A response to the call for evidence from the Department of Health and Social Care

Early years healthy development review

The British Dietetic Association (BDA) is the professional association for dietitians and strives to improve the health of the nation by supporting our members to promote good food and nutrition. Dietitians and the wider dietetic workforce believe in the importance of health to the success and development of our communities.

The BDA Paediatric specialist group bring together paediatric dietitians from across the UK, promotes paediatric dietetic education at undergraduate and post graduate levels and serves as a resource for dietitians and other health professionals.

The BDA Maternal and Fertility Nutrition specialist group represents dietitians with a specialist role or interest in maternal health and nutrition, pregnancy and female and male fertility.

These specialist groups have responded jointly to the current call for evidence by addressing the questions outlined in the questionnaire.

What outcomes do you think are most important for an early years vision?

The vision should address the following key issues:

- Increasing breastfeeding rates (especially during 0-6 months) to help support infant nutrition, health, growth and development and maternal health.
- Establishing healthy diet in preschool children.
- Reducing the rate of childhood obesity (initial targeting infant feeding and including complementary feeding, diet and physical activity in the early years setting).
- Considering the use of varied communication styles: digital media, face to face workshops and community centres to educate, identify maternal barriers and understand their motivations to drive behaviour change.
- Improving supplement uptake (vitamin D).
- Improving dietary habits during complementary feeding and first years of life.
- Reducing the risk of under-nutrition and growth faltering.

Informed and supported choice

Improved access to evidence-based resources that help to promote the benefits of breastfeeding and provide advice on appropriate, safe formula feeding for mothers choosing not to breastfeed their infant, or in whom breastfeeding is contraindicated.

In the UK 32-39% of women stop breastfeeding by six weeks. To promote breastfeeding which will ultimately benefit baby and potentially childhood obesity, during pregnancy, offer parents breastfeeding workshops to highlight the immediate benefits to both mother and baby (e.g. baby's immunity, reduced hospital admission secondary to gastrointestinal infection (three studies) and neurodevelopment (IQ scores). This evidence is not promoted or publicised enough.

Maternal benefits as a result of breastfeeding uptake include reduced risk of maternal cancer and endometriosis, greater postpartum weight loss & lower BMI.

If more women were to breastfeed evidence indicates that there is reduced respiratory morbidity, diarrhoea and vomiting in babies: 0.72 (95% CI 0.58 to 0.89), 0.43 (95% CI 0.03 to 0.61) and 0.60 (95% CI 0.39 to 0.92), respectively (Fisk et al., 2011).

Workshops need to be delivered and led by dietitians or midwives to address reasons why women stop breastfeeding. Note that the 2010 Infant feeding survey (*McAndrew et al, 2012)* highlighted reasons why women stop breastfeeding:

- Infant too hungry/demanding
- Inconvenient/formula more convenient
- Found breastfeeding exhausting/too difficult
- Had little or no support

Workshops or education sessions should address the above issues, myths and offer a support strategy (helplines/access to trained breastfeeding staff or drop-in clinics when things go wrong during breastfeeding) with strategies to increase engagement and uptake. These sessions should run frequently, weekly so that as many women interested in breastfeeding can access.

Note that breastfeeding mothers are also more likely to follow national guidelines for complementary feeding.

Cover techniques for bottle feeding e.g. responsive feeding, correct ways of positioning bottles when feeding.

Clarification on complementary feeding/portion sizes/how to feed infants. Infants exceed EAR for energy. In 2013, 75% of children surveyed of age 4-18 months had parent-reported intakes >EAR for energy (SACN, 2018).

Having time off from school, work for prospective parents and children to access services. Co-ordinating services is really important to enable this too. Having an appropriately trained dietitian co-located with other HCPs could be a way of reducing time off required if women/infants/children require support.

Measurable outcomes

The BDA feel this is very important and that national surveys are essential for monitoring early years heathy development. This should include the reinstatement of the national infant feeding survey using a nationally representative sample to monitor trends in breastfeeding initiation, exclusive breastfeeding, complementary feeding, vitamin D supplementation.

There is also potential for digitisation of routine nutritional information recording in infants: https://pubmed.ncbi.nlm.nih.gov/31100804/

Weight management. Targets to reduce obesity prevalence need to be set. These can be based on NCMP data for England. Scotland, Wales and NI have separate data and guidelines.

Targeted actions

The BDA feels strongly that this review should ensure that support targets those families in most need as a priority.

A holistic approach should encompass Non-didactic, involving families in the co-creation of interventions. Joined up advice and a consistent approach should exist across healthcare professional groups. Ensuring that consistent messages are relayed and that all opportunities are taken (e.g. vitamin D advice antenatally) across dietitian, midwife, health visitor interactions.

Integrated services and pathways must follow NICE guidelines and build on them to accommodate local needs. A flexible regional, national, local approach will help to ensure that interventions encourage engagement and consider the best settings for families (e.g. home visits, remote consultations, children's' centres).

Reliable, accessible with timely nutrition and weight management services pre and during pregnancy are essential to protect the health of mother and child. Pre-conceptual advice is most important to maximise likelihood that mothers enter pregnancy at a healthy weight and with good nutritional status

Improved awareness across healthcare professionals through shared learning across professions, reinforced by integrated training. Wider collaborations are required across the professions.

It is unlikely that there are never going to be enough dietitians to see every pregnant woman and child, therefore, we need to have access to high quality up to date evidence-based training and advice across all disciplines involved.

Clinical policies of different organisations employing these staff need to be shared and patient pathways agreed. Often different organisations are employing staff involved in early years.

Better co-ordination is key to ensure that information is not confusing for families.

How do your families prefer to access services, help and advice?

During pregnancy, access to weight management services is often poor and where services are available, they often report poor attendance/engagement (Atkinson et al., 2013). Patient and Public involvement work regarding weight management services for pregnant women found that women preferred to receive this advice from their midwife during antenatal clinics; they did not want referrals to specialist services (Abayomi et al 2020). Atkinson et al., (2013) found that many overweight pregnant women declined or failed to engage with weight management services; poor/no explanation of referral and/or a perception that the service would not meet their need were cited as the main reasons for this.

Families prefer to access services using a combination of methods including via phone, chat to health (texting service run by health visitors), video, and face to face (breastfeeding support run using a combination of these). In some local areas (such as Leicester) access to phone and video provides language interpreters which helps support.

There are also other factors which need to be considered in relation to access:

- Language barriers
- A lack of transport- poor integration and frequency, as well as affordability.
- Limited internet or phone access for digital support
- Literacy and numeracy can be a really hard factor for some families. We need to ensure that resources meet a diversity of needs.
- Time off to attend appointments from school or work can be really challenging

Enabled care challenges - How does digital work on a day to day basis?

Digital working is very often reliant on parents accurately reporting. Many parents may not have scales or other equipment, struggle to read numbers or readings or simply don't know whether to put the digital point in the right place.

HCPs require training on topics such as appropriate foods for different ethnic groups, cooking methods and supporting low-income groups if nutrition messages are to be well received across target communities.

Digital working can work well but it is yet to proven to be an effective substitute for face to face clinics. Its success will require multiple platforms to reach a wider audience and to adapt to various learning styles. Visual, audio and written materials (e.g. guides and resources written by dietitians/registered nutritionists that health care visitors can share) can be repurposed and made available via the NHS website, Youtube or Google.

Data sharing

Specific services need to be properly aligned and integrated with online digital support.

There is huge scope for more investment in NHS IT and digital support. Many parents who do not speak English as a first language respond well to short videos that they can easily access from their mobile phones.

Online interventions to improve lifestyle behaviours have been successful (Wen et al., 2017) and could be piloted more actively in the UK.

Poverty, health inequalities and unequal access

There is clearly a need for a wider understanding and better focus beyond those who are unwell or with an immediate care need. Early years support should be for communities, not just specific individuals within them. More work is needed in providing better breastfeeding support, tackling obesity and obesity prevention.

Where is there most scope to improve services and help?

Antenatal Care Guidelines (NICE 2017) state that midwives should discuss nutrition, diet and vitamin supplementation at booking-in appointments. Patient and Public involvement work with midwives and pregnant women reports that women want to receive advice from midwives (Abayomi et al 2020) and midwives acknowledge that this is a key aspect of their role (McCann et al 2018); however, both studies report a lack of skills and knowledge in this area, for midwives to effectively support women. Midwives report receiving no updates or training regarding nutrition and/or weight management and admit that they probably spend the least amount of time discussing nutrition during ante natal appointments (McCann et al 2018). Other research reveals that midwives score low for nutritional knowledge and that they do not feel confident offering advice about nutrition; particularly when women are overweight (Mulliner et al., 1995; Olander et al., 2011).

To be able to close this knowledge gap, midwives need to be taught about nutrition by nutrition experts (i.e. dietitians); this would also help to raise the profile of nutrition as a specialist, key aspect of antenatal care.

Weight management

Prevention is the most effective strategy for management of childhood weight (Brown et al., 2019). However, there is a lack of tier 1 and 2 weight management services in the UK as a whole.

Interventions should begin early and take a life course approach. Evidence suggests lifestyle interventions during pregnancy have little impact on modifying obesity risk in the infant (2017). However, preventing excessive weight gain in pregnancy can protect the health of the mother and child (reduced gestational weight gain and hypertension)(Muktabhant et al., 2015). Subsequent offspring may benefit from lifestyle intervention in previous pregnancies. This suggests lifestyle interventions in pregnancy should start pre-conceptually.

Knowledge of a healthy lifestyle should be included in school curricula. Education on appropriate lifestyle can help reduce the risk of excessive gestational weight gain and support health of mother and infant. Mothers to be need access to ante natal support services. To ensure this, dietitians should be funded to provide ante natal advice for diet preconceptually and during pregnancy.

Support for mothers to breastfeed, i.e. lactation counsellors, health visitors is currently inadequate. Urgent intervention essential to improve breastfeeding rates. Breastfeeding is protective against the development of overweight, yet in the UK only a small percentage of women breastfeed their infants beyond 6 weeks (Arenz et al., 2004). Reasons for this are unclear but a cultural change needed in the UK where breastfeeding rates are among the lowest in Europe.

Optimum nutrition

Nutrition is central to healthy growth and development. Breastfeeding is protective against overweight and obesity development and provides numerous other benefits for mother and child (Singhal and Lanigan, 2007). The complementary feeding period is key to establishing a healthy diet. Dietary patterns established here persist into adult life. Access to education and resources to support appropriate complementary feeding is essential to reduce the risk of rapid weight gain and help achieve a healthy dietary pattern. High protein intake is strongly linked to increased obesity risk (J Lanigan, 2017). Protein increases markedly during the CF period. Interventions are needed to help parents establish healthy dietary patterns in young children (Lanigan, 2018).

The sugar reformulation scheme has shown reduction in sugar in yoghurts but not in chocolate confectionary and puddings *(see PHE Report on progress between 2015 and 2019).* Yoghurts are a useful source of calcium for children and some contain beneficial bacteria, which have an important role in gut health. Consider including yoghurt as part of the approved snack choices for children even if sweetened (and define an appropriate upper cut-off for sugar (per 100g) in fruit flavoured yoghurts).

Nutrition knowledge of midwives and other health professional

Training in nutrition for HCPs is limited. It is not in the curricula for medics or nurses who rely on non-NHS training, often supported by industry. This is becoming less available due to the unclear landscape regarding interactions between HCPs and manufacturers of nutritional products for use in the care of infants and children.

Publicly funded training would help to bridge this gap[1].

Breastfeeding support

Breastfeeding is protective against overweight and obesity development and provides numerous other benefits for mother and child (Singhal and Lanigan, 2007). More support is needed to encourage mothers to breastfeed for as long as they wish but at least for the first 4-6 months.

Improved training for early years staff and of specific providers needs to be addressed. External companies for childcare providers need access to accredited high-quality training.

Consecutive national Nutrition Survey report children are not meeting recommendation for 5+ servings of fruits and vegetables a day. Consider making it mandatory for nurseries to provide two servings of fruit and 3 of vegetables a day for children attending full-time day care.

Guidelines for outdoor play could be reconsidered so that children meet their daily recommendations of 180 minutes of activity per day. Some nurseries are very limited by space and only have very small outdoor play areas.

The short-term investment and disinvestment in services and projects is counterproductive. If services are going to be put in place, there needs to be sustainable and considered for the longer term (such as minimum three-year contracts).

What are the most common barriers to developing your offer to families, particularly those with higher needs?

Funding.

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[1] BDA is already supporting some work in this area: https://www.associationfornutrition.org/latest-news/consultation-on-nutrition-in-ug-medical-education and https://www.nnedpro.org.uk/

Access to dietitians in antenatal/pre-conception care is a barrier; there are few dietitians who specialise in this area. In situations where there are long waiting lists to access dietitians, the window of opportunity (i.e. during pregnancy) is often missed.

For pregnancy weight management services, referral criteria is often set at BMI > 40 kg/m^2; whilst NICE considers a BMI > 30 kg/m^2 to impart additional risk to pregnancy. Pregnant women with BMI > 30 kg/m^2 are at risk of excessive gestational weight gain, alongside increased risk of pregnancy complications; yet may be unable to access services (Narayanan et al., 2016).

Funding to health visiting services has been cut which has had a negative impact on families, as dietitian's we are seeing more cases of toddler obesity coming through, which could have been nipped in the bud if there had been more health visitor support.

Cuts to sure start children centres have greatly reduced access to early years' interventions.

NICE recommends lifestyle interventions as the first line intervention for weight management in children. However, these are not widely available. Children's centres (CCs) were set up in areas where families with young children could easily access a wide range of services including midwifery, health visiting, nutrition, activity classes etc. Their reduction has directly affected children and families with the most socially disadvantaged worst affected.

Lifestyle interventions for families with young children that have evidence to show they are effective at reducing health risks and improving outcomes are urgently needed. These are rare in the UK and not widely commissioned, e.g. Planet Munch, Healthy Lifestyle Programme for Preshool Children delivered by dietetically led TrimTots CIC (Lanigan et al., 2013).

In addition, partnership working can be of benefit. However, this can also hamper access to funds. Many services for families are provided by small to medium enterprises (SMEs). These businesses often have limited funds that prevent their participation in grant consortia.

Funding to deliver training to non-nutrition professionals (AHPs ,nurses, medics) has been cut over the years. Reinstatement of these services is essential to meet training needs, as well as ensuring protected time for dietitians to help meet these needs.

Other common barriers include governance across multi-disciplinary working, varied reporting systems, ensuring effective safeguarding is in place, information & data sharing compliance (GDPR) and working across integrating IT systems.

Service evaluation is hampered by demands on HCPs time. It is essential that feasible and effective interventions that can prove a cost benefit are widely available. Proposed interventions should undergo service evaluation and ideally, rigorous evaluation. Researchers invest considerable sums in developing and evaluating interventions that may not be taken up by commissioners due to financial constraints. Economic analysis essential.

There is a lack of investment in NHS IT systems.

> ***Specific example:*** *'We all have laptops > 6 years of age and work phones > 2 years of age. Would love to be developing videos and other resources for families but the NHS IT systems are unable to cope, have outdated software and there is a general lack of IT support within the NHS' (Direct quote from BDA member).*

Make training available for HCPs on how to develop digital teaching resources e.g. content creation – videos/audio-podcast/e-guides and resources for families to access in a central location e.g. NHS website with reference to registered nutrition groups so that it's clearer to families on who to seek for expert advice in paediatrics.

Awareness of services to refer to. Professionals need to keep up with the many changes in the healthcare landscape. It is often really confusing to know what exists.

> ***Specific example: '****Our Birmingham Community Dietetic Service is so stretched so we do not advertise for referrals. Pregnancy and infant-related interventions are time-limited so it cannot develop a waiting list! Also really hard to recruit dietitians to work in this area. Much improved workforce planning is needed to train enough dietetic staff'(Direct quote from BDA member)..*

What else would help develop 'excellence' in early years healthy development?

Primarily, we would like to see a model that improves joint working across public health teams and maternal dietitians across their communities. Increased maternal dietitian presence and timely interventions will help to ensure good nutrition in the first 1000 days window.

Weight monitoring during pregnancy is important with currently pregnant women only routinely weighed at their initial appointment. Abayomi et al., (2020) found that women were open to weight monitoring if it was conducted sensitively & 'with a purpose'.

A focus on the quality of diet in pregnancy, rather than focusing on energy intake and weight gain. Health professionals, especially midwives will need more in-depth knowledge of nutrition to allow this.

Improved access to dietitians at antenatal clinics or complementing dietetic services with registered nutritionists to deliver healthy eating messages.

Useful conversations about diet and weight gain before & during pregnancy, again health professionals, especially midwives will need more in-depth knowledge of nutrition to allow this.

Upskilling GPs & midwives regarding weight/nutrition knowledge; during undergraduate education, plus regular updates after qualifying. Education should be delivered by nutrition experts; raising the profile of nutrition and allowing recognition that nutrition is a highly specialised, key aspect of patient care.

Co-creation of interventions could increase the likelihood of engagement and promote joint initiatives between public, private and voluntary sectors.

We need to ensure that we all work to agreed outcomes and that these are accompanied by rigorous evaluation.

Improved and longer-term community breastfeeding support is essential. A cultural change is needed in the UK to help improve breastfeeding rates. We should consider increased use of peer support and raising funding levels to children's' centres and community groups who are key to providing these services (e.g. Best Beginnings).

Working with NHS Trusts and fellow organisations on common business case applications will also help to share case studies, developing pathways, outcomes and good practice.

> **Specific example 1:** '*In Leicester, Leicestershire and Rutland we have an Infant Feeding Team (specially trained health visitors) who run breastfeeding training sessions for dietitians and health visitors with annual updates. They have close links with the hospital infant feeding coordinator. They also run quarterly infant feeding updates for dietitians, health visitors, public health professionals, breastfeeding peer supporters and early years. Dietitians in Leicester, Leicestershire and Rutland work closely with members of the infant feeding team to deliver health visitor nutritional training 1-2 times a year. This training has always been well received and evaluated' (Direct quote from BDA member)..*
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> **Specific example 2: '***Birmingham previously had links with Infant Feeding co-ordinators and community midwifery to allow for targeted referrals but this was all stopped with decommissioned*

services. We had a dietitian co-located in a Health Visitor clinic which was well-received by staff and targeted many clinical areas, eg breastfeeding, weaning, post-partum weight management. It meant that families could easily be referred and reduced barriers. This also allowed for 'on the job' training and professionals learned a lot from each other. However as this was only funded short term the dietitian chose a permanent role and this was subsequently decommissioned. (this is an example of excellence that didn't continue!)' (Direct quote from BDA member).

Improved adherence to prenatal supplementation inclusive of higher folate amongst high-risk groups is very important and ill require active health promotion and targeted intervention.

Early intervention for Preventing Gestational Diabetes

Healthy lifestyle interventions across the life course are effective in prevention of obesity. Obesity is a key risk factor for diabetes. In the USA the Community Preventive Services Task Force (CPSTF) recommends lifestyle interventions delivered during the first two trimesters of pregnancy to reduce the risk of gestational diabetes. The CPSTF found:

- Strong evidence of effectiveness for lifestyle interventions that provide supervised exercise classes, either alone or in combination with other components
- Sufficient evidence of effectiveness for lifestyle interventions that provide education and counselling for diet or physical activity, diet activities, or a combination of these components

Collated by Julie Lanigan Ph.D. RD MBDA on behalf of the BDA Paediatric & Maternal and Fertility Specialist Groups and compiled by James Sandy, Policy Officer (England).

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