CHILD UNDERNUTRITION

PROJECT REPORT

A report about the current undernourishment of children in England

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**Executive Summary**

The issue of malnutrition amongst children has traditionally, although not exclusively, focused on malnutrition in the developing world. However, malnutrition or under-nutrition in children in the UK was highlighted as an increasing problem in a report produced by the Patients Association in 2014. This report outlined the discussion points and recommendations from a round table meeting where issues raised by an expert panel highlighted malnutrition amongst children as a growing problem in the UK. It suggested that existing methods of detection of malnutrition amongst children were inadequate, with recommendations for a more joined up approach.

The report in 2014 also raised some key concerns but little appears to have been published since then with a lack of any significant evidence base about the issues raised. Whilst much focus has been on obesity as a growing national problem in adults and children the associated links between this and under-nutrition (which may be manifested in either under or over weight) does not appear to be highlighted as an alternative way to tackle this problem.

In an attempt to explore the issues further a short term qualitative project was undertaken by the Patients Association between Sept 2016 and March 2017. This report outlines the findings from this project, which have been developed by a Child Malnutrition Advisory Group following on from the previous work.

A sample of 40 telephone interviews were carried out with a cross section of health and care staff in four sites: Bradford, Cornwall, Tower Hamlets and Birmingham. The project also included face to face meetings with over 50 parents with under school age children in two of these sites (Bradford and Cornwall), in order to better understand the issues from staff and parents at the point of care.

What emerged were numerous examples of positive efforts being put into working with children and families across agencies on this topic, particularly by public health teams, community and acute health staff. Also worthy of note are the development of local pathways and protocols, the use of specialist teams; use of innovative practical solutions and the tremendous work being carried out by the voluntary sector in providing creative developments/ local projects which included the important role of food banks to address the growing problem.

What was surprising to hear was the growing problem of under-nutrition in children in some areas of the UK and the concern by professionals about the potential impact this will have on future generations in terms of health and wellbeing and life expectancy.

Interviews were carried out with a range of professionals and included, health visitors, school nurses, community dietitians, paediatricians, children’s centre staff, GPs, social workers and public health staff. We also heard from parents living in isolated rural communities in Cornwall and from ethnic minority communities in Bradford, Tower Hamlets and Birmingham. Project staff interviewed

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Slovakian, Romanian and Polish families with the support of an interpreter as well as Muslim and Asian families at the HENRY\(^2\) centre.

There were some really informative discussions and some innovative and practical suggestions for improving information, supporting parents and tackling the problem from a different perspective. This included focusing more on the importance of nutritional content of food, explaining why this is important rather than a more negative, judgemental approach which parents felt was sending out confusing messages about what not to eat.

Suggestions about more detailed research and recommendations for future action including the production of useful tools and practical solutions which have been suggested by parents are outlined at the end of the report as well as highlighting some examples of best practice.

“It is good to be involved in this survey as makes you examine your practice and identify gaps”.

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1 Introduction

1.1 The issue of malnutrition amongst children has traditionally, although not exclusively, focused on malnutrition in the developing world. However malnutrition or under-nutrition in children in the UK was highlighted as an increasing problem in a report produced by the Patients Association in 2014\(^3\). This report outlined the discussion points and recommendations from a Round Table meeting where issues raised by an expert panel highlighted malnutrition amongst children as a growing problem in the UK. It suggested that existing methods of detection of malnutrition amongst children were inadequate, with suggestions for a more joined up approach.

1.2 The report in 2014 raised some key concerns but little appears to have been published since then with a lack of a significant evidence base about the issues raised. Whilst much focus has been on obesity as a growing national problem in adults and children the associated links between this and under-nutrition (which may be manifested in either under or over weight) does not appear to be highlighted as an alternative way to tackle this problem.

1.3 In an attempt to explore the issues further a short term qualitative project was undertaken by the Patients Association between September 2016 and March 2017. This report outlines the findings of the Child Malnutrition Advisory Group, which oversaw the project and analysed the results of the research, following on from the previous work.

1.4 A sample of 40 telephone interviews were carried out with a cross section of health and care staff in four sites: Bradford, Cornwall, Tower Hamlets and Birmingham. The project also included face to face meetings with over 50 parents with under school age children in two of these sites (Bradford and Cornwall) in order to better understand the issues from staff and parents at the frontline. We were particularly interested in aspects of child under-nutrition within different ethnic minority groups, inner city areas and comparisons within a rural area.

2 Context

2.1 “London has been dubbed 'the food poverty capital of Britain’ with as many as half of children in its poorest boroughs going hungry.” BBC Inside Out in 2016 reported and also an increase in the number of malnutrition-related hospital admissions in children under 16.

2.2 “Serious signs of malnutrition in children are on the increase, and medical experts believe poor diet due to poverty is the main driving factor. There are 600,000 children in London living below the poverty line, many of whom are not receiving a healthy diet.”\(^4\)

What is malnutrition?

2.3 At the most immediate level, malnutrition is caused by inadequate diet and by infection. These primary causes of malnutrition are influenced by food access and availability, healthcare, water and sanitation, and the way a child is cared for (including whether an infant is breastfed and whether basic hygiene practices are used, such as hand-washing). Underlying all of these primary and intermediate causes of malnutrition are poverty, lack of resources (e.g., financial and human resources), and social, economic and political

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\(^3\) Child Malnutrition Report – Patients Association Nov 2014 [https://www.patients-association.org.uk/reports/](https://www.patients-association.org.uk/reports/)

factors (e.g., women’s status). According to Save the Children\(^5\) there are three types of malnutrition:

- **Stunting:** when a child is too short for their age – a result of chronic malnutrition
- **Wasting:** a child’s weight is too low for their height – a result of acute malnutrition;
- **Micronutrient deficiency:** a lack of one or more essential vitamins and minerals, such as vitamin A, iron or zinc.

2.4 One in four of the world’s children are stunted. In developing countries this figure is as high as one in three. That means their body and brain has failed to develop properly because of malnutrition.

2.5 Whilst many of these figures relate to global information the following quote is taken from nearer to home:

“We meet families from across the UK struggling to put enough food on the table and, at the extreme end, you get people who are malnourished,” he said. “We often see parents who are going without food so that they can feed their children, and these parents often struggle to afford enough nutritious food for their children, too. We don’t think anyone should have to go hungry in the UK, which is why we’re working to engage the public, other charities and politicians across parties to find solutions to the underlying causes of food poverty.”\(^6\)

2.6 In 2014 figures suggested that amongst hospitalised children in the UK, 16% were severely stunted, 14% wasted and 20% at risk of severe malnutrition.\(^7\) Additionally the National Child Measurement Programme\(^8\) determined that 11,317 children in the United Kingdom were classed as underweight in 2010.

2.7 Children who suffer malnutrition in the long term suffer from issues with both growth and cognitive function\(^9\). Children are more likely to contract infections due to poor nutrition, including gastrointestinal infections. A gastrointestinal infection can then compound the issue, given that nutrients are then less likely to be absorbed properly. As such, malnutrition combined with infection can undermine a child’s growth, and in the long term, can undermine brain development, causing delays in motor and cognitive functions.

**Health inequalities in the UK**

2.8 There are striking health inequalities in the UK, resulting from increasing social inequalities. Despite being a prosperous country, in the UK these inequalities are widening. In recent years many individuals have found themselves reaching crisis point following extensive welfare reforms. This has led to significant increases in the number of people living in food poverty. Individuals struggling to support themselves and their families financially are unable to retain control over their lives, and are unable to give their children the best start in life. The 2011 Child Poverty Needs Assessment carried out in Cornwall found that 19% of

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\(^5\) A Life Free of Hunger – Save the Children 2012

\(^6\) https://www.trusselltrust.org/


\(^9\) NCMP data sets: http://www.hscic.gov.uk/ncmp - overview

\(^\) Food for Thought, Save the Children, 2013.
children aged under 16 live in poverty in Cornwall, a total of 16,650 children.

Foodbanks

2.9 The foodbank network in the UK has grown rapidly over the last few years in response to the growing levels of need. Foodbanks are a valuable and often essential resource for people in times of crisis, but are also an opportunity to reach out to vulnerable people in times of crisis and support them to maximise their capabilities, ensure a healthy standard of living, and help to prevent ill health.10

“We provide help with food or refer to GP or others - an example was last week when a school contacted us as a 13 year old girl had collapsed at school - we visited the home and discovered the family hadn’t eaten for 3 days - husband was self-employed and had no work - didn’t know about benefits (which is often the case) so we signposted them” – Source: Foodbank Cornwall

2.10 The recently published report ‘Feeding Britain’ from the All-Party Parliamentary Group on Hunger and Food Poverty 11 sets out the extent and causes of food poverty in the UK. The report also sets out a description of what is currently being done to alleviate the problem, and makes a number of recommendations on how this issue should be tackled going forwards. The Inquiry advocates a ‘Zero Hunger Britain’ in which everybody has the resources, abilities and facilities to purchase, prepare and cook fresh, healthy and affordable food, no matter where they live.

3 Background

3.1 In February 2014 the Patients Association carried out a project to look at child malnutrition in the United Kingdom. The project aimed to establish if the issue of child malnutrition was increasing, whether existing methods of detection were adequate and finally to develop suggestions for a joined up approach to address these issues. The project was to specifically focus on the ability of primary, acute and public health sectors to identify and effectively tackle malnutrition in children.

3.2 In order to understand the current issues the Patients Association undertook a desk top review of current published research in the United Kingdom and held a set of qualitative one to one interviews with experts in the field. A round table of experts was convened in June 2014. Following this event a number of the experts attending were invited to form an advisory panel. The first meeting of that advisory panel was held in April 2015 and a subsequent more detailed project was set up in 2016 to take the issues raised further.

3.3 The key issues raised by the Child Malnutrition Project Advisory Board in 2015 included:

- Concerns about routine monitoring of the child measurement programme;
- Concerns that the school nursing service has been heavily impacted by local authority cost savings;
- How midwifery, health visiting and school nursing work together;

10 The Trussell Trust was founded in 1997. Originally set up to help people living in poverty in Bulgaria, it soon became apparent that people were living in poverty back home in the UK, with many people facing hunger due to short term crises. The first Trussell Trust foodbank was set up in Salisbury, operating out of a garden shed. Today the Trussell Trust operates over 420 foodbanks across the UK- https://www.trusselltrust.org/
3.4 The main areas it suggested this project should look at were:

- Policy changes required by government;
- Lack of clarity regarding the national guidance for measuring children and the need for a national data set.

3.5 Other issues raised by the advisory board and which it was keen to see addressed included:

- The rising problem of Vitamin D deficiency and the need for universal supplementation;
- A proposal for a national child malnutrition strategy in the UK with identification of what is currently in place and any gaps;
- A screening strategy for pre-school children;
- National analysis of the National Child Measurement Programme (NCMP) data.

4 Methodology

4.1 Based on a “co-production” approach, working with patients as equal partners the project was set up by the Patients Association in June 2016.

4.2 Using a simple and practical version of PRINCE 2 the project was led by the Patients Association Development Director, managed and facilitated by two Patients Association Project Managers and a Patients Association Ambassador and supported by a Project Assistant.

4.3 The project has been overseen by a Child Malnutrition Advisory Group which provided the overall leadership and governance for the project with monthly progress reports submitted to all members of the advisory group and discussed at the meetings. This report’s conclusions and recommendations are the work of the Child Malnutrition Advisory Group.

Project Scope

4.4 This project took place across four pilot sites in different localities over a six-month period between November 2016 and March 2017. The pilot sites were chosen to provide a mixture of inner city and rural localities in the north, midlands and south of England, focusing on areas where there is a high population of people from ethnic minorities and/or rural issues.

4.5 We used an action research approach and gathered qualitative data based on real experience of front line staff and also carried out four focus group discussions with parents of children under five in two of the pilot sites (Cornwall and Bradford).

4.6 Baseline data was collected by interviewing a range of staff from different professional groups and analysing the feedback to produce this report with recommendations. The aim was to develop draft tools if identified as a gap for testing in the pilot sites at a later stage.

4.7 As part of the methodology for this project, we produced an interview pro-forma. We identified at least 8-10 key practitioners from a range of different professional

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12 The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children. This data can be used at a national level to support local public health initiatives and inform the local planning and delivery of services for children.

13 https://en.wikipedia.org/wiki/Coproduction_(public_services)
backgrounds and designed an interview pro-forma consisting of 16 questions (see Appendix 3) to support our telephone interviews in order to better understand their views and issues. This included what was currently happening in practice – what is the baseline data, current pathways, protocols and procedures (if any) and where are the gaps.

4.8 We also carried out four focus groups in two of the pilot sites Bradford and Cornwall talking to over 50 parents in order to get a better idea of their views and the issues important to them. The parent focus groups/individual interviews were based on a simplified version of the staff interview pro-forma consisting of eight questions – see Section 8.

4.9 The data was to be mainly qualitative and focus on operational practice, audit and service user/parent feedback;

- This was not seen as a research project and therefore ethics approval was not required and the scope of this work was more aligned to service improvement and audit. The advisory group were tasked to ensure the project did not encroach into research.

**Project Aim**

4.10 To determine how under-nutrition and faltering growth are diagnosed and dealt with, in order to recommend some core principles to be used by staff both locally and nationally.

**Project Objectives**

a) To set up at least four pilot sites across England to identify the issues for practitioners and what is practically needed to be of assistance to prevent, alleviate and recognise undernourishment in children under 5;
b) To improve awareness in health and social care professionals and parents about under-nutrition in children;
c) To identify the training needs of staff, community leads and parents re child under-nutrition;
d) To identify national and local policy issues for NICE, NHS England, local authorities, commissioners, early years and education, private and voluntary sectors and other key decision makers re child under-nutrition;
e) To produce a set of guidelines for practitioners/clinicians (if required);
f) To explore and identify avenues to share the findings and tools such as through voluntary sector organisations, food banks, dietitians, pharmacists and outreach community workers etc.;
g) To identify the size of the problem within the pilot sites in order to recognise and identify the local prevalence of child malnutrition;
h) To consider how this links to the red book and the digital child health strategy and identify any gaps.

**4.11 Outputs**

a) A set of core principles to influence the development of tools to understand the contributing factors which could lead to under-nutrition and faltering growth in infants and children under 5;
b) An information leaflet for staff and parents to raise awareness (if required);
c) To develop recommendations for an online resource to help practitioners identify under-nutrition and make dietary recommendations (if required);
d) A suggested care pathway if not already in place.
Outcomes

a) Practitioners will feel better equipped to identify and take action on children who are undernourished;
b) Parents of younger children will have better access to resources for recognising and treating undernourishment;
c) A clear pathway which practitioners can follow for screening/identifying children who may be under-nourished;
d) To encourage healthy eating, including breastfeeding.

5 Interview sites – demographic and health profiles

5.1 Due to limited resources and the need to focus the project the Project Advisory Board suggested interviewing frontline staff in areas with a high number of people from ethnic minorities and a rural area in contrast. This section provides a short demographic and health profile on each of the interviews sites.

Birmingham

5.2 Birmingham is an ethnically and culturally diverse city and the second most populated city in the United Kingdom after London. Birmingham city’s total population, according to the 2001 UK census, was 977,099. 33.3% of Birmingham’s population is non-white, whereas London, commonly seen as the most diverse of British cities is 30.4% non-white. No ethnicity forms a majority and the white ethnic group is still expected to be the largest. Birmingham has a Gypsy and Irish Traveller population of 53,554, making them 5.2% of the total population of the city. Birmingham has a young population compared to England as a whole with a higher proportion of the population being under the age of 34. Of the 20 to 24 year age group, the proportion in Birmingham is about 2% above the national figure and 23.4% of people were aged under 16.

5.3 Birmingham is considered the European Union’s fattest city. 29% of the adult population are classified as obese while the European average is 14%. A quarter of Birmingham’s 11- and 12-year-olds are considered obese.

Tower Hamlets

5.4 The current population is approx. 295,200. The borough hosts the world headquarters of many global financial businesses, employing some of the highest paid workers in London, but also has high rates of long term illness and premature death and the 2nd highest unemployment rate in London.

5.5 Tower Hamlets has one of the smallest indigenous populations of the boroughs in Britain. No ethnic group forms a majority of the population; a plurality of residents are of White ethnicity (45%) of which 31% are White British.

5.6 The Asian community forms 41% of the population, of which 32% identified as Bangladeshi which is the largest ethnic minority in the borough. A small proportion of people are of Black African and Caribbean descent (7%), with people from the Somali community representing the second largest minority ethnic group. People of mixed ethnic backgrounds form 4%, while other ethnic groups form 2%. The White British proportion was 31.2% in the 2011 census, falling from 42.9% in 2001. Tower Hamlets has the highest proportion of Muslims in England and is considered one of the world’s most racially diverse zones.
5.7 Tower Hamlets has the fifth highest proportion of obese 10 to 11-year-olds in London and the sixth highest in the country. Childhood obesity is often associated with a wide range of health problems in both childhood and later in life, reducing obesity in Tower Hamlets is a key public health priority locally\textsuperscript{14}.

Bradford

5.8 Bradford is an ethnically and culturally diverse city. It is the sixth most populated city in the United Kingdom with a total population of 522,452\textsuperscript{15}. The population of Bradford is ethnically diverse.

5.9 Most households own their own home (29.3% outright and 35.7% with a mortgage). The percentage of privately rented households is 18.1%. 29.6% of households were single person households.

5.10 The largest proportion of the district’s population (63.9%) identifies as White British. The district has the largest proportion of people of Pakistani ethnic origin (20.3%) in England. The Annual Population Survey in June 2016 found that Bradford has 214,000 people aged 16-64 in employment. At 65.1% this is significantly lower than the national rate (74.0%). 111,100 (around 1 in 3 people) aged 16-64, are not in work. The claimant count rate is 2.7% which is higher than the regional and national averages.

5.11 The largest religious group in Bradford is Christian (45.9% of the population) and nearly one quarter of the population (24.7%) are Muslim. There are 199, 296 households in the Bradford district. A large proportion of Bradford’s population is dominated by the younger age groups. More than one-quarter (29%) of the District’s population is aged less than 20 and nearly seven in ten people are aged less than 50. Bradford has the third highest percentage of the under 16 population in England.

Cornwall

5.12 Cornwall’s population estimate in 2015 was 549,400. There are no cities in Cornwall, but there are several mid-sized towns with a population of more than 20,000. The largest urban area in Cornwall is the Camborne-Redruth area, which has a total population of 55,400 (2011 data). 98.2% of people in Cornwall were White and just 1.8% of the population was non-white. (2011 census) English is the most commonly spoken language in Cornwall, followed by Polish. The Indices of Multiple Deprivation 2015 data show that Cornwall is now ranked 143 out of 326 local authority areas for deprivation (where 1 is having the highest proportion of the population living in the most deprived neighbourhoods). The 2010 data showed that Cornwall ranked 154.

5.13 About 17% (14,800) of children live in low income families. In terms of child health in Year 6, 17.1% (808) of children are classified as obese, which is better than the average for England. The rate of alcohol specific hospital stays among those under 18 was 46.5%, worse than the average for England. Levels of teenage pregnancy and breast feeding initiation are better than the England average\textsuperscript{16}. 17 neighbourhoods are amongst the most deprived (worst 10%) in England and 5% of neighbourhoods in Cornwall are among the

\textsuperscript{14} www.towerhamlets.gov.uk/lgnl/health _ social.../healthy _ lifestyle..._ children.aspx
\textsuperscript{15} UK census 2011
\textsuperscript{16} https://www.cornwall.gov.uk/media/22115533/health-profile-2016-cornwall.pdf
The interviews were carried out by three representatives from the Patients Association and inputted responses onto survey monkey for ease of data collection and analysis. However, it should be noted that this was a qualitative exercise and the number of interviews in each site was not comparable due to a number of factors including whether an organisation was willing to take part or not, availability of staff etc. The findings have therefore been reported as stories and quotes of qualitative information rather than any quantitative information.

40 interviews took place in the following pilot site localities:

- Birmingham (5)
- Bradford (15)
- Cornwall (13)
- Tower Hamlets (7)

In each pilot site we achieved a broad range of different professional types from acute and community care settings, local authority and public health teams. The range of professionals we interviewed included a core set of professions in each area: community dietitian, health visitor, school nurse, paediatrician, children’s centre and public health staff. We also interviewed other professionals in some pilot sites – e.g. HENRY charity, social worker, food bank director. GPs were more difficult to access but we were able to speak to two GPs in different roles: a mother who was a GP at a focus group and a Clinical Commissioning Group lead who was also a GP. We also heard the views of GPs relayed by other professionals such as health visitors.

The question asked and a summary of the responses with key themes is listed below under the question header.

**What do you understand about the term under-nutrition?**

Whilst originally the project referred to “malnutrition” it was decided by the Advisory Group that the term “under-nutrition” would be a better description for children in the UK. Both parents and staff were asked for their understanding of the term “under-nutrition” which produced a variation in responses and interpretations in all pilot sites.

Sometimes “under-nutrition” was more often referred to as synonymous with “failure to thrive” or “faltering growth”, whilst other professionals (often dietitians) made much more reference to lack of micro or macro nutrients. Issues of poverty were often mentioned with low income cited as a factor. Safeguarding issues were also raised. In Tower Hamlets there was more reference to “failure to thrive” but all staff in all sites gave similar definitions.

Most staff equated under-nutrition with underweight but then went on to state that they see a much higher prevalence of obesity these days which could also mean malnourishment. A common theme was the difficulty staff found in discussing under-nutrition concerns being linked to obesity. The reason given was that they felt parents found this much harder to grasp as an issue and this was therefore so much more difficult to convince parents that this could be a problem affecting a child’s health and wellbeing. In general all the professionals felt that under-nutrition could apply to underweight and overweight children. Comments included:
“Firstly, it makes you think of children with failure to thrive but on reflection it is really any lack of nutrients that doesn’t meet a child’s requirements for healthy development”

“Not getting healthy balance and full range of vitamins and minerals and calories from their diet”

6.8 Do you have a protocol or pathway in place if you have any concerns about under-nutrition in children?

6.9 There were mixed responses to this question in all of the pilot sites. Whilst some professionals/organisations do have a protocol or pathway in place others do not. In many organisations there are different pathways and protocols for obesity, faltering growth and safeguarding with the opportunity for some confusion between the different pathways and across organisations.

6.10 In Bradford out of the professionals interviewed, most felt they had a pathway or protocol in place, regarding concerns about under-nutrition.

“We have a protocol but not a pathway and a pro-forma assessment tool for 0-19 years-if we could have a pathway we could add to ours that would be good”

6.11 In Bradford it appears a lot of work has taken place in developing referral routes and innovative services across a large inner city area with high numbers of children from different ethnic groups.

6.12 In Birmingham staff spoken to felt what they had in place was sufficient although we were not able to interview any community health service staff:

“A protocol exists in the hospital, referral to dietitians is via consultant paediatrician for underweight children only. There is currently no service for an overweight undernourished child unless there is also faltering growth which is unlikely”

6.13 In Cornwall the majority of professionals spoken to felt they had a pathway or protocol in place but this was often more about safeguarding, obesity or the National Child Measurement Programme rather than a specific under-nutrition pathway. There was also reference to this being a quick fix but not providing a remedy to the underlying problems. Some staff felt that by making things too formalised and rigid this could create more problems by raising unnecessary concerns which could be better dealt with more informally.

6.14 In Tower Hamlets the professionals interviewed highlighted a need for better guidance and a clearer pathway or protocol across organisations. Even if there was a protocol in place there seemed to be more confusion with more requests for better guidance in this area than any of the other areas. Some responses stated not having a specialist dietitian or paediatrician or needing to travel out of the borough. However, this was apparently inaccurate and highlighted a lack of knowledge about the services available locally.

6.15 In most areas where a protocol exists this was seen as sufficient although there were several comments about how useful a national pathway specifically for under-nutrition might be. Some pathways and protocols were designed for only one organisation or for faltering growth, safeguarding or obesity so that “under-nutrition” as a specific topic was not generally addressed in a pathway. Gaps also exist between organisations especially across health and social care and many staff said they would welcome more guidance or a national care pathway.
How would you determine if a child is undernourished?

6.16 This question was designed to better gauge how a diagnosis is made and whether any specific assessment processes or tools are used.

6.17 The majority of professionals/organisations in the pilot sites use visual observation, growth charts, weight and height measurement and holistic assessments to ascertain if a child is undernourished. This did not seem to vary across regions and each professional group had a clear assessment process which included measuring height, weight and BMI and recording these in the Red Book and on either electronic or hard copy files. It was surprising how many professionals still did not have access to electronic recording systems.

6.18 The National Child Measurement programme also appeared to be well established in each area. However there were concerns expressed about the accuracy levels in using this and the fact that this does not identify undernourishment, but only whether a child is under or over weight.

6.19 In Tower Hamlets, having adequate equipment to take measurements such as availability of mats was also raised. Variations of “normal” in the guidance was requested as well as guidance for children who had been ill.

“I mean common things that happen that are normal patterns but shouldn't alert you to referring on”.

6.20 Many of the professionals spoke about making every contact count and having conversations about nutrition based on age and stage of child. Vitamins are also discussed - both healthy start and Vitamin D. Rickets was identified as a big problem in Bradford which had generated a public health campaign about vitamin D. In Cornwall Vitamin D deficiency was also identified as a problem and was linked to lack of exposure to the sun and a fear by children’s nurseries of letting children outside without sun screen. The dietitians all cited the use of nutritional assessment, food diaries, in-depth assessment of eating behaviour and liaison with any other services involved. Referral to GP for tests seemed to be a common problem. Many health visitors and dietitians wanted better access to blood tests and other diagnostic tools particularly with regards to vitamin or mineral deficiencies. This was more to do with GPs knowledge of the subject, time constraints and possibly cost.

6.21 Observation was also used as an assessment tool and some of the unqualified staff in children’s centres or other schemes used this as a prompt to seek professional advice. Gut instinct was frequently referred to as well as signs of lethargy, coldness etc. Concern was also expressed in all areas that use of BMI was not a good indicator of under-nutrition.

If undernourishment was suspected/identified what would you do and who would you refer to?

6.22 All the professionals spoken to indicated that they had a clear process to follow regarding what they would do if under-nourishment was suspected. This seemed to happen regardless of whether a written pathway was in place or not. All agreed that a referral to a GP or a paediatrician would take place if they had any concerns about the child’s health and usually a referral to a health visitor prior to that.

“The GP is a key point in assessing and providing health care solutions yet ill equipped to provide a holistic assessment with little understanding or training about nutrition”
6.23 There was a common theme about the lack of and need for community dietitians as part of the primary care team. Some staff would provide general advice to parents and may suggest vitamin drops, high calorie milks, build up drinks or a fortified diet depending on the age of the child. Safeguarding concerns were often an issue and referrals would then be made to the safeguarding team.

6.24 In Bradford there appeared to be more access to a range of programmes to refer to and help parents. These included groups, dietitians or 1:1 work with families to introduce more variety and healthy food. In Cornwall if there are specific concerns about a child’s eating habits then a referral to the Eating Disorder Service would be made. Cornwall also has a Lifestyle Eating, Activity for Families (LEAF) Programme and Child Obesity Programme which are discussed in section 7.3

“Referral is usually into programme. Other colleagues would refer. Work is with parents regarding healthy lifestyle. They are piloting a 1:1 programme in parents’ home. This might be for parents who need more help after attending HENRY, or because of a specific concern raised by health visitors etc, or parent might not be confident to attend a group or have language difficulties”

HENRY – good practice example

Health Exercise Nutrition for the really young. The HENRY programme is the initial point of referral and has two parts: training for staff and delivery of the HENRY programme. Delivery is via the six clusters of children’s centres with three HENRY sessions running each term with 12 places on each. Dietitian referrals are for more serious cases.

How many children do you see as diagnosed or suspected with under-nutrition?

6.25 The numbers of children with under-nutrition and low weight seems to be very small in all of the pilot sites. Depending on the professional group, the specialist in the acute or community setting tends to see more children who are undernourished but these are mainly children with other special needs such as autism, swallowing difficulties etc.

“Approximately three–four children may require input from the service for training in enteral feeding”.

6.26 Caseloads remain fairly low in number due in part, to the complexities of the cases and vary according to the profession or agency and the amount of in-depth work carried as well if safeguarding is involved. Some staff said they had no idea of numbers and would need to access the data whereas others could give approximate figure such as:

“As a team approximately 6 children a week. Individually approximately 2/3 a week” or “Approximately 20 new patients per month”.

6.27 All the professionals spoken to felt they needed more time and resources and could achieve much more if they had this.
Do you take weight, height and other measurements?

6.28 At least 50-70% of all staff interviewed take weight, height and BMI measurements, and record this on growth charts and in the Red Book\(^\text{17}\). Several professionals are still using manual records in community teams. There appeared to be a strong commitment to recognising the importance of measuring height and weight and recording this - but only if this was in the remit of their job description.

6.29 Children’s Centre staff and social care staff would not do this but would use observation and instinct and then refer to a health professional. In Cornwall the community teams only have access to paper records whilst acute staff have electronic. In Tower Hamlets and Bradford all community staff appear to have access to electronic records but there is still no IT platform to share records electronically between acute and community services. Apparently this has been a longstanding problem for many years in many areas. In Cornwall the Red book is made good use of and all records are included in that which is given to the parent.

6.30 In Tower Hamlets it was suggested that it would be useful to have guidance for GPs on when and how to investigate and how to proceed if blood tests reveal abnormal readings.

“As a GP I may do a full blood count / Iron and check Vitamin D and also check micro nutrients if under-nutrition is suspected. These are not commonly measured as GPs are not aware of this or what to do if abnormal.”

Do you have any educational tools or information you can use with parents/families if you have any concerns about under-nutrition?

6.31 There was a mixed response to the availability of educational tools for use with parents/families. Some professionals thought there were almost too many to choose from and an overload of information whilst others felt much more is needed.

6.32 There were several references to the fact that Department of Health leaflets are frequently out of print and the need for hard copy leaflets to go through with parents rather than printing off black and white PDF versions. See section 8 on parents’ views.

6.33 In terms of variations between the areas the comments have been separately listed but highlight similarity in each area. It is noticeable that Bradford has some very innovative projects stemming from the Born in Bradford study and other programmes. This includes “HENRY” \(^\text{18}\) which not all areas have access to but even in Bradford there still appears to be gaps. Many professionals are also using their own tools which they have adapted from BAPEN\(^\text{19}\) or other websites.

6.34 Some staff signpost to the NHS Choices and First Steps Nutrition Trust websites, whilst others use nationally provided leaflets such as Start for Life and resources linked to local delivery (Bradford) of the HENRY programme’. It was stated that tools are used that


\(^{18}\) ‘HENRY provides evidence-based early years training courses for all practitioners working with families of young children and can be commissioned throughout the UK. HENRY training helps practitioners support families to develop a healthier lifestyle. Their early years training courses are suitable for health visitors, midwives, children’s centre workers [www.henry.org.uk](http://www.henry.org.uk)

\(^{19}\) [http://www.bapen.org.uk/](http://www.bapen.org.uk/)
encourage exercise and eating well but are not specifically about under-nutrition. Some organisations do not have tools of their own but commission services that they can refer people to for such materials. In Bradford it was also suggested that consideration needed to be given to reading ability and language barriers in the design of the resources used.

6.35 In Cornwall an organisation called LEAF20 (Lifestyle Eating, Activity for Families) is used to ensure parents receive all the correct information and tools. Some staff access the national NHS information and feel bombarded with too much information whilst other staff said there was nothing specifically for under-nutrition. A programme in Cornwall called Ready Steady Eat provides information advice and support.

6.36 At age 2 years staff say they often identify children who are overweight and that it would be useful to have a Department of Health leaflet on something more directive such as why it is important to do something about a raised BMI.

“Very difficult for the practitioner to raise this with parents - often parents don’t hear what you say. When we see raised BMI we offer activity, information and then review 3 months later. Then can refer to LEAF project which is brilliant if parents are willing to engage. BMI has to be above 98 centile”.

6.37 In Tower Hamlets there is the Healthy Early Years tool which is an audit and accreditation process. Staff also offer infant nutrition and wellbeing courses for parents and complimentary feeding workshops on weaning. There are also various diet sheets and lots of written dietary information and some staff reported having given written advice to GPs about fortified milks.

“We have workshops for healthy start vitamins. Also we have workshops for eating well guides, considering food groups/portion sizes. We do lots of work around food labels considering sugar and fat”.

6.38 One staff member interviewed said she had no specific literature. “I guess it would be useful to have this in the relevant languages e g Bengali, Somali, but a lot of families I work with are better in conversation.”

6.39 Several staff members from different areas said they produced their own resources which were not provided by their employers. This raised the question about whether these were governed or quality checked and if senior managers were aware this was happening?

“I have evidence based information but these are my own resources and not provided by my employer”

20 https://www.cornwallhealthyweight.org.uk/professional/referral-programmes/
What are the key issues for you as a practitioner/clinician/manager in dealing with children with under-nutrition?

6.40 The key issues raised at each pilot site were very similar and varied. These can be summarised as follows:

**Investigations, assessment and diagnosis**

- Time taken to get medical investigations;
- Insufficient time for full assessment;
- Complex tools for assessment needing interpretation and may differ between individuals /professional group;
- High number of safeguarding taking up a lot of staff time;
- Delay in identifying safeguarding because of time taken for medical investigations to rule out clinical cause;
- Making sure GPs recognise the need for this and are equipped to undertake a holistic assessment which includes consideration about nutrition;
- Identifying deficiencies in minerals, Vitamin C, Vitamin D and Zinc.

**Social and psychological issues**

- Food poverty and lack of income;
- Social norm around desirability of weight gain in first few weeks of life;
- Families need to be ready to engage;
- Consistency of approach and message;
- Child in control - parents don’t know what to do and give in;
- Multi-cultural society and separation from families with resultant loss of traditional skills and support;
- Safeguarding issues and failure to thrive.

**Policy context**

- Money has been wasted on new initiatives to external agencies; rather than adequate resourcing of health visitors and school nurses;
- Lack of resources for specialist staff such as community dietitians;
- Blurred pathways and insufficient guidance.

6.41 In Birmingham children have a half-hour appointment which it was suggested was not really sufficient to do a full assessment and give advice to parents. Due to waiting lists children can only be seen every three months and only in a hospital environment as there is no domiciliary service. There was also concern that although there are tools available to assess nutritional status they require interpretation which may differ between individuals.

6.42 In Bradford issues such as families being ready to engage, food poverty and families understanding of the issues was a challenge. Also the need to have services to refer to especially for families who may fall through the gaps. The need to teach children about how to grow and prepare food was also seen as important.

6.43 Whilst much focus has been put onto obesity staff report that failure to thrive is also being highlighted as a problem. There is a need to adapt programmes to cover both ends of the spectrum as a result of poor nutrition and also address the continuous re - referrals and
In Bradford multicultural communities being separated from their families with a resultant loss of traditional skills and support was also an issue which was not so explicit in other areas.

There was a need highlighted for expert practitioners to work with and communicate with families and to have access to further support if required and to be open to issues of safeguarding such as neglect. The need also to be aware of socio-economic issues that may affect nutrition and to consider social habits of the family so that any intervention is specific to them. Also identified was the need for an action plan that is clear and agreed with the family/carer and which could be part of a national requirement.

“Can be other reasons such as behavioural issues around food; eating too many snacks, lack of routine, financial implications. Parents sometimes have unrealistic expectations - the child may be naturally small, increasing centiles takes time. Parents may need to be re-educated about what is possible or they may be worrying unnecessarily”.

In Cornwall the problem of high safeguarding caseloads was frequently mentioned which detracted from the ability to use health visiting and school nursing skills more widely with families. There was also concern that public money had been wasted on many new short term initiatives to external agencies who come and go. It was considered to be much more cost effective to go to the school nursing and health visitor teams where there is well established knowledge and experience and expand these services. A specialist community dietitian for children with special needs is available providing a team approach to special needs which appeared to be very effective.

Children holding control and parents not being able to challenge fussy eating was also raised several times in Cornwall. The need for more local training for multidisciplinary staff groups including GPs and paediatricians was seen as vital. This would help in addressing the growing problems of under-nutrition in order to recognise this and offer some positive and creative solutions.

In Tower Hamlets there was concern about a growing number of children at risk of under-nutrition which also created a resource issue. There is a specialist feeding clinic but a lot of GPs are unaware of this service. A pathway for under-nutrition would help but this is not currently in place. More community dietitians, psychologists and speech and language therapists allied to a multidisciplinary team approach to support the high proportion of children with special / complex needs and behavioral feeding issues was also identified as a deficit in Tower Hamlets.

All areas raised the issue of being falsely reassured about children being overweight and therefore assuming they were being well nourished. Vitamin D deficiency again was raised by Tower Hamlets as a key issue, stating that a lot of guidance is contradictory and local guidance not completely compliant with National Guidance.

“Having a clear pathway of support so everyone knows where to refer on. Also what is the longer term support for these families”.

Finally, the fact that society is becoming more and more accepting of obesity as the norm is exacerbated by a general lack of knowledge about the importance of nutrition. It was also suggested that parents get very confused with mixed messages from product information and marketing from food companies.
“Trying to get people to link obesity with undernourishment is a key issue. I think there needs to be more resources available and a recognised pathway for children who are undernourished”

To what extent are parents recognising that there is an issue with undernourishment in children and what are the issues surrounding this?

6.51 In all of the areas where we interviewed staff, there was a general concern about the lack of recognition by parents about the issues of under-nutrition and what might contribute to this. A common theme was that the majority of parents recognise when their child is under-weight. However, the relevance of nutrients is more difficult as most parents do not associate a lack of good nutrition if their child is the correct weight or over-weight.

6.52 Many of the professionals spoken to described a very sensitive situation especially with parents of obese children who may also be under-nourished. Staff felt inhibited and ill equipped to raise the issues as this was often perceived by parents to be judgmental and as a consequence concerns were often dismissed. The need for clearer, non-judgmental educational messages about the importance of food nutrients and the impact on health seems to be a gap and one worth pursuing further.

6.53 In Birmingham, comments were made about the fact that knowledge of nutrition is generally poor, education can also be poor with English often not a first language. It was felt that cultural issues can impact on nutrition and underlined the need for interpreters. However, staff felt that parents are generally quick to notice if a child is underweight or not growing.

“Parents usually recognise failure to put on weight and go to GP or HV with their concerns and referral would take place.”

6.54 In Bradford, it was suggested that at least 50% of children seen would not be getting a nutritional diet and that if blood tests were carried out they would show a lack of Iron or Vitamin D.

“Many parents don't link a problem with diet to poor health or behaviour”.

6.55 Families from different cultures have distinct views on feeding and what constitutes a healthy diet. Some cultures, especially those with a history of food not being plentiful, believe that children should be “bonny” and rounded so this can be a challenge for practitioners. The importance of training GPs in recording weights in children both under and over-weight was seen as very important.

6.56 Generally it was felt there was a lack of understanding amongst parents regarding nutrition or what to do if children are not eating. Parents may be unsupported, isolated or coping with a lack of facilities to cook. Socio-economic issues very much impact on parents who are really struggling. This is combined with a lack of understanding by parents of how to deal with behaviour issues such as not knowing how to restrict sweets, fizzy drinks etc.

“Some parents over-compensate with milk at the cost of other nutritional needs”.

6.57 Cornwall cited very similar issues, with the main challenge being parents’ understanding of the need for micro nutrients. Healthy food is often seen as a punishment or a chore and many staff felt parental recognition is more likely to be about their child being underweight and not about under nourishment. There was also concern that parents are
not aware of the low nutritional content in ready and take away meals.

“The knowledge about how to cook has been lost and not passed on by parents. More cooking classes are needed. It’s not about neglect just lack of education massive gap in knowledge”

6.58 There were also concerns about the negative coverage and approach to tackling undernourishment.

“Every year when the NCMP letters are sent out it was reported that at least one parent is unhappy and takes this to social media resulting in a big negative story.”

6.59 In Tower Hamlets there are also cultural issues with a feeling that many parents prefer their children to look slightly fatter and that gaining weight and being overweight is seen as desirable. The complexities of autism and feeding was also raised in several areas with some families of children with autism often perceiving that their child was not eating enough.

What other support is available or needed to work with parents/children?

6.60 There seemed to be some variation between the different areas in terms of available resources and the gaps identified. In Bradford and Cornwall there were some innovative initiatives across organisations including use of the voluntary sector. Local delivery (in Bradford) of the HENRY programme appeared to be very affective. The practical training for parents and young children was well received and appearing to have some impact – this resource is available nationally where locally commissioned, but not every local authority has commissioned the HENRY programme.

6.61 In Cornwall families relied more on the network of children’s centres which are highly valued by parents but often only known about by chance. Recently financial pressures are now beginning to impact on what can be offered. The LEAF service in Cornwall for 0-5 year olds which is part of the healthy weight programme 21 was praised as were the foodbanks which were doing much more than just providing food at times of crisis.

6.62 In Birmingham the community services are highly valued but were inhibited by a lack of more specialist dietetic support and health visitors in the community.

6.63 In Bradford there is a long wait to see a paediatrician if a child does not have a significant health problem. There is not a “one size fits all” but in terms of what is available - groups and practical help seem to work best. In terms of what is needed many agreed it would be helpful to have a longer period of time to work with families to encourage changes in behaviour.

6.64 There appear to be many innovative schemes in Bradford with a very proactive public health team. The Henry programme has already been mentioned, a pilot “cook and eat programme” is currently taking place, weaning groups, children’s centres and a new initiative which links up to community projects such as mini markets selling produce at an affordable price.

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21This is run in partnership with Royal Cornwall Hospital Trust and forms a Multi-Disciplinary Team Obesity Clinic that brings together the expertise of dieticians, physical activity specialists and paediatricians. The programme runs over four months. [https://www.cornwallhealthyweight.org.uk/professional/referral-programmes/](https://www.cornwallhealthyweight.org.uk/professional/referral-programmes/)
The Jamie Oliver Bradford Centre offers cookery groups for parents with children, young adults, families, disabled people, cultural groups as well as the general public. However, still more joint work with parents and children was stated as needed in Bradford as some services have been lost due to cutbacks such as nurses working specifically with young parents and a midwife/HV team working with drug dependent parents.

"Both were very helpful. We need a coordinated approach and more time for community led interventions or home visits”.

In Cornwall staff felt that further work was needed with parents to better understand what would help them engage so we had some good support in setting up our informal discussion groups which proved very useful (see Parent feedback section). Some staff felt that the current messages and information for parents was not suitable and that these need to be very short brief statements with some good research based evidence re what are the outcomes for children if undernourished. Four or five key messages could be put into the media which are not there at the moment. The current scoping work with the Eating disorder service in Cornwall has highlighted a gap in terms of key messages for under nourishment. Training and knowing where to signpost was also a gap which staff in all areas said a national pathway might help with. A programme in the USA was mentioned which provides weekly support for parents over 12 weeks.

In Cornwall there is a community hub which provides information and signposting which is an important aspect in providing support to families. This model is being adopted in other areas providing benefits advice for parents including support with problems about fuel costs which was frequently mentioned as a cause of under-nutrition, with families going without food because of lack of income. One case example from a food bank described finding a family who had not eaten for three days (following the collapse of a 13 year old girl at school) which occurred because the father who was self-employed had no work and didn’t know how to claim benefits. Also mentioned was the need for mental health support as sometimes issues were caused by a mental health problem with very little support available.

All areas felt that having clear NICE guidelines would move undernourishment up the agenda but that these should include a macro and micro-nutrient balance. Finally all areas mentioned the need for schools to do more to raise the importance of healthy eating. At meal times there is still a large amount of unhealthy foods available and limited healthy options.

In Tower Hamlets there are workshops and courses and referrals to Educational Psychologists and Speech and Language Therapists. The key professional group is seen as Health Visitors who have access to good information and can give consistent messages but there was concern that lack of resources is putting increasing pressure on this professional group with high levels of staff sickness and stress. The other major issue in Tower Hamlets is having access to a community paediatric dietitian which is only available through the hospital. The need for GPs to access dietary advice was also seen as a gap.

Tower Hamlets staff made a strong case for more sustained classes and workshops throughout the whole of Tower Hamlets. One member of staff said she ran nutrition workshops in Poplar as this area is funded by Morgan Stanley as part of the Healthy Cities Project.

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programme. Poplar has been chosen as it is one of the poorest areas in Tower Hamlets and is behind Canary Wharf, one of the richest areas. Having the right level of staff running the classes was also seen as important with a danger of less qualified staff putting their own slant on the classes and not necessarily giving the right advice.

What do you need to help you with children who are undernourished?

6.71 There were some good suggestions in terms of what help staff said they needed. These can be summarised under the specific headings below:

- **Healthy eating awareness/ training for families.**
- **Community based service** - using staff with nutritional training to deliver sessions on healthy eating or one to one support with feeding, cooking or shopping and budgeting and how to grow food.
- **Specialist support in the community** - from speech and language, Health Visitors, School nurses, paediatricians, GPs with a knowledge or interest in nutrition.
- **Access to diagnostic tests, blood tests etc.**
- **Translators and interpreters** for parents who don’t speak English.
- **A clear referral pathway** - for under-nutrition which includes both underweight and overweight and a holistic assessment approach.
- **Staff training** - to provide better knowledge, skills, understanding and consistent messages.
- **Access to vitamins** - more easily accessible for those who do not qualify for vouchers.
- **Information** – in different formats. DH leaflets available in printed format; social media, videos showing what could be done such as showing preparation, cooking, eating, in small chunks.

Do you have access to food banks? What do you think of them?

6.72 In all the areas there seems to be an increasing reliance on food banks which are now well established. As reported by the Marmot review23 in 2010 there are striking health inequalities in the UK resulting from social inequalities. This has led to a significant increase in the number of people living in food poverty and the foodbank network has grown rapidly in the last few years to meet this need24. The All Party Parliamentary Group on Hunger and Food poverty has also made recommendations aiming to promote and share models of support for individuals.

6.73 In Bradford food banks are run independently but in conjunction with a seven days a week project to provide hot meals available in different areas each day. Health and social care staff can signpost to these services for families in greatest need. Vouchers are provided by various agencies to give to families or they can be signposted through children’s centres where other help is also available such as financial advice”

6.74 In Cornwall there are 15 food bank hubs with a further eight distribution centres in neighbouring towns. Many staff said they accessed the food bank by providing vouchers for parents, but also stated how shameful it is that these are required in the UK. Over the last year a more structured network is beginning to develop and the Foodbanks in Cornwall

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23 The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.

24 Foodbanks in Cornwall- Dr Emma Kain 2015
2015 report\textsuperscript{25} outlines a sustainable food bank-plus model. This ensures that food banks offer more than just tinned food parcels, with fresh food. Relationships are being developed with farms and supermarkets, cooking classes and additional financial and benefits advice and support for families. The public health team is also working with food banks to get across important oral health messages and it was suggested that this could also be a route for more education about undernourishment.

“We are starting to get some oral health messages into food banks so could do same with undernourishment. Working with a charity to provide some free tooth brushes and training for food bank staff”.

6.75 In Tower Hamlets food banks are used by staff who provide vouchers but also use these to distribute the healthy start vitamins. Other staff in Tower Hamlets said they had never used them and that under-nutrition is not just about food poverty. Some health staff said they did not go into details about socio-economic status.

6.76 In summary food banks seem to be a useful and necessary resource in all areas where interviews were conducted. They are developing into useful centres to reach some families with the potential to do more. Based on the fact they rely on people donating food a campaign to raise awareness about standards and requirements for food banks may be useful as a national charter or campaign if not already being addressed in this way.

\begin{table}[h]
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\begin{tabular}{|p{0.9\textwidth}|}
\hline
\textbf{Comments from a food bank} \\
\hline
We started 6 years ago. Our food bank also runs IT sessions for over 60s, healthy weight programme for NHS, Slimming World, Krafty Kids after school club- where we see a need we try and meet it. We run from a Methodist Church. We have two paid drivers and the rest are volunteers. Grants are difficult to get for sustainability - they are given for new short term projects. We also include people coming out of prison helping in our warehouse, ex probation etc. Four more towns in Cornwall have this same system and a woman on holiday from Doncaster also started one and we provide information about how to get started. The problem is getting worse – government doesn’t recognise it and people don’t believe this is happening- I’ve had drivers come back in tears unable to continue driving because of the terrible things they have seen and conditions people are living in. One person was living in a pig sty - literally.

We provide a list of types of food we need but still people give us big bags of crisps, sugary drinks. The biggest problem is people emptying their cupboards with out of date food - if they won’t eat it why should others!

We try and set out three balanced meals per day and a freebie box with extras. People don’t understand what hunger is - if a family is hungry nutritional content is low on the list and we can only give out what we get given. We are careful to try and help people to cook and give recipe cards - we have a lady who comes in to teach children cookery and where food comes from. We aim to meet the need where it is.

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\end{tabular}
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\textsuperscript{25} Foodbanks in Cornwall- Dr Emma Kain 2015
Do you have any other comments?

At the end of the interviews we asked staff if they had any other comments. These can be summarised as follows:

- Issues of safeguarding and under-nutrition;
- Multi-cultural issues when English is not the first language and the use of interpreters is required to discuss nutrition and feeding with associated cultural issues;
- Uptake of free vitamins was mentioned a lot – either not available or if they are staff /families do not know about them or cannot access them;
- Lack of community dietitians and reliance on feedback from Health visitor /School nurse as don’t see what is going on in the community;
- Support for children with nutritional needs due to trauma or surgery, where adequate nutrition is linked to healing;
- Referrals to GPs and what is available does vary widely according to the area;
- Underweight in early years often turns to obesity in later years but is all related to poor nutrition;
- Commissioning: what is currently available; how services are being used and how existing services can be delivered closer to home and in a more joined up way;
- Both staff and parents welcomed the opportunity to talk about these issues in a non-threatening and non-judgmental environment;
- Staff keen to learn about what is happening in others areas;
- Under-nutrition is a growing health need which will manifest later in life so need to act now;
- Concern about poverty/ cheap fast food and impact this is having on people’s health;
- The impact of different cultures on parenting and the need for translation and work with different ethnic groups about nutrition;
- Lack of use of fruit and vegetables in some areas – “food desert”;
- Need to work with not be judgemental;
- Need to include in schools’ curriculum;
- Poor relationships between health visitors and parents – need time to develop relationships, often only one visit.

7 Findings from parent interviews and focus groups

7.1 As well as interviewing professionals from the four sites we carried out four discussion groups and eight individual interviews with parents in Cornwall and Bradford.

7.2 We adapted the staff interview pro-forma to structure the discussions with parents both in small groups and individually. The questions covered these topics:

a) What do you understand by the term under-nutrition/malnutrition?

b) What would you do if you thought your child might be under nourished or you were concerned?

c) Do you have enough information about keeping your child fit and healthy?

d) How do you know what to feed your child? Where did you learn this? What did your parents feed you? Some discussion about ready-made meals and takeaways if appropriate – any issues with these?

e) Any ideas- where should the information be? What type?
f) Do you know anything about food-banks – what do you think of them?

7.3 In Cornwall six individual interviews and three small discussion groups were held in a children’s centre with five to six parents in each informal group. Six interviews were also carried out in a playgroup and one small discussion group. At least 25 mothers were spoken to both in groups and individually. All parents interviewed were mothers and very interested in the topic and keen to take part in the discussions.

7.4 In Bradford feedback was obtained from two planned focus groups: one was hosted by and involved HENRY Parent Champions and a HENRY Coordinator with six Muslim and Asian parents and the second focus group was held in a local Children’s Centre and involved five Slovakian Roma and Polish Families with the support of an interpreter.

7.5 A summary of the key themes from all parents (groups and interviews) in each area is shown in the tables below headed by each question/discussion topic.

**What do you understand by the term under-nutrition/malnutrition?**

7.6 Most parents described under-nutrition in terms of not having the right foods, lack of vitamins, children underweight or overweight or showing signs of lethargy or sleepiness. Some parents also referred to the need for hydration as well as nutrition.

7.7 **Table 1: What do you understand by the term under-nutrition/malnutrition?**

<table>
<thead>
<tr>
<th>Cornwall - key themes</th>
<th>Bradford - key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Concerns over sugar / fats content;</td>
<td>• Insufficient or poor diet;</td>
</tr>
<tr>
<td>• Cost of good food;</td>
<td>• Insufficient vitamins/nutrients;</td>
</tr>
<tr>
<td>• Impact on health and wellbeing;</td>
<td>• Dietary requirements /portion size;</td>
</tr>
<tr>
<td>• Insufficient or poor diet;</td>
<td>• Impact on health and wellbeing;</td>
</tr>
<tr>
<td>• Insufficient vitamins nutrients;</td>
<td>• Health eating vs fads where there is a</td>
</tr>
<tr>
<td>• Lack of fluids/water;</td>
<td>medical reason;</td>
</tr>
<tr>
<td>• Dietary requirements /portion size;</td>
<td>• Cost of good food.</td>
</tr>
<tr>
<td>• Health eating v fads where there is a medical reason.</td>
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</tr>
</tbody>
</table>

**Other important feedback**

Some parents reported a conflict between generations citing grandparent’s attitude in conflict with their own. Others suggested that in busy lives convenience food was an easy option. One parent suggested that parents would not realise that a child was undernourished if they were over-weight.

7.8 **Table 2: What would you do if you thought your child might be undernourished?**

<table>
<thead>
<tr>
<th>Cornwall – key themes</th>
<th>Bradford -key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Concerns about talking to professionals are we doing it right /will they tell us off;</td>
<td>• Speak to family or friends for advice;</td>
</tr>
<tr>
<td>• Contact GP or health visitor;</td>
<td>• Contact GP or health visitor;</td>
</tr>
<tr>
<td>• Concerns over repercussions if parent is struggling mentally;</td>
<td>• Check online.</td>
</tr>
<tr>
<td>• Weighing a bit of an obsession.</td>
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</tbody>
</table>
Other important feedback
Some parents expressed a fear of being judged by health care professionals and others indicated that advice was often contradictory and confusing. One person said they would return home to Poland for advice and several people thought that the language barrier made getting help or advice very difficult, as there were no interpreters or information in their language. One woman had a child who was autistic and said that autism affected the way they ate but was offered advice on different ideas for helping them eat, offering a selection of foods they could pick up; was there a colour of food that was more attractive; using stories and making mealtime fun. The lady said her family worker and the HENRY programme had been helpful.

Interestingly almost as many people suggested they would contact family, friends or go online for advice than those who indicated they would contact a health care professional. Lack of information, fear of being judged and language barriers were all cited as obstacles to contacting statutory agencies.

Do you have enough information about keeping your child fit and healthy? Where are the gaps?

Several references were made to the need for practical advice and lessons on how to cook fresh food allied to the availability of simple, affordable recipes for meals which can be made from everyday ingredients. These issues are also cited as obstacles and perhaps reasons why fast food options are so popular. The availability of information in other languages was also seen as important.

Table 3: The main gaps identified by parents.

<table>
<thead>
<tr>
<th>Cornwall – key themes</th>
<th>Bradford- key themes</th>
</tr>
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<tbody>
<tr>
<td>• Practical advice / lessons on how to cook fresh ingredients;</td>
<td>• Surrounded by fast food, smell, convenience and cost is very appealing;</td>
</tr>
<tr>
<td>• Quick &amp; easy meal planners &amp; simple recipes;</td>
<td>• Information not always accessible to those where English is second language;</td>
</tr>
<tr>
<td>• Free weaning sessions / leaflets including issues such as diabetes;</td>
<td>• Time pressures – working and looking after children;</td>
</tr>
<tr>
<td>• Recipe ingredients that are available and affordable;</td>
<td>• Families more isolated, less help with children and cooking;</td>
</tr>
<tr>
<td>• Facebook group to ask advice of other mums linked to TV campaign;</td>
<td>• Nutrition Transition – lack of information on changing to Western diet and impact.</td>
</tr>
<tr>
<td>• Cooking classes for children at primary school;</td>
<td></td>
</tr>
<tr>
<td>• Need the “why” rather than “why not”;</td>
<td></td>
</tr>
<tr>
<td>• Pre-birth advice on nutrition.</td>
<td></td>
</tr>
</tbody>
</table>

Other important feedback
Several people from both communities commented on how fresh food was better value and better nutritionally but often people don’t realise that fast food is unhealthy and do not make the link with nutrition. Others made reference to the lack of nutritional advice / information at anti natal and weaning stage.
Table 4: How do you know what to feed your child? Where did you learn this?

<table>
<thead>
<tr>
<th>Cornwall – key themes</th>
<th>Bradford – key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Children’s Centre cooking classes – but stopped due to recent cutbacks;</td>
<td>● Lack of translated information;</td>
</tr>
<tr>
<td>● Issues mostly income related;</td>
<td>● Lack of interpreters when speaking to HV GPs;</td>
</tr>
<tr>
<td>● Parents/grandparents good and bad;</td>
<td>● Role of St Edmunds and the help of their European Union worker;</td>
</tr>
<tr>
<td>● Adverts – always about “don’t “rather than “why”;</td>
<td>● High level of awareness that home cooked food was much better than fast food or prepared foods;</td>
</tr>
<tr>
<td>● Many people don’t have or use blenders;</td>
<td>● Parents/grandparents taught how to cook by their mother, mother-in-law or grandmother;</td>
</tr>
<tr>
<td>● Accessible information – people are more aware and keen to learn more but lack of information.</td>
<td>● Information about cooking they would ring friends, family or go to the intranet / helped others</td>
</tr>
</tbody>
</table>

Other important feedback
Significant numbers suggested it was a lack of time, money or information which lead to an over reliance on fast food. Both communities found isolation due to rurality or culture an inhibiting factor in obtaining information / advice.

7.12 This question provoked a lot of discussion with parents commenting on their own upbringing, the confusion and conflicting messages and the influence of grandparents. The lack of education about nutrition and cooking skills in schools was a frequent comment. Whilst some parents had cookery classes at school some of the younger mums said this had now stopped and their own children were getting nothing. Some also made comments about their own parents and what poor diets they were given as children – “everything out of a packet” whilst so many grandparents are looking after their grandchildren they are still having a huge influence yet the information is not reaching them. The need for help with meal planners, shopping guides, budgeting etc. was frequently mentioned as well as where to learn what their child needed. Some parents suggested it could be cheaper to cook from scratch whilst others said it was easier to have a takeaway.

Table 5: Any ideas- where should the information be? What type?

<table>
<thead>
<tr>
<th>Cornwall - key themes</th>
<th>Bradford - key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Overload of existing information which is poor or irrelevant;</td>
<td>● Information easy to read if English is not first language;</td>
</tr>
<tr>
<td>● Demos, displays, talks would be good;</td>
<td>● More accessible information about what help is available locally, including links to web-sites /helpline;</td>
</tr>
<tr>
<td>● Recipes often obscure ingredients/ not suitable for toddlers;</td>
<td>● Need sessions on how to cook;</td>
</tr>
<tr>
<td>● Within GP surgeries on notice boards;</td>
<td>● Access to culturally appropriate food;</td>
</tr>
<tr>
<td>● CBeebies – should promote healthy eating;</td>
<td>● Faith based groups useful source;</td>
</tr>
<tr>
<td>● Health visitor – need to be more approachable;</td>
<td>● Existing information poor;</td>
</tr>
<tr>
<td>● Information and signposting in Red Book.</td>
<td>● Children’s centres were really useful source of information/ support but many closed because of council cuts.</td>
</tr>
</tbody>
</table>
Other important feedback
Feedback suggested children’s centres were a useful source of information, advice and practical help but this appears to be on the decline. Several people wanted information on how to grow food. This particular exercise was well supported partly because the group was non-judgmental and that they had an interpreter.

7.13 A common theme which emerged from both groups was the lack of information about what to cook, how to cook; how to shop for meals and how to budget. Both groups identified the benefits of practical sessions which would help skills development, information exchange, learning and support. All parents spoken to felt there was insufficient information provided about nutrition both at the children’s centre, playgroup or in other places such as libraries, supermarkets, health centres etc. There were some very useful suggestions about the type of information needed and how this could be presented. They also commented on the huge amount of publicity nationally which they felt is very confusing with different messages.

7.14 There were a variety of responses which indicated that one method does not suit everyone. Some people wanted more leaflets, others less. Timing seemed important – at the weaning stage there seems an opportunity for longer term information about health diet and what constitutes good nutrition. One suggestion was the use of a toy library to obtain free recipes, meal planners, recipes/swaps seemed a good idea.

Table 6: Do you know anything about food-banks – what do you think of them?

<table>
<thead>
<tr>
<th>Cornwall - key themes</th>
<th>Bradford- key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Education element and advice on how to cook or shop such as using cheap cuts of meat etc;</td>
<td>• Food is often not appropriate/not fresh;</td>
</tr>
<tr>
<td>• No fresh food - all tinned;</td>
<td>• Access only if on benefits - no help if you have suddenly lost your job or you are without money:</td>
</tr>
<tr>
<td>• No free vitamins offered;</td>
<td>• Can’t make a meal from items available;</td>
</tr>
<tr>
<td>• No information about healthy eating / nutritional value of food.</td>
<td>• Often located in wrong area.</td>
</tr>
</tbody>
</table>

Other important feedback
Several people cited the lack of information / advice at some sites and these were seen as an opportunity to reach people in an informal setting.

7.15 Interestingly both groups made reference to the lack of fresh food and the over reliance of tinned or processed foods. Equally both groups made mention of the lack of information / advice.

Suggestions and ideas from parents for improvements in information

7.16 Education

• When we do baby weaning classes, rather than a chat, a six week course on weaning could include two weeks on weaning then four weeks of basic cooking which would be much more useful;
• Lot more things needed in schools – you’d be surprised how it’s changed – no cooking or wood tech - they don’t do much in primary school now;
There’s never encouragement or positivity – we need more of that in our culture – it’s always “no don’t do this”, when we should encourage children more.

7.17 Information and advice

- Information about the benefits of fruit and vegetables;
- Social media - lot of people use this - Facebook, Twitter, Instagram, even posters;
- Where people go - bus-stops, train stations, doctor’s surgeries, dentists- there’s nothing about food that makes your teeth bad;
- A leaflet early on with the green book or with the breast feeding guide – so much emphasis on that – add the information to an existing book;
- Displays are good – look nothing here ( in Children’s Centre ) – nothing been done on vitamins;
- Your check-up get a free tooth brush – what about healthy eating tips
- Could get local farms / supermarkets involved;
- Last year Jamie Oliver did something on TV– if we could get local chefs such as Rick Stein to do short 15 minute films with ideas on healthy, easy recipes would be good;
- School dinners – one day a week dinner ladies could do something to raise awareness – could easily grow veg in schools;
- Could also encourage more on growing food – last year they grew strawberries – what about vegetables?
- Best place is TV adverts targeting all ages;
- Local radio- information about importance of healthy fats /diets;
- Supermarkets could advertise more and put information on the food about why it is important to eat;
- Avoid fear of contacting professional by use of possible third sector / helpline;
- Language difficulties can make getting help or advice very difficult so there needs to be greater access to interpretation services in person/online or by phone.

7.18 Practical sessions

- Need more activities like cooking and trying news foods. Sugar tax hasn’t got the message across;
- Libraries could do more about food – they have some great activities like singing and reading;
- Leisure centres- St Ives do baby singing lessons so could do something there;
- Boots parenting club is good - could make more use of this and other clubs – extra points – send free information;
- Lessons / advice on how to prepare and cook affordable meals from ingredients that are readily available – cost v convenience;
- Practical advice on different ideas for helping children too, offering a selection of foods they could pick up; was there a colour of food that was more attractive and using stories and games to make meal times more enjoyable.

7.19 The message that any national or local campaign must be non-threatening, non-
judgmental and work with parents explaining the reasons and what good nutrition is rather than telling us what we should and shouldn’t do. If parents were better informed about why certain foods are better than others and what their children need for healthy development it would make much more sense rather than a confusing array of messages and provide an incentive for changing eating behaviour.

8 Conclusion

8.1 This project has provided a very useful opportunity to talk with both frontline staff and parents and identify the issues that are important to them with regards to under-nutrition. When we began the project we decided to focus on 0-5 year olds and look in more detail at whether ethnic origin played any part in affecting the size of the problem, take up of services and parental awareness. We were also interested in looking at a rural, predominantly white community in comparison.

8.2 This has been a relatively small study of staff and parent feedback and can in no way be considered a piece of research. However the qualitative nature of the interviews and the richness of material gathered highlights very similar themes and issues which seem very well worth exploring in more detail. The practical ideas and suggestions from parents as well as the honest and informed discussions with staff from different professions and organisations provide some valuable input into the recommendations and provide some very insightful comments about what is working well and where are the gaps.

8.3 Whilst there appears to be a common understanding about the definition of “under-nutrition” and what this means as a concept, the linkage between symptoms and cause seems to be missing. There are clearly some very committed professionals working in each of the areas we targeted who are providing a good service to many families. However staff are increasingly stretched due to lack of resources and feel so much more could be done if priority is given to this important aspect. Food is so fundamental to our health that unless we get this right this will affect our health and well-being for many years to come and the pressure on future NHS and care services.

8.4 Although there were many similarities between the different communities spoken to there were several common themes, family support, language barriers and cultural views about food, diet and weight do also play a part.

8.5 A clear pathway and protocols with some national guidance were requested without being too overly rigid and causing concerns when not there, alongside a need for better diagnostic and assessment tools such as access to blood tests.

8.6 An overreliance on the National Child Measurement Programme and use of BMI measures meant the vital signs of malnutrition are often missed. Training, greater awareness by GPs and a need for more community dietitians was a common plea. Whilst staff on the whole felt there was sufficient information for parents and at times overload, this did not concur with what parents were telling us and some staff are still producing their own information.

8.7 Parents are very confused about what is “good nutrition” and desperate for more information about the “why’s” and “how” rather than what they should or shouldn’t do and being held in judgement. Alongside this was a need for health and social care staff to be more confident in discussing such issues with parents and having the skills, knowledge and tools to do this.
All the parents spoken to seemed to benefit from the opportunity to discuss this topic and asked for more similar sessions. Parents in both Bradford and Cornwall said they liked the informality and non-judgmental approach we had taken to provide some time to discuss the issues which are important to them and the amount of good ideas generated by parents will be used to inform our recommendations below.
9 Recommendations

Based on the findings outlined in this report, the Child Malnutrition Advisory Group makes the following recommendations:

**Recommendation 1:** A staff awareness raising campaign about “under-nutrition” is developed for all relevant professionals including commissioners and providers in the NHS and Local Authorities.

**Recommendation 2:** A public awareness raising campaign about “under-nutrition” and its potential impact on health is developed in conjunction with Change 4 life, Public Health England and NHS England building on the ideas suggested by parents and staff in this project.

**Recommendation 3:** A campaign is targeted at professionals and the public via social media which includes links with Change 4 life.

**Recommendation 4:** Links are made with Health Education England to ensure that the identification and treatment of “under-nutrition” are included in existing and new staff training programmes.

**Recommendation 5:** A greater focus is given to the use of an assessment tool which identifies under-nutrition.

**Recommendation 6:** The role of the Chief Medical Officer is explored to champion the issues around under-nutrition.

**Recommendation 7:** The use of food banks and children’s centres is maximized to communicate with parents about nutrition to ensure a non-judgmental and non-threatening approach based on the learning from the consultation in this project.

**Recommendation 8:** The Red book is explored as a means of providing information to parents such as a one page summary of information on nutrition or a template for local areas to add information to.

**Recommendation 9:** National guidance and a care pathway is developed specifically for under-nutrition to cover wider aspects of underweight and overweight.

**Recommendation 10:** A definition of under-nutrition is agreed which includes both underweight and overweight – i.e. when there is a lack of nutrients.

**Recommendation 11:** A series of templates should be produced centrally which could be downloaded locally to ensure consistency of messages.

**Recommendation 12:** The findings are submitted to NICE as part of the Faltering Growth Guidelines but also to ask whether guidelines for Children re Nutritional support could be provided.
10 References


2. NCMP data sets: [http://www.hscic.gov.uk/ncmp - overview NCMP local data sets](http://www.hscic.gov.uk/ncmp - overview NCMP local data sets) [http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22national+child+measurement+programme%22&area=&size=10&sort=Relevance](http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22national+child+measurement+programme%22&area=&size=10&sort=Relevance) data (select the year required)


6. Giving children the best start in life, supporting healthy lifestyles and communities and preventing ill-health were identified as key actions to reduce health inequalities in the Marmot Review, Fair Society, Healthy Lives (2010). at [www.ucl.ac.uk/marmotreview](http://www.ucl.ac.uk/marmotreview)


8. Trussell Trust. [http://www.trusselltrust.org/how-it-works](http://www.trusselltrust.org/how-it-works)


16. [https://www.cornwallhealthyweight.org.uk/professional/referral-programmes/](https://www.cornwallhealthyweight.org.uk/professional/referral-programmes/)


**Useful resources**

[www.firststepsnutrition.org](http://www.firststepsnutrition.org)
[www.nhs.uk/change4life](http://www.nhs.uk/change4life)

Working in partnership- information leaflet – “Growing up well”-Liverpool Primary Care Trust and Liverpool Community Health NHS Trust= Helpful information for families where a child may be underweight or growing slower than expected.2011
## Appendix 1: Child Malnutrition Project Advisory Board Members

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Institution/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>James Bunn</td>
<td>Alder Hey Children’s Hospital, Children’s Food Trust, Consultant Paediatrician</td>
</tr>
<tr>
<td>2</td>
<td>Kath Evans</td>
<td>NHS England Nursing Directorate, Experience of Care Lead – Maternity, Infants, Children and Young People</td>
</tr>
<tr>
<td>3</td>
<td>Mary Fewtrell</td>
<td>Royal College of Paediatrics and Child Health Nutrition Committee, Chair and Consultant Paediatrician</td>
</tr>
<tr>
<td>4</td>
<td>Annette James</td>
<td>Public Health, Liverpool City Council, Head of Children’s Health Improvement</td>
</tr>
<tr>
<td>5</td>
<td>Sue Hatton</td>
<td>Health Education North Central and East London, (SH) Nursing and Child Health Lead</td>
</tr>
<tr>
<td>6</td>
<td>Susan Hill</td>
<td>Great Ormond Street Hospital, Consultant Paediatrician - Nutrition and Intestinal Failure Working Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of the British Society of Gastroenterology, Hepatology and Nutrition (BSPGHAN) and as the paediatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Council Member of BAPEN.</td>
</tr>
<tr>
<td>7</td>
<td>Louis Levy</td>
<td>Public Health England, Head of Nutrition Science Diet &amp; Obesity Health and Wellbeing Directorate,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Health England-unable to attend meetings but keen to be kept informed.</td>
</tr>
<tr>
<td>8</td>
<td>Elaine Mealey</td>
<td>London Metropolitan University, Paediatric Dietitian</td>
</tr>
<tr>
<td>9</td>
<td>Angus Milton</td>
<td>Oxford Health NHS Foundation Trust, Paediatric Dietitian</td>
</tr>
<tr>
<td>10</td>
<td>Katherine Murphy</td>
<td>The Patients Association, Chief Executive</td>
</tr>
<tr>
<td>11</td>
<td>Hana Najsrova</td>
<td>Royal College of Paediatrics and Child Health, Children and Young Peopleʼs Participation and Advocacy</td>
</tr>
<tr>
<td>12</td>
<td>Wendy Nicholson</td>
<td>Public Health England, School Nursing lead</td>
</tr>
<tr>
<td>13</td>
<td>Sue Protheroe</td>
<td>Birmingham Children's Hospital NHS Foundation trust, British Society for Paediatric Gastroenterology,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatology and Nutrition, Tertiary Specialist.</td>
</tr>
<tr>
<td>14</td>
<td>Astor Rodrigues</td>
<td>Oxford Health NHS Foundation Trust, Consultant Paediatrician</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Organization</td>
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<tr>
<td>15</td>
<td>Ashlee Mulimba</td>
<td>London Borough of Tower Hamlets</td>
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<tr>
<td>16</td>
<td>Cheryl De Sousa</td>
<td>London Borough of Tower Hamlets</td>
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<tr>
<td>17</td>
<td>Manuwuba Eke</td>
<td>London Borough of Tower Hamlets</td>
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<tr>
<td>18</td>
<td>Leonora Weil</td>
<td>NHS England Nursing Directorate</td>
</tr>
<tr>
<td>19</td>
<td>Teresa Wilson</td>
<td>The Patients Association</td>
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<tr>
<td>20</td>
<td>Jane Casterton</td>
<td>The Patients Association</td>
</tr>
<tr>
<td>21</td>
<td>Heather Eardley</td>
<td>The Patients Association</td>
</tr>
</tbody>
</table>

**Appendix 2: Range of staff interviewed in each pilot site**

**Bradford n=15**

- School Nurse Team Leader
- Head of Service Development
- GP; Clinical Board Member Bradford District CCG Clinical; Specialty Lead for Children and Young People; Named Doctor Safeguarding Children
- HENRY Coordinator (Health, Exercise, Nutrition for the Really Young)
- Nutrition Improvement Dietitian
- Interim Head of Children’s Services
- Health Visitor
- Environment Officer
- Clinical Lead - Health Visiting,
- Neonatal & Paediatric Dietitian, CSS Nutrition & Dietetics
- Child Health Specialist
- Health Improvement Practitioner
- Development Manager VCS and Chair of Health and Wellbeing Forum
- Principle Dietitian Paediatrics and Nutrition Improvement
- Senior Manager, Public Health

**Birmingham n=5**

- Head of Child Protection Service; Named Nurse Child Protection
- Senior Paediatric Dietician
• Paediatric Dietitian – Team Leader
• Royal College Curriculum Advisor on Nutrition for Gastroenterology and Hepatology
• Team Leader Community Children’s Nursing & Palliative Care

Cornwall n=13

• Child Protection Social Worker
• Senior School Nurse
• Dietitian for Disabled Children
• Children’s Dietitian
• Children’s Centre Cluster Manager x 2
• Community Paediatric Consultant
• Children & Young Peoples Lead
• Director of Operations
• Infant Feeding Co-ordinator / Health Visitor
• Public Health practitioner
• Children’s Paediatric Dietitian
• GP

Tower Hamlets n = 7

• Health Visitor
• Lead Speech and Language Therapist for Dysphagia
• Senior Educational Psychologist
• Community Nutritionist
• Clinical Lead Child Health Paediatrician/ GP
• Play and Learning Lead.
• Lead Paediatric Dietitian

Total professionals interviewed = 40