matters arising from the minutes.

5. STRATEGIC ISSUES

5.1 Annual Communications Update

The Manager, Administration and Communication summarised the report.

The Committee questioned whether information around short term loans would be made available to the public. The Director, Patient Safety and Clinical Effectivenesswere advised that a new short term loan equipment process was underway to improve rehabilitation and home safety once discharged from hospital to the community. This process went live on Thursday 30 June. Media would be advised of this scheme via a media release after the next steering group committee meeting.

It was noted that short term loan equipment could be returned to any MDHB facility around the community.

It was recommended:

that the report be received.

5.2 Disability Facilities Stocktake Update

The Group Manager, Commercial Support Services summarised the Disability Facility Stocktake Update. It was noted that the contrast colour strip on nosing of stairs was underway throughout the hospital. This work was valued at $140 - $170k. All new buildings/construction would meet current regulations.

The committee requested information on the number of falls/trips in areas where the colour strip on nosing of stairs had been upgraded. It was agreed that this information would be provided for the committee's next meeting.

The CEO advised the committee that major expenditure was being planned as part of the Clinical Services Plan on upgrades to the hospital in 2015 to 2017. The approximate value of the upgrades would be between $30 to $50m.

It was recommended:

that this report be received.

5.3 NZ Disability Strategy Contracts: Update

The Portfolio Manager, Health of Older Persons summarised the report. He emphasised that all MDHB contracts include a section on disability considerations.

A large proportion of the elderly made up the current demand of disability services. Stringent monitoring was ongoing and the standard of care was improving continuously.

The Portfolio Manager, Health of Older persons advised the committee that MidCentral DHB was meeting the demands for beds for dementia and respite care. A lot of this was to do with a strategy that was in place to try and support people at home for as long as possible before entry level rest care was required. Demand for beds fluctuated week by week. However, Horowhenua currently was experiencing high demand for beds.

It was recommended:

this report be received.

5.4 Annual Update – Stocktake of Employment Practices and Education & Development

The Manager, Human Resources summarised the report. The committee commended MDHB for being an equal opportunities employer.

It was recommended:

that this report be received.

5.5 New Zealand Disability Support Network Update

The CEO advised that a meeting took place on 30 June 2011 with the Disability Support Network. Information on this meeting would be provided to the next Disability Advisory Support Committee in October.

It was recommended:

that the report be received.

5.6 Health Passport

The Director, Patient Safety and Clinical Effectiveness summarised the report. A comparison of the HDC health passport and MDHB's health passport were made. It was noted that MDHB's passport had no visuals, less space to write, and there were no social, culture or spiritual references included.

MDHB had been piloting the health passport since 2006, but feedback had only just started to be received. The health passport was known within the community, and care centre people were becoming very familiar with it. It was also noted that the health passport needed earlier implementation rather then later.

The committee raised a number of concerns as follows:

- It was requested that details of the patient's disabilities be placed on the front cover of the health passport, either by a standard set of icons/stickers. This would enable staff (clinical and non-clinical) to be aware of the patient's disability immediately. It was advised that it was not just nursing staff that need this information, but also cleaning or kitchen staff. For example, if a patient is blind advice on where his food would be placed may be required.

- Patients who had filled in a health passport may not necessary carry this documentation with them, so if they attend ED they still may not get the treatment/ communications they require. It was requested that the health passport be documented on MDHB's Patient Administration System so that staff could access this on patient files as required.

- It was requested that the health passport be widely communicated to the public and that it is made available on line for people to complete.

Management undertook to pass these suggestions onto the Health and Disability Commission.

MDHB will continue to use its own version of the passport whilst it considers feedback from the ongoing pilot and early implementation in some of the northern DHBs.

It was recommended:

this report be received.

5.7 United Nations Convention on the Rights of Persons with Disabilities

The CEO advised the committee that this was the first report on implementing the United Nations Convention on the Rights of Persons with Disabilities. It was hoped that once developed at the United Nations level that this would filter through to New Zealand policy. However, this would take time.

It was noted that there was also a non-government report that was being developed by the Convention Coalition. This report was often known as the Shadow report and provided more of a disabled person's view.

that this report be received.

6 GOVERNANCE ISSUES

6.1 2011/12 Reporting Framework

The CEO presented the 2011/12 Reporting Framework.

The CEO noted updates on the Paid Caregivers case would be provided to the Disability Advisory Committee as they come to hand. At this time the Ministry of Health had appealed the decision and a further hearing date was still to be advised.

A member requested an update on the centralAlliance from a committee perspective. Management advised that in respect to the governance workstream although the terms of references for statutory committees had been aligned, at this stage the board had decided not to proceed with combining committees.

It was recommended:

that the Committee's 2011/12 work programme be noted.

7. LATE ITEMS

8. DATE OF MEETING

Tuesday 4 October 2011 at 4pm, MidCentral DHB Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North.

9. EXCLUSION OF THE PUBLIC

It was recommended:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	*For reasons stated in the previous agenda*	

Confirmed this 4th day of October 2011.

.....
Chairperson

4.6

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Disability Support Advisory Committee held on Tuesday 5 July 2011 at 4.00pm in Board Room, Board Office, Gate 2 Heretaunga Street, Palmerston North.

In Committee

PRESENT

Lindsay Burnell (Chair)
Ann Chapman
Jonathan Godfrey
Tawhiti Kunaiti
Kevin Miles
Phil Sunderland

IN ATTENDANCE

Murray Georgel, Chief Executive Officer
Craig Johnston, Acting General Manager, Funding Division
Muriel Hanratty, Director, Patient Safety and Clinical Effectiveness
Anne Amoore, Manager, Human Resources
Jill Matthews, Manager, Administration and Communications
Jeff Small, Group Manager, Commercial Support Services
Brad Grimmer, Portfolio Manager, Health of Older Persons
Karen Nisbet, Committee Secretary

APOLOGIES

Mavis Mullins, Committee member
Pat Kelly, Committee member
Heather Browning, General Manager, Enable New Zealand

10. Minutes of Previous Meeting

It was recommended:

that the minutes of the previous meeting held "in committee" on 1 March 2011 be confirmed as a true and correct record.

12. LATE ITEMS

There were no late items

13. RESOLUTION OF AVAILABILITY OF IN COMMITTEE MATTERS

It was agreed that all matters considered in the committee remain confidential

The meeting closed at 5.15pm.

Confirmed this 4th day of October 2011.

.....
Chairperson

TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 23 September 2011

SUBJECT **Implementation of Disability Stocktake**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE OF REPORT

This report is for the Committee's information and discussion. It provides a schedule of all recommendations arising from the 2006 Stocktake and details the current status of their implementation.

2. EXECUTIVE SUMMARY

In 2006 MidCentral DHB commissioned Diversityworks to undertake a stocktake of MidCentral DHB's progress in implementing the principles of the NZ Disability Strategy. The stocktake resulted in a number of recommendations. Annual updates on the implementation of these recommendations have been provided to the Disability Support Advisory Committee each year since that time.

As new issues have arisen, these have been added to the work programme, eg items 16 and 17 – oral health and clinical records building.

Implementation is now largely complete and this will likely be last update – refer schedule attached.

It is intended that we undertake a further stocktake in 2012 and discussions are underway with the New Zealand Disability Services Network (refer separate report). The results of that stocktake will be reported to DSAC, followed by annual updates re the implementation of any associated recommendations.

3. RECOMMENDATION

It is recommended:

that the report be received.

Murray George
Chief Executive Officer

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2006 Disability Stocktake: Implementation Reporting Template

No.	2006 Stocktake Recommendations	Proposed Action	Achieved			Out Year Task	Status as at 19 September 2011
			Fully	Partially	No		
1	Establish a Disability Strategy Implementation Plan including a dedicated position to co-ordinate/manage NZDS implementation within one year	Work programme agreed with DSAC	✓				Board's annual reporting framework includes disability section, which translates into the Disability Support Advisory Committee's annual work programme. The 2011/12 Reporting Framework and associated work programmes were approved by the Board in June 2011.
		Reporting requirements for major reports include "disability perspective"	✓				Achieved and ongoing.
		Annual report against 2006 Stocktake implementation	✓				Annual updated provided yearly since October 2007. This is expected to be the last update against the 2006 stocktake. During 2011/12 it is intended a new stocktake will be undertaken. Annual reporting against that will then occur.
2	Communicate the results of this stocktake, the work programme, and subsequent implementation successes to the DHB and disabled community within one year	Stocktake results and resultant work programme published on web site, provided to key stakeholders, and summarised in MDHB newsletters.	✓				Achieved.
		Reports against stocktake items include "communication perspective"	✓				Provided as appropriate.
		DSAC reports provided to Reference/Focus Group for its information			✓		Decision taken by DSAC not to establish a focus group. Instead it was agreed Enable NZ be responsible for maintaining a current network of groups & key stakeholders that MDHB recognise as a key group with whom it will consult. New item (No 15) added to stocktake accordingly.
3	Eliminate inconsistencies between the "short term" (non-residential) DSS provider agreement and "long term" DSS provider agreement within one year	Inconsistencies investigated and addressed	✓				Inconsistencies relate to differences between short and long term contracts and the length of support required. Annual updates provided to the Committee regarding these contracts.
4	Develop a communications plan to ensure consistent, role-appropriate knowledge of the NZDS throughout the DHB within one year	Staff awareness strategy developed and implemented	✓				Communications, HR and customer feedback reports provided to DSAC on annual basis.
5	Establish, test and review a more robust system for recording and tracking implementation progress within one year	Annual report against stocktake provided as per 1 above.	✓				Annual updates provided October 2007. This will likely be the last update, with plans to undertake a new stocktake getting underway as per 1 above.

No.	2006 Stocktake Recommendations	Proposed Action	Achieved			Out Year Task	Status as at 19 September 2011
			Fully	Partially	No		
6	Complete building maintenance/upgrade work, including re-commissioning access audits and responding to recommendations from the Facility Review (refer Appendix A) within three years*						
	• Enable NZ	Ensure that handrails extend 300mm plus the depth of a tread past the bottom of the stairs. (Priority 1)	✓				Completed 2006/07.
		Ensure that the ends of handrails are turned down 100mm, or returned fully. (Priority 1)	✓				Completed 2006/07.
		Increase the contrast on the nosings of the stairs. For the stairs to the server room, consider using yellow nosings to contrast with the dark blue carpet. For the stairs to the storage area, consider using black to contrast with the light natural wood colour of the steps. (Priority 2)	✓				Completed 2006/07.
		Round the nosing of the steps to the storage area. (Priority 2)	✓				Completed 2006/07.
		Ensure that handrails are round with a dimension of 32mm to 50mm. (Priority 2)	✓				Completed 2006/07.
		Ensure that the new reception counter has at least one accessible area with a maximum height of 775mm above the floor, and a minimum depth clearance of 675mm. (Priority 2)	✓				Completed 2006/07.
		Provide Braille signage on each door, indicating what the door is. Current informational signage exists, but only for sighted people. If installing Braille signage, make sure the signs are located in a consistent manner so they can be found easily. (Priority 3)			✓		Reviewed by the Blind Foundation assessors and it was advised that Braille was not required. Sufficient visual cues already present.
	• Horowhenua new facility	The wall behind the outside door should not be solid glass. We recommend either a solid half wall with a glass upper section, or the use of opaque glass "blocks". (Priority 1)	✓				Compliance achieved with new facility.
		Do not label the ensuite toilet facilities in the	✓				Compliance achieved with new facility.

No.	2006 Stocktake Recommendations	Proposed Action	Achieved			Out Year Task	Status as at 19 September 2011
			Fully	Partially	No		
		ward as "accessible". (Priority 2)					
		Mount paper and soap dispensers in accessible toilet facilities at a height between 900mm and 1200mm, ideally 1000mm, and no closer than 450mm from corner. (Priority 2)	✓				Compliance achieved with new facility.
		Ensure that solid horizontal visibility strips of at least 20mm width and high visible contrast are placed on the glass sliding doors. (Priority 2)	✓				Compliance achieved with new facility.
		Mount a horizontal grab bar on the inside of the swinging door to the accessible toilet facility, to make it easier for a wheelchair user to close the door during entry, rather than having to manoeuvre back and forth to shut the door. (Priority 3)	✓				Compliance achieved with new facility.
	• MidCentral Block B	Place a high contrast colour strip on the nosing of the stairs that do not currently have high contrast. (Priority 1)				✓	Options have been explored further and estimated costs obtained. Any agreed action to be undertaken on CAPEX Programme 2011/12. In the meantime areas are addressed as and when new works are undertaken.
		Ensure that the ends of handrails are turned down 100mm, or returned fully. (Priority 1)	✓				Scheduled under PNH redevelopment.
		Replace the horizontal visibility marking on the sliding door to the main entrance with a solid strip of a more contrasting colour than the existing grey. (Priority 2)	✓				Completed 2006/07.
		Adjust the sensor to activate the A&E door from a shallower approach. (Priority 2)	✓				Completed.
		Ensure that all accessible areas are kept clear of clutter and available for service to people who use wheelchairs. (Priority 2)	✓				Completed 2006/07 and ongoing.
		Where possible, modify the public service counters to provide a lower, accessible area. (Priority 2)				✓	Scheduled for 2008/09. Previously postponed and is now rescheduled for 2011/2 Capex or under the redevelopment of Palmerston North Hospital.
		Where double swing doors do not have at least one panel that is wide enough (760mm), replace the doors so at least one of the two panels provides a clear opening width of at least 760mm. (Priority 2)	✓				Not required by Building Code as both doors open.

No.	2006 Stocktake Recommendations	Proposed Action	Achieved			Out Year Task	Status as at 19 September 2011
			Fully	Partially	No		
		Ensure all informational signs are appropriately located on toilet facilities. (Priority 2)	✓				Completed.
		Improve directional signage, in particular to accessible toilet facilities. (Priority 2)	✓				Completed 2006/07.
		If the "non-bed" lifts are replaced, and it is possible to do so, use a lift with a larger internal dimension. (Priority 2)	✓				Not applicable.
		Maintain light bulbs, and ensure that the bulbs selected provide enough light. (Priority 2)	✓				Ongoing maintenance.
		Add increased contrast indicator signs beside each call button in lifts. (Priority 2)	✓				Completed.
		Install a hearing loop in lecture hall, and publicise its availability through proper signage. (Priority 2)				✓	On CAPEX Programme 2011/12.
		Review and replace signs appropriately, as is currently being done. Ensure that signs are easy to read, properly located and provide sufficient information. (Priority 2)	✓				Completed.
		Ensure that handrails extend 300mm plus the depth of a tread past the bottom of the stairs.				✓	Scheduled under PNH redevelopment.
7	Establish, test and review and engagement plan and partnership opportunities with the disability sector – in particular the disabled community – and internal and external disabled professionals within three years	Terms of reference for reference/focus group established	✓				Proposal submitted DSAC, October 2007 and agreed this be held over pending potential changes to governance arrangements in light of centralAlliance with Whanganui DHB. This position re-reviewed October 2011 with separate paper to DSAC.
		Reference/focus group appointed			✓		DSAC determined not to proceed with focus group.
8	Prioritise disabled Maori workforce development within three years	No further action. To be progressed through Maori Health and Disability Strategies as per DAP.	✓				
9	Develop, test and review a robust disability responsiveness-training plan to feed into staff and service development plans within three years			✓			Part of staff awareness strategy – refer 4.
10	Adopt an affirmative action employment policy for disabled people		✓				Policy MDHB1890. Policy was revised in August 2008 and will be reviewed in 2012.

No.	2006 Stocktake Recommendations	Proposed Action	Achieved			Out Year Task	Status as at 19 September 2011
			Fully	Partially	No		
	within three years						
11	Establish a leadership initiative for disabled people within five years	No further action. Not to be progressed.	✓				
12	That a self-audit tool be used to measure progress in implementing the principles of the NZ Disability Strategy	Need for audit tool and approach to be reviewed, including input from Reference/Focus Group.				✓	We have not been able to either develop or source a self-audit tool. This will form a key part of the planned 2011/12 stocktake and preliminary discussions with NZ Disability Services Network in this regard have been positive.
13	That a centralised budget be established for NZ Disability Strategy implementation, with spending monitored and evaluated against clear quality outcomes. A "virtual" budget with money tagged from other budget sources could be used.	No further action. Centralised budget not to be established.	✓				
14	That a disability consultant vet language used in MidCentral DHB's DAP in reference to disabled people.	To be undertaken by DSAC as part of DAP development process.	✓				Undertaken by DSAC.
15	Enable New Zealand establish current network of groups & key stakeholders recognised by MDHB of key groups it will consult with on issues/ plans/proposals as required. Group listing to be maintained by Enable NZ. With annual update provided to DSAC on usage of the disability network.			✓			Network list established. Not used to date but will be accessed for upcoming major projects such as Regional Clinical Service Plan, MidCentral Health's Clinical Services Plan and District Strategic Plan. Sept 09 – Network list has not been used by GMs to date. Aug 10 – DPA utilised very effectively for Child Adolescent Oral Health Universal access issue. Sep 11 – In the year ahead the network will be utilised to communicate the Regional Services Plan.
16	Child and Adolescent Oral Health Service universal access to be provided for new model of care being introduced	The issue of disability access on the mobile dental clinics to be considered by the Ministry of Health Disability Consortium.	✓				Local use of Disabled Persons Assembly has been of considerable assistance. Service reconfiguration completed, with universal access addressed via the provision fixed clinics across the district.
17	Clinical Records Building	Building is planned to comply with all disability access, egress and internal service requirement (eg. Toilets)	✓				Completed. Building constructed to meet all building code standards, including disability access, egress and internal service requirements.

*Facility stocktake recommendations were prioritised. Priority one - addressing hazardous situations/complete lack of accessibility. Priority 2 - other non complying items impacting accessibility and usability. Priority 3 - recommendations which would improve the level of access.

TO Disability Support Advisory Committee

FROM Heather Browning, General Manager, Enable New Zealand

DATE 19 September 2011

SUBJECT **New Zealand Disability Support Network update**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. Purpose

This report is provided to update members on the progress to date with the New Zealand Disability Support Network and its support to MidCentral District Health Board in the ongoing development of the Disability Stocktake.

2. Executive Summary

As described in the last meeting Heather Browning planned to meet with Sandie Waddell, CEO of the New Zealand Disability Support Network on 30th June. This meeting did take place and a plan was agreed with Sandie to develop support from the Disability Support Network to assist MidCentral District Health Board in developing a mechanism for ongoing monitoring and review of accessibility for disabled people to District Health Board services.

Unfortunately Sandie Waddell left the New Zealand Disability Services Network in early August and this work has not progressed.

Viv Maidaborn who is on the Board of the New Zealand Disability Services Network is temporarily holding the role of CEO for the network (until a permanent appointment is made) and has undertaken to follow up and give a verbal report before 4 October to the General Manager, Enable New Zealand, as to how the Network can assist in the development of a self audit tool or similar.

3. Recommendation

It is recommended that:

that the report be received.

Heather Browning
General Manager
Enable New Zealand

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TO Disabilty Support Advisory Committee

FROM Muriel Hanratty

DATE 7 September 2011

SUBJECT **Disability Strategy Stocktake**

MIDCENTRAL HEALTH

MEMORANDUM

1. Purpose

To respond to a question from a member regarding any reduction in reported falls as a result of nosing fitted to stairs. No decision is required.

2. Current Situation

There has been one staircase that has had nosing fitted since the stocktake was undertaken. At the time the nosing was fitted a handrail was also fitted. This staircase leads from the ground floor of the hospital administration building to the first floor and is primarily used by staff.

Nosing has also been put in place on the new stairs in the Clinical Records building. No falls reported since building opened in June 2011.

There have been no reported falls in this area in the last two years. Anecdotally staff report that they feel safer with the addition of the nosing and handrail.

As upgrades are progressed in other areas of the facility, nosing and additional handrails will be fitted in line with the stocktake recommendations.

3. Recommendation

It is recommended that

This report is received

Muriel Hanratty
Director
Patient Safety and Clinical Effectiveness

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TO Disability Support Advisory Committee

FROM Muriel Hanratty
Director, Patient Safety and Clinical Effectiveness

DATE 9 September 2011

SUBJECT **Disability Consumer Feedback January – June 2011 (inclusive)**

MidCentral District Health Board
Te Pae Hauora O Ruahine O Tararua

MEMORANDUM

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1. PURPOSE

This report provides an update on patient satisfaction survey results as they apply to those patients who self identify as having a disability. This report covers the period January – June 2011. No decision is required.

2. SUMMARY

- A total of 2256 questionnaires were sent out in each period.
- Return rate of 50% compared to 51% in the last period.
- Respondents identifying as having a disability in this period 39% compared to 35% in the previous period.
- Satisfaction rating for inpatients remained similar in all 16 areas.
- Satisfaction ratings for outpatients remained similar in all 14 areas.
- Whilst there are some fluctuations overall satisfaction is comparable to those without a disability both for this period and over the past seven periods.
- No specific actions have been implemented to address any of the ratings.

3. CONCLUSION

Patient satisfaction surveys will continue to be undertaken and will be reported six monthly with the next report to cover the July to December 2011 period.

4. RECOMMENDATION

It is recommended that:

this report be received

5. BACKGROUND

The patient satisfaction survey canvasses the views of hospital service users from both inpatient and outpatient services. The survey tool was designed in the year 2000 by a representative group of the Ministry of Health, consumers and expert advisory personnel. The current survey tool (questionnaires) and methodology (random sampling) has been in use since June 2000.

In early 2003 the Disability Support Advisory Committee requested that the question "Do you have a disability?" be added to the demographic set within the survey and subsequently to report specific feedback from respondents to the survey who identify as having a disability.

The capacity for reporting specific, meaningful information as a result of statistical analysis and trends over time is limited and rudimentary, notwithstanding the need for sufficient volume of respondents with a disability to ensure statistical validity.

In April 2006 the survey questions were modified around the disability question, to bring it in line with questions asked on New Zealand Census Forms.

The information and graphs included in this report compare results provided by respondents identifying as having a disability in the January – June 2011 period with those in the July - December 2010 period.

6. THE SURVEY QUESTIONS

There are a total of 17 questions for the inpatient survey and 15 questions for the outpatient survey. Respondents are asked to rate performance against a five-point scale ranging from one being "very poor" to five being "very good", identifying their assessment of events and encounters that occurred during their episode of care. The questions are founded on the patient centred survey approach developed by the Picker Institute, which identifies eight key determinants of patient satisfaction.

7. LIMITATION OF THE DATA

The survey questionnaire asks "Do you have any disability or handicap that is long term (lasting six months or more)?" This requires a yes/no response. Where respondents self identify as having a disability it is the respondent's perception of what disability means to them.

8. COMPARATIVE RESULTS

In the January – June 2011 period, 2256 questionnaires were sent out with 1131 (50%) being completed and returned. 504 (45%) of surveys were returned by inpatient respondents and 627 (55%) by outpatient respondents

In the July – December 2010 period, 2256 questionnaires were sent out with 1240 (55%) being completed and returned. 550 (45%) surveys were returned by inpatient respondents and 690 (55%) by outpatient respondents.

Respondents identified as having a disability in the January – June 2011 period numbered 438 or 39% of the total number of respondents. This compares to 450 or 35% of the total number of respondents for the July - December 2010 period.

Respondents identifying as not having a disability in the January – June 2011 period numbered 600 or 53%. The number of respondents identifying as not having a disability for the July - December 2010 period was 555 or 47%.

Respondents not disclosing their disability status totalled 93 or 8% in the January – June 2011 period. This compares to 115 or 18% for the period July - December 2010.

Table 1 shows the proportion of respondents stating their disability status for the July - December 2010 period. Table 2 shows the January – June 2011 period.

Table 1: Proportion of respondents stating their disability status July - December 2010

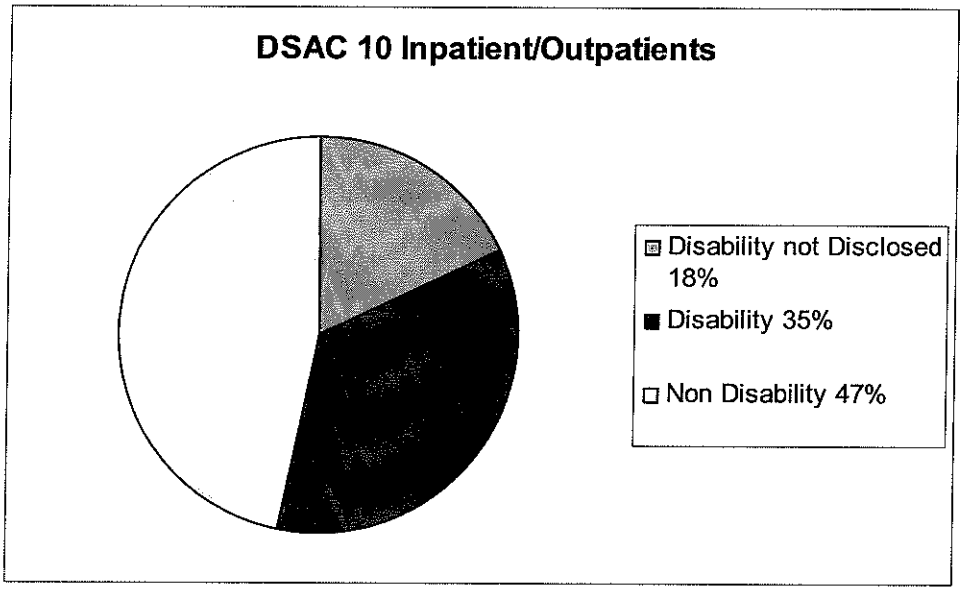
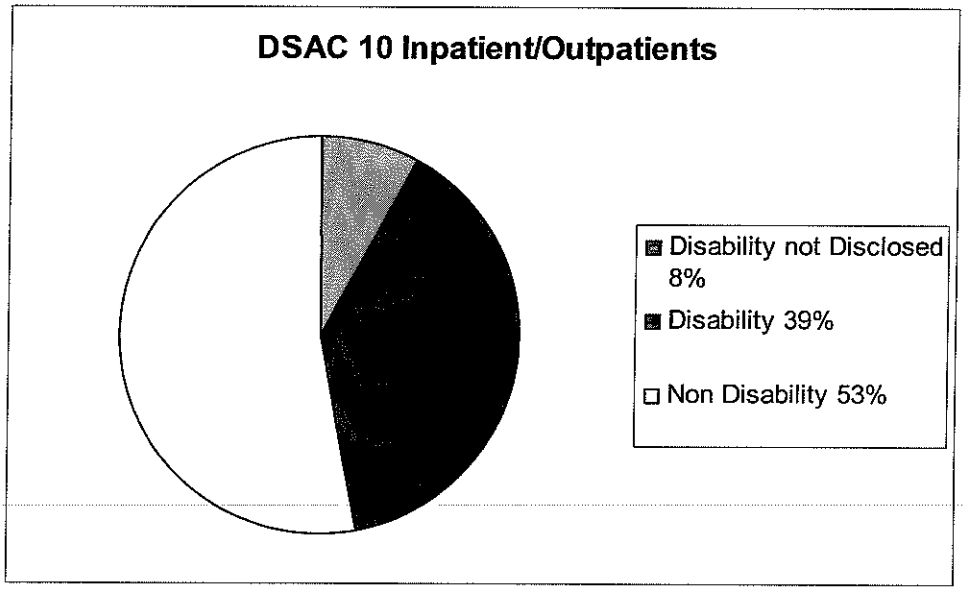


Table 2: Proportion of respondents stating their disability status January – June 2011



9. INPATIENT RESULTS

Table 3 shows the combined total for ratings 'good' and 'very good' given to questions 1 - 16 in the January – June 2011 period and compares these to the July - December 2010 period for inpatients who identified that they had a disability.

Table 3 Inpatient satisfaction rating good and very good for patients identifying that they have a disability compared to total number of respondents

	Patients who identified as having a disability		Total respondents
INPATIENT QUESTIONS	**Jan - June 2011 % Good and Very Good**	**July – Dec 2010 % Good and Very Good**	Jan - June 2011 % Good and Very Good
1. Telling you how long you would wait (Emergency Department)?	**68**	**63**	65
2. Telling you how the Emergency Department would treat your problem?	**76**	**65**	70
3. Explaining what was wrong with you?	**82**	**82**	82
4. Informing you about different treatment options?	**75**	**75**	75
5. Asking your permission to treat you?	**87**	**86**	86
6. Listening to you?	**82**	**83**	82
7. Involving your family/whanau as much as you wanted?	**86**	**85**	85
8. Offering specific choices to your culture?	**83**	**76**	79
9. Treating you with dignity and respect?	**91**	**94**	92
10. Organising your care with other health care providers (such as your Doctor or Midwife)?	**88**	**91**	89
11. Preparing you for leaving hospital?	**79**	**80**	79
12. Organising your care with other departments in the hospital?	**81**	**82**	81
13. If staff were around when you needed them?	**79**	**75**	77
14. How clean your ward or room was?	**88**	**86**	87
15. How much you like the food we gave you?	**65**	**61**	63
16. How safe and secure you felt in hospital?	**90**	**90**	90

Satisfaction rating comparisons across all 16 of the questions remain within 5% of the ratings from the previous period.

5.13

Results of these surveys are discussed at Quality Improvement meetings and suggestions for improvement are discussed. If relevant, a quality project may be set up to improve the process.

10. OUTPATIENT RESPONDENTS

Table 4 shows the combined total for ratings 'good' and 'very good' given to questions 1 - 14 in the January – June 2011 period and compares these to the July – December 2010 period for outpatient respondents who identified as having a disability.

Table 4 Outpatient satisfaction rating good and very good for patients identifying that they have a disability compared with total number of respondents

	Patients who identified as having a disability		Total respondents
OUTPATIENT QUESTIONS	**Jan – June 2011 % Good and Very Good**	**July –Dec 2010 % Good and Very Good**	Jan – June 2011 % Good and Very Good
1. How well did your appointment time suit you?	**83**	**84**	83
2. Their effort to make an appointment time that suited you?	**84**	**87**	85
3 Providing clear information to prepare you for your appointment?	**89**	**90**	89
4. Making you feel welcome when you arrived?	**84**	**85**	84
5. Telling you how long you would wait, when you arrived?	**58**	**61**	60
6. Explaining what was wrong with you?	**86**	**85**	85
7. Informing you about different treat options?	**80**	**85**	83
8 Asking your permission to treat you?	**86**	**92**	89
9. Listening to you?	**86**	**87**	86
10. Meeting any needs specific to your culture?	**83**	**87**	85
11. Treating you with dignity and respect?	**91**	**92**	91
12. Organising your care with other health care providers (such as your Doctor or Midwife)?	**87**	**85**	86
13. How clean our facilities were?	**85**	**89**	87
14. The information we gave you on how to manage your condition after your visit?	**85**	**84**	84

Satisfaction rating comparisons between all 14 of the questions remain within 5% of the ratings from the previous quarter.

Results of these surveys are discussed at Quality Improvement meetings and suggestions for improvement are discussed. If relevant a quality project may be set up to improve the process.

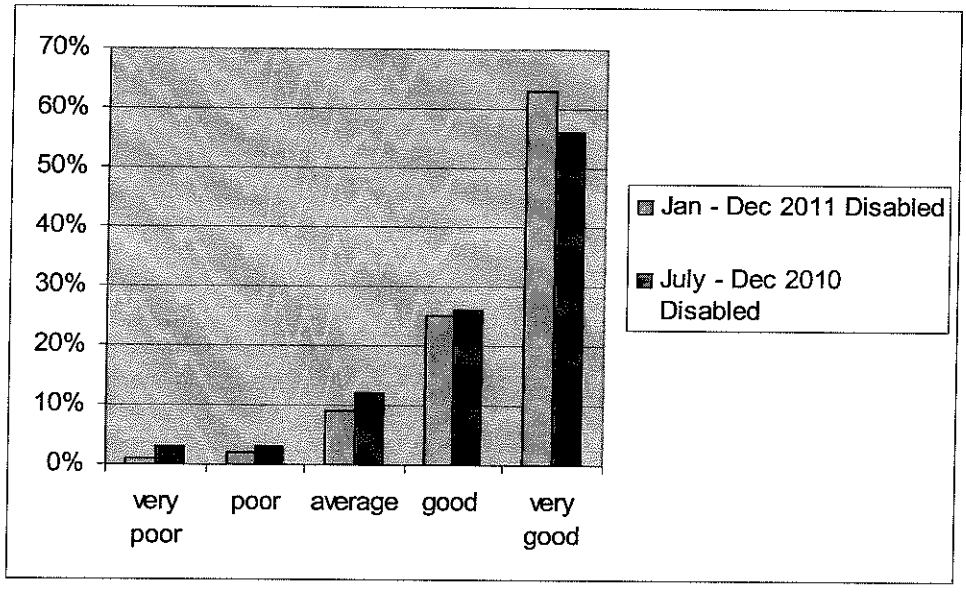
11. OVERALL SATISFACTION

a. Inpatients

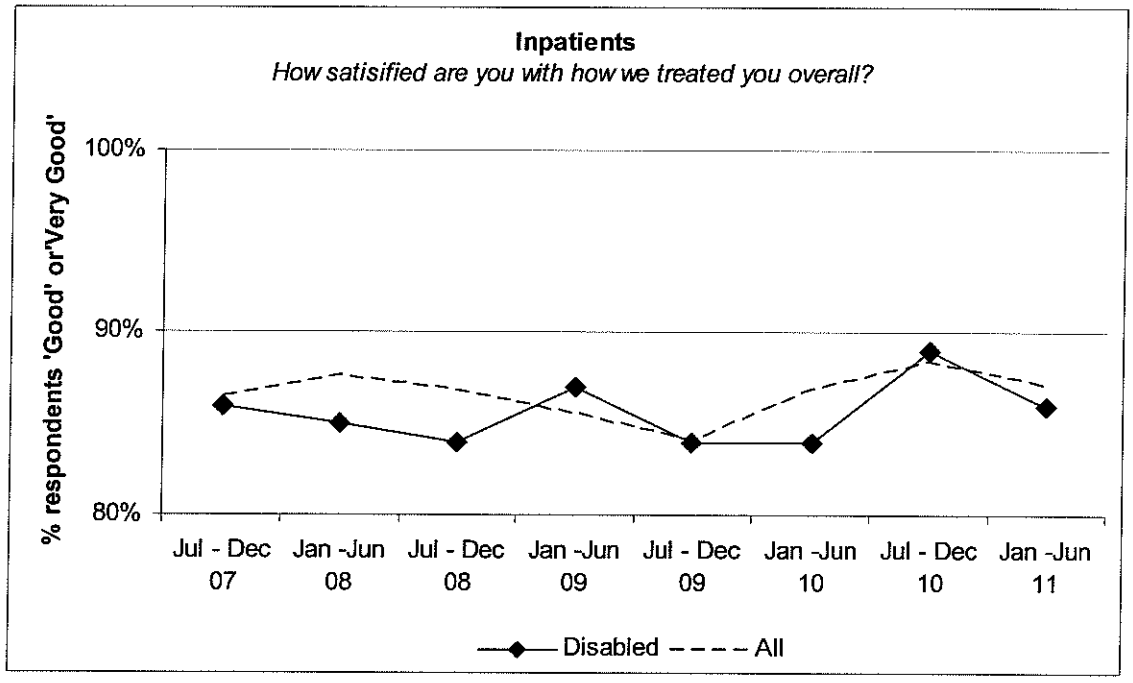
Graph 1 shows the overall satisfaction for this period January – June 2011 for inpatients that identified as having a disability and compares this with the number of responses received in the July - December 2010 period. Overall, levels of satisfaction have been steady over this period.

Graph 2 shows a comparison for those identifying as having a disability with satisfaction for all others. There are no significant fluctuations over the past four years with the greatest difference at any point being 3%.

Graph 1 Inpatients Question 17: How satisfied are you with how we treated you overall - Disability Responses



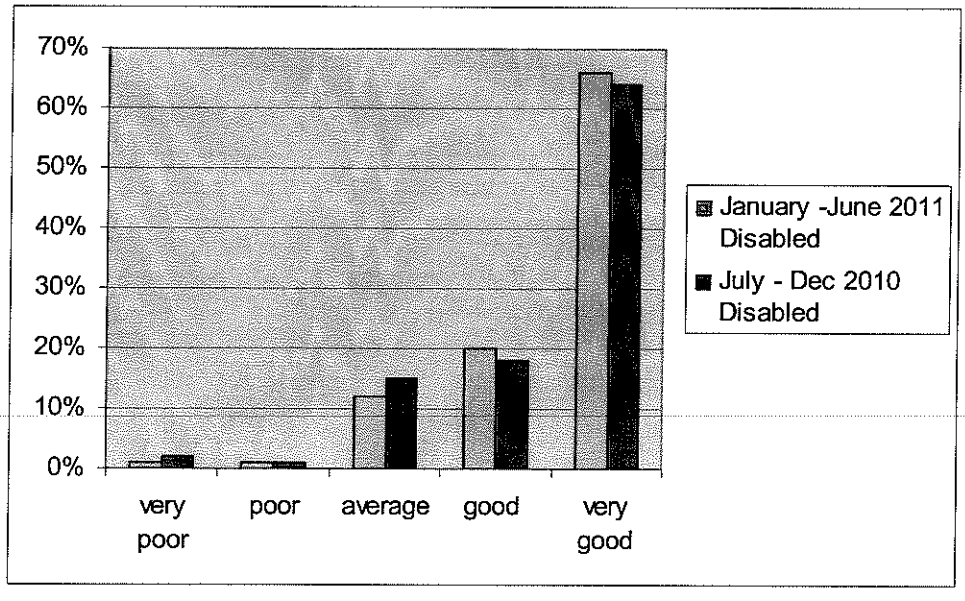
Graph 2 Six month totals for question 17 relating to inpatients 2007-2011 – Disability Responses compared to overall satisfaction.



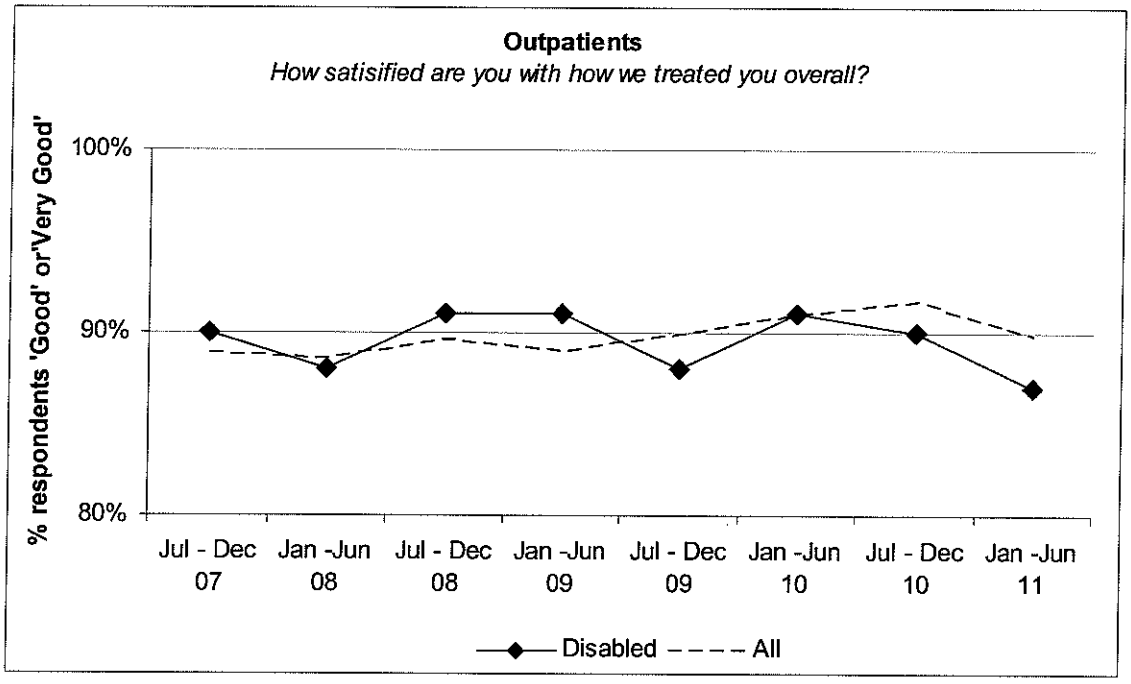
b. Outpatients

Graph 3 shows the overall satisfaction for the period January – June 2011 for outpatients that identified as having a disability and compares this with the number of responses received in the July - December 2010 period. As in previous reports there are no significant variations between the groups. Graph 4 shows a comparison for those identifying as having a disability with satisfaction for all others. There are no significant fluctuations over the past four years with the greatest difference at any point being 3%.

Graph 3 Outpatients Question 15: How satisfied are you with how we treated you overall - Disability Responses



Graph 4 Six month totals for question 15 relating to outpatients 2007-2011 – Disability Responses compared to overall satisfaction.



12. SUMMARY

While there are some small fluctuations in satisfaction noted for this period for patients with a disability, their level of satisfaction overall is similar to those without a disability.

A number of District Health Boards have suspended the Patient Satisfaction Survey required by the Ministry of Health while the Health Quality and Safety Commission (HQSC) work on developing a new patient satisfaction survey and process. DHBs are participating in this work via Quality and Risk Managers. It is likely the new survey will still be based on the Picker Institute dimensions similar to the current survey. The Ministry of Health require a recommendation from HQSC by July 2012 so that a new survey can be implemented by all DHBs later in 2012.

The results of these surveys continue to be brought to the attention of services, for active consideration as part of the service improvement process.

Muriel Hanratty
Director
Patient Safety and Clinical Effectiveness

TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 19 September 2011

SUBJECT **National Policy update**

MidCentral District Health Board
Te Poe Hauora o Ruahine o Tararua

MEMORANDUM

1. Purpose

This report is provided to update members on developments regarding the Human Rights Review Tribunal hearing on the Paid Family Caregivers Case and the negotiations regarding caregivers sleepover. No decision is required.

2. Executive Summary

As previously advised at the Disability Support Advisory Committee meetings in 2010, the Human Rights Review Tribunal considered a case taken against the Ministry of Health regarding the non-payment of resident family members who provide care for a disabled person(s). The Tribunal ruled that the Ministry's policy of not funding the employment of specified family members to provide support services to their disabled family member(s) discriminated on the grounds of family status.

On December 22nd the Crown advised that they would appeal this decision for a second time. To date there are no further developments.

In October 2010 a brief summary was provided to the committee regarding the Employment Court's decision requesting IDEA Services to backdate and pay the minimum wage to support people for the time they sleepover in residential facilities. A settlement has now been agreed.

3. Recommendation

It is recommended:

that the report be received.

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5.18

Care givers sleepover deal

In 2007 a disability worker made a complaint regarding payments of sleepover shifts. A deal between the government, IHC and Service and Food Workers Union was reached in an out-of-court settlement on 12 September 2011. Cabinet agreed to the proposal to increase caregivers sleepover pay to the minimum wage by 2013.

Cabinet approved the sleepover agreement to the figure of $150 million. This will see the government contributing $90 million to the agreement, with further contributions being made by IHC and other providers.

The government has agreed to pay 50% of the minimum hourly wage to workers from 1 July 2011, and then 75% from 1 July 2012, with the full minimum wage being paid by 1 July 2013.

An additional contribution of $27.5 million will be provided by the government to help with back pay which dates back to July 2005. All past and present employees who have lodged claims by 2 September 2011 will be entitled to backpay.

DHBs are not directly impacted by this matter as responsibility for funding and planning services for the young disabled rests with the Ministry of Health.

Murray Georgel
Chief Executive Officer

TO Disability Support Advisory Committee

FROM Muriel Hanratty

DATE 5 September 2011

SUBJECT **Health Passport**

MidCentral Health

MEMORANDUM

Purpose

To provide an update on the response from the Health and Disability Commission with regard to members suggestions on the proposed passport.

Health and Disability Commission Response

Will the passport be available to update on line and will there be able to be links with hospitals' patient administration systems?

"The passport is on line and can be completed on line prior to printing off. It is not however intended at this stage to be an electronic document. This may change once we can operate through a database of electronic patient NHI numbers, it seems this is a couple of years away. One key difficulty is that that they may rapidly become out of date and cannot easily be updated, as a hard copy patient held version can."

Will there be some way to flag on the front of the passport what the primary disability is eg if the patient is blind the health professional needs to read the book to ascertain this, whereas if a universal symbol could be put on the front it would be an early alert?

"Your comment about the flag on the front re a primary disability (should the person want this) is a good one. Perhaps the passport holder could affix a label bearing this message"

"Please pass on our thanks to your Committee and we will consider all feedback as part of our overall evaluation"

Next Steps

As reported in June we will consider implementation over the next 9-12 months, planning for this has not yet commenced. A further report will be provided in March 2012.

Recommendation

It is recommended that

This report be received.

Muriel Hanratty
Director
Patient Safety and Clinical Effectiveness

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TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 23 September 2011

SUBJECT **Health Indicators for NZers with Intellectual Disability**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report outlines the findings of the Ministry of Health's review of the health status and health care utilisation indicators for New Zealanders with an intellectual disability. It is provided for the Committee's information only.

2. SUMMARY

People with intellectual disability are more disadvantaged, in terms of their health and life expectancy, compared to people without intellectual disability.

People with an intellectual disability experience higher rates of specific health conditions, and use health services more than people without an intellectual disability.

The results are consistent with those from similar overseas studies.

1,307 people with an intellectual disability reside in MidCentral DHB's district, or 0.8%. This is slightly above the national average of 0.7%.

A copy of the Ministry's report is available from its website – www.moh.govt.nz

For members' information, a copy of the Summary and Table of Contents are attached.

3. RECOMMENDATION

It is recommended:

that the report be received.

Murray Georgel
Chief Executive Officer

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Health Indicators for New Zealanders with Intellectual Disability

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Authors

This report was developed by a project team lead by the Ministry of Health. The team comprised Marianne Linton (Ministry of Health), Caroline Maskill (HealthSearch Ltd) and Craig Wright (Ministry of Health).

The project management, contract management and coordination of the internal and external peer review and editorial process of this report was undertaken by Marianne Linton.

The development of health status and health care utilisation indicators was carried out by the project team with consultation across the Ministry of Health.

The development of the study population, intellectual disability indicator and calculation of rates and confidence intervals was carried out by Craig Wright.

All chapters were written by Caroline Maskill. Further processing of data, all data analysis and preparation of the report's appendices tables was also carried out by Caroline Maskill.

Acknowledgements

The complete report was externally peer reviewed by Professor Gwynnyth Llewellyn (Faculty of Health Sciences, The University of Sydney), Dr Martin Tobias (Ministry of Health), Alexandra Bonardi (Center for Developmental Disabilities Evaluation and Research, University of Massachusetts Medical School) and the Office for Disability Issues, Ministry of Social Development.

Acknowledgement is also made to the many others who provided peer review comments on specific chapters or data for the indicators.

Disclaimer

S.25

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Summary

This report presents a selection of health status and health care utilisation indicators for New Zealanders with and without intellectual disability. The indicators have been developed using data from a range of Ministry of Health data sets.

Because of the nature of the data available, the study uses a broad definition of intellectual disability that encompasses a range of causes of this disability. For example, because age of onset could not be established from the available data, the study includes people whose intellectual disability was evident prior to adulthood, as well as some whose cognitive impairment may have started later in life and were recorded as having an intellectual disability in Ministry of Health data sets.

Internationally, studies have shown that people with intellectual disability tend to experience poorer health outcomes than the rest of the population. However, there is a distinct lack of up-to-date, New Zealand-specific health status and health care utilisation data for people with intellectual disability. This makes it difficult to evaluate the extent to which this group of New Zealanders are currently experiencing poorer health than the rest of the population.

The report's study population consisted of 31,847 people identified as having intellectual disability, and 4,261,600 people identified as not having intellectual disability. Altogether, 0.7 percent of the study population were classified as having intellectual disability. Compared to the group without intellectual disability, the group with intellectual disability included relatively high proportions of children, teenagers and people aged 85 and over. People with intellectual disability were also more likely to live in the most socioeconomically deprived areas of New Zealand.

Overall results

For all indicators examined in this report, people with intellectual disability were more disadvantaged, in terms of their health and life expectancy, compared to people without intellectual disability. The group with intellectual disability experienced higher rates of specific health conditions, and they also used health services more (apart from preventive screening services). These results are consistent with those from similar overseas studies.

Life expectancy

- Males with intellectual disability had 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 with intellectual disability had 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).

Care and treatment for health conditions

Compared to people without intellectual disability, people with intellectual disability were:

- about 1.5 times more likely to receive care or treatment for one or more of six selected chronic health conditions (nearly a third of people with intellectual disability, 31.5 percent, had care or treatment for one or more of these conditions)
- about 1.5 times more likely to receive care or treatment for chronic respiratory disease (22.2 percent had care or treatment for chronic respiratory disease)
- almost twice as likely to receive care or treatment for coronary heart disease
- about 1.5 times more likely to receive care or treatment for cancer
- almost twice as likely to receive care or treatment for diabetes
- twice as likely to receive renal replacement therapy in a public hospital
- over four times more likely to receive morbid obesity treatment in a public hospital
- over 30 times more likely to be getting care or treatment for epilepsy
- almost twice as likely to receive injury treatment in a public hospital
- over 15 times more likely to receive dental treatment in a public hospital
- over three times more likely to receive care or treatment for any type of mental disorder
- twice as likely to receive care or treatment for a mood disorder
- 17 times more likely to receive care or treatment for a psychotic mental disorder
- 10 times more likely to receive care or treatment for dementia.

Use of primary health care, screening services and pharmaceuticals

Compared to people without intellectual disability, people with intellectual disability were:

- slightly more likely to be enrolled in a primary health organisation (an age-adjusted rate of 95.2 percent, compared with 91.8 percent)
- more than twice as likely to be enrolled in Care Plus primary health care services (for people who use high levels of care or have high needs because of chronic conditions)
- nearly 1.5 times more likely to consult a general practitioner in a three-month period
- less likely to have had breast screening and much less likely to have had cervical screening (for women)
- likely to be dispensed almost twice as many different types of prescription drugs from community pharmacies.

Use of public hospital services

Compared to people without intellectual disability, people with intellectual disability were:

- over twice as likely to receive elective or arranged public hospital treatment
- almost three times more likely to receive acute public hospital treatment
- two-and-a-half times more likely to go to public hospital emergency departments
- over four times more likely to have public hospital admissions that could have been avoided.

Cost of government-funded primary and secondary health services

In the financial year to 30 June 2008, the average annual total cost per person of government-funded health care (primary health services plus secondary health services) for people with intellectual disability was $3,001, which is nearly three times higher than the cost for people without intellectual disability ($1,028).

Limitations of the study

There were a number of limitations to the research methods used for this study, including the following.

- The study relied on information available from Ministry of Health databases, which did not record information about the age of onset, or the causes or severity[1] of intellectual disability, meaning that analyses relating to these factors could not be done.
- Apart from life expectancy, the health indicators reported were related to health service use rather than a more direct measurement of health status; people's actual need for the services was unable to be measured directly.
- People with moderate or severe intellectual disability who needed health and support services were more likely to have been identified as having intellectual disability than people with mild intellectual disability.

[1] It was possible to identify cause and severity for only a relatively small proportion of people with an intellectual disability in the study population.

TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 23 September 2011

SUBJECT **Role of Disability Support Advisory Committee**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report reviews the Committee' s role and terms of reference. It seeks a decision from the Committee.

2. SUMMARY

The Committee's terms of reference were established in 2001 and have been regularly reviewed since that time. The last review took place in 2008. This was done in conjunction with Whanganui DHB, as part of the centralAlliance, and the ToR of both DHB's committees were aligned.

The terms of reference are once again due for review. From management's perspective they remain relevant and no change is recommended. We consulted with the joint centralAlliance sub-committee (which comprises representatives of both Whanganui and MidCentral DHB's board) and it concurs.

In 2008, the Board requested that the role of DSAC be reviewed. A report was subsequently provided to the Committee (copy attached). At that time, it was agreed no change to made to the Committee's role due to the pending change in governance arrangements as a result of the centralAlliance. This matter has remained on the Committee's work programme.

From management's perspective, the Committee's role is aligned to DHBs' responsibilities for disability support services, noting that responsibility for those services referred to as "young-disabled services" rests with the Ministry of Health.

3. RECOMMENDATION

It is recommended:

> *that the Disability Support Advisory Committee's terms of reference be noted and reviewed in 36 month's time.*

MGeorge.

Murray George
Chief Executive Officer

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6.2

MidCentral District Health Board
Te Poe Hauora o Ruahine o Tararua

Whanganui District Health Board

Disability Support Advisory Committee Terms of Reference

1 Committee of the Board

The Disability Support Advisory Committee is a committee of the Board, established in accordance with Section 35 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2 Functions of the Disability Support Advisory Committee

a. To provide advice to the Board on the disability support needs of the resident population of the district health board.
b. To provide advice to the Board on priorities for use of the disability support funding provided.
c. To ensure that the following promote the inclusion and participation in society, and maximise the independence of people with disabilities within the district health board's resident population:
    i. The kinds of disability support services the district health board has provided or funded or could provide or fund for those people.
    ii. All policies the district health board has adopted or could adopt for those people.
d. Such advice must not be inconsistent with the New Zealand Disability Strategy.
e. To advocate to external parties and organisations on the means by which their practices may be modified so as to assist, on a population basis, those experiencing disability.
f. To consider and recommend the disability support component of the annual purchasing plan and the annual provider business plan.
g. To recommend policies relating to the planning and purchasing of disability support services for the district.
h. To develop an annual workplan for the Board's consideration and approval.
i. To report regularly to the Board on the committee's findings (generally the Minutes of each meeting will be placed on the Agenda of the next Board meeting).

3 Delegated Authority

The Disability Support Advisory Committee shall not have any powers except as specifically delegated by the Board from time to time. The following authorities are delegated to the Disability Support Advisory Committee:

a. To require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.
b. To interface with any other committee(s) that may be formed from time to time.

4 Membership and Procedure

Membership of the Disability Support Advisory Committee shall be as directed by the Board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with Board and Committee Standing Orders.

5 Meetings

The Disability Support Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the Board. It is anticipated that at least three to four meetings will be held annually.

Note
For the purposes of this document, the definition of 'disability support services' is as incorporated in the Act, which means disability support for all of the community in the district health board's region.

TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 25 September 2008

SUBJECT **Role of Disability Support Advisory Committee**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

Earlier this year the Board requested that the terms of reference and role of the Disability Support Advisory Committee be reviewed. The intent behind the review was to increase the value of this Committee, particularly for its members.

Givens

1. MDHB must have a Disability Support Advisory Committee (DSAC) to meet is legislative responsibilities as per the New Zealand Public Health and Disability Act 2000.

   Schedule 3, NZ Public Health & Disability Act 2000

   3. Functions of disability support advisory committees

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

   (a) the disability support needs of the resident population of the DHB; and
   (b) priorities for use of the disability support funding provided.

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

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

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

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

2. The Ministry of Health is responsible for establishing disability services policy (within the health sector). It is also responsible for planning and funding services for people with a physical, intellectual or sensory impairment or disability (or a combination of these) - generally referred to as young-disabled services.

   MidCentral DHB is responsible for aged-related health and disability services (generally those for people over 65 years of age).

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This split in responsibility makes it more challenging for DSAC to undertake its role.

3. Board has confirmed that DSAC is to remain in its current form. That is, amalgamation with the Community & Public Health Advisory Committee, the Enable New Zealand Governance Group or other committee is not for consideration.

4. The frequency of DSAC meetings has been determined by Board. There shall be three per year, with an additional meeting in April if required for annual planning purposes.

5. A copy of MidCentral DHB's terms of reference for DSAC is attached. (Appendix A.) These largely reflect the minimum role outlined in legislation (refer 1 above).

Discussion

6. The Executive Management Team has considered how the role of DSAC can be enhanced. Current, the Committee's work programme covers six key aspects, namely:

   6.1 Strategic and annual planning – Annual review and establishment of future direction for disability services

   6.2 Staff – Employment practices, training and development, and staff awareness of disability issues

   6.3 Facilities – MDHB's facilities (owned and leased) and how they meet the requirements of the disability community

   6.4 MDHB Services – Customer feedback from disabled people regarding services provided by MidCentral Health

   6.5 Other Providers – Contractual requirements on contracted providers of health and disability services regarding disability matters

   6.6 Communication – MDHB's communication processes and how they meet the requirements of the disability community

   It also keeps abreast of progress in implementing MidCentral DHB's health of older persons strategy, though decision-making on this portfolio rests with the Community & Public Health Advisory Committee (CPHAC).

7. MidCentral DHB's management structure is based on a clear delineation between "planning and funding" and "providing" health and disability services. Responsibility for funding is carried out by the DHB's Funding Division. The Board's CPHAC oversees the Funding Division's work and responsibilities. Similarly the Hospital Advisory Committee oversees hospital and health services (MidCentral Health) and the Enable New Zealand Governance Group looks after the activities of Enable New Zealand.

8. The EMT does not wish to establish parallel or duplicate responsibilities. For example, planning and funding roles for disability support services being separated and run through DSAC. It is considered this would create confusion. Also, there is a risk planning/funding for age disability services would be fragmented, whereas

MDHB has taken a conscious decision that service planning be integrated. For example, chronic disease state services cover the total population, with particular attention given to specific groups such as the elderly.

9. EMT considered that DSAC's role could be enhanced by it taking a stronger overview of the demand for, and supply of, disability support services. This would assist it in considering and reviewing annual plans.

   This information could include:

   - aged disability across the district
   - disability support services (DSS) funded services from within MidCentral Health
   - DSS funded services provided by Enable New Zealand

   It would be our intention to provide information that is already captured and available, including:

   - Supportlinks information
   - Applications for equipment and housing modifications ex Enable New Zealand
   - Services provided via MidCentral Health's Assessment Treatment & Rehabilitation Service
   - Elder Health information ex Funding Division

10. We looked at the role/work of other DSACs within the DHB sector. It appears most DHBs face similar challenges in making the DSAC role meaningful, when policy is set nationally. Some DHBs have merged DSAC with CPHAC.

11. MidCentral DHB is currently in discussions with Whanganui DHB regarding the establishment of a formal alliance between the two entities. It is envisaged that under an alliance governance functions would be shared over time, ie a regional CPHAC and a regional DSAC committee.

    If this eventuates we would need to jointly review the role of each Committee.

12. It is proposed that no decision be taken on an enhanced role for DSAC until the outcome of the alliances discussions are known. Meantime, the possibility of an additional oversight role re the demand and supply of disability support services to be noted for consideration at the appropriate time.

13. A further report on this matter will be provided to the Committee when it next meets. It is envisaged that by that time a decision regarding the alliance will be known.

Recommendation

that the report be received.

Murray Georgel
Chief Executive Officer

Disability Support Advisory Committee

TERMS OF REFERENCE

1. In accordance with the NZ Public Health and Disability Act, the Board shall create a Disability Support Advisory Committee whose members and chairperson shall be as determined by the Board from time to time.

2. The terms of reference for the Disability Support Advisory Committee shall be:

   a. To provide advice to the Board on the disability support needs of the resident population of the District Health Board.

   b. To provide advice to the Board on priorities for use of the disability support funding provided.

   c. To ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

      i. the kinds of disability support services the DHB has provided or funded or could provide or fund for those people;

      ii. all policies the DHB has adopted or could adopt for those people.

   d. Such advice must not be inconsistent with the New Zealand Disability Strategy.

   e. To consider and recommend the disability support component of the annual purchasing plan and the annual provider business plan.

   f. To recommend policies relating to the planning, purchasing and provision of disability support services for the district.

   g. To develop an annual workplan for the Board's consideration and approval.

   h. To recommend what "expert" assistance will be required in order for the Committee to fulfil its obligations, and achieve its annual workplan.

   i. To report regularly to the Board on their findings (generally the minutes of each meeting will be placed on the agenda of the next Board Meeting).

3. The following authorities are delegated in the Disability Support Advisory Committee:

   a. To require the Chief Executive Officer (or delegate) to attend its meetings, provide advice and prepare reports as requested.

   b. To interface with any other committee(s) that may be formed from time to time.

4. The Disability Support Advisory Committee shall hold meetings as frequently as it considers necessary. It is anticipated that at least three meetings will be held annually.

(Note: For the purposes of this document, the definition of "disability support services" is as incorporated in the New Zealand Public Health and Disability Act 2000 and includes goods, services and facilities (a) provided to people with disabilities for their care or support or to promote their inclusion and participation in society, and independence; or, (b) provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the inclusion and participation in society, and independence of such people)

TO Disability Support Advisory Committee

FROM Chief Executive Officer

DATE 26 September 2011

SUBJECT **Committee's Work Programme, 2011/12**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. Purpose

This report updates progress against the Committee's 2011/12 work programme. It is provided for the Committee's information and discussion.

2. Summary

Reporting is occurring in accordance with the timeline.

A schedule of all reports scheduled for consideration at the Committee's next meeting are set out below. If there are any new items which members require, or any issues they would like canvassed in future reports, please advise.

- Draft 2012/13 Annual Plan
- Customer satisfaction update
- New Disability Stocktake: update
- Human Rights Tribunal Case: update

3. Recommendation

It is recommended:

that the updated work programme for 2011/12 be noted.

M Georgel.

Murray Georgel
Chief Executive Officer

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ID		Task Name
1		**DSAC, 2011/12**
2		
3		**NZ DISABILITY STRATEGY**
4	✓	Review of Disablity Stocktake
5	✓	Update re Re-doing Disability Stocktake
6	✓	Update re implementation of 2006 disability stocktake
7		Update for Re-doing Disabiltiy Stocktake
8	✓	**Portfolio Updates 2011**
9	✓	Communication
10	✓	Facilities (inc rental accommodation)
11	✓	Contracts (FD)
12	✓	HR
13	✓	No of incidence of falls in areas where sta
14		**Portfolio Updates 2012**
15		Communication
16		Facilities (inc rental accommodation)
17		Contracts (FD)
18		HR
19		**Customer Satisfaction**
20		Update 1
21	✓	Update 2
22		**GENERAL BUSINESS**
23	✓	Update re DSAC Role & ToR
24	✓	Update re Human Rights Tribunal Case
25		Update re Human Rights Tribunal Case
26	✓	Update re Health Passport & HDC response to ideas
27	✓	**GOVERNANCE**
28	✓	Terms of Reference Review
29		**STRATEGIC PLANNING**
30		Annual Plan 12/13 Draft 1