Sub-Regional Disability Strategy 2017 – 2022

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

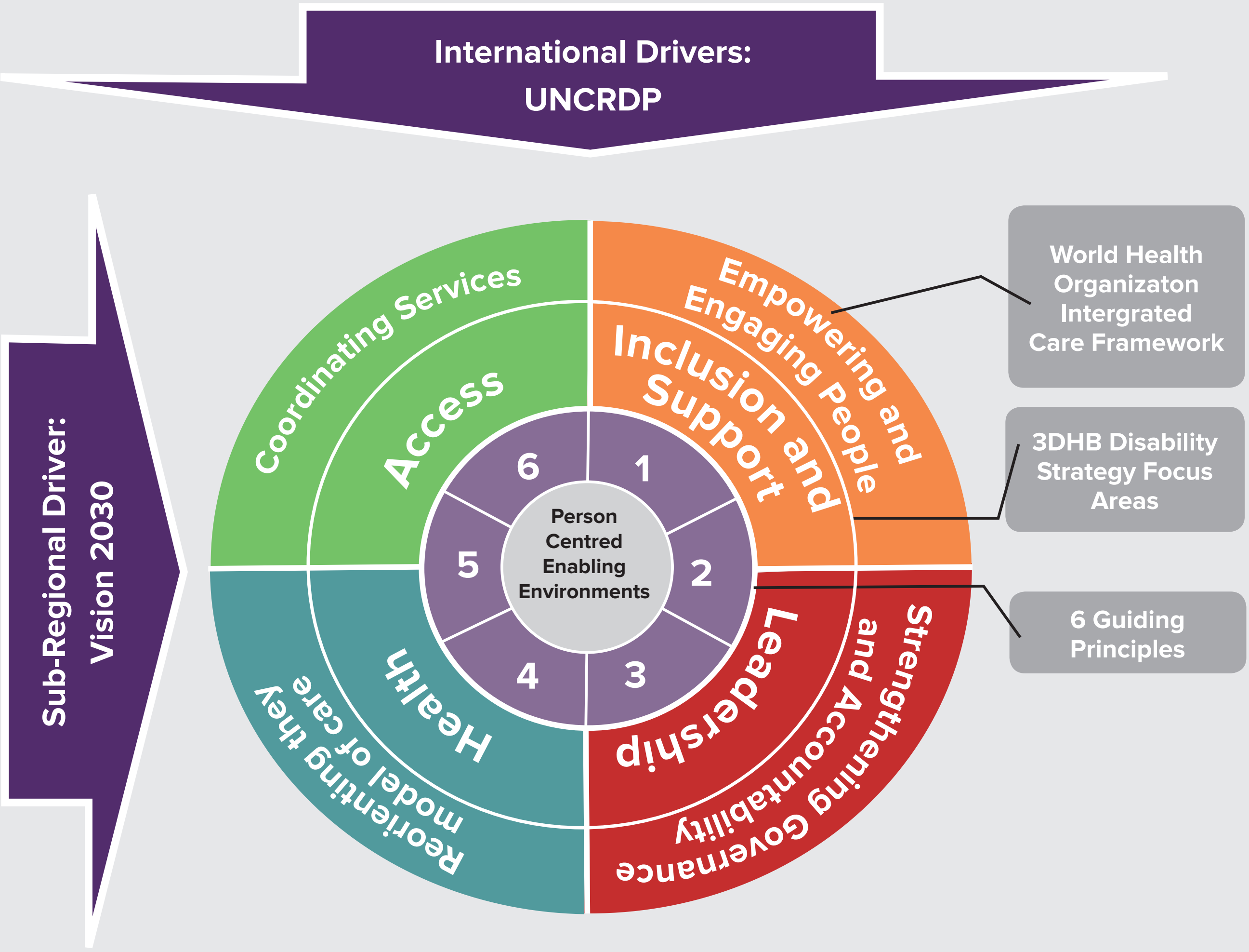
Enabling Partnerships: Collaboration for effective access to health services

Wairarapa DHB
Waira apa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

ENABLING PARTNERSHIPS:
COLLABORATION FOR EFFECTIVE ACCESS TO HEALTH SERVICES



International Drivers:
UNCRDP

Sub-Regional Driver:
Vision 2030

World Health Organizaton Intergrated Care Framework

3DHB Disability Strategy Focus Areas

6 Guiding Principles

New Zealand Drivers:

- Whaia Te Ao Marama: The Maori Disability Action (2012).
- Plan for Disability Support Services (2012 to 2017).
- He Korowai Oranga: Maori Health Strategy (2014).
- Faiva Ora – National Pasifika Disability Plan (2016).
- New Zealand Disability Strategy and Action Plan (2001).
- Public Health and Disability Act (2000).

Guiding Principles

1. Creation of an enabling and more accessible environment.
2. Inclusion of disabled people in the design of all services and activities.
3. Movement towards a holistic model of wellbeing that improves health outcomes for disabled people.
4. Improved support for people to make well informed decisions.
5. Strategies that build community resilience.
6. Active commitment to strengthening leadership and partnership across the sector.

Actions

1. Work alongside government agencies involved in the health and disability workforce and disability communities.
2. Develop an approach to engage communities alongside SRDAG and community networks.
3. Disability Strategy team leads implementation of good practice models (CoDesign etc) for both hospital and community staff.
4. Partner with Maori to collaboratively design and implement initiatives that achieve equity in health.
5. Prioritise monitoring of data as measure to show improvement and check quality.
6. Model safe CoDesign practices where individuals and whanau are respected for their experience, community linkages and expertise.

Outcomes

1. A disability literate health workforce who work to local and national practice standards.
2. A seamless, ‘whole of life journey across health system where individuals and whanau are well informed.
3. Within 10 years the health work force are able to deal with cross system complexity.
4. Disability Communities are health literate. Meaning they are able to: identify individual and whanau support needs, share knowledge and support each other.
5. Where Staff use person centred/directed approaches so that individuals and whanau are included in decision making.
6. Health equity is achieved through partnerships; which lead to the break down of system barriers and changes, which benefit the whole population.

FOREWORD

As the three chief executives of the sub-regional district health boards, we have been involved in and endorsed the development of this updated strategy.

The strategy provides both challenges and opportunities.

The continuing work with communities on disability strategy and actions is forward thinking, practical and has already made a difference in the health journey and lives of people from all age groups. These developments and our united approach across the sub-region are something to be proud of.

This plan continues the journey and aims to improve health outcomes for future generations.

Naku noa na

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- Participants of local forums 2014–2016.
- The Sub-Regional Disability Advisory Group (SRDAG) and their allies.
- The three Chief Executives and their teams.
- The three district health board members.
- The Disability Strategy and Performance team across the sub-region.

> *"The work being undertaken in the Wellington sub-region to improve health services and health outcomes for people with disabilities, is not only of significance nationally but also of international significance."*

Paul Gibson Disability Rights Commissioner
3 June 2016 – Sub-regional disability forum, Silverstream Retreat

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THE PURPOSE OF THIS DOCUMENT

1 in 4 New Zealanders experiences disability. *2013 census*

Disability can include physical, mental health, intellectual, sensory and other impairments. Disability is created by various barriers that hinder the full and effective participation of people in society on an equal basis with others.[2]

This document provides a clear strategic direction for leaders within the health sector working with disability communities to address inequities across the population and ensure better health outcomes.

In the context of health services, those who have a range of clinical and support requirements tend to have the most complex interactions with the health system. The easier it is to navigate vital health services, the more enabling the health system becomes. With this in mind, we are moving to a more positive, proactive approach that will improve health systems and services for all, including those with the highest needs. The approach in this Strategy is consistent with mainstream policy on integration and innovation. This includes the call for services closer to home and a more people powered health service.

The aim of this Strategy is to provide guidance, direction and structure for all stakeholders involved, including DHB Hospital Services, funders, contracted services and their intersectoral partners.

Internally, the Strategy and the table of priorities will be complemented by a detailed dashboard of indicators.[3] This sits alongside a monitoring framework which will enable tracking and reporting progress against each expected outcome. Each priority area has a significant work plan allocated to key people which will be used by the Disability Strategy Team led by the Director of Disability Strategy and Performance.[4]

The Strategy reinforces a commitment by the three DHBs to involve and collaborate with disability communities and their allies across the sub-region. The Strategy is a published document, and a more detailed work plan and dashboard is available on request.

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[2] This is adapted from the definition used in the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities.

[3] Endorsed at the sub-regional intersectoral forum ‘Develop a performance monitoring framework to measure success’.

[4] SIDU was disestablished on 9 January 2017 and each of the three DHBS have established their own directorate or unit responsible for planning and funding. The office of the Director of Disability Strategy and Performance is based in the CCDHB Service Innovation and Performance Directorate. The work continues to be developed across all three DHBs.

THE REVISED STRATEGY AND HOW IT HAS BEEN DEVELOPED

The strategic priorities presented in this document are based on stakeholder feedback, most recently from participants of the Sub-regional Disability Forum held on 3 June 2016 at the Silverstream Retreat. The forum was attended by the Minister for Disability issues, the CEOs of Wairarapa, Hutt Valley and Capital & Coast DHBs, and consumers and leaders from across the sector. The content has been developed through a co-design process led by the Disability Strategy and Performance team with an expert group of leaders from Sub Regional Disability Advisory Group (SRDAG) and other partners. The diagram at the beginning lays out a strategic road map including community identified principles, high level expected outcomes and key major actions proposed.

Section one of the Strategy provides a background to the development of strategic priorities. They have been informed by the following foundational documents:

- UN Convention on the Rights of Persons with Disabilities (2008).
- Public Health & Disability Act (2000).
- The Treaty of Waitangi.
- New Zealand Disability Strategy (2001).
- New Zealand Disability Action Plan (2001).
- He Korowai Oranga: Māori Health Strategy (2014).
- Faiva Ora: National Pasifika Disability Plan (2016).
- Whāia Te Ao Mārama: The Māori Disability Action Plan (2012).
- Sub-Regional Disability Plan 2013–2018 (Valued Lives, Full Participation).

Section two presents an overview of the outcomes of the current sub-regional plan and programme of work up to December 2016.

Section three provides lists of priorities under each focus area and expected outcomes. This section clarifies what change will mean for people and their allies.

Section four gives an overview of a strategic framework that will guide the downloadable year-by-year action plan. A link to the table is available to download from our website (www.ccdhb.org.nz) under Disability Responsiveness. For more discussion of work plans and specific projects, please call 0800 DISABILITY (0800 3472245489).

TERMINOLOGY

For the purposes of this document the term ‘disabled people’ is used most often, reflecting language used in the Government Disability Action Plan (2014–2018). We acknowledge an important partnership with People First who are a self advocacy organisation that is led and directed by people with learning (intellectual) disabilities. People First members prefer 'people with learning disabilities' while other groups describe ‘people who experience disability’. [1]

Other terms less used here include: ‘people with impairments’, ‘tangata haua’ and ‘people with disabilities’.

The terms impairment and disability are dynamic and interchangeable, as a change of environment and circumstance can significantly increase the level of disability.

Throughout the document we refer to the Sub-Regional Disability Strategy as ‘the Strategy’.

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[1] This term is sometimes preferred to reflect that the disability is not the impairment itself – it is rather the barriers experienced as a result of the impairment. Intellectual disability is still used as a diagnostic term hence the preferred terminology.

SECTION 1: BACKGROUND

1.1 Meet the disability population in the Wellington sub-region

Disability communities in the greater Wellington region are rich in their diversity and breadth of experience. Factors such as age, gender and ethnicity are critical, but even more importantly a unique individual and group identity has emerged. This has emerged from from promotion of 'disability pride' by disability advocates. Disabled people locally, nationally and internationally have fought for recognition of their full potential as citizens and for the rights now enshrined in international legislation. There are many people who have life-long impairments as well as a growing number who acquire disability later in life, often as a result of long-term health conditions.

Census data has provided some information about the Greater Wellington disability population but there is still a lot to learn as data improves. The infographic below shows the population broken down by age. We know that Māori and Pacific disability prevalence rates are higher than the total population, even after adjusting for differences in their respective age profiles.

As of 2013, 32 percent of Māori and 26 percent of Pacific peoples have a disability.[5] There is overwhelming evidence of the need to improve access to health and disability services for Māori and Pacific people. To make changes over the next five years, we need to know more about the barriers people face.

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[5] Statistics New Zealand, 2013, New Zealand Disability Survey, http://www.stats.govt.nz/browse_for_stats/health/disabilities/disabilitysurvey_hotp2013.aspx

‘Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.’ *United Nations Convention of Rights of Persons with Disabilities*

1.2 International drivers

New Zealand signed the United Nations Convention on Rights of Persons with Disabilities [6] (UNCRPD) at the United Nations in 2007, and ratified it in 2008. The purpose of the Convention is 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.’ [7]

1.3 New Zealand: A unique bicultural nation

The New Zealand Public Health and Disability Act 2000 (NZPHD Act) laid out specific expectations for DHBs to follow regarding disability support. This was strengthened by The New Zealand Disability Strategy (NZDS) launched in 2001 and recently updated in 2016. This aims to guide the work of government agencies in addressing disability issues until 2026. The strategy outlines eight outcome areas and the updated sub-regional plan is similarly modelled as a strategy for health services. It has provided guidance to policy makers on eradication of systemic, attitudinal and structural barriers in all aspects of service delivery and legislation. This was clear in its vision for ‘a society that highly values our lives and continually enhances our full participation’. The NZDS[8] 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.’*

The goals within the NZPHD Act established new expectations for all organisations and professionals operating within the health and disability sector. These expectations include; improved health, independence, participation and inclusion of disabled people. Their aim was to provide guidance to health services to eliminate disparities and provide quality care for all people with disabilities. The Disability Support Advisory Committees (DSACs) within DHBs were established as a result of the Act requiring DHBs to reflect the principles from the NZDS (newly updated 2016) and the UNCRPD in all their health policies.

Aotearoa New Zealand follows the Treaty of Waitangi’s three main principles of Partnership, Participation and Protection. In health, the Treaty is used alongside the current New Zealand Public Health and Disability Act 2000 (NZPHD) to ensure equitable health outcomes for Māori.

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[6] United Nations. *United Nations General Assembly A/61/611 Convention on the Rights of Persons with Disabilities Dec 2006,* www.un.org/disabilities/default.asp?id=61 (accessed Nov 14, 2016)

[7] Office for Disability Issues, *United Nations Convention on Rights of Persons with Disabilities,* www.odi.govt.nz/united-nations-convention-on-the-rights-of-persons-with-disabilities

[8] Dalziel, L. (2001). The New Zealand Disability Strategy: Making a world of difference: Whakanui Oranga. Wellington: Ministry of Health.

[9] Office for Disability Issues, *New Zealand Disability Strategy 2001,* www.odi.govt.nz/nz-disability-strategy/about-the-strategy/new-zealand-disability-strategy-2001

[10] Ministry of Health, He Korowai Oranga: Māori Health Strategy, www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

1.3.1 He Korowai Oranga: Māori Health Strategy

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori. [10] The incidence of poorer health outcomes for Māori is caused by a variety of social determinants which are reinforced where people also live with long term health conditions or lifelong impairment. The particular access issues for Māori with disabilities are addressed in a dedicated action plan as described below.

1.3.2 Whāia Te Ao Mārama

The Māori Disability Action Plan [11] for Disability Support Services was similarly conceived to enable tangata haua (Māori people with disability) to achieve their aspirations and to reduce barriers that may impede them and their whānau. This plan reflects a number of priorities that collectively seek to improve outcomes for Māori by incorporating a range of new and innovative support options, providing greater choice and control, and ensuring that all services are culturally appropriate. The plan also recognises the need to ensure better support for whānau, partnerships with Iwi and Māori communities, and effective monitoring and reporting.

1.3.3 Pacific Nations and Disability

The Ministry of Health's 'Faiva Ora: National Pasifika Disability Plan' sets out priorities that guide us when working towards the wellbeing of Pacific peoples with disabilities. The plan clearly includes those who have long-term physical, mental, intellectual or sensory impairments. Interaction with various barriers may hinder the full and effective participation of these people in society on an equal basis with others.

We recognise that the term 'Pacific communities' includes a number of Pacific Island nations, each with its own language and culture, each of which are to be respected. There are some commonalities across the community in terms of their collective values, gatherings, identities and the role culture, stories and values in their lives. The church features largely as a central meeting place for the community and could provide greater opportunities to connect with people with disabilities.

Understanding 'disability' within Pacific communities is evolving. The Convention on the Rights of Persons with Disabilities has created a shared understanding that informs our collective conversations. Culturally respectful relationships with Pacific peoples with disabilities are critical to ensure development of culturally accessible health services. [12]

> *'People with disabilities have generally poorer health, fewer educational achievements, less economic opportunities and higher rates of poverty due to the lack of services available to them'. World Health Organization 2011*

1.4 The health of disabled people

The World Health Organization report recommends increasing awareness of disability issues and the inclusion of disability as a component in international and national health policies and programmes. [13]

Measurement of health equity for disabled people is largely excluded from nationwide health needs assessment reports. Lack of coherent data has contributed to this gap as well as the discrete separation of funding and services for health and disability.

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[11] Ministry of Health, Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017, www.health.govt.nz/publication/whaia-te-ao-marama-maori-disability-action-plan-disability-support-services-2012-2017

[12] Ministry of Health, Faiva Ora – National Pasifika Disability Plan, www.health.govt.nz/our-work/disability-services/pasifika-disability-support-services/faiva-ora-national-pasifika-disability-plan

[13] *World Health Organization,* World report on disability, www.who.int/disabilities/world_report/2011/en/

National research into the health of people with learning disabilities [14] identifies the much higher rates of chronic illness and early death for this group of people. In 2013 another research report was commissioned by the Ministry of Health and Te Pou o te Whakaaro Nui to look more widely at access to health services. [15] The report outlines multiple barriers faced by people of all ages and disability categories when accessing primary and secondary care. [16]

This has contributed to a call for action on access for people with learning disabilities, with an initial national focus on primary care strategy. 59 percent of people over 65 now identify as having a disability and there is no doubt that health and wellbeing will deteriorate for many with the ageing process. It is likely that fewer people who have lived with lifelong disability are represented in the over 65 age group. Although data is difficult to obtain to back this assertion, research has revealed that life expectancy is often reduced particularly for people with certain conditions. [17]

It is notable that in the 2017/18 annual planning guidelines the Minister has included Disability Support as a planning priority and is asking for reporting from all DHBs on disability training for staff and use of a range of tools to improve access to health services for disabled people. This is warmly welcomed by disability community leaders as a milestone in the journey for health equity.

1.5 Disability literacy and the health workforce

Over the past 25 years disabled people have advocated for a change in the way disability is defined. Over the same period de-institutionalisation [18] has occurred nationally and internationally so people formerly locked away have become present and visible in the community. Both policy and philosophy have led to a shift away from what is known as a ‘medical model of disability’ where the focus is on individual deficiencies, or what is ‘wrong’ with the person. The more inclusive social model of disability makes a distinction between impairments (which people have) and disability (which lies in their experience of barriers to participation). This change in perspective has led to a reduction in what disabled people describe as disability literacy particularly within the health workforce.

Patient centred and person directed care terminology [19] is now embraced as significant across mainstream health services and is providing a means of greater understanding of the health experience of people with disabilities. ‘Patient centred care’ takes place when the person’s preferences, needs and values are taken into account. In turn, the patient-centred care puts the individual in control of their own care, driving the decision-making process. Both concepts are relevant as they will apply to different individuals. These approaches benefit all people who have multiple interactions with health services and will improve the experience of those with long term health conditions, as well as people of all ages with life long impairments.

The success of the Health System Plan (Vision 2030) which has been proposed by the sub-regional DHBs depends on a shift from service-centric planning to an approach that is led and directed by people in their communities. [20] This Strategy is consistent with that vision and direction, and provides initial steps to its achievement for disabled people.

In line with the social model of disability, there is a continued push for policies which remove barriers for people with disabilities and enable them to participate in all areas of society.

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[14] Ministry of Health, *Living a good life, 2001, and Health indicators of people with intellectual disabilities,* 2011.

[15] Te Pou o te Whakaaro Nui, *Improving access to primary care for disabled people,* www.tepou.co.nz/library/tepou/improving-access-to-primary-care-for-disabled-people

[16] The research provides a thorough literature review and is timely in the focus for the wider population on better sooner more convenient and integrated primary and secondary care. The work on improving access to primary care has been facilitated in the Wellington sub-region as part of reporting against key focus areas of the disability plan (2013–2018). Practices with poorer populations are now making good progress on consideration of disability and have embraced the need for staff training in improved disability literacy and the need for tools such as disability alerts.

[17] People with intellectual disabilities are 4.5 times more likely to die prematurely than their peer group (Ministry of Health. 2011. Health Indicators for New Zealanders with Intellectual Disability.). Those who do survive age prematurely and are experiencing access issues to Age Residential Care. ARC providers understand the clinical needs but the behaviours caused often by trauma due to change of environment cause problems for staff. Workforce development is being implemented for affected providers. Other degenerative disabilities lead to premature death at a much younger age. Huntingdon’s Disease, Muscular Dystrophy and Motor Neurone Disease are examples of such conditions but there are many more.

[18] In the Wellington sub-region between 1992 and 1997 Porirua Hospital moved hundreds of people with intellectual disabilities and mental illness into the community. Kimberley Hospital in Levin was later closed.

[19] It is acknowledged that within health services people still identify as patients and are referred to as patients. A discussion and emphasis on approaches to how people are supported in health is seen as more critical than an attempt at this stage to change language comprehensively.

[20] Vision 2030, December 2016 Health System Planning.

SECTION 2: WHERE WE ARE NOW

2.1 Planning health services within the Wellington sub-region

In 2013, an implementation plan for Wairarapa, Hutt Valley and Capital & Coast DHBs (sub-regional DHBS) was created. It aimed to identify and address specific inequities within health services for each of the local communities and to reflect the principles of the NZDS and the more recent UNCRPD. The 2013 plan was developed and led by the Service Integration and Development Unit with combined board sub-committees and the newly established Sub-Regional Disability Advisory Group (SRDAG). A mandate and overwhelming support for the work was given at the first sub-regional forum in 2013 at Orongomai Marae. It was attended by disabled people, family members as well as health and disability professionals from each locality within the sub-region.

The three DHBs in the Wellington Region have shown leadership in their joint endorsement and ongoing support for the establishment of SRDAG. The commitment to a joint approach for disability remains and a small team led by the Director of Disability Strategy and Performance provides leadership and support for the three DHBs.

Additional sub-regional and local forums were held from 2013 to 2016 to monitor and update key priorities for each population.

The results of a comprehensive process of co-design, collaboration and community engagement have informed this document and the updated planned priorities.

2.2 What we have achieved

The timeline above shows the long road we are all still on towards equitable health outcomes for people with disabilities. Along the way there have been many achievements thanks to the commitment from the three DHBs. The diagram below outlines in more detail some of the work undertaken to date and the influences of the updated Strategy.

A number of committed leaders have successfully demonstrated system and service changes over the last few years. Successive Chief Executives locally and sub-regionally have made a commitment to leadership on disability. A Senior Disability Advisor role established in 2009 at CCDHB became sub-regional in 2013. Leadership demonstrated by the Chief Executives has made the work of the sub-regional DHBs nationally significant. Other DHBs are learning from the implementation of the plan that transformation occurs through initiatives that are innovative, community-driven and personcentred. Well-planned integration within business as usual practices has embedded these learnings.

Changes across the sub-region have been gradual, but staff and communities across all localities have embraced the changes. The relationships between service users and DHBs have been improved by increased visibility, transparency of communication (including collaboration and planning with communities of interest) and obvious willingness by DHBs to recognise the real issues faced by people with disabilities.

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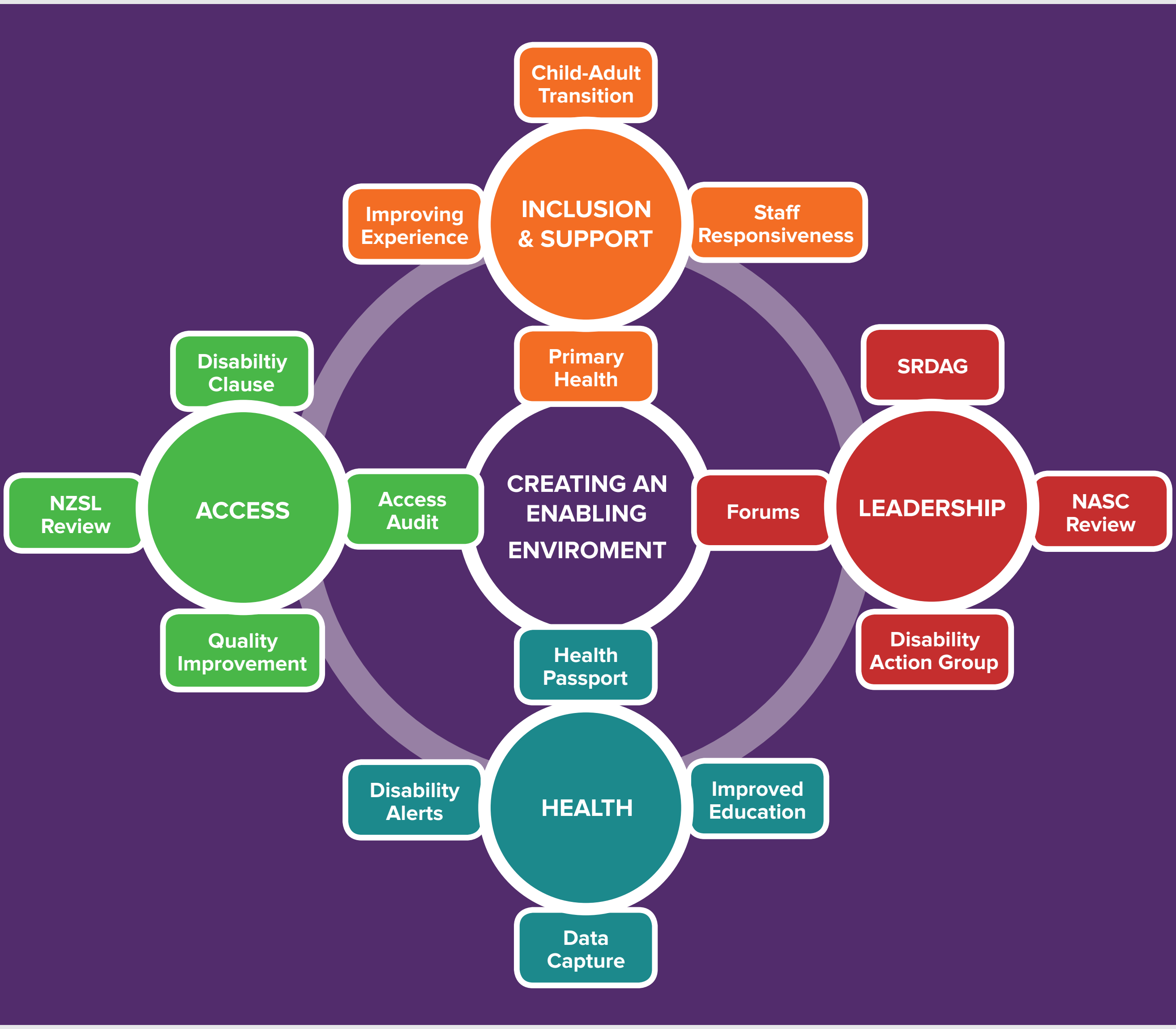
[21] CPHAC/DSAC community and Public Health advisory committee and Disability Support Advisory Committees joined to support the work of the three DHB unit SIDU.

[22] The Office of the Director of Disability Strategy and Performance has oversight of disability programmes across the sub-region and sits within the new CCDHB strategy innovation and performance directorate.

Mainstream health services provide the best base for improved practice and are funded for the whole population. However, health services must work in a sustainable manner to meet the challenges that exist. These strategies and principles also reflect current health thinking with the added innovation of disability communities who are best placed to lead and drive their own health care.



2.3 Valued Lives, Full Participation: Sub-Regional Disability Plan 2013–2018

In partnership with disability communities, the sub-regional DHBs launched in 2013 an implementation plan for the New Zealand Disability Strategy and the United Nations Convention on Rights of Persons with Disabilities.[23] Key goals are as follows:

- Improve the health of disability communities.
- Increase independence, participation and inclusion of disabled people.
- Reduce disparity.
- Ensure better care.

Below is a brief summary of what was achieved in relation to the Plan's four focus areas and what it meant for all involved.

Throughout the document we refer to the Valued Lives, Full Participation: Disability Plan as 'the Plan'.

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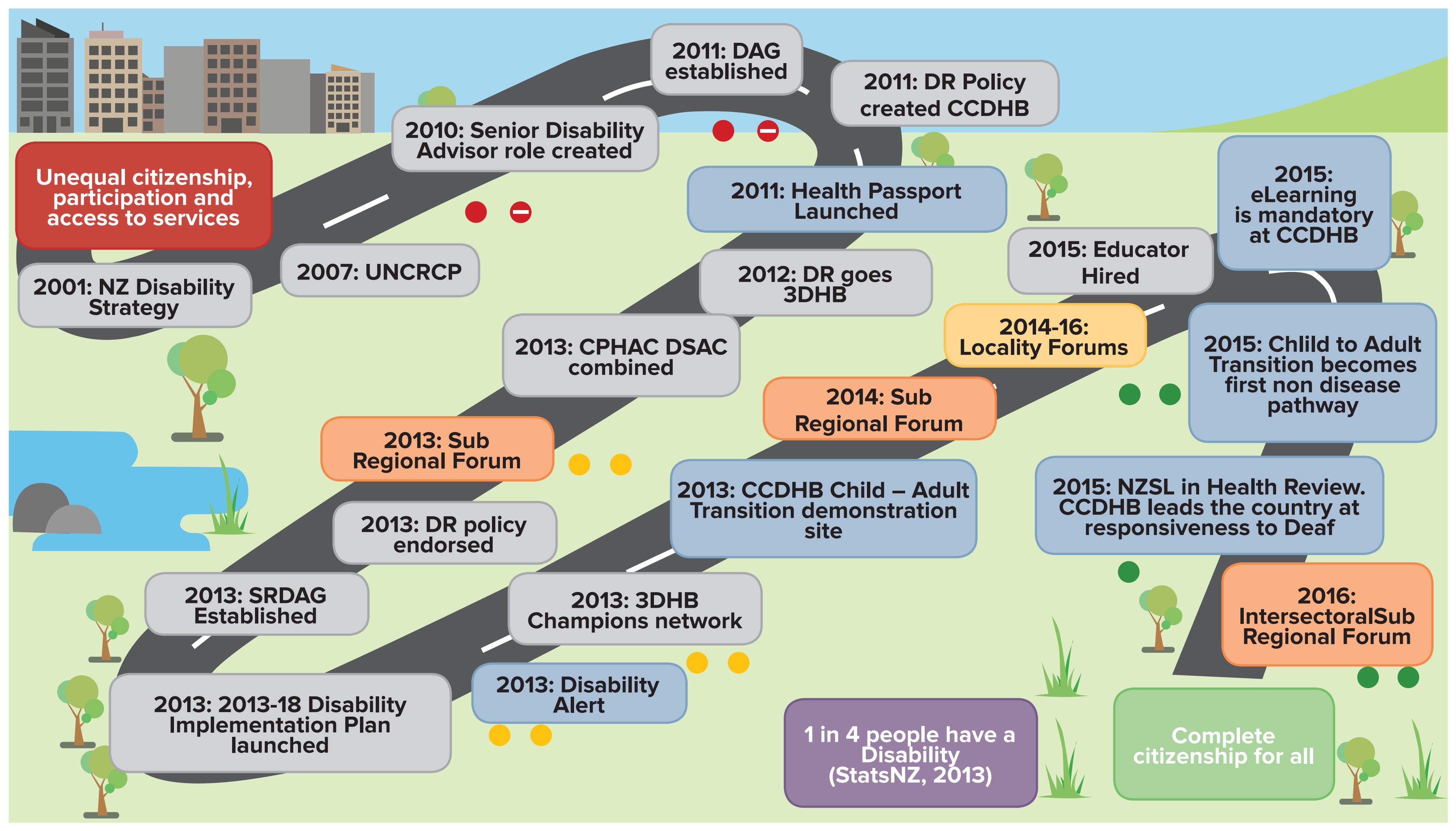
[23] *Valued Lives: Full Participation, Implementation Plan 2013–2018,* www.huttvalleydhb.org.nz/about-us/reports-and-publications/other-planning-documents/disability-strategy-implementation-plan-2013-2018.pdf

FOCUS AREAS	THE STRATEGIC GOAL
ONE – LEADERSHIP: Wairarapa, Hutt Valley and Capital & Coast DHBs will provide or share leadership with disability communities and others to develop strategies to meet and adapt to current and new expectations.	The three DHBs will engage with disability communities and consumers.
	We will be an employer of choice for disabled people and their families.
	Ensure leadership of and engagement with Māori and Pacific peoples with disabilities.
TWO – 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.	Disabled children will be supported to live and grow as they choose.
	Where we have a role as funder or provider, working-age disabled people are supported to live as they choose.
	People with experience of mental illness recover and live well.
THREE – ACCESS: Disabled people will have more independent access to services to meet their health and support needs.	Information and communication meet everyone's needs.
	Physical environment and signage meet everyone's needs.
FOUR – HEALTH: Health Disparities will be reduced by providing best care and improving, protecting and promoting the health of disabled people.	Primary Health Care and better integration across services keep disabled people healthier and address their needs earlier.

HOW WE ACHIEVED THIS	WHAT THIS MEANT FOR US
Sub-Regional Disability Advisory Group (SRDAG) was developed and now govern, implement and champion our work programme in the community.	SRDAG demonstrate the critical importance of leadership by disabled people and show the diverse talents of disabled people irrespective of impairment type. SRDAG is a clear example of successful co-design.
All three DHBs have demonstrated openness to employment of disabled people and implemented a range of trainee schemes. In order to support disabled people in the workforce we have adapted the Equal Employment Opportunity Form to ensure the DHB meet the support needs of employees with disabilities.	We are starting to change the culture around employment of people with disabilities; this will ultimately grow into a more diverse workforce.
We held a Hui 2010 and Fono in 2012 to meet and engage with consumers. The Māori and Pacific expertise on SRDAG has led better understanding of barriers faced by Māori and Pacific peoples with disabilities.	The commitment to reducing barriers for Pacific peoples with a disability has been proven as it is now included as a top priority in the CCDHB Pacific Plan. Māori with disability are represented at and listened to at a senior level.
A project focusing on the needs of children and whānau in transition from child service to adult services.	Young people, their whānau, primary care and hospital services are working together to co-design better systems and tools.
When the DHB acts as a funder, any contract provided now includes a disability clause so providers report on what they are doing to improve access for people with a range of impairments in their services.	The Disability Clause creates a mandate for providers to rethink what access means. Community services and other providers are starting to become more accessible to disability communities.
A disability perspective has been integrated into mental health services and consumer groups.	The inclusion of a disability perspective to discussions has started to address access issues and promotes co-design.
We conducted comprehensive research with New Zealand Sign Language users leading to an improvement on current interpreter policy and the creation of staff education plans.	As well as publishing research, we have created a five year work plan targeting isolated deaf people, New Zealand Sign Language users and staff to improve access to health services.
As part of a full communication plan, the internet and intranet pages have been updated. Video resource has been created with captions.	Information has become more readily available and accessible.
Access audits across Hut and Wairarapa DHBs facilitated training and some simple changes to improve access in each locality.	We continually work to improve physical access and implement audit results.
Health Passport launched sub-regionally.	The expertise and needs of people and their whānau are recognised and respected.
Disability Alert implemented. This has led to a programme which gathers data to help to plan services. It also puts the patient's preferences in the hospital computer system where needs are identified.	In a national first, data is available to monitor how people use the health system. This helps improve the patient journey and ensure their needs are met safely and without delay.
We now have access to tools such as eLearning and video resources which were made alongside people using services. Such education is now mandatory for all staff in direct contact with patients.	Health professionals and consumers are more confident in discussing experiences. This allows us to make more targeted education plans.
A network of expert champions was established by CCDHB Disability Action Group to advise both staff and service use.	A network of champions who work across community and hospital services have often provided quick and timely information to enable people and their families – to take control of their health journey.

Disability Responsiveness 2011 – 2016 The Road so Far:



Unequal citizenship, participation and access to services

2001: NZ Disability Strategy

2007: UNCRCP

2010: Senior Disability Advisor role created

2011: DAG established

2011: DR Policy created CCDHB

2011: Health Passport Launched

2012: DR goes 3DHB

2013: CPHAC DSAC combined

2013: Sub Regional Forum

2013: DR policy endorsed

2013: SRDAG Established

2013: 2013-18 Disability Implementation Plan launched

2013: Disability Alert

2013: 3DHB Champions network

2013: CCDHB Child – Adult Transition demonstration site

2014: Sub Regional Forum

2014-16: Locality Forums

2015: Educator Hired

2015: eLearning is mandatory at CCDHB

2015: Chlild to Adult Transition becomes first non disease pathway

2015: NZSL in Health Review. CCDHB leads the country at responsiveness to Deaf

2016: IntersectoralSub Regional Forum

Complete citizenship for all

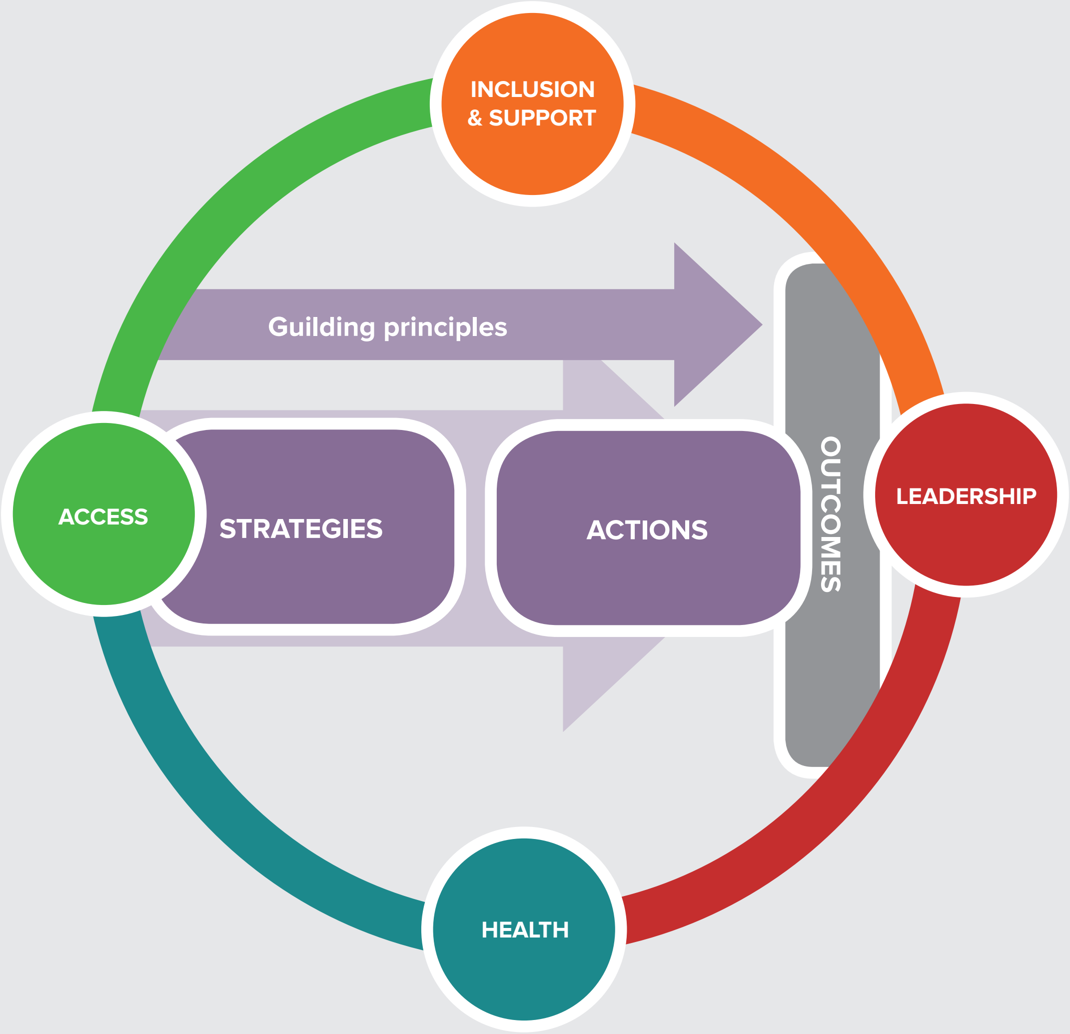
1 in 4 people have a Disability (StatsNZ, 2013)

SECTION 3: MOVING FORWARD

3.1 How to read this section

This section gives the detail of the Disability Strategy 2017–2022, Enabling Partnerships: collaboration for effective health services. There are four levels of detail in the Strategy:

- The guiding principles.
- The four focus areas.
- The strategic framework under each focus area.
- What achievement will mean for people (predicted outcomes).



3.2 Creation of enabling environments

This Strategy draws on the World Health Organization Integrated care model ‘Enabling Environments’, the health system plan Vision 2030 and addresses the principles of the refreshed NZDS and UNCRPD.

A common theme across the frameworks is that any system and service change to improve responsiveness involves the following:

- Proactive initiatives collectively led by staff and the communities.
- Intentional integration using available tools to identify areas of need.
- Long term commitment to transformation led by communities of interest working with staff. A shared vision to achieve long term radical system change.

While disability initiatives and tools provide opportunities for innovation the journey to real whole of system change will happen over a long period of time. Every part of the programme aims to enhance the autonomy and wellbeing of people who experience disability within current and planned health system development.

To reflect the above, much of the detail that has been used in this plan is a result of direct feedback from consumers and key stakeholders that attended our local and sub-regional forums. The last sub-regional forum was held on 3 June 2016 in Upper Hutt and was an opportunity to refresh, reform and update the current strategic plan used by the sub-regional DHBs.

3DHB Disability Implementation Plan	World Health Organisation Integrated Care Model	CCDHB Health System Plan Integration	6 Guiding Principles
Creation of enabling environments			
LEADERSHIP	**Strengthening governance and accountability**	Community leadership in health care and system monitoring. A health system fit for all.	Strategies that build community resilience. Active commitment to strengthening leadership and partnership across the sector.
ACCESS	**Empowering and engaging people**	Community leadership in education for health and disability literacy and service co-design.	Inclusion of disabled people in the design of all services and activities.
INCLUSION + SUPPORT	**Coordinating services**	Improving access to information about funded services across age groups.	Improved support for people to make well-informed decisions.
HEALTH	**Reorienting the model of care**	All people using services have improved health literacy and information, and lead their care.	Movement toward holistic model of wellbeing. Creation of an enabling and more accessible environment.

3.2.1 The guiding principles

From the workshops at the 2016 Forum, there were several issues which seemed prevalent across each group discussion. To ensure there is a continued focus on these issues, we have created guiding principles. These six principles hold the voices, the values and the aspirations of the disability communities within the Greater Wellington region:

1. **Creation of an enabling and more accessible environment.**
2. **Inclusion of disabled people in the design of all services and activities.**
3. **Movement towards a holistic model of wellbeing that improves health outcomes for disabled people.**
4. **Improved support for people to make well informed decisions.**
5. **Strategies that build community resilience.**
6. **Active commitment to strengthening leadership and partnership across the sector.**

3.2.2 The focus areas

Historically, the Disability Responsiveness programme has always followed the four key focus areas identified by the disability communities: Leadership, Inclusion & Support, Health, and Access. The Sub-Regional Group chose to retain the four areas but asked that leadership should become number one. These continue to act as the foundations of the work carried out by the newly named Disability Strategy Team and are colour-coded in unison with the World Health Organization Integrated Model of Care diagram.

FOCUS AREAS
LEADERSHIP
The sub-regional DHBs, in partnership with disabled people, their families, whānau and communities; plus, other relevant stakeholders, will provide leadership to achieve equity in health and wellbeing on an equal basis to others.
INCLUSION & SUPPORT
The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis.
ACCESS
Services are more accessible and meet the health, well-being and social needs of disabled people, their families and whānau.
HEALTH
Heath disparities will be reduced and equity will be promoted, in order to improve and promote the health of disabled people.

3.2.3 The strategies

Using the guiding principles, the strategies for improvement across 2017 to 2022 are listed in the tables in section four. The strategies form the framework for the Disability Strategy work programme including annual plans and targets. Under each strategy is a description of the action that will be taken to achieve this.

3.2.4 How we will implement the strategies

While the strategies are high level, below each title in the table is a list of ways we propose to implement the strategy. Further still, the downloadable action framework shows the actions we will take to achieve our overarching focus area.

3.2.5 The outcomes

For each of the strategies and actions, we are trying to achieve an outcome. The desired outcome is shown in the Action Framework (see page 28) alongside the year we aim to do this.

HIGH LEVEL SUMMARY OF THE STRATEGIES AND AIMS:

FOCUS AREA ONE: LEADERSHIP

The sub-regional DHBs, in partnership with disabled people, their families, whānau and communities; plus, other relevant stakeholders, will provide leadership to achieve equity in health and wellbeing on an equal basis to others.

This will be achieved through actions linked to the following priorities:

1. Encourage intersectoral leadership on disability issues across key government organisations including Community and Public Health Services to partner work with local communities.
2. Practice positive partnerships to enhance collaboration and co-design.
3. Uphold the key principles of the Treaty of Waitangi.
4. Ensure better accountability by creating a monitoring framework.
5. Lead a disability responsiveness education programme throughout the 3 DHBs.

This will mean:

1. Intersectoral leadership that has begun ensures that the commonalities and a shared social investment approach lead to improved access to health and social services and therefore improved health outcomes.
2. People and their families are respected as experts in their own health care and proactively engaged at different levels in advising and co-design of new and existing health services and systems.
3. Whāia Te Ao Mārama guiding principles embedded in all actions lead to improved engagement with Māori with Disabilities.
4. Accountability for improvement of practice is measurable and leads to initiatives reduced admissions to hospital, shorter stays where admission is necessary and by increased quality feedback from people using community and hospital services.
5. Consumer led education targeted to for clinical and non-clinical staff contributes to greater understanding by staff leading to improved patient experience and a seamless patient journey.

FOCUS AREA TWO: INCLUSION & SUPPORT

The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis.

This will be achieved through actions linked to the following priorities (see appendix for more detail):

1. Improve access to funding, information, services and support.
2. Ensure IT platforms accommodate disability responsiveness tools.
3. Improve transition for children and young people from child to adult services within the healthcare system.
4. Ensure health professionals are flexible and responsive to person specific needs.
5. Encourage better use of technology.
6. Improve accountability and integration across the planning and funding arms of the DHBs.
7. Ensure people are supported in decision-making.
8. Promote a whole of life approach to needs assessment and service coordination.

This will mean:

1. The guide to funded services means people will understand what they can access and where. This enables people and their families to be more in control of their support.
2. Technology used across health and disability services enables health practitioners to understand the various components and inputs to the overall support of people and their families.
3. The electronic pathway and tool kit co-designed with families enable them to access community health and disability services with general practice as allies.
4. Tools such as the disability alerts, the health passport and shared care planning enable staff to facilitate a seamless journey through health services, including funded health and disability services.
5. Its tools give people options on ensuring critical information about individuals can be shared. An electronic version of the health passport enables disabled people who prefer to use their devices enables to share support information in real time.
6. A disability clause obligates providers to develop plans and improve access on a developmental basis each year. This improves access to general health and community services.
7. Staff understand supported decision-making enabling people to better participate in decision-making about their health care.
8. A whole of life approach across needs assessment services reduces fragmentation and enables more timely access to the appropriate support pathways irrespective of age group and condition.

FOCUS AREA THREE: ACCESS

Services are more accessible and meet the health, wellbeing and social needs of disabled people, their families and whānau.

This will be achieved through actions linked to the following priorities (see appendix for more detail):

1. Create an enabling environment where the person is at the centre. [24]
2. Promote community resilience across the sub-region.
3. Ensure that physical access remains a priority for the 3 DHBs.
4. Improve access to New Zealand Sign Language interpreters and quality of care for the deaf community.

This will mean:

1. Information available in plain language documents and in accessible formats across the 3 DHBs electronically and in hard copy puts the person in charge of their journey through the health system.
2. Collaboration with councils, other government bodies and community members working across localities provides safety and better emergency preparedness as well improved connection with neighbours and other natural supports.
3. As buildings are developed, input from access experts ensures that future health care is fit for all groups irrespective of impairment.
4. Each year deaf people using general and mental health services have a safer journey through the health system, have improved health literacy and a large proportion of staff understand the cultural needs of deaf people.

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[24] Based on World Health Organization model of service integration.

FOCUS AREA FOUR: HEALTH

Health Disparities will be reduced and equity will be promoted, in order to improve and promote the health of disabled people.

This will be achieved through actions linked to the following priorities (see appendix for more detail):

1. Shift to person/whānau-directed care model is promoted by the Executive leadership teams.
2. Support Primary Health Organisations (PHOs) [25] to improve access to services by utilising education information from and by empowered consumers.
3. Support initiatives that improves access to rehabilitation by providing advice and expertise available to the Disability Strategy Team and the responsible leads across the three DHBs.
4. Disability Responsiveness Education and training will be mandatory for all DHB staff involved in patient care and other front line DHB disability services.

This will mean:

1. A disability lens consistently applied in new models of care mean disabled people are able to access quality health care in community and hospital irrespective of multiple specialists and conditions.
2. Alliance Leadership Teams and PHOs lead the way in improving disability responsiveness in general practice settings by integrating a professional and consumer disability lens in education.
3. Rehabilitation services improve with disability community input and good practice models are shared across health ACC and MOH.
4. Staff at pre-registration and post-registration are competent in disability literacy and adapt care to meet the needs of any person irrespective of impairments or health.

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[25] PHOs are the management bodies that oversee general practice services. There are three in Wellington one in Wairarapa and one in Hutt Valley.

SECTION 4: ACTION TABLE

Using the guiding principles, the strategies for improvement across 2017 to 2022 are listed in the tables below. These strategies create the framework of the Disability Directorate work programme as well as annual plans and targets.

The tables below show the strategies we will be implementing and how we will do this.

Further to this document, a downloadable action plan with timelines and monitoring framework is available from our website https://www.ccdhb.org.nz/your-health/support-services/disability-responsiveness/

The Framework shows specific actions against each of the points below.

Targets are set each year by each DHB and the achievement of many are long term while others are clearly identified as short and will aim to be completed between 2017–2019. Other goals are set by 2022. The table shows both actions planned to meet these goals as well as a description of our current progress.

The table below should provide you with a solid grasp of our intended plans, but should you want more information, please refer to the Action Framework.

The Action Framework shows:

- The Overarching Aim: What we want to do.
- The Expected Outcome: What we expect to see if we achieve this.
- The Strategy: How we expect to achieve this.
- The Action Plan: How we put this strategy into action and achieve our aim.
- The Progress: Have these actions been started? Have they been completed?
- The Project Status: An overview of where we currently stand with these actions.
- Date of Completion: The year we should expect to see this implemented. 2017–2022.

FOCUS AREA 1: LEADERSHIP

The sub-regional DHBs, in partnership with disabled people, their families, whānau and communities; plus other relevant stakeholders, will provide leadership to achieve equity in health and wellbeing on an equal basis to others.

1.1 Encourage intersectoral leadership on disability issues across key government organizations including community and Public Health Services to partner work with local communities	1.1.1	SRDAG continues to govern the programme of activities, lead engagement and maintain community partnerships across the region.
	1.1.2	Annual local forums led and supported by local communities.
	1.1.3	Biennial sub-regional forums led and supported by local communities.
	1.1.4	The Disability Strategy Team works with the Chief Executives and DHB Planning and Funding Directorates to take an investment approach and build capacity within the integration programme to respond to disability strategies.
	1.1.5	Research and innovation is proactively planned and monitored by the Disability Directorate in partnership with the three DHBs.
1.2 Practice positive partnerships to enhance collaboration and co-design	1.2.1	Promote best practice in co-design with expertise of communities facilitated by the SRDAG model.
	1.2.3	Provide Disability expertise to the Mental Health Integrated Strategic Leadership Group and the mental health consumer leadership group.
	1.2.3	1.2.3 Create a shared understanding of accessibility and joint responsibility for addressing social determinants by working with the Councils and local communities.
	1.2.4	1.2.4 Review the use and content of the Health Passport in partnership with the Health and Disability Commissioner, clinicians and consumers.
1.3 Uphold the key principles of the Treaty of Waitangi	1.3.1	Uphold Whāia Te Ao Mārama Principles by engaging Māori disabled people.
	1.3.2	Ensure relevant and informative disability related information is available to community and health leaders through the Māori Health services.
	1.3.3	Work to influence the Whāia Te Ao Mārama strategy within disability responsiveness for Māori disabled individuals, whānau and key stakeholders.
1.4 Utilise the skills and resource of the Disability Action Group and refresh the Champions network to ensure efficient action within the DHBs	1.4.1	The DAG leads a proactive plan of work to contribute to quality and clinical service improvement for people who experience disability.
	1.4.2	The DAG and Champion Network are interlinked and share both skill and resource with the Disability Directorate.

1.5 Ensure better accountability by creating a monitoring framework	1.5.1	Review the current monitoring framework and continue to build a dashboard of meaningful indicators.
	1.5.2	Increase the employment of people who experience disability within the 3 DHBS by educating staff, leaders and Human Resources on how best to support them.
	1.5.3	Continue to promote work placements in disability fields where appropriate.
	1.5.4	DHB Executive Teams to evaluate and improve the effectiveness of services for Māori people with disabilities.

1.6 Lead a disability responsiveness education programme throughout the 3 DHBs	1.6.1	Ensure all learning and development programmes sub-regionally gradually incorporate a rights based approach which is comprehensive and encompasses disability responsiveness.
	1.6.2	Engage with pre-registration students on placement within health services to provide disability responsiveness training.
	1.6.3	Promote core competencies, principles and values within all training programmes to create a culture change more suited to a holistic model of wellbeing.
	1.6.4	Advance disability literacy at all levels and promote disability literacy as a mandatory competency in undergraduate education.
	1.6.5	Continue to develop, upgrade and review tools that provide a focus for staff and people using services to practically understand the diversity of need across the disability population.
	1.6.6	Work in partnership with Māori Health and community leaders to develop a strategy to reach out to the Māori disability communities.
	1.6.7	Uphold the key principles of Faiva Ora and engage with Pacific Health and community leaders to reach out to the Pacific disability community.

FOCUS AREA 2: INCLUSION AND SUPPORT

The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis.

2.1 Improve access to funding, information, services and support	2.1.1	Create a simple guide to Disability Support funding and funding mechanisms which is accessible to all and offers a reference point which is regularly updated.
	2.1.2	Work towards an improved system of data sharing which enables a person to own and control their health and support needs information.
2.2 Ensure IT platforms accommodate disability responsiveness tools	2.2.1	Disability Alert project is fully operational and the quality of information is monitored.
	2.2.2	Investigate opportunities for disability support or access information to be accommodated on other IT systems used by the patient.
2.3 Improve transition for children and young people from child to adult services within the healthcare system	2.3.1	Complete the development of an electronic pathway to guide and support healthcare professionals when working with children, young people and families are transitioning between services.
	2.3.2	Families, children and young people continue to provide information to guide projects around transition as part of a co-design method.
	2.3.3	Create a resource kit in partnership with families and health professionals that can be used during transition to ensure continuity of care.
	2.3.4	Create a policy on transition with clinical staff to enable safer and more timely transition for young people requiring a number of health and disability supports.
	2.3.5	The youth leaders of the SRDAG work with youth networks to encourage and promote a proactive approach to supported decision making.
2.4 Ensure health professionals are flexible and responsive to a persons specific needs	2.4.1	Encourage co-design process to model of care and service models that takes a holistic approach to service development and delivery.
	2.4.2	Promote the updated guidelines/algorithm for staff to ensure the service and placement needs of people who do not meet required criteria for services or funding are addressed in a timely way.
	2.4.3	Initiate a clinical governance group with clinicians and NASCs to ensure people with the most diverse needs are prioritised and placed in the most appropriate setting.

2.5 Encourage better use of technology	2.5.1	Scope the use of the technology that is currently being used by disability communities and consider the interface of those being developed for health services.
	2.5.2	Support a more coherent approach to data sharing in relation to disability identification across PHOS sub-regionally.
	2.5.3	Continue to innovate in healthcare education and promote existing tools such as video resource and the Child to Adult Transitions pathway (CAT). (references 1 - 6.5 and 2 - 3.1)
2.6 Improve accountability and integration across the planning and funding arms of the DHBs	2.6.1	The disability clause ensures mandatory reporting from all providers across all three DHBs outlining how they have implemented the NZ Disability Strategy.
	2.6.2	The existing Disability responsiveness policy at CCDHB is promoted and localised to Hutt Valley and Wairarapa DHBs.
	2.6.3	Work with quality and strategy and innovation units to incrementally include a disability lens on all new and reviewed DHB plans and policies.
2.7 Ensure people are supported in decision-making	2.7.1	The disability strategy team become familiar with 'Supported Decision Making' practice and tools and share knowledge across the DHBs as part of wider education.
	2.7.2	Documents are provided in plain language and in accessible formats to ensure the person is fully informed when making decisions. (reference 3 - 1.1)
	2.7.3	Clinicians and service providers are supported to use the information provided within a persons health passport and disability alert.
	2.7.4	Collaborate with the advanced care planning project which aims to encourage all people to plan for the future.
2.8 Promote a whole of life approach to needs assessment and service coordination	2.8.1	Establish a whole of life approach to NASC which encompasses knowledge from across the DHB, Ministry of Health, primary care and providers towards an integrated NASC
	2.8.2	Promote disability literacy as a core competency for all staff working in needs assessment and the home and community support service sector
	2.8.3	Use appropriate cultural frameworks for NASCs to reflect Te Ao Māori and Pacific communities.
	2.8.4	Provide guidance to reduce fragmentation and streamline funding streams and services (as above 2 - 4.3)

FOCUS AREA 3: ACCESS

Services are more accessible and meet the health, well-being and social needs of disabled people, their families and whānau.

3.1 Create an enabling environment	3.1.1	Information is available in plain language documents and in accessible formats across the 3 DHBs.
	3.2.1	Improve access to information via internet and intranet.
3.2 Promote Community Resilience across the sub-region	3.2.1	Provide education and resources to regional councils.
	3.2.2	Support and promote leadership by disabled people in partnership with local entities to contribute to health system planning and other sector development.
	3.2.3	Promote better engagement and collaboration with leaders from disability communities.
	3.2.4	Inform communities by creating resources and tools that can be shared easily.
3.3 Ensure that physical access remains a priority for the sub-regional DHBs	3.3.1	Access is monitored across the three DHBs and periodic access audits are used to provide feedback.
	3.3.2	Promote the benefits of improving access to services.
3.4 Improve access to New Zealand Sign Language interpreters and quality of care for deaf community	3.4.1	Develop and implement a 3DHB NZSL policy.
	3.4.2	Create a framework for education for staff and improve responsiveness to deaf patients.
	3.4.3	Improve access to NZSL interpreters and improve the booking processes.
	3.4.4	Utilise technology to improve access to healthcare services.

FOCUS AREA 4: HEALTH

Heath disparities will be reduced and equity will be promoted, in order to improve and promote the health of disabled people.

4.1 Shift to person/ whānau-directed care model is promoted by the Executive leadership teams	4.1.1	Define and promote the concept of a person/whānau-directed care model and empowered self-care.
	4.1.2	Work with leaders across the sector to implement better systems for a single coordinated plan for each person *long term goal.
	4.1.3	A regional approach is used to improve services and support options.
4.2 Support PHOs to improve access to services by utilizing education information from and by empowered consumers	4.2.1	Create a tangible action plan to work with all levels within a Primary Health Organisation; from senior leaders to clinical staff to administration staff.
	4.2.2	Ensure there is active engagement and disability perspectives provided on the Healthcare Home project.
	4.2.3	Actively engage with primary care services to promote the use of DR tools.
4.3 Support initiatives that improves access to rehabilitation by providing advice and expertise available to the Disability Directorate	4.3.1	Seek to influence the development of age and life stage appropriate rehabilitation services which are available to all and ensure smooth transition points.
4.4 Disability Responsiveness Education and training will be mandatory for all DHB staff involved in patient care and other frontline DHB disability services	4.4.1	Create annual communication plans targeted to all levels of health care professionals and actively engage with staff members to provide tailored information and education.
	4.4.2	Hold events across the 3 DHBs every year to celebrate International Day of Persons with Disabilities, in the form of Disability Responsiveness Week.
	4.4.3	Work closely with Pacific Health Unit and whānau care to ensure staff are provided with efficient training.

APPENDIX: GLOSSARY OF ACRONYMS

CCDHB	Capital & Coast District Health Board
CPHAC DSAC	Community and Public Health Advisory Committee Disability Support Advisory Committee
DAG	Disability Action Group
DHB	District Health Board
ELT	Executive Leadership Team (3DHB's)
HOP	Health of Older People
HVDHB	Hutt Valley District Health Board
LTS-CHC	Long Term Supports – Chronic Health Conditions
MoH	Ministry of Health
NASC	Needs Assessment and Service Coordination
NGO	Non-Government Organisation
NZDS	New Zealand Disability Strategy (2001)
NZSL	New Zealand Sign Language
PH&DA	Public Health & Disability Act (2000)
PHO	Primary Health Organisations
PHOAG	Primary Health Organisation Advisory Group
SRDAG	Sub-Regional Disability Advisory Group
SIDU	Service Integration and Development Unit
TOR	Terms of Reference
UNCRPD (2009)	United Nations Convention on the Rights of Persons with Disabilities
3DHBs	Capital & Coast District Health Board, Hutt Valley District Health Board and Wairarapa District Health Board