Disability Support Advisory Committee Meeting

Wednesday, 21 June 2017
2.00pm

Terrace Board Room
Auckland Deaf Society
164 Balmoral Road
Balmoral, Auckland

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Published 14 June 2017
**Agenda**

**Disability Support Advisory Committee**

**21 June 2017**

**Venue:** Auckland Deaf Society, Terrace Boardroom, 164 Balmoral Road, Auckland

**Time:** 2.00pm

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**Committee Members**
- Jo Agnew (Chair)
- Michelle Atkinson
- Edward Benson-Cooper
- Matire Harwood (Deputy Chair)
- Robyn Northey
- Allison Roe

**In attendance:**
- Amanda Bleckmann, Ministry of Health

**Auckland DHB and Waitemata DHB Staff**
- Dr Dale Bramley: Chief Executive Officer Waitemata DHB
- Ailsa Claire: Chief Executive Officer Auckland DHB
- Samantha Dalwood: Disability Advisor Waitemata DHB
- Kim Herrick: Organisational Development Practice Leader, Auckland DHB
- Dr Debbie Holdsworth: Director of Funding Auckland and Waitemata DHBs
- Fiona Michel: Chief Human Resources Officer, Auckland DHB
- Kate Sladden: Funding and Development Manager, Health of Older People
- Michelle Webb: Corporate Committee Administrator
- Sue Waters: Chief Health Professions Officer
- Tim Wood: Funding and Development Manager, Primary Care

(Other staff members who attend for a particular item are named at the start of the respective minute)

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**Apologies Members:** Nil.

**Apologies Staff:** Ailsa Claire, Fiona Michel, Tim Wood.

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**Agenda**

Please note that agenda times are estimates only

- **2.00pm**
  1. Attendance and Apologies
  2. Register and Conflicts of Interest
     - Does any member have an interest they have not previously disclosed?
     - Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

- **2.05pm**
  3. Confirmation of Minutes 29 March 2017

- **2.10pm**
  4. Action Points

- **2.10pm**
  5. CHAIR’S REPORT
<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>6.00pm</td>
<td><strong>PRESENTATIONS</strong></td>
</tr>
<tr>
<td>2.15pm</td>
<td>6.1 The New Zealand Disability Sector and Linkages to the DHBs</td>
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<td>2.30pm</td>
<td>6.2 Healing Environments Design Guide and Wayfinding Strategy – Progress Update (Justin Kennedy-Good, Auckland DHB)</td>
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<td>2.50pm</td>
<td>6.3 Waitemata 2025 and Wayfinding Update (Facilities and Development, Waitemata DHB) Employment (Outcome 2)</td>
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<td>6.4</td>
<td>7. <strong>STANDING ITEMS</strong></td>
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<tr>
<td>3.05pm</td>
<td>7.1 Disability Advisor Update</td>
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<td>3.15pm</td>
<td>7.2 Draft New Zealand Disability Strategy 2016 to 2026 Implementation Plan</td>
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<td>8. <strong>INFORMATION PAPERS</strong></td>
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<tr>
<td>3.25pm</td>
<td>8.1 New Zealand Disability Support Network Employment Practice Guidelines Update (Sarah Halliday, NZDSN Employment Advisory Committee)</td>
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<td>3.40pm</td>
<td>8.2 Disability Data and Evidence Working Group Update (Samuel Murray, NZDSN to join the meeting by Skype)</td>
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<td>3.55pm</td>
<td>8.3 Ministry of Health Disability Sector Update (verbal) (Amanda Bleckmann, MOH)</td>
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<td>4.10pm</td>
<td>8.4 General Business</td>
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**Next Meeting:** Wednesday, 13 September 2017 at 2.00pm  
Auckland Deaf Society, Terrace Boardroom, 164 Balmoral Road, Auckland
### Attendance at Disability Support Advisory Committee Meetings

<table>
<thead>
<tr>
<th>Members</th>
<th>29 Mar. 17</th>
<th>21 Jun. 17</th>
<th>13 Sep. 17</th>
<th>06 Dec. 17</th>
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<td>Jo Agnew (Chair)</td>
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<td>Matire Harwood (Deputy Chair)</td>
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<td>Robyn Northey</td>
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<td>Allison Roe</td>
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Key: x = absent, # = leave of absence, c = meeting cancelled

### 2016 Attendance

<table>
<thead>
<tr>
<th>Members</th>
<th>13 July 16</th>
<th>24 Aug. 16</th>
<th>16 Nov. 16</th>
<th>29 Mar. 17</th>
<th>21 Jun. 17</th>
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<td>Jo Agnew</td>
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<td>Max Abbott</td>
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<td>Judith Bassett</td>
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<td>Marie Hull-Brown</td>
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<td>Sandra Coney</td>
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<td>Jade Farrar</td>
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<td>Dairne Kirton</td>
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<td>Lester Levy</td>
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<td>Jan Moss</td>
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<td>Russell Vickery</td>
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<td>Shayne WiJohn</td>
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Key: x = absent, # = leave of absence, c = meeting cancelled

Auckland and Waitemata District Health Boards
Disability Support Advisory Committee Meeting 29 March 2017
Conflicts of Interest Quick Reference Guide

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.

<table>
<thead>
<tr>
<th>Member</th>
<th>Interest</th>
<th>Latest Disclosure</th>
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<tbody>
<tr>
<td>Jo AGNEW</td>
<td>Professional Teaching Fellow – School of Nursing, Auckland University</td>
<td>17.01.2017</td>
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<tr>
<td></td>
<td>Casual Staff Nurse – Auckland District Health Board</td>
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<td></td>
<td>Director/Shareholder 99% of GI Agnew &amp; Assoc. LTD</td>
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<td></td>
<td>Trustee - Agnew Family Trust</td>
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<td></td>
<td>Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder)</td>
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<tr>
<td>Michelle ATKINSON</td>
<td>Evaluation Officer – Counties Manukau District Health Board</td>
<td>29.03.2017</td>
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<td>Director – Stripey Limited</td>
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<td></td>
<td>Trustee – Starship Foundation</td>
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<tr>
<td>Edward BENSON-COOPER</td>
<td>Chiropractor – Milford, Auckland (with private practice commitments)</td>
<td>15.03.2017</td>
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<tr>
<td>Matire HARWOOD</td>
<td>Senior Lecturer – Auckland University</td>
<td>29.03.2017</td>
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<td>Board Director – Health Research Council</td>
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<td>Director – Ngarongoa Limited, which is contractor providing services to National Hauora Coalition.</td>
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<td>GP at Papakura Marae Health Clinic</td>
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<td>Advisory Committee Member – Stroke Foundation NZ (Maori Health)</td>
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<td>Member Te Ora, Maori Medical Practitioners</td>
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<tr>
<td>Robyn NORTHEY</td>
<td>Shareholder of Fisher &amp; Paykel Healthcare</td>
<td>17.05.2017</td>
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<td>Member – New Zealand Labour Party</td>
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<td>Husband - member Waitemata Local Board</td>
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<td>Husband – shareholder of Fisher &amp; Paykel Healthcare</td>
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<td>Husband – shareholder of Fletcher Building</td>
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<td>Husband – Chair, Problem Gambling Foundation</td>
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<td>Husband – Chair, Community Housing Foundation</td>
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<tr>
<td>Allison ROE</td>
<td>Chairperson – Matakana Coast Trail Trust</td>
<td>15.03.2017</td>
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<td>Member - Rodney Local Board, Auckland Council</td>
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Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 29 March 2017 in the Auckland Deaf Society Terrace Boardroom, 164 Balmoral Road, Auckland commencing at 1.30pm

<table>
<thead>
<tr>
<th>Committee Members Present</th>
<th>Auckland and Waitemata DHB Staff Present</th>
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<tbody>
<tr>
<td>Jo Agnew (Chair)</td>
<td>Samantha Dalwood</td>
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<tr>
<td>Michelle Atkinson</td>
<td>Dr Debbie Holdsworth</td>
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<td>Edward Benson-Cooper</td>
<td>Gil Sewell</td>
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<tr>
<td>Matire Harwood (Deputy Chair)</td>
<td>Kate Sladden</td>
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<tr>
<td>Robyn Northey [arrived during item 5.3]</td>
<td>Michelle Webb</td>
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<tr>
<td>Allison Roe</td>
<td>Sue Waters</td>
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KARAKIA

Nga Mihi

Matire Harwood led a Karakia and welcomed everyone present.

1. ATTENDANCE AND APOLOGIES

The apologies of executive staff Dale Bramley, Ailsa Claire and Fiona Michel and of senior staff member Kim Herrick were received.

2. CONFLICTS OF INTEREST

The following amendments were advised:

- Michelle Atkinson requested that her interest in the Starship Foundation be added.
- Matire Harwood advised her role with the Stroke Foundation NZ (Maori Health) was incorrectly appearing as the ‘State’ Foundation and should be amended.

There were no declarations of interest for any item on the agenda.
3. **MINUTES 16 November 2016** (Pages 7 to 12)

These minutes were confirmed and signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 16 November 2016 by the outgoing Chairperson and Chief Executive under Standing Order 2.12.2. They were submitted for the information of the new committee.

4. **ACTION POINTS** (Pages 13 to 14)

All actions were either in progress or complete. The Chair advised that the actions relating to the Disability Support Advisory Committee Terms of Reference would be incorporated into discussion of Item 5.2 of this agenda.

5. **CHAIR’S REPORT** (Pages 15 to 30)

5.1 **The Authority of a Statutory Advisory Committee** (Pages 18 to 19)

Jo Agnew, Committee Chair spoke to the report highlighting the functions and authorities of the Disability Support Advisory Committee, the role of the Committee and that whilst Auckland and Waitemata DHBs have separate constituted their own Disability Support Advisory Committees they meet and act as one committee.

**Resolution:** Moved Michelle Atkinson / Seconded Allison Roe

That the Disability Support Advisory Committee:

1. Receives the Authority of a Statutory Advisory Committee report.
2. Notes that the function of advisory committees is to provide advice and recommendations to the Board for consideration and decision.
3. Notes that advisory committees focus purely on the strategic aspects of the DHB.
4. Notes that advisory committees have no delegated decision-making powers.

**Carried**

5.2 **Disability Support Advisory Committee Terms of Reference** (Pages 20 to 26)

The Chair highlighted that:

- The role of the Committee was to focus on strategic matters and future discussions would be positioned at a high level.
- Separate agencies hold funding responsibilities for disability support services mainly dependent on patient age. DHBs are responsible for funding services for over 65 year old people (or those who are close in age) with age related disabilities. The Ministry of Health fund services for people who present for assessment before the age of 65 years.

Debbie Holdsworth, Director Funding informed that, because DHBs do not hold the funding and contract management responsibilities for disability support services for under 65 year olds, reporting effectively to the Committee on these matters had previously been challenging.
The Chair added that reporting on this topic could be provided by the Ministry of Health. To obtain this, the Chair had sent correspondence to Ministry of Health management inviting the attendance of a Ministry representative at Disability Support Advisory Committee meetings. A positive response had been received and was tabled (attached to these minutes as Item 5.2.1).

It was noted that Terms of Reference currently assigned responsibility to the Disability Support Advisory Committee for receiving reporting on Health of Older People across the full range of issues and services for the over 65 year old age group. Formal reporting on the broader issues in Health of Older People might more appropriately sit with the Community Public Health Advisory Committee (CPHAC), with the Disability Support Advisory Committee retaining responsibility for the disability specific aspects. An amendment to the Terms of Reference supported by a recommendation to the Auckland and Waitemata DHB Boards would be required to action this transfer of reporting to CPHAC. Members agreed and were supportive of this approach.

The Chair informed that the Board Chair had signalled the intention for a regional Disability Support Advisory Committee from June 2017 onwards. This would also need to be taken into account when revising the Committee Terms of Reference.

A discussion was held regarding membership and attendance, and what considerations the Committee might need to make regarding appointment to the two vacant external appointee roles. It was agreed that until it was known what composition future Disability Support Advisory Committee meetings would have any decisions on co-opted roles be placed on hold.

**Actions:**

That the Disability Support Advisory Committee Terms of Reference be amended to reflect a proposed transfer of reporting for Health of Older People to the Community Public Health Advisory Committee.

That a recommendation report on the proposed changes to the Terms of Reference for the Disability Support Advisory Committee be presented to the next Disability Support Advisory Committee meeting.

**Resolution:** Moved Matire Harwood / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. Receives the Disability Support Advisory Committee Terms of Reference.
2. Notes the responsibilities of the Disability Support Advisory Committee as per the Terms of Reference.
3. Considers and discusses whether the Terms of Reference require amendment.

Carried

5.3 **Draft Work Programme for 2017 (Page 27)**

The Chair asked management how a regional Disability Support Advisory Committee meeting might impact on the proposed work programme presented. Advice was given that work of committees was already well aligned as demonstrated at the previous regional Disability Support Advisory Committee meeting held in June 2016.
It was commented that if Disability Support Advisory Committee meetings were to become regional the current duration of meetings may need to be extended.

5.4 Draft Future Agenda Outline (Page 28)

Sue Waters advised that the outcomes of the New Zealand Disability Strategy had been incorporated into the draft agenda outline. The standing items had been aligned with both the new Disability Strategy and the existing work programmes currently in action at Auckland and Waitemata DHBs to give effect to the previous strategy.

Matire Harwood observed that the new Disability Strategy had eight outcomes in total whilst the draft agenda outline addressed only a selection of those outcomes. It was clarified that some of the outcomes in the strategy may not fall within the remit of the Disability Support Advisory Committee or the DHBs and so the agenda outline focussed on what activities were relevant and already in action. Other outcomes could become relevant in the future and be reported on at that time.

Gil Sewell, Director Organisational Development advised that in relation to Outcome 2: Employment a workforce strategy was in the early stages of development and took into consideration employment opportunities for disabled people. The Committee agreed that a progress report on this at its next meeting would be useful.

It was noted that management hold the community liaison role and would be best placed to report on collaboration and service coordination activities in the community. A standing item for an update report from the Disability Advisor would be valuable for future meetings.

Matire Harwood drew attention to Outcome 7: Choice and Control and asked whether the revised Terms of Reference for the Disability Support Advisory Committee could reflect how the disability community could engage in DHB decision making relating to policies concerning disability supports and services. Advice was given that the Auckland and Waitemata DHB communities differ in how they are arranged and so consultation with those communities required tailored approaches. It was agreed that further discussion between the Committee Chair, Director Funding and Chief Health Professions Officer take place outside of the meeting to consider this.

It was emphasised that progress reporting needed to remain at strategic level, with any operational matters directed to Management.

Actions:

That a progress report on the development of the Auckland DHB workforce strategy be provided to the next Disability Support Advisory Committee meeting.

That a Disability Advisor Community Update report be added to the standing items of future Disability Support Advisory Committee agendas.

That the Committee Chair, Director Funding and Chief Health Professions Officer consider and discuss how the disability community can effectively engage in DHB decision-making processes.
5.5 The Role of the Disability Support Advisory Committee in DHB Submissions to Government

It was noted that the Outcomes Framework that supports implementation of the new Disability Strategy was still in development. Public consultation commencing in mid-2017 would provide opportunities for Disability Support Advisory Committee to comment and to make submissions on the draft framework. Sue Waters encouraged the Committee to consider the responsibilities of the DHBs to disabled people and their families/whānau within the context of any submissions made.

It was advised that any opportunities for consultation and/or submission would be tabled by the Committee Secretary under the advice and guidance of Samantha Dalwood, Disability Advisor. Where timeframes for submissions fell outside of scheduled Disability Support Advisory Committee meeting timeframes, the circulated resolutions process would be employed to enable the Committee to meet closing dates.

5.6 Senior Staff Supporting the Disability Support Advisory Committee (Pages 29 to 30)

Each senior staff member introduced their role, highlighting their key responsibilities relevant to supporting the Disability Support Advisory Committee.

Debbie Holdsworth, Director Funding Auckland and Waitemata DHBs

Key responsibilities:

- Understanding the health needs of the combined Auckland and Waitemata districts.
- Ensuring services delivered within the districts meet the health needs of the population served.
- Delivery of the actions in the Auckland and Waitemata DHB Annual Plans.
- Achieving equity and ensuring services are physically accessible.

Matters covered in discussion and in response to questions included:

- The Director Funding role has no direct authority or accountability for Ministry of Health funding for Disability Support Services. There is a demarcation of responsibility for contract management of disability support services for those people assessed under 65 years and those with age related disabilities.
- The age criteria for Needs Assessment is a potential service access barrier. Regular meetings take place with the Ministry of Health contract manager and Taikura Trust to resolve these boundary issues.
- Responsibility for employment opportunities for disabled staff within the DHBs sits within DHB HR functions.

Sue Waters, Chief Health Professions Officer

Key responsibilities:

- Clinical governance including Allied Health.
- Professional standards and practice.
- Health and safety.

Sue advised that she applies a diversity focus and disability lens to all areas of her portfolio of work. This approach is integrated into work across the entire organisation, supported by disability champions within each service. This includes the interface of health and safety...
with facilities. To ensure physical accessibility is consistently applied to facilities modifications, Barrier Free Assessments have been allowed for in the Capex budget and all Facilities staff have received Barrier Free training.

**Fiona Michel, Chief HR Officer**

[Secretarial note: Gil Sewell spoke on behalf of Fiona Michel]

**Key responsibilities:**
- Organisation culture.
- People systems opportunities.
- Leadership and capability development.
- The People and Workforce strategies.

**Samantha Dalwood, Disability Advisor Waitemata DHB**

**Key responsibilities:**
- Addressing inequity in health outcomes.
- Community relationships, collaboration and coordination.
- Delivery of staff awareness training.
- Provision of environmental accessibility advice for building works and refurbishments.

**Resolution:** Moved Robyn Northey / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. Receives the report.
2. Notes the key roles and responsibilities of the Executive team members supporting the Disability Support Advisory Committee.

**Carried**

6. **STANDARD REPORTS** (Pages 31 to 91)

6.1 **New Zealand Disability Strategy 2016 to 2026** (Pages 31 to 82)

It was noted that the pending Outcomes framework and action plan were required to enable an implementation plan for Auckland and Waitemata DHBs to be developed.

**Resolution:** Moved Edward Benson-Cooper / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. Receives the New Zealand Disability Strategy 2016 to 2026.
2. Notes that the new Disability Strategy 2016 to 2026 has been launched and replaces the Disability Strategy 2013 to 2016.
3. Notes that an Outcomes Framework is currently under development and will be consulted on by the Office of Disability Issues in mid-2017.
4. Notes that the Disability Action Plan is being updated to align with the new Disability Strategy 2016 to 2026.

**Carried**
6.2 Final Report: Implementation of the New Zealand Disability Strategy in Auckland and Waitemata DHBs (Pages 83 to 91)

It was advised that this would be the final report against the previous New Zealand Disability Strategy Implementation Plan 2013 to 2016 in this format. There would be ongoing elements where activities currently in progress would still be relevant to the new strategy. These would be reported in a new format. Management were currently considering the best way to report this information in the future.

**Action:**

That revised reporting on implementation of the New Zealand Disability Strategy within Auckland and Waitemata DHBs be provided to the June 2017 Disability Support Advisory Committee meeting.

**Resolution:** Moved Allison Roe / Seconded Matire Harwood

That the Disability Support Advisory Committee:

1. Receives the report.
2. Notes that this is the final report on the implementation of the 2013 to 2016 Disability Strategy.
3. Notes that reporting on implementation of the new Disability Strategy 2016 to 2026 will commence in June 2017.

Carried

7. INFORMATION REPORTS (Pages 92 to 99)

7.1 Ministry of Health Disability Sector Update (Pages 92 to 99)

A copy of the quarterly newsletter produced by the Ministry of Health was included in the agenda. The newsletter is also available electronically on their website and by email on registration.

In future, sector updates can be provided by the Ministry of Health representative in attendance at the meeting.

8. GENERAL BUSINESS (verbal)

Members suggested a later start time be considered for future meetings to allow those travelling from the Community Public Health Advisory Committee meeting in the morning to arrive on time. This would need to be discussed with the Board Chair prior to any new start time coming into effect.

**Action:**

That the Committee Secretary seeks Board Chair approval for Disability Support Advisory Committee meetings to commence at a later time to allow adequate travel time for members attending prior meetings on the same day.
The meeting closed at 3.06pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 29 March 2017

Chair: ___________________________ Date: _________________

Jo Agnew
## Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 21 June 2017

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail of Action</th>
<th>Designated to</th>
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| 29 Mar 17 Item 5.2 | **Disability Support Advisory Committee Terms of Reference**  
1. That the Disability Support Advisory Committee Terms of Reference be amended to reflect a proposed transfer of reporting for Health of Older People to the Community Public Health Advisory Committee.  
2. That a recommendation report on the proposed changes to the Terms of Reference for the Disability Support Advisory Committee be presented to the next Disability Support Advisory Committee meeting.  
1. Advise the Minister of Health of the proposed amendments to the Committees’ Terms of Reference.  
2. Subject to the Minister of Health’s agreement to the proposed amendments to the Committees’ Terms of Reference, submit the draft paper to the Auckland and Waitemata District Health Board Boards.  
3. That the Committee Secretary seek an update on the status of the Disability Support Advisory Committee Terms of Reference from the Board Chair and report back to the June Committee Meeting.  
That the Corporate Business Manager remind the Board Chair that this Disability Support Advisory Committee had recommended that the terms of Reference required review and that this issue currently remains with the Board Chair for action. | D Holdsworth | 21 June 2017 – on hold |
| 3 Jun 2015 Item 8.1 | And 9 Mar 2016 Item 4 | Chair of Auckland and Waitemata Health Boards | On hold |
| And 16 Nov 2016 Item 4 | And 9 Mar 2016 Item 4 | M Skelton | 29 March 2017 – on hold |
| 29 Mar 17 Item 5.4 | **Draft Future Agenda Outline**  
1. That a progress report on the development of the Auckland DHB workforce strategy be provided to the next Disability Support Advisory Committee meeting.  
*Update: The ‘workforce strategy’ referred to is the Auckland DHB People Strategy and no further update is necessary at this time.*  
2. That a Disability Advisor Community Update report be added to the standing items of future Disability Support Advisory Committee agendas. | K Herrick | 21 June 2017 – completed |
<p>| | | Committee Secretary/S Dalwood | 21 June 2017 – Complete (refer to item 7.1 of this agenda) |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Item Number</th>
<th>Agenda Item</th>
<th>Decision</th>
<th>Responsible Parties</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 Mar 17</td>
<td>Item 6.2</td>
<td><strong>Final Report: Implementation of the New Zealand Disability Support Advisory Strategy in Auckland and Waitemata DHBs</strong>&lt;br&gt;That revised reporting on implementation of the New Zealand Disability Strategy within Auckland and Waitemata DHBs be provided to the June 2017 Disability Support Advisory Committee meeting.</td>
<td>J Agnew, S Waters, D Holdsworth&lt;br&gt;21 June 2017 – deferred to 13 September 2017</td>
<td>S Dalwood&lt;br&gt;21 June 2017 – in progress (refer to item 7.2 of this agenda)</td>
<td></td>
</tr>
<tr>
<td>29 Mar 17</td>
<td>Item 8</td>
<td><strong>General Business: Meeting Start Time</strong>&lt;br&gt;That the Disability Support Advisory Committee Secretary seeks Board Chair approval for Disability Support Advisory Committee meetings to commence at a later time to allow adequate travel time for members attending prior meetings on the same day.</td>
<td>Committee Secretary&lt;br&gt;21 June 2017 in progress</td>
<td>Committee Secretary</td>
<td></td>
</tr>
<tr>
<td>3 Jun 2015</td>
<td>Item 8.2</td>
<td><strong>Update on Collation of Statistic that Identify People with Impairments</strong>&lt;br&gt;That the Auckland Metro DiSAC groups recommend to their Boards that:&lt;br&gt;3.1 The same method of data collection be employed across the three regional DHBs&lt;br&gt;3.2 They investigate processes for the collection of the identified data about staff with disabilities.&lt;br&gt;3.3 A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.&lt;br&gt;Passed: Auckland DHB on 3 August 2016&lt;br&gt;Counties Manukau DHB on 7 September 2016&lt;br&gt;Waitemata DHB on 14 December 2016</td>
<td>F Michel&lt;br&gt;Ongoing&lt;br&gt;Discussion held between Committee Secretaries of ADHB &amp; CMDHB on proposal to action. To be considered by DSAC Chair and Chief Human Resources Officer</td>
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</table>
Disability Support Advisory Committee Chairs Report

Recommendation

That the Disability Support Advisory Committee receives the Disability Support Advisory Committee Chairs report for June 2017.

Prepared by: Jo Agnew (Chair, Disability Support Advisory Committee)

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>DSAC</td>
<td>Disability Support Advisory Committee</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>NZDS</td>
<td>New Zealand Disability Strategy</td>
</tr>
<tr>
<td>DAP</td>
<td>Disability Action Plan</td>
</tr>
</tbody>
</table>

1. Board Strategic Alignment

<table>
<thead>
<tr>
<th>Community, whanau and patient-centred model of care</th>
<th>The DHBs commitment to its communities, patients and families aligned to the specific outcomes of the New Zealand Disability Strategy 2016 to 2026 will be reviewed and monitored, and advice will be given to the Boards on how they can effectively meet their responsibilities towards the government’s vision and strategies for people with disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligence and insight</td>
<td>The focus and work programme of the Disability Support Advisory Committee will be based on the disability support needs of the resident population of Auckland and Waitemata DHBs and the strategic priorities for giving action to the outcome areas of the New Zealand Disability Support Strategy 2016 to 2026.</td>
</tr>
<tr>
<td>Outward focus and flexible service orientation</td>
<td>The Committee will focus on strategies and provision of advice that will reduce inequalities in health outcomes for disabled people. It will develop and maintain stakeholder relationships to promote an inclusive healthcare environment that maximises health outcomes for disabled people in the region.</td>
</tr>
</tbody>
</table>

1. Executive Summary

Since the last Committee meeting held in March 2017, we have been successful in obtaining the attendance of a Ministry of Health representative and further exploring the potential for a regional Disability Support Advisory Committee. Good progress has been made towards development of a draft plan for implementation of the new Disability Strategy 2016 to 2026.
2. Welcome to Ministry of Health representative Amanda Bleckmann

Amanda Bleckmann is part of the Disability Senior Leadership Team within the Ministry of Health. Amanda manages the Family and Community Support Team.

The areas Amanda’s team covers are:

- Respite
- Child Development Services
- Home and Community Services
- Behaviour Support
- Autism Spectrum Disorder Work Programme
- Children/Foster Care/Shared Care
- Individualised Funding/Enhanced Individualised Funding
- Day Services
- Individualised Wraparound Services

Amanda is based in Auckland and will be attending the Regional DiSAC meeting on a regular basis. An update of any identified issues would be helpful.

3. Proposal for a Regional Disability Support Advisory Committee

The Chair of Auckland /Waitemata and Counties Manukau DHBs have met to discuss the potential for a metro-Auckland Disability Support Advisory Committee.

A proposal has been developed recommending a merge of the Auckland, Waitemata and Counties Manukau DHBs DSACs to become a regional DSAC.

It is envisaged that a regional DSAC would result in benefits such as:

- More timely and coordinated provision of advice to the Boards
- Less protracted processes for making recommendations to the Boards and referrals to the Boards occurring in a coordinated timeframe
- A reduced number of meetings and duplication of content
- Greater alignment of activities to implement the New Zealand Disability Strategy.

The goal being: consistency for service users within the community who have impairments and a common patient experience across all three DHBs.

Board papers have been drafted and are pending approval of the Board Chair to submit to each board seeking endorsement. Once they have been approved by the Board Chair they can be shared with this Committee.

4. Draft Plan for Implementation of the New Disability Strategy 2016 to 2026

The Disability Advisor has made significant progress in preparation and planning for implementation of the new Disability Strategy and a draft for comment by the Committee is included in this agenda as Item 7.2.
5. Conclusion

This agenda provides the Committee with the opportunity to be updated on current status and activity both within the Auckland and Waitemata DHBs around physical and employment accessibility, within the disability sector relating to New Zealand Disability Strategy outcomes 5 (accessibility) and 2 (employment).
Overview of Disability

Samantha Dalwood
Disability Advisor
What is Disability?
Medical Model of Disability

• Historically how we have understood disability
• Focus on cure and rehabilitation with the aim of making people as close to ‘normal’ or non-disabled as possible.
  • Individually focused around what’s wrong with a person
  • Useful when people are sick BUT most disabled people are very healthy
Social Model of Disability

• Originally from UK – Michael Oliver 1980’s
• Challenged the Medical Model as moved focus away from individual and onto society
• Disability is what happens to people with impairments when society is built without including all people
• People are disabled by society
• Aim to remove barriers and enable inclusion
What is Disability?

- People have impairments.
- Impairments may be sensory, physical, neurological or intellectual.
- Impairments may be obvious or hidden.
- Individuals experiences vary.

- Disability relates to the interaction between the person with the impairment and the environment.
Disability Support Services (DSS)

• MoH define disabled people as “people who have a physical, intellectual or sensory disability (or a combination of these) which:
  1. is likely to continue for at least 6 months
  2. limits their ability to function independently, to the extent that on-going support is required.”
• These are mainly younger people under the age of 65 years.
• Approx. 32,000 people supported and 80,000 with equipment.
Who can’t get MoH Disability Support Services?

The Ministry of Health DSS does not generally fund disability support services for people with:

- personal health conditions such as diabetes or asthma
- mental health and addiction conditions such as schizophrenia, severe depression or long-term addiction to alcohol and drugs
- conditions more commonly associated with ageing such as Alzheimer’s disease.

Disability Support Services are not funded for most people with impairments caused by accident or injury.

Older Adults – In most cases people over 65 are DHB funded.
Accident Compensation Corporation

- Accident Compensation Corporation (ACC) provides support and services to people with lasting impairments after accidents, like spinal and brain injuries, so they can live every day lives in their communities.
- Anyone in New Zealand who has an accident that results in a personal injury can get help from ACC for as long as they need it, regardless of the cause of the accident.
- The New Zealand public health system, funded by the Ministry of Health, provides support and services to people with congenital and health-related disabilities.
Services for Disabled People

Funders
• ACC
• Ministry of Health
• Ministry of Education
• Ministry of Social Development

Types of services
• Behaviour Support
• Child Development
• Community Day Services
• Community Residential Support
• Equipment and modifications
• Hearing and Vision Services
• Home and Community Support
• Individualised Funding
• Respite and carer support

NASC
• Taikura Trust – Auckland region
• District Health Boards

Services delivered by
• NGOs & DPOs
• Health Services - GPs & DHB
New Zealand Disability Strategy

- Published on 3 December 2016.
- 8 Outcome areas.
- Developed with input from the Disability Sector.
- Vision of a non-disabling society.
- Most outcomes relevant to District Health Board services.
UN Convention on the Rights of Persons with Disability

• Ratified by NZ in Sept 2008
• Government now required to implement
• NZ took a leading role in establishing so expectation on us to fulfil our obligations
• Partnerships with Disabled People’s organisations is critical in implementing, promotion and monitoring
• From Oct 2016 disabled people are able to access Complaints process (optional protocol)
Why is this important to DHBs?

- A commitment to the NZ Disability Strategy.
- People identifying as having a disability make up approximately 24% of the population.
- An aging population will increase the number of people with impairments.
- The voice of disabled people must be heard in planning services.
- DHBs should lead by example in the delivery of accessible services.
Disability Support Advisory Committee

• The Disability Support Advisory Committee (DSAC) has specific aims and functions prescribed within the NZ Health and Disability Act 2000 (Schedule 4, Clause 3).

"The functions of the Disability Support Advisory Committee are to give the Board advice on:

• the disability support needs of the resident population of the DHB; and

• priorities for use of the disability support funding provided

• Waitemata and Auckland DHBs have had a joint DSAC Committee since 2012.
People with learning disabilities have worse health outcomes than people without learning disabilities.

The average life expectancy of a male with a learning disability is 59.7 years. Other New Zealand males (78.4 years).

The average life expectancy of a female with a learning disability is 59.5 years. Other New Zealand females (82.4 years).
‘Health Indicators for New Zealanders with Intellectual Disabilities’ MoH, 2011

• 4 x more likely to be obese
• 30 x more likely to have epilepsy
• 17 x more likely to have a psychotic disorder
• 15 x more likely to have poor oral health
• 10 x more likely to have dementia
• 4 x more likely to be admitted to hospital
• Half as likely to have cervical screening
What does the Disability Advisor do?

• Health Gain - inequity in health outcomes
• Ensures the voice of disabled people is included across the DHB
• Connector – internal & external
• Brings lived experience, knowledge & networks
Contact Details

Samantha Dalwood
Disability Advisor
Direct:  442 3289
Mobile:  021 221 7810
samantha.dalwood@waitematadhb.govt.nz
Healing Environments and Wayfinding Strategy

Recommendation

That the Disability Support Advisory Committee receives the Healing Environments and Wayfinding Strategy report.

Prepared by: Justin Kennedy-Good (Programme Director Performance Improvement, Co-Director Design Lab)  
Endorsed by: Sue Waters (Chief Health Professions Officer)

1. Executive Summary

The purpose of this document is to provide an update on Healing Environments and Wayfinding strategy development.

2. Healing Environments

Focus remains on the level 5 Carpark A retail area:

- Flooring and paint work will be completed between September 2017 to December 2017.
- New wayfinding elements (signage) will follow the painting of walls and ceilings.
- Pharmacy, Florist and A+ Trust will receive a refurbished look and feel by December 2017.
- Paperplus has opened with a set up that is consistent with the principles of the Healing Environments approach (in particular it is more accessible and less cluttered).

As a programme of activity Healing Environments is currently under review with a change in emphasis likely. We expect to address service related aspects of our environment rather than facility refurbishments (an example of something done previously was the establishment of wheelchair bays in public spaces).

3. Wayfinding Strategy

The Strategy and its implications for the refurbishment of Level 5 (Carpark A Retail area) were presented to the Auckland DHB Board on 17 May 2017. Both the approach and the recommendations were well received. Elements highlighted included:

- Colour blocking elevator banks
- New Wayfinding signage elements of international standard Typeface and Iconography
- The use of digital screens for main wayfinding directory boards

Formal approval for the Wayfinding system and strategy will be sought from the Board at the next meeting.

4. Other Activity

Our accessibility group continues to meet. They were asked to provide feedback on the approach in development for an Outpatients Programme of work at Auckland DHB.
Wayfinding
I honestly think that I’m more at risk of being killed out there [outside the building] than I am of cancer.

PATIENT (VISUALLY IMPAIRED), 2016
I was told to follow the blue line but I’m blind.

PATIENT, 2014
I was in shock when diagnosed. Where do I go? Where do I sit? What do I do?

PATIENT, 2014
1. Sustainable Transport
2. Wayfinding
3. Healing Environments
Knowing where you are
Knowing where you are going
Knowing how to get there
Stress level is the single most important factor to take into account when developing a wayfinding system.

Wayfinding needs to be simplified as much as possible in order to intercept a very distracted typical user.
Lack of clarity around routes and journeys

Operations: Journey Mapping
Critical Items to Address

1. Pre-visit information material
2. Lack of clarity around routes and journeys
3. Consistency of language and nomenclature
4. Main Entrance driveway
5. Lack of information in critical areas
6. Starship entrance experience
7. Health & Safety risks
External order of priorities

Expert recommendations

Phase 1A

> Enable drop-off on Level 5. The perceived Main Entrance and close proximity to 'Main Entrance Car Park' is an expected norm.
> Redesign information at Main Entrance driveway to reduce decision fatigue, confusion and bottle-necks.
> Redesign information at Gate 2, 3, 4 and include dynamic parking displays to better distribute traffic flow to the landmark destinations prior to entering the campus.
> Enforce parking regulations.

Phase 1B

> Reconsider Emergency drop-off layout which if blocked could lead to critical circumstances.
> Follow up each destination.
> Review exit journeys.
> Review regulatory information i.e. speed limit signs, the expected behaviour when entering the site.

Phase 1C

> Implement campus pedestrian wayfinding. The nature of the site and building layout often requires people to journey externally to their destination, however, there is a lack of wayfinding to assist them in reaching it.
> Implement campus identity. There is no identification of Auckland Hospital at a high level from outside the campus.
# Internal order of priorities

## Expert recommendations

<table>
<thead>
<tr>
<th>Phase 2A</th>
<th>Phase 2B</th>
<th>Phase 2C</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Consolidate Level 5 concept.</td>
<td>&gt; Improve entrance experience to Starship.</td>
<td>&gt; Follow up destinations at each level.</td>
</tr>
<tr>
<td>&gt; Extend Level 5 concept to critical areas e.g. Radiology.</td>
<td>&gt; Improve quality of environment for internal journeys to: ED, Starship, Parking B and Oncology (review information provision).</td>
<td>&gt; Improve identification of wards.</td>
</tr>
<tr>
<td>&gt; Remove information at Level 4 entrance, push people up to Level 5.</td>
<td></td>
<td>&gt; Review room signage.</td>
</tr>
<tr>
<td>&gt; Resolve internal journeys to: ED, Starship, Parking B and Oncology (review information provision).</td>
<td></td>
<td>&gt; Implement campus identity. There is no identification of Auckland Hospital at a high level from outside the campus.</td>
</tr>
</tbody>
</table>
Challenges

A. Upfront investment versus hidden ongoing cost.

1. We are already paying for a Wayfinding system that doesn’t work.

2. Journey maps and operating model discipline.
Appendix

> Critical Items to address 1-8
1. Pre-visit Information Material

Patient Letter & Website

Gate 3: overwhelming and misleading information for non public access

Main entry layout:
Very short time and limited space to make critical turn decision.
2. Lack of clarity around routes and journeys

Journey Mapping
3. Consistency of language and nomenclature

E.G. Outpatient Clinic is labelled three different ways in one area
4. Signage Elements

Colour

**Colour palette**
For all major signage elements

- **White**
- **Navigation Blue**
  - Pantone 281 C
  - Resene ‘Surfs Up’
- **Emergency Red**
  - Pantone 485 C
  - Resene ‘Havoc’

**Colour system**
For environmental graphics & supporting elements

- **Blue**
  - Pantone 299 C
  - Resene ‘Curious Blue’
- **Purple**
  - Pantone 2593 C
  - Resene ‘Daisy Bush’
- **Orange**
  - Pantone 1585 C
  - Resene ‘Hyperactive’
Signage Elements

Typography

Typeface
Wayfinding Sans

Auckland City Hospital
Signage Elements

Iconography

Icons
Wayfinding Sans tailored for Auckland DHB
Signage Elements

Sign Family

- Cashier
- Staff only
- Nutrition Services

- Stairs ➔ Lift A
- Radiology
- Way Out Lift A B C
- Lift C ➔

- Radiology
- Lift A i

- Car Park A ➔ Transition Lounge Lift B

- Lift B ➔

- Radiology
- Lift B C

- Car Park A
- Transition Lounge
- Lift B

- Wayfinding Board Presentation 17 May 2017
Signage Elements

Level 5 Application
5. Main Entrance driveway

Update Park Road entrance and remove unnecessary information

Caption: Concept artwork for Park Road entrance.
6. Lack of information in critical areas

E.G. Lift B—no directory board of destinations
7. Starship Entrance experience

Entry point from car park B—back of house

Caption: Concept artwork for Starship entrance—car park B
8. Health & Safety Risks

E.G. Pedestrian safety in car park A
Related material

> ACH Wayfinding Strategy version 1.0
Diversity and Inclusion at Auckland DHB

Recommendation

That the Disability Support Advisory Committee:

1. Receives the Diversity and Inclusion at Auckland DHB presentation.
2. Notes the commitment and focus on disability and accessibility as aligned with the New Zealand Disability Strategy 2016-2026.

Prepared by: Kim Herrick (Organisational Development Practice Leader)
Endorsed by: Fiona Michel (Chief Human Resources Officer)

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

Auckland DHB has developed a Diversity and Inclusion high level plan aligned to both Auckland DHB’s strategy and vision and the New Zealand Disability Strategy 2016-2026. The Diversity and Inclusion high level plan focuses on two areas, namely ethnic diversity and accessibility.

2. Background

Diversity and Inclusion embraces many aspects including age, gender, sexual orientation, personality, ethnicity and disability. At Auckland DHB the two key areas that are aligned to our strategy and vision are ethnic diversity and accessibility.

To build a more inclusive culture at Auckland’s DHB we need to adopt an inclusive mind-set, especially towards disabled people (who make up 19% of Auckland regional population). In addition, Māori and Pacific people have higher-than-average disability rates, after adjusting for differences in ethnic population age profiles. (Statistics NZ, 2013)

An operational plan will need to be developed to deliver on the New Zealand Disability Strategy 2016-2026. Therefore, we are researching best practice disability plans across national and international companies. In addition, we would like to develop a working group with Waitemata DHB across Recruitment, Māori Workforce, Human Resources and Health Care Professionals to successfully implement the Diversity and Inclusion operational plan.

3. Conclusion

The Diversity and Inclusion high level plan at Auckland DHB is targeted to focus support for disabled employees and job candidates to improve accessibility to employment within the DHB, and deliver against the New Zealand Disability Strategy 2016-2026.
Diversity & Inclusion @ Auckland DHB

Kim Herrick
May 2017

Disability Advisory Support Committee
High Level Plan for feedback
Diversity & Inclusion linked to our wider strategy

<table>
<thead>
<tr>
<th>Auckland DHB Strategy to 2020</th>
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</thead>
<tbody>
<tr>
<td><strong>New Zealand Health Strategy Themes</strong></td>
</tr>
<tr>
<td><strong>Healthy communities</strong></td>
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<tr>
<td>Healthy communities</td>
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<tr>
<td>World-class healthcare</td>
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<tr>
<td>Achieve together</td>
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<tr>
<td><strong>Our Strategic Goals</strong></td>
</tr>
<tr>
<td><strong>Our Strategic Themes</strong></td>
</tr>
<tr>
<td>Community, family/whānau and patient-centric model of healthcare</td>
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<tr>
<td>Emphasis and investment on treatment and keeping people healthy</td>
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<tr>
<td>Service integration and/or consolidation</td>
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<tr>
<td>Intelligence and insight</td>
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<tr>
<td>Consistent evidence informed decision making practice</td>
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<tr>
<td>Outward focus and flexible service orientation</td>
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<tr>
<td>Emphasis on operational and financial sustainability</td>
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<tr>
<td><strong>Our Strategic Mandatories</strong></td>
</tr>
<tr>
<td>Equity of access to services and outcomes for the population</td>
</tr>
<tr>
<td>Cultural awareness and sensitivity</td>
</tr>
<tr>
<td>Patient safety</td>
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<tr>
<td>Workplace safety</td>
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<tr>
<td>Risk minimisation</td>
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<tr>
<td>Integrity: meet ethical and legal obligations</td>
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<tr>
<td>Meet financial obligations</td>
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<tr>
<td><strong>Our Purpose</strong></td>
</tr>
<tr>
<td>Enabling health and wellbeing through high-quality health and healthcare services, and a commitment to innovation, education and research</td>
</tr>
</tbody>
</table>
Diversity & Inclusion link to our People Strategy
“Do your life's best work”

Accelerating Capability & Skill
- Clear understanding of the expectations of managers, leaders and employees
- Raising awareness of ways to address conscious and unconscious bias to tackle inequities at work

Building Constructive Relationships
- Promoting respect for diversity
- Building colleague empathy

Delivering on our promises
- Recruiting and developing more Maori and Pacific Island employees
- Planning ahead to ensure our future workforce is ready

Ensuring a quality start
- Clarifying what Auckland DHB stands for and the behaviours we expect of each other
Diversity & Inclusion link to our Values

Diversity & Inclusion principles are vital to ensure Auckland DHB is a values led organisation.

<table>
<thead>
<tr>
<th>Auckland DHB values</th>
<th>D&amp;I Principles</th>
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<tbody>
<tr>
<td><strong>Welcome Haere Mai</strong></td>
<td>Encourage people to be themselves and speak up about what is important to them</td>
</tr>
<tr>
<td>We see you, we welcome you as a person</td>
<td></td>
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<tr>
<td><strong>Respect Manaaki</strong></td>
<td>Encourage people to listen and learn from each other. Respect builds staff engagement</td>
</tr>
<tr>
<td>We respect, nurture and care for each other</td>
<td></td>
</tr>
<tr>
<td><strong>Together Tuhono</strong></td>
<td>High performance is about working together to develop greater diversity of thought, creativity and innovation</td>
</tr>
<tr>
<td>We are a high performing team</td>
<td></td>
</tr>
<tr>
<td><strong>Aim High Angamua</strong></td>
<td>Everyone is unique and we need to leverage everyone’s potential and strengths to provide the highest quality health care</td>
</tr>
<tr>
<td>We aspire to excellence and the safest care</td>
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Diversity & Inclusion @ Auckland DHB

Definitions

We define ‘Diversity’ as:
“who you are, and recognising the value you bring to work”

We define ‘Inclusion’ as:
“the degree to which people feel unique and recognised for their differences as well as feeling a sense of belonging based on sharing common attributes and goals with their peers”

We define ‘Discrimination’ as:
“Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances. It is a breach of the Human Rights Amendment Act 2016”

We define ‘Bias’ as:
“Bias is a preference for one thing over another, and is part of being human; biases help us make decisions every day. Sometimes bias (conscious and unconscious) can impact the quality of decision making, reflecting our preferences and experiences”
Diversity & Inclusion @ Auckland DHB

THE WHY:
Diversity Dividend
- Diversity of thought drives creativity & innovation
- Creating a sense of inclusion and belonging that we fully unlock the potential of our people, patients, partners and suppliers.
- Greater diversity & inclusion will enable us to forge stronger relationships and anticipate patient needs to deliver high quality healthcare
- A diverse workforce will lead to improved public health by increasing access to care for underserved populations and increasing opportunities for these populations to see practitioners with whom they share a common culture (1&2)
- To build trust and respect we need to be mindful of ‘patients unique fears, rationalisations and biases’ to work towards equitable care for all patients (3 &4)

THE WHAT:
Diversity & Inclusion
- To seek to belong is a hard wired instinct that binds us all together.
- Diversity is broader than ethnicity or gender. It is made up of visible and invisible attributes which create our identity.
- Diversity is an opportunity, not a problem.
- Inclusion is not tolerance, it is unconditional acceptance.
- Without inclusion, diversity is impossible.

THE HOW:
Built in, Not bolted on
- It is not about ticking a box. Diversity, Inclusion & Belonging is not a one off programme, it’s a mind-set that is built in to all that we do.
- It requires collaboration, empathy, a learning mind set and role modelling our values.
- Full support from Executive Team and Leaders
Diversity & Inclusion @ Auckland DHB
Two Prioritised areas:

**Cultural Diversity / Equity**

- We focus on equity rather than equality.
- Equality focuses on creating the same starting line for everyone. **Equity** is about providing everyone with the full range of opportunities and benefits to reach the same finish line.
- This reinforces the everyone is different, and some groups need more support than others (e.g. Māori and Pacific) because they have the worst health issues.
- We need to focus on creating opportunities and removing barriers.

**Disability / Accessibility**

- We are committed to creating a diverse and accessible work environment at Auckland DHB.
- We are focussing on understanding the real issues for disabled job candidates, employees and patients, and developing a plan to address these issues aligned to NZ Disability Strategy 2016-2026.
- Accessibility includes:
  - Mental Health – building awareness via Speak Up campaign and Managers having conversations
Diversity & Inclusion @ Auckland DHB

References

3. Mandell, Brian F, “Not all patients think like doctors, but we need to be able to think like patients”, Cleveland Clinic Journal of Medicine. Volume 79, Number 2, February 2012
4. Misra-Hebert, Anita & Isaacson, Harry, “Overcoming health care disparities via better cross-cultural communication and health literacy” Cleveland Clinic Journal of Medicine, Volume 79, Number 2, February 2012
Disability Advisor Update

Recommendation

That the Disability Support Advisory Committee receives the Disability Advisor Update report for May 2017.

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata DHBs)

Glossary

ARD - Auckland Regional Dental Service
ASD - Autistic Spectrum Disorders
DISAC - Disability Support Advisory Committee

1. Executive Summary

This report is a summary of collaboration and service coordination activities in the period since the last DSAC meeting in March 2017. It is a standing agenda item.

2. Work Areas

2.1 Auckland Regional Dental Service – Working with Children with Autistic Spectrum Disorders (ASD) (Outcome 7 – choice and control)

In 2011 Waitemata District Health Board (DHB) ran three sessions of ‘Working with children on the autistic spectrum’ for Auckland Regional Dental Service (ARD) staff across the three metro Auckland DHB areas. Further to conversations with staff and parents, plus the likely staff changes during this time, it was timely to repeat these sessions. The Disability Advisor delivers this training, bringing years of experience of working with people with ASD. Training is scheduled for delivery during 2017, with seven of 12 sessions completed by the end of May.

2.2 Health & Wellness Group – Making the most of your GP (Outcome 3 – health and wellbeing)

Discussions in the Health & Wellness Group, led by Samantha Dalwood, Waitemata DHB Disability Advisor and Sue Sherrard from CCS Disability Action, focused on improving the health of disabled people. Feedback indicated a lack of understanding of the structure of health care in New Zealand and a need to understand how to maximise primary care experiences. The Health & Wellness Group are developing a training tool, “How to make the most of your GP” which focusses on how primary care works, how to work with your GP and how to keep yourself well. This work aligns with the Health Quality & Safety Commission’s Let’s PLAN for better care health literacy initiative to help consumers prepare well for their visit to the GP or other primary care health professional.

2.3 Central HR Fund to support the employment of disabled people (Outcome 2 – employment and economic security)

Equal opportunity for people with disabilities is the focus of a new $10,000 central HR fund being implemented by Waitemata DHB. The fund will enable hiring managers to make any reasonable adjustments for new employees with disabilities without costs coming out of their individual
budgets. Most disabled people need very little extra support to start a new job, but if there is a cost involved, for example, a new piece of software, hiring managers can apply for funding through the central fund, therefore making the recruitment process more equitable. Please see the reference below for the link to the article in Healthlines.

The Disability Advisor is also working with the DHB Recruitment Team to identify roles that could be recruited for through the Ministry of Social Development Mainstream Programme. The programme has been on hold for the last couple of years, but funding is now available again. Both DHBs are keen to use the programme to give meaningful work experience to disabled people, hopefully leading to permanent work.

2.4 Working with Waitemata PHO – engaging with disabled people (Outcome 3 – health and wellbeing)

Waitemata PHO is keen to increase engagement with disabled people in the Waitemata PHO area. Initial feedback from disabled people indicates a need for support in areas such as health eating, cooking and fitness. This ties in well with the Green Prescriptions work that is currently funded by the Ministry of Health. An initial meeting has taken place, which will be followed by further discussion with the Health & Wellness Group.

2.5 Working with Counties Manukau Health (Outcome 3 – health and wellbeing)

Since the last DiSAC meeting, the Disability Advisor has been to meet with Bernadette County, People and Professional Development Manager at Counties Manukau Health to discuss work they are doing with the disability sector. This included holding a ‘Sharing experiences’ event in February for disabled people to discuss their experiences using Counties Manukau Health services and how these could be improved. Although only seven people came to the event, feedback provided was useful.

3. Conclusion

The above are examples of work that has been happening since the March 2017 DiSAC meeting and will be ongoing. This report will be a standing item.

4. References

HQSC Let’s PLAN for Better Care
https://www.hqsc.govt.nz/publications-and-resources/publication/2633/

Waitemata DHB’s Healthlines magazine – article on new HR fund (page 10)

Mainstream Programme
Draft Disability Strategy Implementation Plan 2016 - 2026

Recommendation

That the Disability Support Advisory Committee:
1. Receives the draft Disability Strategy Implementation Plan 2016-2026.
2. Give feedback on the draft Implementation Plan, noting that the document will be going out for community consultation.

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)
Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata DHBs)

Glossary

DiSAC - Disability Support Advisory Committee

1. Executive Summary

Please find attached the DRAFT joint Auckland DHB and Waitemata DHB Disability Strategy Implementation Plan 2016 - 2026 for feedback and comments from the Disability Support Advisory Committee (DiSAC). Following feedback from the DiSAC, this document will go out to the disability sector and disability community for their feedback. Following that, a more detailed action plan will be developed.

2. Community Consultation

Once initial feedback has been received from the DiSAC, the Disability Advisor will be working with the Community Engagement Manager to get feedback from the disability sector and the disability community. Feedback will be given through the DHB on-line channel, phone, email or post. A number of meetings in the community will also be held for those who would like to attend or prefer this method of communication.

Following feedback, the final Implementation Plan for 2016 – 2026 will be developed. We will also develop a more detailed Action Plan for 2017 - 2020, with a review planned in 2020.

3. Conclusion

The attached document is the DRAFT Disability Strategy Implementation Plan 2016 - 2026. Following feedback from DiSAC, community consultation will take place on the content. A final Implementation Plan and more detailed Action Plan 2017-2020 will then be developed.

4. References


Waitemata & Auckland District Health Board’s Disability Strategy Implementation Plan 2016-2026

Waitemata and Auckland District Health Boards have a shared vision of being fully inclusive.

Being fully inclusive means ensuring the rights of disabled people, eliminating barriers so that people can get to, into and around our physical spaces; and everyone can access information and services that they need and enabling full participation.

The New Zealand Disability Strategy 2016-2026 provides a framework for organisations to focus on enabling the full participation of disabled people. It has a vision of New Zealand as a non-disabling society – a place where disabled people have an opportunity to achieve their goals and aspirations and all of New Zealand works together to make this happen.

The Vision, principles and approach of the NZ Disability Strategy 2016-2026, with input from the disability sector and disability community, have shaped our joint District Health Board (DHBs)’ Disability Strategy Implementation Plan 2016-2026.

Our ten year implementation plan aligns with the timeline of the NZ Disability Strategy 2016-2026. There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.
New Zealand Disability Strategy 2016-2026

Figure 1 | Disability Strategy Framework
The Disability Strategy identifies eight outcome areas -

The outcome areas that will contribute to achieving the vision of the Strategy are:

**Outcome 1 – Education**
We get an excellent education and achieve our potential throughout our lives

**Outcome 2 – Employment and economic security**
We have security in our economic situation and can achieve our full potential

**Outcome 3 – Health and wellbeing**
We have the highest attainable standards of health and wellbeing

**Outcome 4 – Rights protection and justice**
Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system

**Outcome 5 – Accessibility**
We access all places, services and information with ease and dignity

**Outcome 6 – Attitudes**
We are treated with dignity and respect

**Outcome 7 – Choice and control**
We have choice and control over our lives

**Outcome 8 – Leadership**
We have great opportunities to demonstrate our leadership

All eight outcomes are relevant to the work of the District Health Boards and will drive our core work over the next ten years. Our work will have a particular focus on five outcomes – Employment & economic security, Health & wellbeing, Accessibility, Attitudes and Choice & control.

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**Influences**

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

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

This is a key document in the implementation of the Disability Strategy. The Disability Action Plan presents priorities set by the Ministerial Committee on Disability Issues for actions that advance the implementation of the UN Convention on the Rights of Persons with Disabilities and the New Zealand Disability Strategy 2016-2026. These priorities emphasise actions requiring government agencies to work together, as well as with disability sector organisations and others.

Five Person Directed outcomes:
- Safety/autonomy
- Wellbeing
- Self-determination
- Community
- Representation

Four main areas of focus:
- Increase employment opportunities
- Ensure personal safety (includes decision making and consent)
- Transform Disability Support system
- Promote access in the community

‘Promote access in the Community’ includes 11c – Access to health services and improve health outcomes for disabled people with a focus on people with learning disabilities.

Values

The Values of Auckland and Waitemata DHBs reflect a shared vision for equity and inclusion of disabled people in their care and in the design of patient facilities and services.
Monitoring and Reporting

Work is underway at the Office for Disability Issues to ensure that progress toward achieving the outcomes of the New Zealand Disability Strategy can be measured. This will involve the development of an Outcomes Framework which will specify targets and indicators that will be regularly reported on. Work on this will include getting advice from disabled people, the disability sector and other government agencies.

The Auckland and Waitemata DHBs’ New Zealand Disability Strategy Implementation Plan 2016-2026 will be monitored internally and progress of actions will be reported to the Disability Support Advisory Committee (DSAC) on a quarterly basis.

We will ensure that the DHB Disability Strategy Implementation Plan continues to align with the NZ Disability Strategy, as well as other government strategies and action plans.

There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.

Current Priorities

Both Auckland and Waitemata DHBs are committed to the vision of being fully inclusive and non-disabling. Current work that will continue across both DHBs as part of the Disability Strategy Action Plan includes improving health literacy and enhancing the patient experience.

Health Literacy

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

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

Patient Experience

There is a focus on Patient Experience and Community Engagement across both DHBs. This has led to greater inclusion of disabled people in design and planning of both facilities and services. Examples of this are the Public Spaces work at Auckland DHB and the Waitemata 2025 commitment to universal design as a core design principle.

Outcomes
Of the eight outcome areas of the New Zealand Disability Strategy 2016-2026, there are five key outcome areas that align with the work of District Health Boards.

<table>
<thead>
<tr>
<th>Outcome 2: employment &amp; economic security</th>
<th>Outcome 3: health &amp; wellbeing</th>
<th>Outcome 5: accessibility</th>
<th>Outcome 6: attitudes</th>
<th>Outcome 7: choice &amp; control</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>We have security in our economic situation and can achieve our potential.</em></td>
<td><em>We have the highest attainable standards of health and wellbeing.</em></td>
<td><em>We access all places, services and information with ease and dignity.</em></td>
<td><em>We are treated with dignity and respect.</em></td>
<td><em>We have choice and control over our lives.</em></td>
</tr>
<tr>
<td>Increase the number of disabled people into paid employment.</td>
<td>Robust data and evidence inform decision making.</td>
<td>Barrier free and inclusive access to health services.</td>
<td>All health and well-being professionals treat disabled people with dignity and respect.</td>
<td>Engage regularly with the disability sector and community.</td>
</tr>
<tr>
<td>Record the number of staff with impairments working for the DHB.</td>
<td>Barrier free and inclusive access to health services.</td>
<td>The principles of universal design and the needs of disabled people are understood and taken into account.</td>
<td>Provide a range of disability responsiveness training.</td>
<td>Ensure a diverse range of disabled people are identified as stake-holders.</td>
</tr>
<tr>
<td>Increase the confidence of Hiring Managers to recruit disabled people.</td>
<td>Improve the health outcomes of disabled people, with a specific focus on people with learning disabilities.</td>
<td>Improve &amp; increase accessible information across the DHB.</td>
<td>Disabled people able to access supports that they need in hospital.</td>
<td>Supported decision making and informed consent.</td>
</tr>
<tr>
<td></td>
<td>Ensure physical access to DHB buildings and services.</td>
<td></td>
<td></td>
<td>Ensure services are responsive to disabled people and provide choice and flexibility.</td>
</tr>
</tbody>
</table>
New Zealand Disability Support Network Employment Practice Guidelines

Recommendation

That the Disability Support Advisory Committee notes and welcomes the attendance of Sarah Halliday, New Zealand Disability Support Network Employment Advisory Committee at the meeting.

Prepared by: Michelle Webb (Committee Secretary)
Endorsed by: Jo Agnew (Chair, Disability Support Advisory Committee)

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

Sarah Halliday, General Manager Geneva Elevator is a representative from the New Zealand Disability Support Network Employment Advisory Committee. Sarah will join the meeting to provide an update on the progress of the Employment Practice Guidelines and discussion on practices and approaches that will maximise employment outcomes for disabled people within our organisations.
Report on the Disability Data and Evidence Working Group

Recommendation

That the Disability Support Advisory Committee receives the Disability Data and Evidence Working Group report from Samuel Murray, National Policy Coordinator, CCS Disability Action.

Prepared by: Michelle Webb (Committee Secretary)
Endorsed by: Jo Agnew (Chair, Disability Support Advisory Committee)

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

The purpose of this report is to provide the Committee with an update on progress to date of the Disability Data and Evidence Working Group and the future of disability data collection in New Zealand.

2. Background

Further to discussions at previous meetings, and at the metro-Auckland Regional Disability Support Advisory Committee meeting held in June 2016, the Committees agreed that there needed to be a consistent approach across the Auckland region in the way data is collected to increase knowledge about the needs of the Auckland population and support the DHBs activities to become an employer of choice for disabled people.

The Committees passed a resolution and subsequently recommended to their Boards as follows:

That the Auckland Metro DiSAC groups:

1. Actively engage with the disability data and evidence working group
2. Seek to understand how the need for better disability population data will be reflected in the review of the disability strategy.

That the Auckland Metro DiSAC groups recommend to their Boards that:

1. The same method of data collection be employed across the three regional DHBs
2. They investigate processes for the collection of the identified data about staff with disabilities.
3. A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.

Samuel Murray, National Policy Coordinator at CCS Disability Action is the lead contact for the Disability Data and Evidence Working Group and will join the meeting to speak to his attached report.
Report on the Disability Data and Evidence Working Group

The status of the Disability Data and Evidence Working Group

The Disability Data and Evidence Working Group is not officially disbanded, but has no meetings planned at the moment (the last meeting was in October last year). The Office for Disability Issues has advised the group that they will call on them as needed. Possible future work for the group could be around the New Zealand Disability Strategy Outcomes Framework (which I will explain later).

Previous work by the Disability Data and Evidence Working Group


The group also did a similar stocktake of data held by non-government agencies, but this was not comprehensive enough to be released (the response rate was too low). It is clear, however that a large amount of data on disability is held by non-government organisations.

The group completed a list of enduring questions on disability (these are long-term disability policy questions that the government should be answering using data and evidence). I have attached the questions in a separate document.

The group looked at whether the International Classification of Functioning, Disability and Health (ICF) could be used as an overall framework for disability data collection. You can read more about the ICF here (also see the attached paper disability data in New Zealand):

http://www.who.int/classifications/icf/en/

The group agreed to use the ICF (we agreed this, however, during the last meeting in October so there was no time to discuss in detail what this actually means in practice or plan how we will implement the ICF as a framework). I personally remain sceptical about the value of the ICF and prefer the Canadian approach to disability data collection (which you can read more about here:...
Related disability data work by Statistics New Zealand

Statistics New Zealand is working on a number of areas to do with disability data. Statistics New Zealand has put disability identification questions into the General Social Survey (release of data likely to be in July 2017) and the Household Labour Force Survey (release of data likely to be September 2017).

Statistics New Zealand has also released a tool for estimating the disability population of small areas (based on 2013 Disability Survey data). You can access the tool here (and I highly recommend you do):


Statistics New Zealand is also investigating putting actual disability identification questions in the 2018 Census (the disability-related questions in previous Census have never been accurate enough to provide quality data. This is why a separate Disability Survey was needed). The questions proposed for the 2018 Census should be accurate enough to provide quality data on disability. There is competition for space in the 2018 Census though so these questions may not be included.

Outcomes Framework

As part of the latest New Zealand Disability Strategy, the government is planning to create an Outcomes Framework. This framework would set out what data the government needs to collect to show progress in achieving the New Zealand Disability Strategy.

The Outcomes Framework is likely to be a focus for government data collection on disability. The government is planning to publicly consult on the Outcomes Framework this year.
The future of disability data in New Zealand

Although the Disability Data and Evidence Working Group has no planned meetings, there is still plenty of work going on with disability data and there is still far more to do.

There is a great need for more work on how to identify disability populations through surveys and in admin data. Whom you want to identify will depend on the purpose of the data collection. For some purposes you may only want people who self-identify as disabled people (if your purpose is about identity, politics and culture, for example), for other purposes you may want a far broader population of people with access needs/impairments (Statistics New Zealand attempts to identify this broader population).

There has been little work to date on how to identify people with impairments amongst different ethnic groups (some ethnic groups are known to underreport disability/impairment), especially in the specific context of New Zealand.

We also need to do more to get disability data collection into mainstream data collection. Getting disability identification questions into the General Social Survey and the Household Labour Force Survey is a large improvement, but we need disability to be included far more in data collection across government and academia.

END
Briefing for
Hon. Amy Adams
Minister responsible for
Social Investment

30 January 2017
Executive summary

- Disabled people often have some of the greatest needs for support and are often at a high risk of negative outcomes.
- Despite this, disability has had a low profile under the social investment approach.
- Limited data is collected on disability and it is only occasionally included in social investment analysis.
- While disability-related spending as a whole is relatively high at around $4.7 billion a year, government teams responsible for disability policy and service delivery are split between large departments and are funded by different budget votes.
- Rather than breaking down the traditional “siloed” separation of disability policy from other social policy, the social investment approach appears to be reinforcing “siloes”.
- There are significant risks the investment approach may disadvantage disabled people if applied over zealously, especially those with higher support needs.
- A narrow investment approach based only on future welfare liability is likely to reinforce any negative assumptions and prejudices in government about which people are worth investing in.
- When disabled people are included in investment analysis and initiatives, the focus is often on people with lower support needs, the perceived “low hanging fruit.”
- There is a clear need to make collecting and including data on disability a default for social investment analysis, rather than an occasional one-off.
- The key is to not collect data on disabled people as a homogenised group, but to identify the specific needs disabled people have, both as individuals and within households.
- Addressing the possible equity issues for disabled people with the social investment approach requires the use of measures beyond future welfare liability. You need to see services as delivering more than just fiscal benefits for the government.
Recommendations
That as Minister responsible for Social Investment:

1. You make clear your expectations to officials that disability should be included as a default in social investment analysis.

2. You also make clear to officials that quality data on disability should be used and must be collected through modern approaches.

3. You encourage officials to consult with the Disability Data and Evidence Working Group if they need advice on what data to collect, or include, on disability.

4. You require officials to use broader measures than just future welfare liability, especially for assessing the return generated by investing in disabled people.
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About us

CCS Disability Action is a community organisation that has been advocating for disabled people to be included in the community since 1935. As of 30 June 2016, we were providing 3,505 children, young people and adults with supports through our 17 branches, which operate from Northland to Invercargill. Our support focuses on breaking down barriers to participation. We receive a mixture of government and private funding.

CCS Disability Action has a national network of access coordinators who work with local government and transport operators to create a more inclusive society. We also run the Mobility Parking scheme. As of 30 June 2016, this scheme supported more than 130,037 people to more easily access their local towns and facilities.

What unites and drives our organisation is a common philosophy. We believe that disabled people should be valued and included in their communities.

The social investment approach and disability

We are interested in the use of the social investment approach in social services. This is because of both the risks and opportunities of the approach for people receiving social services, especially disabled people.

At its best, the social investment approach ensures limited resources are allocated efficiently and effectively in ways that maximise good outcomes for people receiving support. At their worst, the social investment approach reinforces biases about who is worth investing in and effectively writes-off those deemed to be unlikely to generate a return for the government, especially if a narrow approach is taken.

The problem is the social investment approach has not always resulted in a focus on those that need the most support. There has been naivety about how government departments actually operate and prioritise their spending. This has been very apparent around support for disabled people, who often have the greatest needs and are often at a high risk of negative outcomes (McLeod, Templeton, Ball, Tumen, Crichton, & Dixon, 2015, p. 20).
Disabled people are at a high risk of negative outcomes

Disabled people aged under 40 on the Supported Living Payment have amongst the highest average future welfare liability (Taylor Fry, 2013, p. 130). In the 2013 Disability Survey, which uses a functional limitations approach based on the World Health Organisation’s definition of disability\(^1\), disabled people;

1. were twice as likely to be the victim of violent crime;
2. were more likely to have no qualification and less likely to have a Bachelor’s degree or higher;
3. had higher unemployment and lower labour force participation; and
4. were more likely to have lower incomes and live in lower income households (Statistics New Zealand, 2014).

To pick a particular cohort, 77% of working-age people receiving Ministry of Health Disability Support Services were on a main benefit. Of this number, 96% are on the Supported Living Payment. Most of these people remain on the Payment until they pass away or become eligible for Superannuation. Only 5% of working-age people receiving Ministry of Health Disability Support Services got their main income from work\(^2\).

Further, the largest group of people entering residential care are aged between 16 and 30. About 85% of people who enter residential care will remain there for life. The lifetime costs to the government of someone entering residential care can be over $1 million (Office for Disability Issues, 2016).

\(^1\) The International Classification of Functioning, Disability and Health (ICF)
\(^2\) This data came from matching Ministry of Health data with IRD data through the Integrated Data Infrastructure. 18% of working age people receiving Disability Supports Services did not have IRD records, either because family members supported them or because of issues with the data matching process (Office for Disability Issues, 2016).
The Treasury predicts the following for teenagers on a Supported Living Payment, attending a special school or receiving special education services:

1. 75% will achieve below NCEA 2;
2. 35% will use mental health services; and
3. 62% will receive a long-term benefit for five plus years (McLeod, Templeton, Ball, Tumen, Crichton, & Dixon, 2015).

Despite the strong evidence of negative outcomes and costs to the government, reforms have moved at a slow pace in these areas and they have not been a focus for the government under the social investment approach.

**Disability has had a low profile within the social investment approach**

There are two chief reasons why disability has had a low profile under the social investment approach. Firstly, limited data is collected on disability and it is only occasionally included in social investment analysis. The type of data collected is also not always suited to social investment analysis, both in terms of what is collected and how regularly.

Secondly, while disability-related spending as a whole is relatively high at around $4.7 billion a year, government teams responsible for disability policy and service delivery are split between large departments and are funded by different budget votes (Office for Disability Issues, 2016). The Social Services Select Committee found in 2008 that these teams often have low overall priority within their department (Social Services Committee Forty-eighth Parliament, 2008, p. 13). Of course, this feature also makes disability-related spending an ideal candidate for the social investment approach.

Rather than breaking down the traditional siloed separation of disability policy from other social policy, the social investment approach appears to be reinforcing it. Disability-related social services and disability policy in general is still seen as separate from general social services. This is a crucial flaw for the social investment approach. It stops policy-makers from seeing the whole of the dynamics that increase the risk that families and individuals will experience negative outcomes. The
picture will always be incomplete if disability and its implications are not included in
the analysis.

**Disabled people should be a key part of social investment approaches**
The Productivity Commission clearly saw a key place for disabled people in the
social investment approach with its archetype for Quadrant C being a person with
muscular dystrophy, a physical disability (The New Zealand Productivity
Commission, 2015, p. 1). Disabled people with higher support needs, especially
learning disability and/or neurodiversity conditions, will often be in Quadrant D.

People in these two Quadrants have complex needs and require coordinated
services (The New Zealand Productivity Commission, 2015, p. 3). Yet there has
been a persistent desire by the mainstream parts of government departments to silo
disabled people into specialised services and specialised sections of these
departments. This has largely carried through to social investment analysis. The
Treasury did include some disabled teenagers in its youth at risk work. Too often,
however, the Treasury, and other government departments, do not include disability
as a demographic characteristic or a specific risk factor, such as with the Treasury’s
recent report into using the Integrated Data Infrastructure to estimate the fiscal
impacts of social sector performance (Templeton, 2016)(McLeod, Templeton, Ball ,
Tumen, Crichton, & Dixon, 2015).

Disability can affect whole families. It is quite common for families to have multiple
family members with disabilities. If disability is not part of the analysis the real reason
for an individual or family’s risk of negative outcomes may not be identified. For
example, a family may be at high risk of long-term benefit dependency because of a
disabled family member’s unmet support needs. Likewise, an individual with a
disability may be unable to find a job because of a lack of equipment or accessible
transport. This will not be apparent if disability and disability-related needs are
ignored.
Equity issues with the investment approach

There are significant risks the investment approach if applied overzealously may disadvantage disabled people, especially those with higher support needs. This is particularly the case with narrow investment approaches based solely on future welfare liability. If disabled people are seen as not capable of working more than 15 hours a week, they cannot generate a positive return on investment, under a future welfare liability approach.

Further, some disabled people may be capable of working more than 15 hours a week, but face complex social and environmental barriers to work, such as employer attitudes as well as inaccessible buildings and transport (Woodley, Nadine, & Dylan, 2012)(United Kingdom Parliament Office of Science and Technology, 2012, p. 3). Removing these barriers may be more costly and take longer than addressing barriers for other groups. People with more complex barriers may generate a lower rate of return per dollar invested than other groups that have easier to fix barriers. A longer term view will not change this if officials think full-time work is an unlikely prospect for a group, or would require a large ongoing investment.

The idea that an investment approach based on future welfare liability, or other fiscal criteria, will automatically result in the government focusing on those with the greatest needs is demonstrably false (The New Zealand Productivity Commission, 2015, p. 70). This was proven in an initial proposal by the Ministry of Social Development for disability vocational and employment services in March 2015.

The Ministry initially wanted to target employment support, using an investment approach, to those capable of finding more than 15 hours of paid work per week. The Ministry wanted to focus funding on reducing future welfare liability (Ministry of Social Development, 2015, pp. 5-8, 11). People considered as not capable of doing paid work of 15 or more hours per week would have had limited access to employment services in this proposal. Yet often their need for (and wider benefits derived from) paid work is as great, or even greater, than those considered capable of working 15 hours or more per week.
These initial proposals for employment support were halted and the Ministry of Social Development is now working with representatives of the disability community on further proposals. Nevertheless, the initial proposals showed how in practice, a narrow investment approach based only on future welfare liability may further disadvantage those with the greatest needs. Such an approach is likely to reinforce the negative assumptions and prejudices in government about which people are worth investing in. A focus on using data and evidence cannot overturn this on its own. This is because assumptions may stop the government from investing in a group to begin with or from collecting enough data to test their assumptions.

The Productivity Commission now recognises this flaw with the social investment approach, in part due to our input. Its suggestion of simply setting a minimum level of service fails to address the underlying inequity of a group of people with some of the greatest needs receiving lesser support than others do (The New Zealand Productivity Commission, 2015, pp. 232-233). Redirecting support away from people with greater needs goes heavily against a rights-based approach as well as widely held views in New Zealand about the importance of a fair go for all (James, 2005) (Bromell, 2014)

The Treasury, in its advice on distributive equity, gives emphasis to improving the outcomes of those with the lowest standards of living, which is a fundamentally different approach from maximising net social benefit, especially if the latter is based solely on reducing future welfare liability (The New Zealand Treasury, 2011, p. 28). Specifically, the Treasury notes that equity sometimes means protecting the most vulnerable members of society, even if this does not improve overall efficiency from a narrow fiscal perspective (The New Zealand Treasury, 2013, p. 1).

**The lack of focus on disabled people is having a negative effect**

The social investment approach relies on high-quality data being available about target populations and the effects of policy interventions (State Service Commission, 2016). The lack of data collection and focus on disabled people has real negative effects. For example, as part of the second Better Public Services target to increase the rate of early childhood participation, there are several priority populations, including children with special education needs (Basham, 2012, p. 7). Unlike other
priority populations, however, no data is collected on the participation of children with special education needs (Ministry of Education). It is unlikely to be a coincidence that the Ministry of Education’s Early Learning Taskforce has four strands in which the other priority populations are targeted, but not, explicitly, children with special education needs (Ministry of Education, 2016). What gets measured gets done.

When disabled people are included in investment initiatives, the focus is often on people with lower support needs, the perceived low hanging fruit. Nearly all of the participants in Project 300, which focused on getting disabled people and people with health conditions into work, were on the Jobseeker Health Condition and Disability, not the Supported Living Payment (the payment for people with higher needs). Of the 505 people supported into full-time work, only 13 people (or 2.6%) had been on the Supported Living Payment (Office for Disability Issues, 2016, p. 19). There is simply no evidence that officials have been focusing on those with the greatest needs, even when using the investment approach.

The way forward

Making disability a default in social investment analysis

Social investment analysis relies on the ability to segment people receiving services into identifiable groups based on their specific needs, rather than taking a uniform approach. Different ways to address those needs can then be tested (Destremau & Wilson, 2016, p. 32). There is a clear need to make collecting and including data on disability-related needs a default for social investment analysis, rather than an occasional one-off. Better services and support for disabled people is one of the keys to improving individual's and families' wellbeing as well as reducing future costs to the government.

As Minister, you can play a key role by setting the expectation that social investment analysis will include disability-related needs by default. You can also require social investment analysis to be based on quality data on disability, which is collected using modern approaches. Modern data collection on disability does not involve simply asking people whether they have a disability or not. This is because it has been
difficult in practice to get people to identify as having a disability, even if they meet formal definitions of disability and/or use disability-related services.

For example:

1. Of the 4,525 people who accessed New Zealand Tertiary Education Disability Services in 2015, 44% (or 2,010 people) did not identify as having a disability (Ministry of Education, 2016).

2. A 2004 United Kingdom survey found that 52% of people who met the Disability Discrimination Act definition of disability did not define themselves as disabled people. This was especially apparent with younger people (Grewal, Joy, Lewis, Swales, & Woodfield, 2002) (Shakespeare, 2014, p. 97).

3. An estimated 56% of the people who were identified as having a disability in the 2013 New Zealand Disability Survey, did not identify as having a disability in the 2013 Census (Statistics New Zealand, 2015, p. 19).

Instead of asking directly, the modern way to collect data on disability is to use questions that ask about what people can and cannot do in their environment. The best two examples are the Washington Group on Disability Statistics' Short Set of Questions on Disability and the Canadian Disability Screening Questions (The Washington Group on Disability Statistics, 2010)(Grondin, 2016). In New Zealand, the Ministry of Justice has also designed a data standard for identifying impairment needs when delivering services and/or for monitoring purposes, which could be more widely used (Statistics New Zealand, 2015, p. 7).

The key is to not collect data on disabled people as a homogenised group, but to identify the specific needs disabled people have, both as individuals and within households. There is also a need to use data to shine a light on the diversity amongst disabled people and their households, especially as this can significantly affect what their support needs are. Most importantly, disability, and the needs it generates, should be seen as a key factor to include in social investment analysis, wherever possible, rather than a separate special category that is only of relevance for specialised services.
The Government Disability Data and Evidence Working Group may be able to advise on the best way to collect data on disability. This group is co-chaired by the Office for Disability Issues and Statistics New Zealand (Office for Disability Issues, 2016).

**Addressing the equity issues**
Addressing the equity issues for disabled people requires the use of measures beyond future welfare liability. You need to see services as delivering more than just fiscal benefits for the government. In order to include these wider benefits in the social investment approach, you need tools such as Wellbeing Valuation, Social Return on Investment and the Treasury’s CBAX (Nicholls, Lawlor, Neitzert, & Goodspeed, 2012) (Trotter, Vine, Leach, & Fujiwara, 2014).

For example, the Treasury’s CBAX social investment tool takes into consideration the future benefits for individual (private benefits) and wider social effects as well as ways to reduce future government spending (The Treasury, 2015). In CBAX, there could be a variety of reasons to invest money now, including improving people’s quality of life as well as education and health outcomes. This wider social investment approach is a better fit for the current focus of disability policy, including the New Zealand Disability Strategy and the Convention on the Rights of Persons with Disabilities (Office for Disability Issues, 2016) (Convention on the Rights of Persons with Disabilities).

By broadening the focus of what counts as a return on investment, fairer investment decisions can be made, while still improving the efficiency and effectiveness of social services. The key is recognising that investment in disabled people with higher needs, including those unlikely to work, still generates a return on investment. This investment generates a return for those individuals, their friends and families and communities. It does not, however, always generate a direct fiscal return for the government and that is fine.
Conclusion

We remain optimistic that the social investment approach can be applied in a way that simultaneously improves the effectiveness of government-funded services and ensures those with the greatest needs receive the support they need to thrive. We are not convinced that this will happen by default though. We believe officials need to be encouraged to avoid seeing disability as a specialist area that should remain in specific silos. As the Minister responsible for Social Investment, we look to you to establish a new default of disability being included in social investment analysis, wherever possible.
Bibliography


The Treasury. (2015, October 22). *The Treasury’s CBAx Tool.* Retrieved November 3, 2015, from The Treasury:
http://www.treasury.govt.nz/publications/guidance/planning/costbenefitanalyses/cbax

https://www.cdc.gov/nchs/washington_group/wg_questions.htm

