

The Health & Wellbeing of Children in the Early Years

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The Health & Wellbeing of Children in the Early Years

This is the first of four reports setting out a practical plan for action by Government to reverse the serious decline in the health and wellbeing of our children and young people



“The Early Years is our starting point. Sensible interventions at a young age stand a far better chance of improving lives than trying to clean up problems in later years.”

BARONESS FRANCES D'SOUZA
Honorary President



'THE EARLY YEARS'

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PREFACE

Baroness (Frances) D'Souza, Honorary President, The Children's Alliance

I am delighted to welcome this template for action to improve the health and wellbeing of children in the Early Years.

This is the first of four reports which, when taken together, will set out a practical plan for action by Government to halt and reverse the serious decline in the health and wellbeing of our children and young people. Future reports will focus on Physical Health, Mental Health and Family & Community.

It seems that every day, more bad news is revealed. Physical activity levels were dropping alarmingly even before the pandemic, mental health problems have overwhelmed the services available and the connection between poverty and health has been clearly established.

The Early Years is our starting point. Sensible interventions at a young age stand a far better chance of improving lives than trying to clean up problems in later years. The cost of obesity alone today is put at £5.1 billion. If this growing trend is not reversed, we run the risk that the next generation of UK adults will be the least healthy in living memory. I urge you all to join us in campaigning for a Cabinet Minister to take responsibility for the health and wellbeing of children and young people. The issues are so deep and widespread that only a dedicated voice at the top table will have the authority needed to push through a co-ordinated programme to address these issues.

While we focus on fixing the many, urgent problems, we should not forget that a lot of children do grow up fit and healthy. They can therefore enjoy their childhood and go on to make a positive contribution to society.

We want this for all our children.

I would like to thank the many people who have made this report possible and to urge everybody who reads it to join us in our cross-sector campaign on behalf of children and young people.

INTRODUCTION

Giving children the best start in life is by far the most effective way to address health inequalities in the long term.

The wisest investment we can make to achieve the goal of a healthier population is during the first 1001 critical days of a child's life. Good nutrition and safe environments supported by nurturing early relationships are the essential components of children's cognitive, emotional and physical development. The importance of this age-range is acknowledged by the World Health Organisation's Global Strategy for Women's, Children's and Adolescents' Health, the UNICEF Baby Friendly Initiative and in England, both the NHS Long Term Plan and Public Health England's 2016 guidance on 'Giving every child the best start in life'.

Covid-19 is having a continuing impact on babies born before and during the pandemic and children in the early years. The impact has been unequal for children, with a disproportionate number of BAME families, those living with poverty and children with SEND facing the greatest challenges.

Parents and carers had less face-to-face interaction with health professionals and early years settings and studies reported families found it harder to stay active and access healthy food choices. In the UK, 14% of families with children experienced food insecurity during the first six months of the pandemic as opposed to 11.5% beforehand. There are now widespread and burgeoning concerns that Covid-19 has exacerbated nutritional problems linked to food insecurity including obesity, under-nourishment, nutrient deficiencies and mental health problems such as anxiety, low self-worth, and depression. Children have been subjected to violence and abuse at home as a corollary of lockdown whether as direct recipients or helpless observers. We are now reeling in the aftermath of such challenges as children's emotional well-being and education faltered, instead of thriving. Children need to be put at the heart of any recovery plans to ensure Covid-19 is not the legacy of their future outcomes.

It is probable that the true impact of the pandemic may not become clear for many years. Schools are already reporting an increasing number of their pupils requiring extra support with language and communication and personal social and emotional development.

Early years settings were the one constant in the lives of young children providing a stable and safe space during Covid-19. They continue to play a central role in supporting parents, carers and young children in establishing lifelong healthy eating habits. Good quality early education has a positive impact on young children's development and safe, excellent childcare enables parents and carers to work, while their children have the opportunity to interact with other children and be enriched by new challenges and experiences within a safe space. Nursery settings support children's care and development from birth to five years and are a vital source of information, guidance and support for parents, carers and families. Early years providers continued to provide this support throughout the pandemic yet Covid-19 has impacted greatly on early years providers with over 2000 settings closing between January and May 2021. Staff from early years settings are at the

forefront of providing support for our youngest children yet it is a resource that remains underfunded. There is a clear need to ensure training requirements for the early years' workforce supports them to achieve the requirements set out in the Early Years Foundation Stage Framework.

Children, families and the early years' work force need to be at the heart of a national strategy to ensure children can enter adulthood with improved health and wellbeing outcomes. The recommendations that form this report highlight that we are already falling short of meeting children's minimum requirements for nutrition, immunisation, education and emotional support.

Chair: Helen Clark

Co-Chair: Edwina Revel

Helen Clark is a Policy Consultant specialising in issues concerning the health and wellbeing of children and young people.

Edwina Revel, a Registered Nutritionist, supports early years settings to put nutrition at the heart of their practice through her work with the award-winning Early Start Nutrition team.

SUMMARY OF RECOMMENDATIONS

1. NUTRITION:

- 1.1 Training and support on nutrition (to include hydration) to be included within the curricula for the Early Years workforce
- 1.2 Mandatory food and drink standards for EY settings to be recognised in the Ofsted Common Inspection Framework
- 1.3 National strategy to improve preconception, pregnancy and postnatal diets and the feeding of infants and young children
- 1.4 Improved data collection and monitoring of the quality of young children's diets focusing on the consumption of ultra-processed foods. The UK to establish future research priority here with necessary funding
- 1.5 Strategy to address food inequality to include review and extension of the Healthy Start scheme
- 1.6 More innovative and engaging communication strategies to promote healthier eating and inspire new and prospective parents.

2. ORAL HEALTH:

- 2.1 National strategy to prioritise early identification of children at high risk of caries, together with population-based preventive public health measures including reduction in rates of smoking during pregnancy and promotion of infant feeding guidelines
- 2.2 Oral care to be included in core training for EY professionals
- 2.3 Dental care and oral health to be included in all prenatal, perinatal and postnatal programmes delivered both online and in person; available at all advice points to include health centres, children's centres and family hubs
- 2.4 Free child 'dental pack' available at birth (or first meeting with the health visitor)
- 2.5 Tooth brushing to be included within the curriculum for all nursery/EY settings.

3. SPEECH AND LANGUAGE:

- 3.1 All babies to be screened for hearing loss no later than one month of age; where a baby does not pass hearing screening, a diagnostic test timed as for immediate response to be carried out no later than 3 months of age
- 3.2 A national awareness programme to promote the importance of activity, interaction and conversation to families of children from birth to age 5 together with funded 'stay and play' physical activities for parents and children at family hubs/children's centres
- 3.3 A reform of the '2-year check' criteria with clear assessment in speech and language so that children needing support at an early age can be identified while practitioners and specialists are afforded a reasonable time-span to prepare the child for school
- 3.4 Training in how to support speech and language development to be embedded across all early years and primary education ITT routes

- 3.5 Improved availability of specialist support for children with speech and language delays/difficulties through the expansion of speech and language services and EAL support; targeted funding to areas of greatest need and promotion of degree level courses in speech and language therapy and teaching English to speakers of another language (TESOL)
- 3.6 Investment in policies designed to combat child poverty including increasing the Primary Premium Grant (PPG) funding.

4. MENTAL AND EMOTIONAL HEALTH AND WELLBEING:

- 4.1 Effective and targeted training within the early years sector; with a mandatory Level 7 qualification attainment for all practitioners
- 4.2 All early years' practitioners required to undertake CPD in child development to include the latest neuroscience information in order to assist in promoting children's mental health and wellbeing
- 4.3 Ensure a positive mental health culture across the sector:
<https://www.time-to-change.org.uk>
a mental health and wellbeing policy to be a mandatory requirement in each setting and a mental health worker (play therapist/peer worker/mental health 'first aider') required in each setting to identify and implement a strong wellbeing and resilience culture and to assist individual children
- 4.4 Increased access to support for parents/carers from outside services (eg bereavement, estranged parents, anxiety, adopted/fostered children)
- 4.5 Offering parents access to a range of simple and effective support aids for helping their children at home such as TRE UK (c/o Caroline Purvey, evaluated by Canterbury Christ Church University, April 2021)
- 4.6 National recommended guidelines; universal to the children's activity sector to ensure a consistent quality of provision to children and a quality of expectation for parents, schools, nurseries and local authorities. This to be combined with an awareness campaign directed at all stakeholders together with an accessible national database of providers who are compliant.

5. ACCESS TO SUPPORT FOR CHILDREN/FAMILIES WITH DISABILITIES AND SPECIAL EDUCATIONAL NEEDS:

- 5.1 Introduction of national standardised Early Years SEND Support Packages detailing exactly what all parents and children are entitled to; thus ending the support 'postcode lottery'
- 5.2 Guaranteed long-term investment and spending as a proportion of GDP on disabled people, bringing England in line with the best performing OECD member nations:
<https://data.oecd.org/socialexp/social-spending.htm>
Immediate publication of the delayed SEND report
- 5.3 Dedicated training for early years practitioners to support inclusive working and to help children with SEND recover from gaps in their learning or support; in particular focusing on speech and language and physical development
- 5.4 Investment in reducing the backlog of health assessments for children in the early

years as of urgency with sufficient funding for early years settings to provide the right support at the right time for SEND children so that they can access settings as soon as possible for recovery activities

- 5.5 Increased focus on family support to identify needs as early as possible and ensure that families have the information and assistance that they need to recover from their experiences of isolation and stress
- 5.6 Strategic long-term planning for the early years SEND child who must be supported to recover through targeted strategies to improve key areas of learning.

6. ACCESS TO SUPPORT FOR CHILDREN FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES:

- 6.1 The Government to revise and update the information available to local authorities, schools and early years settings concerning education provision and entitlement of children from refugee and migrant families; providing additional support for such families to navigate the admissions process and offering a free school meal to all such children regardless of the status of their family's application to remain
- 6.2 National and local governments and associated bodies to implement innovative solutions and disseminate existing best practice to address the consequences of periods of time in initial temporary accommodation for children in asylum-seeking families, as well as participation in the National Transfer Scheme
- 6.3 Better support and sufficient places to be created for children with Special Educational Needs and provision of a wider range of support and resources for pupils for whom English is an additional language
- 6.4 All EY settings to be required to have an Equality Policy to include building relationships with refugee parents; the presence of interpreters and the employment (where at all possible) of at least one assistant who speaks the language of the refugees
- 6.5 EY settings to prioritise the use of play as a core activity; producing a play strategy
- 6.6 Teachers and childcare professionals in EY settings to be trained in Trauma Informed Practice (TIP) to enable them to use this to mitigate the effects of ACEs. EY settings should be encouraged to employ a play therapist who (in the interests of child protection) is registered through an independent government-approved agency such as the Professional Authority's Accredited Register Programme or the Health and Care Professions Council.

7. MATTERS RELATING TO IMMUNISATION:

- 7.1 Early years settings such as family hubs and children's centres to receive accreditation and recommendation by national and local government as immunisation centres
- 7.2 National child immunisation campaign to be organised, focusing on 'trust', 'local' and 'accessible' and the role of Vaccine Minister to include setting goals and strategies for increasing take-up for childhood immunisations as well as Covid-specific initiatives

- 7.3 Early years settings to be subject to NHS audit for immunisation suitability and GP settings required to audit their own immunisation offer for accessibility and take-up potential cross-population
- 7.4 National compendium of 'good practice' to be used to issue immunisation guidance to all health and community centres offering an immunisation service so that they can produce their own 'take-up' campaign materials and modernise their practice in accordance with the needs and character of their local communities.

8. EARLY YEARS SUPPORT AND FUNDING:

- 8.1 Government to re-evaluate existing provision of Sure Start/Children's Centres and new provision such as Family Hubs guaranteeing that 1) services provide for the needs of all children 2) services maximise the engagement of all parents and carers and 3) decline in number and coverage of these services is reversed, especially in areas of disadvantage
- 8.2 Raise UK expenditure on early education and care for children aged 0-2 years in line with the highest spending of the 16 OECD countries for which measures are available
- 8.3 Government to re-affirm the 2004 recognition that 'a first-class workforce is fundamental' to excellent early years provision and release its comprehensive strategy to raise the entry qualification level, providing a training fund and ensure access to ongoing professional development in all settings with published remuneration scales to benefit a professional workforce
- 8.4 Review SEND funding processes, ensuring that application processes are simpler; hours taken to fill in forms are funded; funding is available for the full 30 hours and available to the under 2 SEND age group
- 8.5 Provide funding to enable settings to release staff for training in SEND and inclusion strategies
- 8.6 Ring fence high needs block funding to ensure that budget is available for children with SEND in the early years and investment is made in the right kind of support regardless of whether the child is nearing school age or not.

THE CHILDREN'S ALLIANCE

(1) 'THE EARLY YEARS'

CHAPTER 1: NUTRITION

'The destiny of nations depends on the way they nourish themselves', (Jean-Anthelme Brillat-Savarin, 'The Physiology of Taste', 1825).

'For every child and young person everywhere, food is life – a fundamental right and a foundation of healthy nutrition and sound physical and mental development', (Henrietta H Fore, UNICEF Executive Director, 2019).

The Covid-19 pandemic uncovered a state of dietary mayhem in the UK and the Food Foundation has highlighted a unique obesity and food insecurity 'double whammy', making it the worst for overall diets across Europe ('The Broken Plate Report', 7 July 2021, London). However, despite the publication of The National Food Strategy ('The Plan. An Independent Review for Government', 2021):

www.nationalfoodstrategy.org

the overwhelming propensity for policymakers is still to concentrate predominantly upon the adult population; a cohort whose health risks have been shaped already, although:

'Science suggests that a more effective approach to health promotion would invest more resources in the reduction of significant adversity during the prenatal and early childhood periods, in contrast to the current disproportionate emphasis on campaigns to encourage more exercise and better eating habits in middle-aged adults', (page 31-72, Centre on the Developing Child', Harvard University, July 2010).

By contrast, a life-course approach embraces the opportunity to minimise risk indicators and enhances protective factors via a 'step' strategy; starting from the preconception, pregnancy and perinatal periods through early childhood and thence to adolescence and beyond.

Opportunities Across the Life Course

A growing body of evidence suggests that the children of mothers who consume a poor-quality diet before and during pregnancy are likely to replicate the pattern by consuming inferior quality diets themselves.

A nutritionally nourishing diet during pregnancy can help to lay the foundation for the child's future health by supporting a baby to be born at a healthy birth weight, with adequate nutrition stores. It is now acknowledged that a mother's influence on her baby's tastes and food pre-dates birth. Flavours from her own diet can permeate the amniotic fluid swallowed by the foetus from around 12 weeks' gestation; impacting the child's palate later on (Mennella JA et al, 2002, 'Prenatal and postnatal flavour learning by human infants', Pediatrics; 107(6):E88):

www.ncbi.nlm.nih.gov/pmc/articles/PMC1351272/

Children who 'learn' a varied and healthy diet via experience and example during infancy are more likely to continue it into adulthood; also true of unhealthy behaviours (Mennella JA, 2006, 'Development of food preferences: Lessons learned from longitudinal and experimental studies', *Food Qual Prefer.* 17 (7-8):635-637 and Public Health England, 2017, 'Influencing healthy eating habits through early years settings'):

<https://publichealthmatters.blog.gov.uk/2017/11/28/influencing-healthy-eating-habits-through-early-years-settings/>

Similarly, the canard that pregnancy entails 'eating for two' represents a disservice to both mother and baby.

Around 1 in 5 women (rising slightly with subsequent pregnancies) are obese on first becoming pregnant; and this is particularly marked in the case of younger women (Public Health England, 2019, 'Health of women before and during pregnancy: health behaviours, risk factors and inequalities'):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/844210/Health_of_women_before_and_during_pregnancy_2019.pdf

Maternal obesity-triggered complications for women and babies can include gestational diabetes, pre-eclampsia, stillbirth and congenital abnormalities.

Later-life illnesses for a mother consequent upon her obese pregnancy include heart disease and type-2 diabetes. The World Health Organisation Report of the Commission on Ending Childhood Obesity (Geneva 2016):

<https://www.who.int/end-childhood-obesity/commission-ending-childhood-obesity-draft-final-report-en.pdf>

concludes that reducing childhood obesity rates requires the identification of critical life-course periods before conception and during a child's first 1,000 days when intervention is most efficacious.

Other adverse influences in the incidence of childhood obesity include smoking in pregnancy (Robinson et al, 'Modifiable early-life risk factors for childhood adiposity and overweight: an analysis of their combined impact and potential for prevention', *AM J Clin Nutr.* 2015 Feb;101(2):368-75), poor quality maternal antenatal diet (Martin et al, 'Maternal Dietary Patterns During Pregnancy are Associated with Child Growth in the First 3 Years of Life', *J Nutr.* 2016; 146:2281-8), low maternal vitamin D status (Crozier et al, SWS Study Group, 'Maternal vitamin D status in pregnancy is associated with adiposity in offspring: findings from the Southampton Women's Survey', *AM J Clin Nutr.* 2012 Jul; 96(1):57-63) and short duration of breastfeeding (Rito et al, 'Association between Characteristics at Birth Breastfeeding and Obesity in 22 Countries: the WHO European Childhood Obesity Surveillance Initiative' – COSI 2015/2017. *Obes Facts.* 2019;12:226-43).

Various risk factor studies show large differences in child obesity.

In one study, children with 4 or more risk factors incurred a 4-fold overweight or obese risk compared with those who had none (Robinson et al, 'Modifiable early-life risk factors for childhood adiposity and overweight: an analysis of their combined impact and potential for prevention', *AM J Clin Nutr.* 2015 Feb; 101(2):368-75) and there is growing

consensus that encouraging healthy dietary practice in prospective parents prior to conception should have a key role in public health strategies to avert childhood obesity and related chronic diseases later in life (Public Health England, 2021):

<https://www.gov.uk/government/publications/preconception-care-making-the-case>

Professional Help

Pregnancy, new parenthood and the attendant risk of isolation present an ideal opportunity for health visitors and maternity staff to offer support for women to eat well and be active during pregnancy, while furthering understanding of why some women are becoming more affected by obesity between pregnancies. There are strong grounds for developing information and advice to women pre-pregnancy about the benefits of maintaining a healthy weight during their childbearing years (National Institute for Health and Care Excellence, 2014, 'Maternal and Child Nutrition'):

<https://www.nice.org.uk/guidance/PH11/chapter/4-Recommendations#obesity>

The professional curricula for healthcare professionals should equip them with the skills, confidence and knowledge to support nutrition and healthy weight pre-pregnancy as well as during pregnancy and in the postnatal period.

Infant Feeding

A report by First Steps Nutrition Trust identifies key actions required to protect children from overweight and obesity in the first 1,000 days of life; with a number of recommendations including the establishment of a national strategy to improve mothers' diets and infant and young children feeding practices; investing in universal breastfeeding support and protecting and expanding universal health visiting services (First Steps Nutrition, 2021, 'Enabling children to be a healthy weight: What we need to do better in the first 1,000 days'):

<https://static1.squarespace.com/static/59f75004f09ca48694070f3b/t/60ae5c369213347627bb9075/1622039612853/Obesity+reportMay2021+for+web.pdf>

Broadly-based evidence cites the benefit of breastfeeding in safeguarding children from future risk of overweight and obesity (Rito et al, as above) and the mother's post-pregnancy weight outcomes (Bobrow K, et al, 2009, 'The long term effects of childbearing and breastfeeding on body mass index in middle-aged women', results from the Million Women Study *Journal of Epidemiology & Community Health*. 63:56). Being overweight pre-pregnancy can impact adversely on breastfeeding with overweight or obese women more likely to stop in the first week (Campbell T, Shackleton N, 2018, 'Pre-pregnancy body mass index and breastfeeding initiation, early cessation and longevity': Evidence from the first wave of the UK Millennium Cohort Study, *J Epidemiol Community Health*, 2018 Dec; 72(12):1124-1131).

Food Access Outside the Home

Increasing numbers of children are accessing early years childcare and education provision and in spring 2019, an estimated 72,000 providers offered 1.7 million Ofsted-

registered childcare places in England delivered by an estimated 363,400 staff (Department for Education, 2019, 'Childcare and early years providers survey'): <https://www.gov.uk/government/statistics/childcare-and-early-years-providers-survey-2019>

The Early Years workforce is therefore crucially important in promoting healthy nutrition and helping to establish healthy eating habits to steer children into their school years and beyond. In 2019, the Mayor of London announced 'Ten Ambitions' for London to support every child to have a healthy weight (London's Child Obesity Task Force, 'Every Child a Healthy Weight. Ten ambitions for London'): https://www.london.gov.uk/sites/default/files/every_child_a_healthy_weight.pdf

One stated ambition is to skill EY professionals in understanding healthy eating principles for young children thereby to better assist the families who increasingly request guidance. The Early Start Nutrition team currently provide evidence-based nutrition training for early years settings to ensure consistent content and message delivery (Early Start Nutrition): <https://www.earlystartgroup.com/nutrition/>

However, nutrition training is not a core area of learning for Early Years professionals.

The Early Years Foundation Stage (EYFS) specifies that:

'Where children are provided with meals, snacks and drinks, they must be healthy, balanced and nutritious', (Department for Education, 2017, 'Statutory framework for the early years foundation stage'): <https://www.gov.uk/government/publications/early-years-foundation-stage-framework--2>

Yet there is no specific mandatory food and nutrition guidance, such as the food-based 'Standards for School Food', (Department for Education, 2021, 'School food and standards practical guide'):

<https://www.gov.uk/government/publications/school-food-standards-resources-for-schools/school-food-standards-practical-guide>

currently in place for primary and secondary schools, to support providers and ensure that food is 'healthy, balanced and nutritious'.

EY standards must be mandatory and recognised in the Ofsted Common Inspection Framework, with training and support on nutrition as mandatory curricula component for the Early Years workforce.

Food and Hydration Policy

UK policies should promote and encourage access to healthy food choices in the early years. Regulation is necessary to protect families from inappropriate marketing of baby foods, snacks and drinks (including in the area of 'child-targeted' food and drink packaging) but the acquisition of eating habits in a child is often challenging to parents; augmented by modern day eating patterns.

The 'three meals per day and a planned snack at bedtime' mantra is long obsolete.

Today's family spends whole days eating 'on the go' with no space for communal meals. Ultra-processed food fits the lifestyle and the more potent and multi-sensory the food industry makes the products, 'the greater the reward and the greater the consumption' (Dr David Kessler, 2010, 'The End of Overeating: Taking control of our insatiable appetite', P240, Penguin USA).

'Ultra-processed' food and drink according to the NOVA classification (Monteiro CA, Cannon G et al, 2018, 'The UN Decade of Nutrition, the NOVA classification and the trouble with ultra-processing', Public Health Nutrition 21(1):5-17. NOVA system simplified by Professor Robert Lustig – Review by CNN Lisa Drayer. 13 May 2021) are products where the matrix of the food has been destroyed and ingredients included for palatability; eg shop-bought biscuits and cakes; mass-produced bread and desserts; reconstituted meat products and many ready-made meals. Fibre is usually removed and sugar added to essentially industrial creations that are nutritionally unbalanced and injurious to health; their powerful flavour tweaked to a 'bliss point' of irresistibility to young children.

Links between predominantly ultra-processed food and obesity are familiar; less so, the positive associations between consumption of ultra-processed foods, cardiovascular disease and all-cause mortality (Srouf B et al, 2019, 'Ultra-processed food intake and risk of cardiovascular disease: prospective cohort study', BMJ 2019;365: 11451; Rico-Campa A et al, 2019, 'Urgent action needed to reduce harm of ultra-processed foods to British children', Imperial College London) the diminishing of the gut microbiome and disruption of the endocrine system and appetite pathways in the brain (BBC One Documentary, 2021, 'What are We Feeding Our Kids?', The UK's addiction to ultra-processed foods, highlighting their prevalence in the national diet and the threat they pose to children's health', Dr Chris van Tulleken).

Parents of young children need, deserve and want more guidance about healthier food choices including information on which are ultra-processed.

According to the latest infant feeding survey (IFS) 2011, around 42% of babies were fed ready-made foods between the ages of 5 to 7 months; increasing to 45% at 8 to 10 months (Official Statistics, National Statistics Survey. Infant Feeding Survey – 2011): <https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-2010-early-results>

75% of parents had also introduced solid food before the recommended age.

Public Health England Draft proposals ('Commercial baby food and drink guidelines', November 2020):

<https://www.babymilkaction.org/wp-content/uploads/2020/11/DRAFT-PHE-proposals-for-2023-commercial-baby-food-and-drink-guidelines.pdf>

advocate reducing the total and free sugar content of commercial baby foods, avoiding the production of treats or desserts and ensuring appropriate portion sizes and The National Food Strategy Part 2 ('The Plan. An Independent Review for Government'):

www.nationalfoodstrategy.org

is a policy 'wake-up call' including amongst other measures:

- The introduction of the world's first sugar and salt reformulation tax
- A £1bn innovation fund to improve the food system
- A Community Eat Well pilot of GPs prescribing fruit and vegetables to improve diets
- Food Standards to be protected in any trade deals.

However, while UK Government is yet to respond, Brazil, Uruguay, Ecuador, Peru, France, Canada and Israel have already modified their national dietary guidelines to limit the consumption of ultra-processed food.

Implementation of NFS Part 2 is now urgent because:

'We eat more ultra-processed unhealthy food than any other European country and it is getting cheaper and more deadly each year', (Tim Sector, 2021 Introduction to the National Food Strategy):

www.nationalfoodstrategy.org

When early years nutrition is considered, the main focus is upon food and healthy eating but recent research suggests that:

'Drinking and the impact of fluid intake is often the forgotten part of food and diet' (Howells K, Musgrave J, 2021, 'Health and Nutrition – A real thirst? It's not all about healthy eating – what about healthy drinking?':

<https://www.nurseryworld.co.uk/features/article/health-nutrition-a-real-thirst>

Sufficient hydration is essential for maintaining children's health (European Food Safety Authority. Scientific Opinion on Dietary Reference Values for Water. EFSA Panel on Dietetic Products, Nutrition and Allergies (NDA). Eur. Food Saf.Auth.J.2010, 8, 1459-1507) but there has been little public health data examining teachers' and early years practitioners' understanding of children's fluid intake.

Howells and Coppinger report a lack of active encouragement of drinking water throughout the day by teachers and practitioners.

They recommend that children in educational settings consume an extra cup of water at lunchtimes and before, during and after physical activity as well as stressing the importance of drinking as children play and learn (Howells K and Coppinger T, 2020, 'Teachers' Perceptions and Understanding of Children's Fluid Intake', International Journal of Environmental Research and Public Health, 17 (11) 4040):

<https://doi.org/10.3390/ijerph17114050>

Adequate hydration is essential for life but children do not always know when and what to drink because their thirst response is undeveloped. (Shaw, 2010, 'Hydration in infants and children').

The last focused awareness initiative ('Water is Cool in School') occurred in 2000 and it is paramount that policymakers establish new strategies to increase the hydration knowledge of parents, care-givers and teachers so that lifelong and life-wide habits are developed to support children's own understanding and ensure their health and wellbeing (Williamson J and Howells K, 2019, 'Young Children's Understanding of Fluid Intake', International Journal of Nutrition 4(4) pp.1-8, and 2021, 'The Influence of siblings on young children's understanding of fluid intake', International Journal of Nutrition 6(3) pp.13-20).

Food Availability

Over 8.4 million people in the UK have limited access to healthy food choices and those with a disability and from BAME backgrounds are worst affected.

Millions of UK children aged 4 and under do not meet the daily requirement for eating at least five portions of fruit and vegetables and almost 116,000 children eat no vegetables per day. Vegetable-poor diets are attributed to 18,000 premature deaths every year in the UK (Food Foundation. 'Peas Please, Veg Facts 2021':

<https://foodfoundation.org.uk/publications/>

The advent of the Covid-19 pandemic has exacerbated the situation with more families unable to afford and access a nutritious diet; especially lone parents and large, low-income families (Food Foundation. A CRISIS WITHIN A CRISIS: The Impact of Covid-19 on Household Food Security):

<https://foodfoundation.org.uk/publications>

However, the UK crisis pre-dates Covid and aligns poorly with other European countries.

The UKSSD report 'Measuring up' reveals large UK variations according to socioeconomic status of high and increasing levels of obesity and diet-related disease, confounded by some of the highest levels of household food insecurity in Europe (UKSSD, 2018, 'Measuring up; How the UK is performing on the UK Sustainable Development Goals').

Children in the most deprived fifth of households are almost twice as likely to have obesity as those in the least deprived fifth ('The Broken Plate 2021. The State of the Nation's Food System').

Obesity increases the risk of developing adverse health conditions in childhood and later life including heart disease, stroke, high blood pressure, diabetes and some cancers. Children living in poverty can experience a low birth weight, poor physical health and academic underachievement and the disparities in child obesity are widening as shown by the National Child Measurement Programme:

<https://fingertips.phe.org.uk/profile/national-child-measurement-programme>

In a typical UK classroom, 30% of children live in poverty (RCPH, 'State of Child Health'):

<https://stateofchildhealth.rcpch.ac.uk/>

The Government's Healthy Start scheme provides vital vitamins and food vouchers to young and low-income pregnant women and low-income families with children up to age

4. Uptake has increased slightly, as the value of food vouchers has risen from £3.10 to £4.25. But 59% uptake in July 2021 (Healthy Start):

<https://www.healthystart.nhs.uk/healthcare-professionals/>

means that many eligible families are still missing out. Help is also available from the Family Nurse Partnership; a voluntary, preventive programme for vulnerable first-time mothers. The FNP offers intensive, structured home visiting, delivered by specially trained nurses and is operational from early pregnancy until the child is 2 years old:

<https://fingertips.phe.org.uk/profile/national-child-measurement-programme>

Some local areas have been proactive. Since May 2021, the London Borough of Newham has supplied free universal vitamins to all families with children under age 4, pregnant and breastfeeding mothers and has seen a boost in uptake (London Borough of Newham, 'Well Newham, 50 steps to a healthier borough', Health and Wellbeing strategy 2020-2023):

<https://www.newham.gov.uk/downloads/file/2595/steps-strategy-document>

Yet 40% of families nationally are still slipping through the net. Much has yet to be done in order to dislodge the creeping equation of nutrition and inequality impacting young children in the UK.

Recommendations:

- 1.1 Training and support on nutrition (to include hydration) to be included within the curricula for the Early Years workforce
- 1.2 Mandatory food and drink standards for EY settings to be recognised in the Ofsted Common Inspection Framework
- 1.3 National strategy to improve preconception, pregnancy and postnatal diets and the feeding of infants and young children
- 1.4 Improved data collection and monitoring of the quality of young children's diets focusing on the consumption of ultra-processed foods. The UK to establish future research priority here with necessary funding
- 1.5 Strategy to address food inequality to include review and extension of the Healthy Start scheme
- 1.6 More innovative and engaging communication strategies to promote healthier eating and inspire new and prospective parents.

CHAPTER 2: ORAL HEALTH

Children receiving medication for some long-term health conditions may have side effects such as gum disease, but for the majority, poor oral health is completely avoidable. However, children's dental health is reliant upon responsible adults understanding what needs to be done and poor dental health starting in childhood may blight health and wellbeing throughout the life course.

Tooth decay necessitating extraction is the most common reason for young children to be admitted to hospital and to go under general anaesthetic. For some, it is a recurring

problem, requiring admission on more than one occasion (Goodwin et al, 'Issues arising following a referral a subsequent wait for extraction under general anaesthetic: impact on children', BMC Oral Health 15, 3, 2015):

<https://doi.org/10.1186/1472-6831-15-3>

Difficulty in eating and consequent reduction in nutritional intake may lead to stunted growth; disrupted sleep can impair concentration in school and high levels of distress and lack of wellbeing inhibit emotional development and socialisation. There may also be hindrance to speech and language development and stigma due to an unsightly appearance.

Dental health must be prioritised for early years children.

Population-based research indicates that risk factors for early childhood caries include:

- Ethnicity
- Prenatal tobacco smoke exposure
- History of allergies before the age of one
- History of chronic maternal illness
- Maternal brushing frequency and childbearing age.

Collectively, these account for 20-35% of variation in the prevalence of early childhood caries (Kalhan et al: 'Caries Risk Prediction Models in a Medical Health Care setting', J Dent Res.2020, Jul; 99 (7):787-796. doi: 10.1177/0022034520913476) and it is likely that a substantial additional proportion of the variation is due to interactions between nutrition and the oral microbiome.

Nearly a quarter of England's 5-year-olds have tooth decay; affecting on average, 3-4 teeth (Gov.uk, 2021, 'Get help to improve your practice. Oral Health'):

<https://www.gov.uk/government/collections/oral-health>

A Public Health England report (2021, 'National Dental Epidemiology Programme for England: oral health survey of 3-year-old children, 2020. A report of the prevalence and severity of dental decay', Version 2):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/987179/NDEP_for_England_OH_Survey_3yr_2020_v2.0.pdf

noted that 10.7% of the children surveyed already had tooth decay; despite only having back teeth for between 1-2 years. There were also significant geographical discrepancies, with children living in the most deprived areas of England 3 times more likely to experience tooth decay.

A combination of oral care and dietary intake is needed for healthy teeth and gums.

Sugary food is known to be a strong factor in the development of childhood caries. In the USA, despite the recommendation that toddlers avoid added sugar altogether, Centres for Disease Control and Prevention data found that they were consuming on average 5.8 teaspoons of it per day (Chandler V, 2019, 'Nearly all US kids eating added sugars before age two', Health News Reuters):

<https://www.reuters.com/article/us-health-children-sugar/nearly-all-us-kids-eating-added-sugars-before-age-two-idUKKBN1YO2GK?edition-redirect=uk>

This level of added sugar in young children's diets has been linked to tooth decay and caries and also in instilling a clear preference for sugary food and drink. Recent research in pre-school children demonstrates that feeding infants in line with current dietary guidelines has a strong protective effect on later caries (Hu S et al, 'Infant dietary patterns and early childhood caries in a multi-ethnic Asian cohort', *Sci Rep*, 2019 Jan 29; 9(1):852. doi: 10. 1038/s41598-018-37183-5).

Good oral health relies on integrating the habit of tooth brushing into daily routines (including play and story times) early on; ideally when the first deciduous tooth starts to emerge at about 6 months of age.

Many resources are now being developed for early years children such as the 'brush your teeth' song developed by Amanda's Action Club, 2020:

<https://www.youtube.com/watch?v=lq70K20zVB8>

The Oral Health Foundation (2021, 'Better oral health for all. Dental Buddy'):

<https://www.dentalhealth.org/dentalbuddy>

have devised educational lesson plans and resources, with discussions and demonstrations to aid in the teaching of oral health; specifically for early years children. A character designed as a role model, 'Dental Buddy', is used to help with brushing charts and normalising oral health as part of a daily routine. Information is also provided about toothbrush storage, cleaning procedures within nurseries and childcare educational settings and how to run group brushing sessions.

Education settings are places where healthy practices can be promoted and Early Years professionals are especially well placed to promote good oral health.

From September 2021, the Early Years Foundation Stage statutory framework must explicitly include a new requirement to promote the good oral health of children in the existing requirement to promote good overall health. While it is up to individual providers to determine how they meet this requirement in a way that works best for their setting, all providers will need to take steps to find ways in which they can encourage children to care for their teeth and gums:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974907/EYFS framework - March 2021.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974907/EYFS_framework_-_March_2021.pdf)

Practitioners have the opportunity to build good relationships with parents which are critical in the identification, implementation, and evaluation of effective ways in which to promote children's health including oral health (Musgrave J and Payler J, 2021, 'Proposing a model for promoting Children's Health in Early Years Childhood Education and Care Settings', *Children and Society* Vol 35, Issue 5, September 2021, Pages 766-783):

<https://onlinelibrary.wiley.com/doi/full/10.1111/chso.12449>

Clearly a high degree of care is required when raising sensitive and potentially emotive matters with parents such as the treatment of extraction and tooth decay (Goodwin M et

al, 'Issues arising following a referral and subsequent wait for extraction under general anaesthetic: impact on children', BMC Oral Health 15, 3(2015):
<https://doi.org/10.1186/1472-6831-15-3>

The provision of healthy food and drink is a statutory requirement in England's Early Years Foundation Stage (DfE, 2021, 'Statutory framework for the Early Years Foundation Stage: setting the standards for learning, development and care for children from birth to five'): <https://www.gov.uk/government/publications/early-years-foundation-stage-framework--2> and can make a significant contribution to the healthy development of babies' and children's oral health.

The Effect of the Covid-19 Pandemic

The familial and social restrictions introduced in response to the Covid-19 pandemic have had a huge effect upon the dental health and welfare of children. These include:

- Different birth experiences; therefore limited contact with health professionals for new parents
- 'Shielding' and 'social bubbles'; preventing information gathering via habitual, familiar patterns of socialising
- Inability of some people to access professional sources of information via websites and social networking forums
- Lack of opportunity to see dental professionals
- Disruption to family structures and routines.

Official statistics show a significant drop in the number of children who visited a dentist during the pandemic. Dental appointments fell from 58.7% (31.03.20) to 23% (31.03.21) meaning that 9 million children have missed out on treatment. 12 million cases of dental treatment were delivered in 2020-21; a drop of 69% compared to the year before.

A total of 30 million dental treatment courses have been lost since the first national lockdown of the Covid-19 pandemic:

<https://dentistry.co.uk/2021/08/27/two-fifths-of-dentists-say-it-will-take-at-least-a-year-to-clear-covid-backlog/>

Policy Initiatives

The new version of the statutory curriculum for the 0-5 cohort in England requires nurseries to take responsibility for children's oral health, stating in the Early Years Foundation Statement (DfE 2021) that:

'Providers must promote the good health, including the oral health, of children attending the setting' (p.31).

A further issue is the potential increase in fluoridation of water (shown by research to be a safe, effective, public health intervention that can improve overall dental health and help to reduce dental inequalities). In February 2021, the then Secretary of State for Health and

Social Care, highlighted the importance of increasing the fluoridation of water nationwide and the Health and Care Bill 2021-2022 will transfer powers from Local Authorities and allow the Department of Health and Social Care to streamline processes and assume responsibility (with opportunities for public consultation in place) for the introduction of new fluoridation schemes:

<https://post.parliament.uk/water-fluoridation-and-dental-health/>

A national roll-out of water fluoridation would increase the likelihood of keeping a consistent low-level of fluoride in the mouth, making enamel more resistant to chemical erosion once teeth have developed.....which, combined with a national campaign to increase children's water drinking would contribute toward a lessening of the inequalities presently besetting young children's dental care and oral health. In line with the above, there is a new recommendation from the Chief Medical Officer for water fluoridisation in the UK:

<https://www.gov.uk/government/publications/water-fluoridation-statement-from-the-uk-chief-medical-officers>

Recommendations:

- 2.1 National strategy to prioritise early identification of children at high risk of caries, together with population-based preventive public health measures including reduction in rates of smoking during pregnancy and promotion of infant feeding guidelines
- 2.2 Oral care to be included in core training for EY professionals
- 2.3 Dental care and oral health to be included in all prenatal, perinatal and postnatal programmes delivered both online and in person; available at all advice points to include health centres, children's centres and family hubs
- 2.4 Free child 'dental pack' available at birth (or first meeting with the health visitor)
- 2.5 Tooth brushing to be included within the curriculum for all nursery/EY settings.

CHAPTER 3: SPEECH AND LANGUAGE

'A child's early development of language will lay the foundations for future learning and communication, and ultimately success in life':

<https://www.arcpathway.com/blog-article/how-can-i-help-my-childs-early-communication-skills>

It is widely understood that children entering primary school with strong language skills are readier to learn and show higher achievement across all areas of learning.

Only 11% of children who do not reach the expected standard in English at the end of primary school will eventually achieve Level 4 or above in English and Mathematics GCSE examinations and children with poor vocabulary at age 5 are more than twice as likely to be unemployed at age 34 ('Language Unlocks Reading', National Literacy Trust, 2019):

<https://literacytrust.org.uk/policy-and-campaigns/all-party-parliamentary-group-literacy/language-unlocks-reading/>

However, 'falling behind' is not restricted to school and work opportunities, because as they get older, these children are at heightened risk of involvement in antisocial behaviour and crime ('Speaking Up for the Covid Generation', 2021):

<https://ican.org.uk/speaking-up-for-the-covid-generation/>

Communication and language in the early years is therefore a central aspect of every child's development with parents, carers and early years practitioners carrying a high burden of expectation and responsibility.

The early years child's experience of speech and language is crucial because it establishes the foundation of the skills, knowledge and confidence that helps future challenges to be navigated and potential realised throughout the life course, ('State of the Nation: Understanding Public Attitudes to the Early Years', The Royal Foundation, 2021):

<https://royalfoundation.com/understanding-public-attitudes-to-the-early-years/>

A child's ability to speak is intertwined with the ability to listen and listening habits stem from life in utero 'Prenatal Personality Formation and Ego States', Bale A, pages 59-63, 2017):

<https://www.tandfonline.com/doi/abs/10.1177/036215379902900110>

The hearing capacity enables the progression of speech and language skills.

Strategies to ensure the earliest possible detection of hearing loss in infants are essential so that the early detection of auditory or acoustic issues are screened. All babies should be screened for hearing loss at no later than 1 month of age ('Centres for Disease Control and Prevention'):

<https://www.cdc.gov/>

and if a baby does not pass hearing screening, diagnostic hearing test timed as for immediate response should be undertaken at no less than the baby's three-month milestone ('Centres for Disease Prevention', as above).

Early mishearing detection has been shown to arrest damage, and better outcomes in supporting speech and language are achieved when a hearing deficiency is treated before a baby reaches 6 months of age ('Hearing Loss in children', Victory J, 2021, Healthy Hearing):

<https://www.healthyhearing.com/help>

The English Government's Statutory Framework for the Early Years Foundation Stage:

http://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974907/EYFS_framework_-_March_2021.pdf

and accompanying non-statutory guidance document ('Development Matters'):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1007446/6.7534_DfE_Development_Matters_Report_and_illustrations_web_2_.pdf

have raised the profile of the importance of spoken language; clarifying that it is integral to all 7 learning areas in the birth-to-5 foundation stage. These are:

- Communication and language development
- Physical development

- Personal, social and emotional development
- Literacy development
- Mathematics
- Understanding the world
- Expressive arts and design.

Key areas of early years practice are specified as paramount in supporting progress in child's language development with a strong emphasis on each of the following teaching and learning aspects:

- Adult modelled language
- Promoting interaction and conversation between children/adults and children/peers
- Introducing and applying new vocabulary
- Maximising opportunities for storytelling
- Strengthening parent and family partnerships.

It is widely accepted that young children learn primarily through play. Play provides rich opportunities for the development of speech and language. The Statutory Framework for the Early Years Foundation Stage (reference as above) does acknowledge this, but while insisting that it does not 'prescribe a particular teaching approach' suggests that:

'As children grow older and move into the reception year, there should be a greater focus on teaching the essential skills and knowledge in the specific areas of learning.'

This advice coupled with the introduction in 2021 of the Reception Baseline Assessment (RBA) and the fact that many qualified teachers lack sufficient early years input during their initial teacher training (ITT) and subsequent ongoing professional development means that many are heavily reliant upon the use of didactic teaching strategies for systematic, synthetic phonics and encouraging the memorisation of number facts through recitation and repetition.

Yet the physical activity involved in play provides many opportunities for language development.

Experiences are memorable and engage and introduce vocabulary such as nouns for naming, adjectives for describing and verbs to describe actions. Language and communication skills help children to strengthen their physical development in everyday life and acquire the physical skills that are needed to grow and acquire other skills. A child's physical development can impact significantly on the ways in which they interact with others and access and interpret the world around them. An increasing body of research evidence now supports the existence of a link between physical activity and cognitive outcome (Education Endowment Foundation: 'Physical Development Approaches'):

<https://educationendowmentfoundation.org.uk/education-evidence/early-years-toolkit/physical-development-approaches>

The Covid-19 Pandemic

Covid-19 has derailed the lives of adults and children worldwide in innumerable ways.

The Education Endowment Foundation conducted a survey to ascertain the pandemic's effect on children starting school ('The Impact of Covid-19 on School Starters: interim briefing (1) Parent and school concerns about children starting school', April 2021) and key findings include the following:

- 76% of schools (44 out of 58 schools) reported that Autumn 2020 school starters required more support than those in previous cohorts
- 56% of parents were concerned about their children starting school following lockdown
- 96% of schools expressed concern about pupils' speech and language development
- Three quarters of primary schools said that children entering reception class in September 2020 needed more help with language than in the previous academic year.

Comments from the surveyed schools included the following:

'Many children have entered reception at much lower level than in previous years, particularly in number, mark making and speech, focus and attention and behaviour.'

'(Focus needed on) basic skills, language development, establishing a baseline, behaviour for learning, personal and social skills, activity levels.'

The charity ICAN published a report in 2021: 'Speaking Up for the Covid Generation', 2021: <https://ican.org.uk/media/3753/speaking-up-for-the-covid-generation-i-can-report.pdf> highlighting how the various lockdowns have exacerbated speech and language difficulties and noting that:

'Children learn to speak and understand language through their interaction with others.'

The Covid-19 pandemic has hugely reduced the amount of social interaction for children of all ages during the past two years and the inevitable consequence has been to limit the range of things that they learn to talk about. Without trips outside the classroom and new, shared experiences, there is less reason for children to speak or use new words and there are fewer opportunities to hear and copy new words and phrases.

During the pandemic, social distancing and 'bubbling' have combined to cap children's social interaction and communication, resulting in an adverse impact on their language development and key socially interactive skills such as turn-taking, shared play, initiating and extending play sequences with narrative.

As a result of Covid-19, two fifths of primary schools in England have signed up to participate in the Nuffield Early Language Intervention (NELI) to support those 4 and 5 year-olds who have been most impacted by the pandemic:

<https://educationendowmentfoundation.org.uk/news/62000-reception-pupils-to-take-part-in-early-language-programme/>

There is at present, no comparable programme for children below the age of 4.

Although the full impact of the pandemic cannot be fully known for some time, schools are consistently reporting an increase in the number of pupils requiring additional support with speech and language. There is a clear need for policy-makers to introduce measures to address the complex factors which inhibit speech and language development.

Economic and social inequalities

Almost a third of Britain's children live in poverty, with 73% coming from homes with at least one working adult:

<https://www.gov.uk/government/statistics/households-below-average-income-for-financial-years-ending-1995-to-2020/households-below-average-income-an-analysis-of-the-income-distribution-fye-1995-to-fye-2020#children-in-low-income-households>

Speech and language development, working memory and the ability to moderate behaviour, are amongst the developmental areas most affected by poverty (Perkins S et al, 2013, 'Poverty and Language Development: Roles of Parenting and Stress', Innovations in Clinical Neuroscience. 10(4) pp 10-19).

It is therefore unsurprising that 81% of children identified as having emotional or behavioural difficulties are also believed to have undiagnosed speech and language problems (Hollo A et al, 2014, 'Unidentified Language Deficits in Children with Emotional and Behavioural Disorders: A Meta-Analysis', Exceptional Children 80(2): 169-186).

A disproportionate number of those affected by poverty are from black and minority ethnic families (BAME):

<https://neu.org.uk/child-poverty-facts>

and there is a clear correlation between this data and official statistics which show that, while approximately a third of school-age children are from BAME backgrounds, the proportion of children from BAME backgrounds in pupil referral units is significantly higher:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812539/Schools Pupils and their Characteristics 2019 Main Text.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812539/Schools_Pupils_and_their_Characteristics_2019_Main_Text.pdf)

In addition to the impact of poverty and ethnicity, government data shows that 20% of UK children are learning English as an additional language (EAL):

<https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics>

Those who experience early childhood education and care acquire language more readily than those who start to learn English in Key Stage 1 or 2 by the end of the reception year and two thirds of children with EAL have not yet gained sufficient competency and fluency

to meet age-related expectations in speech and language. They continue to struggle both with comprehension and with expressing their needs, feelings and ideas linguistically: <https://mk0bellfoundatiw1chu.kinstacdn.com/app/uploads/2020/02/University-of-Oxford-Report-Feb-2020-web.pdf>

This can have a significant negative impact on a child's mental health, self-esteem, behaviour, academic attainment and long-term outcomes.

Recommendations:

- 3.1 All babies to be screened for hearing loss no later than one month of age; where a baby does not pass hearing screening, a diagnostic test timed as for immediate response to be carried out no later than 3 months of age
- 3.2 A national awareness programme to promote the importance of activity, interaction and conversation to families of children from birth to age 5 together with funded 'stay and play' physical activities for parents and children at family hubs/children's centres
- 3.3 A reform of the '2-year check' criteria with clear assessment in speech and language so that children needing support at an early age can be identified while practitioners and specialists are afforded a reasonable time-span to prepare the child for school
- 3.4 Training in how to support speech and language development to be embedded across all early years and primary education ITT routes
- 3.5 Improved availability of specialist support for children with speech and language delays/difficulties through the expansion of speech and language services and EAL support; targeted funding to areas of greatest need and promotion of degree level courses in speech and language therapy and teaching English to speakers of another language (TESOL)
- 3.6 Investment in policies designed to combat child poverty including increasing the Primary Premium Grant (PPG) funding.

CHAPTER 4: MENTAL AND EMOTIONAL HEALTH AND WELLBEING

The sense of touch develops in utero and from this point onwards, plays a seminal role in mother and baby bonding (Ardial E, & Rankin C, 2010, 'The importance of touch in development', *Paediatrics and Child Health*, 15(3) 153-156. doi: 10.1093/pch/15.3.153). Evidence suggests that a lack of affective touch in early infancy is strongly associated with increased physiological, cognitive and emotional reactivity later in life (Olausson H, Wessberg J, Morrison I, McGlone F & Vallbo A, 2008, 'The neurophysiology of unmyelinated tactile afferents', *Neuroscience 7 Biobehavioural Reviews*, 34(2), 185-191. doi: 10.1016/j.neubiorev.2008.09.011).

In the 1980s, over 65,000 children were placed in orphanages in Romania; 85% of them under 1 month old (Chugani et al, 2001, 'Local Brain Functional Activity Following Early Deprivation; A Study of Post institutionalized Romanian Orphans', *Neuroimage*, 14(6) 1290-1301. doi: 10.1006/mimh.2001.0917). They were fed but not touched and when placed with adoptive parents, showed mild neurocognitive impairment, impulsivity and attention

and social deficits and were still exhibiting signs of developmental delay in adolescence (Field T, 2019, 'Social touch, CT touch and massage therapy; A narrative review', *Developmental Review*, 51, 123-145. doi: 10.1016/j.dr.2019.01.002).

Increasing evidence now suggests that nurturing touch as part of investment in the early years of life produces substantial benefits whereas tactile deprivation at that time can have a profound adverse mental and emotional impact throughout the life course including poor social bonding and later life neurodevelopment.

Sleep deprivation in early childhood can be detrimental to their psychological states and mental health.

Research from the Institute for Mental Health at the University of Birmingham and the Finnish Institute for Health and Welfare in Helsinki found correlations between early infancy sleep problems including frequent night waking, short sleep duration (or difficulty in falling asleep) and specific mental and behavioural problems at age 2. The study concluded that sleep problems during infancy and very early childhood could be linked with emotional and behavioural problems in later childhood. Dr Isobel Morales-Munoz said:

'Our results show that infants who sleep for shorter periods of time, take longer to fall asleep and wake up frequently during the night are more likely to show emotional and behavioural problems in later stages of childhood. It's likely that sleep quality in these early months and the development of self-regulation – the ability to control our behaviour – are closely related.'

The study suggested that infant sleep problems may be due to a variety of mechanisms, including genetic and environmental factors:

<https://www.birmingham.ac.uk/news/latest/2020/03/poor-sleep-in-infancy-linked-to-behavioural-and-emotional-problems-in-toddlers.aspx>

It is anticipated that the Covid-19 pandemic and associated societal response will have wide-ranging impacts on child development and mental health. Sleep is crucial for child health and wellbeing and the potential for sleep problems to emerge or worsen during and post pandemic is high. The Millpond sleep clinic in London recorded a marked increase in reported sleep problems for young children, according to founder Mandy Gurney:

'At the moment we are very busy' with sleep problems even in very young children 'who are not seeing other babies in parenting groups':

<https://www.theguardian.com/lifeandstyle/2020/jul/17/childrens-sleep-severely-affected-coronavirus-experts-anxiety-routine>

It is therefore imperative that sleep considerations continue and become a part of the clinical initiatives and research directed at understanding and mitigating the impact of the Covid-19 pandemic on young children's mental health and wellbeing, to include a role for active sleep strategies:

<https://www.evelinalondon.nhs.uk/our-services/hospital/sleep-medicine-department/coronavirus-sleep-tips.aspx>

Article 31 of the United Nations Convention on the Rights of the Child (1989) states that:

'States Parties recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.'

and developmental psychologist Peter Gray describes free play as:

'The primary means by which children learn to control their lives, solve problems, get along with peers and become emotionally resilient' ('The Culture of Childhood: We've Almost Destroyed It'):

<https://www.psychologytoday.com/gb/blog/freedom-learn/201610/the-culture-childhood-we-ve-almost-destroyed-it>

Froebel, Montessori and Steiner were pioneers in their exposition of the interconnectedness of physical, mental and emotional health (Sue Palmer, 'Play is the Way: Child development, early years and the future of Scottish education', Postcards from Scotland, 2020) and it is now widely accepted that play is beneficial during periods of anxiety, stress and adversity, fostering independence, helping children to interpret the things that they find hard to understand and supporting their resilience and coping strategies (Dodds et al, 'Play First: Supporting Children's Social and Emotional Wellbeing after lockdown', 2020).

Play therapy is a well-recognised and respected discipline in itself; especially useful in helping early years children to cope with experiences of trauma, abuse and other psychosocial issues (whereas counselling-based 'talking therapies' may be inappropriate for this age group):

<https://www.playtherapy.org.uk>

However, the social and physical impositions of the Covid-19 pandemic have placed radical restrictions upon opportunities for play outdoors and within early years settings - thus depriving children of a vital support to their mental and emotional health and wellbeing:

'Play can help build resilience, the capacity for children to thrive despite adversity and stress in their lives,' (Lester S and Russell W, 'Play for a Change,' National Children's Bureau, 2008).

Opportunities for social interaction with peers outside immediate family settings are essential in laying the foundation for emotional health and wellbeing in children of all ages. In 2020, Mental Wellbeing was added to the national curriculum with training guidance for teachers (Government Guidance: Teaching About Mental Wellbeing):

<https://www.gov.uk/guidance/teaching-about-mental-wellbeing>

Similarly, independent organisations like Wellbeing Through Sport have addressed the need to improve mental health and wellbeing in primary and secondary schools:
<https://www.wellbeingthroughsport.co.uk/about-us>

However, despite an increasing number of studies illustrating the importance of the first 1,001 days in a child's immediate and future mental and emotional development ('The Best Start for Life; A Vision for the 1,001 Critical Days: 'The Early Years Healthy Development Review Report', March 2021):

<https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days>

current interventions predominantly focus on school-age children via the structure in place and this channel is not as consistently available to the preschool age group. In 2018, only 40% of 0-2-year-olds accessed any formal childcare provision. The figure rose to 88% for the 3-4-year-old cohort but the disparity is clear.

Even before the pandemic, the early years sector was both under pressure and under-recognised and despite its significant role in the future physical, mental and emotional health of children, was too frequently pigeon-holed as single-purpose 'childcare'. As a consequence, the sector entered the pandemic underfunded, under-resourced and the mental health and wellbeing of children, parents and providers were at an all-time low. The mental health and wellbeing of parents in particular should not be seen as a separate entity. It is a key determinant of a child's emotional wellbeing as evidenced in 'State of the Nation: Understanding public attitudes to the early years':

<https://royalfoundation.com/understanding-public-attitudes-to-the-early-years/>

With the above backdrop, the devastation to the sector wreaked by Covid-19 ('Nurseries and the impact of closure in the first year of the pandemic', National Day Nurseries Association, 2021) is captured by data:

- 13.4% of closures occurred in postcodes classified as containing the most deprived communities in England
- 38% of closures were in areas in receipt of the lowest funding rate in 2020/21
- Over 11,000 children's places have been impacted by these closures
- Ofsted data from childcare registers reveals that from 1st April 2020 – 31st March 2021, 442 nurseries and preschools have closed
- From 1st April 2020 – 31st May 2021 a total net reduction of 3,533 providers registered with Ofsted.

Permanent closure has become inevitable for many settings and for those still open, financial pressure has created an increasingly stressed workforce; many with experience of personal grief and social isolation. In such circumstances the task of maintaining emotional and mental equilibrium in children has become even more challenging.

The availability of extra-curricular activities for early years children is also relevant to their emotional and mental health and wellbeing.

Providers offer opportunities for parents and children to attend and participate together and joint presence is seen more predominantly with babies and younger children. Data suggests that children attend approximately 8.4m extra curricular activities in the UK each week (survey conducted by Thinksmart Software Ltd available to government organisations by contacting info@childrensactivitiesassociation.org). Activities include messy play, yoga, circus skills and baby massage.

The Children's Activities Sector Overview Report (2020) found that 90% of parents surveyed rated extra curricular activities' importance as 7/10 or higher for their child's physical, social, emotional and mental health:
<https://www.childrensactivitiesassociation.org/news/8808739>

As a consequence of Covid-19, many providers have been forced to reduce the size and frequency of sessions; in particular, those involving parents and under 5s participating together. In order to control Covid-19 infection spread, the likelihood is that numbers of children missing out (estimated by the CAA as over 1 million on waiting lists (Thinksmart survey, as above) are expected to remain high for the foreseeable future.

Casework study

Educational consultant and trainer Jean Barlow specialises in children's emotional and mental health:
<http://www.jeanbarlowtrainingsolutions.co.uk/>

She invited many of her colleagues who are 0-5 years providers and practitioners to complete a questionnaire to share first-hand experiences of the ways in which the children were affected during and since the return from lockdown.

This took place in a part of the North West of England where Covid-19 infections and death have been very high. Responses came from 6 primary schools, 4 private nurseries, 2 childminders, 1 local authority advisor, a social worker with responsibility for looked-after children and team members.

The questions were:

1. In your experience what impact has the pandemic had on your infants and young children?
2. What strategies or modifications have you taken to improve their wellbeing and learning since their return?
3. Are there further steps that you feel need to be undertaken to improve the current situation in your setting?
4. Can you suggest anything that needs to happen to help compensate or to help lessen the effects of the pandemic on the children and their providers or practitioners?

Each setting expressed that the children had suffered much anxiety and displayed more overt, unpredictable or 'difficult' behaviours and emotional outbursts during their time

with them. Even children of essential workers who missed very little time with their practitioners displayed greater mood swings.

The unpredictability of staff attendance, restructuring of groups and changes to normal routines resulted in children choosing isolated play, withdrawal from some activities and reluctance to speak despite a previous propensity to talk and be curious.

On their return, children who had been taught remotely, exhibited regressive behaviours; crying for their parent/carer and signs of 'not wanting to be there' such as reluctance to remove coats or wellingtons.

Many 3 and 4-year-olds developed a higher dependency on their parent/carer with some needing more 1:1 adult attention for longer periods; choosing to watch others rather than joining in. Some children's language skills were 'forgotten' and invariably, many children had to 'start again' with the transition period from home to the setting. It was often necessary to replace full group work with individual planning programmes in order to help a child to recover lost skills.

For practitioners in all settings, a focus on wellbeing and play became a priority. In some settings, staff undertook online training in CPD courses for wellbeing initiatives with indoor and outdoor play activities built into the day.

In all settings, staff prioritised encouraging the children to express their feelings, often by drawing. Small group child-inspired activities, were slotted into the day involving exploring and investigating nature indoors and outdoors with staff guided by the children in pace, content and readiness.

Stories focused on social experiences, bereavement, illness and separation. New activities included 'Forest school' each day with children gardening, rummaging and treasure hunting; 'Relax Kids' sessions, peer massage, a 'Child2Child kind and caring hands' programme; Emilia Reggio strategies, practitioner-led activities utilising materials that improve skills and ignite a child's interest while providing experiential learning opportunities.

All settings observed health practices such as rigorous hand-washing. Staff used these simple steps to help children to increase their understanding and built-in structured play with a focus on language skills, independent curiosity, autonomy and small group communication. Similarly in all settings, daily music, singing and oral work became core activities; helping to heal some of the emotional damage inflicted by the pandemic.

Children born during this time were placed in a unique position. Restrictions on face-to-face visits from medical staff, family workers, and extended family, neighbours and friends disrupted the traditional socialisation process for a newborn. Parents and other adults were masked and at a distance from them in the interests of safeguarding from Covid-19 infection. The lack of facial expression and natural interactions made the babies wary and unsure when meeting new people.

Staff needed to attend more home visits; especially with non-English speaking families.

They were urged to be observant of nuances and non-verbal interaction between family members and children, because without the presence of an interpreter, language was a barrier. Parents were encouraged to join shared children and parent classes and maintain contact with the setting via telephone or online meetings. In all cases, staff were under great strain and one provider observed that it was difficult to explain the need for 'PPE and flow test' procedures to non-English speakers.

All questionnaire participants agreed that the mental health of children and families has been drastically affected during this pandemic and must now be prioritised in the interests of society as a whole. A strong emphasis was required on 'repair and rebuild' activities to assist very young children in improving their relationships; primacy being given to socialisation and oral communication skills. Parents and staff will need closer co-ordination of shared time to monitor and evaluate each child's development and progress.

Recommendations:

- 4.1 Effective and targeted training within the early years sector; with a mandatory Level 7 qualification attainment for all practitioners
- 4.2 All early years' practitioners required to undertake CPD in child development to include the latest neuroscience information in order to assist in promoting children's mental health and wellbeing
- 4.3 Ensure a positive mental health culture across the sector:
<https://www.time-to-change.org.uk>
a mental health and wellbeing policy to be a mandatory requirement in each setting and a mental health worker (play therapist/peer worker/mental health 'first aider') required in each setting to identify and implement a strong wellbeing and resilience culture and to assist individual children
- 4.4 Increased access to support for parents/carers from outside services (eg bereavement, estranged parents, anxiety, adopted/fostered children)
- 4.5 Offering parents access to a range of simple and effective support aids for helping their children at home such as TRE UK (c/o Caroline Purvey, evaluated by Canterbury Christ Church University, April 2021)
- 4.6 National recommended guidelines; universal to the children's activity sector to ensure a consistent quality of provision to children and a quality of expectation for parents, schools, nurseries and local authorities. This to be combined with an awareness campaign directed at all stakeholders together with an accessible national database of providers who are compliant.

CHAPTER 5: ACCESS TO SUPPORT FOR CHILDREN/FAMILIES WITH DISABILITIES AND SPECIAL EDUCATIONAL NEEDS

The 2020 report by the House of Commons Committee of Public Accounts on support for children with special educational needs and disability concluded:

'Many of the 1.3 million school-age children in England who have special educational needs and disabilities (SEND) are not getting the support that they need. This is a failure that damages their education, wellbeing and future life chances. Half of the local authority areas inspected are not supporting children and young people with SEND as well as they should, and the action plans these areas have in place are not addressing their weaknesses quickly enough', ('Support for children with special educational needs and disabilities', First Report of Session 2019-21, ordered to be printed 29th April 2020, London, House of Commons).

Some statistics concerning the number of children in England needing SEND services over the past 5 years are given below and show a determinedly upward trajectory:

- The number of children requiring access to services has grown incrementally year-on-year since 2015
- Of the 12.2% of all pupils requiring SEN support, 3.7% have a formal Statement or Education and Health Care Plan (EHCP)
- There has been a 0.9% increase in EHC plans in England between 2015-2021.

These statistics are unsurprising; the disparity in provision for children with special educational needs or disabilities and their families has long been acknowledged; initially by Brian Lamb (Lamb Inquiry: Special educational needs and parental confidence: The Department for Education, nationalarchives.gov.uk) then by the Children and Families Act 2014 (Children and Families Act 2014, legislation.gov.uk) and finally by the (as yet unpublished) 2020 Government SEND Review (Major Review Into Support For Children With Special Educational Needs) :

www.gov.uk

In 2021, only 9% of disabled people and 10% of carers believe that disabled people are treated fairly (UK Disability Survey research report, June 2021):

www.gov.uk

Before the Covid-19 pandemic, Achievement for All (AfA), a not-for-profit organisation, working in partnership with early years settings, schools and colleges to improve outcomes for all children and young people, published a collaborative manifesto 'Every Child Included in Education', 2018:

<https://afaeducation.org/content/manifesto/manifesto/>

One of the recommendations was to 'close the gap' for SEND children; often the most marginalised and forgotten group.

The early years SEND cohort face an even bleaker prospect.

According to the annual early years report from children's charity, Coram, prior to the pandemic, only 19% of local authorities had sufficient places for all early years children with SEND but following the advent of Covid-19 and the closure of many existing facilities, children and their families were left isolated in an even worse position:

<https://www.coram.org.uk>

While EY settings remained open, vital therapies and assessments were late or discontinued and organisations such as the Dingley's Promise Centres reported delays in existing children moving on and new children coming to access support later than usual: <https://dingley.org.uk>

These experiences are corroborated by research from the Sutton Trust stating that children with SEND are:

'Most likely to be struggling, but many have dropped off the radar without regular attendance at their provider, despite the efforts of many providers to support such children remotely':

<https://www.suttontrust.com/wp-content/uploads/2020/06/Early-Years-Impact-Brief.pdf>

The Left Behind report from the Disabled Children's Partnership (DCP):

<https://disabledchildrenpartnership.org.uk/leftinlockdown>

captures the experiences of disabled children (in particular the early years cohort) and their families; finding that:

- Over 50% of disabled children have been unable to access therapies including speech and language therapy, physiotherapy and occupational therapy
- 73% of early years children have also experienced delays to essential health appointments (the average across all disabled children was 60%). These included treatments, operations and accessing equipment
- 75% of disabled children have been socially isolated with parents reporting a high proportion of child anxiety symptoms and 72% of parents stating that their child is often unhappy, downhearted or tearful
- 79% of parents of early years children are themselves severely socially isolated
- More than 80% of families have seen formal and informal support services cut during the pandemic, including short breaks, day and residential care
- As a result of delays and continued isolation, over half of disabled children have seen their condition worsen during the pandemic
- Many parents have reported a noticeable regression in confidence in basic life skills in their children with 49% of parents reporting a specific deterioration in their children's communication skills
- In all, 71% of children's development regressed; 70% had still not seen their therapies and health services restored to pre-pandemic level and 60% of parents remain socially isolated.

The October 2020 Ofsted Early Years Briefing:

<https://www.gov.uk/government/publications/covid-19-series-briefing-on-early-years-october-2020>

states that most providers have concerns about the development of SEND children in the wake of the pandemic. Particular areas (also raised by Dingley's Promise) are physical development, language and communication. The Ofsted report observes that children:

'had not received the additional support they needed from other professionals because many services had closed or were limiting face-to-face visits.'

A more recent Ofsted report ('SEND: Old issues, new issues, next steps') confirmed that:

<https://www.gov.uk/government/news/children-and-young-people-with-send-disproportionately-affected-by-pandemic>

<https://www.gov.uk/government/news/children-and-young-people-with-send-disproportionately-affected-by-pandemic>

'Children and young people with SEND [were] disproportionately affected by the pandemic.'

The report highlights 'the cumulative effects of disruption caused by the pandemic on the health, learning and development of children with SEND.'

The Council for Disabled Children's Early Years SEND Partnership survey (June 2020) on the impact of the pandemic on children with SEND in the early years describes ongoing issues for children and their families:

<https://councilfordisabledchildren.org.uk/what-we-do-0/networks/early-years-send/early-years-send-partnership-resources/research/eysend>

91% of respondents considered that Covid-19 had widened the gap between children with SEND and their peers with 89% feeling that the loss of observation and assessment has had an impact on SEND support.

It is clear that during the Covid-19 pandemic, children with SEND in the early years were amongst the most affected and new inequalities have been created as well as existing ones worsened.

It is vital that these children and their families are prioritised in recovery policy because the loss of their services and support has depressed the opportunities open to them; isolating them still further from the wider society in which they live.

Recommendations:

- 5.1 Introduction of national standardised Early Years SEND Support Packages detailing exactly what all parents and children are entitled to; thus ending the support 'postcode lottery'
- 5.2 Guaranteed long-term investment and spending as a proportion of GDP on disabled people, bringing England in line with the best performing OECD member nations:
<https://data.oecd.org/socialexp/social-spending.htm>
Immediate publication of the delayed SEND report
- 5.3 Dedicated training for early years practitioners to support inclusive working and to help children with SEND recover from gaps in their learning or support; in particular focusing on speech and language and physical development

- 5.4 Investment in reducing the backlog of health assessments for children in the early years as of urgency with sufficient funding for early years settings to provide the right support at the right time for SEND children so that they can access settings as soon as possible for recovery activities
- 5.5 Increased focus on family support to identify needs as early as possible and ensure that families have the information and assistance that they need to recover from their experiences of isolation and stress
- 5.6 Strategic long-term planning for the early years SEND child who must be supported to recover through targeted strategies to improve key areas of learning.

CHAPTER 6: ACCESS TO SUPPORT FOR CHILDREN FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES

Article 22 of the United Nations Convention on the Rights of the Child (refugee children) states that children who have, or seek, refugee status, are entitled to have the rights set out in the UNCRC:

'Governments must provide protection and support and must help children who are separated from their parents to be reunited with their family' (Save the Children):
<https://www.savethechildren.org.uk/content/dam/gb/reports/humanitarian/uncrc19-summary2.pdf>

International human rights law guarantees an education for all without discrimination and this principle extends to all persons of school-going age residing in the territory of a state including non-nationals irrespective of their legal status. Special measures for the protection of the right to education are given in the UN General Assembly (1951) Convention Relating to Refugees, 28th July 1951 (United Nations, Treaty Series, vol. 189, p. 137):
<https://www.refworld.org/docid/3be01b964.html>

Prior to their arrival in the UK, it is likely that these children's education may have been fragmentary, intermittent or interrupted; they will present from a variety of standpoints carrying an array of past experiences. The British Red Cross is the largest support provider and is often the first port of call for new refugees (British Red Cross, 2021):
<https://www.redcross.org.uk/about-us/what-we-do>

The Refugee Council is similarly, a substantial organisation that is also highly supportive of integration. One of its foremost aims is to enable refugees to make a positive contribution to UK society:

'The total cost of training a refugee doctor to work in the NHS is just 12% that of training a new doctor for one year', Refugee Council, 2021:
<https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/the-truth-about-asylum>

But of course not all refugees, or even most, are educated to a level that eases their pathway to integration so smoothly (a key issue for refugees and for the communities in receipt of them).

Children have developmental needs beyond the immediate life-sustaining necessities of food, shelter and safety. Before they reach the UK, they are likely to have endured traumatic, even life-threatening experiences in their home country as well as encountering danger and deprivation on the journey. Difficulties do not conclude on arrival in the UK. For many (perhaps the majority) the difficulties are now just different; contingent upon becoming part of an existing group of communities, experiencing a mix of social isolation, poor living conditions and other disadvantageous conditions. The particulars may differ from child to child, but all have potential to impede development and trigger significant mental health problems.

Individual and culturally appropriate interventions are needed as a matter of urgency but for the most part are not available.

While their legal right is undisputed, a variety of barriers exclude the access to education in the UK of some children with a refugee background:

- Local authorities aim to afford newly-arrived unaccompanied asylum seeker children access to education within 20 days of being taken into care. However, admissions are invariably delayed; especially for those who arrive with their families as their routes to support and information are reduced. Local authorities may draw upon Pupil Premium money to fund 1-2 hours of English Language tuition while children await a school place (Unicef, 2018, Case study: School-based interim provision – Croydon Virtual School):
<https://www.unicef.org.uk/publications/access-to-education-refugee-asylum-seeking-children/>
- Some European countries like Belgium provide preparatory classes to facilitate access; such as dedicated reception centres to address language/cultural barriers. This happens in Oxfordshire (Unicef, 2018, Case study: Educational mentoring in London, Oxford and Birmingham’):
<https://www.unicef.org.uk/publications/access-to-education-refugee-asylum-seeking-children/>
and the Croydon Virtual School (as above) but is not universal
- Refugee families residing within initial and temporary accommodation may be unable to access education
- Formal schooling and early years provision are available for all, but destitution may inhibit access. For example, children on Section 4 support are not entitled to free school meals or other benefits
- Some refugee children and their families have poor literacy skills and therefore cannot access information about education and their entitlements
- Although children seeking asylum can be assessed for special needs and those needs met as for other children (European Council on Refugees and Exiles, 2021, Access to education):

<https://asylumineurope.org/reports/country/united-kingdom/reception-conditions/employment-and-education/access-education/>

mental health issues, trauma and caring responsibilities for family members can lessen opportunity.

UNICEF UK has made a range of recommendations to address these barriers ('Education for refugee and asylum-seeking children: Access and quality in England, Scotland and Wales', Unicef UK) and advocates that national and local government and partners adopt them:

<https://downloads.unicef.org.uk/wp-content/uploads/2018/09/Access-to-Education-report-PDF.pdf>

A safe and welcoming environment

The City of Sanctuary movement (originating in Sheffield, 2005) draws inspiration from the Old Testament 'Cities of Refuge' (Numbers 35:9-34) with an emphasis on inclusion, welcome and safety.

The Schools of Sanctuary network across the UK and Ireland includes nursery schools and primary schools with an early-years setting (Schools of Sanctuary, 2021, 'A very warm welcome to schools of sanctuary'):

<https://schools.cityofsanctuary.org/>

To meet the criteria, a setting must demonstrate qualities of safety and welcome to those seeking sanctuary and pursue activities in educating the whole community to understand what it might mean to be a forced migrant. A potential School of Sanctuary must satisfy assessors that it fulfils the following requirements:

- **LEARN:** Schools help students, staff and wider communities learn about what it means to be seeking sanctuary and issues around forced migration
- **EMBED:** Schools are committed to the creation of a safe, inclusive and welcoming culture to the benefit of everybody, including anyone in the community who is seeking sanctuary
- **SHARE:** Schools share their values and activities with the whole community.

The Brighton and Hove 'Sanctuary on Sea' has a number of Schools of Sanctuary including Acorn Nursery and One World Nursery.

Acorn Nursery worked with children in considering the meaning of 'home.' The children discussed what home and family meant to them and how these terms made them feel. They then took part in a 'den building' exercise in which they moved to a tent in a nearby garden. As part of the activity, the children discussed what they needed to feel secure and happy when moving (Brighton and Hove Education and Enterprise Marketplace 9BEEM 2021 Schools of Sanctuary):

<https://beem.org.uk/Page/10046>

During Refugee Week, One World Nursery committed to undertake activities including choosing stories such as 'Welcome' by Barroux as a prompt for discussion and writing their own stories such as 'The Three Refugee Bears.' In this nursery setting, key staff members are assigned to work with families of forced migration.

Providing a sense of security and belonging is crucial when welcoming children seeking sanctuary (and their families) into a community (McIntyre J and Abrams F, 2021, 'Refugee Education: theorising practice in schools', London: Routledge).

Nurseries often show multi-lingual 'Welcome' signs and Royal Spa Nursery displayed a 'Refugees are welcome here' poster in their foyer (BEEM 2021). The nursery also devised stories about welcome and safety using a 'persona doll' to represent a child seeking sanctuary. Staff members in this setting asked families what they had found to be helpful on arrival and they replied that they had found that coffee mornings and 'drop-ins' to meet other families were activities that they had found to be supportive.

For schools to succeed in their reception and welcome of refugee children, existing teachers and children 'in situ' must adapt and be prepared to accept the new entrants 'as they are' (Hamilton R, 2003, 'Schools, teachers and the education of refugee children', Educational Interventions for Refugee Children, Routledge). Early Years teachers endorse social contact with English speaking children and adults as a way in which to encourage early language learning (Bolloten B and Spafford T, 2015, 'Refugee children in the EYFS').

Play has great potential to break down cultural barriers and enable all children to integrate; instilling confidence and nurturing social skills. It can be of immense therapeutic value in helping children to interpret and comprehend their experiences.

Trauma

The UK Government recognises that:

'Migrants may be at increased risk of mental health problems as a result of their experiences prior to, during, or after migration to the UK' (Public Health England, 2021, 'Advice and guidance on the health needs of migrant patients for healthcare practitioners' Mental Health: Migrant Health Guide, gov.uk, 2017, updated 2nd August 2021): <https://www.gov.uk/guidance/mental-health-migrant-health-guide>

The guide acknowledges that vulnerable groups may be at particular risk of post traumatic stress disorder (PTSD) and despite the fact that children receive no specific mention, there is signposting to the 'Save the Children Psychological First Aid Training Manual for the Child Practitioner.'

Adverse Childhood Experiences (ACEs) are now seen to be extremely important in the consideration of policies to address dysfunctional families and in the development of preventative strategies (Edwards R et al, 2019, 'Introduction; Adverse Childhood Experiences (ACEs) – Implications and Challenges', Cambridge University Press, 7 June 2019).

The approach is considered to be an important way in which to identify situations and experiences that can cause long-term harm; demonstrating how professionals can use Trauma Informed Practice (TIP) to mitigate the effect of ACEs, support children in dealing with the consequences of harm and developing appropriate coping strategies.

The ACE paradigm (established in the USA) is now employed in many high-income countries and although it is recognised that ACEs can occur across a population, children in high areas of deprivation are at greater risk. Teachers trained in TIP are better equipped to support children from socioeconomically deprived communities who may also have faced some of the more usual ACEs such as physical, emotional or sexual abuse or neglect, witnessing domestic violence, parental divorce/separation, death of a parent or sibling, living with a person who has a mental illness, living with an abuser of alcohol or drugs and a parent or close family member being in prison.

However, the children of refugees and those seeking asylum as well as lone children, will have experienced a greater range and depth of adversity through living in countries where they have encountered conflict or oppression as they journeyed across borders and also in the country where they sought sanctuary (Wood et al, 2020, 'Adverse Experiences in child refugees and asylum-seeking populations', Public Health Wales NHS Trust).

Early years care and education settings can provide a constant in the lives of these young children and can function as a stable place in their lives. It is therefore imperative that employees are aware of the ACEs that children may have endured and that they receive training in TIP so that they can support all children in trauma to integrate, survive and thrive.

Recommendations:

- 6.1 The Government to revise and update the information available to local authorities, schools and early years settings concerning education provision and entitlement of children from refugee and migrant families; providing additional support for such families to navigate the admissions process and offering a free school meal to all such children regardless of the status of their family's application to remain
- 6.2 National and local governments and associated bodies to implement innovative solutions and disseminate existing best practice to address the consequences of periods of time in initial temporary accommodation for children in asylum-seeking families, as well as participation in the National Transfer Scheme
- 6.3 Better support and sufficient places to be created for children with Special Educational Needs and provision of a wider range of support and resources for pupils for whom English is an additional language
- 6.4 All EY settings to be required to have an Equality Policy to include building relationships with refugee parents; the presence of interpreters and the employment (where at all possible) of at least one assistant who speaks the language of the refugees
- 6.5 EY settings to prioritise the use of play as a core activity; producing a play strategy
- 6.6 Teachers and childcare professionals in EY settings to be trained in Trauma

Informed Practice (TIP) to enable them to use this to mitigate the effects of ACEs. EY settings should be encouraged to employ a play therapist who (in the interests of child protection) is registered through an independent government-approved agency such as the Professional Authority's Accredited Register Programme or the Health and Care Professions Council.

CHAPTER 7: MATTERS RELATING TO IMMUNISATION

An abundance of evidence demonstrates the importance of wide-scale childhood vaccination programmes to combat the potentially lethal impact of diseases such as measles.

Early immunisation reduces children's likelihood of catching and transmitting infectious diseases to other children and the wider community. Evidence also suggests that the earlier the vaccination, the greater the level of completion and coverage (PHE, 2021, 'National Immunisation Programme: healthy equity audit'):
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957670/immnstn-equity_AUDIT_v11.pdf

In addition to reducing infectious disease-instigated mortality, vaccination helps to prevent some disabilities, including those that impair children's growth and cognitive development (World Health Organisation (WHO), 2020, 'Immunization Agenda 2030: A global strategy to leave no one behind'):

<https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030>

Children who are protected by immunisation are also likely to remain longer in education and achieve higher scores in cognitive tests than those who are not immunised (WHO, as above).

Vaccines are therefore essential for surviving and flourishing throughout the life course.

During the 2019-2020 period, vaccination coverage statistics for England show an increase in childhood immunisations for all but one routine vaccination; thus largely in line with other OECD countries (OECD, 2019 'Child vaccination rates'):

<https://data.oecd.org/healthcare/child-vaccination-rates.htm>

However, uptake varies across the country; possibly indicating relatively lower levels within the most vulnerable communities.

41 Local Authorities (LAs) achieved 95% + coverage with 28 showing a rate below 95%; of which 20 (70%) were in London. The Public Health England (PHE) Health Equity Audit of the National Immunisation programme (2021, as above) found that:

- Vaccine coverage rates are lower among children with learning disabilities
- Vaccine coverage rates are lower among looked-after children
- Vaccine coverage is low among migrant communities and traveller populations such as Gypsy travellers
- Lower socioeconomic status is linked to lower vaccination coverage

- Vaccine coverage is typically lower among Black Caribbean, Somali, White Irish and White Polish populations than in children from groups identifying as White British or Southern Asian.

Gaps in vaccination coverage can increase the likelihood of infectious disease outbreak; necessitating the closure of early years settings.

The Covid-19 pandemic has demonstrated the devastating impact on attendance at early years settings of an infectious disease outbreak with children required to stay away in the interests of curtailing spread. A large body of evidence now shows that poor attendance at early years settings has a strong adverse impact on a child's development and overall readiness for school:

Public Health England, 2021, 'The impact of COVID-19 on London's children and young people':

<https://www.bacaph.org.uk/images/PDFs/The%20impact%20of%20COVID-19%20on%20London's%20CYP.pdf>

The Sutton Trust, 2020 'COVID-19 and Social Mobility Impact Brief - Early Years':

<https://www.suttontrust.com/our-research/coronavirus-impacts-early-years>

YouGov 2020 'Kindred-School Readiness':

<https://www.kindredsquared.org.uk/not-school-ready/>

Newham as a case study

Dr Farzana Hussain, GP Principal and Clinical Director for Newham Central 1 says:

'We want to make sure that the very youngest of our residents have the best chance of being healthy and avoid the consequences of diseases, which should only be read about in history books. Vaccines are our weapon to combat these illnesses but parents have to be proactive and ensure their children get vaccinated when they're meant to. It not only benefits our children but it also stops the spread of these diseases in our community – protecting other vulnerable community members.'

In December 2020, the Newham Public Health team conducted a series of interviews with partners across the immunisation system including primary care representatives (GPs, practice nurses, practice managers) midwifery, health visitors, school nurses, head teachers and the vaccination provider for the borough's school-aged children.

Analysis of the interviews indicated that current processes of administering routine childhood immunisations are not always sensitive to the needs of some families as shown by the sample below.

'We need to put up fewer barriers...a proof of address and proof of ID, we don't need that.'

'We need to work innovatively to reach those people who won't come to a GP because they are scared...'

'The leaflets and letters we give are in English only.'

'We invite them somewhere [to get vaccinated] ...they have no connection with us so not surprising they don't turn up.'

'My feeling was that we hadn't done enough to break down the barriers. The things we were sending out were wordy, complex and not easy to understand and so the messages are not getting through.'

'Some schools were sending consent forms out electronically and that leads to a very low uptake. Not every parent has a printer, email or access to the internet etc.'

'There is currently a big issue in terms of uptake. It isn't just about the pandemic and people bringing their children in. The timing and flexibility of appointments – Mon-Fri average working people are working at that time. A lot of practices don't offer weekend services, so offering more timeslots I think would encourage more people.'

'Every child should have a right to be registered with the GP. (The) current system is that an adult needs to be registered in order for the child to be registered, if they can't do this, then we lose the opportunity to immunise the child.'

The London Health Inequalities Strategy advocates addressing the wider determinants of health in order to reduce health inequalities (Greater London Authority, 2018, 'The London Health Inequalities Strategy'):

<https://www.london.gov.uk/what-we-do/health/london-health-inequalities-strategy> citing good access to population-wide preventative programmes such as immunisations as a major component. A 'whole systems' multidisciplinary approach is likely to achieve the best outcomes so that families are enabled to access immunisation-related support via a variety of entry points. Primary care (ie GP) is currently the most common of these but community-based settings offer another option.

As part of the national Early Years Healthy Development Review (HM Government, 2021, 'The Best Start for Life. A Vision for the 1,001 Critical Days', The Early Years Healthy Development Review Report':

<https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days>

Action areas 1 and 2 advocate 'seamless support for new families' and the development of 'a welcoming hub for families' as a 'place where parents can access Start for Life services'. For both it is essential to strengthen the role of community-based services within early years settings; including a closer integration of health and immunisation partners into these (and other) sources of provision for this age group.

Partners in Newham have already introduced immunisation clinics into some children's centres. Children's centres regularly host immunisation providers who rotate across early year's settings to administer the BCG vaccine within trusted environments that are attended by families.

The words 'trust' and 'local' define the Newham approach to supporting the borough's most vulnerable residents: ie local provision delivered in trusted community settings. Children's centres are ideal venues for the purpose:

'Immunisations are vitally important and the turn out for the clinics has been quite high and constantly high each time they are run from our site. (The) benefits are that families are often coming to a children's centre for the first time when they bring their baby for immunisations. This allows them to know where we are based in the local community and also allows us to share with them the sessions and services on offer to them locally.

I feel that as we are more of a community venue, we may appear less daunting to families when they attend, especially to families who may not have ventured out often due to Covid.

Also, as we start to reintroduce healthy baby clinics, families will feel more familiar with our site and (be) more likely to attend. We will also be the sites they are invited to when health [visiting teams] book in further developmental checks with the family. From September, we will be ensuring that our admin support is available when these clinics run so that we are also able to talk to and register the families for healthy start vitamins and allocate them their first Bookstart pack and ensure they have a copy of the East Ham neighbourhood time table.' (Oliver Thomas Nursery Schools and Children's Centre, London Borough of Newham).

This vaccination delivery model stimulates multi-agency working and broader ownership of the actions required to encourage and empower families to book in for routine childhood immunisations. By expanding the number of centres available for vaccine provision; embedding clinics in early years settings that families are already known to access and introducing sites into settings that families trust and with which they already have strong relationships, the availability, accessibility and acceptability of routine childhood immunisations should be increased.

Using early years settings as places to provide wider wrap-around support for families will enable children to grow, develop and flourish.

Childhood immunisation strategies are expected to continue their concentration upon increasing coverage.

However, the real emphasis should be on how this is best achieved. Community-based environments such as early years settings and family hubs as outlined in the Action areas of the Early Years Healthy Development Review can be an excellent addition to the historical GP surgery model in widening access to families and children. As the Newham case study has illustrated, utilising early years settings in the delivery of immunisation can help to lay the strong foundation needed to help a child to grow and flourish well into adult life.

Recommendations:

- 7.1 Early years settings such as family hubs and children's centres to receive accreditation and recommendation by national and local government as immunisation centres
- 7.2 National child immunisation campaign to be organised, focusing on 'trust', 'local' and 'accessible' and the role of Vaccine Minister to include setting goals and strategies for increasing take-up for childhood immunisations as well as Covid-specific initiatives
- 7.3 Early years settings to be subject to NHS audit for immunisation suitability and GP settings required to audit their own immunisation offer for accessibility and take-up potential cross-population
- 7.4 National compendium of 'good practice' to be used to issue immunisation guidance to all health and community centres offering an immunisation service so that they can produce their own 'take-up' campaign materials and modernise their practice in accordance with the needs and character of their local communities.

CHAPTER 8: EARLY YEARS SUPPORT AND FUNDING

'High quality, well-funded, prioritised early years education, particularly for the most disadvantaged, is crucial. The brain is most optimal for absorbing information from the age of 3 and good intervention then can impact on attainment – and thus employment and crime rates-in the long run', (Blandford S, 2019, 'Social Mobility, Chance or Choice?' interview with Natalie Perera, Education Policy Institute, 2018, Woodbridge: John Catt Education).

In 2017, the Social Mobility Commission report 'Time for Change' (2017, 'Time for Change: An Assessment of Government Policies on Social Mobility', 1997-2017, London: Social Mobility Commission):

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/622214/Time for Change report - An assessement of government policies on social mobility 1997-2017.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/622214/Time_for_Change_report_-_An_assessment_of_government_policies_on_social_mobility_1997-2017.pdf)

tracked the rise in child poverty and the way in which the attainment gap between disadvantaged and more affluent pupils extends during a child's time in statutory education. If this progression is maintained, it will be 15 years before all children are 'school-ready' by age 5 and over 40 years before the attainment gap between poor 5-year-olds and their better-off peers is closed.

High quality education in the early years is a prerequisite if the needs of vulnerable and disadvantaged children are to be addressed and early years education must be a priority for funding and government support.

The early years profession has argued persistently that increased support and funding is essential to attract and retain the necessary levels of skill and experience to nurture children's early development.

Despite this, UK expenditure on early years education and care for 0-2-year-olds is amongst the lowest of all 16 countries for which measures are available; at 0.1% of GDP (OECD, 2019, 'Education at a glance 2019'):

https://www.oecd.org/education/education-at-a-glance/EAG2019_CN_GBR.pdf

The UK is also the only OECD country (other than Japan) where private funds amount to over 40% of total expenditure on pre-primary education (International Standard Classification of Education 02). In the UK, most private funding is supplied by the household; in Japan the high cost of childcare is shared by households, foundations and the business sector.

In England, the value of the funding received by a setting is calculated on rate per-hour based on estimated number of hours of free childcare used in the local authority. However, due to a fluctuating use of childcare places consequent on the pandemic, concerns have been raised about the way in which funding is calculated (Crawford C and Farquharson C, 2021, 'Today's early years census likely to reduce government spending on childcare significantly', Institute for Fiscal Studies):

<https://ifs.org.uk/publications/15268>

and many providers are receiving inaccurate allocations of funding that no longer 'follows the child.'

A lack of funding is likely to be most acutely felt where provision and support for children is most needed; in particular, those with SEND.

Across the country, the Disability Access Fund (£615 per-child-per-annum) and Inclusion Funding can be given for children with emerging needs; also Inclusion Funding (set locally). For children with higher needs, application can be made for Education, Health and Care Plans (EHCP) which provide a higher level of funding. It is becoming more usual to see EHCPs in the early years, as local authorities recognise that early years' settings do skilled and vital work to afford SEND children very best start in life.

However, at present, the extra costs of support for children with SEND are being funded by nurseries themselves rather than using the Government funding streams that are available.

Unpublished research from the Early Years Alliance in January 2020 found that:

- 81% of settings had funded the costs of supporting children with SEND
- 41% were regularly funding support for SEND themselves
- 73% reported a rise in the number of children with SEND in the past 2 years.

In line with this, the number of Education, Health and Care Plan (EHCPs) nationwide has risen steadily since 2017 with the latest figures showing that 3.7% of children have an EHCP (an increase of over 10% in the past year alone):

<https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england>

The reasons given by settings for self-funding are the length of time that it has been proved to take to complete detailed funding applications; the lack of available funding for children aged under 2 years and the fact that some authorities have capped support at 15 hours although many parents are now entitled to access 30 hours.

The Local Government Authority has observed that high quality provision is essential in order to achieve the best outcomes for SEND children and that this is not funded effectively in the early years:

<https://www.local.gov.uk/publications/child-centred-recovery#covid-19-the-impact-on-children-young-people-and-families-and-our-immediate-recovery>

Currently children with SEND are clustered in maintained nurseries where there are higher funding levels and higher quality provision which suggests that in order for children with SEND to be afforded the best start in all nurseries, both the level of funding and the quality of provision must increase.

With increasing numbers of SEND children in the system and an ongoing need to fund that support themselves, settings have to choose between admitting children with SEND and their own financial sustainability. Without a funding model that works better for early year's settings, they will continue to pay for children with SEND out of their own pocket which puts major pressure on their finances and could even work as a disincentive to accepting children with SEND in mainstream early years settings.

For too long, the early years sector has been reliant on the commitment of its workforce to continue unabated, despite its lack of funding, and parity with a teaching profession that itself suggests is underfunded and underpaid.

The work of the early years is highly complex and specialised and needs appreciating, celebrating and validating via the support and funding that it attracts.

The link between higher quality provision, better outcomes for children and higher-level qualifications for practitioners has been well-established (Nutbrown C, 2012, 'Foundations for Quality', London Department for Education):

<https://www.gov.uk/government/publications/nutbrown-review-foundations-for-quality>

There is a clear demarcation in qualification levels between the school sector (predominantly providing for children aged 4-5 years and above) and the pre-school sector (predominantly providing for children aged 0-4 years). In 2018, the estimated number of practitioners in the Early Childhood Education and Care sector was 430,000 (Department for Education (DfE), 2018, 'Survey of Childcare and Early Years Providers: Main Summary, England'):

<https://www.gov.uk/government/statistics/childcare-and-early-years-providers-survey-2018>

With regard to degree-level qualifications, 37.1% of all female workers have a degree, compared to 92% of school teachers and 25.1% of practitioners in the early years sector. Over the past decade, those in the early years sector studying for a higher qualification has dropped from 22.7% to 14.9%.

It is generally agreed that professional and effective early years practitioners and high-quality early years settings are foundation-builders for children's futures and best placed to close the disadvantage gap, drive social mobility and provide real choices for children.

In 2018, the Government dropped proposals to grow the early years graduate workforce in disadvantaged areas (Gault C, 2018, 'Government scraps early years workforce strategy's graduates' plans, Nursery World, 19 July 2018):

<https://www.nurseryworld.co.uk/news/article/government-scraps-early-years-workforce-strategy-s-graduate-plans>

In order to banish disparity based on socioeconomic advantage, it would make sense to have more children in disadvantaged areas than in advantaged areas who are accessing high-quality provision.

The impact of low pay within the sector is significant with 44.5% of the workforce claiming benefits/tax credits in order to manage financially (Bonetti S, 2019, 'The Early Years Workforce in England', Education Policy Institute):

<https://epi.org.uk/publications-and-research/the-early-years-workforce-in-england>

The private sector relies heavily on the early years workforce, employing approximately 80% of practitioners and the qualification level of those who work with children aged 0-4 years is often lower than that of those who work with school-age children. In the private sector, there is also often less job security, contracts with variable hours and fewer development and career progression opportunities (Bonetti, as above).

An early years' sector fulfilling its function by providing the best foundation from which to launch a life-course, will be one that is highly qualified, stable and valued as demonstrated by its working conditions, remuneration and the public esteem in which it is held. In 2004, the then Government recognised that for this sector, 'a first-class workforce is fundamental', (Department for Education and Skills, DfES, 2004a, 'The Effective Provision of Pre-School Education EPPE Project':

<https://discovery.ucl.ac.uk/id/eprint/10005309>

and DfES 2004b 'The Ten-Year Strategy Choice for Parents, the Best Start for Children'):

https://dera.ioe.ac.uk/5274/2/02_12_04_pbr04childcare_480-1.pdf

The ethos of these documents; that working with pre-school children should have as much status as teaching in schools and be professionally led; thereby affording higher quality places and greater choice for parents remains true today – as does the need to act on it.

Scotland

The Scottish Government acknowledges that the early years sector has fallen behind and in August 2021, First Minister, Nicola Sturgeon announced a much-awaited expansion of Early Learning and Childcare (ELC):

'All children deserve the best start in life. Providing access to free, high quality early learning and child care enriches children's early years and provides them with skills and

confidence for starting school and beyond. It also supports parents' ability to work, train or study.'

The legislation provides for families across Scotland to benefit from 1,140 hours per year of free ELC, funded by the Scottish Government and local authorities. Authorities are encouraged to promote flexibility and choice for parents. Up to around 130,000 children can benefit, saving families childcare costs of around £5,000 per child each year. The blended model of free ELC amounts to approximately 30 hours per week if used during school term time or 22 hours per year if used all year round. The intention is that the 1,140 hours can be used flexibly as appropriate on a mix of provision.

Funded provision in the private and voluntary sectors and childminders encompasses nearly a third of all funded provision. Being able to access a rich combination of ELC environments may benefit disadvantaged children most; however, the perpetual challenge of providing capacity at all times and places that parents need, will mean that not every family will have the choice of provision that suits them best.

Quality is described as the 'golden thread' at the heart of the ELC (The Scottish Government, 'Expansion of Early Learning and Childcare in Scotland', October 2017) with a high-quality workforce considered to be the single most important driver for a child's ELC experience. To achieve this, the Scottish Government has invested in a workforce development programme with Continuous Professional Learning (CPL) as an essential component of ELC quality (Scottish Government, 2017, as above).

Education Scotland's national practice resource also increases expectations of high quality and provides support for all who work in the early years sector:

'We know how babies and children learn best. They learn best in an environment of quality interactions, interesting spaces and when the experiences on offer are set in meaningful contexts. They learn best in environments that inspire them to be curious and creative' (Education Scotland, 'Realising the Ambition: Being Me', 2020).

To support a whole school approach to excellence in ELC and school settings, play Scotland has developed a Playful Pedagogy Toolkit and is piloting a Play Pedagogy Award for schools and teachers (Play Scotland, 2020).

Recommendations:

- 8.1 Government to re-evaluate existing provision of Sure Start/Children's Centres and new provision such as Family Hubs guaranteeing that 1) services provide for the needs of all children 2) services maximise the engagement of all parents and carers and 3) decline in number and coverage of these services is reversed, especially in areas of disadvantage
- 8.2 Raise UK expenditure on early education and care for children aged 0-2 years in line with the highest spending of the 16 OECD countries for which measures are available
- 8.3 Government to re-affirm the 2004 recognition that 'a first-class workforce is

fundamental' to excellent early years provision and release its comprehensive strategy to raise the entry qualification level, providing a training fund and ensure access to ongoing professional development in all settings with published remuneration scales to benefit a professional workforce

- 8.4 Review SEND funding processes, ensuring that application processes are simpler; hours taken to fill in forms are funded; funding is available for the full 30 hours and available to the under 2 SEND age group
- 8.5 Provide funding to enable settings to release staff for training in SEND and inclusion strategies
- 8.6 Ring fence high needs block funding to ensure that budget is available for children with SEND in the early years and investment is made in the right kind of support regardless of whether the child is nearing school age or not.

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