Māori Relationship Board Meeting

Date:	**Wednesday, 9 May 2018**
Meeting:	**9.00am to Noon**
Venue:	**Te Waiora (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Kerri Nuku
Lynlee Aitcheson-Johnson
Trish Giddens
Ana Apatu
Hine Flood
Dr Fiona Cram
Beverly Te Huia

Apologies: Ngahiwi Tomoana

In Attendance:

Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Management Team
Member of Hawke's Bay (HB) Consumer Council
Member of HB Clinical Council
Member of Ngāti Kahungunu Iwi Inc.
Member of Health Hawke's Bay Primary Health Organisation (HHB PHO)
Members of the Māori Health Service
Members of the Public

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

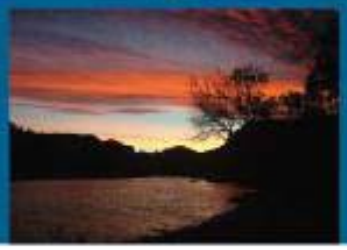
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do



PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	9.00am
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of the Previous Meetings held 11th and 18th April	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2018	
8.	MRB Chair's Report	
9.	General Manager Māori Health Report	
10.	Clinical Council Verbal Update	
	Section 2: Presentations and Discussion	
11.	Clinical Services Plan - Planning for Consultation – Ken Foote	09:45
12.	Maternal Wellbeing Model of Health Presentation – Jules Arthur	10:05
13.	National Bowel Screening Roll-Out Presentation – Lynda Mockett	10:25
	Section 3: For Information only (no presenters)	
14.	HBDHB Performance Framework Exceptions Q3 (Jan-Mar 2018)	10.45
15.	Te Ara Whakawaiora – Improving Access Indicator (local Indicator) *Formerly "Did not Attend"*	10.50
16.	Best Start Healthy Eating & Activity Plan (6 monthly update)	10.55
17.	The Place of Alcohol in Schools - Young people and under-age exposure	11.00
18.	HB Health Sector Leadership Forum Report	11.05
19.	**Section 4: General Business**	11.10
	Karakia Whakamutunga (Closing)	

Māori Relationship Board Interest Register - 24 April 2018

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The HBDHB Chair	28.03.18
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	Treasurer for Ikaroa Rawhiti Maori Party Electorate		No conflict	The Chair	04.07.17
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
	Active	Board member of Hauora Tairawhiti	Relationship with Tairawhiti may have contractural issues.	Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	27.03.17
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective) The U-Turn Trust renamed /rebranded "Whararikí Trust" advised 30-8-17	Relationship and and may be contractural from time to time	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	23.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	23.02.17
Dr Fiona Cram	Active	Board Member, Ahuriri District Health Trust	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare and interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HBDHB.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17
	Active	Director and Shareholder of Katoa Limited	An indigenous research organisation that undertakes research and work for organisations by Maori for Maori.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	11.04.18
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Member Heatlh HB Priority Population Health	Health Advisors		The Chair	1.01.17
	Active	Committee Member, HB Foundation			The Chair	1.01.17
	Active	Committee Member, Children' Holding Foundation			The Chair	1.01.17
	Active	Trustee, Waipukurau Community Marae			The Chair	1.01.17
Beverley TeHuia	Active	Trustee of Kahungunu Health Services	Contracted by DHB to deliver health services	Will declare an interest prior to and will not take part in any discussion or matters relating to the provision of services through Kahungunu Health Services.	The Chair	7.11.17
	Active	Employee of Totara Health	GP Practice providing heatlh services	Perceived conflict	The Chair	7.11.17
	Active	Chairperson of Nga Maia, a Maori Midwifery and Maternity body	Health Advisors		The Chair	7.11.17
	Active	Committee Member of the Priority Population Committee (PPC)	Health Advisors		The Chair	7.11.17

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 11 APRIL 2018, IN TE WAIORA MEETING ROOM, CORPORATE ADMIN BUILDING CNR OF MCLEOD & OMAHU RD, HASTINGS COMMENCING AT 9.00AM

Members:	Heather Skipworth (Deputy Chair) Na Raihania George Mackey Trish Giddens Kerri Nuku Ana Apatu Dr Fiona Cram Hine Flood Beverly Te Huia
Apologies:	Lynlee Aitchenson-Johnson Hine Flood Kevin Atkinson (Board Chair HBDHB) Ngahiwi Tomoana (Chair arriving at 10am)
In Attendance:	Peter Dunkerley (Board Member HBDHB) Chris Ash (Executive Director Primary Care HBDHB) Chris McKenna (Chief Nursing and Midwifery Officer, HBDHB) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Graeme Norton (Previous HBDHB Consumer Council Chair) Kevin Snee (CEO, HBDHB) Sharon Mason (Executive Director, Provider Services) Ngaira Harker (Nursing Director – Māori Health, HBDHB) A member of the Public
Minute Taker:	Casey Duff (MRB Adminstrator/ Administration Coordinator Māori Health HBDHB)

SECTION 1: ROUTINE

1. KARAKIA

Na Raihania opened the meeting with a karakia.

2. WHAKAWHANAUNGATANGA

The Chair welcomed everyone to the meeting today held at Te Waiora Board Room, and asked for a brief mihi from all attendees.

3. APOLOGIES

Apologies were received from Ngahiwi Tomoana who will be arriving at 10am, and Hine Flood, Lynlee Aitchenson-Johnson, Kevin Atkinson, Anita Rarere and Karen Franklin. There were no further apologies received.

Moved: A Apatu
Seconded: T Giddens
CARRIED

4. INTERESTS REGISTER

No MRB members declared any conflict of interest with any agenda items for today's meeting.

Beverly Te Huia to update Interest Register

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB Board meeting held 14 February 2018 were taken as read and confirmed as a correct record.

Moved: A Apatu
Seconded: T Giddens
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES

Appendix 1 – Sir Mason Durie to be changed to Meihana Durie

REVIEW OF ACTIONS

The Action and Progress List as at February 2018 was taken as read.

Update:

2. Nuka Model Wānanga **-** Put forward to another date. Developing final presentation for MRB.

3. Te Ara Whakawaiora: Mental Health

- Report would be submitted in October 2018
- Simon Shaw has stepped down, Anoek Dechering-Raes has taken his place.
- Taken a different approach by splitting Aged and Mental Health. Both sectors have Medical Directors overseeing these services.
- Temporary change of leadership and national review of mental health is holding up the process.
- Working collaboratively with all sectors - Police, Health and Mental health
- Review in **Oct** can formalise mental health services

TAW REPORT ON HOLD - Until Oct 2018

5. Student Report – COMPLETED

6. Review form and function of MRB and Youth representative
Chrissy Hape to review
Action Patrick to follow up with Chrissy

7. Engagement with Māori and community.
Patrick to follow up

8. Te Whiti ki te Uru **–** Na Raihania update:

- Next hui in Oct, cannot achieve anything in a small amount of time.
- ToR is basic
- Description support network for DHB CEs: have bi monthly meetings

7. MRB WORKPLAN 2018

The workplan as at April 2018 was taken as read.

8. MRB CHAIRS REPORT

The Deputy Chairs Report for April 2018 was taken as read.

Moved: B Te huia
Seconded: A Apatu
CARRIED

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for April 2018 was taken as read.

Moved: **T Giddens**
Seconded: **B Te Huia**
CARRIED

Ken Foote (Company Secretary) joined the meeting at 9.30am.

10. CLINICAL COUNCIL UPDATE

A Apatu attended the last two Clinical Council Meetings on behalf of MRB as the stand in for K Nuku. The proposition of developing an Equity Committee was discussed in February 2018. Ana requested MRB provide their view to feedback to the Clinical Council on a standalone committee or an equity lens across all committees, and if the committee should sit with the Clinical Council.

The following feedback was also discussed:

- Explicitly addressing equity
- Possibility of John Gohmans and Andy Phillips presenting for Clinical Governance structure at a MRB meeting.
- Improving Practise Group to implement NUKA Model.
- Deliverance of wellness is key.
- Planning and implementing - no more discussions to be put to MRB

MRB were adamant that there is no need to create another committee but there is a need for a 'third eye'. Therefore an Equity Committee, as a subcommittee of Clinical Council, has little relevance. MRB see themselves as the equity committee, focussing on a "Triple Aim" – People, Quality and Finance. MRB agrees that they should be in partnership with Clinical Council, and would like to set up a NUKA model as the preferred model of care.

SECTION 2: FOR INFORMATION/DISCUSSION

11. CLINICAL SERVICE PLAN UPDATE – Ken Foote

Ken Foote (Company Secretary) provided an update on the Clinical Services Plan (CSP). Overall concepts have not yet been developed it is over the next 5 yrs. CSP is only one framework. July 2018 has been identified as having the Draft plan put together and the Final Plan in September 2018 for consultation, and October 2018 to MRB and Board for adoption. Ken advised MRB to look into the ToR, in regards to identifying how to make changes and utilise ToR, Policies and Procedures to challenge any conflict/inequities.

The following feedback was also discussed:

- Possibility of a Leadership forum to discuss extracting what MRB can from the workshops to show what MRB want and to advance the outcomes.
- 5 year plan should focus on setting up what services to provide and meeting the needs that MRB identify
- Process: Clinical Services needed to meet demand
- Future options for workshops identified are Hospital Services of the future, High Needs and Primary Care
- How does DHB best engage with Māori community.
- MRB involvement should be before draft plan – should MRB be involved in workshops.

- Four themes set – 1. Populations – engagement with grassroots service providers, 2. Social Development, 3. Mental health and 4. Māori consumers & Pacific consumers.
- Why are workshops limited? Awareness are is key.
- More MRB involvement/participation to continuously be involved in decision making. Every stage of the process. Start to finish.
- Women Welfare are grassroots working with vulnerable – should they be involved?
- Clinical service plan is wrong approach – consumer development.
- Steps made so far - Themes are set – workshops are in place – invitation to MRB.
- Where the critique on the services in the workshops are identified – is it going to eliminate equity and meet the equity framework?
- MRB recommend creating response.

RECOMMENDATION

It is recommended that the Māori relationship Board
1. Note the work completed to date
2. HBDHB invite MRB members to the CSP Designing Services for Populations with Unmet Health and Social Needs, provide them with a list of workshop attendees, pre-reading material and workshop agenda/questionnaires

Moved: A Apatu
Seconded: F Cram
CARRIED

ACTION Acting GM Māori Health to send invitation and all related material to MRB members

12. TE ARA WHAKAPIRI (Last Days of Life) – Leigh White & Laurie Te Nahu

Te Ara Whakapiri HB Care Plan and toolkit has been developed locally using the MoH Te Ara Whakapiri Principles and Guidance Tool. During the establishment phases of the MoH Te Ara Whakapiri Principles and Guidance Tool, the tool went through a robust evaluation of independent reviews of models/stocktake of services, literature reviews based on evident practice/summaries of finding from family/whānau survey.

As a result the tool has been designed reflective of the Te Whare Tapa Wha.

MRB identified that the Plan is perfect in relation to effectively engaging with Māori whānau.

RECOMMENDATION

It is recommended that the Māori relationship Board

1. Note the work completed to date
2. Approve and support the work
3. Support for implementation and include into the HBDHB Last days Care Plan and Toolkit

Moved: A Apatu
Seconded: F Cram
CARRIED

13. ESTABLISHING HEALTH & SOCIAL CARE LOCALITIES IN HB – Chris Ash & Jill Garrett

A brief update was provided in regards to Locality Development in the Context of Primary Healthcare Development in Wairoa and Central HB. A commitment has been made to reinvigorate the Alliance Agreement for Hawke's Bay by means of a Primary Care Development Partnership ('PCDP'). As the draft working plan for the PCDP has become clearer, it is increasingly evident that there are a number of crucial intersects with the Localities programme. At present, the programme has focused solely on the establishment of a 'localities approach' in the rural areas of Wairoa and Central Hawke's Bay.

In both existing locality areas the breadth and depth of the work undertaken has been evidently different. This has largely fallen into the domain of three core activities, those being:

- Integration of local provider management arrangements, supported by devolved decision rights for DHB services, with the goal of transformation in the delivery of clinical services
- Progressing and supporting local innovation in support of community health and wellbeing priorities, particularly in the intersectoral sphere
- Promoting an enhanced local dimension to health planning, funding and market development

The following points were raised:

- MRB acknowledged the update on Locality Development in the Context of Primary Healthcare Development in Wairoa and Central HB.
- MRB stressed the needs to widen the networks of providers in the community and the need for intersectoral approaches.
- They also acknowledged the need for system readiness in Wairoa to cope with free primary care, but stressed their frustration with the lack of meaningful progress towards implementing free primary care for whānau in Wairoa.
- Hapu development plans also aligned to localities and DHB were encouraged to link with these

ACTION B Te Huia to follow up with C Ash

RECOMMENDATION:

That the Māori Relationship Board:

1. **Note** the content of the report

Moved: **F Cram**
Seconded: **A Apatu**
CARRIED

14. FRAMEWORK FOR DEVELOPING THE PEOPLE STRATEGY –Kate Coley

Kate Coley provided a brief update of the report and describes the draft framework for The People Strategy which is about sharing and demonstrating the ongoing commitment and aspirations for all of those who work in the DHB and creating and building a culture that meets the needs of staff and consumers.

The following was discussed:

- MRB acknowledged the People Strategy Framework demonstrated the DHB's ongoing commitment and aspirations for all the DHB workforce, that creating and building a culture that investing in the needs of staff will ultimately make a positive impact on patient experience.
- MRB questioned why the DHB HeART values were not used as the foundational values for the people strategy and made the following recommendation:
- That the HBDHB People Strategy Framework uses the HeART Values within the framework under 'Our Values'

Talalelei Taufale (HBDHB Pacific Health, Development Manager) arrived 10.31am

RECOMMENDATION:

That the Māori Relationship Board:

1 **Recommend** the HBDHB People Strategy Framework uses the HeART Values within the framework under 'Our Values'.

Moved: **A Apatu**
Seconded: **T Giddens**
CARRIED

15. MAORI & PASIFIKA WORKFORCE ACTION PLAN – Kate Coley

Kat Coley advised MRB that the Māori and Pacific Workforce Action Plan aim is to improve the ethnic diversity of our workforce and improve the cultural competency of our staff and organization. HBDHB value and acknowledge the ethnic diversity of our community and the ethnic diversity of our workforce. We aim to ensure our staff and organisation reflect the community which we serve, in particular the growing Māori and Pacific populations.

The following points were identified:

- MRB acknowledged the Māori and Pacific Workforce Action Plan and that it was important to have a workforce that reflected the community and the important focus required by HBDHB to meet the workforce composition and cultural competency KPIs.

- MRB had a lengthy discussion about the merits of a a combined Māori and Pacific Workforce Action Plan. They preferred individual plans for Māori and Pacific and made the following recommendation:

RECOMMENDATION:

That the Māori Relationship Board:

1. **Note** the contents of this report.

2. **Recommend** Māori and Pacific have separate workforce development action plans

Moved: **T Giddens**
Seconded: **F Cram**
CARRIED

SECTION 3: MONITORING – INFORMATION ONLY

16. TE ARA WHAKAWAIORA – CULTURALLY COMPETENT WORKFORCE – Kate Coley

The following points were raised:

- KPIs – is Māori target at 25%
- Population served is it wider providers or hospital based only? Reporting should be on the individual not the role. As some employees have multiple roles and this adds confusion to the statistics.

RECOMMENDATION

That the Māori relationship Board
1. **Note** the content of this report

Moved: **T Giddens**
Seconded: **A Apatu**
CARRIED

17. TE ARA WHAKAWAIORA – CARDIOVASCULAR

This report is from Dr John Gohmans CMDO-Hospital and champion for the cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators, which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14 - high risk ACS patients accepted for angiogram within three days of admission and ACS patients who have completed data collection.

RECOMMENDATION

That the Māori relationship Board

1. **Note** the content of this report

Moved: **T Giddens**
Seconded: **F Cram**
CARRIED

18. TE ARA WHAKAWAIORA – HEALTHY WEIGHT –Shari Tidswell

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan (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. 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. This report is from Sharon Mason, Champion for the Healthy Weight (national indicator).

RECOMMENDATION

That the Māori relationship Board
1. **Note** the content of this report
2. **Endorse** the next step recommendation

Moved: **T Giddens**
Seconded: **A Apatu**
CARRIED

19. TE ARA WHAKAWAIORA – BREAST FEEDING – Chris McKenna

Significant work has been undertaken in the past 12 months to identify effective approaches to increase breastfeeding rates in Hawke's Bay and then applying this information to a redesign of services from 0 to 6-months. The Women Child and Youth Portfolio Manager completed a report on breastfeeding which included looking at national programmes and international evidence. To action these findings, Māori Health reviewed contracts providing breastfeeding support from six weeks to six months and have invested in a programme with well child providers. Maternity Services have completed a breastfeeding service review and written a service redesign proposal and business case.

The following have been identified:

- It has been better for Maori Mums
- Continuing in-home visits
- Whanau and community driven
- Face to face peer support
- Increasing lactation team – kaiawhina roles.
- Engaging with expecting mums.

RECOMMENDATION

That the Māori relationship Board
1. **Note** the content of this report
2. **Endorse** the next step recommendation

Moved: **F Cram**
Seconded: **A Apatu**
CARRIED

20. SECTION 5: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair accepted a motion to move into Public Excluded.

RESOLUTION

That MRB exclude the public from the following item:

17. Minutes of the previous meeting – Public Excluded

18. Matters Arising from the previous meeting – Public Excluded

Moved: **N Tomoana**
Seconded: **A Apatu**
Carried

The public section of the MRB Meeting closed at 12.25am.

21. MATTERS ARISING FROM THE PREVIOUS MINUTES

There was no previous Public excluded Meeting so therefor there were no matters arising.

REVIEW OF ACTIONS

The Action and Progress List as at February 2018 was taken as read. No actions were discussed.

The meeting closed at 12.28pm with a Karakia Whakamutunga (Closing Prayer) by N Raihania.

Signed: _____
Chair

Date: _____

Next meeting: 9.00am Wednesday, 9 May
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB)
STRATEGIC PRIORITIES WORKSHOP

HELD ON WEDNESDAY, 18 APRIL 2018, IN KAHUREREMOANA MEETING ROOM, TE WHARE MIHIROA, MĀORI HEALTH SERVICES OMAHU RD, HASTINGS COMMENCING AT 3.00PM

Members: Ngahiwi Tomoana
Heather Skipworth
Na Raihania
George Mackey
Trish Giddens
Ana Apatu
Dr Fiona Cram
Hine Flood
Beverly Te Huia

Apologies: Lynlee Aitchenson-Johnson
Kerri Nuku

In Attendance: Patrick Le Geyt (Acting General Manager, Māori Health HBDHB)
Chrissie Hape (General Manager, Ngāti Kahungunu Iwi Inc)

Karakia

Na Raihania opened the meeting with a karakia.

Agenda Overview

The Hawkes Bay Māori Relationship Board (MRB) briefly reviewed the MRB Terms of Reference considered the following questions:

1. What is our role?
2. What are our priorities?
3. How do we get things done?

Health Sector Leadership Forum Themes

The three broad themes from the Health Sector Leadership Forum in March 2018 were discussed:

- **Engagement**

Improving our engagement with consumers, key stakeholders and amongst ourselves has been a consistent theme throughout various DHB consumer engagement exercises.

- **Values/Behaviours and Culture**

Embedding values and behaviours into the organisation has also been a consistent theme. HBDHB completed an extensive consultation exercise to develop the core values set (HEART).

- **Whānau Centred and Integrated Models of Care**

Consumers, key stakeholders and staff have all pointed to integrated care models as ‘our preferred approach’ – especially in primary care.

Strategic Priorities

MRB agreed to work with the Hawkes Bay District Health Board (DHB) to develop a planned approach that significantly changes how we tackle these challenges.

T

he proposed project goals are to:

- enable the development of Māori/whānau centric healthcare models and services
- employ a workforce reflective of the health sectors participant population
- adopt an approach that encourages and supports innovation and change

Critical to the success of achieving these goals will be the ability of the health sector to work with Māori communities to co-design appropriate support and services to give effect to this approach.

Underpinning this is the assurance that Maori will be engaged, participating and benefitting from this revised approach.

MRB agreed to continue to develop the strategic priorities, key actions and timeframes at their next meeting on 9 May 2018.

Meeting Closed approximately 4.45pm.

Karakia Whakamutunga

Na Raihania closed the meeting with a karakia.

ACTIONS FROM PREVIOUS MEETING

Late Paper

Maori Relationship Board Workplan as at 1 May 2018	EMT Member	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	BOARD Meeting date
* Clinical Services Plan - Planning for Consultation (May 18)	Ken Foote	9-May-18	9-May-18	10-May-18	30-May-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-**May**-Nov18)	Sharon Mason	9-May-18	9-May-18	10-May-18	30-May-18
HB Heatlh Sector Leadership Forum Report	Ken Foote	9-May-18	9-May-18	10-May-18	24-Apr-18
Maternal Wellbeing Model of Health **Presentation** (Board action Feb18 Jacoby Poulain)	Sharon Mason	9-May-18	9-May-18	10-May-18	30-May-18
National Bowel Screening Roll-out Update **(presentation**)	Chris Ash	9-May-18	9-May-18	10-May-18	30-May-18
The Place of Alcohol in schools - Young people and under-age exposure	Sharon Mason	9-May-18	9-May-18	10-May-18	30-May-18
HBDHB Performance Framework Exceptions Q3 Feb/**May**/Aug 18 Just in time includes Maori and Pasifika	Kevin Snee	9-May-18			30-May-18
Te Ara Whakawaiora - Did not Attend (local Indicator)	Sharon Mason	9-May-18	9-May-18	10-May-18	30-May-18
* Clinical Services Plan verbal update (May **June** July)	Ken Foote	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Annual Plan 2018/19 First draft (June)	Chris Ash	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Implementing the Consumer Engagement Strategy	Kate Coley	13-Jun-18			27-Jun-18
People Strategy FINAL (email 3/1/18)	Kate Coley	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Policy on Consumer Stories	Kate Coley / John Gommans	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Recognising Consumer Participation - Policy Amendment	Kate Coley	13-Jun-18	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	13-Jun-18	27-Jun-18
Te Ara Whakawaiora - Oral Health (National Indicators)	John Gommans	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Under 16 Free GP service Update	Chris Ash	13-Jun-18	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	13-Jun-18	27-Jun-18
* Clinical Services Plan verbal update (May June **July**)	Ken Foote	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Mobility Action Plan Update **Presentation**	Andy Phillips	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Annual Plan 2018/19 Second draft (August)	Chris Ash	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
HBDHB Performance Framework Exceptions Q4 Feb/May/**Aug 18** Just in time includes Maori and Pasifika	Kevin Snee	8-Aug-18			29-Aug-18
Matariki Regional Development Strategy and Social Inclusion Strategy update from Feb 2018 Timing TBD as required.	Sharon Mason	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)	Mark Peterson	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
Annual Plan 2018/19 - approved Minister timing open	Chris Ash	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Heatlh Equity Report	Sharon Mason	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-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	12-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	John Gommans	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Did not Attend (local Indicator)	Sharon Mason	10-Oct-18	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	10-Oct-18	11-Oct-18	31-Oct-18
HBDHB Performance Framework Exceptions Q1 **Nov 18** Feb 19 /May/Aug 19 Just in time includes Maori and Pasifika	Kevin Snee	14-Nov-18			28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Sharon Mason	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
People Strategy updates (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18

HAWKE'S BAY District Health Board Whakawāteatia	**Chair's Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Ngahiwi Tomoana, Chair
Month:	May 2018
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board

1. **Note** the contents of this report

PURPOSE

The purpose of this report is to update the Māori Relationship Board (MRB) on relevant discussions at the Board meeting held on 24 April 2018 pertaining to Māori health.

INTRODUCTION

The health system has continued to be under pressure in March, however during April there had been a gradual improvement.

Nurses Action (nationally): Nurses picketed outside the Hospital on Monday 23rd May as part of the nationwide action over pay and other matters. One of the key issues for nurses around the country has been the "care capacity demand" (CCDM) part of the MECA agreement. This has not always been deployed as well as it could have been in other regions. We implemented this in HB fairly well and are now being disadvantaged. CCDMs first and major tranche was completed more speedily here in HB with further FTEs being employed over the next 18 months. If there is no agreement on matters nationally, strike action may occur.

FINANCIAL PERFORMANCE MARCH 2018

The Financial Report for March 2018, which showed a $2.0 million variance unfavourable to plan with March being $347 thousand unfavourable, for the nine months year to date. It was a huge month doing a lot of acute and high case weight work which extended services.

CLINICAL SERVICES PLAN

In reference to the Clinical Services Plan and future workshops, MRB had a lengthy discussion about their concerns with how HBDHB engage with Māori community and how they gain Māori input into co-design. They stressed the importance of involving MRB and Māori in any strategic or service co-design from the beginning until the end. MRB had recommend HBDHB invite MRB members to the CSP Designing Services and Populations with Unmet Health and Social Needs. This has been addressed.

ESTABLISHING HEALTH AND LOCAL CARE LOCALITIES IN HB

MRB acknowledged the update on Locality Development in the Context of Primary Healthcare Development in Wairoa and Central HB and stressed the needs to widen the networks of providers in the community and the need for Intersectoral approaches.

They also acknowledged the need for system readiness in Wairoa to cope with free primary care, but stressed their frustration with the lack of meaningful progress towards implementing free primary care for whānau in Wairoa.

FRAMEWORK FOR DEVELOPING THE PEOPLE STRATEGY

MRB acknowledged the People Strategy Framework demonstrated the DHB's ongoing commitment and aspirations for all the DHB workforce, that creating and building a culture that investing in the needs of staff will ultimately make a positive impact on patient experience.

MRB questioned why the DHB HeART values were not used as the foundational values for the people strategy and made the following recommendation: That the HBDHB People Strategy Framework uses the HeART Values within the framework under 'Our Values'

Heather advised that our "Values" should over arch everything as there had been a lot of special assistance provided by Maori to develop those values.

Kate Coley advised that **our values** are what we are trying to create within our culture. Values and behaviours focus on behaviours. This is a similar approach – using a simple one pager to start discussions with our staff which we call our "**guiding principles**" or "**aspirations for our workforce**" which is all about "demonstrating our values".

The People Strategy shares and demonstrates commitment and aspirations for all of those who work in the DHB and building a culture that meets the needs of staff and consumers "person whanau centred".

Ngahiwi offered to meet with Kate for a discussion around connecting everything together.

MAORI & PACIFIC WORKFORCE ACTION PLAN

MRB acknowledged the Māori and Pacific Workforce Action Plan and that it was important to have a workforce that reflected the community and the important focus required by HBDHB to meet the workforce composition and cultural competency KPIs.

A lengthy discussion about the merits of a combined Māori and Pacific Workforce Action Plan took place but preference was that Māori and Pacifica have separate workforce development

At the board meeting, Heather Skipworth asked whether the gap in the Maori workforce presented as numbers were roles or head count. In response, the figures presented are people (not roles). Outstanding against the current target we need 27 more employed with Maori ethnicity. For Maori if you look at how Hawke's Bay stack up against the other 19 DHBs, we have the 2nd most represented workforce in the country and other DHBs look at us for that reason.

The same focus has not applied for Pacific people and employee numbers have declined! Talalelei Taufale (Pacific Health Improvement Manager) relayed that from a pacific perspective, their concerns were similar to Maori but with a difference. The key was to create supportive environment to ensure better opportunities. It is the supportive environment that Pasifika people seek at this time.

TE ARA WHAKAPIRI (Last Days of Life)

MRB were very pleased to see MRB recommendations taken on board and Strategic Services working in partnership with Māori Health Improvement Team to make Te Ara Whakapiri (Last Days of Life) more culturally responsive**.** It was advised this had been a valuable exercise as it had provided a lot more than was expected.

INFORMATION PAPERS RECEIVED

The following papers were received and noted:

- Te Ara Whakawaiora - Culturally Competent Workforce
- Te Ara Whakawaiora - Cardiovascular

The following papers received endorsement on next step recommendations:

- Te Ara Whakawaiora - Healthy Weight
- Te Ara Whakawaiora - Breastfeeding

WINTER & FLU PLANNING

The board received a presentation and noted the H3N2 predominant flu strain in the northern hemisphere (winter) had high rates of hospitalisation reported in the 65 plus age group and the young (0-4 years). Triggers noted were an increase in staff illness, outbreaks in residential care and schools. Pre-phase work was being undertaken with an array of tools identified.

The next "Early phase" relates to surveillance, communication, coordination and training. The Disruptive phase may include EOC activation, bed, discharge, staff and alternate service delivery models.

Current work includes St John Ambulance utilising alternate models of care; community pharmacy monitoring as well as socialisation and communication of alternate plans to the Community

Discussion included:

- A lot of messaging for the community was being prepared by the Communications Department.
- Good indications are that Tamiflu can be used in hostels and/or home care facilities to lessen the severity of illness.
- Planning and processes used during the Gastro Outbreak will be implemented if required.
- If severe enough, all practices would need to divert messages to a central call centre for flu matters and advice 24/7.

HAWKE'S BAY CLINICAL COUNCIL

Report received on Council's meeting held 11 April 2018.

An overview of investments made in the health system (ie spending on areas considered) and it was good to see that most of the funds discussed in the prioritisation process in in had gone to the community (even though such prioritisation decisions were small in comparison to overall funding).

Received an excellent update from Information Services who have certainly come a long way very quickly and were leading the way in the central region. A priority now is for the DHB to get clinical business processes in order to better focus on integration and engagement with primary care.

Quality Dashboard – input from clinical leaders nationally and locally had been provided.

Discussions around choosing wisely had resulted in the number one priority for council members, being "prescribing wisely" and "involving patients in their use and care".

HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 12 April 2018: noting the number of outstanding items and actions planned; advising that recruitment of the Consumer Engagement Manager and Consumer Engagement Coordinator was underway; positive feedback had been received from consumer members attending the CSP workshops held in April. Heard from Kate Coley on the framework for developing the people strategy. Looking to see how it will work in practice and benefit consumers, and how this can be measured.

Barbara Arnott complemented Rachel on her Report as it encapsulated and identified areas and aspects that the Board were waiting on and they shared the same concerns especially around health literacy.

HAWKE'S BAY District Health Board Whakawāteatia	**General Manager Māori Health Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Patrick Le Geyt, Acting General Manager Māori Health
Month:	May, 2018
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board:

Note the contents of this report.

PURPOSE

The purpose of this report is to update the MRB on the implementation progress of the Māori Health Services for the month of April 2018.

The Kaupapa Health Enquiry – WAI 2575

Wai 2575 - the Health Services and Outcomes Enquiry will hear all claims concerning grievances relating to Health services and outcomes, and which are of National Significance. There are currently 170 claims seeking to participate in this enquiry, and there is currently, no cut-off date for the filing of claims.

The Tribunal will hear claimants who clearly specify eligible health-related grievances in their statements of claim. The Wai 2575 Health Services and Outcomes Kaupapa enquiry is currently in its planning phase and will examine breaches of the Treaty of Waitangi in Health services and health outcomes for Māori.

The 'Parties and the Crown' have been directed to hold "Roundtable Discussions" over the next few months to further refine the scope, priorities and process for the enquiry, and file bibliographies of available research.

The Crown has been directed to:

- file any Māori health documentation held by the Ministry for Health.
- provide further background information about the current functioning of the New Zealand health system, including information about the management of the health system and funding flows.
- produce agreed data sets; and commission an independent expert or panel to prepare a background paper on historical issues and the history of Māori health during the 1840's to the 1990's.

Dale Bramley, CEO of Waitemata DHB and Riki Niania, General Manager Māori Health, Waitemata DHB, are leading DHB NZ input into WAI 2575.

HBDHB has been asked to provide information on governance arrangements with Māori, Māori input into decision making at governance and executive levels, including primary care, and HBDHB total funding of primary care from 2002 onwards.

WAI 2575 has adopted a three staged approach:

1. priority areas that demonstrate system issues
2. nationally significant system issues and themes that emerge
3. remaining themes of national significance, including eligible historical claims

Stage one will inquire into primary health care issues (concluded by 31 October 2018).

Stage two proposed areas are: Mental health (including suicide and self-harm); Māori with disabilities; Alcohol and substance abuse.

Prioritization of Te Ara Whakawaiora (TAW) Reports for 2018/19

The Māori Health Service finalized nine background and sector performance papers on priority indicators (i.e. Smoke free: Breastfeeding; Oral health; Mental health; Improving FSA Access; ASH; Cardiovascular diseases; Healthy weight and Workforce development) for 2018/19 Te Ara Whakawaiora (TAW) Champion Reports.

The objectives of these papers include:

i) Reviewing the indicator performance over the past 2 years highlighting areas of progress towards the annual targets, reducing disparities, and improving Māori health outcomes
ii) Challenging Indicator Leads and teams, as well as the Indicator Champions to use the information in these papers in reviewing and prioritizing their strategies and activities where appropriate in their 2018/19 Annual Plan preparations for better traction towards the annual target, reducing health disparities, and improving Māori health outcomes.

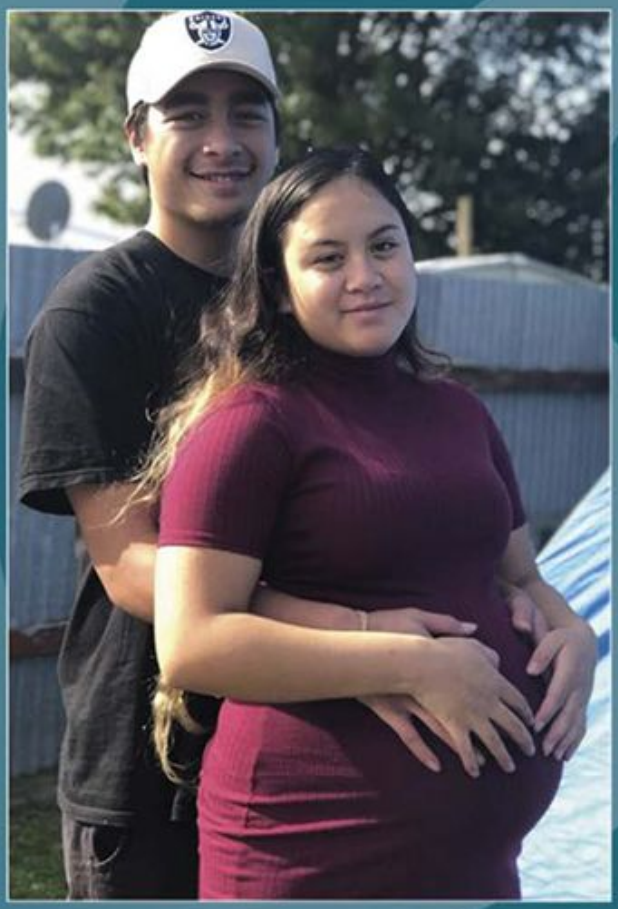
Sexual health and well-being

A paper to EMT is proposing that HBDHB develop a regional sexual health plan to ensure the way we fund, coordinate, and deliver sexual health care is equitable and will improve sexual health outcomes. The plan will be developed through a partnership approach between Population Health, Māori Health, and Strategic Services, with strategic direction and oversight from the Sexual Health Clinical Governance Group. Importantly, the plan will take a collaborative approach with providers, and communities to ensure an inclusive process to develop services and support for all young people. The paper will be considered by EMT on 8th May 2018.

'Whanake te Kura' Pregnancy and Parenting Information and Education Programme

Whanake te Kura, the new Pregnancy and Parenting Education and Information programme delivered by Te Taiwhenua o Heretaunga, will be holding a launch on Friday 18th May. Stakeholders working in maternal and child health, social, and education sectors are invited to attend the launch to be held at Te Taiwhenua o Heretaunga. Whanake te Kura classes have commenced and are free, to all pregnant women and their whānau/families. Whānau have the opportunity to learn about a range of topics, such as breastfeeding, safe sleep, immunisation, and oral health from knowledgeable speakers in a fun, friendly, and interactive way. Whanake te Kura launch will be held on Friday 18th May from 11:30am to 12:00pm, at Te Taiwhenua o Heretaunga, Orchard Road, Hastings.

Having a Baby?
Congratulations!



Whanake Te Kura
(Nurturing Healthy Babies)
is here for you

Learn about

- Who you are as a hapū woman
- Changes to your body
- Lifestyle and wellbeing
- Preparing for labour and birth
- Breastfeeding your baby
- Bonding and caring for baby
- Support and self-care
- Changes in the home

TToH will run a 2-day wānanga for mums-to-be in Napier, Hastings and CHB.

If you're interested in being part of this fantastic kaupapa, contact Moana on **022 010 3351** or email **moana.walford@ttoh.iwi.nz**

Kahungunu Executive will run the 2-day wānanga in Wairoa. Contact Marie Mahey on **06 838 6835** or email **marie.mahey@kahu-exec.co.nz**

Te Taiwhenua o HERETAUNGA

Kahungunu Executive

HAWKE'S BAY District Health Board

Te Taiwhenua o HERETAUNGA

Strong Whānau, Vibrant Communities

Mauri Ora ki te Mana Māori

Visit us at
Te Taiwhenua o Heretaunga, 821 Orchard Road, Hastings

Te Hiringa Tamariki – Māori Child Wellbeing Framework

Te Hiringa Tamariki – a draft Māori Child Wellbeing Framework ('framework') has been developed by Child Advocate and researcher Anton Blank. A member of the Māori Health Leadership Team attended the presentation of the draft framework, and the literature review that informed its development. The framework is based on aspirational Māori values that challenge and change the language we currently use to describe the lived realities of tamariki, toward a sphere of capability, potential, and development. Discussions with sector stakeholders on the draft framework are currently being held, with a tentative visit to Kahungunu and MRB in the pipeline.

Māori Maternal health programme

A paper to EMT and the HBDHB Board has been prepared and proposes to develop a Kaupapa Māori Maternal Health Programme. The intent of the programme is to overcome barriers to access to maternal and child health care, and improve maternal and child health outcomes. The programme will be responsive, accessible, and culturally appropriate to meet the needs of Māori women and their whānau. Fundamental to the development of the programme and its overall success will be the integrated, and collaborative approach between HBDHB, providers, and communities.

Health Workforce New Zealand (HWNZ) and Tūruki Funding Rounds

50 applications have been received to develop career pathways with cultural support advisors for the following areas – NZ Certificate in Study & Career preparation Hauora, NZ Certificate in Health and Wellbeing, Social and Community Services, Diploma in Recreation and Sport, Diploma in Taketake Addictions and Mental Health. 14 Nursing Entry to Practice applicants have also been submitted. The next HWFNZ fundng round is May 1 – June 20th.

Tūruki funding round closes April 30th. 37 applicants have applied for funding. Applicants are attending training at Otago, Massey, Waikato, Victoria University. EIT continues to feature as a place of learning alongside Open Polytechnic. Applicants are studying Master of Business Administration, Bachelor of Nursing,Bachelor of Social work, Bachelor of Oral Health.

Matariki Living Taonga Awards 2018

HBDHB has sponsored the Matariki Living Taonga Awards 2018 – Te Toi Hauora (Kaumātua Health and Wellbeing) Award.

Māori Health Services has nominated Tanira (Nan) Te Au for the Matariki Living Taonga Awards 2018 – Te Toi Huarewa (Employee) category for employees that exemplify Māori values within the workplace.

Mihi

Growing the Māori health workforce is essential in building a workforce that is representative of our community. Approximately 26% of the population within Hawkes Bay identify as Māori. Unfortunately Māori also represent in high numbers among the most deprived in our community. The importance of growing a Māori health workforce that has capacity to engage and deliver care within a Māori world-view, is an essential component in understanding and addressing health needs for the Māori. Collectivey Māori nurses from within the region have advocated strongly for growth, sustainability and leadership within nursing to support this kaupapa.

Chris McKenna Chief Nurse HBDHB, has taken on the challenge and understands the positive input growing the Māori nursing workforce will have for Ngati Kahungunu. This has resulted in a strategic plan to increase the Māori nursing workforce. The current Māori nursing workforce, sits at 12% of the total nursing workforce within Hawkes Bay, one of the highest levels nationally.

Nationally nursing organisations of New Zealand have collectively agreed to an aspirational goal to match the Māori nursing workforce to the population by 2028.
Currently 7% of the national nursing workforce identify as Maori. By 2028 the goal is to raise this to 16%.

Māori nurses are a key health workforce resource with the capacity and capability to engage within our community throughout primary, secondary and tertiary health care. They have the ability to support care that meets both cultural and clinical needs for whanau, hapu and iwi.

I am very proud and humble to be part of the collective of Maōri nurses who are working to continue to support, grow and sustain the Māori nursing workforce within Hawkes Bay DHB. Building and empowering a Māori nursing workforce to better meet community need and tackle health inequities head on is the vision. It is hoped that this newsletter will provide insight into the diverse and unique contribution Maori nurses are making within our community to address inequity and improved health outcome for tangata whenua.

Ngaira Harker

Ngaira Harker,
Nurse Director Māori Health

Ko Wai Au?

Ka tangi te tītī
Ka tangi te kākā
Ka tangi hoki ahau

Ko Whakapunake te māunga
Ko Wairoa te awa
Ko Takitimu te waka
Ko Mei Tipoki tōku tīpuna
Ko Ngāti Kahungungu
Ki Wairoa tōku iwi
Ko Ngāti Hine Hika tōku hapū
Ko Putahi tōku marae
Nō Wairoa ahau
Ko Raiha Harker rāua ko Brian Harker ōku mātua
Ko Ngaira Harker tōku ingoa

"Every whānau should have a Māori Nurse"

Then we will see a paradigm shift occur with Whānau, hapū and Iwi to help further lift the Gains within Māori health

Te Rau Matatini - Maori Health Workforce Development.

IN THIS ISSUE

Kaupapa Māori Nursing Research

Aria Graham RN, Ngāti Kahungunu, Samoa, will be celebrating the completion of her PhD this year. Aria received a Health Research Council Māori PhD Scholarship to support her study. Her kaupapa is entitled: **'Tika Tonu - Young Māori Mothers' Experiences of Wellbeing Surrounding the Birth of their First Tamaiti'**

Aria's research centres on exploring the wellbeing of young māmā Māori from their perspective surrounding pregnancy, birth and early motherhood. Using kaupapa Māori methodology and drawing on kaupapa Māori and mana wahine theories, Aria has explored the concept of Māori mothering. This has involved exploring the notion of wellbeing from a Māori worldview, the wellbeing experiences of young Indigenous mothers and the distinct concepts, values and beliefs that impact on young māmā Māori and child health outcomes. For her PhD, Aria also developed an integrated kaupapa Māori analytical framework to make a contribution to research through new knowledge and methodology.

Aria worked 3-4 roles throughout her study. She only went full time in the last 4 months of her PhD. Her perseverance in completing her thesis demonstrates her tika for this mahi. We are all in awe of Aria and her achievement and look forward to her findings and the difference these findings will make in supporting the wellbeing of whānau, hapū and iwi!!

Aria achieved her PhD oral exams April 19 2018.

Examiners Professor Denise Wilson and Doctor Awanui Te Huia were hugely impressed and see Arias research and findings as making a significant contribution to Māori health, nursing, māmā Māori and tamariki and kaupapa Māori research.

Aria Graham with her two sons Taamai (10yrs) & Maika (13yrs)

Ka Mau te Wehi!

Māori Nurses and Work Development Projects Start

Cultural Lense on Organ Donation

Nayda Heays

Nayda Heays is a registered nurse in the Intensive Care Unit. She hails from Ruatāhuna in Te Urewera and Te Teko in the Bay of Plenty. Nayda recently completed the Nga Manukura o Āpōpō Māori Leadership Programme in 2017. This provided her with the skills, knowledge and confidence to become involved in a project relating to the very real issue for Maori of 'organ donation'.

Anecdotally about 500 people sit on the organ transplant waiting list and while there has been a steady increase in deceased organ donors in the past five years, the number is still a lowly 53. Of this no 5 donors were Maori* (reference 2016).

The donation process takes place in each of the 24 intensive care units (ICU) in New Zealand. Potential donors are sometimes identified in the emergency department, when the patient is unlikely to survive. If the family supports the possibility of donation, the patient is admitted to ICU.
Nayda identified many Māori whanau are not asked the question relating to organ donation. This was reinforced in literature Nayda reviewed where anecdotal evidence suggested organ donation is less likely to be raised with families of potential Maori and Pacific donors." Nayda was keen to find out why?

Naydas research and discussions with colleagues provided information to suggest that that there is perhaps a pre-conceived view from health professional that cultural concerns prevent Māori from donating. The question of donation is then not raised with Maori. The assumption that health professionals may have a fixed view on organ donation and Māori raised flags with Nayda.

Nayda is passionate in supporting the needs of Māori. From a Maori perspective she realized it was important to begin the conversation with health professionals to explore their views pertaining to Māori and organ donation and to discuss this complex issue with her whanau hapu and iwi.

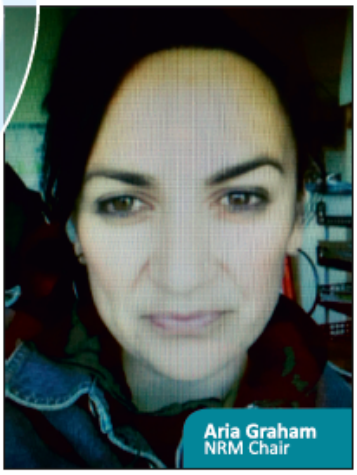
Ultimately the project supports the concept of tino rangatiratanga, allowing Māori to make informed and educated choices on organ donation. It is hoped that this project with Nayda input will contribute to further information and recommendations to sensitively engage effectively and with a more informed view on Maori perspectives of organ donation.

KAUPAPA MĀORI RESEARCH

Kaupapa Māori research and evaluation is done by Māori, with Māori and for Māori. It is informed by tikanga Māori, or Māori ways of doing things.

Māori Nursing Collective
Ngāti Kahungunu Ngā Ringa Manaaki

Ngā Ringa Manaaki is a Māori nursing support group borne out of the region. The group is made up of Māori nurses across the health sector with the aim of providing a forum to discuss nursing and health from within a Māori focus both culturally and clinically. Ngā Ringa Manaaki provides representation on the Hawke's Bay Nursing and Midwifery Leadership Council, and endeavours to promote and develop Māori nursing at a leadership level in the most positive, effective and inclusive way. Membership is open to all Māori Nurses working within the Ngati Kahungunu Rohe.



Aria Graham
NRM Chair

Dates and venues for meetings this year:

- Monday 18 Jun - Whare Kahureremoana, Hastings, 3.30-5.00pm
- Monday 20 Aug- Te Kupenga Hauora Ahuriri, Napier, 3.30-5.00pm
- Monday 15 Oct - Te Taiwhenua o Heretaunga, Hastings, 3.30-5.00pm
- Monday 17 Dec - Central Health, Waipukurau CHB, 3.30-5.00pm

For more information please contact:
Aria Graham (chairperson NRM) ariateao@gmail.com
Penny Thompson (secretary NRM) penny.thompson@hawkesbaydhb.govt.nz

Sonya Smith, Wairoa
Māori Nursing Leader in Action

Clinical Nurse Manager Sonya Smith leads a vibrant and diverse nursing team working within the beautiful rohe of Wairoa. Sonya works closely with Te Pare Meihana (Manager Wairoa Hospital and Health Centre) to provide quality care to whanau, hapu and iwi within the region. Collectively they have established a Hauora environment that supports and champions growing the local nursing and midwifery workforce and supporting models of health relevant to the rohe.

Within the Wairoa district a high proportion of the population identify as Māori (approx. 58.6% total population Wairoa District). A key focus for Sonya and Te Pare is to grow the Māori nursing and midwifery workforce to meet the Māori population demographic within Wairoa. This has seen the employment of 12 Maori nurses and midwives employed at the HBDHB Wairoa site.

Sonya Smith with Wairoa nurses

Growing and employing Māori nurses locally has the dual benefit of aligning with regional iwi development as well as with the strategic priority area in the New Zealand Health Strategy of 'Care Closer to home'. (Reference NZ Health Strategy & NNO meeting Maori nursing workforce update).

Key aspects of Sonia's leadership approach focus on mentorship, relevant professional development, innovation and growing and nurturing leaders from within her team. Some of the activities and initiatives which support this include:

Professional Development

Continually improving the quality and capability of nurses both culturally and clinically is essential within the Wairoa region. Wairoa has a high Māori population and for nurses working within the rohe understanding the importance of tikanga in framing care is vital in engaging and applying appropriate and respectful delivery of care within nursing practice for Wairoa whanau, hapu and iwi. Sonia currently has a nurse and 2 midwives attending Ngā Manukura o Apopo, a Māori nurse leadership programme. This programme provides culturally relevant leadership training for Māori nurses and midwives. She prioritizes this kaupapa and sees this type of training as essential in professional development within her team to improve and grow a relevant nursing workforce.

Tino Rangatiratanga/Leadership

Dione Neri Ngāti Kahungunu ki Wairoa RN has recently been employed as Associate Nurse Manager in Wairoa. Employing Dione for this position will further enhance confidence in other Māori nurses who may not have seen themselves in leadership roles. Sonya and Dione are possibly the only Maori CNM/ACNM duo in HBDHB. Sonia has also employed 2 senior Māori midwives from the region who are not only experts in their field, but also experts in the delivery of Maori models of care .

Innovations

There is no shortage of opportunities for nurses and midwives to take on exciting roles and innovate. Sonya is very aware of the need to innovate and change the way things have always been in order to support the Wairoa community in dealing with the diverse range of health issues impacting on the community.

continued on next page

Māori nursing leader in action - *continued...*

Currently two of the innovations within the rohe include:

- A Victoria research and iwi partnerships that supports new midwife roles in managing the needs for Wairoa Whanau within a strength-based approach.
- Nurse led Interprofessional education – Sonya leads an Interprofessional education initiative in partnership with Otago University which allows new health professionals to immerse and learn within rural Maori health environments.

Sonya is an awesome Māori nurse leader who is providing a kaupapa Māori approach to the delivery of quality care to the region. She is loved by her team and is creating a sustainable and culturally appropriate nursing and midwifery workforce, which is the best fit for Wairoa.

Sonya Smith - Clinical Nurse Manager, Wairoa
Dione Neri - Associate Nurse Manager, Wairoa

"there is no shortage of opportunities for nurses and midwives to take on exciting roles and innovate. Growing your own is important, these opportunities all fill a need in our population and open career pathways" - Sonya Smith

A group of NETP nurses during a study day.
L-R Cheyne Fortune, Adrienne Apiata, Claire McLean, Katherine Tuapawa, Hilary Hape, Cloe Anderson, and Rita Renata

Growing our own Maori Nursing Workforce
Te Puawai Tanga

We are fortunate to have an aspiring nursing workforce growing and developing within NETP (Nurse Entry to Practice). New graduate nurses within NETP undertake a 1 year programme that provides both cultural and clinical support. Within NETP we aim to nurture and grow the number of Māori nurses within HBDHB and support them in developing as future nursing leaders. The importance of growing our Māori nursing workforce at this level is vital both locally to meet our population demographic and nationally to increase the Māori nursing workforce which currently sits at 7% of the total nursing workforce.

Sally Houliston, Helen Riden and Huia Beattie work collaboratively to facilitate both clinical and cultural development for all nurses within NETP. Donna Foxall (Senior Clinical Workforce Coordinator) has also provided strong cultural and clinical support within this workforce programme. NETP nurses are currently undertaking post-graduate study. Please give them encouragement to achieve this important milestone. All are enjoying their practice and support within each unit.

Hawkes Bay NETP programme information
Http://www.hawkesbay.health.nz/jobscareers/nurse-entry-to-practice-netp-programme/

HB CLINICAL COUNCIL

Verbal Update

	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.

MATERNAL WELLBEING MODEL OF HEALTH

Presentation

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NATIONAL BOWEL SCREENING ROLL-OUT

Presentation

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HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 3 2017/18**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership and HBDHB Board**
Document Owner	Anne Speden, Executive Director, Corporate Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
To be reviewed by	Executive Management Team (on 8 May 2018)
Month/Year	May, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Progress: Women registered with and LMC by week 12 of pregnancy. Areas of Focus: Health Target – Shorter Stays in ED. Mental Health – Section 29 Orders. Acute Coronary Syndrome - high-risk patients receiving an angiogram within 3 days of admission.
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA
RECOMMENDATION: It is recommended that the Māori Relationship Board and/or Pasifika Health Leadership Group Clinical & Consumer Council and HBDHB Board: **Note** the contents of this report	

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HBDHB Performance Framework
Quarter 2 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	May 2018

OVERVIEW
The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP).

As this report ends 31st March 2018, the results in some instances may vary to those presented in other reports.

BACKGROUND
The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2017/2018
The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2017/18
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- *Achieving Government's priorities and targets (Policy priorities)*
- *Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)*
- *Providing quality services efficiently (Ownership/Provider Arm)*
- *Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)*

MINISTRY OF HEALTH ASSESSMENT CRITERION

Progress towards each target or measure will be assessed using the following criterion:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2017/18	Target 2017/18
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 98%, Māori at 97% and Pacific at 100% against a target of 95%.

- Number of pre-school children enrolled in DHB funded Oral Health Services – We achieved target for all ethnicities with the total rate being 8% which is below favourable to the target of <10%.

- Time from referral receipt to initial Cranford Hospice contact within 48 hours – We continue to achieve the target of 80% with this quarter's results at 94%

- DNA – Overall we have favourably remained at 5.7% which is below the target of 7.5%.

Areas of Progress

- Women registered with and LMC by week 12 of their pregnancy – We have improved overall from 57.9% to 67.1% in quarter 3, there is also improvement in the Māori result from 50% to 52.4% and Pacific 35.3% to 50%

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Health Target – Shorter Stays in ED is currently at 89.0% against a target of 95% (page 8)

- Improved Management for Long Term Conditions – The number of high-risk patients who receive an angiogram within 3 days of admission decreased this quarter from 72.4% to 55% (page 23)

- Rate of Section 29 orders – Rates have increased again this quarter and we have an overall rate of 129.1 against a target of <81.5 (page 32)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Māori rate is currently 95% and the Pacific rate is 100%, both are similar to the rate for Other 92.9%.

- Equitable care for stroke patients – The Māori is currently 90% and Pacific at 77.6% against a target of 80%. They are similar to the Total Rate of 79.4%

Areas of Progress

- Oral Health MDFT score (Missing, Decayed, Filled Teeth) – Māori is mean scored at 1.04 which is an improvement from the previous year 1.10, this is still unfavourable to the target of <0.96. The mean score for the Other ethnicity is 0.53.

Areas of Focus

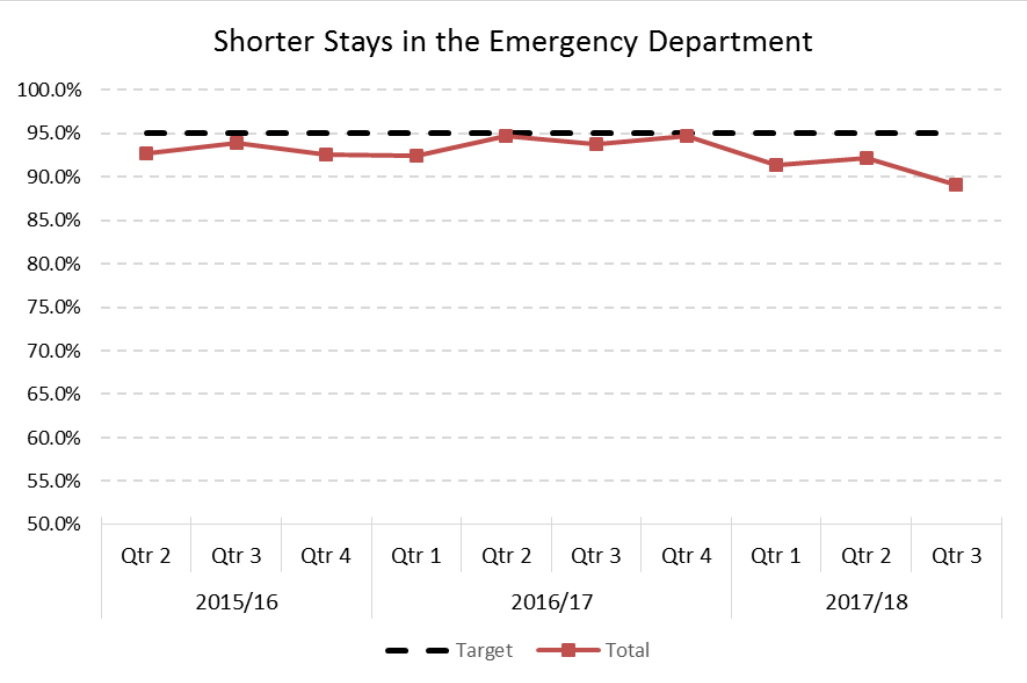
- Rate of Section 29 orders per 100,000 population – Māori Rates are currently 398 per 100,000 against the target of <81.5 and are 3 times higher than the non-Māori Rate (page 32)

- Breastfeeding at 3 months – Māori is currently at 41% compared to the total rate of 51%, the target 60%

HEALTH TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2017/18	Trend Direction
Total	94.7%	92.2% (U)	89.0% (U)	≥95%	▼
Māori	94.7%	93.5% (U)	89.9% (U)	≥95%	▼
Pacific	95.7%	94.1% (U)	92.9% (U)	≥95%	▼
Other	96.5%	91.3% (U)	88.2% (U)	≥95%	▼



Comments:
To support the Shorter Stays in EDs health target the DHB have Implemented a 3rd Nurse Practitioner to independent practice. This enables additional coverage and extended hours of a fast track role at front of house on limited basis. The extended NP hours provides early senior nursing assessment and decision making but is dependent on resource increase. The DHB also increased RMO numbers in ED for both MECA compliance and to resource a revised roster model which more reliably matches resources to known patterns of activity. Due to issues with specialty responsiveness to ED referrals there in ongoing development of a new model of care for general medicine and work being undertaken within Surgical Services to focus upon improving the timeliness and effectiveness of the specialty response to acute presentations. High levels of hospital bed occupancy (including ICU/HDU) are constraining acute patient flow and increasing ED length of stay. Many streams of work are being undertaken under executive level sponsorship including 'stranded' patient initiative (identifying/addressing barriers for people with excessive LOS), implementation of Criteria-based discharge processes across acute ward areas and continued evolution of Integrated Operations Centre activity.

1 October to December 2016
2 October to December 2017
3 January to March 2018

Health Target: Improved access to elective surgery (discharges)				
Key Performance Measures	Baseline [4]	Actual to Date [5]	Period Target	Target 2017/18 [6]
Elective Surgery				
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report				
Comments:				

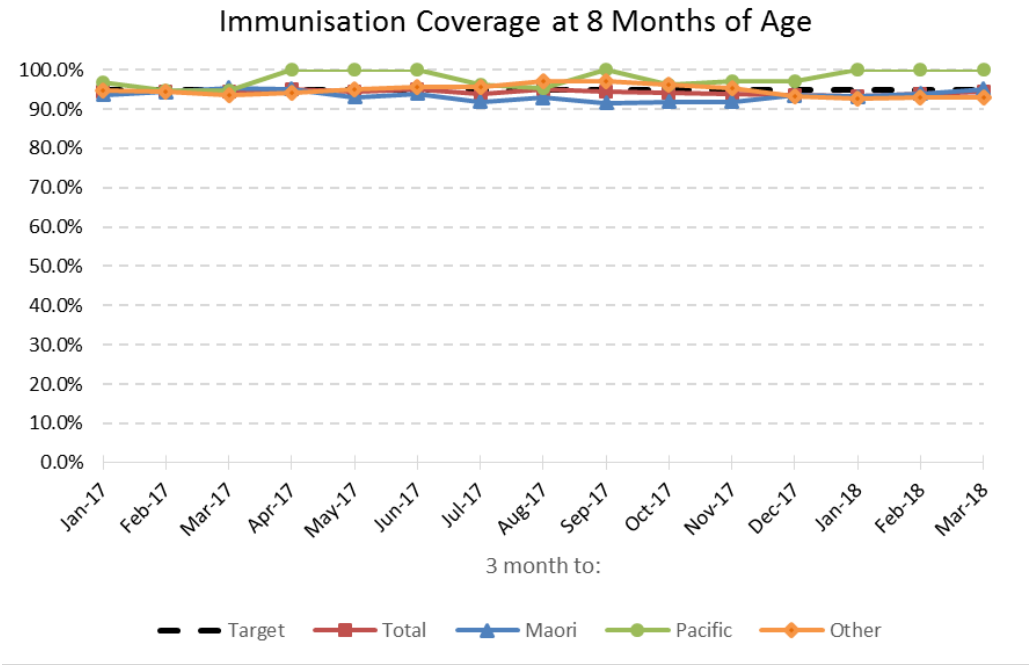
4 2015/16 target

5 July 2016 to June 2017 Source: Ministry of Health

6 July 2017 to September 2017 Source: Ministry of Health

Health Target: Increased immunisation
% of 2 year olds fully immunised

Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2017/18	Trend direction
Total	95.3%	93.6% (U)	94.3% (U)	≥95%	▲
Māori	94.4%	93.4% (U)	95.0% (F)	≥95%	▲
Pacific	100.0%	97.1% (F)	100% (F)	≥95%	▲
Other	95.9%	93.3% (U)	92.9% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:
We are pleased that we have achieved 94.3% overall for this target with equity maintained. We continue to have good communication between all immunisation providers which helps us achieve this result. It continues to be a struggle with hesitant whanau and these families take up a lot of time ensuring that they have opportunity for information and immunisation if wanted. Having a very efficient outreach team allows us the flexibility to vaccinate children within a short time frame if needed.

7 October to December 2016. Source: National Immunisation Register, MOH

8 October to December 2017. Source: National Immunisation Register, MOH

9 January to March 2018. Source: National Immunisation Register, MOH

Health Target: Better help for smokers to quit – Primary Care % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months					
Key Performance Measures	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2017/18	Trend direction
Total					
Māori					
Pacific					
Other					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report Source: PHO					
Comments: We currently have several activities ongoing to help improve the numbers given advice and we are actively dedicated to Support ABC Activities in General Practice. We have purchasing smoke-free merchandise to support smoke-free health promotion activity in general practice and advertising Smoke-free training opportunities on Health Hawke's Bay Information Portal and Health Hawkes Bay receiving reporting on who has completed the on-line Ministry of Health "Helping People to Stop Smoking". There is a contracted Independent Nurse working with 10 practices, a DHB Smokefree Coordinator in Wairoa contacting and updating patient smoking status in Wairoa practices. The contracted Independent Nurse has worked with 10 practices through Quarter 3, contacting patients on behalf of the practice, updating their smoking status, offering them smoking brief advice, referring to cessation support services and providing Quit Cards.					

10 15 months to December 2016. Source: DHB Shared Services

11 15 months to December 2017. Source: DHB Shared Services

12 15 months to March 2018. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2017/18	Trend direction
Total					
Māori					

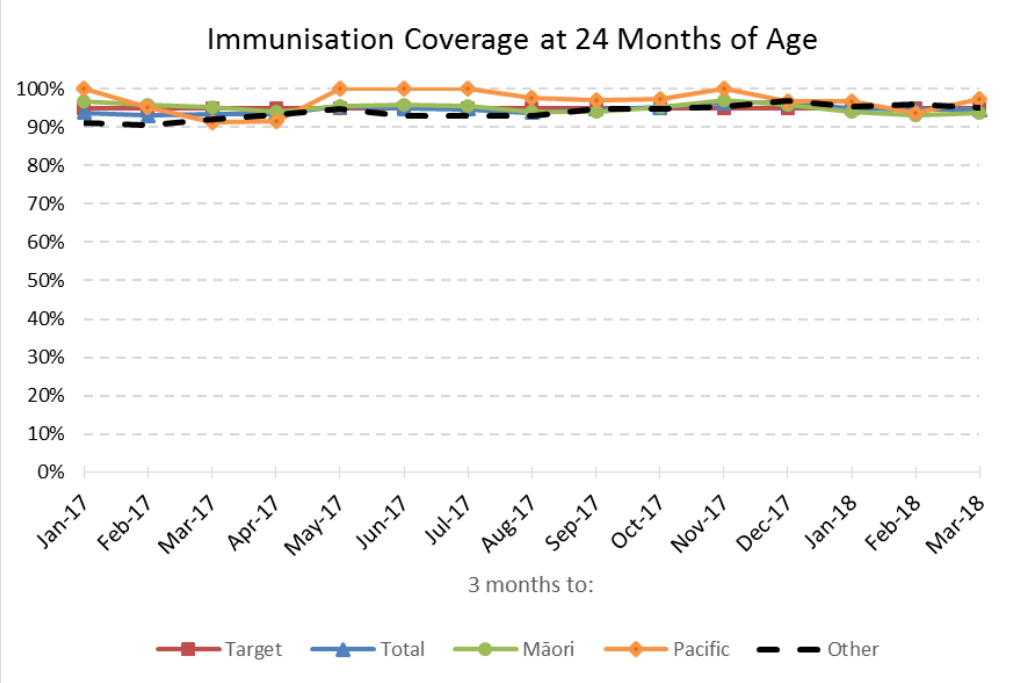
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report

Comments:
The 2017 statistics collected for smokefree status at booking with a Midwife in the Hawkes Bay reveal 48% of pregnant Māori women are not smokefree at booking compared to 12.9% NZE and 14.6% Pacific Island. Of the total referrals received (antenatal, postnatal and whanau) 67% of them were Māori and of those who engaged with the 12 week Wahine Hapu (Increasing Smokefree Pregnancy Programme), 69% were Māori. Breaking the cycle for Māori smoking can be a difficult process as many women are surrounded by Whanau and friends who are not smokefree. Often they are having babies at the age when they are most likely to smoke (18-24). 62% of those who completed the 12 week programme were in the 26 years and over category, this is often a time when women no longer want to smoke socially, the habit is becoming unaffordable and they are recognising this is something they cannot do on their own and are ready and willing to have support to quit. Emails have been sent to the HBDHB midwives and LMCs to remind them of the Wahine Hapu (Increasing Smokefree Pregnancy Programme) and to encourage their referrals early in pregnancy and also reminding the midwives to utilise the carbon monoxide monitor in their smokefree education. The HBDHB team has a newly appointed Smokefree Stop Smoking Practitioner to help with engagement with our stop smoking programme (Wahine Hapu) and the Tame Your Taniwha challenge which has women and whanau enrolled into both programmes. The Maternity Clinical Educator would like all her staff to have a smokefree education update this year and a need for a face to face approach for staff smokefree education has been identified, this has commenced and the Midwives have found this informative. A World Smokefree Day 31st May Quiz will be sent out to DHB staff, regarding the HBDHB Smokefree Policy and Nicotine Replacement Therapy to raise smokefree awareness and also a meeting will be held in June with the HBDHB Smokefree Team to discuss the current Wahine Hapu programme, successes, barriers and innovations.

13 October to December 2016. Source: DHB Shared Services
14 October to December 2017. Source: DHB Shared Services
15 January to March 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Increase Immunisation: % of 2 year olds fully immunised					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date[18]	Target 2017/18	Trend direction
Total	94.7%	96.4% (F)	94.5% (F)	≥95%	▼
Māori	95.4%	95.8% (F)	93.8% (U)	≥95%	▼
Pacific	100.0%	96.7% (F)	97.3% (F)	≥95%	▲
Other	93.6%	96.9% (F)	94.9% (F)	≥95%	▼



Data Source: National Immunisation Register

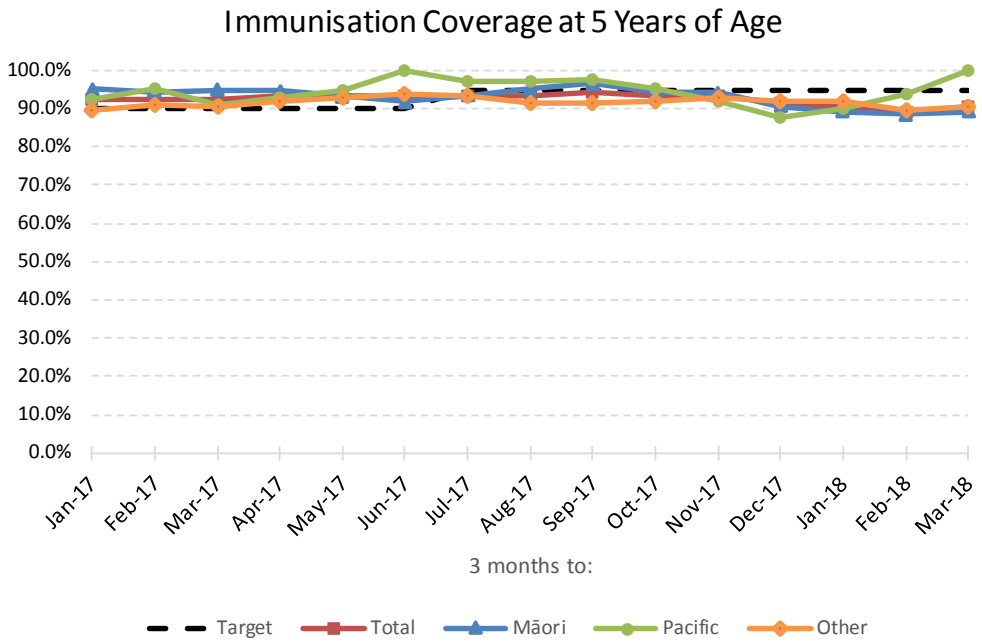
Comments:
We are pleased that we have achieved 94.5% overall for this target with equity nearly maintained. We continue to have good communication between all immunisation providers which helps us achieve this result .It continues to be a struggle with hesitant whanau, these families take up a lot of time ensuring that they have opportunity for information and immunisation if wanted. Having a very efficient outreach team allows us the flexibility to vaccinate children within a short time frame if needed.

16 October to December 2016 . Source: National Immunisation Register, MOH

17 October to December 2017. Source: National Immunisation Register, MOH

18 January to March 2018. Source: National Immunisation Register, MOH

Increase Immunisation: % of 4 year olds fully immunised					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2017/18	Trend direction
Total	93.5%	91.3% (U)	90.3% (U)	≥95%	▼
Māori	95.8%	90.7% (U)	89.1% (U)	≥95%	▼
Pacific	91.2%	87.5% (U)	100% (F)	≥95%	▲
Other	91.8%	92% (U)	90.3% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:
This has dropped slightly this quarter as we have had less time to put into our 4 year olds due to schedule changes and the need to provide education around this and influenza planning, implementation, cold chain and a heavier workload with pharmacists. We are seeing many overseas children who require lots of work regarding education of the families for catch up immunisations and getting records etc.

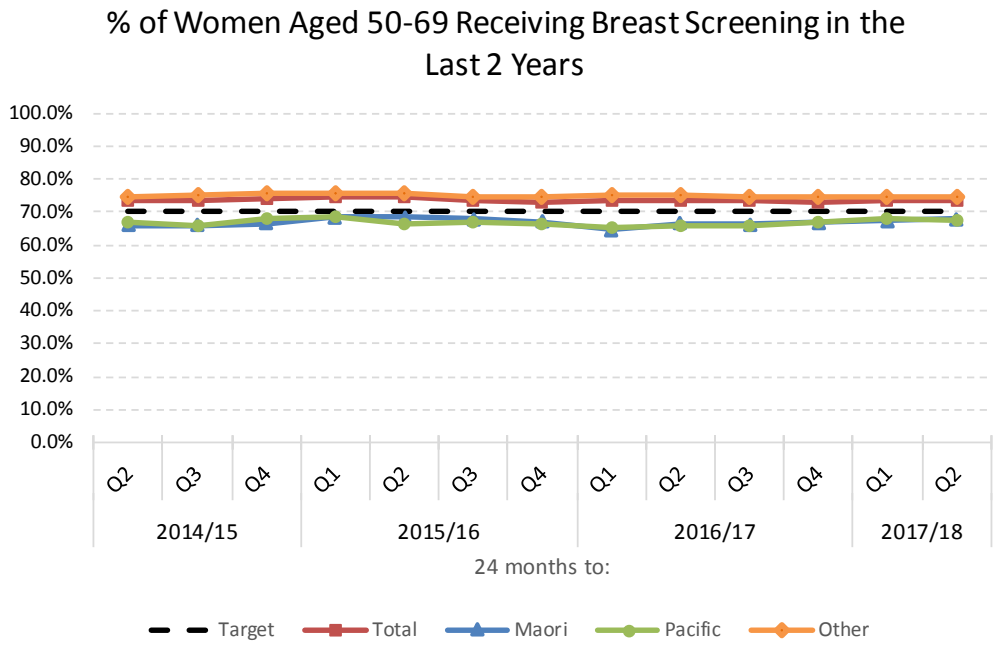
19 October to December 2016 . Source: National Immunisation Register, MOH

20 October to December 2017. Source: National Immunisation Register, MOH

21 January to March 2018. Source: National Immunisation Register, MOH

Improve breast screening rates
% of women aged 50-69 years receiving breast screening in the last 2 years

Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2017/18	Trend direction
Total	73.6%	73.4% (F)	73.6% (F)	≥70%	▲
Māori	64.7%	67.4% (U)	68% (U)	≥70%	▲
Pacific	65.4%	67.9% (U)	67.5% (U)	≥70%	▼
Other	75.0%	74.6% (F)	74.8% (F)	≥70%	▲



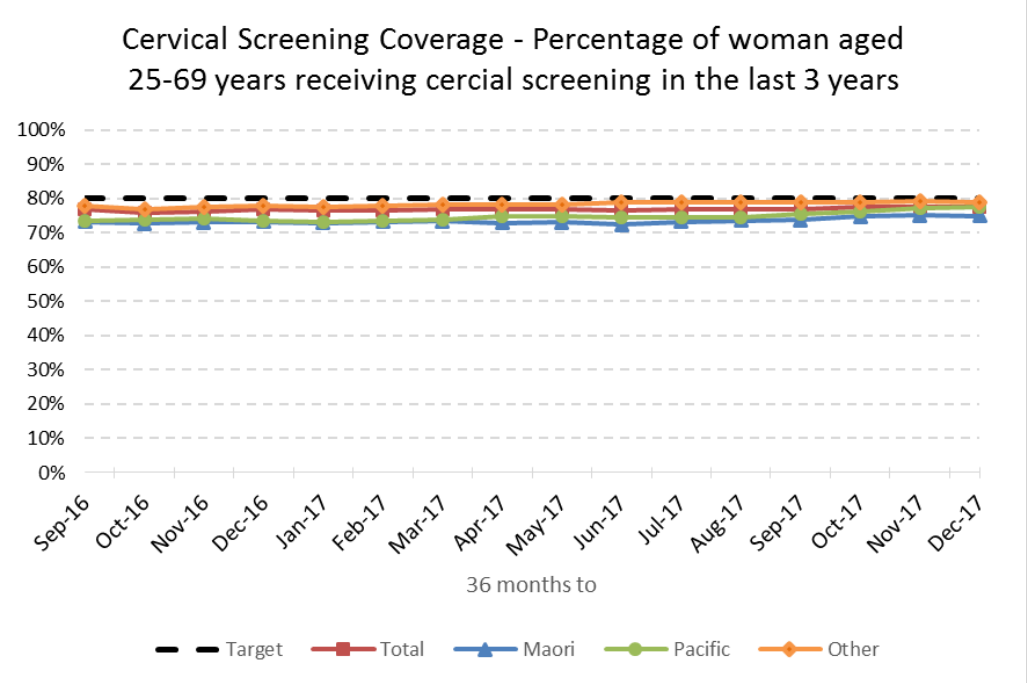
Data Source: BreastScreen Aotearoa

Comments:
The process of contacting BreastScreen Coast to Coast via phone to confirm or rearrange appointments seems to put many women off. Women who have felt discomfort when having had their mammogram talk to others about how it felt, creating a stigma around the process of having a mammogram. There is fear of the unknown or the result could be cancer, so they will often say they would prefer not to know. We continue to refer Māori and Pacific women to one of the five Independent Service Providers when a woman has either not confirmed they will attend their appointment or has DNA. The Breast Screening mobile visited Wairoa for two weeks January to February and the visit was very successful. Lists of registered Māori and Pacific women 45-69 were obtained from the three general practices and Kahungunu Executive, they were data matched against the BSA Register identifying the women who were unenrolled and not screened. These women received a letter inviting them to have enrol and have a mammogram whilst the mobile was present and they would be gifted a $20 Pak n Save card. 41 Māori enrolled and had a mammogram 78% more than in 2016, plus an addition 57 women were screened in comparison to 2016. Support to services were given by the Kahunugunu Executive team and overall there was a 6% DNA. The mobile visited CHB in March and April so far it is progressing well.

22 24 months to December 2016 . Source: National Immunisation Register, MOH
23 24 months to September 2017. Source: National Immunisation Register, MOH
24 24 months to December 2017. Source: National Immunisation Register, MOH

Improve cervical screening rates
% of women aged 25–69 years who have had a cervical screening event in the past 36 months

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	76.7%	77% (U)	77.4% (U)	≥80%	▲
Māori	72.8%	73.8% (U)	74.9% (U)	≥80%	▲
Pacific	74.8%	75.5% (U)	77.7% (U)	≥80%	▲
Other	78.9%	78.9% (U)	78.9% (U)	≥80%	—



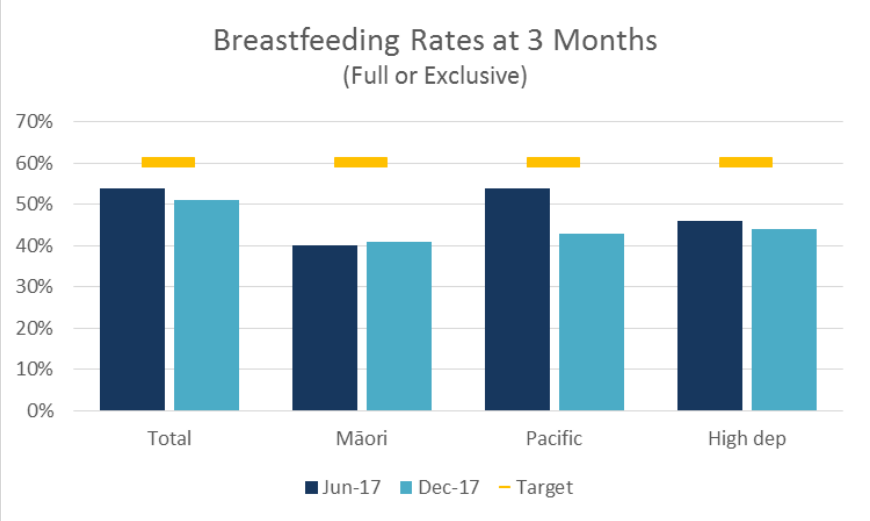
Data Source: National Cervical Screening Programme

Comments:
The availability of opportunistic smears is not as readily available as we would like it to be and the option of when you can have a smear is becoming limited in some practices due to other health demands that need to be covered. Some of the barriers to equity include first time women who have never engaged with their GPs and don't know anything about a smear and why they need to have a smear. Another barrier is time, many of the women we are providing a smear too in their home can take up to 40minutes to explain why they need a smear and what the procedure is, feedback from the women indicates that the time they have been giving in these home visits has made them feel more comfortable and at ease. In order to improve equity the Pak n Save promotional campaign funded by Health HB, all Māori, Pacific and women living in Quintile 5 will receive a Pak n Save gift card of $20 if they have their smear. The Population Screening team have set up two cervical screening clinics per month at the Napier Health Centre, these are for our Māori and Pacific women and women 30 and over who haven't had a smear or it's been more than five years since their last. The Population Screening Kaiawhina and Pacific Community Support worker continue to work in collaboration with Te Taiwhenua o Heretaunga and Choices Outreach nurses offering smears in the community and our Kaiwhakarere works in the community.

25 26 months to December 2016
26 36 months to September 2017
27 36 months to December 2017.

Better rates of breastfeeding
% of infants that are exclusively or fully breastfed at 3 months

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date[30]	Target 2017/18	Trend direction
Total	51.0%	54% (U)	51% (U)	≥60%	▼
Māori	39.0%	40% (U)	41% (U)	≥60%	▲
Pacific	46.0%	54% (U)	43% (U)	≥60%	▼



Data Source: Tamariki Ora Quality Improvement Framework

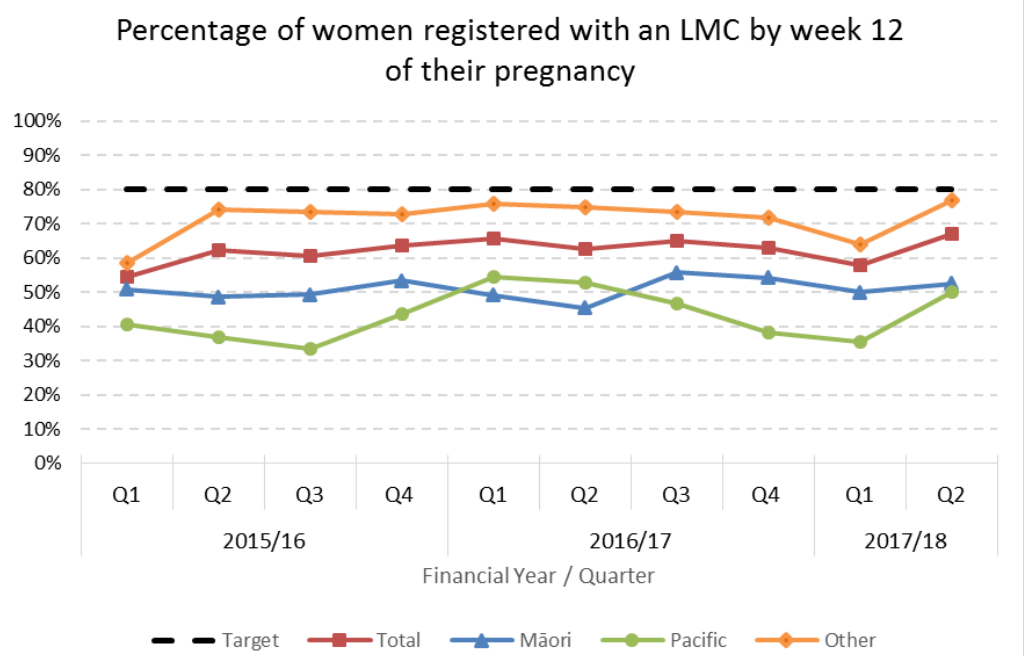
Comments:
Māori Health, Maternity Services and Population Health have worked together over the last 12 months to investigate locally and internationally practises to improve breastfeeding rates. From this, services have been reviewed with Māori Health redesigning the contract for 6 week to 6 months and Maternity Services redesigning breastfeeding support from birth to 6 weeks. Both programmes target Māori whanau with the desired outcome of decreasing the equity gap. We will be monitoring the Pasifika rates closely to respond to any continued downward trend. Overall breastfeeding rates need to improve so we are continuing to work with the community (workplaces, early child education, cafes) to create a supportive breastfeeding culture.

28 6 months to December 2016.
29 6 months to June 2017.
30 6 months to December 2017.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

More pregnant women under the care of a Lead Maternity Carer (LMC)
% of women booked with an LMC by week 12 of their pregnancy

Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 2017/18	Trend direction
Total	65.7%	57.9% (U)	67.1% (U)	≥80%	▲
Māori	49.2%	50.0% (U)	52.4% (U)	≥80%	▲
Pacific	54.5%	35.3% (U)	50.0% (U)	≥80%	▲
Other	75.9%	63.8% (U)	76.9% (U)	≥80%	▲

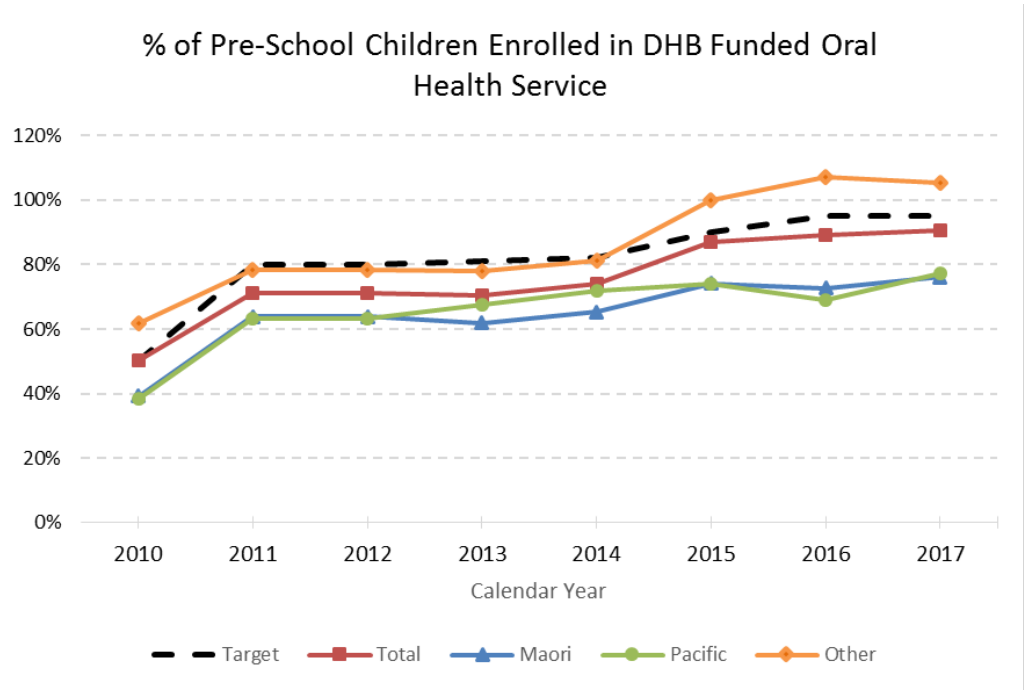


Comments:
Quarter 2 reporting on this target shows evidence of an increase in early engagement across all ethnicities; in particular an improvement in pacific island women booking within the 12 weeks, minimal movement is noted for our Māori women in this quarter. Two changes to note since the last quarter are the addition of the DHB maternity services contact number on the find your midwife Hawke's Bay page to support those women who may be having difficulty finding a midwife available when they are due. Also there are an increasing number of primary women with social complexities either being handed over to DHB community team or booking late with our community midwifery team as unable to find an LMC. There are a series of questions be asked as part of the ongoing quality improvement initiative for Hawke's Bay maternity services.

31 October to December 2016.
32 July to September 2017.
33 October to December 2017.

Better oral health: Pre-school enrolments
% of eligible pre-school enrolments in DHB-funded oral health services

Key Performance Measures	Baseline [34]	Previous result [35]	Actual to Date [36]	Target 2017/18	Trend direction
Total	89.2%	89.2% (U)	90.5% (U)	≥95%	▲
Māori	72.7%	72.7% (U)	76.1% (U)	≥95%	▲
Pacific	69.1%	69.1% (U)	77.1% (U)	≥95%	▲
Other	107.0%	107% (F)	105.2% (F)	≥95%	▼



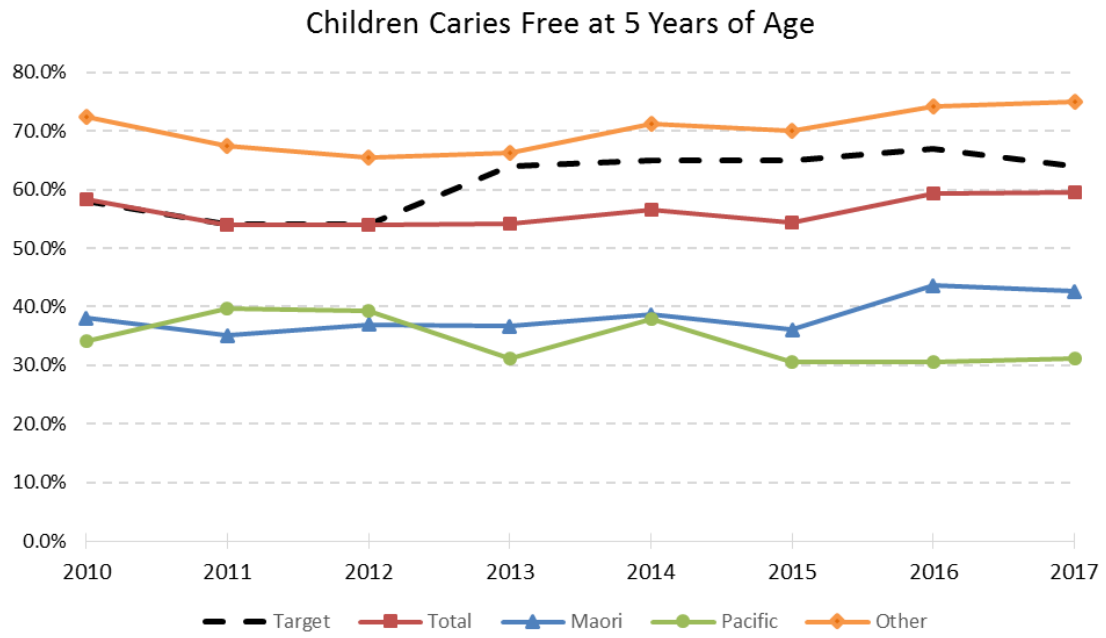
Data Source: Titanium Oral Health System

Comments:
The Hawke's Bay DHB operates a quadruple enrolment system for new born children (primary care, well child, immunisation and oral health). We are pleased to have further grown the enrolled population by 234 children to 10,131 and 90.5%. Māori and Pacific enrolments have increased to 76.1% and 77.1% (from 72.7% and 69.1%). However, the Other enrolments have remained at 105% despite substantial work to ensure correct coding and prioritisation of ethnicity, which leaves us concerned at the denominators provided for calculation of this indicator. We have employed a kaiawhina within the oral health service and in 6 months she has reengaged over 280 preschool children with our community oral health service and we are working with our Roopu Matua and meetings with teenage parents to engage the community and harder to reach whanau.

34 January to December 2016.
35 January to December 2016.
36 January to December 2017

Better oral health: Caries Free
% of children who are carries free at 5 years of age

Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 2017/18	Trend direction
Total	59.0%	59.4% (U)	59.5% (U)	≥64%	▲
Māori	44.0%	43.6% (U)	42.6% (U)	≥64%	▼
Pacific	31.0%	30.5% (U)	31.3% (U)	≥64%	▲
Other	74.0%	74.1% (F)	75% (F)	≥64%	▲



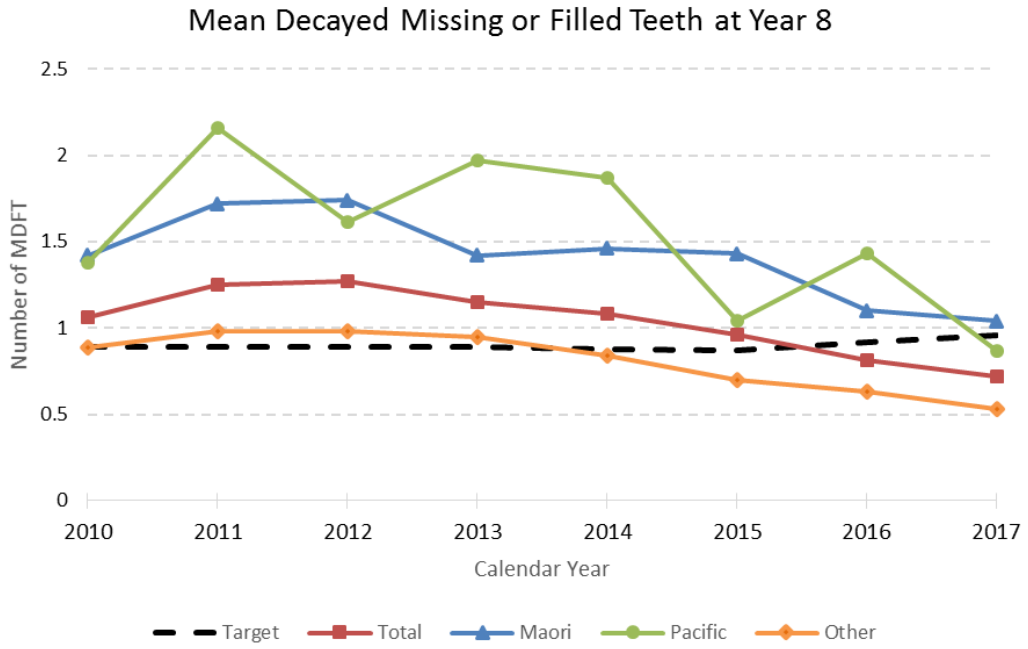
Data Source: Titanium Oral Health System

Comments:
Overall 5 year old results are almost the same in 2017 and for 2016, but pleasingly the gains achieved in 2016 from earlier years appear to have been held. The result for Other children at 75% caries free is well above the target of greater than 64% but Māori and Pacific children are below the target. Hawke's Bay DHB are putting in substantial effort with a project focussed on equity of outcomes for 5 year old children. In 2017 this project has established a Roopu Matua as well as other forms of consumer engagement for example focus groups with teen parents. Partnered with population health to include oral health messages in overall obesity strategy, support tools for B4SC includes water is the best drink and brushing 2x day. The national campaign “Baby Teeth matter” has also been supported locally, a Kaiawhina started in the Dental Service in July 2017 and has been able to bring 282 preschool children back into the service in the first 6 months. They worked in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery.

37 January to December 2015..
38 January to December 2017.
39 January to December 2017.

Better oral health: MDFT Score
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8

Key Performance Measures	Baseline [40]	Previous result [41]	Actual to Date [42]	Target 2017/18	Trend direction
Total	0.81	0.81 (F)	0.72 (F)	≤0.96	▲
Māori	1.1	1.1 (U)	1.04 (U)	≤0.96	▲
Pacific	1.43	1.43 (U)	0.87 (F)	≤0.96	▲
Other	0.63	0.63 (F)	0.53 (F)	≤0.96	▲



Data Source: Titanium Oral Health System

Comments:
Overall Year 8 has again improved in 2017 and is now 0.72 (previous year 0.81). Inequity persists, however Māori have improved to 1.04 (previous year 1.1), Pacific have improved substantially to 0.87 (previous year 1.43) but numbers are small and Other improved to 0.53 (previous year 0.63). Notably the DMFT for children with caries is almost the same suggesting that in each group the overall result is a consequence of more children caries free. Hawke's Bay DHB has introduced strong clinical quality indicators focussed on prevention - fluoride varnish by 4 years, bitewing films by 6 years and fissure sealants by 8 years and is measuring these and reporting to staff 6 monthly. The DHB is also operating a project to address equity of oral health outcomes for children under 5 years and these initiatives do appear to be slowly influencing the Year 8 outcomes.

40 January to December *2016.*
41 January to December 2016.
42 January to December 2017

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)
% of the eligible population will have had a CVD risk assessment in the last 5 years

Key Performance Measures	Baseline [43]	Previous result [44]	Actual to Date [45]	Target 2017/18	Trend direction
Total					
Māori					
Pacific					
Other					

Source: Ministry of Health

*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report

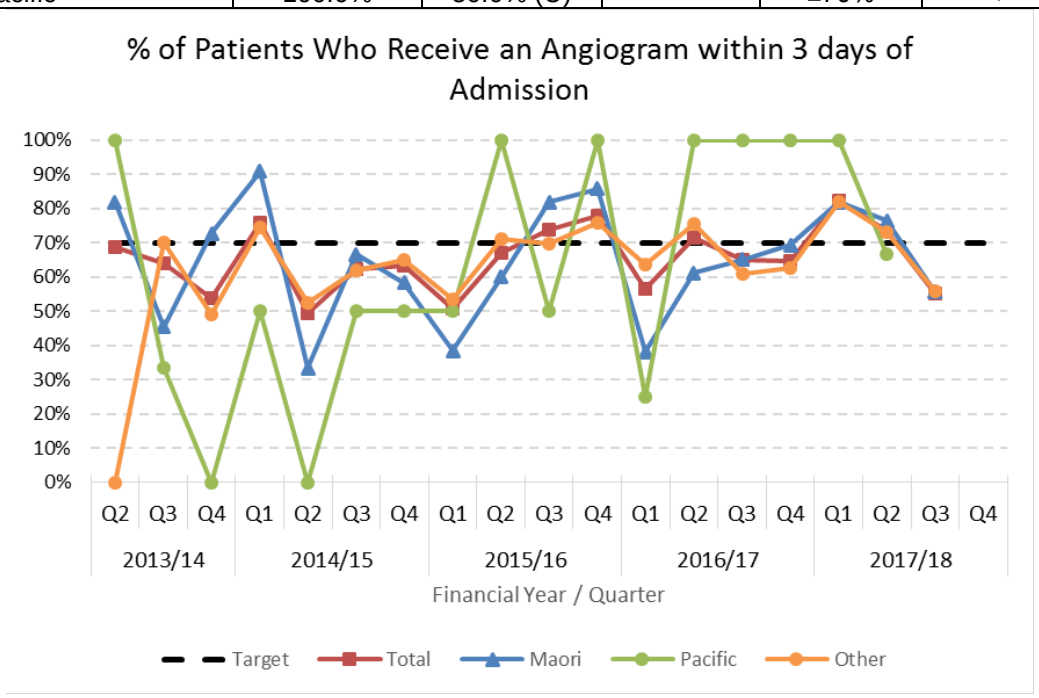
43 5 years to December 2016. Source: Ministry of Health

44 5 years to June 2017. Source: Ministry of Health

45 5 years to September 2017 . Source: Ministry of Health

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Patients with ACS receive seamless, coordinated care across the clinical pathway ***% of high-risk patients will receiving an angiogram within 3 days of admission.***					
Key Performance Measures	Baseline [46]	Previous result [47]	Actual to Date [48]	Target 2017/18	Trend direction
Total	71.6%	72.4% (F)	55.0% (U)	≥70%	▼
Māori	61.1%	75.0% (F)	55.6% (U)	≥70%	▼
Pacific	100.0%	50.0% (U)	-	≥70%	▼



Source: ANZACS-QI

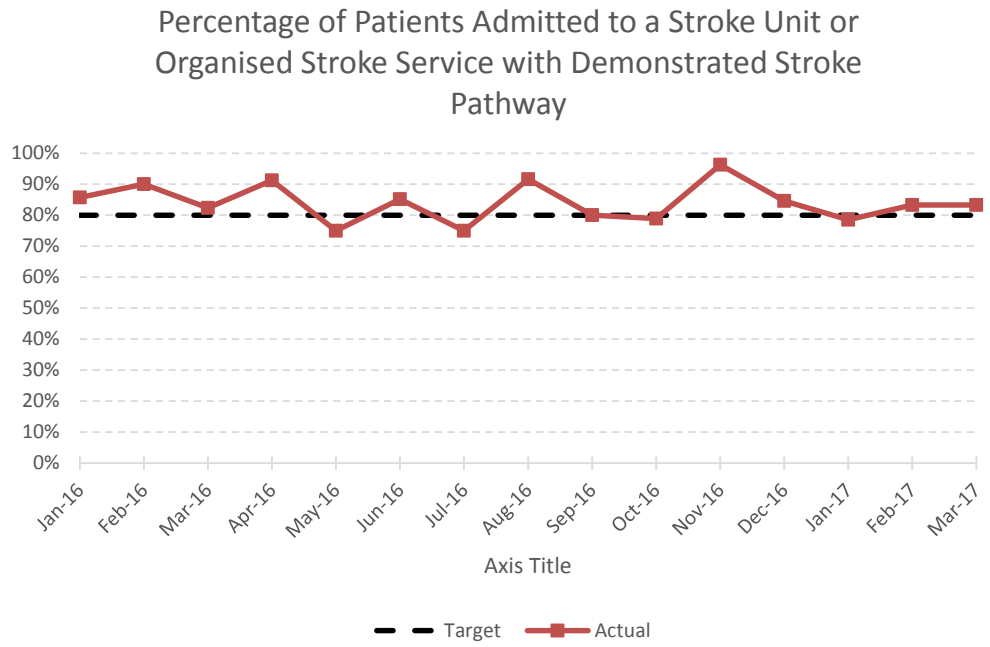
Comments:
January had a reduction in capacity of 2/9 lab days due to holiday period and lack of cover. February had 8 sessions fully utilized for the month, and March had a reduction in capacity of 1/9 lab days due to technical issues with the radiology equipment (list cancelled). This required rescheduling of both the outpatient and inpatient lists, extending time to Rx.

46 October to December 2016. Source: Ministry of Health
47 October to December 2017. Source: Ministry of Health
48 January to March 2018. Source: Ministry of Health

Equitable access to care for stroke patients

% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway

Key Performance Measures	Baseline [49]	Previous result [50]	Actual to Date [51]	Target 2017/18	Trend direction
Total	88.1%	75.6% (U)	79.4% (U)	≥80%	▲
Māori	-	92.3% (F)	90.0% (F)	≥80%	▼
Pacific	-	72% (U)	77.6% (U)	≥80%	▲



Source: HBDHB

Comments:
We were 1 patient short of making the target for this indicator. Patients who do not go onto the pathway are treated in other areas of the hospital as clinically appropriate.

49 October to December 2015. Source: Ministry of Health

50 October to December 2017. Source: Ministry of Health

51 January to March 2018. Source: Ministry of Health

Equitable access to care for stroke patients ***% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission***					
Key Performance Measures	Baseline [52]	Previous result [53]	Actual to Date [54]	Target 2017/18	Trend direction
Total	-	58% (U)	37.5% (U)	≥80%	▲
Māori	-	80% (F)	100% (F)	≥80%	▼
Pacific	-	50% (U)	28.6% (U)	≥80%	▼
*This is a new indicator and a time series chart will be provided one there are enough data points.					
Comments: Patients who are not transferred within the 7 days are reviewed as part of the quarterly reporting process. This quarter we had several patients who were kept on the stroke ward for longer than 7 days for clinical reasons and we continue to review cases.					

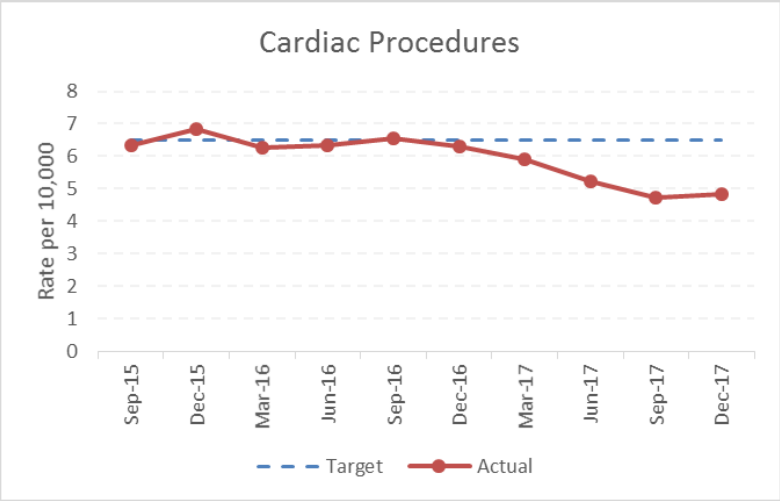
52 October to December 2015. Source: Ministry of Health

53 October to December 2016. Source: Ministry of Health

54 January to March 2018 . Source: Ministry of Health

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline[55]	Previous result[56]	Actual to Date [57]	Target 2017/18	Trend direction
Major joint replacement	21.5	22.9 (F)	22.4 (F)	≥21	▼
Cataract procedures	58.7	49.7 (F)	46.6 (F)	≥27	▼
Cardiac procedures	6.6	4.7 (U)	4.8 (U)	≥6.5	▲
Percutaneous revascularization	13.1	12 (U)	11.9 (U)	≥12.5	▼
Coronary angiography services	39	36.6 (F)	36.4 (F)	≥34.75	▼

*Charts only supplied for the Cardiac Procedure as this is the only one that is significantly below the national average.



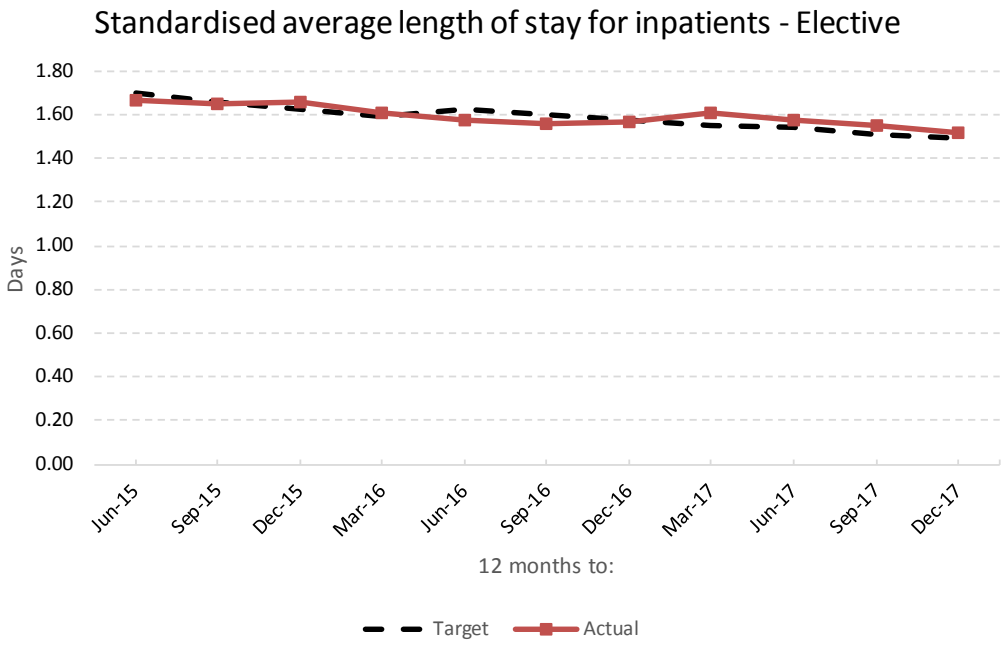
Source: Ministry of Health

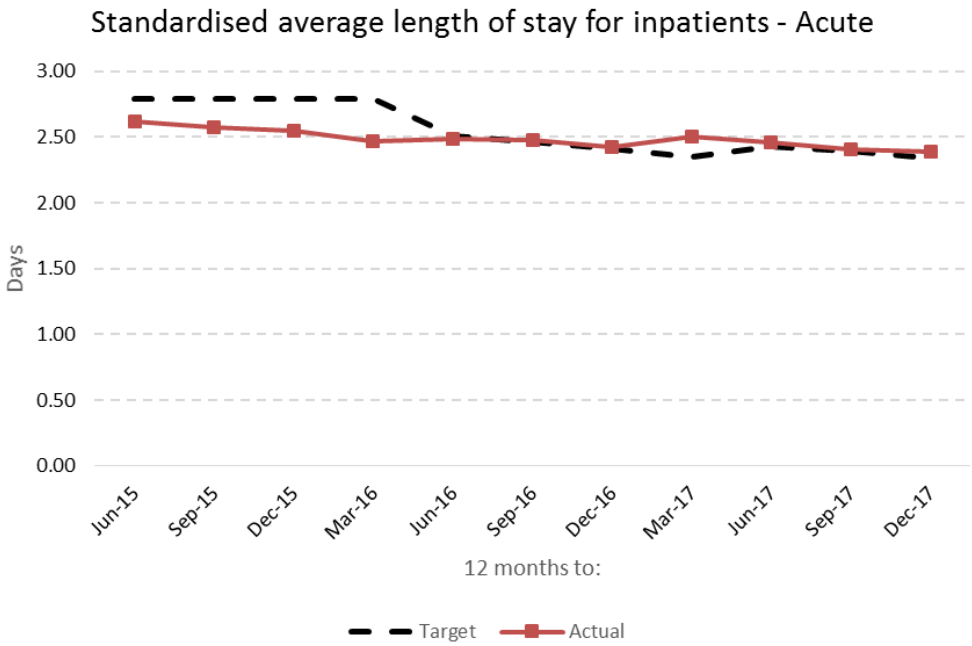
Comments:
Cardiac procedures are demand driven and HB is reliant on Capital & Coast to accept/ pull patients for cardiac surgery and pacemaker implants

55 12 months ending December 2015. Source MoH
56 12 months ending September 2017. Source MoH
57 12 months ending December 2017. Source MoH

Shorter stays in hospital
Length of stay (days)

Key Performance Measures	Baseline [58]	Previous result [59]	Actual to Date [60]	Target 2017/18	Trend direction
Acute	2.41	2.41 (U)	2.39 (U)	≤2.34	▲
Elective	1.51	1.55 (U)	1.52 (U)	≤1.49	▲





Source: Ministry of Health

Comments:

58 12 months to September 2016. Source: Ministry of Health
59 12 months to September 2017. Source: Ministry of Health
60 12 months to December 2017 .Source: Ministry of Health

We are pleased to see that both acute and elective average length of stay rates have reduced further to 2.39 and 1.52 respectively however we are still not meeting the MoH targets. Length of stay for general medicine and orthopaedic specialties had the greatest number of excess bed days. We continue to work on several initiatives within the hospital looking at reducing the length of stay with 'FLOW' and '4000 bed Days'. Improving our systems and process to discharge patients from our inpatient wards by focusing on increased earlier in the day discharges and how we manage patients who have longer stays and Ensuring our processes are effective in managing patients with frailty from presentation in ED, through their patient journey on to discharge.

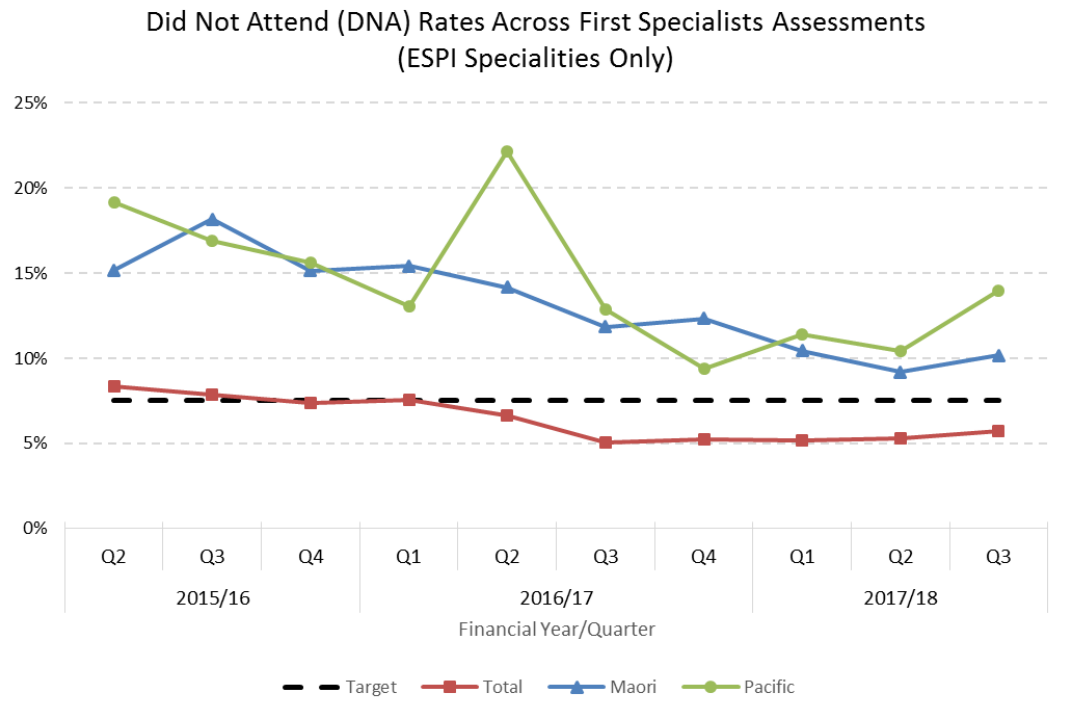
Quicker access to diagnostics					
Key Performance Measures	Baseline [61]	Previous result [62]	Actual to Date[63]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days					
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),					
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)					
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date					
Comments: *Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					

61 December 2015.

62 March 2016.

63 June 2016

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [64]	Previous result [65]	Actual to Date [66]	Target 2017/18	Trend direction
Total	6.7%	5.3% (F)	5.7% (F)	≤7.5%	▼
Māori	14.2%	9.2% (U)	10.2% (U)	≤7.5%	▼
Pacific	22.1%	10.4% (U)	14% (U)	≤7.5%	▼
Other	3.8%	3.7% (F)	4.1% (F)	≤7.5%	▼

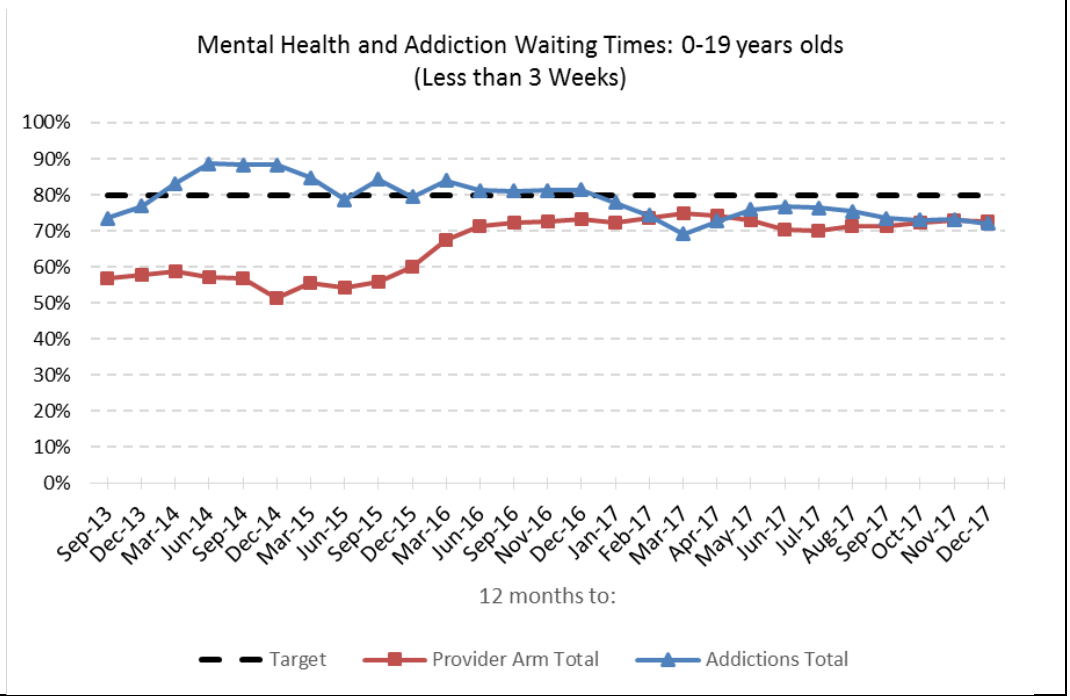


Source: HBDHB

Comments:
For the last Quarter the DNA rate for Māori has consistently trended downwards from 10.9% in Jan to 9.9% in Mar, despite a slight increase in total DNA over the Feb period. The total DNA rate increased by .9% over Feb period, to then fall at 5.4% for March – well under our 7.5% target. Dental and General Surgery continue to be the more difficult specialties for our patients to access this quarter with Paediatrics also showing high DNA for Māori. Due to high volumes of bookings the general surgery booker has been unable to call her new patients. The Administration Service is currently looking to address this issue, and will be monitoring closely to see if it makes a difference in the next quarter results. For Paediatrics and Dental the Bookers call and confirm all FSA's. For both Dental and Paediatrics, on a number of occasions that Bookers are instructed to continue to re-book appointments for repeat DNA patients (children). Unlike other services where after two DNA strikes the patients are referred back to their GP, for Paediatrics and Dental (if its children), appointments continue to be made for patients who DNA. This means there are occasions whereby one patient is responsible for multiple DNA's against the service. Finally the financial costs associated with Dental continue to provide a barrier for certain patients.

64 October to December 2016. Source: Ministry of Health
65 October to December 2017. Source: Ministry of Health
66 January to March 2018 . Source: Ministry of Health

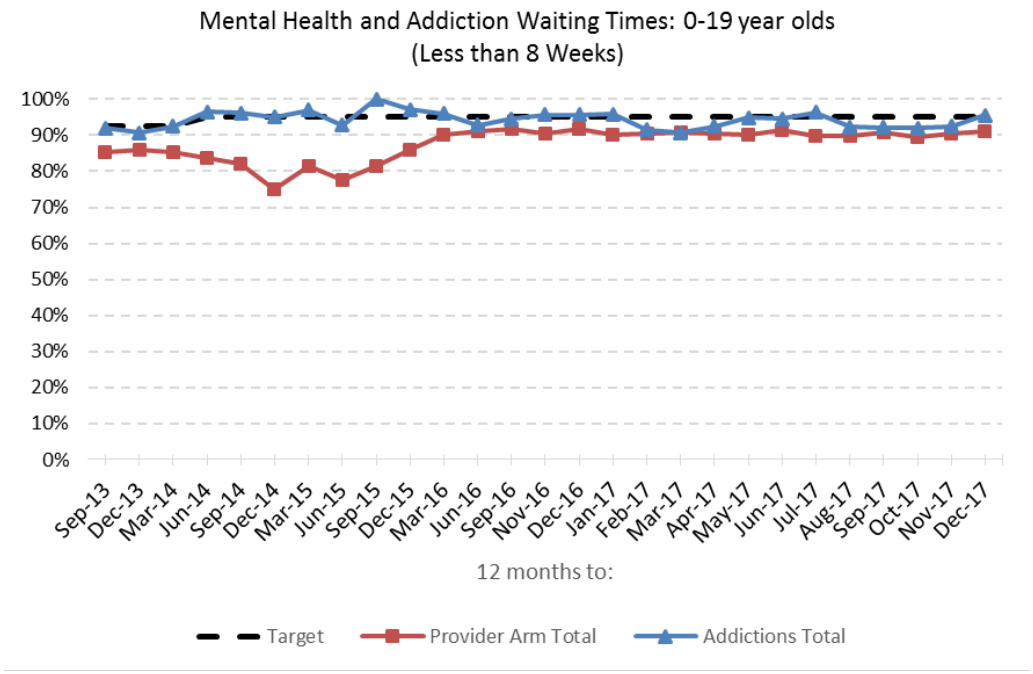
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [67]	Previous result [68]	Actual to Date [69]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	72.3%	71.3% (U)	72.5% (U)	≥80%	▲
<8 weeks	91.7%	90.9% (U)	91.2% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	81.1%	73.4% (U)	72.1% (U)	≥80%	▼
<8 weeks	94.6%	92.2% (U)	95.6% (F)	≥95%	▲



67 12 months to December 2016

68 12 months to September 2017

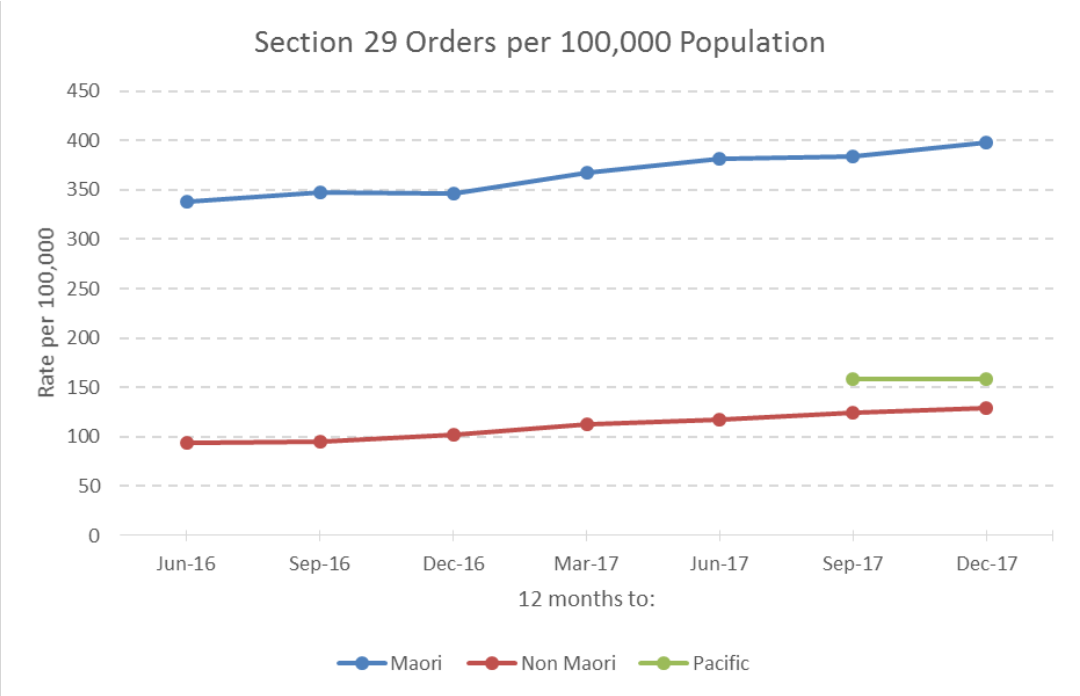
69 12 months to December 2017



Source: Ministry of Health

Comments:
While we have not achieved the target our deficit has been less than 10 % variance of the target, we want to meet the MOH target but we continue to meet a few challenges around DNA's and increased referrals that continue to impact on our KPI's. Since the last quarter, several strategies have been put in place to alleviate this and improve our response times. We have continued to work collaboratively with the family to find appointment times that suit for everyone including the family and young person. Additionally, our electronic record system sends a reminder to the family 24 hours before the appointment to ensure they attend the appointment. This has reduced DNA rate but in other cases families have not received the reminders because their contact details were not entered in format that allows the system to send an automatic reminder. We have also continued to collaborate with NGOs early and have joint clinics in the communities where the families reside. This has improved access due to increased accessibility. Another system related issue that may impact on our wait times is that seeing a family without the young person is not recorded as a contact/encounter with the young person, thus this will show as if we have not met the young person but we have met with the family to understand his presenting problems before arranging another meeting to meet with the young person. The alcohol and drug service did not meet the <=3 week wait time target of 80%. For the 0-19 age range the wait time was 72.7 percent. However, the Alcohol and Drug service met the wait target for 3-8 weeks. The target is 95% and the wait time for Alcohol and drugs was 95.5%. Similar challenges as discussed above continue to affect our KPI's. We have 1.8FTE for drug and alcohol but cases/referrals continue to rise. Similar strategies mentioned above are being implemented to bring the waiting times to or above the MOH targets. We hope to achieve this in the next quarter.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders ***Rate of s29 orders per 100,000 population***					
Ethnicity	Baseline [70]	Previous result [71]	Actual to Date [72]	Target 2017/18	Trend direction
Non- Māori	95	124.1 (U)	129.1 (U)	≤81.5	▼
Māori	338	384 (U)	398.2 (U)	≤81.5	▼
Pacific	0	158.7 (U)	158.7 (U)	≤81.5	—



Data Source: Ministry of Health

Comments:
We continue to monitor and use services to reduce the rate of all patients particularly Māori. We have a number of new services in place that support early intervention such as Home based treatment, Te Ara Manapou and our local response teams. We are setting set up a review panel made up of clinicians and consumers to discuss, review and look at other ways to support people who no longer require CTO support. We also negotiating a police liaison position with police.

RECOMMENDATION:
It is recommended that the Māori Relationship Board and Pasifika Health Leadership Group, and HBDHB Board

1. **Note and appropriately act on the contents of this report**

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q3 - not available

70 October to December 2016
71 12 months to September 2017
72 12 months to December 2017

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

HAWKE'S BAY
District Health Board
Whakawāteatia

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.

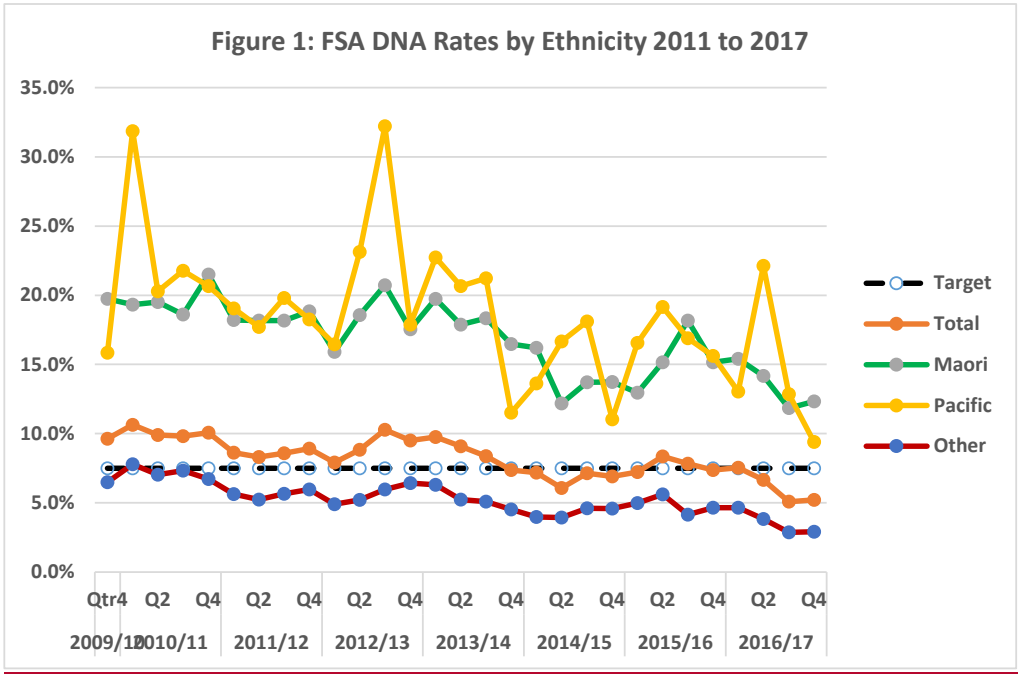
[1] *Paul Malan,A Report on 'Did Not Attend' Rates (DNAs) at Hawke's Bay District Health Board, May 2012*

- 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.

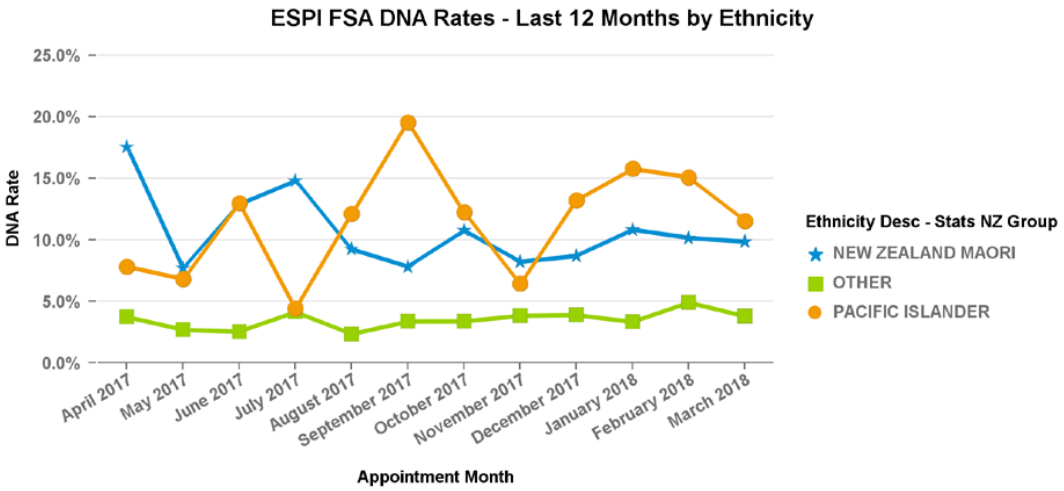
[2] *Nguma, J; Meihana, D; Raihania-White, W; Receveur, C; and Mobin, J: Policy and Health System Implications of the Hawkes Bay District Health Board (HBDHB) DNA Project, A paper presented at the Tu Kaha Conference in Wellington, 2016.*

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

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.

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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.

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

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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.

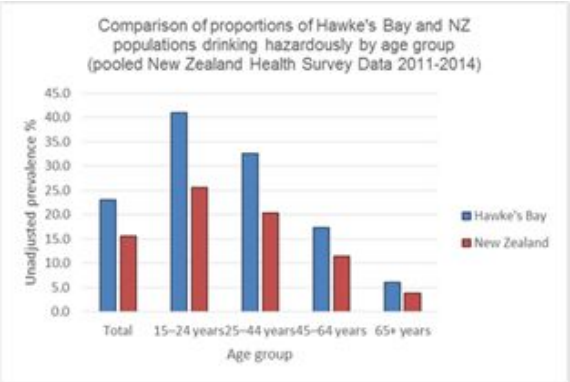
The impact of alcohol exposure in childhood – the facts

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

17.1

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

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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.

17.2

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.

17.2

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

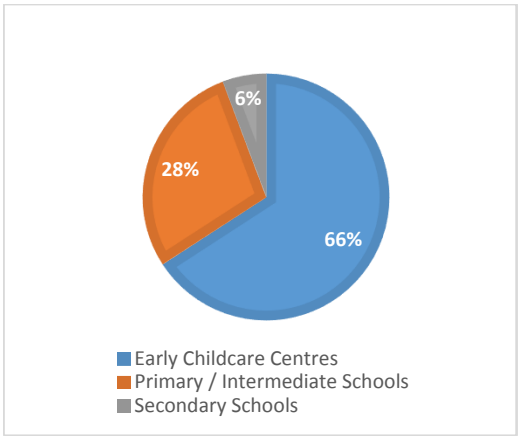
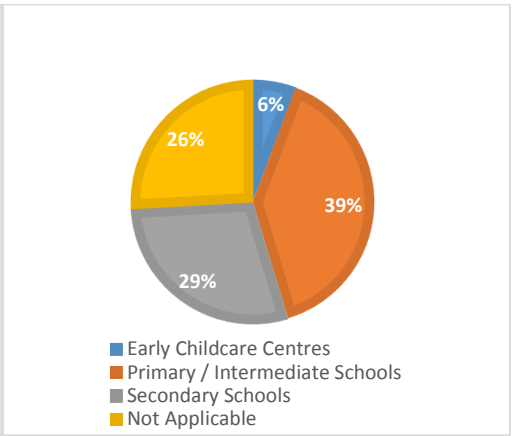


Figure 2: Proportion of applications from schools by type of educational setting



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

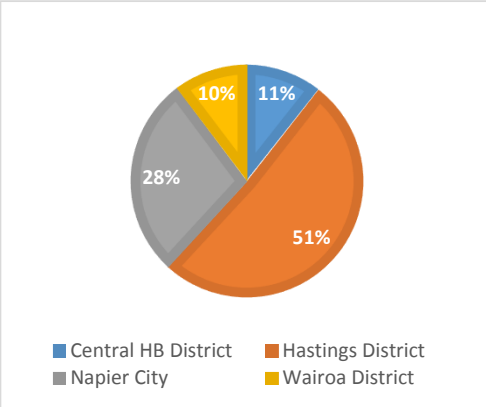
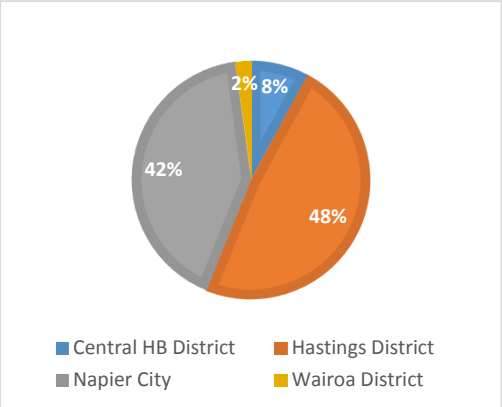
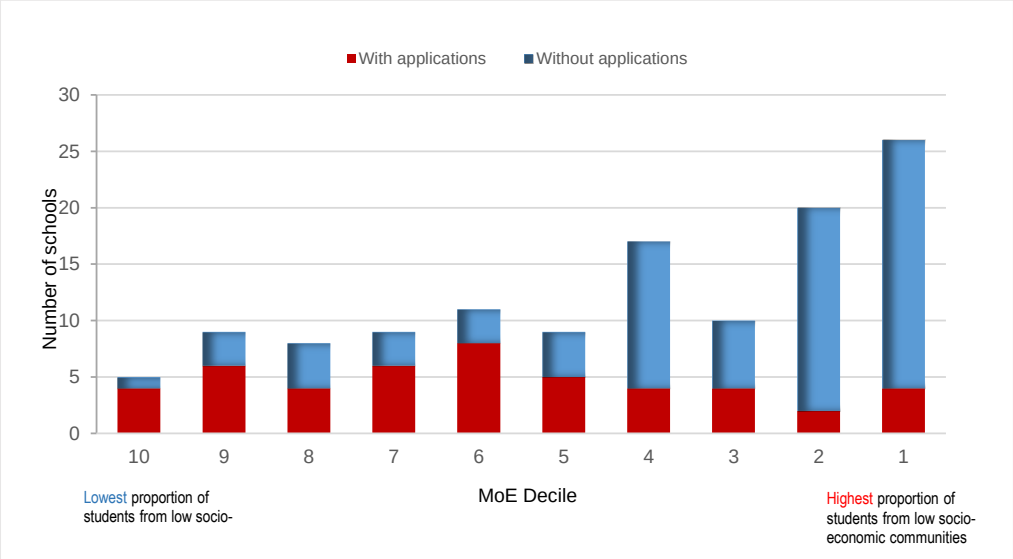


Figure 4: Proportion of applications submitted by schools by Territorial Local Authority



School decile rating and special licence applications

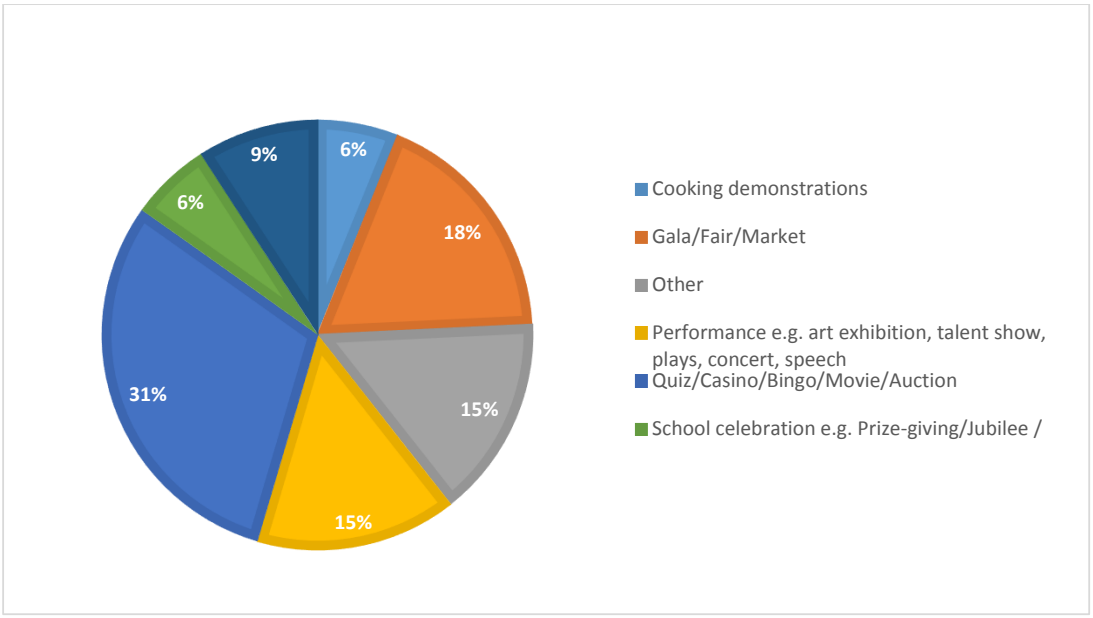
Figure 5: Number of schools with and without a history of special license applications by school decile rating



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

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17.2

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**

17.2

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

WHAKAWATEA TIA

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.

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.

17.2

[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

17.2

[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.

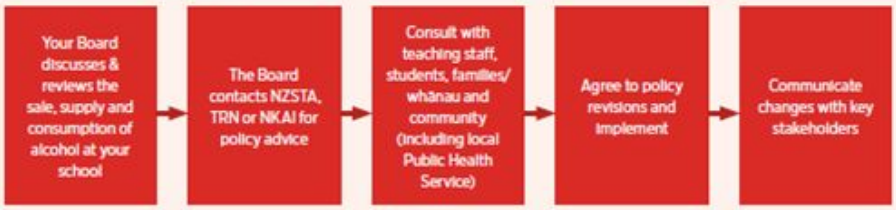
It is illegal for students under 18 years to be sold alcohol.

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	**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.