

Sustainable Programmes of Care  
for  
Children and Young People  
Through Managed Clinical  
Networks

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## Summary

Historically it has been the demand for services that has driven service development and investment rather than community needs. The services that have evolved are often fragmented, disjointed and complex lacking much of the infrastructure for collaborative efficient function.

The Child Health Strategy has as its stated intention “Children seen heard and getting what they need”. A complex continuum of health and disability support services exists to achieve this goal. Within the continuum there are services to support Self Care as well as Primary, Secondary and Tertiary Care service delivery. The health care continuum needs to be closely aligned with other services such as social supports, education, justice and housing. The Paediatric Society believes some gaps in the continuum of care and the organisational systems that support it need urgent attention.

Children and young people need personal health care services that are linked and arranged so that the level of care remains appropriate to changing needs. “Escalation” of care for increasing needs and transition of care to less complex services for reducing needs – “de-escalation”. The goal being to provide care at the simplest appropriate level and as close to home as possible within the bounds of quality and safety. The quality of care should not be determined by where children and young people live.

This document describes the value of linking services into Managed Clinical Networks (MCN) to provide greater emphasis on systems of care rather than individual services. As a direct consequence it is hoped that the patient journey from one service to another can be smoothed as services work better together with a shared understanding. Each MCN should consider services as elements that need to be brought together to deliver programmes of care to individuals and/or populations.

With the appropriate use of networks, linkages can be improved, realising the potential benefits of collaborative work between services and across DHBs. A strategic approach to work towards achieving these goals is suggested. It expresses the collective wisdom of over 400 members of the Society drawn from many professional groups that offer health care to children and young people.

## Background

The provision of high quality health care, personal and preventive to children and young people, carries with it an enormous benefit in mortality, morbidity and dollars. Today we are increasingly realising that early intervention in childhood is crucial if improvements in well being and health outcomes in adult life are to be achieved.

As our population lives longer pressure on dollars for adult services continues to increase, risking the ability to focus on child and youth health services. Creating risks for children and young people for whom the planning, funding and development of sustainable networks of services is not occurring.

## Issues

1. DHBs are primarily funded to serve a “secondary care catchment area” with limited ability to provide clinical networks that extend beyond their own boundaries.
2. Opportunities for health services to improve the care and health status of children and young people they rarely, or never see, are not supported by most current funding models.
3. DHBs are being encouraged to increase investment in primary and preventive health care but the place of these services within wider care programmes that often extend beyond the DHB is largely unrecognized and currently reliant on relationships between individuals.
4. Opportunities for health gain and preventive care, that require “joined up working” and information sharing across a wider network of services within the continuum, are missed as a result of poorly developed infrastructure.
5. Single service by single service delivery of care is especially inappropriate for children with complex health and disability conditions who use multiple services. The prevalence of these conditions in childhood is increasing and with it the need for organised programmes of care for children and young people. .
6. In contrast to many adult services, child and youth services are especially vulnerable to variation of quality as critical mass for sustainability and optimal outcomes is frequently not reached in a single DHB.
7. Systems to plan, fund and audit nationwide services at all levels are poorly developed and not integrated.
8. There have been difficulties supporting DHBs to take up important nationwide initiatives, e.g. Child and Youth Mortality Review, Child Protection Programme, Paediatric Neurology Services.

9. The vulnerability of services may not be recognised or supported until crises arise e.g. Wanganui Paediatrics, Paediatrics Oncology Services Wellington, Neonatal Intensive Care Capacity
10. Nationwide workforce planning and recruitment is becoming increasingly important if New Zealand is to compete successfully in the international market.
11. At times key workforce gaps are not filled despite personnel being available because the planning of services that cross DHB boundaries is rudimentary e.g. until recently paediatric rheumatology
12. Duplication of effort and wastage occurs as a result of poorly developed infrastructure.
13. Existing service specific groups such as the Paediatric Oncology Steering Group or the Paediatric Neurology Group do not have a mandate from all DHBs to manage and lead services.
14. A well defined support infrastructure to enable the delivery of the 'right care by the right person at the right time in the right place' does not exist.

In child and youth health often only a single or small number of DHBs house the full range of services. Networks of services that span DHBs are therefore needed to ensure appropriate care is available wherever a child lives. Extensive collaboration and planning across DHBs is required.

The National Paediatric Oncology Steering Group (POSG) has developed the infrastructure to support quality oncology care. The result has been enhanced quality with national consistency with more children and young people being managed closer to home in secondary care. The close support offered to secondary care in the form of training, protocols, accreditation systems, telephone and telepaediatric services has been invaluable. This has only been possible through a “trans-DHB approach” with national funding and planning processes.

However the POSG did not have a mandate to lead, plan or fund services so was not well positioned to reduce the service vulnerability that led to recent problems in Wellington. Such vulnerability could have been reduced with well developed Managed Clinical Networks that have robust governance and accountability systems. For example a well developed infrastructure has been key to enhancing consistency and quality of immunisation services working across public health, primary and secondary care.

Other paediatric nationwide services are poorly developed, struggling, or on the brink of collapse without a supportive infrastructure and lack of secure funding. A clear national framework for funding, planning and delivering a comprehensive nationwide child health service across DHBs does not exist. A solution needs to be found urgently. Without workforce planning resignations or pending retirements of expert staff poses a major threat. Services already in perilous states are currently under

further threat as the cost of funding nationwide services often falls unevenly on small number of DHBs who are asked to reduce costs.

If any paediatric nationwide service collapses, then children will have no access to this specialized care within New Zealand, and expertise and leadership built up over decades will be lost. The issues raised in the 1998 Paediatric Specialist Services Review remain relevant today. (Appendix A)

Although preventive, primary and secondary health care can do much to improve the health and well being status of New Zealand children and young people a small but significant number of children and young people need the complex high cost consultation and care provided by tertiary services. Some elements of tertiary care are not available to some children and young people who need them. Organising tertiary services as an element within Managed Clinical Networks of nationwide services could make better use of these services.

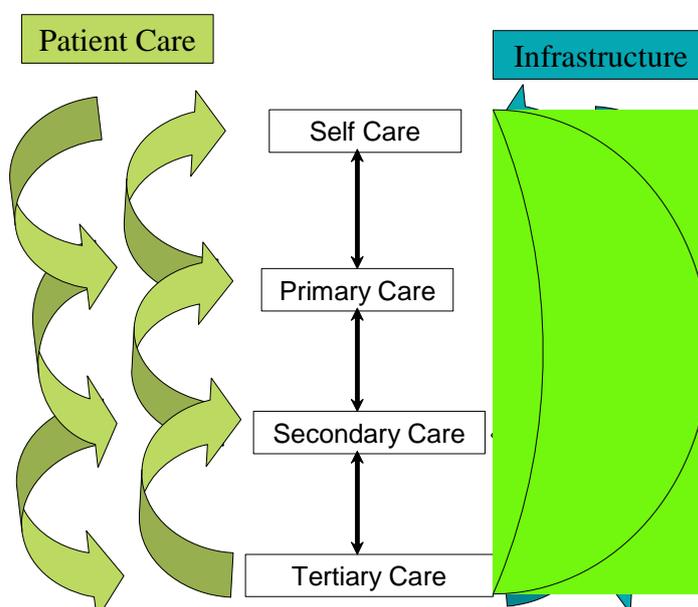
Traditionally many services have been funded based on outputs achieved eg. First specialist assessments, case weighted discharges. Such funding does not provide incentives to support other levels of the continuum. It has created the need to draw in workload to generate income to ensure the survival of the service. The needs of the wider programme of care have been neglected although recent moves to capitation and new models of primary health care delivery have started to better support programmes to improve health status. Work at the secondary and tertiary level has been very limited.

Health professionals at the coal face have known a different approach was needed but efforts were stifled by inappropriate performance indicators and funding streams. For example systems that record and reward services by numbers of consultations encourage the occurrence of consultations, not initiatives to reduce numbers of consultations or improve health status. To move forwards a new set of key performance indicators needs to be developed that charts progress towards and provides incentives to develop, optimal programmes.

## Potential Models for Managed Clinical Networks and Programmes

Many health services have developed to meet needs resulting from acute sudden and life threatening conditions. As needs escalate access to increasingly complex and expensive services has to occur and mostly pathways to meet these needs are well developed and function well. Escalation along these care pathways can at times be inappropriate for instance when some infants and children are admitted to hospital with gastroenteritis following poor community based assessment or inadequate when location of residence limits access to care.

As health needs reduce it is important to consider a “de-escalation” pathway to return children and young people to simpler levels of care in a timely manner. The underpinning principle is that care should be provided “as close to home as possible within the bounds of quality and safety and consistent with good clinical outcomes”.



**Linking the Continuum of Care** – Children and Young People moving from one level to another as needs change. Infrastructure to enhance efficiency, quality, sustainability, audit, collaboration and communication.

To achieve appropriate escalation and de-escalation care pathways need to be planned between services and an appropriate support infra-structure must exist. Infrastructure is vital to link individual services into a cohesive programme to achieve a shared goal. Too often services are planned without consideration of the whole programme within which they must sit.

It is especially important that services to support children and young people with chronic disease or disability needs are delivered in an organised congruent manner. These services are frequently less well developed than acute services yet the need for consistent long term support is far greater.

Managed Clinical Networks (MCN) offer a way of linking services so the patient journey up, down or along the continuum of care can be smoothed as services work better together with a shared understanding. Each MCN considers services as elements that need to be brought together to deliver programmes of care to individuals and/or populations, the focus is on systems of care rather than individual services. A MCN is defined as a linked group of health professionals & organizations from primary, secondary, tertiary care and other services working together in a coordinated manner with clear governance and accountability arrangements.

The benefits of MCN can include:-

1. The needs of children, young people and their families for care and support along a continuum can be achieved more easily than from isolated services. - ***Networks protect families from gaps between services.***
2. Can deliver more by working jointly than the individual parts can by working alone.
3. Facilitate planning funding and leadership across DHB boundaries to achieve best outcomes.
4. Geared to increase adoption of best practices.
5. Linking primary, secondary and tertiary prevention
6. Sustaining vulnerable services through improved access to training and increasing staff availability.
7. Reduce duplication of effort while supporting the implementation of effective interventions across all DHBs.
8. An Infrastructure linking all DHBs can create opportunities to support and maintain the “health” of public health, primary, secondary and tertiary services for children and young people.
9. Can provide a framework for working at local level.
10. Allow specialist staff to be shared more efficiently across boundaries of DHB s and other organisations.
11. Provide infrastructure to better support self care health promotion, health education and services such as telephone help lines, patient information websites, community support groups etc.

MCNs can be designed to link services as needed with some operating at national level while others work effectively at district and local level. Examples working at local levels might include a Family Service Centre, Well Child Steering Group, Immunisation Steering Group, and Suicide Prevention Coalition. While many such groups already exist there are few that can be thought of as a MCN as they operate as networking groups without formal management structure and governance. Without these structures these groups have difficulty influencing the planning and funding of the services from which they are composed.

From the point of view of a child, young person or their family the main output of a MCN will be the “programmes” of care. Each programme can offer seamless quality services that respond to needs of varying levels that may change with time.

### ***Examples of Programmes***

#### *National Immunisation Program*

*Ensures those providing vaccination have the right skills, the vaccine has been kept at the right temperature, an information system supports good levels of coverage, outreach services support those who find it hard to access vaccine, the schedule is regularly revised to keep up to date with changing needs and new vaccine and disease surveillance monitors vaccine preventable conditions.*

#### *Hawkes Bay Developmental Assessment Program*

*Ensures clinical leadership, clear referral processes, consistent comprehensive assessment, modeling excellent practice, workforce development, partnerships with Education, continuous quality improvement, public education resources*

To support care as close to home as possible it is very important that the programme is planned to develop with the correct balance of quality and sustainability. In every programme there is a tension between having a “strong centre” and “strength at the edges”. In some programmes e.g. Paediatric Intensive Care a single centre of care delivery is appropriate with good transport systems while in others e.g. Well Child /Tamariki Ora services including immunisation the strength at the edges is vital.

To allow children and young people to receive high quality seamless care and have easy transitions from one level of care to another, an infra-structure system needs to support and link each part of the continuum of care. Many infra-structural linkages between levels already exist with the development of roles and services e.g. GP liaison, community paediatrician, referral pathways, and evidence based guidelines.

### **Common Infrastructural Elements - Should be Shared when Ever Possible**

**Infrastructure** – Facilitating a nationwide service and linking and supporting preventive, primary, secondary and tertiary care:-

- i) Linking DHBs
- ii) Implementing policy across DHBs
- iii) Leadership – information technology, nursing, medical, allied health
- iv) Training and nationwide training resources – medical, nursing and allied health
- v) Planning
- vi) Staff – medical, nursing and allied health with national roles
- vii) Workforce planning and recruitment
- viii) On-call rosters
- ix) Facilities, equipment
- x) Communication, peer support
- xi) Quality standards, accreditation, up-skilling outreach
- xii) Promulgation of best practice - protocols, guidelines, policies, care pathways, referral pathways
- xiii) Patient education / health promotion materials
- xiv) Population health initiatives
- xv) Evaluation and audit
- xvi) IT solutions, clinical information systems
- xvii) Transport systems and policies

Common elements required for care should not be reinvented across multiple DHBs. Many different programmes have similar infrastructure needs, these should be shared whenever possible in each nationwide service e.g. epidemiology needs may be similar for many services. Some infrastructure needs to be tailored to the needs of individual networks there is no one size fits all solution.

For most services the PSSR recommended the development of a single national service. Such a model was needed to achieve the goals of the review, appendix A. Single national services or programmes can be arranged in a variety of ways depending on the needs of the specialty for example.

- *Single service single center with high quality transport system - Paediatric Intensive Care.*
- *Single service, three centers with outreach clinics and support - Paediatric Oncology, Paediatric Pathology and Neurology,*
- *Disseminated nationwide services with co-ordinators in every DHB supported by organized infrastructure .Immunisation Programme, Child and Youth Mortality Review, B 4 School Checks*

MCN offer ways to support collaborative working, enhance training and leadership, roles expected and needed by all elements of the continuum of care. For example the implementation of a cough and wheeze guideline in South Auckland has been shown to improve education and practice in general practice with improved treatment and assessment of severity.

The development of MCN and better defined programmes of care can provide a more robust framework on which to grow collaboration and successful preventive initiatives such those highlighted below.

#### **Examples of Population Health and Preventive Work**

- *Paediatric intensive care services* have historically often been instrumental in the development of important community initiatives, road safety, cycle helmet wearing and fencing of swimming pools.
- *SafeKids working closely with surgical services* responded effectively to reduce further injury following cluster of dishwashing powder ingestions.
- *Paediatric respiratory services* can offer much to improve the care of conditions through the development of guidelines, protocols, care pathways, patient educational materials and training packages eg. asthma and supporting smoking cessation.
- *National child protection programme* could have a funded leadership role in increasing community and health professional awareness and training in child abuse, improving systems of care, setting up nationally consistent practice, including systems such as a nationwide alerts and training, initiatives which reduce the incidence of child abuse.
- *National Well Child/Tamariki Ora Programme.* More could be done to provide integrated service planning, especially workforce development and programme evaluation.

In the UK a “Duty of Co-operation” is incorporated into The Children’s Act 2004 Section 10 requiring “agencies to make arrangements to promote co-operation between agencies and other appropriate bodies in order to improve the well being of children and young people.”

Evaluation of effectiveness at every level in the care continuum needs to be part of routine care. However this aspect of implementing new programmes or funding strategies is frequently left out or expected to be performed without identified resource built into the programme. A MCN can provide the necessary infrastructure and link the clinical and academic expertise necessary.

## **Recommendations for Implementation of MCN and Health Programmes**

A dramatic transformation of child and youth health services to the model described above would be impossible and inappropriate. However there are already many good models in existence and these should be built upon and a funding and planning environment should be created in which good models of care thrive.

### **Observations**

1. In the future decisions with regard to the planning and provision of services should be made using a “whole of New Zealand” consideration to transform current services into integrated services that improve access, quality and sustainability.
2. A gap exists between Ministry of Health intentions and DHB action. DHBs are frequently unsure of exactly how to modify current services for the better and have little knowledge of how other DHBs have solved similar problems.
3. New service imperatives at national and district level can be supported by development of Managed Clinical Networks.

### **Recommendations**

A national framework for a comprehensive, integrated health services for children and youth is created that informs the planning, and establishment of services, underpinned by strategic assessment of local needs.

Key elements should include:-

**1. The establishment of a Child and Youth Health Supervisory Group (CYHSG)**, key stake holders to include, Ministry of Health, DHB CEO Group, Maori and Pacific peoples, primary care and Paediatric Society of New Zealand.

The roles of the Group should include:-

- a) Supporting DHBs in implementing MOH policy and provide advice with regard to all aspects of service provision for children and young people
- b) Support the development of an environment, and culture, that enables managed clinical networks that cross DHB boundaries to thrive
- c) Support the development of strategic directions for child and youth services, across the continuum of care
- d) Monitor and report on indicators of child and youth health status and service delivery, nationally and locally
- e) Ensure that health services are signed up to an effective, acceptable and integrated model of assessment and information sharing that enables professionals to work together to meet the child, or young persons' health needs however, whenever and wherever these present.
- f) Promote the need to reach the most vulnerable of families and ensure that not only can they access universal services, but their needs for specialist, or additional support, are identified and that multidisciplinary and/or or multi agency care is targeted to meet this need.

- g) Supporting the replication of positive and practical initiatives between DHBs, across service types and workforce groups by regular DHB site visits.
- h) Support workforce planning, and workforce development, at all levels of service with the aim to improve sustainability of the whole framework of services provided for children and youth
- i) Provide advice on future service needs, emerging trends, risks and vulnerabilities
- j) Provide advice on prioritization and effective use of all resources
- k) Reduce the vulnerability of services by increasing resilience through national advanced planning
- l) Increase equity of access to services across the country

A key mechanism to engage DHBs, evaluate current working practices, share information and innovation will be site visits from representatives of the CYHSG.

**2. Create a number of Programme Specific Support Groups** with a mandate to provide leadership and advice on developing managed clinical networks across the 21 DHBs (examples listed in appendix C)

Such groups will explore and support the development of necessary initiatives:-

- a) Plans for senior specialist medical, nursing and allied health staff to be recruited and employed with specific responsibilities allocated to specific national programmes should be considered e.g. National Clinical Director roles.
- b) Development and funding of infrastructural elements crucial for equitable and effective service delivery.
- c) Implementing national policies across DHBs
- d) Workforce development and nationwide training resources for all staff groups to promote and sustain specialist services in all sectors of the continuum of care provided for children and youth
- e) Promote and support the involvement of families and youth in the planning and evaluation of local health services
- f) National planning for highly specialist services and provide advice on call rosters that have national implications.
- g) Quality standards, accreditation, up-skilling outreach and the provision of peer support
- h) Promulgation of best practice - protocols, guidelines, policies, care pathways, referral pathways, evaluation and audit
- i) Joint planning for population health initiatives that includes other government agencies, non government agencies, local councils
- j) Provision of patient education and health promotion materials that meets the changing needs for this population group; e.g robust web site information, hard copy information that is up-to-date, peer reviewed and relevant for today's environment.
- k) Improved IT solutions, clinical information systems
- l) National transport systems and policies
- m) Markers developed to measure service outputs and outcomes in ways that better reflect the work done and support appropriate funding.
- n) Nationwide services not competing for dollars against the continuum of care they support.

## Indicators of Performance and Funding Allocations

– How will we know we have improved things? What will have changed?

In a well functioning decentralized MCN traditional key performance indicators like counting first specialist assessments (FSA) become meaningless. For example an excellent service that meets community need and expectations by seeing only the patients it needs to see, and supports the care of many others that it does not see, is likely to do fewer FSA than poorly performing service that leaves large unmet need, sees patients unnecessarily and fails to transfer care back to lower levels in a timely manner.

A new approach is needed that understands the goals of the services and rewards those that achieve these goals. It is important to consider the distribution of performance from similar services across the country plot the distribution, seek outliers and encourage processes that support improvement – copying success. Outliers are likely to contain both the services that most need to change and the services offering highest quality that need to be duplicated, so intelligent consideration is vital.

- FSA rates by DHB - % considered inappropriate those not following guidelines
- Ratio new / follow up by specialist/service/dhb
- Rates for procedures and investigation e.g. Echocardiogram, MCU
- Presence of guidelines, protocols, and training
- Named staff members who are part of national network in every DHB appropriate for population
- Reduced long-term disability, adverse events
- Patients and families better supported
- Timely referrals that follow guidelines
- Compliance with protocols

Decentralized MCN are very dependent on services that are able to support children and young people who they may never see, via telephone advice, e-mail communication, letters, interpretation of investigations, training, policy and protocol development. Many current funding systems which rely on case weighted discharges, first specialist assessment, follow up outpatient visits and inter-district flows fail to value this work. The importance of telephone advice as a key element of care is recognised and funded to support primary care with the development of health lines. Similar funding systems to support telephone advice from within nationwide services and secondary care do not exist.

## **NATIONAL REVIEW OF PAEDIATRIC SPECIALTY SERVICES EXECUTIVE SUMMARY**

Historically, paediatric specialty services have been purchased throughout New Zealand as a component of general medical and surgical services. This began to change slowly as areas such as paediatric medicine and paediatric surgery were purchased separately from adult services. Paediatric specialty services are thus relatively new, but are growing quickly and becoming increasingly specialised. Many, however, are developing in an ad hoc way, with little thought or planning to ensure there is equal access for children around the country, or to make sure services continue to be safe, effective and appropriate to the children and young people who need them.

The current situation is regarded by many, both clinicians and funders alike, as unsustainable for a number of reasons, including:

- no defined clinical best practice guidelines;
- no account of critical mass of specialists or patients;
- a risk of sub optimal outcomes compared to international standards;
- inequity of access and outcome, with children in some parts of the country able to access services, while others cannot;
- unsupported clinicians;
- lack of peer review;
- no planning for, or consideration of, infrastructures; and
- financial unsustainability.

To remedy this, a National Review of Paediatric Specialty Services was launched in April 1997 by the Health Funding Authority and the Paediatric Society of New Zealand. To ensure that the central focus of the review - the needs of the child - was not over looked, the report of the review was entitled "Through the Eyes of a Child".

With its overarching principle that *children and young people in New Zealand will have their needs treated as paramount*, the review focused on nine subsequent principles which would underlie its recommendations.

That services must be:

- child and family focused;
- as close to home as possible within the bounds of quality and safety;
- provided to achieve equity of outcome;
- based on international best practice, research and education;
- monitored and evaluated regularly;
- integrated with other health services;
- culturally safe; and
- fiscally responsible.

## Appendix B

### Stages of Development of Programmes

Programme	Type of Collaboration*	Linking Group	Funder
<b>Current</b>			
Immunisation	DN	IMAC	MOH
Injury Prevention	A	Kidsafe	MOH/ACC
Family Violence Intervention	DN	National Manager	MOH
Mortality Review	MN	CYMRC/PNMRC	
Well Child	DN		
Paediatric Oncology	DN	POSG	Nil ongoing
<b>Planned</b>			
Eating Disorder	A		
Palliative Care,	F		
Traumatic Brain Injury	A		MOH/ACC
Paeds Rheumatology	Under development	ADHB	
Breastfeeding Support	DN	NZBFA	
Suicide Prevention	F	SPINZ	
Autism	A		
<b>Important</b>			
Health Response to Child Abuse	A	Child Abuse SIG	?MOH/ACC/CYF
Youth Health		NZAHDD	
Paediatric Pathology			
Suicide Prevention		SPINZ	
Epidemiology Information	DN	CYES	DHBs, MOH

**\*Association** An informal group that corresponds or meets to consider specific topics, best practice and other areas of interest.

**Forum** A more formal group that meets regularly and has an agenda that focuses on specific topics. There is an agreement to share audit and formulate jointly agreed protocols.

**Developmental Network** A forum that has started to develop a broader focus on other than purely topic-based issues, with an emphasis on service improvement.

**Managed Network** This includes the function of a forum, has a formal management structure with defined governance arrangements and specific objectives linked to published strategy. (5)

## Appendix C

### Programme Template

#### Areas of Influence

Service	Population	Self Care	Primary	Secondary	Tertiary

<b>Programme Goals</b>	
<b>Personal Health Care</b>	
▪ Key Players	
▪ Additional Support Players	
▪ Clinical Leadership	
▪ Linkages/MCN	
▪ Collaboration Profile*	
▪ Clinical Leadership	
▪	
▪	
<b>Interventions</b>	
▪ Treatments	
▪ Support	
▪ Prevention	
▪ Referrals in and out	
▪ Case management/key workers	
<b>Infrastructure to Support Care</b>	
Funding Streams	
Linkages to Funding distribution	
Day to day Management	
Information Management	
Managers who control funding	
<b>Interventions</b>	
▪ Build Community Capacity	
▪ Training	
▪ Audit and Evaluation Processes	
<b>Key Performance Indicators</b>	
<i>If the programme works what will change and how should it be measured and monitored?</i>	

\*Better at Working Together: Interagency Collaboration: Part III, Self-Assessment Tool and Principles for Collaboration. Wellington: High and Complex Needs Unit. 2007.

What are the attributes of success for programmes?

## **Glossary**

### **District Services**

A service that serves a single DHB supporting care across the continuum for individuals or populations resident within the DHB's boundaries.

### **Regional Services**

A service that services a group of DHBs in the region supporting the continuum of care. A single DHB leads and supports other, usually smaller, DHBs in the region.

### **Nationwide Service**

A service that works across all the DHBs' to support preventive, primary, secondary and tertiary care related to a group of conditions/issues. A Nationwide Service may be led by 1-5 District Health Boards or an organisation not related to a DHB. It has influence/benefit for all District Health Boards offering care/support for individual patients or populations. Clear infrastructure needs to link all DHBs.

### **Health Programme**

The linked health interventions related to a particular area of endeavor resulting from the combined outputs of a number of health services e.g. Immunisation Programme,

### **Managed Clinical Network**

Linked group of health professionals & organisations from primary, secondary, tertiary and other services working together in a co-ordinated manner with clear governance and accountability arrangements.

### **Infrastructure**

The elements within services or across networks of services needed to maintain quality, efficiency and sustainability.

### **Continuum of Care**

The complete range of programmes and services available to offer care.

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