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**Margaret May Blackwell Travel Study Fellowship**

**2011/12**

**Improving the health of children through:**

***Improving the primary-secondary interface for child health***

***Child health practice within the integrated family health centres***

***Improving care for medically fragile children***

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## **Table of contents**

<b>Acknowledgements</b>	<b>2</b>
<b>Executive Summary</b>	<b>4</b>
<b>Recommendations</b>	<b>5</b>
<b>Introduction</b>	<b>6</b>
<b>Preparing the itinerary</b>	<b>8</b>
<b>Reporting the Findings</b>	<b>9</b>
<b>Recommendation 1</b>	<b>10</b>
<b>Recommendation 2 &amp; 3</b>	<b>16</b>
<b>Recommendation 4</b>	<b>21</b>
<b>Discussion of findings</b>	<b>25</b>
<b>Conclusion</b>	<b>26</b>
<b>References</b>	<b>28</b>
<b>Appendix</b>	<b>29</b>

## **Executive summary**

This report provides observations, insights and knowledge gained when undertaking the MMB travel fellowship. The content is based on conversations, shared research and observation of programs visited during the three months as per the attached itinerary (Appendix).

In preparing for the travel fellowship I made contact with health professionals and organisations within child health with a particular interest in the 0-5 year old population. I was interested in service delivery that was seamless and reduced burden to families accessing multiple services and professionals. The key aspects relate to the way need is identified, care is planned and services are integrated.

During the fellowship I had the opportunity to visit with Health professionals across a range of settings. These included hospital, community care, general practice, academic institutions and conference. I was able to observe practice, engage in research seminars and share ideas and experiences from my own practice.

Aside from the opportunity to observe programs and practice, the MMB travel fellowship accorded an opportunity to immerse myself, albeit for a short time, in the ways of other places. The cultural beliefs and history of countries provides a wider context within which to contemplate why a certain way of doing things may be more or less successful than it might be in another setting.

As a result of my observations and experiences I was able to identify tools and approaches to care which when well understood and applied consistently do have the potential to impact on health outcomes for children.

## **Recommendations**

All services and sectors involved in providing care to children and their families should

1. Adopt a single access approach to care, “no door is the wrong door”
2. Ensure all care reflects a genuine patient and family centred approach
3. Utilise common assessment frameworks across health services, education and social services
4. Utilise electronic tools which promote engagement and provide timely access to appropriate care

## Introduction

Prior to embarking on the MMB travel fellowship I rather naively believed I would find the perfect model of seamless care. However, I discovered that similar challenges to those I observe in New Zealand are faced in other places. Navigating the health system can be mind boggling for children, parents even for those of us who work in it. The risk of families falling through gaps in service delivery is reduced when systems support an integrated approach to care. A shift or change in the way services are organised and operate has the potential to improve delivery of a variety of services required by families.

Patients and their families encounter the primary-secondary interface at various points during their care. Families can be overwhelmed by the confusing maze of services and service providers. Managing their child's condition alongside the activities of daily living can place strain on both child and family health. The physicians and health professionals can also be challenged by diminished cohesiveness in the delivery of services. There is a need to ensure that this interface is invisible to the child, their family and those involved in providing care and support.

Smooth transition in care is marked by the engagement of all parties. When care is planned and coordinated across settings health outcomes are improved. Being guided by the principles of patient and family centred care ensures the child and family's needs remain paramount. The risk of the patient and their family becoming disconnected from their care decreases when a key person is identified to support and, if required, advocate for the patient.

Advances in communication and information technology offer opportunities. There might be a variety of ways in which patients interact with service providers. There is now potential to store and access medical records electronically. Seamless access to information regarding

diagnosis and care may reduce the incidence of duplicate or unnecessary care. Privacy concerns can be mitigated by clearly agreed protocols and understandings.

## **Preparing the itinerary**

An academic paper written by Ingrid Woolfe and colleagues (2011) discussed differences between the provision of child health care in Great Britain, Sweden and the Netherlands. This gave me a basis for my travel plans and I began Google searches of these countries, their nursing organisations, hospitals and academic institutions. I canvassed local forums, networks and colleagues within the child health sector supplying them with my travel topic and requesting they forward me any helpful links or contacts. I was given several contacts in the Great Britain, Sweden and the Netherlands and was able to begin compiling an itinerary.

A previous recipient of the travel fellowship recommended including a conference in the itinerary. This would provide an opportunity to cover a large amount of material over a short time. As a registered nurse who has completed clinical Masters of Nursing I was interested in meeting with nurse practitioners and observing how these positions impact on child health outcomes. North America provided an opportunity to both attend a conference and engage with nurse practitioners providing health care to children.

A variety of responses to my international emails and local conversations presented me with a range of options. I was in contact with a variety of health professionals and recommended programmes not offered by nurses or doctors. The varied settings and opportunity to interact with professionals from different disciplines provided a broad approach to examining the question.

## **Reporting the Findings**

During my travel I recorded my personal responses on a blog which can be accessed at <http://judystraveldiary.blogspot.co.nz/> In the report I have included relevant links to my travel blog.

Opportunities to share my learning are available in seminars to my peers. Promoting the MMB travel fellowship to Registered nurses and early childhood educators is a key objective as I now understand the value of looking beyond the confines of one's own practice and environment.

## Recommendation 1

### Adopt a single access approach to care, “no door is the wrong door”

- **Coordinating care across settings**
- **co-locating services**
- **Integrating service delivery**
- **Developing authentic relationships between patient, family, practitioners and services**

Reducing barriers between care offered in primary and secondary settings will improve health outcomes. Using a multidisciplinary approach can provide coordinated and seamless care. Parents, however, may describe the care provided as confusing and sometimes ad hoc. Doctoral students at Lund University Sweden, interviewing families of disabled children regarding care they were receiving, confirmed this view. Early results from their research identify the family’s need for one identified person to be available to them. Their participants referred to this person as a spider, someone who can sit in the middle of a complex web and have a clear overview of all of the strands.

<http://judystraveldiary.blogspot.co.nz/2012/04/spider.html>

The early years’ services in Inverness Scotland recently restructured their service delivery in order to address barriers and improve access to seamless care. (A new look at Hall 4: The early years good health for every child, 2011; Getting it right for every child: Practice Guidance 2010). Where a child would previously have been referred to another service or provider, services are now being requested in. This subtle change in the way care is described seeks to keep the child at the centre of the care. Keeping the family in a central place and bringing the services to them immediately reduces the burden they might experience when accessing specialist services. It may not always be possible to provide

specialist services within a primary setting, however there are ways in which the interface may be invisible. The identifying of a “named person” provides the family with a central point of contact if required.

<http://judystraveldiary.blogspot.co.nz/2012/05/pearls-of-wisdom-reflections-on-visit.html>

Specialist knowledge available within a primary setting can reduce the need to access multiple sites. Registered nurse training in northern Europe distinguishes between pediatric and adult care providing registration as either a paediatric or adult nurse. Medical training in Sweden has traditionally provided more time in general practice including a dedicated focus on paediatrics. A community clinic in Uppsala Sweden provided placements for medical students involving them as active participants rather than observers. This approach to training can increase specialized knowledge and practitioner confidence to treat within the primary setting.

Neonatologists in Uppsala also practiced as pediatricians providing families with continuity in specialist services as their child grew. Locating paediatricians in community practice supports the notion of requesting service in. This can reduce the need for child and family to travel to another facility or another area. The paediatricians working at primary care community clinics also work at the hospital. This provides patients with a consistent relationship with familiar staff.

<http://judystraveldiary.blogspot.co.nz/2012/04/one-door-in.html>

Alder Hey Children’s hospital looked to improve community access to appropriate care at point of access. To this end they developed a dedicated primary care stream alongside their hospital emergency department. Locating primary care on hospital grounds supports triaging patients to the appropriate services within the same space.

<http://judystraveldiary.blogspot.co.nz/2012/04/alder-hey-children-hospital.html>

Many primary care providers have established strong collegial links between their practice and secondary services. This supports integrated consultations happening within primary settings. Liverpool's Alder Hey children's hospital modeled this when linking with families' resident across the north east of Britain. Communication tools such as teleconferencing can provide access to specialists without placing any additional burden on the child and family.

Community nursing services provide access to comprehensive care to children with complex health needs. Alder Hey children's hospital provides care to 770,000 children with some form of disability. Of these approximately 6,000 are technology dependent. The paediatric outreach nurse, I spent the day with, displayed a broad range of knowledge and skills which provided her clients with quality seamless care. The families, we visited, showed considerable confidence in managing complex care. This was supported through the strong interface between the Paediatric outreach service and the specialists caring for the child.

The integration of palliative care principles supports broad care networks. The stress of managing a chronic or terminal condition in a child has the potential to negatively impact on family relationships. Visiting the paediatric palliative care home in Liverpool with the outreach nurse confirmed the importance of relationship between nurse and family and all available services. Strong liaison between the nurse, family and the hospice staff provides a seamless interface between the care settings. The access families have to the staff and resources offered by hospice provide an open door which complements the inpatient and community care the child and family were receiving.

<http://judystraveldiary.blogspot.co.nz/2012/04/medically-fragile-children-in-liverpool.html>

Critical liaison positions can help to close gaps in care delivery for many families. In Alder Hey children's hospital, an experienced health visitor is employed on a part time basis to link families to services. The health visitor liaises with families to identify and follow up any

barriers which may affect their ability to attend and participate in their child's care. As with the named person this position provides advocacy, coordination and support to families across services. This work requires a broad range of skills and excellent knowledge of the community, the region and services available. Valuable time is gained when a family can be located and connected to necessary care. Examples of how this position supported the care of traditionally hard to engage populations such as traveller communities highlighted the value of a central coordinator.

Children's access to specialized services including dietitians, psychologists, optometrists, dentists, pharmacists and social workers can be achieved through integrated family health practice. The family health practices, I visited, in Uppsala and Ontario reduced the need to refer children out, by providing access at a familiar and central location. The integrated family health care practices may share services across several practices and result in improved access for greater numbers of the population.

The Integrated family health practices provide access to a range of services and professionals. Promoting a multidisciplinary approach within this environment improves patient's access to integrated care. In a family health practice in London Ontario, the care of diabetic patients was managed by a nurse practitioner and a pharmacist. They were available for joint consultations with or without the patient. The emergence of more health practitioners being qualified to prescribe has provided opportunities to deliver care in different ways.

<http://judystraveldiary.blogspot.co.nz/2012/05/collegial-times.html>

Devolving service provision to local council level provides an opportunity for a broad approach to service integration. In Derby England, health visitors share a building with Sure Start workers, social workers, speech language therapists, and an early childhood centre. This service hub model seeks to situate health care services alongside other services

utilised by families. Service hubs provide ease of access and have the potential to be the impetus for the development of shared values and principles across sectors.

In London Ontario Canada, a nurse practitioner clinic operated from a high school campus providing classes for students excluded from other high schools. Sociologists, working with the local neighbourhoods on projects including communal gardens and family friendly environments, were located within the same building. The collective vision was articulated as a desire to support neighbourhoods to be participants in improving all aspects of their lives. The integration of health promoting actions with the provision of primary care services supported a sustainable approach to improved health outcomes. The same nurse practitioner provided a clinic across town in a shopping mall. The mall was close to the housing estate where many of the families with young children lived. The ease of access was enhanced by the fact that all the shops and services were within walking distance. The identified need of the predominately lower socio economic refugee and new immigrant population guided the strategic locating of this clinic. Being situated next to the community library provided access to language support and community agencies which were able to address economic and social need. Two general practices a pharmacy and a dental clinic were located close by and a work focus office was about to be established.

<http://judystraveldiary.blogspot.co.nz/2012/05/location-location-location.html>

In Derby, health visitors provide universal home visiting services to families of infants in the area. A parallel service was developed for families with children with special needs. Families are freed from having to engage with multiple services when well child care is integrated with specialised care. The service provided linkages to secondary services through a coordinated response to identified need. Families and children with genetic conditions and complex health need benefit from this relationship. The health visitor, I spent the day with, was fluent in Punjabi which removed a significant barrier to seamless access. Family feedback

suggested they were more likely to seek additional support and follow up because of the relationship between nurse and family.

<http://judystraveldiary.blogspot.co.nz/2012/03/finding-florence.html>

A specialised primary health care service established in Uppsala Sweden in 1991 evolved from research identifying some families required more than the universal service. This service, the only one of its kind in Sweden, provides a multidisciplinary approach to identified need. The team consists of a registered nurse, a psychologist and a paediatrician. Referrals are accepted from public health nurses and family health centres for children aged 0-3 yrs. Most referrals relate to disturbed patterns of sleep, feeding challenges, poor growth and colic concerns. The registered nurse and psychologist make the initial visit together. The visit, at home with both parents, includes a 90 minute health and wellbeing assessment. A plan of care is agreed to by all parties. Families generally only required a single home visit and follow up phone consultations before determining they no longer require the service. The paediatrician saw all the infants with complicated health problems and any growth, gastric concerns. While the service capacity was small the quick turnover of clients provided appropriate access for families within the Uppsala area. The nurse and psychologist insisted the success of their service came from the multidisciplinary approach to identified need. The transition for families to parenting and the challenges of adapting to the role often underpinned the presenting difficulties. Routinely engaging a psychologist in delivering a primary health care service has the advantage of integrating mental health assessment into primary health care. The documentation of assessment and care provided was available to other key services involved with the well child provision of care. This was critical for the ease of movement between the services the family was engaged with.

<http://judystraveldiary.blogspot.co.nz/2012/04/now-here-is-good-idea.html>

## **Recommendation 2 & 3**

**Ensure all care reflects a genuine patient and family centred approach**

**Utilise common assessment frameworks across health services, education and social services**

When professionals across disciplines develop and use common assessment tools a broader lens can be applied to the child's need. Common assessment tools encourage a common understanding of what the child and family need. A multidisciplinary approach reduces the need for many different visitors and consultations resulting in unnecessary burden and potential for duplication of services. Families value a consistent approach to identified need. By engaging families in the care their child potential for quality care is improved.

<http://judystraveldiary.blogspot.co.nz/2012/04/interesting-ideas.html>

Discussions with a public health nurse in Darnoch a rural village north of Inverness Scotland focused on the quality of the relationship between family and nurse. Her practice provided wellness assessments for mothers and babies and included mother craft classes. These classes are frequently offered by parent leaders or health workers, allowing the registered nurse to focus on clinical aspects of assessment and care. Central to this nurse's approach is the integration of care. Parenting confidence was increased and attachment between mother and baby supported through a consistent approach to all identified need. Being able to respond in a timely manner, providing appropriate practical advice can prevent the escalation of issues which may otherwise have remained hidden.

A recurring theme at the Patient and family centred care conference in Washington DC was the manner in which health professionals alienate families through their use of language and approach to care. Being referred to as a visitor restricted to specific hours is

counterproductive to engaging families in the continual care of their child. Fortunately many hospital cultures have changed and continue to evolve care models utilising the principles of patient and family centred care ([www.ipfcc.org](http://www.ipfcc.org)). Medically fragile children may receive care in a variety of settings. The care is continual not finished and begun elsewhere. Referring to the use of the word discharge, a parent suggested it was more appropriately used describing something that oozed from somewhere.

<http://judystraveldiary.blogspot.co.nz/2012/06/patient-and-family-centered-care.html>

Conversations with a health visitor in Kyle, a remote village in the Scottish Highlands confirmed gaps that exist across sectors and services. Solutions can be found in developing improved understandings between practitioners. Shared training days lay the basis for a common approach to identified need. These opportunities offer a forum for cross sector gatherings. This results in improved liaison between services and improved recognition of shared objectives across agencies.

<http://judystraveldiary.blogspot.co.nz/2012/04/processes-and-people.html>

At several of the well child care contacts in Sweden the public health nurse and doctor see the family together. While offering an opportunity for the nurse to utilise the expertise of the doctor and vice versa, it also supports a multidisciplinary approach to assessment. Strong inter-collegial relationships between public health nurse and family doctor provide the family confidence in consulting either the doctor or the nurse. Pressures on primary care practices in Sweden mean that access to a doctor's appointment may require a wait of several days. The anxiety of having an unwell infant may be alleviated by seeing the nurse who can then triage and provide access to medical care if indicated.

<http://judystraveldiary.blogspot.co.nz/2012/04/outside-new-zealand.html>

In Amsterdam Holland, a physical therapist integrated her research findings into a programme providing intensive follow up of pre-term babies for the first year of their life (Koldewijn, 2009). Transitioning from the neonatal unit to home includes the family meeting with the therapist in the unit prior to the family returning home. This was described, by one mother I visited, as being instrumental in her and her baby's smooth transition from the inpatient setting to home. The programme, still in the pilot stage, is showing positive outcomes with regard child parent interaction and reducing developmental problems through consistent early intervention. The outcomes are grounded in the relationship which evolves between the primary care giver of the child and the therapist. A single home visitor imparting consistent support, information and advice is valued by the families.

<http://judystraveldiary.blogspot.co.nz/2012/05/transmural-program-netherlands.html>

Research conducted at Lund University Sweden into fathers' experiences of children born prematurely (Lundqvist, 2008) found that linkages between neonatal intensive care units and the child health care services can provide good opportunities to support both mothers and fathers by reducing strain. Making this linkage early was found to make the difference in fathers making the full transition to taking responsibility for their families. The transition from inpatient care to community was smoother.

The experience shared in Lund, regarding the transition of newly diagnosed Type 1 diabetics from hospital to home, identified the follies of providing important lifestyle management skills in an unfamiliar setting (Jonsson, 2011) What to the practitioners looked like gold standard, evidence based care in the stabilising and managing Type 1 diabetes resulted in frequent readmissions. The problem families faced was the excellent education imparted to them within a secondary setting was hard to replicate at home. Wisely the hospital care evolved to include an outpatient approach to care with families living in Ronald McDonald House on the hospital campus, cooking their own food and as much as possible engaging in familiar

routines and activities. Recognising the need to transition from acutely ill to living with a condition promoted the engagement and confidence of the child and family.

A shared care approach between midwives and health visitors in Britain supports smooth transition in care. Health visitors are included in the delivery of ante-natal care and visit as early as 10 days in the post natal period. This model provides a seamless and integrated approach to care reducing potential for anxiety regarding transitioning to another service provider.

Transfer from paediatric to adult services does not generally concern nurses working with the 0-5 year old population. While visiting with paediatric outreach nurses I was reminded of the difficulties this presented some families. The generic way in which child health services are provided can be in stark contrast to the specialised approach of adult health services. On a visit to a young woman with multiple complex needs I observed the tension between the family, the district nurse and the paediatric outreach nurse as everyone adapted to the differences in the way that care may now be provided. The absence of a common assessment framework and agreed care plan led to perceived barriers to service. The details of when services would be delivered and the differing funding models became obstacles to a smooth transition in care. Placing the patient at the centre of the care improves the chances of engaging them fully in their care. The transition is successful when service delivery is planned in advance and maintains a seamless approach to care.

<http://judystraveldiary.blogspot.co.nz/2012/05/seamless-care-for-children-and-their.html>

A need to reduce waiting times in emergency departments reflects a single service model approach. Physicians in emergency departments are financially incentivised to reduce waiting times and get people through the department quickly. In practice this may result in children, presenting with ailments more appropriately managed in primary care, being treated in emergency department as the turnover of cases can be beneficial to funding

(Greer, NZMJ 2012). Invoicing general practitioners for the treatment of their enrolled patients presenting in emergency department at Alder Hey Children's hospital was a way of encouraging primary care providers to engage more with their enrolled population.

<http://judystraveldiary.blogspot.co.nz/2012/04/alder-hey-children-hospital.html>

## **Recommendation 4**

### **Utilise electronic and other tools to promote engagement and provide timely access to appropriate care**

- **Implement inter-agency protocols which allow for appropriate access to services and information**

Who should have access to a medical record and personal information is a recurring question. Identifying suitable levels of access founded on a need to know basis should reduce the risks associated with inappropriate sharing or disclosure of personal information. The patient centred care model suggests including the family of the child in all dialogue and documentation about the child. Debate regarding the type of information recorded, the language used and the potential for things to be altered or deleted, raises specific barriers to complete access to patient health care records. Including the family in report handover in the inpatient setting, simultaneously briefing nurse and parent on the child's condition and care plan promotes family engagement. The family discussing care with the team at the bedside recognises how integral family is to the child's care. Many hospitals in the United States are now using laptops at the patient bedside giving an opportunity for the family to view all notes concerning their child and to raise questions about things written or events recorded in their absence.

<http://judystraveldiary.blogspot.co.nz/2012/06/so-do-we-need-to-know-everything.html>

Common assessment tools and common care planning across a range of services will reduce burden to child and family and provide continuity in care. The access to accurate and up to date information can prevent delay in providing timely intervention Agreement regarding the sharing of relevant information requires engagement from all parties. Informed consent to share information should be achieved as part of the shared plan of care.

Developing Inter-service/interagency protocols will protect the patient privacy and provide guidance to the professionals across services and sectors.

The electronic storing of data has potential to create ease in retrieving and recording interactions however does pose challenges regarding appropriate access and secure storage. The potential for electronic messaging and request for service can be activated and provide seamless and timely access for children and their family to additional services or complementary care.

Seamless care for medically fragile children can be enhanced through the use of a shared electronic note. Assigning an index number to all residents supports the potential to link databases or creates portals to appropriate information. The paediatric outreach nurse in Liverpool recounted stories of how children living with ventilators in the community were able to holiday with their family in other parts of England. While the family may be confident in the care of their child they often encountered problems when accessing emergency department or general practice with concerns related or unrelated to their chronic condition. In these cases confusion and delay in providing appropriate care could be reduced if the professional had access to a shared electronic record.

The development of Walk In clinics across the United Kingdom has improved access for opportunistic consultations. Criticism of these clinics centres on their potential to undermine continuity of care and provide no integration or connection for the patient to a consistent provider. While the presenting concern is dealt with communication back to the patient's primary care provider (if they are enrolled) is not consistent. The ability to record the consultation and record critical incidents in a shared electronic record can reduce time and support seamless care.

In Ontario Canada families are given the choice of a preferred provider at their baby's birth. Many families choose to have care provided by a paediatrician. Rather than this choice resulting in a comprehensive service to the family it has the potential to create a smorgasbord approach to care. Examples shared with me suggested the family engaged with their paediatrician regarding their infant's growth and development but tended to access their family doctor when the child was unwell. Similarly public health nurses in Uppsala, Sweden advised that while they had shared electronic record with the doctors in family practice, overwhelming demand on doctor's time meant several private doctors' clinics were being established. The same collegial relationships did not exist and while the nurses could request information it was not able to be done at the consultation in a seamless manner.

A practice nurse employed at a family health practice in Ottawa Canada identified the potential risks to care when patients access a variety of clinics. An example of a child who had recently presented with an otitis media illustrated her concern. The local pharmacy phoned the doctor to advise the child had had a previous reaction to the antibiotic which had been prescribed. The doctor was unaware of the previous reaction as the child had attended another clinic. The previous consultation was recorded at that clinic however not messaged back to the child's family doctor. Fortunately the child's family had reacted to the allergic response by returning to the Pharmacist for advice. The pharmacist had recorded the reaction on a database which was not accessed by any of the other health professionals involved.

<http://judystraveldiary.blogspot.co.nz/2012/05/when-funding-impacts-on-service.html>

The well child book used in New Zealand has similar examples in other places. Britain, Ontario and Sweden all give parents a book which is capable of documenting their child's growth and development. While discussing the challenges service providers face when attempting to deliver consistent care to traveller families it occurred to me that this form of hand held record supported their way of life and the principles of seamless care. This record

is generally underutilised but does provide an excellent opportunity for all health interactions to be recorded in a transportable way.

The home visiting program in Amsterdam included the therapist recording the visit both in writing and visually. The family was presented with an accurate record of their child's care and a photo documenting their child's growth and development. The record was not available in electronic form but did result in family's having a hand held record of their child's first year. This was noted as one of the things that supported on-going engagement from families

<http://judystraveldiary.blogspot.co.nz/2012/05/transmural-program-netherlands.html>

## Discussion of Findings

Many of the programs I visited had good intention and had systems and protocols which supported the ideal of delivering seamless and integrated care. While models of shared care, multidisciplinary teams, agreed interagency protocols and electronic health records have the potential to engage all parties and minimise the risk of treatment errors the success rests with the relationships between the patient, the practitioners and the services.

Identifying a named person or a coordinator of care works best when the plan of care is well understood and appropriate mechanisms for sharing information are available.

An appreciation of the central role the family plays in their child's care will promote trust and advocate a partnership in care. The patient and family centred care approach should support the families' right to access services in a way that suits them. This could mean that they do not wish to share some personal information; they may wish to access second opinions or seek treatment which is not recommended by their physicians. This should not be a reason to disengage from a seamless and integrated approach to care. Providing families with the tools and information which support them being the leaders in their child's care may require a shift in the power dynamic. This change in dynamic is supported by a change in the way that care and information is viewed.

When a culture of shared care exists service providers are more likely to view care as continual and consider care and support outside their particular field of expertise. The ease with which the family transition from one setting to another is assisted by a common approach to care. A clearly identified person who supports the family through a complex maze of care can reduce their anxiety and promote engagement. Developing a shared culture of patient and family centred care will promote the practice of viewing care through the eyes of those receiving it.

<http://judystraveldiary.blogspot.co.nz/2012/06/navigators.html>

It is evident that the interface between established services such as community outreach and secondary care operate in an integrated and seamless manner however examples of fragmented care and the potential for fragmented care are not hard to find. The breakdowns are most evident when the interface is between services that have not developed effective relationships. When services and sectors operate in isolation there is less opportunity for seamless care. Different services and sectors will develop effective relationships when they achieve a common approach to need and care planning.

The economics of providing quality seamless care requires consideration. Funding models are sometimes advanced as reasons why patients may not be able to easily access seamless, integrated care. Tagging funding to doctor consultation only, discourages a multi-disciplinary approach to care. Pressures on physicians can be reduced and access enhanced by utilising all available resources. This may require a change in professional's attitudes and behaviours and the expectations of the patient.

Keeping the delivery of care simple and involving as few services and professionals as possible reduces burden to families. Models where broad generic skills are utilised support efficient use of resources and keep the child and family in one place. Programmes where the knowledge and skills being offered are specialised may miss an opportunity to provide a seamless and integrated approach to care. With constant pressure on the health dollar it seems that funding a single focus service is a luxury that may not be able to be sustained.

## **Conclusion**

Child health outcomes improve when authentic partnerships exist between child, family and practitioners. Seamless service delivery depends on the quality of the relationships between child, family and practitioners. Common need assessments and a culture of shared care

support single entry access. Agreement to bring services to the child promotes an integrated approach to care. Improving the coordination of care across primary-secondary interface and between services and sectors will result in improved child health outcomes.

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## Appendix

### **Margaret May Blackwell Travel Study Fellowship 2011/12**

#### **Itinerary**

#### **March 24<sup>th</sup>-April 14<sup>th</sup> 2012: UK sites**

Visit Children's community Specialist Services in **Derby, England**

Visit Alder Hey Children's Hospital **Liverpool, England**

Visit Early Years, NHS Highland Childcare & Early Education Service **Inverness, Scotland**

#### **April 17<sup>th</sup>-May 13<sup>th</sup> 2012: Northern Europe sites**

Visit Lund University Sweden meet with research team led by Inger Halstrom. Visit Public Health nurses in community practice. Visit Lund Children's hospital

Visit Upsala Sweden Karolinska institute and meet with research team led by Anna Sarkadi  
Visit integrated health care centre meeting with public health nurses and integrated team

Visit Academic Medical Centre in **Amsterdam, the Netherlands.**

Observe a transmural preventative intervention programme for very pre term infants and their parents.

#### **May 14<sup>th</sup> –June 1<sup>st</sup> 2012: Northern America sites**

Visit **Ottawa, Canada**

Primary care and family practice

Visit **London, Ontario**

Mary Anne Millson (R.N. Family Practice Nurse)

Visit two Nurse practitioners working with underserved populations

Visit **Washington DC USA**

Attend conference on Patient and Family Centered Care June 4-6 2012

[www.ipfcc.org](http://www.ipfcc.org)

**Return NZ June 12<sup>th</sup>**

