



# **Disability Support Advisory Committee**

## **Meeting**

**Thursday 18 November 2010**

**10:00am**

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

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





# Disability Support Advisory Committee

## For discussion with Board

DSAC Meeting Date:	
Feedback By:	
<b>DAP</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>KPIs</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>RISKS</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
3.	







# **KARAKIA AND INTRODUCTIONS**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life.**

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

### IMPORTANT

If in doubt – declare.

Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at [www.legislation.govt.nz](http://www.legislation.govt.nz)) and “Managing Conflicts of Interest – Guidance for Public Entities” ([www.oag.govt.nz](http://www.oag.govt.nz)).



## ADHB DSAC INTERESTS REGISTER

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Jo AGNEW</b>	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		
<b>Susan BUCKLAND</b>	1. Writing, editing and public relations services	Self-employed	Fees	Writer, editor and public relations services	7 August 2009
	2. Medical Council of NZ	Professional Conduct Committee member	Hourly fee	Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes	
	3. Occupational Therapy Board	Professional Conduct Committee member	Hourly fee	Lay member of PCC to assess complaints and determine outcomes	
<b>Bob TIZARD</b>	1. Nil				27 February 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Maria HULL-BROWN</b>	1. Employee Mental Health Foundation 2. Member Auckland City Council Disability Issues Advisory Group 3. Board member HOPE Foundation for Research on Ageing 4. Council Member Age Concern Auckland.				13 May 2010
<b>Dairne KIRTON</b>	1. Nil				24 June 2008
<b>Susan SHERRARD</b>	1. Team Leader for CCS Disability Action 2. Trustee Ripple Trust				18 February 2010
<b>Nanar TAN</b>	1. Nil				16 July 2008

**CONFIRMATION OF MINUTES**  
**- THURSDAY 16 SEPTEMBER 2010**



# Disability Support Advisory Committee Minutes

<b>MEETING DETAILS</b>							
Date and Time	10:00am, Thursday, 16 September 2010						
Venue	Sir Douglas Robb Boardroom, Level 7, Building 14, Greenlane Clinical Centre, Epsom						
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>						
	<p>The Chair declared the meeting open 10:00am.</p> <p><b>Committee Members</b></p> <table> <tr> <td>Jo Agnew (Chair)</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Marie Hull-Brown</td> <td>Susan Sherrard</td> </tr> <tr> <td>Nanar Tan</td> <td>Rt Hon Bob Tizard</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive  Hilda Faasalele – General Manager Pacific Health  Lisa Gestro – Manager Planning and Funding  Janice Mueller - Director Allied Health  Alison Paulin – Leader Speech Language Therapy  Carolyn Simmons Carlsson – Professional Leader Occupational Therapy  Ian Bell – Board Administrator</p> <p><b>Apologies</b></p> <p>Apologies had been received from Susan Buckland and Dairne Kirton.</p>	Jo Agnew (Chair)	Dr Brian Fergus	Marie Hull-Brown	Susan Sherrard	Nanar Tan	Rt Hon Bob Tizard
Jo Agnew (Chair)	Dr Brian Fergus						
Marie Hull-Brown	Susan Sherrard						
Nanar Tan	Rt Hon Bob Tizard						
<b>3</b>	<b>CONFLICTS OF INTEREST</b>						
	There were no notifications of any conflicts of interest for any item on the agenda.						
<b>4</b>	<b>CONFIRMATION OF MINUTES 15 JULY 2010</b>						
	<p><u>Moved Bob Tizard; seconded Marie Hull-Brown</u></p> <p><i>That the minutes of the Disability Support Advisory Committee meeting held on 15 July 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>Workbridge are to come and speak to the next meeting and Brian Fergus to be confirmed as a member of the Committee.</p>						
<b>6</b>	<b>CHAIRMAN'S REPORT</b>						
	The Chair advised that they had attended a regional meeting at Counties Manukau but Waitemata were unable to attend. The minutes from that meeting are to be followed up.						

<b>8.1</b>	<b>Initial Feedback – Disability Responsiveness Review</b>
	<p>Mary Schnackenberg addressed the meeting advising that she used to work for the Foundation for the Blind but had since set up her own consultancy. While attending the “Step Up” launch she was informed that ADHB wanted to do an audit of accessibility which she had undertaken with Vivienne Naylor, a physical auditor, noting that good design for disability is good design for everyone.</p> <p>The formal report will be available at the end of October. The methodology was focus groups and workshops as well as one on one interviews. With the focus groups of 38 with disability, a third were visually impaired and 10 wheelchair users as well as 6 sign language group. The workshops were with four different groups of staff and staff with disability and interviews with four managers and Moodle specialists in on line training. Sites visited were ACH, Starship, Greenlane and RehabPlus. Three emerging themes were access to ADHB, needs in the physical environment, with equipment and buildings and way finding, and interaction with staff.</p> <p><b>Access to Information</b></p> <p>The journey began with an appointment letter where language was important so that the words could be understood as well as layout including font size, clarity and order of information. How these were obtained by post, email and reminder notices were by text although this was not consistent within ADHB. Pamphlets also needed to cover language, fonts and vocabulary but there was a need to keep these up to date and remove out of date copies. For deaf getting sign language interpreters was difficult.</p> <p><b>Physical Environment</b></p> <p>Way finding signage needed to be consistent and simplified and use international symbols with attention to fonts and height of signs, as well as having maps which should be inside and outside each building entrance with “You Are Here”. Other issues were lighting levels as illumination levels are important, accessibility to toilets and bathrooms and it was noted that wheelchair users disappear with a suggestion that a visual pole be attached to each.</p> <p>Denis Jury joined the meeting at 10:36am.</p> <p>It was good that the Auckland City Hospital car park was getting underway but there was a need to have a barrier free advisor involved in the design.</p> <p><b>Staff Interaction</b></p> <p>There was a goodwill however disability will impact on getting well and it was thought that doctors did not read the notes about disability. Front line staff were important and volunteers helped although there were none available on the weekend. Support should be given to appointing a Disability Officer to champion solutions and provide advice and guidance to staff and management. It was noted that older people became anxious and there was some fear in coming into hospital.</p> <p>The recommendations in the report will be prioritised as to quick fixes, intermediate and long term.</p> <p>In thanking Mary for her presentation the CEO thanked her for the way she expressed her report which he received with sadness and excitement in terms of the opportunities. Examples of where things were done well would be given.</p>
<b>7.1</b>	<b>DAP Report</b>
	<p>Denis Jury explained the structure of the DAP being Goals 1 2 and 3 with high level strategies, objectives and then strategies to achieve the objectives giving the example of the high level strategy of reduced inequalities with the objective to support disabled people with the strategy to achieve that being the development of the accessibility audit report. Other objectives are aimed at older people and with this initiative a subgroup was being established relating to aged residential care.</p>

8.2	<b>Update on National Equipment Assessment and Allocation Project</b>
	The Ministry of Health circular is to be distributed by email.
8.3	<b>Proposed Introduction of the New Zealand Health Passport</b>
	This had been put out by the Health and Disability Commissioner for consultation. This was the second version with the other much more graphic. Mary Schnackenberg advised that she had made a submission and although she supported it to health staff to understand what was going on it may not work and could not be relied upon to be read. Suggestions were to link to NHI numbers and technology could help.
9.3	<b>DSAC Feedback to Board</b>
	Items to feedback were confirmation of Brian Fergus as a member and barrier free advice for the car park as well as any new or refurbishment of buildings.
10	<b>GENERAL BUSINESS</b>
	<p><b>Orientation</b></p> <p>Alison Paulin advised that work was being done on the orientation to the organisation with the aim to get awareness of the social model of disability and the New Zealand Disability Strategy. The CEO did talk on the values of the organisation and what they looked like in practice which would include attitude to disability. Changes would be trialled and include what came out of the audit with an update to the November meeting. There would be a module developed for moodle.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 11:57am</p> <p>The next meeting is scheduled for</p> <p>10:00am, Thursday, 18 November 2010,</p> <p>Sir Douglas Robb Boardroom</p> <p>Level 7, Building 14,</p> <p>Greenlane Clinical Centre, Epsom</p>
<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b> <span style="margin-left: 300px;"><b>DATE:</b></span></p>	



**ACTION POINTS**

- **THURSDAY 16 SEPTEMBER 2010**



**Disability Support Advisory Committee  
Action Points from the Meeting held on Thursday 16 September 2010**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
4	Brian Fergus to confirmed as a member of the Committee	Ian Bell	Board approved 6 Oct 2010
6	Minutes of the Regional meeting 26 August 2010 to be obtained	Ian Bell	Not available
8.2	Ministry of Health circular to be distributed by email	Ian Bell	
10	Orientation Programme changes to be advised	Alison Paulin	



**CHAIRMAN'S REPORT**



# **DISABILITY SUPPORT PERFORMANCE**

## **7.1 DAP Report**





## **Auckland District Health Board**

# **District Annual Plan *2010 - 2011***

*22 June 2010*

## Priority and Developmental Work for 2010-11

### Goal 1: Lift the health of people living in Auckland city

High level strategy	Objective	Strategies to achieve objectives
<b>1.1 Reduce inequities in health status</b>	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> <li>– develop Integrated Family Health Centres/Whanau Ora Centres</li> <li>– develop specific activities that achieve Whanau Ora</li> <li>– develop indicator measures for Whanau Ora</li> <li>– develop a Whanau Ora approach for all services devolved</li> </ul>
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access to health care and support services	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system		

High level strategy	Objective	Strategies to achieve objectives
<b>1.2 Improve outcomes in priority areas</b>		
1.2a Child ren and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: <ul style="list-style-type: none"> <li>- improving access by taking services to pre-schools</li> <li>- enhancing oral health education</li> <li>- increasing early enrolment with a focus on Maori and Pacific populations</li> </ul>
1.2b Older people	1.2b.1 Home -based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Inc rease effectiveness across primary, secondary, tertiary services	1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthe n community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions

High level strategy	Objective	Strategies to achieve objectives
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes) 1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed 1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community 1.2d.3.3 At least 10% of retinal screening to be undertaken in the community
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

**Goal 2: Performance improvement: sooner, better, more convenient**

High level strategy	Objective	Strategies to achieve objectives
<b>2.1 Efficient and effective health care system</b>		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
		2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services
		2.1b.1.5 Improve access to primary care for palliative care clients by 15%
		2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes)
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children’s acute flow projects
		2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
		2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: <ul style="list-style-type: none"> <li>- General medicine</li> <li>- Orthopaedics</li> <li>- Radiology</li> <li>- Paediatrics general surgery</li> <li>- General surgery</li> <li>- Ophthalmology</li> </ul>
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> <li>- Implement new model of care and workforce roles in the Greenlane Surgical Centre</li> <li>- Maintain past elective surgery improvement by including primary care in the</li> </ul>

High level strategy	Objective	Strategies to achieve objectives
		referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
<b>2.2 Improve leadership capability</b>	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
<b>2.3 Improve Clinical Quality and Professional Governance</b>	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity

High level strategy	Objective	Strategies to achieve objectives
<b>2.4 Strengthen the health workforce</b>	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
<b>2.5 Information management</b>	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
<b>2.6 Planning</b> <b>2.6 Planning (cont)</b>	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines 2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> <li>– description of future models of care across the continuum of care</li> <li>– plan the shape, size, setting, and location for future services and inter district flow patients</li> <li>– provide the strategic context for major future developments and business cases</li> <li>– develop workforce response to current and long term service plans via regional and the national workforce planning</li> <li>– increase the focus on regional planning and collaboration with the regional primary care business cases</li> </ul> 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

\* Refer to appendix 8

**Goal 3: Live within our means**

High level strategy	Objective	Strategies to achieve objectives
<b>3.1 Break-even position maintained</b>		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
<b>3.2 Sustainable balance sheet</b>		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans



# Group Pack Report

Group/Committee: Disability Support Advisory Committee



## Goal Level Summary

DAP Projects - total projects: 9

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red	
			Define	Measure																	Analyse
1 Lift the Health of the people in Auckland City	8	8	2	2	3	0	1	0	8	0	0	8	0	0	8	0	0	0	0	0	0
2 Performance improvement	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
3 Live within our means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total #</b>	<b>9</b>	<b>9</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>33%</b>	<b>22%</b>	<b>33%</b>	<b>0%</b>	<b>11%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

### Review

No review entered for this committee report

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

### High Level Summary - total projects: 8

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1.1 Reduce inequalities in health status	3	3	1	1	1	0	0	0	3	0	0	3	0	0	3	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2b Improve outcomes for older people	4	4	2	1	1	0	0	0	4	0	0	4	0	0	4	0	0	0	0	0	
1.2c Improve outcomes for mental health and addictions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2d Improve outcomes for long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2e Improve outcomes for Palliative care	2	2	0	0	1	0	1	0	2	0	0	2	0	0	2	0	0	0	0	0	
<b>Total #</b>	<b>8</b>	<b>8</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>25%</b>	<b>25%</b>	<b>38%</b>	<b>0%</b>	<b>13%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	

### Objectives

Objective	Objective Owner	Comment
1.1.4 Support disabled people and improve their access to health care and support services	Denis Jury (ADHB)	Overall good progress with all projects. Initial Disability Responsive report received strong support from DISAC and final report on time for delivery by the end of Oct. MoH has advised that the Interim Funding Pool will not be devolved this calendar year but discussions continuing with the national Funding GMs regarding the issues raised by the Northern Region about the disproportionate impact of the risk across the country.

### Exceptions

There are no projects that have been marked as an exception

## Goal: 2 Performance improvement

### High Level Summary - total projects: 1

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

### Objectives

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

### Exceptions

There are no projects that have been marked as an exception

40

## Goal: 3 Live within our means

High Level Summary - total projects: 0

No Projects entered against this goal

## PAPERS

- 8.1 Integration Group – The Be Accessible Campaign**
- 8.2 Final Draft Report – Accessibility Audit**
- 8.3 Mainstream Programme**



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# ADHB Briefing Paper

<b>Date</b>	Thursday 18 November 2010
<b>To</b>	SLT - Integration group
<b>From</b>	Lisa Gestro
<b>Author</b>	Lisa Gestro Planning and Funding Manager
<b>Functional Group</b>	
<b>Subject</b>	The Be.Accessible Campaign

## Background

ADHB has been actively working along side the Auckland City Council (Auckland City) and AUT University (AUT) in a collaborative effort to lead and promote increased responsiveness to disability issues across our city.

Initial efforts culminated in the release of the Step Up Auckland report, which was launched by Minister Turia and was warmly received by the local disability community and was nationally recognised as an excellent example of an integrated approach to the implementation of the NZ Disability Strategy.

The launch of the report has lead to the commissioning of an independent disability responsiveness audit across ADHB, which will be launched at the November DSAC meeting, as well as several other conjoint initiatives across the three agencies. Most recently, the group has become involved in discussions at a national level regarding an opportunity for the ADHB to be leaders in the roll out of a significant branding campaign for disability.

## The Be. Accessible campaign

The advent of the Rugby World Cup has presented significant opportunities for the promotion of disability awareness, and the requirements of a large event in terms of disability access creates significant legacy opportunities for a project like Step Up, where initial investment to meet tourism and event requirements mean that ongoing benefit can be derived for communities long after the event has been concluded. This opportunity has resulted in the development of the Be.Accessible campaign, which will be led and rolled out by the three partner agencies in advance of further agencies signing on and achieving the branding. It is anticipated that the roll out of the branding will be done through the Auckland Anchors group, which ADHB is a partner.

## Next Steps

It has been agreed that the Be. Accessible campaign, which has now attracted funding totalling several million dollars to deliver leadership programmes as well as branding projects, should not be project

managed by any of the three agencies, but that a conjoint secondment takes place for one year until such time as the campaign and the centre become self funding. Auckland City have agreed to release Minnie Baragwaneth for one year to fill the role, and both Auckland City and AUT have agreed to contribute \$45,000 for one year to cover the cost of establishment and set up of the centre.

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# ADHB Briefing Paper

<b>Date</b>	Thursday 18 November 2010
<b>To</b>	DSAC
<b>From</b>	Denis Jury, CPFO
<b>Author</b>	Lisa Gestro Planning and Funding Manager
<b>Functional Group</b>	Planning and Funding
<b>Subject</b>	Final Draft report – Accessibility Audit

This will be presented to the DSAC Committee for further discussion at the November meeting.



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# Human Resources Paper

Date	21 August 2010
To	Disability Support Advisory Committee
From	Vivienne Rawlings, General Manager Human Resources Extension 23942 <a href="mailto:vrawlings@adhb.govt.nz">vrawlings@adhb.govt.nz</a>
Subject	Mainstream Programme
<p><b>Purpose</b> The purpose of this paper is to provide information to the Disability Support Advisory Committee about the Mainstream Programme which will be implemented by ADHB and seek the endorsement and support of the committee.</p>	
<p><b>Executive Summary</b> The Mainstream employment programme was set up by the Ministry of Social Development, and aims to place people with disabilities in State Service organisations for two-year job placements. The programme has a four-way partnership model between Mainstream, Placement Specialists (disability employment experts), employers, and people with disabilities.</p> <p>The programme requires employers to create a job (outside the staffing allocation/not using an existing vacancy) and train the employee on the job. Mainstream provides a 100% salary subsidy for year one and 50% for year two, and provides training funding for each year of the placement for both the participant and the participant's supervisor.</p> <ul style="list-style-type: none"> <li>▪ Mainstream helps to ensure that the State service workforce reflects the make-up of the people it serves</li> <li>▪ It empowers employers to feel confident about giving work opportunities to people with disabilities</li> <li>▪ It gives people with disabilities and little work experience the chance to show they are an asset to the workforce</li> <li>▪ It is a stepping stone to independent sustainable employment for people with disabilities</li> </ul> <p>The Mainstream Programme provides:</p> <ul style="list-style-type: none"> <li>▪ A 100% salary subsidy for the first year of employment and 50% of the salary for the second year</li> <li>▪ Funding for external training for Mainstream participants and their direct supervisors</li> <li>▪ Induction training for Mainstream participants and their supervisors</li> <li>▪ Funding to meet participants' adaptive technology or specialised assistance costs</li> <li>▪ An advice and referral service for employers and Mainstream participants</li> <li>▪ Follow-up support for participants and their direct supervisors</li> </ul>	

## How Does Mainstream Work

### Initial Steps to Employing an Employee through the Mainstream Programme

1. Employer is to create a position for a two-year period outside the staffing allocation.
2. Employer draws up a job proposal.
3. Employer contacts the placement agency to discuss possible candidates.
4. The employer is to provide the Mainstream participant with an Employment Agreement that sets out their terms and conditions of employment in accordance with the Employment Relations Act 2000.

## Components of the Mainstream Programme

### Custom-made Employment Position

Positions must be created outside of the staff allocation or staff cap. Existing vacancies cannot be used. The positions are to be specially created and tailored to the skills and aptitude of the participants, and the needs of the employer. This tailored approach allows participants to build job skills, free of undue pressure and stress being placed on them by the organisation. The types of work performed by employees involved in this programme range from basic clerical duties to information technology, tutoring at tertiary level and customer service.

### Fixed Term Employment - 2 Year Duration

- Placements of less than two year's duration are not accepted. The Ministry's reasoning for this is that research shows that a two-year period is needed to enable the participant to become fully competent to compete on the open job market.
- A job does not have to be guaranteed after the two years of the programme but the Mainstream participant should be encouraged and assisted to apply for advertised positions within the organisation.
- If the employer decides that the position is no longer required and for that reason terminates the employment before the two-year placement has concluded, the employer is to pay a lump sum of three month's salary to the participant.

### Rate of Pay

An employee in the Mainstream programme is expected to be paid the same rate as anyone else performing similar duties.

### Administration of Pay

The employer pays the participant's salary. Mainstream then reimburses the employer 100% in the first year and 50% in the second year. Payment of the subsidy is made on receipt of invoices (from 1 July 2010 invoices will be accepted monthly).

### Hours of Work

Working hours for employees in the Mainstream programme can be anything from a minimum of five hours per week up to full-time. It is common for people to begin their Mainstream placement on a small number of hours and build this up over several months.

### On-the-Job Training

The employer is expected to provide on-the-job training to the Mainstream participant, over and above the usual amount and support opportunities for the participant to up-skill. Funding for on-the-job training is the responsibility of the employing organisation.

### Employee Performance

People placed into employment through the Mainstream Employment Programme are not employed on merit. They are not 'job ready' in the conventional sense. It is expected that they will require some external training and some on-the-job training to perform certain duties. Knowledge and skills are expected to be built up over time, with the support and goodwill of co-workers. However, if any disciplinary issues arise they should be dealt with in line with the organisation's usual HR practices.

## Support Provided by Mainstream

### **Mandatory One Day Induction Training for the Participant and their Supervisor**

The training is an induction for both participants into the Mainstream programme. The training is mandatory as Mainstream placement success often depends on the ability of the supervisor to be a coach and a mentor. Mainstream will pay for the actual and reasonable costs associated with travel to and attendance at these workshops.

### **External Training Allowance for the Participant**

Mainstream offers the participant an allowance for training assistance external to the organisation. It can not exceed a total of \$4,000.00 (including GST) over the whole placement.

### **Training Allowance for Participants Supervisors**

A training allowance of \$3,000 (including GST) is provided for direct supervisors of Mainstream participants. Training must be related to either disability equity or performance management that will either enhance the Mainstream participant's employment prospects or increase the supervisor's awareness of the capabilities of people with disabilities or alternatively, training that covers issues related to staff supervision.

### **Cost of Equipment and Services to make the Participant's Workplace more Accessible**

The Mainstream Employment Programme will meet some of these costs. The employer is expected to provide any resources that would normally be provided for employees, including reasonable adjustments to accommodate their disability. If further support or adaptive technology is required, the employee can apply for CODE (Cost of Disability in Employment) funding. The maximum amount of CODE Funding available is \$16,900 (including GST) per year for each of the two years of Mainstream support. The funding is available for adaptive equipment, interpreter service, adaptive software and hardware or other assistance considered reasonable by the Mainstream Employment Programme Manager.

### **On-going Monitoring and Placement Reviews by Placement Specialists**

The Placement Specialist is required to meet with the participant and supervisor to complete the placement progress reviews regularly to make sure the placement is going well and alert the Casework Advisor if problems are developing. Progress reviews are further used as a time to plan for the participant's future. Placement Specialists also provide general ongoing support and help participants and supervisors to apply for training funding and work out what CODE requirements they may have.

### **Telephone and On-site Assistance from Mainstream Casework Advisors**

As an additional support, a Casework Advisor will phone the participant regularly to ensure that the placement is going well. They also act an additional confidant for the participant if they are not confident discussing issues during placement progress reviews.

## Advantages/Disadvantages

### **Advantages**

- Employ someone on a generous subsidy that will get necessary but non-priority tasks done while freeing up existing staff to focus on tasks that require greater experience.
- Provides an opportunity for the supervising staff to gain greater skills in coaching, mentoring and performance management.
- Empowers the employer to be confident about giving work opportunities to people with disabilities.
- Builds a workforce that reflects the population of the people they serve.
- Makes a positive contribution to the community.
- Provides additional learning in how to accommodate disabled clients and customers
- Gives people with disabilities and little work experience the chance to show they are an asset to the workforce and creates a stepping-stone for them to gain independent sustainable employment.
- Social responsibility
- Connecting with our community in a tangible way

### Disadvantages

The most significant downside to the mainstream programme is the amount time that it will require from existing employees. This will occur in a number of ways:

- The designated supervisor will spend a portion of their time training the Mainstream participant on-the-job. This will be over and above the usual amount as the participant will have a significant disability that has limited their employment options (this is a participant specification).
- The Supervisor is also required to attend Mainstream's one-day induction training. Other staff members are also invited to attend.
- Together HR, supervisor and participant will need to plan for the eventual tenure of the Mainstream participant if at all possible.
- Administration time required to set up the programme at ADHB.
- Additional on-going administration that Mainstream will require:
  - Mainstream Employment Programme documentation.
  - Accounts/Payroll/HR will need to provide accurate salary subsidy claims to the Mainstream Employment Programme.

### Cost of Implementing the Mainstream Programme

- Salary for the 2<sup>nd</sup> year of placement at the subsidised rate (50% of salary).
- Cost associated with the time required from existing staff to administer and manage the programme and the continual coaching of the employee.
- Potential cost of adaptive equipment if not covered by [Cost of Disability \(CODE\) funding](#). However, depending on where in the ADHB a potential participant is working this is not foreseen to incur a significant cost.

### Management & Administration FTE Cap

Discussions will need to take place with the Ministry of Health to understand if Mainstream positions during the two years will need to be reported within the management and administration fte cap number or can be reported separately under a Mainstream heading.

## **CONFIRM**

- 9.1 Action Points for next DSAC Meeting**
- 9.2 DSAC Feedback to CPHAC**
- 9.3 DSAC Feedback to Board**

**Use Forms at beginning of Meeting Pack**

# *10*

## **GENERAL BUSINESS**

### **10.1 Auckland City Hospital Car Park Update**





# **Auckland City Hospital Carpark Construction**

## **Newsletter No. 1 – August 2010**

### **LATEST NEWS & NOTIFICATIONS**

Welcome to the first ACH Carpark Project newsletter. The newsletter will be published regularly and be available on the ADHB website.

Overview of the Project: The ACH carpark project will provide 403 car parks for the public on the old Wallace Block site. In addition to this, seven shops will be constructed on the Park Road frontage with 500 sqm of commercial space above the shops.

The Minister visited the site on 22<sup>nd</sup> July 2010 to announce the government approval and turned the soil. Mainzeal Construction was awarded the construction contract on 30<sup>th</sup> July 2010.

### **UPCOMING KEY DATES**

#### **23<sup>rd</sup> August 2010 - Services Location**

In the week beginning 23<sup>rd</sup> August 2010 a small section of the Wallace Block will be closed to allow a digger to expose and pin point the exact location of the 11kv power cable. By identifying the exact location we will be able to establish if the cables conflict with the proposed foundation design.

A hole approx 1m by 1m close to the 3 ARG car parks is to be dug.

The work should take 2 days however we have allowed 1 week to cover for any rainy days.

#### **7<sup>th</sup> September 2010 – Karakia**

A karakia will be held on the site before removal of the Mauri from the trees.

**When:** Tuesday, 7 September 2010

**Time:** 8:00 am - 08:30 am

**Where:** ACH outside Level 5



### KEY DATES CONTINUED

The date for burial of the Mauri stone for the car park has yet to be established, but it will be after the ground works on the site are completed (around December 2010).

#### **25<sup>th</sup> October 2010 - Site Services Relocation**

The incoming gas line is to be relocated. The 11kv power cable may also have to be relocated. Planning for this event is underway.

#### **24<sup>th</sup> November 2010 - Site Possession**

Mainzeal take possession of the site on 24<sup>th</sup> November 2010 and will start erecting hoarding.

#### **December 2011 - Construction Completion**

### PARKING AND LOADING BAY

A working group has been liaising with stakeholders to ease traffic congestion and parking around the Oncology Building and the Loading Bay / Chimney area.

Key proposals are:

- Remarking roads and minor roading works.

- Establish Oncology Parking in Area A (see attached).

- All pool cars to be relocated to Area B (see attached).

- Main Ramp - only one lane open and available to ambulance, transit pick up and taxis.

- Motorbikes to be relocated to the Co-Gen deck.

- Create loading bay truck waiting areas.

There will be a loss of approx 80 staff car parks as we tidy up parking around Oncology and reassign parking areas for Oncology and pool cars. Staff are advised to use the Newmarket off-site parking and shuttle services provided.

Security will be asked to strictly enforce parking restrictions in this area.



## DISTRIBUTION LIST

AK Security Services (First Security)	Manoj Singh (Wilson)
Ashoo Ranjith (ADHB)	Marjikke Blommestijn (ADHB)
Chris Fellows (Wilson)	Mark Fenwick (ADHB)
Chris Morgan (ADHB)	Matthew Rogers (ADHB)
Clark MacKinnon (PAE)	Michelle Holmes (Auckland Radiology)
Colin Usher (Mainzeal)	Mike Commins (Meridian Energy)
Craig Curling (Mainzeal)	Murray Svendsen (Mainzeal)
David Cockell (Coffey)	Ngaire Buchanan (ADHB)
David Houlihan (ADHB)	Paul Green (ADHB)
Denise Manning (ADHB)	Paul Marks (PAE)
Feroz Buksh (ADHB)	Penny King (ADHB)
Gordon Chisholm (ADHB)	Robyn Dunningham (ADHB)
Ian Harper (ADHB)	Shift Engineers (PAE)
Ipu Hilihetule (ADHB)	Stephen Paterson (ADHB)
Jonathan Tham (ADHB)	Vasu Munsamy (First Security)
Julie Maehl (ADHB)	Vicki Dolphin (ADHB)
Kay Hyman (ADHB)	Warren McIvor (ADHB)



**APPENDICES**

**Nil**

# Disability Support Advisory Committee Agenda

<b>MEETING DETAILS</b>		
Time and Date	Thursday 18 November 2010, 10:00 a.m.	
Venue	Sir Douglas Robb Board Room, Level7, Building 14, Greenlane Clinical Centre	
Members	Jo Agnew (Chair), Susan Buckland, Peter Druskovich, Tunumafono Ava Fa'amoe, Dr Brian Fergus, Marie Hull-Brown, Dairne Kirton, Susan Sherrard, Nanar Tan, Rt Hon Bob Tizard	
Apologies		
In Attendance	Garry Smith, Dr Denis Jury, Lisa Gestro, Janice Mueller, Ian Bell.	
	<b>Item</b>	<b>Page No</b>
1	<b>Karakia and Introductions</b>	<b>001</b>
2	<b>Attendance and Apologies</b>	<b>005</b>
3	<b>Conflicts of Interest</b>	<b>007</b>
4	<b>Confirmation of Minutes Thursday, 16 September 2010</b>	<b>013</b>
5	<b>Action Points Thursday 16 September 2010</b>	<b>019</b>
6	<b>Chairman's Report</b>	<b>023</b>
7	<b>Disability Support Performance</b> 7.1 DAP Report	<b>025</b>
8	<b>Papers</b> 8.1 Integration Group – The Be Accessible Campaign 8.2 Final Draft Report - Accessibility Audit 8.3 Mainstream Programme	<b>041</b>
9	<b>Confirm</b> 9.1 Action Points for next DSAC Meeting 9.2 DSAC Feedback to CPHAC 9.3 DSAC Feedback to Board	<b>057</b>
10	<b>General Business</b> 10.1 Auckland City Hospital Car Park update	<b>059</b>
11	11.1 Appendices - Nil	<b>065</b>
<b>NEXT MEETING</b>		
	<b>Date and Time:</b> Thursday 27 January 2011	
	<b>Venue:</b> Sir Douglas Robb Board Room, Level 7, Building 14, Greenlane Clinical Centre	

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