NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Early years: promoting health and wellbeing in under 5s

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the quality standard for Early years: promoting health and wellbeing in under 5s. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

Social and emotional wellbeing: early years NICE public health guideline PH40 (2012). Review date scheduled for October 2016.

Social and emotional wellbeing in primary education NICE public health guideline PH12 (2008). Review date scheduled for October 2016. The guideline was reviewed and overall, it was agreed that the recommendations still stood. However there was additional evidence available to further elaborate the detail in recommendations. The guidance will therefore be updated.

Paediatric Continence Commissioning Guide (2014) Paediatric Continence Forum NICE accredited guidance.

2 Overview

2.1 Focus of quality standard

This quality standard will cover supporting the health, and social and emotional wellbeing of children aged under 5 years, through home visiting, childcare and early education. It will include vulnerable children who have or are at risk of health, social and emotional problems, and who need additional support. It will not cover the clinical treatment of emotional and behavioural difficulties or mental health conditions, or the role of child protection services.

2.2 Definition

Social and emotional wellbeing provides the building block for healthy behaviours and educational attainment. It also helps prevent behavioural problems, including substance misuse, and mental

illness. For the purposes of this quality standard, the following definitions are used, in line with the Department for Education's statutory framework for the early years foundation stage:

- emotional wellbeing – this includes being happy and confident and not anxious or depressed
- psychological wellbeing – this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive
- social wellbeing – has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully.

2.3 Incidence and prevalence

Social and emotional wellbeing is important in its own right and it also provides the basis for future health and life chances. Poor social and emotional capabilities increase the likelihood of antisocial behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity. For example, aggressive behaviour at the age of 8 is a predictor of criminal behaviour, arrests, convictions, traffic offences, spouse abuse and punitive treatment of their own children.

Relationships and environment

The child's relationship with their mother or main carer has a major impact on social and emotional development. In turn, the mother's ability to provide a nurturing relationship is dependent on her own emotional and social wellbeing and intellectual development and on her living circumstances. This includes family environment, social networks and employment status.

Most parents living in poor social circumstances provide a loving and nurturing environment, despite many difficulties. However, children living in a disadvantaged family are more likely to be exposed to adverse factors such as parental substance misuse and mental illness, or neglect, abuse and domestic violence. Consequently, they are more likely to experience emotional and behavioural problems that can impact on their development and opportunities in life. For example, measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5, compared to children from more affluent backgrounds. There are less opportunities after the preschool period to close the gap in behavioural, social and educational outcomes.

Early childcare and education

The level and quality of early childcare and education services varies, with the most disadvantaged children likely to get the worse provision. In addition, only an estimated 50% of children aged 2 and 2½ years in England are being assessed as part of the Healthy Child Programme and not all women are being offered antenatal and parenting support services.

There is limited UK data on the indicators that provide an overall measure of the social and emotional wellbeing of children aged under 5 years. Independent reviews recommend that measures should be developed to assess children's cognitive, physical and emotional development at ages 3 and 5 years.

Unexplained infant deaths

249 unexplained infant deaths occurred in England and Wales in 2013[1], a rate of 0.36 deaths per 1,000 live births. This was the first rise in unexplained infant deaths since 2008. Before 2013, the rate had fallen steadily from 0.41 in 2008 to 0.32 in 2012. The rate of unexplained infant deaths rose from 0.92 to 1.27 for mothers aged under 20. This was four times greater than the combined categories of babies born to mothers aged 20 and over (0.32). Rates of unexplained infant deaths where the mother was aged between 20 and 24 years were also high (0.55 deaths per 1,000 live births) followed by babies born to mothers aged 40 and over (0.31 deaths per 1,000 live births). The unexplained infant death rate was 0.41 per 1,000 live births for babies of mothers born in England and Wales and 0.22 for babies of mothers born in other countries.

Speech and language

Approximately 50%[2] of children and young people in some socio-economically disadvantaged populations have speech and language skills that are significantly lower than those of other children of the same age. These children need access to early years provision which is specifically designed to meet their language learning needs and they may also benefit from specific targeted intervention at key points in their development.

Approximately 7% of five year olds entering school in England, nearly 40,000 children in 2007, have significant difficulties with speech and/or language. These children are likely to need specialist and/or targeted intervention at key points in their development.

2.4 Services and standards

Government policy puts a significant emphasis on early intervention services to ensure all children have the best possible start in life. The aim is to address the inequalities in health and life chances that exist between children living in disadvantaged circumstances and those in better-off families. The importance of social and emotional wellbeing in relation to healthy child development is set out in a joint Department for Education and Department of Health publication, 'Supporting families in the foundation years' (2011). The primary aim of the foundation years (years 0–5) is defined as 'promoting a child's physical, emotional, cognitive and social development so that all children have a fair chance to succeed at school and in later life'.

[1] Unexplained Deaths in Infancy: England and Wales Office for National Statistics
[2] The Bercow Report Department for Education

National developments

There have been important national developments to promote and protect the social and emotional wellbeing of children, especially vulnerable children. These include:

- Expansion of the health visitor workforce. The Health Visiting Programme[3] started in 2011 as a national programme of work to deliver on the Government's commitment by 2015 to increase health visitors by 4,200 and create a health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it.

- The new core purpose of children's centres to improve outcomes for young children and their families with a particular focus on the most disadvantaged, so that children are equipped for life and ready for school, irrespective of their background or family circumstances.

- Free early education extended to 40% of infants aged 2 years, starting with those who are from disadvantaged families.

- The designation of personal, social and emotional development as one of the key themes in the new early years foundation stage.

- Stronger links between the Healthy Child Programme and early years foundation stage processes of assessment and review to help identify and respond to children with particular needs. From September 2015 health and education reviews of children aged between 24 and 30 months old have been integrated, bringing together Healthy Child Programme assessments by health visitors, and the Early Years Progress Check at age 2 years by early years practitioners, to provide parents with a more complete picture of their child.

Healthy Child Programme 0-5

Public Health England's Healthy Child Programme: rapid review to update evidence document[4] states that the Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes.

The Department of Health's Healthy Child Programme: pregnancy and the first 5 years of life document[5] states that the HCP offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. It is led by health visitors, is delivered through integrated services that bring together Sure Start children's centre staff, GPs, midwives, community nurses and others. Children's centres are a way of delivering community-based services which are visible and accessible to families who might be less inclined to access traditional services.

[3] Services for children aged 0 to 5: transfer to local authorities Department of Health and Public Health England
[4] Healthy child programme: rapid review to update evidence Public Health England
[5] Healthy Child Programme: Pregnancy and the First 5 Years of Life Department of Health

The HCP ensures that children receive appropriate referral to specialist services, and signposts families to wider support. The programme ensures that each family receives support that is appropriate for their needs, with the most vulnerable families receiving intensive interventions and co-ordinated support packages. Working in partnership with other agencies, the HCP sits at the heart of services for children and families.

Early Years Foundation Stage

The Early Years Foundation Stage (EYFS)[6] sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. It makes personal, social and emotional development a cornerstone of early years learning and education, promotes teaching and learning to ensure children's 'school readiness' and gives children the broad range of knowledge and skills that provide the right foundation for good future progress through school and life.

The EYFS seeks to provide:

- quality and consistency in all early years settings, so that every child makes good progress and no child gets left behind
- a secure foundation through learning and development opportunities which are planned around the needs and interests of each individual child and are assessed and reviewed regularly
- partnership working between practitioners and with parents and/or carers
- equality of opportunity and anti-discriminatory practice, ensuring that every child is included and supported.

The EYFS contains 4 guiding principles which should shape practice in early years settings. These are:

- every child is a unique child, who is constantly learning and can be resilient, capable, confident and self-assured;
- children learn to be strong and independent through positive relationships;
- children learn and develop well in enabling environments, in which their experiences respond to their individual needs and there is a strong partnership between practitioners and parents and/or carers; and
- children develop and learn in different ways and at different rates. The framework covers the education and care of all children in early years provision, including children with special educational needs and disabilities.

[6] Early years (under 5s) foundation stage framework (EYFS) Department for Education

Family Nurse Partnership programme

The Family Nurse Partnership programme (FNP)[7] is a voluntary programme for vulnerable first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age 2 and has 3 aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency.

FNP uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood. Family nurses build trusting and supportive relationships with families, guide first-time young parents and use behaviour change methods so that young parents adopt healthier lifestyles for themselves and their babies, provide good care for their babies and toddlers, and plan their futures.

The formative evaluation of the first 10 pilot sites completed in 2010 suggested that the mothers who took part now have aspirations for the future, had reduced smoking during pregnancy and coped better with pregnancy, labour and parenthood. Breast feeding initiation was higher than the national rate for same age group (FNP = 63% UK under 20s=53%) and mothers were returning to education and employment, making regular use of effective birth control methods and spacing subsequent pregnancies. In addition, FNP children appeared to be developing in line with the population in general.

See appendix 1 for the associated care pathway from NICE public health guideline PH40.

2.5 National Outcome Frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[7] Family Nurse Partnership Programme Information Leaflet Department of Health

Table 1 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.1 Children in poverty 1.2 School readiness 1.16 Utilisation of outdoor space for exercise/health reasons 1.17 Fuel poverty
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.1 Low birth weight of term babies 2.3 Smoking status at time of delivery 2.5 Child development at 2–2$^{1}/_{2}$ years 2.6 Excess weight in 4–5 and 10–11 year olds 2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years 2.11 Diet
3 Health protection	***Objective*** The population's health is protected from major incidents and other threats, whilst reducing health inequalities ***Indicators*** 3.3 Population vaccination coverage
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.1 Infant mortality* 4.3 Mortality rate from causes considered preventable**
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Table 2 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare ii Children and young people 1c Neonatal mortality and stillbirths ***Improvement areas***

	Reducing mortality in children 1.6 i Infant mortality* ii Neonatal mortality and stillbirths
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers**
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary	

3 Summary of suggestions

3.1 Responses

In total 17 stakeholders responded to the 2-week engagement exercise 06/11/15 – 20/11/15.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Early years services • Mandated contacts • Care pathways for common social care risks • Provision of services via social media • Universal primary preventative service model • Parenting programmes, antenatal education and early weeks	SCM, LFB, IHV, GHNHSFT
Infant mental health • Identification and reduction of bullying • Identification and management of emotional problems in under 5s • Early days	RCPCH, IHV, RCN, GHNHSFT
Long term conditions • Information • Measuring wellbeing • Early access to psychological services • Needs assessment/ education, health and care plan • Emergency care plans • Referrals (emergent practice)	EA
Sudden infant death syndrome (SIDS) • Advice on reducing the risk • Younger mothers • Disadvantaged families	LT
Development • Speech, language and communication • Continence	CT, PCF
Paternal mental health	0 to 5
Experience of support	NHSE

Suggested area for improvement	Stakeholders
0 to 5, 0 to 5 Curriculum Development Group Action Cerebral Palsy British Dental association CT, The Communication Trust Dental Clinical Board, Cardiff and Vale University Local Health Board EA, Epilepsy Action GHNHSFT, Gloucestershire Hospitals NHS Foundation Trust IHV, The Institute of Health Visiting London Fire Brigade LT, The Lullaby Trust NHSE, NHS England PCF, Paediatric Continence Forum RCN, Royal College of Nursing RCPCH, Royal College of Paediatrics and Child Health SCMs School and Nursery Milk Alliance	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 606 studies were identified for QS topic. In addition, current practice examples were suggested by stakeholders at topic engagement (12 studies) and internally at project scoping and through analyst searches (17 studies).

Of these studies, 38 were assessed as having potential relevance to this topic and the suggested areas for quality improvement identified by stakeholders (see appendix 2). A summary of relevant studies is included in the current practice sections for each suggested area of improvement.

4 Suggested improvement areas

4.1 Early years services

4.1.1 Summary of suggestions

Mandated contacts

A stakeholder commented that health visiting teams should maximise the benefit from mandated contacts and opportunities for integrated working with local authority.

Care pathways for common social care risks

A stakeholder commented that health visitors and midwives, GPs, children's social care and specialist services for parental mental health, substance misuse and domestic violence need better care pathways especially for lower levels of need. There is a need for all early years services to be integrated better around care pathways.

Provision of services via social media

A stakeholder felt better information on the groups of parents that respond to contact via social media is needed so that a range of support can be in place for all families.

Universal primary preventative service model

A stakeholder commented that the greatest impact will be achieved by addressing needs across the population as a whole in order to improve health and reduce the severity and number of cases with the greatest needs that make the greatest demands on public services over the long term.

Parenting programmes, antenatal education and early weeks

A stakeholder commented that there is local variability in the commissioning of parenting programmes, which should be part of a wider local system of measures to support parents

Stakeholders commented that antenatal contact has become limited to preparation for the actual birth, with very little preparation for becoming a parent and that targeted interventions should be provided to a wider group of parents through integrated working.

Stakeholders highlighted that the health visiting antenatal contact is a mandated element of the Healthy Child Programme and the use of an antenatal promotional guide is regarded as best practice. The contacts during the antenatal period and early weeks take place when parents are more receptive to health information and advice and inform the level and type of support needed. However, full adoption of antenatal visits and reviews has not yet been achieved and the use of the promotional guide is not universal.

A stakeholder stated that health visiting is the universal service which identifies risks and needs in the under 5s and there is a need to improve data collection on medical and social risks.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Mandated contacts	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2
Care pathways for common social care risks	**Delivering services** NICE PH40 Recommendation 5
Provision of services via social media	Not directly covered in NICE PH40 and no recommendations are presented
Universal primary preventative service model	**Strategy, commissioning and review** NICE PH40 Recommendation 1
Parenting programmes, antenatal education and early weeks	**Antenatal and postnatal home visiting for vulnerable children and their families** NICE PH40 Recommendation 3

Mandated contacts

NICE PH40 Recommendation 2

- Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. This includes factors that could affect the parents' capacity to provide a loving and nurturing environment. For example, they should discuss with the parents any problems they may have in relation to the father or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support.

- Health and early years professionals should ensure procedures are in place:

    - to collect, consistently record and share information as part of the common assessment framework (relevant child and adult datasets should be linked)

    - for integrated team working

Care pathways for common social care risks

NICE PH40 Recommendation 5

- Health and early years practitioners should be clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families. This involves

developing and agreeing pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services within a given locality.

Universal primary preventative service model

NICE PH40 Recommendation 1

- Health and wellbeing boards should ensure the social and emotional wellbeing of vulnerable children features in the 'Health and wellbeing strategy', as one of the most effective ways of addressing health inequalities. The resulting plan should include outcomes to ensure healthy child development and 'readiness for school' and to prevent mental health and behavioural problems. (See the Department of Health's Public health outcomes framework indicators for early years.)

- Directors of public health, directors of children's services and commissioners of maternity care should ensure the social and emotional wellbeing of under-5s is assessed as part of the joint strategic needs assessment. This includes vulnerable children and their families. Population-based models (such as PREview, a set of planning tools published by the Child and Maternity Health Observatory) should be considered as a way of determining need and ensuring resources and services are effectively distributed.

- Health and wellbeing boards should ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers. The aim is to ensure:

    - vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services

    - targeted, evidence-based and structured interventions (see recommendations 3 and 4) are available to help vulnerable children and their families – these should be monitored against outcomes

    - children and families with multiple needs have access to specialist services, including child safeguarding and mental health services.

Parenting programmes, antenatal education and early weeks

NICE PH40 Recommendation 3

- Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support (see recommendation 2).

- The trained nurse should visit families in need of additional support a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes). Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:
    - maternal sensitivity (how sensitive the mother is to her child's needs)
    - the mother–child relationship
    - home learning (including speech, language and communication skills)
    - parenting skills and practice.
- The nurse should, where possible, focus on developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities.
- Health visitors or midwives should explain to parents that home visits aim to ensure the healthy development of the child (see recommendation 2). They should take into account the parents' first language and make provision for those who do not speak English. They should also be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting.
- Health visitors or midwives should try to ensure both parents can fully participate in home visits, by taking into account their domestic and working priorities and commitments. They should also try to involve other family members, if appropriate and acceptable to the parents.
- Health visitors and midwives should consider evidence-based interventions, such as baby massage and video interaction guidance, to improve maternal sensitivity and mother–infant attachment. For example, this approach might be effective when the mother has depression or the infant shows signs of behaviourial difficulties.
- Health visitors and midwives should encourage parents to participate in other services delivered by children's centres and as part of the Healthy Child Programme.
- Health visitors and midwives should work in partnership with other early years practitioners to ensure families receive coordinated support. This includes psychologists, therapists, family support workers and other professionals who deliver services provided by children's centres and as part of the Healthy Child Programme.

4.1.3 Current UK practice

Mandated contacts

NHS England developed the Health Visitor Service Delivery metrics[8] to provide assurance on service transformation in England. These showed an increase in the percentage of children receiving health visiting services from Quarter 2 2013/14 to Quarter 3 2014/15:

- The percentage of new born visits undertaken within 14 days in England increased from 74% in Quarter 2 2013/14 to 82% in Quarter 3 2014/15.
- The percentage of children receiving the 12 month development review by the time they turn 15 months increased from 64% in Quarter 2 2013/14 to 76% in Quarter 3 2014/15.
- The percentage of children in England who received a 2-2.5 year review by the time they turned 2.5 years increased from 63% in Quarter 2 2013/14 to 69% in Quarter 3 2014/15.

Overall delivery of the new birth visit remained high at 95% in Q3 2014-15.

Care pathways for common social care risks

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Provision of services via social media

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Universal primary preventative service model

No published studies on current practice were highlighted for this suggested area for quality improvement. However, the HCP[9] is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes.

The HCP[10] offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. It is led by health visitors, is delivered through integrated services that bring together Sure Start children's centre staff, GPs, midwives, community nurses and others. Children's centres are a way of delivering community-based services which are visible and accessible to families who might be less inclined to access traditional services.

[8] Health Visitors Service Delivery Metrics NHS England
[9] Healthy child programme: rapid review to update evidence Public Health England
[10] Healthy Child Programme: Pregnancy and the First 5 Years of Life Department of Health

The HCP ensures that children receive appropriate referral to specialist services, and signposts families to wider support. The programme ensures that each family receives support that is appropriate for their needs, with the most vulnerable families receiving intensive interventions and co-ordinated support packages.

Parenting programmes, antenatal education and early weeks

There are a number of parenting programmes available in England including[11]:

The FNP for children aged 0-2 years is a home visiting programme in the UK for teenage mothers. Evidence from the US shows positive effects on breastfeeding, less smoking, mental health, fewer emergency visits, children's cognitive and language development, fewer arrests, fewer teenage pregnancies, households less likely to be on welfare and less child abuse.

The Home Interaction Programme for Pre-school Youngsters (HIPPY) programme helps parents teach 3-5-year olds at home. It believes that parents play a critical role in their children's education, and supports those who may not feel sufficiently confident to prepare their children for 'school knowledge'.

Families and Schools Together (FAST), ages 3-11, is a programme where parents attend eight weekly sessions where they learn how to manage stress and reduce their isolation, become more involved in their children's school, develop warm and supportive relationships with their children and encourage their children's pro-social behaviour. After parents complete the programme, they continue to meet at monthly parents' sessions.

The Health Visitor Service Delivery metrics[12] showed that the number of mothers in England who received a first face to face antenatal contact with a Health Visitor at 28 weeks or above in Quarter 3 2014/15 was 50,162. This indicator has increased from 74% in Quarter 2 2013/14 to 98% in Quarter 3 2014/15. Between 2014-15 Q2 to 2014-15 Q3 an additional 4930 antenatal visits were reported.

The Health Visitor Service Delivery metrics notes that coverage for all indicators is measured as the percentage of providers submitting data that passed validation checks. Coverage across all indicators (the percentage of providers submitting data that passed validation checks) showed an average of 69% in Quarter 2 2013/14 and is around 96% in Quarter 3 2014/15. It notes that a small number of issues remain with data coverage and quality.

Great Expectations antenatal education programme[13] is a multidisciplinary parenting course for pregnant women, their partner (or chosen supporter) in Plymouth. The health of people in Plymouth is generally worse than the England average and around 10,400 children live in poverty. Levels of teenage pregnancy, breast feeding initiation and smoking in pregnancy are worse than the England average.

[11] Good quality parenting programmes and the home to school transition Public Health England
[12] Health Visitors Service Delivery Metrics NHS England
[13] Plymouth Great Expectations Antenatal education programme

The programme is delivered in 6 weekly sessions, which have key objectives relating to the chronology of a pregnancy and birth covering:

- the key public health messages for a healthy pregnancy (smoking, nutrition, emotional attachment and physical activity)
- changing relationships, managing challenges, emotional and mental health, developing an emotional attachment with the foetus/baby, understanding the baby's development and the impact of environmental factors, stimulation, stress and health
- normal birth processes, stages of labour, birth interventions, coping strategies, being a birth partner, birth choices and possible interventions
- meeting the baby for the first time, skin to skin contact, understanding early communication, responsive parenting, breastfeeding and bonding
- the healthy child programme, support networks, community resources, managing time, prioritising infant's needs, maintaining a safe environment and child health.

4.2 Infant mental health

4.2.1 Summary of suggestions

Identification and reduction of bullying

A stakeholder commented that bullying in all age groups results in child depressions, poor self-esteem and increased rates of physical symptoms e.g. headaches, stomach aches and school avoidance. These problems often continue after bullying has ceased. Management of the mental health sequelae from bullying requires a multiagency approach with input from schools, psychology, primary care and often child and adolescent mental health services.

Identification and management of emotional problems in under 5s

Stakeholders commented that emotional disorders in young children are increasing in rates and severity. Signs such as being withdrawn or unengaged in activities, behavioural problems, delayed speech or poor language and communication skills may all be indicators of underlying emotional problems. Identification can be variable and if untreated, emotional problems at a young age can lead to more severe depression, anxiety, self-harm alongside other poor mental health outcomes. Targeting poor emotional health in younger children requires improved multi-agency working and access to support networks for vulnerable families. Emphasis is required in supporting children who are already affected and implementation by wider evidence-based strategies such as resilience training and emotional regulation from an early age.

Early days

A stakeholder highlighted that infant mental health is crucial for all babies and infants in the early critical days (‘1001 critical days’). Adverse childhood experiences embed social disadvantage biologically due to the impact on the developing brain of ‘toxic stress’, for example due to exposure to domestic violence; while sensitive and responsive care from primary care-givers, parents and others within the family circle, shape a sturdy architecture of brain development and secure attachment.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Identification and reduction of bullying	**Targeted approaches** NICE PH12* Recommendations 1, 2 and 3 *Note to committee members: this guideline relates to children aged 4 and over therefore

	it will apply only to children aged 4 in the context of this quality standard.
Identification and management of emotional problems in under 5s.	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2 **Delivering services** NICE PH40 Recommendation 5
Early days	Not directly covered in NICE PH40 and no recommendations are presented

Identification and reduction of bullying

NICE PH12 Recommendation 1

- Develop and agree arrangements as part of the 'Children and young people's plan' (and joint commissioning activities) to ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing. All primary schools should:
    - provide an emotionally secure and safe environment that prevents any form of bullying or violence

NICE PH12 Recommendation 2

Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing. This should include:

- Integrated activities to support the development of social and emotional skills and wellbeing and to prevent bullying and violence in all areas of school life. For example, classroom-based teaching should be reinforced in assemblies, homework and play periods (in class as well as in the playground).

NICE PH12 Recommendation 3

- Ensure teachers and practitioners are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren. They should also be able to assess whether a specialist should be involved and make an appropriate request. Children who are exposed to difficult situations such as bullying or racism, or who are coping with socially disadvantaged circumstances are at higher risk. They may include: looked after children (including those who have subsequently been adopted), those living in families where there is conflict or instability, those who persistently refuse to go to school, those who have experienced adverse life events (such as bereavement or parental separation), and those who have been exposed to abuse or violence.

Identification and management of emotional problems in under 5s.

NICE PH40 Recommendation 2

- Health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of

their development. They should use the 'Early years foundation stage' assessment process to help identify and share any needs and concerns. Specifically, they should look for risk factors that were not evident at an earlier stage. For an infant or child, this could include:

- being withdrawn
- being unresponsive
- showing signs of behavioural problems
- delayed speech
- poor language and communication skills.

NICE PH40 Recommendation 5

- Health and early years practitioners should be clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families. This involves developing and agreeing pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services within a given locality.

4.2.3 Current UK practice

Identification and reduction of bullying

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Identification and management of emotional problems in under 5s

Manchester Children And Parents Service (CAPS)[14] is a jointly commissioned, multi-agency, early intervention service for pre-school children and their families. It delivers Incredible Years Parent Programmes in community settings to families with children experiencing emotional and behaviour problems across Manchester. The results of the programme demonstrate improvements in child behaviour, improvements in parental depression and improvements in parental stress at post intervention and at follow up.

Post-course, between 76% and 82% of families who were previously in the clinical range for parental depression, parent stress and child behaviour problems, were in the normal range representing significant cost savings to multiple agencies.

Unexpected positive results include the added value of parental empowerment following successful completion of the parent course. At 3 month follow up 24% of parents were back in work, 21% were attending college and were 10% doing voluntary work.

[14] Manchester CAPS: A Sustainable Implementation of Incredible Years NICE Shared Learning Database

Early days

The 1001 Critical Days Manifesto[15] was officially launched at each political party conference in October 2013 and was relaunched in November 2015. Its goal is for every baby to receive sensitive, appropriate and responsive care from their main caregivers in the first years of life. It states that parents need to feel confident that they are raising their children in a loving and supportive environment. A holistic approach to all ante, peri (around 20th week of pregnancy to around the 28th day of life) and postnatal services would enable seamless access for all families. This includes Midwives, Health Visitors, GPs, and Children's Centres, and services should engage with families as soon as possible, ideally during pregnancy. The manifesto states that the contacts that all parents have with services before and after the birth of their child, provides a unique opportunity to work with them at a stage which is vitally important to the development of children.

[15] 1001 critical days

4.3 Long term conditions

4.3.1 Summary of suggestions

Information

A stakeholder felt there needs to be an increase in the number of children with long-term medical conditions, their parents and carers, who have ongoing access to information about their condition, its treatment, and the medical, educational and social impact of their conditions.

Measuring wellbeing

A stakeholder commented that there needs to be an improvement in the strengths and difficulties questionnaire scores (alternative to Quality of Life scores in young children) of children with a long-term medical condition, siblings and/or children identified as a very young carer.

Early access to psychological services

A stakeholder felt there should be an increase in the number of children with a long term medical condition that receive early access to psychological services to evaluate learning disabilities and cognitive dysfunction, particularly in regard to language and memory, before they start school.

Needs assessment/ education, health and care plan

A stakeholder commented that there needs to be an increase in the number of children holding an Education, Health and Care needs assessment and plan and/or Birth -25 education, health and care plan that was developed with input from an appropriate health professional and with expertise in their medical condition.

Emergency care plans

A stakeholder felt there should be an increase in communication and coordination of emergency care plans between appropriate health professionals, early years education providers and children and their families.

Referrals (emergent practice)

A stakeholder commented that there needs to be an increase in the number of children with a suspected long term medical condition referred to a paediatrician within the appropriate wait time in line with the NICE clinical guideline appropriate for the condition. They also felt there should be an increase in the number of children who meet the criteria for a tertiary care referral, who receive it in a timely manner, and a reduction in non-elective admissions to secondary and acute care.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Information	Not directly covered in NICE PH40 and no recommendations are presented
Measuring wellbeing	Not directly covered in NICE PH40 and no recommendations are presented
Early access to psychological services	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2
Needs assessment/ education, health and care plan	Not directly covered in NICE PH40 and no recommendations are presented
Emergency care plans	Not directly covered in NICE PH40 and no recommendations are presented
Referrals (emergent practice)	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2 **Delivering services** NICE PH40 Recommendation 5

Early access to psychological services

NICE PH40 Recommendation 2

- Health and early years professionals should ensure procedures are in place:
    - to make referrals to specialist services, based on an assessment of need
    - to collect, consistently record and share information as part of the common assessment framework (relevant child and adult datasets should be linked)
    - for integrated team working
    - for continuity of care
    - to avoid multiple assessments.

NICE PH40 Recommendation 5

- Health and early years practitioners should be clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families. This involves

developing and agreeing pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services within a given locality.

Referrals (emergent practice)

NICE PH40 Recommendation 2

- Health and early years professionals should ensure procedures are in place:
    - to make referrals to specialist services, based on an assessment of need

NICE PH40 Recommendation 5

- Health and early years practitioners should be clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families. This involves developing and agreeing pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services within a given locality.

4.3.3 Current UK practice

Information

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Measuring wellbeing

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Early access to psychological services

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Needs assessment/ education, health and care plan

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Emergency care plans

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Referrals (emergent practice)

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.4 Sudden infant death syndrome (SIDS)

4.4.1 Summary of suggestions

Advice on reducing the risk

A stakeholder commented that all parents need good quality, consistent and accessible advice on how to reduce the risk of SIDS. They stated the key risk factors for SIDS are largely preventable (including maternal and passive smoking, overheating, supine sleeping and co-sleeping in high-risk circumstances). Healthcare professionals such as midwives and health visitors are best-placed to discuss SIDS and how to reduce the risk and should do so antenatally and postnatally.

Younger mothers

A stakeholder commented that mothers under 20 are 4 times more likely to lose a child to SIDS than all other age categories combined. They are also more likely to face deprivation and smoke during pregnancy, which is associated a 200% higher incidence of SIDS. The stakeholder commented that the Family Nurse Partnership programme could have the potential to address health inequality for younger mothers and their families, but has not made an impact on outcome measures including key risk factors for SIDS: birth weight and smoking during pregnancy.

Disadvantaged families

A stakeholder stated that deprivation is independently associated with SIDS, although deprived families are also more likely to smoke, have babies of low birth weight, poor prenatal care, substance abuse and poor nutrition during pregnancy. They are also less likely to breastfeed, which has a protective effect on SIDS.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Advice on reducing the risk	Not directly covered in NICE PH40 and no recommendations are presented Note to committee members: the risk of co-sleeping is covered in statement 4 of the postnatal care quality standard QS37 and maternal smoking cessation is covered in statement 5 of the antenatal care quality standard QS22.
Younger mothers	**Delivering services** NICE PH40 Recommendation 5

Disadvantaged families	Not directly covered in NICE PH40 and no recommendations are presented

Younger mothers

NICE PH40 Recommendation 5

- The trained nurse should visit families in need of additional support a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes)*
    - Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to:
    - maternal sensitivity (how sensitive the mother is to her child's needs)
    - the mother–child relationship
    - home learning (including speech, language and communication skills)
    - parenting skills and practice.

* It is not clear from current evidence how many home visits are needed. The Family Nurse Partnership, an evidence-based, intensive home visiting programme, provides weekly or fortnightly home visits for 60–90 minutes throughout most stages of the programme (with more in the early stages and less later).

4.4.3 Current UK practice

Advice on reducing the risk

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Younger mothers

249 unexplained infant deaths occurred in England and Wales in 2013[16]. The rate of unexplained infant deaths rose from 0.92 to 1.27 for mothers aged under 20. This was four times greater than the combined categories of babies born to mothers aged 20 and over (0.32). The family nurse partnership programme[17] is a voluntary programme for vulnerable first time mothers aged 19 and under at conception offering intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two and has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency. It operates in a number of locations across England but is not available in all areas.

[16] Unexplained Deaths in Infancy: England and Wales Office for National Statistics
[17] Family Nurse Partnership Programme website

Disadvantaged families

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5 Development

4.5.1 Summary of suggestions

Speech, language and communication

A stakeholder commented that children with speech, language and communication needs (SLCN) often go unidentified. Early identification of SLCN is crucial for children's health and wellbeing; children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health issues. Without the right support, children who start school with gaps in their language development do not catch up with their peers. The stakeholder stated that universal practice and practitioner knowledge around SLCN varies.

Continence

A stakeholder commented that toilet training in early years can help prevent incidences of day time wetting and bedwetting before and after the age of 5. Toilet training is best provided by health visitors and school nurses in the first instance and by a paediatric continence nurse specialist should continence problems persist.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Speech, language and communication	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2 **Antenatal and postnatal home visiting for vulnerable children and their families** NICE PH40 Recommendation 3
Continence	**1.7 Service description** NICE-accredited Paediatric Continence Commissioning Guide

Speech, language and communication

NICE PH40 Recommendation 2

- Health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development. They should use the 'Early years foundation stage' assessment process

to help identify and share any needs and concerns. Specifically, they should look for risk factors that were not evident at an earlier stage. For an infant or child, this could include:

- delayed speech
- poor language and communication skills.

- Health and early years professionals should ensure procedures are in place:
  - to make referrals to specialist services, based on an assessment of need

Continence

NICE-accredited Paediatric Continence Commissioning Guide Recommendation 1.7

- The Community Paediatric Continence Service (CPCS) should work closely with (train and support) local GP, community nursing/ health visitor colleagues to enable them to carry out work at the preventative early treatment stage (Level 1 – see below).

Pre-Service Level 1:

This would normally be undertaken by nurses competent in providing advice and information on nocturnal enuresis, constipation and toilet training problems and initiate first line treatments. These could be school nurses, health visitors or community nurses, but would also include GPs.

This includes basic advice and support to, for example, help promote “healthy” bladders and bowels – to reduce the risk of problems, such as constipation, developing, or, once developed, being missed. It would also include toilet training programmes, assessing and reviewing input and output charts (bladder/bowel/fluid diaries) and introducing first line treatments, including; toileting and fluid/diet advice, treatments for bedwetting e.g. enuresis alarm or medication and treatments for constipation e.g. use of stimulant laxatives or macrogols (via the GP or a nurse prescriber).

4.5.3 Current UK practice

Speech, language and communication

Talk of the Town[18] is an integrated, community led approach to supporting speech, language and communication in children and young people. It was piloted in an area of social deprivation in Manchester from April 2011- September 2012 and has been commissioned for 2015/16 by a cluster of schools in Stevenage/North Hertfordshire. It has 4 key aims;

1. Early identification of children and young people with speech, language and communication needs

2. Joint working between parents and practitioners across health and education

[18] Talk of the Town The Communications Trust

3. Positive outcomes for children and young people with improved speech, language and communication skills

4. A sustainable approach, so that policy and practice continues to support positive outcomes.

Before the pilot took place, more than a quarter of 3-4 year olds in the schools' nursery classes had standardised scores below 70, meeting the criteria for a Statement of Special Educational Needs in many local authorities. After the pilot, children's language levels improved across both nurseries with a 15% overall increase in children no longer scoring below the expected levels. Staff reported increased skills in identifying children's SLCN with under identification falling from between 31-50% at the beginning of the project to 5-15% at the end (note that these figures include all children in the project, not just those aged 3-4).

Continence

The National Foundation for Educational Research Teacher Voice omnibus survey[19] in March 2014 found that six per cent of teachers surveyed (602) said they had experience of children wearing nappies in Key Stage 1 (age 4 – 7). This did not include children with a recognised Special Educational Need or with a recognised medical condition that meant they would need to wear a nappy.

The Blackpool continence[20] service for children and young people has 2 levels of service delivery:-

- Level 1: Service is delivered by the health visitor and school nursing service, ensuring early intervention at community level to educate parents/carers in early identification of bladder and bowel problems, preventing constipation and facilitating early recognition of constipation and wetting problems.

- Level 2: Service is delivered by the specialist continence nurses within the community, with only severe or "red flag" issues being referred to secondary care. Ongoing communication, training and advice are offered by the nominated consultant.

[19] Teacher Voice panel National Foundation for Educational Research
[20] Blackpool Continence Service Paediatric Continence Service

4.6 Paternal mental health

4.6.1 Summary of suggestions

A stakeholder commented that extensive evidence indicates that parental psychiatric disturbance adversely affects the development of young children across multiple domains and paternal depression is important but is under-recognised.

4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Paternal mental health	**Identifying vulnerable children and assessing their needs** NICE PH40 Recommendation 2

Paternal mental health

NICE PH40 Recommendation 2

- Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. This includes factors that could affect the parents' capacity to provide a loving and nurturing environment. For example, they should discuss with the parents any problems they may have in relation to the father or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support.

4.6.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.7 Experience of support

4.7.1 Summary of suggestions

A stakeholder queried how the experience of support received by children and families in the early years to promote health and wellbeing will be measured and addressed.

4.7.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Experience of support	**Delivering services** NICE PH40 Recommendation 5

Evidence of support

NICE PH40 Recommendation 5

- Health and early years providers should ensure a process is in place to systematically involve parents and families in reviewing services and suggesting how they can be improved. As part of this process, vulnerable parents and families should be asked about their needs and concerns – and their experiences of the services on offer

4.7.3 Current UK practice

The government's standards for early education and childcare are set out in the Statutory Framework for the Early Years Foundation Stage and providers, including children's centres and nurseries, are inspected by OFSTED. During these inspections, parents' views are obtained.

Many local early years services providers obtain feedback on the services they provide, for example Bridgewater Community Healthcare NHS Trust piloted SMS texting[21] to obtain feedback from parents in 2012, however obtaining this information is not done in a set format around the country.

[21] SMS texting supporting the delivery of health visiting services in Bridgewater Community Healthcare NHS Trust Department of Health

4.8 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 7 January 2016.

Training

A stakeholder commented that some children living in disadvantaged families experience emotional and behavioural problems which manifest as a fascination with fire and fire setting. The stakeholder felt that early years practitioners should be trained to identify fire risk in children and families. Training is not usually included in quality statements as all health and social care practitioners should have the appropriate training and competencies to carry out the interventions in the quality standard. This area is covered by the Antisocial behaviour and conduct disorders in children and young people quality standard QS59.

Milk

A stakeholder commented that cow's milk contains the vitamins and nutrients required to build strong and healthy bones, teeth and gums. Its high energy content benefits toddlers, who require energy for growth and play. This area is within the scope of the Maternal and child nutrition quality standard QS98.

Identification of neuro-developmental conditions eg ASD

A stakeholder commented that families with younger children (under 3s) suspected to be on the Autistic Spectrum often need a lot of support from all services. This area is within the scope of the Autism quality standard QS51.

Looked after children

A stakeholder commented that sensitive caregiving has been shown to be one of the key predictors of attachment security and other important developmental outcomes. Young children who are in care or on the edge of care require foster and adoptive carers who are able to meet their attachment needs. Late removal followed by repeat moves for young children needing out of home care can play a significant role in traumatising children already traumatized. These areas are within the scope of the looked after children quality standard QS31.

Oral health

Stakeholders commented that poor oral health disproportionately affects disadvantaged children and has a significant impact on quality of life, including pain, time off school, difficulty with eating and speech, and social discomfort. Young children are also having to undergo general anaesthetics for tooth extractions. These areas are within the scope of the Oral health in the community quality standard which has been referred.

Child attachment

Stakeholders felt vulnerable families should be targeted to set-up support and advice to encourage bonding and attachment between mother and. They stated that children who are in care or on the edge of care should have access to an assessment to identify their needs however access to specialist assessment services is currently poor. In addition, young children need to be looked after in settings that support their attachment needs however early years workers are not routinely trained about attachment. areas are within the scope of the Child attachment quality standard which has been referred.

Domestic violence

Stakeholders commented that in households where domestic violence is present, children witness on average three quarters of abusive incidents and approximately half of children themselves have been subjected to physical abuse. Domestic violence has been shown to adversely affect the mental health of children. These areas are within the scope of the Domestic violence quality standard which is currently in development and the Child abuse and neglect quality standard which has been referred.

Smoking in pregnancy

A stakeholder commented that good evidence shows smoking during pregnancy affects mother’s and baby's health before, during, and after the baby is born. However rates for smoking in pregnancy remain high. This area is within the scope of theAntenatal care QS22.

Maternal mental health

Stakeholders commented that parental psychiatric disturbance adversely affects the development of young children. Although some systems are in place to identify postnatal depression in routine clinical care, the quality of training, assessment and provision of tailored treatment is variable. Stakeholders stated mental health problems during pregnancy and post-natally cause distress and interfere with adjustment to motherhood, the care of the new born baby and existing children. These areas are covered by the Antenatal and postnatal health quality standard which is currently in development and the Maternal health: promoting maternal health through community based strategies quality standard which has been referred.

Obesity

Stakeholders commented that childhood obesity leads to an increased risk of obesity later life and carries an increased risk of multiple diseases in childhood and throughout life. A stakeholder commented that increased maternal weight or excessive weight gain in pregnancy is associated with adverse pregnancy outcomes. Maternal obesity is a major risk factor for childhood obesity, which persists into adulthood independent of other factors. These areas are covered by the Obesity – prevention and management in children quality standard which is currently in development and the Maternal and child nutrition quality standard QS98.

Cerebral palsy

A stakeholder commented that children with cerebral palsy are not being diagnosed quickly enough, with many parents encountering considerable difficulty getting a diagnosis for their child. The stakeholder felt that practitioners in early years settings should adopt a joined up approach which recognises the inter-relationship and inter-dependency of the learning needs of children with cerebral palsy. Local authorities should ensure that children have straightforward access to specialist educational provision as this leads to better long-term outcomes for children with cerebral palsy. This area is covered by the Cerebral palsy quality standard which has been referred.

Breastfeeding

Stakeholders commented that breast feeding contributes significantly to a wide range of health and developmental benefits for children. While the uptake of breast feeding has improved, the duration of breast feeding remains low and in particular reflects the social gradient of social disadvantage. This area is covered by the Postnatal care quality standard QS37 and the Maternal and child nutrition quality standard QS98.

ADHD

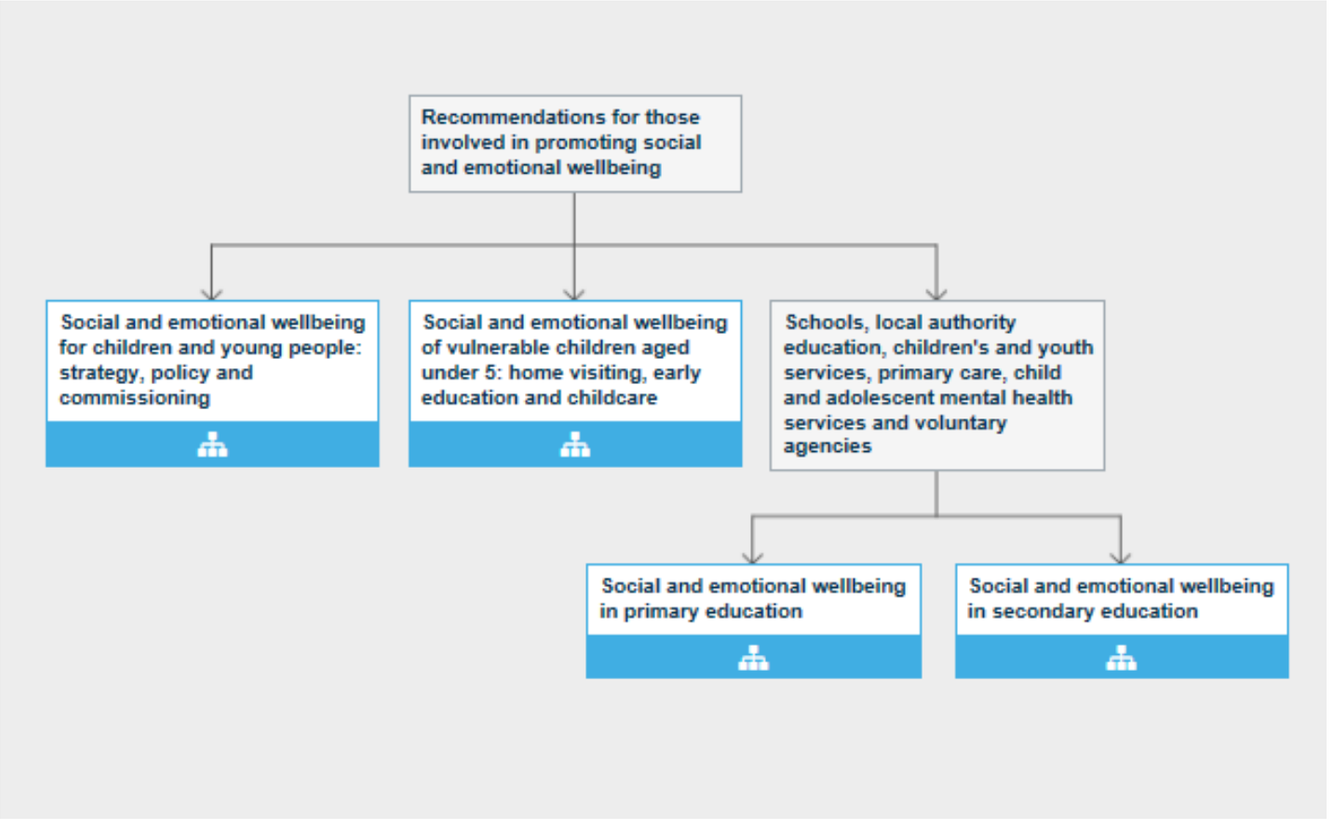
A stakeholder stated that ADHD diagnosis and management varies widely. Instigating specialist multi agency service management would support these children and families to achieve better long term outcomes in education and wellbeing. Instigation of appropriate behavioural strategies may lead to reduced necessity for use of medication in mild cases. This area is covered by the ADHD quality standard QS39.

Early diagnosis of behavioural problems

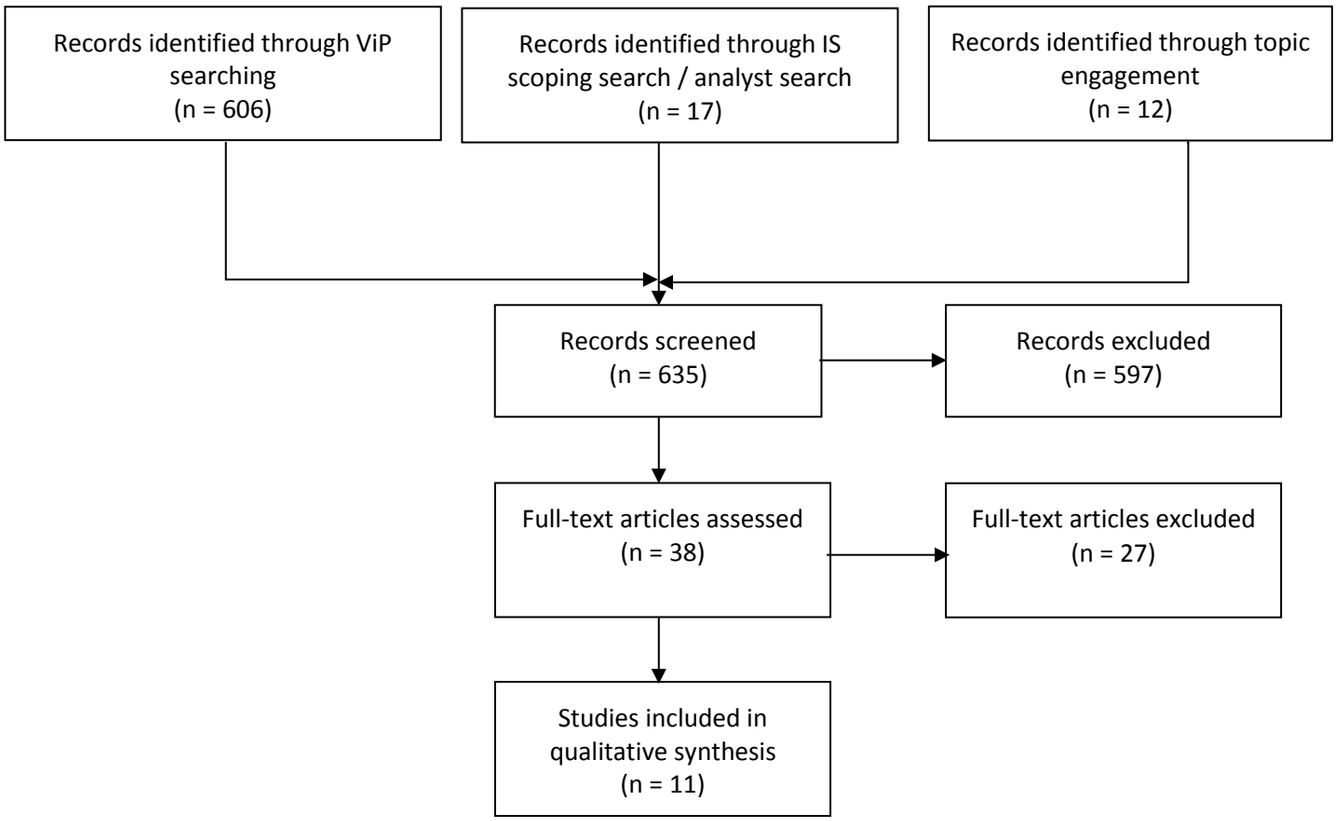
A stakeholder commented that Oppositional Defiance Disorder and other behavioural disorders affect development, education and relationships. Children have greater involvement with violent physical fights, stealing and rule breaking. Early diagnosis and management strategies at home in schools are important to give children a better chance for improvements and hope for the future. Improved management would have positive impacts at individual levels and in wider society. This area is covered by the Antisocial behaviour and conduct disorders in children and young people quality standard QS59.

Appendix 1: Additional information

Social and emotional wellbeing for children and young people pathway.



Appendix 2: Review flowchart



Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Early years services			
1	SCM1	Key skills for Health Visiting teams	Maximise benefit from mandated contacts and opportunities for integrated working with local authority.	1. Focus on integrated working will identify requirement for some new skills and increase emphasis on other skills 2. Ensure Early Years services reflect emerging evidence on what works in the early years	EIF: The Best Start at Home. Mar 15
2	SCM1	Care pathways for common social care risks	HV and MWs have always worked alongside children's social care and specialist services for parental mental health, substance misuse and domestic violence. However care pathways not well developed, especially for lower levels of need. There is a need for all early years services to be integrated better around care pathways. Also specific issue of HV moving to local authority boundaries – risks may be ameliorated. Can also ensure strong links with GPs remain in place.	1. Expectations from local authorities will be to improve this area of integrated working. Early intervention services in local authorities have huge levels of expertise and experience in running Children's Centres and providing parenting programmes. Pre-school Education also has key role. 2. Key opportunity to improve care for families, not just those who reach the level of Children's Social Care, CHiN or CAF, but all families who would benefit from support. 3. Improving evidence base (Early Intervention Foundation) on what works.	NICE quality standard: Postnatal Care only covers some of this area and only in first few weeks of life. EIF work in this area. *eif.org.uk/wp-content/uploads/2014/03/**Health-Visitor-Path**…* EIF: The Best Start at Home. Mar 15
3	SCM1	Delivery of universal services via social media	Need better information on which groups of parents this works for and which it doesn't so that can ensure range of support in place for all families		
4	The Institute of Health Visiting	Key area for quality improvement 5: Improve health inequalities	Widening health inequalities reflect social forces beyond health and care services; however, the greatest impact will be achieved by addressing needs across the population as a whole in order to improve	Children's services face huge pressures to safeguard and protect children at risk of significant harm due to abuse or neglect. 'Early help' mobilises services around the child to work with families to prevent escalation of risk and	**Key area for quality improvement 5: Improve health inequalities through a universal primary preventative service model**

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		through a universal primary preventative service model	health as well as reducing the severity and number of cases with the greatest needs that make the greatest demands on public services over the long term. Recent advances in developmental neuroscience have strengthened the evidence base for the critical importance of early infancy for subsequent health and development including readiness for school and as a foundation for forming healthy social relationships in later child/ adulthood. Marmot (2010) has demonstrated the health gains at population level to be achieved through improving health and reducing inequalities in the earliest years of life; and Heckman has depicted graphically the return on investment and the costs of failure. Moreover WAVE (2013) has demonstrated that 'early years' interventions are a rare opportunity to spend money in a way that delivers social and economic benefits at the same time' (p.101).	safeguard from harm. 'Early' help from children's (social) services is often 'late' help in the context of the universal preventative health visiting service. The 'prevention paradox' means that the greatest volume of need is at levels that precede child protective or even early help strategies. Hence health visiting is based upon 'proportionate universalism' (Marmot, 2010) along the continuum from universal primary prevention, through 'early help', 'early intervention', safeguarding and child protection. The *Healthy Child Programme* (HCP), the evidence for which has recently been reviewed (PHE, 2015), is the 'key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes' (PHE, 2015). The HCP includes five child health and development reviews mandated by the commissioning of 0-5 services by local authorities. It operates on the basis of unsolicited proportionate universalism in a tiered manner to build on the 'universal' spine of the HCP. It provides additional support directly (Universal Plus) and / or in partnership with others (Universal Partnership Plus) in accordance with the Harvard Center on the Developing Child recommendations to which, in the Health Visitor Implementation Plan (Department of Health, 2011), the community level of service delivery is added to strengthen community capacity. The six high impact areas for public health outcomes in the early years are those for which there is evidence of sensitivity to health visiting interventions and for which the	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				health visiting workforce is well equipped to deliver. The four levels of service delivery, five mandated reviews and six high impact areas combine to form the 4/5/6 service model of health visiting. Key to improving health and developmental outcomes for children is implementation of the HCP as more than a collection of individual interventions but, rather, a comprehensive and integrated suite of evidence based interventions within a primary preventative universal service model that is complementary to Children's Centre services, children's social services and primary and secondary health services.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
5	Gloucestershire Hospitals NHS Foundation Trust	Key area for quality improvement 1 Provision of good quality parenting programmes	A recent evidence review by Sir Michael Marmot's team at UCL concluded that "there is good evidence that the quality of parenting affects children's long-term physical, emotional, social and educational outcomes and therefore differences in parenting between social groups have implications for health inequalities." (Evidence review available at http://www.instituteofhealthequity.org/projects/good-quality-parenting-programmes-and-the-home-to-school-transition) There is local variability in the commissioning of parenting programmes, that should be part of a wider local system of measures to support parents.		
6	SCM1	Improve Antenatal education, together with maternity services	This has become limited to preparation for the actual birth, with very little preparation for becoming a parent. Opportunity to support all families better and potentially provide targeted interventions to wider group of parents through integrated working than possible through specific programmes for single issue.	1. Emerging evidence base (Early Intervention Foundation, PHE) on what works. 2. Currently "owned" by maternity services, but should be developed using skills from all relevant agencies	NICE quality standard: Postnatal Care. Supports specific programmes. PHE Rapid Review to Update Evidence for the Healthy Child Programme 0-5. On page 16 a summary of Antenatal Education describes the use of integrated interventions.
7	The Institute of Health Visiting	Key area for quality improvement 1: Transition to Parenthood and the Early Weeks	Transition to parenthood is a High Impact Area for Early Years that is sensitive to health visiting intervention.	A health visiting antenatal contact is a mandated element of the *Healthy Child Programme*(HCP). The use of an Antenatal Promotional Guide is regarded as best practice. The contacts during the antenatal period and early weeks take place when parents are more receptive to health information and advice. Contacts at this time inform the level and type of support needed, including	The six High Impact Area for Early Years health and development, especially Area 1. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413128/2903110_Early_Years_Impact_1_V0_2W.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				safeguarding concerns, potential and actual mental health issues, domestic violence and abuse and alcohol and drug issues. However, full adoption of antenatal visits / reviews has not yet been achieved and the use of the Promotional Guide is not universal. The NHS should promote **full adoption of the health visitor-led 0-5 HCP during and beyond the period of mandation** of Local Authorities to commission health visiting services to meet the Core Health Visiting Service Specification.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
8	SCM1	Health Visiting service data collection	HV is the universal service which identifies risks and needs in the under 5s. There is a recent mandated requirement for a universal antenatal contact. There is a need to improve data collection on medical and social risks	1. Maternity services collect data on medical and social risks, but in practice the data on social risks is limited. The move of HV commissioning to local authorities gives Public Health the opportunity to maximise the utility of this antenatal contact by commissioning a full assessment of health and social risks at this contact and collecting appropriate data. Also, as there are 2 other HV contacts shortly afterwards (new birth visit and 6 week review), there is opportunity to build relationship with clients and improve identification of risk in sensitive areas. 2. HV teams are now using the ASQ questionnaire for parents of children aged 2 - 2½ years. This gives data using a standardised system on five different areas: communication and language, fine motor skills, gross motor skills, problem-solving and personal-social development. There does not appear to be a system in place for collating this data at borough level or above for Public Health and commissioning purposes.	HV services have had to amend their data collection already to collect data on the 5 mandated checks and ASQ
		Infant mental health			
9	Royal College of Paediatrics and Child Health	Key area for quality improvement Better identification and reduction in bullying.	**Why is this important?** Bullying at all age groups results in children depressions, poor self-esteem, increased rates of physical symptoms e.g. headaches, stomach aches and school avoidance. These problems often continue even after bullying has ceased. Bullying is taking on different forms within youth culture; the recent rise of cyber bullying necessitates novel management strategies which are yet to be widely implemented.	**Why is this a key area for quality improvement?** Management of the mental health sequelae from bullying requires a multiagency approach with input from schools, psychology, primary care and often CAMHS services. Joined up working is required for a reduction in rates of bullying and improved mental health and education attainment for affected children.	**Supporting information** National Institute for Health and Clinical Excellence. (2008) Promoting children's social and emotional wellbeing in primary education (public health guidance 12.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
10	Royal College of Paediatrics and Child Health	Key area for quality improvement Improved identification and management of emotional problems in under 5s.	**Why is this important?** Emotional disorders in young children are increasing in rates and severity. Signs such as being withdrawn or unengaged in activities, behavioural problems, delayed speech or poor language and communication skills may all be indicators of underlying emotional problems. Identification can be variable and if untreated, emotional problems at a young age can lead to more severe depression, anxiety, self-harm alongside other poor mental health outcomes.	**Why is this a key area for quality improvement?** Targeting poor emotional health in younger children requires improved multiagency working and access to support networks for vulnerable families. Emphasis is required not only in supporting children who are already affected, but implemented by wider evidence-based strategies such as resilience training and emotional regulation from an early age.	**Supporting information** https://www.nice.org.uk/guidance/ph40
11	The Institute of Health Visiting	Key area for quality improvement 4: Infant mental health	Infant mental health is crucial for *all* babies & infants in the early critical days (sometimes denoted as '1001 critical days' (WAVE, 2013)). Adverse childhood experiences embed social disadvantage biologically due to the impact on the developing brain of 'toxic stress', for example due to exposure to domestic violence; while sensitive and responsive care from primary care-givers, parents & others within the family circle, shape a sturdy architecture of brain development and secure attachment.	Perinatal mental health problems, domestic violence and abuse, or drug and alcohol abuse are found throughout the population. These contribute to insecure infant attachment which is estimated to be present in around 40% of the population (Andreassen and West, 2007). Such children are more likely to have difficulty in regulating their own emotions and behaviours needed to interact effectively with others, to be resilient and to fully benefit from learning opportunities in school. Hence universal supportive and preventative services are essential to 'shift the curve' and prevent the later development of mental health problems. Health visitors have developed their skills based on in-depth applied knowledge of attachment such as by adoption of the Solihull Approach and, more recently, use of tools such as Newborn Behavioural Observation (NBO) and Baby Steps to promote parental sensitivity and secure infant attachment.	Key area for quality improvement 4: **Infant mental health**

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				The NHS should support: 1. Long term **full implementation** of the Healthy Child Programme and further enhancement by the use of such tools to assess and promote infant mental health including universal assessment and support for good attunement between parent and baby. (WAVE, 2015) 2. Embedding such approaches in practice provides the bedrock for establishing infant mental health pathways to specialist services, reducing demand on CAMHS. 3. Ensure that there is comprehensive provision of pathways to specialist infant and perinatal mental health services.	

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12	Royal College of Nursing	Key area for quality improvement 1 Inclusion of psychological risk and resilience measures in the early years assessment of children	While we appreciate that this standard will not cover the clinical treatment of emotional and behavioural difficulties or mental health conditions, we are aware of some research from the University College of London (UCL) Development Risk and Resilience Unit considers that there is now good evidence that genetic and environmental risk factors operate together to disrupt cognitive-affective and neuro-physiological development with long term mental health consequences. The inclusion of Psychological Risk and Resilience measures in the early year's assessments of infants and children will consider the current evidence from the Developmental Risk and Resilience Unit at University College London (UCL) and the Centre for the Developing Child at Harvard University. The findings of this research highlight the evidence of the potential to identify in early years significant predictive risks to later mental health problems. This is focussed on the behavioural presentation of the infant and on the child/ adult interactive patterns.	The impact of long term emotional wellbeing on the individual child is impacting on the individual, trans-generational, capacity to engage as fully engaged citizens in the economic, and cultural aspects of our communities. It has a serious economic cost in health, social care and welfare. International competitiveness depends on a citizenship that is highly engaged in creative and complex systems so the need for an emotionally stable population is crucial to the future welfare of the individual and the state. Poor psychological health leads to ill-health, disengagement, vulnerability to antisocial and extreme behaviour.	Research Evidence UCL- http://www.drru-research.org/pages/research.html Harvard- https://www.youtube.com/user/HarvardCenter
13	Gloucestershire Hospitals NHS Foundation Trust	Key area for quality improvement 3 Promoting mental wellbeing	The 2012 guideline due to be the primary source for these quality standards sets out the evidence for early intervention in this area.		

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		Long term conditions			
14	Epilepsy Action	Key area for quality improvement 1	An increase in the number of children with long-term medical conditions, their parents and carers, who have ongoing access to information about their condition, it's treatment, and the medical, educational and social impact of their conditions.	There's a dearth of research looking specifically at the medical information given to children under the age of five and their parents. Thus the evidence I have provided relates to children and young people. PREM results in the Epilepsy 12, national report, Round 2 (November 2014) showed small room for improvement in the amount and detail of information given to young people with epilepsy and their parents. While on the whole, the overwhelming majority were satisfied with the amount of information they were given, only 60% of young people and 77% of parents felt that the information they received was not difficult to understand. Furthermore, only 30% of young people and 32% of parents said that they didn't require any more information. Key information needs (across the young person and their parents) include causes of epilepsy, medication side effects, Guidance on what the person can or can't do. There are several studies that have looked at the behaviour of parents, carers and families of children with long-term medical conditions. Some studies have shown problems with the quality of information that they have been given, others have concentrated on the impact of a health condition on the family and implications on the child or young adult (for example loved ones	Epilepsy 12, national report, Round 2 (November 2014) http://www.rcpch.ac.uk/improving-child-health/quality-improvement-and-clinical-audit/epilepsy12-national-audit/national-rep Quality of life in children with epilepsy - National Center for ... www.ncbi.nlm.nih.gov › NCBI › Literature › PubMed Central (PMC) Health-related quality of life in children with epilepsy ... www.ncbi.nlm.nih.gov/pubmed/12681011 by GM Ronen - 2003 - Cited by 115 - Related articles Health-related quality of life in children with epilepsy: development and validation of self-report and parent proxy measures. Ronen GM(1), Streiner DL, ...

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				placing barriers that unnecessarily prevent children from part-taking in leisure activities, socialising or making their own age appropriate decisions due to parental anxiety). Epilepsy Action believe that information enables children, their families and carers to make more appropriate and informed decisions in relation to activity, education/employment aspirations, risks and safety.	

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15	Epilepsy Action	Key area for quality improvement 2	An improvement in the Strengths and difficulties questioner scores (alternative to Quality of Life scores in young children) scores of children with a long-term medical condition, siblings and/or children identified as a very young carer.	To improve wellbeing – we need to track and measure wellbeing.	The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden http://journals.cambridge.org/abstract_S0021963099004096
16	Epilepsy Action	Key area for quality improvement 3	An increase in the number of children with a long term medical condition that received early access to psychological services to evaluate learning disabilities and cognitive dysfunction, particularly in regard to language and memory, before they started school.	This measure has been suggested in relation to Education, Health and Care (EHC) and Birth -25 education, health and care plan. From our experience, having a long-term medical condition such as epilepsy and taking medications cane have serious social and educational implications on the child. Until those impacts and level of cognitive dysfunction are assessed and an appropriate plan of action to support the child is put in place, the child will continue to fall further behind their peers. This might also impact on the child's self-esteem, interaction with their peers (high risk of a child being labelled as naughty) and thus their wellbeing. We have heard from too many families who have experienced delays in accessing paediatricians, psychologists and CAMHS	Jimi's story https://www.youtube.com/watch?v=BG_61xmvOaE
17	Epilepsy Action	Key area for quality improvement 4	An increase in the number of children holding an Education, Health and Care (EHC) needs assessment and plan and/or Birth -25 education, health and care plan (within an early years educational setting) that was developed with input from an appropriate health professional and with expertise in their medical condition.	The Children and Families Act introduced a range of legal requirements, including EHCs for children with a health condition, and new birth- to-25 education, health and care plan for children and young people with special educational needs (SEN). Given the importance of this ACT and the aim to boost the life chances, health and wellbeing of children with a long-term medical condition and/or SEN – it seems salient to include reflective measures in this Quality standard.	0 to 25 SEND code of practice: guide for health professionals https://www.gov.uk/.../Health_professionals_guide_to_the_SEND_code_...

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18	Epilepsy Action	Key area for quality improvement 5	An increase in communication and coordination of emergency care plans between appropriate health professionals, early years education providers and children and their families.	This measure would complement the Children and Families ACT and the NHS ambition to reduce premature mortality. From talking to parents, we are aware of individual cases where an education and/or childcare provider has been reluctant to look after a child who was likely to need rescue medication.	Key area for quality improvement 5
19	Epilepsy Action	Additional developmental areas of emergent practice	An increase in the number of children with a suspected long term medical condition referred to a paediatrician within the appropriate wait time in line with NICE CG appropriate for that suspected condition. An increase in the number of children who meet the criteria for a tertiary care referral, receive it in a timely manner. A reduction in non-elective admissions to secondary and acute care.	These measures would promote quality healthcare practice and play an important role in reducing child mortality, accidents, while receiving the most appropriate care and treatment boosts health and wellbeing for the child and their family/carers	Additional developmental areas of emergent practice
		Sudden Infant Death Syndrome (SIDS)			
20	The Lullaby Trust	Key area for quality improvement 1 All parents need good quality, consistent and accessible advice on how to reduce the risk of sudden infant death syndrome (SIDS).	The key risk factors for SIDS are largely preventable (including maternal and passive smoking, overheating, supine sleeping and co-sleeping in high-risk circumstances). Healthcare professionals such as midwives and health visitors are best-placed to discuss SIDS and how to reduce the risk and should do so both antenatally and postnatally.	The rate of SIDS has been declining in the UK since the Back to Sleep campaign of the early 1990s, yet it has now plateaued and in the most recent figures slightly increased. Almost 300 babies die every year in the UK due to causes that are largely preventable. Parents need to be informed of the risks consistently and clearly. Healthcare professionals need to be educated and empowered on how to speak to parents about SIDS and safer sleep.	The most recent data on sudden infant death rates comes from 2013 and is published by the Office of National Statistics http://www.ons.gov.uk/ons/rel/child-health/unexplained-deaths-in-infancy--england-and-wales/2013/stb-unexplained-deaths--2013.html

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21	The Lullaby Trust	Key area for quality improvement 2 Better support for younger mothers	Mothers under 20 are four times more likely to lose a child to SIDS than all other age categories combined. They are also more likely to face deprivation and smoke during pregnancy, which is associated a 200% higher incidence of SIDS.	The Family Nurse Partnership programme could have the potential to address health inequality for younger mothers and their families, but has failed to make an impact on all four of its main outcome measures, two of which are key risk factors for SIDS: birth weight and smoking during pregnancy.	Robling M *et al.* Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. *Lancet* 2015.
22	The Lullaby Trust	Key area for quality improvement 3 Better support for disadvantaged families	Deprivation is independently associated with SIDS, although deprived families are also more likely to smoke, have babies of low birth weight, poor prenatal care, substance abuse and poor nutrition during pregnancy. They are also less likely to breastfeed, which has a protective effect on SIDS.	The UK has one of the highest infant mortality rates in the developed world and there are stark inequalities in the survival chances between rich and poor children in the UK.	Wolfe I *et al.* Why young children die: death in infants, children and young people in the UK Part A. Report from Royal College of Paediatrics and Child Health and National Children's Bureau. 2014
		Development			
23	The Communication Trust	Promotion of the importance of speech, language and communication, including identification and support for children with speech, language and communication needs (SLCN)	There is clear evidence that supporting children's early language and communication has an impact on their later social and emotional wellbeing and later achievements. Where children are struggling with their language and communication, identifying their needs early and implementing early support minimises the potential impact of these difficulties.	Children with speech, language and communication needs (SLCN) often go unidentified. In a pilot project developed by The Communication Trust, it was found that nursery staff were under identifying children with SLCN by up to 50%. Early identification of SLCN is crucial for children's health and wellbeing; children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health issues. Evidence suggests that without the right support, children who start school with gaps in their language development don't catch up with their peers. Promoting the importance of speech, language and communication and identifying SLCN is of particular importance for vulnerable children who are growing up in areas of disadvantage, where	Please see the following resources and information for further detail regarding the impact of early language delay and under-identification of SLCN: Language Delays in the UK: http://www.ncl.ac.uk/cflat/news/documents/Lawetal2013EarlyLanguageDelaysintheUK.pdf Speech, language and communication needs and the early years: http://www.ican.org.uk/~/media/Ican2/Whats%20the%20Issue/Evidence/7%20Speech%20Langua

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				many children are starting school without the speech, language and communication skills they need to thrive. Studies have found that in some areas, this is between 40-50% of children (Law et al 2011, Locke et al 2002). Universal practice and practitioner knowledge around speech, language and communication and SLCN varies. There is a need for all practitioners, particularly those offering universal support to families, to be aware of what typical speech, language and communication development looks like. It's also crucial that all professionals working with under 5s are able to work with families and colleagues to ensure that all children are achieving their potential in this area. The quality of early years provision has been shown to relate strongly to long term outcomes for children (Taggart et al 2015). This quality has been shown to be variable across settings – particularly in relation to how communication and language are supported (Mathers and Smees 2014).	ge%20and%20Communication%20Needs%20and%20the%20Early%20Years.ashx The Communication Trust's Talk of the Town pilot http://www.thecommunicationtrust.org.uk/projects/talk-of-the-town/pilot-study/

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24	Paediatric Continence Forum	Toilet training through health visiting services in early years settings to help prevent continence problems from occurring later in childhood.	Toilet training in early years can help prevent incidences of day time wetting and bedwetting (nocturnal enuresis) before and after the age of five. The NICE-accredited Paediatric Continence Commissioning Guide notes that toilet training is best provided by health visitors and school nurses in first instance, and by a paediatric continence nurse specialist should continence problems persist. NICE clinical guideline 99, bedwetting in under 19s, outlines that children should be dry at night by a developmental age of five years. It recommends that advice on toilet training should be offered to any child under five if a need is identified.	Independent toilet usage is outlined as a physical development early learning goal in the latest Early Years Foundation Stage, which is statutory and must be followed by all early education settings. The Department for Health estimated in 2003 that one in 12 children has some form of bladder or bowel problem. A 2014 survey by the National Foundation for Educational Research of teachers (ranging from the Early Years Foundation Stage to Key Stage 2) found that 6% said that they had seen children wear nappies in Key Stage 1; the figure was1% in Key Stage 2. Of the 163 senior leaders that completed the survey, 9% said that they had experience of children wearing nappies in Key Stage 1, and 4% in Key Stage 2. NICE quality standard 70, bedwetting in children and young people, outlines that for children over the age of five, bedwetting is a “widespread and distressing condition that can have a deep impact on a child or young person's behaviour, emotional wellbeing and social life”. Some incidences can be prevented through better toilet training before the age of five. Failure to intervene early and prevent bladder problems from developing and getting worse can have significant cost implications for the NHS, due to the need for ongoing clinical treatment. Freedom of Information research conducted by the PCF on the provision of paediatric continence services, responded to by all 211 English CCGs, found that 36% commissioned all four of the main	Please see the Department for Education’s Early Years Foundation Stage Framework, published in March 2014 and effective September 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335504/EYFS_framework_from_1_September_2014__with_clarification_note.pdf Please see the Department of Health’s Good Practice in Paediatric Continence Services – Benchmarking in Action, which estimates the figure of children with continence problems. http://collections.europarchive.org/tna/20081112112652/www.cgsupport.nhs.uk/PDFs/articles/good_practice_paediatric_continence_services.pdf Please see the National Foundation for Educational Research survey (2014), which found that many children over the age of five are still wearing nappies as they have not been adequately toilet trained. http://www.nfer.ac.uk/about-nfer/media-and-events/sky-news-questions-nfer-teacher-voice-panel-about-pupils-in-nappies.cfm Please see NICE quality standard 70, bedwetting in

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				paediatric continence services (daytime wetting, bedwetting, constipation/soiling and toilet training). This has meant that primary care clinicians are referring children straight to secondary/tertiary care at a significant cost to the NHS. For example, a secondary or tertiary outpatient referral costs £160 to £220 for first appointments and £94 to £123 for follow-ups, with the risk of financial penalties being imposed as a consequence of breaching new consultation to follow up ratio targets. A&E attendances on average cost £108, with day case treatment costing an average of £693. This is compared to a specialist nurse in primary care, which costs £17.66 an hour (excluding on-costs).	children and young people, which outlines the impact that continuing to wet the bed can have on children over the age of five: https://www.nice.org.uk/guidance/qs70/resources/bedwetting-in-children-and-young-people-2098841389765 Please see NICE clinical guideline 99, which outlines that toilet training should be provided as a treatment option for children under the age of five who wet the bed. https://www.nice.org.uk/guidance/cg99/resources/constipation-in-children-and-young-people-diagnosis-and-management-975757753285 Please see the NICE-accredited Paediatric Continence Commissioning Guide, developed by the clinical members of the Paediatric Continence Forum, which outlines that toilet training should be provided by health visitors and school nurses. http://www.paediatriccontinenceforum.org/wp-content/uploads/2015/09/Paediatric-Continence-Commissioning-Guide-2014-PCF.pdf Please see the PCF's 2014 FOI

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					data, as well as information on service costing, available through ChiMat's Continence Needs Assessment Module (data is broken down by CCG and local authority area, with a general national summary provided in each report). http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=45

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		Paternal mental health			
25	0 to 5 Curriculum Development Group	Identification and ready availability of treatment for maternal and paternal mental health problems	Extensive evidence indicates that parental psychiatric disturbance adversely affects the development of young children across multiple domains (ref).	Although some systems are in place to identify postnatal depression in routine clinical care, the quality of training, consistency of assessment, and provision of treatment tailored to the peri- and postnatal period is highly variable. Paternal depression is also important and is under-recognised.	See http://www.nice.org.uk/guidance/cg192/ http://www.centreformentalhealth.org.uk/falling-through-the-gaps
		Experience of support			
26	NHS England	Key area for quality improvement 1	**'This quality standard will cover supporting the health, and social and emotional wellbeing of children aged under 5 years, through home visiting, childcare and early education. It will include vulnerable children who have or are at risk of health, social and emotional problems, and who need additional support'** How will the measurement of experience of support received by children and families in the early years to promote health and wellbeing be addressed?	Demonstration of Public Value of the delivery of services via the measurement of experience provides evidence of impact of interventions with the child and family, demonstrated by the Care Quality Commission Children & Young People's Inpatient and Day Surgery Survey Results published in July 2015. It is essential that the experiences of the child along with the experiences of the adult are measured; both groups will have valid and differing perspectives to offer. Measuring experience of support will assist in driving improvement; ensuring support is appropriate and correctly targeted so that it delivers maximum impact. It is essential that seldom heard groups are addressed to measure their experiences e.g. families with Learning Disabilities, Mental Health/Substance misuse needs, BME Communities etc	Whilst NICE has a quality Standard (15) to measure the experience of adults it does not have this evidence based quality standard for children, young people & family's experiences of care. Organisations such as IPSOS Mori, Picker et al have undertaken extensive work with children, young people and families to robustly capture experiences of care to drive improvement.
		Additional areas			
27	London	The London Fire	Evidence that certain factors increase risk	Evidence that opportunities to identify and	London Fire Brigade

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	Fire Brigade	and Emergency Planning Authority (LFEPA) runs the London Fire Brigade (LFB). The 17 members of the Fire Authority are appointed by the Mayor of London. Eight are nominated from the London Assembly, seven are nominated from the London boroughs and two are Mayoral appointees. LFB is the busiest fire and rescue service in the country and one of the largest firefighting and	of fire including socioeconomic deprivation and care need arising from physical and/or mental health conditions.	address fire risk for people in receipt of care have been missed by care and support. LFB note that this quality standard will cover supporting the health, and social and emotional wellbeing of children aged under 5 years, including vulnerable children, and is aimed not just at population groups sharing the 'protected characteristics' defined in the Equality Act but also those affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. We also note that this quality standard states that children living in disadvantaged families are more likely to be exposed to adverse factors and consequently more likely to experience emotional and behavioural problems. This is of interest to LFB as our published evidence[22] shows that people with care and support needs arising from physical and/or mental health issues are significantly at risk from fire and that there is an established link between deprivation and increased risk of fire. We also know that many of the children that our Juvenile Firesetter Intervention Scheme (JFIS) work with are living in disadvantaged families and	Annual Review Of Accidental Dwelling Fires and Fatalities – FEP 2484 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384

[22] Reports:

Review Of Accidental Dwelling Fires and Fatalities – FEP 2484
http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384

Fire Safety of People in receipt of Domiciliary Care – FEP 1952
http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=920

Fire Safety for people with Mental Health issues – FEP 2303
http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=3292

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		rescue organisations in the world. We are here to make London a safer city and our vision is to be a world class fire and rescue service for London, Londoners and visitors. We will always respond to fires and other emergencies, but our work has changed over the years with a much stronger emphasis now on fire prevention and community safety. Reduction in fires, fire deaths and fire injuries for people in receipt of care and support.		experience emotional and behavioural problems which manifests as a fascination with fire and fire setting. As such, we would ask that the quality standard includes a requirement for those working in all early years settings to receive training on how to identify and reduce fire risk for the children and families they work with. We would also ask that this quality standard includes a prompt for those working in all early years settings to contact their local Fire and Rescue Service to carry out a joint fire risk assessment at the child's home and for advice on reducing fire risk, including referral to a JFIS service where appropriate. The JFIS service work with children as young as 3 years old up to 17, is usually offered free of charge and advisors work on a one-to-one basis with the young person either at home or in a school setting, with the parent/carer present if possible, to identify the drivers for the fire setting behaviour.	

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28	School and Nursery Milk Alliance	Provision and encouragement of consuming cow's milk in early years to strengthen children's bones.	Cow's milk contains the vitamins and nutrients required to build strong and healthy bones. This will help them in the short term by protecting against fractures resulting from play, and in the long term by guarding against osteoporosis. NHS Choices states that the denser a child's bones are at the time of peak bone mass, the greater the reserves of bone to protect against fragile bone disease osteoporosis later in life. This has been verified by the National Osteoporosis Society, which said that "banking" plenty of bone in early years puts the skeleton in a better position to withstand the bone loss that occurs with advancing age NHS Choices also notes that children require calcium or healthy bones. A food factsheet by the British Dietetic Association, hosted by the NHS, outlines that children aged 1-3 required 350mg of calcium per day, with children aged 4-6 requiring 450mg a day. The factsheet states that a 1/3rd pint of a milk – the standard serving for children under five – contains 240mg per serving.	NICE clinical guideline on osteoporosis (CG146, August 2012) notes that "reduced bone density is a major risk factor for fragility fracture". These fractures can cause "substantial pain and severe disability, often leading to a reduced quality of life" as well as "decreased life expectancy". CG146 also outlines that direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential increase to £2.2 billion by 2025.	Please see NHS Choices page on children's bones. http://www.nhs.uk/Livewell/healthy-bones/Pages/strong-bones-in-children.aspx Please see a factsheet by the National Osteoporosis Society on children and bone health. https://www.nos.org.uk/health-professionals/~/document.doc?id=500 Please see a factsheet by the British Dietetic Association on calcium consumption. http://www.nhs.uk/ipgmedia/National/British%20Dietetic%20Association/assets/Calcium-Areyougettingenough.pdf Please see NICE clinical guideline 146 – osteoporosis https://www.nice.org.uk/guidance/cg146
29	School and Nursery Milk Alliance	Provision and encouragement of consuming cow's milk in early years – as a mid-morning snack – as part of a child focussed diet.	Cow's milk is an energy dense fluid. Its high energy content makes it a valuable beverage for toddlers, who require energy for growth and play NHS Choices recognises that children need energy as they are growing, and that as children have smaller stomachs, they may not get all the energy they need from three meals a day – they will need to eat	The Faculty of Public Health, part of the Royal College of Physicians of the UK, published a briefing on food poverty and health (2005) which outlines that poor diet impacts on nearly three million children. This document recommends improving nutrition through providing breakfast in schools and early years settings, to help those who are not given breakfast at home.	Please see the NHS Choices page on underweight children aged 2-5. http://www.nhs.uk/Livewell/Goodfood/Pages/Underweightyoungchild.aspx Please see the Faculty of Public Health's publication on food

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			small snacks to boost their energy intake. In particular, it suggests that children are provided with some milk and dairy foods, as these are “great sources of protein and calcium”.		poverty and health. http://www.fph.org.uk/uploads/bs_food_poverty.pdf

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30	SCM1	Earlier identification of neuro-developmental conditions, e.g. ASD	Families with younger children (under 3s) suspected to be on the Autistic Spectrum are often needing a lot of support from all services	ASQ tools available at younger ages and used by many HV teams for 8-12 month review. Possible and probably desirable to identify neuro-developmental needs at earlier stage in order to commission appropriate and timely support for families.	Autism in under 19s: recognition, referral and diagnosis **.** NICE guidelines, 2011, states "Refer children younger than 3 years to the autism team if there is regression in language or social skills". The Checklist for Autism in Toddlers (CHAT) was designed to identify 18 month old children at risk of ASD. It has been tested in a general population setting and was found to have acceptable specificity, but the sensitivity was too low for it to be used in total population screening (SIGN guidelines)
31	0 to 5 Curriculum Development Group	Key area for quality improvement 1 Sensitive Caregiving	Sensitive caregiving has been shown to be one of the key predictors of attachment security and other important developmental outcomes. Young children who are in care, or on the edge of care have experienced high levels of insensitive and abusive parenting, and require foster and adoptive carers who are able to meet their attachment needs.	Guidance is now available concerning the training, support and development needs of foster carers. However, we do not currently know what proportion of foster and adoptive carers are provided with access to evidence-based programmes that will enable them to properly support the attachment needs of their child.	See for example: DfE Training, Support and Development Standards for Foster Carers: https://www.gov.uk/government/collections/guidance-for-foster-carers See also draft NICE guideline: https://www.nice.org.uk/guidance/GID-CGWAVE0675/documents/childrens-attachment-full-guideline2
32	0 to 5 Curriculum Development Group	Key area for quality improvement 5 Reduction in lateness and exposure to	Late removal followed by repeat moves for young children needing out of home care, can play a significant role in traumatising children already traumatised by failures in their early caregiving.	Recent prospective research showed that the long-term wellbeing of permanently separated children is jeopardised by late separation from the abusive birth family, and by disruption of a close attachment with an interim carer.	See Ward et al (2010) Infants Suffering, or Likely to Suffer, Significant Harm: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182461/DFE-

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		repeat moves			RB053.pdf

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33	British Dental Association	Key area for quality improvement 1 Children's oral health	Poor oral health disproportionately affects disadvantaged children and has a significant impact on quality of life, including pain, time off school/work for families, difficulty with eating and speech, and social discomfort. In 2013, 41 per cent of five-year-olds eligible for free school meals had obvious decay experience in primary teeth, compared to 29 per cent of other children of the same age. 21 per cent of those eligible for free school meals had severe or extensive tooth decay, compared to 11 per cent of five-year-olds not eligible. Children with severe special educational needs and disabilities attending special schools who experience decay have more teeth affected and poorer oral hygiene, and are more likely to face tooth extractions, than those in mainstream schools. Tooth decay also places a substantial financial burden on the NHS, with tooth extractions for children (mostly under general anaesthetic) costing £30 million in 2012-13. Poor oral health in childhood is a predictor of oral health problems in adult life. The importance of the oral health of young children is recognised by its inclusion as an indicator in the Public Health Outcomes Framework.	Oral disease in children is almost entirely preventable. It is caused by a combination of lifestyle factors such as diet (especially frequency of sugar consumption), insufficient exposure to fluoride and poor oral hygiene. Diet in particular is a common risk factor shared by high-priority systemic conditions including obesity and type 2 diabetes. Improvements in child oral health require a combination of measures such as improved education for children, parents and carers, access to fluoride and oral hygiene aids, and dietary improvement (restriction of sugar intake, particularly between meals). The Childsmile scheme in Scotland provides an example of an effective and cost-effective scheme that could be adopted in more widely in the UK, alongside other measures.	Child Dental Health Survey, 2013: http://www.hscic.gov.uk/catalogue/PUB17137 PHE survey of three-year-old children, 2013: http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf PHE oral health survey of children in special schools, 2014: http://www.nwph.net/dentalhealth/2013_14specsurvey.aspx Public Health Outcomes Framework: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency Childsmile: http://www.child-smile.org.uk/professionals/research-and-evaluation.aspx
34	British Dental Association	Key area for quality improvement 1	Poor oral health disproportionately affects disadvantaged children and has a significant impact on quality of life,	Oral disease in children is almost entirely preventable. It is caused by a combination of lifestyle factors such as diet (especially frequency	Child Dental Health Survey, 2013: http://www.hscic.gov.uk/catalogu

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		Children's oral health	including pain, time off school/work for families, difficulty with eating and speech, and social discomfort. In 2013, 41 per cent of five-year-olds eligible for free school meals had obvious decay experience in primary teeth, compared to 29 per cent of other children of the same age. 21 per cent of those eligible for free school meals had severe or extensive tooth decay, compared to 11 per cent of five-year-olds not eligible. Children with severe special educational needs and disabilities attending special schools who experience decay have more teeth affected and poorer oral hygiene, and are more likely to face tooth extractions, than those in mainstream schools. Tooth decay also places a substantial financial burden on the NHS, with tooth extractions for children (mostly under general anaesthetic) costing £30 million in 2012-13. Poor oral health in childhood is a predictor of oral health problems in adult life. The importance of the oral health of young children is recognised by its inclusion as an indicator in the Public Health Outcomes Framework.	of sugar consumption), insufficient exposure to fluoride and poor oral hygiene. Diet in particular is a common risk factor shared by high-priority systemic conditions including obesity and type 2 diabetes. Improvements in child oral health require a combination of measures such as improved education for children, parents and carers, access to fluoride and oral hygiene aids, and dietary improvement (restriction of sugar intake, particularly between meals). The Childsmile scheme in Scotland provides an example of an effective and cost-effective scheme that could be adopted in more widely in the UK, alongside other measures.	e/PUB17137 PHE survey of three-year-old children, 2013: http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf PHE oral health survey of children in special schools, 2014: http://www.nwph.net/dentalhealth/2013_14specsurvey.aspx Public Health Outcomes Framework: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency Childsmile: http://www.child-smile.org.uk/professionals/research-and-evaluation.aspx

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35	Royal College of Paediatrics and Child Health	Key area for quality improvement Improved dental health for under 5s.	Why is this important? In the Child Dental Health Survey in 2013, a third of 5 year olds and nearly a half of 8 year olds had obvious decay in their primary teeth. Management for dental caries is the most common single reason why five- to nine-year-olds are admitted to hospital and the rates of inpatient stays are increasing. Poor dental health is also known to affect the health and wellbeing of children and their families	**Why is this a key area for quality improvement?** Tooth decay is almost entirely preventable. There are also significant regional variations between dental health in the UK. Targeting the problem requires a multifaceted approach involving improved education regarding the role of sugar and teeth brushing, wider access to specialist paediatric dentistry, and improved water fluoridation by local authorities.	**Supporting information** https://www.rcseng.ac.uk/fds/policy/documents/fds-report-on-the-state-of-childrens-oral-health
36	School and Nursery Milk Alliance	Provision and encouragement of consuming cow's milk in early years to reduce oral health problems amongst children	Cow's milk contains the vitamins and nutrients required for children to develop strong teeth and gums. This will protect children's teeth from tooth decay and other oral health problems. A portion of semi-skimmed milk contains the following percentages of the reference nutrient intake for children aged 4-6: 8% retinol (vitamin A); 8% thiamin (vitamin B_1); 59% riboflavin (vitamin B_2); 10% niacin (vitamin B_3); 13% vitamin B_6; 17% folate (vitamin B_9); 213% vitamin B_{12}; 13% vitamin C; 17% magnesium; and 12% zinc. A food factsheet by the British Dietetic Association, hosted by the NHS, outlines that children aged 1-3 required 350mg of calcium per day, with children aged 4-6 requiring 450mg a day. The factsheet states that a 1/3rd pint of a milk – the standard serving for children under five – contains 240mg per serving. Vitamins and minerals have a diverse range of functions which in general keep people healthy, particularly their teeth,	The 2013 Children's Dental Health Survey, commissioned by Health and Social Care Information Centre and published in March 2015, found that 31% of five year olds and 46% of eight year olds had obvious dental decay in their primary teeth. Untreated decay into dentine in primary teeth was found in 28% of five year olds and 39% of eight year olds. A 2015 report by the Royal College of Surgeons' Faculty of Dental Surgery found that the NHS spent £30 million on hospital-based tooth extractions for children aged 18 years and under in 2012-13. The RCS report also found that 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013-14. These numbers were highest in the five to nine year age group, which showed a 14% increase between 2010-11 and 2013-14, from 22,574 and 25,812. Dental caries are "by far" the most common reason for children aged five to nine being admitted to hospital, ahead of tonsillitis	Please see the 2013 Children's Dental Health Survey report, available via the Health and Social Care Information Centre. http://www.hscic.gov.uk/catalogue/PUB17137 Please see the 2015 Royal College of Surgeons' Faculty of Dental Surgery report, *The state of children's oral health in England*, available here: https://www.rcseng.ac.uk/fds/policy/documents/fds-report-on-the-state-of-childrens-oral-health Please see information on the nutritional value of milk: http://milkfacts.info/Nutrition%20Facts/Nutritional%20Components.htm Please see a factsheet by the British Dietetic Association on calcium consumption. http://www.nhs.uk/ipgmedia/National/British%20Dietetic%20Asso

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			bones, skin and immune system. Of particular importance is calcium, which is used in tooth development, as well as vitamin B3 (niacin), which protects against bad breath and canker sores, and vitamin B12 and B2 (riboflavin), which helps prevent mouth sores. An inadequate level of Vitamin C can also lead to bleeding gums.	with approximately 11,500 admissions in 2013-14.	ciation/assets/Calcium-Areyougettingenough.pdf Please see information by the Academy of General Dentistry on why minerals and nutrients are important for oral health http://www.knowyourteeth.com/infobites/abc/article/?abc=w&iid=315&aid=3805

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37	Dental Clinical Board, Cardiff and Vale University Local Health Board	Key area for quality improvement 1 Dental caries in children	Dental caries (tooth decay) remains a significant source of morbidity among children in the UK. Dental caries can result in pain and infection, and can affects children's quality of life. On average within the UK, 12.0% of English children, and 14.5% of Welsh children will have experienced dental decay by the age of three. In some areas this is as high as 34.0%.	Dental caries is a preventable disease. In most instances dental caries are attributable to lifestyle factors, and there are well-recognised, evidence-based strategies known to prevent decay. The UK has a high burden of dental caries in young children, which is unevenly distributed throughout the population. The association of the disease with social and economic deprivation is well recognised, In Wales, within the most deprived quintile 20.2% of three-year-olds have decayed teeth, compared to 11.2% in the least deprived quintile. Reducing the prevalence of tooth decay in three-year-olds from deprived communities will not only reduce the incidence of pain from acute dental conditions and improve children's quality of life, it will also reduce health inequalities.	For further details: Public Health England. Dental Public Health Epidemiology Programme. Oral Health Survey of Three-Year-Old Children 2013. http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf Cardiff University/Public Health Wales. Dental Epidemiological Survey of 3 year olds in Wales 2013-14 http://www.cardiff.ac.uk/__data/assets/pdf_file/0011/86546/First-report-for-WG-3yo-survey-2013-14v3.pdf Related guidance: NICE guidelines [PH55]. Oral health: local authorities and partners. https://www.nice.org.uk/guidance/ph55/chapter/4-considerations#early-years
38	Dental Clinical Board, Cardiff and Vale University Local Health Board	Key area for quality improvement 2 Number of children receiving general anaesthetics for dental extractions	By the age of three, 1 in 150 children in England and 1 in 100 children in Wales will have undergone a general anaesthetic for dental extractions. In some areas of England this is as high as one in thirty children.	Dental extractions undertaken under general anaesthetic carry a risk of patient morbidity and mortality. General anaesthetics for preventable conditions such as dental caries represent a failure of preventative dental treatment and an avoidable risk to child health. This is not in line with the principles of prudent healthcare. General anaesthetics for dental extractions are one of the most common reasons why a child may	For further details: Public Health England. Dental Public Health Epidemiology Programme. Oral Health Survey of Three-Year-Old Children 2013. http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf

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				be admitted to hospital in the UK. Rates of admission due to dental caries have also increased year on year in England between 2010 and 2014. Evidence suggests that like dental caries, hospital admission for dental treatment under general anaesthetic in children increases with deprivation. Reducing the number of children receiving dental treatment under general anaesthetic may therefore contribute to reducing inequalities in health.	Cardiff University/Public Health Wales. Dental Epidemiological Survey of 3 year olds in Wales 2013-14 http://www.cardiff.ac.uk/__data/assets/pdf_file/0011/86546/First-report-for-WG-3yo-survey-2013-14v3.pdf Royal College of Surgeons England. Faculty of Dental Surgery. The State of Children's Oral Health in England. 2015. https://www.rcseng.ac.uk/fds/policy/documents/fds-report-on-the-state-of-childrens-oral-health Public Health Wales report to the Chief Dental Officer – Child Dental General Anaesthetics in Wales, 2014. http://www.wales.nhs.uk/sitesplus/888/opendoc/249614

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39	Royal College of Paediatrics and Child Health	Key area for quality improvement Early identification and support for mothers who may struggle with bonding and attachment with their baby	**Why is this important?** There is good evidence to show that problems with early bonding and attachment can lead on to mental health problems later in life.	**Why is this a key area for quality improvement?** Early targeting of vulnerable mothers and families to set-up support and advice to encourage bonding and attachment between mother and baby to decrease likelihood of mental health issues in the child later in life. This may include mothers identified antenatally to have mental health issues, young or single mothers, those who have experienced abuse, parents with a history of substance abuse, mother with postnatal depression, parents who have very premature babies etc	**Supporting information** WHO 2003: Literature review of risk factors and interventions on Postpartum Depression (NICE - Antenatal and postnatal mental health: implementation advice Barnes, J. & Lagevardi-Freude, A. (2002). From pregnancy to early childhood: early intervention to enhance the mental health of children and families: vol 1 – report. London: Mental Health Foundation. URL: http://www.mentalhealth.org.uk/html/content/pregnancy_early_childhood.pdf Young minds policy: mental health in infancy The best Start at Home: A Report on what works to improve quality of parent-child interactions from conception to age 5. Early Years Intervention Foundation, March 2015.
40	0 to 5 Curriculum Development Group	Key area for quality improvement 2 Comprehensive assessment of attachment needs	Children who are in care or on the edge of care should have access to an assessment that identifies what their attachment needs are, and the appropriate services to meet these.	Access to specialist assessment services is currently poor. Attachment disorders in fostered and adopted children can be overdiagnosed or misdiagnosed thereby preventing these children from receiving appropriate support.	See for example, House of Commons Health Committee 2014-15: Children's and Adolescents' Mental Health, and CAMHS: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf See Woolgar and Baldock

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					(2014). Attachment disorders versus more common problems in looked after and adopted children: comparing community and expert assessments: http://onlinelibrary.wiley.com/doi/10.1111/camh.12052/abstract See also draft NICE guideline: https://www.nice.org.uk/guidance/GID-CGWAVE0675/documents/childrens-attachment-full-guideline2

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41	0 to 5 Curriculum Development Group	Key area for quality improvement 3 Access to interventions to support the development of attachment	A high proportion of children have attachment problems, and a range of interventions have been found to be effective in reducing insecure attachment in young children. Particularly in-need groups including children on the edge of care, those whose parents experiencing multiple chronic social adversity, or parental psychiatric disorder (including substance abuse).	Effective interventions to address children's attachment problems are not yet routinely available either in tier 2 or 3 services and perinatal services have also been highlighted as being a significant area needing improvement.	See for example, House of Commons Health Committee 2014-15: Children's and Adolescents' Mental Health, and CAMHS: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf See also All Party Parliamentary Group for Conception to Age 2 report "Building Great Britons", http://www.1001criticaldays.co.uk/buildinggreatbritonsreport.pdf.
42	0 to 5 Curriculum Development Group	Key area for quality improvement 4 Support for attachment across a range of settings (e.g. nurseries)	Young children need to be looked after in settings that support their attachment needs.	Although there are systems in place to support the attachment of children in some early years settings (e.g. Key Worker System in nurseries), early years workers are not routinely trained about attachment, and there is a need for improvement in terms of the early identification of problems in children in early years settings.	See for example, Furnivall et al (2012) Attachment Matters for All: http://www.celcis.org/media/resources/publications/Attachment-Matters-For-All.pdf Tickell (2011) The Early Years: Foundation for Life, Health and Learning: http://www.educationengland.org.uk/documents/pdfs/2011-tickell-report-eyfs.pdf
43	Royal College of Paediatrics and Child Health	Key area for quality improvement Early identification and targeted support for children living in homes with	**Why is this important?** In households where domestic violence in present, children witness on average 3/4 of abusive incidents, approximately 1/2 children themselves have been subjected to physical abuse. There are also greater incidences of sexual and emotional abuse. These features are all risk factors for poor	**Why is this a key area for quality improvement?** Domestic Violence has been shown to adversely affect the mental health of children. In particular, anxiety, medically unexplained symptoms, sleep disorders and behavioural disorders have higher prevalence.	**Supporting information** NICE - Domestic Violence and Abuse - how services can respond effectively (PH50) Feb 2014 Improving safety, reducing harm: children, young people and domestic violence; A practical toolkit for frontline

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		domestic violence	mental health.		practitioners.Department of Health, 2009.

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44	SCM2	Key area for quality improvement 3 Domestic Abuse identification	Vulnerability of under 5's to violence. Acknowledged association between pregnancy and first exposure to domestic violence. Importance of identification and referral. 8.5% of women and 4.5% of men experienced domestic abuse in 13/14. This is likely to be an underestimate as many cases are unreported. In many cases of domestic abuse children are involved.	Early intervention and referral. Maternity services have training to recognise signs of domestic abuse and refer to appropriate services. A&E departments recognise signs of domestic abuse and refer to appropriate services. Specialist support is available to people experiencing domestic violence which support the needs of the family.	UNICEF: Behind Closed Doors & earliest years of life having highest vulnerability. Refuge assessment and intervention for pre-school children exposed to domestic violence, (August 2005): Under 5s at significant risk from effects of domestic violence. DoH Guidance for Health Visitors & School Nurses: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf
45	SCM2	Key area for quality improvement 1 Smoking in pregnancy (-9 months)	Good evidence that shows Smoking during pregnancy affects mother's and your baby's health before, during, and after the baby is born. The nicotine (the addictive substance in cigarettes), carbon monoxide, and numerous other poisons inhaled from a cigarette are carried through your bloodstream and go directly to the baby. Smoking while pregnant will: Lower the amount of oxygen available to you and your growing baby. Increase the baby's heart rate. Increase the chances of miscarriage and stillbirth. Increase the risk that the baby is born prematurely and/or born with low birth weight. 20 to 30% higher likelihood of stillbirth, a 40% higher rate of infant mortality and a 200% higher incidence of Sudden Infant Death Syndrome (SIDS)	Rates for smoking in pregnancy remain stubbornly high At all stages of pregnancy and when in contact with services the opportunity should be given to opt OUT rather than in to consistent specialist advice	NICE quidance Marmot review Rotherham Borough Council has commissioned a specialist midwifery service that is embedded within routine antenatal care for a number of years; this ensures all pregnant smokers receive at least one intensive specialist intervention to encourage a quit attempt, regardless of stated desire to quit. SATOD rate has reduced from 26.3% (9/10) to 18.3% (14/15) Published paper available – link here:  BJM_20_4_238_smokingfinal.pdf

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			Increase the baby's risk of developing respiratory (lung) problems. Increases risks of birth defects. Increases risk of Sudden Infant Death Syndrome		

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46	The Institute of Health Visiting	Key area for quality improvement 2: Maternal Mental Health (Perinatal Depression)	One in seven women suffers from perinatal mental illness (PNMI). There is significant evidence that maternal mood impacts on the development of the foetus and has been shown to influence later outcomes. (iHV, 2015) Untreated perinatal mental illnesses have a wide range of effects on the mental and physical health of women, their children, partners and significant others. They are one of the leading causes of death for women during pregnancy and the year after birth. PNMI impacts on parental bonding and infant attachment essential for the social and emotional development of young children at a critical period.	Approximately half of all cases of perinatal depression and anxiety go undetected and many of those which are, fail to receive evidence-based forms of treatment (iHV, 2015). Updated **NICE (2014) guidelines** highlight key contributions of the health visitor in the recognition and response to mental health problems. The Health Visiting Core Service Specification includes the expectation that health visitors **assess mental health** at the antenatal contact, the New Birth Review and at 6-8 weeks making use of evidence based tools and the skills that support a trusting relationship that is key to sharing concerns at a vulnerable time of life. The PHE (2015) Rapid Review of evidence for the HCP also includes a review at 3-4months. The NHS should: 1. promote **full adoption** of the health visitor-led 0-5 HCP during and beyond the period of mandation of Local Authorities to commission health visiting services to meet the Core health Visiting service, including postnatal promotional interviewing and the PHE (2015) schedule of reviews.. 2. Ensure that there is comprehensive provision of pathways to specialist infant and perinatal mental health services.	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413129/2902452_Early_Years_Impact_2_V0_1W.pdf
47	Royal College of Paediatrics and Child Health	Antenatal and postnatal mental health	Mental health problems during pregnancy and post-natal period causes enormous distress and seriously interfere with adjustment to motherhood, the care of the new born baby and the existing children. Poorly managed mental health problems can have lasting effects on family	Untreated or chronic maternal mental illness along with social adversity have been shown to affect infant's mental health and longstanding effects on the child's emotional ,social and cognitive development. Currently, the parent-infant mental health service provision in England is variable and Inequitable.	• NICE guidelines- Antenatal and postnatal mental health: clinical management and service guidance. • Joint commissioning for mental health-Guidance for

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			relationships and social adjustment of the child.	There is little available data to assess the unmet need. Services with parenting focus can substantially improve infant mental health and social and cognitive development of the child. Hence early detection of maternal mental illness and referral to an appropriate Parent-Infant mental health service will be essential to promote healthy Social ,cognitive and emotional development in under 5's.	commissioners of perinatal mental health services. • Rcpsych website.

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48	SCM2	Key area for quality improvement 2 Perinatal Mental Health	There is good evidence of the impact on childhood development, attachment, cognitive and physical health and for future mental health	Currently 75% of mental health issues starts in child hood and early years Lack of support for those who become mentally ill	PHE doc due out late 2015 A World Health Organization (WHO) study compared depression with angina, asthma, arthritis and diabetes and concluded that the effect of depression on a person's ability to function was 50% more serious than the impact of any of the four physical conditions on them PIMH: Impact of parental mental health on children CHiMAT
49	Royal College of Paediatrics and Child Health	Key area for quality improvement Addressing diet and lifestyle early on to prevent obesity	**Why is this important?** Childhood obesity leads to an increased risk of obesity later life and carries an increased risk of multiple diseases in childhood and throughout life including type 2 diabetes, fatty liver disease, gastro-oesophageal reflux and cardiovascular disease. There is evidence that better diet and increased physical activity can lead to better developmental and behavioural outcomes. The cost of being overweight and obese to society and the economy was estimated to be almost £16 billion in 2007 and this cost will rise with increasing rates of obesity	**Why is this a key area for quality improvement?** Rates of childhood obesity are on the rise globally and in the UK. In 2011, about 3/10 children aged 2-15y in the UK were overweight or obese. Early interventional measures are needed to educate and support families in providing healthy nutrition for their children and encouraging active lifestyles. Poorer families have higher rates of obesity and therefore should be identified and supported early on. There is evidence that interventions that involve the family and encourage more physical activity and less sedentary activities are effective. Education through schools and public awareness campaigns may also be helpful	**Supporting information** Eime RM, Young JA, Harvey JT, Charity MJ, Payne WR. (2013) A systematic review of the psychological and social benefits of participation in sport for children and adolescents: informing development of a conceptual model of health through sport. Int J Behav Nutr Phys Act;10:98. www.toybox-study.eu. te Velde SJ, van Nassau F, Uijtdewilligen L et al (2012) Energy balance-related behaviours associated with overweight and obesity in preschool children: a systematic

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					review of prospective studies. Obes Rev;13 Suppl 1:56-74. Nixon CA, Moore HJ, Douthwaite W et al. (2012) Identifying effective behavioural models and behaviour change strategies underpinning preschool- and school-based obesity prevention interventions aimed at 4-6- year-olds: a systematic review. Obes Rev;13 Suppl 1:106-17. WHO. (2010) Population-based prevention strategies for childhood obesity. Report of a WHO forum and technical meeting, 15–17 December 2009. Geneva; World Health Organization. Nice guidance: Obesity Prevention

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50	School and Nursery Milk Alliance	Provision and encouragement of consuming cow's milk in early years to encourage healthy diets later in life, playing a role in preventing obesity.	Cow's milk as a natural option for children, enabling them to develop a good understanding of food and good eating habits. In turn, this contributes towards a reduction in obesity rates later in life. Public Health England's Change4Life programme recognises that if children learn basic food and nutrition principles early on and are introduced to a healthy and balanced diet, they will continue to eat sensibly as they grow older and become more independent.	NICE clinical guideline 189, Obesity: identification, assessment and management, outlines that UK obesity rates nearly doubled between 1993 and 2011, from 13% to 24% in men and from 16% to 26% in women. In 2011, about 3 in 10 children aged 2–15 years were overweight or obese. The guideline notes that the cost of being overweight and obese to society and the economy was estimated to be almost £16 billion in 2007 (over 1% of gross domestic product). The cost could increase to just under £50 billion in 2050 if obesity rates continue to rise, according to projections from the Department of Health. A simulated model reported in the Lancet predicted that there would be 11 million more obese adults in the UK by 2030, with combined medical costs for treatment of associated diseases estimated to increase by up to £2 billion per year. NHS England chief executive Simon Stevens has also identified tackling obesity as one his main priorities over the next five years. Stevens said that "one in 10 children when they start primary school are obese. When they leave primary school, one in five are obese. So something's going seriously wrong with how we're helping our kids with their future health and wellbeing, and a focus particularly on school-age kids will be important". The Department of Health is also developing a childhood obesity strategy, given the importance of prevention as a policy objective.	Please see NICE clinical guideline 189, Obesity: identification, assessment and management. https://www.nice.org.uk/guidance/cg189/resources/obesity-identification-assessment-and-management-35109821097925 Please see a copy of NHS England chief executive Simon Stevens' speech on obesity prevention, focusing on early years. https://www.politicshome.com/health-and-care/articles/house/simon-stevens-interview-tackling-obesity-not-just-health-issue-its
51	SCM2	Key area for quality improvement 5	There is good evidence that Increased maternal weight or excessive weight gain in pregnancy is associated with adverse pregnancy outcomes.. Maternal obesity is	Half the women who die during pregnancy, childbirth, or puerperium in the United Kingdom are either obese or overweight Nice Introduced a quality standard for nutrition on	NICE Guidance Obesity in pregnancy: an evidence-based commentary RCM

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		Obesity – maternal -9 once child born weaning health diet reccs re PA	a major risk factor for childhood obesity, which persists into adulthood independent of other factors.	maternal and child nutrition in July which says: • Pregnant women attending antenatal and health visitor appointments are advised how to eat healthily in pregnancy • Women with a BMI of 30 or more following childbirth are offered a structured weight-loss programme • Pregnant women and parents and carers of children under 4 years who may be eligible for the Healthy Start scheme are given information and support to apply • Women receive breastfeeding support from a service that uses an evaluated, structured programme.	The Impact of Maternal Obesity on Maternal and Fetal Health Meaghan A Leddy,*,† Michael L Power, PhD,* and Jay Schulkin, PhD*

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	Gloucestershire Hospitals NHS Foundation Trust	Key area for quality improvement 2 Increasing physical activity and preventing overweight / obesity	The recent NICE quality standard on preventing obesity in children and young people (https://www.nice.org.uk/guidance/qs94) does not specifically mention the under 5s, or the importance of identifying children at risk of becoming overweight / obese as early as possible.		
52	Action Cerebral Palsy	Children presenting symptoms of cerebral palsy should have these symptoms identified by their health visitor or GP, with swift referral made to a consultant paediatrician.	Infancy and early childhood is a critical period in a child's brain development, as this is when neuroplasticity is the most active and when the brain is most responsive to sensor motor movement and environmental learning. Children who receive early specialist intervention from multidisciplinary teams including physiotherapists, speech and language therapists, occupational therapists, and practitioners of conductive education, are substantially more independent later in life than those who do not.	Children with cerebral palsy are not being diagnosed quickly enough, with many parents encountering considerable difficulty getting a diagnosis for their child. Parents often have to undertake a lot of work to force through a diagnosis from clinicians. Action Cerebral Palsy conducted a parliamentary inquiry over the summer of 2014, reporting in January 2015, which included a survey of almost 250 parents/carers of children with cerebral palsy. A fifth responded that their child was diagnosed aged two or older, with 54% believing that the process of diagnosis did not work as well as it should have (largely due to GPs not taking the concerns of parents/carers seriously). It is important that health visitors are provided with adequate training and resources to enable them to identify and refer children presenting children with cerebral palsy. Health visitors need investment in training, as well as high quality and clear guidance to ensure that they are best equipped to do their jobs. ACP's survey found that 28% of parents/carers did not believe that health professionals took their concerns seriously, with	Please see the following academic publications, which highlights that infancy and early childhood is a crucial time for neuroplasticity: • Pascual-Leone, A., Freitas, C., Oberman, L., Horvath, J. C., Halko, M., Eldaief, M. et al. (2011). Characterizing brain cortical plasticity and network dynamics across the age-span in health and disease with TMS-EEG and TMS-fMRI. Brain Topography, 24, 302-315 • Basu, A. (2014), Early intervention after perinatal stroke: opportunities and challenges, Developmental Medicine & Child Neurology 2014, 56: 516–521 • Herskind, A., Greisen, G., Nielsen, J., (2014), Early identification and intervention in cerebral

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				complaints that some were adopting a “wait and see approach” – something that was verified by practitioners who gave oral evidence as part of the inquiry. The inquiry also identified that parents believed NHS professionals should have more awareness of cerebral palsy and the follow-up options available. Some parents complained that NHS professionals were either unaware of existing specialist centres or reluctant to refer families to them. Finally, the inquiry found that early intervention and screening can dramatically improve the quality of life and opportunities available for children with cerebral palsy.	palsies, Developmental Medicine & Child Neurology 2014 Review, 1-8 • McIntyre, F., Morgan C., Walker, K., Novak, I., (2011) Cerebral palsy, don’t delay, Developmental Disabilities Research Reviews 17, 114-129 Please see Action Cerebral Palsy’s parliamentary inquiry. The survey results are in the Appendix on page 34 onwards. http://issuu.com/actioncerebralpalsy/docs/acp_report_21st_jan_2015/0

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53	Action Cerebral Palsy	Educational settings and educational practitioners should see cerebral palsy as a condition requiring specialist educational intervention, rather than one requiring just specialist physical intervention.	The inquiry identified a poor awareness of cerebral palsy amongst general educational practitioners. A child with a neurological condition such as a cerebral palsy may, in addition to physical and health challenges, have extensive difficulties in other areas of development: communication, the ability to learn and to process information, self-care and independence, self-esteem, confidence and often mental health/emotional wellbeing. There was a strong consensus from inquiry participants that significant impairments brought about by cerebral palsy require children to receive specialist intervention to develop their cognitive, physical, social and emotional skills in a joined up approach, which would otherwise be learnt through spontaneous play and interaction amongst able bodied children. The statutory Early Years Foundation Stage Framework also requires that all children – including those with SEND – adhere to communication and language early learning goals, such as expressing themselves clearly and effectively through speech. This is an area that children with cerebral palsy tend to have problems with.	The inquiry found that cerebral palsy is often labelled exclusively as a physical disability and that the child's impaired ability to learn is not addressed properly. A recurring theme in evidence to the inquiry was a lack of recognition by the education system and local authorities of the specific learning needs of children with cerebral palsies, with a dominating "one size fits all" attitude. The inquiry found that educational settings tend to respond to cerebral palsy through delivering a physically accessible environment (ramps, handrails and lifts) rather than by understanding the condition and responding to each child's specific needs. The inquiry also found a disequilibrium between cerebral palsy and other conditions like visual impairments, hearing impairments and autism, which are often catered for through highly specialist educational input.	Please see Action Cerebral Palsy's parliamentary inquiry. Section 2 (page 24) outlines the role that specialist educational support can play in helping children with cerebral palsy develop their potential. http://issuu.com/actioncerebralpalsy/docs/acp_report_21st_jan_2015/0
54	Action Cerebral Palsy	Practitioners in early years settings should adopt a joined up approach which recognises the	A unified approach, either from a specialist practitioner or a transdisciplinary team, avoids the tendency to treat a child with cerebral palsy as a raft of separate unrelated conditions, meaning a single programme can be put in place	The inquiry found that when children with cerebral palsies had their needs correctly identified early and were able to access high quality specialist educational support, progress has been marked across all areas of development.	Please see Action Cerebral Palsy's parliamentary inquiry. Section 2 (page 24) outlines the role that specialist educational support can play in helping children with cerebral palsy

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		inter-relationship and inter-dependency of the learning needs of children with cerebral palsy.	successfully to address all of the child's needs.	It also found that without early, specialised help, the child starts to experience failure in everyday activities. This leads to a 'learned behaviour' that can indeed manifest in an increasing perceived level of disability than the actual site of neurological damage.	develop their potential. http://issuu.com/actioncerebralpalsy/docs/acp_report_21st_jan_2015/0

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55	Action Cerebral Palsy	Local authorities should ensure that children have straightforward access to specialist educational provision.	As outlined above, access to specialist educational provision leads to better long-term outcomes for children with cerebral palsy. This also should now be a priority given that local authorities have now assumed commissioning responsibility for health visiting services from Public Health England. This means that they are broadly responsible for identification, referral and access.	The inquiry found parents had encountered extreme difficulty in securing access to specialist educational intervention. One parent said that they had found dealing with education authorities a “profoundly isolating experience” and had been left “bitter and saddened by the whole experience” and fearing that “we will be forever fighting our corner to ensure [our son] gets what he deserves”. Many of these difficulties appear to have arisen because of a culture of short-term cost saving within local authorities. Parents complain that the local authority approach appears to default to the option that requires the least input with recommended actions being based on resources available rather than actual needs. The inquiry heard from a good number of parents and specialist centres that local authorities are using valuable resources to hire specialist barristers and solicitors to manage appeals to educational tribunals where the costs of this were likely to have covered much of the provision that the parents were seeking on behalf of their children. As a result of these difficulties, many parents have had to use their own resources to seek out and self-fund specialist assessments, reports, input and equipment for their child. This inevitably leads to high levels of stress and in some cases, to family breakdown (with its own evident financial and social costs). Parents have had to leave paid work in order to ensure that their child’s educational and health needs are fully met.	Please see Action Cerebral Palsy’s parliamentary inquiry. Section 2 (page 24) outlines the role that specialist educational support can play in helping children with cerebral palsy develop their potential. http://issuu.com/actioncerebralpalsy/docs/acp_report_21st_jan_2015/0
56	The Institute of	Key area for quality	Breast feeding contributes significantly to a wide range of health and developmental	While the uptake of breast feeding has improved, the duration of breast feeding remains low and in	https://www.gov.uk/government/uploads/system/uploads/attachm

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	Health Visiting	improvement 3: Breastfeeding (Initiation and Duration)	benefits for children.	particular reflects the social gradient of social disadvantage. 1. The UNICEF Baby Friendly Standard should be adopted across early years services to provide consistency of practice and service provision across services and disciplines. 2. It should be part of the National Strategy for Obesity that is under development.	ent_data/file/413130/2902452_Early_Years_Impact_3_V0_1W.pdf

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57	SCM2	Key area for quality improvement 4 Breast feeding	Breast milk In addition to containing all the vitamins and nutrients a baby needs in the first six months of life, it protects your baby from infections and diseases, provides health benefits for mum, and it can build a strong physical and emotional bond between mother and baby (attachment)	Breast feeding rates still stubbornly low yet key for attachment and future health of child and mother	NICE guidance UNICEF Baby Friendly WHO evidence of long lasting benefits of Breast feeding
58	Royal College of Paediatrics and Child Health	Key area for quality improvement Early and appropriate diagnosis and management for children with ADHD	Why is this important? Prevalence of ADHD is between 2-5% within the population of school age children. The disorder can impact on learning, friendships and adversely affect family life. Children with ADHD also may endanger themselves and others. Understanding the condition and instigating appropriate management leads to better emotional, behavioural and educational outcomes. Instigation of appropriate behavioural strategies may lead to reduced necessity for use of medication in mild cases.	Why is this a key area for quality improvement? ADHD diagnosis and management varies widely. Instigating specialist multi agency service management will holistically support these children and families to achieve better long term outcomes in education and wellbeing.	Supporting information • National Institute for Health and Clinical Excellence: Attention deficit hyperactivity disorder (ADHD). Clinical Guideline (September 2008); Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults
59	Royal College of Paediatrics and Child Health	Key area for quality improvement Early diagnosis and management implementation for children with behavioural disorders.	Why is this important? Oppositional Defiance Disorder and other behavioural disorders affect development, education and relationships. Children have greater involvement with violent physical fights, stealing and rule breaking. This leads to risky behaviours, truancy and law breaking in later years. Behavioural disorders cause significant of distress to children, families, schools and local communities. Unmanaged, behavioural disorders lead to poor educational outcomes, social isolation, substance	Why is this a key area for quality improvement? For behavioural disorders, early diagnosis and management strategies at home in schools are important to give children a better chance for improvements and hope for the future. Improved management would have positive impacts at individual levels and in wider society.	**Supporting information** • https://www.nice.org.uk/guidance/cg158/resources/anti social-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-and-management-35109638019781

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			misuse and involvement with the criminal justice system.		