Wairarapa District Health Board, Hutt Valley District Health Board,

Capital & Coast District Health Board

Valued Lives Full Participation

New Zealand Disability Strategy

United Nations Convention on the Rights of Persons with Disabilities

Implementation Plan

2013 - 2018

Contents

New Zealand Disability Strategy and United Nations Convention on the Rights of Persons with Disabilities Implementation Plan: Wairarapa, Hutt Valley and Capital and Coast District Health Boards 2013-2018

Background

After the merger of the Community and Public Health Advisory Committee (CPHAC) and the Disability Support Advisory Committee (DSAC) in February 2013 into joint meetings, the opportunity to begin to work with the three District Health Board (DHB) communities was realised. This included all District Health Board population and funding groups and brought a new more integrated focus on the health and disability support issues of the sub regional population.

A Sub Regional Disability Forum in June 2013 led to a community mandate for a sub regional approach to disability planning. A renewed energy for improving health outcomes for all who experience disability irrespective of age, ethnicity, gender or locality

The outcomes of the workshops have laid the foundation of the Draft Plan. The Plan will be developed and overseen by a newly appointed Sub Regional Advisory Group which will link into CPHAC and DSAC and support the Senior Leadership Teams in each DHB district.

Note: This is a living document subject to change.

Legislation Underpinning the Plan

Public Health and Disability Act (2000)
This important piece of legislation in term of health
Goals

- Improved Health
- Independence, participation, and inclusion of disabled people
- Reduce disparity
- Better care
- CCDHB: 'Better Health and Independence…
- DSAC's Disability Support Advisory Committees

Which gave rise to the ground breaking New Zealand Disability Strategy 2001

The NZDS has 14 key focus areas which gave guidance to policy makers on eradication if systemic, attitudinal and structural barriers in all aspects of service delivery and legislation.
http://www.moh.govt.nz/disability
The strategy has been hailed globally as the first of its kind. It re-defined disability for the 21st Century. The strategy was further strengthened by the United Nations Convention on the Rights of Disabled Persons (2009).
Both the strategy and the UN Convention focus on structural and systemic factors rather than trying to fix the individual. The most significant component was the way disability was re-framed within a social model, moving away from an individual concept of deficit and a focus on what is wrong with the person. In addition the strategy included people with chronic illness (long term conditions not only age related) and those with mental illness. This meant for the first time, in spite of the fiscal ring fence around mental health, the central experience of living with mental illness aligns with that of living with disability. A focus on what happens to people, for example: isolation, marginalisation, social stigma and poverty related to lack of employment to name just a few, breaks down silos and unites people in a powerful way. (Part Three talks about work being done at CCDHB)
The New Zealand Disability Strategy states that: **"Disability is not something individuals have. What individuals have are impairments. … Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have."** Underpinning the Strategy is the vision of: "A Society that highly values our lives and continually enhances our full participation." While the New Zealand Disability Strategy in 2001 gave direction to all government bodies on a way forward for New Zealanders experiencing disability, 10 years on, the Strategy is even more significant in the light of societal changes. It is expected that the 2013 census will give government a better set of data to guide and plan health and disability services going forward.

New Zealand signed the United Nations Convention on Rights of Persons with Disabilities at the United Nations on 30 March 2007, and ratified it on 26 September 2008. The Convention does not create new rights for people with disabilities, but builds on what is required to implement existing human rights as they relate to people with disabilities.

The Convention covers all areas of life, all ages and life stages. It states that õpersons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability[1]ò The Convention includes children, older adults and those with mental illness. (See Appendix Three)

Local, national and international research provides empirical evidence of the need to improve approaches to the support of those with a range of impairments within health services.

[1] Please see Article 25 of the Convention, which is on health.[1] The full Convention document can be viewed at: http://www.odi.govt.nz/documents/convention/index.html

Health professionals are experts in the treatment of disease and geared to treat illness in the usually well. Those who experience disability due to the impact of long term conditions, congenital and/or acquired conditions through accident or illness, often have a range of complex health and support needs.

It is the understanding of and the ability to respond to support needs that leads to the requirement for policy that applies equally at all levels. Hutt Valley and Capital and Coast District Health Boards signed up to a Four Year Implementation Plan June 2012. Wairarapa District Board also developed a Disability Plan for 2005ï 2009. It is important to take the opportunity to align planning across the 3 DHBs to achieve the best outcomes across the sub region. The plan represents background information and both plans can be viewed on the link below:
http://www.ccdhb.org.nz/planning/disability/

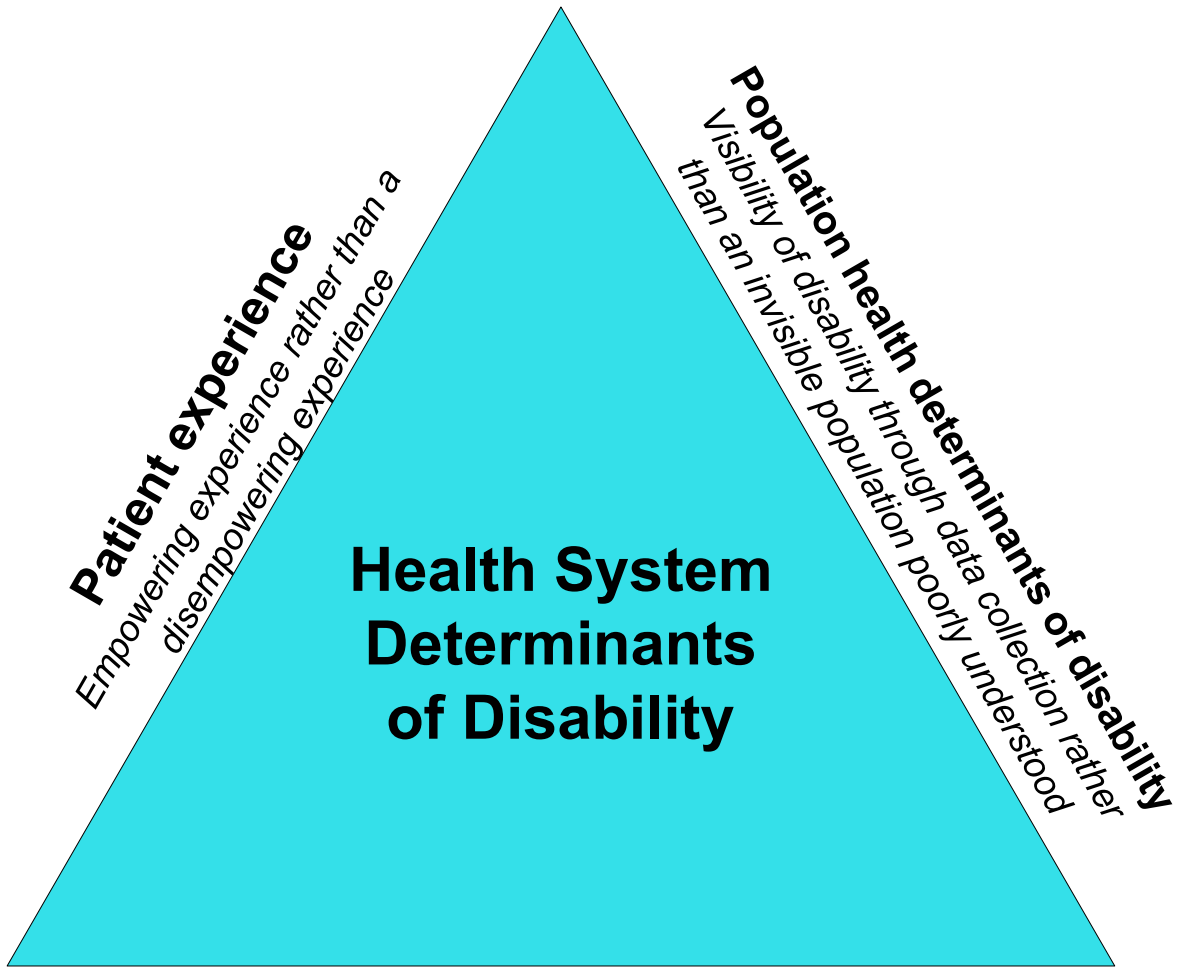
In respect of the terminology pertaining to disability used in this Implementation Plan, it is important to note that different people have different ways of expressing disability. People First, for example, use ñpeople with learning disabilityò Other terms used include: ñDisabled peopleòwith a capital D, ñpeople who experience disabilityò People with impairments and ñpeople with disabilities. No judgement is being made as everyone has a right to identify as they wish. Also it is important to respect the wishes and perspectives of all with regard to language. The fact is impairment and disability are dynamic and interchangeable due to the fact that a change of environment and circumstance can significantly increase the level of disability. In the context of health services, those who have many clinical and support pathways tend to have the most complex interactions with the health system. The easier those pathways are to navigate the more enabling the health system becomes for all

For the purposes of this plan we will use the term ñDisabled Peopleòand where appropriate People who experience Disability

Disability Planning and the Principle of Triple Aim

Triple Aim is a known national framework which is the cornerstone guiding philosophy for all health service delivery natioinally. It defines an approach to optimizing health system performance. Changing one element of the triple aim framework will create a change in another aspect of the framework. Applied to disability, this means:

- Improving the patient experience – patients' needs are met safely efficiently and respectfully and the voices and wishes of people have been incorporated into their overall care.. A preson has a positive experience where the care is centred on their needs.
- Improve the health of the population – there is visibility of those membres of the population who experience disability through data collection and a focus on public healtn targetted prevention . This counteres the current invisibility of the of the disabled population through lack of information.
- Financial and clinical sustainability – our heatlh systems are designed to enable rather than disable, with admission prevention, shorter stays due to targeted plannung and good coordination between primary and secondary services.



Identifying the population – what do we know?

The 2006 census identified 1 in 5 New Zealanders had some level of impairment that leads to disability. A follow up disability survey was held in August 2013 based on sampling from the main census earlier this year.

General demographic and population projection information for the 3 DHBs is provided as an appendix to this paper.

People receiving support services in the community

Disability Support Services funding for people aged under 65 years is held by the Ministry of Health. Services are coordinated by Needs Assessment and Service Coordination (NASCs) in CCDHB and WDHB. A private NASC operates in the Hutt Valley. The District Health Boards NASCS assess those with Long term chronic conditions (LTS_CHC).. For this group of under 65s funding devolved from the Ministry of Health to DHBs in 2011. While this fund ing initially was intended for those 50 – 65 with high health needs and who did not qualify as "close in interest" for Health of Older People Finding. However increasing families with children who have been born prematurely or who have high health needs not yet eligible for Ministry of Health Funding.

128 people a year are receiving :Long Term Conditions Funding with the highest volume at CCDHB. 50% are placed in under 65 or Aged Residential Care

Capital Support in Capital & Coast has 1383 clients:

- Approximately 12% are Maori and 10% are Pacific

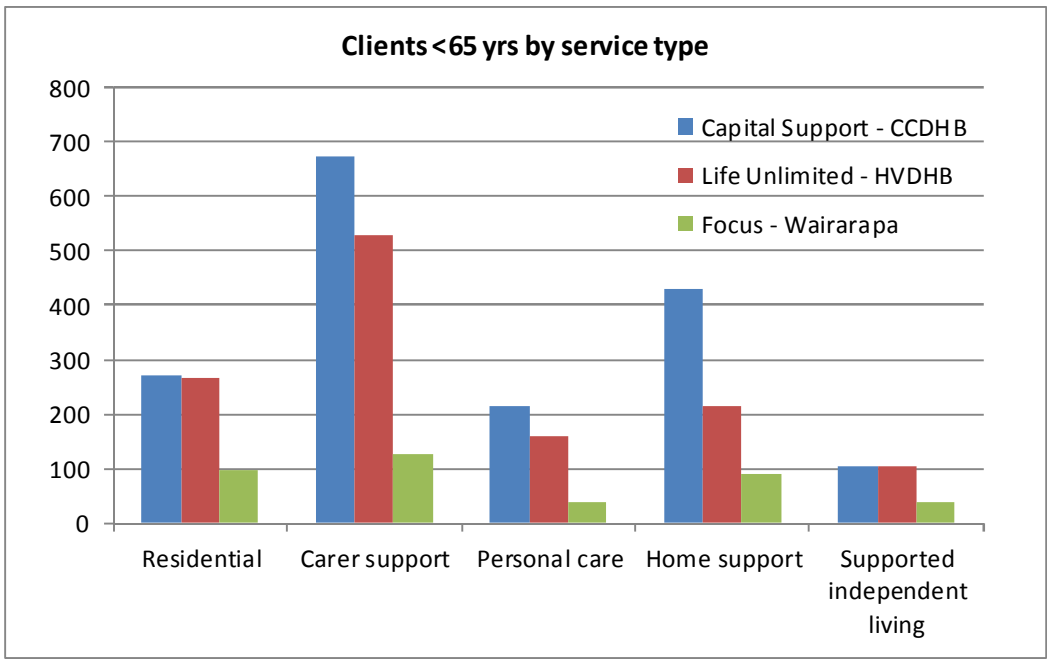
- 6% have low support needs, 36% have medium, 31% have high and 27% have very high support needs
- 416 (30%) are aged 16 years or under.

Life Unlimited in Hutt Valley has 1100 clients. 296 (23%) are aged 16 years or under.

Focus in Wairarapa has 329 clients:

- Approximately 17% are Maori and 6% are Pacific
- 2% have low support needs, 34% have medium, 46% have high and 19% have very high support needs
- 83 (25%) are aged 16 years or under.

Data on the types of support clients in both Hutt Valley and Capital & Coast receive is provided in the chart below. Note that clients may be counted in more than one category if they receive more than one service.

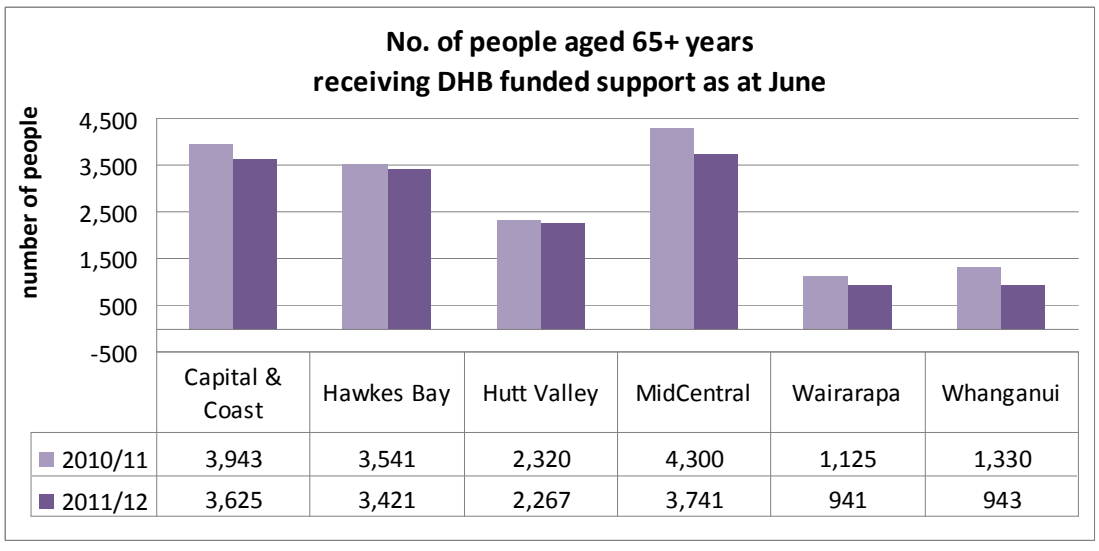


The chart above represents only the numbers with the highest support needs and who cannot be supported without residential or home support services. The equipment management service data identifies others who have high needs but can be supported through use of equipment. We are working to put together a picture of this client group across the sub-region.

The Hutt Valley population is comparatively high which may reflect the greater accessibility of the Hutt geographical area as well as the cost of housing. These figures have implications for planning.

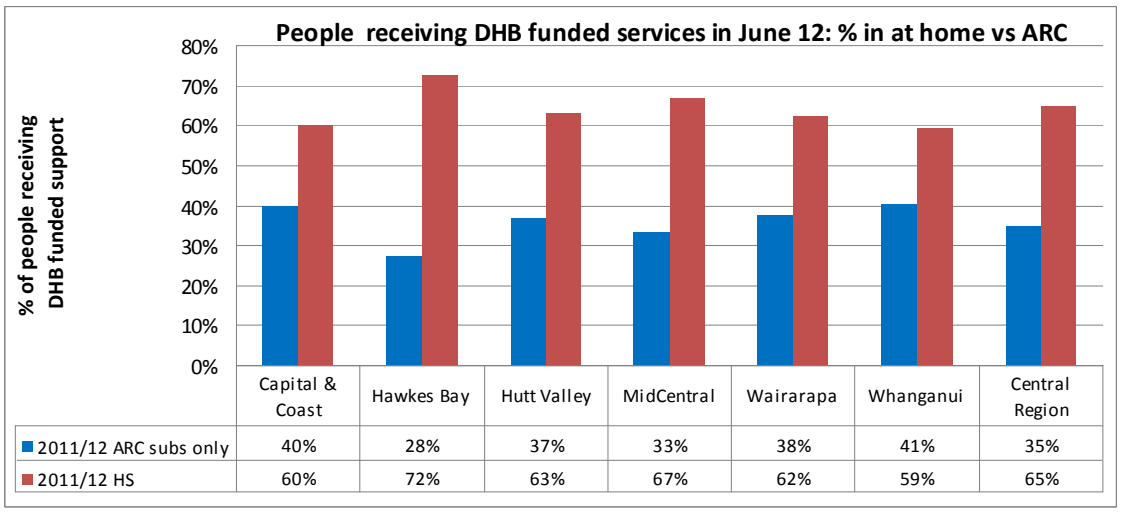
District Health Boards directly fund home support and residential care services for older people (65+ years). Again, these services are coordinated via NASCs or Care Coordination services. The charts below show the number of clients receiving DHB funded support and the split between home support and residential care.
There are a small num

In all the central region DHBs, there were less people aged 65+ years receiving DHB funded support in 2011/12 compared with the previous year.



	Capital & Coast	Hawkes Bay	Hutt Valley	MidCentral	Wairarapa	Whanganui
2010/11	3,943	3,541	2,320	4,300	1,125	1,330
2011/12	3,625	3,421	2,267	3,741	941	943

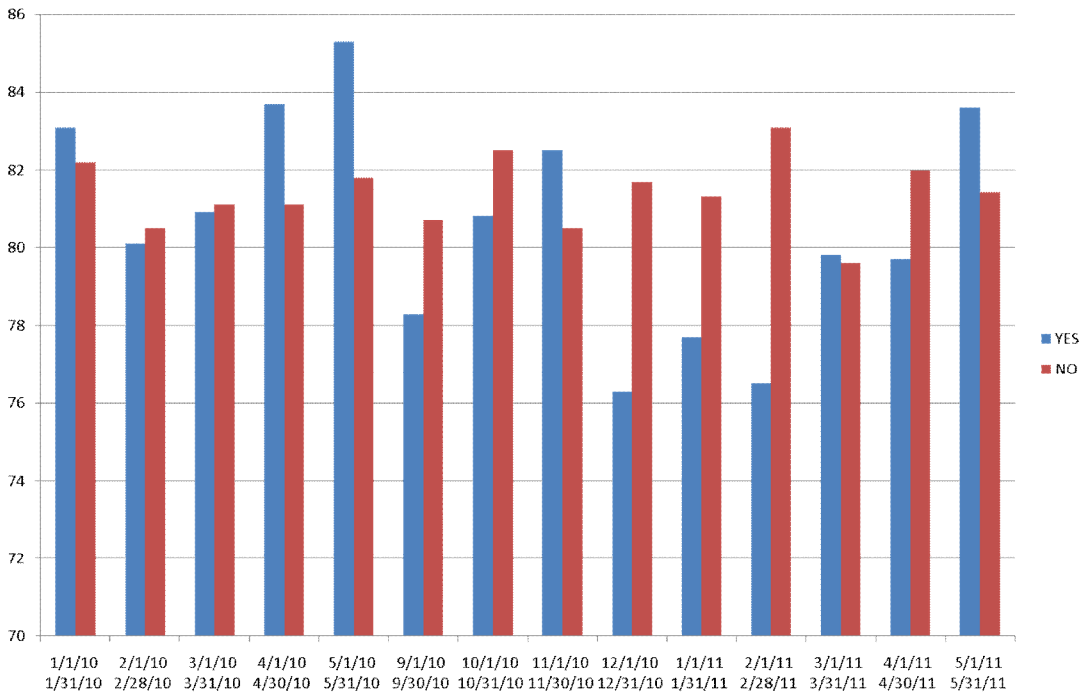
In all the Central region DHBs, the percentage of people receiving DHB funded services at home was higher than those receiving them in aged residential care facilities.



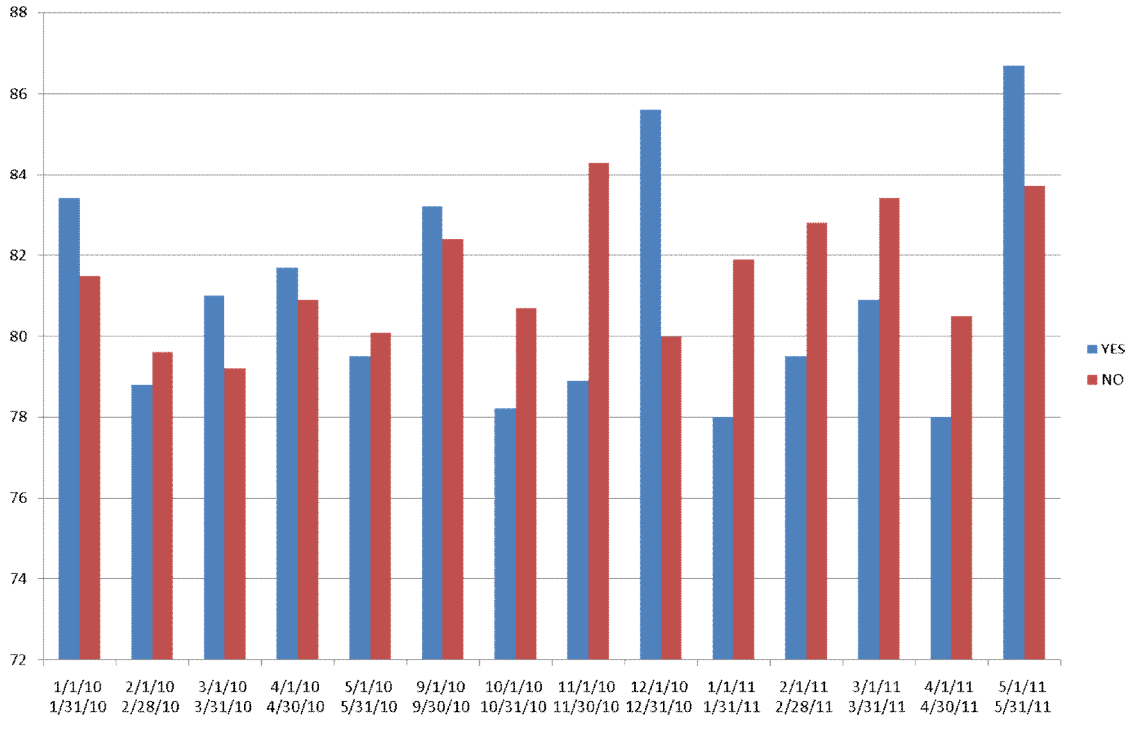
	Capital & Coast	Hawkes Bay	Hutt Valley	MidCentral	Wairarapa	Whanganui	Central Region
2011/12 ARC subs only	40%	28%	37%	33%	38%	41%	35%
2011/12 HS	60%	72%	63%	67%	62%	59%	65%

People using hospital services

Within hospital services (both inpatient and outpatient), patient satisfaction data over 14 months between January 2010 to May 2011, estimated that 30% of all patients identify as experiencing disability.
24% of inpatients and 42% of outpatients identify disability.



Inpatient Satisfaction – "Do you have a disability?"



Outpatient Satisfaction – "Do you have a disability?"

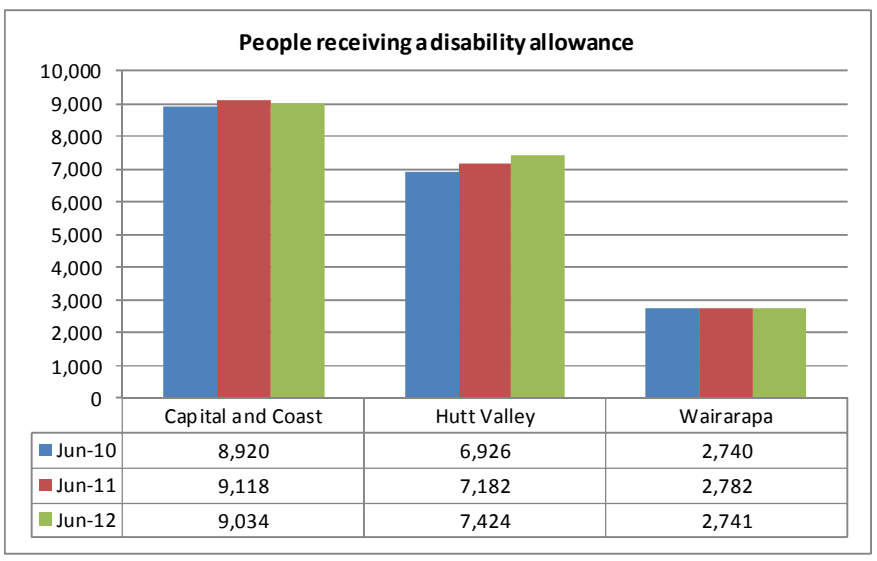
These figures are likely to be an under-estimate across all DHB services as mental health surveys were not included. A secondary issue is that due to the stigma still associated with disability many people with significant impairments refuse to identify.

The population is ageing, people are living longer with complex health conditions and the number of people using hospital services who experience disability as a result has increased. Primary care and general practice are also under more pressure as increasingly people age in place and wish to be supported in their own homes.

In addition, similar pressures are impacting on health services related to younger people with a disability due to higher survival rates of those born with a disability or who acquire one at a young age, improvements in medical and assistive technology, and higher expectations due to the impact of the human rights movement.

People receiving income support

The Disability Allowance, administered by Work and Income, is a weekly payment for people who have regular ongoing costs because of a disability, such as visits to the doctor or hospital, medicines, extra clothing or travel. The chart below shows the number of people receiving the disability allowance of all ages as at June in each of the last three years. Approximately 3,500 are children under 16 (WINZ Statistics 2013 July)



	Capital and Coast	Hutt Valley	Wairarapa
Jun-10	8,920	6,926	2,740
Jun-11	9,118	7,182	2,782
Jun-12	9,034	7,424	2,741

Summary of key goals of a draft 3 DHB New Zealand Disability Strategy Implementation Plan 2013-2018

A Draft Plan presented to the new Sub Regional Disability Advisory Group is built on the identified strategic areas for development from the Sub Regional Forum in June and the Draft Plan presented in July to CPHAC_DSAC. The Plan seeks to ensure sustainable progress across a five year period by building capacity across SIDU (Service Integration and Development Unit) and community and hospital providers across the sub region.

Having explored the development priorities identified sub regionally (Appendix Two), the four overarching themes inherent in the original Hutt Valley and CCDHB Implementation Plan (2012-2016) have been retained. For each of the four strategic areas the relevant link to both the New Zealand Disability Strategy (2001) and the UN Convention on the Rights of Disabled Persons (2009[2]) will be made explicit. In the summary below the relevant development areas from the June Forum have been identified.

STRATEGIC FOCUS AREAS of the Three DHB NZDS and UNCRPD Implementation Plan 2013-2018

Focus Area 1: Health
Health Disparities will be reduced by providing best care & improving, protecting & promoting the health of disabled people

Focus Area 2: Inclusion and support
Our districts will better include and promote the full participation of disabled people, and services will ensure the best support for disabled people and their families

Focus Area 3: Access
Disabled people will have more independent access to services to meet their health and support needs

Focus Area 4: Leadership

The three DHBs will provide and share leadership with disability communities and others to develop, adapt, and meet current and new expectations.

1. Health

Health Disparities will be reduced by providing best care & improving, protecting & promoting the health of disabled people (Development Areas 1, 3, 4: Appendix Two)[3]

Strategic Objective 1.1	**Primary Health Care & better integration across services keep disabled people healthier & address needs earlier**	Links to Objective 7 of the NZDS: *Create long-term support systems centred on the individual*)

One key overarching strategic objective is fundamental to the improvement of the whole of system journey. The key areas for action are as follows:

Key Project 1.1.1	**Improve system responsiveness by developing a dash board of indicators to measure outcomes and to target areas for quality improvement**

A lack of national and international data has led to significant disparity in the health and social needs of people who experience disability[4]

A system for electronic reporting is planned beginning with a baseline set of indicators collated across Hutt Valley and Capital and Coast in 13/14. Aligning systems to ensure there is a means of measurement within existing systems to include Wairarapa DHB, will be a focus for 14/15. This could be further facilitated by the development of capacity within Manage My Health across all three DHBs. The health passport flagged in the electronic system is a means of increasing visibility of disability support needs

Key Project 1.1.2	**Disability responsiveness will be integrated into clinical practice in the hospital and health services**

The need for training of health professionals has now been recognized by health professionals[5] within local and national consumer consortia and by the UN Convention. This goes alongside the international demand for improved data collection from multiple

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[2] The UN Convention was first ratified 2006 but signed by New Zeland in 2009)

[3] **Article 25 Health** "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability**.** States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.

[4] **Article 31 - Statistics and data collection** "1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention.

The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights". Extract UN Convention Monitoring Report 2011/12

[5] Tom Shakespeare, Lisa I Iezzoni, Nora E Groce, (2009) Perspectives Disability and the training of health professionals *http://www.thelancet.com/* November 28th 2009 1815 edition to celebrate the UN Convention See series of articles

sources. The integration of disability responsiveness into all clinical and professional areas across the sub region will remain as an operational goal over the next five years as shared capacity is built

Key Project 1.1.3	**Disability Action Group CCDHB combines with Hutt Valley and Wairarapa DHB to collaborate on joint initiatives Champion networks are in place across three District Health Boards (supported by Combined Disability Action Group)**

Disability Action Group will become sub-regional and oversee a group of champions in the sub-region.
The alignment of an organisational mechanism to champion disability initiatives is fundamental to a five year plan. Through the prioritised project launches (the passport and the icon) the core of a 3 D action group has developed. This will be based on roles as opposed to individuals to ensure future proofing of this mechanism

Not only will this group lead focused initiatives, they will be up-skilled to support staff, patients and community members with specific issues and enquiries. One ñdisability co-ordinatorò or navigator is unlikely to be sustainable in the immediate or medium term future but a core network of roles that are named and publically accessible will bridge a current gap experienced across the board for answering certain questions. It is intended that over future years a community network will link in to provide a more comprehensive network

Network examples include:

- Pre assessment planning and support prior to elective admissions for young people with significant behaviour challenges
- Referral pathways across multiple funding streams that delay discharge or impede optimal outcomes (queries on this usually from staff)
- Coordination of networks and professionals across a number of areas to prevent hospitalisation or to support early discharge and optimal living in the community (e.g. enhance knowledge of community options)
- Linkages with Primary care practitioners
- Paediatric to adult transition queries and linking
- Sources of support for families of older people and those with mental health issues Equipment queries

These examples are listed as these and more have been raised as critical barriers to appropriate access to health services. While some pathways can be improved through systemic changes, the complexity of the issues means that navigating all these issues will remain challenging for many years to come.

2. Inclusion and Support

Our district will better include and promote the full participation of disabled people, and services will ensure the best support for disabled people and their families (Development Areas 3,5 and 6: Appendix Two)

Actions to achieve integration will involve strong sustainable intersectoral initiatives and within health services an improved shared understanding of the experience of disability. People who experience disability include all age groups with lifelong or acquired long term physical, sensory, intellectual or mental health conditions and the families of people who support them. While funding silos compartmentalise groups, innovation in this area demands a commitment within every area of planning to recognize people not usually identified as belonging to groups experiencing disparity[6].

Strategic Objective 2.1	**Disabled Children will be supported to live and grow as they choose**

Key Project 2.1.1	As part of a single child health service an integrated approach across the 3 DHBs will be used in planning for children We will develop a Child Disability Plan:

This objective ensures the specific needs of children are addressed and will Include the needs of children who have chronic health conditions as well as congenital and other forms of developmental impairments. An integrated approach within the 3 D Child Health Plan will be developed. The specific work occurring within Primary Care at Capital and Coast has a national focus[7] and will remain a key driver for future planning

Key Project 2.1.2	The ongoing work to develop a quality module as part of the Cornerstone accreditation as part of a national project to develop standards for General Practice around clinical effectiveness with children and young people with impairments[8] This work begins with Paediatric to Adult Transition

Extend the work completed within one demonstration site to inform improved transition as a Cornerstone module nationally available to all accredited General Practices

Strategic Objective 2.2	**Where we have a role as funder or provider, working age disabled people are supported to live as they choose**

[6] Disabled people belong to all sociio economic groups and while they may not experience high deprivation the level of disparity due to limited access in a range of areas

[7] Development of a Cornerstone module Child Disability Plan CCDHB 2012-16.

[8] Please see Child Health Plan 2012-2016 Child Disability Plan http://www.ccdhb.org.nz/planning/disability report on progress November 2013 Please see latest repprt`

Key Project 2.2.1	Inclusion of disability clause in all new contracts to enable providers to be more responsive

This key theme acknowledges the limitations of health services but enables health funded services to ensure the needs of people under 65 are addressed within all activity. To this end, a disability clause in which services across the three boards will be supported to implement the 3 D Plan that considers what is possible within service provision.

Strategic Objective 2.3	**People with experience of mental illness recover and live well**

Key Project 2.3.1	Mental Health Strategic Leadership Group has disability expertise

Due to the development of a 3 D mental health network, the opportunity through sponsorship and development of a Consumer Guardianship Group[9] across the sub region gives the optimal driver for improving the lives and service experience for all people who use them.

Strategic Objective 2.4	**Our planning will include how we support people with disability**

Key Project 2.4.1	Inclusion of disability focus in all new and reviewed DHB plans and groups

A disability focus will be integrated into all new and reviewed plans and groups in the 3DHBs.

[9] As a result of a 3 D Mental Health Workshop a MH Strategy underpinned by Consumer guardianship is being developed. The local Partnership Advisory Group has laid the foundations for this approach by including those who experience disability

Strategic Objective 2.5	**Older people as far as possible live in their own homes, are well supported and optimal independence is restored.**

Key Project 2.5.1	Long Term Conditions Clinical Panel supports independence for under 65s with chronic health conditions

The focus on maximising independence and preventing dependency created by services is critical in all service provision. The key action identified in the Plan provides a mechanism to ensure appropriate support outside of aged care facilities for those under 65. The research undertaken by the Clinical Panel CCDHB[10] has exposed the fragmentation of community services that inhibit natural support networks from being able to function to keep family members in the community. A sub regional and regional approach to this work is the desired direction

Key Project 2.5.2	A regional approach to improving service options will be implemented for people under 65

All programme development will include the principle that pathways will address health disparities experienced by Disabled People as part of explicit equity statements and frameworks

Strategic Objective 2.6	**We work with other entities to make our region and its diverse communities caring and more inclusive of everyone**

Key Project 2.6.1	Provide an effective Community Directory to ensure improved access particularly for those in transition to adult services.

This commitment is to maximise intersectoral links, funding and resources. The 13/14 commitment in the Plan is to complete the Regional Community Directory which links councils and improves information for all groups. The unique feature of the Plan for the Directory is to integrate access across all areas, including health and mental health information. The Plan is particularly central for improved services for those groups experiencing the most barriers. Over five years the challenge is to ensure a sustainable and updated Directory that remains appropriate and useable across the region.

The Sub Regional Advisory Group will provide necessary leadership in retaining and building on links to local councils and wider disability communities across all populations and age groups

3. Access

Disabled people will have more independent access to services to meet their health and support needs (See Development Areas 2,3 and 4 Appendix Two) (Links to Objective 8 of the NZDS: Support quality living in the community for disabled people, and Objective 1: Encourage and educate for a non-disabling society)

Strategic Objective 3.1	**Information and communication meet everyone's needs**

Key Project 3.1.1	We will develop and implement a New Zealand Sign Language policy

This policy will be developed alongside the Deaf community and will be phased in over five years[11]

Key Project 3.1.2	Increase access to information about services across internet and intranet

Learning will be shared from the experiences and good practice across the three District Health Boardsôwider populations

Key Project 3.1.3	Produce newsletter and develop other forms of consumer engagement to invite feedback on CCDHB projects

The Sub Regional Advisory Group linked with the 3 D Disability Action Group will produce a sub regional newsletter every quarter to communicate events across all areas and to provide a point of contact for information on health service development

Key Project 3.1.4	Plain language documentation becomes increasingly available across the 3 DHBs

Plain language documentation is already prioritised to improve information for the wider populations over five years. Clinical and corporate services will be engaged in improving access to information, including clinical information

Mechanisms to gather information about the unique information needs of various populations are being developed, for example health literacy work streams to address the needs of Maori and Pacific will benefit and integrate the needs of other groups

[10] A Clinical Panel was set up in 2012 to both oversee Long Term Conditions funding decisions and to research service gaps for older people under 65. The work has exposed gaps in community services which lead to premature admission to aged care facilities. A regional approach will now be proposed to support development of alternative approaches to services for people with complex health needs

[11] District Health Boards have an operational obligation (since 2006) to develop a New Zealand Sign Language policy to include services for Deaf A review commissioned by the Human Rights Commission and launched at parliament in September asked for leadership by the Wellington sub region.

Access issues in terms of information and physical access are subject to audit and standards.
Cornerstone will continue to work with health boards to ensure all aspects of access are addressed

Strategic Objective 3.2	**Physical Environment and signage meet everyone's needs**

Key Project 3.2.1	Improve responsiveness of primary care, secondary and community providers

Access issues in terms of information and physical access are subject to audit and standards. Cornerstone will continue to work with health boards to ensure all aspects are addressed. Contract reporting regarding disability will contribute to improving access within NGOs.

Strategic Objective 3.3	Our services are more welcoming and responsive (Links to Objective 8 of the NZDS: Support quality living in the community for disabled people, and Objective 1: Encourage and educate for a non-disabling society)

Key Project 3.3.1	Access is improved and monitored across all DHB sites

Access issues in terms of the physical environment are vastly different across the three districts. Access audits to establish urgent priorities will be built into this Plan. There are some common areas that can be aligned more readily named below.
All key documents will be available in plain language and/or easi read

A bi monthly sub regional newsletter led by the proposed Sub Regional Disability Advisory Group has already been defined as a key action and will ensure horizontal and vertical sharing of information to inform the Plan moving forward

4. Leadership

CCDHB will provide and/or share leadership with disability communities & others to develop, adapt & meet current and new expectations

Wairarapa, Hutt Valley and Capital and Coast District Health Boards will provide and/or share leadership with disability communities & others to develop strategies to meet and adapt to current and new expectations. (See Development Areas 1, 6 and 7 Appendix One)[12] (Links to Objective 1 of the NZDS: *Encourage and educate for a non-disabling society*, and Action 1.2 of the NZDS: *Recognise that it is disabled people who are experts on their own experience.* Also links to objective *5: Foster leadership by disabled people*.)

The sub region already leads nationally in the examples of innovation achieved in current and past initiatives. The Five Year Plan outlines a sustainable pathway to ensure integration into health and disability service planning

Strategic Objective 4.1	**The three District Health Boards will engage with disability communities and consumers**

Key Project 4.1.1	Sub Regional Disability Forum is held annually Appointment of and engagement with the sub regional disability advisory group

The core driver for this objective will be the appointment of and engagement with the Sub Regional Disability Advisory Group

I. One local forum each year linked with each council
II. One sub regional forum each year to monitor and update issues as they progress

Strategic Objective 4.2	**We will be an employer of choice for disabled people and their families**

Key Project 4.2.1	Human resource policies will be aligned across the 3 DHBs and will support employment choices for disabled people

Positive policies across three DHBs will seek to employ people who experience disability at every level of the organisation. Current available subsidies from the Ministry of Social Development will be used where appropriate to ensure people who wish to gain work experience or return to work can be employed. Human Resource Policy development will engage disability expertise across the sub region

[12] **Article 29 - Participation in political and public life**

"States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake to:

a. Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected…"

Strategic Objective 4.3	**Ensure leadership of and engagement with Maori and Pacific people with disabilities**

Key Project 4.3.1	Improve responsiveness for Maori and Pacific peoples with disability in accordance with Maori and Pacific Disability Action Plans

Appropriate representation on the sub regional DAG will build on the current sub regional approach initiated by CCDHB and Hutt Valley DHBs. It is proposed that Maori Partnership Boards in all three areas encourage representation of people who experience disability and/or engage with the sub regional group to support specific initiatives that improve inclusion of Maori people with disabilities in health services
The Regional Pacific Health Strategic Group has already endorsed disability representation on their group linked to the new Sub Regional Disability Advisory Group. Specific population based plans for Maori and Pacific will be developed in partnership with the relevant leaders and sub regional group members

Strategic Objective 4.4	**We will grow and develop through research and innovation**

Key Project 4.4.1	Contribute to research and innovation

Over five years the following areas of innovation will be addressed:

I. Analysis of data to contribute to high level equity indicators for the sub region
II. Evaluation of the health passport and other initiatives to contribute to national and international knowledge gaps (particularly with regard to the experience of and utilisation of health services)
III. Evaluation of initiatives that improve services for children and young people, particularly, transition to Primary Care and adult health services where required. A focus on service gaps for children in the Wairarapa will be linked in to the 3 D Child Health Services in early planning stages currently

The Draft Plan in a more comprehensive form will be provided at the CPHAC-DSAC meeting in November with gradual alignment across three areas over a five year period

FOCUS AREA 1: HEALTH

Health Disparities will be reduced by providing best care & improving, protecting & promoting the health of disabled people

Strategic Objective 1.1	**Primary Health Care & better integration across services keep disabled people healthier & address needs earlier**	Links to: UN Convention Article 25: Health UN Convention Article 16: Freedom from exploitation, violence and abuse NZDS 7: Create long-term support systems centred on the individual
Key Project 1.1.1	Improve system responsiveness by developing a dash board of indicators to measure outcomes and to target areas for quality improvement	UN Convention Article 31: Statistics and data collection NZDS 10: Collect and use relevant information about disabled people and disability issues

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Actions	**Measures**	**Action**	**Measures**	**Action**	**Measures**		
2013/14	C1.1.11 Work with alerts group to set up disability icon & identify individual support needs within WebPAS	Disability icon established Baseline information established	H1.1.11 Launch Disability Alert as an Outpatients Pilot at Hutt Valley DHB	Icon is established and leadership team is identified to review alerts - December 2013	W1.1.11 Launch health passport for the first time and link to Primary Care	Health passport launched and read coded in Primary Care	Nov-13	Disability Advisor
2013/14	C1.1.12 Develop pilot project to track admissions and discharges of disabled people who receive Vote Health funding over one year – Oct 13	Baseline information on avoidable admissions, failed attendances and patient satisfaction	H1.1.12 People receiving Vote Health funding are entered into the system to determine baseline	Baseline information on avoidable admissions, failed attendances and patient satisfaction.	H1.1.12Investigate implementation of alert system	Report completed on alert establishment	June 14	
2014/15	C1.1.13 Develop dashboard of key disability indicators	Dashboard developed and includes regular reporting	H1.1.13 Extend disability alerts to other depts. In 14/15	Disability icon established Baseline information established	H1.1.13 Launch Disability Alert in one department	Icon is established and leadership team is identified to review alerts - December 2014	Jun 15	
	C1.1.14 People receiving Vote Health funding are entered into the system to determine baseline	Baseline information on avoidable admissions, failed attendances and patient satisfaction.	H1.1.14 People receiving Vote Health funding are entered into the system to determine baseline	Baseline information on avoidable admissions, failed attendances and patient satisfaction.	H1.1.14 People receiving Vote Health funding are entered into the system to determine baseline	Baseline information on avoidable admissions, failed attendances and patient satisfaction.	Jun 15	
2015-18	C1.1.15 Utilise data to inform planning & target areas for quality improvement	Planning incorporates disability information	H1.1.15 Utilise data to inform planning & target areas for quality improvement	Planning incorporates disability information	H1.1.15 Utilise data to inform planning & target areas for quality improvement	Planning incorporates disability information	Jun 18	

Key Project 1.1.2	Disability responsiveness will be integrated into clinical practice in hospital and health services	UN Convention Article 25: Health & Article 16: Freedom from exploitation, violence and abuse NZDS 6 Foster an aware and responsive public service NZDS 1 Encourage and educate for a non-disabling society	

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C1.2.11 Provide disability responsiveness training (DRT)	95% of new staff receives disability responsiveness training sessions. No. of current staff areas receiving DRT	H1.2.11 In conjunction with the health passport launch, staff receive basic disability responsiveness training	Quality team lead training around icon and health passport	W1.2.11 In conjunction with the health passport launch, staff receive basic disability responsiveness training	Quality team lead training around icon and health passport	Jun-14	
	C1.2.12 New admin staff are provided with DRT (ongoing action)	All Admin staff are trained in disability responsiveness	H1.2.12 Admin staff involved in icon establishment have training	Quality team monitor training and quality of data input	W1.2.12 Admin staff involved in icon establishment have training	Quality team monitor training and quality of data input	Jun 14	
	C1.2.13 Year 1 doctors receive disability responsiveness training as core part of curriculum	No. of Year 1 doctors receiving DRT	H1.2.13 Year 1 doctors receive disability responsiveness training as core part of curriculum	Doctors are set test post training to measure retention of knowledge, as opposed to the baseline reading	W1.2.13 Doctors Year 1 receive DRT as core part of curriculum	Doctors are set test post training to measure retention of knowledge, as opposed to the baseline reading	Ongoing	

2014/15	C1.2.14 Stocktake of 3 DHB DRT plan in conjunction with Sub Regional Advisory Group	DRT complete and implementation started	H1.2.14 Stocktake of 3 DHB DRT plan in conjunction with Sub Regional Advisory Group	DRT complete and implementation started	W1.2.14 Complete stocktake of disability services for children	Stocktake of services complete	June 14	
2014/15	C1.2.15 HCAs receive training as core curriculum	No. of HCAs receiving DRT						
2015/16	C1.2.16 Key resources to be put in place for addressing abuse and violence, and communication with people who are non verbal	People who communicate non-verbally have resources available	H1.2.16 Key resources to be put in place for addressing abuse and violence, and communication with people who are non verbal	People who communicate non-verbally have resources available	W1.2.16 Key resources to be put in place for addressing abuse and violence, and communication with people who are non verbal	People who communicate non-verbally have resources available	Jun 16	

Key Project 1.1.3	Disability Action Group CCDHB combines with Hutt Valley and Wairarapa DHB to collaborate on joint initiatives	UN Convention Article 25: Health NZDS 10: Collect and use relevant information about disabled people and disability issues NZDS 5: Foster leadership by disabled people

	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Actions	**Measures**	**Action**			**Measures**		
2013/14	C1.3.11 Health passport is relaunched and linked to alerts programme	Baseline of numbers is electronically available for the first time via the icon The health passport is flagged within the alerts systems and utilisation is measureable	H1.3.11 Health passport is relaunched and linked to alerts programme	Baseline of numbers is electronically available for the first time via the icon The health passport is flagged within the alerts systems and utilisation is measureable	W1.3.11 Develop system for tracking health passport through Primary Care and Hospital system	Baseline of uptake of passport numbers is established	Jun-14	
2014/15	C1.3.12 CCDHB endorses disability responsiveness policy DHB wide	Policy has been implemented					Jun 15	

	3 DHBS		**Target date**	**Responsible**
	Action	**Measure**		
2014/15	3D1.3.13 Align disability polices across the 3 DHBs	Policies in all 3 DHBs are aligned by June 2015	Jun 15	
2015 -18	3D1.3.14 Implement sub regional policy	Sub regional policy is in place and visible in all systems	Jun 18	
2013/14	C1.2.14 Disability Action Group with representation from all levels of management oversees the implementation of the icon and passport	Passport reporting is included in Action Group monitoring	Jun 14	

	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Actions	**Measures**	**Action**			**Measures**		
2014/15	C1.2.15 Network of champions across the DHB is established and published on the DHB intranets and internets as a disability resource Identify clinical champions for disability responsiveness	Learning from CCDHB Action Group are shared and applied to 3 DHB leadership groups	H1.2.15 Network of champions across the DHB is established and published on the DHB intranets and internets as a disability resource	Active leadership group set up at Hutt Valley DHB	W1.2.15 Network of champions across the DHB is established and published on the internet as a disability resource	Network of champions across Hutt Valley and Wairarapa with local membership is set up led by SDA	June 15	

FOCUS AREA 2: Inclusion and Support

Our district will better include and promote the full participation of disabled people, and services will ensure the best support for disabled people and their family.

Strategic Objective 2.1	**Disabled children with their families are supported to grow, learn, have fun, develop and be connected with their communities.**	UN Convention Article 7: Children with disabilities NZDS 13: Enable disabled children and youth to lead full and active lives
Key Project 2.1.1	As part of a single child health service an integrated approach across the 3 DHBs will be used in planning for children	

	3 DHBS			
	Action	**Measure**	**Target date**	**Responsible**
2013/15	3D2.1.1 Develop a 3D child disability plan as part of child planning	Specific needs of children are addressed in planning, including those with chronic health conditions and congenital and developmental impairments	June 2015	

Key Project 2.1.2	Continue work with clinical and family group to Cornerstone as part of a national project to develop a module for General Practice around clinical effectiveness with Disabled children and young people	UN Convention Article 7: Children with disabilities NZDS 13: Enable disabled children and youth to lead full and active lives

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C2.1.21 Work with demonstration site Primary Care and CDS Team to establish pathway for transition	Evaluation of pathway informs the next step of transition project	H2.1.21 Carry out stocktake of CDS including waiting times and analysis of needs and service gaps. This iis linked into the MOH CDS stocktake	Baseline information from stocktake informs planning	W2.1.21 Carry out s stocktake of CDS including waiting times and analysis of needs and service gaps. Wairarapa access to CDS is limited	Baseline information from stocktake informs planning	June 2014	
2014/15	C2.1.22 Project presented for peer review to the panel of the Royal College of General Practitioners	Paper completed and presented to RCGP	H2.1.22 Work with CDS team Hutt Valley to establish improved visibility in Primary Care	Data shared with Primary Care Hutt Valley	W2.1.22 Work with CDS team Hutt Valley to establish improved visibility in Primary Care for Wairarapa children	Plan established for children with disabilities in Wairarapa	June 15	

Strategic Objective 2.2	**Where we have a role as funder or provider, working age disabled people are supported to live as they choose.**	UN Convention Article 3C: Full and effective participation and inclusion in society NZDS 1: Encourage and educate for a non-disabling society, DHB Strategic Objective 1.2
Key Project 2.2.1	Inclusion of disability clause in all new contracts to enable providers to be more responsive	NZDS 6,7,10,11,12,13,14,15

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C2.2.1 Include a standard disability clause in all health of older people, mental health and community contracts	NGOs report their plan and progress on implementing the disability strategy	H2.2.1 Include a standard disability clause in all health of older people, mental health, and community contracts	Services are asked to consider strategy to be integrated into business as usual 2014/15	W2.2.1 Include a standard disability clause in all health of older people, mental health, and community contracts	Services are asked to consider strategy to be integrated into business as usual 2014/15	Jan-13	

Strategic Objective 2.3	**People with experience of mental illness recover and live well**	Links to: UN Convention Article 25: Health
Key Project 2.3.1	Mental Health Strategic Leadership Group has disability expertise	NZDS 6,7,10,11,12,13,14,15

	3 DHBS			
	Action	**Measure**	**Target date**	**Responsible**
2013 - 18	C2.3.11 Lead set up of Guardianship Group for 3 DHB mental health	Guardianship Group in place across the 3 DHBs as part of the 3 DHBs strategic plan for mental health	Jun 15	Disability Advisor

Strategic Objective 2.4	**Our planning will include how we support people with disability**				UN Convention Article 25: Health			
Key Project 2.4.1	Inclusion of disability focus in all new and reviewed DHB plans and groups				NZDS 6,7,10,11,12,13,14,15			
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013 - 18	C2.4.11 Support DHB staff to include disability as they develop /update plans, including: children & youth, older people, mental health	% of plans developed with actions related to supporting people with disability	H2.4.11 Support DHB staff to include disability as they develop /update plans	% of plans developed with actions related to supporting people with disability	W2.4.11 Support DHB staff to include disability as they develop /update plans	% of plans developed with actions related to supporting people with disability	Ongoing	Disability Advisor

Strategic Objective 2.5	**Older people as far as possible live in their own homes, are well supported and optimal independence is restored, and carers are supported with no carer overburdened**		UN Convention Article 9: Accessibility NZDS7: Create Long-term support systems centred on the individual NZDS15: Value families, whanau and people providing ongoing support		
Key Project 2.5.1	Long Term Conditions Clinical Panel supports independence for under 65s with chronic health conditions				
	3 DHBs			**Target date**	**Responsible**
	Action	**Measure**			
2013- 18	C2.5.11 Work with older persons team to ensure planning includes a disability focus	Older persons plans have disability focus		Ongoing	
Key Project 2.5.2	A regional approach to improving service options will be implemented for people under 65				
	3 DHBs			**Target date**	**Responsible**
	Action	**Measure**			
2014/15	3D2.5.21 Develop regional panel for improved options	Regional panel in place		Jun 15	

Strategic Objective 2.6	We work with other entities to make our district and communities within it caring and more inclusive of everyone		UN Convention Article 9 – Accessibility & Article 25 - Health NZDS 1: Encourage and educate for a non disabling society NZDS7: Create Long-term support systems centred on the individual		
Key Project 2.6.1	Provide an effective community directory to ensure improved access particularly for those in transition to adult services.				
	3 DHBs			**Target date**	**Responsible**
	Action	**Measure**			
2013/14	3D2.6.11 Community Directory planning enhanced to extend across mental health community	Community Directory ready to go live July 14		July 1st 2014	

FOCUS AREA 3: ACCESS - Disabled people will have more independent access to services to meet their health support needs								
Strategic Objective 3.1	**Information and communication meet everyone's needs**					UN Convention Article 9 – Accessibility & Article 25 - Health NZDS8: Support quality living in the community for disabled people, NZDS1: Encourage and educate for a non-disabling society		
Key Project 3.1.1	We will develop and implement a New Zealand Sign Language policy					NZDS8: Support quality living in the community for disabled people,		
	3 DHBS						**Target date**	**Responsible**
	Action	**Measure**						
2014/15	3D 3.1.11 Develop a policy in conjunction with the deaf community for NZ Sign Language to be used across the 3 DHBs	NZ sign language policy developed					Jun-15	
2015 - 18	3D 3.1.12 Implementation of policy across the 3 DHBs	Policy in active and positive use in 3 DHBs					June 2018	
Key Project 3.1.2	Increase access to information about services across internet and intranet							
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C3.1.21 GP information updated	Clear linkages to accessibility information from relevant websites					Jun-14	
2014/15	C3.1.22 Seek feedback via Sub Regional Disability Advisory Group	Feedback informs future access audits						
Key Project 3.1.3	Produce newsletter and develop other forms of consumer engagement to invite feedback on CCDHB projects							
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
	C3.1.31 Regular 3 DHB disability Newsletter is set up	6 issues of newsletter per year. newsletter link is included in other publications such as the primary care newsletter	H3.1.31 Regular 3 DHB disability newsletter is sent out and other forms of media, including online surveys, email groups and social media are explored.	6 issues of newsletter per year.	W3.1.31 Regular 3 DHB disability Newsletter is sent out and other forms of media including online surveys, email groups and social media are explored.	6 issues of newsletter per year.		
Key Project 3.1.4	Plain language documentation becomes increasingly available across the 3 DHBs							
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
	C3.1.41 Ensure engagement with Patient Administration and Corporate Services	Plan for plain language at CCDHB developed	H3.1.41 Ensure engagement with Patient Administration and Corporate Services Review use of plain language in all public communications	Plain language use reviewed in all public communications	W3.1.41 Ensure engagement with Patient Administration and Corporate Services Review use of plain language in all public communications	Plain language use reviewed in all public communications		
Strategic Objective 3.2	Physical environment and signage meet everyone's needs					UN Convention Article 9 – Accessibility NZDS8: Support quality living in the community for disabled people		

Key Project 3.2.1	Improve responsiveness of primary care, secondary and community providers				**NZDS8.4*: Ensure disabled people are able to access appropriate health services within their community*** ***NZDS8.6: Encourage the development of accessible routes to connect buildings, public spaces and transport systems***			
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C3.2.11 Review documents for accuracy and currency with PHOs to identify barriers to integration	Key barriers updated and recommendations made for 14/15	H3.2.11 Work with PHOs to identify barriers to integration	Key barriers identified and recommendations made for 14/15	W3.2.11 Work with PHOs to identify barriers to integration	Key barriers identified and recommendations made for 14/15	Jun 14	
2014/15	C3.2.12 Patients with impairments have improved support to attend outpatients appointments	Numbers of people booking support from volunteers to reach their appointments	H3.2.12 Patients with impairments have improved support to attend outpatients appointments	Numbers of people booking support from volunteers to reach their appointments	W3.2.12 Patients with impairments have improved support to attend outpatients appointments	Numbers of people booking support from volunteers to reach their appointments	Jun 15	
Strategic Objective 3.3	**Our services are more welcoming and responsive** (Links to Objective 8 of the NZDS: Support quality living in the community for disabled people, and Objective 1: Encourage and educate for a non-disabling society.)				UN Convention Article 9 – Accessibility & Article 25 - Health NZDS: NZDS:			
Key Project 3.3.1	Access is improved and monitored across all DHB sites							
	CCDHB		**HVDHB**		**WDHB**		**Target date**	**Responsible**
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C3.3.11 In conjunction with CCDHB Disability Advisory Group remaining access issues are addressed with clinical and corporate services	Access issues are addressed					Jun 14	
2013/14	C3.3.12 Ensure parking at WRH is improved by inclusion of more parks within Riddiford to allow disabled people to utilise underground parking.	Increase of disability parks and blue signage for disability parks	H3.3.12 Investigate access requirements at HVDHB	Report of findings and recommendations Plan developed to gradually improve access	W3.3.12 Investigate access requirements at WDHB	Report of findings and recommendations Plan developed to gradually improve access	Jun 14	
	3 DHBS						**Target date**	**Responsible**
	Action	**Measure**						
2014/15	3D3.3.13 Review physical requirements across all sites through high level access audit	Access audit completed					Jun 15	
2015 - 18	3D3.3.14 Act on findings of access audit to improve access to services	Progress is made on improving physical access to services					Jun 18	

FOCUS AREA 4: LEADERSHIP

CCDHB will provide and/or share leadership with disability communities & others to develop, adapt & meet current and new expectations.

Strategic Objective 4.1	**The 3 DHBs will engage with disability communities and consumers**	UN Convention Article 4 – General Obligations, Consultation NZDS1: Encourage and educate for a non-disabling society NZDS5: Foster leadership by disabled people
Key Project 4.1.1	Sub Regional Disability Forum is held annually	NZDS1.2: Recognise that it is disabled people who are experts on their own experience

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C4.1.11 Disability forums are formalised and engagement is recorded. Feedback through Sub Regional Advisory Group and CPHAC DSAC	Sub Regional Forum is established At least one sub regional and one local forum per year	H4.1.11 Disability forums are formalised and engagement is recorded. Feedback through Disability Action Group and CPHAC/DSAC.	At least one sub regional and one local forum per year	W4.1.11 Disability forums are formalised and engagement is recorded. Feedback through Disability Action Group and DSAC.	At least one sub regional and one local forum per year	Jun-14	

Strategic Objective 4.2	**We will be an employer of choice for disabled people and their families**	UN Convention Article 3 – Social Inclusion NZDS4: Provide opportunities in employment and economic development for disabled people NZDS15: Value families, whanau and people providing ongoing support
Key Project 4.2.1	Human resource policies will be aligned across the 3 DHBs and will support employment choices for disabled people	

	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C4.2.11 Improve recordings of disability and positively support the provision of this information to include disability responsiveness	Positive and proactive engagement by disability leaders is required across all organisation 3 DHB Increase from baseline annually	H4.2.11 Establish baseline of staff identifying as experiencing disability	Baseline established in 13/14 Increase from baseline annually	W4.2.11 Establish baseline of staff identifying as experiencing disability	Baseline established in 13/14 Increase from baseline annually	Jun-14	
2014-18	C4.2.12 Promote value of Disabled People as employees Encourage use of subsidies where open employment is not an option	Increase from baseline annually	H4.2.12 Encourage a positive profile for staff who experience disability	Increase from baseline annually	W4.2.12 Encourage a positive profile for staff who experience disability	Increase from baseline annually	Jun 18	

	3 DHBs		Target date	Responsible
	Action	**Measure**		
2014/15	3D4.2.13 Align human resource policies across 3 DHBs as they relate to staff with disability	Policies in all 3 DHBs are aligned	Jun 15	

Strategic Objective 4.3	Ensure leadership of and engagement with Maori and Pacific people with disabilities	UN Convention Article 3 – Social Inclusion NZDS1: Encourage and educate for a non-disabling society NZDS5: Foster leadership by disabled people
Key Project 4.3.1	Improve responsiveness for Maori and Pacific peoples with disability in accordance with Maori and Pacific Disability Action Plans	

	3 DHBs		Target date	Responsible
	Action	**Measure**		
2013/14	3D4.3.11 Maori and Pacific leaders are engaged in Sub Regional Disability Advisory Group to support integration of Maori	Initial plans to improve disability responsiveness are implemented	Jun 14	

	and Pacific issues into disability planning				
2014/15	3D4.3.12 Sub Regional Disability Advisory Group with support from Maori and Pacifc representatives integrates needs of Maori and Pacific people into existing plans	Maori Partnership Board and Sub Regional Pacific Health Group endorse representatives on Disability Advisory Group		Jun 15	
2015-18	3D4.3.13 Implement identified actions	Progress is made against planned actions		Jun 18	
2014/15	3D4.3.14 Identify research findings to analyse gaps in access to disability support services for Maori and Pacific people led by Maori and Pacific disabled people.	Available information is used			

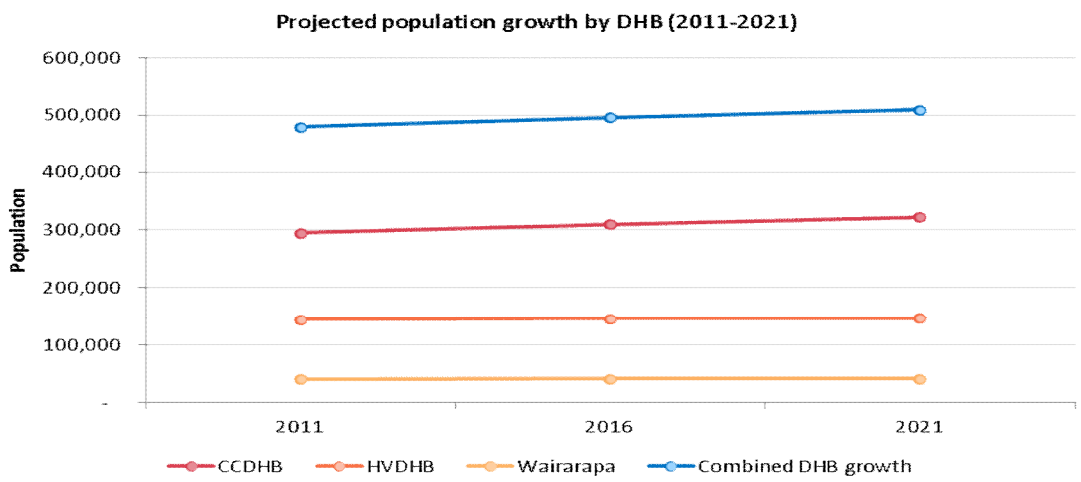
Strategic Objective 4.4	**We will grow and develop through research and innovation**	UN Convention Article 25 - Health NZDS1: Encourage and educate for a non-disabling society
Key Project 4.4.1	Contribute to research and innovation	

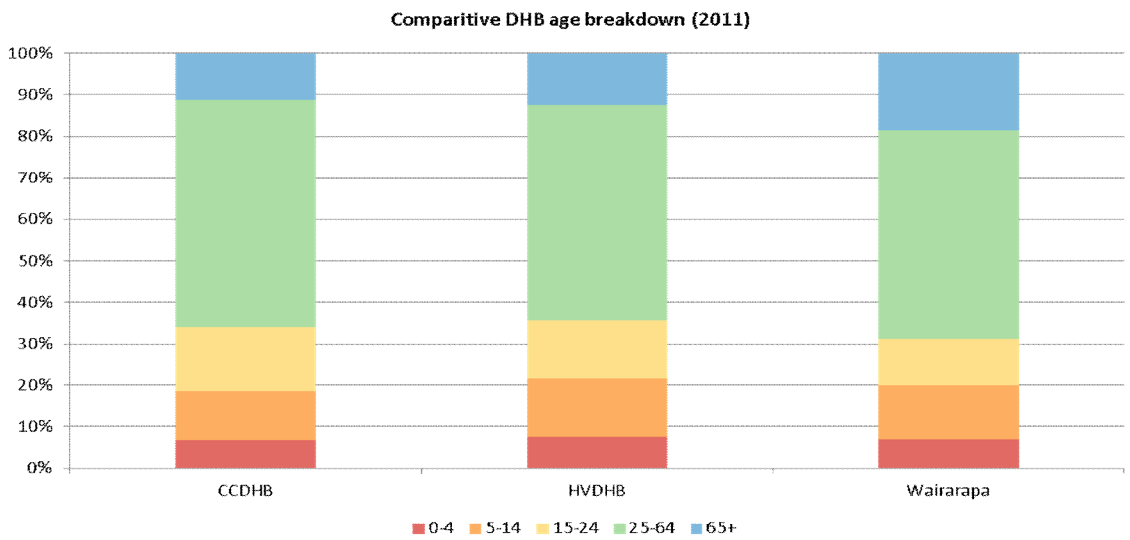
	CCDHB		HVDHB		WDHB		Target date	Responsible
	Action	**Measure**	**Action**	**Measure**	**Action**	**Measure**		
2013/14	C4.4.11 Collect evidence via disability alert on health service utilisation by disabled people	Evidence of health service utilisation is collated and analysed	H4.4.11 DNAs for disabled people are linked to equity indicators	Evidence of health service utilisation is collated and analysed	W4.4.11 Develop and conduct evaluation of how health passport meets users' needs	Aim for 1000 health passports	June 14	
2014/15	C4.4.12 Report and provide recommendations to 3DHBs on Health Passport Evaluation	Evidence collated and presented to the Health and Disability Commissioner			W4.4.12 Analyse collated health passport information	Evidence of health service utilisation is collated and analysed	June 15	

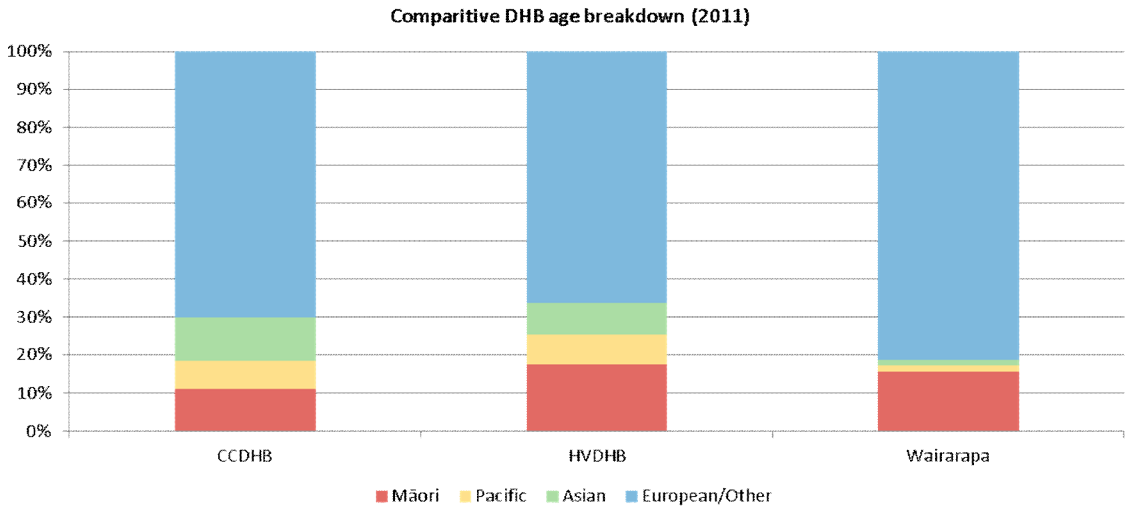
	3 DHBs				Target date	Responsible
	Action	**Measure**				
2015- 18	3D4.4.13 Violence against children and adults with disabilities is addressed via collaborative research with community clinicians	Research funding sought			June 18	
2015- 18	3D4.4.14 Develop research proposal to produce robust evidence on usage of health services by people with impairments.	Baseline data using high needs cohort is produced to inform services.			Jun 18	
2013/14	3D4.4.15 Sub egional Disability Plan is monitored via this process	Three deliverables are identified and documented with groups			Annual	

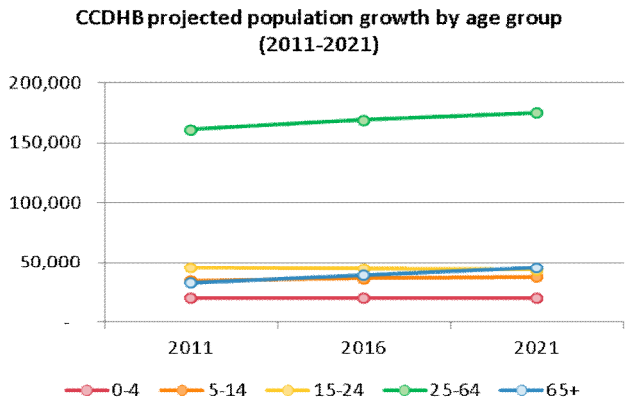
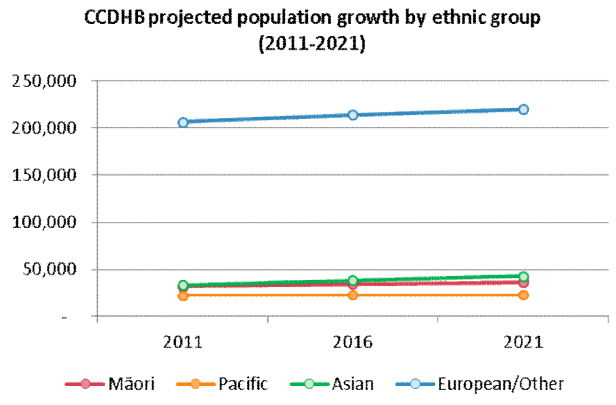
Appendices

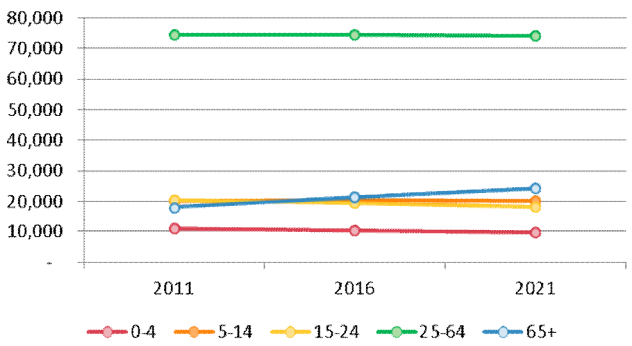
Appendix One - Sub-Regional Population Information: Projected Growth

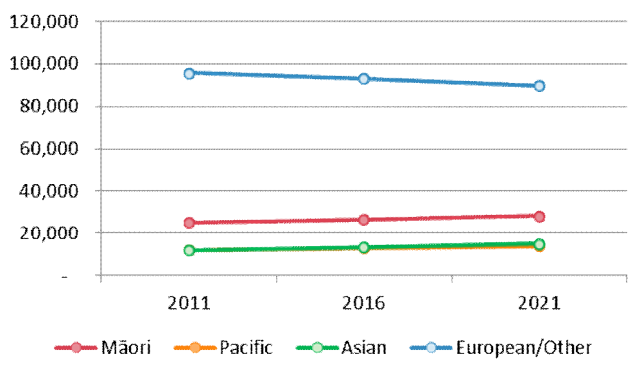


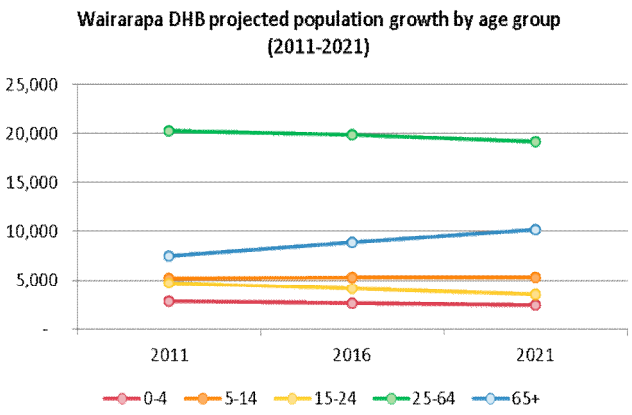


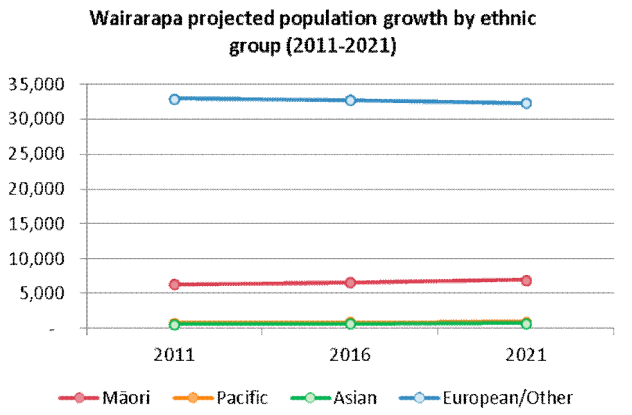


Population growth by age	Population growth by ethnicity
	


HVDHB projected population growth by age group (2011-2021)
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
2011
2016
2021
0-4
5-14
15-24
25-64
65+


HVDHB projected population growth by ethnic group (2011-2021)
120,000
100,000
80,000
60,000
40,000
20,000
-
2011
2016
2021
Māori
Pacific
Asian
European/Other


Wairarapa DHB projected population growth by age group (2011-2021)
25,000
20,000
15,000
10,000
5,000
-
2011
2016
2021
0-4
5-14
15-24
25-64
65+


Wairarapa projected population growth by ethnic group (2011-2021)
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
2011
2016
2021
Māori
Pacific
Asian
European/Other

Appendix Two - Disability Development Priorities & Actions

DISABILITY DEVELOPMENT PRIORITIES & ACTIONS		
Development Areas	***Development Priorities***	***Key actions***
1. DATA COLLECTION	• Accurate data essential for building knowledge, for identifying needs and planning services for people with disabilities. While the census data will give better population information, this is not specific enough for health service • Disability equity indicators framework for Board monitoring. • Inadequate consumer satisfaction data.	• Urgent need for classification of disability e.g using 10 categories in census question • Standardised patient information form for all hospitals a priority • Implementation of one assessment form with shared record between DHBs & PHOs • Board needs to be well informed • Linking across the DHBs is a key challenge, need regular reporting of disability data summary to consumer representatives from 3 DHBs. • Need to quantify the benefits of integration as a key outcome • Need for representation/membership at Board level
2 ENVIRONMENTAL ACCESS	• Consultation with disability experts often missing from new build projects • Health services, especially Primary Care services, often exclude people experiencing disability due to inaccessible features such as lack of hi/lo beds • Accreditation for access is achievable at a basic level and is not mandatory • Need to link with wider determinants of health agencies - housing, transport etc that impact on health	• Involve disability experts in planning for new build projects to include a range of experiences for universal design • Health services to work collaboratively with Primary Health Organisations and Cornerstone to raise the expectation that full access Is in the interests of all who use their service • Need to link with all agencies whose services impact on health determinant, for example, Regional and local councils and transport agencies
3 VALUE & RESPECT	• Disability responsiveness training for all staff is not a priority • Integration of understanding of disability support needs is not evident in the practices of many health professionals • Lack of clarity of access to interpreters for Deaf and where the funding responsibility lies	• Some services still have long waiting lists- develop responses to improve access • Review all programmes to ensure professional input on access for the whole population, not just the 70% • Health and disability support needs are inextricably linked. All systems need to address for example electronic record of health and disability • Manage my health in Primary care to include disability support information held in the health passport • Culture of responsibility for disability - should be across the organisation, not reliant on one individual. Acknowledgement of the need for leadership and champions who understand • Local needs analysis is required as part of overall sub-regional Health needs assessment • Improved Information systems that allow useful info to be collected for decision-making • Single electronic record across health and disability services
4 EDUCATION, INFORMATION & COMMUNICATION	• Importance of training pre- registration as above • Lack of information around Health Pathways • Less than 1% of staff within many Health Boards identifying as having disability • Health literacy programmes excludes many people with a range of impairments. Focus is often more on ethnicity	• Training in disability responsiveness for all DHB staff within current learning and development provision • A strategic focus on Learning and Development across DHBs will ensure professional input on disability within a co-design framework • Ensuring sustainable systemic change not impacted by the political demands of the day on District Health Boards • Ensure sustainability through quality monitoring perspective • Improve information on health pathways including within primary care • Improve plain language information for all • Ensure health passport is embedded across all health services and electronically available • Ensure health passport is central to all training and education • Develop strategy to increase utilisation of health passport
5 WORKFORCE & TRAINING	• DHBs need to acknowledge and value the lived experience of disabled people and employ them in a range of roles, not just administration roles • Policies should be developed to ensure workers reflect the current known population mix between 15 and 20%	• Training and development for staff and Board Members • Processes that support appropriate consideration of disability issues, for example, Admission and Discharge Plan • Input of disability expertise into tertiary training • Inclusion of mandatory training at a high level within health workforce guidelines

6 **SERVICE PROVISIONS**	• Lack of services within the community for people to maintain and improve health and wellness • Lack of habilitation and rehabilitation services for those with different needs. WHO recommended community based rehab • Whanau Ora concept not yet a reality for health and disability services • Systems remain difficult to navigate • People using services lack a voice in the planning of services • People with intellectual disabilities remain the most vulnerable within service provision	• Improved access to services required, especially equipment services, through better systemic advocacy with Ministry of Health • Improved early intervention for families with children with developmental needs • Improved discharge planning and service co-ordination/integration • Eradicate duplication and fragmentation • Whanau/family centred approaches especially for children and young people • Mechanisms to achieve this include: <u>System Change</u> • WHO recommended community based rehab, • Whanau Ora concept integrated to include disability • Multiple approaches to improving system navigation <u>Political Action</u> • Through a Royal Commission to create a viable, coherent system • Political lobbying to improve awareness of health disparity • DPO strengthening • 'improved community connections
7 **GOVERNANCE, PLANNING & RESOURCING**	• Lack of community engagement, particularly on specific disability equity in health services • Compliance monitoring ignores disability responsiveness • Absence of lived experience of disability at Board level • Tends to be little attention to having the disabled population involved in Board Committees formally, eg, not appointed by Minister –requires direct representation at the Board level and monitoring of equity in relation to the disability population	• Board champion for disability recommended • Sub-Regional dDsability Forum/Group to feed into Disability Partnership Board • Integrated model of responsiveness to Maori health need (ie, everybody responsible). Maori however should define what those needs are • Single Sub-Regional Plan across the 3 DHBs • Board papers to include consideration of impact on PWD (disability lens) at planning and operational levels including acknowledgement of need for senior input at key decision making • Resourcing of initiatives on population basis eg consideration of 20% disability population within all resourcing • Have a look at Wellington Regional Council Group and operationalise and link in to other consumer groups, for example, Hutt Valley Advisory Group

Appendix Three – Extract from Convention on the Rights of Persons with Disabilities

The **Convention on the Rights of Persons with Disabilities** is an international human rights treaty of the United Nations intended to protect the rights and dignity of persons with disabilities. Parties to the Convention are required to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law. The Convention has served as the major catalyst in the global movement from viewing persons with disabilities as objects of charity, medical treatment and social protection towards viewing them as full and equal members of society, with human rights.

There are eight guiding principles that underlie the Convention:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Full and effective participation and inclusion in society
5. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
6. Equality of opportunity
7. Accessibility
8. Equality between men and women
9. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities
10. The Convention follows the civil law tradition, with a preamble, in which the principle that "all human rights are universal, indivisible, interdependent and interrelated ". Vienna Declaration and Programme of Action is cited, followed by 50 articles. Unlike many UN covenants and conventions, it is not formally divided into parts.
11. **Article 1** defines the purpose of the Convention:
12. *to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity*
13. **Articles 2 and 3** provide definitions and general principles including communication, reasonable accommodation and universal design.
14. **Articles 4–32** define the rights of persons with disabilities and the obligations of states parties towards them. Many of these mirror rights affirmed in other UN conventions such as the International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights or the Convention Against Torture, but with specific obligations ensuring that they can be fully realised by persons with disabilities.
15. Rights specific to this Convention include the rights to accessibility (including information technology), the rights to live independently and be included in the community (Article 19), to personal mobility (Article 20), habilitation and rehabilitation (Article 26), and to participation in political and public life, and cultural life, recreation and sport (Articles 29 and 30).
16. In addition, parties to the Convention must raise awareness of the human rights of persons with disabilities (Article 8), and ensure access to roads, buildings, and information (Article 9).
17. **Articles 33–39** govern reporting and monitoring of the Convention by national human rights institutions (Article 33) and by the Committee on the Rights of Persons with Disabilities (Article 34).
18. **Articles 40–50** govern ratification, entry into force, and amendment of the Convention. **Article 49** also requires that the Convention be available in accessible formats.

Appendix 4 – New Zealand Disability Strategy Objectives

To advance New Zealand towards a fully inclusive society, the New Zealand Disability Strategy includes fifteen objectives, underpinned by detailed actions. The objectives are to:

	New Zealand Disability Strategy Objective	DHB Plan Strategic Objective
1	Encourage and educate for a non-disabling society	Yes
2	Ensure rights for disabled people	
3	Provide the best education for disabled people	
4	Provide opportunities in employment and economic development for disabled people	Yes
5	Foster leadership by disabled people	Yes
6	Foster an aware and responsive public service	Yes
7	Create long-term support systems centred on the individual	Yes
8	Support quality living in the community for disabled people	Yes
9	Support lifestyle choices, recreation and culture for disabled people	
10	Collect and use relevant information about disabled people and disability issues	Yes
11	Promote participation of disabled Mäori	Yes
12	Promote participation of disabled Pacific peoples	Yes
13	Enable disabled children and youth to lead full and active lives	Yes
14	Promote participation of disabled women in order to improve their quality of life	
15	Value families, whänau and people providing ongoing support.	Yes