NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Early years: promoting health and wellbeing in under 5s

Date of Quality Standards Advisory Committee post-consultation meeting:
5 May 2016.

2 Introduction

The draft quality standard for early years: promoting health and wellbeing in under 5s was made available on the NICE website for a 4-week public consultation period between 14 March and 11 April 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 16 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the

process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect the data for the proposed quality measures? If not, how feasible would it be for these systems and structures to be put in place?

3. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources required to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 2: What are the potential risks which should be acted upon and what support should be provided?

6. For draft quality statement 3: Are there other validated tools that could be used at the integrated review to assess the child's speech and language?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality statements are vaguely worded.
- Health is not mentioned in the quality standard so remove from title or make the boundary clear.
- It was noted that there is no mention of smoking or tobacco in the document.
- Concern raised that midwives are not mentioned in the quality standard.
- References to the main carer should be gender neutral.
- Suggestion to change substance misuse to drug and alcohol misuse throughout.
- Young and inexperienced parents usually require more support and Sure Start is an effective intervention. Support services must be in place to follow up the health visitor prescription.
- The overall direction of this quality standard seems sensible however the health visiting service may find some difficulties in the delivery. Emphasising routine work for all families may take health visitors away from work with the most vulnerable.
- The quality standard does not highlight the importance of identifying and addressing parental needs and the impact of domestic abuse on children's health.
- Suggestion to include supporting evidence for the information presented in the 'reasons this quality standard is needed' section.
- Suggestions of updates to the introduction and some additions to the frameworks, overarching outcomes, policy context and related quality standards sections.
- Suggestion to add detail to some of the definitions in the quality standard.

General consultation comments on key areas for quality improvement (question 1)

- Families with multiple risk factors and at risk of poor outcomes may be 'hard to reach' but the quality standard does not address ensuring that they are reached.

General consultation comments on data collection (question 2)

- Delivery of universal services by occupational therapists is increasing and those services routinely collect data.
- The collation of outcomes is challenging as these services are often delivered at a whole population level. Many areas audit awareness/knowledge amongst parents and the wider workforce of the need for children to participate and develop skills in daily occupations in preparation for school.
- Systems and structures can be put in place but currently information is collected separately by NHS and Local Authority service providers. This could be better aligned around a shared local outcomes framework.
- Current data systems to collect data such as KPIs tend to be number of contacts and may not include content or description of interventions.
- Local audits could reveal what is included in key contacts and what 'tailored support' is offered but there are resource implications.
- There is no national system for collecting and comparing this data at this time.

General consultation comments on resource impact (question 4)

- Achievement of the quality statements relies on the universal workforce and the training they receive on an ongoing basis to support assessment and interventions. A significant amount of training and support is required to meet the quality standard from the specialist workforce.
- Potential cost saving would be the production of e-learning materials to support the quality standard and areas of omission to be rolled out across services.
- Emphasis on prevention and early intervention can produce a cost saving in the longer term but early years workforce services are often identifying unmet need for targeted support.
- This would be achievable with a fully resourced HCP (Healthy Child Programme) workforce in partnership with early years colleagues and specialist services. However with locally planned reductions in health visiting and related workforce there may be inadequate resources to deliver.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Parents and carers of children under 5 are offered a discussion during each of the 5 key visits about factors that may pose a risk to their child's social and emotional wellbeing.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Practitioners need to understand the links between parent and child social and emotional wellbeing, parenting and a healthy lifestyle, and be able to discuss these holistically.
- Concern was raised that this statement may be difficult to implement and is trying to introduce a screening programme which could become a tick box exercise, taking time away from those families most in need.
- Concerns that nutrition and a healthy diet is rarely discussed with parents at the 5 key visits and should have higher prominence in statements 1 and 2.
- There will have to be processes or services in place (charities/local support services) available for families not requiring social services referral but these may not be available in all areas.
- This should include an 'assessment' as well as a discussion.
- The health visitor is the lead for the healthy child programme and will be undertaking the 5 key contacts, therefore this should be stated.
- The health visitor will not just 'visit' clients, therefore 'contact' is a better term
- It should be clear all of these reviews should be face to face.
- The measure states a visit which implies the child's home, but the measures and audience descriptor state appointment which could imply attendance at a centre
- The measures could be supported by recommended instruments such as:
    - the ADBB (Alarm distress baby scale) at the 10-14 day mandated visit
    - the EPDS (Edinburgh Post Natal Depression Scale) and a paternal depression questionnaire at 6-8 week visit and 9-12 months review

    - a parental SDQ (Strengths and Difficulties Questionnaire) and SCQ (Social Communication Questionnaire) or similar at 2-2.5 year review
    - a formal EYFS (Early Years foundation Stage) review completed by age 5 for all children where concerns were previously identified.
- Suggestion to state ‘12 month’ developmental review rather than ‘9-12 month’.
- Suggestions made to update some terms / data sources.
- The common assessment framework (CAF) is almost entirely discretionary beyond its basic framework which could be problematic.
- Discussions should use suitable approaches relevant to the five contacts by health visitors, e.g. the use of ‘Promotional Guides’.
- Interpreters will need to be readily available.

Consultation comments on data collection (question 2)

- There are local systems in place to record and share information e.g. E-Taf (Electronic Team Around Family) computer system which has potential to allow all interactions with all clients to be recorded in a single database.

5.2 Draft statement 2

Children under 5 with identified risks to their social and emotional wellbeing, and their families, receive tailored support.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Children with special educational needs are particularly at risk of not having needs met due to difficulties in cognitive functioning and ability to communicate.
- Some measures, such as the ASQ:SE (Ages and Stages Questionnaire: Social and Emotional) lack validity and need support such as the SCQ (Social Communication Questionnaire).
- Strongly agree with focus on securing shared approaches, holistic assessments, pathways to support multi-disciplinary working, integrated and joint commissioning around targeted and universal services.
- Risks to health should be considered as well as social and emotional wellbeing.
- Nutrition should be addressed within assessment/contacts with appropriate resources provided and needs higher prominence in statements 1 and 2.
- Excess child weight gain should be included in risk factors.
- Statement 2 should follow from the problems identified in statement 1.
- The statement would be improved by being more specific on tailored support, still allowing local initiatives for the measures.
- Tailored support definition needs more information, for example:
  - include obesity programmes
  - under early help include training health visitors to support, give advice on and monitor oral health.

Consultation comments on data collection (question 2)

Stakeholders made the following comments in relation to consultation question 2:

- Systems are in place for measurement, eg the National Drug Treatment Monitoring System monitors referral to specialist alcohol and drug treatment services.

- There are local systems in place e.g. E-Taf (Electronic Team Around Family) computer system which has potential to allow all interactions with all clients to be recorded in a single database.

Consultation comments on resource impact (question 4)

Stakeholders made the following comments in relation to consultation question 4:

- This standard is already being achieved locally through highly developed and effective integrated early support.

Consultation comments on the potential risks which should be acted upon and the support which should be provided? (question 5)

Stakeholders made the following comments in relation to consultation question 5:

Risks

- Mental health issues in the family, especially parental mental health problems during pregnancy and post-natal period.
- Domestic violence / abusive environment including neglect.
- Parent - child relationships and inter-parental relationships.
- Drug and alcohol misuse.
- Developmental concerns or a known physical disability.
- Childhood obesity.
- Emotional and behavioural concerns in the child.
- Securing and sustaining parent engagement and organisational buy-in.
- Effective information and knowledge management.

Support

- Access to a wide range of services including; psychiatric services and therapies, health visitors, social services, hostels, charities, police, drug and alcohol services, community paediatrics, audiology, occupational therapy, physiotherapy, healthy eating community programmes, exercise and nutrition projects.
- Health visitor led interventions; multi agency programmes with early years through to specialist support services.

- Healthy child programme recommends 6th contact at 3-4 months to identify maternal mental health risks impacting on the child's social and emotional development.
- Shared strategic direction and commitment / joint outcomes and accountability.
- Pooled budgets / joint commissioning.
- Information sharing protocols.
- Ongoing continuing professional development and workforce development.
- Clear rationale for service users.

5.3 Draft statement 3

Children are offered an assessment of their speech and language skills at their 2–2 ½ years integrated review.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Health visitors should assess parental interactions with the baby at the 6 week review and early language skills development at the 9-12 month review.
- Early communication and language skills should be promoted from birth.
- Statement is useful but detection at 12 months gives a better window for autism.
- Assessment at 2+ years old could mean delayed support provision due to waiting times and capacity levels in speech and language services. Presumably tailored support under statement 2 includes this.
- Statement should explicitly acknowledge the needs of parents with no or low literacy.
- Statement applies universally but should include a caveat such as: if not already targeted for extra support.
- Assessment is important but appropriate interventions and referral pathways need to be in place if issues are identified.

Consultation comments on resource impact (question 4)

Stakeholders made the following comments in relation to consultation question 4:

- Cost savings could be achieved through reductions in waiting times, improved access and uptake of appropriate support. Targeted and universal opportunities are available through Children's Centres and delivered in partnership with the commissioned Speech and Language service.

Consultation comments on other validated tools that could be used at the integrated review to assess the child's speech and language (question 6)

Stakeholders made the following comments in relation to consultation question 6:

- The National Health Visiting Service Specification 2015/16 states the Ages and Stages Questionnaire (ASQ) must be used as the assessment tool for the 2- 2 ½ year review.
- Query of whether another tool would be necessary. The ASQ, delivered by a trained member of the health visiting team, identifies issues with speech and language.
- The professional should observe and ask questions during the review to see if the child performs at the level reported by parents on the pre-filled questionnaire.
- Another tool which could be used is WELLComm (Speech and Language Therapy national tool).
- Autism spectrum disorders are increasingly common so suggesting an M-CHAT (Modified Checklist for Autism in Toddlers) questionnaire is used if there is speech and language delay, especially if there are other related concerns, may be useful.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Play, connection with living world, participation in daily occupations and school readiness skills.

This area was not explicitly raised at topic engagement but was briefly discussed at the last committee meeting in the context of development. School readiness is mentioned in the source guidance NICE PH40 Social and emotional wellbeing: early years under recommendation 1 in the context of services being commissioned to ensure school readiness. The definition of school readiness in PH40 is '… 'readiness for school' refers to a child's cognitive, social and emotional development. Development during the child's early years may be achieved through interaction with their parents or through the processes of play and learning'. There are no other recommendations in PH40 relating to this area.

- Infant mental health.

This was discussed at the last committee meeting and it was agreed this would not be progressed as a key area for quality improvement.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
		GENERAL	
1	Royal College of Psychiatrists (Child and Adolescent Faculty)		Though the focus is on public health and well-being, it is noted that no national-level mental health body (such as the RCPsych or BPS) is represented. The 0-5 curriculum group may not be a sufficient substitute, as it is partly off-topic for this (as the remit explicitly excludes "treatment of mental disorders")
2	Royal College of Psychiatrists (Child and Adolescent Faculty)		The impact of the lack of representation can be seen in the briefing paper where, e.g., bullying is suggested as a particular problem in relation to infant mental health.
3	Royal College of Psychiatrists (Child and Adolescent Faculty)		Regarding the very important aspect of learning disability in the early years, only epilepsy appears to be represented, though the points the organisation made are of general applicability
4	Royal College of Psychiatrists (Child and Adolescent Faculty)		The quality standards themselves are worded too vaguely.
5	HENRY (Health, Exercise, Nutrition for the Really Young)		Whilst this quality standard focuses on emotional and social development, the impact on physical health should not be entirely omitted. In addition to improvements in the outcomes listed, the quality standard is likely to also impact on the prevention of obesity and/or eating disorders: • The emotional significance of food mean that low self-esteem and poor emotional health are strongly associated with eating for non-hunger reasons - shame, mental and emotional distress, a need for comfort – with the risk of development of eating disorders and/or obesity. • Research evidence points to a correlation between parenting style/efficacy and obesity e.g. Marvicsin, D., & Danford, C. A. (2013). Parenting efficacy related to childhood obesity: Comparison of parent and child perceptions. *Journal of Pediatric Nursing*, *28*(5), 422-429.
6	HENRY (Health,		As obesity impacts significantly on emotional and social health, related quality standards should include

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
	Exercise, Nutrition for the Really Young)		NG7: maintaining a healthy weight and preventing excess weight gain amongst adults and children. The negative social and emotional consequences of obesity can begin early in the developmental trajectory and impact all aspects of an individual's quality of life: Taylor, Valerie H., et al. "The impact of obesity on quality of life." *Best practice & research Clinical endocrinology & metabolism* 27.2 (2013): 139-146. The most immediate consequence of being overweight as perceived by children themselves is social discrimination, bullying and low self-esteem. A 2003 study found that obese children often rated their quality of life with scores as low as those of young cancer patients on chemotherapy: Schwimmer, Jeffrey B., Tasha M. Burwinkle, and James W. Varni. "Health-related quality of life of severely obese children and adolescents." *Jama*289.14 (2003): 1813-1819.
7	The Royal College of Midwives		The RCM is very concerned that despite the recommendations in the source document Social and emotional wellbeing: early years (2012) NICE guideline PH40. - All health and early years professionals should develop trusting relationships with vulnerable families and adopt a non-judgmental approach, while focusing on the child's needs. - 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 and the frequent mention of the role of midwives in the Briefing paper, that the activity of midwives is not mentioned in the quality standard at all. We consider this to be a serious omission considering the well established role and ability of midwives to develop a trusting relationship with the family.
8	UK Society for Behavioural Medicine		We are disappointed that while the title of the draft quality standard is "promoting health and wellbeing", the focus is entirely on social and emotional wellbeing and health is neglected. This is confusing as it is not clear who the guidance applies to. Further we consider this to be a missed opportunity to provide guidance and recommendations for children's health in the early years. Guidance and recommendations are needed to promote a range of health issues in the early years, including diet and physical activity. We propose that the quality standard should address children's health or the term health should be removed from the title to avoid confusion.
9	UK Society for Behavioural Medicine		While the draft quality standard makes explicit that it is not concerned with clinical health it is not clear what the perceived/suggested boundary is. For children at the highest risk of long term problems, and in most need of proactive early promotion of health and wellbeing (i.e., children with comorbid health and wellbeing

ID	Stakeholder	Statement number	Comments[1]
			difficulties), it is fundamental to have integrated support across health, education and wellbeing. This is the cornerstone of the Education, Health and Care plans (mentioned in this draft). In the proposed quality standard it is not clear what 'clinical' means, but if it is defined as meaning the NHS then this is problematic., Many NHS interventions are active health promotions targeted at those most at risk, for example community-based speech and language therapy, occupational therapy, and physiotherapy. These interventions focus on supporting parents and others to adapt the child's physical and social environment so that they are able to participate in a full range of activities. Further the draft quality standard makes references to health professionals who would be considered clinical, such as health visitors and mental health specialist services. The quality standard should clarify the boundary with clinical health more clearly.
10	UK Society for Behavioural Medicine		References are made throughout the draft quality standard to the mother as the assumed main carer of children under 5 years of age. We feel that it would be more appropriate to refer to the main carer in gender neutral terms.
11	UK Society for Behavioural Medicine		There are a number of terms in the draft quality standard which need to be defined more clearly to enhance implementation. Terms such as 'healthy behaviours', 'social and emotional wellbeing', and 'loving and nurturing environments' should be defined early and comprehensively in the quality standard document.
12	UK Society for Behavioural Medicine		The draft quality standard seems to suggest a link between family deprivation level, developmental risk factors, a lack of opportunity to access interventions, and poor outcomes. However, the links are not always made fully explicit and supported by evidence. For example, it is not clear that it is specifically those from more deprived backgrounds and/or at risk of poor outcomes that are not currently accessing services – if this is the case then it should be clearly documented. These comments do not detract from the need for universal access to health and wellbeing promotion, and indeed the draft suggests that everyone should be provided with the opportunity to access interventions, rather they refer to the assumptions which seem to underlie the draft quality standard and yet are not made explicit. These assumptions need to be fully documented with supporting evidence or the draft rewritten accordingly.
13	Royal College of GPs		The document is a thoughtful examination of the necessary monitoring and support of the young child and his/her family. It would be helpful to have some quantification of the requirements based on the birth rate and ethnic/ social mix and those families identified as at greater risk. The RCGP feels that young and inexperienced parents, particularly on their own will usually require more support. Thus Sure Start proved an effective intervention. There will need to be the support services to

ID	Stakeholder	Statement number	Comments[1]
			follow up the Health visitor prescription. Effective monitoring of the child population requires a parent held under five card and electronic back up. The child's growth-height and weight, immunisations, developmental milestones and dental checks are essential in ensuring the physical development of the young child is ensured even as their emotional and behavioural growth. (PS)
14	Royal College of GPs		Some practices may feel that the health visiting team is often understaffed, changed with bewildering speed, and always seemed overworked. While the overall direction of this quality standard seems sensible the RCGP finds the workforce may find some difficulties in the delivery of the service. The RCGP feels that by emphasising routine work for all families it will have an opportunity cost in taking them away from their work with the most vulnerable and needy. (DJ)
15	Royal College of GPs		Rapid Review to update evidence for the healthy Child Programme March 2015 – date should be added otherwise it is easily confused with the QS. (JA)
16	Royal College of GPs		It is quoted that only 50% attend the 2 year Healthy Child Programme checks – is there evidence of which 50%? (JA)
17	Public Health England		Young parents The Standard rightly mentions the connection between teenage pregnancy and the health & wellbeing of the under-5s. It would be helpful if it made clear that it is both a cause and consequence i.e. At age 5, children of teenage mothers are 4 months behind on spatial ability, 7 months behind on non-verbal ability and 11 months behind on verbal ability; in a report on Serious Case Reviews, 60% of the children involved were born to mothers under 21. In turn poor educational attainment, poor mental health and experience of abuse, which may start in early years, are all risk factors for early pregnancy
18	Public Health England		The Standard doesn't make sufficiently clear the critical importance of identifying and addressing parental needs which will be influencing the child's social and emotional health and wellbeing. For example, Ofsted's Ages of Concern report highlighted that practitioners sometimes failed to recognise that the teenage mother (and young father) may be a child(ren) in need – in addition to their baby/child. The same report also highlighted the importance of ensuring young fathers are provided with good support to help them be good parents.
19	Public Health England		The impact of domestic abuse/violence on children's health and wellbeing needs to be more visible in the Standard. The negative impact on children witnessing domestic violence (not experiencing it themselves) is particularly evident in the behaviour and social and emotional wellbeing of boys.

ID	Stakeholder	Statement number	Comments[1]
	Public Health England		Oral health First paragraph could insert Oral health is a sentinel marker of wider health and social care issues. Early Childhood caries has negative effects on speech, appearance and self-esteem, school performance and quality of life.
20	Public Health England		bulleted list: include oral health
21	Public Health England		*Rapid Review to Update Evidence for the Healthy Child Programme 0–5* is listed under policy context and 'Oral health promotion in the community' is referred to under 'Future Quality Standards'. Under 'Related NICE quality standards - published' NICE PH55 is not referenced. There are no references to CBOH/DBOH and LA statutory instruments (this is also at the back of the draft guidance on page 24 under the heading Development sources).
22	Public Health England		Suggested additional Domain: Helping people to recover from episodes of ill health or following injury (this is not in the document): 3.7i: Decaying teeth and ii: Tooth extractions in secondary care for children under 10
23	Public Health England		Measures Many of the measures used are out of date. Comments below: On page 2 it mentions: "Only around 50% of children aged between 2 and 2½ years in England are assessed as part of the Healthy Child Programme". Interim reporting has shown that the % of 2-2½ year reviews completed is 75% across England.
24	Public Health England		Include: Public Health Outcomes Framework indicator 2.02: Breastfeeding (initiation and prevalence), Public Health Outcomes Framework indicator 4.02: Tooth decay in children under 5 years. The under-18 conception rate (PHOF) could be included. As poor parental mental health is the most prevalent risk factor for poor child development outcomes, it would be helpful to include the maternal mental health indicator which is currently a placeholder in the PHOF
25	Public Health England		Public Health Outcomes Framework indicator 2.11: Diet should be taken out as it is an adult indicator. Child development indicator data not available until at least 17/18
26	Public Health England		Change substance misuse to drug and alcohol misuse
27	Public Health England		Please add: The Government's Alcohol Strategy 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf Drug Strategy 201 https://www.gov.uk/government/publications/drug-strategy-20100 - **please note that**

ID	Stakeholder	Statement number	Comments[1]
			this is being updated and is pending publication Life Chances Strategy – should be referenced due for publication July 2016 **[NB – awaiting confirmation of publication date]**
28	Public Health England		Alcohol-use disorders: prevention, NICE guidelines [PH24] June 2010 https://www.nice.org.uk/guidance/ph24 Smoking: stopping in pregnancy and after childbirth, NICE guidelines [PH26] June 201 https://www.nice.org.uk/guidance/ph26 Drug use disorders in adults, NICE quality standard [QS23] November 2012 https://www.nice.org.uk/guidance/qs23
29	Public Health England		There is no mention of smoking or tobacco in the document. Recommend aligning with NICE smoking cessation in maternity services (which includes guidance for smoking cessation for women with infants) http://pathways.nice.org.uk/pathways/smoking/support-from-general-nhs-services-to-help-people-stop-smoking#path=view%3A/pathways/smoking/smoking-cessation-in-maternity-services.xml&content=view-index
30	Public Health England		Suggested additional information on contraception and family spacing Suggested content from Public Health England's Missed Opportunities Project (due for publication June/July): There is an argument for contraception to be provided as part of maternity, abortion and early pregnancy loss care, i.e. before women leave hospital/ specialist provider unit to ensure contraception happens and is at a time when women are engaged/ motivated. Recent research shows an increased risk of adverse maternal and neonatal outcomes with short interval pregnancies (Smith et al 2003; WHO 2006; Bigelow and Bryant 2015). The social impact may also be underestimated: a number of studies show that deprivation is associated with the interval between children as well as family size (Smith 2003). There is significant evidence that family spacing and preventing unplanned pregnancy can improve the physical and mental health of women and children, avoiding harmful effects of repeated short interval pregnancies (McCance K and Cameron S, 2014). Evidence suggests an unmet need for contraception soon after the birth of a child. The UK National Survey of Sexual Health and Lifestyles (NATSAL) consistently reports high levels of unplanned pregnancies across the age range including a large proportion within two years of giving birth; reports from

ID	Stakeholder	Statement number	Comments[1]
			abortion clinics report high numbers of women seeking abortion in the period within one to two years after the birth of a child. The Millennium Cohort Study reported up to 58% of pregnancies are unplanned, and the 2014 Maternity Survey found that one in four were unplanned with a further 17% of mothers ambivalent or with mixed feelings about the pregnancy. A recent study from an antenatal setting in Scotland reported that one third of conceptions may have been unplanned and a further study reported almost one in 13 women presenting for abortion or giving birth have conceived within a year of giving birth (Heller et al., 2015). The trend towards earlier sexual activity and later childbearing means that most women in the UK require timely, accurate sexual health education and effective reversible contraception for up to three decades including following the birth of a child (Natsal 2013). Unplanned or mistimed pregnancy can be associated with adverse outcomes (DH 2013; Carson et al 2011; Gipson 2008). A number of studies report poor mental health, including a deleterious effect on mother-child relationships (RCM 2012) as a direct sequelae. Women can exert choice in their inter-pregnancy interval but WHO recommend a birth to next pregnancy interval of two years (WHO 2006); recent research shows an increased risk of adverse maternal and neonatal outcomes with short interval pregnancies. The social impact may also be underestimated: a number of studies show that deprivation is associated with the interval between children as well as family size. There is significant evidence that family spacing and preventing unplanned pregnancy can improve the physical and mental health of women and children, avoiding harmful effects of repeated short interval pregnancies. Yet, there is variation in provision of effective strategies for prevention across the country, reinforcing inequalities in sexual and reproductive health. Discussions about contraception are raised by midwives as part of the routine care for women in the antenatal and postnatal period. Yet studies continue to show that a third to half of women resume sex at six weeks after the birth of a child (Heller 2015), with many women misunderstanding the nature of fertility following pregnancy and childbirth and using no method or a method of low effectiveness. Lactational amenorrhoea may be relied on providing the women is breast feeding exclusively and frequently and the baby is under six months of age (FSRH 2009) though the Infant Feeding Survey 2010 showed that just under one in four women continue to exclusively breast feed beyond six weeks. Intervals of less than 1 year between birth and the next pregnancy place the pregnancy at higher risk for

ID	Stakeholder	Statement number	Comments[1]
			preterm birth and even neonatal death. Research we conducted in Lothian showed that 1 in 8 mums who present for an abortion, have given birth in the preceding year, and that 1 in 8 mums giving birth have conceived the pregnancy within 1 year of another birth. **[DN – this information can be incorporated following the publication of PHE's Missed Opportunities Project (MOPP), publication of which is due in June/July but awaiting final confirmation)]** To be taken into account is NICE guidance to promote the most effective long acting reversible contraception, all of which can be given at birth to most women.
	QUESTION 1 - general		
31	UK Society for Behavioural Medicine		It seems likely that those experiencing multiple risk factors and being at risk of poor outcomes may be 'hard to reach' yet there seems to be little consideration in the draft guidance as to how the guidance and recommendations will be implemented to ensure that these populations are reached. For example, while it is reasonable to provide an opportunity to discuss risks to health and wellbeing at all 5 key visits if at risks families are repeatedly missing these visits then the opportunities for intervention, and also assessment, are limited. The quality standard should consider how this problem will be addressed.
32	Royal College of GPs		Other standards that could be considered that are used in Scotland http://www.forhighlandschildren.org/4-icspublication/index_92_3087541717.pdf 1. Every child has a named person who is responsible for making sure that while the family is in touch with their service, the child has the right help in place to support his/her development and well-being. The Named Person for a child aged 0-5 years will usually be the child's own Family Health Visitor; 2. Every pre-school education centre has a named Public Health Nurse with whom they can liaise – their 'Link Health Visitor'. (MH)
	QUESTION 2 - general		
33	College of Occupational Therapists		Delivery of universal services by occupational therapists is increasing and those services would be routinely collecting data regarding the service offer at that level. The collation of outcomes is more challenging as these services are often delivered at a whole population level, however work is in progress in many areas to audit awareness and knowledge amongst parents and the wider workforce of the need for children to participate and development skills in daily occupations in preparation for school.
34	Institute of health visiting	Q2	Systems and structures can be put in place but presently much effort is expended collecting information separately by NHS and Local Authority service providers that could be better aligned around a shared local outcomes framework. Additionally current data systems to collect data such as KPIs tend to be number of

ID	Stakeholder	Statement number	Comments[1]
			contacts and may not include content or description of interventions. Some information may not be available from local service specifications and policies – local audits could reveal what is included in key contacts and what 'tailored support' is offered but there are resource implications. There is no national system for collecting and comparing this data at this time.
	QUESTION 4 - general		
35	College of Occupational Therapists		The achievement of the quality statements relies on both the universal workforce and the training they receive on an ongoing basis to support their assessment and interventions across the breadth of health and wellbeing. The investment in the Health Visitor workforce supports this but a significant amount of training and support is required to meet the quality standards from the specialist workforce including CAMHS staff, occupational therapists and speech and language therapists. The emphasis on prevention and early intervention can produce a cost saving in the longer term but in terms of the early years workforce services are often identifying unmet need for targeted support A potential cost saving would be the production of e-learning materials to support the quality standards and areas of omission as outlined in question 1, to be rolled out across services. This would not be sufficient in isolation but could cover some of the core elements of the training required and could be revisited more readily.
36	College of Occupational Therapists		Dunn W, Cox J, Foster L, Mische-Lawson L, Tanquary J (2012) Impact of a contextual intervention on child participation and parent competence among children with autism spectrum disorders: A pretest–posttest repeated-measures design. *American Journal of Occupational Therapy, 66(5),* 520–528. Available at: http://dx.doi.org/10.5014/ajot.2012.004119 Farrar E, Goldfield S, Moore T (2007) *School readiness*. Perth, Australia: Australian Research Alliance for Children and Youth. Graham F, Rodger S, Ziviani J (2013) Effectiveness of occupational performance coaching in improving children's and mothers' performance and mothers' self-competence. *American Journal of Occupational Therapy, 67(1),*10-18. Available at: http://dx.doi.org/10.5014/ajot.2013.004648 Sheppard L, Osmond J, Stagnitti K (2013) The Effectiveness of a multidisciplinary intervention to improve school readiness in children with developmental concerns: children's skill development and parent perspective. *Journal of Occupational Therapy, Schools, & Early Intervention, 6(2),* 94-107, DOI: 10.1080/19411243.2013.811346

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37	Institute of health visiting		This would be achievable with a fully resourced HCP workforce to deliver in partnership with early years colleagues and specialist services such as speech and language therapy. However, if health visiting resources are reduced following the £320m cut to the public health budget as is happening in many areas, health visitors may be forced to provide a 'minimum' core service and these standards would not be achievable. However there is anecdotal evidence of actual or planned reductions in health visiting and related workforce reflecting local commissioning decisions and therefore it is difficult to have confidence in the adequacy of resources to deliver
	STATEMENT 1		
38	Royal College of Paediatrics and Child Health	1	Would it be beneficial to develop a screening tool, like a modified CAF form to use at these meetings allowing the HV to go through key areas or to use as a prompt? The CAF form is quite heavy and should be used if concerns are identified.
39	Royal College of Paediatrics and Child Health	1	A key concern is that locally people often struggle to get social service support as they are extremely stretched and we worry that many of the families identified will not reach the threshold for SS involvement. There will therefore have to be processes or services in place (charities/local support services) available that do not require SS referral. We are not sure if these services are currently available and what their capacity is locally.
40	Royal College of Paediatrics and Child Health	1	Interpreters will need to be readily available to attend these meetings in order to have a chance of reaching some vulnerable families who do not speak English well.
41	Royal College of Psychiatrists (Child and Adolescent Faculty)	1	In statement 1, this could be supported by recommended instruments e.g., the ADBB at the 10-14 day mandated visit, the EPDS and a paternal depression questionnaire at the 6-8 week visit and the 9-12 months review, at least a professional judgment of attachment at the 9-12 months review, a parental SDQ and SCQ or equivalent at the 2-2.5 year review, and a formal EYFS review completed for all children where concerns have been previously identified by five years. "According to local frameworks" based on the CAF poses problems, as the CAF as a whole is almost entirely discretionary beyond its basic framework. Parental mental health should not be neglected, hence the suggestions for EPDS etc. Also, there is increasing evidence for the ability to identify children at risk of autism as early as 12 months, and given the public health issues regarding increasing prevalence of autistic disorders, serious consideration should be given to including some assessment at that point, as early parent-mediated intervention does have some impact.

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42	HENRY (Health, Exercise, Nutrition for the Really Young)	1	In the light of research referenced above, excess weight gain is also a risk factor for emotional and social health. Practitioners need to understand the links between parent and child social and emotional wellbeing, parenting and a healthy lifestyle, and be able to discuss these holistically with parents, rather than present them in isolation. The interplay between emotional and physical health is documented in Rudolf M. (2010) *Tackling Obesity through the Healthy Child Programme: A Framework for Action*. Available on the PHE National Obesity Observatory website, http://www.noo.org.uk/Mary_Rudolf last accessed April 2016
43	Royal College of GPs	1	The measure states a visit which implies the child's home, but in the explanatory text it states appointment which could imply attendance at a centre. (JA)
44	Royal College of GPs	1	The RCGP feels that this quality standard may be difficult to implement. Regarding NICE guideline PH40, the RCGP finds that it is a sensible document about the importance of identifying families in need; however it provides no evidence to support the kind of screening programme that the Quality Standard is effectively trying to introduce. The standard recommends offering a discussion about needs at each of the five visits. This may have a number of unintended effects: 1. It is intended to use as a measure of the practice so it is likely to become an empty, box-ticking exercise. 2. By insisting that HVs offer this to all families at all visits, it may reduce the professionals' wish to identify and focus on those families most in need. By doing so this will tend to deprofessionalise health visitors. The RCGP feels that by introducing some screening instrument, in order to tick a box and meet a score target, will not encourage any meaningful identification of social and emotional needs. For instance, in a climate where mothers feared for social services taking their children into care, the mothers were answering the questions not honestly, but with a view to ensuring that the score reflected their own felt needs. (DJ)
45	Public Health England	1	Out of date: PHE are publishing health visiting delivery metrics for 15/16 and 16/17 (www.chimat.org.uk/transfer), following which it will become the responsibility of HSCIC
46	Public Health England	1	'The universal health reviews – 5 key visits': replace with *Best start in life and beyond: Improving public health outcomes for children, young people and families: Guidance to support the commissioning of the Healthy Child Programme 0-19:* *Health Visiting and School Nursing services*
47	Public Health England	1	Health visiting The document talks about "5 key visits" all the way through and describes what they are near the end (p10/11), which is confusing. Similar for the "Definition of terms" on p20 – it would have been helpful to

ID	Stakeholder	Statement number	Comments[1]
			have this nearer the start of the section. Where the document refers to parents "attending" the key visits, the more accurate terminology is "receiving". The document mentions a 9-12 month developmental review; although there is local variation as to when it is provided, but for consistency it would be clearer if only the 12 month review is referenced. The document should emphasise that all of the reviews should be face-to-face.
48	Public Health England	1	This includes factors that could affect the carers' capacity to provide a loving and nurturing environment. For example, problems with mental health, substance or alcohol misuse, family relationships or lack of support networks. Signs of problems could include the parent or carer being indifferent, insensitive or harsh towards the child. The child could be withdrawn or unresponsive, showing signs of behavioural problems, delayed speech or poor language and communication skills. *Add: not all parents with drug and alcohol problems cause harm to their children, but substance misuse can reduce their ability to provide practical and emotional care. It can have serious consequences for children, including neglect, educational problems, emotional difficulties, abuse, and the possibility of becoming drug and alcohol misusers themselves.*
49	Cheshire West and Chester Council	1	Agreed that embedding discussions around support /risk factors through the 5 key visits is a valuable way to identify strengths and difficulties and co-ordinate appropriate support.
50	Infant & Toddler Forum	1	We know that poor diet is strongly linked to the social determinants of health. This includes factors such as low income, social and material deprivation, poor educational opportunities, unemployment and adverse early childhood experiences [BMA Foof for thought report: July 2015]. Although the Healthy Child Programme 0-5 requires nutrition and a healthy diet to be discussed with parents at each of these 5 key visits, this is rarely achieved. This is because it is often dropped due to time constraints and the nutrition training of healthcare professionals and early years practitioners is very limited with most practitioners relying on their own views and opinions. The Healthy Child Programme states that parents should be advised on a healthy diet but does expand on what constitutes a healthy diet. This is a set number of servings from five food groups to ensure provision of adequate energy and nutrients for growth and both physical and mental health development.
51	Infant & Toddler Forum	1	Nutrition is intrinsically linked to children's social and emotional wellbeing through the provision of adequate nutrients and energy for growth and both physical and mental development. Therefore, the nutrition of under-fives needs higher prominence in both these sections.
52	Institute of health	1	As the first area is 'identifying risk' this should include an 'assessment' as well as a discussion. The health

ID	Stakeholder	Statement number	Comments[1]
	visiting		visitor is the lead for the HCP and will be undertaking the 5 key contacts, therefore this should be stated. Additionally the health visitor will not be just 'visiting' clients, therefore 'contact' is a better term. No all families may receive the 5 key contacts from the health visitor, therefore these should remain mandated to ensure equity and quality of service. Therefore this statement could be amended to: Parents and carers of children under 5 are offered an assessment and discussion during each of the 5 key health visitor mandated contacts about factors that may pose a risk to their child's social and emotional well being.
53	Cheshire West and Chester Council	1 – Q2	Yes there are local systems in place to record and share information e.g. E-Taf (Electronic Team Around Family - computer system which has potential to allow all interactions with all clients recorded in a single database)
54	Cheshire West and Chester Council	1 – Q3	Yes - G&RT (Gypsy Roma and Traveller) Pathway being developed in partnership with Health Visiting.
55	Institute of health visiting	1 - Q3	In respect of **quality statement 1**, Discussions should make use suitable approaches relevant to the five contacts by health visitors, e.g. the use of 'Promotional Guides'. An example of good practice is the adoption across Greater Manchester of the use of the Brazleton Newborn Behavioural Observation (NBO) at the New Birth visit to promote parental awareness and sensitivity to the capabilities of the newborn infant. Competencies to be considered are those commissioned by HEE and developed by the Institute of Health Visiting as national standards for CPD for health visitors to deliver the 6 high impact areas for public health in the early years.
56	Cheshire West and Chester Council	1 – Q4	Yes – statement is achievable and partnership approach maximises available resources and provides enhanced opportunities to deliver integrated support to secure improved outcomes.
	STATEMENT 2		
57	Association of Catholic Nurses England and Wales	2	Children with special educational needs are particularly at risk of not having their social and emotional wellbeing needs met due to differences or difficulties they may have in cognitive functioning and abilities around communicating with their carers. 1001 Critical Days highlights the need for intervention as early as possible to maximise the child's potential level of achievement. Referral to Early Years Inclusion Support services as soon as the child is identified as likely to have special educational needs can ensure appropriate supports are in place as early as possible to help prepare the child before the child reaches the age of eligibility for statutory nursery provision at 3 years .
58	Royal College of	2	Statement 2 should really follow from the problems derived from statement 1. Use of standardised

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	Psychiatrists (Child and Adolescent Faculty)		measures such as those suggested above would allow definition of the issues to address, rather than posing them as a separate question, in advance of knowing what application of statement 1 will show. It is unfortunate that some government recommended measures, such as the ASQ:SE have been shown to be lacking in validity, and so will need further support (e.g. the SCQ as above)
59	Royal College of GPs	2	The tailored support statement would be improved by being more specific, still allowing local initiatives for the measures. General practice has historically worked closely with health visiting and so the statement should specify this tailored support with the involvement of General Practice. (This then would be subject to local pathways and the configuration of specialist and universal local services). (JA)
60	Public Health England	2	Under bullet point Early Help: at the end of the sentence put something around training HV's to support and monitor oral health can lead to a better start in life and home visits where health and social care staff are able to give advice on the importance of oral health.
61	Cheshire West and Chester Council	2	Strongly agree with focus on securing shared approaches, holistic assessments, pathways to support multi-disciplinary working, integrated and joint commissioning around targeted and universal services.
62	Infant & Toddler Forum	2	The e-learning programme for the Healthy Child programme developed by the Royal College of Paediatrics and Child Health (RCPCH) gives the necessary detail of what constitutes an evidence-based, balanced and nutritious diet for preconception, pregnancy and under-fives. However, access to this e-learning programme is very limited for NHS and local authority practitioners. In particular it provides the evidence-based theory and advice on diet to alleviate the common nutritional problems encountered in under fives that can affect their health and consequently their social and emotional development. This includes the prevalent conditions of iron deficiency, obesity and low vitamin D levels: • Iron deficiency affects brain development and growth • Obesity commonly leads to bullying and lower educational attainment through low self esteem. It also restricts the development of physical activity skills that can result in poorer social and emotional development. • Low vitamin D levels reduce optimal immunity and probably increase poor mental health. Omega 3 fats are important in mental development for both mother and child. The RCPCH e-learning programme also highlights useful resources to recommend for parents including evidence-based portion sizes that can be useful in preventing and addressing childhood obesity in the under fives. Free, downloadable, evidence-based resources on nutrition and for pregnancy and under fives are also available from the Infant and Toddler Forum website: www.infantandtoddlerforum.org.

ID	Stakeholder	Statement number	Comments[1]
			The ITF recommends: 1. Nutrition to be addressed within assessment/contacts 2. Standardised, evidence-based nutrition advice/resources to be given 3. Specific training for HCPs on nutrition - more than is currently available 4. Access to tailored nutrition services for those at greatest risk e.g. obesity intervention programmes, nutrition
63	Infant & Toddler Forum	2	The integrated universal and targeted resources required by children with identified needs include healthcare practitioners and early years practitioners who have been suitably trained in nutrition. For the reasons discussed in the comment above, this is necessary to assess a family's diet and advise on changes for improvements. Training should be from a registered dietitian or a nutritionist registered with the Association for Nutrition rather than someone less qualified. These practitioners also need access to evidence-based resources on nutrition to use with families with whom they are working. The ITF recommends: 1. Nutrition to be addressed within assessment/contacts 2. Standardised, evidence-based nutrition advice/resources to be given 3. Specific training for HCPs on nutrition - more than is currently available 4. Access to tailored nutrition services for those at greatest risk e.g. obesity intervention programmes, nutrition
64	Institute of health visiting	2	This is clear though more explanation is needed re 'tailored support' and the resources needed to provide this.
65	Infant & Toddler Forum	2	Nutrition is intrinsically linked to children's social and emotional wellbeing through the provision of adequate nutrients and energy for growth and both physical and mental development. Therefore, the nutrition of under-fives needs higher prominence in both these sections.
66	Public Health England	2 – Q2	Are local systems and structures in place to collect the data for the proposed quality measures? Yes Data source: Local data collection. Data from National Drug Treatment Monitoring System can monitor referrals to specialist alcohol and drug treatment services. http://www.nta.nhs.uk/ndtms.aspx
67	Cheshire West and Chester Council	2 – Q2	Yes – E-Taf (see above)

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68	Cheshire West and Chester Council	2 – Q3	Yes – TAF/IES(Integrated Early Support) case study evidence available. Integrated Core Offer and Behaviour pathway.
69	Cheshire West and Chester Council	2 – Q4	Yes – feel that this standard is already being achieved locally through highly developed and effective integrated early support.
70	Royal College of Paediatrics and Child Health	2 – Q5	Potential risks and services needed. Mental health issues in the family – especially parental mental health problems during pregnancy and post-natal period - access to psychiatric services /psychological therapies /health visitor/social services. Domestic Violence – HV/SS/local hostels/links with supportive charities/police. Drug and alcohol misuse – link with drug and alcohol services/HV/SS/community paediatrics/charities. Developmental concerns or a known physical disability – community paediatrician/audiology/OT/physio/HV. Abusive environment including neglect – SS/community paediatrics/police. Childhood obesity – healthy eating community programmes, Mind, Exercise, Nutrition projects. Emotional and behavioural concerns in the child – in Tower Hamlets, Children's Centres are plentiful, and each have an educational psychologist who is able to see children for whom there are behavioural concerns. Visits can be at home or at children's centres and in our commenters' experience is working extremely well for families and is addressing early behavioural concerns.
71	Institute of health visiting	2 - Q5	Potential risks must include maternal mental health and relationship issues including domestic abuse. Support provided should range from HV led interventions; multi agency programmes with early years; through to specialist support services. In respect of **quality statement 2**, the Healthy Child Programme recommends a 6th contact at 3-4 months to more effectively identify risks to maternal mental health that also impact upon the infants social and emotional development (X-reference to NICE Guidance on perinatal mental health),
72	HENRY (Health, Exercise, Nutrition for the Really Young)	2 – Q5	Excess child weight gain should be included in risk factors and any tailored support should address this in addition to social and emotional wellbeing, using an evidence-based programme. Evaluation of the HENRY programme that addresses parenting, family lifestyle, diet and emotional well-being shows that this holistic approach leads to increased parenting efficacy and emotional well-being as well as a healthier family lifestyle and diet: Willis, T.A., George, J., Hunt, C., Roberts K.P.J., Evans, C.E.L., Brown, R.E., & Rudolf, M.C.J. (2014). *Combating child obesity: impact of HENRY on parenting and family lifestyle.* Pediatric Obesity, 9(5), 339-350 doi: 10.1111/j.2047-6310.2013.00183.x

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73	UK Society for Behavioural Medicine	2 – Q5	In relation to statement 2: there is a need to consider risks to health as well as social and emotional wellbeing. Anything which impacts upon the potential for the child to reach and the parent to support their child to achieve good health and wellbeing should be considered as risk factors. Further the support which is offered to families should be based on the best available evidence of intervention evaluations.
74	Cheshire West and Chester Council	2 – Q5	Risks: • Securing and sustaining parent engagement • Securing organisational buy-in; • Effective information and knowledge management Support: • Common vision • Shared strategic direction and commitment • Joint outcomes and accountability • Pooled budgets / joint commissioning • Information Sharing Protocols • Ongoing CPD / Workforce development • Clear rationale for service users
75	British Psychological Society	2 – Q5	Q5) What are the potential risks [to a child's social and emotional wellbeing] which should be acted upon and what support should be provided? The Society believes that there are two main areas of risk; • The parent child relationships and • The inter-parental relationship. The quality of the parent infant relationship (especially the relationship between babies and their primary caregivers) is foundational for later social-emotional but also cognitive and physical development, health and wellbeing (see 1001 Critical Days, Early Intervention Foundation and Adverse Childhood Experiences study (Anda and Felitti). The key aspects of this relationship are the parents' ability to sensitively read the babies cues and respond in a timely and appropriate way – i.e. to show sensitive responsiveness and an ability to read the baby's mind (reflective capacity/mentalisation). A lack of either of these things will

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			jeopardise the parent infant (and later the parent child) relationship and hence the child's developing social and emotional wellbeing. So parent-baby interaction is a vital characteristic to assess. In order to do this the parent needs to be observed interacting with the baby/child. There are a number of tools designed to help do this; - Parent-Infant Interaction Observation Scale. - (Svanberg, et al, 2013). - (Svanberg and Barlow, 2013). - Keys to Interactive Parenting Scale - (Comfort et al, 2006). On identifying difficulties/distress/disconnection in the parent-infant relationship these families should be referred for targeted and/or specialist help. See Early Intervention report "What works in enhancing social and emotional skills development" (2015). Work needs to focus on the parent infant relationship, and therefore probably involves working with parent(s) and infant together. The second risk to children's social and emotional development is the parental relationship – conflict between parents has a negative impact on children's emotional wellbeing and development even if each parent-child relationship is good enough. (See report by Early Intervention Foundation, 2016). At present there are not agreed measures for screening/assessing the parental relationship, and there is little research evidence for programmes which target inter-parental conflict in terms of the outcomes for children. However there is the systemic literature regarding the clinical and cost-effectiveness of working with couples more generally (Leff, J., et al, 2000). Comfort, M., Gordon, P., and Unger, D. (2006). *The Keys to Interactive Parenting Scale: a window into the many facets of parenting*. Zero to Three, **26(5)**, 37-44. Leff, J., Vearnals, S., Brewin, C. R., Wolff, G., Alexander, B., Asen, E., Dayson, D., Jones, E., Chisholm, D. and Everitt, B. (2000). *The London Depression Intervention Trial: Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs*. British Journal of Psychiatry, **177**, 95-100 Early Intervention report "*What works in enhancing social and emotional skills development*" (2015) Early Intervention Foundation "*What works to Improve Inter-Parental Relationships and Improve Outcomes for Children*" (2016) Svanberg, P.O., and Barlow, J. (2013). *The effectiveness of training in Parent-Infant Interaction Observation Scale for health visitors*. Journal of Health Visiting, **1(3)**, 162-166

ID	Stakeholder	Statement number	Comments[1]
			Svanberg, P.O., and Barlow, J. and Tigbe, W. (2013). *The Parent-Infant Interaction Observation Scale: reliability and validity of a screening tool*. Journal of Reproductive and Infant Psychology, **31(1)**.
	STATEMENT 3		
76	Association of Catholic Nurses England and Wales	3	The Book Trust charity provides Bookstart packs that are given all to babies by health visitors during the first year of life to encourage and help parents to develop early communication skills. There is opportunity for health visitors to assess the quality of parental interactions with the baby at the 6 week review and that early language skills are starting to develop through babbling (and short words around 12 months) at the 9-12 month review .The National Health Visiting Service Specification 2015/16 specifies the Ages and Stages Questionnaire must be used as the assessment tool for the 2- 2 ½ year review by the Health Visiting service. Observations should be made and questioning should occur by the professional during the contact for the 2- 2 ½ year review to ensure the child can perform developmentally at the same level as parents report on the pre-filled questionnaire.
77	Royal College of Psychiatrists (Child and Adolescent Faculty)	3	Standard 3 is useful, but, as discussed under standard 1, detection at 12 months may give a better window for autism.
78	Royal College of GPs	3	The statement applies universally but it should include a qualifier such as: if not already targeted for extra support. This recognises that some children require targeted intervention at a much earlier stage such as those with hearing problems, congenital problems such as oro-facial abnormalities, or those with developmental delay already diagnosed. (JA)
79	Royal College of GPs	3	If the assessment is left until two + years old, the waiting time and lack of capacity in Speech and Language services could mean that much needed support is delayed further, impacting on Early Years achievement. Presumably tailored support under statement 2 includes this. (JA)
80	Public Health England	3	The speech and language statement should more explicitly acknowledge the needs of parents with no/low literacy. It would also be helpful to include any evidence of effective use of new technologies to encourage, rather than obstruct, communication between parents and their children.
81	Institute of health visiting	3	It is important that children are offered an assessment but there also needs to be appropriate interventions and referral pathways if issues are identified. Therefore this statement could be amended to: Children are offered an assessment of their speech and language and language skills at their 2 – 2.5 yr integrated review and appropriate therapeutic interventions are available if issues are identified.
82	Cheshire West and Chester Council	3	Agreed - however we feel that the development of early communication and language skills should be

ID	Stakeholder	Statement number	Comments[1]
			promoted and supported from birth
83	Public Health England	3 – Q2	Include link to Department of Health guidance on the Ages and Stages Questionnaire (ASQ) and implementation of data collection and national reporting: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/467602/ASQ-3_acc.pdf
84	Cheshire West and Chester Council	3 – Q2	Unsure – work in progress to establish integrated review however unaware of any locally defined pathways at present.
85	Cheshire West and Chester Council	3 – Q3	Not around integrated review
86	Cheshire West and Chester Council	3 – Q4	Yes – through an integrated approach supported by nursery, early years practitioner and health. Cost saving – reduction in waiting times; improved access and uptake of appropriate support. Range of targeted and universal opportunities available through Children's Centres and delivered in partnership with the commissioned Speech and Language service to observe, assess and support early communication and language development E.g. Playing with Words, Explorers to Talkers.
87	Cheshire West and Chester Council	3 – Q6	Yes – • WELLComm (Speech and Language Therapy national tool) • C-CAT Cheshire version of "Every Child a Talker".
88	Royal College of Paediatrics and Child Health	3 – Q6	This question would be best directed to Speech and Language Therapists – do you have contacts to whom this question could be directed? An increasingly common presentation is Autism Spectrum Disorders and therefore adding a suggestion that an M-CHAT questionnaire is used if there is speech and language delay, especially in association with social interaction concerns/concerns about play/behaviour/ poor eye contact etc may be useful.
89	Institute of health visiting	3 - Q6	Is another tool necessary/ The ASQ, delivered by a trained member of the HV team should identify any issues with speech and language development. **In** respect of **quality statement 3,** Greater Manchester service providers and Children's Services have adopted WellComm, A Speech and Language Toolkit for Screening and Intervention in the Early Years
	ADDITIONAL AREAS		
90	NHS England		As a chair of a charity (Dandelion Time) dedicated to children's emotional wellbeing (a subject on which we perform badly as a nation) I felt disappointed on reading the standard that there was no mention of the

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			importance of play (particularly imaginative play) or of the importance of connection with the living world/nature for the healthy development of children. I would consider both of these vital and all our guidance should be aimed at encouraging these, alongside speech and language and the vital importance of attachment.
91	College of Occupational Therapists		The three quality standards go some way to reflect the key areas for quality improvement. However, a significant omission in addressing the health and wellbeing needs of the children in their early years is the **ability and opportunity to participate in daily occupations such as play, self-care tasks such as toileting and school readiness skills such as mark-making, turn-taking**. Moreover, the paper refers to school readiness but this is not sufficiently represented in the quality standards. There are skills and experiences required for school readiness that are not appropriately mentioned, particularly with respect to self-care (such as using cutlery, getting changed for sport, managing toileting needs) and school skills (such as pre-writing, scissor use etc.). These are daily occupations in schools which are commonly under developed at the point of entry into reception (Farrar et al 2007; Shepherd et al 2013). Occupational therapy services working in early years services focus on the participation in, and development of, school readiness skills in partnership with the wider workforce and with parents (e.g. Dunn et al 2012; Graham et al 2013). The links between educational attainment and deprivation are well recorded and for many children in areas of socioeconomic deprivation the opportunities to play, use cutlery, toilet themselves and experiment with the early learning activities are limited until they start school. At this point they are already behind their peers and developmental expectations. Occupational therapists are trained to implement the strategies that precede reception age skills which are vital if these children are to be provided with the best start in life. Projects in in many areas including Kent, Buckinghamshire and Hackney have contributed to the development of these skills by: • Auditing Early years settings to ensure that they offer opportunities to participate in daily occupations on a regular basis. • Training health visitors, child minders, nursery staff regarding the development of these skills and the importance of regular opportunities to participate. • Offering easily accessible resources and support to parents to increase their awareness of how to encourage their children to experience and participate in daily occupations ready for school. Further information in each of these areas is available upon request.

ID	Stakeholder	Statement number	Comments[1]
92	The Royal College of Midwives		The quality standard needs to include a statement about infant mental health which includes newborns to age three. As discussed by Balbernie (2013) • The first few months and years of life are a sensitive period when children learn about emotions and social interactions in their family • Recent research on the brain has found that, starting before birth, the brain is affected by environmental conditions, including the kind of nourishment, care, surroundings and stimulation a baby receives. • The period in our lives when we are most influenced by what happens to us is the first 3 years, beginning at conception • In the first 3 years of life, we are most dependent upon the environment; and the most important aspect of the environment is defined by relationships • Through significant relationships in this pre-verbal time: The unconscious world is structured, including our 'internal working model' of relationships • The basic neuronal networks in the developing brain are laid down on a 'use it or lose it' basis such that the architecture of the child's brain will reflect early experiences. Help, when necessary, can be most effectively offered Balbernie, Robin. "The importance of secure attachment for infant mental health." *Journal of Health Visiting* 1.4 (2013): 210-217. Midwives are the key healthcare professionals who provide hands on clinical care throughout the antenatal period. They provide care for the woman`s emotional and mental health but also start to support the mental health of the baby by preparing the woman to meet her baby at birth. Midwives can discuss the importance of getting to know the baby during antenatal care to help prepare her for attachment and a nurturing mother baby relationship.
	NO COMMENTS		
93	Department of Health		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
94	Royal College of Nursing		There are no further comments to make on this document on behalf of the Royal College of Nursing.

Registered stakeholders who submitted comments at consultation

- Association of Catholic Nurses England and Wales (ACNEW)
- British Psychological Society (BPS)
- Cheshire West and Chester Council (CWCC)
- College of Occupational Therapists (COT)
- Department of Health (DH)
- Health, Exercise, Nutrition for the Really Young (HENRY)
- Infant & Toddler Forum (ITF)
- Institute of Health Visiting (iHV)
- NHS England (NHSE)
- Public Health England (PHE)
- Royal College of GPs (RCGPs)
- Royal College of Midwives (RCM)
- Royal College of Nursing (RCN)
- Royal College of Paediatrics and Child Health (RCPCH)
- Royal College of Psychiatrists (Child and Adolescent Faculty) (RCP)
- UK Society for Behavioural Medicine (UKSBM)