University of Exeter | South-West Social Mobility Commission

A PLAN FOR EARLY ACTION:

Opportunities for Change in Early Years Policy and Practice

August 2024

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Acknowledgements

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About the Author

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The report was overseen by **Dr Anne-Marie Sim** and **Professor Lee Elliot-Major**, in the South-West Social Mobility Commission.

About the South-West Social Mobility Commission

The South-West Social Mobility Commission was set up to bring about transformational change in education and employment outcomes for children and young people from under-resourced backgrounds. Chaired by Sir Michael Barber, it brings together a dedicated and passionate group of civic leaders from across the South-West peninsula to drive cross-sectoral work to break down the barriers facing young people in the region.

We are extremely grateful to receive funding from a core group of key supporters for this work, without which none of this would be possible. These include:

- Cobalt Trust
- Cornwall Council
- Devon County Council
- Great South West
- Somerset Council
- University of Exeter

Foreword

Throughout my career, I have remained close to work in early childhood education and childcare. I began my working life as a primary school teacher and headteacher. Later, as a local authority director of education and chief executive, the early years were always an important part of my responsibilities.

When I led Ofsted as Her Majesty's Chief Inspector between 2002 and 2005, I oversaw the first national registration and regulation of around 100,000 early education providers.

That was followed by my time as Permanent Secretary at the Department for Education during a period when the Labour government's Children's Plan sought to integrate all aspects of work in the early years to ensure that children got the best start in life.

More recently, I was asked by the then Shadow Secretary of State – now Secretary of State – for Education, Rt Hon Bridget Phillipson MP, to undertake a review of the early years.

Although the final publication of my review was overtaken by the calling of the general election, it is clear that early years will be a significant priority for the Labour government. For that reason, this South-West Social Mobility Commission report is a timely contribution to the debate and should be widely read by politicians, policymakers and practitioners.

For me, this report has two important starting points. First, it acts as a reminder that anyone who is interested in social mobility, and making our society fairer and more just, must be interested in the early years. In every sense, they are foundational and, as research has consistently demonstrated, a high-quality experience in the early years can have a profoundly positive effect on children, particularly those from the most disadvantaged backgrounds.

Second, the report encourages collaborative action at the local level, drawing upon work done by the South-West Social Mobility Commission. Combined with a review of existing literature, **the report expertly binds together practice and policy to provide a series of important recommendations including the interesting proposal for an Early Action Group within each local authority**. I welcome this approach as it speaks to the diverse pattern of provision locally and the need to ensure that it is coordinated properly.

It is always tempting for those working in government at any level to 'compartmentalise' the lives of children and families. That is exacerbated by different arms of government having different responsibilities, whether that be in education, health, housing, or welfare.

But that is not the way people live their lives and seek to bring up their children. Rather, every facet of life comes together to provide either a good, or not so good, experience in the earliest years. Therefore, it is incumbent on those in power to ensure that, as far as possible, services are provided in a way that reflects the reality of life.

So, there is no contradiction between supporting children properly in their earliest years – either at home, or in an external setting, or both – as a means of boosting life-long outcomes in education, health, and employment while, at the same time, providing appropriate support for parents, so that they can make the personal and work choices that best suit their circumstances.

Over the past 30 years, successive governments have given much more prominence to the early years than had been the case historically. The 1997 Labour government's Sure Start initiative was groundbreaking as a means of bringing local services together to provide better opportunities for children and their families.

Whilst the Coalition government removed much of the Sure Start infrastructure, the important work done in the later 2010s by Dame Andrea Leadsom was an attempt to reintegrate services via Family Hubs. In addition, there was a significant injection of new money announced in the spring 2023 budget to provide additional entitlement to government-funded places in the early years.

Yet, in doing my pre-election review on the early years, I was struck by the precariousness and complexity of much of the system. That reflected the conclusions of the cross-party Education Select Committee report published in July 2023, which warned of a system that is 'incoherent' and 'overly complex' and one that parents found difficult to navigate.

Not only that, as this report highlights, the previous government's roll-out of new entitlements put at risk the opportunity to use the early years as an engine of social mobility if families are 'priced out' or 'crowded out' from accessing high-quality provision. These impacts require serious consideration and will be important as the 2024 Labour government considers its forward plan for early childhood education and childhood and seeks to make it more sustainable and robust.

This report is also very useful in emphasising the crucial importance of promoting health in the earliest years, whether that is through the vital role played by Health Visitors as the first 'universal service' that new parents encounter, or in promoting good nutrition which has a vital role in dealing with some of the adverse effects of poverty.

The report helpfully reminds us too that adverse childhood experiences can also lead to mental health problems in later life and thus positive, nourishing and affirming experiences in the early years can help build resilience in later life.

There is no doubt that the ambition of providing high quality, affordable, accessible early education and childcare is one that unites parents, politicians and the wider public because it is vital to our collective health and wellbeing, as well as our social, economic, and cultural success as a nation.

With such a consensus, thoughtful and well-evidenced reports such as this one will play a key role as we work together to make the United Kingdom the best place in the world to be a child and to grow up.

Sir David Bell KCB DL
Vice-Chancellor and Chief Executive
University of Sunderland

HM Chief Inspector
Ofsted
2002 – 2005

Permanent Secretary
Department for Education
2006 – 2012

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1 Executive Summary

As the new UK government sets out its programme for the next parliament, one of the policy areas vying for its attention is early years: the health and educational development of children, aged 0-5. **This report sets out the compelling reasons why early years needs to be given urgent attention to address the loss of childcare places, the crisis in recruitment and retention in both health visiting and early years provision, and the lack of resource and funding in local government.**

The scale of the challenge in early years is national. Underfunding, underappreciation and misunderstanding are widely seen as universal problems within the early years sector across the country. Yet the South-West's challenges are compounded by regionally unique factors: its rurality causes greater isolation; the scale of nursery closures in the South West is greater than anywhere else in the country; and take-up of the national Healthy Start scheme is lower here than in any other region.

The statistics across early years are truly shocking. Last year:

- **Health Visitors reported a 91% increase in poverty issues;** an 83% increase in perinatal mental illness; a 75% increase in domestic abuse; and a 60% increase in child safeguarding concerns compared with the previous year – showing the rocketing level of need.[1]
- **Fewer than half (46%) of infants eligible for Free School Meals in the South West reached expected levels of development at age 5** – the lowest proportion in the country.
- **The number of FTE Health Visitors in England reached a record low**, decreasing by 40% since 2015 (with 6,688 Health Visitors remaining). In the South-West peninsula, every local authority except Cornwall was below the England average for the number of New Birth visits delivered within 14 days.
- **The South West lost over 30,000 childcare places**, whilst nationally around 25% of the average wage is now spent on childcare (a 171% increase since 2000).
- **Only 57.5% of families in the South West eligible for the government's Healthy Start scheme**, aimed at providing nutrition to pregnant women and infants, were enrolled on it.
- Despite growing need, **48% of NHS mental health professionals surveyed said they have no experience** working with children aged 0-2.

The recommendations in this report are intended to improve social mobility at an early stage of life, which – it is widely acknowledged – is foundational to future success. From poor speech and language development to childhood trauma, difficulties in the early years are not simply an obstacle for healthy development in the 0-5 age group, but for future years too. While long-term, large-scale investment in the sector is needed, this report's recommendations aim to address some of the sector's urgent issues through low- and no-cost solutions that can be implemented a) locally and b) relatively quickly.

The report calls for local authorities – alone or in clusters – to establish Early Action Groups to tackle these issues with a series of educational and health interventions. These groups are designed to enable Councils to use their convening power to bring together the public, private and voluntary sector in the cause of implementing four core ideas:

1. **Making health visiting a universal gateway service,** including promoting parent-infant reading and recording progress in a new reading log to accompany the red book and being able to trigger a multi-agency visit where there is parental need.
2. **Engaging multi-academy trusts and schools** to support with early years workforce development – through training and qualifications offered at their sites.
3. **Making nutritional guidelines mandatory** rather than voluntary.
4. **Establishing a new Cabinet Member for Infants within Councils** to prioritise action on early years.

1 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

1.1 Headline Findings

We have investigated four distinct areas of early years provision:

- Health Visiting;
- Childcare and School Preparedness;
- Nutrition; and
- Mental Health.

Health Visiting

Health visits are mandatory from birth to the age of two to two-and-a-half years but there are challenges in the way health visiting is delivered that causes concern among professionals and has an impact upon delivery of the service.

- A clear problem with recruitment and retention exists across the country: the number of FTE Health Visitors has reached a record low – and interviewees attributed this to older staff retiring and not being replaced; better pay and conditions elsewhere in the NHS and beyond; and a number of Health Visitors taking on second jobs within the NHS, remaining as Health Visitors for just one to two days per week.
- The delivery model of health visiting has been unintentionally impacted by the way that local government commissions the service. Interviewees said that health visiting was previously delivered on a geographic casework basis, but that this is increasingly delivered on a first-come, first-served basis. The former means that Health Visitors had a better understanding of the family and would make informal visits when in the area; the new approach prevents that and means – in extreme circumstances – that families with two infants or more don't necessarily have the same Health Visitor for both children.
- The pressure on Health Visitors is also changing as increasingly they are expected to deal with parental issues like drug abuse, financial issues and domestic abuse problems. This reflects the fact that they are often the first (or only) social service that the parent encounters and because other forms of support are limited, or unavailable, at a local level.
- This led interviewees to raise concerns about the extent to which children's services have become 'parent services' – and nobody in positions of power or decision-making has a responsibility for seeing the infant. It was the view of several professionals that local authorities do not allocate discretionary spend to initiatives for infant development, focusing on other age groups and social issues instead.
- An example of innovative practice to prepare children for school was shared by one interviewee who said that Health Visitors within their service promote and support parent-infant reading, both to develop speech and language skills, but also to encourage early literacy development. This is an example of good practice which, combined with a monitoring framework across the visits, could support children (and especially those in deprivation) to meet EYFS goals relating to speech, language and communication.

Childcare and School Preparedness

The government funding for childcare that expanded the roll-out of additional free provision from April 2024 is a double-edged sword: on the one hand it is welcomed by parents and some charitable-status childcare providers, but most providers are concerned that it represents an "expanded underfunding."

- The government funding per hour is still not sufficient to meet the actual per hour costs of looking after a child and so providers are either having to charge additional fees (for sustenance, etc.) or to absorb the operating costs themselves, by keeping staff wages low and cutting corners elsewhere.
- The social mobility implications raised by interviewees are concerning: interviewees fear that some providers will turn away infants whose parents require funded placements in favour of those whose parents can pay full fees, to keep the provider financially afloat.
- The only provider type that welcomed the additional funding was a charity-run nursery which said that it often provides for children for free, as parents cannot afford to pay anything, and so the expanded funding was better than not receiving any financial support at all.
- There is also a concern about the pace and scale at which local authority areas are losing childcare places. This has the potential to escalate if the concerns about the "expanded underfunding" are correct and borne out.

Nutrition

Nutrition is important to child development and growth and there is a substantial literature to support this, both nationally and globally. Poverty is closely linked to poor nutrition – and this is also widely understood.

- However, whilst government guidance exists for nutritional standards in early years settings, these are often not followed or not known by childcare providers. This is usually because either the provider cannot afford to spend money that they do not have on higher quality foods or because they were not aware of the government guidance.
- By contrast, we found that higher standards of nutrition exist in EY settings run by academy trusts, because those trusts often provide their EY classes with the same meals as their primary pupils (for whom mandatory government standards must be followed).
- Whilst there is government support available to families in the form of Healthy Start, take-up of this support is 62% nationally and lower in the South-West region.

Mental Health

A recent review has identified that the percentage of infants with mental health issues is likely similar to adolescents with such problems (16-18%). Moreover, it was the view of health experts interviewed that infant trauma and attachment issues can lead to mental health issues in later childhood, adolescence and even adulthood.

- Interviewees reported that mental health problems in young people can be caused by adverse childhood experiences (ACEs) in infanthood which lead to attachment issues in later childhood and adolescence.
- Particular note should be paid to the issue of infant mental health in the South West, given above average rates of mental health issues amongst both children and adults.[2]
- One interviewee said that their Family Hub has developed a specialism in infant mental health and infant counselling, but the roll-out of this kind of service is limited by the lack of expertise in this area of child psychology and, therefore, by the prohibitive fees charged by those working in it.

2 Anne-Marie Sim and Lee Elliot-Major (2022). "Social Mobility in the South West: Levelling up through education". Available at: **https://www.exeter.ac.uk/media/universityofexeter/newsarchive/researchgeneral/Social_Mobility_in_the_South_West_Report.pdf**

1.2 Our Recommendations in Full

We propose that local authorities should set up an Early Action Group, to bring together council, NHS, business, third sector, schools and multi-academy trusts, and childcare/nursery partners, to deliver on the following recommendations:

1. Enable Health Visitors to Trigger a Multi-Service Visit

Health visitors are not only in contact with the infant but with parents. Often they will be the first contact with any form of social service that parents have – and it is the case that they are being confronted with problems outside of their remit. This occurs within the context of 86% of surveyed Health Visitors saying that other services do not have capacity for onward referrals.[3] We propose that local authorities should provide published guides which signpost parents to the correct social service which Health Visitors can hand over to ensure their focus is on the infant. Councils should be prepared to send other social service professionals (such as welfare rights advisors or drug abuse counsellors) with Health Visitors so that a multi-service approach to the wider family is delivered: our suggestion is that Health Visitors should be able to trigger these joint visits.

2. Signposting on Day One

It is proposed that Health Visitors should signpost two vital services to parents on the first visit: the Healthy Start scheme and local mental health support (including introducing the concept of infant mental health).

A) Include a Healthy Start Eligibility Assessment

There is a need to increase awareness and promote take-up of the Healthy Start scheme, ensuring that parents are aware of their entitlement. The Institute for Public Policy Research notes that Health Visitors can have a positive impact upon nutrition by providing advice to parents.[4]

Health Visitors should include as part of their discussions at Visit 1 a consideration of whether the family is eligible for Healthy Start vouchers and understand the barriers (e.g. lack of internet connection, literacy issues, financial literacy problems) that might stop an eligible family from applying. Signposting to welfare rights services within the local authority should also take place at this meeting, for advice on wider benefits entitlement, if the Health Visitor has concerns about the family income emerging from the discussion about the Healthy Start entitlement. (See Nutrition chapter for further details on the Healthy Start scheme.)

B) Signpost Mental Health Services

A review by the Scottish government found that infants with mental health issues are isolated from services that might support them because of a lack of parent engagement – and particularly so during COVID.[5] As the NHS introduces mental health services for infants aged 0-4, it is recommended that Health Visitors should explain to parents the importance of good mental health and advertise what services are available in the South West – and how these can be accessed. In thinking about adult mental health and how this can impact upon infants, the Health Visitor should also signpost the adult counselling and mental health support services available in the local area (including virtual services where travel may be a barrier).

3. Develop Attachment and Literacy through Reading

Local authorities should provide a supplementary reading log, to accompany the red book, in which parents should record examples of literacy activities that they have undertaken with their children. Public Health and Children's Services departments could collaborate on developing infant libraries or resources to give away to bookless households to encourage the practice of reading to, and with, the child. Health Visitors could then engage in discussion about the log at the time of the fifth visit to review the reading that parents have done with their children over a circa 18-month period. This is already done in some parts of the country (minus the reading log, which we propose to formalise and document this arrangement). See Appendix Two for an example of what this may look like.

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3 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

4 Dean Hochlaf and Chris Thomas (2020) "The whole society approach: Making a giant leap on childhood health". Institute of Public Policy Research. Available at: **https://www.ippr.org/articles/the-whole-society-approach** and Rebecca O'Connell, Abigail Knight and Julia Brannen (2019) "Living Hand to Mouth". Child Poverty Action Group. Available at: **https://cpag.org.uk/news/living-hand-mouth**

5 Scottish Government (2022). "Infant mental health: evidence review". Available at: **https://www.gov.scot/publications/infant-mental-health-evidence-review**

4. Geographic Caseload

When commissioning health visiting services, councils should seek an agreement in advance that providers will deliver health visits based on geographic caseload, as described in the report, and not use a first-come, first-served system for visits. There will be challenges relating to staffing and availability of full-time staff, but where possible this should be achieved. It should be a priority that families with multiple children do not have different Health Visitors for each child.

5. Monitor Childcare Child:Place Ratio

Local authorities should work together on a regional basis to continue to monitor the child:place ratio set out in Figure 7 of this report. This can be used as a tool to report to government on the state of the sector and make the case for additional funding to expand provision within the sector, according to need. This information will be important to national government too, to ensure that new places are prioritised in areas where they are most needed, not simply where space allows.

6. Cabinet or Deputy Cabinet Member for the Infant

In addition to their main cabinet members, several local authorities now have a system of deputy cabinet members who have responsibilities within a specific remit. We propose that Council Leaders should consider appointing a joint deputy to the cabinet member for Children's Services and Public Health (or otherwise allocate this to a full cabinet member position). This person will have responsibility for 'seeing the child' within the local authority; for promoting better cooperation and data sharing between health and education teams within the Council; and be the point of contact for childcare providers concerned about the financial situation. This person may also be the Chair of the proposed Early Action Group if its geography is coterminous with the local authority area.

7. Support Better Transition

A perception that school Reception classes often expect children to be ready for them, rather than schools being prepared for children as they are, suggests a rigid and inflexible approach to transition. It is therefore recommended that schools and multi-academy trusts work more closely – as members of the Early Action Group – to develop transition strategies (which may include nursery visits, improved data sharing through the Group and more visits for nursery children to the school setting) that address this concern. One means of doing this is to consider – where possible – the introduction of a Cradle to Career (C2C) model, as outlined in the case study.

8. Careers Advice Made Simple

People seeking to enter the early years workforce, who are often mothers of young children considering a career change, are put off by poor careers guidance, an array of inappropriate qualifications and a lack of clarity about initial steps into the sector. We propose a simple but authoritative recruitment poster (which can be localised on a council-by-council area basis) to be displayed in Family Hubs, schools, doctors' surgeries, supermarkets and other key locations where potential career switchers might visit. An example of this is displayed at Appendix Three.

9. Explore opportunities for multi-academy trusts to support Early Years workforce development by offering training and qualifications through their school settings

Based on the success of the Reach model, we recommend that the Early Action Group should explore the role of multi-academy trusts in supporting routes to formal Early Years qualifications through their school settings. Partnership between trusts and their local FE or HE provider could be facilitated by the Early Action Group.

10. Drive take-up of government Early Years nutrition guidance through 4 steps:

A) Issue clear, simple guidance to all early years providers

We suggest local authorities develop and circulate a pamphlet to all early years providers registered with them, setting out key tips from the government's guidance document on nutrition and food preparation. The British Nutrition Foundation's graphic which displays meal planning guidance in simple terms should be shared alongside this. Both documents can be found at Appendix Four.

B) Develop a local EY Food Standards Charter

As a further step, we suggest that local authorities develop a local Food Standards Charter based on the government's guidance, to which they ask early years providers to sign up. This could be accompanied by a form of accreditation that providers can use to show that they are a 'good nutrition' provider. See Appendix Five for a version of this designed for use within North Cornwall.

C) Put on Continuous Professional Development workshops for smaller providers

To support smaller and private sector childcare providers, the local authority or a partner organisation should offer occasional one-day, or half-day, workshops on nutrition. These could discuss key issues and low-cost solutions such as the importance of using neutral language to describe foods, how to promote healthy eating, and how to procure ingredients for healthy meals at low cost to the provider. Responsibility for this could be delegated to partner organisations within the Early Action Group such as a multi-academy trust that has the capacity to deliver training or a private catering company, some of which offer training of this kind as part of their corporate social responsibility activities.

D) Lobby central government to make guidance mandatory

Finally, we recommend that local authorities' Directors of Children's Services (or equivalent) and related Cabinet Members write to the Secretary of State for Education and the Minister of State for Local Government to request that government considers making nutrition guidelines mandatory, rather than voluntary.

11. Expand the Specialist Psychologist Base

The lack of professional psychologists working in the field of infant mental health means that, even if every Family Hub had the financial resource to hire one, there would be too few to do so. The small number of specialists in the field also means higher costs for those who do use them. South-West local authorities and Family Hubs should therefore speak with one voice to government about the need to provide training in the area; to create new routes to retraining and specialising; and to funding these posts.

12. Councils Should Coordinate the Third Sector and Childcare Settings

The Scottish review identified the need to coordinate the voluntary sector with statutory services.[6] This recommendation goes one step further and suggests that councils should seek to join up mental health providers in the third sector with childcare settings, to enable promotional work, sessions with parents to raise awareness, and referrals (where concerns exist in relation to a specific child). Encouraging third sector partners to deliver mental health support virtually and in conjunction with other services (such as Family Hubs) to overcome the challenges of rurality and isolation is especially important in places like the South West – or where physical services are not easily accessible.

13. Elected Members Should Put Infant Mental Health on the Political Agenda

Councillors have the ability to scrutinise and to raise awareness through campaigns. They are influential in their ability to influence partners and the direction of their own local authorities. It is recommended that cross-party groups – such as Health Scrutiny Committees – should build infant mental health into their scrutiny work programming, ask questions of the relevant Cabinet Member about services in the area, and use funding available to them (or over which they have influence) to help develop the third-sector offer in the infant mental health space.

6 Scottish Government (2022). "Infant mental health: evidence review". Available at: **https://www.gov.scot/publications/infant-mental-health-evidence-review**

2 Introduction

Giving an infant a best start in the early years (0-5 years) relies upon a series of health and educational interventions – and that responsibility falls variously to parents, local authorities, national governments, nurseries, Health Visitors and others.

This report makes recommendations primarily for local authorities in addressing the key challenges within the early years system, based on the themes highlighted in interviews with early years experts and practitioners from each of these professions. This is particularly important in the context of budget constraints: as councils seek to do more with less, there is a clear indication that investment in early years provision is not usually considered beyond statutory requirements.

The aims of the report are threefold:

- To share best practice for improving social mobility in the early years, offering low-cost and no-cost approaches to enhance provision.
- To influence the way that organisations 'see' infants – and especially local authority Chief Executives, given the regional focus of the South-West Social Mobility Commission.
- To speak up for, and represent the views of, early years sector workers, who we have interviewed, who feel like they are overlooked and unheard by those in positions of power and influence.

In the interests of pragmatism, the report concludes with an implementation chapter taking North Cornwall as a proposed pilot area. The chapter considers the practical steps to implement the report's recommendations, potential barriers, and reflections on whose participation or 'buy in' is needed to make them happen. The report also provides within its Appendices a series of tools that can be used as starting templates for implementing several of the recommendations.

Relation to existing Early Years policy

In recent years, the previous government commissioned, and subsequently began to implement the findings of, a review into early years. Dame Andrea Leadsom's "The Best Start for Life: A Vision for the 1,001 Critical Days" was published in 2021 and focused on the period from pregnancy to age two.[7] Its recommendations fell into two main areas:

Improving access to services

- Offering a seamless, joined-up Start for Life programme to all families.
- Establishing Family Hubs as a place for families to access Start for Life services.
- Providing digital, virtual and telephone offers to meet access requirements.

Joining up different parts of the system

- Developing the workforce to meet the changing needs of families.
- Improving data, evaluation and inspection to keep the Start for Life offer up to date.
- Establishing local and national leadership for change within the sector and to make the economic case for early years.

This report builds upon this foundation – and, indeed, has included interviews with some of the people responsible for implementing Leadsom's recommendations. The themes of access, information sharing, meeting families' differing needs and providing support to the workforce all appear throughout this report.

Whilst the new Labour government is yet to set out detail around its early years approach, where relevant the report also comments on Labour proposals relating to the early years, as referenced in its manifesto.

Structure of the Report

The report does not try to speak about the entire sector or all its problems; instead, it makes interventions in four key areas. Namely:

- Health Visiting;
- Childcare and School Preparedness;
- Nutrition; and
- Mental Health.

Each section of the report contains reflections from the expert interviews that have informed the recommendations. A list of recommendations specific to each theme is presented at the end of each section. These recommendations are principally for local government, but some are necessarily aimed at national government, given the scale of the challenge and the unavoidable subject of government funding.

7 Andrea Leadsom (2021). "The Best Start for Life: A Vision for the 1,001 Critical Days".

3 Health Visiting

3.1 Key points:

- Five mandated health visits constitute the principal and sometimes only touchpoint prospective parents and babies have with professionals until children enter early years settings.
- For the most part, the five visits are taking place although there are concerns in some parts of the region, especially Devon.
- Delivering these mandated visits to a high standard is being challenged by workforce recruitment and retention issues and changes to how they are administered.
- The content covered in each visit is prescribed but can be derailed by increasing levels of parental need, e.g. around substance abuse or domestic abuse.
- Our recommendations focus on implementing a place-based health visiting service, enhancing literacy and providing troubled families with the right social service support.

3.2 Health visiting in England: key touchpoints between families and professionals in the first 1,001 days

Infants in England, from birth to age two, are offered Health and Development Reviews by professional Health Visitors as part of the Healthy Child programme. Health Visitors conduct the reviews, which occur either in the home, GP surgery, baby clinic or children's centre.[8]

The aim of the Healthy Child programme is to "ensure that all children are ready to learn at two and ready for school at five" by helping to "establish vital foundations for good health and development".[9]

Following the birth of a child, parents are issued with a Personal Child Health Record (PCHR) known colloquially as the 'red book', due to the red cover. This is intended to record information about the child's health – including height, weight and vaccination status – and it contains records inputted by health professionals as well as parents (e.g. records of illness).[10]

In 2015, the responsibility for health visiting in England transferred from the NHS to local government. This was part of a wider transfer of Public Health responsibilities from the NHS to councils, meaning that all health commissioning for young people aged 0 to 19 (and up to 25 for those with SEND) now falls within the remit of local government. There are two exceptions to this, with two services remaining within the NHS:

i) **Child Health Information Services (CHIS)** – the health records, 'red book' information and other information (such as review datapoints) about a child are contained within an IT system which is commissioned by NHS England. A 2020 review was set to consider whether this too should be transferred to local government but, as of 2023, it remains an NHS service.[11]

ii) **The 6-8 week GP check** (known as the Child Health Surveillance) due to the complexity of the commissioning of this service.[12]

8 NHS (2023). "Your baby's health and development reviews". Available at: **https://www.nhs.uk/conditions/baby/babys-development/height-weight-and-reviews/baby-reviews/#:~:text=You%20will%20be%20offered%20regular,a%20member%20of%20their%20team**

9 UK Health Security Agency (2017). "Continuing the mandation of the universal 5 health visiting checks". Available at: **https://ukhsa.blog.gov.uk/2017/03/01/continuing-the-mandation-of-the-universal-five-health-visiting-checks/**

10 NHS (2023). "Your baby's health and development reviews". Available at: **https://www.nhs.uk/conditions/baby/babys-development/height-weight-and-reviews/baby reviews/#:~:text=You%20will%20be%20offered%20regular,a%20member%20of%20their%20team**

11 Local Government Association. "Child Health Information Services". Available at: **https://www.local.gov.uk/topics/social-care-health-and-integration/public-health/children-public-health-transfer/child-health-information-services**

12 Local Government Association. "Children's public health transfer". Available at: **https://www.local.gov.uk/topics/social-care-health-and-integration/public-health/children-public-health-transfer#:~:text=The%20Healthy%20Child%20Programme%20(HCP,the%20overall%20public%20health%20transfer**

One interviewee (in an NHS role) said that the downside to this transfer was that local government finance is more strictly regulated than NHS spending. They said that the NHS has a culture of 'spend now, worry later' whilst councils had to retain balanced budgets by law.

The UK Health Security Agency (formerly Public Health England) outlines the timing and intention of the 5 health visits which local authorities are mandated to undertake:

Visit 1 – 28 Weeks Pregnant – Health Promotion

Health Visitor completes a health needs assessment with the parent(s) covering physical health (e.g. not smoking, breastfeeding), mental health and emotional health. Discusses parenthood and supporting child development.

Visit 2 – 10-14 Days Old – New Baby Review

Health Visitor checks the health and wellbeing of the parent(s) and baby. Discussion includes early bonding, feeding, baby weight, immunisation and safety measures such as car seats. Provides advice on crying, routine and sleep.

Visit 3 – 6-8 Weeks Old – 6-8 Week Assessment

Looks particularly for signs of postnatal depression, discusses progress with breastfeeding and immunisation, and specific issues relating to sleep. Health Visitors promote local services at this stage.

Visit 4 – 9-12 Months Old – One Year Assessment

Examines growth, development and immunisation status of the infant. Dental health, nutrition and safety discussed at this meeting.

Visit 5 – 2-2½ Years Old – 2-2½ Year Review

Identifies specific behavioural and speech and language issues. Checks development of the child and promotes other services to help the family prepare the child for school.

3.3 State of health visiting in the South-West peninsula

This section looks at the extent to which the mandated health visits are being delivered at the correct point.

The following charts use NHS Health Visitor Delivery metrics data for the year 2022-23. They demonstrate how areas within the South West compare to the regional and England average for delivery of these health visits from the point the child is born.

As these charts show, the South-West peninsula performs below the England average for the initial visits, but above the England average for timely delivery of the latter two visits. In some of these areas, we see that many of the visits are missed or not delivered on time.[13]

However, when speaking to Health Visitors, there was a general sense that this data should be treated with caution. One Health Visitor said that if a parent has a scheduled appointment on a Friday, but cancels and reschedules for the following Monday, this will count as a late visit, despite the very brief period between the original and actual appointment. In this sense, the quality of the visit was seen as more appropriate – and the way in which casework is allocated (which is discussed in greater depth under 'Geographic Focus').

13 In two instances, no data is available (either because it was not statistically valid or not reported by the local authority).

New Birth Visits

Figure 1 demonstrates that whilst Devon delivers the highest percentage of new birth visits overall (99%), only 34.1% of these were within the first 14 days during the year 2022/23. Only Cornwall, at 84%, exceeded the England average (79.9%) for the number of visits delivered within 14 days.

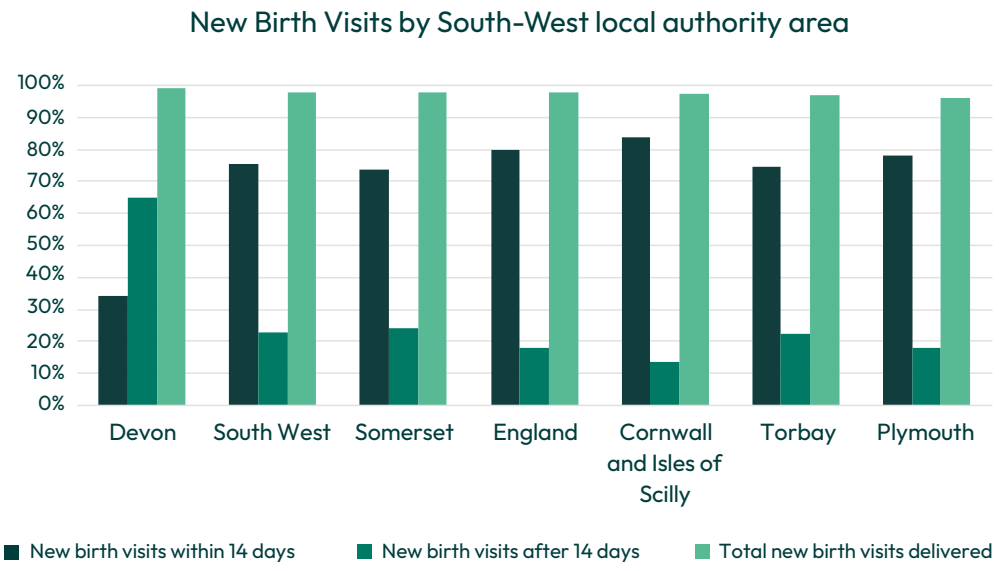

Figure 1: Percentage of New Birth Visits delivered within and after 14 days, by local authority area (Source: DfE and ONS: April 2024)

6-8 Week Visits

Figure 2 shows the percentage of 6-8 Week Reviews taking place in each area. The England average for 2022/23 was 79.6% and the South West average was 76.6%. Somerset, Cornwall and Isles of Scilly and Torbay delivered a 6-8 week visit in over 90% of cases, but for Plymouth this was 33.4% and for Devon it was 4.9%.[14]

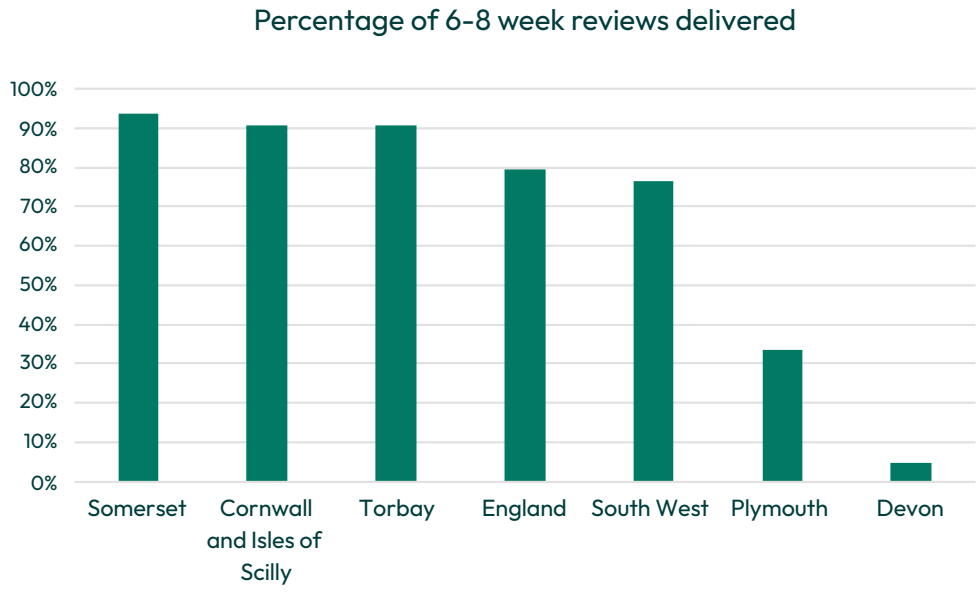

Figure 2: Percentage of 6 Week Reviews delivered, by local authority area (Source: DfE and ONS: April 2024)

14 A caveat to this is that the data surrounding health visits was submitted to the Office for Health Improvement and Disparities (OHID) on a voluntary basis. The data is therefore limited to reflecting what was submitted on an authority-by-authority basis, rather than a more objective, universal picture of the region.

12 Month Reviews

Figure 3 shows the percentage of 12-month reviews delivered within a) 12 months and b) 15 months. Torbay and Plymouth did not report data for the visits delivered by 15 months, though both (along with Somerset) outperformed the England average for delivery within 12 months.

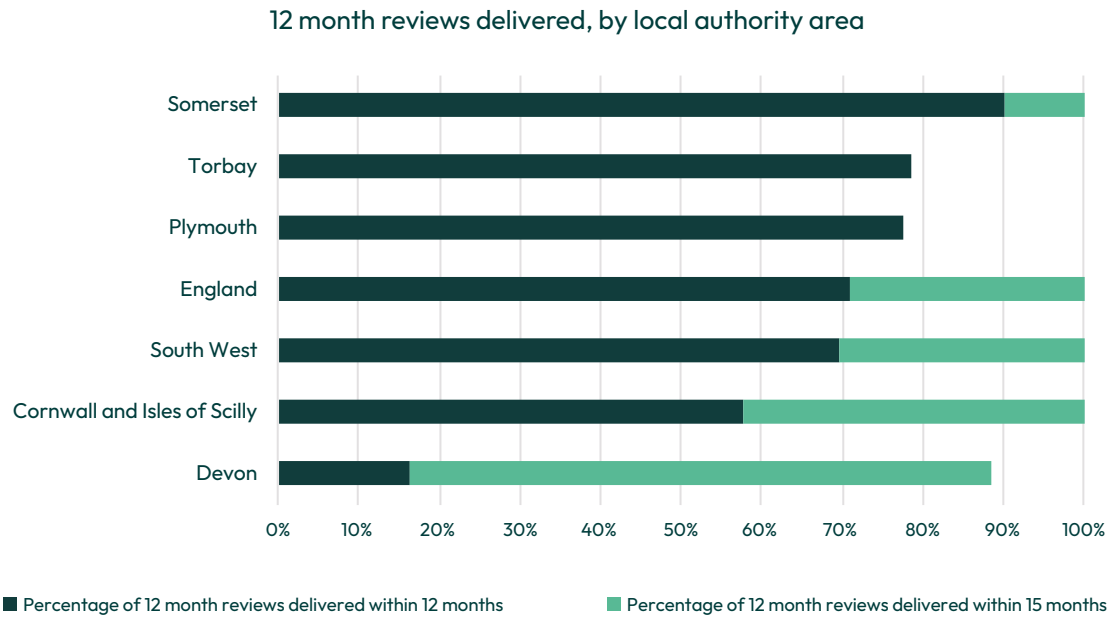

Figure 3: Percentage of 12 Month Reviews delivered, by local authority area (Source: DfE and ONS: April 2024)

2 - 2½ Year Reviews

Figure 4 shows the percentage of 2 - 2½ year reviews delivered by local authority area.[15] The England average is 73.6% and the South West average is higher, at 76%. All areas exceeded both the England and the South West average, except Devon – which achieved just 21.3% of reviews at this stage.

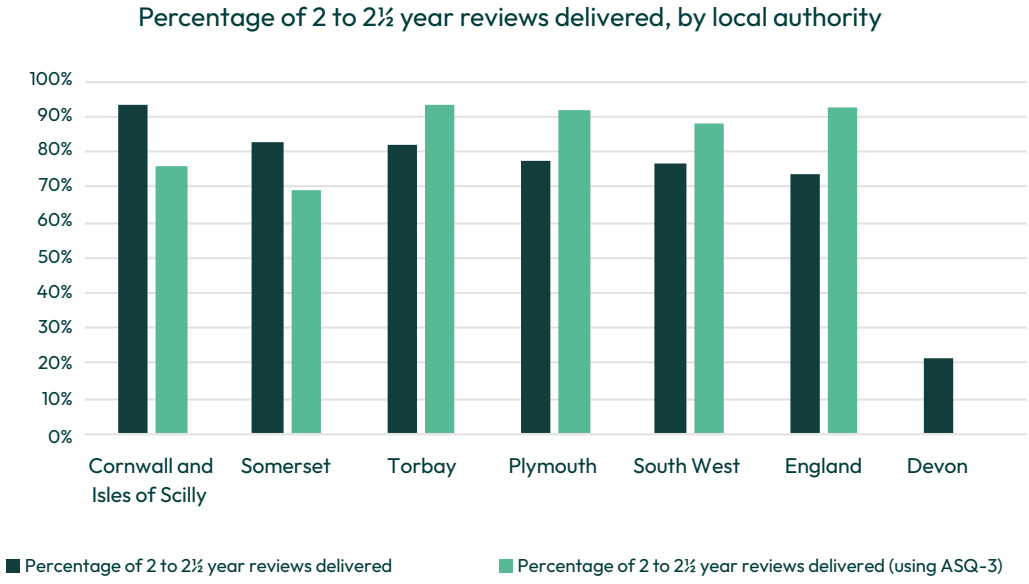

Figure 4: Percentage of 2-2½ Year Reviews delivered, by area (Source: DfE and ONS: April 2024)

15 Where a review is said to have been delivered using ASQ-3, this refers to the use of the specific Ages and Stages Questionnaire 3, which screens for development in communication; gross motor; fine motor; problem solving; and personal development. When the use of ASQ-3 is not specified, this is because the survey was not used (alternatives such as the Bayley Scales exist) or not reported to have been used by the local authority.

3.4 Recruitment and retention

Health Visitor interviewees and others from NHS backgrounds were clear that the challenge of recruitment and retention, prevalent in other parts of the early years sector, was acute in their profession.

The story in health visiting, though, is slightly different to in nurseries for example – not least because two interviewees reported that the health visiting profession is losing staff to other parts of the NHS, rather than to other sectors entirely.

In 2015, the number of FTE Health Visitors in England reached 11,192 – a record high by recent standards. However, this proved to be unsustainable as this began to decline in the years that followed. By 2023, only 6,688 FTE Health Visitors remained – a decline of 40%.[16]

One Health Visitor interviewee who doubles up as an NHS manager said that one of the concerns within the profession is that many Health Visitors are older women and that, as they retire, they will not be replaced at the same rate. This is supported by evidence that 85% of surveyed Health Visitors believed that there are not enough people in the profession.[17] Moreover, the Local Government Association notes that the number of trainees entering the profession has not met the scale of demand.[18]

This loss of talent has deep professional consequences. Two Health Visitors described different situations in which inexperienced Health Visitors were being confronted with a multitude of problems when entering the family home – and that they did not know how to navigate this situation. Parents would, for example, present signs of domestic abuse, suffer with drug and alcohol addiction or discuss financial hardship with the Health Visitor on the basis that they are often the first form of social service the parent has encountered.

- One interviewee said that the loss of institutional knowledge from within the profession has led to a lack of knowledge sharing or practical advice about dealing with such matters.
- Another interviewee said that the reliance upon agency staff meant that Health Visitors did not have the familiarity with a family context that another non-agency worker might have had. They said that, in part, the reliance upon agency staff is not just down to people leaving the profession, but also to NHS Health Visitors taking on other roles (e.g. a management role) and only conducting health visits for one or two days per week.

In addition to older staff retiring and not being replaced, interviewees also highlighted other causes: namely, that there are better pay and conditions elsewhere in the NHS and beyond.

3.5 Health professionals' concerns about 'seeing the child'

Among health professional interviewees, there was a prevailing view that people in positions of power and influence – at local and national level – do not fully recognise the importance of a child's early years (or, if they do, they are not doing enough about it).

These interviewees said that too many of those who are involved in an infant's life do not see the child; instead, children's services are often better understood as parent services. Some interviewees saw this in negative terms (believing it led to services neglecting the infants) whilst others thought that helping parents had direct, positive consequences for children. Putting aside whether this is a positive thing or not, there was a consensus view that services intended for children are often parent focused.

16 Fiona Simpson (2024). "Plan to Boost Number of Health Visitors". Children and Young People Now. Available at: **https://www.cypnow.co.uk/analysis/article/plan-to-boost-number-of-health-visitors#:~:text=Over%20the%20past%20eight%20years,6%2C688%20in%20April%20last%20year**

17 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

18 LGA (2019). "The reduction in the number of Health Visitors in England, House of Commons, 23 October 2019". Available at: **https://www.local.gov.uk/parliament/briefings-and-responses/reduction-number-health-visitors-england-house-commons-23**

In what ways does this failure to 'see the child' manifest? Examples given by interviewees were:

- Physical spaces that are designed for adults, but not for infants – such as children's centres with no access for prams and pushchairs.
- Health visits which are more focused on dealing with substance addiction or domestic abuse, with little time given to discussions of the child's welfare, because the Health Visitor is preoccupied with adults' issues.
- Budgeting decisions made by local authorities in which senior policymakers do not consider funding or enhancing their early years provision beyond the statutory duties imposed upon councils by government.
- Perhaps controversially, parents who do not consider it their responsibility to take their child to appointments, to engage with services or to understand the development needs of their children.

Each of these is an example offered by interview participants of how, in their view, infants are often seen as secondary – either by accident or design – by the very services that are designed to improve their education, health and wellbeing. Instead of being child focused, these services are either geared up towards adults or otherwise do not have someone in a position of authority (e.g. within the Council's budgeting process) who is actively championing infants.

Some, though not many, did defend the policy of the 'parent' service approach. Largely this emerged from the view that parents are the primary care givers and that there is little point providing high-quality childcare or health services if the primary care provider (i.e. the family unit) was not capable of providing adequate care. That is to say, the view of some professionals is that government must think about how to solve the problems of adults, so that those adults can be good parents. If their problems (whether they are health related, financial or educational) linger, then they will be less well equipped to provide for their children.

These interview findings – i.e. not 'seeing the child' because of parents presenting their own needs – are supported by a 2023 survey by the Institute of Health Visiting in which Health Visitors reported, compared to the 2022 survey, a 91% increase in poverty issues; an 83% increase in perinatal mental illness; a 75% increase in domestic abuse; and a 60% increase in child safeguarding concerns.[19]

3.6 Geographic caseload

In speaking to Health Visitors working in England, there is a clear sense that the commissioning process – which has led to an inconsistent approach from authority to authority – sometimes produces a poorer quality service through seemingly innocuous decisions. One such example is the backroom administrative process and how Health Visitors are assigned to families.

One Health Visitor explained that their NHS Trust has adopted a 'first come, first served' administrative system (in part due to the number of part-time and agency Health Visitors and in part to save costs) which sees infants allocated to Health Visitors based on their place in a queue. Previously, they explained, the casework was assigned based on postcode. Each Health Visitor would be assigned a geographic area and all families within that defined geography would be 'their' family. This meant that – as the interviewee put it – they could conduct a formal visit but 'pop in' to see another of 'their' families whilst in the neighbourhood, leading to more familiarity with the family and more visits to check on the infant's health than mandated. It also meant that the Health Visitor had a deeper knowledge of local children's play groups, for example, and could refer isolated mothers and assist them to make new friends.

The 'first come, first served' approach may deliver the mandated visits, but it does not enable the degree of familiarity and additional visits that the geographic casework allocation did. This is supported by a 2023 Institute of Health Visiting report which found that only 3% of Health Visitors in England provide families with a continuity of Health Visitor (compared to 88% in Scotland, 80% in Wales and 87% in Northern Ireland).[20]

19 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

20 **Ibid**.

That said, we acknowledge that the benefits of geographic approach were reported by interviewees in two areas and is not a guarantee in and of itself to lead Health Visitors to take this proactive approach. The fact, though, is that this approach does at least enable it to happen.

We also know, from a 2013 report, that Health Visitors experience greater job satisfaction (and are therefore more inclined to stay in the profession) when they have professional autonomy, flexibility to respond to local need, and are connected to families and communities.[21]

That the geographic approach is preferable, and familiarity with the family desirable, was strongly endorsed by a senior NHS figure who participated in the research and it was a key theme of the Leadsom report on early years, as outlined in the Introduction.

3.7 Promoting interaction

When speaking to health professionals, they emphasised the importance of attachment and developing the bond between parents and the child. One of the ways in which this can be achieved, whilst also promoting literacy from an early age, is through parental reading. In one area of the country where an interviewee managed a Family Hub, they had encouraged parents to read to children from birth, as a matter of best practice. This was initially to facilitate bonding and attachment, as well as to introduce the infant to a range of sounds and emotions. One interviewee said that some parents did not recognise the importance of talking to a newborn child, or otherwise said they felt awkward doing so; reading is a beneficial way of achieving this whilst also encouraging the early development of literacy skills (if the practice continues throughout the early years).

One of our recommendations, therefore, takes the idea of bonding through reading and suggests the development of a literacy log that Health Visitors can use with parents and which parents can continue to use after formal health visits end.

Case Study: Warwickshire

An interviewee from Warwickshire discussed the Alarm Distress Baby Scale (ADBB), a new method for monitoring how the infant's eye contact, facial expressions, vocalisation and activity levels help parents to understand their child's emotional situation.

The method has been trialled in Warwickshire and elsewhere, funded by the Royal Foundation Centre for Early Childhood. The benefits of the ADBB method were that Health Visitors could:

- Have more meaningful conversations with parents about their child;
- Promote positive parent-infant interactions, bonding and attachment;
- Identify those children in greater need of support.[22]

3.8 Recommendations

1. Enable Health Visitors to Trigger a Multi-Service Visit

Health Visitors are not only in contact with the infant but with parents. Often they will be the first contact with any form of social service that parents have – and it is the case that they are being confronted with problems outside of their remit. This occurs within the context of 86% of surveyed Health Visitors saying that others services do not have capacity for onward referrals.[23] We propose that local authorities should provide published guides which signpost parents to the correct social service which Health Visitors can hand over to ensure their focus is on the infant. Councils should be prepared to send other social service professionals (such as welfare rights advisors or drug abuse counsellors) with Health Visitors so that a multi-service approach to the wider family is delivered: our suggestion is that Health Visitors should be able to trigger these joint visits.

21 Whittaker, K et al. (2013) "Start and Stay: The Recruitment and Retention of Health Visitors". London: King's College London. Available at: **https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Clinical-Topics/Children-and-Young-People/National-Nursing-and-Research-Unit-Start-and-Stay-Report.pdf**

22 Centre for Early Childhood (2024) ""Overwhelmingly positive" results for Royal Foundation-backed early years trial as report recommends expansion to more UK health visiting teams". Available at: **https://centreforearlychildhood.org/latest-learnings/news/positive-results-early-years-trial/**

23 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

2. Signposting on Day One

It is proposed that Health Visitors should signpost two vital services to parents on the first visit: the Healthy Start scheme and local mental health support (including introducing the concept of infant mental health).

A) Include a Healthy Start Eligibility Assessment

There is a need to increase awareness and promote take-up of the Healthy Start scheme, ensuring that parents are aware of their entitlement. The Institute for Public Policy Research notes that Health Visitors can have a positive impact upon nutrition by providing advice to parents.[24]

Health Visitors should include as part of their discussions at Visit 1 a consideration of whether the family is eligible for Healthy Start and understand the barriers (e.g. lack of internet connection, literacy issues, financial literacy problems) that might stop an eligible family from applying. Signposting to welfare rights services within the local authority should also take place at this meeting, for advice on wider benefits entitlement, if the Health Visitor has concerns about the family income emerging from the discussion about the Healthy Start entitlement. (See Nutrition chapter for further details on the Healthy Start scheme.)

B) Signpost Mental Health Services

A review by the Scottish government found that infants with mental health issues are isolated from services that might support them because of a lack of parent engagement – and particularly so during COVID.[25] As the NHS introduces mental health services for infants aged 0-4, it is recommended that Health Visitors should explain to parents the importance of good mental health and advertise what services are available in the South West – and how these can be accessed.

In thinking about adult mental health and how this can impact upon infants, the Health Visitor should also signpost the adult counselling and mental health support services available in the local area (including virtual services where travel may be a barrier).

3. Develop Attachment and Literacy through Reading

Local authorities should provide a supplementary reading log, to accompany the red book, in which parents should record examples of literacy activities that they have undertaken with their children. Public Health and Children's Services departments could collaborate on developing infant libraries or resources to give away to bookless households to encourage the practice of reading to, and with, the child. Health Visitors could then engage in discussion about the log at the time of the fifth visit to review the reading that parents have done with their children over a circa 18-month period. This is already done in some parts of the country (minus the reading log, which we propose to formalise and document this arrangement). See Appendix Two for an example of what this may look like.

4. Geographic Caseload

When commissioning health visiting services, councils should seek an agreement in advance that providers will deliver health visits based on geographic caseload, as described in the report, and not use a first-come, first-served system for visits. There will be challenges relates to staffing and availability of full-time staff, but where possible this should be achieved. It should be a priority that families with multiple children do not have different Health Visitors for each child.

24 Dean Hochlaf and Chris Thomas (2020) "The whole society approach: Making a giant leap on childhood health". Institute of Public Policy Research. Available at: **https://www.ippr.org/articles/the-whole-society-approach** and Rebecca O'Connell, Abigail Knight and Julia Brannen (2019) "Living Hand to Mouth". Child Poverty Action Group. Available at: **https://cpag.org.uk/news/living-hand-mouth**

25 Scottish Government (2022). "Infant mental health: evidence review". Available at: **https://www.gov.scot/publications/infant-mental-health-evidence-review**

4 Childcare and School Preparedness

4.1 Key points:

- The last government's expansion of free childcare places is a double-edged sword: whilst it appeals to parents, it has the potential to put some private providers out of business because the government funding does not meet the actual cost of caring for a child.
- The South-West peninsula is losing childcare places at an alarming rate. In Torbay, where the situation is worst, there are five children for every one place.
- There is a recruitment and retention crisis in childcare. Not only is it seen as overly complex to get into (with some people reportedly undertaking the wrong qualifications), but there is a perception of the profession as underpaid and overworked. A common refrain in interviews was: "you're better off working in a supermarket".
- Whilst the headline figures suggest that infants in the South West outperform the England average for school preparedness (based on EYFS goals), the data shows poorer outcomes for those who are disadvantaged (as indicated by FSM eligibility).

Early years pre-school provision in England is a patchwork quilt of different types of settings, in terms of size, scale and purpose. Some nurseries are run by local schools or multi-academy trusts; some are private businesses which operate to make a profit; some provision is offered on a charitable basis or offered by local volunteers; and there are individual childminders operating as sole traders many of whom take on this work whilst caring for their own children.

Our interviews included representatives of each of these settings and all of the practitioners interviewed were concerned about the funding arrangements for childcare, the recruitment and retention crisis in the sector, and the sense that pre-school provision is – on the whole – not taken as seriously as primary education. This latter point did not just apply to policymakers, but to society at large which does not see early years education as 'proper' education. These concerns are set in the context of childcare places declining in every English local authority area bar one.[26] This decline is most acute in the South West: of the top ten biggest reductions in childcare places, six were in the region (Torbay, Isles of Scilly, Dorset, Devon, Cornwall and Somerset). Torbay, which lost 25% of childcare places between 2015-2021, saw the worst decline in the country. The loss of places in Torbay went hand-in-hand with a loss of 20% of providers, through closure.[27]

This section of the report discusses the funding, recruitment and retention issues in the sector, before thinking about the consequences of these issues for primary school preparedness.

26 Catherine Gaunt (2021). "Loss of childcare places highest in South West". Nursery World. Available at: **https://www.nurseryworld.co.uk/news/article/loss-of-childcare-places-highest-in-south-west**

27 **Ibid**.

4.2 Recruitment, retention and perception

Like health visiting, the childminding profession faces a complex recruitment and retention crisis – and the reasons behind it are both financial and cultural. Every single interviewee during my research identified this as the primary or secondary challenge facing the sector. The Early Years Alliance (EYA) suggests this is a problem for all regions of the country: the South West is ranked fifth (of 9 English regions) in terms of the greatest difficulty to recruit into the sector.[28]

One of the key drivers of this problem is pay. The TUC indicates that 63% of early years practitioners earn less than £10.90 per hour (i.e. the Real Living Wage at the time of the report's publication). Many of the professionals responsible for delivering childcare in private nurseries or as sole traders are on low pay and businesses operating in the sector often struggle to make ends meet, meaning that pay increases are uncommon and unaffordable. This, in turn, means that childcare roles are associated with uncertainty and challenging work for low wages.

One qualified teacher I spoke with is working in a charitable nursery setting on National Living Wage pay. Whilst her earnings in a school environment would be substantially better, she is committed to her work helping the children of parents who cannot afford childcare. This is an atypical story of someone who tolerates pay far lower than she might expect relative to her qualifications: most people are leaving the sector to be paid more elsewhere. A common refrain among interviewees was that one could work in a supermarket stacking shelves and be paid more than someone in a childcare role. This is a huge contrast with some other European countries. In Sweden, for example, the early years childcare system is largely made up of pre-schools. Around 40% of the workforce in the Swedish early years sector are qualified pre-school teachers and their teaching assistants hold the equivalent of a Level 3 qualification.[29]

There are wide consequences of the sector's professionals being low paid: it leads to a sense of worthlessness, being undervalued, and a strong perception that early years is not 'proper' education (unlike primary schooling). This wider culture is seen as a reason people do not wish to enter the profession – and why some are leaving it. Interviewees reported that recruitment into the sector is hindered by the societal perception that early years education is not 'proper' education – and therefore that the professionals working in this sector can be paid less, have lower level qualifications, and not be afforded the same status as school teachers. To attract qualified professionals, there is a clear need to provide better pay and conditions. Whilst this report is aimed primarily at local government, this issue requires the attention of national government.

There is also a problem with knowing how to get into a role in childcare in the first place. One interviewee, based in a childminding recruitment agency, said that often people interested in the role do not have the right qualifications, as they will undertake self-directed learning online for a qualification that they do not realise is irrelevant to the posts they wish to apply to. Another interviewee, in a managerial role in a pre-school setting, noted that local authorities need to do more to set out the step-by-step pathway into a career in the sector, because those who are interested – typically new mothers themselves – often meet a wall of bureaucracy.

28 Jess Gibson (2023). "Each region in England struggling with early years recruitment, according to TUC analysis". Early Years Alliance. Available at: **https://www.eyalliance.org.uk/news/2023/08/each-region-england-struggling-early-years-recruitment-according-tuc-analysis**

29 Peter Moss (2022). "Early education in Sweden – No comparison". Available at: **https://www.nurseryworld.co.uk/features/article/early-education-in-sweden-no-comparison**

Case Study: Reach Foundation and CELT

Reach Foundation has taken an innovative approach to addressing recruitment and retention issues in the local early years workforce.

To recruit new staff to the profession, it offers City and Guilds (Level 1 and 2) qualifications from its head office. These qualifications are aimed at those looking to enter the sector and are designed as an initial, entry-level qualification. Not all those who take the qualification will necessarily go on to work in the early years, but this pipeline approach to upskilling does help bolster the local talent pool.

Reach has also become a partner college of Kingston University to offer existing staff members and early years educators working in other local settings the chance to gain an Early Years Foundation degree. This helps employees gain the skills needed for advancement, acknowledging the limited room for career progression within the sector.

Offering the opportunity to gain an early years qualification within the school setting provides familiarity to staff who might be put off by a traditional educational setting or who might have logistical issues in attending an on-campus course.

The qualification accredited by Kingston University is eligible for traditional student loan payments, to support the learner financially for the duration of their course.

A similar approach is also being developed by Cornwall Education Learning Trust (CELT) which offers higher education provision through Bodmin College. The multi-academy trust intends to offer its own support staff and parents the opportunity to develop their skills and achieve a formal Early Years qualification, on site, through a workplace scheme.

4.3 Insufficient funding: risk of provider closure and withdrawal of childcare places, especially in deprived areas

The last government's roll-out of funded childcare places in England has been viewed with scepticism by professionals in the sector. They are concerned that it risks the closure of more providers who will struggle to meet the cost of offering state-funded places (because the cost of offering a child a place is not met in full by government subsidy) or that some providers will only register children whose parents can pay in full. This would have significant consequences for social mobility, as it would lead to the poorest families losing out on provision first.

From April 2024, parents across the South West and other parts of England will be supported by the roll-out of a funding plan intended to reduce the upfront cost of childcare. The primary focus of this policy is to free up parents – mothers in particular – to get back to work and be economically productive. Interviewees have warned that the social mobility implications may be severe.

The policy was phased in as part of a staged implementation. In April 2024, eligible working parents of 2-year-olds started to receive 15 hours of funded childcare. In September, this will broaden out to include the working parents of eligible infants aged between 9 months and 3 years. Then, from September 2025, eligible working parents will receive 30 hours of funded childcare for children from the age of 9 months to the point at which they start primary school.

As Figure 5 demonstrates, the cost of childcare increased by 171% between 2000 and 2021: only electricity (+210%) and house prices (+189%) increased by a bigger percentage, according to the Office for National Statistics.[30]

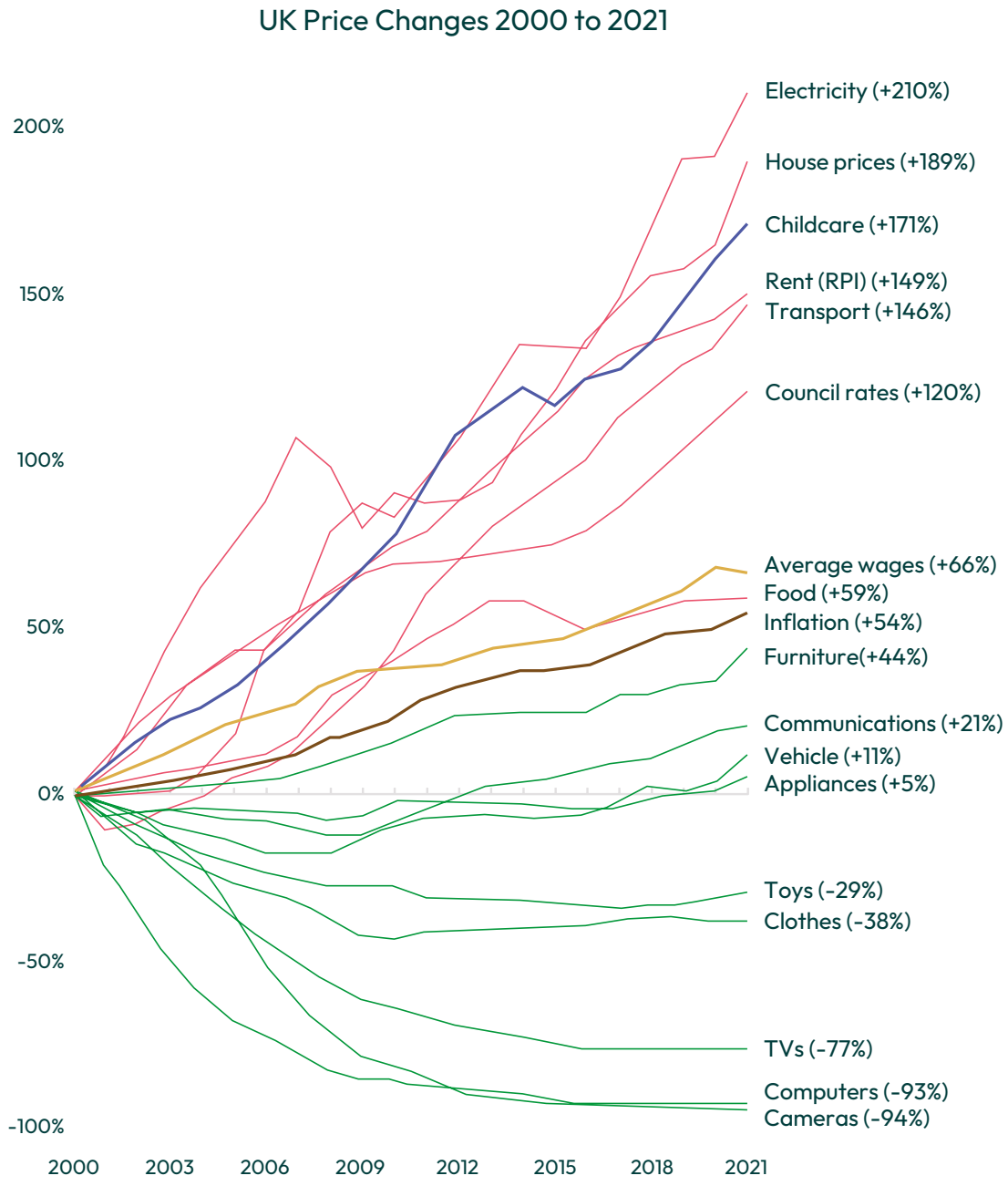

Figure 5: UK Price Changes, 2000-2021 (Source: Office for National Statistics)

The OECD suggests that, in the UK, childcare costs amount to 25% of the average wage. This percentage is higher in just 5 other countries in the world: New Zealand, the USA, Ireland, Czechia and Cyprus.[31] The Centre for Progressive Policy (CPP) has documented the impact on the UK economy of unaffordable childcare. They estimate that 1% of the UK's GPD (equivalent to £27bn) was lost due to parents being unable to work additional hours. This disproportionately affected women: 880,000 are reported to have reduced their working hours since becoming a parent whilst 470,000 have quit work entirely.[32]

30 Matthew Lesh of the Institute of Economic Affairs builds upon this and, using ONS data for 2022 and 2023, notes that childcare costs increased by 193% in the period 2000 to 2023 – behind electricity (+425%), house prices (254+) and insurance (+227%).

31 OECD. "Net Childcare Costs". Available at: **https://data.oecd.org/benwage/net-childcare-costs.htm**

32 Ben Franklin and Rosie Fogden (2023). "Growing pains: the economic cost of a failing childcare system". Centre for Progressive Policy. Available at: **https://www.progressive-policy.net/publications/growing-pains**

For many parents, childcare costs have become unaffordable and the impact of this is substantial – but from Directors of Children's Services through to Family Hubs Managers and childminders, the consensus view among interviewees is that the last government's policy to extend funding is a double-edged sword.

On the one hand, interviewees did acknowledge that the financial support offered by the last government is both (a) substantial as an overall financial package during difficult economic circumstances, and (b) helpful to parents who are concerned about the cost of childcare. The 2023 CPP report confirms the latter point: its survey found that 64% of parents would use more childcare if their upfront costs were lower.[33]

However, most interviewees were concerned that this leads to a form of 'expanded underfunding': the expansion of free childcare is financially damaging for providers because they are funded by government (for free places) at a rate that is not sustainable. The amount providers receive is less than it costs them to operate (when salary, pensions and energy costs are considered) and the expansion of free hours means that providers' scope for charging parents for additional hours is lessened, because parents are entitled to more government-funded (or underfunded) provision.

One nursery provider reported that they receive around £6 per hour per child as part of the government funding package but that it costs them closer to £10 per hour per child to deliver a quality service, good nutrition and pay staff a reasonable wage. That this is common explains why providers have to pass on to their customers the maximum possible charges for what one interviewee called the 'additionals'. Government policy allows providers to charge parents extra for meals, consumables and additional activities with the caveat that they should be mindful this doesn't impact on disadvantaged parents.[34] But this is not uncontroversial: the Local Government and Social Care Ombudsman criticised this approach to top-up fees in 2021.[35]

The reverberations will be felt differently across the sector. School-run nurseries can address the 'expanded underfunding' scenario by using money elsewhere in a wider school trust. An interviewee who runs a large trust said that they are able to do this and to reap other benefits by being in a trust too: for example, they can deliver good quality nutrition to early years, using the same catering provider used for the primary school meals, because they have greater purchasing power when placing a bulk order.

Only one interviewee told me that they welcomed the government funding announcement without caveat: a not-for-profit nursery operating in a deprived area often accepts children whose parents cannot afford to pay – and so the small amount of government funding, whilst insufficient on its own terms, is better than nothing.

Yet for most of the sector, there are stark warnings that this will impact negatively on social mobility: if providers cannot afford to take on government-funded infants, they will only accept children of parents who can pay 100% of the costs themselves, leaving children from deprived families without provision. This is particularly worrying amid an alarming rate of nursery closures. In 2023, the National Day Nurseries Association (NDNA) reported a 50% increase in the rate of nursery closures in 2022. Most closures were in places of deprivation: 37% of closures occurred in the 30% most deprived areas.[36]

In February 2024, Plymouth MP Luke Pollard led a Westminster Hall debate on the closure of nurseries in the South West of England. The Local Government Association noted, in the same month, that the South West (along with London, the West Midlands and the North West) had seen a net loss of 40 nurseries in the 5 months leading up to September 2022 (according to Ofsted).[37] Pollard referred to the loss of 886 childcare provider places in the South West between August 2022 and August 2023.[38]

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33 **Ibid**.

34 Hannah Crown (2019). "Guide to: charging for extras – Feel free?". Nursery World. Available at: **https://www.nurseryworld.co.uk/features/article/guide-to-charging-for-extras-feel-free**

35 Mandy Garner (2021). "Ombudsman rules on top-up fees for 30 hours childcare". Working Mums. Available at: **https://www.workingmums.co.uk/ombudsman-rules-on-top-up-fees-for-30-hours-childcare/**

36 Anne-Marie Argile (2023). "Nursery closure rates up fifty per cent on last year". National Day Nursery Association. Available at: **https://ndna.org.uk/news/nursery-closure-rates-up-fifty-per-cent-on-last-year/**

37 LGA (2024). "Westminster Hall Debate: Nursery Provision in the South West". Available at: **https://www.local.gov.uk/parliament/briefings-and-responses/westminster-hall-debate-nursery-provision-south-west**

38 Though this refers to a total loss, not a net loss which factors in net entries to the market, as demonstrated below. Pollard's comments available at: **https://www.theyworkforyou.com/whall/?id=2024-02-06b.60.0&s=sewage**

These comments resonate with what interviewees have described: unless funded places enable childcare providers to build a sustainable business model, then the future of nursey provision in England could be that only those infants whose parents can afford to pay private fees are properly looked after. The social mobility implications would be substantial, because nurseries would be forced to turn away infants whose parents are reliant upon funded places and accept only those whose parents can pay.

Indeed, DfE data shows that childcare provision across the country was in decline in every English region in the period 31st March 2022 to 31st August 2023 – including in the South-West peninsula, where four local authority areas suffered losses far greater than the England average.[39]

As Figure 6 demonstrates, the most substantial decrease in childcare places (as a percentage) occurred in Plymouth, Cornwall and Somerset.

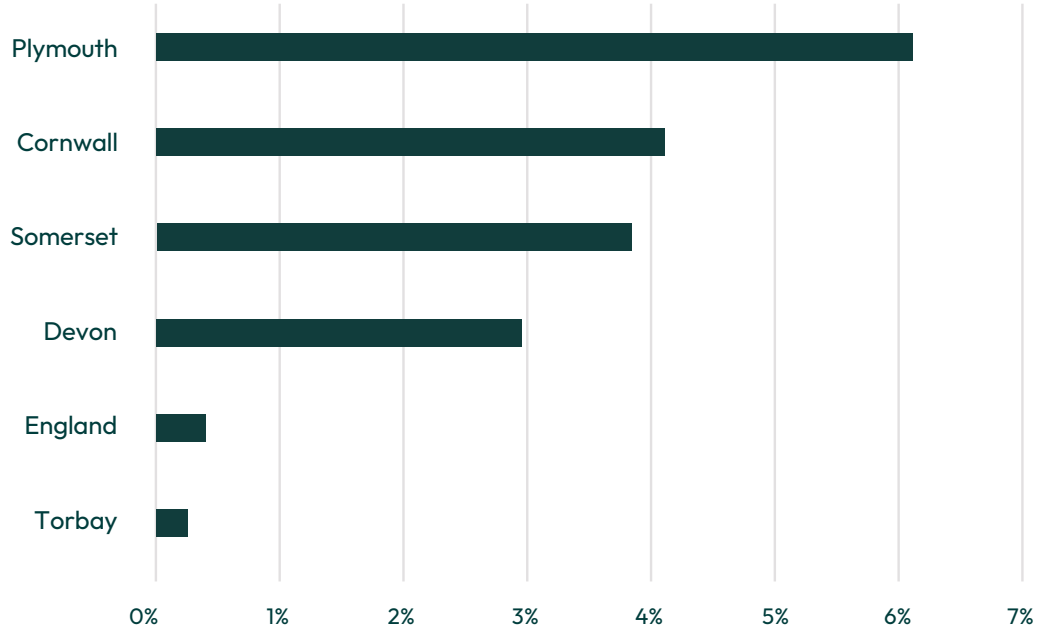

Figure 6: Percentage of childcare places lost, by local authority area (Source: DfE: April 2024)

Figure 7 shows that Torbay was the only local authority not to lose hundreds of childcare places in 2022/23, but this is because it started from a much lower base than every other local authority area; it had very little to lose in the first place (for reasons outlined at the opening of this chapter) and has the highest child:place ratio of any local authority area in the South-West peninsula.

Local authority area	Childcare places left (as of August 2023)	0-5 Population (2021 census)	Children per place
England	1,263,184	3,735,639	2.9
Devon	12,677	43,396	3.4
Somerset	8,925	33,043	3.7
Cornwall	8,607	31,339	3.7
Plymouth	4,519	16,150	3.6
Torbay	1,622	7,441	4.6

Figure 7: Childcare places left in each local authority area, as of August 2023 (Source: DfE and ONS: April 2024)

39 A note on methodology: this figure is calculated by adding together the total number of providers joining the sector (both those on the Early Years Register and those not) and the total number of providers leaving the sector (both EYR and non-EYR) and subtracting the number of new joiners from the number leaving. The data is released by the DfE in a dataset entitled 'Movement in the childcare sector, by region and local authority'. See here: **https://www.gov.uk/government/collections/early-years-and-childcare-statistics**

The decline of childcare places is of concern – and councils should be encouraged to monitor the number of places available against an assessment of what they understand to be the need in their area.

One interviewee, reflecting upon the nature of the sector, commented that childcare provision in England had in effect become a mostly nationalised service and was 'private' in name only, due to the fact that government was in essence funding most of the sector directly (through subsidy) but the operational elements of running the nursery remained in private hands. One recommendation emerging from this conversation was that – to address the decline in places – councils should be much freer to establish local authority run provision, so that it can target local need and cut out the middleman in what is essentially a nationalised service. However, this is not a formal recommendation of this report because of concerns about council capacity to deliver this: instead, the proposed Early Action Group should be responsive to the requests of local private sector providers to help them overcome barriers to creating new provision. A large part of this will be addressing the recruitment challenges faced by the sector across the country.

The Labour Party's 2024 general election manifesto committed to transforming empty primary school classrooms into nurseries, at a cost of £140m. The proposal is estimated to create 100,000 new places at 3,334 new nursery sites. This works out at an average of 29 places per nursery.[40] The challenge, though, will be more complex for two reasons:

- First, there will be challenges around the recruitment and retention of staff. These new nurseries will require properly trained and experienced staff members, but it will also require government to ensure that these new nurseries are not staffed at the expense of existing local providers that may close as a result if their staff simply transfer to the new nurseries.
- Second, and more crucially, the need for new nursery spaces may not align directly with the availability of primary school classrooms. As we have demonstrated, some parts of the country have a higher child:place ratio than others – and it is these areas that require the greatest attention.

The Institute for Fiscal Studies (IFS) has said that Labour's plans "may nudge the market in a different direction" but that they will not lead to a transformation of it. The IFS notes, for example, that Labour remains committed to the Conservatives' expansion of funding and it shares the concern outlined above regarding how this policy will be delivered in the context of staffing shortages.[41]

4.4 Scepticism about whether childcare works

It is worth noting that there is not a consensus view – either in the literature or among the interviewees that participated in this research – that expanded or universal childcare is good for children.

Two interviewees who have held senior roles in health and education policymaking were both sceptical of whether increasing the number of hours that a child spends in the care of professionals, during infancy, rather than with parents was a good thing. Rather, these informants said that there needed to be a much clearer policy on how national and local government should help families to be good families, in which infants develop strong attachments to their parents and the parents, in turn, understand the needs of their children.

One of these interviewees said that, in expanding childcare, not enough consideration was given to the child's attachment to the primary care giver (often the mother) which impacts upon the child's emotions/psychology and which goes on to shape their future relationships. This has been well documented in the literature on child psychology, but of note is Vivien Prior and Danya Glaser's (2006) assertion that the first two years of a child's life are the most critical for forming these attachments.[42]

40 Freddie Whittaker (2024). "Labour will convert 'spare' primary classrooms into 3,334 nurseries". Schools Week. Available at: **https://schoolsweek.co.uk/labour-will-convert-spare-primary-classrooms-into-3334-nurseries/**

41 Christine Farquharson (2024) "Labour's plans to build childcare spaces in schools will nudge the market in a different direction – but not transform it". Institute for Fiscal Studies. Available at: **https://ifs.org.uk/articles/labours-plans-build-childcare-spaces-schools-will-nudge-market-different-direction-not**

42 Vivien Prior and Danya Glaser (2006). Understanding attachment and attachment disorders: theory, evidence and practice. London: Jessica Kingsley. See also: Bowlby, John (1997) Attachment and loss. Volume 1: attachment. London: Pimlico and Howe, David (2011) Attachment across the lifecourse: a brief introduction. Basingstoke: Palgrave Macmillan.

In tune with these concerns, Maria Lyons (2024) has produced an early years literature review for Civitas in which she concludes that there is no evidence to support claims that childcare expansion (to include children at younger ages and to cover more hours) will benefit the education of infants.[43] This supports the view that the expansion of childcare by the Sunak government was principally concerned with getting economically inactive parents back into work. Lyons is also critical of the replacement of parents with professional care services. She describes as 'sheer hubris' the notion that the state could provide every child with care in a formal setting which is superior to that which can be provided by parents. In support of this, she cites the limited evidence to back up claims that even high-quality childcare is good for children. In contrast to this, Lyons presents the findings of the Effective Pre-school, Primary and Secondary Education Project (EPPSE) – a longitudinal study of the attainment of around 3,000 children between 1997 and 2013 – which indicated that the single most important predictor of exam success was early parental education.[44]

Regardless, there is a clear parental demand for childcare and the two main political parties are committed to expanding it in one way or another. What is crucial, therefore, is that as these policies are implemented, consideration is given to ensuring that infants from under-resourced backgrounds are able to access support and that smaller providers are safeguarded from the downsides of the 'expanded underfunding' or of the potential exacerbation of the recruitment crisis that Labour's proposals could lead to.

4.5 Reception preparedness

Early Years Foundation Stage (EYFS) Goals are a method of measuring a child's preparedness for starting Key Stage One. On this measure, the South West appears to outperform the national average – but when looking specifically at those living in deprivation, these infants underperform the England average on every measure.

An interviewee who had held a nationally significant role in NHS England highlighted school preparedness as one of the key challenges to early years. They noted that, if children are not ready to learn when they start school, then they will constantly be playing catch up.

Perhaps offering a slightly different position, an Early Years Lead in a local authority challenged the framing and language around school preparedness: this informant pointed out that preparedness for school is not the same as preparedness for Reception – and that the former refers to a point at which the child is assessed at the end of the Early Years framework and the latter a more informal consideration of whether the child is ready for Reception. In this respect, the interviewee emphasised the need for Reception settings to be ready for the child – rather than expecting all children (who, after all, have each been in different pre-school environments) to fit into a standardised classroom experience.

One of the key indicators of preparedness for Key Stage One is the measure of a child's development against the Early Learning Goals. These goals are part of the Early Years Foundation Stage and Reception class teachers complete an Early Years Foundation Stage Profile which records a 5-year-old's progress against measures including speech and language development; personal, social and emotional development; and literacy and mathematics.[45] The Reception teacher's assessment is then used to inform the child's Year One teacher of their progress and learning needs.

In 2021/22 and 2022/23, infants in the South West outperformed the England average on all three key EYFS measures included in Figure 8 – and improved on each from one year to the next. However, FSM-eligible children in the South West underperformed the England average in both years.

43 Maria Lyons (2024). "Universal childcare: Is it good for children?". Civitas. Available at: **https://www.civitas.org.uk/publications/universal-childcare/**

44 **Ibid**.

45 Department for Education. "Early years foundation stage". Available at: **https://www.gov.uk/early-years-foundation-stage**

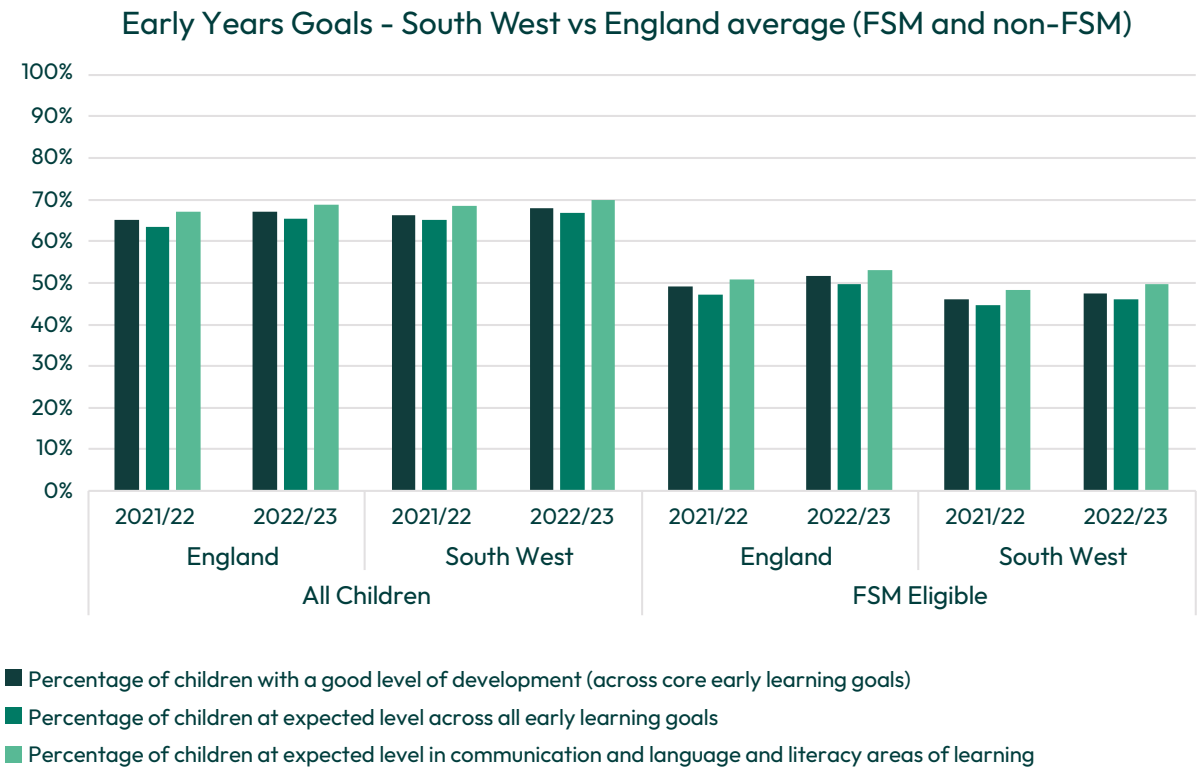

Figure 8: Early Years Goals - South West vs England Average (Source: DfE, April 2024) [46]

When broken down by parliamentary constituency, the picture is even more stark for FSM-eligible infants. Figure 9 shows that Camborne and Redruth was the only constituency in the South-West peninsula to outperform the England average for FSM-eligible infants meeting EYFS goals.[47]

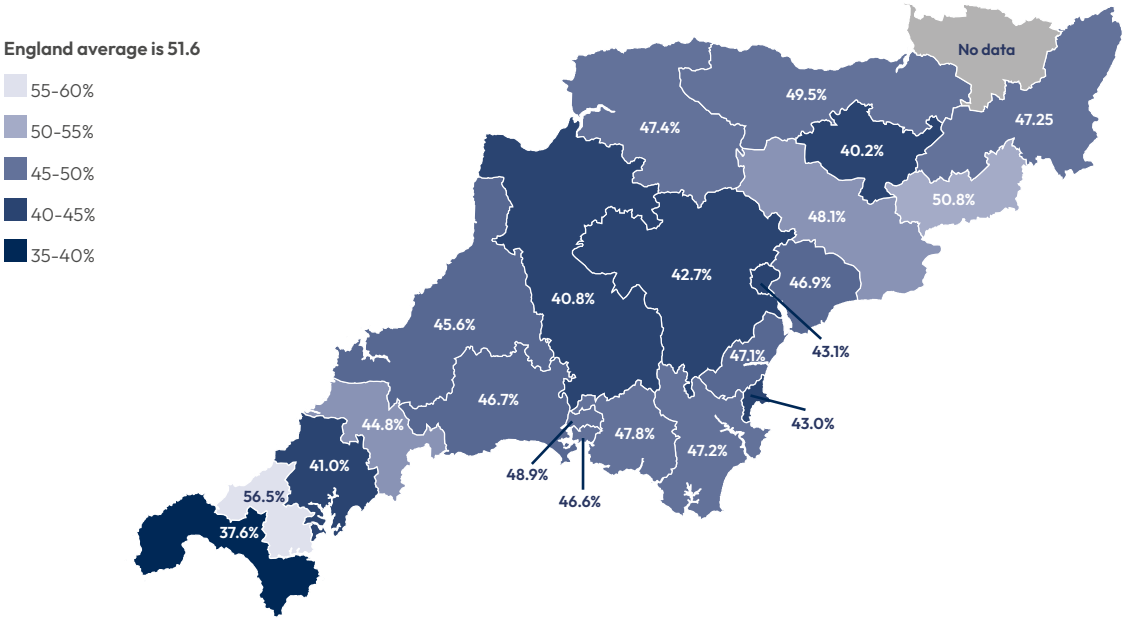

Figure 9: Percentage of FSM eligible infants meeting EYFS goals, by parliamentary constituency (Source: DfE, April 2024)

46 A note on the measures in this chart. Good level of development refers only to prime EYFS areas (communication and language; personal, social and emotional development; and physical development) as well as mathematics and literacy. All early learning goals takes into account all 17 EYFS measures across 7 different areas of learning – and so it is possible, therefore, that the percentage of infants meeting a 'good level of development' is higher than the percentage at expected development across 'all early learning goals'.

47 Appendix One contains a map which lists the names of each parliamentary constituency in the South West.

Case Study: Camborne and Redruth

One of the possible contributors to Camborne and Redruth performing better than every other constituency in the South-West peninsula for FSM-eligible infants meeting EYFS goals may be the targeted literacy intervention undertaken by the National Literacy Trust.

The scheme, "Chat, Play, Read Camborne Redruth", is a whole cohort approach to raising early years' literacy levels. It aimed to engage with every family with a new-born baby within a designated geography (approx. 600 per year) and to continue the intervention until the child reached Year One (i.e. the end of the early years). National Literacy Trust worked with local partners to combine resource distribution, activities, events and campaigning.[48]

In its aim to support parents to understand and improve their child's literacy, the scheme placed books for loan in local foodbanks, engaged volunteers to support the project and held events locally to enable attendance. As a result, the project engaged 75% of its target audience (of families with new-born children) and continues to engage them with a view to retaining their involvement over the course of their child's early years journey. It is a multi-year project and its evaluation measures behavioural change and improved parental understanding; improving nursery readiness; supporting families to improve school readiness; and building community capacity to promote literacy.

4.6 Data sharing

An interviewee in a nursery based in a deprived area said that data sharing is a key barrier to them properly supporting children. They indicated that they do not receive any information from health visiting teams about the children starting at their nursery, nor are they asked to provide any information to primary schools once the child starts. The interviewee gave an example of a child who the nursery recognised needed a speech and language therapist, only to later find out from the parents that the child's Health Visitor had previously identified speech and language issues. The nursery informant said that they wasted weeks identifying this for themselves but could have provided support much earlier on had they had better information from the local authority.

Case Study: Cranbrook Cradle to Career (C2C) model and hub

Cranbrook Education Campus, an all-through school for children aged between 2 and 16 (located in the new town of Cranbrook, six miles outside of Exeter), is in its third year of running a C2C model, in partnership with Reach Foundation.

A key part of the vision for CEC's C2C model is to coordinate a joined-up service across the early years (including antenatal support and on-site health visiting, early years services like speech and language therapy, and identifying vulnerable families) to support children's transition into school. The ambition is that this will better engage families and better support all children to start school on an even footing.

Public health, mental health and midwifery services provide over 2,000 on-site appointments between them within its co-located community hub, removing geographic barriers in a town that was otherwise without these services.

The school and hub collaborate across the 0 – 16+ age range on challenges such as poor attendance to identify and address the causes of school absence, as well as on matters such as how to look after pupils during school holidays. Between them, they share information about changing community needs and provision required.

The C2C model allows the school to better understand the demographics of the community it serves as well as the needs of individuals and families within it, therefore providing a better means of transitioning at every stage including from early years to key stage one.

48 Based on internal information provided directly to SWSMC by National Literacy Trust.

4.7 Recommendations

5. Monitor Child:Place Ratio

Local authorities should work together on a regional basis to continue to monitor the child:place ratio set out in Figure 7 of this report. This can be used as a tool to report to government the state of the sector and make the case for additional funding to expand the provision within the sector, according to need. This information will be important to national government too, to ensure that new places are prioritised in areas where they are most needed, not simply where space allows.

6. Cabinet or Deputy Cabinet Member for the Infant

In addition to their main cabinet members, several local authorities now have a system of deputy cabinet members who have responsibilities within a specific remit. We propose that Council Leaders should consider appointing a joint deputy to the cabinet member for Children's Services and Public Health (or otherwise allocate this to a full cabinet member position). This person will have responsibility for 'seeing the child' within the local authority; for promoting better cooperation and data sharing between health and education teams within the Council; and be the point of contact for childcare providers concerned about the financial situation. This person may also be the Chair of the proposed Early Action Group if its geography is coterminous with the local authority area.

7. Support Better Transition

A perception that school Reception classes often expect children to be ready for them, rather than schools being prepared for children as they are, suggests a rigid and inflexible approach to transition. It is therefore recommended that schools and multi-academy trusts work more closely – as members of the Early Action Group – to develop transition strategies (which may include nursery visits, improved data sharing through the Group and more visits for nursery children to the school setting) that address this concern. One means of doing this is to consider – where possible – the introduction of a Cradle to Career (C2C) model, as outlined in the case study.

8. Careers Advice Made Simple

People, particularly mothers, seeking to enter the early years workforce are put off by poor careers guidance, an array of inappropriate qualifications and a lack of clarity about initial steps into the sector. We propose a simple but authoritative recruitment poster (which can be localised on a council-by-council area basis) to be displayed in Family Hubs, schools, doctors' surgeries, supermarkets and other key locations where potential career switchers might visit. An example of this is displayed at Appendix Three.

9. Explore opportunities for multi-academy trusts to support Early Years workforce development by offering training and qualifications through their school settings

Based on the success of the Reach model, we recommend that the Early Action Group should explore the role of multi-academy trusts in supporting routes to formal Early Years qualifications through their school settings. Partnership between trusts and their local FE or HE provider could be facilitated by the Early Action Group.

5 Nutrition

5.1 Key points:

- A strong body of evidence links good early years nutrition with healthy development and later educational outcomes.
- Poor nutrition is highly associated with poverty; addressing poor nutrition is essential to improving social mobility but rising child poverty and the rising cost of living are key current concerns.
- Government guidance on good early years nutrition exists; the key issue is awareness and take-up of this guidance by early years providers, especially in non-school settings.
- This is similarly the case for monetary support for nutrition provided direct to families, where take-up is around 62% nationally and lower in the South West.
- Our recommendations for local authorities focus on mechanisms to increase understanding and take-up of government nutrition guidance by early years providers and take-up of monetary support by families.

5.2 Early years nutrition and outcomes: a strong link

There is a strong body of evidence that links good nutrition with reaching expected levels of development in the early years. Multiple academic studies have identified a correlation between substandard nutrition and a poor diet in children under the age of 5 on the one hand and, on the other, long-term consequences for academic attainment.[49] There is an urgency to address poor nutritional provision, therefore, in the context of rising cost of living when families may be struggling to meet the cost of grocery bills. One of these studies has also linked the provision of good nutrition with positive early development.[50] UNICEF meanwhile describes the first 1,000 days of a child's life – from birth to their second birthday – as "the most critical time for good nutrition".[51] UNICEF's report places weight upon both the types of food that children eat as well as the conditions in which food is prepared.

Whilst UNICEF's report is international in scope, The Food Foundation makes similar claims regarding the importance of nutrition in early childhood in the context of a UK-focused study. Shona Goudie writes that food consumption in the early years sets the foundation for adolescent and adult health, noting – for example – that one in five children starting primary school is overweight and that strategies aimed at tackling childhood obesity are too late to be fully effective.[52]

It is therefore important to think about the role of nutrition, and the contexts in which under-nutrition occurs (i.e. food insecurity, deprivation and poverty), when determining how early childhood interventions can enhance long-term social mobility.

49 Kristen M. Hurley, Aisha K. Yousafzai and Florencia Lopez-Boo (2016). "Early Child Development and Nutrition: A Review of the Benefits and Challenges of Implementing Integrated Interventions". Advances in Nutrition. Available at: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785470/** and Sally Grantham-McGregor, Yin Bun Cheung, Santiago Cueto, Paul Glewwe, Linda Richter, Barbara Strupp and the International Child Development Steering Group (2007). "Developmental potential in the first 5 years for children in developing countries". Available at: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2270351/ and Robert E. Black et al. (2013). "Maternal and child undernutrition and overweight in low-income and middle-income countries". Lancet. Available at: https://pubmed.ncbi.nlm.nih.gov/23746772/**

50 In both cases, these studies indicate that the impact of nutrition is context dependent: if appropriate early learning and development opportunities are not present, good nutrition alone will not lead to optimal academic development.

51 UNICEF. "Early childhood nutrition". Available at: **https://www.unicef.org/nutrition/early-childhood-nutrition**

52 Shona Goudie (2021). "The Critical Importance of Early Years Nutrition in Prevention of Childhood Obesity". The Food Foundation. Available at: **https://foodfoundation.org.uk/publication/critical-importance-early-years-nutrition-prevention-childhood-obesity**

5.3 Nutrition indicators: an unhealthy start in life, particularly in deprived areas

Childhood obesity is a consequence of poverty, but it is an area where the UK has made notable progress in recent years. The South West performs well on this measure. It has the third lowest childhood obesity rates in the country.

There are a number of possible indicators for measuring the health and developmental effects of nutrition including obesity, low weight and height. The general picture is that we should be concerned about the nutrition of children in the UK, and in particular children in deprived areas. Whilst there has been some progress on reducing childhood obesity, children aged 5 in the UK are shorter than those in comparable countries and underweight prevalence among year 6 pupils has increased to the highest percentage since records began in 2009/10.

There is some evidence that government intervention to prevent childhood obesity has had a positive impact. The UK government's National Child Measurement Programme (NCMP) report for 2022/23 shows that progress has been made on childhood obesity since the introduction of the government strategy *Childhood Obesity: A Plan for Action*.[53] The NCMP 2022/23 report shows:

- A decrease in obesity in reception children (0.8% decrease on previous year).
- A decrease in obesity in year 6 children ((0.7% decrease on previous year).
- Obesity is more prevalent in boys than in girls, in both reception and year 6.

From a regional perspective, the South West has the third lowest level of childhood obesity in England among Reception age children (8.2%), whilst it is highest in the North East (11.3%).[54] By year 6, the percentage of obese children in each region at least doubles, but the South West is joint lowest in this regard (19.4%).[55]

However, the data also indicates regional inequalities and an increase in year 6 children who are underweight:

- Obesity is twice as high in deprived areas (reception: 12.4%, year 6: 30.2%) as it is the least deprived areas (reception: 5.8%, 13.1%).
- Underweight prevalence among year 6 pupils has increased to the highest percentage since records began in 2009/10 (though only a 0.1% increase in 2022/23 compared to 2021/22).[56]

The South West fares well in comparison to the rest of England on this measure. Only 0.8% of Reception children are underweight (joint lowest with the North East), rising to 1.4% by year 6. This is compared to 1.8% at Reception age and 2% at year 6 in London, which is the region with the highest prevalence of underweight children at both stages.[57]

Alongside these concerns about obesity and undernourishment, the Food Foundation also reports concerns with height as an indicator of under development (which Danny Dorling has reflected upon in *The Conversation*).[58] Data shows that children in the UK do not receive sufficient nutrition required to grow, compared to OECD and EU peers. UK boys at the age of 5 are shorter than their peers in all comparable countries; UK girls at the same are shorter than their peers in all but one comparable country.

53 UK Government (2017). "Childhood obesity: a plan for action". Available at: **https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action**

54 NHS Digital (2023) "Latest figures show drop in obesity rates among primary school children: statistical press release". Available at: **https://digital.nhs.uk/news/2023/latest-figures-show-drop-in-obesity-rates-among-primary-school-children-statistical-press-release#:~:text=Geography9%3A,and%20South%20West%20(8.2%25)**

55 NHS Digital (2023) "National Child Measurement Programme, England, 2022/23 School Year". Available at: **https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2022-23-school-year/geography**

56 NHS Digital (2023) "National Child Measurement Programme, England, 2022/23 School Year". Available at: **https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2022-23-school-year**

57 **Ibid**.

58 Danny Dorling (2023). "Ed Balls and George Osborne's new podcast is essential listening – but not for the reasons they think". The Conversation. Available at: **https://theconversation.com/ed-balls-and-george-osbornes-new-podcast-is-essential-listening-but-not-for-the-reasons-they-think-214747**

5.4 Correlation between poverty and poor nutrition

Of key concern is the link between poor nutrition and poverty. Research by the Institute for Public Policy Research (IPPR) links households in poverty to nutritional deficits, stating that poverty creates the environment in which "health problems thrive" because of factors like food insecurity.[59] Moreover, as Goudie notes, 21% of households with a child aged 0-4 live with some level of food insecurity – which is defined by the Child Poverty Action Group as families that "cannot (or are uncertain about whether they can) acquire an adequate quality or sufficient quantity of food in socially acceptable ways".[60]

To set this within a national context, UNICEF has reported that the percentage change in children living in poverty between 2014 and 2021 was worse in the UK (which ranked 37th out of 39) than almost every country in either the OECD or EU. The total percentage of children in poverty in the UK was reported as 20.7, below France, Canada, Japan and Estonia but above the USA, Mexico, Spain and New Zealand.[61]

The International Social Survey Programme ranks the UK fourth internationally for food poverty.[62] Food poverty, in this study, is defined as households in which someone skips a meal at least once a month due to not having enough money for food. In the UK, this is close to 9% - and is higher only in Czechia (9%), Israel (10%) and the USA (12%).[63] [64]

Children living in poverty in the UK are often:

- In single parent families (44%) rather than in coupled families (25%).
- In families of three or more children (43%) rather than one or two children (22%) or lone children (23%).
- In a family where the youngest child is aged 0-4 (32%) rather than aged 5-10 (30%), 11-15 (25%) or 16-19 (24%).[65]

The South-West peninsula has five local authority areas with a child poverty rate above the English average. The Joseph Rowntree Foundation has documented child poverty rates by South-West local authority (as of 2024).[66]

59 Dean Hochlaf and Chris Thomas (2020) "The whole society approach: Making a giant leap on childhood health". Institute of Public Policy Research. Available at: **https://www.ippr.org/articles/the-whole-society-approach** and Rebecca O'Connell, Abigail Knight and Julia Brannen (2019) "Living Hand to Mouth". Child Poverty Action Group. Available at: **https://cpag.org.uk/news/living-hand-mouth**

60 Shona Goudie (2021). "The Critical Importance of Early Years Nutrition in Prevention of Childhood Obesity". The Food Foundation. Available at: **https://foodfoundation.org.uk/publication/critical-importance-early-years-nutrition-prevention-childhood-obesity**

61 Gwyther Rees, Eszter Timar, Finagnon Antoine Dedewanou, Frank Otchere, Alessandro Carraro and Sabbiana Cunsolo (2023). "Child Poverty in the Midst of Wealth". UNICEF. Available at: **https://www.unicef.org/innocenti/reports/child-poverty-midst-wealth#report**

62 Scott Winship (2023). "Has inequality made American poorer than Bulgarians, Russians and Filipinos?". Center on Opportunity and Social Mobility. Available at: **https://cosm.aei.org/has-inequality-made-americans-poorer-than-bulgarians-russians-and-filipinos/#:~:text=The%20ISSP%20food%20hardship%20rates,9.9%20percent%20in%20the%20US**

63 **Ibid**.

64 In the same article, it is reported that UK citizens are most likely to support redistributive measures to tackle poverty, after reading about inequality in their country (over 70%), whilst Americans are least likely to support such measures.

65 Joseph Rowntree Foundation (2024). "UK Poverty 2024". Available at: **https://www.jrf.org.uk/uk-poverty-2024-the-essential-guide-to-understanding-poverty-in-the-uk**

66 **Ibid**.

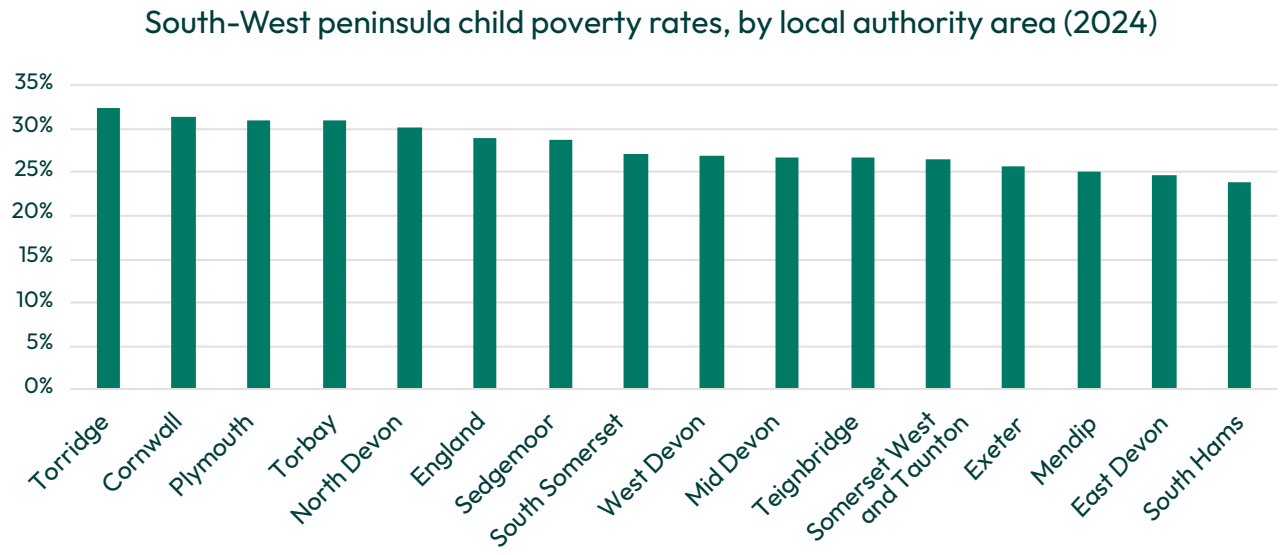

Figure 10: 2024 child poverty rate by South-West peninsula local authority area (Source: Joseph Rowntree Foundation)

5.5 Existing government interventions

5.5.1 Government guidance on early years nutrition

In 2014, the then government introduced Universal Infant FSM, for school-aged children between 4 and 7 years old, but this did not extend to those under the age of 4 years old or those in non-state funded settings.[67]

It was not until 2017 that the government introduced updated guidance, with example meal plans, to early years providers. The guidance included information about what constitutes acceptable food for providers to offer. Whilst it was introduced in the context of tackling childhood obesity, it contributes to a wider understanding of what a balanced and healthy menu for infants looks like.[68] However, this guidance remains voluntary in early years settings and it is unclear how widely it has been implemented.

The childcare providers interviewed for this report either said that they did not know about this guidance or, if they did know, were sometimes not in a financial position to provide meals that met this standard. It was in school-based settings that nutritional standards were highest – and this pertained to the fact that school and academy trusts have the purchasing power to bulk buy the same foods for all children in their care making it more affordable. For example, one interviewee from a South-West academy trust, which offers its own nursery provision, said that they provide the same food for their early years cohort as their primary pupils. This includes using the same catering contract and, therefore, extending (by choice) the standards required at primary level to early years.

One nursery-based interviewee said that the issue with nutrition was not what was provided in their setting, but the lack of knowledge among some parents. The interviewee said that they had concerns that Health Visitors did not properly educate parents about their responsibilities to properly feed their children and that the nursery's capacity to intervene was limited due to their financial restraints. In previous years the nursery had been funded by the Council to offer parent and child cookery classes which provided bonding opportunities but were also educational for the parents, teaching them how to prepare food and cook healthy meals.

The lack of council support with promoting nutrition best practice to providers and parents was put to local authority interviewees. One senior figure within a local government role said that they had not considered nutrition as part of their early years strategy but did recognise that it was an important element of early years care – and that they would consider recommendations relating to this, as they believed their council could do more.

67 Emily Warren, Lorraine Williams and Cecil Knai (2022). "The "Cinderella sector": The challenges of promoting food and nutrition for young children in early years' settings in England". Ecology of Food and Nutrition. Available at: **https://www.tandfonline.com/doi/full/10.1080/03670244.2022.2073353**

68 Department for Education (2017). "Healthy eating guidance published for the early years sector". Available at: **https://www.gov.uk/government/news/healthy-eating-guidance-published-for-the-early-years-sector**

The limitations of national policy relating to early years nutrition – including the 2017 guidance – has been discussed by Emily Warren, Lorraine Williams and Cecile Knai (2022).[69]

Their research notes that although Ofsted assessments conducted using the Early Years Foundation Stage framework includes a welfare requirement for the provision of healthy, balanced and nutritious food, there are no mandatory standards against which food is assessed, only voluntary guidance. Moreover, it is up to individual settings whether children are allowed to bring their own food from home which, evidence suggests, tends to be less healthy than food prepared by the childcare provider.[70]

Some of the key findings from the interviews with 18 early years professionals conducted by Warren et al. include:

- Early years settings are the best place to promote healthy eating – but some providers overlook simple changes to cultivate a better relationship between infants and food (e.g. not framing dessert as a 'reward' for eating a main or 'best bit' of a meal and discussing vegetables in neutral language).
- There is a difficulty for some early years providers to access food-related training opportunities, for example because they are cost prohibitive or only offered to certain providers (e.g. those that care for the most vulnerable children).
- Some settings had not even heard of the government's non-mandatory 'Eat Better, Start Better' guidance – which is in line with my own interviews.
- Providers can feel uncomfortable discussing food choices with parents who are not feeding their children appropriately – and there are differing views on whether this is a family matter or, as some saw it, a safeguarding concern.
- The expansion of 'free' childcare often results in providers having to absorb costs when government funding does not cover a provider's outgoings and, related to this, the childcare expansion money issued by government does not cover food costs. Again, this was a common theme in the interviews conducted for this report.

The findings of this research, including these specific points, led the authors to reflect that their participants felt like early years is secondary to school settings when it comes to prioritisation for funding and resource.

5.5.2 Healthy Start Scheme

To address food insecurity among families with infants, government has made available support through the Healthy Start scheme. This is a programme for which all pregnant women are eligible (from 10 weeks onwards) and those with children under the age of four in receipt of specific benefits.

The scheme provides funding to families to support with the cost of purchasing healthy food and milk (including baby formula). Recipients are also provided with baby vitamins.

Payments amount to the following at different stages of infancy:

- £4.25 for each week of pregnancy from the 10th week.
- £8.50 each week for children from birth to 1 year.
- £4.25 each week for children between 1 and 4 years.[71]

Yet despite this support being available, take-up is poor in some areas: according to one expert informant, this is due to either not knowing it exists or not knowing how to apply for it. DEFRA has reported that, across the UK, only 61.9% of eligible people took up the offer of this support in 2021. The South West was below the UK average, at 57.5% (an increase from 52% in 2019). Within the region – and indeed all UK regions – there remains a need to better promote the scheme to families that are entitled to and require the support.

69 Emily Warren, Lorraine Williams and Cecil Knai (2022). "The "Cinderella sector": The challenges of promoting food and nutrition for young children in early years' settings in England". Ecology of Food and Nutrition. Available at: **https://www.tandfonline.com/doi/full/10.1080/03670244.2022.2073353**

70 Emily Warren, Lorraine Williams and Cecil Knai (2022). "The "Cinderella sector": The challenges of promoting food and nutrition for young children in early years' settings in England". Ecology of Food and Nutrition. Available at: **https://www.tandfonline.com/doi/full/10.1080/03670244.2022.2073353**

71 NHS (2024). "What is Healthy Start?". Available at: **https://www.healthystart.nhs.uk/**

5.6 Gap between government provision and take-up

The importance of nutrition for infant children's physical and mental development is well documented and understood. Government reflected this in its publications surrounding its early years policies, yet there remains a gap between the standards required of school settings and the expectations of early years providers. Whilst schools are held to a rigorous framework, early years settings can merely take advice from voluntary guidance – but research in this area has noted from interviewees with practitioners that some are unaware of the guidance's existence.

The fact that there is support available (to providers, in terms of guidance; to parents, in financial terms) indicates that there is work to be done to promote government interventions to improve infant nutrition at the grassroots among those they are intended to support.

5.7 Recommendations

10. Local authorities to drive increased take-up of government Early Years nutrition guidance through 4 steps:

A) Issue clear, simple guidance to all early years providers

We suggest local authorities develop and circulate a pamphlet to all early years providers registered with them, setting out key tips from the government's guidance document on nutrition and food preparation. The British Nutrition Foundation's graphic which displays meal planning guidance in simple terms should be shared alongside this. Both documents can be found at Appendix Four.

B) Develop a local EY Food Standards Charter

As a further step, we suggest that local authorities develop a local Food Standards Charter based on the government's guidance, to which they ask early years providers to sign up. This could be accompanied by a form of accreditation that providers can use to show that they are a 'good nutrition' provider. See Appendix Five for a version of this designed for use within North Cornwall.

C) Put on Continuous Professional Development workshops for smaller providers

To support smaller and private sector childcare providers, the local authority or a partner organisation should offer occasional one-day, or half-day, workshops on nutrition. These could discuss key issues and low-cost solutions such as the importance of using neutral language to describe foods, how to promote healthy eating, and how to procure ingredients for healthy meals at low cost to the provider. The Early Action Group could outsource this to a partner organisation such as a multi-academy trust that has the capacity to deliver training or a private catering company, some of which offer training of this kind as part of their corporate social responsibility activities.

D) Lobby central government to make guidance mandatory

Finally, we recommend that local authorities' Directors of Children's Services (or equivalent) and related Cabinet Members write to the Secretary of State for Education and the Minister of State for Local Government to request that government considers making nutrition guidelines mandatory, rather than voluntary.

See also recommendation 2, part A which relates to the promotion of the Healthy Start scheme as a 'day one' priority by Health Visitors.

6 Mental Health

6.1 Key points:

- A recent review has identified that the percentage of infants with mental health issues is likely similar to adolescents with such problems (16-18%). Moreover, it was the view of health experts interviewed that infant trauma and attachment issues can lead to mental health issues in later childhood, adolescence and even adulthood.
- A health expert said that adverse childhood experiences (ACEs) in the early years create attachment issues and, subsequently, behavioural issues: this is the underpinning for poor behaviour in school which, in turn, leads to diminished academic performance.
- The interest in infant mental health has led one Family Hub to specialise in counselling for infants – but the limited human resource in the field of educational and child psychology means that the ability to deliver services on a large scale is limited.

6.2 Effect of poor infant mental health on later childhood, including school performance

Two interviewees stressed that the emerging interest among early years practitioners – academically and medically – was in relation to infant mental health: the literature in this area shows why this is the case. In 2023, the National Centre for Social Research reported that one in five children and young people aged 8-25 had a probable mental health disorder – and on a number of measures, young people with mental health issues reported that these related to money (e.g. parents unable to afford after school activities; not having enough disposable income).[72] It was the view of the health experts interviewed that mental health issues in later childhood likely originated in the early years.

These interviewees reported that mental health problems in young people, caused by adverse childhood experiences (ACEs) in infanthood, lead to attachment issues which may explain, for example, behaviour within schools in later childhood.

A 2014 study found that 47% of people reported experiencing one ACE and that 9% of the population likely experienced 4 or more ACEs.[73] An ACE can be a single event or a series of events. According to the NHS, these could include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Living with someone who abuses drugs
- Living with someone who abuses alcohol
- Exposure to domestic violence
- Living with someone who has gone to prison
- Living with someone with serious mental illness
- Losing a parent through divorce, death or abandonment.[74]

72 Children and Young People's Mental Health Coalition (2024). Available at: **https://cypmhc.org.uk/resources/facts-and-figures/#:~:text=In%202023%2C%20around%20one%20in,(NHS%20Digital%2C%202023)**

73 Manchester University NHS Foundation Trust (2024). "Adverse Childhood Experiences (ACEs) and Attachment". Available at: **https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/**

74 **Ibid**.

The interviews with health visiting professionals, supported by an Institute of Health Visiting survey, indicates that there is an increase in circumstances such as substance abuse and domestic violence within the family setting.[75] It stands, therefore, that a potential consequence of this not noted by the Institute of Health Visiting alongside its survey findings is more adverse experiences among infants. This gives greater weight to the need for Health Visitors to be able to trigger a multi-agency social service response, as previously recommended, to be able to address ACE-inducing circumstances as soon as possible.

A 2022 report examining social mobility in the South-West peninsula highlighted that the region has above average rates of poor mental health among children and across a number of mental health indicators. This data should make us concerned about infant mental health in the region.[76]

Infant mental health is a new area of psychological practice – and parents do not particularly understand it.

In 2020, the Scottish government commissioned a review of infant mental health.[77] The report found that around 16-18% of infants aged 0-5 demonstrated mental health issues; it notes also that definitions of 'infant' in the context of mental health vary, with 0-3 and 3-5 being seen as distinctive phases of development. Among its key findings were that:

- There is generally a lack of awareness of infant mental health as a concept. As it is a new area of psychological clinical practice, there is a need to develop easy-to-understand language to achieve parental buy-in.
- Measuring and assessing the mental health of infants who cannot yet speak is difficult, but some tools currently used with older children are being tested for use with infants.
- There is a need to join up the work of the NHS, statutory services and the voluntary (third) sector – particularly for communication of services available and raising awareness.

Notably, one of the key recommendations of the Scottish government's report was to "keep the baby in mind", ensuring that children are not overlooked by gaps in service. The tone and intention here echo this report's earlier point about "seeing the child": the similarity of these findings underscores the importance of the points made in both reports – i.e. that children's services should be joined-up and child-centric. The report states: ""Keeping the baby in mind" was a concept that surfaced multiple times throughout both interviews. This phrase was alluded to in conversations regarding the importance of ensuring that the infant is always being considered when working with at-risk families, when the immediate needs of older members of the family may be more apparent."[78] It goes on to cite the relative ease with which older children can be referred to Child and Adolescent Mental Health Services (CAMHS) whilst infants are "left behind".

6.3 Lack of specialist knowledge and experience

Whilst promoting an understanding of infant mental health is important, it is also not a guarantee that services will be easily accessed. There is a shortage of child and educational psychologists and even fewer specialise in the 0-3 age range.

One interviewee said that their Family Hub has developed a specialism in infant mental health and infant counselling, but the roll-out of this kind of service is limited by the lack of expertise in this area of child psychology and, therefore, by the prohibitive fees charged by those working in it.

75 Institute of Health Visiting (2023). "State of Health Visiting, UK survey report: A vital safety net under pressure". Available at: **https://files.localgov.co.uk/ihv.pdf**

76 Anne-Marie Sim and Lee Elliot-Major (2022). "Social mobility in the South West: Levelling up through education". Available at: **https://www.exeter.ac.uk/media/universityofexeter/aboutusresponsive/documents/Social_Mobility_in_the_South_West_Report.pdf**

77 Scottish Government (2022). "Infant mental health: evidence review". Available at: **https://www.gov.scot/publications/infant-mental-health-evidence-review/**

78 **Ibid**.

A survey of professionals in the field, conducted by the Parent-Infant Foundation and published in 2021, found that:

- 26% of NHS mental health professionals were not trained to work with 0-2 year olds and 48% had no work experience with this age range, during their training.
- Psychotherapists were more likely to have received training to work with babies (63%), compared to 15% of psychiatrists and 12% of clinical or counselling psychologists.
- When asked to rate their understanding of infant mental health on a scale of 1 (low) to 5 (high), 31% of respondents gave themselves a 1.
- Only 9% of respondents said that their area sufficiently catered for infants whose mental health is at risk.[79]

This report concludes that there exists a "baby blindspot" – reflecting the sentiment of this report and that of the Scottish government – whereby training of mental health professionals does not consider the needs of infants.

One potential means of addressing this is developing a strong relationship with the third sector. The Good Governance Institute has noted the importance of the third sector in health and care support in the wake of the COVID pandemic. It notes that whilst a recent Health and Social Care White Paper called for collaboration between the NHS and local authorities, it did not include a statutory duty for these bodies to include the voluntary and community sector (VCS). The report therefore recommends that the VCS should be "around the table" with a specific aim and that a collaborative approach to dealing with local problems can help avoid the situation whereby charities are "chasing the same money".[80]

Case Study: Greater Manchester

Bobbie Dutton, Neil Humphrey and Pamela Qualter have reported on NHS/third sector collaboration in Greater Manchester to provide young people's mental health support.[81] Their study identified a range of benefits to collaborative delivery including:

- The ability to **do things differently** which enabled innovation and moved beyond traditional methods of delivery
- Greater **flexibility** which came as a result of operating outside of NHS red tape
- A **hybrid approach** which combined youth work expertise with medical knowledge
- The production of **shared experience** and **shared learning** for those involved.

The report also identified a series of challenges within this approach. The most significant in the context of the South West is geography: Dutton et al noted that the collaboration between the NHS and VCS did not equitably cover the geographic footprint of their area (in this case, all Greater Manchester).

Rurality and isolation are a particular challenge in the South-West peninsula. To overcome the challenges of rurality and poor transport links, local authorities should encourage partners in the third sector to implement support services which include: utilising virtual communications; being part of the Family Hub service; travelling with services like mobile libraries; arranging visits to nurseries; and accompanying Health Visitors as part of the recommended multi-agency response.

79 Parent-Infant Foundation (2021). "Where are the infants in children and young people's mental health". Available at: **https://parentinfantfoundation.org.uk/wp-content/uploads/2021/06/PIF-Where-are-the-Infants-in-CYP-MH-26-May.pdf**

80 The Good Governance Institute (2021). "Third sector mental health approach post covid-19". Available at: **https://www.good-governance.org.uk/publications/insights/third-sector-mental-health-approach-post-covid-19**

81 Bobbie Dutton, Neil Humphrey and Pamela Qualter (2023). "Getting the pieces to fit: NHS and third sector collaboration to enhance crisis mental health service provision for young people". BMC Health Services Research. Available at: **https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09198-w**

Within the South-West peninsula, a range of mental health charities operate in conjunction with local NHS and council partners, including:

- **Headstart Kernow** in Cornwall
- **Young Devon** in Devon
- **Mind** in Devon, Cornwall and Somerset and others
- **Mental Health Matters** in Devon, Plymouth, Exeter, Barnstaple and Torquay.

There are signs of struggle within the VCS though: in 2022, **Valued Lives**, which provided mental health support in Cornwall, gave notice that it was no longer able to deliver NHS contracted services.[82]

These partners should be invited to form part of a local authority's Early Action Group.

6.4 Recommendations

11. Expand the Specialist Psychologist Base

The lack of professional psychologists working in the field of infant mental health means that, even if every Family Hub had the financial resource to hire one, there would be too few to do so. The small number of specialists in the field also means higher costs for those who do use them. South-West local authorities and Family Hubs should therefore speak with one voice to government about the need to provide training in the area; to create new routes to retraining and specialising; and to funding these posts.

12. Councils Should Coordinate the Third Sector and Childcare Settings

The Scottish review identified the need to coordinate the voluntary sector with statutory services. This recommendation goes one step further and suggests that councils should seek to join up mental health providers in the third sector with childcare settings, to enable promotional work, sessions with parents to raise awareness, and referrals (where concerns exist in relation to a specific child). Encouraging third sector partners to deliver mental health support virtually and in conjunction with other services (such as Family Hubs) to overcome the challenges of rurality and isolation is especially important in places like the South West – or where physical services are not easily accessible.

13. Elected Members Should Put Infant Mental Health on the Political Agenda

Councillors have the ability to scrutinise and to raise awareness through campaigns. They are influential in their ability to influence partners and the direction of their own local authorities. It is recommended that cross-party groups – such as Health Scrutiny Committees – should build infant mental health into their scrutiny work programming, ask questions of the relevant Cabinet Member about services in the area, and use funding available to them (or over which they have influence) to help develop the third-sector offer in the infant mental health space.

See also recommendation 2, part B which relates to the promotion of mental health services as a 'day one' priority by Health Visitors.

82 Valued Lives (2022). "Important Announcement". Available at: **https://www.valuedlives.co.uk/#:~:text=Valued%20Lives%20was%20launched%20almost,on%20behalf%20of%20the%20NHS**

7 Implementing the Recommendations

Following completion of the research, experts and practitioners were presented with a copy of the recommendations and asked a series of questions about the steps necessary to implement them in a specific locality. North Cornwall was chosen as the focus of these discussions, to enable the conversations to cover challenges such as isolation, rurality and deprivation – as well as councils' and other partners' financial constraints.

Interviewees reflected upon:

- Their initial thoughts on the recommendations;
- How these recommendations could be put into practice in an area like North Cornwall, taking account of the challenges noted above;
- The individuals and organisations whose involvement would be required; and
- What requests of government might be required to remove the barriers to implementing these.

7.1 Local government cannot deliver these changes alone: the Early Action Group

Participants' responses clearly indicated the need for collaboration across local government; the early years and education sector; the voluntary sector; and private enterprise. It was noted that a forum in which representatives of these sectors are convened would be necessary to implement these recommendations – and to coordinate resources (often with a view to keeping costs low for councils and leveraging the input of the voluntary and private sectors).

This led to the overarching recommendation (stated earlier in the report) that local councils – either on their own or with neighbouring authorities – should establish an Early Action Group which is chaired by a relevant political figure (e.g. the Deputy Cabinet Member for Infants) and which includes members such as:

- Representatives of the Council's Early Years and Public Health teams
- Local childcare providers of different types
- Mental health specialists from within the local voluntary sector
- Business and business forum representatives
- Health Visitor representatives
- A representative of the local Family Hub
- The Chair of the local Integrated Care Board
- School representatives with responsibility for transition
- A representative of each political party on the Council.

The establishment of the Early Action Group would likely occur over three phases:

7.1.1 Phase One: Groundwork within the Council

The first phase of establishing an Early Action Group will require local authority officers and/or leaders agreeing that it is something they want to do – and then determining its footprint. Will this be an authority-wide initiative, or should it be done in conjunction with neighbouring councils?

Depending upon who within the Council has proposed the Early Action Group, there will be a requirement for consensus to be achieved among the Council's political leadership and its relevant chief officers. Conversely, it may be that an opposition party pushes for the introduction of an Early Action Group via a motion to Council (an example of which can be found at Appendix Six).

Practical steps, such as appointing the Cabinet/Deputy Cabinet Member for Infants, will vary depending upon the political makeup of the local authority and the governance arrangements in place within it. To this end, it will be up to each authority to decide if they wish to allocate, through their Independent Remuneration schemes, an allowance to Early Action Group board places or to cover expenses for participants. This would then require budgetary decisions to be made and the process of gaining cabinet approval or, indeed, passing the Council's budget may slow this process down.

There may also be consideration given to internal structuring. Cornwall Council is unusual in that its Education and Public Health officer teams – insofar as they relate to Early Years – are already integrated within a single directorate. Local authorities whose directorates for Education and Public Health are totally separate may need to give consideration to either a) restructuring or b) better data sharing, cooperation and resourcing – particularly under the joint direction of the new Cabinet/Deputy Cabinet Member.

7.1.2 Phase Two: Gaining Partner Support

Achieving buy-in from partner organisations is the next step.

Key partners are the NHS, Family Hubs and childcare provider partners. These are the services that deal directly with children and families in the locality and their involvement is essential; they should be contacted first.

Local schools and multi-academy trusts, charities and private sector organisations should be contacted second, once the initial partnership between the Council, NHS and childcare providers is in place, so that the core of the Early Action Group is formed and other partners are able to think seriously about their own involvement. A potential barrier to the involvement of the private sector, local schools or the voluntary sector is that the proposal is seen as in its infancy or lacking credibility: forming this initial partnership will help overcome that barrier.

The involvement of organisations – particularly from the voluntary sector and from the private sector – may evolve on an ongoing basis, either in response to local need or to fill gaps where key partners are underrepresented.

7.1.3 Phase Three: Meeting and Delivering

The third phase involves the first meeting of the Early Action Group, agreeing its terms of reference and setting out a schedule of meetings and meeting objectives. Hybrid participation will help organisations to overcome geographic challenges, especially in larger counties.

The Early Action Group should meet at regular intervals, as determined by the convening local authority, to determine how local resource within the public, private and voluntary sector can implement the recommendations of this report over a period of, for example, 3-5 years.

The table below indicates what interviewees saw as being the responsibility of each organisation represented on the Early Action Group. In this instance, the examples have been made applicable to North Cornwall and they are based on an 'ideal world' scenario. Nonetheless, it is recognised each local authority operates within a different context and the potential partner organisations will differ.

Interviewees recognised that the human resource within services across the early years sector is limited; a potential barrier, therefore, is the perception that participation in the Early Action Group might be a waste of time. It will be essential to communicate the proposed time and regularity of the meetings (including venue or hybrid options); to demonstrate that clear, worthwhile objectives that will lead to positive outcomes have been set; and that the expectations of partner organisations are commensurate with their current activities.

Organisation	Individual	Responsibility
Cornwall County Council	Leader of the Council	To appoint a Cabinet or Deputy Cabinet Member for Infants or to otherwise assign responsibility for Infants and the Early Action Group to an existing cabinet member.
	Cabinet/Deputy Cabinet Member	To chair the Early Action Group; to establish its terms of reference; to achieve buy-in from partner organisations to be part of the Early Action Group; to oversee multi-agency implementation of the recommendations; keeping the infant on the political agenda, fighting for higher spend on early years and ensuring that infants are always 'seen' by services designed for children and families
	Chief Executive, Director of Public Health and Director of Children's Services	Attend meetings of the Early Action Group; ensure a joined-up approach between different Council directorates, the voluntary sector and the role of the private sector; to coordinate – with the input of all members – localised literature and materials (as outlined in the Appendices).
	Elected Members	Apply political pressure to partner organisations; promote Early Years as a priority area within the Council; scrutinise the Early Action Group members' delivery of their individual objectives.
Local schools and Multi-Academy School Trusts (e.g. Cornwall Education Learning Trust)	Head or equivalent representative	To work with feeder nurseries and Family Hubs to improve transition to school/Reception; to provide relevant training to upskill staff – for example training on nutrition or literacy – to private nurseries and other local childcare providers.
NHS Cornwall and Isles of Scilly	Health Visitors	To inform other services of the problems faced by local families and the response required by other agencies; to support the implementation of the reading log programme.
	ICB Chair	To observe discussions at Early Action Group meetings and feed these issues into ICB meetings.
Bodin, Wadebridge and Launceston Family Hubs	Manager	To co-ordinate a directory of locally available services and third sector support and signpost families accordingly; to flag to the Early Action Group where there may be gaps in provision; to provide opportunities for services to be co-located within the hub (e.g. mental health counsellor); to co-ordinate appropriate outreach services – for example, a mobile book drop service – where appropriate; to work with partners (e.g. Health Visitors).

Organisation	Individual	Responsibility
Literacy charities (e.g. National Literacy Trust)	Representative	To provide books for distribution to new families via Health Visitors and Family Hubs; to – where possible – develop an app as an alternative to the physical reading log; to integrate literacy activities within other services.
School catering company (e.g. Chartwells)	Representative	To provide nutrition training to childcare providers upon request; to consider bulk purchasing of meals for a range of local nurseries via the Early Action Group.
Local nurseries (e.g. Early Birds Nursery)	Managers	To work with Family Hubs and schools and trusts to improve transition to school/Reception; to report concerns regarding the availability of childcare places and the financial health of private provision.
Mental health charities (e.g. Mind)	Representative	To participate in the coordination of multi-agency responses with, or on behalf of, Health Visitors; to develop services for infant mental health in line with local need, flagging personnel, training and funding needs to the Early Action Group; to promote services through Council communications.
Welfare and financial support charities (e.g. Citizens Advice)	Representative	To work with Family Hubs to provide up-to-date details of the scope and scale of available support locally and enable Hubs to signpost to support; to provide welfare advice in response to a multi-agency trigger.
Local Further and Higher Education providers (e.g. Bodmin College)	Early Years course representative	To support multi-academy trusts and childcare providers to upskill their staff with formal qualifications; to advise the local authority on the contents of any promotional work done around routes into childcare and early years education.

Establishing an Early Action Group in each local authority will present different challenges, relating to different financial, geographic and political landscapes – as well as based on the nature of the local voluntary sector and private sector. The challenges outlined here – e.g. concerns over time commitment or lack of credibility – arose from conversations with experts about the implementation of this idea; no doubt others will emerge when putting the proposal into practice. The key point is that the Early Action Group should a) act as a forum in which the local authority can use its convening powers to bring together the array of organisations that can contribute to an improved early years offer and b) keep the welfare and development of the infant high on the agenda of these organisations.

8 Conclusion

It is widely accepted that a child's early years are foundational to the rest of their lives – and that appropriate, positive interventions are required to give them the best possible start in life. From the food they eat to their mental health, children's life chances are shaped by the decisions adults (whether parents or professionals) make on their behalf.

But this report has exposed severe challenges within the early years at a national level which are exacerbated by local barriers that exist within the South-West peninsula specifically. These include social isolation caused by geography; high levels of deprivation leading to above average levels of child poverty; and higher nursery closure rates than any other region.

Funding and recruitment issues are the biggest concerns among the professionals working in the sector; from these, many other problems stem. The recommendations in this report reflect ways to implement best practice and effective service delivery methods at a local level.

But without national intervention on some of the fundamental challenges to the sector – the lack of money, the pressure on local government, the perception that early years education is a low-status sector to work in – local leaders will struggle to overcome these problems.

There are also other issues to consider:

- Affordable housing for families close to, or with good public transport links to, the centre of a community to improve engagement and overcome isolation.
- The structure of pension schemes to make early years careers more attractive.
- Addressing barriers experienced by SEND children – and providing councils with financial support for increasing SEND cost pressures.
- Improving the employment prospects of parents in low-income families to raise the total income of the household in which the child is being raised.

These factors sit outside of the remit of this report, but they contribute to the bigger picture when it comes to addressing challenges in the sector and giving a child the best start in life.

Delivering on a vision of a level playing field for children across the country – regardless of background, parental income or geography – will require a joined-up approach at a local level coupled with significant interventions by national government.

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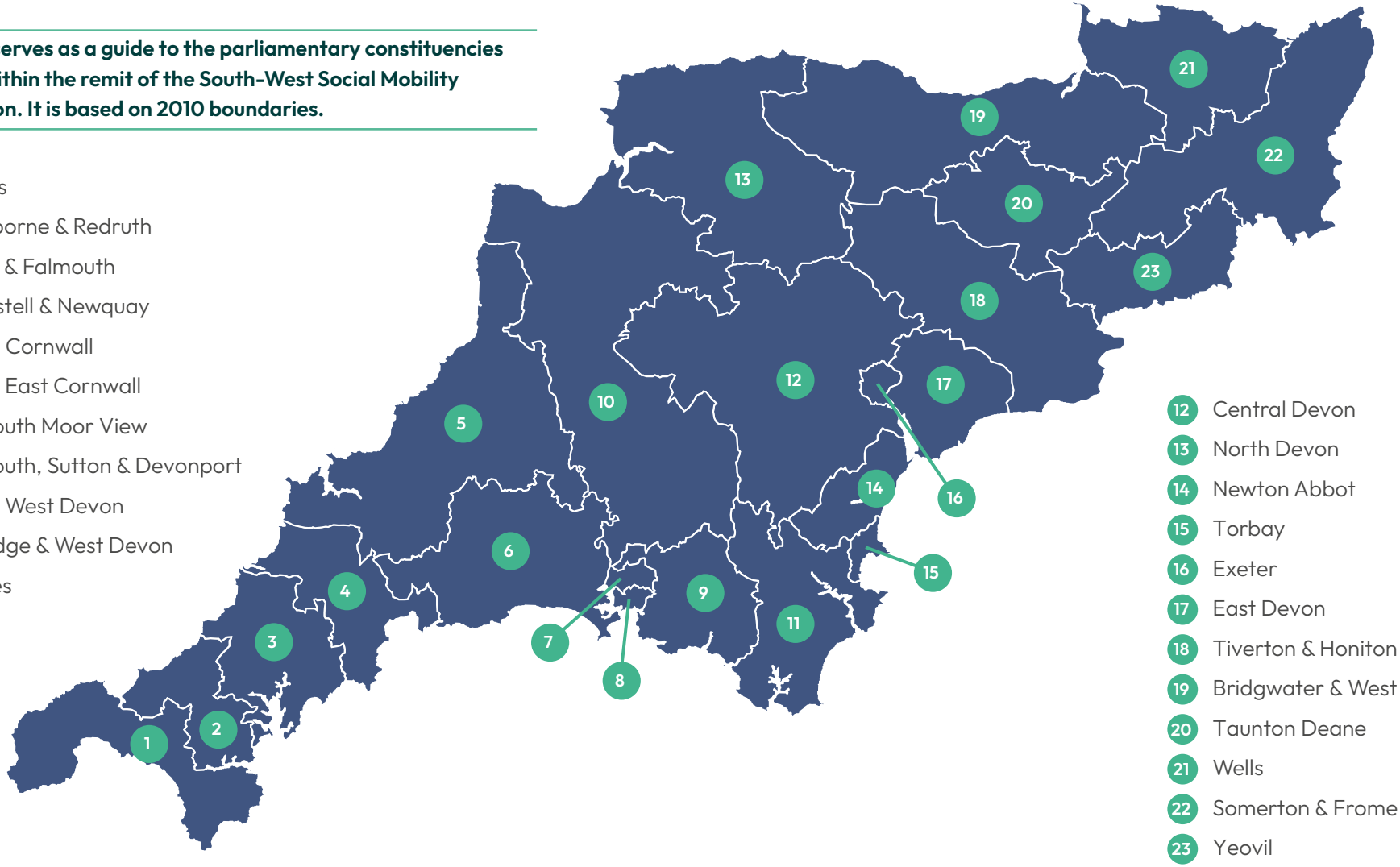
Appendix One:
Map of South-West Peninsula Parliamentary Constituencies (2010 Boundaries)

This map serves as a guide to the parliamentary constituencies that fall within the remit of the South-West Social Mobility Commission. It is based on 2010 boundaries.



1. St Ives
2. Camborne & Redruth
3. Truro & Falmouth
4. St Austell & Newquay
5. North Cornwall
6. South East Cornwall
7. Plymouth Moor View
8. Plymouth, Sutton & Devonport
9. South West Devon
10. Torridge & West Devon
11. Totnes
12. Central Devon
13. North Devon
14. Newton Abbot
15. Torbay
16. Exeter
17. East Devon
18. Tiverton & Honiton
19. Bridgwater & West Somerset
20. Taunton Deane
21. Wells
22. Somerton & Frome
23. Yeovil

Appendix Two: Reading Log

This is a proposal for what a reading log, to accompany the red book, may look like. It requires minimal parental input, but still encourages reading from an early age and records evidence that can be viewed by the Health Visitor initially and, subsequently, provided to the child's Reception teacher to show evidence of literacy development. The log is designed to facilitate a minimum of two reading sessions per week, of up to 15 minutes, with a space to log key milestones, as in the red book.

INFANT READING LOG

Name of child:

MILESTONES

MILESTONE	DATE ACHIEVED
First time you read together	
First time you finished a book together	
First time your child pointed at a picture	
First time your child laughed at a story	
First time your child repeated a word	
First time your child read a sentence out loud	
First time your child read to you at length	

MONTH 1: _____

	Name of book	Who was reading
1	*e.g. Welcome to the World*	e.g. baby and dad
2		
3		
4		
5		
6		
7		
8		
9		

MONTH 2: _____

	Name of book	Who was reading
1	*e.g. Welcome to the World*	e.g. baby and dad
2		
3		
4		
5		
6		
7		
8		
9		

Appendix Three: Careers Advice for Childcare

This is designed to provide an authoritative source of information to parents, and others, seeking to enter the early years education workforce. It is designed to be modified on a council-by-council basis with localised information inserted.

THINKING ABOUT A CAREER WORKING WITH INFANTS AND TODDLERS?

You could change a child's life for the better as an Early Years Practitioner or Educator. Find out how.

Early Years Practitioner
(Salary range: £21,000 - £27,000)

As an EY Practitioner, you can work in supporting roles in schools, nurseries and from home. Scan the QR code to find our more - including the right qualifications for you.

Localised QR code

Early Years Educator
(Salary range: £22,000 - £28,000)

EY Educators can go on to management roles within schools and nurseries, develop a specialism within early years, and go onto become teachers.

Scan the QR code to learn more.

Localised QR code

Visit [Council website] for accurate information about the qualifications you need for this profession.

Appendix Four: Nutritional Guidance for Early Years Settings

These documents try to simplify the UK government's nutrition guidance for early years settings, overcoming the barriers that a) it is not widely known and b) that the guidance itself runs to over 50 pages. These 'on a page' documents provide key guidance that can be easily accessed and understood.

10 KEY TIPS FOR PLANNING AND PREPARING EARLY YEARS MEALS

1. **Planning meals in advance can help with bulk buying and food preparation – saving time and keeping costs low.**
2. If shopping in a supermarket, look out for buy one get one free and own brand 'value' range products.
3. **Preparing meals from scratch can be cost effective. Try batch cooking and freezing meals to save time whilst reducing costs. Consider using a slow cooker if preparing meals for a small number of children.**
4. Cheaper cuts of meat can be just as tasty as more expensive ones, but need cooking for longer to make them tender. Factor in some extra cooking time to save money.
5. **Frozen and canned fruits can be used as alternatives to fresh fruit - but if purchasing fresh fruit, you should aim to buy what is in season as it will be cheapest and tastiest.**
6. Manage food waste wisely: check dates before use; put leftover food to good use; and store food correctly to keep it fresh.
7. **Food should be prepared, cooked and served in a clean and hygienic environment –wash hands thoroughly; wipe down food prep surfaces with an antibacterial cleaner before and after use; and use different chopping boards for meat and fruit or veg.**
8. Food should be cooked until it is steaming hot to ensure harmful bacteria is killed, but it needs to be given time to cool before serving.
9. **Children should be seated appropriately at meal times (e.g. at a high chair) and should be supervised whilst eating.**
10. Encourage good food habits by not labelling pudding or sweet snacks as 'rewards' for finishing a main meal.

Contact [name] from [Council] at [email] to organise nutrition training for you or your organisation.

Based on guidance published by the UK government and best practice research.

British Nutrition Foundation

5532-a-day

Perfect portions for little tums (1-4 years)

5 -a-day Starchy Foods
(Potatoes, bread, rice & pasta)

½-1 slice bread
1-2 oat cakes
3-6 tbsp breakfast cereal
1-3 tbsp mashed potato
2-5 tbsp cooked pasta/rice

5 -a-day Fruit & Vegetables
(Apples, oranges, broccoli & carrots)

2-6 carrot sticks
¼-1 banana
3-10 grapes (halved lengthways or ideally quartered)
½-2 tbsp peas
½-2 tbsp broccoli

3 -a-day Dairy Foods
(Milk, cheese & yogurt)

1 beaker of milk (100-120ml)
1 pot of yogurt (125ml)
1 cheese triangle

2 -a-day (3 portions if child is vegetarian) Protein Foods
(Beans, pulses, fish, eggs, meat and other proteins)

2-4 tbsp chickpeas, kidney beans, dhal, lentils or beans
2-4 tbsp cooked minced meat
¼-1 small fillet of fish

See overleaf for more examples...

www.nutrition.org.uk

Appendix Five: Food Standards Charter

This is intended to be printed as a large board to accompany an event (e.g. a CPD event) which will encourage early years providers to agree to follow a local authority charter on good nutrition. The idea is that those who sign up to the charter will sign this and pose with it for publicity purposes, with a view to encouraging other providers to sign up.

GOOD NUTRITION CHARTER

The following childcare providers have pledged to follow the Cornwall Council Good Nutrition Best Practice Guidance for Early Years Settings:

To follow published government guidance for early years food preparation and standards.

To actively participate in training opportunities provided by the Cornwall Early Action Group.

To ensure no child goes hungry whilst in our care.

Signed:

Appendix Six: Draft Motion (Early Action Group)

This draft motion is designed to enable opposition party elected members of a local authority to put the formation of an Early Action Group on their council's political agenda. It acknowledges that institution change within local government can be driven by political actors who are not in the governing party.

Draft Motion

(Early Action Group)

An infant's early years are foundational to the rest of their lives. Getting the best start in life requires a combination of health and education interventions – and research by the South-West Social Mobility Commission has outlined the role local government and its partners can play in that.

The Council therefore agrees to work towards the establishment of an Early Action Group which will take responsibility for implementing the recommendations of the University of Exeter's 2024 A Plan for Early Action report.

Signatories:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____