Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 9 May 2018**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

Dr John Gommans (Co-Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Nicholas Jones
Jules Arthur
Maurice King
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham

Apology: Anne McLeod

In Attendance:

Kate Coley, Executive Director - People & Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Kerri Nuku, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	**3:00**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions - First **1,000 days** of Life (Outstanding Action from Dec 17)	
5.	Workplan	

	Section 2 – Presentations /Discussion	
6.	The Place of Alcohol in Schools - Young people and under-age exposure – Rowan Manhire-Heath	3.15
7.	Community Prescribing for Nurses (presentation and discussion) – Chris McKenna	3.25
8.	Co-ordinated Primary Care Options (CPO) - Chris Ash and Mark Peterson Executive Management Team & Councils prior to scoping for next financial year	3.40
9.	Collaborative Pathways Update - Chris Ash and Mark Peterson	4.00
10.	Early Warning Score System Update – Chris McKenna, John Gommans	4.15
11.	Clinical Services Plan – Planning for Consultation – Ken Foote	4.25
12.	Midwifery Governance – Jules Arthur	4.40
13.	Maternal Wellbeing Model of Health Presentation (Board action) – Jules Arthur 10 mins	4.55
	Section 3 – Monitoring & Information Only (no presenters)	
14.	HB Health Sector Leadership Forum Update	-
15.	HBDHB Performance Framework Exceptions Q3 Dashboard	-
16.	Te Ara Whakawaiora - Did not Attend (local Indicator)	-
17.	Best Start Healthy Eating & Activity Plan update	-
	Section 4 – Reporting Committees	
18.	HHB Clinical Advisory and Governance Committee - for information	-
	Section 5 – General Business	
19.	Topics of Interest – Member Issues / Updates	
20.	**Section 6 – Recommendation to Exclude the Public**	

Public Excluded

Item	**Section 7 – Routine**	
21.	Minutes of Previous Meeting	
22.	National Bowel Screening Roll-out Presentation – Lynda Mockett & Malcolm Arnold	5:10

NEXT MEETING: Joint Meeting with Consumer Council on
Wednesday 13 June at Magdalinos Room, Havelock North Function Centre.

Interests Register
May-18

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Family member employed by HBDHB since November 2015	Daughter, RMO	Will note interest if discussions occur around RMOs.	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Chair of NZ AMDC	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMDC representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory & Governance Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Clinical Advisory & Governance Committee (CAG) for Health HB (Tenure ends 27/06/18)	Member	Report on CAG meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
	Locum General Practitioner			No	
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Pharmacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Pharmaceutical Society of NZ	Member	Pharmacy advocacy, professional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 11 APRIL 2018 AT 3.00 PM

PUBLIC

Present:
Dr John Gommans (Chair)
Dr Andy Phillips (Co-Chair)
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Nicholas Jones
Dr Tae Richardson *(until 5 pm)*
Debs Higgins
David Warrington
Maurice King
Anne McLeod
Lee-ora Lusis
Dr Mark Peterson
Chris McKenna *(until 5 pm)*

In Attendance:
Kate Coley, Executive Director – People & Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to ED P&Q
Dr Kevin Snee, Chief Executive Officer *(from 4 pm)*
Dr Frank Rawlinson, Chief Medical Officer, Whanganui DHB

Apologies: Jules Arthur and Dr Peter Culham

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Apologies were noted as above.

2. INTEREST REGISTER

No conflicts were noted for items on the agenda. Dr Tae Richardson has emailed changes to her interests. These will be updated for the next meeting. Lee-Ora Lusis to also send through a change in her interests.

Action: Changes to be made to interest register.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 14 March 2018, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 IS Roadmap Presentation
On today's agenda under item #8.

Item #2 Person and Whanau Centred Care
Included on workplan for discussion at the next joint meeting with Consumer Council.

Item #3 Budget Prioritisation Presentation
On today's agenda under item #7.

Item #4 Clinical Governance Structure – Value Assessment
On today's agenda under item #21.

Item #5 Choosing Wisely
On today's agenda under item #12.

5. WORKPLAN

The workplan was included in the meeting papers for information. No discussion held.

SECTION 2: PRESENTATIONS / DISCUSSION

6. HOMEOPATHS WORKING WITH PRIMARY CARE CLINICIANS

Dr Andy Phillips (Co-Chair) welcomed Angela Hair and her colleagues to the meeting to discuss homeopathy, following on from the development of the complementary therapies policy which was approved by Clinical Council last year.

Angela Hair introduced Lila Joffe, President, New Zealand Council of Homeopaths, Heidi Beck, Homeopath, Napier and Jude Henry, Homeopath, Waipukurau and thanked the Clinical Council for the opportunity to come to speak today.

Discussion included integration of homeopathy with conventional medicine; educating and helping patients to find solutions with homeopathy; New Zealand Council of Homeopaths vetting and training process, protocols and scope of practice; the importance of communication and working together to provide better health outcomes for our patients.

Dr John Gommans (Chair) commented that we recognise that our community make choices on what treatments they use and it is important that we agree how the two groups of clinicians work together. It is important to recognise the scope of practice and the role of others.

Suggestion that the "Manage My Health" patient health record might provide an opportunity for recording what complementary medicine is being used by patients.

Further feedback and requests for contact information for Homeopaths in Hawke's Bay can be sent to Leila Joffe (Leila_Joffe@hotmail.com).

The Chair thanked the team for their presentation.

7. INVESTMENTS UPDATE (OUTCOMES OF BUDGET PRIORITISATION)

The Chair welcomed Tim Evans, Executive Director – Corporate Services & Kate Rawstron, Project Management Office Manager to the meeting.

A snapshot of investments approved by Clinical Council from 2015-16 $3.5M and 2016-17 $2M for new investment was included in the papers for information.

Discussion took place on reviewing the past; overall impact of using the Clinical Council in the prioritisation process and thinking about the future, transparency of the process; funds being

used for new and innovative projects, looking at the quality outcomes, government priorities, improving quality of life and reducing inequities.

It was acknowledged that the $2-3M funds allocated via this process were only a very small proportion of DHB spend. In addition other recent large investments proposed such as Radiology, ICU, Laboratories, etc had come separately to Clinical Council for discussion and been supported by Clinical Council prior to being considered by the Board.

The Chair summarised that we recognise we need to change the way we do things if we want to improve how we make a difference across the whole health system. Once it is known what dollars the government will put against its priorities, it will help us to make the important decisions. It also needs to be determined how the Clinical Council can best be involved in the bigger picture discussions. In particular, the Co-Chairs need to ensure that innovative models of working in primary care come to Clinical Council for discussion and to inform future investment decisions. It was acknowledged that there are issues in capability and capacity within primary care for working up and presenting innovative models and the Executive Director of Primary Care is taking this issue forward.

Action: ***Process for presentation, discussion and decision making on innovative service models and funding to be worked up and brought back to a future meeting.***

8. INFORMATION SERVICES OVERVIEW AND ROADMAP - A CONVERSATION

The Chair welcomed Anne Speden, Chief Information Officer, Jos Buurmans, Enterprise Architect and Frank Rawlinson, CMO WDHB and for Regional Clinical Portal to the meeting.

A presentation was provided on the "IS Transformation", key points included:

- Move from being an IT supplier to a trusted business partner
- IS putting their house in order – looking at customer requirements, planning – resources/prioritisation, competent workforce and agreed deliverables
- Progress with changes – business led governance and prioritisation; service design – enabling workflow and enterprise architecture – strategy across environment
- How IS transformation is making a difference – laying foundations for the future; predictable planned delivery, business enabling, measureable business benefits; improved services; secure and resilient
- How we get there - working collegially to understand business strategy and refine IS strategy to enable foundations in place.

Frank Rawlinson provided a brief update on the Clinical Portal, which was presented at the Grand Round today.

The Chair commented that IS have changed their model and have their house in order. The DHB needs to get clinical business processes in order, which will be in place by the end of this year. Once this is in place, we will have a system which is able to evolve to achieve better integration and engagement will occur with primary care.

9. WINTER & FLU PLANNING

The Chair welcomed Carleine Receveur, Operations Director, Jacqui Akuhata-Brown, Integrated Operations Centre Manager and Sandra Bee, Emergency Response Advisor to the meeting.

The plan was introduced by Andy Phillips who gave context that this is part of planning following an earlier presentation to council on demand and capacity constraints on the health system. This is part of a whole of health system plan that includes current work underway to use existing capacity more effectively, to plan for increased demand in the winter, emergency planning for the expected flu outbreak later in the year and contingency planning for possible industrial action. It was emphasised that the work presented to council was very much in draft form and a more complete plan would be developed over the next few weeks.

Sandra Bee provided a presentation on the work to date, including stakeholder engagement; current situation in the Northern Hemisphere; what we can expect; triggers; tools – pre-phase, early phase and disruptive phase. Current work underway is a residential care forum, St John Ambulance alternative models of care; GP feedback, Community Pharmacy monitoring and socialisation of the plan.

There had been very positive feedback from the MoH on the HBDHB planning work to date.

Contributions to the plan from Council members, particularly Dr Rodgers and Dr Culham were acknowledged. Members were asked to provide further feedback on the plan to Carleine (Carleine.Receveur@hbdhb.govt.nz) as soon as possible.

10. QUALITY DASHBOARD PRESENTATION

Kate Coley, ED P&Q and Andy Phillips provided a presentation on the quality dashboard. The dashboard is a national one developed by the Health Quality Safety Commission (HQSC) with input from HBDHB clinical leaders. Comparisons are able to be made with individual DHBs or nationally. We would also like to be able to compare regionally. Work is continuing on the indications being used in the dashboard. HBDHB has had the opportunity to provide feedback on the dashboard and Andy Phillips is working closely with HQSC to develop it further.

Clinical Council **endorsed** the use of the Dashboard.

11. FRAMEWORK FOR DEVELOPING THE PEOPLE STRATEGY

Kate Coley, ED P&Q provided an overview of the first draft of the People Strategy Framework "Growing our People" which includes our "guiding principles" and "our culture". This has been developed from feedback received from staff during the Big Listen and Clinical Services Plan (CSP) meetings.

Brief discussion held regarding the need to develop a wellbeing programme; linking this to the CSP and the primary workforce and investing in our staff.

Maurice King asked the question whether the principles in the people strategy would be applied to dealings with NGO's and other contract holders with the DHB using pharmacy as an example. The Chair pointed out that pharmacy contracting was a national issue but that the contract was held local by HBDHB. Following the meeting the Co-Chairs asked Maurice to discuss this issue with Kate Coley and bring back to Council at the next meeting.

Actions: ***Further feedback can be emailed to*** kate.coley@hbdhb.govt.nz.
Maurice King to discuss his concern directly with Kate Coley outside of meeting.

12. CHOOSING WISELY UPDATE

The Chair advised that following the presentation at the last meeting he had had feedback from 11 council members; 7 providing their top 3-5 items, 2 agreeing with others, 1 providing 3 of their own making and 1 commenting on implementation challenges. The key themes from the recommendations chosen so far have been about the importance of minimising medication use by prescribing wisely and engaging patients in discussions/decision around their care.

Choosing Wisely would potentially be a good topic of discussion to be had at the joint meeting with the Consumer Council. Andy Phillips had been asked to provide a brief presentation to consumer council the next day.

Action: ***Meeting to be held to discuss agenda for the joint meeting and adding choosing wisely.***

SECTION 4: MONITORING AND INFORMATION ONLY

13. TE ARA WHAKAWAIORA - CULTURALLY COMPETENT WORKFORCE (LOCAL INDICATOR)

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

14. MĀORI & PACIFIC WORKFORCE ACTION PLAN - A COMPONENT OF BUILDING A DIVERSE WORKFORCE STRATEGY

The paper was included for information only. Kate Coley advised that the report was tabled at the Maori Relationship Board this morning and they requested that Maori and Pacific have their own reports and are not combined.

15. HAVELOCK NORTH GASTROENTERITIS OUTBREAK – PROGRESS REPORT

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

16. TE ARA WHAKAWAIORA - BREASTFEEDING (NATIONAL INDICATOR)

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

17. TE ARA WHAKAWAIORA - CARDIOVASCULAR (NATIONAL INDICATOR)

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

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

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

19. HB NURSING & MIDWIFERY LEADERSHIP COUNCIL & DASHBOARD

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

20. CLINICAL PORTAL PROJECT UPDATE

Item not discussed. Brief update provided under item #8.

SECTION 4: REPORTING COMMITTEES

21. IMPLEMENTING NEW CLINICAL GOVERANCE STRUCTURE

The Chair advised that the structure was approved at the Board meeting last month.

A meeting has been scheduled for next week to develop an implementation plan to progress the work of setting up the committees, reporting processes, membership including consumer and primary care, administration and co-ordination etc.

Andy Phillips described that one of the first examples of implementation of the Governance structure was to assign corrective actions from the recent compliance audit to relevant Advisory Groups.

SECTION 5: GENERAL BUSINESS

22. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***David Warrington*** – an issue has been raised with him regarding no acute care and mental health representatives on Clinical Council.

  The Chair advised that he had had similar feedback, which ignores the presence on Council of a Physician and Paediatrician who do acute call and the Medical Services Nurse Director who also covers ED. Further the Council is not meant to be representative for colleagues or services; instead it is a collection of 'wise heads' whose prime role is providing clinical governance support to the Board. The Chair noted that the work of Council had changed since it was first established and a good discussion on its purpose and membership and the risk of executive capture needs to be had at the Annual General Meeting. There is an issue of the wider clinical communities understanding of the role of Clinical Council and how Council communicate with and connects to them.

- ***David Rodgers*** – a local Hawke's Bay General Practice Conference is being held at the Napier War Memorial Conference Centre on 8-9 September. As a member of the organising committee he is considering how to use this as an opportunity to improve networking with colleagues.

- ***Maurice King*** – negotiation for the new national community pharmacy contract is underway with significant change in service. General consensus from Pharmacists is that it is an 'average' proposal with little thought, no analysis and suspect delivery. The negotiation process does not appear to reflect the stated values of the DHB.

- ***May meeting*** – decision to be made by end of next week whether the joint meeting with Consumer Council is deferred until June and have a regular meeting in May. The Co-Chairs will make this decision in conjunction with Rachel Ritchie, Consumer Council Chair.

23. SECTION 6: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

24. Minutes of Previous Meeting
25 Draft ACC "Supporting Treatment Safety"

The meeting closed at 5.25 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	14/02/18	***Person & Whanau Cented Care*** • Strategy document to be prepared	ED P&Q	June	In progress *Included on Workplan for June Combined Meeting*
2	15/03/18	***Clinical Governance Structure*** • Obtain TOR for IS Governance Group • Meeting to be held to discuss information management requirements with one group • Meeting to discuss implementation plan for structure	Co-Chairs Co-Chairs Co-Chairs / Com. Sec, ED P&Q	TBC TBC April	Mtg booked for 19 April
3	15/03/18	***Choosing Wisely*** • Members to provide top three items they would like to focus on • To be added to agenda for joint meeting with Consumer Council	All Members Co-Chairs / Com. Sec	April June	Ongoing *Included on Workplan for June Combined Meeting*
4	11/04/18	***Interest Register*** • Change to Tae Richardson's interests as per email sent 9/04/18 • Lee-Ora Lusis to advise change to interests	Admin	April	Actioned Not yet received
5	11/04/18	***Framework for Developing the People Strategy*** • Discussion outside of meeting re: applying strategy to NGO's and other contract holders • Members to provide further feedback on Framework	Kate Coley / Maurice King All	May	TBC
6	11/04/18	***Investments Update (Outcomes of Bubget Prioritisation)*** • Process for presentation, discussion and decision making on innovative service models and funding to be worked up and brought back to a future meeting	CEO / CFO	TBC	TBC

Clinical Council Workplan as at 1 May 2018 (subject to change)	Destination Month	EMT Member	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Council Meeting - Magdalinos Room, Havelock North Function Centre 1.00pm lunch - meeting 1.30-5pm 13 June 2018						
'Planned MRI and Fluoroscopy Equipment Replacement Programme Detailed Business Case	Jun-18	Sharon Mason	13-Jun-18			27-Jun-18
Legislative Compliance (normally Nov-Apr18) - not seen - moved to June Clinical and FRAC	Jun-18	Kate Coley	13-Jun-18		27-Jun-18	
Compliance Certification (with Legislative Compliance)	Jun-18	Kate Coley	13-Jun-18		27-Jun-18	
*Infection Prevention Control Committee - Quarterly (May 17 - Oct - May moved to **June 18**)*	Jun-18	Chris McKenna	13-Jun-18			
*HB Clinical Research Committee Update (May - Nov **-june18**)*	Jun-18	John Gommans	13-Jun-18			
*Clinical Advisory & Governance Group Report (Feb, Apr, May **June,** July Aug)*	Jun-18	John Gommans & Andy P	13-Jun-18			
*HB Laboratory Service Committee (Feb 18, **June**, Oct)*	Jun-18	Andy Phillips	13-Jun-18			
*HB Radiology Services Committee (Feb 18, **June**, Oct)*	Jun-18	Mark Peterson	13-Jun-18			
Combined with Consumer Council from 2.00pm						
Person and Whanau Centred Care (Clinical and Consumer Council June joint meeting)	Jun-18	Co Chairs councils	13-Jun-18	13-Jun-18		
Choosing Wisely (discussion between Clinical and Consumer Council at June Joint Meeting)	Jun-18	Co Chairs councils	13-Jun-18	13-Jun-18		
Annual Plan 2018/19 *First draft (June)*	Jun-18	Chris Ash	13-Jun-18	13-Jun-18		27-Jun-18
People Strategy FINAL (email 3/1/18)	Jun-18	Kate Coley	13-Jun-18	13-Jun-18		27-Jun-18
Recognising Consumer Participation - Policy Amendment	Jun-18	Kate Coley	13-Jun-18	13-Jun-18		27-Jun-18
Policy on Consumer Stories	Jun-18	Kate Coley / John Gommans	13-Jun-18	13-Jun-18		27-Jun-18
Clinical Services Plan verbal update (May **June** July)	Jun-18	Ken Foote	13-Jun-18	13-Jun-18		27-Jun-18
IS **Presentation** and Discussion (informed by CSP) June 18	Jun-18	Kevin Snee	13-Jun-18	13-Jun-18		
Alcohol Positon Statement INTERNAL and Strategy *for EMT consideration* (board action)	Jun-18	Sharon Mason	13-Jun-18	13-Jun-18		27-Jun-18
Te Ara Whakawaiora "Smokefree update" (6 monthly **May/June**-Nov)	Jun-18	Sharon Mason	13-Jun-18	13-Jun-18		27-Jun-18
Te Ara Whakawaiora - Oral Health (National Indicators)	Jun-18	John Gommans	13-Jun-18	13-Jun-18		27-Jun-18
Under 16 Free GP service Update	Jun-18	Chris Ash	13-Jun-18	13-Jun-18		27-Jun-18
Urgent Care Service Update (6 monthly **June** Dec 18)	Jun-18	Wayne Woolrich	13-Jun-18	13-Jun-18		27-Jun-18
Youth Health Strategy (board action June 17 for Update June 18 including Youth Consumer representative in attendance	Jun-18	Kate Coley	13-Jun-18	13-Jun-18		27-Jun-18
Proposed Annual General Meeting of Council - HBDHB Boardroom	Jul-18					
* Clinical Services Plan verbal update (May June **July**)	Jul-18	Ken Foote	11-Jul-18	12-Jul-18		25-Jul-18
Addressing Essential Services for People with Diabetes across the Healtlh Continuum (EMT and Clinical - further afiteld	Jul-18	Sharon Mason	11-Jul-18			
Clinical Advisory & Governance Group Report (**July** Aug Oct Nov Dec Feb Mar 19)	Jul-18	John Gommans & Andy P	11-Jul-18			
Clinical Portal Project update - monthly + Clinical Council	Jul-18	Kevin Snee	11-Jul-18		25-Jul-18	
Mobility Action Plan Update **Presentation**	Jul-18	Andy Phillips	11-Jul-18	12-Jul-18		25-Jul-18
Te Ara Whakapiri Next Steps (Last Days of Life) - MRB considered in April - moved to July for rest	Jul-18	Chris Ash	11-Jul-18	12-Jul-18		25-Jul-18
Annual Plan 2018/19 Second draft (August)	Aug-18	Chris Ash	8-Aug-18	9-Aug-19		29-Aug-18
Clinical Advisory & Governance Group Report (July **Aug** Oct Nov Dec Feb Mar 19)	Aug-18	John Gommans & Andy P	8-Aug-18			
Collaborative Pathways update (May - **Aug** - Nov) Aug include Consumer and Board	Aug-18	Chris Ash & Mark Peterson	8-Aug-18	9-Aug-19		29-Aug-18
HBDHB Performance Framework Exceptions Q4 **Dashboard** (from main report)	Aug-18	Kevin Snee	8-Aug-18	9-Aug-19		
Matariki Regional Development Strategy and Social Inclusion Strategy update from Feb 2018 Timing TBD as required.	Aug-18	Sharon Mason	8-Aug-18	9-Aug-19		29-Aug-18
Quality Annual Plan - 2017/18 - Annual review **August 18** / Feb 19 progress against objectives	Aug-18	Kate Coley	8-Aug-18		29-Aug-18	
Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)	Aug-18	Mark Peterson	8-Aug-18	9-Aug-19		29-Aug-18
Annual Plan 2018/19 - approved Minister timing open	Sep-18	Chris Ash	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	Sep-18	Chris Ash	12-Sep-18	12-Sep-18		26-Sep-18
Falls Minimisation Committee Update (Mar-**Sept 18**) - ceases when Gov Com Structure operational	Sep-18	Chris McKenna	12-Sep-18			
Heatlh Equity Report	Sep-18	Sharon Mason	12-Sep-18	13-Sep-18		26-Sep-18
Maternity Clinical Governance Group Update (Mar-**Sept**) - ceases when Gov Com Structure operational	Sep-18	Chris McKenna	12-Sep-18			
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Sep-18	Chris McKenna	12-Sep-18	13-Sep-18		26-Sep-18

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

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

RECOMMENDATION:

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

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

ATTACHMENTS:

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

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

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

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

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

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

The issue

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

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

How can Hawke's Bay achieve this?

Health

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

Councils

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

Education sector

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

Everybody

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

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

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

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

[4] Ward et al., 2014

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

Why is alcohol being used in schools?

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

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

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

The data shows:

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

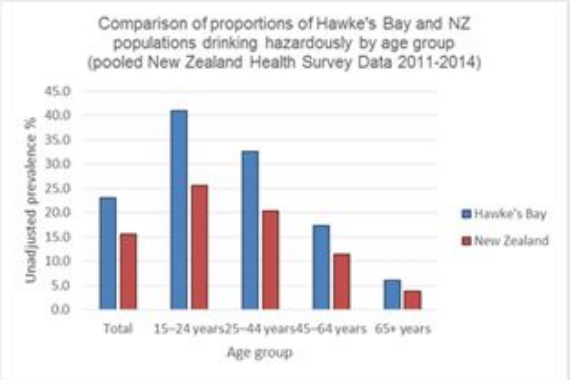
The impact of alcohol exposure in childhood – the facts

What's wrong with alcohol anyway?

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

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

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



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

Educational outcomes

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

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

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

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

5. Munro et al., 2014

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

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

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

Harm from alcohol can only come from drinking it

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

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

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

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

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

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

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

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

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

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

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

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

Why not focus on alcoholics?

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

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

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

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

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

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

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

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

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

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

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

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

[10] New Zealand Health survey, 2011/14

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

March 2018

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

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

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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.

HAZARDOUS DRINKING IN HAWKE'S BAY

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

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

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

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

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

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

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

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

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

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

YOUNG PEOPLE AND EXPOSURE TO ALCOHOL

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

Exposure to parental drinking

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

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

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

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

Exposure to alcohol marketing

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

Supermarkets

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

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

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

Sport

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

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

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

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

Online advertising

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

Schools

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

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

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

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

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

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

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

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

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

School alcohol policies

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

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

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

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

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

THE POLICY SETTING

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

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

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

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

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

Community views on alcohol

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

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

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

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

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

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

The role of the District Health Board in alcohol regulation

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

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

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

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

Licence oppositions

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

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

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

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

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

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

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

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

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

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

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

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

[8] Application no. SP-300-2013

PREVALENCE DATA

Total number of special licenses in Hawke's Bay

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

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

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

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

Type of school submitting applications for a special licence

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

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

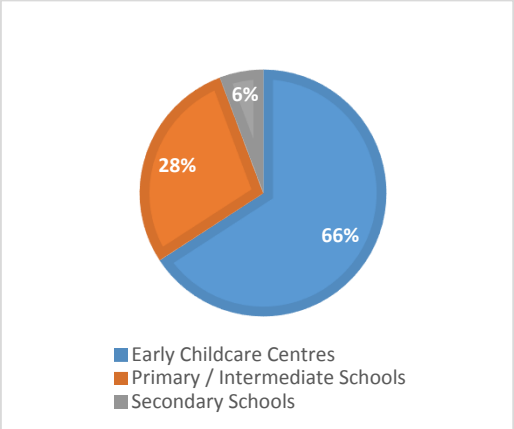
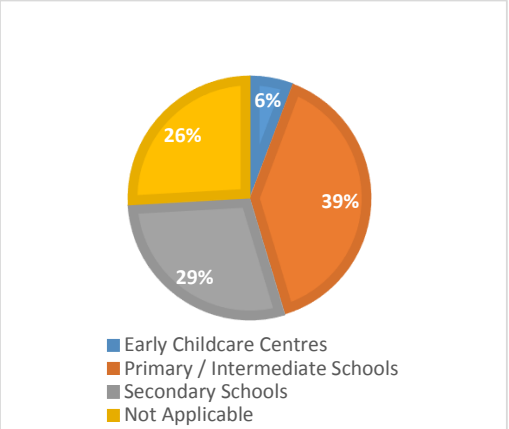


Figure 2: Proportion of applications from schools by type of educational setting



Location of schools submitting applications for a special licence

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

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

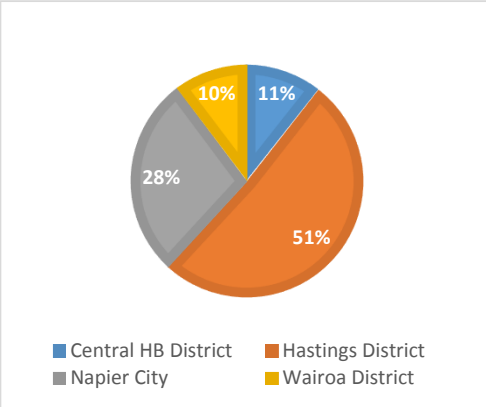
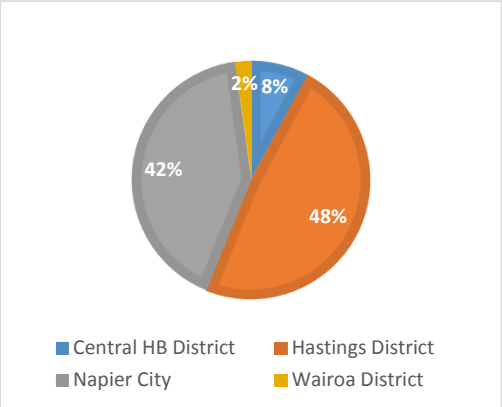
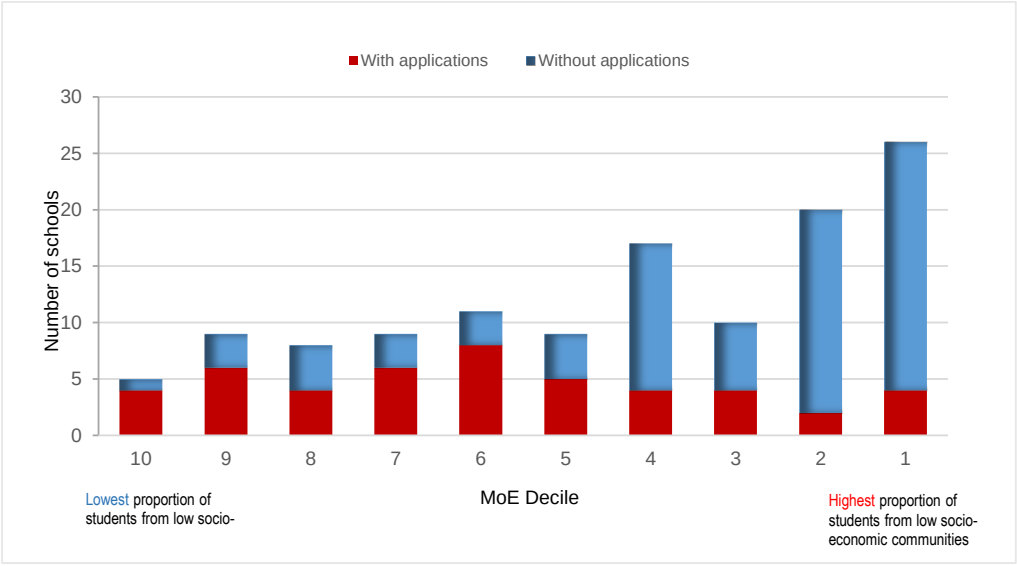


Figure 4: Proportion of applications submitted by schools by Territorial Local Authority



School decile rating and special licence applications

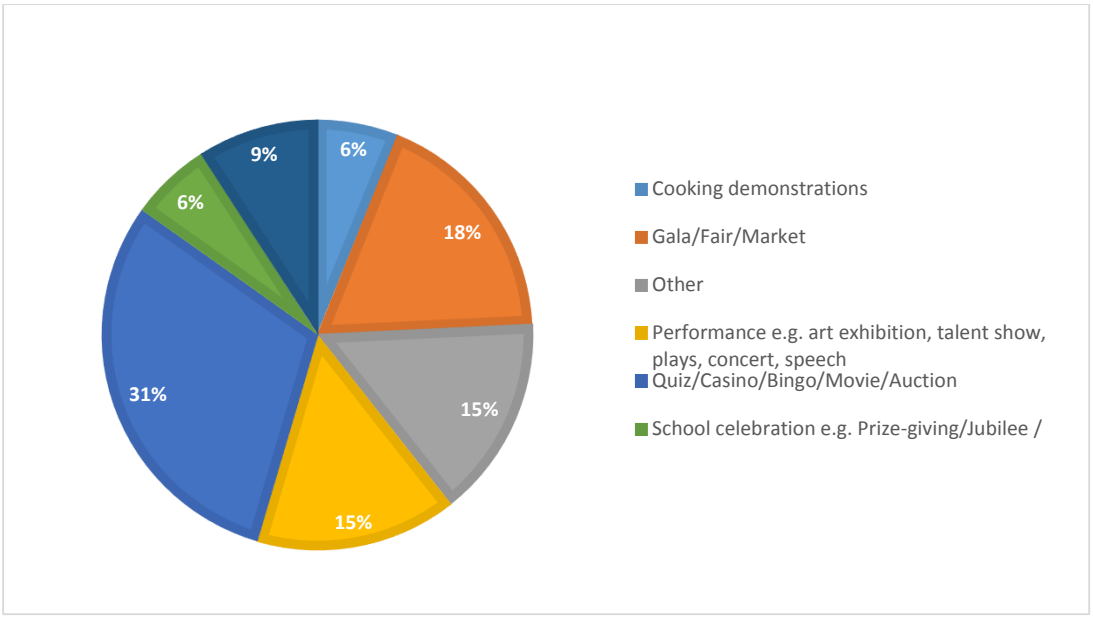
Figure 5: Number of schools with and without a history of special license applications by school decile rating



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

Type of event and notification of attendance by minors

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



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

HAWKE'S BAY DISTRICT HEALTH BOARD OPPOSITION ACTIVITY

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

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

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

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

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

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

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

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

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

SUMMARY

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

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

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

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

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

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

RECOMMENDATIONS

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

How can Hawke's Bay achieve this?

Health

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

Councils

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

Education sector

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

Everybody

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

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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**

6.2

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

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

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

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

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

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

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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

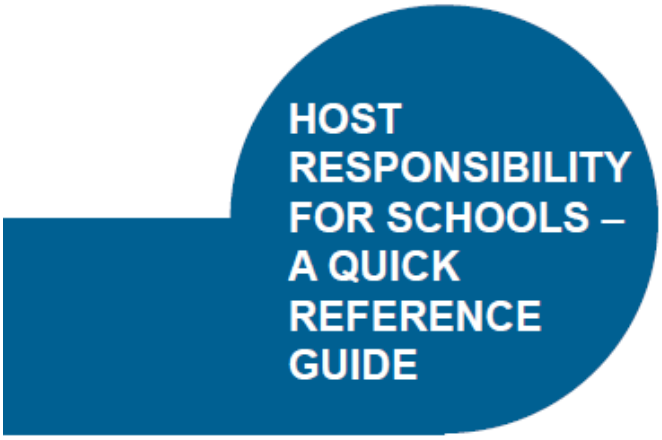
NOTES:

[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]



HAWKE'S BAY
District Health Board
Whakawateatia

Introduction

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

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

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

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

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

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

School alcohol policy

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

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

Reviewed March 2018

Host responsibility

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

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

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

Alcohol and host responsibility

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

Key issues to consider include:

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

Intoxication and transport

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

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

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

Food and water

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

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

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

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

Your responsibilities

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

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

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

✓ CHECKLIST

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

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

Contacts

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

Hawke's Bay District Health Board

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

District Licensing Inspectors

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

Police

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

See our other guides

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

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

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

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

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

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

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

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

NOTES:

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

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

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

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

HAWKE'S BAY District Health Board Whakawateatia

SAMPLE HOST RESPONSIBILITY POLICY - SCHOOLS

Host Responsibility Policy

Our Commitment to You, Our School Community

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

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

We want our school community to remain safe.

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

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

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

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

Reviewed March 2018

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

MINISTRY OF EDUCATION
TE TĀHUHU O TE MĀTAURANGA

SALE, SUPPLY AND CONSUMPTION OF ALCOHOL

GUIDELINES FOR SCHOOLS

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

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

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

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

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

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

A policy will:

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

Your policy will cover:

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

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

www.education.govt.nz

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

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

Legal Requirements

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

The licence identifies:

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

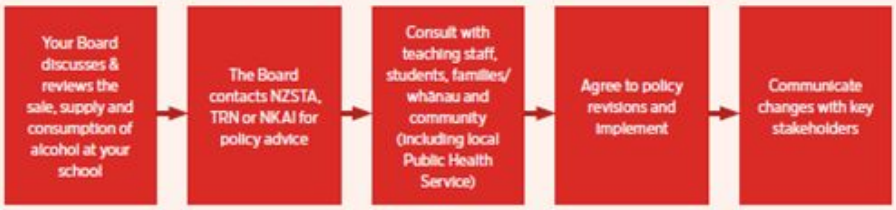
It is illegal for students under 18 years to be sold alcohol.

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

You may want to consider the following when developing your Policy

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

Steps in developing your Policy



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

The following resources may also help to develop your Policy.

Click on the links highlighted in red:

Resources to help to develop your Policy

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

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

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

COMMUNITY PRESCRIBING FOR NURSES

Presentation and Discussion

8

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

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

RECOMMENDATION:

That HB Clinical Council and HB Health Consumer Council

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

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

8

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

RECOMMENDATION

That HB Clinical Council and HB Health Consumer Council

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

DEFINITION

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

Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL COMMENTS

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

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

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

[2] PMS - Patient Management System

PROPOSED NEXT STEPS

Scope expansion of the CPO programme informed by:

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

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

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

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

RECOMMENDATION

That HB Clinical Council:

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

ATTACHMENTS:

Appendix One

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

Additional material available

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

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

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

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

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

Key:

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

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

[6] Joint Injections may be added.

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

HAWKE'S BAY District Health Board Whakawāteatia	**Collaborative Pathways**
	For the attention of: **Hawke's Bay Clinical Council**
Document Owner:	Chris Ash, Executive Director of Primary Care
Document Author(s):	Leigh White, Portfolio Manager - Long Term Conditions
Reviewed by:	Paul Malan, Head of Planning & Strategic Services; and Executive Management Team
Month:	May, 2018
Purpose	• Decision • Input/Discussion
Previous Consideration Discussions	• Historical papers • An Information and Decision Paper that outlines the options, analysis and IT vendors in details can be submitted
Summary	• Pathways need to continue as they are an integral component of other system-wide programmes of work, especially when seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings great value in fostering relationships.
Contribution to Goals and Strategic Implications	**WHAT DO WE WANT** A strengthened programme: • A selected pathway tool that becomes respected as a "go to" platform for evidence-based clinical guidelines and localised information pertaining to our Hawke's Bay demographics • That has enough of the right resources/people involved in development • That Providers understand and disseminate the value of the collaboration and the use of pathways at the coalface • A tool that we can pursue further service integration through increased IT enablement by way of electronic decision support (e.g. e-referrals) and dynamic pathways. • That will enhance continual improvement of quality, safety, case management and increasing awareness of self-care – e.g. patient resources • Will improve value for public health system resources e.g. stop the duplication or over diagnostics
Impact on Reducing Inequities/Disparities	The work of pathways aligns to equity and tripple aim. HEAT aligns with LTC HEAT
Consumer Engagement	N/A

Other Consultation /Involvement	Chief Medical Officer – Primary Care
Financial/Budget Impact	$233,092 – current budget
Timing Issues	Service Agreement with map of Medincie expires June 30 2019
Announcements/ Communications	Clinical and Consumer Council

RECOMMENDATION

That Clinical Council recommend to HBDHB Board that they:

1. **Commence** robust discussions with Chief Executive Streamliners on the transitional and permanent adoption of Health Pathways
2. **Review** the budget lines for 2018/2019 to disinvest temporarily some of the Pathway budget ($233,092) but excluding HBDHB FTE as it is necessary to keep employment status due to the historical knowledge of the programme) and reinvest temporary into the development process of e-referrals and/or winter planning aligning with CPO initiatives.

HAWKE'S BAY
District Health Board
Whakawāteatia

Collaborative Pathways

Author:	**Leigh White**
Designation:	**Portfolio Manager - Long Term Conditions**
Date:	**March, 2018**

OVERVIEW

Business Objective – Rule out and recommended option			
HBDHB Budget for Pathway Programme 18/19	Annual: 18/19 $233,092	**Current FTE Budget (0.9FTE)**	$65,391 (Does not include LTC P/Manager or Outsourced Clinical Support)
		Option	Indicative $
Option 1: **Status quo**: We will no longer be supported by the Map of Medicine tool. ***Explanation*** MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).		Not an option If extending till December	$0
Option 2: **Build an in-house tool for promulgation Explanation Comments from Jos Buurmans (IS)** **"***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal."*		Not an option	$0
Option 3: **Dispense with IT solutions & use a paper-based Explanation** This could be considered but not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.		Not an option	$0

Option 4: **Procure Community Health Pathways** **Explanation** • known tool - 'tried and tested' transition process from Map of Medicine to Health Pathways • provides extensive knowledge based and proven model • IS comments: "*Health Pathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of Health Pathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a Health Pathways 'governance process' that involves increasing the local pathways management team."* **Note: Additional cost implications** • Health Pathways comes with its own framework of development systems • Variable costs are based on number of pathway development Secondary HealthPathways are not inclusive in this costing	Option Note $TBC but based on population of 159,000 in 2015 Excludes FTE Prescribed FTE is 3.5	Yr 1 Yr 2 Yr 3 Yr 4 Yr 5	$137,950 $99,200 $99,200 $99,200 $99,200
Business Objective – Transition Option			
Put programme on hold for 6-12 months ***Explanation*** • Accept the previous work requires further refining pertaining to costings. • Commence confirmative discussions with Streamliners. Informal discussions have been held and both parties agree with 6-12 months led in time for a "go live" but with agreement there is an option for users to have access to pathways (unsure if there are costs implications – this needs to be confirmed) • IS comments: "*It's my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual 'integrated care' architecture that aims to support pathways, referrals, and workflow across the various layers of care"* • Temporary reinvest the Pathway Programme funding to focus on e-referrals and winter planning aligning to CPO ***Implications*** • Delay of programme may cause a break in what we have now and we will lose momentum and standardisation. • Risk of not doing pathways – will not align with strategic thinking. • If agreed during transition, users can have access to Health Pathways but will need to be informed that they are guidance and not localised.			Consideration

RECOMMENDATION

It is recommended that the HBDHB Board:

1. **Commence** robust discussions with Chief Executive Streamliners on the transitional and permanent adoption of Health Pathways
2. **Review** the budget lines for 2018/2019 to disinvest temporarily some of the Pathway budget (233,092) but excluding HBDHB FTE as it is necessary to keep employment status due to the historical knowledge of the programmer) and reinvest temporary into the development process of e-referrals and/or winter planning aligning with CPO initiatives.

Hawke's Bay District Health Board

9.1

Information and Decision paper

Pathways Programme of Work

In order to achieve the expected benefits, collaboration of the workforce involved in the said system, is a critical element in managing the "system of care," as Nightingale once described. This is more vital today than ever before, for the evidenced-based medicine revolution is now causing a heightened awareness for the need for better bridges between research evidence and local clinical best-practice. Thus, the clinical pathway has emerged as an important knowledge translation strategy for promoting effective healthcare.' [Blanchet & Flarey, Jabour]

Document Information

	Position	
Document ID	Pathways – Information and decisions Paper – version 3.0	
Document Owner	Chris Ash, Primary Director/Mark Peterson, Chief Medical Officer Primary Care	
Document Writer	Leigh White, Long Term Conditions Portfolio Manager	
Issue Date	7 March 2018	21/03/2018
File Name	I:\Projects\Clincial Pathways 2018	
Classification	Commercial in Confidence	

Document History

Version	Issue Date	Changes
0.1		Shared Central Region template – but localised for HBDHB. Ongoing relationships with Midcentral, Whanganui, Midlands PHO and DHBs
1.0.	27/12/2017	Initial work.
1.1	8/01/2018	Rework
1.2	15/01/2017	Feedback from various contributors (Clinical Pathway Editors/Information Services); distributed as DRAFT 1
1.3	26/01/2017	Rework and have meet with IT Services
2.0	12/03/2018	Include feedback from others Clinical Pathway Editors/Information Services
2.1		Feedback collated ready for submissions – sent to J. Garrett, J. Buurmans, A. Speden, M. Peterson, C. McKenna and L. Dubbledam
2.2	12/03/2018	Sent to J. Garrett (QA review), J. Buurmans, A. Speden, M. Peterson, C. McKenna and L. Dubbledam (No feedback received)
3.0	21/03/2017	**FINAL DRAFT** – Sent to M. Peterson and A. Speden

Document Review

Role	Name	Review Status
Clinical Pathway Editors	Wendy Wasson and Louise Patterson	Done
Anne Speden/Jos Buurmans	IS Department	Done
Linda Dubbledam	Health Hawke's bay	Nil feedback
Jill Garrett	Strategic Services Manager – Primary care	For QA review – not completed

Document Sign-off

Role	Name	Sign-off Date
Head of Strategic Services	Paul Malan	
Primary Care Director	Chris Ash	

Setting the scene

Barbara is 80 and lives with Malcolm, who was diagnosed with dementia after being admitted to his local hospital for recurrent falls. Barbara is his main carer. Their daughter, Alice lives in Australia.

On two occasions Malcolm needed to have day surgery under general anaesthetic. Barbara received the appointment letters but forgot where she put them. Malcolm missed his appointments. Barbara's daughter was concerned that her father had not attended surgery and got frustrated over the phone with her mother, so much so that she made her mother cry. Alice noted that her mother gets very tearful and irritable of late and wonders if she is depressed by looking after her father, Malcolm. Has it all become too much for her?

Alice flew to NZ to review the situation. It was obvious they were not coping at home and her mother was making excuses for the untidiness of the house and was uncooperative when Alice asked some questions. Alice was worried her mother was depressed and drove her to see her GP.

In Appendix 1 (a): *The diagram Alzheimer Web of Care shows some of the complexity in accessing services without a clinical pathway and model of care re-design.*

In Appendix 1 (b)*: The diagram depicts the different experience an individual and family will have when a pathway is implemented as part of the wider model of care re-designed.*

Excerpt taken from Business case of Clinical pathways Programme of work – Northern Region

Table of Contents

Executive Summary

Pathways need to continue as they are an integral component of other system-wide programmes of work, especially seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings value in fostering relationships – e.g. key questions such as "*how will this improve the timeliness of care for the patient*?", "*who is best to treat the patient?*", "*how can we prevent this condition from occurring in the population*?", and "*how do we improve the health outcomes for Maori*? Significant business impact can be made where we make available localised pathways for prevalent conditions, for example, better use of resources, reduction in inappropriate variation in care, improved patient experiences and outcomes. It is vital that this programme remains clinically led with wide clinician engagement, ownership and support.

The Problem

The Map of Medicine static pathway has been in use in Hawke's Bay for the past three to four years. The vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year). **This is the trigger for this review and information and decision paper.** Overall decisions need to be made on the continuation of the pathway programme and a replacement IT tool. The purpose of this document is to document, guide with recommendations to assist decisions and/or recommendations.

Decision

A decision needs to be sought on next steps to address the Pathways Programme otherwise:

- clinicians will not have access to workflows and pathways
- all benefits realised to date will be lost
- programme will lose momentum
- clinicians will lose faith in supporting tools
- clinicians will revert back to paper-based systems – standardisations will be lost

Description

In order for us to be able to pick the best option for Hawke's Bay, it is recommended that we need to be clear about what we want, are hoping to achieve and options as summarised in SECTION 1.

SECTION 2 describes where we have been and to date. SECTION 3 describes an analysis of differing pathway frameworks that have been explored with a focus on the technical options available for Hawke's Bay to transition and/or replace Map of Medicine. A comprehensive IT appraisal has been outlined in SECTION 3 looking at static and dynamic pathway tools in use in New Zealand.

Influencing factors are

- the value the DHB places on being part of a formalised clinical community for the development of pathways
- the risk to the pathway programme if localised pathways are no longer accessible
- for all options, an important consideration is the limited time now available.

Acknowledgement

Support for this paper in particular the review of differing pathway tools has been conducted and assisted by Midlands DHB with a collegial relationship formed with Midcentral PHO, Whanganui PHO.

SECTION ONE

1.1 Summary of business consideration

Business Objective	Priority

SUMMARY – WHAT DO WE WANT
Pathways need to continue as they are an integral component of other system-wide programmes of work, especially when seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings value in fostering relationships.
We need a tool that has the following needs:
• is user friendly, easy to navigate, quick to load
• functions on mobiles, tablets and desktops
• is as future proof as it can be, cognisant of the wish to integrate with systems, to drive up pathway usage and to continuously improve pathways.
• provides an easy to use content management system that supports an approach to developing, approving and publishing pathways, plus to receiving feedback to drive ongoing improvements
The objectives are:
• A strengthened programme:
  • a selected pathway tool that becomes respected as a "go to" platform for evidence-based clinical guidelines and localised information pertaining to our HB demographics
  • that has enough of the right resources/people involved in development
  • that Providers understand and disseminate the value of the collaboration and the use of pathways at the coal face
  • a tool that we can pursue further service integration through increased IT enablement by way of electronic decision support (e.g. e-referrals) and dynamic pathways.
  • that will enhance continual improvement of quality, safety, case management and increasing awareness of self-care – e.g. patient resources
  • that aligns to improving equity
  • will improve value for public health system resources e.g. stop the duplication or over diagnostics
	Priority – Decision making – Pathways to stay or go

Business Options	**Priority**
Option 1: ***Status quo***: We will no longer be supported by the Map of Medicine tool. MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).	Not an option
Option 2*: Build an in-house pathways tool or connect with Midlands Bespoke Model*: This option was explored in the original Business Case for Pathways 2014 and considered not an option at this time by IS due to the large amount of technical support. Additionally, we would be 'reinventing the wheel' to build a tool for disseminating our pathways, without any of the benefits of working with a provider and, potentially, other regions already using a tool. **Comments from Jos Buurmans (IS) "***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal".*	Not an Option
Option 3: ***Dispense with an IT solution*** and use a paper-based system, however this is considered not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.	Not an Option

Business Objective	Priority
Option 4: Procure Community HealthPathways **Explanation** • known tool with 'tried and tested' transition process from Map of Medicine to Health Pathways • provides extensive knowledge based and proven model • IS comments: "*HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.*" **Note: Additional cost implications** • HealthPathways comes with its own framework of development systems • Variable costs are based on number of pathway development	Option
Business – Transition Options	
Put programme on hold for 6-12 months. **Explanation** • accept the previous work requires further refining pertaining to costings. • commence confirmative discussions with Streamliners. Informal discussions have been held and both parties agree with 6-12 months led in time for a "go live" but with agreement there is an option for users to have access to pathways (unsure if there are costs implications – this needs to be confirmed) • IS comments: "*It's my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual 'integrated care' architecture that aims to support pathways, referrals, and workflow across the various layers of care*" • Temporary reinvest the Pathway Programme funding to focus on e-referrals and winter planning aligning to CPO **Implications** • delay of programme may cause a break in what we have now and we will lose momentum and standardisation. • risk of not doing pathways – will not align with strategic thinking. • if agreed during transition, users can have access to HealthPathways but will need to be informed that they are guidance and not localised. **To minimise the negative impact of transition to a new tool** • current localised pathways continue to be available during transition • strong change management – training awareness and support • good communication and clinical leadership are provided by stakeholder	Agreement

Potential Risks

ID#	Risk description	Risk Response	Probability	Impact
R-01	Limited resourcing available to further refine costings and new work	ACCEPT The business requirements require a thorough review of costings.	20%	2

Potential Risks				
ID#	**Risk description**	**Risk Response**	**Probability**	**Impact**
R-02	The ability of the pathways programme to deliver is compromised by inadequate resourcing.	AVOID Additional resourcing requested in this paper.	80%	3
R-03	The unclear position distracts delivery and pursuit of other temporary solutions for ensuring business continuity.	AVOID Ongoing consultation	60%	4
R-04	Delays in decision making by 1 July 2018 may cause delays in implementation for HealthPathways, who have a queue of prospective customers	AVOID Pursue recommended procurement approach as soon as possible to start the connections. Use contract, relationship management and technical advisory group to reduce risk	60%	4
R-05	Secondary HealthPathways comes at a significant cost and will require further investigations	REDUCE/EXPLOIT Discuss in contractual negotiations with Streamliners re Community HealthPathways Opportunity to lobby with other members of the HealthPathways community.	60%	3
R-06	Low confidence in the integration costs which look higher than expected.	REDUCE/EXPLOIT Direct discussions between vendors re integration points will address this.	80%	2
R-07	Delivery and capability	Streamliners experience	40%	1
Legend:		**Threat**: Avoid, Reduce, Accept **Opportunity**: Exploit, Enhance, Reject	20% Rare 40% Unlikely 60% Possible 80% Likely 100% Almost Certain	1:Minimal 2:Minor 3:Moderate 4:Major 5:Extreme

1.2 Summary of Technical Option - HealthPathways

IT Platform Objective: *It is important that a tool is selected that supports rather than hinders this improvement programme*

By way of context, pathways are a core enabler. Any IT tool is simply a vehicle for organising and disseminating information to care providers. Quality improvement comes from the collaboration in development of the pathways which brings together clinicians and management to focus on specific patient journeys where the region can share knowledge, learnings and current innovations to improve the health of people in the region.

Following evaluation of six alternatives against specific criteria's and against strategies, **ONE option** is preferred. For full overview of all other alternatives please refer to Section 2:

Criteria	Technical Option – Community HealthPathways
Summary of the Option (Community HealthPathways)	HealthPathways is a very established model with established governance. The tool is used by 12 of 20 New Zealand DHBs, and offers the lowest risk for reputation and clinical engagement. 550 pathways are available national and internationally. It is a static tool based on a community managing multiple pathways.
Advantages	Joining a large clinical community with ability to create and lead pathways that are nationally adopted, plus access to large Australasian group of pathways. Access to clinical, evaluation and technical groups as part of the HealthPathways Community. Library of pathways speeds up pathway development Clinicians will be able to move to any other NZ region and many in Australia and use the same system Potential to integrated with e-Referral/work committed/discussions with Healthlink
Risks/disadvantages	Regional change management and transition Reduction in number of new pathways developed due to reallocation of resourcing to transition Technical writing per hour fee charged by HealthPathways and is a 'must' of pathway localisation. Technical writing is done by a Health Pathways team. They are able to provide quick turnarounds, but this nonetheless adds a step to the localisation process and the potential for delays outside of our control Need to follow HealthPathways recommended service model which implies an increase in programme resources and role and responsibility changes for the current team. Cannot have pathways all the way through the patient journey due to the separate secondary pathway model Cannot open pathways to public Not fully integrated but there are no vendors in NZ who are
Hard benefits	Not easily quantified plus accurate attribution of where financial benefit comes from is difficult. International evidence demonstrates cost saving benefits around pathway development and use.
Indicative timescale	Due to the demand of business HealthPathways would prefer a 6-12 month led in time. Commence with localising some and will make the remaining as PDFs on the HealthPathways site. Clinical knowledge base of 425 pathways would also be available (unlocalised but still in a NZ/Australian context).
Usability and Stakeholder support	High, as evidenced by the clinician feedback e.g. GP Registrars Clinicians' have stated the speed with which you could find info in Health Pathways Same number of clicks however layout makes it easier to find the information Mobility functions on various screen sizes
Able to replace MoM	Low risk, as is off-the-shelf
Usage	Reporting via Google Support, maintenance and hosting via SaaS Technical fit HTML and Hosted by HealthPathways
The impact of transitioning to a new tool	Medium risk, as known tool with 'tried and tested' transition process from Map of Medicine to HealthPathways User base would have to move to new tool, and there would be short term loss of functionality and integration. Would involve user change management, IS integration resource and clinical advice for transitioned pathways.
Regional/ local needs	Low risk, as HealthPathways comes with its own framework
Analysis of option	Established model with established governance. Used by 12 of 20 NZ DHBs, and offers the lowest risk for reputation and clinical engagement.

Criteria	Technical Option – Community HealthPathways				
	Downside is cost of Secondary HealthPathways.				
Option appraisal	Meets all objectives. Low risk.				
Indicative costs	Yr 1 $137,950	Yr 2 $99,200	Yr 3 $99,200	Yr 4 $99,200	Yr 5 $99,200
	Cost above exclude FTE and are based on a population of $159,000 in 2015 – TBC Cost do not include Secondary HealthPathways Ballpark cost. Further vendor engagement required to validate.				
Recommendation	RECOMMENDED - Next step – to validate costs and proceed to business case				

1.3 Feedback from HBDHB IS Department regarding technical options

"Out of the options considered to replace the Map of Medicine tool (MoM) we currently use to document and publish clinical pathways, the HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.

I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal.

Furthermore, it's my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual 'integrated care' architecture that aims to support pathways, referrals, and workflow across the various layers of care that I am more than happy to discuss with you.

I suggest that we explore implementing a transition solution while defining this end-to-end solution. Options include:

- *Negotiating an extension for MoM support*
- *Retaining MoM for viewing only (we would not be creating or updating pathways in MoM anymore). This would depend on whether MoM would still be accessible from 1 July 2018.*
- *Extracting pathway documentation from MoM (e.g. as PDFs) and publishing these on a public website*
- *Advising users of MoM (e.g. GPs) to extract relevant pathways themselves"*

1.4 Delivery Capability from HealthPathways Teams

- The likely team (including any potential vendors) have a proven, successful track record relevant to the outcomes of this initiative, AND
- Strong leadership is in place, AND
- Any capability gaps can be addressed through explicit training and the use of defined support, AND
- There is a clearly defined scope and agreement of the clinical and business benefits required

1.5 Suggested Transition Process

IT tool

Community HealthPathways is recommended.

Secondary HealthPathways is an additional cost which has been de-scoped from this document for revisiting at a later point.

Note: there may be an issue of timeliness of transitioning to HealthPathways and there may need to be an interim solution as it is estimated approximately 75 fully localised pathways may take some time to complete – *this will need to be confirmed*.

- Additional resourcing of 1.0 x FTE to investigate and strengthen the Pathways Programme around pathway implementation, localisation, change management and pursuit of further IT enablement for example:
    - we can pursue further service integration through increased IT enablement of high impact pathways by way of electronic decision support and dynamic pathways
    - enough of the right resources/people are involved in pathway development as currently "light on the ground"
    - providers understand and disseminate the value of the collaboration on pathways and the use of them at the coal face
    - the pathways tool becomes a respected "go to" platform for evidence-based clinical guidelines and localised service and primary/secondary arrangements
- Approach and progress the implementation of preferred option: HealthPathways is recommended as the preferred option to replace Map of Medicine.
- Explore the following temporary solutions by way of mitigation for the risk that the HealthPathways implementation overruns:
    - make PDFs of the current localised pathways available on a website, which would still allow the Midland region to access the localised pathways electronically that contain the information for referral and management.
    - continue to liaise with our Midlands and Central Regions partners, this way we have the potential of financial benefits of a regional pricing tool with HealthPathways rather than individual
    - continue to support Facilitator and Editor FTE for transition period

Transitional milestones – dependent on approval process

	Duration:	**Target Dates 2018**
Milestones: Deadline 30 June 2018	12wks	
Additional resourcing of 1.0 x FTE to investigate and strengthen the Pathways Programme (2 year review). Ongoing programme resourcing has been identified as a critical success factor to a strengthened Pathways of Care programme that delivers on the region's needs around IT enablement (electronic clinical decision support) and around development and usage of pathways (relies on availability of local pathway development resource, plus on change management at a central regional and at a local level). Adequate resourcing for the programme is essential to its success (refer to Appendix 6)	?	
Confirm current FTE	6 weeks	By end of May
Establish discussions with Streamliners (quotes, transition planning)	5 days	
Prepare exit clause from Map of Medicine	2 days	
Retrieve Localised Pathways from Map of Medicine Tool	1 week	Done – in PDF

Catalogue current and future integration pathways	3 days	Done – Template attached
Catalogue integration needs with e-Referral System	3 days	Discussions commenced
Communications to stakeholders	4 days	

1.6 Procurement Compliance

Does this solution involve external parties/suppliers?	Yes
Is a current and relevant contract already in place for the same product/hardware/service?	?
If no contract in place, will need to engage with Procurement to discuss the Procurement activity required to ensure compliance with the Procurement and Contracts Policy?	Yes

SECTION TWO

2.0 Purpose

This document has been requested by Hawke's Bay District Health Board Clinical Council (CC), to inform and assist CC with decision making for the continuation of this on-going programme of work, but most of all the procurement of a Pathways IT tool. This document has been developed using the learnings acquired during the last three years, from the views and comments of key stakeholders and existing knowledge shared by other DHB regions.

2.1 The Problem

Hearst Group UK has announced that they are ceasing development of several of their tools: side bar and e-Referrals Map of Medicine® static pathway tool. This is due to the National Health Service (NHS) developing a national e-Referral solution which is not linked to the Map of Medicine® pathways system and makes the Map of Medicine® e-Referrals obsolete. By March 2018, any non NZ customer support will be stopped.

It is likely that by the end of June 2018, HBDHB agreement will cease however there can be an option of extension to align with Midlands's extension till September 2018. Note all of the HBDHB pathways that have been developed within the Map of Medicine product will no longer be accessible when agreement ceases.

This poses significant clinical risk:

- clinicians will not have access to the workflows and pathways
- all benefits (e.g. reductions in variations in care, quality and timeliness, unnecessary hospitalisation) realised to date will be lost
- programme will lose momentum
- clinicians will lose faith in a regionally supported tool
- clinicians will revert back to paper-based systems – standardisations will be lost

2.2 Background

HBDHB and Health Hawke's Bay (PHOs), service about 163,580 residents and have been on the pathway of development journey for more than four years using the UK evidence based pathway publishing tool "Map of Medicine".

2.3 Overall statements

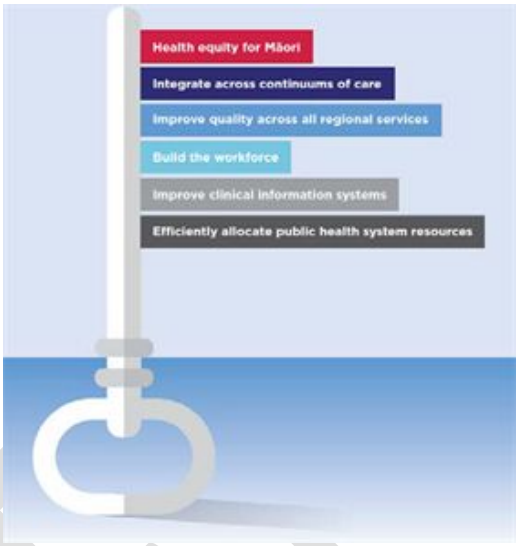
The process of creating a pathway is as essential as the outcome – it's not a cookbook that others can simply lift off the shelf!

The local "health system" benefits through less demand on acute and residential care services as patients can be better managed in the community, freeing up resources to provide more elective services and increase assistance to primary care.

As well as finding a replacement tool for Map of Medicine, an objective of this work is to improve and support central region's priorities (continue to work together).

The Pathways Programme supports the New Zealand Triple Aim Framework.

The Pathways Programme is integral to achieving all HBDHB regional objectives.



2.4 Pathways Context

Pathways can be as simple as the translation of clinical guidelines, referral criteria for clarity in a regional and local context or a fully integrated pathway transforming a person's journey. Pathways allow clinicians that face similar challenges on behalf of their patients each day to standardise and streamline clinical processes. The European Pathway Association in 2006 defined a pathway as: *"A methodology for the mutual decision making and organization of care for a well-defined group of patients, during a well-defined period"*.

An example: HBDHB Corticosteroid Pathway 2017: Radiology became overwhelmed with referrals (no capacity and identified some GPs had no capability). Referrals were assessed by Clinicans (primary/secondary) and a MDT working group. Outcomes: consultation, communication, change of process and GP education – **a success!!**

2.5 Supporting Literature

Conceptually, there are benefits in differentiating pathways from medical guidelines. The Institute of Medicine, 1990, created the most widely used definition of guidelines: "*Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances*". While guidelines are a consensus of medical experts, pathways require a consensus among different stakeholders in the complete patient treatment process. As a consequence, pathways may deviate from guidelines on which they are based in the case where a hospital or practice does not have all the resources necessary to complete the recommended procedure (Lenz & Reichert, 2007).There are numerous other terms used for pathways: 17 different terms were identified by de Luc and Kitchiner (2001) on the concept of pathways. The most common terms besides pathway, include: care pathway, clinical pathway, integrated care pathway, care map, care protocol, anticipated pathway, care profile, collaborative care plan.

The reason for having a Pathways Programme is not so much about financial benefit but more about *"this is the right thing to do"* and will assist other models of care re-design work taking place across the health system. In relation to cost effectiveness of pathways, there have been many international studies and literature reviews that have documented a positive effect on health system costs. In the review by Van Herck et al, 82.5% of the studies reported a positive effect on reducing costs; Dautremont et al, Olson et al and Sermeus et al also came to this conclusion in their study.

International experience shows that benefits are achieved when pathways are part of a whole of system change. Literature states that pathways can be significant enablers for integrating health care across primary and secondary settings and have the potential to achieve policy objectives that are captured within the Triple Aim. That is:

- improve the quality, safety and experience of care
- improve health and equity for all populations
- gain best value for public health system resources

2.6 Key benefits of Pathways

Key Benefits	
The implementation of pathways has shown significant improvement in care both in New Zealand and internationally. Our pathways have been a vehicle to bring clinicians together as a region to focus on specific patient journeys (e.g. Faster Cancer Pathways). They have been collaborative as there has been sharing of knowledge, learnings and current innovations to improve the health of people e.g. change to Outpatient letters for Hips/Knees) region. The current approach to development of pathways predicates affordability of efficiencies through reduced duplication and through a shared ethos in pathway development.	
Strategic fit The pathways and tools are used to align with the NZ Health Strategy 2015 strategic themes with an emphasis on integration, which is critically dependent on a team approach. Integration across continuums of care is one of the HBDHB strategic objectives. A key enabler of integration is the regional partnerships. Currently, regional pathways of care are published on the international evidence based software tool 'Map of Medicine' containing up-to-date international best practice guidance.	
Other benefits	
Person-centric design making for improved quality of care and improved patient outcomes An example is reducing Radiology wait times for Corticosteroid injections	The pathway development process is a process of co-creation and highlights opportunities for service redesign, operational process improvement and possibilities to shift services closer to home, leading to better people satisfaction and outcomes. Some of the questions that may be asked as a pathway is developed include, "*how will this improve the timeliness of care for the person*?", "*who is best to treat the person*?", "*how can we prevent this condition occurring in the population*?", and "*how do we improve the health outcomes for Māori.*"

Improved communications between professionals, with patients and their family/whanau An example is people learning how to self-manage gives empowerment	The voice of the person is of central importance in the design of pathways and wherever possible this occurs to ensure that the needs of people and their carers and whānau can be included. These pathways include referrals to: • Non-governmental Organisations (NGO) • education and support resources • self-help information and information to promote independence and goal setting (e.g. ACP links)
Increased collaboration improves health outcomes and reduces inequity	The pathways of care draw together groups of clinicians and management from primary, secondary and other stakeholders to critically evaluate current pathways of care which may include inefficiencies, variation in practice, inequity and gaps in service across our region.
Create system level efficiencies and improve financial sustainability An example is reducing avoidable hospitalisation by increasing primary care options	Pathways are a key step in transforming a person's care. Many common issues are being dealt with simultaneously across sectors and this can lead to duplication of effort. Pathways support sharing of knowledge, learnings and current innovations that are occurring locally. Collaborating and taking a whole of system view across all sectors uncovers opportunities to reconfigure services to benefit both the person and the bottom line.

2.7 Supporting quality improvement

Pathways need to be implemented as part of an overall quality improvement framework by successfully communicating changes, training staff and ensuring that projects do not become IT projects, but rather clinician led projects aimed at improving quality of care for individuals.

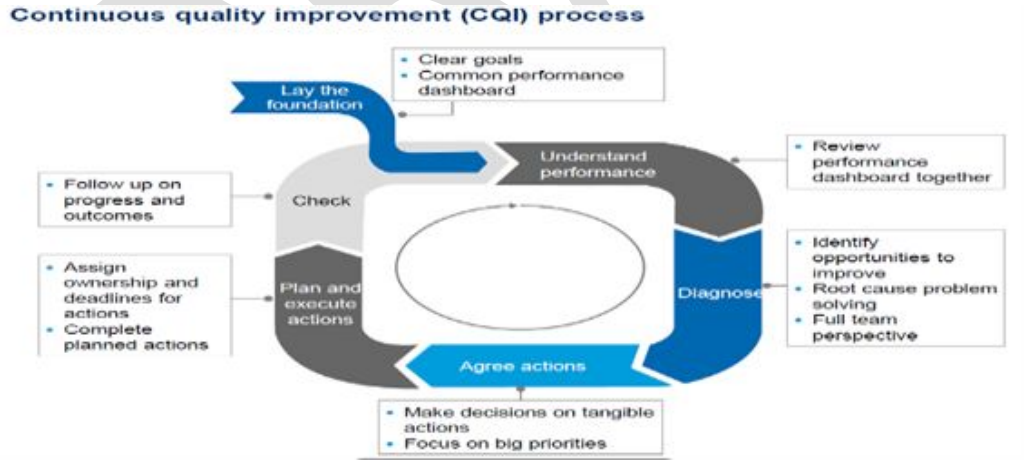


Figure above: Taken for the evaluation report of the Diabetes Care Project, McKinsey & C0, Canberra, Australia 2015

At its most complex, a pathway can act as a fully integrated information system, guiding and monitoring a person's journey of care between health professionals and across sectors. The key question is, "*Can integration improve quality and save money*?" Dr John Ovretveit states that, "*yes it can*". Dr Ovretveit provides an example of a central

problem of inappropriate referrals – delays and unnecessary referrals. The solution to this requires approaches that change referral practice.

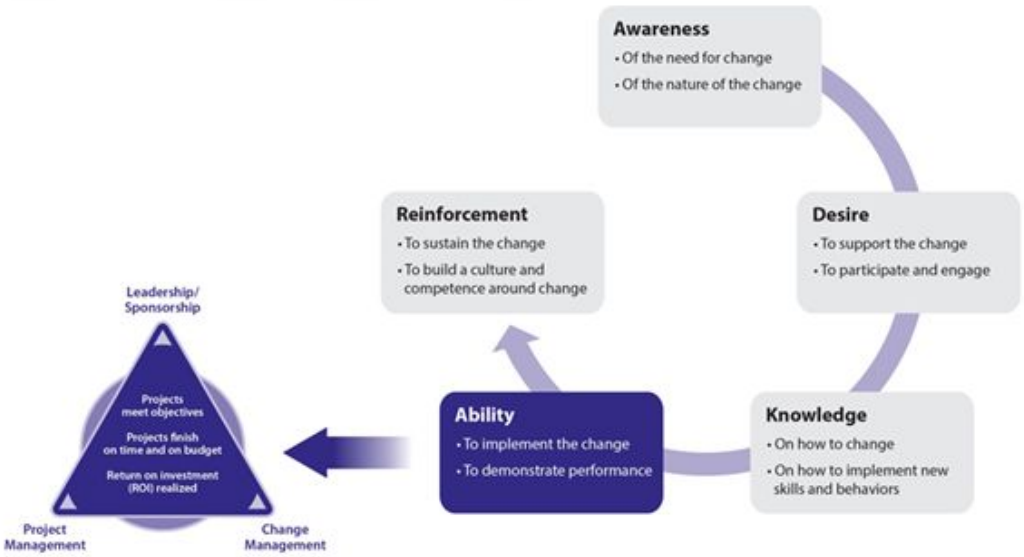
2.8 Supporting culture and transformation change

The enduring value of implementing pathways is the **culture and transformational change.** This change comes from successful implementation and understanding change management issues and barriers. Developing strategies to overcome issues and barriers are seen to be a foundational building block irrespective of the technology which could be used in the future to deliver pathways. The Pathway Programme seeks to address and minimise inequalities by ensuring that documentation and resource activities are undertaken to promote and maximise Māori and Pasifica participation (Refer to HEAT, Appendix 2). The clinicians and managers participating in the development of pathways need to consider the person's/family/ whānau and others who they meet along the way through their care journey. Some of the questions that may be asked as a pathway is developed include "*how will this improve the timeliness of care for the person*?", "*who is best to treat the person?*", "*how can we prevent this condition occurring in the population*?", and "*how do we improve the health outcomes for Maori*?"

To be successful and achieve the benefits the Pathways Program of work requires all organisations and stakeholders to work collaboratively. Primary care clinicians need to work in partnership with hospital clinicians, Health Hawke's Bay practice facilitators' need to work in partnership and the software developers need to be agile enough to respond to clinical feedback and improvement and to work with the Pathways Program team to assist with implementation. The Executive Management Team (EMT), Funders and clinicians need to support new development/ new models of care and together provide leadership in respective stakeholder organisations to work in partnership at the strategic level.

Change management is core to this initiative. Transitioning a whole region to a new tool is a significant undertaking. Why in favour of the HealthPathways option? - the tool is known and respected by clinicians across the region, some of whom have already used the tool in other regions. This will facilitate driving awareness of the nature of the change, plus the desire to change.

To roll out HealthPathways will require significant change management, potentially using the current governance framework (Clinical Council) and the current resourcing framework. An ideal would be investment and local champions that can drive localisation and usage of the pathways.



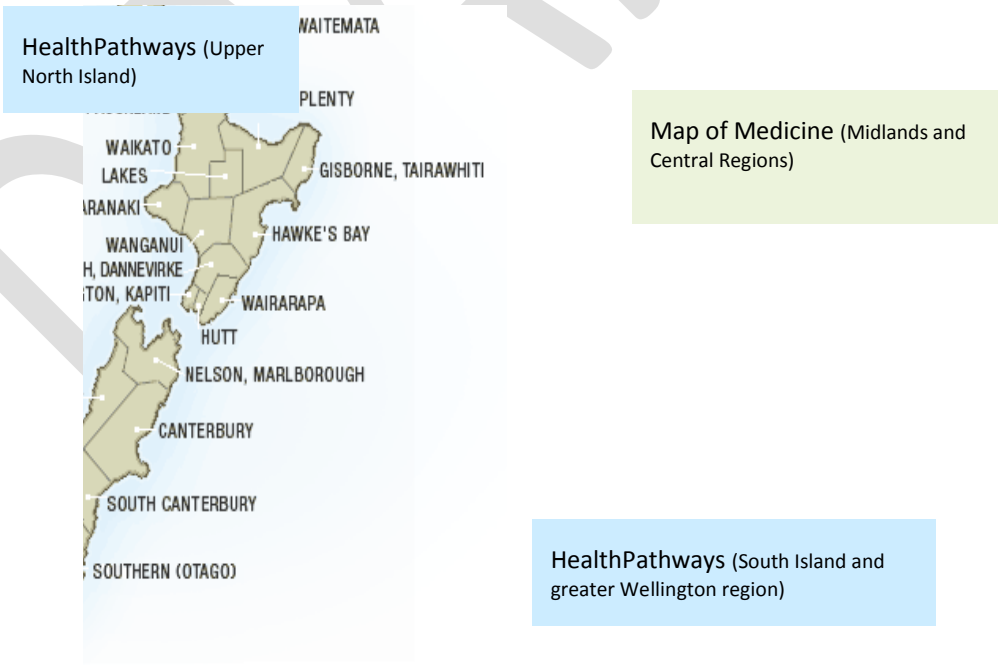
2.9 The National journey

In 2010, the National Health IT Board undertook a study to identify the 'requirements of a tool that would provide the greatest opportunity for improvements in the quality of patient care along the total health spectrum'. In defining the requirements, the study panel identified the main problems in the health sector that a pathways tool would help. These were:

- inconsistency of decision making (in diagnosis and treatment, also resource allocation, and service and capacity planning),
- difficulty in spreading the best models of care (significant duplication of effort in developing pathways that are then not shared with others, culture that entrenches current thinking),
- achieving systematic quality improvement (lack of governance and auditing mechanisms).

Despite the Health IT Board's emphasis on a single national tool, the ensuing years have seen the implementation of other tools. An example is the Canterbury Initiative, which rolled out a 'home-grown' HealthPathways tool as a localisable package of pathways and processes to all of the South Island DHBs, as well as those of the greater Wellington and Wairarapa. Health pathways (known as Streamliners) are now moving into Australia and UK. Other areas chose other vendors e.g. Map of Medicine, Health Navigator. In 2017, Auckland regions made the decision to move to HealthPathways.

***Figure below**: The distribution of Pathway tools currently in use in NZ*



2.10 The Hawke's Bay Journey

This context is important in understanding the HB region's three to four year journey with Map of Medicine. A pilot programme facilitated by MidCentral DHB was conducted in October-December 2013 to trial the pathways development process. This resulted in four completed pathways and three pathway outlines across three patient conditions. During this pilot, the Map of Medicine tool was utilised through MidCentral DHB. In July 2014, Clinical Council agreed to sponsor the establishment of Clinical Pathways within the Hawke's Bay district, focusing on two interrelated aspects:

(1) development of pathways (the collaborative process of determining best practice health care for a specified condition) and
(2) Identification of an IT tool that can promulgate pathways throughout the sector. Tool chosen Map of Medicine

2.10.1 Current Situation

In October 2017 HBDHB was given notice from Hearst group (vendors of Map of Medicine) that they were exiting out of UK. The purpose of ceasing development was due to the United Kingdom National Health System (NHS) developing a national e-Referral solution which is not linked to the Map of Medicine pathways system and makes the Map of Medicine e-Referrals obsolete. By March 2018, any non NZ customer support will be stopped.

HBDHB Map of Medicine Licence Agreement expired December 31 2017, but after renegotiation has been extended to June 2018 but with an out clause of a month's notice if decisions are made earlier.

2.10.2 Current Investment

- HBDHB patient population: 163,580
- Fixed annual licencing fee Cost: 18p/$0.34NZD per eligible service user
- Variable annual Map publishing cost: £500 - £1500/$984 -$2837.21 NZD per pathway. Some maps may hold up to eight pathways with no further cost for publishing or changing these pathways.
- For further budget breakdown and analysis refer to Appendix 3

2.10.3 Stakeholder Requirements

Primary and secondary clinicians are the key stakeholders for this programme along with other health providers, who access and use pathways to inform and streamline their recommendations of a person's care, treatment and education. A key issue for this group is gaining buy-in through empowerment and collaboration to develop, use and ultimately 'own' the pathways and the outcomes. Usability of an IT tool is an issue in that it needs to fit with current work flows and processes; these requirements are further explored and detailed in Appendix 5.

Health sector managers, both publicly and privately funded, can reasonably expect that this programme provides for a cost effective solution that delivers benefits over and above the implementation and operational costs.

Whilst consumers may not directly access the Pathways Programme, they can expect that expenditure and effort is focused on areas that will provide the most benefit. Therefore, this programme is tailored such that it impacts positively on the consumer experience in terms of waiting times, length of stay, access to procedures, choice and empowerment.

2.10.4 Our current profile

To date over 75 localised clinical pathways have been published, with a large focus on pathways that support primary care.

Figure below: demonstrates the Top 10 pathways being used for the period 1/01/2017 – 31/12/2017.

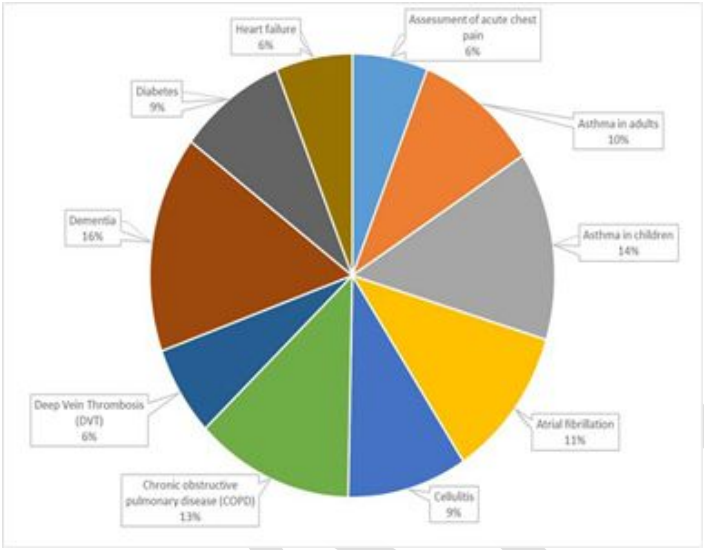
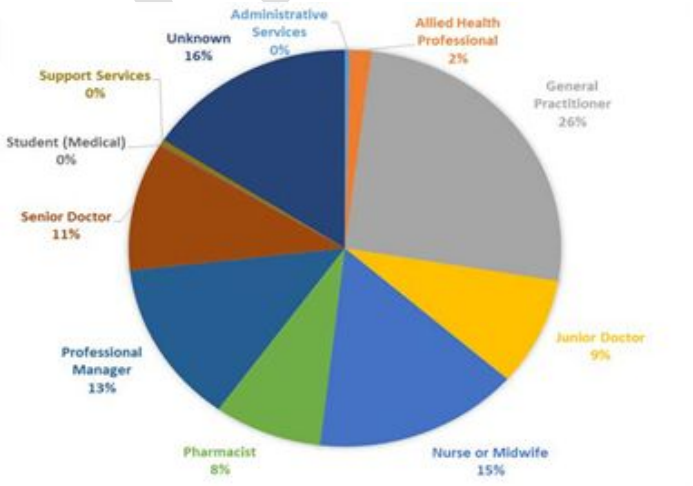


Figure below: demonstrates the users of pathways by professional groupings for the period 01/01/2017 – 31/12/2017



2.10.5 Our challenges

- confusion over whether pathways are for both primary and secondary care – a "whole of system" approach?
- pathways are not embedded 100% in clinical practice - the fact is that most GPs don't use the pathways, comments as " *not adding value to their day to day work practice - only when required scenarios, clunky to us*e"
- confusion over the "right" number of pathways to be developed? Should the aim be to maximise the number of published pathways, or focus on effectively implementing a smaller number that would make a significant difference?
- getting the right people in the room as many stakeholders require weeks' notice to attend or take part in a pathway review
- concerns about the length of time it takes to localise a pathway
- tools being too clunky to use efficiently in a consultation
- how to get the pathway used by hospital clinicians? - pathways are perceived as being weighted more towards primary care
- pathway localisation processes can vary dependent on clinicians (primary and secondary) availability to partake in development
- communication processes

2.10.6 Our effectiveness, benefits and impacts

- improved connectedness between primary and secondary
- acknowledgment that change can take years
- the strength of the approach is in how the overall change process is managed
- pathways have been integrated into the work flow of some secondary care clinicians
- time for workforce education supported by Health Hawke's Bay (HHB)
- a vehicle to assist health providers to move away from episodic care to a more holistic approach to health that puts the requirements and experience of a person at the centre of how services are planned and provided
- we have a local library of information that has been collated and sits within HHB IT systems
- the knowledge sharing aspects of pathways are arguably core to its success in changing behavior's and reducing the variation that will lead to efficiencies in care delivery and improvements in a person's outcomes. In this respect, the work by Rowe et, can be considered looking at the application of behavioural theory to health care worker practices: "***change occurs when people have personal experience of a problem and help to develop a solution***".

2.10.7 A General Practitioner's point of view (Dr Alan Wright)

"Clinical management pathways designed and supported across the whole local health sector are clearly the best way forward to allow timely, effective clinical care to be delivered in the best place at the best time. This is what we have been trying to achieve with the Coordinated Primary Options (CPO) programme for the last 14 years since its inception. Over the last few years we have been cooperating with Map of Medicine to offer some uniformity to the process. It has been a good start, but there are some significant flaws with the process and it appears now that this will be discontinued. This is a great opportunity to get on board with the "Pathways" programme that had its roots in Canterbury but has rapidly spread to become an international programme as well as its support from throughout New Zealand. I was fortunate to be invited to a meeting in 2017 where we were given an opportunity to explore this programme in some detail, and it is evident to me that this is the way forward for Hawkes Bay. Pathways offers comprehensive understanding of clinical conditions and current "best-practice" but clearly shows that there has been extensive cooperation between Primary and Secondary care with "ownership" of the relevant pathway by all involved. There appears to be widespread access to investigative services such as Radiology, which is one of our major limitations here. With these things in mind, the implementation of Pathways here in Hawkes Bay can only be successful with the following requirements:

1. Excellent clinical leadership and cooperation between Primary and Secondary care

2. Appropriate funding to remove barriers to its use

3. Regular supervision and review, both clinically and financially, to ensure ongoing relevance

4. Adherence to evidence based programmes

5. Incentives for good use of the programmes

This is a great opportunity for the HBDHB to show some sector-wide leadership and demonstrate that it has a good understanding of the rapidly changing environment of health care delivery".

2.10.8 Our Strategic Alignment

Table below: *Demonstrates alignment with key DHB and Regional Strategies*

Strategy	Investment Delivers
NZ Health Strategy	• The pathways and tools are used to align with the NZ Health Strategy 2015 strategic themes with an emphasis on integration, which is critically dependent on a team approach. For example, integrated care for a disease condition or population that improves an individual person's journey (e.g. Hepatitis C Pathway).
Our HBDHB sector vision	• "Excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community"
Transform & Sustain, December 2013	• Key challenges acknowledged to be driven by an increasing burden of long-term conditions and an ageing population with areas of significant deprivation. • Highlights the need for an equity approach to our work, emphasising our Maori and Pasifika populations. • Aims to improve responsiveness to the population, deliver consistent high-quality health care, and be more efficient at what we do. • Key intentions to address the challenges: o Transforming our engagement with Maori o Transforming people involvement o Transforming health promotion and health literacy o Transforming multi-agency working o Transforming clinical quality through clinical governance o Transforming a person's experience through better clinical pathways o Transforming integration of rural services o Transforming primary health care o Transforming urgent care o Transforming out of hours hospital inpatient care o Transforming business models.
Hawke's Bay DHB Annual Plan, 2017/18	• Ensuring appropriate access across services • Engagement • Work with Central Region to apply learnings from other pathways
Central Region Regional Services Plan 2016/17	• Integration across continuums of care is one of the six HBDHB strategic objectives in the 2016-2019 regional services plan. • A key enabler of integration is the shared regional pathways. This takes a structured approach to the development of local protocols of care. Currently, regional pathways are published on the international evidence based software tool 'Map of Medicine,' which contains up-to-date international best practice guidance (e.g. NICE guidelines). Building on this best practice guidance, the pathway development process incorporates national, regional and local guidance. The publishing of a pathway allows all health providers in HB to have visibility of the international/regional/locally agreed pathways. There is a feedback mechanism within 'Map of Medicine' which can be used by clinicians to continually improve the pathways.
Interdependencies	
Alliance Framework	May affect the structure for the Pathways Program going forward.

Strategy	Investment Delivers
CRISP (Central Regional Information System Programme)	Will inform integration requirements, timing etc.
Elective and Outpatient	Will streamline all pathways where people require an elective procedure – introduces e-Referrals
Gastroenterology	Will inform any Gastro and Bowel Screening related pathways
Faster Cancer Treatment	Changing secondary pathways for all Cancer Streams
Mental Health Model of Care	Implementing new Mental Health Services pathways

SECTION THREE

3.1 Technology Enablement

Technology plays an important role in making available the pathway information at the point of care to the time-pressured clinician. The key is integrating pathway guidance into the clinicians' workflow and ensuring that: ***"The right thing to do is the easiest thing to do."***

Figure below: *illustrates the progression of pathways of care and how technology can be used to embed pathway guidance into workflow, facilitating contextual application in a person's care.*

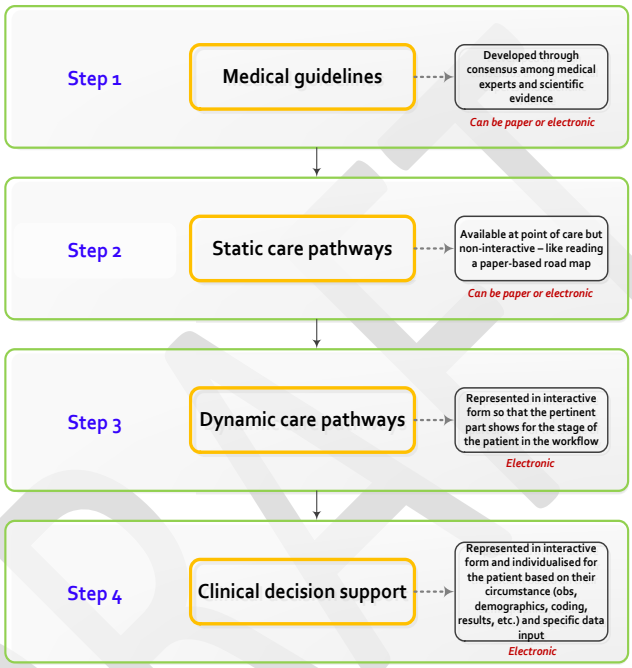
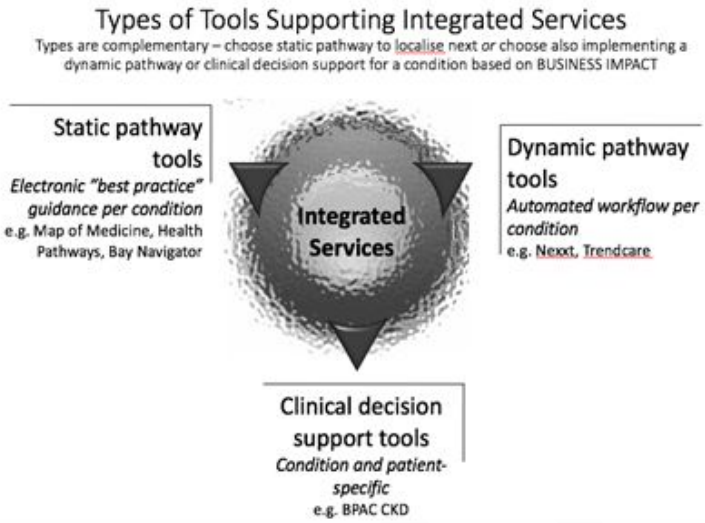


Figure above: Evolution of pathways of care

HBDHB has **reached Step 2** in the Pathway roadmap. Our pathways provide links to relevant websites for additional information, downloadable information and/or links to suitable online advice for the person or clinician. Best practice guidance and collaborative agreements are aligned. But for now the whole pathway/map is static, and the clinician is required to take the time to read through to find the pertinent information.

The next step in the journey is using technology to provide dynamic pathways of care specific to the person's presentation and their stage (e.g. diagnosis, management, and referral) in the clinical workflow, hence the trial of NexXT. This trial ceased due to a review of the pathways programme.



There is work being completed parallel to pathways and that is the work of the development of E-Referrals for the Faster Cancer Pathway. **This work sits outside the brief of this paper, however would be amiss not to mention a vision as:**

1) Continue to use a static pathway tool to support the Pathways Programme towards the integrated services goal.
2) For priority, high impact conditions, complement this with dynamic e-referral tool which also assists with decision support. Candidate conditions for this could be pathways aligning to System Level Measures (e.g. myocardial infarction, stroke, respiratory conditions, COPD, heart failure), Community Primary Options (e.g. hydration, cellulitis, and pneumonia), Faster Cancer Targets (melanoma, endometrial cancer, lung cancer, breast cancer, prostate cancer, bowel cancer) and mental health and addictions, transgender.

Support for this vision would be the importance of the co-creation process and awareness of the potential "cookbook medicine". Change management to drive usage will continue to be important, especially if the choice is to transition to a new tool and changes to e-referral systems. This would also require a robust evaluation framework for the pathway programme and support and funding for the team to continue this work.

3.2 IT Options Analysis

HBDHB has been fortunate to form a relationship with Midlands so that we could together analyse IT options. This work started mid October 2017 by Midlands DHB on behalf and in partnership with Central Region (Mid-central, Whanganui PHOs and HBDHB). Criteria was developed for a high level evaluation of the options available with the objective of 'shortlisting' preferred option(s) for further exploration of costs, benefits and implementation timelines.

Note: the National Health Information Technology Board (NHITB) criteria for evaluating pathway-related tools have been referenced in compiling this criteria and additional high level criteria have also been added to facilitate an objective assessment.

3.2.1 Evaluation Criteria

The following criteria was considered. The criteria aim is to allow for an objective high level evaluation of the options available with the objective of 'shortlisting' preferred option(s) for further exploration of costs, benefits and implementation timelines. Please note for detailed evaluation refer to Appendix 5.

Note: HBDHB has not engaged other partners in a GP survey (like other areas) as it was considered that we know the comments as outlined in our Clinical Service Plan.

#	Criteria	Description
1	**Availability and breadth of clinical content**	Current clinical content, international, national and localised.
2	**Ease of localisation**	Ability to cater for the local differences of individual DHB, PHOs and services on the pathway. The ability to edit the information easily and have updates in a timely manner.
3	**Clinical knowledge sharing**	Number of organisations contributing to the available pathways.
4	**Usability and layout**	Has a modern feel with few clicks to display and view relevant information. This also considers the ease of access to the tool, by clinicians and patients alike – e.g. how easy is it to open up the tool and use it, assist with health literacy is pertinent – by making information readily available to health consumers, it assists in the goals of increased self-management and health literacy.
5	**Mobility**	Functions on various screen sizes
6	**Integration**	Single sign on with the major clinical solutions used in the Midland region. Linked to the E-Referral system Integrated into the person's record in context
7	**Usage reporting**	The level of detail and tools used to create governance and user reports.
8	**Support, maintenance, hosting**	IS helpdesk, configuration, hosting platform or service.
9	**Confidence in vendor**	Current track record in software development, strategic direction and reputation among NZ Health community.
10	**Fit with strategy and roadmap**	Aligns with HBDHB and Regional IS strategy which is aligned with Ministry of Health's Digital Health 2020 Strategy and the Government ICT Strategy.
11	**Technical fit**	Aligns with the regional IS architectural standards.
12	**Indicative costs**	High level indicative costs of the ongoing licencing, development, configuration and upkeep of the solution. Intangible costs are also considered, such as the cost of disruption.
13	**Risks, disadvantages**	Risks to regional engagement and progress with the pathways of care programme. Negative effects of option selection.
14	**Advantages**	Positive factors of option selection
15	**Ease of transition**	Effort to transition from current electronic pathways tool to selected option

3.3 Identification of HBDHB Options for Action

Business Options	Priority
Option 1: ***Status quo***: We will no longer be supported by the Map of Medicine tool. MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).	Not an option
Option 2*: Build an in-house pathways tool or connect with Midlands Bespoke Model*: This option was explored in the original Business Case for Pathways 2014 and considered not an option at this time by IS due to the large amount of technical support. Additionally, we would be 'reinventing the wheel' to build a tool for disseminating our pathways, without any of the benefits of working with a provider and, potentially, other regions already using a tool. **Comments from Jos Buurmans (IS) "***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal".*	Not an Option
Option 3: ***Dispense with an IT solution*** and use a paper-based system, however this is considered not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.	Not an Option
Option 4: Procure Community HealthPathways **The HealthPathways** (HP) tool resulted from the wider Canterbury Initiative. It is a clinically-led collaborative with a purpose of addressing and resolving challenges in health care delivery within the Canterbury region. It is a web-based database of condition-specific information, together with details of service providers assembled into approximately 600 pathways plus hundreds of pages of related resources that have been developed over the last five years. It is 'localisable' to other regions and has been implemented by all DHBs in the South Island, the greater Wellington and Auckland region, and some organisations in Australia. As an initiative of the Canterbury DHB, it is owned by the New Zealand Government. A key aspect of HP is its supportive role in facilitating discourse between primary and secondary care clinicians. Features include online discussion groups, newsletters and video links that help to build the collaborative community nature that is essential to pathways development. Pathway content appears to be mostly derived from practice-based knowledge, although senior clinicians provide an over-view function and content reflects New Zealand guidelines. All subscribing regions gain access to the pathways from other regions, so it may be that localising content is all that is needed, avoiding most workflow redesign initiatives. The choice of formats – narrative or flowchart – has been voiced by some clinicians, with the wordy nature of the narrative being a negative comment. Some secondary users have commented that the product initially appeared overly focused on primary care, perceiving that an appreciation of the whole patient journey was lost and leaving little functionality for hospital-based staff, however over the later years there has been work in this sphere. Integration with primary patient management systems (PMS) has been demonstrated with MedTech and My Practice, and work is being done to integrate Health Link forms for e-referrals. It is been the collaborative effort, along with impressive improvements in service delivery that recently earned *HealthPathways* accolades from Kings Fund researchers. **Explanation** • known tool with 'tried and tested' transition process from Map of Medicine to Health Pathways • provides extensive knowledge based and proven model	Option

• IS comments: "*HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.*" **Note: Additional cost implications** • HealthPathways comes with its own framework of development systems • Variable costs are based on number of pathway development	

3.4 Recommended Option

The recommended option for a Pathways tool for HBDHB is HealthPathways. This recommendation is based on the opportunity to continue our relationship with our Central Region partners and also form greater relationships with the wider NZ users.

This recommendation has several caveats:

- rationalisation of tool use across the country supports cohesiveness
- feedback informs there is a strong focus on clinician led collaborative effort, making HP feel more like an initiative, compared with other IT tools in which the vendor appears more focused on the tool
- it is recognised that there is some work to be done in order to gain integration between e-referrals (Health Link forms). This challenge exists independent of the tool we choose, as no tools have demonstrated integration with the particular cohort of IT systems in use in our district.
- what could we achieve nationally being on the same tool could further benefit MOH
- we would have local (regional, national) support when we go to transition.

3.5 Business Impact – From transitional to business as usual

Identified impacts are:

- The need to involve IS staff from the PHO, DHB and individual practices to gain access and achieve integration with other systems assuming that there is capability and capacity within these groups. Additional external support may be required, although this is probably limited to the vendors of the various software (Medtech, My Practice and HealthLink).
- Human resource input to manage the Pathways Programme implementation, governance, operations and development of individual condition-specific pathways is significant and, therefore, this may present challenges in terms of work commitments and prioritisation for existing staff or the need for additional staff or 'back fill'. This is particularly so for LTC Portfolio Manager, senior and specialist staff as this adds additional pressure. It has been recommended in previous papers that we at least appoint approximately 4-6 of each primary and secondary leads to assist with facilitation, one clinical lead and increase FTE of Editors (this has to date has not been supported as programme was "on hold").
- Initially we can expect that some training will be required for use of the pathways tool itself, however additional training for GPs and nurses to new skill development, consideration will need to be made as to what entity pays for this cost and the staffing to provide this training.
- A consequence of the 'one system' approach is that there are likely to be shifts in who does what procedures, and where. Movement of some services into community settings means that there should also be movement of funding to support it. Where there are out-right cost savings, i.e. where costs have been avoided through, say, self-management, we need to decide what happens with the savings; for example, do they contribute to

a financial surplus or are they funnelled back into further procedures? A good example is the capability of GPs performing a Pippelle Biopsy but no money to take this initiative further.

3.6 Risk Analysis

The management of risks will follow the standard HBDHB approach. See Risks and mitigations in Appendix 7.

3.7 Ongoing financing of the Pathway the Programme

Clinical Council had agreed to fund the Pathways Programme, but over the last few years there has not been full funding commitment to this Programme. Recommended on-going costs in future years will need to be budgeted for during annual processes.

3.8 Key Performance Indicators

The proposed Key Performance Indicators (KPI's) set out below are intended as an interim set until an evaluation framework and Benefits Realisation Program measures have been established. The KPIs serve to measure and evaluate the process of development/localisation of pathways, the transition of already established pathways to the new IT platform, the socialisation and communication of the pathways to clinicians and ultimately the uptake of the pathways information into individual clinician, patient consultation and management.

Socialisation - Ensures adequate representation and therefore development and socialisation

- Number of Pathways published
- Number of new Pathways localised and published
- Number of primary care clinicians taking leadership and participating in workgroups
- Number of secondary care clinicians taking leadership and participating in workgroups
- Number of Allied health clinicians that have participated in workgroups
- Number of Pharmacists that have participated in workgroups

Utilisation

- Total number of users
- Top 10 clinical pathways viewed per month
- Top 10 clinical pathways by average time on page per month

3.9 Consultation

Timeframes for options paper development and distribution are provided.

Group	Date
EMT	26 March 2018
Clinical Council	April 2018

3.10 Stakeholder consultations

Midlands have consulted on our behalf with the following vendors:

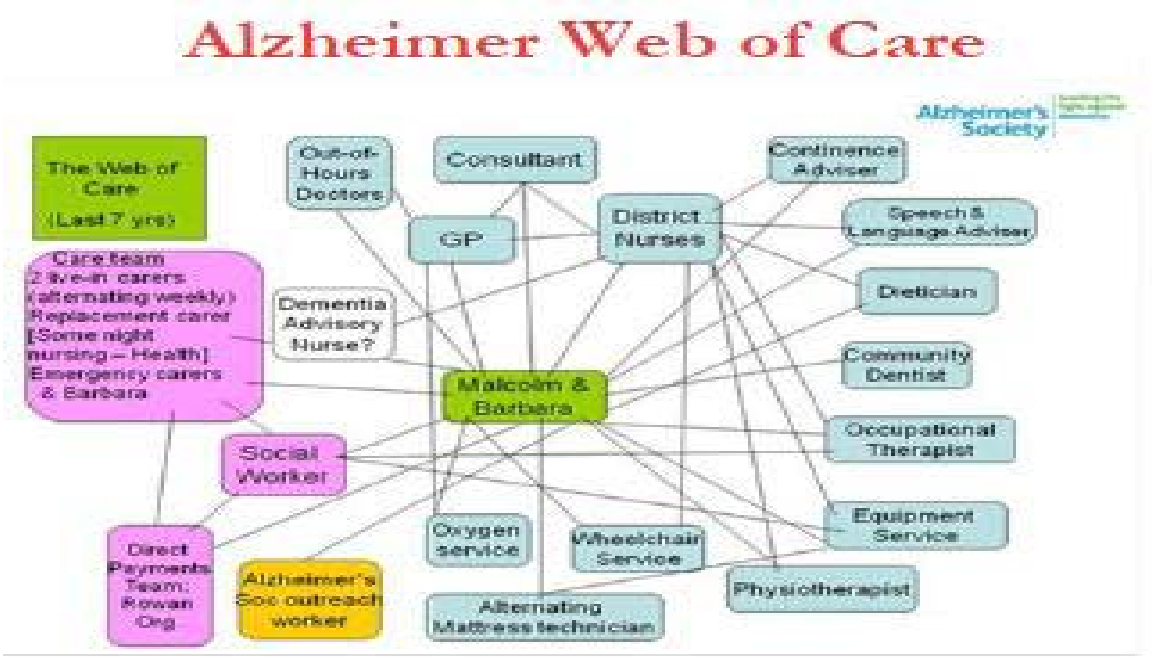
- Auckland – CM – Pathways team
- Northland GP liaison
- HealthPathways CEO
- People who have previously worked on the NexXT product
- Trendcare Rep

- Waikato DHB IS around bringing Map of Medicine here
- Awaiting information from BOP if they could scale up Bay Navigator
- Regional IS Manager – around fit and architecture
- Multiple other conversations with regional project managers, clinical leads and GP liaisons

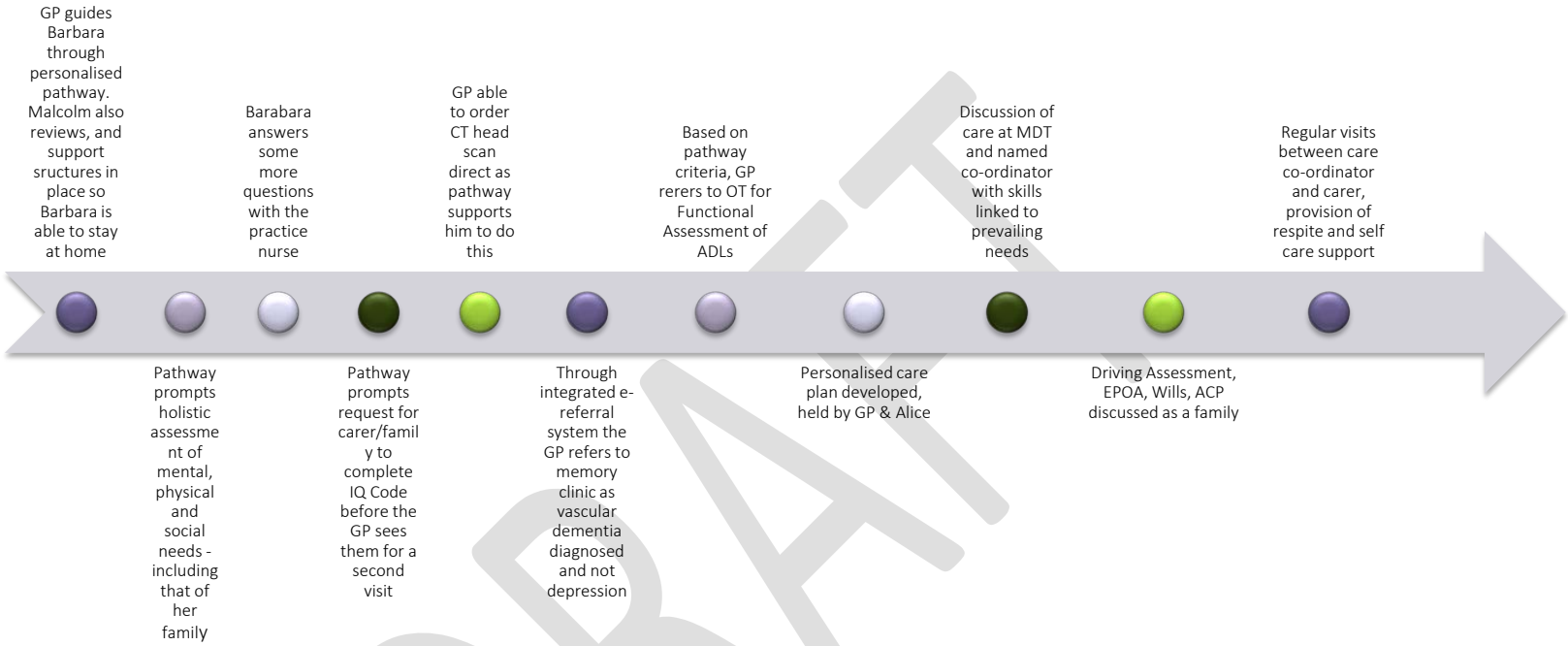
HBDHB Consultation to date:

- HealthPathways CEO and presentation by Streamlines (July/August 2017 and 22/03/2018)
- Auckland – CM – Pathways team also there feedback on NexXt
- Central Region – Midcentral and Whanganui PHOs
- Health Hawke's Bay Medical Advisor

APPENDIX 1 (a): Malcom, and Barbara's tangled web of services



APPENDIX 1 (b): Malcom and Barbara's services mapped out within a pathway



Appendix 2: HEAT Assessment-Pathways align to Long Term Conditions Framework

Background[1]**:** Key findings from the burden of disease study 2013 tells us that people are living longer with chronic long term conditions which contributes to associated disability and or challenges that face individuals needing to access care or manage their own self-care. Hawke's Bay, has significantly higher risk factors associated with the development of a chronic condition. Māori and Pasifika are over represented within this statistic.

Understanding Health Inequalities

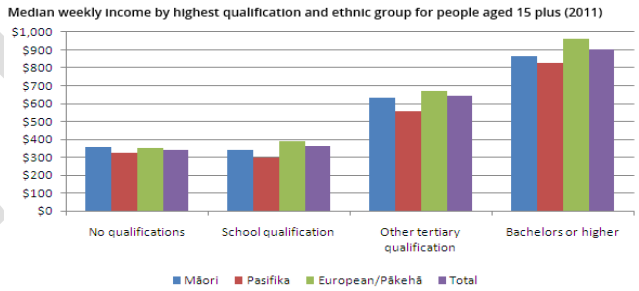
Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Why did the inequality occur?
Consider the range of inequalities	**What do you know about inequalities in relation to this health issue?**	**Who is advantaged in relation to the health issue being considered and how?**	**What causal chain(s) lead to this inequality?**
Ethnicity[2]	Currently Māori and Pasifika people are over represented in all of our Health Risk Factors[3] which are listed in order of risk; Tobacco use, high body mass index, high blood pressure, high blood glucose level and low levels of physical activity. All of these risk factors contribute to premature mortality, increased incidence long term condition and co-morbidity rates. The disparity gap is greatest for smoking and high body mass index.	Female Non- Māori Pasifika (NMPI[4]) are least represented in the LTC (Generic) cohort, followed by Male NMPI, however this is dependent on the specific condition(s).	Educational levels of females (mothers) is identified as having a high impact on future population outcomes inclusive of health. A 15% gap exists between Māori (70%) and European females (85%) 18yr+ leaving school with NCEA L2 or above. The gap for males is 16%. Education leading to improved choice re employment, housing, lifestyle etc. Influence directly the determinants of health as identified below in this table.

[1] Adapted and taken from "Chronic Disease: Current Situation Analysis- (Prevalence, Morbidity and Mortality)" – Lisa Jones HBDHB Business Intelligence Team

[2] Ethnicity inequality – not counted twice – each separate component…

[3] Risk Factors listed are those identified in the Chronic Disease: Current Situation Analysis(Prevalence, Morbidity and Mortality) – Lisa Jones HBDHB Business Intelligence Team taken from the NZ Burden of Disease Study 2013 and the Health Equity Report – 2016.

[4] MPI-Maori Pasifika peoples vs Non Maori Pasifika (NMPI). This comparison is used to identify that the gap between MPI and NMPI is where health effort needs to be concentrated the most. By comparing MPI with total population we lose sight of the real difference that exists within population health outcomes.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Levels of generic literacy [5]	Currently only 1:5 New Zealanders are operating at a highly effective level of literacy. The majority of Māori, Pasifika and those from other ethnic minority groups are functioning below the level of competence in literacy required to effectively meet the demands of everyday life.	Research suggests that people with high (health) literacy: • are more likely to use prevention services (such as screening) • have more knowledge of their illness, treatment and medicines • are more likely to manage their long-term/chronic condition • are less likely to be hospitalised due to a chronic condition • are more likely to use emergency services • are less vulnerable to (workplace) injury because they understand safety (precautionary) messages.	 *Source: Education Counts* Education initiatives in the last 10 yrs have focused on improving literacy (numeracy) levels with a particular focus for Māori and Pasifika as they are overly represented in the low academic achievement stats, unskilled or low skilled labour workforce, unemployment and involvement with the justice services and utilisation of assisted social services. The inclusion of non-mainstream schools, Kura Kaupapa Māori and charter schools, introduction of NCEA and NZQA standards, and literacy benchmarking attempt to address the disparity that exists going forward, however the legacy of low literacy has had an impact on our current health and quality of life indicators. Low literacy levels can contribute to a lack of confidence in navigating the health systems and social support networks. This in turn contributes to the
Health literacy[6]	56% of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the needs of the demands of everyday life. Māori who live in a rural location have on average the poorest health literacy skills, closely followed by Māori who live in an urban location. The findings in the Korero Marama report show that overall the majority of New		

[5] Health Literacy is defined as; 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions' (Kickbusch et al 2005). Statistics NZ – level of Adult Literacy and http://www.healthliteracy.org.nz/about-health-literacy/health-literacy-statistics

[6] Korero Marama (2010)

Health Literacy (cont.)	Zealanders are limited in their ability to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions.		inability to access the care and support that exists and that one is entitled to. Systems and processes that have been set up without consumer input in their design, use of consumer feedback post design and analysis of data that demonstrates consumer engagement with services contributes to lack of institutional awareness of the level of (health) literacy of their client base.
Socio economic factors inclusive of wider determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution and accessibility of resources at a personal (individual) and population health level. Addressing equity is about unequal distribution of resources in order to advantage the disadvantaged in order to create as close to a level playing field as possible.	Those who enjoy economic wellbeing and resilience gained through, stable and supportive family dynamics, good to excellent educational achievement, employment, and participation as a contributor to local and regional community (networks)	Limiting or limited access to education, employment and or social supports, at a personal or population level contributes to disadvantaged individuals and populations. Continuous and exponential increases in compromised quality of life indicators will directly impact on the 'resilience' of a family and or community to address, self-manage, create opportunity and work their way out of adversity. Lack of understanding around compounding factors that influence levels of resilience can contribute to inappropriate 'care and or self-care' being prescribed or expected of the person affected by compromised health.
Disability	With the onset of the development of a long term condition the level of ability to manage everyday life activities is affected. Those with one or more comorbidities have the greater challenges to face. Age will impact on the ability of the individual, partner and or whanau to manage the compromised health state of the consumer	Those with good family support, an able bodied partner, access to transportation to access care assistance, financially able to 'buy' assistance required or modify lifestyle to accommodate the condition(s). Those who have built resilience over time to cope with change and or changes in circumstance. Those who have developed self-managing skills that enable them or their family, network to problem solve presenting issues. Those who are not at saturation point in regard to the compromises they are having to make in-order to maintain a level of wellness that is acceptable to them.	By treating the person/family as a whole and addressing the items that 'matter to the person' instead of the 'condition or what is the matter with them' we will begin to mitigate, minimise and hopefully eliminate the impact that their change in health status has on their ability to enjoy the lifestyle of their choosing.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Age - 65+	At the age of 35yrs the prevalence and onset of Long Term Conditions increases. This is particularly relevant to Māori (Female).		Contributing factors that lead to the onset of Long Term Conditions is believed to begin as early as pregnancy. Lifestyle influenced or compromised by low education levels, which contribute to economic well-being impact on the capacity of individuals and whanau to choose well in in terms of health choices.
Gender	There is approximately a 10% differential between (Māori) Male and female risk factors within the HBDHB demographic	Females are advantaged	Screening programs for females and the incidence of attendance of general practice by females presenting with whanau who are unwell has had an impact on female visibility to health professionals. On average attendance differentials between male and females is a 75:25 ratio. Screening is the first point of prevention, risk identification and management. Lack of screening impacts on both the identification of risk factors and the timeliness (acuity) of the person's health status when they engage in and access active management.
Mental wellness[7]	Many people with long term physical health conditions also have mental wellness issues. This can lead to significantly poorer health outcomes and reduced quality of life.	Those with a single long term condition (1:5 of the 4:5 adults who have a Long Term Condition. Those with high levels of resilience, low acuity, early stages and highly skilled in self-management. Those with high health literacy Those with good whanau support	In providing disease specific health care we overlook the holistic approach that should be engendered with Long Term Conditions. People with long term conditions and co morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation make a significant contribution to generating and maintaining equalities.
Access to health care services[8]	Those living in rural communities.	Those living within easy driving distance to services required. Those living in an area with good mobile / outreach services. Ability and desire of people to have residences in areas with easy access to services.	Residence of choice or determined by full range of health determinants. Economies of scale –as determined financially viable by the DHB Attraction and retention of staff.

[7] The King's Fund and Centre for Mental Health 2012 - https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

[8] This section ONLY covers physical access as all other barriers to access have been identified above e.g. socio economic section/health literacy, gender et. al.

Level	Determinants with associated possible interventions (May or may not be the responsibility of the health system)
Structural:	Based on consumer and service feedback gathered in the consultation process (Refer to – LTC Framework – not inclusive in this paper) **Education -** Healthy families, confident in their own identity, able to make choices that suit their own individual context is the focus of Ka Hikitia – Māori education strategy, designed for the purpose of Māori achieving success as Māori. Literacy and numeracy project have been introduced to the education system to address underperformance of all students. Valuing kaupapa Māori education – within a Te Ao Māori framework has also been identified as mechanisms to ensure that tailored responses to differing needs within our population are needed instead of the 'one size fits all' model of thinking. **Access points – multiple and varied –** consumers consistently repeated the same messages. They want multiple access points to health care/support at varying levels. This includes hours including late nights, early mornings, weekend clinics, and the ability to phone, email, visit or have someone visit them were needed. The use of IT – web based patient portals were seen as only being advantageous. This was reaffirmed in Wairoa – by and 82 yr old male who said "My patient portal is the best thing out – time saver and ease of access to all the information I need. I'm not that stable on my feet so coming in to town can be a real issue." A recently unemployed forestry worker was quick to mention that he had no time off working in Forestry to get to the doctor as there are early morning starts and long hard days and relying on forestry transport all were factors contributing to intermittent access to care. **Utilisation of regulated health and non-health/non-regulated workforce –** the consumers wanted the right people with the right skills to support them in taking care of themselves but what was most important was the right fit of person. Diversification of our workforce (bi and multicultural) was identified as a need. The right fit also extended to what level of expertise was needed and the use of non–regulated workforce to provide levels of care appropriate to the consumer. Youth for example are wanting to engage with people with an affinity for youth issues and do not need to see a GP when their needs can be managed and or coordinated by a range of other staff such as Nurse Practitioner , Youth social worker or a Youth counsellor. Navigation of the system was identified as a need. This can be achieved through advocating for an interdisciplinary team approach to care / support. **Interdisciplinary approach to care/support – using a wellness model :** the Long Term Conditions Framework advocates for a holistic wellness approach to care based on the Four Aka. In order for care not to be focused solely on the condition but on the consumer and whanau leads to the need to have an interdisciplinary approach. - **Generic approach, not disease specific:** the incidence of consumers with co morbidities dictated to the framework that what is needed is a generic approach to care. The consumer wants a primary – centralised coordinator of their care that can provide access points to specialist care as and when needed. - **Mental health focus:** Care for large numbers of people with long-term conditions will improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. Service commissioning groups should prioritise integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care.
Intermediate Pathways: *Material, psychosocial and behavioural factors. The impact of structural factors on health*	**Patient and relationship centred care:–** is the response that is needed to tailor care and support for consumers that will engender ease of access to all stages in one's healthy development. Taking into consideration quality of life measures as well as clinical measures to guide the health workforce and consumer as to 'what matters to them most' as a means of directing what type of care is needed – against an agreed set of priorities dictated by the consumer but advised and supported by the health professional.

	Raising consumer expectations:– By not accepting that health inequities is an expectation if you are Māori or Pasifika and or in a group that is not experiencing equitable health outcomes (aged , disabled, living in remote areas, male) we address the issue from the consumer demand perspectives. This can be mitigated through; - **Dis-establishing myths that** exist about conditions that you should or should not expect if you fall into a particular population or age group. - **Raising health literacy -** becoming a focus of all information that is shared in a transformational vs transactional manner with the first step of finding out what is 'known to the consumer' before exchanging information that is intended to grow that information that will lead to greater understanding and self-determination in decision making - **Creating multiple avenues to enhance self-management –** by examining and evaluating the paternal aspect to health care provision, based on the level of acuity required of the consumer at any given time, we create the opportunity for the consumer to be the decision maker in their own care. If all the above is considered in the determination of the care and support that is needed then we create the right environment to implement – co designed models of care that have had the receiver and provider of care involved in its design process.	
Health and Disability Services	**Flexible services** that can respond to variability in baseline health status and needs (mental and physical) - (see interdisciplinary teams above) **Risk mitigation:** Promotion of CQI initiatives that focus on snap shot tracer auditing that examine the pathway / care journey of the patient to identify routinely areas for improvement without them being attached to or a response to an incident – accident or death **Promoting the use of the Health and Disability advocacy service** and taking learnings from any investigations or cases	
Impact: *the impact on socioeconomic position*	• Work with national, regional and local health promotion teams • Work with ACC and other funding bodies that support employment and understanding of the determinants of health for those with a disability • Cross-sector initiatives to co-fund tailored packages of care inclusive of MSD as a funder of subsidies and benefits for consumers • Fund existing community providers to care for consumers building capacity and capability within our available work force • Work with local education providers to inform curricular content, education pathways and career pathways • Ensure step-up, step down options and the flexibility to do so within the patient journey of wellness and unwellness.	
Pathway (AKA)	**Questions**	**Responses**
Tuatahi – *Developing whānau, hapū, iwi and Māori communities*	*How have Māori been involved in the use of HEAT?* *Have Māori health inequalities been fully considered?*	The focus of the framework is to address equity and gap in health outcomes Consumer consultation was representative of our demographic profile for Hawke's Bay. Wairoa – consultation group – 70% Māori and chosen due to its high Maori population as well as high needs in relation to Long Term Conditions.

		PAG included 3 Māori members Consumer council members represented our rural isolated communities (Parongahau)
Tuarua – *Māori participation in the health and disability sector*	*How will you involve Māori in the health and disability service interventions?* *How will you build Māori workforce capability?*	Health and disability service: engage the 'right fit of person to work with the individual engaged in any service intervention. Utilise the kaitakwaenga who have recently been appointed within the Maori health team. Ensure consumers know they can request a change of person – should the right fit not be achieved (Code of Rights). Workforce development forms part of Aka toru – workforce development and enablement.
Tuatoru – *Effective health and disability services*	*How will you ensure that the health and disability service intervention(s) proposed are timely, high-quality, effective and culturally appropriate for Māori?*	Identify this in the service plans and use the driver diagram (LTC Framework figure 1.0) to ensure that activities engaged in by services align to high level outcomes and objectives; example provided is – addressing the inequality gap in health outcomes for Maori and Pasifika with the enabler identified as – prioritising work programs that address the determinants of health
Tuawhā – *Working across sectors*	*How will you work collaboratively with other sectors to reduce Māori health inequalities?*	The inter sectoral approach of the health and social care networks in conjunction with the multidisciplinary approach to providing non disease specific care to those with or at risk of having a Long Term Condition.

Questions	Responses
1. Health inequality outcomes *What are the predicted outcomes of this intervention for health inequalities?*	System level measures and contributing measures identified in Aka Tahi Use of quality of life tools to measure non clinical outcomes for consumers Reduction to within 5% of gap between Māori and non-Māori
2. Groups Benefiting *Who stands to benefit the most from this intervention?*	Those with long term conditions – who are then able to access interdisciplinary teams and increase their confidence in their self-management.
3. Unintended Consequences *Are there any unintended consequences that can be foreseen?*	By focusing on generic approach – specialised care may be impacted on. The time frame leading up to high functioning IDTs may impact on patient care coordination. Workforce capacity and capability to work in a generic approach will need lead in time and to be managed well.
4. Risk Mitigation *What needs to be done to ensure that the benefits accrue to the intended populations?*	Establish a LTC advisory group inclusive of Māori and Pasifika members Support and monitor service plans and operational management

	Work closely with the QUIPs team to ensure systems for improvement are in place Ensure clinical leads are in place to manage care and coordination of care

How will you know if inequalities have been reduced?

By ensuring that all data is presented in MPI vs NMPI (not MPI vs Total population which masks the gap)

- Outcomes measures identified and monitored against each of the "Teams of Practice" or Service targets
- Utilisation of the System Level Measures and the contributing measures to map progress towards agreed outcomes

Reduction in the gap between MPI and NMPI

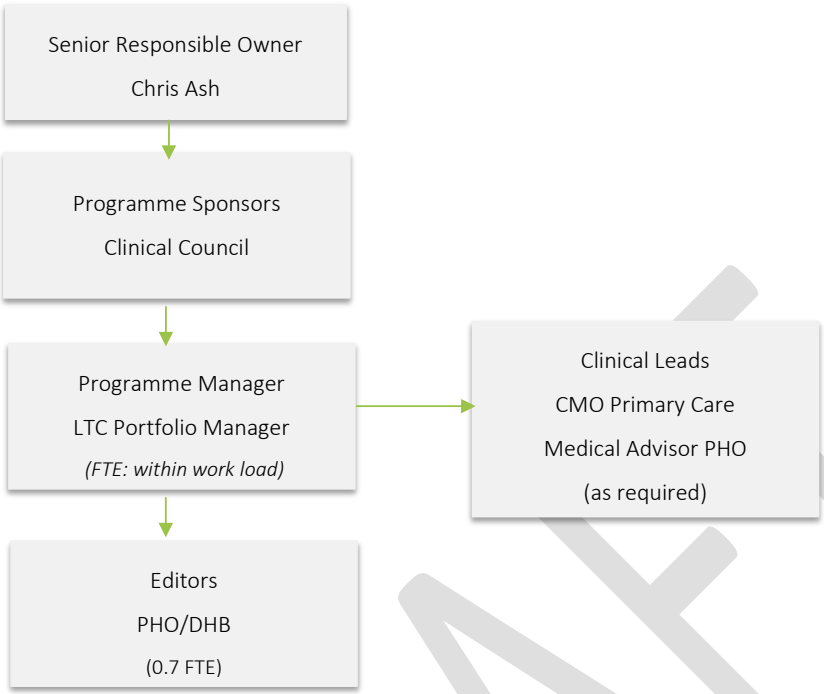
- Across the board

APPENDIX 3: Current Budget

9238 Care Pathways
Cost Centre Financial Report
For the Month Ended 28 February 2018

February Actual $	February Budget $	February Variance $	Description	Year to Date Actual $	Year to Date Budget $	Year to Date Variance $	Last Year $	Annual Budget $	
			Revenue						
			Funding - Price Volume Schedule						
-	-	-		-	-	-	-	-	
			PVS Volumes						
-	-	-		-	-	-	-	-	
			Other Income						
-	-	-	183500 - Professional & Consultancy Fees	37,083	-	37,083	-	-	
-	-	-		37,083	-	37,083	-	-	
-	-	-	**Total Income**	37,083	-	37,083	-	-	
			Expenditure						
			Personnel Costs						
			Management & Administration Personnel						
4,181	2,152	(2,029)	282400 - Professional Staff	24,025	18,474	(5,550)	18,851	27,742	
4,181	2,152	(2,029)		24,025	18,474	(5,550)	18,851	27,742	
4,181	2,152	(2,029)	**Total Personnel Costs**	24,025	18,474	(5,550)	18,851	27,742	
			Full Time Equivalent Staffing						
			Management & Administration Personnel						
0.8	*0.4*	*(0.4)*	*282400 - Professional Staff*	*0.5*	*0.4*	*(0.1)*	*0.4*	*0.4*	
0.8	***0.4***	***(0.4)***		***0.5***	***0.4***	***(0.1)***	***0.4***	***0.4***	
0.8	***0.4***	***(0.4)***	***Total FTEs***	***0.5***	***0.4***	***(0.1)***	***0.4***	***0.4***	
			Outsourced Costs						
			Outsourced - Medical Personnel						
-	667	667	310500 - Medical Fees For Service - Smo	2,151	5,333	3,183	28,156	8,000	
-	667	667		2,151	5,333	3,183	28,156	8,000	
			Outsourced - Support Personnel						
-	-	-	342001 - Interpreters	-	-	-	440	-	
-	-	-		-	-	-	440	-	
			Outsourced - Management/Admin						
-	3,200	3,200	353500 - Supervisors & Professional Staff	11,667	25,600	13,933	8,813	38,400	Off set by revenue reduced FTE with
-	3,200	3,200		11,667	25,600	13,933	8,813	38,400	
-	3,867	3,867	**Total Outsourced Services**	13,817	30,933	17,116	37,410	46,400	
			Clinical Supplies						
			Diagnostic Supplies & Other Clinical Supplies						
-	-	-	429000 - Other Diagnostic Supplies	-	-	-	0	-	
-	-	-		-	-	-	0	-	
-	-	-	**Total Clinical Supplies**	-	-	-	0	-	
			Infrastructure and Non Clinical						
			IT Systems & Telecommunications						
-	9,621	9,621	534000 - Software Charges	27,701	76,967	49,266	3,549	115,450	
1	-	(1)	535001 - Internet Connection	7	-	(7)	3	-	
1	9,621	9,620		27,707	76,967	49,259	3,552	115,450	
			Professional Fees & Expenses						
-	2,917	2,917	551000 - Consultants Fees	35,000	23,333	(11,667)	-	35,000	
-	2,917	2,917		35,000	23,333	(11,667)	-	35,000	
			Other Operating Expenses						
-	417	417	567500 - Reception And Catering	-	3,333	3,333	-	5,000	
-	292	292	570000 - Corporate Training	-	2,333	2,333	-	3,500	
-	708	708		-	5,667	5,667	-	8,500	
1	13,246	13,245	**Total Infrastructure/Non Clinical**	62,707	105,967	43,259	3,552	158,950	
4,182	19,264	15,082	**Total Expenditure**	100,549	155,375	54,825	59,813	233,092	

APPENDIX 4: Current Pathway Programme Structure, FTE, Roles and Responsibilities



Key roles and responsibilities are summarised in the following table.

Table 1: Key Roles and Responsibilities

Role	Responsibilities
Senior Responsible Owner	• Champions the Programme • Resolves issues at executive and service level • Holds/allocates Programme budget • Authorises Programme change control and communicates with the CEO and external stakeholders Ensures that the Programme remains aligned with the organisation' strategy and supports projects through internal or external approval forums.
Programme Sponsor	• Ensures business benefits are met • Responsible for programme *assurance* • Key communication point to Executive / Organisational management • Resolution of issues outside of the scope of the Programme Manager
Clinical Leads	• Represents the clinical perspectives of interest and provides a key point of contact in decisions related to clinical matters • Act as champions to socialise the Pathway • Assist to develop an education programme to inform clinicians, allied health and stakeholders of the Pathway and its use • Works with the clinical stakeholder community to resolve strategic issues within the programme which need the agreement of clinical stakeholders to ensure progress • Ensures realisation of benefits by supporting clinical change to achieve project goals • Members of the Sponsor Group (Clinical Council)
Programme Manager	• Accountable for delivery • Escalates issues to the Senior Responsible owner so no surprise • Facilitates the project management process at all points as per HBDHB project management methodology including: o Planning - Develops the work stream plan

Role	Responsibilities
Senior Responsible Owner	• Champions the Programme • Resolves issues at executive and service level • Holds/allocates Programme budget • Authorises Programme change control and communicates with the CEO and external stakeholders Ensures that the Programme remains aligned with the organisation' strategy and supports projects through internal or external approval forums.
Programme Sponsor	• Ensures business benefits are met • Responsible for programme *assurance* • Key communication point to Executive / Organisational management • Resolution of issues outside of the scope of the Programme Manager
	o Delegating –secures resources and ensures allocation of tasks to these resources that clarify what is required by when. o Monitoring – Monitors delivery ensuring that all expectations are meet o Controlling the programme – ensure all issues and risks to are identified, analysed and responded to effectively using prescribed escalation routes and change control procedures if required o Motivation of those involved to achieve objectives within the expected performance targets for time, cost, quality, scope, benefits and risks. o Formally reports to the Programme Sponsor on a regular basis including appropriate and timely escalation of issues and risks. o Relationship with Project Management Office
Programme Editors	• Accurately records Pathway information from development teams into the chosen tool editing module • Receives feedback from the consultation, collates and distributes it to the development team for consideration • Incorporates information and feedback as requested by the development team
Project management office	• Provides pro-active project assurance input to support the programme to use best practice processes to create the deliverables and appropriately follow the project management processes

APPENDIX 5: Option Analysis of differing IT tools

MAP OF MEDICINE

Map of Medicine is the current HBDHB pathway tool. It has been in use since 2013 and is integrated into the workflow of primary care, some areas in secondary care and in some NGOs. This integration has improved utilisation of the pathways and supported further clinical buy-in with the tool and pathways where the information is easily accessible.

Map of Medicine offers a comprehensive repository of evidence-based agreed local and regional guidance at the point of care. The pathways also contain tools and resources that are used in clinical assessment and supporting operational processes e.g. MOCA cognitive assessment tool on the dementia pathway. http://mapofmedicine.com/

The proposal for this option would be to align with Midlands, who may bring Map of Medicine software in-house to the Midland Region and fully support the ongoing development and maintenance of the tool. This option could be used long–term if the software is considered robust enough to be improved to meet the clinical usability requirements e.g. mobility, document layout.

The Intellectual property of the HBDHB contained in the Map of Medicine tool can be retrieved at a time prior to a decision to not pursue this option and the current Map of Medicine tool is decommissioned.

Evaluation notes

Options	Map of Medicine	Detail
Description	Static Pathway tool that has an algorithm layout. A static pathway tool.	
Availability and breadth of clinical content Usage:	330 International 75 localised Medium - general practice Low - secondary care Low – community/allied	**Coverage of clinical pathways** Map of Medicine currently holds 350 international pathways with 75 localised to the HBDHB region.
Ease of localisation	High Pathways can be localised and made available within a timeframe.	
Clinical knowledge sharing	8 NZ DHBs	**Shared community** Once the Map of Medicine is unsupported from the UK the shared clinical community could consist of the Midland region DHBs and may also include the three Central region DHBs who are currently using the Map of Medicine.
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	Medium	There is a different in opinion about whether the click through from the Map of Medicine algorithm diagrams is the quickest way to access info. The clinicians' survey, for the purpose of this options paper, showed that some liked it and some did not. The first view on Map of Medicine is the algorithm diagram, whereas on Health Pathways, you are taken straight to the reference info.
Mobility – functions on various screen sizes	No	Not usable on mobile.

Integration	High	Can integrate with Medtech32 connected care, Dashboard My Practice Medtech32 connected care $14,000 In Clinical Workflow – not in all
Usage Reporting	Granular	
Support, maintenance, hosting	Amazon Web Services or some other cloud service	IS support IS manager Mthly Amazon hosting Implementation Cost: $0 *Multiple databases for different modules with a lot of open source code used. *Developers often not willing to make changes as fragile code base and unsure of full code set. *Lack of skill in DHB resource in this area as do not currently uses these systems.
Confidence in Vendor Basis is consultation with DHBs who use the solution and their feedback	No	
Fit with Strategy and road map	Yes	**Regional Services Plan 2017-2020** The use of the Map of Medicine tool supports strategic alignment with the regional services plan Objective 2: Integrate across continuums of care. Acting as a repository of both agreed regional care pathways e.g. Lung Cancer and locally developed pathways that can be localised for each DHB e.g. Suspected Skin Cancer. One instance of the tool and therefore the pathway with localisation would assist with the issue that many common issues are being dealt with simultaneously across our region and this can lead to duplication of effort. Regional pathways enable shared knowledge, learnings and current innovations that are occurring locally to improve patients' health outcomes for the entire region.
Technical Fit	Partial Linux/SQL DB/Open Source/Java C+ Cloud hosting	
Risks, disadvantages	Feedback tells us lack of support for Map of Medicine tool Old technology/unstable code set/ability to improve layout and usability unknown/timeframe to transfer existing IP Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development	Loss of regional and international engagement

Advantages	Low level of transition and change management required Tool is solely owned and supported by the Midland region (NZ) Updates and changes to technology and formatting can be passed quickly Retention of existing integrations	
Ease of Transition	Easy User base could continue using current tool.	Transition is in setting up Tech team at Midlands to support in NZ
Recommendation	Not an Option	

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be on Amazon Web Services.
Operational	TBC Further consultation required to obtain an accurate costing.	Resource per annum: IS support resource IS management resource CP Team Hosting per annum

Note: Further consultation would be required to confirm cost implications

HEALTH PATHWAYS

HealthPathways is an online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions.

Rather than being traditional guidelines, each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context. Each health jurisdiction tailors the content of HealthPathways to reflect local arrangements and opinion, and deploys their own instance of HealthPathways to their clinical community.
https://www.healthpathwayscommunity.org

Health Pathways has two separate offerings: the community pathways element, which is widely used, and the secondary pathways element which they are currently implementing in Canterbury and promoting as another offering to other customers.

Evaluation notes

Options	HealthPathways	Detail
Description	Static Pathway tool based on a pathway community managing multiple pathways. Document layout with secondary/primary/allied and patient facing pathways. A static pathway tool.	
Availability and breadth of clinical content Usage:	550 national and international High - general practice Low - secondary care Medium – community/allied	Coverage of clinical pathways 550 conditions, separated into primary and secondary pathways.
Ease of localisation	Medium Technical writing is done by a Health Pathways team. They are able to provide quick turnarounds, but this nonetheless adds a step to the process and the potential for delays outside of our control	
Clinical knowledge sharing	13 NZ DHB, 30 Australian regions 1 UK Trust	Health Pathways place considerable value in the clinical community. There is a commitment to updating pathways. Annual fee of 5 cents per ESU for being part of this community. TBA whether there is an additional fee for the Secondary Health Pathways product.
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	High	Clinicians' rate the speed with which you could find info in Health Pathways.
Mobility – functions on various screen sizes	Yes	
Integration	Medium (future version of e-Referrals)	New integrations would need to be built: BPAC Patient Prompt Medtech Clinical Workstation My Practice Integration with e-Referrals platform.
Usage Reporting	Google	Report down to user level and page view
Support, maintenance, hosting	SaaS	Pay $6,250 per annum to Health Pathways (this is for Community Health Pathways only; cost for Secondary Health Pathways is not yet known).
Confidence in Vendor	High	The vendor has a good reputation in health. The enormity of the task they have in aligning core pathways across multiple

Basis is consultation with DHBs who use the solution and their feedback.		clients in New Zealand, the UK and Australia was noted in recent discussions with them, which might present a minor risk to the level of service they can offer.
Fit with Strategy and road map	Yes	Integrate across continuums of care. Acting as a repository of both agreed regional care pathways e.g. Lung Cancer and locally developed pathways that can be localised for each DHB e.g. Suspected Skin Cancer One instance of the tool and therefore the pathway with localisation would assist with the issue that many common issues are being dealt with simultaneously across our region. Regional pathways enable shared knowledge, learnings and current innovations that are occurring locally to improve patients' health outcomes for the entire region.
Technical Fit	Yes HTML Hosted by HealthPathway	
Risks, disadvantages	• Loss of local identity • Significant regional change management and transition • Like for like integration cost and timeframes • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Technical writing per hour fee is charged by Health Pathways and is a 'must' of pathway localisation, so impacting the re-creation of the 75 existing Map of Medicine pathways as well as creation of new pathways thereon. • Need to follow Health Pathways recommended service model which implies an increase in programme resources per DHB, and so significant role and responsibility changes for the current team. Negotiation would be required with Health Pathways to this end.	A localisation process for the region would need to be established.
Advantages	• Clinicians state high level of support for Health Pathways • Joining a large clinical community with ability to create and lead pathways	

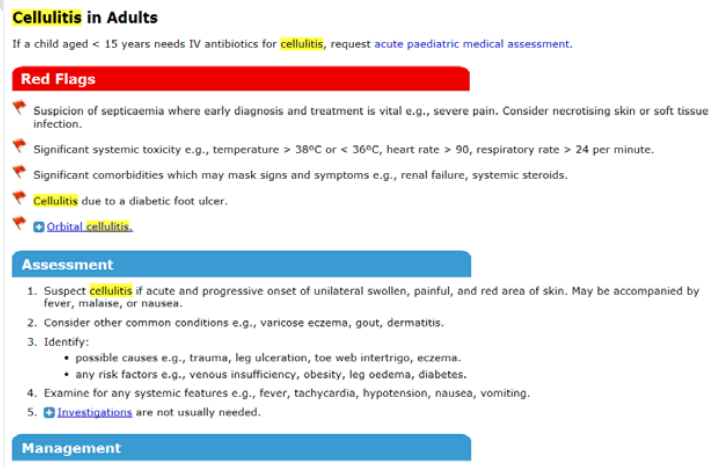
	that are nationally adopted , plus access to large Australasian clinical interest groups • Library of pathways provides starting point speeding up pathway development • Clinicians will be able to move to any other NZ region and many in Australia and use the same system	
Ease of Transition	Medium User base would have to move to new tool, and there would be short term loss of functionality.	Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	**Shortlisted option** Next step would be validating costs and proceeding to business case on the preferred option.	

Cost Breakdown

Expenditure Type	**Value**	**Purpose**
Capital	$0	SaaS – no cost Cost of purchasing source code TBA.
One-off Operational	$137,950 (TBC) *(2018/19 year) – based on pop of 156,000 (Northlands Agreement)*	Breakdown: Components of costs ($69,950) Training advice ,knowledge - $31,000 Website set-up - $6,250 Annual website - $6,250 HP administration systems/support - $15,000 Contribution to developments - $7,950 Breakdown: Fixed costs $71,000 Technical writing @ $115/h5 – 60 -100 pathways - $65,000 Transport, accommodation for training and advice $6,000 *Prices are nominal sums, before adjustments for CPI*
	TBC	IS resource requirement
	Not quantifiable but a risk for consideration	Intangible cost– disruption and short-term loss of productivity transitioning to a new tool

Ongoing Operational	$99,200 TBC *per annum*	Breakdown: Components of costs ($29,200) Annual website - $6,250 HP administration systems/support - $15,000 Contribution to developments - $7,950 Breakdown: Fixed costs $70,000 for technical writing Costs would need to be negotiated/confirmed with Health Pathway. According to their literature, 500 hours of technical writing will result in complete localisation of 30-40 pathways and resources, with a further 30-40 in various stages of localisation. There is an hourly charged for technical writing services. The above estimate assumes an hourly rate of up to $250 and 500 hours of technical writing per year. This may be less depending on negotiations. Ongoing costs for Health Pathways for secondary: unknown at this stage. This is a risk to adoption of this solution, so will require follow up should this be chosen as the preferred Health Pathways recommended service model implies increasing internal support resource to include an additional: 1 FTE Implementation Lead – ballpark $100,000 per annum 0.8 FTE Clinical Lead – ballpark $100,000 per annum propose retaining current complement of staff in Year 1 and then reviewing pathway editor requirements from Year 2 onwards
Total	$ $137,950 (TBC) Ongoing $ 99,200	This is an estimated cost: the first estimate includes implementation of Community only not secondary care

Note: Further consultation would be required to confirm cost implications.



Cellulitis in Adults

If a child aged < 15 years needs IV antibiotics for cellulitis, request acute paediatric medical assessment.

Red Flags

- Suspicion of septicaemia where early diagnosis and treatment is vital e.g., severe pain. Consider necrotising skin or soft tissue infection.
- Significant systemic toxicity e.g., temperature > 38ºC or < 36ºC, heart rate > 90, respiratory rate > 24 per minute.
- Significant comorbidities which may mask signs and symptoms e.g., renal failure, systemic steroids.
- Cellulitis due to a diabetic foot ulcer.
- Orbital cellulitis.

Assessment

1. Suspect cellulitis if acute and progressive onset of unilateral swollen, painful, and red area of skin. May be accompanied by fever, malaise, or nausea.
2. Consider other common conditions e.g., varicose eczema, gout, dermatitis.
3. Identify:
   - possible causes e.g., trauma, leg ulceration, toe web intertrigo, eczema.
   - any risk factors e.g., venous insufficiency, obesity, leg oedema, diabetes.
4. Examine for any systemic features e.g., fever, tachycardia, hypotension, nausea, vomiting.
5. Investigations are not usually needed.

Management

BESPOKE

One option is for the Midland region to "go it alone" and purchase their own responsible website/content management system, outsource initial set-up (e.g. development of 5 page templates) and recruit 1 FTE to complement the existing regional pathways team in maintaining the website content. HBDHB would link into this option.

Evaluation notes

Options	**Bespoke**	**Detail**
Description	Website – move all of the pathways from Map of Medicine into website and the Midland region manages the content. Purchase responsive website/content management system and outsource development of around five web page templates (style sheets) for initial implementation. A static pathway tool.	
Availability and breadth of clinical content Usage:	All Map of Medicine pathways would be transitioned to the new solution. None.	
Ease of localisation	High Partnerships with other DHBs – although Midland region-owner solution would have full autonomy over changes.	
Clinical knowledge sharing	DHBs, and ongoing effort to develop relationships with a wider community	
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	Opportunity to feed clinicians' survey feedback into optimising a design, and also to make the website openly available and so with the same advantage as the Bay Navigator around the time-pressured clinician not needing to remember another logon and password.	E.g. provide a short summary of the pathway on first view, and ability to click through to obtain further detail.
Mobility – functions on various screen sizes	Yes	Consultation would be required around how best to present diagrams on a mobile view with consideration of usability and cost.
Usage Reporting	Google Analytics and potentially Tag Manager tool to track document downloads Google Analytics and potentially Tag Manager tool to track document downloads	Market-recognised product and straightforward to implement New integrations would need to be built: • Medtech • Clinical Workstation • My Practice • Single sign-ons would not be required, but clinical workflow integrations would. $See cost table above.

Support, maintenance, hosting	Amazon Web Services or some other cloud service	
Confidence in Vendor	Unsure	Midlands would leverage Bay Navigator lessons learned plus experience of existing in-house Map of Medicine team (management, editors, GP liaisons, etc.).
Fit with Strategy and road map	Yes	
Technical fit	HTML Cloud hosting	
Risks, disadvantages	• Uncertainty on the long term sustainability of the pathway tool supported at a regional level and competitive market • Responsibility for maintaining toolset lies with region, rather than vendor who has prior experience – do we wish to 're-invent the wheel and go it alone'? • Significant regional change management and transition • Does not benefit from shared clinical pathway community • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Like for like integration cost and timeframes • One DHB IS department supporting a regional system • Can e-Referral links can be developed and incorporated • Midland region have sole ownership of solution, and more control over the pace of transition	Investigating the sustainability of this option would be a priority were it chosen as the preferred option.
Advantages	• Open access website so no barrier to pathways with no need for user registration • Lower variable OPEX • Pathways accessible to public	

	• Solution can be developed and updated regularly to meet programme need	
Ease of Transition	High Commissioning and implementing a new content-management website and recruiting a content manager for all Regional and Central DHBs make this a significant undertaking.	
Recommendation	**Is there a will to 'go it alone'?** Next step would be validating costs and proceeding to business case on the preferred option.	

Expenditure Type	**Value**	**Purpose**
Capital	TBC	Likely $0 as hosting will be an ongoing cost on Amazon Web Services.
One-off Operational	TBC	Management of transition (requirements, procurement, implementation)
Ongoing Operational	TBC	1 FTE clinical writer – 1 FTE programme coordinator Clinical manager/Editor Hosting cost – Support, maintenance contract with website/CMS vendor Ongoing enhancements to website

Note: These are estimated costs for the purpose of initial analysis.

BAY NAVIGATOR

Bay Navigator is a joint initiative between community and hospital-based health care professionals in the Bay of Plenty, designed to improve the delivery of care for patients across the region.
Bay Navigator works to increase communication and collaboration between medical professionals, with the patient at the centre of service design and pathway development to deliver better, sooner and more convenient healthcare for our community.
The Bay Navigator website was established in early 2011 as an information and communication portal for all health professionals in the Bay of Plenty, with the goal of being the Bay of Plenty's leading clinical resource.

http://baynav.bopdhb.govt.nz/pathways/

Evaluation Notes

Options	Bay Navigator	Detail
Description	Bespoke Static Pathway open website with bespoke pathway tool and algorithm display. Created by BOP DHB to support their clinicians to increase communication and collaboration between medical professionals, with the patient at the centre of service design and pathway development. A static pathway tool.	
Availability and breadth of clinical content Usage:	Map of Medicine pathways would need to be transitioned. High - general practice Low - secondary care Low – community/allied	
Ease of localisation	High Ownership is with BoP DHB and so they have full autonomy over changes.	
Clinical knowledge sharing		
Usability Rating – the rating allocated is based on responses from BOP DHB to clinicians survey and user experience	Medium - High	Positive feedback from clinicians' on tool, with a clear bonus for the time-pressured clinician being that there is no need to remember another log on and password. However it it's not well integrated into their clinical work flow. Modern user interface Layout – pictures – consistency – embed images – flexible in configuration but have to scroll Print version - info only printed Pop up boxes are CMS pages
Mobility – functions on various screen sizes	No	Pages re-size on smaller screens but do not display optimally.
Integration	Medium	New integrations would need to be built: • BPAC Patient Prompt • Medtech • Clinical Workstation • My Practice Link with some e-Referrals is already in place.
Usage Reporting	Google	

Support, maintenance, hosting	In house	
Confidence in Vendor Basis is consultation with BOP DHB who use the solution and their feedback	High	
Fit with Strategy and road map	Yes	
Technical Fit	Yes HTML	
Risks, disadvantages	• Uncertainty on the ability of existing software, infrastructure, available development resources and IS support to upscale to a regional solution • One DHB IS department supporting a regional system • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development • Change management and transition – moving a number of DHBs onto a new system • Reduction in number of new pathways developed due to reallocation of resourcing to transition	
Ease of Transition	• Medium • Upscaling the platform to handle additional user base could be complex.	• Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	Not shortlisted – unless there is a will to investigate further Upscaling the current solution would require investment. As per bespoke option, advice sought on whether there is a will to investigate this option further.	Upscaling the current solution would require investment.

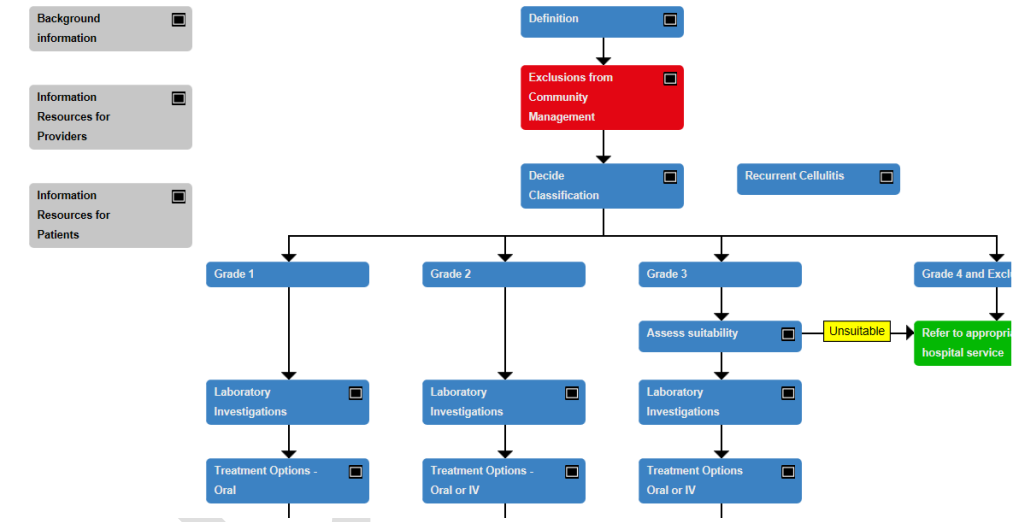
Cost breakdown

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be AWS.
One-off Operational	$TBC *(2018/19 year)*	Awaiting cost info from BoP. Integration costs (BPAC, Medtech, Profile, Indici, My Practice, Clinical Workstation, Hauraki Dashboard, Midlands Clinical Portal) – ballpark $100K
Ongoing Operational	$TBA *per annum*	Awaiting cost info from BoP.
Total (Year 1)	$TBC	This is an estimated cost. Further consultation required to obtain an accurate costing.

Cellulitis

Map of medicine

Print



NEXXT

NexXt is a patient-centric Dynamic Clinical Pathway solution that supports best practice to reduce variation of care, improve quality of life for citizens and reduce pressure on healthcare budgets.
It has a cost effective Software as a Service / web architecture that scales to support clinics, regions or an entire country with a single patient-centric view

http://www.nexxtpathways.com/about/product-overview

Evaluation

NEXXT	Detail	
Description	Dynamic Pathway tool built into the workflow of general practice into the major PMS's in NZ covering the top twenty most common pathways. A dynamic pathway tool.	
Availability and breadth of clinical content Useage	20 National integrated into clinical workflow of primary care Low - general practice Nil - secondary care Nil – community/allied	Current Map numbers – 12 pathways • Cognitive Impairment • Asthma • Severe Asthma • COPD • Diabetes Type 2 • Gout • AF • Cellulitis • DVT • Dyspepsia • Iron Deficiency • Sore Throat • Full journey pathways if system integrated into secondary/allied care in region
Ease of localisation	Low Effort to implement a new automated workflow is significant.	
Clinical knowledge sharing	4 NZ DHB's	
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience		Further investigation required to determine usability. By their nature, dynamic pathway tools provide workflow-specific advice to the clinician which makes them more accessible.
Mobility – functions on various screen sizes		
Integration	Low (Primary only) Low (Primary only)	Integrated with Primary Care – Medtech 32, Profile Integrated with Primary Care – Medtech 32, Profile
Usage Reporting	Granular	
Support, maintenance, hosting	SaaS	

Confidence in Vendor Basis is consultation with DHBs who use the solution and their feedback.	Low* (has been withdrawn from general practices in some regions)	
Fit with Strategy and road map	Partial	
Technical Fit	TBC	
Indicative Costs (ballpark)*	TBC	$35,000 for a 6mth pilot occurred – delivery on 2 Pathways
Risks, disadvantages	• Tool has had poor usability feedback • Effort to implement is high for single pathways and conditions • Only used in primary • Vendor appears to have halted new implementations • Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Does not have the breadth and detail of a static pathway tool • Does not benefit from shared clinical pathway community	
Advantages	• Pathway is integrated in individual patient journey	
Ease of Transition	High This would not replace but complement a static pathway tool. Transition would be complex.	
Recommendation	**Not preferred at this stage** Not currently fit for purpose as a regional electronic pathway tool	

Cost Breakdown

Expenditure Type	Value	Purpose
Capital	$0	
One-off Operational	$TBC *(2018/19 year)*	Costs would need to be elicited for all practices in region. Integration not done previously with secondary systems
Ongoing Operational	$TBC *per annum*	
Total (Year 1)		Further consultation required to obtain an accurate costing.

Note: These are estimated costs for the purpose of initial analysis.

TRENDCARE

TrendCare is a workforce planning and workload management system that provides dynamic data for clinicians, department managers, hospital executives and high level healthcare planners. Care planning components within the system ensure best practice

http://www.trendcare.com.au/

Evaluation Notes

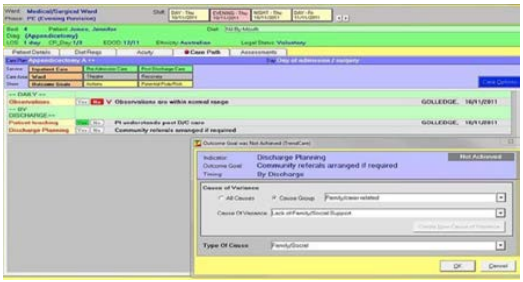
Options	Trend Care	Detail
Description	Workflow care planning tool that can be configured for local use and is commonly used in secondary nursing. A static pathway tool.	
Availability and breadth of clinical content	N/A	
Usage:	Nil - general practice High - secondary care Nil – community/allied	Nil - general practice High - secondary care Nil – community/allied
Ease of localisation	Medium Configuration is devolved to the owner, but effort to implement a new automated workflow is significant.	
Clinical knowledge sharing	1 NZ DHB *pathways are created and localised in each DHB setting	
Usability Rating – the rating allocated is based on responses to clinicians' survey and user experience		Further investigation required to determine usability. By their nature, dynamic pathway tools provide workflow-specific advice to the clinician which makes them more accessible.
Mobility – functions on various screen sizes	TBC	
Integration	Low (Secondary only)	Integrates with main secondary care PAS. No primary care integrations currently. HL7 formatted.
Usage Reporting	Granular??	
Support, maintenance, hosting	SaaS – Partial	
Confidence in Vendor	Basis is consultation with DHBs who use the solution and their feedback. Medium	

Fit with Strategy and road map	No	
Technical Fit	Yes HL7 compatible	
Risks, disadvantages	• Tool is only used in secondary care setting in nursing work flows • Effort to implement is high for single pathways and conditions • Does not have the breadth and detail of a static pathway tool • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Does not benefit from shared clinical pathway community Tool has existing templates but due to high Localisation (configurability) will not support programme principle of regional consistency and equity of access to care	
Advantages	• Tool is highly configurable • Can produce workflows, care plans and patient assessments in patient context • Pathway is integrated in individual patient journey Tool is HL7 compatible – higher level of interoperability	
Ease of Transition	High This would not replace but complement a static pathway tool. Were we to consider transitioning the 75 localised pathways to an automated workflow, transition would be complex	Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	**Not preferred -** Not currently fit for purpose as a regional electronic pathway tool	

Cost Breakdown

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be AWS.
One-off Operational	$ TBC *(2018/19 year)*	Costs would need to be obtained. Integration costs (BPAC, Medtech, Clinical Portal) – ballpark $100K
Ongoing Operational	$ TBC	Costs would need to be obtained
Total (Year 1) Example for Waikato DHB only	$ TBC	This is an estimated cost – further consultation required to obtain an accurate costing for all DHBs and not just Waikato.

Note: These are estimated costs for the purpose of initial analysis.



APPENDIX 6: Example of Agreement costs with Streamliners and a DHB.

The example on the next page is an example only – *note this was the price range in 2015/ based on a population of 159,000.*

Summary key points:

- Streamliners hold the intellectual property including software and documentation (including all upgrades, updates, improvements, enhancements, modifications)
- Any intellectual property prior to agreement stays with HBDHB
- Development and implementation of pathways must meet Streamliners standards
- Pathways are hosted on the Canterbury Pathways site – hence no HBDHB IT requirements
- There may be a gap with transition planning if we go with this option if decisions are delayed
- Cost of the technical writers per hour (average 2-12 hours) – this is to advise, change and ensure meets standard formats
- Minimum requirements at HBDHB level for composition and certification
    - Contract Liaison
    - Programme Management – lead the work
    - Clinical leaders (Combined 0.3 FTE) – experienced and respected
    - GP Clinical Editors (Combined 1.2 FTE / over three people) – Purpose: identify what information is needed, engagement, correct and relevant to GP, champions the expectations, maintain overview of all information – must have training and certification
    - HealthPathways Co-Ordinator (1 FTE) Purpose: gathers non-clinical information, range of communication, supports process of editors, must have training and certification
    - Other governance groups - Purpose – support, collaboration, communications and education and undertakes audit and evaluation.
- Set-up costs:
    - Set-up of live and drafting of Canterbury Pathways – to then localise Planning Seminar led by Canterbury Team
        - one day
        - whole of system thinking and practice
        - planning and operation of work programme
        - local pathways management and customisation
        - Lessons learnt
        - Function and benefits of *HealthPathways* Community
        - Expectations of attendees: CEO – Primary/Secondary, CMOs, key clinical leaders, Operational managers, Integration Managers, those involved in the work-programme
    - Practical Workshop led by Canterbury Team
        - one day
        - modelling of the service provision of the work programme – identifying
        - understanding subject matters
        - Expectations of attendees: Work-programme Manager, Clinical leaders, Clinical Editors, *HealthPathwys* Co-Ordinator, Work-group Facilitators, Hospital Clinicians (2-5), General Practitioners (4-6), other clinicians (Allied Health, Pharmacists).
    - Extensive knowledge and transfer support via phone, video and/or email

Appendix 7: Risk Management Plan – Example of

Risk	Mitigation Strategy	Likelihood	Impact
Lack of stakeholder buy-in with competing agendas as this is a multi-dimension piece of work involving all services	• Establish meetings • Ensure membership covers all stakeholders • Regular updates	Low	High
Costs associated with implementing any tool and integrating that with the existing GP Practice PMS are higher than anticipated	• Gain agreement from new Vendor during the contract negotiation that they will work with DHB/PHO/Practice IT staff and suppliers to gain integration with existing systems, and that they will contribute to the cost of any development needed	Med	High
Reduced number of pathways. The slower rate of localisation of pathways means the utility of the platform is compromised and may affect uptake in its use by primary care	• Gain agreement on the numbers to be developed per year	Med	Med
Need robust communication available to roll out and localize.	• Important for HBDHB to be consistent with messaging and health literacy requirements • Communication resources require localisation and local launches. Need to embed equity and make appropriate for local communities.	High	High
Disconnected IT solutions can have impact into usability	• Time resources need to be included in financial planning • Involve IT	High	High
Reporting structures have not been well established – what will the impact be on resourcing	• Involve IS • Establish and monitor performance indicators and clearly publicise improvements to those indicators that are due to Pathways implementation and use (e.g. shorter wait times for elective surgery)	Med	High
Integration of new tool into GP Practice Systems or e-referrals is not possible	• Work with PHO to achieve the best work-around in order to gain a workable system • Gain tacit agreement from PHO during contract negotiation that they will work towards developing full integration within an acceptable and known timeframe	Med	Med
Clinician engagement is lower than anticipated	• Work with early adopter clinicians as Pathways champions • Provide ample and varied opportunities to engage with the initiative		

APPENIDX 8: Definitions and References

Definitions

Pathway

- the ideal journey of care that a patient should receive within a healthcare setting
- should include all aspects of health and social care, not forgetting self-care, and importantly should move the patient towards a defined positive clinical outcome
- should be based on the best clinical evidence available, from reputable evidence-based sources, e.g. NICE, Health Navigator

Static Pathway

- A pathway represented in a fixed format such as an algorithm or text on paper or in a non-interactive form on a computer.
- It is similar to viewing a paper-based road map. An individual has to pick out the shortest and most convenient route based on a picture of all the different road

Dynamic Pathway

- A pathway represented in an interactive form on a computer interface that is individualised for each patient based on specific data being input.
- It is similar to a satellite navigation system in a car. The system will regularly update you of the shortest and most convenient route however you can override its instructions

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10

EARLY WARNING SCORE SYSTEM UPDATE

Verbal

	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.

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MIDWIFERY GOVERNANCE

Presentation

MATERNAL WELLBEING MODEL OF HEALTH

Presentation

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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

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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.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER 3 DASHBOARD

Late Paper

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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

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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.

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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.

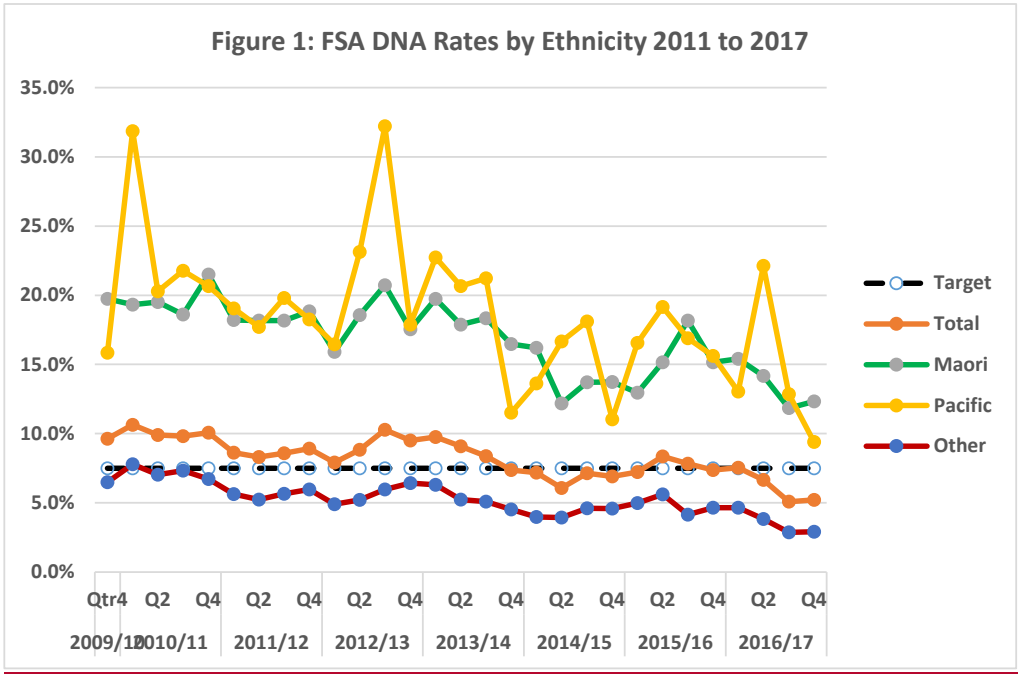
[1] *Paul Malan,A Report on 'Did Not Attend' Rates (DNAs) at Hawke's Bay District Health Board, May 2012*

- 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.

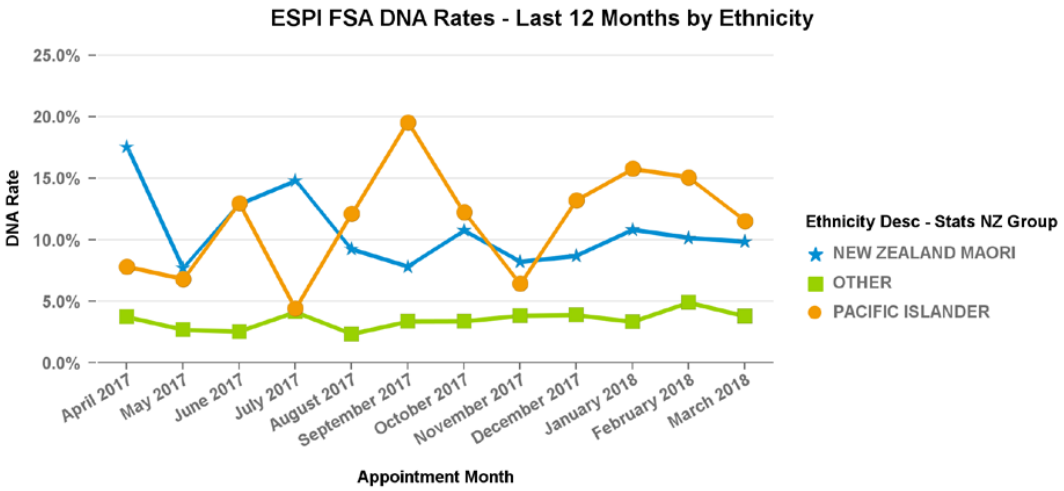
[2] *Nguma, J; Meihana, D; Raihania-White, W; Receveur, C; and Mobin, J: Policy and Health System Implications of the Hawkes Bay District Health Board (HBDHB) DNA Project, A paper presented at the Tu Kaha Conference in Wellington, 2016.*

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.

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

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

OVERVIEW

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

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

REPORTING ON PROGRESS

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

1) Increasing healthy eating and activity environments

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

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

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

2) Develop and deliver prevention programmes

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

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

3) Intervention to support children to have healthy weight

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

4) Provide leadership in healthy eating

The HBDHB continues to provide leadership across sectors to provide advice and support to implement healthy weight programmes, activities and sharing of information.

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

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

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

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

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

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

NEXT STEPS

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

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

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

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

RECOMMENDATIONS

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

RECOMMENDATION:

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

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

Appendix One

Objective 1: Increase healthy eating and activity environments

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

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

What the data shows

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

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

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

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

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

What the data shows

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

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

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

Objective 3: Intervention to support children to have healthy weight

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

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

What the data shows

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

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

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

Objective 4: Provide leadership in healthy eating

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

Indicator 4b: Engage support from key partners

What the data shows

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

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

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

Appendix Two

DRAFT
SECOND MEASUREMENT POINT FOR CHILD WEIGHT

PURPOSE

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

BACKGROUND

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

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

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

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

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

INTRODUCTION

This report will cover the following questions:

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

THE MEASURES

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

Table 1

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

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

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

Recommendation

- Use BMI as the measure.

THE AGE GROUPS

There are three points to consider:

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

4-6 years

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

7-9 years

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

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

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

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

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

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

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

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

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

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

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

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

OVERALL RECOMMENDATION

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

This would

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

NEXT STEPS

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

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

Agenda

Health Hawke's Bay Clinical Advisory and Governance Committee

Date:	20 March 2018	**Time:**	5.30 – 7.30pm
Venue:	Tukituki Meeting Room, Second Floor, GJ Gardner Building		
Invitees:	Chris McKenna (Chair), Bayden Barber, Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Tae Richardson, Catrina Riley; Val Shirley		
In Attendance:	HHB: Wayne Woolrich, General Manager; Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Stephanie Maggin (minutes)		
Guests:	Anne Speden, HBDHB; Michael Sheehan (Clinical Portal PM); Ken Foote, Company Secretary, HBDHB; Victoria Speers, PHO Performance Manager		

	Paper	Action	Lead
1. Administration			
1.1 Apologies	Verbal	Acknowledge	Chair
1.2 Interest Register	Paper	Noting	Chair
1.3 Conflicts with today's Agenda	Paper	Noting	Chair
1.4 Draft Minutes – 13 February 2018	Paper	Confirm	Chair
1.5 Action Items	Paper	Noting	Chair
1.6 Committee Work Plan	Paper	Acknowledge	Linda Dubbeldam
1.7 Items approved since last meeting	Verbal	Verbal	Chair
1.8 Additional Agenda items	Verbal	Verbal	Chair
2. Items for Approval None.			
3. Presentation (20 mins)			
3.1 Clinical Portal and Impacts on Primary Care including lab and radiology	Presentation	Acknowledge	Anne Speden and Michael Sheehan
4. Strategic Discussion (45 mins)			
4.1 Strategic Plan Discussion	Paper		Wayne Woolrich
5. Items for Discussion			
5.1 Clinical Services Plan update (10 mins)	Presentation		Ken Foote
5.2 External reporting of Professional Misconduct	Paper	Acknowledge	Linda Dubbeldam
5.3 Flexible Funding Pool Project Start-up – Draft	Paper	Acknowledge	Linda Dubbeldam
5.4 SLM Performance Report	Paper	Acknowledge	Victoria Speers
6. Business Performance Reports for Info. None.			
7. Other Items for Information			
7.1 Integrated Primary Care Workforce Strategy Update	Paper	Acknowledge	Linda Dubbeldam
7.2 Update – Misdirected Patient Information – Secondary Services to General Practice	Paper	Acknowledge	Linda Dubbeldam
Any other business			
Next Meeting	15 May 2018	5.30pm	

18.1

Minutes

Clinical Advisory and Governance Committee

Date	20 March 2018	**Start Time:**	5.30pm
Venue	Tukituki Meeting Room, 2nd Floor, GJ Gardner Building		
Present	Chris McKenna (Chair), Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Catrina Riley, Valerie Shirley		
In Attendance	HHB: Wayne Woolrich, GM; Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Stephanie Maggin (minutes)		
Guests	Ken Foote, Company Secretary, HBDHB; Victoria Speers, PHO Performance Manager		
Apologies	Bayden Barber, Tae Richardson		

Item	Minute
1. Administration	**1.1 Apologies** Bayden Barber, Tae Richardson **1.2 Interest Register** Updates received from Dr Mark Peterson. **1.3 Conflicts with today's Agenda** None. **1.4 Draft Minutes** It was noted that Valerie Shirley was incorrectly referred to as a full Committee member in the Minutes of 13 February 2018. Valerie has been accepted as an Advisor onto the Committee; this will be corrected in the February Minutes. **1.5 Action Items** The Action Register was worked through: CAG 01 0917. Completed CAG 01 0218. Completed. CAG 02 0218. Completed **1.6 Committee Work plan** Acknowledged. The 2018-19 workplan is to be finalised. HHB management to confirm the process for the development of if 2018-19 sub-committee workplans. **1.7 Items approved since last meeting** None. **1.8 Additional Agenda Item** None.
2. Items for Approval	None.
3. Presentation	**3.1 Clinical Portal and Impacts on Primary Care incl. lab and radiology** Apologies were received from Anne Speden and Michael Sheehan. This presentation will be seen at the 15 May meeting.
4. Strategic Discussion	**4.1 Strategic Plan Discussion** Wayne Woolrich, General Manager, Health Hawke's Bay, outlined the Strategic Plan to the Committee.

	The Health Hawke's Bay (HHB) Board has agreed to focus on a key area which is setting distance and key strategic priorities for the future. A draft framework will be bought to this Committee, linked to the Annual Plan and our 3-year priorities. The intent is to look to work more as a sector through a reinvigorated primary care development partnership. Committee comments: • Have the District Nursing Service closer to general practices. • Pharmacist group with a voice. Could HHB create an avenue for community pharmacy in Hawke's Bay?
5 Items for Discussion	**5.1 Clinical Services Plan update** Ken Foote, Company Secretary, HBDHB, spoke to the Committee on the Clinical Services Plan Sector Update March 2018. A draft CSP will be available in October and will be circulated to all governance committees for recommendation to the HBDHB Board, for their approval at the end of October. **5.2 External reporting of Professional Misconduct** Linda Dubbeldam, Manager Innovation and Development, asked for Committee feedback on the paper, the import of which was requested by the Board. Question: • Should Health Hawke's Bay receive feedback and how is our (non-clinical) GM supported; how do we mitigate any associated risks? Feedback from PHOLT: reporting isn't taken likely; how do we provide the GM with that clinical advice and support in leadership alongside decision-making that he might have to take with respect to reporting. • Clinical guidance or input alongside our GM is something that should be required and an algorithm/pathway might need to be taken in terms of decision. Is this something that should be separated from governance in terms of the decision making that the GM may or may not need to take? • The PHO has obligations as stated in the Minimum Requirements of the PHO Services Agreement which includes a process to manage related to health professionals' health or competence. What is our mechanism for this? Committee comments • Balance of duty of care to the organisation, to your patients and to the employee. Clear process is required. • As a professional you have a duty to notify the relevant responsible authority. • Clinical advice is needed. **5.3 Flexible Funding Pool Project Start-up - Draft** Linda Dubbeldam, Manager Innovation and Development, restated that this paper formalises HHB's plan to evaluate the FFP and its intentions. The Committee supported the purposes of the evaluation as proposed by Health Hawke's Bay. The Committee asked HHB to review the timeframe. **5.4 SLM Performance Report**

	Victoria Speers, PHO Performance Manager, asked the Committee for advice around how to improve the CVDRA results for Māori men aged 35-44 years. The Committee suggested that a focus group could be a useful way to find out the challenges this cohort faces when presenting at general practices. **ACTION:** Chris McKenna and Andrew Phillips to discuss with Mark Barlow [ED doctor] the possibility of a cholesterol blood test being taken when a person presents at ED. This would be current and would come through on the Discharge Summary.		
6 Business Performance Reports for Information	None.		
7 Other Items for Information	**7.2 Integrated Primary Care Workforce Strategy Update** Taken as read. **7.3 Update – Misdirected Patient Information – Secondary Services to General Practice** Taken as read.		
8 Any other Business	**8.1 Prescribing Bulletin** Sara Salman, Clinical Advisory Pharmacist, tabled a Prescribing Bulletin on Shingles Vaccine (Herpes Zoster). Sara explained that there has been a push from the Ministry of Health to double vaccinate with the flu vaccine and Zostavax, but there is clear clinical risk with this vaccine. Following advice from the PHO Medical Advisors, and some local general practitioners, they would like to advise that Zostavax be considered at the end of winter and using the flu vaccination appointment as an opportunity to chat about Zostavax. The Committee agreed to endorse that Health Hawke's Bay is not advising in line with what the Ministry of Health is saying. **8.2 Community Nurse Prescriber** The Chair reported that she funded a contingent of people to Counties Manukau to look at Community Nurse Prescriber. They will be invited to present to CAG in the future.		
Meeting closed	7.00pm	**Next meeting**	15 May 2018

18.2

TOPICS OF INTEREST / MEMBER ISSUES / UPDATES

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

21. Minutes of Previous Meeting

22. National Bowel Screening Roll-Out

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).