Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 10 May 2018**

Meeting: **4.00 pm to 6.00 pm**

Venue: **Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Rachel Ritchie (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Sami McIntosh
Deborah Grace
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Sarah Hansen
Dallas Adams
Kylarni Tamaiva-Eria
Dr Diane Mara

Apologies:

In Attendance:

Kate Coley, Executive Director People & Quality (EDP&Q)
Ken Foote, Company Secretary (Co Sec)
Tracy Fricker, Council Administrator / EA to EDP&Q
Debs Higgins, Clinical Council Representative
Linda Dubbeldam, Health Hawke's Bay Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4:00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising – Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Report (verbal) – Rachel Ritchie	
8.	Youth Consumer Council Report (verbal) – Dallas Adams	
9.	Consumer Engagement Update (verbal) – Kate Coley	
	Section 2 – Presentations / Updates	
10.	Health & Social Care Localities – Wairoa Update – Te Pare Meihana	4.25
11.	Maternal Wellbeing Model of Health Presentation – Jules Arthur	4:35
12.	National Bowel Screening Roll-out Update – Lynda Mockett	4:50
	Section 3 – Discussion	
13.	The Place of Alcohol in Schools - Young people and under-age exposure – Rowan Manhire-Heath	5:00
14.	Co-ordinated Primary Care Options Programme (CPO) – Chris Ash	5:10
15.	Clinical Services Plan - Planning for Consultation – Ken Foote	5:20
16.	Consumer Council Representatives - Clinical Governance Structure – Ken Foote	5:35
17.	Implementing the Consumer Engagement Strategy – Kate Coley	5:40
	Section 4 – For Information Only (no presenters)	
18.	HB Health Sector Leadership Forum Report	-
19.	Best Start Healthy Eating & Activity Plan (6 month update)	-
20.	HBDHB Performance Framework Exceptions Q3 Dashboard	-
21.	Te Ara Whakawaiora - Did not Attend (local Indicator)	-
	Section 5 – General	
22.	Reports back from Consumer Representatives • Urgent Care – Jenny Peters • Disability Strategy – Dianne Mara	5:45
23.	Topics of Interest – Member Issues / Updates	
	Karakia Whakamutunga (Closing)	6:00

NEXT MEETING: Joint meeting with Clinical Council on Wednesday 13th June, 2.00-5.00 pm
Venue: Magdalinos Room, Havelock North Function Centre, Te Mata Road, Havelock North

Interest Register

Hawke's Bay Health Consumer Council

Mar-18

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Rosemary Marriott	YMCA of Hawke's Bay	Member	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.			No	
	Age Concern Hawke's Bay	Board Member		No	
	Positive Aging Trust	Committee Member		No	
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Scott Foundation	Allocation Committee		No	
	HB Medical Research Foundation Inc	Hastings District Council Rep		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara	Napier Family Centre	Chair	Social Service Organisation	Yes	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
	IHC Hawke's Bay Association	Chair	Disability Intellectual Stakeholder	No	
	Pacifica Women's Tiare Ahuriri Branch (Inc)	Branch Chair	Development Leadership for Pacific Women	No	

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL
HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD
CORPORATE OFFICE ON THURSDAY, 12 APRIL 2018 AT 4.00 PM

PUBLIC

Present: Rachel Ritchie (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
James Henry
Sarah Hansen *(until 6.00 pm)*
Olive Tanielu
Deborah Grace
Malcolm Dixon
Jenny Peters
Dr Diane Mara
Leona Karauria
Dallas Adams
Kylarni Tamaiva-Eria
Sami McIntosh (from 4.40 pm)
Terry Kingston (from 5.10 pm)

In Attendance: Ken Foote, Company Secretary
Kate Coley, Executive Director – People & Quality (ED P&Q)
Tracy Fricker, Council Administrator and EA to ED P&Q
Trish Freer, Health Hawke's Bay Representative

Apologies:

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Rachel Ritchie (Chair) welcomed everyone to the meeting. Tessa Robin provided a karakia/reflection to open the meeting.

2. APOLOGIES

The Chair advised that Terry Kingston would be late. No other apologies received.

3. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda. Leona Karauria noted that she had a change.

Action: Change in register for Leona Karauria to be made when received.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 15 March 2018 were confirmed as a correct record of the meeting.

Moved and Carried.

5. MATTERS ARISING AND ACTIONS

Item 1: IS Workshop
This item will be scheduled for the May meeting.

Item 2: Consumers on Projects
List of projects sent out to members with the meeting minutes. The high level report on Transform and Sustain projects was attached to meeting papers for information.

Action: Members requested project report be re-sent to them.

Item 3: Clinical Portal Project
Document provided by Jos Buurmans, Enterprise Architect sent to members with the meeting minutes. *Item can now be closed.*

Item 4: Workplan
Bowel Screening Programme and Establishing Health & Social Care Localities presentations to be added to the workplan for a future meeting.

Item 5: Youth Consumer Council
Copy of proposal not yet sent through to members. Dallas Adams provided an update under item #8.

6. CONSUMER COUNCIL WORK PLAN

The work plan was provided in the meeting papers. Priorities in the workplan keep changing.

A meeting is being held next week to discuss the agenda for the joint meeting with Clinical Council. Person and Whanau Centred Care and Choosing Wisely are two key topics which have been suggested for discussion at this meeting.

7. CHAIR'S REPORT

The Chair provided a report on activities:

- Terms of Reference have been agreed for the leadership group from the Leadership Forum workshop in March. First meeting yet to be arranged
- Workshops for the Clinical Services Plan have started and she attended the Future Hospital one yesterday
- The joint meeting with the Clinical Council has been proposed for May but may be pushed out to June
- Tenure of five Consumer Council Members is coming to an end in June
- Appointment of Deputy Chairs to assist the Chair to attend meetings. Malcom Dixon and Diane Mara have agreed to take this role.

8. YOUTH CONSUMER COUNCIL REPORT

Dallas Adams, Chair of the Youth Consumer Council provided an update on activities undertaken by the Youth Consumer Council (YCC):

- The education proposal outline for Hastings District Council (HDC) funding was submitted by the due date. Waiting to hear back from HDC re: speaking to the proposal
- YCC member Nikela-Eve Franklin is working with the DHB Suicide Prevention Team

- Kylarni Tamaiva-Eria's will be attending her last meeting next month as she needs to focus on her Masters on Creative Practice. Jemma Russell, YCC member will attend meetings in her place
- The first quarter of 2018 has been very challenging and the YCC Chair wants things to move forward and gain traction.

The Chair thanked the YCC Chair for his report and commented that YCC input on Consumer Council brings a lot of value to the discussions.

9. CONSUMER ENGAGEMENT UPDATE

Kate Coley, ED P&Q provided an update on activities:

- Recruitment has begun for a Consumer Engagement and Health Literacy Manager and an additional position of a Patient Experience Improvement Co-ordinator
- The Consumer Engagement Strategy and Recognising Consumer Participation Policy will be ready for feedback in May
- Working with Ken Foote on the Person & Whanau Centered Care approach ready for discussion at the joint meeting with Clinical Council
- Health Literacy – "making health easy to understand" guidelines, toolkits, training and information for staff will be completed by end of April
- Supporting the Mobility Action Programme – gathering patient stories from those who have been through the programme to identify if there are things that should be done differently to ensure what is being done has the impact we want
- Patient Experience Committee – joint committee with Clinical and Consumer Council members, plan is to be up and running in June/July.

SECTION 2: DISCUSSION

10. CLINICAL SERVICES PLAN SECTOR UPDATE

Ken Foote, Company Secretary advised that the future options workshops had begun this week with Aged Care/Frailty on 9 April and Hospital on 10 April. The next two are on 2 and 3 May. The Company Secretary asked for feedback from members who attended the workshops this week.

Aged Care/Frailty Workshop:

- Encouraged by the cross section at the meeting
- Questions were well discussed and people were very positive
- Was warmly welcomed and input solicited, a lot worked in the community and was impressed with the passion and determination to make a difference
- The blue sky was challenging, by the time of the third question ran out of momentum
- Hugely impressed with a fantastic group of people
- There is learning needed around terminology navigator/support person – very different. A support person is someone that knows the person and understands their needs

Hospital Workshop:

- Very interesting and liked being prodded to do blue sky work not just thinking what is happening now
- There was a different range of people at the table
- Felt at the end of the time looking at how the hospital can work out in the community still hasn't been tackled well, still struggling with what is the concept of a hospital going forward
- Exciting to think about possibilities and what patients will look like in 10 years' time, hopefully more assertive and able to voice what they want
- Good process
- Made to feel very welcome and included as a consumer
- Workshop was well handled

- Discussion around the table was good
- Good prodding from the facilitators, lots of questions asked and given time to think

The integrated workshop will be held on 31 May. Attendees from the four workshops will come together to integrate all the aspects which have come out of the separate workshops. The draft CSP will be available in July for comment and then a full consultation process with the community will occur in August/September. The Company Secretary will be seeking advice from members on groups they think we should consult with and the best way to do this. We want to make sure that this consultation/engagement process goes well – getting the right messages to the right people so that it is a genuine and open engagement process. When the consultation process is complete, all information will be sent to Sapere and the final CSP will come back in early October which will be the opportunity to make any final comments. It will go to the Board at the end of October for approval.

The Chair encouraged everyone to go to the meetings and voice their opinions.

11. INFORMATION SERVICES OVERVIEW AND ROADMAP

The Company Secretary advised that this item has been postponed for a future meeting.

12. FRAMEWORK FOR DEVELOPING THE PEOPLE STRATEGY

Kate Coley, ED P&Q advised that the document is a framework to build the people strategy on. It is for people who work in the health sector, investing in our people and building our culture. To develop the framework and to understand what it is like to work in the system we have done the Big Listen, Clinical Services Plan and Korero Mai. This document is a collation of the feedback received, turned into a framework for developing a plan for investing in our staff. There is a lot of evidence that if you invest in your staff, it has a positive impact on patients in terms of their experience and outcomes with better, higher quality care.

The framework is for HBDHB staff, but any wellbeing initiatives, training programmes etc will be opened up for staff within the whole of the health sector. The words used have come directly from feedback from the Big Listen. The values will also be intertwined in everything we will be doing, they are our foundation.

Comments / Feedback:

- Measures of success – need to include individual performance; education; bullying
- Good to have aspirations, but make it more real – what does it look like when we work together, include examples/stories from consumers
- Individual KPIs for accountability for those who are resistant to change
- Explanation on what KPIs are, success has different meanings for people, cultural dimensions to being successful
- Cultural sensitivity / competency – if staff attend a programme they need to apply the skills they have learnt
- Nurses are wanting safer working conditions
- Health inequities is not just in Maori and Pacifica, there is a greater growing need
- Culture is not just ethnicity – need to define what culture means, ultimately it is respect for each other

Further feedback can be sent to kate.coley@hbdhb.govt.nz

The detailed People Strategy document will come for feedback in June, it will set the scene for the next five years and there will be a detailed one year action plan and an overarching five year action plan. The document is an evolving piece of work. The Chair thanked everyone for their valuable feedback.

13. Māori & Pacific Workforce Action Plan - a component of Building a Diverse Workforce Strategy

Kate Coley, ED P&Q introduced Patrick Le Geyte, Acting General Manager Maori Health to the meeting. Patrick introduced his colleagues Ngaira Harker, Nursing Director – Maori Health and Donna Foxall, Māori Clinical Workforce Co-ordinator

The Maori and Pacific Workforce Action Plan has been developed because we want to have a workforce that is reflective of our community, and when this is in place you have better patient experience and outcomes. The drivers for the action plan are the Treaty of Waitangi – health inequities are over represented in Maori and Pacific populations; Employment social determinants of health; Workforce should reflect the population served; HBDHB performance indicators; Employment composition and culture competency.

General discussion held regarding cultural competency/sensitivity training and support mechanisms for staff; cultural empathy and understanding; recruitment of Maori, Pacific and Asian staff; structural racism, leadership development; workforce development and looking at areas of demand, providing scholarships and "growing our own"; education at school level to get children interested in science; Turuki blended scholarships; incubator and learning from past negative experiences.

Patrick Le Geyte commented that HBDHB is doing well in comparison to other DHBs, we don't have to convince our Board and Executive Management Team about equity issues, but there is still a lot of work to be done.

Issues around nurse training and placement were raised and discussed. Further communication outside of the meeting was encouraged due to lack of time.

The Chair thanked the team for their presentation.

SECTION 3: INFORMATION ONLY (No Presenters)

14. TE ARA WHAKAWAIORA – CULTURALLY COMPETENT WORKFORCE (LOCAL INDICATOR)

The paper was included for information only. No issues discussed.

15. TE ARA WHAKAWAIORA - CARDIOVASCULAR (NATIONAL INDICATOR)

The paper was included for information only. No issues discussed.

16. TE ARA WHAKAWAIORA - HEALTHY WEIGHT (NATIONAL INDICATOR)

The paper was included for information only. No issues discussed.

17. TE ARA WHAKAWAIORA - BREASTFEEDING (NATIONAL INDICATOR)

The paper was included for information only. No issues discussed.

18. TRANSFORM & SUSTAIN PROGRAMME – 5 YEAR OVERVIEW

The paper was included for information only. No issues discussed.

SECTION 4: GENERAL

19. REPORTS BACK FROM CONSUMER REPRESENTATIVES

Item not discussed. The Chair requested members to provide their updates via email.

- Urgent Care
- Disability Strategy

20. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***NASC Assessments*** - the Company Secretary advised that members may be aware of the article in the paper around NASC assessments and have concerns about Hawke's Bay people being withheld from rest homes. Resources have been focused the last few years on keeping people in their own homes, giving them the choice (which a lot are choosing to do). If someone is assessed as needing rest home level care this is arranged within days. The impression created by the article is false and the DHB's response will be in tomorrow's paper.

- ***Membership Tenure*** – the Company Secretary handed out the current tenure schedule. Five members are at the end of their tenures having served 3 terms. A process needs to be run for replacement, and advertisements will be run in the local papers, on our website and Facebook page. Letters will also go out to community groups associated with health. There are three members who are eligible for re-appointment. The Chair will talk to each member individually re: re-appointment. Nomination forms will be available at the next meeting if you know of someone who may be interested. The changeover will occur at the end of June, with new members starting at the July meeting. When Rachel Ritchie was nominated to Chair her position was not appointed to, so there is a vacant position to be filled. There is an opportunity to appoint six new members or look at extending the Youth Consumer Council membership to two. This can be discussed further at the May meeting.

  Discussion regarding consumer members who are on various other working groups and committees. They are able to remain on these as consumer representatives. It is only the Patient Experience Committee that they are required to be a current member of the Consumer Council. We want to develop a database of consumers who are able to take on consumer representative roles outside of the Consumer Council members.

- ***Choosing Wisely Presentation*** - a presentation was provided by Dr Andy Phillips, Chief Allied Health Professions Officer. The Choosing Wisely campaign has been driven by the Medical Colleges in New Zealand and they are clear that it is not about rationing, it is about quality of care, getting the best value and encouraging conversations between health professions and consumers.

  Questions that a consumer should ask were proposed and good discussion followed. The discussion focused on the different "contexts" for consumers when e.g. English is not first language (for patient or clinician), sufficient time to make decisions, need for support person, ability to process a lot of information in a stressful situation and different cultural context.

  The topic of choosing wisely will be discussed further at the joint meeting with the Clinical Council. A copy of the presentation was provided for members' information.

The meeting closed at 6.35 pm.

Confirmed: _____
Chair

Date: _____

5

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/08/17	**IS Workshop** IS Workshop will be delayed as IS will receive output from the Big Listen and CSP workshops prior to enable a constructive workshop with Consumer Council at a future date.	Company Secretary	TBC	Request from IS Manager - latter part of 2018
2	12/09/17	**Consumers on Projects** List of projects requested by Consumer Members (spreadsheet).	Kate Coley	April	
3	15/3/18	**Workplan** – items to be added: • Bowel Screening Programme presentation • Patient and Whanau Centred Care (for joint meeting with Clinical Council) • Establishing Health & Social Care Localities – invite Te Pare Meihana from Wairoa to present re: progress to date	Admin Admin Admin	May June May	All actioned
4	15/3/18	**Youth Consumer Council** Proposal for HDC funding to be sent out to Consumer Council Members for comment/endorsement (note: application due by 31 March)	Dallas Adams	Apr	Awaiting document
5	12/04/18	**Framework for Developing the People Strategy** Additional feedback re: framework to be emailed to Kate Coley directly kate.coley@hbdhb.govt.nz	All	Apr	

Consumer Council Workplan as at 1 May 2018	EMT Member	Clinical Council Meeting Date	Consumer Council Meeting Date	BOARD Meeting date
Combined Clinical and Consumer - Magdalinos Room, Havelock North Function Centre				
* Clinical Services Plan verbal update (May **June** July)	Ken Foote	13-Jun-18	13-Jun-18	27-Jun-18
Alcohol Positon Statement INTERNAL and Strategy *for EMT consideration* (board action August 2017) now June	Sharon Mason	13-Jun-18	13-Jun-18	27-Jun-18
Annual Plan 2018/19 First draft (June)	Chris Ash	13-Jun-18	13-Jun-18	27-Jun-18
Choosing Wisely (discussion between Clinical and Consumer Council at June Joint Meeting)	Co Chairs councils	13-Jun-18	13-Jun-18	
People Strategy FINAL (email 3/1/18)	Kate Coley	13-Jun-18	13-Jun-18	27-Jun-18
Person and Whanau Centred Care (Clinical and Consumer Council June joint meeting)	Co Chairs councils	13-Jun-18	13-Jun-18	
Recognising Consumer Participation - Policy Amendment	Kate Coley	13-Jun-18	13-Jun-18	27-Jun-18
Policy on Consumer Stories	Kate Coley / John Gommans	13-Jun-18	13-Jun-18	27-Jun-18
Te Ara Whakawaiora "Smokefree update" (6 monthly **May/June**-Nov) - board action Nov17	Sharon Mason	13-Jun-18	13-Jun-18	27-Jun-18
Te Ara Whakawaiora - Oral Health (National Indicators)	John Gommans	13-Jun-18	13-Jun-18	27-Jun-18
Under 16 Free GP service Update	Chris Ash	13-Jun-18	13-Jun-18	27-Jun-18
Urgent Care Service Update (6 monthly **June** Dec 18) paper or **presentation** TBC	Wayne Woolrich	13-Jun-18	13-Jun-18	27-Jun-18
Youth Health Strategy (board action June 17 for Update June 18 including Youth Consumer representative in attendance	Kate Coley	13-Jun-18	13-Jun-18	27-Jun-18
IS **Presentation** and Discussion (informed by CSP) June 18	Kevin Snee	13-Jun-18	13-Jun-18	
* Clinical Services Plan verbal update (May June **July**)	Ken Foote	11-Jul-18	12-Jul-18	25-Jul-18
Mobility Action Plan Update **Presentation**	Andy Phillips	11-Jul-18	12-Jul-18	25-Jul-18
Te Ara Whakapiri Next Steps (Last Days of Life) - MRB considered in April - moved to July for rest	Chris Ash	11-Jul-18	12-Jul-18	25-Jul-18
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** - update on activity planned Board action March18	Chris Ash	12-Sep-18	12-Sep-18	26-Sep-18
Annual Plan 2018/19 - approved Minister timing open	Chris Ash	12-Sep-18	13-Sep-18	26-Sep-18
Heatlh Equity Report	Sharon Mason	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	John Gommans	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Did not Attend (local Indicator)	Sharon Mason	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Chris Ash / Sharon M	10-Oct-18	11-Oct-18	31-Oct-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-**Nov18**)	Sharon Mason	14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Performance Framework Exceptions Q1 **Dashboard** (from main report)	Kevin Snee	14-Nov-18	15-Nov-18	
People Strategy updates (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	6-Dec-18	19-Dec-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Sharon Mason	14-Nov-18	6-Dec-18	28-Nov-18
Urgent Care Service Update (6 monthly June **Dec 18**) paper or **presentation** TBC	Wayne Woolrich	5-Dec-18	6-Dec-18	19-Dec-18

CHAIR'S REPORT

Verbal

YOUTH CONSUMER COUNCIL REPORT

Verbal

CONSUMER ENGAGEMENT UPDATE

Verbal

HEALTH & SOCIAL CARE LOCALITIES – WAIROA UPDATE

Te Pare Meihana

MATERNAL WELLBEING MODEL OF HEALTH

Presentation

12

NATIONAL BOWEL SCREENING ROLL-OUT

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**The place of alcohol in schools: Young people and under-age exposure** For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner	Sharon Mason – Executive Director, Provider Services
Document Author(s)	Rowan Manhire-Heath, Population Health Advisor
Reviewed by	Dr Nicholas Jones – Acting Clinical Director, Population Health and Executive Management Team
Month/Year	May 2018
Purpose	For endorsement
Previous Consideration Discussions	Nil
Summary	This paper seeks District Health Board endorsement of the attached report on alcohol use at school events attended by children. The report will be circulated to school boards or trustees and other relevant parties to inform school alcohol policy development and decisions about the use of alcohol at school events. The report includes: • A review of scientific literature concerning the impact of exposure to alcohol in childhood • A summary of Hawke's Bay data on alcohol licenses and schools • Recommendations for actions A summary of the full report is also provided for DHB endorsement
Contribution to Goals and Strategic Implications	• Reducing alcohol related harms in Hawke's Bay by: o Addressing underlying drivers of alcohol use o Shifting attitudes towards alcohol o Delay uptake of drinking by young people o Reduce hazardous drinking in whole population
Impact on Reducing Inequities/Disparities	Will reduce indirect harms caused by exposure to alcohol, protecting young people who are affected by alcohol-related harm in their home or community. Will contribute to reducing disparities in harmful alcohol use particularly among young people.
Consumer Engagement	To be reviewed by Consumer Council and Youth Consumer Council prior to endorsement by the Board
Other Consultation /Involvement	Alcohol Harm Reduction Steering Group Māori Health Service
Financial/Budget Impact	No financial impact
Timing Issues	Not applicable

Announcements/ Communications	A risk management plan will be developed in respect to sharing the report and will include some key messages.

RECOMMENDATION:

It is recommended that the HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and/or Pasifika Health Leadership Group.

1. **Endorse** the report and summary and approve for distribution as District Health Board documents

ATTACHMENTS:

- The place of alcohol in schools: Young people and under-age exposure report
- Summary – Fact Sheet : The Place of Alcohol in Schools

The place of alcohol in schools: Young people and under-age exposure

The Hawke's Bay population as a whole is drinking more hazardously than New Zealanders on average.[1]

Of the approximately 20 thousand[2] young people aged 15-24 living in the region, over one in two males are drinking hazardously, and almost one in three females[3], a rate significantly higher than the national average for the same age group (one in four).

In order to reduce the prevalence of hazardous drinking—particularly by Hawke's Bay young people—it is important that we all understand the harm caused by alcohol and the impact of alcohol exposure on children and young people.

Alcohol is heavily promoted in many settings in New Zealand. Of particular concern to the District Health Board is the presence and promotion of alcohol in schools and educational settings. The District Health Board is clear in its position: **alcohol and schools do not mix**. This position is shared by Medical Officers of Health throughout New Zealand and is evident in Australia, where concerns have been raised about alcohol's 'distinct presence' in schools.[4]

The issue

At present, a number of schools and educational settings in Hawke's Bay are using alcohol as a method of fundraising and entertainment. This is in spite of evidence demonstrating that exposure to alcohol during childhood and adolescence—either through witnessing adults drinking or via alcohol marketing—has shown to increase the likelihood of a young person drinking alcohol both at an earlier age, and of drinking more hazardously.[5]

Our vision: Schools are recognised as significant spaces where the best interests of children are a primary consideration. Schools embrace their responsibility to create healthy and safe environments for children and communities by choosing to be alcohol-free.

How can Hawke's Bay achieve this?

Health

- **Share** health information with the Hawke's Bay population on the harms caused by alcohol, with particular attention to Boards of Trustees, school staff and parents
- Continue to **oppose** to special license applications for events held on school grounds when children's attendance is anticipated

Councils

- Host and advocate for more alcohol-free and family friendly events in Hawke's Bay
- Provide discounted alternative venues for schools that choose to sell and supply alcohol at their fundraising events – a great way to keep school grounds alcohol-free 24/7

Education sector

- Develop an Alcohol Policy that represents your school's community (for a template and guide visit: http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/
- Get creative with other ways to fundraise – the DHB is producing a resource to help

Everybody

- Support by attending alcohol-free events in the region
- Talk to your child's school or ECE about alcohol – does their approach fit with the values of the community?
- Share your concerns about alcohol in your region with the District Health Board. Email us at healthpromotion@hbdhb.govt.nz

[1] *The Ministry of Health define hazardous drinking as an established pattern of drinking that carries a risk of harming physical or mental health, or having harmful social effects to the drinker or others. Hazardous drinking is defined by a score of 8 or more on the alcohol screening tool known as AUDIT, the Alcohol Use Disorders Identification Test*

[2] *Source data from Stats NZ Subnational population estimates (RC, AU), by age and sex at 30 June 1996, 2001, 2006-17 (2017 boundaries)*

[3] *41.1% of age group 15-24 years (or 53.9% males, 30.6% females) in Hawke's Bay (2011-14) as compared with 25.6% for NZ overall for same age group*

[4] Ward et al., 2014

[5] Anderson, et al., 2009; Smith & Foxcroft, 2009; Ryan et al., 2010.

Why is alcohol being used in schools?

Schools and educational settings may choose to sell alcohol for one of three purposes:

1. To generate revenue—for example for immediate consumption at school fundraising events such as school fairs or quiz nights.
2. For celebration such as a prize-giving or jubilee celebration.
3. For recreational purposes—for example student discos, art shows or plays. Alternatively alcohol may be consumed by staff on school camps or at after work drinks.[5]

The HBDHB have collected data for the period March 2014 to October 2017 on the educational settings and the types of events where a license to sell alcohol was granted.

The data shows:

- 39% of applications were from primary or intermediate schools, 29% from secondary schools and 6% from early childhood centres
- Napier City had the highest number of applications per number of schools
- Lower decile schools were less likely to apply for a license
- Quiz, casino, bingo, movie and auction nights were the most common event where an alcohol license was granted and young people's attendance was anticipated.

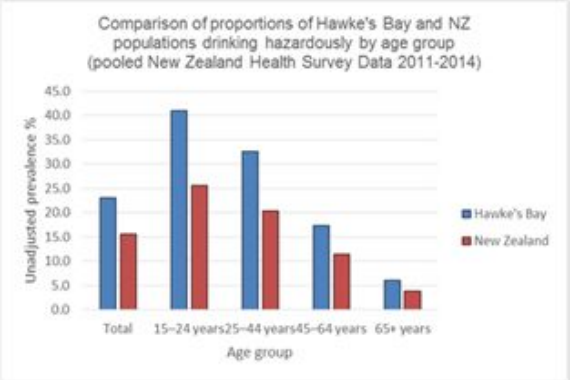
The impact of alcohol exposure in childhood – the facts

What's wrong with alcohol anyway?

Although alcohol is sold next to the bread and milk in the supermarket, it is actually an addictive toxin that also causes cancer. Alcohol causes the most harm to the most people compared to any other drug.[1] Every year approximately 800 New Zealanders die from alcohol-related causes.

Despite this, alcohol is a product that is aggressively marketed, is very cheap and is available at almost all times of the day and night.

The human brain is not fully developed until the age of 25. Drinking alcohol regularly or binge-drinking before this age may prevent the brain developing properly.



The proportion of Hawke's Bay residents drinking hazardously is highest amongst the 15-24 year age group (as shown above).

Educational outcomes

We know that all schools work to give their students the best possible opportunities in life, and schools are quick to recognise that their influence extends beyond the classroom.

Many have vision statements or ambitions reflecting "Preparation for Life", or "Developing Young Minds", or "Nurturing Tomorrow's Leaders". These statements acknowledge that there is a wide curriculum of values and life skills. The importance of creating an environment that supports the development of positive values is also reflected in the National Administration Guideline 5. This guideline requires Boards of Trustees to provide a safe physical and emotional environment for students.

Educators know that their students learn not only what they are explicitly taught, but also from the actions and choices of the adults around them at school and in the community.

This role-modelling presents a contradiction between what young people might learn in their class about self-care and mind-altering substances and what they see from their school leaders when they rely on alcohol for fundraising or to have a good time.

5. Munro et al., 2014

What evidence is there to show that drinking around children will cause them harm?

There is a growing body of evidence to show that children and young people who witness adults, particularly parents, consuming alcohol are more likely to start drinking at an earlier age, and drink more hazardously.[6]

Research also shows that children who witness their parents tipsy or drunk report feeling embarrassed, worried, that their parents had argued with them more than usual, paid them less attention and that their bedtime routine had been disrupted.[7]

Harm from alcohol can only come from drinking it

There are many ways that alcohol can cause harm and, unlike all other drugs, the harm from alcohol is more likely to be experienced by others, not the drinker.

Harm to others can be direct (such as assaults, crime, healthcare costs, child neglect) or indirect (such as the normalisation and acceptance of hazardous drinking and the inheritance of hazardous drinking patterns).

Drinking responsibly in front of children teaches them how to drink responsibly

There is no evidence to show that drinking in front of children has positive benefits: in fact, research shows that children who witness adults drinking are more likely to start drinking at an earlier age and more hazardously.[8]

Children see adults drinking at home – what difference does it make if it's on school grounds?

The school environment represents one setting that has children's wellbeing interests at the centre. Schools may be the only safe space where young people can escape from the impact of alcohol misuse that may be occurring in their home or community.

And, allowing alcohol in these settings reduces the effect of health promotion programmes and campaigns on the harms related to alcohol.

Alcohol is a normal part of social events – having the event on school grounds shouldn't make a difference

Allowing alcohol to be consumed in the school environment normalises and increases the perceived acceptability of alcohol use in all settings.

Using alcohol to fundraise at school events may also contravene the United Nations Convention of the Rights of the Child, of which New Zealand is a signatory. Article 33 states that:

"Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.[9]

It can be reasonably argued that some fundraising events in schools using children to promote the sale of alcohol, could be seen as a contravention to this Article and others under UNCROC.

Why not focus on alcoholics?

It is a myth that a small minority of heavy drinkers cause the harm. Hawke's Bay rates of hazardous drinking are 60 per cent higher than New Zealand as a whole.[10] This means that between one third and a quarter (27.1%) of the population in Hawke's Bay are harming themselves or others as a result of their drinking.

It's not parents that are the problem – young people are the worst drinkers – why not focus on them?

Young people learn from what adults' role model to them about what is, and what is not acceptable. A shift in attitude towards alcohol is needed to positively influence the next generation and reduce the alcohol-related harm.

Schools need alcohol to fundraise – we have to make alcohol available or people won't attend

The majority of schools in Hawke's Bay do not use alcohol to fundraise. Instead, they host family-friendly events that the whole community can attend.

If the evidence is really there – why isn't selling alcohol at school fundraising events banned?

Currently, there is no legislation that prohibits the selling or supplying of alcohol on school property. Boards of Trustees currently decide school policy matters. There is however both a strong moral argument and evidence that supports the removal of alcohol from schools.

This report was prepared by Rowan Manhire-Heath with support from the Hawke's Bay District Health Board Population Health and Business Intelligence teams. Please contact: Rowan.Manhire-Heath@hawkesbaydhb.govt.nz

[6] Anderson et al., 2009; Smith & Foxcroft, 2009; Ryan et al., 2010

[7] *Institute of Alcohol Studies,* 2017, http://www.ias.org.uk/News/2017/18-October-2017-Like-sugar-for-adults-report-highlights-anxiety-about-parents-drinking.aspx

[8] Anderson et al., 2009; Smith & Foxcroft, 2009; Ryan et al., 2010

[9] http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

[10] New Zealand Health survey, 2011/14

The place of alcohol in schools: Young people and under-age exposure

March 2018

Prepared by:	Rowan Manhire-Heath (Population Health Advisor) With support from the Hawke's Bay District Health Board Population Health and Business Intelligence teams
Please contact:	Rowan.Manhire-Heath@hawkesbaydhb.govt.nz

E whanake te rākau mahuri pokepoke, he rakau whakatangatatia - as a young sapling is moulded, that is the growth of an adult tree

Table of Contents

EXECUTIVE SUMMARY

Exposure to alcohol during childhood and adolescence—either through witnessing adults drinking or via alcohol marketing—has shown to increase the likelihood of a young person drinking alcohol both at an earlier age, and of drinking more hazardously.

A number of settings where alcohol promotion is pervasive—particularly in respect to the influence on children and young people—are of concern to the Hawke's Bay District Health Board and these include: supermarkets, in association with sport and online and, most significant to this report, schools and educational settings. The District Health Board's concern results from the potentially high number of children and young people exposed in these settings. This report will explore exposure to alcohol in these settings, the impact of exposure to alcohol on children and young people[1] and will present data on the prevalence of alcohol use by adults in schools and educational settings in Hawke's Bay.

The District Health Board is clear in its position: alcohol and schools do not mix. This stance is supported by a growing body of evidence showing that exposure to alcohol in childhood increases the likelihood of adolescent and hazardous drinking. 'Exposure' in the capacity of this report refers to the visual presence and modelling of drinking behaviours as opposed to the actual consumption of alcohol. This position is shared by Medical Officers of Health throughout New Zealand and is evident in Australia, where concerns have been raised about alcohol's 'distinct presence' in schools (Ward et al., 2014).

Within the recently developed Hawke's Bay District Health Board *Alcohol Harm Reduction Strategy*, 'denormalising alcohol use' is emphasised as imperative to achieving the key outcomes:

- Delayed uptake of drinking by young people
- Reduced hazardous drinking prevalence across the whole Hawke's Bay population.

Ministry of Education guidelines for schools on the sale and supply of alcohol emphasise that "…schools are a core part of our community and social structure and are important settings for promoting health and wellbeing through education, policies and modelling behaviour" (2016, p.1).

The District Health Board maintain that consumption of alcohol within the school environment reinforces the inaccurate perception that alcohol is a safe product that must be accommodated in all settings. Given the increase in alcohol availability and acceptability in New Zealand society—and the consequent increased harms that are resulting—the school environment represents one setting that must have children's wellbeing interests at the centre. This is not to downplay the role of other settings or influences on young people's attitudes and behaviour towards alcohol. However few would argue that schools and early education centres (ECEs) in particular play a very significant symbolic place in children's lives, where it is expected that children's, rather than adult's needs predominate.

Indeed within the United Nations Convention on the Rights of the Child (UNCROC)—a global human rights treaty ratified by the New Zealand government in 1993—the best interests of the child must be a primary

[1] References to children in this report include all young people under the age of 18.

consideration "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies…". The convention goes on to state that "…parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs or psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances." It can be reasonably argued that some fundraising events in schools using children to promote the sale of alcohol could be seen as a contravention to this article and others under UNCROC.

The District Health Board has a vision that schools are recognised as significant spaces where the best interests of children are a primary consideration and that they embrace their responsibility to create healthy and safe environments for children and communities by choosing to be alcohol-free.

We encourage feedback on this report and its subject matter.

THIS REPORT SEEKS TO:

1. Highlight the evidence associated with exposure to alcohol and the harm it can cause young people
2. Share data on the prevalence of the sale and supply of alcohol to adults in schools and educational settings in Hawke's Bay
3. Provide practical recommendations for all stakeholders that support the achievement of the Hawke's Bay District Health Board's vision.

HAZARDOUS DRINKING IN HAWKE'S BAY

The Hawke's Bay population as a whole is drinking more hazardously than the rest of New Zealand. The Ministry of Health define hazardous drinking as an established pattern of drinking that carries a risk of harming physical or mental health, or having harmful social effects to the drinker or others. Hazardous drinking is defined by a score of 8 or more on the alcohol screening tool known as AUDIT, the Alcohol Use Disorders Identification Test (Ministry of Health, 2015). Of the approximately 20,000[2] young people aged 15-24 living in the region, over one in two males are drinking hazardously, and almost one in three females[3], a rate significantly higher than the national average for the same age group (one in four).

Estimates suggest that one in three young people aged 12-16 years engage in binge-drinking (Fortune, et al., 2010). Evidence also shows that young people experience more harm per drink than older adults (The Law Commission, 2010) and that the impact of alcohol on the developing brain (up to the age of 25) is enough to bring about learning and memory difficulties, depression and alcohol dependency problems later in life (Crews, He & Hodge, 2007). Positively, there appears to be a shift emerging in young people's drinking patterns, with more young people choosing not to drink yet the harmful pattern of drinking in those that choose to drink remains unchanged (Ministry of Health, 2015).

A high level of hazardous drinking exists within a region known nationally and globally for its strong and successful wine industry—a major source of employment and income for Hawke's Bay.

As such, the promotion of the benefits of alcohol production and consumption are likely conveying the message to the population of Hawke's Bay that drinking alcohol is a normal and socially accepted activity that has positive and wide-reaching consequences.

This is in spite of the stark data that shows that up to 800 New Zealanders die from alcohol-related causes each year and that alcohol misuse is associated with over 200 conditions ranging from cancer to osteoporosis and pancreatitis. Further, alcohol-related harm is more than an individual issue as the impact of alcohol consumption on others, such as families, communities and wider society is substantial and is estimated to cost an overall $6.5 billion each year.

Although the District Health Board understands that not all consequences of drinking alcohol is negative, it is important to ensure messages around safer consumption of alcohol are heard. Many drinkers for example, cannot identify a standard drink (Kerr & Stockwel, 2011).

Many myths about alcohol consumption exist. For example, it is commonly believed that low risk drinking is 'no risk', yet any consumption of alcohol carries a risk. Factors such as; the rate of drinking, body and genetic makeup, gender, age, existing health problems and any medications influence this risk. Also, there is no safe limit in pregnancy.

[2] Source data from Stats NZ Subnational population estimates (RC, AU), by age and sex at 30 June 1996, 2001, 2006-17 (2017 boundaries)

[3] 41.1% of age group 15-24 years (or 53.9% males, 30.6% females) in Hawke's Bay (2011-14) as compared with 25.6% for NZ overall for same age group

In order to reduce the prevalence of hazardous drinking—particularly by Hawke's Bay young people—it is important that the population understands the harm caused by alcohol and the impact of alcohol exposure on children and young people.

YOUNG PEOPLE AND EXPOSURE TO ALCOHOL

As previously emphasised, a growing body of evidence exists to show that exposure to parental consumption and alcohol marketing directly influences a young person's decision to start drinking alcohol and the amount of alcohol they consume (Anderson et al., 2009; Smith & Foxcroft, 2009; Ryan et al., 2010).

Exposure to parental drinking

Although little evidence exists that demonstrates the benefits of a child seeing a parent consuming alcohol, the impact of exposure to parental drinking is a highly contested topic. A popular discourse in New Zealand that supports exposure to parental drinking as a method of teaching 'responsible' drinking, references the 'European approach' to alcohol consumption, whereby children are exposed to alcohol consumption via parental drinking and may be given small amounts of alcohol from an early age. Evidence suggests that this is an inaccurate and harmful belief, and instead results in young people more likely to drink hazardously at an earlier age (Kaynak et al., 2014). The belief also precedes and undermines messaging around the harms of alcohol that children may receive through school-based health education or wider health promotion messages.

In October 2017, the Institute of Alcohol Studies Scotland released findings of a study exploring the impact of non-addicted parental drinking on children. The authors found that children who had witnessed their parent tipsy or drunk were less likely to consider their parent as a positive role model, and were more likely to experience negative impacts (such as feeling worried or embarrassed) as a result (IAS, 2017). The same children were also more likely to report a parent being more unpredictable than usual, more argumentative or being less comforting and sensitive (IAS, 2017). These results were the same across all levels of parental alcohol consumption (from low to high).

Due to the prevalence of hazardous drinking in Hawke's Bay, we can assume that many of the region's schools and early childhood education centres will include families where students will experience the consequences of harmful drinking at home. In addition to the IAS findings, evidence also exists to show an association between hazardous parental alcohol use and child abuse and neglect (Bays, 1990; Freisler, Midanik & Gruenewald, 2004). By being alcohol-free, schools and early childhood education centres can offer a 'safe haven' for these children.

Although the impact of parental drinking on children is significant, other social influences are believed to also play a role in a child's future beliefs and behaviours around alcohol. Bendsten et al. (2013) identified an association between adolescent drunkenness and the levels of alcohol consumption in their community that cannot be explained by parental drinking patterns. Such research provides evidence of the extent of the influence community behaviours have on young people, even when parents role model positive behaviours around alcohol to their children in the home.

Exposure to alcohol marketing

There is evidence of an association between young people's exposure to alcohol marketing and sponsorship, and subsequent earlier age of initiation to drinking alcohol, increased consumption and increased experience of alcohol-related harm (Bryden et al., 2012; De Bruijn, 2012: De Bruijn et al., 2012; Gordon et al., 2011; Grenard, Dent & Stacy, 2013; Lin et al., 2012).

Supermarkets

Although legislation exists that prohibits the marketing of alcohol to young people (Sale and Supply of Alcohol Act 2012), the presence of alcohol in supermarkets—an outlet regularly visited by children and young people—undermines this safeguard.

Since 1990, the sale of alcohol in supermarkets has heralded the normalisation of alcohol as a commonly used commodity. Recent research from Otago University shows how frequently children are exposed to alcohol marketing in New Zealand supermarkets, recording exposure on 85 percent of study participants' supermarket visits (Chambers et al., 2017). Further, alcohol was found to be located near staple foods such as bread and milk, reinforcing the perception of alcohol as just another ordinary food stuff.

Despite instruction on methods of reducing exposure in supermarkets within the Sale and Supply of Alcohol Act 2012 (SSAA)—such as single alcohol areas (SAA)—it is highly questionable whether the new Act has led to any reduction in exposure (Chambers et al., 2017).

Sport

What is often considered a staple of New Zealand life, sport—is yet another setting where the marketing of alcohol is widespread and participation of children and young people is high. This is in spite of the clear conflicting association of sport—a healthy activity—and alcohol—a product that causes harm.

One New Zealand study found that sports sponsorship by 'unhealthy' industries (alcohol, gambling and unhealthy foods) was twice as common as those sponsored by 'healthy' industries (Maher et al., 2006). The authors also identified rugby as the sport most commonly sponsored by the alcohol industry, a concerning result as this sport is arguably the most popular and high profile in New Zealand. Maher et al. (2006) describe the impact of such sponsorship as both obscuring the health risk of alcohol while simultaneously promoting consumption.

This phenomenon has been epitomised by a 2017 large scale review of New Zealand Rugby following a series of alcohol-fueled incidents. Although the Research and Responsibility Review received much attention, there appears to be a reluctance to relinquish alcohol sponsorship. Concerns have been raised about the impact of such sponsorship in a report by the New Zealand Law Commission who called alcohol "…an unquestioned adjunct to New Zealander's social, cultural and sporting life for many generations" (2010, p. 37).

In 2014, the Ministerial Forum on Alcohol Advertising and Sponsorship concluded the need to change the sponsorship of sporting, cultural and musical events away from alcohol to reduce youth exposure. The Forum recognised the established evidence that voluntary self-regulation codes by the alcohol industry have not been successful in reducing rates of alcohol consumption among young people (Fergusson & Boden, 2011).

Online advertising

Social media is an emerging platform for the marketing of alcohol, one that is less regulated and importantly, one that is well-used by young people. In New Zealand, advertising of alcohol on television is restricted to hours where young people are not expected to be viewing (after 10pm), there are no such restrictions on online advertising. Young people may also use social media to share stories and images of alcohol consumption and this has the potential to normalise and humourise hazardous drinking. The use of social media to promote alcohol was also highlighted by The Ministerial Forum (Ministerial Forum on Alcohol Advertising & Sponsorship, 2014) whose recommendations have yet to be actioned.

Schools

Evidence suggests that sponsorship of schools by the alcohol industry is already occurring. Sponsorship by alcohol and other 'unhealthy' industries has been identified within school fundraising programmes in New Zealand, particularly sponsorship by trusts and charity organisations, for example pub charities (gambling) and alcohol licensing trusts. Richards et al. (2005) emphasise that the value of an endorsement by schools in exchange for such sponsorship is significant and their study demonstrates the increasing global trend of corporate involvement in schools, a phenomenon that Hawke's Bay is not immune from.

According to Munro et al. (2014), schools and educational settings choose to sell alcohol for one of three purposes:

1. To generate revenue – an example - for immediate consumption at school fundraising events such as school fairs or quiz nights.
2. For celebration such as prize-giving or jubilee celebration.
3. For recreational purposes - an example - student discos, art shows or plays. Alternatively alcohol may be consumed by staff on school camps or at after work drinks.

In the case of purpose 1. above, the District Health Board are aware that schools and educational settings in Hawke's Bay sell and supply alcohol at fundraising events as an easy method of revenue generation. Given that the wine industry is a significant employer in Hawke's Bay, special deals are likely to be struck by parents who work in the industry, facilitating such fundraising opportunities.

Munro et al. (2014) reference anecdotal evidence showing that the likely effects of the presence of alcohol at school fundraising events where children are present in Australia. Notwithstanding, a basic concern is that parental drinking at such events diverts attention away from children who are (or should be) the primary focus of the event. This relates to both purpose 1. and 3. listed above. Other identified harms include:

- Disruption of children's activities and events
- Public modelling of harmful alcohol consumption
- Violent assault
- Children's embarrassment and shame resulting from parental behaviour
- Division within school communities (Munro et al., 2014).

A further pathway the District Health Board have observed through which young people are exposed to alcohol whilst at school is the sale of alcohol by fundraising students who act as a conduit for, in most cases, a local winery. Additionally, a project promoting and selling alcohol by young people for charity purposes has been celebrated as a successful Young Enterprise Scheme, a New Zealand-wide programme teaching business and enterprise skills to high school students, sponsored by the Lion Foundation.

The ethics of children being used to promote an event because alcohol will be available to consume or as a product in its own right, acting as an intermediary for the industry whether it is for charitable purposes or not, is highly questionable.

It is the Hawke's Bay District Health Board's view that schools currently fundraising by selling alcohol, both on schools grounds and through corporate fundraising schemes, would be better to seek alternative methods of revenue gathering.

School alcohol policies

As stated by the Ministry of Education, "*there is no legal reason to stop alcohol being consumed on school sites",* school Boards of

Trustees are required to provide safe environments for students (Ministry of Education, 2017a). One way of achieving this is for educational settings to create a policy on the sale, supply and consumption of alcohol.

According to Ministry of Education's guidelines (see Appendix E), an alcohol policy can:

- "outline the school's approach to the sale, supply and consumption of alcohol
- highlight the school's alcohol prevention and intervention strategies
- be developed in partnership with the school's wider community to ensure that it reflects the community values, philosophies, ethos, goals and lived experiences" (2016, p.1).

It is a vision of the Hawke's Bay District Health Board that all schools and educational settings in the region develop and implement their own 'alcohol policy'. An essential part of the development of an alcohol policy is community consultation to determine the values and views of the community in relation to alcohol.

THE POLICY SETTING

Alcohol regulation and governance within Hawke's Bay is the responsibility of the four Councils: Napier City Council, Hastings District Council, Wairoa District Council and Central Hawke's Bay District Council. Under the Sale and Supply of Alcohol Act, 2012, all Councils are encouraged to develop and implement a Local Alcohol Policy that sets in place rules around the sale and supply of alcohol in their geographical area to include; hours of sale, the location of licensed premises and conditions and restrictions on licenses where necessary[4]. As evidenced within the Tasman District Local Alcohol Policy, a discretionary rule can be included that stipulates what is deemed acceptable and unacceptable use of alcohol in school settings[5].

Councils may also choose to have an 'alcohol strategy' that provides direction for the work required to reduce alcohol-related harm. Napier City and Hastings District Councils are in the process of revising their 2011 Joint Alcohol Strategy. Listed as an objective within both versions of the strategy is to *'foster safe and responsible events and environments'*. Additionally, *'young people (including under-age drinkers)'* are listed as an 'at risk group'.

A positive example of this is the local iwi, Ngāti Kahungunu, who choose to keep all events alcohol-free as a way of enhancing the environment for whānau growth and wellbeing (as per strategic outcome 1.3 of Te Ara Toiora O Ngāti Kahungunu 2007-2026 (2006): 'Wellbeing of whānau flourishes as Kahungunu'). Such a move has not diminished the popularity or attendance and role models to the community that fun can be had without alcohol.

A further objective within Councils' Joint Strategy is to *'change attitudes towards alcohol to reduce tolerance for alcohol harms'*, a goal that is highly relevant to this report. Although changing attitudes about what is socially acceptable is challenging, encouragement and lessons can be learnt from the smokefree movement where, over the past five decades, smoking has moved from a normalised and accommodated activity, to one that is highly regulated and widely unacceptable in most settings. Strong political will and policy were critical to this attitude shift.

It is hoped that local Councils will show leadership and support the District Health Board's stance on the sale and supply of alcohol by schools and educational settings in Hawke's Bay.

Community views on alcohol

A number of data sources provide a helpful insight into the attitudes and beliefs of members in the Hawke's Bay community around alcohol access and the impact of alcohol in their community.

The recently released 'Attitudes and Behaviours Towards Alcohol – Hawke's Bay Regional Analysis' from the Health Promotion Agency reported that 35 percent of respondents agreed that 'some licensed premises are too close to public facilities like schools', demonstrating an awareness of safety issues surrounding alcohol outlets. Half of

[4] At the time of writing this report, Central Hawke's Bay are implementing their Local Alcohol Policy, while Napier City and Hastings District Councils have developed a joint provisional policy. Wairoa District Council are in the early stages of developing a Local Alcohol Policy for their area.

[5] It is writ within Tasman District Council's Local Alcohol Policy as a discretionary condition that, "*No school fate, gala or similar event held on school grounds at which the participation of children can be reasonably expected shall allow for the consumption of alcohol on the premises*" (2.3.3)

respondents agreed or strongly agreed with the statement: 'there are places I no longer go to because of others' behaviour when drinking'.

Perhaps as a response to the high level of hazardous drinking in the region, data from a Hawke's Bay regional community survey (conducted in 2015) show that almost two-thirds (62 percent) of those interviewed felt that alcohol had a negative impact on their community. Results from the same survey indicated that 56 percent want fewer bottle stores and almost 80 percent wanted more alcohol-free entertainment.

The role of the District Health Board in alcohol regulation

Under the Act, if a school (or other event holder) wishes to hold an event that sells or supplies alcohol they are required to apply for a 'special licence'. The Medical Officer of Health[6] has a statutory reporting role for licensing decisions that occur at a legislative level. As a requirement of the Sale and Supply of Alcohol Act 2012, Medical Officers of Health are required to submit a report with their views on the application to the District Licensing Committee, who ultimately make the decision on whether a licence should be granted or not.

The District Health Board is also involved with providing health promotion advice and support to schools. On receipt of an alcohol licence application[7] involving a school or educational setting, a Health Protection Officer will contact the applicant to obtain further information on whether the event is on school grounds and whether children are present. If children are present, they will talk with the applicant, questioning whether alcohol is needed at the event.

The following documents are supplied to all applicants of licenses that are connected to school grounds or an education setting:

- A letter from the District Health Board listing the resources available for schools and educational settings including contact details for further information (Appendix A)
- A guide to developing a school alcohol policy (Appendix B)
- A 'quick reference' host responsibility guide, should applicants decide to sell or supply alcohol at their event (Appendix C)
- A sample 'Host Responsibility Policy' (Appendix D)
- Ministry of Education guidelines on the sale, supply and consumption of alcohol (Appendix E).

Licence oppositions

Medical Officers of Health throughout New Zealand are unanimous in their view that alcohol consumption by adults (particularly parents) on school grounds causes indirect harm to children. Australian health officials are also concerned with this phenomenon and struggle, as health in New Zealand does, with the inconsistent and ambiguous guidelines that currently exist around alcohol use on school property (Ward et al., 2014).

Some progress has been achieved in Australia with the New South Wales policy stating firmly that:

"Alcohol must not be consumed or brought to school premises during school hours. This

[6] *Medical Officers of Health are medical doctors who have specialised in public health medicine. They are designated under the 1956 Health Act by the Director General of Health to improve, protect and promote the health of the population in their district.*

[7] *Hawke's Bay District Health Board use a database called Healthscape to record all alcohol license applications.*

includes employees, students and visitors and other people who use school premises. The consumption of alcohol is not permitted at any school function (including those conducted outside school premises) at any time when school students, from any school are present" (Ward et al., 2014).

Unfortunately, oppositions by Medical Officers of Health throughout New Zealand have had mixed results, largely due to the expectation for health professionals and communities to prove that indirect harm will occur (as opposed to the licence applicant proving that it won't).

Section 4(2) of the Sale and Supply of Alcohol Act defines harm as "…any harm to society generally or the community, directly or indirectly caused, or indirectly contributed to by any crime, damage, death, disease, disorderly behaviour, illness or injury". Although the Act emphasises both direct and indirect harm caused by alcohol in its definition of alcohol-related harm, it appears that indirect harms are poorly understood by District Licensing Committees due to the limited success of Medical Officers of Health who have objected on the grounds of the potential for the licence to cause indirect harm.

Providing evidence of direct harm, for example where there is a correlation between a licensed event and the number of associated admissions to an emergency department following an event is relatively simple. Indirect harm, such as the role modelling of adults at a school event, requires robust and peer reviewed literature to prove an association with, for example, subsequent behaviours of young people.

In 2013, Elm Grove School in Mosgiel applied for a special licence to sell alcohol gifted by a parent for the purpose of raising funds for the school. The Elm Grove School decision[8] however, demonstrates recognition by a District Licensing Committee of the indirect harm caused by the sale and supply of alcohol on school grounds. The Committee remarked that:

"It must be noted first that New Zealand is moving into a more restrictive era with regards to alcohol licensing. The object of the Act now considers not only the sale and supply of alcohol but also the consumption of alcohol. The Committee was mindful that the Act imposes tighter controls and greater responsibility on the decision makers".

The Committee noted that the views of the Medical Officer of Health concerning the adverse effects of parental modelling were supported by research. On the basis of the 'overpowering evidence' of the Medical Officer of Health, the Committee declined the application.

[8] Application no. SP-300-2013

PREVALENCE DATA

Total number of special licenses in Hawke's Bay

Table 1: Total special license applications received relating to schools or educational settings (March 2014-October 2017)

Table 1 illustrates 139 applications have been included in this analysis and the total number of special licenses granted each year. These licenses are included as they have an association with an educational setting: either the event was on school grounds or the application was submitted by a Board of Trustees, Primary Teachers Association (PTA) or staff member.

Year	Number
2014	25
2015	37
2016	45
2017	32
Total:	**139**

Applications for special licenses were received from only 50 of the 351 educational settings in Hawke's Bay, demonstrating that the majority of schools are choosing not to utilise alcohol for revenue gathering, celebration or leisure purposes (Hammond, 2014). This is a positive finding and challenges the argument that alcohol is needed for schools to host successful fundraising events.

Type of school submitting applications for a special licence

Figures 1 and 2 illustrate when a number of educational settings are taken into account, secondary schools had the highest number of applications per education setting despite making up only 6 percent of educational settings in Hawke's Bay. Fewer applications were received from early childhood education centres, despite having the largest proportion of educational settings in Hawke's Bay (66 percent).

Figure 1: Proportion of educational settings in Hawke's Bay by type

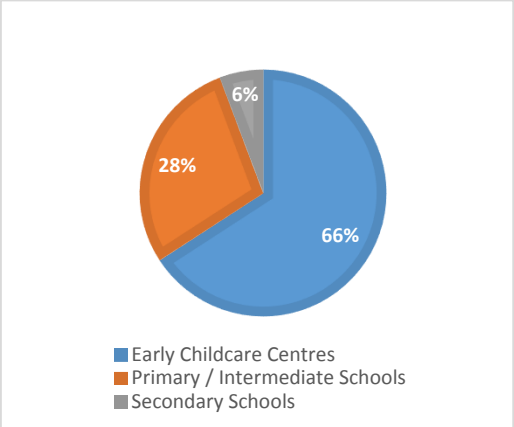
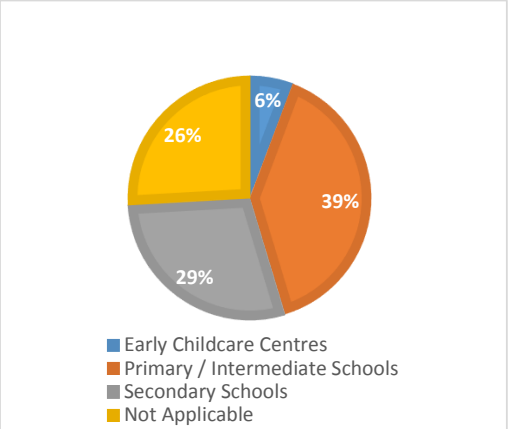


Figure 2: Proportion of applications from schools by type of educational setting



Location of schools submitting applications for a special licence

Figures 3 and 4 compare the proportion of educational settings by Territorial Local Authority (TLA) with the proportion of applications from educational settings by TLA over the four year period. As shown, although the Hastings District has the highest proportion of educational settings (51 percent), only 48 percent of applications came from the Hastings District TLA. Napier City in comparison accounts for 42 percent of applications yet only 28 percent of educational settings in Hawke's Bay in are located in this TLA. Source data is provided in Appendix A.

Figure 3: Proportion of Hawke's Bay educational settings by Territorial Local Authority

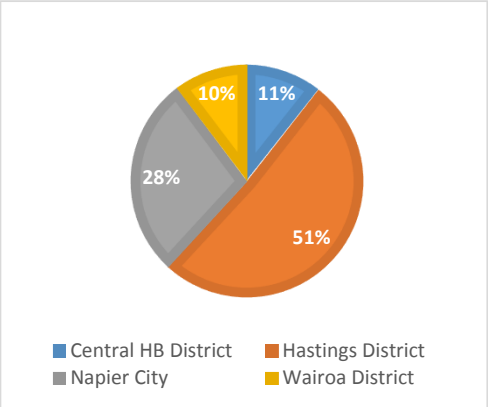
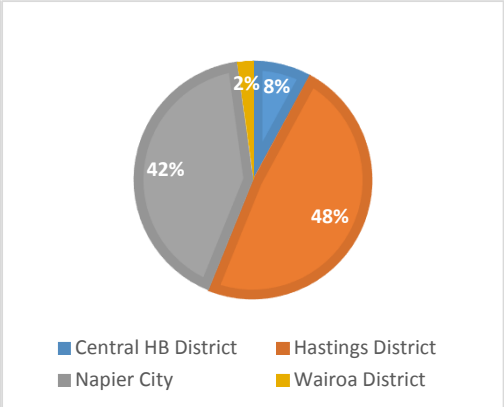
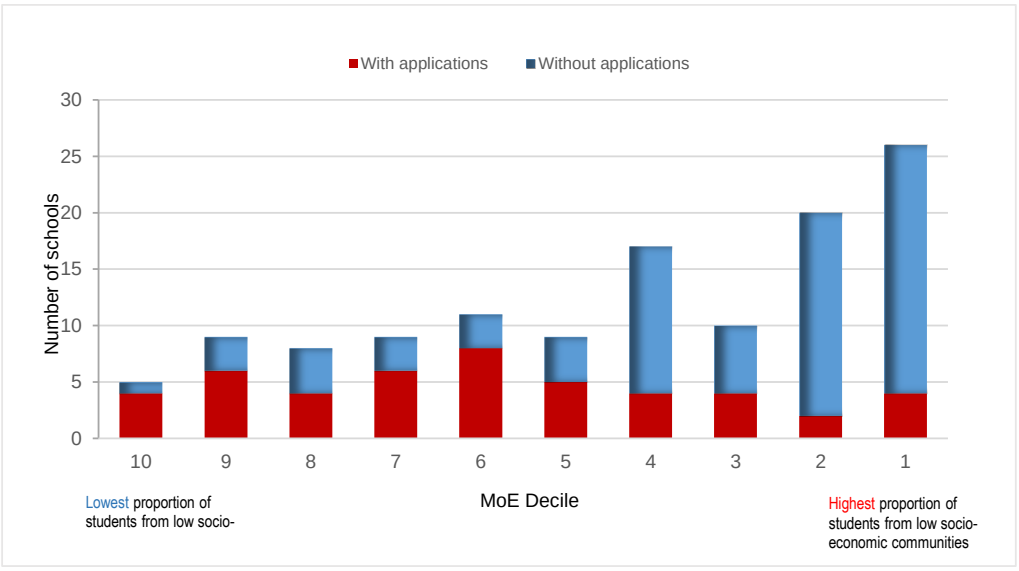


Figure 4: Proportion of applications submitted by schools by Territorial Local Authority



School decile rating and special licence applications

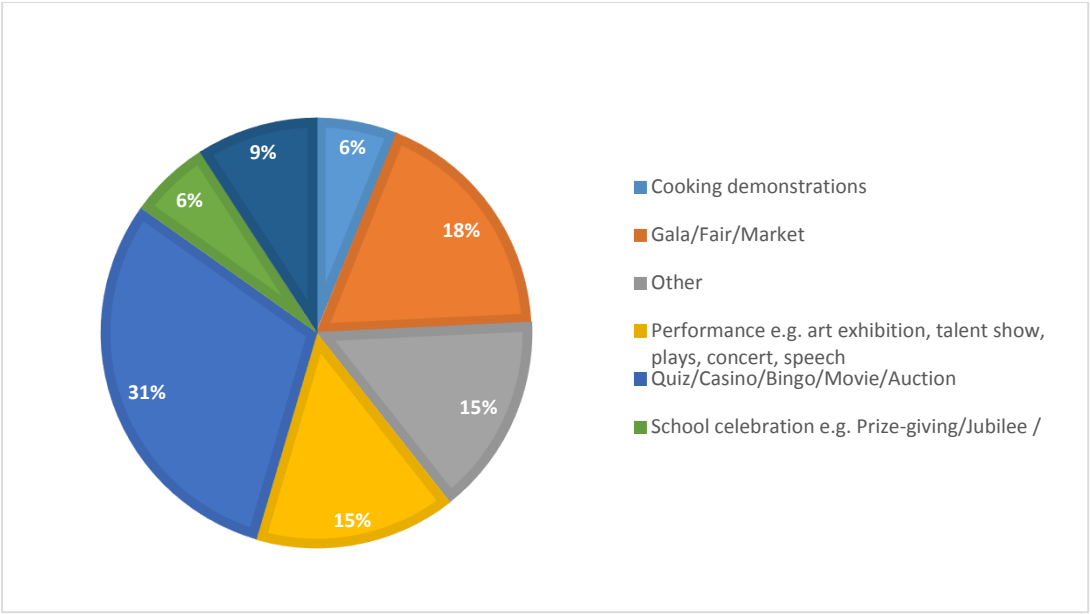
Figure 5: Number of schools with and without a history of special license applications by school decile rating



The Ministry of Education 'deciles' are a measure of the socio-economic position of a school's student community relative to other schools throughout New Zealand (Ministry of Education, 2017b). Figure 5 demonstrates the number of applications received and the corresponding decile rating of the applicant/schools (source data is provided in Appendix A). Figure 5 also shows the number of schools without any history of applying for a special licence. From this data, a trend showing higher numbers of higher decile schools applying for special licenses is apparent. It also shows the inverse of this trend for the decile rating of all primary and secondary schools with a history of no applications for special licenses (source data is provided in Appendix A). It is important to note that decile measure are used to calculate the levels of funding each school receives. Broadly put, the lower the decile, the more funding a school will receive. Whether funding pressures in higher decile schools plays a role in the pattern evident in Figure 5 is unclear and further consultation is required.

Type of event and notification of attendance by minors

Figure 6: Attendance by children for event type where alcohol licence was granted



Special licence applications were submitted for a diverse range of events. The numbers listed in Figure 6 represent events where alcohol was sold or supplied to adults. From the category of events listed in Figure 6, the most likely to expect the attendance of minors were; quiz, casino, bingo or movie nights or auctions. Although applications that explicitly state that minors (those under 18) will be attending are small, anecdotal evidence suggests that children are attending events that may not have indicated so on the special licence application form. Additionally, initial data collection did not capture this information and therefore underestimates are expected.

HAWKE'S BAY DISTRICT HEALTH BOARD OPPOSITION ACTIVITY

At the time of writing this report, a total of four applications had been opposed by a Medical Officer of Health. All events were family-focused, held on school grounds and children were in attendance. Of these oppositions, three related to the same school hosting the same event over three consecutive years. Oppositions were made on the grounds that the events were contrary to the object of the Sale and Supply of Alcohol Act 2012, relating to inappropriate consumption, nature of the event and the risk of indirect harm to young people.

Despite Medical Officer of Health's oppositions, the District Licensing Committee involved granted special licenses for all four events with similar conditions on the licenses. Examples of conditions placed on these licenses include:

i) *Persons under the age of 18 shall not be served at the beer and wine outlet (including non-alcoholic beverages)*
j) *Alcohol may be sold in the following types of containers only: - plastic vessels.*

Although only a small percentage of the total licence applications received were opposed by the Medical Officer of Health, the Medical Officer of Health and delegates have regularly proposed changes to the licence application (ergo the event) following discussions with the applicant. In most cases, further conditions were advised in order to reduce the risk of alcohol-related harm. Unfortunately, in many cases, the applicant had already promoted the event after submitting their application, creating a challenge situation to make any changes to the event.

The following is an example of advice provided by the Medical Officer of Health in response to an application for a children's art exhibition:

We requested further information from the applicant and note the following key points:

- *Whilst children are present to welcome guests and discuss their art work, we understand that they will not be directly involved in serving alcohol.*
- *Alcohol will only be sold and served from the bar area children will not be in the bar area.*
- *The ticket price includes one standard drink of any type and food/nibbles provided throughout the night.*
- *That the main focus of the event is art and not alcohol.*

Whilst we don't oppose this application for the above reasons, we do encourage the School to consider making this event alcohol free in the future. We have provided the applicant with some of our resources relating to schools and alcohol including a sample 'Host Responsibility Policy' for schools. Please find a copy of these three resources attached for your information.

The Medical Officer of Health has indicated that oppositions to applications for future events held on school grounds where children are present will increase substantially.

SUMMARY

In view of the high prevalence of hazardous drinking in Hawke's Bay, it is apparent that rangatahi (young people) are living in what McCreanor et al. (2008) call an 'intoxigenic environment'. This means an environment that normalises and accommodates alcohol consumption in all settings, allows the sale of alcohol at almost all times of day and in most premises (irrespective of who may also frequent those premises) and enables the widespread marketing of alcohol. In such an environment, it is essential that schools and educational settings are maintained as a setting where children are protected from exposure to alcohol and where their rights are paramount.

Evidence suggests that children are not only influenced by their parents and caregivers drinking patterns, but also those of the community in which they live (Bendsten et al., 2013). Schools and educational settings are an inherent part of all communities in New Zealand, and therefore have a role to play in creating a safe space for children to experience life without alcohol.

It appears that many schools in Hawke's Bay are proving that school community events can be social, fun and financially benefit the school or educational setting without the need for alcohol to be supplied.

The Hawke's Bay District Health Board intends to increase its opposition to special licence applications for events that are held on schools grounds and at which children are expected to be present as a result of this report and its findings. Positively, it appears only a small number of schools continue to hold these events, and the Hawke's Bay District Health Board are optimistic that a vision of no licenses coming from schools or educational settings can be achieved. Such events, as demonstrated by the evidence within this report, promote and normalise alcohol use and are likely causing indirect harm to children and young people. Recognising and ameliorating exposure of alcohol to children and young people in this setting will contribute to the reduction in hazardous youth drinking levels in Hawke's Bay – a key objective of the Hawke's Bay District Health Board Alcohol Harm Reduction Strategy.

Strong leadership has been demonstrated by Ngāti Kahungunu Iwi who, as mentioned earlier, maintain a strong position around alcohol and demonstrate that successful and popular events can be alcohol and tobacco free. This stance and these events provide great role-modelling for our communities and challenge other organisations to make the same commitment.

As emphasised by Hammond (2014), Boards of Trustees must recognise their role in normalising alcohol consumption through their willingness to use it to fundraise. The District Health Board acknowledge however, that schools and educational settings must be supported to be alcohol-free and understand the impact on children and young people of exposure to alcohol. Working in collaboration with the Ministry of Education, Councils and educational settings to reduce exposure to young people is essential if we are to deliver consistent messages around alcohol harms and 'turn the curve' on our poor alcohol-related health statistics in Hawke's Bay.

RECOMMENDATIONS

The District Health Board has a vision that schools in Hawke's Bay are recognised as significant spaces where the best interests of children are a primary consideration and that they embrace their responsibility to create healthy and safe environments for children and communities by choosing to be alcohol-free.

How can Hawke's Bay achieve this?

Health

- Share health information with the Hawke's Bay population on the harms caused by alcohol, with particular attention to Boards of Trustees, school staff and parents
- Continue to oppose to special license applications for events held on school grounds that children are expected to attend

Councils

- Host and advocate for more alcohol-free and family friendly events in Hawke's Bay
- Provide discounted alternative venues for schools that choose to sell and supply alcohol at their fundraising events – a great way to keep school grounds alcohol-free 24/7

Education sector

- Develop an Alcohol Policy that represents your school's community (for a template and guide visit: http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/
- Get creative with other ways to fundraise – the DHB is producing a resource to help

Everybody

- Support by attending alcohol-free events in the region
- Talk to your child's school or ECE about alcohol – does their approach fit with the values of the community?
- Share your concerns about alcohol in your region with the District Health Board. Email us at healthpromotion@hbdhb.govt.nz

REFERENCES

Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44(3).

Bays, J. (1990). Substance abuse and child abuse: Impact of addiction on the child. *Pediatric Clinics of North America*, 37(4), 881-904.

Bryden, A., Roberts, B., McKee, M., & Pettigrew, M. (2012). A systematic review of the influence on alcohol use of community level availability and marketing of alcohol. *Health Place*, 18(2), 349-357.

Chambers, T., Pearson, A.L., Stanley, J., Smith, M., Barr, M., Ni Mhurchu, C., & Signal, L. (2017). Children's exposure to alcohol marketing within supermarkets: An objective analysis using GPS technology and wearable cameras. *Health & Place*, 46.

Crews, F., He, J., & Hodge, C. (2007). Adolescent cortical development: A critical period of vulnerability for addiction. *Pharmacology Biochemistry and Behavior*, 86(2).

De Bruijn, A. (2012). Exposure to online alcohol marketing and adolescents' binge drinking: A cross-sectional study in four European countries. In P. Adderson, F. Braddick, J. Reynolds, & A Gual (Eds.), *Alcohol policy in Europe: Evidence from AMPHORA*

De Bruijn, A., Tanghe, J., Beccaria, F., Bujalski, M., Celata, C., Gosslet, J., Schreckedberg, D. & Slowdonik, L. (2012). Report on the impact of European alcohol marketing exposure on youth alcohol expectancies and youth drinking. *Alcohol Measures for Public Health Research Alliance (AMPHORA).*

Fergusson, D., & Boden, J. (2011). *Improving the transition: Reducing social and psychological morbidity during adolescence. A report from the Prime Minister's Chief Science Advisor*. Auckland: Office of the Prime Minister's Science Advisory Committee.

Freisler, B., Midanik, L., & Gruenewald, P.J. (2004). Alcohol outlets and child physical abuse and neglect: Applying routine activities theory to the study of child maltreatment. *Journal of Studies on Alcohol*, 65, 586-592.

Grenard, J.L., Dent, C.W., & Stacy, A.W. (2013). Exposure to alcohol advertisements and teenage alcohol-related problems. *Pediatrics*, 131(2), 369-379.

Hay, G.C., Whigham, P.A., Kypri, K., & Langley, J.D. (2009). Neighbourhood deprivation and access to alcohol outlets: A national study. *Health Place*, 15(4).

Health Promotion Agency, 2017. *Attitudes and behaviours towards alcohol survey 2013/14 to 2015/16: Hawke's Bay regional analysis*. Wellington: Health Promotion Agency. Available at https://www.hpa.org.nz/research-library/research-publications/2013-14-to-2015-16-attitudes-and-behaviour-towards-alcohol-survey-hawkes-bay-regional-analysis

Institute of Alcohol Studies, (2017). *Like sugar for adults: The effect of non-dependent parental drinking on children and families*. Available at http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp28102017.pdf

Kaynak, Ö., Winters, C., Cacciola, J., Kirby, C., & Arria, M. (2014). Providing alcohol for underage youth: what messages should we be sending parents? *Journal of Studies on Alcohol and Drugs*, 75(4), 590-605

Kerr, W.C, & Stockwel, T. (2012). Understanding standard drinks and drinking guidelines. *Drug and Alcohol Review*, 31(2), 200-205.

Lewis, A. (2013). Alcohol-related injury attendances to Hastings Regional Hospital Emergency Department. *Hawke's Bay District Health Board* (unpublished).

Lin, E., Casswell, S., You, R., & Huckle, T. (2012). Engagement with alcohol marketing and early brand allegiance in relation to early years of drinking. *Alcohol Research & Theory*, 20(4), 329-338.

Maher, A., Wilson, N., Signal, L., & Thomson, G. (2006). Patterns of sports sponsorship by gambling, alcohol and food companies: An internet survey. *BMC Public Health*, 6(95). https://doi.org/10.1186/1471-2458-6-95

McCreanor, T., Barnes, H.M., Kaiwai, H., Borrell, S., Gregory, A. (2008). Creating intoxigenic environments: Marketing alcohol to young people in Aotearoa New Zealand. *Social Science Medicine*, 67(6). doi: 10.1016/j.socscimed.2008.05.027

Ministry of Education – Te Tāhuhu o te Mātauranga. (2016). *Guidelines for schools: Developing a policy on the sale, supply and consumption of alcohol*. Retrieved from https://www.education.govt.nz/assets/Uploads/Alcohol-Guidance-for-Schools.pdf

Ministry of Education – Te Tāhuhu o te Mātauranga. (2017a). *The national administration guidelines (NAGs).* Retrieved via http://www.education.govt.nz/ministry-of-education/legislation/nags/#NAG5

Ministry of Education – Te Tāhuhu o te Mātauranga. (2017b). *School deciles*. Retrieved from https://www.education.govt.nz/school/running-a-school/resourcing/operational-funding/school-decile-ratings/

Ministry of Health - Manatū Hauora. (2015). *Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey*. Retrieved from https://www.health.govt.nz/publication/hazardous-drinking-2011-12-findings-new-zealand-health-survey

New Zealand Law Commission, 2010. *Alcohol in our lives: curbing the harm. A report of the review of the regulatory framework for the sale and supply of liquor*. Report 114. Wellington: New Zealand Law Commission. Available at http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R114.pdf

Ngāti Kahungunu Iwi Incorporated (2006). *Te Ara Toiora o Ngāti Kahungunu 2007-2026*.

Richards, R., Darling, H., & Reeder, A.I. (2005). Sponsorship and fund-raising in New Zealand schools: Implications for health. *Australian New Zealand Journal of Public Health*, 29(4).

Ryan S.M., Jorm, A.F., & Lubman, D.I. (2010). Parenting factors associated with reduced adolescent alcohol use: A systematic review of longitudinal studies. *Australian New Zealand Journal of Psychiatry*, 44(9), 774-83.

Sale and Supply of Alcohol Act 2012. Retrieved 22 November 2017, from http://www.legislation.govt.nz/act/public/2012/0120/84.0/DLM3339333.html

Smith, L.A., & Foxcroft, D.R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health*, 9(51).

Ward, B.M., Buykx, P., Munro, G., Hausdorf, K., & Wiggers, J. (2014). Review of policies and guidelines concerning adults' alcohol consumption and promotion in Australian government schools. *Health Promotion Journal of Australia*, 25, 125-128.

APPENDIX A: DATA TABLES

Educational setting by type

(A graph and narrative of this data is available on page 14)

Educational Setting Type	Total number of applications	Number of educational settings	Rate per 100 educational settings
Early Childcare Centres	8	231	3.5
Primary / Intermediate Schools	55	100	55.0
Secondary Schools	40	20	200.0
Not Applicable	36		
Total:	139	351	

Applications by Territorial Local Authority

(A graph and narrative of this data is available on page 15)

Territorial Local Authority	Total number of applications	Number of educational settings	Rate per 100 educational settings
Central HB District	11	37	29.7
Hastings District	67	180	37.2
Napier City	58	98	59.2
Wairoa District	3	36	8.3
Total:	**139**	**351**	

Decile rating for schools that have applied for a special license

(A graph and narrative of this data is displayed on page 15)

	Ministry of Education School Decile	Total number of applications
Lowest proportion of students from low socio-economic communities	**10**	16
	9	26
	8	12
	7	14
	6	19
	5	12
	4	12
	3	12
	2	2
Highest proportion of students from low socio-economic communities	**1**	7
	Not known	7
	Total	**139**

Decile rating for schools with a history of no applications for special licenses
(A graph and narrative of this data is displayed on page 16)

	Ministry of Education School Decile	Number of schools with NO Applications
Lowest proportion of students from low socio-economic communities	**10**	1
	9	3
	8	4
	7	3
	6	3
	5	4
	4	13
	3	6
	2	18
Highest proportion of students from low socio-economic communities	**1**	22
	Total	**77**

Type of event by attendance of minors (under 18 years of age)
(A graph and narrative of this data is available on page 17)

Event Type	**Minors Attending**			
	Y	**N**	**U**	**Total**
Cooking demonstrations	2	0	0	2
Gala/Fair/Market	6	0	1	7
Other	5	10	9	24
Performance e.g. art exhibition, talent show, plays, concert, speech	5	5	3	13
Quiz/Casino/Bingo/Movie/Auction	10	58	6	74
School celebration e.g. Prize-giving/Jubilee /	2	8	1	11
Sporting e.g. pig hunting, horse trek, 4WD	3	2	0	5
Not Known	1	0	2	3
Total:	**34**	**83**	**22**	**139**

APPENDIX B: HBDHB LETTER TO SCHOOLS AND EDUCATIONAL FACILITIES ON APPLICATION OF AN ALCOHOL LICENCE

Corporate Services

WHAKAWATEATIA

HAWKE'S BAY
District Health Board

16 January 2015

All Principals and Board of Trustees
Hawke's Bay Schools

Dear Principals and Board of Trustees

Alcohol and Educational Facilities

The recently introduced Sale and Supply of Alcohol Act (2012) has a strong emphasis on improving New Zealand's drinking culture and reducing alcohol-related harm. The District Health Board has a key role in promoting host responsibility at functions and events where alcohol is supplied or sold.

Increasing access to and availability of alcohol are key drivers for increasing alcohol harm in our community. There is no evidence that 'normalising' drinking – even with the best intentions of promoting more 'sensible' drinking – reduces alcohol harm. From conception through to adolescence, exposure to alcohol has the potential both to cause and be associated with a range of negative outcomes for children.[1]

We have prepared a set of resources for schools and educational facilities. These aim to generate discussion within your school, including with your Board of Trustees, to develop an alcohol policy for the school and to decide if, or when, alcohol will play a part in school events.

We attach the following three documents for you:

- *School Alcohol Policy – Supporting Schools*: a guide to developing a school alcohol policy
- *Supporting Schools – Host Responsibility and Alcohol*: a quick reference host responsibility guide, should you decide to have alcohol available at events
- *Sample Host Responsibility Policy*: a template to use for events where alcohol is available.

If you would like more copies of these resources or would like to talk with us about host responsibility and alcohol use, please contact Michele Grigg, Population Health Advisor, on 06 834 1815 extension 4297. We are also more than happy to attend one of your Board of Trustees meetings.

You can find more information at www.alcohol.org.nz.

Yours sincerely

Dr Caroline McElnay
Director of Population Health/Health Equity Champion
Medical Officer of Health

[1] Law Commission. 2010. *Alcohol in Our Lives: Curbing the harm*. Wellington: Law Commission.

Population Health

Phone 06 87 8 8109. Fax 06 834 1816. Email: caroline.mcelnay@hbdhb.govt.nz
Private Bag 9014, Hastings, New Zealand. Website: www.hawkesbaydhb.govt.nz

APPENDIX C: HBDHB GUIDE TO DEVELOPING A SCHOOL ALCOHOL POLICY[9]

DEVELOPING A SCHOOL ALCOHOL POLICY

HAWKE'S BAY District Health Board Whakawateatia

Introduction

This guide provides information for developing an alcohol policy for your school or educational facility. Having a school alcohol policy means everyone is clear about if and when alcohol will be made available on your premises or at school events.

Schools have an obligation to provide a safe environment for their students. Increasing access to and availability of alcohol is a key driver in increasing alcohol harm in our community. This guide gives you tips and pointers for developing your alcohol policy.

The Hawke's Bay DHB feels very strongly that alcohol should not be on school grounds when children are present. It is widely understood that schools act as role-models for children, families and communities. Allowing alcohol to be sold or promoted in a setting where minors are present further normalises alcohol use in every day settings.

Please note that the District Health Board's Medical Officer of Health is likely to oppose a school alcohol licence application if children are likely to be present at the event for which the licence is being applied for.

We recommend your Board of Trustees works with staff, relevant school committees and the parent teacher association (PTA) to develop an alcohol policy for your school or facility. The policy should reflect the intentions of the Sale and Supply of Alcohol Act 2012.

Why have a school alcohol policy?

Educational facilities have an important role in our society. They are a core part of our community and social structure. Schools are required to provide a safe physical and emotional environment for students. They are also required to fully comply with any legislation to ensure the safety of students and employees.

While alcohol may be seen as a normal part of socialised behaviour, normalisation has led to the acceptance of excessive consumption. Alcohol consumption in the presence of minors further reinforces this. There is no evidence that 'normalising' drinking – even with the best intentions of promoting more sensible drinking – reduces alcohol harm. Instead it offers greater access to alcohol by those most likely to be affected by alcohol harm.

Your school might like to consider being both alcohol-free and smoke-free – to create a special place in your community where children will feel safe, knowing that parents and caregivers will not be drinking or smoking on school premises.
If you apply for a liquor licence we will ask to see your alcohol policy.

Produced December 2014

Points to consider

The Ministry of Education suggests that schools have an alcohol policy.[1]

You might like to discuss these questions when considering your policy:

a) Does having alcohol available on school premises or at school events have any benefit to our school community?

b) Does it have any benefit to the children in our community?

c) How does our school/educational setting contribute to reducing alcohol harm in our community?

d) What example do we want to set for our children and community?

e) How can we support the intention of the Sale and Supply of Alcohol Act 2012?

Having a policy means everyone in the school community is clear about the place of alcohol in their school/educational facility.

13

PROMPTS

For developing your school alcohol policy

- How does your school or educational facility promote a healthy and safe environment in relation to alcohol?
- If alcohol is provided and/or consumed, are the six key principles of Host Responsibility followed?[2]
- Is alcohol consumed when adults or staff have responsibility for student welfare?
- Will alcohol be permitted at times of the day/week when students are not on school grounds? Will it be provided if children are present?
- Is alcohol permitted at staff social functions at school? If alcohol is available, are non-alcoholic drinks, water, and food also available? Are adults asked to drink sensibly and moderately? Is alcohol served to or by students?
- Is alcohol sold on the school property for the purposes of raising money where minors have access to alcohol?
- Is alcohol offered as prizes at functions or in raffles? Note this is prohibited under the Gambling Act 2003.[3]
- Is it clear that no staff member, while acting in the capacity of a staff member, shall give alcohol to a student or enable a student to obtain alcohol?
- Do staff make sure that they do not provide students with alcohol (unless the student is their child – in accordance with the Act) or consume alcohol with students in a situation that may bring the school into disrepute?
- How frequently will the policy be reviewed?
- Who is responsible for the policy?

[9] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

Contacts

We are here to help. Feel free to contact us with any questions about your school alcohol policy.

Hawke's Bay District Health Board

Population Health: ph 06 834 1815, liquorlicensing@hbdhb.govt.nz

District Licensing Inspectors

Napier City Council: ph 06 834 4154, info@napier.govt.nz
Hastings District Council: ph 06 871 5000, council@hdc.govt.nz
Wairoa District Council: ph 06 838 7309, administrator@wairoadc.govt.nz
Central Hawke's Bay District Council: ph 06 857 8060, info@chbdc.govt.nz

Police

Eastern District Headquarters: ph 06 831 0700, HB.liquorlicensing@police.govt.nz

See our other guides

Supporting Schools – Host Responsibility and Alcohol: Host responsibility – a quick reference guide. December 2014. Population Health, Hawke's Bay District Health Board.

Sample Host Responsibility Policy – Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Preparing a Host Responsibility Implementation Plan: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility and Alcohol: A guide to being a responsible host. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility Resources: Order form. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Small Events: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Large Events: A quick reference guide. Population Health, Hawke's Bay District Health Board.

These and more information can be found at:
http://www.hawkesbay.health.nz/page/pageid/2145883919/Licensing_and_Host_Responsibility

NOTES:

[1] http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/PropertyToolBox/StateSchools/DayToDayManagement/Alcohol.aspx Accessed November 2014

[2] See *Supporting Schools – Host Responsibility and Alcohol: Host responsibility – a quick reference guide.* December 2014. Population Health, Hawke's Bay District Health Board and *Sample Host Responsibility Policy – Schools.* December 2014. Population Health, Hawke's Bay District Health Board.

[3] The Gambling Act (2003) prohibits certain prizes from being offered. This includes alcohol, or vouchers or entitlements to alcohol, among other products including tobacco.

APPENDIX D: HBDHB SUPPORTING SCHOOLS – HOST RESPONSIBILITY AND ALCOHOL GUIDE[10]

HOST RESPONSIBILITY FOR SCHOOLS – A QUICK REFERENCE GUIDE

HAWKE'S BAY District Health Board Whakawateatia

Introduction

The Hawke's Bay DHB feels very strongly that alcohol should not be on school grounds when children are present. It is widely understood that schools act as role-models for children, families and communities. Allowing alcohol to be sold or promoted in a setting where minors are present further normalises alcohol use in every day settings.

Please note that the District Health Board's Medical Officer of Health is likely to oppose a school alcohol licence application if children are likely to be present at the event for which the licence is being applied for.

The Sale and Supply of Alcohol Act (2012) aims to improve New Zealand's drinking culture and reduce the harm caused by excessive drinking. Specifically, the object of the Act is:

- That the sale, supply, and consumption of alcohol should be undertaken safely and responsibly
- That the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

This guide aims to help educational facilities, including schools and early childhood centres, plan events where it is agreed that alcohol will be made available. It includes tips, a checklist, and contact details for the safe use of alcohol at your school event.[11]

If you decide to provide alcohol at your event(s), we can work with you to identify what's needed to make your event safe and enjoyable. We can put you on track with your planning and help you access resources.

School alcohol policy

We recommend that all schools have an alcohol policy. Having a school alcohol policy means everyone is clear about if and when alcohol will be made available on your premises or at school events.

For further information on developing a school alcohol policy, check out our guide: *Developing a School Alcohol Policy*.

Reviewed March 2018

Host responsibility

Host responsibility is based on six concepts. **A responsible host:**

1) **Prevents intoxication**
2) **Does not serve alcohol to minors**
3) **Provides and actively promotes free drinking water, low alcohol and non-alcoholic drinks**
4) **Provides and actively promotes substantial food**
5) **Serves alcohol responsibly**
6) **Arranges safe transport options.**

For further information visit: www.alcohol.org.nz/legislation-policy/host-responsibility

Alcohol and host responsibility

The management of alcohol consumption is an important component of event management that must be planned well in advance.

Key issues to consider include:

* The way alcohol is served or made available at your event
* The physical environment in which alcohol is consumed
* The ways in which the relevant regulatory frameworks are monitored and enforced.

Intoxication and transport

Host responsibility means managing and monitoring patron consumption of alcohol – not waiting until intoxication becomes evident before doing anything.

Your alcohol management procedures should aim to both manage intoxication and assist any intoxicated patrons to slow their consumption and/or consider food and non alcoholic options.

It is wise to provide a safe place for intoxicated people to sober up and consider ways to get them home. It is your responsibility to set this space up so it is adequately monitored.

Food and water

Patrons should have easy access to quality food and water before and during your event. Ensuring there is enough food conveniently available, and promoting it, are standard licence conditions.

Food outlets should be either close to alcohol outlets or integrated with them – and free water should be provided (and well publicised) at convenient, queue-free places within the venue.

If food is to be provided, check with your local council about applying for a food permit. Ensure all food is prepared and handled in accordance with Council requirements.

[10] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

Your responsibilities

Your responsibilities in providing alcohol are clearly outlined in the Sale and Supply of Alcohol Act (2012)

Listed in the Act are the responsibilities of licence holders around preventing intoxication and disorderly conduct on the premises for which their licence applies (refer Part 2, Sections 248-253, pp146–148). To allow either is an offence under the Act.

The Act also requires licence holders, among other things, to provide free water for people to drink, which is easily accessible. The requirements around this are clearly spelt out in the Act (refer Part 1, Section 5 Interpretation: 'freely available to customers', p23).

✓ CHECKLIST

If you decide to provide alcohol at your event, these are the things you will need to consider in your planning:

- Find out from your local Council (see Contacts) if you need a liquor licence
- Providing free and easily accessible water – if your event is in a rural area you will need to work with us to check that your water supply is safe
- Providing and promoting low alcohol and non-alcoholic beverages
- Providing and promoting substantial food options and having these readily available[2]
- How alcohol will be served, and by whom
- Controlling the number of alcohol serves per person
- Security may be needed for the event, especially for preventing the entry of intoxicated people
- Strategies for dealing with intoxicated people, including a safe place to sober up while transport home is arranged
- Ensuring you don't provide alcohol to anyone under 18 without the express consent of their parent or legal guardian[3] (unless their parent or legal guardian is also present)
- The availability of safe transport options to and from the event
- If there will be over 400 people at the event you will be required to provide an Alcohol Management Plan when you apply for your licence.[1]

Contacts

We are here to help. Feel free to contact us with any questions about your event.

Hawke's Bay District Health Board

Population Health: ph 06 834 1815, liquorlicensing@hbdhb.govt.nz

District Licensing Inspectors

Napier City Council: ph 06 834 4154, info@napier.govt.nz
Hastings District Council: ph 06 871 5000, council@hdc.govt.nz
Wairoa District Council: ph 06 838 7309, administrator@wairoadc.govt.nz
Central Hawke's Bay District Council: ph 06 857 8060, info@chbdc.govt.nz

Police

Eastern District Headquarters: ph 06 831 0700, HB.liquorlicensing@police.govt.nz

See our other guides

School Alcohol Policy – Supporting Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Sample Host Responsibility Policy – Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Preparing a Host Responsibility Implementation Plan: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility and Alcohol: A guide to being a responsible host. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility Resources: Order form. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Small Events: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Large Events: A quick reference guide. Population Health, Hawke's Bay District Health Board.

These and more information can be found at:
http://www.hawkesbay.health.nz/page/pageid/2145883919/Licensing_and_Host_Responsibility

NOTES:

[1] If your event is for 400 people or more, go to the HBDHB website to download a 'Supporting Safe Alcohol Use at Large Events' guide.

[2] Make sure any food is prepared and handled safely.

[3] A person supplying alcohol to anyone under 18 must do so in a 'responsible' manner (ie, under supervision, with food, with a choice of low alcohol and non-alcoholic drinks, with safe transport options in place). A person is only considered a minor's legal guardian if he/she is recognised as a guardian under the Care of Children Act 2004. 'Express consent' means a personal conversation, an email, or a text message that you have good reason to believe is genuine.

APPENDIX E: HBDHB SAMPLE HOST RESPONSIBILITY POLICY - SCHOOLS[11]

HAWKE'S BAY District Health Board Whakawateatia

SAMPLE HOST RESPONSIBILITY POLICY - SCHOOLS

Host Responsibility Policy

Our Commitment to You, Our School Community

As a responsible educational facility, we model positive and responsible behaviour around alcohol.

We have an obligation to provide a safe physical and emotional environment for our students, and to comply fully with the Sale and Supply of Alcohol Act 2012.

We want our school community to remain safe.

The Management and Staff of *[insert name of school/facility]* have a responsibility to provide an environment where alcohol and other products are served responsibly in a smokefree environment. We have therefore implemented the following Host Responsibility Policy for this event.

- **We won't serve alcohol at school fundraising events where minors are present on school grounds**
- It is against the law to sell or supply alcohol and tobacco products to minors (under the age of 18 years). If we believe you are under the age of 25, we will ask for identification. Acceptable forms of proof of age are a NZ photo driver's licence, the Hospitality NZ 18+ card, and an original, valid passport.
- It is against the law to smoke on school grounds and in school buildings. We are Smokefree at all times.
- Our aim is to provide a safe and enjoyable environment. Anyone who is intoxicated will not be served alcohol, will be asked to leave and encouraged to take advantage of safe transport options.
- We promote transport options to get you safely home. Please ask us for further information.
- We encourage you to have a lifesaver (designated driver). We will make the lifesaver's job more attractive by providing non-alcoholic drinks.
- We make sure all of our food, water and transport options are well promoted – you won't have to go looking for them.
- We will provide, and actively promote, a range of non-alcoholic drinks *[specify here the types of non-alcoholic drinks eg, fruit juices, soft drinks, tea and coffee]*.
- Water is available free of charge at all times and is clearly sign-posted.
- Low alcohol drink options are available and include *[enter names here]*.
- We encourage you to choose from our selection of food.

Host responsibility makes sure that everyone has a good time, and leaves in safe shape for the trip home.

Thank you for attending our event and supporting our host responsibility policy.
We hope you have an enjoyable time.

Reviewed March 2018

APPENDIX F: MINISTRY OF EDUCATION GUIDELINES FOR SCHOOLS – DEVELOPING A POLICY ON THE SALE, SUPPLY AND CONSUMPTION OF ALCOHOL[12]

MINISTRY OF EDUCATION
TE TĀHUHU O TE MĀTAURANGA

SALE, SUPPLY AND CONSUMPTION OF ALCOHOL

GUIDELINES FOR SCHOOLS

Developing a policy on the sale, supply and consumption of alcohol

Schools are a core part of our community and social structure and are important settings for promoting health and wellbeing through education, policies and modelling behaviour. This guidance provides information for schools to consider, when reviewing or developing a school policy on the sale, supply and consumption of alcohol.

Why have a policy on the sale, supply and consumption of alcohol?

Under the **National Administration Guideline** (NAG) 5 (http://www.education.govt.nz/ministry-of-education/legislation/nags/#NAG5), boards of trustees are required to "provide a safe physical and emotional environment for students" (NAG 5a) and to "comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees" (NAG 5c).

A policy on the sale, supply and consumption of alcohol will help boards of trustees, staff, parents and students to have a clear understanding of what is acceptable in terms of the sale, supply and consumption of alcohol on school grounds, at school events and in (or not in) the presence of students.

- If, as a board of trustees, you decide you do not want alcohol sold or supplied at your school, it is important to document that in a policy
- If you do want alcohol sold or supplied on school premises or during school activities, your policy should explain when alcohol will be available and at what kinds of events. You must also apply for a **special license** (http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339490.html) when selling or supplying alcohol or charging an entrance fee to an event where alcohol is available.

A policy will:

- outline the school's approach to the sale, supply and consumption of alcohol
- highlight the school's alcohol prevention and intervention strategies
- be developed in partnership with the school's wider community to ensure that it reflects the community values, philosophies, ethos, goals and lived experiences.

Your policy will cover:

- Education Outside the Classroom (EOTC)[1] events such as school picnics, camps and offsite activities
- school events, such as galas, fundraisers and staff social events
- school balls and leavers dinners held at licensed premises or on school grounds
- sponsorship or discounted/free alcohol provided for school events
- where alcohol is available
- **serving alcohol safely** (http://alcohol.org.nz/sites/default/files/field/file_attachment/AL576 Serving Alcohol SAFELY at Workplace Events April 2014.pdf) at school events
- gifts, prizes and raffles
- external public bookings, such as weddings or parties, where non-school groups use the school under a **lease agreement** (http://www.education.govt.nz/school/property/state-schools/day-to-day-management/leasing-or-hiring-to-third-parties/)

1 *The EOTC guidelines recommend non-consumption of alcohol by parents and teachers at a school EOTC event as it impairs a person's ability to provide a high level of supervision and to respond to an emergency*

www.education.govt.nz

[11] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

[12] Electronic version available online at https://www.education.govt.nz/assets/Uploads/Alcohol-Guidance-for-Schools.pdf

Legal Requirements

Your policy must comply with the **Sale and Supply of Alcohol Act 2012** (http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339333.html).
All schools need to obtain a special licence if alcohol will be sold or supplied on a school site, at a school event and/or where an entrance fee or koha/donation for a school event is charged that covers alcohol available at the event.
A special licence must be filed at least 20 working days before an event and can take up 3-4 weeks before a decision is made by your local council's licensing committee. A special licence can be challenged by the public, police and the Medical Officer of Health and may be declined. An application **fee** (http://www.justice.govt.nz/justice-sector-policy/key-initiatives/sale-and-supply-of-alcohol/licensing/fee-system-for-alcohol-licensing/) will also apply.

The licence identifies:

- whom alcohol can be sold or supplied to
- the hours and days alcohol can be sold or supplied
- who is allowed on the premises
- conditions related to promotion and prizes, and
- the range of food and non-alcoholic drinks that will be available.

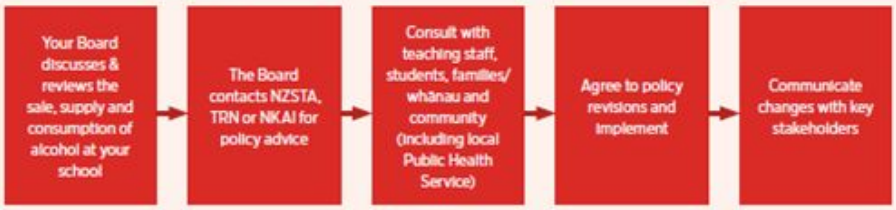
It is illegal for students under 18 years to be sold alcohol.

Under the **Gambling Act 2003** (http://www.legislation.govt.nz/regulation/public/2005/0299/latest/DLM359440.html?search=sw_096be8ed8134046a_alcohol_25_se&p=1%20-%20DLM359440), alcohol is prohibited from being offered as a prize for gambling activities (e.g. raffle prizes).

You may want to consider the following when developing your Policy

- How can we comply with the Sale and Supply of Alcohol Act 2012?
- The Sale and Supply of Alcohol Act 2012 requires a special licence to be obtained if alcohol will be sold on a school site.
- The non-consumption of alcohol by staff, parents and caregivers while students are in their care during school events.
- What steps will be taken if students, staff and parents are intoxicated at school events?
- How can we ensure that students, families and staff are safe at school and at school events?
- When does the school allow alcohol at school events? Does the school accept sponsorship from alcohol producers or providers?
- What is the school's position on the sale, supply and consumption of alcohol by the public/community groups who are using the school site?

Steps in developing your Policy



The New Zealand School Trustees Association (NZSTA), Te Rūnanga Nui (TRN) and Ngā Kura ā Iwi (NKAI) provide services to affiliated schools, to enhance their governance capability.

The following resources may also help to develop your Policy.

Click on the links highlighted in red:

Resources to help to develop your Policy

- **The Southern District Health Board:** Setting the Standard (http://www.southerndhb.govt.nz/files/17281_20160616120652-1466035612.pdf) identifies social modelling of alcohol consumption in the presence of minors, normalises alcohol use and leads to earlier initiation of alcohol consumption and heavier consumption. The **website** (http://www.southerndhb.govt.nz/index.php?page=2827) also has useful fact sheets for schools on alcohol.
- **The Ministry of Health:** National Drug policy 2015-2020 (http://www.health.govt.nz/system/files/documents/publications/national-drug-policy-2015-2020-aug15.pdf) promotes a collaborative approach to reducing alcohol and other drug related harm and the role of community organisations such as schools.
- **CAYAD (Community Action Youth and Drugs):** More Than Just a Policy **toolkit** (http://www.healthaction.org.nz/index.php/what-we-do/cayad) is for people wishing to develop or review existing alcohol and other drug policies. The toolkit consists of a guide and a practical workbook.
- **The New Zealand Police** provide information on **Alcohol and Other Drug Guidelines** (http://www.police.govt.nz/advice/personal-and-community-advice/school-portal/information-and-guidelines/alcohol-and-other-drug) and the development of prevention policies/activities in schools.
- **The Health Promotion Agency's alcohol website** (http://alcohol.org.nz/) has useful information including advice, research and resources to help prevent and reduce alcohol-related harm
- **The University of Auckland:** The health and wellbeing of secondary school students in 2012 (https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/Final%20Substance%20Abuse%20Report%2016.9.14.pdf) presents findings from 91 composite and secondary schools in New Zealand who took part in the national health and wellbeing survey.

The Ministry of Education wishes to acknowledge and thank the following people and organisations for their contribution in the development of this guideline:

- Public Health Clinical Network, Alcohol Regulatory Advisory Group
- Ministry of Health
- Health Promotion Agency
- Ngā Kura a-Iwi o Aotearoa
- Te Rūnanga Nui o Ngā Kura Kaupapa Māori o Aotearoa
- New Zealand School Trustees Association

HAWKE'S BAY District Health Board Whakawāteatia	**The Strategic Development of a revised Coordinated Primary Options (CPO) Programme Fit for Purpose for the populations of Hawke's Bay**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner	Chris Ash – Executive Director Primary Care
Document Author(s)	Jill Garrett – Strategic Services Manager - Primary Care
Reviewed by	Alan Wright – Clinical Governance Chair – CPO; Mark Petersen – Chief Medical Officer – Primary; Linda Dubbeldam – Innovation and Development Manager – HHB; Sonya Harwood – CPO Coordinator HHB and the Executive Management Team
Month/Year	May 2018
Purpose	Request input and discussion on a staged approach to the proposed expansion of existing, and inclusion of additional services within the CPO programme. Scope: • Prioritisation mechanism to inform a staged approach to programme expansion • Utilisation of clinical pathways to inform Best Practice and service design • Mechanisms that support sustained utilisation of the programme to avoid duplication of service provision that lead to inefficiencies • IS systems that support collection and collation of clinical and non-clinical data • Input into evaluation, Continuous Quality Improvement (CQI) and risk mitigation processes informed by clinical and administrative metrics • Financial and contract modelling • Linking CPO to other relevant services provided by the DHB, e.g. supported discharge – EngAGE, Sexual Health Services, District Nursing Services The scoping paper to be presented to EMT
Previous Consideration Discussions	Presentation provided by Alan Wright (Clinical Lead, CPO) - EMT 27 March 2018
Contribution to Goals and Strategic Implications	The CPO programme has the potential to impact on: • Effective use of health resources • Addressing indicators within the SLM framework • Implementation of key areas (integration) within the NZ Health Strategy

Impact on reducing inequities / Disparities	Preference would be to use the Health Impact Assessment Tool to inform programme development to address equity.
Consumer engagement	Consumer input and feedback into service design will form part of evaluation framework for new expanded programme
Other Consultation /Involvement	As listed in reviewers
Financial/Budget Impact	Current total spend: $790K ($5 per head of population) Propose scoping staged expansion and identifying budget requirements
Timing Issues	TBC

RECOMMENDATION:

That HB Clinical Council

1. **Support** the scoping of an expanded CPO Programme

The Strategic Development of a revised Coordinated Primary Options (CPO) Programme Fit for Purpose for the populations of Hawke's Bay

Author:	Jill Garrett
Designations:	Strategic Services Manager – Primary Care
Date:	April 2018

RECOMMENDATION

That HB Clinical Council

1. **Support** the scoping of an expanded CPO Programme.

DEFINITION

CPO is the delivery of services, by a recognised health professional, within a primary care or community care setting that would otherwise have been delivered by a secondary-hospital based service inclusive of outpatient services, ED provided services, in-patient delivered services.

Overview

1. Redeployment of relevant services to primary care versus utilisation of hospital resources makes economic and clinical sense if utilisation reaches ≥75% uptake. Operating parallel will otherwise result in in efficiencies.

2. Providing care closer to home supports evolution of the primary health care team. It also reinforces, to our population, the function of primary care in the delivery of more complex care and thus reduces demand on hospital-based services.

3. Nationally, Coordinated Primary Options programmes or Primary Options for Acute Care (POAC), have proven their efficacy in reducing demand on hospital based services. The programme in place for Hawke's Bay is set up to deliver expanded services through: established processes and systems; utilisation of standardised guidelines within the clinical pathways programme for clinical management; and, and a primary care workforce that has the capacity and capability to extend services provided.

4. Hawke's Bay currently have a CPO budget of $790k, serving a population of 160,000 ($5 per head of population). Redesign of this service will be benchmarked against the clinical and financial modelling used by Canterbury in their development of Primary Options for Acute Care (POAC).

5. Currently there are only 7 services[1] included in the Hawke's Bay CPO programme. (Refer Appendix One). Listed are 26 additional services that potentially could make up an expanded service. For example, PHARMAC are planning to include a number of infusion items on their community schedule, some of which would appropriately be managed within primary care through a CPO program, for example Ferric Carboxymaltose (iron infusions).

[1] To note that within some services they may be a number of separate pathways e.g. in acute care there are 7 separate pathways of care

6. The current programme is managed within five contracts. Contract bundling has been applied to three service areas that had previously been managed by three individual contracts. It has been a successful mechanism to reduce accounting and administrative burden, optimise the use of funds to meet service demands and enable the contract holder to manage under and overspend/utilisation of service within budget limitations. This has been closely monitored by: the Planning and Funding team and CPO steering group who are satisfied with the result.

7. The expansion of the CPO programme would work towards a greater number of contracts being bundled together with the goal of all services contracted under CPO with a single provider to fall under the one contract. Individual service reporting and review would be against individual services specifications within the one contract.

8. Expansion to the current programme could be managed within a staged process that:

   a) Expands the current programme gradually to a full complement of services; or
   b) Follows Canterbury's approach and opens the programme entirely.

Both options would have strict moderation and monitoring processes in place.

9. Clinical pathways provide the mechanism for guiding adherence to best practice, the ability to inform clinical auditing, and promote confidence in the services that can be provided through a CPO programme. There are currently 36 clinical pathways that have been developed for our local environment. Nationally the Canterbury pathways are available to inform a wider scope of practice. Pathways are an essential component of an expanded effective CPO program.

10. Information Service (IS) enhancements to the CPO programme would include further development of e-Referral processes, replacement of the advanced form within the Primary Care Patient Management System (PMS)[2] which currently only supports claims information and outputs/volumes data, but does not collect clinical data or case management for episodes of care.

11. The redesign process would include clinical input from the CPO Steering Group, members of which include primary and secondary clinical leads. Their input would drive the formation of the evaluation framework, CQI processes, and risk mitigation strategies as well as innovation in clinical practice.

GENERAL COMMENTS

1. CPO has been utilised to address need in times of crisis. The sector has responded well to ensure patient safety and appropriate care has been provided: right-place-right time-right care. The primary sector ask that any extension to the programme be consistent and any additions remain. This provides surety to the patient as to where care can be provided and assurance to practitioners as to what care can be provided under the programme. Appendix one highlights areas that were added during the gastro outbreak and in times when hospital bed capacity is an issue.

2. The cost of consumables can be used as a reason for retention of consumers within a service that is provided free of charge through the hospital system. Administering consumables takes time and resources. Providing for the cost of consumables so that care can be provided within a primary care setting under the CPO may reduce demand on follow up appointments for wound cares from for example: outpatients, ED, burns and complex skin lesions.

3. It is suggested that the CPO steering group become a Clinical Governance Group as it: is well supported by clinical leads across both primary and secondary service provision, they meet regularly and provide advice and recommendations regarding current and future opportunities for CPO services and the group is well placed to act as t advisors to the expansion of the service.

[2] PMS - Patient Management System

PROPOSED NEXT STEPS

Scope expansion of the CPO programme informed by:

- CPO steering group clinical leads
- Agreed capacity and capability within the primary care sector
- Clinical Pathways best practice modelling
- Utilisation of agreed metrics that can be used to inform development of KPIs[3] and ongoing CQI processes
- A programme of education and promotion to support 75% sustained referral into the programme[4]
- IS improvements[5] to support the existing e-Referral system, but includes: mandatory – regulatory fields; the collection and collation of clinical data; claiming information and high quality imaging transferal
- Example of contract bundling.

Present scoping paper to EMT **end of June 2018** detailing:

- Staged approach to programme expansion
- Draft service specs for bundled contracting
- Evaluation framework with key KPIs and CQI processes to inform Risk Management strategy.

The final proposal to be taken through the prioritisation process in the next financial year.

RECOMMENDATION

That HB Clinical Council:

1. **Support** the scoping of an expanded CPO programme.

ATTACHMENTS:

Appendix One

- Hawke's Bay DHB – Coordinated Primary Options existing and proposed extension services

Additional material available

- March CPO report
- ED Back referral Pathway – DVT
- DVT Evaluation March 2018

[3] Refer to Canterbury POAC service metrics that informs milestone reporting and any service expansion

[4] This takes into account the need for ongoing education of the fixed and often changing locum workforce

[5] Currently the each service has an advanced form attached that assists only in informing claiming information demographics and volumes. It is neither collects clinical nor outcomes data.

Appendix One: Hawke's Bay DHB – Coordinated Primary Options Existing and Proposed services

Key:

	Extension to the programme during gastro outbreak and periods of maximum hospital capacity

CPO Services[6]	Existing CPO Programme	Opportunity for Extension	Supported by a Clinical Pathway
Abscess (non ACC)		•	
ACC Burns follow up		•	
Aclasta infusions (Zoledronic Acid) in conjunction with fracture liaison service		•	
Acute care – IV Therapy – Aged Residential Care setting		•	Yes
Acute care – General Practice setting • Cellulitis – including referrals from ED • Pyelonephritis • Rehydration • Tonsillitis • DVT • Childhood eczema	•		Yes
2. DVT self-presentation to ED – refer to GP		•	Yes
3. Infusions (Future extensions to the PHARMAC schedule)		•	Yes
Asthma Management + Observation		•	Yes
Catheterisation + observation (Aged Residential Care)		•	
Catheterisation + observation (General Practice)		•	
Chest pain (low risk)		•	
CHF IV Frusemide and monitoring		•	
Consumables - Burns follow-up		•	
- generic wound management		•	
- complex skin lesion follow-up		•	
- Enuresis		•	
ECG informed drug administration		•	Yes
Engage intermediate care beds	•		yes
Enuresis		•	
Epistaxis		•	

[6] Joint Injections may be added.

Hospital discharge	•		Yes
CPO Services	Existing CPO Programme	Opportunity for Extension	Supported by a Clinical Pathway
IV Rehydration – Paediatrics		•	
Iron Infusion		•	
Mental Health POC		•	
Pipelle Biopsy		•	Yes
Pneumonia Pathway		•	Yes
Radiology Services – e.g Chest (pneumonia)		•	
Rheumatic Fever – Primary Care Says Ahh	•		Yes
Sexual & Reproductive health	•		
High Cost Gynae and Vasectomy	•		Yes
Sexual health visit <20yrs (&<24 yrs Wairoa)	•		Yes
Skin (Cancer) lesions	•		Yes
Skin (Cancer) lesions – complex		•	
TPN		•	Yes

14

	Clinical Services Plan – Planning for Consultation
	For the attention of: **HBDHB Executive Management Team; HHB Executive Management Team; Māori Relationship Board, Pasifika Health Leadership Group; HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner & Author:	Ken Foote, Company Secretary & Clinical Services Plan Project Lead
Reviewed by:	Hayley Turner, Paul Malan and Executive Management Team
Month:	May 2018
Consideration:	For Advice

RECOMMENDATION:

That the governance and advisory groups:

- **Provide** advice to assist with the development of a plan for the consultation / engagement phase of the Clinical Services Plan (CSP) process, to take place over August / September 2018.

1. PURPOSE

It has previously been agreed that consultation/engagement on the Draft CSP will take place during August and early September 2018. The CSP Project Team is currently developing a plan for this.

The purpose of this report is to seek advice from the HB health sector executive and governance groups on who we should be consulting with and the best way to do this. The Project Team wants to make sure that this consultation/engagement process goes well, by engaging with the right groups and people, in the right place and in the right way, to gain feedback, understanding and acceptance.

2. BACKGROUND

In developing a plan for consultation, it is important to remind ourselves of the background, context and process that has led to the development of the Draft CSP, on which we will be consulting. Summaries of these issues are set out below:

2.1 Why do we need a CSP?

- Planning is important to sustain a growing population and a healthier Hawke's Bay
- Need to identify the clinical services and models of care that will best meet future demand
- Need to confirm what works well, what needs improvement and new opportunities
- Take Transform & Sustain to the next level
- Planning a 10 year outlook is imperative for reducing inequity and ensuring we meet the basic and most comprehensive needs of our consumers.

2.2 What is a CSP?

A CSP will:

- Describe the current capability and capacity of services (Baseline)
- Describe the challenges and opportunities facing service provision now and in the future.
- Describe high-level options that will help meet those challenges and take advantage of those opportunities.
- Provide an indication of strategic direction and important areas for investment.
- Be able to be realistically implemented within funding projections
- Inform the next HB health sector 5 year Strategic Plan

A CSP will not:

- Address details of implementation or operational service planning
- Provide detailed financial modelling
- Provide a workforce strategy and plan
- Include a facilities Master Plan.

2.3 What else will inform the next HB health sector 5 year Strategic Plan?

- Government Policy and MoH direction
- Central Region Planning
- People Strategy (Big Listen, Korero Mai)
- Health Equity Report
- Matariki - Regional Economic Development and Social Inclusion Strategy
- Existing/Updated Plans eg,
  - Maori Health
  - Pacific Health
  - Population Health
  - Workforce
  - Information Services / Information Technology
  - Facilities
  - Finance
- Existing/Evolving Strategies eg,
  - Integration
  - Primary Care Development
  - Disability
  - Quality Framework
  - Person & Whanau Centred Care
  - Consumer Engagement/Experience
  - Clinical Leadership/Governance
  - Health Literacy / Making Health Easy to Understand
  - Health and Safety

2.4 What process has been used to develop the Draft CSP?

In June 2017, HBDHB engaged Sapere Research Group to facilitate a whole of sector, bottom up approach to the development of a CSP for the HB health system.

Over the nine month period 1 June 2017 to 28 February 2018, the process was focussed on engaging with key stakeholders to confirm ‘current state analysis’ and identify issues and challenges.

Key stakeholders significantly engaged during this time included:

- General Practice
- Community Providers
- Aged Care Providers
- HBDHB services
- Consumers
- HB health sector leadership.

During April and May 2018, the focus has been on exploring future options, with four themed workshops and an integrative workshop. The four themed workshops had health professionals and consumers working together to produce a long list of options for the future design and delivery of relevant services.

The themes for the workshops were:

- Looking after frail people in our care
- What is the character of our hospital in 10 years' time?
- Supporting our people in vulnerable situations
- Reorganising primary care for the challenge.

The Integrative Workshop to be held on 31 May 2018, will seek to integrate and prioritise the options developed at the four future options (themed) workshops.

2.5 What outputs have been produced along the way?

Output documents have been progressively produced along the way, documenting analysis and issues raised to inform the next stage of the process.

Key documents have included:

- Data Packs – July 2017
  - Population and service data analysis
  - Benchmarking
  - Demographic service volumes (demand)
- Horizon Scan – October 2017
  - Looks at trends in workforce, technology and integrated models of care that will impact on the future delivery of services and the ways people access and participate in their healthcare
- Patient Journey Workshop write ups – November 2017
  - What is working well – what isn't working so well.
  - Suggestions on how to improve
- Baseline Document – February 2018
  - Provides a summary of the current state of services delivered across general practice and other community providers, as well as district health board health services provided both in the community and hospital.
- Summary Statement – February 2018
  - Summarises findings from the *Baseline Document.* Also integrates findings from the patient journey workshops held in September 2017.

2.6 How will the Draft CSP be developed?

Sapere will use all the information collated and ideas generated from all the above, along with the options/issues agreed through the themed and integrative workshops, to produce an Initial Draft CSP by 30 June 2018.

Throughout July, all HB health sector executive and governance groups will have the opportunity to review this initial draft for accuracy, completeness, understanding and reality checking. Feedback from these reviews will be provided to Sapere. Sapere will update/amend the initial draft as appropriate and have the Draft CSP for consultation back to us by the end of July 2018.

It needs to be noted that this review during July will not involve any discussion on the merits of any of the options or suggested strategies presented, other than that necessary for a "reality check". There will be significant opportunity to review these issues during regular meetings in both August and September as well as potential time provided during the next HB Health Sector Leadership Forum Workshop currently planned for 5 September 2018.

3. CONSULTATION, OBJECTIVES & PRINCIPLES

Comment would be appreciated on the following:

3.1 Objectives

Objectives of consultation / engagement are to:

- Inform, explain, review and validate the draft CSP
- Seek feedback and comment on changes/enhancements required
- Honour our Treaty of Waitangi obligations
- Commence a process to gain understanding and acceptance of the need for change
- Listen for and note 'operational' issues/concerns raised for future detailed planning

3.2 Principles

- Acknowledge what the CSP is and what it is not – focus on strategic direction and input into the new 5 year Strategic Plan
- Draft CSP is 'owned' by HBDHB on behalf of the HB heath sector – Sapere have assisted with its development
- Acknowledge robust, objective analysis and engagement/co-design process to date
- Consultation process/engagement to be led by HBDHB
- Acknowledge the need for change – the status quo is not sustainable
- Openness and transparency – everything on the table
- Consultation/engagement is genuine - Draft can be changed
- Ensure all key stakeholders are appropriately engaged – preferably in their own environment and in ways that suit them
- Maximise use of existing forums and meetings
- Make it 'easy to understand'
- Where possible 'translate' CSP into 'what does this mean for me and my whanau/community'.

4. CONSULTATION PROCESS

As indicated above, this consultation/engagement process will only go well if we engage with the right groups and people, in the right place and in the right way.

Advice is therefore requested on all three of these factors, as well as on proposed pre-consultation briefings.

The framework and suggestions below are provided as a starting point for discussion:

4.1 Pre-Consultation Briefings:

- *Minister/Ministry of Health*
- *Members of Parliament*
- *Mayors and Chairs of Local Authorities*
- *Other 'Community leaders"*
- *Media*

4.2 Stakeholder Engagement:

- *Consumers/community*
- *Maori community*
- *Pacific Island Community*
- *HBDHB & Health HB Ltd staff*
- *HB health service providers*
  - *General Practice*
  - *Community Pharmacy*
  - *Aged Care*
  - *NGOs*
- *Community health groups*
  - *Cancer society*
  - *etc*
- *Other community groups*
  - *Aged Concern*

- *etc*

4.3 Methods:

- *Meetings/presentations*
  - *Public*
  - *groups*
- *Digital*
  - *Website*
  - *Facebook*
- *Print*
  - *Media*
    - ✓ *"News" articles*
    - ✓ *Paid advertisements*
    - ✓ *Community papers*
  - *Pamphlet*
    - ✓ *Mail drop*
    - ✓ *"Selected" availability*
  - *CEO In Focus*
    - ✓ *Special Edition*
- *Feedback*
  - *meeting notes*
  - *Pamphlet card*
  - *Email*

4.4 Leadership:

- *Overall leadership / ownership / spokesperson*
- *Delegated leadership*
- *Presenters*
  - *Coordination*
  - *Training*

4.5 Management and Administration:

- *Summaries / presentation development*
- *Programme coordination*
- *Logistics*
- *Budget / cost management*
- *Feedback collation / review / submission to Sapere*

5. CONSULTATION PLAN

Following receipt of all comments and advice from this process, the CSP Project Team and Communications Manager will develop a detailed Consultation Plan, including a full Communications Plan.

Once approved by HBDHB CEO, implementation of the Plan will commence in June, with all governance groups being provided with a copy for information. Alterations and variations to the Plan will still be possible however, where identified as necessary or desirable, and approved by HBDHB CEO.

6. COMMENTS / ADVICE

As indicated at the beginning and throughout, comments and advice on any/all issues included in this report, would be appreciated.

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Council Representatives – Clinical Governance Structure**
	For the attention of: **HB Health Consumer Council**
Document Owner & Author:	Ken Foote, Company Secretary
Month:	May 2018
Consideration:	For Discussion / Decision

RECOMMENDATION:

That HB Consumer Council:

- **Review** previous decisions on the appointment of Consumer Council representatives to "new" Clinical Governance Committees
- **Confirm** a policy on who may be appointed to these Committees in the future and how such appointments are made
- **Confirm** names of initial representatives from May 2018

BACKGROUND

A 'new' clinical governance structure for the Hawke's Bay health sector has recently been approved by the HBDHB Board. A copy of this 'new' structure is attached.

Although only recently approved, this structure has been under consideration for nearly a year. In August 2017, Consumer Council endorsed the structure as it existed at the time and identified Council members to sit on each of the five Committees as "Consumer Council Representatives" in accordance with the draft Terms of Reference.

Those named were:

Patient Experience	James Henry, Terry Kingston, Deborah Grace and Rosemary Marriott
Professional Standards and Performance	Sami McIntosh
Patient Safety & Risk	Heather Robertson
Clinical Effectiveness and Audit	Malcolm Dixon (Terry Kingston as back up)
Information Management	Leona Karauria

Although the structure at Committee level has remained largely unchanged, the passage of time has brought us close to the pending retirements in June, of four of the members named: Terry Kingston, Rosemary Marriott, Heather Robertson and Leona Karauria.

This now then raises the question of whether these members should be replaced because they are no longer members of Consumer Council (which was the original (intent) or whether they can continue to be Consumer Council representatives without actually being Consumer Council members.

POLICY

The key question in determining a policy on such appointments:

"Do the Consumer Council Representatives on each of the 'new' clinical governance committees need to be Consumer Council Members**?**

Given the standing or status of these committees, the original thinking was that they should, as being on Council provide members with a wider perspective and understanding of health sector issues at a governance level which all better equip such representatives to confidently reflect a consumer perspective on these committees.

Now that we are starting to get a number of retirements from Council, with such members having had five or more years' experience on Council, it would appear appropriate to change the original thinking to make it possible for those experienced people to be considered for appointments.

The only exception to this however should be the "Consumer Experience Committee". This Committee is a joint 'relationship' committee with Clinical Council, made up of four members from each Council. The Terms of Reference for this committee also has provision for one of the Consumer Council members to be a co-chair of the Committee. Given that Consumer Council now has two deputy chairs, it would seem appropriate for one of these to be appointed to the Committee and be the Consumer Council appointed co-Chair.

Given all the above, a simple policy could then be:

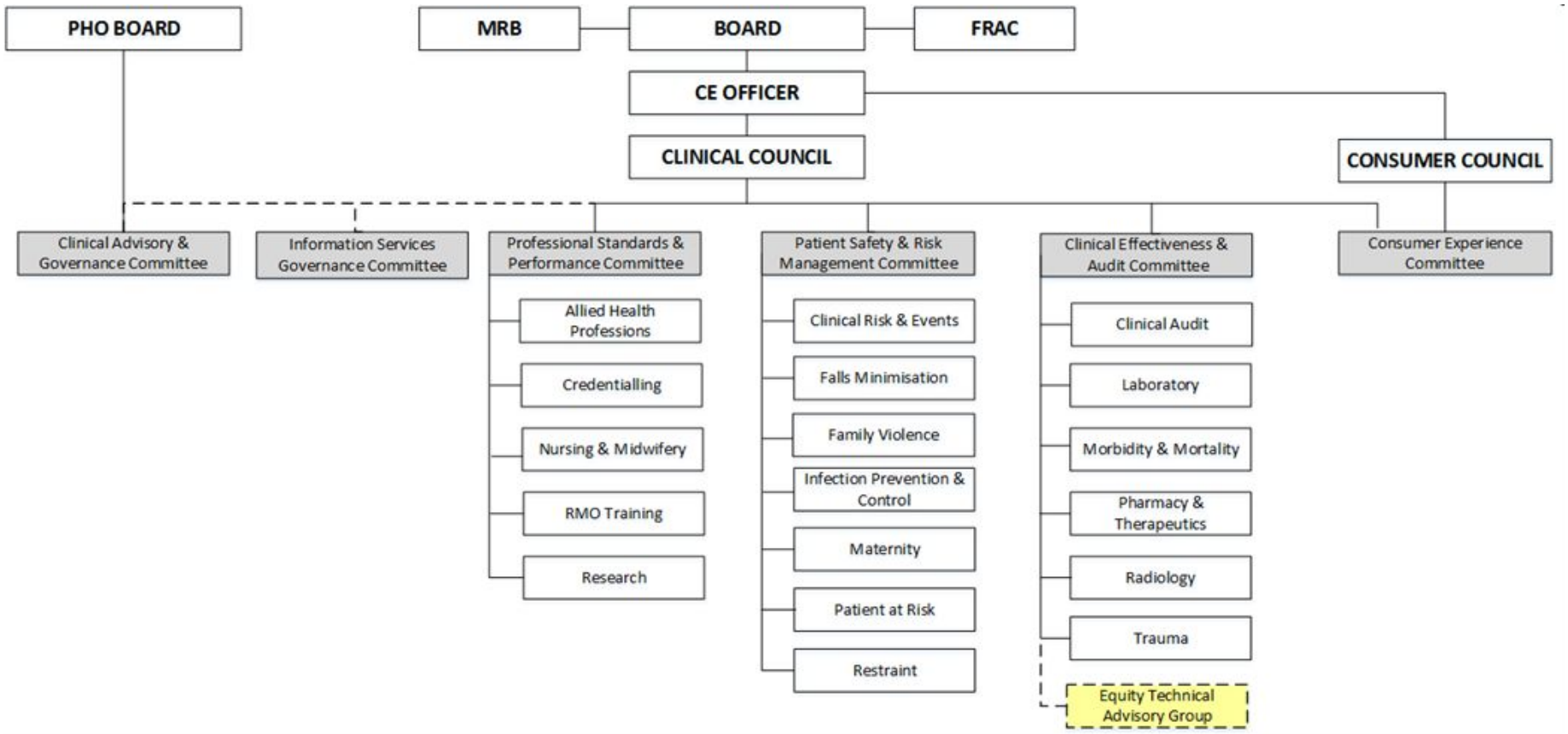
Policy on Consumer Council Appointments to Clinical Governance Committees

- Appointments to the Consumer Experience Committee must be current Consumer Council members, one of whom shall be the/a Consumer Council Deputy Chair, who shall be the Consumer Council appointed Co-Chair of the Committee
- Consumer Council representatives on the following committees may be Consumer Council members, OR other suitably qualified consumers:
  - ✓ Professional Standards and Performance Committee
  - ✓ Patient Safety and Risk Management Committee
  - ✓ Clinical Effectiveness & Audit Committee
  - ✓ Information Services Governance Committee
- All appointments of Consumer Council representatives to the Clinical Governance Committees shall be approved by resolution of Consumer Council.
- Consumer Council may replace any Consumer Council representative at any time, for any reason.
- All Consumer Council representatives appointed to any Clinical Governance Committee shall provide reports, on the activities of the committee to Consumer Council, on a regular basis (no less than six monthly).

INITIAL APPOINTMENTS

Once a policy has been agreed, it would be appropriate to confirm all initial appointments now, as it is likely that committees may be constituted for initial meetings within the next month or so.

CLINICAL GOVERNANCE COMMITTEE STRUCTURE



Pending any changes to Executive Management Team

16

HAWKE'S BAY District Health Board Whakawāteatia	**Implementing the Consumer Engagement Strategy**
	For the attention of: **HB Health Consumer Council**
Document Owner:	Kate Coley, Executive Director People & Quality
Document Authors	Ken Foote, Company Secretary & Hayley Turner, Project Manager
Reviewed by:	N/A
Month:	April 2018
Consideration:	For Endorsement

RECOMMENDATION

That HB Clinical Council and MRB

1. Note the contents of this paper and the Consumer Engagement Strategy
2. Endorse the Strategy to go to Board via Clinical Council and MRB.

PURPOSE

The purpose of this paper is to present the final draft of the Consumer Engagement Strategy, and to outline the proposed approach which will support effective implementation of the strategy.

A Strategy was originally endorsed by HB Health Consumer Council in September 2017 and has since incorporated feedback received from EMT and MRB. The proposed implementation approach has evolved as the overall People Strategy and has been developed, and its various components integrated.

OVERVIEW

It is our ultimate aim to create a culture which puts people at the centre of everything that we do, and one that is respectful of, and responsive to the needs, preferences, and values of our community. Consumer engagement is one enabler of a people centred culture.

The attached consumer engagement strategy has been developed as a key piece of work alongside others to:

- Achieve culture change.
- Strengthen and embed consumer participation at all levels in the health sector
- Ensure consumers are active partners in how we design, deliver and improve services
- Drive improvements - experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture'. It should be linked to other organisational plans and build on existing skills and the work we are already doing. The strategy supports the Hawke's Bay Health Sector vision of "*Healthy Hawkes Bay*" and mission of *"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring however there is also a lack of guidance, practical resources and tools to support effective engagement. A systematic approach needs to be developed and implemented to support engagement being effortless and part of business as usual. Consistent processes, policies and guidelines for engagement need to be developed.

IMPLEMENTATION APPROACH

Given that this is not a standalone strategy, an integrated approach to implementation has been adopted. A number of issues have been grouped under the general heading of '**Consumer Experience'**. These include:

- Consumer Engagement
- Recognising Consumer Participation
- Patient Experience
- Health Literacy

This grouping aligns exactly with the terms of reference of the recently approved (but yet to be established) Consumer Experience Committee within the new clinical governance structure, and also with the roles and responsibilities of the currently advertised positions of Consumer Experience Manager and Consumer Experience Advisor. With these structures and resources in place, a Consumer Experience Project team is about to be established to develop the required systems, processes, toolkits and champions that will assist and enable them to achieve their desired outcomes, and ultimately influence the desired culture change and improved experience for consumers.

A project brief is currently being developed for the Consumer Experience Project. The prime purpose of the Project is to assist and provide support to the Consumer Experience Committee and dedicated operational staff. Current objectives for the project include:

- Develop and implement a consumer engagement toolkit for the DHB, and make available for the HB health sector
- Strengthen and embed the level of consumer participation in service redesign and improvement initiatives through co-design methodology
- Ensure that consumer feedback is the key driver in improving experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement and how to engage with consumers
- Develop databases and processes for recording and matching service requests for consumer engagement with available and appropriate consumers
- Develop guidelines and procedures for implementing the 'Recognising Consumer Participation' policy
- Develop communication channels for keeping health related community groups informed and engaged in health related developments
- Define specific roles and responsibilities for consumer experience issues
- Develop a preferred patient experience monitoring tool and simplify centralised surveys
- Ensure appropriate IS tools are available to support consumer experience activities and measures
- Further develop 'health literacy' framework, assessment surveys and toolkits
- Champion the goal of a HB 'health literate sector', where health is 'easy to understand'.

- Develop measures of success and relevant monitoring tools and reports.

An update of progress and further details will be provided once the project brief is completed and the project team is established.

PERSON & WHANAU CENTRED CARE

Apart from addressing specific issues included within the scope of 'Consumer Experience' as set out above, it needs to be acknowledged that this is a component of the wider concept of 'Person and Whanau centred Care'. As this concept is being further developed, those involved in Consumer Experience (and therefore Consumer Engagement) will be ideally placed to assist and support this, to ensure that all relevant components are fully integrated and that 'consumers remain at the centre'.

ATTACHMENT Consumer Engagement Strategy.

CONSUMER ENGAGEMENT STRATEGY

EXECUTIVE SUMMARY

Consumer engagement refers to the wide range of approaches in which consumers are involved in the planning, service delivery and evaluation of healthcare. Done well, it contributes to fostering a relationship led culture of person & whānau centred care. It supports active, ongoing partnerships, relationships and communication that benefits consumers, staff and will ultimately transform the system.

This strategy is not a detailed work plan. It provides a clear direction for the future and a framework for making decisions. It provides guidance around types and levels of engagement and the benefits of engaging. The goal being that consumer engagement is embedded in all of the ways we work with consumers and is a key driver for achievement of the 'Triple Aim'.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture', rather than additional work on top of an already demanding workload. It should be linked to other organisational plans and build on existing skills and the work we are already doing. Effective consumer engagement supports the Hawke's Bay Health Sector vision of "*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

PURPOSE

The goal of this strategy is to strengthen and embed consumer participation at all levels in the health sector, ensuring consumers are active partners in their own care and how we design, deliver and improve services. It is a driver for improving experience of care, quality and safety of care, health outcomes and best value. The strategy also exists to build knowledge and educate health sector staff about the value of consumer engagement.

Ultimately, our aim is to create a relationship and values led culture which puts our consumers and their whānau at the centre of everything that we do, and one that is respectful of, and responsive to their needs, preference, and values. Consumer engagement is one enabler of a person & whānau centred culture and this strategy sits alongside others to achieve culture change.

WHAT IS CONSUMER ENGAGEMENT?

Consumer engagement refers to the wide range of strategies in which consumers/whānau are involved in their care planning, service delivery and evaluation of healthcare. It can be at an individual, service, governance or community level. Engagement should always be mana enhancing building strong and sustainable relationships.

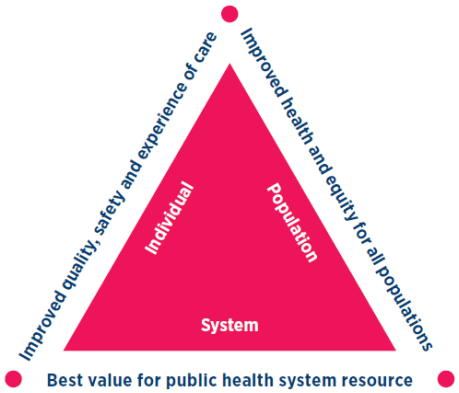
Consumer refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

WHY ENGAGE WITH CONSUMERS?

Consumer engagement done well fosters a culture of person and whānau centred care. It supports active, ongoing partnership, relationships and communication that will benefit consumers, staff and ultimately transform the system.

There is evidence to support the benefits of engaging with consumers. These include improvements, such as reduction in inequities, more responsive services, improved clinical quality outcomes, and improved patient experience. In addition, safer care, less waste, reduced length of stay, lower costs, better consumer and health provider satisfaction and staff retention.

Consumer Engagement supports the New Zealand Triple Aim framework (right) for quality improvement at individual, population and system levels. One of its aims is improved health and equity for all populations. Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Health inequities exist in some parts of our community. Successful consumer engagement will focus on how to be effective within this broader context.



Without proactive consumer engagement, the drive for change is usually either motivated through system failures (e.g. adverse events) or from external advocacy to improve the quality and safety of care. Waiting until there is a problem creates avoidable costs for consumers (physical, psychological and economic) and organisations (review processes, staff morale and more expensive treatments).

HOW DO WE ENGAGE?

Engaging with consumers can and should happen at different levels depending on the situation, and as early as possible. How we engage will be determined by the purpose, timeframes and level of impact of different projects, initiatives or programmes of work. Many will require multiple engagement methods at multiple levels.

Principles of engagement

The principles of partnership, participation and protection underpin the involvement of maori and the wider community. In addition to these core principles there are a number of other guiding principles in relation to effectively embedding consumer engagement at all levels alongside the shared values and behaviours of our sector.

These are:

1. **Being open and honest -** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. **Providing support -** Support for consumer engagement means being welcoming when meeting consumers, valuing their expertise, considering their cultural needs and acknowledging and taking their viewpoints seriously.

3. **Being real -** Consumers and providers know when we are simply going through the motions of consulting with consumers. Consumer engagement needs to be genuine. All parties should know the purpose of why engagement is taking place and real possibilities for change and improvement.

4. **Patient and whānau focus -** All consumer engagement needs to keep the focus on patient and whānau centred care. It is important that providers and staff are supported to maintain their focus on patient/family/whānau as a core aspect of care.

5. **Making health easy to understand** – all engagement needs to done in a way that meets the needs of the consumer, is easy to understand and so that they can contribute as an active partner in the engagement.

6. **Culturally appropriate:** - all engagement needs to meet the needs, values and be culturally appropriate to the consumer.

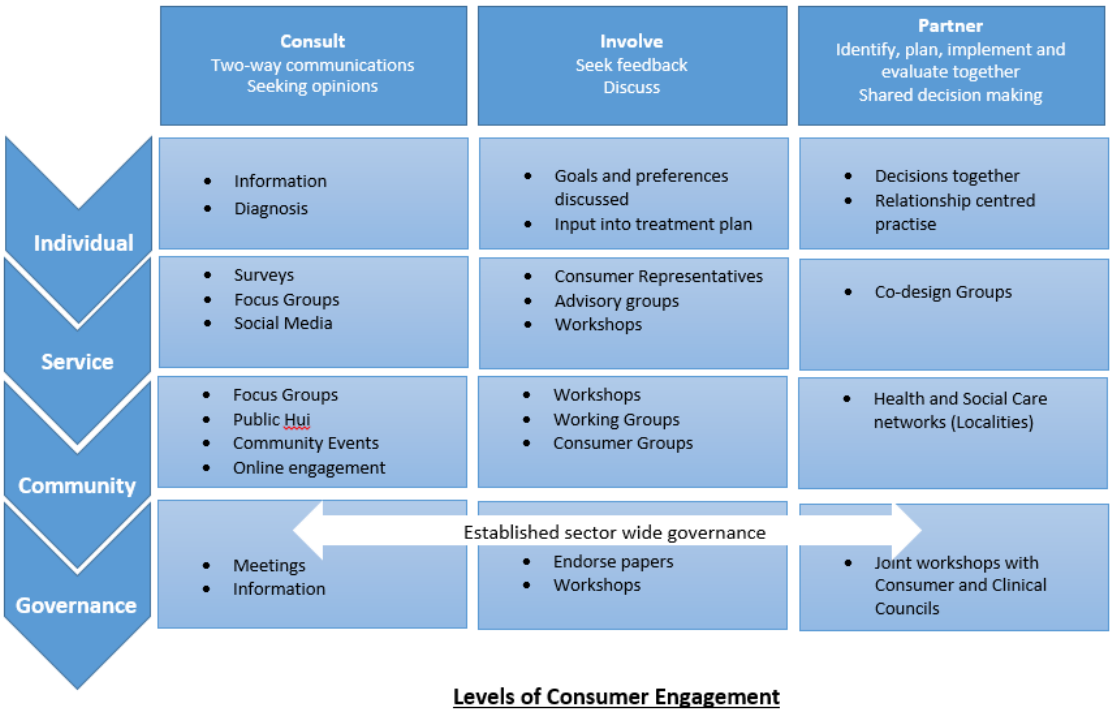
Levels of engagement

Individual engagement includes consulting, involving and partnering with consumers in shared decision making about their own health. Put another way – *" 'my say' in decisions about my own care and treatment".* It is easy to see and value the role of consumers at an individual level – engaging in and contributing to decisions about their own care, or that of loved ones. This is covered in more detail within the work being undertaken in the making health easy to understand framework, engaging effectively with Māori, and relationship centred practice training.

Collective engagement includes collaborating, involving and partnering with individuals or groups of consumers at a service, community or governance level. Put another way – *" 'my' or 'our say' in decisions about planning, design and delivery of services".*

As seen in the below diagram, consumers can be engaged collectively in various ways, at multiple levels including:

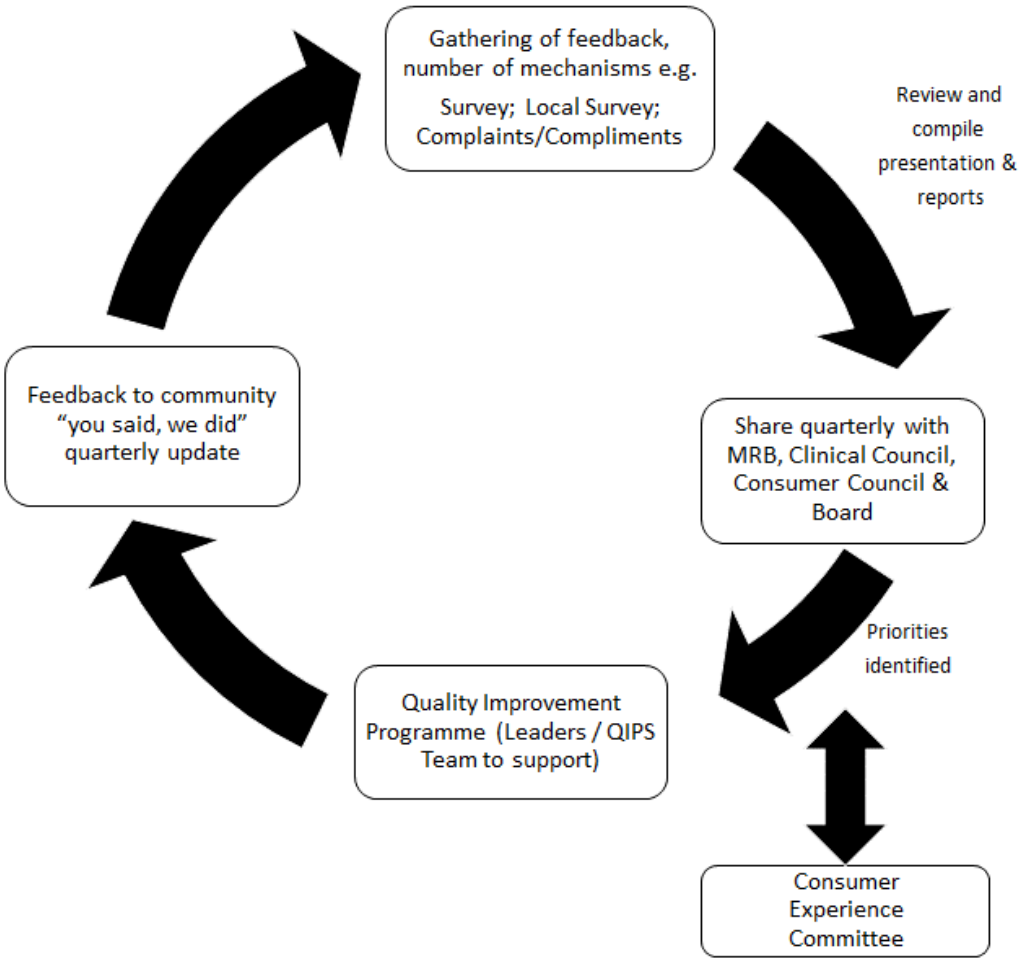
- As partners when redesigning services through co-design groups
- As members of committees, advisory and governance groups
- Through workshops, working groups, steering groups, focus groups and public hui's
- Through consumer and patient experience surveys and feedback mechanisms
- Involvement in consumer interviews, patient stories, patient journey mapping



Levels of Consumer Engagement

UTILISING CONSUMER FEEDBACK

One form of engagement with consumers relates to feedback that we receive through various formats, including complaints, patient experience surveys, focus groups and hui's. To ensure that this is effectively used to support system design improvements and changes the following process will be followed:



LINKS TO OTHER STRATEGIES

It is important to acknowledge other strategies and frameworks that link to the implementation of this strategy:

- The Quality Improvement and Safety framework "Working in Partnership for Quality Healthcare in Hawke's Bay" (2013) outlines priorities that support consumer engagement in Hawke's Bay.

- Patients and Whānau at the centre and services developed around the needs of our patients is a core principle of Hawke's Bay Health System – Transform and Sustain 2013 – 2018

- Youth involvement is a core principle of The Youth Health Strategy 2016 – 2019 in building health system resiliency through youth participation in governance, leadership, design and delivery of work.

- The Mai Māori health strategy focuses on engaging better with whānau and responding to the needs of Māori in the way they prefer services and care.

- The Pasifika Health Action Plan 2014 – 2018 supports a collaborative approach with pacific communities.

- Significant consumer input will be required to make a 'health literate sector' a reality.

- The People Strategy will address the development of a culture for the health sector that will need to include respecting and communicating effectively with consumers

- The development of Health and Social Care Localities includes significant requirements to consult with and engage local communities in decision making.

HAWKE'S BAY District Health Board Whakawāteatia	**HB Health Sector Leadership Forum**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, and HB Health Consumer Council**
Document Owner & Author:	Ken Foote, Company Secretary
Reviewed by	Executive Management Team and HBDHB Board
Month:	May 2018
Consideration:	For Information

RECOMMENDATION

That Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, and HB Health Consumer Council

1. **Note** the draft Terms of Reference for the Hawke's Bay Heatlh Sector Leadership Forum – Leadership Group approved by the Board at their April Meeting
2. **Note** the summary of previous Leadership Forum workshops

Following discussion on the Outcome Notes of the most recent Leadership Forum Workshop held on 7 March 2018, at the March Board meeting the Board requested:

- That the draft Terms of Reference for the proposed Forum Leadership Group be provided to the April Board meeting for consideration.
- That details of past Forum Workshops be updated and provided to the Board at the April meeting for information.

The draft Terms of Reference and workshop summary are attached, as requested.

The draft Leadership Group Terms of Reference have been circulated to the proposed members for comment. All responses received to date have been positive and supportive.

D R A F T
TERMS OF REFERENCE

Hawke's Bay Health Sector Leadership Forum – Leadership Group

March 2018

Purpose	To promote and lead the development and implementation of strategies and initiatives discussed and generally agreed at Leadership Forum Workshops.
Functions	• To promote and support change and innovation generally agreed by the Leadership Forum • To deal with barriers and obstructions to necessary and agreed change • To oversee, coordinate, encourage and monitor progress and performance on agreed actions, between Leadership Forum Workshops • To agree the theme, objectives and general programme for future Forum Workshops, to ensure accountability and maintenance of momentum.
Level of Authority	• To recommend development and implementation of agreed actions, and to address consequential issues, within the direction provided and level of authority and influence held by the Leadership Forum. • Has no formal authority to make decisions that will bind HBDHB or Health Hawke's Bay (HHB), unless such specific authority has been delegated to it.
Membership	Members shall be: • HBDHB Chair • HHB Ltd Chair • Clinical Council Co-Chair (one only) • Consumer Council Chair • Māori Relationship Board Chair • Pasifika Health Leadership Group Chair • HBDHB CEO Alternates may be appointed with full speaking and voting rights, should any named member not be able to attend any meeting of the Group. Consistency and continuity of representation / membership needs to be considered in the appointment of alternates.

Accountability	• All members will remain accountable to their own governance structures, but at times will be expected to exercise discretion and implied delegated authority to decide on issues without reference back to their respective organisations. • The Leadership Group as a whole, will be held to account by the Leadership Forum, for their actions and progress achieved.
Chair	• The Chair shall be the HBDHB Chair • The Deputy Chair shall be the HHB Ltd Chair
Quorum	• The quorum for any meeting / conference shall be five members or alternates, two of whom must be the Chairs of the HBDHB and HHB Ltd (or alternates).
Meetings	• The Group shall meet as required, but no less than twice during the six month interval between Forum Workshops. • Meeting may be conducted by members being physically present in the same room and/or otherwise connected in such a way that they are able to hear each other and participate in the discussion. • Matters arising between meetings may be discussed and resolved via email.
Support	• The Group will be supported as appropriate by the HBDHB Executive Director Primary Care, Company Secretary & General Manager Maori Health, and the HHB Ltd General Manager. • Minutes of any meeting shall be circulated to all members within one week of the meeting taking place.
Reporting	• An update report on Group actions and progress shall be sent to each of the Leadership Forum member organisations soon after each Group meeting. • It is expected that such report will be placed on the relevant agendas of each member organisation'snext meeting, for information / discussion / endorsement as appropriate.

HAWKE'S BAY HEALTH SECTOR LEADERSHIP FORUM
WORKSHOP SUMMARY

October 2011 to March 2018

Date	Aim / Theme	Objectives / Expected Outcomes
5 October 2011 ***Ormlie Lodge***	• To develop and consolidate a common purpose across leadership group of the health sector to which all are committed. • To make progress in relation to key strategic objectives	• A common understanding about where we are as a sector • An agreed narrative which describes the journey we are on as a sector and how we will work together to achieve the agreed goals • An agreed process for developing a vision and values for the sector • A common understanding about a strategic direction and the work that needs to be done to deliver.
15 February 2012 ***Te Aranga Marae***	• To involve key stakeholders in the development of a Strategic Plan and the 2012/13 Annual Plan for the Hawke's Bay Health Sector.	• To take stock of the outcome of the last leadership group workshop • To reflect on progress to date (including the draft Strategic Framework) • To further develop HB Health Sector Vision and values • To review progress on the development of an Integrated Community Health Service for HB • To continue to build relationships and trust within this key leadership group • To discuss and agree key 'investment' and 'disinvestment' priorities for 2012/13.
5 September 2012 ***Havelock North Community Centre***	• Reducing Health Disparities – how we can make better progress. • To develop a prioritised set of strategies and actions that will significantly reduce the levels of health disparities in the Hawke's Bay population in both the short and longer terms.	• To gain / ensure a common understanding on the contributing factors, levels and implications of existing disparities • To learn/clarify respective roles and responsibilities in reducing disparities • To discuss and agree who and how disparities can best be addressed. • To gain a collective commitment to implement respective strategies and actions • To agree how we will measure success.

Date	Aim / Theme	Objectives / Expected Outcomes
3 April 2013 ***Pukemokomoki Marae***	• The Challenge Ahead – Need for Sustainability and Transformation • To develop a common understanding of the challenges facing the health sector in Hawke's Bay in 2013/14 and beyond.	• To provide feedback on the priorities agreed at the last forum. • To ensure there is a common understanding of service and financial challenges facing the HB health sector • To discuss and agree strategically how these challenges can be met. • To discuss and agree respective roles and responsibilities in progressing the changes required. • To gain collective commitment to work together to develop a more detailed 'Hawke's Bay Health Sector Plan' for Sustainability and Transformation' incorporating specific strategies, actions and responsibilities and timeframes.
23 October 2013 ***Napier Sailing Club***	• Transform and Sustain – the next five years for the Hawke's Bay Health System • To further commit to the development and implementation of Transform and Sustain as the strategic direction for the Hawke's Bay Health System over the next five years.	• To enhance collective leadership commitment to the 'One Health System' concept for Hawke's Bay • To review the context, background, development and implementation of Transform and Sustain to date. • To identify new areas for future development • To discuss and agree respective roles, responsibilities and relationships in progressing the changes required. • To discuss and agree key components of significant enabling strategies: - Organisational development - Quality and Safety Strategies.
19 February 2014 **Havelock North Community Centre**	• Strategic Alignment and programme planning for 2014/15	• To gain clarity and consensus about the alignment of current national, regional and local strategies and policies in respect of planning priorities for 2014/15, including issues, challenges, opportunities and decision making processes. • To highlight key programmes to give sector leadership some detail of progress and to seek advice and consensus on key objectives and activities for 2014/15.
15 October 2014 ***Te Taiwhenua o Heretaunga***	• Equity and Wellbeing • Focus on these two key components of the HB Health Sector vision.	• To look at Equity and Wellbeing through a Māori / Pacific, to identify / agree a prioritised set of key strategies and actions that will achieve the greatest levels of improvement, both short term and long term.

Date	Aim / Theme	Objectives / Expected Outcomes
22 April 2015 ***Napier Sailing Club***	• Accelerating Action to Make a Difference	• To provide an opportunity for all participating in Hawke's Bay health sector governance to reflect on progress to date against key strategic priorities and towards the achievement of the HB Health Sector Vision.
7 October 2015 ***Cheval Lounge***	• Integration and the development of primary care in Hawke's Bay	• To discuss the development of primary care in Hawke's Bay • To review a concept proposal to bring the Primary and Community Health Care Strategic Framework to life. • To discuss how to effectively involve community providers, the broader community and specific customers in development.
17 May 2016 ***Waipatu Marae***	• Update and refresh Transform & Sustain.	• To review and note the implications of the new national health strategy • To consider and develop revised / updated strategic priorities within Transform and Sustain. • To discuss and agree key actions and enablers to making progress.
15 March 2017 ***Cheval Lounge***	• Integrating and improving the performance of the HB Health system. • To achieve priority outcomes.	• To identify what matters in terms of performance of the health system to the leadership group • To update the leadership group and receive feedback on: - The work we are doing to put in place a culture that is consistent with our values across the health system which will stimulate innovation - The progress we have made on integration and what our next steps are - Multiagency working - where we are and where we are going? - Social Inclusion Strategy • To introduce Anne Speden, our new CIO, and to hear her first thoughts on key opportunities across the health system.

Date	Aim / Theme	Objectives / Expected Outcomes
6 September 2017 ***East Pier***	• The future of health services in Hawke's Bay • Refine current thinking, planning and actions.	• To review and clarify the background to the three big issues, and how they all fit together and align • To introduce Chris Ash, HBDHB Executive Director Primary Care. • To provide an update and receive feedback on the goals, timelines and processes for the development of the Clinical Services Plan and the People Strategy • To update progress on wider integration issues: - HB Health Alliance • To present and discuss primary care integration issues / options: - Nuka model (including feedback from MRB) - International developments - Kings Fund
7 March 2018 ***Napier Sailing Club***	• Changing the way we do things • To review, discuss and agree on some fundamental changes we need to make.	• To review and discuss the '2017 NKII Delegation' perspective on the **NUKA** approach • Discuss and agree what we in Hawkes Bay can learn and apply from this. • To review and discuss key findings from recent feedback processes (Big Listen, CSP Patient Journey Workshops & Korero Mai) and their relevance to **CULTURE CHANGE** • To identify and discus key themes that will contribute to **CULTURE CHANGE** • To consider and agree where and what the focus should be in the redesign and modernisation of **PRIMARY CARE** • To commence a discussion on how we address **EQUITY** as a sector and build it in to everything we do.

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council and HB Health Consumer Council**
Document Owner	Sharon Mason, Executive Director Provider Services
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Phil Moore (Clinical Lead) and the Executive Managment Team
Month/Year	May 2018
Purpose	The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Best Start Plan's delivery.
Previous Consideration Discussions	Reported six monthly.
Summary	Work delivered is part of the Best Start Plan that includes; supporting healthy eating environments, delivers prevention programmes, provides intervention pathways and supports health leadership in healthy weight. In the last six months we have worked on the final Healthy Conversation Tool for health professional working with 3 and 4-year olds, delivering increased referral places lifestyle programmes for whānau with under 5s and maintaining the effective programme delivered under this Plan.
Contribution to Goals and Strategic Implications	Health equity – Healthy weight is the second highest contributor to wellbeing. Transform and Sustain – increasing focus on prevention. Improving health outcomes for Māori and Pasifika peoples.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika.
Consumer Engagement	Delivered by the Best Start: Healthy Eating and Activity Plan Development and Delivery
Other Consultation /Involvement	Ongoing - as part of all delivery and programme development.
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Will launch the new webpage and "Water Only" kit for schools.

RECOMMENDATION:

It is recommended that the Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and Pasifika Health Leadership Team:

1. **Note** the content of the report.
2. **Endorse** the next step recommendations.

19

HAWKE'S BAY
District Health Board
Whakawāteatia

Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy

Author(s):	Shari Tidswell,
Designations:	Intersector Development Manager
Date:	**May 2018**

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawaiora performance programme and nationally through the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for work.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix One provides further detail of the progress on the Plan's activities to date.

1) ***Increasing healthy eating and activity environments***

The work undertaken with early childhood providers identified steps to support healthy weight practises. Sector representatives continue to be engaged in developing resources and creating changes in this setting. An education sector web page is under development and will provide easy access to the resources for early childhood services and schools. Planning has commenced with the Heart Foundation to support the delivery of the Healthy Heart Programme.

HBDHB have worked with Sport Hawke's Bay to support healthy weight environments in sport clubs and codes, including encouraging water only and having no treat foods. Sport Hawke's Bay now have a Healthy Clubs Coordinator to work with clubs to implement their aspirations in supporting the health and wellbeing of children and whānau.

In HBDHB secondary services, the Paediatric ward have gone "water only" – this included staff training, promotional activities and supporting ongoing implementation. This is great role modelling for children and whānau around wellbeing.

2) ***Develop and deliver prevention programmes***

Programmes are now at the embedding stage with key messages going to wāhine and whānau during pregnancy; via Mama Aroha – messaging is consistently provided to new parents/whānau; Healthy First Foods programme is part of Well Child Tamariki Ora and Plunket services; Healthy Conversation and BESMARTER Tools are used by health

professionals engaging with 2-4 year olds and "Water is the Best Drink" messaging is consistently being used from 2 to 10 years.

3) ***Intervention to support children to have healthy weight***
HBDHB met the Raising Healthy Kids target six months earlier than the target date and has now achieved 98% of children identified at a B4 School Check in the 98th percentile weight being referred to a primary care assessment. Further supportive pathways and tools have been developed to support whānau to make lifestyle changes which support healthy weight. This includes Active Families Under Five and the BESMARTER goal setting tool.

4) ***Provide leadership in healthy eating***
The HBDHB continues to provide leadership across sectors to provide advice and support to implement healthy weight programmes, activities and sharing of information.

HBDHB have contributed to training events for primary care, early childhood services and HB Community Fitness Trust.

Hastings District Council has led the way by making all their facilities sugar sweetened beverage free.

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

Obesity is the second leading risk to population health outcomes in Hawke's Bay. Medium and long-term costs of not addressing obesity are very high, as obesity leads to a range of diseases with high health sector costs. A third of our adult population are obese; 48% and 68% for Māori and Pacific adult populations respectively. Childhood weight is a significant influence for adult weight and changing behaviours to increase healthy weight are more effective during childhood years.

The national target (Raising Healthy Kids) has been in place for 18 months and Hawke's Bay performs well in our consistent achievement of this target. Alongside this work is a national group who are evaluating the work delivered as part of the target. This will include investigating a second measurement point for BMI in children and collating the evaluations completed in each DHB. Progress has been slow to date and the HBDHB Best Start Advisory Group has supported HBDHB developing a measurement of 8-year olds in the school setting (see attached short report).

HB Community Fitness Trust held an event to celebrate the beginning of the building process at the HB Sports Park – this is stage one of this facility. HBDHB have been activity supporting the development within Flaxmere primary schools and early childhood providers, including liaising with the research team working alongside the programme.

NEXT STEPS

1. Establish a working group to set up a BMI measurement for 8-year olds, which will provide whānau referrals for obese children, resources for whānau and support for schools.

2. Address the identified need for a nutrition and physical activity advice/resource for early childhood education. This will reinforce key messages whānau receive via maternity services, primary care, hauora, Well Child/Plunket and B4 School Checks.

3. Develop primary school tools to support effective healthy weight environments – utilising currently engagement resources, Public Health Nurses, Health Promoting Schools and Population Health Advisor working with community partners such as; MoE East Coast, Hawke's Bay Community Fitness Centre Trust and schools.

4. Develop a pilot to support breastfeeding from 0 to 6-weeks of age to support whānau at home to maintain or re-establish breastfeeding. The pilot aims to build on the success of whanau to continue breastfeeding once they leave the care of Maternity Services.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Develop a pilot programme for in-home support for breastfeeding	Take the recommendations to the Best Start Advisory Group to develop actions for improvement	Jules Arthur/ Shari Tidswell	July 2018
Develop a pilot for monitoring and measuring children at 8-years	Work with the national evaluation group to determine a process/tool to track children identified at B4SC and measure change.	Child Health Team/ Shari Tidswell	November 2018

RECOMMENDATION:

It is recommended that the Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and Pasifika Health Leadership Team:

1. **Note** the contents of the report.
2. **Endorse** the key recommendations.

Appendix One

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

The data we have is improving, there will be a survey completed by June 2018 for all primary schools and data for the school environments has been collected with Auckland University (Informas) and reported.

Activity to deliver objective one				
	What	**How**	**Progress**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going sugar sweeten beverage free at their facilities. • Water only messaging promoted in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. events to provide health messages and supplying water. • Schools project lead has established a working group including PHNs, Health Promoting Schools, Māori Health, and Pasifika Health.	July 2017

Activity to deliver objective one				
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools, • Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• 50% increase in schools with "water only" policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually • All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke's Bay • Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually	• Working group established to design a second survey for primary schools • Presented Healthy Weight Strategy to Hastings and Napier Council. • Food Environment data collection complete and report shared with stakeholders • Best Start Advisory Group has been meeting monthly to support coordination and the development of resources/programmes/project. Includes: Health HB, Child Health, Oral Health, Maori Health, Population Health, Pasifika Health, Paediatrics, Primary Care Directorate. Current work is looking at delivering an 8 year measurement for weight	Reported annually to 2020

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% for total population, 66% Māori and 82% Pasifka (December 2015 Ministry of Health), these show slight increases
- 67.8% of Hawke's Bay four year olds are healthy weight, 62.7% Māori and 55.7% Pasifika (2016 Before School Check data, Health Hawke's Bay), this is 2016 data. Most recent data is obesity data with 13% of Māori, 26% Pasifika and 5.8% other four year old children in the 98th percentile for weight (June –Dec 2017 B4SC)

Actions and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers. Training with Heart Foundation planned for this year. • Training is completed for Tamariki Ora and Plunket staff, LMCs and B4SC nurses. Training plan being delivered for ECEs. • Maternal Nutrition and Physical Activity programme being delivered in Wairoa – great response	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation,	• Active Families contracts in place and delivered by Iron Māori and Sport HB. Tamariki Ora and Plunket staff trained and delivering Healthy First Foods programmes.	Reported annually until 2020

Actions and Stakeholders				
	support B4 School Check providers • Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	Healthy First Foods, B4 School Check resources • Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	• Project manager appointed for school programme and working with Kimi Ora School. • Working with early childhood providers to identity resources to support healthy weight messages for whānau and children – expert group set up and reviewed current resources. • Healthy conversation tool implemented and evaluated – this includes BE SMARTER whānau plan, B4 Schools Check nurses • Working group developing the survey for all primary schools and tool to support design and delivery of healthy weight schools.	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI in the 98th percentile

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 119 Hawke's Bay children were identified with BMI in the 98th percentile, of these, 90 accepted a referred to a primary care follow, 2 already in care and 27 declined at referral. 98% Māori, 100% other and 100% Pasifika children received a referral to primary care. (Dec 2017 B4 School Check reported Data - MoH)
- 100 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan. 63 early childhood teaching attended an information session

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target has been met. • Active Families under 5 is funded and DHB has received additional funding from MoH • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training	Annually until 2020

Activities and Stakeholders				
	• Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	• Active Families – delivered by Iron Māori and Sport HB. New contracts in place from Oct 2017. • Clinical pathway for B4 School Check complete. Working with diabetes pathway • Training in healthy conversation completed in 2016. Delivered the Healthy Food conversation tool 2017. Complete.	

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Auckland University review of the policy has HBDHB ranked 3rd most effective policy for DHBs. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB. Intersector Group has been established

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website. Communication Plan developed to increase awareness • Policy complete	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • Shared Healthy Eating Strategy with Intersectorial Forum – Intersector Group	Ongoing until 2020

Activities and Stakeholders				
	• Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	establish and setting out leadership activities • Messaging is “water is the best drink” and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and promoted water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff), available on DHB website. • Partner agencies have delivered policies – HDC has “no fizzy” at the venues, Sport HB is working clubs and code to implement “water is the best drink” and healthy food options.	

Appendix Two

DRAFT
SECOND MEASUREMENT POINT FOR CHILD WEIGHT

PURPOSE

1. To provide a recommendation for a second weight measurement point for Hawke's Bay children.
2. To monitor the impact of key interventions designed to increase childhood healthy weight.

BACKGROUND

Hawke's Bay District Health Board (Hawke's Bay DHB) developed a Healthy Weight Strategy and Best Start Plan to direct and coordinate the activity supporting population increases in healthy weight for Hawkes's Bay. These documents are based on evidence (both local and international) that illustrated how early intervention, environmental changes and a range of approaches (settings, whānau programmes, screening and leadership) have the greatest impact.

The National Obesity Plan was developed (2015) and a national target implemented in (2016) by Ministry of Health. This Plan is currently being reviewed that will now better reflect the evidence. The national target – Raising Healthy Kids, is:

> *"By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions." Obese children are defined as being 98th percentile and above for BMI.*

This target measures the delivery of services to obese four year old children and their whānau. To show the impact of this activity and other activities included in the Best Start Plan, an additional measurement point is required.

The weight data collected at the B4SC provides a national and regional population measurement point for four year old children, which can show over time, the impact of the activities delivered from conception to 4-years. In Hawke's Bay, 98% of children complete a B4SC and the data is collected by nurses and is monitored so provides data that is reliable and representative.

INTRODUCTION

This report will cover the following questions:

- What measure is used? Includes BMI, waist measurement and skin folds. These are regarded as the most effective weight measurement for children.
- Which age provides the most effective point for measurement for Hawke's Bay? Assessed using the following criteria – accessibility to a health professional (including reducing impact/harm for children), age prevalence of obesity, effective measurement point for population change.
- Who collects the weight data, where is the data stored and how is it used?
- How will data be collected? Population coverage – targeted groups, opportunistic versus screening approaches and which setting. To include; data collection risk and costs, consent, privacy, psychosocial risks, obligation to intervene and financial costs.

THE MEASURES

There are three measures that effectively quantify obesity; BMI. waist measurement and skin folds. Below is a comparison table.

Table 1

Measure	Effectiveness	Current use in NZ	Comparison
Waist measurement	• Generally seen as an effective anthrometric measure. • Publications (Elaine Rush) have been rigorously reviewed.	• Used for 10 years. • Project Energise Measuring impact	No opportunity to compare data in Hawke's Bay
Skin fold measures	Effective in establish fat levels	Technical process and interpreting. Not widely used.	No opportunity to compare data in Hawke's Bay
BMI	• More widely used measures provides a good population measure. • International data provides pattern for weight gain and obesity.	• Used in the B4SC • Limitation is providing information on individuals i.e. risk – does not measure the level of 'fat'. • There have been challenges in terms of relevance for Māori and Pasifika	Will provide an efficient comparison to measure change over time

(MoH – https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-tauwehe-tupono-me-te-marumaru-risk-and-protective-factors/body-size)

As noted in Table 1, BMI is the best measure for comparing data in Hawke's Bay and as a population indicator, to measure impact of Best Start activity. If we wish to use this as the screening tool there will need to be a clinical judgement made on the category and the need for referrals.

Recommendation

- Use BMI as the measure.

THE AGE GROUPS

There are three points to consider:

1. Timing in relation to the B4SC (at 4-years) - how long will it take for lifestyle changes to have an impact?
2. Developmental trends in growth - when are children more likely to be obese?
3. Interaction with a health professional - what systematic health checks/activity could support measuring BMI?

4-6 years

There is a comprehensive measure for 4-year olds (B4SC). Children require time to grow into their weight and embed lifestyle changes. International data indicates a low prevalence of obesity.
There is one scheduled check – oral health.

7-9 years

No current measure for this group. The interventions from 4-years onward should be having an effect. The prevalence of obesity would be higher so should be able to measure change.
There is one scheduled check – oral health.

10-12 years
There is no current measure for this age group, however young people in low decile schools are screened a 12-13-years via the HEADSS assessment. International evidence notes little ability to influence behaviour change or reduce obesity from 10-years onward. Prevalence of obesity is higher.
There are two checks - oral health and immunisation.

In summary, data is collated at 4-years and 12-13-years. Older age groups have a higher prevalence of obesity. 7-9-years have high levels of engagement in school. Oral health is the only consistent scheduled health check.

Recommendation
- Measure at 8-years which will allow three measurement points, but requires the implementation of a new programme.

WHO AND WHERE BMI IS COLLECTED?
Critical factors are clinical competence, ability to manage psychosocial impact, provide privacy and be able to support individuals/whānau with lifestyle changes and referrals.

There are two settings with eight year old children enrolment – schools and primary care. Given the above criteria, the person carrying out the BMI measure should be a health professional, as it is their professional conduct that will; ensure competence, understand psychosocial issues and provide a need for privacy and support.

The literature identifies schools as the most effective setting as programmes delivered in schools demonstrate high levels of participation – Rheumatic Fever Throat Swabbing, HEADSS assessments and immunisation. Primary care would provide opportunistic measurement and screening and can provide better tracking of individual weight patterns over time. Primary care also deliver the B4SC, however this is a funded programme within a national support structure.

Recommendation
- A health professional (e.g. dental nurse, public health nurse or school nurse) employed and delivering in a school setting. Work toward the individual's information going to primary care as part of the process.

HOW BMI IS COLLECTED?
To effectively implement a population-based measure the programme needs to:
- Engage schools - be a mutually beneficial programme
- Engage health professionals – include training and ongoing development. Have linked to primary care.
- Establish consent from child and whānau
- Have a programme to support and deliver – include measuring resources, conversation tool, information for child and whānau, referral pathways and school activities
- Database to collect the information and protocols for monitoring, analysing and reporting the data.
- Identify the resources to support both the screening programme and the data analysis.

Opportunistic screening will not provide the population level data needed. Universal screening or measuring will require a high level of resource investment. The middle ground is alignment with the 12-13-year old HEADSS assessment by focussing on high deprivation communities. High deprivation schools have access to a school nursing service, Public Health Nurses and Health Promoting Schools. There is the potential to look at include measuring as part of this delivery. Prevalence of obesity rates are higher in high deprivation communities (which have higher proportions of Māori and Pasifika living in them).

Currently interventions have been targeted at high deprivation communities. Screening or measuring in school in high deprivation communities will effectively measure the impact of interventions.

Developing a programme provides the structure to ensure effective measurement and the opportunity to provide individual follow-up to respond to overweight and obese children via education or referrals to programmes which support lifestyle changes. It also mean population data can be used at the schools level to inform practise.

OVERALL RECOMMENDATION

BMI measurement for children aged 4-years, 8-years and 13-years be collected via existing screening programmes (B4SC and HEADSS) and the implementation of a new school based programme for 8-year olds in high deprivation communities.

This would

- Limit increases to workloads and maximise the current data
- Target the most likely groups to have high obesity
- Provide data comparison opportunities including change over time for age groups and impact of population healthy weight activities
- Allow the Health Survey to be used that will provide cross-reference data and a way to look at equity
- Provide opportunities to further promote healthy weight activities in schools by sharing data, providing resources and supporting school outcomes.

NEXT STEPS

- Investigate delivery options and resourcing
- Establish a working group to develop the process, supporting documents and training
- Engage with schools to gain support via understanding and mutual benefit
- Deliver a trial in term four 2018, review and plan for 2019 roll out
- Roll out programme term two 2019
- Begin analysis of data in September 2019

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER 3 DASHBOARD

Late Paper

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Wakawaiora: Improving FSA Access Local indicator (historically referred to as "Did Not Attend")**
	For the attention of: **Executive Management Team, Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Sharon Mason (Executive Director of Provider Services)
Document Author(s)	Carleine Receveur (Operations Director); Jacqui Mabin (Administration Manager); Justin Nguma (Senior Health and Social Policy Advisor) and Taina Puketapu (Kaitakawaenga)
Reviewed by	Health Leadership Team
Month/Year	May, 2018
Purpose	Discussion for Monitoring
Previous Consideration Discussions	As per scheduled Te Ara Wakawairoa reporting and discussions
Contribution to Goals and Strategic Implications	Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board.
Impact on Reducing Inequities/Disparities	The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions
Financial/Budget Impact	Business As Usual

RECOMMENDATION:

That the Executive Management Team, Māori i Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board:

1. **Note** the contents of this report, specifically:
    - The current performance of this target
    - Review of activities to support access for First Specialist Assessments
    - Recommendations

Te Ara Wakawaiora: Improving FSA Access Local indicator

Authors:	Carleine Receveur (Operations Director); Jacqui Mabin (Administration Manager) Justin Nguma (Senior Health and Social Policy Advisor) and Tania Puketapu (Kaitakawaenga)
Date:	**May 2018**

OVERVIEW

Following concerns from the National Māori General Managers (Tumu Whakarae) about the slow pace of progress on some indicators in reducing health disparities for Māori, the Hawke's Bay DHB Executive Management Team (EMT) decided to establish a championship role in 2013 for each of the indicators to spur faster traction on implementation. The Champions were tasked to provide the Board with a monthly Te Ara Whakawaiora (TAW) exceptions based report drawn from AMHP quarterly reporting highlighting the implementation progress on these indicators along with recommendations for improvement towards achievement of the annual targets and reducing health disparities. This report is from Sharon Mason, Champion for Improving FSA Access Indicator.

MĀORI HEALTH PLAN INDICATOR: Improving FSA Access

Historically Māori and Pacific people have endured lower access rates to First Specialist Assessments (FSAs) compared to other people in Hawke's Bay. This is a result of missing their FSAs. Did not attend (DNA) is a label that has been used to describe this behaviour irrespective of the circumstances in which it takes place. This label has raised concerns over the years because of the negative connotation often associated with it. Improving FSA Access has now been accepted as a new name for this indicator because in actual fact this indicator is about accessibility to health advice and or treatment services. The rates of DNA will still continue to be used as a measure of accessibility to FSAs. The higher the DNA rates the poor the levels of accessibility to FSAs.
Apparently the DNA rates for Māori and Pacific people are 3-4 times higher than those of other people in Hawke's Bay therefore they are not gaining the benefit of timely health advice and or treatment.
The indicator target for FSA DNA rate of <7.5% was introduced into the 2014 – 15 Annual Māori Health Plan (AMHP), with specific actions to implement a DNA project across all ESPI FSA clinics. It is important to note that this indicator is for FSA only, and does not include DNA's for Follow Ups.

The indicator target for FSA DNA rate of <7.5% was introduced into the 2014 – 15 Annual Māori Health Plan (AMHP), with specific actions to implement a DNA project across all ESPI FSA clinics.

It is important to note that this indicator is for FSA only, and does not include DNA's for Follow Ups.

The indicator reports on the ESPI specialties as defined by the Ministry of Health (MoH). These reports provide important information on how well DHB's are managing access to their health services.

The 18 ESPI's included in the DNA report are as follows:

Dental, Paediatric Medical, Ear Nose Throat (ENT), General Surgery, Ophthalmology, Orthopaedic Fracture, Urology, Gynaecology, Neurology, Rheumatology, Respiratory Medicine, Renal Medicine, Gastro-Entomology, Maxillo-Facial, Dermatology, General Medicine, Endocrinology and Cardiology.

WHY IS THIS INDICATOR IMPORTANT?

The indicator reflects how well our consumers our accessing services for treatment across the elective pathway at the HBDHB. Low DNA rates across all populations signify an equitable health care system that has good access for all, and ensures consumers are benefiting equally from timely health care advice and treatment. High DNA rates indicate that there are significant barriers preventing consumers from accessing services across the HBDHB, which has a negative impact on the population of Hawkes Bay. Variations in DNA across different groups of consumers in Hawke's Bay signify there are more complex issues to address that are adversely effecting some groups of the population whilst others benefit.

The DNA indicator measures and monitors Māori attendance rates in Outpatient specialist clinics and compares those rates against Pacific and Other populations. This data help us to target areas within our DHB that need more support and engagement to reduce barriers currently preventing the Māori population from accessing health care services.

The DNA rate is indicative of how efficient the elective service are currently operating. An efficient elective service ensures resources are used in the best possible way to ensure equitable health outcomes for all. Reducing DNA rates ensures full clinic and theatre utilisation, and reduced waste within the system.

CHAMPION'S UPDATE

The last TAW paper presented to the EMT, HB Health Consumer Council, and MRB by the Indicator Champion was in June 2015. In this paper the Indicator Champion highlighted a number of initiatives that had been planned and were being implemented to progress the indicator performance. These included the recommendations made in the initial assessment of the DNA problem in 2012[1]: DNA policy referrals; text to remind; the DNA project; and Kaitakawaenga DNA. We would specifically like to highlights the progress of the DNA project here because of its implications to the DNA work streams. Phase two of the DNA project commenced 01 July 2014, targeting the nine specialties with high Māori and Pacific DNA volumes and rates. Since the beginning of 2015, the scope increased to the 18 ESPI's outlined above. The DNA Project Steering Group met in March 2015 and agreed to further extend the project until the end of September 2015. The DNA project focused on the following objectives:

- Develop KPI and reporting systems to support effective tracking of DNA project implementation across the service
- Engage the services of two Kaitakawaenga and equip them with transport support for DNA tracing across the district.
- Review clinic information to identify speciality clinics with high variations in DNA rates for DNA tracing.
- Review and analyse patient journey within elective and out-patients environment to inform system changes that will improve the patient clinic experiences and outcomes.
- Carry out health literacy activities to promote patients and whanau understanding of health implications of DNA and encourage and support their clinic attendance for specialist appointment.

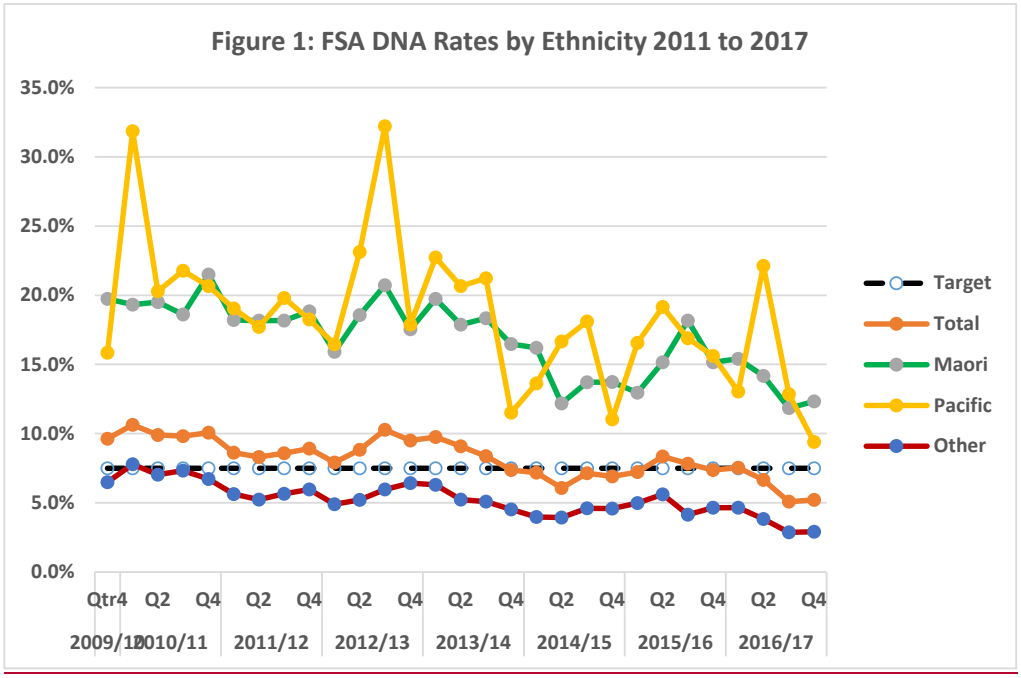
[1] *Paul Malan,A Report on 'Did Not Attend' Rates (DNAs) at Hawke's Bay District Health Board, May 2012*

- Propose and implement system changes including staff education as needed to enhance documentation and confirmation of responsibilities/ ownership for systems that support positive patient journey and minimised DNA.
- Propose systems changes needed for sustainability beyond the project through policy, practice expectations, and related accountabilities for performance monitoring by the Board.

It should be noted here that some of the objectives of the projects have been achieved while others are currently being addressed through collaboration between the Administration and Maori Health Service.

Lessons Learnt from the DNA Project Implementation

As shown in Figure 1, through the proactive role of the DNA project made significant progress in minimizing the DNA rates since its inception in 2013/14 reducing the DNA rates among Maori from 19.7% in Q1 2013/14 to12.2% in Q2 2014/15 and trending towards the target of 7.5% within one year of operation. While the downward trend is encouraging, the disparities between Māori and non-Māori on this indicator continues to remain high which is still a major concern. Nonetheless, the work already done and continues to be done by Kaitakawaenga is to be commended and encouraged for effectively tracing and supporting the 'true' hard to reach patients to attend their FSA and follow up appointments. In the course of implementing this project however, a number of lessons/factors influencing patient behaviour were noted[2]. These are divided into two major categories: health system (i.e. poor communication with patients and whānau, and poor administrative services); and patient/whanau related factors (i.e. never got the mail, forgetting appointments, lack of transport, lack of financial resources, and competing whanau demands).



Source: Ministry of Health.

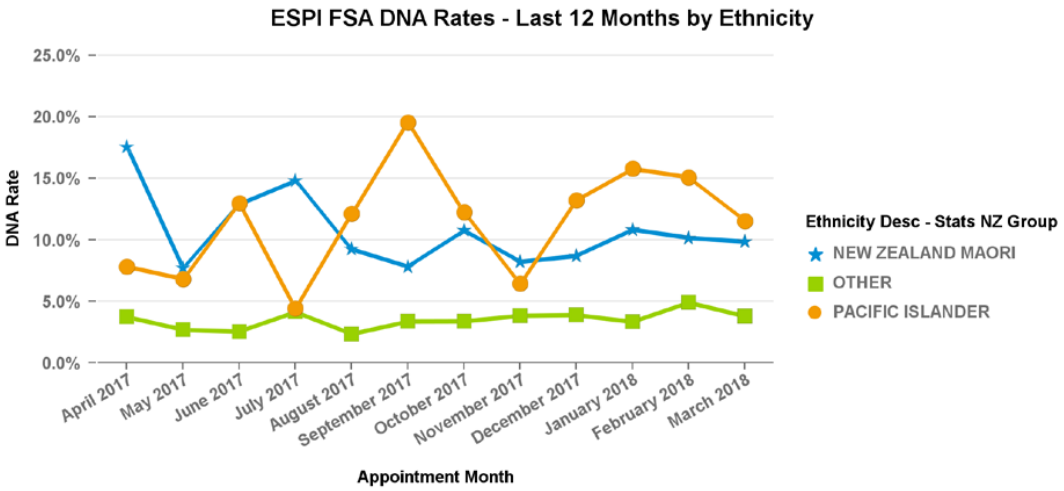
[2]*Nguma, J; Meihana, D; Raihania-White, W; Receveur, C; and Mobin, J: Policy and Health System Implications of the Hawkes Bay District Health Board (HBDHB) DNA Project, A paper presented at the Tu Kaha Conference in Wellington, 2016.*

Current Performance

Over the 2016– 17 period, the organization has made considerable improvement in strengthening communication channels and improving the Administration Services across the service. Strengthening the partnership between the Administration and Māori Health Services, for example, has been instrumental in continued improvement of access to FSA among Māori as shown in Figure 2. The Māori DNA rates now has been hovering around the 10 – 11%. Overall the total DNA is 7.1%, below the target of 7.5%.

Improving technology and clinic scheduling will be vital, along with improving relationships across the health sector to improve understanding of our changing consumer needs. To continue to reduce health disparity between Māori and Other populations, HBDHB needs to continue its shift into a proactive, agile state that can provide better flexibility to accommodate the changing needs of the Hawke's Bay population.

Figure 2 FSA DNA rates by ethnicity



CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

1. Amalgamation of Transform and Sustain projects under DNA project

The key findings from the DNA project identified poor communication with patients /whanau and poor Administration Services as the key areas contributing to the 19% DNA rate among Māori. In 2015 the HBDHB transferred the remaining DNA project work streams across to the Customer Focused Booking Project, as there was a natural alignment of goals.

2. Customer Focused Booking

Customer Focused Booking was introduced across Outpatient Booking over 2016 / 17 period following recognition that standardisation was needed across all ESPI services, and that it was critical to have the customer at the centre of the Booking process. Customer Focused Booking is now business as usual for Administration Services, who are committed towards driving efficiencies and improving communication with the Consumer.

A number of work streams were created to improve engagement and communication with HBDHB's consumers / whanau, including developing proactive processes to avoid DNA. These work streams have all had a positive impact on DNA levels. In 2017 our Māori population has seen DNA levels drop consistently to 10 – 11%. More importantly there are now mechanisms in place to ensure the most vulnerable of our population remain visible, and are not falling through cracks in the system.

A number of initiatives carried out over 2016 / 17 to improve communication and Administration Services included updating desk diaries and standardising process across all booking specialties. Cross training of booking staff was carried out to ensure better cross cover and customer service. Expectations were set with the Booking team that all New Patients must be called prior to Booking FSA, and referred to Kaitakawaenga if patients were Māori and couldn't be contacted prior to their FSA.

Demographic data collection processes were reviewed and updated, with auditing and monitoring processes put in place, and a policy of 'all phones must be answered' was also introduced to ensure confirmations or cancellations were captured, and to ensure consumers were given the opportunity to talk with a person rather than be directed to voicemail.

Regular meetings with staff and Kaitakawaenga ensure a customer focus is retained and a forward looking culture driving for continuous improvement is encouraged as business as usual for the Outpatient Booking staff.

3. DNA Policy

The DNA project highlighted the need to review the DNA policy, as there were inconsistencies among staff regarding the definition of DNA. Following promotion of the current DNA policy, all Booking staff have a uniform understanding of what constitutes a DNA, and record DNA consistently against a patient 'that does not communicate right up until the assessment is due to occur'.

Currently the DNA Policy is a reactive policy not a preventative policy that only comes into effect once a DNA has occurred. Administration Services and Kaitakawaenga have successfully trailed and are using a preventative pathway that now needs to be captured in the DNA policy to make the policy more effective across the HBDHB.

Outpatient Bookers refer Māori patients to Māori Health Services if they cannot be contacted prior to FSA. This allows the Kaitakawaenga an opportunity to engage before a DNA occurs, thus minimising opportunity for DNA, and ensures better utilisation of clinics. There is now a strong working partnership between Booking and Kaitakawaenga as both teams work together to take ownership to improve access to FSA appointments.

4. Text to Remind

Technical enhancements to the text to remind system have helped lead to a reduction in DNA. All clinics managed via the Outpatient Booking Centre issue a minimum of 1 text reminder requesting confirmation of the patient's attendance 72 hours prior to appointment. All bookers are monitoring responses daily and updating patient responses on the Electronic Clinical Application (ECA). This ensures clinics are fully utilised and wasted appointments minimalised.

Text replies to confirm appointments were made free of charge to consumers in 2017, following a change in contract with the HBDHB's telecommunications provider. This removed the barrier of 'lack of credit' on consumers phones, enabling consumers to text responses back to the HBDHB at no cost.

5. Regular review of the Issues Register to improve DNA results

The monthly DNA report is reviewed by the Outpatient Booking team on a monthly basis with Kaitakawaenga. This allows opportunity for all to discuss reasons behind DNA's over the last month, and as a group take ownership around how to avoid the same problem next month. The fact that DNA is a KPI for the Outpatient Booking staff helps to drive Bookers to minimise opportunity for DNA in the future.

6. Demographic Data Collection

Poor demographic data collection has been a major factor behind high DNA. A lack of policy meant a lack of consistency, expectation and guidance on the principles of demographic data collection.

A new guidance policy was created in 2017 that provided HBDHB staff with the guiding principles of best practise when collecting demographic details from patients. Administration staff were all given training on the policy, and are continuously reminded of the importance of checking patient demographics at every opportunity.

Regular monthly auditing of Patient Demographic forms generating from the Emergency Department (ED) and the Outpatient Villas has led to an increase in quality of demographic information now being entered into ECA. Corrective action for staff members who are not accurately capturing demographic information is taken monthly if necessary.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

- **Transition to a purpose built Text to Remind solution.**

Currently the text to remind system is an in-house designed system built onto ECA. It does not have the full technical capacity most text to remind systems have on the market today, and is very labour intensive for the Outpatient Booking team. An automated text to remind system that automatically updates ECA would enable the Outpatient Bookers to more clearly identify those patients who have not confirmed their bookings, and would save the Outpatient Booking team hours of searching and clicking of the mouse to manually confirm clinic appointments.

- **Review the current DNA Policy and promote an orientation towards improving access**

It is now timely to review the DNA policy to reflect the preventative pathway now firmly embedded between Outpatient Booking and Māori Health Services. This will ensure guidance and standardisation across all services at the HBDHB as well as orientating the organisation to a proactive improving access perspective.

- **Implementation of an Elective Pathway Project**

Customer Focused Booking identified a number of issues across the Elective Pathway that prohibited the roll out of the online patient booking system 'uBook'. The system currently experiences issues in relation to rescheduling, constraints in the process to book clinics and theatre lists more than 2 weeks out, and high levels of urgent appointments. Systems improvements are required to enable the implementing of the online patient booking system. This is part of a wider conversation within Health Services, recognising that this body of work is across directorate teams and would require resourcing and prioritisation.

RECOMMENDATIONS FROM TARGET CHAMPION

Key Recommendation	Description	Responsible	Timeframe
Transition to a purpose built Text to Remind solution	Automated text to remind system that automatically updates ECA would enable the Outpatient Bookers to more clearly identify those patients who have not confirmed their bookings,	IS and Administration services	To be confirmed (dependent on IS prioritisation)
Review and update the current DNA Policy	Amend the policy to include an orientation towards improving access to FSA and proactive management	Maori Health and Administration services	Draft completed by Q2 18/19
Implementation of an Elective Pathway Project	Improvement of patient flow	Partnership approach with Surgical, Medical and Operations Directorate	Commence planning Q2 18/19

REPORTS FROM CONSUMER REPRESENTATIVES

Verbal

TOPICS OF INTEREST

MEMBER ISSUES / UPDATES

Verbal