IT TAKES A VILLAGE

EMPOWERING FAMILIES AND COMMUNITIES TO IMPROVE CHILDREN'S HEALTH

Amy Gandon
and **Sebastian Rees**

November 2025

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is an independent charity working towards a fairer, greener, and more prosperous society. We are researchers, communicators, and policy experts creating tangible progressive change, and turning bold ideas into common sense realities. Working across the UK, IPPR, IPPR North, and IPPR Scotland are deeply connected to the people of our nations and regions, and the issues our communities face.

We have helped shape national conversations and progressive policy change for more than 30 years. From making the early case for the minimum wage and tackling regional inequality, to proposing a windfall tax on energy companies, IPPR's research and policy work has put forward practical solutions for the crises facing society.

IPPR
8 Storey's Gate
London
SW1P 3AY
E: info@ippr.org
www.ippr.org
Registered charity no: 800065 (England and Wales),
SC046557 (Scotland)

This paper was first published in November 2025.

CONTENTS

ABOUT THE AUTHOR

Amy Gandon is an associate fellow at IPPR.

Sebastian Rees is a principal research fellow and head of health at IPPR.

ACKNOWLEDGEMENTS

The authors would like to thank Impact on Urban Health who generously funded this project.

We are also grateful to Public First for their skill and collaboration on the national survey of parents in England, which provided vital insights for this report.

The authors would also like to thank Jamie O'Halloran, Ranya Hossein, Avnee Morjaria, Ashwin Kumar, Emma Norris, David Wastell, Liam Evans, Abi Hynes, Richard Maclean, Rosie Okumbe and Hosam Dahimi for their contributions to this work. We are also grateful to colleagues at the Royal College of Paediatrics and Child Health who agreed to be interviewed as part of this project.

Most of all, we would like to thank the parents and carers who generously shared their time and experiences with us, and whose insights now form the basis of this report and its recommendations.

Supported by

Impact on Urban Health

Download
This document is available to download as a free PDF and in other formats at:
http://www.ippr.org/articles/it-takes-a-village-childrens-health

Citation
If you are using this document in your own writing, our preferred citation is:
Gandon A and Rees S (2025) *It takes a village: Empowering families and communities to improve children's health*, IPPR. http://www.ippr.org/articles/it-takes-a-village-childrens-health

SUMMARY

Improving children's health has been a priority for decades. Yet, despite billions of pounds of investment and countless initiatives, outcomes are stagnating or getting worse. This government has pledged to create the "healthiest generation of children ever" and signalled a renewed focus on prevention and community health through the NHS 10 Year Plan. However, **rhetoric risks running ahead of reality, with few new policies that add up to the scale of change required**.

As our previous report *Fixing the Foundations* (2025) warned, children's health too often commands rhetorical commitment but limited follow-through, constrained by political short-termism, fragmented responsibility and a health system locked into reactive spending as immediate demand continues to rise.

THE MISSING PIECE IN CHILDREN'S HEALTH POLICY

This report argues that **we need a decisive break with the status quo**. Policy has too often focussed on the most visible and accessible levers – establishing new services or increasing treatment capacity – rather than the deeper work of changing the conditions that make children unwell in the first place. The system has been busy, but not effective.

By contrast, the biggest improvements in young people's health over recent decades – from declining smoking rates to the sharp drop in teenage pregnancy – were driven by government facilitating shifts in everyday habits and social norms. **A new kind of statecraft** – rooted in the everyday lives of families and communities – **is essential if we are to build the healthiest generation of children ever**.

THE CASE FOR CHANGE

IPPR conducted new primary research – a nationally representative survey of more than 1,500 parents and six focus groups across England – to look beyond the statistics into the everyday realities of raising children in the UK today.

Parents described a healthy childhood in holistic terms, placing as much importance on emotional wellbeing as on physical health. They wanted their children to feel safe, loved and free to be themselves, and to have varied, active experiences rather than the screen-based childhoods they feared were becoming the norm. Yet they also described growing barriers to that ideal – from the cost of healthy food and activities to pressures from work, new technology and overstretched public services.

Parents felt they were the most responsible and influential actors in their children's health, but also that they were at the mercy of wider forces – from the food industry to tech companies, both of which they viewed as more powerful than the NHS or national government. Many described shouldering more of the burden as the health system struggled: turning to expensive private care, piecing together 'DIY' packages of support or simply hoping problems would resolve on their own. But in doing so, many felt ill-prepared from the outset, overwhelmed by conflicting information, and lacking informal, trusted support to navigate it.

A NEW SOCIAL CONTRACT FOR CHILDREN'S HEALTH

Families are the hidden frontline in the mission to improve children's health. They already provide most of the day-to-day care that keeps children well — from meals and routines to responding to illness and distress. This is truer now than ever, as the NHS faces sustained pressure that shows little sign of easing in the short term. Yet this reality is barely acknowledged in policy. Across decades, political thought has often swung between two unhelpful poles: a minimal state that leaves families to fend for themselves, and a paternalistic state that treats them as passive subjects of professional oversight. Both have failed.

A progressive alternative must see parents and families as trusted and capable partners and back them with the knowledge, support and conditions to help them perform these roles. Around them, communities must provide connection and practical help, while the state is braver and clearer about its own role, using levers only the state has to confront the wider socioeconomic forces that no family can tackle alone.

A VISION FOR REFORM

To rebuild the 'village' around every child, this report calls for action on three fronts.

1. Empowered families: giving parents the information and confidence to succeed.

National government and the NHS – working with local services and trusted charitable and media partners should:

- introduce a 'Growing Together' Guarantee: universal antenatal education and postnatal support through the first year of parenthood
- reboot the parental information ecosystem, harnessing new media to share trusted, human and relatable advice rather than formal, clinical messaging.

2. Supportive communities: rebuilding local infrastructure for family life.

Local authorities – with national investment and co-ordination through Integrated Care Systems – should:

- establish 'Family Connect', countering poor signposting through proactive, personalised outreach linking parents to local support
- introduce 'Bridges', offering professional and peer support to parents of children awaiting treatment, helping families meet needs in the meantime
- ensure Neighbourhood Health Centres are designed around families and children, with family-friendly spaces and co-location with relevant services.

3. An enabling state: creating the conditions for families to thrive.

Acting on the structural conditions shaping family life, national government should:

- make healthy food affordable and accessible: integrate affordability into the Healthy Food Standard, extend Free School Meals and close marketing loopholes
- protect children from technology and social media harms, tightening Online Safety Act protections and expanding free 'offline' activities in the community
- act on income and work to give families time to care: removing the two-child limit, extending paternity leave and promoting family-friendly working standards.

By rebalancing care and power across families, communities and the state, government can build a society that gives every child the strongest start in life and secures a healthier, fairer and more prosperous future for the nation as a whole.

METHODOLOGY

This report draws on new primary research undertaken by IPPR: a qualitative study and a nationally representative survey of parents and carers.

NATIONALLY REPRESENTATIVE SURVEY

A nationally representative survey of 1,523 parents in England was conducted by **Public First** between 19–26 September 2025. The survey explored parents' views on their children's health and wellbeing, their sense of responsibility and agency, their access to services, and their priorities for government action.

Sampling was designed to be representative by region, age, gender, income and education, and results were weighted using Iterative Proportional Fitting ('raking') to align with the national parent population. Findings were analysed across socioeconomic, educational and political groups to identify patterns in attitudes and experiences.

QUALITATIVE RESEARCH

IPPR conducted six 90-minute focus groups with 43 parents and carers of children aged 0–18, held across England in summer and early autumn 2025. Three groups focussed on the early years (0–5) and three on adolescence (11–18) – two pivotal stages for laying the foundations of lifelong health.

Participants were primarily recruited through local children's services, with additional recruitment to ensure diversity by socioeconomic background, working status, ethnicity, gender and geography. (For full sample details, see Appendix 1).[1]

Discussions explored what parents believe makes a healthy childhood, the barriers they face, and what forms of support and policy change would make the biggest difference.

Together, these two strands of research combine robust national evidence with rich qualitative insight into the lived realities of parenting and children's health in England today.

1 The appendices for this report are available at: http://www.ippr.org/articles/it-takes-a-village-childrens-health

1. THE STATE WE'RE IN: CHILDREN'S HEALTH AND THE LIMITS OF THE STATUS QUO

IPPR's previous report made the case for investing in children's health and for reshaping government architecture to overcome the short-term incentives that threaten lasting progress. This report shifts the lens to policy design itself: exploring why, even when investment and attention are secured, interventions on the ground so often fail to deliver lasting change.

1.1 BUILDING ON THE FOUNDATIONS

In May 2025, IPPR published *Fixing the Foundations: The case for investing in children's health* (Gandon and O'Halloran 2025). That report highlighted widespread and entrenched problems across children's physical and mental wellbeing: stubbornly high rates of obesity, worsening mental health outcomes and stark inequalities between rich and poor. Drawing on new analysis of the 1970 British Cohort Study,[2] it also showed that poor health in childhood casts a long shadow, threatening individuals' health in later life but also the nation's long-term prosperity.

While it drew on fresh data, this was not a brand-new insight, reflecting decades of evidence and political consensus around prevention and early intervention. *Fixing the Foundations* showcased that – despite this – children's health has struggled to command sustained political attention: the benefits of investment accrue decades later, outside electoral cycles; children have no vote and little voice; and our political and media culture draws ministers towards the visible, the urgent and – ultimately – the adult.

Since that report was published, the government has renewed its commitment to prevention and other ambitions relating to children: expanding Mental Health Support Teams and Free School Meals in schools, continuing Family Hubs and the Start for Life programme, proceeding with restrictions on energy drinks and junk food advertising, and rolling out vaccination and supervised toothbrushing initiatives. But as IPPR warned in *Fixing the Foundations*, these are unlikely to add up to the ambition to create 'the healthiest generation of children ever' (Labour Party 2024). And despite positive signals, there is a risk that the political spotlight on children's health is beginning to dim. It held less prominence in the 10 Year Plan (DHSC 2025b) than in Lord Darzi's diagnostic review (Darzi 2024), and the prime minister's recent 'reset' – with a focus on 'delivery, delivery, delivery' (BBC News 2025) – may signal a narrowing of focus on quick wins that can be readily counted before the next election.

With all of this in mind, it is worth re-emphasising the recommendations made in our previous report, designed to better align political, institutional and financial incentives with a more sustained focus on children.

2 See https://cls.ucl.ac.uk/cls-studies/1970-british-cohort-study-2/

Recommendations from *Fixing the Foundations*

- **Reframe child health as a nation-building mission**, on a par with net zero or major infrastructure projects
- **Introduce a children's investment standard** to safeguard spending on children and 'hardwire' preventative spending in the NHS and other public services
- **Strengthen internal and external accountability for delivery**, giving a single person oversight of children's wellbeing, creating a single, coherent view of spending and expanding the role of the children's commissioner
- **Adopt a phased prevention strategy**, targeting the 'quick wins' needed first to reduce acute demand and release resources to unlock longer-term reform
- **Take bold regulatory action**, including through levies that tackle health harms while raising additional revenue.

1.2 FROM SERVICES TO SYSTEMS: LEARNING FROM THE PAST

This is not the whole picture, however. The challenge is not simply one of political follow-through, but of policy design. Even where governments have delivered on their ambitions, progress has stalled because interventions have been too narrow in focus. Mental health and obesity illustrate the point: no two policy areas have received more attention or investment over the past 15 years, yet outcomes have barely shifted — or in some cases gone into reverse.

Mental health and wellbeing

Box 1.1 sets out 15 years of policy on children's mental health – and investment totalling over £5 billion. The targets governments have set for themselves are telling: the expressed aim of policy has been to *treat more sick children,* rather than *reducing the number of sick children in the first place.*

Of course, to some extent this focus on services has been necessary. One of the achievements of this same period has been the destigmatisation of mental ill-health and recognition that it can befall any of us, including children, and in such instances, professional support must be available. However, young people's lives have also been buffeted by profound changes over that same period: a more pressurised education system, the encroachment of digital technology, rising poverty and family stress, and a broader backdrop of geopolitical tension, social division and climate anxiety. Substantial research points to the role of these forces in children's wellbeing, yet these insights are surprisingly absent from the national policy response.

BOX 1.1: 15 YEARS OF ACTION ON CHILDREN'S MENTAL HEALTH - AMBITION VERSUS OUTCOMES

Target(s):

- 2015: "By 2020, every child and young person should have timely access to clinically effective mental health support when they need it" (DoH and NHSE 2015)
- 2019: "To provide support for an additional 345,000 children and young people through NHS and school-based Mental Health Support teams by 2023/4" (NHSE 2019)
- 2024: "Ensure every child has access to a specialist mental health professional at school, supported by 8,500 new staff and a Young Futures hub in every community" (DfE 2024).

Reality:

- Prevalence of mental ill-health has risen sharply: the share of children with a probable mental disorder has nearly doubled from 10.8 per cent (2017) to 20.3 per cent (2023) (NHS Digital 2023)
- Access to services has improved but remains below demand: 320,000 children had an active referral but were still waiting to start treatment at the end of 2023/24 (Children's Commissioner 2025).

Initiatives and spending

Initiative (and when introduced)	What it involves	Associated spending
Improving Access to Psychological Therapies (Children and Young People) (2011)	Expanding access to evidence-based therapies.	£60m over 4 years (2011–15/16) (DoH 2015)
Local Transformation Plans (2015)	Redesigning and expanding local CAMHS systems.	£1.25bn over 5 years (2015–19) (NHSE 2019)
School-based Mental Health Support Teams (2018)	Multidisciplinary teams providing support in schools and colleges.	£300m over 3 years (2018–21) (DHSC and DfE 2017)
NHS Long Term Plan: expansion of specialist CAMHS access (2019)	Expanded access to 345,000 more children and young people.	c. £700m per year (of a 2.3bn uplift) (NHSE 2019)
Crisis and Liaison Services (2019)	Rollout of 24/7 community crisis response and mental health liaison in hospitals.	(Funded within broader Long Term Plan uplift – ibid)
Eating Disorder Service Expansion (2019)	Strengthening community eating disorder teams and waiting time standards.	£30m per year, ongoing (ibid)
Mental Health Recovery Plan (post-Covid) (2021)	Targeted funding to address backlog and expand community CAMHS.	£79m for children and young people (of a £500m total) (DHSC 2021)
Early Support/Young Futures Hubs (2023)	Open-access 'drop-in' support for 11–25-year-olds.	£8 million (2023–25), followed by £2 million (2025–2026) (DHSC 2024; DHSC and PM's Office 2025)

Source: Authors' analysis

Diet, weight and nutrition

This same period has seen a flurry of initiatives on childhood obesity and other food-related ill-health (see box 1.2) representing hundreds of millions in annual spending and multiple rounds of regulatory reform. These include some notable successes: the Soft Industry Drinks Levy removed nearly half of the sugar in soft drinks (HMRC and HM Treasury 2025), and School Food Standards – when reliably followed – improve the nutrition of the food that children consume during the school day (Pallan et al 2024). But despite this, childhood obesity rates have in fact increased. The gap between this reality and the 2018 target to 'halve childhood obesity rates by 2030' is sobering.

At the same time, there have been huge changes to the way children and families buy and consume food. Ultra-processed foods have come to dominate diets, family meals and home cooking have declined (University of Cambridge 2024; Griffith et al 2022), and eating has become more convenient and commercialised. Digital

devices have meanwhile created new channels for food to be marketed to children, and further enticement away from physical activity and in-person socialising. In practice, the regulatory reforms set out in box 1.2 target only a fraction of the products and settings that shape children's diets, and in many cases have been diluted or delayed to spare industry discomfort.

BOX 1.2: 15 YEARS OF ACTION ON CHILDREN'S DIETS, WEIGHT AND NUTRITION - AMBITION VERSUS OUTCOMES

Target(s)

- 2011: "A sustained downward trend in the level of excess weight in children by 2020 (DoH 2011a)
- 2016: "Significantly reduce England's rate of obesity within the next 10 years" (DHSC 2016)
- 2018: "Halve childhood obesity rates by 2030" (DHSC 2018)

Reality

- Obesity prevalence has either remained the same or increased since 2011 (OHID 2025b):
  - Reception: 9.5 per cent (2011/12) to 10.5 per cent (2024/25)
  - Year 6: 19.2 per cent (2011/2012) to 22.2 per cent (2024/25)

Initiatives and spending

Initiative (and when introduced)	What it involves	Associated spending
National Child Measurement Programme (2006)	Annual weighing and measuring of reception and year 6 children.	£20m a year via Public Health Grant (UK Parliament 2024)
Change4Life/Better Health (2009)	National campaign to promote healthier diets and activity.	Initial budget £75m over three years (2009–12); thereafter lower spend. (DoH 2009; DoH 2011b)
Weight management services (2013)	Behaviour change programmes to support child/family weight loss.	Variable by local area from 2013; £4.4m on national pilots (2021–22) (DoH 2013; OHID 2025a)
PE and Sport premium for primary schools (2013)	Ring-fenced funding to improve school sport provision.	Initially £150m per year; doubled to £320m per year as of 2024/5 (DfE 2017)
Improved nutritional information on food packaging (various from 2013)	Voluntary 'traffic light' labelling; mandatory calorie labelling on 'out of home' foods.	*N/A – costs to industry* (DoH 2013)
New school food standards (2014)	Statutory nutrition standards for all maintained schools and academies.	*N/A – within DfE budgets* (DfE 2014)
Universal Infant Free School Meals (2014)	Free, nutritious lunches for all children in reception–year 2.	£600m per year in 2014 (c. £900m–£1bn in 2024/5 prices) (DfE and Deputy PM's Office 2013)
Soft Drinks Industry Levy (2018)	Levy on manufacturers for sugar content of drinks.	*N/A – generates £300–350m a year in revenues* (HM Treasury 2018; HMRC 2025)

National School Breakfast Club Programme (2018)	Free nutritious breakfasts in schools with high levels of deprivation. To be extended to all schools under current government.	£26m over 2 years (2018–20); £80m (2026–) (DfE 2018; DfE 2025)
Restrictions on advertising unhealthy food (announced 2020; enforcement delayed to 2026)	9pm watershed and ban on paid-for online ads.	*N/A – costs to industry* (DHSC 2020; DHSC 2025a)
Ban on energy drinks (consultation announced 2018 and again in 2025)	Sale restricted to over 16s.	*N/A – costs to industry* (DHSC 2018; DHSC and DfE 2025)
Ban on promotions of unhealthy foods (announced 2020; some enforcement delayed to 2025)	Restrictions on unhealthy foods being placed in prominent locations or being part of promotions (e.g. Buy One Get One Free).	*N/A – costs to industry* (DHSC 2020; DHSC 2022)

Source: Authors' analysis

1.4 CHANGE IS POSSIBLE

The experiences of childhood obesity and mental health illustrate a familiar pattern: a system of policymaking and implementation that feels exhaustingly busy but achieves little. They highlight Westminster's tendency to reach for the most familiar levers – for example, increasing investment in an existing service – rather than understand and influence the deeper systems that shape people's lives. There is a sense that government is swimming against the tide – as powerful social and economic currents reshape modern childhood – using tools that are too narrow and short-range to alter their course.

A new form of statecraft is needed – one that takes its cue from where genuine, lasting improvements in children's health have been achieved over the past two decades: the steep declines in teenage pregnancy, smoking and drinking (see figure 1.1) did not stem from new services or bureaucratic interventions, but from government facilitating shifts in everyday habits and social norms.

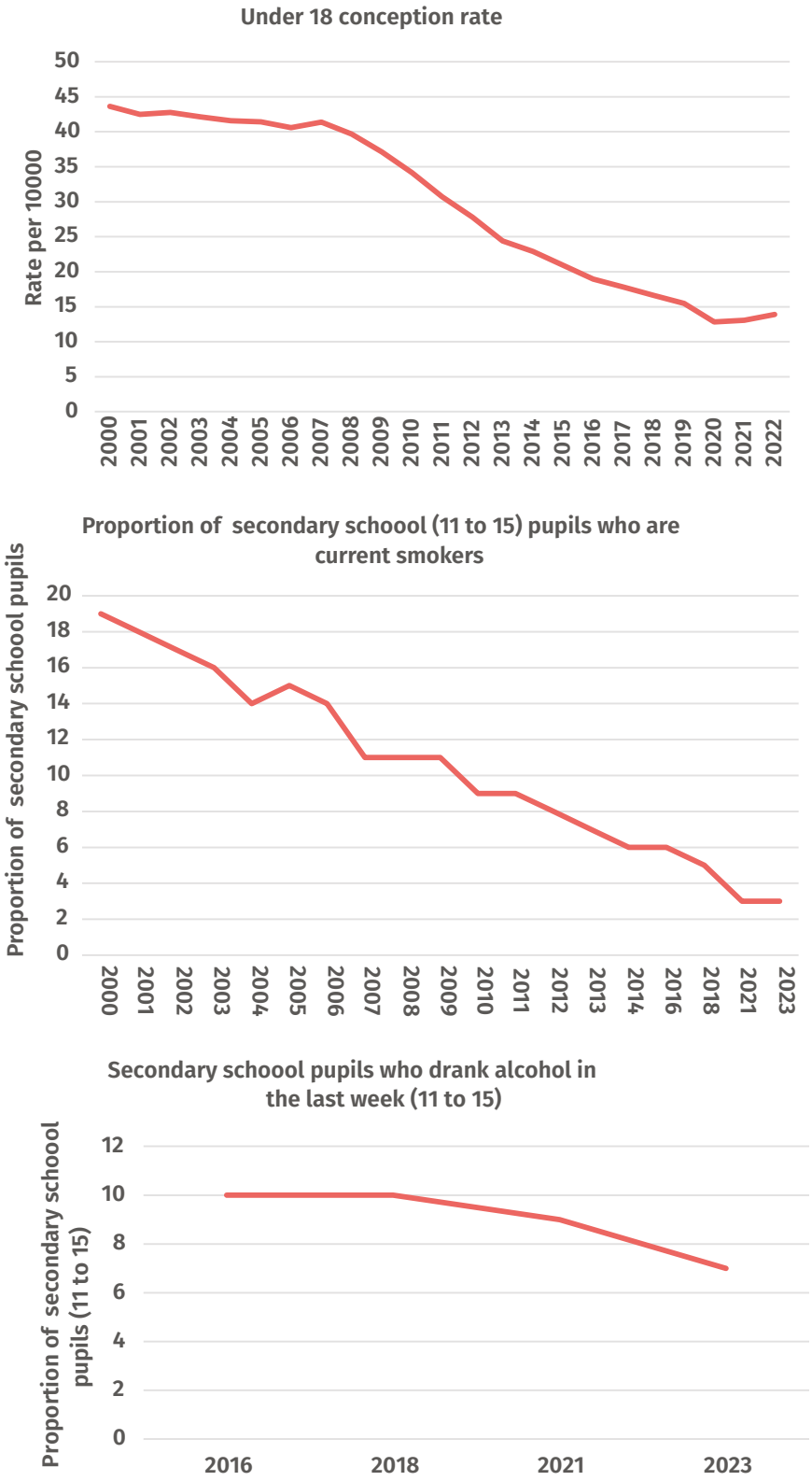
In the case of teenage pregnancy, early progress owed much to the Teenage Pregnancy Strategy (1999–2010), which improved sex education and contraceptive access. But it was sustained by longer participation in education and delayed transitions to adulthood – trends that made early parenthood less compatible with young people's aspirations (Hadley and Chandra-Mouli 2016; Wellings et al 2016). The decline in smoking was shaped not only by regulation but by the denormalisation of the habit: a generation raised in smoke-free homes and public spaces came to see smoking as unattractive and antisocial (Amos et al 2009; Katikireddi et al 2016; Tattan-Birch and Jarvis 2022).

The fall in youth drinking, meanwhile, has been explained as part of a broader cultural shift towards health, self-control and image-consciousness, shaped also by changes in how and when young people now socialise (particularly online) (Caluzzi et al 2021; Whitaker et al 2023). (Though in this latter case, some of the same digital forces that drive restraint may also carry risks for young people's wellbeing).

These examples show that when policy aligns with people's motives, relationships and everyday realities, it can deliver rapid, generational change. The task now is for government to bring that same imagination to the wider challenges of children's health, seeking to better understand – and work with the grain of – family and community life.

FIGURE 1.1: RATES OF TEENAGE PREGNANCY, SMOKING AND DRINKING AMONG YOUNG PEOPLE HAVE STEADILY DECLINED OVER THE PAST FEW DECADES

Under-18s conception rate (2000–22), and the proportion of secondary school pupils who are current smokers (2000–23) and drank alcohol in the last week (2016–23), England



Sources: OHID (2025c); NHS Digital (2024

2. THE HOME FRONT: WHY FAMILIES MUST BE AT THE HEART OF A HEALTHIER GENERATION

Chapter 1 called for a new form of statecraft to reverse Britain's stubbornly poor child health outcomes. A more imaginative and effective approach requires us to look harder at the everyday environments that shape how children live – none more formative than the family home.

2.1 HEALTH STARTS AT HOME: THE ROLE OF FAMILIES IN KEY CHILD HEALTH CHALLENGES

An indicative look at two of the most pressing child health challenges in the UK – the same as our case studies in chapter 1 – shows how critical parents and carers are in shaping and sustaining child wellbeing.

Mental health and wellbeing

Rates of mental ill-health among children and young people have surged over the past decade. This registers not only in official statistics but among parents and carers: in our survey, 7 in 10 felt mental health problems had become more common over the past decade, and conditions like anxiety and depression were respondents' top concern among other common health challenges.

A long-standing evidence base has shown the critical relationship between children's emotional wellbeing and their home environment. Studies have repeatedly shown positive associations between 'Adverse Childhood Experiences' (ACEs) – from psychological or physical abuse to mental ill-health in the family – and later mental ill-health (Felitti et al 1998; Hughes et al 2017). One of the mechanisms for this is attachment in infancy, with children who form strong early bonds with reliable and responsive caregivers less likely to develop mental health problems in later life – and vice versa (see for example Fearon et al 2010). There is also evidence around parenting styles: parents who exhibited warmth, granted their children reasonable autonomy and were authoritative in setting and maintaining boundaries were more likely to have mentally well children, while harsh, cold, controlling or overly permissive parenting had the opposite effect (Pinquart 2017).

The recent increase in distress among children has also prompted debate about its drivers. Some suggest that greater awareness around mental health has achieved many positive benefits – reducing shame and stigma and promoting help-seeking – but also may have blurred the boundary between temporary distress and diagnosable disorder. If normal, albeit painful, aspects of growing up are increasingly medicalised, children may come to fear or avoid manageable challenges, or seek external solutions rather than developing coping skills of their own (Foulkes 2021). Others point to the impact of smartphone-based childhoods,

where the loss of real-world play, risk-taking and social learning leaves children with fewer opportunities to build resilience (Haidt 2024).

While these theories remain contested, they build on an established evidence base: children's mental health is deeply shaped by early relationships and home environments. A policy response that overemphasises clinical services, while underplaying the conditions in which children learn to cope with the changing and complex demands of modern life, will always be missing a vital piece of the puzzle.

Diet, weight and nutrition

Policymakers' concern about obesity and other food-related ill-health had also registered in homes up and down the country: obesity was the second highest source of concern for parents in our survey, and 'the cost of healthy food' was considered the single biggest obstacle to a healthy childhood. A substantial body of evidence also points to the role families play in creating children's everyday interactions with food and shaping how they navigate food environments as they grow older.

Early exposures to food – through pregnancy, breastfeeding and the introduction of solids – have been shown to shape long-term outcomes in taste preferences and relationships with food (Mennella and Beauchamp 2005; Remy et al 2013; Nicklaus 2017). Breastfeeding is consistently associated with lower risk of childhood obesity and infections, improved cognitive outcomes, and healthier dietary patterns later in childhood (Victora et al 2016), while introducing a wide range of tastes and textures in infancy predicts greater dietary variety and food acceptance in later childhood (Nicklaus 2017; Coulthard et al 2009). Early nutrition also influences immune and metabolic programming, shaping the microbiome and later risks of allergy and obesity (Arrieta et al 2014).

Longitudinal studies also show that families who eat together have children with higher fruit and vegetable intake, lower consumption of sugary or ultra-processed foods, and reduced risk of overweight and disordered eating (Hammons and Fiese 2011; Berge et al 2014). Parents' own habits strongly influence those of their children: parental role-modelling of healthy eating is associated with healthier diets among children (Draxten et al 2015) and the same for other healthy behaviours like physical activity and avoiding smoking and alcohol (Dhana et al 2018). Adolescents who cook or share in meal preparation at home are also more likely to maintain healthier diets in adulthood (Utter et al 2018).

This is not to suggest that these insights have been entirely absent from policy. Recent efforts to improve breastfeeding rates, recognising their link to later obesity, and new regulations to restrict the marketing of unhealthy foods – particularly to children – represent important steps forward. Yet these remain partial responses to a much wider set of patterns shaping how families eat and live. A fuller reckoning would require government to engage more directly with the realities of family life and the politics that surround it.

2.2 THE ROLE OF THE STATE AND THE POLITICS OF PARENTING

Even the most loving and capable families cannot nurture healthy children in isolation. Parents' ability to provide stability, be present and loving, and offer a varied and nutritious diet depends on wider conditions: from working hours and income and to the strength of their own relationships and emotional wellbeing (see table 2.1). So while parents and carers must be recognised as the frontline of any serious effort to improve children's health and wellbeing, it's equally important to articulate the role of the state in creating the conditions to allow them to do so.

TABLE 2.1: WHY FAMILIES MATTER – AND WHY THEY CAN'T DO IT ALONE

	Mental health and wellbeing	Healthy diets, weight and nutrition
Why parents and families matter	- Fostering warm, responsive and predictable relationships. - Ongoing support as children navigate everyday difficulties and distress. - Advocating for their children's needs with clinicians and navigating access to services.	- Good nutrition in pregnancy and perinatal period. - Offering a variety of nutritious foods, tastes and textures. - Creating routines and shared experiences around meals and food preparation. - Modelling balanced eating and positive attitudes around food and exercise.
Why parents and families can't act alone	- Parents' capacity to be warm, present and consistent is shaped by external factors such as work, stress and social support - Other drivers of mental ill-health lie beyond the home (e.g. bullying, exam pressures, climate anxiety) - Some children will still need specialist clinical care and professional support.	- The affordability and availability of healthy food are shaped by the wider economy and food system - Food marketing is pervasive and often targeted at children to establish preferences early - Many meals are eaten outside the home, particularly in schools and childcare settings.

Source: Authors' analysis

On this, successive governments have struggled to achieve the right balance. Policy tends to swing between two unhelpful poles: a minimalist view of the state, which treats the care of children as a private matter for families alone and frames public health action as 'nanny statism'; and a paternalistic state – found across the political spectrum – which portrays parents either as passive victims of structural disadvantage or as problems to be 'fixed' by professionals presumed to know better. We see these latter tendencies in initiatives like *Troubled Families*[3] or in elements of the current public health discourse, with children and families abstracted to 'high-risk groups' or 'target populations': the subject of observation and intervention rather than trusted and capable partners to work alongside.

This speaks to the difficulty of maintaining a human, respectful way of *working with* – and not *doing* to – families in large bureaucracies. And it also points to the importance of more devolved, locally grounded public services, where there is a more realistic prospect of the state understanding and responding to people in the full context of their lives. The government confirmed its commitment to this kind of public service reform in its spending review (HM Treasury 2025), though the extent to which it has materialised in different departmental policy agendas has varied. For example, while the government's 10 Year Health Plan (DHSC 2025b) advocates for a shift towards more community-oriented forms of service delivery, families

3 See https://www.gov.uk/government/speeches/troubled-families-speech

and communities are often presented as the taken-for-granted backdrop to the 'main stage' of professional services (see box 2.1).

BOX 2.1: THE FRAMING OF FAMILIES IN THE 10 YEAR HEALTH PLAN

In the 10 Year Health Plan (DHSC 2025b), the role of parents and families is often administrative or transactional, highlighting a missed opportunity to recognise families as active partners in the creation of children's health.

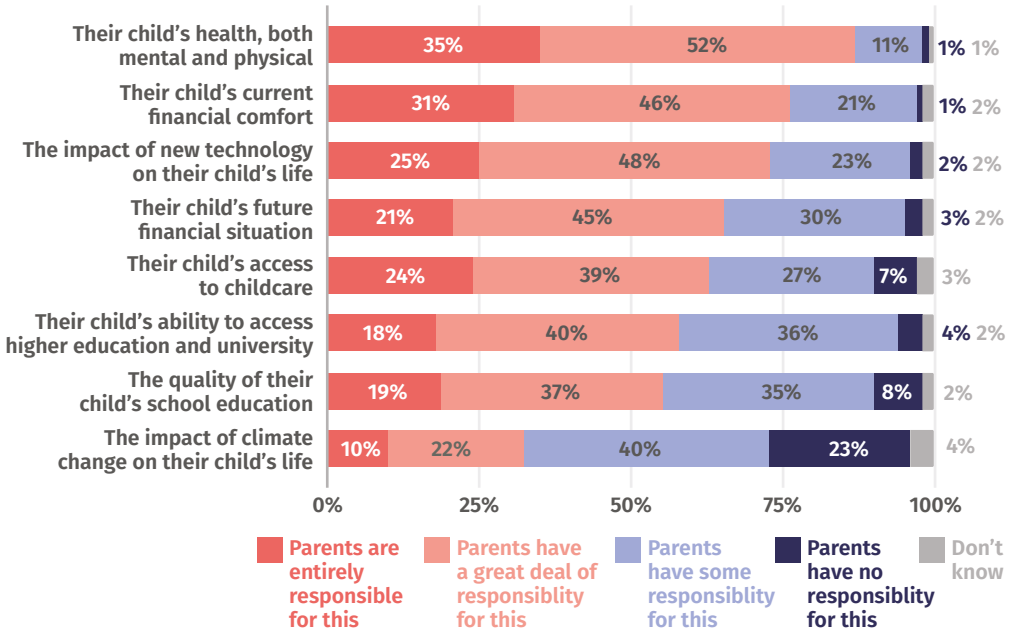
The word 'families' appears three times, in relation to:

- recipients of support through Family Hubs
- beneficiaries of Healthy Start vouchers and Free School Meals
- participants in vaccination consent processes.

The past decade has seen far less substantive engagement with questions of the family than the decade before – perhaps a reaction to the backlash against earlier efforts, or reflecting a broader strategy of electoral caution. While technocratic framings of parents and families may feel politically safer, they risk leaving policy hollow. What is more, they stand at odds with how parents themselves see their role. In our survey, parents reported both the greatest sense of responsibility and the greatest sense of agency over their children's health – more so than for any other aspect of their lives, including education or financial comfort, and any other actor, from market forces to national government. Ultimately, a significant majority felt it was more important for children's health to educate and support parents than to invest in further professional services. These patterns held across income and voter groups (see figures 2.1 to 2.6).

FIGURE 2.1: PARENTS REPORT THE GREATEST SENSE OF RESPONSIBILITY FOR THEIR CHILDREN'S HEALTH

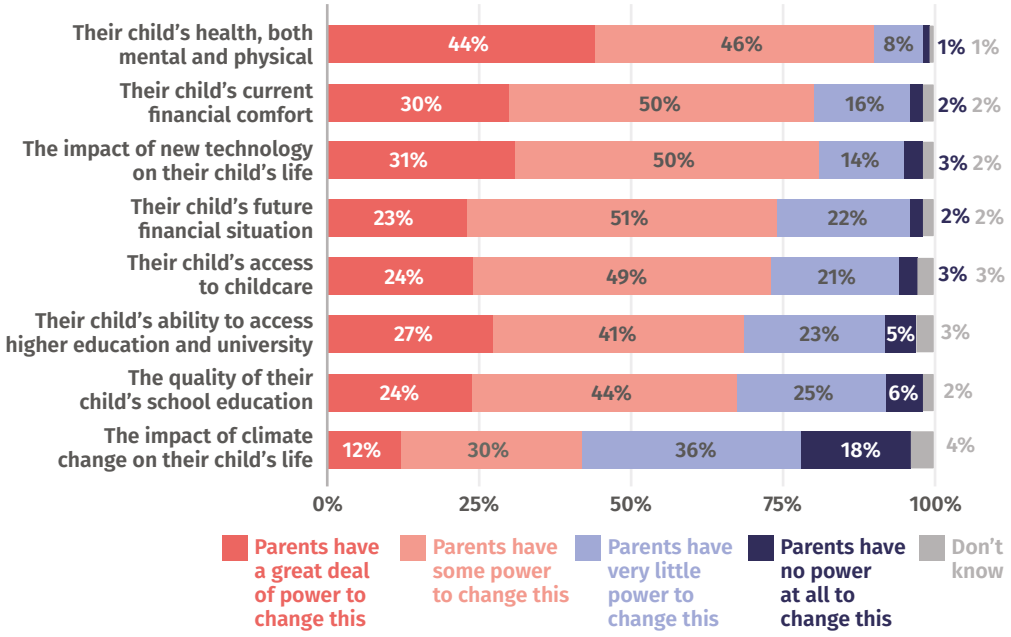
Q: How much responsibility do you feel parents have to support or to change the following?



Source: Public First survey (2025)

FIGURE 2.2: PARENTS ALSO REPORT THE GREATEST POWER TO INFLUENCE THEIR CHILDREN'S HEALTH

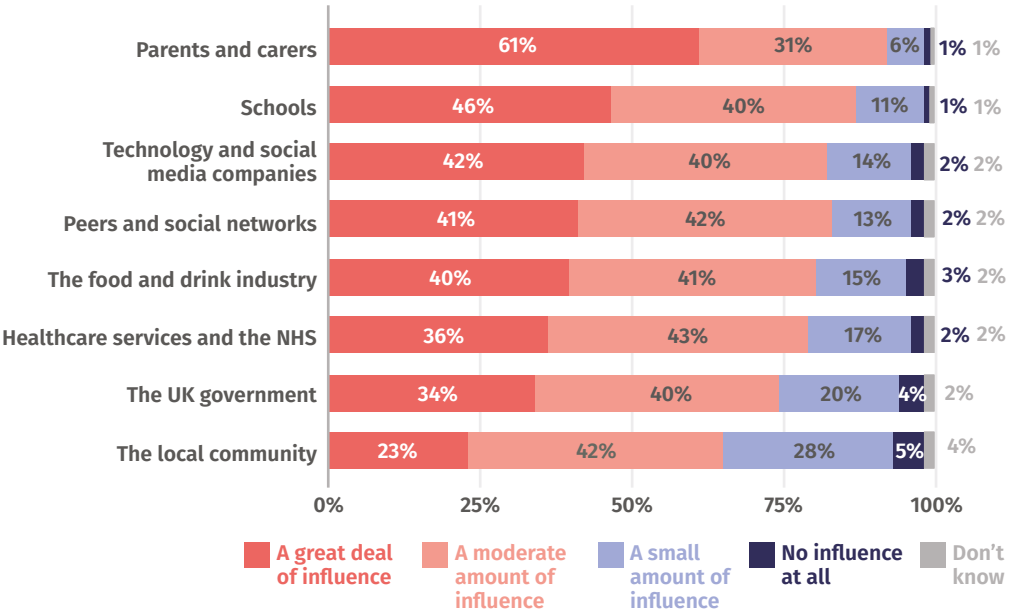
Q: How much power to change the following do you believe parents have?



Source: Public First survey (2025)

FIGURE 2.3: PARENTS ALSO RANKED THEMSELVES ABOVE ANY OTHER ACTOR – INCLUDING SCHOOLS, THE NHS, OR GOVERNMENT

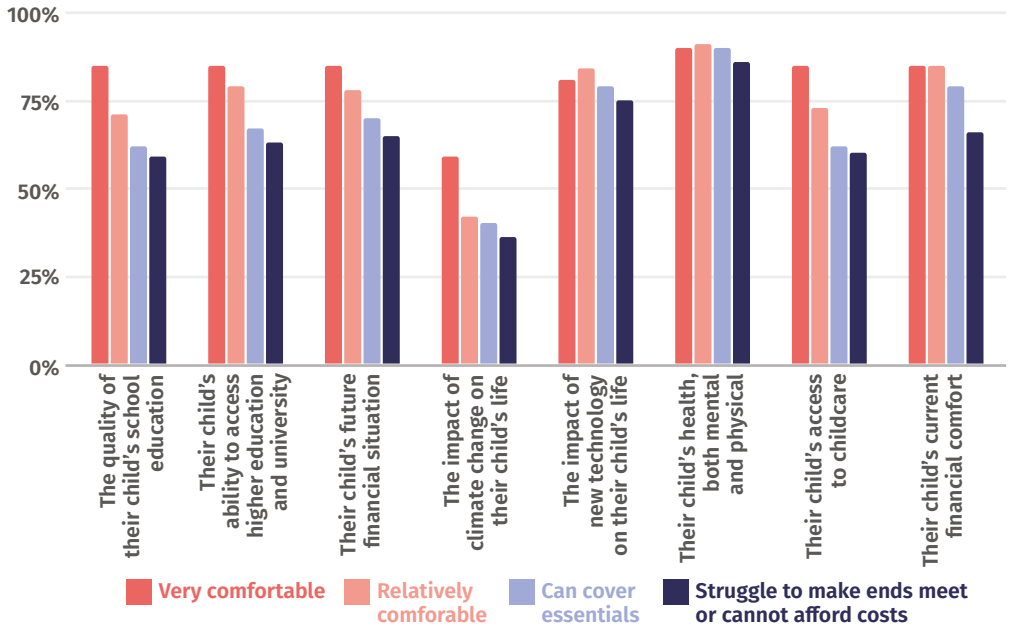
Q: Overall, how much influence do you think the following have on children's health in the UK?



Source: Public First survey (2025)

FIGURE 2.4: THERE WAS MUCH LESS VARIATION BY FINANCIAL SITUATION ON THE QUESTION OF PARENTAL INFLUENCE OVER HEALTH VS OTHER ASPECTS OF CHILDREN'S LIVES

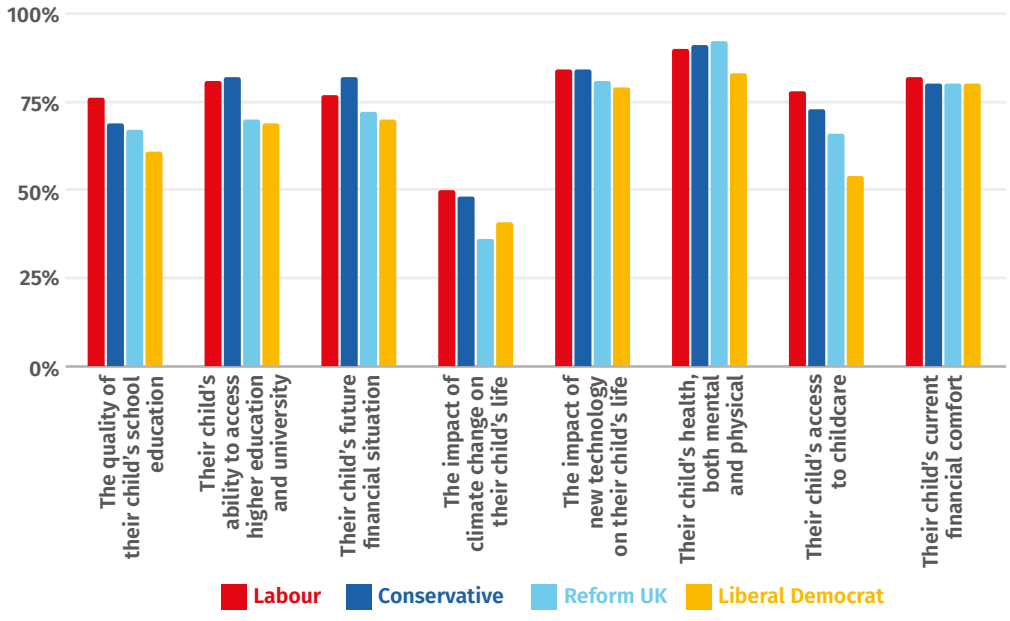
Q: How much power to change the following do you believe parents have?



Source: Public First survey (2025)

FIGURE 2.5: DIFFERENT VOTER GROUPS WERE UNITED IN IDENTIFYING HEALTH AS THE AREA WHERE PARENTS HAD THE MOST POWER AND AGENCY

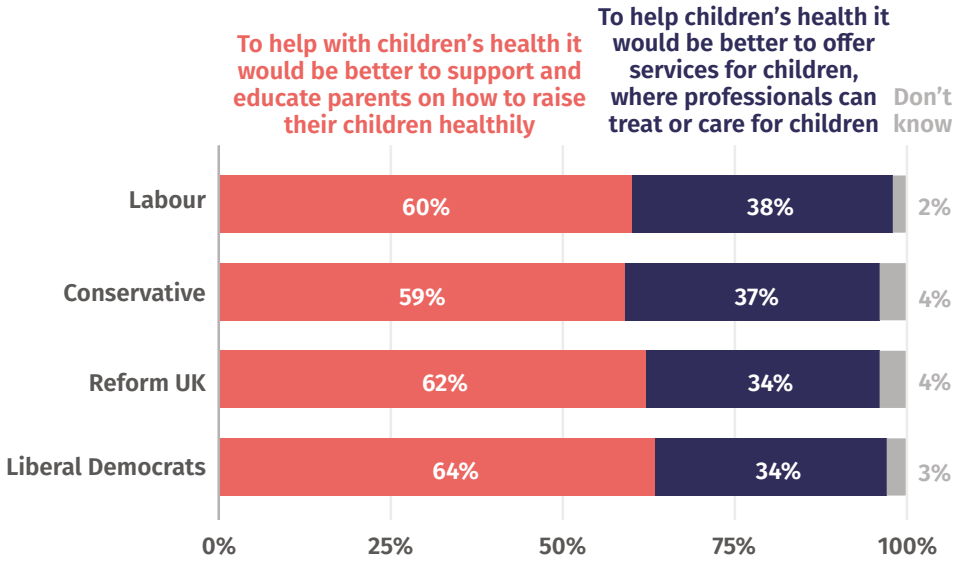
Q: How much power to change the following do you believe parents have?



Source: Public First survey (2025)

FIGURE 2.6: REGARDLESS OF VOTING INTENTION, SIX IN 10 PARENTS VALUED PARENTAL SUPPORT OVER SERVICES TO IMPROVE CHILDREN'S HEALTH

Q: Which of the following comes closest to your view on how the government should help parents?

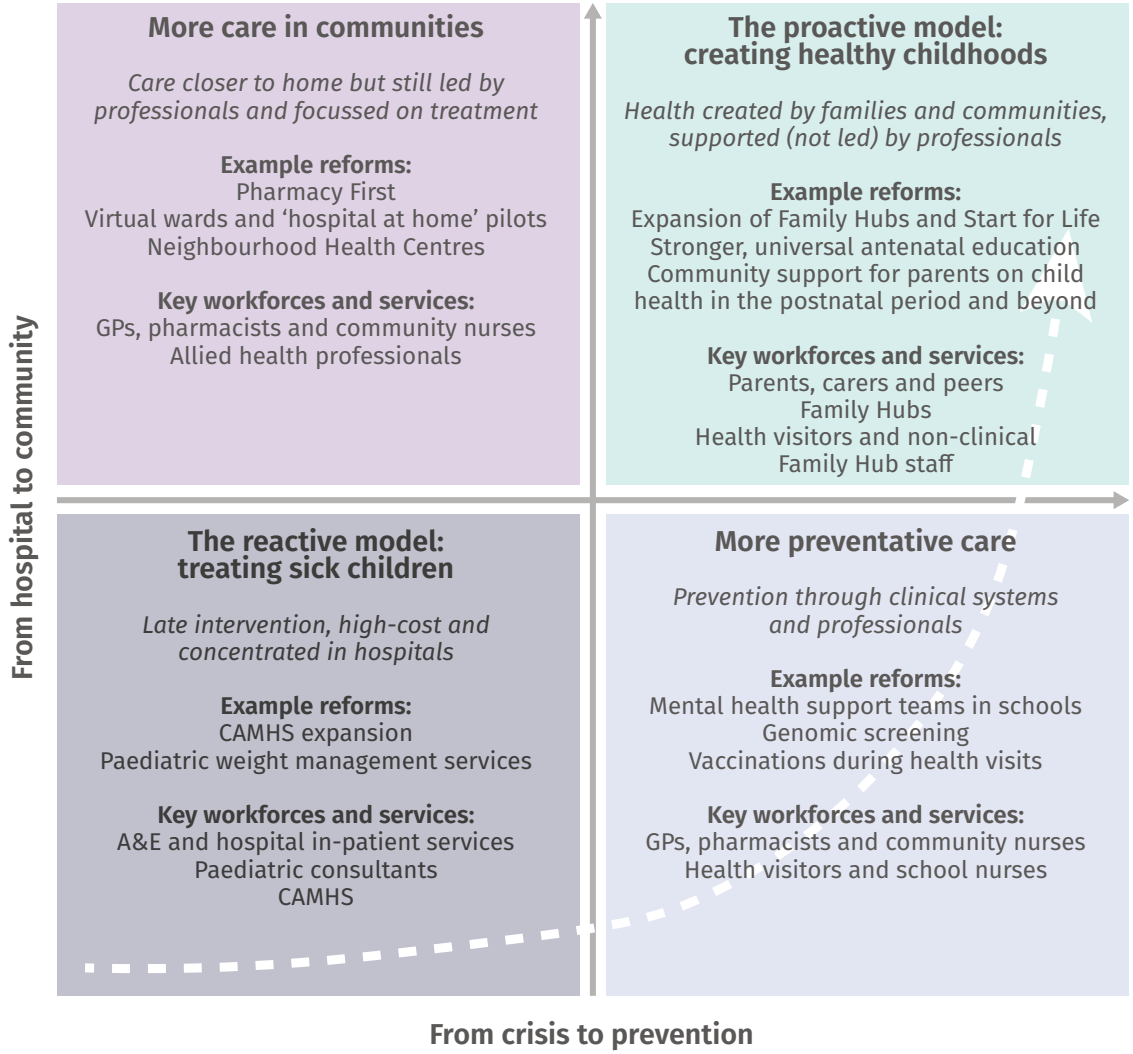


Source: Public First survey (2025)

Finally, failing to embrace parents and families as valued partners in public services misses a major opportunity. As the health system embarks on a generational challenge of shifting care from hospital to the community, and changing gear from sickness to prevention, there are limits to how much can be achieved through professional workforces alone. When children already receive a significant share of their 'healthcare' through the everyday acts and decisions made by their families, the impact of these reforms will be limited where they are exclusively thought about in institutional terms. A bolder, higher-potential approach is moving beyond thinking only in tasks between different care professionals – for example from GPs to pharmacists – and to explore what progress could be made by empowering and equipping parents in home environments (see figure 2.7).

Importantly, this is not a question of outsourcing responsibility or reviving a 'Big Society' model of state retreat, but of a genuinely progressive alternative: a trusting partnership between empowered parents, supportive communities, and an active, enabling state.

FIGURE 2.7: THE UNFINISHED SHIFT: FAMILIES AND COMMUNITIES AS THE BACKBONE OF THE SHIFT TO A MORE COMMUNITY-CENTRED, PREVENTATIVE HEALTH SYSTEM



Source: Authors' analysis

3.
IN THEIR OWN WORDS: PARENTS ON THE REALITIES OF RAISING HEALTHY CHILDREN TODAY

The first two chapters in this report have argued that efforts to improve children's health have fallen short by failing to consider the full fabric of children's everyday lives. To address this gap, IPPR set out to hear directly from parents and carers – through six focus groups with parents and carers from a wide range of backgrounds, and a nationally representative survey of more than 1,500 parents in England. This chapter draws on their experiences to show what it is like to raise healthy children in the UK today: the pressures families face, and the support they believe would make the greatest difference.

3.1 HAPPY, SECURE, WELL-ROUNDED: WHAT PARENTS THINK MAKES A HEALTHY CHILDHOOD

A key area of inquiry was hearing how parents defined a 'healthy childhood' and what matters most in making it possible. Parents were remarkably consistent across focus groups and the survey in describing something very holistic, encompassing both mental and physical wellbeing (see table 3.1). Social and emotional aspects were noticeably more prominent in the focus groups, with responses centring on children's happiness, confidence and the strength of their relationships with family, peers and other adults.

> *"For me, a healthy child really is a happy child, a very well-rounded child that thinks about the future in a positive way, sleeps well and communicates with you well, and has hopes and desires for the future ... a well-rounded child that is very healthy, emotionally, physically and mentally."*
>
> Parent of 18-, 16-, 14-, 12- and 2-year-old, London – Focus Group 5

In describing the ingredients of a healthy childhood, parents emphasised exposure to different experiences, people and places. Many contrasted the stimulation and curiosity this fosters with what they saw as an increasingly sedentary, device-centred model of childhood. Parents also spoke about the importance of balance – between their children's wellbeing and other considerations like studying or socialising, or between their priorities as parents and their child learning to exercise autonomy. In terms of their role in facilitating this, parents emphasised being 'present' and engaged, making their children feel safe and loved, and creating predictability through routines and boundaries.

"I think for me, it's mainly giving them opportunities ... finding out what's on in the local area, whether it's sports activities or, when they were younger, taking them to the park, Sure Starts, things like that. Now they're getting older, it's trying to find things that they can still do ... because otherwise they'd be happy just stuck at home and on the devices."

Parent of 10-, 11- and 14-year-old, Rochdale – Focus Group 4

Interestingly, healthcare services were rarely mentioned as part of this picture. This was partly a response to services feeling increasingly inaccessible or unhelpful, but health was also clearly rooted in family and community life – in everyday decisions about mealtimes, daily activities, and the quality of conversations and relationships between parents and children. Note that these insights are also strikingly consistent with the academic evidence set out in chapter 2, which shows that warm, responsive and structured parenting styles – balancing authority with autonomy – are most strongly associated with child wellbeing., lending weight to a more parent-centred approach.

"For me, it's always been about, do they feel safe? Do they feel loved? Are they able to be themselves?"

Parent of 13- and 17-year-old, Liverpool – Focus Group 6

TABLE 3.1: PARENTS' OWN WORDS: THEMES FROM OPEN-TEXT SURVEY RESPONSES ON "IN YOUR OWN WORDS, WHAT MAKES A HEALTHY CHILDHOOD?"

Based on analysis of more than 1,500 parents' written responses using a large language model (LLM)

Theme	Description	Percentage of responses
Nutrition and diet	Nutritious food, healthy eating, balance, fruit and vegetables.	36.6%
Physical activity and play	Exercise, sport, outdoor play, keeping active.	33.7%
Emotional wellbeing and love	Feeling loved, safe, happy, cared for, emotionally secure.	33.7%
Family and home environment	Supportive family life, stability, good parenting.	28.4%
Balance and routine	Structure, rest and sleep, education and learning.	23.5%
Socialising and relationships	Friendships, social interaction, confidence, sense of belonging.	9.2%

Source: Authors' analysis of Public First survey responses (2025)

3.2 ROWING AGAINST THE TIDE: WHAT MAKES IT HARD FOR PARENTS

While parents expressed a strong and instinctive sense of what a healthy childhood looks like, they also described multiple barriers to realising it. Chief among these was the cost of healthy options – both in terms of food and activities – which were the first (51 per cent) and third (28 per cent) most commonly cited barriers to a healthy childhood in our survey (see figure 3.1). Focus group participants highlighted how hard it was to provide nutritious meals for their children, citing the perverse economics of food pricing – with biscuits multiple times cheaper than fresh fruit – and the battle they often needed to wage with (particularly older) children over their own tastes and preferences, conditioned by food marketing and peer influences. Parents also spoke about the growing commercialisation

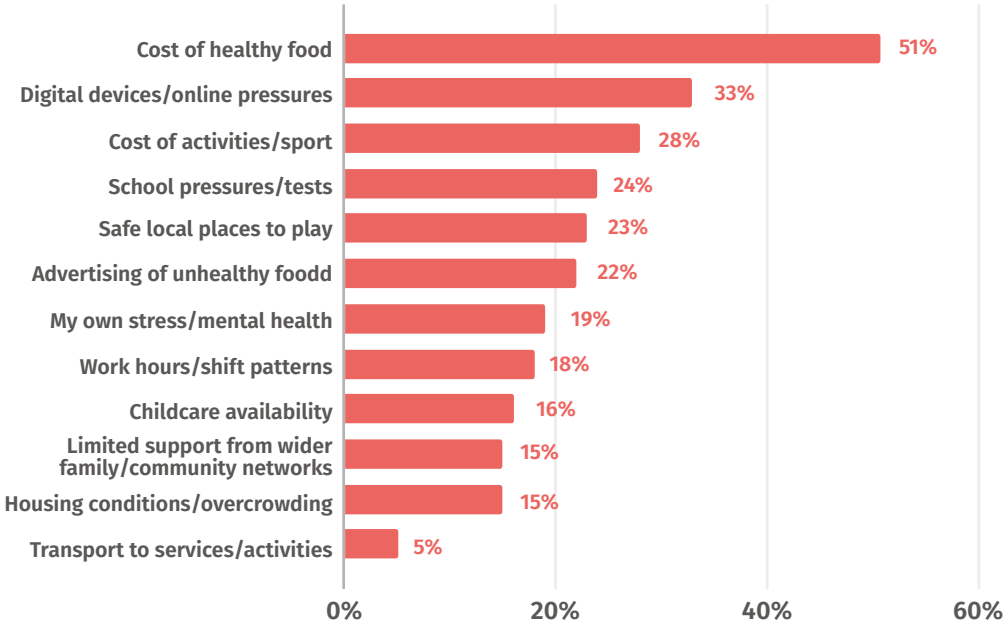
of physical activity, contrasting it with their own childhoods (or those of older children), when free, community-based opportunities to be active were easier to come by.

> *"I'd say cost ... shopping to buy strawberries is, I don't know, five pounds, but I can buy a whole pack of Jammie Dodgers, which I could give her for a whole week, for one pound 90, which is just crazy."*
> Parent of 0- and 2-year-old, Kent – Focus Group 3

> *"When my older three children were younger, they used to have free swimming sessions. There was free boxing, even gym sessions that you could go to at certain leisure centres ... But number four and five ... there's not really anything ... We're paying for his gym, but it's so expensive."*
> Parent of 4-, 17-, 21-, 24- and 25-year-old, Kent – Focus Group 4

FIGURE 3.1: PARENTS CITE THE COST OF HEALTHY FOOD AND ACTIVITIES, ALONGSIDE ONLINE PRESSURES, AS THE BIGGEST BARRIERS PARENTS FACE TO A HEALTHY CHILDHOOD

Q: What would you consider the greatest barriers to your children experiencing a healthy childhood? Select up to three of the following.



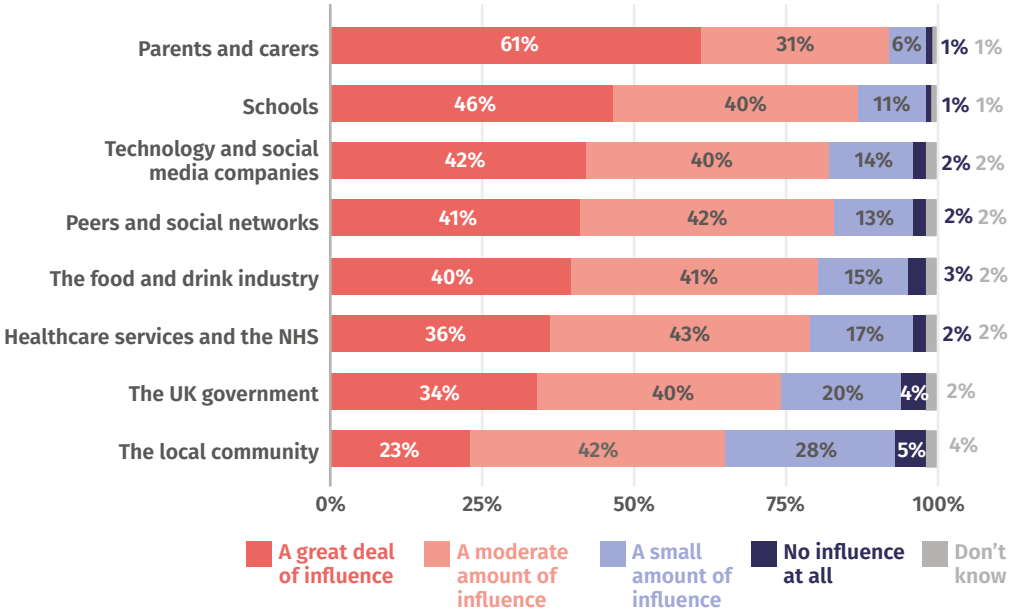
Source: Public First survey (2025)

As we saw in chapter 2, parents felt a strong sense of responsibility and agency over their children's health. However, this did not mean they viewed external influences as unimportant. While 92 per cent felt parents had a 'great deal' or 'moderate amount' of influence in their children's health, 82 per cent said the same of technology and social media companies and 81 per cent of the food and drink industry. Strikingly, both were seen to be more influential on children's health than either the NHS or national government (see figure 3.2). These findings were echoed in the focus groups, where parents described feeling powerless in the face of pervasive commercial and digital pressures. They spoke about the ubiquity of unhealthy food products and marketing, as well as the encroachment of technology and social media in their children's lives. Many also felt at the mercy of school policies about phones – including requiring digital engagement

for homework or communication – and the practices of other parents on devices, creating pressure or points of comparison with peers.

FIGURE 3.2: PARENTS BELIEVE SCHOOLS, PEERS, TECHNOLOGY COMPANIES AND THE FOOD INDUSTRY HAVE GREATER INFLUENCE ON CHILDREN'S HEALTH THAN GOVERNMENT OR THE NHS

Q. Overall, how much influence do you think the following have on children's health in the UK?



Source: Public First survey (2025)

> *"How readily accessible everything is ... I'm quite restrictive around things like social media, for example, because I want my daughter to have a good sense of self-esteem, and I don't think it's conducive to that, but it's really hard when everybody else has access to it ... Likewise, I might be able to provide healthy food at home, but that doesn't mean that she won't choose to eat bad food when she's with her friends or in school. In the society we live in at the moment, it can be quite hard to regulate that when everything's so easily on tap."*
>
> Parent of 7- and 13-year-old, Plymouth – Focus Group 5

Parents also spoke about the difficult balance between earning a living and being present for their children. Many described a constant 'juggle' between work, childcare and household responsibilities, with trade-offs that often came at the expense of their own energy and wellbeing. There was a sense that not only had economic circumstances changed – with families needing two earners to 'get by' and single parents struggling – but that expectations around raising children had become more demanding and complex to meet. Many contrasted their experiences of parenting with those of their parents, presenting childhoods of the past as simpler, freer and characterised by less parental oversight or anxiety. Evocations of 'knocking on friends' doors' and 'going out on my bike' for long, unsupervised sessions of outdoor play were common. Technology and social media were part of this new complexity, introducing fresh risks to monitor while flooding parents with a constant stream of – often conflicting – advice.

"We are living in a world at the moment where you are expected to go to work, earn money, have a great career, raise fantastic children, feed them, take them on holidays, give them experiences, be at home … You try to do all of these things, but it gets to the point where you just can't."

Parent of 2- and 4-year-old, Nottinghamshire – Focus Group 2

"[It's] complete overload, all the different information from so many different people and companies … advertising, social media, just people that you're around, things that you hear, things you're seeing … it's a lot of opinions."

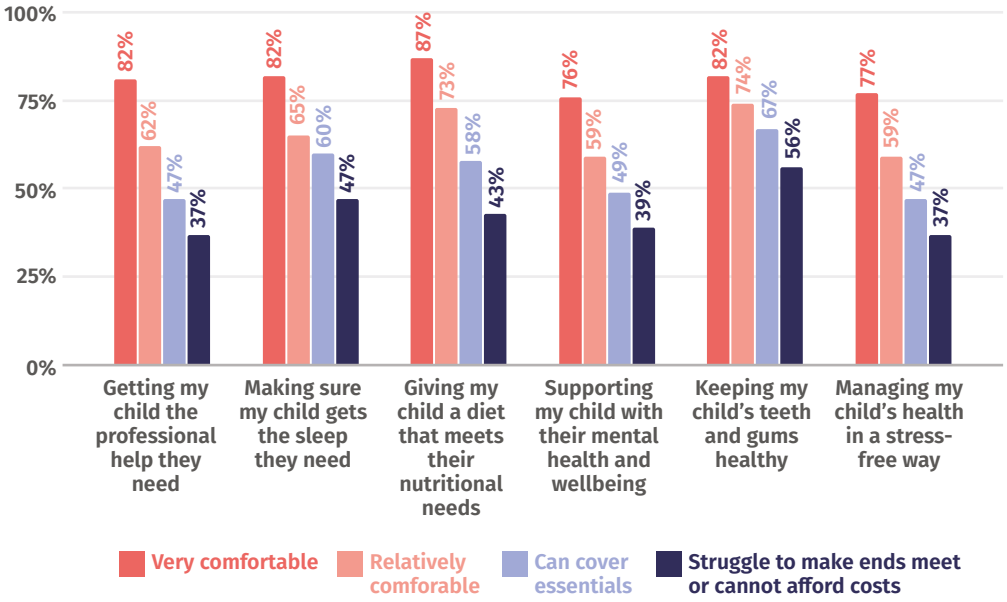
Parent of 5-, 7- and 8-year-old, Kent – Focus Group 3

3.3 MAKING DO: PARENTS' EXPERIENCES OF SERVICES AND SUPPORT

When it came to the support available to help navigate these pressures, parents described a system under palpable strain. Many described turning to costly private options – for issues from tongue-tie to mental ill-health and SEND assessments – because NHS waiting times felt incompatible with their child's wellbeing. Others talked about 'figuring it out' alone, piecing together their own 'DIY' packages of support or hoping things would resolve on their own. Those who persisted with NHS routes often described access as a battle – having to 'fight' to get their child seen or to have their concerns taken seriously. Increasingly, the NHS felt like a service of last resort for a narrow set of high-threshold 'medical' needs, in contrast with parents' own holistic ideas of health in childhood.

FIGURE 3.3: PARENTS' EASE OF MANAGING KEY ASPECTS OF THEIR CHILDREN'S HEALTH – INCLUDING GAINING ACCESS TO PROFESSIONAL HELP (FAR LEFT) – VARIES SHARPLY BY FINANCIAL COMFORT

Q: How easy or difficult do you find the following? (% 'Easy' or 'very easy')



Source: Public First survey (2025)

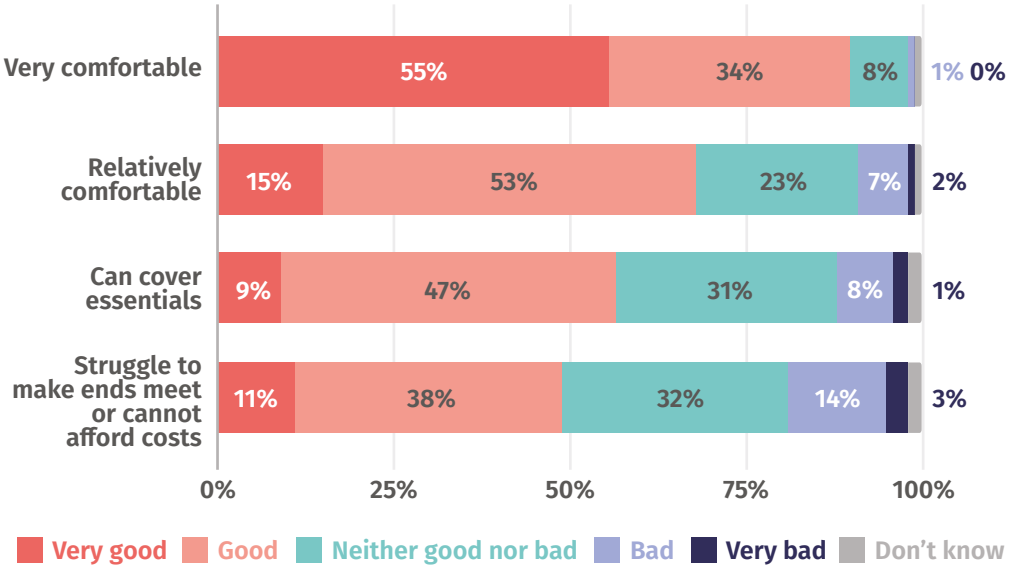
This also emerged in the survey: one in five parents said it was 'difficult' or 'very difficult' to get their child the professional support they needed. Concerningly, access also seemed to be patterned by financial circumstances: more than twice as many parents in the most financially comfortable group (81 per cent) described service access as 'easy' or 'very easy' than the least comfortable group (37 per cent) (see figure 3.3). A similar financial gradient can be observed in responses to a more general question about the quality of services available to support parents (see figure 3.4). And while it may not be surprising, it is nonetheless problematic that parents whose children had a long-term health condition found it more difficult to access services, as well as to manage other dimensions of their health (see figure 3.5).

> *"Because of the waiting times, in the end you're just like 'you know what? I'm just going to do it myself' ... If we have a sick child at home, we'll just take care of that child ourselves, rather than calling the doctors, like we used to do."*
>
> Parent of 18- and 22-year-old, Essex – Focus Group 6

> *"It takes a lot for me to access, even my GP, for my children ... I don't think I've had a necessarily bad experience ... you've just got to fight sometimes for basic things."*
>
> Parent of 4- and 12-year-old, Nottinghamshire – Focus Group 5

FIGURE 3.4: THERE ARE SIGNIFICANT DIFFERENCES IN HOW WELL PARENTS FEEL SERVICES SUPPORT THEM BY LEVELS OF FINANCIAL COMFORT

Q: In general, how would you rate the services available to support parents with children's health?

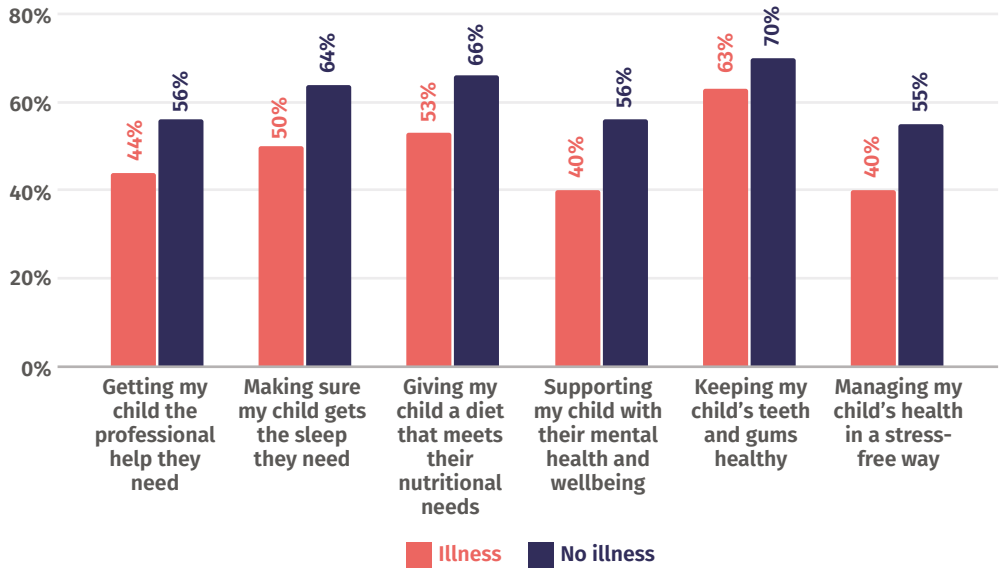


Source: Public First survey (2025)

Parents understood the pressure that services were under – and expressed admiration for the NHS' performance in emergency situations especially – but described interactions with health professionals that felt transactional or rushed. Some recounted feeling judged, for example for their difficulties with breastfeeding or decisions about their child's health they had received little support to make. Contact with services often felt overly formal or escalatory, with attempts to seek reassurance or light-touch guidance met with either

dismissal or overreaction – for example, onward referrals for specialist assessments or flags about safeguarding risk.

FIGURE 3.5: PARENTS WITH SICK CHILDREN FIND IT HARDER AND MORE STRESSFUL TO MANAGE THEIR CHILDREN'S HEALTH, INCLUDING ACCESS TO PROFESSIONAL HELP
Q: How easy or difficult do you find the following? (% 'Easy' or 'very easy')



Source: Public First survey (2025)

This narrowing of professional focus onto statutory minima felt like another symptom of a system under strain. Parents contrasted this with the reassurance and trust they found in more informal settings – such as children's centres or among friends, family or local 'mum's groups' – whose support was both a necessity, filling gaps left by formal services, and a preference, offering the kind of empathetic, everyday guidance families most valued.

> *"One of the things I struggle with is you're not able to talk to anyone at our doctor's ... They don't want you to phone ... There's no personal service ... as parents, we have genuine concerns about our children, just because they may see from what you've sent them: 'That's nothing to worry about', we still deserve a bit of a bit of reassurance ... and to be treated as, as real people, as individuals, not just this faceless person on the other end of the computer."*
>
> Parent of 4 children, youngest 15, Plymouth – Focus Group 5

> *"I'm quite fortunate that my mum is SENCO trained ... which then puts us in touch with different people she's got connections with ... It helps when I can speak to those people, because they're family friends. I'm not using their services ... I can sit with them an evening, have a cup of tea, and I benefit so much more. And if that was available for parents, like a Family Hub situation, I think that would relieve a lot of stress and pressure of people trying to get hold of certain services. Because I don't want assessments. I don't want to go to the doctors and them to assume instantly there's something wrong, or that I'm trying to go down one path."*
>
> Parent of 0- and 2-year-old, Kent – Focus Group 2

Alongside these frustrations were stories of individual practitioners – in settings from CAMHS to health visiting – who went above and beyond. Yet these examples were often presented as exceptions, acts of dedication that were unusual in a system that was not wired to offer this level of compassion by default. Parents also spoke about 'stumbling upon' support by chance rather than design, hearing about services or support groups long after they would have been most useful. This fragmentation left many feeling that services were not built around their needs, wasting valuable resources on provision that people were not accessing.

> *"We came across [The Healthy Families team] stall at … one of those summer play day things. They ended up coming to the house and giving us a bit of advice on potty training … I suppose my point is that we came across them quite randomly at the right time, but they were always there and then, once we had them in our house, they told us about other stuff that we could have asked them about."*
>
> Parent of 0- and 3-year-old, Nottinghamshire – Focus Group 2

With this in mind, it is worth highlighting an unfortunate but necessary reality. It will take time to get the NHS back on its feet: to recover waiting times, reinvest in key workforces, and restore access to timely, face-to-face primary care. If parents are increasingly substituting for NHS services, it is worth reflecting on how prepared and equipped they are for that role, not least as it is likely to persist for some time yet. And if the NHS is to be placed on a more sustainable footing, there may be value in considering how parents could contribute – by design, rather than by accident – as partners in a future model of care.

> *"So I'm still waiting now for a private clinic. So I think one of the main things in terms of CAMHS … is that waiting time. Other than that, when you get the service, it's really good … I have one child where everything was diagnosed, and after that, they were brilliant … But then then they kind of just leave you in the lurch … They're like, 'oh, there's this parenting group, there's this parenting group', but nothing very concrete … You're just on your own to deal with it, and you have to search around to find the next steps you have to do … I always feel like I'm doing things on my own and using Google a lot."*
>
> Parent of 18-, 16-, 14-, 12- and 2-year-old, London – Focus Group 5

In this regard, many parents described feeling underprepared for parenthood, and unexpectedly alone – especially as they moved beyond the early years – in managing complex aspects of their child's health and wellbeing. One in three parents said they felt 'not very' or 'not at all' prepared to tend to their child's health needs (see figure 3.6). The same proportion – one in three – had not attended any antenatal classes before the birth of their first child, a figure rising to two in five among the least financially comfortable (see figure 3.7). 85 per cent of parents agreed that you learned to keep a child healthy 'as you go' rather than through structured or quality-assured sources of guidance. In their absence, parents spoke about seeking out – or being targeted by – information online or on social media, with varying levels of consistency or credibility. Figure 3.8 shows that while GPs remain parents' most trusted sources of health advice, younger parents were less likely to seek out clinical guidance and more likely to look for help informally or online. This may reflect their greater immersion in the digital world, or the reality of becoming parents at a time when the NHS can no longer be relied upon for timely support.

"It was very much that you left the hospital, and I was like 'I don't really know if I'm doing the right thing. I don't know who to talk to or where to go to.' And it wasn't until we went to the Children's Centre that we stumbled upon, 'oh, actually, there's a group that speaks about this', but without that … you leave the hospital with a baby and you're kind of just winging it."

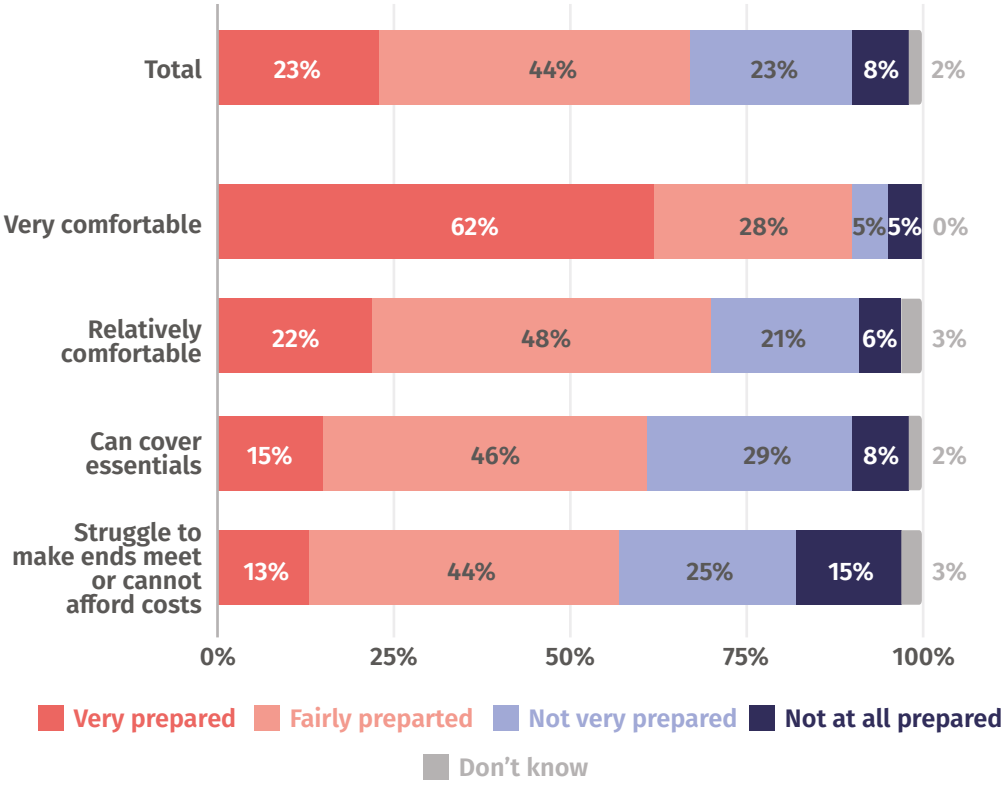
Parent of 1-year-old, Nottinghamshire – Focus Group 1

"I think about when my daughter was younger, you know, like baby, toddler sort of age, there was lots of support in place … as they get older, I think that actually things get more complex. You've got to navigate hormonal changes, puberty, social media, going to secondary school … all of these huge parts of their life which have huge impacts on them. And there's none of that support that you had in those earlier days, when you could call the health visitor and say 'I'm not sure about this.'

Parent of 6- and 11-year-old, Plymouth – Focus Group 5

FIGURE 3.6: PREPARATION FOR PARENTHOOD VARIES SIGNIFICANTLY BY FINANCIAL COMFORT

Q: Before you became a parent, how prepared did you feel to look after your child's health and wellbeing?



Source: Public First survey (2025)

"There's so much information out there, but it's all contradictory. I think 'I'm going to go on the internet and get my advice there' … You could read something and think, 'right, I know what I'm doing' and then someone will go, 'Well, have you read this?' And it's a complete contradiction … It's completely saturated with information. Whether

it's true or not, it's still there and it has the same space … it just creates anxiety."

Parent of 4-, 17-, 21-, 24- and 25-year-old, Kent – Focus Group 1

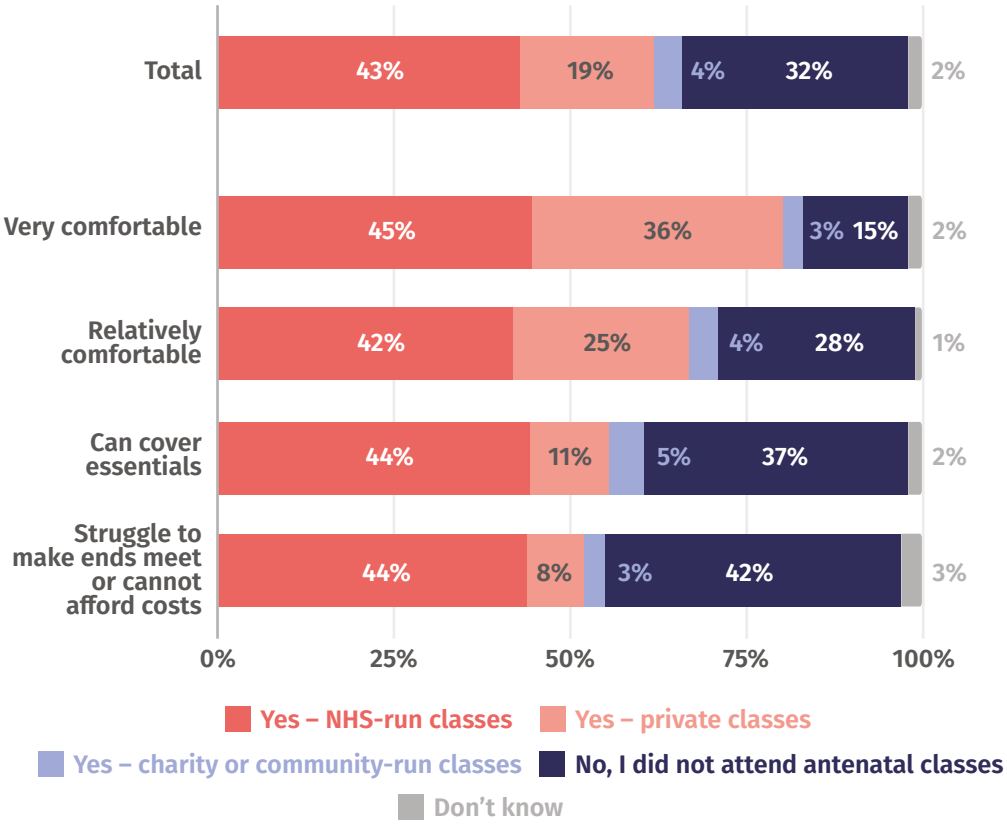
"The amount of bad stuff there – you know, on the second page of Google, or we call them 'mummy forums'. Some of the opinions that are on there are just sometimes downright dangerous occasionally."

Parent of 0- and 3-year-old, Nottinghamshire – Focus Group 2

These accounts underscore the critical role parents already play in raising healthy children and the growing burden many are shouldering as service pressures mount. There is huge potential in supporting parents with better information and tools to care for their children, but this is not something they can do alone. External forces – from an economy that makes healthy choices unaffordable and decent earnings incompatible with parental presence, to the pervasive reach of food marketing and social media – pose threats that no parent, however loving or capable, can overcome without the state's help.

FIGURE 3.7: ONE-THIRD OF ALL PARENTS – AND TWO-FIFTHS OF THE LEAST FINANCIALLY SECURE – DID NOT ATTEND ANY ANTENATAL CLASSES

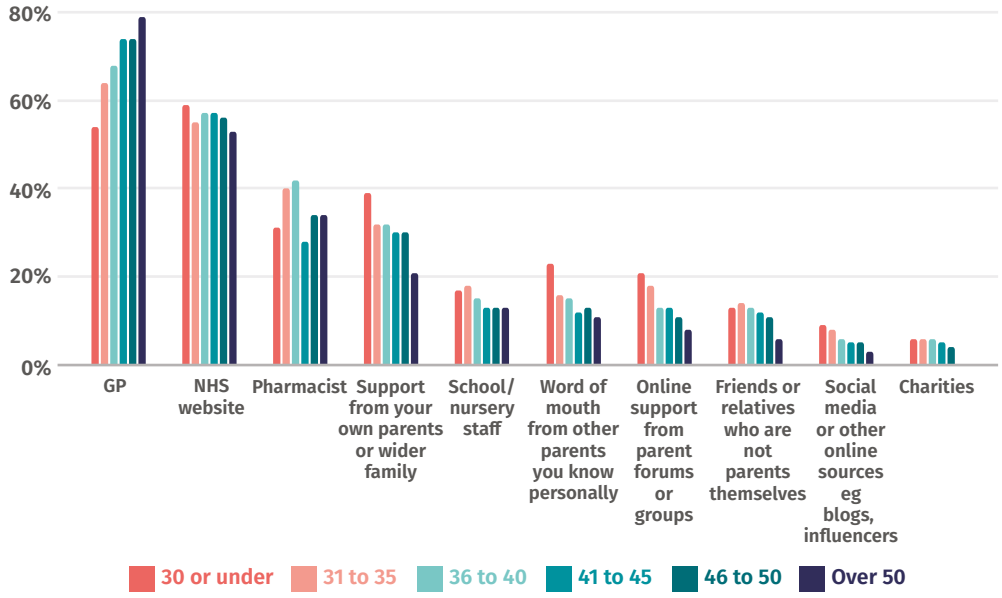
Q: Did you attend any antenatal classes before the birth of your child(ren)?



Source: Public First survey (2025)

FIGURE 3.8: PARENTS TEND TO TRUST NHS SOURCES THE MOST WHEN IT COMES TO HEALTH ADVICE, BUT THERE ARE SIGNS YOUNGER PARENTS ARE SEEKING OUT ALTERNATIVES

Q: When it comes to managing your children's health, which of the following do you most trust for advice? Select up to three of the following.



Source: Public First survey (2025)

The next chapter sets out how policy can change this: how a more enabling, facilitative state can empower parents to play their full role in shaping their children's health and rebuild the wider 'village' of supportive communities around them.

4.
REBUILDING THE VILLAGE: EMPOWERED FAMILIES, SUPPORTIVE COMMUNITIES AND AN ENABLING STATE

Despite repeated commitments from governments of all stripes, policy has long failed to improve children's health. Too often it has focussed narrowly on the levers most visible to government – such as services – rather than on the everyday conditions that most shape children's wellbeing.

A new social contract for children's health must start from a simple truth: parents deliver most of the care that keeps children well. A more sustainable and effective health system – one that truly shifts towards prevention and community-based care – should recognise and support that contribution more explicitly. That means better equipping and empowering parents for the role they already play, while rebuilding the wider village around them: communities that offer connection and support, and an enabling state that acts on the wider conditions families cannot change.

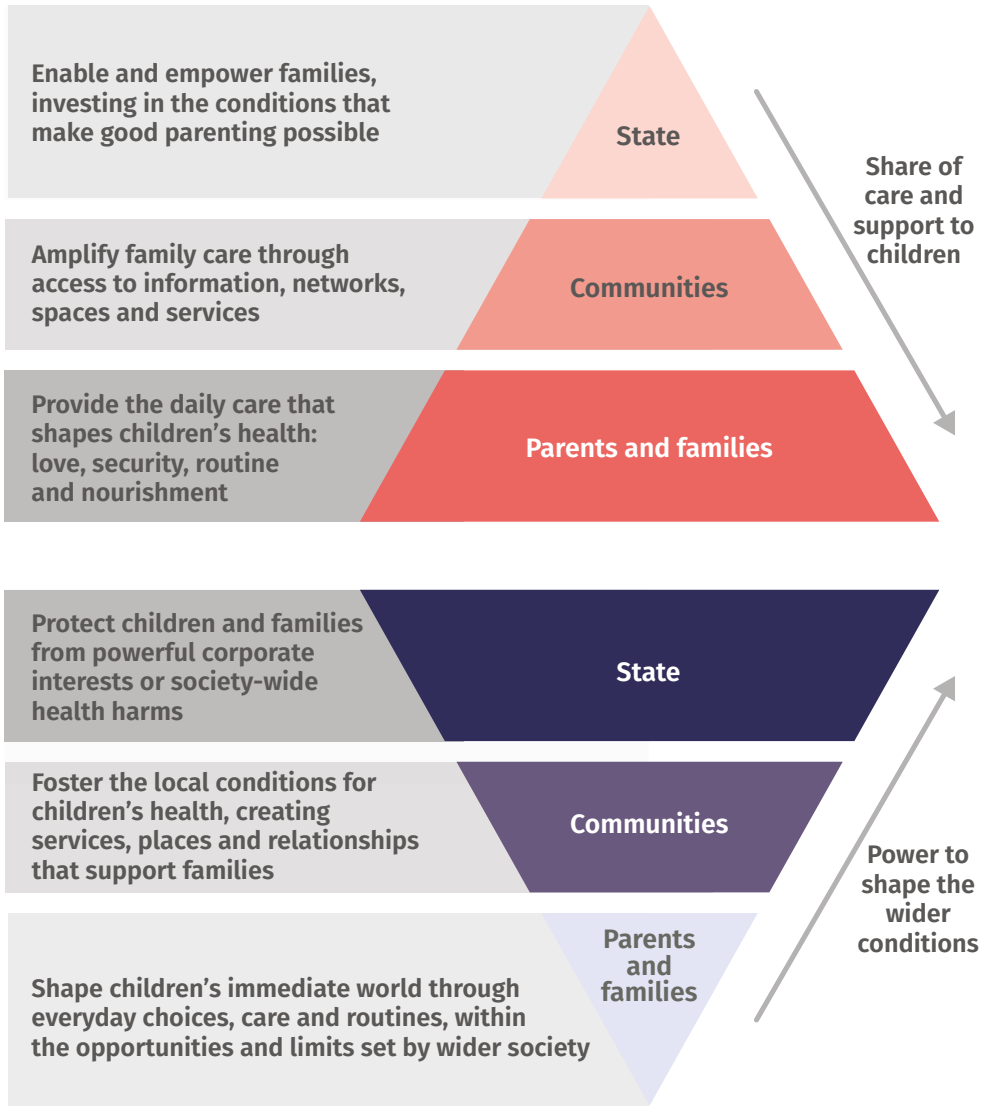
4.1 A NEW SOCIAL CONTRACT FOR CHILDREN'S HEALTH

Figure 4.1 represents what a new social contract between families, communities and the state could look like, with the breadth of the pyramids reflecting the quantum of a different resource: care (upper graphic) and power to shape wider conditions (lower graphic). This reflects an inverse relationship between the two: families deliver the vast majority of day-to-day care, while the state holds the greatest power to shape the wider conditions in which that care takes place.

Communities form the connective tissue between the two. They amplify families' capacity to care through both informal relationships and more formal services. They also help to foster the local conditions for health – from safe spaces to joined-up local provision – using the levers available at place and community level.

As set out in chapter 2, governments have either been reluctant to articulate this relationship or got it confused, seeking to micromanage families or leave them to cope alone. But this need not be politically contentious, simply reflecting where only families, and where only the state, can make a difference – and ensuring that each is equipped to play its part.

FIGURE 4.1: REBALANCING CARE AND POWER: DEFINING RESPONSIBILITIES FOR IMPROVING CHILDREN'S HEALTH



Source: Authors' analysis

4.2 FROM PRINCIPLE TO PRACTICE: WHAT FAMILIES TOLD US THEY NEED

Focussing the health system on how it can empower parents to deliver better, preventative care for their children means listening to what families say they need. There was striking consistency in what parents and carers wanted to change about the support available to them.

- **More personal, human relationships with practitioners.** Parents wanted professionals who take time to build trust and understand their circumstances. Ideally this meant continuity of care, but where that was not possible, it was about staff making a conscious effort to "see the person behind the message".

> *"Something I said to each of my consultants ... was that their every day is my literal once-in-a-lifetime. They have to see the person behind the message."*
>
> Parent of 7-month-old, Plymouth – Focus Group 3

- **More informal, low-pressure spaces for support**. Parents valued approachable, community-based places – such as Children's Centres, Family Hubs and play spaces – where they could seek advice and connection without stigma.

  "The Children's Centre was a huge help ... probably the non-clinical nature ... and often there are mums actually running [them] ... when I speak of community, that's where it should be."

  Parent of 4-, 17-, 21-, 24- and 25-year-old, Kent – Focus Group 1

- **Clearer, easier access to information.** Many parents described being "left alone" after early health visitor visits, uncertain where to turn as new challenges arose. They wanted a single, trusted place to find help – the intention behind a government initiative called the 'Start For Life offer' where all services would be advertised in one digital location – but parents wanted something that was more proactive in reaching them during an exhausting and often overwhelming period.

  "Once you link with one thing ... it opens up more, but after that health visitor visit, at two months, you are just left at 'call us if you need us'. But over time, you're tired and you forget what you can call them for. There needs to be more regular visibility of what is available ... You know, emails to all the parents of three-year-olds in the area [saying] 'do you need help with this? ... We're here still'."

  Parent of 0- and 3-year-old, Nottinghamshire – Focus Group 2

- **Better preparation and ongoing guidance for parenthood.** Parents felt antenatal education was too brief and too focussed on birth rather than the realities of parenting. They wanted longer-lasting, practical and peer-led support alongside professional advice.

  "Antenatal support is very focussed on the first few days ... the very basics... There needs to be more available ... I'd prefer it to be in a repeatable format – you know, like webinars or videos – because I don't think I would have really understood much before I actually had a kid."

  Parent of 0- and 3-year-old, Nottinghamshire – Focus Group 2

  "Some sort of charity – a group of mums that run it, a course that you sign up from when you first find out when you're pregnant till the child's two or three years old. And there's the same group of people – maybe monthly – and you get together for a couple of hours, You just have mums' real stories, advice, tips, things that the NHS don't tell you ... and build up that community around someone".

  Parent of 5-, 7- and 8-year-old, Kent – Focus Group 3

BOX 4.1 PREPARING FOR PARENTHOOD: ANTENATAL EDUCATION IN ENGLAND

Antenatal education is the main way parents are prepared for life with a child. It aims to equip them with the knowledge and confidence to care for their baby — covering birth, feeding, development and early health. Given this, it is striking that the state takes so little interest in the quality, content or consistency of provision.

Provision in England is largely discretionary. While NICE guidance recommends the topics that should be covered (NICE 2021), it is not mandatory and local commissioning by maternity services and integrated care boards (ICBs) sees significant variation in what is offered. Alongside NHS provision, a large private industry has developed, where there is little regulation or oversight.

Parents in our focus groups described NHS antenatal education as difficult to access – often booked up before they could join or held at times that didn't work for them. Many said courses focussed too narrowly on birth and the first few weeks, rather than on meeting their child's health needs in the long term. At the same time, some felt that certain content could only be absorbed once the baby had arrived, suggesting that follow-up sessions in the postnatal period would be valuable.

Survey findings echoed this: one in three parents said they received no antenatal education at all, rising to two in five among the least financially comfortable. Seventy-seven per cent agreed they would have liked more sessions on keeping their child healthy after birth (only 7 per cent disagreed). Nearly two in three (62 per cent) said classes focussed too much on birth and not enough on long-term care, and an equal proportion (64 per cent) wanted more classes overall.

Antenatal education also represents good value for money, improving birth and early childhood outcomes for relatively low investment (Hooper et al 2025).

- **An education system that prioritises life skills and resilience.** Parents worried that emphasis on narrow academic success – combined with new pressures from technology – was not preparing children for the realities of adult life.

  "I wonder about whether the education system needs to be changed … kids are spending more and more time indoors, on phones, not developing social skills, developing mental health problems … And even if they can navigate themselves through school or get good grades, I'm not convinced they're being built to be resilient human beings who can … look after themselves and have relationships."

  Parent of 8-, 12- and 14-year-old, London – Focus Group 5

- **More free, appealing alternatives to screen time.** Parents wanted more opportunities for children to play, socialise and be active offline – especially affordable local activities that create community and connection.

  "I think back to when I was young: I used to go to youth clubs and had a community of friends that I was out face-to-face with, doing things … it would be really helpful to have more sports clubs, more community groups, more opportunities that are free, cheap, for young people to get together without the pressure of social media."

  Parent of 7- and 13-year-old, Plymouth – Focus Group 5

- **A healthier environment for families, with stronger action on commercial and social pressures** – from social media to unhealthy food marketing – that make parenting harder.

  "Social media companies and food companies should be held accountable, with stringent rules to make sure what they're putting out is beneficial to our children … It also comes down to us as parents to manage our children and what they are looking at. But governments should step in … because if we can do both [intervention by] government and at home, then maybe the waiting list will come down and the need for professionals won't be so great."

  Parent of 10- and 12-year-old, Surrey – Focus Group 6

Together, these insights point to a clear agenda for change: one that strengthens the support and relationships around families, while tackling the wider conditions that make healthy choices harder. The recommendations that follow in the concluding chapter outline how national and local government can begin to rebuild that 'village' at each of the three levels of state, communities, and parents and families presented in figure 4.1.

5. RECOMMENDATIONS

5.1 EMPOWERING PARENTS AND FAMILIES

The proposals in this concluding chapter are deliberately cost-conscious, recognising the tight fiscal context and limited headroom for new spending. They focus on high-impact, low-cost reforms that build on existing infrastructure and commitments.

Furthermore, although this agenda looks to the long term, many of its elements could be delivered quickly, giving families tangible evidence of progress within the Parliament.. Rapid action to establish a new national standard for antenatal education, modernise parental information, and extend the reach and family-centredness of local services could be achieved well before 2029, while building the infrastructure for more sustained reform over the coming decade.

They should also be read alongside those set out in Fixing the Foundations **(Gandon and O'Halloran 2025) together forming a comprehensive reform agenda: both the central government architecture and incentives needed to drive long-term change and practical improvements to empower families and frontline services now.**

Recommendation 1. Introduce a 'Growing Together' Guarantee: a universal offer of parental information and support before birth and through the first year of parenthood

Children, families and the state all stand to benefit when parents feel confident and informed before taking on one of the most important and demanding roles of their lives. Yet antenatal education remains patchy, inconsistent and too narrow in focus. The Growing Together Guarantee would correct for this, establishing a universal national standard for antenatal education and creating a new expectation of postnatal learning and support, delivered through the NHS and Family Hubs.

The government should:

- establish a national quality framework, overseen by the Department of Health and Social Care, with flexibility for local services to tailor provision to their population's needs
- make participation opt-out rather than opt-in, with registration early in pregnancy (for example, at booking appointment)
- deliver the offer in-person through Family Hubs wherever possible, helping to connect families early to local spaces, staff and other families
- fund outreach to reach young, low-income and marginalised parents to improve equity.

The costs of antenatal courses are modest (around £200 per family) but can reduce avoidable costs elsewhere – such as hospital admissions – and increase the impact of other early-years investments by ensuring more families benefit.

Recommendation 2. Reboot the parental information ecosystem – building a modern, trusted and relatable public voice for parenthood

Every parent deserves access to clear, consistent and trustworthy advice about caring for their child. Yet today's information landscape is crowded and confusing, with professional, peer and online voices competing for attention and varying widely in tone and reliability. Parents are turning increasingly to social media, not because they distrust official sources, but because those spaces feel more immediate, human and emotionally supportive.

The government and NHS should modernise how they communicate with parents – meeting them in the digital spaces they already inhabit and rebuilding appeal through relatable, evidence-based information.

The government should:

- launch a unified, social media-led campaign under a single brand – Growing Together: Advice You Can Trust – across Instagram, YouTube and TikTok, signposting to NHS-verified guidance
- cocreate content with health visitors, midwives, psychologists, and trusted parenting creators to blend evidence with authentic, human stories
- introduce an NHS 'verified advice' badge for approved accounts, ensuring clarity without losing authenticity
- partner with Family Hubs and local services to share content, helping families link digital information to real-world support.

Digital-first campaigns generally offer better value for money than traditional print or broadcast media, consistently reaching larger audiences with more verifiable engagement (Deloitte 2021).

5.2 MORE SUPPORTIVE COMMUNITIES

Recommendation 3. Establish 'Family Connect': proactive outreach and signposting for parents from pregnancy to school age

Parents consistently told us they struggle to know what support exists and when it is relevant to them. 'Family Connect' would turn the current Start for Life offer into a proactive, personalised outreach system that brings services to families instead of expecting families to find them.

The government, via local services, should:

- enrol families automatically at maternity booking or birth registration, using data already collected
- provide regular milestone-based messages, tailored by child age (for example, weaning, sleep, language development or school readiness) as well as regular (such as monthly) local round-ups
- include links to local activities, resources and services
- build on existing Start for Life and NHS App infrastructure to ensure security, simplicity and joined-up delivery
- ensure that digital messages and tools are complemented by offline options, such as paper mailings, text alerts, or direct contact from health visitors and Family Hubs, for families without reliable digital access.

Increased awareness and uptake of existing support would increase the value of the investment in those services and support wider health system objectives by harnessing the power of digital tools to improve efficiency.

Recommendation 4. Introduce 'Bridges': short, structured support for parents of children with health or developmental needs awaiting specialist help

Many families caring for children with health needs – especially for mental ill-health or developmental and behavioural issues – face long waits for assessment or treatment, with little help in the meantime. Accepting this tough but unavoidable reality, 'Bridges' would provide information, guidance and peer support to help parents to feel supported and better equipped to meet their child's needs in the meantime.

The government, via local services, should:

- deliver 'Bridges' through Family Hubs and online platforms, cofacilitated by professionals and trained parents
- create onward opportunities for informal peer support, countering isolation by connecting parents with others in similar situations
- be promoted through Family Hubs, schools, CAMHS and SEND services to reach families early and ensure equitable access.

Recommendation 5. Ensure Neighbourhood Health Centres are designed around the needs of families and children

Neighbourhood Health Centres (NHCs) are a flagship commitment of the government's 10 Year Health Plan and align with what parents say they want from services: local, accessible and 'human' care rooted in their communities. Delivering on their promise will mean ensuring these new centres are designed with children and families in mind, not simply as add-ons to adult care models.

The government should:

- ensure centres include welcoming, family-friendly spaces that enable informal connection and peer support alongside professional care
- default to co-location with – or at least close proximity to – services for children, young people and families, such as Family Hubs, Young Futures Hubs, community midwifery and health visiting
- embed multidisciplinary pathways specifically for children and young people within NHCs, integrating community paediatrics, health visiting, speech and language, and SEND and mental health support as appropriate.

This has the potential to reduce duplication, improve access, and ensure earlier help in keeping with a more preventative and efficient health service.

5.3 AN ACTIVE, ENABLING STATE

Recommendation 6. Intervene to make healthy food affordable and accessible for every family

Families consistently told us that they want to feed their children well but that the cost, availability and marketing of food stack the odds against them. Building on the proposed Healthy Food Standard, the government should make affordability a core measure of success, ensuring that healthy choices are not only available but financially realistic for families.

The government should:

- adapt the Healthy Food Standard to include affordability targets – requiring retailers to demonstrate year-on-year progress in narrowing the price gap between healthy and unhealthy products, with stronger expectations in deprived areas
- use revenue from a new salt and sugar levy to extend Free School Meals and improve school food standards in line with the most recent nutritional research

- require local authorities to map and address food deserts, using planning powers, business rate relief, or partnerships with community retailers to improve access to affordable healthy food
- fully implement and extend junk food marketing restrictions, closing loopholes for small retailers and out-of-home food environments.

Recommendation 7. Further protect children and young people from technology and social media harms

Parents were clear that they need help monitoring and managing screen-dominated childhoods, from the pull of devices, social media and gaming to the loss of appealing, affordable offline alternatives. There is a clear case for government, and its agents – schools, local authorities and regulators – to address both these push and pull factors.

The government should:

- support schools to strengthen smartphone-free school policies, ensuring consistent implementation and offering offline options for homework and parental communication
- work with local authorities, sports bodies and the voluntary and private sector to expand free and affordable alternatives to screen-time, for example, community sports, creative and performing arts, and youth clubs
- go further on the Online Safety Act, tightening child protection duties to require safer default settings, limits on addictive design features such as autoplay and infinite scroll, and stronger independent enforcement of age assurance.

Recommendation 8. Act on income and working conditions to give families the time and economic stability to care

Financial strain and insecure work remain major drivers of stress and poor health for families. Poverty and long, unpredictable working hours can undermine children's wellbeing, affecting everything from nutrition to emotional security. The government has already taken important steps – through the employment rights bill and the expansion of childcare – to support working parents, but further action is needed.

The government should:

- remove the two-child limit and benefit cap, uprate child benefits in line with inflation, and link universal credit rates to minimum living costs
- extend the right to paternity and partner leave to six weeks' paid leave at ~90 per cent of earnings, available as a Day-One right for all employed and self-employed second parents
- design and champion a 'Family-Friendly Work Standard', promoting long part-time roles (for instance 25–30 hours a week, based on a 10am to 3pm workday) with predictable hours, liveable pay and flexibility, backed by pilots to assess productivity impacts.

Together, these recommendations offer the basis for a new social contract for children's health – one that recognises the vital role families play but ensures they are no longer left to carry that responsibility alone.

By rebalancing care and power across families, communities and the state, government can build a society that gives every child the strongest start in life, and in doing so, lay the foundations for a healthier, fairer and more prosperous future for the whole nation.

REFERENCES

Amos A, Angus K, Bostock Y, Fidler J and Hastings G (2009) *A review of young people and smoking in England*. PHRC A7-08 Final Report. Public Health Research Consortium. https://www.pure.ed.ac.uk/ws/portalfiles/portal/8472628/PHRC_A7_08_Final_Report.pdf

Arrieta MC, Stiemsma LT, Amenyogbe N, Brown EM and Finlay B (2014) 'The intestinal microbiome in early life: Health and disease', *Frontiers in Immunology*, 5: 427. https://doi.org/10.3389/fimmu.2014.00427

BBC News (2025, 2 September) 'Chris Mason: Starmer faces pressure to deliver as he tries to strike contrast with Reform'. https://www.bbc.co.uk/news/articles/c8jpj8knvn8o

Berge JM, Rowley S, Trofholz A, Hanson C, Rueter M, MacLehose RF and Neumark-Sztainer D (2014) 'Childhood obesity and interpersonal dynamics during family meals', *Pediatrics*, 134(5): 923–932. https://doi.org/10.1542/peds.2014-1936

Caluzzi G, Livingston M, Holmes J, MacLean S, Lubman D, Dietze P, Vashishtha R, Herring R and Pennay A (2021) 'Declining drinking among adolescents: Are we seeing a denormalisation of drinking and a normalisation of non-drinking?', *Addiction*, 117(5): 1204–1212. https://doi.org/10.1111/add.15611

Children's Commissioner for England (2025) *Children's mental health services 2023-24: Annual briefing May 2025.* https://assets.childrenscommissioner.gov.uk/wpuploads/2025/05/cco-childrens-mental-health-annual-briefing-may-2025.pdf

Coulthard H, Harris G and Emmett P (2009) 'Delayed introduction of lumpy foods to children during the complementary feeding period affects child's food acceptance and feeding at 7 years of age.' *Maternal and Child Nutrition*, 5(1): 75–85. HTTPS://DOI.ORG/10.1111/j.1740-8709.2008.00153.x

Darzi A (2024) Independent investigation of the National Health Service in England. Crown. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

Deloitte (2021) 'The future of public health campaigns: Digital strategies for amplifying influence and effectiveness'. *Deloitte Insights*. https://www.deloitte.com/us/en/insights/industry/government-public-sector-services/successful-digital-public-health-campaigns.html

Department for Education [DfE] and Deputy Prime Minister's Office (2013) 'Free school lunch for every child in infant school'. https://www.gov.uk/government/news/free-school-lunch-for-every-child-in-infant-school

Department for Education [DfE] (2014) Requirements for School Food Regulations 2014. Statutory Instrument 2014 No. 1603. https://www.legislation.gov.uk/uksi/2014/1603/pdfs/uksi_20141603_en.pdf

Department for Education [DfE] (2017) 'PE and Sport Premium doubles to £320 million'. https://www.gov.uk/government/news/pe-and-sports-premium-doubles-to-320-million

Department for Education [DfE] (2018) 'Thousands more school children receiving a nutritious breakfast'. https://www.gov.uk/government/news/thousands-more-school-children-receiving-a-nutritious-breakfast

Department for Education [DfE] (2024) Pupils: Mental Health Services. Written Answer UIN 4311, 13 Sep 2024. UK Parliament. https://questions-statements.parliament.uk/written-questions/detail/2024-09-04/4311/

Department for Education [DfE] (2025) 'Free breakfast clubs for half a million extra children next year'. https://www.gov.uk/government/news/free-breakfast-clubs-for-half-a-million-extra-children-next-year

Department of Health [DoH] (2009) *Departmental report 2009: The Health and Personal Social Services Programmes* (Cm 7593). https://assets.publishing.service.gov.uk/media/5a74e92bed915d502d6cbfdb/7593.pdf

Department of Health [DoH] (2011a) *A call to action on obesity in England*. https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england

Department of Health [DoH] (2011b) *Change4Life: Three year social marketing strategy 2011-14*. https://assets.publishing.service.gov.uk/media/5a7baa68e5274a7318b9020a/dh_130488.pdf

Department of Health [DoH] (2013) 'Final design of consistent nutritional labelling system given green light'. https://www.gov.uk/government/news/final-design-of-consistent-nutritional-labelling-system-given-green-light

Department of Health [DoH] (2017) *Developing a specification for lifestyle weight management services*. https://assets.publishing.service.gov.uk/media/5a75911f40f0b6360e475174/Weight_Management_Service_Spec_FINAL_with_IRB.pdf

Department of Health and NHS England [DoH and NHSE] (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* https://assets.publishing.service.gov.uk/media/5a80b26bed915d74e33fbe3c/Childrens_Mental_Health.pdf

Department of Health and Social Care [DHSC] (2016) *Childhood obesity: A plan for action*. https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

Department of Health and Social Care [DHSC] (2018) *Childhood obesity: A plan for action – chapter 2*. https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2

Department of Health and Department for Education [DoH and DfE] (2017) *Transforming children and young people's mental health provision: A Green Paper.* Cm 9523. https://assets.publishing.service.gov.uk/media/5a823518e5274a2e87dc1b56/Transforming_children_and_young_people_s_mental_health_provision.pdf

Department of Health and Social Care [DHSC] (2020) *Tackling obesity: Empowering adults and children to live healthier lives*. https://www.gov.uk/government/publications/tackling-obesity-government-strategy

Department of Health and Social Care [DHSC] (2021) 'Mental health recovery plan backed by £500 million'. https://www.gov.uk/government/news/mental-health-recovery-plan-backed-by-500-million

Department of Health and Social Care [DHSC] (2022) *Restricting promotions of products high in fat, sugar or salt by location and by volume price: Implementation guidance*. https://www.gov.uk/government/publications/restricting-promotions-of-products-high-in-fat-sugar-or-salt-by-location-and-by-volume-price/restricting-promotions-of-products-high-in-fat-sugar-or-salt-by-location-and-by-volume-price-implementation-guidance

Department of Health and Social Care [DHSC] (2024) 'Extra funding for Early Support Hubs'. https://www.gov.uk/government/news/extra-funding-for-early-support-hubs

Department of Health and Social Care [DHSC] (2025a) Restricting advertising of less healthy food or drink on TV and online – Products in scope. https://www.gov.uk/government/publications/restricting-advertising-of-less-healthy-food-or-drink-on-tv-and-online-products-in-scope/restricting-advertising-of-less-healthy-food-or-drink-on-tv-and-online-products-in-scope

Department of Health and Social Care [DHSC] (2025b) *10 Year Health Plan for England: fit for the future*. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Department of Health and Social Care and Department for Education [DHSC and DfE] (2025b) 'Ban on selling high-caffeine energy drinks to boost kids' health'. https://www.gov.uk/government/news/ban-on-selling-high-caffeine-energy-drinks-to-boost-kids-health

Department of Health and Social Care and Prime Minister's Office [DHSC and PM's Office] (2025) 'Young Futures Hubs to launch offering vulnerable young people lifeline'. https://www.gov.uk/government/news/young-futures-hubs-to-launch-offering-vulnerable-young-people-lifeline

Dhana K, Haines J, Liu G, Zhang C, Wang X, Field AE, Chavarro JE, Sun Q (2018) 'Association between maternal adherence to healthy lifestyle practices and risk of obesity in offspring: Results from two prospective cohort studies of mother–child pairs in the United States', *BMJ*, 362: k2486. https://doi.org/10.1136/bmj.k2486

Draxten M, Fulkerson JA, Friend S, Flattum C and Stafford M (2014) 'Parental role modelling of fruits and vegetables at meals and child intake', *Appetite*, 76: 114–121. https://doi.org/10.1016/j.appet.2014.02.017

Fearon RP, Bakermans-Kranenburg MJ, van Ijzendoorn MH, Lapsley A and Roisman GI (2010) 'The significance of insecure attachment and disorganization in the development of children's externalizing behavior: a meta-analytic study', Child Development, 81(2): 435–456. doi: 10.1111/j.1467-8624.2009.01405.x

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP and Marks JS (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4): 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Foulkes L (2021). *What mental illness really is... (and what it isn't)*, Vintage

Gandon A and O'Halloran J (2025) *Fixing the foundations: The case for investing in children's health.* IPPR. https://www.ippr.org/articles/fixing-the-foundations.

Griffith R, Jin W and Lechene V (2022) 'The decline of home-cooked food', *Fiscal Studies*, 43(2): 105–120. https://doi.org/10.1111/1475-5890.12298

Hadley A and Chandra-Mouli V (2016) 'Implementing the United Kingdom's ten-year teenage pregnancy strategy for England (1999–2010): How was this done and what did it achieve?', *Reproductive Health*, 13: 139. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0255-4

Haidt J (2024) *The anxious generation: How the great rewiring of childhood is causing an epidemic of mental illness*. Allen Lane.

Hammons AJ and Fiese BH (2011) 'Is frequency of shared family meals related to the nutritional health of children and adolescents?' *Pediatrics*, 127(6): e1565-e1574. https://doi.org/10.1542/peds.2010-1440

HM Revenue and Customs [HMRC] (2025) 'Soft Drinks Industry Levy statistics commentary'. https://www.gov.uk/government/statistics/soft-drinks-industry-levy-statistics/soft-drinks-industry-levy-statistics-commentary-2021

HM Revenue and Customs [HMRC] and HM Treasury (2025) *Strengthening the Soft Drinks Industry Levy consultation*. https://www.gov.uk/government/consultations/strengthening-the-soft-drinks-industry-levy/strengthening-the-soft-drinks-industry-levy-consultation

HM Treasury (2018) 'Soft Drinks Industry Levy comes into effect'. https://www.gov.uk/government/news/soft-drinks-industry-levy-comes-into-effect

HM Treasury (2025) *Spending review 2025*. https://www.gov.uk/government/publications/spending-review-2025-document

Hooper E, Mechkaroff O, Upitis A, Schofield E, Carland JE and Henry A (2025) 'The effectiveness of antenatal education on improving labour and birth outcomes: A systematic review and meta-analysis', *Women and Birth*, 38(1), 101843. https://doi.org/10.1016/j.wombi.2024.101843

Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L and Dunne MP (2017) 'The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis', *The Lancet Public Health*, 2(8): e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Katikireddi S V, Der G, Roberts C and Haw S (2016) 'Has childhood smoking reduced following smoke-free public places legislation? A segmented regression analysis of cross-sectional UK school-based surveys', *Nicotine & Tobacco Research*, 18 (7): 1670–1674. doi: 10.1093/ntr/ntw018

Labour Party (2024, January 10) 'Starmer pledges the healthiest generation of children ever as Labour launches Child Health Action Plan'. [Press release]. https://labour.org.uk/updates/press-releases/starmer-pledges-the-healthiest-generation-of-children-ever-as-labour-launches-child-health-action-plan/

Mennella JA and Beauchamp GK (2005) Understanding the origin of flavor preferences. *Physiology and Behavior*, 86(5), 989–993. https://pmc.ncbi.nlm.nih.gov/articles/PMC2364714/

National Institute for Health and Care Excellence [NICE] (2021) *Antenatal care* (NG201). https://www.nice.org.uk/guidance/ng201

NHS Digital (2023) *Mental health of children and young people in England, 2023: Wave 4 follow up to the 2017 survey*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up

NHS Digital (2024) Smoking, Drinking and Drug Use among Young People in England 2023, dataset. https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england

NHS England [NHSE] (2019) *The NHS Long Term Plan*. https://www.england.nhs.uk/2019/01/long-term-plan/

Nicklaus S (2017) 'The role of food experiences during early childhood in food pleasure learning'. *Appetite*, 104, 3–9. https://doi.org/10.1016/j.appet.2015.08.022

Office for Health Improvement and Disparities [OHID] (2025a) 'Child and family weight management services: Statistical summary – April 2021 to May 2023'. https://www.gov.uk/government/publications/child-and-family-weight-management-services-april-2021-to-may-2023/child-and-family-weight-management-services-statistical-summary

Office for Health Improvement and Disparities (2025b) National Child Measurement Programme, England: academic year 2024-2025, Public Health England/Fingertips. https://fingertips.phe.org.uk/static-reports/obesity-physical-activity-nutrition/national-child-measurement-programme-2024-2025-academic-year.html

Office for Health Improvement and Disparities (2025c) Teenage conception rate (under 18 years) – indicator 20401, Public Health Profiles. https://fingertips.phe.org.uk/search/20401#page/6

Pinquart M (2017) 'Associations of parenting dimensions and styles with externalizing problems of children and adolescents: An updated meta-analysis', Developmental Psychology, 53(5): 873–932. doi: 10.1037/dev0000295

Pallan M, Murphy M, Morrison B, Sitch A, Adamson A, Bartington S, Dobell A, Duff R, Frew E, Griffin T, Hurley K, Lancashire E, McLeman L, Passmore S, Pokhilenko I, Rowland M, Ravaghi V, Spence S and Adab P (2024) 'National school food standards in England: A cross-sectional study to explore compliance in secondary schools and impact on pupil nutritional intake', *International Journal of Behavioral Nutrition and Physical Activity*, 21, Article 123. https://doi.org/10.1186/s12966-024-01672-w

Remy E, Issanchou S, Chabanet C and Nicklaus S (2013) 'Repeated exposure of infants at complementary feeding to a vegetable puree increases acceptance as effectively as flavour-flavour learning and more effectively than flavour-nutrient learning', *The Journal of Nutrition*, 143(7): 1194–1200. https://doi.org/10.3945/jn.113.175646

Tattan-Birch H, Jarvis M J et al (2022) 'Children's exposure to second-hand smoke 10 years on from smoke-free legislation in England: cotinine data from the Health Survey for England 1998–2018', *The Lancet Regional Health – Europe*, 15: 100315. doi: 10.1016/j.lanepe.2022.100315

UK Parliament (2024) 'National Child Measurement Programme: Question for the Department of Health and Social Care' (UIN 15707), 22 November. https://questions-statements.parliament.uk/written-questions/detail/2024-11-22/15707

Utter J, Larson N, Berge JM, Eisenberg ME and Fulkerson JA (2018) 'Family meals among parents: Associations with nutritional, social and emotional wellbeing', *Preventive Medicine*, 113, 7–12. https://doi.org/10.1016/j.ypmed.2018.04.017

University of Cambridge (2024) 'Ultra-processed food makes up almost two-thirds of calorie intake of UK adolescents'. https://www.cam.ac.uk/research/news/ultra-processed-food-makes-up-almost-two-thirds-of-calorie-intake-of-uk-adolescents

Victora CG, Bahl R, Barros AJ, França GV, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N and Rollins NC (2016) 'Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect', *Lancet*, 387(10017): 475–490. https://doi.org/10.1016/S0140-6736(15)01024-7

Whitaker V, Curtis P, Fairbrother H, Oldham M and Holmes J (2023) 'Young people's explanations for the decline in youth drinking in England', *BMC Public Health*, 23: 402. https://doi.org/10.1186/s12889-022-14760-y

Wellings K, Palmer MJ, Gear RS … and Wilkinson P (2016) 'The decline of teenage pregnancy in England', *The Lancet*, 382(9907): 486–495. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30449-4/fulltext

GET IN TOUCH

For more information about the Institute for Public Policy Research, please go to www.ippr.org

You can also call us on +44 (0)20 7470 6100, e-mail info@ippr.org or tweet us @ippr

Institute for Public Policy Research
Registered Charity no. 800065 (England & Wales), SC046557 (Scotland), Company no, 2292601 (England & Wales)