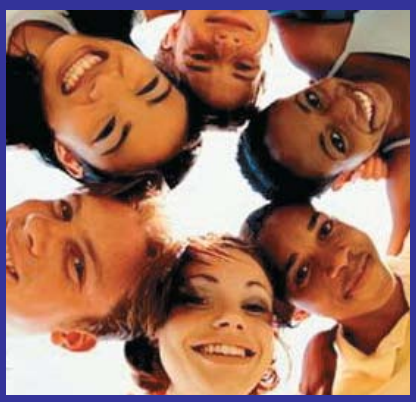
PAEDIATRIC SOCIETY NEW ZEALAND

Health of our Children, Wealth of our Nation

CYNet



Newsletter of the Advisory Group for National Child and Youth Networks April 2012

From the chair..

After a rather uninspiring summer in terms of weather for most of New Zealand we bring you some stories about ways of working with complex and difficult situations which we hope will inspire you. Many of you will have spent time this summer reading and thinking about The Green Paper. Many of you will have contributed to the many submission that have been made by child health organisations and many will have made individual submissions. As we go about our clinical work each day it is all too easy to feel overwhelmed by the challenges of providing health care to children and young people with complex needs and families struggling with a range of issues.

In this issue of CYNet you will read about how others are tackling these situations and making a difference to vulnerable children. Gateway assessments address the unmet health needs of our most vulnerable children and young people while the Choice and Partnership Approach offers a new way of working in Child and Adolescent Mental Health Services that both results in better outcomes for patients and less stress for professionals.

Also, in this edition we are bringing you an update from the Health Quality Safety Commission. This will become a regular feature and we will be circulating their newsletters on the listserver. You will note that one of the themes they have identified is delays in responding to a patient's changing or deteriorating condition. In a later issue of CYNet we plan to bring you information on the Paediatric Early Warning Score (PEWS), which aims to identify children whose condition is deteriorating before the situation becomes critical.

Meanwhile, the Advisory Group and Secretariat have been busy with the development of clinical networks for

- Child Protection
- Paediatric Palliative Care
- Diabetes and
- Eczema

We plan to bring you updates from each of these groups in our next edition.

We have also been gathering information on many other initiatives that are happening around the country. If you are engaged in network activity – we would love to hear from you.

Rosemary Marks
National Child and Youth Clinical Network Advisory Group

Public Health Association Conference 2012

The Public Health Association of New Zealand is pleased to announce its 2012 conference: *Equity from the start – valuing our children,* to be held 3-5 September in Wellington. This is New Zealand's premiere public health event of the year and you don't want to miss it!

A number of high-profile speakers have already been confirmed, including Sir Michael Marmot, Chair of the World Health Organization's Commission on Social Determinants of Health.

The conference will feature the usual wide variety of presentations, workshops and panel discussions around equity for children and other important public health themes. A variety of innovative gateway events will also be held on 3 September prior to the opening of the conference.

Find out more about speakers, conference streams and submitting abstracts at http://conference.pha.org.nz.

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

The Choice and Partnership Approach (CAPA)

An effective clinical system for Mental Health Services from one side of the globe to the other.

The challenge facing many Mental Health services is delivering quality service within limited resources. Services can often be overwhelmed by demand and seemingly not have the capacity to manage the growing workloads effectively. Not only does this result in staff dissatisfaction the question must be asked, "Is the service user's needs being met in the best way possible?"

The Choice and Partnership Approach (CAPA) is a clinical system developed by Consultant Psychiatrists Dr Ann York and Dr Steve Kingsbury who describe themselves as "ordinary outpatient child & adolescent psychiatrists" who "struggle with relentless demands on our services, target pressures and lack of time" in their respective services in London, UK. The Choice and Partnership Approach brings together:

- The active involvement of young people and their families
- Demand & capacity ideas
- A new approach to clinical skills & job planning
- Introduces the 7 HELPFUL habits of effective mental health services

The benefit of a using a CAPA system is that Services can then:

- Do the right things (have a clear working goal with the client and their family, adding value a every step)
- With the right people (use clinicians with the appropriate clinical skills)
- At the right time (without any external or internal waits)

The core value which underpins CAPA is that Service Users are at the heart of the process. The premise is that service involvement is led by families and guided by the clinician.

In New Zealand, keeping close liaison with Anne and Steve, the Werry Centre workforce development programme has been supporting DHB Child & Adolescent Mental Health Services (CAMHS) to implement CAPA/7HH by providing workshops and supporting services. CAPA is now implemented in 15 of the 20 of DHB CAMHS across New Zealand. Building capacity in a service is further enhanced by developing a capable and competent workforce.

Competency frameworks such as Real Skills Plus CAMHS complements CAPA and provides managers with a mechanism for identifying current strengths and areas needing further development in their service.

Acknowledging the importance of introducing a system which is relevant to the NZ/Aoteoroa context the Werry Centre under the guidance of our Kaumatua Rawiri Wharemate and our Maori Advisory Group have identified clear alignment of CAPAs ideas, principles and values to Maori models of care. The focus on the service user, enhanced by a shift in stance from being the "expert" to being the "facilitator" of a therapeutic process which embraces choice and partnership from referral to discharge.

Does CAPA work?

The Werry Centre is currently collecting data from services throughout the country to gauge the impact of CAPA on services. Our preliminary findings suggest that CAPA results in improvements in service delivery. This includes reduced waiting times for first appointment, improved flow of referrals through the service, improved satisfaction reported by families, improved use of existing resources to meet referral demand, and improved use treatment goals and planning processes.

The benefits reported by services have been so encouraging that Services within the Adult Mental Health Sector have begun to implement the model in 5 DHBs. Overall CAPA together with the Seven HELPFUL HABITS appear to be an effective mechanism for reducing inefficiencies while preserving a focus on the service user.

If you are interested in more information about CAPA please contact Tania Wilson, Senior Advisor at the Werry Centre at t.wilson@auckland.ac.nz

The Werry Centre recently hosted Drs Ann York and Steve Kingsland, Child and Adolescent Psychiatrists, UK, the original developers of The Choice and Partnership Approach (CAPA) and the 7 Helpful Habits (7HH) to a interactive Masters Class workshop in Auckland. The successful day was designed to support champions who have implemented CAPA/7HH and want solutions to trouble spots or want to hear how to overcome some of the common challenges of bringing a new system into services. CAPA /7HH have now been implemented in 15 New Zealand DHBs, Scotland, Ireland, Australia and more recently Canada. Ann and Steve have written a book The Choice and Partnership Approach – a guide to CAPA and further information can be accessed at www.camhsnetwork.co.uk or www.werrycentre.org.nz •

How Hawke's Bay DHB implemented CAPA

Our Team

The Child, Adolescent and Family Service (CAFS) is a secondary Hawke's Bay DHB (HBDHB) service, providing mental health assessment, diagnosis and treatment for children, young people between 0-2 years old, and their whanau/families in the Hawke's Bay region. This is provided by a multi-disciplinary team with 27 FTEs.

CAFS is based at Hastings Hospital site. Clients and their families are seen here, as well as in their homes, schools, or in meetings with other agencies. CAFS has satellite bases in Napier, Waipukurau, and Wairoa.

The service specification is to reach the 3% of moderate to severe end of the spectrum of young people experiencing a psychiatric, psychological, or family-based disorder.

Implementation of the Choice and Partnership Approach (CAPA)

In 2009 Vincent Rasell (CAFS Team Leader) and Benita Stiles-Smith (CAFS Clinical Coordinator) decided to implement a new clinical system at CAFS and CAPA was fully implemented in November 2009.

The CAPA system of mental health care delivery is focused on the patient and their family. The stance is collaborative, and provides choices. For the clinician there is a shift in position from "expert with power" to "facilitator with expertise". The CAPA system has two fundamental principles; CHOICE for service users, and PARTNERSHIP work with the health provider. The "seven helpful habits" that underpin CAPA include:

Handle demand

Managing how referrals come into the system;

- Eligibility criteria being specific about what you see and for what, and naming the service exclusion criteria
- Diversion and service level agreements, which involve establishing written MOUs with partner agencies about who sees which clients, and trying to avoid providing the same service at different agencies
- Priority criteria having only two criteria: Emergency and Routine. Being specific what falls into the criteria, and avoiding multiple priorities which produce "churn" and leave clients as "sediment"
- Service strategies for understanding the "bigger" picture
- Full booking, meaning that families get the choice of two bookings at first contact, which smoothes service flow and prevents development of treatment waiting lists
- Screening referrals by direct contact, instead of by paper, telephone, or provider triage. Choice combines triage process with a change focused, face to face, motivational enhancement, and solution focused experience. Think "single session therapy" rather than triage assessment

Extend Capacity

Making the most of what you've got;

- Knowing the team capacity through understanding our statistics, and creating team job plans describing the average working week
- Avoiding unnecessary follow-ups through knowing what will be offered at each and every appointment, and enlisting other agencies follow-up as appropriate
- Reducing unnecessary meetings; e.g. a whole team meeting for screening, triaging, or allocating, is not necessary
- Recruiting specific skills rather than profession or discipline, understanding demand and capacity of clients and staff, identifying skill shortages. Process mapping of client movement through treatment, noting "bottle necks", helps understand staff need and skill shortages
- Extending clinicians' skill base strategically, related to service need

Let go of families

Families and individuals have the skills to cope;

- Only follow-up for a reason
- Use client Care Plans, and review with client at regular intervals
- Have a systematic approach to long-term problems. Enable families to become the expert on their condition, and in their self management. Develop support networks for specific assistance and purpose

Process map and redesign

- Map and understand the client journey, identify waits, bottlenecks, handoffs. This must be from the clients' experience rather than the service perspective. Regularly discuss clients' process in team
- Communicate with other CAFS teams to explore what works

Flow management

- Reduce queues for service, with no internal waiting lists. Book two appointments at first contact. If specialist skills are "bottlenecked", use additional support from referrer, or offer self-help materials to clients in the interim
- Ensure job planning for staff, with dedicated time for clinical sessions, administrative duties, professional involvement, and community networking
- Utilise generic clinics for families that present with similar needs
- Develop bundles of care that streamline service delivery for various similar presentations, e.g. eating disorder, ADHD assessment, etc.
- Daily referral screening
- Give therapeutic assignments to families between appointment times, encouraging collaboration, commitment and independent growth

Use care bundles

- Care bundles are a systematic way of measuring and improving clinical processes by grouping together interventions that are more effective if given together than alone.
- Ensure reliability of interventions by
  – Identifying groups that could benefit
  – Designing Care Bundle based on best practice
  – Intervention delivered follow best practice
  – Measure compliance with Bundle frequently

Look after staff

- Team away days
- Staff job plans
- All staff have annual appraisal
- Listen to, value, and involve staff especially in service change
- Encourage staff relationships

(The Choice and Partnership Approach, 2009)

Why CAPA?

Child and Adolescent mental health services face an increasing demand to see more young people every year, both public and Ministry of Health expectations expect local CAFS services to meet the presenting demand. Pre CAPA implementation CAFS locally had in a place a standard triage based clinical system. Unfortunately the triage based system failed to meet the service users and the public's expectation to access to services. Consequently the pre CAPA CAFS team had a Waitlist list of 80+ children at any one time, was in place for 5 to 10 years and increasing monthly. We felt that working smarter was required, our driver was getting our clients to have CHOICE and to work in PARTNERSHIP, to focus our services to clients at the right time, with the right person. Implementation involved; a microscopic look at our clinical system, stock take of the current service provision, reviewed past and current 'best practice', reviewed CAFS role within the DHB. To change, we formed the 'critical mass' and developed the 'road map' forward, we implemented the new clinical system over 6 months, and now we continue to 'refine' and 'improve' our new clinical system

Benefits and results

- Increased access for under 20 year olds to MHS….from 1.2% of total 20< population (remained static for past several years) to 3.1% of total 20< population (11th July 2011). The MOH target is set at 1.7 % for Hawke's Bay
- MORE than DOUBLE (does not include non face to face contacts) the amount of young people accessing services since November 2009. Throughput in cases from 268 open and 242 closed (Oct 2009-Sep 2010), to 433 open and 367 closed (Oct 2010 to Sep 2011)
- Increase in Maori accessing service, 3.1% of total under 20< population. The MOH target is set at 1.8 % for Hawke's Bay
- Increase in average caseload from 17 to 19 service users / practitioner
- Increase in referrals to CAFS
- Increase in discharges from CAFS (more than referrals on average)
- Slight reduction in Sick Leave within the Team despite increasing staff
- Reduction in time on NON face to face contact with service users, due to reducing MDTs and focused MDT discussions on clinical review
- Disestablishment of the 'triage' function and 1.0 FTE
- A shift to 'group' work with service users
- Our service user group 'Fostering Security' won the 2010 National Innovation award for Child and Adolescent Mental Health!
- The development of 'bundles of care'
- A change in language with key stakeholders, GPs and referrers now asking for CHOICE appointments!
- Increased inter agency co working, we have now established a local inter agency accord and we have a resident CYFS social worker on site weekly
- Service user survey indicates clear satisfaction with CAPA process
- No WAITLIST since November 2009

Our Experience

Our team has experienced significant professional and interdisciplinary growth through the course of implementing CAPA.

Examining our practice and service delivery has enabled the team to expand core capability in practice, to plan service growth in specific skills that had previously been unavailable in our area, and to refine and extend many aspects of our daily work. In addition to the collaborative work with our clients, our team has been able to use opportunities presented through the CAPA process to develop cooperative ventures with other service providers in both the government and community sectors. Evaluative feedback from our team, our clients, and our colleague providers has been positive, and we are encouraged to continue the development in each of these areas that is possible with the CAPA process. •

Vince Rasell Manager, Community Mental Health, Hawke's Bay DHB
Dr Benita Stiles-Smith Psychologist/Clinical Coordinator, Child, Adolescent and Family Service, Hawke's Bay DHB

Pre CAPA (pre November 2009)	CAPA (Post November 2009)
✖ Practitioners at heart of process	✔ Service users at heart of process
✖ Expert (practitioner) with power	✔ Facilitator with expertise
✖ Capacity determined Nationally	✔ Capacity determined on demand
✖ Allocation to practitioners based on triage	✔ Allocation based after face to face appointments
✖ Appointed therapist based on 'who puts their hand up'	✔ Appointed therapist matched by skills required
✖ Therapists 'keeping' clients on caseload 'just in case'	✔ 'Letting go of family' a key driver
✖ Numerous 'clinical' review points, requiring large MDTs	✔ Set review points, with small MDT
✖ Waitlists growing monthly (80+)	✔ No waitlists since implementation (Nov 2009)

Regular feature: Health Quality Safety Commission update

Serious and sentinel events report has learnings for paediatric care

Each year, a report is released on the serious and sentinel events that occur in our hospitals. The Health Quality & Safety Commission has recently taken over responsibility for reporting this information.

For the 2010/11 year, District Health Boards reported 377 serious and sentinel events. This included 195 falls (up from 130 falls reported for the previous year), 108 clinical management incidents, and 25 medication errors. There were 86 deaths, although not necessarily as a result of the event.

These events include harm to children, often centred around the provision of maternity care – however, learnings from all events have relevance to paediatric care. In your future newsletters we would like to share some specific examples of these events.

The latest event findings have several recurring themes:

- delays in responding to a patient's changing or deteriorating condition
- medication errors, including incorrect doses and administration of drugs to which a patient was known to be allergic
- poor communication between health professionals, resulting in harm to a patient
- delayed diagnoses due to failings in referral processes and the reporting of investigation results.

The Commission is concentrating on a number of specific work programmes to support the health and disability sector to reduce the incidence of harm from preventable events by making systems safer.

For more information about events that occurred in 2010/11 see the Commission's website: www.hqsc.govt.nz. •

Gateway Assessments in Counties Manukau

The Gateway Assessment Programme was piloted in 16 Child, Youth and Family sites in New Zealand and within five District Health Board regions. From July 2012 all DHB regions will be implementing the programme.

A collaboration between the ministries of Social Development, Education and Health offer Gateway Assessments to those children and young people who have come into care. The literature clearly identifies this cohort of children and young people as some of the most vulnerable in society. Counties Manukau District Health Board (CMDHB) was one of the original pilot sites. In partnership with the seven Child Youth and Family Service (CYFS) site offices in the area, CMDHB have completed comprehensive assessments on many of the children in care. This has identified those children with three or more health needs, ranging from significant behavioural or mental health needs to dental and skin conditions that have been unidentified or untreated.

CMDHB was committed to providing this service and a team of clinicians comprising of a coordinator, Paediatrician, Medical Officer of Special Scale (MOSS) and a Clinical Nurse Specialist were established. It was estimated that there were some 500 children in the care of CYFS in the Counties Manukau area who would be referred for a Gateway Assessment.

Currently, the CMDHB Gateway team expect to assess between 36-40 children and young people a month.

There have been some barriers to overcome from all three agencies, which have included:

- Completion of referrals from CYFS sites in a timely manner
- Acquisition of education profiles to support the assessment
- Compilation of all relevant health records from other DHBs

However, all three agencies have worked together to overcome impediments to the Gateway process and it appears that a greater cohesion has begun to enable the best outcomes for the children and young people involved.

In the course of the development and augmentation of this service there have been some children that have astounded the health professionals with their resilience, connection to each other and self efficacy. The Gateway process should offer these children opportunities to ensure their life trajectory progresses on a positive contour as it encompasses both their health and educational needs. For many of these children this will be the first time they have had a comprehensive report that identifies a chronological history from birth to present date of any health events they have had. For many transience has been a significant issue.

Many of these children require support with behavioural and emotional issues. In 2012 a health professional from the local Child and Adolescent Mental Health Service (CAMHS) will attend the peer review process for all children and young people seen at CMDHB Gateway and offer expert opinion and guidance on recommendations and outcomes. It is believed this will further enrich the final report and fundamental to offering children and young people effective and purposeful management plans.

CMDHB also have the ability to have any adolescents in the gateway process seen by expert clinicians from the Centre for Youth Health, which will begin this year. The uniqueness of adolescents and their own specific health, educational and developmental needs can be better served by a team of health professionals who can not only complete the initial assessment but offer ongoing engagement for those young people who require it.

Case example

A family of 9 children attended clinic having been taken into the care of CYF with a history of serious neglect and exposure to family violence and parental substance misuse. The children were all a little nervous and unsure of why they were at the clinic. A lot of time was spent explaining the purpose of their clinic visit and what they could expect.

What became obvious within a short space of time was the resilience of these children and their deep connection to each other. The age range of the children was 4 yrs through to 14yrs and the older children appeared to have taken on a parenting role. The children had not seen each other for over a month as they were with different caregivers.

The younger children were delighted to see their older siblings and after much hugging and kissing they settled down to the forthcoming assessment process. After screening the children it became clear that the older two children were exceptionally smart and superseded their peer groups in all of the cognitive tests.

Once again their resilience and ability to remain focused on their studies in the face of such adversity was astounding and given the right circumstances they could achieve great things.

It is families such as these that affirm your belief that effective interventions and the necessary resource can alter the life trajectory for children such as this in a positive and beneficial way. •

Happy ending

20 month old Tim Tim is a 20 month old toddler who, until he came into care, had a childhood diet of pies and fizzy drink and his only "toy" had been the keys on a computer which he would bang. Tim was starting to make good progress with new caregivers, and was on a healthy diet, however he couldn't yet sit, crawl or stand and had no verbal skills, so he got very frustrated and was prone to tantrums. The Gateway Assessment found him obese (16kg) and developmentally delayed. Tim and his caregivers were referred to a dietician, speech and language therapist, a developmental therapist an audiologist and general Paediatrics to meet his identified needs. After 9 months of Tim being with his permanent caregivers the review showed that Tim was making great developmental progress and he was running around playing, at the normal weight for his age and able to play with a variety of toys: a much happier boy.