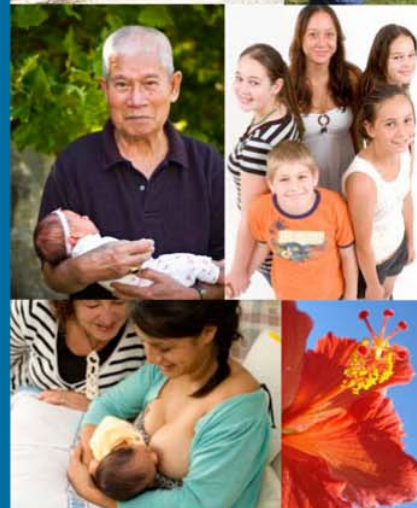




Child Health Improvement Plan 2012 – 2017





Mihi

E nga mana, e nga reo, e nga karangarangatanga tangata

Ko te Toka Tu Tahi o Tamaki Makaurau tenei

E mihi atu nei kia koutou,

Tena koutou, tena koutou, tena koutou katoa.

Ki o tatou tini mate, kua tangihia, kua mihia kua ea

Ratou, kia ratou, haere, haere, haere.

Ko tatou enei nga kanohi ora kia tatou

Ko tenei te kaupapa, Hauora Māori, o Te Toka Tu Mai

Hei huarahi puta, hei hapai tahi mo tatou

Hei oranga mo te katoa.

No reira tena koutou, tena koutou, tena tatou katoa.

To the authority, and the voices, of all people within the communities.

*This is the message from the Auckland and Waitemata District Health
Boards.*

We send greetings to you all.

*We acknowledge the spirituality and wisdom of those who have crossed
beyond the veil. We farewell them.*

*We of today who continue the aspirations of yesterday to ensure a healthy
tomorrow. Greetings.*

*Embarking on a journey through a pathway that requires your support to
ensure success for all.*

Greetings, greetings, greetings.

Auckland and Waitemata Child Health Improvement Plan 2012 – 2017

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Auckland and Waitemata Child Health Improvement Plan 2012 – 2017

Foreword

Auckland and Waitemata District Health Boards are committed to lifting the health of children in our districts. While many children in our city are growing up in an environment of safety and support, others experience significant deprivation, which limits their social, educational and physical potential. Deprivation is associated with lower life expectancy and poorer life chances that pass to the next generation.

The greatest number of children needing hospital treatment present with health problems that are associated with, and influenced by social and environmental factors. Children from poorer families are affected by poor health more frequently and more severely.

Five child health problems are the focus of our Northern Regional Health Services Plan 2012; Sudden Unexplained Death in Infancy (SUDI), Rheumatic Fever, skin sepsis, lower respiratory illness, and childhood injury.

Many of these conditions could have been prevented, or stopped from becoming serious, by appropriate health care in the community. Inequities between groups are also preventable. Poverty, maternal mental health, parental smoking, family diet and exercise, all challenge us to think broadly about solutions. We know, for example, that overcrowding and unhealthy housing contributes to unacceptable rates of diseases such as skin sepsis and Rheumatic Fever.

Improving child health requires us to work with other social services including Education, Housing, Auckland Council and the Ministry of Social Development (which includes Child, Youth and Family; Family and Community Services, and Work and Income). We need to work better across agencies including with providers in the non-governmental organisation (NGO) sector and with independent providers including General Practitioners and Lead Maternity Carers (LMCs).

As a health sector, we have to improve access to primary health care services¹ for all children – any time of the day, any day of the week. This includes provision of information so families know when they should get medical care for their child. Government wants community and hospital health services more closely linked to achieve "better, sooner, more convenient" care for patients. Integrated Family Health Centres and the Whānau Ora model of service make it possible to facilitate better health care for children. Having more General Practice and related primary health care in the community is a priority. At the same time we have increasing demands on health services, limited resources and

¹“Primary health care relates to the professional health care received in the community, usually from a General Practitioner or practice nurse. Primary health care covers a broad range of health and preventative services, including health education, counselling, disease prevention and screening.” (www.moh.govt.nz/primaryhealthcare) A range of other child health services are also delivered in the community notably by Well Child/Tamariki Ora nurses, by others such as nurse practitioners but also by family and whānau.

competition within health services for funding. This challenges us to make smarter choices about the services we invest in to achieve the greatest health gains for children.

The purpose of this ADHB and WDHB *Child Health Improvement Plan* is to focus our efforts over the five years to 2017. We will refer to this plan as we make prioritisation and funding decisions over the next five years.

To this end this plan presents two overarching actions for the DHBs:

- 1) The establishment of specific indicators and targets to measure progress towards the 5 goals.
- 2) The production of an annual Child Health Report which measures the DHBs' performance against the *Child Health Improvement Plan*.

We have adopted five key goals:

Goal 1: We will achieve equitable health outcomes for all populations.

Goal 2: Infants have the highest attainable standard of health and equity of life expectancy. Parents are confident, knowledgeable and supported to nurture.

Goal 3: Children have the highest attainable standard of health and are engaged in learning in Early Childhood Education (ECE) and the first school year.

Goal 4: Young people have the highest attainable standard of health and are engaged, resilient and poised to fulfil their potential.

Goal 5: The right people, working to the best standards of care, are supported by structures and systems that allow them to deliver the best health care to every child.

Nine Principles underpin this plan:

1. Children are our highest priority.
2. Children's best interests are paramount.
3. Children's rights must be upheld.
4. Children and family and whānau are at the centre of everything we do.
5. Inequity in health outcomes must be addressed.
6. The first years of life are the most important for future health.
7. Excellence in health care service delivery.
8. Our obligations under the Treaty of Waitangi of partnership, protection and participation.
9. Families actively engage with health services

We will lead child health in New Zealand and, over time, help return New Zealand to a place of health status excellence relative to other OECD countries. To do this we must work with the many and various child health stakeholders. Most importantly, we must listen to the voices of our children and their families and whānau.

This plan is ambitious. Its success lies beyond the direct control of the DHB, most importantly with: Primary Health Care, Lead Maternity Carers, NGOs, and sectors such as Housing and Social Development. We will work closely with these partners to achieve health gains for all our children. Monitoring and reviewing performance against targets will tell us if we are making a difference.ⁱⁱ

This plan sets out the necessary elements that will lift the health of Auckland and Waitemata children.



Richard Aickin FRACP FACEM
Director of Child Health, ADHB
On behalf of the ADHB Child
Healthcare Service Group
Auckland District Health Board



Tim Jelleyman MB CHB FRACP
Head of Division (Medical), Child Women
and Family Services, WDHB
On behalf of the Waitemata DHB Child
Health Services

ⁱⁱ Health Equity Assessment Tools and a Whānau Ora lens will be applied as we operationalise this plan. A Results Based Accountability Framework will also be used.

The Context for the Child Health Improvement Plan

Introduction

Healthy children through healthy whānau, families, and communities.

Healthy children are a priority for the Auckland and Waitemata District Health Boards. Health and well being for children encompasses physical health (taha tinana); spiritual health (taha wairua); family health (taha whānau), and; mental health (taha hinengaro).

This plan is our strategy for improving the health and well being of children living in the Auckland and Waitemata districts. We focus on child health through to adolescence with the first three years of life being particularly important for long term good health.

There are five goals that guide our activities in implementing the plan:

Goal 1: We will achieve equitable health outcomes for all populations.

Goal 2: Infants have the highest attainable standard of health and equity of life expectancy. Parents are confident, knowledgeable and supported to nurture.

Goal 3: Children have the highest attainable standard of health and are engaged in learning in Early Childhood Education (ECE) and the first school year.

Goal 4: Young people have the highest attainable standard of health and are engaged, resilient and poised to fulfil their potential.

Goal 5: The right people, working to the best standards of care, are supported by structures and systems that allow them to deliver the best health care to every child.

We will achieve the goals through improving the health of children, whānau, families and communities. We will work with the entire health sector, other government agencies, other sectors, and with communities to provide children with the best start to life. We have identified three significant phases in a child's life to help structure our approach.

Phase 1 The first phase encompasses pre-conception, pregnancy and the first year of life. If a baby has a good outcome by their first birthday they will be well on the way to positive child and adult health outcomes.

Phase 2 The second phase follows the first birthday and goes through early engagement in early childhood education and on to the first year of school life. Engagement in learning is essential for positive outcomes.

Phase 3 The third phase follows the first school year and goes through to early adolescence up to the age of 15 years. This final phase includes the transitional stage towards independence. Thus, the building blocks for positive health outcomes

need to be in place before the stage when potentially significant risk taking behaviour begins.

Background

Auckland DHB is equivalent to the area formerly known as Auckland City. Waitemata comprises the historical council boundaries of Rodney, North Shore City and Waitakere. Both districts are urban with areas of high population density. Waitemata also has a significant rural population.

The population profile of the metropolitan Auckland is diverse with 233 ethnic groups living in our areas. The Auckland and Waitemata DHB populations are broadly made up of:

Demographics

| Ethnicity | ADHB | WDHB |
|-----------|-------|-------------------------------|
| Maori | 13% | 10% |
| Pacific | 20% | 10% |
| Asian | 26% | 18% |
| Other | 40.5% | 62% ¹ ₅ |

Auckland and Waitemata are also home to many families from refugee backgrounds. In the future, the proportion of Asian people is expected to increase, Māori and Pacific populations to increase slightly and Others are expected to decline.

Around 6,000 (ADHB) and 8,000 (WDHB) babies are born to families and whānau residents in the Auckland and Waitemata District Health Board's areas every year.²³

Auckland DHB has over 468,000 people with a projected growth of 19% or 86,000 more people by 2026. Waitemata is the largest (550,000) and second fastest growing DHB district with a 20% projected increase in people (119,000 people) in the next fifteen years.

Approximately 193,000 children aged up to 14 years live in the two districts – nearly 80,000 in ADHB and nearly 113,000 in Waitemata. This represents approximately 17% (ADHB) and 20% (WDHB) of the respective populations. While the absolute number of children is projected to increase, children will comprise a smaller proportion of the total population in the future.

A Good Start to Life

Evidence demonstrates the importance of a baby's and infant's earliest environment. *The Best Start in Life* discusses the importance of the early years and drivers of health outcomes, noting that the first three years are fundamental for engagement in school and for future success.

"The most critical period for brain growth and development is during pregnancy and in the first three years of life. The brain develops through a complex interaction between genes and the environment, determining capacity for future learning, behaviour and health. In the

early years of life, the brain chemistry of a child growing up in an environment of sustained neglect, stress or trauma (for example, abuse or poverty) can alter, causing irreversible neurological and cognitive deficits. The result can be a lifetime of increased risk of ill health and learning and behavioural problems.”

Breastfeeding has well established short and long term health and neurodevelopmental benefits. Exclusive breastfeeding is recommended from birth to six months and as a complementary food for up to two years of age.⁴

The National Breastfeeding Advisory Committee of New Zealand state:

“Breastfeeding is important for the physical, social, emotional and mental health and wellbeing of infants, mothers, fathers/partners and families.”⁵

We also know the importance of good maternal mental health and of infant mental health as predictors of good health outcomes.

“Infant mental health is the developing capacity from birth to the age of three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn – all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development.”⁶

Social Determinants and the significance of poor health

Most children born or living in Auckland and Waitemata enjoy good health, but some do not. The distribution of poor health is not equitable, and is marked by significant socio-economic and ethnic differences. Māori children and Pacific children experience poorer health than non-Māori, non-Pacific children. Children living in more deprived neighbourhoods also have poorer health.

Pacific (three times) and Māori (two times) children are more likely of being hospitalised with a medical condition (associated with factors such as poverty, crowded housing and smoking) compared with European children. Asian children were less likely than Māori, Pacific or European children to be admitted.

Cultural identity (Durie⁷) is another important contributor to peoples' wellbeing. Identifying with a particular culture helps people feel they belong and gives them a sense of security. An established cultural identity is also linked with positive health outcomes in areas such as health and education⁸.

The most marked inequalities occur in health conditions that are preventable and can be eliminated through improved housing, social and community care. For example, admissions to hospital for Bronchiectasis (a chronic lung condition associated with frequent hospitalisations and reduced life expectancy) are ten times higher for Pacific children and four times higher for Maori children than NZ European children. The level of deprivation is

even more important than ethnicity as children living in the poorest circumstances are even worse off being over 15 times more likely to be admitted with Bronchiectasis than a child from one of the wealthiest households.

Rheumatic Fever is another childhood illness strongly associated with inequity. Māori children are 23 times more likely and Pacific children almost 50 times more likely than NZ European children to be admitted to hospital due to Rheumatic Fever.

These rates of poor health reduce overall population health and contribute to New Zealand having some of the poorest health outcomes compared to other OECD countries.⁹

The Best Start in Life report notes:

“The early years are important because they shape a person’s ability to engage in work, family and community life. Substantial international evidence shows that adult unemployment, welfare dependence, violence and ill health are largely the results of negative factors in the early years [yet] New Zealand’s investment in the early years is low by international standards.”

The costs of an unhealthy start to life are borne by individuals, families and society as a whole. Having a child with a disability, chronic illness or high health needs often has a significant impact on families in terms of financial cost, time cost, emotional well being and relationship breakdown. These costs are unreasonably borne by Maori, Pacific and families living in areas of highest need (quintile 5).

Some groups of children are at increased risk of adverse health outcomes due to trauma experienced early in life. These include children who have been placed under the protection of the State under the statutory authority of Children, Youth and Family (CYF).

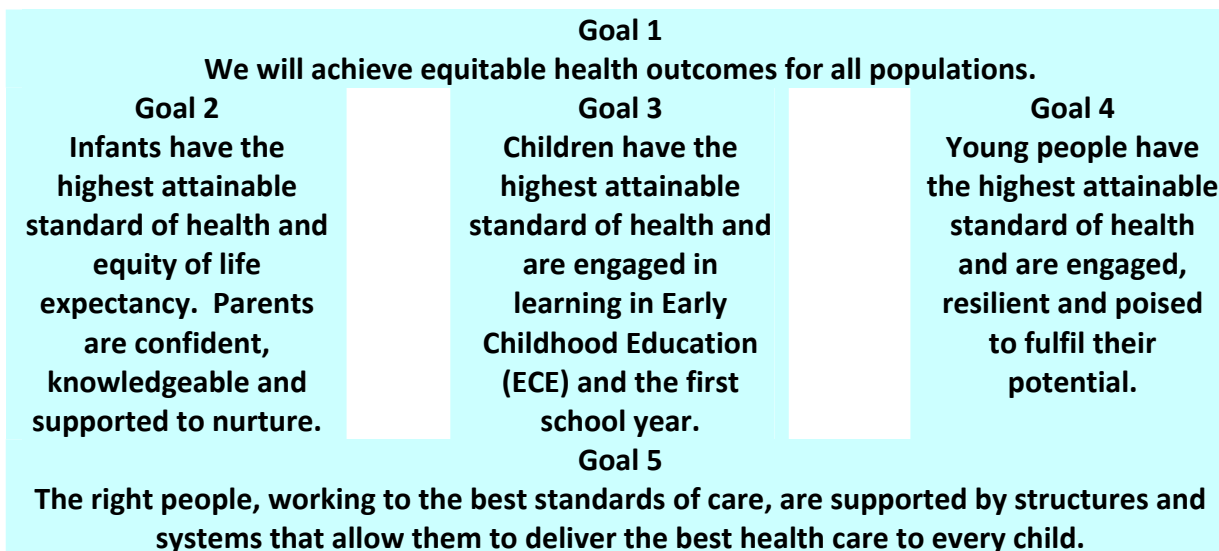
Another group of children at risk of adverse health outcomes due to early trauma have entered the country as refugees, or their parents have. They are likely to have significant negative health consequences due to malnourishment or lack of access to necessities of life such as clean water, shelter, basic health care or education in their home country. They are also likely to have been the victims of or witnessed significant violence.

Children of non-English speaking new migrants may also experience many barriers to accessing health care. This can include poor health literacy and difficulty in navigating their way through the health system. They often experience issues of social disconnectedness.

Our Plan

Healthy children are a priority for the Auckland and Waitemata District Health Boards. Health and well being for children encompasses physical health (taha tinana); spiritual health (taha wairua); family health (taha whānau), and; mental health (taha hinengaro).

This plan is our strategy for improving the health and well being of children living in the Auckland and Waitemata districts. We have five goals.



We will achieve the goals through improving the health of children, whānau, families and communities and will work with many others to do so across the whole health sector and beyond the health sector.

The age range of children covered under this plan includes babies from conception through to adolescents 15 years of age. The approach also includes the whānau and family. This plan focuses on three significant phases in a child's life:

Phase 1 The first phase encompasses pre-conception, pregnancy and the first year of life. If a baby has a good outcome by their first birthday they will be well on the way to positive child and adult health outcomes.

Phase 2 The second phase follows the first birthday and goes through early engagement in early childhood education and on to the first year of school life. Engagement in learning is essential for positive outcomes.

Phase 3 The third phase follows the first school year and goes through to early adolescence up to the age of 15 years. This final phase includes the transitional stage towards independence. Thus, the building blocks for positive health outcomes need to be in place before the stage when potentially significant risk taking behaviour begins.

A good outcome from one stage bodes well for a positive outcome from the next phase in terms of child and ultimately adult health and well being.

Goal 1

We will achieve equitable health outcomes for all populations

Priority Groups

To address inequity we have identified seven priority groups that will have greater emphasis in this plan. They are:

- Babies and children aged 0 – 3 years, especially those living in challenging socio-economic conditions
- Māori children
- Pacific children
- Children with disabilities, chronic illness and high health needs
- Children in state care
- Children who have suffered abuse or neglect, and
- Children who are at high risk of adverse outcomes
- Children from refugee backgrounds
- Children from non-English speaking new migrant families

Health services in future will focus on specific localities with high levels of deprivation. In Auckland, our poorest neighbourhoods flow in a horse shoe shape from Tamaki, Point England and Glen Innes down to Otahuhu, through Mt Roskill and Wesley to Avondale and beyond. In Waitemata, there are clusters of poverty in Helensville, Wellsford, Henderson, Ranui, Massey, Birkdale and Beach Haven. There are also communities of disadvantage in other areas. Services need to be designed to increase access for children and their family and whānau living in the poorest areas.

This plan both supports and is supported by the Northern Region Health Services Plan (NRHSP). The NRHSP identifies five priority child health issues: Rheumatic Fever; Sudden Unexplained Death in Infancy (SUDI); Lower Respiratory illness; Childhood Injury and Skin Sepsis.

The Rights of the Child

The rights and best interests of children are paramount. Therefore this plan recognises and fully incorporates the United Nations' Convention on the Rights of the Child (UNCROC). New Zealand is a signatory of UNCROC. This convention sets out the rights of all children. UNCROC recognises "that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding". In addition to rights such as adequate nutrition, clothing and housing UNCROC specifies health rights which "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health ... no child [should be] deprived of his or her right of access to such

health care services.” Article 24 of the Convention lists health specific rights (see Appendix 1).

Additionally the plan recognises and fully incorporates the Charter on the Rights of Tamariki Children & Rangatahi Young People in Health Care Services in Aotearoa New Zealand. Every child and young person has the right to:

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

Children are unable to effectively advocate for improved health and social outcomes on their own behalf. The DHBs will advocate, on behalf of our children, with other sectors. In particular we will advocate for:

- Housing that is warm and not crowded.
- Education that is responsive to their health and education needs.
- Families where abuse is not tolerated.
- Health services that are responsive to their and their family and whānau needs.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems.

Whānau Ora describes some of the key principles of our approach in improving the health of our children. The following diagram sets out a vision of a Whānau Ora framework, and shows the pivotal role of factors such as leadership (whānau, hapū and iwi), funding, government, whānau-centred services and whānau engagement in enhancing Whānau Ora.



As a method of practice, Whānau Ora focuses on the whānau as a whole, builds on whānau strengths and increasing their capacity. There are six key operational elements:

- whānau-centred methodologies shaped by the values, protocols and knowledge contained within te ao Māori
- cooperation across sectors
- a primary focus on best outcomes for whānau, through integrated and comprehensive delivery
- skilled whānau practitioners
- expertise in whānau dynamics, relationships, aspirations
- practices that increase whānau skills, knowledge and self management (e.g. online health records)

The key aim of Whānau Ora is for Māori families to be supported to achieve their maximum potential, where the whānau is able to make informed health decisions and effectively navigate through their health choices and the health system. It is important that both ADHB and WDHB contribute to Whānau Ora in a way that focuses on health, but recognises the wider dimensions of wellbeing. This will be demonstrated by:

- whānau self-management
- healthy whānau lifestyles
- full whānau participation in society
- confident whānau participation in te ao Māori
- economic security and active involvement in wealth creation
- whānau cohesion.

Opportunities, challenges and lessons from the past

Working with Others

Over the recent years, awareness of the importance of engaging with other sectors to achieve health gain has grown. One of the mechanisms for inter-sectoral action in ADHB has been the Child Health Stakeholder Advisory Group (CHSAG) which brings together strategic leaders in child health, housing, social policy, education and other sectors. This is to become an Auckland regional DHB forum. While each agency has different drivers, we are communicating more effectively and finding ways to support each other's objectives.

Achievement of this plan's goals will rely upon DHBs having successful relationships with services and agencies in other sectors, community leaders and both Government and non-Government organisations (NGOs). Of particular note are the Ministry of Social Development, Auckland Council, Whanau Ora, Pacific leadership, education agencies, and NGOs.

We acknowledge the important role played by the Ministry of Social Development in relation to providing a range of early intervention services that contribute to positive health and well being outcomes. These include Strengthening Families and parenting programmes such as: Strategies with Kids Information for Parents (SKIP); Home Interaction Programme for Parents and Youngsters (HIPPY), and Parents As First Teachers (PAFT). Other Ministry of Social Development services include targeted financial assistance such as the Child Disability Allowance. ADHB/WDHB have recently formalised our relationship with Child, Youth and Family (CYF) to help combat child abuse through a Memorandum of Understanding between Health, the New Zealand Police and Child, Youth and Family. This Memorandum covers the specifics of relationships and processes regarding children who are at high risk of or have suffered from abuse.

We also acknowledge the important relationship we have with Education such as through School Based Health Services.

The Auckland Council has identified the importance of children and young people in their planning documents. We will seek opportunities to influence policies that impact on child health. These include the areas of injury prevention, healthy eating and activity, access to quality ECE, location of liquor outlets and factors associated with the built environment.

The health workforce is a key means of delivering improved health outcomes. The DHBs will continue to build strong relationships with a wide range of tertiary education providers to ensure we develop the type of workforce required for now and the future.

Starship, North Shore and Waitakere Hospitals are university teaching hospitals. In collaboration with The University of Auckland both ADHB/WDHB are major teaching sites for undergraduate medical students. Additionally collaborative arrangements with

Auckland University of Technology, Massey University, and other institutions teaching sites for nurses and the allied health workforces.

The concept that health services should be built around the service user has been around for some time and presents clear opportunities in the current planning environment for achieving all 5 goals set out by this plan. Better inter-connection of services to improve usability for children and their family and whānau are required.¹¹ There is now also an expectation of ‘Better, Sooner, More Convenient’¹² health care.

We have strong Primary Care and NGO sectors which include providers who continue to deliver health gains for Maori, Pacific and other children. We need to better understand the work that Primary Care and NGOs do in the community so that we can work together better to improve outcomes for children.

A recent success of working with NGOs is the Pacific leadership and community engagement through ADHB’s Healthy Village Action Zone (HVAZ) and WDHB’s Enea Ola Pacific Health Programme. These healthy lifestyle programmes are funded and supported by the DHBs but driven by Pacific communities themselves. Recent success in immunisation rates is a positive outcome. The rate of immunisation for Pacific children 2 years of age has reached 97% for both DHBs.¹²

We need to continue to learn from and build on the successes of these initiatives.

Challenges for Child Health

The major challenge for child health services is to address the current inequities in health outcomes for children living in our DHB areas. This is a focus throughout this plan.

Auckland and Waitemata DHBs face a number of challenges associated with the current economic environment. We will need to be able to do more with similar levels of funding. A focus on the best use of funding and resources will be held throughout the delivery of this plan. However evidence supports investing in child health to promote long term health benefits for the entire population.¹³ The DHBs will consider how additional resourcing can be applied to child health within a constrained fiscal environment.

Starship is positioned for excellence in delivery of tertiary child health services at national, regional and local levels. There has been significant investment in technology with the introduction of new medical radiology imaging (MRI) and computed tomography (CT) scanners. These and other technologies support provision of complex technology dependent interventions. Starship is the only provider of; cardiac surgery, liver transplants, and paediatric intensive care.

The age of the physical Starship building and its facilities means that significant capital investment is required to maintain and develop this role. A separate and detailed plan regarding the re-development of Starship is being prepared. This plan also considers the role of facilities in other DHBs to undertake some secondary care services, thereby relieving pressure on the Starship infrastructure.

Waitemata DHB has been developing a range of secondary child health services over the past 10 years with a Special Care Baby Unit (SCBU) in North Shore and Waitakere Hospitals, and inpatient services at Waitakere Hospital.

The Wilson Centre (WDHB) supports children with disabilities and their families with a range of services including accommodation, education, equipment and other practical support. Children from all over New Zealand access these facilities and they are critical to the achievement of equitable access to the best specialist care these children.

The way our health care services are organised does not always support the workforce to do their best. We will look at how we can best organise services that maximises their effectiveness to deliver improved health care and outcomes. There have been advances in using information systems to improve access to information such as TestSafe, however, there are opportunities for further development. For example, we will continue to work towards a shared, electronic child health record.

Building on Past Successes

We acknowledge the gains made and want to learn from past successes. Both DHBs have introduced successful innovations and programmes to support child health including:

- Participating in inter-sectoral initiatives such as the Strengthening Families Programme
- Establishing a Child and Youth Mortality Review Group
- Enhancing the family violence prevention and intervention programme (including child abuse prevention and child protection)
- Participating in home insulation programmes to improve health outcomes for children in high needs areas
- Implementing the Gateway Assessment programme
- Improving Immunisation rates particularly for Maori and high need populations
- Enhancing breastfeeding and other healthy eating, healthy action, and smoking cessation programmes
- Enhancing Maternity Quality and Safety.

Auckland DHB has also:

- Established a multi-sectoral Child Health Stakeholder Advisory Group (CHSAG)
- Developed and implemented a Shaken Baby Prevention Programme.
- Developed and piloted the Gateway Assessment programme.
- Established Immunisation Coordination positions within primary care.

Waitemata DHB has also:

- Required all providers of maternity services to meet the New Zealand Breastfeeding Association criteria

- Funded a number of community based intensive smoking cessation programmes, one to work with pregnant women and their families and another to work with families who have children under 16 years of age.

In addition, both DHBs have responded to Ministry of Health initiatives which have seen the introduction of: a universal newborn hearing screening and early intervention programme, the national immunisation register, and the HPV cervical cancer vaccine.

Within hospital services we have seen major advances over the last five years. For example the strengthening of sub-speciality services delivered from Starship, including:

- cardiology and cardiac surgery
- emergency medicine
- gastroenterology
- metabolic medicine
- neonatal intensive care
- respiratory medicine.

We will continue to support and build on these and other developments over the next five years.

Realising the Vision by the First Year of Life

Goal 2

Infants have the highest attainable standard of health and equity of life expectancy. Parents are confident, knowledgeable and supported to nurture.

Good health outcomes by an infant's first birthday are the result of factors prior to conception, throughout the pregnancy, during birth, as well as the first year of the baby's life. A baby's health is dependent on that of the mother's. If we are going to have healthy babies, mothers need to be healthy, educated and well supported. Fathers need to be engaged and enabled to parent effectively. "Cohesive, resilient and nurturing" whānau are a key. As with all aspects of good health, elements determining health outcomes often sit beyond the health sector – in housing, in social and economic policy and in education. Where ever possible we will work with other agencies to recognise and address the determinants of good health.

Prevention

We will:

1. Develop health care and relationship management systems that engage with women and their partners before conception, keep them engaged throughout their pregnancy and maintain connections following birth.
2. Screen all pregnant women and new mothers for mental health issues, substance abuse, family violence and other behaviours associated with high risk parenting.
3. Ensure all babies are enrolled with a primary health care, Well Child and oral health providers at birth.
4. Work to improve health literacy and deliver better messages and information about and access to sexual health services so that there are fewer unwanted pregnancies and young teenage pregnancies.
5. Improve the knowledge of parents, particularly first time parents, regarding what is best for baby and mother. This will include:
 - breastfeeding
 - maternal nutrition and lifestyle prior to conception and during pregnancy
 - smoke-free, alcohol-free and drug-free pregnancies
 - injury prevention including:
 - increasing the understanding of the dangers of and triggers for shaking a baby
 - reducing drownings
 - reducing burns
 - disease prevention including hygiene and timely vaccination
 - safe sleeping practices

- early connection and interaction with baby
 - know when and how to access health care providers.
6. Put the baby, family and whānau at the centre of service delivery models and improve the integration of service providers around them.
 7. Identify children at risk of poorer outcomes and through Whānau Ora or wrap around services for families and whānau mitigate the risk.
 8. Work with other agencies to improve housing quality to reduce the number of avoidable housing related hospital admissions.

We will know we are delivering improved health care when:

- More babies are breastfed.
- Fewer pregnant women smoke, drink alcohol or take drugs at any time during pregnancy.
- More women are a healthy weight throughout their pregnancy.
- Fewer babies are born to young women, 16 years of age or younger.
- All pregnant women are engaged with a primary health care home throughout their pregnancy.
- All women identified through screening with mental health issues, substance abuse, family violence and other behaviours associated with high risk parenting receive appropriate interventions to support healthy mental functioning and attachment.
- All children are enrolled with a General Practice, Well Child Provider, the National Immunisation Register, and Dental Services.
- Fewer babies have attachment problems.
- New parents, particularly mothers, tell us they received the information they needed to parent effectively during the first year of their first baby's life.
- At least 95 % of babies are age appropriately immunised.
- Fewer infants are hospitalised in the first year of life.
- The infant mortality rate improves, particularly for Māori and for Pacific infants.
- The SUDI numbers and rates reduce.
- There are fewer shaken babies or babies subjected to other forms of child abuse.

Early Detection and Management

We will:

1. Ensure that Primary Health Care is actively promoting pre-conception services to enrolled women before their first pregnancy.
2. Work towards every pregnant woman meeting her Lead Maternity Carer by week ten of her pregnancy.

3. Ensure babies at risk of transmitted maternal infection are identified and provided with preventive care or interventions such as vaccination.
4. Ensure every baby has a confirmed Primary Health Care home and Well Child/Tamariki Ora provider before leaving hospital or within their first week of life.
5. Ensure screening programmes such as Newborn Metabolic Screening and Family Violence screening identify health and social needs and facilitate engagement with effective intervention services or programmes.
6. Work to improve integration between Well Child/Tamariki Ora and Primary Health Care providers.
7. Ensure that all health care providers understand the risk factors and early signs of child abuse and are able to respond appropriately to ensure the child's safety.

We will know we are delivering improved health care when:

- All formal screening programmes have high participation rates and mothers and babies with risk factors are successfully identified and access appropriate interventions that meet their needs.
- Maternal and infant mental health outcomes improve.
- There is less family violence as evidenced by reduced intentional child injury rates in the first year of life.

Specialist and Hospital Services

We will:

1. Continue to provide high quality birthing services.
2. Meet the needs of mothers with significant mental health issues.
3. Improve communication between health professionals and ensure the most appropriate provider takes a lead role in supporting the infant's health care needs.
4. Support families and whānau to understand complex information and to make decisions that take into account the best outcome for the baby.
5. Maintain effective risk management systems; learn from reviews of significant events and 'near misses' and share what is learnt with other providers.
6. Provide a quality family violence screening programme that identifies women and children at risk and work with specialist services including CYF and Police to respond appropriately.

We will know we are delivering improved health care when:

- Fewer babies and infants are harmed as a result of avoidable medical or health service system error.
- Families receive clear and consistent information, feel supported and know they are receiving the care they need to achieve the right outcome for their baby.

- The most appropriate health care provider initiates and coordinates care for the infant.
- Children born to mothers with significant mental health issues receive the care they need to thrive.
- Every health care provider involved with a family is informed in a timely manner about outcomes related to an infant's care, including following a death, so they can provide appropriate cultural and other support to the family.
- Women who are victims of family violence and children who have been abused are accurately identified through a screening programme and provided with the services they need to ensure their safety.

Rehabilitation and Support

We will:

1. Ensure every infant with significant rehabilitation and support needs has a key worker or advocate who leads care coordination for the baby and family and whānau. If a baby returns to another district we will ensure that transfer of care is seamless.
2. Ensure information systems support coordination between primary and specialist services, within and across DHBs, and with other agencies, so clinicians can support families more effectively.
3. Provide the most appropriate care in consultation with the family and whānau to maximise positive outcomes for the baby.
4. Ensure discharge planning for infants with high needs is consistently implemented and that guidelines for children with long term complex health needs are followed.
5. Ensure systems for monitoring predictable health needs (such as hip surveillance) support appropriate and timely follow up.
6. Ensure families are well informed about the range of support services provided by NGOs and others in the community prior to discharge.

We will know we are delivering improved health care when:

- Families feel supported and know they are receiving the care they need to achieve the right outcome for their baby.
- Families feel supported to maintain family and community responsibilities.

Realising the Vision by the End of the First School Year

Goal 3: Children have the highest attainable standard of health and are engaged in learning in Early Childhood Education and the first school year.

The first three years of life are critical for establishing the pathways for life long health and well being. Active engagement and participation in pre-school and school are key to achieving positive life outcomes.

Providing high quality Well Child/Tamariki Ora for all children helps prevent poor outcomes during these years. Encouraging families to seek medical help earlier by reducing access barriers and increasing awareness will allow early intervention.

Prevention

We will:

1. Work to reduce the barriers (including cost) for children to free primary health for children.
2. Ensure that the Well Child/Tamariki Ora Framework for pre-school aged children is effective in promoting healthy child development, healthy lifestyles, oral health, healthy relationships and engagement in ECE.
3. Support high uptake and timeliness of vaccination.
4. Ensure that all children are enrolled with an oral health provider.
5. Advocate for physical environments that facilitate and promote healthy eating, physical activity, and safety.
6. Support trauma prevention activities and services.
7. Reduce respiratory illness rates in Māori and Pacific children in particular.
8. Work with families and communities to improve health literacy.
9. Ensure that a family's broader socio-economic situation is recognised and promote remedies such as quality housing.
10. Reducing exposure to environmental tobacco smoke
11. Reduce poisonings

We will know we are delivering improved health care when:

- Families can access free primary health care for children under six years of age.
- Parents have the skills to support healthy emotional development.
- Children are a healthy weight.
- There is no vaccine preventable disease.
- The number of children with dental cavities is significantly reduced.
- There are fewer preventable injuries.

- Preventable and avoidable hospital admissions reduce particularly respiratory illnesses.
- More children are enrolled and participating in ECE, with proportions of Māori and Pacific equal to other ethnic groups.

Early Detection and Management

We will:

1. Ensure every child has a B4 School Check during their fourth year and interventions take effect before the child begins school.
2. Support those children not accessing services at appropriate levels to engage with a Primary Health Care home and other services.
3. Improve management of asthma and other Respiratory Tract infections and reduce inequities associated with these diseases.
4. Reduce hospitalisations due to Respiratory Tract Infections.
5. Ensure effective screening tools are used in primary health care to detect early signs of poor health, disruptive behaviour and conduct problems, with referral to the appropriate services.
6. Ensure family violence, mental health, developmental, social and behavioural problems are identified early and are addressed through appropriate services.
7. Have an integrated approach between mental health and child health services.

We will know we are delivering improved health care when:

- All children receive the Primary Health Care services they need in a timely manner at all times.
- All children receive a B4 School Check.
- Children are healthy, participating and engaged in learning in their first school year.
- Whānau feel supported to be cohesive, resilient and nurturing.

Specialist and Hospital Services

We will:

1. Work with national, regional and local clinicians, and funders and planners to re-orient specialist and hospital services so children get the best care as close to their home as possible.
2. Ensure that Starship provides sufficient capacity to accommodate all children requiring advanced levels of care.
3. Build our networks and technology solutions so that our colleagues in the rest of the country can deliver more care closer to home for the child and their family and whanau.
4. Develop an integrated trauma system.

5. Ensure children under the care of CYF receive appropriate health needs assessments and coordinated health services to meet their needs.
6. Improve access and timeliness of programmes for pre-schoolers with significant developmental and behavioural problems.

We will know we are delivering improved health care when:

- Children with traumatic injuries have better survival rates and outcomes.
- Every child going into State care receives a health assessment and receives well coordinated health care.

Rehabilitation and Support

We will:

1. Ensure every child living with significant rehabilitation and support needs has a key worker/advocate who leads care coordination for the child, family and whānau.
2. Improve psychological and social supports for children with chronic conditions.
3. Provide the most appropriate care in consultation with the family and whānau to maximise positive outcomes.

We will know we are delivering improved health care when:

- Families and whānau feel supported and know they are receiving the care their child needs.
- Families and whānau feel supported to maintain family and community responsibilities.

Realising the Vision by Early Adolescence

Goal 4: Young people have the highest attainable standard of health and are engaged, resilient and poised to fulfil their potential

Primary school years are mostly happy and healthy ones. However, poverty related and preventable health conditions such as rheumatic fever, skin sepsis and respiratory disease continue to prevail particularly for Maori and Pacific children.

This plan covers the earliest years of adolescence. Separate but linked DHB plans set out improvement initiatives for Youth Health. Access to youth friendly primary care and mental health services are important to prevent abnormal development creating a negative life outcome.

Health can encourage integration of key messages in the school health curriculum that will help with relationship and other life skills and that provide the building blocks for managing adolescent relationships.

Prevention

We will:

1. Advocate to the Ministry of Education regarding the importance of consistent, accurate health and well being education in schools.
2. Ensure that primary health care services are easily accessible for school aged children.
3. Support health promoting environments in schools.
4. Work with other agencies to ensure parents and care givers have the knowledge, skills and resources to parent teenagers effectively.
5. Implement a Rheumatic Fever programme that includes prevention, detection, and treatment.
6. Implement effective activities to reduce respiratory illness.

We will know we are delivering improved health care when:

- Families and whānau child health literacy increases.
- More young people are a healthy weight.
- Fewer children and young people attend hospital emergency departments with preventable and/or avoidable conditions.
- Pregnancy in young adolescents decreases.
- ADHB achieves Government's Better Public Sector Rheumatic Fever target of 1.4 cases per 100,000 children by 2017

Early Detection and Management

We will:

1. Develop a system alongside education to identify children and young people at risk of poor outcomes and improve access to appropriate interventions.
2. Provide targeted age appropriate screening assessments to young people at higher risk of poor health outcomes
3. Ensure that interventions are coordinated around the child/young person and their family and whānau.
4. Provide a sore throat swabbing programme for Rheumatic fever in high risk, high density areas.
5. Promote and maintain nurse-led primary health care services and coordinated health care in secondary schools.
6. Improve access to effective primary mental health services for children and young people.
7. Develop a suicide prevention programme that addresses the issues for young adolescents.
8. Ensure that children and young people are able to access appropriate and timely secondary mental health services as required.

We will know we are delivering improved health care when:

- Young people's health needs are met in a timely way.
- Children and young people are not excluded from school.
- The number of new confirmed cases of Acute Rheumatic Fever drops to a level no greater than the Government target.
- Fewer young people commit suicide.

Specialist and Hospital Services

We will:

1. Embed the *Charter on the Rights of Tamariki Children and Rangatahi Young People* in Health Care.
2. Ensure children and young people can participate in decision-making about their care, their privacy is respected, their participation in education, play, creative activities and recreation is enabled, and there is continuity of health care.
3. Improve transition planning from children's specialist and hospital services to other appropriate services.
4. Improve access to services for disruptive behaviour disorders.
5. Ensure that children diagnosed with Acute Rheumatic Fever receive long term antibiotic treatment as indicated by National Heart Foundation Guidelines.

We will know we are delivering improved health care when:

- Children and young people tell us that they:
 - participate meaningfully in decision-making about their care
 - feel respected
 - experience coordinated services which always consider their best interests.
- Transition processes meet international benchmarks for all children with chronic conditions
- The numbers of children requiring long term antibiotic treatment reduces to no greater than the Government target by 2017.

Rehabilitation and Support

We will:

1. Have rehabilitation and support services that meet the needs of young people.
2. Have a cohesive approach to youth health services.

We will know we are delivering improved health care when:

- Children and young people with disabilities tell us that they:
 - participate meaningfully in decision-making about their care
 - feel respected
 - experience coordinated services which always consider their best interests.

The Enablers

Goal 5: *The right people, working to the best standards of care, are supported by structures and systems that allow them to deliver the best health care to every child.*

A range of factors enable effective and efficient service delivery. These enablers include:

- Access
- Whānau Ora
- Service design and system alignment
- Workforce and culture
- Communication and health literacy
- Information systems and information sharing.

Availability of funding can also enable effective and efficient services. The economic outlook for the period of this plan remains challenging. Therefore, there is likely to be limited new money for health. Thus, in implementing this plan there will be a strong focus on maximising the use of existing funding to ensure:

- value for money
- appropriate targeting of resources
- integration of services
- services have demonstrable positive outcomes.

Access – Cost, Location and Timeliness

Access to health services is a result of a number of factors including:

- Cost
- Transport
- Ability to take time off work
- Hours of service operation
- Location
- Whānau anxiety
- Health literacy
- Language and culture.

There will be a focus on elimination or reduction of these barriers.

Some services are free (maternity and oral health) or of low cost (GP visits for under 6s). However, many services have significant costs. We will explore opportunities to reduce the barriers due to cost for children.

‘Better, Sooner, More Convenient’ recognises that the location of services affects access. One of the design features of that policy is the Integrated Family Health Centre (IFHC). We will work closely with IFHCs to:

- enhance Primary Health Care in the community
- have more secondary care services closer to communities either at local DHB facilities or at IFHC where appropriate

Timeliness of services can improve outcomes. For children this is particularly important as delays in treatment can result in a rapid deterioration of a condition or missed opportunities for general growth and development. The goal is to reduce waiting times to access services through improved hours of operation and improved performance.

Service Design and System Alignment

Services need to be designed to maximise outcomes, efficiency and effectiveness. Children, family and whānau will be at the centre of service design.

Over the next five years, we envisage an improved integrated model being developed in partnership with providers. This will focus on development of mother/child/family centric integrated care which will deliver the best outcome for mothers, babies, children and the family and whānau.

Workforce and Culture

Over the term of this plan we need to ensure that the people working in health are enabled to deliver the right care, at the right time, in the right place. The community is diverse and being able to best meet people’s needs demands a diverse workforce. We are committed to employing a diverse workforce and will continue to encourage young people from diverse backgrounds into health careers.

We are committed to our relationships with the tertiary education sector to develop a workforce that meets the changing demographics and needs of our services.

Further progress will be made in the growth of cultural competencies amongst our health providers working with Māori, Pacific and Other communities.

Developing roles for key workers and/or advocates who will support and lead care coordination for children with chronic conditions, disabilities and for vulnerable families will help improve service coordination and consequently outcomes. This may be a role that a family and whānau member takes.

The health workforce will improve its ability to relate to and respond appropriately to young people in a youth friendly way.

Communication and Health Literacy

Communicating effectively with families and with children is an essential part of health care. As the diversity within our community increases communicating effectively becomes more complex due to language and cultural barriers. Families sometimes feel it is difficult to communicate with health professionals or to be understood.

“Health literacy is the ability to obtain, process, and understand basic health information and services to make appropriate health decisions ... Health literacy includes how an individual navigates and interacts with our complex health system. Health literacy includes people’s expectations about health and well-being, and their understanding of health messages, medicine labels and nutrition information, as well as their ability to fill out medical forms and talk with their doctor.”¹⁴

Health literacy is important if families and whānau are to be self managing and live healthy lifestyles. We will explore opportunities to improve both health literacy of our communities and our means of communicating health information to families and Whānau. Improving health literacy of our communities will be enhanced by working with other agencies including the Auckland Regional Council, Education and others.

Ensuring the health workforce is diverse is one means by which communication skills will be enhanced. Diversity training to improve understanding of different cultures will be further developed.

Information Systems and Information Sharing

Effective information systems and information sharing across the whole health care system is a key element to improving the effectiveness and efficiency of health care. We will work towards improving the information systems and moving towards a single child health record.

Indicators and Targets

How we will know child health is improving

We will monitor and report our progress against targets. Equity is a primary goal in this plan therefore for each target, where ever possible, data will be routinely analysed by:

- Ethnicity: Total, Māori, Pacific, Asian, Other, and
- Deprivation: Quintile 1 - 5.

Age breakdowns will also be used where applicable using the ranges:

- < 12 months
- 1 - 4 years
- 5 - 9 years and
- 10 – 14 years.

We recognise that some of these targets and indicators may need to be refined over time as better information becomes available, more effective indicators are developed, or additional priorities emerge. We further recognise that a sound understanding of what lies behind the data will be essential to interpret the information and enhance services or practice. Over time, we intend to take this information to the level of an annual child health report where we benchmark our performance systematically against similar populations and/or services. The fundamental purpose of measurement is to encourage systematic performance improvement. Results will be reported at least annually to the Child Health Stakeholder Advisory Group, and to the ADHB and WDHB Boards.

Note: this section on indicators and targets is preliminary only and will be subject to further work.

Indicators for health issues impacted by social determinants

| Indicator | Other information | Reporting Frequency | Link to Priority Goals |
|--|--------------------------|----------------------------|-------------------------------|
| <i>Number of babies born to women < 16 years of age</i> | Total and by ethnicity | Annual | 2 |
| <i>Infant mortality</i> | Total and by ethnicity | Annual | 2 |
| <i>Low for gestational age birth weight</i> | Total and by ethnicity | Annual | 2 |
| <i>Housing related hospital admissions</i> | Total and by ethnicity | Annual | 2,3,4 |
| <i>Number of Injury Admissions 0 -14 years</i> | Total and by ethnicity | Annual | 2,3,4 |
| <i>Sudden Unexplained Death in Infancy (SUDI) rates</i> | Rate by 100,000 | Annual | 2 |
| <i>Oral health: % caries free at age 5</i> | Total and by ethnicity | Annual | 3 |

Indicators of child health outcomes

Indicators of child health outcomes

| Indicator | Other information | Reporting Frequency | Link to Priority Goals |
|--|--------------------------|----------------------------|-------------------------------|
| <i>Maternal smoking: % smoke free at initial antenatal visit and at delivery</i> | Total and by ethnicity | Annual | 2 |
| <i>Maternal alcohol: % alcohol free at initial antenatal visit</i> | Total and by ethnicity | Annual | 2 |
| <i>Breastfeeding: % exclusively breastfeeding on discharge</i> | Total and by ethnicity | Quarterly | 2 |
| <i>Breastfeeding: % exclusively and fully breastfeeding at 6 weeks</i> | Total and by ethnicity | Quarterly | 2 |
| <i>Breastfeeding: % exclusively breastfeeding at 3 months</i> | Total and by ethnicity | Quarterly | 2 |
| <i>Breastfeeding: % exclusively breastfeeding at 6 months</i> | Total and by ethnicity | Quarterly | 2 |
| <i>Oral health: Decayed, missing due to caries and filled teeth (DMFT)</i> | Total and by ethnicity | Annual | 4 |
| <i>Obesity: % 4 year olds within normal weight range</i> | Total and by ethnicity | Annual | 3 |
| <i>Ambulatory Sensitive Hospital Admissions* 0-4 years</i> | Total and by ethnicity | Quarterly | 2,3 |
| <i>Rheumatic fever: cases per 100,000 5-14 year olds</i> | Total and by ethnicity | Annual | 3,4 |
| <i>Mothers gestational age at booking pregnancy with LMC</i> | Total and by deprivation | Annual | 2 |

* see Appendix 2

Indicators that act as markers of health activity

| Indicator | Other information | Reporting Frequency | Link to Priority Goals |
|---|--------------------------|----------------------------|-------------------------------|
| <i>Immunisation: coverage at 8 months</i> | Total and by ethnicity | Quarterly | 2 |
| <i>Immunisation: coverage at 2 years</i> | Total and by ethnicity | Quarterly | 2 |
| <i>PHO enrolment: % babies enrolled by 2 weeks</i> | Total and by Ethnicity. | Annual (TBC) | 2 |
| <i>Percentage of 5 year olds enrolled in primary care</i> | Total and by ethnicity | Annual (TBC) | 2 |
| <i>B4 School Check: % percent eligible children receiving a Check</i> | Total and by deprivation | Annual | 3 |

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Appendices

Appendix 1: Article 24 of the United Nations Convention on the Rights of the Child

Article 24

1. *States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

2. *States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*
 - (a) *To diminish infant and child mortality;*
 - (b) *To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
 - (c) *To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;*
 - (d) *To ensure appropriate pre-natal and post-natal health care for mothers;*
 - (e) *To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
 - (f) *To develop preventive health care, guidance for parents and family planning education and services.*

3. *States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.*

4. *States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.*

Appendix 2: Commonly used acronyms

| Acronym | Term | Explanation as required |
|---------|---|--|
| ADHB | Auckland District Health Board | |
| ASH | Ambulatory Sensitive Hospital (ASH) admissions | This term applies to hospital admissions where these conditions may be preventable and/or avoidable through primary care intervention |
| BSMC | 'Better, Sooner, More Convenient' | The Government's philosophy of creating a better model of healthcare for New Zealand's |
| CHSAG | Child Health Stakeholder Advisory Group | A group of health and other sector representatives providing strategic advice on child health to ADHB. |
| CT | Computed Tomography | Used as a medical imaging tool to assist diagnosis. |
| CYF | Children, Young People and Family | |
| ECE | Early Childhood Education | |
| GP | General Practitioner | |
| HSG | Health Service Group | The strategic leadership group for health groups in ADHB. There are six HSG including one for child and youth health. This is headed by a Medical Director and includes a Nurse Director and a Performance Director. |
| HVAZ | Healthy Village Action Zone | An ADHB based Pacific Healthy Lifestyles Programme |
| IFHC | Integrated Family Health Centre | A Medical Centre providing a cluster of medical and other health services for the local community |
| IT | Information Technology | |
| LMC | Lead Maternity Carer | Usually this person takes the lead in managing a woman's ante-natal care, birth and immediate post-natal care. |
| MRI | Magnetic Resonance Imaging | Used as a medical imaging tool to assist diagnosis. |
| OECD | Organisation for Economic Cooperation and Development | International Governmental Organisation |
| PHO | Primary Healthcare Organisation | Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO. |

| | | |
|--------|---|--|
| SCBU | <i>Special Care Baby Unit</i> | <i>Hospital unit providing care for newborns with a high level of clinical need.</i> |
| UNCROC | <i>United Nations Convention on the Rights of the Child</i> | |
| WDHB | <i>Waitemata District Health Board</i> | |

Appendix 3: Development of draft plan

A range of methods were used to guide the development of this draft plan.

These included:

- *Both ADHB and WDHB utilised project Steering Groups during the development of the plan. The members of both groups are listed in the acknowledgements.*
- *A facilitated workshop was held on 1 April 2011. Attendees were invited from across ADHB, other regional DHBs and other sectors. The following people attended the workshop: Dr Richard Aickin (ADHB), Carol Stott (ADHB), Ruth Bijl (ADHB), Dr Pat Tuohy (MoH), Dr Rosemary Marks (ADHB and Paediatric Society), Tepora Peseta (Alliance Health+), Mary Roberts (Alliance Health +), Sarah MacDonald (ADHB), Dr Brad Novak (ARPHS), Georgina Gymer (IMAC), Sandra Innes (Plunket), Mike Butcher (ADHB), Carolynn Whiteman (ADHB), Dr Louise Webster (ADHB), Lorraine Heteraka-Stevens (ADHB), Kathy Peacock (ADHB), Sue Miller (CMDHB), Stacey Strang (WDHB), Leani O'Connor (ADHB), Peter Tranter (Procure), Taima Campbell (ADHB), Susan Aitkinhead (ADHB), Michele Cavanagh (ADHB), Angela Drake (MSD), Dr Tim Jellyman (WDHB).*
- *An ADHB on-line survey invited feedback from health and other professionals with an interest in child health as well as from the community. 621 responses were received, 464 of these were from the general community and 157 were from health and allied professions. Responses were compiled into a report by Tony O'Connor, Consultation Manager, ADHB.*
- *WDHB forwarded their survey to its stakeholders and promoted it through community newspapers. The survey was also accessible on their website and staff intranet. 72 responses were received. However many stakeholders had already had the opportunity to provide input into the plan's development during the ADHB consultation process.*
- *A small number of people sent letters or emails to inform the draft plan. One group from the Community Child Health and Disability Service (CCHADS) also requested to meet.*
- *Four hui were held with Māori providers and others interested in child health. Hui were held at: Te Mahurehure Marae, Ruapotaka Marae, Tihi Ora and Te Hononga o Tamaki me Hoturoa. Attendees included: Hiria Nepe, Jill Walker, Vanessa Watene, Aroha Haggie, Kere Cookson – Ua, Joanne Albrecht, Liz Mitchelson, Mahia Winder, Janie Ingram, Patrick Taylor, Heta Tobin, Naida Glavish, Megan Tunks, Michelle Cavanagh, John Patterson, Denise Ewe, Te Aroha Law, Kate Nelson, Stella Ford, Emma Lamb, Hoki Aperehama, David Hillman, George Taipari, Dale –Lynne Sherman Godinet, Ruth Davy, Jack Scanlan, Janine Jolly, Graeme Porter, Paul Bray, Kerry Hiini, Andrew Coe, Kura Marsters, Rachel Nelson, Tui Makoare, Margaret Chopping, Aroha Sarah Tumai, Karla Matua, Lee Tamatoa, Heta Tobin, Marion Hakaraia, Aroha Sinclair, Blackie*

Tohiariki, Sanshan, Matt Appleyard, Hinemoa Buffett, Sugar Te Paa, Te Kanga Skipper.

- *The ADHB Pacific Health Team undertook consultation with the Pacific community across both DHBs.*
- *A meeting of the ADHB PHO Chief Executive forum was attended to obtain input as was a meeting of the Primary Health Care Clinical Leaders' Group.*
- *A draft Child Health Improvement Plan was written, approved by the ADHB Steering Group for consultation and made available to the health community and general public. The draft Plan was published on-line with invitations sent to stakeholders inviting comment. The draft Plan was sent to all general practices in Auckland and Waitemata, with a letter inviting feedback. 45 responses were received either through the on-line response form, email or by letter. Some were on behalf of organisations or groups of respondents. An independent researcher reviewed and collated a summary of the feedback. Overall, responses to the draft Plan were very positive. The summary was provided to the steering group to review. A small working group then considered the feedback in full and agreed changes to the draft.*
- *WDHB consulted with its community including four meetings with Asian stakeholders, Māori stakeholders, migrant stakeholders and with stakeholders concerning children with disabilities.*

Indicators were developed once feedback on the draft Plan was available. Drafts were reviewed by Dr Elizabeth Craig from the New Zealand Child and Youth Epidemiology Service based at the University of Otago. Targets will be developed following further work.

The final draft was taken to the joint ADHB/WDHB Community and Public Health Advisory Committee (CPHAC) for endorsement on 21 November 2012.

- *The finalised Plan will be made available electronically on the ADHB/WDHB websites.*

References

- ¹ Ethnicity data and projections used 2006 Census information.
- ² In 2010, 7709 women birthed at National Women's. Of these, 5,550 (72%) were resident in ADHB. (National Women's Annual Clinical Report 2010). Another approximately 400 women gave birth at the primary birthing facility, Birthcare, and a further approximately 100 women had a home birth. For the entire Auckland region, 21,695 live births were recorded in 2006 by Statistics NZ (http://www.stats.govt.nz/browse_for_stats/population/births/births-tables.aspx).
- ³ Maternity and newborn information was obtained from Healthware for 2010
- ⁴ Breastfeeding and the Use of Human Milk. American Academy of Pediatrics. Policy Statement Pediatrics Vol. 129, No. 3
- ⁵ National Breastfeeding Advisory Committee of New Zealand 2009. *National Strategic Plan of Action for Breastfeeding 2008 – 2012: National Breastfeeding Advisory Committee of New Zealand's advice to the Director General of Health*. Wellington. Ministry of Health
- ⁶ Turner N. Asher I. Bach K. Denny S. Fancourt N. Merry S. Child Health and Poverty. Chapter in Dale MC, St John S, O'Brien M. *Left Further Behind. How social and income inequalities damage New Zealand children* ISBN 0-9582263-9-3 Child Poverty Action Group; 2011. <http://www.cpag.org.nz/assets/sm/upload/g4/gp/1n/xu/111010%20FINAL%20%20Left%20Further%20Behind%20Brochure.pdf>
- ⁷ Durie et al (2002)
- ⁸ Durie (1999).
- ⁹ Ibid.
- ¹⁰ Inter-agency Working Group. 2007. *Inter-agency Plan for Conduct Disorder/Severe Antisocial Behaviour 2007 – 2012*. Ministry of Social Development. Accessed on-line <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/anti-social-behaviour>
- ¹¹ Whanau Ora Taskforce <http://www.tpk.govt.nz/documents/whanau-ora-taskforce-report.pdf>
- ¹³ Data from the NZ National Immunisation Register
- ¹² *Better, Sooner, More Convenient* Primary Health Care is the Government's initiative to deliver a more personalised primary health care system that provides services closer to home and makes Kiwis healthier." See the Ministry of Health website <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-bsmc>
- ¹³ Data obtained from the National Immunisation Register.
- ¹⁴ Northern Region's Health Plan 2012