REPORT FOR: CABINET

Date of Meeting:	17 September 2015
Subject:	Public Health– Transfer of Public Health Commissioning Responsibilities for 0-5 year olds (Healthy Child Programme delivered by Health Visiting service)
Key Decision:	Yes
Responsible Officer:	Andrew Howe, Director of Public Health
Portfolio Holder:	Councillor Varsha Parmar, Portfolio Holder for Public Health, Equality and Wellbeing
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All
Enclosures:	Appendix 1 – Department of Health, Scope of 0-5 public health services transfer Annexes A-D: Supporting documents setting out the examples of the Health Child Programme

Section 1 – Summary and Recommendations

This report sets out the processes and activities that the shared Public Health Service for Barnet and Harrow has undertaken in order to ensure a smooth transition of the commissioning function for the Health Visiting Service (0-5 component of the Healthy Child Programme). The NHS England (NHSE) currently carried out this function and since 2012 it was always the intention to

move all aspects of the 0-19 Healthy Child Programming Commissioning to local authorities. The School Nursing service (5-19) transferred over in April 2013. This transfer will complete the 0-5 component of the Healthy Child Programme.

Recommendations:

Cabinet is requested to:

Note that the Public Health commissioning responsibilities for 0-5 year olds (Healthy Child Programme delivered by Health Visiting service) will transfer over to the council in October 2015

Note that a rigorous process has taken place in the preparation of Harrow Council assuming responsibility for the commissioning of Health Visiting.

Note that the findings from an independent review informed the strategy for securing additional funding to deliver a challenging Healthy Child Programme for Harrow

Note that grant funding of £1.577m (including £15k for commissioning costs) has been allocated to Harrow for the six months October to March 2016.

Note a national service specification will be followed for this service and in order to provider stability a novated contract with the existing provider will remain in place up to 30 April 2017.

Approve the novation and extension of the contract for a further 2 years subject to central government funding with an option to extend for a further year to ensure stability of the service and allow time to assess the service.

Delegate authority to novate and extend the contract with the current provider to the Director of Public Health in consultation with the Director of Finance and the Divisional Director Commercial, Contracts and Procurement, following consultation with the Portfolio Holder for Public Health, Equality and Wellbeing.

Reason: (For recommendation)

The transfer for Health Visiting from NHS England is part of the undertaking to have the commissioning responsibility for the Healthy Child Programme 0-19 move to Councils. This will also result in a better fit with the wider public health functions, which were transferred since April 2013 under the Health and Social Care Act 2012.

Section 2 – Report

Introductory paragraph

The transfer of the commissioning responsibility for Health Visiting to the council from the NHSE will ensure a consistent and co-ordinated approach to the commissioning of a key public health service to 0-19 children and young people. The overall programme will help the council meet its priorities to "Make a difference for vulnerable residents" and "Giving all children the best start" by ensuring dedicated resources are used locally to meet universal health needs for 0-19 children and young people.

Options considered

a) Do nothing: This is not a realistic option given that since 2012, London councils have asked that the 0-19 Healthy Child Programme is commissioned locally with local intelligence and greater accountability.
b) Commission locally: This is the preferred option. Like all other councils, Harrow will need to become familiar with the requirements of the service and ensure the best fit with its commissioning plans and intentions.

Background

Since 1 April 2013, NHS England has been responsible for commissioning the Healthy Child Programme (HCP) for 0-5 year olds, which is delivered by health visitors in Harrow. As of 1 October 2015, the commissioning responsibility for this service area will transfer to public health teams in local government. This transition marks the final part of the overall public health transfer to local authorities from the NHS following implementation of the Health and Social Care Act 2012.

Nationally a '0-5 Healthy Child Programme task and finish group' is leading the process. The national group includes representation from NHS England, Public Health England, the Local Government Association (LGA), the Society of Local Authority Chief Executives (SOLACE), the Association of Directors of Public Health (ADPH), the Association of Directors of Children's Services (ADCS), and the central government department for Communities and Local Government.

Six work streams support the national group. These are: finance, mandatory checks, local authority and NHS preparedness, communication, information and IT.

To aid the transfer process, the 0-5 Healthy Child Programme task and finish group issued a timetable with key dates for the transition process. Public Health Officers have led this work and crucially used the local intelligence and the results of a Review to argue for additional funding and staffing.

Current situation

For 2015/16 the transfer of commissioning responsibilities is to be effectively a 'lift and shift'. NHSE indicated back in January that it preferred a novation of the contracts, with the main priority being stability of service. With legal advice, we notified NHSE of the intention to roll over the existing contract for the full year and have been involved in the negotiation process between January to June 2015. The Joint Public Health Service for Barnet and Harrow

(JPHSBH) have vociferously argued the position for additional health visiting funding and this has been acknowledged as both Barnet and Harrow are now two of twelve boroughs nationwide that have received substantial growth in funding for 2015/16.

Funding allocation - £160 per child

Proposed allocations were published as part of the Baseline Agreement Exercise on 11 December 2014 and Harrow was initially allocated £113 per child. There followed a five-week period in which Harrow and other councils had the opportunity to comment and raise concerns regarding the accuracy of the allocations. We raised specific issues around the demographic changes, caseloads, workforce pressures, deprivation, the need for funding to support the commissioning responsibility for an ambitious programme and so on. A floor ceiling is set based on a minimum funding so that no local authority is funded to a level below an adjusted spend per head (0-5) set at £160. The Department of Health recognises that this will not address all needs based issues, nor is it a full funding formula. An Advisory Committee on Resource Allocation (ACRA) will be developing the funding formula to better reflect needs in the future. Public Health Harrow & Barnet has presented formal submission on its pressures and challenges, which have been well received by ACRA.

JPHSBH used the findings from its School Nursing and Health Visiting research as the basis of a robust business case for both boroughs. This has been widely acknowledged by NHSE as a good approach and led to increased allocations for both boroughs.

The funding allocation to Harrow includes an uplift to reach the national floor of £160 per head for 2015/16. It also includes a £30k per annum to support the commissioning support costs, as this will be a new function to be carried out by the council. Although it has not been announced as yet, the overall Public Health allocation is expected to be £3.154m (based on the 2015/16 six month allocation). Whilst there is growth, Public Health will continue to pursue further growth funding as it remain one of eleven other areas starting from the lowest base. Officers have and continue to push for growth funding through ACRA

Public Health continues to make progress on the transfer with the current provider to ensure a seamless transition and that services are protected. A key focus is progressing the local communications plan to reassure Health Visiting staff and key stakeholders.

From 2016-17 the allocations are expected to move towards a distribution based on population needs. The fair shares formula will be based on advice from ACRA. It is hoped that the methodology developed by ACRA will lead to an increased allocation to Harrow in 2016-7 and beyond.

Why a change is needed

Since 2012 councils have asked for the transfer of the Healthy Child Programme to be commissioned and co-ordinated on a borough level to fit with the delivery of improved outcomes and integration with 0-5 early years provision.

Implications of the Recommendation

Considerations

- **Resources, costs**

No financial commitment is being requested from Harrow Council. The council's commitments extend to officer time to assist with the commissioning of Health Visiting Services. The Department of Health will fund £30k towards the commissioning support costs.

- **Staffing/workforce**

No staffing or workforce commitment is being transferred to Harrow Council. Health Visitors are employed by a NHS provider and the terms and conditions of service will remain in tact.

Performance Issues

Prior to transition, a review of school nursing and health visiting services was commissioned which included a workforce analysis that showed an ageing workforce with recruitment and retention issues. The provider also needs to deliver the Healthy Child programme including meeting safeguarding concerns in full. There was concern that the current service was not resourced to detect all cases of postnatal depression. This was indicative of staffing levels for Health Visitors at less than recommended levels. The provider has since reported no current vacancies in staffing and has planned for the increase in staffing that will come with the uplifted funding.

The delivery of health visiting services will be measured against mandated checks against the Healthy Child Programme. Local Authorities will be expected to provide the same level of service as the NHS at the point of transfer and act with a view to securing continuous improvement in the uptake of these reviews.

The Department of Health is aware that the delivery of these universal services is not currently at 100% and that this will be an ongoing process. They have been working with the Local Government Association and the Department of Communities and Local Government to ensure that they are not imposing an additional unfunded burden upon Local Authorities.

Public Health and the provider are working together to ensure that robust KPIs are in place to measure and monitor the performance against the mandated services and to ensure that all safeguarding requirements are met..

Environmental Impact

The transfer of this commissioning function to the JPHSBH will have minimal effect on the environment in general or on climate change.

Risk Management Implications

The risks for Harrow are:

Risks	Mitigating Actions
• Financial allocations: The funding formula is not needs based and in spite of a funding growth there remain challenges for the service to	The Department of Health has used a 'lift and shift' principle as a basis for the transfer of commissioning responsibilities to support contracts, which are in place. The request that

meet 5 key mandatory elements from October 1, 2015.	the baseline funding is adjusted following agreement with NHS England to reflect the cost of Harrow Contract has been reflected in the allocation. In addition Harrow has benefitted within the minimum floor target of £160 per child. We are actively engaging with London North West Healthcare Trust on caseloads management, risk management, skills mix, mandatary requirements and so on. We have established a positive relationship with NHS England, London Councils and ACRA and will feedback any pressures.
• Contracting: The council does not adequately prepare for the transfer of the contractual obligations relation to public health functions	Preparation for the transfer of contractual obligations include active input from Legal and category management as well as interim commissioning expertise
Reputational: The council inherits an underperforming service and is held to account on performance in respect of delivery of the mandated checks.	The regulations make it clear that there is no expectation of an uplift in performance at the point of transfer, and that councils will only be expected to take reasonably practicable approach to delivering the checks and to continuous improvement over time. Performance issues are being addressed with London North West Healthcare Trust by NHS England

Legal Implications

The transfer of the contract is a 'lift and shift' of the current HV arrangements from the NHSE to the council which followed a decision to enter into a deed of novation by the Director of Public Health following consultation with each borough and legal advice provided by HB Public Law.

The Department of Health is mandating five universal reviews within the Healthy Child Programme. Mandatory Regulations that require local authorities so far as reasonably practicable to secure the provision of the specified five universal health visitor reviews have now been approved by Parliament and will be in force from 1 October 2015.[1]

The Regulations provide for a 'sunset clause'[2] which has the effect of ending the mandatory period after 18 months, unless further legislation is introduced

[1] Transfer of 0-5 children's public health commissioning to Local Authorities: 0-5 Public Health Allocations for 2015/16; Department of Health 2015

[2] A provision in a Bill or Regulations that gives them an 'expiry date' once passed into law. 'Sunset clauses' are included in legislation when it is felt that Parliament should have the chance to decide on its merits again after a fixed period

that continues the provisions in force. A review, involving Public Health England, is intended to inform whether the 'sunset clause' needs to be amended.

Financial Implications

Harrow has been allocated funding of £1,577k for the 6 months to March 2016 when it takes over the responsibility for health visiting in October 2015. This funding includes £15k for commissioning support. The commissioning intentions for 2015/16 assumed an additional commissioner post in relation to this function and made provision of £80k in a full year for this additional post. The additional funding has been allocated from the public health ring fenced grant.

The annual value of the contract being novated is currently expected to be £3.154m (based on 6 month allocation). Final 2016/17 allocations will be dependent on the amount of funding announced for public health in the 2015 Spending Review and on the fair shares formula developed following advice from ACRA.

This level of funding provides scope for additional investment in the service to meet historically underfunded overheads and provide for or at least 10 additional qualified health visitors which will allow us to meet the mandated requirements. The funding, which although not ring fenced, is required for the novation of the contract and the provision of the mandated services for 18 months (to 31st March 2017) as stated in the "sunset" clause[2].

The consultation paper issued by the Department of Health on 31st July indicates that the £200m in year savings will include the Health Visiting grant and have proposed, subject to the outcome of the consultation, a standard reduction of 6.2% which would equate to a reduction in the Health Visiting element of £98k. This reduction in grant impacts the ability to create flexibility within the grant and achieve MTFS reductions by charging wider determinants of health across the Council to the grant.

The annual review of commissioning intentions will seek to ensure that the cost of these services can be contained within the wider financial envelope on an annual basis, taking any action as required to mitigate any financial pressures should these arise.

It should be noted that the novation of this contract (and any extension) results in contractual obligations with the provider for services which are funded by external grant and which cannot be guaranteed in the longer term.

Equalities implications / Public Sector Equality Duty

The services are required to comply with Equality legislation, providing services which respect the diversity of local communities in safe environments free of discrimination, where individuals are treated fairly with dignity and respect appropriate to their needs. There will be a small positive impact for pregnant women as the health visiting service is required to increase the uptake of the antenatal health promoting assessment within a year. There is

also likely to be a small positive impact on poverty over time through the delivery of targeted model based on early and directed support to new parents and young families. This could result in more young parents staying engaged with education and employment. There will be no change in the impact (negative or positive) to people who fall within the other protected characteristics.

Council Priorities

The transfer of the commissioning responsibility from the NHSE will contribute to the Council's vision: **Working Together to Make a Difference for Harrow** as the service will work with a range of stakeholders: schools, Clinical Commissioning Group, NHSE, parents/carers, children and young people to improve health and wellbeing of Harrow's youth.

The report incorporates the following administration's priorities.

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for families

Section 3 - Statutory Officer Clearance

Name: Donna Edwards Date: 7 September 2015	x	on behalf of the Chief Financial Officer
Name: Sarah Inverary Date: 17 August 2015	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO, as it impacts on all Wards**
EqIA carried out:	**YES**
EqIA cleared by:	Carol Yarde

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Background Papers:

a) Briefing Paper to the C&YP Commissioning Board: Health Visiting Progress Report
b) Department of Health Proposal on Health Visiting Finances
https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

Call-In Waived by the Chairman of Overview and Scrutiny Committee	**NOT APPLICABLE** *[Call-in applies]*

Appendix 1

Scope of 0-5 public health services transfer

1. Background

Children's public health commissioning responsibilities for 0-5 year olds will transfer from NHS England to local authorities on 1 October 2015. Local authorities are well placed to identify health needs and commission services for local people to improve health, this transfer will join up that already done by local authorities for children and young people aged 5–19.

The Children's Health and Wellbeing Partnership (CHWP) has established the 0-5 Public Health Commissioning Transfer Programme Board to coordinate and have oversight of the transition.

This appendix sets out the scope of 0-5 children's public health commissioning in greater detail, providing background information and further detail that capture existing commissioned services, where they belong currently and where their future destinations are planned.

2. Transition and the different elements of service

The following **commissioning responsibilities will transfer** to local authorities on 1 October 2015:

- The 0-5 Healthy Child Programme (HCP) - this includes the Health Visiting Service incorporating universal to targeted programmes and the Family Nurse Partnership (FNP) (targeted services for teenage mothers, where a family nurse will take on this role until the child is two years old).

The following commissioning responsibilities **will be retained** by NHS England:

- Child Health Information Systems, to be reviewed in 2020
- The 6 – 8 week GP check, (also known as Child Health Surveillance).

Only the commissioning responsibility is being transferred. Health visitors will continue to be employed by their current employer – in most cases this is the NHS.

3. Scope of the Health Visiting Service

Evidence shows that what happens in pregnancy and the early years of life impacts throughout the life course. Therefore a healthy start for all our children is vital for individuals, families, communities and ultimately society.

Health visitors have a vital role to play and the scope of work involves a wide range of interventions and activities at a population and community level as well as at family and individual level. These are best described through the

Health Visiting Service Model, the Healthy Child Programme (HCP) and 6 High Impact Areas. These three components are inextricably linked. They describe the what, how and why of the scope of Public Health work and focus on specific opportunities within the universal and targeted services to focus on interventions and advice that will have the greatest impact on child health and wellbeing outcomes. The interventions are informed by National Institute for Clinical Excellence guidance and other evidence based approaches.

Examples of interventions at population, community and individual level can be seen in Annex B and Annex C

4. The Health Visitor Service Model

The Health Visitor Improvement Plan 2011-2015 outlines the four level (sometimes known as tiers) model as the basis to develop and expand health visiting services in England. The four levels, which are based on assessment of children's/families' needs, are:

Community Services - linking families and resources and building community capacity,

Universal Services - primary prevention services and early intervention provided for all families with children aged 0-5 as per the HCP universal schedule of visits assessments and development reviews,

Universal Plus Services - time limited support on specific issues offered to families with children aged 0-5 where there has been an assessed or expressed need for more targeted support,

Universal Partnership Plus Services - offered to families with children aged 0-5 where there is a need for ongoing support and interagency partnership working. Particularly for families with more complex needs.

5. The Healthy Child Programme (HCP)

Health visitors lead delivery of the HCP, this is a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. It is underpinned by an up-to-date evidence base such as set out in Health for All Children (Hall and Elliman, 2006) and is aimed at children up to the age of 19 and their families.

The programme is offered to all families and core elements include health and development reviews, screening, immunisations, promotion of social and emotional development, support for parenting, and effective promotion of health and behaviour change. It provides significant opportunities for highly skilled professionals to identify and deliver appropriate interventions to those with specific needs (including in some families, safeguarding needs).

Delivery of the universal elements of the HCP will see a team led by health visitors working in ways most appropriate to local public health needs and across a range of settings and organisations including: general practice,

maternity services and children's centres. Where families are accessing FNP a family nurse will take on this role until the child is two years old.

In addition to the core universal programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Commissioning public health services includes joining up with other services supporting children and families, other local authority commissioning services, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups, etc. to determine which services are offered locally and by whom.

6. The 6 High Impact Areas

Six early years High Impact Areas have been developed that focus on the universal service areas having the biggest impact on a child's life. They also align with a number of the public health priority areas and have been identified to support the transition of commissioning to local authorities - helping inform decisions around the commissioning of the health visiting service and integrated children's early years services. They aim to;

- articulate the contribution of health visitors to the 0-5 agenda and improving outcomes for children, families and communities;
- describe areas where health visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities. The universal contacts provide the opportunity to engage families on these issues at the time when they are most receptive to advice and support.

The 6 areas are:

- transition to parenthood and the early week
- maternal mental health (includes post natal depression)
- breastfeeding (initiation and duration)
- healthy weight, healthy nutrition (includes physical activity)
- managing minor illness and reducing accidents (reducing hospital attendance/admissions)
- health, wellbeing and development of the child age 2 – two year old review (integrated review) and support to be 'ready for school'.

Examples of rationale for inclusion can be seen in Annex C

7. Commissioning responsibilities – summary table

The table below captures what commissioning responsibilities currently exist and where they will be on 1 October 2015.

Commissioning Responsibility	Current Commissioner	Current Provider	Future Commissioner
Healthy Child Programme (most but not all elements – see Annex A) and Health Visiting	NHS England	Various, mainly NHS	LA
Family Nurse Partnership	NHS England	Various,	LA

Programme		mainly NHS	
Health promotion and prevention interventions from the multi-professional team	NHS England	Various, mainly NHS	LA
Child Health Information Systems	NHS England	Various NHS	NHS England*
Child Health Surveillance (6-8 week check)	NHS England	GPs	NHS England

*NHS England has announced that they will be commissioning a new interoperable system for CHIS in 2016 and that it will be in place nationally by April 2017.

Annex A Schedule of universal elements of the Healthy Child Programme outlined in the 2014/15 Service Specification No. 27 (Public health functions to be exercised by NHS England – Children's public health services (from pregnancy to age 5)).

Review	Description	Delivered by	Commissioned by
Antenatal Review	A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy Identifying and sharing information about women eligible for the FNP	Midwives or maternity healthcare professionals	CCGs
	Antenatal screening for fetal conditions	Midwives or maternity healthcare professionals Screening services	NHS England
Antenatal health promoting visits	Includes preparation for parenthood	**Health visitors** **Family nurse** (where the family is accessing FNP)	NHS England (expected to move to LAs from October 2015)
By 72 hours	Physical examination – heart, hips, eyes, testes (boys), general examination and matters of concern	Midwives or maternity healthcare professionals	CCGs
At 5 – 8 days (ideally 5 days)	Bloodspot screening	Midwives or maternity healthcare professionals Screening services	NHS England
New Baby Review	Face-to-face review by **14 days** with mother and father to include: • Infant feeding • Promoting sensitive parenting • Promoting development • Assessing maternal mental health • SIDS (Sudden Infant	**Health visitors** **Family nurse** (where the family is accessing FNP)	NHS England (expected to move to LAs from October 2015)

Review	Description	Delivered by	Commissioned by
	Death Syndrome • Keeping safe • If parents wish or there are professional concerns an assessment of baby's growth • On-going review and monitoring of the baby's health • Safeguarding		
6 – 8 Week Assessment	Includes: • - On-going support with breastfeeding involving both parents • - Assessing maternal mental health	**Health visitors** **Family nurse** (where the family is accessing FNP)	NHS England (expected to move to LAs from October 2015)
	- Health review and comprehensive physical examination of the baby with emphasis on eyes, heart and hips (and testes for boys)	**GPs** (physical examination of the baby)	NHS England – through primary care commissioning
By 1 Year	Includes: • - Assessment of the baby's physical, emotional and social needs in the context of their family, including predictive risk factors • - Supporting parenting, provide parents with information about attachment and the type of developmental issues that they may now encounter • - Monitoring growth - Health promotion, raise awareness of dental health and prevention, healthy	**Health visitors** **Family nurse** (where the family is accessing FNP)	NHS England (expected to move to LAs from October 2015)

Review	Description	Delivered by	Commissioned by
	eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention		
By 2 – 21⁄2 Years	Includes: • - Review with parents the child's social, emotional, behavioural and language development • - Respond to any parental concerns about physical health, growth, development, hearing and vision – • Offer parents guidance on behaviour management and opportunity to share concerns • Offer parent information on what to do if worried about their child • Promote language development • Encourage and support to take up early years education • Give health information and guidance • Review immunisation status • Offer advice on nutrition and physical activity for the family • Raise awareness of dental care, accident prevention, sleep management, toilet training and sources	**Health visitors** **Family nurse** (where the family is accessing FNP) Clients on the FNP programme will leave the programme when the child is two and receive usual universal health visiting services.	NHS England (expected to move to LAs from October 2015)

Review	Description	Delivered by	Commissioned by
	of parenting advice and family information • This review should be integrated with the Early Years Foundation Stage two-year-old summary from 2015 as appropriate to the needs of the children and families.		

Annex B Examples of community/population activity:

- Search for health needs, using population data, demographics
- Provision of antenatal and new-born screening programmes
- Achieving population wide “herd” immunity through increased uptake of immunisations
- Stimulation of awareness of health needs, linking to housing, poverty issues
- Influencing policies affecting health
- Influencing Joint Strategic Needs assessments and commissioning intentions
- Raising awareness, reducing stigma e.g. to mental health issues
- Supporting health campaigns/promoting safety messaging
- Facilitating health enhancing behaviours
- Aligning work with other services to improve health and well-being outcomes and building community capacity.
- Linking people to community resources, signposting to information e.g. Parenting support, benefits, housing, relationship advice
- Signposting to or delivery of targeted Parenting Programmes
- Reducing social isolation, links to community groups e.g. cookery classes, outdoor activities
- Developing peer support groups e.g. breast feeding cafés, signposting to support services

Annex C Examples of interventions at family/individual level = Universal, Universal Plus and Universal Partnership Plus elements of the Health Visitor Model

- Leading and delivering the Healthy Child Programme
- Early Identification of need/risk factors and early intervention
- Supporting healthy attachment and supporting sensitive attuned parenting
- Supporting mothers to breastfeed (Technical knowledge and emotional support)
- Advice on breastfeeding and medication
- Support to parents on managing minor illness and building parental confidence
- Home safety advice/bottle hygiene awareness
- Encouraging healthy weight pre conception
- Nutrition advice and weaning advice cooking nutritious meals on a budget
- Advice on use of vitamin supplements
- Immunisation advice, linking with hard to reach families
- Supporting Healthy lifestyle choices (behaviour change)
- Referrals to other services where need is identified

Annex D Why the focus on the first 1001 days and 6 High Impact Areas

Transition to Parenthood and the first 1001 days from Conception to age 2 is widely recognised as a crucial period that will have an impact and influence on the rest of the life course.

Pregnancy and the first years of life is a time when parents are particularly receptive to learning and making changes.

There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life.

A healthy pregnancy is important to the health of the baby. Health messages on the need to stop smoking and drinking during pregnancy are key, as is the importance of emphasising uptake of immunisations.

New information about neurological development and the impact of stress in pregnancy, and further recognition of the importance of bonding and attachment, all make early intervention and prevention an imperative.

Secure attachment and bonding will have an impact on resilience and physical, mental and socioeconomic outcomes in later life.

Transition to Parenthood

• Conception to age 2 is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing; Strong positive attachment is essential for healthy brain development and social and emotional resilience in later life;

Maternal Mental Health

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

Breastfeeding

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

Obesity

• Healthy eating habits are established in the early years. Over a fifth of 4-5 year olds are overweight or obese.

Hospital Admissions

• Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of

attendances at Accident & Emergency departments and hospitalisation amongst the under 5s.

Development of child

• Age 2 is an important time for identifying developmental concerns and for providing advice to support and enhance readiness to learn and grow. Many children start school with poor communication skills, still wearing nappies and not emotionally ready to learn.