Waitemata
District Health Board

Te Wai Awhina

A summary of the Waitemata District Health Board Youth Health Services Programme Review

Background
In December 2009 E Tu Taitamamariki Strategic Direction for Youth Health was endorsed by the Waitemata DHB Board. The strategic plan has five specific actions, these are:

- Improved access to primary health care for the youth population;
- Consistent high quality school based health services;
- Development of youth specific community based health services that are targeted to the most vulnerable populations;
- Ensuring young people receive a "fair share" of health services, maximising configuration of services to improve health outcomes and reduce inequalities and health status;
- On-going youth participation through the youth advisory group and link to existing networks.

To inform and support the implementation of the strategic direction a review of current services funded by the Waitemata District Health Board (WDHB) was undertaken.

Programme review
A review of the youth specific primary and secondary services funded by Waitemata DHB was undertaken to ascertain the coverage, utilisation, and models of care of these services. In addition the review was able to identify service gaps and duplication. The review was conducted using a standardised questionnaire and guide on the information to be obtained. The review covered the following areas:

- Programme logic and reach;
- Equity and whanau ora;
- Youth participation;
- Collaboration/partnership;
- Professional development;
- Sustainability;
- Evaluation.

The review also took into account relevant documents such as; provider-monitoring reports, audits, Education Review Office reports, other reviews and evaluations.

Twenty six services positioned to contribute to improvements in youth health were reviewed.

The review findings will inform and support planning of youth service reconfiguration and provision across the WDHB district.

Review Method
The services were reviewed between April and May 2010. Reviewers undertook provider visits during this period in order to complete the review using the standardised questionnaire. The questionnaire considered the following elements; programme logic and reach, equity, whanau ora, evidence base, accessibility, youth participation, collaboration and partnerships, professional development, sustainability, and evaluation.

Providers received written notification of the review and a copy of the review questionnaire. On completion of the review providers had the opportunity to review the completed questionnaires for accuracy. Providers were able to provide any supporting information they held and wished to share.

Summary of Review Findings
The key findings from the review are:

Overall
- A lack of consistency across school-based health services;
- Inequitable service provision across the district;
- Accessibility issues for young people, particularly those in Rodney and on the North Shore;
- Potential lack of continuity of care and integration for young people when school services are isolated from primary and community care;
- The 'youth friendliness' of general practice and other adult services that see young people is inconsistent;
- Limited youth health specific clinical expertise within the region;
- A lack of consistency in service indicators and reporting of measurable outcomes;
- Limited data and information to assess reach of the current services.

School-Based Health Services
- Most schools in WDHB have some level of health provision to students;
- Services vary from a school counsellor and/or first aider to a full range of health services, including nursing, GPs, physiotherapists, youth, community and social workers;
- Lower decile schools generally have higher levels of health provision than higher decile schools;
- There are multiple sources of funding including WDHB, Ministry of Education, Ministry of Social Development and Accident Compensation Corporation.

Community Health Services
- A range of youth health provision exists including specialist youth care co-ordination, counselling, mental health, and drug and alcohol services;
- Utilisation of services appears variable, although there are significant gaps in service utilisation data and service reach;
- There are accessibility issues for young people, especially in Rodney and the North Shore;
- There is a need to assess youth-friendliness and integration of general practice and adult service provision.

Services to Increase Access (SIA)
- PHOs receive SIA funding based on their enrolled populations;
- Some PHOs are purchasing youth-specific services with this funding;
- Services funded include GPs, nurses, social workers in high schools, sexual health clinics or free GP sexual health consultations;
- There is a need to better understand levels of service provision relative to funding provided across all of the PHOs.

Programme Logic
The services reviewed had been in existence for various periods of times. Some services were started under the Health Funding Authority, whereas others started more recently by the District Health Board. Services generally had not been comprehensively reviewed by the Funder since inception.

In a number of cases the service needs had changed from the original contract and providers had altered the services they delivered accordingly. Consequently, contract specifications did not always align with the service being provided. Providers had used recent youth health information to modify services to align to current evidence.

Programme Reach
The reach of services was difficult to ascertain. Total target populations for services were in some cases vague and inconsistently defined in the contracts and service specifications. In many cases it was difficult to determine the percentage of the target population served.

Impact
There was limited ability to identify the overall impact of the current configuration of services.

Some services were measuring the outcomes from their interventions; this was particularly evident in mental health. However, not all services were measuring service outcomes.

Equity
There was widespread variability in the aims, objectives and specific approaches to enable equity. While not consistently contracted for across the services, some providers were able to demonstrate detailed and specific strategies they used for reducing health inequalities. This mostly consisted of hiring Maori and or Pacific staff, and providing staff cultural training.

Whanau Ora
Many services cited collaboration with Maori organisations under this component of the questionnaire. The degree to which this effected Maori participation in service planning, development, and decision-making could not be demonstrated.

Many providers cited the employment of Maori staff in service delivery, as a component of whanau ora. Many services had policies around engaging whanau in service provision. Only a few providers could provide explicit policy documentation regarding the safeguarding of Maori cultural concepts, values and practices. Maori health improvement was most often reported in relation to a high number of Maori service users in relation to catchment population demographics.

Evidence-Base
Most providers drew extensively from published literature and needs assessments in their service design. Providers are commended for using their initiative in using an evidence base.

It was also noted that historic service specifications were no longer aligned to current evidence and models of care for youth health service provision. Overall, providers identified the need to balance accountability requirements and programming with the need for service flexibility to respond to the changing evidence and needs of young people.

Accessibility
Most youth-specific services had clear service promotion strategies, and confidentiality policies.

Although there was variability of the physical accessibility of services most providers aimed to ensure premises were easily accessible i.e. within the school grounds. For those that were not on a school site outreach initiatives were common such as evening sessions and/or provision of transport.

Providers understood the importance of the services being private and available through a variety of means.

Many providers had multiple ways of engaging with youth e.g. email, social networking sites, texting, and open clinic times. Rigorous and persistent follow-up was practiced by many services.

A few services had waiting lists; and some noted a growing demand.

Providers that were not located in the WDHB area generally had a lower profile and access by WDHB clients.

All of the services were provided free to youth.

Youth Participation
This appeared to be a developing area for many providers. Only a few providers had comprehensive and robust youth participation mechanisms and involved youth in delivering staff training.

The majority of providers did not provide or promote opportunities for youth to develop skills in participation mechanisms.

Some providers had a youth advisor or youth advisory group. A few providers were considering developing such roles.

Most services had client feedback mechanisms; however for some this was only through verbal feedback during treatment sessions.

Collaboration and Partnerships
Many services had working relationships with numerous community, health and government organisations e.g. recreation providers, schools, and Public Health Nurses. Some organisations had a Memorandum of Understanding with statutory agencies such as; Child, Youth and Family; and the Department of Justice.

Most providers were part of a network and had regular meetings with key stakeholders or other agency forums such as the Youth Offending Team. Partnering agreements with agencies were also in place in some cases e.g. specialist health programmes that were provided by other agencies within schools such as Stand Up! (An alcohol and drug programme).

Where Med-tech (a patient management system) was available in schools it assisted with the continuity of on-going primary care for the young person.

Sustainability
Schools and some Non Government Organisations had multiple funding sources including DHBs, PHOs, Ministry of Education, and philanthropic trusts. Most services, including all secondary care services were entirely dependent on DHB and MoH contracts.

Short term contracts potentially threaten the continuity and viability of some programmes as a consequence of the uncertainty of funding continuity.

Some services found it difficult to recruit, retain and train the right staff.

Contracts often were reported as not providing sufficient funding to cover infrastructure, evaluation and professional development.

Professional Development
There are limited youth-specific training opportunities available within the Waitemata district. This is compromised further as there is limited youth health specific clinical expertise within the region. Training is available within the Auckland region however some providers were not aware of them and/or found it difficult to access.

Many providers provided some in-house training that was sometimes shared with other providers. Most services provided an induction and orientation, and had a means of identifying professional development needs.

In most instances, professional development was not clearly or specifically stipulated and defined in contracts. Accordingly resources were not defined for professional development requirements.

There was variable knowledge within providers of available professional development support and training opportunities.

Evaluation
Overall, evaluation features poorly in current youth health contracting, with limited requirements and resources allocated to this.