



Waitemata
District Health Board
Best Care for Everyone

Disability Support Advisory Committee Meeting

Wednesday, 21 June 2017

2.00pm

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

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Published 14 June 2017



Waitemata
District Health Board
Best Care for Everyone

Agenda

Disability Support Advisory Committee

21 June 2017

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

Time: 2.00pm

<p>Committee Members Jo Agnew (Chair) Michelle Atkinson Edward Benson-Cooper Matire Harwood (Deputy Chair) Robyn Northey Allison Roe</p> <p>In attendance: Amanda Bleckmann, Ministry of Health</p>	<p>Auckland DHB and Waitemata DHB Staff</p> <table border="0"> <tr> <td>Dr Dale Bramley</td><td>Chief Executive Officer Waitemata DHB</td></tr> <tr> <td>Ailsa Claire</td><td>Chief Executive Officer Auckland DHB</td></tr> <tr> <td>Samantha Dalwood</td><td>Disability Advisor Waitemata DHB</td></tr> <tr> <td>Kim Herrick</td><td>Organisational Development Practice Leader, Auckland DHB</td></tr> <tr> <td>Dr Debbie Holdsworth</td><td>Director of Funding Auckland and Waitemata DHBs</td></tr> <tr> <td>Fiona Michel</td><td>Chief Human Resources Officer, Auckland DHB</td></tr> <tr> <td>Kate Sladden</td><td>Funding and Development Manager, Health of Older People</td></tr> <tr> <td>Michelle Webb</td><td>Corporate Committee Administrator</td></tr> <tr> <td>Sue Waters</td><td>Chief Health Professions Officer</td></tr> <tr> <td>Tim Wood</td><td>Funding and Development Manager, Primary Care</td></tr> </table> <p>(Other staff members who attend for a particular item are named at the start of the respective minute)</p>	Dr Dale Bramley	Chief Executive Officer Waitemata DHB	Ailsa Claire	Chief Executive Officer Auckland DHB	Samantha Dalwood	Disability Advisor Waitemata DHB	Kim Herrick	Organisational Development Practice Leader, Auckland DHB	Dr Debbie Holdsworth	Director of Funding Auckland and Waitemata DHBs	Fiona Michel	Chief Human Resources Officer, Auckland DHB	Kate Sladden	Funding and Development Manager, Health of Older People	Michelle Webb	Corporate Committee Administrator	Sue Waters	Chief Health Professions Officer	Tim Wood	Funding and Development Manager, Primary Care
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Tim Wood	Funding and Development Manager, Primary Care																				

Apologies Members: Nil.

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

Agenda

Please note that agenda times are estimates only

- | | |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.00pm | 1. Attendance and Apologies
2. Register and Conflicts of Interest
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda? |
| | 3. Confirmation of Minutes 29 March 2017 |
| 2.05pm | 4. Action Points |
| 2.10pm | 5. CHAIR'S REPORT |

	6.	PRESENTATIONS
2.15pm	6.1	The New Zealand Disability Sector and Linkages to the DHBs Environmental Accessibility (Outcome 5)
2.30pm	6.2	Healing Environments Design Guide and Wayfinding Strategy – Progress Update (Justin Kennedy-Good, Auckland DHB)
2.50pm	6.3	Waitemata DHB Wayfinding Update (Matthew Knight, Senior Project Manager, Facilities and Development, Waitemata DHB) Employment (Outcome 2)
	6.4	Diversity and Inclusion at Auckland DHB
	7.	STANDING ITEMS
3.05pm	7.1	Disability Advisor Update
3.15pm	7.2	Draft New Zealand Disability Strategy 2016 to 2026 Implementation Plan
	8.	INFORMATION PAPERS
		Employment (Outcome 2)
3.25pm	8.1	New Zealand Disability Support Network Employment Practice Guidelines Update (Sarah Halliday, NZDSN Employment Advisory Committee)
3.40pm	8.2	Disability Data and Evidence Working Group Update (Samuel Murray, NZDSN to join the meeting by Skype)
3.55pm		Service Access (Outcome 5)
4.10pm	8.3	Ministry of Health Disability Sector Update (verbal) (Amanda Bleckmann, MOH)
4.20pm	8.4	General Business

Next Meeting: Wednesday, 13 September 2017 at 2.00pm Auckland Deaf Society, Terrace Boardroom, 164 Balmoral Road, Auckland

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Attendance at Disability Support Advisory Committee Meetings

Members	29 Mar. 17	21 Jun. 17	13 Sep. 17	06 Dec. 17
Jo Agnew (Chair)	1			
Michelle Atkinson	1			
Edward Benson-Cooper	1			
Matire Harwood (Deputy Chair)	1			
Robyn Northey	1			
Allison Roe	1			
Key: x = absent, # = leave of absence, c = meeting cancelled				

2016 Attendance

Members	13 July 16	24 Aug. 16	16 Nov. 16	29 Mar. 17	21 Jun. 17	13 Sep. 17	06 Dec. 17
Jo Agnew	1	1	1				
Max Abbott	1	x	1				
Judith Bassett	x	1	1				
Marie Hull-Brown	x	x	1				
Sandra Coney	1	#	1				
Jade Farrar	1	1	x				
Dairne Kirton	1	1	1				
Lester Levy	x	x	x				
Jan Moss	x	1	x				
Robyn Northey	1	1	1				
Russell Vickery	1	1	x				
Shayne WiJohn	1	x	x				
Key: x = absent, # = leave of absence, c = meeting cancelled							

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Disability Support Advisory Committee

Member	Interest	Latest Disclosure
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder)	17.01.2017
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited Trustee – Starship Foundation	29.03.2017
Edward BENSON-COOPER	Chiropractor – Milford, Auckland (with private practice commitments)	15.03.2017
Matire HARWOOD	Senior Lecturer – Auckland University Board Director – Health Research Council Director – Ngarongo Limited, which is contractor providing services to National Hauora Coalition. GP at Papakura Marae Health Clinic Advisory Committee Member – Stroke Foundation NZ (Maori Health) Member Te Ora, Maori Medical Practitioners	29.03.2017
Robyn NORTHEY	Shareholder of Fisher & Paykel Healthcare Member – New Zealand Labour Party Husband - member Waitemata Local Board Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Community Housing Foundation	17.05.2017
Allison ROE	Chairperson – Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council	15.03.2017



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Minutes Disability Support Advisory Committee Meeting 29 March 2017

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 29 March 2017 in the Auckland Deaf Society Terrace Boardroom, 164 Balmoral Road, Auckland commencing at 1.30pm

<p>Committee Members Present</p> <p>Jo Agnew (Chair) Michelle Atkinson Edward Benson-Cooper Matire Harwood (Deputy Chair) Robyn Northey [arrived during item 5.3] Allison Roe</p>	<p>Auckland and Waitemata DHB Staff Present</p> <table border="0"> <tr> <td>Samantha Dalwood</td><td>Disability Advisor Waitemata DHB</td></tr> <tr> <td>Dr Debbie Holdsworth</td><td>Director of Funding Auckland and Waitemata DHBs</td></tr> <tr> <td>Gil Sewell</td><td>Director Organisational Development Auckland DHB</td></tr> <tr> <td>Kate Sladden</td><td>Funding and Development Manager, Health of Older People</td></tr> <tr> <td>Michelle Webb</td><td>Committee Secretary</td></tr> <tr> <td>Sue Waters</td><td>Chief Health Professions Officer</td></tr> </table> <p>(Other staff members who attend for a particular item are named at the start of the respective minute)</p>	Samantha Dalwood	Disability Advisor Waitemata DHB	Dr Debbie Holdsworth	Director of Funding Auckland and Waitemata DHBs	Gil Sewell	Director Organisational Development Auckland DHB	Kate Sladden	Funding and Development Manager, Health of Older People	Michelle Webb	Committee Secretary	Sue Waters	Chief Health Professions Officer
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Kate Sladden	Funding and Development Manager, Health of Older People												
Michelle Webb	Committee Secretary												
Sue Waters	Chief Health Professions Officer												

KARAKIA

Nga Mihi

Matire Harwood led a Karakia and welcomed everyone present.

1. ATTENDANCE AND APOLOGIES

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

2. CONFLICTS OF INTEREST

The following amendments were advised:

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

There were no declarations of interest for any item on the agenda.

3. MINUTES 16 November 2016 (Pages 7 to 12)

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

4. ACTION POINTS (Pages 13 to 14)

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

5. CHAIR'S REPORT (Pages 15 to 30)

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

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

Resolution: Moved Michelle Atkinson / Seconded Allison Roe

That the Disability Support Advisory Committee:

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

Carried

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

The Chair highlighted that:

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

Debbie Holdsworth, Director Funding informed that, because DHBs do not hold the funding and contract management responsibilities for disability support services for under 65 year olds, reporting effectively to the Committee on these matters had previously been challenging.

The Chair added that reporting on this topic could be provided by the Ministry of Health. To obtain this, the Chair had sent correspondence to Ministry of Health management inviting the attendance of a Ministry representative at Disability Support Advisory Committee meetings. A positive response had been received and was tabled (attached to these minutes as Item 5.2.1).

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

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

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

Actions:

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

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

Resolution: Moved Matire Harwood / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

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

Carried

5.3 Draft Work Programme for 2017 (Page 27)

The Chair asked management how a regional Disability Support Advisory Committee meeting might impact on the proposed work programme presented. Advice was given that work of committees was already well aligned as demonstrated at the previous regional Disability Support Advisory Committee meeting held in June 2016.

[Secretarial note: Robyn Northey joined the meeting].

It was commented that if Disability Support Advisory Committee meetings were to become regional the current duration of meetings may need to be extended.

5.4 Draft Future Agenda Outline (Page 28)

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

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

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

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

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

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

Actions:

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

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

That the Committee Chair, Director Funding and Chief Health Professions Officer consider and discuss how the disability community can effectively engage in DHB decision-making processes.

5.5 The Role of the Disability Support Advisory Committee in DHB Submissions to Government

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

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

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

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

Debbie Holdsworth, Director Funding Auckland and Waitemata DHBs

Key responsibilities:

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

Matters covered in discussion and in response to questions included:

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

Sue Waters, Chief Health Professions Officer

Key responsibilities:

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

Sue advised that she applies a diversity focus and disability lens to all areas of her portfolio of work. This approach is integrated into work across the entire organisation, supported by disability champions within each service. This includes the interface of health and safety

with facilities. To ensure physical accessibility is consistently applied to facilities modifications, Barrier Free Assessments have been allowed for in the Capex budget and all Facilities staff have received Barrier Free training.

Fiona Michel, Chief HR Officer

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

Key responsibilities:

- Organisation culture.
- People systems opportunities.
- Leadership and capability development.
- The People and Workforce strategies.

Samantha Dalwood, Disability Advisor Waitemata DHB

Key responsibilities:

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

Resolution: Moved Robyn Northey / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

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

Carried

6. STANDARD REPORTS (Pages 31 to 91)

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

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

Resolution: Moved Edward Benson-Cooper / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

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

Carried

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

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

Action:

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

Resolution: Moved Allison Roe / Seconded Matire Harwood

That the Disability Support Advisory Committee:

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

Carried

7. INFORMATION REPORTS (Pages 92 to 99)

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

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

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

8. GENERAL BUSINESS (verbal)

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

Action:

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

The meeting closed at 3.06pm.

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

Chair: _____ Date: _____
Jo Agnew

Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 21 June 2017

Meeting and Item	Detail of Action	Designated to	Action by
29 Mar 17 Item 5.2	Disability Support Advisory Committee Terms of Reference 1. That the Disability Support Advisory Committee Terms of Reference be amended to reflect a proposed transfer of reporting for Health of Older People to the Community Public Health Advisory Committee. 2. That a recommendation report on the proposed changes to the Terms of Reference for the Disability Support Advisory Committee be presented to the next Disability Support Advisory Committee meeting.	D Holdsworth	21 June 2017 – on hold
And 3 Jun 2015 Item 8.1	1. Advise the Minister of Health of the proposed amendments to the Committees' Terms of Reference. 2. Subject to the Minister of Health's agreement to the proposed amendments to the Committees' Terms of Reference, submit the draft paper to the Auckland and Waitemata District Health Board Boards.	Chair of Auckland and Waitemata Health Boards	On hold
And 9 Mar 2016 Item 4	3. That the Committee Secretary seek an update on the status of the Disability Support Advisory Committee Terms of Reference from the Board Chair and report back to the June Committee Meeting.		
And 16 Nov 2016 Item 4	That the Corporate Business Manager remind the Board Chair that this Disability Support Advisory Committee had recommended that the terms of Reference required review and that this issue currently remains with the Board Chair for action.	M Skelton	29 March 2017 – on hold
29 Mar 17 Item 5.4	Draft Future Agenda Outline 1. That a progress report on the development of the Auckland DHB workforce strategy be provided to the next Disability Support Advisory Committee meeting. <i>Update: The 'workforce strategy' referred to is the Auckland DHB People Strategy and no further update is necessary at this time.</i> 2. That a Disability Advisor Community Update report be added to the standing items of future Disability Support Advisory Committee agendas.	K Herrick Committee Secretary/ S Dalwood	21 June 2017 – completed 21 June 2017 – Complete (refer to item 7.1 of this agenda)

	3. That the Committee Chair, Director Funding and Chief Health Professions Officer consider and discuss how the disability community can effectively engage in DHB decision-making processes.	J Agnew, S Waters, D Holdsworth	21 June 2017 – deferred to 13 September 2017
29 Mar 17 Item 6.2	Final Report: Implementation of the New Zealand Disability Support Advisory Strategy in Auckland and Waitemata DHBs That revised reporting on implementation of the New Zealand Disability Strategy within Auckland and Waitemata DHBs be provided to the June 2017 Disability Support Advisory Committee meeting.	S Dalwood	21 June 2017 – in progress (refer to item 7.2 of this agenda)
29 Mar 17 Item 8	General Business: Meeting Start Time That the Disability Support Advisory Committee Secretary seeks Board Chair approval for Disability Support Advisory Committee meetings to commence at a later time to allow adequate travel time for members attending prior meetings on the same day.	Committee Secretary	21 June 2017 in progress
3 Jun 2015 Item 8.2	Update on Collation of Statistic that Identify People with Impairments That the Auckland Metro DiSAC groups recommend to their Boards that: 3.1 The same method of data collection be employed across the three regional DHBs 3.2 They investigate processes for the collection of the identified data about staff with disabilities. 3.3 A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities. Passed: Auckland DHB on 3 August 2016 Counties Manukau DHB on 7 September 2016 Waitemata DHB on 14 December 2016	F Michel	Ongoing Discussion held between Committee Secretaries of ADHB & CMDHB on proposal to action. To be considered by DSAC Chair and Chief Human Resources Officer

Disability Support Advisory Committee Chairs Report

Recommendation

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

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

Glossary

DSAC	Disability Support Advisory Committee
TOR	Terms of Reference
NZDS	New Zealand Disability Strategy
DAP	Disability Action Plan

1. Board Strategic Alignment

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

1. Executive Summary

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

2. Welcome to Ministry of Health representative Amanda Bleckmann

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

The areas Amanda's team covers are:

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



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

3. Proposal for a Regional Disability Support Advisory Committee

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

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

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

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

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

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

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

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

5. Conclusion

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

Overview of Disability

6.1

Samantha Dalwood
Disability Advisor



What is Disability?



Medical Model of Disability

- Historically how we have understood disability
- Focus on cure and rehabilitation with the aim of making people as close to 'normal' or non-disabled as possible.



- Individually focused around what's wrong with a person
- Useful when people are sick BUT most disabled people are very healthy



Social Model of Disability

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



What is Disability?

- People have impairments.
- Impairments may be sensory, physical, neurological or intellectual.
- Impairments may be obvious or hidden.
- Individuals experiences vary.
- Disability relates to the interaction between the person with the impairment and the environment.



Disability Support Services (DSS)

- MoH define disabled people as “people who have a physical, intellectual or sensory disability (or a combination of these) which:
 1. is likely to continue for at least 6 months
 2. limits their ability to function independently, to the extent that on-going support is required.”
- These are mainly younger people under the age of 65 years.
- Approx. 32,000 people supported and 80,000 with equipment.



Who can't get MoH Disability Support Services?

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

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

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

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



Accident Compensation Corporation

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



Services for Disabled People

Funders

- ACC
- Ministry of Health
- Ministry of Education
- Ministry of Social Development

NASC

- Taikura Trust – Auckland region
- District Health Boards

Services delivered by

- NGOs & DPOs
- Health Services - GPs & DHB

Types of services

- Behaviour Support
- Child Development
- Community Day Services
- Community Residential Support
- Equipment and modifications
- Hearing and Vision Services
- Home and Community Support
- Individualised Funding
- Respite and carer support

6.1



New Zealand Disability Strategy

- Published on 3 December 2016.
- 8 Outcome areas.
- Developed with input from the Disability Sector.
- Vision of a non-disabling society.
- Most outcomes relevant to District Health Board services.
- 2014-2018 Action Plan drives government priorities.

**New Zealand
Disability
Strategy**
2016–2026



UN Convention on the Rights of Persons with Disability

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



6.1



Why is this important to DHBs?

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



Disability Support Advisory Committee

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

6.1

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

- *the disability support needs of the resident population of the DHB;*
 - *and*
 - *priorities for use of the disability support funding provided*
- Waitemata and Auckland DHBs have had a joint DSAC Committee since 2012.



‘Health Indicators for New Zealanders with Intellectual Disabilities’ MoH, 2011

- People with learning disabilities have worse health outcomes than people without learning disabilities.
- The average life expectancy of a male with a learning disability is 59.7 years. Other New Zealand males (78.4 years).
- The average life expectancy of a female with a learning disability is 59.5 years. Other New Zealand females (82.4 years).



'Health Indicators for New Zealanders with Intellectual Disabilities' MoH, 2011

- 4 x more likely to be obese
- 30 x more likely to have epilepsy
- 17 x more likely to have a psychotic disorder
- 15 x more likely to have poor oral health
- 10 x more likely to have dementia
- 4 x more likely to be admitted to hospital
- Half as likely to have cervical screening

6.1



What does the Disability Advisor do?

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



Contact Details

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Disability Advisor

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Mobile: 021 221 7810

samantha.dalwood@waitematadhb.govt.nz

6.1



Healing Environments and Wayfinding Strategy

Recommendation

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

Prepared by: Justin Kennedy-Good (Programme Director Performance Improvement, Co-Director Design Lab)

Endorsed by: Sue Waters (Chief Health Professions Officer)

1. Executive Summary

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

2. Healing Environments

Focus remains on the level 5 Carpark A retail area:

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

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

3. Wayfinding Strategy

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

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

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

4. Other Activity

Our accessibility group continues to meet. They were asked to provide feedback on the approach in development for an Outpatients Programme of work at Auckland DHB.

17 MAY 2017

Wayfinding

EXECUTIVE SPONSOR: Sue Waters **TEAM:** Justin Kennedy-Good, Eden Short, Reid Douglas, Lauren Stewart

I honestly think that I'm more
at risk of being killed out
there [outside the building]
than I am of cancer.

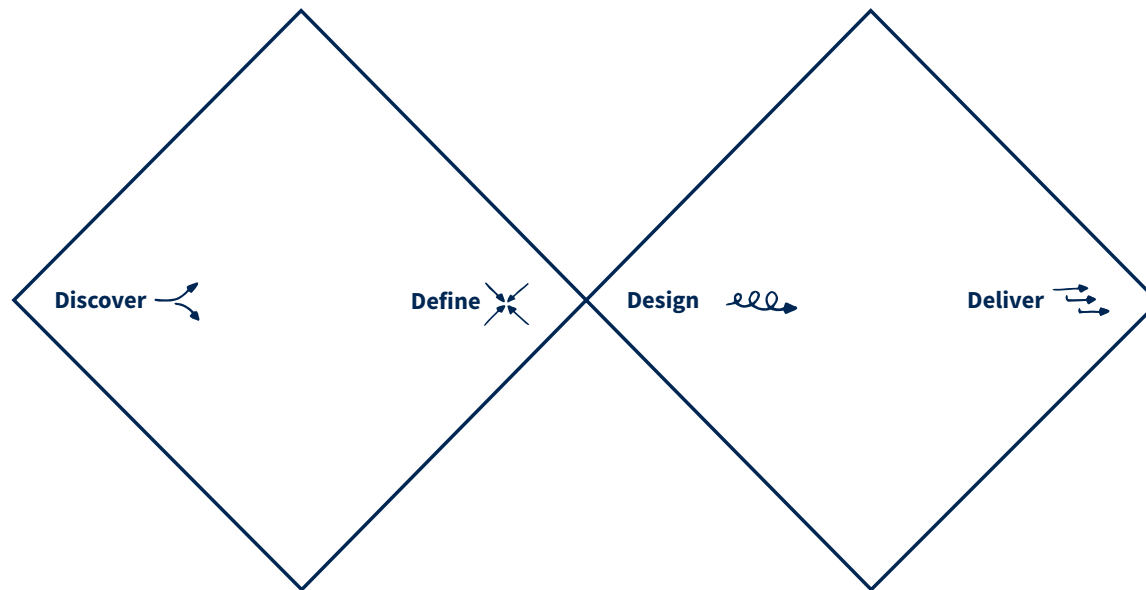
PATIENT (VISUALLY IMPAIRED), 2016

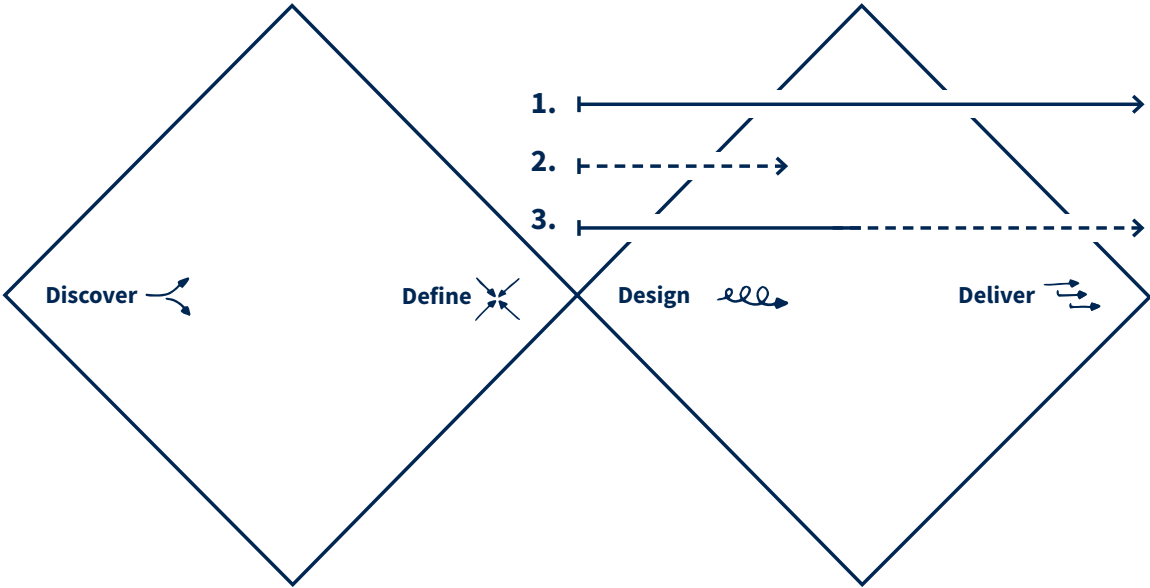
I was told to follow the blue
line but I'm blind.

PATIENT, 2014

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

PATIENT, 2014





- 1. Sustainable Transport
- 2. Wayfinding
- 3. Healing Environments

Knowing where you are



Knowing where you are going



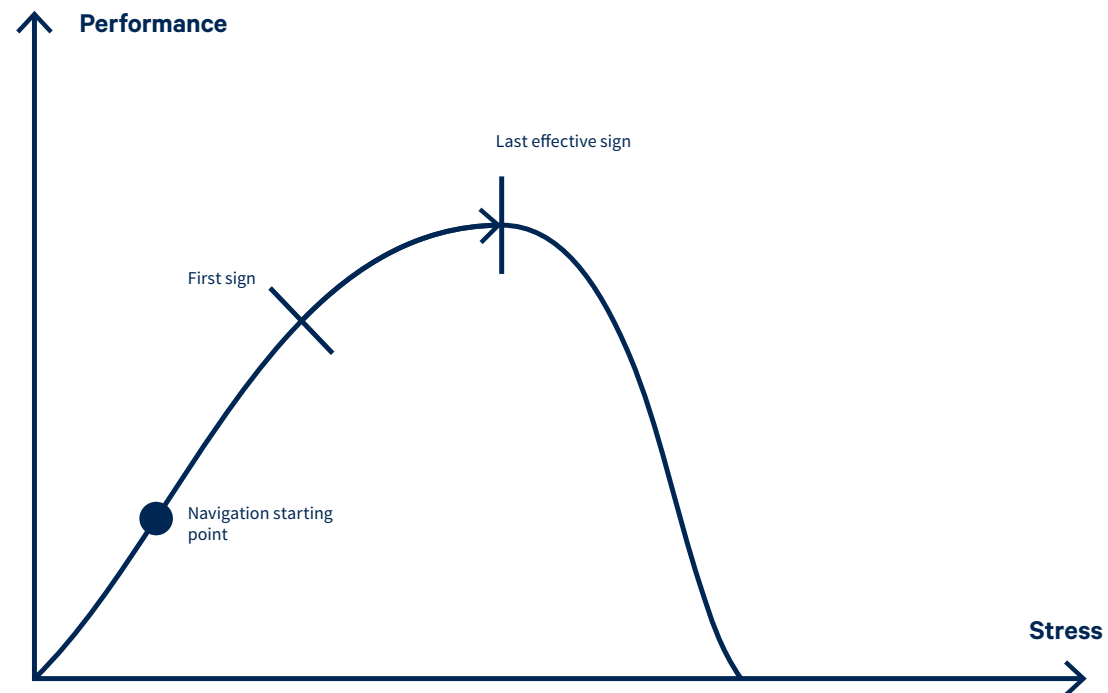
Knowing how to get there

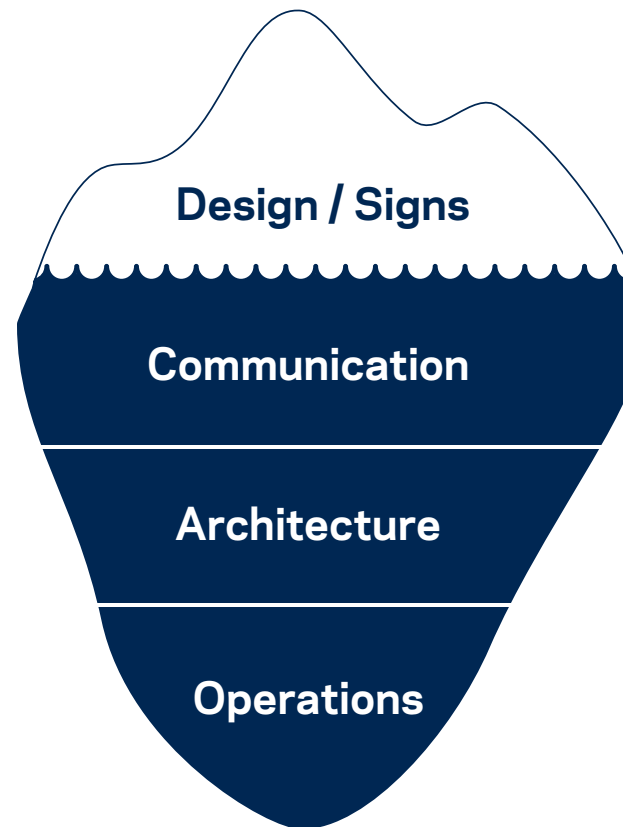
Wayfinding Performance

6.2

Stress level is the single most important factor to take into account when developing a wayfinding system.

Wayfinding needs to be simplified as much as possible in order to intercept a very distracted typical user.

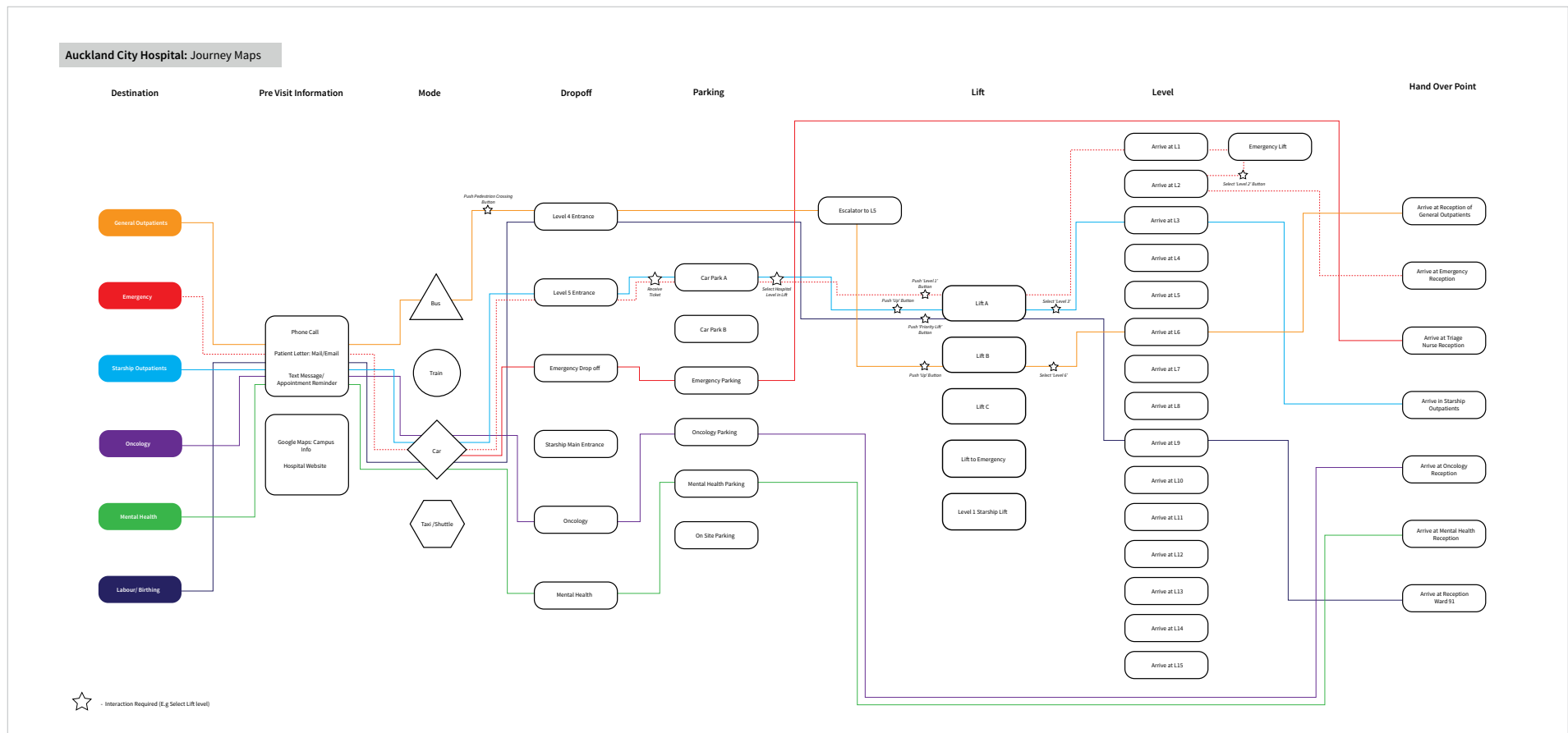




Lack of clarity around routes and journeys

Operations: Journey Mapping

6.2



Critical Items to Address

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

External order of priorities

Expert recommendations

6.2

Phase 1A

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

Phase 1B

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

Phase 1C

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

Internal order of priorities

Expert recommendations

Phase 2A

- > Consolidate Level 5 concept.
- > Extend Level 5 concept to critical areas e.g. Radiology.
- > Remove information at Level 4 entrance, push people up to Level 5.
- > Resolve internal journeys to: ED, Starship, Parking B and Oncology (review information provision).

Phase 2B

- > Improve entrance experience to Starship.
- > Improve quality of environment for internal journeys to: ED, Starship, Parking B and Oncology (review information provision).

Phase 2C

- > Follow up destinations at each level.
- > Improve identification of wards.
- > Review room signage.
- > Implement campus identity. There is no identification of Auckland Hospital at a high level from outside the campus.

Challenges

6.2

A. Upfront investment versus hidden ongoing cost.

1. We are already paying for a Wayfinding system that doesn't work.
2. Journey maps and operating model discipline.

Appendix

> Critical Items to address 1-8

1. Pre-visit Information Material

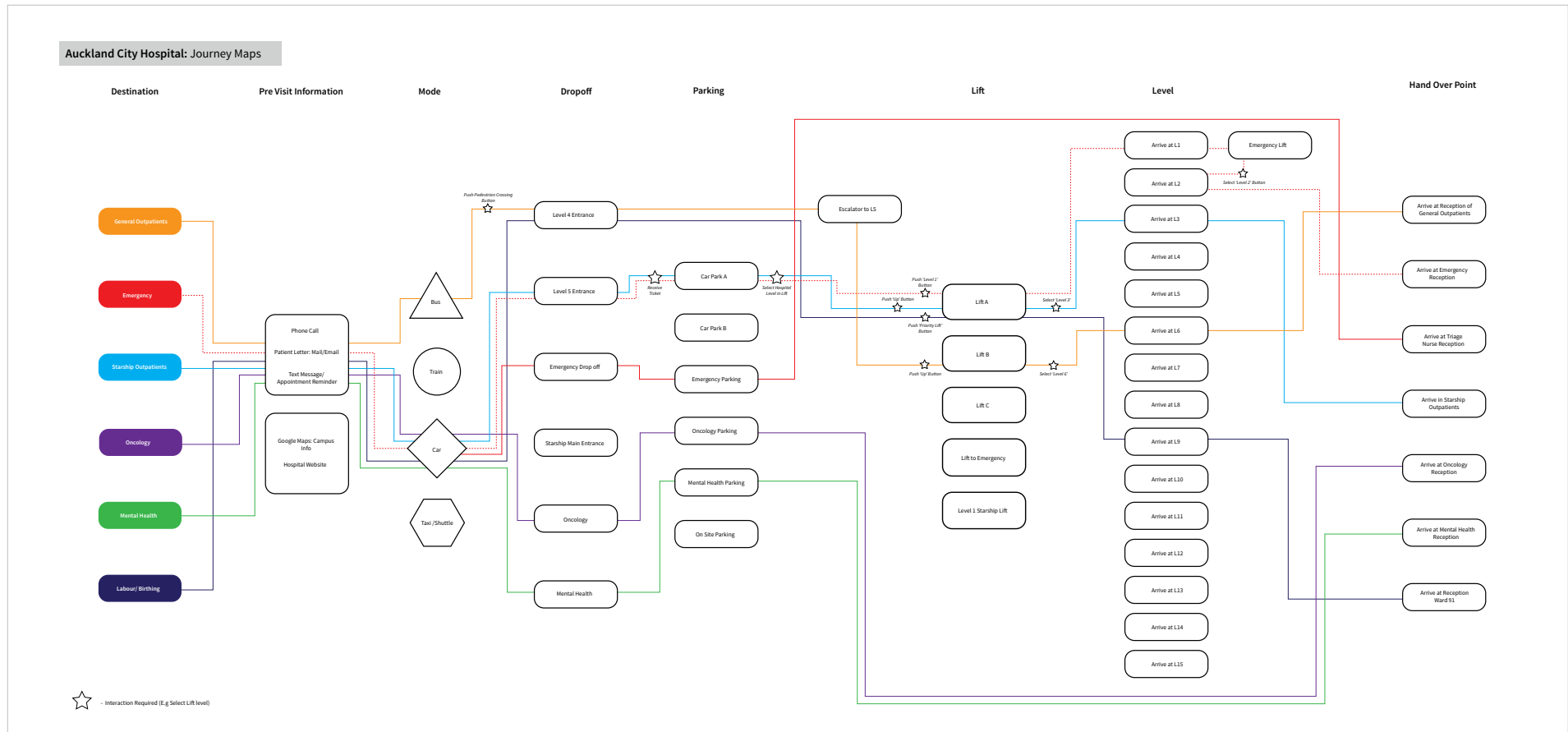
Patient Letter & Website



6.2

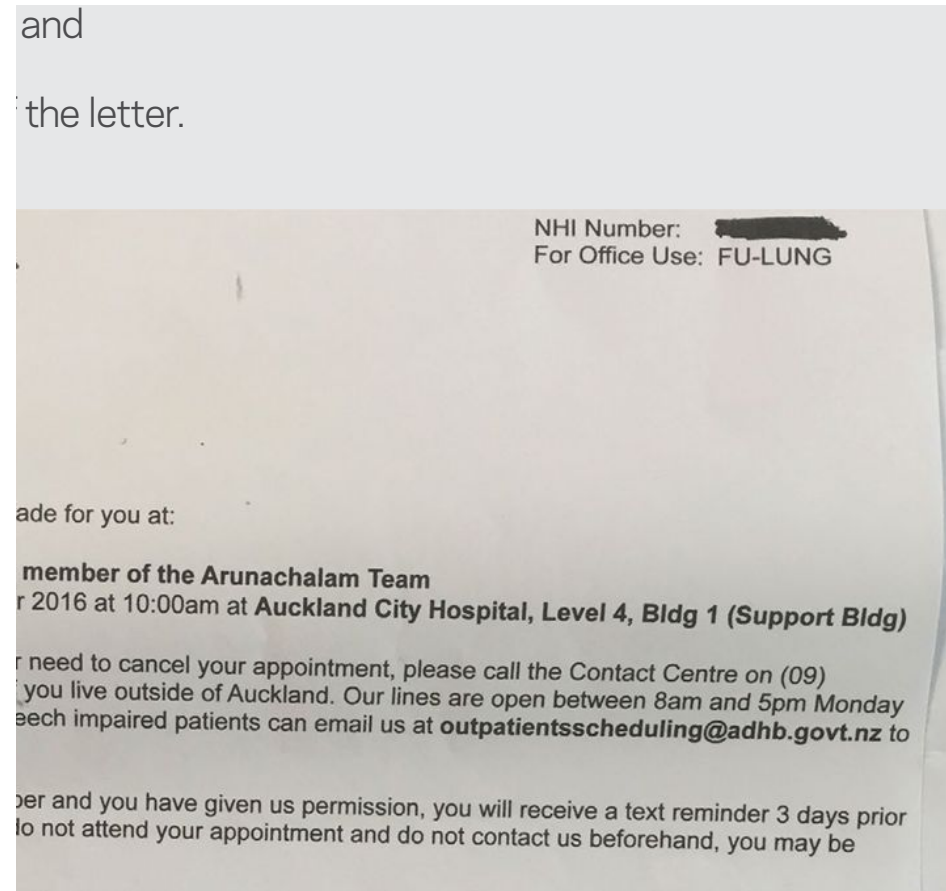
2. Lack of clarity around routes and journeys

Journey Mapping



3. Consistency of language and nomenclature

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



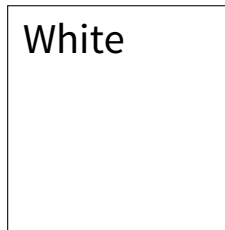
6.2

4. Signage Elements

Colour

Colour palette

For all major signage elements



Colour system

For environmental graphics
& supporting elements



Signage Elements

Typography

Typeface
Wayfinding Sans

6.2

Auckland
City Hospital

Signage Elements

Iconography

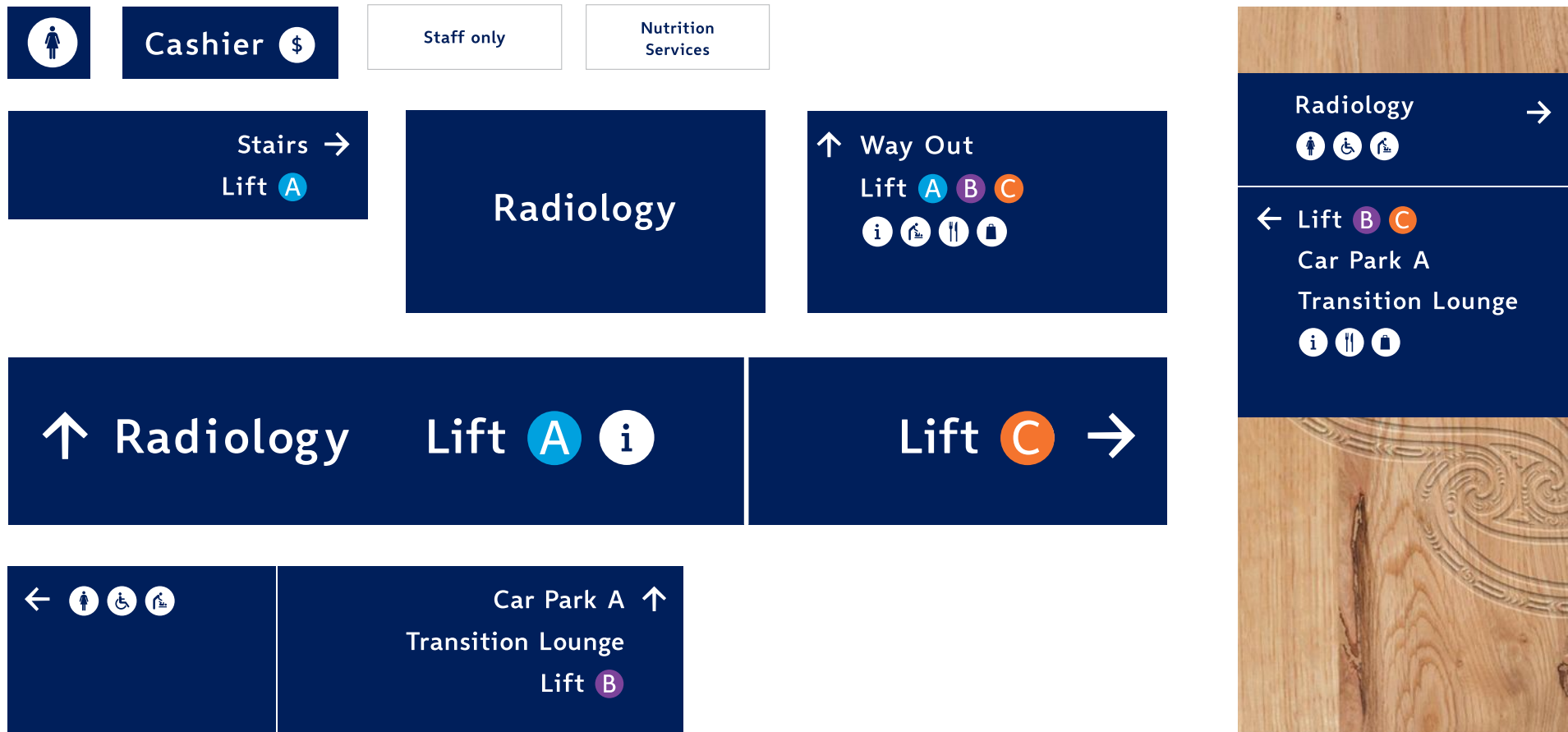
Icons

Wayfinding Sans tailored for Auckland DHB



Signage Elements

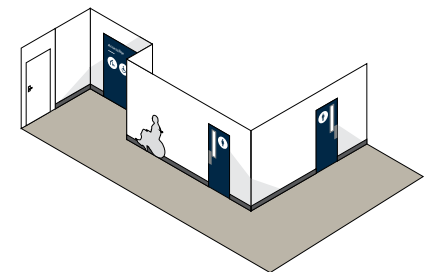
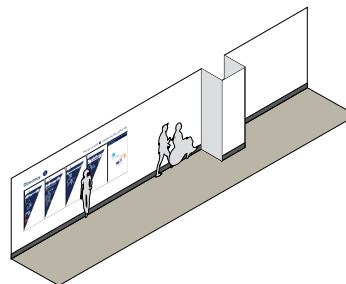
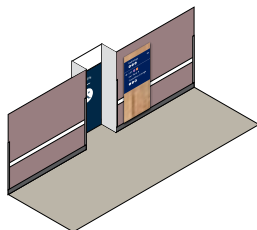
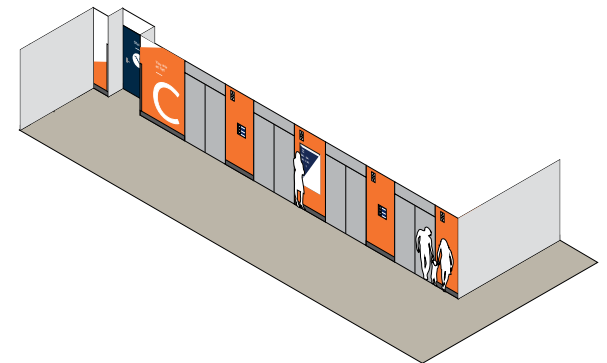
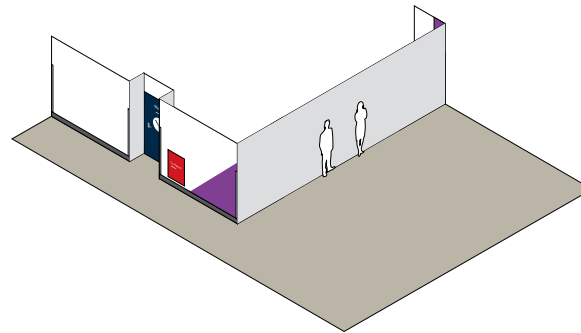
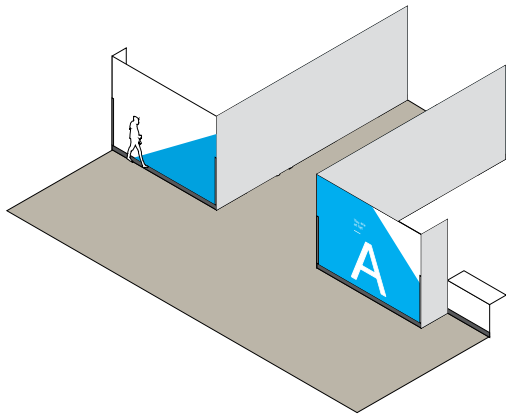
Sign Family



6.2

Signage Elements

Level 5 Application



5. Main Entrance driveway

Update Park Road entrance and remove unnecessary information



Caption: Concept artwork for Park Road entrance.

6. Lack of information in critical areas

E.G. Lift B—no directory board of destinations



7. Starship Entrance experience

Entry point from car park B—back of house



Caption: Concept artwork for Starship entrance—car park B

8. Health & Safety Risks

E.G. Pedestrian safety in car park A



Related material

> ACH Wayfinding Strategy version 1.0

6.2



Waitemata DHB Wayfinding Progress Update

Recommendation

That the Disability Support Advisory Committee receives the Waitemata DHB Wayfinding Progress Update report.

6.3

Prepared by: Carol Hayward (Community Engagement Manager, Waitemata DHB)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

1. Introduction/Background

In 2014 work commenced to develop an approach to signage and wayfinding. A steering group was established with membership representing the Executive Leadership Team, Facilities, Patient Experience, Community Engagement, Disability Advisor, Hospital Operations and Communications. Health Links joined the group in 2016 to provide an additional consumer perspective. The group agreed the following work programme which is in the process of being progressed:

		Current state	
Phase 1	Confirm policy and principles	Approved	
	Confirm approved supplier	Tendering process followed and supplier appointed	
	Approved signage for new builds	Ongoing	
Phase 2	External signage	External signage installed during 2017 at NSH, WTH and Mason	
	Improve communication	Review and update of patient letters with improved wayfinding details	
	Accessibility issues	Site walk-about with consumers identified a number of improvements required. Implementation to be further scoped	
	Confirm naming conventions	Initial draft. Further work required	
Phase 3	Internal way finding improvements	To do. Plan once external signage is progressed	
	Improve maps/collateral	Printed maps and collateral have been reviewed by health literacy groups and updates are in progress	
Phase 4	Deliver interactive strategy	To do	

The External Way-Finding Signage upgrade was presented to a special meeting of the Disability and Support Advisory Committee in July 2016. This report provides an update subsequent to that meeting.

2. Progress Update

Policy

The Wayfinding and Signage policy was implemented in May 2016 which establishes the following principles:

- Public and visitor focused - a first time users perspective
- Text kept simple, concise and legible
- Consistent across the patient journey
- Easy to understand for patients
- Evidence-based
- Step by step wayfinding stages to guide the patient's journey through hospital sites

Waitemata and Auckland DHBs have shared information about their approaches to wayfinding and have identified many common learnings and synergies. The wayfinding group have also carried out site visits to Middlemore Hospital and Auckland airport to identify good and bad examples of wayfinding that will inform future work.

External signage

Feedback was solicited from key groups: Greencoat Volunteers, Asian Health and the Health Links to inform the scope of this work. A Request for Tender (RFT) was published on via Government Tendering System in late 2015, requesting submissions from suppliers to design, manufacture and installation of external signage across Waitemata DHB three main sites (Mason Clinic, North Shore Hospital, and Waitakere Hospital). The consultants were appointed in 2016 who carried out a review of existing external signage and made recommendations on changes in line with international good practice. New signage has been designed, and was presented to the Committee at a special meeting in July 2017. It has now been signed off by the Wayfinding Committee, and manufactured. 90% of new external signage will be installed across North Shore Hospital, Waitakere Hospital, and Mason Clinic sites by 30 June 2017. All signage will be installed by end of August 2017.

Communication

A process of review and updating of letters that are used for patient service centre / outpatient communication started in late 2016. Letters have been reviewed by the Health Links health literacy groups. This has included the revision of an outpatient leaflet that accompanies letters and provides guidance about what to bring to appointments, where to park and what support is available. The north shore hospital map has also been reviewed and is currently being updated.

Accessibility issues

In October and November 2016, as part of the Waitemata DHB Listening Week, site walkabouts with community members were organized to explore issues, particularly around accessibility and language barriers. Some issues raised by participants will have already been alleviated by the new external signage but others are being worked through as the work programme is progressed. The full report is attached at appendix 1 for information but the following are recommendations as a result of this work:

- Declutter the main reception and make it more welcoming with welcome signs on arrival and signage for reception desks and the volunteer desks using the universal symbol for information. Reposition the volunteer desk to be more visible at both hospitals
- Provide important information on arrival in different languages such as maps, how to... leaflets etc.

- Increase the use of maps within and outside the hospital – this could be technology based (which could potentially be provided in a range of different languages) or tear off maps. QR codes could be used to enable digital access to information
- Provide information online about different ways people can get here, site maps and details about accessibility so that people can orientate themselves before they come
- Use big screens with rotating content to provide a range of information in different languages where appropriate
- Provide touch screens which allow visitors and patients search and find information in their language i.e. Auckland International Airport
- Simplify and reposition hospital directories near to the main entrance door
- Provide information about opening and closing times at each entrance and alternative entry points
- Increase signage for toilets and refreshments
- Upgrade toilet facilities. Include a 'Changing Place' toilet – with change facilities large enough for an adult
- Use more universal and visual symbols that relate to the service being provided
- Use larger font and a consistent look and feel
- Increase the use of colour and artwork to help people to orientate themselves – consider coloured lines and footprints
- Improve accessibility by decreasing gradients for ramps and considering the needs of people with a wide range of impairments.
- Increase colour contrast and repaint faded lines on the roads and pavements to make it easier for people with a visual impairment to navigate
- Consider the introduction of assistive technology such as spoken word site navigation
- Ensure signage to, from and at drop off points is clear
- Better information for people using public transport

Recommendations specific to Waitakere

- Replace signage at the drop-off point to make it clearer who can use it
- Provide pay machines in the car park
- Review location of existing crossings and make them a consistent colour
- Ensure all wards and services have clear signage at their entrances
- Replace or remove existing symbols and use arrows to navigate patients and visitors to wards or services
- Review and upgrade the baby change facilities

Recommendations specific to the North Shore Hospital

- Improve signage to Outpatients and the Elective Surgery Centre which continue to be challenging services for people to find
- Ensure mobility parking spaces are close to the main entrance and improve signage to access ramps
- Provide occasional seats or seating areas for people to be able to take a break if they have a long distance to walk
- Clearer signage for taxi rank

Appendix One – Wayfinding Report – Community Insights



Waitemata
District Health Board
Best Care for Everyone

6.3

Wayfinding – community insights

Wayfinding Steering Group

Prepared by Carol Hayward, Community Engagement Manager

Executive Summary

A wayfinding policy has now been endorsed and work is currently underway to manage the installation of external signage at Waitakere, North Shore and the Mason Clinic. However, there is still a lot of work required to consider internal signage and accessibility issues around the hospital sites.

In October and November 2016, as part of the Waitemata DHB Listening Week, site walkabouts with community members were organized to explore issues, particularly around accessibility and language barriers.

Key findings

In general, participants found the hospitals difficult to get around, with Waitakere found to be the most difficult. Getting into the hospital for people with mobility or vision impairments, as well as people with pushchairs, was felt to be challenging: ramps were felt to be quite steep for those with limited mobility and it was felt that there should be a flat covered walkway from the car park.

The signs on arrival were not felt to be very welcoming and friendly – there are more messages about not smoking or immunization than confirmation that people are in the right place or being welcomed.

At both hospitals, there was a common theme that the signage was inconsistent in relation to colour, font sizes and styles. Many signs were felt to be too small to read from a distance. It was also noted that there were many temporary signs which made the sites cluttered.

At both sites, participants felt that they would be most likely to ask for help either from volunteers or from the reception desk as it was difficult to know how to start their journey. They said that signage confirming who to ask for help was lacking.

There was a significant amount of feedback that the use of technology could aid wayfinding, in particular from those who did not speak English well and from the participant with a visual impairment.

Some difficulties will be improved or alleviated by the new external signage programme but other recommendations follow.

Overarching recommendations

- Declutter the main reception and make it more welcoming with welcome signs on arrival and signage for reception desks and the volunteer desks using the universal symbol for information. Reposition the volunteer desk to be more visible at both hospitals
- Provide important information on arrival in different languages such as maps, how to... leaflets etc
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- Clearer signage for taxi rank

Introduction

A wayfinding policy has now been endorsed and work is currently underway to manage the installation of external signage at Waitakere, North Shore and the Mason Clinic. However, there is still a lot of work required to consider internal signage and accessibility issues around the hospital sites.

In October and November 2016, as part of the Waitemata DHB Listening Week, site walkabouts with community members were organized to explore issues, particularly around accessibility and language barriers.

Community involvement

An initial session was held with the Waitemata Youth Advisory Group at Waitakere Hospital. In addition to that, two sessions were arranged for each site with a mixture of working days, an early evening and a Saturday morning to allow a mixture of community members to attend including those who might be working during the week.

Community members were recruited through a range of approaches to try to gain a mixture of perspectives from people who are regularly engaged with the DHB and those who are not:

1. Reo Ora Health Voice members who had identified as having a disability
2. Consumer representatives who had shown an interest in the Waitemata 2025 facilities work
3. Health Links
4. Personal contacts

In addition, Green coat volunteers were invited to participate as either members of the public on a site they are unfamiliar with or as observers at their usual hospital site.

Each event had between 6-8 community members and 4-5 members of staff who acted as observers. Interpreters were provided for Korean and Chinese speaking community members. Each member of staff observed between 1-3 participants at each event depending on the number of attendees and observers. An additional session was held with a partially sighted person at Waitakere Hospital.

Participants were given a scenario to find a specific place within the hospital, starting their journey from either the car park or the bus stop, and they were given other tasks to carry out while they were there, for example, finding refreshments, toilets, the pharmacy or paying for parking. Participants were asked to reflect on the things that helped them to find their way and what didn't.

There was then a group discussion with participants over light refreshments to collate feedback, identify common issues and discuss possible solutions.

Who participated

- A good age range from youth to older adults.
- A mixture of ethnicities including Chinese, Korean, Congolese, Pacific People and European.
- People with a range of impairments – mobility, autism and partially sighted.

Key findings and recommendations

Getting in and out of the hospital

Getting into the hospital for people with mobility impairments or pushchairs was felt to be challenging: ramps were felt to be quite steep for those with limited mobility and it was felt that there should be a flat covered walkway from the car park. However, once inside the building, railings throughout the hospital (North Shore Hospital particularly) were appreciated. For those with a visual impairment, it can be particularly difficult identifying entrance ways and having enough tactile or visual contrast to identify the edge of pavements or the start of crossings.

Drop-off points were not felt to be well signed outside the main entrance so some participants missed these and others felt that it was unclear where they should go once they had dropped off their passenger.

There were no signs to public transport from the hospital or advice about taxi services for those who were not travelling by car.

The signs on arrival were not felt to be very welcoming and friendly – there are more messages about not smoking or immunization rather than confirmation that people are in the right place or being welcomed.

Finding their way within the hospital

At both hospitals, there was a common theme that the signage was inconsistent in relation to colour, font sizes and styles. Many signs were felt to be too small to read from a distance. It was also noted that there were many temporary signs which made the sites cluttered or took the focus away from ward signs. Signage above people's heads was often missed. Arrows pointing people in the right direction were insufficient.

Signage for amenities such as toilets and refreshments were limited in most cases although the ESC café was the exception which was felt to be better signed than the ESC itself.

At both sites, participants felt that they would be likely to ask for help either from volunteers or from the reception desk as it was difficult to know how to start their journey. It was felt that signage confirming who to ask for help was lacking.

Once they found the ward or unit, signage to help them find their way back to the entry point they used was limited and there were a number of comments that once people were outside they could orientate themselves but that this was difficult when they were inside the building. Colour contrast on the wall or floor outside a ward or service was suggested as an aid, particularly for partially sighted people to know they had arrived.

Language barriers made it difficult for those who weren't confident English speakers – there were limited icons and relevant visual signs and there was no information in any languages apart from English. There were some Maori translations or words, but these were not used consistently

Where there are directories, they are not often comprehensive or easy to follow.

Many participants felt that the corridors all looked the same so it was difficult to orientate themselves. For long journeys in particular they would have preferred more ongoing signage or the use of colour or artworks to help provide markers such as lines on the wall or footprints. For those who were partially sighted, they would prefer greater contrast in colour (bright colours such as fluorescent or orange work best for some people) or assistive technology (eg audio broadcasts at key points) to help them be able to navigate their way around the building.

Other comments

The markets were felt to provide a nice atmosphere for staff, patients and visitors.

There is an app used by some blind or partially sighted people in New Zealand called BlindSquare (it is only available for i-phone at the moment but apparently android versions are coming). The app is currently available in English and a number of European languages plus Russian, Arabic and Japanese.

“BlindSquare is the World’s Most Popular accessible GPS-app developed for the blind and visually impaired. It describes the environment, announces points of interest and street intersections as you travel.”

www.blindsquare.com

BlindSquare could be used as technology to assist blind or partially sighted people around with the introduction of iBeacons which transmit information either inside and outside buildings to aid navigation (eg identifying where doors or stairs are).

Overarching recommendations

- Welcome signs on arrival and signage for reception desks and the volunteer desks using the universal symbol for information. Reposition the volunteer desk to be more visible
- Provide some information on arrival in different languages
- Increase the use of maps within and outside the hospital – this could be technology based (which could potentially be provided in a range of different languages) or tear off maps. QR codes could be used to enable digital access to information
- Provide information online about different ways people can get here, site maps and details about accessibility so that people can orientate themselves before they come
- Use big screens with rotating content to provide a range of information in different languages where appropriate
- Provide touch screens which allow visitors and patients search and find information in their language i.e. Auckland International Airport
- Simplify and reposition hospital directories near to the main entrance door
- When entry points are closed (eg out of hours), provide information about where to go
- Increase signage for toilets and refreshments
- Use more universal and visual symbols that relate to the service being provided
- Use larger font and consistent look and feel
- Increase the use of colour and artwork to help people to orientate themselves - – consider coloured lines and footprints
- Increase colour contrast and repaint faded lines on the roads and pavements to make it easier for people with a visual impairment to navigate
- Consider the introduction of assistive technology such as spoken word site navigation
- Ensure signage to, from and at drop off points is clear

Waitakere Hospital specific findings

Getting in and out of the hospital

Finding a space to park was a real challenge for participants. Participants felt that there should be site maps within the car park and that a pay machine should also be located there. The pay machine by the main entrance was easy to miss on the way out as it wasn't clearly labeled.



The drop-off point states that it is for emergencies only which leads to confusion about whether it is the drop off point for the Emergency Department. The drop off area was not spotted by many participants and once a passenger has been dropped off, it was not felt to be obvious where to go to park. Signage for the public car park should be bigger.

6.3

Some participants felt that there should be a covered walkway from the public car park to the main entrance. There were several comments that the crossings were not all in logical positions. One person was confused by the red crossing by the Emergency Department.



The sitemap was not obvious – even on foot - and could be located in a better place. The lettering on it is very faded.

Participants found it difficult to know which the Main Entrance was and which departments they could access via which door. The participants coming by bus or on foot found the main entrance more by following other people than by signs. They felt that signs should be bigger. This should be helped by the new external signage but could be supported by additional maps and guidance in patient letters. They felt it was odd that there was no C on the main entrance to be consistent with the other entrances being labeled. There were some suggestions that coloured lines would be helpful for them to find the right entrance.



The main entrance was thought to be confusing as there is a lot of clutter (pay machines, poles, side doors, umbrella bags) and signage on entry doors is not welcoming – for example, there are more signs telling people not to smoke.

Doors A and B are closed at the weekends and the corridors are blocked off but there is no information about alternative entries or exits.

Finding their way within the hospital

Most participants asked staff where to go as there was no obvious signage. They might have asked volunteers but there were none available on any of the days. Those who did spot the signage felt that it was too small and too far away from the main entrance.



Participants found the symbols on the signs confusing. They would have preferred arrows to symbols and while some thought they were attractive, they were generally felt to not be relevant to the wards or areas they were linked to. Those who didn't speak English well found it particularly difficult to follow and found that the ward name also not relating to the service added to the confusion.

Some participants including native English speakers did not understand the words used to describe the services eg Outpatients.

Participants felt that the main signage points contained too much information which added to the confusion. Some wards or departments were missing from the main wayfinding signs eg Rangitara Ward, Pharmacy. There were temporary signs that were more obvious than the original signs and some of these covered words from existing signs.

Participants felt that it was not clear which floor they were on.

Some participants felt that it would have been helpful to have had more signs reassuring them they were going in the right direction. It was difficult for some participants to know when they had arrived at some wards or service as there was no clear sign above the door, eg Radiology.



Participants who used the stairs to go to the lower floor found it particularly confusing to come into an area filled with kitchen trolleys.

Many participants found it difficult to find their way back to the main lobby area after visiting the ward or service but some found that coloured walls and artwork helped them to orientate themselves.

Other comments



Participants liked the gardens, sculptures and greenery outside the hospital. There were also comments that the courtyard helped to provide that and made the main area feel light and airy.

Youth in particular commented on how welcoming and colourful the children's area was with art on the walls and felt that more colour around the hospital would be beneficial. Youth also liked the couches and play area in the maternity area and suggested that there should be children's play areas in more of the wards – even in the older adults – for children accompanying visiting adults.

The baby change area in the main lobby was welcomed but the facilities provided were not felt to be ideal. The participant felt that it would be good to have something to hold the baby down, a separate bin for nappies, a toilet in there (as it is difficult to get a pram into the other small cubicles), a hand sanitiser and a better chair for breastfeeding.

The corridor leading to the toilets was felt to be very dark and uninviting.

The accessible toilet door was felt to be appropriate for those in wheelchairs.

There was positive feedback about what was provided in the café but the shop was felt to be lacking goods that people might wish to buy for patients eg reading material, gifts, games.

Recommendations specific to Waitakere

- Replace signage at the drop-off point to make it clearer who can use it
- Provide pay machines in the car park
- Review location of existing crossings and make them a consistent colour
- Ensure all wards and services have clear signage at their entrances
- Replace or remove existing symbols and use arrows to navigate patients and visitors to wards or services
- Review and upgrade the baby change facilities and toilets

North Shore Hospital specific findings

Getting in and out of the hospital

The drop-off area was not spotted by all participants and once a passenger has been dropped off, it was not felt to be obvious where to go to park. Some people commented that it was not clear that the drop off was only temporary parking. It is difficult to find the entrance to the car park and a bigger sign on the outside of the car park was suggested to help this.



Mobility parking was felt to be adequate but it was felt to be a long way to go from the park to the main entrance and the ramp was quite steep. Signage from the mobility parking spaces was limited and it was suggested that a painted symbol would be helpful to identify the route.

Finding the way to the ESC was felt to be particularly difficult and the signs to the café were felt to be more obvious. There was a small sign directing people to use the crossing but there was no pedestrian crossing.

It was confusing knowing which entrance to go to so most would default to the main entrance whereas using the right entrance would have made the journey shorter.

Signs between the main entrance and the bus stop were felt to be lacking and the sign to the taxi rank was not obvious.

Paying for parking seemed straightforward to most participants – they had either spotted the machine on their way in or they went to the car park and paid there.

Finding their way within the hospital

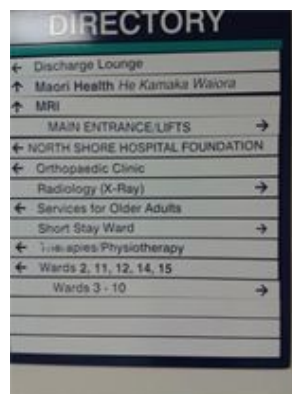


The receptionist desk was felt to be pointing in the wrong direction which was away from the direction that people needed to go into – it was felt to be more helpful if the receptionist could point straight ahead. The volunteer desk came after the receptionist which was felt to be the wrong way round. It was suggested that the volunteers could have a communication board with symbols to help those who have language difficulties. Some felt that the volunteers should stand out more as the green blended in too much with our WDHB colours – perhaps with yellow vests or with 'Volunteer' or 'Ask Me' written on them. It was not clear to all participants what their role was.

It was felt that the buildings and wards were quite scattered and that it was a long way to go in some instances. Information about how far people needed to travel was suggested as being helpful. Seats along the route would also be beneficial.

Digital maps, directories and online information or apps were felt to be helpful to guide people through the site.

Some wayfinding signage did not list the wards or services in alphabetical order which was felt to be difficult to follow. Some signs were particularly confusing with arrows going in different directions. Lakeview Cardiology having its own symbol was felt to be inconsistent. There is a sign for a public telephone but no telephone.



The Outpatients department was felt to be more confusing having more than one reception and there was no signage within the department for toilets or exits. There was a green-coloured public toilet sign outside the Outpatients department but this was felt to be confusing with the exit and fire exit signs.

Using letters within the Hine Ora Ward (A, B, C, D...) was felt to be helpful.

Following feet or coloured lines was also suggested by some but others commented that signs on the floor could get confusing because it can get so busy.

Other comments

Having toilets and an ATM in the main entrance was seen to be helpful. However, comments from participants were that the toilets were grubby and quite small and crowded including the mobility toilet. It was felt that the doors were too heavy.

Having access to a water cooler would have been helpful.

Railings throughout the building were commended as being well located and at a great width and height. An older person using a walker found it difficult getting into the main entrance due to a small lip on the door. She also found it difficult getting on and off the crossings through the yellow tactile paving and across some roads due to the gradient of the slope.

A participant commented that she thought the wet umbrella bags was a great idea.

Recommendations specific to the North Shore Hospital

- Improve signage to Outpatients and the ESC which continue to be challenging services for people to find
- Ensure mobility parking spaces are close to the main entrance and improve signage to access ramps
- Provide occasional seats or seating areas for people to be able to take a break if they have a long distance to walk
- Improve toilets in main Reception area.

Diversity and Inclusion at Auckland DHB

Recommendation

That the Disability Support Advisory Committee:

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

Prepared by: Kim Herrick (Organisational Development Practice Leader)

Endorsed by: Fiona Michel (Chief Human Resources Officer)

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

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

2. Background

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

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

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

3. Conclusion

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

Diversity & Inclusion @ Auckland DHB

Kim Herrick

May 2017

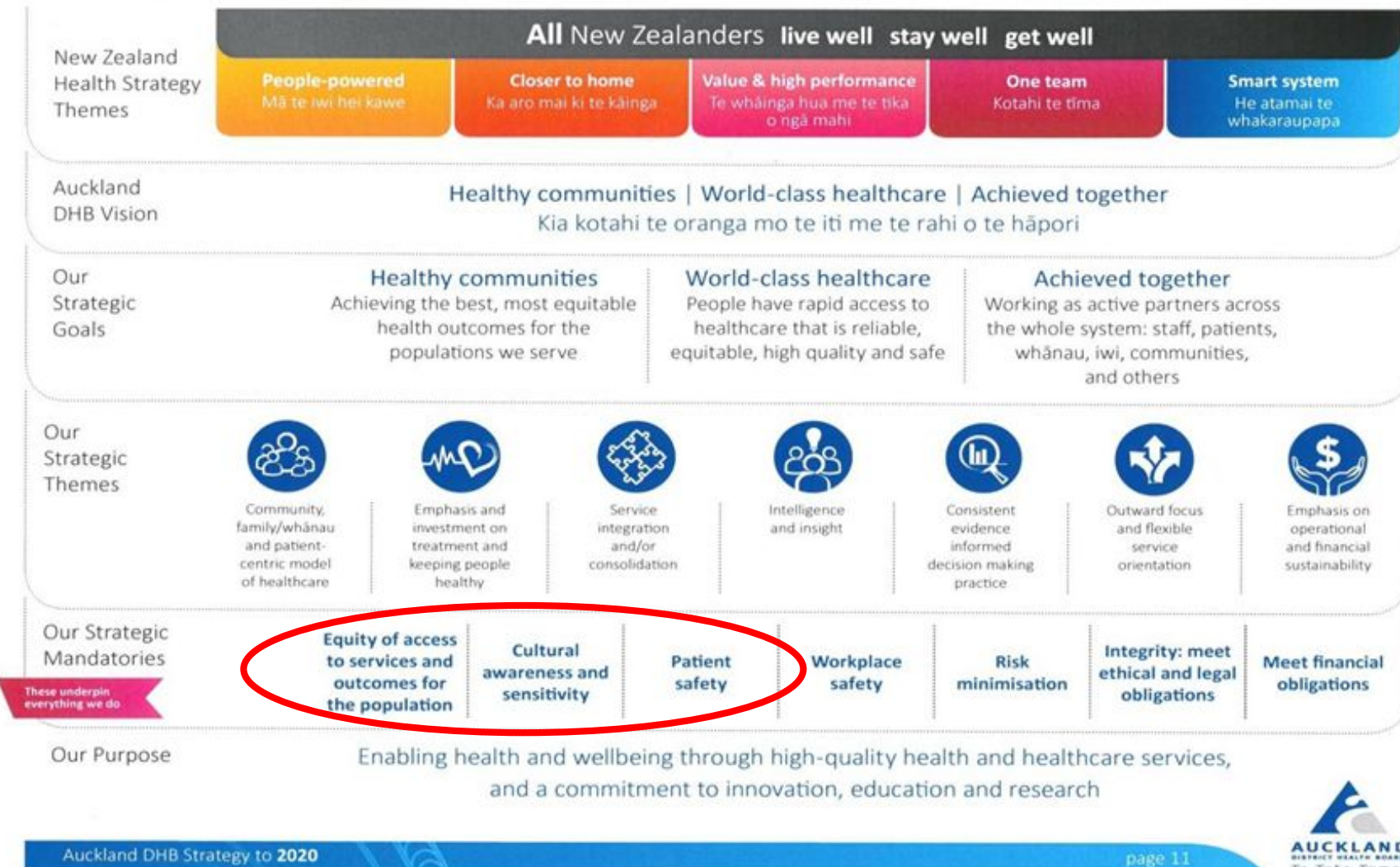
Disability Advisory Support Committee High Level Plan for feedback

Diversity & Inclusion linked to our wider strategy

Auckland District Health Board

6.4

Auckland DHB Strategy to 2020



Healthy communities | World-class healthcare | Achieve together | Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Diversity & Inclusion link to our People Strategy

“Do your life's best work”

Accelerating Capability & Skill

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

Building Constructive Relationships

- Promoting respect for diversity
- Building colleague empathy

Delivering on our promises

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

Ensuring a quality start

- Clarifying what Auckland DHB stands for and the behaviours we expect of each other



Diversity & Inclusion link to our Values

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

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

6.4

Diversity & Inclusion @ Auckland DHB

Definitions

We define 'Diversity' as:

“who you are, and recognising the value you bring to work”

We define 'Inclusion' as:

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

We define 'Discrimination' as:

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

We define 'Bias' as:

“Bias is a preference for one thing over another, and is part of being human; biases help us make decisions every day. Sometimes bias (conscious and unconscious) can impact the quality of decision making, reflecting our preferences and experiences”

Diversity & Inclusion @ Auckland DHB

THE WHY :

Diversity Dividend

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

THE WHAT:

Diversity & Inclusion

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

THE HOW:

Built in, Not bolted on

- It is not about ticking a box. Diversity, Inclusion & Belonging is not a one off programme, it's a mind-set that is built in to all that we do.
- It requires collaboration, empathy, a learning mind set and role modelling our values.
- Full support from Executive Team and Leaders

6.4

Diversity & Inclusion @ Auckland DHB

Two Prioritised areas:



Cultural Diversity / Equity

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



Disability / Accessibility

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

Diversity & Inclusion @ Auckland DHB

References

6.4

1. Bureau of Health Professional. The Rationale for Diversity in Health Professionals: A Review of Evidence. Rockville, MD; US Dept of Health & Human Services; 2006
2. National Centre for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of US Health Occupations (2010-2012). Rockville, MD US Dept of Health & Human Services; 2015
3. Mandell, Brian F, “Not all patients think like doctors, but we need to be able to think like patients”, Cleveland Clinic Journal of Medicine. Volume 79, Number 2, February 2012
4. Misra-Hebert, Anita & Isaacson, Harry, “Overcoming health care disparities via better cross-cultural communication and health literacy” Cleveland Clinic Journal of Medicine, Volume 79, Number 2, February 2012

Disability Advisor Update

Recommendation

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

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)

Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata DHBs)

7.1

Glossary

ARDS	-	Auckland Regional Dental Service
ASD	-	Autistic Spectrum Disorders
DiSAC	-	Disability Support Advisory Committee

1. Executive Summary

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

2. Work Areas

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

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

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

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

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

Equal opportunity for people with disabilities is the focus of a new \$10,000 central HR fund being implemented by Waitemata DHB. The fund will enable hiring managers to make any reasonable adjustments for new employees with disabilities without costs coming out of their individual

Auckland and Waitemata District Health Boards

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budgets. Most disabled people need very little extra support to start a new job, but if there is a cost involved, for example, a new piece of software, hiring managers can apply for funding through the central fund, therefore making the recruitment process more equitable. Please see the reference below for the link to the article in Healthlines.

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

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

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

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

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

3. Conclusion

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

4. References

HQSC Let’s PLAN for Better Care

<https://www.hqsc.govt.nz/publications-and-resources/publication/2633/>

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

<http://www.waitematadhb.govt.nz/assets/Documents/news/healthlines/Healthlines-Issue-220-April-May-2017.pdf>

Mainstream Programme

<http://www.msd.govt.nz/what-we-can-do/disability-services/mainstream/index.html>

Draft Disability Strategy Implementation Plan 2016 - 2026

Recommendation

That the Disability Support Advisory Committee:

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

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)

Endorsed by: Dr Debbie Holdsworth (Director Funding, Auckland and Waitemata DHBs)

Glossary

DiSAC - Disability Support Advisory Committee

1. Executive Summary

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

2. Community Consultation

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

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

3. Conclusion

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

4. References

Office for Disability Issues – Disability Strategy 2016-2026.

<https://www.odi.govt.nz/nz-disability-strategy/>

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

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

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



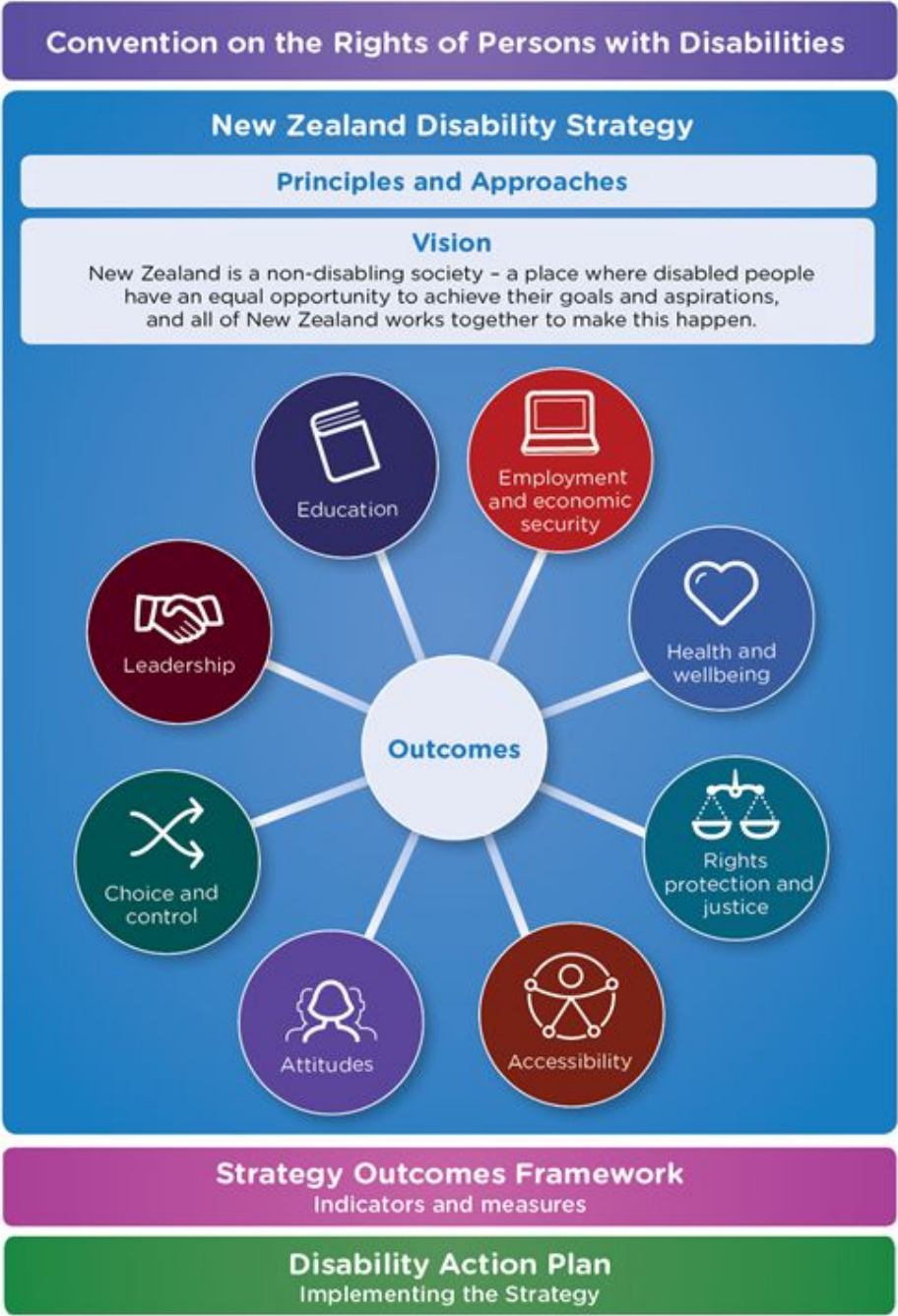
The New Zealand Disability Strategy 2016-2026 provides a framework for organisations to focus on enabling the full participation of disabled people. It has a vision of New Zealand as a non-disabling society – a place where disabled people have an opportunity to achieve their goals and aspirations and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

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



7.2

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
- 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 & Waitemata DHB Annual Plans

Disability Action Plan 2014-2018

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

Five Person Directed outcomes:

- Safety/autonomy
- Wellbeing
- Self-determination
- Community
- Representation

Four main areas of focus:

- Increase employment opportunities
- Ensure personal safety (includes decision making and consent)
- Transform Disability Support system
- Promote access in the community

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

Values

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

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

Auckland and Waitemata District Health Boards
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Monitoring and Reporting

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

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

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

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

Current Priorities

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

Health Literacy

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

This work focusses on two areas:






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

Patient Experience

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

Outcomes

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

				
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>
<p>Increase the number of disabled people into paid employment.</p> <p>Record the number of staff with impairments working for the DHB.</p> <p>Increase the confidence of Hiring Managers to recruit disabled people.</p>	<p>Robust data and evidence inform decision making.</p> <p>Barrier free and inclusive access to health services.</p> <p>Improve the health outcomes of disabled people, with a specific focus on people with learning disabilities.</p>	<p>Barrier free and inclusive access to health services.</p> <p>The principles of universal design and the needs of disabled people are understood and taken into account.</p> <p>Improve & increase accessible information across the DHB.</p> <p>Ensure physical access to DHB buildings and services.</p>	<p>All health and well-being professionals treat disabled people with dignity and respect.</p> <p>Provide a range of disability responsiveness training.</p> <p>Disabled people able to access supports that they need in hospital.</p>	<p>Engage regularly with the disability sector and community.</p> <p>Ensure a diverse range of disabled people are identified as stake-holders.</p> <p>Supported decision making and informed consent.</p> <p>Ensure services are responsive to disabled people and provide choice and flexibility.</p>

7.2

New Zealand Disability Support Network Employment Practice Guidelines

Recommendation

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

Prepared by: Michelle Webb (Committee Secretary)

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

8.1

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

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

Report on the Disability Data and Evidence Working Group

Recommendation

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

Prepared by: Michelle Webb (Committee Secretary)

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

8.2

New Zealand Disability Strategy Outcome 2: Employment

1. Executive Summary

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

2. Background

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

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

That the Auckland Metro DiSAC groups:

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

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

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

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

Report on the Disability Data and Evidence Working Group

The status of the Disability Data and Evidence Working Group

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

Previous work by the Disability Data and Evidence Working Group

The Disability Data and Evidence Working Group has completed a stocktake of disability-related data held by government agencies. The stocktake is available here: <https://www.odi.govt.nz/whats-happening/disability-data-and-evidence-working-group/>

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

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

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

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

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

<http://www.statcan.gc.ca/pub/89-654-x/89-654-x2016003-eng.htm> or in the attached paper disability data in New Zealand).

Related disability data work by Statistics New Zealand

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

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

http://www.stats.govt.nz/browse_for_stats/health/disabilities/disability-small-areas-2013.aspx

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

Outcomes Framework

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

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

The future of disability data in New Zealand

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

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

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

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

END

TE HUNGA HAUĀ MAURI MŌ NGĀ TĀNGATA KĀTOA



8.2

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

30 January 2017

Executive summary

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

Recommendations

That as Minister responsible for Social Investment:

1. You make clear your expectations to officials that disability should be included as a default in social investment analysis.
2. You also make clear to officials that quality data on disability should be used and must be collected through modern approaches.
3. You encourage officials to consult with the Disability Data and Evidence Working Group if they need advice on what data to collect, or include, on disability.
4. You require officials to use broader measures than just future welfare liability, especially for assessing the return generated by investing in disabled people.

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About us

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

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

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

The social investment approach and disability

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

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

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

Disabled people are at a high risk of negative outcomes

Disabled people aged under 40 on the Supported Living Payment have amongst the highest average future welfare liability (Taylor Fry, 2013, p. 130). In the 2013 Disability Survey, which uses a functional limitations approach based on the World Health Organisation's definition of disability¹, disabled people;

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

To pick a particular cohort, 77% of working-age people receiving Ministry of Health Disability Support Services were on a main benefit. Of this number, 96% are on the Supported Living Payment. Most of these people remain on the Payment until they pass away or become eligible for Superannuation. Only 5% of working-age people receiving Ministry of Health Disability Support Services got their main income from work².

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

¹ The International Classification of Functioning, Disability and Health (ICF)

² This data came from matching Ministry of Health data with IRD data through the Integrated Data Infrastructure. 18% of working age people receiving Disability Supports Services did not have IRD records, either because family members supported them or because of issues with the data matching process (Office for Disability Issues, 2016).

The Treasury predicts the following for teenagers on a Supported Living Payment, attending a special school or receiving special education services:

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

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

Disability has had a low profile within the social investment approach

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

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

Rather than breaking down the traditional siloed separation of disability policy from other social policy, the social investment approach appears to be reinforcing it. Disability-related social services and disability policy in general is still seen as separate from general social services. This is a crucial flaw for the social investment approach. It stops policy-makers from seeing the whole of the dynamics that increase the risk that families and individuals will experience negative outcomes. The

picture will always be incomplete if disability and its implications are not included in the analysis.

Disabled people should be a key part of social investment approaches

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

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

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

Equity issues with the investment approach

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

Further, some disabled people may be capable of working more than 15 hours a week, but face complex social and environmental barriers to work, such as employer attitudes as well as inaccessible buildings and transport (Woodley, Nadine , & Dylan, 2012)(United Kingdom Parliament Office of Science and Technology, 2012, p. 3).

Removing these barriers may be more costly and take longer than addressing barriers for other groups. People with more complex barriers may generate a lower rate of return per dollar invested than other groups that have easier to fix barriers. A longer term view will not change this if officials think full-time work is an unlikely prospect for a group, or would require a large ongoing investment.

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

The Ministry initially wanted to target employment support, using an investment approach, to those capable of finding more than 15 hours of paid work per week. The Ministry wanted to focus funding on reducing future welfare liability (Ministry of Social Development, 2015, pp. 5-8, 11). People considered as not capable of doing paid work of 15 or more hours per week would have had limited access to employment services in this proposal. Yet often their need for (and wider benefits derived from) paid work is as great, or even greater, than those considered capable of working 15 hours or more per week.

These initial proposals for employment support were halted and the Ministry of Social Development is now working with representatives of the disability community on further proposals. Nevertheless, the initial proposals showed how in practice, a narrow investment approach based only on future welfare liability may further disadvantage those with the greatest needs. Such an approach is likely to reinforce the negative assumptions and prejudices in government about which people are worth investing in. A focus on using data and evidence cannot overturn this on its own. This is because assumptions may stop the government from investing in a group to begin with or from collecting enough data to test their assumptions.

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

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

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

The social Investment approach relies on high-quality data being available about target populations and the effects of policy interventions (State Service Commission, 2016). The lack of data collection and focus on disabled people has real negative effects. For example, as part of the second Better Public Services target to increase the rate of early childhood participation, there are several priority populations, including children with special education needs (Basham, 2012, p. 7). Unlike other

priority populations, however, no data is collected on the participation of children with special education needs (Ministry of Education). It is unlikely to be a coincidence that the Ministry of Education's Early Learning Taskforce has four strands in which the other priority populations are targeted, but not, explicitly, children with special education needs (Ministry of Education, 2016). What gets measured gets done.

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

The way forward

Making disability a default in social investment analysis

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

As Minister, you can play a key role by setting the expectation that social investment analysis will include disability-related needs by default. You can also require social investment analysis to be based on quality data on disability, which is collected using modern approaches. Modern data collection on disability does not involve simply asking people whether they have a disability or not. This is because it has been

difficult in practice to get people to identify as having a disability, even if they meet formal definitions of disability and/or use disability-related services.

For example:

1. Of the 4,525 people who accessed New Zealand Tertiary Education Disability Services in 2015, 44% (or 2,010 people) did not identify as having a disability (Ministry of Education, 2016).
2. A 2004 United Kingdom survey found that 52% of people who met the Disability Discrimination Act definition of disability did not define themselves as disabled people. This was especially apparent with younger people (Grewal, Joy, Lewis, Swales, & Woodfield, 2002) (Shakespeare, 2014, p. 97).
3. An estimated 56% of the people who were identified as having a disability in the 2013 New Zealand Disability Survey, did not identify as having a disability in the 2013 Census (Statistics New Zealand, 2015, p. 19).

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

The key is to not collect data on disabled people as a homogenised group, but to identify the specific needs disabled people have, both as individuals and within households. There is also a need to use data to shine a light on the diversity amongst disabled people and their households, especially as this can significantly affect what their support needs are. Most importantly, disability, and the needs it generates, should be seen as a key factor to include in social investment analysis, wherever possible, rather than a separate special category that is only of relevance for specialised services.

The Government Disability Data and Evidence Working Group may be able to advise on the best way to collect data on disability. This group is co-chaired by the Office for Disability Issues and Statistics New Zealand (Office for Disability Issues, 2016).

Addressing the equity issues

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

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

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

Conclusion

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

Bibliography

- Bromell, D. (2014). 'A Fair Go' in public policy. *Policy Quarterly*, 12-21.
- Convention on the Rights of Persons with Disabilities. (n.d.).
- Destremau, K., & Wilson, P. (2016). *Defining social investment, Kiwi-style*. New Zealand Institute of Economic Research.
- Grewal, I., Joy, S., Lewis, J., Swales, K., & Woodfield, K. (2002). *'Disabled for life?' attitudes towards, and experiences of, disability in Britain*. Department for Work and Pensions.
- Grondin, C. (2016). *A New Survey Measure of Disability: the Disability Screening Questions (DSQ)*. Statistics Canada.
- James, C. (2005, March 1). How about a fair go? *Management Magazine*.
- McLeod, K., Templeton, R., Ball, C., Tumen, S., Crichton, S., & Dixon, S. (2015). *Using Integrated Administrative Data to Identify Youth Who Are at Risk of Poor Outcomes as Adults*. The Treasury.
- Ministry of Education. (2016, April 6). *More children in early childhood education*. Retrieved from Education.govt.nz: <http://www.education.govt.nz/ministry-of-education/government-education-initiatives/better-public-services/more-children-in-early-childhood-education/>
- Ministry of Education. (2016, October). *Provider-based Enrolments*. Retrieved January 18, 2017, from Education Counts: <https://www.educationcounts.govt.nz/statistics/tertiary-education/participation>
- Ministry of Education. (n.d.). *Participation in early childhood education*. Retrieved from Education Counts: <https://www.educationcounts.govt.nz/indicators/main/student-engagement-participation/1923>
- Ministry of Social Development. (2015). *Employment, Participation and Inclusion Services: Draft Proposals for Change Discussion document for service providers*.
- Nicholls, J., Lawlor, E., Neitzert, E., & Goodspeed, T. (2012). *A guide to Social Return on Investment*. The SROI Network.
- Office for Disability Issues. (2016). *Disability Survey - update*. Retrieved from Office for Disability Issues: <http://www.odi.govt.nz/what-we-do/better-evidence/update-on-the-disability-survey.html>

- Office for Disability Issues. (2016, December 08). *Improving information about disabled people*. Retrieved January 19, 2017, from Office for Disability Issues: <http://www.odi.govt.nz/whats-happening/disability-data-and-evidence-working-group/>
- Office for Disability Issues. (2016). *New Zealand Disability Strategy 2016-2026*. Wellington: Ministry of Social Development.
- Office for Disability Issues. (2016). *What do we know about people receiving MoH Disability Support Services?* .
- Shakespeare, T. (2014). *Disability Rights and Wrongs Revisited*. Routledge.
- Social Services Committee Forty-eighth Parliament. (2008). *Inquiry into the quality of care and service provision for people with disabilities - Report of the Social Services Committee*. Parliament.
- State Service Commission. (2016, March 14). *Better Public Services*. Retrieved from State Service Commission: <https://www.ssc.govt.nz/better-public-services>
- Statistics New Zealand . (2014). *2013 Disability Survey: Labour market tables*. Statistics New Zealand .
- Statistics New Zealand. (2014). *2013 Disability Survey: Social and economic outcome tables*.
- Statistics New Zealand. (2015). *Measuring disability in New Zealand: Current status and issues: A discussion document for the Working Group on Disability Data and Evidence*.
- Taylor Fry. (2013). *Actuarial valuation of the Benefit System for Working-age Adults as at 30 June 2013*. The Ministry of Social Development and Treasury.
- Templeton, R. (2016). *Using IDI Data to Estimate Fiscal Impacts of Better Social Sector Performance*. The Treasury.
- The New Zealand Productivity Commission. (2015). *More effective Social Services*. The New Zealand Productivity Commission.
- The New Zealand Treasury. (2011). *Working Towards Higher Living Standards for New Zealanders - New Zealand Treasury Paper 11/02*. The New Zealand Treasury.
- The New Zealand Treasury. (2013). *Living Standards: A Short Guide to 'Increasing Equity'*. The New Zealand Treasury.
- The Treasury. (2015, October 22). *The Treasury's CBAX Tool*. Retrieved November 3, 2015, from The Treasury:

<http://www.treasury.govt.nz/publications/guidance/planning/costbenefitanalyses/cbax>

The Washington Group on Disability Statistics. (2010, March 31). *Short Set of Questions on Disability*. Retrieved January 18, 2017, from National Center for Health Statistics:

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

Trotter, L., Vine, J., Leach, M., & Fujiwara, D. (2014). *Measuring the Social Impact of Community Investment: A Guide to using the Wellbeing Valuation Approach*. HACT.

United Kingdom Parliament Office of Science and Technology. (2012). *Assessing Capacity for Work - Post Note*. United Kingdom Parliament Office of Science and Technology.

Woodley, A., Nadine, M., & Dylan, S. (2012). *Employer attitudes towards employing disabled people*. Point Research.