



THE CHILD AND YOUTH HEALTH

Compass

SUPPORTING INNOVATION, GOOD PRACTICE AND EQUITY



THE CHILD & YOUTH HEALTH COMPASS QUESTIONNAIRE TOOL | MARCH 2013

WELCOME TO THE CHILD AND YOUTH HEALTH COMPASS QUESTIONNAIRE TOOL

This pdf document is a self-contained online tool that does not need to be printed out. It has been designed to be used online.

- This tool is divided into six named themes, each containing a question, description of good practice, and an assessment framework.
- Supplementary material describing evidence-based rationale for good practice is presented in the appendices.
- When navigating in the pdf document, to return to a page in one step after using a hyperlink, use the ALT key and back arrow.
- Each DHB will have received one printed copy of this tool, and the online Compass Answer Template to provide your responses to the questions.

THE CHILD AND YOUTH HEALTH COMPASS

SUPPORTING INNOVATION, GOOD PRACTICE AND EQUITY

VISION

All children and young people in Aotearoa/ New Zealand are able to achieve their fullest health potential

GOALS

CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES/WHĀNAU:

- > receive high quality and well-coordinated health services at the right place, at the right time
- > receive health services that are appropriate & acceptable to them and their families/whānau
- > are respected and active participants in health care decision-making, in line with their evolving capacities

HEALTH SERVICES ARE EFFECTIVE FOR:

- > tamariki Māori, rangatahi and whānau/hapū
- > Pasifika children, young people and their families
- > children and young people who experience a disproportionate burden of poor health and disadvantage

OBJECTIVES

- > Identify and showcase innovation and good practice

- Share innovation and good practice by:
- > providing opportunities for peer support
 - > sharing information, knowledge and skills

COMPASS THEMES

Best start to a healthy life

Child development and disability

Child, youth and whānau-centred care

Leadership and governance

Primary care

Youth health

EQUITY

UNDERPINNING FOUNDATIONS

Te Tiriti o Waitangi, United Nations Convention on the Rights of the Child, Whānau Ora

CONTENTS

INTRODUCTION

[PAGE 5](#)

Background and scope

[PAGE 5](#)

Selection of themes

[PAGE 6](#)

Equity and Te Tiriti of Waitangi

[PAGE 7](#)

How will completing the Compass

Questionnaire Tool improve child and

youth health outcomes?

[PAGE 8](#)

Responding to the Compass Questionnaire Tool

[PAGE 10](#)

BEST START TO A HEALTHY LIFE

[PAGE 14](#)

1. Maternal/newborn enrolment & engagement

[PAGE 15](#)

2. Continuity of care for women & infants

identified as experiencing multiple

adversities before/after birth

[PAGE 19](#)

CHILD DEVELOPMENT & DISABILITY

[PAGE 22](#)

3. Severe conduct problems in children

& young people

[PAGE 23](#)

CHILD, YOUTH & WHĀNAU-CENTRED CARE

[PAGE 27](#)

4. Staff training & professional development

[PAGE 28](#)

5. Participation & consumer voice

[PAGE 32](#)

LEADERSHIP & GOVERNANCE

[PAGE 36](#)

6. Leadership & governance

[PAGE 37](#)

PRIMARY CARE

[PAGE 40](#)

7. Access to primary care services

[PAGE 41](#)

8. Ambulatory Sensitive Hospitalisations (ASH)

[PAGE 45](#)

YOUTH HEALTH

[PAGE 49](#)

9. Youth specific services

[PAGE 50](#)

10. Support for young people with chronic

illness and/or disability

[PAGE 53](#)

APPENDICIES

[PAGE 56](#)

COMPASS

ACKNOWLEDGEMENTS

[PAGE 86](#)

INTRODUCTION TO THE CHILD & YOUTH HEALTH COMPASS

*Mā te tuakana ka
tōtika te teina, mā
te teina ka tōtika te
tuakana*

From the older sibling
the younger one learns
the right way to
do things, and from the
younger sibling
the older one learns to
be understanding.

PROJECT BACKGROUND

Compared to other developed countries, Aotearoa/New Zealand (NZ) has poor child and youth health outcomes, with high levels of preventable ill health and marked health inequalities. There is substantial knowledge of good practice in child and youth health; however there is a wide variation in practice and outcomes across the country.

The Compass is a pilot project that aims to identify, showcase and share innovation and good practice in child and youth health across NZ. It aims to support and add value to existing District Health Board (DHB) activities and [public sector priorities](#) that improve services and reduce inequities for children and young people.

The Compass is being undertaken in partnership between the Office of the Children's Commissioner, the Paediatric Society New Zealand, and Ko Awatea – Centre for Health System Innovation and Improvement, with guidance and support from the Health Quality and Safety Commission (HQSC), and the New Zealand Child and Youth Epidemiology Service (NZCYES). The Compass is governed by a [Steering Group](#) of child and youth health leaders, representing a broad range of expertise from across NZ.

With the Compass being a pilot project, there is the expectation that the process will be repeated in future years in order to ensure that the process of quality improvement in child and youth health services is ongoing.

SCOPE OF THE CHILD & YOUTH HEALTH COMPASS

As the Compass is a pilot project, the scope of the Compass is currently focused on health services funded or influenced by DHBs. These include:

- > **public health** services such as public health nursing and health promotion
- > **primary care** services including DHB-funded Well Child/Tamariki Ora nursing, Before-School Check, immunisation, breastfeeding, and acute and chronic illness management in primary care
- > **secondary care** services such as children's inpatient and outpatient services
- > **disability services** including those funded by the Needs Assessment and Support Coordination Agency, and Child Development Services
- > **mental health** services such as the Child and Adolescent Mental Health Service.

INTRODUCTION TO THE CHILD & YOUTH HEALTH COMPASS (CONT)

The Compass excludes health services for children largely outside of DHB funding or influence e.g. ambulance services, Plunket, ACC-funded rehabilitation services, and services funded or provided by the Ministry of Education (e.g. Special Education), and Ministry of Social Development (e.g. MSD funded social services).

However, DHB engagement with other organisations is within the scope of the Compass.

SELECTION OF THEMES FOR THE COMPASS 2013

There are six Compass themes for 2013 that cover the continuum of child and youth health services from antenatal towards adulthood. These are:

1. Best start to a healthy life
2. Child development & disability
3. Child, youth & whānau-centred care
4. Leadership & governance
5. Primary care
6. Youth health

The Compass themes for 2013 were selected based upon consideration of many factors such as importance, potential to reduce health inequities, knowledge of good practice, current variation in practice, measurability, stakeholder support, existing work programmes or initiatives, current health sector priorities, reporting burden, and the extent of DHB influence

or control. Some important topics have not been included in the Compass for 2013 because of existing initiatives, for example, in child protection and some aspects of mental health.

Six [Working Groups](#) have developed the questions within each of the themes.

EQUITY AND THE COMPASS

The World Health Organization defines equity as, “the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically. Health inequities involve more than inequalities – whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health – but also a failure to avoid or overcome such inequality that infringes human rights norms, or is otherwise unfair”.

Within the Compass, Equity is not a singular theme but rather has a crosscutting dimension across all themes. Equity has been addressed in the development of the questions, models of good practice, and assessment frameworks for each theme. An [Equity Advisory Group](#) has provided advisory support throughout the process.

INTRODUCTION TO THE CHILD & YOUTH HEALTH COMPASS (CONT)

TE TIRITI O WAITANGI (1840) AND REDUCING HEALTH INEQUITIES

In addition to children and young people's rights to experience equitable health affirmed by the United Nations Convention on the Rights of the Child, tamariki and rangatahi Māori as tangata whenua have the right to experience equitable health affirmed by Te Tiriti o Waitangi, the United Nation's Declaration on the Rights of Indigenous Peoples, and international human rights pertaining to indigenous peoples. Government acknowledges the special relationship between Iwi and the Crown under Te Tiriti o Waitangi, and has expressed a commitment toward the reduction of Māori versus non-Māori health disparities. This is legislated under

section 22(1)(e) and (f) of the New Zealand Public Health and Disability Act 2000 (the Act), where DHBs have a statutory objective to reduce (with a view to eliminating) health outcome disparities by improving health outcomes for Māori and other population groups. Therefore, the importance of Te Tiriti o Waitangi in the achievement of equitable child and youth health outcomes has been considered throughout the Compass in the development of the questions, models of good practice, and assessment frameworks for each theme. An [Equity Advisory Group](#) has provided advisory support throughout the process.



HOW WILL COMPLETING THE COMPASS QUESTIONNAIRE TOOL IMPROVE CHILD AND YOUTH HEALTH OUTCOMES?

The purpose of the Compass Questionnaire Tool is to identify examples of exemplary practice, innovation, and resources that could be shared between DHBs to improve health services, leading to improved health outcomes for children and young people. By completing the Compass Questionnaire Tool, DHBs will engage in a collaborative learning process, and increase their own self-awareness of their practice compared with evidence-based good practice. Upon completion of the Compass Questionnaire Tool, feedback will be sent to individual DHBs and will include tailored information and resources to help improve child and youth health services. DHBs who are leading within specific areas of health services

for children and young people will be encouraged and supported to mentor other DHBs. This may include providing good practice resources e.g. policies/strategies, participating in facilitated regional/national workshops, or a system of peer support to provide advice or assistance within a particular area of child and youth health.

Government priorities have been considered throughout the development of the Compass Questionnaire Tool themes. The table on the following page outlines the public sector priorities, work programmes and activities that the six themes of the Compass aim to support.

COMPASS THEMES AND SUPPORT OF PUBLIC SECTOR PRIORITIES

	BEST START TO A HEALTHY LIFE	CHILD DEVELOPMENT & DISABILITY	CHILD, YOUTH & WHĀNAU- CENTRED CARE	LEADERSHIP & GOVERNANCE	PRIMARY CARE	YOUTH HEALTH
HEALTH TARGETS 2012/2013						
Shorter stays in emergency departments	✓		✓	✓	✓	✓
Increased immunisation	✓		✓	✓	✓	
Improved access to elective surgery				✓	✓	✓
Better help for smokers to quit	✓		✓	✓	✓	✓
DHB Planning Package 2013/14	✓	✓	✓	✓	✓	✓
DHB Māori Health Plan 2013/14	✓	✓	✓	✓	✓	✓
BETTER PUBLIC SERVICES						
Result 2: Increase participation in early childhood education	✓	✓				
Result 3: Increase infant immunisation rates and reduce the incidence of rheumatic fever	✓		✓	✓	✓	✓
Result 4: Reduce the number of assaults on children	✓	✓			✓	
Result 7: Reduce the rates of total crime, violent crime and youth crime		✓			✓	✓
OTHER PUBLIC SECTOR PRIORITIES						
<i>Whānau Ora</i>	✓	✓	✓	✓	✓	✓
<i>Prime Minister's Youth Mental Health Project</i>	✓	✓	✓	✓	✓	✓
<i>Children's Action Plan</i>	✓	✓	✓	✓	✓	✓
<i>Drivers of Crime</i>	✓	✓	✓	✓	✓	✓

RESPONDING TO THE COMPASS QUESTIONNAIRE TOOL

An online Compass Answer Template is provided for DHB responses to the Compass Questionnaire Tool.

The completed Compass Answer Template and all supporting documentation should be emailed to compass@occ.org.nz by May 31st 2013.

- > For each Compass question, please indicate whether you believe your DHB is 'leading', 'progressing', or 'emerging' according to the assessment framework that is provided for each question. The online Compass Answer Template has a section for you to provide your response. For most questions no further information will be required.
- > For the questions where you have indicated that you believe your DHB is 'leading', please provide detailed answers in the relevant section(s) in the Compass Answer Template, and attach any supporting evidence for your response.
- > For the questions where you have indicated that you believe your DHB is 'emerging' or 'progressing', **AND** you would like support to develop and improve your services in this area, please provide detailed answers in the relevant section(s) in the Compass Answer Template, and attach any supporting evidence for your response.

RESPONDING TO THE COMPASS QUESTIONNAIRE TOOL (CONT)

THE CORE UNDERLYING PRINCIPLE OF THE COMPASS IS TO LEARN FROM EACH OTHER, NOT TO JUDGE.

On the basis of DHB responses to questions within each of the Compass themes, DHBs will be assigned a role within each area of child and youth health services using a framework drawn from the Tuakana/Teina (older sibling/younger sibling) Māori method of teaching and learning. The Tuakana/Teina model is derived from the principles of Whanaungatanga and Ako (to learn as well as to teach). DHBs with skills and experience in one area will be encouraged to take on the tuakana role, supporting the learning of other DHBs, while those with less experience or capacity within the same area will take on the teina role. The purpose is to uphold the mana of the people involved, where each learns from the other.

Each DHB will self-identify as leading, progressing or emerging based on the following framework.

Leading

The health service clearly demonstrates they are leading within the specific area of child and youth health services. DHBs who are leading will be encouraged to share their skills and experience (in the tuakana role), supporting other DHBs to improve their services within this same area.

Progressing

The health service demonstrates they are progressing within the specific area of child and youth health services. DHBs who are progressing will be encouraged to learn from DHBs who are leading within this same area (in the teina role), in order to continue improving their services.

Emerging

The health service demonstrates they are emerging within the specific area of child and youth health services. DHBs who are emerging will be encouraged and supported to learn from DHBs leading within this same area (in the teina role), in order to progress and improve their services.

In addition to the self-assessment process carried out by the DHBs for each of the ten questions, for those questions where detailed answers and attached supporting evidence have been provided, the six [Working Groups](#) will consider the responses to further substantiate whether a DHB is 'leading', 'progressing', or 'emerging' in each area.

RESPONDING TO THE COMPASS QUESTIONNAIRE TOOL (CONT)

When providing answers for those questions where you have indicated your DHB is 'leading', and for the questions where you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please consider the following points.

EACH QUESTION IS PHRASED IN AN OPEN-ENDED WAY.

This is to give you the maximum opportunity to describe the good things that you are doing.

THERE IS NO RIGHT ANSWER.

We are conscious of the workload of DHB managers and clinicians and do not want you to spend unnecessary time adding detail that is not helpful. Each question should take no more than 1–2 hours to complete by the person who knows the area best within the DHB. Some may require a brief meeting of relevant staff to agree to the response.

EACH QUESTION IS ASKING FOR INFORMATION FOR YOUR DHB RESIDENT POPULATION.

When providing your response please consider your DHB from a residential population point of view (rather than DHB facilities only).

EACH QUESTION HAS CURRENT EXAMPLES OF GOOD PRACTICE, AND THE RELEVANT EVIDENCE-BASED RATIONALE IS ATTACHED WITHIN THE APPENDICIES.

We acknowledge that there may not be consensus about 'good' practice and indeed, the purpose of the Compass is to identify examples of innovation and exemplary practice that can be shared.

FOR EACH QUESTION, PLEASE PROVIDE EVIDENCE FOR YOUR RESPONSE.

This may include attaching the relevant section of your Statement of Intent, Annual Plan, Annual Report, Terms of Reference, or other relevant documentation. This is so that we may all learn from the innovative work that you are carrying out in child and youth health services.

FOR EACH QUESTION, PLEASE CONSIDER TREATY AND EQUITY ISSUES.

When responding to each question please provide a description of how health disparities for children and young people are identified, addressed and monitored within that area. Included within this description, please outline how Māori are enabled to work in partnership with, and contribute toward DHB strategies for improving the health of Māori children and young people within their communities.

RESPONDING TO THE COMPASS QUESTIONNAIRE TOOL (CONT)

FOR EACH QUESTION, PLEASE CONSIDER THE CONTEXT IN WHICH YOUR DHB PROVIDES SERVICES

We recognise that DHBs work within different contexts e.g. size, geography, demographics, relative disparities etc. When responding to each question, where relevant, please provide details of how your unique situation (enablers/barriers) may influence the way in which your services are provided, either by offering opportunities for success, or presenting particular challenges.

FOR THE QUESTION(S) WHERE YOU HAVE INDICATED YOUR DHB IS 'EMERGING' OR 'PROGRESSING', AND YOU WOULD LIKE SUPPORT TO DEVELOP AND IMPROVE YOUR SERVICES IN THIS AREA, PLEASE INDICATE THE TYPE OF SUPPORT YOU FEEL WOULD BE MOST USEFUL FOR YOUR DHB.

We would like to know what would be most helpful for you to improve your child and youth health services.

REPORTING ON RESPONSES TO THE COMPASS

Responses from all DHBs will be reviewed by the six [Working Groups](#) who will, using the Tuakana/Teina model, assign DHBs a role either as Tuakana (leader) or Teina (learner) across the areas in child and youth health that the DHBs have provided responses to. Draft results will be returned to each DHB for their feedback. Following consultation with each DHB on their draft, final reports will be sent to DHBs. These will include tailored information and resources about good practice in child and youth health services, and will identify exemplar DHBs.

THEME ONE

Best start to a healthy life

MATERNAL/NEWBORN ENROLMENT & ENGAGEMENT

QUESTION

1.

Please describe the systems in place in your DHB that support universal enrolment and engagement of unborn and newborn infants with health care services.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please attach evidence for your response including details of the processes in place to achieve high and equitable levels of early engagement with antenatal care, and services that support infants after birth.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

Please note that we do not expect you attach data as it is likely that you will have already reported this elsewhere, but rather demonstrate that you have processes in place that monitor regularly and report annually using relevant datasets, and that you respond to this data in order to improve services.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

BOX 1: GOOD PRACTICE: MATERNAL/NEWBORN ENROLMENT & ENGAGEMENT**THE HEALTH SERVICE WILL:**

- > Demonstrate within planning processes, attention to and reporting of key quality measures around early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services to the Board and relevant committees, or intersectoral approaches toward ensuring early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services e.g. PHO, Māori Provider, Pacific Health Provider, Whānau Ora Provider, Well Child/Tamariki Ora services, and examples of initiatives underway to integrate LMCs into primary care.
- > Monitor early enrolment and engagement processes by ethnicity and deprivation, highlighting systems that respond to identified issues and report annually on levels of equitable enrolment and service usage e.g.
 - LMC before 12 weeks
 - named GP/practice
 - Well Child/Tamariki Ora services
 - National Immunisation Register
 - newborn hearing screening
 - oral health care.
- > Demonstrate formal as well as informal intersectoral relationships which encourage high levels of equitable coverage.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 1: MATERNAL/NEWBORN ENROLMENT & ENGAGEMENT

Leading

The health service clearly demonstrates all elements of a comprehensive approach toward early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services including:

- > Demonstrate within planning processes, attention to and reporting of key quality measures around early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services to the Board and relevant committees, or intersectoral approaches toward ensuring early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services e.g. PHO, Māori Provider, Pacific Health Provider, Whānau Ora Provider, Well Child/Tamariki Ora services, and examples of initiatives underway to integrate LMCs into primary care.

- > Monitor early enrolment and engagement processes by ethnicity and deprivation, highlighting systems that respond to identified issues and report annually on levels of equitable enrolment and service usage e.g.
 - LMC before 12 weeks
 - named GP/practice
 - Well Child/Tamariki Ora services
 - National Immunisation Register
 - newborn hearing screening
 - oral health care.
- > Demonstration of formal as well as informal intersectoral relationships which encourage high levels of equitable coverage.

(Note that high levels of coverage may not be necessary to be a leading DHB, but a plan and evidence of improvement would be expected).

Progressing

The health service demonstrates *some* evidence of a comprehensive approach toward early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services. For example:

- > Demonstration within the planning process that the service aims to ensure early enrolment and engagement, however the planning is not intersectoral, and/or there is no monitoring
- > Demonstrate within annual reporting levels of equitable coverage in some but not all of the parameters described.

Emerging

The health service demonstrates few features of a comprehensive approach toward early maternal enrolment and engagement with antenatal care, and enrolment and engagement of newborn infants with essential primary care services.

CONTINUITY OF CARE FOR WOMEN AND INFANTS IDENTIFIED AS EXPERIENCING MULTIPLE ADVERSITIES BEFORE OR AFTER BIRTH

QUESTION

2.

Please describe the systems in place in your DHB, which ensure ongoing support for women and infants who have been identified as experiencing multiple adversities, before or after birth.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

BOX 2: GOOD PRACTICE: CONTINUITY OF CARE FOR WOMEN AND INFANTS IDENTIFIED AS EXPERIENCING MULTIPLE ADVERSITIES BEFORE OR AFTER BIRTH

THE HEALTH SERVICE WILL:

- > Demonstrate equitable systems for the early identification and support of pregnant women experiencing domestic violence, mental illness, addiction issues, previous CYF involvement and adverse childhood experiences, and poor social supports. These systems include on-going support to ensure the mothers and infants' needs are met with continuous integrated care.

These systems will include:

- > Training and support (inclusive of culturally safe practice) for LMCs in the early identification of the above issues.
- > A midwifery-led forum where complex cases can be brought for discussion:
 - The forum will include representation from relevant agencies including (as appropriate): hospital social work; Violence Intervention Programme, and Care and Protection Programme Coordinators; mental health and addictions; Child, Youth and Family; children's teams and Women's Refuge. The forum will develop in partnership with families/whānau, clear needs assessments which lead directly to planning, interventions and supports for mothers and infants.

- Discussions in the forum will be recorded in the woman's clinical record, and a clear plan agreed with accountability to the forum.
- The forum will have referral processes in place to evidence-based interventions. Please see [Appendix Box 1](#) for list of evidence-based interventions.
- The forum will have referral processes in place to refer to Māori Health providers and social services, Pacific Health providers, or Whānau Ora Providers.
- Processes are in place to ensure that the woman's clinical plan is appropriately communicated to relevant primary care providers.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 2: CONTINUITY OF CARE FOR WOMEN/INFANTS IDENTIFIED AS EXPERIENCING MULTIPLE ADVERSITIES BEFORE OR AFTER BIRTH

Leading

The health service clearly demonstrates provision of:

- > Training and support (inclusive of culturally safe practice) for LMCs in the identification of early identification and support of pregnant women experiencing domestic violence, mental illness, addiction issues, previous CYF involvement, and poor social supports. These systems include on-going support to ensure the mothers and infants' needs are met with continuous integrated care.
- > A midwifery-led forum where complex cases can be brought for discussion:
 - There is strong LMC support for the forum, e.g. reflected in high rates of referral.
 - The forum will include representation from relevant agencies including (as appropriate): hospital social work; Violence Intervention Programme, and Care and Protection Programme Coordinators; mental health and addictions; Child, Youth and Family; and Women's Refuge and Well Child/ Tamariki Ora services'. The forum will develop in partnership with families/whānau, clear needs assessments which lead directly to planning, interventions and supports for mothers and infants.

- > Processes are in place to ensure that the woman's clinical plan is appropriately communicated to relevant primary care providers:
 - Discussions in the forum will be recorded in the women's clinical record, and a clear plan agreed with accountability to the forum.
 - The forum will have referral processes in place to refer to Māori Health Providers and social services, Pacific Health Providers, or Whānau Ora Providers and Well Child/ Tamariki Ora services'.
- > Processes are in place to ensure that the woman's clinical plan is appropriately communicated to relevant primary and secondary care providers.

(Note that a midwifery-led forum may not be necessary to be a leading DHB if the above elements are present).

Progressing

The health service provides *some* evidence of the above, e.g. training for LMCs, but no forum, or a forum that is not multidisciplinary, poorly supported, or documentation is unclear.

Emerging

The health service demonstrates few features of the above.

THEME TWO

Child development & disability

SEVERE CONDUCT PROBLEMS IN CHILDREN & YOUNG PEOPLE

QUESTION

3.

Please describe the systems in place in your DHB which address the needs of children and young people with severe conduct problems.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

The definition of conduct problems is based upon the NZ Advisory Group on Conduct Problems definition. Conduct problems in children and young people are defined as a spectrum that includes, "antisocial, aggressive, dishonest, delinquent, defiant and disruptive behaviours. These behaviours may vary from none to severe, and may have the following consequences for the child/young person and those around him/her – stress; distress and concern to adult caregivers and authority figures; threats to the physical safety of the young people involved and their peers; disruption of home, school or other environments; and involvement of the criminal justice system".

PLEASE SEE [BOX](#) OF GOOD PRACTICE FOR FURTHER INFORMATION.

BOX 3: GOOD PRACTICE: SEVERE CONDUCT PROBLEMS IN CHILDREN & YOUNG PEOPLE

To effectively address the needs of children and young people with severe conduct problems, a plan or overall portfolio of interventions making up a comprehensive whole is required. This plan should include:

- > Population-level prevention e.g. alcohol harm minimisation.
- > Primary prevention e.g. prevention of foetal alcohol spectrum disorder (alcohol harm reduction approaches particularly targeting young people and women), Vulnerable Pregnant Women's Programmes, Violence Intervention Programmes, early identification and referral for women with postnatal depression, and more broadly for children of parents with mental illness and addictions (COPMIA).
- > Secondary prevention e.g. early identification and referral of young children with conduct problems – Before School Check.
- > Tertiary prevention e.g. identification and effective intervention children and young people with established conduct problems.
- > Collaborative initiatives that are supportive of the above e.g. formalised relationships through Memoranda of Understanding, regular meetings of managers and clinical leaders, joint service planning and monitoring, joint allocation and training.

- > Evidence of a culturally relevant and effective response to Māori and Pacific children/young people and their whānau, experiencing the effects of severe conduct problems e.g. cultural competence of generic services and the development of culturally specific services and workforce.

The plan should demonstrate effective intersectoral collaboration in the planning, purchasing, monitoring, and delivery of services to children or young people with severe conduct problems, and their whānau. This should include input from:

- > Primary care (e.g. Before School Check, management of postnatal depression and support for children of parents with mental illness and addictions, violence intervention in primary care).
- > Public health (e.g. referrals for severe conduct problems in school-age children from public health nurses)
- > Child and adolescent mental health.
- > Paediatrics.
- > Needs Assessment and Service Coordination (NASC) e.g. referrals of children with intellectual disability and severe conduct problems to specialist providers.
- > Ministry of Education – Special Education.
- > Child, Youth and Family.
- > Non-governmental social services.

Continued...

Continued...

The plan should have a reporting requirement to monitor progress against the plan e.g. referral and assessment rates. To demonstrate progress in reducing inequities, data should be reported as rates by ethnicity and deprivation (in addition to age). Other parameters should include:

- > Inputs (e.g. FTEs).
- > Processes (e.g. waiting times, uptake/engagement rates, relevant quality indicators).
- > Outputs (e.g. early identification and referrals, such as from the Before-School Check Programme, and later referrals for severe conduct problems to health, education and social services, access rates/numbers of children assessed and who receive interventions).
- > Outcomes (e.g. improved behaviour following interventions, stand-downs and exclusions from school, and child and adolescent crime data).

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 3: SEVERE CONDUCT PROBLEMS IN CHILDREN & YOUNG PEOPLE

Leading

The health service clearly demonstrates the following:

- > A child and youth health strategy/plan that includes a section on addressing the needs of children and young people with severe conduct problems. The plan is written collaboratively with relevant local education and social service funders and providers. It is comprehensive, culturally responsive, and includes prevention, early identification, and early intervention, and collaborative, multidisciplinary assessment and interventions for children with established conduct problems.
- > Regular monitoring and annual reporting of progress against the strategy/plan for children and young people with severe conduct problems e.g. improving early identification and referral of young children with severe conduct problems, and monitoring of severe conduct problems across other services (behaviour referrals to Special Education and Resource Teachers Learning and Behaviour, Stand-downs and exclusions from school, police and CYF youth crime data).
- > Effective intersectoral collaboration between child and adolescent mental health services, child development and personal health services (e.g. joint allocation, joint workforce development, collaborative case management via formalised agreement).

Progressing

The health service demonstrates:

- > A child and youth health strategy/plan with elements of the above, e.g. culturally responsive, collaborative, intersectoral management of complex cases, but no approach to early identification and intervention, or vice versa.
- > Incomplete reporting of outcomes, or a plan with no evidence of monitoring and annual reporting progress.
- > Limited intersectoral collaboration e.g. participation in high and complex needs but no joint allocation or training or other joint working.

Emerging

The health service demonstrates:

- > Very limited or no integration of paediatric, child development and mental health services.
- > Little planning for severe conduct problems, or a plan of very limited scope e.g. a single issue, such as autism or prevention of foetal alcohol spectrum disorder.
- > Very limited monitoring and reporting.

THEME THREE

Child, youth & whānau-centred care

STAFF TRAINING & PROFESSIONAL DEVELOPMENT

QUESTION

4.

Please describe the child, youth and whānau-centred specific components of your workforce development plan/framework for staff who provide care for children, young people and their whānau in non-dedicated paediatric areas of your DHB e.g. Emergency Department, Intensive Care Unit, Surgical etc.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

Child, youth and whānau-centred care is defined as a best practice health care approach that centers on the rights of children and young people, takes into account the best interests of children and young people, supports the physical, developmental, mental, emotional, social, cultural, and spiritual needs of children, young people and their whānau; involves collaborative partnerships between health care providers and children, young people and their whānau; and results in the best possible health care for children, young people and their whānau experiencing health services within Aotearoa/ New Zealand.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

Box 4: GOOD PRACTICE: STAFF TRAINING AND PROFESSIONAL DEVELOPMENT**THE HEALTH SERVICE WILL:**

- > Have a paediatric competency workforce development plan/framework adhered to, for all staff caring for children, young people, and their whānau that:
 - uses appropriate quality frameworks applied to the local setting
 - has named leader(s) who are accountable
 - demonstrates collaboration with other services within the DHB
 - demonstrates integration with broader goals of the service
 - enables staff to develop a professional development plan, regardless of their specialty from primary care to tertiary care.
- > Demonstrate a monitoring and auditing process that reviews level of staff skills, and progress of the workforce against the paediatric competency workforce development plan/framework.
- > In non dedicated paediatric areas, have an identified paediatric liaison coordinator with advanced knowledge in child and youth health e.g. nurse practitioner/nurse educator/clinical nurse specialist that meets regularly with paediatric specialty services to discuss common problems, plan education sessions, and share policies and procedures; negotiates resources to provide safe

and effective care; and advocates for child and young people friendly facilities, equipment and resources to ensure the needs of children and young people are met.

- > Have developed DHB generic policies, guidelines, and pathways toward ensuring monitoring of, and accountability for cultural competency and equity training for all staff.

Note that for a health service committed toward ensuring that services for children, young people, and whānau are appropriate, staff training/education needs to include those staff that care for children and young people in both dedicated and non-dedicated paediatric areas e.g. Emergency Medicine, Intensive Care Medicine, Primary Care, rural areas etc. An overview of appropriate staff training/education based upon the 'Standards for the Care of Children and Adolescents in Health Services', the 'Health and Disability Sector Standards (Children and Young People) – Audit Workbook', the 'Charter of Tamariki/Children's and Rangatahi/Young People's Rights in Healthcare Services in Aotearoa New Zealand Charter', and the 'Report of the Taskforce on Whānau-Centred Initiatives' is presented within the [Appendix \(Box 2\)](#).

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 4: STAFF TRAINING & PROFESSIONAL DEVELOPMENT

Leading

THE HEALTH SERVICE:

- > Has a paediatric competency workforce development plan/framework adhered to, for all staff caring for children, young people, and their whānau in non-dedicated paediatric areas that:
 - uses appropriate quality frameworks applied to the local setting
 - has named leader(s) who are accountable
 - demonstrates collaboration with other services within the DHB
 - demonstrates integration with broader goals of the service
 - enables staff to develop a professional development plan, regardless of their specialty from primary care to tertiary care.
- > Demonstrates a monitoring and auditing process that reviews level of staff skills, and progress of the workforce against the paediatric competency workforce development plan/framework.
- > In non-dedicated paediatric areas, has an identified paediatric liaison coordinator with advanced knowledge in child and youth health e.g. nurse practitioner/nurse educator/clinical nurse specialist that meets regularly with paediatric specialty services to discuss common problems, plan education sessions, and share policies and procedures; negotiates resources to provide safe and effective care; and advocates for child and young people friendly facilities, equipment and resources to ensure the needs of children and young people are met.
- > Has developed DHB generic policies, guidelines, and pathways toward ensuring monitoring of, and accountability for cultural competency and equity training for all staff.

Progressing

THE HEALTH SERVICE DEMONSTRATES A NUMBER OF FEATURES OF GOOD PRACTICE IN STAFF TRAINING AND PROFESSIONAL DEVELOPMENT. EXAMPLES INCLUDE:

- > DHB generic policies, guidelines, and pathways toward ensuring monitoring of, and accountability for cultural competency and equity training for all staff.
- > A paediatric competency workforce development plan/framework adhered to, that meets the features of good practice described. However the plan is not monitored/audited.

Emerging

THE HEALTH SERVICE DEMONSTRATES A FEW FEATURES OF GOOD PRACTICE. EXAMPLES INCLUDE:

- > Some evidence of staff training/education, but no paediatric competency workforce development plan/framework is adhered to for staff caring for children, young people, and their whānau.

PARTICIPATION & CONSUMER VOICE

QUESTION

5.

Please describe at a strategic level, how you include children, young people and whānau participation and consumer voice in the planning, delivery and evaluation (including feedback and complaints) of health services.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please include within your description:
 - Processes that support inclusiveness of all groups when engaging with children, young people and whānau.
 - Examples of how participation and consumer voice have influenced or informed quality improvement within your health services.
 - Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

BOX 5: GOOD PRACTICE: PARTICIPATION & CONSUMER VOICE

THE HEALTH SERVICE HAS PROCESSES IN PLACE TO ENSURE THAT:

- > Children, young people and whānau are involved in consultation on the development, implementation and evaluation of the services, policies and strategies that have an impact on them, and there is evidence that this contributes to quality improvement in services. Such consultation includes meaningful participation by all children, young people and their whānau. This may include, but is not limited to Young People's Reference Groups, Family Advisory Councils etc. There are processes in place that support inclusiveness of all groups when engaging with children, young people and whānau.
- > The service supports children and young people to be involved in the decision-making about their health care, in line with their capacities for understanding, and families/whānau are supported to be involved in decision-making about their child or young person's health care.
- > The service provides relevant health information that is appropriate to the level of development and capacity of the child or young person, and is available in the range of cultural and linguistic diversity within the community, taking into consideration health literacy of different groups. This information is available service-wide.
- > The service supports staff to work in partnership with children, young people and their whānau, to identify health and wellbeing goals, and develop pathways to achieve these to take control of their wellbeing and manage their own solutions.
- > Children, young people and whānau are informed of their right to advocacy, and there are processes in place to support children, young people and whānau accessing culturally and developmentally appropriate advocacy services.
- > In order to inform and improve quality of child and youth health services, consultation is actively sought to enable children, young people and their whānau to provide feedback on their experience of the service, for example, culturally and developmentally appropriate consumer satisfaction surveys. This also includes support for children, young people and their whānau to voice any concerns they may have about their health care. Processes in place to manage complaints are appropriate to the development and capacity of the child or young person, and children, young people and their whānau are informed of any complaints investigations and outcomes.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 5: PARTICIPATION & CONSUMER VOICE

Leading

THE HEALTH SERVICE HAS PROCESSES IN PLACE TO ENSURE THAT:

- > Children, young people and whānau are involved in consultation on the development, implementation and evaluation of the services, policies and strategies that have an impact on them, and there is evidence that this contributes to quality improvement in services. Such consultation includes meaningful participation by all children, young people and their whānau. This may include, but is not limited to Young People's Reference Groups, Family Advisory Councils etc. There are processes in place that support inclusiveness of all groups when engaging with children, young people and whānau.
 - > The service supports children and young people to be involved in the decision-making about their health care, in line with their capacities for understanding, and families/whānau are supported to be involved in decision-making about their child or young person's health care.
- > The service provides relevant health information that is appropriate to the level of development and capacity of the child or young person, and is available in the range of cultural and linguistic diversity within the community, taking into consideration health literacy of different groups. This information is available service-wide.
 - > The service supports staff to work in partnership with children, young people and their whānau, to identify health and wellbeing goals, and develop pathways to achieve these to take control of their wellbeing and manage their own solutions.
 - > Children, young people and whānau are informed of their right to advocacy, and there are processes in place to support children, young people and whānau accessing culturally and developmentally appropriate advocacy services.

- › In order to inform and improve quality of child and youth health services, consultation is actively sought to enable children, young people and their whānau to provide feedback on their experience of the service, for example, culturally and developmentally appropriate consumer satisfaction surveys. This also includes support for children, young people and their whānau to voice any concerns they may have about their health care. Processes in place to manage complaints are appropriate to the development and capacity of the child or young person, and children, young people and their whānau are informed of any complaints investigations and outcomes.

Progressing

THE HEALTH SERVICE DEMONSTRATES A NUMBER OF FEATURES AROUND GOOD PRACTICE IN PARTICIPATION AND CONSUMER VOICE. EXAMPLES INCLUDE:

- › Children, young people and whānau may be involved in consultation on the development, implementation and evaluation of the services, policies and strategies that have an impact on them. Such consultation may include meaningful participation by all children, young people and their whānau. There are no processes in place that support inclusiveness of all groups when engaging with children, young people and whānau.

- › The service supports families/whānau to be involved in decision-making about their child or young person's health care.
- › The service provides health information that may not be appropriate to the level of development and capacity of the child or young person available in paediatric-specific areas but not service-wide.
- › Children, young people and whānau are informed of their right to advocacy.

Emerging

THE HEALTH SERVICE DEMONSTRATES A FEW FEATURES OF GOOD PRACTICE. EXAMPLES INCLUDE:

- › There is limited involvement of children, young people and whānau in the consultation on the development, implementation and evaluation of the services, policies and strategies that have an impact on them.
- › The service provides some health information that may not be appropriate to the level of development and capacity of the child or young person.

THEME FOUR

Leadership & governance

LEADERSHIP & GOVERNANCE

QUESTION

6.

Please describe the leadership and governance structure in your DHB child and youth health service.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please include details of any child or youth health strategies or plans in place
- > Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

PLEASE SEE [BOX](#) OF GOOD PRACTICE FOR FURTHER INFORMATION.

BOX 6: GOOD PRACTICE: LEADERSHIP & GOVERNANCE**THE HEALTH SERVICE WILL:**

- Demonstrate intersectoral collaboration that effectively engages stakeholders at *both governance level and operationally*. These could include (according to local circumstance):
 - DHB stakeholders: Planning and Funding, Child Health, Mental Health, NASC, Child Development and Public Health services, GM Māori, GM Pacific, Māori Partnership Boards.
 - Primary Care stakeholders: Primary Healthcare Organisations, Well Child/Tamariki Ora, Māori Providers, Pacific Health Providers, Before-School Check, Whānau Ora Providers.
 - External stakeholders: Child, Youth and Family, Ministry of Education: Special Education, Work and Income, Housing New Zealand, NGO social services, Strengthening Families, Ministry of Youth Development.
 - Consumers and advocacy groups on behalf of consumers, e.g. Young People’s Reference Group, Family Advisory Council, parent support groups Māori and Pacific representation.
 - Have a child and/or youth health strategy or plan that:
 - Includes strategies and commitment to reduce inequities in child and youth health outcomes, e.g. using tools such as the Health Equity Assessment Tool, Health Impact Assessment (HIA), Whānau Ora HIA or the ‘Roadmap to Reduce Racial Disparities’ by the Robert Wood Johnson Foundation
 - Demonstrates evidence of a needs assessment
 - Has clearly stated objectives
 - Applies a published evidence base with fidelity to each objective
 - Demonstrates cognisance of local realities
 - Uses appropriate quality frameworks applied to the local setting
 - Has named leader(s) who are accountable for each objective in the plan.
- Monitor regularly and report annually on progress against the objectives.
 - Have Māori partnership arrangements where Māori partners have governance body status, for example, Māori partners sign off DHB Statement of Intent and Annual Plans. These Māori partnership arrangements are clearly stated in DHB accountability documents e.g. Statement of Intent, Annual Plan, Annual Report, Māori Health Plan.
 - Identify and monitor disparities in child and youth health outcomes for Māori and other population groups, and demonstrate the progress that has been made toward the reduction of these disparities in DHB accountability documents e.g. Annual Report, Māori Health Plan.
 - Demonstrates examples of cross-sector work to address the determinants of health.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 6: LEADERSHIP & GOVERNANCE

Leading

The health service clearly demonstrates implementation of the process, systems and/or structures considered good practice in this area e.g. the service demonstrates *all three* of:

- > effective intersectoral collaboration at a governance level (e.g. DHB committee or similar) including most of the above stakeholders
- > a child and/or youth health strategy/plan that meets all the criteria of [good practice](#)
- > regular monitoring and annual reporting of progress against the strategy/plan (e.g. improved outcomes).

Progressing

The health service demonstrates *some* evidence of the process, systems and/or structures considered good practice in this area such as:

- > incomplete process, system or structure, or a process, system, or
- > process, system or structure without evidence of implementation.

> Examples include:

- intersectoral collaboration at a governance level that excludes key stakeholders
- a child and/or youth health strategy/plan that meets some of the criteria of [good practice](#)
- regular monitoring and annual reporting of progress against the strategy/plan (e.g. improved outcomes)
- a governance group with a plan but no annual reporting against progress.

Emerging

The health service does not demonstrate any, or only a few features of a process, system or structure considered good practice in this area. Examples include:

- > no governance group, or a governance group for a single issue only
- > no child and/or youth health strategy/plan, or a plan of very limited scope (e.g. a single issue, such as immunisation or preventable admissions)
- > very limited monitoring and no annual reporting.

THEME FIVE

Primary care

ACCESS TO PRIMARY CARE SERVICES

QUESTION

7.

Please describe the access to primary care services in your DHB for children and young people.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > In your description, please include details of:
 - Enablers facilitating progress in your plans for addressing access.
 - Challenges and/or barriers you have identified to progressing your plans for addressing access.
- > Please attach evidence for your response including details of access arrangements for different primary care providers, particularly in relation to out of office hours access.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

Please note that we do not expect you attach data as it is likely that you will have already reported this elsewhere, but rather demonstrate that you have processes in place that monitor regularly and report annually using relevant datasets, and that you respond to this data in order to improve services.

PLEASE SEE [BOX](#) OF GOOD PRACTICE FOR FURTHER INFORMATION.

Box 7: GOOD PRACTICE: ACCESS TO PRIMARY CARE SERVICES

- > The health service will have knowledge about the following parameters of access:
 - Percentage of babies enrolled with a PHO, NIR, and a WCTO provider by 4 weeks of age by ethnicity and deprivation.
 - Percentage of children < 6 years of age with access to free primary care – standard hours and afterhours, by ethnicity and deprivation.
 - Percentage of children < 18 years of age with access to free primary care – standard hours and afterhours, by ethnicity and deprivation.
 - Percentage of the PHO ‘Services to Increase Access’ (SIA) funding used for children and young people.
- > Service utilisation rates (where available) by:
 - ethnicity
 - deprivation
- > The health service will have access arrangements detailed in funding and planning discussions, and in strategic planning documents.
- > The health service will have consulted with key stakeholders in this area, and depending on access arrangements, have brokered meetings to improve access.
- > The health service will include access criteria in all their formal monitoring/audit/evaluation/service review documents and processes for primary care.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 7: ACCESS TO PRIMARY CARE SERVICES

Leading

The health service clearly demonstrates implementation of the process, systems and/or structures considered good practice.

The health service demonstrates *all three* of the following:

- > Full knowledge about the parameters of child and youth health access. The access parameters are easily available to managers and clinicians.
- > The DHB has included access arrangements in all relevant funding and planning discussions and included them in strategic planning documents.
- > The DHB has consulted with key stakeholders in this area. Where problems have been identified, significant progress has been made to improve access.

Progressing

The health service demonstrates *some* evidence of the process, systems and/or structures considered good practice e.g. incomplete process, system and/or structure, or a process, system and/or structure without evidence of implementation. This could include:

- > Some knowledge about the parameters of child and youth health access. The access parameters are available to managers and clinicians, but not in a routine or easily accessible way.
- > The service has included access arrangements in some relevant funding and planning discussions and included them in some strategic planning documents. There is no overall coherence or articulation of the access arrangements.
- > The service has consulted with some of the key stakeholders in this area. Where problems have been identified, some progress has been made to improve access, but implementation has not been completed.

Emerging

The health service does not demonstrate any, or only a few features of a process, system and/or structure considered good practice. For example:

- > Very little or no knowledge about the parameters of child and youth health access. The access parameters are not routinely available to managers and clinicians.
- > The service has not included access arrangements in relevant funding and planning discussions or only in a very limited way. There is no coherence or articulation of the access arrangements.
- > The service has not consulted with key stakeholders in this area or only in a very limited way. Where problems have been identified, little progress has been made to improve access.

AMBULATORY SENSITIVE HOSPITALISATIONS (ASH)

QUESTION

8.

Please describe the arrangements for addressing Ambulatory Sensitive Hospitalisations (ASH) for children and young people in your DHB.

Please note that we do not expect you attach data as it is likely that you will have already reported this elsewhere, but rather demonstrate that you have processes in place that monitor regularly and report annually using relevant datasets, and that you respond to this data in order to improve services.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > In your description, please include details of:
 - Enablers facilitating progress in your plans for addressing ASH.
 - Challenges and/or barriers you have identified to progressing your plans for addressing ASH.
 - Any analyses that have been undertaken to determine the inequities in ASH rates (across all dimensions), in order to inform effective and equitable interventions by your service and/or PHO.
 - The extent to which your service and/or PHO has developed and implemented management and support protocols for ASH related conditions.
- > Please attach evidence for your response including details of access arrangements for different primary care providers, particularly in relation to out of office hours access.
- > If you have indicated your DHB is ‘emerging’ or ‘progressing’, AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

BOX 8: GOOD PRACTICE: AMBULATORY SENSITIVE HOSPITALISATIONS

- > The health service analyses ASH rates by ethnicity and deprivation. The health service also considers within their analyses, the full range of factors that may lead to inequitable rates of admissions for different child and youth sub-populations.
- > The health service will have utilised existing knowledge from routine ASH reporting and augmented it where possible with other information e.g. ASH utilisation figures from emergency departments and general practice.
- > The health service will have included ASH in funding and planning discussions, and will have included them in strategic planning documents.
- > The health service will have consulted with key stakeholders in this area, and have brokered meetings to improve ASH rates.
- > The health service and/or PHO will have sponsored specific initiatives to explore ASH rates and influence change e.g. skin sepsis management programmes in primary care.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 8: AMBULATORY SENSITIVE HOSPITALISATIONS (ASH)

Leading

The health service demonstrates implementation of the process, systems and/or structures considered good practice.

The service has demonstrated *all five* of the following:

- > Analysis of ASH rates by ethnicity and deprivation. The health service also considers within their analyses, the full range of factors that may lead to inequitable rates of admissions for different child and youth sub-populations.
- > Fully utilised existing knowledge from routine ASH reporting and augmented it with other information e.g. ASH utilisation figures from emergency departments and general practice, and there may specific information projects in this area.
- > Included ASH in funding and planning discussions, and included ASH in strategic planning documents.
- > Consulted with key stakeholders in this area, and brokered meetings to improve ASH rates.
- > The health service and/or PHO have sponsored specific initiatives to explore ASH rates and influence change, and have carried out an evaluation of their effectiveness.

Progressing

The health service demonstrates *some* evidence of the process, systems and/or structures considered good practice e.g. incomplete process, system and/or structure, or a process, system and/or structure without evidence of implementation. This could include:

- > Existing knowledge from routine ASH reporting is utilised but is not augmented with other information.
- > ASH is included in funding and planning discussions but conclusions are not formally identified in strategic planning.
- > The health service will have consulted with stakeholders in this area, but there is little transfer of consultation into implementation plans.
- > The health service and/or PHO will have considered specific initiatives to explore ASH rates and influence change, but implementation and/or evaluation are incomplete.

Emerging

The health service does not demonstrate any, or only a few features of a process, system and/or structure considered good practice. For example:

- > Very little or no utilisation of existing knowledge from routine ASH reporting.
- > Very little or no inclusion of ASH in funding and planning discussions or strategic planning documents. There is no coherence or articulation of efforts to optimise ASH rates.
- > Very little or no consultation with key stakeholders in this area, and no organised efforts or meetings to improve ASH rates.
- > There are no specific initiatives to explore ASH rates.

THEME SIX

Youth health

YOUTH SPECIFIC SERVICES

QUESTION

9.

Please describe the range of youth specific services your DHB provides.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > In your description, please include details of:
 - Access rates to these services by ethnicity and deprivation.
 - Total FTE and amount of funding provided by the DHB.
 - Support and integration with secondary medical and CAMHS services.
 - Enablers and barriers you have identified regarding the development of youth specific services in your DHB.
- > Please attach evidence for your response.
- > Please indicate if you would like any support in this area, and if so, the type of support that would be most helpful for your DHB.

Please note that these services should be youth specific services (such as youth one-stop health services, school-based health clinics e.t.c.), rather than generic services and should exclude CAMHS, sexual health services, and AOD services.

PLEASE SEE [BOX](#) OF GOOD PRACTICE FOR FURTHER INFORMATION.

BOX 9: GOOD PRACTICE: YOUTH SPECIFIC SERVICES**THE HEALTH SERVICE:**

- > Funds and provides a full range of specific youth health services across primary and secondary care. For example:
 - Youth one-stop health services
 - School-based health care services in secondary schools
 - Health services for alternative education students
 - Youth health clinicians within secondary and tertiary care settings e.g. youth health nurse specialists, physicians specialising in the care of adolescents.
 - > Has a specific Youth Health Plan/Strategy that guides the implementation of these services.
 - > Has youth advisory boards that guide DHB decision-making processes about youth health services.
 - > Gives consideration to location of services for young people in terms of access, transport and safety.
 - > Provides youth health leadership and training to the region.
- > Funds and supports school-based health services across all secondary schools in the region with more than 6.5 hours of nursing and doctor time per 100 students, per week, in each school. There is funded support from local GPs for standing orders and medical care.
 - > Provides a high level of integration between school-based clinicians and secondary medical and CAMHS services. There are school health policies for mental health and specialist services that have been collaboratively and formally agreed upon by secondary health services and education.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 9: YOUTH SPECIFIC SERVICES

Leading

THE HEALTH SERVICE DEMONSTRATES EVIDENCE OF:

- > Funding and provision of a full range of specific youth health services across primary and secondary care.
For example:
 - youth one-stop health services
 - school-based health care services in secondary schools
 - health services for alternative education students
 - youth health clinicians within secondary and tertiary care settings e.g. youth health nurse specialists, physicians specialising in the care of adolescents.
- > A specific Youth Health Plan/Strategy that guides the implementation of these services.
- > Youth advisory boards that guide DHB decision-making processes about youth health services.
- > Consideration to location of services for young people in terms of access, transport and safety.
- > Provision of youth health leadership and training to the region.
- > Funding and support of school-based health services across all secondary schools in the region with more than 6.5 hours of nursing and doctor time per 100 students, per week, in each school. There is funded support from local GPs for standing orders and medical care.

- > High level of integration between school-based clinicians and secondary medical and CAMHS services. There are school health policies for mental health and specialist services that have been collaboratively and formally agreed upon by secondary health services and education.

Progressing

- > The health service funds and provides some youth specific services, such as school-based health care services.
- > Funds and supports school-based health services for secondary schools in the region. These schools provide more than 6.5 hours of nursing and doctor time per 100 students per week in each school. There is funded support from local GPs for standing orders and medical care.
- > Provides some level of integration between school-based clinicians and secondary medical and CAMHS services.

Emerging

- > No specific youth health services provided except for mandated services in decile 1 – 3 schools, teen parent units and alternative education schools. There is no support or integration between school-based nurses and local GPs or secondary services.

SUPPORT FOR YOUNG PEOPLE WITH CHRONIC ILLNESS AND/OR DISABILITY

QUESTION

10.

Please describe the level of support your DHB provides for young people with chronic health conditions and/or disability.

Please indicate whether you believe your DHB is [leading](#), [progressing](#), or [emerging](#) in this area.

TO COMPLETE YOUR RESPONSE:

- > Please attach evidence for your response.
- > If you have indicated your DHB is 'emerging' or 'progressing', AND you would like support to develop and improve your services in this area, please detail the type of support you feel would be most useful for your DHB.

Please note that this may include specific youth health services within secondary or tertiary settings such as transition clinics, specialist youth health clinicians, adolescent wards, and training for health care personnel who deliver care to young people in hospital settings.

PLEASE SEE [BOX OF GOOD PRACTICE](#) FOR FURTHER INFORMATION.

Box 10: GOOD PRACTICE: SUPPORT FOR YOUNG PEOPLE WITH CHRONIC ILLNESS/DISABILITY**THE HEALTH SERVICE:**

- > Has a range of specific youth health services for young people with chronic illness and/or disability. This may include specific youth health services within secondary or tertiary settings such as transition clinics, specialist youth health clinicians, adolescent wards, and training for health care personnel who deliver care to young people in hospital settings.
- > Provides transition planning and/or transitions clinics for all young people with chronic illness and/or disability who are looked after by specialist services. Clear pathways for transfer of information between young people/families/primary/secondary/tertiary providers are demonstrated and maintained, and there is clarity around case-management.
- > Provides specialist youth health clinicians who are available to support secondary services both within the hospital and in clinics.
- > Has youth health activities/areas within the hospital setting, and young people are roomed together.

Further information can be found within the [Appendix](#).

ASSESSMENT FRAMEWORK FOR QUESTION 10: SUPPORT FOR YOUNG PEOPLE WITH CHRONIC ILLNESS AND/OR DISABILITY

Leading

THE HEALTH SERVICE:

- > Funds specific youth health services for young people with chronic illness and/or disability.
- > Provides transition planning and/or transitions clinics for all young people with chronic illness and/or disability who are looked after by specialist services. Clear pathways for transfer of information between young people/families/primary/secondary/tertiary providers are demonstrated and maintained, and there is clarity around case-management.
- > Provides specialist youth health clinicians who are available to support secondary services both within the hospital and in clinics.
- > Has youth health activities/areas within the hospital setting, and young people are roomed together.

Progressing

THE HEALTH SERVICE:

- > Funds some specific youth health services for young people with chronic illness and/or disability.
- > Provides some transition planning and/or transitions clinics for young people with chronic illness and/or disability who are looked after by specialist services.
- > Has some supports for young people in hospital but this may be limited to certain areas.

Emerging

The health service has no specific services for young people with chronic illness and/or disability. There is no support for young people in the hospital setting.



Appendices

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Early childhood development has a determining influence on subsequent health and the opportunity for children to fulfil their potential. A 'best start to a healthy life' for infants, children and young people means that all of the essential building blocks that enable them to lead a flourishing life are provided.¹

MATERNAL/NEWBORN ENROLMENT & ENGAGEMENT

In this context the term enrolment is considered to be the administrative process by which an individual is listed as being connected to a particular service provider. Engagement in this context is the relationship that develops when a family/whānau use a service. All infants must be supported by health services in order to reach their potential. Key services include: Lead Maternity Carers (LMC), General Practitioners (GP) and primary care, the National Immunisation Register (NIR), newborn hearing screening, Well Child/Tamariki Ora services (WC/TO) Services, Māori health providers, Whānau Ora providers, social service providers, Early Childhood Education, and oral health services.² Good practice ensures that active enrolment and engagement with services occurs, there is monitoring of access, and there are systems for feedback to providers. Families experiencing barriers to access may need additional support in order to access services that may be more responsive to their needs (e.g. home visiting or outreach services). Ideally, providers should be readily able to access records to identify which services an infant has and has not received e.g. hospital clinicians accessing the NIR and identifying whether children are enrolled with a GP or practice, and a WC/TO provider.

Early enrolment and engagement with antenatal care

The National Institute for Health and Clinical Excellence (NICE) guidelines and the Perinatal and Maternal Mortality Review Committee (PMMRC) both recommend early enrolment and engagement for antenatal care before 10 weeks gestation.^{3,4} In New Zealand, data is routinely collected for 12 weeks gestation.

The antenatal period is a crucial time. To ensure optimum health and connections for the infant, this period of health care provides an opportunity for a LMC to support a woman to find a GP for herself, and her unborn infant. It is also an opportunity to provide education information about the NIR and promote the importance of immunisation.⁵

Early enrolment and engagement with a General Practitioner/ practice

There are a number of reasons why early enrolment and engagement with a GP or practice is recommended. These include:

1. Acute care needs

Some infants under an LMC need GP care. It is important that this can occur easily, and that this should come from the GP who will subsequently be the infant's GP. Early enrolment and engagement with a GP will promote continuity of care; one of the key components of primary care delivery, and health outcomes are improved when a specific provider is recognised.⁶

Appendix A.

BEST START TO A HEALTHY LIFE

Appendix A.

BEST START TO A HEALTHY LIFE

2. A 'patient-centred medical home'

Primary care provides long-term and comprehensive services, and enables access to further services. Having a 'patient-centred medical home' or 'regular source of care' is important for health outcomes, and is better embedded in a primary care service than elsewhere. Identification of a particular practitioner provides more than a specified place, and results in a range of benefits including: better needs recognition; earlier diagnosis; fewer hospitalisations; fewer unmet needs; and increased satisfaction. Early enrolment is a foundation to its development and is fostered with ongoing contact, developing relationships and trust from an early stage. Identification of risk, prevention and reduction in vulnerability and coordination across services are enabled by this model.⁷

3. Timely vaccination coverage

In order to facilitate timely vaccination, practices need to be made aware of the infant's birth to pre-call for vaccination prior to six weeks of age, and take enrolment for the delivery of vaccinations. Early registration with a practice has been found to be an important determinant of the coverage and timeliness of infant vaccination.⁸

Early enrolment and engagement with other services providing essential primary care

There exist alternative providers to mainstream primary care. Many Māori and Pasifika children will also enrol with, or attend a range of services providing essential primary care including Māori Health providers, Pacific Health providers and Whānau Ora providers. Existing relationships between providers and whānau can be important to link whānau with other services

e.g. whānau may already be registered with a Pacific Health provider when the mother becomes pregnant. It is appropriate for the Pacific Health provider to assist the mother to enrol and engage with a LMC, GP and WC/TO provider. Likewise, if a mother enrolls with a LMC and is not enrolled with a GP, it is appropriate for the LMC to support the mother's enrolment and engagement with a GP for herself and her infant.

CONTINUITY OF CARE FOR WOMEN AND INFANTS IDENTIFIED AS EXPERIENCING MULTIPLE ADVERSITIES BEFORE OR AFTER BIRTH

Maternal exposure to a range of adversities before and after birth is associated with a number of adverse outcomes which can affect the health and wellbeing of the mother and infant, and the longer-term development of the child. There exist in NZ marked social gradients in a number of adverse outcomes in pregnancy by ethnicity, and for younger pregnant women compared with older pregnant women. As such, investment in the prenatal period and in early childhood has one of the greatest potentials to significantly reduce health inequalities.⁹ Mental health and/or addiction issues, domestic violence, previous involvement with care and protection services, and poor social supports should be identified as early as possible in pregnancy as they carry high risks for poor antenatal outcomes. Adverse pregnancy and infant outcomes can include: stillbirth; foetal death; neonatal mortality; perinatal mortality; preterm birth; low birth weight; with intra-uterine growth restriction (IUGR); small for gestational age (SGA); sudden unexpected death in infancy (SUDI)⁹ – or neglect and/or abuse leading to poor physical health and/or mental health outcomes; poor educational outcomes; or serious injury and death.^{9,10}

Appendix A.

BEST START TO A HEALTHY LIFE

It is well established within the literature that high quality maternity care, with early booking and continuity of care through pregnancy to early childhood is important for improving outcomes in pregnancy for women and infants.¹¹ There is also an evidence-base within the international literature of the effectiveness of interventions aimed at addressing the needs of pregnant women identified as experiencing multiple adversities.¹² The NZ Child and Youth Epidemiology Service recently undertook an in-depth topic review examining multiple adversities in pregnancy for NZ women, and the evidence-base for services and interventions developed to address these adversities. Findings suggest there are a number of interventions likely to improve outcomes for pregnant women and their infants who experience multiple adversities (Box 1).

BOX 1: EFFECTIVE INTERVENTIONS TO IMPROVE OUTCOMES FOR PREGNANT WOMEN AND THEIR INFANTS WHO EXPERIENC MULTIPLE ADVERSITIES

- > Group antenatal care for socioeconomically disadvantaged women and young women, in which groups of eight to twelve women meet regularly with a stable group leader, usually a midwife, for antenatal care, education and relationship building.
- > For young women: multi-agency approaches targeted at young parents; nutritional programmes as adjuncts to routine care; educational and career development interventions; parenting programmes; and the provision of accessible child care.
- > For women who use alcohol and/or other drugs during pregnancy: coordination and co-location of antenatal care; drug treatment services and social services; brief interventions in pregnant women who are not dependent on alcohol or consume alcohol at low to moderate levels; and smoking cessation interventions.
- > For women exposed to family violence: integration of substance misuse treatment; advocacy interventions; and staff training.

Source: NZCYES (2012)

Appendix A.

BEST START TO A HEALTHY LIFE

Within the national literature, evidence suggests that serious social risks can be identified through direct questioning within the context of a trusting relationship with a health professional. Such practice is standard practice in the Ministry of Health's 'Violence Intervention Programme'.¹³ Assessments and interventions need to be culturally appropriate for optimal outcomes e.g. staff training around non-judgmental/non-discriminatory assessment, and referral to culturally appropriate services.¹⁴ When serious social risks are identified, systems that ensure high quality referrals to appropriate agencies depending on identified needs are necessary e.g. referrals to non-governmental social services such as Women's Refuge, mental health and addiction services, or Child, Youth and Family.¹³

Evidence within the national literature also indicates that systems supportive of LMCs identifying and referring pregnant women experiencing multiple adversities to appropriate services, share a number of common features. These include: trusting and formalised relationships between services; forum (often midwifery-led) where complex cases can be brought for discussion; structures that ensure discussions are documented; and action plans that are agreed upon with clear accountabilities.¹⁵ These systems currently exist in several DHBs across NZ. In addition, a quality framework needs to support the development of systems that ensure quality care and cultural safety, e.g. inviting patient feedback, complaints procedures, and clinical audits.¹⁵

Appendix A.

BEST START TO A HEALTHY LIFE

REFERENCES

1. Commission on Social Determinants of Health. *Closing the gap in a generation: Health Equity through action on the social determinants of health*. Geneva: World Health Organization. 2008.
2. Child and Youth Mortality Review Committee: Te Rōpū Arotake Auau Mate o te Hunga Tamariki Taiohi. *The Child and Youth Mortality Review Committee's submission to the Green Paper for Vulnerable Children*. 2012.
3. National Institute for Health and Clinical Excellence. *Antenatal Care: NICE clinical guideline 62*. 2010.
4. Perinatal and Maternal Mortality Review Committee (PMMRC). *Sixth Annual Report of the Perinatal and Maternal Mortality Review Committee Reporting mortality 2010: Second report to the Health Quality & Safety Commission New Zealand*. 2012; <http://www.hqsc.govt.nz/assets/PMMRC/Publications/PMMRC-6th-Report-2010-Lkd.pdf>.
5. Hoare KJ, Fishman TG, Francis K, Mills J. A practice development initiative to improve the health of pregnant women and infants in New Zealand. *International Journal of Person-Centered Medicine*. 2011;1(3):618-626.
6. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502.
7. Starfield B, Shi L. The Medical Home, Access to care and Insurance: A review of the Evidence. *Pediatrics*. 2004;113(5):1493.
8. Grant CG et al. Factors associated with immunisation coverage and timeliness in New Zealand. *Br J Gen Pract*. 2010;60(572):e113-e120.
9. NZCYES. *In-depth topic: Services and interventions for women experiencing multiple adversities in pregnancy*. Dunedin: NZ Child and Youth Epidemiology Service. 2013.
10. Centers for Disease Control and Prevention, Kaiser Permanente's Health Appraisal Clinic. *Adverse Childhood Experiences (ACE) Study*. 2012; <http://www.cdc.gov/ace/index.htm>.
11. National Collaborating Centre for Women's and Children's Health. *Pregnancy and complex social factors*. 2010. <http://www.nice.org.uk/nicemedia/live/13167/50861/50861.pdf>.
12. Hodnett ED, Fredericks S, Weston J. Support during pregnancy for women at increased risk of low birthweight babies. *Cochrane Database of Systematic Reviews (6)*doi:10.1002/14651858.CD000198.pub2. 2010. <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000198/frame.html>
13. Ministry of Health. *Family Violence Intervention Guidelines: Child and Partner Abuse*. Wellington: Ministry of Health. 2002.
14. Downe S, Finlayson K, Walsh D et al. 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *BJOG*. 2009;116(4):518-529.
15. Cram F, Ormond A. *Vulnerable Pregnant Women's Multidisciplinary Team, Hawke's Bay District Health Board: Evaluation Report. Prepared for the Hawke's Bay District Health Board*. Auckland: Katoa Ltd. 2011.

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Appendix B.

CHILD DEVELOPMENT & DISABILITY

The New Zealand Advisory Group on Conduct Problems defines conduct problems in children and young people as a spectrum which includes, “antisocial, aggressive, dishonest, delinquent, defiant and disruptive behaviours. These behaviours may vary from none to severe, and may have the following consequences for the child/young person and those around him/her - stress, distress and concern to adult caregivers and authority figures; threats to the physical safety of the young people involved and their peers; disruption of home, school or other environments; and involvement of the criminal justice system”.^{1,p.2} Severe conduct problems in children and young people are not only challenging, they threaten the individual and those around them, and may result in injury, exclusion from education, family disruption, and compromised function.¹ National and international surveys suggest a prevalence of 5-10%, depending on age and definition.¹⁻⁴ It has been estimated that 15-20% of tamariki and rangatahi Māori will display conduct problems of sufficient severity to warrant intervention.¹ The prevalence of severe conduct problems in Pacifica children and young people is currently unknown. However the Advisory Group on Conduct Problems has highlighted anecdotal evidence suggesting that conduct problems are a significant issue for Pacifica children, young people and their whānau/communities.¹

Most children and young people with severe conduct problems present undifferentiated. Following assessment, diagnoses

can include: Attention Deficit Hyperactivity Disorder; Foetal Alcohol Spectrum Disorder; Reactive Attachment Disorder (and related behavioural sequelae of abuse and neglect such as post-traumatic stress disorder); Oppositional Defiant Disorder; Conduct Disorder; Autism Spectrum Disorders; severe behaviour disturbance in children with intellectual disability; and Adjustment Disorders in children with chronic illness. Many children and young people have multiple co-morbidities.^{1-3,5,6}

There is strong national and international evidence that severe conduct problems in childhood have long-lasting or lifelong consequences for mental health including suicide, addiction, education, behaviour, employment, and welfare dependency outcomes.¹ As such, addressing severe conduct problems aligns with many Government priorities. Such priorities include the reduction of crime, improving educational outcomes, reducing adult chronic illness, improving labour force productivity, and reducing welfare dependency.^{1,4,7-9}

There are multiple contributors to the severity, chronicity and pervasiveness of conduct problems. These include: learning difficulties; intellectual disabilities; autism spectrum disorders and other developmental disorders; parental mental health and addiction disorders; foetal exposure to alcohol and other drugs; young and poorly supported parents; family disruption; social and economic disadvantage and child poverty; and exposure to neglect, abuse, and family

Appendix B.

CHILD DEVELOPMENT & DISABILITY

violence. Evidence suggests there is no single ‘most important’ factor that contributes to the prevalence of severe conduct problems, but rather, it is the overall number of adverse factors that increases the risk of developing severe conduct problems in childhood.^{8,10,11} This important finding means that interventions targeting ‘poor parenting’ alone are unlikely to be effective. However, systems that identify children at risk antenatally and postnatally, support early identification of children who are developing conduct problems, offer comprehensive assessment of children with established conduct problems, and practice evidence-based interventions, are more likely to be effective at reducing the overall prevalence and severity of conduct problems.^{1,12}

There is also a large and growing evidence base of effective interventions for severe conduct problems. In general, the evidence suggests that early identification and intervention (before school entry) holds the most promise for improved outcomes.^{1,7} As children become older, interventions tend to take longer, require more qualified clinicians, and can be more expensive – however there are a number of cost-effective interventions available addressing severe conduct problems in young people.¹³ The Advisory Group on Conduct Problems has published an integrated series of reports looking at the prevention, management and treatment of conduct problems from early childhood into adolescence. The four reports released to date focus on the identification, implementation and evaluation of programmes and interventions. Effective interventions for established conduct problems have consistent features. These include^{1,12,14,15}:

- > Interventions and programmes for the treatment of conduct problems in children and young people that are evidence-based.
- > Multidisciplinary teams of senior professionals undergoing regular clinical supervision.
- > Clear referral pathways that include clear plans for transition of care.
- > Intersectoral relationships that are formalised e.g. Memoranda of Understanding.
- > Clear quality frameworks, regular reporting of outcomes, and clear accountabilities.

In Aotearoa/New Zealand, there are likely to be considerable inequalities in access to services for severe conduct problems, driven by factors relating to location, clinical expertise, and local or national funding priorities. These factors necessitate a planned, flexible multi-system approach toward prevention, early identification assessment, intervention, and on-going management of severe conduct problems. Children and young people with severe conduct problems are often already known to health, education, police, justice and social services, and require significant resources and support.¹

There appear to be significant delays in accessing services in many areas, and in other areas, suitable services may be scarce or non-existent.¹ Compounding this, adult mental health and forensic health facilities are generally not suitable for children and young people, for whom they were not designed.

Government recognises the costs of severe conduct problems in children and young people, and has invested considerably in prevention, early identification, and early intervention.

Appendix B.

CHILD DEVELOPMENT & DISABILITY

Such investment includes funding for Well Child Tamariki Ora services; child and adolescent mental health services; the Before-School Check; NGO social services; suicide prevention; the Prime Minister's Youth Mental Health initiative; Whānau Ora; and the Children's Action Plan.^{16,17} However at a local level, such initiatives may not be brought together into a planned and cohesive whole, potentially leading to duplication of costs, and lost opportunities for more efficient and effective service provision, secondary to limited integration and co-ordination across sectors.

The Ministry for Social Development has recognised the potential for improved outcomes from integrated planning and delivery, with policies including the Children's Action Plan, Investment in Services for Outcomes, and the Social Sector Trials.^{11,18-22} The health sector however, does not have a national integrated approach toward addressing severe conduct problems for children and young people. Lack of access to services; poor integration of services; lack of resources for assessment, intervention and support; and lack of trained staff can often result in considerable costs to the individual, family, and community.

Appendix B.

CHILD DEVELOPMENT & DISABILITY

REFERENCES

1. Advisory Group on Conduct Problems. *Conduct Problems: Best Practice Report*. Wellington: Ministry of Social Development;2009.
2. Special Education Division. *Church Report - The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties*. Wellington: Ministry of Education;2003.
3. Church RJ. *The prevalence of children with behaviour disorders in Canterbury primary schools*. Christchurch: University of Canterbury in association with the Canterbury Primary Principals' Association;1996.
4. Ferguson DM, Horwood LJ. Early conduct problems and later life opportunities. *J Child Psychol Psychiatry*. 1998;39(8):1097-1108.
5. Bretherton M. *The prevalence of children with behaviour disorders in Otago Primary Schools*. Dunedin: Wakari School in Association with the Otago Primary Principals' Association;1997.
6. Bretherton M. *The prevalence of children with serious behaviour problems in Otago Schools*. Dunedin: Otago Primary Principals' Association;2000.
7. Centers for Disease Control and Prevention, Kaiser Permanente's Health Appraisal Clinic. *Adverse Childhood Experiences (ACE) Study*. 2012; <http://www.cdc.gov/ace/index.htm>.
8. Jakobsen IS, Fergusson DM, Horwood LJ. Early conduct problems, school achievement and later crime: Findings from a 30-year longitudinal study. *New Zealand Journal of Educational Studies*. 2012;47(1):123-135.
9. Silva & Stanton (eds). *From Child to Adult: The Dunedin Multidisciplinary Health & Development Study*. Auckland: Oxford University Press; 1996.
10. Ministry of Justice. *Addressing the Drivers of Crime: Background Information*. Wellington: Ministry of Justice;2009.
11. State Services Commission. *Better Public Services: Results for New Zealanders*. 2012; <http://www.ssc.govt.nz/bps-results-for-nzers>.
12. National Institute for Health and Clinical Excellence. *Parent-training/ education programmes in the management of children with conduct disorders: NICE technology appraisal guidance 102*. London: NICE;2007.
13. Washington State Institute for Public Policy. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA. 2004.
14. Advisory Group on Conduct Problems. *Conduct Problems: Effective Services for 8-12 Year Olds*. Wellington: Ministry of Social Development;2009.
15. Ferguson DM, JM B. *The prevention, treatment and management of conduct problems in childhood and adolescence*. Christchurch: Christchurch Health and Development Study, Department of Psychological Medicine, University of Otago;2009.
16. Wills R, Morris Matthews K, C H, Freer T, Morris H. Improving School Readiness with the Before School Check: Early Experience in Hawke's Bay. *New Zealand Medical Journal*. 2012;123:47-58.
17. Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *Journal of Paediatrics and Child Health*. 2008;44:92-98.
18. Ministry of Health. *Whānau Ora: Transforming our futures*. Wellington: Ministry of Health;2011.
19. Ministry of Social Development. *The White Paper for Vulnerable Children Volume II*. Wellington: Ministry of Social Development;2012.
20. New Zealand Government: Better Public Services Advisory Group. *Better Public Services Advisory Group Report*. Wellington.2010.
21. Ministry of Health. *Well Child/Tamariki Ora*. 2012; <http://www.health.govt.nz/yourhealth-topics/children/well-child-tamariki-ora>.
22. Ministry of Health. *Prime Minister's Youth Mental Health Project*. 2012.

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

In the NZ context, the definition of child, youth and whānau-centred care is drawn from the international health literature around child-friendly health care, and patient and family-centred care. Such initiatives have either developed core principles that strengthen child rights within a health care environment, or use a rights-based framework underpinned by the United Nations Convention on the Rights of the Child (UNCROC), in the provision of health services for children and young people.

Child, youth and whānau-centred care is defined as, *... a best practice health care approach that centers on the rights of children and young people, takes into account the best interests of children and young people, supports the physical, developmental, mental, emotional, social, cultural, and spiritual needs of children, young people and their whānau; involves collaborative partnerships between health care providers and children, young people and their whānau; and results in the best possible health care for children, young people and their whānau experiencing health services within Aotearoa/New Zealand.*

Within this definition, the terms family and whānau are not considered to be interchangeable whereby family and caregivers are considered to be a subset of whānau. In the context of child, youth and whānau-centred care, the term whānau includes both preeminent models of whānau – whakapapa (kinship) and kaupapa (purpose driven) outlined by te Kōmihana ā Whānau. Whakapapa whānau is defined as, “a collective of people connected through a common ancestor (whakapapa)”^{2,p.9} where “whakapapa whānau is an integral part of hapū and hapū an integral part of iwi”^{2,p.16} and kaupapa whānau is defined as a collective of people who “are bound together in relationships to fulfill a common purpose or goal. Kaupapa whānau may or may not share whakapapa”^{2,p.26} However it is important to acknowledge that these are not mutually exclusive.

EVIDENTIAL SUPPORT FOR CHILD-FRIENDLY HEALTH CARE AND PATIENT AND FAMILY CENTRED-CARE APPROACHES

There is strong evidential support for a child-friendly health care and patient and family-centred care approaches toward health service provision for children and young people.

³⁻¹⁶ Evidence also suggests that reconfiguration of child health services, underpinned by articles of UNCROC can improve quality of health care and child health outcomes. ^{17,18} Furthermore, supporting child health care providers to increase their understanding and practice of the articles of UNCROC can lead to improvements in the quality of health

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

service provision for children and young people.¹⁷⁻¹⁹

The Council of Europe have highlighted a number of important benefits of child-friendly health care, a major benefit being the integration of systems enabling collaboration between governments, organisations, professional bodies, children, young people and families, to plan health services for children and improve existing health services. In addition to the body of literature supporting the association between patient and family-centred care and positive child health outcomes, the American Academy of Pediatrics and the Institute for Patient and Family-Centered Care have highlighted a number of benefits of engaging in patient and family-centred care approaches toward health service provision for children and young people.²⁰

Patient and family-centred care builds upon child and family strengths,²¹⁻²³ and is grounded in the collaborative partnerships between children, their families and health care providers in the planning, delivery, and evaluation of health care, and in health research and the education of health professionals.²⁴ Recent literature inclusive of systematic reviews and meta-analysis links patient and family-centred care to improvements in child health outcomes,³⁻¹⁶ as well as improvements in child and family experience of health care,³⁻⁶ increased child and family satisfaction with health care received,^{16,25} increased satisfaction for health professionals working with children and families,²⁵ and reduction in child health care costs.²⁵⁻²⁷

Evidence suggests that presence of family during invasive procedures decreases anxiety for both children and parents. In addition, parents who are prepared prior to invasive procedures do not prolong procedures or increase anxiety for the health professional.⁶ There is also considerable evidence that patient and family-centred care approaches are associated with an increase in parents' psychological health,^{7-14,16} and that this is associated with improvement in the psychological health and wellbeing of their children.^{7,15} Other evidence highlights the association between patient and family-centred care and improved health literacy and self-management,^{16,21-23,27} leading to improvement in child health outcomes.^{3-5,16,27} Decreased health service costs are secondary to earlier discharges from neonatal units, fewer hospital admission days, fewer re-hospitalisations, and reduction in non-urgent emergency department visits.^{16,25-28}

In addition to the large body of research, patient and family-centred care is supported by a number of professional bodies and organisations within the United States. These include the American Academy of Pediatrics;^{20,26} Institute for Patient and Family-Centered Care;²⁶ Institute of Medicine;²⁹ Institute for Healthcare Improvement;^{30,31} and the American Hospital Association.³² The Australian Commission on Safety and Quality in Health Care also supports a patient and family-centred care approach in the 'Australian Safety and Quality Framework for Health Care'.³³

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

THE AOTEAROA/NEW ZEALAND CONTEXT

As outlined in the 'Standards for the Care of Children and Adolescents in Health Services', core principles of patient and family-centred care are supported in Australasia by a number of professional bodies and organisations.³⁴ Patient and family-centred health care approaches are also endorsed by the 'Health and Disability Sector Standards (Children and Young People) - Audit Workbook' which sets the requirement for children and young people to experience quality health care in safe and appropriate child/young people-friendly health care environments.³⁵ In addition, the 'New Zealand Triple Aim' for quality improvement supports patient and family-centred health care.³⁶

The 'Charter of Tamariki/Children's and Rangatahi/Young People's Rights in Healthcare Services in Aotearoa New Zealand' (the 'Charter') was launched in 2011 by the Paediatric Society of New Zealand and Children's Hospitals Australasia.³⁷ Based upon UNCROC, the 'New Zealand Code of Health and Disability Services Consumer's Rights', the 'Australian Charter of Healthcare Rights', and the 'Charter of the European Association for Children in Hospital', the 'Charter' provides an approach toward the implementation of rights for children and young people experiencing health services within NZ.

BOX 1: TAMARIKI/CHILDREN'S AND RANGATAHI/YOUNG PEOPLE'S RIGHTS IN HEALTH CARE SERVICES

EVERY CHILD AND YOUNG PERSON HAS A RIGHT TO:

1. Consideration of their best interests as the primary concern of all involved in his or her care.
2. Express their views, and to be heard and taken seriously.
3. The highest attainable standard of health care.
4. Respect for themselves as a whole person, as well as respect for their family/whānau and the family's/whānau individual characteristics, beliefs, tikanga, culture and contexts.
5. Be nurtured by their parents and family/whānau, and to have family/whānau relationships supported by the service in which the child or young person is receiving health care.
6. Information, in a form that is understandable to them.
7. Participate in decision-making and, as appropriate to their capabilities, to make decisions about their care.
8. Be kept safe from all forms of harm.
9. Have their privacy respected.
10. Participate in education, play, creative activities and recreation, even if this is difficult due to their illness or disability.
11. Continuity of health care, including well-planned care that takes them beyond the paediatric context.

Source: Children's Hospitals Australasia and Paediatric Society New Zealand (2011)

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

For a DHB committed toward ensuring that services for children, young people, and whānau are appropriate, a number of processes supporting staff training and professional development need to be in place. This training needs to include staff that care for children and young people in both dedicated and non-dedicated paediatric areas e.g. Emergency Medicine, Intensive Care Medicine, Primary Care, rural areas etc. Box 2 provides an outline of such processes based upon the ‘Standards for the Care of Children and Adolescents in Health Services’, the ‘Health and Disability Sector Standards (Children and Young People) – Audit Workbook’, the ‘Charter’, and the ‘Report of the Taskforce on Whānau-Centred Initiatives’.^{34,35,37,38}

BOX 2: EXAMPLE OF APPROPRIATE STAFF EDUCATION/ TRAINING IN CHILD, YOUTH & WHĀNAU-CENTRED CARE

STAFF ARE SUPPORTED TO RECEIVE TRAINING/EDUCATION IN:

- > Developmental stages children and young people.
- > Anatomical, physiological, immunological differences for children and young people compared with adults.
- > Communicating with children, young people and families/whānau at an appropriate developmental level, and in a non-judgemental and empathetic manner.
- > Whānau-centred care including understandings of definitions and characteristics of whānau, ways of effectively engaging with whānau, strengths-based practice, and whānau-centred design and delivery of services.
- > Care and protection, child maltreatment, family violence.
- > Care for children and young people with special needs.
- > Paediatric life support. Basic paediatric life support. skills are sufficient in most areas of the health service where children are cared for. In clinical areas such as the Emergency Department, inpatient paediatric medical and surgical wards, surgical recovery areas and day care facilities, and acute after hours services e.g. after hours medical centre, life support training should be at the advanced life support level.
- > Breastfeeding.

Continued...

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

Continued...

- > Immunisation.
- > Smokefree.
- > Sexual health.
- > Paediatric pain assessment and management including communicating strategies to assess using age appropriate pain score tools, minimise physical and emotional pain, trauma and distress of children, young people, and families/whānau.
- > Development of comprehensive assessments which reflect the individual needs of children, young people and families/whānau e.g. use of appropriate tools e.g. HEADSS assessment risk; developing developmentally appropriate and meaningful care plans in partnership with the child, young person and their family/whānau; and identification of exit and/or discharge planning needs, including co-ordination with schools, community services.
- > Knowledge of community support agencies/programs and referral pathways to assist with identified health or social needs.
- > Cultural competency enabling them to identify and respond sensitively to the belief and value systems of children, young people and their families/whānau. This includes understanding of and application of the Treaty of Waitangi to health service delivery, and Māori and Pacific models of holistic wellbeing influencing practice.
- > The Charter of Tamariki/Children's and Rangatahi/Young People's Rights in Healthcare Services in Aotearoa New Zealand, and the United Nations Convention on the Rights of the Child (UNCROC) as a rights-based tool for health and wellbeing.
- > The Code of Health and Disability Consumer Rights, and the Privacy Code as they relate to children and young people.
- > Informed consent for children and young people.
- > Knowledge of tools that support health equity assessment, e.g. Health Equity Assessment Tool, Whānau Ora Health Impact Assessment Tool, Whānau Ora Tool.

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

STAFF TRAINING/EDUCATION IS SUPPORTED BY:

- > Access to support systems e.g. guidelines, pathways, policies in order to provide equitable, consistent care e.g. management of common paediatric presentations/ admissions guidelines.
- > Access to the required equipment for the care of children and young people which meet appropriate guidelines.
- > Integrated multi-service delivery approaches toward child and youth health service delivery, collaborative relationships between providers, whānau, relevant professional communities, government agencies.
- > Health service waiting rooms equipped with developmentally appropriate toys, activities.
- > In non-dedicated paediatric areas, staff with advanced knowledge in the care of children and young people who, recognising their unique needs, negotiates resources to provide for their safe and effective care, and liaises with paediatric speciality services e.g. paediatric liaison role.

There currently exist innovative practices within NZ that align with child, youth and whānau-centred care. Paediatric liaison nurses – a concept first developed twenty years ago in the United States, are responsible for conducting quality assurance, planning staff education, and acting as a child and youth advocate, to improve the delivery of paediatric emergency care.¹ This role is currently recognised within a number of emergency departments in NZ. There is also the potential for paediatric liaison nurses within NZ to form a cooperative group, meeting regularly to network, discuss common problems in caring for children and young people, plan educational programs, share policies and procedures, and assist with multicenter research in paediatric emergency care.

Canterbury DHB have an established Family Advisory Council that provides the mechanism by which parents and caregivers offer advice and input into issues impacting upon child health care and quality improvement.³⁹ Regarding children and young people's views, Regional Public Health, through a collaborative participatory documentary film project, provided support for children and young people from Pomare in Lower Hutt to have their voices heard on issues impacting upon their health and wellbeing. Using a child rights framework underpinned by UNCROC, Pomare children and young people provided their views, through artwork, stories, songs, and drama, on the impacts of alcohol and housing on their health and wellbeing.⁴⁰

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

REFERENCES

1. American Academy of Pediatrics Committee on Pediatric Emergency Medicine, American College of Emergency Physicians Pediatric Committee. Care of Children in the Emergency Department: Guidelines for Preparedness. *Pediatrics*. 2001;107(4):777-781.
2. Lawson-Te Aho K. *Definitions of Whānau: A review of the selected literature*. Wellington: Families Commission: Kōmihana ā Whānau. 2010.
3. Shelton TL, Stepanek JS. *Family-Centered Care for Children Needing Specialized Health and Developmental Services*. Bethesda, MD: Association for the Care of Children's Health. 1994.
4. Fina DK, Lopas LJ, Stagnone JH, Santucci PR. Parent participation in the postanesthesia care unit: fourteen years of progress at one hospital. *J Perianesth Nurs*. 1997;12:152-162.
5. American Academy of Pediatrics Committee on Hospital Care. Child life services. *Pediatrics*. 2000;106:1156-1159.
6. Dingeman RS, Mitchell EA, Meyer EC, Curley MAQ. Parent presence during complex invasive procedures and cardiopulmonary resuscitation: a systematic review of the literature. *Pediatrics*. 2007;120(4):842-854.
7. Dunst CJ, Trivette CM, Hamby DW. *Research Synthesis and Meta-Analysis of Studies of Family-Centered Practices*. Asheville, NC, USA: Winterberry Monograph Series, Winterberry Press. 2008.
8. Dunst CJ, Trivette CM, Hamby DW. Meta-analysis of family-centered help giving practices research. *Mental Retardation and Developmental Disabilities Research Reviews*. 2007;13(4):370-378.
9. Meyer EC et al. Family-based intervention improves maternal psychological well-being and feeding interaction of preterm infants. *Pediatrics*. 1994;93(2):241-246.
10. Ireys H, Chernoff R, DeVet KA, Kim Y. Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illnesses. *Arch Pediatr Adolesc Med*. 2001; 155:771-777.
11. LaRosa-Nash PA, Murphy JM. An approach to pediatric perioperative care: parent-present induction. *Nurs Clin North Am*. 1997;32:183-199.
12. Blesch P, Fisher ML. The impact of parental presence on parental anxiety and satisfaction. *AORN J*. 1996;63:761-768.
13. Wolfram RW, Turner ED. Effects of parental presence during children's venipuncture. *Acad Emerg Med*. 1996;3:58-64.
14. Powers KS, Rubenstein JS. Family presence during invasive procedures in pediatric intensive care unit: a prospective study. *Arch Pediatr Adolesc Med*. 1999;153:955-958.
15. Dunst CJ, Trivette CM. Meta-analytic structural equation modeling of the influences of family-centered care on parent and child psychological health. *International Journal of Pediatrics*. 2009. <http://www.hindawi.com/journals/ijped/2009/576840/>.
16. Forsythe P. New practices in the transitional care center improve outcomes for babies and their families. *J Perinatol*. 1998;18 (6 pt 2 suppl):S13-S17.
17. Nicholson S, Clarke A. *Child friendly healthcare: A manual for health workers*. In: Burr S, Southall D, eds. Nottingham. 2005.
18. Clarke A, Nicholson S. The Child Friendly Healthcare Initiative – an update. *Paediatric Nursing*. 2007;19(8):36-37.
19. Southall DP, Burr S, Smith RD, et al. The Child-friendly Healthcare Initiative (CFHI): Healthcare Provision in Accordance with the UN Convention on the Rights of the Child. *Pediatrics*. 2000;106(5):1054-1064.
20. American Academy of Pediatrics Committee on Hospital Care. Family-Centered Care and the Pediatrician's Role. *Pediatrics*. 2003;112(3): 691-696.
21. Coulter A, Ellins J. Effectiveness of strategies for informing, educating, and involving patients. *BMJ*. 2007;335(7609):24-27.

Appendix C.

CHILD, YOUTH & WHĀNAU- CENTRED CARE

22. Singer GHS, Marquis J, Powers LK, et al. A multi-site evaluation of parent to parent programs for parents of children with disabilities. *J Early Intervent*. 1999;22:217-229.
23. Ainbinder JG, Blanchard LW, Singer GH, et al. A qualitative study of parent to parent support for parents of children with special needs. Consortium to evaluate Parent to Parent. *J Pediatr Psychol*. 1998; 23:99-109.
24. Johnson B et al. *Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices*: Institute for Family-Centered Care and Institute for Healthcare Improvement. 2008.
25. Sodomka P, Scott HH, Lambert AM, Meeks BD. Patient and family centered care in an academic medical center: informatics, partnerships and future vision. In: Weaver CA, Delaney CW, Weber P, Carr R, eds. *Nursing and Informatics for the 21st Century: An International Look at Practice, Trends and the Future*. Chicago, IL: Healthcare Information and Management Systems Society. 2006:501-506.
26. American Academy of Pediatrics Committee on Hospital Care, Institute for Patient and Family-centered care. *Patient- and Family-Centered Care and the Pediatrician's Role*. 2012:394-404. <http://pediatrics.aappublications.org/content/129/2/394>.
27. Solberg B. Wisconsin prenatal care coordination proves its worth. Case management becomes Medicaid benefit. *Inside Prev Care*. 1996;2(1):5-6.
28. Brousseau DC, Hoffmann RG, Nattinger AB, Flores G, Zhang Y, Gorelick M. Quality of primary care and subsequent pediatric emergency department utilization. *Pediatrics*. 2007;119(6):1131-1138.
29. Institute of Medicine Committee on Quality Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press. 2001.
30. Conway J, Johnson BH, Edgman-Levitan S, et al. *Partnering with patients and families to design a patient and family-centered health care system: a roadmap for the future—a work in progress*. Bethesda, MD: Institute for Family-Centered Care and Institute for Healthcare Improvement. 2006.
31. Balik B, Conway J, Zipperer L, Watson J. *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care*. Cambridge, Massachusetts: Institute for Healthcare Improvement. 2011.
32. American Hospital Association. *Strategies for Leadership: Patient and Family-Centered Care*. Chicago, IL: American Hospital Association. 2004.
33. Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care*. 2010.
34. RACP Paediatrics & Child Health Division, Association for the Wellbeing of Children in Healthcare, Children's Hospitals Australasia. *Standards for the Care of Children and Adolescents in Health Services*. Sydney. 2008.
35. Standards New Zealand. *Health and Disability Sector Standards (Children and Young People) - Audit Workbook*, SNZ HB 8134.4. Wellington.2004.
36. Health Quality & Safety Commission New Zealand. *Summary of 2011-2014 Statement of Intent*. Wellington. 2011.
37. Children's Hospitals Australasia, Paediatric Society New Zealand. *Charter on the Rights of Tamariki/Children and Rangatahi/Young People in Healthcare Services in Aotearoa New Zealand*. 2011.
38. Taskforce on Whānau-Centred Initiatives. *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*. Wellington. 2010.
39. Canterbury DHB. *Family Advisory Council*. 2012; http://www.cdhb.govt.nz/child-health/Parent_Advisory_Council.htm.
40. King P, Gough D. *Rise UP! Pomare - The Pomare Child Health Video Project*. Lower Hutt: Regional Public Health. 2012.

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Appendix D.

LEADERSHIP & GOVERNANCE

Governance is the process of decision-making, and the process by which decisions are implemented, or not implemented. Decision-making and implementation can involve both formal and informal actors and structures. Clinical governance includes the culture needed to ensure that healthcare organisations – and all individuals within them – can assure the quality of the care they provide, and are continuously seeking to improve it.^{1,2}

There are nearly as many different strategies and plans for child health services as there are services themselves and little consistency between them.³⁻⁶ There are also many different ways of planning and strategising e.g. clinical governance,⁷ ‘New Zealand Triple Aim’,⁸ and the ‘University of Kansas Community Toolbox’.⁹ In addition, there exist resources that support building equity improvement within health services, for example, the ‘Roadmap to Reduce Racial Disparities’ released by the Robert Wood Johnson Foundation. This useful resource provides a step-by-step guide to reducing health inequalities.¹⁰

There is limited (but growing) evidence of strategies improving outcomes, so ‘best practice’ cannot be defined. The ‘Cochrane Effective Practice and Organisation of Care Group’ found no well designed studies of changing organisational culture to improve healthcare performance.¹¹ The ‘Centres for Disease Control Guide to Community Preventive Services: Adolescent Health’,¹² and ‘National Institute for Health and

Clinical Excellence’ (NICE)¹³ offer evidence-based approaches for reducing specific issues (e.g. alcohol-related harm to adolescents) but not for planning of organising health services generally.

However, examples of planning for child health services where there is an emerging consensus can be described. These include (but are not limited to) the following examples: 1) Standards; 2) Community Development; and 3) Wicked Problems.

1. STANDARDS APPROACH

The NICE Specialist Neonatal Quality Standard contains nine statements, each supported by specific quality measures.¹⁴ Three of the nine statements are listed as examples (Box 1). Each statement is supported by specific quality measures e.g. for Statement 1 (neonatal transfers), one measure is the proportion of infants with diagnosed foetal malformations delivered in a designated surgical centre.

Appendix D.

LEADERSHIP & GOVERNANCE

BOX 1: NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE SPECIALIST NEONATAL CARE QUALITY STANDARDS¹⁴

Statement 1 In-utero and postnatal transfers for neonatal special, high-dependency, intensive and surgical care follow perinatal network guidelines and care pathways that are integrated with other maternity and newborn network guidelines and pathways.

Statement 2 Networks, commissioners and providers of specialist neonatal care undertake an annual needs assessment and ensure each network has adequate capacity.

Statement 3 Specialist neonatal services have a sufficient, skilled and competent multidisciplinary workforce.

Another widely known standards document is the 'Charter on the Rights of Tamariki/Children and Rangatahi/Young People in Healthcare Services in Aotearoa New Zealand' published by the Children's Hospitals Australasia and the Paediatric Society of New Zealand.¹⁵ The Charter lists eleven rights for children and young people and explains what each right means from a practical perspective. For example, Right 6 states that "Every child has the right to information in a form that is understandable to them".^{15,p.8} Similarly, Standards New Zealand has published the 'Health and Disability Sector Standards (Children and Young People) Audit Workbook',¹⁶ providing a self-assessment and risk assessment framework to help organisations assess their risk, and prioritise actions accordingly.

2. COMMUNITY DEVELOPMENT APPROACH

The 'University of Kansas Community Toolbox'⁹ offers a conceptual framework for building healthier communities. The toolbox is informed by extensive experience in developing effective and sustained community health initiatives across several countries. Examples of application have been published.^{17,18} The conceptual framework is outlined in Box 2.

BOX 2: 'UNIVERSITY OF KANSAS COMMUNITY TOOLBOX' CONCEPTUAL FRAMEWORK⁹

1. **Understanding Community Context** e.g. assessing community assets and needs.
2. **Collaborative Planning** e.g. developing a vision, mission, objectives, strategies, and action plans .
3. **Developing Leadership and Enhancing Participation** e.g. building relationships, recruiting participants.
4. **Community Action and Intervention** e.g. designing interventions, advocacy.
5. **Evaluating Community Initiatives** e.g. program evaluation, documentation of community and system change.
6. **Promoting and Sustaining the Initiative** e.g. social marketing, obtaining grants .

Appendix D.

LEADERSHIP & GOVERNANCE

3. WICKED PROBLEMS APPROACH

In 1973, Rittel and Webber coined the term ‘Wicked Problems’ to describe socially complex problems. These include issues that child health services are ‘supposed to solve’ or at least address, such as child abuse and poverty-related disease.¹⁹

Wicked problems are difficult to solve because they are difficult to define; there is no stopping point; solutions are not true/false but good/bad; there is no simple solution; the problems are interconnected with other problems; knowledge about them is incomplete or contradictory; there are many people and opinions involved; and the economic burden is large. Rittel and Weber also noted that many attempts to address such problems failed, despite what should have been good leadership and generous funding. Traditional planning did not deliver the outcomes it should have.

Tackling wicked problems is an evolving science, however evidence suggests the following is required for success²⁰: holistic, rather than linear thinking; innovation and flexibility; working across agency boundaries; an accountability framework that does not constrain the response; effectively engaging stakeholders, especially when behaviour change is required; sophisticated communication and influencing skills and collaborative teamwork as well as more traditional project management skills; a comprehensive strategy and focus; tolerance of uncertainty and failure; and patience and persistence.

EFFECTIVE SOLUTIONS IN THE AOTEAROA/ NEW ZEALAND CONTEXT

There are several effective programmes in child and youth health in Aotearoa/New Zealand. Examples include the Hawkes Bay DHB’s ‘Family Violence Intervention’²¹ and ‘Before-School Check’²² programmes, Waikato DHB’s ‘Project Energize’ programme,²³ and the national improvement in immunisation rates.²⁴

These successful programmes shared features of all the above approaches. All used quality frameworks, elements of community development, and solutions to wicked problems approach. In particular, all contained the following:

- > intersectoral collaborations that effectively engaged stakeholders
- > comprehensive strategies
- > published evidence base with fidelity
- > quality frameworks applied to the local setting
- > cognisance of local realities
- > clear plan and regular monitoring against the plan using specific outcome measures
- > named leader accountable for the plan.

In addition, there is evidence of health service processes to enable Māori to work in partnership with, and contribute toward, DHB strategies for improving Māori health and achieving equitable child and youth health outcomes²⁵⁻²⁷:

- > In Lakes DHB, Māori partners have the status of a governance body, signing off the DHB's Statement of Intent and Annual Plans. Lakes DHB's Annual Report also provides detailed description of both governance and health service initiatives toward the improvement of Māori health outcomes.²⁵
- > In Counties Manukau DHB Annual Report 2011,²⁶ measures of progress toward the reduction of disparities in health outcomes (outlined in the 'Whaanau Ora Plan 2006 – 2011')²⁷ were reported against DHB performance results. Among these for children and young people were avoidable hospitalisations for 0 – 14 years, and increasing the number of children who are fully immunised at 2 years of age.²⁶

Appendix D.

LEADERSHIP & GOVERNANCE

Appendix D.

LEADERSHIP & GOVERNANCE

REFERENCES

1. MPDD United Nations Economic and Social Commission for Asia and the Pacific. <http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp>
2. Department of Health United Kingdom. <http://www.dh.gov.uk/health/2011/09/clinical-governance/>
3. Capital & Coast DHB. *CCDHB Child Health Strategy*. 2011. <http://www.ccdhb.org.nz/planning/chag/childhealthstrategyinterventionlogic.pdf>.
4. Midland DHB. Child Health Strategy. 2005. <http://www.midcentraldhb.govt.nz/Publications/AllPublications/Documents/Child-Health-Strategy-August-2005.pdf>.
5. Ministry of Health. *Child Health Strategy*. 1998. <http://www.health.govt.nz/publication/child-health-strategy>.
6. Department of Health, Department for children schools and families. *Healthy lives, brighter futures: The strategy for children and young people's health - Executive Summary*. 2009. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094399.pdf.
7. G Scally, LJ Donaldson. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ*. 1998;317(7150):61-65.
8. Health Quality & Safety Commission New Zealand. *Summary of 2011-2014 Statement of Intent*. Wellington. 2011.
9. Fawcett SB, Francisco VT, Schultz JA, Nagy G. The Community Tool Box: An Internet-Based Resource for Building Healthier Communities. *Public Health Reports*. 2000;115:274-278.
10. Robert Wood Johnson Foundation. *Roadmap to Reduce Disparities*. 2012; <http://www.solvingdisparities.org/tools/roadmap>.
11. Parmelli E, Flodgren G, Schaafsma ME, Baillie N, Beyer FR, Eccles MP. Strategies to change organisational culture to improve healthcare performance. *Cochrane Summaries*. 2011. <http://summaries.cochrane.org/CD008315/strategies-to-change-organisational-culture-to-improve-healthcare-performance>.
12. CDC Community Preventive Services Task Force. Guide to Community Preventive Services: *Adolescent health*. 2012. <http://www.thecommunityguide.org/adolescenthealth/index.html>.
13. National Institute for Health and Clinical Excellence. *Child Health*. 2012; <http://www.nice.org.uk>.
14. National Institute for Health and Clinical Excellence. *QS4 Specialist neonatal care quality standard*. 2010. <http://publications.nice.org.uk/specialist-neonatal-care-quality-standard-qs4/list-of-statements>.
15. Children's Hospitals Australasia, Paediatric Society New Zealand. *Charter on the Rights of Tamariki/Children and Rangatahi/Young People in Healthcare Services in Aotearoa New Zealand*. 2011.
16. Standards New Zealand. *Health and Disability Sector Standards (Children and Young People) - Audit Workbook, SNZ HB 8134.4*. Wellington.2004.
17. Fawcett SB, Francisco VT, Paine-Andrews A, Schultz JA. Working together for healthier communities: A research-based memorandum of collaboration. *Public Health Reports*. 2000;115(174-179).
18. Fawcett SB, Paine-Andrews A, Francisco VT et al. Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology*. 1995;23:677-697.
19. Rittel H, Webber M. Dilemmas in a general theory of planning. *Policy Sciences*. 1973;5:155-169.
20. Australian Public Service Commission. *Tackling Wicked Problems: A Public Policy Perspective*. Canberra: Australian Public Service Commission. 2007.
21. Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *Journal of Paediatrics and Child Health*. 2008;44:92-98.
22. Wills R, Morris Matthews K, C H, Freer T, Morris H. Improving School Readiness with the Before School Check: Early Experience in Hawke's Bay. *New Zealand Medical Journal*. 2012;123:47-58.
23. Project Energize, Sport Waikato, AUT University. *An evaluation of nutrition and physical activity in Waikato primary schools Project Energize: June 2008 to June 2011 - Executive Summary*: Waikato District Health Board and the Ministry of Health. 2011.

24. Immunisation Advisory Centre. Improving coverage: the next step. *ImmNuZ : The Official Newsletter of the Immunisation Advisory Centre*. 2012;66(2).
25. Lakes District Health Board. *Annual Report for the year ended 30 June 2012*. 2012. <http://www.lakesdhb.govt.nz/Resource.aspx?ID=23253>.
26. CMDHB. *Counties Manukau District Health Board Annual Report as at 30 June 2011*. 2011. http://www.cmdhb.org.nz/about_cmdhb/planning/Annual-Report/30-06-2011/CMDHBAnnualReport2011.pdf.
27. CMDHB. *Whaanau Ora Plan 2006-2011*. 2006. http://www.cmdhb.org.nz/about_cmdhb/planning/Maori-Health-Plan/WhanauOraPlan.pdf.

Appendix D.

LEADERSHIP & GOVERNANCE

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Appendix E.

PRIMARY CARE

Primary care is health care received in the community, delivered by generalist first-level services, such as general practice services, mobile nursing services, community health services and pharmacy services. Primary health care covers a broad range of health and preventative services, including health education, counselling, disease prevention and screening.¹ Primary care services have four main components: first-contact access for each new need; long-term person focused care; comprehensive care for most needs; and coordinated care when it must be sought elsewhere.²

Within the description of good practice, an upper age level of 18 years has been used. However, it should be highlighted that there are inconsistencies across health services providing care for children and young people with respect to relevant ages.

ACCESS TO PRIMARY CARE SERVICES

Access to health care can be defined as the timely use of health services to achieve the best possible outcomes.³ Access to health care is one of the components of a framework used to define the quality of care that individuals receive. Dimensions of access include: geographical proximity and physical access to premises; availability of services and practitioners; and organisational (such as appointment) systems. Access is whether or not “individuals can access health structures and processes of care which they need”.^{4,p.1615} Significant barriers to accessing care include travel time to the

provider service, time to wait for an appointment,⁵ cost,^{6,7} and out-of-hours service provision.⁸

Greater and better provision of primary health care services, and delivery of care from an identified primary health care physician has consistently shown a positive relationship with health outcomes, including all-cause mortality, disease-specific mortalities, infant mortality and self-rated health, after account has been taken of socioeconomic, and lifestyle factors.²

The impact of many childhood illnesses is reduced with early intervention with access to primary care being pivotal to improving health outcomes.⁸ Timeliness and coverage of childhood vaccination is better at primary care practices that are more resourced, and have organised to enrol children at a younger age.⁹ For families with children and young people with disabilities, it is recognised that families need help to connect and coordinate between varied services, and receive timely access to specialist and diagnostic services¹⁰ for which primary care has a key role.

Access to primary care is recognised as important to reducing health inequities.¹¹ Increased access to primary care for high needs groups by Capital and Coast DHB lead to improved health outcomes for these population groups.¹²

Appendix E.

PRIMARY CARE

AMBULATORY SENSITIVE HOSPITALISATIONS (ASH)

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions in those aged < 75 years of age, that are considered potentially preventable if well managed in primary care.¹³ While ASH rates have traditionally tended to focus on primary care provision (particularly in general practice), it is important to remain aware that many other aspects of the health care system – hospital supply and configuration, emergency care department management, community care provision etc. – can have an effect on ASH. It is important to note the deliberate use of the word ‘sensitive’ in the title of ASH – not all these admissions would be able to be prevented even in a perfect health system. Moreover, many ‘unplanned’ admissions are planned in the acute sense by the primary care clinician, and are not ‘avoidable’ given current health service resources, and the psycho social circumstances of children and their families.

In NZ, ASH accounts for approximately 24% of all medical and surgical discharges (approximately 370,000 admissions). However, discharges for Māori and Pacific peoples are disproportionately higher than other groups being 28% and 31% respectively.¹⁴ While ASH is commonly reported as rates for whole populations there are significant differences between ASH in adults and in children. In children, infectious causes of admissions predominate, although asthma is the most common single condition.¹⁵ Most affected are pre-school children, Māori children, and those living in deprived neighbourhoods.¹⁶ Data from Counties Manukau District Health reports the following common causes for acute

admissions in children < 15 years of age: whooping cough and acute bronchiolitis, cellulitis, respiratory infections/ inflammation, neonate (>2.5kg), bronchitis and asthma, gastroenteritis (< 10 years of age), other circulatory system, otitis media and upper respiratory tract infections, hip/femur fractures, and viral illness.¹⁷

Determining the reasons for high or low ASH rates are complex, as it is in part a whole of system measure. The Agency for Healthcare Quality and Research suggests that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.¹⁸ This indicator can also highlight variation between different population groups, prompt debate and raise questions about health service use as to why differences exist, stimulate improvement through this debate that will assist with DHB planning to reduce disparities.¹⁹

Appendix E.

PRIMARY CARE

REFERENCES

1. Ministry of Health. *The Primary Health Care Strategy*. Wellington: Ministry of Health. 2001.
2. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502.
3. Millman ML (ed), *Access to Health Care in America*. Washington DC: National Academy Press. 1993. Institute of Medicine.
4. Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Social Science and Medicine*. 2000;51:1611-1625.
5. Forrester CB, Starfield B. Entry into Primary Care and Continuity: The Effects of Access. *American Journal Of Public Health*. 1998;88(9):1330.
6. Barnett JR. Coping with the costs of primary care? Household and locational variations in the survival strategies of the urban poor. *Health and Place*. 2001;7:141-157.
7. Jatrana S, Crampton P, Norris P. Ethnic differences in access to prescription medication because of cost in New Zealand. *J Epidemiol Community Health*. 2011(65):454-460.
8. Fancourt N, Turner N, Dowell A C, Asher I. Primary health care funding for children under six years of age in New Zealand: why is this so hard? *Prim Health Care*. 2010;2:338-342.
9. Grant CG et al. Factors associated with immunisation coverage and timeliness in New Zealand. *Br J Gen Pract*. 2010;60(572):e113-e120.
10. IHC. *Call to action: What needs to be change for children and young people with disabilities and their families*. 2011.
11. Andrulis DP. Access to care in the centrepiece in the elimination of socioeconomic disparities in health *Ann Intern Med*. 1998;129:412-416.
12. Tan L, Carr J, Reidy J. New Zealand evidence for the impact of primary healthcare investment in Capital and Coast District Health Board. *New Zealand Medical Journal*. 2012;125(1352):7-27.
13. Health Quality and Safety Commission New Zealand. *Health Quality Measures*. From: <http://www.hqmz.org.nz/measures/staying-healthy/ambulatory-sensitive-avoidable-hospitalisations>.
14. Ministry of Health & Minister of Health. *Health and Independence Report 2007*. Wellington: Ministry of Health. 2007.
15. Jackson G, Tobias M. Potentially avoidable hospitalisations in New Zealand, 1989-98. *Aust N Z J Public Health*. 2001;25(3):212-221.
16. O'Sullivan C et al. The epidemiology of serious skin infections in New Zealand children: comparing the Tairāwhiti region with national trends. *NZ Med J*. 2012;125(1351):40-54.
17. Winnard D, Chan W. *CMDHB Acute Demand Overview 2012*: Counties Manukau District Health Board. 2012.
18. Agency for Healthcare Research and Quality (AHRQ). *Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years*. 2010. From: <http://qualitymeasures.ahrq.gov/content.aspx?id=27275&search=primary+care+access+and+admission>.
19. Health Quality & Safety Commission New Zealand. *Atlas of Healthcare Variation - Domain Initiation Document*. 2012.

EVIDENCE-BASED RATIONALE FOR GOOD PRACTICE

Adolescence is a developmental period with unique challenges and opportunities. Unfortunately Aotearoa/ New Zealand (NZ) has a poor record when it comes to young people's health. Rates of youth suicide, death from motor vehicle injuries, unintended pregnancy and drug and alcohol use have been among the highest in the Western world.¹

YOUTH SPECIFIC SERVICES

Young people require developmentally appropriate services, delivered at sites that are accessible by public transport, or in schools, and are low-cost or free.² Young people in NZ experience numerous barriers to health care,³ including those that are related to the developmental stage of young people, and those systemic barriers that reflect an inability of current systems to meet the needs of young people (Box 1).² Ongoing efforts to improve youth health in NZ therefore require specific youth health services.

BOX 1: BARRIERS TO HEALTH CARE FOR YOUNG PEOPLE IN NZ

DEVELOPMENTAL:

- > lack of confidence
- > fear of embarrassment
- > perception of lack of confidentiality
- > need to have privacy and be independent
- > other priorities
- > lack of future thinking.

SYSTEMIC:

- > cost
- > appointments not accessible
- > transport problems
- > perceived as healthy
- > main health issue mental health.

Source: Bagshaw (2012)

Appendix F.

YOUTH HEALTH

Appendix F.

YOUTH HEALTH

Youth specific services, whether they are provided in schools, the community, or in the hospital, have the ability to provide improved access, more appropriate care, comprehensive health care, and specialised interventions to improve youth health outcomes and morbidity.⁴ For example, school-based health care (SBHCs) are primary health care services located in schools that provide youth-appropriate health services through their accessible, low-cost, youth-focused services and comprehensive care.⁵ High quality school-based health care has the potential to greatly improve the health status of young people in NZ by increasing health care access,^{6,7} providing comprehensive health care, improving access to mental health care,⁸ preventing unwanted pregnancies,⁹ and reducing alcohol and substance use disorders.¹⁰

However, access to youth specific services can be extremely variable nationwide, reflective of the current distribution of services. A number of areas in NZ do not have youth one-stop health services or school-based health care services, to meet their youth population's needs.²

SUPPORT FOR YOUNG PEOPLE WITH CHRONIC ILLNESS/DISABILITY

In NZ, approximately 18% of secondary school students report a long term chronic health condition or disability, and 7% of secondary school students report a long term chronic health condition or disability that impacts significantly on their activities or functioning.¹¹ During adolescence, chronic health conditions can often worsen due to disease progression or problems adolescents face around trying to comply with treatments and care. Adolescence is also a period in which young people are transitioned to adult health services from paediatric services, and many young people find these transitions difficult and challenging.

Health services can do a lot to help and support young people with chronic health conditions and/or disabilities.² At present there is substantial variation in the level of support for young people with chronic illness and/or disability nationally.¹² Providing better support to young people with chronic illness can improve their immediate wellbeing, and enhance long-term health outcomes. Young people with chronic illness and/or disability, who are well supported through the adolescent period, are more empowered to look after themselves, have better relationships with health care clinicians, are more able to access appropriate medical care, and have better engagement with services.^{13,14}

Appendix F.

YOUTH HEALTH

REFERENCES

1. Ministry of Health, *New Zealand Youth Health Status Report*. Ministry of Health: Wellington. 2002.
2. Bagshaw S. Breaking down barriers and supporting our young people to flourish: Making best practice standard practice in youth health. *Children*. 2012; 82:29-31.
3. Denny S et al, Foregone healthcare among high school students in New Zealand. *Journal of Primary Health Care*, (Accepted April 26th 2012).
4. Tylee A et al., Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet*. 2007. 369(9572): p. 1565-73.
5. Brindis C.D et al., School-based health centers: accessibility and accountability. *J Adolesc Health*. 2003. 32(6 Suppl): p. 98-107.
6. Kaplan DW et al., Managed care and school-based health centers. Use of health services. *Arch Pediatr Adolesc Med*. 1998. 152(1): p. 25-33.
7. Kisker EE, and Brown RS, Do school-based health centers improve adolescents' access to health care, health status, and risk-taking behavior? *J Adolesc Health*. 1996. 18(5): p. 335-43.
8. Juszczak L, Melinkovich P, and Kaplan D, Use of health and mental health services by adolescents across multiple delivery sites. *J Adolesc Health*. 2003. 32(6 Suppl): p. 108-18.
9. Denny S et al., Association between availability and quality of health services in schools and reproductive health outcomes among students: a multilevel observational study. *American Journal of Public Health*. 2012. 102:e14-e29.
10. Robinson WL, Harper GW, and Schoeny ME, Reducing Substance Use Among African American Adolescents: Effectiveness of School-Based Health Centers. *Clinical Psychology: Science and Practice*. 2003. 10(4): p. 491-504.
11. de Silva M et al., Depressive symptoms and emotional wellbeing among high school students with long-term health problems or disabilities. *Journal of Adolescent Health* (submitted July 17th 2012).
12. IHC. Call to action: *What needs to be change for children and young people with disabilities and their families*. 2011.
13. Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Social Science and Medicine*. 2000;51:1611-1625.
14. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502.

COMPASS ACKNOWLEDGEMENTS

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Special thanks to Dr Amanda D'Souza and Donna Provoost for all their support and hard work.

Thank you also to all the staff at the Office of the Children's Commissioner: Audrey Barber, Rebecca Blaikie, Zoey Caldwell, Dr Justine Cornwall, Michelle Egan-Bitran, Sheryn Elborn, John Hancock, Jay Ikiua, Kirsten Le Harivel, William Leith, Anna Santos, Kirsten Sharman, Maggie Wear and Marlane Welsh-Sauni.