

Changes to the Well Child / Tamariki Ora Framework

Ministry of Health. *Changes to the Well Child / Tamariki Ora Framework*.
Wellington: Ministry of Health.

Published in August 2010 by the
Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-36614-3 (online)
HP 5167

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



MANATŪ HAUORA

Contents

1	Introduction	1
1.1	Background	1
1.2	Whānau ora	2
2	Review of the Well Child / Tamariki Ora Framework	3
2.1	Overview	3
2.2	Recommendations from the review	3
3	Key Changes to the Framework and National Schedule	13
3.1	Content, timing and flexibility of core and additional contacts	13
3.2	Needs assessment and care planning	13
3.3	Family violence and child protection	13
3.4	Maternal and infant mental health	14
3.5	Child development and behaviour	14
3.6	Growth and nutrition	14
3.7	Oral health	14
3.8	Vision and hearing	14
3.9	Quality improvement and measuring outcomes	15
3.10	Revision of national service specification for Well Child / Tamariki Ora Services	15
3.11	Workforce development	15
	References	16

Summary of key changes in the direction of the Well Child / Tamariki Ora Framework

We are moving towards:

1. a greater focus on social and emotional developmental stages as well as physical developmental stages
2. a greater emphasis on psychosocial factors that have an impact on children and families and whānau, such as parent health and wellbeing, access to resources, family functioning and parenting
3. an increased focus on identification of and response to individual family and whānau needs, in the context of a child's health and wellbeing, focusing on strengths and protective factors as well as risks
4. family and whānau-centred practice – this will involve strengthened relationships between parents, whānau and Well Child / Tamariki Ora practitioners to increase long-term engagement with services and the effectiveness of the programme over both the short and long term, particularly for families and whānau with the greatest needs
5. a more proactive promotion of attachment and the prevention of behavioural problems
6. the introduction of evidence-based assessment tools to support care planning
7. better co-ordination between Well Child / Tamariki Ora practitioners, lead maternity carers, general practice, specialist health services, education and social services in order to achieve the desired goals and outcomes for families and whānau
8. improved use of information gathered antenatally to assist in postnatal care
9. an increased focus on quality improvement and monitoring the quality and outcomes of the Well Child / Tamariki Ora programme.

1 Introduction

1.1 Background

This document sets out the changes that are being made to the 2002 Well Child / Tamariki Ora Framework (the framework) following a major review. It describes the findings of the review and the changes to the framework that will be phased in from 1 July 2010 and implemented over a two- to three-year period. The framework sets out the policy context for the Well Child / Tamariki Ora programme and should be read in conjunction with the revised National Schedule (2010) and the national service specification for Well Child / Tamariki Ora services.

Pregnancy and the first years of life are critical stages in the life cycle. There is good evidence that the outcomes in both childhood and adulthood are strongly influenced by the factors that operate during this period. It is therefore important to consider all of the systems and environments surrounding the child that combine to influence the child's outcomes (Bronfenbrenner 1979; Dahlgren and Whitehead 1991; Minister of Health 2001). At the centre is the child, surrounded by their family or whānau, then the community that supports families and whānau, and finally the societal factors that enable communities to support children and families/whānau.

The Child Health Strategy (Ministry of Health 1998) presented a vision of healthy New Zealand children who are 'seen, heard and getting what they need'. All children need to have the same opportunity to reach their highest attainable standard of health, development and wellbeing. The primary objective of the framework is to ensure that all families and whānau are supported to maximise their child's developmental potential and health status in those early years, in order to establish a strong foundation for ongoing health and development.

The Well Child / Tamariki Ora programme provides a universal health assessment, health promotion and support service for children and families from birth to five years. It also serves as an important gateway to targeted and specialist health, education and social services for children, families and whānau with additional needs. The programme provides an integrated package of care, as set out in the Well Child / Tamariki Ora National Schedule.

The framework has been in place since 2002. Its original aims were to reduce fragmentation and inconsistencies in the delivery of the Well Child / Tamariki Ora programme, to enhance co-ordination between child health services and other early intervention strategies, and to reduce inequalities. The framework has led to improvements in access for many New Zealand children, but further work needs to be done to reduce fragmentation and inconsistencies in programme delivery and to make sure the programme is meeting children's needs.

The Child Health Strategy identified Māori and Pacific children as priority groups that were more likely than the overall child population to experience poor health outcomes and to have specific health needs. Analysis of the 2006/07 New Zealand Health Survey has found that Māori and Pacific children continue to experience poorer health outcomes than other New Zealand children (Ministry of Health 2008a). The causes of unequal health outcomes are complex, and are generally linked to the uneven distribution of the determinants of health, such as income, housing, education and employment. For example, low income or poverty is a key mediator of poor child health outcomes. It often leads to poor-quality accommodation, with consequent overcrowding and susceptibility to infectious diseases. It can also lead to early cessation of breastfeeding, because a mother may be required to return to work soon after the infant is born, and to poor-quality food, leading to nutritional disorders. Poverty also leads to poorer access to health care, whether due to unpaid doctor's bills or difficulty obtaining transport.

Given the multiple interacting factors within the family, community and society that influence child health outcomes, it is important that the Well Child / Tamariki Ora programme is part of integrated service delivery and partnerships with other primary health care services, specialist health services, and education and social services. This is particularly important for vulnerable families and whānau if they are to develop the skills and access the support and resources they need for ongoing healthy family and whānau functioning.

1.2 Whānau ora

A key aim of the health and disability sector is to improve Māori health outcomes and reduce Māori health inequalities. The Well Child / Tamariki Ora programme, with reference to He Korowai Oranga (the Māori Health Strategy) and Whakatātaka Tuarua 2006–2011 (the second Māori Health Action Plan), is expected to contribute to improvements in whānau ora (Māori families supported to achieve their maximum health and wellbeing) and to reduce Māori health inequalities.

Whānau ora is a priority for reducing inequalities between the health outcomes of Māori and other New Zealanders. For organisations involved in planning and providing Well Child / Tamariki Ora services, this means having measures that influence the structure, strategies, systems, management, staff and culture of their organisation to effectively account for the needs and aspirations of Māori.

2 Review of the Well Child / Tamariki Ora Framework

2.1 Overview

In July 2006 the Ministry commenced a review of the 2002 framework (hereafter referred to as ‘the review’) in order to:

- determine the best way to improve child health outcomes and reduce inequalities
- identify/confirm the health outcomes the Government should seek for children from birth to five years of age
- determine what types of activities can assist in meeting these outcomes
- assess the extent to which the clinical content and processes underpinning the framework will achieve these outcomes
- identify opportunities for reprioritising existing funding and priorities for new funding.

The review was framed by the New Zealand Health Strategy, the Primary Health Care Strategy, He Korowai Oranga (the Māori Health Strategy) and the Child Health Strategy.

In July 2007 the Ministry released the *Preferred Options for Changes to the Content of the Well Child / Tamariki Ora Framework* and its accompanying background paper, *Supporting Evidence for Changes to the Content of the Well Child / Tamariki Ora Framework*, to key stakeholders and sought their feedback. An inter-departmental steering group consisting of senior officials from the Ministries of Health, Education and Social Development, along with a broad multi-sector reference group, provided oversight for developing the options. The Ministry also commissioned an extensive review of the evidence. Submissions from a wide range of external health professionals and organisations were received through the consultation process.

2.2 Recommendations from the review

The evidence¹ and stakeholder feedback supported retaining the fundamentals of the existing framework (ie, a universal service, with additional services targeted at families with extra need). Emerging research about neurological development, the impact of stress during pregnancy, parental stress and the importance of attachment reinforces the importance of early intervention and prevention approaches, particularly for vulnerable children and families (Center on the Developing Child at Harvard University 2007).

¹ The Ministry commissioned a review of aspects of recent literature (2000–2006) from the US, UK, Australia, Canada and New Zealand to identify new and emerging health issues for preschool children and the current interventions used to address these issues.

The review identified a number of specific areas where greater emphasis and/or evidence-based best-practice changes are needed within the Well Child / Tamariki Ora programme, including identification of and response to maternal postnatal depression (PND), infant and child mental health and attachment, developmental delay and behavioural problems, child maltreatment, obesity, nutrition and breastfeeding, and oral health and dental care.

The programme presents opportunities to improve child and family/whānau outcomes. An important goal of the programme is to strengthen links and co-ordination with general practice and other primary health care providers, specialist health services, early childhood education, social services and parenting programmes. The evidence supports a stronger emphasis on health, with input from the social development and education sectors up to age three years. After three years of age there will be a stronger focus on the educational and behavioural aspects of a child's development.

2.2.1 Timing and flexibility of core contacts

The review supported a greater focus on core contacts in the first year of a child's life. In response, a new core contact will be introduced at nine weeks, and the previous two core contacts at 21–24 months and three years will be combined into one core contact at two to three years. Most children between three and four years of age will have ongoing development and behavioural surveillance through early childhood education, with health services available on referral.

The eighth and final Well Child core contact is the B4 School Check, which is offered from the child's fourth birthday. The B4 School Check is a health and development assessment for all four-year-olds and has replaced the new entrant check. The purpose of the B4 School Check is to promote health and wellbeing, and to identify and respond to any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school (see <http://www.moh.govt.nz/b4schoolcheck>).

2.2.2 Needs assessment and care planning

The Well Child / Tamariki Ora programme is a universal programme that is offered to all families, with additional contacts for those with specific needs and risks. The evidence and sector feedback indicated that the 2002 framework's risk assessment approach, and the use of the deprivation index and first-time parent status as a proxy for need and the targeting of services, has limitations.

Needs assessment is a complex process, and factors such as PND, breastfeeding difficulties and social isolation cut across deprivation levels, although socioeconomic factors will continue to be an important consideration. The review supported Well Child / Tamariki Ora practitioners having the flexibility to be more responsive to individual family and whānau needs, particularly vulnerable families and whānau.

A review of needs assessment literature undertaken by Plunket New Zealand and the New Zealand College of Midwives (2009) supports a family partnership approach, with a focus on family and whānau strengths and resiliency factors, as well as needs and risk factors. A needs assessment process and tool for preparing child and family/whānau-based care plans is being developed to guide parent and practitioner decisions about additional Well Child / Tamariki Ora contacts, resources and/or referrals to a range of health, social and other community-based services. The Whānau Ora Taskforce's 2010 report, *Whānau Ora: Report of the Taskforce on Whānau Centred Initiatives* (Durie et al 2010), will inform the development of the needs assessment and care-planning process.

The review also supported a greater use of information collected antenatally to support postnatal care. As a result, the needs assessment and care-planning process will begin in pregnancy, with information gathered during pregnancy and the early postnatal period being standardised and shared with the Well Child / Tamariki Ora provider and general practice, subject to parental consent. The information passed on by the lead maternity carer will form the basis for ongoing assessment of a child and their family's or whānau's needs within the programme. It will also form part of a child's ongoing health record.

2.2.3 Family violence, including child abuse and neglect

Many studies have shown that family violence, including child abuse, is not only harmful for the current life of the child but also has detrimental effects on later development. In the case of child abuse, no other social risk factor has a stronger association with developmental psychopathology, and the negative sequelae have been documented across a range of developmental domains, including cognition, language, learning and socio-emotional development.

Although the evidence suggests that screening for child abuse is not useful for predicting child abuse or neglect, it does indicate that well-trained professionals are able to identify vulnerable families and whānau. The review supports an increased focus on the identification of and response to family violence and child abuse and neglect within existing training programmes for Well Child / Tamariki Ora practitioners.

2.2.4 Maternal postnatal depression

Screening to detect postnatal depression (PND) has not been undertaken routinely or universally within the Well Child / Tamariki Ora programme. This practice results in PND not being detected in many instances, and therefore not being treated. Non-treatment of PND may have negative impacts on an infant's cognitive, emotional and behavioural development. PND screening, while promising, does not meet the criteria for a national screening programme. There are, however, opportunities to improve the recognition and management of PND within the programme and through better links with primary care and other support services. The Ministry will be supporting the routine use of the Patient Health Questionnaire (PHQ3) within the programme. It is an easily administered, validated tool to assess the possibility of PND (New Zealand Guidelines Group 2008).

The review supports screening early in the postnatal period to detect women at the beginning of their depressive period. The review also supports screening more than once, as many depressive episodes occur later in the postpartum period, with the highest prevalence recorded between the third and fifth month after childbirth.

2.2.5 Infant and preschool mental health

Infant mental health is a subspecialty of child mental health and applies to the infant from birth to the fourth birthday. The Zero to Three Infant Mental Health Taskforce² developed a definition of infant mental health which focuses on the individual child's social-emotional development within the context of his/her early environment. This definition describes early childhood mental health as:

the young child's capacity to experience, regulate and express emotions, form close, secure relationships; and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes the family, community and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development. [Zero to Three 2001 cited in Zeanah 2009]

Experiences in the first years are critical for establishing the building blocks for ongoing development (National Scientific Council on the Developing Child 2005). The first few months and years of a child's life are important for establishing social, cognitive and emotional patterns of functioning, which influence the child and their future mental health.

Parenting and the family environment are the most significant influences on the infant and preschooler's social and emotional health. There is substantial evidence of the impact of environment on the neurological development of infants, and the impact of poor attachment and negative parenting on a child's physical, cognitive and socio-emotional development. Supporting vulnerable parents and infants is central to infant mental health. In doing so, it is important to have an understanding of both the strengths of each family/whānau and the difficulties that are known to have an impact on an infant's development.

The review identified the need for an increased focus on infant mental health within Well Child / Tamariki Ora practitioner training.

² Zero to Three is a national non-profit organization in the United States that informs, trains and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers. More information can be found at: <http://main.zerotothree.org/>

2.2.6 Child development and behaviour

There is evidence that early identification of developmental delay and subsequent intervention can improve developmental and other social and health outcomes. The link between early developmental delay and later school learning difficulties is well established (Nelson 2000; and Shonkoff and Phillips 2000; cited in Williams and Holmes 2004). Currently, developmental surveillance is undertaken from six weeks onwards as part of the health protection and clinical assessment activities within the National Schedule. However, no formal developmental surveillance tools are used, and the effectiveness of existing surveillance is unknown.

An Australian review of child health screening concluded that although there is insufficient evidence to recommend for or against developmental screening, there is evidence that the earlier the intervention, the better the outcome (National Health and Medical Research Council 2002). In recognition of the fact that a child's development is continual, most tools recommend that screening be undertaken more than once. Developmental delays may occur and be identifiable from birth, or they may develop as the child ages.

Developmental surveillance is an activity that is best shared between the parent and the health professional and uses both parties' knowledge about the child to monitor ongoing development and emotional wellbeing. The Parental Evaluation of Developmental Status (PEDS) is a short questionnaire for parents to use to detect developmental and behavioural problems in children from birth to eight years. It was initially developed in the USA and has since been adopted (with small adaptations) for use in Australia, where it is accepted as a reliable way to elicit information from parents and to undertake developmental surveillance. If PEDS raises concerns about a child's development, then a more formal developmental assessment needs to take place before clinical conclusions can be made.

The review supported the use of PEDS in the Well Child / Tamariki Ora programme. It is already being used in the B4 School Check (the eighth Well Child check), and early indications are that parents find the tool helpful.

Behavioural screening is the first step in the process of identifying children who are at risk for poor educational outcomes. The Strengths and Difficulties Questionnaire (SDQ), although behavioural in focus, contains good principles for considering a child's strengths as well as any areas of difficulty. The SDQ reflects current academic thought about risk and resilience, and the impact these have on a child's development and learning. There are a number of international studies that support the reliability and validity of the SDQ as a tool for identifying child behavioural issues. The SDQ is currently being used in the B4 School Check. This was supported in the review.

2.2.7 Sudden unexpected death in infancy

The Child and Youth Mortality Review Committee notes (CYMRC 2009) that sudden infant death syndrome (SIDS) has been defined as ‘the sudden and unexpected death of an infant, which is unexplained after the review of the clinical history, examination of the circumstances of death, and post-mortem examination’ (Rognum and Willinger 1995). The CYMRC goes on to say that:

controversies associated with the classification of SIDS (eg, deaths in the presence of known risk factors such as cigarette smoke, prematurity, bed sharing or minor infections, where the contribution of the risk factor remains uncertain) have led more recently to the adoption of the term Sudden Unexpected Death in Infancy (SUDI), which encompasses SIDS and these more grey scenarios. [Fleming et al 2006]

In New Zealand, SUDI rates for European babies have declined markedly over the last two decades. However, declines for Māori babies have been much less marked, possibly because of a higher proportion of risk factors other than sleep position among Māori babies (Tipene-Leach et al 2000). During 2003–2007 328 infants (aged 4 to 52 weeks) died as a result of SUDI. Of these, 61.6 percent were Māori infants, 24.4 percent were Other (including European) infants, 12.8 percent were Pacific and 1.2 percent were Asian. Rates for Māori (2.34 per 1000) and Pacific (1.31 per 1000) infants were significantly higher than for Other infants (0.52 per 1000), while rates for Asian infants (0.14 per 1000) were significantly lower.

The CYMRC has made a number of recommendations to further reduce the number of SUDI in New Zealand. They advise that the importance placed on the safe sleeping of infants – by the community as a whole and families and professionals in particular – needs to increase. They also advise that:

New approaches to the dissemination of SUDI messages to families with infants at high risk of SUDI need to be developed, with particular emphasis on meeting the information needs of Māori and Pacific families and those living with significant socio-economic constraints. Lead maternity carers and Well Child / Tamariki Ora providers are ideally placed to disseminate such messages but need to be supported with workforce development and resources.

2.2.8 Safety

Unintentional injuries cause over a third of all child deaths in the one-to four-year-old age group (35.1 percent) (CYMRC 2009:18) and 2589 child hospital admissions annually (averaged over 2004–2008).³ Many more children are treated for injuries at accident and emergency clinics, by their local GP and at home. Around half of these injuries and deaths occur in the child’s home (Gulliver et al 2005).

³ Otago University IPRU. <http://ipru3.otago.ac.nz/niqs/Morbidity.php>. Accessed February 2010.

Causes of unintentional injury are strongly linked to a child's age and developmental stage. When broken down by cause, injury admissions for 'falls' peaked among those aged five years, while accidental poisoning, inanimate mechanical forces (eg, crushing injury), burns from hot substances (hot drinks and foods) and fire were highest for those aged one to two years of age (Craig et al 2007:245).

There is evidence to support injury prevention and control. The most effective way to prevent child injury is to use a variety of strategies and deliver these across many agencies and communities (McClure et al 2004). Injury prevention messages and initiatives can be delivered with and through hapū, iwi, whānau, cohorts, groups and communities. They can be grouped into the broad categories of: legislative measures, safety products and devices, and education and safety counselling.

Well Child / Tamariki Ora practitioners are able to promote safe environments and reduce the incidence of unintentional injuries at each stage of a child's growth and development by delivering age-appropriate messages, providing evaluated resources, and promoting actions that will reduce the risk and incidence of unintentional injury occurring to New Zealand children.

2.2.9 Breastfeeding

Breastfeeding is important for the health of the infant, mother and family/whānau and has both short- and long-term benefits. The evidence indicates that antepartum structured breastfeeding education is effective at improving both initiation and continuation of breastfeeding during the first two months after birth. The review supported an additional visit for breastfeeding mothers at five to six weeks if breastfeeding issues are identified at the first visit. Any additional visits required for breastfeeding support could be resourced from the pool of additional needs-based visits. The World Health Organization-defined ages for monitoring breastfeeding status for population-level surveillance will be retained (ie, six weeks, three months and six months).

The review also recommended that Well Child / Tamariki Ora providers adopt the World Health Organization (WHO) Growth Standards as the default growth monitoring charts for the framework. The WHO Growth Standards establish breastfed infants as the normative model for growth and development. The adoption of the WHO Growth Standards aligns with the recent WHO (and now New Zealand) recommendation that infants be exclusively breastfed to around six months of age. The lower weight gain in late infancy of breastfed infants, as seen in the WHO Growth Standards, may be beneficial to health.

2.2.10 Growth and nutrition

Improving nutrition, increasing physical activity and reducing New Zealand's rates of obesity could make a real difference to improving our health. Obesity is an important risk factor for many chronic, debilitating and life-threatening diseases. Childhood obesity has become a significant problem in New Zealand, and promoting healthy eating, good nutrition and physical activity is crucial to addressing this problem.

As part of a comprehensive strategy to prevent and manage obesity and its associated chronic diseases, population monitoring is required. Use of body mass index (BMI) as a population measure of obesity has begun through the B4 School Check. In addition, BMI is used in the assessment stage of the Ministry's *Guidelines for Weight Management in Children and Young People (2 to 18 years)* (Ministry of Health and Clinical Trials Research 2009), and so further use of it in the Well Child Tamariki Ora programme is being considered.

In addition to increasing obesity, there is evidence that micronutrient deficiency may be an issue for a small number of New Zealand children. Iron and vitamin A and D deficiency have been identified, most commonly among Māori and Pacific children and children from low-income families. Low income or poverty is a key mediator of poor child health outcomes, including poor nutrition. The review recommended that Well Child / Tamariki Ora practitioners should use the Ministry's *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0 to 2): A background paper* (Ministry of Health 2008b) as best practice guidelines for nutrition. These guidelines provide health practitioners with information on, for example, healthy eating to provide an optimal diet, and on breastfeeding. They also recommend adopting the WHO Growth Standards for routine childhood growth monitoring, which have now been incorporated into the *Well Child Health Books*.

2.2.11 Oral health

Promoting oral health is one of the seven action areas identified in *Good Oral Health for All, for Life* (Ministry of Health 2006). Improving and maintaining oral health through prevention and promotion is regarded as one of the most effective ways to achieve oral health over the long term. An increased focus on oral health within the framework has the potential to help improve oral health for all children with poor oral health, of whom Māori and Pacific children and children from low-income families are over-represented (Ministry of Health 2008a).

Oral health assessment by Well Child / Tamariki Ora practitioners provides an opportunity to identify early or more severe dental decay in children. The Lift the Lip check is a quick and easy technique for non-oral health professionals to identify visible decay by looking in the child's mouth. It also provides an opportunity for Well Child / Tamariki Ora practitioners to check that all children are enrolled with community dental services and to remind parents of the importance of taking their child to a dental clinic regularly for a full clinical examination by a dental therapist or dentist. The review recommended the routine use of the Lift the Lip check in all core Well Child contacts from nine months of age onwards.

2.2.12 Hearing screening

Hearing loss is divided into two types: sensorineural and conductive hearing loss. It is estimated that 60 percent of sensorineural hearing loss has a genetic basis, with the remainder of children progressively developing hearing loss due to environmental factors such as prematurity and meningitis. The Universal Newborn Hearing Screening and Early Intervention Programme will identify many of those with a genetic hearing loss in the neonatal period. The remaining children with a non-genetic hearing loss will be identified in early childhood through routine Well Child / Tamariki Ora checks and preschool audiometry screening as part of the B4 School Check.

The most common cause of conductive hearing loss is otitis media with effusion (OME), which is a chronic inflammation and fluid collection of the middle ear. Current research and professional opinion indicate that for most children OME is not associated with significant learning problems, delays in speech acquisition or behavioural difficulties, and therefore universal screening for OME is not well supported by the evidence. However, children with existing difficulties or risk factors for these conditions should still undergo OME screening. The review therefore supported phasing out routine tympanometry screening at three years and replacing it with targeted screening for those identified as being at high risk of harm from OME (Ministry of Health 2009).

2.2.13 Vision screening

The purpose of vision screening of infants and preschool children is to:

- detect preventable and treatable conditions that may lead to amblyopia
- detect significant refractive errors.

There is adequate evidence that screening for visual defects reduces the incidence of amblyopia. The available evidence suggests that screening in preschool years is the most effective, and that treatment before the age of five years leads to the best outcomes.

Current evidence supports the continuation of screening for amblyopia using distance visual acuity in four-year-olds, and this has been retained as part of the B4 School Check. Infants will also continue to be checked for congenital cataracts by either the lead maternity carer or GP by six weeks of age.

Other than the above screens, identification of vision or hearing problems should rely on parental concern and professional awareness. Parents will continue to be asked if they have any concerns about their child's vision or hearing at core Well Child / Tamariki Ora contacts using the 'Can your child hear/see?' questionnaires.

2.2.14 Quality improvement and monitoring outcomes

The review highlighted the difficulties involved in measuring the effectiveness of Well Child / Tamariki Ora services, and assessing improvement in child health outcomes and in reducing inequalities. The review also identified that an efficient means of collecting and reporting information is required in order to measure the effectiveness of the Well Child / Tamariki Ora programme.

There are many examples of high-quality Well Child / Tamariki Ora services being delivered across the country. However, given the range of people and organisations involved in delivering the programme across the country, it is important to outline what good practice should look like rather than making assumptions.

2.2.15 Workforce development

The review also highlighted the need to build capacity in the sector by ensuring all Well Child / Tamariki Ora practitioners have access to ongoing professional development, to maintain clinical competency and to enhance their knowledge and skills. This is necessary if they are to meet the increasing demand for advanced competence in a specialised service.

3 Key Changes to the Framework and National Schedule

3.1 Content, timing and flexibility of core and additional contacts

The framework retains eight core universal contacts from four weeks to five years, and a pool of additional visits. However, the content, timing and flexibility of core and additional Well Child / Tamariki Ora contacts have been refocused to better address emerging issues for children and their families and whānau, particularly those that have a significant impact across the life cycle (eg, infant/parent bonding, maternal mental health, oral health, obesity, and family violence).

A new core contact has been included at nine weeks, and the two existing core contacts at 21–24 months and three years will be combined into one core contact at two to three years. The transition from lead maternity carer to Well Child / Tamariki Ora practitioner could occur at a stage earlier than four weeks after birth if it is in the best interests of the family and whānau.

3.2 Needs assessment and care planning

Additional Well Child / Tamariki Ora contacts will now be allocated on the basis of need. The Ministry will be working with a preferred provider and the sector to develop a needs assessment and care-planning process and tool to assist parents and practitioners. The new needs assessment and care-planning process and tool will be used to guide parent and practitioner decisions about additional Well Child / Tamariki Ora contacts, and resources and/or referrals to a range of health, social and other community-based services.

The process will begin in pregnancy, with information gathered during pregnancy and the early postnatal period being standardised and shared with the Well Child / Tamariki Ora provider and general practice, subject to parental consent. The information passed on by the lead maternity carer will form the basis for ongoing assessment of a child and their family's or whānau's needs within the Well Child / Tamariki Ora programme. It will also form part of a child's ongoing health record.

The process, including training and implementation, will be piloted and evaluated in selected sites over the 12 months to 30 May 2011 before it is rolled out nationally. The Ministry will work with the sector to ensure the training complements or enhances rather than duplicates existing training in this area.

3.3 Family violence and child protection

There will be an increased focus on the identification and management of family violence and child abuse and neglect within the Well Child / Tamariki Ora programme, based on the Ministry of Health's *Family Violence Intervention Guidelines: Child and partner abuse*. This will also be a component of the needs assessment and care-planning process and training.

3.4 Maternal and infant mental health

The Patient Health Questionnaire (PHQ3) will be routinely used within the Well Child / Tamariki Ora programme. It is an easily administered, validated tool to assess the possibility of PND. The Ministry supports an increased evidence-based focus on infant mental or social and emotional health within the programme.

Needs assessment and care-planning training (referred to above) will include a component on maternal and infant mental health, and will be an opportunity for Well Child / Tamariki Ora practitioners to increase their knowledge and skills in these areas.

3.5 Child development and behaviour

The Parental Evaluation of Developmental Status (PEDS) questionnaire, which is a well-validated, evidence-based questionnaire for identifying child development issues, will be introduced as a tool to assist Well Child / Tamariki Ora practitioners in assessing child development, from the three-month core contact through to the B4 School Check. The SDQ is administered at age four as a component of the B4 School Check.

3.6 Growth and nutrition

Breastfeeding will be assessed at the first core contact, and additional visits may be allocated where breastfeeding issues are identified. The WHO Growth Standards (2007) have been adopted for children from birth to five years.

3.7 Oral health

An oral health screen (Lift the Lip), risk assessment and completion of enrolment for dental services at the 9–12-month core contact will be introduced, along with Lift the Lip assessments at subsequent core contacts.

3.8 Vision and hearing

The tympanometry check for OME at three years of age has been phased out of the National Schedule (with at-risk children continuing to be checked in line with current vision and hearing screening protocols) and replaced with screening audiometry as part of the B4 School Check. Early childhood hearing and vision screening protocols have been updated to reflect recent evidence on the most appropriate use of resources to identify these issues (see the *National Vision and Hearing Protocols*, updated by the Ministry of Health in February 2010).

Routine preschool vision and hearing screening is now provided at age four as a component of the B4 School Check, replacing the school-entry screening programme.

3.9 Quality improvement and measuring outcomes

An evidence-based quality framework for the Well Child / Tamariki Ora programme will be developed over 2010/11 to ensure the programme consistently achieves good outcomes for all children and their families and whānau, especially those with greater need. The framework will be developed in consultation with the sector.

There are a number of common elements for quality improvement systems in health care, including the need for a set of clear standards for care and a set of indicators that help to measure whether the standards are being met. These elements will be addressed in the framework.

3.10 Revision of national service specification for Well Child / Tamariki Ora Services

The national service specification for Well Child / Tamariki Ora services will be revised over 2010/11 and it is expected that a new national service specification will come into effect from July 2011. There is strong support from stakeholders to revise the national service specification to provide greater clarity and promote national consistency in the delivery and reporting of Well Child / Tamariki Ora services and outcomes. The development of the new service specification will follow the Ministry of Health *Guidelines for Developing, Reviewing and Maintaining Service Specifications*.

3.11 Workforce development

The Ministry will work with the sector to ensure that the Well Child / Tamariki Ora workforce has the competencies needed to deliver the Well Child / Tamariki Ora programme and is supported with appropriate training. The quality framework will address issues of professional competency and leadership within the programme.

References

- Bronfenbrenner U. 1979. *The Ecology of Human Development: Experiments by nature and design*. Cambridge MA: Harvard University Press.
- Center on the Developing Child at Harvard University. 2007. *A Science-Based Framework for Early Childhood Policy: Using evidence to improve outcomes in learning, behaviour and health for vulnerable children*. Cambridge MA: Harvard University Press
- Craig E, Jackson C, Han DY, et al. 2007. *Monitoring the Health of New Zealand Children and Young People: Indicator handbook*. Auckland: Paediatric Society of New Zealand, Child and Youth Epidemiology Service.
- CYMRC (Child and Youth Mortality Review Committee). 2009. *Fifth Report to the Minister of Health*. Wellington: Ministry of Health.
- Dahlgren G, Whitehead M. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Futures Studies.
- Durie M, Cooper R, Grennell D, et al. 2010. *Whanau Ora: Report of the Taskforce on Whanau-Centred Initiatives to: Hon Tariana Turia, Minister for the Community and Voluntary Sector*. Wellington.
- Fleming P, Tsgot B, Blair P. 2006. Modifiable risk factors, sleep environment, developmental physiology and common polymorphisms: understanding and preventing sudden infant deaths. *Early Human Development* 82: 761–6.
- Gulliver P, Dow N, Simpson J, et al. 2005. The epidemiology of home injuries to children under five years in New Zealand. *Australian and New Zealand Journal of Public Health* 29: 29–34.
- McClure R, Stevenson M, McEvoy S (eds). 2004. *The Scientific Basis of Injury Prevention and Control*. Melbourne: IP Communications.
- Minister of Health. 2001. *The Primary Health Care Strategy*. New Zealand.
- Minister of Health and Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- Minister of Health and Associate Minister of Health. 2006. *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011*. Wellington: Ministry of Health.
- Ministry of Health. 1998. *Child Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2002a. *Family Violence Intervention Guidelines*. Wellington: Ministry of Health.
- Ministry of Health. 2006. *Good Oral Health for All, for Life*. Wellington: Ministry of Health.
- Ministry of Health. 2008a. *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2008b. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0 to 2): A background paper*. Wellington: Ministry of Health.
- Ministry of Health. 2010. *National Vision and Hearing Screening Protocols*. Wellington: Ministry of Health.

Ministry of Health and Clinical Trials Research. 2009. *Clinical Guidelines for Weight Management in New Zealand Children and Young People*. Wellington: Ministry of Health.

NHMRC (National Health and Medical Research Council). 2002. *Child Health Screening and Surveillance: A critical review of the evidence*. Melbourne: National Health and Medical Research Council.

National Scientific Council on the Developing Child. 2005. *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3*. Retrieved from www.developingchild.harvard.edu.

New Zealand Guidelines Group. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care: Evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group.

Rognum T, Willinger M. 1995. The story of the 'Stavanger Definition'. In T Tognum (ed) *Sudden Infant Death Syndrome: New trends in the nineties*. Oslo: Scandinavian University Press.

Tipene-Leach D, Abel S, Finau SA, et al. 2000. Māori infant care practices: implications for health messages, infant care services and SIDS prevention in Māori communities. *Pacific Health Dialog* 7(1): 29–37. Auckland: University of Auckland.

Williams J, Holmes C. 2004. Children of the 21st century: slipping through the net. *Contemporary Nurse* 18(1–2): 57–66. Australia: John Libbey & Company Pty Ltd.

Rules and Guidelines for Developing, Reviewing and Maintaining Service Specifications. Retrieved from

[http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/312/\\$File/RUles+and+Guidelines+for+Developing+SS+April+2010.doc](http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/312/$File/RUles+and+Guidelines+for+Developing+SS+April+2010.doc). Wellington: Ministry of Health.

Zeanah, C, Zeanah P. 2009. The scope of infant mental health. In: C Zeanah (ed) *Handbook of Infant Mental Health* (3rd edition). New York: Guilford Press.