# Early Years (0-4 years)

## Chapter 3

## 1. Introduction

A child's experience during the early years is critical to their physical, cognitive and social development. During this development phase the groundwork is laid for the rest of the child's life. During the early years it is important that every child has the optimum conditions for success. According to Marmot (2010) and Allen (2011), this period of life influences school readiness, educational attainment, economic participation and long term health. During these years important milestones and tasks for children's physical development, social and emotional development and language and cognitive development occur[1].

Evidence shows that poor development in the early years frequently results in continuing cycles of poverty and deprivation throughout life[2]. The Marmot review of health inequalities[3] provides evidence of the long-lasting effects of child poverty leading to lower life expectancy and poor health outcomes as an adult.

During the early years there are a variety of factors that are important for long term health and wellbeing. Breastfeeding is a key determinant of health for both the child and the mother. Nutrition behaviours and habits are established during the early years and are likely to influence eating patterns into adulthood. Deprivation plays a role in dental decay which is a largely preventable burden on children. Many of the issues facing young children are influenced to some degree by deprivation.

## 2. Who is at Risk, and Why

The main risk factors that can adversely affect longer term health and wellbeing outcomes for children aged 0-4 years are as follows[1,4,5,6,7,8,9].

Deprivation: Poor social and economic circumstances affect health and wellbeing throughout life. Death rates amongst 0-4 year olds from families with 'manual' or routine occupations are three times higher than children from families with occupations 'classed as 'managerial' or

[1] Barlow J and Blair M (2012).. Life stage: early years. Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays. Available at: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

2 Field, F. (2010) "The Foundation Years: preventing poor children becoming poor adults - The report of the Independent Review on Poverty and Life Chances", HM Government http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk

3 Marmot, M. (2008), "Review of Health Inequalities – Fair Society, Healthy Lives", Institute of Health Equity http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

4http://www.barnardos.org.uk/what_we_do/our_work/child_poverty/child_poverty_what_is_poverty/child_poverty_statistics_facts.htm

5 Watt, R. & Sheiham, A. (1999) "Inequalities in oral health: a review of the evidence and recommendations for action", British Dental Journal Jul 10; 187(1):6-12

6 Nuttall, N. & Harker, R. (2004) "Impact of Oral Health: Children's Dental Health in the United Kingdom, 2003"

7 Clarke, M. & Et al. (2006) "Malnourishment in a population of young children with severe early childhood caries", Paediatr. Dent. 28, 254–259

8 Child and adolescent mental health: A guide for healthcare professionals (2006) BMA Board of Science http://www.familieslink.co.uk/download/jan07/ChildAdolescentMentalHealth%202006.pdf

9 Feinstein, L. "How early can we predict future educational achievement? Very early?" Centrepiece (2003) http://cep.lse.ac.uk/pubs/download/CP146.pdf

'professional'. Child poverty is also a significant barrier to improving outcomes for children (e.g. chronic illness and infant mortality).

Ethnicity: There is a complex interplay of factors affecting health and wellbeing in some minority ethnic communities in the UK.

Area of residence: Children living in urban areas can have higher rates of emergency hospital admission compared to those in rural areas.

Obesity: Obese and overweight children are more likely to become obese adults. They also have a higher risk of morbidity, disability and premature mortality in adulthood.

Readiness for school: The development score a child attains at age 22 months has been found to accurately predict their educational outcomes at age 26 years. These educational outcomes are related to long-term health outcomes and are a major contributing factor to patterns of social mobility.

Lifestyle: Parental lifestyle choices such as smoking, alcohol and substance misuse can negatively affect children's health in different ways.

Parenting: Poor parenting can have a detrimental effect on a child's early development of cognitive skills, emotional wellbeing, social competence, physical and mental health.

## 3. Summary

### 3.1 Population Profile

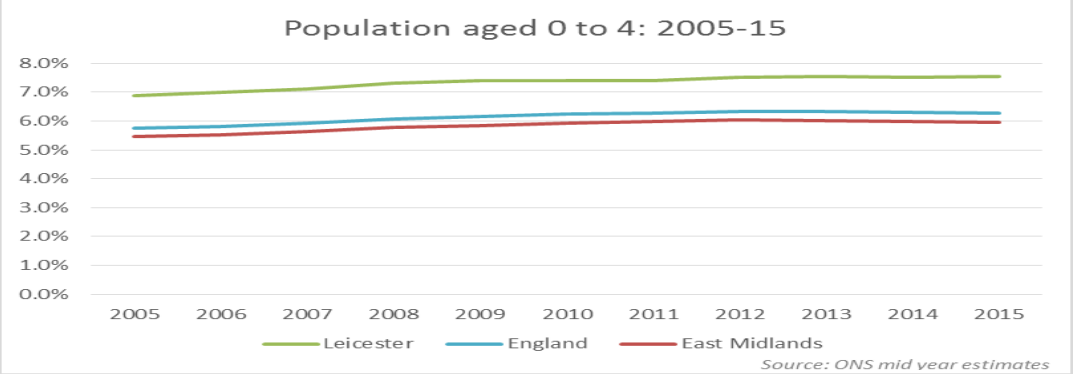
The population of children in Leicester who are aged 0 to 4 years old is detailed in this section.

Children aged 0-4 years old living in Leicester made up 7.6% (25,884) of the total population in 2015. This is significantly greater than the East Midlands and England averages.

There is a larger proportion of males in Leicester's 0 to 4 years population compared to females (51% and 49%, respectively).

There has been a faster growth in the proportion of 0-4 year old children in Leicester when compared against the East Midlands and England (Figure 1).

**Figure 1: Population trend for 0-4 year olds (2005-2015)**

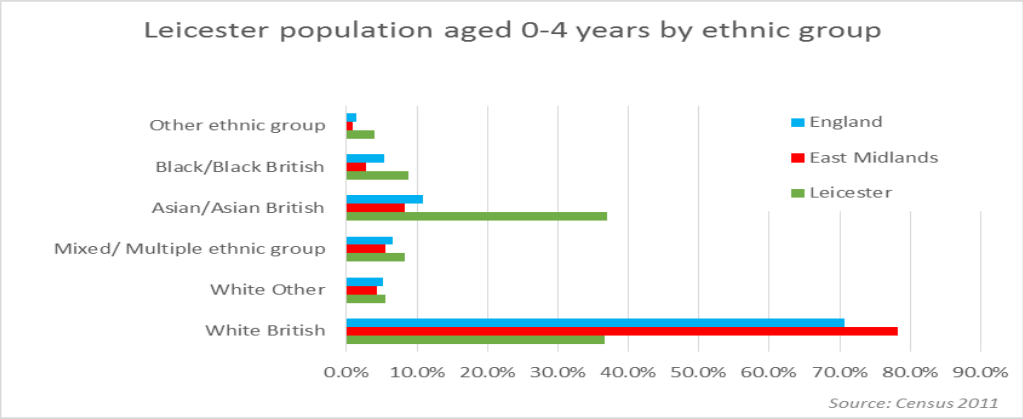


### 4.3.2 Ethnicity

Leicester is a diverse city with Black Minority Ethnic (BME) and White ethnic groups each comprising 49.5% of the whole local population.

The proportions of the different ethnic groups of the 0-4 years old population in Leicester are shown in Figure 2. Asian/Asian British children aged 0 to 4 years constitute a significantly larger proportion (36.9%) of this age group compared to the East Midlands (8.3%) and England (10.8%) averages.

**Figure 2: Leicester's 0 to 4 years old population by ethnic group (2011)**




## 1. The level of need in the population

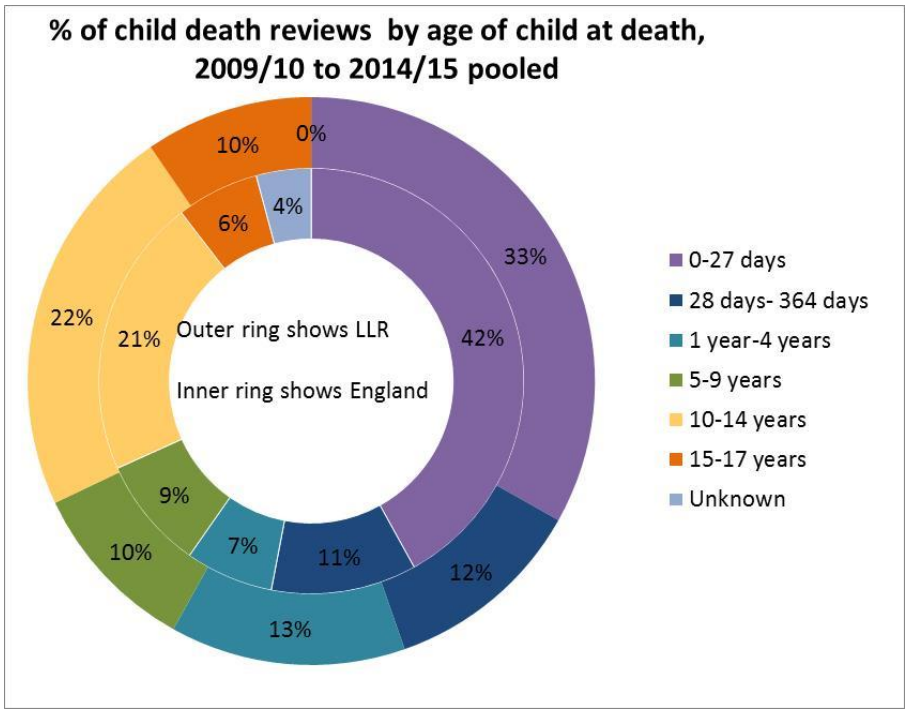
### 4.1 Outcomes

#### 4.1.1 Child Mortality

For information regarding 'infant mortality' (deaths of infants from birth to the age of 1) please refer to the 'Pre-birth to antenatal' chapter.

The Child Death Overview Panel (CDOP) for Leicester, Leicestershire and Rutland undertook a thorough review of cases reported to them between 2009/10 and 2014/15. Due to small numbers of child deaths, it is not possible to separate Leicester for every aspect of the report.

**Figure 3: CDOP Child Death Reviews by Age, 2009/10 to 2014/15**




CDOP found that children aged 1 to 4 years contributed 13% of all child deaths between 2009/10 and 2014/15. This is significantly more deaths in this age group when compared to England (7%).

The detailed findings of that review may be found here http://lrsb.org.uk/uploads/llr-child-death-review-analysis.pdf. Continued to monitoring and taking action to reduce child deaths through the City's Safeguarding Children's Board will remain a priority.

### 4.1.2 Healthy Weight and Nutrition

During the early years a child's diet and physical activity are determinants for short and long term health and wellbeing. Nutrition and dietary behaviours and habits are established during the early years and are likely to influence eating patterns into adulthood. Local data about diet and obesity are covered in the next chapter which assesses how healthy weight patterns change through the primary school years.

Breastfeeding and deprivation are key determinants of health for both the child and the mother. Breastfeeding can help reduce some inequalities between the least and most deprived children.

#### *4.1.2.1 Breastfeeding*

Breastfeeding is a key early intervention that improves the health of infants and mothers. Current UK policy is to promote feeding only breastmilk for the first 6 months before gradually introducing a more varied diet.

The risk of illness during infancy and childhood are reduced for breastfed babies. Breastfed babies are at a lower risk for gastrointestinal infections, SIDS, ear infections and insulin-dependent diabetes.

With respect to maternal health, breastfeeding confers benefits in re-gaining their pre-pregnancy weight and protection against certain types of cancer. Mothers who breastfed also have a lower risk of breast cancer and ovarian cancer.

By increasing breastfeeding rates in lower socioeconomic groups, some inequalities between the least and most deprived can be reduced. For example, breastfed babies born into lower socioeconomic groups have better health outcomes than formula fed infants born into higher socioeconomic groups.[10]

Breastfeeding levels are reported at initiation and at 6 to 8 weeks after giving birth. Breastfeeding initiation is assessed as the proportion of babies who are put to the breast compared to the total of babies born during a specified period. It measures the proportion of babies who received colostrum; the first milk produced during pregnancy. It does not measure the proportion of babies for whom breastfeeding has been established. Current levels in England are amongst the lowest in Europe.

The proportion of women in Leicester initiating breastfeeding at time of delivery is better than the England average, but the areas with the highest level of deprivation have the lowest rates of breastfeeding initiation. National data for 2014/15 show the breastfeeding initiation rate in Leicester was 76.9% which was significantly higher than the England average of 74.3%.[11] Lower rates of breastfeeding initiation are found in areas of greatest deprivation in Leicester.

Breastfeeding rates at 6 to 8 weeks after birth in Leicester are reported as 62.1%. This is significantly higher than the England average (43.8%).[12]

### 4.1.3 Injuries

Intentional injuries are a major cause of morbidity and mortality during the early years of life. Intentional injuries have increased in the UK over the last 10 years which is linked to violence and stress in society. For example, high levels of domestic conflict, lack of basic resources and unemployment contribute to an increase in abuse. Such incidents can negatively impact the health and wellbeing of both the child and the family.

Leicester has a rate of 78.7 per 1000 children aged 0 to 4 years (2014/15) who are admitted to hospital due to accidental and deliberate injuries. This rate is significantly lower than the England average.

### 4.1.4 Oral Health

Dental decay for young children in Leicester is significantly higher than the average for England. In addition to the risk of dental diseases for the general population of children, children taken into the care system are at an increased risk of poor dental health.

Long-term dental disease can result in severe acute and chronic infection. For young children whose milk teeth are affected, dental disease may also cause damage and consequential loss to the underlying permanent teeth. Additionally, older children with dental disease are also at risk of losing

[10] Forsyth S (2004). *Influence of infant feeding practice on health inequalities during childhood.*

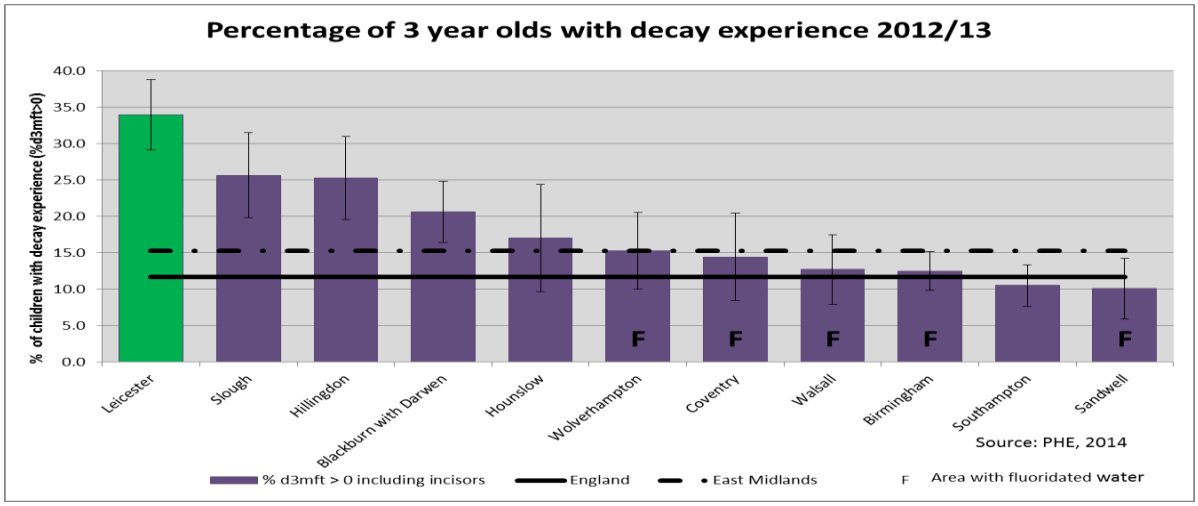
[11] There is a discrepancy in the data, as the local provider indicates that Leicester's breastfeeding rates for 2014/15 was 74.8%.

[12] NHS England Statistical Release: Breastfeeding Initiation & Breastfeeding Prevalence 6-8 weeks, 2014/15

their permanent/adult teeth due to extensive dental decay. Treatment of extensive symptomatic disease, both with and without general anaesthesia, which may distress the child has risks for morbidity and mortality[13] and is also a significant avoidable cost to the NHS.

Three year old children living in Leicester have the highest experience of dental decay observed in England, with 34% of them having had experience of obvious dental decay. These are the most recent data available. These data should not be confused with the more recent data for decay in 5 year olds. Those data are available in the School Years chapter.

**Figure 4: Percentage of children with decay experience (2012/13)**




*Delivering Better Oral Health*[14] recommends the application of fluoride varnish twice a year for all children from age 3 years (with increased applications for those with higher need) for preventative purposes. Although the national guidance states that fluoride varnish should be applied from 3 years, only 6% of eligible children in England and 14.4% of eligible children in Leicester received fluoride varnish applications in 2014/15.

### 4.1.5 Children with Disabilities or Special Educational Needs

Children with disabilities or special educational needs are a vulnerable group in society. Their disabilities and needs have a large impact on their health and wellbeing. Appropriate care for such disabilities and needs may require regular visits to hospital, a requirement to adhere to all medical and pharmaceutical regimen, consideration of diet and what types of activities may be done. Children in this age group are not fully able to understand what is happening to them.

Disability may limit the amount of time a child can attend early education and begin to prepare for attending school and building social relationships with peers; both of which are determinants of long term achievement and wellbeing.

[13] Flick RP, Katusic SK, et al (2011) Cognitive and behavioural outcomes after early exposure to anesthesia and surgery. Pediatrics 128(5): e1053-61.

[14] Public Health England (2014): Delivering Better Oral Health – an evidence based toolkit for prevention; available at https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

## 4.2 Children with Disabilities

Many children and young people who have SEN may also have a disability. A disability is described in law (the Equality Act 2010[15]) as 'a physical or mental impairment which has a long-term (i.e. a year or more) and substantial adverse effect on their ability to carry out normal day-to-day activities.'

This includes, for example, sensory impairments such as those that affect sight and hearing, and long-term health conditions such as asthma, diabetes or epilepsy.

There are no local data on the number of disabled children aged 0-4 years living in Leicester. It has been estimated that between 3 and 5.4% of all children experience some form of disability[16].84.1.5.2 Children with Special Educational Needs

The Children and Families Act (2014)[17] sets out the matters to which Local Authorities must have regard when they are supporting children and young people with Special Educational Needs and/or disabilities (SEND) including the importance of their participation in decisions about services and the provision of information to facilitate the best possible outcomes for the child.

The SEN Code of Practice refers to the different types of educational support available for children with SEN[18] to replace the old code. The new code of practice provided new guidance for education and training settings on taking a graduated approach to identify and support pupils with SEN to replace School Action and School Action Plus.

Also, for children with more complex needs a co-ordinated assessment process and the new 0-25 Education, Health and Care plan (EHC plan) replace statements and Learning Difficulty Assessments (LDAs).

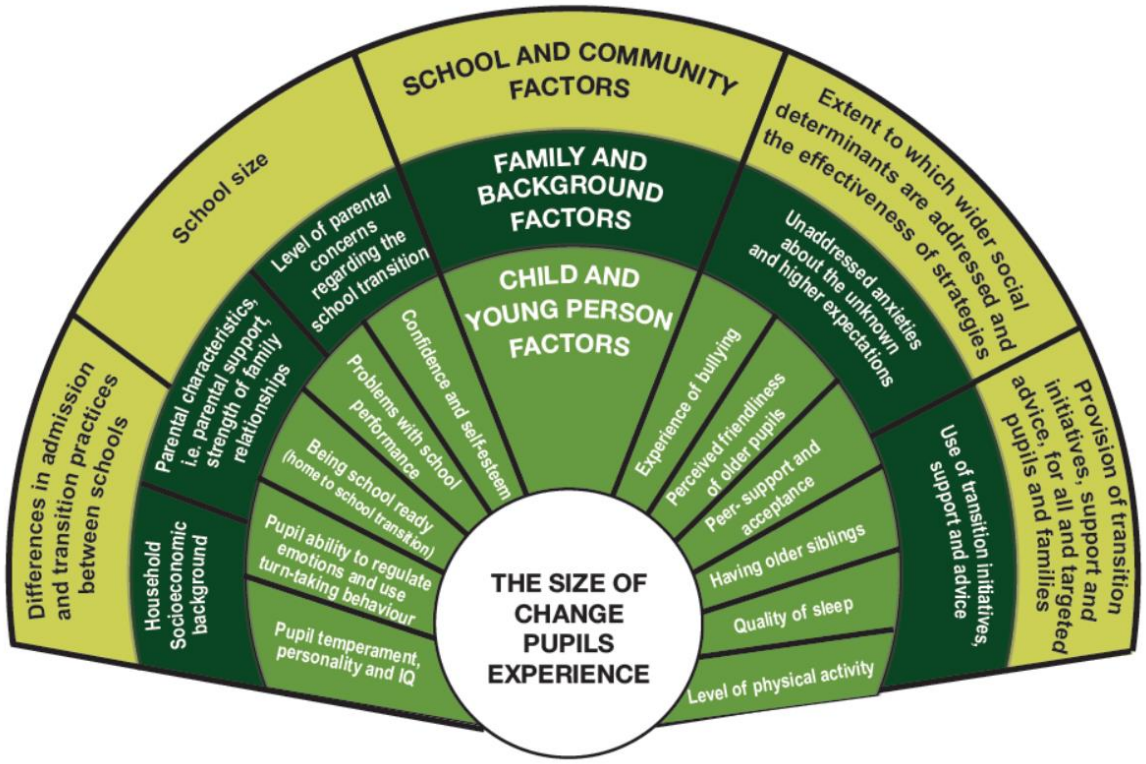
## 4.3 School Readiness

School readiness is a determinant of a child's future health and well-being across the life course. Improved school readiness and better educational attainment influence one's physical and mental health, positive peer relations, confidence, and ability to earn a high wage.[19]

The transition to school is a stressful and challenging time for children and their parents or carers. Concerns about expectations, new environments and social relationships can be difficult. Figure 5 illustrates the wide variety of factors that affect the success of pupils transitioning to school. School transitions also offer the opportunity to build resilience, and resilience is a key life skill that enables individuals to deal with adversity and difficulty. Therefore, ensuring children are ready for school is important for ensuring they have the best start to their educations and future careers.

[15] Source: https://www.gov.uk/definition-of-disability-under-equality-act-2010
[16] Thomas Coram Research Unit (TCRU)
[17] Source: http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf
18 Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf
[19] Roberts, Jill (2015). *Improving School Transitions for Health Equity.* Available at: http://www.instituteofhealthequity.org/projects/improving-school-transitions-for-health-equity

**Figure 5: Factors affecting the success of school transitions**




Taken from: Roberts (Improving School Transitions For Health Equity

Children who are ready for school should have the basic minimum skills and knowledge to enable them to succeed in school. A broader definition of school readiness includes domains such as physical well-being, motor development, social and emotional development, learning approaches, language development and general knowledge.

This section includes information on continence, Early Education provision, language development and emotional health and well-being which are key building blocks to a successful start in education. Other aspects of physical health for children aged 0 to 4 years are covered through this chapter.

### 4.3.1 Continence

The ability to use the toilet on one's own is a vital self-care skill that provides some independence and confidence to young children. Continence problems include bedwetting, daytime urinary incontinence, or constipation and faecal incontinence, or a combination of these. On the absence of local data on this issue, local estimations have been undertaken from reported national prevalence.

Local estimates suggest that around 1,900 children aged 4 ½ will experience significant problems with bed-wetting, with around 700 of these having problems during the day. Around 145 boys and 90 girls in Leicester will have more serious problems with faecal incontinence with implications for their self-esteem, socialisation and ability to learn and play. In most cases, through the support of parents or carers, these problems will resolve with age but for a small number of children, more specialist support or advice may be needed through the city's 0-19 Healthy Child Programme.

### 4.3.2 Early Education

Access to good quality early education programmes is a determinant for longer term educational attainment and wages. Attendance to nursery and preschool allows children to learn some of the necessary skills for school success such as social interactions, following instructions, engaging in activities, and language development. According to UNICEF, the return on investment of for early childhood programmes is higher than for any other 'human capital development programmes'.

The number of Leicester's 2 year olds that are eligible to access a Funded Early Education Entitlement (FEEE) place will vary depending upon the numbers of families living in the city meeting the criteria. LCC receives regular lists of potentially eligible families from the Department for Work and Pensions. The average number of eligible children is 2,500 which equates to 50% of the total population of 2 year olds in the city. Nationally, the 2 year old FEEE offer is accessible by the 40% most disadvantaged low income families and so Leicester's higher percentage of the 2 year old cohort being eligible reflects the relative levels of deprivation in the city.

All 3 and 4 year olds are entitled to access a FEEE place. Take up of this offer by three year olds in Leicester is fairly high, but is lower than the England average. The delivery of places for three year olds is split between the private/voluntary/independent sector and nurseries in local schools. Take up of the offer for 4 year olds is higher in Leicester than the England average. The majority of 4 year olds access their place through their local school foundation stage.

### 4.3.3 Language Development

A child's ability to communicate verbally is important for his/her confidence and success at school. Poor language development can impact school performance, social inclusion and self esteem. Children who do not speak English as their first language are less likely to be school ready. Children's understanding and use of vocabulary and their use of two-three word sentences at 24 months is very strongly associated with their later performance on the school entry assessment when adjusted for social class. Therefore a child's language improves a child's development irrespective of their social background.

Children's Speech and Language Therapy (SALT) is provided by Leicestershire Partnership Trust to work in settings across the city clinics, CYPFCs, nurseries and schools. The caseload in 2014/15 was 1,055 (of children aged 0-4 years). The breakdown of boys to girls in this age group mirrors the England statistics (approximately 3:1).

### 4.3.4 Emotional Health

Children with poor socio-emotional skills, low self-esteem or low confidence are more likely to find transition to school very difficult. Children with good socio-emotional health can form close relationships with others (e.g. parents, teachers and peers), express and manage their emotions and confidently explore new environments. All three of these domains are important for being ready for and succeeding at school.

There are relatively little data about prevalence rates for mental health disorders in pre-school age children. A literature review[20] of four studies looking at 1,021 children aged 2 to 5 years inclusive found that the average prevalence rate of any mental health disorder was 19.6%. When this average prevalence rate is applied to Leicester, a figure of 3,740 children aged 2 to 5 years are estimated to have a mental health disorder. National estimates show that the number of children who experience lower level mental health issues is rising with significant differences across the social gradient pointing to an emerging health issue.

## 4.4 Neglect

Child maltreatment is both a human rights violation and a complex public health issue, likely caused by a myriad of factors that involve the individual, the family and the community. Aside from the serious physical and health consequences of child maltreatment, several emotional and behavioural consequences for children have been noted in the literature. Neglected children do not usually have a good relationship or attachment with their parent/carer. Persistent neglect can lead to serious impairment of health and development, and long term difficulties with social functioning, relationships and educational progress. In extreme cases, neglect can also result in death.

Amongst children aged 0 to 4 years old in Leicester, there were 223 Child Protection Plans started between 1 April 2015 and 31 March 2016. This data is monitored and reported on a continuing basis. Neglect was documented as the initial category of abuse for 111 children (49%) aged 0 to 4 years old during this time period in Leicester.

In Leicester there have been a number of serious case reviews which featured aspects of neglect, and the Local Safeguarding Children's Boards have therefore made neglect a priority. The LSCB recently launched a Neglect Toolkit and Strategy for practitioners to use when working with children and families suspected of neglect.

## 4.5 Determinants of health

### 4.5.1 Deprivation

Deprivation is a key determinant for life long health and wellbeing. Deprivation covers a broad range of issues that may affect an individual's health and wellbeing because they have unmet needs caused by a lack of resources, not just financial. More information on the level of deprivation and child poverty in Leicester is available in Chapter 3.

### 4.5.2 Immunisations

Vaccinations are the most effective method for preventing disease and maintaining the public's health. Children are protected against diseases that can kill or result in long term poor health. As a result of the UK's Immunisations Programme, the numbers of deaths due to vaccine-preventable deaths is low. The costs to the NHS and other local services to treat and support children who suffer from such illnesses is considerable.

[20] Egger H.L., Kondo D. & Angold A. (2006) "The epidemiology and diagnostic issues in preschool attention-deficit/hyperactivity disorder: A review", Infants & Young Children. 2006b;19:109–122.

The proportion of coverage for childhood immunisations to age 5 years for 2015/16 in Leicester, East Midlands and England are depicted in Table 1. The World Health Organisation (WHO)[21] recommends a threshold of 95% for all vaccinations, and Leicester achieves this threshold except for the 1st and 2nd doses of MMR and the 5 year Hib/MenC booster. However, Leicester's overall performance is above (or comparable to) the regional and England averages.

The schedule of vaccinations is primarily completed between the ages of 0 and 5 years old, however there are three vaccines given to adolescents. These vaccines are for Human Papillomavirus (HPV); tetanus, polio and diphtheria (Td/IPV); and Meningitis C.

[21] 'Herd' immunity is the immunity that occurs when the vaccination of a significant proportion of the population provides a measure of protection and reduces the probability of infection for the whole population, including individuals who have not developed immunity

**Table 1 – Percentage of coverage for childhood immunisations (2015/16)**

| | 1 year olds: | | 2 year olds | | | | 5 year olds | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Diphtheria, Tetanus, Polio, Pertussis, Hib: primary | PCV: primary | Diphtheria, Tetanus, Polio, Pertussis, Hib: primary | MMR: dose 1 | Hib/MenC: booster | PCV: booster | Diphtheria, Tetanus, Polio, Pertussis, Hib: primary | Diphtheria, Tetanus, Polio, Pertussis: booster | MMR: dose 1 | MMR: dose 2 | Hib/MenC: booster |
| | | | | 1st dose | Booster | Booster | | Booster | 1st dose | 2nd dose | Booster |
| England | 93.6 | 93.5 | 95.2 | 91.9 | 91.6 | 91.5 | 95.6 | 86.3 | 94.8 | 88.2 | 92.6 |
| East Midlands | 95.6 | 95.5 | 97.0 | 94.1 | 94.0 | 94.0 | 97.0 | 89.2 | 96.5 | 90.5 | 93.4 |
| Leicester | 95.8 | 95.4 | 97.1 | 94.5 | 94.0 | 94.1 | 96.9 | 88.3 | 96.5 | 90.3 | 91.6 |
| 95% | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 | 95.0 |

DTap/IPV/Hib: Diptheria, tetanus, pertussis (whooping cough), polio and Haemophillus influenza B
MenC: Meningococcal Group C disease
PCV: Pneumococcal conjugate vaccination
MMR: Measles, Mumps, Rubella (German Measles)

### 4.5.3 Safeguarding

Safeguarding is everyone's responsibility. Safeguarding is defined as "protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances" (Working Together to Safeguard Children). The maltreatment of children – physically, emotionally, sexually or through neglect – can have major longterm effects on all aspects of a child's health, development and wellbeing.

Some safeguarding risks to children aged 0 to 4 years include poor life chances, compromised care, bullying and mental health problems. Poor life chances include social and economic circumstances that shape a child's life course for example his/her life expectancy. A child lives in a home with domestic abuse, illegal behaviour, parental substance misuse and/or parent mental illness will most likely have compromised care.

Children, Young People and Family Centres (CYPFCs) work with families to provide a range of services aimed at ensuring the best start for children. Families may also access targeted Early Help provision to meet their needs at an earlier stage and prevent any issues from escalating. Approximately 55.1% of families with children aged 0-4 years who were registered with CYPFCs accessed services provided by CYPFCs across a 12 month period (2015/16).

The Local Safeguarding Children Boards (LSCB) works to coordinate local work to safeguard and promote the welfare of children and to ensure the effectiveness of member organisations' work individually and together. The LSCBs participate in the planning of services for children in the local authority area, monitor the effectiveness of what is done to safeguard and promote the welfare of children, and collect and analyse information about child deaths.

## 5. Current services

### 5.1 General Practice (GP) Registration

All children are eligible to register with a General Practice to receive health care. New arrivals are provided information that recommends registering with a GP.

### 5.2 Oral Health

Children under-18 in Leicester are entitled to free dental treatment by an NHS dentist. There are currently 62 dental practices within the Leicester city boundary.

It is recommended that children see the dentist as a minimum once per year. The recommended recall interval for children is between 4 and 12 months, compared to adults where it is 6-24 months[22].

Leicester City Council is focused on improving oral health for children in Leicester. The Oral Health Promotion Partnership Board was created in September 2013 to further this agenda. The Healthy

22 NICE Dental Recall Clinical Guideline 2004

Teeth, Happy Smiles! programme is currently running in the city to promote good oral health. Some work being done by the programme includes: providing oral health training to frontline staff, raising awareness of the Healthy Teeth, Happy Smiles! programme and supporting a variety of national oral health initiatives.

### 5.3 Services for New Arrivals

ASSIST provides care and support asylum seekers and refugees. There is also a partnership group which meets 4 times a year which discusses a co-ordinated response for new arrivals in Leicester. At any one time there are about 1,000 asylum seekers in Leicester, many of whom will be children.

### 5.4 Children, Young People and Family Centres

CYPFCs are at the centre of the early help (EH) offer, with a renewed focus on the most disadvantaged families. CYPFCs are also expected to be a hub of the local community and enhance their role in promoting parenting and nurturing skills. They are accessible to all families with young children and have an important role in identifying and supporting families in greatest need.

The EH offer includes the provision of integrated education, care, family support, family learning and health services which are crucial to increasing the wellbeing of children and their parents. There are a number of CYPF buildings spread across the city in a hub and spoke model linked to 6 geographical clusters. Each cluster has one registered CYPFC which is identified as the registered centre with Ofsted.

An integral part of Leicester's CYPFC delivery is its offer for 0-4 year olds, working in partnership with statutory as well as community and voluntary agencies. This enables the CYPFC universal offer to include health, early education and information services across a range of determinants of health. This co-delivery of a range of core services across the CYPFCs includes activities and programmes focused on learning, development and engagement of families delivered at the cluster level and include the following:

- Specific support for dads and male carers
- Breastfeeding support and support of breast feeding peer support
- Welfare Rights Advice sessions
- Drop-in access to family support workers to provide advice and guidance as required
- Parenting programmes
- Ante-natal and post-natal services
- Speech and language advice, guidance and early support
- Housing advice
- Co-ordinated support for children with lower level SEND (special educational needs and disabilities) in settings and the home
- Access to targeted and specialist services, such as mental health, 0-5s Supporting Families Team, CAMHS
- Advice/access to funded early education
- Domestic violence support - one stop shop

### 5.5 Childcare and Funded Early Education Entitlement (FEEE)

Leicester City Council (LCC) has a statutory duty to secure sufficient childcare to enable parents to work or to undertake training leading to employment under the Childcare Act 2006. LCC also has a statutory duty to secure a free minimum amount of early learning and care for all 3 and 4 year olds whose parents want it. FEEE is available for 15 hours per week up to 38 weeks per year.

Childcare sufficiency requires there to be enough childcare provision to meet parental demand. LCC has a statutory duty to produce a Childcare Sufficiency Assessment (CSA) which analyses and reviews the childcare market across the city to ensure that there is sufficient, sustainable, good quality provision to meet parental demand. The last full CSA was completed in November 2016; this showed that overall there is sufficient childcare provision in place to meet demand.

### 5.6 Early Help (EH)

EH services in Leicester are for children, young people and families whose needs are not being met by routine services but who do not need specialist services. The services are for children of all ages and not just the very young. LCC leads on the EH offer, but there is now greater emphasis on staff in all agencies working with children to provide direct support, signposting and a co-ordination of agencies working with the family. EH services can be provided at any point of need and can be very effective in supporting a child, young person and/or their family to step down from statutory services as well as preventing the escalation of issues.

More information may be found at www.leicester.gov.uk/earlyhelp

### 5.7 Voluntary Sector

The voluntary sector provides a large number of pre-schools, play groups and family support services such as parent and toddler groups. Voluntary groups also provide information, advice and support to new mothers on issues such as breastfeeding. These voluntary groups are well placed to provide school readiness, new parent support and recreational activities to the youngest children.

## 6. Projected service use for 0-4 years olds

The 0-4 year- old population in Leicester has increased by 16.3% over the last 10 years, which is significantly higher than the national and regional averages. The latest population projections from the Office of National Statistics predict that by 2037 the 0 to 4 year- old population will increase by an additional 13.6%.

The increase in the 0-4 year- old population will impact on future demand for health, education and care services. Services must take into account not only the number of children but also the composition of the ethnic groups to reflect the educational, care and health need for services now and in the future.

Leicester also has a range of recently arrived communities to the city with new families arriving that have an impact on service planning and provision, as well as on the outcomes for young children who have language needs or may experience difficulties settling in to their new environments.