

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

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**DISABILITY SUPPORT  
ADVISORY COMMITTEE  
MEETING**

**19 AUGUST 2009**

**AGENDA  
AND  
MEETING PAPERS**

All information contained in these committee papers is subject to change

# AGENDA

## FOR THE WEST COAST DISTRICT HEALTH BOARD DISABILITY SUPPORT ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREY BASE HOSPITAL ON WEDNESDAY 19 AUGUST 2009 COMMENCING 10.00AM

- 1 Welcome / Introductions / Apologies
- 2 Karakia
- 3 Disclosure of Advisory Committee Members' Interests
- 4 Agenda Check
- 5 Minutes of the Last Meeting - 8 July 2009
- 6 Action / Responsibility List, Matters Arising and Updates
- 7 Chairs Report
- 8 Correspondence
- 9 General Business
  - 9.1 Workplan
    - a) General Manager Planning and Funding Report to Disability Support Advisory Committee
    - b) Draft Disability Action Plan
    - c) 2009/2010 Disability Support Advisory Committee Workplan
    - d) Terms of reference for discussion paper on the idea of merging Disability Support Advisory Committee and Community and Public Health Advisory Committee.
  - 9.2 Carelink Presentation by Robyn McLachlan

**NEXT MEETING - Wednesday 30 September 2009**

# KARAKIA

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.

## DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' DISCLOSURES OF INTERESTS

<b>Member</b>	<b>Disclosure of Interest</b>
<b>CHAIR</b> John Vaile West Coast District Health Board Member	Member - CCS Disability Action - Westport Branch Director - Vaile Hardware Ltd
<b>DEPUTY CHAIR</b> Elinor Stratford West Coast District Health Board Member	Manager - Disability Information Service Member - NZCCS Greymouth Branch Chairperson - West Coast Sub-branch - Canterbury Neonatal Trust Trustee - Canterbury Neonatal Trust Vice-Chair Victim Support, Greymouth Member - Clinical Governance Committee West Coast Primary Health Organisation
Mohammed Shahadat West Coast District Health Board Member	Director - Asia Pacific Immigration Consultants Ltd, trading as Aspac Immigration Consultants
Patricia Nolan	Member - Brain Injury Association Member - Independent Living Centre Committee Member - Hokitika CCS Disability Action
Lynnette Beirne	Secretary of the West Coast Stroke Support Group Educator, Arthritis New Zealand Committee Member, Southern Regional Stroke Committee
Kevin Brown West Coast District Health Board Member	Trustee, Juvenile Diabetes Trust Member, CCS Disability Action Councillor, Grey District Council Wife employed by West Coast District Health Board pharmacy Daughter employed by ISS, working at Grey Base Hospital Trustee, WestPower
Rick Barber	Trustee, Greymouth High School Member, Runanga o Ngati Waewae Executive
Graeme Axford	Independent Advocate and Consultant for several companies

# DRAFT MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD WEDNESDAY 8 JULY 2009 AT 10.00AM IN THE BOARDROOM, CORPORATE OFFICE.

**PRESENT** John Vaile, Chair, West Coast District Health Board Member  
Elinor Stratford, Deputy Chair, West Coast District Health Board Member  
Kevin Brown, West Coast District Health Board Member  
Mohammed Shahadat, West Coast District Health Board Member  
Lynnette Beirne  
Graeme Axford  
Patricia Nolan

**IN ATTENDANCE** Wayne Turp, General Manager Planning and Funding  
Torfrida Wainwright, Planning and Funding Analyst (via video conference  
for part of the meeting)  
Juliette Reese, Minute Secretary

**APOLOGIES** Rick Barber  
Rex Williams, West Coast District Health Board Chair  
Joel George, Chief Executive Officer, West Coast District Health Board

1. **APOLOGIES, WELCOME**

The Chair welcomed those present to the meeting. Apologies from Rick Barber were acknowledged.

2. **KARAKIA**

Wayne Turp and the committee members said the karakia.

3. **DISCLOSURES OF INTEREST**

Graeme Axford advised that he has become an Independent Advocate and Consultant on contract for several companies.

4. **AGENDA CHECK**

Draft Disability Strategic Action Plan 2009-2015 prepared by Torfrida Wainwright, Planning and Funding Analyst was tabled as a late item.

**Moved: Kevin Brown**

**Seconded Elinor Stratford**

**Planning and Funding Analyst joined the meeting by video conference.**

9. **GENERAL BUSINESS**

### **9.1c Update against the West Coast Improving Services for Elderly Plan**

The Planning and Funding Analyst spoke to her report.

General Manager Planning and Funding gave an update of progress on the Request For Proposal process for Residential Beds in the Buller region.

The Planning and Funding Analyst asked the committee members for suggestions regarding Respite Beds. Additional funding will be provided by the Ministry which equates to one Residential Bed across the whole of the West Coast region. However respite requirements are better served across all the regions but are not required all the time.

Space is often available at rest homes, however staffing can be the issue that effects availability. There was some discussion around the possibility of the funding being used to combine palliative / respite etc requirements.

It was acknowledged that a flexible option would be required and that funding one bed for the whole year would not be the best option. Also that respite care can be taken across regions (ie a client in Greymouth can seek respite in Hokitika), and this could be utilised for greater flexibility, perhaps contracts could be raised for three months per year per region.

It is noted that it is preferred that existing bed spaces be taken up before 'purchasing' additional bed spaces. Carelink may be able to assist with taking up or allocating these bed spaces. Additional comments noted that there are advantages with utilising Hannan beds as Physiotherapy and Occupational Therapy are available onsite.

Carelink is well positioned to develop processes following the requirements that arise from specific client needs. Carelink also is building and maintaining excellent collaborative relationships between District Nurses, Social Workers, Dementia and Assessment, Treatment and Rehabilitation Service Nurse Specialists to develop individual packages of care.

Discussion continued around the client being the best monitor of services being provided or not, with Carelink able to be a neutral contact point should there be any dissatisfaction with service provision. Clients would need to be advised exactly what services they can expect and how to respond or who to contact if those services are not being provided. It was identified that robust needs assessment and review plays a significant part in the process of providing suitable client care.

The committee would welcome a presentation from Carelink regarding its services.

The committee also discussed that education of rest home staff to focus on creating and supporting independence, as well as the need to remove the perception common to some older clients that a rest home is a place to go to die. Emphasis needs to be placed on the restorative model with new processes and that rest homes need to come on board.

The General Manager Planning and Funding Manager and Planning and Funding Analyst will discuss further options around respite / palliative / short term care / step down and convalescent bed options and bring this back to the committee at the next meeting.

### **9.1d Draft Disability Strategy Action Plan 2009-2015**

Tabled document. The Planning and Funding Analyst spoke to this document.

Discussion was had around funding implications - actions must be able to be funded within existing resources. Acknowledgement that services and systems either need to be streamlined to be more cost effective or non-productive areas may need to be removed.

Overlap of the District Annual Plan and inclusion of Ministry of Health Strategic Plan need to be incorporated.

Further consideration required around patient journey and support and inclusion of family and carers. Acceptance of additional requirements for support and information for disabled clients as responses to anaesthetic and recovery may be slower or different than generally expected. Consideration that it may be difficult for the patient to pass onto family information they have received because the client does not understand this information.

Some concerns raised around wording such as “..... exceeds the Building Standard NZS 4121, 2001” and the implications this may have on legislation and monitoring and compliance. Other comments included ensuring that numbers and percentages were not tied to employment opportunity requirements as competency must be the first requirement.

The General Manager Planning and Funding and the Planning and Funding Analyst will update the draft further incorporating the committee members concerns and with consideration to the District Annual Plan and Ministry of Health Strategy.

**Planning and Funding Analyst concluded the video conference.**

**5. MINUTES OF THE PREVIOUS MEETING HELD 27 MAY 2009**

**Moved: Kevin Brown**

**Seconded: Patricia Nolan**

**MOTION:**

**“It was RESOLVED that the Minutes of the Disability Support Advisory Committee meeting held 27 May 2009 were a true and accurate record”.**

**Carried.**

**6. MATTERS ARISING**

**Action Points**

Planning and Funding Analyst to update West Coast Improving Services for Elderly workplan to reflect District Annual Plan and dates for new financial year.

*Completed.*

General Manager Planning and Funding to send copy of the Dementia Pathway to Committee Members.

*Dementia Pathway document is still being developed, it is hoped that it can be presented by the next meeting.*

General Manager Planning and Funding Analyst to update Disability Action Plan.

*Completed.*

Healthy Eating Healthy Action Manager to update Committee re Healthy Eating Healthy Action funding and focus for next financial year.

*Completed.*

General Manager Planning and Funding, Chair and Deputy Chair to discuss Section 3 of Workplan reporting timelines.

*Discussion held. The Workplan to be updated and presented at the next Disability Support Advisory Committee meeting.*

General Manager Planning and Funding to advise on options around Disability Awareness Training for Committee Members.

*Completed - if Board training opportunities exist, committee members can attend on a voluntary basis.*

7. **CHAIRS REPORT**

Received.

8. **CORRESPONDENCE**

No correspondence was received.

9. **GENERAL BUSINESS**

**9.1a General Manager Planning and Funding Report to Disability Support Advisory Committee**

The report was taken as read. The General Manager Planning and Funding spoke to his report and invited questions / comments.

Community Liaison

Committee members were asked to advise of any interest groups or contacts that could be incorporated into the community consultation process.

Advertising / Contact / Communication - U-Tube? Brief discussion as to where other areas to advertise events etc could be incorporated. Currently are there too many people doing similar things? Perhaps combine meetings with expos, or liaise with similar events.

**9.1b Healthy Eating Healthy Action Report**

The report was taken as read. The General Manager Planning and Funding advised that Government policy on Healthy Eating Healthy Action means that national funding for Healthy Eating Healthy Action will be reduced after July 2009. The local Healthy Eating Healthy Action programme will not be significantly affected until the end of the calendar year.

10. **GENERAL DISCUSSION**

Disability Information Services - training of Disability policy writers to increase understanding of people with disabilities needs. To be aimed at professionals, doctors, Primary Health Organisation, Board and Advisory Committee members and District Health Board staff to be able to attend. Dates to be confirmed.

11. **NEXT MEETING**

The next meeting is scheduled for Wednesday 19 August 2009, Board Room, Corporate Office, Grey Base Hospital.

There being no further business to discuss, the meeting concluded at 12.15pm.

## MATTERS ARISING FROM DISABILITY SERVICES ADVISORY COMMITTEE MEETINGS

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref
1	27 May 2009	<b>General Manager Planning and Funding</b> to send copy of the Dementia Pathway to Committee Members	General Manager Planning and Funding	By next meeting 19 August 2009 (assuming document finalised)	9.1a - General Manager Planning and Funding Report
2	8 July 2009	<b>General Manager Planning and Funding and Planning and Funding Analyst</b> to produce a draft on possible options around respite / palliative / short term care / step down / convalescent beds.	General Manager Planning and Funding	To be presented for discussion at the next meeting 19 August 2009.	9.1c - West Coast Improving Services for Elderly Plan
3	8 July 2009	<b>Carelink Manager</b> to update Committee re Carelink's Services	Carelink Manager	To be presented at the next meeting 19 August 2009.	9.1c - West Coast Improving Services for Elderly Plan
4	8 July 2009	<b>Minute Secretary</b> to complete updates from General Manager Planning and Funding, Chair and Deputy Chair's discussion around Disability Support Advisory Committee Draft Workplan	Minute Secretary	To be presented for discussion at the next meeting 19 August 2009.	6 - Matters Arising
5	8 July 2009	<b>General Manager Planning and Funding and Planning and Funding Analyst</b> to update Draft Disability Strategy Action Plan 2009-2015 incorporating Disability Support Advisory Committee concerns, District Annual Plan and Ministry of Health Strategies.	General Manager Planning and Funding	To be presented at the next meeting 19 August and on approval recommended to the Board.	

# CHAIR'S REPORT TO DISABILITY SUPPORT ADVISORY COMMITTEE

**TO:** Members, Disability Support Advisory Committee

**FROM:** John Vaile, Chair of Disability Support Advisory Committee

**DATE:** for 19 August 2009 meeting

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## MATTERS REPORTED TO THE BOARD FROM DISABILITY SUPPORT ADVISORY COMMITTEE

Nil

## MATTERS REFERRED TO DISABILITY SUPPORT ADVISORY COMMITTEE FROM THE BOARD

Nil

## ITEMS OF INTEREST FROM THE BOARD MEETING

Nil to report.

**Author:** John Vaile, 5 August 2009

# CORRESPONDENCE

No correspondence received.

# GENERAL MANAGER PLANNING AND FUNDING REPORT TO THE DISABILITY SUPPORT ADVISORY COMMITTEE

**TO:** Members, Disability Support Advisory Committee

**FROM:** Wayne Turp, General Manager Planning and Funding

**DATE:** 19 August 2009

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## STRATEGIC ISSUES

### *Older Persons' Services*

#### **Protecting older peoples health and independence**

**Tai Chi and exercise classes** - these have been expanding throughout the Coast, and work continues to extend the falls prevention programme to Buller

**Health promotion** - funding for the Healthy Eating Healthy Action workers is expected to continue for another year.

**Supportive housing** - discussions continue with potential funders (eg Housing New Zealand) and providers about supportive housing, and we are considering whether to tender for this service.

**Home insulation** - the Government's home insulation programme has made subsidies available for eligible West Coasters again.

#### **Dealing with illness and disability before they worsen**

**A wrap-around service** for frail older people, with General Practitioners, hospital services and homecare services working together is gradually being developed through Carelink's case management of people with complex problems and through the upcoming review of homecare services.

#### **Improving the range and quality of long-term care services**

##### **Home-based care**

**Home support services** - we are currently reviewing home support services in preparation for putting out a tender later in the 2009-10 year for restorative homecare services. A consultation document should be out for discussion in a month or so.

**Home carer training** - the two homecare providers are now being funded for 18 months to ensure that all their carers are trained to at least basic level and a minority to the next level. The contract with the providers requires that qualifications be recognised in the pay scale.

**Respite care** - the new contracts are in place and working well. The Board has new funding from the Government from next January specifically for planned respite and Planning and Funding staff are working with the rest homes to decide how best to do this.

**Day care** - Presbyterian Support will open a HomeShare day care service on the Coast by 1 November

## **Residential Care**

**Westport** - We are hopeful of a positive conclusion soon to the tender for long-term residential care beds in Westport.

**Dementia care** - demand for beds at Kahurangi remains high. This is partly being managed by the individualised funding scheme (currently seven people with mild/moderate dementia live in rest homes at a higher rate of funding). We hope to strengthen the dementia outreach service soon with the addition of a part-time Occupational Therapy position for assessment and carer training.

**Collaboration** - the quarterly collaboration meetings between rest home and DHB staff have continued.

**Vitamin D** - an ACC funded two-year programme to provide free Vitamin D supplements to all residents in aged care facilities is about to start in all West Coast rest homes. Vitamin D has been shown to reduce both falls and fractures in this high risk group of older people.

## **Services for carers**

**Carer support** - as part of the development of planned respite care, we are evaluating the use of carer support funding and ways of making it more effective and flexible.

**Carer Strategy** - we are working with patient support organisations (eg Disability Information Service, Stroke, Arthritis etc) to evaluate the Buller and Westland expos and see how best to support these information and advocacy organisations. We envisage preparing a strategy for this for consultation by the end of 2009-2010.

## **Managing the long-term care budget**

We are developing a robust system to monitor how much we are spending and using in terms of residential and non-residential services.

## **A smooth path into and out of specialist services**

### **Carelink**

**InterRAI** - implementation is progressing fast in collaboration with Canterbury District Health Board and we expect it will be running by the end of the year.

**Pathways** - the Carelink manager has been working with other services to identify and resolve problems over boundaries between services.

**Carelink as single point of entry** - this is being developed slowly and carefully as Carelink develops working relationships with other services.

## **Community focus for Assessment, Treatment and Rehabilitation Service and Allied Health**

**Sector training in a restorative model of care** - a plan and timeline for this is being worked out as part of the home care review and will follow the implementation of InterRAI

**Community rehab service and increased availability of community allied health** - this will be developed out of Carelink and in conjunction with the home support review and tender.

**Non-acute beds for convalescence/slowstream rehabilitation** - being discussed by Carelink manager with the West Coast District Health Board provider arm and will be explored on a case by case basis.

## **Stroke**

**Implement stroke pathway recommendations** - improvements to in-hospital services are being implemented by the provider arm. Ways of improving transfers between hospital and

community will be developed by the Carelink and Assessment, Treatment and Rehabilitation Service Managers on a case by case basis as a community rehabilitation service is set up.

### **A stronger older persons service**

**Adviser for older persons' services** - the concept of combining this Adviser role with the Carelink manager role is working well, as Carelink is proving crucial to creating a stronger service for older people on the Coast. InterRAI and the sector training in restorative model of care planned for later in 2009-10 will also help to strengthen the service over the coming year by bringing staff from different services together to discuss case management etc.

**West Coast Improving Services for Elderly group** - this group continue to meet quarterly. This will be reviewed by the Adviser by the end of 2009-2010.

**Webpage** - this has not proven so useful as first envisaged as a way of communicating within the sector.

### ***Disability Services***

#### **Maintaining liaison with disability advocacy groups**

Planning and Funding staff have been working with Disability Information Service as part of their trust board.

#### **Funding disability awareness training for both West Coast District Health Board staff and the community**

This funding has been maintained and we are working with Disability Information Service on ways of making

#### **Implement the West Coast Disability Strategic Action Plan**

The West Coast District Health Board Disability Strategy Action Plan has been drafted and feedback has received from Disability Support Advisory Committee and the plan will be presented to the Board for approval in the next month or so.

#### **Sign Language Act**

Work has started on a paper for the West Coast District Health Board on how the West Coast District Health Board needs to address the New Zealand Sign Language Act.

**Author: Wayne Turp, 5 August 2009**

# WEST COAST DISTRICT HEALTH BOARD

## *Version 2 DRAFT* DISABILITY ACTION PLAN 2009-2015

Prepared by Torfrida Wainwright, Planning & Funding

Revised 4 August 2009

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### **Purpose of this paper**

This is a revision of the West Coast Disability Strategy Action Plan 2004-2010, for re-consideration by West Coast DHB's Disability Services Advisory Committee at their August 2009 meeting.

### **Context**

In 2004 the West Coast DHB adopted a Disability Strategic Action Plan 2004-2010, based on a wide consultation with the public and stakeholders. Parts of this plan have been achieved but other parts of the plan had not been achieved at 30 June 2009.

DSAC asked Planning and Funding to revise the Action Plan in the light of more recent national guidelines and to revise and tighten up the timeframes and responsibilities.

This document includes elements of the earlier action plan that have not yet been achieved, takes into consideration the recent national guidelines on disability<sup>1</sup> and adopts a different format which may make it easier to monitor progress on the proposed actions and timeframes.

### **Key points**

The key areas covered in the plan follow those key aspects of the New Zealand Disability Strategy and its updates, which are relevant to DHB health and support services:

- Disability awareness training for DHB staff and contractors
- Overcoming a disabling society – reducing barriers to the use of West Coast DHB-funded facilities by people with disabling conditions.
- A web of information – ensuring that information on all West Coast DHB-funded services are accessible for people with disabilities
- Providing employment opportunities to disabled people – ensuring West Coast DHB is an Equal Opportunity Employer
- Providing disability information, advocacy and support services for people with personal health conditions, and ensuring these services work smoothly alongside the disability support services funded by the Ministry of Health
- Community and consumer engagement – ensuring that West Coast DHB actively engages with people with disabilities in all its consultation activity

### **Recommendations**

It is recommended that:

- DSAC consider this plan for adoption by West Coast DHB to guide the development of West Coast DHB funded services

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<sup>1</sup> Disability Services, Ministry of Health (2008). *Strategic Plan 2008-2010 – towards a more flexible disability support system*. Wellington:MoH

<b>1.</b>	<b>DISABILITY AWARENESS TRAINING</b>
<b>Strategic goal</b>	To encourage and educate all relevant staff and contractors in disability awareness.
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Increase the overall understanding, and knowledge of the New Zealand Disability Strategy disability issues amongst WCDHB's employees and Board Members through 100% training attendance by 2011.</li> <li>• Improve the level of disability knowledge amongst, all staff so that disabled people receive health and disability services that are appropriate and meet their needs.</li> </ul>
<b>Actions</b>	<p><b>By June 2011, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Include a disability issues training component in staff orientation and Board induction training process.</li> <li>• Provide up to date information, training, and continuing education for Recruitment, HR, Managers, Occupational health (staff who deal with employment issues) in order to increase their awareness and understanding of the needs of disabled people</li> <li>• .Provide up to date information, training, and continuing education for clinical and first contact staff (staff who deal with the public) in order to increase their awareness and understanding of the needs of disabled people.</li> <li>• Develop a regular disability column promoting community issues in communications to staff</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Measure the number and percentage of new employees and Board members who receive disability awareness training as part of their orientation/induction training.</li> <li>• Measure the number and percentage of HR, Recruitment, Service Managers and Occupational health staff who have received disability awareness training</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• 100% of new employees/board members receive a disability component in induction/orientation training by June 2011</li> <li>• 30% of clinical, recruitment, HR, service managers, and first contact staff receive disability competency training by June 2011</li> </ul>
<b>Responsibility</b>	<p>Planning and Funding General Manager  Human Resources manager  Service Managers  CEO</p>

<b>2.</b>	<b>PHYSICAL ACCESS</b>
<b>Strategic goal</b>	Overcoming a Disabling Society
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Provide an accessible journey for all people to all services within its physical environment by 2012.</li> </ul>
<b>Actions</b>	<p><b>By June 2011, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Assess through surveys and audits the accessibility of WCDHB facilities for compliance with access requirements of, and exceed the Building Act NZS 4121:2001, the Building Code, and the Human Rights Act.</li> <li>• Assess through surveys and audits the accessibility of primary and community providers facilities for compliance with the access requirements of, and exceed the Building NZS 4121:2001, the Building Code, and the Human Rights Act.</li> <li>• Ensure best practice barrier free component is a priority in the design and development of any new WCDHB buildings or contracted services.</li> <li>• Develop action plans to deal with issues of non-compliance with access requirements.</li> <li>• Audit all new buildings plans to ensure compliance is maintained</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Measure the number and percentage of hospital and health service buildings (including entrances, car parks, toilet, examination tables etc) which are accessible and meet or exceed the NZS 4121, 2001.</li> <li>• Identify and provide resources to support barrier free initiatives for new buildings and existing buildings.</li> <li>• Monitor the accessibility of primary and community provider facilities, to ensure their accessibility increases over time.</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• 100% of buildings built after June 2010 meet NZS 4121,2001</li> <li>• Percentage of other provider buildings/facilities that are accessible increased by 2011</li> </ul>
<b>Responsibility</b>	<p>Planning and Funding General Manager  Facilities Manager  Service Managers  CEO</p>

<b>3.</b>	<b>COMMUNICATION AND ACCESS TO INFORMATION</b>
<b>Strategic goal</b>	A Web of Information
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Ensure that people who cannot use usual formats such as written letters or telephones will be able to send and receive confidential information to/from WCDHB in a timely manner by 2011.</li> <li>• Improve the accessibility of public information produced by WCDHB through publication in alternative formats (audio, plain language, large print, pictorial etc) and accessible electronic facilities by 2011.</li> <li>• Support the New Zealand Sign Language Act</li> </ul>
<b>Actions</b>	<p><b>By June 2011, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Publish an easy to read brochure on access to WCDHB services for disabled people</li> <li>• Ensure that the complaints procedure is accessible.</li> <li>• Increase WCDHB provision of Braille, large print, audio, and assistive hearing systems, and provide access to NZ Sign Language interpreters where requested</li> <li>• Upgrade our intranet, internet, and signage to incorporate accessibility features and guidelines.</li> <li>• Develop and implement a communications style guide for all publications.</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Measure our ability to produce, on request and free of charge, information in a range of formats</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• Brochure published by July 2010</li> <li>• WCDHB signage, intranet, and internet upgraded by July 2010</li> <li>• Production/availability of information in alternative formats increased every year through to 2015</li> </ul>
<b>Responsibility</b>	<p>Planning &amp; Funding General Manager  Community Liaison Officer  IT manager  Quality and Safety Manager  Service Managers  CEO</p>

<b>4.</b>	<b>EMPLOYMENT OPPORTUNITIES</b>
<b>Strategic goal</b>	Providing Employment Opportunities for Disabled People
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Have the number of disabled people employed reflect the percentage of disabled people in the general working age population, if possible.</li> <li>• Reduce barriers for employees with disabilities by ensuring working environments and conditions are appropriate</li> <li>• Ensure learning opportunities and pathways for professional development are available and accessible to all staff.</li> <li>• Become an EEO employer</li> <li>• Capture statistics on disabled employees within WCDHB and identify any potential barriers.</li> </ul>
<b>Actions</b>	<p><b>By June 2012, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Review all employment policies and procedures to ensure they maximise employment opportunities for disabled people.</li> <li>• Review all employment policies and procedures to ensure they maximise employment opportunities for carers of disabled people.</li> <li>• Ensure that reliable statistics are collected for the percentage of disabled employees, and what support needs they may have.</li> <li>• Learning and Development courses and training opportunities are made accessible for staff with suitable notice.</li> <li>• Advertise widely and in many formats when recruiting.</li> <li>• Develop a staff survey to capture the statistics on disabled employees within WCDHB and develop an action plan to remove any potential barriers identified</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Measure the number and percentage of employees with a disability and analyse comparisons between those figures and the percentage of disabled people in the general working age population.</li> <li>• Develop pathways for disabled employees to get support in the workplace.</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• Reliable statistics collected on the number of disabled employees by June 2010</li> <li>• Increase the percentage of disabled employees by 2012</li> </ul>
<b>Responsibility</b>	<p>Planning &amp; Funding General Manager  Human Resources General Manager  Quality and Safety Manager  Service Managers  CEO</p>

<b>5.</b>	<b>INFORMATION, ADVOCACY AND SUPPORT FOR FAMILIES AND CARERS</b>
<b>Strategic goal</b>	To collaborate with other funders to ensure good support services for people with disabilities and those caring for them
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Collaborate with the Ministry of Health and other funders to ensure that good information, advocacy and carer support services are available for people with disabilities and their families, whatever the cause of the disability</li> <li>• Ensure that services work closely together so that people receive the disability information, advocacy and carer support services they need, regardless of funding stream or diagnosis</li> </ul>
<b>Actions</b>	<p><b>By June 2010, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Initiate collaboration with other funders to improve the accessibility and effectiveness of disability information, advocacy and support services on the West Coast, including access to the services of voluntary agencies such as Stroke Foundation, Alzheimer's NZ and Arthritis Society etc</li> <li>• Ensure smooth working relationships between Carelink and Lifelinks</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Support the work of agencies providing disability information, advocacy and carer support services for people with personal health related conditions</li> <li>• Identify and implement resources to support the work of disability information, advocacy and support agencies for people with personal health needs</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• Increased service usage by July 2012</li> <li>• Clearly designated funding for these services by July 2011</li> </ul>
<b>Responsibility</b>	<p>Planning &amp; Funding General Manager  DSAC  Carelink manager  CEO</p>

<b>6.</b>	<b>COMMUNITY AND CONSUMER ENGAGEMENT</b>
<b>Strategic goal</b>	To develop pathways for meaningful engagement with key stakeholders.
<b>Objectives</b>	<p><b>West Coast District Health Board aims to:</b></p> <ul style="list-style-type: none"> <li>• Ensure people from all parts of the community have the opportunity to participate in public consultation processes.</li> <li>• Build strong relationships and partnerships with the disability community</li> <li>• Provide advice/ inform DSAC and related committees around disability issues</li> </ul>
<b>Actions</b>	<p><b>By June 2010, WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Host forums on matters that may affect disabled people</li> <li>• Work with other DHBs proactively to network and raise awareness of disability issues and advocate for removal of barriers in the health sector.</li> <li>• Regularly maintain relationships and seek feedback from agencies, groups and in the disability sector organisations.</li> </ul>
<b>Measurement</b>	<p><b>WCDHB will:</b></p> <ul style="list-style-type: none"> <li>• Monitor participants rates of disabled people on WCDHB matters that may affect them, particularly participation rates of disabled Maori, disabled Pacific and people with severe or multiple impairments.</li> <li>• Monitor and record stories of people encountering barriers</li> </ul> <p><b>Targets:</b></p> <ul style="list-style-type: none"> <li>• Increased participation rates every year through to 2015</li> <li>• Reduction of examples of people encountering barriers to participation.</li> </ul>
<b>Responsibility</b>	<p>Planning &amp; Funding General Manager  DSAC  Community Liaison Officer  Quality &amp; Safety Manager  Service managers  CEO</p>



**DISABILITY SUPPORT ADVISORY COMMITTEE**

**Mission Statement:** To fund a continuum of quality health services aimed at providing improved health outcomes and maximise the independence of people with disabilities.

Objective	Responsibility	Next Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
<b>Annual processes</b>							
1. District Strategic Plan	General Manager Planning and Funding	June 2010	Annually		✓		The 10-year District Strategic Plan is to be reviewed and revised in time to inform the 2010/2011 District Annual Plan and Statement of Intent
2. District Annual Plan	General Manager Planning and Funding	December 2009	Annually		✓		Combined Board and Advisory Committee workshops to develop this will occur over December 2009 and January 2010.
3. Statement of Intent	General Manager Planning and Funding	December 2009	Annually		✓		Combined Board and Advisory Committee workshops to develop this will occur over December 2009 and January 2010.
4. Annual Report	Chief Finance Officer / General Manager Planning and Funding	September 2009					
5. Health Needs Assessment	General Manager Planning and Funding	June 2010					The four yearly update of the Health Needs Assessment is due for completion by July 2010
<b>Quarterly and six-monthly progress reporting</b>							
6. District Annual Plan 'traffic light report'	General Manager Planning and Funding	August 2009	Quarterly		✓		Exception reporting against the District Annual Plan Goals and objectives relating to Disability Support Advisory Committee
7. Indicators of DHB performance (IDPs)	General Manager Planning and Funding	August 2009					Quarterly progress reporting against ministerial priorities and Government Health Targets
<b>Regular review of key priority areas (District)</b>							
8. Reducing Inequalities / barriers / discrimination			Quarterly				See District Annual Plan / Disability Action Plan
9. Improving Maori Health and implementing He Korowai Oranga			Six Monthly				With specific regard to Maori with Disabilities
10. Improving the Health of Older People			Quarterly				Elder Care Needs
11. Implementing the Healthy Eating Healthy Action Strategy		July / January	Six Monthly				
12. Minimise Family Violence, Child Abuse and Neglect			Six Monthly				Issues relevant to care of the elderly and those with disabilities
13. Workforce			Annually				Human Resources Manager to provide annual updates on



**DISABILITY SUPPORT ADVISORY COMMITTEE**

Objective	Responsibility	Next Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
							staff development re disability awareness.
14. Other							
<b>Regular review of key priority areas (Regional)</b>							
South Island Health Services Plan							
Healthy South (public health network)							
Regional Collaboration - West Coast District Health Board / Canterbury District Health Board / Nelson Marlborough District Health Board							
Carelink - InterRAI Implementation			Six Monthly				
Regional planning for Elder Care Service Delivery			Six Monthly				

???

[Canadian health paper on elder care service delivery????](#)

# **TERMS OF REFERENCE FOR DISCUSSION PAPER ON MERGING DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE**

**TO: Members, Disability Support Advisory Committee**

**FROM: Wayne Turp, General Manager Planning and Funding**

**DATE: 19 August 2009**

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## **TERMS OF REFERENCE**

*Discussion Paper on Merging of Disability Support Advisory Committee and Community and Public Health Advisory Committee*

**Author: Wayne Turp, 19 August 2009**

## ORIGINAL RESEARCH

# What older people want: evidence from a study of remote Scottish communities

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King G, Farmer J

**What older people want: evidence from a study of remote Scottish communities**

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Available from: <http://www.rrh.org.au>

## ABSTRACT

**Introduction:** The growing proportions of older people in rural areas have implications for the provision of health and social care services. Older people are more likely to have complex health needs compared with other age groups, requiring a full range of primary, community and acute hospital services. The provision of services to older people in rural areas is challenged by diseconomies of scale, travel costs and difficulties in attracting staff. Policy-makers are requested to include the 'voice' of older people to help provide services that match needs and context. In spite of this, what older people want from health and social care services is a neglected area of investigation. The reported study was conducted in 2005/2006 as part of a European Union Northern Periphery Programme (EU NPP) project called Our Life as Elderly. Its aims were to explore the views of those aged 55 years and over and living in remote communities about current and future health and social care service provision for older people. Evidence was to be collected that could inform policy-makers about changing or improving service delivery. This article summarises emergent themes and considers their implications.

**Methods:** The study selected two small remote mainland Scottish Highland communities for in-depth case study. Semi-structured interviews ( $n = 23$ ), 10 'informal conversations' and 4 focus groups were held with community members aged 55 years and over, in order to provide different types of qualitative data and 'layers' of data to allow reflection. Data analysis was assisted by computerised data management software and performed using the 'framework analysis' approach.



**Results:** Participants did not consider themselves 'old' and expressed the need for independence in older age to be supported by services. Several aspects of services that were undergoing change or restructuring were identified, including arrangements for home care services, meals provision and technological support. Participants valued elements of the traditional model of care they had been receiving; these were local, personal emphasis and continuity. They were suspicious of new arrangements perceived to emphasise technical efficiency. Health and care services were described as inter-linked with other aspects of rural living, including transport and housing (which might have to be relinquished to pay for care). Proximity to family was desired for social and domestic support only; health and related support should be from generic service providers. Community members were involved in reciprocal help-giving of many types.

**Conclusion:** The findings compare with results of other studies of older rural people internationally, and generic 'principles' of service derived could guide restructuring. There may be systemic challenges to empowering older people's 'voice' in designing sustainable rural services that stem from society's views of older people, attitudes of communities to collective roles and responsibilities, and the fragmented ways that services are sometimes provided.

**Key words:** change, citizen involvement, health policy, older people, rural health care, service restructuring.

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## Introduction

*Economic and social restructuring has altered forever the circumstances and prospects of the majority of people growing old in communities.<sup>1</sup>*

*The localities where older people live are of enormous importance. As they get frailer, their lives are increasingly affected by, and bounded within, their immediate physical and social environments.<sup>2</sup>*

The growing proportions of older people in the population are acknowledged by policy to have implications for providing health and social care services<sup>3</sup>. The challenge is greater for rural areas which have higher percentages of older people compared with urban areas<sup>4</sup>, and where the provision of services is more costly<sup>5</sup>. Older people are substantial consumers of health and social care services; in Scotland, the 15% of the population who were aged over 65 years in 2002 consumed 40% of health and social care spending<sup>6</sup>. Leeson has highlighted that, in the UK in comparison with other age groups, spending on older age groups has actually decreased over time as more care moved into the community<sup>7</sup>.

As a group, older people have complex health needs, requiring a range of primary, community and acute hospital services<sup>8</sup>. Philip suggests that the greatest challenge facing health and social care systems is to get services right for older people<sup>9</sup>. There have been numerous calls to involve older people in planning their service provision<sup>10</sup>, particularly as disparities between what they desire and what service providers think they desire have been noted<sup>11</sup>. However, both asking older people what they want and the study of best practice in involving older people still seem neglected areas of study<sup>12</sup>.

In recent years considerable policy<sup>8,13</sup> and growing research attention has turned to older people, in the face of the demographic challenge, but there is still relatively little attention given to the experience of ageing in rural areas. This is surprising given that extant evidence suggests there may be distinct features of rural disadvantage. Isolation may be experienced, particularly by in-migrants who are distanced from families and social networks<sup>4</sup>. Access to public transport is problematic<sup>14</sup>, exacerbating difficulties in accessing services that include hospitals, pharmacies and banks<sup>9</sup>. Access to social care is reported as difficult due to few younger people to work or volunteer<sup>15-17</sup>. Conversely,



rural advantages have been found. Support networks, family support and a culture of reciprocity are reported<sup>4,18,19</sup>.

A feature of older age is adaptation to changes in health and mobility<sup>2</sup>. Simultaneously expecting older people to adapt to structural change in service provision may be unfair<sup>1</sup>. Milligan notes that neo-liberal social policy has resulted in a push to mixed providers and a focus on care at home and in the community<sup>20</sup>. These changes may be difficult to effect in rural areas due to a lack of private providers and staff generally. Free personal and nursing care (FPNC) is currently available for everyone in Scotland aged 65 years and over, whether at home, in hospital or in a care home. However, this policy is judged to be unsustainable due to the huge financial burden it represents, the gap in funding available to fairly implement the policy and the fact that basic services for older people (eg domestic help and shopping) are being restricted to concentrate on financing FPNC<sup>21</sup>.

The present study was conducted as part of a European Union Northern Periphery Programme (EU NPP) project called Our Life as Elderly (OLE). The EU NPP is specifically focused on funding projects that address issues shared by countries in the north of Europe, including harsh climate, sparse population, transport difficulties and uneven demography. The project required partner countries including Sweden, Norway, the Faroe Islands and Finland to find out what older people thought of their health and social care services now, and what they would like to see in the future. The intention was to provide information for policy-makers to help shape future services for older people. Study and commentary on this topic, as with many issues pertaining to the provision of rural health services, converges from geography, rural sociology, health services research and policy. While this article is potentially relevant across these disciplines, the goal is to influence the development of appropriate policy and service provision.

The Scottish aspect of the project involved interviews, 'informal conversations' and focus groups in two remote communities in the Highland region. The study was

conducted in 2005/2006 and involved people aged 55 years and over. In this article the findings are presented and their implications for service provision reflected on with the aim of encouraging a 'voice' for older people in local planning.

## Methods

Desiring to be completely open to respondents' views and to understand the world from the subjects' perspective<sup>22</sup>, an exploratory design was adopted. Two small remote mainland Scottish Highland communities were selected for in-depth study using three qualitative data collection methods. Ethical committee and NHS R&D approval was gained for the study.

### *Sample and settings*

The study took place in the Scottish Highland region because this area is within the European Union Northern Periphery Programme area. The Highlands covers 39 050 km<sup>2</sup> and has a population of 373 000, making the area one of the most sparsely populated within the European Union. Data were collected from two 'very remote' communities (classified as settlements of less than 3000 people and with a drive time of over 60 min to a settlement of 10 000 or more)<sup>23</sup>. Case study site 1 had a population of approximately 400 people and case study site 2 had approximately 900 inhabitants. Both settlements are coastal. The area is characterised by dispersed dwellings and crofting townships. Both study sites have a high proportion of older people. In 2005, 29.9% and 24% of the population were aged over 65 years for sites 1 and 2, respectively, compared with Highland and UK proportions of 16.7% and 16%, respectively. Both are within 70 miles of a rural district general hospital and have day-care facilities and limited respite-care facilities. Both study sites have a general practice/health centre located within the community and GPs who provide out-of-hours cover. Site 2 has nursing home facilities. These communities were purposively chosen to represent 'extreme cases' that it was anticipated would reveal attitudes to service provision and behaviours at the periphery of the mainland. They also had



Highland Community Care Forum (HCCF) workers assigned and these workers recruited study participants.

The HCCF workers recruited participants by approaching people in communities and obtaining initial consent. A sample was requested that included men and women aged 55 years and over; of varied socio-economic background, who had involvement in community activities, and whose lengths of time locally resident ranged from life-long to recent in-migration. For interviews, once initial consent was obtained by the HCCF worker, a researcher contacted the subject, obtained further verbal consent and arranged an interview time. Written, informed consent was obtained prior to interviews. HCCF workers asked a further sample of 10 individuals to be involved in an 'informal conversation'. Researchers specifically asked HCCF workers to try to include people who might normally be 'missed out' or would not put themselves forward to take part in research. This aspect of the study was intended to provide more information on the topics from the perspective of 'one local person to another' and from those who might be reticent about formal interview. Finally, groups of people at each settlement were invited to attend a focus group.

Focus group participants consisted of those who had already participated ( $n = 9$ ) and new participants ( $n = 24$ ; invited through HCCF). The focus groups presented emergent themes from the interviews and informal conversations and asked participants to comment on these. This aspect of the study allowed assessment of whether themes deemed important by the communities had been arrived at, and further discussion of these.

## ***Data collection***

Semi-structured face-to-face interviews were held with 11 individuals aged 55–64 years and 12 individuals aged 65 years and over (age range 55–87 years; median age 64 years). Numbers of interviews were approximately evenly split between communities.

A researcher (GK) conducted interviews with individuals that lasted approximately 1 hour, took place in participants' homes and were recorded, with consent. An interview topic guide prompted the interviewer to ask about: experiences of current health and social care services; desired attributes of future services; the role of family and the community in supporting older people; and the role of technology. Additional elements of the topic guide were developed following pilot interviews and four early interviews. These included vignettes to assist with focusing on aspects of service delivery (eg new technology); use of data on morbidity of older people to illustrate that most people would encounter chronic illness in later life; a change from asking 'Do you provide informal help?' to 'What do you do in a normal week?' because participants found it difficult to identify when they were helping others. Demographic data were recorded.

The informal conversations held in each community by the HCCF workers followed guidelines given by researchers and used the same topic guide. Formal written consent was gained. These were not audio-recorded but notes written by HCCF workers following the conversations were given to the researchers.

Two focus groups were held in each community (a total of four; with four, five, six and 18 participants). Author GK and the HCCF workers facilitated the groups. Consent was gained and focus groups recorded.

Using three data collection methods, and at different stages, aided deeper penetration and understanding of the issues as viewed by different participants. Re-visiting the issues in the focus groups allowed reflexivity for researchers and community members. For community members, it was pertinent to discover that both communities raised similar issues.

## ***Analysis***

All data, including recordings and notes, were transcribed verbatim. 'Framework analysis' – a five-stage process,



involving familiarisation with data, development of a coding schedule, data coding, description of main themes, linking themes and developing explanations of their relationships to each other – was employed<sup>24</sup>. Codes were entered into the qualitative data management program NU\*DIST QRS International; Melbourne, VIC, Australia). Once codes were applied, data were grouped into categories and thematic analysis was performed, identifying similar and divergent perspectives. Three researchers independently analysed samples of the data to check inter-coder reliability. Data were anonymised to protect participants' identities. In this article provides excerpts from interviews, informal conversations and focus groups to illustrate some of the points.

## Results

### *Study participants*

The total of 23 participants represented an approximately even mix of men and women. Demographic data were collected at interview and, of the interviewees, nine lived alone and 14 lived with others; 13 had moved into the area in the last 10 years and 10 were long-term locals. Five interviewees were in receipt of 'formal' care, either council provided or purchased privately locally using the 'direct payment' scheme. Several provided informal care for neighbours or relatives.

### *(Not) being old*

A primary issue for the study was asking people about 'being old'. Some people were concerned that they had been asked to participate in a study about being older. Even the oldest participants did not view themselves as being old:

*I kept thinking about some of the old buddies I know and I thought 'Gosh, if they took ill at night ...I don't consider I'm an old buddy living alone. (Female, 82 years, lives alone)*

Reluctance to use statutory or voluntary services was a common theme; because participants thought they 'were not old enough', 'don't want charity' or did not want to 'spend time with a lot of old people'.

When asked about needs for care, most participants said it was difficult to imagine 'being old' and needing help to do basic things. Most said they wanted to 'just drop dead!' After several people said this at pilot and initial interviews, data were obtained from the local NHS Board about what happened to people in later life to show that most people required care of varying sorts. While this helped to focus participants on services and care provision, responses to questions tended to draw on their own experiences; for example what had happened when their parents' health declined.

Participants emphasised the importance of maintaining their independence and suggested a key principle for services should be supporting independent living:

*...it might take me half an hour to put the washing in the machine, there's always that, you know, but it's a challenge. I can still do it, I still want to do it. If they [service providers] get someone else to do it, what the hell am I going to do? Sit on my backside watching the news, listening to the radio, reading a book... (Male, 59 years)*

There were mixed feelings about what should happen when people could no longer be maintained at home. Some would consider moving into residential care but emphasised it needed to be in the local community or they would lose contact with friends. Others were adamant that they would move only as a last resort. People commented on the facilities that they knew about and did not mention a need to develop new kinds of facilities, such as supported accommodation.



## *Services in transition*

Service areas that might be predicted to be problematic for remote areas were reported to be good; including access to ambulance services, support for carers and facilities for residential care. Several services that were in a state of transition or had recently changed were discussed and new arrangements often compared unfavourably with previous arrangements.

Participants were positive about local GPs and nurses who were regarded as 'locals'. As such, they, their practices and their times and places of availability were known. The aspect of being 'local' was emphasised as important as participants believed that knowing individuals, their family and their context contributed to good care. (This also pertained if local people were acting as formal or informal carers). Local GPs were viewed positively because they had opted out of NHS 24 and out-of-hours co-operatives for unscheduled care, choosing instead to be the first line of contact for local people. The NHS 24 Helpline was viewed with suspicion:

*They [GPs] still come out at night, none of this NHS 24 stuff. People here try not to bother the doctor, they only phone if it's urgent. Then they want to speak to someone who knows about them and their medical history. (Informal conversation, woman, mid-70s).*

Arrangements for home-care services had recently changed and there was confusion about who should be providing home care and its costs. Some people had access to 'direct payments' from the local authority. This meant they could purchase care themselves, either from local authority providers or privately. Those purchasing care privately thought this was cheaper, but it could affect local authority provision if several people withdrew because the hours for staff would be few and irregular, making it difficult to recruit staff.

Who should provide care was divided between local authority social services (personal care) and health services

(nursing care). Several participants stated that there should be one service provider from a health background to provide all the care that might be needed. Fragmentation of care was a fear, anticipated to cause confusion for the recipient and poorer quality care, due to lack of continuity. Provision of 'intimate' care by local social services carers was considered inappropriate because these people were perceived to lack qualifications and appropriate professional status.

'Meals-on-wheels' (the delivery of meals to people who find it difficult to prepare a meal at home) was another service that had recently changed. This had moved from being a locally cooked and supplied service to one that was outsourced to provide mass-produced frozen, microwaveable meals. Many people thought this epitomised an impersonal approach to service provision and a lack of appreciation that 'meals-on-wheels' was about more than food, as it facilitated social interaction and gave people a sense of community support and belonging.

Technology was perceived to be 'coming' and the researchers wanted to gauge opinions. To do this a vignette was used that discussed home monitoring devices as well as the use of telemedicine at GPs' surgeries. The vignette was used because, in early interviews, participants found it difficult to comment on the abstract idea of technology. Perhaps surprisingly, most participants were supportive of, or accepted the inevitability of, technological support of various types if it would help maintain people at home. Their reservation was that it would remove the personal aspects of care and, as with 'meals on wheels', they emphasised that the social dimension of interaction with health and care professionals was as important as the 'technical' intervention provided.

## *Interconnections*

As with other issues, participants did not strictly focus on health and social care when asked about these services now and in the future. Their discussion quickly moved to issues that they perceived to be intrinsically interconnected. Transport was a key issue. Most thought that living in a



remote area meant accepting an element of personal responsibility in accessing services; for example it was likely to be quicker to drive to hospital rather than calling an ambulance. However for those who could no longer drive, there were mobility problems due to a lack of public transport and implications for community support:

*Contributor 1: It's all very well the government giving out free bus passes, but where are the buses for us to use them on?!" If it weren't for the community spirit in this area a lot of people wouldn't survive.*

*Contributor 2: People look out for one another. You won't be stuck if you need to go somewhere. (Focus group)*

Similarly, consideration of paying for high levels of care and moving from home elicited discussion of housing in remote areas. Several participants were concerned that they would have to sell their houses, but homes in remote Scottish villages are in short supply and they thought it important to keep houses 'in the family'. They did not want their homes sold to incomers for holiday homes. This fear was discussed as a reason for not seeking help from statutory authorities.

## **Support networks**

Policy seeks 'active ageing'<sup>13</sup> in 'resilient communities'<sup>25</sup>. Simultaneously, remote communities have high proportions of older people and service providers experience difficulties recruiting to care posts. How should older people continue to live in remote communities? To consider this question, we were particularly interested to explore participants' support networks.

No-one expected their children to look after them in their old age, but they thought having family living close by would help older people to stay at home. The role of family was to help, domestically and socially, but not to provide care for physical or intimate needs:

*I would cramp their style probably. I don't know if they'd want me! My eldest daughter keeps on saying 'I'll have to buy a house, mother, with a granny flat'. I says, 'I don't know who the granny's going to be!' (Female, 63 years)*

If they could not live independently, they would have to live in a residential-care home. Participants wanted to avoid being a 'burden' to their children and reflected on their own experience of caring for their own parents or elderly relatives:

*Having experienced living with my father-in-law...because I really wouldn't want to do that to my children. I don't know what it is, elderly people have become very selfish and self centred and orientated to routine and food and me, me, that's what I felt my father-in-law did and whether that...well, you do see it in older people. (Female, 64 years)*

While feeling they should not be a burden, participants said there was a loss to the social fabric of communities when different generations lived at a distance and that it would be beneficial if families lived more closely together.

Participants were asked about how they helped others in their communities. When asked this question initially, most said they did not provide much help; however, when asked how they 'filled their week', it was found that most contributed to their community, some substantially. For example, one woman provided daily childcare for her neighbour, nursing care to her friend's mother, cooked lunch for an older people's group, spent one day a week helping at a local care home, cooked and baked for activities at the village hall, organised newspaper swaps, conducted fundraising for the community, as well as having a part-time paid job at the general practice. Men spoke about helping each other with crofting tasks like sheep dipping, lambing and peat cutting. These activities were described as 'declining', with fewer villagers crofting and younger men working elsewhere, for example in the offshore oil industry. Some of the men were involved in bowling and sports clubs



and the church. In one community the men cook the annual Christmas dinner for the older people.

Organised voluntary initiatives were thriving, including lunch clubs, a community car scheme, a clothes washing service and social groups for older people. Community members 'kept an eye' on each other. They looked to see if neighbours' house lights went on and off at 'normal' times. Some said house lights were used as communication between houses to signal that things were alright. Participants regarded their help-giving as part of community life. Concern was expressed about whether people would continue to support each other in these ways in the future:

*Three people do not have family living in [village] because when their children grew up, they either went away to university and did not return, or they left the area to find work. This is something that the group are alarmed about. They are concerned about [village] becoming an 'ageing population' and they wonder who is going to look after all the 'older people' in the future. (Focus group)*

## Discussion

This study found that older people living in the remote communities rejected the notion of 'being old' and expressed the desire to remain independent. In a situation of service restructuring, they valued local, personal aspects and were suspicious of arrangements they perceived emphasised technical efficiency. Health and care services were described as linked with other aspects of rural living, including transport and housing. Social support networks are key to maintaining older people's quality of life as part of a community. In this study, participants delineated the boundaries of the family support it was fair to expect. They were mostly active in helping others in their community but feared community support networks might be unsustainable.

The study considered only two remote communities, both of which are currently well served by local health professionals

and have access to local care facilities. This is not a universal situation in Scotland and the findings are therefore limited because they do not report the thoughts of residents in communities with differing service accessibility. Small numbers of older residents were involved and it is possible that these were more prominent residents, due to our method of sampling using local workers. We did not include older people living in urban settings and therefore cannot comment on contrasts or similarities. Some aspects are likely to be unique, such the fear of losing ancestral cottages in Highland villages sought as holiday destinations. The study's strengths lie in the layers of data collection used. Some participants were involved in two data collection rounds, allowing them time for reflection. Themes were verified at focus groups. While the approach was open (thereby potentially attracting an incoherent range of responses), emergent themes were surprisingly focused, similar in both communities and, importantly, reflected the concerns of older people rather than ideas identified by researchers.

The goal of the study was to collect information about service provision now and in the future, to inform policy-makers and service provision. In many respects, older people in remote Scotland reflect opinions from elsewhere; for example Hinck (USA) noted older people's desire to remain independent at home<sup>26</sup>, and the findings agree with Scharf et al's literature review of European studies that rural people use, and contribute to social networks for relationships, help and support<sup>27</sup>.

McCann (Ireland) noted a sense of stigma in applying to statutory services for support<sup>15</sup>. In this study, lack of demand for services appeared to be more linked to not wanting to identify oneself as vulnerable, fear of losing independence and perceived threats to continued ownership of property. Further, use of services could be linked to the apparent complexity surrounding their provision. Fragmented experiences of service providers and the different options available (for example direct payments versus council provision and different packages of care) meant confusion. It is important for service providers to be alert to how



community members have to simultaneously cope with ageing, service restructuring, lack of access to information sources and possible limited access to sources of personal support<sup>1</sup>. Participants sought straightforward, trusted, known conduits into 'the system' and saw those with medical and health professional qualifications as credible to fill this role. McCann also noted this desire for personal connection with service providers in an Irish study<sup>15</sup>. Thus, community members were adherent to traditional, local models of provision and suspicious of new ways of service provision. Walsh and O'Shea note the difficulty of achieving 'transcendence' (that is, getting communities to broaden their horizon) beyond the 'what has always happened here'<sup>16</sup>.

While participants portrayed their relationships with local health professionals and supportive communities as positive, the objective observer might see a paternalistic context that hinders individual and group responsibility and voice. In addition, these apparently supportive Highland communities can belie complex, enmeshed, limiting relationships<sup>28</sup>. The dilemma of participants with regard to the dark and light sides of 'social support' is perhaps highlighted in their contested perspective on community support for older people. They, personally, should not be a burden to their families or might regard it limiting to be viewed as a 'granny', but families, in the abstract, and communities *should* look after their members.

The study sought to bring the 'voice' of older rural community members to policy-makers. Gaining the input of older people to policy and service design continues to be noted as both important and problematical. Here, it was seen that people did not want to identify with being old or want to try to envisage their needs as an older person because this was complex and depressing. While participants tended not to focus on how particular services, as envisaged by their providers (such as social care), could be specifically improved, their discussions did raise overall 'principles' considered significant in service provision; chiefly, continuity rather than fragmentation, and personal and social emphasis rather than technical efficiency. Participants

viewed services as interconnected, for example connecting rural transport with accessing services was raised. Linking transport with accessibility has been a theme internationally in studies of older rural residents<sup>14,17,29</sup>. Interconnections highlight the need for good 'territorial' community planning processes that treat services together and not in silos<sup>30</sup>. Older people in rural communities are concerned about the future and, in respect of their support from other community members and services, tend to have an ominous view. This is perhaps fertile ground for initiatives that generate solutions and initiatives from older people themselves.

## Conclusion

This paper opened with two quotes: one suggesting how changes to rural society, including service restructuring, have dramatically and irrevocably altered the lives of older people; the other suggesting the fundamental role of place as we age. In common with international work cited, this study highlighted rural community members wrestling with a changing structural environment while they and their communities age. Policy suggests innovative solutions are required from competent communities' to support older rural people to live out their lives in the communities that are, or that they have made, their homes. While the communities in this study appear informally supportive, more formal community structures may be required in the future. If residents want continuing and personal care within a retracting welfare state, they may have to assume responsibilities for community governance and enterprise.

Originally, the study findings provide in-depth and substantiated (through layers of data collection) insights in relation to a group ageing, in a particular context, at a perhaps particularly complex snapshot in time. It has been repeatedly suggested that older people should be more participative in informing their service design, both at a policy and local governance level. This study revealed complex barriers to older people influencing service provision, either through uptake of services and benefits or by using collective 'voice'. There is reluctance even to be



identified as 'older' and therefore to harness the potential of forming a group 'voice'. Older people and their local service providers co-construct a paternalistic context where service providers are regarded as the experts in decision-making. Service providers' emphasis on efficiency is perceived to erode the personal contact associated with valuing older people; therefore, confidence as an older person may be eroded. If vulnerability is admitted, accessing the range of services and benefits is complex, with different types linked to silo-ed service provision. This could hinder service uptake and feedback. Finally, confusion over the conditions under which services are provided may prevent older people coming forward (for example, receiving some care packages is thought to threaten home ownership).

Looking to a vision of the future for older people in rural communities, society perhaps needs to achieve simultaneous 'tipping points'. One, may occur where communities take more formal responsibility for supporting their older members; a second where being older loses stigma; a third where services work interconnectedly in ways that make sense to consumers, rather than providers.

## Acknowledgement

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# DSAC Advisory Committee Timeframes - Actions for Committee Members

## Summary to November 2009

Week	Day	Date	Date	Date	Date	Action
-2	W	24/6	5/8	16/9	28/10	<b>Papers to be submitted to Committee Secretary by 1pm. Including Chairs report to DSAC from Board meeting.</b>
0	M	6/7	17/8	28/9	9/11	DSAC Papers loaded to website by 10am
	W	8/7	19/8	30/9	11/11	DSAC Meeting 10am. Previous meeting's Draft Minutes confirmed and become Final (v1.3). <b>This version printed and signed off by Chair</b> <b>Committee Members to complete Reimbursement Forms (for the current meeting) and Chair to sign</b>
+1	M	13/7	24/8	5/10	16/11	<b>DSAC Chair confirms Draft Minutes including Action and Responsibilities List (v1.2) and provides Chair Report to Board to Committee Secretary.</b> DSAC Committee Secretary forwards Draft Minutes including <b>Action and Responsibilities List (v1.2) to Advisory Committee members</b> and any other persons named in the Action and Responsibilities list.
+2	F	24/7	4/9	16/10	27/11	Board Meeting

# WEST COAST DISTRICT HEALTH BOARD AND ADVISORY COMMITTEE TIMETABLE JANUARY 2009 TO DECEMBER 2009

DATE	MEETING	TIME	VENUE
Thursday 29 January 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 4 March 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 5 March 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 6 March 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 6 March 2009	ARF	1.00 PM	Boardroom, Corporate Office
Thursday 19 March 2009	BOARD	10.00 AM	Boardroom Corporate Office
Wednesday 15 April 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 16 April 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 17 April 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 17 April 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 1 May 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 27 May 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 28 May 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 29 May 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 29 May 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 12 June 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 8 July 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 9 July 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 10 July 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 10 July 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 24 July 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 19 August 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 20 August 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 21 August 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 21 August 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 4 September 2009	BOARD	10.00 AM	Boardroom Corporate Office
Wednesday 30 September 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 1 October 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 2 October 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 2 October 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 16 October 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 11 November 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 12 November 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 13 November 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 13 November 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 27 November 2009	BOARD	10.00 AM	Boardroom, Corporate Office

# ABBREVIATIONS

# NOF	Fractured Neck of Femur (broken hip)
1°	Primary
2°	Secondary
3°	Tertiary
A&E	Accident & Emergency
A+	Auckland Healthcare
ADHB	Auckland DHB
ALOS	Average Length of Stay
ANDRG	Australian National Diagnosis Related Group
APAU	Adult and Paediatric Assessment Unit
ARC	Aged Residential Care
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation Service
BDC	Buller District Council
BOPDHB	Bay of Plenty DHB
C&CDHB	Capital and Coast DHB
CAA	Child Acute Assessment
CAMHS	Child & Adolescent Mental Health Service
CAP	Canterbury Association of Physicians
CC	Complications & Co-morbidity
CCMAU	Crown Companies Monitoring Unit
CCN	Clinical Charge Nurse
CCU	Critical Care Unit
CD	Clinical Director
CDHB	Canterbury DHB
CEA	Collective Employment Agreement
CFA	Crown Financing Agency
CHA	Crown Health Association
CHL	Canterbury Health Labs
CICU	Cardiac Intensive Care Unit
CMDHB	Counties Manukau DHB
COMRAD	Radiology Reporting System
CPAC	Clinical Priority Assessment Criteria
CPHAC	Community & Public Health Advisory Committee
CSC	Community Services Card
CSSD	Central Sterile Supplies Department
CTA	Clinical Training Agency
CWD	Case Weighted Discharge
DAO	Duly Authorised Officer
DAP	District Annual Plan
DDG	Deputy Director General
DHB	District Health Board
DHBNZ	District Health Boards New Zealand

DIS	Disability Information Service
DNA	Did Not Attend
DON	Director of Nursing
DOSA	Day Of Surgery Admission
DRG	Diagnostic Related Grouping
DSAC	Disability Services Advisory Committee
DSD	Disability Support Directorate
DSP	District Strategic Plan
DSS	Disability Support Services
EAP	Employee Assistance Programme
ED	Emergency Department
EMT	Executive Management Team
ENT	Ear, Nose and Throat
ER	Employment Relations
ESR	Institute of Environmental Science and Research
FSA	First Specialist Assessment
FTE	Full Time Equivalent (Staff)
GP	General Practitioner
HAC	Hospital Advisory Committee
HAHS	Hospital and Health Services
HBDHB	Hawke's Bay DHB
HBSS	Home Based Support Services
HEHA	Health Eating – Health Action
HFA	Health Funding Authority
HHS	Hospital & Health Service
HMD	Hospital Monitoring Directorate (former CCMAU)
HNA	Health Needs Analysis
HOP	Health of Older Persons
HR	Human Resources
HTG	Hospital Technical Group
HUHC	High User Health Card
HVDHB	Hutt Valley DHB
ICD 9	International Code of Diseases
ICU	Intensive Care Unit
IDF	Inter District Flow
IEA	Individual Employment Agreement
IEC	Individual Employment Contract
InterRAI	An assessment tool for assessing older people's needs
IPA	Independent Practice Association (GP Group)
IRF	Inter Regional Flow
ISDN	Integrated Services Digital Network
ISSP	Information Services Strategic Plan
IT	Information Technology
Kai Arahi	Term generally refers to “guide” and / or advisor
KPI's	Key Performance Indicators
LDHB	Lakes DHB
LMC	Lead Maternity Carer
MDHB	MidCentral DHB
MECA	Multi Employer Collective Agreement

MHAC	Mental Health Advisory Committee
MOH	Ministry of Health
MOSS	Medical Officer Special Scale. A doctor with 4+ years post-graduate experience but not a specialist
MRT	Medical Radiation Technologist
NDHB	Northland DHB
NGO	Non Government Organisation
NHI	National Health Index
NICU	Neonatal Intensive Care Unit
NMDHB	Nelson Marlborough DHB
NRT	Nicotine Replacement Therapy
NZBS	New Zealand Blood Service
NZCM	New Zealand College of Midwives
NZNO	New Zealand Nurses Organisation
O&G	Obstetrician and Gynaecologist
ODHB	Otago DHB
OIA	Official Information Act
OP	Outpatients
OPD	Operational Policy Framework
Ora Services	Term used to describe all activities that promote health and prevent diseases that are undertaken in the primary care setting for children and their families and whanau
P&F	Planning and Funding
PBFF	Population Based Funding Formula
PCG	Project Control Group
Pegasus	One of the IPA's
PHO	Primary Health Organisation
PMS	Patient Management System
PNA	Professional Nursing Advisor
Primary Services	Services that receive self referred patients
PRIME	Primary Response in Medical Emergencies
PSA	Public Services Association
QA	Quality Assurance
QHNZ	Quality Health New Zealand
RDA	Resident Doctors Association
REOI	Request for Expression Of Interest (pre-tender)
RFP	Request for Proposal (tender)
RHA	Regional Health Authority
RHMU	Residual Health Management Unit
RMO	Registered Medical Officer. A junior doctor with 0-4 years post-graduate experience
Runanga	Tribal Council
SCDHB	South Canterbury DHB
SDHB	Southland DHB
Secondary Services	Services where a primary carer must refer patients. Provided in a hospital supported by specialists, and meeting standard clinical criteria
SHO	Senior House Officer
SIRMHN	South Island Regional Mental Health Network
SMO	Senior Medical Officer
SMT	Senior Management Team
SOI	Statement of Intent
SSC	State Services Commission

SSP	Statement of Service Performance
Stargarden	Payroll System
STD	Sexually Transmitted Diseases
TAIRDHB	Tairāwhiti DHB
Tamariki	Children – usually refers to children up to and including 14 years of age
Tangata Whenua	People of the land”, most commonly referring to traditional Maori iwi occupants of a region or district
TARADHB	Taranaki DHB
Tino Rangatiratanga	Sovereignty / Autonomy
VLCA	Very Low Cost Access
WAIKDHB	Waikato DHB
WAIRDHB	Wairarapa DHB
WAITDHB	Waitemata DHB
WCDHB	West Coast DHB
Whanau	Family and Extended Family
Whanau Ora	Health and wellbeing of families
WHANDHB	Whanganui DHB
WISE	West Coast Improving Services for Elderly
WTF	Waiting Times Fund
XM	Crossmatch
YTD	Year to Date