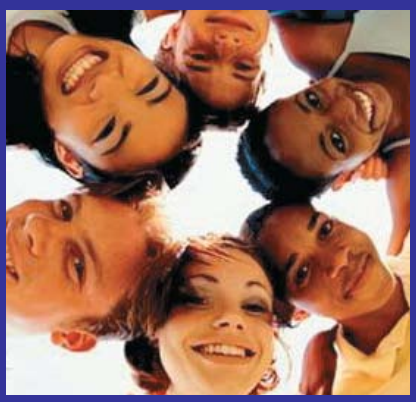
PAEDIATRIC SOCIETY NEW ZEALAND

Health of our Children, Wealth of our Nation

Networking News



Newsletter of the National Child and Youth Clinical Network Advisory Group February 2011

From the chair..

Much has been achieved in the first year of the Society's contract to establish a structure for child and youth clinical networks in New Zealand. We have established a diverse and vigorous advisory group. The members bring a range of skills and perspectives which ensure that our work is focussed and effective.

The advisory group provided the clinical leadership to support the recommendations on vulnerable services that went to the National Health Board in September. The willingness of clinicians from those services that were recommended to participate in consultation at short notice was invaluable.

The National Health Board is working closely with relevant clinicians, service managers and DHBs to develop and progress arrangements for National Services. Technical advisory groups (TAGs) have been established for each Paediatric speciality area, to support the development of service specific contract specifications and clinical network arrangements. You can have your say by putting your name forward for these TAGs. It is expected that the National Services will be effective from 1 July 2011.

Since September the Advisory Group has worked intensively on developing a structure for clinical networks and making recommendations regarding further programmes of work. A report was forwarded to the Ministry of Health at the end of November and we have been working through this with the Ministry.

From my perspective there are three key issues that need to be addressed in the coming year.

First, we need a robust and fair process for determining which programmes and services should be addressed first. I stress that this is a process, and the intention is to develop a comprehensive approach which will support the development of all areas of child and youth health in a rational way. However, we cannot change the world overnight! A staged approach is necessary. To this end, we need to determine a fair way of assessing priority to replace the ad hoc approach that has been used in the past. Progress towards developing a transparent process is well underway.

Second, we need ongoing advocacy to ensure that child and youth health services receive "a fair go" from funders. This is not specifically the work of the advisory group, but needs ongoing work from a range of agencies with an interest in child and youth health and welfare. Policy makers need to understand that neglecting the health and wellbeing of children and young people will have long term impacts on the economic health of our country.

Thirdly, we need an infrastructure that supports services to be "better, sooner and more convenient". This means that the funding structures that support outreach services and inter-district flows need to be clear and fair. Use of telehealth to provide services closer to home needs to be easy and convenient for patients and clinicians, as well as supported by appropriate funding structures

How will we achieve these lofty goals? We need to understand the views of service providers – clinicians and management – and service users. Early in 2011 we will be arranging a series of consultation meetings to find out your views. As soon as we know the dates we'll let you know. The dates will also be on the Paediatric Society website www.paediatrics.org.nz.

See you there!

Rosemary Marks
Chair
National Child and Youth Clinical Network Advisory Group

Your contributions

We welcome thoughts, contributions and articles and notices of upcoming events. We anticipate publishing updates around every three months. Please email the editor, Lauren Young on lauren@laurenyoung.co.nz

Do contribute by putting your name forward for a Technical Advisory Group - check your inbox for Rosemary's email to the listserver of 5 January. We need more than one Society member passionate enough about excellent services for children and young people to get involved.

Name this newsletter competition

A nice bottle of Hawke's Bay's finest to whomever comes up with the best title. Send your suggestions to lauren@laurenyoung.co.nz by the end of March.

Why we need Clinical networks

We have all heard about Clinical Networks and feel quite good about them, but we also have different ideas about how they can work, both for us and for our patients. In this issue we want to give some of examples of how Clinical Networks work for you but even more importantly, how they work for your patients and their families.

The formal definition of Clinical Networks describes a process of leadership – a way of working in a managed way which encourages practitioners to work in a coordinated way across traditional professional and organisational boundaries to tackle complex problems which cannot be solved in just one area of the service in isolation.

There is a lot of work going on around Clinical Networks, although the work may not be labelled as such. In Auckland there is Greater Auckland Integrated Health Networks (GAIHN) which is aiming for breaking down the barriers between primary and secondary care. There is also a lot of work going into Better, Sooner, More Convenient (BSMC), which also aims to improve the patient journey through more integrated and collaborative health care. While these initiatives are not paediatric-focused, there is clearly support for improving clinical networks at the highest levels.

So there is a ground-swell of patient-centred work going on all over New Zealand. This is being driven by the Minister and clinicians but is being supported by MoH, NHB, PHOs, DHB regional groups and many, many others.

The other tranche of work being carried out is looking at specific services and how they can work towards growing their own Clinical Networks. Later in this newsletter we will give some examples of Clinical Networks not only working well in terms of providing children and their families will excellent care when and where they need it, but also providing clinicians with continuing education and career upskilling opportunities.

The initial service focus is on gastroenterology, rheumatology, child protection and oncology.

What's happening in the South Island

The South Island DHB clinicians have been working very well towards establishing a South Island Child Health Clinical Network. Approval has been given to commence a closer collaboration in the New Year. Development of Secondary Clinical Referral Pathways using methodology developed by Canterbury Initiative, a primary care / secondary care interface that has developed pathways for primary care providers referring children to outpatients, is one of the first proposals. The pathways use an electronic template, for common conditions such as heart murmurs, asthma, gastro-oesophageal reflux, constipation and chronic coughs. A thorough review process by GPs and Paediatricians suggests a process whereby the best solution for that child and family are managed in a consistent way, using all services available. This has reduced out-patient appointments and reduced waiting times when they are referred.

The group is meeting again in early February to determine priorities for 2011. The utilisation of early-warning scores in a standardised way and the secondary to tertiary links within the South Island and to Starship are likely first areas to be considered. This work is eagerly awaited in a spirit of sharing and collaboration!

Lauren Young with input from Nick Baker and Nicola Austin.

Future healthcare

Don Berwick, the plain-speaking guru of quality healthcare, is very clear on his recommendations for improving patient care through better use of the resources we now have and rethinking the health paradigm we are in. He points out that the least expensive fifth of hospital service areas in the USA have better care and better outcomes than the most expensive fifth. So it's not just a matter of throwing more money at improving and regionalising expensive tertiary services to provide more hospital beds. It is, in the immortal words of Richard Till, a matter of working smarter. (Slight liberty with his words – he advocates shopping smarter!). Berwick's (abridged) suggestions include;

- **And always number one – put the patient at the centre of the system of care.** It feels risky for both professionals and managers, especially at first. It is the active presence of patients, families and communities in the design, management, assessment and improvement of care. It means customizing care literally to the level of the individual. It means asking "How would you like this done?" It means equipping every patient for self-care as much as each wants.
- **Stop restructuring.** In good faith and with sound logic, the leaders of health and government have sorted and resorted local, regional and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn't make sense. It drains energy and confidence from the workforce and middle managers who learn not to take risks, but rather hold their breaths and wait for the nest change. It is time to stop.
- **Strengthen the local health care systems – community care systems – as a whole.** Our patients need integrated journeys. We have gone too far in the past decade towards optimising hospitalised patient care – a fragment of a whole – and not yet optimised the processes of improving care for communities.
- **Reinvest in General Practice and Primary Care.** These, not hospital care, are the soul of a proper, community-oriented, health-preserving care system. General practice, not the hospital, is the jewel in the crown. . .save it, build it.
- **Don't put your faith in market forces.** This has failed in the US where competing forces slug it out in public. Total transparency, strong managerial skills and accountability for improvement weigh far more than consumer choice.
- **Avoid supply-driven care like the plague.** Unfettered growth and pursuit of institutional self-interest has been the engine of low value for the US health system. It has made it unaffordable and has not helped patients at all.
- **Develop an integrated approach to the assessment, assurance and improvement of quality.** Speaks for itself. . .needs to be owned by every person working in health.
- **Heal the divide amongst the professions, managers and government.** The toll has been heavy: resistance, divided leadership, demoralization, confusion, frustration, excess costs and technical mistakes in the design of care. We cannot afford another decade of this – it is the duty of both to set it aside.
- **Train healthcare workforce for the future, not for the past.** This workforce needs a whole new set of skills relevant to the leadership of patient safety, continual improvement, teamwork, measurement and patient-centred care, to name a few.
- **Aim for health.** Great health care alone cannot produce great health. Developed nations who forget this suffer the embarrassment of growing investments in health care with declining indices of health. Charismatic epidemics such as SARS, mad cow and influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance abuse and physical inactivity.

We are not trying to tell you how to suck eggs, however, the commonsense suggestions of Berwick's underpin what Clinical Networks are all about.

Child Health Advisory Group

ADHB Child Health Stakeholder Advisory Group (CHSAG)

This multi-sector group was formed in late 2006 under the auspices of the Auckland DHB Child Health Improvement Plan 2006 – 2011. A broad multi-sector membership at a senior level has been maintained with the aim of fostering a strategic approach to identifying and addressing issues affecting child health in ADHB. Membership includes primary and secondary clinicians as well as senior managers from other sectors including MSD, Ministry of Education, Housing New Zealand, Auckland City Council, CYF, Children's Commissioner's Office, NGOs and some individuals with a commitment to and interest in child health such as Dr Ian Hassall. Two hour bi-monthly meetings have been held for 4 years with each meeting providing information on current issues in child health and focusing on a particular issue e.g. truancy, immunisation coverage, housing, disability, childhood injury, conduct disorder, community links (MSD). The Group has also contributed to the ADHB planning process and has advocated on specific issues such as the repeal of Section 59. The major benefit to date is probably a growing understanding amongst members of the key role of social determinants in child health, development of a common 'big picture' view with common goals, as well as a real enthusiasm by members for working together to make a difference for ADHB children.

Sub-groups with special interests have also dropped out of CHSAG such as ADHB Immunisation Governance Group. This is a multi-sector group that meets bi-monthly and reports to the CHSAG. CHSAG members are joined by others with a particular interest in immunisation e.g. NIR staff, primary care Immunisation Co-ordinators and IMAC staff.

Auckland central Strengthening Families Regional Governance Group is chaired by ADHB and membership includes a number of members of CHSAG but also senior managers from others such as police and IRD.

Auckland Social Sector Leaders Group is a group of social sector government agencies represented in the Auckland region. Membership is at the highest level and DHBs are represented by the ADHB CEO. This group is currently undertaking a project of action on agency identified key objectives that all will contribute to. The health objective is to improve immunisation coverage and ADHB is leading the work on this utilising its established networks.

Overall ADHB has established a well connected and active network of agencies, NGOs, academics and individuals committed to improving the health status of children in ADHB.

Carol Stott
Strategy and Planning Manager
Children, Youth & Women Auckland District Health Board

Violence Intervention

Violence Intervention Programmes (VIP) in DHBs funded by the Ministry of Health since 2007 have achieved measured progress in improving health service responsiveness to victims of family violence.

Evaluation results suggest that by June 2011 75% of hospitals can achieve target scores in both Partner Abuse and Child Abuse and Neglect Programmes.

While this is significant, recent events strongly reinforce that there is still work to be done to build on the national VIP network grown by Family Violence Intervention Coordinators and their supporters over the last three years.

Lessons learned include the importance of remembering that network development, like programme implementation, requires careful and responsive investment of support and resources to grow integrated and sustainable family violence prevention and intervention services. They don't happen by themselves!

VIP has learned that public health models of leadership supported by evaluation and research can create supportive environments. These are further strengthened by good relationships with referral services including NGOs, government agencies and other health services, and best systematised by meaningful relationship agreements that define roles and responsibilities and agreed practice.

Focussing on quality improvement is generating a forwarding-looking VIP network. Doing, and being, 'better' is more engaging and efficient when good information is available about how and where improvement is most needed. The VIP network developed its own quality improvement 'Toolkit' in 2009 for this purpose. In 2010 this approach has led to a new challenge – improving the cultural responsiveness of VIP programmes by linking with Government's Whanau Ora Taskforce directions and the providers recently funded to respond to them.

Collated by Mollie Wilson

Oral Health team

From a clinical networking perspective, this very tricky (adolescent) patient group, dental services are generally outside traditional GPs and Paediatrics, except for referrals when there are health issues caused by dental disease being caries, periodontal (gum) disease and dental trauma caused by accidents

We could regard the Child and Adolescent Dental Service as a managed care network from birth to adulthood (up to the 18th birthday). However in child and adolescent dental services the continuum of care is managed from Wellchild provider referrals and enrolments for preschool children to the School Dental Service (children aged from 0 years - year 8 at 12 years). There is considerable work to transfer children in year 8 (12 years) into the Adolescent Dental Service and to encourage adolescents to give oral health and dental appointments any importance in their busy lives.

In our region where dental disease is high risk, there are great disparities of access and utilisation of Oral Health service for Maori, Pacific and communities with high deprivation, particularly with a lack of priority given to the importance of oral health and dental check ups over generations.

In recent years a major advance has been the intensive work done by the school dental service to get children enrolled at preschool ages to promote good oral health before they go to school, to maintain their oral health education and care at school and then hand them over to adolescent dental services. In this way oral health education managed by the School Dental Service dental therapists, to Wellchild providers and education networks, plus individually to children, has all assisted in more adolescents using services.

In the Adolescent Dental Service there is extensive clinical networking across the Northern region of Northland, Auckland, Waitemata and Counties Manukau to;

- increase the numbers of registered Dentists with Adolescent Dental contracts
- increase access and increase utilisation from this very hard-to-reach adolescent group
- enable more efficient transfer of year 8 children from the School Dental Service to Adolescent Dental Service
- provide more Oral Health promotion through School and Adolescent Dental Services raising the importance of good Oral Health for Life
- increased use of Mobile Dental Services on-site within secondary schools, and
- support the considerable networking to provide “Special Dental Services” for complex dental issues or treatment.

Additionally, overarching clinical support is provided to maintain standards of care and increase the numbers of registered dentists with adolescent dental contracts. This important role is managed regionally between the DHBs by Dr John Dalton, a Public Health Dentist .

Only 5 years ago we were struggling to reach past 40% of adolescents utilising Adolescent Dental Services in our region and we were struggling to find dentists to provide services under the Adolescent Dental Contract. Therefore to achieve over 60% utilisation in 2010 in Adolescent Dental Services and of preschool children, and 97% of school children enrolled, is a significant result that can be viewed as an excellent investment in this populations’ long term health.

Contributors:

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Preschool children being examined in the new Mobile Diagnostic Screening van at Port Waikato. 2010