



Waitematā
District Health Board

Best Care for Everyone

DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC) MEETING

**Wednesday 5 August 2020
1.00pm**

AGENDA

VENUE

**Waitematā District Health Board
Boardroom, Level 1, Shea Tce, Takapuna**

Venue: Waitematā DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna

Time: 1.00pm

<p><u>Committee Members</u> Edward Benson-Cooper –Committee Chair Sandra Coney –Committee Chair Judy McGregor – WDHB Board Chair Allison Roe – WDHB Board Member Renata Watene - WDHB Board Member cc All Board members</p>	<p><u>WDHB Management</u> Andrew Brant – Acting Chief Executive Officer Debbie Holdsworth – Director Funding Karen Bartholomew – Director Health Outcomes Samantha Dalwood – Disability Advisor Peta Molloy – Board Secretary</p>
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APOLOGIES: Dr Dale Bramley and Samantha Dalwood

AGENDA

DISCLOSURE OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

1.00pm	1.	AGENDA ORDER AND TIMING
	2.	DISCUSSION ITEMS
1.05pm	2.1	Improving the Employment of Disabled People in the Health Sector
1.15pm	2.2	Verbal: Co-opted members for the Disability Support Advisory Committee
	3.	INFORMATION ITEMS
1.25pm	3.1	Progress Report – Disability Strategy Implementation Plan 2016-2026
1.35pm	3.2	Update on the Accessibility Tick Action Plan
1.45pm	3.3	Services by the Wilson Home Trust for Children Physical Disabilities
2.05pm	3.4	Enhancement of Child Development Services
2.15pm	3.5	New Zealand Health & Disability system Review – Disability/Te Huātanga
2.30pm	4.	GENERAL BUSINESS

Waitematā District Health Board
Disability Support Advisory Committee Member Attendance Schedule 2020

NAME	AUG	OCT	DEC
Edward Benson-Cooper (Committee Chair)			
Sandra Coney			
Judy McGregor			
Allison Roe			
Renata Watene			

- ✓ **Attended the meeting**
- x **Apologies**
- * **Attended part of the meeting only**
- # **Absent on Board business**
- ^ **Leave of absence**

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Edward Benson-Cooper (Committee Chair)	Chiropractor - Milford, Auckland (with private practice commitments) Edward has three (different) family members who hold the following positions: Family member - FRANZCR. Specialist at Mercy Radiology. Chairman for Intra Limited. Director of Mercy Radiology Group. Director of Mercy Breast Clinic Family member - Radiology registrar in Auckland Radiology Regional Training Scheme Family member - FANZCA FCICM. Intensive Care specialist at the Department of Critical Care Medicine and Anaesthetist at Mercy Hospital	25/03/19
Sandra Coney	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women’s Health Action Trust	18/12/19
Judy McGregor (Board Chair)	Chair – Health Workforce Advisory Board Associate Dean Post Graduate - Faculty of Culture and Society, AUT Member - AUT’s Academic Board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women’s Centre Life Member - Hauturu Little Barrier Island Supporters’ Trust	11/09/19
Allison Roe	Chairperson – Matakana Coast Trail Trust Member – Rodney Local Board, Auckland Council Member – Wilson Home Committee of Management (past role)	22/08/18
Renata Watene	Owner – Occhiali Optometrist Board Member – OCANZ Strategic Indigenous Task Force Council Member - NZAO	17/12/19

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is 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 responsibilities, then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a 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.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board's integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

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

Note: This sheet provides summary information only.

2.1 Improving the Employment of Disabled People in the Health Sector

Recommendation

That the Committee:

- a) Notes and supports the paper and recommendations considered by the Health Workforce Advisory Board.
- b) Notes the following Waitematā DHB's actions in this area:
 - i) Required action: the Waitematā DHB's Annual Plan for 20/2021 includes:
Building an inclusive culture through reducing barriers in employment and appreciating difference (EOA)
 - *Deliver disability responsiveness and confidence training*
 - *Re-image our online recruitment process*
 - *Explore recruitment initiatives that support disability in the workplace*
 - ii) In recent years, the Waitematā DHB commenced collecting robust data, and reporting the number of disabled staff in the DHBs Annual Report

Prepared by: Dr Judy McGregor (Board Chair) for the Health Workforce Advisory Board

The following paper was prepared by Dr Judy McGregor for the Health Workforce Advisory Board.

Introduction

New Zealand led the world in its international leadership ensuring that disabled people were involved in the preparation of the Convention on the Rights of People with Disabilities, the most modern of the seven international human rights treaties. The convention, which was signed by New Zealand on 30 March 2007 and ratified on 26 September 2008, sets out core basic human rights that the State guarantees its disabled citizens. Human rights treaties place the duty on the State party, the government of the day, to promote, protect and fulfil the rights contained in treaty documents. Several years later New Zealand signed the Optional Protocol to the Convention, which allows disabled people to complain to the United Nations mechanisms in certain circumstances if their complaints relating to convention breaches have exhausted domestic remedies.

Accessibility, inclusiveness and changing societal attitudes are recurring themes in the disability convention reflecting a shift in thinking from viewing disability in terms of social welfare to seeing it as a human rights paradigm. The Convention is more explicit than any other human rights treaty about employment rights providing substantially more context and texture.¹ Article 27 recognises the rights of persons with disabilities to work on an equal basis with others, refers to a work environment that is open, inclusive and accessible to persons with disabilities, and recognises the prohibition of discrimination in recruitment, hiring, continuing employment, career advancement

¹ McGregor, J. Bell, S, Wilson, M. (2016). *Human Rights in New Zealand: Emerging faultlines*. Bridget Williams Books with the New Zealand Law Foundation. Wellington. Chapter 8.

and safe and health work conditions. Domestically, anti-discrimination commitments are also outlined in the New Zealand Bill of Rights Act 1990 and the New Zealand Human Rights Act 1993.

Increased employment has long been acknowledged as one of the best predictors of increased economic, social and professional independence of people with disabilities and of their material and psychological wellbeing. Equally the barriers of physical inaccessibility, of explicit discrimination and implicit bias and the absence of a proactive and empowering approach to recruitment, retention and promotion, have seen low rates of decent employment both in the public and private sectors in New Zealand. For example, in the Government's latest response to the United Nations about implementation of the convention in 2018, Household Labour Force Survey material shows labour force participation rates of disabled people at 25% compared with 73% for non-disabled people.

State parties are urged to employ persons with disabilities in the public sector (Article 27(g) of the Convention and ensure that the principle of "reasonable accommodation" is applied to disabled people in employment contexts (Article 27(i)). Toolkits providing in-depth guidance to employers on employment for disabled people with a particular focus on the public sector have recently been developed, and employment is one of six focus points in the new Disability Action Plan 2019-2022. Increasing the participation of disabled people in decent paid work in the health sector fits into the Framework for developing New Zealand's health workforce, with its focus on capability, capacity, culture and criticality developed by the Health Workforce Directorate of the Ministry of Health.

Future Directions

The Health Workforce Advisory Board has in its Terms of Reference the purpose of developing "a strategic approach to planning and development of our workforce" which is "key to ensuring New Zealand's health and disability system can deliver safe, effective and accessible services to New Zealanders now and in the future." Its key functions include advising on the development of any health workforce strategic priorities "and associated action plans", including identifying areas for priority investment. The Terms of Reference include advice on enabling greater Māori and Pacific representation in the health workforce which should be inclusive of Māori and Pacific disabled people and other "under-represented populations."

People with disabilities remain under-represented, marginalised and disadvantaged in the health sector workforce despite reference to disability in the legislation and in many strategic planning documents which talk of "health and disability", but often place less measurable emphasis on disability. The HWAB must play a part in improving the representation and participation of people with disabilities in the health workforce in accordance with their human rights. It could aim through greater participation to improve health sector knowledge of the aspirations and experiences of disabled people, to ensure that the human capital of disabled people is appropriately utilised and to increase social cohesion in communities that DHBs cover.

The Interim Report of the Health and Disability System Review suggested that the District Health Boards (DHB) need to lead by example in terms of employment of disabled people.²

The Panel's view is that, as the largest employer in many regions, the system should lead in employing people with disabilities. Boosting employment of disabled people overall may be the single biggest contributor to improving wellbeing of disabled people. Bringing their skills to the workforce in health will also make the sector more responsive, adaptive, inclusive and reflective of the community.

² Interim Report Health and Disability System Review, p.14.

In the Letter of Expectations for District Health Boards and subsidiary entities for 2020/21, the Minister of Health Hon. David Clark includes a similar reference and writes:

Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.³

The Minister stated that as with previous years “your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities.”

Additionally documentation referring to the development of Annual Plans by DHBs makes mention of the need for Disability Action Plans:

Commit to working with the Ministry of Health to develop your own or a regional Disability Action Plan to be published by July 2021. The purpose of the Plan is to improve access to quality health services and improve the health outcomes of disabled people. The Plan will focus on data, access and workforce.

The disruption to existing ways of working and innovative responses of DHBs to COVID-19 with the use of technology, working from home, virtual consultations and telephone-based therapies suggests an opportunity for some disabled people in work that may no longer require delivery from hospital sites or community locations.

Policy focusing on people with disabilities working in DHBs

Many DHBs already have Disability Action Plans that focus on improving disabled people’s employment participation. Those DHBs who have achieved the Accessibility Tick, for example, have worked hard to ensure recruitment policies and practices do not discriminate in any way against people with disabilities offering themselves as applicants for jobs. Some of this work includes completing an accessibility review of our online recruitment process, amending policies to ensure reasonable accommodation and workplace adjustments are met, encouraging all staff to complete the Disability Responsiveness e-Learning module and providing information to managers to support employees’ mental health.

DHB Directors of Human Resources have also committed to building an inclusive culture through reducing barriers in employment and appreciating difference:

- Deliver disability responsiveness and confidence training to recruitment teams and hiring managers
- Re-image recruitment process to ensure it is inclusive
- Establish an employee accessibility network – nothing about us without us
- Explore recruitment initiatives that support disability in the workplace
- Disability Champions – staff who have lived experience of disability who can advocate for disabled staff and patients

Being part of the Accessibility Tick work has also ensured that HR Directors are more aware of the barriers to disabled people being employed and are actively committed to working in a more inclusive way.

³ Clark, David. Hon. “Letter of Expectations for District Health Boards and subsidiary entities for 2020/21.” Appendix one: Ministerial Planning Priority Areas,, page 7.

However, two issues often bedevil discussion about how to improve participation of disabled people in employment. The first relates to a definition of disability relating to identification of disability and the second relates to statistical benchmarking. It is worth clearing these off the table so debate on implementation does not become mired in old controversies and myth-making.

First, the question of who is disabled and what is disability? The definition of people with disabilities in the convention includes “those who have long term physical, mental, intellectual or sensory impairments which interact with various barriers and may hinder their full and effective participation in society on an equal basis with others in society.” It is often not the definition of disability *per se* that causes difficulty. Some people who fit within the definition may not necessarily identify as disabled, because of personal choice or because of the potential stigma attached to its identification. In other cases, such as older people, some are frail with impairments that may be disabling but they still do not regard themselves as “disabled”.

The definitional difficulties surrounding disability have historically been linked to the second problem, that of statistical accuracy. It is often suggested that we cannot begin the process of increasing representation of disabled people in employment because we do not have benchmark information from which we can start. The problem of inadequate statistical disaggregation relating to disability has inhibited proactive policy and practice in employment for many years. The problem is acknowledged in the Convention on the Rights of Persons with Disabilities, Article 31, which urges State parties to undertake to collect appropriate information including statistical and research data, to enable them to formulate and implement policies to give effect to the convention and to identify and address the barriers faced by disabled people in exercising their rights. Information shall be disaggregated as appropriate and used to help assess the implementation of obligations under the Convention.

Inevitably different DHBs will have variable statistical data relating to disabled people in their workforces. Some DHBs will have better data than others. This may, or may not, have been helped by DHB workers in their identification as “vulnerable” during the COVID-19 period. Nonetheless the policy issue that needs to be resolved is whether there is a practical and reasonable way of increasing disabled people’s workforce representation without accurate status quo benchmark data? TAS has usefully provided comparative DHB data on Māori and Pacific staff representation and it may have, or be able to collate, baseline data on the number of disabled people employed by DHBs that can be used for benchmarking.

A pragmatic suggestion is to make 2020 a new start-point for DHBs with or without reliable disaggregated data. They would be asked to commit to raising the representation of people with disabilities as employees in the 2020-2021 Disability Action Plans. This would mean that each DHB would forecast its own potential increase and audit and report on its annual progress. This would be from a zero base if disability data collection is non-existent or from an already existing benchmark included in the DHB’s human resources reporting. This would align with the increased emphasis on equity of process and outcomes in the health sector.

There are other useful recent examples within the DHB environment of other under-represented workforces gaining traction in employment participation. Most recently, Tumu Whakarāe gained the commitment of DHB CEOs to a range of measures to increase Māori participation in DHB workforces in a position statement in March 2019. These included that all DHBs would actively grow their Māori workforce to achieve a Māori workforce that reflects the proportionately for their Māori populations with a particular focus on clinical professions. It also included that all DHBs will measure and report on the recruitment and retention of Māori staff in clinical and non-clinical occupations.

Recommended next steps

Increased employment of disabled people is a powerful equity indicator and could accelerate DHB knowledge and understanding of health gains for disabled people. Unemployment is also a critical barrier for the material, physical and psycho-social health of disabled people. More disabled people in the workforce and an appreciation of the value they bring will also raise the disability awareness of DHB workforces.

The annual planning cycle for DHBs which includes the need for Disability Action Plans has been extended due to COVID-19. This would allow the Health Workforce Advisory Board to recommend to the Minister of Health that:

- * every DHB commits to active new recruitment of disabled people in their workforces and specifies in their 2020-21 Disability Action Plan either a number or a percentage increase of new disabled people employed in its workforce (in anticipation that some DHBs may not have disaggregated data.)
- * DHBs are asked to measure and report on the recruitment and retention of disabled people disaggregated by clinical and non-clinical occupations
- * the Ministry in regular reporting against annual plans will actively monitor DHBs and their commitments to disabled people's employment representation with support from the Disability directorate.
- * DHB comparative data is collated, analysed and reported annually by the Ministry and that this material is available to individual DHB disability advisory committees, Boards and senior leadership teams.

There may be other more practical suggestions to motivate greater participation by disabled people in DHB workforces which can be considered. These might include collective CEO commitment, a focus of particular human resource strategies such as attaining and maintaining the Accessibility Tick, or a particular emphasis on community services. These could complement action plan activity.

This paper is intended as a conversation starter and does not exclude any other perspectives or ways of achieving increased representation of disabled people in the wider DHB health sector, whether it be administration, hospital services or community provision.

In the spirit of "nothing about us without us" I suggest that we ask the MOH if its disability advisory mechanisms can provide feedback. I want to acknowledge Samantha Dalwood, Disability Advisor at Waitemata DHB, for her help with this paper. I would like to provide advice to the Minister as soon as practicable.

3.1 Update: Implementation Plan

Recommendation

That the update report be received.

Prepared by: Samantha Dalwood (Disability Advisor)

The following report provides an update or informs of new work for Waitematā DHB against the Implementation of the New Zealand Disability strategy 2016-2026. A copy of the Implementation Plan is also attached for Committee members.

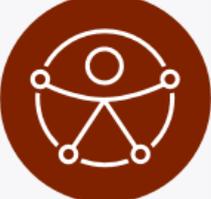


Waitemata DHB, Auckland DHB
and Counties Manukau Health
are fully inclusive

Please note: This document is updated for each DiSAC meeting to report updates or new work since the previous meeting.

Waitematā District Health Board Implementation of the New Zealand Disability Strategy 2016-2026

Current Status at 1 August 2020

				
Outcome 2: employment & economic security	Outcome 3: health & wellbeing	Outcome 5: accessibility	Outcome 6: attitudes	Outcome 7: choice & control
<i>We have security in our economic situation and can achieve our potential</i>	<i>We have the highest attainable standards of health and wellbeing.</i>	<i>We access all places, services and information with ease and dignity.</i>	<i>We are treated with dignity and respect.</i>	<i>We have choice and control over our lives.</i>



Outcome 2: Employment & Economic Security

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

Current Status at 1 August 2020

What we will do... actions	Where we are now...current status
1. Increase the number of disabled people into paid employment.	<p>August 2020 - Recruitment process accessibility barriers identified and supportive processes implemented.</p> <p>Supportive Employment Consultant working with supported employment agencies, and recruitment to support disabled people into roles at Waitematā DHB.</p> <p>Retention of Disabled Staff policy has been updated.</p>
2. Increase the confidence of Hiring Managers to recruit disabled people.	<p>August 2020 – Accessibility Tick training booked for October 2020.</p> <ol style="list-style-type: none"> 1. An Employer’s Story – Selwyn Cook, 2016 NZer of the Year Selwyn Cook has employed over 100 people with disabilities. His presentation focuses on the benefits of employing disabled people. This will be a Zoom presentation and available to all staff. 2. Practical employment guidelines for hiring people with disabilities from creating a job description through to on-boarding and retention. This is classroom based training for HR and Recruitment Teams.
3. Record the number of staff with impairments working for the DHB.	Ongoing
4. Ensure DHB Diversity & Equality work includes disabled people.	
5. Awarded the Accessibility Tick.	<p>August 2020 – Waitematā DHB has completed two quarterly reviews since becoming a member and is showing our commitment to inclusion by the work that we are doing. The next review is due in August. Work will now begin on the 2021/22 Accessibility Tick Action Plan. The Steering Committee meets quarterly and we are currently recruiting a disabled staff member to join.</p>

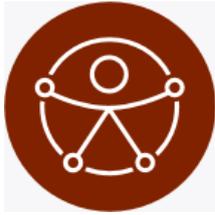


Outcome 3: Health & Wellbeing

We have the highest attainable standards of health and wellbeing

Current Status at 1 August 2020

What we will do... actions	Where we are now...current status
5. Improve the health outcomes of disabled people.	August 2020 – work is being done to look at the way that disability is recorded in our alert system. The alert system could be improved and could make a real difference to the experiences of disabled people. Capital & Coast DHB are one year into a project reviewing and making recommendations on their alert system across the three Wellington region DHBs – Capital & Coast, Hutt Valley & Wairarapa. They have kindly shared their findings with us and these have been given to i3 to scope what a project could look like.
6. Robust data and evidence to inform decision making.	August 2020 – The Director of Funding has written to Adri Asbister, DDG-Disability requesting access to data on people accessing services through Taikura Trust (NASC). This will enable us to gather accurate data and to complete a Health Needs Assessment about disabled people in our DHB. We are aware that this will not capture information about all disabled people in our DHB, but will be a great starting point.
7. Barrier free and inclusive access to health services.	August 2020 – Work is being done to look at the booking of appointments. Currently, patients are offered to book by phone only, which doesn't work for Deaf people or people that prefer to text or email. Also working with the PSO (Projects Office) asking them to include accessibility as part of the criteria for each project.
8. Increased understanding of the support needs of people with learning disabilities.	August 2020 – Disability Advisor has met with Henrietta Trip from Otago University to discuss the work that she does leading a group of nurses focusing on working with people with learning/intellectual disabilities. We have also met with the Director of Nursing at IDEA Services and the Quality Manager at Creative Abilities to discuss how we can support people with learning disabilities better.
9. Better understanding of the needs of Deaf people. This includes access to interpreters, information available in NZSL and knowledge of Deaf culture.	August 2020 – We are currently recruiting for an NZ Sign Language interpreter to join the DHB Interpreting Service. Initially this is a six month contract. As well as interpreting for patients, the role will develop NZSL resources and videos. Longer term work may include cultural support for Deaf patients and staff training.
10. Better support for young people moving from child to adult health.	August 2020 - Waitematā DHB has a project to improve the experience of young, disabled people transitioning from Child Health into adult health services. Work includes: identifying transition work that has already been undertaken within the Child Women and Family (CWF) division, identifying WDHB work that feeds in to this pathway, Co-designing a new pathway informed by current literature and whānau experience and trialling the new pathway.



Outcome 5: Accessibility

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

Current Status at 1 August 2020

What we will do... actions	Where we are now...current status
11. Barrier free and inclusive access to health services.	August 2020 – exploring the possibility of a Changing Places toilet in Totara Humaru. This would be the third such toilet in NZ and the first one in a DHB building. http://www.changingplaces.org.nz/Home.htm
12. The principles of universal design and the needs of disabled people are understood and taken into account.	February 2020 – staff training given to Waitematā DHB Facilities Project Managers on accessibility and universal design August 2020 – Worked with AUT Design Master’s students looking at the Auckland Regional Dental Service (ARDS) and ward design to ensure accessibility is considered as part of their work.
13. Improve & increase accessible information across the DHB.	Ongoing
14. Information available in different formats, eg. Easy Read	Ongoing
15. Ensure physical access to DHB buildings and services, including signage and way finding.	August 2020 – focus on the accessibility of Totara Haumaru from patient and visitor perspective. This includes access to get to the building, to get inside the building and to move within the building.



Outcome 6: Attitudes

We are treated with dignity and respect.

Current Status at 1 August 2020

What we will do... actions	Where we are now...current status
16. All health and well-being professionals treat disabled people with dignity and respect.	August 2020 - Waitemata DHB have updated the Disability & Accessibility page on the staff intranet site. This has lots of useful information and links to the e-Learning Disability Responsiveness training. Staff are encouraged to complete the training.
17. Disabled people and their families respected as the experts in themselves.	
18. Provide a range of disability responsiveness training.	
19. Promote the Disability Awareness e-Learning module to all staff across the DHBs.	August 2020 – the e-Learning module is mandatory at Counties Manukau Health. The RDiSAC Committee previously discussed if a recommendation should be made that this training is mandatory across the three Auckland DHBs.
20. Ensure disabled people are able to access supports that they need in hospital.	August 2020 – The Alerts project work will support this (see item 5 above).
21. Increase cultural awareness of disability.	August 2020 – We are currently recruiting for an NZ Sign Language interpreter to join the DHB Interpreting Service. Initially this is a six month contract. As well as interpreting for patients, the role will develop NZSL resources and videos. Longer term work may include cultural support for Deaf patients and staff training.



Outcome 7: Choice & Control

We have choice and control over our lives.

Current Status at 1 August 2020

What we will do... actions	Where we are now...current status
22. Engage regularly with the disability sector and community.	August 2020 – The Health & Wellness Group still meets bi-monthly at CCS Disability Action to hear from disabled people. Meet regularly with NZDSN (New Zealand Disability Support Network) for service provider perspective. Good on-line networks of disability community and disability sector for input into specific pieces of work.
23. Ensure a diverse range of disabled people are identified as stakeholders.	
24. Ensure the voice of disabled people from the community is included.	August 2020 – At the November 2019 RDiSAC, it was decided to recommend to each Board that they sign off an agreement for a community representative from each District to sit on Metro-Auckland DiSAC. The Director of Patient Experience will lead this work with support from the Disability Advisor.
25. Enable supported decision making and informed consent.	
26. Ensure services are responsive to disabled people and provide choice and flexibility.	
27. Improve access to screening services for disabled people.	
28. Continue the implementation of the Health Passport across both DHBs.	August 2020 – Capital & Coast DHB are launching the updated Health Passport on 3 August. The content has been refreshed to ensure it remains fit for purpose both consumers and service providers, and it has been re-named “My Health Passport”. Samantha Dalwood is acknowledged for her work in developing the original Health Passport on 2011.

Metro-Auckland District Health Board's Implementation of the New Zealand Disability Strategy 2016-2026

Waitematā & Auckland District Health Boards and Counties Manukau Health 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.



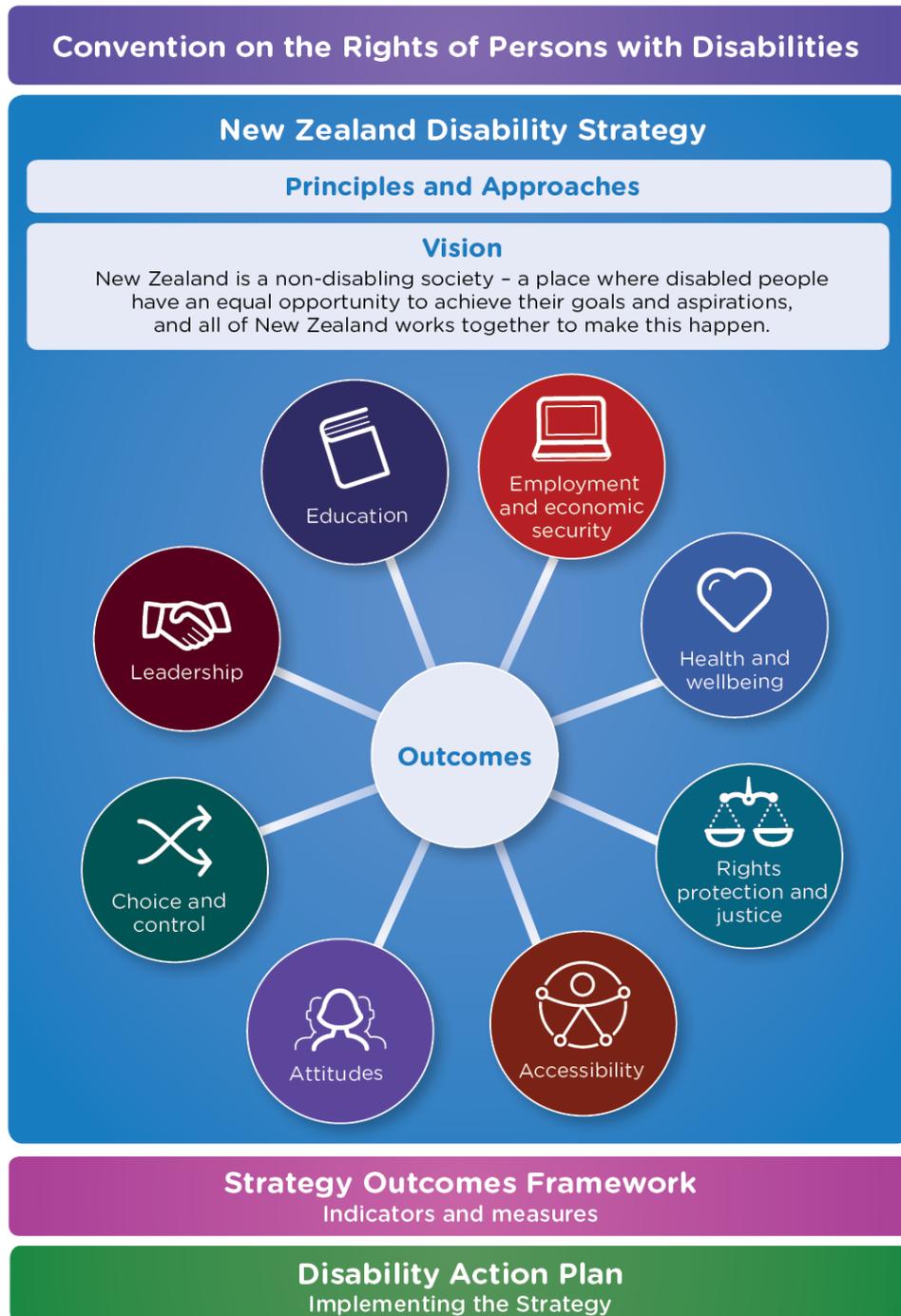
The New Zealand Disability Strategy 2016-2026 provides a framework for organisations to focus on enabling the full participation of disabled people. It has a vision of New Zealand as a non-disabling society – a place where disabled people have an opportunity to achieve their goals and aspirations and 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 (DHB)s **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.

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 / The Treaty of Waitangi
- Disability Action Plan 2014-2018
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- Whāia Te Ao Mārama: The Māori Disability Action Plan 2017-2022
- Faiva Ora: National Pasifika Disability Plan 2016–2021
- Auckland DHB, Waitematā DHB & Counties Manukau Health 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 Waitematā & Auckland DHBs and Counties Manukau Health reflect a shared vision for equity and inclusion of disabled people in their care and in the design of patient facilities and services.



“ best care for everyone

This is our promise to the Waitemata community and the standard for how we work together.

Regardless of whether we work directly with patients/clients, or support the work of the organisation in other ways, each of us makes an essential contribution to ensuring Waitemata DHB delivers the best care for every single patient/client using our services.

“ everyone matters

Every single person matters, whether patients/clients, family members or staff members.

“ with compassion

We see our work in health as a vocation and more than a job. We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness.

“ connected

We need to be connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families.

“ better, best, brilliant...

We seek continuous improvement in everything we do. We will become the national leader in health care delivery.



Waitemata
District Health Board
Best Care for Everyone

Welcome | Haere Mai

We see you, we welcome you as a person

Respect | Manaaki

We respect, nurture and care for each other

Together | Tūhono

We are a high performing team

Aim High | Angamua

We aspire to excellence and the safest care

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 metro-Auckland 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

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

Health Literacy

The three 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:

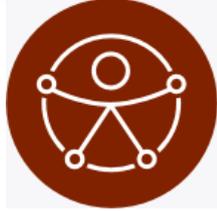
- improving health literacy of both organisations and their staff
- enabling communities to become more health literate

Patient Experience

There is a focus on Patient Experience and Community Engagement across the three DHBs. This has led to greater inclusion of disabled people in design and planning of both facilities and services. Examples of this are the Public Spaces work at Auckland DHB and the Waitemata 2025 commitment to universal design as a core design principle. Counties Manukau Health has included disability experience questions to their Inpatient Patient Experience Survey to learn from the experiences of disabled patients.

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.

				
Outcome 2: employment & economic security	Outcome 3: health & wellbeing	Outcome 5: accessibility	Outcome 6: attitudes	Outcome 7: choice & control
<i>We have security in our economic situation and can achieve our potential</i>	<i>We have the highest attainable standards of health and wellbeing.</i>	<i>We access all places, services and information with ease and dignity.</i>	<i>We are treated with dignity and respect.</i>	<i>We have choice and control over our lives.</i>



Outcome 2: employment & economic security

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

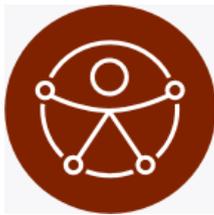
1. Increase the number of disabled people in paid employment.
2. Increase the confidence of Hiring Managers to recruit disabled people.
3. Record the number of staff with impairments working for the DHB.
4. Ensure Diversity & Equity work includes disabled people.
5. Awarded the Accessibility Tick.



Outcome 3: health & wellbeing

We have the highest attainable standards of health and wellbeing.

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



Outcome 5: accessibility

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

11. Barrier free and inclusive access to health services.
12. The principles of universal design and the needs of disabled people are understood and taken into account.
13. Improve & increase accessible information across the DHBs.
14. Ensure information is available in different formats, eg. Easy Read
15. Ensure physical access to DHB buildings and services, including signage and way finding.



Outcome 6: attitudes

We are treated with dignity and respect.

16. All health and well-being professionals treat disabled people with dignity and respect.
17. Disabled people and their families respected as the experts in themselves.
18. Provide a range of disability responsiveness training.
19. Promote the Disability Responsiveness e-Learning module to all staff.
20. Ensure disabled people are able to access supports that they need in hospital.
21. Increase cultural awareness of disability.



Outcome 7: choice & control

We have choice and control over our lives.

22. Engage regularly with the disability sector and community.
23. Ensure a diverse range of disabled people are identified as stake-holders.
24. Ensure the voice of disabled people from the community is included.
25. Enable supported decision making and informed consent.
26. Ensure services are responsive to disabled people and provide choice and flexibility.
27. Improve access to screening services for disabled people.
28. Continue the implementation of the Health Passport across the DHBs.

3.2 Progress Report: Accessibility Tick Action Plan

Recommendation

That the report be received.

Prepared by: Samantha Dalwood (Disability Advisor)

The following report provides a progress update against the Accessibility Tick Action Plan. A copy of the Plan is also attached for Committee members.



Accessibility Tick: Action Plan

2019-2020

Progress Update – May 2020

Please note that COVID-19 has caused delay to the progression of the Accessibility Tick Action Plan.

Our Patients

“We strive to make it easy for our patients and visitors to interact with us. To do this we want to lead the way with digital accessibility and ensure our products, services, facilities and buildings are inclusive of people with a disability.”

David Price, Director of Patient Experience

Our Five Year Objective (By 2022)

Our services and buildings will be accessible for our patients, staff and the wider community.

Actions 2019-2020	When	Progress Update
A commitment to create alternative formats of marketing and communications material, including electronic, Easy Read and NZ Sign Language.	2020	COVID-19 has emphasized the need for information to be fully accessible.
Complete Annual accessibility audits of the physical environments as well as after any changes to the environment.	Ongoing	Gave Universal Design presentation to Facilities Project Team in Feb 2020
Engage experts in accessibility environments before designing new physical spaces to ensure accessibility needs are met.	2020	This is currently happening with new buildings – eg. Totara Haumaru.
Encourage all staff to complete Disability Responsiveness e-Learning modules.	2020	Pushing for training to be mandatory, at least for all new staff.
Conduct an audit of our website and intranet to determine if it is accessible and identify accessibility gaps.	2020	Work has started on this, but is currently on hold.

Our People

“At Waitematā DHB, we’re always working towards an inclusive culture, so that our people thrive and differences are celebrated. We are committed to the wellbeing of our people, and supporting them by considering accessibility needs in everything we do.”

Fiona McCarthy, Director of Human Resources

Our Five Year Objective (By 2022)

Build an inclusive culture through an appreciation of difference.

Actions 2019-2020	When	Progress Update
Deliver Disability Confidence and unconscious bias training to the Recruitment team and Hiring Managers.	2020	Recruitment Manager & Disability Advisor planning dates for 2020
Establish an Accessibility page on the intranet.	2020	Completed
Establish an employee accessibility network within WDHB.	2020	Draft plan started.
Encourage all staff to complete Disability Responsiveness e-Learning modules.	2020	Pushing for training to be mandatory, at least for all new staff.
Update and amend relevant policies to increase awareness of accessibility and inclusion.	2020	
Complete an accessibility review of our online recruitment process.	2020	Review completed and recommendations made. Website updated.
Amend recruitment policy to add asking about access needs when inviting candidates to interview.	2020	Completed
Amend policies to ensure reasonable accommodation and workplace adjustments are met.	2020	Retention of Disabled Staff policy updated and waiting final approval.
Provide information to managers to support employees’ mental health.	2020	Completed - Occ Health provides training to Managers.

Our Community

Advocating for those with accessibility needs extends beyond our employees and patients. We want to have an impact in the communities we support and are committed to sharing our expertise so that others can learn and benefit.

Our Five Year Objective (By 2022)

Contribute to creating inclusive communities through accessibility.

Actions 2019-2020	When	Progress Update
Improve understanding of accessibility with Waitematā DHB partners and suppliers.	2020	
Actively seek information on the accessibility and inclusion practices of suppliers.	2020	



Accessibility Tick: Action Plan

2019-2020

What you need to know

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Our Action Plan

“We believe being a diverse and inclusive workplace brings out the best in our workforce and helps us provide better services to the community we serve.”

Dr Dale Bramley, CEO

Actions underway

Waitematā DHB is working to ensure that meeting the accessibility needs of our patients and our employees is how we do business.

At Waitematā DHB we provide healthcare services and support for a diverse community. We know that for our patients, having a workforce that reflects the diversity of our community is a good thing.

We are also striving to provide an inclusive workforce where everyone is accepted for who they are and are supported to do their best work.

More to come

Our Accessibility Tick Action Plan is a big part of our inclusive ‘Everyone Matters – Orā Ki Te Katoa’ cultural values and our vision to improve accessibility for our people and our patients. We want to make it easy for people with access needs to work here.

To do this we are focusing on:

- Creating a more diverse workforce through developing a fully accessible recruitment process. This will reach qualified applicants with access needs and reduce the likelihood of disability discrimination and unconscious bias in hiring.
- Further driving inclusion by educating our people about accessibility.
- Demonstrating a consultative commitment to all areas of accessibility and inclusion.

Governance

Actions within this Action Plan are reported to the Accessibility Tick Steering Committee.

Our Patients

“We strive to make it easy for our patients and visitors to interact with us. To do this we want to lead the way with digital accessibility and ensure our products, services, facilities and buildings are inclusive of people with a disability.”

David Price, Director of Patient Experience

Our Five Year Objective (By 2022)

Our services and buildings will be accessible for our patients, staff and the wider community.

Actions 2019-2020	When
A commitment to create alternative formats of marketing and communications material, including electronic, Easy Read and NZ Sign Language.	2020
Complete Annual accessibility audits of the physical environments as well as after any changes to the environment.	Ongoing
Engage experts in accessibility environments before designing new physical spaces to ensure accessibility needs are met.	2020
Encourage all staff to complete Disability Responsiveness e-Learning modules.	2020
Conduct an audit of our website and intranet to determine if it is accessible and identify accessibility gaps.	2020

Our People

“At Waitematā DHB, we’re always working towards an inclusive culture, so that our people thrive and differences are celebrated. We are committed to the wellbeing of our people, and supporting them by considering accessibility needs in everything we do.”

Fiona McCarthy, Director of Human Resources

Our Five Year Objective (By 2022)

Build an inclusive culture through an appreciation of difference.

Actions 2019-2020	When
Deliver Disability Confidence and unconscious bias training to the Recruitment team and Hiring Managers.	2020
Establish an Accessibility page on the intranet.	2020
Establish an employee accessibility network within WDHB.	2020
Encourage all staff to complete Disability Responsiveness e-Learning modules.	2020
Update and amend relevant policies to increase awareness of accessibility and inclusion.	2020
Complete an accessibility review of our online recruitment process.	2020
Amend recruitment policy to add asking about access needs when inviting candidates to interview.	2020
Amend policies to ensure reasonable accommodation and workplace adjustments are met.	2020
Provide information to managers to support employees’ mental health.	2020

Our Community

Advocating for those with accessibility needs extends beyond our employees and patients. We want to have an impact in the communities we support and are committed to sharing our expertise so that others can learn and benefit.

Our Five Year Objective (By 2022)

Contribute to creating inclusive communities through accessibility.

Actions 2019-2020	When
Improve understanding of accessibility with Waitematā DHB partners and suppliers.	2020
Actively seek information on the accessibility and inclusion practices of suppliers.	2020

Feedback

If you have feedback or suggestions about this plan, please email

samantha.dalwood@waitematadhb.govt.nz

Other Formats

Our Accessibility Action Plan 2019-2020 is available on our website:

<http://www.waitematadhb.govt.nz/>

If you would like to be provided with the plan in an alternative format, please email

Samantha Dalwood, Disability Advisor samantha.dalwood@waitematadhb.govt.nz



3.3 Overview of Services Provided from the Wilson Centre

Recommendation:

That the report be received.

Prepared by: Stephanie Doe (General Manager – Child, Women and Family)

Endorsed by: Dr Andrew Brant (Acting Chief Executive)

1. Introduction

The Wilson Centre is a stand-alone off-site facility located on Lake Road (Takapuna). The facility is currently leased by the Waitematā DHB from the Wilson Home Trust.

Waitematā DHB provides two services from the site:

1. *The Child Rehabilitation Service* – a national specialist paediatric rehabilitation service that provides comprehensive and intensive rehabilitation to children aged 0 – 16 years (or for older children who are still at school).
2. *The Out of Home Respite Service* - for children and young people who are medically fragile or who have a disability. Intensive, planned respite is also provided for children who require additional supervision in a contained, low stimulus environment. This service provides periodic relief to families who have children with multiple or complex needs living at home or in the community.

This paper provides a brief overview of these two services and the current key issues and risks.

2. Child Rehabilitation Service

The Child Rehabilitation Service is a specialist paediatric rehabilitation service that provides comprehensive and intensive rehabilitation for children aged 0-16 years (or for older children who are still at school). The cohort of children who access the service is small, but they have highly complex needs.

The service is part of the tertiary continuum of care for children, which begins with an unexpected/acute (trauma or illness) or planned event (surgery). Specifically, rehabilitation is provided following a severe illness, injury or complex surgical intervention (for example, acquired brain injury, complex orthopaedic interventions, spinal cord injury or chronic, complex pain). This includes an assessment of functional abilities and the provision of a goal based interdisciplinary rehabilitation programme to maximize the child's potential to ensure a successful return to community living and school.

Inpatient, day patient and outpatient services are provided. There are 18 inpatient bed spaces available and 12 beds for parent accommodation on site. The average length of stay is six to eight weeks.

Entry into the service is via referral and is criteria based. To be accepted into, the child or young person must:

- Be under 16 years of age or still in full time education and under paediatric care.
- Be medically stable.
- Have needs that cannot be met by primary or secondary services.
- Have complex sequelae requiring specialised rehabilitation to maximise functional potential.
- Have an identified lead paediatric consultant and/or a link to a tertiary consultant in Auckland.
- Be able to participate in a rehabilitation programme which is family-centred, goal-directed and time-framed.
- Meet the criteria of requiring a specialised rehabilitation multidisciplinary team.

Initially, children and their families are admitted into the inpatient rehabilitation villa for nursing assessment and intervention. Over the course of the rehabilitation process, children will transition to stay with their family/whānau in the on-site parent accommodation facilities. This enables families and/or caregivers to actively participate in therapy and care for their child.

Children who reside in metropolitan Auckland have the option to transition to day-patient and/or outpatient care as their rehabilitation progresses.

There is a nationally agreed model of care for specialist paediatric rehabilitation services. In 2018, a review of the service components, that Waitematā DHB is responsible for delivering, was undertaken. This indicated that the service is consistent with the agreed national model.

3. Out of Home Respite Service

Out of Home Respite Service aims to provide families/whānau or carers with a planned, temporary break from caring for a person with disability. The primary purpose of respite is to relieve carer stress as a way of supporting them to continue in their caring role. Respite also gives the disabled person a break from their normal routine. It can provide them with new experiences, chances to develop their independence or opportunities to visit different places or make new friends.

There are a range of respite options available to families across a continuum of intensity – from Carer Support (which contributes some of the costs of a break for carers that is paid on a half-day or daily rate) to the provision of nurse led care at a specialised facility.

The Waitematā DHB Out of Home Respite Service is a nurse-led, specialised respite facility that provides care to children and young people living in metropolitan Auckland, aged 0 – 21 years, who have a disability and/or are medically fragile. There are no specialist respite facilities of this kind available in the rest of the country. The other facilities for children do not provide specialist nursing care – they are operated by non-government organisations and care is provided by non-registered staff.

The service provides safe, fun, flexible and individual family centred care 24-hours a day by a multidisciplinary team. It is available for day-stay, overnight, weekends and school holidays. Weekends and school holidays are particular periods of high demand.

Access into the service is solely via the Needs Assessment Co-ordination Service (Taikura Trust), who allocates the number of bed days per annum a child can receive following the completion of a needs

assessment. Once bed days have been allocated, families are able to directly manage access into the service, provided it is within their bed day allocation.

Intensive respite (also known as radical respite) is provided and designed to meet the needs of children who require additional intensive supervision and intervention in a low stimulus environment. Of note, new referrals are no longer being accepted for intensive respite (due to a change in the contract), but children currently under the care of service continue to receive support.

There are 22 beds – four of which are intensive respite beds. Current bed utilisation fluctuates between four and 22 beds, noting that there is particularly high demand during weekends and school holiday times.

In 2018, a comprehensive review of Respite Service model of care was completed, as there were concerns that the current model of care did not best meet the needs of the children and families who accessed the service. Initially, it was proposed that the service move to delivering respite care from smaller facilities based within local communities. However, there was insufficient evidence that the change would improve patient outcomes, whānau satisfaction or equity of access. There was also concern that the new model would not be financially viable. Given this, it was agreed that the current model would continue to be operated.

4. Risks/Issues

The identified risks and issues are summarised below:

1. **Financial** - in April 2018, the Ministry of Health advised that they were proposing to change the way in which they contracted respite services for children. Specifically, they advised they would be reducing the bed day-rate for intensive respite and move to a fee-for-service model. This change was implemented from 1 September 2018 and resulted in an approximate \$1m reduction in revenue.

The service has investigated opportunities to redesign the current model of care to align the cost of delivering the service to the revenue available.

2. **Relationships with family/whānau and the community** – families hold the services in high regard and indicate that the Out of Home Respite Service is critical in maintaining their ability to care for their child.
3. **Facilities** - the current facilities the services operate from are not 'fit for purpose' and do not support the delivery of contemporary care. The service is currently working with the Wilson Home Trust to investigate the feasibility of re-developing the site, to address these issues. However, there is a risk that any development will increase fixed costs and further impact on financial sustainability.
4. **Availability of community residential placements** – there is a lack of developmentally appropriate community residential placements for young people who have a complex disability and/or are medically fragile. As a result, there are a group of young people who have been resident at the Wilson Centre for an extended period of time. The service has been actively working with Taikura Trust, the Ministry of Health and Oranga Tamariki, but to date, no suitable placements have been identified.

5. ***Changes within the Disability Support sector*** – at present, there is significant change underway within the disability sector. The impact of this remains unclear at this point in time. However, the changes outlined in the Ministry of Health's *Transforming Respite 2017-2022* may provide new options to families (reducing demand for the service). Alternatively, families who may not have previously been able to access out of home respite may choose to receive this support.

3.4 Enhancement of Child Development Services

Recommendation:

That the report be received.

Prepared by: Susan Peters (Head of Division Allied Health – Child, Women and Family) and Stephanie Doe (General Manager – Child, Women and Family).

Endorsed by: Mark Shepherd (Director – Provider Healthcare Services)

Glossary

CDS - Child Development Service

1. Introduction/Background

Child Development Services (CDS) provide multidisciplinary allied health and community based services for children with physical, sensory or intellectual disabilities (which are likely to persist for a minimum of six months). They also offer services for children with developmental delay or those at risk of developing a disability – including: assessment; diagnosis; therapy; education and support. There is an emphasis placed on early intervention (children under five years), but services also extend to some school-aged children.

In Budget 2019, the government allocated an additional \$3.5 million over four years to improve the health and social outcomes of children who are not meeting their developmental milestones and who have additional needs. Specifically, this funding aims to improve access to CDS by ensuring services have the appropriate mix of allied health staff available to meet demand.

In addition to improved access, the Ministry of Health funded the Northern Region to deliver a number of innovation projects, which aim to improve access, engagement and models of care. Waitematā DHB is leading three of these projects.

This paper provides a brief overview of the additional funding allocated to Waitematā DHB and the progress with implementation to date.

2. Improved Access to Services

Waitematā DHB received funding to provide care to an additional 99 children, who are either currently on the waiting list or who would not previously had access to the service. This has enabled the recruitment of eight additional allied health staff.

Recruitment into these new positions commenced in February 2020. Seven roles have been successfully recruited into, which is a significant achievement as nationally, it is challenging to recruit experienced child health allied health staff.

Despite the impact of the COVID-19 lockdown restrictions, the service has already seen a reduction in overall waitlists. Of particular note, families are no longer having to wait for their child to receive an intervention with a speech language therapist or visiting neurodevelopmental therapist.

To date, the number children waiting to receive a service has reduced to 74.

3. Innovation Projects

Waitematā DHB received funding to deliver three innovation projects and employ a 0.40FTE improvement lead to support the delivery of these.

The projects are detailed in the table below:

Project	Objective(s)
Pathway for neonates	<ul style="list-style-type: none"> ▪ Develop a child-centred pathway for families/whānau of infants with complex disabilities, which supports the delivery of well-coordinated services. ▪ Empower families/whānau to take the lead in caring for their child from the beginning of their journey. ▪ Define the role of the care coordinator.
By parent for parent	<ul style="list-style-type: none"> ▪ Scope the use of peers (those with lived experience) to enhance family/whānau and child experience and improve access and engagement with services. ▪ Identify a preferred model of care and evaluate the sustainability of this.
Transitioning young people from Child Health Services	<ul style="list-style-type: none"> ▪ Develop a process for ensuring that all young people with disabilities and their family/whānau are well informed and prepared to transition from Child Health Services. ▪ Ensure the transition process begins early, is well coordinated and is based on the goals that have been set by the young person and their family/whānau.

All three projects are currently on track. Each has a dedicated project lead and working group established. Oversight is being provided by a small steering group, which includes consumer representation.

4. Risks/Issues

The funding allocated to improve access to the service is time-limited. This has required the additional staff appointed to be employed on fixed term contracts. Advice is being awaited on whether the funding will be extended into 2020/21. However, the roles have been temporarily extended using underspend from last financial year (as a result of COVID-19).

The funding for the innovation projects is due to cease by the end of 2020. However, it is hoped that this will be extended to support the evaluation, implementation and dissemination of the work regionally and nationally.

5. Conclusion

In conclusion, the Ministry of Health has allocated additional funding to improve access to CDS and improve models of care. This has enabled Waitemata DHB to recruit additional staff and lead three innovation projects.

To date excellent progress has been made – there has been a demonstrable increase in access to the service and all three projects are on track.

3.5 New Zealand Health & Disability System Review - Disability/Te Huātanga

Recommendation

That the Disability Support Advisory Committee receives the information.

Prepared by: Samantha Dalwood (Disability Advisor)
Endorsed by: Debbie Holdsworth (Director Funding)

1. Executive Summary

Please find attached Section 8 of the New Zealand Health & Disability System Review. This has a focus on Disability/Te Huātanga and makes a number of recommendations. These include responding to disability as more of a norm and focusing on a non-disabling approach to service design and delivery. Better health, inclusion, and participation of disabled people must be a priority for action across the whole health and disability system. This includes the health & disability system being a leading employer of disabled people.

2. Background

The Health and Disability System Review was charged with taking a system-wide approach to what needs to change to ensure our future system achieves better and more equitable health and wellbeing outcomes for all New Zealanders.

The final report discusses a range of detailed proposals regarding all the elements that need to change for the New Zealand health and disability system to produce more equitable health outcomes and to become more financially sustainable.

The recommendations set out in the report are now the remit of Government to determine what happens next.

3. Conclusion

There are a number of recommendations for improving the experience of disabled people using the Health & Disability system. Waitematā DHB is currently doing work in these areas and is committed to making continuous improvement.

8 Disability / Te Huātanga

Increasing numbers of people are living with impairments, and more disabilities are being recognised. The principles of Enabling Good Lives (EGL) should drive service design so that the fact that any individual has an impairment is not what defines their life chances. The system needs to respond to disability becoming more of a norm and must be focused on a nondisabling approach to service design and delivery.

Better health, inclusion, and participation of disabled people must be a priority for action across the whole health and disability system. Disability support system should move away from relying on diagnosis for initiating eligibility for assistance, towards providing assistance to live well, according to an individual's need. Assessment and reassessment processes should be streamlined so that those who require more service coordination support receive this in a timely manner, the need for regular reassessment is reduced, and people gain more freedom to manage their own support. Over time, needs assessment and service coordination services should be integrated into Tier 1 service networks.

Commissioning rules should encourage providers to use more salaried staff with the aim of building a better trained and more secure disability support services workforce and Health NZ should lead a programme of work to engage and support the system to become a leading employer of disabled people in New Zealand.

Disability in New Zealand

An increasing number of New Zealanders are living with a disability. The range of disabilities is diverse and the impacts for people vary substantially. Half of disabled children have had impairments since birth.¹⁵⁷ Throughout life, more people become disabled through illness or injury and many disabled people have more than one impairment or health condition.

The Government has committed to reducing disadvantages faced by disabled people and aspires for New Zealand to be 'a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen'.¹⁵⁸ The health and disability system has a major role in achieving this ambition.

Disability support and funding

Responsibilities for providing disability supports are divided across the system.

- ▶ The Ministry funded \$1.4 billion¹⁵⁹ in 2018/19 for:
 - disability support services for 38,000¹⁶⁰ disabled people, aged under 65 years when they entered the system
 - equipment and modifications (such as to homes and vehicles) - 82,500¹⁶¹ requests from people of all ages, many of whom also accessed other disability supports funded either by the Ministry or DHBs
- ▶ DHBs funded more than \$1.4 billion of support services for:
 - people aged over 65 years: 75,000 received home and community-based support and 33,000 received aged residential care^{162 163}
 - people disabled by mental health conditions and associated social and attitudinal consequences.

These groups are a subset of the total population living with disabilities. The 2013 New Zealand Disability Survey¹⁶⁴ asked participants about their ability to carry out everyday activities that were associated with specific impairment types. The survey identified one-quarter of the population as having difficulty doing everyday things, even with equipment that helps.

The survey showed that disability rates vary markedly across the population:

- ▶ Higher rates of disability are found in families living in high deprivation communities
- ▶ Māori have significantly higher rates of disability across all age bands
- ▶ People aged 65 or over are much more likely to have disabilities (59%) than adults under 65 years (21 %) or children under 15 years (11%).

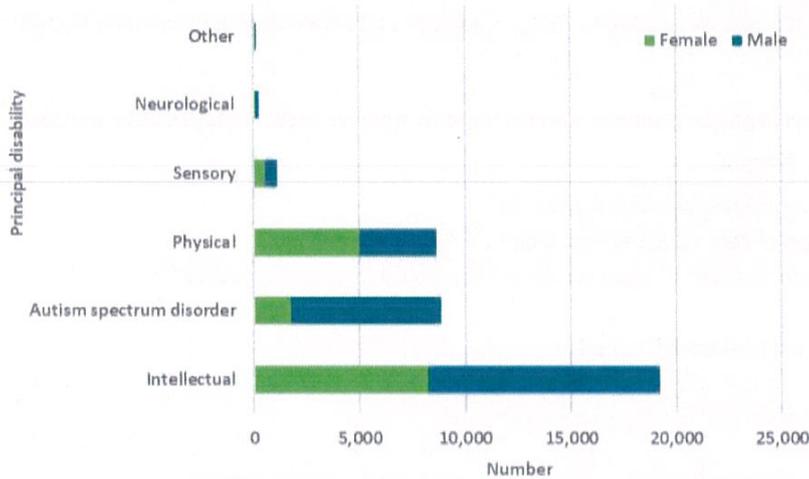
The proportion of people living with disabilities in 2013 was higher than in previous surveys,¹⁶⁵ with the growth driven largely by an ageing population. This trend is expected to continue as the number of people living with comorbidity and complications associated with age increases. The future system will need to recognise this and ensure that supports are in place to address changing needs as living with disability becomes the norm. The system will need to move away from reliance on a diagnosis, to providing assistance to live well according to the need for support.

Understanding the population

Of the people currently receiving Ministry funded disability support services:

- ▶ more than half have an intellectual disability as their principal disability. Many may also have a physical disability.
- ▶ Just under one-quarter (23%) have Autism Spectrum Disorder (ASD) as their principal disability.
- ▶ Just under one-quarter (23%) have a physical disability as their principal disability.¹⁶⁶

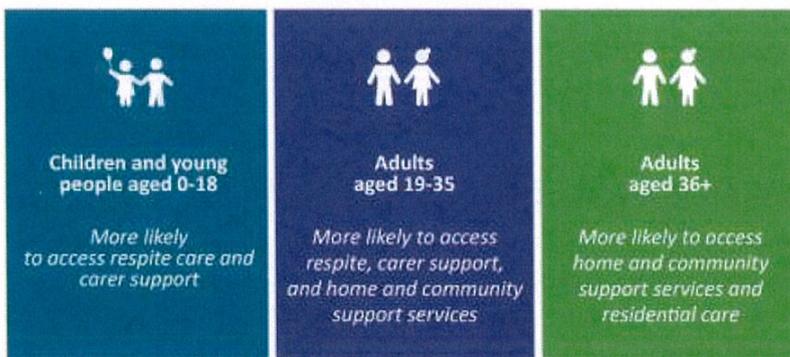
Figure 8.1: Number of Disability Support Services clients, by principal disability and sex, 2018¹⁶⁷



European/Other and Māori are over-represented among people receiving disability support services. Asian people are significantly under-represented but have had the highest recent increase with numbers of people who receive disability support increasing by 60% over the last four years.¹⁶⁸ Māori and Pacific peoples are under-represented when compared to Disability Survey aged adjusted prevalence rates. Māori also have higher rates of impairment and comorbidity.¹⁶⁹

There are considerable differences in the types of services accessed across different age groups, ethnicities and disability types, as shown in Figure 8.2.

Figure 8.2: Typical services by age group



The population receiving Disability Support Services and their service mix is changing. The median age of people receiving disability support services has decreased from 31 years in 2014 to 26 years in 2018 due to the large growth in children (driven by the inclusion of ASD in 2014). The adult population has stayed relatively stable with 8% growth from 2016 to 2018, compared to a 20% increase in the number of children aged 5 to 14 years.^{170 171}

In addition, the total mix of people is shifting towards those with higher needs. Between 2016 and 2018, the number of people receiving:

- ▶ low and very low packages decreased by 24.7%
- ▶ medium packages of care increased minimally by 0.4%
- ▶ high and very high packages of support increased by 9.6% and 11.0% respectively.¹⁷²

Challenges that need to be addressed

Challenges identified in the Interim Report include:

- ▶ greater visibility of disability is needed at a system level so that the health outcomes of disabled people are properly focused on and equity is improved
- ▶ more joined-up information, advice, and service delivery within health and across the wider government system
- ▶ a focus on wellbeing and an increase in preventative strategies that make this possible
- ▶ improved services and workforce development, designed around Enabling Good Lives (EGL) principles
- ▶ ensuring whānau and carer needs are an integral part of all aspects of disability service assessment and provision
- ▶ the health and disability system leading by example by employing disabled people.

These challenges are discussed below.

More visibility and integration of disability in planning

The Review faced many of the same challenges sourcing data that those working in the system encounter when trying to develop policies and improve the performance of the system.

Improved data collection and use

Much of the current information on disability is sourced from survey data or contracting and payment systems. Survey information on disability is improving. The Washington Group Short Set questions¹⁷³ that were developed to create robust measures of disability status and promote international comparability in disability data are being used more widely. While useful for understanding disability at a macro level, surveys generally do not provide person-level information.

Data from contract and payment systems can support analysis of disability support services use and expenditure. This data can be linked with health service data through the National Health Index and with wider government datasets through Stats NZ's IDI data collection. There is potential to use this data better for planning services but only a comparatively small number of people can access and effectively analyse all these datasets.

Currently New Zealand does not have readily available patient-level data to identify if a person has an impairment. If available, it could be used by those involved with service delivery or to inform analysis of health outcomes. Some jurisdictions have introduced a disability flag across all health data collections to help improve service delivery and inform analysis of health outcomes. The Review considers it a high priority to improve data collection and sharing of disability data across the health and disability system and with other government agencies. Technological advancements already exist to facilitate this but the lack of investment in data analytics and digital systems has been a barrier to progress. Building an improved national dataset and analytics capability is an essential next step, with consideration being given to whether this should include a disability flag.

Australia developed a 'standardised disability flag', which is intended to be used in all mainstream services data collections (eg, health care, housing, education) to identify people with disabilities or long-term health conditions. The flag is determined through a set of questions that are based on the International Classification of Functioning, Disability and Health.

The flag is designed to provide consistent and comparable information on the interactions of disabled people with mainstream services to understand the gap in health and social outcomes between disabled people compared to the wider population. This is essential for measuring the effectiveness of services in improving outcomes for disabled people, to ensure visibility of disability issues and improve the performance of mainstream services in addressing the needs of people with disability.¹⁷⁴

Engaging with disabled people (both as a consumer and community)

Data is important to inform planning but, equally important, is the lived experience and views of disabled people and their whānau. As emphasised in the Interim Report, the Review considers that:

- ▶ 'greater inclusion and participation of disabled people through all levels and parts of the system [...] are fundamental'.

Consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006), engaging disabled people and their whānau is a valuable way to inform and improve long-term planning, policies, service design and delivery.

Disabled Person's Organisations (DPOs) currently work with government to promote and protect the rights and interests of disabled people. District health boards engage with disabled people through disability reference or advisory groups. At a national level, the Ministry has established a disability sector strategic reference group and Māori advisory group Te Ao Mārama. The cross-government Enabling Good Lives governance and leadership groups are further examples of national and community partnerships.

Some of these engagement approaches are working well, while others have limited influence on planning, decision making and service design. Enabling disabled people to be partners in service design and delivery requires expertise in a wide range of inclusive practices.¹⁷⁵ For example, engaging with tāngata whaikaha and their whānau must come from a Māori world view and there needs to be a commitment to establish and maintain good partnerships with tāngata whaikaha and their whānau, hapū, iwi and Māori communities.¹⁷⁶

A continued shift in culture is needed to give disability communities a real say in the system so they have formal ways to influence, see the changes made because of their input and the results of those changes.

Creating more ways for disabled people, their whānau and carers to get involved would be an important element of DHB strategic and locality service planning.

Improving equity and health outcomes for disabled people

The Interim Report signalled a strong commitment to improving health outcomes for disabled people.

- ▶ ‘A focus on living well and preventing the exacerbation of disability should be a priority. This will require more integration both within the system and across other parts of government. Promoting living well for everyone, with and without disability, and preventing different abilities and health conditions from becoming disabling, need to be a focus.’

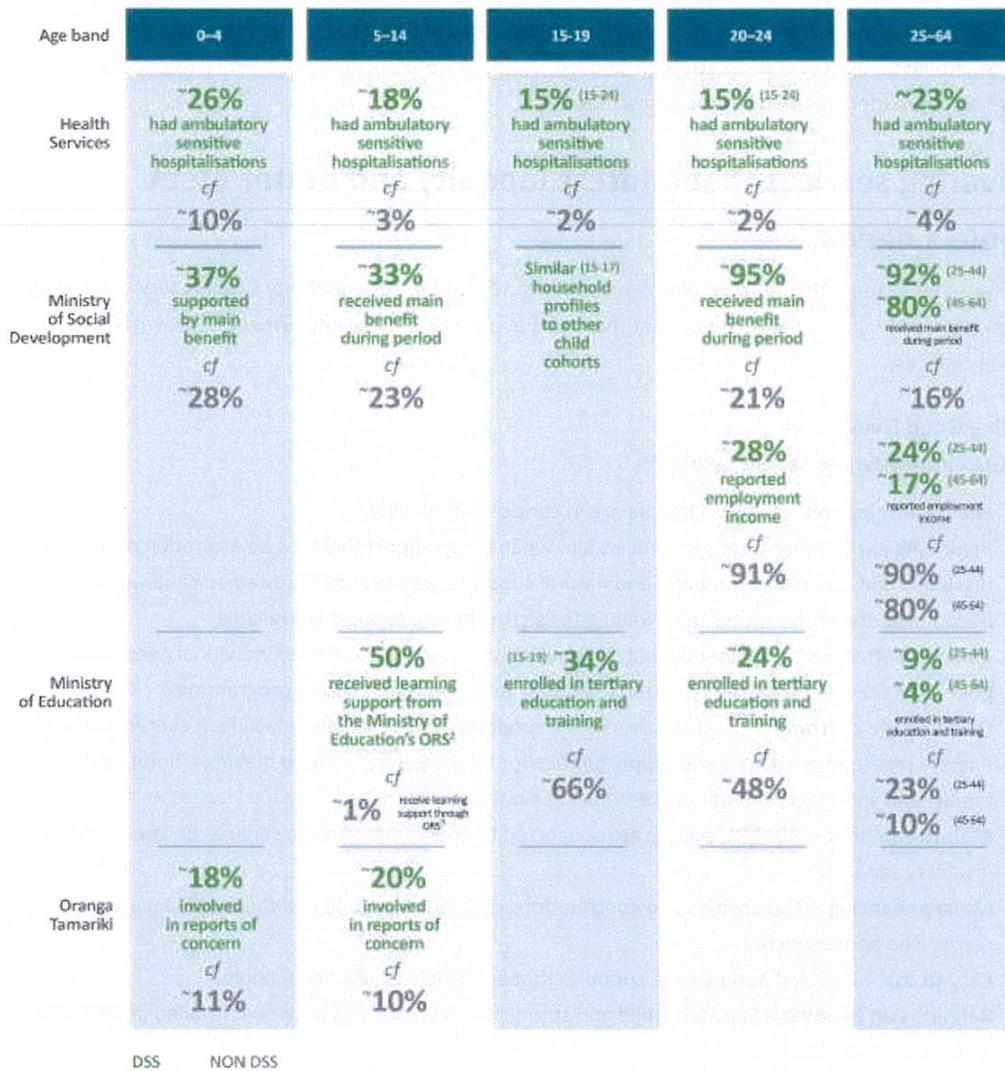
Disabled people, regardless of their age or disability, are high users of the health system. Data suggests that their use of health services is generally at least double that of the non-disabled population.¹⁷⁷ In addition, people receiving disability support services are high users of other government services. For example, disabled people are more likely to receive benefit and employment support from the Ministry of Social Development and use learning support services from the Ministry of Education.¹⁷⁸ (refer Figure 8.3.)

Evidence shows that disabled people have more frequent contact with the health and disability system but do not achieve equity of health outcomes when compared with the rest of the population. They report poorer health than their non-disabled peers and may experience multiple barriers in accessing health services.¹⁷⁹

Research has found that ‘physically disabled adults experience a higher prevalence of chronic diseases including arthritis, asthma, cardiovascular disease, diabetes, high blood pressure, high cholesterol and stroke’.¹⁸⁰ National and international research identifies higher rates of chronic illness and early death for people with learning and intellectual disabilities.^{181 182 183} Tāngata whaikaha and Pacific peoples also report higher levels of unmet health need.^{184 185}

Most DHBs have developed disability responsiveness plans with recommendations for change, following in-depth engagement with disabled people and their whānau in their local communities. These plans do have similarities but lack coherency between DHBs.¹⁸⁶

Figure 8.3: Interface with health services and other agencies¹



NOTES:

- 1 The statistics are based on incidence rates over three years to June 2018, except for health indicators which are for the 3 year period to 30 June 2017 due to limited data availability at the time of analysis.
- 2 It is important to note that actual learning support is higher than this once MOE funded services linked to schools (but not individual children) are included, eg funding for teacher's aides. Schools may also provide support not funded by MOE.
- 3 <https://www.educationcounts.govt.nz/statistics/learning-support/ongoing-resourcing-scheme>

Reference: Draft Ministry of Health. 2020. Mana Whaikaha program evaluation – Baseline outcomes analysis results from administrative and population survey data.

In some instances, the plans are high level with limited evidence of measurable, evidence-based improvements. Other initiatives under way in New Zealand, such as health passports, annual health checks and specialist disability coordinators are showing signs of success and should be considered further across the system.^{187 188}

Health NZ should use its national role to improve health outcomes and track progress in reducing the disparity in health outcomes for disabled people. DHB strategic planning processes should have a specific focus on what is required for disabled people and include tāngata whaikaha in their planning processes. Progress should be tracked against strategic and locality plans from the point of disability identification through to population health outcome assessments.

Delivering services that address inequity and better meet people's needs

If the system is to meet the needs of disabled people, it needs to ensure disability support services fulfil the principles of Enabling Good Lives (EGL): that the fact that a person has an impairment is not what defines their life chances.

Enabling Good Lives

The EGL principles are as set out below:¹⁸⁹

- ▶ **Self-determination** – disabled people are in control of their lives.
- ▶ **Beginning early** – invest early in families and whānau to support them; to be aspirational for their disabled child; to build community and natural supports; and to support disabled children to become independent, rather than waiting for a crisis before support is available
- ▶ **Person-centred** – disabled people have supports that are tailored to their individual needs and goals, and that take a whole life approach rather than being split across programmes.
- ▶ **Ordinary life outcomes** – disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation – like others at similar stages of life.
- ▶ **Mainstream first** – Disabled people are supported to access mainstream services before specialist disability services.
- ▶ **Mana enhancing** – The abilities and contributions of disabled people and their whānau are recognised and respected.
- ▶ **Easy to use** – Disabled people have supports that are simple to use and flexible.
- ▶ **Relationship building** – Supports build and strengthen relationships between disabled people, their whānau and community.

The three Enabling Good Lives initiatives in Waikato, Christchurch and, most recently, MidCentral (Mana Whaikaha) are demonstrating a new approach that has been positively received by the disability sector.

Disabled people and their whānau are making decisions (with assistance as needed) about what supports would work best for them. People who had not previously accessed the system are now accessing services and, with more information about services, some are choosing options that they previously did not think were possible; for example, a group of families pooling funding so their young disabled family members can flat together with support. Some are holding and managing budgets, but the option of individualised funding packages is being used by more participants of the EGL Waikato initiative. In MidCentral, the majority are continuing to access services through traditional approaches.

The role of the tūhono/connector has been particularly valued by disabled people and their whānau.

- ▶ ‘Some successes are that whānau identified that they felt safe and supported, particularly in comparison with previous systems they had engaged with. In addition, whānau reported having positive relationships with Tūhono/Connectors and were appreciative there were Tūhono Māori, noting that they “love that they are Māori, it makes a big difference”. It was also clear in the interviews that open and ongoing communication is critical and strengthens relationships between Tūhono/Connectors and participants.”¹⁹⁰

The Review identified some changes within the health and disability system that have the potential to make a real difference for disabled people. Some of these relate to disability support services and some to health services.

Better access to disability information and advice

Given the varied nature of disability it is not surprising that people, particularly those new to the system, often find it challenging to know where to find information.

While the health and disability system currently spends \$9 million¹⁹¹ to fund more than 100 organisations to provide disability information advisory services (DIAS), there is no central point to access information about disability and wider community supports.¹⁹² Instead, multiple sources exist with the potential for disjointed and confusing information and advice. Significant numbers of people, particularly Māori and Pacific peoples, struggle to find out about or access disability supports and entitlements.^{193 194} While some variation in information sources and channels is helpful in meeting people’s needs, greater consistency and coordination would ensure quality and reliability of the range of information available.

The following changes are proposed to improve access to information:

- ▶ Health NZ should take overall accountability for ensuring that nationally-consistent information and advice about impairments and disability-related supports and services is available and easily accessible through a variety of channels for disabled people, family and whānau. The recommendations in a recent report for ‘national branding of disability in New Zealand’ should be considered further.¹⁹⁵
- ▶ DHBs and, particularly, Tier 1 service networks should play a greater role in providing advice. The proposed integration of needs assessment and coordination services into these networks would facilitate this.
- ▶ All information and digital and data standards should meet accessibility requirements.

Accessing information – what the future could look like

- ▶ A fully accessible website, app and helpline provides consistent information and advice to disabled people and whānau. The website and app are linked to information from other government agencies, as well as to local and specialist information.

Diagnosis and early intervention

Families and carers often experience lengthy delays in obtaining a diagnosis and accessing supports. While this cannot always be avoided, there is considerable scope to improve outcomes by investing in early intervention.

For example, research has demonstrated the benefits of early intervention for children with autism spectrum disorder (ASD). ‘Evidence-based practices in early intervention for autism spectrum disorder has the potential to improve children’s developmental trajectories and address family needs. [...] Early intervention is a critical component to any ASD service design.’¹⁹⁶

Early intervention in ASD can improve outcomes

- ▶ Children who are part of an early intervention programme before they are three years old experience significantly improved outcomes. When children and young people with ASD receive coordinated support and interventions at home, early childhood education and school there is a greater likelihood of them completing their education,¹⁹⁷ gaining employment and/or having meaningful life outcomes.¹⁹⁸
- ▶ Currently, however, many children are not diagnosed early enough, resulting in critical learning and development time being lost. Access to early intervention programmes for young children is also not readily available.

A lack of data and research, limited long-term planning and the current purchasing model for disability support services has contributed to limited focus and investment in early diagnosis and intervention.

Changes that are required include:

- ▶ identifying opportunities to extend the focus of current health checks to support early diagnosis (eg, extending Well Child/ Tamariki Ora checks to include behavioural checks that may assist with early diagnosis of conditions such as ASD)
- ▶ improving information sharing and care planning across the health and disability system to better support early identification and diagnosis
- ▶ increasing the capacity and capability of the workforce and services that undertake the diagnostic and intervention processes.

These changes cannot happen overnight. However, the case for investment should be developed with a view to having improved early diagnostic and intervention pathways in place within five years.

Needs assessment and service coordination

Needs assessment and service coordination services are delivered by 12 needs assessment and service coordination providers (NASCs). Five NASCs cover 13 DHBs (and about 70% of the population) although their coverage is not always contiguous. Also, the scale of coverage varies significantly, from 44,000 to 1.6 million people.

The Ministry of Health’s 2013 and 2018 demographic reports show a 19% increase in the numbers of people accessing NASCs over this time period, or around 5% growth per annum.^{199 200} However, funding for NASCs has been largely unchanged. This is one of the factors making it increasingly hard for NASCs to fulfil their role.

Issues with the current NASC system include:

- ▶ the one-size-fits-all NASC system is inefficient, too invasive for many, and slows down outcomes for people
- ▶ people find it difficult to navigate the disability system and wider system(s)
- ▶ some people require service coordination that is more intensive to ensure their needs are met.²⁰¹

A recent review found that scheduled NASC reassessments accounted for 92% of service coordination events and may be putting pressure on the system, potentially for little purpose. An analysis of annual client reviews indicated that for 68% of people, this did not lead to any change in the number, type, or volume of services allocated. Similarly, there was no change for 63% of people at their full three-yearly assessment.²⁰²

This suggests there is considerable scope to reduce multiple reassessments when impairments and support needs are stable. Resources could be better directed towards providing a greater level of support for those who need more assistance to navigate the system.

Disabled people also raised significant concerns about inconsistencies between NASC assessments and the challenges associated with leaving one NASC and enrolling with another if they move.

Significant improvements in the NASC processes are proposed. They include the following.

- ▶ Ensuring that:
 - a nationally consistent needs assessment and funding allocation framework is in place and is used consistently across all NASCs
 - information is shared (with appropriate consents) between NASCs and the requirement to re-enrol is removed when a person moves between NASCs
 - evidence of impairment only needs to be provided once and then updated if it changes.
- ▶ Assessment and reassessment processes should be streamlined so that those:
 - with stable impairment and support needs engage with the system on an as-required basis, rather than having regular assessments
 - who want to, can essentially self-manage by accessing an online portal, where people could decide the supports they require and request these through the portal
 - who need or request more hands-on service coordination can access this in a timely manner. In time this service would be integrated into Tier 1 localities as many of these people may also have high health needs. In Motueka, a similar approach is being trialled where people with complex health needs are connected to services using planned and integrated locality-oriented models of coordinated care.

Streamlining access to supports – what the future could look like

Casey is a graphic designer and has a physical impairment, which is stable. When he first registered on the portal, he uploaded a photo of a letter from his GP as evidence of his impairment and completed a self-assessment.

The portal offered options including speaking with a coordinator online or meeting a local coordinator face to face. Casey didn't need this level of assistance and was pleased he could do everything online. His assessment was processed quickly and he received exactly what he requested – funding for three hours' housework and gardening a week. Casey's funding is paid to him directly and rolls over each year. He understands the process for initiating another assessment if things were to change in his life.

System improvements need to be designed in a way that works for Māori. This includes the growth of kaupapa Māori services and mātauranga Māori models of care.

Current barriers to kaupapa Māori services include inflexible funding models that do not recognise different levels of need and a focus on the individual without acknowledging the needs of whānau.²⁰³ Historical provider arrangements and a lack of system-wide knowledge and capability may be prohibiting the development of services that Māori and Māori communities want.

Disability support services

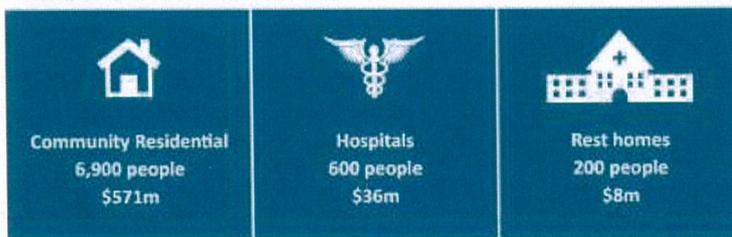
Around \$1,358 million is spent annually on disability support services.

Figure 8.4: Disability support services - cost and client numbers

Community care



Residential care



Other services



The trend towards using home-based services is expected to continue. However, there is likely to be an ongoing requirement for residential services for many people already in residential care and for some people with complex health needs,

The changes required to better meet current needs are not so much about the range of services available, but more about the design and delivery of them. The EGL pilots have demonstrated that a comparatively small number of people want to budget and manage services themselves. For some, individualised funding packages have provided an opportunity to manage or part manage services in a way that better meets their needs. Access to a coordinator also helps people to plan and change supports as they need to.

Getting more assistance when things are difficult – what the future could look like

Afa and Langi are Tongan and live in Wellington. They have two teenagers living at home and three adult children living nearby. Because Langi has multiple health and disability needs, she works with a coordinator to ensure her wellbeing and that of her kāinga is maintained. Langi was given the choice of having a Tongan coordinator who liaises with the hospital and all services on their behalf.

The coordinator is currently working on getting an accessible bathroom and van with hoist funded for them. The coordinator keeps in close contact with Afa and Langi to plan ahead and ensure any issues are quickly resolved.

More focus needs to be placed on achieving consistent national service coverage, recognising that services may be delivered differently in rural and urban settings. It is also essential that services are culturally responsive (eg, kaupapa Māori services) and focus on improving outcomes for disabled people and whānau.

In addition to the disability support services set out above, around 82,500 requests, from around 58,000 people, are received annually for access to environmental support services.

Figure 8.5: Environmental supports - cost and client numbers



Around 90% of referrals are for equipment, with the balance being for housing or vehicle modifications. Expenditure on this service is growing rapidly, with a 31% increase over the last five years.²⁰⁴ The option to streamline requests for equipment so that straightforward requests are processed in a more automated way should be considered, particularly where this supports people to live independently. For example, investing in environmental supports can improve outcomes for the individual, family and whānau. It may also result in lower downstream costs for government: if a person can live a more independent life and complete tasks that they previously needed support workers for.

ACC interface with the health and disability system

As discussed in the Interim Report, submitters raised concerns about the inequities between people whose impairments result from injury compared to those whose impairments result from other causes.

ACC provides income compensation and a wide range of services and support, including up to 24-hour home-based support, childcare, and any aids or assistive technology that supports increased independence, including housing and vehicle modifications. Services can be accessed irrespective of income.

In contrast, Ministry-funded disability support services tend to be more restricted and complex to access, particularly for housing and vehicle modifications. Disability support services also provide home-based support services, but anyone requiring 24-hour care will likely be referred to residential services. Some supports are means-tested, such as household management.

The Review acknowledges that some differences in the levels of assistance provided will continue to exist, as ACC is an entitlement-based scheme that compensates people for their injury and loss of earnings.

Calls for all disability supports to be included in the ACC scheme fall outside the scope of this Review and the recent move to a Disability Insurance Scheme in Australia has illustrated the complexity and risks of making such changes.

There are, however, opportunities to learn from ACC's approaches.

- ▶ **Long-term planning and early intervention:** ACC projects lifetime costs for all injury claims which assists with long-term planning. While an actuarial type approach is not suggested for health, the case for early intervention for long-term benefit needs to be given more prominence in future planning and decision-making.
- ▶ **Case management:** ACC is launching a new case management model that gives clients greater control, with much of it being managed online. A dedicated case manager supports those with more intensive support needs. The case management approach is holistic and client directed. It aims to be an agile system that ensures people receive support according to their level of need, with no one being under- or over-served. 'Serious injury' clients can also opt for the 'Living My Life Service' where ACC provides a case manager but a community-based service provides the day-to-day service and can coordinate services from a variety of providers to provide seamless support for the client.

Other actions could include more collaboration between ACC and the health and disability system to develop best practice guidelines for service providers. Joint purchasing with shared service specifications for disability support services could also be considered to ensure that services are delivered with the same standards and quality, whether purchased by ACC or the health and disability system.

To that end, provisions under the Commerce Act 1986 should not be a barrier to joint purchasing between DHBs (or Health NZ) and ACC where this is in the interests of improving health outcomes and equity. At present, legislation prohibits joint purchasing with the health system in all but very few circumstances, as set out in the Accident Compensation Act (2001) (eg, emergency services).

Funding and contracting to provide services

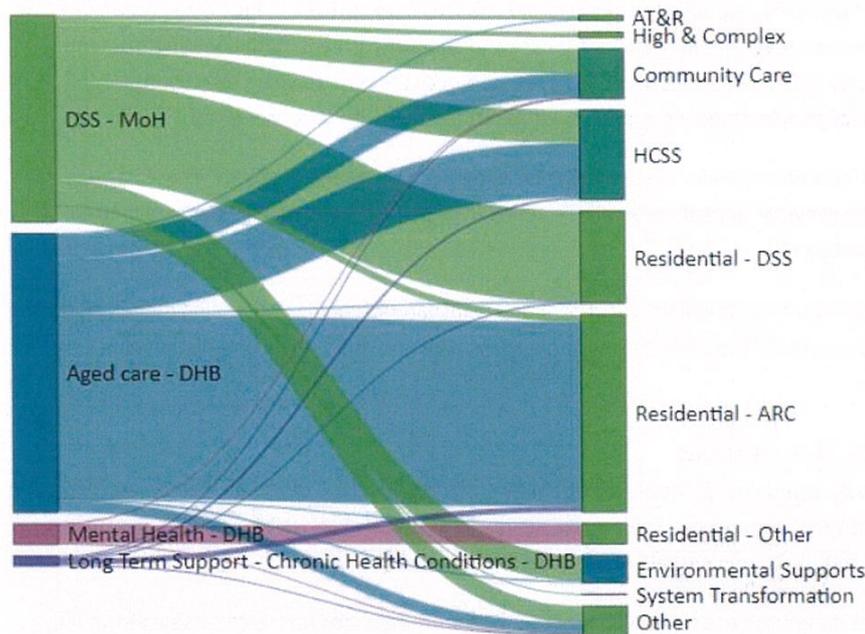
Funding flows

Funding arrangements in the disability system are complex. Government agencies, including the Ministry, ACC, Ministry of Social Development and Ministry of Education, fund disability supports using varied assessment criteria, processes and delivery methods.

Disability support services for people under 65 years are funded mostly by the Ministry. This is inconsistent with other health and disability services, which are largely devolved to DHBs. For example, aged care, long-term support for chronic health conditions and mental health-related disability supports are funded and purchased by DHBs.

The diagram below illustrates the funding flows from the Ministry and DHBs to different service types in 2018/19.

Figure 8.6: Funding flows to different service areas, 2018/19



*DSS = Disability Support Services, ARC = Aged Residential Care [formatting TBC]
 Note that some of the mental health service types are excluded from the flow diagram.

Source: Ministry of Health, Oracle Payments System, FY 18/19

While similar services (eg, home and community support services (HCSS), community care and residential care) are purchased by the Ministry and DHBs, there are often variations of service specifications and pricing. In addition, the high number of providers delivering services, contributes to the complexity of the provider landscape.

Funding for disability support services has not kept up with need. There has been an increase in overspend each year, but no serious attempt to forecast future demand and service requirements, or assess the funding required to deliver these services. Rather, the funding path has been informed largely by spend in the previous year with some adjustment for inflation.

The Review considers that data analytics and better planning is a critical first step to assessing what level of investment is likely required to better meet future requirements for disability support services. This work should be completed before disability support services are rolled into the DHB baseline and funded via the population-based funding formula.

Sustainability of services

The health and disability system should be accountable for ensuring that services are available to people right across the country to meet their support needs. This requires an ecosystem of providers who are paid a fair price for delivering services to the quality and service specification standard set out in contracts. For providers of residential services with five or more beds, certification standards also need to be met.

The current model of service delivery relies on non-governmental organisations (NGOs) to provide many of these services. The disability sector has had regulatory changes in recent years, including settlements for sleepovers, in-between-travel, and pay equity for care and support workers. While funding from the Ministry and Ministry of Social Development has increased over the past 10 years to account for the increasing number of people accessing supports, it has not kept up with cost pressures.

Overall, analysis shows that provider sustainability is becoming increasingly fragile.²⁰⁵ There has been a consolidation of the provider market, generally resulting in larger providers taking over small, often unsustainable providers.²⁰⁶

The Review considers that a sustainable, consistent and transparent funding and pricing model should be developed to ensure sufficient services are available and enable providers to deliver high quality and innovative services.

Purchasing and contract terms

The current contracting and pricing model for disability support services is based on historic arrangements which have been largely unchanged in the past 25 years. An example of this is Ministry-funded residential care, which has different funding models around the country.

Providers that operate around the country may receive different rates for the same service as funding arrangements vary depending on the geographic location and funders (eg, Ministry, ACC and DHBs). This results in a significant administrative burden for both funders and providers.

In addition, a large proportion of disability support services are funded on a fee-for-service basis. While this is easy to administer, it lacks flexibility to address changing needs and provides no incentive to discharge or reduce services for people that no longer need them. It also makes it difficult for providers to introduce new ways of meeting people's needs.²⁰⁷

Various attempts have been made to move towards outcomes-based contracting and reporting for NGO-led services, most recently the introduction of a streamlined contracting framework and outcome agreements for contracted providers. Current analysis suggests there is still a way to go to deliver outcomes through contracting, as the quality of what is requested, data inputs and how it is used for planning purposes has room for improvement.

The Review considers that funding for disability support services should be devolved to DHBs so that it can be managed with primary and community services. It is expected that there would be only a small number of contracts managed nationally for highly specialised services (eg, secure facilities for those under the Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003).

Health NZ should develop a consistent commissioning framework for disability support contracts that aligns with the Tier 1 framework. This should specify core components that must be nationally consistent, while allowing DHBs the flexibility to contract for services that would best meet their population's needs.

Meeting people's desired outcomes within the current contracting regime.

Marama's daughter Kyra, who has a learning disability, is finishing school at the end of the year. Marama wants to find a service provider who can support Kyra find a job and participate in things she enjoys, such as kapa haka and weaving kete harakeke and rourou.

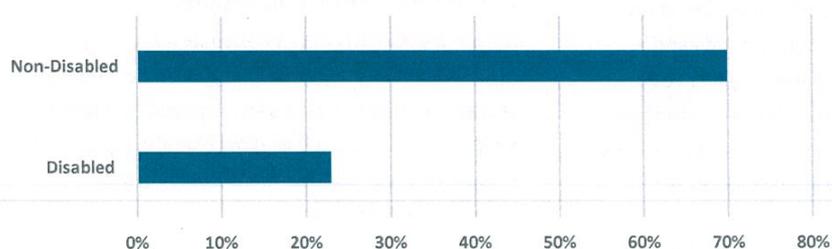
Marama and her whānau want Kyra to be based at a marae where she can take part in marae-based wānanga and learn work skills, but the local disability providers are unable to offer this. Marama tries an iwi-based social service but they are unable to assist as they have no funding to support disabled people.

After months of further frustration dealing with the system Marama and her whānau decide to provide Kyra's support themselves and not use disability services at all.

Leading by example in employment

Employing disabled people

Many disabled people want to work, and some methods that support disabled people into work have demonstrated success.^{208 209} Good work has many benefits – income, social connections, achievement and purpose all enhance wellbeing and lead to better health outcomes. Despite this, employment rates for disabled people are low in New Zealand, at 23% compared with 70% for non-disabled people.²¹⁰ The number of disabled people employed within the health and disability sector is also low. Analysis of DHB and Ministry select committee answers suggests the proportion of disabled people working in the health sector is between 1% and 3%.²¹¹ However, this data is weak, with most DHBs not having this information.

Figure 8.7: Employment rate by disability status

Source: Statistics New Zealand. 2019. Employment Gap for disabled people remains high.

As set out in the Interim Report, the Review considers that:

‘as the largest employer in many regions, the system should lead in employing people with disabilities. Boosting employment of disabled people overall may be the single biggest contributor to improving wellbeing of disabled people. Bringing their skills to the workforce in health will also make the sector more responsive, adaptive, inclusive, and reflective of the community’.

The Draft Disability Employment Action Plan is a call to action and states: ‘The Government’s Employment Strategy aims to make sure all New Zealanders can reach their potential to learn skills and find a good job’.²¹² Health NZ should lead a programme of work to engage and support the health and disability system to become a leading employer of disabled people in New Zealand. This work needs to draw on the expertise of disabled people in the design, implementation and review phases, as it would require improvements in flexibility and inclusiveness for both education and workplace environments and cultures.

Factors that increase employment of disabled people include:²¹³

- ▶ leadership – a senior executive who is a disabled person or an ally of disabled people, and disabled people in senior roles
- ▶ employment practices – recruitment, induction, career development, tailored support, and retention practices that are inclusive and accessible
- ▶ accessibility – requirement that all buildings and facilities are accessible to and usable by all people and that employees’ requirements for access are met
- ▶ engaging with disabled people – having formal programmes in place to learn from and address the needs of the disability community and for disabled employees.

Health NZ should learn from international successes. The DXC Dandelion programme,²¹⁴ designed to build valuable information technology skills and careers for people on the autism spectrum, and Project SEARCH in Ireland²¹⁵ are two examples that could be adapted for New Zealand. Developing a career path for disabled people from school into employment in the health and disability sector would be particularly beneficial and start these young people on a positive life trajectory.

There are opportunities to increase the number of disabled Māori in the health and disability system workforce by extending DHB Māori health workforce programmes, which don't currently have a disability focus.

Project SEARCH's primary objective is to secure competitive employment for disabled people. It was first developed at Cincinnati Children's Hospital Medical Center, which began training people with learning disabilities to fill entry-level posts at the hospital.

Since its inception, Project SEARCH has grown from a single programme to a large and continuously expanding international network. In Ireland, a programme at Naas General Hospital offers young people with learning disabilities an internship programme. Participants rotate through various departments to learn about administration, patient care, customer interaction, catering, housekeeping and general communication skills. The programme has a high success rate in securing paid employment for the interns.

Developing a valued workforce

In the disability support system, the demand for a skilled and caring workforce is expected to increase significantly, due to an ageing population with increasingly complex needs. Retaining and upskilling staff will be critical, as well as attracting new workers with appropriate skills and ensuring that the workforce is delivering culturally responsive services.

This is particularly relevant for home and community support services (HCSS). These services have been delivered by a semi-trained workforce with low wages, low qualification levels and poor working conditions.²¹⁶ Despite recent regulatory changes that include in-between-travel, pay equity for care and support workers and provisions for guaranteed hours, workers are still faced with irregular hours and a lack of job security. In addition, the current system is complex and bureaucratic, as different top-up rates exist for travel times, guaranteed hours and pay equity.

Addressing casualisation – an example of home-based support services

This issue is not restricted solely to those providing home-based support services. To promote the overall growth of a better trained and fairly paid workforce, Health NZ's commissioning rules throughout the health and disability system should specify that the workforce should be predominantly on secure salaried contracts. This would also simplify the current payment system for both providers and the workforce. Simulating this scenario for home and community support services shows that costs and expected gains from moving to secure salaried contracts may be offset, and therefore may not substantially increase costs for the sector.

Having secure salaried contracts is expected to help grow a skilled workforce by improving staff retention and attracting new people to the sector. This would help meet future demand. A skilled workforce can better support disabled people using an Enabling Good Lives approach, as well as whānau and wider society. It is expected to improve wellbeing for workers, including the Kaiāwhina workforce, which has a high representation of Māori and Pacific peoples, by providing more job security.

Supporting independence

The workforce should be trained in how to maximise opportunities for people to do things for themselves. The traditional model of care has focused on providing hands-on care with a limited focus on maintaining or building skills. While some providers do promote self-determination and work in a mana-enhancing way, others create dependency that results in a reliance on workers and an ineffective use of the workforce. For example, cooking for someone rather than teaching them how to cook and promoting their independence. There are also opportunities to adopt digital skills and use mobile devices, which has the potential to be transformative in how they enable people to be in control of their daily lives.

Delivering these skill improvements would require more flexible models. Modular training modules that are accessible online and provide group learning support can fit with earn-as-you-learn models and improve health literacy, inclusion and promote independence for all staff.

Building the future

The Review proposes the following changes

Strong focus on improving equity and health outcomes for disabled people

- ▶ Health NZ and DHBs should engage with disabled people including tāngata whaikaha and their whānau as part of the planning and design processes, nationally and locally using a range of inclusive practices.
- ▶ The disability support system should move away from relying on diagnosis for initiating eligibility for assistance, towards providing assistance to live well, according to an individual's need

Better data collection, analytics and meaningful engagement of disabled people

- ▶ Increased capability and use of data analytics to ensure better disability data collection and sharing that would underpin planning and services delivery.

Improved information, advice and early intervention

- ▶ Health NZ should have overall accountability for ensuring that nationally consistent information and advice about disabilities, and disability-related supports and services is available and accessible through different channels; this should be linked into the Tier 1 networks.
- ▶ Well Child / Tamariki Ora or other health checks could be extended to support early diagnosis and early intervention with improved information sharing and care planning across the health and disability system.

Accessing disability support services is an easy process for disabled people and whānau

- ▶ Health NZ should ensure there is a consistent needs assessment framework in place and used across the country.
- ▶ Assessment and reassessment processes should be streamlined so that those who require more service coordination support receive this in a timely manner, the need for regular reassessment is reduced, and people gain more freedom to manage their own support.
- ▶ Service coordination support should work more closely with other agencies to ensure disabled people receive more joined-up services.
- ▶ Over time, needs assessment and service coordination services should be integrated into Tier 1 service networks.

▶ *Continued*

Building the future – continued

The Review proposes the following changes – continued

Disability support commissioning and funding transitions to Health NZ and DHBs

- ▶ Health NZ should develop a consistent commissioning framework for disability support contracts that aligns with the Tier 1 framework and supports the integration of purchasing of these services. The framework should specify core components that should be nationally consistent, while allowing DHBs the flexibility to contract for services that best meet their population's needs.
- ▶ Funding for disability support services should, over time, be devolved to DHBs so that it can be managed with Tier 1 services.
- ▶ Health NZ commissioning rules should aim at building a better trained and more secure disability support services workforce.
- ▶ Health NZ commissioning rules should specify that the majority of services should be supplied by workforces on a secured salary basis and that salary rates should be consistent.

The system is a leading employer of disabled people

- ▶ Health NZ should lead a programme of work to engage and support the system to become a leading employer of disabled people in New Zealand.