Disability Support Advisory Committee Meeting

Wednesday, 24 August 2016

1:30pm

NOTE: NEW VENUE

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

Healthy communities | World-class healthcare | Achieved together

Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Published 16 August 2016

Agenda
Disability Support Advisory Committee
24 August 2016

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

Time: 1.30pm

Committee Members	**Auckland DHB and Waitemata DHB Staff**	
Sandra Coney (Chair)	Dr Dale Bramley	Chief Executive Officer Waitemata DHB
Max Abbott	Ailsa Claire	Chief Executive Officer Auckland DHB
Jo Agnew (Deputy Chair)	Samantha Dalwood	Disability Advisor Waitemata DHB
Judith Bassett	Aroha Haggie	Acting Māori Health Gain Manager
Marie Hull-Brown	Dr Debbie Holdsworth	Director of Funding Auckland and Waitemata DHBs
Dairne Kirton	Fiona Michel	Chief of People and Capability Auckland DHB
Dr Lester Levy	Kate Sladden	Funding and Development Manager, Health of Older People
Jan Moss		
Robyn Northey	Marlene Skelton	Corporate Business Manager
Russell Vickery	Sue Waters	Chief Health Professions Officer
Shayne WiJohn	Tim Wood	Funding and Development Manager, Primary Care
Jade Farrar	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff: Fiona Michel

Agenda

Please note that agenda times are estimates only

1.30pm	**1.**	**ATTENDANCE AND APOLOGIES**
1.35pm	**2.**	**REGISTER OF INTEREST AND CONFLICTS OF INTEREST** Does any member have an interest they have not previously disclosed? Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
1.40pm	**3.**	**CONFIRMATION OF MINUTES**
	3.1	Confirmation of Minutes 09 March 2016
	3.2	Confirmation of Minutes 01 June 2016
	3.3	Confirmation of Minutes 13 July 2016
1.50pm	**4.**	**ACTION POINTS**

	4.1	Facilities and Development Project Stocktake for Auckland and Waitemata DHBs
	4.2	Care of High Needs Young Patients While in Hospital [Verbal Update]
2.15pm	**5.**	**CHAIR'S REPORT**
2.20pm	**6.**	**PRESENTATIONS**
	6.1	Finding My Way and Healing Environments at Auckland DHB [Malini Subramoney – Project Manager Performance Improvement Auckland DHB]
2:35pm	**7.**	**IMPROVEMENT ACTIVITIES**
	7.1	Public Spaces Look and Feel Guideline [Abbi Harwood-Tobin – Service Improvement Manager Auckland DHB]
	7.2	Waitemata DHB Sky Bridge Project – Pedestrian Access Issues Report - [Nigel Ellis and Matthew Knight]
3.00pm	**8.**	**INFORMATION PAPERS**
	8.1	Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs
	8.2	Waitemata 2025 Ideal Ward Community Engagement Plan [Robyn Whittaker/Carol Hayward]
	8.3	Community Engagement with People with Disabilities
	8.4	Disability Strategy Implementation Plan 2013-16 - Update
	8.5	Draft NZ Disability Strategy 2016-2026
4.00pm	**9.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 16 November 2016 at 1.30pm Auckland Deaf Society, Terrace Boardroom, 164 Balmoral Road, Auckland

Healthy communities \| World-class healthcare \| Achieved together

Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Attendance at Auckland and Waitemata DHBs Disability Support Advisory Committee Meetings

Members	11 Mar. 15	03 Jun. 15	26 Aug. 15	18 Nov. 15	09 Mar. 16	01 Jun. 16	13 July 16	24 Aug. 16	16 Nov. 16
Sandra Coney (Chair)	1	1	1	1	1	1	1		
Max Abbott	x	1	1	x	1	1	1		
Jo Agnew (Deputy Chair)	1	1	1	x	1	1	1		
Judith Bassett	1	1	1	1	1	1	X		
Marie Hull-Brown	1	1	x	1	1	1	X		
Dairne Kirton	1	1	1	x	x	1	1		
Lester Levy	x	x	x	x	1	1	X		
Jan Moss	1	1	x	x	1	1	X		
Robyn Northey	1	1	1	1	1	1	1		
Russell Vickery	1	1	1	1	x	1	1		
Shayne WiJohn	n/a	1	x	1	1	x	1		
Jade Farrar	n/a	1	x	1	1	x	1		
Key: x = absent, # = leave of absence, c = meeting cancelled									

Conflicts of Interest Quick Reference Guide

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

An "interest" can include, but is not limited to:

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Disability Support Advisory Committee

Member	Interest	Latest Disclosure
Sandra CONEY (Chair)	Chair – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust Member – Cartwright Collective	09.03.2016
Max ABBOTT	Pro Vice Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member – AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28.09.2011
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband is a shareholder of Westpac Banking Group Daughter is a shareholder of Westpac Banking Group	13.07.2015
Jade FARRAR	Disability Advisor for Te Pou National Leadership Group Member (Enabling Good Lives) Enabling Good Lives Christchurch "Local Area Group member" Cerebral Palsy Society Domestic Violence & Disability Group PHAB association (Auckland) Inc Auckland City Advisory Panel Member Director of Epic Studios Limited IT Support Consultant (community Connections Supported Living Trust) Owner/Webmaster of enablingoodlives.co.nz	18.11.2015
Marie HULL-BROWN	Board Member – Age Concern Auckland Board Member – HOPE Foundation for Research on Ageing Advisory Committee Member – Selwyn Centre for Ageing and Spirituality	18.11.2015
Dairne KIRTON	Northern Regional Representative – CCS Disability Action National Board Mentor – ImagineBetter – Raise Your Bar Project Vice President – CCS Disability Action National Board	09.03.2016
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016

Jan MOSS	Coordinator of Complex Care Group Contractor to MoH, DS.S Board member YES Disability Centre, Albany Reference Group Member – MOH Disability Workforce NZ & Choices in Community Living	12.03.2014
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Auckland District Council of Social Service	17.02.2016
Russell VICKERY	Wilson Home Management Committee Auckland Disability Law Chairman of Waitemata Community Law Life Member Auckland Branch of NZCCS Disability Action Cook Opie Hi Tech Trust Private Disability Consultant Australasian Rep for Inclusion Press	13.07.2015
Shayne WIJOHN	General Manager of Te Runanga o Ngati Whatua Ngati Whatua Representative – in affiliations to Te Rarava, Te Aupouri and Ngati Whatua	29.05.2015

Minutes
Disability Support Advisory Committee Meeting
09 March 2016

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 09 March 2016 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1.30pm

Committee Members present	**Auckland DHB and Waitemata DHB Staff present**	
Sandra Coney (Chair)	Samantha Dalwood	Disability Advisor Waitemata DHB
Jo Agnew (Deputy Chair)	Fiona Michel	Chief of People and Capability Auckland DHB
Judith Bassett	Kate Sladden	Funding and Development Manager, Health of Older People
Marie Hull-Brown		
Jan Moss [arrived during Item 4]	Sue Waters	Chief Health Professions Officer
Robyn Northey	Michelle Webb	Corporate Committee Administrator
Shayne WiJohn	Tim Wood	Funding and Development Manager, Primary Care
Jade Farrar		
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

Apologies were received from committee members Dairne Kirton and Russell Vickery.

The apologies of senior staff members Ailsa Claire, Dale Bramley, Debbie Holdsworth and Lester Levy were received. In the absence of Debbie Holdsworth, Tim Wood was the nominated delegate.

Fiona Michel, Chief of People and Capability Auckland DHB was introduced and welcomed to the meeting.

The recognitions received in the New Year's Honours by committee members Max Abbott and Jan Moss were acknowledged. Max has been made a Companion of the New Zealand Order of Merit (CNZM) for services to health, science and education. Jan has been made a member of the New Zealand Order of Merit for services to the care of disabled people.

Resolution: Moved Robyn Northey / Seconded Jo Agnew

That the apologies be received.

Carried

2. CONFLICTS OF INTEREST

Dairne Kirton had advised that she has been appointed Vice President of the CCS Disability Action National Board, and that she is no longer a Grants Committee Member of the Variety Children's Charity.

Robyn Northey advised that she has closed her private practice and is no longer a Board Member of the Hope Foundation.

Sandra Coney advised that she is a patron of Women's Health Action Trust and a member of the Cartwright Collective.

3. CONFIRMATION OF MINUTES 18 November 2015 (Pages 8 to 15)

Item 4.1 Care of High Needs Young Patients While in Hospital

Tim Wood, Funding and Development Manager Primary Care provided an update.

Since the last Disability Support Advisory Committee meeting further discussions have occurred with the Ministry of Health. The Ministry are still comfortable to discuss funding for individuals requiring support on a case-by-case basis. A process is in place to resolve with the Ministry collectively. Based on this, it is the view of Planning and Funding that a briefing paper is no longer required.

The outcome of discussions with Taikura Trust and Individualised Funding Services regarding tracking cases of individuals accessing funding for support was queried. It was advised that this information was held by the Ministry of Health. The Ministry have agreed to share information with the Disability Support Advisory Committee prior to June 2016. The Chair reiterated the wish of the Committee for an update on this arrangement to be provided to the Committee at its June meeting.

Jan Moss added that individuals with short hospital stays may not be recorded as having accessed funding for support with complex needs. Additionally it would be worthwhile knowing if those in hospital resulting from and accident were also accessing this support and what the Accident Compensation Corporation (ACC) process was. Pam McNeil has recently left the Ministry of Health for a new role at ACC and so may be a point of contact for enquiring about this information.

Action:

That the process for ACC patients with complex needs accessing funding for support whilst in hospital be investigated and reported back to the June Disability Support Advisory Committee meeting.

Resolution: Moved Sandra Coney / Seconded Judith Bassett

That the minutes of the Disability Support Advisory Committee meeting held on 18 November 2015 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 16 to 18)

[Secretarial Note: Jan Moss joined the meeting at 2.00pm]

The following updates were received:

Disability Support Advisory Committee Terms of Reference

No further progress report had been received. The Chair requested that an update be sought from the Board Chair and reported back to the Committee.

Draft Disability Support Advisory Committee Annual Work Plan

Michelle Webb, Committee Secretary updated as follows:

Regional Disability Support Advisory Committee Meeting: Planning is in progress for a regional Disability Support Advisory Committee meeting. A draft agenda has been developed in collaboration with the Counties Manukau. Once their Committee Chair has reviewed the draft agenda it will be shared. It is intended to invite a representative from the Ministry of Health to provide an update on the implementation of the Putting People First Review as all three Disability Support Advisory Committees could benefit from receiving the presentation.

Joint Meetings: Contact has been made with the Auckland Council Disability Advisory Panel. Channels for engagement are prescriptive. The Committee Secretary will seek details for an alternate point of contact outside of this meeting to progress this in a more flexible way.

Action:

That the Committee Secretary seek an update on the status of the Disability Support Advisory Committee Terms of Reference from the Board Chair and report back to the June Committee Meeting.

4.1 Support of High Needs Patients While in Hospital Update

This item was covered during consideration of Item 3.

[Secretarial Note: Item 6.1 was taken next]

4.2 Venues for Future Disability Support Advisory Committee Meetings (Pages 19 to 21)

[Secretarial Note: this Item was considered after Item 6.1]

Members discussed the merits and limitations of the four venue options provided. It was commented that the Fickling Convention Centre only had one dedicated disability car park which is insufficient, that the costs for Alexandra Park Convention Centre are prohibitive and that the Best Western in Newmarket is not accessible and therefore cannot be considered.

Members indicated that their preference was the Auckland Deaf Society – Potters Park Events Centre as it best meets all requirements.

In discussion regarding venue fees the need to be considerate of costs was highlighted and acknowledged. Current costs for use of the rooms at CSS Disability Action were not available at the meeting but it was advised they were similar to that of the Auckland Deaf Society.

It was agreed that members would delegate authority to the Committee Chair to make a final decision based on costs.

Resolution: Moved Sandra Coney / Seconded Jo Agnew

That the Disability Support Advisory Committee:

1. **Receives the Venues for Future Disability Support Advisory Committee Meetings report.**
2. **Confirms that the preferred venue for future Disability Support Advisory Committee meetings is Option 1, Auckland Deaf Society – Potters Park Events Centre.**

3. **Delegates authority to the Committee Chair to make a final decision based on costs.**
4. **Endorses the Committee Secretary to make the required arrangements for Disability Support Advisory Committee meetings to take place at the preferred venue as of June 2016.**

Carried

[Secretarial Note: Item 7.1 was taken next]

5. CHAIR'S REPORT (VERBAL)

The Chair has met with the Director of Planning and Funding to discuss priority items for the attention and focus of the Disability Support Advisory Committee at future meetings. Also discussed was the issue of items that the Committee have a responsibility to provide input to and advice on not being directed to the Committee. The Chair advised that this discussion had been productive and there was a strong level of confidence that processes are now in place to address the issue.

The Chair recently attended an informative event in honour of International Women's day which was focussed on women with disabilities.

6. PRESENTATIONS

6.1 Abuse of Older Adults and Vulnerable Adults E-learning Module

Delia McKenna, Professional and Clinical Leader Social Work was in attendance for this item.

The handout "Vulnerable Adults" was tabled and is appended to these minutes as Attachment 6.1.1.

Delia informed the reasons for the development of the E-learning module and the legislative responsibilities of families and staff when caring for vulnerable patients.

It was highlighted that:

- The Crimes Amendment Act (No.3) 2011 came about to ensure that family members and all professionals whom have frequent contact with a person who is a vulnerable adult have a responsibility to make it known if someone in the home is suffering abuse or neglect.
- It is imperative for hospital staff to recognise who is a vulnerable patient and take all necessary steps to protect them from injury or harm.

Delia then displayed the module webpage online.

Matters covered in discussion and in response to questions included:

- The module is interactive. It presents six different scenarios, representing different sectors of the population and a variety of situations. On completion of the module the programme provides feedback and tools to the user. Refreshers would be required by staff annually and the learning would sit as part of their performance review process. Content will be reviewed in 2 years' time to ensure that staff are not completing the same questions each time they undertake the training.
- The pilot module is currently only available within Waitemata DHB. It is mandatory for all Allied Health staff across 42 disciplines. Once the module has been through the Waitemata Education Committee process it will be determined if it will become mandatory for all staff. Given there is criminal liability associated with non-compliance with the legislation, the Committee's view was that the training should

be mandatory.

- Members expressed concern with the length of time involved in development and assessment of the module. It was advised that this was a prioritisation of funding issue. Contingency is in place to ensure that DHB's are meeting the needs of vulnerable patients and achieving legislative compliance during the interim. Policies and regular reporting to each DHB have been implemented during this time.
- Auckland DHB are currently working to achieve access to the Ko Awatea Learning site to make it available to staff and gain access to all training modalities.
- The legislative requirements are being addressing through the Elder Abuse Group and Family Violence Steering Group and workstreams.
- The timeframe for other health professionals being able to access training was queried by members. It was advised that the Education Committee were due to consider the module in the early part of this year. Achieving publication of the e-learning platform is challenging due to the multiple competing priority trainings. It has taken 18 months to progress the module to this point.

Members noted that they would welcome a report back at a future Disability Support Advisory Committee meeting.

Action:

That a status update on progress of the Abuse of Older Adults and Vulnerable Adults E-learning Module for Auckland and Waitemata DHBs be provided at the next Disability Support Advisory Committee meeting.

Resolution: Moved Sandra Coney / Seconded Jo Agnew

That Delia McKenna, Professional and Clinical Leader Social Work be thanked for the presentation.

Carried

[Secretarial Note: Item 4.2 was considered next]

7. IMPROVEMENT ACTIVITIES (Pages 22 to 39)

7.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs (Pages 22 to 25)

Kate Sladden, Funding and Development Manager Health of Older People asked that the report be taken as read, highlighting the following:

- The Home Based Support Services contract now includes a one band model for travel up to 15km other than for the first client visit of the day. There will be two single standard payments for travel time and travel distance; $2.09 (8.5 minutes) and $1.85 (3.7km). Parties have agreed to an exceptional travel policy, which is paid on an actuals basis and is only payable when travel exceeds 15km. The Ministry of Health's Audit and Compliance team will closely monitor and audit Inbetween Travel Time (IBT) claims for exceptional travel.
- Pressure injuries graded stage 3 or 4 are now required to be reported to the Ministry of Health. It is anticipated that we will see an increase in reporting and corrective actions as a result.
- The Business Case to seek approval and secure resource from both Boards to rollout the 'living well with dementia model of care' to all GPs across Waitemata and Auckland DHBs will soon commence the pre-approval steps before being submitted

to the Boards.

- The Dementia eLearning resource for GPs and practice nurses is currently in development.
- The MoH has prepared a draft document *Care Guide for Secure Dementia Unit Design from a Person Centred Perspective,* which is soon to be released for consultation.
- A joint working group established in conjunction with ACC to implement a community fall prevention project.

Matters covered in response to questions included:

- The Inbetween Travel Time (IBT) rates will be linked with any increases in the minimum wage. When wages increase the reimbursement rates will change in parity. There are implications for DHBs as there will be cost associated. IBT has been included on the risk register. An interim report on IBT is anticipated in June and will take account of these aspects.
- Clarification was sought on the audit outcomes relating to the number of facilities achieving continuous improvements. It was advised that the number is increasing and showing good progress. The starting point for all facilities was a baseline of zero. Now that quality improvement processes are becoming routine achievement rates are improving. The draft Care Guide for Secure Dementia Unit Design document is due out in late March and will have a consultation period of 2 weeks. It was noted that this provided only a short period of time for Committee members to comment or determine whether or not to make a submission. It was agreed that in the interests of expediency the consultation document would be circulated to members of the Disability Support Advisory Committee immediately upon release to allow this decision to be made.

Actions:

That the Audits table be amended to provide cumulative data of all facilities achieving continuous improvement.

That, upon release of the Ministry of Health draft 'Care Guide for Secure Dementia Unit Design from a Person Centred Perspective' document for consultation, the information be circulated to Disability Support Advisory Committee members for comment and decision on whether or not a submission be made.

Resolution: Moved Robyn Northey / Seconded Jan Moss

That the report be received.

Carried

7.2 Progress Update: Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards (Pages 26 to 33)

Samantha Dalwood, Disability Strategy Advisor Waitemata DHB asked that the report be taken as read highlighting the following:

- The New Zealand Disability Strategy is due for review by the Ministry of Social Development this year.
- The principles will be similar to those of the current strategy.

Matters covered in response to questions included:

- There have been delays due to IT issues with action item "Review the automated telephone system with regard to access for people with disabilities".
- In relation to the action item "Work with the Deaf community to improve access to interpreters", DHB policies are in place to support the provision of interpreters to be offered. Other activities are in place to support this objective and raise awareness such as the training of new graduate nurses in basic sign language and processes for booking interpreters.
- Regarding action item "Encourage the use of symbols and pictograms in signage and way finding" it was the view of the Committee that consultation with both DHBs and the community should occur. It would be useful for the selected signage provider to attend a future Committee meeting to allow members the opportunity to provide input into the proposed programme of work and pictogram development. Members noted that wayfinding was critical for people with disabilities and that good improvement had been seen at Auckland DHB facilities recently. Auckland DHB have a strategic alliance with Design Labs and AUT which incorporates co-design principles and the consideration of international images and standards into all Facilities work which ensures positive outcomes such as this.
- It was suggested that Environmental sustainability be added to action item "Adoption of Universal Design principals in all Facilities work".
- The Health of Older People Strategy Review consultation workshops are currently in progress. Robyn Northey will attend the 'not health professional' session.

Actions:

That feedback be given to the Waitemata DHB Core Design Principles team that reference to Environmental Sustainability should be included in domains for Waitemata Core Design Principles

That, once appointed, the provider undertaking the review of current signage be invited to:

- **Present the signage review findings to the Disability Support Advisory Committee.**
- **Consult the Disability Support Advisory Committee on the design of new signage, symbols and pictograms.**

Resolution: Moved Sandra Coney / Seconded Jan Moss

That the report be received.

Carried

7.3 Facility Project Stocktake for Auckland and Waitemata DHBs (Pages 34 to 39)

The Chair advised that this report had resulted from the discussion between the Committee Chair and Director of Planning and Funding as it was considered the role of this Committee to have visibility of facilities projects and accessibility considerations.

Samantha Dalwood, Disability Strategy Advisor Waitemata DHB then spoke to the report on behalf of Allan Johns, General Manager Facilities and Development.

Matters covered in discussion and in response to questions included:

- The Committee sought clarification on how it is determined which facilities projects require an accessibility assessment. It was advised that Auckland DHB engage with a Barrier Free Trust advisor during the design stage of any refurbishment. The business case for each project is checked to see if any accessibility elements are involved.

All significant investment projects have senior management visibility. For Waitemata DHB the Disability Strategy Advisor is the key point of consultation.

- It was noted that the scope of Barrier Free Trust audits is physical accessibility only.
- There is no requirement for the inclusion of accessibility in order to meet Building Code compliance. Lobbying for a change in the code has been challenging and ongoing for many years.
- The need for hoists to be installed in hospital changing facilities for large adults with incontinence was raised.

Actions

That confirmation of what processes and considerations exist for determining the requirement for accessibility assessments for facilities projects be sought from the General Manager Facilities and Development.

That the processes for determining the requirement for accessibility assessments for facilities projects be reported to a future Disability Support Advisory Committee meeting.

Resolution: Moved Judith Bassett / Seconded Robyn Northey

That the report be received.

Carried

8. PAPERS (Pages 40 to 134)

8.1 Access to Bowel Screening and Cervical Screening Services for Disabled People – Barriers and Enablers (Pages 40 to 42)

Samantha Dalwood, Disability Strategy Advisor Waitemata DHB spoke to the report and responded to questions from the Committee.

Matters covered in discussion and in response to questions included:

- Evaluations of people that use the services would not be achievable. Data for screening programmes is not recorded or coded for disability and some service users prefer not to be identified in data as having a disability.
- Each screening programme has its own evaluation process, such as the patient experience surveys used by DHB's.

The Chair noted the positive improvements resulting from the meeting held by the Disability Advisors with the Metro Auckland Regional Cervical Screening Project Manager and Regional Cervical Screening Nurse Specialist.

Resolution: Moved Sandra Coney / Seconded Jo Agnew

That the report be received.

Carried

8.2 Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017 and the joint Waitemata and Auckland DHBs Disability Strategy Implementation Plan 2013-2016 (Pages 43 to 66)

The New Zealand Disability Strategy was developed in 2001 and is being revised in 2016. Both DHB's will working together to develop a joint 2016-2019 implementation plan over the coming months. These draft documents will come to the Committee for input once available.

It was advised that the work that the Disability Support Advisory Committee and DHB's are currently undertaking is aligned with the Maori Disability Action Plan.

Shane WiJohn highlighted that the action plan priority regarding good partnerships with Maori made reference to engagement processes in partnership with iwi. Shane advised that he is the iwi representative for Auckland however hasn't been engaged in any conversations about this action plan priority to date. Samantha Dalwood advised that it was expected that this would occur later in the implementation process. Shane added that the Disability Support Advisory Committee could add further context around some of the activities and could participate and provide input into the consultation process for the review of the New Zealand Disability Strategy.

Resolution: Moved Shane WiJohn / Seconded Robyn Northey

That the report be received.

That the Disability Advisory Support Committee:

1. **Extend their thanks to the Manawa Ora Committee for seeking its views on Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017.**
2. **Advise the Manawa Ora Committee that the Disability Support Advisory Committee are supportive of priorities of the Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017.**
3. **Advise the Manawa Ora Committee that it will work to ensure that the priorities within the Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017 are included in the New Zealand Disability Strategy 2016-2019.**

Carried

8.3 Health and Disability Commission Finding – Death of a Disabled Person in a Residential Care Home (Pages 67 to 134)

Members commented that unfortunately this type of case was not uncommon. Contributing factors included underpaid and undertrained staff, lack of supervision and experienced clinical staff and lack of resource to manage complex clinical need. NGO's also have limited funding. This leads to the increased vulnerability of disabled people with complex needs.

There was no further discussion.

Resolution: Moved Jo Agnew / Seconded Judith Bassett

That the report be received.

Carried

4. FOR INFORMATION (Pages 135 to 143)

9.1 Update on Putting People First Implementation

As mentioned earlier in the meeting, it was noted that the Ministry of Health are to be invited to the present to the June regional meeting.

Resolution: Moved Sandra Coney / Seconded Jade Farrar

That the report be received.

Carried

5. GENERAL BUSINESS

Nil.

The meeting closed at 3.53pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 09 March 2016

Chair: _____ Date: _____

Sandra Coney

Minutes
Regional Disability Support Advisory Committee Meeting
01 June 2016

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 01 June 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

Auckland and Waitemata DHB Committee Members Present Sandra Coney (Chair) Max Abbott Jo Agnew (Deputy Chair) Judith Bassett Marie Hull-Brown Dairne Kirton Dr Lester Levy Jan Moss Robyn Northey Russell Vickery	**Auckland and Waitemata DHB Staff Present** Ailsa Claire — Chief Executive Officer Auckland DHB Samantha Dalwood — Disability Advisor Waitemata DHB Dr Debbie Holdsworth — Director of Funding – Auckland and Waitemata DHB Brigita Krismayanti — Corporate Business Services Administrator Fiona Michel — Chief of People and Capability Auckland DHB Tony O'Connor — Director of Participation and Experience Auckland DHB Corina Paterson — Corporate Committee Administrator David Price — Director Patient Experience Waitemata DHB Marlene Skelton — Corporate Business Manager Kate Sladden — Funding and Development Manager, Health of Older People Sue Waters — Chief Health Professions Officer (Other staff members who attend for a particular item are named at the start of the minute for that item)
Counties Manukau DHB Committee Members Present Dr Lee Mathias (Board Chair) Colleen Brown (DiSAC Chair) Dianne Glenn Mr Sefita Hao'uli Ms Wendy Bremner Mr Ezekiel Robson Mr John Wong Arthur Anae	**Counties Manukau DHB Staff Present** Martin Chadwick — Director Allied Health Counties Manukau Health (DSAC Liaison) (Other staff members who attend for a particular item are named at the start of the respective minute)

Guests	Toni Atkinson	Group Manager, Disability Support Services, Ministry of Health

1. ATTENDANCE AND APOLOGIES

The Chair welcomed everyone to the meeting and asked that since it had been quite some time since the last regional meeting, that everyone around the table introduced themselves to the meeting.

Apologies were received from committee members Sandra Alofivae, Jade Farrar and Reese Autagaviaia. Apologies for late arrival were received from Marie Hull-Brown.

The apologies of Dale Bramley, Waitemata DHB Chief Executive were received.

Resolution: Moved Sandra Coney / Seconded Jan Moss

That the apologies be received.

Carried

2. CONFLICTS OF INTEREST (pages 6 to 11)

Russell Vickery advised he was temporary Acting Chair of the Wilson Home Trust from 13 June 2016.

3. PRESENTATIONS

3.1 People First Review Recommendations Implementation

Presenter: Toni Atkinson, Group Manager – Disability Support Services, Ministry of Health (MOH). (Attachment 3.3.1)

Toni provided the background to the review of performance and quality management services of MOH funded providers of disability support services.

An independent review was commissioned in 2013 by Minister, Tony Ryall, to review client and family complaints received by the MOH and to consider how to deal with such complaints. The review and all recommendations were accepted by the Minister in November 2013. There were 36 recommendations which evolved into 86 action points to be implemented over a two year period.

Three working groups were established which included support providers to disabled people, with governance being through a Ministry steering group (including a Disabled Persons' Assembly (DPA) representative).

Key points were:

Recommendation 1:

- Establish a process to streamline contracting with outcome measures rather than outputs.
- An annual provider forum would be organised across the country to share new and good practices beneficial to other providers.
- A special edition disability support newsletter would be published each year on International Day of People with Disabilities.

Recommendation 9:

- To support development of a new model of more flexible support options which would give individuals more choice and options for community living. This has proved to be successful in Auckland and Waikato with Hutt Valley and Christchurch the next regions to be rolled out.
- The introduction of Flexible Disability Support (FDS) contracts to 11 providers to offer support options for employing staff.
- Purchasing guidelines are currently being updated for enhanced individualised funding to make funding more beneficial to individuals.

Recommendation 10: The MOH has implemented a two year intern programme. So far, four interns have completed the programme with three being in employment (two fulltime, one in temporary work). The MOH encourages DHBs to employ disabled people and to look at the way they employ people and the barriers which stop people applying for roles, such as requiring a driver's licence.

Recommendation 13: The MOH has adopted a policy of 'no tolerance for abuse'. It has developed guidelines which will be published on its website shortly. It is a practical guide for providers and others in the disabled space.

Recommendation 14: A consumer consortium meets twice a year to ensure that those who cannot speak for themselves (and their families) are fairly represented at forums.

Recommendation 15: To ensure disabled people are safe after laying a complaint. MOH requires providers to have policies and guidelines in place, to report any complaints to the Police and to ensure the resident is kept safe while an investigation is underway.

Recommendation 16: The MOH has set up an expert panel to review complaints of allegations of abuse and can co-op other specialists to assist with a review as required. A trial was run in March with the process to be reviewed later this year.

Recommendation 22: The MOH has developed new incident reporting forms and will provide guidelines to providers as to what constitutes an incident and serious misconduct. More sophisticated tools are being investigated to capture this data.

Recommendation 28: All evaluation agencies are to place routine evaluation reports on their websites.

Recommendation 29: Conduct 'No notice' issues-based audits where the MOH appears on the provider's doorstep unannounced. The MOH has established criteria for 'no notice' audits which include complaints of cleanliness, the state of the facility, or an issue that needs to be addressed. The MOH is seeking to establish stronger links with the Police, CYFs and Housing NZ. The first RBA (results based accountability) results will be available in July. There is further work required in refining the outcome measures to be more useable.

Discussion was then invited from the floor.

- In answer to a question of, "*How do we give more voice and participation in communities – what tools are different to give flexible options to people?";* it was advised that a new model had been introduced to give 'independent facilitation' and navigation of the local area to assist disabled people outside the system to connect with the community and obtain the support they require. Individualised funding will allow a person to take allocated funding and make it work for them to buy services, choose staff, pay staff, give flexibility when staff come, etc.
- A comment was made in regard to the *consumer consortium*; it was felt that the Police had an issue with young people who are non-verbal. They are brushed off as unreliable witnesses and this is why they have yet to bring any successful cases in these situations.
- Concern was expressed about *incident reporting* and how it was determined who was at fault. Where an incident occurs between a disabled person and staff, sometimes this is due to the incompetency of staff. Young people have large lists of incident reports where there are no witnesses. They are often labelled as violent but this may be due to the poor management by or competency of staff. It was acknowledged that autistic teenagers have unpredictable behaviours and that often they can become aggressive through frustration due to their lack of communication skill.
- It was felt that *"enabling a good life"* was not possible in the Auckland region. There was very little choice for autistic people. Parents do not have the same choice when it came to respite care or additional services. There is a lack of training in this area and it tends to have the most poorly paid people providing these services. Opportunities for training young people were discussed. Free services to providers for training are available. The MOH provide backfill while staff are training.

- In answer to a question; "*Does there need to be a complaint before the MOH undertakes an audit or are there regular audits and if so, how regularly are they undertaken?"*
  It was advised that a residential provider with 5+ patients is audited regularly; however, there is no statutory requirement to audit smaller providers. Due to insufficient resourcing, MOH performs an audit on average, every three years. Work is being undertaken to look at regulating the frequency of audits for residential and aged providers.

  John Wong cited an incident where a migrant family whose mother was in a rest home was being abused. The mother had told the daughter who had complained to the Chinese Ageing Trust. The daughter was afraid that if she reported the abuse, her mother would be further abused. John asked how the Trust could further support the family. It was advised that nothing could be done unless the family laid a formal complaint.

  It was acknowledged that there was a challenge in what an auditor should be looking for when conducting an audit. The things that an auditor would look at are not always the things that are important to a resident or their families.

  It was commented that it was often what was heard from the GP and other support carers that provided some clarity and quality to data collected.

  It was acknowledged that there was a distance between MOH and DHBs at the operational level. It was questioned whether the model of distant commissioning was the right one in this instance. It was noted that the disabled community itself for some time had wanted it to be this way and did not want that direct relationship with a DHB.

  It was advised that the MOH has Contract Relationship Managers across the country who have the required links into local regions to reach the disabled community.

The Chair thanked Toni Atkinson for making the time to come and address the joint committee and for her report which had generated such a robust discussion.

4. DISCUSSION TOPICS (Pages 13 to 102)

4.1 Current and Future Areas of Focus for each DSAC (Pages 13 to 30)

Martin Chadwick, Director Allied Health Counties Manukau Health (DSAC Liaison) spoke to his report advising that he had been working with the Disabled Action Group as to what it wants as an organisation and what specific things need to be looked at.

Areas to be focussed on are:

- Clinician literacy to enable staff members to understand what it is like to work alongside or with someone with a disability.
- The establishment of localities and getting disabled people and older peoples communities to be part of localities projects was a challenge.

It was noted that one of the key issues was the lack of data on disabilities which inhibits specific planning.

An open discussion followed to determine what areas the DiSAC groups could focus on.

- It was noted that there was a lack of clinician health literary which was especially challenging in the disability sector and especially for those disabled people who sit outside recognised disability groups. It was agreed that a truly regional collaboration was required to deal with this issue. Auckland and Waitemata DHBs were working together to complete the current three year Disability Strategy Implementation Plan which has been split into five main areas to focus on. Samantha Dalwood (WDHB) advised they are waiting for the government review of the New Zealand Disability Strategy to be completed and key areas identified for the DHBs to develop their implementation plan for the next three years.

Resolution: Moved Sandra Coney / Seconded Jo Agnew

That the Regional Disability Support Advisory Committee:

1. **Receives the reports.**
   Noting that the focus of the Counties Manukau Health DiSAC for 2016 onward is on:
   - **Monitoring progress on the initiatives underway around clinician literacy.**
   - **Monitoring the maturation of the Localities and Local Boards to be able to ensure the voice of the disability community is heard.**
   - **Learning from social media campaigns that have been undertaken by CM Health and to determine if there are any lessons that can be applied to raising awareness around the disability community.**
   - **Continuing to engage with Health Point and Health Navigator to ensure there is adequate representation of material pertaining to the disability community.**
   - **Building the focus on data as it pertains to the disability community.**

   Noting that the five main works areas Auckland and Waitemata DHB are focussing on to ensure both are fully inclusive (as outlined in the 2013 – 16 Disability Strategy Implementation Plan) are:
   - **Communication and Access to Information**
   - **Physical Access**
     Disability Responsiveness
   - **Community and Consumer Engagement**
   - **Employment Opportunities**

   Notes that Auckland and Waitemata DHBs have commenced work to develop the 2016-2019 Disability Strategy Implementation Plan

2. **Supports there being a regional approach with the required resource allocated to support increasing consumer health literacy across the region.**

Carried

4.2 Collection of Data for Patients with Disabilities (Pages 31 to 34)

Martin Chadwick, Director Allied Health Counties Manukau Health (DSAC Liaison) spoke to his report advising that coding was being conducted in its own right utilising a very crude tool. This does not address the innate difficulties at a granular level or to understand exactly what is occurring.

Dr Doone Winnard was invited to make a short presentation. (Attachment 4.4.2)

Discussion was then invited from the floor.

- A Disability Data and Evidence Working Group has been established to focus on the lack of data. Contact has been made with Statistics New Zealand in order to get questions into relevant surveys. It was advised that there had been talk that there may not be specific questions relating to disability in the survey after the next census.
- A stocktake has been carried out to determine what information is held on people with disabilities and highlights current limitations. It has also provided a good summary of just what information is available.
- Some key questions were posed; "what are the core enduring questions in the disabilities domain?" and "what information is required to do the right thing for people to feel involved?" It was acknowledged that there was a need to think very clearly about what data is required. Data in itself will not change a situation unless it is used wisely.

- It was noted that there is disability data available but it raises more questions than it answers. The DiSAC committees need to engage with the Disability Data and Evidence Working Group in a way to ensure a regional and connected voice is heard.
- It was advised that some well attended disability workshops had recently been held across Auckland and in Hamilton. What was highlighted was that Pacifika people have quite a limited voice in the community as do older people who tend to distance themselves from disability. While the voices are filtering freely there is a requirement for strong thematic principles regionally owned and driven.
- Dr Doone Winnard said consideration needed to be given to whether we really knew what data we needed for good decision-making? Are we comfortable the decisions we are already making don't already include disabled people? The situation is a complex one. Disabilities are so wide ranging and varied. A high level strategic view is required along with deep dives that provide granular detail. There is also the need to understand the role of prevention and be aware that some issues are disease related, aging and childhood prevention of rheumatic fever for example.

A discussion was had as to what the next steps for this group should be.

It was agreed that there needs to be a consistent approach across the Auckland region in the way data is collected. There was not a lot known about the Auckland population or how accurate the data is. Information is currently only collected in an adult space and then only used for specific purposes. No detail is collected, for example if a baby is diagnosed with a disability.

It was acknowledged that Auckland DHB does not know the numbers of staff with disabilities it employs. It was unlikely that Waitemata or Counties Manukau DHBs have this information either. The need for caution due to privacy reasons was noted when collecting information pertaining to staff.

It was agreed that for the DHBs to be an organisation of choice for disabled people, support needed to be provided. As a group there is a need to be clear of the objectives then ask Human Resources how to implement this. It was suggested that a small number of metro DiSAC committee members formulate a working group to work in collaboration with Human Resources departments to this end.

Resolution: Moved Jo Agnew / Seconded Diane Glenn

1. That the reports be received.

2. That the Auckland Metro DiSAC groups:
- **2.1 Actively engage with the disability data and evidence working group**
- **2.2 Seek to understand how the need for better disability population data will be reflected in the review of the disability strategy.**

3. That the Auckland Metro DiSAC groups recommend to their Boards that:
- **3.1 The same method of data collection be employed across the three regional DHBs**
- **3.2 They investigate processes for the collection of the identified data about staff with disabilities.**
- **3.3 A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.**

Carried

[Secretarial Note: Max Abbott and Marie Hull-Brown were welcomed to the meeting.]

4.3 Auckland and Waitemata DHB Patient Experience Reports (Pages 35 to 44)

Tony O'Connor – Director of Participation and Experience Auckland DHB spoke to his report David Price - Director Patient Experience Waitemata DHB was present to answer any questions about Waitemata's work.

The survey received 3,000 responses with between 40-45% of patients having a disability. Patients with sight impairment struggled to complete the survey so it was suggested that future surveys be made accessible through screen readers.

The responses showed there was not a great difference between those with or without a disability, although those with a disability gave slightly lower scores. Good communication and confident health professionals who understood their patient's requirements rated highly followed by accessibility (beds with motors, wheelchairs, staff availability and helpfulness). What appeared to matter most was good discharge and connection plans.

Discussion was then invited from the floor.

- Jan Moss questioned how the experience of autistic, severely disabled or non-verbal patients would be captured. It was acknowledged it would be a challenge to collect this data which required good connections into the disabled community. She suggested consulting with families with autism or a severe disability on their experiences, especially those with experiences of the emergency department.
- Ezekiel Robson shared a positive patient experience where staff had been flexible in recording a patient complaint. If a complaint to a DHB could not put in writing, people were happy to simply verbalise their complaint over the telephone provided it was given the same weight as a written complaint. In the end, it was all about the patient getting what they required.

Resolution: Moved Sandra Coney / Seconded Lee Mathias

That the report be received.

Carried

4.4 Environmental Accessibility at Auckland and Waitemata DHBs (Pages 45 to 102)

Tony O'Connor – Director of Participation and Experience Auckland DHB spoke to his report.

The key roles of the project are to ensure welcoming public spaces and the safe and comfortable movement around the hospital. This is based on what patients and families have related that they want the spaces to do for them and what is international best practice.

Completed to date is improved entry to the hospital, wheelchair bays now placed at the entrances of the hospital, a taxi telephone installed on L4 with improved signage, (this was not previously accessible for people in wheelchairs) and confusing signage removed from Reception on level 5.

Discussion was then invited from the floor.

- There needs to be a consistent look and feel across all the DHBs not just Auckland Hospital so that a common experience is provided.
- The question was raised whether the recommendations in the Be.Accessible report meet NZ4121 standards? Martin advised that Counties DiSAC don't want to be code compliant, they want to exceed that. They are 1% away from attaining Gold status. Counties Manukau cautioned that this was an expensive exercise.

- Jan Moss commented that there were no dedicated changing places for incontinent or disabled young people in the regional hospitals. Families were confined to being only able to leave home for very short periods. It would be good if hospitals would consider that sort of facility.
- The question was raised as to what our strategy is for making sure all facilities are accessible. There was a time when hospitals had their own staff doing this. Samantha Dalwood advised that Waitemata DHB had eight members of staff attending Barrier Free training in June.

Resolution: Moved Sandra Coney / Seconded Judith Bassett

1. **That the reports be received.**
2. **That the approach by Counties Manukau Health to test using an external agency to review facility accessibility.**

Carried

5 GENERAL BUSINESS

Ezekiel Robson tabled an open invitation received from the Blind Foundation, Chief Executive on its, 'Why Accessibility Matters Research Day' seminar. (Attachment 5) This was an opportunity for staff and board members, leaders, researchers and policymakers to attend.

6 CLOSING COMMENTS

The Chair, Sandra Coney, closed the meeting and thanked everyone for attending. Sandra acknowledged that it had been a very useful and valuable meeting where learning was shared and an opportunity provided to work together to get some consistency across the region. Colleen Brown, Counties Manukau DHB DiSAC Chair reiterated that by working together in a complementary fashion, it would provide patients a consistency in experience and be cost effective.

Both Chairs undertook to meet to discuss next steps in how to make the most of opportunities that promoted a regional approach to disability support.

The meeting closed at 3.35 pm.

Signed as a true and correct record of the Regional Disability Support Advisory Committee meeting held on Wednesday, 01 June 2016

Chair: _____ Date: _____

Sandra Coney

Minutes
Special Disability Support Advisory Committee Meeting
13 July 2016

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 13 July 2016 in the the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 12.00pm

Committee Members present	**Auckland DHB and Waitemata DHB Staff present**	
Sandra Coney (Chair)	Samantha Dalwood	Disability Advisor Waitemata DHB
Max Abbott	Ian Grant	Senior Project Manager Auckland DHB
Jo Agnew (Deputy Chair)	Dr Debbie Holdsworth	Director of Funding – Auckland and Waitemata DHBs
Dairne Kirton		
Robyn Northey	Marlene Skelton	Corporate Business Manager
Russell Vickery	Sue Waters	Chief Health Professions Officer
Jade Farrar	Matthew Knight	Senior Project Manager Waitemata DHB
	Brigita Krismayanti	Committee Administrator
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apologies of committee members Judith Bassett, Marie Hull-Brown, Lester Levy and Jan Moss be received.

That the apologies of senior management, Ailsa Claire and Dale Bramley be received.

2. CONFLICTS OF INTEREST

There were none.

3. RESOLUTION TO EXCLUDE THE PUBLIC FROM THE MEETING (Pages 11)

Resolution: Moved Jo Agnew / Seconded Robyn Northey

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting

for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Implementation of the External Signage and Way-Finding Upgrade	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 1.30pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 13 July 2016

Chair: _____ Date: _____

Sandra Coney

Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 24 August 2016

Meeting and Item	Detail of Action	Designated to	Action by
9 Mar 16 Item 3.0	**Care of High Needs Young Patients While in Hospital** That the process for ACC patients with complex needs accessing funding for support whilst in hospital be investigated and reported back to the June Disability Support Advisory Committee meeting.	S Dalwood	See item 4.2 on this agenda
9 Mar 16 Item 7.2	**Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs** 1. That the Audits table be amended to provide cumulative data of all facilities achieving continuous improvement. 2. That, upon release of the Ministry of Health draft 'Care Guide for Secure Dementia Unit Design from a Person Centred Perspective' document for consultation, the information be circulated to Disability Support Advisory Committee members for comment and decision on whether or not a submission be made.	K Sladden K Sladden, M Webb	1 June 2016 Once available
9 Mar 16 Item 7.3	**Facility Project Stocktake for Auckland and Waitemata DHBs** 1. That confirmation of what processes and considerations exist for determining the requirement for accessibility assessments for facilities projects be sought from the General Manager Facilities and Development. 2. That the processes for determining the requirement for accessibility assessments for facilities projects be reported to a future Disability Support Advisory Committee meeting.	S Waters S Waters / A Johns	 See item 4.1 on this agenda
3 Jun 2015	**Care of High Needs Young Patients While in Hospital** That a progress report be brought back to the Committee at its June 2016 meeting, with a view to reporting to the Ministry of Health how well the interim process for access to support	S Dalwood	1 June 2016

	funding for hospital patients requiring complex care is working.		
3 Jun 2015 Item 8.1 And 9 Mar 2016 Item 4	**Disability Support Advisory Committees' Terms of Reference** 1. Advise the Minister of Health of the proposed amendments to the Committees' Terms of Reference. 2. Subject to the Minister of Health's agreement to the proposed amendments to the Committees' Terms of Reference, submit the draft paper to the Auckland and Waitemata District Health Board Boards. 3. That the Committee Secretary seek an update on the status of the Disability Support Advisory Committee Terms of Reference from the Board Chair and report back to the June Committee Meeting.	Chair of Auckland and Waitemata Health Boards	TBA
3 Jun 15 Item 8.2	**Update on Collation of Statistic that Identify People with Impairments** That the Funder explore with both Auckland and Waitemata DHBs the implications of establishing a mechanism in future reporting systems that uses the definition of 'disability' and 2013 Census Questions 16 and 17 to capture functioning and disability information when reporting on serious adverse events.	D Holdsworth	Ongoing
11 Mar 2015 Item 7.1	**Age Related Residential Care** All age related residential care providers will be using InterRAI by 2015. When baseline information becomes available from MoH a report is to be provided to the Committee, focusing on the impact InterRAI has had on outcomes in the community.	K Sladden	When information becomes available

Facilities and Development Project List

That the Disability Support Advisory Committee receive the report.

Prepared by: Marlene Skelton (Corporate Business Manager)

1. Background

The Disability Support Advisory Committee at its 9 March 2016 meeting asked that confirmation of what processes and considerations exist for determining the requirement for accessibility assessments for facilities projects be sought from the General Manager Facilities and Development.

Attached are a list of projects to be undertaken for both Auckland and Waitemata District Health Boards, either currently or in the near future, and an indication where the Disability Advisor has been involved or will be involved.

A more detailed verbal explanation of what processes and considerations exist for determining the requirement for accessibility assessments for facilities projects will be provided at the meeting.

Facilities & Development - Project list - August 2016 - DSAC Report

#	Campus	Building	Project Title	Go Live Date (Indicative)	F&D PM	Stage of Project	Accessibility Assessment? Disability Advisor Involved	Comment
1	218 Gt South Rd	218	218 Gt Sth Rd - YTP House Renovation	tbc	Steve Smith	ON HOLD	N/a	confirm when project off hold
1	Mountwell Cres, Panmure	new	Renal Dialysis - Satellite	Dec-17	Kathy Peacock	Planning	no	CCS Consultant to be engaged for design review
1	Grafton Campus	A01 - Support	Primary Birthing Unit Development - Level 10 A01	tbc	Kathy Peacock	ON HOLD	N/a	confirm when project off hold
1	Grafton Campus	A01 - Support	Level 10 Tamaki Ward Carpet to Vinyl	tbc	Steve Smith	ON HOLD	n/a	confirm when project off hold
1	Grafton Campus	A01 - Support	Acute Haemodialysis Unit - minor modifications	Mar-17	Kathy Peacock	Planning	No	
1	Grafton Campus	A01 - Support	Level 5 Retail Review and Quick Fixes	Jan-17	Tania Cottew	Planning	no	
1	Grafton Campus	A01 - Support	RMO Lounge Roof Repair	Jun-17	Tania Cottew	Planning	no	Not required
1	Grafton Campus	A01 - Support	L4 PAE Relocation	Mar-17	Tania Cottew	Planning	no	
1	Grafton Campus	A01 - Support	L4 Facilities Offices Relocation	Mar-17	Tania Cottew	Planning	no	
1	Grafton Campus	A01 - Support	ACH Public Spaces - Level 5, L6, L7, L8, L9 bridges	tbc	Tania Cottew	Planning	no	Design facilitated by PIT & Design Lab
1	Grafton Campus	A01 - Support	RMO Lounge Refurbishment	tbc	Tania Cottew	Planning	no	
1	Grafton Campus	A02 - Starship	Starship Radiology Nuclear Medicine - Gamma Camera	tbc	Tania Cottew	ON HOLD	N/a	confirm when project off hold
1	Grafton Campus	A02 - Starship	Paediatric Cath Lab Upgrade (Rm18.049) - Stage 2	Mar-17	Tania Cottew	Planning	no	Not required
1	Grafton Campus	A02 - Starship	Ward 25 A & B Refurbishment	Jun-17	Albert Lee	Planning	Yes	CCS Consultant to be engaged for design review
1	Grafton Campus	A07	ACH Bldg 7 Decant - SMO & Palliative Care	Feb-17	Kathy Peacock	Planning	No	
1	Grafton Campus	A08 - Oncology	MV 3 Linear Accelerator 16-17 - replacement	Dec-17	Steve Smith	Initiate	No	Consultation with the DA to occur at detailed design stage
1	Grafton Campus	A08 - Oncology	A08 L4 Brachytherapy Project - HDR Bunker	tbc	Kathy Peacock	ON HOLD	n/a	confirm when project off hold
1	Grafton Campus	A08 - Oncology	Oncology Building Toilet Upgrade	Jun-17	Steve Smith	Planning	No	
1	Grafton Campus	A08 - Oncology	MV 2 Linear Accelerator 15-16 - replacement	Jun-17	Steve Smith	Planning	No	
1	Grafton Campus	A08 - Oncology	ACH Oncology Lift Car Refurbishment	tbc	Steve Smith	Planning	no	
1	Grafton Campus	A15 - FMU	A15 Fraser McDonald Unit Upgrade	Jun-17	Tania Cottew	Planning	no	CCS Consultant to be engaged for design review
1	Grafton Campus	A32 - Main Building	Echo Toilets	Dec-16	Robert Mustart	Initiate	No	Consultation with the DA to occur at detailed design stage
1	Grafton Campus	A32 - Main Building	Ward 71 - Replace Carpet with Vinyl in corridors	tbc	Steve Smith	ON HOLD	n/a	confirm when project off hold
1	Grafton Campus	A32 - Main Building	Clinical Decision Unit - Level 2, A32	Dec-17	Kathy Peacock	Planning	No	CCS Consultant to be engaged for design review
1	Grafton Campus	A32 - Main Building	Ward 97 Medication Room - RTC	Mar-17	Robert Mustart	Planning	No	
1	Grafton Campus	A32 - Main Building	Releasing Time to Care - Inpatient Ward Signage - A32	Dec-16	Steve Smith	Planning	No	Design facilitated by PIT & Design Lab
1	Grafton Campus	A32 - Main Building	Gamma Camera - Level 5, ACH	Jun-17	Steve Smith	Planning	No	
1	Grafton Campus	A32 - Main Building	ACH A32 Main Hospital - theatre lift doors upgrade	Dec-16	Steve Smith	Planning	no	Not required
1	Grafton Campus	A32 - Main Building	ACH Bathroom upgrades / renewals	tbc	Steve Smith / Robert Mustart	Planning	no	
1	Grafton Campus	A32 - Main Building	ACH Cath Lab 1 Rm no. 31.049	Feb-17	Tania Cottew	Planning	no	
1	Grafton Campus	A32 - Main Building	ACH Service Lifts Repair/ Refurbishment	tbc	Steve Smith	Planning	no	
1	Grafton Campus	A33 - Car Park B	Car Park B anti-suicide fencing	tbc	Steve Smith	ON HOLD	n/a	confirm when project off hold
1	Grafton Campus	A35 - TWT	Anti-Ligature Audit and Review - Mental Health	Feb-17	Albert Lee	Planning	no	Not required
1	Grafton Campus	A56	Haemodialysis Relocation from Grafton to Greenlane	Dec-20	Kathy Peacock	Initiate	No	Consultation with the DA to occur at detailed design stage
1	Grafton Campus	External	Paedestrian Safety Project	Jun-17	Ian Grant	Planning	No	Consultation with the DA to occur at detailed design stage
1	Grafton Campus	new	Auckland Integrated Cancer Centre	Dec-20	Kathy Peacock	Planning	No	Consultation with the DA to occur at detailed design stage
1	Greenlane Campus	External	Car Park Redevelopment	tbc	Steve Smith	ON HOLD	n/a	confirm when project off hold
1	Greenlane Campus	External	Demolition of Greenlane Bldg 10 - final stage	tbc	Steve Smith	ON HOLD	N/a	confirm when project off hold
1	Greenlane Campus	External	GCC Traffic safety review	Jun-17	Albert Lee	Planning	no	
1	Greenlane Campus	G04	Radiology Reception Refurbishment	tbc	Robert Mustart	Initiate	no	
1	Greenlane Campus	G07	Physiotherapy Outpatient Redevelopment - Greenlane	tbc	Kathy Peacock	ON HOLD	N/a	confirm when project off hold
1	Greenlane Campus	G07	Epsom Day Unit - Refurbishment - Building 7, Level 5	tbc	Kathy Peacock	ON HOLD	N/a	confirm when project off hold
1	Greenlane Campus	G13	Building 13 - Refurb to L3, L5, L6, L7 - kitchens, corridors, bath	tbc	Steve Smith	Initiate	no	
1	Greenlane Campus	G17	Greenlane Bldg 17 Home Health - Ground and First Floor Refurb	tbc	Albert Lee	ON HOLD	N/a	confirm when project off hold
1	Greenlane Campus	tbc	Endoscopy Service - long term expansion at Greenlane	tbc	Kathy Peacock	ON HOLD	no	confirm when project off hold

Waitemata District Health Board
Best Care for Everyone

PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES
NORTH SHORE CAMPUS APPROVED/IN PROGRESS			
Bridge Link Elective Surgery Centre to Main Building	Jun 16	Yes	Project in Defects Liability period. Review of pedestrian access underway. Remedial works under review. Presentation to DSAC on proposed solution following consultation with project team and WDHB stakeholders.
Community Building 5 - Relocation of Outpatients & Office refurbishment	March 16	Yes	Regular meetings with the DA to discuss access and facilities.
Site Master Plan – NSH & WTK / Procurement	Dec 16	No	Consultation with DA/ DSAC to occur at detailed design stage.
WDHB Medical Tower	2020	No	Consultation with DSAC to occur at detailed design stage.
Ground Floor Redevelopment • Antenatal • Cardiology			Project stopped in February 2016
Ground Floor Redevelopment • Diagnostic Breast Service • SSW	TBC	No	Consultation with DA/ DSAC to occur at detailed design stage.
Operating Theatre Refurbishment, Level 1, Main Building (1, 6, 7 & 8)	Oct 16	No	Refurbishment of 4/4 theatres underway.
Awhina Clinical and Learning Skills Centre, Lakeside (detailed design)	Mar 17	No	Consultation to occur to occur at detailed design stage.
Taharoto at NSH - Seismic Strengthening/ North Wing Refurb	June 2016	No	Siesmic upgrade no change to access.
Gastroenterology Re-Processing Room Alterations, Level 1, Main Building	tbc	No	Consultation with DA/ DSAC to occur at detailed design stage..
WDHB Infrastructure Upgrade NSH & WTH	tbc	No	Consultation with DA/ DSAC to occur at detailed design stage..
NS Procedure Suite & Short Stay/Day Stay Wards	Jun 18	No	Consultation with DA/ DSAC to occur at detailed design stage..
In patient Pharmacy Expansion	tbc	Yes	Reviewed PD drawings
Car park building, NSH	tbc	No	Consultation with DA/ DSAC to occur at detailed design stage.
Relocation of Child and Youth MHS and North Child Health Services- Pupuke Building		No	Consultation with DA/DSAC once new location is found.
NORTH SHORE CAMPUS/UNDER DEVELOPMENT			
SCBU (Special Care Baby Unit) Redevelopment, Level 2, Building 15 – NSH	March 17		Consultation with DA/ DSAC to occur at detailed design stage..
NSH office refurbishments • Surgical Pathology Office – Relocation and Refurbishment – NSH • 3 Mary Poynton • 15 Shea Terrace • 17 Shea Terrace • Telephonists Office • Level 8 offices	Sep 16		Drawings shared via email. DA shall be consulted if proceed. Concept design to be shared with DA Concept design to be shared with DA DA shall be consulted if proceed. Concept design to be shared with DA
Hyperbaric Oxygen Treatment Chamber – Feasibility Study – NSH • Feasibility report	2017/18		Consultation with DA/ DSAC to occur at detailed design stage..

Waitemata District Health Board
Best Care for Everyone

PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES
• Construction • Helipad feasibility report complete			
Ambulatory & Outpatient Precinct including: Breast Care & Mammography Screening Ambulatory Module Oncology & Haematology Ambulatory Module	tbc tbc tbc		Consultation with DA/ DSAC to occur at detailed design stage..
Whanau Home Away from Home Accommodation, Lakeside – NSH	tbc		Consultation with DA/ DSAC to occur at detailed design stage..
Signage & Way finding – External	tbc		Member of DSAC on the Signage and Way Finding Steering Group. Artwork presented to June DSAC Board meeting. Further update to be provided at August Board meeting.
WAITAKERE HOSPITAL CAMPUS APPROVED/IN PROGRESS			
Emergency Department Redevelopment	Aug 16		DA worked on preliminary design to identify access issues and improve waiting spaces for patients. Separate waiting area for people who find waiting difficult. Presentation to DiSAC June 2015. Stage 1 – new build complete and Go Live Aug 2016
Emergency Department Refurbishment	Apr 17		
Dangerous Goods Store	Oct 16		DA/ DSAC to be consulted on design
Seismic Strengthening - Snelgar & Health West	Q1 2017		DA/ DSAC to be consulted on design
Signage & Wayfinding - External	Q4 2016		Member of DSAC on the Signage and Way Finding Steering Group. Artwork presented to June DSAC Board meeting. Further update to be provided at August Board meeting.
CT & Waiting Area	March 17		DA/DSAC to be consulted on design
Waitakere Additional Beds	Dec 2016		DA/DSAC to be consulted ongoing.
WAITAKERE HOSPITAL CAMPUS/UNDER DEVELOPMENT			
WTH Redevelopment	tbc		
Waitakere Campus Staff Gymnasium	tbc		
Waitakere MRI	Mid 17		DA/ DSAC to be consulted on design
MASON CLINIC APPROVED/IN PROGRESS /UNDER DEVELOPMENT			
Remedial Weather Tightness Works	2022		These are reclads of existing buildings. 3 Buildings fully remediated, one building currently undergoing remediation.
15-Bed Medium Secure Inpatient Unit	May 2017		Plans reviewed by DA
Additional Projects in Feasibility Phase	TBC		On Hold pending approval
COMMUNITY CAMPUS APPROVED/ IN PROGRESS/UNDER DEVELOPMENT			
Hibiscus Coast Mental Health			
Pitman House Refurbishment			DA completed access audit in 2012. This report will still be relevant. The current refurbishment work is only decorative involving painting and floor covering replacement.

PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES	
COMPLETED PROJECTS - MONITORING				
Department of Medicine Office Suite – Level 3, Podium	Feb 16	No		Project in Defects Liability period.
Ward 3 Refurbishment, Building 15, Tower	Apr 16	Yes		Project in defects liability period.
Store Room Kanban Modernisation, Inpatient wards, North Shore	May 2016	No		Installation of shelving to clean utilities. Project in Defects Liability period.
Te Atarau Demolition and Establishment of On-Grade Car Park	Apr 16	Yes		DA given guidance to Facilities on exceeding Standards NZ4121 mobility car park gudielines.
Store Room Kanban Modernisation, inpatient wards, Waitakere Hospital	May 2016	No		Project in defects liability period.
Karaka St – barrier installation	Mar 16	No		
Podium Extension L3	Dec 15	Yes		
15 Bed Gynaecology Inpatient Unit – Level 2	Oct 15	Yes		
Loading Dock Safety Improvements, Lower GF, Main Building	Sep 15	No		
Front Of House Interior Refurbishment, Ground Floor, Main Building	Nov 15	Yes		
Histology (Surgical Pathology) Refurbishment – Level 1, Main Building	Aug 15	No		Refurbishment within Surgical Pathology lab only.
Clinical Records Office Refurbishment – Lower GF, Main Building; Stage 2 completion	Jan 16	Yes		
Flagpole Erection	Dec 15	No		Project completed
Campus Wide Security Review – Mason Clinic	Aug 15	No		

Public Spaces

Update for DISAC

EXECUTIVE SPONSOR: Andrew Old

STEERING COMMITTEE: Ailsa Clare, Rosalie Percival, Allan Johns, Sue Waters, Clare Thompson

Finding My Way

Update for DISAC | August 2016

EXECUTIVE SPONSOR: Sue Waters

TEAM: Malini Subramoney, Eden Short, Reid Douglas, Lisa Couldrey, Ian Grant, Janet Brown, Carla Jacobsen, Annemarie Hay, Maxine Stead.

Project Overview

Goal

Well-designed wayfinding for people to navigate our facilities with ease and confidence

Background

In 2014 ADHB embarked on a Discovery Week to better understand people's experience of the public areas at Auckland City Hospital.

Public feedback during that week confirmed what we hear through patient complaints, patient experience surveys, and our staff, which is that our facilities are difficult to navigate. As a result some patients and family members arrive feeling anxious, stressed and have a severely compromised ability to face minor challenges. Poor wayfinding and inconsistent assistance from staff at the entrances add to frustrations and fears already present.

Key Roles

- Enable safe, comfortable movement around the hospital
- Be welcoming, inviting and comfortable
- Enable safe arrival and entry at Auckland City Hospital

Principles

- Consistent look and feel
- Patient and family focussed
- Accessible
- Multicultural
- Use of Te Reo
- Flexible and easy to update
- Reflect local context

Strategy Developement

- Completed a literature review
- Reviewed best practice health wayfinding guidelines: American Disability Association (ADA), National Health Service (NHS), New South Wales (NSW), Australasian Health Facility Guidelines (AHFG), The Centre for Health Design.
- 'Go See' site visits to Taranaki DHB, Middlemore Hospital, Auckland Airport, Auckland Art Gallery, Auckland Museum and Auckland Transport.
- Interim hospital wayfinding guidelines.

External Wayfinding

The route to emergency is a frequently asked question of our Bluecoat volunteers.

Finding your way to emergency is especially confusing for people entering the hospital from level 5 via Car park A. In addition, the Quality department recently completed a root cause analysis for an incident that impacted patient safety and recommended a review of all directional signage leading to the Emergency Department.

We will be undertaking a scoping exercise in July 2016 to explore the routes to emergency to understand the issues for access experienced by our patients and visitors accessing Emergency.

Wayfinding Strategy

Without a sustainable program, anything we achieve now make little difference in the future.

This document will provide visibility of the 'big picture', outline design principles, and have indicative concept designs. It can be used internally, and externally, to collaborate with externals in expert detail designs for specific projects. Additionally, a site audit will be conducted to inform recommendations and direction for the campuses future wayfinding.

References

- *American Disability Association (ADA)*, 2010
- *Australasian Health Facility Guidelines (AHFG)* , 2016
- *The Centre for Health Design,* 2007
- *National Health Service (NHS) Wayfinding*, 2005
- *New South Wales (NSW) Wayfinding for Healthcare Facilities*, 2014
- *ISO 7001: 2007 Graphical Symbols—public information symbols*
- *ISO 22727: 2007 Graphical Symbols—creation and design of public information symbols—requirements*
- *Signage & Wayfinding Design*, Chris Calori & David Vanden-Eynden, 2015
- *Wayfinding: Embedding knowledge in hospital environments,* Clementinah Ndhlovu Rooke et al., 2009
- *The Wayfinding Handbook,* David Gibson, 2012
- *Wayfinding > Wayshowing,* Per Mollerup, 2013

Wayfinding Design Guideline

To sign off an agreed approach for all wayfinding initiatives at ADHB

- Guidelines we will follow (NHS, NSW)
- Principles e.g. use of iconography
- Typeface
- Colour System
- Naming Conventions
- Process for requesting and installing signage

Icon Placement

For the sake of clarity, only standard icons are used as a wayfinding aid, excluding the healthcare specific set for various specialities, equipment etc. In cases where custom signage is needed (other than what is visible in the following catalogue), such as stairs, etc. indicate this requirement to the DHW Lab., and further icons can be provided as needed.

Directional

Primary directional

150x150mm

Progress in this direction

Lifts

Secondary directional

100x100mm

Tea & coffee

Progress in this direction

Lifts

Text & Typography

Text

- Title case to be used on all signage
- An ampersand [&] to be used in place of 'and' to maximise real estate of the sign
- Whilst the template displays numbers in '00', no zero is to come before a number '01' '1'
- When identifying or directing to a destination in a ward, the ward number should always be mentioned to reiterate the relationship between colour coding and the signs.
- An en dash '–' should always be used when stating room numbers e.g. 'Rooms 1 – 4' with a space cushioning each side. The short cut for this is (option + hyphen).

Text aligned to the left Text centred Text aligned to the right

Kern / Space between letters

- Follows the ADA requirements of /the character spacing to be between 10-30% of character height.
- 'Everything' consultancy in their initial review tested 15%-30% spacing with the typeface Avenir, and final recommendations concluded with 10% spacing on characters.
- For the sake of clarity, at times longer viewing distance, and varying character size on signage, 20% is the standard, and 30% for the smaller size font within the signage design.
- 10% is used in cases where signage real estate is at a non-negotiable minimum, e.g. wall flags, or on a sign covering an previous marker.

Leading / Space between lines

- Follows the ADA requirements of the character lines between 135-170% of character height.
- 'Everything' consultancy in their initial review tested 170% spacing with the typeface Avenir.
- For the sake of clarity, at times longer viewing distance, and varying character size on signage, 170% is the standard, and 135% for the smaller size font (the lower hierarchy information) within the signage design.

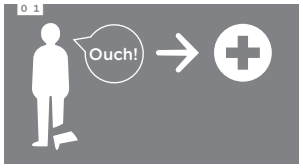
Tool – User Journey Mapping

Getting to the facility in an emergency

MORE INFO

THE USER'S JOURNEY

Step 01
Getting Ready To Go

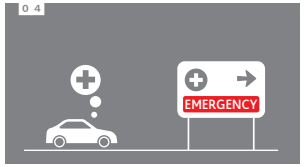


A person is injured, and requires emergency medical treatment.

They have a friend or relative drive them to the nearest hospital.

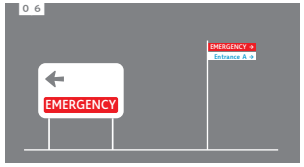
Step 02
Getting There

They already understand generally where the hospital is and drive towards it. Road signs within the vicinity provide gradually more specific information.



As they get closer, road signs begin to indicate the presence of Emergency.

Signs at precinct entrances show where emergency is located, in clear white text on a red field.

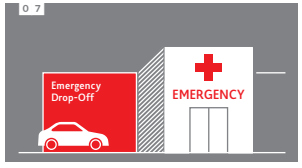


They follow on-site signs to Emergency. These signs conform to the same white on red convention.

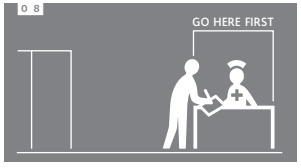
MORE INFO

THE USER'S JOURNEY

Step 04
Arriving/ Departing



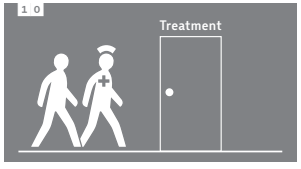
The Emergency entrance is highly visible & clearly labeled. It is within easy walking distance of the drop off point.



The reception desk is clearly visible from the entrance. It is signed as the first place to attend upon entering.

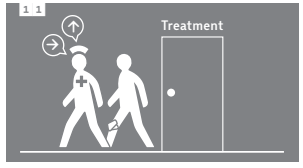
Step 03
Getting Around

The person is assessed, and asked to wait. Signs provided throughout the space indicate that they are to approach staff if they start to feel worse, or have been waiting along time.



Staff guide patient to treatment room.

Step 04
Arriving/ Departing



Having been treated, the patient is guided back to reception and given verbal directions for how to make their way out.

Healing Environments

Update for DISAC | August 2016

EXECUTIVE SPONSOR: Andrew Old **SPONSOR:** TBD **TEAM:** Abbi Harwood-Tobin, Ivana Nakarada-Kordic, Nick Hayes, Reid Douglas, Alasdair Nelson, Tania Cottew.

Project Overview

Goal

Well-designed spaces that instil confidence in the care that is provided and improve the user experience at Auckland City Hospital.

Background

Healing environments, for healthcare buildings describes a physical setting and organisational culture that supports patients and families through the stresses imposed by illness, hospitalisation, medical visits, the process of healing, and sometimes, bereavement.

Key roles of public spaces

- Be welcoming, inviting and comfortable
- Enable safe arrival, entry and exit
- Enable safe, comfortable movement
- Enable better life management within the hospital
- Enable calm, privacy and refuge
- Enable recreation and social interaction
- Build and promote community partnership

Principles

- Consistent look and feel
- Patient and family focussed
- Accessible
- Multicultural
- Use of Te Reo
- Flexible and easy to update
- Reflect local context

Interior Look and Feel Guidelines

EXECUTIVE SPONSOR: Andrew Old

BUSINESS OWNER: Allan Johns

STATUS: Approaching final draft for review by ELT and SLT

This document has been put together to help lift the standard of public spaces at Auckland hospital.

The look and feel guidelines provides practical guidance in the areas of furniture, lighting, flooring, colour usage and planting, as well as our local Iwi story. The principles outlined in this document will help to bring a consistant look and feel to our public spaces and move away from dysfunctional environments that often result in a negative experiences for patients, visitors and staff. This document does not replace the role of a spatial designer or architect considering specific areas in a more focussed and creative design process.

Patients & Visitors

Patients and visitors spend considerable time in public spaces out of necessity. It is important to consider design decisions that help people cope with the everyday struggles of illness and caring for a loved one. Easy movement, line-of-sight, natural light, noise management, privacy, decor, flexible seating and social areas all have a direct impact on their experience.

Mobility Impaired Users

Accessibility should never be an afterthought at our hospital. There should be clear paths for wheelchair users to navigate through a space, or to reside comfortably in public spaces.

Cleaners

Hospital cleaners are responsible for the up-keep and cleanliness of all public spaces. Design decisions around materials, form, scale and practicality should be heavily dictated by a cleaners ability to efficiently maintain a space.

Clinicians

Clinicians operate within hospital spaces every day, both during work and break times. They require quick access to public resources during busy periods as well as privacy, refuge and calm to deal with the challenges posed by demanding shift work.

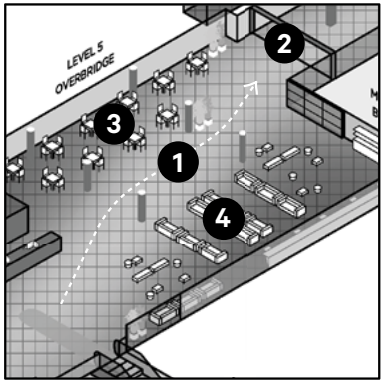
Elderly

It is common for elderly to have cognitive or physical impairment regardless of whether they are a patient or a visitor. Sufficient lighting, simple colours and patterns, consistent evenly-surfaced flooring, upholstered seating and heating are all design elements that help create a safe and comfortable environment for elderly.

Children

Children will often spend long periods of time in the hospital with other family members so it is important to cater to their needs and relieve the stress of parents or caregivers. Design elements such as playful colours and areas help create spaces that are fun and engaging.

1_Thoroughfare | 2_Entrance / Exit | 3_Short Stay | 4_Long Stay



1 Thoroughfare

These spaces are high foot-traffic, dynamic environments where user volumes fluctuate. They should be spacious, well-lit and capitalise on available natural light in the area. Wayfinding and clear line of sight is a priority in thoroughfares, facilitating the efficient movement of patients, visitors and staff to key destinations in the hospital.

2 Entrance / Exit

Entrance and Exit spaces include welcoming atrium/foyer spaces between outside and inside, as well as transitions between environments (such as moving from an overbridge into the retail space). Entrances / Exits should be highly accessible, uncluttered, memorable, well lit and have clear wayfinding cues, as they often host large volumes of people navigating to key destinations.

3 Short Stay

Places for meeting others, or taking short breaks, often with high volumes of people and noise levels. Breakout furniture such as stools, benches and unupholstered chairs should be used to encourage short stays. Purposeful manipulation of natural light should be used to enhance the welcoming nature of the space.

4 Long Stay

Calming spaces that often accommodate high volumes but are much more personal and quiet in tone. These environments should be inviting and include elements of escape and refuge from the busy hospital atmosphere. Comfortable furniture such as modular couches and ottomans should be used to encourage longer stays, alongside low side tables, which can be used for eating and storing belongings. Larger installations of plants can be used such as green walls or planter boxes to connect with nature.

- Gov.uk, 2015. Accessed December 17 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf.
- Pangrazio JR. All access: Planning public spaces for health care facilities. Health Facil Manage. 2013 Mar;26(3):26-30.

Example:

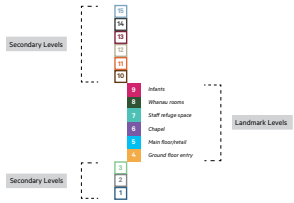
Large wayfinding colour blocking stands out against subtle tones and wood grains.

Smaller wayfinding still stands out because the interior finishes are subtle hues and tones.

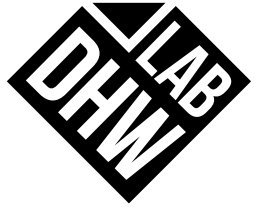
Interior design elements are tonal as opposed to bright feature walls.

Wayfinding in the environment:

Here are the landmark levels and secondary levels to be used for environmental cues such as colour blocking pillars, elevators and stairwells.




AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai


LAB
DHW

DRAFT

15_6_16

Working document - for reference use only.
Formal review from Auckland DHB is required before implementation of these guidelines.

Public Spaces_Look & Feel Guidelines

Auckland District Health Board
Design for Health & Wellbeing

Contents

7.1

_Introduction

How To Use This Guide

This document has been put together to help lift the standard of public spaces at Auckland Hospital.

The 7 roles of our public spaces are:

- Enable safe arrival, entry and exit
- Be welcoming, inviting and comfortable
- Enable safe, comfortable movement
- Enable better life management
- Enable calm, privacy and refuge
- Enable recreation and social connection
- Build and promote community partnership

This document **does** provide practical guidance in the areas of furniture, lighting, flooring, colour usage and planting, as well as our local Iwi story.

The principles outlined in this document will help to bring a consistent look and feel to our public spaces, and move away from dysfunctional environments that often result in negative experiences for patients, visitors and staff.

This document **does not** replace the role of a spatial designer or architect's consideration of specific areas in a focussed, creative design process.

Project Brief Considerations

Before fitting out or refurbishing a space, ask the following questions:

What type of space is it?

Is the space an entrance, a thoroughfare or a resting place for privacy and rest? The type of space should strongly dictate core design decisions, particularly around flooring, furniture and lighting, in order to encourage appropriate behaviour.

Is the space safe & accessible?

As a hospital, it's important to design for extreme users to help prevent the likelihood of further injury or distress. This could include anything from non-slip surfaces and consistent flooring, to reception desks and retail areas that allow for wheelchair access. Design decisions should also consider people with cognitive impairment navigating public spaces.

Wayfinding is more than just signage. What visual or structural cues are there to support wayfinding?

Design elements such as structure, line of sight, layout and colour all affect a user's ability to navigate confidently and accurately through a space. The most effective examples of wayfinding co-ordinate these elements together to create a coherent, harmonious system. Ideally, explicit signs should be considered as a last resort and not a default means of facilitating wayfinding.

What services operate within the space, and how does the design cater to them?

Each space has its own unique set of users, all with their own particular needs. Cleaners, clinicians, social workers, patients, families, children, kitchen-hands and retail staff are just a handful of the different types of people using hospital spaces every day. Some users' needs may conflict with others, so it is important to understand which groups or services are prioritised. This consideration also has implications for the type of maintenance required and how hard-wearing the space should be.

Which aspects of the space are welcoming?

Due to limited resources, staff or volunteers are not always available to welcome people into the hospital and other areas of a building, therefore the space itself needs to be welcoming. Layout, transparency of services, colour, light and nature are all design elements that can dramatically affect a person's first impressions and confidence in a hospital environment.

What cultural considerations are there; what's the story behind the design?

Cultural design considerations both honour the past and create an identity that people can relate to and engage with. The connection with the local iwi and the history of the domain are two examples of strong cultural ties that should be embedded in the design of hospital spaces.

What are the security considerations of the space?

The layout of a space should minimise security risks. For example, there should not be any areas for people to fully conceal themselves from security guards or other hospital users.

Services & User Examples

Patients & Visitors

Patients and visitors spend considerable time in public spaces out of necessity. It is important to consider design decisions that help people cope with the everyday struggles of illness and caring for a loved one. Easy movement, line-of-sight, natural light, noise management, privacy, decor, flexible seating and social areas all have a direct impact on their experience.

Mobility Impaired Users

Accessibility should never be an afterthought at our hospital. There should be clear paths for wheelchair users to navigate through a space, or to reside comfortably in public spaces.

Cleaners

Hospital cleaners are responsible for the up-keep and cleanliness of all public spaces. Design decisions around materials, form, scale and practicality should be heavily dictated by a cleaners ability to efficiently maintain a space.

Clinicians

Clinicians operate within hospital spaces every day, both during work and break times. They require quick access to public resources during busy periods as well as privacy, refuge and calm to deal with the challenges posed by demanding shift work.

Elderly

It is common for elderly to have cognitive or physical impairment regardless of whether they are a patient or a visitor. Sufficient lighting, simple colours and patterns, consistent evenly-surfaced flooring, upholstered seating and heating are all design elements that help create a safe and comfortable environment for elderly.

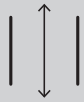
Children

Children will often spend long periods of time in the hospital with other family members so it is important to cater to their needs and relieve the stress of parents or caregivers. Design elements such as playful colours and areas help create spaces that are fun and engaging.

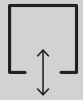
Types Of Space Descriptions

Building on research from other international healthcare facilities, there are four types of public space at Auckland City Hospital that are referred to in this document:

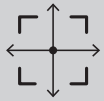
1_Thoroughfare



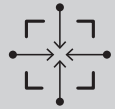
2_Entrance / Exit

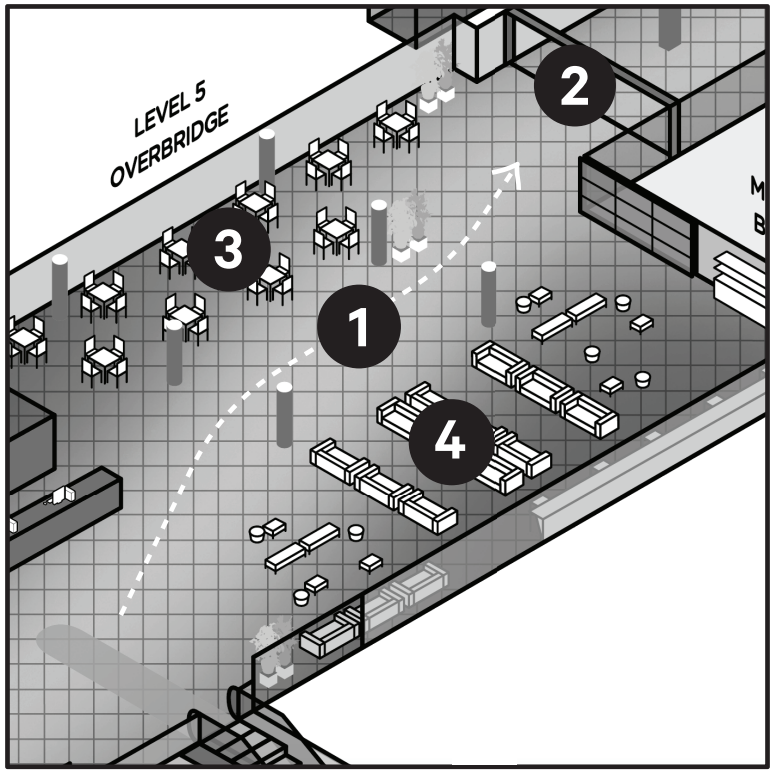


3_Short Stay



4_Long Stay





1 Thoroughfare

These spaces are high foot-traffic, dynamic environments where user volumes fluctuate. They should be spacious, well-lit and capitalise on available natural light in the area. Wayfinding and clear line of sight is a priority in thoroughfares, facilitating the efficient movement of patients, visitors and staff to key destinations in the hospital.

2 Entrance / Exit

Entrance and Exit spaces include welcoming atrium/foyer spaces between outside and inside, as well as transitions between environments (such as moving from an overbridge into the retail space). Entrances / Exits should be highly accessible, uncluttered, memorable, well lit and have clear wayfinding cues, as they often host large volumes of people navigating to key destinations.

3 Short Stay

Places for meeting others, or taking short breaks, often with high volumes of people and noise levels.
Breakout furniture such as stools, benches and unupholstered chairs should be used to encourage short stays. Purposeful manipulation of natural light should be used to enhance the welcoming nature of the space.

4 Long Stay

Calming spaces that often accommodate high volumes but are much more personal and quiet in tone. These environments should be inviting and include elements of escape and refuge from the busy hospital atmosphere. Comfortable furniture such as modular couches and ottomans should be used to encourage longer stays, alongside low side tables, which can be used for eating and storing belongings. Larger installations of plants can be used such as green walls or planter boxes to connect with nature.

- Gov.uk,. 2015. Accessed December 17 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf.
- Pangrazio JR. All access: Planning public spaces for health care facilities. Health Facil Manage. 2013 Mar;26(3):26-30.

_Guidelines In Practice

7.1

Our Pepeha

A Pepeha is a way of introducing ourselves, acknowleding our identity, our relationship to the land, and those who have gone before us. These photographs represent our Pepeha; they can be seen as inspiration for our four types of public space.

Ko Pukekawa te Maunga
Ko Waitematā te Moana
Ko Horotiu me Waipapa nga Puna Wai
Ko Waikāhanga te Pā

Pukekawa is the Mountain
Waitematā is the sea
Horotiu and Waipapa are the fresh water springs
Waikahanga is the Fort

Thoroughfare

Ko Horotiu me Waipapa nga Puna Wai

The river currents following through this domain site are like thoroughfares moving people through space.

Entrance / Exit

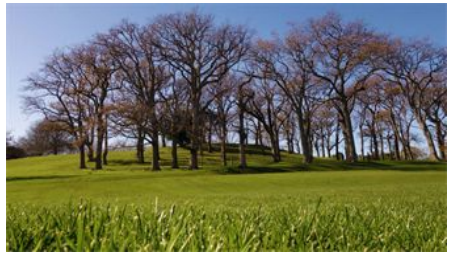
Ko Te Waitematā te Moana

Where the sea meets the land - inspiration for our entrances and exits.

Short Stay

Ko Pukekawa te Maunga

Our short stay spaces are likened to the mountains dotted throughout our landscape.



Long stay

Ko Waikāhanga te Pā

The forts of this landscape are likened to zones where people are able to take refuge and feel safe and secure.

Our Birds

These are some of our native birds. These birds can be used to inspire artwork on our ‘Landmark Levels.’

Designers and artists can tell the stories of our native birds through artwork and installations in our public spaces. The imagery and sounds associated with each bird would support environmental wayfinding on each Landmark Level.

For example:

The selfless and nurturing behaviour of the riroriro (Grey Warbler) has a striking similarity to the ethos of healthcare - to raise the young of the cuckoo bird as its own, until it is mature enough to leave the nest. This narrative could be represented in an area of level 5 (the main floor of the hospital), accompanied by the riroriro bird call, subtly projected throughout the space.

By adding an acoustic sensory layer to the environment (through the bird call), navigation and wayfinding would be improved for elderly and visually impaired users.

Call of the ‘riroriro’

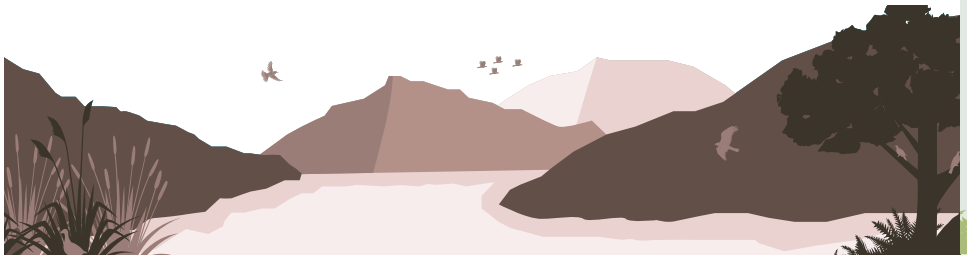
Level		
4	kereru	
5	riroriro	
6	tūī	
7	kāhu	
8	pūkeko	
9	korimako	

7.1

Interpreting Our Story Examples

The story and inspiration imagery established in the document is a foundation for designers and creatives to build upon. These are the core elements of our Auckland Hospital heritage that can be interpreted and developed over time, whilst still maintaining strong connections back to the established story. Here is an example of some environmental artwork building on the types of space examples and the native birds described on p.10-11.

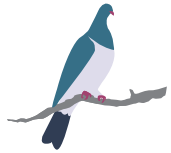
Thoroughfare



Short Stay

Entrance / Exit

Long Stay

Level		
4	kereru	
5	riroriro	
6	tūī	
7	kāhu	
8	pūkeko	
9	korimako	

Patient Stories and Cultural Diversity

Key Principles:

- Celebrate the faces of our community, people from all cultures and walks of life.
- Stories would be displayed both in public spaces and the wards, to encourage people to consider those who have been in the hospital before them and instil a sense of community.
- Designers could present the patient images in creative ways, and would not be limited to printed banners/canvases. The display area should be spot lit to draw attention to the images. Large, simple quotes would accompany the bold imagery.
- This type of initiative would set up the potential for culturally specific areas in the public space in the future.

I can understand, but I can’t always explain what I want to say in English... I appreciated everyone being polite, and the smiley faces.”

Landmark Levels and Secondary Levels

Key Principles:

- 'Landmark levels' 4, 5, 6, 7, 8, 9 are the most commonly visited floors in the hospital and have extensive opportunity for environmental wayfinding.
- 'Secondary levels' 1, 2, 3, 10, 11, 12, 13, 14, 15. These floors have smaller floor areas of public space, or are predominantly for staff and require less environmental wayfinding.

1. Before choosing wall colours and finishes, the wayfinding colour for the must be established.
2. Is the area on a 'Landmark level?' If so, there will be areas where colour blocking will be used to highlight lifts, stair wells, pillars etc.
3. Is the area on a 'Secondary level?' If so, which areas are suitable for small amounts of colour blocking?

Example:

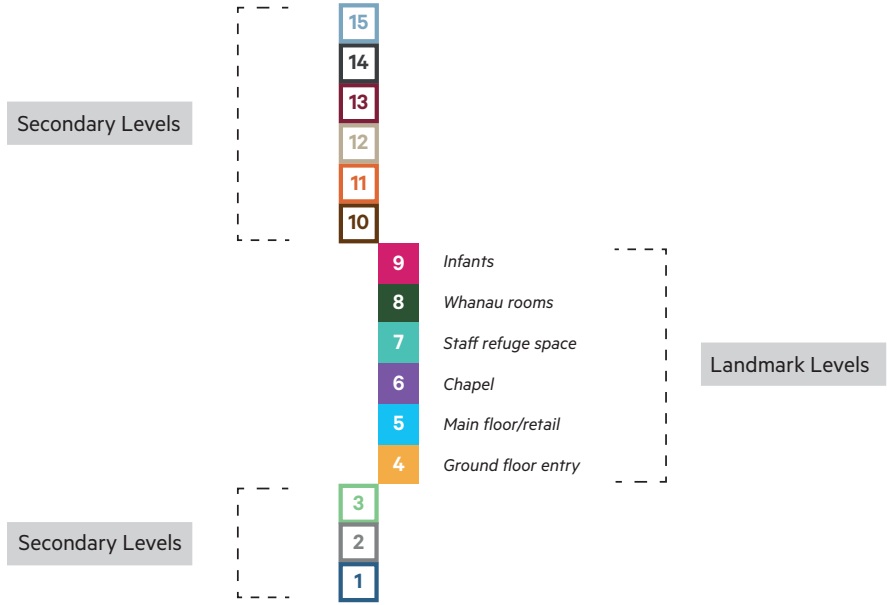
Large wayfinding colour blocking stands out against subtle tones and wood grains.

Smaller wayfinding still stands out because the interior finishes are subtle hues and tones.

Interior design elements are tonal as opposed to bright feature walls.

Wayfinding in the environment:

Here are the landmark levels and secondary levels to be used for environmental cues such as colour blocking pillars, elevators and stairwells.

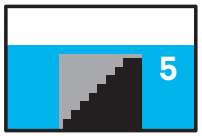


Landmark Levels

More comprehensive use of colour blocking and level colour details used on landmark levels.

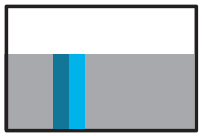
Floor: 5

Lift Banks



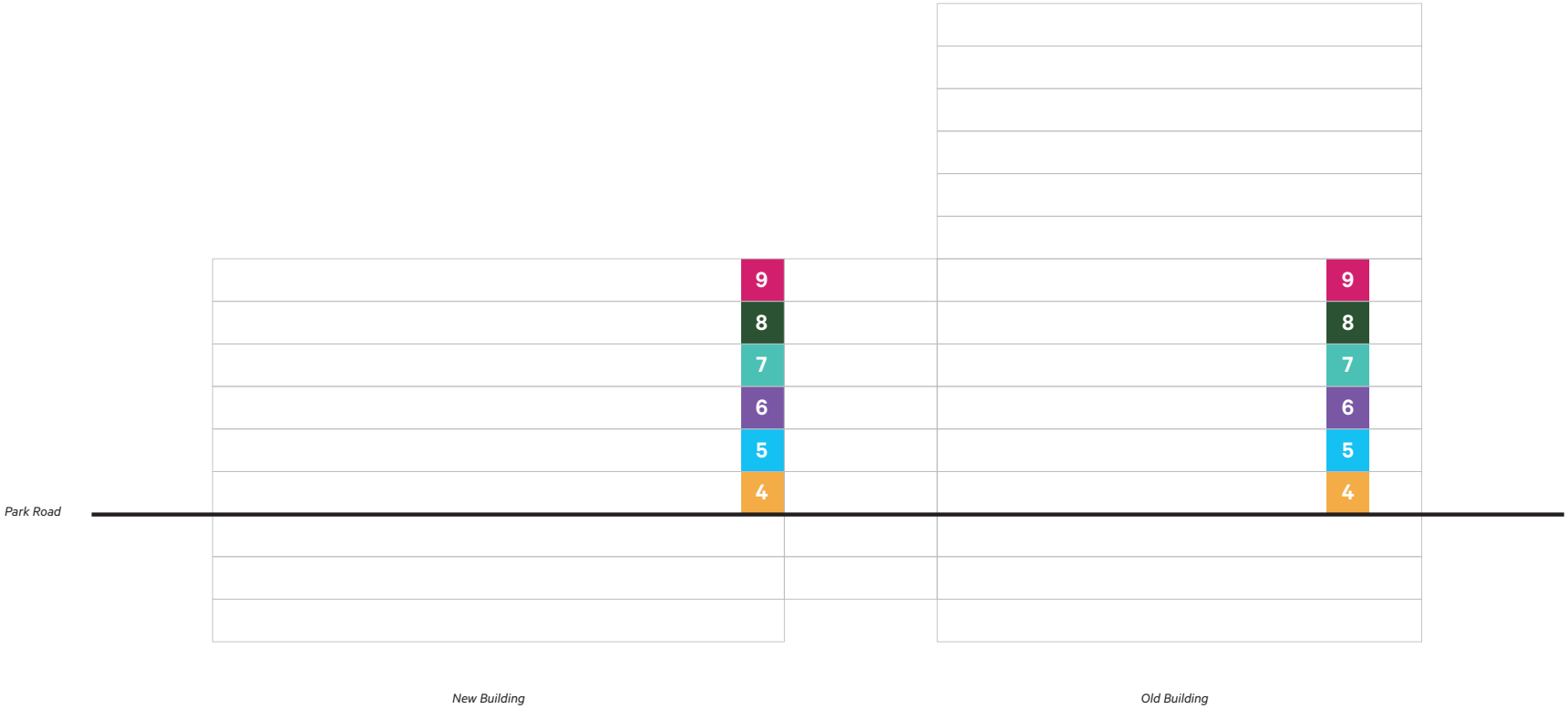
Stairwells

Overbridge



Pillars

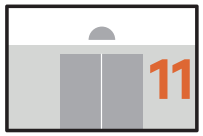
Carpet tile accent



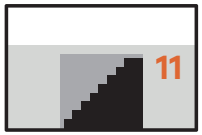
Secondary Levels

The ‘inverse’ colour remains striking and clear but is less dominate in these zones

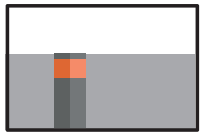
Floor: 11



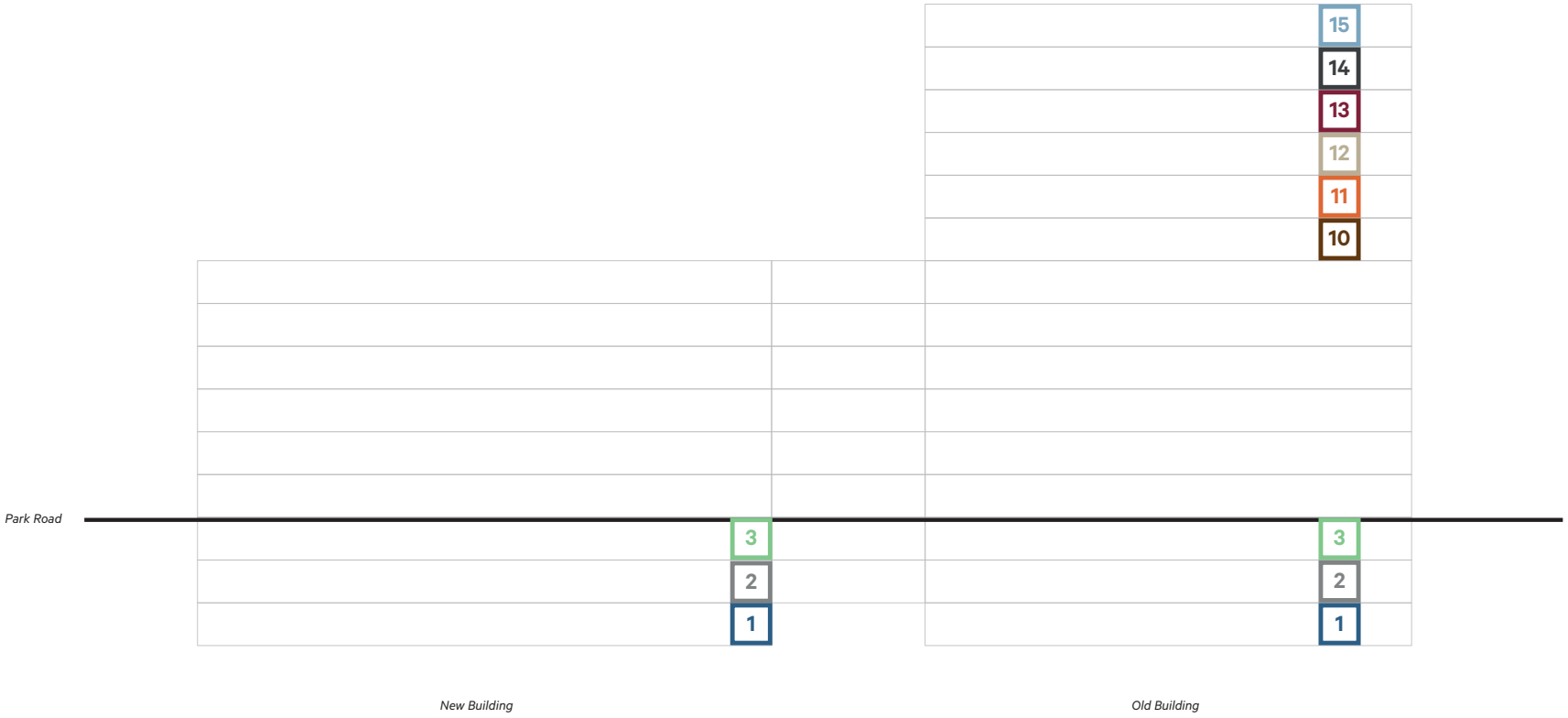
Lift Banks



Stairwells



Pillars



7.1

Colour Decision Matrix

Key Principles:

- Once the wayfinding colour has been used to identify elevator bays, stairwell entrances etc., the colour palette for the walls/ceilings can be assembled.
- Establishing the types of public space (see introduction) that make up an area is vital to choosing suitable wall colours.
- Keep to the guide unless there has been specific sign-off to use colour outside those outlined here.

Type of Space	Inspiration Image	Location *(Refer to previous page)*	Wall Colour	Door Colours	Ceiling	Flooring	Timber Accent
Thoroughfare		*Landmark Level:* ☐ *or* *Secondary Level:* ☐	*Primary Pantone #* *Accent Pantone #*	*Staff only doors should be painted the same colour as the surrounding wall.*	*Ceilings should all be painted white:* ☐ *Primary Pantone #*	***Carpet:*** ***Charcoal 1:*** *Supplier:* *Product:* ***Charcoal 2:*** *Supplier:* *Product:* ***Lino:*** ***Grey fleck 1:*** *Supplier:* *Product:* ***Grey fleck 1:*** *Supplier:* *Product:* ***Wood grain:*** ***Wood Grain lino:*** *Supplier:* *Product:*	*Native Timber Accent. (Bench tops etc.)* ***Light Totara:*** *Supplier:* *Product:*
Entrance/Exit		*Landmark Level:* ☐ *or* *Secondary Level:* ☐	*Primary Pantone #* *Accent Pantone #*				
Short Stay		*Landmark Level:* ☐ *or* *Secondary Level:* ☐	*Primary Pantone #* *Accent Pantone #*	*Amenities such as bathrooms or breast feeding rooms should be painted with the wayfinding directional colour:* *Primary Pantone #*			
Long Stay		*Landmark Level:* ☐ *or* *Secondary Level:* ☐	*Primary Pantone #* *Accent Pantone #*				

Flooring Decisions

Key Principles:

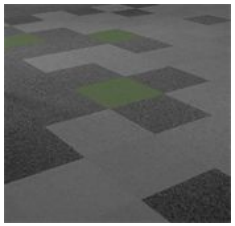
- Colours: at transitions between floor finishes there should be as little tonal contrast as possible – i.e. lightness as opposed to sharp changes in colour.
NB: This may be an issue with retail tenancies if we can not impose conditions on what flooring they can use.
- Wayfinding Accents: the benefit of carpet tiles extends beyond replaceability for maintenance; carpet tiles could optionally be used to co-ordinate with the hue of the wayfinding attributed to each floor (see example below).

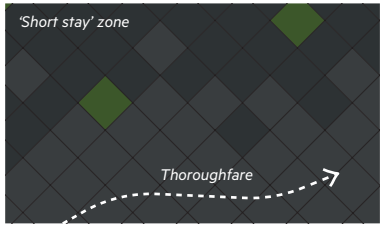
‘Carpet’ means carpet tiles, 500x500mm, with extra stock ordered and kept on site to accommodate replacement.

‘Vinyl’ means homogeneous sheet (not tiled) vinyl; matte is preferable to glossy finish; colour is preferably subtle, lower contrast; non-slip vinyl should be used around wet areas.

Examples: Best Practise ✓

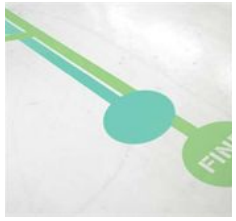
Carpet





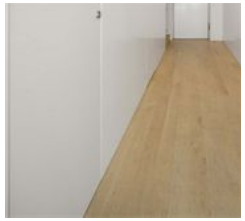
Low contrast, simple charcoal tones. Mosaic patterns are uncomplicated and are used to indicate zones in a space.

Vinyl



Low sheen, unpatterned, untextured flooring. Wayfinding vinyls are a point of contrast, and should be located off the main thoroughfare.

Transtions in flooring colour should be gradual and not ‘jarring.’



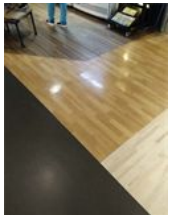
There should be strong contrast between wall and floor treatments so visually and cognitively impaired users can navigate the space safely.

*In a thoroughfare, the wood grain direction should flow with space. Wood grain lino should **never** be ‘coved’ where it meets the wall.*

Examples: What to avoid ✗

Avoid bright, high contrast patterns, as they can cause confusion for visual/cognitively impaired users.

High gloss lino can produce distracting reflections and can appear as water on the floor.



Unnecessary and confusing junctions between flooring.

Lighting Decisions

Key Principles:

- Celebrate natural lighting conditions wherever possible and establish whether the space receives direct sunlight during the day.
- Because the hospital is a 24 hour facility, day lighting and night lighting of a space should always be considered.
- Building code requirements for emergency exit pathways should be a part of the lighting discussion from the outset.
- Colour rendering of LED's can vary in quality dramatically. Cheap LED lighting solutions can result in a cold, washed out environment.
- The lighting products selected for a space should be considered in relation to the functionality of the environment.

Thoroughfare: *Bright, even light illuminating pathways through public spaces. Wayfinding spotlights to identify signage easily, especially low-light areas. At night these areas should still be clearly illuminated.*

Entrance/Exit: *Bright, welcoming natural light. Pendant lighting and wall wash lighting can be used to create landmarks at entrance/ exit points. Key areas such as receptions should be spot lit, especially at night.*

Short Stay: *Warm, ambient lighting that capitalises on natural light wherever possible. Areas of planting can be spot lit (or shadow lit by hiding the light source) to create calming green environments. At night these areas should still be clearly illuminated.*

Long Stay: *Dimmable, diffused lighting, and purposeful manipulation of natural light to enhance the intimate qualities of the space. At night these zones should have a warm, quiet feel with the potential to create softly lit areas for resting.*

Panel lighting		LED panels which are sized to fit with the existing ceiling grid - 1200mm x 300mm is fairly standard.
Ambient Lighting		Lux and colour temperature to suit the task – higher (whiter) colour temps that more closely resemble daylight may work better in areas of planting, warmer lighting for more intimate situations (locally dimmable).
Spot Lighting		Direct spotlighting for illuminating wayfinding elements, artwork or landmarks in a space. These can also be used to highlight areas such as reception desks or entries/exits to stair wells etc.
Lighting Installations and Pendants		Feature lighting installations are ideal for double-height areas or welcoming spaces such as entries and exits. They can also act as subtle landmarks in the busy hospital environment.
Wall Wash/ Shadow Lighting		Used to draw attention to details in the built environment or features such as green walls or planters. This type of lighting can also be used to create ambient environments.

Lighting Examples:

Examples: Best Practise ✓

What to Avoid ✗

7.1

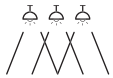
Panel Lighting

Bright, similar to day light.

Even coverage.

Dim and patchy panel lighting.

Ambient Lighting



Reinforcing daylight.

Calmer, restful environments.

Too dark and moody.

Bland and office-like.

Spot Lighting

Clearly illuminating wayfinding.

Drawing attention to key landmarks.

Low contrast, reflective surfaces.

Lighting Installations and Pendants

Simple forms. Landmarks.

Attractive both lit and unlit.

Bland and dated.

Overly decorative.

Wall Wash/ Shadow Lighting

Simple shadow lighting.

Used to highlight key details.

Too distracting and colourful.

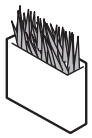
Planting Considerations

Key Principles:

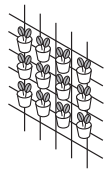
- Planting should be used wherever possible to connect with the outdoors. This is especially important for patients who are not able to leave the facility.
- The cost associated with planting is twofold: the upfront cost of buying the plants; and the upkeep and maintenance involved to keep them alive and fresh.
- The Auckland DHB's current supplier 'Ambius' supply and maintain a range of options from simple planter boxes through to green walls.
- The intensity of planting and its placement in the hospital depends on where it is in relation to ward areas. For example, inside the wards, no planting is suitable; outside the wards, contained planter boxes are suitable; in main public areas and hospital entrances/exits, more comprehensive planting is suitable.
- Wherever possible, suitable native specimens should be chosen to celebrate New Zealand flora.
- Auckland DHB Infection Control are very conscious of exposed soil producing airborne spores. Covering the soil properly with pebbles or mesh is vital.
- Where no planting is suitable, full-bleed (floor to ceiling) landscape photographs should be used to connect the hospital environment with nature.
- When selecting planting for an area, take note of the surrounding wards and the type of patients staying there.
- Ensure planters and potted walls are at a height that a small child cannot climb.
- Plants should not be flowering (producing pollen) or have a strong odour.
- Any deviation from this guideline needs to be approved by infection control.
- Full-wall photography should be treated with graffiti guard.
- Full-wall photography should be spotlight or shadow lit where possible.

Planting in Proximity to Entry/Exits:

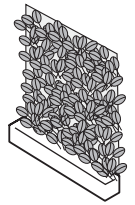
Full-wall photography of NZ landscapes



Self-contained planters



'Potted' green wall



Living walls and gardens

Wards

(No planting suitable)

Entry/Exits

(More comprehensive planting)

Planting Examples:

Examples: Best Practise ✓

What to avoid ✗

7.1

Full-wall photographs of NZ landscapes

Hi resolution - no boarder.

Simple environmental graphics.

Overly stylised.

Self-contained planters

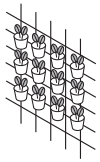
Simple forms. One material.

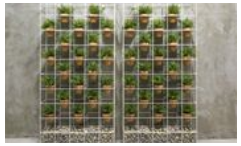
Rectangular forms for breaking up space.

Quirky designs that date.

Traditional designs.

'Potted' green wall



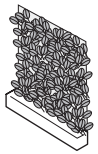


Contained in frame.

Easily replaceable pockets.

Felt pockets with exposed soil.

Living walls and gardens



Simple forms. Landmarks.

Attractive both lit and unlit.

Full gardens located in high risk areas.

Furniture Types

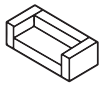
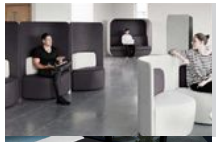
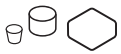
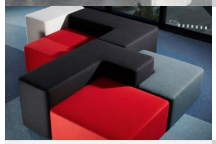
Key Principles:

- Safety, design aesthetic, practicality and cost (both immediate and ongoing) are factors to be considered when choosing furniture.
- Regardless of 'short 'stay' or 'long stay' locations, there should be a variety of heights with and without backrest and armrests to accommodate mobility issues.
- Furniture should be simple in form, easy to reupholster and preferably made of vinyl-backed fabric (Infection Control).
- Crevices harbour bacteria and should be minimised where possible in the furniture design.
- For the sake of cleaning and replaceability, furniture should have removable elements (squabs etc).
- 'Mix and Match': establish an ecosystem of furniture,colours and fabrics so the overall look and feel is not compromised by a certain product going out of stock.
- For those with cognitive impairment, such as dementia, it is vital that furniture is 'archetypal' e.g. it is easily identifiable as a chair.

Furniture Types:

Modular couch		Minimal couch module allows the design to be extended to create longer stretches of seating. This would need to be paired with a more conventional option with armrests.
Tall seating		There should be mix of lower profile and taller seating options available. The elderly, or those with mobility issues, need seating at an appropriate height to minimise diffilculties when sitting down and standing up. Arm rests are also important to support these users.
Single seat/chair		Single chairs are especially important for individuals who wish to sit by themselves in a public space. They should compliment the shape and proportion of the couch design.
Low tables		Couch height tables are great for people who choose to eat in the seating/breakout area, or don't have a full-height table to eat at. They are also useful for people using laptops/tablets in seated areas.
High-back seating		High-back seating will help to create areas of privacy. This type of furniture should not be overused as there is a risk of creating awkward, inaccessible zones in the space.
Breakout ottomans		Low-profile, breakout ottomans are great to contrast with conventional chairs and couches. They are suitable for furnishing areas where children will be waiting with families, without specifically designating a 'kids' corner.'
Tables		Small cafe-style table are suitbale for overbridge areas. Folding functionality allows for tables to be cleared away efficiently and quickly.
Chairs		Simple dining chairs for the overbridge area for groups of up to 4 or 5 per table.
Stools		Perching furniture for bench leaners along windows etc.

Furniture Examples:

Type		Style	Potential suppliers	
Modular couch				http://www.kada.co.nz/products/modulo
Tall seating				http://silkimpex.co.nz/seating/guest-chairs/bebe.html
Single seat/chair				http://www.vidak.co.nz/catalogue/furniture-type/seating/soft-seating/escape-softseating.htm
Low tables				http://www.paulas.co.nz/shop/item/DM_-_SANDALO_COFFEE_TABLE_Rectangle/2446
High-back seating				http://www.vidak.co.nz/collection/seating/shuffle.html
Breakout ottomans				http://selector.com/nz/products/tetromino-modular-sofa-system#img1
Tables				http://www.furniturelab.co.nz/product/cafe-dining-tables/kross-table_scp_ptid=3275_ctid=740_.html
Chairs				http://www.vidak.co.nz/catalogue/furniture-type/seating/cafe-seating/polka-chair.html
Stools				http://www.vidak.co.nz/collection/seating/polka-stool.html

_Appendix

Retail Fitout Guide

The public spaces at Auckland Hospital host a number of external vendors. They are responsible for their own shop fit-outs according to their brand etc. This page outlines a set of key considerations for new vendors to avoid poor fit-out decisions:

Colour

Branding and Wayfinding Conflicts

- Emergency Red is not a suitable colour to be used in fit-outs. If 'Emergency Red' is part of the retail brand colour, work closely with the vendor to minimise the risk of confusion.

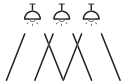
- 'Exit Green' is also to be dealt with carefully to avoid any confusion for cognitively impaired users.

- If there are pillars outside the retail frontage, they are not to be used for advertising or branding. Pillars are reserved for environmental wayfinding in the hospital. Dark navy blue and cyan is the pending directional wayfinding colour for the hospital.

Lighting

Key Considerations

- Lighting must aim to emulate natural daylight and avoid being dark and 'moody.'
- Light must be even without creating dark spots in the space. Feature 'pendants' must be simple and geometric in form (not overly decorative).



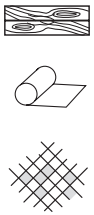
Flooring

Key Considerations

- The direction of wood-grain must be considered carefully - especially if it meets other wood grain vinyl in the retail area.

- Lino must be a matte finish. Glossy finishes can produce unwanted glare or be perceived as water on the floor. Patterned designs must be signed off as they can be confusing for visually/ cognitively impaired users.

- Carpet tiles should be low contrast, simple tones and patterns should be uncomplicated.



Furniture

Key Considerations

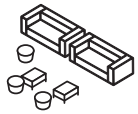
Simple geometric forms for furniture are much more suitable both from a functional and aesthetic perspective.

- For those with cognitive impairment, such as dementia, it is vital that furniture is 'archetypal' e.g. it is easily identifiable as a chair.

Furniture within the hospital is a key concern for Infection Control.
- Crevices harbour bacteria and should be minimised where possible in the furniture design.
- For the sake of cleaning and replaceability, furniture should have removable elements (squabs etc).
- There should be a variety of heights, with and without backrest and armrests to accommodate mobility issues.

- Display cabinets or shelving must not protrude out into the public space thoroughfare.

- The layout of the store must accommodate mobility impaired users - (likewise when designing counters and bench top heights).



Planting

Key Considerations

- The Auckland DHB's current supplier 'Ambius' supply and maintain a range of options from simple planter boxes to potted walls.

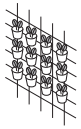
- The intensity of planting and its placement in the hospital depends on where it is in relation to ward areas. For example, inside the wards, no planting is suitable; outside the wards, contained planter boxes are suitable; in main public areas and hospital entrances/exits, more comprehensive planting is suitable.

- Wherever possible, suitable native specimens should be chosen to celebrate New Zealand flora.

- Auckland DHB Infection Control are very conscious of exposed soil producing airborne spores. Covering the soil properly with pebbles or mesh is vital. Ensure planters and potted walls are at a height that small children cannot climb.

- Plants should not be flowering (producing pollen) or have a strong odour.

- Any deviation from these guideline needs to be approved by Auckland DHB Infection Control.



Type of Space Decision Matrix

This matrix is a good starting point when beginning to look at refurbishing a new public space at Auckland City Hospital. Refer back to the sections in this guide for more detailed information on each category.

	Is this a food/ retail area?	Flooring	Furniture	Lighting	Colour	Planting
Thoroughfare	*Yes*	*Vinyl flooring*	*Not applicable because of high foot traffic.*	*Bright, even light, illuminating pathways through public spaces.* *Full description on p.20*	*Refer to full matrix on p.18*	*The occasional pot plant, suitable in higher traffic areas. Planter boxes can also be used to separate thoroughfares from short or long stay spaces.*
	No	*Carpet tile*				
Entrance/Exit	*Yes*	*Vinyl flooring*	*Generally not applicable because of high foot traffic.*	*Bright, welcoming, natural light. Pendant lighting and wall wash lighting can be used to create landmarks.* *Full description on p.20*	*Refer to full matrix on p.18*	*More comprehensive planting (such as gardens or green walls) are suitable at entry/exits to hospital. Internal entry/ exits should not be cluttered with planters.*
	No	*Carpet tile*				
Short Stay	*Yes*	*Vinyl flooring*	*Breakout furniture that encourages short stays, such as stools, benches and ottomans. Minimal use of upholstered furniture.*	*Warm, ambient lighting that capitalises on natural light wherever possible.* *Full description on p.20*	*Refer to full matrix on p.18*	*Potted green walls or planter boxes to create green, calming environments.*
	No	*Carpet tile*				
Long Stay	*Yes*	*Vinyl flooring*	*More comfortable, upholstered furniture and ottomans with low side/ coffee tables for eating and storing belongings.*	*Dimmable, diffused light and purposeful manipulation of natural light to enhance the intimate qualities of the space.* *Full description on p.20*	*Refer to full matrix on p.18*	*Larger installations of plants such as green walls or planter boxes to create a greater sense of calm and refuge.*
	No	*Carpet tile*				

Welcoming Spaces: UK Department of Health

Here are some extracts from the *UK Department of Health Design Guidelines for Healthcare Buildings*, that refer to similar principles to those established in this document.

7.1

*- **Entrances** to the hospital need to be sheltered, well-lit, directional, accessible, memorable, aesthetically pleasing, and provide easy drop-off and collection.*

*- **Inside Welcome Areas** need to be light, spacious, recognisable, uncluttered, minimal, provide a variety of seating, clearly indicate available services, and use spatial elements such as plants or sculpture to create a non-institutional, homely environment.*

*- **Circulation Areas** need to be well-lit, accessible, make use of natural light, provide clear and consistent wayfinding, facilitate fast and fluid movement and provide line of sight.*

*- **Waiting Areas** need be light, spacious, highly visible, uncluttered, minimal, accessible, comfortable and provide a variety of seating for both private and social engagement.*

*- **Socialising and Meeting Areas** need to be colourful, well-lit, obvious, encourage both interaction or privacy, use suitable easy-to-clean flooring and provide a homely, non-clinical atmosphere.*

*- **Sanctuary Areas** need to encourage interaction with nature and/or outdoors and physical activity if spatially possible, inspire and install confidence, be well-lit, facilitate multi-sensory experiences, use calming colours and provide comfortable furniture, obvious visual wayfinding and clearly indicate available services.*

Gov.uk,. 2015. Accessed December 17 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pd

Entrances

Socialising/Meeting

Waiting

Sanctuary

Inside Welcome

Circulation

Wayfinding Examples

The Auckland DHB is currently reviewing its wayfinding strategy. In the public spaces the use of colour is extremely important for spatial wayfinding cues and signage. Interior design decisions, such as feature walls or colour blocking receptions, must be co-ordinated with future wayfinding refurbishments. Therefore, spatial/interior design decisions should avoid 'decorative' use of colours that directly clash with wayfinding principals. Here are some examples of good wayfinding and the principles behind them.

Bright, back-lit signs for low-light areas

Icons/pictograms

Differentiating areas

Clear line-of-sight

Colour coding

Contrast and distinction

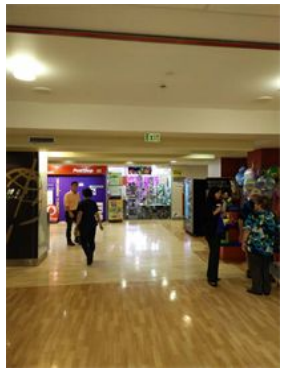
Colour blocking

Directional pathways

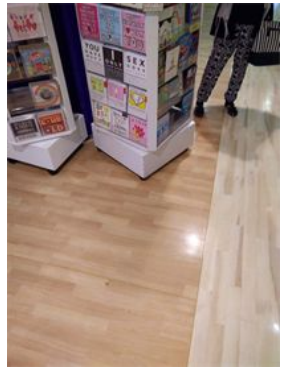
Safety & Accessibility Examples

These examples describe the types of discrepancies in the public spaces that should be avoided when designing new environments at Auckland City Hospital. They are considered through the lens of those who may be mobility or cognitively impaired.

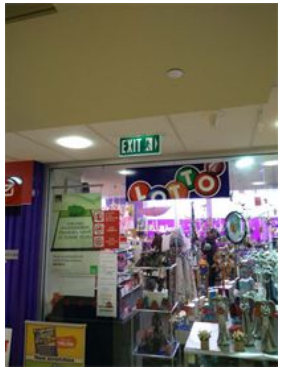
Structurally weak furniture is a risk for bariatrics, elderly and people with physical disability.



Areas with inconsistent lighting could be perceived as uneven surfaces by someone with visual or cognitive impairment.



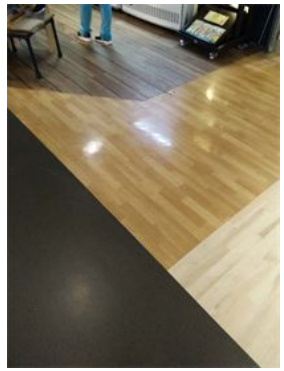
Objects obstructing thoroughfares increase the risk of falls and difficulty of wheelchair access.



Blocked exit signage could hinder escape during an emergency.

Lack of clear differentiation between steps is confusing and dangerous for someone with cognitive or visual impairment.

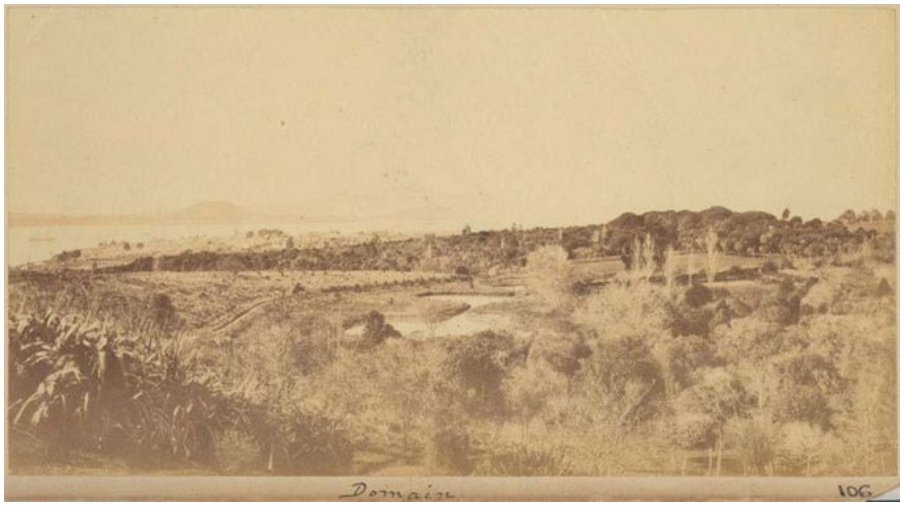
Seating in front of hospital directories does not allow wheelchair access, and creates a visual barrier when in use.



Variation in vinyl flooring could be perceived as a change of level for someone with cognitive impairment.

Iwi Gifting of The Auckland Hospital Site

The Auckland hospital site was gifted Ngati Whatua land. The origins of this hospital site are important to us and should be honoured as part of our relationship with the local iwi.



1860 Auckland Domain
View across flax, ponds and trees to the harbour.

http://www.aucklandmuseum.com/collection/object/am_library-photography-58414

Manea & Mauri Stones

The Auckland DHB displays a number of cultural artefacts in its public spaces. The *Manea stone* - perhaps the most significant artefact - is located on the main floor of the hospital (level 5) In Maori tradition, the *Manea stone* is connected to the *Mauri stone* that is buried deep within the foundation of a building. People can touch the Manea stone, 'releasing negative energy and sending it to the centre of the earth.' The *Mauri* and *Manea* stones are from various locations around the Ngati Whatua region. They are incised with designs unique to the Ngati Whatua iwi.

The Manea stone located in the level 5 public space. The corresponding Mauri stone is buried deep within the foundations of the new hospital building.

Waitemata DHB Sky Bridge Project - Pedestrian Access Issues Report

Recommendation

That the Disability Support Advisory Committee:

1. **Receives the report.**

Prepared by: Hatish Padharia (Facilities & Development, Project Manager)
Endorsed by: Nigel Ellis (Facilities & Development, General Manager)

Glossary

ESC	Elective Surgery Centre

1. Executive Summary

The Sky Bridge project was implemented to assist in meeting the demand for additional beds at the North Shore Hospital site by connecting the Tower block to the Elective Surgery Centre (ESC). The design commenced in May 2015 and the ESC Bridge was opened on 21 June 2016.

A number of issues have been identified that impact on pedestrian access around the new Sky Bridge. This paper outlines what has been put in place to correct these issues. This will also improve the process for inclusion of the Disability Advisor's input in new projects and buildings.

2. Issues Identified

The following issues were identified:

Issue A: Advice from Disability Advisor was not reflected in design/ built environment.

Issue B: Visibility around column on the corner of the Car Park.

Issue C: Accessibility between column and kerb edge/road adjacent the ESC Management Suite.

These are discussed in detail in the attached paper.

3. Conclusion

Following the identification of these issues, actions have been completed to rectify them. A better process for engagement with the Disability Advisor has also been identified.

Waitemata DHB

Sky Bridge Project

Pedestrian Access Issues Report

3 August 2016

Prepared & recommended:	Endorsed by:	Endorsed by:	Approved by:
H. Padharia	M. Knight	J. Cauvain	N. Ellis
F&D Project Manager	F&D Senior PM	F&D Project Director	F&D General Manager
Date: 03.08.16	Date: 03.08.16	04.08.16	05.08.2016

1. Purpose

- The purpose of this report is to provide the background and actions being planned to correct pedestrian flow issues identified upon completion of the Sky Bridge project.
- To highlight the involvement within a typical construction project.

2. Project Overview

The Sky Bridge project was implemented to assist in meeting the demand for additional beds at the North Shore Hospital site by connecting the Tower block to the Elective Surgery Centre (ESC).

The design commenced in May 2015 and the ESC Bridge was opened on 21st June 2016.

During the design stages (Preliminary, Developed and Detailed design), User Group consultation was undertaken with representatives from the following teams:

- Hospital Operation
- Facilities
- Traffic and Parking
- Security
- Emergency Response
- Fire
- ESC Charge Nurse Manager
- Moving and Handling
- Disability Advisor Occupational Health & Safety

3. Design & Pedestrian/ Vehicle Issues

The ESC Bridge design evolved over three key stages (Preliminary / Developed / Detailed) involving User Group Consultation and sign-off at the end of each design stage by specific WDHB stakeholders.

In relation to the pedestrian and vehicle flow the following design consultants were engaged:

- A specialist transportation engineering company (Flow Transportation Specialists Ltd).
- Civil Engineers (Woods Consulting Engineers Ltd)
- Architect (Jasmax Ltd)

4. Issue A: Advice from Disability Advisor was not reflected in design/ built environment.

Background: As part of Developed Design sign off Waitemata DHB's Disability Advisor on behalf of Disability Support Advisory Committee (DSAC) was consulted at each design stage. In Developed design the Disability Advisor advised, "That the design should make sure there are no impacts on access once the kerbs have been built".

Issue: Even though these comments were considered the comments were not reflected in the design and therefore the final built environment.

Recommendation: WDHB DHB Disability Advisor reviews plans at design stage with consultant team and attends Safety in Design meeting with consultant team to highlight and mitigate any issues.

5. **Issue B: Visibility around column B on the corner of the Car Park (ref: sketch page 5).**

Background: During the developed design Flow suggested that Column B should be removed. As construction has begun, repositioning the column was no longer an option. Therefore, the advice was to:

- Change the intersection "Give Way" markings to "Stop" and mark the limit line at the intersection edge (previously 1-2 metres up on the link road).
- Install a convex mirror opposite the column to assist pedestrians to see vehicles travelling east to west and potentially turning into the link road.

Issue: Visibility around column B on the corner of the Car Park.

Recommendation: The road markings were changed as part of the construction works. The convex mirror requirement has been superseded as part of proposed remedial works (see recommendations relating to Issue C and figure 3 – page 7).

6. **Issue C: Accessibility between column A and kerb edge/ road adjacent the ESC Management suite (ref: sketch page 5)**

Background to issue: In the design stage Flow Transportation Specialists suggested that Column A should be moved. This column is as close to the ESC Management suite as possible.

Therefore, the advice from Flow and Woods was to:

- Change the kerb adjacent the column A to a dropped kerb to 2m both sides and replicate the same kerbing opposite (on the car park side). This is the current situation.

Flow's specific advice which the current design is based on was:

- Having the kerb ramp either side of the column will ensure pedestrians from either direction can easily cross the road (or use the road) to get past the column.
- Given that most pedestrians will be travelling past the proposed crossing a gentler ramp grade of 1:20 is a good idea, and we agree that the kerb ramps should be the same size on both sides of the road, directly opposite each other.
- The visibility from the proposed location is sufficient given the distance from the intersection and the low speeds of vehicles on the road.
- The minimum width of a pram crossing is generally 1.5m. The lowered landing either side of the column could be reduced from 2m to 1.5m.
- Tactile pavers should be installed on the both sides of the crossing as per RTS14 Guidelines for facilities for blind and vision impaired pedestrians. These will also more clearly define it as a crossing point to both pedestrians and drivers.
- Sufficient crossfall is needed on the landing to ensure it does not pool with water when it rains. Max cross fall is 2%.

Current issue: The gap between Column A and the kerb/ road edge is narrow. Pedestrians may need to travel on the road to get past the column. Following opening of the ESC Bridge on 21st June 2016 the pedestrian crossing and access issues became apparent. Obviously this is not acceptable and proposed alternatives have been discussed with WDHB Disability Advisor (see recommendation below).

Recommendation: Flow Transportation Specialists have provided a post contract solution to resolve issue. The following were consulted:

- Group Manager, Occupational Health & Safety
- Disability Advisor
- Operations Manager, Traffic
- Project Manager (Delivery) from Beca
- Project Manager, Facilities
- Transportation Engineer, Flow Transportation Specialists
- Civil Engineer, Woods

Following consultation a proposed scheme (See figure 3 – page 7) was approved by the above team on 27th July 2016 with the following recommendations:

1. Relocating the current crossing away from the column A adjacent the ESC Management suite. The crossing is to be raised and line marked as a 'zebra' crossing in red (see photo 3 – page 8).
2. A fence be installed to both corners of the link road to direct pedestrians to the new crossing and avoid the 'blind spot' created by the column on the corner of the car park.
3. Provide an additional crossing further up the link road closer to the car park entry/exit. The crossing is to be raised and line marked as a 'zebra' crossing in red.
4. Closed of the footpath between the two crossing to prevent pedestrians attempting to continue and walk past the narrow section of the footpath next to the column adjacent the ESC Management suite.
5. Providing signage to warn pedestrians of the hazards.
6. Adequate lighting around the crossings.

The above scheme is currently being detailed and priced.

In the interim, the following temporary measures are being carried out mitigate some of the issues whilst the procurement of the contractor is underway:

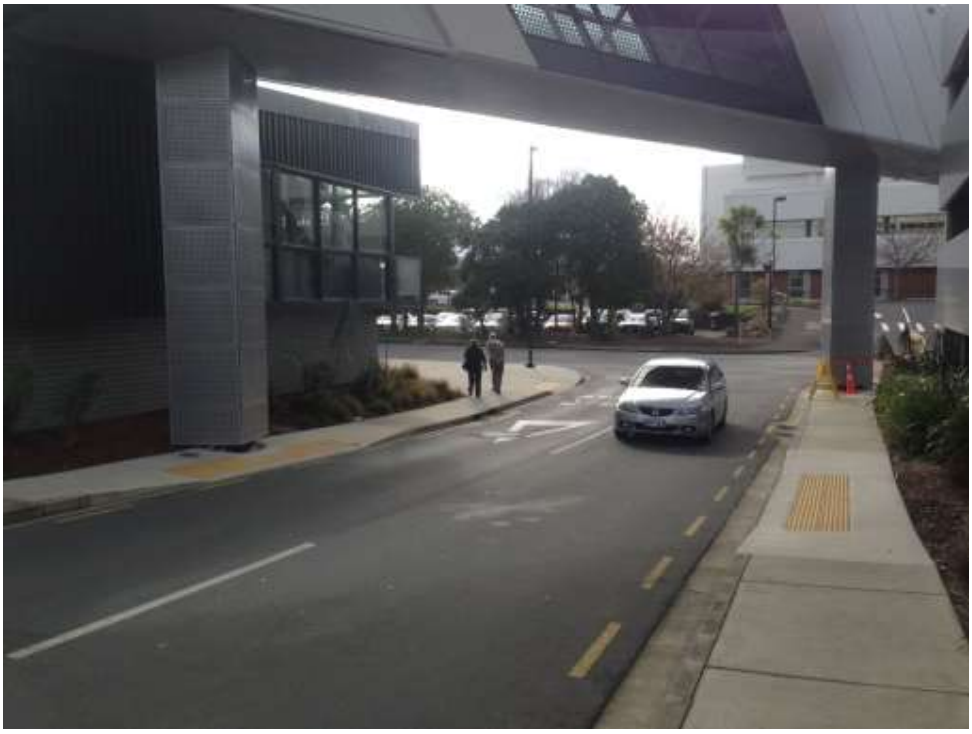
- Fence to both corners of the link road to direct pedestrians to the crossing.
- Signage to pre-warn pedestrians of the narrow section next to the column.

It is expected to complete the temporary and final solution as quickly as possible as follows:

1. Temporary works complete by Friday 5th August 2016 (picture 4 on page1)
2. Completion of final solution by proposed by end August 2016.

Figure 1: As-built Design and Construction Layout

Photograph 1: Current Pedestrian Crossing (Column A to left/ Column B to right)



<u>Photograph 2:</u> Column B at Car Park Corner

<u>Figure 2:</u> Proposed Alterations To Address Pedestrian Issues below ESC Bridge

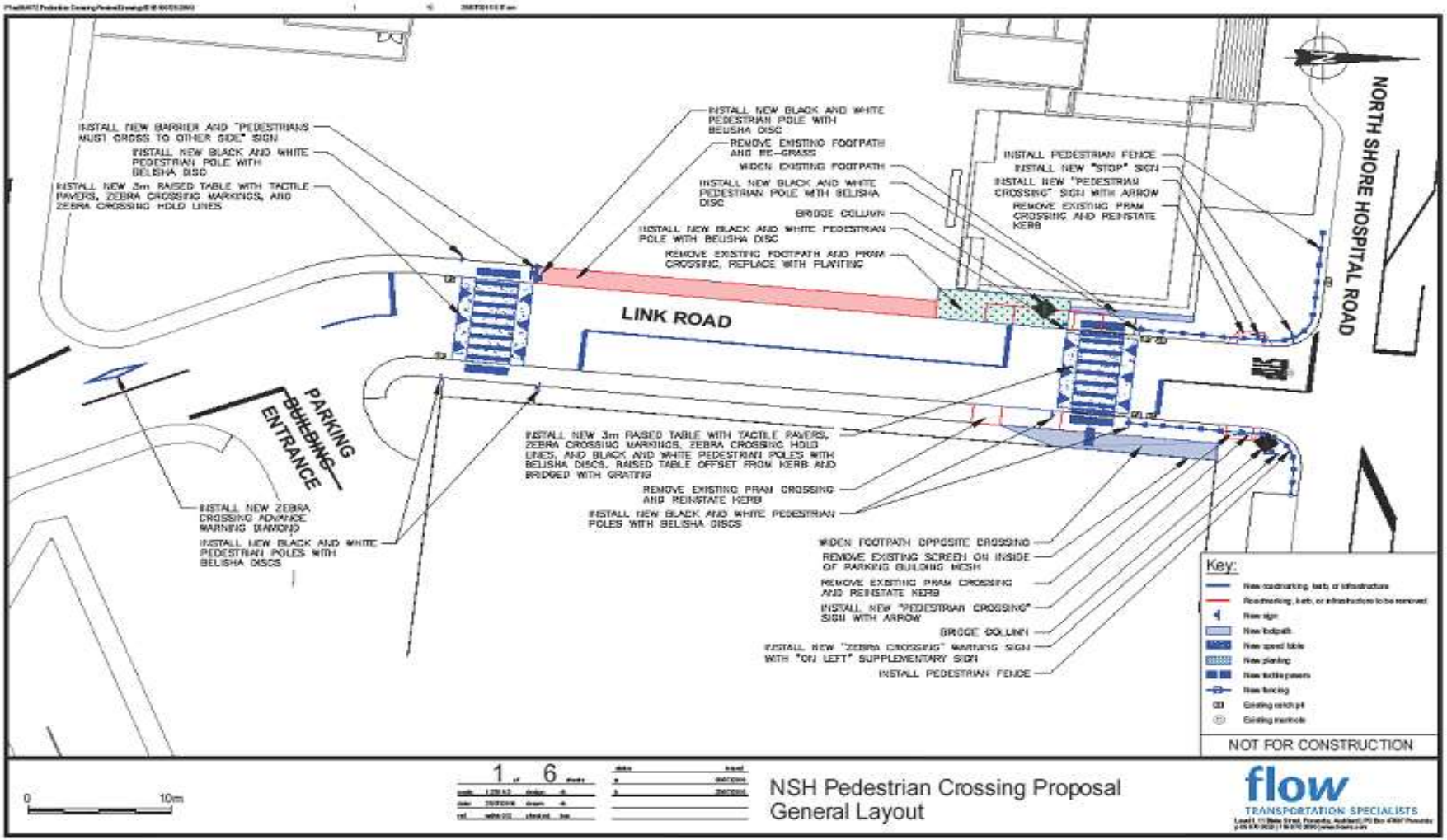


Photo 3: Proposed Red & White Pedestrian Crossing

Photo 4 – Temporary work done

HEALTH OF OLDER PEOPLE QUARTERLY REPORT ON ACTIVITIES IN AUCKLAND & WAITEMATA DHB

Recommendation:

That the Health of Older People Report is received.

Prepared by: Kate Sladden (Funding and Development Manager Health of Older People)
Endorsed by: Dr Debbie Holdsworth (Director Funding Auckland and Waitemata DHBs)

Glossary

ARRC – Age Related Residential Care
CI – Continuous improvement
DHB – District Health Board
HCSS – Home and Community Support Services
HOP – Health of Older People
IBT – In-between Travel time
LTCF – Long Term Care Facility interRAI
NASC – Needs Assessment Service Coordination
PBF – Population Based Funding

1. Purpose

The purpose of this report is to provide an update to DiSAC on the progress and activities occurring across Auckland and Waitemata DHBs for Health Older People and areas of focus at a regional and national level. The report includes material common to both DHBs and where appropriate material specific to an individual DHB.

2. Home and Community Support Services (HCSS)

2.1 Director General's Reference Group Report

Part B of the In-between Travel (IBT) Settlement Agreement led to the The Director General's Reference Group Report 'Towards Better Home and Community Support Services for all New Zealanders', which has now been released. There are 15 recommendations in the report that stem from two working groups set up to provide advice to the Reference Group covering:

- a review of home and community support services (workstream 1)
- the impact and affordability of transitioning to a regularised workforce (workstream 2).

The majority of recommendations are likely to be agreed to however there are some fundamental issues that have not been agreed including a move to a national agreement for HCSS.

To progress the commitments on regularising the HCSS workforce a working group was set up to develop a transition plan for sign off the by the Settlement Parties. The IBT Settlement Agreement states that 'it is intended that a regularised workforce will provide the majority of workers with guaranteed hours and workloads, and the that the workforce is paid a wage as opposed to the

current workforce which is paid on piecemeal basis as assignment workers. The wages will be paid based on the required level of training of the worker. Training will enable level 3 NZ Certification qualifications within two years of commencing work consistent with the service needs of the population."

The working group for a regularised workforce has proposed that the pragmatic way forward it to conduct two pilots; one in Auckland DHB and one in Taranaki DHB to trial a form of guaranteed hours for HCSS support workers. We are involved in initial discussions with the Providers, Unions and MoH to determine the structure of this pilot.

2.3 Changes to HCSS providers

Waitemata DHB has had some changes in the makeup of its HCSS providers. Pasifika Integrated Healthcare (PIHC) was placed in liquidation on 23 May 2016. Planning and Funding and the Needs Assessment Service Coordination (NASC) team worked to ensure all 130 clients were transferred to other HCSS providers by 30 May and approximately 30 of the 35 support workers employed by PIHC also took up the offer to transfer to these providers and continue to service their existing clients. Management of the liquidation was a streamlined process and we endeavoured to ensure that services to clients were not interrupted and consideration was given to the PIHC workforce.

We have also received notification that the Salvation Army is selling its HCSS business in Waitemata to Vision West Community Trust, an existing Waitemata DHB provider. The assignment of contracts is likely to occur at the end of July. This means there will be four HCSS providers contracted by Waitemata DHB for Health of Older People during 2016/17.

2.4 Medication Guidelines

A clinical working group set up by the Waitemata DHB HCSS providers to develop Medication Management Guidelines is progressing. The intention is that HCSS providers will use the guidelines to develop policies and procedures for their services to ensure safe practice. Advice is also being sought from the Ministry of Health (MoH), auditing agencies, Quality Use of Medicines Pharmacist, Maori Health Gain Team, Accident Compensation Corporation (ACC) and the Home and Community Health Association (HCHA). An initial draft is planned to be ready by September 2016.

2.5 HCSS Enhancement projects

Auckland DHB HCSS providers and the DHB are working on a number of enhancement projects in order to improve service integration across the client journey. Two projects that are now completed are a standard communication template summarising an individual's receipt of services and a process for managing clients receiving a high number of HCSS hours including regular clinical reviews. A projects enabling HCSS providers 'read only' access to HCC (a patient platform detailing clinical information) is making good progress. Another key project focusing on 7 day admission to HCSS is progressing.

2.6 interRAI – standardised clinical assessments

The table below reports on the MoH interRAI measure i.e. the proportion of clients receiving HCSS who have had an interRAI assessment (reported one quarter in arrears) for 2015/16.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Auckland DHB	97.1%	97.5%	97.7%	97.6%
Waitemata DHB	88.6%	92.4%	95.4%	96.8%

3. Aged Related Residential Care (ARRC)

4.1 interRAI – standardised clinical assessment (Action 7.1)

Previous reports to DiSAC have reported on the proportion of registered nurses in ARRC trained to undertake interRAI long term care facility (LTCF) assessments. The 2015/16 ARRC Agreement had a new clause that requires all facilities to use interRAI as their primary assessment tool. The table below shows performance against the MoH LTCF measure i.e. percentage of people in aged residential care who have a subsequent assessment completed within 230 days of their previous assessment.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Auckland DHB	49%	62%	76%	78%
Waitemata DHB	42%	56%	68%	74%

4.2 Audits

Eighty nine facilities have been audited since 1 July 2015.

2015/16	**ADHB**	**WDHB**
Number of audits	41	48
Average number of corrective action per audit	3.0	3.3
% of facilities > 5 corrective actions	22%	19%
% of corrective actions relating to health & safety*	57%	53.7%
% of facilities with no corrective actions	20%	21%
% of facilities achieving a continuous improvement**	20%	19%
Number of complaints the DHB received on ARRC	14	18

* Analysis of corrective actions relating to health and safety is only for quarter 3 and 4 2015/16 after a request for visibility of ARRC audit performance in this area. Over half the corrective actions related to areas that could be considered health and safety issues. Appendix 1 is a list of the standards and criteria that we have identified as relating to health and safety.

** The gold standard attainment against an audit criterion is 'continuous improvement' (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.

4.3 Aged residential care facilities - reconfigurations, closures and new builds

There are a number of closures of ARRC facilities occurring:

- Ranfurly Village Bob Reed Unit; all male 23 bed dementia unit closed in March (ADHB)
- Lady Ascot; 15 bed rest home closing in June (ADHB)
- Upland House at Caughey Preston; 19 rest home beds closing in June (ADHB)
- St Catherine's; closing 17 rest home beds (ADHB)
- Leigh Rd Cottage (WDHB) transitioned from a rest home facility to a dementia unit in June/July

The closures are a reflection of the declining use of rest home beds and issues around the viability of stand-alone rest home only facilities. Planning and Funding and the DHB NASC supported residents and their families in transition to new facilities.

There are also a number of facility new builds recently completed or underway and some facilities that have reconfigured. Appendix 2 provides a list of these for both DHBS.

4.4 Aged residential care beds and occupancy

Quarterly ARRC bed surveys are now being undertaken and completing the survey is a mandatory requirement for all providers.

In the most recent survey (quarter 3), the occupancy rate for Auckland DHB was 87% and for Waitemata DHB was 92%. Appendix 3 provides the bed numbers and occupancy at each level of care.

4.5 ARRC Agreement 2016/17

A fundamental change to the ARRC Agreement for 2016/17 is an amendment so that it applies to all needs assessed residents. This aligns the Agreement with the intent of the Social Security Act. Many of the provisions in the ARRC Agreement were inconsistent with the statutory regimen set out in the Social Security Act in that it could be interpreted that it applied to subsidised residents only. Therefore, throughout the Agreement, with a few exceptions, the term "subsidised resident" has been replaced with "resident".

5. Falls Prevention

Waitemata DHB and Auckland DHB have been working with the ACC to plan a range of services to prevent injurious falls under the guidance of the ADHB/WDHB/ACC Falls Prevention Working Group. The Falls Prevention Programme aims to reduce injury falls and fragility fractures in people aged 65 years and over living in Waitemata and Auckland DHBs, specifically to reduce hospitalisations and ACC injury claims.

The programme will deliver across three key areas:

- extending the Fracture Liaison Service at both DHBs
- establishing and in-home strength and balance exercise programme for highest risk people, including traditional delivery and a trial using HCSS providers
- facilitating further development on group strength and balance sessions (this component will be led by ACC)
- developing a clinical pathway.

Appendix 1: Health and safety corrective actions identified in age residential care audits

Analysis of corrective actions relating to health and safety started for quarter 3 and 4 2015/16 after a request for visibility of ARRC audit performance in this area. Below are the areas that the DHB Quality and Monitoring managers have identified as relevant to health and safety and the number of corrective actions for quarter 3. During this quarter 12 and 11 audits were undertaken at Auckland DHB and Waitemata DHB respectively.

Standards	Criteria Areas	ADHB	WDHB
Quality and risk	Quality & risk management systems	14	6
	Adverse event reporting	3	4
Continuum of service	Medication	7	5
Safe and appropriate environment	Human resource	9	6
	Management of waste and hazardous substances	0	0
	Facility specifications standards	5	3
	Toilet, shower and bathing facilities	0	0
	Personal space / bed area	0	1
	Communal areas for entertaining, recreation and dining	0	0
	Cleaning and laundry services	1	1
	Essential emergency and security systems	2	2
	Natural light, ventilation and heating	0	0
Restraint minimisation & safe practice		0	1
Infection prevention & control	Infection control management	0	0
	Total	**41**	**44**

Appendix 2: Age residential care facility new builds and reconfigurations

Waitemata DHB

The table below has new aged residential care beds that have opened in Waitemata DHB since January 2015.

Facility/location	Rest home beds	Dementia beds	Hospital beds	Psycho-geriatric beds	Total beds
Tasman Care (Bupa), Henderson	10	-	62	-	72
Kumeu Village, Kumeu	20	20	42	-	82
The Orchards (Metlifecare), Glenfield	4	-	32	-	36
Summerset Falls, Warkworth	36*	-	-	-	36
Pinehaven, Hatfields Beach	-	16	-	-	16
Apollo Drive (Bupa), Albany	-	24	76	-	100
Rangatira Rd (Ryman), Birkenhead	70 (30*)	40	40	-	150
Total	**140**	**100**	**252**	**-**	**492**

* Rest home level certified apartments – 66 of the new rest home beds are in apartments

There are another approximately 332 beds across five sites (new builds and extensions) that are planned to open in 2017 – 2018

Auckland DHB

The table below has new aged residential care beds that have opened in Auckland DHB since January 2015.

Facility/location	Rest home beds	Dementia beds	Hospital beds	Psycho-geriatric beds	Total beds
Sunset (Bupa), Blockhouse Bay	-	6	20	-	26
Capella House, Blockhouse Bay	-	19	9	-	28
Anne Marie Gardens, Avondale	-	-	30	6	36
St Johns (CHT), Greenlane	-	20	-	-	20
Campbell Rd (Ryman), Greenlane	43 (30*)	30	43	0	116
Tropicana Drive (Ryman), Mt Roskill	40	30	40		110
Meadowbank Village (Oceania)	-	-	30	-	30
Summerset at Heritage, Ellerslie	40	-	40	-	80
Total	**123**	**105**	**212**	**6**	**446**

* Rest home level certified apartments – 30 of the new rest home beds are in apartments

There are another approximately 346 beds (new builds and extensions) that are planned to open in in 2017-2018.

Appendix 3: Quarterly age residential Care Bed Survey

The tables below provide the most recent data from the ARRC Quarterly Bed Surveys (Quarter 3 2015/16)

Auckland DHB

Beds	Number	Occupancy
Dedicated Rest home	1,165	81%
Dedicated hospital	1,112	90%
Dual service	966	90%
ORA rest home only	65	92%
ORA hospital only	0	0
ORA dual service	119	97%
Dementia	335	84%
Psychogeriatric	44	89%
Dedicated YPD	7	57%
Other beds	1	0
Total	**3814**	**87%**

Waitemata DHB

Beds	Number	Occupancy
Dedicated Rest home	1,027	90%
Dedicated hospital	722	92%
Dual service	1,122	93%
ORA rest home only	41	83%
ORA hospital only	0	0
ORA dual service	31	103%
Dementia	374	93%
Psychogeriatric	111	92%
Dedicated YPD	0	0
Other beds	4	50%
Total	**3,452**	**92%**

WAITEMATA 2025 IDEAL WARD COMMUNITY ENGAGEMENT PLAN

Recommendation:

That the Disability Strategic Advisory Committee:

a) **Provide feedback on ideal ward draft concept designs**

b) **Provide feedback on the community engagement plan**

Prepared by: Dr Robyn Whittaker, Public Health Physician - Research & Innovation; Helen Olsen, Project Manager W2025; Carol Hayward, Community Engagement Manager, Waitemata District Health Board

Glossary

W2025 – Waitemata 2025 programme
WDG – Waitemata 2025 Design Group
ESC – Elective Surgical Centre
YAG – Youth Advisory Group
CEF - Community Engagement Forum
WDHB- Waitemata District Health Board
ADHB – Auckland District Health Board
AUT – Auckland University of Technology
HQSC - Health Quality and Safety Commission

1. Executive Summary

WDHB is developing its clinical facilities to ensure it can meet the needs of its growing population in the Waitemata district sustainably.

To help shape this programme of work the Waitemata 2025 Design Group (WDG) has been established to work with clinicians and external experts to develop best practice design principles, new models of care, research and innovation and to provide advice and support particularly with respect to community, patient and family engagement and co-design processes.

This report outlines core design principles that have been developed, concept designs for an ideal ward and proposed community input into the design of all future facilities to be built by Waitemata DHB.

Community engagement is proposed to take place to review a mocked up ideal ward – both virtually and physically, review of design briefs, concept designs and detailed designs for future build processes . This will occur through a range of approaches to ensure that a wide range of potentially interested stakeholders will be invited to participate such as people with a disability and those from diverse community and cultural backgrounds

2. Introduction/Background

WDHB is developing its clinical facilities to ensure it can meet the needs of its growing population in the Waitemata district sustainably. A coordinated approach to facilities work at Waitemata is

bringing together building projects, master site plans and health services plans to ensure appropriate and necessary clinical facilities are built in the interim and longer term.

To help shape this programme of work the Waitemata 2025 Design Group (WDG) has been established to work with clinicians and external experts to develop best practice design principles, new models of care, research and innovation as well as to provide advice and support particularly with respect to community, patient and family engagement and co-design processes. Two consumer representatives have been recruited to join the WDG while a wider group of patients, whānau and community members will be engaged with at key design phases to ensure that a range of cultural, accessibility and consumer needs are taken into consideration during facility design.

This community engagement plan has been developed to facilitate community input into the design of facilities built under within WDHB and ensure an appropriate level of community input into clinical facility design. The large build projects currently the focus of this plan are the ESC Expansion and the Replacement Wards project. There are also a number of interim projects that may benefit from community input and the level of engagement required for these projects will be determined on a project by project basis.

3. Risks/Issues

It is important that new designs take into consideration the different needs of the Waitemata community and reflects changing demographics and good practice evidence both from within New Zealand and from overseas. This engagement plan will help to ensure that community views and perspectives are considered during the design and development of this programme of work.

4. Approach/Methodology/Analysis/Justification

4.1 Investigation/Research/Evidence

Design principles
In order to ensure the DHB continues to provide health service facilities that enhance patient and whānau experiences and enable the best care for everyone, it has been recommended that a core set of principles be applied to all facilities design projects. This will also, as much as is possible, future-proof current and planned design and redesign projects to be adaptable for changes in the way care is provided.

These principles were developed based on the Guiding Principles developed for the North Shore Hospital ward 8 redesign project, Evidence-based Healthcare Design paper (presented to the Waitemata board in 2014), other background research being conducted into new models of care, and direct learnings from national/international programmes (such as the new Christchurch hospital, ADHB/AUT design lab, ASPECT tool, Queensland Health documents). In addition, a short consultation period was held which provided community feedback. This included feedback from Blind Citizens NZ, the Health Quality and Safety Commission (HQSC) and the National Foundation for the Deaf.

As with everything else we do, facilities design is underpinned by Waitemata DHB's core values: everyone matters; with compassion; connected; better, best, brilliant.

The intention is that these principles will be applied through-out the design process for all new building and re-design projects across Waitemata DHB. This will mean the consideration of the principles in the work up of all design briefs by the services and facilities, inclusion of the principles in design briefs given to architects/designers, requirements to include consideration of/responses to the principles in design documents from contracted designers/architects and others, and inclusion of consideration of the principles in all business cases including justification for how these principles have been addressed or not addressed as appropriate.

Checklists have been provided to aid the inclusion of these design principles.

Ideal ward

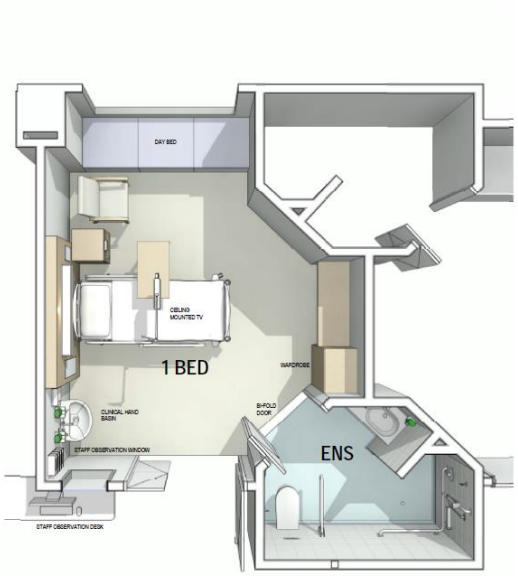
The design principles were also used to develop an 'Ideal Ward' for general medicine to inform:

- The likely total footprint of the ward, to assist with high level planning
- Audit parameters for assessing current state of medical wards
- Options for ward layouts for a general medical and an Assessment, Treatment and Rehabilitation ward

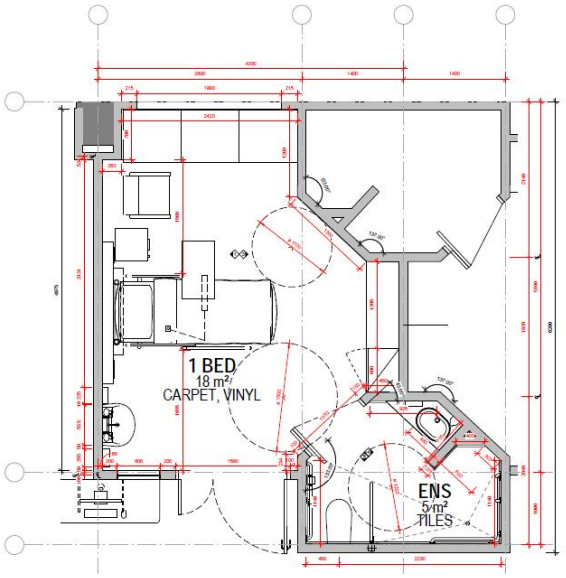
This was developed by reviewing best practice from literature review, consideration of manual handling guidelines, infection control requirements and the Australian Health Facility Guidelines. The ideal ward has considered a range of issues such as ward size, proportion of single rooms, mixed gender rooms, toilets & showers, room size, ceiling tracking, number of toilets, accessible/assisted toilets, day rooms and beverage bays, utility rooms, medication rooms, teaching spaces, staff break rooms, technology, patients with delirium/dementia, patients with CVA, cost savings and impacts on furniture/fittings.

4.2 Options considered

This ideal ward has been developed into concept designs which are shown below and will be used to develop a mocked-up ideal ward for testing with staff and the community as outlined further within this report.



Aerial Plan



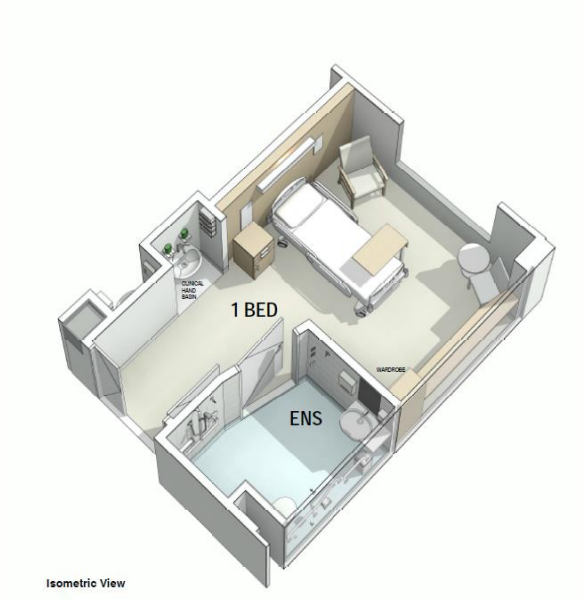
Plan

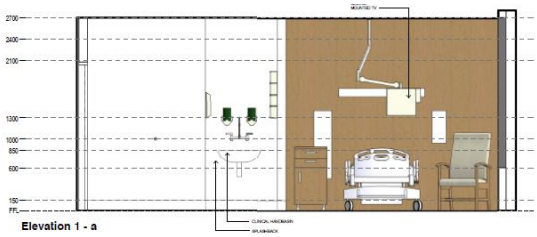
Waitemata District Health Board
Best Care for Everyone

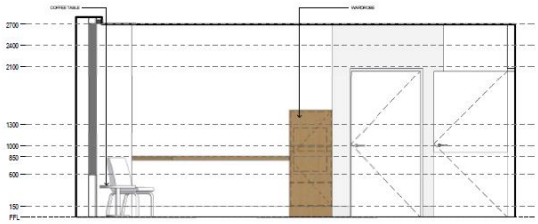
1 BED ROOM & ENSUITE - OPTION 2 - PLANS
THE IDEAL INPATIENT UNIT

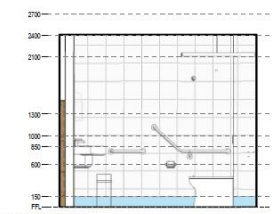
Project Number 10269.02
Drawing Number A104
Scale 1 : 20
Revision
Date 06/04/16

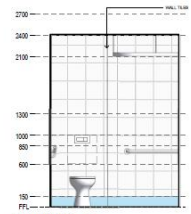
STH









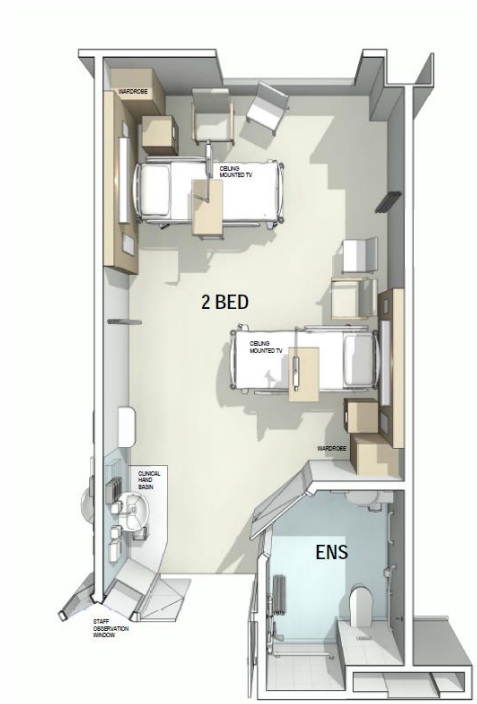


Waitemata District Health Board
Best Care for Everyone

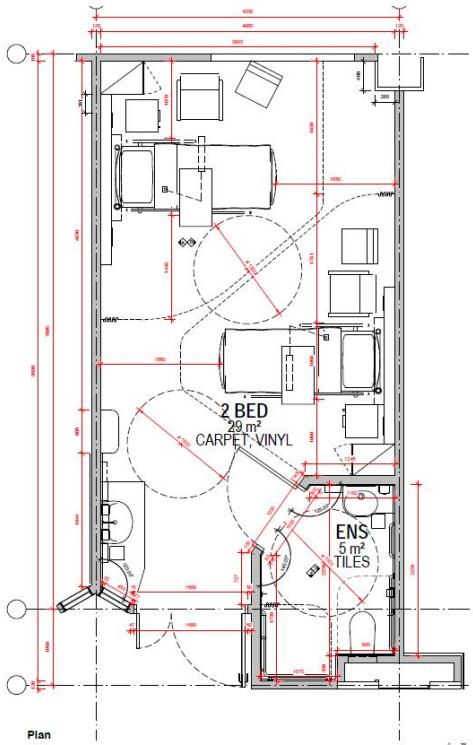
1 BED ROOM & ENSUITE - ELEVATIONS
THE IDEAL INPATIENT UNIT

Project Number 10269.02 | Scale 1 : 20 | Date 06/04/16
Drawing Number A101 | Revision

STH



Aerial Plan



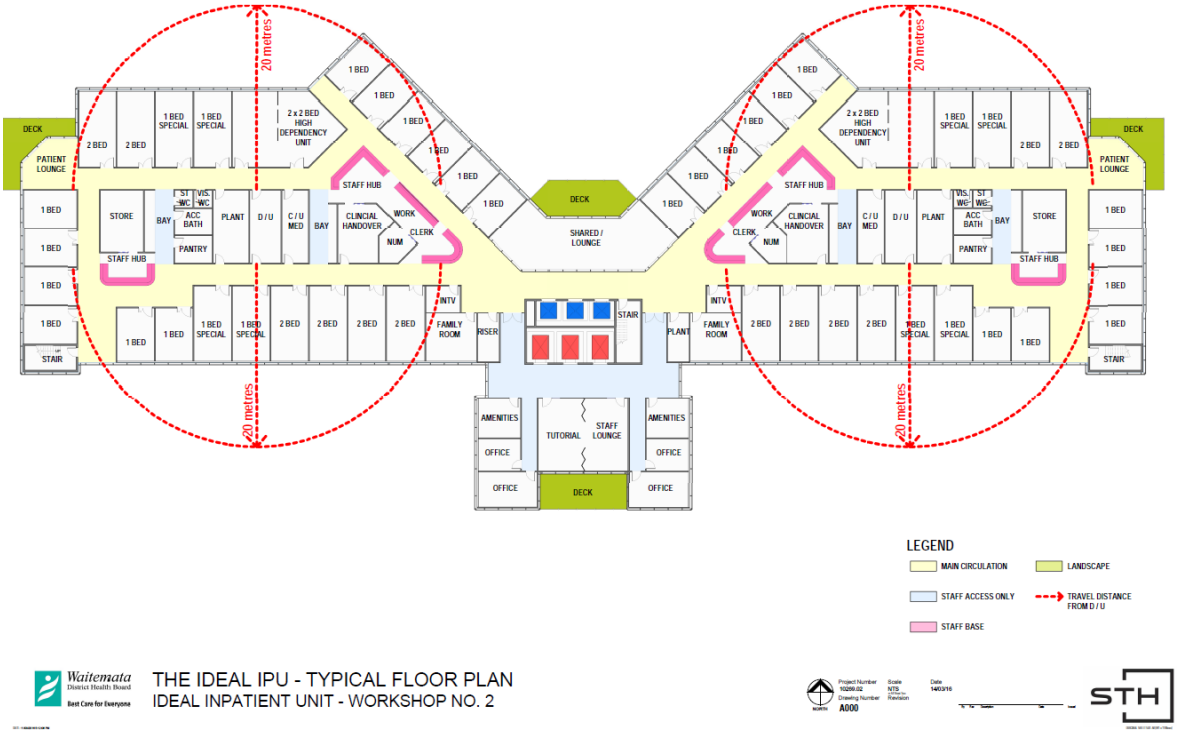
Plan

Waitemata District Health Board
Best Care for Everyone

2 BED ROOM & ENSUITE - PLANS
THE IDEAL INPATIENT UNIT

Project Number 10269.02 | Scale 1 : 20 | Date 04/01/16
Drawing Number A102 | Revision

STH



Waitemata District Health Board — Best Care for Everyone

THE IDEAL IPU - TYPICAL FLOOR PLAN
IDEAL INPATIENT UNIT - WORKSHOP NO. 2

STH

4.3 Decision Criteria

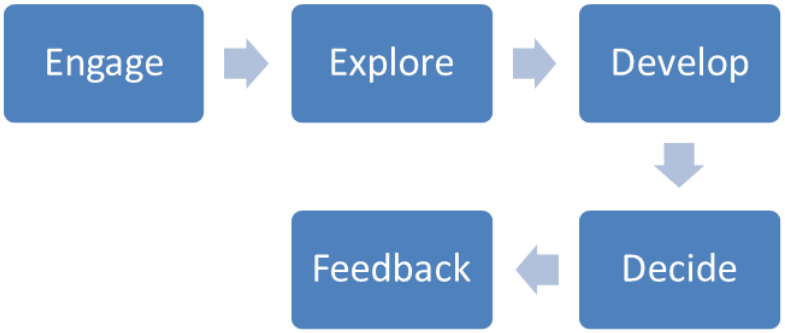
Consumer Idea Generation & Decision Making

An important step in consumer engagement is the development of ideas to evolve design principles that consumers value highly for their effectiveness. At this point consumers can be asked to determine their priorities in design given specific funding/resource or area constraints.

Healthcare planning decisions can be primarily based on the needs and interests of the service. This does not exclude patient needs and experiences, but invariably demotes them to secondary importance. Involving consumers in decision making helps ensure balanced and effective design.

Closing the Feedback Loop

Stakeholders expect that if they are to take the time to provide feedback and/or provide solutions that they receive information about how their feedback has been used to influence the final design. This can be done in variety of ways: regular email correspondence, newsletter updates, internet site updates or at relevant community engagement events.



5. Linkages/Impact

5.1 Strategic Context

The community engagement plan is in line with the Waitemata 2025 Health Services Plan, the Māori Health plan, the Waitemata Engagement Strategy and the Waitemata 2025/2016 Annual Plan.

5.2 Impact on reducing inequalities and Maori Health Gain.

Enabling Māori to participate and contribute towards building design will ensure that whenever possible strategies are in place to improve Māori health outcomes. The approach of whānau centred care has been incorporated in to the ideal ward thus strengthening whānau capacity to undertake functions that that contribute the wellbeing or Māori.

6. Consultation/Engagement

7.1 Consultation already undertaken

Patient feedback and past consultations have informed the core design principles and ideal ward work. This includes Ward 8 redesign work during mid to late 2014.

7.2 Planned consultation

Community stakeholder overview

Stakeholder	Comment
Volunteers	Those who work on wards may be particularly interested but this will be promoted to all those working within the hospital
Health Links	Waitakere Health Link and Health Link North have independent boards who are interested in a wide range of health issues. In addition the health links run health literacy groups who are interested members of the community with some health experience who can provide a range of insights – they are predominantly used to review WDHB patient information but also can be invited to provide feedback on DHB activities. The Health Links are funded to run occasional focus groups so could be asked to recruit and facilitate a session each which may be

	different or broader than their current health literacy group membership (e.g. including consumer representatives or targeting a specific population group)
Disability Support Advisory Committee	To gain feedback and advice on disability issues relating to Waitemata 2025 and support in promoting the engagement opportunities through their networks
Patients and the wider community	Reo Ora Health Voice online community panel members – WDHB has a panel of 424 community members who have signed up to receive surveys and invitations to participate in DHB activities Youth Advisory Group (YAG) – the DHB funds a youth advisory group who meet monthly and who have provided some insights into the reception area of the North Shore Hospital already. Other ways of involving youth could be explored with the YAG or with Youthline who currently run the group Older adults stakeholder group – may also be interested but this could be managed through Health Links Māori / Pacific / Asian – it would be beneficial to consider different cultural perspectives so targeted engagement is also recommended

Engagement methods

Stakeholder group	Engagement method
Volunteers	• Focus group with Ward 2 volunteers plus others who might be interested • Invitation to attend open day (If open days are offered first to volunteers, they may be interested in helping out on the public open days)
Health Links	• Face to face discussions at board level • Focus groups in partnership with them • Promotion through their newsletters
Disability Support Advisory Group	• Committee paper and presentation as appropriate. Invitation to attend open days
Patients and the wider community	• Focus groups for specific community groups or an invitation to attend open day – these could be held on a number of work days, one or two evenings and a Saturday to provide the different stakeholders with an opportunity to see the information and provide feedback. This could include: o An overview of the Waitemata 2025 programme – what's proposed and why o Design guidelines with an opportunity to provide feedback through structured feedback o Ideal ward mock-up with opportunities to provide feedback through structured questions e.g. on flipcharts around the room o Concept plans of how the ideal ward would look as a complete ward with opportunities to provide feedback through structured questions, e.g. on flipcharts around the room

Stakeholder group	Engagement method
	○ Other Waitemata 2025 related activities where feedback might be helpful ○ Possibility of site tours for members of the public to see changes that have already been made and to show them where new buildings / changes are going to be made •

Exploring & Understanding Patient/Consumer Experiences
Exploring and understanding patient/consumer experiences builds on community engagement methodologies above. Exploring is learning about and understanding patient experiences of services and building design and identifying potential service or building design improvement ideas.

The following exploring methodologies should be considered:

- Patient/consumer shadowing – identifying what happens during a patient visit to a service/building
- Patient/consumer journey mapping – summarising the service experiences and building navigation over journey
- Patient/consumer stories – assessing patients' service experiences in their life context

7. Communications/Marketing

8.1 Internal

- Through internal news and the intranet.
- Possibility of promoting within the hospital itself e.g. at ED or in the main reception area.

8.2 External

- Online survey with key questions and use of images where possible – it may also be possible to develop a virtual tour of the ideal ward.
- Email through mailing lists and networks (supported by CEF members).
- Promotion on the public consultation webpage - http://www.waitematadhb.govt.nz/News/Public-Consultations
- Social media promotion.

8. Implementation

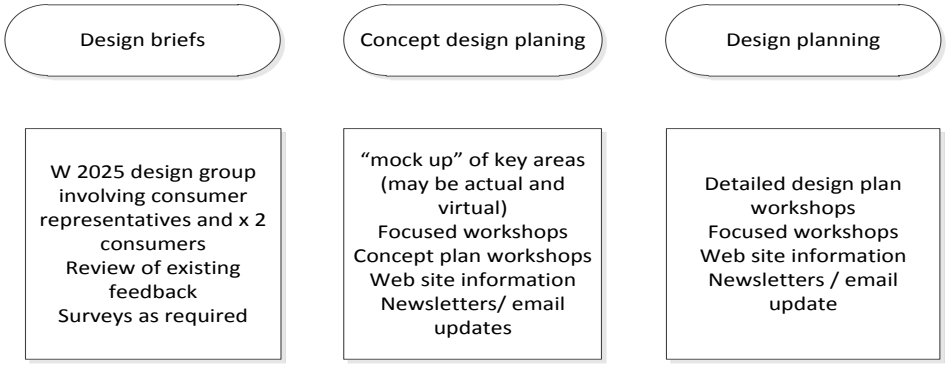
9.1 Issues/considerations

Depending on the input required consumers will be reimbursed for their time in line with the new Recognising Community Participation policy. This will be a minimum of petrol vouchers to enable consumers to attend site mock ups and workshops.

Budget will be included in business cases for this function.

9.2 Timelines

The diagram below indicates the process that will be used for the future build process at WDHB. Actual timelines have not been applied due to the varying nature of work.



9. Conclusion

This report provides an overview of the patient focused process so far and the proposed engagement plan to ensure ongoing involvement of the community in the design of all future facilities to be built by Waitemata DHB.

10. Authorities/Sign-offs

The engagement plan has been developed by members of the Waitemata 2025 Programme Design Group and has received endorsement from the Waitemata 2025 Project Control Group and the Community Engagement Forum (CEF).

Community Engagement with People with Disabilities

Recommendation

That the Disability Support Advisory Committee:

1. **Receives the report.**

Prepared by: Samantha Dalwood (Disability Advisor), Carol Hayward, WDHB Community Engagement manager
Endorsed by: Debbie Holdsworth (Director of Funding)

Glossary

DHB	District Health Board

1. Executive Summary

In May 2016, the Ministry of Health launched *A Guide to Community Engagement with People with Disabilities*. A copy of this document is attached.

Waitemata and Auckland DHBs already have an understanding of the ways to meaningfully engage disabled people.

The Ministry guide supports the work that both DHBs are currently doing and is a useful reference document.

2. Current Work

Waitemata and Auckland DHBs value the information that engaging with disabled people brings. Both DHBs appreciate that by making facilities and services more accessible to disabled people, they become more accessible to the general population.

The Disability Advisor works closely with the disability sector to engage people in both the disability sector and the disability community. This role ensures that a disability lens is applied to the DHB work. The Health and Disability Group was set up with CCS Disability Action and has a number of people from disability organisations and the community, as well as a member of the Counties Manakau DSAC. As well as regular monthly meetings, this is a group of people who are very well networked and able to get the perspective of a large number of disabled people very easily.

The Waitemata DHB Engagement Strategy has identified disabled people as a population group that it is vital to engage with in a meaningful way. In planning consultation and engagement activities, the DHB assesses the accessibility of venues, offers sign language interpreters and has checked online survey tools to ensure that they are fully accessible to those with screen readers. These new guidelines build on the DHB's existing inclusive engagement guidelines (attached) and provide additional considerations, particularly around key demographics.

Auckland DHB is also working to ensure that disabled people are engaged in the work that they are doing. The Public Spaces Team is setting an Accessibility User Group to ensure access for everyone to the new public spaces. The Blind Foundation has provided an audit of the Reo Ora Healthvoice online community website which is guiding improvements in its redesign so that can also be used effectively to engage in an accessible way.

3. Conclusion

The Ministry of Health's *Guide to Community Engagement with People with Disabilities* is a useful reference tool when planning engagement with disabled people and is aligned with the work that Waitemata and Auckland DHBs are currently doing.

4. References

http://www.health.govt.nz/publication/guide-community-engagement-people-disabilities

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

8.3

A Guide to Community Engagement with People with Disabilities

Released 2016 **health.govt.nz**

The Ministry of Health would like to thank Balance NZ, Disabled Persons Assembly, the Association of Blind Citizens of New Zealand Inc (Blind Citizens NZ), Deaf Aotearoa New Zealand, Kāpō Māori Aotearoa New Zealand (Ngāti Kāpō), Deafblind (NZ) Incorporated and People First New Zealand Ngā Tāngata Tuatahi for their active involvement in, and support for, the development of this guide.

Citation: Ministry of Health. 2016. *A Guide to Community Engagement with People with Disabilities*. Wellington: Ministry of Health.

Published in May 2016
by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-0-947491-71-0 (online)
HP 6361

This document is available at health.govt.nz

Contents

8.3

Introduction

People with disabilities represent a significant percentage of the community.[1] This guide offers practical advice about consulting with people with disabilities and reducing barriers to their full participation in their communities. It was developed in association with disabled people's organisations, to assist agencies such as government departments, local bodies, district health boards, schools and community groups to engage with people with disabilities.

Disabilities are diverse and can range from obvious impairments to invisible conditions. This includes people with:

- a learning/intellectual disability
- physical impairments including mobility impairments, and those who use mobility devices or other assistive technology
- sensory impairments/loss, including those with a vision impairment or who are blind and those with a hearing loss, who are hard of hearing or who are Deaf
- mental health conditions, including those who experience disabling symptoms such as depression, anxiety or psychosis
- neurological impairments such as brain injury
- chronic illness (such as diabetes), as well as those whose experience of disability is 'invisible' (eg, people with auditory processing disorders might be able to hear well in one-to-one conversation, but not if there is background noise in a crowded room).

This guide focuses on engaging with people with learning/intellectual,[2] physical and/or sensory disabilities. However, much of its advice can also be applied to work with people who experience mental health conditions.

The principles of the Treaty of Waitangi (Te Tiriti o Waitangi), the New Zealand Disability Strategy,[a] the Kia Tūtahi Relationship Accord and the United Nations Convention on the Rights of Persons with Disabilities (the UN Convention) all informed the development of this guide.

The UN Convention was established 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'. This guide will help organisations to ensure people with disabilities can access, on an equal basis with others, the physical environment, information and communications.[b]

This guide is a living document that will change over time. If you have feedback or content to add please contact Disability Support Services within the Ministry of Health: disability@moh.govt.nz

[1] In the 2013 New Zealand Disability Survey, almost one in four New Zealanders or 1.1 million people identified as disabled. The survey noted that: 'disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. The limitations identified were self-reported or reported on behalf of the disabled person by their parent or primary caregiver.'
See Statistics New Zealand. 2014. One in four New Zealanders identified as disabled.
URL: www.stats.govt.nz/browse_for_stats/health/disabilities/DisabilitySurvey_MR2013.aspx
(accessed 16 November 2015).

[2] 'Learning/intellectual disability' refers to people previously labelled as 'intellectually disabled'. It does not include learning difficulties experienced in the school setting (eg, dyslexia).

Why equal participation is important

Equal participation of people with disabilities

People with disabilities have long faced considerable barriers to equal participation and involvement in society. The three main barriers that prevent people with disabilities from being active in their communities and having their voices heard are:

- access to information and services – for example, a person with a vision impairment may have difficulty accessing written information about changes in their community; or a person with a hearing loss, is hard of hearing or Deaf, may have difficulties accessing information available only through an 0800 telephone line
- social attitudes and behaviours – for example, there can be an assumption that people with disabilities do not work or have children and therefore do not need accessible transport or parenting support; or that because a disabled person has a physical or sensory loss they will also have a learning/intellectual disability. Discrimination can result in people being marginalised and devalued
- the built environment – for example, a person who uses a wheelchair cannot access a building where the entrance is only accessible by steps.

Building an inclusive society with strong community relationships

This guide aims to improve the lives of people with disabilities by ensuring their voices are heard and that their views inform decision-making. This guide also focuses on strengthening government and community partnerships.

Kia Tūtahi, signed by the Prime Minister and community representatives in 2011, supports building strong relationships between communities and the government. In particular, it commits the government to listening and responding to those not usually included in policy development.

The New Zealand Disability Strategy, launched in 2001, aims to move from a disabling to an inclusive society. The strategy committed the government to developing meaningful partnerships with people with disabilities; it recognises that disabled people are expert in their own lives and their experience of disability. The strategy aims to ensure people with disabilities are informed about, and involved in, decision-making regarding matters that affect them. In the spirit of the strategy, disabled people's organisations and government agencies together led the design of the Disability Action Plan.

Organisations can promote the rights of people with disabilities through accessible and inclusive community engagement. An important step towards meaningful partnership is ensuring all information and communication methods offered to the public are also available in formats appropriate to the differing requirements of people with disabilities.

Engagement planning

Before engaging with people with disabilities

First find out whether there has been any previous engagement. This shows respect for the time and effort of people who have already provided their expert advice.

Then clearly define the:

- purpose and type of engagement you are planning
- timeframe
- feedback you will provide to participants
- expectations of your organisation and the expectations of the participants.

Consider consulting in a number of ways: some forms of communication may be essential for one group, but totally inaccessible to another. Communication aids such as computer technologies/software, picture-based communication boards, whiteboards/pens and speaking devices may help. Your engagement may involve public meetings with New Zealand Sign Language interpreters, accessible online surveys, postal surveys or one-on-one conversations.

Types of engagement

Identify what level of engagement is appropriate for your purpose. The following table describes different levels of engagement.

Inform	One-way communication of information – from your organisation to the community including people with disabilities. In this form of engagement, the community has no input into decision-making	• Websites • Letters
Consult	Two-way communication – between your organisation and the community including people with disabilities. Its purpose is to seek the opinion of the community	• Surveys • Focus groups • Social media
Involve	Working directly with the community during the engagement process, including by seeking feedback and discussing questions	• Workshops • Working/planning groups
Collaborate	A community partnership, including shared decision-making and a co-design approach	• Advisory committees • Reference groups
Lead	A method of engagement in which final decision-making sits with the community	• Voting

Who to engage with

Depending on the purpose of the engagement, in addition to people with disabilities, consider involving other groups, such as disabled people's organisations, carers/carer groups, advocacy groups and whānau support groups.

Disabled people's organisations represent different disability groups; it may be useful to approach organisations representing the particular groups you wish to engage with. See 'Disabled people's organisations and resources' (page 36).

Make an effort to reach people who are often excluded from community engagement. Disabled people's organisations can help with this. In smaller towns there may not be any active disabled people's organisations. In this situation, find out whether other networks or relationships could serve a similar purpose.

Early planning

Begin the process of engagement with people with disabilities as early as possible, allowing enough time to make arrangements such as booking New Zealand Sign Language interpreters, organising travel, or creating accessible information. Keep in mind that when engaging with people with disabilities, some processes may take longer, or involve additional resources. Allow for the possibility that some people might experience difficulties taking part in your engagement process and allow extra time to address potential accessibility issues before they arise.

If the issue you wish to engage on is of widespread interest, allow several months for the engagement process. People with disabilities often find out about an opportunity for engagement or consultation by word of mouth; your time frame should allow for this.

Provide sufficient notice to allow time for people to make arrangements for things like childcare, absence from work and enlisting support people.

Creating Easy Read versions of documents also takes time. Easy Read documents, used by people with learning/intellectual disabilities, use everyday language and use images to assist meaning. See 'Engaging with people with learning/intellectual disabilities' (page 30) for more information and 'Disabled people's organisations and resources' (page 36) for details on People First New Zealand Ngā Tangata Tuatahi's translation service.

Choose a suitable time or times for the engagement, keeping in mind that different people will have different needs. Some people with disabilities prefer to avoid starting a meeting too early in the morning, because they require assistance to start the day. Wheelchair-accessible taxis are often busiest around the time of school runs (9am and 3pm), and are more commonly available during school holidays and at the weekend. Some people with learning/intellectual disabilities may prefer mornings, because they are more rested and find it easier to concentrate at that time.

Personal assistants sometimes help disabled people with tasks such as mobility, communication or personal cares. Ask ahead about personal assistants, and factor them into your planning for engagement.

Allow adequate time for people with disabilities to have proper input. The methods you use (eg, online surveys, focus groups, etc) and people's interest in the topic or issue can influence the time you need to allocate.

Think about whether payment is appropriate to support people with disabilities and/or their support people to participate. Depending on the kind of engagement, an honorarium may be appropriate, or you may consider paying for transport and accommodation costs.

Communication considerations

In order to access information and engage on the same basis as other people, people with disabilities may require particular formats. For example, blind people or those with vision impairments may need you to provide information in a Microsoft Word document (so that it may be read aloud using screen reader software), in a large font, in Braille or in an audible format.

People experience communication difficulties for a range of reasons, including learning/intellectual disabilities, autism spectrum disorder (ASD), brain injuries, cerebral palsy and motor neurone disease. People experience these difficulties in a range of ways. Some may have difficulty in understanding information, or knowing how to respond. Others may have a physical impairment related to the muscles connected to voice or speech. People with ASD experience social and communication impairments. See 'Engaging with people with autism spectrum disorder' (page 32).

Each individual's communication needs will be different; take the time to understand these needs.

On the subject of communication, see also:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19)
- Engaging with people with complex communication needs (page 28)
- Engaging with people with learning/intellectual disabilities (page 30) – this includes more information on meeting assistants.

Terminology and language

The Office for Disability Issues, the Ministry of Health and many other agencies use the 'social model of disability'[c] and related terminology.[3] The New Zealand Disability Strategy also uses such terminology.[4] Be aware that not all people with disabilities use the same terminology; some may not even identify themselves as experiencing disability. Some people do not want to be labelled as a person with a disability; others may identify with a particular group – for example the Deaf community – rather than with the group of people with disabilities as a whole. In preference to the term 'people with disabilities', some people prefer 'disabled people' or 'people with impairments'.

[3] The 'social model' is based on the notion that although a person may have an 'impairment' (meaning some difference in the body affecting sensory, physical, neurological, mental health or intellectual attributes), disability is created by society. Disability occurs when the world is designed for only one way of being. People are 'disabled' by attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.

[4] Refer to introduction of *The New Zealand Disability Strategy* for information and discussion on the use of the terms 'person with an impairment' and 'disabled people'.

It is best not to make assumptions about preferred terminology; always ask what words the person/group prefers. Respect the preference of an individual or a group in terms of self-identification.

Language has a significant influence on self-identity. Inappropriate language can result in people feeling excluded. The following guidelines may be helpful.

- The word 'disabled' is a description, not a group of people. The collective term 'disabled people' is preferable to 'the disabled'.
- Many people, including People First New Zealand Ngā Tangata Tuatahi, prefer the term 'learning disabilities' instead of 'intellectual disabilities'.
- Many people prefer the term 'psycho-social disability' or 'mental health condition' instead of 'mental illness'.
- Medical labels, such as 'paraplegic', say little about people as individuals, and tend to reinforce stereotypes of people with disabilities as 'patients' or 'sick'. Instead use 'person with/who has/who experiences paraplegia'.
- The term 'vision impaired' is generally accepted by most people. The term 'blind' may not be acceptable, particularly among those who consider they are vision impaired, are partially sighted or have low vision. The term 'legally blind' has different meanings in New Zealand (eg, within the Social Security Act 1964 and within the Blind Foundation's criteria). Therefore, although some people may use this term to describe themselves, avoid using it as a generic term.
- Wheelchairs provide their users with mobility. It is therefore inaccurate to describe people who use wheelchairs as 'confined to' their wheelchairs or 'wheelchair-bound', and can be offensive.
- Most people with disabilities are comfortable with words used to describe daily living that do not apply to them literally. People who use wheelchairs 'go for walks'. People with vision impairments may be pleased to 'see' you.
- In talking about disabilities, avoid emotive language; in particular, phrases such as 'suffers from', 'victim of' or 'afflicted with'. These are likely to evoke discomfort; they are inappropriate, incorrect and potentially offensive.
- People with disabilities prefer to be treated the same as everyone else. For this reason, terms such as 'inspirational' and 'brave' can be perceived as condescending. Just like everyone else, people with disabilities have a range of skills, expertise and life experiences.

Cultural considerations

People with disabilities are members of many groups and may identify more immediately with one of these groups. For example some people who have a hearing loss identify primarily as being Deaf. This identity is grounded within the Deaf culture with its own sign language, beliefs, values and history.

Engagement with Māori

Te Tiriti o Waitangi is the foundation document of New Zealand. It places a significant responsibility on government agencies to address the needs of Māori as the indigenous people of Aotearoa (New Zealand). The Ministry of Health implements the Treaty by applying the principles of partnership, protection and participation. This includes Māori participation in policy development and service delivery.

The New Zealand government has committed to improving outcomes for Māori with disabilities as set out in Whāia Te Ao Mārama, the Māori Disability Action Plan.[d]
www.health.govt.nz/our-work/disability-services/maori-disability-support-services/whaia-te-ao-marama-maori-disability-action-plan

Whāia Te Ao Mārama is a 'culturally anchored approach developed in collaboration with Māori disabled and whānau to support Māori disabled and their whānau through Ministry of Health-funded disability support services. The approach is from a Māori world view which also recognises that Māori disabled know what works for them'. The plan is based on the concept of tino rangatiratanga (personal sovereignty or self-determination) and taking control of one's own life.

Whāia Te Ao Mārama makes a commitment to establishing and maintaining 'Good partnerships with whānau, hapū, iwi and Māori communities'. Accordingly, it aims to improve the quality of community engagement with whānau, hapū and iwi; community leaders; and other groups. It is important to build effective relationships with Māori and to acknowledge and respect the mana and tikanga of Māori individuals and groups when participating in community engagement.

In 2010, Te Roopu Tīaki Hunga Hauā Māori Disability Network Group produced *Te Whakaaheitanga Marae – Kua wātea te huarahi, the Marae Accessibility Report*, a resource which aims to enable 'Kaumātua and whānau with health and disability impairments to actively engage at marae and remain effective contributors to their marae'.[e]
www.kapomaori.com/docs/accessable_marae_toolkit.pdf

For more information on Kāpō Māori Aotearoa, see 'A Guide to Community Engagement with People with Disabilities' (page 36). For more information about accessible marae and disability support services, see the Ministry of Health's website.
www.health.govt.nz/our-work/disability-services/maori-disability-support-services

Engagement with Pacific peoples

The New Zealand government has committed to improving outcomes for Pacific peoples with disabilities, as set out in Faiva Ora, the Pasifika Disability Action Plan.[f]

Pacific peoples in New Zealand usually identify with the Pacific Island nation(s) they or their aiga/families descend from (Samoa, Tonga, Fiji, Cook Islands, Niue, Tokelau or Tuvalu). Each of these nations has a distinct culture, language and set of values. Consider these aspects when engaging with members of the Pacific community. Some older Pacific peoples do not understand spoken or written English, and interpreters may be needed.

Open a meeting/fono with a prayer. Acknowledge individuals who have cultural status in a meeting, such as Tongan nobility, church ministers, Samoan matai (chief), respected elders and others. Pasifika people with disabilities may have aiga present to support them in a fono; in some cases, they may have their aiga speak on their behalf. Take the time to observe protocols and practices. See 'Further resources and organisations' (page 39).

Le Va's *Organisational Guidelines for Disability Support Services*[g] provides useful advice on engaging and working with Pasifika people with disabilities and their families, supported by case studies, best practice and reflective questions.
www.leva.co.nz/library/leva/organisational-guidelines-for-disability-support-services-working-with-pasifika-people-with-disabilities-and-their-families

Engagement with Asian communities

Consider the cultural and linguistic diversity of Asian communities, and whether or not you will need a translator. Although it is unlikely that a qualified tri-lingual Asian language sign language interpreter will be available, a New Zealand Sign Language agency may have alternate suggestions to assist your engagement with a particular group.

Refugees and other culturally and linguistically diverse groups

Different cultures have different understandings of, and attitudes towards, disability. For example, some cultures see disability as a 'curse' and something to be kept hidden from society. This may influence the approach you need to engage with particular communities.

In planning engagement with these communities, consider the role, and attendance, of family members, including their attendance at meetings. A communication plan specifically for culturally and linguistically diverse communities may be helpful. The Ministry of Health's *Refugee Health Care: A Handbook for Health Professionals*[h] contains useful advice on engaging with refugees, supported by case studies, best practice and reflective questions.
www.health.govt.nz/our-work/populations/refugee-health

Keep in mind certain times of year hold particular cultural and religious significance for groups (eg, Christmas, Chinese New Year, Ramadan). Try to avoid these dates when setting meetings and consultation timeframes.

On the subject of cultural considerations, see 'Government agencies and resources' (page 37) for information on:

- refugee health from the Ministry of Health
- working with ethnic communities from the Office of Ethnic Communities
- consulting diverse communities and groups (available on the Community Matters website)
  www.communitymatters.govt.nz/Good-Practice-Participate
- resources designed to strengthen communities (available on the CommunityNet Aotearoa website), including diversity toolkits and communication guides
  www.community.net.nz
- eCald, a website who are migrants and refugees from Asian, Middle Eastern, Latin American and African (MELAA) backgrounds. This website has resources on how to ensure services for culturally and linguistically diverse groups are accessible, culturally appropriate, effective and safe.
  www.ecald.com

Venue accessibility

Choose an accessible venue when you are planning for community engagement, particularly for events with an open invitation. Allow time to secure an accessible venue. Before you book a venue, visit it to ensure that it meets the needs of your intended participants. If you are unsure, consult intended participants themselves.

New Zealand Standard 4121 sets out the accessibility requirements for many public buildings.
www.standards.co.nz/assets/Publication-files/NZS4121-2001.pdf

Often an accessible venue uses the International Symbol of Access (the symbol of a person in a wheelchair) to indicate that it meets this standard and can be used by people with disabilities

(not just those people who use wheelchairs). In addition to letting people know if the venue is accessible, the symbol can also be used on directional signage to let people know where ramps, mobility parks or accessible toilets are located and on these facilities directly.[i]
www.building.govt.nz/international-symbol#aid2

See 'Venue accessibility' (page 21) for more information.

Web accessibility and online engagement

If some or all of your engagement process will be online (eg, surveys, publication of results, etc), consider accessibility. The New Zealand Web Accessibility Standard 1.1 and the Web Usability Standard 1.2 came into effect on 1 July 2013,[j] to bring government websites up to the international Web Content Accessibility Guidelines (WCAG) 2.0.[k]

All website information must be:

- perceivable – available in multiple formats, to suit users' requirements (eg, non-text content is also available in text form)
- operable – able to be navigated by all people without causing issues (including by people who navigate pages solely through the keyboard, or who can have seizures triggered by flashing content)
- understandable – easy to understand, and presented according to a website design that is simple to interact with and minimise user mistakes
- robust – compatible with other technologies (eg, assistive technology such as screen readers).

There are increasing opportunities to New Zealand Sign Language video clips on your website. For more information see the New Zealand Government Web Toolkit.
www.webtoolkit.govt.nz

Remember that many people may not have access to the internet.

Feedback

Prior to or during the engagement process, tell those participating that you will communicate your findings back to them, and follow through on this promise. If you have undertaken a survey, consider publishing the results in your next newsletter or on your website. If people are consulted with, they generally want to know that their views helped inform decision-making.

As with all community engagement, providing feedback helps build trust in your organisation. Poor communication, attitudes, or experiences can compromise future engagement.

When providing feedback to people with disabilities, ensure it is accessible.

Ensuring safety in the engagement process

While you are carrying out an engagement process, you may see or overhear something that indicates that a person with a disability may be a victim of violence, abuse, neglect or exploitation. Such maltreatment can be physical, sexual, verbal, emotional, financial or organisational.

The Crimes Amendment Act (No 3) 2011 requires the reporting of harm to vulnerable adults. The Act defines a vulnerable adult as 'a person unable, by reason of detention, age, sickness, mental impairment, or any other cause to withdraw himself or herself from the care or charge of another person'.
www.legislation.govt.nz/act/public/2011/0079/latest/DLM3650006.html

Protecting vulnerable children is everyone's responsibility. The Vulnerable Children Act 2014 and the Vulnerable Children's Action Plan support the safety and protection of all children. Whether you're a family or whānau member, friend, neighbour, teacher, or workmate, there are things you can do to protect children from abuse and neglect.
www.legislation.govt.nz/act/public/2014/0040/latest/DLM5501618.html

If you suspect a disabled person is being abused, first raise the concerns with that person: he or she has the right to make a complaint and is the only one who understands the situation. If after this discussion you remain concerned, see 'Making a complaint or raising concerns' (page 35) for more details on agencies and organisations that can help.

Ensure that your own actions or inactions, and those of others in your organisation, do not cause injury or harm to those participating.

Undertaking an accessible community engagement process

In undertaking the engagement, the following guidelines may be useful.

- Ask disabled people about the support they require. If you feel the question may be sensitive, wait for an appropriate opportunity to discuss it privately.
- Some people with disabilities will need slightly more time for an activity, or will require alternative forms of communication.
- You may need to conduct conversations at a slightly slower pace than you are used to. Allow people time to finish what they are saying.
- At the beginning of a meeting, facilitate a round of introductions; one important purpose of this is to help people who are blind or those with low vision know who is in the room.
- Make sure that only one person speaks at a time; this will make it easier for everyone including New Zealand Sign Language interpreters. Ask people to raise their hands if they wish to speak, or otherwise visually indicate the intention; this will give Deaf people an equal opportunity to contribute.
- Provide breaks. These may need to be slightly longer than you are used to. Let people know that they are welcome to leave the room to meet their own needs and that they can return when they are ready. Also consider allowing time before and after the meeting for people to talk to each other. People may use this time as an informal opportunity to discuss the issues, to clarify their thoughts and to make community connections.
- Make sure everyone knows where the toilets and the accessible toilets are, keeping in mind that some people may need spoken directions, or may require sighted guide assistance.
- Provide food if necessary. Finger food may be easiest.
  - Make sure the food is accessible to everyone, and that assistance is available if necessary. Think about the placement of food in the room; for example, keep in mind people who use a wheelchair.
  - Supply plenty of napkins and a range of cups, including mugs with handles. Some people may require straws; although some who require straws will bring their own.
- Do not interact with guide or assistance dogs while they are working – even by making eye contact. Never attempt to feed an assistance dog.
- Speak louder only if someone requests it. Respectfully repeat what has been said if someone asks you to.
- When you are communicating directly with someone, make eye contact with that person, rather than with their interpreter or assistant. Some people may come to a meeting with an assistant whose role it is to translate complex information to aid the person's understanding. The assistant's role is to enhance the person's participation and understanding, and to foster opportunities for the person to contribute to discussion.

Engagement checklist

Purpose

- What is the purpose of the engagement?
- What will be gained from the engagement process?
- What questions/issues will the engagement process cover?
- Has engagement occurred previously on these issues? If so, consider feedback from that engagement so as to avoid an unnecessary and repetitive process. Similarly, have other organisations undertaken engagement that would be useful to you?

Who are you engaging?

- Which individuals and groups should contribute to the issues and decisions?
- Who is affected by the decisions?
- Have you considered all groups (including people with disabilities, disabled people's organisations, advocacy groups, carers, whānau and associated support groups)?
  - See 'Who to engage with' (page 4) for more information on stakeholder groups and the range of impairments within the disability community.
  - See 'Cultural considerations' (page 6) for information on protocols and other customs to consider when planning the engagement.

For information on working with people with particular impairments, see:

- Engaging with people who are blind or vision impaired (page 23)
- Engaging with people with hearing loss, who are hard of hearing or who are Deaf (page 26)
- Engaging with people with complex communication needs (page 28)
- Engaging with people with learning/intellectual disabilities (page 30)
- Engaging with people with autism spectrum disorder (page 32).

How will the engagement process work?

What type of engagement will you undertake? See 'Types of engagement' (page 3).

Communication

- Is it clear who is being consulted, about what, when and for what purpose?
- Is the information as clear, simple and concise as possible?
- Will the engagement process generate interest from the media? Consider developing a communications plan, key messages and/or media statements.
- See the accessibility section below to ensure your communications are suitable.

Accessibility

- Have you considered the needs of all participants?
- Will you use images, diagrams, graphs or tables in the engagement materials?
  See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Will you use a website or other online tools in the engagement process?
  See 'Web accessibility and online engagement' (page 9).
- Will you produce written material in the engagement process?
  See 'Using written information and printed materials accessibly' (page 17).
- Will you give presentations in the engagement process?
  See 'Accessible presentations and other verbal communication' (page 19).
- If you are using a venue, is it accessible?
  See 'Venue accessibility' (page 21).

Timelines

- When will things happen or need to happen?
- What are the timeframes for decisions?
- Has sufficient preparation time been allowed?
- Consider the time it will take to book New Zealand Sign Language interpreters and accessible venues, and to make travel arrangements. See 'Early planning' (page 4) for more information.

Resources and budget

- What is your available budget?
- Will you incur costs for the following?
  - Venue hire
  - Catering (food, coffee, tea, etc)
  - Koha
  - Engagement materials (including publication, printing and distribution)
  - Stationery or equipment (rental of projectors, laptops, large paper and pens for workshops, etc)
  - Advertisement or promotion costs (including promoting your event and recruit of participants)
  - External facilitators
  - Interpreters/translators (See 'Further resources and organisations' on page 39 for information on booking New Zealand Sign Language interpreters)
  - Data analysts or data entry
  - Compensation for participants for their time (honorarium or payment) and/or travel (taxis, mileage, petrol and/or parking) or any other associated expenses.

Analysis and reporting

- What information will be collected from participants?
- What reporting is needed? (eg, to decision makers, community, stakeholders)
- Will you use images, diagrams, graphs or tables in your reports?
  See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Will you use testimonials to support the reports?
  See 'Using testimonials' (page 18).
- How will the success of the engagement be determined?
- After the process is complete, it is helpful to reflect on the engagement. Can any improvements be made next time?
- Is any support required for data analysis or data entry?

Feedback

- Will you provide feedback to participants? If so, what level and type? When will you provide feedback?
  See 'Feedback' (page 9).
- How will you provide feedback? Consider the format – including the accessibility of your communication, follow-up meetings, websites, etc. For information on ensuring feedback is accessible, see:
  - Web accessibility and online engagement (page 9)
  - Using written information and printed materials accessibly (page 17)
  - Accessible presentations and other verbal communication (page 19).
- Will participants continue to be contacted? Is ongoing discussion or communication needed?
- Ensure that participants are acknowledged and thanked for their time and expertise in the consultation process.

Review and reflection

- Will you seek feedback on the engagement process?
- If so, you could ask some of the following questions.
  - Was anyone left out who should have been included?
  - Did participants feel satisfied with the process?
  - Did people feel listened to, heard and respected?
  - Were participants satisfied with the feedback you provided on how their input was used?
  - Was the process useful for achieving the desired outcomes?
  - Were time and money used efficiently?
  - Were there any unintended consequences?
  - What could have been done differently and why?

Using images, diagrams, graphs and tables accessibly

Using images, diagrams and graphs

When using images, diagrams and graphs, include a brief written description of the image, to help those who are blind or vision impaired engage with the material.

Consider these tips.

- Some software programmes offer accessibility features for images. For example, Microsoft uses Alt Text, which allows the writer to include a title and description of the image. The screen reader reads the title of the image and allows the person to choose whether or not to hear the content of the description. Alt Text is accessed by right clicking on the picture, selecting Format Picture, then selecting Alt Text.
- When you are presenting in person, describe images verbally. Do not tell the whole room that this is for the benefit of a particular person or people who are blind or who have a vision impairment.
- Microsoft Office 2010 and Acrobat Pro (and some other programmes) have an 'Accessibility Checker' feature that will check a document for accessibility issues. Note that it may not check for all potential issues (eg, it cannot check for colour contrast).

An example of an image and description

This is a photograph of a young man in his wheelchair on the Wellington waterfront with distant people walking in the background. The man's attention is focused past the camera at whatever he is moving towards.

Using tables

Information provided in table formats is sometimes incompatible with screen reader software. Tables are also difficult when you are producing large print documents – in this case, think about other ways to present the same information without a table.

Consider these tips.

- Use a table only for presenting data, rather than for design/layout purposes.
- Do not merge cells or split cells, as screen readers are unable to interpret this information accurately.
- Keep tables simple to understand by including one piece of information per cell.
- Avoid using blank cells for formatting purposes, as this can be misleading.
- When using Microsoft Word, use the bookmark feature for tables; this enables people using screen readers to effectively navigate the document. To do this, put the cursor in the top right-hand box of the table, click 'insert', then type a bookmark name (eg, 'title1') and click 'add'. Different bookmark names are needed for each table.
- Where available use programmes' 'Accessibility Checker' features, as described in 'Using images, diagrams and graphs' above.

Using written information and printed materials accessibly

When preparing written information for use within your engagement process, consider the following guidelines.

- To meet most people's needs, use a larger-than-usual font size, and ensure the font size is never less than 12 points.
- Produce a large print version (a minimum of 16-point font, but preferably 18) for people with vision impairments or those with learning/intellectual disabilities.
- Use plain sans-serif fonts (a font without the 'serifs' or small lines attached to the bottom of letters or symbols), such as Arial, Tahoma or Calibri
- Information provided in table formats is sometimes incompatible with screen reader software packages used by blind people or those with vision impairments. Tables are also difficult when producing large print – think about ways you could present the same information without a table. See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Use paper thick enough so that text from the other side of the page will not show through.
- Use standard capital and lower case sentences, even in headings: text in all-capitals is harder to read. Use bold text for emphasis, rather than italics, which are harder to read. Reserve underscored text for hyperlinks.
- Have an identical margin width on either side of the text.
- Set margins justified to the left, with the right margin unjustified.
- Use non-reflective paper in white or pale colours, and print in a dark colour, preferably black: high-contrast text is easier to read. Avoid colour combinations with low contrast (eg, blue print on a green background).
- Include a brief description under images and diagrams. See further 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Do not place text over graphics, background patterns, blocks of colour or dark shading.
- Many PDF files (eg, scanned documents) are incompatible with screen reader software packages (which turn text into speech), and therefore people with vision impairments might find it difficult to use them. In this case, publish a Word document or HTML version (if you are publishing on the web) alongside PDFs.
- Electronic Word documents are generally accessible to people with low or no vision if they are using electronic screen readers. You may also consider providing an audible version of a document (eg, in a DVD/CD or MP3 file) or a Braille translation. Discuss participants' preferences in this regard ahead of time.
- Use everyday language and avoid jargon.
- You may need to provide an Easy Read translation of a document for people with learning/intellectual disabilities. A support person or meeting assistant may be able to assist the person to understand the documents prior to the meeting. Regardless, providing the information in advance to meeting assistants can help them be prepared to support the person during the event. See 'Engaging with people with learning/intellectual disabilities' (page 30).

Using testimonials

Testimonials are a great way of capturing the voice of your participants at the feedback stage. They enable your audience to better understand the material you have provided. They can add credibility and substantiate the results you are presenting.

Seek permission from participants before using a testimonial.

Here is an example testimonial.

Testimonial: government disability strategy development

> During the planning stage of their new disability strategy, one of the government departments got in touch with DPOs [disabled people's organisations] and asked them the best ways to plan a consultation meeting with disabled people. They wanted advice from a diverse range of disabled people on the development and implementation of the strategy, so we worked with them on planning the content and form of the meeting, and they got a disabled person to facilitate it too. It was really great – I thought the meeting was inclusive, and engaged with the right people. And the department were happy too – they said they received helpful feedback on their new strategy and had ideas about how to move forward.
>
> – Feedback from a person after attending a joint planning meeting

Accessible presentations and other verbal communication

When preparing for discussions, presentations and any other verbal communication, consider the following guidelines.

- Speak clearly, at a measured pace, with even intonation.
- Consider how many New Zealand Sign Language interpreters you require. You will need two interpreters, who can take turns, if a meeting goes longer than 1.5 hours or requires technically complicated signing. It is best to discuss this with the interpreting agency.
- It can be difficult to book New Zealand Sign Language interpreters, as there is a shortage, so do so in advance – this is particularly true of tri-lingual interpreters (eg, Te Reo–English–New Zealand Sign Language). See 'Further resources and organisations' (page 39) for information on booking New Zealand Sign Language interpreters.
- Send any written material to be used at the event to the interpreters ahead of time.
- If a sign language interpreter is not available, or you wish to engage with Deaf participants who do not use New Zealand Sign Language, consider using an electronic note-taker/live captioning to transcribe the discussion in real time; this will transfer your material on to a data show or computer screen which the participant can read.
- Ensure there is enough light on the Sign Language interpreter, so that participants can clearly see both the interpreter's hand movements as well as their lips.
- Consider using a hearing loop. Set it up in advance, and test it before the event to ensure it is functioning. Always use a microphone when a hearing loop[5] is in use, and say your name before speaking. People using hearing loops often cannot differentiate between different voices over the loop, as all voices tend to sound mechanical.
- Deafblind people use a variety of communication strategies, depending on the nature and extent of their vision and hearing impairment/loss, including modified sign language and tactile signing. Appropriate lighting is particularly important. Discuss communication options with participants, and contact Deafblind New Zealand for advice.
- If you are conducting a meeting, provide an agenda, and then try to keep to the agenda topics in the order they are listed. This will be helpful for people with learning/intellectual disabilities.
- At times, you may need to conduct conversation and presentations at a slightly slower pace, to enable all participants time to have their say.
- When you are asking for comments from the audience, have at least one person (depending on the size and configuration of the group) ready to take a microphone to participants, and ensure that Sign Language interpreters have a microphone available. Be aware that you may need more than one microphone.
- Be prepared to offer to have a minute taker. Also consider the use of a reader/writer for people who have short-term memory loss and for those with learning/intellectual disabilities, when conducting surveys or asking for feedback.
- Avoid using acronyms, and say all names in full.

[5] A hearing loop is a system that enhances sound sources such as a microphone or PA system, and is transmitted directly to hearing aids that have a telecoil attachment. With a telecoil, hearing aids do not have to use their microphone, and ambient noise is decreased. Hearing loops can be permanently set up in a venue, or portable varieties can be used.

Presentations

- When planning for a presentation, find out the specific needs of the audience in advance, so that you can prepare accessible materials.
- When using a PowerPoint or overhead presentation, keep sentences short and easy to read. Limit key ideas to four per slide.
- Read presentations in full, and describe images, diagrams, graphs and tables. Do not tell the whole room that this is for the benefit of people who are blind or have a vision impairment. See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- If possible, prior to the meeting, provide a copy of PowerPoint presentations or Word documents electronically and/or in large font to anyone with a vision impairment, and to meeting assistants. For more information on meeting assistants, see 'Engaging with people with learning/intellectual disabilities' (page 30).
- Provide a copy of your presentation to New Zealand Sign Language interpreters in advance, so that they can familiarise themselves with the content.
- Consider providing information in advance to people with learning/intellectual disabilities, to allow them time to read and understand your material.
- If you are engaging New Zealand Sign Language interpreters, discuss with them the speed at which presenters should speak, and whether they will need to pause to allow interpreters to swap over.
- If you are going to use videos in presentations, consider inserting captions or video clips of New Zealand Sign Language interpreters.
- Where possible, do not have presenters stand in front of windows or with a lot of light behind them. Lighting may obstruct some people's ability to pick up on visual cues and other non-verbal messages, such as gestures. It also restricts communication with people who depend on lip-reading.

Venue accessibility

New Zealand Standard 4121 sets out the accessibility requirements for many public buildings. It is a useful resource to help understand accessibility requirements for a venue and when looking to confirm if a venue meets these requirements.
www.standards.co.nz/assets/Publication-files/NZS4121-2001.pdf

Some key points to consider when choosing a venue are as follows.

- When planning events with an open invitation, ensure the venue is accessible for all people with disabilities.
- Often an accessible venue uses the International Symbol of Access (the symbol of a person in a wheelchair) to indicate that it meets this standard and can be used by people with disabilities (not just by people who use wheelchairs).
  www.building.govt.nz/international-symbol#aid2
- Allow time to secure an accessible venue for your engagement. Before you book a venue, visit it to ensure that it meets the needs of your intended participants. If you are unsure, consult intended participants themselves.
- Consider availability and cost of transport to and from the venue. Venues should be accessible by public transport. Provide directions and transport information. This is likely to include public transport options, the availability of mobility/accessible parking and kerb ramps, and whether there is a telephone in the venue for ringing taxis. It may be appropriate to organise accessible transport if several people require it.
- Check whether venue, the toilets and the dining areas, are wheelchair accessible.
- Ideally, door widths should be 850mm, to accommodate wheelchairs and mobility scooters, and should be easy to open. Doors should be light, preferably sliding, and with low door handles. If doors are difficult to open, consider having someone to assist people to open them.
- Plan and communicate emergency evacuation procedures. Ask people if they require assistance in an emergency, and be prepared to provide the necessary support. Note how many people indicated that they would require such assistance, and make sure you have a plan to provide it to everybody.
- Ideally, if there are stairs at the venue they should have handrails.
- Check the venue has toilets that are able to be accessed by people using wheelchairs or other mobility aids. Note toilets are not accessible if they are up or down a flight of stairs.
- Preferably, the venue should include a lawn area for guide or assistance dogs, or one should be available close enough that the handler can safely toilet their dogs.
- Ideally, the venue should have high-contrast signage on entries, exits, and toilet facilities for people with vision impairments. The signs should include pictures, as well as text, for people who find reading difficult.
- Make sure the venue has appropriate lighting for people with vision impairments and for users of New Zealand Sign Language. Sign language interpreters need to be well positioned, so that their face, hands and body can be easily seen. Reserve seats opposite the sign language interpreter(s) for Deaf people. Ensure there are no barriers, such as poles, that may obstruct the Deaf person's view of the interpreters.
- Many people who use wheelchairs prefer to sit at tables in meetings.

- Check the venue has sufficient space for people using wheelchairs and mobility scooters to enter, exit and circulate easily. Ideally, hallways should be able to accommodate two people using wheelchairs side by side.
- Check whether the venue has a hearing loop; if not, consider hiring one. Set it up in advance, and test it before the event to ensure it is functioning.
- Some people with disabilities use electronic equipment such as laptops and tablets for communication, and will need access to a multi-plug power outlet.
- Provide participants with the name of a contact person (and their phone number and email address) who will be available to answer questions or address issues on the day.
- There may be people unable to attend a venue regardless of its level of accessibility. In this case, consider using teleconferencing facilities. Bear in mind that teleconferences do not work well for people with learning/intellectual disabilities and Deaf people, and do not work at all for people who use hearing loops.
- If you are planning a standing-only event, provide some seating for those who may require it.
- Consider how to accommodate people who benefit from a quiet space free from a lot of people and noise.

Engaging with people who are blind or vision impaired

This section provides a summary of the information in this guide, and additional tips to support an effective engagement process with people who are blind or who have a vision impairment.

General

The term 'vision impaired' is generally accepted by most people. The term 'blind' may not be acceptable, particularly among those who consider they are vision impaired, are partially sighted or have low vision. The term 'legally blind' has different meanings in New Zealand (eg, within the Social Security Act 1964 and within the Blind Foundation's criteria). Therefore, although some people may use this term to describe themselves, you should avoid using it as a generic term.

As a general principle, when you are undertaking engagement with people who are blind or vision impaired, let people know what is happening. For example, let people know where their chair is, and where you have placed their tea or coffee, or what food is available.

Where possible, keep pathways clear to allow people to easily navigate throughout the room.

Accessible materials

In creating accessible materials for people who are blind or vision impaired, follow these guidelines.

- Consider providing written information in advance in large print format, as a Word document (so that it may be read aloud using screen reader software), in Braille or in audible format.
- In electronic publications, provide descriptions below images, or, alternatively, use Microsoft's feature for screen readers called Alt Text. Alt Text allows the writer to include a title and description of the image. The screen reader will read the title of the image and allow the person to choose whether or not to hear the description of its content. Alt Text is accessed by right clicking on the picture, selecting Format Picture, then selecting Alt Text. Other software programmes may offer similar features. See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Information provided in table formats is sometimes incompatible with screen reader software packages used by blind people or those with vision impairments. Again the Alt Text function can be used to give the table a title and description which can be read by the electronic screen reader.
- Tables are also difficult when producing large print – think about ways you could present the same information without a table. See 'Using images, diagrams, graphs and tables accessibly' (page 15).
- Expense claim and feedback forms need to be accessible. If possible provide these to people in advance or accept feedback in alternative forms, such as electronically after the meeting.
- Microsoft Office 2010 and Acrobat Pro (and some other programmes) have an 'Accessibility Checker' feature that will check a document for accessibility issues. Note that it cannot check for all potential issues (eg, it cannot check for colour contrast).

Presentations

In planning presentations for people who are blind or vision impaired, follow these guidelines.

- At the beginning of a meeting, facilitate a round of introductions. If it is not possible to introduce everyone, ensure you note key people and presenters. One important purpose of this is to help people who are blind or those with low vision know who is in the room.
- Read presentations in full, and describe images, diagrams, graphs and tables. Do not tell the whole room that this is for the benefit of people who are blind or have a vision impairment. See further 'Using images, diagrams, graphs and tables accessibly' (page 15).

Inclusive meeting practices for blind participants

Blind Citizens NZ is a disabled people's organisation that provides advocacy for blind and vision impaired people. The material that appears here was originally produced by the Association of Blind Citizens NZ, and is reproduced with their kind permission.
www.abcnz.org.nz

The following guidelines are designed to assist organisations to make their meeting practices and/or committee processes inclusive of the needs of blind and vision impaired people.

1. **Meeting agendas and minutes:** Blind representatives must be able to specify the format in which they choose to receive these documents (ie, large print, Braille, audio cassette or an electronic format). Their first choice should be honoured regardless of their ability to access the material by other means. Some forward planning may be needed to ensure that blind participants receive their material at approximately the same time as sighted participants receive theirs.

2. **Venue:** As a common courtesy, it is often helpful for a blind person to receive information about and/or a 'conducted tour' of the facilities being used. If the blind participant uses a guide dog as a mobility aid, the dog's toileting requirements must also be considered when choosing a venue. If the venue has no grass or garden area, or such areas are not in easy reach of the venue, then some other party may need to be on hand to accompany the blind dog-handler to find a suitable area.

3. **Roll call:** Every meeting should begin with a 'roll call' in which participants are asked to clearly identify themselves. This also indicates to the blind person where everyone is seated. If someone arrives late or departs during the meeting, this information should also be conveyed at the earliest possible opportunity. These steps are critical, since even if all meeting participants are known to one another, a blind person can often be unaware of who is in the room. The roll call should be repeated in future sessions if a change has occurred in those present or seating arrangements have altered.

4. **Establishing the process for seeking the floor:** The process for gaining the right to speak at a meeting should be made clear by the chairperson at the beginning of discussion. Unless clearly indicated, a blind person may be unclear as to whether hands are being raised to catch the attention of the chairperson, whether people simply speak up, or some other method is being used. Whatever the method, visual techniques such as catching the chairperson's eye to get their attention should be avoided.

5. **Use of printed or visual material in meetings:** Any material distributed in print during a meeting must also be available in the blind participant's preferred format. As the reading speed of some participants may not permit them to read the information as quickly as a standard print user, and certain computer technologies may not be portable, such material should be circulated in advance if at all possible. The use of overheads and

black/whiteboards should be accompanied with copies of the material in the blind person's preferred format in advance of the meeting. At the very least, a verbal description of the content of each overhead or white/blackboard currently displayed should be standard practice.

6. **Taking notes:** When a blind participant wishes to take notes of a meeting, and an audio recording is the only option available to them, they should be allowed to do so but must inform the meeting that a recording is being made. It must be clear that the audio recording is for the blind participant's exclusive use unless otherwise agreed, that recording will take place only in those parts of the meeting when taking notes is permitted and that any misuse of the recording may constitute a breach of confidentiality.

Guidelines for interacting with guide dogs

The Blind Foundation is an organisation that provides support to people who are blind or have low vision. The material that appears here was originally produced by the Blind Foundation, and is reproduced with their kind permission.
www.blindfoundation.org.nz

Guide dogs are friendly by nature; your help is required to maintain their good manners.

Please DO NOT interact with a guide dog unless the dog's handler gives permission.

When settling a guide dog into a new environment, no interaction is advisable for the first couple of weeks. Once the dog has settled in, the handler may start to allow limited interaction, dependent on the dog's behaviour.

No interaction includes:

- avoid eye contact with the dog
- don't talk to the dog
- don't feed the dog.

If the dog attempts to interact with you, please ignore it, move away if necessary, or turn your back on the dog.

These guidelines are for the safety of the guide dog handler. If a guide dog gets distracted or excited by people then it can be a safety risk and may have to be withdrawn from guiding work.

If the handler does give permission for you to interact with the guide dog, please ensure you maintain a calm voice and gentle handling. The aim is not to excite the dog too much in a workplace or public place. Guide dogs get plenty of time to play and have fun when off duty. But when in a workplace we must ensure appropriate behaviour is maintained.

If you have any questions please feel free to contact Blind Foundation Guide Dogs (09 269 0400) or talk to the guide dog handler directly.

For more information also see:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19).

Engaging with people with hearing loss, who are hard of hearing or who are Deaf

This section provides a summary of the information in this guide, and gives additional tips to support an effective engagement process with people with a hearing loss, who are hard of hearing or who are Deaf.

General

In general, follow these guidelines.

- Make sure that only one person speaks at a time; this will make it easier for everyone, including New Zealand Sign Language interpreters. Ask people to raise their hands if they wish to speak, or otherwise visually indicate the intention; this will give Deaf people an equal opportunity to contribute.
- Some people who have a hearing loss identify as being Deaf. This identity is grounded within the Deaf culture with its own language, values and history.
- Many people with a hearing loss do not use sign language interpreters. They may however use a personal assistive listening system. This can either be in the form of a personal microphone which amplifies sound, or it may use FM radio frequencies to send sound from the source e.g. a presenter using a microphone, directly to the listener. The system can be connected to a hearing aid, a cochlear implant, or received through a headset.
- Make sure that people with hearing impairments have the option of sitting near the front of the room as many people with hearing loss need to be able to see body language and lip movements in order to understand what is being said.
- If you are using breakout groups, be prepared to offer a separate room for people with hearing impairments, as the background noise of multiple groups working in the same room can make it very difficult for people using hearing aids or other assistive listening devices to hear what is being said in their own group.
- Always use a microphone when a hearing loop is in use, and request speakers to say their names before speaking. People using hearing loops often cannot differentiate between different voices, as all tend to sound mechanical.

New Zealand Sign Language interpreters

If you are considering hiring a New Zealand Sign Language interpreter, follow these guidelines.

- Preferably, book New Zealand Sign Language interpreters at least four weeks in advance, as there is a shortage of trained interpreters. This is particularly true of tri-lingual interpreters (eg, Te Reo–English–New Zealand Sign Language).
- Although it is unlikely that a qualified tri-lingual sign language interpreter will be available, a New Zealand Sign Language agency may have alternate suggestions that could assist the engagement with a particular non-English speaking group; discuss your needs with them.
- Consider how many interpreters you require. You will need at least two interpreters, who can take turns, if a meeting goes longer than 1.5 hours or requires technically complicated signing. It is best to discuss this with the interpreting agency.
- If you are engaging interpreters, discuss with them the speed at which presenters should speak, and whether they will need a pause to allow interpreters to swap over.
- Send any written material you will use at the event to the interpreters ahead of time, to allow them to familiarise themselves with the content.

- Make sure the venue has appropriate lighting for hard of hearing people who rely on lip-reading and for users of sign language. Sign language interpreters need to be well lit, so that their face, hands and body can be easily seen. Reserve seats opposite interpreters for Deaf people. Ensure there are no barriers, such as poles, that may obstruct people's view of the interpreters.
- When you are asking for comments from the audience, have at least one person (depending on the size and configuration of the group) ready to take a microphone to participants, and ensure that sign language interpreters have a microphone available. Be aware that you may need more than one microphone.
- If a New Zealand Sign Language interpreter is not available, or you wish to engage with Deaf participants who do not use New Zealand Sign Language, consider using an electronic note-taker/live captioning to transcribe the discussion in real time; this will transfer your material on to a data show or computer screen which the participant can read.
- If you are going to use videos in presentations, consider inserting captions or video clips of New Zealand Sign Language interpreters.
- See 'Further resources and organisations' (page 39) for information on booking New Zealand Sign Language interpreters.
- For more information about working with interpreters, see *Effective communication with deaf people: A guide to working with New Zealand Sign Language interpreters*, produced by the Office for Disability Issues.
  www.odi.govt.nz/resources/guides-and-toolkits/working-with-nzsl-interpreters/index.html

Working with hearing dogs

This information is adapted from the information produced by the Blind Foundation's guidelines for interacting with guide dogs.

- Hearing dogs need to concentrate on doing their job. Do not interact with them unless the dog's handler gives permission – avoid eye contact with the dog, do not talk to or pat the dog and do not feed him/her.
- Ideally, the venue should include a lawn area for hearing or assistance dogs, or one should be available close enough that the handler can safely toilet their dogs.
- For more information contact Hearing Dogs New Zealand.
  www.hearingdogs.org.nz

For more information, see also:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19).

Engaging with people with complex communication needs

This section provides a summary of the information in this guide, and gives additional tips to support an effective engagement process with people with complex communication needs.

General

In general, follow these guidelines.

- People experience communication difficulties for a range of reasons, including learning/intellectual disabilities, autism spectrum disorder (ASD), brain injuries, cerebral palsy and motor neurone disease.
- People experience communication difficulties differently. Some may have difficulty in understanding information, or knowing how to respond. Others may have a physical impairment related to the muscles connected to voice or speech. People with ASD experience social and communication impairments. See 'Engaging with people with autism spectrum disorder' (page 32).
- Take the time to understand these needs – start by asking them how they prefer to communicate.
- Speak to the person, not their support person.[l]
- Start by assuming a person can understand you, and then adjust your approach according to their response. For example, some people find it difficult to respond to open-ended questions. Try these first, and if you need to, move to yes or no or closed option questions. If using closed questions, consider including a 'something else' option, so the person is not limited to the options you have provided. For example, ask, 'would you like a coffee, tea or something else?'
- Some people may prefer whānau members or carers to express their preferences on their behalf, as they trust them to understand and communicate their individual needs and communication methods. Ask permission from the person to gather this information.
- People with complex communication needs may make use of various methods of communication, including communication aids or devices (eg, computer technologies/software, picture-based communication boards, whiteboards or speaking devices), gestures (eg, eye gaze or head/hand movements), facial expressions or visual aids (eg, pictures, diagrams, signs or objects).

Communication aids/technologies

In terms of communication aids/technologies used by people with complex needs, consider the following.

- The tips in the above section also apply when you are having a conversation with someone who uses a communication aid. It is important to respect a person's individual methods of communication.
- Allow the conversation to take place at a slightly slower pace. Allow the person time to respond to questions, and take the time to listen and understand their response.[m]
- Be patient, and allow the person sufficient time to use an aid to finish what they are saying. Never attempt to finish a sentence for the person. If it is not clear what the person has said, politely ask them to repeat themselves.

For more information, see also:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19)
- Engaging with people with learning/intellectual disabilities (page 30).

Engaging with people with learning/intellectual disabilities

This section provides a summary of the information in this guide, and additional tips to support an effective engagement process with people with learning/intellectual disabilities.

Meeting protocols

In planning a meeting involving participants who have learning/intellectual disabilities, follow these guidelines.

- When considering a suitable time, keep in mind that some people with learning/intellectual disabilities prefer mornings, as they are more rested at this time of the day, and find it easier to concentrate.
- Provide an agenda and then keep to the agenda topics in the order they are listed.
- Be prepared to offer to have a minute taker. Also consider the use of a reader/writer when conducting surveys or asking for feedback.
- Avoid teleconferences. This will make it easier to ensure information is provided at the right pace and is understood.
- Make sure that only one person speaks at a time.

Verbal information

In providing verbal information, follow these guidelines.

- Keep information simple, and avoid jargon. Also avoid using acronyms, and say all names in full.
- Where possible, accompany information with relevant pictures or visual aids.
- Speak at a pace that allows people time to consider your questions and how they might respond. Pause where you need to. Ask one question at a time.
- Provide a copy of your presentation to participants in advance, to allow them time to familiarise themselves with it.
- Let people know they are entitled to their opinion.
- Allow time for people to have their say, and listen to them carefully.
- Check your understanding of what people have said. Ask questions to clarify your understanding, or get people to repeat what they have said so that you are sure you understand. Do not pretend to understand.
- Check that people have understood what has been said. If someone does not understand, consider using an alternative approach; for example, by moving from open-ended to closed questions (yes or no, etc), repeating or rephrasing information, or using pictures or visual aids.
- To check that someone has understood, consider asking them to put the information into their own words. This will eliminate the risk of people saying ‘yes’ because that is what they believe they should say, and allow them to avoid having to answer ‘no’ to the question ‘Do you understand?’.
- Some people may prefer that whānau members or carers express their preferences on their behalf, as they trust them to understand and communicate their individual needs. Ask permission from the person to gather this information.

Meeting assistants

In relation to meeting assistants for people with a learning/intellectual disability, follow these guidelines.

- The role of meeting assistant can be helpful for a person with a learning/intellectual disability when meetings run at a fast pace or use complex or conceptual information that can be a barrier to that person's equal participation. Meeting assistants guide people to build trusting relationships within the group/meeting.
- An assistant's role depends on the individual's support needs. The person and their assistant agree on a plan prior to the meeting. The focus is always on enhancing the person's participation and understanding and providing support for equal opportunities for the person to contribute to discussions and decisions.
- A meeting assistant often:
  - helps to translate complex information so as to aid the person's understanding
  - helps with the complex social skills required to engage within a large group at a meeting, or during break times
  - discusses items or completes tasks with the person after the meeting.
- Assistants often quietly talk to the person they are assisting during the meeting. Often at this time the assistants are helping to foster the person's better understanding of conceptual or complex information.
- Allow time for people to have their say in whatever way suits them.
- People First New Zealand Ngā Tangata Tuatahi, a disabled people's organisation directed by people with learning/intellectual disabilities, provides trained meeting assistants. See 'Disabled people's organisations and resources' (page 36) for more information on People First.
  www.peoplefirst.org.nz

Written information and Easy Read documents

Easy Read is a way of producing information in everyday language that is consistent, acronym- and jargon-free and includes images to assist meaning. Easy Read documents have a large amount of clear/white space. Easy Read can also be used to support people with low literacy levels, or who have English as a second language. When putting together written information including Easy Read documents for people with a learning/intellectual disability, follow these guidelines.

- Contact People First about their Easy Read translation service, 'Make it easy'. Make contact early, as translations take a minimum of three weeks.
- Consider producing a large print version (at minimum a 16-point font, but preferably 18) of written information. If you are not producing an Easy Read document, consider the clarity of your documents anyway, to ensure the information will be understood.

For more information, see also:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19)
- Engaging with people with complex communication needs (page 28).

Engaging with people with autism spectrum disorder

This section provides a summary of the information found within this guide, and gives additional tips to support an effective engagement process with people with autism spectrum disorder (ASD).

What is autism spectrum disorder?

Autism spectrum disorder refers to a range of conditions that affect communication, social interaction and behaviour. Each person with ASD tends to experience some difficulties with the following areas:

- understanding and using verbal (language) and non-verbal (facial expression, gesture and body language) communication
- understanding social behaviour, which affects their ability to interact with other people
- thinking and behaving flexibly, which may show in restricted, obsessional or repetitive activities.[n]

Some people may experience sensory issues, such as a hypersensitivity to sound.[o]

Verbal information and communication

When you are planning to engage with people with ASD, follow these guidelines.

- Some people may prefer whānau members or carers to express their preferences on their behalf, as they trust them to understand and communicate their individual needs. Ask permission from the person to gather this information.
- Be aware that some people with ASD may:
  - operate according to a particular set of routines or rules. Being aware of these will help you to avoid inadvertently doing or saying something that triggers difficulties[p]
  - have difficulty engaging in a face-to-face interview. Some people may prefer to sit side by side, to minimise eye contact[q]
  - have difficulty in understanding and following verbal information. It might be helpful to send questions in advance or have a printed copy for the person to refer to
  - have difficulty organising and planning, and recognising what information is important
  - have difficulty thinking flexibly and problem solving. For example, the person may return to one or a few specific topics, or may not know how to resolve a particular problem
  - be anxious about making mistakes, which may mean they say nothing or too much. They may overanalyse information, or second guess it.
- Use simple, clear and concise words. Be mindful of using words that have multiple meanings, sarcasm, irony and figures of speech, as some people with ASD may take words quite literally.[r, s]
- Allow the conversation to take place at a slightly slower pace. Allow the person time to respond to questions, and take time to listen and understand their response.[t]
- Be prepared to communicate in ways other than verbally, for example through writing or using pictures or visual aids (eg, visual timetables, photographs/pictures, social stories, objects and symbols).[u]

- Check that you have understood what the person has communicated. Ask questions to clarify your understanding, or get people to repeat what they have said so that you are sure you understand. Do not pretend to understand.
- Try to choose a venue that has minimal distractions. Avoid rooms with high background noise, such as traffic, and rooms with harsh lighting/bright sunlight. Keep distractions to a minimum.[v, w]

For more information, see also:

- Using written information and printed materials accessibly (page 17)
- Accessible presentations and other verbal communication (page 19).

Legal rights and obligations

Disability is one of the prohibited grounds of discrimination under the Human Rights Act 1993. The New Zealand Human Rights Commission has stated that '[the] right to participate in political and public life [is] integral to a functioning democracy … through involvement in political activity, law and policy reform'.[x] The Commission has emphasised that disabled people's participation in political process is an integral part of the full realisation of their human rights.[y] It has also noted the need to provide 'information intended for the general public to disabled people in accessible formats and technologies appropriate to different kinds of disabilities'.[z]

New Zealand was one of the first signatories to the United Nations Convention on the Rights of Persons with Disabilities 2008. The Convention aims 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'.

The Convention does not set out any new human rights; it clarifies the government's role to ensure that people with disabilities enjoy human rights on an equal basis with others. The Convention's 50 articles clarify the rights of people with disabilities covering all aspects of economic, social, political, legal and cultural life.[aa] One of the core tenets of the Convention is that people with disabilities 'should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them'.[bb]

The Convention addresses the protection and promotion of the human rights of people with disabilities in all policies and programmes (Article 4.1c). It specifies the need for government agencies to closely consult with and actively involve people, including children, with disabilities in the development and implementation of legislation and policies, through their representative organisations (Article 4.3).

The Treaty of Waitangi (Te Tiriti o Waitangi) is both the founding document of Aotearoa New Zealand and includes the concept of partnership. The principles of the Treaty have been translated as 'active protection, the […] right to self-regulation, the right of redress for past breaches, and the duty to consult'. The duty to consult and the right to self-regulation underpin this guide.

Making a complaint or raising concerns

This section contains information on how to make a complaint or raise concerns about potential violence, abuse, neglect and exploitation. For further information see the section on 'Ensuring safety in the engagement process' (page 9) in this guide.

If you suspect a person is being abused, it is respectful to first raise the concerns with the person first and involve them in the decision-making process.

If your concerns relate to disability support services funded by the Ministry of Health, contact the manager of the service. The service will have a complaints process which they are required to make known.

Alternatively, you can contact one of the following organisations if:

- you or the person feel unable to make a complaint to the organisation that provides the services
- the complaint is not about a service provider
- you want to take your complaint further.

Disability Support Services within the Ministry of Health: responsible for funding supports and services for people with disabilities. You have the right to make a complaint about the disability support services you, your whānau, people you are working with, or others are receiving.

The Health and Disability Commissioner: responsible for ensuring the rights of people receiving health and disability services are upheld. This includes making sure complaints about health or disability service providers are taken care of fairly and efficiently.

If you need support and information to raise your concerns or make a complaint, you can contact the Health and Disability Advocacy Service.

The Human Rights Commission: promotes and protects the human rights of all people in Aotearoa New Zealand. The Commission can help if you are not sure of your rights or want to make a complaint about discrimination.

The Commission's website publishes a plain language resource about making complaints: *Your human rights and making complaints: A guide for disabled people and their families*.
www.hrc.co.nz/enquiries-and-complaints/what-you-can-complain-about/disability

The Police: responsible for protecting public safety and maintaining law and order. If you feel that your complaint involves a criminal act, you should contact the police.

Child, Youth and Family: Ministry of Social Development. Contact Child, Youth and Family if you have concerns about the safety of child or young person and need some advice.

The Office of the Ombudsman: an independent resource to help the community deal with government agencies, with a focus on fairness and impartiality. It will undertake investigations where necessary.

See 'Government agencies and resources' (page 37) for contact details for all of these agencies and organisations.

Disabled people's organisations and resources

Disabled people's organisations are organisations run by and for people with disabilities. The table below lists New Zealand disabled people's organisations and some of the resources they produce.

Organisation	Resources
Association of Blind Citizens of New Zealand An advocacy organisation for blind and vision impaired people. www.abcnz.org.nz	• Inclusive meeting practices for blind or vision impaired participants www.hdc.org.nz/publications/other-publications-from-hdc/disability-resources/inclusive-meeting-practices-for-blind--or-vision-impaired-participants-(association-of-blind-citizens-of-nz)
Balance NZ An organisation of people with mental health issues and mood disorders that provides support and advocacy. www.balance.org.nz	• *Living Well Booklet* (compiled for the information of those who suffer from bipolar disorder (manic depression) and their families and friends www.balance.org.nz/index.php/information/bipolar-disorder/living-well-booklet • Information on bipolar disorder for families www.balance.org.nz/index.php/information/bipolar-disorder/family-booklet • Information on Seasonal Affective Disorder www.balance.org.nz/index.php/information/sad
Deaf Aotearoa New Zealand An organisation that provides information and resources on life for Deaf New Zealanders, Deaf culture and New Zealand Sign Language. Deaf Aotearoa also provides New Zealand Sign Language classes and Deaf awareness training. www.deaf.org.nz	• *Tips for Communicating with Deaf People* www.deaf.org.nz/resources/communication-tips • Deaf awareness training www.deaf.org.nz/services/awareness • New Zealand Sign Language classes www.deaf.org.nz/services/sign-language
Deafblind (NZ) Inc An organisation that provides advocacy and support for Deafblind people in New Zealand. www.deafblind.org.nz	• Information about deafblindness www.deafblind.org.nz/learn
Disabled Persons Assembly NZ A national pan-disability organisation. Its website publishes various resources, including on the rights of disabled people. www.dpa.org.nz	• Disabled Persons Assembly Resources and links to sector resources www.dpa.org.nz/resources
Kāpō Māori Aotearoa New Zealand (Ngāti Kāpō) An organisation that offers kaupapa Māori-based disability support services with a focus on kāpo Māori and their whānau. www.kapomaori.com	• *Te Whakaaheitanga Marae – Kua wātea te* haurahi: a resource which aims to enable 'Kaumātua and whānau with health and disability impairments to actively engage at marae and remain effective contributors to their marae' www.kapomaori.com/docs/accessable_marae_toolkit.pdf
People First New Zealand Ngā Tangata Tuatahi A national self-advocacy organisation that is led and directed by people with learning disabilities. The organisation provides an Easy Read translation service, which involves translating a document into an accessible format. It also provides trained meeting assistants. www.peoplefirst.org.nz	• 'Guide to writing Easy Read Information' - Easy Read Version www.peoplefirst.org.nz/news-and-resources/easy-read-resources - Online version at Office for Disability Issues website www.odi.govt.nz/resources/guides-and-toolkits/disability-perspective/resources/plain-language.html#Aboutthisguide1

Government agencies and resources

The table below lists some government agencies relevant to people with disabilities and some of the resources they produce.

Organisation	Resources
Ministry of Health Disability Support Services (DSS) within the Ministry of Health is responsible for funding support and services for people with disabilities. It also leads the development and implementation of strategic plans that aim to ensure people with disabilities and their families are supported to live the lives they choose. www.health.govt.nz/our-work/disability-services	• Disability Support Services Strategic Plan 2014 to 2018 www.health.govt.nz/publication/disability-support-services-strategic-plan-2014-2018 • 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 • Māori disability support services (including information on accessible marae) www.health.govt.nz/our-work/disability-services/maori-disability-support-services • Faiva Ora – National Pasifika Disability Plan www.health.govt.nz/our-work/disability-services/disability-projects-and-programmes/faiva-ora-national-pasifika-disability-plan • Refugee health www.health.govt.nz/our-work/populations/refugee-health • Information on making a complaint www.health.govt.nz/your-health/services-and-support/disability-services/more-information-disability-support/contact-disability-support-services
Accident Compensation Corporation The Accident Compensation Corporation (ACC) provides funding and support for individuals who have an impairment as a result of an accident. www.acc.co.nz	• Serious injury and disability – help for people affected by injury-related disabilities https://disability.acc.co.nz • A range of resources are available on the ACC website on specific injuries, disabilities, rights and advocacy as well as information for parents, carers https://disability.acc.co.nz/useful-resources
Department of Internal Affairs The Department of Internal Affairs (DIA) website hosts the Kia Tūtahi Relationship Accord. The DIA's Community Matters website provides advice for involving the community in decision-making, targeted at government officials but generally applicable. The DIA is also responsible for the New Zealand Government Web Toolkit. www.dia.govt.nz	• Kia Tūtahi Relationship Accord www.dia.govt.nz/kiatutahi • Good Practice Participate on Community Matters www.communitymatters.govt.nz/good-practice-participate • CommunityNet Aotearoa is 'an online hub of resources designed to strengthen communities'. It enables organisations to post and share resources on a variety of topics, including leadership, communication and evaluation. Materials include Diversity Toolkits, a how-to guide on communications and project management templates www.community.net.nz • The New Zealand Government Web Toolkit, 'provides standards, guidance, tips and strategic advice on effectively using the online channel'. It outlines the Web Accessibility Standard www.webtoolkit.govt.nz

Organisation	Resources
Health and Disability Commissioner The Health and Disability Commissioner (HDC) aims to 'ensure that the rights of consumers are upheld. This includes making sure complaints about health or disability services providers are taken care of fairly and efficiently'. The HDC also provides the support of free independent advocates to assist with concerns or complaints about a health or disability service. www.hdc.org.nz	• Disability Resources www.hdc.org.nz/about-us/disability • Health and Disability Advocacy advocacy.hdc.org.nz • *Making communication easy – Useful tips to make it easy to communicate effectively with people with impairments* www.hdc.org.nz/publications/other-publications-from-hdc/disability-resources/making-communication-easy---useful-tips-to-make-it-easy-to-communicate-effectively-with-people-with-impairments
Human Rights Commission The Human Rights Commission (HRC) promotes and protects the human rights of all people in Aotearoa New Zealand. It provides information about discrimination and offers a free and confidential service for people with human rights enquiries or complaints of unlawful discrimination. www.hrc.co.nz	• *Your human rights and making complaints: A guide for disabled people and their families* www.hrc.co.nz/enquiries-and-complaints/what-you-can-complain-about/disability • How to make a complaint www.hrc.co.nz/enquiries-and-complaints/how-make-complaint
Ministry of Education Special education supports children and students to access the curriculum by providing extra help, adapted programmes or learning environments, and specialised equipment or materials. www.education.govt.nz	• Students with special education needs www.education.govt.nz/school/student-support/special-education
Ministry of Pacific Island Affairs The Ministry of Pacific Island Affairs liaises and communicates with Pasifika communities about government policies, processes and services. It aims to foster greater engagement with, and participation by, Pasifika peoples in government decision-making. www.mpia.govt.nz	• Pacific Analysis Framework, with Pacific Consultation Guidelines (written 'to provide assistance to government agencies in the development of policies and programmes aimed at Pacific people') www.mpia.govt.nz/engaging-with-pacific-communities
Ministry of Social Development The Ministry of Social Development (MSD) runs a range of services to support people with disabilities through: • Community Investment www.familyservices.govt.nz • Community Link www.msd.govt.nz/what-we-can-do/community/community-link • Work and Income www.workandincome.govt.nz Child, Youth and Family is a service of the Ministry of Social Development. The service employs social workers who are able to help if you have concerns about the safety of a child or young person. www.cyf.govt.nz	• Think Differently is a social change campaign to encourage and support a fundamental shift in attitudes and behaviour towards disabled people. It's about maximising opportunities and focusing on what people can do rather than what they can't'. The campaign is led in partnership with the Office for Disability Issues. www.thinkdifferently.org.nz Think Differently produces a Social Change Toolkit with a range of useful resources, templates and tips. socialchangetoolkit.org.nz • Child, Youth and Family: *'If you are worried'* www.cyf.govt.nz/keeping-kids-safe/if-you-are-worried
New Zealand Police The Police are responsible for protecting public safety and maintaining law and order. www.police.govt.nz	• How to report a crime www.police.govt.nz/contact-us/how-report-crime • 'I suspect a child is being abused. What should I do?' www.police.govt.nz/faq/i-suspect-a-child-is-being-abused-what-should-i-do

Organisation	Resources
Office for Disability Issues The Office for Disability Issues (ODI) is a strategic and whole-of-government focused policy group, located within the MSD. It promotes and monitors the implementation of the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities. It also works in partnership with the MSD to lead the Think Differently campaign (see the MSD resource list above). The ODI's website publishes helpful access guides and toolkits to inclusive practice. www.odi.govt.nz	• New Zealand Disability Strategy www.odi.govt.nz/nzds • Key points on running an accessible meeting www.odi.govt.nz/resources/guides-and-toolkits/disability-perspective/resources/running-accessible-meeting.html • Effective communication with deaf people: A guide to working with New Zealand Sign Language interpreters www.odi.govt.nz/resources/guides-and-toolkits/working-with-nzsl-interpreters/index.html • The United Nations Convention on the Rights of Persons with Disabilities www.un.org/disabilities/convention/conventionfull.shtml
Office of Ethnic Communities (previously the Office of Ethnic Affairs) The Office of Ethnic Communities provides advice and information to support people working with ethnic communities. ethniccommunities.govt.nz	• Language Line (a telephone interpreting service available in 44 languages) www.ethniccommunities.govt.nz/story/how-language-line-works
Office of the Ombudsman The Office of the Ombudsman is an independent resource to help the community deal with government agencies, with a focus on fairness and impartiality. It undertakes investigations where necessary. www.ombudsman.parliament.nz	• Make a complaint www.ombudsman.parliament.nz/make-a-complaint • Information about the Ombudsman's role under the United Nations Convention on the Rights of Persons with Disabilities www.ombudsman.parliament.nz/what-we-do/protecting-your-rights/disabilities-convention

Further resources and organisations

The table below lists further disability sector organisations and service providers and some of the resources they produce.

Organisation	Resources
Altogether Autism Altogether Autism is a nationwide information and advisory service for people living on the autism spectrum, their families/whānau and the professionals who work with them. www.altogetherautism.org.nz Altogether Autism is a service funded by the Ministry of Health. It is provided in partnership by Parent to Parent (see below) and Life Unlimited (a charitable trust whose mission is 'to enhance individual wellbeing by enabling people to live the life they choose'). lifeunlimited.net.nz	• Altogether Autism Journal (a publication for professionals, families and people on the Autism spectrum) www.altogetherautism.org.nz/subscribe-journal • Questions People Ask (answers to commonly asked questions) www.altogetherautism.org.nz/question-people-ask • Resources www.altogetherautism.org.nz/information/resources
Autism NZ Autism NZ provides support, training, advocacy, resources and information on autism spectrum disorder (ASD) to those with these conditions, their family/whānau, caregivers and professionals. www.autismnz.org.nz	• About Autism www.autismnz.org.nz/about_autism • Resources www.autismnz.org.nz/links
Blind Foundation The Blind Foundation provides its members with adaptive skills, technology, resources and support with moving around (including through the use of guide dogs) and accessing information. It also provides services to the wider community, including: web accessibility consultation, accessible format production, built environment advice and awareness training. www.blindfoundation.org.nz	• Information for businesses www.blindfoundation.org.nz/learn/information-for-businesses • Information on guide dogs – contact Blind Foundation Guide Dogs (09 269 0400)
Brain Injury Association The Brain Injury Association provides support, education and information services throughout New Zealand to people living with brain injuries. www.brain-injury.org.nz	• Information on brain injuries www.brain-injury.org.nz/html/brain_injury.html • Brain injury resources www.brain-injury.org.nz/html/resources.html
Carers New Zealand Carers New Zealand is the national body supporting family, whānau and aiga carers. It provides information, advice, learning and support for families with health and disability needs. www.carers.net.nz	• Resources for Carers www.carers.net.nz/information
CCS Disability Action CCS Action's purpose is to strengthen communities and provide information, advocacy and support so people with disabilities are included in the life of their family and in their community. It also has 16 branches nationally that provide frontline support and services, create local awareness and education around disability issues. www.ccsdisabilityaction.org.nz	• Information about mobility parking spaces across New Zealand mobilityparking.org.nz/index.php/mobility-parking-near-you • Disability awareness and education www.ccsdisabilityaction.org.nz/regions/northern-region/working-with-the-community/disability-awareness-and-education

Organisation	Resources
Cerebral Palsy Society The Cerebral Palsy Society of New Zealand's purpose is to enhance the lives and wellbeing of people with cerebral palsy (CP). It provides programmes designed to enhance the independence and quality of life of people living with CP and their families, and grants to its members for this purpose. www.cerebralpalsy.org.nz	• About Cerebral Palsy www.cerebralpalsy.org.nz/Category?Action=View&Category_id=88
eCALD eCALD is a website developed and managed by Waitemata District Health Board Asian Health Support Services. CALD refers to culturally and linguistically diverse groups who are migrants and refugees from Asian, Middle Eastern, Latin American and African (MELAA) backgrounds. It provides resources for the health workforce with the aim of ensuring services are accessible, culturally appropriate, effective and safe for culturally and linguistically diverse communities. www.ecald.com	• Cross-cultural Resources and translated information www.ecald.com/Resources
Hearing Association The Hearing Association is a volunteer-based organisation that helps people with any type of hearing problem. Local branches offer one-to-one support for members and non-members alike, socially and in the workplace. www.hearing.org.nz	• Hearing information cards www.hearing.org.nz/info_cards.php
Hearing Dogs Hearing Dogs supports and trains hearing dogs for people with hearing problems. www.hearingdogs.org.nz	• Information on 'What is a hearing dog?' hearingdogs.org.nz/What-is-a-Hearing-Dog/0,2710,11032,00.html
IHC New Zealand IHC New Zealand is a membership-based organisation that supports people with intellectual disabilities to live satisfying lives in the community. IHC provides a range of services, including advocacy and a library related to intellectual disability. www.ihc.org.nz	• Information and resources on intellectual disability www.ihc.org.nz/resources
iSign iSign is a nationwide booking organisation providing New Zealand Sign Language interpreters. www.isign.co.nz	• Information on 'What is an interpreter?' www.isign.co.nz/interpreters/what-is-an-interpreter • Interpreter booking process www.isign.co.nz/services/interpreter-booking-process
Te Pou o Te Whakaaro Nui Te Pou o Te Whakaaro Nui is a national centre of evidence-based workforce development for the mental health, addiction and disability sectors. www.tepou.co.nz	• Let's get real: Disability (a workforce quality initiative created to help the disability workforce meet the needs of disabled people, whānau and communities) www.tepou.co.nz/disability-workforce/lets-get-real-disability/101
Mental Health Foundation The Mental Health Foundation provides a range of services and campaigns addressing all aspects of mental health and wellbeing. It provides free information and training, and advocates for policies and services that support people with experience of mental illness and their families/whānau and friends. www.mentalhealth.org.nz	• Mental Health Awareness Week www.mentalhealth.org.nz/home/our-work/category/16/mental-health-awareness-week • Like Minds Like Mine www.mentalhealth.org.nz/home/our-work/category/15/like-minds-like-mine

Organisation	Resources
Multiple Sclerosis Society of New Zealand Inc The Multiple Sclerosis (MS) Society of New Zealand is a non-profit organisation that provides on-going support, education and advocacy for people with MS and their support networks. It also aims to educate the general public, employers and health professionals about MS and actively funds key research into the condition. https://www.msnz.org.nz	• Information on MS www.msnz.org.nz/Page.aspx?pid=276 • MS publications www.msnz.org.nz/Page.aspx?pid=329
Muscular Dystrophy Association The Muscular Dystrophy Association is a New Zealand not-for-profit organisation which provides information and support to people affected by neuromuscular conditions. Its services include a national fieldwork service, as well as specialist information and advice. www.mda.org.nz	• Information and resources on specific neuromuscular conditions www.mda.org.nz/information
National Foundation for the Deaf The National Foundation for the Deaf works to promote the rights, interests and welfare of people with hearing loss. It offers support, prevention and advocacy programmes. The Foundation's website publishes various resources. www.nfd.org.nz	• Communication tips www.nfd.org.nz/help-and-advice/your-hearing/communication-tips
Needs Assessment Service Co-ordination Association The Needs Assessment Service Co-ordination Association (NASCA) is the national association for managers of NASC organisations. The Ministry of Health contracts these organisations to: • work with people with disabilities to identify their strengths and support needs • tell people about available support services • determine people's eligibility for Ministry of Health-funded support services • allocate Ministry-funded support services • help people access other supports. Support services are then delivered by their respective service providers. www.nznasca.co.nz	• Regional contacts/locations www.nznasca.co.nz/services/younger-peoples-nasc-services
New Zealand Disability Support Network The New Zealand Disability Support Network is a national association of disability support providers. www.nzdsn.org.nz	• Directory of member service providers www.nzdsn.org.nz/directory
New Zealand Down Syndrome Association The New Zealand Down Syndrome Association promotes the participation of people with Down syndrome in their community. It provides: • information, support, education and advocacy services for the Down syndrome community • support for parents and families/whānau • information resources and a quarterly journal • support for regional groups so that they can offer support and services to the Down syndrome community in their area through family events, social groups, guest speakers, individual support and advocacy. www.nzdsa.org.nz	• Information on Down Syndrome www.nzdsa.org.nz/whatis.htm

Organisation	Resources
Le Va Le Va is the national hub for Pasifika mental health and addiction workforce development and coordination for the disability support services sector. www.leva.co.nz	• *Organisational Guidelines for Disability Support Services: Working with Pasifika People with Disabilities and their Families* www.leva.co.nz/library/leva/organisational-guidelines-for-disability-support-services-working-with-pasifika-people-with-disabilities-and-their-families
Parent to Parent Parent to Parent supports parents of children with a disability, health impairment or health issue by connecting them with trained volunteer support parents who have a child or family member in a similar situation. It also provides training programmes for families and siblings. www.parent2parent.org.nz	• Parent to Parent Magazine www.parent2parent.org.nz/parent-parent-magazine • Parent to Parent Library www.parent2parent.org.nz/library/nationallibrary
Vaka Tautua Vaka Tautua is a charitable organisation that aims to help improve the health and wellbeing of Pasifika people in New Zealand. It provides community support for older people, people with a disability and those needing support for mental health. www.vakatautua.co.nz	• Resources and publications www.vakatautua.co.nz/#!resources/ckoy
Rescare NZ Rescare NZ is an umbrella organisation for support groups and individuals who support people with an intellectual disability. www.rescarenz.org.nz	• RescareNZ publications and resources www.rescarenz.org.nz/publications.html
Sign Language Interpreters Association of New Zealand Sign Language Interpreters Association of New Zealand is a national professional association of sign language interpreters. www.slianz.org.nz	• SLIANZ Member Directory (includes qualifications and areas of specialty) www.slianz.org.nz/directory/member-directory
Weka Weka is a website providing information on a range of disabilities, resources, support and services. www.weka.net.nz	• Regional information centres www.weka.net.nz/information-centres • General information sheets on a range of disabilities www.weka.net.nz/Information-by-Category/fact-sheet-test

Endnotes

[a] Minister for Disability Issues. 2001. *The New Zealand Disability Strategy: Making a World of Difference: Whakanui Oranga*. Wellington: Minister for Disability Issues.

[b] The full text of the UN Convention can be found at www.un.org/disabilities/convention/conventionfull.shtml (accessed 16 November 2015).

[c] Oliver M. 1990. *The Politics of Disablement*. MacMillan.

[d] Ministry of Health. 2012. *Whāia Te Ao Mārama: The Maori Disability Action Plan for Disability Support Services 2012 to 2017*. Wellington: Ministry of Health.

[e] Available on Kāpō Māori Aotearoa (Ngāti Kāpō)'s website: www.kapomaori.com/resources/index.htm (accessed 17 November 2015).

[f] Ministry of Health. 2010. *Faiva Ora: Pasifika Disability Action Plan*. Wellington: Ministry of Health.

[g] Le Va. 2014. *Organisational Guidelines for Disability Support Services: Working with Pasifika People with Disabilities and their Families*. Auckland: Le Va.

[h] Ministry of Health. 2012. *Refugee Health Care: A Handbook for Health Professionals*. Wellington: Ministry of Health.

[i] See www.building.govt.nz/international-symbol#aid6 (accessed 14 December 2015)

[j] See www.webtoolkit.govt.nz (accessed 18 November 2015).

[k] See www.w3.org/TR/WCAG20 (accessed 18 November 2015).

[l] Communication Matters. 2015. Having a conversation with someone who uses AAC. URL: www.communicationmatters.org.uk/page/having-conversation (accessed 21 November 2015).

[m] Communication Matters. 2015. Having a conversation with someone who uses AAC. URL: www.communicationmatters.org.uk/page/having-conversation (accessed 21 November 2015).

[n] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, p 2.

[o] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, p 2.

[p] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, pp 14–15.

[q] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, pp 12, 14.

[r] Ministries of Health and Education. 2008. *New Zealand Autism Spectrum Disorder Guideline*. Wellington: Ministries of Health and Education, p 96.

[s] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, p 5.

[t] Communication Matters. 2015. Having a conversation with someone who uses AAC. URL: www.communicationmatters.org.uk/page/having-conversation (accessed 21 November 2015).

[u] Ministries of Health and Education. 2008. *New Zealand Autism Spectrum Disorder Guideline*. Wellington: Ministries of Health and Education, p 99.

[v] Ministries of Health and Education. 2008. *New Zealand Autism Spectrum Disorder Guideline*. Wellington: Ministries of Health and Education, pp 111–112.

[w] Ministry of Health. 2014. *Working with People with Autism Spectrum Disorder: A guideline for Ministry of Health needs assessment and service coordination organisations*. Wellington: Ministry of Health, p 15.

[x] Human Rights Commission. 2012. *Political Participation for Everyone: Disabled People's Rights and the Political Process*. Wellington: Human Rights Commission, p 4.

[y] Human Rights Commission. 2012. *Political Participation for Everyone: Disabled People's Rights and the Political Process*. Wellington: Human Rights Commission, p 6.

[z] Human Rights Commission. 2012. *Better Information for Everybody: Disabled People's Rights in the Information Age*. Wellington: Human Rights Commission, p 6.

[aa] See www.un.org/disabilities/default.asp?id=223 (accessed 18 November 2015).

[bb] Preamble (o).

Waitemata District Health Board
Best Care for Everyone

Inclusive engagement events guide

Planning for inclusion

There isn't a single way of doing things that will make your event accessible to everyone – that's why this guide is about planning your event with inclusion in mind and helping you to understand that flexibility and thinking ahead about the kind of people who might come along is good practice.

With one in four people in New Zealand identifying as having an impairment in the 2013 Census, disabled people are likely to come to your event whether you expect them to be there or not. If the information you have provided or the way you run a session is inaccessible to blind or Deaf people or your venue is not wheelchair accessible, for example, it can be an embarrassing and frustrating waste of time for everyone. Inclusion and accessibility must be incorporated into the planning process. It should be remembered that inclusive planning will be beneficial to all participants.

With some straightforward planning, you can not only make your event more meaningful and accessible for everyone, but you can make sure that disabled people are able to engage along with everyone else. With some thought about how you describe and publicise your event, you can also make it more likely that disabled people will want to come along.

This resource does not focus on people's individual impairments. Instead, it guides you through the stages of planning an event, encouraging you to think about inclusion at each step. The ultimate goal is that you incorporate this planning into all of your future events, not just those aimed at disabled people.

Accessible venue and facilities

While it is of course important to use the most accessible venues available, it is equally important to tell potential participants about the accessibility of the venue, facilities and human support available. Furthermore, it is worth contacting participants, after looking at the information on their booking forms, to discuss how to best meet their access requirements. Never make claims about accessibility that you can't substantiate – nothing will cause more anger and upset than claims that an event is accessible when clearly it is not. As a minimum it should be visited before it is booked to check the accessibility. For advice on accessible venues, contact the WDHB Disability Advisor.

You may also want to consider how people travel to your event - the cost and ease of travel can sometimes be a barrier to people attending. You may want to consider the possibility of giving participants petrol vouchers or providing accessible transport.

Encourage the use of public transport. Is there public transport to the event? Where is the nearest train station? Is the journey accessible from the train station? What bus routes pass by the venue?

Venue

Check:

- The venue is accessible to wheelchair users including the external approach and parking areas
- That there is adequate parking and sufficient mobility parking
- The distance from the parking spaces to the venue
- That the venue will allow you to put up accessible signage - in large print and contrasting colours
- That all rooms to be used have movable furniture
- That all rooms to be used will be laid out in such a way as to provide circulation space for wheelchair users
- That all rooms to be used will enable all participants to sit together
- That areas used for break out discussions, stalls, and dining areas are easily accessible (avoid narrow corridors or dining rooms with fixed chairs)
- That there are adequate accessible toilets

Sound Systems

Check:

- The volume and clarity of the sound system
- That loop or infra-red systems are available and in working order
- That radio or infra-red systems used for translation do not interfere with those used by hearing-aid users (ensure liaison between the providers of both)
- That there are working roving microphones and people to take them to participants called to speak
- That microphone stands or lapel microphones are also available for participants or speakers making longer contributions

Lighting

- Avoid venues with bare strip lighting or flickering fluorescent tubes
- Prevent glare by closing blinds and curtains
- If lights are require to be dimmed for showing videos or slides ensure that both the speaker and the sign language interpreters are well spot lit
- When lights are dimmed ensure there is good light to read by

Check:

- That the event starts late enough and ends early enough for people to be able to get there. This is of particular importance in areas with limited access to mobility taxis.
- There are sufficient breaks and that the lunch break is long enough, including negotiating with the sign language Interpreters regarding their required breaks
- Sign Language Interpreters and other assistance is available during breaks, meals and informal networking activities
- There is sufficient time for some communication taking longer
- Time is built in for participants to get to breakout sessions on time
- All participants can participate in all activities or that reasonable accommodations can be made to chosen activities to ensure the inclusion of all
- Staff involved with all aspects of the event are briefed on disability equality/awareness

Accessible pre-event information and event booking

In order to encourage disabled people to come along to your event you will need to ensure that your pre-event and promotional material is accessible and welcoming to disabled people. Make sure that you make the booking process helpful and accessible and inform potential participants about the venue accessibility, human support and facilities available.

Publicity:

- The event invitation should be in accessible formats, large enough fonts with good contrast. It should be available in Word as well as pdf

formats to allow screen readers to read the information to blind/low vision people.

- The invitation includes access information including letting people know that the venue is accessible, sign language interpreters have been booked, and who people should contact for more information on access requirements. Make sure you provide both email address and phone number so people can contact you in the way that makes most sense for them.
- The event is publicised around networks that include disabled people and their organisations. Some people do not use email to access information, so networks and organisations will help get the word out through their own channels.
- Websites used to promote the event should be accessible, which means complying with Government Web Standards 2.0 as a minimum. If in doubt, ask your Communications Advisor.

Event Booking

Disabled people may be reluctant to attend events if they are unsure whether there will be good access on the day. You should encourage people to contact you if they want to check access arrangements, and the people dealing with these enquiries should provide clear information, be ready to offer additional accommodations, and keep a proper record of and follow up any accommodations agreed. It is important that booking forms provide information on the accessibility of the venue including facilities and parking, for example.

Check:

- Booking forms should be in accessible formats
- Booking forms should state what human support is available including Sign Language Interpreters, guides etc
- Alternative ways of booking should be available e.g. online, mail, email, phone, text.
- A telephone number and email address should be provided in order that potential participants can contact organisers to discuss access issues.
- The booking form should ask for the following information:
    - preferred format for materials e.g. email, disc, audio, braille, large print, easy read etc

  - If the person requires a Sign Language Interpreter
  - If the person will be bringing a support worker or facilitator (support workers and facilitators should be exempt from any attendance payments)
  - If the person will be bringing an Assistance dog
  - Any dietary requirements
  - Any other access requirements (provide a space for these to be included)
  - Contact details so you can discuss any access requests
- The booking form should state a date by which people need to say they require an Interpreter.

The following are some basic points to follow regarding written material.

Presentation guide

Written Material

- Remind presenters of the need to use plain language and follow good practice guidelines on accessibility when preparing any materials for the event, such as using sans serif fonts, and providing materials in 14pt font if possible, but never smaller that 12pt.
- Ensure that speakers, workshop facilitators and presenters provide copies of all material to be used in advance of the event so you have time to check them for accessibility, have them converted into alternative formats if required, and can send them to participants and sign language interpreters in advance.
- Email material to participants in advance of the event, remembering to provide html and word versions of any PDF documents.
- Make sure you leave plenty of time to have materials converted into accessible formats, particularly braille and easy read versions.

Presentations using powerpoint slides

When it is used well PowerPoint can be a creative communication medium. When used badly, it becomes a significant barrier to disabled peoples' participation. We recommend that PowerPoint presentations try to conform to the following general guidelines:

Slide backgrounds

- Backgrounds should be in pastel colours.
- When using slides that are predominantly text based, background colour should be in a solid block, not textured or graduated
- Text should never be overlaid across images.

Text:

- text should be in a sans serif font
- minimal use of capitalisation and underlining
- recommended sizes: headings 36 point in bold, subheadings 28 point in bold, text at least 24 point (not bold)
- There should be clear line spacing
- Avoid large blocks of text.
- Avoid italics wherever possible.
- Use bullet points consistently and have no more than four per slide, wherever possible.

Coloured text on coloured backgrounds

- The text colour should contrast clearly with the slide background.
- Avoid red, dark grey, brown, green or purple for text and backgrounds and don't use these colours next to each other as they do not provide enough contrast.

Animation

- Animation should be used sparingly to maximise impact and minimise confusion.

Slide numbering

- All slides should be numbered in both the presentation and if they are to be given as handouts.

Images

- These should be clear and uncluttered.
- Text should never be overlaid across images.
- Complex images, such as flow charts etc, should be provided in hard copy and accessible formats with a text descriptor.

- Images should be described by the speaker during the presentation to ensure any information conveyed by the image is also conveyed to those who are not able to see the image. This includes any diagrams or maps that may be within the presentation.

Use of multimedia clips

- Sound clips should be available in alternative formats and/or subtitles.
- Visual clips with no sound should be accompanied by descriptors in alternative formats and should be described by the speaker.

Slide transition

- Slide transition should be wiped left to right, at medium speed.
- A sound should also indicate slide transition.

Useful Resources:

- Recommended New Zealand Sign Language Interpreters:
  - www.connectinterpreting.co.nz 021 555 181
  - www.iSign.co.nz 0800 934 683

- UN Convention on the Rights of Persons with Disabilities

- Blind Foundation Accessible Signage Guidelines

Waitemata District Health Board
Best Care for Everyone

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitemata DHB and Auckland DHB
Implementation of the New Zealand Disability Strategy 2013-2016
Current Status at 1 August 2016

Communication and Information Empowering people through knowledge and understanding
Current Status at 1 August 2016

What we will do… actions	**Where** we are now…current status
1. Accessible Communication guidelines developed.	**August 2016** – Health Literacy Project Manager has developed a joint ADHB/WDHB Terms of Reference and initial project milestones for the Health Literacy Steering Group. These include Identifying project structures to lead health literacy project work streams, a health literacy engagement plan developed to sit alongside the Project Charter document and Plan, develop and implement a health literacy awareness campaign across both DHBs, including a health literacy awareness week.
2. Review of Web content and presentation.	**August 2016** – ongoing work. Changes will be made as part of the Health Literacy work.
3. Increase formats of key documents, e.g. Strategic Plans.	**August 2016** – Changes will be made as part of the Health Literacy work.
4. Review the automated telephone system with regard to access for people with disabilities.	**August 2016 –** The new telephone system went live on 1 June 2016.
5. Review the possibility of improved text communication to patients.	**August 2016** – Once the new system has moved from project stage to 'business as usual' then work can start of the second phase, which includes the ability to respond to text messages.
6. Continue the implementation of the Health Passport across both DHBs.	**August 2016** – Ongoing work. The Health Passport is a key part of the new Disability Responsiveness e-learning training. This will continue to raise its profile and promote staff awareness of this communication tool.
7. Work with the Deaf community to improve access to interpreters.	May 2016 – Disability Advisor was a member of the panel at Deaf Action's community meeting on how to improve the experiences of Deaf people in hospitals by improving interpreting and communication. The key points that came out of the meeting were: • DHB systems do not make it easy to book interpreters quickly. It is often quicker for Deaf people to book their own interpreters on the way to the hospital and the NZSL agencies sort out payment with the DHBs at a later date. • It is important that Deaf people complain when they do not get an interpreter. If people complain this means that the DHBs get an idea of how widespread problems are. • There is concern about Deaf people who do not have an

	interpreter consenting to treatment without really understanding what they have agreed to. • Lack of understanding means that Deaf people may not follow treatment recommendations and this can lead to poorer health outcomes. • The Deaf community would like their NHI number to be attached to information that they are Deaf. Some people wanted this to mean an interpreter was booked automatically, while other people said that this should mean they are asked the best way to communicate with them. • There are plenty of NZSL interpreters in Auckland. • There is limited understanding of Deaf culture in the health system. • People at the meeting said that they use the 'Deaf nod' frequently if they don't have an interpreter – this is where a person nods vigorously while not understanding what is being said. Deaf Aotearoa is running an NZ Sign Language workshop with the joint ADHB/WDHB Funding & Planning Team as part of NZSL Week.
8. Encourage the use of interpreters for non-English speaking families.	

Community and Engagement Working within a family and patient centred framework
Current Status at 1 August 2016

What we will do… actions	**Where** we are now…current status
9. Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.	**August 2016** –The ADHB Public spaces programme is setting up an Accessibility Reference Group to support project work around improving public spaces. We have identified the need to have a stakeholder group with lived experience of impairment and knowledge of how design impacts on disabled people's lives.
10. Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.	**August 2016** – Disability Advisor is working with Te Pou, CCS Disability Action & Mental Health Foundation to develop and run two workshops for disabled people on 10 August. The first is 'Disability & Mental Health' looking at mental wellbeing, mental illness and stigma & discrimination. The second is run by Te Pou and will focus on disabled people getting the most from their supports both as employers and service users. This will be in the context of the "Let's get real" framework. For more information on Let's Get Real, see http://www.tepou.co.nz/initiatives/lets-get-real/107 Disability Advisor has regularly contributed to ADHB's Grafton retail upgrade design process including workshops with retailer to ensure a disability lens is applied to all design decisions.
11. Ensure the voice of people with learning/intellectual disabilities, particularly people with high/complex needs, is included in consumer reviews of service planning and development.	**August 2016** – ADHB The Public spaces programme is setting up an Accessibility Reference Group to support project work around improving public spaces. "Public spaces" include entry/exit points, foyers, corridors, waiting areas and reception areas. The public spaces project teams will be looking for the Accessibility Reference Group to give them insight review designs and ensure the process is robust to help them provide achieve a better and more accessible experience in our public spaces for all people, but specifically for people with mobility, sensory and cognitive impairments. Both DHBs continue to draw information from our Patient Experience feedback to inform how we are doing.
12. Continue working with Health Links to increase health literacy through fully accessible patient information.	May 2016 – Health Links continue to improve new and updated patient information before it is made available to the public. The DHBs Health Literacy drive will also improve the accessibility of patient information.

Employment Opportunities Equal employment opportunities for people with impairments and carers
Current Status at 1 August 2016

What we will do… actions	**Where** we are now…current status
13. Encourage the use of supported employment agencies.	
14. Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.	**August 2016** – WDHB has approved a fund of $10k as part of the healthy workplaces strategy in 2017/18 for a centralised pool of money to support the employment of disabled people. At the moment, if a department employs a disabled person who needs specific supports these costs come from the department budget. This is potentially a disincentive to employ a disabled person, but once any costs come from a central HR pool, there is a more equal process.
15. Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	May 2016 – Waitemata DHB are in the process of getting costs for the customisation of the HR database to record information on staff with impairments. The Disability Advisor has been working with HR so that the information recorded matches the information in the census, rather than space for just a yes/no response.
16. Work with Hiring Managers to increase disability awareness.	**August 2016** – Working with Recruitment Manager to raise awareness of centralized funding for disability supports, if requited. Also, role of Workbridge in supporting disabled people into and during work.
17. Working with HR to look at how the DHBs support staff with Carer responsibilities.	

Disability Responsiveness Educating staff and challenging stereotypes & assumptions
Current Status at 1 August 2016

What we will do… actions	**Where** we are now…current status
18. Work with Dieticians to improve the nutritional outcomes for disabled patients.	August 2015 - Nutrition and Hydration are embedded into the Patient Care Standards at Waitemata DHB. There are 'Nutrition Champions' in place across the nursing teams and great improvements have been made.
19. Develop 'Disability Champion' roles across the DHBs.	**August 2016** – Seventeen ADHB Directors and Facilities & Development Project Managers and the Design Manager attended Barrier Free training in July 2016. WDHB will complete training later in the year.
20. Promote the Disability Awareness e-learning module to all staff across the DHBs.	May 2016 –The updated Disability Responsiveness e-learning module has been completed. The focus is on Communication (Ask the person) and Attitude (unconscious bias) and improving the patient experience. There is less focus on legislation and more on a practical response in a health setting. This will be available for both Waitemata and Auckland DHBs.
21. Provide a range of disability awareness training, targeting specific services.	
22. Develop tools to increase staff skills for working with people with communication difficulties.	**August 2016** – ADHB looking at practical low tech options for communication e.g. small whiteboards on wards.
23. Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.	**August 2016** – The ADHB Public spaces programme is setting up an Accessibility Reference Group to support project work around improving public spaces.

Physical Access Overcoming a disabling society
Current Status at 1 August 2016

What we will do… actions	**Where** we are now…current status
24. Encourage the use of symbols and pictograms in signage and way finding.	**August 2016** – The WDHB Facilities and Development Senior Project Manager presented to an extraordinary DISAC Committee the proposed design for external signage and way finding for North Shore Hospital, Waitakere Hospital and the Mason Clinic. Feedback was provided and will be followed up by the project. The DSAC Committee endorsed the signage design colours, font type and size with minor recommendations to some text.
25. ADHB Disability Champions will complete the 2-day Barrier Free Training.	**August 2016** – Seventeen ADHB Directors and Facilities & Development Project Managers and the Design Manager attended Barrier Free training in July. Members of WDHB Facilities Team will attend later in the year.
26. An accredited Barrier Free Advisor will be involved in all new Facilities work.	**August 2016** – Seventeen ADHB Directors and Facilities & Development Project Managers and the Design Manager attended Barrier Free training in July. Members of WDHB Facilities Team will attend later in the year.
27. Adoption of Universal Design principles in all Facilities work.	**August 2016** – Improved understanding of the principles of Universal Design, particularly since the Barrier Free training. This will impact positively on all Facilities work.
28. Building standards document developed in ADHB.	**August 2016** – ADHB have developed a Look and Feel Guideline for public spaces to provide practical guidance in the areas of furniture, lighting, flooring, colour usage and planting, as well as telling the local Iwi story. The principles outlined in this document will help to bring a consistent look and feel to our public spaces, and move away from dysfunctional environments that often result in negative experiences for patients, visitors and staff.
29. A review of accessible toilets in ADHB buildings to be completed.	**August 2016** – The ADHB Design Manager, together with a lead Disability Champion, will review the current state in next quarter. Facilities & Development will review the accessible toilet requirements under each new project and maintenance up-grade.
30. Work with Auckland Transport to improve accessible transport between hospital sites.	**August 2016** - Conversations between ADHB and Auckland Transport are ongoing.
31. Investigate the reported shortage of wheelchairs available - both numbers and sizes.	May 2016 **-** Auckland DHB has purchased a fleet of new wheelchairs and has replacement built into the wheelchairs budget for 2016-17. Wheelchair bays have been installed at each of the entrances on the Grafton site and a replenishment process has been agreed with our Orderly service.

Support of High Needs Patients While in Hospital Update

Since the November 2015 Disability Support Advisory Committee (DSAC) meeting, the Disability Advisor has discussed with Disability Support Services (DSS) at the Ministry of Health the process for people who need support while in hospital. The Ministry are very clear that they are happy to respond on an individual level and that this will be made clear when the MoH policy is updated. On 29 July, the Ministry said that they have received no requests for support in hospital in 2016.

At the March 2016 meeting, Jan Moss added that it would be worthwhile knowing if those in hospital resulting from and accident were also accessing this support and what the Accident Compensation Corporation (ACC) process was. Jan is working with ACC on this issue as part of her work as Complex Carers. Jan will report back once she has an outcome from ACC.

Public Spaces Accessibility Reference Group

Purpose
Auckland DHB is seeking to create an Accessibility Reference Group to support its work around improving public spaces. “Public spaces” include entry/exit points, foyers, corridors, waiting areas and reception areas.

The Group will discuss issues, improvement proposals and provide feedback and advice to the public spaces project teams. These teams include members of the performance improvement team, designers from the DHW Lab and other experts such as clinicians, security staff and facilities managers. The public spaces project teams will be looking for the Accessibility Reference Group to give them insight, review designs and ensure the process is robust to help them achieve a better and more accessible experience in our public spaces for all people, but with a focus on people with mobility, sensory and cognitive impairments.

ADHB’s Public Spaces project encompasses developing a long term strategy and consistent solution to wayfinding, creating healing environments that support patients and families through the stresses associated with being in or visiting the hospital and developing a sustainable approach to transport that ensures easy access to patients and visitors.

Frequency and Duration
It is anticipated the accessibility reference group will meet monthly at a set time for up to 2 hours. There is likely to be material to review before these meetings. There might be material to take away to provide feedback on from time-to-time.
To ensure a good level of engagement and sound understanding of the programme of work we are seeking a group of people who will be available for the majority of meetings over the next 12 months. It is possible this activity will continue beyond this initial 12 months.

Where
These meetings will be held at Auckland City Hospital in the Design for Health and Wellbeing Lab

Composition
The group will be made up of people with knowledge and experience of how design impacts on disabled people’s lives. The group will represent a wide range of consumers with impairments and will ideally be part of wider disability networks.

Compensation
ADHB would like to acknowledge the time and contribution of those within the group. We are able to offer $40p/h plus reimbursement for parking/travel.

Draft New Zealand Disability Strategy 2016-2026

Recommendation

That the Disability Support Advisory Committee:

1. **Receives the report.**

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

Glossary

ODI	Office for Disability Issues

1. Executive Summary

Following the first round of consultation, The Office for Disability Issues (ODI) has completed the first draft of the updated New Zealand Disability Strategy 2016-2026.

Eight priority areas of work have been identified.

A second round of consultation will take place in August 2016, with an aim to produce the final Strategy in December 2016.

Planning has been underway to develop the 2016-2019 Disability Strategy Implementation Plan. The DHBs Disability Strategy 2016-2019 will be heavily influenced by the priority work areas identified in the New Zealand Disability Strategy 2016-2026, as well as information that comes out of our own consultation work.

2. Background

The Office for Disability Issues (ODI) is currently reviewing the New Zealand Disability Strategy (2001) to develop an updated version.

Following the first round of consultation, a draft New Zealand Disability Strategy has been developed. During August 2016, ODI will be completing a second round of consultation focussing on the eight 'priorities for change' that have been identified.

The eight 'priorities for change' identified are:

1. Education – I have the same education outcomes as everyone else
2. Employment – I have the same employment outcomes and opportunities as everyone else
3. Health and Wellbeing – I have the same level of health and wellbeing as everyone else
4. Justice – I am treated the same way as everyone else by the justice system
5. Accessibility – I can access place, services and information just like everyone else
6. Attitudes – I am valued by society just like everyone else
7. Choice and Control – I can make my own choices and have control over my life just like everyone else

8. Leadership – I have the same opportunities for leadership as everyone else and there are leaders who can represent me

The final version of the New Zealand Disability Strategy should be completed by December 2016.

There are also a number of other strategies around disability that will need to be considered in both the NZ Disability Strategy and our joint DHB 2016-2019 Disability Strategy Implementation Plan:

- Disability Action Plan 2014-2018; focuses on cross government priorities
- UN Convention on the rights of Persons with Disabilities (UNCRPD)
- Whaia Te Ao Marama: the Maori disability Action Plan 2012-2017

The New Zealand Health Strategy has a focus on achieving equitable health outcomes, through targeting and tailoring services for those groups who have poorer health and social outcomes. Disabled people are included as part of this group and our work will continue with the aim of reducing inequality across health outcomes.

Planning has been underway to develop the 2016-2019 Disability Strategy Implementation Plan. This includes the development of an online survey, as well as consultation meetings. The priority areas identified in the draft of the updated NZ Disability Strategy, along with the information from our consultation, will influence the development of our updated Disability Strategy Implementation Plan. We still plan to hold out consultation meetings in late September/October 2016.

3. References

http://www.waitematadhb.govt.nz/DHB-Planning/Organisation-Wide-Planning/Disability-Strategy

http://jointheconversation.nz/draft-strategy/

http://www.health.govt.nz/publication/new-zealand-health-strategy-2016

Draft New Zealand Disability Strategy

2016 – 2026

JULY 2016

New Zealand Government

Office for Disability issues
Te Tari Mō Ngā Take Hauātanga
Administered by the Ministry of Social Development

Contents page

Our journey – an introduction

E hara taku toa, I te toa takitahi ēngari he toa taku tini.

My strength is not from myself alone, but from the strength of the group.

The New Zealand Disability Strategy – A map to guide our thinking

The New Zealand Disability Strategy (the Strategy) will guide the work of government agencies on disability issues from 2016 to 2026. It is a tool that can be used by any individual or organisation who wants to learn more about, and make the right decisions on, things that impact on disabled people. Achieving the vision and outcomes of the Strategy will support implementation of the United Nations Convention on the Rights of Persons with Disabilities (the Convention) in New Zealand. The Strategy is the vehicle for the realisation of the rights of disabled people.

Written from the disabled person's perspective

This Strategy is based on what disabled people said was most important during consultation in 2016. In order to remain true to the vision and priorities of the people at the centre of this Strategy, it has been written from a disabled person's perspective.

The way we look at disability in New Zealand

The journey since the 2001 Strategy was developed has seen real progress in the lives of many disabled people and our families. The most significant milestone was the development of the Convention, which New Zealand ratified in 2008.

Disabled children are now growing up wanting the same things from our adult lives as our non-disabled peers. There is also a growing recognition that we are all experts in our own lives, and ensuring that we are involved in the decisions that impact on us leads to better results.

There is still more work to be done

The Strategy is needed because disabled people remain worse off than other New Zealanders across all social and economic outcomes.[1] The persistent gap between disabled and non-disabled people also has a flow-on effect to our country as a whole; it impacts on families, friends and communities. When disabled people aren't able to participate, the entire country misses out.

What we want is no different to anyone else; we don't want to be treated as special or different. We aspire to the same things as everyone else: education; jobs; family; and happiness. Getting a fair go is a unique part of New Zealand's culture and is something all Kiwis take pride in. Harnessing the New Zealand culture of giving people a fair go is key to us achieving the aspirations that we have for ourselves, our families, and New Zealand.

[1] Statistics New Zealand (2014) *Disability Survey: 2013*

Our vision – where to from here

This vision of this Strategy is:

New Zealand is an enabling society – A place where disabled people have the same opportunities as everyone else to achieve outcomes, their aspirations become a reality, and all of New Zealand works together to achieve this.

Who we are – our community

We are ordinary Kiwis. We are children, we are parents, grandparents and we are friends. We want to be able to contribute to our families and participate in our communities, just like everyone else.

We are the 1.1 million New Zealanders who identify as being disabled and we represent almost a quarter of New Zealand's population.

What disability means to us

Disability is something that happens when people with impairments face barriers, because the world we live in has been designed by people who don't realise that not everyone is the same. It is society that disables us, not our impairments.

Even if we have the same impairment as someone else, we will experience different opportunities and barriers because of where we live and how we are treated by those around us. Every human being is a unique individual, and this is no different for a disabled person.

This social model of disability was how we understood disability in the first New Zealand Disability Strategy (2001), and it still holds true today. It's also the same understanding of disability that is now embodied in the Convention. The Convention says that disabled people include 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

While there are lots of different terms for disability, the one we use in New Zealand is 'disabled people'. In other countries, the term 'people with disability' is used. The New Zealand Disability Strategy Reference Group[2] has recommended that the 2016 Strategy should continue to use the term 'disabled people' to refer to the people at the heart of the Strategy. This term was adopted for the 2001 New Zealand Disability Strategy, and in the years since then, it has become a term that is widely understood and accepted.

We are diversity and we are diverse

Disabled people are part of the vast and diverse human experience. Just as we accept and respect differences such as gender, ethnicity or belief, the difference and diversity of disabled people needs to be accepted and respected.

Just like other communities, the disability community has different groups of people who experience life in different ways. We think it's important to acknowledge the diversity of our community, both because we are proud of it and also because we want to make sure that no one is left behind. The Strategy is for all of us.

[2] The New Zealand Disability Strategy reference group was appointed in January 2016 to support the revision of the Strategy. The 14 members include 12 nominated individuals who bring the perspectives of different disabilities, older and younger ages, gender, ethnicity, and support organisations. There is also one member from the Ministry of Health and the Ministry of Education.

Māori are over-represented in our community, with 26 percent of Māori being identified as disabled in 2013. When adjusted for age, the Māori disability rate is 32 percent.[3] We believe it's important to acknowledge this in order to address the inequality that our Maori community members face compared to others. There is also a special relationship between the Crown and Māori through the founding document of New Zealand, the Treaty of Waitangi.

The demographics of our country are changing, and we are increasingly a multicultural society. This is important to the disability community, as people from different ethnic and cultural backgrounds can sometimes understand and experience disability in different ways to others.

Pacific peoples make up a growing proportion of our country and of the disability community (19 percent of Pacific people identify as disabled in 2013), as do people from Asian backgrounds (13 percent in 2013). People from Middle Eastern, Latin American and African (MELAA) backgrounds were reported as having 28 percent identify as disabled in 2013. Over the coming decades, we will see more cultural and ethnic diversity.

New Zealand has an ageing population which will result over time in an increasing incidence of disability. People over the age of 65 were reported as having 59 percent identify as disabled in 2013.[4] Disabled people are also living longer, and there will be an increasing number of people with age-related disabilities. This is also a global trend and one that is drawing greater attention to disability. Meeting the needs and challenges of our ageing population is going to be a significant issue over the coming decades.

Gender norms play out in the disability community, just like they do in society more generally. Disabled women and girls can face different barriers to disabled men and boys. The disability community also has members who do not identify as part of the gender binary. Their experiences of disability can be different from others too.

The international catch-cry of disabled people is 'nothing about us, without us'. For our disability community here in New Zealand, this also includes people who find it hard to, or are not able to, speak for themselves and who can sometimes be amongst our most vulnerable and marginalised members. While there may be different terms used for this group, such as people with intensive support needs, the thing they have in common is that they often rely on other people to help make decisions for them, or with them.

The language that is used around disability is also not something that all members of the disability community identify with. For example, older people and their families may think about disability as a normal part of the ageing process. People with invisible impairments such as mental health issues can sometimes identify as part of the mental health community, and not the disability community. Some Deaf people also identify as part of a Deaf community with its own unique language and culture, and don't see themselves as being disabled.

---

[3] Statistics New Zealand (2015). *He hauā Māori: Findings from the 2013 Disability Survey*

[4] Statistics New Zealand (2014*) Disability Survey: 2013*

Disability impacts on many non-disabled people too

Our families, friends and those who support or care for us, are an important part of our community. Often they must confront the disabling society as they go about supporting us to participate. In this sense disability is something that impacts on more than just those of us with impairments.

The workforce in New Zealand is also ageing, and skill and labour shortages have the potential to constrain future economic growth. The low employment rates of disabled people represent a significant loss of potential contribution to New Zealand's economy.

Our community will change

This is just a snapshot of the rich diversity of the disability community. Because disability is about the way other people treat us, it is a dynamic concept and one that will change and grow as our society changes. This means that over the next ten years, there will be emerging and evolving groups of people who experience disability in different ways for different reasons.

This Strategy has been created, based on the views of the disabled people of New Zealand and their families, for the people of New Zealand, both now and into the future.

What's important to us

This section outlines the principles and approaches that will be used to implement the Strategy. These are the 'how' and the 'what' of the outcomes; they will help ensure that we achieve the same outcomes as other New Zealanders. It's about living a life with dignity, feeling valued and making sure that all of our community is visible, acknowledged and respected on an equal basis as others.

Respecting diversity

Disability is part of human diversity and the disability community itself is also diverse. To make sure this diversity is understood, acknowledged and celebrated; implementation of the Strategy will be guided by the principles of the Treaty of Waitangi and the Convention. This recognises what is unique about our community, as disabled people but also as citizens of New Zealand.

The principles of the Treaty are:

- **Partnership:** Māori and the Crown have a relationship of good faith, mutual respect and understanding, and shared decision-making.
- **Participation:** the Crown and Māori will work together to ensure Māori (including whānau, hapū, iwi and communities) participate in the disability sector at all levels of decision-making around disability issues. Participation includes the right to seek opportunities for self-determination and self-management.
- **Protection:** the Crown actively contributes to improving the wellbeing of Māori, including support for independent living and the protection of Māori property and identity, in accordance with Māori values. Māori have the same rights and privileges as other citizens.

The principles of the Convention are:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of disabled people as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of disabled children and respect for the right of disabled children to preserve their identities.

Investing long-term

Investing in disabled people with a whole-of-life approach will ensure we are more independent, can participate fully, contribute to our communities and reach our full potential. Such an approach will help ensure that:

- Our whole lives as disabled people are considered when investment decisions are made. This means breaking down the barriers between the silos of supports and services and instead focusing on the outcomes we have the potential to achieve.
- We are able to receive the right supports and services throughout our lives. Early support helps us get on track faster and builds our capacity for the future.
- The contribution we make to our families and communities is understood as being broader than just economic. Just like everyone else, good outcomes for us also include community contribution and social participation. The right supports and services for our families and carers are also important.

Twin-track approach

A twin-track approach is recognised internationally as being the best way to make sure we have the same opportunities to achieve outcomes as everyone else. It is about providing disability-specific supports and services, as well as making sure mainstream services or supports are accessible to everyone, including disabled people.

The twin-track approach isn't about picking between disability-specific or mainstream services or supports, it's about having access to the right services and supports when they are needed – services and supports which are both effective and available. Reasonable accommodations are provided as a normal expectation, and not something that disabled people feel that they have to request.

Some disabled people don't need any specific supports or services, whereas others do in order to access the same mainstream opportunities as everyone else. Sometimes the need for disability-specific supports and services can change over time too.

Universal design

Universal design is about good design that works for everyone. It is about making sure everything is accessible to, understood by and used to the greatest extent possible by everyone, without adaptation, or requiring little adaptation. Universal design is often referred to in relation to the built environment, but it applies to services, supports, and technologies as well. Universal design is distinct from accessible design. Accessible design represents the minimum accessibility requirements in built design, whereas universal design seeks accessible design outcomes that work for everyone.

Incorporating universal design thinking into the twin-track approach will help ensure that both disability-specific supports and services, as well as mainstream services and supports, are inclusive of and accessible to everyone in our diverse disability community.

Building evidence

We are a significant and diverse part of the population and yet we are often invisible in the discussions and decisions on things that are relevant to us. This is often because our disability hasn't been counted, recognised or understood, and therefore our needs haven't been considered. Making sure there is the right information and data at the right time to inform those decisions is critical. This also underpins both the investment and twin-track approaches.

Evidence is both quantitative (statistics or numbers) and qualitative (lived experience, or stories, directly from us and those who care for us). We know that both approaches are equally important to help make sure there is a good understanding of the problem (before deciding on solutions) and to understand what interventions work best for us and to measure results.

Our outcomes – priorities for change

This section outlines eight outcomes that will contribute towards achieving the vision of the Strategy. Under each outcome is an outline of the strategic direction of realisation (what my future looks like). These statements describe what an enabling society looks like to us under each outcome, and will be used to inform the development of specific actions for implementation.

Outcome 1: education

I have the same education outcomes just like everyone else.

What my future looks like

As a tangible demonstration of ensuring my right to a great education, my local early childhood education service and school will be the right places for me to have access to a quality education. They will have well-trained teachers who include me in the education journey, and where the technology, equipment, specialist services and other supports that are required for me to learn and achieve is available where and when I need it.

My learning day and my experiences will be the same as that of my friends, and this will be my experience from early childhood, through to leaving school and beyond. Extra assistance to me and my family early in my life will set me up well for my learning journey. Teachers and adults will value me and have high expectations for my achievement and progress. My classmates will value me and will benefit from my being their classmate. This is what an inclusive education looks like for me.

As schools are built or upgraded, universal design will be incorporated so that I can increasingly participate in school life with my peers, as well as my family or whānau. My fellow students will value my difference in a similar way to having a different gender or ethnicity, and they will understand that I may need additional support from time to time.

As I progress through the education system, I will be able to access the teaching and specialist supports I need to reach my potential and as I transition away from school, perhaps to tertiary study, and beyond, these changes will also be well supported.

The specialist services or supports will mainly be provided through resource centres and I won't feel like me, or my family, have to choose segregated education settings to access those supports. If I am deaf, I will have opportunities to learn in New Zealand Sign Language to develop language and identity. If I am blind, or have low vision, I will be able to access specialist training opportunities that may not be available at my local school.

If my learning journey is not as smooth as it could be, skilled teachers and specialists will work with me, my teacher and my family/whānau to understand what is happening and to resolve any challenges. Even if there are times when it is too difficult for me to learn with fellow students, the aim will be for me to be able to return to learning alongside my classmates as soon as possible just like anyone else.

My learning pathway will see me prepared for the future, equipped with skills and knowledge that will support me to be a valued member of society, confident in who I am and in what I can do. This, in turn, will enable me to seek out and take advantage of employment opportunities, and help shift attitudes towards disability and promote further advances in accessibility, choice and control.

Outcome 2: employment

I have the same employment outcomes and opportunities as everyone else.

What my future looks like

I have a good start to my employment as I've had a great education. My transition through school and from school to tertiary study into employment is smooth, with the right supports and services provided at the right time. I leave education with the same expectations of future career opportunities as my non-disabled peers, and these are shared by my family, those who support me, and members of my community.

Decisions on whether or not I need specialised supports and services for employment (including training, equipment or technology) take into consideration my whole life, the principles of reasonable accommodations and the difference work will make for me and my family, now and in the future. I am able to access the same employment supports or opportunities as everyone else because there's an expectation that I should, and also because they have been designed in a way that is accessible to me. I am also able to access on-going employment, including specialised services and supports, in a way that helps me retain work and also progress my career just like others do.

My employers will be open to and confident in employing me, and can focus on what I have to offer. They also have access to on-going support so that when things change, they have somewhere to go, the same as I do. I am treated the same as other employees where I work, and I feel that the work I do is meaningful, valued and real.

Outcome 3: health and wellbeing

I have the same level of health and wellbeing as everyone else.

What my future looks like

The health care professionals I rely on will be able to see me as more than my disability, and help me with any other health need I might have. They will respect the choices I make and listen to my opinions or suggestions for appropriate care, and help facilitate my access to mainstream health services just like my non-disabled peers.

If I need specialised supports and services, these will be flexible to meet my needs and I will have choice and control over what I receive and how it is delivered. Recognising the diversity of disabled people, my needs will be understood as being different to others even if they have the same impairment.

The diversity of our community will also be recognised through the increasing provision of culturally appropriate and effective services for Māori disabled people.

This will be accompanied by a similar recognition of the requirement for culturally appropriate services for Pacific disabled people, and for disabled people from ethnic communities.

Specific health and wellbeing needs of disabled women and girls will be provided in an appropriate and respectful way, allowing treatment that upholds dignity and respect.

I will have access to good information on mainstream health and specialised supports and services, which enables me to make informed decisions. If I need it, I will be provided with support to communicate or make decisions and this will be recognised and respected and be referred to the appropriate services in a timely manner.

I will feel connected to my community in a way that works for me. Having access to sport, recreation and cultural activities that fit with me as a person will also be an important contributor for my wellbeing.

When I am supported to be healthy and well, I am able to enjoy life, am confident in myself and my place in the world. This sees me able to play a stronger role in society and I am more likely to succeed in areas such as education and employment.

Outcome 4: justice

I am treated the same way as everyone else by the justice system.

What my future looks like

I will receive the right support, at the right time, in all interactions with the justice system. The right support will be given regardless of whether I am a victim, perpetrator, witness, or fulfilling a civic duty such as jury service. Information about these supports will be made available to the people I interact with, so that I don't have to keep telling my story or risk missing out on something I need.

If an aspect of my disability has played a role in my offending, I will be treated fairly and with respect by both the justice system and the care and protection system. I will be well supported throughout, and I will be able to make the most out of other opportunities to establish a positive place for myself in society, including in employment and education, and with appropriate health support.

There will be good understanding of the connection between the justice sector and disability and this will be used to prevent offending and reduce reoffending (where appropriate). This will include the right referrals to support services at the right time, both within and outside the adult and youth justice systems.

I will be treated fairly and with respect, just like everyone else. If needed, I will be provided with support to communicate or make decisions and this will be recognised and respected. My rights will be recognised as a person before the law, and I can exercise those rights. I will feel secure that safeguards are available to protect my rights on an equal basis with others.

If I feel unsafe in my home or surroundings, or if I am vulnerable to, or affected by violence, abuse or other offending, the justice system will recognise my situation and respond to my needs both effectively and with sensitivity.

This will give me greater confidence to recognise and act when I find myself in harmful situations, and to seek help for myself or others where needed.

Outcome 5: accessibility

I can access places, services and information just like everyone else.

What my future looks like

I am able to get around, from my house to where I go to school or work, and other places in my community just like others do. I don't feel any different to other people in my ability to get in and out of places with dignity. The buildings and public spaces I go to are accessible not only to me, but also to other people who can sometimes find it difficult to get around, such as families with children in push chairs, or a person with an injury.

When I need public transport services, I find that I can access them in the same way as everyone else. The people who run these services treat me well and they think about what I might need when they are making decisions about how the services are run now and into the future. This also includes when new public transport options become available in future. Private transport services are similarly responsive to disabled people. When I need it, I also have access to specialised transport options that are affordable, readily available, and easy to use.

I have a home that enables me to participate in my community. I am able to make choices about getting a job or where I go to school as I'm not restricted to living in one area because it's the only place where I can find a home that meets my needs. I feel safe when I'm at home, and I find it easy to get from my house to the other places I want to go.

I am able to find information in a way that I can access at the same time as everyone else. This helps me be independent because I don't always have to rely on other people when the information isn't available in formats I can use. This helps me make informed decisions on which services I might want to access. I am able to use technology that has been designed for everyone, as well technology for disabled people, in a way that is innovative, evolving and that helps break down barriers.

Outcome 6: attitudes

I am valued by society just like everyone else.

What my future looks like

I will know that society values me as much as everyone else when I feel that I am treated with dignity and respect, and when I am confident that my rights are recognised and upheld as important by other New Zealanders.

Disability will be recognised as being another part of the diversity of the human experience, and I will feel confident in my role as a contributor to society, rather than as being solely dependent on society.

Society will allow me to choose how I want to be identified. For example, I may be an elderly ethnic woman with a disability. I may choose to identify more closely with other parts of my identity than my disability, and society is OK with this.

I will be able to see a willingness to explore attitudes towards disability, and an appetite for seeking out ways to change attitudes and advance human rights for all people. The wider social environment will support these changes in a safe manner that upholds the voice and values of all members of society without diminishing the value of another.

These changing attitudes will empower me to play the leading role in pursuing and achieving my aspirations, and in the contribution that I make back to my family, community and New Zealand.

The effect of being increasingly valued in society will be reflected in changing attitudes of others towards me, and in my increased confidence in engaging with them. My voice as an individual will be heard without being diminished, and society will not seek to take that voice away, either by accident or design.

Society will encourage and support me to reach my full potential, and to maximise my contribution to society for the benefit of all. By being valued and accepted, and by having a voice equal to that of any other person, I will have the chance to demonstrate to society the value I can bring to my family, my community and New Zealand as a whole.

My voice will be encouraged and listened to, just like anyone else, even though I may communicate differently, use aids, or augmentative devices, and/or have support to communicate or express my preferences.

Outcome 7: choice and control

I can make my own choices and have control over my life just like everyone else.

What my future looks like

When I am young, my family will be supported, if needed, to help me grow up, and we will be able to choose what services we receive and indicate our preferences for the things that work best for us.

As an adult, and a valued member of my family, community, and society I will be able to make the key choices and decisions that affect how I live my life. By enabling me to have greater choice and control, I am able to take charge of my own life, choose what services I receive, and indicate my preference for the things that work best for me. Plans that affect me, or that have implications for my life, will not be developed without my involvement or agreement.

I will not simply be required to settle for a less desirable option because that is all that is offered to me. Like others, I am able to change my mind in relation to my decisions.

Where decisions affect me, my consent will be sought. I will be supported with information and explanations that will help me understand so that I can give that consent in an informed way. Good information and support will also be available to help those who support me, to ensure they understand their roles and responsibilities in supporting me in decision-making, or where they are involved in making decisions on my behalf.

I will be supported to make decisions when I require help to do so, and this support will empower me to make the best choices for me. This support will enhance my voice, and help to ensure that my decisions are heard and respected.

Even where my decisions expose me to risk, the support I receive will allow me to understand risks and let me make decisions in the knowledge that risk alone should not prevent me from living my life. If I choose to take a risk, I will be able to do so, the same as anyone else.

By maximising the control I have over making the decisions that affect me, I am able to dispel negative attitudes about disability and I am better positioned to achieve my full potential in all areas of my life including employment, education and health and wellbeing.

Outcome 8: leadership

I have the same opportunities for leadership as everyone else and there are leaders who can represent me.

What my future looks like

I have opportunities to be a leader or role model in whatever field I choose. I am supported to be on a level playing field with others and am recognised for my skills, talents and leadership potential. When people see me in the same type of leadership roles that non-disabled people have, they just see me as a leader as well as someone experiencing disability. I will be supported to develop my leadership potential, and will be able to take responsibility for the pursuit and achievement of my goals.

When there are discussions and decisions on things that are important to disabled people, I know that there will be strong disabled (and non-disabled) leaders who can represent me. Those who represent me will seek out my views and their work will be underpinned by the voices and needs of disabled people. The diversity of the disability community is also visible in leadership roles within and outside of the disability sector, including the groups within our community who often haven't had a voice. There are opportunities for new leaders in the disability sector to be supported and mentored, helping to make sure that the diversity of our community is well-represented.

Even if I don't want to be a leader myself, when I look around me I see disabled people like me in leadership roles. This includes people doing great things on behalf of our country or at a national level, and also people doing every day ordinary things on behalf of themselves, their families or communities.

I also see non-disabled people being leaders as allies of the disability community, using the important positions they have to influence others to break down the barriers we face. These leaders are doing this not because they feel sorry for us, but because they see our potential, contribution and value.

Making it work – a plan for action

The Strategy outlines the direction for government agencies for the next ten years. In order to make it work, more detailed planning for specific actions is required. This section outlines how the Strategy will be implemented, including how decisions will be made and by whom. There is a schedule of implementation in table format on page 23.

The Disability Action Plan

The Disability Action Plan (the Plan) is an existing tool that will be adapted to be the primary vehicle for effective implementation of the Strategy.

Future plans will:

- focus on high priority and significant actions that require more than one government agency to work together, as well as those actions that are just the responsibility of one government agency
- ensure a complete picture of priorities and progress with implementation of the Strategy
- enable more effective learning across the approaches that are common across the Strategy, regardless of whether they are being implemented by one agency or several.

It is important that the Plan is something that everyone can understand and measure progress against. That is why it is not going to include all of the work happening across government agencies on disability issues; this would make it very long and difficult to understand what the priorities are.

In early 2018, a public consultation process will identify what should be included as high priority and significant actions in a new four-year Disability Action Plan (2019–2022). The new plan will be updated at the mid-point (2020/21) to ensure the actions remain relevant given progress made and the changing context of disability in New Zealand.

A public consultation process will inform the development of the new plan as well as the update. These will build on what has been learnt about inclusive and accessible consultation through the 2015 update of the Disability Action Plan (2014–2018) and the development of the Strategy in 2016.

In 2022, the development of a new Disability Action Plan (2023–2026) will start. This plan will also be updated at the mid-point (2024/25) and both the development and update will build on and learn from processes used to date.

Other Strategies and other Action Plans

Many other Strategies sit alongside the New Zealand Disability Strategy to guide government priorities and policies. As a result, in addition to the Disability Action Plan, other action plans will contribute to the implementation of the Strategy. One example is the New Zealand Māori Health Strategy – He Korowai Oranga and the Māori Disability Action Plan for Disability Support Services 2012-2017: Whāia te Ao

Mārama. The combination of these two action plans will play an important role in supporting the achievement of better outcomes for disabled Māori.

A new outcomes framework and development of targets

It is important to all New Zealanders, including the Government and the disability community that the very-best-informed decisions are made on things that are important to disabled people and their families. Learning from what has happened previously will support continuous improvement for future work. Being able to adapt to a changing context in our country is also important.

An outcomes framework for the Strategy will be developed in 2017. This will specify the indicators and measures for each outcome, the source of data, as well as the frequency and who is responsible for the collection of it. Given the challenge of good quality information on disabled people, it is expected that data sources may not be available for indicators across all outcomes. As such, the outcomes framework will also identify where proxies (that is, something similar to the original indicator) are needed for the time being as well as identifying where new data collection is required.

New Zealanders have clearly told us that the Strategy needs an accountability mechanism so that we can make sure it is implemented. We are developing some measures and targets to include in the Strategy. An example of what these may look like is:

‘Increasing the employment outcomes of disabled people, so that their rates of employment are closer to those of their non-disabled peers’.

These targets and measures will guide the development of actions for future revisions of the Disability Action Plan.

Reporting progress

Every year the Minister for Disability Issues will provide a progress report on implementation of the Strategy (and the Plan) to Cabinet. Every second year the Minister’s report will present a fuller picture of progress against the outcomes framework. This will also identify relevant changes in the operating context.

These reports will be used to inform the development and update of future Disability Action Plans. The Minister will continue to present to Parliament the progress report as required by the New Zealand Public Health and Disability Act 2000.

A process to evaluate the Strategy (including the Disability Action Plans) will start in 2025. This will inform what happens after the end of this current Strategy in 2026.

Supporting implementation of the Convention

Every four years, the Government reports to and receives Concluding Observations from the United Nations Committee on the Rights of Persons with Disabilities. Concluding Observations recognise areas of good progress but also include recommendations where things need to be improved in the United Nations Committee’s opinion. This helps us learn from international experience to inform what happens in our own country.

The first Concluding Observations from the United Nations Committee (received in 2014) were used to inform the 2015 update of the Disability Action Plan (2014–2018). This process will continue under the Strategy.

The Concluding Observations will be included as part of the public consultation process to develop new Disability Action Plans. This will help make sure that recommendations from the United Nations Committee can be considered alongside ideas and suggestions from the disability community here in New Zealand.

It is expected that the Government will report to and receive Concluding Observations from the United Nations Committee in 2018 and 2022. These timeframes, however, may change based on United Nations processes. If this happens, the Concluding Observations will then be used to inform the mid-point update of the Plan.

Making decisions on implementation

As this is a Government Strategy, reports will be considered and decisions on implementation (including through the Disability Action Plan) will be made by Cabinet.

The existing governance and coordination mechanisms will continue, but work will be done to explore ways to embed stronger disability expertise within them. Consideration will also be given to ensuring these mechanisms represent the diversity of the disability community. These mechanisms are the Chief Executives' Group on Disability Issues (and an associated Senior Officials Group) and Disabled People's Organisations, and the Ministerial Committee on Disability Issues.

An independent view of implementation

The Independent Monitoring Mechanism was established by the Government in 2011 to provide for independent monitoring of the Convention. This mechanism fulfils the obligation for the Government to have an independent mechanism to promote, protect and monitor implementation under the Convention (Article 33).

The Independent Monitoring Mechanism will also consider progress against the Strategy (and Disability Action Plans) as part of its work. This is because the Strategy is the vehicle for progressive realisation of the Convention in the New Zealand context.

Just like the recommendations from the United Nations Committee, recommendations from the Independent Monitoring Mechanism will be part of the public consultation process to develop and update the Disability Action Plans.

The Independent Monitoring Mechanism will meet with the Ministerial Committee on Disability Issues every year prior to consideration by Cabinet of progress reports from the Minister for Disability Issues.

Making it work – a schedule of implementation

Year	What happens
2016	• New Disability Strategy 2016–2026 agreed
2017	• Outcomes framework for the Strategy agreed • Annual report from Minister for Disability Issues
2018	• Government reports to and receives recommendations from the United Nations Committee • Government receives report from the Independent Monitoring Mechanism • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism) • Biennial report from Minister for Disability Issues against Strategy outcomes framework
2019	• New Disability Action Plan (2019–2022) starts • Annual report from Minister for Disability Issues
2020	• Start of public consultation process for mid-point update of Disability Action Plan • Biennial report from Minister for Disability Issues against Strategy outcomes framework
2021	• End of public consultation process and mid-point update of Disability Action Plan • Annual report from Minister for Disability Issues
2022	• Government reports to and receives recommendations from the United Nations Committee • Government receives report from the Independent Monitoring Mechanism • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism) • Biennial report from Minister for Disability Issues against Disability Strategy outcomes framework
2023	• New Disability Action Plan (2023–2026) starts • Annual update report from Minister for Disability Issues
2024	• Biennial report from Minister for Disability Issues against Disability Strategy outcomes framework • Start of public consultation process for mid-point update of Disability Action Plan
2025	• End of public consultation process and mid-point update of Disability Action Plan • Evaluation of the Strategy (and Disability Action Plans) starts • Annual update report from Minister for Disability Issues
2026	• Government reports to and receives recommendations from the United Nations Committee • Government receives report from the Independent Monitoring Mechanism • Biennial report from Minister for Disability Issues against outcomes framework • Evaluation of the Disability Strategy (and Disability Action Plans) finishes • End of current Disability Strategy 2016–2026.

Getting it going – who's involved

Achieving the vision and outcomes of the Strategy will take all New Zealanders working together. With rights there also come responsibilities, for everyone. There are also some key groups who have particular responsibilities under the Strategy. They are:

- **Cabinet** – responsible for considering regular reports and making decisions on implementation of the Strategy through the Disability Action Plan.
- **Ministerial Committee on Disability Issues** – meets with the Independent Monitoring Mechanism annually and ensures co-ordination of implementation across government.
- **Independent Monitoring Mechanism** – responsible for monitoring implementation of the Convention, including through implementation of this Strategy and the Disability Action Plans.
- **Chief Executives' Group on Disability Issues (and Senior Officials Group) and Disabled People's Organisations** – responsible for governance and coordination of the Disability Action Plans.
- **Government agencies** – responsible for implementing the Strategy according to the priorities agreed in the Disability Action Plan.
- **Disabled people, families, allies and the disability community and sector** – providing ideas and suggestions through the consultation processes to develop and update the Disability Action Plans.
- **All New Zealanders** – breaking down the barriers of a disabling society and supporting implementation of this Strategy.
- **Local Territorial Authorities** – Consider their responsibility for disabled people in the space they oversee, in line with this Strategy and the Convention.
- **Private sector, businesses and Non-Governmental Organisations** – ensure their business as usual is inclusive and responsive to disabled people on an equal basis with others.

Live a **Good Life** jointheconversation.nz

Join the conversation

Help build a new disability strategy for New Zealand.

8.5

Draft New Zealand Disability Strategy

2016 – 2026

Easy Read

Office for Disability issues
Te Tari Mō Ngā Take Hauātanga
Administered by the Ministry of Social Development

New Zealand Government

About the New Zealand Disability Strategy

The first **New Zealand Disability Strategy** was made in 2001.

The New Zealand Government is making a new **Disability Strategy**.

This is the draft of the new **Disability Strategy**.

The 2016 **New Zealand Disability Strategy** has things in it that disabled people say are important to:

- know about disabled people
- make good decisions.

The **New Zealand Disability Strategy** can be used to:

- know more about disabled people
- make good decisions.

The purpose of the **New Zealand Disability Strategy** is to make sure disabled people:

- are treated fairly
- get what they need to have a good life
- are treated the same as everyone else
- are part of the community
- can make their own decisions
- have good decisions made about them by the Government.

Disabled people want to:

- have a good life
- be treated the same as everyone else.

Disabled people know what they need to have a good life.

Lots of disabled people in New Zealand do not have a good life.

The **New Zealand Disability Strategy** can make sure disabled people have a good life.

In 2008 the New Zealand Government agreed to the rights in the **United Nations Convention on the Rights of Persons with Disabilities**.

This is also called the **Disability Convention**.

The **Disability Convention** says what countries need to do to make sure disabled people have a good life.

The **New Zealand Disability Strategy** can make sure that New Zealand is putting in place the rights in the **Disability Convention**.

New Zealand Disability Strategy Vision

The vision of the **New Zealand Disability Strategy** says New Zealand needs to make sure disabled people can:

- be treated fairly
- get the same things as everyone else in New Zealand.

Everyone in New Zealand needs to work together to make sure:

- New Zealand is a good place for disabled people to live
- disabled people in New Zealand have good lives.

Who is part of the disability community?

There are lots of different people in the disability community in New Zealand.

People that say they have a disability are part of the disability community.

Some people do not want to say they have a disability, for example some:

- Deaf people
- older people
- people in the mental health community.

More than half of older people in New Zealand have a disability.

The number of disabled people in New Zealand is growing because people are living longer.

1 out of 4 people in New Zealand say they have a disability.

1 out of 4 Māori people in New Zealand say they have a disability.

1 out of 5 Pacific Island people in New Zealand say they have a disability.

There are also people from lots of other cultures in New Zealand that have a disability.

Friends, families and people who support and care for disabled people are also part of the disability community.

Barriers

To have a good life disabled people in New Zealand want to join in with:

- friends
- family
- community.

Barriers are things that make it hard for disabled people to join in with:

- friends
- family
- community.

The **social model of disability** says it is the world we live in that puts barriers in place that make it hard for disabled people to live the life they choose.

Not all disabled people face the same barriers.

For example, disabled women and girls can face different barriers than disabled men and boys.

8.5

The **New Zealand Disability Strategy** wants to:

- take away barriers
- make sure disabled people have the same rights as other people in New Zealand.

What is important to disabled people

The **New Zealand Disability Strategy** has things in it that disabled people in New Zealand and their families think are important.

The **New Zealand Disability Strategy** can make sure disabled people:

- have a good life
- get the same things as other people.

Disabled people want to:

- get the same things as other people
- have the same rights as other people
- be treated in a good way
- feel important
- feel valued
- make their own decisions.

It is important that:

- all people are treated in a good way
- all people are respected by everyone.

The **New Zealand Disability Strategy** works with the:

- Treaty of Waitangi
- Disability Convention.

The **New Zealand Disability Strategy** has also been made using these ideas:

- whole of life approach
- twin track approach
- universal design.

The **whole of life approach** means a disabled person's whole life is thought about when decisions are made.

This means:

- barriers between different places that give support and services are taken away
- looking at things disabled people **can** do
- disabled people get the right support and services for their whole life
- families and carers of disabled people get the right support and services.

The **whole of life approach** will mean disabled people can:

- do more things for themselves
- give to the community
- be part of the community
- have the lives they want.

The **twin track approach** means having both:

- disability support services
- community supports that we can be part of.

Working this way means that disabled people:

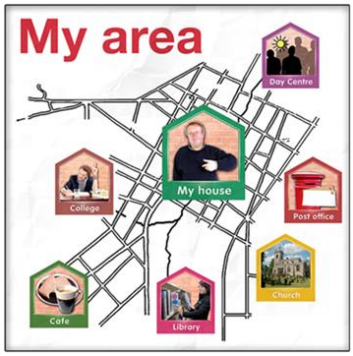
- have the same chances as everyone else to get goals
- can get community services and support
- get the right disability support services at the right time
- can get some things without having to ask.

The **twin track approach** can make sure services and supports are:

- working well
- easy to get and use.

Universal design is about making sure everything is easy to:

- get by everyone
- understand by everyone
- use by everyone.



Universal design is for:

- buildings
- services
- supports
- technology.

Using both **Universal design** and the **twin track approach** can make sure all support and services are easy for everyone to get.

It is also important the Government has **good information** about disabled people so good decisions can be made.

Good information is both:

- numbers of disabled people
- stories about disabled people.

Getting good information about disabled people can make sure the Government:

- knows what disabled people need to have a good life
- can make good decisions.

8.5

Good information can help everyone to:

- find out what problems there are
- think how to fix the problems
- find out how well we are doing.

8 outcomes

There are **8 outcomes** in the **New Zealand Disability Strategy**.

An **outcome** is how we want something to turn out.

The **8 outcomes** can help make sure disabled people in New Zealand:

- get the same things as everyone else
- have a good life
- be treated fairly
- have the life they want.

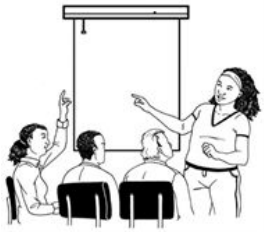
The **8 outcomes** can help make:

- New Zealand a good place for disabled people to live

- everyone in New Zealand work together to make sure disabled people have good lives.

8.5

Here are the 8 outcomes of the draft New Zealand Disability Strategy:

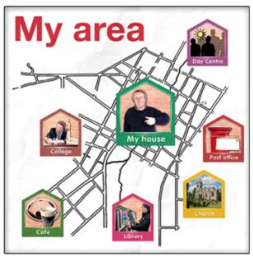


- **Outcome 1: Education / learning new things**

- **Outcome 2: Employment / having a job**

- **Outcome 3: Health / being healthy and well**

- **Outcome 4: Justice / getting my legal rights**



- **Outcome 5: Access / getting in and around my community**

- **Outcome 6: Attitude / how disabled people are treated by others**

- **Outcome 7: Choice and control / making my own choices and being in control of my life**

- **Outcome 8: Leadership / being a leader**

Outcome 1: Education – learning new things

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can get:

- the same education as everyone else
- good education
- good teachers
- good support if I need it
- what I need to help me learn
- what I need to help me get my goals.

I can be:

- part of all the things that other students are
- treated the same as everyone else
- seen as important
- treated in a good way
- seen as able to learn
- taught new things
- good at doing things.

Outcome 2: Employment – having a job

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I have:

- the same chance to get a job as everyone else
- a good job
- good support when I am leaving school and looking for work
- support to get and keep a job if I need it
- a boss who feels like they have good support.

I can be:

- seen as able to get and do a good job
- treated in a good way at work
- treated the same as everyone else at work.

Outcome 3: Health – being healthy and well

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can get:

- good health care
- what I need to be healthy
- health care that suits me
- health care that suits my culture
- my health needs taken care of
- information about health services and support
- support to communicate if I need it.

I can be:

- healthy
- listened to
- treated in a good way
- in control of everything to do with my healthcare
- able to choose
- able to enjoy life by being part of the community.

Outcome 4: Justice – getting my legal rights

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can get:

- the right support at the right time when I have any contact with people in the legal system, like:
  - Police
  - lawyers and judges
  - court staff
- information about the support I can get
- support to communicate if I need it
- support if I do not feel safe.

I can be treated:

- fairly
- well – by people in the legal system who know what support I need so I do not have to tell them again and again.

Outcome 5: Access – getting in and around my community

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can get:

- to the same places as everyone else
- the same services as everyone else
- the same information as everyone else
- good support when using transport services.

I can:

- travel from my home to anywhere I want to go
- choose where I live
- choose where I go to school or work
- use all transport services
- afford disability transport if I need it
- get in and around in buildings
- use technology
- take part in the community.

Outcome 6: Attitude – how disabled people are treated by others

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can:

- make choices about anything in my life
- take part in the community
- get my goals
- get support to communicate if I need it.

I am:

- listened to
- seen as important
- valued the same as everyone else
- treated in a good way.

Outcome 7: Choice and control – making my own choices and being in control of my own life

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can:

- get what I need to help me make my decisions
- choose things I want in my life
- choose things I do not want in my life
- change my mind if I want to
- make my own decisions.

I am in charge of my life.

Families / whanau of disabled children can choose what support is best for them.

People who support me have the support they need to make choices that are right for me.

Outcome 8: Leadership – being a leader

If the **Disability Strategy** works disabled people in New Zealand can say these things:

I can:

- be a leader if I want to
- have other disabled leaders speak up for me
- see other disabled people as leaders.

I am:

- seen as able to be a leader
- supported to be a leader
- valued as a leader.

Making the strategy work

New Zealand also has a document called the **Disability Action Plan**.

8.5

The **Disability Action Plan** says what the Government is doing to make sure disabled people have good lives.

The **Disability Action Plan** can be used to make sure things in the **New Zealand Disability Strategy** are done.

It is important that the **Disability Action Plan** is:

- understood
- used
- can be checked.

Government agencies need to work together to do things in the **Disability Action Plan**.

The **Disability Action Plan** has in it the most important things Government agencies can do to help disabled people have a good life.

The **Disability Action Plan** New Zealand has right now will end in **2018**.

In **2018** people in the disability community will be able to have their say about what needs to be in the next **Disability Action Plan**.

Every few years new **Disability Action Plans** will be made.

The new **Disability Action Plans** can be checked by people in the disability community to make sure things in the **New Zealand Disability Strategy** are done.

They can also check to make sure everything in the **Disability Action Plan** is important.

There are other plans that help disabled people lead good lives.

For example

There are 2 things that can be used with the **Disability Action Plan** to support disabled Māori people to get goals and have good lives:

1. New Zealand Māori Health Strategy – He Korowai Oranga

2. Māori Disability Action Plan for Disability Support Services – 2012 - 2017: Whāia te Ao Mārama.

It is important that we can make sure the new **disability strategy** works.

In 2017 a **Disability Outcomes Framework** for the **New Zealand Disability Strategy** will be made.

A **Disability Outcomes Framework** is a way to check that New Zealand is doing the right things to make sure disabled people have good lives.

The **Disability Outcomes Framework** will make sure:

- good decisions are made about things that are important to disabled people and their families

- everyone learns from mistakes
- things are good for disabled people
- there is good information about disabled people

- we know what information we still need
- we know things we need to work on
- we know what to do next in the **Disability Action Plan**.

Keeping track of what has been done

Every year the Minister for Disability Issues reports on the **New Zealand Disability Strategy** and the **Disability Action Plan**.

The Minister for Disability Issues will also reports on the **outcomes** that are in the **Disability Outcomes Framework**.

The Minister's reports can let everyone know what needs to be changed in the **Disability Action Plan**.

In 2025 the **New Zealand Disability Strategy** can be looked at again.

Looking at the **Disability Strategy** will let us all know what needs to be in the next **Disability Strategy**.

Every 4 years the New Zealand Government gives a report to the **United Nations Committee on the Rights of Persons with Disabilities**.

Every 4 years the **United Nations Committee on the Rights of Persons with Disabilities** gives a report back.

This report is called the **Concluding Observations**.

The **Concluding Observations** tell us things the New Zealand Government:

- is doing well
- needs to do.

What the **2014 Concluding Observations** said helped make the **2014 – 2018 Disability Action Plan**.

The Government will get more **Concluding Observations** in 2018 and 2022.

The **Concluding Observations** will help the Government to know what things in the **Disability Action Plan** need to change.

Who makes sure the strategy gets done

The **New Zealand Disability Strategy** is a New Zealand Government Strategy.

The people that make decisions about the **Strategy** are called the **Cabinet**.

The New Zealand Prime Minister and lots of Ministers are in the **Cabinet**.

The **Cabinet**:

- is part of New Zealand Government
- gets reports on the **New Zealand Disability Strategy** and **Disability Action Plan**

- decides what to do to make sure the **New Zealand Disability Strategy** and **Disability Action Plan** are used.

The Government knows it is important that disabled people are part of decisions that are made.

Here are some groups that make sure things in the **New Zealand Disability Strategy** and **Disability Action Plan** happen.

They are:

- Chief Executives Group on Disability
- Senior Officials Group on Disability
- Disabled People's Organisations
- Ministerial Committee on Disability.

The Government has also made something called the **Independent Monitoring Mechanism**.

There are 3 groups in the **Independent Monitoring Mechanism**:

- The Office of the Ombudsman
- The Human Rights Commission
- The Convention Coalition.

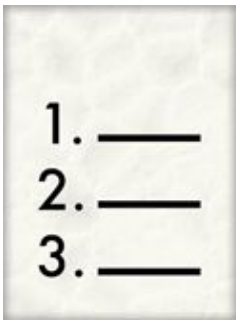
The job of the **Independent Monitoring Mechanism** is to check if disabled people are getting the rights in the **Disability Convention**.

The **Independent Monitoring Mechanism** gives reports to the Government so they know what needs to be done.

Reports from the **Independent Monitoring Mechanism** help the Government know what to put in the **Disability Action Plan**.

What is going to happen over the next 10 years

The new **New Zealand Disability Strategy** will be used for the next **10 years**.



Here is what will happen to make sure the **New Zealand Disability Strategy**:

- is used by everyone
- works well.

In 2016:

- Make the **New Zealand Disability Strategy**.

In 2017:

- Agree to the **Disability Outcomes Framework**
- Get annual report from Minister for Disability Issues.

In 2018:

- Give report to the **United Nations Committee**
- Get report from the **United Nations Committee**
- Get report from the **Independent Monitoring Mechanism**
- Ask people in the disability community about new **Disability Action Plan**
- Get **Disability Outcomes** report from the Minister for Disability Issues.

In 2019:

- Start using new **Disability Action Plan**
- Get annual report from the Minister for Disability Issues.

In 2020:

- Ask people in the disability community about the **Disability Action Plan**
- Get **Disability Outcomes** report from the Minister for Disability Issues.

In 2021:

- Finish asking people in the disability community about the **Disability Action Plan**
- Get annual report from the Minister for Disability Issues.

2022:

- Give report to the **United Nations Committee**
- Get report from the **United Nations Committee**
- Get report from the **Independent Monitoring Mechanism**

- Ask people in the disability community about new **Disability Action Plan**
- Get **Disability Outcomes** report from the Minister for Disability Issues.

In 2023:

- Start new **Disability Action Plan**: 2023 – 2026
- Get annual report from the Minister for Disability Issues.

In 2024:

- Get **Disability Outcomes** report from the Minister for Disability Issues
- Ask people in the disability community about the **Disability Action Plan**.

In 2025:

- Finish asking people in the disability community about the **Disability Action Plan**
- Start looking at how well the **Disability Strategy** and **Disability Action Plan** worked
- Get annual report from the Minister for Disability Issues.

In 2026:

- Give report to the **United Nations Committee**
- Get report from the **United Nations Committee**
- Get report from the **Independent Monitoring Mechanism**
- Get **Disability Outcomes** report from the Minister for Disability Issues
- Finish looking at how well the **Disability Strategy** and **Disability Action Plan** worked.
- End of this **Disability Strategy**.

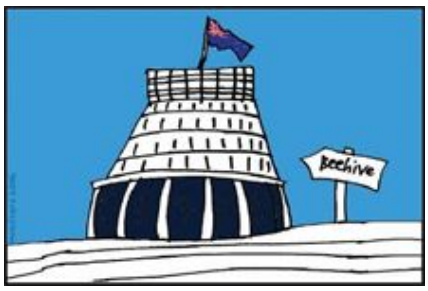
Who is involved

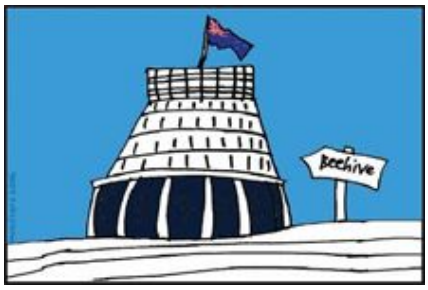
To get the **New Zealand Disability Strategy** used by everyone in New Zealand lots of people need to work together.

Here are some groups that need to help make sure the **New Zealand Disability Strategy** is used by everyone in New Zealand:

1. Cabinet

- This is part of the New Zealand Government.
- The New Zealand Prime Minister and lots of Ministers are in the **Cabinet**.
- The **Cabinet** looks at reports and decides how to get the **New Zealand Disability Strategy** used by everyone in New Zealand.





2. Ministerial Committee on Disability

- This is part of the New Zealand Government.
- Some New Zealand Ministers are in the **Ministerial Committee on Disability**.
- This **Committee** meets with the **Independent Monitoring Mechanism** to help make sure the **New Zealand Disability Strategy** is used.

3. Independent Monitoring Mechanism

- The **Mechanism** checks to make sure the **New Zealand Disability Strategy** is used.

4. Chief Executives Group on Disability

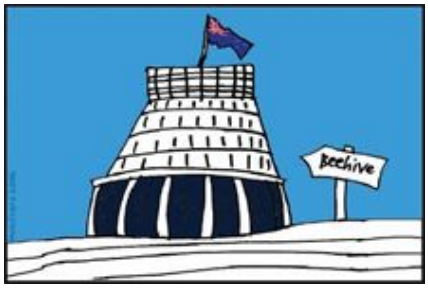
- This Group makes sure the **Disability Action Plan** happens.

5. Senior Officials Group on Disability

- This Group makes sure the **Disability Action Plan** happens.

6. Disabled Peoples Organisations

- Disabled Peoples Organisations make sure the **Disability Action Plan** happens.



7. Government agencies

- Government agencies use the **New Zealand Disability Strategy** and the **Disability Action Plan**.

8. Disability community

- The people in the disability community can give their ideas on what should go in the **Disability Action Plan**.

9. All New Zealand people

- All New Zealand people can do things to make it easier for disabled people to take part and have good lives
- All New Zealand people can support the **New Zealand Disability Strategy**.

10. Councils and Local Groups

- All **Councils** and **Local Groups** can do things to support the **New Zealand Disability Strategy**.

11. Private businesses

- All private businesses can do things to make sure disabled people are:
  - able to take part
  - treated fairly
  - treated in a good way.

12. Other Organisations

- Other organisations that are not part of the Government can do things to make sure disabled people are:
  - able to take part
  - treated fairly
  - treated in a good way.

This information has been translated into Easy Read

by People First New Zealand Inc. Ngā Tāngata Tuatahi

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
3. Confirmation of Confidential Minutes 13 July 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]