Department of Health

Universal Health Visitor Reviews

Advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015

September 2015

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Universal Health Visitor Reviews

Advice for local authorities to support delivery of the mandated universal health visitor reviews from 1 October 2015

Prepared by the Health Visitor Policy Team, Department of Health, based on dialogue and suggestions from representatives of its stakeholders who have made extensive contributions to facilitating the delivery of the new commissioning arrangements for health visitor services from 1 October 2015

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Executive Summary

Introduction

There is a robust evidence base for the importance of a child's early years in influencing outcomes and inequalities throughout their later adult life http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review. How we treat 0 to 5 year-olds will shape their lives – and ultimately our society.

Responsibility for the commissioning of public health services for children age 0 to 5 is moving from NHS England to local authorities (LA) on 1 October 2015. This process will complete the transfer of public health responsibilities from the NHS to LAs that started in April 2013 and will mean that LAs will have commissioning responsibilities for children's and young people's public health services across the 0 to 19 age range.

This document is primarily intended for those in LAs responsible for the commissioning of 0 to 5 public health services and for providers of those services. Its purpose is to help explain and provide the context of Regulations

http://www.legislation.gov.uk/uksi/2015/921/contents/made relating to the mandatory delivery of five key child development reviews as set out in the Healthy Child Programme (HCP)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf. The Regulations refer to these as 'universal health visitor reviews'. Others working in the early years environment may also find it useful. In addition, the document provides signposts to relevant useful materials.

Policy background

The key child development reviews, are sometimes referred to as the 'backbone of the HCP'. Government deemed their mandation necessary to ensure provision of the reviews in the context of a national, standard format, thus supporting universal coverage, and families' overall wellbeing; and to ensure LAs build on the momentum of the Health Visitor Programme working to increase capacity and hence a continuation of service transformation. The mandated reviews – Annex A – are the:

- antenatal health visit;
- new baby review;
- 6 to 8 week assessment;
- one year assessment; and

- the 2 to 2½ year review.

Mandation will also provide a degree of stability for families as the commissioning responsibilities transfer and embed into LAs.

To enable this, Regulations made in March 2015 come into force on 1st October 2015: 'The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015'. These mandate the reviews as set out in the HCP – see Chapter 2 – and describe who should carry them out. In this context, mandation means a public health step prescribed in Regulations as one that all LAs must take.

Over the past year or so, many local partners have been working together closely in the run up to the 0 to 5 years transfer, and we know that all are focused on securing the best outcomes for children.

1. Background to the changes

1.1. Every child is entitled to the best possible start in life and health visitors play an essential role in helping to achieve this. By working with, and supporting families during the crucial early years of a child's life, health visitors have a profound impact on the lifelong health and wellbeing of young children and their families. They also lead on the delivery of the 0 to 5 years elements of the HCP in partnership with other health and social care colleagues.

1.2. The Health Visiting Programme began in 2011, with the aim of providing a universal health visiting service which would give more families valuable help and support from their health visitor. The Programme's aims and objectives were set out in the 2011 'Health Visitor Programme – Call to Action' https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015 and were delivered in partnership by the Department of Health (DH), NHS England, Public Health England (PHE) and Health Education England (HEE).

1.3. LAs know their communities and understand local need, meaning they are able to commission the most vital services to improve local children's health and wellbeing. One of the benefits of LAs commissioning health visitor services is that it offers opportunities to link with wider systems, such as housing, early years education providers and to enable the integration of children's services. This in turn will provide a more joined-up, cost effective service built around individual need, paving the way to deliver across a wider range of public health issues.

1.4. LAs have the flexibility to ensure that the mandated universal services will support early intervention, community development and complex care packages in the context of local need. The smooth transfer of these services to LAs is an important step to reduce health inequalities through the provision of high quality care for every child and their family.

1.5. Mandating elements of the HCP will ensure that the increase in health visiting services' capacity achieved since 2011 continues as the basis for national provision of evidence-based universal services – supporting the best start for all children and enabling impact to be measured.

1.6. To support these aims, a national framework has been published to explain service transformation and help local services make further progress. This is known as 'HV 4-5-6' model (summarised at Annex B).

Health visitors and local government priorities

1.7. Public health improvement and protection is at the heart of what local government does. Health visitors can support and add value to LAs' role in public health by helping people to stay healthy and avoid illness. The latest PHE Health Profile summary shows that a number of LAs are prioritising children's and families wellbeing and development, including in areas such as: the best start in life for children; health inequalities; improving the health and wellbeing of children and young people; domestic abuse; maternity and parenting; mental health and wellbeing; obesity in children; and prevention and early intervention. Health visitors have a role to play in all of these areas.

1.8. Health visitor responsibilities are incredibly varied and with their close working relationship with families, health visitors are ideally placed within the local community to identify any support required and to enable parents to express their needs, through: leading and delivering child and family health services; providing ongoing additional services for vulnerable children and families; and by contributing to multidisciplinary services in providing effective local safeguarding and protecting children.

1.9. Being skilled at identifying vulnerable families means health visitors can enable parents to express their needs and decide on the support they receive. The type of support can include:

- referring families to specialists, such as speech and language therapists.
- arranging access to support groups, such as those provided by Sure Start children's centres.
- organising practical support - for example working with a nursery nurse on the importance of play.

1.10. Health visitors are trained in recognising the risk factors, triggers of concern, and signs of abuse and neglect in children. They also know what needs to be done to protect them.

1.11. Often, they are the first to recognise whether the risk of harm to a child has increased to a point where action needs to be taken to protect them. They will also maintain contact with families while formal safeguarding arrangements are put in place; ensuring families receive the best possible support during this time.

2. Requirements under the Regulations

2.1. This section outlines the nature of each of the five mandated reviews – see Annex A – and who will carry them out. It should be read in conjunction with the HCP and relevant material, including the NHS England national health visitor services specification 2015/16 (http://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf).

2.2. The HCP 0 to 5 is the overarching programme under which the 0 to 5 public health package is delivered as universal and targeted services. The HCP 0 to 5 provides a structured framework for delivery of key interventions to support the health and wellbeing of children 0 to 5. It is a universal service for all children and families which enables risk assessment and early identification of additional needs. The programme can ensure families receive early help and support upstream before problems develop further and reduce demand on downstream, higher cost specialist services – this programme is led by health visitors.

2.3. It is recommended that professional health visitors with specialist public health knowledge and clinical skills are used to deliver the 0 to 5's HCP. We would particularly recommend that at the very least the first three visits: antenatal; new baby; and 6 to 8 week should be carried out by the health visitor due to the need for continuity for the family as this will help assess infant mental health and attachment and enable detection of any concerns around neglect/safeguarding.

2.4. NICE guidance to local government on health visiting has produced guidance of direct relevance to each service level of the HCP. By implementing these guidelines LAs can ensure that an effective and cost effective health visitor service is delivered that acts as a key public health resource and can also help to achieve indicators in the Public Health Outcomes Framework (PHOF) (https://www.nice.org.uk/advice/lgb22/chapter/introduction). A PHE review of the evidence base for the HCP provides evidence of the cost effectiveness of programme interventions (https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence).

Return on investment

2.5. Early years' interventions have been shown to have a higher rate of return per investment than later interventions. The costs of delivery per child provide benefits to the individual, tax payers and others through improved educational outcomes, reduced healthcare costs, reduced crime and increased taxes paid due to increased earnings as an adult.

2.6. Return on investment on well-designed early years' interventions significantly exceed their costs. The benefits range from 75% to over 1,000% higher than costs, with rate of return on investment significantly and repeatedly shown to be higher than those obtained from most public and private investments.

2.7. The Early Intervention Foundation conservatively estimates that spending on 'late intervention' on children (i.e. spending which could have been prevented) costs the NHS £3bn per year (http://www.eif.org.uk/wp-content/uploads/2015/02/SPENDING-ON-LATE-INTERVENTION.pdf). This figure may however be an underestimate as it does not capture potential future costs in adulthood.

2.8. By enabling health visitors to use their skills and clinical judgement to deliver public health strategies to families in personalised ways, government has a delivery vehicle for the public health in the Early Years agenda. NICE guidance to local government sets out how health visiting teams provide expert advice, support and interventions to all families with children in the first years of life (http://www.nice.org.uk/advice/lgb22/chapter/about-this-briefing). It notes that they are uniquely placed to identify the needs of individual children, parents and families (including safeguarding) and refer or direct them to existing local services, thereby promoting early intervention.

2.9. Breastfeeding, for example, reduces the risk of childhood illnesses. If breastfeeding rates increased so that 45% of women exclusively breastfed for four months, and 75% of babies were breastfed at discharge from hospital, it has been estimated that more than £17 million in treatment costs could be saved in the UK each year.

2.10. The recently published OFSTED Chief Inspector's report on early years identifies the important role that health visitors have in school readiness and take up of free childcare for disadvantaged children has on system wide economic and societal benefits (https://www.gov.uk/government/publications/ofsted-early-years-report-2015).

2.11. The mandated reviews referred to in the HCP as being offered to pregnant women and children from birth to age five are set out in Annex A. It is also important to note the aggregated public health benefits of the range of family assessments and delivery of public health messages at key points during the first five years of a child's life when they can make the greatest difference. The assessments undertaken by health visitors go beyond the specific activities summarised here. The mandated reviews are prime opportunities to identify risk, emerging problems, and to pave the way for effective early intervention and signposting. The 'return' on such activity is that issues are tackled before they become more serious, impacting on families and/or impinging on costlier services.

The Family Nurse Partnership

2.12. The Family Nurse Partnership (FNP) is a voluntary home-visiting programme for first time young parents aged 19 or under. It is not a universal service. A specially trained family nurse visits the young parent regularly, from early in pregnancy until the child is two years old. Where a family is under the care of the FNP, described in the Regulations as FNP beneficiary, the mandated reviews will be carried out by the family nurse. To ensure continuity for the family, the family nurse should carry out the 2 to 2½ year review.

3. Requirement to review the new commissioning arrangements

Assessing service delivery

3.1. As part of providing stability to the 0 to 5 public services through the transfer and for a period beyond, the Regulations mandate the reviews for a period of 18 months from the date of transfer (1 October 2015).

3.2. The Regulations contain a 'sunset clause', meaning the mandated arrangements will cease to have effect on 31 March 2017. The Regulations also allow for a review to take place on the effectiveness of their operation.

3.3. DH will work in partnership with PHE to undertake any review of the new arrangements, which would be likely to consider a range of factors. The review would lead to the publication of a report to inform a recommendation to the Government. If it is recommended that the mandated arrangements should continue, the Regulations would need to be amended.

3.4. Establishing the uptake levels against the mandated checks will be fundamental in informing a decision. A report will not be published before 12 months from the transfer; this is to allow time for the new requirements to settle.

3.5. The review will be based on the objectives laid down in the Regulations that it should: (a) set out the objectives intended to be achieved through the mandated reviews and who they were carried out by; (b) assess the extent to which those objectives were achieved; and (c) assess whether those objectives remain appropriate, and if so, the extent to which they could be achieved with less regulation.

Measuring the new arrangements' progress

3.6. The Regulations will impact LAs by requiring them to take the prescribed steps in carrying out their commissioning role in respect of public health improvement services for 0 to 5 age children. In the context of commissioning the wider 0 to 5 programme, this should have a positive impact on LA commissioners, enabling them to provide a joined up public health service for 0 to 19 year olds, through a rejuvenated, expanded profession, following government investment in the Health Visitor Programme.

3.7. It has been made clear that the requirement of LAs to make arrangements for the reviews will be no greater than that of the NHS at the point of transfer; this has been reflected in the funding for LAs – i.e. with the transfer being undertaken on a 'lift and shift' basis, (explained further in the factsheet at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402451/Finance_Factsheet_1.pdf).

3.8. LAs should take a practical approach to the provision of the reviews, ensuring where possible, the number of reviews offered increases from the point of transfer. The Regulations do however require LAs to act with a view to securing continuous improvement in the percentage of eligible persons participating in the five mandated reviews. Increasing the number of reviews offered and improving participation rates will help move towards a truly universal service ensuring as many families as possible are able to benefit.

3.9. The National Health Visiting Service Specification has been published by NHS England ready for use in contracts for 2015/16 http://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf. It has been updated in view of the transfer of responsibility for public health commissioning for 0 to 5 year-olds to LAs from 1 October 2015. The period of use for this specification is 1 April 2015 to October 2015, or to 31 March 2016, subject to local agreement with LAs in regards to transfer of contracts. The preparation of a new specification for 2016/17 is currently under consideration as an aid to LAs.

Data on spend

3.10. Data on spend on the mandated reviews and other 0 to 5 public health children's services will be collected quarterly by the Department for Communities and Local Government; however the first three quarters will be summarised into two lines, total mandated and total non-mandated services. At Q4, data will show spend by each category, including the mandated 0 to 5 children's services and all other 0 to 5 children's services.

Service delivery

3.11. The health visitor service delivery metrics were developed by NHS England in order to provide assurance on service transformation in England. They cover: the antenatal check; new born visit; the 6 to 8 week review; the 12 month assessment; and the 2 to 2½ year assessments, and report on the following indicators:

- number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above;
- percentage of new birth visits completed within 14 days;

- percentage of new birth visits completed after 14 days;
- percentage of 6 to 8 week development reviews completed by 8 weeks;
- percentage breastfeeding (fully or partially) at 6 to 8 weeks;
- percentage of 12 month development reviews completed by the time the child turned 12 months;
- percentage of 12 months development reviews completed by the time the child turned 15 months;
- percentage of 2 to 2½ year reviews completed by age 2½ years;
- percentage of 2 to 2½ year development reviews delivered using the ASQ-3[1].

3.12. The use of the ASQ to monitor child development outcomes at age 2 to 2½ years is a new indicator in the 2015/16 collection. This comprises:

- percentage of 2 to 2½ year development reviews delivered using the ASQ-3;
- a new indicator for child development outcomes will be included in the PHOF from 2015/16. In the first instance this indicator will be coverage of the ASQ but later iterations will include achievement of child development milestones across a number of dimensions.

3.13. We anticipate that Q1 2015/16 data will be available around October 2015.

3.14. Work is ongoing to ensure the service delivery metrics data continues to be available following transfer of commissioning responsibility from NHS England to LAs. An interim reporting solution is being developed by PHE which will be used until the Children's and Young People's Health Dataset is fully in place.

[1] (i) The 6 to 8 week review is a new indicator in the 2015/16 collection.

(ii) The prevalence of breastfeeding at 6-8 weeks is included in the PHOF, http://www.phoutcomes.info/.

(iii) It is anticipated that Q1 2015/16 data will be available around October 2015.

4. Milestones and timings pre & post new arrangements

What	**When**
Transfer of the commissioning of 0 to 5 services	1 October 2015
Mandation Regulations come into force	1 October 2015
First available service delivery metrics data stemming from the new commissioning arrangements	March 2016
Publication of a report of review of the new mandated arrangements	Autumn 2016
Anticipated expiry of the Regulations to mandate the five universal reviews	31 March 2017

5. Annex A: The five mandated reviews

First visit: Antenatal visit at 28 weeks or above (health promoting visit)

The first time that the health visitor will meet with parents to discuss any concerns or issues that they may have about becoming parents; this is particularly important for first time parents. The antenatal appointment is the first time that the health visitor will meet with parents to explain the health visiting service offer and complete the initial holistic family health needs assessment. The health visitor will explore what is going well, as well as any difficulties that the family may be experiencing. This forms the basis for a shared understanding between parents and health visitors about family strengths and needs and mutual decision-making about appropriate goals and actions to improve health outcomes for all children. The assessment will include: emotional support, discuss transition to parenthood and attachment, identify families who need additional support, infant development, feeding, and the Healthy Start programme (https://www.healthystart.nhs.uk/).

A midwife will provide immediate care and support to the mother for the first few days after the birth.

Second visit: 10 to 14 days following the birth (the new baby review)

The first visit made by health visitor at home after the baby is born, where health visitors will check on the health and wellbeing of the parents and baby, support with feeding and other issues and give important advice on keeping safe, and to promote sensitive parenting.

The health visitor will ask the parents how they are feeling and how the family is adjusting to the new arrival. They will also enquire if they have any questions, (and listen to any concerns parents may have about baby's health or their health). This visit forms an important part of the ongoing holistic assessment of family risk and resilience factors started by the health visitor during the antenatal period. The time around the birth of a new child can often bring many unexpected changes to health needs; this may be due to many factors including complications associated with the baby's birth, parental mental health problems and the birth of a child with complex health needs. Parents widely report that they prefer continuity of practitioner which has also been found to improve the identification of health needs and uptake of the health visiting service offer.

Some examples of issues that parents may wish to discuss include: interacting with baby (e.g. songs and music, books); feeding; diet and nutrition; colic; sleep; crying; establishing a routine; safety; car seats; and the immunisation programme. They may also weigh the baby during their visit.

Third visit: When the baby is 6 to 8 weeks old (6 to 8 week assessment)

This visit is crucial for assessing the baby's growth and wellbeing alongside the health of the parent, particularly looking for signs of postnatal depression. It is a key time for discussing key public health messages, including breastfeeding, immunisations, sensitive parenting and for supporting on specific issues such as sleep. The health visitor will review their general health. They will also give contact details for the local health clinic or children's centre where the mother can get the baby weighed and access a range of support.

This visit is, in addition to the 6 to 8 week medical review, which is often completed by the GP and forms part of the child health surveillance programme.

Fourth visit: A review of the child's development at 9 to12 months (the one year assessment)

This visit may take place in the home, or in a local clinic or children's centre and focuses on the assessment of the baby's development. It provides an opportunity to discuss how to respond to their baby's needs and to look at safety and health promotion messages linked to next stages of development. It also provides an opportunity to identify where additional support may be needed, including things such as the child's diet, dental health, and safety issues. As part of the visit, the health visitor may weigh and measure the child and ensure it is being immunised. Ideally this review should take place close to the first birthday, though to allow flexibility, the Regulations direct that this should be between 9 and 15 months.

The health visitor can also put the mother in touch with local mother and baby groups, children's centres or activities in the area. Although the next scheduled visit is not until the child is 2 to 2½ years, the mother can always contact her health visitor or her GP, if there are any questions or concerns about the child's development. The health visitor is able to promote the two year free nursery offer at both the one and two year health reviews, improving school readiness for children from disadvantaged backgrounds.

Fifth visit: A review of the child's development at 2 to 2½ years (two to two and a half year review)

This visit can take place at the home, local clinic or children's centre. The universal two year review provides an opportunity to identify children who are not developing as expected and require additional early intervention to achieve PHE's goal of being "ready to learn at two and ready for school at five". This review is at a key time when specific problems may begin to be evident e.g. behaviour problems, speech and language delays. The review considers the health and development of the child alongside the wider environment of home and family

circumstances. It ensures that families are linked in with the right services and support where additional help is needed or if there are any concerns. It is an opportunity to talk about any issues the parent or carer may have regarding the child's health. This may include their hearing and vision, language development, behaviour, sleeping or toilet training. The child will also be weighed and measured, and parents can discuss immunisations and the various options for childcare and early years education.

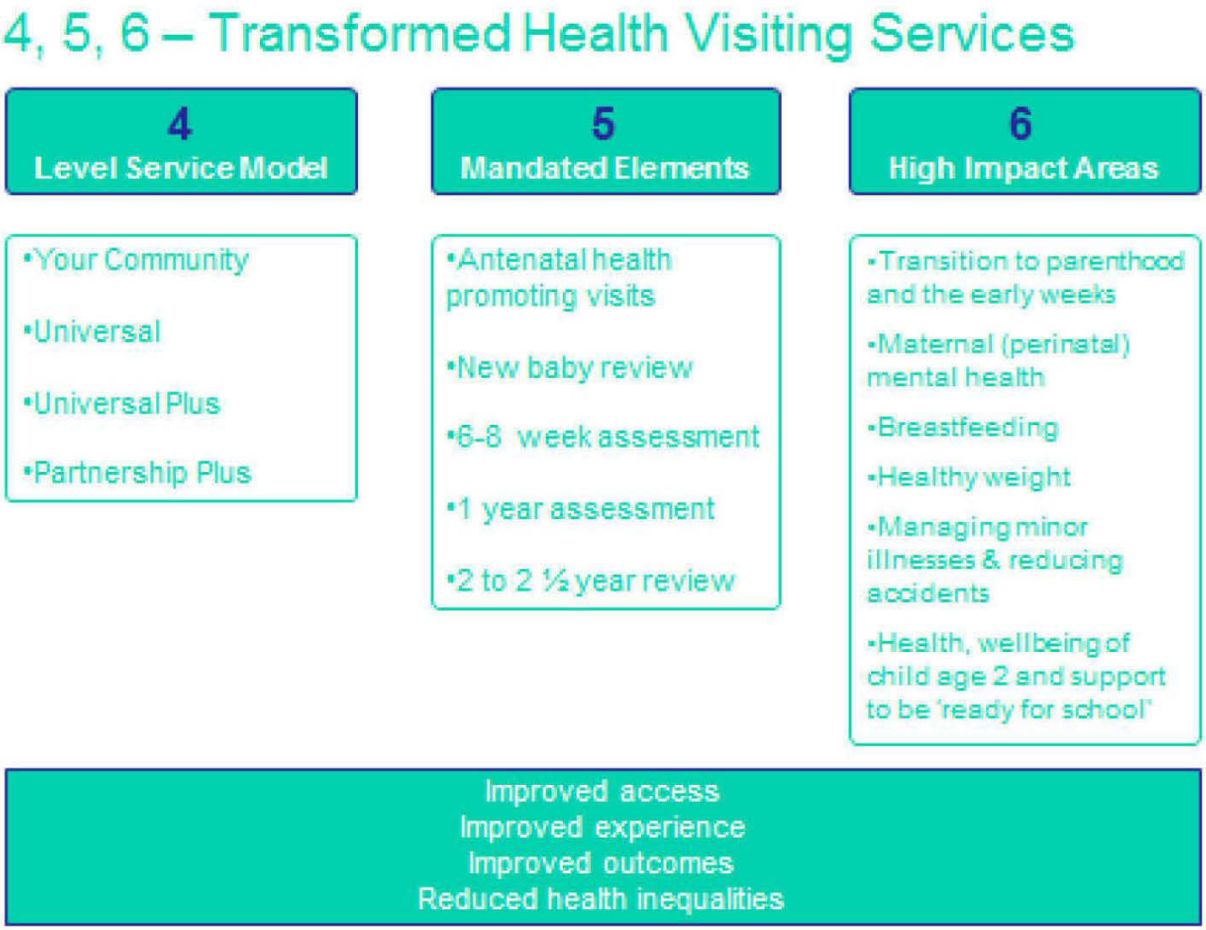
As part of the review, health visitors will work with parents to complete an ASQ about their child's development. Where a child already attends an early years setting, the two year health review may be integrated with the progress check undertaken at age two by early years providers. Integration may be through a joint meeting or information sharing between health and early years practitioners.

Although this is the last scheduled visit provided for in legislation, the health visitor is on hand to offer advice and information on health and development concerns until the child is five years old. The HCP outlines other key times where visits might be helpful, i.e. the 3 to 4 month visit.

Health visitors are highly trained, specialist community public health nurses. The wider health visiting team may also include nursery nurses, healthcare assistants and other specialist health professionals. Health visitors also work in close partnership with midwives who have an important role to play before birth and in the first days of life. The mandated arrangements make clear that health visitors should lead the delivery of the HCP to improve outcomes for children. Effective assessment of need lies at the heart of a good quality public health service for children and families and the health visitor should lead these assessments and only delegate universal health reviews to other suitably qualified members of the team when appropriate. Appropriate, safe delegation is deemed as effectively combining the local team's skill mix, so that it suits the circumstances of the family concerned and does not detract from the purpose of the HCP to improve health outcomes for children.

Health visitors' skills enable them to identify risk and individual need, and it is vital these elements are not missed due to inappropriate delegation. Hence, consideration should always be given to the most appropriate combination of professional inputs. A general principle might be one of ensuring such contributions are holistic and reflect as broad a picture as reasonably attainable about the child.

6. Annex B: HV '4-5-6' model



Health visiting services use a **4 tiered progressive model** to build community capacity to support children. This involves building community capacity to support parents of young children; universal reviews to identify need for early intervention and targeted services; targeted packages of care to meet identified need for example on early attachment, maternal mental health or breastfeeding or nutrition, and contributing and/or leading packages of integrated care for those identified as having complex needs or being at risk, including troubled families and safeguarding.

The **5 evidence-based reviews** are the mandated HCP health and development assessments, reviews forming the basis for a range of preventive and early intervention services to meet need: the antenatal health promoting visit; new baby review; 6 to 8 week (health visiting) assessment; one year assessment; and 2 to 2½ year review.

The **6 high impact outcomes** of health visiting and 0 to 5 services contribute to setting the foundation for future health and wellbeing set out above. These six are the transition to parenthood and supporting early attachment; maternal mental health; breast-feeding; healthy weight; preventing accidents and managing minor illness; and development at age two, underpinning school readiness.

7. Annex C: References

Health visitor and 0 to 5 transfer programme: case studies

Examples of good practice in the transformed health visitor programme, divided into the six high impact areas.

https://www.gov.uk/government/publications/health-visitor-and-0-5-transfer-programme-case-studies

Advice and support

Tools and models to support the development of the public health contribution of health visitors, nurses, midwives and allied health professionals.

https://www.gov.uk/government/collections/developing-the-public-health-contribution-of-nurses-and-midwives-tools-and-models

Developing Resilience in Practice: A Health Visiting Framework.

http://ihv.org.uk/uploads/iHV_Practitioner%20Document_AW%20WEB%2030.04.15.pdf

NICE's recommendations for LAs/partner organisations responsible for commissioning the HCP for pregnancy and the first 5 years of life, (Sept 2014).

https://www.nice.org.uk/advice/lgb22/chapter/Introduction

FNP information pack.

http://www.fnp.nhs.uk/fnp-information-pack

Planning and commissioning of public health services for 0 to 5 year olds transfers from the NHS to LAs in October 2015. Guidance documents.

https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

Minimum standardised data collection and reporting requirements to enable the effective commissioning of children's 0 to 5 years public health services.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409735/0-5_transfer_data_collection_and_reporting__3_.pdf

The Integrated Review guidance.

http://www.ncb.org.uk/what-we-do/research/our-research/a-z-research-projects/integrated-review-at-2-a-toolkit-for-local-authorities

http://www.ncb.org.uk/media/1201160/ncb_integrated_review_supporting_materials_for_practitioners_march_2015.pdf

Six high impact areas

Transition to parenthood and the early weeks. Pregnancy to age 2 is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing. Strong positive attachment is essential for healthy brain development and social and emotional resilience in later life.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326890/Early_Years_Impact_1.pdf

Maternal (perinatal) mental health. Around 1 in 10 mothers will experience mild to moderate postnatal depression and it can have a significant impact not only on the mother and baby, but also on her partner and the rest of the family.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326891/Early_Years_Impact_2.pdf

Breastfeeding (initiation and duration). Breastfeeding is a priority for improving children's health. Breastfed babies have a reduced risk of respiratory infections, gastroenteritis, ear infections, allergic disease and Sudden Infant Death Syndrome.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326892/Early_Years_Impact_3.pdf

Healthy weight, healthy nutrition (to include physical activity). Healthy eating habits are established in the early years. Over a fifth of 4 to 5 year olds are overweight or obese.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326893/Early_Years_Impact_4.pdf

Managing minor illness and reducing accidents (reducing hospital attendance/admissions). Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at Accident & Emergency departments and hospitalisation amongst the under 5s.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326894/Early_Years_Impact_5.pdf

Health, wellbeing and development of the child age 2 review (integrated review) and support to be 'ready for school'. Age 2 is an important time for identifying developmental concerns and for

providing advice to support and enhance readiness to learn and grow. Many children start school with poor communication skills, still wearing nappies and not emotionally ready to learn.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326895/Early_Years_Impact_6.pdf