East Sussex
County Council

The best possible start for all babies and young children

Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 1: The best possible start for all babies and young children.

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Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year's report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the East Sussex Health and Wellbeing Board's Health and Wellbeing Strategy for 2013-2016 "Healthy Lives, Healthy People".

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

To make the recommendations more easily accessible a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in the full annual report for that area, including all the recommendations contained in the appropriate appendix.

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries
Booklet 5:	Enabling people to manage and maintain their mental health and wellbeing

Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings
- may be viewed as potentially contentious or difficult to implement for other reasons.

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 1: The best possible start for all babies and young children

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 1 – all babies and young children have the best possible start in life

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 1: All Babies and Young Children have the best possible		
Babies and young children develop well and are safe and healthy.	• Ensure sufficient capacity is identified within midwifery, health visiting and children's centre services to provide high quality targeted support to all vulnerable parents who need it. • Roll out across the county an integrated partnership approach to identifying those who need extra support and coordinating support with regular meetings between all relevant services in local areas. • Increase breastfeeding support for women in the first five days after birth. • Ensure that all pregnant women who smoke are identified and offered support to give up. • Provide coordinated, personalised specialist support through a "single plan" for parents whose babies have special educational needs or disabilities.	• Fewer referr care. • More familie targeted "ea • Further impr proportion o and able to babies. • Fewer wome pregnancy. • Improved ra immunisatio • More babies with special disabilities health, care

S	STRATEGIC OUTCOME INDICATORS
start in life	
als to children's social es with babies given arly help" support. rovement in the of mothers choosing breastfeed their en smoking in tes of infant on and vaccination. s and young children educational needs or have a single plan for and education.	1.1 Increase the percentage of children who have been immunised for measles, mumps and rubella (MMR) by age 2. Indicator definition: MMR vaccination coverage for one dose (2 year olds). Baselines: (2011/12) England 91.2%; East Sussex 92.0%; Eastbourne 92.5%; Hastings 94.4%; Lewes 90.3%; Rother 91.4%; Wealden 91.4%. Targets by 2016: To achieve the World Health Organisation (WHO) recommended coverage of 95.0% by 2015/16 by achieving 94.0% in 2013/14; 94.5% in 2014/15; 95% in 2015/16 and to reduce the gap at district/borough level from 4.2% in 2011/12. 1.2 Improve the level of skills development of the lowest performing children at age 5. Indicator definition: Percentage of children achieving at least 78 points with at least 6 in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy of the Early Years Foundation Stage resident-based. Baselines: Academic year 2011/12: 29.8%. Target by 2016: Reduce percentage point gap between the lowest achieving 20% in the Early Years Foundation Stage profile and the rest. Targets to be set following new criteria from the Department for Education .

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The reviews focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 1: The best possible start for all babies and young children

Priority area	Sub-topic
The best possible start for all babies and young children	a. Interventions to support smoking cessation during pregnancy
	b. Interventions to support breastfeeding initiation and continuation
	c. Interventions to support parents of babies with special educational needs/disabilities
	d. Interventions to improve rates of infant immunisation and vaccination
	e. Interventions to achieve healthy weight during childhood (addressing obese and underweight children)

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality, perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source's methodology. Scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Controlled Trials, or RCTs with a very low risk of bias.
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
2++	High quality systematic reviews of case control or cohort or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
3	Non-analytic studies, e.g. case reports, case series.
4	Expert opinion.

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

2.2 Commissioning prioritisation

This booklet aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings; and
- may be viewed as potentially contentious or difficult to implement for other reasons.

Chapter 3: The best possible start for all babies and young children

Focus on	
3.1	Interventions to support smoking cessation during pregnancy
3.2	Interventions to support breastfeeding initiation and continuation
3.3	Interventions to support parents of babies with special educational needs/disabilities
3.4	Interventions to improve rates of infant immunisation and vaccination
3.5	Interventions to achieve healthy weight during childhood (addressing obese & underweight children)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013.

Public Health Outcome Indicator		Comparison to England
2.01	Low birth weight of term babies	Significantly better
2.02	Breastfeeding	
ii	prevalence at 6-8 weeks after birth	Better
2.06	Excess weight in 4-5 and 10-11 year olds	
i	4-5 year olds	Better
ii	10-11 year olds	Significantly better
3.03	Population vaccination coverage	
iii	Diphtheria/Polio/Haemophilus influenzae type B (1 year old)	Better
iii	Diphtheria/Polio/Haemophilus influenzae type B (2 years old)	Worse
iv	Meningitis C	Better
v	Pneumococcal Conjugate Vaccine	Better
vi	Haemophilus influenzae type B/Meningitis C booster (5 years)	**Significantly worse**
vi	Haemophilus influenzae type B/Meningitis C booster (2 years old)	Better
vii	Pneumococcal Conjugate Vaccine booster	Worse
viii	Measles Mumps Rubella for one dose (2 years old)	Worse
ix	Measles Mumps Rubella for one dose (5 years old)	Worse
x	Measles Mumps Rubella for two doses (5 years old)	**Significantly worse**

3.1 Key facts and figures: smoking in pregnancy

Smoking during pregnancy increases the risk of infant mortality by an estimated 40%. Around a third of all perinatal deaths in the UK are thought to be caused by smoking. Passive exposure to tobacco smoke, both before and after birth, also has a substantial impact on the risks of a range of foetal and childhood health problems. Smoking during pregnancy is strongly associated with younger age and lower socioeconomic status. It is the single most modifiable risk factor for adverse outcomes in pregnancy.[1]

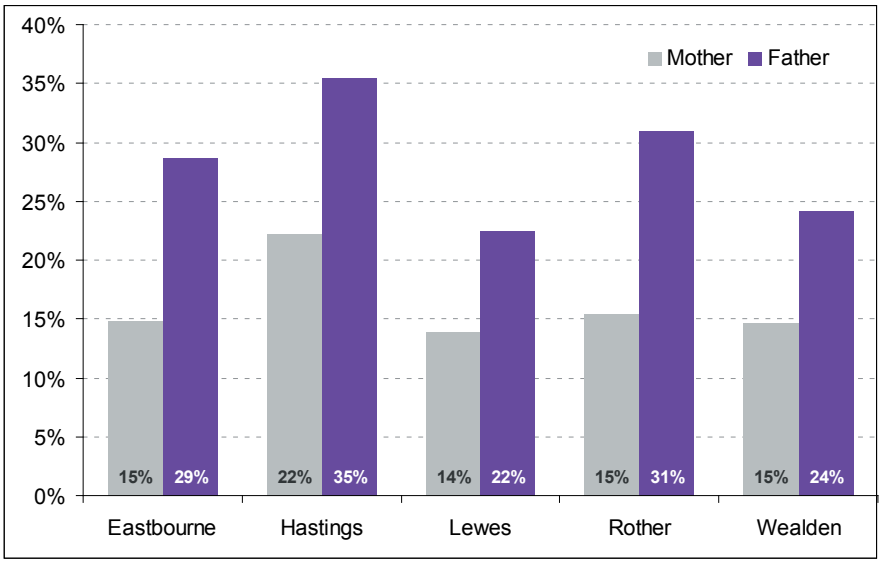
Figure 3.1 Percentage of mothers smoking at booking and time of delivery, by district and borough, 2011/12

Source: East Sussex JSNA, Local Briefing - Maternal Smoking in East Sussex 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

In East Sussex 18% of women are smoking at the time they book with the midwife at 10-12 weeks of pregnancy; 16% are still smoking at delivery suggesting that only 2% of women give up during pregnancy. Smoking rates are highest in Hastings both at booking (24%) and at the time of delivery (22%). They are lowest at booking in Wealden (14%) and at delivery in Lewes (11%) where more women appear to give up smoking during pregnancy.

At the 6 week health visitor review the smoking status of both parents is identified. Rates range from 14-22% in mothers and 22-35% in fathers. The highest rates for mothers and fathers are in Hastings.

Figure 3.2 Percentage of parents smoking at babies 6 week Health Visitor review, babies born in 2011/12



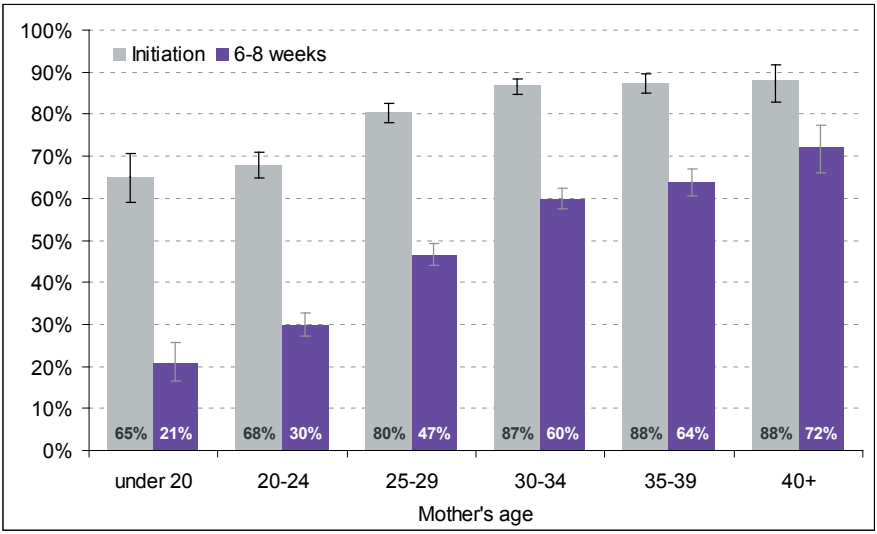
Source: East Sussex JSNA, Local Briefing - Maternal Smoking in East Sussex 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

There is a clear socioeconomic gradient across East Sussex with smoking rates being highest in the most deprived areas and lowest in the least areas.

3.2 Key facts and figures: breastfeeding

Breastfeeding has been shown to benefit infant health in terms of reducing the risk of infection, improving intellectual and motor development, and reducing chronic disease risk as well as benefiting maternal health in the short and long term. There are also additional economic benefits for the family, the NHS, employers and society. There are well-recognised age, education and socio-economic gradients in infant feeding practices with younger women from the lowest educational and socio-economic groups least likely to breastfeed.

Figure 3.3 Prevalence of breastfeeding initiation and breastfeeding at 6-8 weeks amongst babies of known status by maternal age, 2011/12

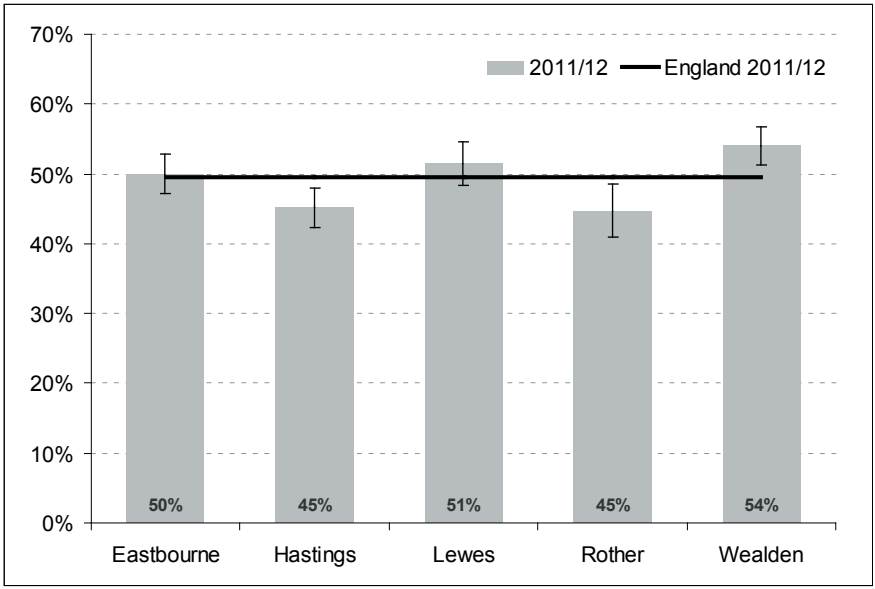


Source: East Sussex JSNA, Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012
www.eastsussexjsna.org.uk/briefings

In East Sussex the breastfeeding initiation rate and the rate at 6-8 weeks increase with the age of the mother with drop off rates being highest for younger women. Over two thirds of mothers aged under 20 who initiated breastfeeding in 2011/12 had stopped by 6-8 weeks, compared to less than half of those aged 25-29 years and around a quarter of those aged 35+ years.

Overall East Sussex breastfeeding rates at 6-8 weeks are in line with the England average with the highest rates being in Wealden and the lowest in Hastings. In both Hastings and Rother rates are significantly below the national average.

Figure 3.4 Percentage of mothers breastfeeding at 6-8 weeks by East Sussex local authorities with 95% confidence intervals, 2011/12



Source: East Sussex JSNA, Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012
www.eastsussexjsna.org.uk/briefings

3.3 Key facts and figures: babies with special educational needs or disabilities

Finding out their child has a complex health need and/or learning disability can be a very confusing and emotional time for parents. Whilst some may be given a specific diagnosis, others may be told their child has global developmental delay, or in some cases may never receive a specific diagnosis at all.

The prevalence of learning disability in England for babies up to 2 years of age is estimated at 39 per 10,000 for girls and 60 per 10,000 for boys. Based on these rates it is estimated that in East Sussex there are 50 children aged 2 years and under (30 boys and 20 girls) with learning disabilities.

There is a declining trend for congenital anomalies nationally. In 2010 (the latest available data) about 121 babies were born with congenital anomalies in East Sussex. Nationally the major cause of congenital abnormality is congenital heart defects (59/10,000) followed by chromosomal abnormalities (40.2/10,000). Congenital anomaly rates are likely to be higher than reported as most cardiac anomalies are diagnosed later in infancy and childhood.

Schools have a number of stages of increasing support for children with special educational needs. The first two stages are School Action and School Action Plus. The stage depends on the child's individual learning needs.

According to the January 2013 school census 21.3% (13,567) of children attending East Sussex Schools and Academies had Special Educational Needs: 3.6% (2,319) had a Statement of Special Educational Need; 6% (3,798) were at stage School Action Plus and 11.7% (7,450) School Action. Table 3.1 provides the breakdown in terms of primary, secondary and special schools.

Table 3.1: Special Educational Needs (SEN) in East Sussex Schools and Academies: January 2013

	SEN provision				
	School Action	School Action Plus	Statement of SEN	Total Number SEN	% SEN
Primary school	4103	2239	816	7158	19.9%
Secondary school	3344	1543	657	5544	20.6%
Special school	<5	<20	846	865	100.0%
All local authority schools	7450	3798	2319	13567	21.3%

Source data: School Census January 2013
Note: Some data suppressed to maintain confidentiality

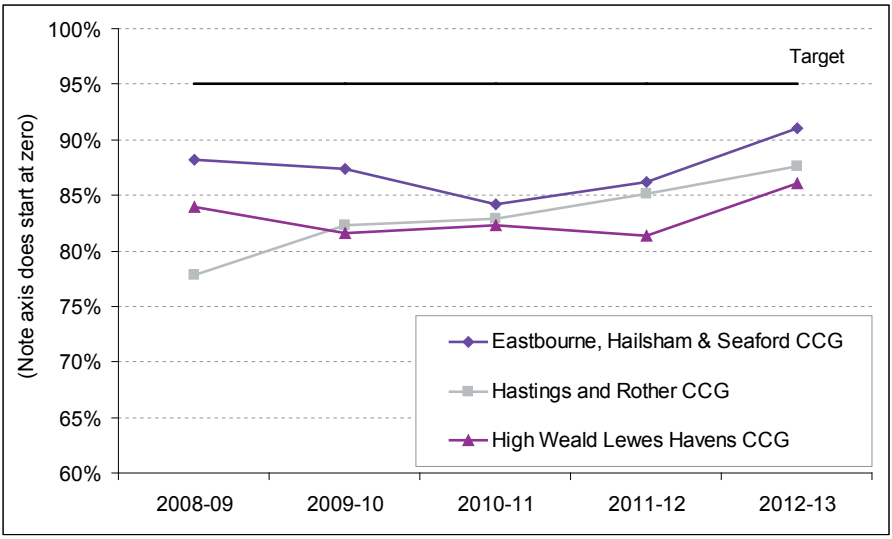
In the January 2013 school census there were 2,319 children with a Statement of Educational Need maintained by East Sussex County Council; of whom 4% (112) were under 5s. In the calendar year 2012, there were 410 Statements of SEN issued by East Sussex for the first time 26% (106) of which were for under 5s.

In 2014 the stages of support for children with SEN will be replaced by the new Education Health Care Plan. This will provide a simpler single assessment process for children from birth to 25 years and enable parents to buy in specialist SEN and disabled care. East Sussex is a pathfinder for the new system with over 300 students receiving services.

3.4 Key facts and figures: infant immunisation and vaccination

Immunisation is the most important way of protecting babies and children from some illnesses. Complications, including deaths, from vaccine preventable diseases such as measles, whooping cough, meningococcal serogroup C and tetanus have been greatly reduced since the implementation of the routine childhood immunisation programme.

Figure 3.5 Percentage of children who have been immunised for measles, mumps and rubella (MMR) by their 5th birthday



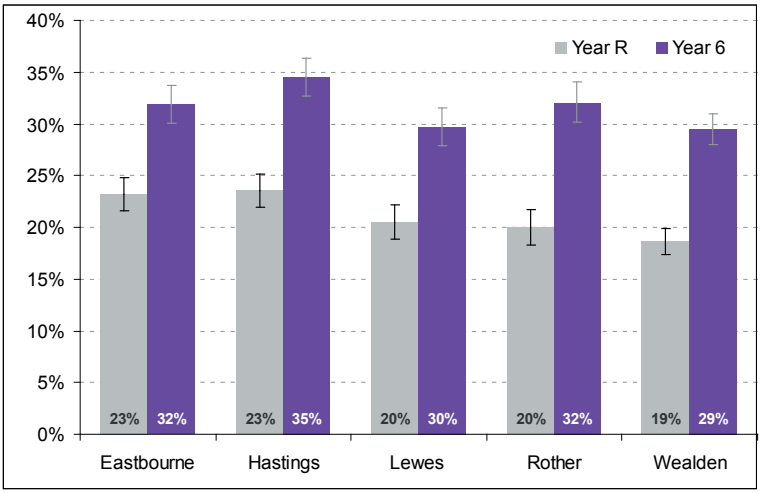
Source: East Sussex Child Health Information Systems

Whilst vaccination rates in East Sussex are generally better than the national average, uptake rates for MMR at 5 years still fall short of the national target of 95%, the level required to prevent disease outbreaks (herd immunity). Rates are highest in Eastbourne Hailsham and Seaford CCG and lowest in High Weald Lewes Havens CCG.

3.5 Key facts and figures: healthy weight during childhood

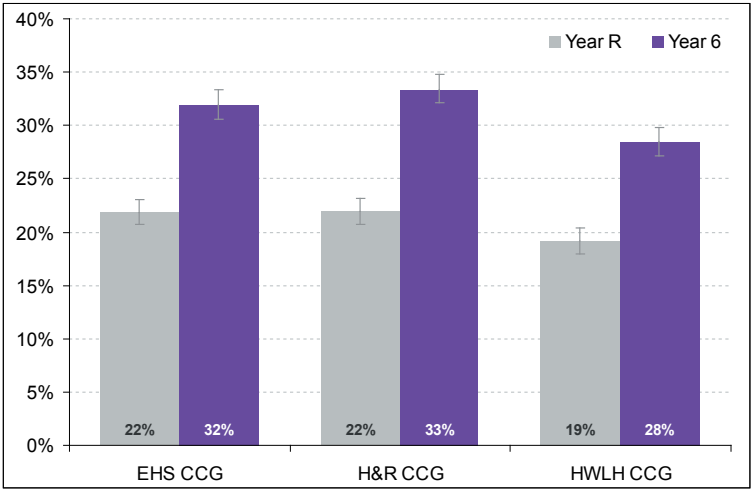
The World Health Organisation has declared childhood obesity to be one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

Figure 3.6a Prevalence of overweight and obese children by local authority and year group with 95% confidence intervals, 2009/10 to 2011/12



Source: East Sussex JSNA, Local Briefing - East Sussex National Child Measurement Programme 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

Figure 3.6b: Prevalence of overweight and obese children by clinical commissioning group and year group with 95% confidence intervals, 2009/10 to 2011/12



Source: East Sussex JSNA, Local Briefing - East Sussex National Child Measurement Programme 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

The National Child Measurement Programme annually measures the height and weight of English school children in reception year and year 6 to calculate the percentage who are overweight and obese. In East Sussex in the 2011/12 school year 97% of reception age children and 90% of year 6 children took part.

Nationally, obesity prevalence increases between Reception Year and Year 6 which is also the case in East Sussex. In Reception the prevalence of overweight and obesity are highest in Hastings and Eastbourne areas, and in Year 6 they are highest in Hastings, Rother and Eastbourne.

Across the East Sussex CCGs prevalence of overweight and obesity are lower in High Weald Lewes Havens CCG compared to Hastings & Rother CCG and Eastbourne, Hailsham & Seaford CCG.

There is a clear link between deprivation and obesity for both Reception and Year 6. The percentage of pupils who are obese in the most deprived areas is almost double that of the least deprived (based on national IMD 2010 quintiles).

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Chapter 4. Where gaps or weaknesses are identified, interventions for implementation should be prioritised using criteria outlined in Chapter 2.

1. **References:**

National Institute for Health and Clinical Excellence (NICE) (2010) Quitting smoking in pregnancy and following childbirth NICE public health guidance 26 www.nice.org.uk

Chapter 4: Evidence based recommendations for priority area 1

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted in this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK

2.2 Recommendations for interventions to support smoking cessation during

This evidence review recommends:

Intervention
Smoking cessation interventions
Promote:
2.2.1 the 5 A's (Ask, Advise, Assess, Assist, Arrange)
2.2.2 cognitive behaviour therapy, motivational interviewing and structured self-help and s
2.2.3 smoking cessation programs in all maternity care settings.
2.2.4 telephone counselling as an intervention to help pregnant women stop smoking.
2.2.5 the provision of incentives to quit; this has been effective in other countries in helpin whether it would work in UK).
2.2.6 interventions to increase smoking cessation among the partners of pregnant women.
2.2.7 group therapy.
Midwives
Ensure midwives:
2.2.8 identify pregnant women who smoke through discussion and the use of CO tests.
2.2.9 provide information in a variety of formats to pregnant women who smoke about the r exposure to second-hand smoke for both mother and baby.
2.2.10 refer all pregnant women who smoke, have stopped smoking within the last 2 weeks Services and are given the NHS Pregnancy Smoking Helpline number and local numbe
2.2.11 check if referral was taken up at the next appointment and, if not, offer another refer
2.2.12 identify if anyone in the household smokes and, if so, suggest they contact the NHS
2.2.13 who deliver intensive stop-smoking interventions are trained to the same standard a

pregnancy

	Grade
	A
upport from NHS stop smoking services	A
	A
	A
g women who are pregnant to quit smoking (research is required to see	A
	A
	A
risks to the unborn child of smoking when pregnant, and the hazards of	A
s, or have a CO reading of 7 parts per million or above to NHS Stop Smoking er when available.	A
ral to NHS stop smoking services	A
stop smoking services.	A
as NHS stop-smoking advisers.	A

Intervention
Health and support services
2.2.14 Ensure those responsible for providing health and support services for pregnant wor of smoking; refer them to NHS Stop Smoking Services; give the NHS Pregnancy Smok
Stop smoking services
Ensure NHS stop smoking services:
2.2.15 telephone all women who have been referred for help, and attempt to see those who
2.2.16 address any factors which prevent the women from using smoking cessation services
2.2.17 provide structured self-help materials.
2.2.18 send information on smoking and pregnancy to those who opt out during the initial t
2.2.19 are delivered in an impartial, sensitive, client-centred manner; they should take into
2.2.20 are tailored to meet individual needs and take place at times and in locations that m
2.2.21 collaborate with the family nurse partnership pilot and other outreach schemes to id and work in partnership with agencies that support women who have complex socia
2.2.22 identify partners that smoke and provide clear advice about the danger that other p and after birth.
2.2.23 recommend not smoking around the pregnant woman, mother or baby including not
2.2.24 offer partners who smoke help to stop using a multi-component intervention that co
2.2.25 choose an appropriate medication for the partner that seems most likely to succeed.
2.2.26 discuss the risks and benefits of NRT with pregnant women who smoke, particularly use only if smoking cessation without NRT fails.

	Grade
men identify pregnant women who smoke; provide information about the risks king Helpline number and local number when available.	A
o cannot be contacted by telephone.	A
s.	A
	A
telephone call.	A
account factors such as age, ethnicity, culture and language.	A
nake them easily accessible.	A
lentify additional opportunities for providing intensive and on-going support, al and emotional needs.	A
eople's tobacco smoke poses to the pregnant woman and to the baby – before	A
smoking in the house or car.	A
mprises three or more elements and multiple contacts.	A
.	A
y those who do not wish to accept other help from NHS Stop Smoking Services;	A

Intervention
Community
2.2.27 Promote strategies in the wider community to reduce social inequalities.
2.2.29 Support population-wide strategies for smoking control to reduce the initiation of sm

This evidence review does not recommend:

Intervention
2.2.30 Giving pregnant women feedback on the effects of smoking on the unborn child and
2.2.31 intensive counselling over brief counselling sessions.
2.2.33 Interventions involving additional group sessions during pregnancy.
2.2.34 smoking cessation materials without the direct input of health professionals, couns

2.3 Recommendations for interventions to support breastfeeding initiation an

This evidence review recommends:

Intervention
Ensure:
2.3.2 there is a written, audited and well-publicised breastfeeding policy that includes train professional responsible for implementing this policy should be identified.
2.3.3 all relevant healthcare professionals have demonstrated competency and sufficient on sound understanding of the physiology of lactation, neonatal metabolic adaptation an
2.3.4 all healthcare providers have a written breastfeeding policy that is communicated to a professional responsible for implementing this policy.
2.3.5 healthcare professionals have sufficient time to give support to a woman and baby du
2.3.6 health professionals are trained as part of a coordinated programme of interventions
2.3.7 health professionals who provide information and advice to breastfeeding mothers ha
2.3.8 support workers receive training in breastfeeding management from someone with th mothers.

	Grade
noking by young people	A

	Grade
on their own health.	A
	A
	A
ellors or group support.	A

d continuation

	Grade
ning for staff and support for staff who may be breastfeeding; a health	A
n-going clinical experience in supporting breastfeeding women, including a nd the ability to communicate this to parents.	A
ll staff and parents, each provider should identify a lead healthcare	A
ring initiation and continuation of breastfeeding.	A
across different settings to increase breastfeeding rates.	A
ave the required knowledge and skills.	A
e relevant skills and experience before they start working with breastfeeding	A

Intervention
2.3.10 midwives and health visitors provide pregnant women and their partners with breas this should be provided by someone trained in breastfeeding management and sho
2.3.11 new mothers are contacted directly within 48 hours of their transfer home (or within
2.3.12 new mothers are offered on-going support according to their individual needs.
2.3.13 GPs, obstetricians and midwives encourage breastfeeding during individual antenata who are least likely to breastfeed (e.g. young women, those who have low educatio
2.3.14 a midwife or health visitor trained in breastfeeding management provides informal g effectively by covering feeding position and how to attach the baby correctly.
2.3.15 that midwives or health visitors check that a mother can demonstrate how to positio feeding well before she leaves hospital (or before the midwife leaves the mother aft
2.3.16 that midwives or health visitors provide breastfeeding support at home and record a
2.3.17 that midwives or health visitors advise mothers that a healthy diet is important for e
2.3.18 nurses deliver early postpartum support to initiate breastfeeding.
2.3.19 that midwives or health visitors do not provide written materials in isolation but use
2.3.20 midwives, health visitors, paediatric nurses, nurses working in special-care baby un breast milk and advise mothers on how expressed milk can be stored and subsequ
2.3.9 education and information is provided to pregnant women on how to breastfeed, foll
Promote:
2.3.1 a multifaceted approach or a coordinated programme of interventions across different
2.3.21 the UNICEF/WHO Baby Friendly Hospital Initiative (BFI) training to improve breastfeed
2.3.22 structured breastfeeding programmes in acute maternity care settings to improve br

	Grade
stfeeding information, education and support on an individual or group basis; ould be delivered in a setting and style that best meets the woman's needs.	A
48 hours of a home birth).	A
	A
al consultations; they should pay particular attention to the needs of women nal achievement and those from disadvantaged groups).	A
roup sessions in the last trimester of pregnancy on how to breastfeed	A
n and attach the baby to the breast and can identify signs that the baby is er a home birth).	A
ll advice in the mother's hand-held records.	A
veryone and that they do not need to modify their diet to breastfeed.	A
	B
them to reinforce face-to-face advice about breastfeeding.	A
its, and nursery nurses show all breastfeeding mothers how to hand-express ently prepared.	A
lowed by proactive support during the postnatal period	A
settings to increase breastfeeding rates.	A
ding duration.	B
eastfeeding initiation.	A

Intervention
2.3.23 all forms of extra support to improve breastfeeding initiation, duration or exclusivity.
2.3.24 face-to-face support among healthy breastfeeding mothers with healthy term babies
2.3.25 peer counselling interventions (alone or in combination with a health professional) t
2.3.26 interventions that aim to increase maternal self-efficacy.
2.3.27 breastfeeding education and support, spanning from antenatal to postnatal period a mothers).
2.3.28 educational interventions with hands-on activities and role playing to enhance mate
2.3.29 breastfeeding promotion programs delivered via the internet.
2.3.30 breastfeeding specific clinic appointments to improve breastfeeding initiation, durat
2.3.31 group prenatal education to improve breastfeeding initiation, duration or exclusivity.
2.3.32 interventions for minority women that include: group prenatal breastfeeding educati and nutrition programs for women, infants and children.
2.3.33 professional support interventions spanning from pregnancy to the intrapartum peri
Adolescent mothers
2.3.34 Ensure adolescent mothers receive:
• practical and tangible assistance from nurses;
• practical help when initiating breastfeeding;
• emotional support (convey empathy, trust, and concern);
• network support.

	Grade
	A
.	A
o improve breastfeeding initiation, duration or exclusivity.	B
	B
and involving women's social network (including women's partners or	B
rnal self-efficacy.	B
	B
tion or exclusivity.	B
	B
on, breastfeeding specific clinic appointments, peer counselling interventions	B
od and throughout the postnatal period.	B
	B

Intervention
Neonatal
Promote:
2.3.35 close, continuing skin-to-skin contact between mother and infant for infants in neon
2.3.36 multifaceted interventions for infants in neonatal units to improve breastfeeding rat
Formula milk
Ensure:
2.3.37 that all parents and carers who are giving their babies formula feed are offered appr
2.3.38 that formula milk is not given to breastfed babies unless medically indicated. Comm be distributed.
2.3.39 breastfeeding women are offered skilled support in preventing, identifying and treat Inverted nipples, tongue tie, sleepy baby).

This evidence review does not recommend:

Intervention
2.3.40 support only offered if women seek help.
2.3.41 postpartum professional support delivered by nurses was found to be the least effec
2.3.42 written breastfeeding education materials as a stand-alone intervention.

2.4 Recommendations for interventions to support parents of babies with sp

This evidence review recommends:

Intervention
Commissioners and Managers
Ensure:

	Grade
atal units to promote breastfeeding/breast milk feeding	B
es.	B
opriate and tailored advice on formula feeding.	A
ercial packs containing formula milk or advertisements for formula should not	A
ing breastfeeding concerns (including nipple pain, engorgement, mastitis,	A

	Grade
	A
tive intervention type.	B
	A

ecial educational needs/disabilities

	Grade

Intervention
2.4.1 the social and emotional wellbeing of under-5s is assessed as part of the joint strateg
2.4.3 vulnerable children at risk of developing (or who are already showing signs of) social a universal children and family services
2.4.4 children and families with multiple needs have access to specialist services, includin
2.4.2 the promotion of integrated commissioning of universal and targeted services for chil
Tools
2.4.5 Promote population-based models as a way of determining need and ensuring resour
Local Authority
Ensure:
2.4.6 local authority scrutiny committees for health and wellbeing review delivery of plans a vulnerable children aged under 5.
2.4.7 family welfare, housing, voluntary services, the police and others who are in contact w the child's social and emotional wellbeing and raise any concerns they have with the f
2.4.8 Support children's services in ensuring that all vulnerable children can benefit from h up their entitlement to early childhood education, where appropriate.
Health Visitors or Midwives
Ensure:
2.4.9 health professionals in antenatal and postnatal services, school nurses and early yea emotional wellbeing.
2.4.10 a trained nurse visits families in need of additional support a set number of times ov positive changes.
2.4.11 during the home visit the nurse focuses on, where possible, developing the father–ch
2.4.12 they regularly check the parents' level of involvement in the intensive home visiting p

	Grade
ic needs assessment; this includes vulnerable children and their families.	A
and emotional and behavioural problems are identified as early as possible by	A
g child safeguarding and mental health services.	A
dren aged under 5.	A
ces and services are effectively distributed.	A
and programmes designed to improve the social and emotional wellbeing of	A
with a vulnerable child and their family are aware of factors that pose a risk to family GP or health visitor.	A
igh quality childcare outside the home on a part or full-time basis and can take	A
r's practitioners identify factors that may pose a risk to a child's social and	A
ver a sustained period of time, sufficient to establish trust and help make	A
hild relationship as part of an approach that involves the whole family.	A
programme.	A

Intervention
2.4.13 they explain to parents that home visits aim to promote the healthy development of t to a wide range of attitudes, expectations and approaches in relation to parenting.
2.4.14 they enable both parents to fully participate in home visits, by taking into account th
2.4.15 they work in partnership with other early year's practitioners to ensure families receiv
2.4.16 they promote evidence-based interventions to improve maternal sensitivity and moth
2.4.17 they encourage parents to participate in other services delivered by children's centre
Child care and Early Years Services
2.4.18 Ensure that child care and education services:
• offer flexible attendance times, so that parents or carers can take up education, tra
• address any barriers that may hinder participation by vulnerable children such as s stigma.
• are run by well-trained qualified staff, including graduates and qualified teachers.
• based on an ethos of openness and inclusion.
Managers and providers of child care and Early Years Services
Ensure:
2.4.19 services enable all vulnerable children to benefit from high quality services which ai learn.
2.4.20 services
• provide a structured, daily schedule comprising a balance of adult-led and child in
• ensure parents and other family members are fully involved
• ensure the indoor and outdoor environment is spacious and well maintained.
2.4.21 a process is in place to systematically involve parents and families in reviewing servi
2.4.22 they are systematic and persistent in their efforts to encourage vulnerable parents to
2.4.23 use outreach methods to maintain or improve the participation of vulnerable parents

	Grade
he child. Taking into consideration the parents' first language and sensitivities	A
eir domestic and working priorities and commitments.	A
ve coordinated support.	A
ner–infant attachment.	A
s and as part of the Healthy Child Programme.	A
	A
aining or employment opportunities.	
geographical access, the cost of transport or a sense of discrimination and	
m to enhance their social and emotional wellbeing and build their capacity to	A
	A
itiated activities	
ces and suggesting how they can be improved.	A
use Early Years Services.	A
s and children in programmes and activities.	A

Intervention
2.4.24 work with community and voluntary organisations to help vulnerable parents who m
Parents and children
Ensure:
2.4.25 parents who lack confidence or who are isolated, receive particular encouragement.
2.4.26 parents are included in psychological therapies that reduce pain in children with pai
2.4.27 parents are included in CBT programmes focussed on improving the primary symptom
Promote:
2.4.28 problem solving therapy delivered to parents to improve parent problem solving skil
2.4.29 group-based parenting programmes.
Parents of babies with special educational needs/disabilities
Promote:
2.4.30 parenting and stress management interventions for parents of children with develop
2.4.31 early intervention programmes for children from birth to nine years who have a physi
2.4.32 parent training as a centre piece for interventions geared toward children with intelle
2.4.34 parent training for the parents of children with Attention Deficit Hyperactivity Disorde
2.4.33 Ensure: developmental disabilities are paired with instructions and teaching occurri

This evidence review does not recommend:

Intervention
2.4.35 Psychological therapies that include parents in most outcome domains of functionin

	Grade
ay find it difficult to use health and Early Years Services.	A
	A
inful conditions.	A
m complaints	A
ls and parent mental health.	A
	A
omental disabilities.	B
cal disability.	C
ectual disability (ID).	B
er (ADHD) aged 5 to 18 years.	B
ng at school or through early intensive behavioural intervention programs.	B

	Grade
g, for a large number of common chronic illnesses in children.	A

2.5 Recommendations for interventions to improve rates of infant immunisati

This evidence review recommends:

Intervention
Reminder/recall systems
Promote:
2.5.1 interventions that incorporate tailored invitations for immunisation and reminder/rec
2.5.2 patient reminder and recall in the following order (1) Person-to-person telephone remi
Home visits
Promote:
2.5.3 home-visit interventions that consist of a healthcare professional or trained communi offering to give their children vaccinations there and then (or arrange a convenient tim
2.5.4 a home vaccination service targeted at children not up-to-date with immunisation sch
2.5.5 home visits for groups that may not use primary care services, for example, travellers
Knowledge and education
Ensure children aged under 19 years and their parents:
2.5.6 are provided with tailored information, advice and support to ensure they know about
2.5.7 have an opportunity to discuss any concerns they might have about immunisation. Th paediatrician, health visitor, school nurse or practice nurse.
2.5.8 are provided with accurate, up-to-date information in a variety of formats on the bene tailored for different communities and groups.
2.5.10 Ensure: health professionals have enough time to discuss immunisation
2.5.9 Promote interventions that encourage parents to base their decisions less on emotion benefits and risks of immunising on the basis of scientific evidence.

ion and vaccination

	Grade
all systems followed up by telephone or text message.	A
inders (2) Letter reminders (3) Postcard reminders.	A
ty support worker visiting parents in their homes to discuss immunisation, and ne in the future).	A
edule.	B
or asylum seekers.	A
t the recommended routine childhood vaccinations and the benefits and risks.	A
is could either be in person or by telephone and could involve a GP, community	A
fits of immunisation against vaccine-preventable infections. This should be	A
	C
nal variables, such as anticipated responsibility or regret, and to assess the	B

Intervention
School
Encourage:
2.5.11 head teachers to ask about immunisation status on school entry.
2.5.12 school nursing teams to work with GP practices and schools to check the vaccination college.
2.5.14 schools to become venues for vaccinating local children.
2.5.13 Ensure school nursing teams explain to parents of children and young people that ar
2.5.15 Promote vaccination requirements for child care, school, and college attendance.
Hospital-based opportunistic immunisation
2.5.16 Promote opportunistic immunisation of children in accident and emergency departm
Multi-component
2.5.17 Promote targeted multi-component community-based interventions.
Monitoring and feedback of vaccination status
Ensure:
2.5.18 vaccination status of all children aged under 19 is checked at every appropriate oppo
2.5.19 GP practices have a structured, systematic method for recording, maintaining and tra than 19.
2.5.20 private providers are encouraged and enabled to give the relevant GP practice detail recorded in the appropriate information system.
2.5.21 the databases for recording children and young people's immunisation status is regu

	Grade
	C
status of children and young people when they transfer to a new school or	A
	A
e not up-to-date with their vaccinations, why immunisation is important.	A
	B
ents, or during a hospital admission.	A
	B
rtunity.	A
ansferring accurate information on the vaccination status of all children aged less	A
s of all vaccinations administered to children and young people, so they can be	A
ularly updated and maintained	A

Intervention
2.5.22 the Healthy Child Team checks the immunisation record of each child aged up to 5 ye school, playgroup, children's centre or when they start primary school. The check sh parents.
2.5.23 Promote: audit and feedback of children and young people's immunisation status an
Health professionals
Ensure:
2.5.24 there is an identified healthcare professional in every GP practice who is responsible
2.5.25 all immunisation services staff are appropriately trained.
2.5.26 health professionals who deliver vaccinations have received training that complies w
2.5.27 health professionals working with children and young people have the appropriate k
2.5.28 staff are appropriately trained to document vaccinations accurately in the correct rec
2.5.30 all staff involved in immunisation services for children aged under 19 have access to
Access and capacity of immunisation programmes:
Ensure
2.5.31 good access to immunisation services by extending clinic times, ensuring children ar family friendly.
2.5.32 that enough immunisation appointments are available so that all local children unde
2.5.33 that the age composition of the practice population is monitored so that there is eno
2.5.34 good access to immunisation services for those with transport, language or commun
2.5.29 Promote: registered nurses, physician assistants, and medical assistants to indepen vaccines under physician supervision.

	Grade
ears. They should carry out this check when the child joins a day nursery, nursery hould be carried out in conjunction with childcare or education staff and the	A
nd vaccination coverage.	B
e – and provides leadership – for the local childhood immunisation programme.	A
	A
with the national minimum standard for immunisation training.	A
nowledge and skills to give advice on the benefits and risks of immunisation.	A
ords.	A
the 'Green book'.	A
nd young people are seen promptly and by making sure clinics are child and	A
er the age of 19 can receive the recommended vaccinations on time.	A
ugh capacity to provide timely immunisations.	A
ication difficulties, and physical or learning disabilities.	A
ndently screen patients, identify opportunities for immunisation, and administer	B

Intervention
Hepatitis B
Ensure:
2.5.37 there is an identified person responsible for coordinating the local hepatitis B vaccin
2.5.38 babies born to hepatitis B-positive mothers are given a first dose of the vaccine prom all other recommended doses, a blood test to check for infection and, where approp

This evidence review does not recommend:

Intervention
2.5.39 Client/family incentives (or disincentives) at increasing uptake of immunisations in c

2.6 Recommendations for interventions to achieve healthy weight during c

This evidence review recommends:

Intervention
Commissioning
Encourage:
2.6.1 commissioners to develop a coordinated approach to the prevention of obesity.
2.6.6 clinical commissioning groups to identify an obesity or public health lead to work with
2.6.2 Raise awareness of the health problems caused by obesity and the benefits of being a
2.6.3 Provide training to meet the needs of staff and volunteers.
2.6.4 Influence the wider determinants of health that encourage physical activity.
2.6.5 Ensure commissioners and organisations promote, through the health and wellbeing address obesity prevention and management.
2.6.7 Support the identification of a senior council member to be a champion for children a

	Grade
ation programme.	A
mptly, whether they are delivered in hospital or at home. They should then receive oriate, hepatitis B immunoglobulin, in line with the 'Green book'.	A

	Grade
children of low-income families.	B

hildhood (addressing obese and underweight children)

	Grade
n the public health team on joint approaches to tackling obesity.	A
a healthier weight among partners and the public.	
	A
board, a coherent, community-wide, multi-agency approach is in place to	A
nd young people's physical activity.	A

Intervention
Community engagement
Encourage:
2.6.8 community engagement and capacity-building methods to identify, train, and provide potential to co-produce action on obesity as part of an integrated health and wellbein
2.6.9 coordinators and community engagement workers to jointly plan how they will work w
Training
Ensure:
2.6.10 frontline staff set aside dedicated time to deliver specific aspects of the obesity agen community and improve their practical implementation skills.
2.6.11 health professionals have the appropriate knowledge and skills to give advice on the during and after pregnancy.
2.6.12 health professionals are trained in strategies for changing people's eating behaviour
2.6.13 health professionals discuss the woman's diet and eating habits early in pregnancy.
Healthy eating interventions
Encourage:
2.6.14 health professionals to inform pregnant women with a pre-pregnancy body mass ind BMI over 30, about the increased risks this poses to themselves and their babies a
2.6.16 commissioning agencies, local authorities, and public health nutritionists and dietic community-based initiatives which aim to make a balanced diet more accessible to cooperatives, 'cook and eat' clubs, 'weaning parties' and 'baby cafes'.
2.6.15 Ensure all people working with infants and pre-school children up to the age of 5 yea eating. They should encourage children to handle and taste a wide range of foods th

	Grade
e resources to networks of local people, champions and advocates who have the g strategy.	A
ith population groups, or in geographic areas, with high levels of obesity.	A
nda and receive training to improve their understanding of the needs of the local	A
nutritional needs of women and the importance of a balanced diet before,	A
, particularly by offering practical, food-based advice.	A
	A
ex (BMI) over 30, and those who have a baby or who may become pregnant with a nd encourage them to lose weight before becoming pregnant or after pregnancy.	A
cians to provide support (both practical and financial) to develop and maintain families with children under 5 years on a low income. Examples include: food	A
rs implement a food policy which takes a 'whole settings' approach to healthy hat make up a healthy diet.	A

Intervention
Physical activity
Ensure:
2.6.17 Children and young people's plans, joint strategic needs assessments, local develop explicitly address the need for children and young people to be physically active.
2.6.18 there is a coordinated local strategy to increase physical activity among children and
2.6.19 physical activity initiatives aimed at children and young people are regularly evaluat
Support:
2.6.20 provision of places and facilities (both indoors and outdoors) where children and yo
2.6.22 physical activity programmes for all ages of children that ensure children have the o they can enjoy by themselves and those they can do with friends and family.
2.6.21 Encourage: employers or supervisors of people who provide programmes or opportu ensure staff and volunteers have the skills, including interpersonal skills, to design meet children and young people's different needs and abilities. Those leading activ
Parent involvement
2.6.23 Support interventions combining general parenting components with lifestyle compo

This evidence review does not recommend:
Intervention
2.6.24 programs offering additional support during pregnancy. Additional support was defi in home visits or during clinic appointments, and could include tangible assistance

	Grade
oment and planning frameworks, sustainable community plans and strategies all	A
young people, their families and carers.	A
ed.	A
ung people feel safe to take part in physical activities.	A
opportunity to explore a range of physical activities to help them identify those	A
nities for children and young people aged 18 and under to be physically active to , plan and deliver physical activity sessions including active play sessions, that ities should make them enjoyable.	A
onents.	B

	Grade
ned as some form of emotional support and information or advice or both, either to clinic appointments, assistance with care of other children at home.	A

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