133 Molesworth St
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

[redacted]

Response to your request for official information

I refer to your request of 19 December 2018 under the Official Information Act 1982 (the Act) relating to Māori disability data.

A copy of your request in full and the information relating to your request is itemised in Appendix One to this letter.

I trust this information fulfils your request. You have the right, under section 28 of the Act, to ask the Ombudsman to review any of the decisions made relating to this request.

Please note that this letter, with your personal details removed, and attachments may be published on the Ministry of Health website.

Yours sincerely

Mathew Parr
Acting Deputy-Director General
Disability

OIA Request on Wai 2575 Māori Disability Research – Ministry of Health response to Waitangi Tribunal Researchers on 8 Feb 19

The Ministry of Health (the Ministry) seeks to improve, promote and protect the health and wellbeing of New Zealanders through its leadership of New Zealand's health and disability system, advising the Minister of Health, and government, on health and disability issues. As the health system steward the Ministry is responsible for responding and participating in the Waitangi Tribunal kaupapa inquiry on health services and outcomes – Wai 2575. While this inquiry is driven by a number of claims, the outcome of understanding more and delivering better and more effective services for Māori is very important.

Māori health is a priority for the Government and the Ministry. Improving Māori health outcomes and addressing long standing inequities is a responsibility for everyone, in the Ministry and across sectors. This requires focussed effort and leadership. The Ministry provides collective leadership to ensure it delivers on the Government's priorities and delivers better and more equitable health outcomes for New Zealanders. As part of this, all Ministry staff members have a responsibility for improving Māori health and driving increased equity of health outcomes.

A Deputy Director-General Māori Health has been appointed with an explicit focus on the Crown's Treaty obligations to protect and improve Māori health outcomes, by providing strategic advice and guidance on Māori health improvement in a collaborative and integrated manner across the Ministry and the sector.

A Deputy Director-General Disability role has also been established with responsibility for providing the oversight of 'end-to-end' activities and functions for the disability community, which includes the Māori disability community. This includes purchasing disability support services for people wi h a long-term physical, intellectual and/or sensory impairment that require ongoing Government support to enhance their health and wellbeing, as well as advising on disability policy and ensuring disabled people receive the health care services they need."

The Ministry's response follows the order of the Wai 2575 Māori Disability questions. Context is provided to assist the understanding of the response. Appendices are used to provide large spreadsheets, where required.

Question 1. What mechanisms does the organisation use to ensure disabled Māori are involved in its strategy, policy, implementation, service design, delivery, evaluation and monitoring? Please provide any terms of reference or supporting documents.

Response

There are mechanisms to allow Māori people with disabilities to be involved in its strategy, policy, implementation, service design, delivery, evaluation and monitoring across the Ministry's range of health and disability responsibilities. Each business unit determines how it involves Māori with disabilities, seeking advice from the Disability Directora e (see below).

The Ministry also has an 'achieving equity' programme because it is a priority for the government to deliver equitable health outcomes for all New Zealanders. The achieving equity programme focuses on:

- building understanding through data, analytics and insights
- working with system partners
- enhancing innovation and trialling more responsive service models
- weaving an equity focus into the operational landscape.

The Disability Directorate is responsible for the Ministry's advice on disability issues and the disability system. Responsiveness to Māori with disabilities is embedded in all the Directorate's strategies and plans, including the Disability Support Services Strategic Plan 2014 to 2018, Whāia Te Ao Mārama, and service specifications. These documents are published on the Ministry's website.

The Directorate aims to have positive partnerships with its stakeholders, in particular with disabled people, their family/whānau, carers, and disability support providers, to support disabled people to have a good life and take part in their community in the same way other New Zealanders do.

The Directorate's key mechanisms for involving Māori disabled in disability policy, service planning and development are:

- Consumer Consortium - The consortium provides a link between the Ministry and the people who use the services funded. The Consortium meets 6-monthly, discussing a range of topics such as policy development, service quality and service gaps. Disabled people and/or family or whānau representatives make up the consortium. Membership includes two representatives from Māori disability organisations: Kāpō Māori / Ngāti Kāpō and Mana Turi o Aotearoa/ Tu Tāngata Turi o Aotearoa. There are Māori consortium members who are linked to non-kaupapa Māori organisations.
- Te Ao Mārama – Te Ao Mārama is a group of external advisors that supports the implementation of Whāia Te Ao Mārama: The Māori Disability Action Plan and provides advice to the Ministry on issues that affect Māori with disabilities (tāngata whaikaha Māori). The group includes tāngata whaikaha Māori, whānau of tāngata whaikaha Māori, Māori that work within the disability sector and exper s on Māori cultural matters. Te Ao Mārama Group is responsible for monitoring the implementation of Whāia Te Ao Mārama and providing advice to the Ministry on the effectiveness of the plan's implementation in improving the lives of tāngata whaikaha Māori and their whānau. The group meets at least three times a year. See also Question 4 below.
- Te Piringa – A Māori disability provider collective.
- Te Arero – A Māori NASC operations group.
- Targeted sector engagement – e.g Funded family care legislation and policy development.

In the Ministry's System Transformation/Mana Whaikaha project, one in five people who live in the MidCentral District Health Board (DHB) region identify as Māori and this was one of the drivers behind the decision to trial the prototype in this area. System Transformation/Mana Whaikaha has used a co-design approach in designing the prototype. Many of the co-design groups included members that identified as Māori. Some policy work was tested and consulted with groups, organisations or individuals that had Te Ao Māori and tikanga expertise such as Manawhenua Hauora, Te Ao Mārama, Te Roopu Taurima and Kāpō Māori Aotearoa.

Implementation	In the lead-up to the launch, Māori living with a disability have been involved in leadership and decision making groups in the design of the prototype, and are also now involved in the governance groups. For a transformed system to embed a kaupapa Māori approach, Māori must be visible and actively across the system transformation work. There are Kaitūhono/Connectors, allies for disabled people and their whānau, employed by Mana Whaikaha, who identify as Māori. As part of a four week induction process, Connectors received training in Te Tiriti ō Waitangi and developed a Treaty framework to underpin service delivery practice in Mana Whaikaha.
Service design	One of the focus areas for the design of the prototype was responsiveness to Māori, and it included the perspectives of disabled Māori people, in line with Whāia Te Ao Mārama 2018-2022: The Māori Disability Action Plan.

Service delivery	In the year prior to the launch, we conducted around 20 empathy interviews and observations to better understand the experiences and perspectives of tāngata whaikaha Māori and whānau whaikaha, and held a wānanga. During the wānanga, participants affirmed that a kaupapa Māori approach (i.e. a Māori way of doing things) can help tāngata whaikaha and whānau engage with disability support services. Participants emphasised that Māori values, concepts and practices should be fused within a transformed disability system in an authentic way, rather than attached as an afterthought or appendage.
Monitoring	There are multiple platforms where information, specific to individuals accessing the prototype, has been stored and maintained since 1 October 2018. These include: • Socrates • Client Relationship Management (CRM) system • Spreadsheets Information from spreadsheets and Socrates are being centralised into the CRM system which will allow for more effective data collection and accurate reporting going forward. The CRM has the potential to provide a more centralised system which will keep relevant and appropriate data of contacts and disabled people and their whānau participating in the prototype. The CRM includes functionality for people to access their own information held in the system. Teams in Mana Whaikaha continue to become familiar and comfortable with the potential that the system provides.
Evaluation	Further to the wānanga, a baseline study of the MidCentral disability sector was conducted which included: • System mapping of existing services • A survey of 170 disabled people, with 18% of respondents identifying as Māori • A survey of 152 whānau members, with 15% of respondents identifying as Māori • Surveys of provider organisations and support workers Māori were less satisfied with disability support services on a number of indicators, including: • respect for culture • their personal preferences for support • their views not being valued • not being valued for the support they provided

Question 2. For each of the Ministerial committees administered by the Ministry of Health:

- How many members are Māori?
- How many members are non-Māori?
- How many members are disabled Māori?
- How many members are disabled non-Māori?

Response

The spreadsheet in Appendix 1 provides breakdown for Māori and non-Māori members on Ministerial committees (including DHBs, non-DHB Crown Entities and professional regulatory boards) as at 31 December 2018 is listed in the attached table entitled *WAI 2575 Request – Proportion of Māori and non-Māori members on Ministerial Committees*. Please note that full ethnicity data is not available for all Boards and Committees, and this information has been listed in the table.

The Ministry does not hold information on the number of appointed members with disabilities as there are no specific reporting requirements for this information. This part of the request is therefore refused under section 18(e) of the Act as the information does not exist. There are occasions where a Ministerial Committee will require a member to provide a disability perspective, and these members will be recruited specifically for their skills.

In general, the Minister appoints or recommends a person who, in their opinion, has the appropriate knowledge, skills, and experience to assist the statutory entity or Committee to achieve its objectives and perform its functions. Ministers must also take into account the desirability of promoting diversity in the membership of statutory entities and Committees.

Explanatory note: 'Ministerial committees' are interpreted to be any committee where the Minister has a legislative or cabinet-directed (e.g. Hospital Rebuild Partnership Group) responsibility for appointments. The relevant sections of the Act where an appointment is made is highlighted in the table for reference. Committees appointed solely under a Terms of Reference have been excluded from the response.

Question 3. Does the Ministry of Health offer the Ministerial committees any training to build their skills and expertise in cultural safety / competence and in disability responsiveness? Please provide evidence of this.

Response

The Ministry provides training and induction material for Ministerial Committees and new appointees when appropriate. Members appointed to Ministerial Advisory Committees are selected on the basis of the skills they have acquired over their careers, and there is an expectation that all members are aware and responsive to the various cultural considerations required for Māori, as well as other community groups.

Question 4. Please provide a detailed implementation plan for Whāia Te Ao Marama (2018-2022).

Response

Whāia Te Ao Mārama, the Māori Disability Action Plan was published on 4 April 2018. It describes what the Ministry is committing to do from 2018 to 2022, and provides examples of actions that disability providers, other organisations, whānau and tāngata whaikaha Māori can take. Implementing this plan successfully requires the support of the whole health and disability sector and other organisations (eg, local government, iwi, hapū and marae) in order to achieve the vision of Whāia Te Ao Mārama – that tāngata whaikaha Māori pursue a good life with support. This action plan also provides useful information for health and disability providers, practitioners and organisations, who deliver support services to and for tāngata whaikaha Māori. Disability providers are encouraged to develop their own plans to support the achievement of the goals of Whāia Te Ao Mārama.

An implementation plan for Whāia Te Ao Mārama to 30 June 2019 was developed by Disability Support Services and is attached as Appendix 2. An updated implementation plan for 1 July 2019 to 30 June 2020 will be developed by 30 June 2019.

Question 5. Please provide details of participation by disabled Māori in the Ministry of Health-led Disability System Transformation.

Response

A prototype for the transformation started in the MidCentral District Health Board's area[1] from October 2018. This prototype is called Mana Whaikaha. Key features of the prototype are that disabled children, disabled young people and disabled adults and their families/whānau are welcomed into the system in multiple ways, having access to a Connector[2] to walk alongside disabled people and family/whānau. Information and processes will be accessible to meet the diverse needs of the community.

The Prototype has multiple platforms where information on individuals accessing services has been stored and maintained since 1 October 2018.

A. System Transformation client uptake data from Socrates (as of 24/01/18)

The following table presents the total number of individuals in the uptake, sourced from Socrates (the national database of clients accessing Ministry funded disability support services). It breaks down this total number of people into two groups: Individuals identifying as Māori, and individuals identifying as another ethnicity (this does not include those identifying as both Māori and other).

Total individuals in uptake	Total individuals Identifying as Māori	Total individuals identifying as another ethnicity
1,736	311	1,425

B. On 24 January 2018, System Transformation/Mana Whaikaha client uptake data from the Client Relationship Management (CRM) system indicates that 57 people identify as Māori, making up around 15% of total individuals allocated to a connector/kaitūhono. It is important to note that the information from the CRM is not yet fully up to date. Therefore, the information provided may not be a true account of the total number of people, including those identifying as Māori, who are currently allocated to a connector/kaitūhono.

Question 6. Please provide details of participation by disabled Māori in the development of the Transforming Respite: Disability Support Services Respite Strategy 2017-2022 and its associated action plan.

Response

The Transforming Respite Strategy sets the future direction for improving disability respite support. Changes to the respite model will include:

- offering disabled people and their families/whānau a flexible respite budget that they can use to take breaks in the ways that suit them best
- increasing the range of quality respite options available – this includes the development of new and expanded respite services
- recognising the value of respite and taking a lifelong approach to allocation and funding
- making the administration and payment methods easier
- providing better access to information about respite and support to find and use the respite options available.

Initial engagement with stakeholders during strategy development was through an online survey, which resulted in 1,268 responses, 14% of which were from people identifying as Māori. Interpretation of the survey results was discussed with Te Ao Mārama, who were also involved in presentations and workshops several times during strategy development. Māori providers were consulted, and Māori people attended sector workshops throughout country and made written submissions on the draft strategy. Te Ao Mārama continue to be involved with implementation of the strategy.

Question 7. Please provide details of participation by disabled Māori in the development of Where I Live, How I Live: Disability Support Services Community Residential Support Services Strategy 2018-2020 and its associated action plan.

Response

Where I Live; How I Live is about optimising the independence and self-determination of disabled people. It is in line with the Enabling Good Lives (EGL) principles that support people with a disability to make decisions about the kind of life they want.

This strategy guides the Ministry's Disability Support Services, disabled people and their families/whānau, and residential service providers, in achieving the following outcomes:

- greater choice, control and flexibility over where and how disabled people live
- access to information and support to enable well-considered choices about where and how disabled people choose to live and receive support
- increasing independence and choice fostered by service providers.

Disability Support Services consulted with Te Ao Marama on the development of the strategy and associated plan. The Community Living Team Manager also met face to face with the group, delivering a presentation on the plan on which they were asked to provide feedback. These responses were incorporated into the plan. Further workshops were held, which included Māori disabled people, family and whānau, and providers of residential services.

Question 8. Please provide details of participation by disabled Māori in the Office of the Director of Mental Health-led Action 9(d) of the Disability Action Plan 2014-2018.

[1] The New Zealand Public Health and Disability Act 2000 created District Health Boards. District Health Boards are responsible for providing or funding the provision of health services in their geographical district. There are currently 20 District Health Boards in New Zealand. Available at: www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards

[2] Connectors/Kaitūhono are the people in the transformed system who can walk alongside disabled people and family/whānau if they choose, to help them identify what they want in their lives, how to build their life, and the range of supports available to live their life

Response

The Ministry worked in partnership with Balance Aotearoa (Balance), which is one of seven Disabled People's Organisations mandated to work with Government on the Disability Action Plan, to complete Action 9(d) of the Disability Action Plan 2014-2018. Together the Ministry and Balance convened a stakeholder reference group which included representation of Māori consumer and service provider perspectives (the reference group members are listed in Appendix 1 of the document '*Submissions on the Mental Health Act and Human Rights discussion document – An analysis*', available on the Ministry's website).

With this reference group a discussion document was produced and provided to targeted stakeholders for comment, an easy read version was made available as well. A targeted, rather than public, consultation was used as the Ministry and Balance were particularly interested in hearing the experiences and perspectives of people who have been treated under the Mental Health Act, family/whānau and those who apply or monitor the Act. The targeted stakeholders included:

- NGOs representing people who are and who have been subject to the Mental Health Act (tāngata whaiora/service users)
- NGOs representing family/whānau of the above
- clinicians and services who treat service users under the Mental Health Act, including district health boards (DHBs) and NGOs
- academics, researchers and opinion leaders working in the field of mental health law, mental health practice and Māori mental health
- mental health professional associations
- agencies involved in administering or monitoring the Mental Health Act or with an interest in the issues, including the Ministry of Justice, the Office of the Ombudsman, the Human Rights Commission, the Health and Disability Commissioner and the Mental Health Foundation.

A number of these organisations circulated the document to their networks and the Ministry received submissions via that process, including from individual tāngata whaiora/service users and family/whānau.

In total, the Ministry received 67 submissions. Of those, there were 40 individuals and 27 groups; 33 of the 67 were from tāngata whaiora/service users/families/whānau (both ind viduals and organisations). The remainder were from a range of professional associations, academics/researchers, clinicians, DHBs/service providers, central Government agencies and quasi-Government organisations including the Office of the Ombudsman, the Health & Disability Commissioner and he Human Rights Commission.

The thematic analysis of the submissions indicated a strong Māori voice was represented through the process. A summary of the thematic analysis of the submissions which includes the list of reference group members, as well as the both the standard and easy read version of the discussion document are publicly available online at: ht ps://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment.

Question 9. Please provide details of participation by disabled Māori in the Ministry of Health led Action 9(c) of the Disability Action Plan 2014-2018 "Increase access to health services and improve health outcomes for disabled people with a specific focus on people with learning/intellectual disabilities".

Response

The Ministry uses the term learning/intellectual disability to recognise the diversity of this population. Eligibility for Ministry funded Disability Support Services (DSS) on the basis of an intellectual disability requires a cognitive assessment (generally an IQ test score of under 70) and decreased adaptive functioning in the areas of conceptual skills, social skills and practical skills. The term 'learning disability' refers to the wider, self-identified, population who experience barriers similar to those with an intellectual disability but do not meet all requirements for an eligible diagnosis.

The New Zealand Disability Survey 2013 found that approximately 89,000 people se f-identified as having an intellectual impairment (about two percent of the total population) and 212,000 had a learning impairment.

In August 2018, there were 17,961 people receiving Ministry funded Disability Support Services (DSS) who had an intellectual disability as their principal disability. Of the 6,465 Māori clients receiving DSS, approximately 56.4 % had a primary disability of intellectual disability.

The Action 9(c) project aims to improve health outcomes of people with learning / intellectual disability.

- The Project Reference Group (established in 2015 and consists of clinicians, service providers and consumers) provided a high level oversight and recommendations on pieces of work taking into account the entire population of people w th a learning/intellectual disability, with the vision that when specific pieces of work (such as the five year action plan) were being advanced they would ensure Māori disabled people were consulted with. The five year action plan has not been advanced, the Ministry is currently seeking gu dance from the Minister on whether to advance this work.
- Other recommendations from the Project Reference Group were focussed on overcoming systemic barr ers faced by both Māori and non-Māori such as navigating the health system, and ensuring appropriate data is collected.

In the new Disability Action Plan 2019-2022 the Ministry is recommending that action 9(c) be re-scoped for inclusion in the plan, it is recognised that if this action is to be included in the new plan it needs much more defined outcome and measures will be taken to ensure the participation of disabled Māori.

Question 10. What guidance does the Ministry of Health provide DHBs and other health sector crown entities about involving disabled Māori in decision-making processes?

Response

DHB accountability arrangements reflect expectations that in the service planning process DHBs use a framework for the consultation of different groups and communities, such as Māori and people with a disability and NGOs representing service users and communities, that is consistent with Kia Tūtahi, Standing Together: The Relationship Accord between the Communities of Aotearoa New Zealand and the Government of New Zealand signed in August 2011. The Ministry provides DHBs with planning guidance that reinforces that DHB obligations as Treaty partners are specified in legislation, and planning guidance for DHBs includes tools to help with planning equity outcome actions.

Question 11. How does the Ministry of Health monitor DHBs' obligations to disabled Māori under the following? Please provide evidence:

- NZ Public Health and Disability Act 2000.
- NZ Health Strategy 2016.
- NZ Disability Strategy 2016-2026.
- He Korowai Oranga 2014.
- Whāia Te Ao Mārama 2012-17 and 2018-22.

Response

DHBs operate in a devolved funding environment where they are responsible for making decisions on the mix, level and quality of health and disability services and are responsible for ensuring services are delivered for their populations. DHB accountability arrangements require that DHBs meet legislative requirements and respond to key national strategies. This includes:

- The New Zealand Health Strategy sets the platform for the Government's action on health, focusing in particular on tackling inequalities of health.
- The New Zealand Disability Strategy provides a framework to change New Zealand from a disabling to an inclusive society.

DHB accountability arrangements also require that DHBs ensure priority for access is granted on the basis of need, ability to benefit and/or an improved opportunity for independence for those with a disability and that the responsible funder will, where appropriate, target delivery of services to those groups with poor health status and those who are most likely to benefit.

The Ministry monitors a set of key marker measures of DHB performance. The measures included within the DHB non-financial monitoring framework are those where formal performance expectations are agreed with DHBs in their annual plans. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. For example, the Ministry has been monitoring the number of Māori subject to community treatment orders (CTOs) under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). This action recognises that Māori are significantly over-represented in populations treated under the Mental Health Act and there is variation a ound the country regarding the disparity between Māori and non-Māori subject to CTOs.

Question 12. How does the Ministry of Health monitor DHB compliance with the Operational Policy Framework 2018/19 with respect to disabled Māori (especially with regard to Sections 3.9-3.13)? Please provide evidence.

Response

The Operational Policy Framework is a set of business rules and guidelines for DHBs that they are not routinely monitored against, including sections 3.9 to 3.13. In recent years ach eving equity and improving Māori health have been included as government planning priorities. DHBs are routinely monitored against Government priorities and the Ministry's strategic work programme.

The Ministry provides DHBs with a planning package, including planning guidance and supplementary information, which is emailed to DHBs and published on the Nationwide Service Framework website. DHBs also receive the Minister's letter of expectations setting out his priorities for the year. Annual planning guidance reinforces that DHB obligations as a Treaty partner are specified in legislation and planning guidance for DHBs includes tools to help with planning equity outcome actions For 2019/20 Engagement and obligations as a Treaty partner is one of the planning priority areas for DHB annual plans.

DHBs are required to include equity actions in their annual plans for each of the planning priority areas and the Ministry monitors delivery of these actions through its quarterly reporting processes. All measures included in the DHB monitoring framework are reported and monitored by ethnicity where data allows.

Further monitoring may occur where an emerging system performance concern is raised through the Ministry's senior leadership team. For example in recent quarters DHBs have been requested to report on a range of emerging issues not embedded in routine reporting requirements, including:

- how DHBs are addressing the rising number of syphilis cases
- the processes DHBs have in place for providing access to and maintaining Positive Airway Pressure CPAP machines
- DHB self-assessment of worker safety initiatives
- progress updates on DHB implementation of Te Ara Whakapiri: Principles and guidance for the last days of life.

Question 13. How does the Ministry of Health monitor DHB compliance with the following requirements?

- Accessibility of DHB buildings and facilities under NZS4121:2001.
- Accurate ethnicity data recording and reporting under the Ministry of Health HISO 10001:2017 Ethnicity Data Protocols.
- Accessibility of public consultation for disabled Māori (e.g, Ministry of Health Guide to Community Engagement with People with Disabilities 2017).
- Implementation of NZ Web accessibility standard 1.0.
- Implementation of NZ Web usability standard 1.2.
- Compliance with the Code of Health and Disability Services Consumers' Rights, particularly, Right 4 and Right 5.

Response

The Ministry of Health does not monitor DHB compliance regarding building accessibility, ethnicity data collection, public engagement, web accessibility or the Code of Rights. This part of the request is therefore refused under section 18(e) of the Act as the information does not exist.

DHB disability focus: Disability Support Services has been a DHB annual planning priority since 2017/18. DHBs have identified actions to deliver on the priority areas and delivery of agreed actions has been monitored by the Ministry. For example in their 2017/18 plans, DHBs were expected to identify the mechanisms and processes they currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). In the 2019/20 disability support services planning guidance, the focus on equity has been strengthened and DHBs are required to include actions to improve equity for Māori and/or Pacific people.

Ethnicity data collection: The Ministry's role is to provide the sector with guidance on the high-quality ethnicity data that will assist the Government to track health trends by ethnicity and effectively monitor its performance to improve health outcomes and achieve health equity. It also provides Māori with quality information about their health status. In 2017, the Ministry updated the *Ethnicity Data Protocols for the Health and Disability Sector.* These protocols describe procedures for the standardised collection, recording and output of ethnicity data for the New Zealand health and disability sector (see https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols).

Public consultation: The New Zealand Public Health and Disability Act 2000 (the NZPHD Act) and its regulations, for example, impose a number of consultation requirements on DHBs. For example, a DHB must consult with the public when preparing a regional service plan or an annual plan if the Minister of Health considers that DHBs are proposing changes to services that will have a significant impact on recipients of services, their caregivers or providers.[3]

- The Ministry has previously developed public consultation guidelines to assist DHBs consult with the public, including consumers and providers (2002, 2011).
- In 2017, the Ministry developed a *Guide to Community Engagement with People with Disabilities* to assist agencies to engage with people with disabilities; available on line at (see https://www.health.govt.nz/publication/guide-community-engagement-people-disabilities). There is no requirement for any agency to use this resource. The guide focuses on engaging with people with learning/intellectual, physical and/or sensory disabilities. However, much of its advice can also be applied to work with people who experience mental health conditions. The guide

[3] Regulations 7 and 9 of the New Zealand Public Health and Disability (Planning) Regulations 2011.

recognises that disabled people are members of many groups and may identify more immediately with one of these groups. There is a section on engagement with Māori.
- For 2019/20 Engagement and obligations as a Treaty partner is one of the planning priority areas for DHB annual plans.

Web accessibility and usability: All Public Service departments and Non-Public Service departments in the State Services must meet the New Zealand Government Web Accessibility Standard 1.0 and Web Usability Standard 1.2. DHBs are not Public Service departments or Non-Public Service departments, but are Crown Entities. DHBs are encouraged to meet the standards but because they are not mandated to meet the standard, the Ministry of Health does not monitor this.

Code of Rights: Consumers' rights are protected by the Code of Health and Disability Services Consumers' Rights when using health and disability services. The Health and Disability Commission is a "consumer watchdog" that provides health and disability services consumers with a voice, resolving complaints, and holds providers (including DHB funded providers) to account for improving their practices at an individual and system-wide level – see https://www.hdc.org.nz/about-us/.

Question 14. How much did the Ministry of Health spend, per year, for the past five years, on "contractors and consultants", "staff" and "training and development" broken down by:

- Māori.
- Non-Māori.
- Disabled Māori
- Disabled non-Māori.

Response

Expenditure on contractors, consultants and other

The total spend on contractors, consultants and providers of professional services for 2018, and the past four financial years is listed in the table below (Source: https://www.parliament.nz/en/pb/sc/submissions-and-advice/document/52SCHE_EVI_80830_5069/ministry-of-health-response-to-2017-18-written-questions)

Excluded from the list are IT contractors and consultants and temporary replacement of staff during short-term absences. The Ministry is not able to provide details on the ethnicity as our systems do not routinely capture this information. This part of the request is therefore refused under section 18(e) of the Act as the information does not exist

Year	Number of contractors and consultants	Amount
2017/18	160	$24,106,910
2016/17	137	$17,850,066
2015/16	115	$12,138,445
2014/15	178	$12,121,380
2013/14	178	$12,527,182

Expenditure on staff training and development

The Ministry spent $1.022 million in 2017/18. This represents .50% of the vote (Source: https://www.parliament.nz/en/pb/sc/submissions-and-advice/document/52SCHE_EVI_80830_5069/ministry-of-health-response-to-2017-18-written-questions).

Year	$000'	% of Vote
2017/18	1,022	0.50
2016/17	964	0.49
2015/16	895	0.46
2014/15	1,490	0.77
2013/14	1,517	0.79

Question 15. What training does the Ministry of Health offer staff to build their skills and expertise in cultural safety / competence and disability responsiveness? Please provide evidence.

Response

The Ministry has a 'Te Reo Māori and Tikanga' framework in place that outlines the different levels of Māori capability required at the Ministry. Mā te Rongo ki te Ora is part of the Ministry's playbook, which uses Māori concepts to support understanding and decision making when working collaboratively with Māori. Other cultural training available includes:

- Te Rito – online modules available to all staff on the Ministry's Learning Management System. This enables staff to learn about Te Ao Māori, tikanga, te reo Māori and Te Tiriti of Waitangi
- Te Reo Māori programme (pilot first run in August 2018). Courses to begin in March 2019. This programme is designed to focus on level 1 of the 'Te Reo Māori and Tikanga' framework (pronunciation, mihi, waiata, protocol)
- Orientation Day – visit to He Tohu (National Library) to help new employees understand the significance of the three tāonga that shape Aotearoa New Zealand

- Diversity and Inclusion Strategy (recently approved with 3 year action plan) - The behaviours “Values Diversity” and “Responsiveness to Māori” specifically support diversity and inclusion at the Ministry.

In development for 2019/20:

- Embedding of Te Reo Māori in all our key people initiatives (e.g. capability framework, culture strategy, wellbeing strategy, leadership development)
- Wellbeing strategy underpinned by Māori Health Model (Te Whare Tapa Whā)
- Cultural Celebrations including Mataraki and Te Wiki o Te Reo Māori
- Bilingual documentation.

The Ministry also provides a foundational cultural competency course, which people can do as part of our online training. The course is available to the public via www.learnonline.health.nz. As at January 2019, there were 11,894 active users across the health sector. Further, individual business units may undertake cultural competency and responsiveness training as required.

The Ministry does not currently provide any in-house Māori health policy courses, but individuals may be supported to undertake external study and short courses as part of their professional development.

There are Māori health equity tools available to support policy and advisory work. The Ministry is initiating an equity-focused work programme, and developed a report on the programme – see https://www.health.govt.nz/publication/achieving-equity-health-outcomes-highlights-selected-papers.

Question 16. What proportion of staff (by profession) have undergone 1) cultural safety / competence training, 2) disability responsiveness training, and 3) both cultural safety / competence and disability responsiveness training?

Response

In the Ministry:

- Te Rito e-learning modu es are available to all staff on the Ministry's Learning Management System. This enables staff to learn about Te Ao Māori and Te Tiriti of Waitangi
- Te Reo Māori programme. This programme is designed to focus on level 1 of the 'Te Reo Māori and Tikanga' framework (pronunciation, mihi, waiata, protocol)

The Ministry does not hold information on the number of staff who have completed cultural safety / competence or disability responsiveness training. This part of the request is therefore refused under section 18(f) of the Act as producing the information would require substantial collation.

The Disability Directorate has been active in supporting staff with cultural competency training. In 2016/17, a key objective in building DSS staff capability was for staff to complete cultural competency training: 90% of staff completed the foundation course (see https://www.health.govt.nz/news-media/news-items/cultural-competency-course-added- earnonline). Further cultural competency and Te Tiriti o Waitangi training is scheduled in 2019 to build on this foundation course.

Question 17. How do Ministry of Health policies align w th the UNCRPD, particularly with regard to the following articles:

- Article 12 (Equal recognition before the law).
- Article 17 (Right to bodily integrity)
- Article 19 (Live independently)
- Article 20 (Personal mobility)
- Article 21 (Access to information)
- Article 22 (Respect for privacy)

Response

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) sets out the obligations on States, including New Zealand, to promote, protect and ensure the rights of persons with disabilities. The Ministry recognises and promotes the need for disabled people to be treated equally with anyone else.

In New Zealand, the Disability Action Plan presents priorities set by the Ministerial Committee on Disability Issues for action that advance implementation of the UNCRPD and the New Zealand Disability Strategy (see https://www.odi.govt.nz/nz-disability-strategy/disability-action-plan/).

The Disability Directorate is responsible for the Ministry's advice on disability issues and the disability system. The UNCRPD is aligned to all the Directorate's strategies and plans, including the Disability Support Services Strategic Plan 2014 to 2018 and Whāia te Ao Mārama, and service specifications.

Article 12 Equal recognition before the law requires that States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. This includes supported decision making, which is a process of providing information, resources and tools needed to enable a person to make their own decisions.

The Ministry has been progressing work on supported decision making across the health and disability system, particularly in the mental health, disability and aged care sectors. The work will consider the needs of Māori disabled.

- The Ministry has supported the Office of Disability Issues' work on legal capacity issues for disabled people through Action 7(a) under the Disability Action Plan 2014-18. This action was focused on supported decision making.
- The mental health sector has considered supported decision making in the Disability Action Plan 2014-18 work that explored how the Mental Health Act 1992 relates to the New Zealand Bill of Rights Act 1990 and the Convention (see also the Ministry's response to Question 8).
- Requirements for advocacy and supported decision making have been added to the Ministry's current Funded Family Care Operational Policy (see https://www.health.govt.nz/system/files/documents/publications/funded-family-care-operational-policy-mar16.pdf
- Supported decision making is being trialled in the new disability system transformation project in the MidCentral DHB region (see also Ministry's response to Question 1 regarding System Transformation).

Article 17 Right to bodily integrity requires that every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others. Bodily integrity is about a person's body belonging to them and only them being able to decide and choose what happens to their body or how to use their body. All people have a right to bodily integrity, including disabled people. Not having capacity to make informed decisions and give consent does not void an individual's bodily integrity.

The Ministry has been progressing work under Action 7(b) of the Disability Action Plan 2014-2018, working with Disabled People's Organisations and disability sector groups to improve safeguards for disabled people against unconsented sterilisation, including consideration of legislative protective measures. In 2018, the Ministry held a hui with the project reference group, which included a representative from the Te Ao Mārama group.

Article 19 Living independently and being included in the community requires that States recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and support their full inclusion and participation in the community.

The Ministry supports people to live independently by funding of range of disability support services including (see Ministry Response to Question 7).

- Community residential services (assist disabled people to live in a supported community environment)
- Choices in community Living (an option for people to be supported in a different way instead of moving into community residential care)
- Supported living (helps disabled people to live independently by providing support in those areas of their life where help is needed)
- Home and community support (services to help disabled people live at home, including through household management and personal care)
- Funded family care (allows payment of people to care for resident family members assessed as having high or very high needs relating to disability, long term chronic health conditions, mental health and addiction and aged care needs)
- System Transformation (prototype in the MidCentral District Health Board's area based on the Enabling Good Lives approach, which supports disabled people, their families, whānau and aiga by offering greater choice and decision-making authority over the supports they receive)
- Equipment and modification services (cover equipment, housing modifications and vehicle purchase and modifications).

Article 20 Personal mobility requires that States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities.

The Ministry funds Environmental Support Services (Vision, Hearing and Equipment and Modification Services) which cater for approximately 75,000 people of all ages with long-term physical, intellectual, sensory and age-related impairments. This includes funding for housing modifications. Between 2013 and 2017, the Ministry funded 10,851 housing modifications, covering categories of Own Home, Private Rental and Social Housing.

Article 21 Freedom of expression and opinion, and access to information requires that State parties seek to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice.

The Ministry supports access to information through a range of measures:

- Websites comply with New Zealand Government's Web Standards to better ensure that the Government is providing usable, accessible information:
- Publications and downloads are accessible as HTML, PDFs and Word/Excel.
- High contrast versions are available, including a high contrast version of MOH's website.
- Some information is available in New Zealand Sign Language.
- Some information is provided in easy-to-read versions, such as information about community residential support services and a review on the way disability services are organised.
- All video content carries captions and is accompanied by a transcript.
- Ministry funded Disability Information Advisory Services provide information which is both accessible to and appropriate for the needs of disabled consumers and the public.

Planning priorities that DHBs are currently focused on with respect to disabled patients include:

- promotion of the use of the Health Passport which provides detailed information about a disabled patient, including how they like to be communicated with.
- introduction of e-learning modules for staff and clinicians to provide advice and information on what might be important to consider when interacting with a disabled patient.
- DHBs also offer translation services for people who need them (e.g. http://www.adhb.govt.nz/Sites-Services/interpreting.html, http://www.hawkesbay.health.nz/page/pageid/2145869744/Interpreting_Service).

Article 22 Respect for privacy requires States Parties shall protect the privacy of personal health and rehabilitation information of persons with disabilities on an equal basis with others.

The Ministry's data collection is governed by data protection and privacy legislation (see https://www.health.govt.nz/nz-health-statistics/access-and-use/data-protection-and-privacy). This includes compliance with the Privacy Act 1993 and the Health Information Privacy Code 1994. The *Health Information Governance Guidelines* provide good practice advice on the safe sharing of personal health information. It provides information on the policies and procedures that are to be implemented to ensure that any health provider who holds health information meets its obligations in terms of the Privacy Act 1993, the Health Information Privacy Code 1994 and other relevant legislation.

All of the Ministry's population databases (e.g. Socrates/ Disability, PRIMHD/ Mental health; and inteRAI/ over 65 population) that collect and hold information on disabled people adhere to these standards. '

Question 18. For the timeframe 1 January to 31 December 2017, across all inpatient services (including adult, forensic, intellectual disability and youth services), please provide information on the following seclusion indicators:

- People secluded per 100,000 population for Māori and non-Māori.
- People secluded per 100,000 population for disabled Māori and disabled non-Māori.
- Seclusion events per 100,000 population for Māori and non-Māori.
- Seclusion events per 100,000 population for disabled Māori and disabled non-Māori.

Response

Mental Health seclusion

The programme for the Integration of Mental Health Data (PRIMHD) is a national database of information collected by the Ministry to support policy formation, monitoring and research (see https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data).

The PRIMHD national data collection does not contain information about whether an individual is disabled. However, the UNCRPD defines the term disability to include mental illness. Seclusion in a mental health facility can only occur under the Mental Health Act, therefore anyone who is secluded could be considered as having a disability as per the CRPD.

Please see tables in the response to question 20 for 2017 seclusion data under the Mental Health Act. In 2017, Māori were 4.5 times more likely to be secluded in adult inpatient services than people from other ethnic groups. Of those secluded in adult inpatient services during 2017, 41 percent were

Māori[4]. Further statistics will on seclusion of Māori in comparison with non-Māori will be published in the Office of the Director of Mental Health and Addiction Services Annual Report 2017 in early 2019.

Guidelines on the use of seclusion under the Mental Health Act is available on the Ministry's website at: https://www.health.govt.nz/publication/seclusion-under-mental-health-compulsory-assessment-and-treatment-act-1992

In March 2018, the Health Quality and Safety Commission (HQSC) launched the *Zero Seclusion: towards eliminating seclusion by 2020* project in collaboration with Te Pou o te Whakaaro Nui and DHBs. The project is guided by the HQSC's Māori Advisory Group.

Intellectual Disability seclusion

Care recipients under the IDDCR Act 2003 can also be subject to seclusion on accordance with the MH(CAT) Act 1992 in hospital level services. Development work is underway on reporting seclusion of people by statute under ID(CC&R) Act. This is only available for the 2017 year as reported below.

Question 19. For the timeframe 1 January to 31 December 2017, please provide the following information for people defined as care recipients or special care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:
- Number of Māori and non-Māori secluded.
- Number of seclusion events for Māori and non-Māori.

Response

The following table shows the number of Māori and Non-Māori with intellectual disability who were secluded during 2017 under the provisions of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act).

Ethnicity	Number of People	Number of Seclusion Events
Māori	9	322
Non-Māori	19	187
Total	28	509

Use of seclusion under the ID(CC&R) Act 2003 can only occur in hospital level services and in reference to the guidelines issues under the Mental Health Act. Guidelines on the use of seclusion under the Mental Health Act is available on the Ministry's website at: https://www.health.govt.nz/publication/seclusion-under-mental-health-compulsory-assessment-and-treatment-act-1992. Māori are overrepresented under the ID(CC&R) Act with 37% of care recipients being identified as Māori at the end of 2017 and 48% of care recipients secluded identifying as Māori.

Question 20. Over the ten-year period from 2008 to 2017, please provide the following information per year:
- Number of Māori and non-Māori secluded.
- Number of disabled Māori and disabled non-Māori secluded.
- People secluded per 100,000 population for Māori and non-Māori.
- People secluded per 100,000 population for disabled Māori and disabled non-Māori.
- Seclusion events per 100,000 population for Māori and non-Māori.
- Seclusion events per 100,000 population for disabled Māori and disabled non-Māori.

Response

Mental Health seclusion

Please see data presented in the following tables, noting the information given in response to question 18.

Please note that the seclusion event data is more complex and time-consuming to produce. Therefore it was only possible to provide data from 2011 within the timeframe of this request, using existing data extracts. Therefore, part of the request is therefore refused under section 18(f) of the Act producing the information would require substantial collation.

[4] Data for 2017 is provisional and is due to be published in the Office of the Director of Mental Health and Addiction Services Annual Report 2017 in early 2019.

Table 1: People secluded under the Mental Health Act 2008 to 2017

		Total		Adult Services		Adult Forensic Services		Youth Forensic Services		Youth Services	
Year	Ethnicity	Number of clients secluded	People secluded per 100,000 population	Number of clients secluded	People secluded per 100,000	Number of clients secluded	People secluded per 100,000	Number of clients secluded	People secluded per 100,000 population	Number of clients secluded	People secluded per 100,000
2008	Maori	176	27	131	40	28	8	N/A	N/A	5	4.6
	Non-Maori	282	8	219	10	29	1	N/A	N/A	8	2.0
	Total	458	11	350	14	57	2	N/A	N/A	13	2.6
2009	Maori	421	64	297	89	77	21	N/A	N/A	18	16.4
	Non-Maori	684	19	554	25	72	3	N/A	N/A	11	2.8
	Total	1105	26	851	33	149	5	N/A	N/A	29	5.7
2010	Maori	411	62	304	90	58	16	N/A	N/A	22	20.2
	Non-Maori	730	20	595	27	68	2	N/A	N/A	13	3.3
	Total	1141	26	899	35	126	4	N/A	N/A	35	7.0
2011	Maori	434	65	338	99	62	17	N/A	N/A	14	13.1
	Non-Maori	630	17	510	23	67	2	N/A	N/A	10	2.6
	Total	1064	24	848	33	129	4	N/A	N/A	24	4.9
2012	Maori	436	65	310	90	66	17	N/A	N/A	25	23.6
	Non Maori	675	18	531	23	66	2	N/A	N/A	15	3.9
	Total	1111	25	841	32	132	4	N/A	N/A	40	8.2
2013	Maori	436	62	337	94	57	14	N/A	N/A	8	7.1
	Non-Maori	633	17	520	23	47	2	N/A	N/A	12	3.2
	Total	1069	24	857	33	104	3	N/A	N/A	20	4.0
2014	Maori	421	59	292	80	87	21	N/A	N/A	7	6.1
	Non-Maori	551	14	441	19	56	2	N/A	N/A	10	2.6
	Total	972	21	733	27	143	4	N/A	N/A	17	3.4
2015	Maori	465	64	350	94	69	17	N/A	N/A	8	6.9
	Non-Maori	541	14	421	18	62	2	N/A	N/A	7	1.8
	Total	1006	22	771	28	131	4	N/A	N/A	15	3.0
2016	Maori	442	59	350	92	58	14	2	1.7	8	6.8
	Non-Maori	534	13	434	18	43	1	1	0.3	7	1.9
	Total	976	21	784	28	101	3	3	0.6	15	3.0
2017	Maori	429	57	327	84	55	13	5	4.2	4	3.4
	Non-Maori	526	13	440	18	39	1	1	0.3	1	0.3
	Total	955	20	767	27	94	3	6	1.2	5	1.0

Source: PRIMHD 22/1/19

Note: figures in the above table do not match the Office of the Director of Menta Health Reports due to different extraction dates and the inclusion of manual data for some DHBs in the ODMH Reports. The 2017 Office of the Director of Mental Health Report also includes 8 ID clients (not reported to PRIMHD) and excludes one outlier client.

Note: a few clients appear twice in the above table as they are included in both a ult and adult forensic, or were seen by both youth and adult units.

Note: Youth Services defined as team codes 6764,7204,015472. Youth forensic defined as team code 015291, Adult services defined as clients not seen by teams 6764,7204,015472,015291 and excludes team type 05, Adult forensic defined as clients not seen by teams 6764,7204,015472 and team type is 05.

Table 2: Seclusion events under the Mental Health Act 2011 to 2017

		All Clients		Adults		Forensic		Youth	
Year	Ethnicity	Events	Events per 100,000	Events	Events per 100,000	Events	Events per 100,000	Events	Events per 100,000
2011	Maori	1,179	173.4	814	234.5	200	57.6	181	60.5
	Non-Maori	2,779	74.8	1,496	67	1,106	49.5	141	15.2
	Total	3,958	90	2,310	89.5	1,306	50.6	322	26.3
2012	Maori	1,139	165.5	681	193.6	232	66	192	63.8
	Non-Maori	2,827	75.7	1,559	69.7	1,017	45.5	217	23.6
	Total	3,966	89.6	2,240	86.5	1,249	48.3	409	33.5
2013	Maori	1,173	167.7	747	208.8	203	56.7	162	53.3
	Non-Maori	2,210	58.5	1,404	62.2	596	26.4	193	21
	Total	3,383	75.6	2,151	82.3	799	30.6	355	29
2014	Maori	1,066	149.2	609	166.3	248	67.7	155	50.3
	Non-Maori	2,007	52.3	1,219	53.1	574	25	194	21.1
	Total	3,073	67.5	1,828	68.7	822	30.9	349	28.4
2015	Maori	1,055	144.5	718	191.5	200	53.3	136	43.5
	Non-Maori	1,438	36.8	1,009	43.2	262	11.2	157	17
	Total	2,493	53.7	1,727	63.7	462	17.1	293	23.7
2016	Maori	982	131.7	583	151.9	288	75	105	33.1
	Non-Maori	1,198	30.2	807	34.1	164	6.9	202	21.8
	Total	2,180	46.2	1,390	50.5	452	16.4	307	24.7
2017	Maori	1,184	156.1	631	161.7	420	107.6	131	40.8
	Non-Maori	1,925	47.2	1,490	60.6	312	12.7	107	11.5
	Total	3,109	64.3	2,121	74.5	732	25.7	238	19
Notes:									
Source: MoH PRIMHD									
2011-2015 data ref: MHP1480 extracted August 2017									
2016 data ref: MHP1472 extracted July 2017									
2017 data ref: MHP1661 extracted August 2018									
Adult events are those with people 20-64 years old at the start of each year where the team type does not equal '05'									
Forensic events are those with people aged 20-64 at the start of each year with a team type code of 05 'forensic'									
Children events are those with people aged under 20 at the start of each year									
Events less than an hour apart have been joined together									
This reporting does not include manual data supplied by DHBs and may therefore differ from the Office of the Director of Mental Health Annual Report 2017									

Intellectual disability seclusion

Care recipients under the IDDCR Act 2003 can also be subject to seclusion. During this time period seclusion data for people subject to the ID(CC&R) Act was provided by DHBs as part of forensic mental health data. This was reported by unit or diagnosis rather than statute. Data for individuals with a disability is included in mental health data.

Question 21. How does the Ministry of Health monitor access to screening services for disabled Māori compared with disabled non-Māori? Please provide details of the monitoring framework used.

Response

While the Ministry's National Screening Unit monitors access to services (and outcomes) by ethnicity its programmes are currently unable to identify participants by their disability status. Screening service providers are, however, expected to consider the needs of participants with disabilities:

Breast Screen Aotearoa (BSA)

Further information is available on the website: https://www.nsu.govt.nz/health-professionals/breastscreen-aotearoa policies-and-standards)

Excerpts from *BSA National Policy and Quality Standards*:

1.2 Providers are required to have services which are "accessible to the eligible population, including women from culturally and linguistically diverse backgrounds and women with a disability, and especially tāngata whenua"

2.3.4 Specifically, during appointment making process women are asked if they have "an impairment, disability or special need/requirement that will need to be accommodated at the time of her screen, so that:

- interpreters and any other additional services required to assist a woman are organised prior to her attending
- disabled women are encouraged to attend a fixed site that is better equipped to provide access and additional time, and can accommodate carers"

National Cervical Screening Programme (NCSP)

Excerpts from *NCSP Policies and Standards Section 3: Cervical Screening Services*:

3.2.2 The sample taker and/or provider is responsive to cultural diversity and is committed to ongoing development of cultural competency.

- The sample taker and/or provider considers cultural preferences in the design and/or delivery of services.
- The sample taker reflects on their own practice and values the impact their practice has on health care in relation to the woman's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability (Nursing Council of New Zealand 2007)

3.2.14 Sample takers need to make every effort to accommodate women with special needs when performing cervical screening, including women living with disabilities.

END

OIA Request on Wai 2575 Māori Disability Research – Ministry of Health response to Waitangi Tribunal Researchers on 8 Feb 19

Appendix 1. Question 2. Breakdown of Māori and Non-Māori members on Ministerial Committees

WAI 2575 Request - Proportion of Māori and non-Māori members on Ministerial Committees					
Crown Entity/Board/Committee	**Māori Members**	**Non-Māori Members**	**Total Members (including Māori members)**	**Responsible Legislation**	**Notes**
Advisory Committee on Assisted Reproductive Technology	2	7	9	Section 32, Human Assisted Reproductive Technology Act	
Ethics Committee on Assisted Reproductive Technology	0	7	7	Secton 27, Human Assisted Reproductive Technology Act	Committee must have a minimum of two Māori members. These are currently under consideration by the Minister of Health.
Expert Advisory Committee on Drugs	0	9	9	Section 5AA Misuse of Drugs Act	Ethnicity data is not collected for this Committee
Auckland District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	
Bay of Plenty District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Canterbury District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	
Capital & Coast District Health Board	2	8	10	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Central Health and Disability Ethics Committee	1	5	6	Section 11, New Zealand Public Health and Disability Act	
Chiropractic Board	1	6	7	Section 120, Health Practitioners Competence Assurance Act	
National Cervical Screening Programme Review Committee	1	2	3	Section 112O, Health Act 1956	
Counties Manukau District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	
Dental Council of New Zealand	2	10	12	Section 120, Health Practitioners Competence Assurance Act	
Dieticians Board of New Zealand	1	8	9	Section 120, Health Practitioners Competence Assurance Act	Total membership includes a member with undisclosed ethnicity.
Hawke's Bay District Health Board	4	7	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Health and Disability Commissioner	0	4	4	Health and Disability Commissioner Act Crown Entities Act	
Health and Disability System Review Panel	0	7	7	Section 11, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Health Promotion Agency	2	5	7	New Zealand Public Health and Disability Act, Crown Entities Act	
Health Practitioners Disciplinary Tribunal	13	162	175	Section 87, Health Practitioners Competence Assurance Act	Total membership includes members with undisclosed ethnicity.
Health Quality and Safety Commission	2	6	8	New Zealand Public Health and Disability Act, Crown Entities Act	
Health Research Council of New Zealand	1	9	10	Health Research Council Act, Crown Entities Act	
Hospital Rebuild Partnership Group	0	4	4	Cabinet directive - CAB Min (12) 30/3A	
Hutt Valley District Health Board	1	9	10	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity. There is currently one Māori member vacancy.
Lakes District Health Board	3	8	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.

Medical Council of New Zealand	2	9	11	Section 120, Health Practitioners Competence Assurance Act	
Mental Health Review Tribunal	3	16	19	Section 101, Mental Health (Compulsory Assessment and Treatment) Act 1992	Total membership includes members with undisclosed ethnicity.
MidCentral District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Midwifery Council of New Zealand	1	7	8	Section 120, Health Practitioners Competence Assurance Act	
Medical Radiation Technologists Board	0	8	8	Section 120, Health Practitioners Competence Assurance Act	
Medical Sciences Council of New Zealand	0	8	8	Section 120, Health Practitioners Competence Assurance Act	Total membership includes members with undisclosed ethnicity.
National Kaitiaki Group	5	0	5	Health (Cervical Screening (Kaitiaki)) Regulations	
National Ethics Advisory Committee	3	6	9	Section 16, New Zealand Public Health and Disability Act	
Nelson Marlborough District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Northern A Health and Disability Ethics Committee	1	5	6	Section 11, New Zealand Public Health and Disability Act	
Northern B Health and Disability Ethics Committee	1	7	8	Section 11, New Zealand Public Health and Disability Act	
Northland District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Nursing Council of New Zealand	2	7	9	Section 120, Health Practitioners Competence Assurance Act	Total membership includes members with undisclosed ethnicity.
New Zealand Blood Service	1	6	7	New Zealand Public Health and Disability Act, Crown Entities Act	
Occupational Therapy Board of New Zealand	1	6	7	Section 120, Health Practitioners Competence Assurance Act	
Optometrists and Dispensing Opticians Board of New Zealand	0	8	8	Section 120, Health Practitioners Competence Assurance Act	
Osteopathic Council of New Zealand	1	8	9	Section 120, Health Practitioners Competence Assurance Act	
PHARMAC	1	4	5	New Zealand Public Health nd Disability Act, Crown Entities Act	
Pharmacy Council of New Zealand	1	6	7	Section 120, Health Practitioners Competence Assurance Act	
Physiotherapist Board of New Zealand	1	7	8	Section 120, Health Practitioners Competence Assurance Act	
Podiatrists Board of New Zealand	2	5	7	Section 120, Health Practitioners Competence Assurance Act	
Psychoactive Substances Expert Advisory Committee	0	6	6	Section 44, Psychoactive Substances Act	
Psychologist Board of New Zealand	2	6	8	Section 120, Health Practitioners Competence Assu ance Act	
Psychotherapists Board of New Zealand	0	6	6	Section 120, Health Practitioners Competence Assurance Act	
South Canterbury District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	
Southern District Health Board	0	3	3	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Southern Health and Disability Ethics Committee	1	5	6	Section 11, New Zealand Public Health and Disability Act	
Southern Partnership Group	0	5	5	Cabinet approval	

Tairāwhiti District Health Board	4	7	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Taranaki District Health Board	3	8	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Waikato District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Wairarapa District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Waitemata District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
West Coast Partnership Group	0	5	5	Cabinet approval	Total membership includes members with undisclosed ethnicity.
West Coast District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Whanganui District Health Board	2	9	11	Section 29, New Zealand Public Health and Disability Act	Total membership includes members with undisclosed ethnicity.
Medicines Adverse Reactions Committee	1	12	13	Section 8, Medicines Act	Total membership includes members with undisclosed ethnicity.
Medicines Assessment Advisory Committee	0	12	12	Section 8, Medicines Act	Total membership includes members with undisclosed ethnicity.
Medicines Classification Committee	0	6	6	Section 9, Medicines Act	Total membership includes members with undisclosed ethnicity.
Total:	**99**	**604**	**703**		

TE RANGATIRA: ARE INFORMED, CONSIDER OPTIONS AND MAKE DECISIONS FOR SELF. ARE ABLE TO TAKE RESPONSIBILITY FOR GUIDING OR LEADING OTHERS. (TE RANGATIRA, WHAKAMANA, MĀRAMATANGA, TINANA, WAIRUA, PŪKENGA, KAWENGA) **Goal 1: Participate in the development of health and disability services** Tāngata whaikaha[5] and their whānau are active contributors to and engaged participants in health and disability support service development, service delivery and monitoring disability service performance.				
Action 1.1: Actively involve tāngata whaikaha and whānau in co-designing, implementing, monitoring and evaluating the disability support system.				
Activities	**Deliverables**	**Monitoring**	**Owner**	**Timeframes**
1.1.1 Involve tāngata whaikaha and their whānau in the co-design of the disability system transformation.	1.1.1a Co-design a prototype for the transformation of the disability support system with tāngata whaikaha in mid-Central.	# of tāngata whaikaha time spent on the system transformation prototype in mid-Central by role	Programme Lead System Transformation	1 July 2018
	1.1.1b Adapt the prototype with the involvement of tāngata whaikaha and their whānau in other regions.	# of tāngata whaikaha time spent on adapting the prototype in other regions	Programme Lead System Transformation	30 June 2019
1.1.2 Involve Te Ao Mārama in the ongoing design, implementation, monitoring and evaluation of the disability support system.	1.1.2a Establish full membership of Te Ao Mārama[6] and confirm their commitment to Whāia Te Ao Mārama.	Full membership Terms of reference agreed	Senior Advisor Māori	1 April 2018
	1.1.2b Te Ao Mārama members are involved in the disability support system design, implementation, monitoring, evaluation and transfo mation.	# of times Te Ao Mārama involved in the design of the disability support system and system transformation	Programme Lead System Transformation DSS Service Managers	30 June 2019
	1.1.2c Te Ao Mārama functions well and provides valuable and timely feedback on disability support system matters.	Te Ao Mārama undertake to collectively provide advice with two weeks and feedback is fit for purpose.	Senior Advisor Māori	30 June 2019
1.1.3 Establish an informal virtual network of tāngata whaikaha, whānau and providers to be a sounding board for Disability Support Services on non-sensitive issues.	1.1.3a A new virtual network established for tāngata whaikaha whānau and providers.	New networks established # of tāngata whaikaha, whānau and providers on the network	Senior Advisor Māori	30 June 2019
	1.1.3b Disability Support Services use the informal virtual networks for feedback on the disability support system, moderated by the Senior Advisor Māori.	# times feedback sought by team	DSS Service Managers Programme Lead System Transformation	30 June 2019
	1.1.3c Feedback provided by the informal virtual networks on the design of the disabi ity support system and system transformation.	# and % of feedback received by team Feedback is fit for purpose	DSS Service Managers Programme Lead System Transformation	30 June 2019
1.1.4 Involve tāngata whaikaha in the planned review of community rehabilitation services.	1.1.4a Rehabilitation services that are more responsive to tāngata whaikaha in a proactive way.	Tāngata whaikaha involvement	Manager, Community Living	31 December 2018
Action 1.2: Work with DSS providers and district health boards to ensure they involve tāngata whaikaha in developing, delivering and monitoring services.				
1.2.1 Work with Tumu Whakarae[7] to promote Whāia Te Ao Mārama and the involvement of tāngata whaikaha in the development, delivery and monitoring of services.	1.2.1a Attend Tumu Whakarae meetings.	Tumu Whakarae meeting attended Whā a Te Ao Mārama promoted	Senior Advisor Māori	30 June 2019
	1.2.1b Opportunities identified to involve tāngata whaikaha in the development, delivery and monitoring of DHB services.	Opportunities identified and taken up by Tumu Whakarae	Senior Advisor Māori	30 June 2019
1.2.2 Leverage the involvement of tāngata whaikaha in the development, delivery and monitoring of services through provider outcome agreements and service specifications.	1.2.2a DSS provider services that are more responsive to tāngata whaikaha.	Tāngata whaikaha involvement	Manager, Community Living	31 December 2018
	1.2.2b Update the developmental evaluation / audit tools to reflect the vision and goals of Whāia Te Ao Mārama, so that future evaluations and audits check how well DSS providers involve tāngata whaikaha.	# and % of evaluation and audit tools updated	Manager Quality Team	30 June 2019

[5] Tāngata whaikaha in this document refers to 'Māori with disabilities'.
[6] Te Ao Mārama is the Māori Disability Advisory Group.
[7] Te Tumu Whakarae: National Reference Group of Māori Health Strategy Managers within District Health Boards.

TE RANGATIRA: ARE INFORMED, CONSIDER OPTIONS AND MAKE DECISIONS FOR SELF. ARE ABLE TO TAKE RESPONSIBILITY FOR GUIDING OR LEADING OTHERS.
(TE RANGATIRA, WHAKAMANA, MĀRAMATANGA, TINANA, WAIRUA, PŪKENGA, KAWENGA)
Goal 2: Have control over their disability support
Increase the number of tāngata whaikaha who have choice and control over what supports they have and where, when and how they are supported.

Activities	Deliverables	Monitoring	Owner	Timeframes
Action 2.1: Ensure that tāngata whaikaha can access self directed funding arrangements for their disability supports.				
2.1.1 Increase availability of self-directed funding options	2.1.1a Convert low budget respite into flexible respite budgets.	# people using low budget flexible respite Uptake by Māori is equitable with non-Māori	Manager, Family and Community	31 December 2018
	2.1.1b Increase availa ility of Choice in Community Living to tāngata whaikaha.	# tāngata whaikaha using low budget Choice in Community Living Uptake by Māori is equitable to Non-Māori.	Manager, Community Living	31 December 2018
2.1.2 Promote self-directed funding to tāngata whaikaha through Māori networks.	2.1.2a Use Māori networks, which includes whānau, hapū, iwi and marae, to raise awareness of self-directed funding to tāngata whaikaha.	Network established # of people on the network	Senior Advisor Māori	30 June 2019
	2.1.2b Self-directed funding information promoted through Māori networks.	Self-directed funding promoted	Manager, Family and Community	30 June 2019
2.1.3 Promote self-directed funding to tāngata whaikaha in hard to reach areas through new communication channels (e.g. social media).	2.1.3a Establish new communication channels to promote self-directed funding to tāngata whaikaha and whānau in hard to reach areas.	New communication channels established	Manager, Family and Community	30 June 2018
	2.1.3b Self-directed funding promoted to tāngata whaikaha and whānau through new communication channels.	Self-directed funding promoted through new communication channels	Manager, Family and Community	30 June 2019
Action 2.2: Ensure that tāngata whaikaha can access the disability supports they choose.				
2.2.1 Identify and minimise barriers to tāngata whaikaha accessing the disability supports they prefer.	2.2.1a Identify barriers to tāngata whaikaha in accessing the disability supports they prefer.	Stocktake report of all barriers identified	Senior Advisor Māori Programme Lead System Transformation	1 October 2018
	2.2.1b Implement actions to remove barriers to disability supports for tāngata whaikaha.	Actions implemented to remove barriers	DSS Service Managers Programme Lead System Transformation	30 June 2019
2.2.2 Ensure disability support information is accessible to tāngata whaikaha and fully explains the supports available to them.	2.2.2a Seek feedback from Te Ao Mārama, tāngata whaikaha and whānau on the quality of existing disability support information.	Feedback sought	Senior Advisor Māori	31 December 2018
	2.2.2b Update disability support information based on feedback from Te Ao Mārama, tāngata whaikaha and whānau.	Disability information updated and distributed	DSS Service Managers	By 30 June 2019

TE AO MĀORI: ARE ACTIVE IN WHĀNAU HAPŪ AND IWI INCLUDING HUI, TANGIHANGA, IWI DEVELOPMENT AND CELEBRATIONS. (WHĀNAU, HAPŪ, IWI, REO, TIKANGA) **Goal 3: Participate in Te Ao Māori** Tāngata whaikaha are active participants in thei whānau, hapū and iwi.				
3.1 Ensure that the disability support system suppor s tāngata whaikaha to maintain their connection to Te Ao Māori.				
Activities	**Deliverables**	**Monitoring**	**Owner**	**Timeframes**
3.1.1 Ensure that the transformed disability support system design enables tāngata whaikaha to access Te Ao Māori.	3.1.1a The transformed disability support system design demonstrates how tāngata whaikaha can access Te Ao Māori with fewer barriers.	# of supports that allow tāngata whaikaha to access Te Ao Māori	Programme Lead System Transformation	30 June 2019
3.1.2 Consistently implement cultural assessments for tāngata whaikaha in high and complex services.	3.1.2a Guidelines for cultural assessments for high and complex tāngata whaikaha reviewed, approved and published on the Ministry's website.	Cultural assessment guidelines published	Chief Advisor Disability	30 September 2018
	3.1.2b Tāngata whaikaha in high and complex services are monitored to ensure they are offered access to a cultural assessment.	# of tāngata whaikaha offered cultural assessments # of tāngata whaikaha that take up cultural assessment	Chief Advisor Disability	31 December 2018
3.1.3 Develop guidance, best practice examples, and training for Contract Relationship Managers to discuss with providers how they are connecting tāngata whaikaha to Te Ao Māori.	3.1.3a Guidance and training to assist Contract Relationship Managers to have discussions with providers to connect tāngata whaikaha to Te Ao Māori.	Guidance, best practice and training developed and delivered.	Manager, Community Living Senior Advisor Māori	31 December 2018
3.1.4 Update the developmental evaluation / audit tools so that future evaluations and audits check performance against outcome / RBA measures.	3.1.4a Improved evaluation and audit checks, which result in better outcomes for Māori.	# and % of evaluation and audit tools updated	Manager Quality Team	30 June 2019

TE AO HURIHURI: ARE ACTIVE IN COMMUNITY INCLUDING SOCIAL NETWORKS, EMPLOYMENT (OR EDUCATION) AND SERVICES (DISABILITY, HEALTH, COMMUNITY, GOVERNMENT) **Goal 4: Participate in their community** Tāngata whaikaha have greater opportunities for employment and engagement with their local community.				
4.1 Support tāngata whaikaha to access disability workforce training and development.				
Activities	**Deliverables**	**Monitoring**	**Owner**	**Timeframes**
4.1.1 Engage with Health Workforce New Zealand to increase tāngata whaikaha access to disability workforce development and training.	4.1.1a Improved access for tāngata whaikaha to disability workforce training and development.	# of tāngata whaikaha accessing workforce tra ning and development	Manager, Community Living	31 December 2018
	4.1.1b Improved workforce uptake of tāngata whaikaha Māori	# of tāngata whaikaha Māori in employment % of Māori employed is equitable with non-Māori	Manager, Community Living	30 June 2019
4.2 Collaborate with other government departments to recognise opportunities for tāngata whaikaha.				
4.2.1 Engage with other government departments to seek opportunities for tāngata whaikaha to engage with their local community.	4.2.1a Engage with the Office of Disability Issues to seek opportunities for tāngata whaikaha, including through the NZ Disability Strategy Action Plan and how we might contribute to that plan.	# of opportunities created	Senior Advisor Māori	30 June 2018
	4.2.1b Engage with Te Puni Kōkiri to seek opportunities for tāngata whaikaha through Whānau Ora.	# of opportunities created	Sen or Advisor Māori	30 June 2018

NGĀ TŪHONOHONO: CAN CONNECT BETWEEN TE AO MĀORI AND TE AO HURIHURI WHILE MAINTAINING THEIR MANA. KEY WAYS OF MAKING THIS HAPPEN THROUGHOUT LIFE INCLUDE EDUCATION, SUPPORT AND RESOURCES (EG. TRANSPORT). (MANAAKI, MAURI, MANA, TAPU, TŪMANAKO) **Goal 5: Receive disability support services that are responsive to Te Ao Māori** DSS are responsive to tāngata whaikaha, provide choice and tailoring of services and support tāngata whaikaha to maintain their connection to Te Ao Māori.				
5.1 Drive service improvements using data and evidence.				
Activities	**Deliverable**	**Monitoring**	**Owner**	**Timeframes**
5.1.1 Produce data on tāngata whaikaha for all Disability Support Services.	5.1.1a Data analysis that indicates how responsive disability support services are to Te Ao Māori.	Data analysis produced	Manager Disability Information and Advice	30 June 2018
	5.1.1b All DSS monitor ng reports include a Māori/tāngata whaikaha cut, which is monitored by Te Ao Mārama.	Māori data available in all DSS monitoring reports # Data presented Te Ao Mārama	Manager Disability Information and Advice	30 June 2018
	5.1.1c Develop a DSS baseline comparative statistical report on tāngata whaikaha and non-Māori with disabilities.	Report completed	Manager Disability Information and Advice	30 June 2018
5.1.2 Produce an evidence base report for Disability Support Services and the System Transformation programme to drive service improvements and quality.	5.1.2a An evidence report that drives service improvements so that tāngata whaikaha can maintain or enhance their connection to Te Ao Māori, and highlight areas of inequality and service improvement.	Report completed Service improvements identified	Manager Disability Information and Advice	31 October 2018
	5.1.2b Implement service improvements for tāngata whaikaha based on evidence.	# service improvements implemented	DSS Service Managers Programme Lead System Transformation	30 June 2019
	5.1.2c Update DSS complaints mechanism to incorporate he vision and goals of Whāia Te Ao Mārama, including ensuring tāngata whaikaha can complain if supports are not responsive to Te Ao Māori.	Complaints mechanism updated Report on number of complaints received relating to responsiveness to Te Ao Māori	Manager Quality Team	30 June 2018
5.2 With tāngata whaikaha, co-design new services that best support tāngata whaikaha to achieve a good life.				
5.2.1 Refer to 1.1.1, 1.1.2, 1.1.3	5.2.1a Refer to 1.1.1, 1.1.2, 1.1.3	5.2.1a Refer to 1.1.1, 1.1.2, 1.1.3	Programme Lead System Transformation	1 October 2018 30 June 2019
5.3 Grow Māori capacity and capability, including cultural competency, within the Ministry's Disability Support Services group.				
5.3.1 Develop and deliver a tāngata whaikaha cultural competency training module for Disability Support Services.	5.3.1a Include Māori as a key cultural competency for new Disability Support Services staff.	Competencies reviewed for all DSS job descriptions	DSS Service Managers	31 December 2018
	5.3.1b Cultural competency training provider selected and training material developed	Training selected Material developed	Senior Advisor Māori	30 June 2018
	5.3.1c Deliver cultural competency training to Disability Support Services staff	Training delivered	Senior Advisor Māori	31 December 2018
	5.3.1d Include cultural competency in staff performance development agreements	PDAs include cultural competencies	DSS Service Managers	30 September 2018
	5.3.1e Develop and implement a plan to grow Māori capacity across Disability Support Services	Plan agreed Plan implemented	Senior Advisor Māori	31 December 2018 30 June 2019

NGĀ TŪHONOHONO: CAN CONNECT BETWEEN TE AO MĀORI AND TE AO HURIHURI WHILE MAINTAINING THEIR MANA. KEY WAYS OF MAKING THIS HAPPEN THROUGHOUT LIFE INCLUDE EDUCATION, SUPPORT AND RESOURCES (EG. TRANSPORT). (MANAAKI, MAURI, MANA, TAPU, TŪMANAKO) **Goal 6: Have informed and responsive communities.** Iwi, hapū and whānau are informed about and responsive to disability and disability issues through training and education, training incentives and resources that tāngata whaikaha are involved in co-designing and leading.				
6.1 Work with tāngata whaikaha and Māori leaders to develop information about disability support services for Māori and disseminate through Māori community channels.				
Activities	**Deliverables**	**Monitoring**	**Owner**	**Timeframes**
6.1.1 Distribute disability resources to Māori networks.	6.1.1a Disabili y resources distributed to Māori networks through DIAS.	Resources distributed	Manager Service Access	30 June 2019
6.2 Support development of resources to build disability literacy in Māori communities.				
6.2.1 Develop disability resources specific to tāngata whaikaha in Te Reo Maori.	6.2.1a Appropriate resources produced into Te Reo Māori.	Resources produced in Te Reo Māori	Senior Advisor Māori Communications	30 June 2019
	6.2.1b Incorporate Te Reo Māori in English disability literatures.	English resources include Te Reo Māori phrases or words	Programme Lead System Transformation	30 June 2019