Chapter of Community Child Health
Chapter Chat
Issue 18, December 2014

Dr Chris Pearson

A word from the Chair ...

As we come to the end of further year it is important to reflect on what has happened or not happened in 2014.

The NDIS is continuing in the pilot sites and those of us who are in those areas know that whilst the process is well meant not all families see it that way. There is a lag both in the rollout by age and in moving from registration to provision of services. The delay of at least 4 months before the provision of services is significant in a young child with a developmental disorder where we as adherents of the principles of early intervention see precious months slipping away. The Council for the Care of Children in SA has just published a paper on hearing from children with disability and their families about their experiences of the NDIS (www.childrensa.sa.gov.au/assets/documents/Trialling%20the%20NDIS_Aug%202014%20FINAL%202014-10-31.pdf) and this is worth reading.

The saga of the fate of refugee children in custody continues without obvious resolution. We have ample evidence that these children are suffering harm and the statistics from the Australian Human Rights Commission provide ample reason for concern (https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/national-inquiry-children-immigration-detention-2014). As good citizens it is our responsibility to continue to agitate for these vulnerable children in any way that we can as indeed does the College.

The Advanced training Committee for Community Child health continues to work tirelessly to improve the quality of the training program both in terms of a new approach to training in Child Protection and the development of Entrustable Professional Attributes (EPAs). Mick O'Keeffe's leadership in this area has been invaluable. He provided an article in our journal at the beginning of the year (Title: Clinical competence in developmental-behavioural paediatrics: raising the bar) and gave a presentation at the satellite day in Auckland this year. There will be a pilot in 2015 of which some of you will be aware. There is no doubt that this will require extra thought on the part of supervisors assuming this new approach is adopted and I would encourage you to watch out for the training package for supervisors in due course.

Your committee has met twice this year and has 3 pieces of work that it is sponsoring. The first is developing the Satellite Day for Cairns where we are looking at at least one new and interesting feature for the day. The second is the development of a paper on the importance of the family in the way that we work. Finally chapter members are contributing to an important policy in development, namely "The role of paediatricians in providing for the mental health of children and young people".

Finally The Chapter Committee wishes you well for the festive season and a successful personal and professional 2015.

Chris Pearson,
Chair of CCCH

We would love to receive some pictures to place in Chapter Chat!
We require the event name, date and the names of people in the pictures. It is assumed that you have sought permission from those in the pictures.

From the Editor

Welcome to the Christmas edition of Chapter Chat! 2014 has been another exciting year for the Chapter of Community Child Health and in this newsletter we hoped to highlight some of the main activities and ongoing work of the Chapter in the past 12 months.

As you can see from Dr Chris Pearson's chair report, the Chapter Committee continues to be hard at work in many different areas including advocacy, particularly for refugee children; policy development around mental health and role of families; and establishing the new training program for Advanced Trainees in partnership with Community Child Health SAC. A major calendar event this year was the College Congress in Auckland as well as the Chapter Satellite Day just preceding it. Thank you also to Dr Michael McDowell for providing us with an update about the activities of the NBPSA.

Finally, congratulations to Dr Caroline Mahon, the winner of this year's Rue Wright Memorial Award, which was presented at the RACP Congress. Dr Mahon's study on the incidence of empyema in South Auckland children is well worth reading and we thank her for allowing us to include her abstract in this newsletter.

I would like to add my best wishes to all members for a happy and joyous holiday period, and hope to see many of you at various Chapter and College activities in the coming year.

Chapter of Community Child Health Committee
Current Membership List

Chair & Child Development & Behaviour SIG Chair Dr Chris Pearson	**Child Protection SIG Chair & SAC in Community Child Health Chair** Dr Terence Donald
Child Population Health SIG Chair A/Professor John Eastwood	**Appointed Member** Dr Sharon Greenwood
Appointed Member Dr Deepa Jeyaseelan	**Appointed Member** Dr Tim Jelleyman
Appointed Member Dr Brad Jongeling	**Adolescent Health representative** Dr Bessy Lampropoulos
Appointed Member Dr Catherine Marraffa	**Advanced Trainee Representative** Dr Angela Titmuss
Casual Vacancy Dr Murray Webber	

Inside this issue:

Welcome to new members of the Chapter

- Dr Vinita Prasad
- Dr Su Ling Chua
- Dr Tharmarajah Sorubarajan
- Dr Suparna Chakrabarty
- Dr Theresa Pitts
- Dr Ianthe Sayers
- Dr Marie Nazar
- Dr Megan Watson
- Dr Kate Alexander
- Dr Anna Bamford
- Dr Priya Kamalanathan
- Dr Alicia Montgomery
- Dr Christine Peng
- Dr Sinthu Vivekanandarajah

CCCH Satellite Day & Dinner

The Chapter Satellite Day will be held Sunday 24 May, 2015 in Cairns, Queensland. For the first time the Satellite Day will be aligned to the RACP Congress, program. This means that registrations will open at the same time – all online via the RACP website – and the program will be made available to a broader audience.
In recognition of the important work underway to gain specialty recognition of Adolescent & Young Adult Medicine, the Satellite Day will be themed as such. A working group is diligently preparing the agenda, topics and speakers and in due course these will be announced to you.

Other dates to hold in your diary are:

Sunday 24 May	• Child Protection SIG, Child Development & Behaviour, and Child Population Health annual meetings • the Chapter Annual Dinner
Monday 25 May	• Chapter Annual Meeting • Rue Wright Memorial Award • RACP Annual General Meeting • PCHD Annual Dinner
Tuesday 26 May	• Howard Williams Oration • PCHD Annual Meeting • Congress Gala Dinner

So, 'watch this space' as they say – and hold the dates in your diary!
In the meantime the call for abstracts for the RACP Congress is open – see HERE for details.

An Increase in the Incidence of Empyema in South Auckland Children: A Retrospective Review of Empyema and Parapneumonic Effusion (PPE) 1998-2012

Caroline Mahon FRACP[1], Wendy Walker FRACP[1], Emma Best FRACP[2]

[1]Kidz First General Paediatric Department, Middlemore Hospital, South Auckland, New Zealand.
[2]Department of Paediatric Infectious Diseases, Starship Children's Health, Auckland New Zealand.

Background

The incidence of empyema in children is increasing worldwide and the reasons for this are obscure. *Steptococcus pneumoniae* is the most common organism causing empyema and PPE in children in the developed world. It has been speculated that the introduction of the 7-valent pneumococcal vaccine into routine childhood immunization schedules between 2000-2006 in Europe and North America has favoured the emergence of empyema-causing, non-vaccine serotypes.

There is no data describing the incidence of childhood empyema in New Zealand, and little data about the clinical features, microbiology, epidemiology and outcomes.

We undertook a retrospective chart review of all children hospitalized with empyema and PPE in South Auckland, New Zealand from 1998-2012. The clinical features, epidemiology microbiology and outcomes of children with empyema were compared with those with PPE.

Results

184 children with empyema and PPE were hospitalised in South Auckland over the study period. 104 of these were diagnosed with empyema.

We found that the incidence of empyema increased ten fold over the 15 years of the study, with a peak incidence in 2009 of 13/100,000, coinciding with circulating H1N1 influenza in that year. The incidence of empyema in children aged < 5 years was particularly high. The increase in empyema incidence was apparent before the introduction of PCV-7 into New Zealand's routine childhood immunisation schedule in June 2008.

Staphylococcus aureus was the most frequently isolated organism (45%), followed by *S. pneumoniae* (37%) and *Streptococcus pyogenes* (10%).

Children of Pacific and Maori ethnicity with empyema were over-represented compared with the respective proportions of these ethnicities in the South Auckland population.

Children eventually diagnosed with PPE or empyema who were prescribed oral antibiotics in primary care in the days leading up to their hospitalisation were 2.5 times less likely to have surgical intervention.

Conclusions

This study contributes to the significant body of literature documenting health inequalities in Maori and Pacific people in New Zealand. The increases in rates of hospital admissions for childhood PPE and empyema documented in our study, are a small part of an alarming rise in rates of admission for infectious diseases in New Zealand overall in the last two decades, especially in children <5 years of age. The role of early antibiotic prescribing in children presenting to primary care with respiratory tract infections in South Auckland in preventing PPE and empyema and its complications requires further research.

In New Zealand, the Paediatric Surveillance Unit commenced prospective study of childhood empyema cases in June 2014. The authors would like to urge general and specialist paediatricians working in New Zealand to participate in this study so that a better understanding of the clinical features, epidemiology and microbiology of childhood empyema and PPE can be achieved on a national level.

Caroline Mahon
2014 Rue Wright Memorial Award winner

National Disability Insurance Scheme (NDIS) – experiences from South Australia and New South Wales

History of the NDIS

In July 2013, the first stage of the National Disability Insurance Scheme commenced at trial sites across Australia, initially as "DisabilityCare Australia," to provide ***reasonable and necessary*** support for people with significant and permanent disability or those who would benefit from early intervention.[1] It was estimated to service 3,000 children & adults in the Hunter region in New South Wales, 1,500 children 0 to 5 years in South Australia (SA), 800 young people 15 to 24 years in Tasmania and 4,000 adults in Barwon, Victoria.

Additional trial sites were launched in Western Australia (2 year trial of NDIS versus State-funded program), the Northern Territory (supported by SA office) and the Australia Capital Territory. Queensland will await full roll out of the NDIS in 2016. By 2015, the NDIS is expected to support 20,000 people with a disability.

In September 2013, the name of the scheme reverted from DisabilityCare Australia to the National Disability Insurance Scheme, with the agency responsible for delivering the scheme known as the National Disability Insurance Agency (NDIA). A further change has been the relocation of the national office from Canberra to Geelong, with loss of some executive staff involved in the initial roll out of the scheme.

NDIS costs

In 2010, the Productivity Commission estimated the NDIS would cost approximately $13.5 billion per year ($6.5 billion more than the $7 billion already spent annually by the Federal and State Governments on Disability prior to the role out of the NDIS).[2] By 2012, a Government Report revised this to an estimate of $22 billion per year by 2019-20, the first year of full operation of the NDIS, to provide support to 460,000 people. Funding is to be provided by ***Federal and State Governments*** (partly by increases in the Medicare Levy), but it is currently not completely funded. Funding will be directed to private providers and also to agencies previously fully or partly funded by State Governments. NDIS funding covers a range of different support options, but will not fund services that should be covered by health or education.

Accessing the NDIS

Families initially need to complete the "My Access Checker" online tool on the NDIS website (www.ndis.gov.au/) to determine if their child meets residential and other criteria. They are then allocated a reference number and need to telephone the NDIS to proceed further. Families meet with a NDIS Planner to review eligibility by completion of the Support Needs Assessment Tool. The family must provide evidence of a disability or developmental delay, via a form to be completed by a doctor or allied health professional.

The Planner will assist the family to complete a funding plan by determining which services to access from a list of registered providers. Current family and other supports are taken into account. The plan is reviewed 6-12 monthly. Children who are now eligible for the NDIS will no longer be able to access early intervention funding previously available under The Helping Children with Autism or Better Start Initiatives. They can still access the Medicare based supports available under these schemes.

NDIA in SA

Two types of funding groups:

1. Permanent disability (usually older group of children) – disability has a big impact on life and participation in the community; the child will have ongoing needs for the rest of their life.

The children must have been a resident in SA prior to 1/7/13.

2. Early Intervention (EI) requirement

May only have 1-2 areas of need in developmental delay

Must have evidence that receiving EI now will reduce future needs AND the supports will help the family to keep supporting their child's development.

As of March 2014, 1152 children had been deemed eligible for support, with 979 children approved or receiving funded plans for early intervention support. With the age group being expanded to 13 years of age, it is expected that a further 1565 or more children will register for eligibility and services.

75% of the plans are fully managed by NDIA, with 20% of families managing 1-2 parts of an intervention plan by themselves and the NDIA team managing the rest, 5% of families managing funds themselves and a small percentage using a third party management source. The NDIS publishes a catalogue of current registered support agencies/therapists available. In South Australia, 283 service providers have registered, with this number continuing to increase.

Cont. over

National Disability Insurance Scheme (NDIS) – experiences from South Australia and New South Wales … Cont.

NDIS in NSW

The Hunter was chosen as the first region in NSW to trial the NDIS transition process. Newcastle local government area commenced on 1st July 2013 followed by Lake Macquarie on 1st July 2014. By 2016, approximately 10,000 children and adults with a disability living in the Newcastle, Lake Macquarie and Maitland local government areas (LGAs) will be transferred to the NDIS from existing disability services. "As at 30 June 2014, the Hunter trial site had 2612 participants who were eligible for the Scheme, and 2268 participants under an approved plan"[3]. Regular (monthly) consultations are taking place between NDIA and Hunter New England Local Health District staff.

National review of the NDIA

"A Review of the Capabilities of the National Disability Insurance Agency" [4] raised concerns regarding the NDIA, stating that "The capability of the Agency is weaker than it otherwise would have been and the systems and processes to help ensure consistency of approach are less developed" and that there has been a "lack of clear guidance for staff on the way the Scheme operates, including eligibility and reasonable and necessary support."

Family and NDIA concerns

Families have provided feedback that the planning period is too rushed, but conversely, the time to finalise plans and for them to access funding is too long. Families have also reported that intervention plans need to be more flexible for families.

The number of access requests and the number of children expected to enter the scheme has also been higher than was expected.

Unfortunately, but not unexpectedly, there have been difficulties delivering services in regional areas due to limitations in NDIA workforce and funded therapists numbers.

Clinicians' emerging concerns

Clinicians (medical, allied health) have also raised concerns regarding limitations of the NDIS including:

- Caps placed on funding versus the costs and sustainability of the scheme.
- The apparent inconsistency and possible inequality of funding allocation (favours educated, articulate, motivated families).
- The ability of planners to determine who can attend planning meetings (e.g. allied health professionals may be excluded on the basis that they may unduly influence the family's choice of support).
- The type and degree training provided to NDIA planners.
- No ability for paediatric or allied health staff to provide input/recommendations for NDIS plans (however this may be changing).
- The method of referral into the NDIS, determining eligibility and developing plans which is very dependent upon the motivation and knowledge of families.
- The shift to diagnosis-based eligibility and funding.
- The lack of feedback to clinicians re a child's involvement in the NDIS.
- The loss of expertise in providing therapy (for instance, non-government agencies previously only providing services to children with autism spectrum disorder now providing services for all types of disability).

References:

1. Our History [Internet]. Cited 2014 Nov 18. Available from: **http://www.ndis.gov.au/about-us/our-history**
2. Productivity Commission 2011. *Disability Care and Support. Executive Summary.* Report no. 54. Canberra. http://pc.gov.au/__data/assets/pdf_file/0011/111404/disability-support-executive-summary.pdf
3. NDIS Annual Report 2013-14 http://www.ndis.gov.au/document/925
4. Whalan J, Acton P, Harmer J. A review of the capabilities of the National Disability Insurance Agency.2014 http://www.ndis.gov.au/sites/default/files/documents/capability_review_2014_3.pdf

Deepa Jeyaseelan, Murray Webber & Liberty Gallus

Neurodevelopmental and Behavioural Paediatric Society of Australasia

The NBPSA continue to grow, with membership now more than 130. The primary benefit remains as an organisation where members are able to meet and share around their clinical and academic common interests.

RACP and Chapter CCH

NBPSA is committed to maintaining and building partnerships with the RACP. Chris Pearson has a position on our Executive specifically for this liaison role. We recognise the importance of the Chapter particularly with the Child Protection and Public Health areas that are important to many of our membership who work in a Community Paediatric role particularly.

Conferences.

We ran our second annual conference in Brisbane this year, on the theme of 'Bridging the Gap' between Paediatrics and Mental Health.

Our Sydney group, led by Con Papadopolous, are well underway planning our next conference for August 27th to 29th. This will be a joint venture with the Sydney Children's Hospital Network. Please save the dates in your calendar. The program will cater for generalist and specialist audiences.

Professional Resilience Program

A session at the June conference considered the mental health of ourselves. We work in an area that impacts on the mental and physical well-being of paediatricians. From this discussion we have a project underway to build a Professional Resilience Program (PRP). The goal of this is to identify a variety of strategies potentially applicable to paediatricians across a range of circumstances (city, regional, rural, public, private, early, mid or late career).

These strategies are designed to create a structured method of individual support that extends beyond professional education to include consideration of the stresses and resilience strategies of clinical practice. We hope to pilot this program, and present early results at the August conference.

Special Interest Groups

An emerging area of NBPSA activity is to support groups. At the June conference, we ran sessions for Private Practice, Paediatric Trainee, and Early Career Paediatricians. Each of these groups expressed a desire to continue the conversation across the year.

We have also hosted location based groups. A Brisbane group has met on several occasions now, as has groups in Sydney and Melbourne.

Sustainability

Finally, a key consideration for 2015 is the sustainability of the organisation. We are building methodologies around finance, administration, and particularly the activities of the society, intended to support and maintain the well-being of our group into the future.

Michael McDowell

Chapter of Community Child Health Specialist Advisory Committee (SAC)

A MATTER OF TRUST – ENTRUSTABLE PROFESSIONAL ACTIVITIES IN OUR TRAINING PROGRAMS

Supervisors make decisions based on trust every day when working with trainees. We decide if and when trainees are capable of independently performing their various tasks. Entrustable Professional Activities, or EPAs, are a relatively recent innovation in medical education, with the potential to transform our training programs. While the title may sound like educational jargon, it is really quite descriptive – these are the essential work activities that we need to be able to entrust our trainees to carry out.

The use of Entrustable Professional Activities within the College context will be evaluated over 2015–2016 through pilot studies in Basic Training for Physicians and Paediatricians and in Advanced Training in Community Child Health.

The Community Child Health pilot aims to make four key changes to our current educational approach:

1. Focus learning and assessment more keenly on the core activities trainees need to be able to perform independently at the completion of Advanced Training in Community Child Health (through the use of Entrustable Professional Activities)
2. Streamline the workplace-based learning and assessment process
3. Improve the collection of evidence on trainee progression by focusing existing formative assessments on EPAs
4. Improve certification decisions by ensuring that learning goals are more clearly defined at the outset of a training rotation, are reviewed midpoint and are checked at the conclusion of the rotation.

An example of an Entrustable Professional Activity for Community Child Health is:
Assessment in Developmental–Behavioural Paediatrics Performs a comprehensive assessment of a child's development, behaviour, learning and emotional state, taking into account biological, psychological and social environmental factors.

This is an activity that is central to what we do in Community Child Health and captures a number of components of professional practice, such as clinical knowledge, communication skills, cultural competence, ethical behaviour, and quality and safety.

Additional EPAs have been developed across the three Community Child Health subspecialty areas: Developmental–Behavioural Paediatrics, Child Protection, and Child Population Health. A group of EPAs encompassing general Community Child Health Professional Skills has also been developed.

The pilot will run across Australia and New Zealand from December 2014 to August 2015. The input of the supervisors and trainees taking part in this pilot is essential to us in designing the most effective Advanced Training program we can deliver for Community Child Health.

I am really looking forward to the outcome of these pilots. It is an exciting time to be involved in education and training within the College!

Dr Mick O'Keeffe FRACP
Chair, Community Child Health Entrustable Professional Activities Pilot Working Group

Trainee Corner

Chapter Chat December 2014

Welcome! To those of you who have just started advanced training in Community Child Health, this is your first Chapter Chat (representing the Chapter of Community Child Health of the RACP). And congratulations to those who are coming to the end of their training!

There are quite a few things happening in Community Child Health which will affect trainees over the next few years, and if you have particular questions about your training pathway, please contact the CCH Specialist Advisory Committee (SAC).

The SAC has been doing a lot of work to try to streamline and improve the process regarding certification of terms and response to trainees. When looking at prospective jobs, it is important to clarify early whether this position is accredited for CCH training. We acknowledge it can be confusing as positions that may fulfil the 'community' requirements of general paediatrics training may not fulfil CCH training requirements. It is much better to have these discussions early in the job *application* process, confirm that the position is accredited for CCH training and to put in training applications early (so that they can get approved early) than to be disappointed later on! Similarly, to ensure that your project will be approved by the Community Child Health SAC it is best to submit a brief project plan *prior* to starting work on the project, just to make sure the topic is sufficiently relevant to Community Paediatrics.

Another recurring area of confusion relates to undertaking a Master of Public Health. The MPH is a great course that provides wonderful opportunities to explore many areas of population health. It also counts towards the CCH non-clinical core requirement. However, it does not count as a project, unlike in general paediatrics training. If you would like more information about the requirements for CCH please check the CCH website or contact a member of the SAC.

As some of you may know, there are several interest groups within the Chapter of Community Child Health – child protection, child development and behavior, and child population health. This reflects the wide membership of our Chapter, from people working in specialized child protection units, to those focusing on public health, advocacy and research in community child health. If you are interested in joining any of these committees, please contact the Chapter or myself, it is a fantastic opportunity to explore your interests. These are also reflected in the proposed training streams for the future, which will be further explained in an upcoming newsletter from the SAC.

A trial is currently underway in Victoria of recognition of child protection experience and training through the use of in depth case reports, and a pilot will be implemented in 2015. It will involve 15 cases over the 3 years of advanced training, with 5 cases in detail, of which two must represent tertiary level forensic examinations. This is not intended to replace training within tertiary child protection units for those wishing to work in this field but recognizes the difficulty many trainees have faced in obtaining child protection positions so as to fulfil their core CCH training requirements.

Also look out for more information regarding the Chapter satellite day to be held immediately prior to the commencement of the RACP conference in Cairns in May 2015. The theme for the day is refugee health, which is sure to provoke interesting discussions and to be a fascinating day. The overarching themes for the Congress are palliative care, sexual dysmorphia and refugee health, all of which are of interest to our Chapter.

Dr Angela Titmuss and
Dr Talia Maayan

I am pleased to advise that the inaugural CCH SAC newsletter is published. This is available via the SAC webpage under useful links.

Dr Terry Donald

Please note that the views contained in this edition may be those of individuals and do not necessarily represent the Division or the Chapter of Community Child Health.