## AGED & DISABILITY SUPPORT ADVISORY COMMITTEE

**Tuesday, 4 December 2018, Boardroom, Corporate Offices Hauora Tairāwhiti**

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>9.00am</td>
<td>Meeting starts</td>
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</tbody>
</table>

## APOLOGIES

1.1. As notified

## INTERESTS

2.1. Committee Members’ schedule of interests for review

2.2. Conflicts in relation to Agenda items

## PREVIOUS MEETING

3.1. Previous Minutes for approval: 14/08/2018

3.2. Minutes ADSAC/CPHAC Open Forum 12/10/18

## ACTION ITEMS

4.1. Actions from previous meeting

## CORRESPONDENCE

5.1. Nil

## INFORMATION ITEMS

6.1. NASC Quarter 4 Report 2017/18

6.2. Te Puna Waiora Group Manager’s update report

## DECISION ITEMS

7.0. Nil

## GENERAL BUSINESS

8.0. 2019 ADSAC meeting dates

## RESOLUTION TO EXCLUDE THE PUBLIC

RESOLVED that:

In accordance with the provisions of Schedule 3, of the NZ Public Health and Disability Act 2000, that the public be excluded from the next part of the proceedings of this meeting.

The reason for passing this resolution and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public areas are as follows:
10.1-2 As shown on resolution to exclude the public in Minutes.

12.1 Negotiations or Commercial Activities – The disclosure of that information would not be in the public interest because of the greater need to enable Hauora Tairāwhiti to carry on, without prejudice or disadvantage, negotiations or activities.

[OIA 1982 S.9 (2) (j) & (i)]

Ground(s) under Clause 32 for passing this resolution:
That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2) (g) (i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S.32(a)]

PREVIOUS IN COMMITTEE MEETING

10.1. Previous In Committee Minutes for approval  14/08/2018
10.2. Action Items (Nil)                                      n/a

IN COMMITTEE INFORMATION ITEMS

11.0  Nil                                                  n/a

IN COMMITTEE DECISION ITEMS

12.0  Nil                                                  n/a

PUBLIC RELEASE OF IN COMMITTEE ITEMS

DATE OF NEXT MEETING: Tuesday, 12 February 2019
Minutes

Aged & Disability Support Advisory Committee

Tuesday 14 August 2018

Present
David Scott (Chair)
Na Raihania
Roimata Waihi
Lois McCarthy Robinson
Meredith Akuhata-Brown
Josh Wharehinga

Attending
Jim Green (Chief Executive)
Nicola Ehau (Group Manager, Planning, Funding & Population Health)
Claire Campbell (Portfolio Manager, Health of Older People and Disability Support Services)
Joyce O’Donnell (Minutes)

Presentation
Mental Health Services for Older People (Support for Ngāti Porou Hauora) on the Coast by Cilla Allen, Service Manager, Community Mental Health & Addictions (and staff)

Karakia
Welcome from the Chair

Item 1: Apologies
Prue Younger

Item 2: Interests
2.1 Changes to Register
Nil
2.2 Conflicts Related to Agenda items
Nil

Item 3: Minutes of the Previous ADSAC meeting
ADOPTED
The public minutes of the ADSAC meeting held on 15 May 2018.

Matters Arising
Nil

Item 4: Action Items
Noted

Item 5: Correspondence
Nil

Item 6: Information Items
6.1 Annual Advance Care Planning Report 2017-18
Noted and discussed.
6.2 Falls Report – November 2017 – June 2018
Noted and discussed.

6.3 NASC Quarter 4 Report 2017/18
Noted. The Group Manager commented that residential care facilities occupancy is at 90% and has been consistently high for last six months. One provider is providing only access to premium beds currently.

6.4 Equity Dashboard
Noted. ADSAC were advised the report was developed at the request of Clinical Governance Committee who are seeking to address inequity in health outcomes in Tairāwhiti, particularly for Māori.

The Chief Executive commented that whilst some outcomes are measurable i.e. Ambulatory Sensitive Hospitalisation rates, there are social equations in relation to equity that are more difficult to measure such as how people are living.

In response to a question, the Group Manager advised that the base line equity targets should be a reflection of the percentage of the population and there is opportunity to improve further on those thereafter.

Members noted the new national Health Targets will also have an equity lens across them.

6.5 Te Puna Waiora Group Manager’s Update Report
Noted

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### Item 7: Decision Items
Nil

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### Item 8: General Business
Nil

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### Item 9: Resolution to Exclude the Public
RESOLVED that:
In accordance with the provisions of Schedule 3, of the NZ Public Health and Disability Act 2000, that the public be excluded from the following part of the of the proceedings of this, meeting namely:

<table>
<thead>
<tr>
<th>10.1</th>
<th>Previous In Committee Minutes for Approval (nil)</th>
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<tbody>
<tr>
<td>10.2</td>
<td>Action Items (nil)</td>
</tr>
</tbody>
</table>

Information Items
11.0 Nil

Decision Items
12.1 Home & Community Support Services New Model of Care

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Meeting Ended: 10.20am
Next Meeting: 16 October 2018 (Open Forum – details tbc).

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Chair
Date
Welcome: Prue Younger (ADSAC Chair) on behalf of ADSAC & CPHAC Committees

Karakia: Josh Wharehinga

Chairs Welcome:

As chair of the ADSAC committee we have as one of its guiding mandates the Healthy Ageing Strategy. New Zealand Health Strategy 2016 replaced the Health of Older People Strategy 2002. The
Strategy's vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities".

Part of the Strategy focuses on Home and community support services. These are currently not delivered under a national contract and funding arrangements vary considerably between the Ministry of Health, Accident Compensation Corporation and the 20 District Health Boards (DHBs), making it difficult for providers to reliably forecast their income and consequently cover their overheads, maintain service standards and pay their workforce.

This sector of our health care model has certainly had its share of "significant legislative change". Pay equity, guaranteed hours, in-between travel, and employment standards have all landed on the shoulders of home and community support services providers. Collectively these requirements suck up the majority of the sector's funding.

"What we have now is eight DHBs which are using some form of case-mix. The rest are using fee-for-service. All of them are trying to hold or reduce spend when demand is rising. The current system doesn't give the consumer much say and it frustrates workforce planning.

Ministry of Health, Accident Compensation Corporation commissioned the Fernhill Solutions' report, Putting the Case*, which backed up several major independent reports each outlining what needs to change and why and it researched similar conclusions that the status quo is not sustainable.

This new report calls for a nationally consistent case-mix funding model, echoing the recommendations of previous reports and the pleas of the home and community support services (HCSS) sector over the last five years. The new "case mix" model allows clients to be assessed to identify their needs and then be allocated the services that best meet these needs but there are also challenges to adopting a case mix model.

What we hope to achieve today is a chance to understand what the current Home Based Support Service Delivery looks like in Tairāwhiti and then get an overview of the new Home & Community Support Service model of care.

We will have opportunity for discussion on this at the end.

CCS Disability Action (Colene Herbert, General Manager)/ Jenny Christophers)


- 5,000 membership
- Logo - recognises that each of us regardless of our ability, age and circumstances is unique and deserves to be nurtured and recognised.
- Range of contracts nationally from advocacy through to foster care and contract ward.
- Caters for pan-disability (not just people with Polio).
- In Tairāwhiti also provide Over 65 contract (600+) customers.
- Vision – every disabled person will be included in the life of their whānau and community.
- Whānau centred approach.
- Going through sector transformation (Enabling Good Lives Principles). Roll out – started 1 October in Midcentral. Involves changing the system so that people have more choice and control in terms of how their supports are delivered. Philosophical change which we are excited about.

High level challenges in support, particularly for Home based contract are:
- recruitment in terms of the length of time it takes to get Ministry of Justice Police Check completed (currently 8 weeks which is too long).
- impact of Pay Equity – increase in pay is recognition they deserve but it has had an impact on their availability now in terms of covering or increased shifts. Need to work out how to close that gap.

Service Provision:
- 7 passionate co-ordinators and 120 support workers.
- Supporting a client and finding out how they would like to be supported (post a NASC referral)
- Try to match support workers with the client - Job match.
- 3 after-hours co-ordinators so people can change arrangements if necessary.
- Clients often commence with one hour home help and progress to increased support/personal cares towards end of life. Staff need to be supported through their loss also.
- Supporting support workers – newsletters about the organisation/ information’ upskilling/core training opportunities.
- Needs include the growing trend of family abuse
- Client choice in terms of services has had a huge impact on training requirements i.e. Palliative for those people who want to die at home.
- Funded for basic home help (independent in their homes); personal cares (assisting to fully washing someone; falls etc.), Heat & serve, medication prompting (alongside Pharmacies),
- Staff – reference checks, core training and a 3 month induction training, career force training (level 2, 3, 4 NZQA recognised training); regular hui (i.e. with Police around suicide or sudden death); Huntington’s disease etc.
- CCS Disability Action with the focus on disability action - (not Crippled Children Society)
- May engage with other agencies for additional support for clients who have been assessed.

Home Based Support (Ngāti Porou Hauora) Cara-Lee Pewharangi- Lawton, Ngāti Porou Hauora
- Manage Te Puia services including Home based Support Care.
- Provider of health services since 1997.
- Community based service – focus is on service integration with primary health teams (giving direct contact with clinicians).
- Vision – our generation living longer than the rest.
- Ngāti Pakeke – service for community engaging elder care.
- Nurturing and looking after the people we have still remaining with us.
- Cover long distances and isolated areas
- 50 caregivers and 66 HBS clients.
- Provide different contracts in HBSS – under 65, Over 65, long term conditions and some ACC.
- Contracted also by other DHBS to provide services to pakeke in rural/isolated localities.
- Endeavour to have core care-giver groups in each community. A benefit to the service because they are locally known to clients and their whānau.
- Have encouraged family members to become the care workers and a lot of pakeke do want their own to look after them and caregivers in small communities can be hard positions to fill. Sometimes that unachievable as we also have to go through employment process – police and drug tests and sometimes that causes obstacles. Also employment law dictates we can’t employ family members as casual workers for ever and a day (when client’s lifespan is indeterminable).

Service:

- A pathway that we encourage families to use to access services.
- Post hospital discharge for six weeks – over and above what they currently do.
- Rural Health nurse has a lot of interaction with caregivers in each of our communities. It’s about keeping the lines of communication open to ensure that the care worker working in Potaka for example is not feeling isolated.
- Our rural health nurse can receive referrals from Whānau.
- NASC will do assessment and that establishes the communication lines.
- Communicator (Tanya White) – she looks after the 7 pools of carers.

Challenges

- Isolation and distance
- There is a lot of unmet need limited by the single assessor undertaking a lengthy NASC InterRAI and whānau are reluctant to ask for help. Needs further discussion. We still put in place cares until the InterRAI assessment comes.
- Training – struggle with getting Career force to come north of Tolaga Bay and difficult to bring caregivers to Gisborne.
- Asking Careerforce to come up to Te Puia. Lot of caregivers have level 2 but some no levels at all. Asking Careerforce trainers to walk along-side them and bring them up to competency.
- Sometimes the expectation is that caregivers are asked to do more than they are contracted to do i.e. chopping wood. Needs to be more understanding between providers and whānau about what can be expected in terms of home help and personal cares.

**Home & Community Support Services (Nicola Ehau, Group Manager, Planning, Funding & Population Health, Hauora Tairāwhiti)**

National Programme Underway – aligned to the Health of Older Persons Strategy completed earlier in the year.

MOH & DHBs are charged to work together to develop:
Home Care Support framework
- National Service Specification (not existed prior to now).
- Case-Mix – 8 DHBs in the Country who have undertaken a case-mix programme.

Engagement workshops, organised by MoH and held within regional centres, to discuss the HCSS future model of care framework, principles and other critical elements such as; meeting diverse needs, enabling innovation and future thinking. Midland meeting was held in March 2018.

The current Hauora Tairāwhiti Home Based Support Service (HBSS) contract expires in June 2019 providing the opportunity to develop the new HCSS model of care. The development phase involved reviewing the existing service, the information gathered from the engagement workshops and other District Health Boards’ HCSS models of care.

This presentation is about what is contained in our local draft for HCSS (reflecting the National work) and giving you the opportunity to feedback.

Represents a huge shift for our current workforce – what is the right thing that will enable the person to stay at home longer. And if that’s the answer, that’s what we want to be able to provide.

HBSS is functioned off a fee for service model – looking t a bulk funded approach for HCSS which will be a significant change in terms of how their employment programme runs. Will give benefits but also challenge and risk.

Full draft service spec provided for your feedback until 31 December. Take time to think about it but the national service specification is the mast that we will frame the local service delivery off.

RFP -Currently going through Probity. Expecting it to be available by Friday 26th October.

**Hauora Tairāwhiti Presentation:**

Future Models of Care for Home and Community Support Services (HCSS) - *What is it?*
- The delivery of a home care service that supports and enables older people to live well, safe and independently for longer in their homes, so that;
- They can be active participants in their families/whānau and communities, and
- Receive the appropriate care services they need when it’s needed, in order to
- Reduce possible loss of function; reduce acute admissions or re-admissions; reduce length of stay in hospital
- The new model of care is intended to support older people to:
  - Live well, safe, and independently for longer in their homes
  - Actively participate and contribute in their family’s and community lives
  - Receive the appropriate care support service they need when it’s needed
  - Increase their health literacy so that they can manage their conditions and stay well
  - Live well with long-term conditions
  - Have an integrated support system when they have high and complex needs
  - Navigate the system easier by having one point of contact for their care support service
  - Improve their health outcomes and achieve their health goals
- Receive effective rehabilitation, recovery and restoration health services and support following an acute event
- Reduce their loss of function and acute events that eventuate as an Emergency Department (ED) admission or re-admission

Why Change?

- Current data reports an increase in the acuity and complexity of older people’s care requirements; statistically our older people’s population is growing, and therefore, future trends project that the number of people requiring home and community support services who have complex medical conditions will increase as a result.
- A priority action within the Healthy Ageing Strategy (Action 8a) is to develop and implement a person-centred, needs-based and equitable home and community model of care that delivers high-value, high-quality and improved outcomes.
- The Future Models of Care for Home and Community Support Services (HCSS) national programme was born from Action 8a; agreed to by Cabinet in August 2017 and subsequently began initiation in October 2017.
- The current HBSS contract for Hauora Tairāwhiti is due to expire in June 2019, providing an opportunity to implement an enhanced HCSS model of care that will enable a holistic, integrated and responsive care support service.

Who is it for?
- Māori 55 years+
- Non-Māori 65 years+
- Needing short term care support, or
- Long term care support, or
- Long term services for chronic health conditions

Key Points
- Person-centred: engage with the person to ensure the care offered is tailored to each individual’s personal and cultural needs, and delivers the best experience and outcome possible
- Inclusive: involving the Carer, family/whānau and other natural supports in the care assessment planning and implementation, where appropriate
- Integrated: providing a full holistic care support service from referral through to the end of life, co-ordinating the range of support required with the wider primary healthcare sector, health professionals, community and social services to ensure seamless continuous care
- Restorative: promoting a return to health and oranga by focussing on maximising a person’s level of function and minimising decline; encouraging them to participate in their decision making, goals achievement, daily activities, and physical activity in order to preserve the person’s optimum level of functioning and independence
- Pro-active: using timely interventions to prevent or delay physical, psychological and social deterioration; bringing in and coordinating the care and support service as needed
- Collaborative: better information sharing and cross-care involvement between care services to reduce duplication of effort and resource investment, and to improve efficiency of care for the person
- Health Literate: ensuring, and improving where required, the health literacy and knowledge for older people, their informal carers, family/whānau, and for the HCSS workforce
- Equitable: ensures equity of access for individuals and families, for Māori and Pacific peoples.
- Flexible: enabling the Provider/s to be creative and innovative to meet the person’s levels of need, as it evolves and changes

Whaia te hauora i roto i te kōtahitanga
A healthier Tairāwhiti by working together
- Through a capable, established, credible high performing Provider/s who has:
  - A trained workforce with a planned learning and development pathway
  - A passion for delivering quality, holistic, responsive, innovative care for our older people
  - And with positive goals achievement and outcome focus

Closed 11.33am by Prue Younger
<table>
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<tr>
<th>#</th>
<th>Subject</th>
<th>Narration</th>
<th>Action</th>
<th>Due</th>
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<tbody>
<tr>
<td>1</td>
<td>Falls Prevention</td>
<td>Members agreed the September (ADSAC led) joint ADSAC/CPHAC forum would focus on the activities of the Falls collective. The forum (and Falls initiatives) to be publically promoted.</td>
<td>Heather</td>
<td>11.9.18</td>
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<td>• <em>Included in August agenda</em></td>
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<td>2</td>
<td>Falls Prevention Tairāwhiti</td>
<td>Update reports on the Falls Prevention programme (co-funded between ACC and Hauora Tairāwhiti) including outcomes and the ACC dashboard.</td>
<td>Heather</td>
<td>11.9.18</td>
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<td>• <em>Included in August report</em></td>
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<td>3</td>
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**August 2018**

3. Nil
Information Item

Bed Utilisation

- Occupancy of the four rest homes in Gisborne has remained high although there was a dip in August.
- Te Puia Springs occupancy has dropped to 36%.
- There are currently 27 rest home/hospital level beds available, 20 of these are in the five Gisborne city rest homes. There are 11 dementia level beds available.
- Some older people have been discharged to Aged care under ACC funding following a small number of hospitalisations for injuries.
Referrals

Numbers of referrals are steadily growing, including an increase in requests for permanent residential placement.

![All referrals chart]

![Total of all referrals chart]
Numbers of referrals received requesting permanent rest home placement.
The number of actual admissions will vary slightly as some people die before they are assessed, some people don’t consent and some people do not qualify.

<table>
<thead>
<tr>
<th></th>
<th>Q1 17/18</th>
<th>Q1 18/19</th>
<th>Q2 17/18</th>
<th>Q2 18/19</th>
<th>Q3 17/18</th>
<th>Q3 18/19</th>
<th>Q4 17/18</th>
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<tr>
<td>Series1</td>
<td>45</td>
<td>35</td>
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Number of Clients Receiving Home Based Support Packages of Care

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<tr>
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<th>Q1 17/18</th>
<th>Q1 18/19</th>
<th>Q2 17/18</th>
<th>Q2 18/19</th>
<th>Q3 17/18</th>
<th>Q3 18/19</th>
<th>Q4 17/18</th>
<th>Q4 18/19</th>
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<tbody>
<tr>
<td>Series1</td>
<td>523</td>
<td>548</td>
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</table>

- There has been a steady increase in people who have received home support.
- For the 17/18 financial year the average count of NHIs claimed against each quarter was 523
- In quarter one 18/19 548 NHIs were claimed against
- This does not include people allocated respite and carer support only.
Exit Clients

<table>
<thead>
<tr>
<th>Care Level</th>
<th>Sept-18</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>YTD against Budget (over/under Budget)</th>
<th>2017/18 Sept</th>
<th>YTD against 17/18 (over/under budget)</th>
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</thead>
<tbody>
<tr>
<td>Rest Home and Dementia (6640)</td>
<td>$437,275</td>
<td>$1,327,818</td>
<td>$1,335,815</td>
<td>-1%</td>
<td>$1,251,927</td>
<td>6%</td>
</tr>
<tr>
<td>Hospital (6650)</td>
<td>$534,899</td>
<td>$1,677,565</td>
<td>$1,713,998</td>
<td>-2%</td>
<td>$1,517,467</td>
<td>11%</td>
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<tr>
<td>Home Based Support Services (6630)</td>
<td>$276,566</td>
<td>$920,074</td>
<td>$965,262</td>
<td>-5%</td>
<td>$971,488</td>
<td>-5%</td>
</tr>
<tr>
<td>Carer Support (6635)</td>
<td>$9,592</td>
<td>$17,382</td>
<td>$11,685</td>
<td>49%</td>
<td>$13,067</td>
<td>33%</td>
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<tr>
<td>Residential Respite (6680)</td>
<td>$29,476</td>
<td>$88,428</td>
<td>$88,428</td>
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<td>$111,267</td>
<td>-21%</td>
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<td>NASC Flexible Funding (6664)</td>
<td>$2,057</td>
<td>$14,659</td>
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<td></td>
<td>$23,721</td>
<td>-38%</td>
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**Commentary:**
- NASC continues to note a steady increase in referrals and in people receiving both home support and those moving to aged residential care. The corresponding increase in people exiting the service identifies that NASC are seeing more people who need end of life care and the “turnover” of people receiving services is increasing.

**RECOMMENDATION**

That the Aged & Disability Support Advisory Committee notes the report.
Information Item

Health of Older People and Disability Support Services

Home and Community Support Services Registration of Interest (ROI)
While there was a delay, the tender has now been submitted to GETS. The procurement timeline was updated and the Evaluation Panel members advised. The Project Manager is responding to the recommended actions listed in the Probity Audit review.

Advance Care Planning
- A Level 1 (L1) ACP workshop was held in October, and 12 people attended.
- A train the trainer workshop was also held in October, with 6 people being trained to provide ACP L1 training. Workshops are being planned for next year.
- A national ACP administration training guide has been produced.

Whānau Falls Prevention
- Sport Gisborne is offering to support the East Coast provider in setting up Strength and Balance Programmes.
- East Coast In-Home Strength and Balance numbers are steady.
- Met with the urban strength and balance provider to look at increasing the volumes of those participating in the In-Home Strength and Balance Programme. It was identified that the problem was that they were not capturing all the people they were providing a service to.
- The number of people referred to the fracture liaison service has slowed. This was checked against the number of people with fragility fractures presenting to the Emergency Department, and the number appears to be correct. The Falls Nurse is now engaging with general practice to determine if any of their patient population is missing out on this service.

Needs Assessment Support Coordination (NASC)
- Workload has been high. NASC are not able to meet all MoH timeframes, and referrals are carefully prioritised.
- Some annual reviews are several months overdue due to workload.
- Manager is working with inpatient wards to get clinical information from nursing staff rather than OTs, as OTs are unable to support discharge to permanent aged care facilities.
- Wards have been very busy.
- Manager has met with the new physician/geriatrician.

RECOMMENDATION
That ADSAC ADOPT the recommendation to note the report.
Venue: Boardroom, Hauora Tairāwhiti (unless otherwise advised)

<table>
<thead>
<tr>
<th>Committee</th>
<th>Venue</th>
<th>Time</th>
<th>Agenda Deadline</th>
<th>Meeting Date</th>
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<tr>
<td><strong>HOSPITAL</strong></td>
<td>Boardroom, Hauora Tairāwhiti</td>
<td>Tuesdays, 9.00am</td>
<td>JAN Nil</td>
<td>Feb 08 FEB 19</td>
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<td>March 08 MAR 19</td>
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<td>April 05 APR 16</td>
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*Easter Weekend

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