Bay of Plenty Child and Youth Health and Wellbeing Strategy

2014-2019

MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

MINISTRY OF SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora

The following government agencies support and endorse the implementation of the Bay of Plenty Child and Youth Health and Wellbeing Strategy 2014-2019:

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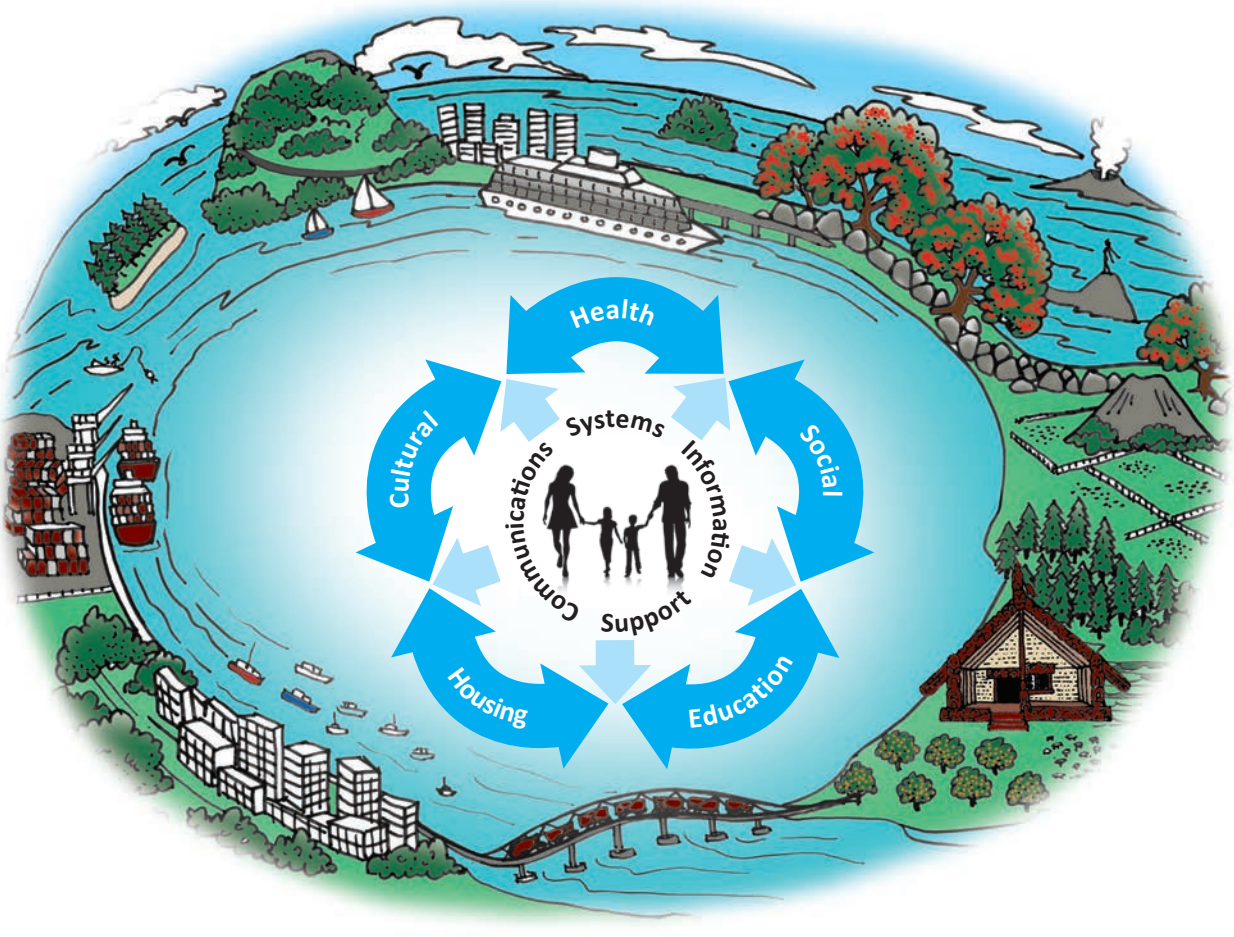

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1. Executive Summary

The vision for this Strategy is equity of outcomes for all infants, children and young people within the Bay of Plenty (BOP) district. This will be achieved by ensuring that:

- all children and young people live in safe and healthy homes and neighbourhoods, having their nutritional and other day-to-day needs met and receiving the emotional support required to successfully transition to adult life
- children and young people have access to timely and appropriate intervention and treatment when physical or mental health concerns arise.

Therefore, the responsibility of the healthcare system is broad and requires multiple levels of expertise as well as partnerships with the Ministries of Education and Social Development, local government, community groups, and non-governmental organisations (NGOs) if these goals are to be achieved.

Outcomes among children in high deprivation areas, especially Māori and Pasifika, and those with disabilities, are poorer than other children. In order to eliminate the gap and achieve equity of outcomes for all children we will focus our actions across health, education and social services over the next five years by adopting the following Strategic Goals:

1) Adopt an integrated approach with a population health focus.
2) Targeted Investment – allocate resources to vulnerable children and young people, especially age conception to five years and vulnerable populations and integrate our collective investment in the district.
3) Workforce – develop a fit-for-purpose workforce to build capacity to enable effective planning, administration and direct service provision to vulnerable children.

This Strategy is closely aligned with, and underpinned by, the BOP Integrated Health Care Strategy (IHS) 2020[1].

1 IHS theme 1: Patient and family-centred care/Whānau Ora; IHS theme 2: Health literacy; IHS theme 3: Access to patient information; IHS theme 4: Co-ordinated care; IHS theme 5: Creating an environment for integration; IHS theme 6: Contracting for outcomes and flexibility of funding; IHS theme 7: Health in all policies

2. About this Strategy

The Bay of Plenty Child and Youth Strategic Alliance (CYSA) is a cross-disciplinary and cross-agency group that advises the District Health Board on how to support the health and wellbeing of infants, children and young people in the BOPDHB district. The Bay of Plenty CYSA members applied their professional knowledge, and reviewed outcome data and input from a range of stakeholders, to reach agreement on the strategic goals and priorities of the Child and Youth Health and Wellbeing Strategy.

Each priority and action in this Strategy links to the national and local initiatives, the Minister's priorities, and the Board's values. Under each it also sets out relevant background information, the evidence-base, examples of good practice in the Bay of Plenty and elsewhere, and the case for change.

This Strategy includes an action plan to achieve its objectives. It is envisaged that, while this document will form a basis for the strategic direction for Child and Youth Health services, it will be reviewed annually to ensure its assumptions and recommendations remain valid and up to date.

Appendix 2, International and New Zealand Reports, summarises numerous policy documents and research findings that support the strategic priorities recommended in the Strategy.

Relationship to Existing Initiatives

The priorities and actions set out in this Strategy represent the next stage of the Bay of Plenty CYSA efforts to transform the current system into an integrated whole. There are many initiatives at national and local levels that are intended to improve outcomes for those children and young people who are most at risk of poor outcomes, both in the short and long-term. Appendix 3, *National and Local Initiatives that Support the Actions*, presents examples of current national and local initiatives that will lead to a more effective system and be the starting point for progressing the priorities of this Strategy. Appendix 4, *Stocktake of Services*, lists the child and youth services currently funded by the DHB and the Ministry of Social Development (MSD).

We acknowledge that many of the actions taken over the five-year period will continue beyond 2019 since establishing equity of outcomes for all of our children and young people is likely to require a transformation of the system. Therefore, this Strategy represents the beginning of establishing a system that embeds integrated and population-specific policies and service delivery to ensure that all children have a good start in life. We suggest that information included in the attached appendices be used as resources to examine the issues in more detail and review the range of child and youth services funded by the DHB and key partners.

2.1 Principles

The following principles underpin the Strategy.

Treaty of Waitangi - recognition that the Treaty of Waitangi is the founding document of New Zealand. Therefore we acknowledge the Treaty principle that Māori will have an equal role in progressing the priorities for Māori.

Māori connecting with Māori - utilise Māori professionals and non-professionals to provide acceptable and culturally-responsive services and support to Māori communities

and families/whānau (eg natural helpers, kaiawhina, Te Pou Kokiri, Māori community health workers - navigators).

Whanau Ora approach - we adopt the principles and values of Whānau Ora; focusing on how the family collective can bring about improvements in an individual's wellbeing.

Partnership - this Strategy relies on health, education, social service providers, local government and community leaders working together to achieve the common goal of equity of outcomes for all children.

Best use of resources - priorities are addressed in ways that provide the best value for money, by eliminating duplication of effort and focusing on what works.

Community focus - the Strategy promotes a community development approach to enable local communities to determine how best to support the wellbeing of children and young people. In addition, the Strategy aims to prevent health problems and identity and ameliorate risk from pre-conception to young adulthood.

3. Who this Strategy is for

This Strategy applies to children and young people aged 0-24 years, incorporating children (defined by the Ministry of Health as 0-14 years of age) and young adults 15-24 years of age (in recognition of the unique health needs of young people during the transition to adulthood).

In BOPDHB, the total number of people aged between 0-24 is 70,400 making up 33% of the population. This is expected to increase by 1% to 71,135 by 2026.

Of the 70,400 people aged 0-24 years, approximately 16,962 people (24%) are living in New Zealand Deprivation (NZDep) 9 and 10 areas, of whom children aged 0-14 years number 10,826 (25%) and young people aged 15-24 years number 6,136 (23%).

The BOPDHB Annual Plan states that "the BOPDHB population is over-represented in high deprivation categories and under-represented in low deprivation categories compared to New Zealand as a whole."[2] Within the BOPDHB district levels of deprivation and the Māori population are higher in the Eastern Bay.[3]

The number of registered BOP hospital and home births in 2012 was 2,515. Of this number nearly 45% were Māori. Although the number of births decreased since the 2006 census, the predicted number of births will remain near this level through to 2026, with Māori births continuing to account for the largest number of registered births by ethnic group. The population forecast to 2026 predicts an increase of 2.8% in the 0-14 age group, with a decrease of 8.1% for the 15-24 year age group.

Our population reflects the national trends, in that in terms of projected future growth (2006-2026) for the BOPDHB district:

- population growth is significantly higher (BOPDHB 20.5%) than it is for New Zealand overall (18.6% total)
- Māori population growth is estimated to be lower (22.3%), compared to that for Māori in New Zealand overall (24.9%). The population of Māori children 0-14 is expected to increase by 4.9% and of Māori young people 15-24 is expected to increase by 3.3% by 2026[4].

This Strategy emphasises the need to tailor actions to match the characteristics of the community and the intensity and type of need.

The DHB Annual Plan 2013-2014 identified child and youth health as a priority based on health needs assessment results that identified gaps in child and youth services. The plan states that the DHB will "continue to analyse service gaps and develop strategies to improve health outcomes and reduce health disparities for children and young people".[5]

With this Strategy we are able to create a collective voice to advocate for those who do not have a voice within the current system. Child and youth are health priorities for both Bay Of Plenty District Health Board and Midland District Health Boards.

This section summarises the health status of children and young people in the BOPDHB district compared with the New Zealand population and the challenges we are likely to face over the coming decades in ensuring

2 Bay of Plenty District Health Board Annual Plan. 2013-2014, p32.
3 Māori Health Plan. 2013-2014. Bay of Plenty District Health Board.
4 Bay of Plenty District Health Board Annual Plan. 2013-2014.
5 Bay of Plenty District Health Board Annual Plan 2013-2014. p 46. Bay of Plenty District Health Board, Tauranga.

children have the best start in life. For further details please refer to Appendix 1. In addition, the differences between Māori and non-Māori on a select set of indicators are presented.

This Strategy promotes the establishment of a framework that encompasses the actions required across systems to establish equity of outcomes for all children. Therefore the Strategy provides framework to support the specific initiatives that are currently underway. It also attends to unaddressed issues that require systematic integration and coordination of effort to progress equity of outcomes for

4. Why the Child and Youth Strategy Matters to Us

those groups who are not sufficiently benefiting from the current system.
Generally, children and young people in New Zealand and the Bay of Plenty enjoy good health, high quality education and a family life that offers safety, security and emotional support. However, inequities among Māori, Pasifika, children with disabilities, and those who live in high deprivation areas, persist. These inequities are likely to increase if we do nothing.

This Strategy matters to us because evidence shows that investment in the early years provides the greatest opportunity to prevent or ameliorate problems later on in life and leads to more sustainable outcomes. There is wide recognition internationally and in New Zealand that a society's health status is closely linked to social determinants, ie the conditions in which people are born, grow, live, work and age. The position on the social gradient correlates with health status. Those people whose social determinates place them at the top of the scale enjoy a much better health status and live longer than those at the lower end of the scale. The incidence of mental health problems (eg anxiety and depression), drug and alcohol addiction, tobacco use, overeating, excessive risk taking (eg traffic accidents) violence and homicide are more prevalent at the lower end of the scale.[6] Minimising the impact these social determinants have on health is now a focus of concern for New Zealand. Apart from the obvious societal gains from a more healthy and equitable nation, there is the potential for addressing the ever-increasing cost of healthcare.[7]

KEY ISSUES

Antenatal, Infant and Child (0-14 years of age):

- Low registration with a Lead Maternity Carer (LMC) before 12 weeks gestation.
- High neonatal mortality rate.
- High childhood obesity rate.
- High Ambulatory Sensitive Hospitalisation (ASH) rates particularly for 0-4 age group. Bay of Plenty hospital admission rates were significantly higher than for New Zealand children as a whole or increased between 2006-2010 particularly for upper respiratory tract conditions, middle ear conditions (otitis media and grommets), bronchiolitis and asthma.
- High rates of assault, neglect, and maltreatment.
- Prevalence of rheumatic fever.
- Poor oral health.

Young Person-specific (13-24 years of age)

- High rate of avoidable hospital admissions
- High rate of mortality particularly through vehicle occupant transport injuries, intentional self-harm and neoplasms
- High youth suicide rate
- Teen pregnancy
- Low use of oral health services by adolescents.

6 Commission on the Social Determinants of Health, 2010. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Final Report Executive Summary, World Health Organisation, Geneva.

7 New Zealand Medical Association: Health Equity

Housing

Overcrowding with damp and poor ventilation conditions which directly lead to high rates of infectious disease such as childhood meningococcal disease and rheumatic fever.

Demographic Challenges

Over the coming decades New Zealand will face significant demographic challenges and opportunities, such as population ageing and the end of growth, with the onset of depopulation in many areas. New Zealand has the highest birth-rate of the OECD (Organisation for Economic Co-operation and Development) countries and some challenges are unique to us. These include the disproportionate concentration of the nation's population in one region (Auckland), the relative youthfulness of the Māori population, and a rapidly changing ethnic composition generated by globally high per capita net international migration gains. These unique challenges will influence how we deliver our services in the future for children and young people in the Bay of Plenty.

The Bay of Plenty has the seventh oldest age structure of New Zealand's 16 regions, with 17.6% of the population aged 65+ years in 2013 (Marlborough being the oldest and Auckland the youngest). The disparity reflects both disproportionate net migration loss at young adult ages, which removes some of the region's reproductive (births) potential, and disproportionate gains at older/retiree ages.

If current trends continue unabated by 2033 only the Opotiki district is projected to have less than 40% aged 65+ years, while Kawerau will have in excess of 65%. Whakatane, Kawerau and Opotiki districts may experience continued decline in population and be considerably smaller in size. Western Bay of Plenty and Tauranga will still be growing, but very slowly, as the majority of growth will be at 65+ years and, in Tauranga's case, increasingly at 85+ years[8].

The region in general will experience increasing competition from other regions (and countries) for their young people. In addition, there will be increasing pressure on the health system to direct funding towards managing the burden of chronic disease, more prevalent in older people. These challenges increase the importance of ensuring that we have a deliberate and targeted strategy to achieve health gains for children and young people, not only for the health of this population but for the health of the nation's future.

The following stories demonstrate why this Strategy matters to us.

8 SmartGrowth 2014 Review - Demographic and Employment Projections 2013 – 2063: Jackson et al. National Institute of Demographic and Economic Analysis.

Aroha's Story

Aroha is a 35-year-old Māori woman who moved to the Eastern Bay of Plenty two years ago with her partner and three of her (then) five children, who were 13, 10 and seven years old. Her other two children are young adults and live elsewhere. Aroha has a history of drug and alcohol problems, as does her partner. As a girl she left school with no qualifications and had her first baby when she was 15 years old. Aroha and her partner both lived lives of alcohol, drugs and prison. When the family moved to the Eastern Bay she had just found out that she was pregnant but this time was different to her previous pregnancies. In the past she did not trust the system, and the health providers seemed to tell her what to do but acted as if what she said did not matter. She ended up taking care of herself throughout the pregnancy until she went to hospital for the delivery. She then returned home and was basically on her own unless she asked someone for help – she was too proud to do that.

Soon after moving into their new place in the Eastern Bay Aroha's neighbour came by and they got acquainted. She told her about the local marae-based health clinic and said that it was different to the other health services she had experienced. She and her partner gave it a try. When they went there they found that not only did the clinic have midwives but also a GP was there twice a week. The clinic also offered Tamariki Ora services, drug and alcohol groups, budgeting services and a social worker to assist with whatever else a family needed. Aroha connected with a midwife, Louisa, who listened to her and her partner, examined her, and helped her understand that she needed to stop smoking and drinking for the sake of her unborn baby and the rest of her children. Aroha and her partner felt accepted and respected by Louisa and soon connected with the drug and alcohol group and the social worker. Together Louisa and the social worker helped them develop a plan for the arrival of their new baby and their future as a family. When baby Moana was born she was registered with the GP who worked at the clinic and with Tamariki Ora. The GP provided health services to all of the family. Throughout the pregnancy, and for a month or so after Moana was born, Louisa came to their home on a regular basis. The clinic also offered a helper to come in and do some of the cooking and housework during those first few weeks so she and her partner could spend time with Moana and take care of the other children. One day Louisa brought the Tamariki Ora nurse over and Aroha could see that she would help them make sure Moana was in good health. Aroha felt confident that she could ask her questions about anything – including how to keep their home healthy and where she could get advice and support for her other children. For the first time Aroha and her family are feeling part of the community. Aroha and her partner are confident in their ability to be good parents and her partner now has a full-time job thanks to an employment programme they heard about through the clinic.

Sam's Story

From the beginning of primary school Sam never really fitted in. He always kept to himself and had difficulty communicating with other kids. His parents thought that he was just more introverted than most children. All through primary school his teachers told his parents that he was a good kid and never caused any trouble. Deep down his parents were starting to worry. Beginning about age 13 he started spending much more time alone in his room than he had before and they suspected he was drinking. It seemed he was becoming more and more isolated from them and other teens. They talked with their GP about this and she suggested that maybe he was depressed and should see a mental health counsellor. Sam was not interested and was quite upset his parents had even made the suggestion. Just before the school year ended he went to the school-based health clinic because a friend had found a person there who helped him with some problems he was having at home. Sam met the person at the clinic. One of the things she offered was a chance to connect with someone called a mentor who she said Sam would probably like. She said being a teenager was hard and that sometimes just having someone to talk to and do things with that is not judgemental can be helpful. She also asked if it would be ok to ask him a few questions to find out if their might be health reasons for him feeling down in the dumps. Sam agreed and an assessment was done. Sam found out what he already suspected – he was depressed. He also decided that he wanted to try the mentor before doing anything else. He was willing to see a counsellor but would rather attend one of the group meetings held at the school where kids got to share their thoughts and feelings. He would go to one meeting and decide whether to continue.

During the last few months of the school year Sam was a regular with the group. He began a mentoring relationship with a group member who spent time with Sam doing the things he liked to do but would not do by himself – eg going to movies, riding bikes, going out to eat, etc. The mentor was not on the school schedule and could spend time with Sam throughout school holidays, including summer. Before long he trusted the mentor and felt that finally he had someone he could really confide in. His parents noticed that he laughed more and spent far less time alone in his room. It even seemed that his health was better! School is going well and Sam now has a circle of friends who are involved in the drama programme. He's thinking about what he wants to do after he gets his qualification.

5. Action Plan

This section sets out the actions planned to achieve our vision: equity of outcomes for all infants, children, and young people. Actions are grouped by Strategic Goals and are underpinned by the principles and actions set out in the BOP Integrated HealthCare Strategy 2020. Additional supporting evidence is provided in Appendix 1, *International and New Zealand Reports*. The Action Plan indicates the estimated timeframes for completion, the organisation or department who has agreed to take a lead in the activity, and who can provide support. Leads have been identified on the basis that they have experience and/or expertise in a particular area. Leads will act as sponsors to oversee or coordinate activity on behalf of the partners. They also agree to prepare or collate progress reports.

Strategic Goal 1: Integration (Population Health Approach)

Integrating health services with other sectors is a means of achieving a healthier population overall. This Strategy recommends adopting a population health approach to tackling health and wellbeing inequalities in the BOP. A population health approach is defined as an approach that will explicitly take account of all the influences on health (the determinants of health) and how they can be tackled to achieve equitable outcomes and improve the overall health of the population and which:[9]

- addresses the social and economic determinants of health, acting through health and disability services (public health, personal health and disability support) in conjunction with other social agencies through intersectorial collaboration
- emphasises the importance of an interdisciplinary and collaborative approach
- plans and delivers services in partnership with communities
- builds on the complementary strengths of all those involved, including those of the communities themselves
- has an emphasis on meeting the needs of those who may otherwise be 'invisible' and marginalised (eg those who rarely seek health services despite having high health needs)
- defines the populations of interest as those children and young people with the greatest disparity in outcomes compared with their peers in the general population.

Reduction of Fragmented Service Delivery
Services and funding for children and youth who are deprived or with disabilities are fragmented, difficult to access, and all too often do not meet the needs of the child and family.

One of the most formidable barriers is the fragmentation of government policy, funding, and delivery of services. In New Zealand the central government allocates funding to distinctly different departments. These departments often serve many of the same clients. Moreover, the Ministry of Education (MOE) and MSD are centrally administered, independent midwives are contracted through the Ministry of Health (MOH), and Plunket is contracted through MOH, while a number of local NGOs receive funding through the DHB to provide well child services. The bulk of primary and secondary health services are administered by the DHBs. An additional complication is that primary health organisations and independent General Practitioners (GPs) are run as small businesses. While the majority of GP practices work collaboratively with the DHB they continue

9 The definition of "population health" is taken from a 2008 discussion paper submitted to support the implementation of the Primary Health Care Strategy. It states that "population health refers to consideration of the health outcomes or status of defined populations - groups, families and communities - and the distribution of such outcomes within populations. Populations may be defined by locality, or by biological, social or cultural criteria".

to retain their independence and can make decisions about policies that do not have to align with DHB policies.

This mix of national, regional and local funding allocations presents challenges to shifting to an integrated system for the DHB and its partner agencies. However, much can be done within the BOP and neighbouring districts to embed governance, planning, funding and service delivery that reduces fragmentation and directs the coordination of services and support. A number of practices and tools are already in place, such as high-trust and integrated contracts, funding of Whānau Ora, various cross-agency advisory and working groups, and multidisciplinary teams for children and young people who are identified with specific disabilities.

The BOP Integrated Healthcare Strategy 2020 sets out the foundations for developing integrated healthcare consistently throughout the Bay of Plenty. It provides strategic direction to undertake system changes that will help the whole Bay of Plenty health system to work together. Achieving the goals of the Integrated Healthcare Strategy is founded on seven core themes (as depicted in Figure 2) and their associated action plans for change over the period 2014 to 2020. Its purpose is to be a lens that can be applied to all healthcare related activity. The result will be a more integrated and well-coordinated system overall that will improve outcomes for all, including the children and young people that are the focus of this Strategy. The Strategy aims to align with this initiative.

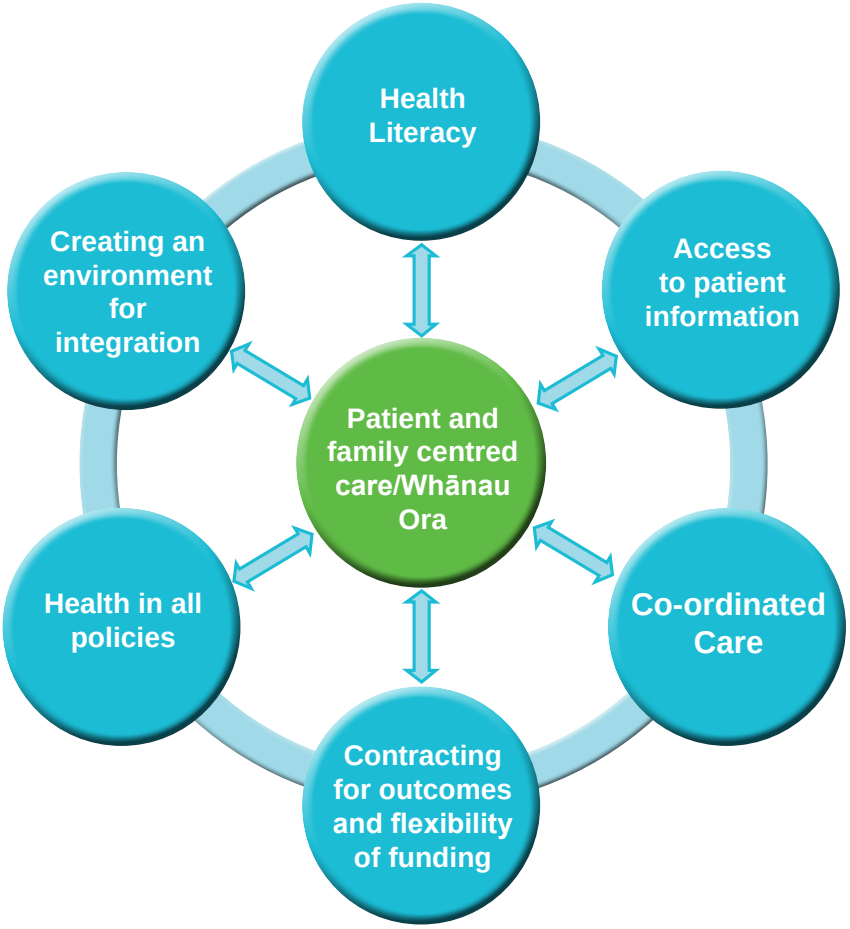


Figure 2: BOP Integrated HealthCare Strategy 2020

Children's Team – Whakatāne

BOPDHB has been identified as one of eight DHBs who will have a Children's Team site, following on from demonstration sites at Lakes (Rotorua) and Northland (Whangarei) DHBs. A Children's Team is one of the initiatives to come out of the Green and White Papers for Vulnerable Children, leading to the Children's Action Plan.

The link to the Children's Action Plan is:
http://www.childrensactionplan.govt.nz/

Children's Teams will work to make sure vulnerable children are safe from harm, thrive, achieve and belong. The team itself will be made up of frontline professionals across government agencies, NGOs, iwi and the community, positioned to respond to the needs of at-risk children and their whānau. It has been emphasised that this is not a new service but rather a new way of working.

It is anticipated that the Whakatāne Children's Team will be established by November 2014 and go live (ie accept referrals) by May 2015. As at 30 June 2014 the following actions have been undertaken:

- An initial briefing took place with Lakes DHB representatives from Planning and Funding who have shared their experience and learnings.
- A presentation has been made to the Runanga.
- A preliminary meeting with Sue Mackwell, the National Children's Director, Ministry of Social Development, and key stakeholders including Eastern Bay Primary Health Alliance, paediatricians, social workers, and nurse leaders was held in Whakatāne.

BOPDHB will host a planning workshop on 18 July 2014. The proposed outcomes from the workshop are:

- key stakeholders are brought together (both within the DHB and other agencies)
- a shared vision is developed, along with a philosophy and guiding principles for the Children's Team
- learning from and leveraging off the experience and expertise of local child-centred services including the Rotorua Children's Teams
- initial discussions around the development of a child/whānau-centred service model
- agreeing a direction of travel.

The actions from this planning workshop will become part of the implementation plan for the Bay of Plenty Child and Youth Health and Wellbeing Strategy, particularly for the first year of operation.

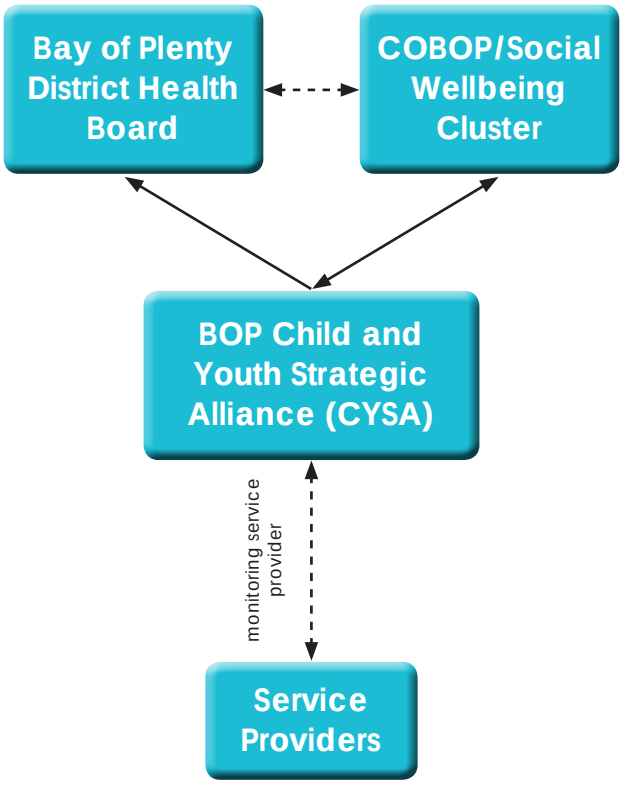
Governance

The first step to progressing this Strategy is to establish joint leadership, possibly within existing interagency forums that include health, social service, education, local government and leaders representing each of the population groups of interest. This joint leadership group is called Bay of Plenty Child and Youth Strategic Alliance (CYSA).

CYSA will be empowered to make recommendations to all relevant agencies and decisions will be made according to each agency's own internal process. CYSA will also monitor the implementation of the Strategy. Therefore, CYSA will become a steering group rather than just an advisory group. We recommend that the membership of the group be reviewed annually to ensure the most effective mix of members.

The Collaboration BOP (COBOP) may be also be a forum that could assist the implementation of this Strategy. COBOP's brief appears to align with many of the desired outcomes and CYSA can potentially relate to COBOP, particularly the social wellbeing cluster which is already working on projects that align with the Government's Better Public Service targets, including health initiatives to reduce rheumatic fever rates and other relevant social initiatives. CYSA should approach COBOP to determine the role it could play in supporting the implementation of this Strategy.

The chart represents one approach to levels of reporting. As with any governance structure a feedback loop will be integral to ensure effective reciprocal communication so that timely and appropriate changes can be made as needed. We recommend that the planning and funding and operational arms of the DHB work in partnership as plans and decisions are made.



Outcomes for Strategic Goal 1: Integration (Population Health Approach)

1. Patients and family/whānau take greater responsibility for their health and their decisions are respected.
2. A Bay of Plenty Child and Youth Strategic Alliance (CYSA) is established. This alliance will consist of health, social service, education, local government, leaders representing each of the population groups of interest, and service users.
3. 'What matters to you and/or your family and whānau?' underpins the approach to all child and youth health service delivery.
4. Consumers have a role in how services are designed and delivered/during the design process there is an opportunity for a service user voice.
5. Policies and service delivery models across systems incorporate common principles, goals and interagency protocols.
6. Contracting entities apply the principles of the Strategy and services are based on best and evidence-based models and practices to successfully connect with disadvantaged groups.
7. Families/whānau have increasing knowledge on:
   - knowing how to get what they need (service pathways understood by users)
   - increased and consistent access and use of services that maintain maternal and child health and wellbeing.
8. Each population group shows:
   - increased trust in the use of the system
   - increased knowledge of maternal and child health, education and social services
   - increased use of primary prevention
   - increased health literacy.

1 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
1.1 Gain a comprehensive understanding of where the populations of greatest concern are living, and the capacity of local services to provide coordinated, timely, and culturally responsive engagement and services, especially to those who tend not to use the current mainstream systems. 1. Establish the population profile(s) and map geographic locations of the children whose outcomes are inequitable compared with the general population 2. Map the type of services and staffing within each geographic area to determine capacity 3. Map Community-led organisations and	July 2014 to December 2014	Joint list of common goals for all agencies to address	CYSA/NGO	IHS Theme 4: Coordinated Care IHS Theme 5: Creating an environment for integration IHS Theme 6: Contracting for outcomes and flexibility of funding Government's Better Public Service Policy

1 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
untapped potential in each geographic area. 4. Conduct a quality assessment to determine the extent that resources within each geographic area are addressing need - evidence-based, culturally responsive, coordinated within and across systems, provide transition support, reach those most vulnerable, etc. (example - PHOs have Whanau Ora contracts – what types of meaningful services are being provided for young people through these contracts?) 5. Establish any additional "service pathways" specific to the population groups (Bay Navigator; modified version for families/whanau)				
1.2 Establish joint plans and terms of reference for the Bay of Plenty Child and Youth Alliance (CYSA)	September 2014	Joint Terms of Reference Joint work plan	**BOPDHB Planning and Funding**/MOE, MSD	BOP Integrated HealthCare Strategic Themes 1 and 7 Whānau Ora – Appendix 2
1.3 Align policy, planning, and service delivery across health, education, social services, and local government. 1. Set up an interagency mechanism to monitor policies and service delivery models to ensure that they are coherent and contribute to a comprehensive approach to supporting pregnant women, children, and young people	September 2014 – December 2014	Joint Service Level Alliance Team	**BOPDHB Planning and Funding**	IHS Theme 4: Coordinated Care IHS Theme 5: Creating an environment for integration IHS Theme 6: Contracting for outcomes and flexibility of funding Government's Better Public Service Policy Streamline contracting between all government agencies lead by Ministry of Business and Innovation.
1.4 Ensure that models of care are evidence-based or based on promising practices and "fit for purpose"	September 2014 – December 2015		**Subgroup of CYSA**/ NGO	IHS Theme 4: Coordinated Care

1 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
1. Review current models of care in BOP, including health literacy approaches, Whanau Ora, outreach to rural areas, patient centred service booking system. 2. Compare existing models of care with recommended models to determine whether they are "fit for purpose" for the populations of interest. 3. Adapt and monitor selected models of care when the evidence shows positive outcomes for the populations of interest. Identify the common features. Examples may include: • Whanau Ora • Natural Helpers (Kaitiata) • New Model for people with disabilities • Te Whiringa Ora (Eastern BOP) • Co-ordinated Primary Options (Western BOP) • BOP Community Response Team • Strengthening Families • Kawerau Suicide Prevention Team. • Models of transition support across developmental periods (eg pregnancy, early years, start of school, secondary school, post-secondary school) 4. Develop, implement, and evaluate innovative approaches to address gaps in services and supports for the populations of interest, include approaches taking place in the BOP, other districts in New Zealand, and overseas models such as patient centred booking.				IHS Theme 5: Creating an environment for integration IHS Theme 6: Contracting for outcomes and flexibility of funding Government's Better Public Service Policy Streamline contracting between all Government agencies lead by Ministry of Business and Innovation.

1 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
1.5 Redefine the role and function of the hospital based services and community based services. Review purchasing and contracting mechanisms and strategies to remove barriers and ensure alignment with principles of integrated healthcare. Explore alternatives to the price volume method of purchasing services. Review existing integrated and "high trust" contracts to assess effectiveness and efficiency and refine as needed. Require all contracts to be monitored for outcomes and use of best and evidence-based practices, with an emphasis on coordination and continuity of support between services and systems (including the extent that the organisation and service provision apply the principles of the Strategy) Develop additional integrated and "high trust" contracts when new models of care are to be implemented. Explore consolidation of contracts and apply changes when such consolidation is recommended.	Jan 2015 – June 2015; implement contracts with these requirements starting July 2015 (using new funding where needed).	Every Bay Navigator pathway aligns with the Bay Navigator framework. Strategies and policies promote and enable integrated healthcare. Alternatives are identified. Pilot services are identified and agreed.	**Bay Navigator Governance Group** **BOPDHB Planning and Funding** **BOPDHB Planning and Funding**/All contractors	Theme 6: Contracting for outcomes and flexibility of funding
1.6 Implementation of Children's Team in Whakatane.	It is anticipated that the Whakatāne Children's Team will be established by November 2014 and go live (ie accept referrals) by May 2015.	Establishment of Children's Team with robust referrals.	**BOPDHB Planning and Funding**/MSD/ MOE/NGO and other government agencies.	Theme 6: Contracting for outcomes and flexibility of funding

Strategic Goal 2: Targeted Investment

Numerous reports and the cost-benefit work of Heckman and colleagues emphasise that investing from conception to the start of school results in better health and wellbeing outcomes during childhood and throughout the course of life. Therefore, we recommend that over the next six years the DHB progressively targets its investment on child and youth health services as defined by the model of care. We emphasise that the investment must be systematically planned and monitored in terms of quality and outcomes for the specific populations of interest. Moreover, we recommend an interagency approach be applied to optimise our collective potential and fund models of services and supports for children and young people who are most at risk of poor outcomes.

Outcomes for Strategic Goal 2: Targeted Investment

1. Service gaps between Māori and Non-Māori are eliminated for all targets.
2. Resources are allocated in a way that supports and encourages integrated services, reduces inequalities and seeks to the collective investment and potential in the district.
3. Resources are allocated to the youngest and most vulnerable population groups. Investments are sustainable and seek the best value for public health system resources.
4. Take a longer term view of 'return on investment' and be prepared to be bold and resource the 'hump' cost, in particular with any acute management strategies.

2 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
2.1 Shift resources to children, especially antenatal to age five and the other vulnerable population groups within existing funding pool as defined by the model of care. Evaluate and review effectiveness of current After Hours Under Sixes service. Explore opportunities to optimise primary and secondary acute management and Emergency Department events.	January 2015 – June 2019	• Oral health measures per Annual Plan • Well Child Tamariki Ora/B4 School Checks • Breastfeeding status at all age markers • Immunisation • Rheumatic fever • PHO Enrolment – 100% for 0-4 for Total and Māori • Low Did Not Attend (DHA) rates • Reduction in acute readmission rates/ED volumes • Reductions in child mortality	**BOPDHB Planning and Funding**	Toi Te Ora Strategic Plan 2013-2025 BOP Integrated Healthcare Strategy Child Poverty Monitor Acute Demand Management project
2.2 Develop an integrated model of resource allocation for child and youth services (evidence-based where possible). The following interagency activities will be recommended to COBOP (based on recommendations from the Social Cluster and			**BOPDHB Planning and funding/** MSD	

2 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
CYSA) for consideration and if approved, incorporated into a memorandum of agreement. • Review current resource allocations across age and population groups to identify duplication of effort and ineffective spending (health, education, social services, local government). • Establish a working group with appropriate range of expertise to review and recommend models of resource allocation to be piloted. Results of the model evaluations will be compared and information used to decide on whether to continue and/or modify one or more of the models. • The resource allocation model will seek to allocate resources to the youngest and most vulnerable population groups and monitor implementation to evaluate effectiveness and modify as needed (qualitative and quantitative; including cost analysis).				
2.3 Integrate our collective investment to achieve the desired outcomes for children and young people in the district. The DHB, education and social service sectors, and philanthropic trusts, develop and implement a model of resource allocation to support integrated services and which seeks to leverage our collective investment and potential in the district.				IHS Themes 6 and 7

Strategic Goal 3: Workforce

We aim to develop a fit-for-purpose workforce with the capacity and capability to enable effective planning, administration, cultural awareness and engagement with Māori and Pasifika, and provide effective direct services.

We recommend that, as a first step, a systematic review of the strengths and weaknesses of the current workforce responsible for improving outcomes for Māori, Pasifika, children living in high deprivation, and those with disabilities, be completed. While there are a number of actions that will be similar across the developmental stages some of the key competencies are specific to each age group.

Regardless of the age of the children, all professionals must have basic knowledge of Māori culture - te reo (language), tikanga (values and beliefs) and kawa (protocol). The areas of knowledge include:

- the importance of building relationships
- the importance of spending time to discuss the issue(s)
- understanding that each iwi is different, with its own language and values
- how Māori navigate the system is often different to non-Māori; one Māori professional stated: "navigating the health system makes them [Māori] unwell".

In order to achieve a fit-for-purpose workforce that progresses the goal of equity of outcomes, support worker roles should become an integral part of the workforce (eg navigators, natural helpers, Māori health workers). In order to accomplish this policies must be set in place that include the definition of each role, competencies required, and procedures for training and ongoing mentoring/supervision.

In addition to overall professional development, the following activities will establish a fit-for-purpose workforce specific to children from pre-conception to age five, ages 14 to 24, and ages five to 13 years.

Outcomes for Strategic Goal 3: Workforce

1. Service providers, including GPs, LMCs, WCTO nurses, community health nurses, the disability sector, teen-parent units, SBHS, ECE services, and Kohanga Reo, family planning and parenting programmes, work in a coordinated manner and receive joint training and mentoring to ensure culturally responsive practices.
2. The populations of interest are able to access health, education, and social services with relative ease and in a timely manner.
3. A greater proportion of pregnant Māori and Pasifika women enrol with a LMC during the first 10 weeks of pregnancy.
4. A greater number of families/whānau and young people from the population groups use primary health services to prevent more serious health issues – this outcome should contribute to decreased ASH rates, especially for children 0-4. (Focus Area 1)
5. Pregnant women and parents report:
   - greater satisfaction, increased confidence and increased positive interactions with professionals
   - increased knowledge of how to prevent child illness and when to take their children to the GP
   - increased confidence in their abilities to navigate the system.
6. A youth specialist-training programme is established and implemented, with an initial enrolment of 20-30 young people and community placements actioned.

7. Parents and their children who retain the support of the natural helper during and after their transition to school, continue to engage with the education system, and maintain contact with their GP and other support services that are needed to ensure child health and wellbeing.

3 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
3.1 Develop a fit-for-purpose Maternity and Early Childhood Workforce.[10] We recommend training and mentoring a cohort of Māori community health workers based on the natural helper's model being piloted in Northland. Each public health nurses' team partners with a community health worker. These workers know their communities and have earned the trust of the families/whānau. The international literature on how to engage with "vulnerable" or "hard to reach" families support this approach. Proposed development and training for local development needs such as allied health.	September 2014 – March 2015	Increase number and the scope of practice for Māori community health workers.	**BOPDHB Planning and Funding**	Maternity Quality Plan
3.2 Develop a fit-for-purpose workforce for young people 14 – 24 years. BOPDHB together with its interagency partners explore the development of a youth specialist training programme[11]. A working group	September 2014 – March 2015	Increase number of youth specialist community health workers.	BOPDHB Planning and Funding	Health Workforce New Zealand

10 During the stakeholder engagement process, the importance of Māori community health workers was emphasised by a range of respondents. The DHB currently funds two Māori health workers to work with community health nurses. We believe this number is inadequate based on the populations who need additional support that is culturally responsive.

11 The training would be multidisciplinary in that participants would learn about the range of issues, current policies, and service systems. The programme would consist of a combination of group training sessions and community-based experiences. Incentives would be provided to encourage Māori and Pasifika young people to participate, including free tuition. Participants who completed the programme would reciprocate by agreeing to a short-term bonding scheme. This scheme would ensure that those individuals trained as youth specialists would live and work in the communities experiencing the poorest youth outcomes for a specified period of time. This early step in professional development may encourage many of these young people to pursue additional higher education in youth health, education and social service fields.

3 Actions	Expected timeframe for completion	Indicator of success	Lead / Support	Links
will be formed to develop a concept paper that presents the design of the youth specialist programme. The group will identify the roles that are needed and may include a range of options such as youth mentorship and youth liaison to work in conjunction with primary care, education, and social services, and transition support worker[12].				
3.3 Develop a fit-for-purpose workforce for children 5-13 years[13]. We recommend that a natural helper, or an equivalent role, aimed at providing continuity of support (continuing through to the adolescent period for those children and families who require this assistance) be designed, implemented and evaluated in two to three locations.	September 2014 – March 2015	A fit-for-purpose workforce for children 5-13 years model is established.	BOPCYSA/Other government agencies	BOP Integrated HealthCare Strategy

12 A specific gap in current services was identified for young people with chronic conditions who rely on secondary and primary care – the lack of transition support for young people leaving secondary care who need to manage their health conditions in the community. The role of the transition worker would be to assist with planning, monitoring and supporting each individual to work effectively with the community health system and manage their care at home. This transition role could also apply to young people with a range of disabilities and those with mental health issues.

13 Once the transition to school takes place, the universal services to children and their families no longer includes the regular monitoring of the LMC or WCTO providers. The free GP visit scheme currently ends at the age of six years. From the start of school the GP is the main health contact. For some parents, appointments with the GP place an additional financial burden on them and their families. Moreover, for those parents who need assistance with navigating the system and understanding how to work with the educational system, the continued support of a natural helper or the equivalent who already knows the family/whānau can make the difference between successful school adjustment or negative experiences with the system.

Appendix 1 – The Leading Causes of Poor Health in Children and Young People for the Bay of Plenty

1.1 Determinants of Health

In order to achieve equity of child health outcomes, the social and environmental circumstances that contribute to poor health and wellbeing must be addressed. The following statement from the World Health Organization (WHO) highlights the complex and multifaceted nature of what it takes to be healthy.

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The WHO goes on to say that, since the context of people's lives determine their health, children and their parents are unlikely to be able to directly control many of the things that make people healthy or not (ie determinants of health).

We know that higher income and social status are linked to better health. The greater the gap between the richest and poorest, the greater the differences are in health. Factors such as education level, safe water and clean air, safe houses, employment, unsafe working conditions, social support networks, genetics and personal behaviour (eg eating habits, physical activity, smoking, alcohol use, dealing with stress) influence health outcomes.

Therefore the policies and actions of the government and private sector, along with each community and neighbourhood, can together either contribute to better outcomes, support the status quo, or have detrimental effects on child and youth health and wellbeing.

The time is right to focus fiscal and human resources on systematically tackling the social determinants of health. The epidemiological data, international and New Zealand research, and policy documents across systems drive the strategic direction. Section 11 of the Strategy summarises the drivers of change and the health status of children and young people in the BOP compared with the rest of New Zealand.

New Zealand possesses rich sources of information to understand how children and young people are faring in terms of their health and wellbeing. A set of indicators are used nationwide to measure the health status of New Zealanders. Primary information sources include Statistics New Zealand, the New Zealand Epidemiological Service (NZES), the Child Poverty Monitor and the Ministry of Health's National Health Survey (NHS). In addition, information from the Health Needs Assessment for the BOP (HNA) informed the BOPDHB 2013-2014 Annual Plan and this Strategy.

The NZES 2011 publication The Health Status of Children and Young People in the Midland Region provides an analysis of child and youth health issues based on quantitative data from numerous national data sets. The report is based on the Indicator Framework on which each region and DHB annually reports. Findings from the 2011 report are consistent with those of the HNA for the BOPDHB and the NHS.

1.2 Antenatal, Infant and Child (0-14 years of age)

Poor Registration with a Lead Maternity Carer (LMC) before 12 Weeks Gestation[14]

Registration with a LMC before 12 weeks gestation is important because this will enable[15]:

- opportunity to offer screening for congenital abnormalities, sexually transmitted infections, family violence and maternal mental health, with referral as appropriate
- education around nutrition, smoking, alcohol and drug use, and other at-risk behaviours
- recognition of underlying medical conditions, with referral to secondary care as appropriate
- identification of at-risk women (maternal age, obesity, maternal mental health problems, multiple pregnancy, socioeconomic deprivation, maternal medical conditions).

In 2012, 68% of women registered with a LMC during the first trimester of pregnancy within BOPDHB. Greater than one-third of Pasifika and nearly one-sixth of Māori women were not attended by a LMC (GP, midwife, obstetrician) during their pregnancies. Pasifika and Māori women are also least likely to enrol with a LMC early in their pregnancy.[16] When other risks are present (eg smoking and alcohol use, family violence, obesity, poor nutrition and inadequate housing) their children are at greater risk of birth defects, infant mortality, poor health and developmental problems in infancy and beyond.

14 The reason for a 12 week cut-off is that this signifies the end of the first trimester.

15 2013 National Maternity Monitoring Group Annual Report, http://www.health.govt.nz/system/files/documents/publications/nnmg-annual-report-2013-4-11-13_web.pdf

16 Craig E, Adams J, Oben G, Reddington A, Wicken A & Simpson J. 2011, p78, The Health Status of Children and Young People in the Midland Region, New Zealand Epidemiological Service, University of Otago.

Neonatal and Infant Mortality

Neonatal mortality is defined as the death of a live born infant in the first 28 days of life. During 2004-2008 the BOPDHB neonatal mortality rate was significantly higher than the national rate and higher than the other four Midland DHBs. Post neonatal death (after 28 days and prior to 365 days) mortality rates have fluctuated with a downward trend. Neonatal rates, while also fluctuating, remained more static. Extreme prematurity was the most frequent cause of neonatal mortality between 2003-2007, accounting for 34.6% of neonatal deaths. SUDI (Sudden Unexpected Death of an Infant) was the most frequent cause of post-neonatal mortality during this period, accounting for 47.1% of post-neonatal deaths.

Childhood Obesity

Obesity in childhood and adolescence has a range of serious adverse health consequences, both in the short-term (for the obese child) and long-term (for the adult who was an obese child).

Children who are obese are more likely to become obese adults, and this likelihood increases the more obese a child is. Obesity in adults is known to lead to both chronic and severe medical problems, such as heart disease, cancer, type 2 diabetes and high blood pressure. These diseases can affect a person's life expectancy.

Results from the 2011/12 New Zealand Health Survey show that about 31% of New Zealand children between two years and 14 years old are either overweight (21%) or obese (10%).[17] The child obesity rate has increased from 8% in 2006/07 to 10% in 2011/12.The many factors that contribute to obesity and obesity-related health issues are complex and include broader social issues, such as poverty, housing conditions, food security and the cost of healthy food.

The prevalence of being overweight and obese in Māori and Pasifika children and young people is higher than in the total population of children and young people. In 2011/12 the rate of obesity in Māori children was 17% and in Pasifika children 23%.[18]

Ambulatory Sensitive Hospitalisation (ASH) Rates

ASH admissions provide an indication of the effectiveness of screening, early intervention and community-based care. The leading reasons for ASH hospitalisation of children aged 0-14 were infectious and respiratory diseases (ie bronchiolitis, asthma, gastroenteritis, acute upper respiratory infections). These conditions along with skin infections are often preventable and treatable through primary care. Dental procedures and grommets account for the main reasons that children are on hospital waiting lists. A reduction in these admissions will reflect better management and treatment of people across the whole system, thus freeing up hospital resources for more complex and urgent cases. An important factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Improving access to primary care and improving its effectiveness will facilitate earlier interventions, particularly for Māori and Pasifika.

Bay of Plenty hospital admission rates were significantly higher than for New Zealand children as a whole, or increased between 2006-2010, for the following health conditions:

- upper respiratory tract conditions
- middle ear conditions (otitis media and grommets)

17 The Health of New Zealand Children: Key Findings of the New Zealand Health Survey 2011/12, Ministry of Health, 2012, Wellington.

18 New Zealand Office of the Auditor General. 2013. Evolving approach to combating child obesity http://www.oag.govt.nz/2013/child-obesity/part-3.

- bronchiolitis - rate in infants was significantly higher in BOPDHB, with the Māori rate higher than for Europeans
- asthma - rate increased; greater increases among Māori children
- serious skin infection - rate significantly higher during 2006-2010; Māori rates higher than European
- gastroenteritis - rate significantly higher for BOPDHB during 2006-2010; European rates for children and young people higher than rates for Māori
- acute rheumatic fever and rheumatic heart disease - significantly higher rates for the BOPDHB but difficult to interpret trends due to small numbers
- pertussis - rate higher than for New Zealand but fluctuated year to year.

Table 1 presents current hospitalisation data broken down by Western and Eastern Bay geographic areas for the top five conditions: upper respiratory tract infections, gastroenteritis, serious skin infections, asthma, middle ear infections (excluding dental). Western Bay includes Tauranga City and Western BOP Territorial Local Authorities (TLAs). Eastern Bay includes Kawerau, Whakatane and Opotiki district areas. Māori children in some communities in the Eastern Bay experience rates of rheumatic fever and chronic rheumatic heart disease that are among the highest in the world.

	Ethnicity	0-4 age group	Multiple Admissions	Single Admissions
Western Bay of Plenty	Māori	3461	57	77
	Other	6948	117	203
	Total	10409	174	280
Eastern Bay of Plenty	Māori	2059	65	91
	Other	1678	7	40
	Total	4637	72	131

Table 1: Actual hospital admissions for top five conditions (excluding dental) in Western and Eastern Bay of Plenty areas (source BOPDHB Planning and Funding, 2012 update).

A common characteristic of many of the conditions affecting ASH rates is an acute or abrupt onset, often superimposed on chronic conditions, of which asthma is the most common. The 2006-07 NZ Health Survey reported that 31.7% of 0-4 year olds have a chronic condition. Improved home and community management of chronic conditions may reduce the number of hospitalisations.

Assault, Neglect and Maltreatment

New Zealand continues to report high rates of child maltreatment death compared with other wealthy nations. The mortality rate represents only a small part of the problem. The numbers of children known to Child Youth and Family and those experiencing abuse and/or neglect who are not known to the system represent social and fiscal costs to individuals and society over the short and long term. Research shows that survivors of child abuse often suffer long-term psychological effects, such as depression, post-traumatic stress disorder, substance abuse, suicide and suicide attempts, and high-risk sexual behaviour.[19]

A comparison across the five DHBs in the Midland Region of hospital data from 2006-2010 for admissions due to injuries arising from the assault, neglect, or maltreatment of children 0-14 shows, on average, the BOP has the second highest rate of admissions. Table 2 provides a summary of the DHB comparisons.

DHB	Total No. Admissions 2006–2010	No. Admissions Annual Average	Rate per 100,000	Rate Ratio	95% CI
Injuries Arising from the Assault, Neglect or Maltreatment of Children 0–14 Years					
Waikato	45	9.0	11.5	0.60	0.44–0.81
Lakes	39	7.8	32.6	1.70	1.23–2.34
Bay of Plenty	76	15.2	34.2	1.78	1.41–2.25
Tairawhiti	21	4.2	36.3	1.89	1.23–2.92
Taranaki	20	4.0	17.9	0.93	0.60–1.45
New Zealand	856	171.2	19.2	1.00	

Table 2: Hospital admissions due to injuries arising from the assault, neglect or maltreatment of children 0–14 years.

19 Kendall-Tackett K, 2002, The Health Effects of Childhood Abuse: Four Pathways by Which Abuse can Influence Health, Child Abuse and Neglect 26 (6-7) 715-29.

Rheumatic Fever

Rates of rheumatic fever in BOPDHB district continue to be high, even though the disease is often preventable. The BOP and Lakes DHBs have completed the Rheumatic Fever Prevention Plan. The concerns are:

- rates for Māori children ages 5-14 years are greater than for all children – in the BOP these rates were significantly higher
- Kawerau has the highest rates, at nearly 100 per 100,000 for children 5-14, with Opotiki second highest, at just over 60 cases per 100,000.

Oral Health

Poor oral health in children and young people remains an issue across the Midland Region and in the BOP.

- Māori hospital admissions for dental caries remain higher than for all other ethnic groups.
- Rates of hospital admission for dental caries are significantly higher for children and young people in the 0-4, 5-14, and 15-24 age groups for all five DHBs in the Midland region compared with the New Zealand population.
- The New Zealand Health Survey reported that during 2011-2012:
  - children 1-4 were less likely to have a dental visit
  - about 4% of children (nearly 34,000) had had a tooth removed due to decay, abscess, or infection within the previous year.

1.3 Young Person-specific (13-24 years of age)

The following concerns are specific to young people ages 13-24 years. Many health issues for young people vary depending on the development stage and social determinants of health (eg social support, positive peer networks, school participation). Young people ages 13-14 are in the process of establishing self-identity. They tend to want to be like their peers and they focus on the here and now rather than considering the future. The late teenage period (15-17) tends to be the period of experimentation and risk taking. From about 18-24 young people tend to focus more on relationships, responsibilities and are more future-oriented.[20]

The outcomes of greatest concern for young people in these age groups in the BOPDHB district area are: avoidable hospital admissions, mortality, youth suicide, teen pregnancy and adolescent oral health.

Avoidable Hospital Admissions

- Leading causes of hospitalisation of young people aged 15-24 in New Zealand and the BOP during 2006-2010 were issues associated with pregnancy, delivery and the post-natal period.
- Most frequently reported reasons for acute admissions were injury/poisoning and abdominal/pelvic pain.
- Leading causes for arranged admissions were dialysis and mental health issues.

20 Crossen, K. 2013. Grand Rounds presentation on youth health, Bay of Plenty District Health Board

Mortality

- Vehicle occupant transport injuries, intentional self-harm and neoplasms were the leading causes of mortality for young people 15-24 in the BOP and all five DHBs in the Midland region during 2004-2008. Vehicle occupant deaths accounted for 38% of deaths for this age group, with intentional self-harm accounting for 19% of deaths.

Youth Suicide

The Ministry of Health reported that in 2010 the national youth suicide rate had declined since its peak in 1995. However the following statistics are of great concern:

- BOP youth suicide rate was significantly higher than the total New Zealand rate[21]
- Māori youth suicide rate for 2010 was 35.3 per 100,000, more than 2.5 times higher than for non-Māori (13.4 per 100,000).

Teen Pregnancy

The numbers of births to teenage women is relatively small. Nearly three quarters of these are to women 18 and 19 years of age. Births to teenage mothers now constitute a small proportion of all births (6.5%). However, young women from provincial regions are over represented among adolescent mothers. Rates of teen pregnancy in the BOP are comparable to the national rate.

Although statistically the rate of teen pregnancy appears low, research indicates that:

- children of young parents have an elevated risk of congenital medical problems and poor health, limited educational attainment, antisocial behaviour, and early parenthood themselves [22]
- growing up in poverty is associated with becoming a teen parent. In New Zealand in 2010, the majority of women giving birth in the most deprived areas were young (<25 years of age) compared with the age of the women in low deprivation areas
- young parents tend to obtain fewer educational qualifications, are more likely to be parenting alone or in unstable partnerships, and experience greater unemployment and welfare dependence than their peers who delay parenthood
- teen pregnancy and parenting can drive young people into poverty, especially when the needed social supports are not available
- without the social and financial support required, teen parents are more likely to disengage with education and less likely to become meaningfully employed.[23]

Adolescent Oral Health

The hospital admission rate for dental caries is one measure of poor oral health among young people in the BOP. Māori hospital admissions for dental caries remain higher than for all other ethnic groups. Rates of hospital admission for dental caries are significantly higher for young people aged 15-24 years for all five DHBs in the Midland region compared with the New Zealand population.

21 Suicide Facts: Deaths and intentional self-harm hospitalisations 2010. Ministry of Health. http://www.health.govt.nz/publication/suicide facts-deaths-and-intentional-self-harm-hospitalisations-2010.

22 Working Paper no.21: Child poverty and disability. 2011. Expert Advisory Group on Solutions to Child Poverty, Office of the Children's Commissioner.

23 Working Paper no.21: Child poverty and disability. 2011. Expert Advisory Group on Solutions to Child Poverty, Office of the Children's Commissioner.

1.4 Housing

Many of the causes of poor health in children and young people could be improved by ensuring access to affordable, safe and suitable housing for all pregnant women and children and young people transitioning to independence. It is evidenced that household overcrowding with damp conditions and poor ventilation lead directly to high rates of infectious disease such as childhood meningococcal disease, rheumatic fever, bronchiolitis, croup, childhood pneumonia, head lice and conjunctivitis. In addition, it has been suggested that crowding impacts negatively on mental health, leading to interpersonal aggression, withdrawal, socially deviant behaviour and psychological distress.[24]

Figure 1 shows the proportion of children and young people aged 0-24 living in crowded households by ethnicity for the five DHBs in the Midland region compared with New Zealand overall. The graph demonstrates the disproportionate percentage of Māori children and young people living in overcrowded housing. BOP is higher than the national average for Māori ie 32% compared with national average of 28%.

BOP resources such as the Tauranga Community Housing Trust (TCHT) and the Western BOP Māori Housing Forum are making gains in ensuring that better quality and more affordable housing is available.

TCHT is a charitable trust that provides housing and housing related services, assists people with physical, intellectual, sensory and mental health disabilities, and low-income families, to help them find quality, affordable housing that meets their needs and includes long-term tenancy agreements. The organisation works with the health, disability, and housing sector to develop housing solutions and advocates for low-income families and those with special housing needs who need new models of housing.

The Western Bay of Plenty Māori Housing Forum, a collective of 52 Māori land trusts in the WBOP area, provides information and tools for Māori communities to develop papa kāinga housing. The Forum has successfully led the development of a small number of housing projects. There is potential for the Forum, along with the government and private sector, to improve housing quality and affordability for many Māori who live in substandard homes. The most recent initiative is the government-led Warrant of Fitness (WOF) for rental housing pilot programme. Tauranga is one of the participating pilot sites. The pilot project will be implemented in 2014.

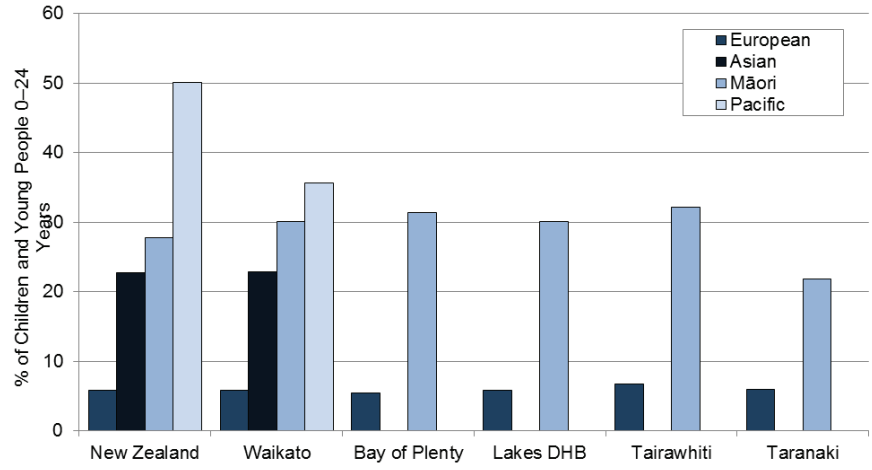


Figure 1: Proportion of Children and Young People Aged 0–24 Years Living in Crowded Households by Ethnicity, Midland DHBs vs. New Zealand at the 2006 Census.

24 2009 Craig, E, The Determinants of Health for Child and Young People in the Bay of Plenty, NZ Child and Youth Epidemiology Service.

Appendix 2 – International and New Zealand Reports

The international reports from the Organisation for Economic Co-operation and Development (OECD) and the World Health Organisation (WHO), together with New Zealand reports, provide compelling evidence of the need to strengthen efforts to ensure health and social equity for all children, young people, families, and communities in New Zealand. Please refer to the detailed findings of these reports later in this appendix.

In addition to the compelling outcome data which points to inequitable outcomes for those children who live in high deprivation areas and are Māori and in many cases Pasifika, the international reports, New Zealand studies and policy statements (as discussed in the 'Drivers of Change' section) provide recommendations for increasing equity of outcomes and in turn improving long-term outcomes. The most frequently recommended actions are to increase funding during the early years of life, take a population health approach to address the social determinants of health and wellbeing, and develop integrated ways of working across systems - both vertical and horizontal integration. In addition, the concept of proportionate universalism is supported, ie providing universal maternal and child services with additional resources applied based on assessment of need and life circumstances.

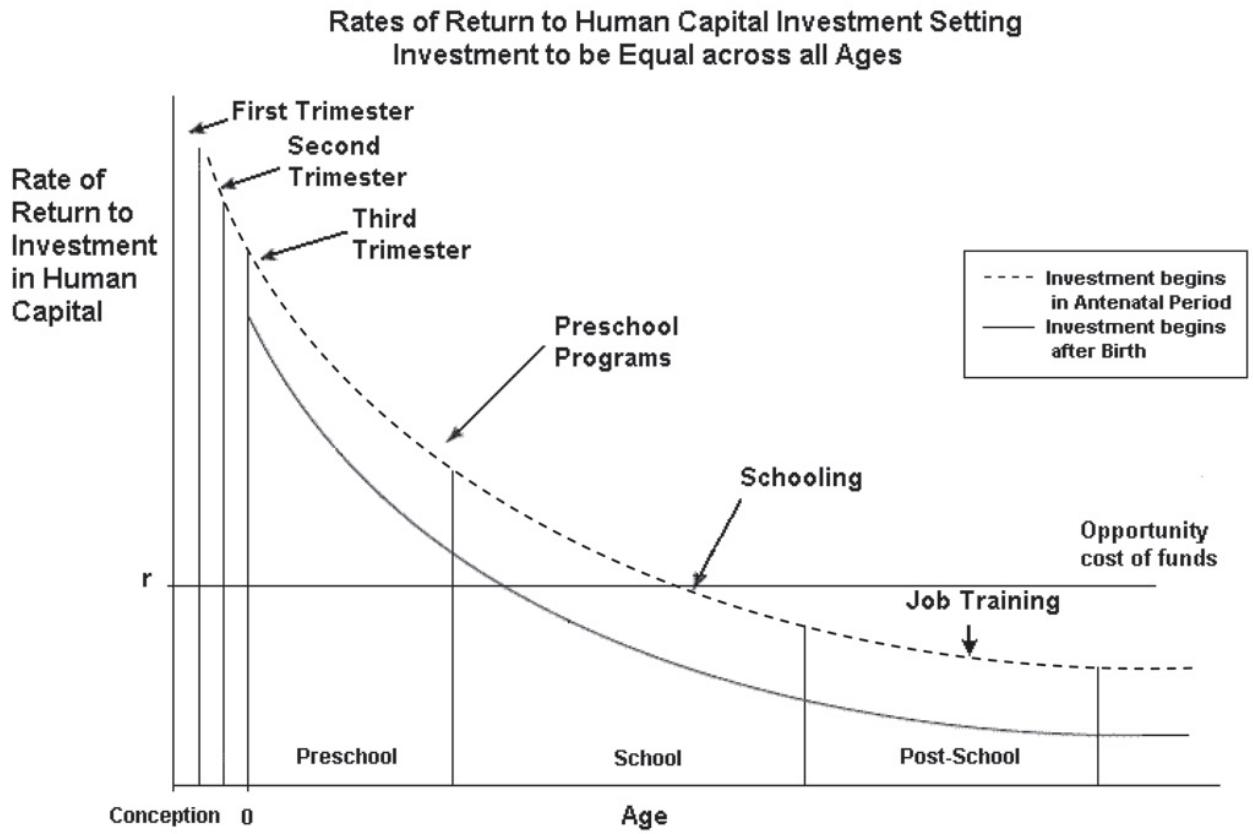
An Investment Approach

International research provides compelling evidence that early investment in preventive programmes aimed at disadvantaged children is often more cost effective than later remediation. Heckman, an American economist, and colleagues have published numerous findings that demonstrate the cost-benefit of significant early investment in evidence-based programmes. By investing early, the benefits are larger and are enjoyed for longer, which in turn increases the return on investment. Figure 2 demonstrates the rate of return to investment at different stages of the life cycle as developed by Carneiro and Heckman. It illustrates that:

There is a higher rate of return at younger ages for a constant level of investment. In addition, as the technology of skill formation and accumulation posits that skill begets skill and early skill facilitates later skill acquisition (early investment raises the productivity of later investment). This return is generated from returns to the individual in terms of increased earnings, higher education, improved physical and mental wellbeing, and also through the positive externalities to society in terms of reduced crime and delinquency, public expenditure savings and increased tax revenues. The economic argument for early investment does not preclude later investment; rather it argues that there are dynamic complementarities to be gained from investing at different stages of the life cycle, starting as early as possible.[25]

25 Economics of Human Biology 2009 March; 7(1): 1–6. Published online 2009 January 21. doi: 10.1016/j.ehb.2009.01.002

As Figure 2 illustrates, the rate of return is significantly greater when government invests equally beginning in the first trimester. This research strongly supports the priority to shift resources to the early years.



Rates of return to human capital investment setting investment to be equal across all ages

OECD: Doing Better for Children

The OECD advised New Zealand to focus its policies on child poverty and child health, especially during the early years of life. The lack of spending particularly on younger children was identified, as this was only half of that spent on older children.

World Health Organisation: Closing the Gap in a Generation

The WHO report, *Closing the Gap in a Generation,* states that there must be equity from the start. In order to accomplish this, a comprehensive approach to the early years of life must be taken. Such an approach requires "policy coherence, commitment, and leadership".[26] The report recommends setting up an interagency mechanism to ensure that policies are coherent and support a comprehensive approach to early childhood development (ie health, early childhood education, social services). All children and mothers must be covered by a comprehensive package of services, regardless of the ability to pay. A *proportionate universalism* approach is recommended whereby universal services are provided to all with additional support provided to a child and family based on identified need.

UNICEF New Zealand: Kids Missing Out

This report, published in November 2013, summarises the first 20 years of the UN Convention on the Rights of the Child (UNCROC) in Aotearoa New Zealand. New Zealand ratified UNCROC in 1993. The purpose of UNCROC is to ensure that "every child has a healthy and happy childhood".[27]

UNCROC defines a healthy and happy child as one who:

Has enough food, access to medical care, being kept safe, spending time with and being guided by parents and family, playing and being with friends, being listened to and treated with respect, going to school, having a warm place to live, and being part of a supportive community.

26 Commission on the Social Determinants of Health, 2010, Closing The Gap In A Generation: Health Equity Through Action on the Social Determinants of Health, Final Report, Executive Summary, World Health Organisation, Geneva.

27 Kids Missing Out: A Summary of the first 20 years of the UN Convention on the Rights of the Child in Aotearoa New Zealand, 2013, UNICEF New Zealand.

The following UNICEF recommendations are those most relevant to the Strategy:

- Develop permanent bodies or mechanisms to promote coordination, monitoring and evaluation of activities across all sectors of government.
- Make children visible in policy development processes throughout government by introducing child impact assessments.
- Analyse government spending to determine the portion of public funds spent on children and ensure that these resources are being used effectively.
- Ensure that sufficient data is being collected and used to improve the situation of all children in each jurisdiction.

The report recognises some positive change, eg the repeal of section 59. However, the report states that, overall, progress in implementing UNCROC has been "patchy and too slow". UNICEF states that the goals of UNCROC will not be achieved without "concerted action by Parliament and all government entities." The report cites hospital admissions data for conditions with a social gradient, especially rheumatic fever and skin conditions, and high rates of child maltreatment.

Child Poverty Monitor

The Child Poverty Monitor 2013 is the first of an annual monitoring report on child poverty in New Zealand.[28] The Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty recommended that the government annually monitor progress to reduce child poverty. Although the government has not implemented this recommendation the Office of the Children's Commissioner partnered with a philanthropic trust to fund the monitoring work.

The Child Poverty Monitor incorporates a number of measures included in the Children's Social Health Monitor[29]. In addition, the technical report was expanded to include each of the four child poverty measures recommended in the *Solutions to Child Poverty* report. The Child Poverty Monitor provides additional information on children's material deprivation and two new measures of poverty severity and persistence. Living on a low income for an extended period is correlated with increasing levels of material deprivation (Imlach Gunasekara and Carter, Department of Public Health, University of Otago, 2012). Persistent poverty in childhood is also linked to worse outcomes, such as lower employment and earnings, over a person's life (Ratcliffe and McKernan, 2010). Just as "advantages accumulate, so do disadvantages" (Heckman and Masterov, 2004).

The following summary of results supports the focus of this Strategy:

- **Income based poverty measures** – during 2010-2012 around 30% of Māori and 30% of Pasifika children lived in poor households, compared with 15% of European children. Poverty rates were higher for younger children (0-6 and 7-11), larger households, sole parent households, households where no adults were in paid work or none worked full time.
- **Material hardship** – 17% of children aged 0-17 were considered in material hardship in 2012 (about 180,000 children). As a group, children in material hardship were exposed to cutting back on fresh fruit, vegetables and meat, not replacing worn out clothes, putting up with feeling cold, and postponing doctor's visits.
- **Poverty persistence** – in any one year, 60% of those in poverty were also in persistent poverty (income averaged over seven years was below the average low income line; <50% of the gross for the year reviewed).

28 Child Poverty Monitor, 2013, Office of the Children's Commissioner. http://nzchildren.co.nz.

29 Children's Social Health Monitor, 2012, Craig, et al. New Zealand Epidemiology Service, Otago University.

- **Unemployment rates** – as of September 2013 younger people (15-19 and 20-24) had the highest rates.
- **Children reliant on benefit recipients** – as of June 2013, 20.1% (214,746 children) of children 0-17 were reliant on a benefit recipient, with the highest proportion of those aged 0-4.
- **Hospitalisations and mortality with a social gradient in children 0-14 years** – during 2008-2012, asthma/wheezing, bronchiolitis, and gastroenteritis were the leading reasons for hospitalisations for medical conditions with a social gradient, with the majority of admissions being for infectious and respiratory diseases. Falls were the leading causes of injury admissions.
- **Hospital admissions for medical conditions with a social gradient in infants aged 29-364 days** – admission rates for all ethnic groups increased between 2007-2012, with higher rates for Pasifika and Māori. Analysis of excess risk ranged from 1.3 times higher to 6.4 times higher for infants living in the most deprived areas (NZ Deprivation decile 9 and 10) depending on the condition.
- **Assault, neglect and maltreatment of children 0-4 years** – during 2008-2012 the most severe injuries seen in children admitted as inpatients aged 0-4 were 22.7% for traumatic subdural haemorrhages and 4.8% for fractures of the skull and facial bones. Some of the children admitted as inpatients and those treated in the Emergency Department also had respiratory and infectious diseases.

New Zealand Government Child Health Inquiry

The House of Representatives Health Committee November 2013 report, *Improving Children's Health Outcomes and Preventing Child Abuse,*[30] is the culmination of an in-depth "inquiry into improving child health outcomes and preventing child abuse, with a focus on pre-conception until three years of age". All members of the cross-party Health Committee supported the inquiry and report recommendations.

The report recommends a whole-of-government plan that incorporates economic analysis to determine the benefits to New Zealand society of prioritising spending on pre-conception to the age of three, and the implementation of best-practices and evidence-based policies and service delivery approaches in the areas of reproductive health, education and nutrition, and maternity and post-natal care for children birth to age three.

The report recommends that government:

- addresses socioeconomic factors, including reducing poverty and discrimination, and provide healthy housing, optimal nutrition, access to health and education services and safe home environments
- improves health promotion
- systematises integrated service delivery to improve primary and non-communicable disease prevention, starting before birth
- sets a national target of at least 90% of pregnant women to be enrolled in antenatal programmes by 10 weeks gestation, coupled with a programme of action to cut alcohol, drug and tobacco use during pregnancy
- supports research into taxing sugary drinks.

The results of this inquiry demonstrate alignment across submissions representing the health, education, social services and disability sectors, advocacy groups, and Māori and Pasifika organisations on the importance of investing from pre-conception through the early years of life. Policies adopted in recent years by central government and by the BOPDHB align

30 Report of the Health Committee, 2013, *Inquiry into Improving Children's Health Outcomes and Preventing Child Abuse, with a Focus on Pre-Conception Until Three Years of Age*, presented to the House of Representatives, Fiftieth Parliament. Wellington, New Zealand.

with the Strategy. The Government's Better Public Services Policy and the Midland DHBs Integrated Healthcare Strategy represent the policy drivers that contribute significantly to the progressing of this Strategy.

Government's Better Public Services Policy

The Government has committed to delivering a set of 10 Better Public Services results. The Better Public Services targets were selected because of their importance in improving the lives of New Zealanders. The Ministry of Health is working closely with the Ministries of Social Development; Business, Innovation and Employment; Education; and the Police on the following three results that contribute to supporting vulnerable children.

1. Increase participation in quality early childhood education. Target: in 2016, 98% of children starting school will have participated in quality early childhood education.
2. Increase infant immunisation rates and reduce the incidence of rheumatic fever. Targets: increase infant immunisation rates so that 95% of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017 and reduce the incidence of rheumatic fever by two thirds to 1.3 cases per 100,000 people by June 2017.
3. Reduce the number of assaults on children. Target: by 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.[31]

New Zealand Medical Association (NZMA) Position Statement

The New Zealand Medical Association Health Equity Position Statement represents one example of New Zealand's medical establishment publicly recognising that New Zealand has systematic disparities in health outcomes and that these disparities must be addressed to ensure a healthy and prosperous future for its citizens. Health equity is defined as:

An ethical principle concerning the absence of systematic disparities (or in the major social determinants of health) between groups with different levels of underlying social advantage/ disadvantage.[32]

The NZMA position paper states that equitable health outcomes may require different (ie unequal) inputs to achieve the same results. This is the concept of vertical equity. This concept could be called unequal treatment of groups whose social and/or health conditions place them at a disadvantage compared with other groups. The Association calls on the

31 Immunisation: example of an effective approach - The Ministry of Health has developed a four-point action plan: Enroll, Engage, Promote and Monitor to assist with achieving the immunisation target. Engagement, as used in the service delivery literature, is synonymous with 'connecting'. We use the term 'connecting' rather than 'engagement' since it seems to better describe a professional's ability to establish a working relationship with the individual or family/whānau. To date, the implementation of this four-point action plan has contributed to significant increases in immunisation across New Zealand and in the BOP. We believe the process used to improve immunisation rates can be adopted and adapted to progress a number of child outcomes for those children whose parents are not accessing the existing universal services that are well established.

32 Braveman P, Guskin S, *Defining Equity in Health,* Journal of Epidemiology and Community Health, 2003; 57:254-258.

Government to:

- give every child the best start in life
- enable all children, young people, and adults to maximise their capabilities and have control over their lives
- create and develop healthy and sustainable places and communities.

First 1000 Days of Life: New Zealand College of Public Health Medicine Policy Statement (NZCPHM)

In August 2013, The NZCPHM published a policy statement supporting the recommendations of the Public Health Advisory Committee report, *The Best Start in Life*, on how to improve outcomes for New Zealand children and the Office of the Children's Commissioner's report on *Solutions to Child Poverty*.[33] [34] The "first 1000 days" includes the time from conception, through pregnancy and birth, up until a child's second birthday. The statement emphasises that improving the circumstances in which a child is conceived and raised will result in "significant public health gains, reduced inequalities in health and wellbeing, and reduced costs in both healthcare and society". The policy will be reviewed in 2017.

The statement recommends using evidence-based approaches to engagement and intervention. The NZCPHC supports a universal approach to improving the health of women who are likely to become pregnant by integrating a woman's assessment of reproductive risks into her routine care to reduce unintended pregnancy and improve preconception wellness. During the perinatal period, the primary recommendation is to increase early and adequate participation in antenatal care so that women receive evidence-based interventions that include:

- improving screening for low birth weight
- smoking cessation in early pregnancy to reduce low birth weight
- sufficient antenatal care to increase use of preventive care during infancy, including immunisation and well-child checks.[35]

The NZCPHM recommends that, to continue effective support during the early childhood period, a system to monitor engagement with early childhood services should be implemented. The monitoring system should be part of the Well Child/Tamariki Ora Framework.

Toi Te Ora Strategic Plan 2013-2025

The principles and strategic direction of Toi Te Ora align with those of the BOP overall and this Strategy in particular. Toi Te Ora aligns its work with the BOP and Lakes DHB's respective strategic visions of 'Healthy Thriving Communities - Kia Momoho Te Hapori Oranga' and 'Healthy Communities – Mauriora.'

The strategic plan for 2013-2025 identifies Māori, children (including maternal health), and youth as the priority populations. Toi Te Ora has adopted five high-level goals aimed at improving the health of these populations. Goals 1-3 are public health goals that align with the priorities set out in this Strategy.

Goal 1 - To reduce childhood admission to hospital from acute rheumatic fever, respiratory infections and skin infections, each by two-thirds in five years.

Goal 2 - To reduce childhood obesity by a third in 10 years.

Goal 3 - To reduce the proportion of year 10 students smoking by two-thirds in five years. Principles that are important for the public

33 Public Health Advisory Committee, 2010, The Best Start in Life: *Achieving Effective Action on Child Health and Wellbeing*, Ministry of Health. http://nhc.health.govt.nz/publications/phac-pre-2011/best-start-in-life-achieving-effective-action-child-health-and-wellbeing

34 Expert Advisory Group on Solutions to Child Poverty, 2012, Solutions to Child Poverty in New Zealand: Evidence for Action, Office of the Children's Commissioner, Wellington.

35 New Zealand College of Public Health Medicine, 2013, *First 1000 Days of Life: New Zealand College of Public Health Medicine Policy Statement*. http://www.nzcphm.org.nz/media/64578/2013_08_first_1000_days_policy_statement.pdf

health unit include designing primary health services so that they can provide more systematic and practical assistance based on what people need and what they can effectively utilise. This principle is also primary to the Child and Youth Health and Wellbeing Strategy. Toi Te Ora proposes that by using the PHO (Primary Health Organisation) as the umbrella organisation for all primary care services, including maternity and well child, better coordination and more effective service delivery could be achieved.[36]

The Bay of Plenty DHB Annual Plan 2013-2014

The annual plan established child and youth health as one of six priorities. The health needs assessment results identified gaps in child and youth services. The plan states that the DHB will "continue to analyse service gaps and develop strategies to improve health outcomes and reduce health disparities for our children and young people".[37] The service priorities for 2013-2014 are:

- Immunisation
- Oral health
- Cellulitis and skin infections
- Whānau Ora
- Rheumatic fever
- Reduction in Ambulatory Sensitive Hospitalisations (ASH) rate
- Support for parents (antenatal care, breastfeeding, parenting programmes)
- Youth Health Service (sexual health, alcohol, drug and suicide prevention).

36 Phil Shoemack and Stephen Twitchin, 2013, personal communication, Toi Te Ora, BOPDHB.

37 Bay of Plenty District Health Board Annual Plan 2013-2014, p.46, Tauranga.

Integrated Healthcare Strategy

The Midland DHBs' Annual Plan includes developing strategies to integrate healthcare to provide better systems and pathways of care for patients. The BOPDHB has gone one step further by leading the development of the *Integrated Healthcare Strategy 2020*. The DHB has drawn on the work of the King's Fund as a primary source of information about what integrated healthcare means and guidelines for progressing this work. The development of the strategy was a collaborative process that drew on the knowledge and expertise of a wide range of stakeholder groups.

Integrated healthcare requires a paradigm shift for administrators and direct service providers. In an integrated system, the key concern is what matters to the patient or service user. An integrated system addresses the social determinants of health along with the physical. It means one system and a seamless experience that is patient and family/whānau-centered.

The Integrated Healthcare working group identified poor health literacy, workplace culture (including patch protection and cynicism) and misunderstanding about privacy obligations, among many other issues, as primary barriers to integration. The group has identified examples of effective integration currently operating in the BOPDHB, including Bay Navigator, Te Whiringa Ora (EBOP), Whānau Ora, Co-ordinated Primary Options in the Western BOP, BOP Community Response Team, Strengthening Families and Kawerau Suicide Prevention Team.

The Child and Youth Health and Wellbeing Strategy aligns with the philosophy and principles of integrated healthcare. The Integrated Healthcare Strategy enables both the implementation of this Strategy and the work to progress equity of outcomes for children and young people.

Appendix 3 - National and Local Initiatives that Support the Actions

We emphasise the importance of understanding what is working and building on the successes already achieved. This part of the process is integral to developing and testing promising practices and unconventional ways to improve the health and wellbeing of those groups most at risk of poor outcomes.

The BOP is participating, either directly or in an advisory capacity, in a range of innovative and evidence-based initiatives to improve services and support for vulnerable groups. Among these are Whānau Ora, the Children's Action Plan, warrant of fitness (WOF) for rental housing pilot project, Early Childhood Education initiative, Prime Minister's Youth Mental Health Project, the new model of disability services demonstration project, Rheumatic Fever Prevention Plan, Maternity Quality Initiative, and Well Child/Tamariki Ora Quality Improvement Framework. Each of these is expected to narrow the inequality gap for infants, children and young people. This section provides an overview of these initiatives.

In addition, the DHB funds numerous discrete services for children and young people. A stocktake of current services is provided in this appendix.

In spite of the numerous and varied initiatives and services on offer, there remain disparities in outcomes for Māori, children in high deprivation areas and those with disabilities. Nonetheless, we are optimistic that the following initiatives provide an excellent starting point to begin joining up services and support that already focus on Māori, children and families/whānau living in high deprivation, and children and young people with disabilities.

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 on individual family members and their problems.

Whānau decide what is needed to improve their lives and how they want to go about making these improvements. Some whānau choose to come up with their own ways to make positive changes and may want to work on this with a hapū, iwi or an NGO.

The Whānau Ora approach empowers families to build and maintain healthy and supportive whānau. It incorporates principles and approaches that align well with international models of support for vulnerable children and families and is especially relevant to the BOP's numerous iwi, with their strong cultural bonds and influence. The role of natural helpers and navigators are recognised by many as key to achieving trust and to empowering the family/whānau to achieve health and wellbeing for their children by addressing the challenges the families/whānau are facing.

Warrant of Fitness for Rental Housing Pilot

Tauranga is a pilot site for the Warrant of Fitness (WOF) for rental housing pilot project to be implemented this year. This work is directly linked to progressing efforts to increase the number of safe and healthy homes, a key determinant of health. The Tauranga City Council is participating in the field-testing of a WOF assessment tool.

Maternity Quality Initiative

The MOH's focus on improving the quality of maternity, child and youth health services provides the regions and the DHBs with opportunities to work systematically toward more equitable health services. The government is enabling regions and local communities to coordinate and integrate services by enacting policies and providing tools to improve the quality of maternity, child and youth health provision. In addition, the MOH is providing funding to regions and the DHBs to establish and implement quality teams. The Maternity Quality Team is one example of a current action within the BOP which works across systems to identify and ameliorate systemic issues that impact maternal and child health.

Integrated Maternity and Early Childhood Services

The Government and BOPDHB policies, initiatives and recent service development approaches recognise the importance of early engagement with maternity and early childhood services and support. Moreover, those mothers and children who are most vulnerable often face barriers to accessing and using the services that are there to support all children. The following activities demonstrate how the Government and the BOPDHB are working to develop seamless services and transitions for pregnant women, infants and young children.

Integrated Maternity and Early Childhood National Pilot Projects

The MOH's recent request for proposals to develop integrated maternity and early childhood services demonstrates the government commitment to actively progress evidence-based approaches to engaging and supporting vulnerable pregnant women and young children. The RFP (Request for Proposal) explicitly states that applicants must be willing to work in partnership with local community-based providers, and with the Ministry, to develop and improve models of care and test innovative new approaches. The key focus is improving the integration and performance of maternity and child health services working alongside/with families/whānau and other social services.

The way to improve outcomes is to develop and implement a single, consistent, joined up network of coordinated health and social services for pregnant women, children up to six years of age and families/whānau. The expectation is that all pregnant women and their children receive the universal services to which they are entitled and additional support and services in response to need. It is expected that the following elements will be part of each funded pilot:

- leadership and shared governance
- outcomes focus
- working together to achieve outcomes – community-based health and social services will work together to collectively meet the needs of pregnant women, children and families, including multi-disciplinary approaches
- needs-based assessment across services
- care planning and pathways – care plans will be developed in partnership with the family and relevant professionals, focusing on family strengths and a seamless transition between universal and secondary/more intensive referred services and support
- monitoring systems – to measure progress and outcomes
- continued focus on government priorities and targets.

Although the BOPDHB has chosen not to respond to this RFP, we anticipate that the

learning from the pilots will be useful for the work currently underway and the strategic actions for the next five years and beyond.

LMC and Well Child Provider Engagement Strategy (Toi Te Ora Led)

This Strategy is in the early stages of development, with a draft document completed at the end of January 2014. The purpose of the work is to provide a coordinated strategic approach to increase engagement of Toi Te Ora with LMCs and Well Child/Tamariki Ora providers. The goal is to reduce risk factors and improve the health status and outcomes of young children. The DHB's public health arm, Toi Te Ora, is providing leadership in this area which will become very important as the Strategy progresses.

Well Child/Tamariki Ora Quality Improvement Framework

The Well Child/Tamariki Ora (WCTO) Quality Improvement Framework (the Framework) was published in July 2013 and is now being rolled out nationally. The Framework has three high-level aims: a focus on individual family/whānau experience, population health, and best value for the health system resource. The Framework sets quality indicators to audit performance. The quality indicators are regularly reported by region, ethnicity and deprivation quintile. The reporting on specific indicators is expected to drive improvements in the delivery of WCTO, with all children and their families/whānau achieving maximum health and wellbeing.

The Framework covers all areas of health and wellbeing, including WCTO, public health, primary maternity, primary care and specialist services, across all levels of healthcare, including policy making, service management and clinical care. The aims of the Framework and the indicators align with the Child and Youth Health Strategy. The Framework document can be found on the MOH Website. The aims are to:

- improve the safety and quality experience for the child, family/whānau and community
- improve health equity for all populations
- provide the best value for the health system resource.

These aims align with those of the Child and Youth Health and Wellbeing Strategy. The BOPDHB has selected three quality indicators as targets for the next two years which are:

- infants to receive all WCTO core contacts in their first year of life
- children to be enrolled with a child oral health service
- mothers to be smoke free at two weeks postnatal.

Immunisation Outreach

The MOH immunisation targets support local DHBs to implement new ways of connecting with families of young children to increase immunisation rates. All children in New Zealand should be vaccinated against 11 potentially serious diseases. The MOH's targeted approach to increasing immunisation rates has proven effective in doing so. The Immunisation Advisory Centre (IMAC) provides information and consultation to local DHBs to improve immunisation rates.

Five Point Enrolment

The BOPDHB, as part of the strategy to reach the immunisation health targets and ensure that children in the system do not fall through the gaps, is discussing how to enrol newborns with five key programmes prior to leaving the hospital, or as soon as possible after birth. These include the National Immunisation Register (NIR), Newborn Hearing Screening (NHS), and enrolment with a GP, community dental service and a WCTO service provider. A one-parent consent form would be used to gain parental permission for their infant to be enrolled in these services. Lakes DHB has developed the single consent form that could be adapted for the BOPDHB.

Rheumatic Fever Plan

Considerable funding from the Government was allocated to prevent rheumatic fever. The BOP and Lakes DHBs have developed a detailed plan to reduce rheumatic fever. The purpose of this plan is to enable BOPDHB, Lakes DHB, and their partner organisations, to co-ordinate services and prioritise initiatives to achieve the national Better Public Services (BPS) target to reduce the incidence of rheumatic fever by two thirds, to 1.3 cases per

100,000 people by 2017. The plan also aims to minimize the impact of rheumatic fever and rheumatic heart disease (RHD) in the population served by BOP and Lakes DHBs. The BOP and Lakes rheumatic fever champions have been nominated by their respective DHBs and are all members of the BOP and Lakes rheumatic fever steering group. One of the key tasks of the champions is to act as the main point of contact for rheumatic fever issues in each DHB.

A range of positive results has been demonstrated. These include increased awareness of rheumatic fever in higher risk communities and the general public; increased awareness of the sore throat guidelines among GPs; the establishment of a register in the Lakes district; improved notification; and school-based throat swabbing programmes that are operating to agreed protocols, having gained the support of local communities.

A wide range of health promotion activities has occurred within the BOP. These activities indicate an already active range of community groups and leaders working to ensure a healthy life for all children and families. Health promotion activities are an essential element to increasing and maintaining high rates of immunisation and reductions in rheumatic fever.

The BOPDHB and local schools participate in the Reducing Rheumatic Fever Programme. The intervention includes sore throat swabbing in schools and follow-up antibiotic treatment if needed. In addition, the MOH is working with the BOP local services to address other common health issues such as skin infections, healthy housing and insulation.

Youth Mental Health Initiative (Part of Prime Minister's Youth Mental Health Initiative)

Minister's Youth Mental Health Initiative)
The Ministry of Health launched the Youth Mental Health Project in 2013. Funding and guidance are available to DHBs to focus on the following services:

- SBHS - maintain and expand funding to School Based Health Services to decile 3 secondary schools.
- HEEADSSS Wellness Check - expand the use of the HEEADSSS wellness checks in schools and primary care settings. HEEADSSS stands for Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Depression, Safety.
- Primary Mental Health - expand funding to extend the current primary mental health service to all youth in the 12-19 year age group and their families.
- E-Therapy - review and implement an Internet based e-therapy tool for young people to provide treatment that will focus on common anxiety and depression.
- Primary Care Responsiveness to Youth - improve the responsiveness of primary care to youth through drop-in services such as YOSS. The government will provide interim funding and develop with the DHBs secure funding pathways.
- CAMHS (Child and Adolescent Mental Health Services) and AOD (Alcohol and Other Drugs) follow-up - review and improve follow-up care for those discharged from CAMHS and youth AOD services.
- CAMHS and Youth AOD Access - improve access to CAMHS and youth AOD services through DHB wait time targets and integrated case management services.

Ministry of Health Actions to Improve Support to Children and Young People with Disabilities

As a result of a 2009 Select Committee Report on the *Inquiry into the Quality of Care and Service Provision for People with Disabilities*, the MOH initiated actions to improve support for children and young people with disabilities. The Ministry funded a trial project in Auckland to give providers funding people with significantly complex needs "wraparound" services, with flexible packages of care to support them to remain in the community and a home environment. The Ministry is trialing this to provide a range of disability services through one provider so that the children, young people and their families/whānau receive proactive, comprehensive, individualised, consistent and streamlined disability support.

In addition, the Ministry completed a set of guidelines on 'Roles and Responsibilities for Supporting Children and Young People with Disabilities under the Children, Young Persons and Their Families Act', and updated the 'Therapy and Equipment Protocols' in partnership with the Ministry of Education (MOE).

A concern nationally and in the BOPDHB is the lack of an effective, seamless transition process from child to adult disability services. Moreover, providers and parents of children with disabilities emphasise that the current system is fragmented, with multiple organisations and departments responsible for specific aspects of services and funding. This fragmentation presents major barriers to families in their ability to access timely and appropriate information and support.

The disability community, service providers and advocacy groups continue to promote and lobby for a range of systems and service delivery changes. These include:

- recognising and providing early intervention that is individualised to match the strengths and needs of the child and family/whānau
- establishing and maintaining connections with a family to provide quality information, coordinated support, and assistance to navigate the complex system over the course of childhood and transition to adulthood
- providing systematic transition at key life transition points – eg preschool, primary school, secondary school, and to adult life
- identifying and providing wraparound services to children and young people with high and complex needs, especially those who do not meet the threshold for Child Youth and Family (CYF) intervention.

The Disability Support Services "New Model" demonstration project provides families/whānau with the opportunity to lead development of the plan for their child and purchase the services and support they choose to meet their child and family's needs. The "New Model" is evidence-based and is funded through the MOH to evaluate its efficacy here in New Zealand.

The Local Area Coordinator (LAC) assists the family/whānau to establish a "circle of support" to ensure the child and family have emotional support and practical assistance. Anecdotal evidence to date shows that families are better able to access the types of support needed, including evenings and weekends, and from individuals or organisations that are not necessarily contracted with the DHB or other agency. The model appears to be working very well in the Eastern Bay's rural and more isolated areas. Examples of how the flexible funding has been used include setting up the home environment to better meet the needs of the child with a disability, purchasing broadband with better communication options for the deaf community, and employing mentors for children and young people.

We anticipate that strategies to better integrate primary and specialist care, along with applying the principles of Integrated Healthcare will result in improved access, referral and transition for children and young people with disabilities. However, we emphasise the need to continually include disability when planning systemic improvements to service delivery. Children with disabilities and their families continue to experience deficit-focused service models and fragmented services and funding rather than holistic, integrated community supports.

Violence Intervention Programme (VIP)

The VIP (Violence Intervention Programme) supports health sector family violence programmes throughout New Zealand. VIP aims to raise health system awareness and capability to identify, assess and refer people experiencing partner abuse, child abuse and neglect as part of routine healthcare practice. The VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme is part of the health sector response which is one component of the multi-agency approach to reduce family violence and child abuse in New Zealand led by the Government's *Taskforce for Action on Violence within Families*.

In 2002, the Ministry of Health published *Family Violence Intervention Guidelines: Child and Partner Abuse* to support health professionals in identifying and responding effectively to cases of family violence. In 2007, the Ministry funded Family Violence Intervention Coordinator (FVIC) appointments to expand the significant progress made by DHBs during the VIP pilot phase. These appointments have proved vital to the continued progress and sustainability of family violence intervention programmes. Local programmes are also being supported by individual hospital evaluation reports, national programme coordination and health professional training - all funded by the Ministry of Health.

Early Childhood Education (Moe Led)

The Government has set a target for participation in early childhood education (ECE) and has allocated resources to meet that target. The Ministry of Education is the lead agency for this work and the health sector plays a supporting role through LMCs, WCTO nurses, district health nurses and GPs by informing parents of the value of ECE and encouraging their participation. Additionally, district health nurses and other health professionals provide training and services on-site in some ECE centres.

Children's Action Plan: Children's Teams (MSD Led)

The most recent initiative to address the needs of children who are at risk of abuse or neglect is the Children's Action Plan's local Children's Teams demonstration projects. Whakatane has been selected as one of the next communities to develop and implement a Children's Team. The goal of this initiative is to ameliorate issues affecting children who are vulnerable and have not reached the threshold required for intervention by Child Youth and Family. This initiative is in the early stages of implementation. However, the work relies on partnerships and effective coordination across systems and with community partners. Moreover, the key to its effectiveness may well come down to the community provider's skill in connecting with the parents of the vulnerable children so that they trust the system enough to participate.

Social Sector Trials (MSD Led)

The Social Sector Trials involve the Ministries of Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered. The trials test what happens when a local organisation or individual directs cross-agency resources, as well as local organisation and government agencies, to deliver collaborative social services. At the core is:

- either a contracted NGO or an employed individual in place in these communities to lead a programme of work using cross agency resources
- NGOs and individuals planning social service delivery for young people, managing relevant contracts and funding that are within the scope of the programme, overseeing resources-in-kind, developing networks, engaging with the community and influencing social services outside of their direct control (like statutory services)
- the establishment of Social Sector Trial local advisory groups in each location – representatives include iwi, council, government agencies, community representatives, and social service providers, that oversee the direction and priority setting, engage community ownership and involvement
- development and implementation of a Social Sector Trials Plan (or Action Plan) for each location.

The Whakatane Social Sector Trial is delivered by WERA, and is based on the NGO model. Its focus is on youth (12-18 year olds) outcomes - reduced offending; reduced truancy; reduced levels of alcohol and drug use; and increased numbers participating in education, training and employment.

Welfare Reform (MSD Led)

New Zealand's Welfare Reform policies were enacted in August 2012. The primary aims of the new policies were to reduce welfare dependency by supporting parents and young people to become work ready and gain meaningful employment, while increasing child participation in early childhood education and school attendance and ensuring that young children received their core health checks and had access to primary healthcare.

A key feature of these policies is the conditions parents and young people must meet in order to receive their benefits. These include:

- once a child is one-year-old, and the next youngest child is:
  - Under five years, the parent must proactively start getting ready for work
  - 5-13 years of age, the parent must be available for part-time work of at least 15 hours per week and accept any suitable job

– 14 years or older, the parent must be available for full-time work of at least 30 hours a week, and accept any suitable job.

Work and Income staff are expected to establish a plan of action with each family to provide appropriate support to ensure parents and young people are able to become "work-ready" and successfully meet these obligations.

The following conditions are specific to the wellbeing of the children of beneficiaries and young people who are receiving a youth payment.

People with Dependent Children

Subject to child age, Work and Income requires beneficiaries to meet certain obligations in order to receive their benefit payments. Parents are required to enrol their children with a GP or PHO.

Parents of children 0-5 are required to ensure that their children are up-to-date with core WCTO checks. Parents of children aged three years-to-school age are required to enrol and make sure their children attend an approved ECE programme or Te Aho o Te Pounamu (Correspondence School) or an approved parenting and early childhood home education programme. The 20 hours free ECE is available for most families. A childcare subsidy is available for those eligible for additional hours or for those not able to access the 20 hours free ECE. Parents are required to make sure their children are enrolled and attending school from the age of five or six years.

Youth Services

The aim of the service is to get young people into education, training or work-based learning. This will help young people gain the skills to find a job and have an independent future. Young people work with community-based providers who provide guidance, support and encouragement to help them find the education, training or work-based learning to meet their needs.

Young people who are receiving a youth payment may also receive incentive payments. However, individuals are obligated to work with their youth advisor, must complete a budgeting course and, if enrolled in education, must complete all course requirements. When these conditions are not met within the required time period, the youth payment and any incentive payment will be stopped.

School-Based Health Services (SBHS) (MOH Led)

The Ministry of Health released a set of guidelines for the establishment of healthcare services in secondary schools, including alternative education and teen pregnancy units, in 2004. Results of an evaluation of SBHS found that 16.8% of young people in the survey reported being unable to access healthcare when they needed it in the previous 12 months. Among schools that have health services, many have been developed as local initiatives with parents and local GPs (often parents themselves) collaborating with school principals and boards of trustees to organise some level of healthcare provision.
The available evidence suggests that students, staff and school health practitioners view SBHS in positive terms, and that they may increase access to primary healthcare. However, school-based services are unable to meet the needs of early school leavers and young adults, and most are unavailable outside of school hours, on weekends, or during the holidays. Further, while qualitative evaluations suggest they are an acceptable form of health delivery for students, research has not been undertaken to assess the effectiveness of these services in achieving health gains or reducing risk-taking behaviours.

In the New Zealand context, the Prime Minister's Youth Mental Health Project is providing additional resources and guidelines for SBHS in low decile schools (decile 1, 2 and 3). Local school-based services will be required to report the utilisation of the services, referrals made to community services, and outcomes for those accessing the services. The Government's commitment to provide more effective services, especially primary mental health services, should bolster the SBHS that are already in place in the Bay of Plenty.

Youth One-Stop-Shop (YOSS)

The BOP does not offer a YOSS as an option for youth health and social services. Nonetheless, we provide this overview of YOSS since some health professionals and young people view it as an effective service delivery option. YOSSs appear to meet the needs of a diverse range of young people, including those who have left school with no qualifications, or are in their early twenties, and those with more sensitive health issues (eg sexual and reproductive health, alcohol and drug issues). However, these services have no overarching framework. They have been developed in local areas by people who have identified unmet needs and have been determined to fill the gap by making these youth-friendly services available at no cost to young people. A 2005 evaluation of YOSS found that services were patchy across sites; with local YOSS struggling to maintain funding and the capacity to provide needed services and support.

A review of YOSS found that the majority of clients were female (70–75%) and aged between 15 and 24 years. A fifth of clients accessed services once or twice, a third used services three to five times and just under half used services six to nine, or 10, times or more. Repeat utilisation was dependent on the continuity of staff and the provision of appropriate and timely services, with high frequency usage also being associated with the uptake of counselling services. The YOSS services most commonly accessed were general practitioners, sexual and reproductive health and counselling services, followed by mental health, family planning and alcohol and drug services.

Child and Youth Health Compass (Office of the Children's Commissioner Initiated)

The Child and Youth Health Compass (the Compass) is one of the Children's Commissioner's priorities for his term and is a major child health priority. The Compass was initiated in 2012 to improve practice across the DHBs by identifying, showcasing and sharing good practice across NZ, in a bottom-up way, with peers supporting peers. The Compass is already informing existing initiatives and will be able to support DHBs to adapt effective models for administering and providing services to improve outcomes for children and youth.

The concept of the Compass is based, in part, upon a DHB Scorecard project conducted by the Paediatric Society of NZ (PSNZ) during 2002-2004. The Compass project starts with the question 'What does a really effective child and youth health service look like?' Key deliverables include DHB reports where each DHB receives their results and a tailored package of good practice resources. The following six themes are the focus of efforts to increase health equity and cover the continuum of child and youth services:

- Best start to a healthy life
- Child development and disability
- Child, youth and whānau-centred care
- Leadership and governance
- Primary care
- Youth health

The first Compass report was published in October 2013 and disseminated to the DHBs. Each DHB completed a self-rating of its status on 10 domains - whether the DHB is tuakana/leading or teina/learning. BOPDHB reported itself as tuakana/leading in the "leadership and governance" domain and teina/learning in the "participation and consumer voice"

and ASH domains. This information will be used in discussions regarding how to proceed with further development of the Compass. The Compass provides tools and information that will be used to measure progress and focus actions to improve child health and wellbeing over the next three years.

Child and Youth Mortality Review Committee

The New Zealand Child and Youth Mortality Review Committee (CYMRC) are appointed under section 59E of the New Zealand Public Health and Disability Act 2000, by the Health Quality and Safety Commission (HQSC). The primary function of the committee is to review and report to the HQSC on deaths that fall within the scope of the committee, with a view to reducing these deaths and support continuous quality improvement.

Local mortality review groups are active in each district and collect data and review deaths of children and young persons aged between 28 days and 24 years. The review process provides a mechanism for identifying causal pathways associated with deaths in this age group. By monitoring patterns over time, or specific clusters of events, the review process can provide evidence-based information on systems and services. This information is used to assist the development of strategies and initiatives that have the potential to reduce preventable deaths in the future.

The CYMRC database provides information that includes deaths by age group and cause. Reports include recommendations for action to reduce mortality rates across the age range. The most recent report by the local review committee, published in June 2013, was a case review report presented to BOPCYSA on Sudden Unexpected Death in Infancy (SUDI). Recommendations included:

- embedding the MOH Safe Sleep Essentials in all relevant settings that are used by pregnant women, infants, and their whanau
- establishing a pepi-pod programme to promote safe sleep
- legislation and service specification changes to assist LMCs and WCTO providers in preventing SUDI
- requiring that the DHB include SUDI prevention as a core component of all PHO contracts that include services for infants.

BOPDHB Actions to Improve Primary Care

The BOPDHB led the development of the Integrated Healthcare Strategy which provides the ideal framework to support this work. The Health Alliance (BOP) - a strategic operations partnership between the DHB, DHB Provider Arm, BOP PHOs and other Community providers - may be one vehicle which can drive the strategic priorities and ensure that agreed actions and outcomes are captured in the 2014-2015 and subsequent annual plans.

Currently the DHB is progressing work to transition management and delivery of district health nursing (and other community-based nursing) services into a primary care setting. This has the potential to significantly enhance the opportunities of drawing together the range of disparate service providers that currently operate within this space. Integration of Public Health Nursing (currently delivering Before School Checks and a range of primary school health services to students in the absence of a direct interface with General Practice), District Nursing, and SBHS (which operate in all secondary schools in the BOP) would start to ensure these service elements become more closely integrated. Stronger alignment between LMCs, WCTO and Outreach Immunisation Services must occur to improve immunisation rates and achieve a comprehensive, joined-up service environment.

The BOPDHB is currently determining how to proceed with a number of these activities. Many of the issues that need to be addressed are systemic and require better coordination and communication across the health, education and social service systems. SBHS are already available in all secondary schools in the BOP. The SBHS focus is on quality improvements, including better integration of the health service into the educational setting and provision of timely referral and follow-up when health and mental health issues are identified. The Integrated Healthcare Strategy will provide the overarching framework for addressing fragmentation and coordination challenges.

Local Government Support

Local government leadership is a key to establishing a system whereby all children are able to have the best start in life. New Zealand legislation empowers local governments to work with government agencies and community leaders to provide better and more efficient services. The BOP has a number of initiatives in place that support the work recommended in the Strategy. This section provides a summary of the key activities.

Local Governance to Support Partnerships: Working Better Together

The Local Government Act legislates the role and functions of local territorial authorities. The purpose of the Act is to provide for democratic and effective local government that recognises the diversity of New Zealand communities. The 2012 amendments to the Act require that local government collaborate with other government agencies and the community to provide better and more efficient services. Each local authority must have a community board. The BOP has established the Collaboration Bay of Plenty (COBOP) to represent and act as an advocate for the interests of the communities in the wider Bay, covering the BOP and Lakes DHB health districts.

The COBOP is a network of local and regional councils and central government agencies in the Bay of Plenty. COBOP is the hub of co-operative interagency work. The group is made up of chief executives and senior managers representing these agencies. The purpose of the collaborative is to meet the current and future needs of communities in the Bay.

The Social/Cultural Cluster subcommittee completed the Youth Plan in 2013. The plan consists of five priority actions. The areas of focus are:

- creating a central region Youth Hub for agencies working with youth
- supporting MoE aims to increase achievement of NCEA 2 and Youth Social Sector Trials
- ensuring more warm homes to prevent illness – Warm Up New Zealand (BOPDHB lead agency)
- involving industry/business in the collaborative efforts to support young people in education/training and employment
- developing BOP youth workforce plan.

SmartGrowth

SmartGrowth is a collaboration between Tauranga City Council, Western Bay of Plenty District Council, Bay of Plenty Regional Council and tangata whenua working in partnership with central Government (particularly the NZTA), businesses, education groups, industry and the community.

The 'SmartGrowth Partnership' refers to an alliance between local and territorial authorities and tangata whenua. However SmartGrowth is wider than local government. The strength of the strategy is largely due to the proactive role of community and strategic partners. The partnership is heavily dependent on a range of government and non-government agencies and community groups to help with the implementation. The partnership sets the strategic vision and direction for the growth and development of the Western Bay, on key issues across the spectrum of social, environmental, economic and cultural objectives. SmartGrowth is a mechanism to harness the collective impact of local government, iwi, business, central government agencies, key industries and the community. It provides a shared pathway to guide us all towards a single vision - making the Western Bay a great place to live, learn, work and play.

Inspiring Communities

Inspiring Communities was created in 2008 to support and strengthen community-led development. The organisation is made up of a virtual development team of people from Wellington, Auckland, the BOP and Nelson. The mission of the organisation is to create change through effective community-led development (CLD). As part of this virtual team, the BOP has sponsored a number of workshops and talks by international community development leaders to build local capacity to strengthen BOP communities. The board that oversees the work of the team includes representation of iwi, business, local government, funders, and a range of other New Zealand leaders. The Child and Youth Health and Wellbeing Strategy includes partnering with communities and committing to a community development approach to increase participation and resilience among the families/whānau, children and young people.

Appendix 4 – List of Current Child and Youth Services in the Bay of Plenty

Stocktake of Child and Youth Health Services in BOPDHB

Provider	Service	Contact
Voyagers, BOPDHB	• Child and Adolescent Specialist Secondary Mental Health Services EBOP	Anja.Theron@bopdhb.govt.nz
CAMHS, BOPDHB	• Child and Adolescent Specialist Secondary Mental Health Services WBOP	
Community Child and Youth Health Services, BOPDHB	• Incredible Years, Baby Program, Toddler Program, Preschool and School Age, Dinosaur Program • B4 School Checks • HPV and MMR vaccination in schools • Well Child and adolescent health services in schools • Community oral health services for children and adolescents	Martin Steinmann martin.steinmann@bopdhb.govt.nz
Healthcare NZ	• Infant, Child, Adolescent and Youth Community Support Service	1st floor, Waitomo House, 9-11 Hull Road, Mount Maunganui Accessed through Voyagers, BOPDHB
Tuwharetoa Ki Kawerau Health, Education and Social Services	• Māori Primary Health - health education and promotion, advisory, liaison and coordination activities specifically targeted to rangatahi • Māori Health Services/Whānau Ora Maori Coordination Service - health coordination service for at-risk individuals and whānau • Sexual health and school-based clinics • Kaupapa Māori Child, Adolescent and Youth Mental Health Services • Kaupapa Māori Early Intervention Alcohol and Drug Services • Support services for mothers and their babies • Tamariki Ora/Well Child services	Chris Majoribanks Ph: 07 323 8025 hauora@tuwharetoa.org.nz
Te Ao Hou Trust	• Suicide Prevention Programme • Kaupapa pregnancy and parenting programme	Emma Kutia (EBOP) emma@teaohou.org.nz Ph: 07 315 7054 Irene Walker (WBOP) irene@teaohou.org.nz Ph: 07 544 8793 Ph: 021 446 422
Manna Support Services	• Lead agency for Strengthening Families in Kawerau • Family therapy and counselling • Family violence counselling • Incredible Years parenting programs • Bullying programs	Lisa Ranapia Lisaranapia.manna@gmail.com

Provider	Service	Contact
	• Teina/tuakana youth mentors • Whānau Ora Co-ordination • Manna Support Services also oversee the Kawerau Youth Community Centre	
Otago University	• Multi-level Intervention for Suicide Prevention Study (MISP)	Karylene Norton karylene.norton@otago.ac.nz
Youth Horizons Trust	• Intensive Clinical Support Service BOP-wide	Naomi Amani-Gillespie naomia@youthhorizons.org.nz 401 Devonport Road, Tauranga BOP Respite Service Ph: 0800 737 748 BOP Intensive Clinical Support Ph: 0800 365 002
Western Bay PHO	• 3D – Disruptive Development Disorders service for children • HPV vaccination • Positive Parenting Programme (Triple P) • Immunisation services to include outreach immunisation, immunisation coordination (opportunistic immunisation within the hospital and General Practice), lay advocate service (education on immunisation pre and post-birth) • School-based health services • SIA – youth health service • General Practice services and after-hours services cater for all ages including: free access to enrolled children under the age of six years with their provider of primary care services during normal business hours, and free access to all children under the age of six years outside normal business hours, regardless of their enrolment status	Roger Taylor rogert@wboppho.org.nz
EBPHA	• Immunisation services to include outreach immunisation, immunisation coordination (opportunistic immunisation within the hospital and General Practice), lay advocate service (education on immunisation pre and post-birth) • HPV vaccination • Sexual health and school-based clinic • Primary Mental Health (includes youth) • Kawerau Rheumatic Fever Prevention Programme • General Practice services and after-hours services cater for all ages including: free access to enrolled children under the age of six years with their provider of primary care services during normal business hours, and free access to all children under the age of six years outside normal business hours, regardless of their enrolment status	Michelle Murray michelle.Murray@ebpha.org.nz

Provider	Service	Contact
	• Whānau Ora which includes Tamariki Ora/Well Child, rheumatic fever, and programmes targeted to meet the needs of tamariki	
Get Smart TGA	• Child and Youth Alcohol and Drug Service	The Village, 17th Ave, Tauranga
Nga Mataapuna Oranga Ltd	• Kaupapa Māori Child and Adolescent Service • Kaupapa Māori Specialist Nursing Services (metabolic services) • Kaupapa Māori Infant, Child, Adolescent and Youth Community Mental Health Service • Kaupapa Māori Primary Mental Health services • Kaupapa Māori Antenatal Pregnancy and Parenting Programme • Community Mental Health Services • Community Dietitian services • HPV vaccination • Whānau Ora • General Practice services and after-hours services (in collaboration with WBOP PHO) cater for all ages including free access to enrolled children under the age of six years with their provider of primary care services during normal business hours, and free access to all children under the age of six years outside normal business hours, regardless of their enrolment status. • Well Child/Tamariki Ora	Janice Kuka ceo@nmopho.org.nz
Te Manu Toroa	• Te Waka Niho • Kaupapa Māori Child and Youth Mental Health Service • Kaupapa Māori Family and Whanau Support • Local diabetes • B4 School Checks • Community awareness raising and opportunistic throat swabbing programme in selected schools and communities for rheumatic fever prevention	Pat Cook p.cook@temanutoroa.org.nz Western Bay only
Ngati Awa Health and Social Services	• Tamariki Ora/ Well child Services • Community awareness raising and opportunistic throat swabbing programme in selected schools and communities for rheumatic fever prevention	Maude.Takarua@nash.org.nz
Huria Management Trust	• Kaupapa Māori Antenatal Pregnancy and Parenting Programme	Sylvia Willison 4 Te Kaponga Street Judea PO Box 398 Tauranga 3140 Ph: 07 5787 838 sylvia.willison@huriamanagement.co.nz

Provider	Service	Contact
Te Runanga o Ngaiterangi Iwi Trust	• Peaceful Warriors - Mental Health Service • A clinical specialised recovery-oriented mental health service that provides interventions for people with co-existing problems of mental illness and alcohol and/or other drug misuse. The services provided include clinical, consultation/ liaison and support services. The treatment model includes traditional Māori healing practices including holistic approach, whānau input and Māori ownership. • This specialised service caters for tamariki/ rangatahi aged 10 to 25 years	Kuku Wawatai Te Awa o Tukorako Lane PO Box 4369 Mount Maunganui 3149 Ph: 07 575 3765 kuku@ngaiterangi.org.nz
Katikati Resource Centre Inc	• Antenatal pregnancy and parenting programme	Chris Ridder Ph: 07 5490399
Parents Centres NZ Inc	• Antenatal pregnancy and parenting programme	Vivienne Lowe Ph: 04 2332022 v.lowe@parentscentre.org.nz
Trust Home Birth Charitable Trust	• Antenatal pregnancy and parenting programme	Holly Clarke Ph: 07 5430334 babycued@xtra.co.nz brilleaux@xtra.co.nz
Poutiri Trust	• Tamariki Ora/Well Child services • Support services for mothers and their babies • Whānau Ora	Mita Ririnui P.O Box 148 Te Puke Ph 07 573 0091 MRirinui@poutiri.com
Te Whānau Kotahi	• Child Development Service in Western Bay of Plenty region.	112 13th Avenue PO Box 15/278 Tauranga Ph: 07 571 4768 Fax: 07 571 4778 Email: info@twk.org.nz
Family Works – Presbyterian Support	• Parenting education	Hillier Centre 31 Gloucester Road Mt Maunganui PO Box 10050 Tauranga 3152 Ph: 07 575 9709 Fax: 07 575 9735 Email: wbop@northern.familyworks.org.nz
St Peter's Care and Counselling Trust	• Parenting education	Gill Kennedy Ph: 07 578 9608 Fax: 07 578 9608 office@stpeters.org.nz
Relationship Services	• Parenting education	Ash Smart ashs@relationships.org.nz
Plunket	• Parenting education	Lynne Carter Lynne.carter@plunket.org.nz
Pirirakau Hauora Charitable Trust	• Whānau Ora	dmotutere@pirirakauhauora.org.nz

Provider	Service	Contact
Te Ha o te Whānau	• Whānau Ora	maude.m@tehaotewhanau.co.nz
Tuhoe Matauranga t/a Te Kaokao o Takapau	• Whānau Ora • Community awareness raising and throat swabbing programme in schools within Tuhoe rohe for rheumatic fever prevention	Wena Harawira wena@tuhoematauranga.org.nz
Toi Te Ora Public Health	• Health Promoting Schools/ECEs • Immunisation promotion, rheumatic fever prevention, communicable diseases follow-up, etc.	Janet Hanvey janethan@bopdhb.govt.nz
Te Ika Whenua Hauora	• Murupara rheumatic fever prevention programme	
Tuhoe Hauora (Ruatoki)	• Mental Health Whānau Peer Support service for child/youth Kaupapa Māori Mental Health services -tamariki/rangatahi • Kaupapa Māori Mental Health services – early intervention strategies for tamariki and rangatahi AOD abuse	Waylyn Tahuri-Whaipakanga waylynt@hauora.tuhoe.org Ph: (07) 312 9896 Cell: 021 021 44272
Whakatohea (Opotiki)	• Kaupapa Māori Infant, Child, Adolescent, Youth Community Mental Health • Well Child/Tamariki Ora • Community awareness raising in communities and throat swabbing programme in schools for rheumatic fever prevention	Louisa Erickson Manager – Social and Health Group Te Wheke Atawhai PO Box 208 Opotiki Ph: (07) 315 6042 Cell: 0274151197 Louisa.erickson@whakatohea.co.nz
Te Ika Whenua Counselling (Murupara)	• Kaupapa Māori alcohol and drug service	Te Aroha Taki mana3@xnet.co.nz
Maketu Health and Social Services Trust	• Early intervention and other drug services	Tasha Knight Ph: 07 533 2551 Ext 805 Mob: 027 320 2560 tasha.k@maketuhauora.org.nz
Nga Kakano Foundation(Te Puke)	• Kaupapa Maori AOD for tamariki/ rangatahi	Pia Callaghan piac@ngakakano.org.nz

Oral Health Service for Child and Adolescent Services

Please refer to the following links for provider details:

1. Oral health services for adolescents:
   http://www.bopdhb.govt.nz/need-a-health-professional/find-a-dental-professional/oral-health-services-for-adolescents/#sthash.uWrwh0Rw.dpbs

2. Emergency dental services for children and adolescents
   http://www.bopdhb.govt.nz/need-a-health-professional/find-a-dental-professional/emergency-dental-services-for-children-and-adolescents/#sthash.EgptNecO.dpbs





MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

MINISTRY OF SOCIAL DEVELOPMENT
Te Manatū Whakahiato Ora