West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

27 July 2017

9.30am

Board Room, Corporate Office
Grey Base Hospital

AGENDA AND MEETING PAPERS

ALL INFORMATION CONTAINED IN THESE COMMITTEE PAPERS IS SUBJECT TO CHANGE

The functions of CPHAC & DSAC, in accordance with their Terms of Reference and the New Zealand Public Health and Disability Act 2000 are:

"With respect to Community and Public Health, is to provide advice and recommendations to the Board of the West Coast District Health Board on:

- *the health needs of the resident population of the West Coast District Health Board; and*
- *any factors that the Committee believes may adversely affect the health status of the resident population; and*
- *the priorities for the use of the health funding available.*

With respect to Disability Support, are to provide advice and recommendations to the Board of the West Coast District Health Board on:

- *the disability support needs of the resident population of the West Coast District Health Board; and*
- *the priorities for the use of the disability support funding provided.*"

The aim of the Committee's advice must be:

- *to ensure that the services that the West Coast District Health Board provides or funds, along with the policies it adopts, will maximize the overall health gain for the resident population of the West Coast District Health Board; and*

- *to ensure that the kind of disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, will promote the inclusion and participation in society, and maximise the independence, of people with disabilities within the resident population of the West Coast District Health Board."*

The Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy, the New Zealand Disability Strategy and with the Strategic Plan and the Disability

AGENDA

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room, Corporate Office, Greymouth Hospital
Thursday 27 July 2017 commencing at 9.30am

ADMINISTRATION — 9.30am

Karakia

Apologies

1. **Interest Register**
   Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.

2. **Confirmation of the Minutes of the Previous Meeting**
   8 June 2017

3. **Carried Forward/ Action Items**

REPORTS/PRESENTATIONS — 9.35am

4.	**Community and Public Health Update**	Derek Benfield *Community and Public Health West Coast Regional Manger*	*9.35am – 9.45am*
5.	**Planning & Funding Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.45am – 9.55am*
6.	**Alliance Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.55am – 10.05am*
7.	**Disability Support Services Respite Strategy 2017-2022**	Kathy O'Neill *Team Leader, Planning & Funding*	*10.05am – 10.15am*
8.	**General Business**	Elinor Stratford *Chair*	*10.15am – 10.20am*

ESTIMATED FINISH TIME — 10.20am

INFORMATION ITEMS

- **Board Agenda – 23 June 2017**
- **Chair's Report to last Board Meeting**
- **2017 Committee Work Plan (Working Document)**
- **West Coast DHB 2017 Meeting Schedule**

NEXT MEETING

Date of Next Meeting: Thursday 14 September 2017

KARAKIA

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

E Te Atua i runga rawa kia tau te rangimarie, te aroha,
ki a matou i tenei wa
Manaaki mai, awhina mai, ki te mahitahi matou, i roto,
i te wairua o kotahitanga, mo nga tangata e noho ana,
i roto i tenei rohe o Te Tai Poutini mai i Karamea tae noa atu ki Awarua.

That which is above all else let your peace and love descend
on us at this time so that we may work together
in the spirit of oneness on behalf of the people of the West Coast.

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' INTERESTS REGISTER

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE REGISTER OF MEMBERS' CONFLICTS/INTEREST

(As disclosed on appointment to the Board/Committee and updated from time-to time, as necessary)

Member	Disclosure of Interest
CHAIR Elinor Stratford **(Board Member)**	• Clinical Governance Committee, West Coast Primary Health Organisation • Committee Member, Active West Coast • Chairperson, West Coast Sub-branch - Canterbury Neonatal Trust • Trustee, Canterbury Neonatal Trust • Member, Arthritis New Zealand, Southern Regional Liaison Group • President of the New Zealand Federation of Disability Information Centres
Lynnette Beirne	• Patron of the West Coast Stroke Group Incorporated • Daughter employed as nurse for West Coast DHB • Chair of West Coast DHB Consumer Council • Consumer Representative on WCDHB Falls Coalition Committee • Consumer Representative on WCDHB Stroke Coalition Committee • Running a Homestay for DHB Students
Sarah Birchfield	• West Coast Autism Support Group – Volunteer and Support Person • West Coast Special Olympics Steering Committee – Member • Parkinsons New Zealand – West Coast Committee Member
Cheryl Brunton	• Medical Officer of Health for West Coast - employed by Community and Public Health, Canterbury District Health Board • Senior Lecturer in Public Health - Christchurch School of Medicine and Health Sciences (University of Otago) • Member - Public Health Association of New Zealand • Member - Association of Salaried Medical Specialists • Member - West Coast Primary Health Organisation Clinical Governance Committee • Member – National Influenza Specialist Group • Member, Alliance Leadership Team, West Coast Better Sooner More Convenient Implementation • Member – DISC Trust
Jenny McGill	• Husband employed by West Coast DHB • Peer Support – Mum4Mum • Information Consultant for West Coast Disability Resource Service
Joseph Mason	• Representative of Te Runanga o Kati Wae Wae Arahura • Employee Community and Public Health, Canterbury DHB

Mary Molloy	• Spokesperson for Farmers Against 1080 • Executive Member - Ban 1080 Political Party • Director, Molloy Farms South Westland Ltd • Trustee, L.B. & M.E. Molloy Family Trust • Executive Member, Wildlands Biodiversity Management Group Inc. • Chair of the West Coast Community Trust
Peter Neame	• White Wreath Action Against Suicide – Member & Research Officer • White Ribbon Ambassador for New Zealand
Francois Tumahai **(Deputy Chair)** (**Board Member)**	• Te Runanga o Ngati Waewae - Chair • Poutini Environmental - Director/Manager • Arahura Holdings Limited - Director • West Coast Regional Council Resource Management Committee - Member • Poutini Waiora Board - Co-Chair • Development West Coast – Trustee • West Coast Development Holdings Limited – Director • Putake West Coast – Director • Waewae Pounamu – General Manager • Westland Wilderness Trust - Chair • Wife, Lisa Tumahai, is Chair, Tatau Pounamu Advisory Group
Jenny Black **(ex-officio)**	• Nelson Marlborough District Health Board – Chair • Diabetes new Zealand – Life Member • South Island Alliance Board – Chair • National DHB Chairs - Chair
Chris Mackenzie **(ex-officio)**	• Development West Coast – Chief Executive • Horizontal Infrastructure Governance Group – Chair • Mainline Steam Trust - Trustee

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

DRAFT
MINUTES OF THE COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE held in the Board Room, Corporate Office, Grey Base Hospital on Thursday 8 June 2017 commencing at 9.30am

PRESENT
Elinor Stratford (Chairperson); Lynnette Beirne; Sarah Birchfield; Cheryl Brunton; Joe Mason; Jenny McGill; Peter Neame; Jenny Black

APOLOGIES
Apologies were received and accepted from Mary Molloy and Francois Tumahai.

EXECUTIVE SUPPORT
Philip Wheble (Interim General Manager, Grey/Westland); Gary Coghlan (General Manager, Maori Health); Kathy O'Neill (Planning & Funding)(via video conference); and Kay Jenkins (Minutes).

WELCOME
Joe Mason led the Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Peter Neame advised that he is the Author of a book: Suicide, Murder, Violence, Assessment & Prevention.

Declarations of Interest for Items on Today's Agenda
There were no interests declared for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. MINUTES OF THE PREVIOUS MEETING
Resolution (3/17)
(Moved: Lynnette Beirne; Seconded: Sarah Birchfield - carried)

"That the minutes of the meeting of the Community and Public Health and Disability Support Advisory Committee held on 27 April 2017 be confirmed as a true and correct record with the addition of a request for a breastfeeding chart in future papers"

3. CARRIED FORWARD/ACTION ITEMS

It was agreed to add breastfeeding chart to the carried forward items until it was included in the reporting.

The Carried Forward/Action Items were noted.

4. COMMUNITY & PUBLIC HEALTH UPDATE

Derek Benfield, Community & Public Health, presented this update on the following topics:

Smokefree May
CPH staff, as part of the West Coast Tobacco Free Coalition, have been raising awareness of Smokefree May and World Smokefree Day with a variety of activities including media articles and promotions at The Warehouse and Salvation Army in Greymouth, and on the main street of Westport. These promotions have included letting people know about the range of Stop Smoking services available on the West Coast.

Alcohol
Three West Coast CPH staff members attended the National Alcohol Public Health Workshop in Auckland in mid-May. This meeting covered both regulatory issues and health promotion. Topics included an update on the Ministerial Review on Alcohol Advertising and Sponsorship, using social media to address social supply of alcohol, and alcohol harm reduction projects in sports clubs. The meeting also discussed a recent decision by the Alcohol Regulatory and Licensing Authority (ARLA) in the matter of a Dannevirke supermarket single area. The ARLA decision has the effect of potentially undermining the work done to reduce exposure to alcohol in supermarkets, including recent High Court and Court of Appeal judgements. Whether or not this decision will be appealed is not yet known.

The Committee noted that in Greymouth CPH have worked with the two Supermarkets with positive results and no need for court action.

Food Security
CPH hosted a workshop on Food Security in Greymouth on 26 April. Attendees included individuals and organisations working with West Coasters who are struggling to provide sufficient nourishing food for themselves and their families. There was a very good response, with approximately thirty people in attendance. The purpose of the workshop was to start to build a picture of what food insecurity looks like on the West Coast, find out what activities are already taking place to address this, as well as highlighting any gaps and potential future actions. The discussion points and findings from the workshop are now being pulled together and a report is being compiled to assist in informing future actions.

Nutrition
CPH ran six cooking skills and nutrition sessions at Alternative Education, Greymouth. During the six week course it became apparent that the students' cooking skills and knowledge have developed and progressed, requiring a change in complexity of meals to continue their development. Alternative Education continues to be a very valuable setting to work in. The evaluations show that the students really enjoy cooking and are learning new things each session. In the last session, one student said that he really enjoyed learning to make his favourite dishes in different ways.

A resource "Nourishing Futures with better Kai" has been developed and will be provided to members at the next meeting.

Kaumātua Flu Vaccination Clinic
CPH, working alongside Westland Medical Centre, West Coast DHB and Poutini Waiora, facilitated a flu vaccination clinic for kaumātua at Arahura marae in April. Twelve kaumātua received their vaccinations, as well as learning more information about vaccinations available for all whanau members, including their mokopuna.

Health Promoting Schools (HPS)
A Community Partnerships meeting at South Westland Area School (SWAS) is scheduled to take place on 31 May 2017. The school has been working actively on establishing and developing

community partnerships over the past year. Those professionals working within the school and/or with students from SWAS have been invited and include Rural Nurse Specialist's, local Police, Resource Teacher, Learning and Behaviour (RTLB), WestREAP youth mentors, West Coast PHO Counsellor, and the HPS facilitator.

Le Va Community Suicide Prevention Workshop
The Le Va Flo Talanoa workshop was held in Runanga on 16 May. Sixteen people attended to learn about suicide prevention with a strong community action focus. This was work which developed from the Runanga leaflet that was produced last year with the Runanga Action Group, and the follow-up to the Regent Theatre event in September with Eroni Clarke and Quintin Pongia. Positive discussion and learning took place, work will continue with the Runanga community as required.

Submissions on Council Annual Plans
Over the last month CPH has made submissions regarding the Grey District Council and Buller District Council draft 2017/18 Annual Plans (Westland District Council did not consult this time around). Submissions covered a range of issues including smokefree outdoor spaces, water quality and other environmental issues. We are now working on a submission for the West Coast Regional Council (WCRC), which is due at the end of June. Amongst other things, the West Coast Regional Council is proposing a new organisational structure and staffing for Civil Defence and Emergency Management which will enhance capacity to plan for and respond to emergencies on the West Coast.

The report was noted.

5. PLANNING & FUNDING UPDATE

Kathy O'Neill, Team Leader, Planning & Funding, presented this update. The report provided the Committee with an update on progress made on the Minister of Health's Health and Disability priorities and the West Coast DHBs Annual Plan key priority areas as follows:

Key Achievements

- **ED Health Target:** Performance continues to be impressive with 100% of patients admitted, discharged or transferred from Grey Base ED within six hours during quarter three. The West Coast continues to lead the country in performance against this target.
- **Elective Services Health Target:** West Coast DHB has provided 1,441 elective surgical discharges to 31 March; delivering 105% of planned discharges against year-to-date target.
- **ESPI 2 |First Specialist Assessment (FSA):** West Coast DHB is now within tolerance parameters for meeting the maximum 120 days' national wait time target for ESPI 2, with just one orthopaedic patient overdue for FSA as at 31 March 2017. A concerted effort was made in March to get those patients who were overdue seen.
- **ESPI 5 | FSA to Treatment:** West Coast DHB was also within compliance tolerance levels for ESPI 5, with only three patients exceeding the 120-day maximum wait time for surgery as at the end of March 2017 (two orthopaedic patients and one plastic surgery patient).

Key Issues & Associated Remedies

- **Aged Residential Care Services:** Work is ongoing with Aged Residential Care Facility Granger House while the organisation is in receivership. The receiver has made a number of new appointments and West Coast DHB has added clinical oversight to support the safety of the residents.

The work taking place across the Older Persons Health team in relation to Granger House was acknowledged by the Committee.

Discussion took place regarding social isolation in regard to keeping people well in their own homes. The role of CCCN in the coordination of health services was also discussed and working with other organisations as much as possible is also a priority.

The Committee noted that in Buller when Kynnersley was closed the Diversional Therapist was reallocated to the community and she has done a lot of work around social isolation and the integration of people into local activities.

The report was noted.

6. HEALTH TARGETS – QUARTER 3

Kathy O'Neill, Team Leader, Planning & Funding also presented this report.

Ms O'Neill advised that in Quarter 3, the West Coast has:

- Achieved the shorter stays in ED health target, with 100% of people admitted or discharged within six hours. The West Coast continues to maintain consistent performance against this health target.
- Achieved the improved access to elective surgery health target, with 1,441 elective surgical discharges year-to-date, delivering 105.5% of planned discharges against target.
- Achieved the better help for smokers to quit health target, with practitioners giving 4,888 smokers cessation advice in the 18 months ending March 2017. This represents 92% of smokers against the 90% target.
- Improved performance against the faster cancer treatment health target with results lifting from 76.2% to 83.3% narrowly missing the target. This result reflects only four patients whose treatment was non-compliant with target. Audits into patient pathways have taken place with no capacity issues identified
- Improved performance against the increased immunisation health target, missing only one child during this quarter and reaching all Maori children. West Coast vaccinated 91.4% of the eligible population.
- Performance slightly increased against raising healthy kids health target to 17%. Four children were identified as obese and not referred. This issue has been discussed at a national level and we will be looking to improve database access.

Discussion took place regarding the Raising Healthy Kids target and the confusion around BMI readings. The Committee noted that this has been quite common nationally and there were also issues around declines of referrals.

The report was noted.

7. ALLIANCE UPDATE

Kathy O'Neill, Team Leader, Planning & Funding, also presented this update which provided an overview of progress made around the West Coast Alliance. The update covered: the Alliance Leadership Team; Health of Older Persons; Integrated Family Health Service Workstreams; Healthy West Coast; & Child and Youth.

Alliance Leadership Team (ALT)

At the last meeting in March the ALT:

- Were pleased to note the clarity in this year's work stream work plans and the work stream leads have been congratulated on this.

- Noted the good engagement with schools in the recent alcohol presentations by Nathan Wallis, "Alcohol and the Amazing Brain".
- Noted again the importance of the system enablers (workforce, settings, integrated information systems & transport) for delivery on the work plans.
- Endorsed both the draft Annual Plan and the draft System Level Measures framework Improvement Plan.

Health of Older Persons

- Work has commenced with Information Services Group to collect data on falls from Emergency Department events to begin identifying patients for the fracture liaison service.
- The work stream noted the closure of Kowhai Manor following MOH withdrawal of certification on failure of their recent audit.
- The work stream will be considering how the gap left by the closure of Kowhai Manor Aged Residential Care facility can be managed in a proactive and sustainable manner.

Integrated Family Health Service (IFHS) Work streams (Grey|Westland, Buller & Reefton)

- The patient portal is now live and will be tested with a select group of patients initially at Grey Medical.
- Development work is underway to create a primary urgent care service to provide greater access for communities to primary care. The service is being designed to ensure that it supports the primary practices in continuing to provide planned and proactive care to our communities.
- The Proposal for change for integrating the workforce at Reefton was approved and as at 1st July the team will be fully integrated

Healthy West Coast (HWC)

- Subject matter expert, Nathan Wallis visited the West Coast in February and spoke to all year 9-13 students from the seven secondary and area schools. There were also three community meetings about alcohol use and its impacts on brain development.
- Rachael Dixon from the Health Education Association (NZHEA) is visiting the Coast in April to run a workshop for secondary teachers on integrating alcohol education into the curriculum for year 9-11 students.

Child and Youth

- Initial discussions have taken place between the DHB Sexual Health service, Community & Public Health, PHO and school based health service (Public Health Nursing) regarding how to reorganise contraceptive advice and treatment in light of the closure of the Greymouth Family Planning clinic.

The report was noted.

8. MAORI HEALTH UPDATE

Gary Coghlan, General Manager, Maori Health, presented this report which was taken as read. Mr Coghlan advised the Committee that at year-end 2015/16 the result for Maori receiving breastmilk at 6 months was 63.2% which is 2% away from the 65% target. The comment was made that this is the first time in many years that this target has not been met. The report noted that West Coast DHB trendly data shows that from January to June 2016 Maori on the West Coast are leading

nationally with 75% of Maori babies being exclusively breastfed at 6 weeks, 62.5 at 3 months and 64.7% at the end of 6 months.

Discussion took place regarding Oral Health where a targeted focus within the West Coast DHB will see strategies focused on increasing the percentage of pre-school children receiving their annual dental check on time and a whole of system approach to reducing the rate of dental decay among our Tamariki. This will be through targeted intervention with families and health promotion and oral health education for all health professionals who come into contact with children from 0 – 5 years.

The Maori Health Update was noted.

9. GENERAL BUSINESS

- Philip Wheble, Interim General Manager, Grey/Westland, provided the Committee with an overview of work that is underway to develop options of targeted support and intervention for families where a child is identified as high needs in regard to their oral health. Work is also to take place around making the Oral Health a sustainable service. The Committee noted that some workshops will be held around this and an invitation will be extended to some Committee members to attend.

- The Chair advised that on 29 May the 70th World Health Assembly was held in Geneva. The link to the agenda is shown below for those interested.
  http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_1Rev2-en.pdf?ua=1
  Of particular note was that the Assembly endorsed a global action plan around dementia.

INFORMATION ITEMS

- Board Agenda – 24 March 2017
- Chair's Report to last Board meeting
- 2017 Committee Workplan
- West Coast DHB 2017 Meeting Schedule
- Community & Public Health 6 Monthly Report to the Ministry of Health

There being no further business the meeting concluded at 10.20am.

Confirmed as a true and correct record:

_____ _____

Elinor Stratford, Chair Date

CARRIED FORWARD/ACTION ITEMS

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE CARRIED FORWARD/ACTION ITEMS AS AT 27 JULY 2017

	DATE RAISED/ LAST UPDATED	ACTION	COMMENTARY	STATUS
1.	8 June 2017	Water Quality	On-going updates to be provided to the Committee	As required
2.	8 June 2017	Breastfeeding chart to be included in reporting	To remain on carried forward until reporting developed.	In progress

UPCOMING PRESENTATIONS

TOPIC	STATUS
Consumer Council	October 2017
Drinking Water Systems and Protection	September 2017
Outcomes around Alcohol Project	Late 2017

COMMUNITY AND PUBLIC HEALTH UPDATE

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Community and Public Health & Disability Support Advisory Committee

SOURCE: **Community and Public Health**

DATE: **27 July 2017**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing information regarding the work of Community and Public Health on the West Coast.

2. RECOMMENDATION

That the Community and Public Health & Disability Support Advisory Committee
i notes the Community and Public Health Update

3. SUMMARY

The purpose of this report is to provide the Committee with information and highlights of Community and Public Health's work.

4. APPENDICES

Appendix 1: Community and Public Health Update

Report prepared by: Claire Robertson – West Coast Team Leader and
Dr Cheryl Brunton, Public Health Specialist
Community and Public Health

Report approved for release by: Derek Benfield, Regional Manager, Community and Public Health

REPORT to CPHAC/DSAC
COMMUNITY AND PUBLIC HEALTH (CPH)

July 2017

Smokefree – Little Lungs
Staff from CPH and the West Coast Primary Health Organisation have recently begun a roll out of the Little Lungs – Pūkahukahu Iti programme to West Coast early childhood centres. Little Lungs is a smokefree initiative to support smokefree homes and cars. A workshop was held recently with twelve staff from the Active Explorers Shakespeare Street, Active Explorers Nelson Street and Learning Adventures Cobden (formerly Scenicland Preschools). Early childhood centres are provided with resources and support to help them have those tricky conversations with parents and whānau to encourage them not to smoke around their children> The aim of the project is to reduce the health effects of second hand smoke on children's developing lungs.

Oranga Hā – Tai Poutini (Stop Smoking Service)
The Ministry of Health recently released national results from quarter 3 (January – March 2017) for the new Stop Smoking Services. For the West Coast service, Oranga Hā – Tai Poutini, this was the first quarter that the service was fully staffed with 3x 0.6FTE practitioners. Oranga Hā had some pleasing results for this quarter including; 6.2% of people who smoke enrolled in the service (target 5%) for this quarter, 35% enrolled were Māori, 41% were quit 4-weeks after their target quit date, with a quit rate of 57% for Māori (target 50%). These targets are challenging to achieve and the service will be continuing to work hard and explore new strategies to maintain this level of performance.

Alcohol Licensing
CPH's Alcohol Licensing Officer (ALO) and the West Coast Police Prevention Manager are having regular discussions with the three District Licensing Inspectors in respect to alcohol licence applications in their respective areas. As the Licence Controller Qualification (LCQ) course at Tai Poutini Polytechnic has now changed from two days in the classroom to one day, the ALO has spoken to the LCQ facilitator and has been allocated time to address students. The ALO has conducted licence premises monitoring visits of Grey District premises with the West Coast Police Prevention Manager and Licensing Inspector and visits of Westland District licensed premises are planned for later this month.

Drinking Water
West Coast district councils are currently compiling their drinking water compliance monitoring results for the 2016/17 year in preparation for the Ministry of Health's Annual Drinking Water Survey. Our Drinking Water Assessor is busy examining these data and will prepare a compliance reports for each council and follow these up late in the year.

New West Coast Team Leader Appointed
We are very pleased to advise that Freedom Preston has been appointed to a one year position as our CPH West Coast Team Leader covering Claire Robertson's maternity leave. Freedom will join us on 2nd August.

Pause Breathe Smile Mindfulness Programme
CPH and BullerREAP staff co-facilitated two "Pause Breathe Smile" eight week mindfulness programmes with Year 4-5 and 5-7 classes at Reefton Area School, involving 43 students. In addition, half hour staff sessions were also held weekly to support staff wellbeing and ensure staff could support the skills taught in the programme. Feedback has been positive and we will continue to support the school with this mahi. *"Many, many thanks for the work you've been doing with our students and staff. I'm pretty sure you're equipping us with great tools to help out in the hurly burly of living in our village. It is greatly appreciated"* is just one example of the positive feedback we have received

Nutrition
CPH staff ran two 'Delicious Nutritious Low Cost Evening Meals' workshops in Greymouth and Hokitika. These were well attended, reaching about 25 people (mostly parents of children under 5). There was a presentation of low cost, handy ingredients to keep in the pantry and some group activities around making a meal with a food basket containing different ingredients. This led to the participants sharing some of their own tips and lessons, which was highly beneficial to all participants. Tasty samples were provided along with recipes.

Working with the Hokitika Public Health Nurse, CPH staff ran a Nutrition Stand targeting oral health and portion sizes at Harper Park Early Childhood Centre. This went well and a lot of conversations were had with parents around how to use their child's hand as a guide for portion sizes, and the importance of using a fluoridated toothpaste.

CPH staff also attended the recent Kowhitirangi Play Day, held at the local hall and run by WestREAP. We took resources and chatted to parents (attendance was excellent, with 25-30 parents and their young children). Many rich conversations were had and the local playgroup have expressed interest in a workshop for their parents, which CPH and West REAP are now organising.

We are also pleased to advise that we have appointed an additional 0.8FTE nutrition health promoter on a two year contract. She will start work later in August and will increase our capacity in community nutrition and our ability to support the Ministry's Raising Healthy Kids target.

Submissions
Following on from submissions regarding the Grey and Buller District Councils draft 2017/18 Annual Plans, CPH has recently submitted on the West Coast Regional Council's Draft Annual Plan indicating our strong support regarding the new structure for Civil Defence and Emergency Management.

In February, CPH staff coordinated the Healthy West Coast submission regarding the *Draft New Zealand Energy Efficiency and Conservation Strategy 2017-2022.* Amongst other recommendations, the submission strongly recommended that the Warm Up New Zealand: Heat Smart Programme be reinstated for home owners (as well as landlords) to ensure that the New Zealand housing stock is continually improved, as the draft strategy did not include actions to support home owners. Following this consultation, the Energy Minister has announced that Warm Up New Zealand will once again be extended to low income home owners as well as landlords. This is particularly significant for the West Coast where we have relatively high home ownership, compared to other regions.

Planning and Reporting
The Ministry of Health has signed off the 2017/18 WCDHB Public Health Plan and CPH's 2016/17 Annual Report has been submitted for Ministry feedback.

PLANNING & FUNDING UPDATE

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Community and Public Health & Disability Support Advisory Committee

SOURCE: **Planning & Funding**

DATE: **27 July 2017**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made on the Minister of Health's health and disability priorities and the key priority areas from the West Coast DHB's Annual Plan.

2. RECOMMENDATION

That the Committee notes the Planning & Funding Update.

3. SUMMARY

✓ Key Achievements

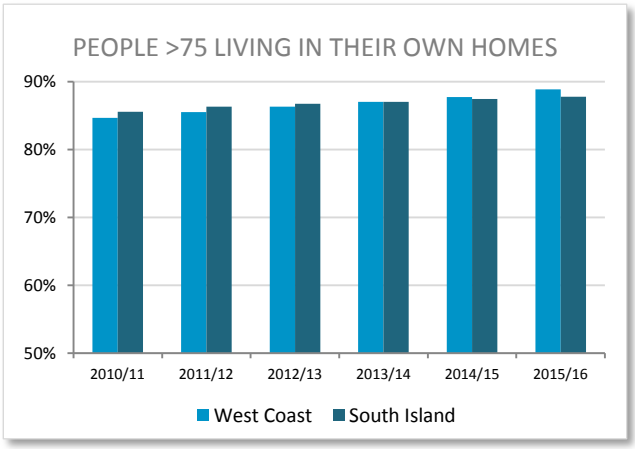
- **ED Health Target:** Performance continues to be impressive with 99.3% of patients admitted, discharged or transferred from Grey Base ED within six hours in June. The same result was achieved for the 2016/17 financial year. The West Coast continues to lead the country in this target.
- **Elective Services Health Target:** The West Coast DHB has exceeded target, delivering 1,770 elective surgical discharges to 31 May - 103% of planned discharges against the year-to-date target.
- **ESPI 5 | First Specialist Assessment (FSA) to treatment:** The West Coast DHB remains within compliance tolerance levels for ESPI 5, with only three patients exceeding the 120-day maximum wait time for receiving surgery as at the end of May 2017 (two plastic surgery patients and one gynaecology patient).
- **B4 School Check Coverage:** When including all children that engaged with the B4SC service, the DHB is pleased to have met the year-end 90% B4SC target for 2016/17.
- **Mental Health:** Consultation with key stakeholders and the public on the model of care document and crisis response has begun West Coast wide. Overall, this has been met with a positive response.

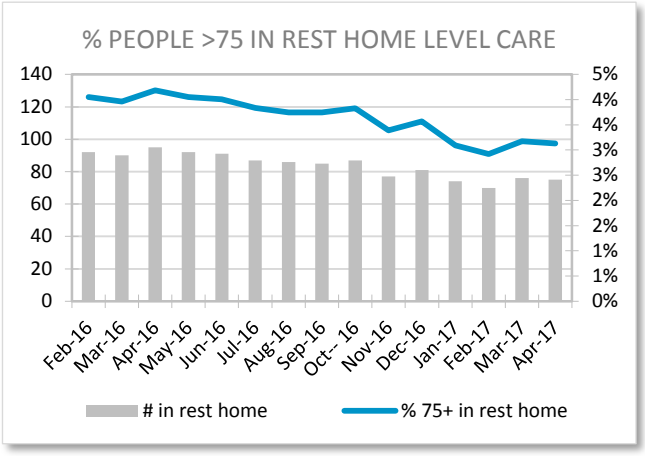
× Key Issues & Associated Remedies

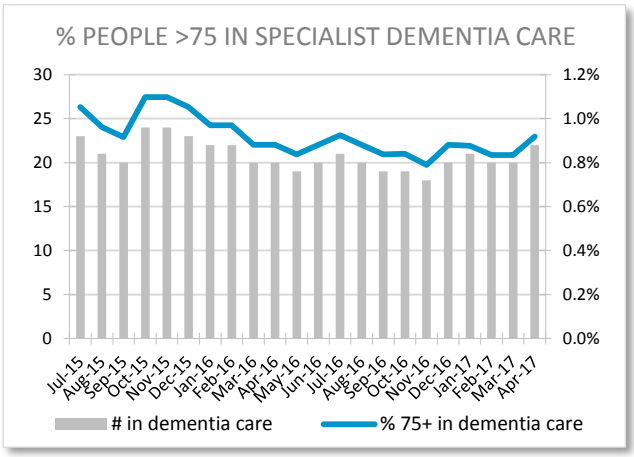
- **ESPI 2 | First Specialist Assessment (FSA):** For a second month, the West Coast DHB is exceeding the maximum 120 days national wait time target for ESPI 2, with 24 orthopaedic patients overdue for FSA as of 31 May 2017. A recovery plan for orthopaedic services is being developed as part of transalpine arrangements.
- **Aged Residential Care Services:** Nursing staff from Canterbury were deployed at Granger House to help with an outbreak of resident and staff illness. Admissions are still limited to ensure that staff are able to focus on the needs of the current residents.

Report prepared by: Planning & Funding
Report approved for release by: Carolyn Gullery, General Manager, Planning & Funding

Health of Older Persons







Achievements / Issues of Note

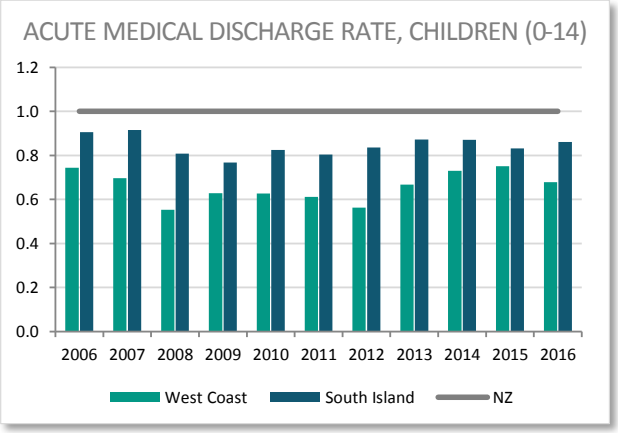
Training: 11 students graduated from the South Island Alliance person-centred training programme "Walking In Another's Shoes' (WIAS). Another 6 students graduated from the registered professionals programme during this quarter. During the year, 29 students have completed these courses. Anecdotal feedback from graduates includes positive improvements both professionally and personally.

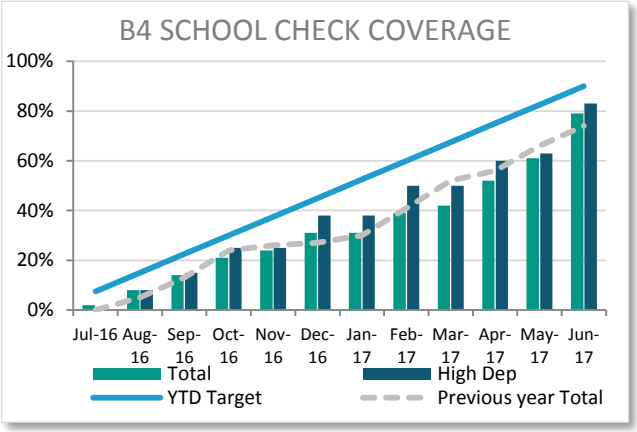
Home Based Support Services: Providers have managed the pay equity process for support workers according to Ministry of Health timelines and work continues.

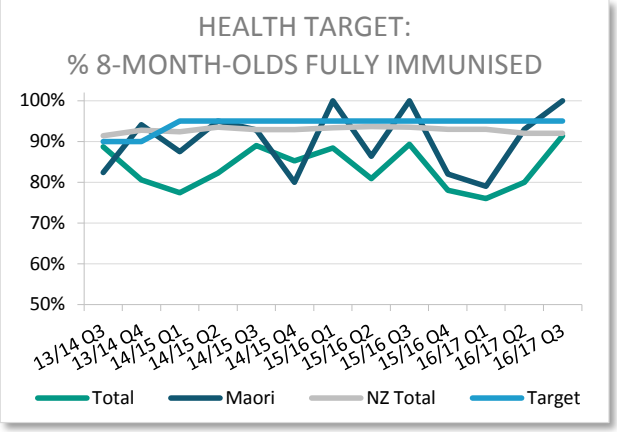
The Home Based Support Service providers have been successfully liaising with support workers on guaranteed hours (Part B of the In-Between Travel settlement). Both providers have the majority of workers signed up to the agreement with processes ongoing around future management.

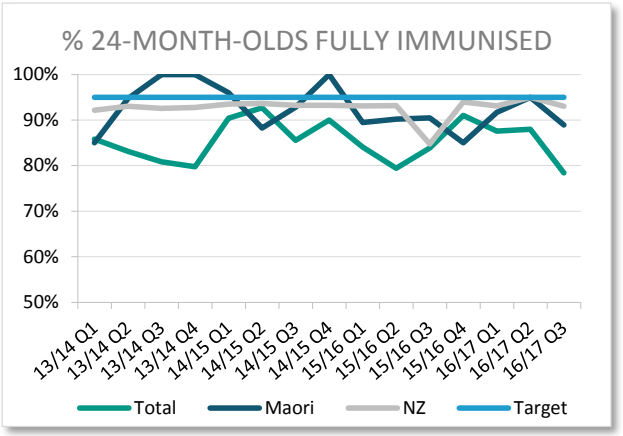
Granger House: Clinical support continues to be provided to Granger House, with the business now on the market. Additional nursing staff from Canterbury were deployed to help with an outbreak of resident illness recently and this was well managed. Admissions are still limited to ensure the staff are able to focus on the needs of the current residents, but it is hoped this will be resolved when a new owner takes over.

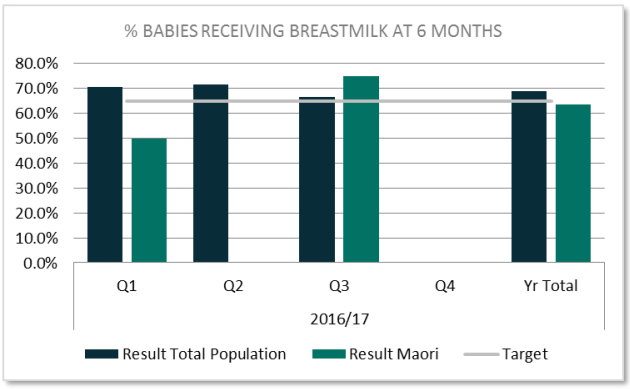
Child, Youth & Maternity











Achievements / Issues of Note

Immunisation: This quarter 80% of all eight-month-olds were fully immunised with only 4 children missed. 95% of Māori children were fully immunised, our rate dropping from 100% due to 1 opt-off.

Opt-offs (8) and declines (4) increased this quarter to a combined 15%. This high percentage is due to the unique community situated on the West Coast that chooses to opt their children off the NIR and declines vaccination.

B4 School Check Coverage: 311 children (including 33 high deprivation children) have received their B4 School Check at the end of the 2016/17 year. This brings the official year end results to 79% for total population and 83% for high deprivation population. There were 42 checks delivered to children in the

Gloriavale community who interacted with the service. We are unable to reflect these checks in official Ministry results, as the community objects to having the children's details recorded on the national database and opts out of some components. If they were included, the total population result would meet the 90% target.

Work continues to find eligible children and the service has increased its flexibility to provide pop up clinics as necessary. This year there were 45 children who missed appointments twice, and of these, 8 missed appointments three times. A significant amount of work has gone into those families, with now only 10 of these 45 children outstanding.

Breastfeeding: Work to more closely monitor progress against breastfeeding targets continues, however complete results are reliant on data from all sources being received. At the time of writing Quarter 4 data was unavailable, however our year to date result shows 69% of babies across the West Coast are receiving breastmilk against the 65% target. The result for Māori is 64%.

Mental Health

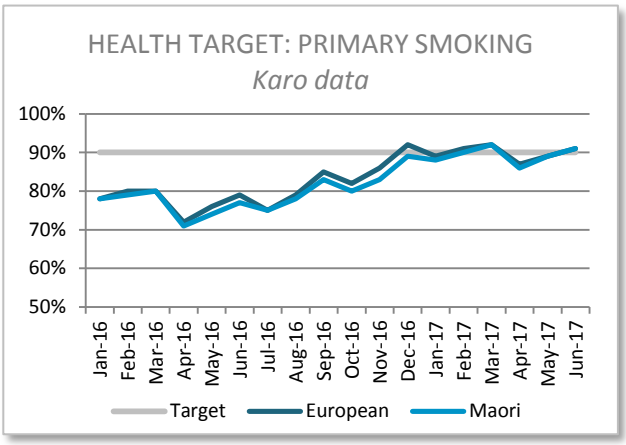
Achievements / Issues of Note

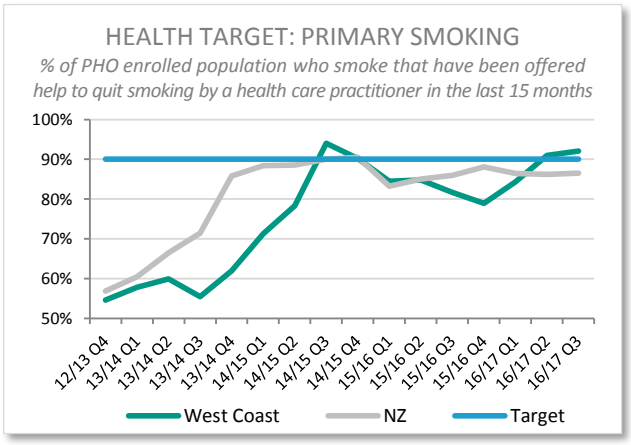
Future Services Project: A series of engagement meetings have been held to gather feedback on the future model of care for the mental health system. People can also provide input online. There has been a positive response and information is being collated to help shape the direction.

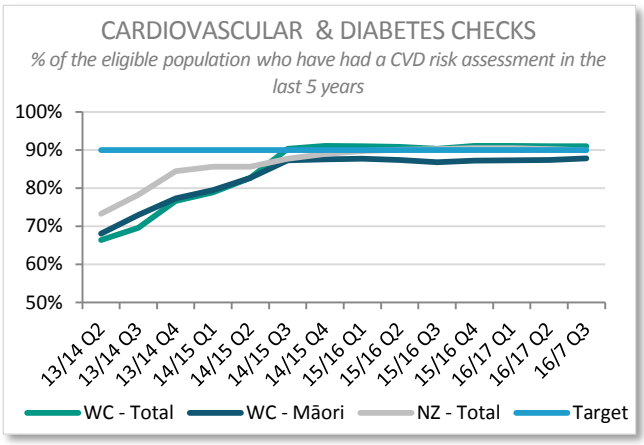
Crisis response is the first focus area. Facilitated workshops have been held with Specialist Mental Health staff and other key stakeholders in Hokitika, Greymouth, and Westport.

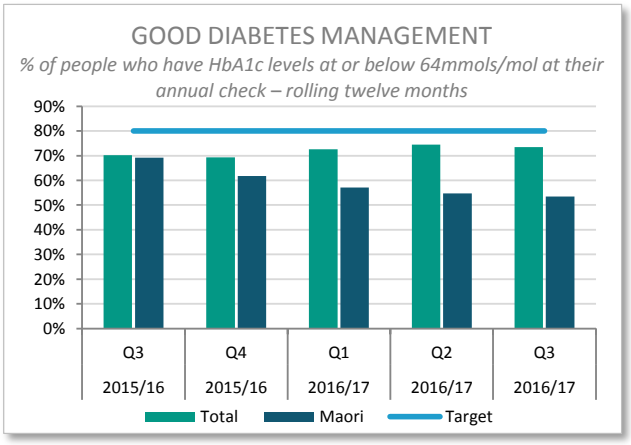
Organisational Excellence: Work is ongoing to improve current service provision and this includes the interface with NGO and PHO teams. Respite services and ongoing care planning are two areas currently being considered to determine if there are more effective ways of providing an integrated response.

Primary Care & Long-Term Conditions









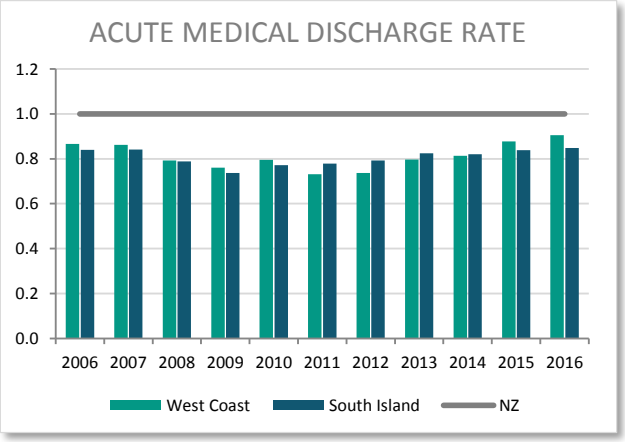
Achievements / Issues of Note

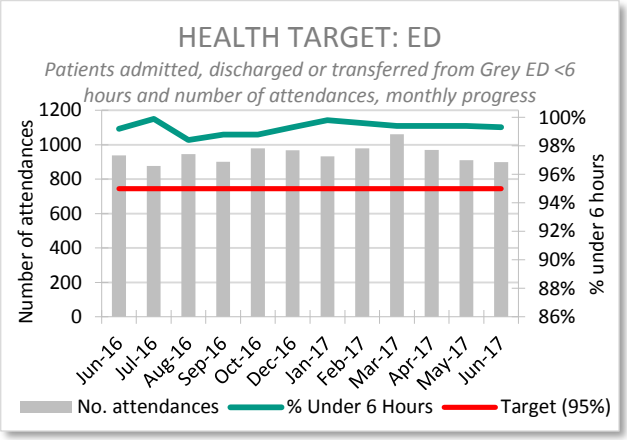
Health Target | Primary Care Smoking: As reported previously, the DHB is pleased to have exceeded the target in Quarter 3 for total population as well as Māori and High Needs. Data for Quarter 4 is due in the coming weeks.

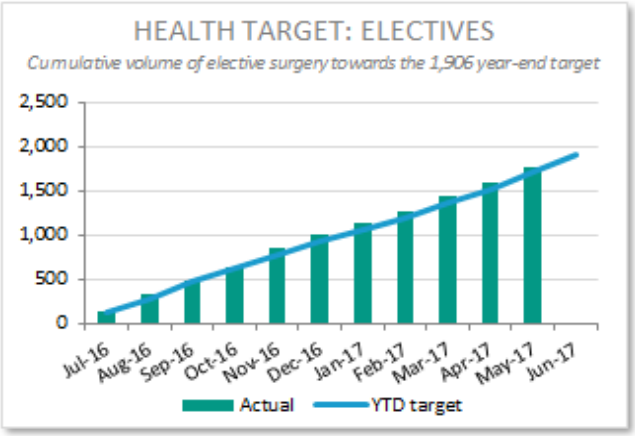
Cardiovascular and Diabetes Checks: As reported previously, the DHB maintained performance in Quarter 3, with 91% of the eligible enrolled population having had a cardiovascular and diabetes risk assessment against the 90% target. Results for West Coast Māori remained lower at 87.8%. Data for Quarter 4 is due in the coming weeks.

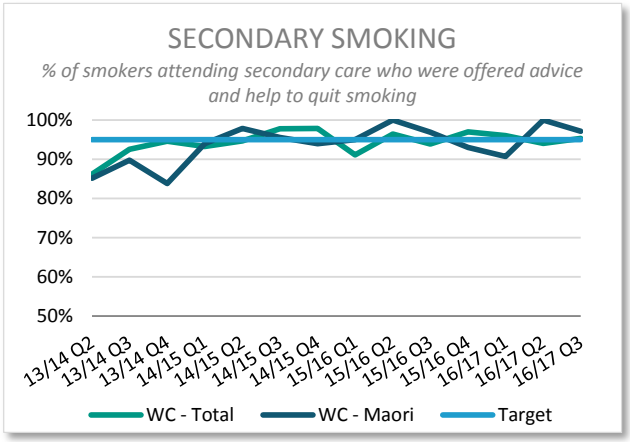
Diabetes Management: As reported previously, 73.5% of people with diabetes had good management of their disease in the twelve months to Quarter 3 (defined by having an HbA1c level at or below 64mmols). This was down from 74.5% in December 2016. Results for our Māori population remained lower at 53.5%.. Data for Quarter 4 is due in the coming weeks.

Secondary Care & System Integration









Achievements / Issues of Note

Health Target | ED: The West Coast DHB continued to achieve impressive results with 99.3% of patients admitted, discharged or transferred from Grey Base ED within six hours; both in the month of June and across the 2016-17 Financial year (national 6-hour Health Target: 95%). Of those attending, 93.5% of people were seen within just four hours across the financial year to June (and 93.0% in the month of June 2017).

Secondary Smoking: As previously reported, West Coast DHB staff provided 95.3% of all hospitalised smokers with smoking cessation advice and support against the 95% national target (97.1% for Māori) in Quarter 3. Data for Quarter 4 is due in the coming weeks.

Health Target | Electives: The West Coast DHB is 53 discharges ahead of the year-to-date progress target at the end of May (103% of target).

ESPI Compliance | ESPI 2 (First Specialist Assessment)*:* There were 24 orthopaedic patients waiting over 120 days for their outpatient First Specialist Assessment at the end of May. Both West Coast and Canterbury DHB orthopaedic services are facing similar non-compliance issues due to service constraints. A recovery plan for orthopaedic services is being developed.

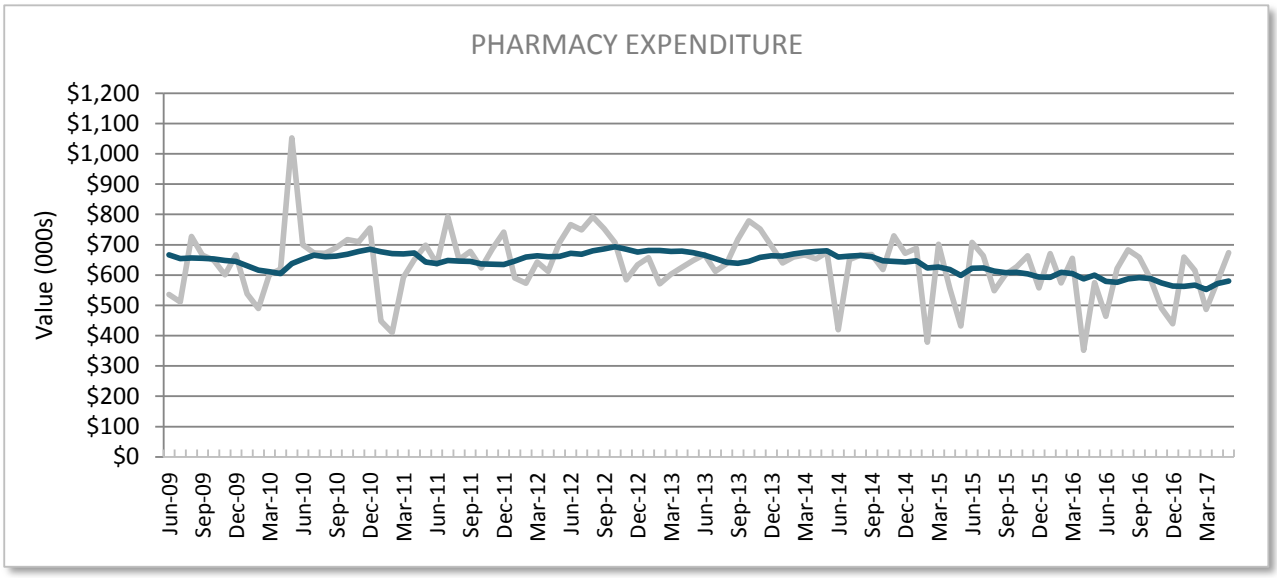
ESPI Compliance | ESPI 5 (FSA to Treatment): The DHB exceeded the 120-day maximum wait time from FSA to surgical treatment with two plastic surgery and one gynaecology patient non-compliant at the end of May 2017. The gynaecology patient cancelled and deferred surgery at their own request. This result was within compliance tolerance levels at 1.7% of total wait listed cases.

Financials

Planning and Funding Division

Month Ended May 2017

Current Month					SERVICES	Year to Date				
Actual	Budget	Variance				Actual	Budget	Variance		
$000	$000	$000	%			$000	$000	$000	%	
					EXPENDITURE					
					Primary Care					
33	28	-5	-16%	✗	Dental-school and adolescent	324	312	-12	-4%	✗
21	21	1	4%	✓	Maternity	217	235	18	8%	✓
1	1	0	40%	✓	Pregnancy & Parent	13	14	1	9%	✓
	0	0		✓	Sexual Health	0	0	0		✓
2	4	2	57%	✓	General Medical Subsidy	21	46	25	54%	✓
513	522	9	2%	✓	Primary Practice Capitation	5,741	5,745	4	0%	✓
91	91	0	0%	✓	Primary Health Care Strategy	1,001	1,002	1	0%	✓
87	87	0	0%	✓	Rural Bonus	961	961	0	0%	✓
4	4	0	-4%	✗	Child and Youth	55	46	-9	-20%	✗
17	10	-6	-60%	✗	Immunisation	89	115	25	22%	✓
5	5	0	1%	✓	Maori Service Development	52	52	0	0%	✓
52	45	-7	-15%	✗	Whanau Ora Services	572	498	-75	-15%	✗
13	14	1	4%	✓	Palliative Care	164	151	-12	-8%	✗
0	6	6	100%	✓	Community Based Allied Health	51	70	19	27%	✓
12	10	-2	-16%	✗	Chronic Disease	130	115	-15	-13%	✗
26	61	35	57%	✓	Minor Expenses	379	670	291	43%	✓
877	**912**	**35**	**4%**	✓		**9,768**	**10,030**	**262**	**3%**	✓
					Referred Services					
27	26	-1	-3%	✗	Laboratory	288	287	-1	0%	✗
674	666	-8	-1%	✗	Pharmaceuticals	6,445	7,325	881	12%	✓
701	**692**	**-9**	**-1%**	✗		**6,733**	**7,612**	**880**	**12%**	✓
					Secondary Care					
170	223	53	24%	✓	Inpatients	1,790	2,455	665	27%	✓
145	126	-20	-16%	✗	Radiolgy services	1,663	1,384	-279	-20%	✗
123	114	-10	-8%	✗	Travel & Accommodation	1,083	1,249	166	13%	✓
1,416	1,425	10	1%	✓	IDF Payments Personal Health	15,154	15,680	525	3%	✓
1,854	**1,888**	**34**	**2%**	✓		**19,690**	**20,767**	**1,077**	**5%**	✓
3,432	**3,492**	**60**	**2%**	✓	**Primary & Secondary Care Total**	**36,191**	**38,410**	**2,219**	**6%**	✓
					Public Health					
17	23	6	27%	✓	Nutrition & Physical Activity	180	256	76	30%	✓
11	11	0	0%	✓	Tobacco control	129	122	-7	-6%	✗
28	**34**	**6**	**18%**	✓	**Public Health Total**	**309**	**378**	**69**	**18%**	✓
					Mental Health					
7	7	0	0%	✓	Dual Diagnosis A&D	78	78	0	0%	✓
1	0	-1		✗	Inpatients	12	0	-12		✗
20	20	0	0%	✓	Child & Youth Mental Health Services	220	220	0	0%	✓
5	8	2	33%	✓	Mental Health Work force	129	83	-47	-57%	✗
37	61	23	39%	✓	Day Activity & Rehab	475	668	193	29%	✓
11	11	0	0%	✗	Advocacy Consumer	117	117	0	0%	✓
103	81	-22	-27%	✗	Other Home Based Residential Support	1,066	889	-177	-20%	✗
11	11	0	0%	✓	Advocacy Family	121	121	0	0%	✓
10	16	6	38%	✓	Community Residential Beds	83	174	91	52%	✓
66	66	0	-1%	✗	IDF Payments Mental Health	723	721	-2	0%	✗
270	**279**	**9**	**3%**	✓		**3,024**	**3,072**	**48**	**2%**	✓
					Older Persons Health					
0	0	0	100%	✓	Needs Assessment	0	1	1	100%	✓
47	84	37	44%	✓	Home Based Support	1,001	928	-73	-8%	✗
7	6	-1	-18%	✗	Caregiver Support	70	64	-6	-9%	✗
210	242	32	13%	✓	Residential Care-Rest Homes	2,316	2,658	342	13%	✓
9	9	0	-1%	✗	Residential Care-Community	100	101	1	1%	✓
390	404	15	4%	✓	Residential Care-Hospital	4,219	4,447	227	5%	✓
17	10	-7	-73%	✗	Day programmes	139	110	-28	-25%	✗
6	11	5	44%	✓	Respite Care	86	121	35	29%	✓
1	1	0	12%	✓	Community Health	14	14	0	1%	✓
-5	1	6	489%	✓	Minor Disability Support Expenditure	23	15	-8	-57%	✗
99	99	0	0%	✓	IDF Payments-DSS	1,092	1,092	1	0%	✓
782	**868**	**85**	**10%**	✓		**9,059**	**9,551**	**492**	**5%**	✓
1,052	**1,147**	**93**	**8%**	✓	**Mental Health & OPH Total**	**12,083**	**12,622**	**540**	**4%**	✓
4,512	**4,674**	**161**	**3%**	✓	**TOTAL EXPENDITURE**	**48,583**	**51,410**	**2,828**	**6%**	✓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Value (000s)
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$1,000
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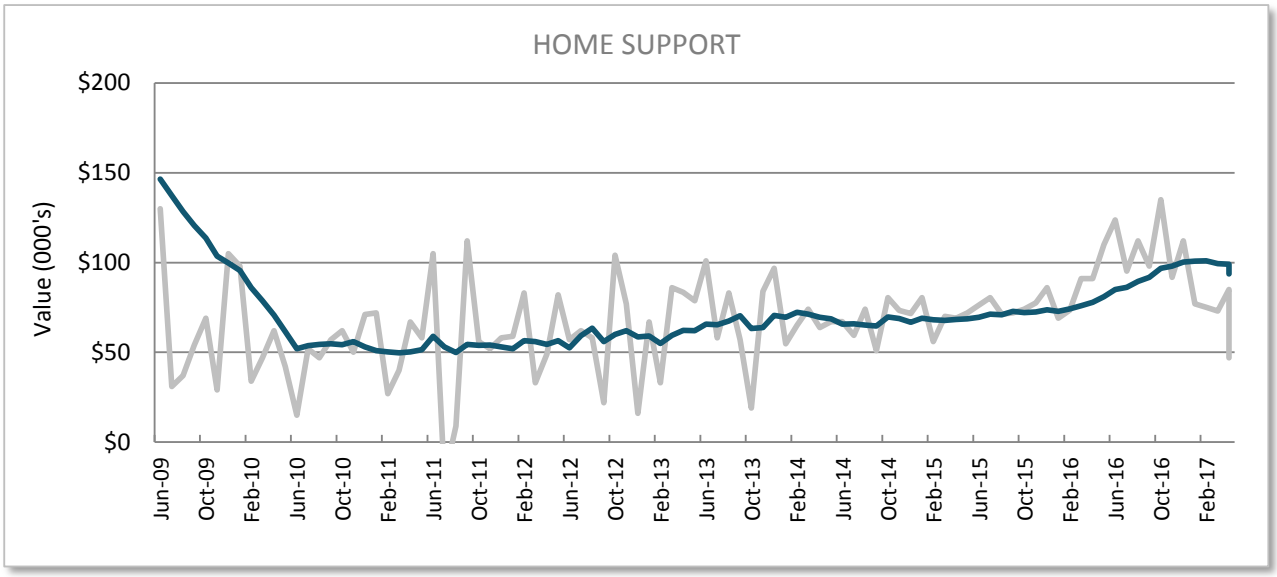
HOME SUPPORT
Value (000's)
$200
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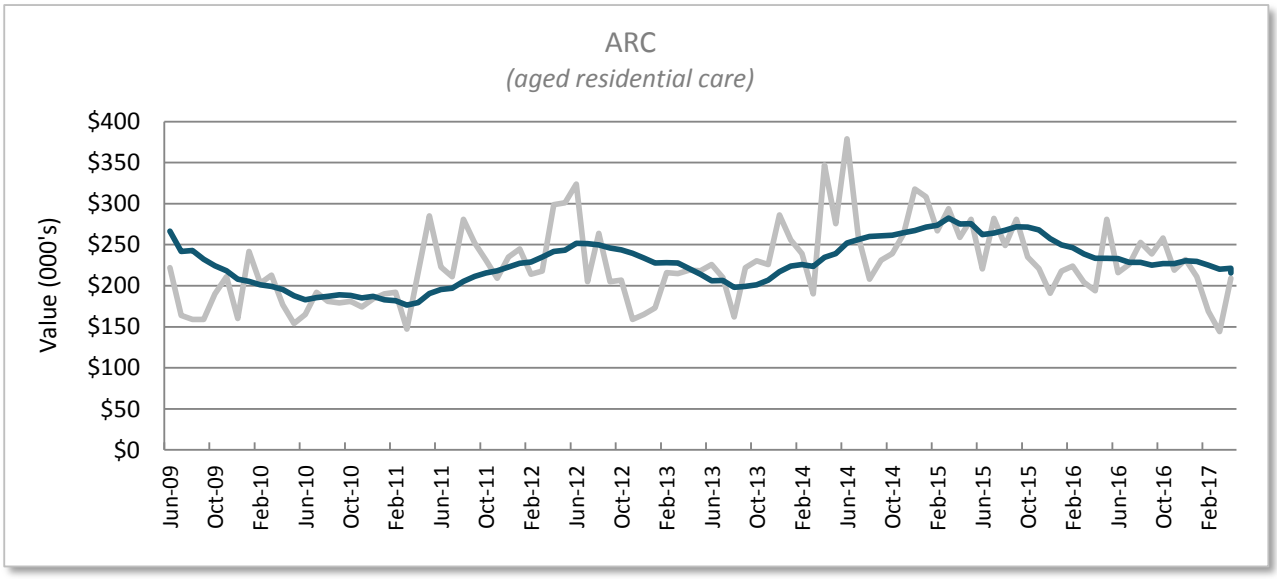
ARC
(aged residential care)
Value (000's)
$400
$350
$300
$250
$200
$150
$100
$50
$0
Jun-09
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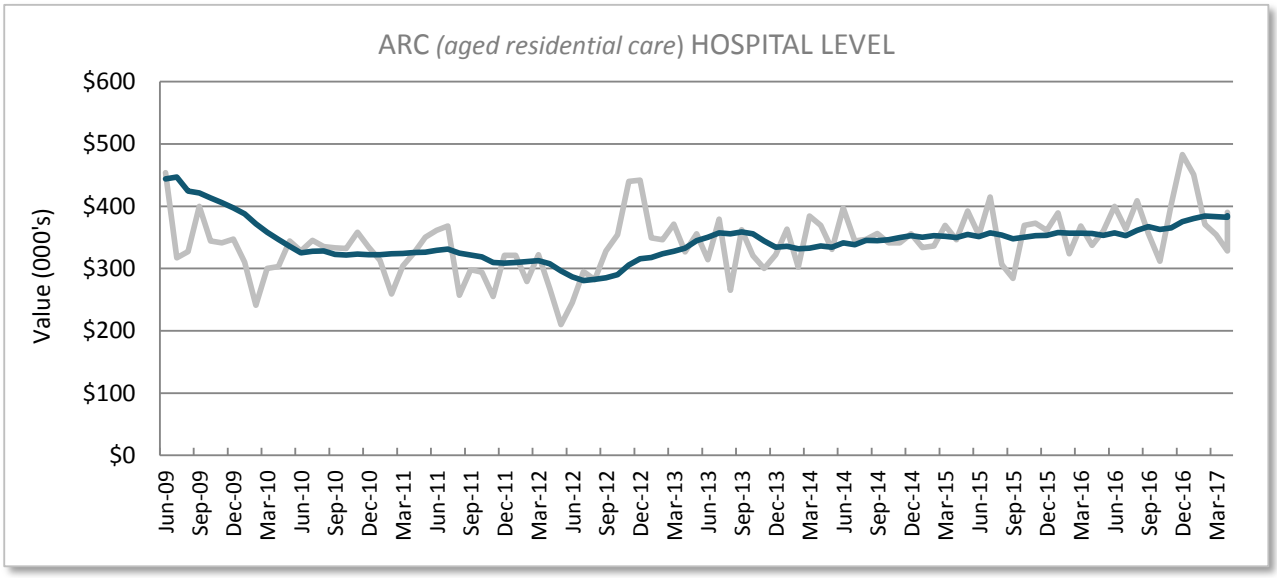
ARC (aged residential care) HOSPITAL LEVEL
Value (000's)
$600
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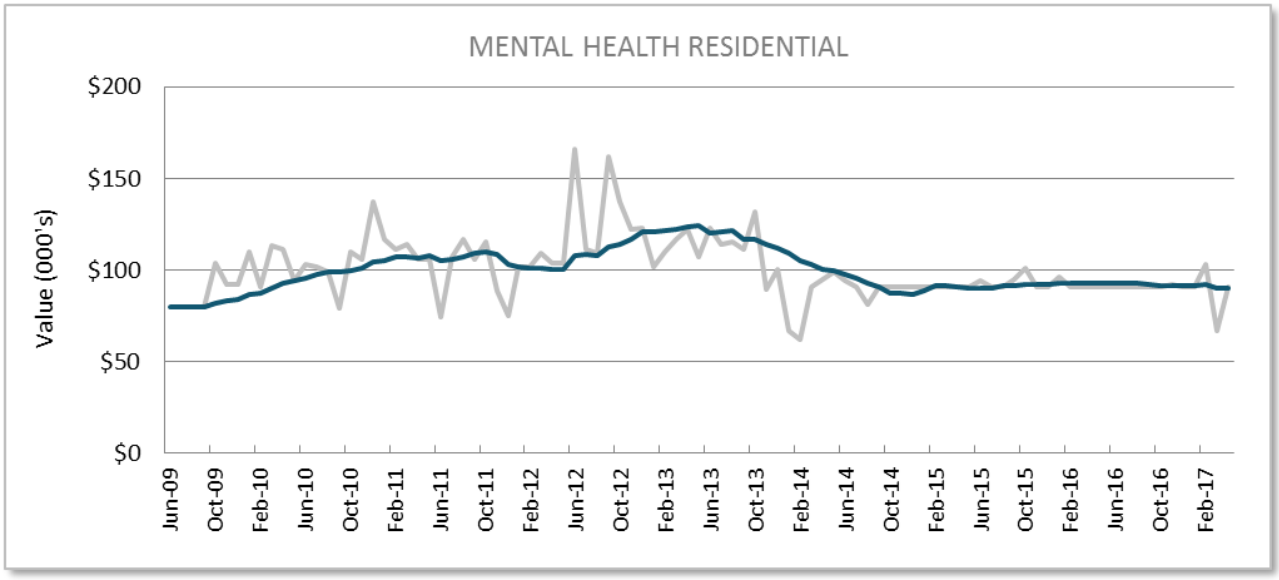
MENTAL HEALTH RESIDENTIAL
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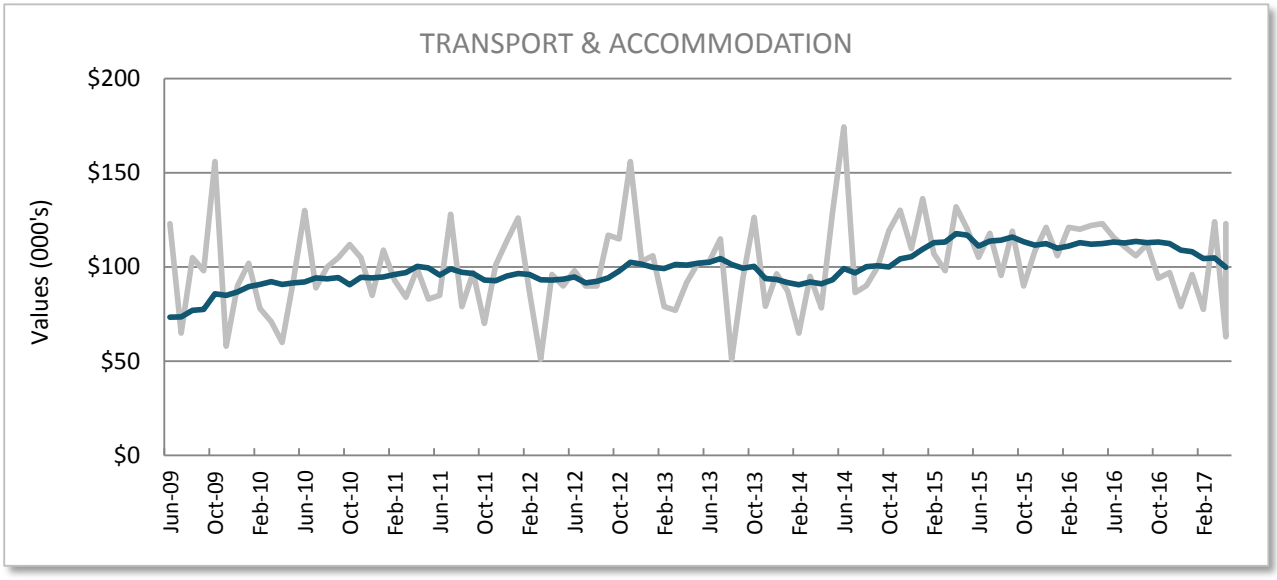
TRANSPORT & ACCOMMODATION
Values (000's)
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ALLIANCE UPDATE

TO: **Chair and Members**
Community and Public Health & Disability Support Advisory Committee

SOURCE: **Planning & Funding**
Alliance Leadership Team

DATE: **27 July 2017**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made by the West Coast Alliance.

2. RECOMMENDATION

That the Committee;

i. Notes the Alliance Update.

3. SUMMARY

Progress of Note:

Alliance Leadership Team (ALT)

At the last meeting in May the ALT:

- Acknowledged and were pleased with the good progress of the change work in Mental Health.
- Recognised the good work being carried out by ISG and noted the inability of some work to progress as a result of financial constraints.
- Noted the delay and impact in the implementation of the Shared Care Plan, currently two years behind schedule.
- Agreed to and endorsed the 17/18 Workstream plans, the 17/18 Annual Plan and the 17/18 System Level Measures Improvement Plan.
- Were pleased to note the positive progress across all workstreams against the 16/17 plans.

Health of Older Persons

- Work has commenced for Home Based Support Services that employ Care and Support Workers to implement the pay equity settlement announced by the Ministry of Health in April. This work has been prioritised by the relevant teams in order to meet with Ministry of Health timelines.
- A regular networking forum has been initiated with the management teams of the Aged Residential Care facilities.
- Several cohorts of healthcare professionals are currently enrolled in the person-centred dementia education programme; Walking In Another's Shoes. Over 30 students across the system are working towards completion. A master class was provided in Quarter 3 with 12 students attending, including Enrolled and Registered Nurses, Diversional Therapists and Support Workers.

Integrated Family Health Service (IFHS) Workstreams (Grey|Westland, Buller & Reefton)

- The Primary & Community Model of Care document consultation took place during June with feedback being received and collated by early July.
- The Greymouth Medical Centre/Rural Academic General Practice merger was completed on 3 July as planned.
- A comprehensive Allied Health Integration Project Plan has been developed to guide the work required between now and the end of the year. This has also been added to the primary & community project plan for reference.

Healthy West Coast (HWC)

- Positive progress is being made towards implementing the Tobacco Harm Reduction Pathway tool in community mental health teams. Teams have been briefed on the pathway and the possibility to use it with clients of the service who are keen to reduce their tobacco use.
- The planned Transalpine Oral Health Steering Group led workshop was rescheduled and is due to take place on 18th July.

Child and Youth

- The workstream were pleased to note that the MoH has decided to continue funding for regional Well Child Tamariki Ora (WCTO) Quality Improvement managers. This role has supported work across the South Island to improve access to the full compliment of WCTO services and the continuation will see further improvements in this area.

Report prepared by: Jenni Stephenson, Planning & Funding
Report approved for release by: Stella Ward, Chair, Alliance Leadership Team

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Transforming Respite

Disability Support Services Respite Strategy 2017 to 2022

Released 2017

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Foreword

It is an exciting time to be the Minister for Disability Issues – the disability system transformation will improve the lives of people with disabilities and their families/whānau by offering more choice and control over the supports they use.

This strategy, *Transforming Respite*, brings choice, control and flexibility to respite supports. It supports both the disability system transformation work and the Government's commitment to the Enabling Good Lives (EGL) approach of empowering disabled people to make their own decisions about the supports they choose to live everyday lives.

This strategy also takes a social investment approach to respite supports – it recognises the important role that family/whānau carers play in supporting people with disabilities to live a fulfilling life within their communities, iwi and hapū. It invests in family/whānau resilience to continue in that caring role and makes it easier for carers of disabled people to take a break.

Transforming Respite draws heavily on the feedback provided by disabled people, their families/whānau, disability organisations, advisory groups and providers about how respite supports can be improved. We have listened to your feedback, and we are very grateful for the time you took out of your busy lives to tell us your stories. Your insight has been invaluable.

Hon Nicky Wagner
Minister for Disability Issues

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Overview

Most parents would agree that parenting is hard. For families/whānau with developmentally typical children, the parenting journey gets easier as their children learn to take care of themselves and help around the house. For these parents, it's natural and relatively easy to get a break from the caring role when their child is invited to a play date, has a holiday with their grandparents or attends a school holiday programme.

For parents of a child with a disability, the caring role may not get easier as the child grows – everyday activities can be challenging and time consuming and may in fact become harder as the child develops toward adulthood. The family/whānau is less likely to have access to the same types of natural supports as their peers – friends and extended family/whānau may not feel confident in having a child with a disability come to stay and therefore do not offer to take them. Parents can feel isolated from their communities and become stressed if leaving the family home requires significant planning and it is difficult to take a break.

For other families/whānau, disability comes later in life (eg, as a result of a stroke or a neurological condition), and spouses, aging parents or children can find themselves in a caring role on top of their other work, parenting or social commitments. Feelings of fear, loneliness, anxiety and grief are typical for carers, and taking a break from caring can be key to a carer's ongoing wellbeing.

For these reasons, the Ministry of Health (the Ministry) supports families/whānau who care for a disabled person by funding 'respite', or a 'short break', for carers. Respite is an investment in protecting the health and wellbeing of the family/whānau and helps them to continue in their caring role.

There are a number of areas for improvement within the existing respite model. Respite needs to align with the Disability Support Services (DSS) strategic direction to give greater choice, control and flexibility to disabled people and their families/whānau. There are also issues with the current funding model, provider availability and the ability of families/whānau to access services.

There is a case for bringing innovative and transformative change to the area of respite. These changes are linked to the wider work programme to transform the disability support system.

When reconsidering how respite is delivered in New Zealand, we need to ask what is required to ensure that both the family/whānau and the disabled person have access to a 'good life'. Respite itself is a means for carers to get a break and refresh themselves. Rather than focusing on what hours or placements someone needs, we need to think about what it takes to enable carers to get the breaks they need.

Ultimately, to meet people's diverse range of respite needs, we must focus on outcomes rather than specific inputs. The outcome we are seeking is to ensure carers are not stressed, are resilient, have capacity to have ordinary life experiences and feel able to continue to provide

care. This requires a new way of thinking; in particular, to trust that families/whānau will access supports that meet their needs, whatever those needs are and in ways that may be unique to them.

Respite support needs to be available early, before families/whānau start to feel that they cannot cope. Respite should be age appropriate and a best match for the family/whānau. Respite needs will change throughout the stages of life. Respite is a lifelong investment in the wellbeing of the disabled person and their family/whānau.

The high-level outcomes we seek through this strategy are to ensure that the respite model:

- offers **choice, control and flexibility** about how disabled people and their families/whānau take a break – this includes offering disabled people and their families/whānau a flexible respite budget that allows them to take breaks in the ways that suit them best
- **enhances the range of quality respite options** that families/whānau who need them most can access – this includes developing new and expanded respite services, in line with what people want
- recognises the **value of respite** and takes a lifelong approach to respite allocation and funding
- is **easy to use** and to access – this includes easier administration and payment methods, better access to information about the respite options available and support to find and use these options.

Introduction

What is 'respite'?

Respite literally means a period of rest or relief. In the context of disability support, respite aims to provide families/whānau or carers with a planned, temporary break from caring for a person with disability. The primary purpose of respite is to relieve carer stress as a way of supporting them to continue in their caring role. A break can be for a few hours, a day, overnight or longer and may take place in or away from the family home.

Carers need the opportunity to rest, recover and re-energise. Each carer will have their own idea about how best to do this: they may want to maintain social connections with their community, to catch up on sleep, to exercise or to spend time with other family/whānau. We need to design our respite services so that carers can get the breaks they need, in whatever form suits them.

Respite is an essential part of the overall support that a family/whānau needs. When we support respite for carers, we invest in protecting the health and wellbeing of the whole family/whānau.

Respite also gives a disabled person a break from their normal routine. It can provide them with new experiences, chances to develop their independence or opportunities to visit different places or make new friends. Most importantly, respite options for the disabled person must be something they look forward to.

> A rest, a break, a breather! A chance to re-energise and 'come up for air' from the, at times, gruelling and exhausting job of caring for a child with special needs. Patience is not infinite – but with a regular break, you can replenish the supply![1]

Why a respite strategy?

The Ministry currently spends approximately $61 million per year on disability respite. There are problems with all the types of disability respite that we currently purchase. In general:

- some current options are inflexible, and do not meet the needs of families/whānau
- finding relief carers who have the right skills, experience and attitudes is very difficult
- the administration and conditions of use of Carer Support[2] are outdated
- some families/whānau do not want to use facility-based respite, and sometimes those who need it most cannot access it
- some contracted respite options do not provide value for money – for example, some of the available options are underused
- there is inconsistency in services available throughout the country.

1 A respondent to the 2016 survey that DSS conducted of disabled people, their families/whānau and providers on the topic of respite. We have included quotes from respondents to this survey throughout this document. A report on the results of the Disability Respite Survey 2016 can be found at: www.health.govt.nz/publication/disability-respite-survey-2016

2 A subsidy for carers of disabled people, reimbursing some of the costs of using a support person to help them take a break from their caring role.

Scope of this strategy

DSS's strategic direction prioritises greater choice, greater control and better outcomes for disabled people. The respite model needs to align with this.

This strategy will set the direction for respite from 2017 to 2022. It will enable a wider range of quality options, funded through flexible budgets. Its scope is:

- respite funded through all current mechanisms (Carer Support, in-home support, host-family respite, Individualised Funding (IF) and facility-based respite)
- respite for disabled children, young people and adults, and their families/whānau and carers
- increasing the ability of the Needs Assessment Service Coordination (NASC) agencies to support families/whānau to access respite
- developing a range of respite options to suit individual families/whānau.

This strategy does not cover respite for people who live permanently in community residential houses or who are primarily clients of mental health services, health of older people services, palliative care or the Accident Compensation Corporation (ACC).[3] We are collaborating with these services where it is efficient and effective to do so.

Vision

This strategy will enable disabled people and their families/whānau:

- greater choice, control and flexibility over their respite options and how those options are funded or purchased
- access to respite at a time and in a way that best suits their needs.

Principles

The principles of this strategy are based on those developed for Enabling Good Lives (EGL) (Enabling Good Lives 2017). They are as follows.

Self-determination	Disabled people are in control of their lives. In the respite context, families/whānau feel empowered and able to take the breaks that they need from caring.
Beginning early	We take an investment approach to respite and recognise that supporting families/whānau to have a break may prevent a crisis and sustain the family unit.
Person-centred	Disabled people and their families/whānau use respite supports that are tailored to their individual needs and goals and that take a whole-life approach.
Ordinary life outcomes	We offer respite options that support disabled people and their families/whānau to access everyday life, learn, grow social networks, increase independence and integrate with their communities.

3 However, we are working with the relevant teams to enable sharing of facilities or other improvements for the purpose of respite, where this is mutually beneficial.

Mainstream first	Everybody experiences full participation and inclusion within their community (people, places, assets, infrastructure and supports) as of right and can choose funded supports to enhance and facilitate this[4].
Mana-enhancing	We recognise and respect the abilities and contributions of disabled people and their families/whānau.
Easy to use	Supports are simple to use and flexible.
Relationship building	Supports build and strengthen relationships between disabled people, their families/whānau and their communities.

In addition, it is essential that disabled people feel safe while accessing respite services.

Strategic context

This strategy is aligned with the United Nations' Convention on the Rights of Persons with Disabilities (United Nations 2006) and our own Treaty of Waitangi. The strategic framework includes the New Zealand Health Strategy (Ministry of Health 2016a and b), He Korowai Oranga (Ministry of Health 2014c), the New Zealand Disability Strategy (Office for Disability Issues 2016) and the disability system transformation work programme.

This strategy is also linked at an operational level with a number of other Ministry, DSS and broader-government action plans, including those set out in Appendix 1: Strategic framework.

History of respite support

The formal concept of respite was developed in response to deinstitutionalisation (a focus on allowing people to remain in their natural homes rather than in long-term care facilities) during the 1960s and 1970s.

From the mid-1970s, government's approach to services for people with disabilities became increasingly community- and rights-based. Increasingly, government recognised the need for people with disabilities to have access to a wide range of community-based support.

The Disabled Persons Community Welfare Act 1975 introduced into New Zealand legislation the concept of 'relief' from the responsibility of caring for disabled children who lived with their parent(s) or guardians. The Act set out a responsibility on the part of the government to fund a relief period of up to four weeks per year.

During the 1980s and 1990s, government introduced a formal contracting system to purchase disability services – this replaced government grants to charitable organisations for this purpose.

In 1992, the Government announced a 'new deal' for people with disabilities. Responsibility for services for people with disabilities (with the exception of vocational services) transferred to the Regional Health Authorities (RHAs).

4 This is the working definition of the EGL principle 'Mainstream first' that was agreed by the National EGL Leadership Group and some system transformation co-design group members in April 2017. The principle may evolve further during the disability system transformation process.

During the late 1990s, RHAs purchased respite support. This took the form of overnight respite in dedicated houses (ie, 'facility-based respite') and was primarily available only for children. The respective RHAs established specialised respite support for children with high and complex needs in Auckland and Waikato. The RHAs also funded one-on-one care 'in-home' or buddy support.

Further government reforms saw the Ministry taking responsibility for disability support funding. Respite has been centrally funded since 2001.

In 2006, the Ministry tendered for more respite support to be provided in dedicated facilities, and, in 2014, it introduced IF respite to try to increase the flexibility of existing respite options.

The current state of respite

People supported and funding

The current respite budget is approximately $61 million per year. Around 70 percent of the people who receive a respite allocation are aged under 25 years. Eighteen percent are Māori, 10 percent are Asian and 7 percent are Pacific peoples.

NASC services allocate respite support based on the needs of individual full-time carers and the needs of the disabled person.

The Ministry currently supports respite through:

a) Carer Support – which contributes to some of the costs of a break for carers (paid on a half-day or daily rate)

b) facility-based respite – which provides care for a disabled person out of their home (usually overnight in a dedicated respite house or other facility, which provides care for a group of about five people at one time)

c) respite – through which disabled people or their families/whānau directly purchase their own respite supports

d) in-home support or one-on-one 'buddy' support – which may be provided in the home, in the community or through after-school, before-school or holiday programmes (paid at an hourly rate)

e) host-family respite – which provides an overnight break in the home of another family/whānau. The host family/whānau receives payment through Carer Support or through a provider contracted to the Ministry. Children and young people are more likely to receive host-family respite.

As at September 2016, the Ministry was allocating Carer Support to 18,331 people: 76 percent were aged under 25 years; 46 percent had an intellectual disability; 32 percent had autism spectrum disorder (ASD); 18 percent had a physical disability and 4 percent had a sensory, neurological or 'other' disability. Eighty-one percent of people receiving Carer Support had a 'medium' or 'high' disability-related need.

Also at September 2016, the Ministry was allocating 2,977 people other types of respite. Of these people, 70 percent were aged under 25 years; 49 percent had intellectual disability; 24 percent had ASD and 89 percent had a 'high' or 'very high' disability-related need.

Table 1: Summary of current respite funding, clients and providers

Type of respite funding	2016/17 budget	Number of clients	Number of providers
Carer Support	$32 m	18,331	19,000
Facility-based/host-family respite	$17 m	1,830	28 (+ rest homes)
In-home support	$11 m	1,924	4
IF respite	$1 m	731	5 hosts
Total	**$61 m**	**19,648***	

* Note that some people are counted more than once.

Current respite options: further details and current issues

Carer Support

A number of conditions govern the use of Carer Support. Carers perceive many of these conditions to be inflexible and outdated. The main areas of complaint are:

- the low rate of subsidy: $76 for 8–24 hours of relief care
- the conditions preventing use of Carer Support while a full-time carer is working
- inconsistency and inflexibility in the conditions, compared with those that govern IF
- inadequate allocation of respite hours, and inconsistency in allocation between regions
- inability to use the funding flexibly.

There are many misconceptions about the Carer Support conditions, and families/whānau need clearer guidance.

Across the country, carers use approximately 75 percent of allocated Carer Support days each year. Carers tell us that it is very difficult to find relief carers in their area who have the right skills, experience and attitudes, especially because of the low subsidy rate.

The system of claiming Carer Support is based on paper forms and conventional mail. This is seen as frustrating, old-fashioned and time consuming. Mistakes in completing forms can lead to delays for families/whānau being reimbursed for care they have already subsidised.

> The paper work! In this day and age, you would think it would be able to be done online. If I make one mistake on the forms they are sent back to me. I have to get the carer to resign the forms and send them back! It takes another two weeks to get paid. I always pay my carers up front and have a reasonably tight budget of my own, so this always creates a hassle for me. Time wasting and time consuming! I spend my whole life filling out forms for all sorts of things, and it is never ending. An online system would be much quicker and more efficient for everyone concerned, and I am sure hundreds of parents would agree with me. From a parent who is very time poor!

Facility-based respite

Our respite survey found that families/whānau that had access to facility-based respite appeared to be among the most satisfied. The break from caring has reduced their stress levels and enabled them to continue in a caring role.

However, families/whānau who receive an allocation for facility-based respite cannot always access this service. Barriers include the following.

- Respite houses are not available in all parts of the country; some families/whānau may need to travel for several hours to access a respite house.
- Some respite houses are at capacity and cannot accept any new referrals.
- Some respite houses may not be able to accept a particular disabled person because that person is not a ‘good match’ with the other people in the house (in terms of age, gender, disability type, level of support needed or challenging behaviour).

- Available respite houses may not be appealing to a disabled person or their family/whānau or may not be available on the days that they would like.

A person may receive facility-based respite in a range of settings, including dedicated respite houses, child- or adult-specific facilities, community residential houses and aged care facilities (rest homes). The remainder of this section discusses each of these in turn.

> During respite times it gives our family the chance to have a break from each other and our busy life. Our son comes back home happy and like a new person [and] we all feel more relaxed. As parents it takes the pressure off us.

Dedicated respite houses

The Ministry currently contracts for dedicated respite houses for children and adults. 'Dedicated' respite houses are generally not used for anything other than providing overnight respite. The occupancy of dedicated respite facilities varies significantly between houses and times – demand is higher during weekends.

Dedicated respite houses carry the most financial risk for providers compared with other respite options as they require investment in leasing or purchasing a property, modifying and furnishing the property and staffing the service. There is currently variability in the rates paid for facility-based respite, which is not necessarily related to the extent of support provided at the service.

It is difficult to get a clear picture of demand for dedicated respite houses. At present there are few alternatives. Our survey found that 48 percent of the respondents would like to use a respite house, and 40 percent said they would not (the remaining respondents were already using a respite house). Reasons people gave for not wanting to use a respite house included:

- fear of and guilt at leaving a disabled family/whānau member with strangers in an unfamiliar environment
- fear for the safety of the disabled person (specific fears included abuse, escape, falls and medical needs not being attended to)
- worry that the disabled person's behaviour would deteriorate and/or trigger anxiety
- belief that a disabled child was too young for overnight respite
- a preference for other options.

Current evidence suggests that dedicated respite houses are an outdated and institutional model of care and that parents in particular would like respite facilities to be more homely and less institutionalised, with more activities and outings available. Younger children can find residential care especially difficult.

Under the current model, some respite houses are closing or in danger of closing due to low occupancy. Some providers tell us that they continue to offer a respite bed because they see the need in the community and their organisational values support the service being continued.

Other providers report that they have waiting lists of people wanting to access their services. Individuals and community groups have sometimes contacted the Ministry seeking to set up new respite houses in response to apparent demand for overnight respite within their communities.

Most facility-based respite is located in cities, where there is higher demand for the service. As a result, people who live rurally or in smaller towns generally have to travel to a larger centre to access a respite house.

The availability and funding model for current facility-based respite is difficult to manage as occupancy rates vary considerably. Trying to find the balance between compatibility of people using the service (eg, not mixing children with adults), their level of need and days that work best for the family/whānau (eg, weekends rather than week days) has resulted in providers struggling to fully utilise available respite beds.

Child- or adult-specific facilities

The current facility-based respite contracts specify a maximum age for children and young people. When a young person turns 16 (or 21 for some facilities), they are required to transfer to an adult facility.

Survey feedback from providers, disabled people and their families/whānau often expressed a desire to remove the age cap from the children's respite house contracts so that people could remain in a respite house they were used to visiting and 'grow with it'.

Community residential houses

Disabled people may be able to access respite where there is a spare bed in a community residential house in which other people with disabilities live permanently. This option is generally available for adults only.

Some feedback from disabled people, their families/whānau and providers expressed the belief that this option is not ideal because it can be unsettling for a home's permanent residents to experience various people coming and going throughout the week. In contrast, some feedback stated that there were potential benefits in some situations: having respite residents to stay could provide some variety for permanent residents and allow for new friendships to develop.

From a provider perspective, it is more cost-effective for residential houses to cater for permanent residents rather than respite residents. There are administration costs involved with providing respite. In addition, where a respite resident visits a community residential house, support workers often need to become familiar with additional medication or behavioural or other support plans.

Some community residential house providers may accept a respite client only until they can fill the bed with a permanent client. This causes disruption for the respite client at that point.

One benefit for providers in having respite clients in community residential houses is that it allows them to show disabled people and their families/whānau what they can offer. A disabled person may later choose to move into the home permanently. Respite thus provides an easy transition for the disabled person; an opportunity to 'try before they buy'.

Aged care facilities

Aged care facilities are not ideal for people under the age of 65, but they have the benefit of being available in all parts of the country and able to provide hospital-level care.

Our survey found that overnight stays in an aged care facility was the least popular option of all those presented. People aged over 65 were more willing to receive respite in an aged care facility, compared with those aged under 65.

Individualised Funding (IF) respite

IF enables a disabled person and/or their family/whānau to decide how and when they receive home and community supports services (HCSS)[5] or respite, who provides the support and how much they're paid.

Of respondents to our survey, 193 people were using IF respite. Many noted that the benefits of this system included increased flexibility and the ability to choose their own carers.

> In terms of IF respite – feedback is great because people make their own choices and are in charge of quality and effectiveness themselves. Feedback is universally about the low rate being insufficient and the hassle therefore of keeping the two budgets separate. Delivery and supports are not the issue.

However, IF users and disability service providers also report that:

- disabled people are sometimes unable to use their full allocation of IF respite (usually because they are unable to find relief carers)
- the IF respite overnight rate is too low and is a barrier to purchasing facility-based respite
- the Ministry requirement for IF users to account for their use of IF respite separately from their use of HCSS is onerous and overly bureaucratic.

In-home support

The Ministry currently allocates approximately 1,924 people with disabilities funding for in-home or buddy support.

People using this type of respite have reported problems with finding support workers or buddies, lack of consistency in the buddy who provides the service and lack of reliability and back-up when buddies are not available.

> We can't find a buddy that wants to work with my son because of our rural location.

Host-family respite

Host-family respite has the benefit of widening the support network of a disabled person and their family/whānau – in this way, a disabled person comes to know and trust the host family, who may also extend their care in a more informal way. Host-family respite can be an option for people with all types of disability, including high and complex needs. The host family can feel like a second family for the disabled person.

It can be difficult to recruit host families to provide this service. In addition, it can be difficult to make their home accessible for a person with a physical disability or to provide them with the necessary equipment (eg, a hoist).

Responses to our survey showed that the host-family respite option works very well for some.

> Having it in our home works best for us as we have young kids too, and they love it when the other kids come to stay.

5 HCSS help disabled people live at home and access the community. They include services supporting household management (eg, meal preparation or household chores) and personal care (eg, eating and drinking, dressing and showering).

Challenges and opportunities

To offer successful respite services, we need skilled support workers and providers who are responsive to what the community wants and who can invest in continuous improvement.

We need to ensure equity of service delivery across the country, for all disability types and all ages. Disabled people and their families/whānau need to know what services are available and how to access them. There is room for improvement in all these areas.

The workforce

Finding suitable support workers or respite services is the main barrier to families/whānau making use of their respite allocation. Finding support workers in rural areas and smaller towns is a particular challenge. Electronic resources (such as the Mycare website: www.mycare.co.nz) could improve the ability of families/whānau to find carers and support workers.

> Hard to find staff, hard to find family, it's just all hard.

A lack of support workers is not unique to the disability sector. We need a cross-Ministry, cross-sector approach to attracting and retaining skilled support workers.

A number of other strategies and action plans, including the *Healthy Aging Strategy* (Associate Minister of Health 2016), *The Health and Disability Kaiāwhina Workforce Action Plan* (HWNZ and Careerforce 2014)), the *Mental Health and Addiction Workforce Action Plan 2017–2021* (Ministry of Health 2017d) and *The Disability Workforce Action Plan 2013–2016* (Ministry of Health 2013b), are already seeking to increase the availability of a competent, qualified, adaptable, person-centred workforce. Improving the availability of a skilled respite workforce is linked to actions within these other strategies and action plans.

The Ministry is also working with Te Pou o te Whakaaro Nui to progress development and leadership in the disability workforce (see Te Pou 2014). This work includes research and evaluation, workforce innovations, career promotion and planning, and sector collaboration and integration. Training and leadership grants are available to the disability workforce. More information about our work with Te Pou o te Whakaaro Nui can be found at www.tepou.co.nz

The care and support workers' pay equity settlement means that, from 1 July 2017, support workers will receive an increase in the hourly rate of pay of between 15 and 50 percent depending on their qualifications and/or experience. The settlement means that, over the next five years, the workforce will see their wages increase to between $19 and $27 per hour.

The settlement also creates incentives to help care and support workers gain formal qualifications and reduce staff turnover in the sector.[6] The settlement is expected to make support work more appealing as a career.

6 For more information about the care and support worker pay equity settlement, see Ministry of Health 2017a.

In addition, the types of respite options promoted in *Transforming Respite* would provide a framework for purposeful, fulfilling, valued and supported work, which would help with staff retention and provide a positive experience for both the disabled person and the support worker.

Managing the market

This strategy seeks to offer disabled people and their families/whānau choice, control and flexibility in their respite options. To do this, we need to consider carefully how we can best support providers to enter and remain in the business of offering flexible respite.

The Ministry would like to move to outcomes-based respite models. This will require reconsideration of the current funding model so that we can move away from paying for respite beds that may not be used and focus the available funding on providing choice for families/whānau that deliver value for money. Such a model needs to work for all parts of the system – disabled people and their families, providers and funders.

Respite allocation

NASC organisations manage disability support services through the allocation of varying types of support or, under IF, an annual budget. Our respite survey found that about one-third of people were not satisfied with their respite allocation. People mentioned having to fight to get the allocation and living in fear of losing it. Single parents considered that their allocation should take into account their greater need for respite compared with two-parent families.

Analysis of Ministry data shows that four out of five people who entered community residential housing during 2014/15 had not been allocated facility-based respite before moving out of their family home. We do not know whether a respite allocation may have prevented or delayed the entry of these people into community residential homes, but we do know that every year that entry into adult residential facilities is delayed represents an average saving to the health system of around $70,000 per person.

Children with disabilities are significantly over represented within the Ministry for Vulnerable Children, Oranga Tamariki care system, and are some of our most vulnerable children. Investment in respite, along with other services to support their family/whānau carers may prevent children from entering out-of-family care.

Investment in service development

Currently, some respite providers have limited resources to fund capital projects or invest in service development. There has been very limited respite service development in recent years, partially because of the lack of attractiveness to providers of the current respite models.

Some smaller providers are running popular and innovative respite services using Carer Support payments and community grant funding. This shows what can be achieved with the right attitude and with community support.

Respite for people with high and complex needs and medical needs

The Ministry currently contracts for a small number of specialist respite facilities that cater for children with high and complex needs who also have co-existing medical conditions (eg, a high

risk of epileptic seizure or a need for suctioning or oxygen use). These facilities have trained nursing staff and therefore receive more funding than other respite options.

The specialist respite facilities are very highly valued by the people who use them. For many of the families/whānau, there are no alternative respite supports that could cater for the level of care needed. The specialist respite facilities provide a level of support to the family/whānau that is essential to their ongoing ability to care for the disabled person in the family home.

These specialist facilities are located in Auckland and the Waikato, and are available to people in neighbouring regions. Out-of-region uptake is low, and occupancy rates are variable – some facilities are continuously full or near full, but others are underused. There are no specialist respite facilities available in the rest of the country, and consideration needs to be given as to whether such services need to be established in other regions.

People with high and complex needs also use other facility-based respite services (that are disability specific but less specialised). A one-on-one support worker may be required so that people can access these services. These services are also highly valued by the families/whānau who use them and often struggle to find any other suitable respite options.

Some young people with high and complex needs told us that they enjoyed respite and hanging out with friends there.

People with high and complex needs are usually well linked with child development services and the wider health and educations systems. However, even with access to these other services, they are not always given information about respite supports that may also be available to them.

Respite for people with challenging behaviours

Family/whānau of disabled people with challenging behaviours often need respite but find it very hard to find a suitable option.

Providers of facility-based respite may decline to accept a referral for people with challenging behaviours. The provider may consider that they are unable to support the person safely or that the person's behaviour would negatively affect others using the facility. It can also be difficult to find carers through Carer Support or in-home (buddy) support funding.

The Ministry funds specialist Behaviour Support Services for disabled people whose behaviour makes it difficult for them to engage in everyday routines, settings, activities and relationships.[7] These services work with the disabled person and their support network to make it easier for the disabled person to be independent and involved in the community.

Where it may help, families/whānau should be supported to access Behaviour Support Services so that the disabled person can participate in respite activities.

A highly skilled and supported workforce is needed to provide respite support for people with challenging behaviours.

7 For more details, see the Ministry's webpage: www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/behaviour-support-services

After-school care, before-school care and school holiday programmes

There is high demand for after-school care, before-school care and school holiday programmes ('out-of-school' care programmes) that cater for children and young people with disabilities. When respite funding becomes more flexible, it is likely that more parents will opt to use it for out-of-school care programmes.

Some mainstream out-of-school care providers we spoke with are eager to run inclusive programmes, and support children and young people with disabilities to attend. A current barrier is a lack of funding for additional staff to support children with disabilities within the programmes.

Some families/whānau currently use Carer Support to fund a support worker to attend a mainstream programme with their child. There is scope for teacher aides to provide similar support in the out-of-school care environment, using respite funding.

Mainstream out-of-school care programmes will not be suitable for all children with disabilities. The Ministry currently funds some providers to run school holiday programmes specifically for children and young people with disabilities, and other school holiday programmes are funded through Carer Support or paid for privately.

Information provision and coordination/ planning of services

The Ministry invests in Disability Information and Advisory Services (DIAS). Its DIAS providers aim to provide high-quality information to disabled people and their families/whānau, including details on where to go for more information, the services available and how to access them.

Under the new model for disability support (the New Model), the Ministry funds local area coordinators (LACs) to support disabled people and their families/whānau to access the community.[8] As part of EGL, the Ministry has also established independent facilitators, who assist disabled people and their families/whānau to 'dream big', make plans for the future and connect with their local community. Each of these roles can play a part in providing disabled people and their families/whānau with information about respite options and widening the respite support networks available to families/whānau.

DIAS, along with the LACs and independent facilitators, came about through a realisation that it is not sufficient to allocate funding for disabled people and their families/whānau – there is also a need to help people work out how to access support in the community and use their funding allocations effectively.

Our survey found that, for some families/whānau, a lack of information about options and their governing conditions was the main barrier to accessing respite. When we asked people how they would like respite delivered in future, they said they needed better information about what is available, early access to respite and help with accessing respite options.

8 The New Model is a new way of supporting disabled people to achieve their goals. It gives people more choice and control over support and funding in their everyday lives. For more information, see the Ministry's webpage New Model for Supporting Disabled People at: www.health.govt.nz/our-work/disability-services/disability-projects/new-model-supporting-disabled-people

In 2016, the Ministry engaged Sapere Research Group to review DIAS and NASC services. The review (Sapere Research Group 2017) recommended a cultural and paradigm shift for some DIAS and NASC functions to simplify and streamline them. It recommended an investment approach: aiming to meet people's needs early and, where possible, reduce the necessity for long-term disability supports, in line with LAC and EGL principles. That finding is consistent with the aims of this strategy: to ensure that families/whānau have access to clear information about respite options and that we see respite as an investment in family/whānau resilience.

> Better coordination and advertising of available services. Every parent I speak to knows of activities and services I have never come across, so a website where specific details can be posted with contact information would make life much easier for parents.

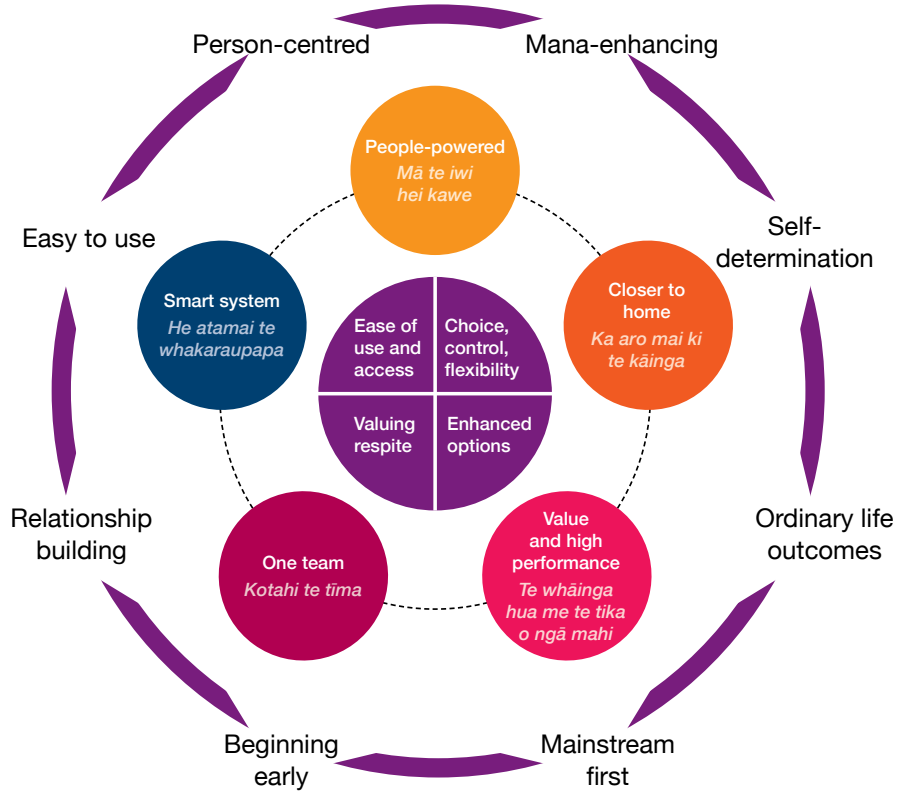
In feedback on the draft DSS respite strategy, people told us that provision of better information on the respite options available and how to access them was a priority. People also told us that they needed both online and other options for receiving information about respite options.

Future direction

The strategic framework for the future of respite encompasses the goals of both the New Zealand Health Strategy and EGL (Ministry of Health 2016a and b; Enabling Good Lives 2017). In the future, we will be focused on where we can improve existing services and where we need to innovate.

This section identifies some outcomes for this respite strategy, listed under headings that reflect our key aims – choice, control and flexibility; enhanced options; valuing respite; and ease of use and access.

Figure 1: The strategic framework for the future direction of respite



Choice, control and flexibility

Outcome 1: Disabled people and their families/whānau have control of a flexible respite budget.

In the context of respite, 'flexibility' means different things to different people, just as people's definitions of effective respite services will differ.

This strategy proposes to introduce flexible respite budgets that disabled people and their families/whānau can use to pay for or subsidise the type of break that suits them best.

Recent research shows that personal budgets can have a positive impact on the life of disabled people and their carers alike. For disabled people, the benefits include feeling in control of their support, improved physical and mental wellbeing and better relationships with family/whānau members. For carers, the benefits include improved quality of life, improved physical and mental wellbeing and support to continue caring (Hamilton et al 2016).

> The Ministry should give everyone who requires it a respite budget and let them determine who they purchase services from and/or how they want to use the budget to suit them. We need to make the 'how' and 'what' you can purchase with the respite budget more flexible and less restrictive. Respite is 'a break', and that is defined differently by everyone – this needs to be recognised and supported so that however the person wants to spend their budget to achieve that is fine. Less residential respite and more individually tailored situations.

Outcome 2: Disabled people and their families/whānau have choice and flexibility to use respite funding in ways that meet their respite needs.

The Ministry's *Purchasing Guidelines for the New Model for Supporting Disabled People* (Ministry of Health 2013a), will be used to set guidelines for the use of flexible respite budgets. These guidelines are currently used for other types of flexible disability supports, such as Enhanced Individualised Funding (EIF). The guidelines are at www.health.govt.nz/publication/purchasing-guidelines-new-model-supporting-disabled-people

Families/whānau will be able to define what a 'break' means for them. People will have clear guidance on the use of respite funding.

Families/whānau may wish to buy or subsidise respite in the following forms (this list is not exhaustive).

- A support worker coming to the family home to assist the disabled person while the family/whānau have a break outside the home, or in the home if they wish.
- Sleepovers/holidays for the disabled person with friends and family/whānau.
- Funding for transport costs for a family/whānau member or friend to come to the family home (or elsewhere) to care for the disabled person.
- A support worker to assist the disabled person while the family/whānau are all on holiday together.
- Activity-based programmes for the disabled person (such as day trips, evenings out or activities at a fixed location).
- Out-of-school care programmes.
- Holiday camps.
- Overnight stays in facility-based respite homes or with another family/whānau.

To meet people's diverse respite needs, we need to focus on outcomes. The main outcome we

are seeking is primary carers who: are not stressed, are resilient, have capacity to have ordinary life experiences and feel able to continue to provide care. This requires a new way of thinking, involving, in particular, support for families/whānau that meet their needs, whatever those needs are.

Enhanced options

Outcome 3: Disabled people can access a range of respite options.

Implementing this strategy will see an expanded range of respite services in response to local demand. We encourage disabled people, providers, families/whānau and groups of parents to work together to design innovative respite solutions.

This strategy will focus on respite that takes the form of active, person-centred and community-based recreation that builds disabled people's competencies rather than additional passive leisure time (Armstrong and Shevallar 2009).

This strategy encourages providers to respond to the changing and evolving desires of disabled people and their families/whānau and develop a new range of services to meet changing needs. Feedback included the need for more meaningful activities programmes available for disabled adults during business hours and for more out-of-school care options for school-aged people with disabilities.

Outcome 4: Families/whānau who care for disabled people with challenging behaviours or high and complex needs can experience a break from the caring role.

This strategy proposes co-designing an appropriate model for ensuring respite services are available to those who need them most. The focus would be on determining how to deliver respite services for those with challenging behaviours, services that cater for high and complex or medical needs and a sustainable model for dedicated facility-based respite.

To achieve this outcome, the Ministry would engage with providers, stakeholders, other agencies and other parts of the health and disability sector to explore how we can share resources and achieve joint outcomes.

Outcome 5: Families/whānau who wish to access mainstream or disability-specific out-of-school care programmes are able to do so.

This strategy proposes to work with out-of-school care providers, alongside other agencies, to reduce barriers to disabled children and young people accessing mainstream and disability-specific programmes.

Outcome 6: Respite services provide a fulfilling work environment for support workers.

This strategy proposes to support the development of a range of respite options that are empowering for disabled people, support workers and providers alike. Where respite options work well, support workers act with initiative and purposefully work to enhance the competencies of disabled people. Both the support worker and the disabled person grow, and the support worker's job is meaningful and fulfilling. An effective workforce also brings benefits to providers.

Valuing respite

Outcome 7: Support for disabled people and their families/whānau to have a break from the caring role begins early and evolves throughout their lives.

An investment approach is about recognising that up-front support will provide stress relief and assist families/whānau to stay together. It involves providing support early to improve outcomes and potentially make savings later. Early investment can:

- reduce future need or escalation of need
- reduce the total cost of support over the lifetime of a person with a disability
- achieve better long-term outcomes
- support people to become more independent.

The Ministry's recent review of NASC organisations (Sapere Research Group 2017) found that a reduction in the costs of care over a disabled person's lifetime should arise from administrative streamlining, more innovative allocations with an investment approach and additional flexibility.

This strategy proposes to introduce a paradigm shift towards an investment approach, through which we allocate supports that will enable disabled people and their families/whānau to live more independently in future.

As we transform respite, we will update NASC allocation guidelines to reflect this investment approach. In future, support to access respite may include:

- working with families/whānau on the importance of taking regular breaks from the caring role
- encouraging families/whānau to build a support network of trusted friends and family/whānau and to ask them for help
- allocating funding for respite where it is needed, *before* the family/whānau becomes stressed and at risk of breakdown
- enabling families/whānau to find and use respite options that work for them.

With children and young people, we find starting early with their family/whānau is important as it allows us to help them build their connection to their community and natural supports from the beginning. We also find using ordinary terms such as babysitting, sleepovers and holiday programmes, rather than the term 'respite' is helpful. In general, it is important that families/whānau do not see respite as something punitive or about sending their family member away but part of everyday life.

Outcome 8: Ongoing improvements to respite supports are identified through measuring the effective achievement of outcomes.

We need a way to measure whether the changes we are making to respite are achieving the improvements that we expect. We need to design a comprehensive framework for evaluating how the outcomes set out in this strategy are being achieved.

The evaluation framework will:

- enable us to identify and implement further quality improvement initiatives
- set out what data needs to be collected and how it will be used to inform our future planning and decision-making
- be linked to the evaluation framework for the disability system transformation
- incorporate feedback and complaints from people using respite services, support workers and providers.

An important part of measuring the quality of service delivery is enabling people to make complaints or suggestions for ways to improve the services they are using. The Ministry encourages providers of disability support services to have a culture that supports people to speak out and provides those people with the opportunity to give feedback regularly. In addition, DSS has a team of people who investigates and responds to complaints made about disability services. More information on how to make a complaint about a disability service can be found on the Ministry's webpage Complaints about Health and Disability Services at: www.health.govt.nz/about-ministry/contact-us/complaints-about-health-and-disability-service

Ease of use and access

Outcome 9: Respite support payments are easy to administer.

This strategy proposes looking at options for replacing the current Carer Support claim and payment system with a flexible respite budget, administered electronically. This may result in an online platform, through which people could find volunteer carers, support workers or respite providers and offer koha or subsidise or pay for services from their flexible respite budget.

Outcome 10: Disabled people and their families/whānau can find and access respite options in their community.

This strategy proposes setting up comprehensive online resources to support families/whānau to find and engage carers or respite services. Printed versions of the resources would be available from NASCs, DIAS and in the community for people who do not have access to computers or the internet.

The strategy proposes setting up a mechanism for providing help to families/whānau who need support to find out what respite options are available and how to access them. This help would include access to LACs, where available, or alternative support through DIAS and/or NASC.

Outcome 11: NASCs are supported to implement changes to respite.

This strategy proposes engaging with NASC staff to support them in moving towards an investment approach. This includes allocating supports, access to Behavioural Support Services (where challenging behaviour is a barrier to accessing respite) and ensuring that families/whānau have help to determine what options are available and how to access them.

Implementation roadmap

The following table sets out a proposed roadmap for implementing the respite strategy.

Choice, control and flexibility		
Outcome 1:	**Disabled people and their families/whānau have control of a flexible respite budget.**	
Outcome 2:	**Disabled people and their families/whānau have choice and flexibility to use respite funding in ways that meet their respite needs.**	
Actions	**Within one or two years**	**Within three to five years**
Action 1: We convert existing respite funding for each family/whānau to a flexible budget with fewer restrictions for its use.	Disabled people and their families/whānau can access and pay for supports online.	Disabled people and their families/whānau can use respite budgets flexibly alongside other support funding they receive (such as funding for personal care, household management and supported/independent living).
Action 2: We develop clear guidelines for funding use.	The market responds to the strategy, offering services that people want to buy.	

Enhanced options		
Outcome 3:	**Disabled people can access a range of respite options.**	
Actions	**Within one or two years**	**Within one or two years**
Action 3: We investigate innovative ways to enable respite service development.	Providers connect with local communities to determine the respite services required in each region. More respite options are available.	A wide range of quality respite options are readily available throughout the country.
Outcome 4:	**Families/whānau who care for disabled people with challenging behaviours or high and complex needs can experience a break from the caring role.**	
Actions	**Within one or two years**	**Within one or two years**
Action 4: The Ministry looks at ways of co-designing new models for respite that include input from across the health sector as well as other agencies.	All agencies understand each other's position regarding access to facilities and other supports. A work plan is established that involves the operation of joint services where possible. A respite purchasing model is completed.	A joint approach to sharing facilities or other supports for disabled people with challenging behaviours or high and complex needs is in place where possible. We are equitably supporting all families/whānau to access respite.

Outcome 5: Families/whānau who wish to access mainstream or disability-specific out-of-school care programmes are able to do so.		
Actions	**Within one or two years**	**Within three to five years**
Action 5: We work with the Ministry of Social Development, the Ministry of Education, schools and out-of-school care providers to remove barriers to access to out-of-school care programmes.	No policy or operational barriers to accessing out-of-school care remain. Out-of-school care providers are responsive to the needs of disabled children and young people.	Children and young people with disabilities can access mainstream out-of-school care programmes if they wish to.
Outcome 6: Respite services provide a fulfilling work environment for support workers.		
Actions	**Within one or two years**	**Within three to five years**
Action 6: The Ministry's Disability Workforce Action Plan includes actions to address current difficulties in attracting and retaining support workers.	Families/whānau find it easier to find paid support workers or volunteer carers.	Families/whānau can find paid support workers or volunteer carers. Work as a support worker is fulfilling and is seen as adding value to the life of disabled people, and to the wider community.

Valuing respite

Outcome 7: Support for disabled people and their families/whānau to have a break from the caring role begins early and evolves throughout their lives.		
Actions	**Within one or two years**	**Within three to five years**
Action 7: We update NASC allocation guidelines and training to encourage an investment approach and more flexibility to allocating respite.	NASC services have access to updated information and training to support them in taking an investment approach to allocating respite.	NASC services are able to provide families/whānau with certainty and confidence that they can take a break through all stages of their lives.
Outcome 8: Ongoing improvements to respite supports are identified through measuring the effective achievement of outcomes.		
Actions	**Within one or two years**	**Within three to five years**
Action 8: The Ministry and stakeholders design a framework for measuring achievement of the outcomes.	An outcomes measurement framework is in place, and necessary data is being collected. People are aware of how to make a complaint if they are unhappy with a service.	Evaluation of outcomes shows that families/whānau are better able to access respite.

Ease of use and access

Outcome 9: Respite support payments are easy to administer.

Actions	Within one or two years	Within three to five years
Action 9: Work is undertaken to improve the current Carer Support administration system with an electronic processing option.	Some people can access their flexible respite budget online and pay for respite supports online. An alternative system for administering respite supports exists for those who wish to use it.	Most people can access their flexible respite budget online and pay for respite supports online.

Outcome 10: Disabled people and their families/whānau can find and access respite options in their community.

Actions	Within one or two years	Within three to five years
Action 10: LAC, NASCs and DIAS have comprehensive information about all available respite options in each region in an easily accessible format and are knowledgeable about changes to respite.	Guidelines are in place, and DIAS have updated their information.	Comprehensive information on the range of respite options in each area is available online and through LAC, NASC and DIAS.

Outcome 11: NASCs are supported to implement changes to respite.

Actions	Within one or two years	Within three to five years
Action 11: We work with NASC services on: • taking an investment approach • using flexible respite funding • offering behavioural support services • supporting families/whānau to understand the need to take a break and how to build a community of support • ensuring families/whānau have help to identify and access respite options.	NASC services begin to take an investment approach to allocating supports. Families/whānau have advice on respite options and access.	Families/whānau feel supported by NASC services to access respite. Families/whānau who want it, have access to independent help to find and access services.

Glossary

Carer: A person assisting a family/whānau member or friend who has a disability to do everyday activities.

Carer Support: A subsidy to cover some of the costs of using a support person to help a carer take a break from the caring role.

Disability Information and Advisory Services (DIAS): Organisations who share information and connect people with disability services and other disability related resources.

Disability Support Services (DSS): The group within the Ministry of Health that is responsible for the planning and funding of disability support services.

Enabling Good Lives (EGL): An approach to supporting disabled people that aims to make it easier for disabled people and their families/whānau to create good lives for themselves by offering them greater choice and control over the supports they receive.

Facility-based respite: Care provided for a disabled person out of their home, usually overnight in a dedicated respite house or other facility, which provides care for a group of about five people at one time.

Individualised Funding/Enhanced Individualised Funding (IF/EIF): Mechanisms that enable disabled people to manage their disability supports directly. IF gives disabled people more choice in how they are supported and includes an option to employ their own support worker directly.

Kaiāwhina: The over-arching term to describe non-regulated roles in the health and disability sector. The term does not replace the specific role titles, for example: health care assistant, orderly, mental health support worker.

Local area coordinator (LAC): A person working in the disability sector to assist disabled people and their families/whānau to live good, everyday lives within welcoming communities, hapū and iwi.

Ministry of Health: The government's principal advisor on health and disability: improving, promoting and protecting the health of all New Zealanders.

Needs Assessment Service Coordination Services (NASCs): Organisations contracted by the Ministry of Health to work with a disabled person and their family/whānau or carers to identify the disabled person's strengths and support needs, outline what disability support services are available and determine their eligibility for Ministry of Health-funded support services.

Respite: Short-term breaks for the carers of a disabled person that also provide a positive, stimulating and worthwhile experience for the disabled person.

Support worker: An individual employed or contracted to perform respite support tasks for the disabled person and their family/whānau. This term also includes volunteers.

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Appendix 1: Strategic framework

The New Zealand Health Strategy

The New Zealand Health Strategy (see Minister of Health 2016a) provides the overarching framework for our country's health system. The central concept is that 'all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system'. The concept of a 'people-powered' system is particularly relevant to this respite strategy.

He Korowai Oranga

New Zealand's Māori Health Strategy, He Korowai Oranga (see Ministry of Health 2014a) sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori.

New Zealand Disability Strategy

The vision of the New Zealand Disability Strategy (see Office for Disability Issues 2016) is to have New Zealand become a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all New Zealanders works together to make this happen. *Transforming Respite* particularly reflects the New Zealand Disability Strategy's principles of choice and control, investing in our whole lives, ensuring disabled people are part of the decision-making process and developing specific and mainstream support and services.

Disability Support System Transformation

Work is under way to transform New Zealand's disability support system, based on the Enabling Good Lives (EGL) vision and principles and informed by evidence of 'what works'. *Transforming Respite* is linked to this transformation work.

Whāia Te Ao Mārama

Whāia Te Ao Mārama (see Ministry of Health 2012) is the Māori Disability Action Plan for Disability Support Services from 2012 to 2017. A refreshed Whāia Te Ao Mārama for 2017 to 2022 will be released in late 2017 on the Ministry's website. This respite strategy contributes to the vision of Whāia Te Ao Mārama; in particular, it supports tangata whaikaha (disabled people) and their whānau to achieve a good quality of life and wellbeing and to participate in their communities as other New Zealanders do.

We discussed *Transforming Respite* with Te Ao Mārama, and invited the group to distribute our respite survey through their networks. We received a significant number of responses from tangata whaikaha and their whānau – 204 responses (14 percent) were from individuals who identified as Māori.

Faiva Ora 2016–2021: the National Pasifika Disability Plan

Faiva Ora 2016–2021, the National Pasifika Disability Plan (see Ministry of Health 2017c) outlines the vision that Pacific disabled people and their families/whānau are supported to live the lives they choose. We engaged with the Faiva Ora Leadership Group in developing this strategy.

This strategy recognises that Pacific peoples have a preference for Pacific-specific disability services. They prefer respite services provided by Pacific relief carers, who understand their language and their cultural needs.

Disability Action Plan 2014–2018 (Update 2015)

The Disability Action Plan 2014–2018 (see Office for Disability Issues 2014) sets out priorities for actions that promote disabled people's participation and contribution in society. It advances implementation of the United Nations' Convention on the Rights of Persons with Disabilities (United Nations 2006) and New Zealand's Disability Strategy (Office for Disability Issues 2016).

Priorities that align with *Transforming Respite* include disabled people having choice and control over their supports/services, making more efficient use of disability support funding and reducing barriers to disabled people making decisions to determine their own lives.

New Zealand Carers' Strategy Action Plan for 2014 to 2018

The New Zealand Carers' Strategy Action Plan for 2014 to 2018 (see Ministry of Social Development 2014) aims to improve support for families/whānau in their role of caring for someone with a health condition or disability.

Enabling carers to take a break is objective 1 of the plan. *Transforming Respite* contributes significantly to meeting this objective, as well as three objectives from the plan: protecting the health and wellbeing of family/whānau and carers; providing information that families/whānau and carers need and improving pathways to employment for carers.

The Health and Disability Kaiāwhina Workforce Action Plan

The Health and Disability Kaiāwhina Workforce Action Plan (see HWNZ and Careerforce 2014) aims to build a kaiāwhina workforce(people who hold unregulated roles in the health and disability sector) that adds value to the health and wellbeing of New Zealanders by being competent and adaptable, as well as an integral part of service provision.

The Disability Workforce Action Plan 2013–2016

This action plan is led by the Ministry, with advice from the disability workforce reference groups. The action plan's aims include increasing the skills of the disability workforce, increasing the skills of people with disabilities and improving the learning options for carers.

Appendix 2: Methodology and stakeholder engagement

We developed this strategy by openly engaging with key stakeholders. We implemented a stakeholder engagement plan to ensure all stakeholders had an opportunity to be involved. We shared information about the objectives and scope of the strategy on the Ministry's website.

We conducted an online survey for disabled people and their families/whānau, and a separate survey for providers, about current and future respite options. We thank those who responded to our survey. We received 1,268 responses to the online survey from disabled people and their families/whānau and 50 responses to the provider survey. We used the information received through the survey extensively during development of this strategy. The results of the survey have been published on the Ministry's website (see Ministry of Health 2017b).

We also engaged stakeholders through:

- meetings with key providers and consumer groups (face to face and by telephone) to inform them of the strategy scope and the impact of potential changes
- presentations and workshops with Te Ao Mārama Group (a Māori advisory group), the Faiva Ora Leadership Group (a forum for Pacific stakeholders), the Consumer Consortium (an advisory group of people representing national disability organisations), Needs Assessment and Service Coordination services (NASCs), the Cerebral Palsy Society and at provider forums and the IF conference
- meetings with other government agencies (including ACC, the Ministry of Social Development and the Ministry of Education) to explore areas of joint interest
- communication with other teams within DSS and the Ministry (Health of Older People, Mental Health, Audit and Compliance, Policy and Payments and Purchasing), to identify areas of potential collaboration and joint service improvement
- email and phone contact with stakeholders who wished to get in touch with us (we provided contact details on the Ministry's website for this purpose).

In addition, in developing this strategy, we took into account:

- a review of how respite is provided overseas
- a literature review to identify best practices in respite
- a cost–benefit analysis
- consideration of the history of respite in New Zealand and previous reviews
- alignment with the New Model, EGL, the New Zealand Health Strategy and the New Zealand Disability Strategy.

The draft strategy (Ministry of Health 2017e) was released for feedback from 31 March to 3 May 2017. During the sector engagement period, around 160 people attended workshops in Auckland, Wellington and Christchurch. We received 114 written and telephone submissions on the draft strategy. A summary of submissions document is available on the Ministry's website (www.health.govt.nz).

We met with approximately 90 parents of children and young people with high and complex needs and attended a public meeting in Dunedin with around 50 attendees. We also discussed the strategy with sector groups, such as the Consumer Consortium, Te Ao Mārama Group and NASC governance groups.

We engaged specifically with youth with disabilities to ensure that we heard what children and young people wanted in a respite service.

AGENDA – PUBLIC

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

WEST COAST DISTRICT HEALTH BOARD MEETING
to be held at the Regional Council, Main Road, Greymouth
on Friday 23 June 2017 commencing at 1.15pm

KARAKIA			
ADMINISTRATION			***1.15pm***
	Apologies		
1.	**Interest Register**		
2.	**Confirmation of the Minutes of the Previous Meetings** • *12 May 2017*		
3.	**Carried Forward/Action List Items** *(there are no carried forward items)*		
REPORTS FOR NOTING			***1.20pm***
4.	**Chair's Update** **(Verbal Update)**	Jenny Black *Chairperson*	*1.20pm – 1.25pm*
5.	**Chief Executive's Update**	Michael Frampton *General Manager, People & Capability*	*1.25pm – 1.35pm*
6.	**Clinical Leader's Update**	Karyn Bousfield *Director of Nursing* Mr Pradu Dayaram *Medical Director, Facilities Development*	*1.35pm – 1.40pm*
7.	**Finance Report**	Justine White *General Manager, Finance*	*1.40pm – 1.50am*
8.	**Wellbeing Health & Safety Update**	Michael Frampton *General Manager, People & Capability*	*1.50pm – 2.00pm*
9.	**Maori Health Update**	Kylie Parkin *Portfolio Manager, Maori Health*	*2.00pm – 2.10pm*
10.	**Reports form Committee Meetings**		
	- CPH&DSAC *8 June 2017*	Elinor Stratford *Chair, CPH&DSA Committee*	*2.10pm – 2.15pm*
	- Hospital Advisory Committee *8 June 2017*	Michelle Lomax *Chair, Hospital Advisory Committee*	*2.15pm – 2.20pm*
11.	**Resolution to Exclude the Public**	*Board Secretary*	*2.20pm*
INFORMATION ITEMS			
ESTIMATED FINISH TIME			***2.20pm***

NEXT MEETING: Friday 11 August 2017

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE 8 JUNE 2017

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Chair, Community & Public Health & Disability Support Advisory Committee**

DATE: **8 June 2017**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as an interim update on the Community & Public Health & Disability Support Advisory Committee (CPH&DSAC) meeting of 8 June 2017.

For the Board's information the functions of CPH&DSAC, in accordance with their Terms of Reference and the New Zealand Public Health and Disability Act 2000:

"*With respect to Community and Public Health, is to provide advice and recommendations to the Board of the West Coast District Health Board on:*
- *the health needs of the resident population of the West Coast District Health Board; and*
- *any factors that the Committee believes may adversely affect the health status of the resident population, and*
- *the priorities for the use of the health funding available*

With respect to Disability Support, are to provide advice and recommendations to the Board of the West Coast District Health Board on:
- *the disability support needs of the resident population of the West Coast District Health Board, and*
- *the priorities for the use of the disability support funding provided.*"

The aim of the Committee's advice must be:
- *to ensure that the services that the West Coast District Health Board provides or funds, along with the policies it adopts, will maximise the overall health gain for the resident population of the West Coast District Health Board, and*
- *to ensure that the kind of disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, will promote the inclusion and participation in society, and maximise the independence, of people with disabilities within the resident population of the West Coast District Health Board."*

The Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy, the New Zealand Disability Strategy and with the Strategic Plan and the Disability Support Action Plan of the West Coast District Health Board."

2. RECOMMENDATION

That the Board:

i. notes the Community & Public Health & Disability Support Advisory Committee Meeting Update – 8 June 2017.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

a) COMMUNITY AND PUBLIC HEALTH UPDATE

This report was provided to the Committee with updates as follows:

Smokefree May
CPH staff, as part of the West Coast Tobacco Free Coalition, have been raising awareness of Smokefree May and World Smokefree Day with a variety of activities including media articles and promotions at The Warehouse and Salvation Army in Greymouth, and on the main street of Westport. These promotions have included letting people know about the range of Stop Smoking services available on the West Coast.

Alcohol
Three West Coast CPH staff members attended the National Alcohol Public Health Workshop in Auckland in mid-May. This meeting covered both regulatory issues and health promotion. Topics included an update on the Ministerial Review on Alcohol Advertising and Sponsorship, using social media to address social supply of alcohol, and alcohol harm reduction projects in sports clubs. The meeting also discussed a recent decision by the Alcohol Regulatory and Licensing Authority (ARLA) in the matter of a Dannevirke supermarket single area. The ARLA decision has the effect of potentially undermining the work done to reduce exposure to alcohol in supermarkets, including recent High Court and Court of Appeal judgements. Whether or not this decision will be appealed is not yet known.

The Committee noted that in Greymouth CPH have worked with the two Supermarkets with positive results and no need for court action.

Food Security
CPH hosted a workshop on Food Security in Greymouth on 26 April. Attendees included individuals and organisations working with West Coasters who are struggling to provide sufficient nourishing food for themselves and their families. There was a very good response, with approximately thirty people in attendance. The purpose of the workshop was to start to build a picture of what food insecurity looks like on the West Coast, find out what activities are already taking place to address this, as well as highlighting any gaps and potential future actions. The discussion points and findings from the workshop are now being pulled together and a report is being compiled to assist in informing future actions.

Nutrition
CPH ran six cooking skills and nutrition sessions at Alternative Education, Greymouth. During the six week course it became apparent that the students' cooking skills and knowledge have developed and progressed, requiring a change in complexity of meals to continue their development. Alternative Education continues to be a very valuable setting to work in. The evaluations show that the students really enjoy cooking and are learning new things each session. In the last session, one student said that he really enjoyed learning to make his favourite dishes in different ways.

A resource "Nourishing Futures with better Kai" has been developed and will be provided to members at the next meeting.

Kaumātua Flu Vaccination Clinic
CPH, working alongside Westland Medical Centre, West Coast DHB and Poutini Waiora, facilitated a flu vaccination clinic for kaumātua at Arahura marae in April. Twelve kaumātua received their vaccinations, as well as learning more information about vaccinations available for all whanau members, including their mokopuna.

Health Promoting Schools (HPS)
A Community Partnerships meeting at South Westland Area School (SWAS) is scheduled to take place on 31 May 2017. The school has been working actively on establishing and developing community partnerships over the past year. Those professionals working within the school and/or with students from SWAS have been invited and include Rural Nurse Specialist's, local Police, Resource Teacher, Learning and Behaviour (RTLB), WestREAP youth mentors, West Coast PHO Counsellor, and the HPS facilitator.

Le Va Community Suicide Prevention Workshop
The Le Va Flo Talanoa workshop was held in Runanga on 16 May. Sixteen people attended to learn about suicide prevention with a strong community action focus. This was work which developed from the Runanga leaflet that was produced last year with the Runanga Action Group, and the follow-up to the Regent Theatre event in September with Eroni Clarke and Quintin Pongia. Positive discussion and learning took place, work will continue with the Runanga community as required.

Submissions on Council Annual Plans
Over the last month CPH has made submissions regarding the Grey District Council and Buller District Council draft 2017/18 Annual Plans (Westland District Council did not consult this time around). Submissions covered a range of issues including smokefree outdoor spaces, water quality and other environmental issues. We are now working on a submission for the West Coast Regional Council (WCRC), which is due at the end of June. Amongst other things, the West Coast Regional Council is proposing a new organisational structure and staffing for Civil Defence and Emergency Management which will enhance capacity to plan for and respond to emergencies on the West Coast.

The report was noted.

b) PLANNING & FUNDING UPDATE

This report provided the Committee with an update on progress made on the Minister of Health's health and disability priorities and the West Coast DHBs Annual Plan key priority areas as follows:

Key Achievements

- **ED Health Target:** Performance continues to be impressive with 100% of patients admitted, discharged or transferred from Grey Base ED within six hours during quarter three. The West Coast continues to lead the country in performance against this target.
- **Elective Services Health Target:** West Coast DHB has provided 1,441 elective surgical discharges to 31 March; delivering 105% of planned discharges against year-to-date target.
- **ESPI 2 |First Specialist Assessment (FSA):** West Coast DHB is now within tolerance parameters for meeting the maximum 120 days' national wait time target for ESPI 2, with just one orthopaedic patient overdue for FSA as at 31 March 2017. A concerted effort was made in March to get those patients who were overdue seen.
- **ESPI 5 | FSA to Treatment:** West Coast DHB was also within compliance tolerance levels for ESPI 5, with only three patients exceeding the 120-day maximum wait time for surgery as at the end of March 2017 (two orthopaedic patients and one plastic surgery patient).

Key Issues & Associated Remedies

- **Aged Residential Care Services:** Work is ongoing with Aged Residential Care Facility Granger House while the organisation is in receivership. The receiver has made a number of new appointments and West Coast DHB has added clinical oversight to support the safety of the residents.

The work taking place across the Older Persons Health team in relation to Granger House was acknowledged by the Committee.

Discussion took place regarding social isolation in regard to keeping people well in their own homes. The role of CCCN in the coordination of health services was also discussed and working with other organisations as much as possible is also a priority.

The Committee noted that in Buller when Kynnersley was closed the Diversional Therapist was reallocated to the community and she has done a lot of work around social isolation and the integration of people into local activities.

The report was noted.

c) HEALTH TARGETS – QUARTER 3

In Quarter 3, the West Coast has:

- Achieved the shorter stays in ED health target, with 100% of people admitted or discharged within six hours. The West Coast continues to maintain consistent performance against this health target.
- Achieved the improved access to elective surgery health target, with 1,441 elective surgical discharges year-to-date, delivering 105.5% of planned discharges against target.
- Achieved the better help for smokers to quit health target, with practitioners giving 4,888 smokers cessation advice in the 18 months ending March 2017. This represents 92% of smokers against the 90% target.
- Improved performance against the faster cancer treatment health target with results lifting from 76.2% to 83.3% narrowly missing the target. This result reflects only four patients whose treatment was non-compliant with target. Audits into patient pathways have taken place with no capacity issues identified
- Improved performance against the increased immunisation health target, missing only one child during this quarter and reaching all Maori children. West Coast vaccinated 91.4% of the eligible population.
- Performance slightly increased against raising healthy kids health target to 17%. Four children were identified as obese and not referred. This issue has been discussed at a national level and we will be looking to improve database access.

Discussion took place regarding the Raising Healthy Kids target and the confusion around BMI readings. The Committee noted that this has been quite common nationally and there were also issues around declines of referrals.

The update was noted.

d) ALLIANCE UPDATE

This report provided an update of progress made around the West Coast Alliance regarding:

Alliance Leadership Team (ALT)

At the last meeting in May the ALT:

- Reviewed the Mental Health project plan and heard about the team leading this work.
- Acknowledged the good work put in to developing the Model of Care document that has been drafted by the Primary & Community project team.
- Noted the report regarding usage of Telehealth on the Coast and the positive impact this is having in terms of patients and the environment.
- Note the planned changes to the eligibility criteria for accessing subsidised (free to patient)

access to Sexual Health services at general practice with the upper age limit being raised to 24 across the Coast from 1st July.

- Were pleased to hear about the progress being made to provide Pregnancy & Parenting Education to hard to reach Māori through a collaborative approach by Plunket, Poutini Waiora and Lead Maternity Carer.

Health of Older Persons

- Work is ongoing with Home-Based Support Services(HBSS) to gather relevant data items to generate monthly reports on time from referral to assessment and number of HBSS clients with a care plan in place.
- 80% of people in Aged Residential Care facilities have had a subsequent interRAI Long Term Care Facility assessment completed within 230 days of the previous assessment. The HOP workstream is encouraged to see this significant improvement from 44% in the previous quarter.

Integrated Family Health Service (IFHS) Workstreams (Grey|Westland, Buller & Reefton)

- Development work is underway to create a primary urgent care service to provide greater access for communities to primary care. The service is being designed to ensure that it supports the primary practices in continuing to provide planned and proactive care to our communities.
- The Proposal for change for integrating the workforce at Reefton was approved and as at 1st July the team will be fully integrated.

Healthy West Coast (HWC)

- Following the presentation "Alcohol & the Amazing Brain" that was delivered to schools and community groups on the Coast, over 70% of the young people who attended have provided feedback regarding their experiences with alcohol; close to 1,000 responses from students in years 9-13. A follow up survey is being sent to adults who attended either the school or community sessions.
- West Coast DHB, PHO and Oranga Hā – Tai Poutini have taken part in the first Regional Tobacco Integration Network meeting. This meeting is aimed at reviewing the approach to Tobacco Control across the South Island. The regional Network is aligned to a National Network. This forms the beginning of phase two of the Tobacco Control Realignment process which begun in 2015. The focus of the work is currently on quality assurance for all training being provided to health professionals in regards to tobacco control and smoking cessation.
- Plunket will be partnering with a local Maori Lead Maternity Carer as well as the Tamariki Ora Nurse and Mama & Pepi Kaimahi from Poutini Waiora to deliver Pregnancy and Parenting Education. It is envisaged that existing relationships will encourage young Maori women in particular to engage in these sessions.
- Community & Public Health hosted a workshop for local stakeholders looking at the Food Security status of our community. A report from the workshop is being compiled and will guide future actions to support our vulnerable families.

Child and Youth

- Recruitment for the realigned Gateway Coordinator role is progressing well and it anticipated that this role will provide improved support for the Gateway programme as well as other initiatives that support vulnerable children and whanau.
- The PHO have raised the age at which young people can access free Sexual Health and Contraception advice via their general practice; from 1 July this will be available to all young people 24 and under.

The report was noted.

e) MAORI HEALTH UPDATE

The Maori Health update is included in todays Board papers.

f) GENERAL BUSINESS

- Philip Wheble, Interim General Manager, Grey/Westland, provided the Committee with an overview of work that is underway to develop options of targeted support and intervention for families where a child is identified as high needs in regard to their oral health. Work is also to take place around making the Oral Health a sustainable service. The Committee noted that some workshops will be held around this and an invitation will be extended to some Committee members to attend.

- The Chair advised that on 29 May the 70th World Health Assembly was held in Geneva. The link to the agenda is shown below for those interested.
  http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_1Rev2-en.pdf?ua=1
  Of particular note was that the Assembly endorsed a global action plan around dementia.

Report prepared by: Elinor Stratford, Chair, Community & Public Health & Disability Support Advisory Committee

AGENDA

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room, Corporate Office, Greymouth Hospital
Thursday 8 June 2017 commencing at 9.30am

ADMINISTRATION — 9.30am

Karakia

Apologies

1. **Interest Register**
   Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.

2. **Confirmation of the Minutes of the Previous Meeting**
   27 April 2017

3. **Carried Forward/ Action Items**

REPORTS/PRESENTATIONS — 9.35am

4.	**Community and Public Health Update**	Derek Benfield *Community and Public Health West Coast Regional Manger*	*9.35am – 9.45am*
5.	**Planning & Funding Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.45am – 9.55am*
6.	**Health Target Q3 Report**	Carolyn Gullery *General Manager, Planning & Funding*	*9.55am – 10.05am*
7.	**Alliance Update**	Carolyn Gullery *General Manager, Planning & Funding*	*10.05am – 10.15am*
8.	**Maori Health Update**	Gary Coghlan *General Manager, Maori Health*	*10.15am – 10.25am*
9.	**General Business**	Elinor Stratford *Chair*	*10.25am – 10.30am*

ESTIMATED FINISH TIME — 10.30am

INFORMATION ITEMS

- **Board Agenda – 12 May 2017**
- **Chair's Report to last Board Meeting**
- **2017 Committee Work Plan (Working Document)**
- **West Coast DHB 2017 Meeting Schedule**

NEXT MEETING

Date of Next Meeting: Thursday 27 July 2017

WORKPLAN FOR CPH&DSAC 2017 (*WORKING DOCUMENT)*

	10 March	27 April	8 June	28 July	14 September	26 October	23 November
STANDING ITEMS	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items
STANDARD REPORTS	Health Target Q2 Report 2016/17 Maori Health Plan Update Planning & Funding Update Community & Public Health Update Alliance Update 2017 Committee Work Plan	Planning & Funding Update Community & Public Health Update Alliance Update	Health Target Q3 Report 2016/17 Maori Health Plan Update Planning & Funding Update Community & Public Health Update Alliance Update	Community & Public Health Update Planning & Funding Update Alliance Update	Health Target Q4 Report 2016/17 Maori Health Plan Update Planning & Funding Update Community & Public Health Update Alliance Update	Planning & Funding Update Community & Public Health Update Alliance Update	Health Target Q1 Report 2017/18 Maori Health Plan Update Planning & Funding Update Community & Public Health Update Alliance Update
PRESENTATIONS	As required	As required	As required	As required	Drinking Water Systems & Protection	Consumer Council	Outcomes around Alcohol Project
PLANNED ITEMS	West Coast Public Health Annual Plan						
GOVERNANCE AND SECRETARIAT							
DSAC Reporting	Disability Action Plan	As available	As available	Disability Support Services Respite Strategy	Disability Action Plan Update	As available	Disability Action Plan Update
INFORMATION ITEMS	Latest Board Agenda Chair's Report to Board from last meeting 2017 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2017 Schedule of Meetings C&PH 6 Monthly report to MoH (July – Dec 2016	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2017 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2017 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2017 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan C&PH 6 Monthly report to MoH (Jan – July 2017) 2017 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2018 Schedule of Meetings

WEST COAST DHB – MEETING SCHEDULE

JANUARY – DECEMBER 2017

DATE	MEETING	TIME	VENUE
Friday 10 February 2017	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Friday 10 March 2017	CPHAC & DSAC	9.30am	Boardroom, Corporate Office
Friday 10 March 2017	HAC	11.00am	Boardroom, Corporate Office
Friday 10 March 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 24 March 2017	BOARD	10.15am	West Coast PHO Boardroom
Thursday 27 April 2017	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 27 April 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 27 April 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 12 May 2017	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 8 June 2017	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 8 June 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 8 June 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 23 June 2017	BOARD	1.15pm	West Coast Regional Council
Thursday 27 July 2017	CPHAC & DSAC	9.30am	Boardroom, Corporate Office
Thursday 27 July 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 27 July 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 11 August 2017	BOARD	10.15am	Arahura Marae
Thursday 14 September 2017	CPHAC & DSAC	9.30am	Boardroom, Corporate Office
Thursday 14 September 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 14 September 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 29 September 2017	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 26 October 2017	CPHAC & DSAC	9.30am	Boardroom, Corporate Office
Thursday 26 October 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 26 October 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 3 November 2017	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 23 November 2017	CPHAC & DSAC	9.30am	Boardroom, Corporate Office
Thursday 23 November 2017	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 November 2017	QFARC	1.30pm	Boardroom, Corporate Office
Friday 8 December 2017	BOARD	10.15am	St John, Waterwalk Rd, Greymouth

The above dates and venues are subject to change. Any changes will be publicly notified.