THE EARLY
YEARS

A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP ON A FIT AND HEALTHY CHILDHOOD

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This report was prepared by a Working Group of the All-Party Group and we are proud to acknowledge the contributions of:

Helen Clark:	Chair of the Working Group
Beverley Kotey:	APG Secretariat
Phil Royal:	APG Secretariat
Linda Baston-Pitt:	Cambridge Childhood Partnership
Neil Coleman:	OPAL
Helen Crichton:	Danone Nutricia
Dr Emma Derbyshire:	Nutritional Insight
Tim Finnigan:	Quorn Foods
Sheila Forster:	Fitmedia Fitness
Claire Graham:	South Tyneside Lifestyle Choices
Sue Greenfield:	University of Roehampton
Dr Glenys Jones:	Association for Nutrition
Yvonne Kelly:	International Centre for Lifecourse Studies, UCL
Ida Kolodziejczyk:	Mytime Active
Dr. Eunice Lumsden:	University of Northampton
Rhiannon Marzocca:	Danone Nutricia
Sharon Smith:	University of Northampton

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THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this report is a sub-group of the All-Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the **APPG** is to develop practical policies to reduce the scale of childhood obesity and promote health and fitness by engaging with a wide variety of interests and experts in the sector and encouraging them to act together to find solutions. Group details are recorded on the Parliamentary website at: **http://www.publications.parliament.uk/pa/cm/cmallparty/register/fit-and-healthy-childhood.htm**

The Officers of the APPG are:

Chair	Baroness (Floella) Benjamin of Beckenham OBE
Vice-Chairs	Lord McColl of Dulwich, Pauline Latham MP, Jim Fitzpatrick MP, Nic Dakin MP, Ian Austin MP, Diana Johnson MP
Hon Treasurer	Caroline Nokes MP
Hon Secretary	Julie Elliott MP

The Working Group is Chaired by Helen Clark, a member of the APPG Secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the front page.

The Report is divided into themed subject chapters with recommendations and an overall conclusion that we hope will influence political thinking in the lead up to and beyond the 2015 General Election.

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EXECUTIVE SUMMARY

'The foundations of virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens in these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing.' *(Marmot Report: 2010)*

Policy concentration on the early years is of vital importance for the wellbeing of children now and for their future health outcomes and life chances. Evidence-based research points to the need for a focus that is properly holistic and to precipitate intervention to promote a healthy diet, regular patterns of activity and rest and give children the best start in life.

In 2005, The United Nations Committee on the Rights of the Child *(General Comment No. 7)* acknowledged the need for a fresh strategy, pinpointing research findings indicating that a failure to prioritise early years' welfare exposes children to the ills of **'malnutrition, disease, poverty, neglect, social exclusion and a range of other adversities.'**

Professor Dame Sally Davies, Chief Medical Officer of the United Kingdom, considers that robust early years' policies make both social and economic sense:

'Too many children and young people do not have the start in life they need, leading to high costs for society, and too many affected lives' *(Forward to 'The 1001 Critical Days', June 16th 2014).*

This observation is significant because there remains much to do. In 2012, the NSPCC reviewed the United Kingdom policy scenario for babies and very young children and concluded that identifiable advances in maternity and early years' provision did not detract from the fact that: '**babies are still particularly vulnerable'** and **'their rights are not always recognised or realised'.** *('All Babies Count – But what about their rights?' Sally Knock and Lorriann Robinson, January 2012).*

Knock and Robinson highlight glaring gaps of support and provision – especially in maternity services whereby the fostering of a strong parent-child bond is invariably sacrificed to a concentration upon purely medical practicalities such as labour, birth and the immunisation programme.

The All Party Group on a Fit and Healthy Childhood aims, in this report, to offer the incoming Government recommendations for an early years' strategy that are credible, feasible and evidence-based and will enable the United Kingdom to set the standard in a crucial policy field both at home and abroad.

In defining 'early childhood', we follow the example of The United Nations (2005) Convention on the Right of the Child by examining the period of 0-8 including, as it does, the vital transition phase from pre-school to primary school. We consider the antenatal period and maternal physical and mental health, methods of feeding the newborn, parental support services both hospital and home-based and infant nutrition and socioeconomic factors that may impact upon the health and wellbeing of young children.

The report examines the optimum balance between sleep, rest and activity, the need for freely-chosen play, safeguarding measures and the importance of respecting cultural diversity in all early years' settings. Above all, we analyse the relationship between young families and the professionals whose role it is to ensure that babies have the very best start in life, supported by parents who have confidence in the choices that they make and the advice that they are given.

Just as new families require mentoring so that they can act in the best interests of their children, so the early years' workforce needs training and continuous professional development to ensure that the advice given is of the highest possible quality and specifically tailored to the individual family.

Early Years' students from The University of Northampton (interviewed) explain what a positive difference their newly acquired knowledge has made to their performance in the settings and Government recognition of The Early Years as a developmental stage in its own right and the creation of the new posts of Early Years Teacher and Early Years Educator have been positive.

Yet as the Ilkeston 'Mums Group' (interviewed) makes clear, there is still no guarantee of uniform excellence in the delivery of services nationwide and no assurance of continuity between, for example, advice on feeding from the midwife and the health visitor, or the emphasis put on freely-chosen play in an early years' setting and a primary school. If young children are to thrive, we believe it is essential that there is a national consensus and political will behind multi-disciplinary working in the early years.

We see the early years as a window of opportunity and make no apology for the fact that each section of this report is accompanied by many policy recommendations. It has not been possible to produce a uniform handful of 'asks', just as the early years itself is a rich, complex and multifarious developmental phase. However, neither do we consider it to be feasible to achieve everything that we recommend in the lifespan of a single Government. This is a two, even three term journey.

However, if the nation's families and the early years workforce are to embark upon it, the Government must be prepared to provide the resources; the Cabinet Minister for Children and Families, the commitment to multi-disciplinary co-operation to achieve an early years workforce that is truly 'joined up' and, above all, the finance to make well–intentioned aspiration a reality.

In an age of austerity, by spending early, the later savings to education, health, social or criminal justice services will be immense. Investing in the children of today is not a gamble – it is sound economic sense.

Helen Clark: February 2015

SUMMARY OF RECOMMENDATIONS

There are many recommendations flowing from this Report. This is a reflection of the massive amount of work required to address this issue and its dangerous consequences.

Whatever the result of the 2015 General Election, one thing is certain: the next Government will be faced with a significant challenge in developing integrated and refreshed Early Years service to help families give their children a good start in life, to the economic and social benefit of the entire community.

The recommendations also appear at the end of each relevant section.

Antenatal Care, Maternal Nutrition and Mental Health

1. Health education for young people and women of child-bearing age (school, Children's Centres and health centre-based) including sex and relationships education, awareness of factors affecting maternal health and pregnancy outcomes and understanding of how to access antenatal services
2. A programme of national training in health targeting and risk management during pregnancy for all healthcare and early years' workers with continuous professional development
3. Requirement for maternity to be included in all Local Authority partnership mental health and wellbeing strategies and partnership substance misuse strategy action plans
4. Expansion of the number of midwives combined with a national guarantee that every woman will have the support of a midwife she knows and trusts through pregnancy to postnatal care
5. Children's Centres to be used as antenatal care hubs with a holistic, multi-professional approach
6. Enhance role of midwife in antenatal period
7. Mental health support to be embedded through every aspect of pregnancy and childbirth
8. Extension of multi-faceted, evidence-based programmes such as the Family Nurse Partnership, prioritising access of 'at risk' groups by improving timeliness of referral and links to other groups
9. A national Government communication strategy to inform women and their families about how to access antenatal care, working with Local Authorities and the voluntary sector on the best ways of reaching vulnerable groups

Infant Nutrition: Promoting, Supporting and Facilitating Breastfeeding, Bonding and Attachment

1. Improved national training for midwives and maternity support workers in breastfeeding and bottle feeding; clarification of the Baby Friendly Initiative standards
2. Equal support at hospital and subsequent service provision for women regardless of their chosen method of feeding
3. Increased resources for recruitment and retention of midwives and breastfeeding mentors in hospital and in the community
4. Evaluation of breastfeeding initiatives and the dissemination of good practice via the Infant Feeding Survey or similar method of capture
5. Establishment of early parenting programmes for parents (to include fathers) at Children's Centres
6. Amendment to the Equality Act (2010) thus requiring an employer to allow paid breaks for breastfeeding mothers and to provide facilities for them to feed/store milk. All employers to provide a formal written policy on breastfeeding
7. Parents/main carers with attachment difficulties to receive a programme of services designed to improve parenting skills and promote secure attachment
8. Education and training of early years workforce in supporting women with breast and bottle feeding
9. Promote the education and training of the early years workforce in supporting infant feeding

Early Years' Nutrition following Weaning

1. Department of Health/Public Health England to refresh Start4life and Change4life strategies; developing clear messages on healthy eating and lifestyle for the toddler age group
2. Revision of The Healthy Child Programme so that advice on weaning and dental health is included before the '6 months - 1 year' section
3. All staff working in the early years to receive appropriate training in oral health
4. Revision of The Healthy Child Programme to include strategies to ensure that health visitors are equipped with the knowledge and skill to advise parents on early life nutrition; identifying this as a key competency for professional development
5. The Health Visitor Implementation plan *(2011-2015)* to be subject to impact evaluation upon conclusion, and forthcoming plans to include initiatives to promote the importance of ongoing professional development and updating the skills/knowledge base of the existing health visiting workforce
6. Composition of statutory specific guidelines for food and drink in the early years to be subject to annual review
7. A National Anti-Obesity Strategy to be established, beginning in infancy, with interventions designed to support parents in improving/changing eating behaviours and diets
8. NICE to examine the cost-effectiveness of universal approaches to address micronutrient deficiencies in children (e.g. Vitamin D supplementation)
9. The Department of Health to work with all stakeholders, including baby and toddler brands and retailers that parents trust, to build consensus around guidelines on the earliest age at which parents can safely introduce solid food into their babies' diets and offer clear, consistent and practical advice for universal application

10. Health and Wellbeing Boards to be given a statutory duty to commission local services to provide timely and consistent advice for parents on the introduction of solid foods and toddler feeding
11. Government to embed early childhood nutrition indicators into the key developmental checks and frameworks that are used to measure child poverty and health inequalities
12. Data testing with regard to brand claims such as 'anti-colic' or anti-reflux' formula to be publicised

Childhood Obesity, Early Years' Nutrition and Health Devolution in the United Kingdom

1. A Cabinet Minister for Children in UK government with a specific early years' remit of co-ordinating devolved government and cross-departmental strategies, thereby creating alignment, evaluation and the sharing of best practice so that young children will be healthier, happier and fitter with reduced incidence of obesity and overweight
2. A Ministerial taskforce to lead a National Framework on early years' nutrition and lifestyle
3. Standardised UK Guidance for all 'front line' healthcare and early years professionals
4. Standardised healthcare professional training (annually reviewed) to enable the uniform delivery of nutritional, play and activity advice for the families and carers of pre-school children, combined with a co-ordinated early intervention strategy
5. Nutritional and lifestyle alignment of practitioner programmes: Child Health Programme and Healthy Child Programme henceforth to be the responsibility of, and evaluated by, national professional Royal Colleges and CPD accredited

The Role of Play

1. Level 3 Early Years Educator and graduate Early Years Teacher (0-5 years) posts to incorporate play work as a part of foundation training

- Revision of the 'National Play Strategy' *(2008)* with a two decade roll-out and proposals for the delivery of play in schools and public spaces

2. Statutory performance measures of children's play using EU indices of child health and wellbeing
3. A standard for the amount of time for play during the early years setting and school day to be established and incorporated into the school inspection process; the current 20% of each school week allocated to playtime is always at threat of erosion
4. Revision of planning process to foster child-friendly communities by including land-use guidelines that are compatible with the needs of children

5. Government to provide core funding for a research programme to identify the ways in which the interpretation of Health and Safety issues is currently frustrating children's opportunities to play freely
6. Promotion of the use of natural materials in playground design
7. Quality standards for play to be included in national minimum standards for all childcare settings

The Educational and Training Needs of Health and Education Professionals

1. A Professional Body for the Early Years' profession with responsibility for registering professionals, developing, monitoring and accrediting ongoing professional development and promoting good practice
2. The Professional Body to structure and embed a Code of Ethical Practices for the Early Years' profession and ensure that employment conditions are commensurate with the professional role
3. Embed physical/nutritional training and development into apprenticeship framework and Early Years Educator qualifications
4. National/Local Government to encourage (via an awareness campaign) early years' settings to gain an 'excellence' award in nutrition *(www.childrensfoodtrust.org.uk/award)*
5. A joined up holistic approach to training in nutrition in which comprehensive use is made by National/Local Government of the Association for Nutrition's workforce competence model in the provision and commissioning of nutrition services
6. Government to develop a tool to simplify the new allergen legislation (in particular targeting Registered Childminders)
7. A standardised universal Early Years Nutrition advice leaflet/accompanying video, to include balance of food groups, portion sizes and how to cope with mealtime eating challenges
8. Commission the Healthy Child Programme in full
9. Implement and evaluate the two–two and a half year old integrated review
10. Promotion of the Graduate–led Early Years work force
11. Recruitment processes for early years' practitioners to assess emotional intelligence as well as knowledge base (recommended by the Wave Trust)
12. Develop clear, consistent and regular models of effective supervision for all professionals working within early years' settings – with CPD that is accredited, ongoing and easily accessible.
13. Embed instruction in play, exercise and sport into professional training courses for all those who work within the Early Years sector
14. Train and educate the early years workforce to deliver the High Impact Areas for early years *(DH, 2014)*

Socioeconomic Inequalities

1. Implement the Marmot Review's strategies for reducing health inequalities, especially those linked to 'Policy Objective A: Give every child the best start in life' (2010)
2. Implement the Allen Report (2011)
3. Increase investment in Health Visitor training so that it is possible to see all mothers antenatally and keep contact with the families
4. Support Children's Centres and increase their numbers so that all families can access them
5. Extend The Healthy Child Programme
6. Encourage all mothers to breastfeed by providing comfortable and accessible feeding places in workplaces, outside-home settings and promotion via TV advertisements as in Europe
7. Support families to develop children's skills
8. Provide quality education and childcare so that early years workers' can properly support parents
9. Design more play areas; revise planning process to facilitate freely-chosen, natural play opportunities and 'all weather' outdoor play at all early years' settings

The use of Legislation, Regulation and Guidance

1. Current legislation stating that food supplied in schools must meet set standards to be extended to all nurseries, Children's Centres and early years' settings
2. Legislation to ensure that the professional training requirement of all early years' workers (including childminders, nursery professionals and primary school teachers) includes adequate knowledge of nutrition
3. Brands required to publish data to support labelling claims such as 'anti colic milk', 'anti-reflux milk' etc.
4. Revised advice in an accessible format to be given to all new parents about early years' nutrition which will include advice on play
5. Government to research and publish outcome - data on child obesity from countries currently legislating to control food and drink content, as a means of informing its own decisions on the use of legislation in consultation with a widely-based interest 'coalition' including health and education professionals, media and advertising concerns and the food and drink industry
6. A national play strategy from early years upwards with the provision of outdoor all-weather play in all early years' settings
7. Increased resources for Local Authority initiatives to promote health and welfare in the early years

Access to Advice and Assistance

1. All who have professional responsibility for pregnant women and new parents to be trained in how to offer advice in a respectful and non-judgemental manner Department of Health to revise and update the 'pregnancy booklet'. All women to be issued with a hard copy at the first hospital antenatal appointment
2. Department of Health to produce a booklet on child nutrition for 0-5 years of age to be given in hard copy to the parents in their home by the health visitor
3. All women to be assigned to a local midwife team for care in the community as soon as the pregnancy is confirmed with the opportunity for women to change/amend decisions about birth choices that they have made at the antenatal booking appointment
4. Midwife/health visitors to make all interventions 'family centred' whether at hospital or in the home
5. All health visitors to provide advice to families on nutrition and play at regular intervals during the pre-school period
6. Government to provide funding to increase the number of midwives and ensure that each new family has access to regular home visits from a health visitor

Cultural Imperatives and Diversity

1. Promotion of community peer programmes, bringing together parents from different cultures to support new families with early feeding practices
2. Better communication of guidelines and promotion of the benefits of being active from an early age across all cultural groups
3. Dissemination of basic principles of a good and varied diet for toddlers aged 1-3 across all cultures, via multi-lingual literature including recipe examples and practical instruction
4. Health visitor training to include cultural diversity aspects in advice on nutritionally-balanced diet for young children
5. Increased provision of free, quality early years' provision for disabled children
6. Extend free quality childcare places for two year olds to children aged 1-2
7. National audit of all early years' settings for production and practice of equality policies
8. All Early Years Teachers, Educators and registered childminders to receive specialist training in working with children who have learning difficulties
9. National and local initiatives to audit take-up of childcare/early years provision in high-density cultural and ethnic diversity areas
10. Initiatives to improve the gender make-up of the early year's workforce, including nationally-driven recruitment campaign and increasing professional pay-scales

The Impact upon the Life Course of the Early Years

1. Single Government Department for Children and Family Life, headed by a Cabinet Minister for Children with a remit to drive and co-ordinate inter-departmental initiatives
2. Increased multi professional training with annual update and revision
3. Integrated (rather than segregated) service provision for children and families
4. Integration of early years' policies on public health, social care and education at national and local level
5. Increased financial investment in the early years, prioritising early identification and support
6. Political recognition and commitment to a prevention agenda across the life course that supersedes political and sector–based ideology and places empirical research and the needs of children and families at the heart of policy

The Role of Sleep

1. New national guidance on the importance of sleep to include good sleep hygiene and regular, consistent bedtimes
2. Safe infant sleeping to be discussed with women/partners/main carers at each postnatal professional contact
3. Guidance for parents on screen-based usage; avoidance of TVs/mobile devices in a child's bedroom
4. Child sleep patterns to form part of professional concern and help from Health Visitors/Early Years Teachers

ANTENATAL CARE, MATERNAL NUTRITION AND MENTAL HEALTH, ESTABLISHING FAMILY PROCEDURES

'Pregnancy and childbirth are normal human conditions but can present risks for the health and wellbeing of the pregnant woman, foetus and newborn child. The health of the woman during pregnancy can also have a lifelong impact on the health and wellbeing of her child.' *(Tower Hamlets Joint Strategic Needs Assessment, 2011-2012).*

This statement finds an echo in the Government Chief Medical Officer's Foreword to 'Our Children deserve Better: Prevention Pays' (2012).

Professor Dame Sally Davies recommends early interventions, education, health checks and immunisation and recognises a connection between psychosocial events and biological factors.

Pregnancy is an especially important period during which the physical and mental wellbeing of the mother can impact upon the lifelong health of the child and the benefits of a holistic approach will stretch beyond the boundaries of individual family units.

Such strategies are not only desirable – but necessary: '**The challenge for us as a society is how to harness this evidence and momentum and turn it into improved outcomes for our current and future generations of children and young people. This is not just a moral responsibility but also an economic imperative. For failure to invest in health leads to poorer educational attainment and affects the nation's future productivity.'** *(Professor Dame Sally Davies: 'Our Children Deserve Better: Prevention Pays', 2012).*

However, the 'health in pregnancy' agenda is complex and whilst there is general agreement about aims; delivery nationwide is inconsistent. What is available is of a patchwork variety – as in the case of antenatal mental health care.

It is now accepted that perinatal mental health problems are closely linked with adverse outcomes for women and their babies and clinical guidelines in England, Scotland, USA, Australia and Canada recommend that women at risk of mental health problems in pregnancy should be identified at an early stage and offered support that is properly tailored to individual need.

In December 2014, NICE updated its 2007 Guidance on the clinical management of antenatal and postnatal mental health with the aim of assisting professionals in the identification of mental health problems in mothers and pregnant women who might then be encouraged to understand and access the services currently available for them. In addition the guideline is designed to offer support to women with a history of mental health problems who are considering starting a pregnancy. Information is also given about the safety status of treatment drugs. The recommendations are accompanied by illustrative case histories and supportive comments from professionals:

'Having a baby is a time of huge change and any woman can find herself needing help. This updated guideline is about spotting what is not normal for each woman and making sure she gets the right treatment.' *(Professor Stephen Pilling, Professor of Clinical Psychology and Clinical Effectiveness, UCL; facilitator of the group that developed the guideline, Dec 18th 2014).*

The updated Guidance has been well-received, but research published by The National Childbirth Trust *(4th July 2014)* suggests that communities are unlikely to derive immediate benefit from it.

Following Freedom of Information requests to 196 Clinical Commissioning Groups, the NCT found that only 3% of the respondents (186) had a perinatal mental health strategy.

The causes of social disadvantage are multifarious and include levels of poverty and deprivation, homelessness and overcrowding, domestic violence, people who are asylum seekers, refugees or migrants (who may encounter difficulties with literacy and speaking the English language) and women who are pregnant in their teens.

Behavioural ills such as drug and alcohol abuse, smoking and poor patterns of nutrition also endanger the pregnant woman and her baby and a multi-faceted strategy addressing a number of risk factors embedded in the social context is more likely to succeed than offering a series of separate and disconnected interventions.
Such a template can be found in the Nurse-Partnership Programme, pioneered in the USA (known as the Family Nurse-Partnership in England) and demonstrating the effectiveness of promoting healthy choices during pregnancy on future child development. Evaluations suggest that the programme has holistic benefits to child health, maternal health and return to employment and wider societal gains including decreasing offender behaviour.

Enhanced recognition of the importance of midwives in sustaining a healthy pregnancy should similarly be accompanied by both an increase in their number and the provision of dedicated training in the recognition and management of societal and behaviour risk for allied professionals such as early years workers. Children's Centres would be appropriate hubs in which to roll out a national programme of properly holistic antenatal care that would be free of stigma and therefore capable of use by 'hard to reach' women.

It is essential that all healthcare professionals with responsibility for overseeing the pregnancy care pathway receive nationally accredited training in health messaging that is both consistent and clear. Certain risk factors during pregnancy (e.g. obesity, starvation, smoking and alcohol consumption) can change particular genes during development, resulting in long term adverse effects on child and adult health. Such 'foetal programming' can be transmitted to subsequent generations.

An antenatal service that includes forward planning for pregnancy should prioritise the importance of individualised advice for women to achieve a healthy body weight prior to conception and guidance on what represents a 'safe' weight gain during the course of the pregnancy. At present, there is no guarantee that the advice and support available to women during pregnancy is uniform and we recommend that Government set and disseminate ambitious national targets for health promotion in pregnancy together with a system of compulsory external audit for service providers. Pregnancy is a time when women are often more motivated to make healthy choices and engage with services and this opportunity must not be lost. Tam Fry, of The National Obesity Forum, suggests that interventions should really begin with women who are considering starting a pregnancy.

Some other key findings were:

- 117 CCGs (60%) have no plans to develop a specific strategy for perinatal mental health
- 34 CCGs (18%) said that they were developing or planning to develop a strategy
- 16 CCGs reported having no GPs with any specialist training
- 50 trusts (28%) provide a perinatal mental health service; 26 of these employed only one specialist perinatal mental health midwife or doctor and frequently the roles were part-time
- 5 trusts (3%) offer some sort of minimum provision

It is therefore unsurprising that the NCT's response to the NICE updated Guideline sounds a note of caution:

'NCT welcomes these guidelines but we question how they will be put into practice given the huge gaps in perinatal mental health services, exposed by our recent research. The Government and NHS need to take immediate action to broaden service provision and ensure that it is consistent.'
(Elizabeth Duff, Senior Policy Advisor, NCT, 17th December 2014).

Other recent research *('Antenatal mental health referrals: Review of local clinical practice and pregnant women's experiences in England. Midwifery, Darwin et al, 2014)* is corroborative, concluding that mental health assessment is frequently introduced without adequate financial resources to provide a consistent response to women whose needs have been identified. Failure to follow through with professional assistance and support could serve to heighten women's existing psychological distress.

Similarly, a welcome for Government plans to make specialist mental health midwifery staff available to every maternity service by 2017 is qualified by a reminder that preparatory work needs to be done to facilitate communication between specialist and non-specialist midwives so that women experiencing mental health difficulties are offered support that is both clear and consistent.

Tackling social disadvantage in the early stages of a pregnancy can effect major improvements in child health outcomes. Sally Davies advocates **'proportionate universalism' – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged groups'** *('Our Children Deserve Better: Prevention Pays', 2012).*

More information should also be disseminated about the risks of continuing unhealthy behaviour patterns such as smoking; associated with increased risk of miscarriage, stillbirth, neonatal death and sudden infant death syndrome (SIDS) as well as the more widely known adverse outcomes of impaired foetal growth, low birth weight and pre-term birth. There is a need for clear guidance, well publicised by trusted community-based professionals such as midwives and health visitors to dispel myths. Low birth weight will not enable the mother to have an 'easier' labour – it is however, according to The Wave Trust, associated with poorer long-term health and educational outcomes for the child.

There has been some consideration of using 'incentives' to encourage pregnant women to stop smoking, such as issuing free shopping vouchers. A trial in Glasgow (2014) reported some success *(British Medical Journal, 28th January 2015)* but this has been modest and not ultimately persuasive.

It seems that there is little viable alternative to education, advice and guidance, delivered by trusted community –based professionals in a consistent but non-judgemental manner.

National targets, however, would provide a welcome framework for the achievement of optimum outcomes in pregnancy and should include:

- Promotion of breastfeeding; initiation and sustaining
- Promotion of smoking cessation
- Improved maternal nutrition with advice on a nutrient-dense diet, i.e. supplementation of 400 micrograms of folic acid per day to reduce birth defects such as spina bifida
- Interventions for reducing alcohol consumption in pregnant women; heavy consumption causes the birth defect Foetal Alcohol Syndrome, and may also damage the foetal brain without affecting other organs or tissues
- Strategies to combat use of illegal drugs; apart from foetal harm, the resultant complex social factors and chaotic life circumstances also pose risks to a pregnancy
- Interventions to reduce excessive gestational weight gain, including referral to evidence-based weight management services. Apart from increased risks to maternal health (such as gestational diabetes), obesity is also associated with large-sized babies. Children of obese mothers run an increased risk of later obesity themselves, as shown by findings from the National Child Measurement Programme
- Interventions to enhance mental health and reduce psychosocial stress. Maternal stress in pregnancy can influence pregnancy outcomes, child development and encourage later risk of disease
- Interventions to identify and reduce the occurrence of domestic violence
- More research and guidance on the effects of vitamin D supplementation in pregnancy, the role of iodine and the adverse effects of maternal under-nutrition in pregnancy

A healthy pregnancy is an essential precursor of child and adult health and wellbeing, and services in all parts of the country, must be accessible and of an equal and excellent quality and quantity. Pregnant women should be able to have confidence in services that are holistic and yet tailored to individual circumstance; secure in the knowledge also that the transition to early years' provision will be smooth, co-ordinated and well managed.

All healthcare and early years' workers must be required to undertake national training in health targeting and risk management during pregnancy with an annual professional requirement to review and update their skills.

What must be paramount is determination on behalf of Government to champion this policy agenda by committing sufficient financial resources to support the mothers and babies of today and therefore the productive society of tomorrow. This will perforce, necessitate a revision of priorities and a change of perspective:

'We need to stop thinking of spend on healthcare for children and young people and instead think of investing in the health of children and young people as a route to improving the economic health of the nation….As a society, we need to ask ourselves how we want to spend our resources to deliver the most for our nation's future.'
(Professor Dame Sally Davies 'Our Children Deserve Better: Prevention Pays', 2012).

Recommendations

1. Health education for young people and women of child-bearing age (school, Children's Centres and health centre-based) including sex and relationships education, awareness of factors affecting maternal health and pregnancy outcomes and understanding of how to access antenatal services
2. A programme of national training in health targeting and risk management during pregnancy for all healthcare and early years' workers with continuous professional development
3. Requirement for maternity to be included in all Local Authority partnership mental health and wellbeing strategies and partnership substance misuse strategy action plans
4. Expansion of the number of midwives combined with a national guarantee that every woman will have the support of a midwife she knows and trusts through pregnancy to postnatal care
5. Children's Centres to be used as antenatal care hubs with a holistic, multi-professional approach
6. Enhance role of midwife in antenatal period
7. Mental health support to be embedded through every aspect of pregnancy and childbirth
8. Extension of multi-faceted, evidence-based programmes such as the Family Nurse Partnership, prioritising access of 'at risk' groups by improving timeliness of referral and links to other groups
9. A national Government communication strategy to inform women and their families about how to access antenatal care, working with Local Authorities and the voluntary sector on the best ways of reaching vulnerable groups

INFANT NUTRITION: PROMOTING, SUPPORTING AND FACILITATING BREASTFEEDING, BONDING AND ATTACHMENT WITHIN AND OUTSIDE THE HOME ENVIRONMENT

The first months of a baby's life are a window of opportunity. The establishment of attachment – and feeding patterns that strengthen this bond, reap inestimable benefit throughout the life course, but this is not the experience of many women and their babies today.

The importance of a safe childbirth cannot be underestimated, but the responsibility of society to a new life does not begin and end in a delivery suite.

All too often, new mothers and the professionals who help them flounder because crucial training, contact time and personnel are inadequately resourced. Facilitating mother/baby bonding, feeding and attachment from the moment of birth is not optional but essential. In the interests of a healthy society, it should not be short-changed.

The World Health Organisation *(WHO long term effects of breastfeeding, a systematic review: 2013)* states that exclusive breastfeeding is the optimal infant food for the first six months of a baby's life, providing protection against a range of diseases across the life course. Breastfed babies contract fewer infections whether lower respiratory tract, gastrointestinal or otitis media; they also have a reduced risk of obesity which is a known trigger for diabetes and a consequent financial burden upon the NHS *(Oddy 2012, Fisk, Crozier, Inskip et al 2005, Kramer, Chalmers, Hodnett et al 2001).*

Pre-term infants who are not breastfed or who do not receive breast milk run an increased risk of developing necrotising enterocolitis *(Henderson, Craig, Brocklehurst et al. 2009).*

Research suggests that breastfeeding enhances a child's cognitive skills *(Kramer, Aboud, Mironoova, 2008)* and that mothers who have breastfed are less likely to develop breast cancer *(do Carmo Franca-Bothelho, Ferreira, Franca et al., 2012,Ip, Chung, Raman et al.,2007)* and ovarian cancer *(Jordan, Cushing-Haugen and Wicklund, 2012).*

These facts have been acknowledged by successive governments. A common target has been to lessen health inequalities by encouraging women from all socio-economic groups to breastfeed. However, the 2019 Infant Feeding Survey *(DH, 2012a)* makes disappointing reading. Of the 81% of mothers who initiated breastfeeding; within one week, 69% had continued. At the six months milestone, the number was 34%. A Royal College of Midwives (RCM) report *('Infant Feeding: supporting parental choice', May 2014)* asserts that the decline is trigged by a lack of resources rather than individual inclination.

'Our research shows that there is a lack of investment in resources such as time, appropriate personnel and training of health and support professionals to provide consistent advice and encouragement to support women to initiate and sustain breastfeeding up to and beyond six months.'

In Scotland, by contrast:

'investment in infant health and breastfeeding is reaping rewards in terms of an upwards trend in breastfeeding duration rates' (*Infant feeding: Supporting Patient Choice, Pressure points, May 2014).*

The Government of Northern Ireland has also championed breastfeeding with the launch of 'Breastfeeding- A great start: A Strategy for Northern Ireland 2013 -2023, *(http://www.dhsspsni.gov.uk/breastfeeding-strategy-2013.htm)*

The Strategy contains 20 strategic actions underpinning four comprehensive outcomes:

- Supportive environment for breastfeeding throughout Northern Ireland
- Equip Health and Social Care with the requisite knowledge, leadership and skills to 'protect, promote and normalize' breastfeeding
- High quality information systems in place that underpin development
- Outcome 4: An informed and supportive public

It includes an action for the introduction of legislation to strengthen support for breastfeeding and the detail of any future legislation will be subject to public consultation at a later date. The new policies have been warmly welcomed by NICE.

The NICE Quality Statement on Breastfeeding *(July 2013)* advocates breastfeeding support for women by means of an 'evaluated and structured' programme.

The response from some new mothers contacted by the RCM and listed in their 'Infant Feeding' report (as above) suggest that this cannot be guaranteed, instancing a lack of confidence because of isolation (**'I didn't know who to contact once out of the hospital'**) feelings of incompetence (**'We had skin-to-skin after the birth which was great but that didn't mean I knew how to latch her'**) or failure (**'I was only able to breastfeed for a month, which I regret'**).

Midwives, trainee midwives and maternity support workers highlight the detrimental effect of inadequate resourcing, stating that short-term economies could have the effect of escalating costs at a later stage:

'This failure to provide proper infant feeding support to all mothers early on in the postnatal period is not cost-effective as it can lead to more visits and higher costs later on' *(Maternity Support Worker, 'Infant Feeding: supporting parental choice', RCM, May 2014).*

Mothers want extra feeding support in hospital to be matched by complementary services that are readily accessible at home. Midwives for their part, express **'frustrat(ion) that I'm not always able to deliver the standard of care that women require and deserve.'** As long as financial resources to support breastfeeding are primarily channelled into advertising campaigns promoting 'targets', a significant increase in the number of women who succeed in sustaining breastfeeding will be unlikely.

Women who breastfeed need support beyond the aegis of the NHS and good practice should be determined by legislation rather than interpretive whim. The Equality Act *(2010)* states that it is **'unlawful for a business to discriminate against a woman because she is breastfeeding a child'**, yet in 2014, Lou Burns was told to cover herself up with a large napkin whilst breastfeeding her baby in a restaurant at the five star Claridge's hotel.

Mrs Burns describes the experience as humiliating for her and disruptive for her daughter:

'A more senior manager….did not 'back down', even though there had been no complaints from other diners. Mrs Burns attempted to use the napkin but her daughter was distressed by being covered by it. Finally, the management said that she could continue if there were no complaints from anyone else.' Mrs Burns said: **'I felt so awkward. They said they were very sorry and wanted to see me back there, but I was so appalled by my treatment. I was not there with my boobs out. I was so discreet one of the waiters did not even realise I was breastfeeding'** *(www.telegraph.co.uk/women/womens-health/11267989/Mother-forced-to-cover).*

All too often, facilities for breastfeeding in commercial outlets are unappealing, (frequently situated in, or adjacent to, the public toilets) making the feeding experience uncomfortable for mother and baby.

Whilst ACAS Guidance 'Accommodating breastfeeding employees in the workplace.' *(January 2014)* states that enabling employees to continue breastfeeding at work can encourage loyalty and benefit the employer because skilled employees will be enabled to return to work earlier, there are limits to 'equality':

'The law doesn't require an employer to grant paid breaks from a job in order to breastfeed or to express milk for storage and later use. Neither does it require an employer to provide facilities to breastfeed or express milk.'

It is understandable therefore if women conclude that breastfeeding may be theoretically 'best', but for those who live and work in the real world it is easier to abandon the struggle.

Whilst breastfeeding requires properly resourced support, healthcare professionals should be equally well-equipped to advise parents about formula feeding. They need to have knowledge and skill on the safe preparation and storage of formula and (without bias or the promotion of any brands) the different formulas available. The RCM report (listed above and from which quotations are taken immediately below) states that almost a quarter of student midwives surveyed mentioned a lack of practical experience in supporting women with bottle feeding and 33% felt the same about their ability to support women with mixed feeding (breast and bottle).

'I have only had one academic session on bottle feeding and the details of formula feeding are generally not extensively discussed in hospital because of the Baby Friendly Initiative.'
(3rd year student midwife).

The UNICEF Baby Friendly Initiative states that women should be able to choose the way in which they feed their babies, but in practice, student midwives reported that using a bottle for sole or part feeding prompted a lack of professional interest:

'I have yet to see a midwife discuss bottle feeding, they just distribute a leaflet.' *(3rd year student midwife).*

Respective public health bodies across the UK have placed a strong emphasis on publishing extensive online feeding guidance about breastfeeding, bottle-feeding and weaning. In all regions, the content is balanced in its emphasis on the type of feeding method. However, the information is arranged and presented in an unconsolidated and inaccessible manner, making it difficult to pursue independent research about how to feed a baby. The personal support of health professionals is thus crucial in 'de-coding' complex written information and helping parents make informed choices.

Modern formulas are developed to high nutritional standards and must comply with European regulations. Many scientifically validated formulas are available in the UK but parents will want to discuss them with maternity support workers and a significant number of midwives and health visitors are inadequately trained in bottle feeding. Some have been forced to make recommendations based on information picked up in a supermarket or the lay advice of friends, due, perhaps to an erroneous belief in the healthcare professional community that The Baby Friendly Initiative only 'permits' communication with mothers about breastfeeding.

A widespread recognition that 'breast is best' should not be accompanied by a lack of interest in a bottle-feeding mother, leading her to experience feelings of guilt and failure *(Lee and Furedi, 2005; Hoddinott, Craig, Britten et al, 2011).* Parents should feel confident that they have received full information, time, training and support about bottle feeding. It remains by far the most common form of feeding with only 24% of mothers in England (22% in Scotland, 17% in Wales, 13% in Northern Ireland) exclusively breast feeding their babies at 6 weeks, dropping to a mere I% by 6 months.

A recent survey (unpublished) conducted for the British Specialist Nutrition Association by Synergy Healthcare Research has estimated that each year approximately 531,000 British mothers might not be receiving sufficient information about their baby's nutrition.

What is needed is for midwives and healthcare professionals to receive full training and resource-allocated support time so that they can inform new parents about all available products, thus enabling them to make choices based upon the particular needs of the baby. Manufacturers have a right to market their products – but the choice of formula should not be reliant upon advertising campaigns alone.

As important as establishing confidence in feeding is the development of a strong bond between parents and the new baby. It cannot be assumed that this will be automatic, or that new parents will not need help. Professor Gillian Leng, Deputy Chief Executive and Director of Health and Social Care at NICE said:

'The period immediately following the birth of a new baby is an exciting, life-changing time, both for the mother, her partner and their family. However, such great changes can sometimes feel overwhelming for the mother, so it is important that there are standards in place that outline clear, sensible ways to support and care for women during this hugely significant time in their lives.' *(UNICEF UK)*

Assessing the emotional wellbeing of women, including their emotional attachment to their baby should therefore be included in each postnatal contact with the health visitor and parents or main carers who are experiencing infant attachment difficulties should receive services designed to improve their relationship with their baby. Services would have the aim of promoting emotional attachment and improving parenting skills.

A report by The Sutton Trust *(Baby Bonds; Parenting, attachment and a secure base for children; Moullin, Waldfogel and Washbrook, March 2014)* states that:

'It is the quality of this attachment that supports the child's social and emotional development which in turn relates to both their cognitive development and ultimately their life chances.'

The report shows that as many as 40% of children lack secure bonds, advocating increased support for good parenting and attachment programmes with evidence –based interventions for those identified as higher risk.

Children whose emotional needs are unmet by their parents are more likely to have behaviour problems, poor educational outcomes, be less resilient to **'poverty, family instability and parental stress and depression.'** They may leave school without progressing to further education, training and employment and are more likely to incur extensive costs from health, education, social and criminal justice services throughout the life course.

Increasing resources to support parenting, attachment from birth and secure and safe feeding patterns, would represent a long-term financial saving for Government.

It would also contribute to a society that is properly productive.

Recommendations

1. Improved national training for midwives and maternity support workers in breastfeeding and bottle feeding; clarification of the Baby Friendly Initiative standards
2. Equal support at hospital and subsequent service provision for women regardless of their chosen method of feeding
3. Increased resources for recruitment and retention of midwives and breastfeeding mentors in hospital and in the community
4. Evaluation of breastfeeding initiatives and the dissemination of good practice via the Infant Feeding Survey or similar method of capture
5. Establishment of early parenting programmes for parents (to include fathers) at Children's Centres
6. Amendment to the Equality Act (2010) thus requiring an employer to allow paid breaks for breastfeeding mothers and to provide facilities for them to feed/store milk. All employers to provide a formal written policy on breastfeeding.
7. Parents/main carers with attachment difficulties to receive a programme of services designed to improve parenting skills and promote secure attachment
8. Education and training of early years workforce in supporting women with breast and bottle feeding
9. Promote the education and training of the early years workforce in supporting infant feeding

EARLY YEARS' NUTRITION FOLLOWING WEANING: EXISTING POLICY, RESEARCH AND POTENTIAL FOR DEVELOPMENT

'The first 1000 days of life i.e. the period from conception to the second birthday is regarded as a critical window of opportunity to save a life and a child's future, namely by providing the right density of nutrients.' (*Solomon NW & Vossenaar M 'Nutrient density in complementary feeding of infants and toddlers', 2013).*

To thrive, infants and toddlers need a varied, balanced diet. Nutrition in the early years impacts lifelong eating habits and subsequently, long term health. Early years' nutrition is therefore a matter of public health.

Some independent reviews commissioned by the UK Government, (notably by Frank Field MP, Graham Allen MP and Dame Clare Ticknall) highlight the early years as a critical developmental phase but whilst the importance of good nutrition is accepted, the unique role that parents and families play in feeding young children merits reconsideration.

According to the State of the Nation Report (2014), parenting has a more profound effect upon a child's life chances in the early years than education, wealth or class and parents, guardians and carers are central in providing foods and exposing children to their own perceptions. By the time children reach school age, most of their food preferences have already been developed *(European Food Information Council, 2012, 'Parental influence on children's food preferences and energy intake: http://www.eufic.org/article/en/artid/Parental-influence-children-food-preferences-and-energy-intake.)*

Unfortunately, in England, over a fifth of children enter primary school presenting as overweight or obese.

Guidance on weaning and diet for toddlers can be perplexing for parents. Government advice is to breastfeed exclusively for the first six months and the Department of Health's official guideline states that babies should not be introduced to solid food until they are around six months in age. This is echoed by Start4Life *(2011),* the Healthy Child Programme *(2009)* and Healthy Start *(2014).* However, the National Infant feeding Survey *(2010)* suggests that 30% of parents introduced solids before 4 months and 75% did so before the baby was 5 months old.

A survey conducted for Demos by the Bounty World of Mum *('For Starters', 2012)* found that 54% of those surveyed considered the information they had received about weaning to be confusing because instructions on many food products sold commercially appeared to contradict Government advice and recommendations from healthcare professionals. Labels stating **'from four months plus.'** appeared to fly in the face of **'around six months.'**

Many parents who responded to the survey said that they would welcome more support and advice from healthcare professionals at this stage.

Studies have shown that the timing of solid food introduction in infants may be associated with childhood obesity. Project Viva, a prospective pre-birth cohort study considered the association between the timing of the introduction of solid foods during infancy and obesity at 3 years of age and concluded that amongst breastfed infants, the timing of solid food introduction was not associated with obesity. However, amongst formula-fed infants, the introduction of solid foods before 4 months was linked with a 6-fold increase in obesity at age 3 years and the association was not explained by rapid early growth *(Huh et al, 2011 'Timing of Solid Food Introduction and the risk of Obesity in Preschool-Aged Children', Pediatrics, Feb 2011, doi: 10.1542/peds.2010-0740).*

There is also justifiable concern about the sugar content of baby foods:

'So many of the jars contain sweetened food – i.e. porridges, apple, banana and cherry-flavoured rice cakes. I think I had to go to about three stores before I could find plain ones! We are giving children a sweet tooth right from weaning which really does not hold them in good stead for the future.' *(Dr Emma Derbyshire: Nutritional Insight)*

Nutrition in the early years lays the foundations of lifelong healthy eating. A major challenge that parents experience is what constitutes a 'healthy' diet for toddlers and babies? How do widely disseminated messages such as 'five a day' translate to young children?

The Infant and Toddler Forum *('Toddler Feeding Time' https://www.infantandtoddlerforum.org/toddlers-to-preschool/little-peoples-plates/feeding-time/)* identifies four key themes: lack of nutritional know-how about the requirements of a toddler diet, poor feeding choices made by parents of under 3s, irregular feeding patterns and the lack of consistent information on feeding the under 3s.

Findings include:

- Almost three times as many Mums obtain nutritional advice for children from the media, books and internet than via healthcare professionals or health education messages
- Mealtimes are a regular battleground for almost a third of Mums with 31% routinely feeling 'angry, tense, anxious, frustrated or upset'
- 29% of the under 3s eat takeaway meals at least once a week
- Only 35% claim to cook most meals for their toddler 'from scratch' with fresh ingredients
- 23% of toddlers eat with their family just once a month or never

Many parents do not understand the principles of good toddler nutrition. After weaning, toddlers should continue to drink milk or consume other dairy products two or three times per day *(Allen RE&Myers AL, 2006 'Nutrition in Toddlers'. Am Fam Physician 74(9):1527-32).*

A nutritious diet should contain foods rich in iron, including lean red meat or iron-fortified foods to prevent iron deficiency *(Domellof M et al, 2014 'Iron requirements of infants and toddlers' J Pediatr Gastroenterol Nutr 58(1): 119-29)* and meat-free foods such as Quorn (a healthier alternative to processed meats) are attractive as valuable sources of fibre and protein. The Department of Health recommends that Quorn can be introduced when an infant has reached the age of 9 months and is eating a range of foods.

Optimal nutritional intake (alongside the promotion of healthy diet and activity patterns) is key to building resilience and protecting against the later onset of chronic diseases.

An iron deficiency in the early years may prefigure a range of later health problems including impaired psychomotor and/or mental development and social/emotional development. The impact on children's physical development of Vitamin D deficiency can be severe, exposing a child to the risk of rickets, hypocalcaemia convulsions and motor delay. There are additional negative implications for calcium absorption and therefore bone health in adult life. As many as 40% of young children have levels of Vitamin D below the optimal threshold, despite the implementation of a targeted supplement strategy (e.g. Healthy Start Vitamins). This makes a strong case for the adoption of a universal approach.

Zinc also tends to be lacking in an early years' diet and inadequate levels of omega-3 fatty acids such as DHA (docosahexaenoic acid, commonly found in oily fish) can impact adversely on visual and brain development. *(Kuratko CN et al, 2013 'The relationship of docosahexaenoic acid with learning and behaviour in healthy children : a review' Nutrients 5(7):2777-810).*

Recent NICE Oral Health Guidance *(2014)* emphasises the importance of oral and dental health in the early years, advising that oral health promotion should be written into the contract specification for all early years' services, including early years' workers and midwifery and health visiting teams. Dental decay is preventative and cost effective and parents need advice about this before their baby is weaned. Again, it is imperative that support provided is readily accessible whether at a 'community hub of expertise' (such as a Children's Centre) or in the home via a visiting healthcare professional.

In conclusion, whether reconsidering existing/previous policy or developing new initiatives, Government should be at all times mindful of the fact that the responsibility for what children eat (and therefore how they grow and develop) does not rest with just one person. Playgroup, preschool and nursery staff; members of the extended family and childminders all share in the care and feeding of toddlers. It is essential that everyone realises that wherever young children are fed, those involved can effect positive improvement in their diets and lifestyle. In order to embrace the responsibility, they must have clear and practical guidance about what foods to offer and what behaviours to instil. There is a need also for local co-ordination and 'bringing together' of reputable sources of assistance so that parents can make a choice according to their circumstances. In 2010, The Children's Food Trust set up a Panel to consider the case for improved guidance on food and nutrition for children aged 1-5 years attending early years settings in England As a consequence, The Trust's 'Eat Better, Start Better' programme was developed, with the aim of supporting healthier food provision in early years settings and in families with young children, and also to increase the food, nutrition and healthy cooking knowledge, skills and confidence of early years and health practitioners and parents.

Nutrition advice is also supplied via the NHS 'Birth to Five' booklet *(http://www.resourcesorg.co.uk/assetspdfs/BirthToFive09.pdf)* formerly distributed by health visitors and midwives – but now it appears that some Local Authorities are only supplying it online. Help in weaning, creating a healthy and balanced diet and nutritious cooking on a budget is also available at Children's Centres (200 in the UK) but the future of these is uncertain. More support can be obtained via health visitor clinics (usually held weekly within the community) and online networks such as **www.mumsnet.com**, but there is no substitute for practical advice given to parents via regular home visits from the health visitor. The most important factor in early years' feeding is the confidence of the parent/carer in their ability to cater for the young child's nutritional needs.

Recommendations

1. Department of Health/Public Health England to refresh Start4life and Change4life strategies; developing clear messages on healthy eating and lifestyle for the toddler age group
2. Revision of The Healthy Child Programme so that advice on weaning and dental health is included before the '6 months - 1 year' section
3. All staff working in the early years to receive appropriate training in oral health
4. Revision of The Healthy Child Programme to include strategies to ensure that health visitors are equipped with the knowledge and skill to advise parents on early life nutrition; identifying this as a key competency for professional development
5. The Health Visitor Implementation plan *(2011-2015)* to be subject to impact evaluation upon conclusion and forthcoming plans to include initiatives to promote the importance of ongoing professional development and updating the skills/knowledge base of the existing health visiting workforce
6. Composition of statutory specific guidelines for food and drink in the early years to be subject to annual review
7. A National Anti-Obesity Strategy to be established, beginning in infancy with interventions designed to support parents in improving/changing eating behaviours and diets
8. NICE to examine the cost-effectiveness of universal approaches to address micronutrient deficiencies in children (e.g. Vitamin D supplementation)
9. The Department of Health to work with all stakeholders, including baby and toddler brands and retailers that parents trust to build consensus around guidelines on the earliest age at which parents can safely introduce solid food into their babies' diets and offer clear, consistent and practical advice for universal application
10. Health and Wellbeing Boards to be given a statutory duty to commission local services to provide timely and consistent advice for parents on the introduction of solid foods and toddler feeding
11. Government to embed early childhood nutrition indicators into the key developmental checks and frameworks that are used to measure child poverty and health inequalities
12. Data testing with regard to brand claims such as 'anti-colic' or anti-reflux' formula to be publicised

CHILDHOOD OBESITY, EARLY YEARS' NUTRITION AND HEALTH DEVOLUTION IN THE UNITED KINGDOM

England, Scotland, Wales and Northern Ireland have devised individualised versions of a cross-departmental national obesity strategy and there is growing consensus that children who are obese or overweight will remain so in later life.

In England, this strategy is 'Healthy Weight, Healthy Lives' *(2008)*. The approach of The Scottish Executive is given in 'The Scottish Diet Action Plan,' and a nutrition policy for Wales is set out in 'Food and Well Being' *(2004)* issued by the Welsh Government. Northern Ireland has launched a 10 year strategy over the life course, 'The Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2011: A Fitter Future for All'.

The plans are specifically designed to address matters of health and fitness during the lifespan, but none offer comprehensive nutritional advice for feeding children of pre-school age. There is a dearth of information about creating balanced menus, sensible portion sizes, or ways of addressing mealtime family tension triggers such as food refusal and 'faddy' eating. Some advice can be sourced in policy documents beyond the three national obesity strategies, in particular in the work of the Children's Food Trust, available at: **www.childrensfoodtrust.org.uk/eatbetterstartbetter** but the overall scenario, (specifically in the case of England) is extremely limited.

Obesity costs the NHS direct around £6.4 billion a year and the indirect price tag to the wider UK economy comes in at a further £4.1 - £6.4 billion. If this trend continues, the annual charge to the economy at the close of 2015 is projected at £27 billion per annum.

'Healthy Weight, Healthy Lives' is designed as a cross-departmental strategy but despite a further Government target to reduce the proportion of overweight and obese children to 2000 levels by 2020, childhood obesity is only mentioned nine times throughout. A subsequent document, 'Healthy Lives, Brighter Futures' *(Department for Education, 2009)* goes some way to rectifying the balance. It focuses on obesity in pregnancy, the value of breastfeeding and the needs of school-aged children but is ultimately incomplete as an obesity strategy for children and young people, because the toddler stage scarcely merits a mention.

The Welsh Government is increasingly attuned to the fact that the quality of child and infant nutrition has the potential to affect health outcomes in the future adult population.

The most recent version of the Welsh Health Survey *(www.wales.gov.uk/statisticsandresearch)* acknowledges that current nutritional behaviours of children and young people in Wales leave much to be desired:

'The majority of children and young people in Wales do not eat guideline amounts of fruit and vegetables daily; with only just over 30% of those aged 11-16 consuming a portion of fruit and vegetables each day, the percentage in Wales being lower than England, Ireland and Scotland.' *(Child profile – key messages chapter 4, 12th March 2014).*

The Survey identifies that 26% per cent of children in Wales can be classified as overweight and 11.3% as obese and presents a bleak scenario for children in the immediate pre-school age group:

'Within Wales, nearly 3 in 10 children aged 4-5 are classified as overweight or obese, with higher rates of obesity found in the more deprived fifths. The prevalence of overweight or obesity in Wales is higher amongst those in reception year than England and any English region. More than a quarter of girls and just fewer than 30% of boys aged between 4 and 5 are overweight or obese.'

On a positive note, since the initial establishment of an Assembly in 1999, the Welsh Government has made a wealth of commitments and published a range of guidance relating to nutrition, including specific advice for the early years. In 2007, this developmental stage was designated as a policy priority. Wales, like Scotland, has been more proactive in the formulation of early years' policy than the UK Government, and has provided clear and comprehensive information for nursery workers. However, its Government has not as yet devised strategies to help the parents and carers of children who have already been classified as overweight or obese.

Scotland has one of the highest obesity levels amongst OECD countries; second only to the United States, with 64.3% of the population categorised as overweight or obese and 27% clinically obese. Data released by the Scottish Government *(3.12.2014)* states that 29% of children aged 2-15 are at risk of being overweight with 16% facing the prospect of obesity. One in eight children (13% of boys and 10% of girls) spent more than four hours on an average day in 2013 sitting watching a television or other screen.

To help address the problem, Scotland has devised a 'Scottish Diet Action Plan' and a national physical activity strategy. However, in common with the English Government's 'Healthy Weight, Healthy Lives' document, the policy papers in support of these strategies fail to provide significant guidance on improving infant and toddler nutrition.

In 2008, the Scottish Government made significant progress in this area by becoming the first nation in the UK to appoint an Infant Nutrition Co-ordinator. The post is currently held by Ruth Campbell *('Community food and health initiatives have long recognised Early Years as a key priority in local communities')* whose remit is to lead the development and implementation of an infant nutrition strategy for Scotland and provide advice and support to Ministers, NHS Health Boards and all people and agencies involved in infant nutrition. Within the brief, references to supporting infants are substantiated by key nutrition performance indicators, drawing from the wider commitment in the National Performance Framework *(2011)* to give children the best possible start in life.

A parallel and complementary way forward is the National Parenting Strategy, bolstered by a child health approach entitled 'Getting it right for every child'. The programme cuts across a range of directorates in the Scottish Government and enables strategic goals to be followed through. This vision of health and welfare is demonstrably 'child-centred' and bodes well for the formulation of applicable early years' policy, through the report of the 'Equally Well: Ministerial Task Force on Health Inequalities' *(2012)* which has previously included some focus on the role that infant nutrition plays in adult health outcomes.

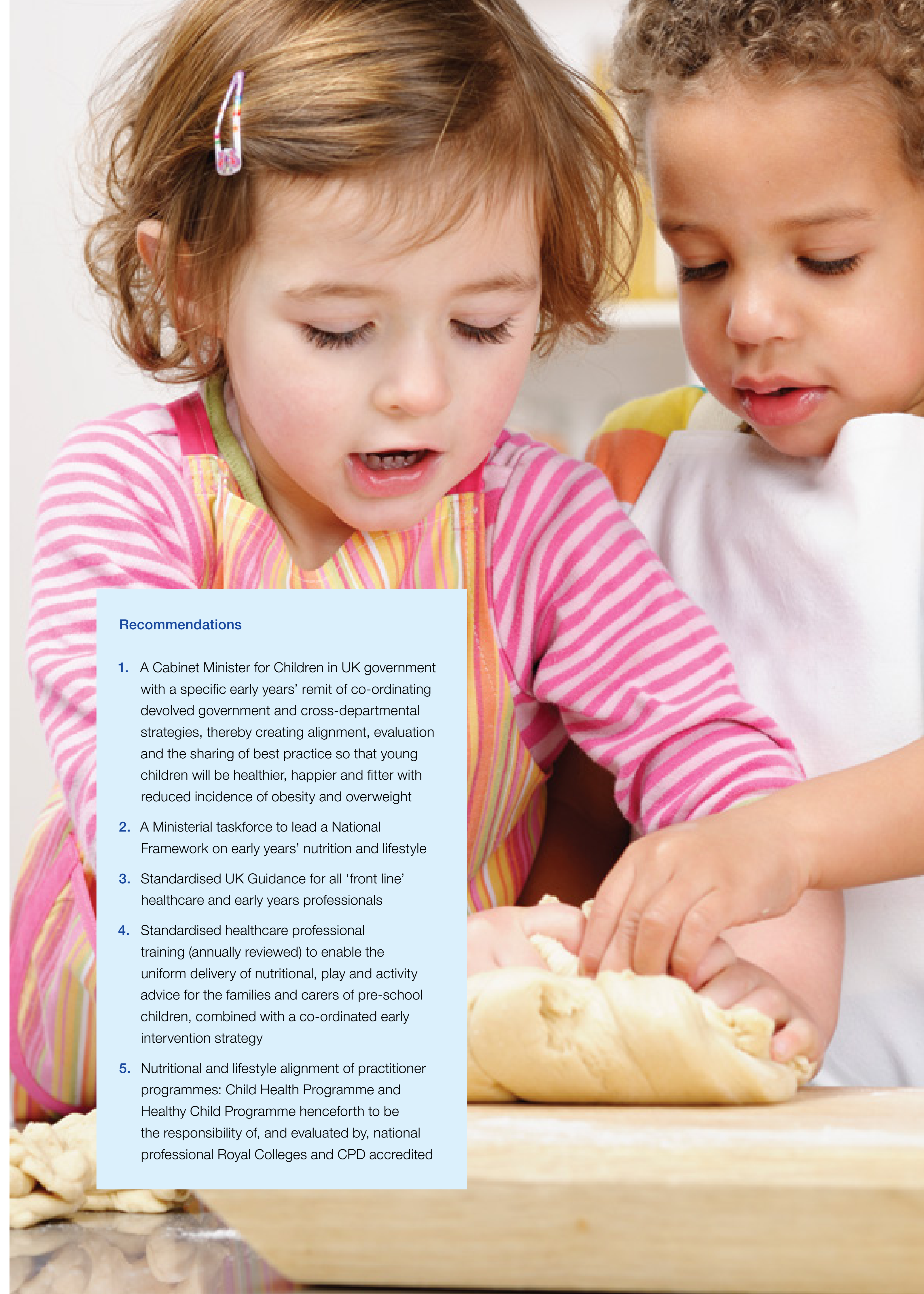
The Northern Ireland Framework proposes measures designed to:

- Increase levels of breastfeeding
- Increase knowledge and skills about food and its preparation
- Encourage participation in physical activity
- Promote walking and cycling
- Ensure the living environment is conducive to physical activity and healthy eating
- Engage and support community interest and involvement

The Health Survey Northern Ireland *(2010-11)* recorded that of the children aged 2-15 years, 8% were assessed as obese, based on the International Obesity Task Force guidelines (9% of girls and 8% of boys).

England, Scotland and Wales promote exclusive breastfeeding as the healthiest choice for babies in the first six months of life and offer guidance to mothers about how this may best be achieved. The respective Governments also give guidance on bottle-feeding (especially concerning the sterilisation of feeding equipment) although none offer clear information about mixed feeding. Scotland's 'Early Years Framework for Action' *(www.scotland.gov.uk/resource/doc/337658/0110855)* stresses the importance of respecting a woman's right to bottle-feed her baby and the Breastfeeding Act *(2005)* makes it law not only to allow women to breastfeed in public places, but also that members of the public offer women who bottle-feed the same level of support as those who breastfeed their babies. Each of the three nations clearly states that babies should not be given solid food until the six month milestone and provides parents with guidance on subsequent diet.

It can be seen that progress, particularly in the case of Scotland, is being made, but overall, there is still a clear gap in the perinatal, infant and toddler nutrition policy space across the nations. It is unsurprising that this deficit is compounded by worrying levels of childhood obesity – however, devolved responsibilities for health and fitness should be viewed as an opportunity to evaluate what does and does not work in each instance - and a chance to pool best practice.



Recommendations

1. A Cabinet Minister for Children in UK government with a specific early years' remit of co-ordinating devolved government and cross-departmental strategies, thereby creating alignment, evaluation and the sharing of best practice so that young children will be healthier, happier and fitter with reduced incidence of obesity and overweight
2. A Ministerial taskforce to lead a National Framework on early years' nutrition and lifestyle
3. Standardised UK Guidance for all 'front line' healthcare and early years professionals
4. Standardised healthcare professional training (annually reviewed) to enable the uniform delivery of nutritional, play and activity advice for the families and carers of pre-school children, combined with a co-ordinated early intervention strategy
5. Nutritional and lifestyle alignment of practitioner programmes: Child Health Programme and Healthy Child Programme henceforth to be the responsibility of, and evaluated by, national professional Royal Colleges and CPD accredited

THE ROLE OF PLAY, BOTH FREELY CHOSEN AND DIRECTED, WITHIN FAMILY AND EDUCATIONAL SETTINGS AND OUTSIDE THE HOME

'The Department of Education should recognise the early years as a unique stage in its own right and not merely a preparation for school, reinstating the vital role of free play in establishing a healthy level of physical activity in young children. To this end, a new Level 3 award of Early Years Educator (EYE) and new graduate award of Early Years Teacher (0-5 years) should include play work as part of the foundation training.' *('Healthy Patterns for Healthy Families: Removing the Hurdles to a Healthy Family,' All-Party Parliamentary Group on a Fit and Healthy Childhood, October 2014).*

A combined physical and emotional approach to better health, allied to balanced, healthy eating habits and the determination of society, will give children a much better start and will help them to form good lifelong health habits. Children's play, if enabled, can make a major contribution to this ambition.

The European Parliament's resolution on Early Years Learning *(12.05.2011)* establishes the primacy of the early years in the developmental cycle of the child and emphasises that in addition to the right to education, children have the right to **'rest, leisure and play'**. On 20th May, 20, the Council of the European Union advocated the formulation of:

'Developmentally appropriate programmes and curricula, which foster the acquisition of both cognitive and non-cognitive skills, whilst recognising the importance of play, which is also crucial to learning in the early years.'

In October 2014, the UK Chief Medical Officer issued guidelines for the desired level of 'physical activity' in children under five years of age, advising that time spent being sedentary for extended periods should be minimised, that children of pre-school age who are capable of walking unaided should be physically active for at least three hours spread throughout the day *('Everybody Active Every Day', Public Health England).*

Whilst not contentious in itself, 'physical activity' is not synonymous with 'play' and neither does 'play' equate to 'physical exercise' or adult-led sporting activity. Playful activity that enhances emotional, social and cognitive development as well as the physical wellbeing of children should be:

'freely chosen, personally directed, intrinsically motivated behaviour that actively engages the child.' *(Fields in Trust, Children's Play England and PLAYLINK, 2000).*

This is the type of play that will help to build a strong foundation for later life in the early years of a child.

'Alongside a major research push, extensive training for all those involved in the care and education of children, concerning the psychological processes embedded in playful activity, the essential qualities of play, the role of adults in supporting it and its benefits for learning and wellbeing is vitally important. Currently, the research in this area is very far ahead of public understanding and of much of the practice of parents and care and educational professionals,' *('The Importance of Play', Dr David Whitbread, April 2012).*

Professional educators of children (teaching and support staff) are not trained in how to provide a high quality environment that will promote intensely active play. Permission for children to 'go outside more' does not equate to increased activity levels and without the right playfully active environment, studies have shown that more than 50% of this 'time outside' can still be of a sedentary nature. *('The Inactivity of Preschoolers Amid Rising Childhood Obesity', Pfieffer,McIver, Dowda, Addy and Pate, 'Medical News Today', February 2009).*

The OPAL Programme (Outdoor Play and Learning) aims to reverse the trend by effecting 'cultural change' in a primary or nursery school: **'moving from an attitude that dismisses play as an inconvenience and a risk, to a wholehearted belief by all staff in the benefits of active, rich, varied and challenging playtimes for all children.'** *(OPAL Programme, 2014-15).*

The Programme offers support consisting of both 'hands on' and more formal training for adult staff which is spread over eight 'on site' mentoring sessions, designed to instil confidence and promote autonomy:

'A particularly effective feature of the mentoring process was the initial site baseline audit. It was so helpful to walk around at a lunchtime/ playtime with an informed 'outsider' and talk about what was happening. Even this basic level of awareness-raising began to facilitate our own problem-solving and the 'fresh eyes' approach meant his questions set us thinking deeply about our ultimate goals and our vision.' *(Clare Fletcher, Executive Head Teacher at the Federation of North Walsham Junior & Infant Schools and Nursery.)*

The newly accredited Early Years Educators and all Early Years Teachers would derive benefit from practical guidance and expert support in their own nursery/school, thereby enabling them to translate professional training into a set of practical tools.

The support should include a site visit from an experienced trainer/designer of play environments who will be responsible for auditing the current quality of the setting, identifying gaps in provision and any cultural or practical barriers to beneficial play. The number of children who are predominantly sedentary during playtime should be assessed and suggestions then made to improve the nature of the play environment in ways that are readily achievable and inexpensive.

Specific training for Early Years Educators and Early Years Teachers could include:

- Sessions in the formal management, observation, reflection, monitoring and planning of fun, healthy, active and beneficial play provision for younger children
- Training in evaluating the importance of, and difference between, adult-led play (commonly occurring within the lesson context) and child-led play; necessary for enjoyment, wellbeing and health during playtimes
- Guidance in monitoring/testing levels of activity, health, fitness and physical literacy (e.g., body control, ball control, motor skills) to ensure that children are acquiring the key skills that will help them to enjoy being physically active (e.g. running, jumping, throwing, catching).

The aim should be to facilitate freely chosen play that is self-determined and supported by professionally trained adults.

Positive play for young children in a home/family environment and in community and neighbourhood public spaces presents different challenges. Home-based outdoor play (e.g. in private gardens and social housing green spaces below blocks of flats) delivers opportunities for diversity; testing boundaries, taking risks, playing longer in the evenings and weekends and developing social and emotional skills via interaction with siblings and neighbouring children.

Barriers might include parental fears of traffic and the extremely rare incidence of 'stranger danger'. Encouraging the spread of 'Play Streets' and 'Home Zones' would offer play scenarios similar to those enjoyed by former generations, whereby town and city children played outside, observed informally from the home by a parent without any suggestion of an abduction or traffic accident. Regular street play activities can be programmed and initiated by the community (with Local Authority support) where playable green space is in short supply. In addition, improving the design of new-build housing and associated road systems so that people and their access to green spaces are prioritised over vehicles, would make families feel safer and encourage parents to allow children more freedom to play outside the home.

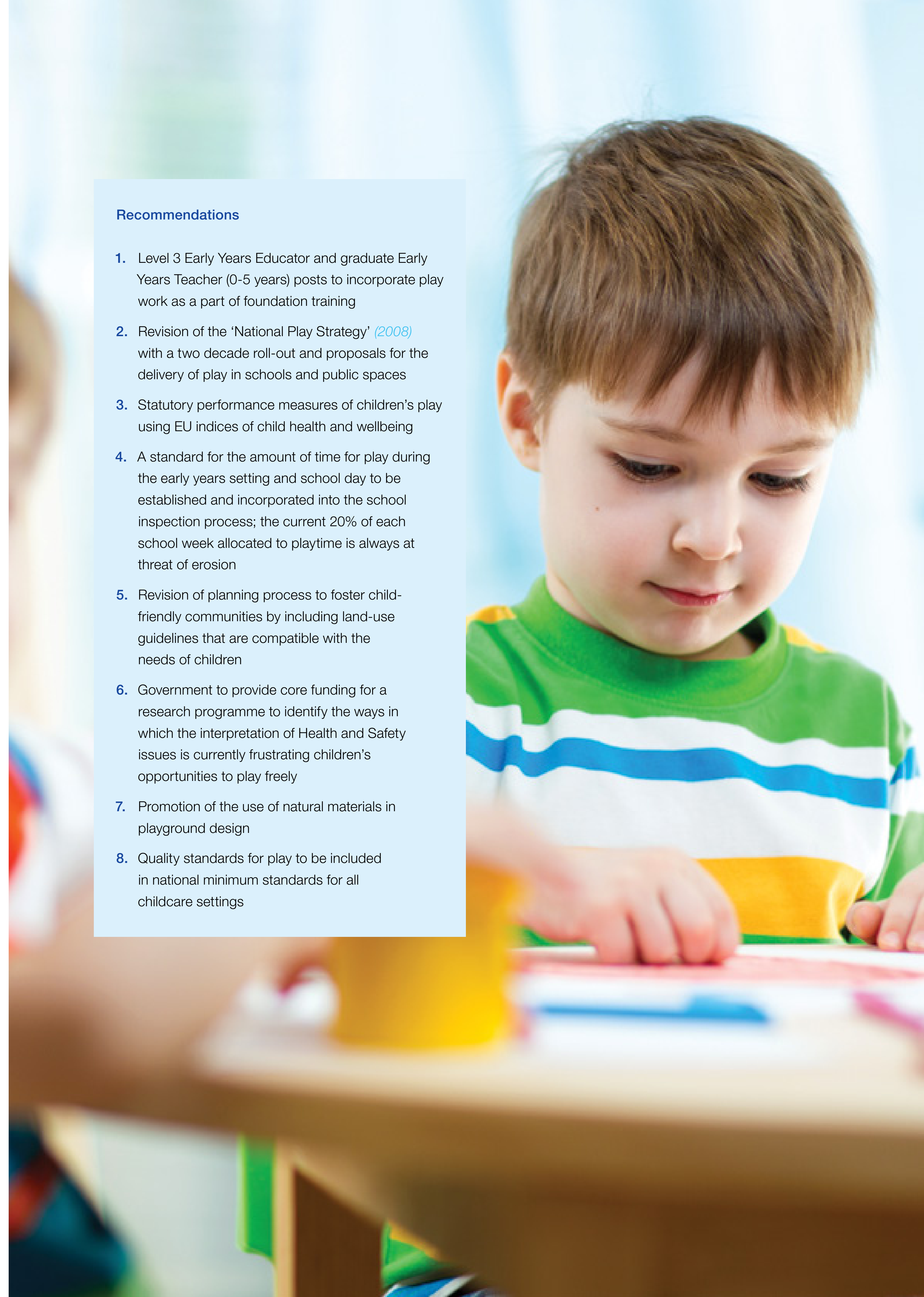
Making imaginative use of public spaces can offer children new and different experiences, not just in obvious but limited ways (skate parks/manufactured play equipment) but in improved street design and developing the potential of green spaces. Direct access to 'naturally enticing' play places of different character, represents an abundance of opportunity for children to jump, get muddy, climb, paddle and swing. The resultant experiences will be inexpensive, easily accessible and of immense benefit to health, wellbeing and activity levels. Each and every community should have several natural 'playable' spaces within easy walking distance from people's homes and these need be no more elaborate than the reclamation by nature of what has been lost.

There are some excellent examples of good practice; i.e. the enjoyable summer walking tours run by PLAYLINK around several of their designated play areas within social housing estates in the Dalston/Hackney area of London and also the opportunity to visit a number of street and social housing play spaces around south Islington.

The European Commission document 'An EU agenda for the Rights of the Child' *(2011)* recognises that a young child's developmental need to play is fundamentally important for society. Whether within an educational, home or outdoor community environment, a rich and varied play landscape can produce a society that is as holistically inclusive as it is physically healthy:

'It is crucially important to address play from the perspective of social inclusion and opportunities for children that face social marginalization and discrimination. There is an ever widening gap in the opportunities children have according to their parents' social and economic background. Increasingly, extra-curricular activities, including access to play spaces have to be purchased, exacerbating social inequalities. Conversely, public investment in play can make an important contribution to social inclusion and equal opportunities.'
(*Eurochild: 'The Importance of Play' Dr David Whitbread, April 2012).*

Prioritising opportunities for freely chosen play of excellent quality in the early years will develop the unique potential of the individual child. It will also lay the groundwork for a more equal and inclusive society.



Recommendations

1. Level 3 Early Years Educator and graduate Early Years Teacher (0-5 years) posts to incorporate play work as a part of foundation training
2. Revision of the 'National Play Strategy' *(2008)* with a two decade roll-out and proposals for the delivery of play in schools and public spaces
3. Statutory performance measures of children's play using EU indices of child health and wellbeing
4. A standard for the amount of time for play during the early years setting and school day to be established and incorporated into the school inspection process; the current 20% of each school week allocated to playtime is always at threat of erosion
5. Revision of planning process to foster child-friendly communities by including land-use guidelines that are compatible with the needs of children
6. Government to provide core funding for a research programme to identify the ways in which the interpretation of Health and Safety issues is currently frustrating children's opportunities to play freely
7. Promotion of the use of natural materials in playground design
8. Quality standards for play to be included in national minimum standards for all childcare settings

THE EDUCATIONAL AND TRAINING NEEDS OF HEALTH AND EDUCATION PROFESSIONALS: THE IMPORTANCE OF A MULTI-PROFESSIONAL APPROACH

Professions in the UK have traditionally evolved separately. This presents challenges in the early years because children and families derive most benefit from a holistic approach.

It is therefore relevant to consider the early years as an area with **'flexible borders'** *(Lumsden E. 2012. 'The early years professional a new professional or a missed opportunity?' PhD thesis, The University of Northampton)* where a multitude of practitioners and professionals come together from a range of disciplines to supply generic and targeted services. However, the ways in which they co-operate and the services they offer, differ both across Local Authorities and the countries that make up the UK.

Despite an increased focus by successive governments on improving working together *(Department of Education, 2013a 'Working together to safeguard children; A guide to inter-agency working to safeguard and promote the welfare of children')* and some excellent examples of good practice, the segregated approach continues to frustrate outcomes for young children and the overall impression leans towards confusion.

The Ofsted report *(2012-2013)* noted that: **'neither parents, nor providers, nor anyone in government is clear enough about which children are going to be ready for school and which are not,'** also **'The choice of an early years'** provider can be too difficult because the information that is available to every parent is not clear and simple enough,' and concluded **'Our recent inspections of children's centres have found a sector that is characterised by turbulence and volatility.'**

If clarity and consistency is to replace well-intentioned happenstance, multi - professional working will be essential.

In recent years, the greatest advancement in the quality of early years' provision has been improvement in the training and competence of the workforce, notably by expanding the graduate level of early years workers. The new role of Early Years Teacher (formerly Early Years Professional) entails interdisciplinary knowledge and requires those who meet the standards to have professional skills and attributes that support them in working with children, their parents and families and other professionals *(Lumsden, E 2014 'Changing landscapes in safeguarding babies and young children in England. Early Childhood Development and Care').*

High-quality pre-school programmes can do much to improve outcomes, especially for disadvantaged children, and the workforce must be holistically trained in child development, including an increased emphasis on child health. The Early Years Foundation Degree and Early Childhood Studies degree programme at The University of Northampton embed child health (taught by Health Professionals) into their early years' programmes. The need for this is highlighted by the continued requirement for integration between the Department of Health and the Department of Education in being able to deliver the child integrated developmental review at two – two and a half years of age.

However, a national emphasis on training in early years' nutrition is in short supply. This presents only as an optional module within the new level 3 Early Years Educator qualification although a number of initiatives are worthwhile, including a new standard to train chefs in the specific needs of young children, launched in November 2014 *(http://www.nurseryworld.co.uk/nursery-world/news/1147924/nutrition-standard-launched)* and combined with some basic nutrition training for Health Care Visitors to be integrated in the extended Healthy Child Programme.

The EYPAN – Early Years Physical and Nutritional Coordinator Cache L4 Qualification is similarly a model of good practice, delivering the development of a lead practitioner for early years' settings (Physical Activity and Nutrition Coordinator – PANCO) and evidence for settings that they are meeting national guidelines for physical activity and nutrition. *(http://ccpinfo.co.uk).*

Conversely, registered childminders receive no specific nutrition training and the feeling persists that knowledge about nutrition is a matter of basic 'common sense' and familiarity with the concept of 'five a day.'

Action to address unhealthy diets and weaning practices is severely limited by the competence and confidence of the early years' workforce to provide effective, scientifically-sound nutrition advice. This fact is highlighted in the SACN report, 'The Nutritional Wellbeing of the British Population', in which the risks that occur from front-line staff being inadequately trained in nutrition is documented. The comprehensive use of the Association for Nutrition's workforce competence model in nutrition (commissioned by the Department of Health) would provide those within local authorities, who are responsible for delivering nutrition and food-related initiatives, with a clear set of defined standards for both measuring nutrition-related skill capacity and confidence in those working at all levels, and for the commissioning of services and initiatives.

UKVRN Registered Nutritionists (RNutr) are professionals that are highly qualified and competent in nutritional science and practice. These individuals are ideally placed and suitably qualified to advise and support early years' workers and parents, in order to promote both healthy lifestyles and behaviour choices throughout the developmental years.

The importance of Continual Professional Development (CPD) in enabling all early years' professionals to remain up to date with the latest evidence-based child feeding and nutrition practices cannot be underestimated. Nutrition knowledge can easily become outdated (for example in relation to vitamin D or fibre guidelines, currently under review) but the roll out of CPD in general is patchy. It can be accessed via various training routes but remains fragmented and in many cases it is limited, difficult to access and non-accredited.

The training on offer for early years' workers in play, sport and physical exercise is variable in content and frequency – and largely reliant upon the enthusiasm and commitment of individuals and particular organisations. The University of Northampton does prioritise this key component of Early Years training via the delivery of health and wellbeing modules which teach the theory of exercise benefits and include collaboration with PE colleagues to apply these skills to work with young children. However, there is no national requirement and all who work within the sector; Early Years Teachers and Educators, early years workers, lunch time supervisors, childminders and health visitors should be taught about the importance of play, sport and exercise and how to teach/facilitate it. This component must be embedded within course curriculum development and practitioners need to 'role model' enjoyment of it if children are to be engaged.

Improvement is also needed in information-sharing across key groups of practitioners e.g. midwives, health visitors and early years workers and support for developing appropriate child health information systems. These practitioners require an understanding of community profiling tools to enable clear identification of health needs and relevant targeting of interventions. Community profiling is an important element to effective cascading of child public health promotion and should form part of education and training for all those professionally tasked with responsibility for improving outcomes for children and families. Investment should be made in both universal and targeted services as recommended by the Healthy Child Programme which should be commissioned in full.

The transition of Health Visiting services to Local Authorities offers a further opportunity to boost a multi-professional approach to the early years. The Department of Health has identified six High Impact Areas spanning milestones from Transition to Parenthood and the Early Weeks to Health, Wellbeing and Development of the Child Age 2-2.5 years integrated review and support to be ready for school.

The documents are informed by NICE Guidance and underpinned by the four principles of Health Visiting *(1977)*

- Search for health needs
- Stimulation of an awareness of health needs
- Influence policies affecting health
- Facilitate health-enhancing activities

Core Principles designed to underpin the High Impact Areas have safeguarding as a common thread, combined with a focus on improving health outcomes and reducing inequalities at individual, family and community level. Partnership, integration, communication and multi-agency working are key to the approach, as is the recognition that child health outcomes are not solely dependent on 'getting it right' in an isolated area.

Professionals specialising in the early years' setting, require a range of advanced interpersonal and practice-related skills to work alongside children, their parents and carers in a variety of contexts. Above all, they must be trained in multi-disciplinary working because the needs of children and their families do not fall neatly into segments. **'I am in no doubt that effective support for children and families cannot be achieved by a single agency acting alone. It depends on a number of agencies working well together. It is a multidisciplinary task.'** *(Laming 2001 para1.30).* This comment was made in relation to child safeguarding. It might equally be applied to all those who work to promote the overall health and wellbeing of young children.

Recommendations

1. A Professional Body for the Early Years' profession with responsibility for registering professionals, developing, monitoring and accrediting ongoing professional development and promoting good practice
2. The Professional Body to structure and embed a Code of Ethical Practices for the Early Years' profession and ensure that employment conditions are commensurate with the professional role
3. Embed physical/nutritional training and development into apprenticeship framework and Early Years Educator qualifications
4. National/Local Government to encourage (via an awareness campaign) early years' settings to gain an 'excellence' award in nutrition *(www.childrensfoodtrust.org.uk/award)*
5. A joined up holistic approach to training in nutrition in which comprehensive use is made by National/ Local Government of the Association for Nutrition's workforce competence model in the provision and commissioning of nutrition services
6. Government to develop a tool to simplify the new allergen legislation (in particular targeting Registered Childminders)
7. A standardised universal Early Years Nutrition advice leaflet/accompanying video, to include balance of food groups, portion sizes and how to cope with mealtime eating challenges
8. Commission the Healthy Child Programme in full
9. Implement and evaluate the two–two and a half year old integrated review
10. Promotion of the Graduate–led Early Years work force
11. Recruitment processes for early years' practitioners to assess emotional intelligence as well as knowledge base (recommended by the Wave Trust)
12. Develop clear, consistent and regular models of effective supervision for all professionals working within early years' settings – with CPD that is accredited, ongoing and easily accessible
13. Embed instruction in play, exercise and sport into professional training courses for all those who work within the Early Years sector
14. Train and educate the early years workforce to deliver the High Impact Areas for early years *(DH, 2014)*

SOCIOECONOMIC INEQUALITIES THAT AFFECT DEVELOPMENT IN THE EARLY YEARS AND METHODS OF SURMOUNTING THEM

'People with higher socioeconomic positions in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health-health care and unhealthy behaviours - it should become the main focus.' *(Michael Marmot, 2012).*

Socioeconomic inequalities in markers of child health and development (unhealthy weight, socioemotional difficulties and intellectual delays) have been widely documented in the UK and elsewhere. If inequalities in early child development are addressed, the later health and wellbeing of the adult population will improve.

Obesity is linked to the incidence of numerous chronic diseases and poses significant health and economic costs. The National Child Measurement Programme *(2012-2013)* has shown that children living in deprived areas are likelier to become obese than those enjoying more affluent circumstances and this is supported by a 2012 study *('Neighbourhood Context and Racial/Ethnic Differences in Young Children's Obesity: Structural Barriers to Interventions,' Rice University and the Kinder Institute Urban Health Programme).*

The conclusion that children from poorer neighbourhoods are almost 30% more likely to be obese than their more affluent counterparts derives from evidence taken from 17,350 5 year old children across approximately 4,700 neighbourhoods nationwide.

It is reinforced by findings from a 20 year study of the electronic health records of 370,500 children aged 2-15, released by Kings College London *(30th January 2015).* Despite the fact that overall figures for child obesity, (still affecting a third of the nation's children) have not changed substantially since 2010: **'For children from the poorest households, levels have continued to worsen so there is no room for complacency.'** *(Eustace de Sousa, Public Health England, 'The Daily Mail', 30th January 2015).*

Further recent research *('Why are poorer children at risk of obesity and overweight?' Goisis A, Sacker A, Kelly Y; under review and available upon request)* examines data on over 10,000 3 and 5 year olds from the Millennium Cohort Study and concludes that:

- At 5 years of age, children in the 205 poorest homes were twice as likely to be classified as obese compared to their richer peers
- By 11 years of age the poorest children were three times more likely to be obese

The study also shows that maternal smoking in pregnancy and early introduction of solid foods (before 4 months) was linked with healthy weight presenters aged 5 becoming overweight or obese by age 11; also that sufficient sleep and adequate fruit consumption protected against healthy weight children becoming overweight or obese by 11. For those with non-healthy weight at age 5, these practices promoted the transition to a healthy weight.

An American study *(Drewnowski, 2010; Drewnowski et al., 2007; Drewnoswki & Specter, 2004; Monsivais & Drewnowski, 2007; Monsivais & Drewnowski, 2009)* contends that what poorer families eat is determined by their economic circumstances. Long, slow, cooking of fresh meat is costly for families on a low income who may have gas and electricity meters in the home and those who cannot afford a car and are unable to access public transport to visit a supermarket, are frequently dependent upon local 'corner' shops where nutritious options are often more expensive – or simply unavailable. Deprived areas are also more likely to have more cheap, fast food outlets where the offer is energy dense, but frequently lacking in nutritional value. *(National Obesity Observatory 2013).*

In addition, a low family income can encourage a health-averse 'feast or famine' approach to eating. When budgets are strained, food consumption is reduced. When money does become available, the consequent risk is of an over-consumption that can trigger metabolic disorders and long-term weight gain. This is significant because some mothers will **'restrict their food intake and sacrifice their own nutrition in order to protect their children from hunger,'** *(Otis & Lino, 2002; Dammann & Smith, 2009; Dietz, 1995; Edin et al., 2013; McIntyre et al., 2003).* If fluctuating maternal eating patterns cause weight problems, the child may become an unwitting casualty because as research has shown, parental obesity (notably that of the mother) is often a strong indicator of child obesity *(Davis et al., 2008; Janjua et al., 2012; Whitaker, 2004).*

However, the relationship between deprivation and children classified as overweight is less clear. The National Child Measurement Programme findings suggest that 11.9% of children (from the most affluent decile) enter Primary school overweight compared with 13.3% of the least affluent children – thus it would seem that the trend to be overweight affects children regardless of socioeconomic status, but the progression to obesity is twice as likely if the child is from the most deprived decile. Furthermore, a very recent systematic review *(Bambra C, Hillier F, Cairns J-M, Kasim A, Moore H, Summerbell C, 'How effective are interventions at reducing socioeconomic inequalities in obesity among children and adults? Two systematic reviews. Public Health Res 2015;3(1))* found very little evidence of effective UK based programmes which address health inequalities in childhood obesity.

The Millennium Cohort Study *(2013)* demonstrates demographic and social variation in levels of physical activity and in areas of deprivation where crime rates may be high and play spaces have either been removed or are widely considered too dangerous for children to be allowed to play there. Similarly, safety concerns may make parents reluctant to allow their children to play outside or walk to school.

The Coalition Government and others have prioritised sport and 'physical exercise' at the expense of (rather than alongside) play – impacting adversely upon lower-income communities and there is a consequent need for the encouragement and provision of outdoor play in all weathers and at all early years' settings.

Intellectual development in the first few years of life sets individuals onto trajectories for academic attainment that influence future life chances and here again, children from economically deprived backgrounds are disadvantaged.

The Millennium Cohort Study found that:

- 3 and 5 year olds from the poorest 20% of families had substantially lower scores on tests of intellectual ability and readiness to learn compared with their more affluent peers
- Aspects of the home learning environment and family routines (sleep schedules/being read to by a parent) contributed to observed income gaps
- The income gap in verbal abilities widened by about 50% between ages 3 - 5
- By age 7, children experiencing multiple adversities were delayed by 18 months in reading tests and by age 11, the gap had widened to over 3 years
- 3 and 5 year olds from the poorest 20% of the income distribution were between 7 and 8 times more likely to have clinically relevant socioemotional problems (impacting upon children's readiness to learn and likelihood of academic success) compared to contemporaries from richer homes

Given the multitude of ways in which children are adversely impacted by socioeconomic disadvantage, the importance of early intervention is clear.

The report entitled 'Early intervention: the next steps' promised **'lasting improvements in the lives of our children',** citing 19 early intervention programmes to enable the goal of: **'a range of well-tested programmes, low in cost, high in results, can have a lasting impact on all children, especially the most vulnerable. If we intervene early enough, we can give children a vital social and emotional foundation which will help them to keep them happy, healthy and achieving throughout their lives and, above all, equip them to raise children of their own, who will also enjoy higher levels of well-being.'** *(Allen, G. (2011) 'Early Years Intervention: the next steps, London: HM Government...')*

However, it is important that such interventions are underpinned by universality in order to reach the widest number of families rather than being subject to targeting and possibly serving to stigmatise those most in need of help. Health visitors currently provide a universal resource for families from the antenatal stage to childhood, but the Family Nurse partnership in which some are now trained is targeted and only reaches a small number of families.

The new Healthy Child Programme (formerly Child Health Promotion Programme) is underpinned by a 'progressive universalism' whereby all children receive a package of health promotion; intensity dependent upon the particular needs of the child.

'Tackling Obesity Through The Healthy Child Programme: A Framework for Action' *(Rudolf M. 2009)* offers an outline of necessary intervention featuring:

- Parenting; working with parents to increase their understanding of infants' nutrition and to enable them to reflect on their own feeding beliefs
- Eating and feeding behaviour; encouraging responsive feeding, positive family mealtimes and finding alternatives for comfort and reward
- Nutrition; encouraging breastfeeding until 6 month and then solids; healthy food, water to replace carbonated drinks and advising on portion size
- Play and sleep; encouraging play, reducing sedentary behaviours, screen time and ensuring a good night's sleep
- Practitioners' effectiveness; recognition of at risk families, providing extra training for all practitioners and encouraging them to model healthy lifestyles

To reduce inequalities in the early years, it must be understood that the circumstances in which young children live impact heavily upon the choices and opportunities available to the adults who look after them. A family living in socioeconomic disadvantage (overcrowded, poor quality housing stock in a deprived residential area) has far fewer options open to it than a family from an affluent background. It is therefore the responsibility of Government to devise policies and interventions that take account of the root causes of disadvantage as well as focusing on the products of these.

In such a context, virtuous strategies for the early years are not only desirable but necessary:

'As individual practitioners, we cannot make the world free of inequalities and a safe place to be, but we can do our very best to ensure that our early years settings are small models of what we would like the world to be like.' *(Lane. (2007), 'Embracing Equality: Promoting Equality and Inclusion in the Early Years.' London Pre-School Alliance.)*

Recommendations

1. Implement the Marmot Review's strategies for reducing health inequalities, especially those linked to 'Policy Objective A: Give every child the best start in life' (2010)
2. Implement the Allen Report (2011)
3. Increase investment in Health Visitor training so that it is possible to see all mothers antenatally and keep contact with the families
4. Support Children's Centres and increase their numbers so that all families can access them
5. Extend The Healthy Child Programme
6. Encourage all mothers to breastfeed by providing comfortable and accessible feeding places in workplaces, outside-home settings and promotion via TV advertisements as in Europe
7. Support families to develop children's skills
8. Provide quality education and childcare so that early years workers' can properly support parents
9. Design more play areas; revise planning process to facilitate freely-chosen, natural play opportunities and 'all weather' outdoor play at all early years' settings

THE USE OF LEGISLATION, REGULATION AND GUIDANCE

Whether optimum outcomes for children in the early years are best realised by legislation, voluntary agreement or a combination of the two remains a matter for debate.

The importance of a healthy, balanced diet during a child's growth and development cannot be over-emphasised, particularly during the period from birth to three years of age, and there is widespread agreement that food produced specifically for this group of children with their critical nutritional and safety requirements should be covered by legislation. UK regulation is based upon European Directives concerning compositional requirements and labelling standards applicable across the European Union. The legislation defines 'infants' as children up to 12 months of age and 'young children' as those in the 1-3 years age group.

In the early months, complete foods, reconstituted as liquid substitutes for breast milk (infant formula), are introduced. These are succeeded by 'follow-on' formulae and are nutritionally balanced to allow for the gradual introduction of solids into the diet *(Infant and Follow-on Formula (England) Regulations 2007 (SI 2007/3521).*

The initial introduction of solids usually takes the form of cereal-based foods, which themselves may be reconstituted with milk. Their composition is also controlled by legislation, as are other types of baby foods having a broader range of animal and vegetable sources of protein *(Processed Cereal-based Foods and Baby Foods for Infants and Young Children (England) Regulations 2003 (SI 2003/3207).*

This legislation ensures that the highest standards of nutrition and safety are maintained; not only in the UK but also in all countries within the EU and EEA. The legislative framework also provides certainty for manufacturers of products in this category that they are not presented with undue barriers to trade when exporting. Exports to third world countries are also subject to legislation in recognition of the need to maintain standards when supplying other, often under-developed, countries.

Cereal foods and baby foods may continue to be used beyond one year, forming a nutritionally sound basis of the diet during the time when foods eaten by older family members are progressively introduced. Use of legislation to protect this age group is not therefore, contentious, but there is no comparable consensus around how best to protect the health and wellbeing of children over 3 years of age whose nutritional needs remain paramount.

Whilst recognising that **'Too many of us are eating too much, drinking too much and not doing enough physical activity,'** *(Department of Health, 2015),* the Coalition Government favours a voluntary approach to turning the tide upon patterns of behaviour that are sustaining a national obesity epidemic and endangering the long-term health prospects of children before they start school.

The Public Health Responsibility Deal enshrines a series of collaborative pledges, encouraging organisations to sign up to commitments covering alcohol, food, health at work and physical activity. The food pledges are designed to improve nutritional content, whilst advocating that businesses promote healthier products and improve the quality of information about them to the consumer.

It is an approach that has been welcomed by some:

'Through voluntary commitments, manufacturers have made significant progress in reducing salt, saturated fat and calories in their products. Salt levels have reduced 9% since 2006 and some manufacturers have introduced calorie caps in particular for snacks and soft drinks.' *(The Food and Drink Federation, 2015).*

Whilst others remain sceptical:

'I don't think anyone in this country actually thinks that the food industry are the right people to decide what we should be eating.'
(Professor Gabriel Scally, 2015).

Health Secretary, Jeremy Hunt has qualified his backing for the Responsibility Deal and assertion that it has led to **'significant reductions'** in the sugar, salt and fat content of supermarket foods by maintaining that **'we do reserve the right to legislate. If we don't meet our targets and continue to make the progress that we have to make, then we would consider legislation.'**

The Labour Party's policy document 'Protecting Children, Empowering All' *(January 15th 2015)* includes an intention to set maximum permitted limits on the levels of fat, sugar and salt in foods primarily marketed to children. The party is also considering measures to address the role of television advertising and non-broadcast media such as 'advergames' that promote food products with high sugar, salt, or fat content. Labour will consult with the Advertising Standards Authority, bearing in mind that: **'If progress cannot be achieved through this route, we will regulate to protect children with options including a time watershed for advertising of products high in sugar, fat and/or salt.'**

Other proposals include permitting Local Authorities to restrict the number of fast food outlets in high streets and reinstate the curricular goal of requiring all children to do a minimum of two hours PE per week.

The Labour document has triggered a range of responses. There has been enthusiasm for the proposals in some quarters: **'the food industry has done quite well over the years, but this would be an extra incentive to go one stage further.'** *(Amanda Ursell; nutritionist, January 2015)*

but the omission of any reference to the importance of play is regarded by others as disappointing: **'Let children do what they really want, without adults forcing them to do something without a choice, and they'll vote for play every time.'** *(Neil Coleman, OPAL, January 2015).*

A study published in 2007 *('Locating quality physical education in early years pedagogy', Elizabeth Marsden and Carrie Watson, University of Paisley, Scotland)* contends that the simple equation of 'physical education' with 'sport' is unhelpful and may not serve the needs of the majority of children in the early years:

'The growing tendency to equate 'sport' with 'physical education' .....is beginning to cascade into primary schools where many young children may find themselves trailing in the wake of only a few who have the ability, talent and drive to be successful; competition is not an inclusive concept. Early-years pedagogy, on the other hand, is inclusive.'

The authors advocate a central role for play, quoting The Rumbold Committee of Inquiry into the Quality of Education Experience of 3-4 year olds. *(DES,1990)*:

'It (play) has a fundamental role in early childhood education, supplying the foundation upon which learning is built.'

However, in recent years, the convergence of informed agreement around the need for a rise in the prevalence of 'sport' in the educational offer to children of all ages has been accompanied by a decline in the promotion of 'play' and without determination, decisive action and political will, this seems set to continue. Further controversy has been generated by the Government's stated intention to introduce new 'baseline' learning aptitude tests for four and five-year-olds during their first few weeks at primary school. The National Union of Teachers has called for a ballot on boycotting the tests and an online petition requesting that the plans be abandoned has been launched by some in the Early Years sector.

Widely-held concerns are that:
'The baseline assessment is complex, difficult to administer and our youngest children develop at different rates. Time spent on administering it could be better spent actually supporting a child with their learning.'
(Dr Eunice Lumsden; The University of Northampton, February, 2015).

Labour's plans to prioritise perinatal mental health are very welcome, however, the announcement from the Shadow Secretary of State for Education, Tristram Hunt, of proposals to legislate on the provision of 'age appropriate' sex and relationship lessons for 5 – 7 year olds if elected to office, has provoked some controversy.

Whilst the measure has been endorsed by some key organisations, its opponents include Christian Concern and Parents Outloud. Labour withdrew similar recommendations prior to the 2010 General Election and an attempt to revive the issue in the Commons in 2013 was unsuccessful.

Whilst it is essential that all teachers should receive intensive and age-related training in these matters, in order to promote equality and undertake supportive interventions with children and families as appropriate, structured lessons for children aged 5 – 7 as proposed could be considered to be counterproductive and subject to misinterpretation.

There is no reason to shelve the issue or stifle the debate, but in this matter, as with others discussed above, a combination of legislation and voluntary agreement that will win broad-based acceptance and support is likely to be of the greatest benefit to young children in the early years.

It remains a work in progress:

Recommendations

1. Current legislation stating that food supplied in schools must meet set standards to be extended to all nurseries, Children's Centres and early years' settings
2. Legislation to ensure that the professional training requirement of all early years' workers (including childminders, nursery professionals and primary school teachers) includes adequate knowledge of nutrition
3. Brands required to publish data to support labelling claims such as 'anti colic milk', 'anti-reflux milk' etc.
4. Revised advice in an accessible format to be given to all new parents about early years' nutrition and to include advice on play and physical activity
5. Government to research and publish outcome - data on child obesity from countries currently legislating to control food and drink content, as a means of informing its own decisions on the use of legislation in consultation with a widely-based interest 'coalition' including health and education professionals, media and advertising concerns and the food and drink industry
6. A national play strategy from early years upwards with the provision of outdoor all-weather play in all early years' settings
7. Increased resources for Local Authority initiatives to promote health and welfare in the early years

ACCESS TO ADVICE AND ASSISTANCE FOR PARENTS AND FAMILIES

Becoming a parent is a life-changing experience. Access to excellent, on-going and consistent advice from non-judgemental professionals is crucial if its challenges are to be met with confidence.

A group of mums from Ilkeston and the surrounding area in Derbyshire aged 17 -34, (selected on basis of geographical/ friendship/family commonality) shared their experiences of pregnancy, childbirth and the early years' services and emphasised the importance of a holistic, family-centred approach. *('The Needs of Young Mums Today', Neisha Noble, February 2015)*

Discussions took place over several months and the conclusions were agreed. The women had accessed a range of hospital/community services in their area.

During the antenatal period, support from family and friends was considered to be extremely important in establishing the confidence of the expectant mother; ideally run in tandem with advice from professionals. However, a frequent observation was that interventions by midwives and hospital –based professionals lacked the consistency and flexibility to cater for individual needs:

'Times of antenatal appointments were too sporadic … I had questions to ask the midwife but felt rushed so didn't get to form a relationship with her.'

'Midwives are far too busy and will openly tell you they are short-staffed so appointments are rushed. The whole experience felt as though it was at the behest of NHS convenience rather than the personal needs of the pregnant patient.' *(Quotations here and subsequently, taken from 'The Needs of Young Mums Today,' Neisha Noble, February 2015).*

Pregnancies presenting as potentially 'difficult' (because of a range of physical and/or social reasons) are consultant–led and centred on hospital appointments. Set procedures were felt to be confusing and inflexible:

'The first antenatal involves giving a family history and decisions I made then were logged on computer – there was no opportunity to change my mind later about things like preferences for the birth. This computerised mechanism takes away the personal matter of childbirth.'

All the women would have preferred some continuity of care, but were rarely seen regularly by the same midwife – or even the same consultant. They would also have appreciated home visits from a midwife during the antenatal period so that matters such as good nutrition in pregnancy could have been discussed. Some advice was given at the first hospital appointment, but not consolidated via home visits from a trusted midwife. Potential mental health issues were not signposted and the increased use of computers in all professional settings meant that hard copies of informative leaflets were unavailable:

'I understand that historically, a booklet was given that supported mums from the moment you were pregnant to giving birth – vital information. For example, this would explain what you might be feeling like at 6 months and also advise how family members could support you – and if they should be concerned for you, if you did show signs of depression.'

A lack of personally-tailored professional advice was seen as evidence of disinterest and sometimes family and friends had stepped into the breach:

'I was told by the midwife that my child aged 6 would *'just get used'* to the idea of a new baby; however, rather than do nothing, I took the advice of an experienced mother and helped my child to understand that the arrival of the new baby was natural, and that the baby wouldn't take her place, instead of saying at the end of nine months – here is your sibling, get on with it!' *(Noble, 2015)*

Many of the mothers felt that a lack of personalised support was most marked if they had arranged to give birth in a hospital:

'When you call the labour suite for admission, you are initially barred by a barrage of questions such as your physical state; why are you calling? How far away do you live? Have your waters broken? You don't need to come right now – call us back in a few hours.'

'No choice is offered to the patient on arrival – if you want a water birth or normal delivery room – you're just given any free room available.'

In the hospital itself, the behaviour of health professionals was sometimes considered to be insensitive:

'During the delivery time, the midwives were absorbed in their paper work rather than supporting the mothers; they appear to ignore the family support person and also any advice offered from the family or woman's mother. One or two mums explained that they had been moved room moments from giving birth and the only answer you get at every opportunity is that the midwives tell you how understaffed they are. This appears to be a barrier that they use when expectant mums and families ask questions or want support. Lots of mums say that their experience isn't like the telly version of 'One Born Every Minute'! The professionals go with medical intervention all the time as a quick fix, rather than involving the family and most importantly, the mother of the expected baby.'

At its worst, the treatment could be described as uncaring

'One mother witnessed an expectant mum crying to be let into the ward – all mums agreed that the operation of the admissions system they had experienced was absolutely appalling and unhelpful – their objective seemed to be to keep us away and keep hospital times and time spent in hospital to a minimum.'

It is likely that a general absence of personalised care is linked to a shortage of resources nationwide, but there is the danger of a 'conveyer belt' approach to maternity services becoming embedded in the culture with unfavourable outcomes for the new mother and her child.

Support with feeding was found to be variable – and post-code linked:

'Very little help was given during the antenatal period – although there is some, depending on where you are living towards the end of the pregnancy…and during the first few weeks but only if you decide to breastfeed.'

The message about beginning weaning at six months of age was understood, but the women would have appreciated more contact with a community health visitor, especially to discuss nutrition up to and including the pre-school period:

'You see a health visitor at 16 weeks, and then your next appointment is when your child is one year old. Up to five – even up to pre-school, no advice is given about the importance of good nutrition. We had no help from the NHS, but other mothers gave good advice on weaning, portion size, using a hand-held blender and food preparation.'

Once again, in the absence of professional advice, the mums relied on family and 'self-help' solutions and this was also the case with toilet training and meeting the child's need for a healthy balance between sleep, activity and play:

'Children should have more play in their day and be encouraged to choose friends and have time to reflect where nothing is required from them. Free thinking time is very important to children for their lifelong mental health.'

The mothers also shared their experiences of childcare in pre-school settings and again, found that the standard and quality of care was variable:

'At some pre-schools, you had to bring food for your child. Some parents couldn't afford to bring a meal, so they stood at the back with their child while the other children ate. So if there are poorer families in the community who can't afford to buy a snack, then the child goes without. I can't see that any care worker should think that this is acceptable.'

The key issue concern in relation to advice and assistance in the UK for young parents and families is not that it does not exist – but that too often, it can be variable in quality, frequently dependent upon a geographical postcode and often hard to access.

Above all, interventions from healthcare professionals during the antenatal period and beyond must be given in ways that are consistent, respectful and non-judgemental.

'Mothers and families are made to feel like the midwives etc are 'power' and their decisions are final. The lack of support and listening is extremely disturbing. Using the NHS as a young mum feels reactive rather than proactive.'

Becoming a new parent in the UK today is often characterised by feelings of confusion, inadequacy and isolation. At times those who are responsible as parents for the health and wellbeing of young children feel judged by the professionals who should be helping them. Clearly, there is a need for such services to be properly resourced but a change in the culture must accompany secure funding streams.

If early years' services are working properly, those responsible for delivery will ensure that their main professional objective is to make the parents feel empowered.

Recommendations

1. All who have professional responsibility for pregnant women and new parents to be trained in how to offer advice in a respectful and non-judgemental manner
2. Department of Health to revise and update the 'pregnancy booklet'. All women to be issued with a hard copy at the first hospital antenatal appointment
3. Department of Health to produce a booklet on child nutrition for 0-5 years of age to be given in hard copy to the parents in their home by the health visitor
4. All women to be assigned to a local midwife team for care in the community as soon as the pregnancy is confirmed with the opportunity for women to change/amend decisions about birth choices that they have made at the antenatal booking appointment
5. Midwife/health visitors to make all interventions 'family centred' whether at hospital or in the home
6. All health visitors to provide advice to families on nutrition and play at regular intervals during the pre-school period
7. Government to provide funding to increase the number of midwives and ensure that each new family has access to regular home visits from a health visitor

CULTURAL IMPERATIVES AND DIVERSITY

The UK is ethnically and socially diverse. Many different communities live in a variety of circumstances in a multicultural Britain.

The Triennial Review *('How Fair is Britain?' Equality and Human Rights Commission, 2010)* argues that 'society should aim to ensure that every individual has the chance to learn and realise their talents to the full.' There is evidence to demonstrate that extending access to quality early years advice, childcare and education would signpost a more integrated society and close the attainment gaps between children from socioeconomically deprived backgrounds and their more affluent counterparts – but to date, the UK lags behind countries such as Sweden and Denmark in creating the early years 'level playing ground'.

For many families 'equality' remains a work in progress.

Issues of diversity are present from the first moments of life, when decisions must be made about how to feed the baby. Established guidelines recommend exclusive breastfeeding for the first six months *(World Health Organisation, 2015, 'Exclusive Breastfeeding' http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/)* but in some cultural situations, this may not always be easy in practice.

A study of UK-born ethnic minority women *(Twamley K et al.2011, UK-born ethnic minority women and their experience of feeding their newborn infant. Midwifery 27(5): 595-602)* found that women living within an extended family often felt too inhibited to breastfeed or were adversely influenced by the persistence of traditional family practices.

However, other analyses have shown that lone mothers were more likely to breastfeed when living in certain high ethnic minority communities. *(Griffiths LJ et al. (2005) 'The contribution of parental and community ethnicity to breastfeeding practices: evidence from the Millennium Cohort Study. Int J Epidemiol 34(6): 1378-86).*

Taken together, community peer programmes uniting women from different cultures could be a way forward in supporting new mothers with early feeding practices.

Different cultural beliefs and exposures, such as periods of fasting, family influence and vegan/vegetarianism can also affect child weaning and the foods they are given in early life.

Basic principles should be applied and disseminated to all cultures which include the need for young children to eat a varied and balanced diet. For toddlers aged 1 - 3 years, this is thought to include:

- Starchy foods x 5 a day
- Fruit and vegetables x 5 a day
- Dairy foods a 3 a day
- Protein foods a 2 a day (x3 a day if the child is vegetarian *(British Nutrition Foundation, 2015, http://www.nutrition.org.uk/healthyliving/toddlers/5532.html)*

The Department of Health and Chief Medical Officers also recommend a supplement of 7–8.5 micrograms of Vitamin D for all British children, from 6 months to 5 years of age. However, this is particularly important for Asian and African children who tend to require more vitamin D due to darker skin needing more sunshine (beyond UK levels) to make vitamin D. *(Chief Medical Officer's advice, 2012, Vitamin D – advice on supplements for at risk groups: https://www.gov.uk/government/publications/vitamin-d-advice-on-supplements-for-at-risk-groups)*

It is important that these messages are conveyed consistently and respectfully to the parents by the health visitor as well as made available in literature in the various languages prevalent in the community.

The activity levels of young children are also impacted by cultural diversity. Recent work amongst UK children found that 73% of White Europeans compared with 35% of South Asians achieved the international physical activity recommendations of 60 minutes of moderate to vigorous daily activity. South Asian children were also found to engage in less after-school activity. *(Eyre EL et al. 'Objectively measured patterns of physical activity in primary school children in Coventry: the influence of ethnicity. Diabet Med 30(8): 939-45).* Similar cultural differences in activity levels are also reported elsewhere. *(Duncan MJ et al, 2012, 'Ambulatory physical activity levels of white and South Asian children in Central England. Acta Paediatr 101(4): e 156-62)*

These findings give cause for concern, especially because of the increased incidence of early-onset diabetes amongst South Asian populations. It is therefore imperative that the Departments of Health and Education ensure that better guidelines and the benefits of being active from an early age are cascaded to all cultural groups and disseminated at local level by professionals who interact with young families.

Equality of provision and widening availability and access should be the guiding principle underpinning all pre-school and early years' settings:

'Benefits of childcare and early years education appear to be particularly significant for children from ethnic minorities, with survey evidence showing that for certain outcomes, especially pre-reading and early number concepts, children from some ethnic groups, including Black Caribbean and Black African children for whom English is not their first language, made greater progress during pre-school than White British children, or those for whom English is a first language.' *('Working Better: Childcare Matters', Equality and Human Rights Commission, 2010).*

However, an earlier report from the Commission *('Early Years, life chances and equality: a literature review,' Johnson and Kossykh, Frontier Economics. Equality and Human Rights Commission Research Report Series, Research report 7, 2008)* uses evidence to show that fewer children from ethnic minority groups participate in formal pre-school childcare; thus demonstrating that those who would benefit most from early years' education are least likely to access it.

There are various reasons for this. Childcare is expensive and some ethnic minority families belong to lower income groups, but other influences, such as a cultural/social norm to stay at home are also pervasive.

Some immigrant families may encounter barriers of language or understanding when accessing information about the nature of early years services in their community and despite the fact that an entitlement to free childcare places for the working parents of 3 and 4 year olds has attracted a high take-up, the most disadvantaged families are less likely to use it even when it is free. There is an urgent need for more vigorous information initiatives about what is locally available; supplied via literature in the appropriate community languages and conveyed in person by health/education professionals at all settings interacting with young families.

Parents of disabled children have less access to quality early years' provision and these families may be forced to manage on a lower income because of the need for one parent to supply the childcare gap by staying at home. What is available is likely to be expensive and is not guaranteed to be near at hand:

'Nearly half (49%) of Family Information Services in both England and Wales reported that there was not enough childcare provision in their area for disabled children.' *(Working Better: Childcare Matters', Equality and Human Rights Commission, 2010).*

Similarly, in non-specialist settings it cannot be assumed that all staff will have been trained in working with this group of children. In the case of children who have been identified with learning difficulties, fewer with Special Educational Needs (whether or not they have been given a Statement) use early year's childcare.

The traditional composition of the early years' workforce is neither gender-balanced nor reflective of contemporary life-styles when fathers are more likely to play an active role in the care and upbringing of their children. 98% of the early years' workforce today are women and the posts are poorly remunerated. A true commitment to equality would prioritise increasing the number of men working in childcare and revising pay scales to validate the status of what is increasingly becoming a graduate-entry profession. Competitive rates of pay, combined with a high profile Government-led recruitment drive would go some way to achieving gender balance in the workforce.

Early years' settings should devise an equalities policy that is agreed and must be followed by all staff. The Equalities Act (2010) contains measures to safeguard people who share the following protected characteristics.

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Such policies should recognise and affirm that there are many different forms of 'family' and ways of parenting and the early years' setting should offer a welcoming atmosphere, with approachable staff and a secure environment in which children have the confidence to explore their own culture and that of their peers. Ways in which this could be achieved might include:

- Information provided in the languages of the community
- Needs of every child and adult identified with all staff sharing an ethos to promote equality in practice
- Celebration of festivals to develop a healthy awareness of similarities or differences between individuals
- Inviting visitors from diverse parts of the community into the setting
- Introduction of different traditional foods and during cooking opportunities
- Provision of a culturally rich environment that is reflective of all languages (including sign language) used in the setting and which affirms the validity of languages other than English, even in groups where English is the only language spoken
- Provision of songs, stories, toys and games from a wide variety of cultures
- Positive visual images of different people and families
- Staff awareness of the fact that racial, cultural and ethnic identity are frequently inter-related with religion and faith

Embedding the principles of equality and respect for cultural diversity into all interventions with young families can play a strong part in uniting fragmented communities, supporting ways of parenting, dispelling distrust and disharmony and improving outcomes for all children regardless of their original home background and family composition.

It is a childcare policy designed to create a country that is at ease with itself and its inhabitants.

Recommendations

1. Promotion of community peer programmes, bringing together parents from different cultures to support new families with early feeding practices
2. Better communication of guidelines and promotion of the benefits of being active from an early age across all cultural groups
3. Dissemination of basic principles of a good and varied diet for toddlers aged 1-3 across all cultures, via multi-lingual literature including recipe examples and practical instruction
4. Health visitor training to include cultural diversity aspects in advice on nutritionally-balanced diet for young children
5. Increased provision of free, quality early years' provision for disabled children
6. Extend free quality childcare places for two year olds to children aged 1-2
7. National audit of all early years' settings for production and practice of equality policies
8. All Early Years Teachers, Educators and registered childminders to receive specialist training in working with children who have learning difficulties
9. National and local initiatives to audit take-up of childcare/early years provision in high-density cultural and ethnic diversity areas
10. Initiatives to improve the gender make-up of the early year's workforce, including nationally-driven recruitment campaign and increasing professional pay-scales

THE IMPACT UPON THE LIFE COURSE OF THE EARLY YEARS: THE IMPORTANCE OF SAFEGUARDING

'Those who suffer multiple adverse childhood events achieve less educationally, earn less, and are less healthy, making it more likely that the cycle of harm is perpetuated, in the following generation,' *(Sally Davies (2013) Forward; Leadsom A., Field, F., Burstow, P., Lucas C. 'The 1001 Critical Days: The Importance of Conception to the Age of Two Period. (http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf)*

What happens in the early years will have direct impact upon health, economic and social outcomes throughout the life course. The environments in which people live **'get under the skin,'** *(Bartley M (Ed.). 'Life Gets Under Your Skin,' ESRC International Centre for Lifecourse Studies in Society and Health, UCL, London, 2012. http://www.ucl.ac.uk/icls/publications/booklets/lguys.pdf)* and social circumstances interact with human biology to determine health, wellbeing and risk of mortality. In turn, these factors steer and colour life chances, including educational achievement, employment opportunities and social interaction. The best start in the early years is therefore, the nearest possible indicator of positive outcomes throughout the rest of life. Conversely, the nature and intensity of adverse experiences during this crucial time have potential to blight future generations in ways that are destructive and injurious.

Good nutrition; that of the pregnant mother initially, in the interest of optimal foetal growth and then how babies and infants are fed, is a key determinant of life course outcomes.

The role of breastfeeding in protecting against a range of infections and diseases is well-known; it also advances socioemotional development and enhances the cognitive abilities of the child, thus lessening the likelihood of downward social mobility in adult life. *(Sacker A, Kelly Y, Iacovou M, Cable N, Bartley M, 'Breast feeding and intergenerational social mobility: what are the mechanisms?' Arch Dis Child 2013; doi: 10.1136/archdischild-2012-303199.)* Breastfeeding is also beneficial to the health and wellbeing of the mother.

Smoking in pregnancy, however, can lead to changes that are negative and irreversible; babies born to mothers who smoke 20 or more cigarettes per day will be around 200 grams lighter at birth and those of low birth weight are more likely to suffer from numerous chronic diseases later in life. They run an increased risk of being overweight or obese children who in turn, become obese adults, suffering from weight-triggered disease. The early years are, crucially, the time when the brain develops most. Much remains unknown about its plasticity and epigenetics during the early years period, but neglect and emotional abuse impact upon its development.

The effects can be devastating.

Neglected children receive less stimulation and therefore fewer neuron connections. The resultant impediment to gene and brain development can trigger low self-esteem and a lack of sense of 'self', attention and focus difficulties, passivity, learning disabilities, inability to regulate emotions, disassociation and poor academic achievement *(Doyle, C and Timms, C, 2014, 'Child Neglect and Emotional Abuse: Understanding, Assessment and Response. London; De Bellias, M.D., 2005' The Psychology of Neglect. Child Maltreatment10 (2), 150-175; Oates, J, Karmiloff-Smith, A; and Johnson, H.H., 2012, 'Developing Brains.').*

Subjecting a young child to verbal abuse has been found to impact on brain development; in particular, size and the area responsible for processing language and speech. Poor linguistic development in the early years is linked adversely to later adult literacy. A child with limited linguistic development aged five will be in the region of 2.5-4.5 times more likely to have poor levels of literacy in adulthood *(Schoon et al. 'Predictive effect of linguistic development in early childhood on adult literacy at 34 years of age'. Pediatrics 20120; 125:e459-466).*

It is a destructive, self-perpetuating cycle; poor levels of adult literacy have strong links with adverse outcomes during the life course including unemployment and interactions with the criminal justice system. Those whose linguistic development in the early years has been limited are also at twice the risk of poor mental health in adulthood. *(Schoon et al).*

Toxic (as opposed to ordinary) levels of stress impact upon the brain *(Gerhardt S, 2015 'Why Love Matters', Second Edition)* and the stress induced by child maltreatment can alter the physiology of the body. Adverse adrenaline and hormonal changes may affect a child's long term health and wellbeing. For example, prolonged increases in cortisol can lead to diabetes and weight gain *(Doyle and Timms, 2014).*

Recent studies have also connected child maltreatment to adult obesity *(Hemmingsson, E., Johansson, K and Reynisdottir, S. (2014) 'Effects of childhood abuse on adult obesity: a systematic review and meta-analysis.' Obesity Reviews 15, 882-893)* and evidence links neglect with the obesity risk and points to a significant correlation between child maltreatment, obesity and mental health. *(Whitaker, R. Phillips, S. Orzol, S. and Burbette, H.2007 'The association between maltreatment and obesity among preschool children. Child Abuse and Neglect 31, 1187-1199).*

The ways in which the victims of adverse early childhood experiences will be affected, vary in relation to severity, length of exposure, wider family and other support systems and the nature and quality of interventions.

A child born into social disadvantage is likely to be exposed in the first instance to a number of social and material ills (parents/carers with few or no qualifications, unemployed carers, poverty, inadequate housing, and deprived residential areas). These in turn escalate the risk of poor practice in infant nutrition, dietary intake, physical activity, sleep schedules, home learning activities and the possibility of maltreatment (sexual, physical, emotional abuse or neglect).

Yet the early years also offer a beacon of opportunity to deflect the spiral of harm; at no other time span in the life course will so many professions, disciplines and agencies interact with families and children.

There have been positive measures; i.e. the 2006 Childcare Act and a consequent removal of the distinction between 'education' and 'care' for children from birth to five. Also, the new professional in the workforce, the Early Years Teacher (0-5) must meet a particular standard in safeguarding the youngest children in England. Much still remains to be done *(Lumsden, E. 2014, 'Changing landscapes in safeguarding babies and young children in England. Early Childhood Development and Care. 184 (9-10) 1347-1363)* and the statistical picture is not fortuitous.

National statistics at the 31st March 2014 indicate that 48,300 children and young people (conception to over 16) in England were on a Child Protection Plan *(Department for Education, 2013)* owing to concerns about their carers' ability to protect them from harm *(National Society for the Prevention of Cruelty to Children, 2014).* Almost 72% (34,741) were pre-birth to the age of nine. Of these, 1011 were unborn, 5290 under the age of one, 14,090 aged 1-4 and 14,350 aged 4-9. It is also argued that for every one child on a Child Protection Plan, a further eight remain undetected *(Harker, L. Juttle, S., Murphy, T., Bentley, H., Miller. and Fitch, K., 2013 'How safe are our children?' NSPCC: http://www.nspcc.org.uk/Inform/research/findings/howsafe/how-safe-2013-report_wdf95435.pdf)*

A further study *(Cuthbert, C., Rayns, G. and Stanley, K., 2011 'All Babies Count: prevention and protection for vulnerable babies, NSPCC: http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-prevention-protection-vulnerable-babies-report.pdf)* reports that:

- 19,500 babies under one year are living with a parent who has used Class A drugs in the last year
- 39,000 babies under one year live in households affected by domestic abuse in the last year
- 93,500 babies under one year live with a parent who is a problem drinker
- 144,000 babies under one year live with a parent who has a common mental health problem

The figures relate to children who are already involved with services and the longitudinal impact of adverse early childhood experiences on the health and wellbeing during the life course has intergenerational implications.

In addition, the impact of abuse on a child's mental health through the life course and the impact of the mental health of the mother upon the infant can include a range of adverse outcomes including drug and alcohol abuse, suicide, sexualised behaviour and sexually transmitted diseases, depression, anxiety and other psychiatric disorders *(Plant et al, 2013 'Intergenerational transmission of maltreatment and psychotherapy: the role of antenatal depression' Psychological Medicine, 43(3), 519-528, Wave Trust, 2013 'Conception to the age of 2: the age of opportunity, Norman et al,2012, 'The Long Term Health Consequences of Child Physical Abuse, Emotional Abuse and Neglect: A Systematic Review and Meta-Analysis. PLOS Medicine).*
Prevention beforehand is clearly more cost-effective than later intervention and the financial burden to society of the above statistics is huge and encompasses all services; health, education, social care and the law.

Preventative measures to drive positive outcomes in early childhood will entail confronting and tackling the inequalities agenda by devising pro-active policies to narrow the gap between the worst and best off. It will involve a revision of spending priorities, but the cost of doing nothing will be financially and socially ruinous.

It is time for Government to grasp the nettle. Spending more on the early years of life makes moral and social sense and it is also financially prudent.

'The time has come… to invest in policies that keep people healthy…. Thus, science suggests that a more effective approach to health promotion would invest more in the reduction of significant adversity during the prenatal and early childhood periods.'
('The Foundations of Lifelong Health Are Built in Early Childhood', Centre on the Developing Child, Harvard University, July 2010).

Recommendations

1. Single Government Department for Children and Family Life, headed by a Cabinet Minister for Children with a remit to drive and co-ordinate inter-departmental initiatives
2. Increased multi professional training with annual update and revision
3. Integrated (rather than segregated) service provision for children and families
4. Integration of early years' policies on public health, social care and education at national and local level
5. Increased financial investment in the early years, prioritising early identification and support
6. Political recognition and commitment to a prevention agenda across the life course that supersedes political and sector–based ideology and places empirical research and the needs of children and families at the heart of policy

LIFE BALANCE IN THE EARLY YEARS: THE ROLE OF SLEEP

Our need for sleep has intrigued scientists for centuries and recent research in children has uncovered definitive links between sleep and healthy development.

It is known that early child health and development predicates health and wellbeing across the life course and early years' life balance is impacted by the lifestyle, habits and routines of parents or carers. Sleep schedules in childhood are central to family life and shaped by a combination of biological and social influences that affect the amount and quality of sleep that children get *(Mindel JA, Meltzer LJ, Carskadon MA et al. 'Developmental aspects of sleep hygiene: Findings from the 2004 National Sleep Foundation Sleep in America Poll. 'Sleep Medicine 2009; 10:771-9. Adam EK, Snell EK, Pendry P. 'Sleep timing and quantity in ecological and family context: a nationally representative time-diary study.' Journal of Family Psychology 2007; 21:4-19).*

Sleep is restorative, and crucial for the maintenance of physical, psychological and cognitive functioning. The amount of sleep will vary amongst individuals and across the life course. Rachael Mayfield-Blake *(Bupa Health Information Team, October 2012)* has recommended optimum hours linked to age-group:

- Newborns: approximately 17 hours
- Pre school-aged children: 10 – 13 hours
- School-aged children : 9-10
- Teens: 9
- Adults, including the elderly: 7-8

Lack of sleep and/or erratic sleep schedules have been cited as sources of stress with attendant physiological and psychological consequences *(Walker MP, Stickgold R. 'Sleep, memory and plasticity.' Annu Rev Psychol 2006; 57:139-66, Bryant PA, Trinder J, Curtis N. 'Sick and tired: Does sleep have a vital role in the immune system?' Nat rev Immunol 2004; 4:457-5-9, Wittmann M, Dinich J, Merrow M, et al. 'Social Jetlag: misalignment of biological and social time.' Chronobiol Int 2006; 23: 497-509).*

The link between clinically diagnosed 'sleep problems' in childhood and adverse behavioural outcomes has also been well-documented *(Beebe DW. 'Cognitive, behavioural and functional consequences of inadequate sleep in children and adolescents.' Pediatr Clin North Am 2011;58:649-65.)*

However, in non-clinical populations, the picture is less clear and debate has centred on whether disrupted sleep patterns are the consequence, or cause, of behavioural problems.

Recent work has used data from the Millennium Cohort Study to examine if – and how – bedtimes through early childhood relate to markers of child behaviour at 7 years of age *(Kelly Y, Kelly J, Sacker A. 'Changes in bedtime schedules and behavioural difficulties in 7 year old children.' Pediatrics 2013; doi:10.1542/peds.2013-1906).*

Outcomes demonstrated that:

- 7 year old children with irregular bedtimes have more behavioural difficulties (rated by parents and teachers) than children with regular bedtimes
- There were clear 'dose'-response relationships; incremental worsening in behaviour scores as exposure to irregular bedtimes throughout childhood increased
- The effects of irregular bedtimes appeared to be reversible
- Improvements in behaviour scores were seen for children who went from irregular to regular bedtimes
- Worsening behaviour scores were observed in children who went from regular to irregular bedtimes.

Sleep-disruption also affects a child's cognitive development and a recent report *(Kelly Y, Kelly J, Sacker A. 'Time for Bed – associations with cognitive performance in 7 year old children: a longitudinal population-based study.' Journal of Epidemiology and Community Health 2013; doi:10.1136/jech-2012-202024)* examined data from a large, nationally representative prospective population-based cohort study to see whether (and how) reported bedtimes through the early years relate to markers of cognitive performance at 7 years of age.

Key findings revealed that:

- Regular bedtimes were linked to cognitive test scores (reading, mathematics and spatial abilities) throughout early childhood – ages 3 - 7
- Sensitive period effects appear to be influential; irregular bedtimes at age 3 predicted cognitive test scores at age 7
- Cumulative effects were apparent; irregular bedtimes throughout early childhood were linked to lower scores.

Research published in January 2015 by Dr Jane Herbert from The University of Sheffield pinpointed a link between sleeping with the development of declarative memory consolidation (knowledge retention). Studies support that napping after learning new skills helps children retain new information and behaviour, lending credence to suggestions that the time preceding naps is the best time to learn, i.e. reading bedtime stories helps children with memory and other cognitive skills. Healthy development can be impeded and circadian rhythms (body clock) disrupted when consistent sleep schedules are not in place.

Lack of sleep and sleep-irregularity has also been linked to unhealthy weight levels and recent work relying upon data obtained from the Millennium Cohort Study examined the effect of sleep schedules on the development of obesity throughout childhood *(Goisis A, Sacker A, Kelly Y. 'Why are poorer children at higher risk of obesity and overweight? A UK cohort study.' International Journal of Obesity).*

Key findings showed that:

- Sleeping longer was linked to a reduced risk of obesity in 5 and 11 year old children
- Longer sleep duration protected healthy weight 5 year olds against becoming overweight or obese by age 11 and for those with non-healthy weight at age 5, promoted their movement to healthy weight by age 11.

A 2014 study *(Speirs, K., Liechty, J. and Wu, CF (2014) 'Sleep, but not other daily routines, mediates the associations between maternal employment and BMI for pre-school children.' Sleep Medicine. 15, 12, December 2014, 1590-1593 doi:10.1016/j.sleep.2014.08.006)* highlights the fact that children who are not getting sufficient sleep are placed at a higher risk of being overweight or obese within a year and also demonstrate a link between maternal employment status and a child's weight over time.

Children whose mothers worked full time were seen to sleep fewer hours than their peers whose mothers worked less than 20 hours per week. Children of full-time working mothers also tended to have higher BMIs at the second weigh-in.

Results of the study revealed that just 18% of pre-school children in the sample were getting 11-13 hours of nightly sleep and were on average, getting about 9.6 hours of sleep at night.

The study has also shown that each additional hour of sleep at night that a child obtained was associated with a 6.8% decrease in their BMI at the second weigh-in. Additional factors from research that have been found to be associated with shorter infant sleeping patterns include maternal depression during pregnancy, the introduction of solid foods before the age of 4 months and infant TV viewing: *(Nevarez M., Rifas-Shirman S., Kleinman K., Gillman M., Taveras E., 'Associations of early life risk factors with infant sleep duration.' Acad Pediatr. 2010; 10:187-93)*

With this in mind, the new NICE postnatal care quality standard, welcomed by the UNICEF UK Baby Friendly Initiative and including a statement on infant sleep, is timely.

Busy lives and working patterns can leave parents and carers feeling as though they do not have enough time to spend with their children and it might be that bedtimes get pushed back or are not routinely in place as a consequence. But mounting evidence from research shows that child development is best enhanced when daily physical activity is balanced by regularly patterned sleep.

For the health of the child – and thence, the whole family - we cannot skimp on sleep.

Recommendations

1. New national guidance on the importance of sleep to include good sleep hygiene and regular, consistent bedtimes
2. Safe infant sleeping to be discussed with women/partners/main carers at each postnatal professional contact
3. Guidance for parents on screen-based usage; avoidance of TVs/mobile devices in a child's bedroom
4. Child sleep patterns to form part of professional concern and help from Health Visitors/Early Years Teachers

CONCLUSION

The University of Northampton is reflective of many universities across the UK in its provision of undergraduate and postgraduate degrees as well as professional training in the early years. The Early Years is an academic subject area in its own right and The University of Northampton's suite of programmes include the BA (Hons) Early Childhood Studies degree, the Foundation Degree in Early Years, the former Early Years Professional Status and its replacement Early Years Teacher Status (0-5).

'The programmes are delivered by a multi-professional team from health, education and social work backgrounds. We support students to develop their knowledge and understanding of interdisciplinary perspectives on early childhood and provide a holistic understanding of how young children grow and develop from conception to the age of eight.'
(Dr Eunice Lumsden, Head of Early Years, School of Education, The University of Northampton).

If parents and carers are to be properly supported in making optimum choices for young children, it is essential that those who advise them are equipped with the confidence that comes from a sound and (regularly updated) knowledge base.

Sharon Smith, Senior Lecturer in The Early Years at The University of Northampton put three questions to a group of students on the topic of infant nutrition and their answers (below) show the importance of intensive theoretical and practical training for the early years' workforce.

1. **What did you find most helpful to learn about infant/child nutrition?**

'I enjoyed the theoretical knowledge as well as the practical experience from you. The chronic illness session has enabled me to identify when children are unwell due to allergy and intolerance. I have a member of staff who has IBS as well as one child who is severely allergic to a number of foods. We have just recently received funding for pupil premium and I'm sure this will support the children with SEN.'

' I enjoyed looking into the mental health aspect of the module. So many mothers appear to have undetected depression on the birth of a child. I think my sister in law probably developed this and unfortunately, it wasn't so commonly identified a few years ago.'

'Thanks to you as well, Sharon, for your information on health and wellbeing. We have a range of lecturers from a variety of backgrounds and it really supports a well-rounded degree.'

'Learning about the importance of early feeding practices and how those behaviours can affect dietary choices when children are older.'

2. **How did this knowledge impact upon your work in the setting?**

'I currently work in an area of extreme deprivation. There are many parents below the poverty line and the free school milk and dinner scheme has benefitted a number of children in my class. Many parents have English as an additional language and struggle to identify healthy food types for their children. They struggle with the change in diet from their native country. A few children have obesity issues and I have been able to observe, plan and implement activities in order to encourage sport and exercise.'

'A child with a severe allergy is continually monitored and I am now aware of the warning signs when he becomes unwell.'

'My newly acquired knowledge has become invaluable. It has enabled me to become a supportive and confident practitioner. I can also sensitively support my colleague when she becomes unwell during a flare up of IBS. I can support a mother's decision in deciding to breastfeed now thanks to the module.'

'We offer facilities for breastfeeding mothers now at our setting.'

'We now run a healthy eating support group for families in our setting.'

3. **Do you think all early years' practitioners would benefit from further knowledge on nutrition and exercise?**

'Yes, definitely. You never stop learning. I love to gain new knowledge and the module has enabled me to look at my own diet and begin to follow a healthier lifestyle. This positive attitude should be visible by the children and staff I work with. It is a positive use of role modelling.'

'I have developed our outside area to ensure all the children can be more physically active using skipping ropes, climbing frames etc.'

'Yes – my manager said she knew nothing about the extent of child obesity or that there was a child measurement programme in place.'

'I have more confidence in discussing the menus with our chef and in explaining to parents why we don't want children bringing in certain high sugar drinks etc.' *(The University of Northampton, February 2015).*

As can be seen, the influences impacting upon children in the early years will shape the course of their lives and may make the difference between a life marked by health, happiness and wellbeing or one characterised by ill health deprivation and missed opportunity. The need for early years' services to be well-resourced and prioritised by Government would therefore seem to be clear-cut.

However, in an age of austerity, it is imperative that the case for increased funding for the early years continues to be made to political decision-makers and that cross-party consensus is sought:

'By addressing adult behaviours only, without also addressing the conditions faced by families of young children (Government) shifts the focus towards individuals whose health risks have been shaped already and away from the circumstances that shaped them. Thus, science suggests that a more effective approach to health promotion would invest more resources in the reduction of significant adversity during the prenatal and early childhood periods, in contrast to the current disproportionate emphasis on campaigns to encourage more exercise and better eating habits in middle-aged adults.' *(Centre on the Developing Child; Harvard University, July 2010).*

The cost to the exchequer of poor health in middle age, has become a familiar theme for commentators, and the economic argument is a powerful reason for channelling increased funding into early years' services:

'Failing to invest sufficiently in quality early care and education short-changes taxpayers because the return on investment is greater than many other development options.' *('Early Childhood Education for All. A wise investment.' Leslie J. Calman, Linda Tarr-Whelan, Legal Momentum, New York, April 2005).*

In 2015, the year of a General Election in the UK, the political party that will properly resource the window of opportunity that is 'the early years' is also best equipped to safeguard the wellbeing and economy of the nation.

Helen Clark: February, 2015.

NOTES

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