Schedule of

Child and Youth Health and Disability

Service Provision and Needs

prepared by the
Nelson Marlborough District Health Board's
Child and Youth Advocacy and Expert Reference Group

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INTRODUCTION

Preamble

At the end of 2001 Nelson Marlborough District Health Board sought nominations for a new committee entitled the *"Child and Youth Advocacy and Expert Reference Group"*. This group has been meeting regularly since February 2002.

A major focus of this group has been collecting information with regard to the needs of children and young people in the community, particularly with reference to the future development of child and youth health services. It is doing this to assist the District Health Board with planning and purchasing of services for the future, utilising evidence of need within the Nelson Marlborough region and evidence of efficacy based on available information.

The attached priority schedule contains an outline of the services currently funded and the group's understanding of the needs of our community to improve the health status of children and young people. Although the group has taken every effort to ensure that it is accurate and complete there will inevitably be some inaccuracies and omissions from this list. The Child and Youth Advocacy and Expert Reference Group (CYAERG) considers this to be 'work in progress' and will continue to update and revise with the input of others.

The lists of funded services exclude services funded by other sectors, e.g. education. However, some major determinants of child and youth health status lie outside of the health sector and thus improvements in this health status requires collaborative and cohesive working between sectors, particularly health, education and welfare services.

Health Needs

Increasingly we are aware that, as lifelong health "trajectories" are established early in life, achieving good child health is vital for later adult health. The NM Health Needs Assessment completed in Oct 2001 notes some information about child and youth health status in the region. In general health status for NM is better or the same as the national picture with the same general areas of concern In addition, some issues of particular concern in this region were mentioned.

Ministry of Health information from 2000/01indicates NM has low rates of admissions for pneumonia under 2 years, injuries 5-14 years, low birth weight, teenage pregnancy and ambulatory sensitive hospitalisations for children. Average rates are seen for most other conditions. Māori have higher rates of hospitalisation for most conditions than non-Māori. The level of inequality in health status is less than seen in many DHB's. Little information about geographical inequalities of health status across the region has been available.

NZ Deprivation Index groups 1-7 are over represented in the region compared with the country as a whole contributing to the relatively good health status. It must also be remembered that the current quality and efficiency of existing services also contributes to current health status. Extreme care should be taken before changing services to ensure the good aspects are retained.

While every effort has been made to base this schedule on evidence, for many issues little detailed evidence exists. A key priority is improving the quantity and quality of evidence available. **The group is very keen to have feedback from the community on the accuracy and issues discussed in this schedule.**

NMDHB Plans

NMDHB's Strategic Plan notes that to address the improvement of health and wellbeing of the people of this region through promoting health and preventing illness and injury, that strategies that will particularly reach our children and young people will contribute to achieving the best outcomes.

NMDHB's particular priorities for improving health and wellbeing for people of all ages in the region are: reducing health inequalities; improving nutrition; increasing physical activity; reducing smoking; reducing the incidence and impact of diabetes; improving oral health; improving mental health; and increasing independence

for people with disabilities. There are particular concerns about Māori health in all these key areas. Consideration also needs to be given to the particular needs of Pacific Island communities, new migrants (such as refugees) and international students at the region's colleges.

The NMDHB Annual Plan 2003/04 reflects the Strategic Plan. In addition to the general strategies, such as quality improvement initiatives, and "business as usual", the annual plan includes several initiatives which will particularly enhance services for children and youth in the region:
[Note: these only include specific strategies that refer to children and youth. There are many other initiatives that will have an impact on children, e.g. Maori Health development, Public Health Services.]

Increase the understanding of the wider determinants of health:
- Identification and commencement of a specific intersectoral project applicable to participants in Talking Heads to improve childhood nutrition and increase physical activity.
- Continue participation in the "Strengthening Families" initiative.
- Continuing to monitor all personal health and population health funding going into schools to ensure delivery of services is consistent with the health promoting schools framework.

Improve the understanding of the factors contributing to the health status inequalities experienced by Māori and people from lower socio-economic groups and work toward reducing these.
- Support the PHOs to develop Māori Health Plans and monitor the implementation of the providers' Māori Health Plans.
- Work to improve access to primary care for Māori and people from low socio-economic groups through the PHOs services to improve access.
- Health promotion and health protection actions as detailed in NMDHB's Public Health Service Plan, for example:
    - Continue to work with the Marlborough community to develop initiatives that improve the literacy of the community.
    - Māori health promoting schools programme in Motueka.
    - Review the utilisation of child development Early Intervention Services by Māori.

Work with the primary providers to implement the Government's Primary Care strategy
- Encourage the development of evidence based health education opportunities for young people.

Advance the implementation of the National Immunisation Register and the meningococcal B vaccination programme
NIR:
- Implementation group will continue to provide advice on the NIR
- Project Manager will work with the Project Sponsor and Implementation group to develop and implement the district NIR Implementation plan
- Establish Provider Liaison role and undertake training of providers
- Provide support and training for Maternity providers
- Establish register infrastructure, staff, equipment and processes to run NIR
- Develop a NIR communications plan.
- Prepare for an Implementation Review

Meningococcal vaccine programme:
- Project Manager will work with local primary health care providers to develop a plan for the co-ordination of the local Meningococcal vaccine programme.

Improve nutrition
- Retain (in Wairau) and achieve (in Nelson) Baby Friendly Hospital status.
- Continue to seek inclusion of non-Plunket infant welfare providers in the national data- base of breast feeding information.
- Evaluate the Food with Attitude pilot programme in Marlborough and modify the programme accordingly.
- Health promotion and health protection actions as detailed in NMDHB's Public Health Service Plan, for example working with Health Promoting schools around improving nutrition through nutrition policies and effective health education.

- Continue to support DHB staff to act as "health ambassadors" in the wider community by role modelling healthy life style choices, for example by exploring the expansion of health promoting hospitals/healthy workplace concepts beyond smokefree to include nutrition and physical activity.
- Continue to fund a post-discharge specialist service to promote and support breastfeeding.
- Continue to fund the Motueka Family Centre to provide a healthy lifestyle programme.

Increase physical activity
- With Sport Marlborough, pilot a physical activity/nutrition programme for inactive/overweight children in a low decile school.
- Continue to work with Sport Tasman on the pilot Green Prescription scheme for children in Nelson.

Reduce smoking and harm from second-hand smoke
- Provide cessation services for pregnant women and parents of children admitted to hospital.
- Utilise the media and work with local personalities, particularly those respected by young people, to role model and promote positive messages on being smokefree

Improve oral health
- Continue to promote and encourage the uptake of fluoride.
- Participate in the review of the School Dental Service Facilities to be conducted by the Ministry of Health.
- Review the value of providing the free toothpaste and brush with the 5 months immunisation, and investigate the feasibility of the DHB funding this.
- School dental service to more actively target children at high risk of tooth decay.
- Review the value of and options for early enrolment (for infants) with the school dental service.

Reduce the incidence and impact of diabetes
- Contribute to funding "carer support" for parents of high personal health and support need children, including those with diabetes where they meet the criteria.

Improve mental health
Implement services using the new "blueprint" funding. Services priorities for NMDHB include:
- Child and Youth Senior Medical (0.5 FTE)

Increase independence for people with a life long disability
- Through the Needs Assessment Service Co-ordination Agency participate in providing a service for students in transition from school to the workforce.
- Work with other Government and NGOs agencies to develop and implement a standard approach to access and provision of carer support for families who have children with a high level of need for support.

Achieve optimal outcomes for patients/clients through "evidence-based practice", including proper use of measurement and statistics
- Explore establishment of a Child and Youth Mortality Review Committee

Provider Division specific strategies:
- Continue move to greater integration of all child and youth services including regional Paediatric service with outreach service at Wairau.
- Continue implementation of family violence/child abuse prevention strategies

Reading this CYAERG report

This year, each issue or service gap has been given a priority based on the matrix below. The Matrix has been developed from the key objectives from within the NZ Health Strategy and aims to look at the importance of addressing a particular issue for the community as a whole. In considering importance, items such as the evidence base that suggests an intervention will be successful have been considered.

Risk Matrix for Assessing Need for Service Realignment or Initiation of New Services

The matrix offers a way to combine a number of variables to establish an overall priority for any item suggested affecting the health or wellbeing of the whole community or groups of individuals.

Items included:-

1. **Number of individuals affected** – map against correct column of matrix using epidemiological background information.

2. **Potential change of consequences** – use the following pathway to map against correct **row** of matrix by obtaining a total score or between 0 and 25

3. **Danger of the event considered – Grade 1 – 5** one for minor problem to five for lethal or disabling.

4. **Probability of successful harm reduction Grade 1 – 5 considering :-**
   i) **Effectiveness** – using evidence based information
   ii) **Sustainability** – can initiative be continued over time
   iii) **Affordability** – are dollars required in keeping with benefits
   iv) **Acceptability** – will community support the intervention
   v) **Reduction of inequalities** – preference given to initiatives which will reduce inequities

The overall score for "**Potential change of consequences"** ***is reached by multiplying a) by b) to obtain a number between 0 and 25. This number then determines the row to map against.*** *The comment on the row should be in keeping with most likely impact of the intervention considered.*

Example:

Fluoridation of Drinking Water

30% reduction in dental caries would follow. Most effective for the most disadvantaged. Any attempt likely to meet major community resistance. Good value for money save $88 for every dollar spent.

What priority should be given to advocate for funding to work towards fluoridation - How do we grade it?

1) Number Affected? > 5000 whole population = **column 1**

2) a) Danger of Event ? Grade 1 – 5

Not life threatening but painful, costly, disfiguring = 3

2) b) Probability of Successful Harm Reduction ? Grade 1 – 5

Excellent effective intervention affordable, sustainable and will reduce inequalities but chances of getting it in place after much cost will remain slim = 2

Score = 3 X 2 = 6 = Row D

Final Score is D1 Moderate

Risk Matrix: Assessing Need for Service Realignment or Initiation of New Services

Number Affected

Potential Change of Consequence[1]

Potential Level of Benefit/Risk	Whole Population **➢ 10,000** 1	Large Subgroup of Population **1000–10,000** 2	Significant Group of Community **200 - 1000** 3	Small Group of Community affected **50 - 200** 4	Small numbers affected **0 - 50** 5	**Action Required**
Very high probability of major benefit or harm reduction. 20 - 25 A	**Critical** **A1**	**Critical** **A2**	**Critical** **A3**	**High** **A4**	**High** **A5**	**Critical** *Immediate risk justifies very urgent action to prevent avoidable mortality or morbidity*
High probability of significant benefit or harm reduction. 15 – 19 B	**Critical** **B1**	**High** **B2**	**High** **B3**	**Moderate** **B4**	**Low** **B5**	**High** *Action needed to prevent adverse outcomes a plan to address the issue should be developed urgently*
Likely to result in benefit or harm reduction. 10 – 14 C	**High** **C1**	**Moderate** **C2**	**Moderate** **C3**	**Low** **C4**	**Low** **C5**	**Moderate** *Planning should be considered as to how this issue can be addressed*
Likely level of benefit or harm reduction is small 5 – 9 D	**Moderate** **D1**	**Low** **D2**	**Low** **D3**	**Negligible** **D4**	**Negligible** **D5**	**Low** *Future interventions might consider addressing this issue*
Minor reduction in harm possible. 0 – 4 E	**Low** **E1**	**Negligible** **E2**	**Negligible** **E3**	**Negligible** **E4**	**Negligible** **E5**	**Negligible** *Little evidence to support intervention or alteration of existing systems*

[1] Potential Change of Consequence = (Danger of Event) X (Probability of Successful Harm Reduction)

The effectiveness, sustainability, affordability and acceptability of the planned intervention determine the probability of successful harm reduction. Preference should be given to initiatives, which are likely to reduce inequalities.

Following the assessment according to the matrix, the group has used a judgement call to advice the NMDHB on the priorities for action. These priorities have been graded:

- ***Gap*** – where extra resourcing is needed in an area;
- ***Realignment*** – where a realignment of services or review of current purchasing and service delivery systems may result in improved health outcomes.
- ***Satisfactory*** – although the item discussed may be considered as a high priority the group has considered that current endeavours to solve the issues are adequate.
- ***Work in progress*** – where the group acknowledges that new initiatives have taken place recently and time needs to be allowed to see how these achieve the desired goals before any clear recommendation can be made.

Readers of this report should therefore focus on those items where the priority for action is a gap or realignment, and that within these groups the highest priorities are those where the matrix indicates a very high level of need. The gap and realignment categories are shaded to assist the reader.

Planning and Funding Overview/Consultative Processes

Overview

The DHB is required by legislation to investigate, assess and monitor the health status and needs of its population and to have participative processes in place to involve the community in health improvement and planning for provision of services. The Child and Youth Advocacy and Expert Reference Group (CYAERG) is one of many new committees that were created with the formation of the District Health Board to assist in fulfilling these requirements.

Current Services

The CYAERG was established in February 2002 to advise the Board and its Committees on child and youth matters. Fifteen other DHBs have similar groups or are contemplating their establishment.

Planning and funding of services for children and youth is managed by the NMDHB Planning Funding and Population Health team, particularly the Personal Health Manager and the Mental Health Manager. Services are provided by a variety of NGO and private providers as well as the NMDHB.

DHB funding is now population-based, with the exception of disability services. The NMDHB funds all health services for the NM region with the exception of maternity services, population health services and disability services for those under 65 years and national contracts such as Plunket.

Evidence/Issues

Resources for research and epidemiology are limited and, while the Health Needs Assessment reports (2001 and draft 2004) give some information, the collection and monitoring of health status information needs to be ongoing rather than a snapshot. To enable appropriate targeting of resources and assessment of gaps, accurate information is needed about:

- inequalities in health status between different parts of the region, ethnicities, and across ages and seasons;
- clients of and services provided by other organisations such as territorial local authorities, Child Youth and Family, Police and ACC. There are a number of initiatives underway (e.g. Ministry of Social Development, nationally, and Talking Heads, regionally) that will contribute to a better understanding of the overall community;
- levels of wellness and service delivery within PHOs;
- the impact on health status of the community of children and young people as a result of the investment in the Primary Health Care Strategy, e.g. increased subsidies have allowed free services from general practitioners for under 5s and reduced co-payments for those under 18.

Information from the 2004 updated Health Needs Assessment Report is used in this report where relevant.

Youth health is a significant concern in NZ. Young people are the only group in our population who have not had significant improvements in mortality and morbidity statistics over the last 15 years. The Ministry of Health has released a Youth Health Action Plan which advises providers of health services how they should approach the challenges of developing youth health services. A key step in addressing these challenges is involving young people in the assessment and development of services that we hope they will use. This route has been shown to remove barriers to accessing care and to improved quality of service delivery. It is therefore very important that some system is set up to consult with young people in the NM region. There could be substantial benefits to funders of DHB services, the PHO, all providers of services and, not least, to young people themselves. If youth forums were to occur, then it is important the MSD guidelines on consulting with young people are followed.

We expect to see increasing numbers/proportions of young families (particularly lower socio-economic groups) living outside the main urban centres due to high costs of living (especially housing). This presents the NMDHB with a particular challenge of decentralising services, including consideration of the potential for mobile services.

Needs/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
1. Planning & consultative processes			
a) Set up good systems for obtaining health information	A1 – Critical	Accurate up-to-date health needs assessment which reports on important health indicators from primary and secondary care and offers sub-regional, regional and national comparisons. Ways on improving data availability and quality though collaboration with expert groups to develop a sustainable service should be considered.	Gap
b) Set up good systems for information gathering	A1 – Critical	Develop good inter-relationships across committees, groups, community services to support information flow	Work in Progress
c) Link to DHB Advisory committee and funding division.	A1 – Critical	CYAERG will report three monthly to Community and Public Health Advisory Committee with gap reports and letters to others as needed.	Satisfactory
d) Link to Iwi Health Board	B3 – High	Holistic approach to Māori needs.	Work in Progress
e) Accurate data collection and coding across DHB– including ethnicity data collection and increasing linkages with primary health care.	C1 – High	The activity of the hospital is in part monitored by the coding of notes on discharge. This is a time consuming and difficult task but it is vital that this is done accurately and in a timely fashion for the purposes of planning and funding. Issues around the accuracy of ethnicity coding are a particular concern. Data linkages with primary health care could help improve data accuracy.	Some Work in Progress, but links with primary health care = Gap
f) Youth involvement in service planning and development	B1 – Critical	Youth Health Advocacy position in Marlborough is vacant and may be disestablished. Health Action funded for youth health services in Nelson. It is suggested that Youth forums be held regularly, perhaps in conjunction with the PHOs in order to hear directly from youth/rangatahi, using the guidelines.	Gap

Māori Health

Overview

There continue to be inequalities in health status between Māori and non-Māori in the NM region, although these differences are probably less than in many other District Health Boards. It is vital that Māori families are empowered to access appropriate services. This can be achieved by having a good range of Kaupapa Māori services and ensuring mainstream providers are appropriate for Māori. To reduce inequalities in health status, more information about current levels of inequality is needed which requires accurate collection of ethnicity data and detailed information about disease state rates.

Māori issues have been woven into many other sections of this schedule. The CYAERG hopes that an opportunity will arise for a joint meeting with the Iwi Health Board will arise so that this section of the report can be further developed.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Whakatu Marae – Whanau Ora (Nelson)	Holistic across the age range and whanau focussed health service delivery.	$156,839
Te Korowai Trust - Whanau Ora (Stoke)	Holistic across the age range; whanau focussed.	[$156,839]
Maata Waka – Mokopuna Toiora	Service focussed on provision of support, advice and health checks to pregnant women, 0-14year old tamariki and their whanau.	[$142,341]
Te Hauora O Ngati Rarua Ltd - Whanau Ora (Marlborough)	Holistic across the age range; whanau focussed. Includes hui on specific health needs & services delivered to individual/whanau as appropriate. Strength in disease management services	[$153,763]
Te Rapuora O Te Waiharekeke Trust – Whanau Ora (Marlborough)	Holistic across the age range; whanau focussed. Includes hui on specific health needs, & services delivered to individual and whanau as appropriate.	[$154,517]
Te Awhina Marae (He Makatea Hauora - Motueka) – Whanau Ora	Holistic across the age range; whanau focussed. Includes hui on specific health needs, & services delivered to individual and whanau as appropriate.	[$70,000]
Poumanawa Oranga (funded by MoH PHD)	Kia Piki Community Development programme – taitamariki Māori (Youth Suicide Prevention, mental health awareness, access to services)	$147,224
Poumanawa Oranga (funded by MoH PHD)	Māori health promotion training for health promoters to work in injury prevention, mental health/alcohol, auahi kore/asthma/hearing loss	[$157,930]

Evidence/Issues

The latest Health Needs Assessment report 2004 (draft) section on child and youth raises some significant questions about appropriate access of Māori children and young people to services and the accuracy of ethnicity data collection. This is particularly striking for childhood injury admissions and primary preventable hospitalisations. In some areas of care however, Māori children are substantially over-represented compared to non-Māori – especially for teenage pregnancy rates, hearing test failure rates and rates of dental caries.

It is vital that Māori families are empowered to access appropriate services. A key step is knowledge of what services are available and other barriers to care may include cost, convenience and cultural appropriateness. Every effort must be made to remove these barriers. A particular target should be ensuring that main stream providers are appropriate for Māori to use given that, in a community of this size, Kaupapa Māori services are not available for all facets of care. Uptake of antenatal care and Well Child care can be improved by similarly removing barriers to care and developing appropriate services.

In an attempt to improve the availability of care to Māori two Pukenga Hauora workers have been appointed to support Māori families who use hospital inpatient services.

Needs/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
2. Improve Access/Reduce Barriers to Health Care for Māori		***Iwi Health Board, Poumanawa Oranga***	
a) Increase knowledge of services available	C2		Work in Progress
b) Address issues of cost/relative deprivation	B2	Support to access care. e.g. through PHO Consider location of services to improve access	Work in Progress
c) Ensure appropriate services: • Kaupapa Māori services • Mainstream providers culturally appropriate		Considerable progress in recent years, e.g. extension of whanau ora services. Recent appointment of Pukenga Hauora, within secondary services	Work in Progress Work in Progress
3. Particular Health Issues for Māori			
a) Pre-conception and Maternal Health	**A3 – critical**	See page 12	Realignment
b) Well Child/Tamariki Ora 0-5 years	**A2 – critical**	See page 15	Work in Progress
c) Mental Health		See page 34	
d) Access for Māori to developmental services	A5 – Moderate	See page 42	Gap
e) Integrated Māori and Pacific Island specialist services for psychiatric problems	C3	See page 36	
f) Youth Health: smoking, teenage pregnancy, access to counselling			Work in Progress?
g) Dental Health		See page 24	Work in Progress?
h) Hearing test failures rate	**B3 – High**	Consider project work to address[2]. Issues may include non-attendance at early childhood education.	Gap
i) Mental health promotion	**B1 – Critical**	Promoting mental well-being for whanau see page 34	Gap

[2] Full access to Well Child services, support with smoking cessation and other whanau ora activities can support such project work.

Maternal and Infant Health

Overview

Maternal health throughout pregnancy has a profound impact on the health of the unborn child and later the infant. The antenatal period offers an excellent opportunity for health advice and guidance. This guidance is delivered by lead maternity carers who are now mostly midwives and through antenatal educational programmes, offered individually or in a group setting.

Important issues include regular access to health care, reduction of smoking in pregnancy, improved nutrition for mothers especially folic acid intake, encouraging high rates of intention to breastfeed and supporting women in minimising the harmful impacts of drug and alcohol usage. Good coverage of quality antenatal care can achieve these goals. Antenatal care should be the first step in an unbroken chain of well-child care for infants.

Service Funding

Maternity services are funded by the Ministry of Health.

CONTRACT & PROVIDER	SERVICE DESCRIPTION	VALUE
Independent and NMDHB midwives, GPs (Lead Maternity Carers)	Ministry of Health funded	
NMDHB Pregnancy and Parenting Education	Courses and support for expectant parents	$47,181
Motueka District Parents Centre Pregnancy and Parenting Education	Courses and support for expectant parents	$5,231
NMDHB Maternity Facility - Fee for labour, delivery & postnatal - rural	Approximately 105 deliveries, 153 postnatal stays	Funded as rural service lump sum
NMDHB Maternity Facility - Fee for labour, delivery & postnatal – Wairau Hosp.	Funded for 470 deliveries ($425,131) *{ $904 / infant}* 450 postnatal stays (610,563) *{ $1356 / infant}*	$1,035,694
NMDHB Maternity Facility - Fee for labour, delivery & postnatal - Nelson Hosp.	Funded for 951 deliveries ($644,060) *{ $677 / infant}* 835 postnatal stays ($848,240) *{ $1015 / infant}*	$1,492,300
NMDHB Secondary Maternity		$2,056,227
NMDHB Lactation Clinic		$12,000
NMDHB Neonatal home care	1,307	$64,923
NMDHB Neonatal inpatients (DRGs)	480 (Tertiary neonatal services in Wellington - see Tertiary Services, page 45)	$1,378,464

Evidence/Issues

The number of births in this region has fallen over the last 12 years. The average number of births per annum 1997-2002 is 1492 (Marlb – 460, Nsn/Tas – 1031). Currently the number of births funded is about 1526.

Over the last 20 years, the proportion of infants being born with low birthweight has shown a slight increase. Infants may be of low birth weight because of prematuriy or being small for gestational age. The proportion of infants born prematurely has increased significantly (47%), while the number small for gestational age has reduced by 45%. These are national trends that are duplicated in NM. The proportion of infants born prematurely has a significant impact on the need for special care baby unit services.

Breastfeeding Support

Breastfeeding networks and support groups exist in Nelson and Blenheim to advocate and share information on breastfeeding and plan education and training. The majority of breastfeeding support is provided in the primary health care sector using the expertise of Lead Maternity Carers, Well Child providers, practice nurses and general practitioners. Secondary care, specialist lactation services can offer clinics and provide support for population health, pre-primary, primary and secondary health care sectors. The clinics should receive referrals from the primary care sector, seeing clients who continue to have difficulties with lactation, despite appropriate support. The group considers it important that these specialist lactation clinics do not act as a primary care service, they should function as a referral-only service to support primary care. The other role of these specialist services is supporting the sectors with advice and training. The Blenheim based service operates from

the hospital maternity services, 8 hours per week. A similar but smaller service existed in Nelson until recently but at the time of writing it has ceased to function pending the outcome of contracting negotiations.

Wairau hospital maternity services are to be congratulated on obtaining Baby Friendly Hospital status (BFHI). Nelson has not yet achieved this goal, reinstating a functional specialist lactation consultation service will be crucial if Nelson is to obtain and sustain Baby Friendly Hospital status (BFHI).

Appropriate Antenatal Care and Education for All

There is concern that antenatal education may not be reaching those who have the most to gain. In order that all pregnant women are able to access appropriate antenatal care and education, it is important that these services are delivered in a variety of ways that allow for cultural, social and geographical diversity. Particular attention needs to be given to ensure that appropriate antenatal education and care, is easily accessed by women who may not be comfortable accessing traditional antenatal services. For instance those services provided in a group setting provided to mothers and fathers to be. This issue is particularly a problem for women who are single, young or Māori. The development of various formats to meet the needs of all members of the community needs to be supported. An additional benefit exists if strong peer support groups can develop which may persist after the birth of the child and act to support parenting.

Needs/Gaps

Collaborative networking groups are in place: Breastfeeding Network (Nsn), Breastfeeding Support Group (Blm), and Maternity Standards Group

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
4. Preconception and Maternal Health			
a) Education: smoking, alcohol, drugs, folate, general health	C1 - High	These issues need special attention in the way information is provided by skilled health professionals, including LMCs and in group classes.	Realignment
b) Comprehensive ante-natal care with high levels of service coverage	A4 - High	Examine alternatives services to reach younger mothers, single mothers, Māori mothers, mothers suffering from socio-economic deprivation and rural isolation	Realignment
5. Breastfeeding Support			
a) GP Information link to PHOs	C3 – Moderate	In consultation draft phase.	Work in Progress
b) Training well child providers	C3– Moderate	Now happening through the Well-Child Steering Group – Needs support of secondary care lactation services	Work in Progress
c) Specialist Lactation Consultant Services	B4 – Moderate	Support for individual women in clinics and support and education for service providers. Blenheim – 8 hrs a week Nelson – 2 hrs a week	Gap - Nelson
6. Maternity Services			
a) Identification and Support for at-risk Families	A4 - High	Should now develop through facilitation of Family Violence Co-ordination	Work in Progress

Well Child 0-18 years

Overview

Well Child/Tamariki Ora care for children 0-5 years is a well-defined service all children are entitled to receive. Not all children receive the services and many of those most at risk miss out. Constant efforts to increase service coverage are required. New Well Child/Tamariki Ora contracts are putting an increased emphasis on reaching families living in NZDep areas 8-10. The focus of Well Child/Tamariki Ora care is keeping children well, with processes involving clinical assessment and screening, health protection, health education, and family whanau support.

There is no clear schedule of services and competencies required for provision of services to those aged 5–18 in stark contrast to Well Child/Tamariki Ora services for 0-5 year olds,. The Health and Physical Education Curriculum together with the Health Promoting Schools initiative provides a framework for well child care for school age children. It is increasingly recognised that young people need health services delivered in a way that is easily accessible to themselves. In many parts of NZ this has been achieved by the development of youth health one-stop-shops. Similar services re in the initial stages of development with The Hub in Nelson. A major challenge remains the delivery of services to young people in more isolated and rural locations.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Plunket	MOH contract, recent increase in services to NZDep 8-10	
He Matapuna Ora Trust - Family Start services (Nelson urban area only) [1]	Targeted services working with at risk families with their children in the first 5 years of life. Funded intersectorally.	$881,611
South Link Health. Covering General Practitioner and Practice Nurse - General Practitioners and Practice Nurse	In well child, GPs are involved in child immunisation and have a specific well child schedule in their generic contract. Practice Nurse funding is channelled through South Link Health and GPs. All practices except those in Richmond (excluding one) provide free services to under 6 year olds. (very hard to separate well child component from sick child under 6 care)	[$6,349,000] (estimate)
NMDHB Public Health • Public Health Nurses - Well Child 0-5yrs in Rural areas; School Health Services (5-18yrs). • Vision and Hearing Testing • Health Promotion	Assessment and referral services, for school age children - Case Management, Immunisation at Form 1, Adolescent clinics and self referral clinics, BCG vaccinations for at risk neo-nates, Catch-up immunisation programmes (MoH Personal Health funded)	[$695,973]
Nelson Tasman Youth Health Network Trust - Adolescent Health Service	Allocated funding for services to improve access to and health service delivery for youth. (Contract ceases 30 Dec 2004 – funding to be reallocated)	$25,000
Robyn Beckingsale - Primary Health Care Nurse Liaison	Coordination of service delivery between various providers in primary care sector – e.g. practice nurse newsletter, advancing govt initiatives around diabetes, asthma, child health etc.	[$20,000]
Nelson GP Health Services (funded by MoH Public Health Directorate)	Immunisation co-ordination service	$48,000
Marlborough GP Network (funded by MoH PHD)	Immunisation co-ordination service	$42,000
NMDHB Public Health Services	Well Child promotion (immunisation, parenting, oral health, Youth Health Advocate, literacy)	$88,978 (tbc)
NMDHB Public Health Services	Health Promoting Schools, Healthy Communities. Māori Health Promoting Schools.	[$316,620] $36,666 (tbc)
NMDHB Public Health Services	Health Protection services, including early childhood centre reports for licensing; communicable diseases; Māori environmental health	

1. Family Start services:

- provide holistic support and a conduit to care for families who most need it before a new baby is born and can continue until the child is 5 years old if necessary.
- Each family has a support worker who provides a home-based service, encompassing health, education and welfare goals.
- At October 2004 were working with 195 families. Most referrals from LMCs (41%).
- Are currently being evaluated at a national level. Nelson is one of 4 sites where detailed information is being gathered. Report due August 2003.
- Service only available in Nelson/Richmond urban area.

Evidence / Issues

Well Child/Tamariki Ora services are quite complicated and involve multiple providers who should all be working together as a single team. The formation of Well Child Steering Groups in both Nelson and Blenheim has been a major leap forward, supporting the organisation, training, and networking of these groups. Some difficulties in information sharing and transfers of care persist between providers for instance a significant number of children miss out of their first well child visit because of delayed or defective hand over by lead maternity carers. It is very pleasing to see increasing capacity for the delivery of well child care by Maori providers eg Te Korowia Trust and Maata Waka – Mokopuna Toiora developing.

Ensuring appropriate high levels of immunisation coverage in NZ remains a significant challenge. The meningococcal vaccination campaign has led to the development of a national immunisation register (NIR). This register will not only support high levels of meningococcal vaccination, but also all other vaccinations. Children born in the region from the last quarter of 2005 will be included in the NIR. Considerable work is required over 2005 to ensure that the implementation of the NIR can occur smoothly together with the large task of offering 3 doses of meningococcal vaccine to every child between the ages of 6 months and their 20th birthday. Project teams is being established to achieve these goals. The delivery of meningococcal vaccination may offer opportunities for additional health promotion.

Immunisation is a one key element of Well Child/Tamariki Ora care. All other elements of Well Child/ Tamariki Ora care could benefit from having an adequate information system to ensure that we know who our children are, where they are, and what they have had and haven't had in the way of services. Without such a system we will continue having relatively poor levels of coverage and wastage of effort as many providers of Well Child/Tamariki Ora services are seeking the same family. The Immunisation co-ordinators have made a significant contribution through training for providers, following up 'hard to reach' children and information/education.

High costs of housing has led to an increasing number of young families, particularly those of lower socio-economic status, moving away from the main urban centres. This presents NMDHB with a number of challenges, as the families represent a high-risk group and should have the easiest access to support services. Unfortunately many support services do not reach these rural districts, e.g. GP services may only be available on a small number of days each week if at all, organisations such as Homebuilders and Open Home Foundation may not be available, the Family Start Service is rationed to a small central geographical area and transport difficulties and cost mean that travel to a central urban area for care is impractical. The basic Well Child Care 0-5 years is offered in these areas usually delivered by Public Health Nurses. The group most at risk of missing out are those who require extra services or are in the age group 5-18 years where a formal framework for Well Child services does not exist.

For children and young people 5-18 yrs school is the logical focus for activities to improve health status. Efforts such as the development of school sexual health services are a positive move. Further school-based health services need to be considered.

The education sector has developed a health curriculum, which should underpin much of school functioning. Implementation of this is extremely variable. In some schools the health curriculum is given low priority as opposed to as what is seen as important academic subjects and there is an ongoing shortage of teachers equipped to deliver the health curriculum. The NMDHB Public Health Service offers a health promoting schools programme, which provides a holistic framework under which schools can address specific problems. Within this framework there are opportunities for specific programmes to go into schools to address specific subjects such as sun safety, drugs and alcohol, mental health problems, the use of peer educators and free counselling programmes. The delivery of these sorts of services is extremely variable across the region. Also health professionals must not attempt to become teachers (a role they are neither experienced nor formally trained in) but should support teachers in the delivery of a health message.

The prevalence of vision impairment and the availability of and need for support to enable children to have appropriate glasses is not certain. Some further investigation of this is warranted.

Issues/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
7. **Well Child/Tamariki Ora 0-5 years**		***Well Child Steering Groups, Nsn & Blm***	
a) Co-ordination/collaboration of services	B3 – High	Nelson and Blenheim groups meetings in tandem monthly	Satisfactory
b) Provision of Well Child services in a variety of ways.	B3 – High	Well Child/Tamariki Ora Services need to be delivered in a way that allows everyone access new initiatives in this area need to be given time to take effect.	Work in Progress
c) Well-Child/Tamariki Ora Information System Implementation of National Immunisation Register (NIR)	A2 – Critical	Project team forming Dec 2004. Funding would be needed for additional schedules to be added to the register.	Work in Progress
d) Consistent access to Family Start	B3 – High	Encourage roll out of Family Start to whole region	Gap
8. **Well Child/Tamariki Ora, 5-18 years**		***Health Promoting Schools***	
a) Define universal entitlement to well child care and ensure good coverage.	C2 – Moderate	Develop clear schedule of services and competencies required for provision of services 5–18; including a guide to the multiple providers involved.	Gap (MoH role?)
b) Health curriculum fully taught to Year 11 and offered and available to Year 12 & 13	B2 – High	Support schools to improve on current variable implementation.	Gap
c) Health Promoting Schools – e.g. drug/alcohol, mental health, mental health peer educators, counselling	B2 – Moderate		Satisfactory
d) Develop principles of best practice for health workers working with schools	C3 – Moderate	Need to promote the MoH Guidelines “Guidelines for School-based Healthcare, 2004” and Ministry of Youth Development “Strengthening Drug Education in School Communities - Best Practice Handbook for schools, 2004”. Nelson Public Health has developed local guidelines.	Work in Progress

Primary Care

Overview

NMDHB believes that as many people as possible should receive their health services within the primary sector and it is within the primary sector that much of the activity required to achieve the Board's strategic goals, including health improvement and reducing inequalities, will need to happen. Key strategies to achieve this involve removing barriers to care and ensuring the community are aware of available services.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Family Planning	(See Sexual Health)	
Independent Nursing Practice	(See Sexual Health)	
St Johns		
South Link Health. Covering General Practitioner and Practice Nurse - General Practitioners and Practice Nurse (See also Well-child care)	GPs are involved in child immunisation, diabetes annual plan checks, and have a specific well child schedule in their generic contract. In addition South Link Health members can access additional funding and services in a range of areas, including: 'Health Activities, 'Palliative Care', 'Rural Allowance' and 'Green Prescriptions' . Practice Nurse funding is channelled through South Link Health and GPs. All practices except 1 provide free services to under 6 year olds.	[$6,349,000] (estimate)
NMDHB Public Health Services - Pre-School (i.e. Plunket type services in Rural areas) and School Health Services (5-18). (See also Well Child care)	For both services this includes as relevant: Assessment and referral services, Case Management, Immunisation at Form 1 (where currently provided), Adolescent clinics and self referral clinics (where currently provided), Catch-up immunisation programmes (MoH Personal Health funded)	$675,443
Nelson/Tasman/Marlborough Pharmacists - Pharmacy services	Pharmacists are contracted to dispense and provide information and advice on items prescribed. NB cost of pharmaceuticals is additional to this cost of service.	Approx. [$7,000,000]
Nelson Diagnostic Laboratories (Nelson) – Community Laboratories	Medical Practitioner referred laboratory services	[$3,329,000] (total incl. C&Y)
Robyn Beckingsale - Primary Health Care Nurse Liaison	Coordination of service delivery between various providers in primary care sector, focus on practice nurse issues with newsletter, focus on forwarding of govt initiatives around diabetes, asthma, child health etc.	[$20,000]
Te Korowai Trust – Reducing Inequalities Funding	Co-ordination of service delivery with Nelson GPs to improve access for members.	[$48,888]

This table of funded services excludes:

- most NMDHB provider arm services
- services held nationally or by other DHBs e.g. Family Planning, St John's
- pharmaceuticals
- services funded by other sectors, e.g. education.
- SPARC funding for the 'green prescription' scheme for children with other related illnesses, such as diabetes.

Evidence / Issues

A key goal of the NZ Primary Health Care strategy is development of Primary Health Organisations (PHOs) which have a strong focus on offering pro-active services to improve the health status of their enrolled population rather than being reactive to disease states. These changes require a dramatic culture shift within some portions of the health sector. The current model for the implementation of the Primary Health Care Strategy is on PHOs based around an existing structure of independent practitioner associations. It is crucial, as PHOs develop, that all elements responsible for primary health care are included.

An early benefit from PHOs in the NM region has been the capping of fees for 6-17 years olds to $23.00 and an increase in prescription subsidies for this same age group. In the majority of general practices, [excluding …,] children under the age of 6 are provided with free services during normal working hours.

Unfortunately families who seek general practice services outside of normal working hours are likely to face significant costs. Services such as the new HealthLine offer families advice to assist them to know that if they seek primary health care, that they are doing do appropriately. Because of the increasing costs of out-of-hours care, the number of children and young people seeking care within the emergency department of Nelson and Wairau hospitals has increased significantly.

Young people need to be aware of the benefits of accessing general practice and some degree of marketing general practice is also required. If young people do attend primary health care it is important that they do not suffer an experience which makes them unlikely to ever return. Primary health care can be made more youth friendly through appropriate education and training. The MOH Youth Health Action Plan provides a framework for the development of youth health services.

In some areas of NZ, PHOs are appointing child and youth health co-ordinators to specifically work across the primary health care sector. To ensure integration and co-ordination of services, together with developing appropriate systems for in service education of providers and support information for children, young people and their families. As the PHOs develop, it would be very important that they look at successful models of child an youth health service delivery already in place across NZ.

Issues/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
9. Access to Primary Care (children)			
a) List of GPs taking new patients	A3 – Critical	In place, published on DHB website	Satisfactory
b) Reduce financial barriers to care	B2 – High	Ensure PHO Initiatives to reduce barriers to care are applicable to children and young people, e.g. Care Plus	Work in Progress
10. Access to youth-friendly Primary Care (youth)		Consider parameters of cost, comfort, confidentiality and youth friendliness, including evaluation of this by youth. Consider appropriate location, e.g. school-bases clinics.	
a) Nelson	B2 – High	***The Hub Mgt Group & YOSS[3] Co-ordinator – Nsn*** The Youth One-Stop-Shop provides a limited service, primarily to youth at risk. No DHB funding as yet.	Realignment
b) Marlborough	B2 – High	No specific services	Gap
c) Rural areas – access difficulties, some schools have health clinics	B2 – High	Support rural school health clinics	Work in Progress
d) Reduce barriers to care	B2 – High	Financial, geographical, knowledge and cultural (including culture of youth)	Gap
e) General practice marketing	C2 – Moderate	Youth Health Network Trust project – Teen Health website and training for general practice.	Satisfactory (in Nsn) Gap (Marlb)
11. PHO Development			
Co-ordination of child and youth health services	B2 – High	Consideration of appointment of child and youth health co-ordinators	Gap

[3] YOSS = Youth One Stop Shop

Strategic Priority Health Issues

Overview

NMDHB has four physical health issue priorities identified in its Strategic Plan, which are: Smoking, Oral Health, Diabetes, Physical Activity/Nutrition.

Service Funding

CONTRACT & PROVIDER	SERVICE DESCRIPTION	VALUE
Most Nelson/Tasman Dentists and 2 Marlborough Dentists – Adolescent Dental Services	Annual check and treatment for adolescents less than 18 years old and not eligible for school dental services (finishing end of form 2). Both School and non-school adolescents eligible. In a minority of instances dentists are on an older contract which focuses on service provision to school attenders.	Approx. $700,000
NMDHB - Adolescent Dental Services	Annual check and treatment for adolescents less than 18 years old and not eligible for school dental services (finishing end of form 2). NMDHB provides this service out of its Wairau hospital site for most of Marlborough. For emergency treatment prior to this point adolescents can see NMDHB, the Picton Dental Surgery or 2 other Blenheim private dentists.	Approx $160,800
NMDHB - School Dental Services	Free dental services to school children from 2.5 yrs up to year 8.	$1,408,076
NMDHB - Public Health	Oral Health promotion, Health Promoting Schools, Māori Health Promoting Schools (see WellChild) Reducing harm from tobacco use Nutrition and Physical Activity;	(tbc) [$112,368] [$175,951]
Te Awhina Marae (He Makatea Hauora, Motueka) – Disease management	Maori Mobile Nursing Disease State Management contract, focussing on Diabetes/Respiratory/Cardiovascular disease.	[$87,865]
Whakatu Marae (Nelson) and Te Hauora O Ngati Rarua (Marlborough)) – Community Diabetes services	Services focussed on improving access of Maori to mainstream diabetes services, diabetes, education focussed on behaviour change.	[$16,736]
Regional Diabetes Team	Advise on co-ordination of diabetes services across Nelson and Marlborough.	[$9,000.00]
NMDHB Provider Division Medical Services - Community Diabetes Services	Services focussed on providing education and advice to people with diabetes in the community and linking them into appropriate services	[$19,000.00]
Hannifin & Gruys (funded by MoH PHD)	Convenience advertising - X-Smoker (secondary schools)	[$61,200]Nsn
Motueka Family Service Centre - Healthy Lifestyles programme	Working with low income families set plans to encourage improved nutrition, physical activity, quit smoking etc.	$5,000

Excludes:

- Hospital dental services which include services for children/young people needing significant dental work under general anaesthetic.
- Rangatahi mai: funded by Sealord – aimed at getting young Māori into physical activity.
- Sport Tasman

Evidence/Issues

Oral Health:

The commonest disease in our children is dental caries. About 50% of children in Nelson Marlborough have some degree of dental caries by their 5th birthday. NM has a slightly higher percentage than NZ as a whole and a slightly higher dmf[4] score among these 5 year olds (NM = 2.19; NZ = 1.95). (2001 data from School dental service review report 2004).

Twelve year old children in NM had 1.3 teeth missing or filled compared with 1.6 for NZ. Around 44% of 12 year olds here are caries free, compared with the NZ average of 43%. (HNA – 1999 data from SDS)- *can we update this information?*

This is slightly higher than the national average but relatively good for an area where there is no fluoride in the drinking water. International studies have demonstrated that fluoridation of drinking water is a safe an effective

[4] dmf = decayed missing and filled teeth in 5 year old children; DMF = decayed missing and filled teeth in year 8 children

way of reducing the rate of dental caries in all age groups and in New Zealand the rate of dental caries in children can be reduced by approximately 30% by the fluoridation of drinking water. Only children living at Woodbourne Military Camp received fluoridated drinking water in Nelson Marlborough.

Toothbrush packs have been given to children of Community Service Card holders, at their 5 month immunisation, in this region for some time. This has been seen as a successful health promotion initiative linking two key events on the well child health schedule. This initiative is currently funded from the Ministry of Health via the Public Health Service. Children whose parents do not hold a community service card are currently missing out on this service. Additional funding would be needed if all children were to be allowed to benefit from this service.

Over the last year there has been significant investment in child and adolescent dental health promotion with the appointment of new adolescent oral health co-ordinators, with a particular focus on reducing the number of children who fail to transition from the school dental service to private dentists funded under the general dental benefit. Unfortunately, with the systems used to record information about this aspect of care, it is currently not possible to access accurate coverage data. For example, ethnicity data is missing from HealthPAC dataset 59% of the time. The same data suggests that 60% of adolescents may be enrolled in the General Dental Benefit.

Smoking:
Rates of smoking in NM are lower than the national average (although only slightly lower for youth). Average smoking rate of 15-19 year olds: NM = 22.5%, NZ = 23.4 (1996) (HNA) The 2003 ASH study found NM rates of smoking among year 10 students to be 15.1% for boys and 20.2% for girls. NM Year 10 students ranked third lowest smoking prevalence among 21 DHBs. (2004 draft HNA)

In Nelson Marlborough, smoking rates for all groups are lower than the NZ average, although Tasman District has a higher percentage of 14-15 year olds smoking than the NZ average in both years surveyed. (HNA 2001 – quoting ASH survey)

A major concern is rates of smoking in pregnancy – up to 30% of non-Māori and 60% of Māori. Smoking in pregnancy has a profound effect on the growing foetus as blood supply to the baby is impaired and various poisons are transferred across the placenta. The result is an infant who is smaller, more likely to be born prematurely and by the age of 10 will have a lower I.Q. than peers who did not smoke inside the womb. Health status through the early years such as cot death, incidence of glue ear and pneumonia are dramatically increased in children who live in a smoking environment. There is a need to ensure appropriate referral to cessation services for pregnant women who smoke.

Physical Activity/Nutrition/Obesity
These are arguably the most important issue affecting future health status and cost of health care in the region. Bringing about the changes in lifestyles required is extremely difficult and requires co-ordinated work across many sectors.

Young people in this region are more active than young people throughout NZ and this is especially true for boys (88% are active compared with 74% nationally. (Girls NM 67% ; NZ 64%). (HNA – from Hilary Commission Survey). A particular concern is a dramatic reduction in levels of physical activity between the ages of 13 and 17 years (NZ Youth Health Status Report). There is a lack of region-specific obesity data, but a 2003 Marlborough survey of 11 year olds, 7% were found to be obese and a total of 30% were overweight or obese. It has been recognised that the growing epidemic of obesity in NZ may best be addressed by interventions in childhood and adolescence.

The Healthy Eating – Healthy Action Implementation Plan 2004 – 2010 (MOH 2004) offers a pathway to develop local initiatives. It is recommended that this plan be used locally. Across the Nelson Marlborough region there has been a dramatic increase in initiatives which include: Food with Attitude, Marlborough; Eat and Move 2B Fit, Nelson; pilot Green Prescription Project, Nelson; Action for Healthy Children, regional; Regional Physical Activity Plan, regional; and work from local authorities such as cycling and pedestrian strategies. Early indications suggest an increasing awareness of the need for physical activity and appropriate nutrition in childhood but evidence would suggest that changing these lifestyle factors will require continuing,

dedicated effort. Considerable effort and resourcing from public health, SPARC, Local Government, Ministry of Education and NGOs such as the Heart Foundation is put into promoting physical activity. At present similar levels of effort are not occurring with regard to the promotion and support of healthy eating with expert guidance and training for health staff and others. NMDHB, possibly via the PHO, should be urgently considering investment in this area as well as supporting the physical activity initiatives of others.

The HeHa recommends strong collaboration between groups. In Nelson the PANT (Physical Activity and Nutrition Team) can hopefully achieve this but no similar group exists in Marlborough. Community dietetics services can support nutrition improvement in the community and, in addition, have other benefits such as dental health and maternal health.

Diabetes
There are 32 children with Type 1 (juvenile onset) diabetes in NM under 14 years, which is not a condition that can be prevented by healthy lifestyles. Co-ordinated care is offered by paediatric services, supported by diabetes nurse educators and dietitians. Individual support from a psychologist within Paediatric Services is not available (see Secondary Care section). There is concern that the onset of Type 2 diabetes is increasingly being seen in younger people, linked to increasing rates of obesity and lack of physical activity, and this has significant health implications for the longer term.

Needs/Gaps

Collaborative networking group in place: Regional Dental Health Project Team; Smokefree Project Teams, Nsn & Blm; Physical Activity & Nutrition Team (PANT)

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
12. Dental Health			
a) Provide toothbrushes to pre-schoolers at 5 month immunisation.	C2 – Moderate	Funding needed to deliver to all children. Current funds from Public Health only allow Community Services card holders to receive this service.	Gap
b) GP guidelines and other resources	C2 – Moderate	Need continued updating, distribution and restocking supported by inservcie educaiton.	Satisfactory
c) Explore options for school age children increasing service coverage and promotion	B2 – High	Pre-school Oral Health Promoter appointed 2004. School Dental Service Facilities Review underway.	Work in Progress
d) Transfer to Adolescent Dental Services	B2 – High	Adolescent Dental Services Co-ordinators appointed early 2004.	Work in Progress
e) Continue pre-school initiatives	B2 – High	A pre-school dental health promoter is working to ensure that children in this age group enrol with the dental service and are aware of the need to brush their teeth, eat healthily and apply fluoride toothpaste.	Satisfactory
f) IT system for dental health service	B2 – High	The school dental service does not have an information technology system. This means tracking children and supporting enrolment and delivering appropriate care is made more difficult.	Gap
g) Increase the uptake of fluoride: • Promote fluoride toothpaste • fluoridation of drinking water	 B2 – High D1 – Moderate	Fluoridation of water supplies is a cost effective intervention and can reduce inequalities, but levels of community resistance are considered in this scoring priority.	Work in Progress
13. Smoke-free Lifestyle			
a) Prevention of Smoking – school age	C1 – High	Ministry of Youth Development guidelines to be implemented (see page 17).	Work in Progress
b) Cessation for youth	D2 – Low	An alarming number of children and young people in our region have started to smoke. When they wish to stop, it is important that appropriate programmes are available to support them. Evidence of benefit for population based smoking cessation programmes for young people is somewhat limited. NRT is not available to those <18 years.	Gap

c) GP to promote supporting parents in stopping smoking	B1 – Critical	Working well in some areas, not all. Explore LMC taking up; LMC training; PHO	Gap
d) Smoking cessation in pregnancy	B2 – High	Specially targeted smoking cessation programmes could be offered in pregnancy.	Gap
14. Nutrition and Physical Activity			
a) Promote healthy lifestyles • increased physical activity • improve nutrition	C2 – Moderate	The promoting of healthy life styles for school aged children requires collaboration between the health and education sector. With childhood obesity reaching epidemic levels, these issues are of rapidly increasing importance. The PANT has re-formed and is becoming more active. Considerable activity now focussed on these issues. PANT has established a Childhood Obesity sub-group	Work in Progress (see initiative above)
b) Community Dietetic Service	C1 – High	Community endeavours to improve nutrition need a sound base with dietitian support for group work and targeted individuals in primary health care.	Gap
c) Green Prescription pilot for children	B3 – Moderate	SPARC funding – started as referrals only from secondary health care for children with chronic disease but wider referral base now being accepted as the pilot is rolled out further	Work in Progress

Ambulatory-Sensitive and Population-Preventable Hospitalisation

Overview

Avoidable hospitalisations are divided into those preventable by appropriate management in primary care (ambulatory-sensitive) and those that are preventable by population level intervention strategies.

Earlier sections of this report, describe ways that access to primary health care can be improved and systems of delivery of well child care. These strategies represent fundamental ways of reducing ambulatory-sensitive and population-preventable hospital discharges. This section of the report focuses on disease-specific intervention that are in place or could be considered.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Nelson Asthma Society Inc. – Community Based Asthma Services	Focus on working with people with Asthma to develop Asthma plans.	[$73,889.81] [$62,867]
NMDHB Public Health Service - Asthma Plus	Community service to reach 'hard to reach' asthmatics in Marlborough	[$7,500]
Other asthma contracts in Marlb????		
Road Safety Co-ordinator		
NMDHB - Public Health	Injury prevention	[$161,558]
PHO – health promotion funding		

Evidence/Issues

Ambulatory sensitive admissions are those potentially preventable by appropriate primary care (including outpatient services) and are often used as an indicator of access to and effectiveness of primary services. Such admissions of particular importance to children and young people are: asthma, gastroenteritis, immunisation preventable diseases, ENT infections, rheumatic fever, dental conditions, ruptured appendix, cellulitis and failure to thrive.

Population preventable hospitalisations are used to measure the effectiveness of public health approaches to disease prevention (excluding accident prevention). They cover a range of conditions of particular relevance to adult health (e.g. oral, skin, lung and colorectal cancer, alcohol related conditions, ischaemic heart disease), although a limited number of these conditions (e.g. TB, HIV/AIDS, nutrition, dental) are also of relevance to children and young people. *(need to clarify this section!)*

In the NM region, ambulatory sensitive admission rates for children and young people are consistently lower than the NZ average. Rates for population preventable admissions for children and young people are similar to or slightly higher than the NZ average.[5]

For NZ as a whole, rates of ambulatory sensitive admission and population preventable admissions rates are consistently and significantly higher for Māori children and young people than for NZ Europeans. In NM, however, it is striking that rates of ambulatory sensitive discharges are remarkably similar for both Māori and NZ European children and young people. While superficially this may suggest equality in effectiveness and access to primary health care, other explanations should be considered, such as undercounting of children of Māori ethnicity in hospital discharge data or a difficulty in Māori children and young people accessing inpatient hospital care. Further analysis of this apparent anomaly in NM should be considered.

Asthma

Over the last 14 years there has been a dramatic reduction in asthma admissions to hospital for both children and young people. NM started with 14 year period with a significantly lower hospital admission rate for

[5] Six leading causes of ambulatory sensitive admissions:
Six leading causes of population preventable hospital admissions

asthma than the rest of NZ. Despite this, hospital admission rates for asthma have continued to decline and continue to remain substantially below the rest of NZ. For instance in the year 2002-03, 1.9 children under the age of 14 were admitted per 1000 of the population for asthma in NM whereas 5 children/1000 were admitted on average for the rest of NZ.

Effective organisation of primary health care services, including asthma preventative services and widespread education would seem to be contributing factors. These efforts are now driven in two project teams, the Special Nelson Asthma Project (SNAP) and the Special Marlborough Asthma Project (SMAP). These teams ensure co-ordination of care between pre-primary, primary and secondary health care through regular team meetings and adequate funding of asthma educators.

An innovative project in Nelson has been called Asthma Plus, which is aimed at supporting families and individuals in managing their asthma. In addition to asthma support the work sets out to address other factors which may predispose to hospital admission, such as poor access to primary health care, inability to fund prescriptions, poor housing social chaos and smoking.

Injury Prevention

Outside the perinatal period, injury is the leading cause of mortality for children and young people, with death due to motor vehicles being the single largest injury-related cause of death in this age group. Over the last 14 years, injury-related admission rates for children 0-14 years have been consistently lower than for NZ as a whole, while injury rates for young people 15-24 have been similar to the NZ average. Injury-related admission rates for Maori young people between 0 and 24 years have been particularly low in the NM region, with figures consistently less than the admission rates for NZ European. The converse of this situation exists for NZ as a whole. This trend, once again, would bear further careful consideration as it could reflect undercounting of Māori children and young people in hospital discharge data.

The major intervention that are likely to result in a reduction in injury result in environmental change, such as cycle helmets, swimming pool fencing or car safety restraints. To retain the benefits of these interventions as well as other interventions, requires ongoing Public Health activity. These require effective collaborative relationships across many sectors. To target these interventions appropriately, good injury surveillance data needs to be collected and be available to preventative services and to the community as a whole in a timely manner.

Needs/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
15. Asthma		***Special Nelson Asthma Project (SNAP), Special Marlborough Asthma Project (SMAP)***	
a) Ongoing SNAP/SMAP work	B2	Roll out spacer usage to community, ongoing education, training and support	Satisfactory
b) Asthma Holistic Support Service, • Nelson = Asthma Plus • Blenheim =?	W	Recently additional services have been provided with the formation of holistic support services in Nelson and Blenheim.	Satisfactory
16. Injury prevention			***Kidsafe Coalitions***
a) Collaborative work	B1 - Critical	Involving Health Promotion, ACC, and service providers with relationships across the entire community and all sectors	Work in Progress
b) Obtain timely, accurate injury-related data	C1 – High	With sufficient detail to allow targeting of interventions and responsiveness to community needs and trends.	Gap
17. Other Diseases			
a) Cross-sectoral work to reduce ambulatory sensitive and population preventable conditions.	B2 0 High	Collaborative work between PHO, Public Health and Secondary Health Care needs to develop further to address specific conditions with the development of care pathways eg gastro-enteritis, ear conditions	Gap

Sexual Health

Overview

Sexual health services aim to reduce the harmful impacts of sexuality. These impacts can include unwanted pregnancy, sexually transmitted infections and sexual assault.

Services are very variable across the region with good access in urban centres but services elsewhere are sporadic.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Nelson Independent Nursing Services [1]	Maternity, Family Support, Contraceptive, Pregnancy Testing, Termination Counselling/Contraceptive assessment and consultation/ sexual health services and advice to adolescents Sexuality education in schools: Provider is funded through Nelson Tasman Youth Health Trust for this service	$133,450
Nelson Tasman Youth Health Network Trust – Adolescent Health Service	Allocated funding for services to improve access to and health service delivery for youth. (see also Primary Care) – To be terminated 31/12/04 and funding reallocated.	$25,000
Motueka Family Service Centre - Family Planning and Sexual Health Services	Service provided in conjunction with Te Awhina marae and at this site. Includes weekly service at Motueka High School.	$16,213
NMDHB Public Health Services - Sexual Health Services: STI clinics [2]		[$206,701]
NMDHB Public Health Services	Sexual health promotion	$90,858 (tbc)
Hannifin & Gruys (funded by MoH PHD)	Convenience advertising - Sexual health service on contraceptive awareness and information	$44,543

1. Similar services are provided in Motueka by the Public Health Nurse (NMDHB), in Golden Bay by the GPs and in Marlborough by the Family Planning Association.
2. In addition to the clinics in Nelson and Blenheim, free services provided by the GPs in Picton, Motueka and Takaka are being established.

Evidence/Issues

For young people to access sexual health services, cost should not be a barrier, they should feel comfortable with the service provider (which frequently means a provider of the same sex), and must feel secure in their confidentiality. No particular sort of service works for all young people and it is important that an appropriate portfolio of services is developed across our region. Services have recently become available based at the Hub Youth One Stop Shop in Nelson and a number of school based sexual health clinics have opened. There continues to be some difficulties particularly in rural communities with access to services and a recent survey in relation to the emergency contraceptive pill (ECP) has indicated some training gaps and access difficulties.

High teenage pregnancy rates across NZ are a concern as young maternal age is associated with a number of adverse outcomes for both mother and baby. Accurate information about termination of pregnancy rates for the NM region is not available, but if rates here reflect the national trend, for every teenage birth there is one termination of pregnancy.

Teenage birth rates in the NM region over the last 12 years have been consistently less than the rate for NZ as a whole. The NZ rate has gradually declined over the last 10 years, although the declining trend is less clear for NM. The fertility rate for Māori women between 15-19 years of age is 54.2 live births per 1000 women per year, compared for 16.4 for NZ European women in the same age group. Some of this trend is likely to represent personal choice to have children early or to delay pregnancy to a later age. Information to fully interpret the health impacts of this trend is not available.

Needs/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
18. Sexual Health		***Sexual Health Project Team, Nsn.***	
a) Sexual health services in youth- friendly environment	C1 – High	Comfort, cost, and confidence as parameters for services	Realignment
b) Access to care	C1 – High	PHO initiatives to improve access	Realignment
c) Address needs for rural youth using different models	C2 – Moderate	?outreach from YOSS ?school based services ?mobile services	Work in Progress
d) Improve access to the ECP	B2 – High	Collaboration between health and education sector and multiple routes of access with minimal barriers.	Work in Progress

Secondary Care

Overview

Inpatient services are offered in both Nelson and Wairau hospitals. Child in Nelson are admitted to a dedicated, fully equipped children's facility that rarely has any adult inpatients. Attached to this facility are appropriate facilities for resident parents as well as play and recreation facilities. In Blenheim, children are admitted to a facility that sits alongside the maternity facility, which is frequently shared with adult inpatients. In both hospitals children in these units are cared for by the admitting consultant from any of the secondary care specialities. Children under the care of paediatricians make up approximately half of admissions to these units. A proportion of inpatient days for children are considered preventable by appropriate interventions in the community.

Paediatric Medical Workload

	Nelson	Wairau	Total (Actual)	Funded
Inpatient Admissions				
• Acute	450	176	626	650
• Elective	18	3	21	0
• **Total**	468	179	647	650
Outpatient Attendances				
• First	453	342	795	920
• Subsequent	1671	648	2319	2170
• **Total**	2124	990	3114	3090

From the Contract Status Report June 2004

The differences in frequency of assessment between the two centres for new and follow up outpatients reflect different models of care. Further exploration of how these differences arise could be of benefit for both units.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Nelson Region Hospice Trust - Palliative Care	Includes Assessment/Co-ordination/Information services; Domiciliary, Inpatient, Carer Relief and Bereavement Counselling and Support	[$655,170]
Salvation Army	Inpatient Hospice – Blenheim	[$235,755]
NMDHB Provider division [to transfer to Salavation Army]	Community-based hospice services, Marlborough	
NMDHB - Paediatric Inpatients	Interdistrict flows - acute	$75,700
NMDHB - Paediatric Inpatients		$1,697,857
NMDHB - Paediatric Medical Outpatient (first attendance)		$163,434
NMDHB - Paediatric Medical Outpatient (Subsequent attendance)		$260,666
NMDHB - Paediatric community programme		$291,262

Evidence/Issues

Ongoing issues exist in Blenheim to secure the sustainability of the children's inpatient facility. These difficulties arise because bed occupancy does not offer critical mass for a sustainable unit. Site redevelopment needs to consider these issues and consider ways of concentrating child and youth expertise in a portion of the hospital. The new Health and Disability Sector Standards: Children and Young People Audit Workbook, (SNZHB 8134.4:2004) offers a range of solutions and suggestions for the appropriate development of child and youth services. The principles in this audit workbook should underpin the further development of child and youth secondary care services.

The needs of children and young people are fundamentally different from those of adults, the diseases they suffer are different as are their responses emotionally and physiologically. Nursing care for children and young people therefore requires specialist knowledge, skills and experience. Maintaining a skilled pool of nursing staff with appropriate child and youth skills can be particularly difficult in smaller districts such as NMDHB especially with the fragmentation of two base hospitals. A clear education strategy needs to be formulated to develop and maintain skills across inpatient, outpatient and community based services. DHBs who have appointed child and youth clinical nurse educators have been more successful at achieving these goals. (DHB Scorecard 2004 - PSNZ)

The development of the PHO offers new opportunities to remove barriers to accessing primary health care, to encourage support of children in the community rather than requiring secondary care hospital services. These pathways are as yet poorly developed and considerable work in this area is required in the coming year. (see Item 17 page 26)

Children who access secondary health care services can often benefit for care from a psychologist. A psychologist is important in completing detailed assessments such as assessment of brain injury or functioning and providing therapeutic interventions. Currently no psychologist support is available for children who do not meet the referral criteria for Child and Adolescent Mental Health Services or Tautoko Trust. This precludes early interventions in some children who do not yet have severe mental health problems, e.g. children with diabetes, cancer, autism, and families do not benefit from support with strategies to help them cope with difficult behaviours and the sequelae of chronic disease.

The model of care for children with cancer has gradually been changing in recent years as the tertiary service in Christchurch is expecting a greater proportion of care to occur in secondary centres. Increased resources have not accompanied this increased expectation. In addition the natural variation in case numbers recently has lead to a major increase in workload as a cluster of new oncology cases has arisen. These factors are placing the local children's oncology services under considerable pressure.

Children using hospital in this region do not have access the play therapy services. In many other part of NZ, including similar smaller centres, children do have access to such services. The advantages are multiple but include reducing duration of stay, reducing need for anaesthesia and sedation, enhancing wellbeing of children, reducing stress and supporting diagnostic processes. New regulations for the Ministry of Education are likely to increase the availability of these services through the provision of early childhood education in hospital. To fully exploit these changes work with be required. Ideally all child users of the hospitals should have access to play therapy services if this is to occur funding from the DHB will be required.

Needs/Gaps

Topic / Service	Matrix Priority	Status/Recommended Action	Priority for Action
19. Access to Secondary Care			
a) Sustainable Services • Nelson Hospital	A2 – Critical		Satisfactory
b) Sustainable Services ▪ Wairau Hospital	A2 – Critical	Wairau: Appropriate site redevelopment with co-location of services to support compliance with Child and Youth Audit Workbook[6]	Gap
c) Transport assistance from parts of the region to Hospital.	C3 – Moderate	Fair transport and accommodation policy	Gap
d) Explore options for outreach clinics	D3 – Low	e.g. consider reinstating Takaka Clinic	Realignment
e) Access to diagnostic and therapeutic psychologist support	B4 – Moderate	Some children who are clients of the paediatric services and child development services need access to services which should occur within child health services as a core component of care. (see also Extra Needs, p40).	Gap
f) Local Oncology Services	A5 – High	Review of caseload and models of care needed to cope with extra needs. Additional resources likely to be required	Gap
g) Access to specialist play therapy services h) Continuing professional development in child and youth nursing.	C3 – Moderate B2 – High	Explore options to link with early childhood education sector. Develop a service for all hospital users. Develop a child and youth training plan and appoint a clinical nurse educator.	Gap Gap

[6] Review of local and regional models of care for child and youth health services delivery may be required.

Mental Health

Planning for mental health services is also undertaken by Te Roopu Tupu Tahi, mental health advisory group to the NMDHB.

Overview

Mental health issues are increasingly recognised as contributing to reduced well being and poor outcomes for children and young people. The primary mental health sector, which might address mild and moderate levels of problems, is poorly defined. Child and Adolescent Mental Health Services (CAMHS) are a secondary care specialist service to assess, treat and support children and young people with serious mental health problems such as suicidal ideation, depression, anxiety, anorexia, and ADHD. The team consists of a wide range of mental health professionals who work together to provide a continuum of care for clients from crisis intervention, outpatient visits and inpatient options. They work closely with community agencies particularly Child Youth and Family and Group Special Education. When appropriate the Strengthening Families model of interagency collaboration is used to provide families and whanau a co-ordinated, accountable service acknowledging the Mental Health Standards.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Te Rapuora	Dedicated outpatient services for Māori consumers who are under 20 years of age.	
Ngati Koata - Kaupapa Maori Alcohol and Drug Services (*Rangatahi)*	Based in Nelson, this service runs an intensive rangatahi AOD programme for young males.	$69,105
Care Solutions - Child and Youth Planned Respite & Child and Youth Crisis Respite	Based in Nelson this service encompasses child and youth planned and crisis respite. Service provision across NMDHB service coverage area. (including workforce development)	$111,900
Horizon Trust – Child and Youth AOD Commmunity Services	Based in Blenheim this service encompasses alcohol and drug assessment and treatment services for people under age 20.	$185,000
Gateway Housing Trust Inc - Child and Youth Community Residential & Community Support Work (2 FTE)	Based in Nelson, this service encompasses dedicated services for consumers who are under the age of 20 years in a residential setting, and provision of youth community support services.	$301,677.75
Complex Need Clients Joint Funding Initiative (Personal, Disability, Mental)	For clients that have high and complex support needs that transverse personal health, disability and mental health funding. (1/3rd contribution).	
NMDHB Mental Health Services - Child and Young People Community Mental Health Teams (CAMHS)	Dedicated outpatient services for children up to and including 18 yrs old, provided by a specialist, multidisciplinary team, from a base facility and including some outreach clinics. Teams will be mobile for some work at other venues. 24 hour access.	$2,117,652
NMDHB Mental Health Services - Child and Youth Inpatient Beds	Inpatient assessment and treatment in a designated psychiatric ward or portion of a ward for consumers who are under the age of 19 and who are suffering from an acute mental disorder and who cannot be safely treated in an outpatient setting.	$431,178
NMDHB Mental Health Services	A&D Youth Worker	$83,494.00
NMDHB Mental Health Services - Child and Youth Day Activity	To assist young people with serious mental health problems and high support needs to improve their life skills, overcome social isolation and to meet their developmental, educational and pre-vocational needs.	$68,569
Kaupapa Maori Mental Health Services Tamariki and Rangatahi (1 FTE with Te Rapuora, Marlborough; 1 FTE under negotiation, possibly Nelson)	Clinical community-based comprehensive assessment, treatment, monitoring and support service for tamariki, rangatahi their whanau/parents in a Kaupapa Maori framework.	$69,105 $67,705
Health Action Trust (funded by MoH PHD)	Youth Mental Health Promotion CAYAD – Youth-based drug and alcohol programmes	$142,500
NMDHB Public Health	Alcohol and Drug harm reduction, health promotion	[$120,426]
NMDHB Public Health	Mental Health promotion	[$150,261]

Note: Contracting for Child and Youth Mental Health Service includes adult services for those up to l9 years. So some of the money in contracts pays for 17-19 years services not provided by CAMHS.

Evidence/Issues

There is a suggestion that there needs to be more emphasis on mental well-being from a positive perspective – assisting young people/tamariki/taitamariki to enjoy healthy mental status. There is some mental health promotion activity but it is limited, particularly for Māori.

Nelson Marlborough youth have access to the Mental Health Admissions Unit and there is a full time position of Adolescent care nurse within the unit. However, with the implementation of day hospital services, the number of bed nights spent by youth in the Mental Health Admission Unit has reduced by more than half over the last year.

Access to regional services has improved considerably and Nelson Marlborough youth are able to access the eating disorders and youth inpatient units more readily. A regional access formula is used and admissions are audited for appropriateness. Regional service support also takes the form of shared care through, utilising technology such as video links, and site visits from regional service staff.

Children and young people being raised by drug and alcohol users are triply disadvantaged. They are likely to be exposed in the womb to tobacco, alcohol or other substances that may lead to developmental and learning difficulties. They are raised by parents whose parenting styles are influenced by drugs and alcohol. Genetically they may be predisposed to drug and alcohol usage because of their parents history. This very high risk group of children and young people who need additional support.

The Life Matters Group, in Nelson, meets regularly and is successfully linking all of the various groups involved in working to prevent suicide. In light of local suicide statistics the group is now looking at suicide across all age groups. The role of Life Matters Group coordinator is currently being filled by the Nelson mental health promoter at the Public Health Service. One of the group's current initiatives is in its final stages of production – a guidance manual (and Secondary Suicide Prevention Coordinator) to formalise notification within the community following a sudden unexpected death to help reduce risk of copy cat suicides. The Youth Health Network Trust has put in some money to help fund this project.

There is recognised to be a strong link between cannabis use and youth mental health and a high level of community concern was evident among representatives of 50 organisations who attended a recent workshop on the issues.

Needs/Gaps

Collaborative networking groups in place: *Te Roopu Tupu Tahi; Liaison on Alcohol and Drugs (LOAD); Nelson/Tasman Liquor Liaison Group; Life Matters (Nelson) and a number of groups dealing with Youth Suicide issues*

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
20. Early Intervention			
a) Early intervention to reduce impact of parental mental illness on children	B4 – Moderate	High need group who are currently unnoticed until problems develop. Need for support programme (e.g. COPMI)	Gap
b) Early intervention for high risk children under 5 years to reduce the risks of developing mental health problems	C3 – Moderate	Work with existing support services (e.g. Family Start) to provide a secondary, intensive service in a group setting, where the need is identified (Attachment & Bonding disorders)	Gap
c) Māori mental health promotion	B1 – Critical.	Promoting mental well-being for whanau	Gap
d) Improved access to counselling for youth	B1 – Critical	Difficult for youth to access counselling for key issues such as relationship issues, mental health, sexual abuse.	Gap
21. Services for Mild to Moderate Mental Illness			
a) Primary mental health – create/enhance especially for rural districts	B1 – Critical	Support primary care services to develop greater capacity to provide for mental health issues, e.g. YOSS, PHO role, Health Curriculum, School guidance counsellors, GPs (both an early intervention and a 'secondary prevention' role.	Gap
b) Further exploration of Strengthening Families model of interagency collaboration for dual diagnosis (disability/mental health).	B4 – Moderate	Some work in progress with discretionary funding; high and complex needs. Also see item 26 (page 40).	Work in Progress
22. Services for Severe Mental Illness			
a) Alternatives to admission	A4 – High	Day hospital implemented.	Satisfactory
b) Access to appropriate inpatient care, including regional services	A5 – High	Christchurch has some spaces but not ideal due to geography. Specialised youth services available within the Mental Health Admissions Unit.	Satisfactory
c) Implement integrated Māori and Pacific Island Specialist services for psychiatric problems.	B5 – Low	A contract for working with mental health problems is operating in Marlborough and under negotiation Nelson. Will have MOU with CAMHS.	Work in Progress
d) Youth Offending	C5 – Low	Youth Offending Teams – National project on process for forensic reports on youth in the court system.	Satisfactory

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
e) Access to Child Psychiatry in Blenheim	B4 – Moderate	New 0.5 fte appointment from February 2004 – position now ongoing.	Satisfactory
23. Alcohol and Other Drug (AOD)			
a) Provision of effective, best practice models of youth health promotion, prevention and treatment, including: • Early intervention • Outpatient counselling • Day programmes • Respite care • Residential care • Liaison with other youth services	High – Moderate	More educational/early intervention work in the community so young people can make informed decisions and discuss issues in open environments. Concern about increasing workloads. Day programme available in Marlborough but not in Nelson/Tasman. Limited residential options for respite and treatment services.	Gaps
b) Increased support for Children of AOD clients	B3 – High	Significant population of these children, difficult group to reach, and have an impact on, unless you change their environment.	Gap
c) Facilitation of attendance at services for young people	B5 – Low	Consider role of: transport (often reliant on adults); linkages with support people; location of services	Gap
24. Youth Suicide			
a) Ensure all groups working toward youth well-being are inter-linking	C2	Many groups working in the area, collaboration could be improved.	Work in Progress
b) Secure funding for co-ordinator: • Ensure protocols working • Work with Ministry of Youth Affairs (MOYA) to get local implementation of strategy • Post-vention support • Information about rates	C2	Fund Co-ordinator for Life Matters Youth Health Network Trust funding ceases from Dec 2004. Manual completed for post-vention support.	Work in Progress
c) Kia Piki Te Ira O Te Taitamariki community development project	B2 – High	Regional contract working on community development including whanau, hapu, iwi development	Satisfactory

Family Violence/Child Protection

Overview

The DHB is required to implement the MOH Family Violence Intervention Guidelines to ensure a cohesive approach to family violence, which includes child abuse, partner abuse and elder abuse. It is increasingly realised that family violence contributes to many poor physical and mental health outcomes. Early detection, through routine screening, is encouraged as it is likely to reduce the toll on the individual and the cost to the health sector.

The James Whakaruru Report, the report into the deaths of the Kaplan sisters, Health and Disability Sector Standards (Children and Young People) Audit Workbook and a recent audit from the Auckland University of Technology lay down components of quality of care with regard to child abuse offering clear direction for service development in our region.

Service Funding

CONTRACT & PROVIDER	SERVICE DESCRIPTION	VALUE
NMDHB Provider Division	Child Abuse Co-ordination – 0.4 FTE Blenheim, 0.6 FTE Nelson.	$36,000

Evidence/Issues

In the period 1999-2001 five children between the ages of 0 – 14 died of assault in the NM region, this represents 12.5% of all child deaths and makes assault the third commonest cause of death for children aged 0-14. In the same time period, three children died of cot death, three died of cancer and two of medical conditions. The leading causes of death were perinatal factors and congenital anomalies. International studies would suggest that childhood death from assault represents the tip of a very substantial iceberg of adverse outcomes related to child abuse and family violence.

Following a gap report to the Hospital Advisory Committee from the CYAERG, two co-ordinators for family violence work across NMDHB were appointed in mid-2004. It has been agreed that, initially at least, 60% of their work would focus on child abuse. Key initiatives will involve improving DHB-wide management systems, implementing mandatory staff training, reviewing systems to establish at-risk registers, supporting the development of departmental protocols, and linkages with other organisation across the community, such as the Violence Intervention Networks, CYF and Police. Steering groups to support the development of this work and the co-ordinators have now been formed in both Nelson and Marlborough.

Sexual abuse assessment services for children and young people remain poorly developed across the region. Some funding is available from ACC and Police which covers the medical expenses of individual assessments. The DHB needs to provide additional support for these services to ensure they are sustainable. The demand for these services is, however, small and it is hoped that they can be supported within secondary services paediatric services. The workload does however need to be recognised and funded within the volumes of care offered by secondary care.

Needs/Gaps

Collaborative networking groups in place: *Violence Intervention Networks (VIN) – Nelson, Motueka, Blenheim*
Six Family Violence Trainers from amongst DHB staff have been trained by the MOH

Item / Issue	Matrix Priority	Status/Recommended Action	Priority for Action
25. Child Abuse /Family Violence			
a) Ensure pathways of care for victims of family violence, including child abuse, are optimised	A3 - Critical	Co-ordinators and Steering groups now in place – protocols for prevention, training and case management are being developed Relationships between all groups working in area are being developed	Work in progress
b) Secure sexual abuse services across region	A5 – High	Medical component of service funded by ACC/Police. Facilities, nursing time, liaison and clerical support require support from NMDHB.	Gap

Children and Youth with Extra Needs

Overview

A group of children and young people have needs substantially in excess of other children of the same age. The needs can arise because of disabilities, medically fragility, mental health problems or social disadvantage. Irrespective of the cause of these additional needs these children and young people have the right to receive additional support services. Often the extra needs are multiple and require extra support from the health, education and welfare sectors and it is easy for these services to become fragmented. The different services need to be co-ordinated otherwise considerable effort is required to develop service co-ordination for the individual. Close collaboration is necessary between the sectors.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Care Solutions	Carer Support	
Support Works	Needs Assessment and Service Co-ordination	
Early Intervention Services		
NMDHB Provider Division (MoH Disability funding)	Child Development Service	$243,000

Background/Evidence

The MOH service specification for child development services lists access to psychologist support as a core component of the service. In this region these services are not purchased. Children and families have no access to health funded psychologist support unless they suffer a severe mental illness and qualify for CAMHS or can access Tautoko Trust service because of intellectual disability. The result is a group of children and families without access to diagnostic and therapeutic psychologist services. Without these services some children with disabilities or major health problems such as pervasive developmental disorder or cancer are left without an appropriate diagnostic and supportive therapeutic service.

Children under 5 with developmental difficulties in 2 or more areas receive holistic support from the Early Intervention Team (EIT). The team relies on collaborative working between Health and Group Special Education (GSE). Strengths of the EIT have been access criteria based on need, active case management and family support.

School age children may receive additional funding from the Ongoing Resourcing Scheme (ORS) of the Ministry of Education, which provides teacher aid and therapy, services. Children who do not qualify can get extra educational support from their schools special education grant. Thresholds for qualifying for ORS funding are very variable when seen from a health need prospective. Recently considerable improvements in the co-ordination of therapy services for school age children have become possible as the GSE team and the health funded team have merged into a single entity so a regional team is developing.

Families who have children with extra need are, at times, placed in the position where they have to co-ordinate multiply agencies to deliver services to their child. As active case management is a principle of work within the EIT and CAMHS, this problem mostly arises for school age children with medical fragility or disability. Attention needs to be given to removing this service gap.

Specific systems for service co-ordination need to be considered at two levels:-

1) The role of 'integrated care co-ordinator' to ensure DHB services are offered in a co-ordinated fashion. Many of these children are under the care of multiple outpatient services and other services within the DHB, eg Paediatrics ENT, Orthopaedics, Eye, Support works. Communication between these services could be improved ensuring the timing and arrangement of appointments best meets the need of the child and seamless communication occurs between services. The goals being to increase support for families with reduced stress and improved efficiency of working for professionals. Underpinning the role of integrated care co-ordinator would be a need for good information systems to record key information and

allow service planning for the individual and groups of families with similar problems. Such systems were recommended in the

2) Every family with a high needs child also needs to have a nominated key worker who ensures active case management is occurring efficiently. For some children a family support social worker will need to be performing this work. At present he lack of active case management leads to the calling of Strengthening Families meetings, which, while extremely valuable at times, should not become a routine way of working because of the very high level of resources they consume.

The Implementation Plan - Autism Services Interdepartmental Working Group report with was produced in 1999 following the death of Casey Albury-Thomson clearly recommends the development of these sort of service co-ordination.

Carer support services for families is a particular area of concern and the CYAERG has presented a gap report on this issue to the CPHAC. Major issues relate to inequity of service delivery and inequity of needs assessment, which is frequently influenced by the diagnosis rather than the level of need. Over the last year, children with high personal health needs have gained access to DHB-funded carer support. Parents who have children who cannot easily be accommodated for respite care in the family homes of others, because of extreme medical fragility, challenging behaviours, or night time wakefulness often have substantial difficulty accessing care. Three beds are available through a MoH contract with the IHC in the Trolove Place house. It is not easy for families who live in Marlborough or Tasman to access these beds and increasingly this facility is full especially at weekends.

Behavioural problems require multi-disciplinary working between the health, education and welfare sectors. Frequently families have great difficulty receiving cohesive support as all three sectors may feel it is the role of one of the other sectors to address the needs. Clear interagency pathways for care need to be developed for a number of conditions including ADD, conduct disorder and the challenging toddler. There is good evidence to suggest that early interventions in the management of conduct disorder are far more cost effective than late interventions, which frequently result in high costs related to imprisonment and crime in individuals who are less productive members of society.

Needs/Gaps

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
26. Access to Support Services			
a) Delivery of planned and co-ordinated services by the DHB	A4 - High	Development of the role of integrated care co-ordinator to work with families who use multiple services and agencies	Gap
b) Information Systems for outpatient care around disability and medically complex cases	A3 – Critical	To allow care planning, facilitate service delivery and improve efficiency to the individual and groups with similar diagnoses	Gap
c) Active case management for all complex cases	A4 – High	Service Co-ordination - for families who use multiple agencies A key worker accessible to all families with the need	Gap – some services
d) Access for Māori to developmental services.	A5 – High	Maori are not using EIT services according to needs. Information has been requested from EIT re Māori clients.	Gap
e) Physiotherapy and occupational therapy for school age children (outside GSE criteria)	B4 – Moderate	Major advances have occurred in this area over the last year with the development of a joint developmental therapy team between GSE and NMDHB but a gap remains for some children	Work in Progress
f) Access to diagnostic and therapeutic psychologist support	B4 – Moderate	Some children who are clients of the paediatric services and child development services need access to services which should occur within child health services as a core component of care. (see also Secondary Care, p31)	Gap
27. Improve Support for Families			
a) Carer Support			
• One stop assessment shop	B4	Equitable assessment of need	Gap
• Good co-ordination of support for families	A4	A role of NASC or part of active case management	Gap
• Co-ordinated training for carers & education support workers	B4	Care Solutions?	Work in Progress
• Respite care for children who cannot be looked after in others family homes	A5	Three beds available for the entire region. Geographical access difficulties exist and bed numbers do not always meet the full needs of the community.	Gap
• Carer support for high personal health needs		In place. Review level of provision at appropriate intervals.	Work in progress
b) Family Support social worker for Early Intervention Clients, Nelson (community-	A4	New half time appointment of family support worker from	Work in Progress

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
based role supporting families)		CCS.	
28. Behavioural Problems			
a) Challenging toddler interagency pathway for care	C2	Some work started from VIN Nelson	Gap
b) Conduct disorder interagency pathway for care	B4	No one agency sees it as their role. Early interventions are most cost effective.	Gap
c) Attention Deficit Disorder care pathway	B4	Draft information sheet in circulation currently awaiting feedback from GSE.	Gap

Child Mortality

Overview

The national Child and Youth Mortality Review Committee has been established. Sophisticated systems to link data about individual fatalities are now in place and this data is now available to regional child and youth mortality committees. All deaths between the ages of 0 and 25 have data collected about them. Systems now need to be developed for local review of these fatalities, seeking preventable factors with the aim of preventing further mortality and morbidity.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE

Evidence/Issues

Plans for development of a local committee have recently been put before the Strengthening Families Management Committee and nominations have come forward from Police and CYF for this committee. It is hoped that in 2005 the first meeting of a Child and Youth Mortality Review Committee can take place. Adequate resources for appropriate administrative support will need to be found.

The number of deaths likely to need to be reviewed is about 18 per year.

Needs/Gaps

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
29. Child and Youth Mortality Review (regional)			
a) Set up some systems – pilot of regional committee	A3 – Critical		Work in Progress
b) Work with national group	A3– Critical		Work in Progress
c) Use to support CYAERG and Strengthening Families	A3– Critical	Also supports item 21	Work in Progress
d) Administrative support for the Local Committee	B2 – High	Needs to be found – level available from within existing resources is unlikely to meet needs	Gap

Tertiary Services

Overview

They are services that cannot be delivered within the Nelson Marlborough region by local staff. They are accessed as the children travel from Nelson Marlborough to tertiary hospitals for care or by specialists from tertiary hospitals coming to Nelson to provide clinics.

Service Funding

CONTRACT PROVIDER	SERVICE DESCRIPTION	VALUE
Travel and Accommodation Funding		
Oncology, Paediatric Surgery, Cardiology Intensive Care, Neonatal Intensive Care, Neurology, Genetics, Paediatric Urology		

Evidence

Tertiary services for children are very complicated. A variety of factors are impeding the development of tertiary services for children across the country. The Ministry of Health regards their further development as the responsibility of DHBs. DHBs major responsibility lies with their secondary care catchment area. Funding available to DHBs offering tertiary services is through a system of interregional flow and does not cover the full cost of offering tertiary services. The systems that are available for funding tertiary services are extremely complicated and vary from service to service.

A combination of these factors makes the further development of tertiary services for NZ's children somewhat uncertain and it is very difficult for a small DHB like Nelson Marlborough to have a substantial influence on the bigger picture. Compared to many other regions of NZ, children in NM are relatively lucky, accessing tertiary services from Christchurch, Wellington and Auckland as the needed to meet their requirements. Over the last year these services have improved further with the availability of paediatric cardiology clinics in the region.

The major gap for tertiary services in this region are for children with complex motor disabilities such as cerebral palsy as there is no single tertiary service that can fully meet these children's needs for a complex assessment (such as gate analysis, augmented communication, wheelchair and seating systems) and this results in fragmented care.

The travel and accommodation funding does not cover the full cost of travel to care. NMDHB therefore runs over budget and some families are being asked to cover some of the costs themselves. In other DHB's the full cost of these services are covered.

Needs/Gaps

Paediatric Services Review - South Island group

Item/issue	Matrix Priority	Status/Recommended Action	Priority for Action
30. Tertiary Services Provision			
a) Clarify funding for national services	B4 - Moderate	Lack of clear funding makes these services vulnerable. Future planning for sustainable services is limited.	Gap
b) Transport and accommodation	B4 - Moderate	Full cost not covered for families. Inconsistency in entitlements within New Zealand.	Gap