Tameside Metropolitan Borough

Progress HEALTH PARTNERSHIPS

Foundations for Healthy Weight

A Maternal and Early Years Healthy Weight Needs Assessment for Tameside

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Produced: November 2025

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1. Introduction

Maintaining a healthy weight during pregnancy and early childhood is critical to lifelong physical and mental health. The early life course—including preconception, pregnancy, infancy, and the preschool years—shapes not only short-term maternal and child outcomes but also trajectories for later obesity, diabetes, cardiovascular disease and health inequalities.

The Tameside Healthy Weight Strategic Framework for Action (2024–2028) establishes a clear ambition to embed prevention across the life course. It sets a long-term vision where 'future generations live in an environment where healthy weight is the norm and the environment around supports people to maintain a healthy weight through a healthy lifestyle'. Maternal and early years health is central to achieving this goal. National and international evidence highlights the early years as a key period where physical, social, emotional and nutritional environments interact to influence weight outcomes.

Locally, while many services already support maternal and early years health, significant inequalities persist. Children living in Tameside's most deprived communities are more likely to experience early obesity, poor maternal diet, and barriers to accessing nutritional or physical activity support. At the same time, the system faces pressures from rising complexity of need, constrained budgets, and a fragmented early years landscape.

This needs assessment was commissioned by Tameside Council to support the delivery of the Healthy Weight Strategy and provide a clear and up-to-date understanding of the challenges, inequalities, and opportunities linked to maternal and early years healthy weight across the borough.

2. Methodology

2.1 Aims and Objectives

The overarching aim of this assessment is to systematically identify the needs, barriers, service gaps and system strengths that affect healthy weight during the maternal and early years in Tameside, and to support evidence-informed planning.

Key objectives include:

- To describe the local epidemiology and current data relating to maternal and early years healthy weight.
- To identify drivers of inequality and populations at heightened risk.
- To map current services, policies and system functions that influence healthy weight.
- To capture lived experience from families and practitioners.
- To identify examples of good practice and innovation in healthy weight promotion.
- To provide actionable recommendations for improving outcomes and reducing inequality.

2.2 Approach to the Assessment

The assessment used a mixed-methods approach structured across four phases. Each element was designed to ensure a rich, triangulated understanding of the issue, drawing together data, policy, practice and voice.

Phase one– Inception and Framework Development
A project initiation phase was undertaken to clarify aims, engage partners, and finalise the methodology. This included the establishment of a time-limited advisory group, bringing together stakeholders from

public health, early years, maternity, and the voluntary sector. A Project Initiation Document (PID) was agreed to govern scope, deliverables and timelines.

Phase two – Literature and Data Review

A comprehensive contextual review was conducted, covering national and local policy, academic literature, and key data sources. Analysis included:

- National and regional surveillance (e.g. NCMP, OHID profiles).
- Maternal health, obesity and lifestyle data.
- Ward-level early years demographic and deprivation analysis.
- Local strategy, service mapping, and JSNA inputs.

Phase three – Stakeholder and Community Engagement

Lines of enquiry included perceived service gaps, barriers to accessing support, community assets, and priorities for action. Lived experience was central to understanding how structural factors shape behaviours.

Engagement was delivered through:

- One-to-one or small group semi-structured interviews (n≈15).
- An electronic professional stakeholder survey (n≈39).
- An electronic survey for parents, pregnant women and carers of under-5s. (n≈85).

Phase four – Synthesis and Reporting

Findings were synthesised into a single evidence-based report. The report includes discussion of unmet need, service effectiveness, system integration, inequalities, and priority areas. Recommendations have been developed in line with the evidence gathered and local priorities, with a focus on equity, prevention and system working.

3. National Policy Drivers

National policy places a strong and growing emphasis on the importance of healthy weight during the maternal and early years. There is widespread recognition that the first 1,001 days, from conception to a child's second birthday, offer a unique opportunity to shape lifelong health outcomes. Overweight and obesity in this early window are associated with long-term risks such as diabetes, cardiovascular disease, and poor mental wellbeing. National strategies increasingly reflect the need for a coordinated, prevention-focused approach across health, early years, maternity and family support services.[1] [2]

The NHS Long Term Plan[3] and the Best Start for Life strategy[4] brings welcome recognition to this issue, setting out commitments *to "provide targeted support to families and children at risk of obesity"* and to invest in *"a more intensive approach to supporting healthy weight in children from birth to adulthood."* The plan recognises that prevention must begin early in the life course and outlines ambitions to improve preconception health, support breastfeeding, and strengthen community services such as health visiting and maternity outreach. Importantly, it highlights the need to reduce inequalities in obesity by addressing the social determinants of health and tailoring support to families in the most deprived communities.

Policies such as the Healthy Child Programme[5] and its successor service models emphasise universal health visiting as a vital means of addressing healthy weight, with particular focus on breastfeeding, infant feeding, healthy eating, and physical activity. In 2023–2024, 83% of families received their new birth visit within 14 days, an improvement since the COVID-19 pandemic.[6] However, challenges remain with gaps in continuity and workforce capacity.

National guidance on service delivery has increasingly promoted integration. Continuity between midwifery and health visiting is

encouraged through guidance and service agreements.[7] [8] The Three-Year Delivery Plan for Maternity and Neonatal Services[9] reaffirm the importance of compassionate care, safety, and better support for the maternity workforce.

Midwifery plays a central role in public health messaging and support for healthy weight. The Nursing and Midwifery Council[10] sets out core proficiencies for midwives, which include nutritional health, lifestyle advice, and engagement with wider community assets. Alongside this, health visitors remain a key element of early years support, delivering both universal and targeted interventions in line with family needs.

The NHS Healthy Start scheme offers a tangible national mechanism to address nutrition and inequality. The scheme provides financial support to low-income families via a prepaid card to buy milk, fruit, vegetables, pulses and formula, alongside access to free vitamins.[11] Although the scheme has gone digital, uptake remains suboptimal, with only 62.4% of eligible households nationally, accessing the scheme.[12] Recent extensions to include families with no recourse to public funds signal a commitment to improving equity.[13] It is important to note that national and local data on NHS Healthy Start Scheme uptake is not currently available to understand uptake of the scheme.

The Family Hubs and Start for Life programme[14] reinforces the importance of joined-up delivery across maternity, health visiting, early help, and parenting services. These national investments aim to reduce fragmentation and strengthen multi-agency collaboration, particularly in the early years.

National bodies such as the Institute of Health Visiting (iHV)[15] continue to highlight challenges in the system, including a reduction in qualified health visitors, data quality issues, and a lack of consistent pathways between services. At the same time, practice innovations—including local use of the Making Every Contact Count (MECC) framework,[16] better digital referral routes, and stronger local partnerships—demonstrate what is possible when national vision is matched by local leadership.

In summary, national policy provides a supportive framework for addressing maternal and early years healthy weight. However, success will depend on local ability to implement integrated pathways, build workforce capacity, and maintain a strong focus on equity and lived experience.

4. Tameside Policy Drivers

"Achieving and maintaining a healthy weight during the maternal and early years is a critical public health objective. This life stage sets the foundation for lifelong health and wellbeing."

Tameside Healthy Weight Plan 2024–2028

Tameside has made a clear commitment to supporting families to achieve and maintain a healthy weight from the earliest stages of life. Local policy reflects a system-wide approach that integrates maternity care, early years development, public health, and social support. Healthy weight in pregnancy and the early years is recognised not just as an outcome, but as a foundation for lifelong wellbeing and reduced inequalities (Tameside Healthy Weight Plan 2024-2028; Tameside Healthy Places Strategic Framework for Action).[17]

At the heart of this work is the Health and Wellbeing Board, which brings together NHS leaders, the local authority, public health, and community partners to set shared strategic priorities. The Board is responsible for the Joint Strategic Needs Assessment (JSNA), which clearly highlights the need to act early on issues such as maternal obesity, breastfeeding, and child nutrition to reduce long-term health inequalities.[18]

This shared ambition is reflected in the borough's Joint Health and Wellbeing Strategy and Locality Plan 2023–2028 – Building Back Fairer, Stronger, Together, which takes a life course approach and prioritises 'Starting Well'. It emphasises children being ready to learn, thriving in supportive families, and growing up in healthier environments, with healthy weight in pregnancy and the early years identified as a critical foundation for reducing inequalities and improving long-term outcomes.[19]

4.1 Integrated Planning and Commissioning

Commissioning arrangements in Tameside are now shaped through the partnership between Tameside Metropolitan Borough Council (TMBC) and the Greater Manchester Integrated Care Board (GM ICB).[20]

In Tameside, joint planning and commissioning continues to bring together the council, GM ICB, and local partners around maternity, early years, and public health priorities. This includes the Tameside Healthy Weight Pathway, a tiered framework enabling both professional and self-referral into weight management support, with tailored provision for pregnant women and families with young children.[21] The pathway reflects the GM ICB ambition to shift from reactive care to a population health approach, embedding prevention and tackling inequalities at place level.[22]

It is important to note that the national context for ICBs is also changing. The UK government has announced significant reforms, including a 50% reduction in ICB operating costs by October 2025.[23] The reorganisation aims to streamline the management of NHS services, with ICBs moving to a primarily strategic commissioning role, as NHS England's functions are absorbed into the Department of Health and Social Care (DHSC) over the next two years.[24] These changes will inevitably shape the way local commissioning partnerships operate in Tameside.

4.2 Whole-System, Life Course Approach

The cornerstone of this approach is the Tameside Healthy Weight Plan 2024–2028, which positions the maternal and early years life stage as a critical public health priority.[25] The plan takes a whole-systems, place-based approach, linking breastfeeding, nutrition, physical activity, early years settings, and family support to reduce health inequalities.

Services across maternity, public health and early years play central roles:

- **Primary care and general practice** provide an important first point of contact for families, with GPs and practice nurses offering advice on healthy weight, child development, and wider lifestyle factors. Practices play a key role in identifying early concerns, supporting continuity of care for pregnant women and young children, and signposting into community and specialist services. They also contribute to prevention programmes such as NHS health checks, vaccination and immunisation, and Healthy Start uptake.[26]
- **Maternity services** in Tameside are delivered by Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT), offering early referral pathways, continuity of care, and personalised support. These services are closely aligned with early help and public health programmes, supporting prevention and family wellbeing.[27]
- The **Health Visiting Service** in Tameside delivers the universal Healthy Child Programme (0–5), including mandated developmental reviews and tailored support on infant feeding, nutrition, and parenting.[28]
- The **Family Nurse Partnership (FNP)** delivers intensive home-based support for young first-time mothers, addressing nutrition, breastfeeding, physical activity and maternal wellbeing.[29]
- The **Parent Infant Mental Health Service** (formerly Early Attachment Service) offers therapeutic support for bonding and responsive caregiving—factors closely linked to emotional eating and infant feeding practices.[30]
- **Family Hubs**, developed through the national *Start for Life* programme, act as accessible spaces for integrated local services, including infant nutrition and broader parenting support.[31]
- The **Healthy Child Programme** (0–19) aligns universal and targeted services to ensure early identification and support around weight and development.[32]

4.3 Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) Contribution

Tameside's VCFSE's are integral partners in promoting healthy weight from the early years. Organisations such as Home-Start HOST provide accessible, community-based parenting and lifestyle support, coaching, and wellbeing advice (Action Together, 2024) .The VCFSE also helps deliver the Tameside Good Food Plan, which works to improve the local food environment and address access to healthy food, food poverty, improve the local food offer amongst other objectives, core components of early years nutrition.[33] [34]

4.4 Enabling Healthy Environments and Supportive Communities

- **Tameside Good Food Plan** work s in partnership with public, private and voluntary sectors and communities in Tameside to create a food environment, system and culture that promotes health, stimulates the local economy, benefits communities and reduces environmental impact.[35]
- The **Active Travel Strategy** promotes walking and cycling, including for prams and buggies, improving physical activity and access to green space.[36]
- The **Poverty Strategy** and local food partnerships work to reduce food insecurity and promote uptake of Healthy Start vouchers.[37] [38]
- The **Children and Young People Plan 2023–26** sets out local priorities for improving outcomes from the early years onwards, including school readiness, nutrition, and reducing health inequalities.[39]

- The **GM Perinatal Mental Health Pathway** addresses the links between maternal mental health, self-care and nutrition.[40]

4.5 Service-Based Interventions and Community Programmes

A range of clinical and community-based services contribute directly to healthy weight in the early years:

- The **Children's Nutrition Team and Dietetics Service** offer specialist support and delivers JUMPS 4 Life, a 10-week healthy weight programme for families.[41]
- The **Infant Feeding Team** supports breastfeeding and responsive feeding across maternity, health visiting and community services.[42]
- **Home-Start HOST** delivers a Breastfeeding Peer Support Service, providing community-based peer supporters who work in Family Hubs and other early years settings.[43]
- **Be Well Tameside** offers healthy lifestyle support such as healthy eating and weight management support, to people who live, work or have a GP or volunteer in Tameside.[44]
- **Cook4Life**, delivered by the Children's Nutrition Team (CNT), offers practical cooking sessions over several weeks in schools or community venues with children and their families, to encourage healthy meal changes.[45]
- The **NHS Healthy Start scheme** provides support to eligible families — those who are more than 10 weeks pregnant or have a child under four and who meet qualifying benefits or income thresholds. Support is provided through a pre-paid card that can be used to purchase fruit, vegetables, pulses, milk, infant formula, and vitamins.[46]

5. National Evidence Review: The Factors Influencing Maternal and Early Years Healthy Weight

This section provides a rapid review of pertinent literature, intended to set the scene for Tameside early years and maternal healthy weight needs assessment. It is not a full systematic academic review but instead presents a structured summary of relevant literature to set the context and frame the assessment. It covers topics including preconception health, maternal behaviours, infant feeding practices, impact of lifestyle factors, mental health and wellbeing, and the wider social determinants of health.

5.1 The Importance of Maternal and Early Years Healthy Weight

Achieving a healthy weight during the maternal and early years is a vital public health priority. This life stage lays the foundation for lifelong physical and mental wellbeing, with clear links between maternal nutrition, infant growth, and later health outcomes. Despite this, public and policy focus has historically centered on obesity in older children and adults, with less attention given to the early years in both research and practice.[47]

5.2 Preconception Health

Maternal health before conception plays a vital role in pregnancy outcomes and a child's long-term risk of unhealthy weight. A high maternal BMI is linked to greater risk of gestational diabetes, pre-eclampsia, and macrosomia, while being underweight increases the risk of foetal growth restriction and low birth weight.[48] Weight gain between pregnancies is also associated with increased risk of overweight in children by age 4–5.[49]

Despite this, the preconception period remains an underused window for intervention. Evidence shows that nutritional counselling, physical activity support, and folic acid supplementation before pregnancy can reduce adverse outcomes and promote healthy infant growth.[50]

Disparities in preconception health reflect wider inequalities. Women from deprived backgrounds are less likely to plan pregnancies and more likely to enter pregnancy with obesity or nutrient deficiencies.[51] Addressing these gaps through targeted public health messaging, school programmes, and community outreach could help shape healthier weight trajectories from the earliest stage of life.

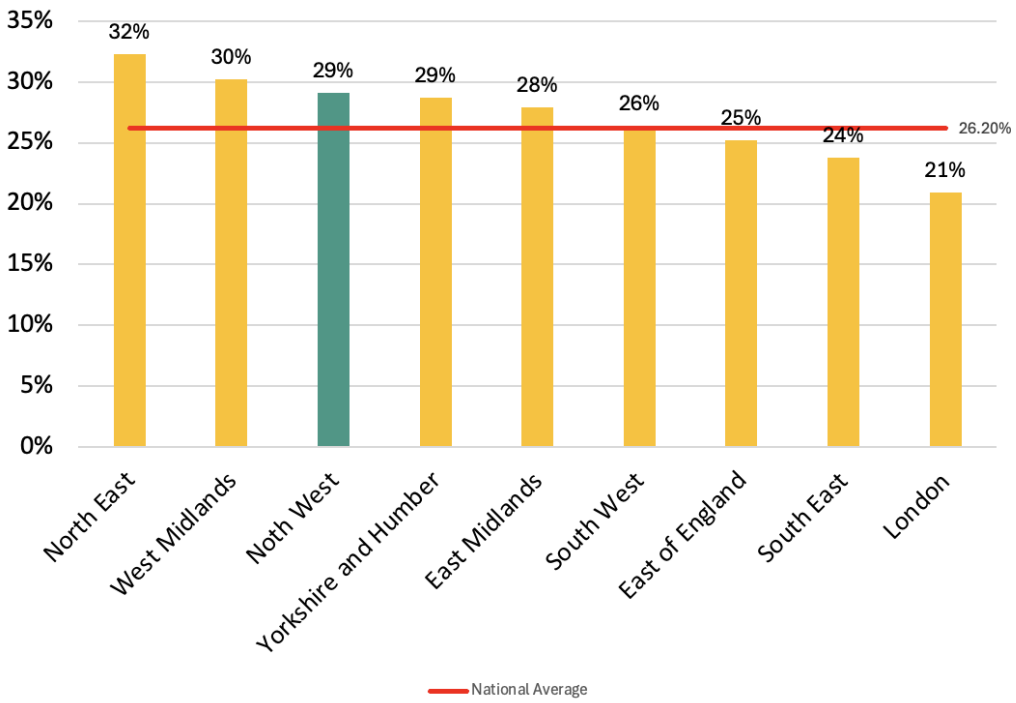
5.3 Weight During Pregnancy

Maternal weight at the first antenatal appointment is a critical indicator of risk. According to national data, 27.4% of women were classified as overweight, 18.3% as obese, and 3.3% as severely obese at booking, highlighting the scale of unhealthy weight before pregnancy progresses.[52] Obesity in pregnancy increases the likelihood of gestational diabetes, hypertensive disorders, caesarean delivery, stillbirth, and macrosomia. It is also a strong predictor of childhood obesity, perpetuating intergenerational health inequalities.

More recent data from NHS England presents maternal BMI using a single threshold (BMI ≥30), without disaggregating categories of overweight or severe obesity.[53] This shift limits comparability over time and may obscure trends in higher-risk groups.

In 2023/24, 26.2% of women in England were recorded as living with obesity at booking.[54] Regional variation remains stark, ranging from 32.3% in the North East to 20.9% in London, with the North West at 29.1%. A clear deprivation gradient persists, with 32.4% of women in the most deprived areas living with obesity compared to 19.8% in the least deprived.[55]

Figure 1: Maternal obesity at antenatal booking by region, 2023/24



While underweight in pregnancy is less common (affecting 4–6% of women), it carries significant risks, including foetal growth restriction, preterm birth and low birth weight.[56] [57] [58] Risk factors include maternal youth, food insecurity, and recent migration. Although less studied, maternal underweight also has important long-term implications for maternal and infant health.

5.4 Weight During the Early Years

At birth, national reporting primarily focuses on low birthweight (under 2,500g). In 2023/24, 7.0% of babies were born with low birthweight, and 1.0% were classified as very low birthweight (under 1,500g).[59] Although high birthweight (macrosomia, typically >4,000g or >4,500g) is a known risk factor for childhood obesity, it is not routinely reported in headline national statistics, despite being recorded in maternity datasets.

National data on infant weight in the first year of life is limited. However, evidence suggests that the trajectory toward overweight can begin in infancy and is often well established by early childhood. According to the National Child Measurement Programme (NCMP) in 2023/24,[60] 9.6% of Reception-aged children (4–5 years) were obese, with a further 12.3% overweight. By Year 6 (ages 10–11), obesity prevalence rose to 22.1%, with an additional 14.3% overweight.[61]

Alongside these findings, a small minority of children are recorded as underweight. Although underweight prevalence is low in absolute terms (around 1–2%), the NCMP shows a deprivation gradient: in 2023/24, 2.0% of Year 6 children in the most deprived areas were underweight compared with 1.2% in the least deprived, and in Reception the figures were 1.5% and 0.9% respectively. There is also a pronounced deprivation gradient for obesity: children living in the most deprived areas were around twice as likely to be obese as those in the least deprived.[62] Taken together, these patterns underline the need to focus on healthy growth and development across the full weight spectrum while addressing the inequalities that drive both extremes of unhealthy weight.

5.5 Demographic Factors Affecting Maternal and Early Years Weight

Maternal and early years weight is influenced by a complex mix of demographic factors, including age, ethnicity, deprivation, and geography. These factors shape nutrition, health behaviours, access to services, and exposure to structural inequalities throughout the life course. Understanding these influences is essential for designing equitable, targeted interventions.

5.5.1 Maternal age

Maternal age has shifted significantly over the past two decades, with a rise in older mothers and a decline in teenage pregnancies. The average age at first birth in England has increased from 23 in 1970 to 30.9 by 2023.[63] [64]

Age strongly influences nutritional status and pregnancy outcomes. Women aged 35 and over are more likely to enter pregnancy overweight or obese, with elevated risks of gestational complications.[65] In contrast, teenage mothers face greater risks of underweight and poor nutrition, increasing the likelihood of low birth weight and developmental concerns.[66] They are also less likely to access early and consistent antenatal care, which may delay crucial dietary and lifestyle support.

Encouragingly, the under-18 conception rate in England more than halved between 2011 and 2021, falling from 30.9 to 13.2 per 1,000 girls aged 15–17.[67] This sustained decline has been linked to national initiatives such as the Teenage Pregnancy Strategy, along with rising educational attainment and shifting aspirations among young women.[68]

Both younger and older mothers face distinct challenges. Older women may benefit from preconception weight support and management of comorbidities, while younger mothers often require more holistic models of care—integrating support for housing, education, parenting, mental health, and nutrition.[69]

5.5.2 Ethnicity

Ethnic background plays a significant role in shaping maternal and early years health outcomes. In the UK, women from Black African and Black Caribbean backgrounds are more likely to enter pregnancy with obesity, and their children have higher rates of overweight and obesity compared to national averages.[70] [71] These disparities are not purely biological, but shaped by cultural norms, dietary practices, lifestyle factors, and socioeconomic conditions.

While the emphasis is often on excess weight, low birth weight is also more common in some ethnic groups. Babies born to South Asian mothers—particularly Indian, Pakistani, and Bangladeshi—have consistently lower average birth weights. One large UK study found these infants were typically 280–350 grams lighter than White British babies, and over twice as likely to be classified as low birthweight.[72] In 2019, 9.3% of babies born to Asian mothers were of low birth weight, compared to 6.1% among White mothers.[73]

Many ethnic minority families also experience multiple structural disadvantages. Higher rates of deprivation, overcrowded housing, and limited access to green space or healthy food all affect weight-related behaviours.[74] Practical barriers—including language, transport, and lack of cultural sensitivity—can further reduce engagement with maternity and early years services. Where health advice does not reflect cultural or dietary traditions, it may cause confusion or disengagement.[75]

These findings highlight the need for services to be both culturally responsive and equity focused. Co-designed approaches with communities, combined with action on structural inequalities, are essential for reducing health disparities in maternal and child weight.

5.5.3 Socioeconomic deprivation

Children growing up in the most deprived areas of the UK are twice as likely to be obese as those in the least deprived.[76] These stark inequalities reflect a complex interplay of structural, behavioural, and environmental factors that disproportionately affect families facing poverty.

Food Environment and Diet: Access to affordable, nutritious food is a persistent challenge in many low-income areas. So-called “food deserts” limit availability of healthy options, while the same communities often have high densities of fast-food outlets and aggressive marketing of energy-dense, nutrient-poor products.[77] [78] This reinforces unhealthy

dietary patterns from early life. The Food Foundation found that healthier foods are more than twice as expensive per calorie than less healthy foods and less available and the most deprived fifth of the population would need to spend 45% of their disposable income on food to afford the government-recommended healthy diet - rising to 70% for households with children. There is a strong income gradient to the underconsumption of healthy foods. Recent UK data highlights marked dietary inequalities: households in the most deprived income quintile show significantly lower fruit and vegetable consumption compared to those in the least deprived.[79]

Physical Activity and Neighbourhood Infrastructure: Opportunities for physical activity are often constrained. Deprived areas may lack safe green space, affordable leisure provision, or walkable environments.[80] These limitations are compounded by financial stress, housing instability, and social isolation, all of which impact weight regulation through disrupted sleep, appetite, and cortisol levels.[81] [82]

Maternal Health and Living Conditions: Women in deprived communities are more likely to smoke during pregnancy, less likely to breastfeed, and more likely to have poor diet and low physical activity.[83] [84] Insecure housing can further disrupt mealtimes, limit access to kitchen facilities, and increase parenting stress, making consistent feeding routines harder to sustain.[85]

Birth Outcomes: The impact of deprivation begins before birth. In 2022, 9.2% of babies born in the most deprived areas of England had low birth weight (under 2,500g), compared with 5.6% in the least deprived areas. Very low birth weight (under 1,500g) was also more common: 1.3% vs. 0.8%.[86] [87]

Food Insecurity and Family Stress: Food insecurity contributes to both undernutrition and obesity in young children, often manifesting as “hidden hunger”—where energy-dense but nutrient-poor foods are consumed in place of balanced meals.[88] Unstable employment, including shift work and zero-hour contracts, further disrupts feeding and activity routines.

5.6 Maternal Mental Health and Emotional Wellbeing

Maternal mental health is a critical but often overlooked factor in shaping early childhood development and healthy weight outcomes. Depression, anxiety, and chronic stress before and during pregnancy have been linked to excessive gestational weight gain, increased smoking, reduced physical activity, and poor diet.[89] [90] These behaviours affect both maternal wellbeing and infant health trajectories.

Poor mental health during pregnancy can disrupt appetite, sleep, and antenatal care engagement, impacting maternal weight and foetal growth. Women facing high stress or mental illness may find it harder to adopt healthy behaviours, particularly in deprived communities where rates of perinatal mental illness are significantly higher.[91] In 2022, maternal suicide remained the leading cause of direct deaths between six weeks and one year after birth, with mental health contributing to 34% of maternal deaths.[92]

After birth, 10–15% of mothers experience postnatal depression, with higher rates among disadvantaged and minoritised groups.[93] This has been associated with shorter breastfeeding duration, inconsistent feeding routines, and suboptimal infant nutrition—all of which can contribute to excess weight gain.[94] In some cases, stress or maternal illness may instead lead to faltering growth or underweight.

Children growing up in the context of maternal mental ill-health may experience less responsive caregiving and more dysregulated feeding—factors that can contribute to either underweight or overweight outcomes depending on the broader environment.

Despite rising need, access to support remains uneven. While over 57,000 women accessed specialist perinatal mental health services in 2023–24, a 33% increase from the previous year. Uptake is lower in

areas of greatest deprivation.[95] Given the close links between mental health, nutrition, and development, integrated support across maternity, health visiting, and early years services is essential. Routine screening, alongside healthy weight advice and family support, could offer a more holistic and effective response.

5.7 Lifestyle and Behavioural Influences

Maternal lifestyle before and during pregnancy plays a critical role in shaping a child's weight trajectory. Poor diet, smoking, inactivity, and high stress can contribute to low or high birth weight and increase the risk of obesity or undernutrition later in life. These behaviours often continue postnatally, influencing feeding, physical activity, and sleep routines.[96] [97] These behaviours are not simply a matter of choice, they are influenced by socioeconomic, cultural, and environmental conditions.

5.7.1 Diet and nutrition

A balanced, nutrient-rich diet supports healthy maternal weight gain and foetal development.[98] In contrast, processed and high-sugar diets are more common in low-income households, where affordability and access limit healthier choices.[99] Micronutrient deficiencies—especially folic acid, iron, and vitamin D—remain widespread, particularly among younger and ethnic minority mothers.[100]

5.7.2 Breastfeeding

Breastfeeding supports healthy infant appetite regulation and reduces obesity risk.[101] Yet uptake remains lowest in deprived areas, due to limited support, stigma, and inflexible work conditions.[102]

5.7.3 Formula feeding and early weaning

Without adequate guidance, formula feeding can lead to overfeeding and rapid weight gain.[103] Early weaning (before six months) is also associated with increased risk of obesity in infancy.[104]

5.7.4 Smoking

Smoking during pregnancy is linked to intrauterine growth restriction and low birth weight,[105] and may increase later obesity risk through disrupted foetal programming.[106]

5.7.5 Substance misuse

Alcohol and drug use in pregnancy increase risks of growth restriction, feeding difficulties, and impaired bonding.[107] FASD and other developmental disorders are associated with prenatal exposure.[108] Substance misuse often coexists with mental health challenges and social disadvantage.

5.7.6 Physical activity

Activity during pregnancy supports healthy weight gain and reduces risks of gestational diabetes.[109] Postnatal activity also aids recovery, but uptake is often hindered by fatigue, time pressures, low confidence, and childcare barriers.[110]

5.7.7 Sleep and weight regulation

Sleep deprivation in pregnancy and postpartum is linked to weight gain, poor diet, and gestational diabetes.[111] Poor sleep also disrupts infant feeding and routines, affecting early growth.[112]

5.8 Fathers and the Family Environment

While most evidence focuses on mothers, there is growing recognition of the role of fathers/co-parents and the wider family environment in shaping early weight outcomes. Paternal diet, physical activity, caregiving involvement, and emotional wellbeing all influence household routines and child feeding practices.

Paternal obesity has been shown to independently increase the risk of childhood obesity, while supportive co-parenting can buffer the effects of maternal stress on family health behaviours.[113] [114]

Promoting healthy weight in the early years requires a whole-family approach—one that actively engages fathers/co-parents and extended caregivers in nutrition, activity, and caregiving interventions.

5.9 Early Years Lifestyle (Birth to Age 4)

From birth to age four, nutrition, movement, sleep, and caregiving shape a child's growth trajectory, determining whether they maintain a healthy weight, become underweight, or develop early signs of obesity.

5.9.1 Nutrition in infancy and toddlerhood

Rapid weight gain in the first year is a recognised risk factor for later obesity, particularly when linked to early formula use or weaning before six months.[115] [116] Early introduction of solids can disrupt appetite regulation, while delayed or inadequate weaning can cause nutrient deficiencies and underweight. Iron and vitamin D deficiencies in this period are associated with poor cognitive development and the re-emergence of rickets in the UK.[117] [118]

5.9.2 Feeding environment and caregiver responsiveness

How children are fed matters as much as what they are fed. Responsive feeding—recognising and responding to hunger and satiety cues—supports healthy self-regulation. In contrast, coercive practices such as pressuring or restricting food can lead to disordered eating and poor weight outcomes.[119] Parental stress and low health literacy may also increase reliance on convenience or less balanced diets.

5.9.3 Physical activity and sedentary behaviour

Regular movement is essential for growth and development. WHO recommends children aged 1–5 engage in at least 180 minutes of activity daily, yet many fall short—especially those in disadvantaged areas with limited access to safe, stimulating environments.[120] High screen time and sedentary routines have been linked to obesity and delayed motor skills.[121]

5.9.4 Sleep and weight regulation

Short or poor-quality sleep is associated with higher BMI in early childhood, due to hormonal impacts on appetite and disruption to daily routines.[122] Sleep quality is influenced by parenting practices, household conditions, and stress.

5.9.5 Inequalities and growth outcomes

Children in low-income families are more likely to face obesogenic environments—characterised by poor food access, limited support for breastfeeding, and fewer opportunities for active play.[123] Yet food insecurity can also lead to underweight or stunted growth when essential nutrients are lacking. These dual risks highlight the complex, bidirectional links between poverty, nutrition, and early development.

5.10 Commercial and Digital Influences

The broader commercial landscape, including the marketing of formula, ultra-processed foods, and digital content—significantly shapes parental choices and early life behaviours.

5.10.1 Formula and food marketing

Aggressive marketing of infant formula can undermine breastfeeding by promoting it as more modern, convenient, or superior, even in contexts where breastfeeding is medically advised. Similarly, widespread advertising of high-calorie snacks, sugary drinks, and ultra-processed foods disproportionately targets lower-income households, where healthier alternatives may be less affordable or accessible.[124]

5.10.2 Digital media and early behaviours

Screen exposure among infants and young children is increasingly common and linked to a range of weight outcomes, both overweight and underweight, depending on other factors like diet, activity, and sleep.[125] Excessive screen time may displace physical movement, disrupt

appetite regulation, and reduce caregiver interaction during feeding and play.

5.11 Gaps in Data and Surveillance

Despite growing attention on childhood obesity, there are still major gaps in how weight is monitored from birth to age four. National surveillance does not begin until school entry, leaving a critical window where underweight and overweight can emerge undetected.[126]

While the NCMP provides robust data at ages 4–5 and 10–11, no equivalent system exists for younger children.[127] This limits the ability to identify early signs of rapid weight gain or poor growth—both of which are known predictors of later obesity or developmental risk.[128] [129]

Without routine data in the first 1,000 days, opportunities for early intervention are lost. Public health teams are left to plan without a full picture, making it harder to design proportionate, targeted support. Expanding early surveillance is essential to promoting healthy growth and reducing inequalities from the earliest stage of life.

5.12 Access to Services and Continuity of Care

Reliable access to antenatal, postnatal, and early years services is a key protective factor for healthy maternal and child weight. Timely guidance on nutrition, feeding, and growth monitoring is most effective when delivered early, consistently, and through trusted professionals. Yet access remains uneven across geographic, ethnic, and socioeconomic lines.[130]

5.12.1 Disparities in access and uptake

Service availability and uptake vary widely. Black African women in the UK are over three times more likely to access antenatal care later than White British women, reducing opportunities for early intervention on diet, smoking, and weight.[131] In deprived areas, stretched services and fragmented pathways further limit consistent support.[132]

5.12.2 The role of continuity

Continuity of care, particularly through midwives and health visitors—improves outcomes. A Cochrane review found midwife-led continuity models improve satisfaction, reduce preterm births, and support better birth outcomes.[133] However, implementing these models is more challenging in areas with complex social needs and diverse populations.[134]

5.12.3 Health Visiting and Integrated Care

Underinvestment in health visiting has weakened the early years offer. Despite policy emphasis on integrated midwifery and health visiting pathways, inconsistent practice and communication gaps continue to affect care quality.[135]

5.13 Conclusion

This rapid evidence review highlights the complexity and significance of achieving a healthy weight in the maternal and early years. Weight outcomes in this critical life stage are shaped by a web of interrelated biological, behavioural, and structural influences, with clear links to deprivation, mental health, service access, and family environments. Both overweight and underweight in mothers and young children present serious public health concerns yet are often under-recognised in strategy and service delivery. The evidence supports a life-course and whole-system approach that begins before conception and extends through infancy and the early years. These insights provide essential context for understanding local needs and planning responsive, equitable, and preventative interventions in Tameside.

6. Local Data and Intelligence

6.1 Demographic Trends among Women of Childbearing Age in Tameside

Understanding the demographic composition of women in Tameside is essential for planning maternity, early years, and women's health services. Drawing on the 2021 Census, this section outlines key age and ethnic trends relevant to maternal and early years healthy weight.

6.1.1 Age profile and change over-time

In 2021, there were 61,858 women aged 16–54 in Tameside.[136] The age distribution was relatively even across five-year bands, with around 13.5% in each of the 20–34 age bands, the age groups most associated with childbearing.

Figure 2: Age profile of women in Tameside (2021)

Age Band	Female Population	% of Female Pop. (aged 16–54)
16–19	4947	8.1%
20–24	8266	13.5%
25–29	8298	13.6%
30–34	8299	13.6%
35–39	7741	12.7%
40–44	7742	12.7%
45–49	7783	12.8%
50–54	7782	12.8%

Source: Office for National Statistics (ONS) (2023) Census 2021

Between 2011 and 2021, the number of women aged 16–54 increased by 6.5% in Tameside, outpacing the national increase of 3.8%. The most notable trends were a decline in younger women (16–24) -4.9% (16–19) and -2.8% (20–24), likely due to declining birth cohorts and outward migration, and growth in women aged 35–54 (+6.0% to +14.4%), exceeding national averages and suggesting a shift towards an older reproductive-age population.[137]

Figure 3: Percent change in female population by age band (2011-2021)

Age Band	Tameside % Change	England % Change
16–19	-4.9%	-3.3%
20–24	-2.8%	-3.1%
25–29	+2.4%	+2.9%
30–34	+3.7%	+6.3%
35–39	+6.0%	+6.7%
40–44	+7.5%	+7.1%
45–49	+11.2%	+7.7%
50–54	+14.4%	+8.3%

Source: Data derived from the 2011 and 2021 Census datasets provided by the Office for National Statistics (ONS).

The Office for National Statistics defines women of reproductive age as 15–44 years. In 2021, Tameside had approximately 47,000 women in this group, accounting for around one-fifth of the total population.[138] Fertility in Tameside is slightly above the national average. The General Fertility Rate (GFR) in 2022 was 55.6 live births per 1,000 women aged 15–44, compared with 51.9 for England overall.[139] This data indicates that while the reproductive-age population in Tameside is ageing, fertility remains relatively high, reinforcing the importance of maternity, early years, and family support services.

6.1.2 Ethnic Composition of Women Aged Under 65

The majority (86%) of women under 65 in Tameside identified as White, though this masks increasing diversity among younger women:

- South Asian women (9.2%) are particularly concentrated in younger age bands.
- 6.2% of women under 25 identified as Pakistani.
- 4.2% as Bangladeshi.
- Mixed and African heritage groups also showed higher representation in younger cohorts.

These trends suggest a growing proportion of minority ethnic women of childbearing age, particularly in younger and future early years populations.[140]

Figure 4: Ethnic breakdown of Tameside female population (Selected ethnicities aged under 65 years)

Ethnic Group	% of females aged under 65 years
White	86%
└ White: English, Welsh, Scottish, NI British	82.5%
└ Other White	3.2%
Asian, Asian British or Asian Welsh	9.2%
└ Pakistani	3.8%
└ Bangladeshi	2.6%
└ Indian	1.7%
Black, Black British, Black Welsh, Caribbean or African	2.2%
└ African	1.8%
Mixed/Multiple Ethnic Groups	2.1%
Other ethnic group	0.7%

Figure 5: Ethnic Make-up of Tameside female population (Selected ethnicities by age band)

Ethnic Group	Aged under 65 years	Aged under 25 years	Aged 25 to 34 years	Aged 35 to 49 years	Aged 50 to 64 years
White	85.8%	78.4%	83.6%	82.5%	91.8%
└ White: English, Welsh, Scottish, NI British	82.5%	76.1%	78.7%	77.8%	89.3%
└ Other White	3.2%	2.3%	4.9%	4.7%	2.4%
Asian, Asian British or Asian Welsh	9.2%	12.8%	10.4%	5.4%	5.4%
└ Pakistani	3.8%	6.2%	4.3%	4.7%	1.8%
└ Bangladeshi	2.6%	4.2%	3.1%	3.3%	0.7%
└ Indian	1.7%	1.1%	1.7%	2.2%	1.8%
Black, Black British, Black Welsh, Caribbean or African	2.2%	3.2%	2.5%	3.1%	3.0%
└ African	1.8%	2.6%	2.2%	2.7%	1.0%
Mixed/Multiple Ethnic Groups	2.1%	4.6%	2.4%	1.3%	1.7%
Other ethnic group	0.7%	0.9%	0.9%	0.5%	0.9%

Source: ONS (2023) Ethnic group by sex by age – Census 2021, RM032 Dataset. Available at: https://www.nomisweb.co.uk (Accessed: 13 May 2025).

6.1.3 Implications for healthy weight in maternal and early years

The changing demographic profile has several implications:

- Older maternal age is associated with increased risks such as obesity, gestational diabetes, and pregnancy complications.[141]
- South Asian communities are at higher risk of adverse maternal and child weight outcomes, reinforcing the need for culturally adapted, community-informed services.[142]
- Health messaging must be inclusive, considering language, dietary patterns, and extended family roles.[143]
- Young mothers, while declining in number, remain a priority due to higher risks of poor nutrition and disengagement from services.[144]
- Early years services must reflect the growing ethnic diversity among children and families, ensuring culturally competent delivery of feeding, nutrition, and physical activity support.[145]

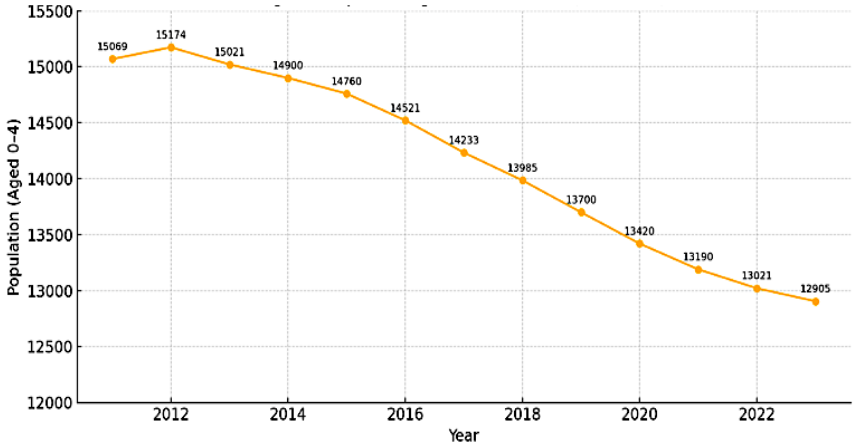
6.2 Demographic Trends among Early Years Population in Tameside

Over the last decade, Tameside has seen a sustained decline in live births alongside a clear shift towards older maternal age. These patterns mirror national trends and reflect wider socioeconomic and demographic change, with direct implications for maternity and early years services.

6.2.1 Decline in the 0–4 population in Tameside

The number of children aged 0–4 in Tameside fell from 15,174 in 2012 to 12,905 by 2023. This represents a decline of 2,269 children or approximately 15%.[146]

Figure 6: Tameside population aged 0-4 years (2011-2023)



for National Statistics (ONS) (2024) Population Estimates by Single Year of Age and Sex, Mid-2011 to Mid-2023. Available at: https://www.nomisweb.co.uk (Accessed: 13 May 2025).

6.2.2 Decline in live births

Between 2014 and 2023, live births in Tameside fell from 3,441 to 2,747 (–20%). Births to Tameside residents dropped from 3,003 to 2,457 (–18%). Although numbers have levelled since 2021, national projections suggest only temporary stabilisation, with overall declines likely to continue.[147] The trend points to a shrinking base of young families in the borough.

Figure 7: All live births in Tameside (2014-2024)

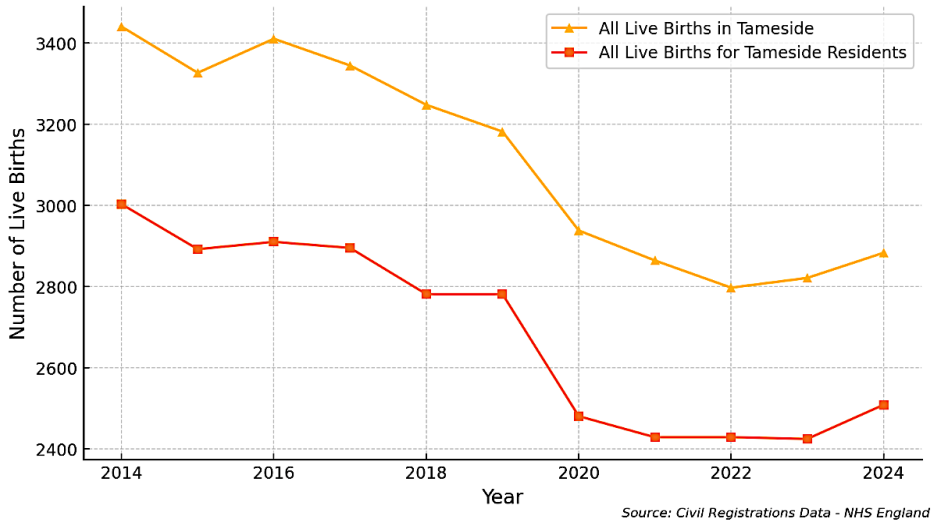
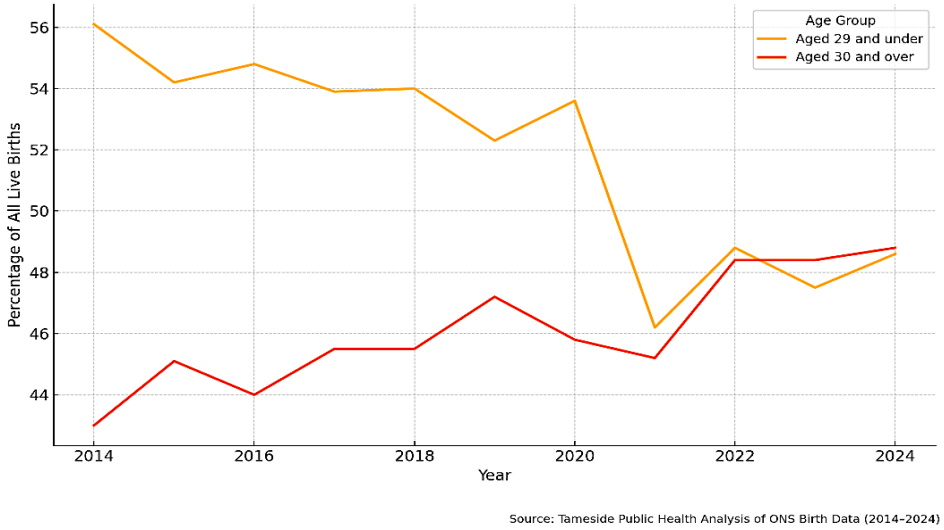


Figure 8: Percent of all live birth in Tameside by mothers age group



6.2.3 Rising maternal age

The age profile of mothers in Tameside has shifted markedly over the past decade. Births to younger women have declined: in 2014, mothers aged 20–24 accounted for 624 births (20.8%) and those aged 16–19 for 137 (4.6%). By 2023, these had fallen to 445 (13.5%) and 63 (3.3%). Births to under-16s remain rare, at only one or two per year.

In contrast, older age groups now represent a growing share of births. Mothers aged 30–34 rose from 28.0% of all births in 2013 to 34% in 2023, while those aged 35–39 increased from 12.9% to 17.2%. Births to women aged 40–44 remained stable (63 in 2014; 79 in 2023), with a small but consistent number to women aged 45+ (between two and nine annually).[148]

6.2.4 Implications of falling births and rising maternal age

The decline in live births and the 0–4 population indicates a gradual contraction of the early years cohort in Tameside, with knock-on effects for service demand, school places and community provision. At the same time, the shift towards older motherhood increases risks of maternal overweight, gestational complications and childhood obesity.[149] [150] These trends highlight the need to sustain universal early years provision for a smaller child population while strengthening preconception and pregnancy support for women at higher metabolic risk.

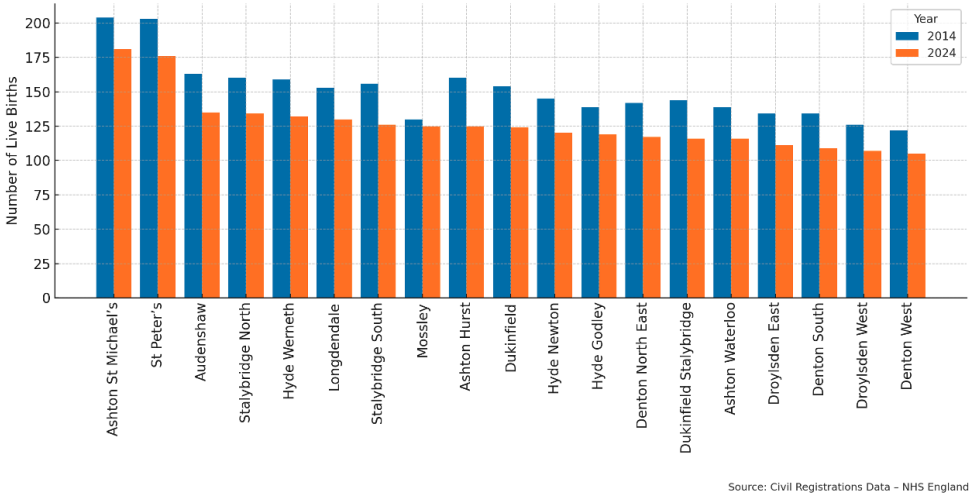
6.3 Geographic Variations in Births: Ward and IMD Trends (2014–2024)

Birth data over the last decade highlights clear geographic patterns in Tameside, with consistent differences between wards and strong links to deprivation.

6.3.1 Births by ward

Birth volumes vary widely across Tameside's 19 wards. In 2014, areas such as Ashton St Michael's (204 births) and St Peter's recorded substantially higher numbers than other wards. A comparison of 2014 and 2024 shows that although overall births have declined, wards with historically high birth volumes continue to do so. This stability in spatial distribution has implications for the siting of early years services.[151]

Figure 9: Comparison of live births by ward in Tameside (2014-2024)

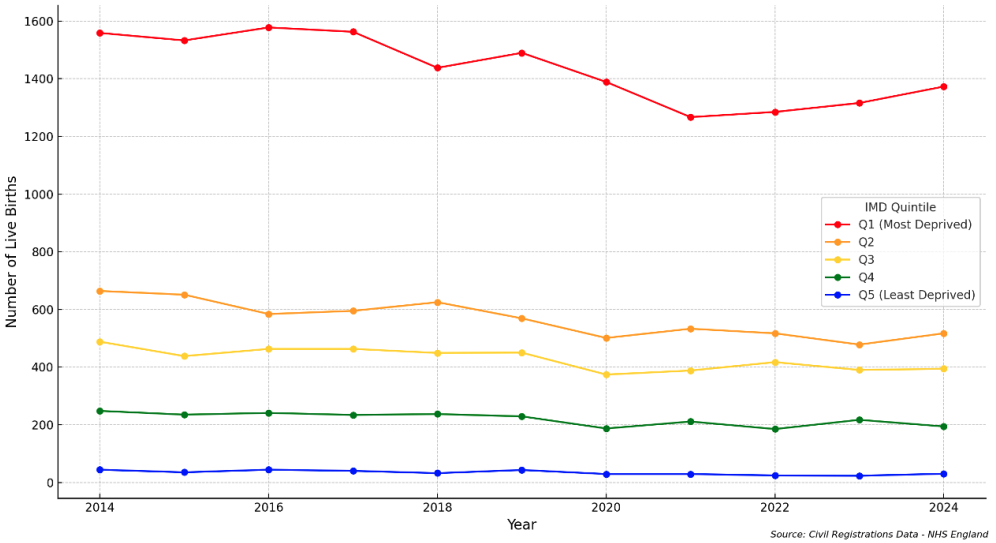


Source: Civil Registrations Data – NHS England

6.3.2 Births by IMD quintile

Deprivation is strongly associated with where births occur. In 2024, Tameside's most deprived areas (IMD Decile 1) recorded 709 births, compared with just 15 in the least deprived (Decile 10), a 46:1 ratio.[152] [153]Across 2014–2024, the most deprived 40% of neighbourhoods (Quintiles 1 and 2) consistently accounted for 70–75% of all births. This reflects a sustained concentration of births in areas of socioeconomic disadvantage.

Figure 10: Tameside live births by IMD quintile (2014-2024)



Source: Civil Registrations Data - NHS England

6.3.3 Implications of geographic birth patterns

The concentration of births in Tameside's most deprived areas means that improving maternal and child healthy weight outcomes depends on targeted place-based action. Women in these communities face intersecting risks such as higher rates of overweight at conception, stress, and reduced access to healthy food, all of which increase the likelihood of excessive gestational weight gain and childhood obesity.[154] [155] Ward-level data provides practical intelligence for locating antenatal, parenting, and Best Start for Life programmes, while stronger integrated delivery (co-locating maternity, health visiting and early years services) is essential to address these overlapping needs.

6.4 Country of Birth: Mothers and Fathers (2014–2024)

The country of birth of parents provides insight into Tameside's changing demographics, with a gradual decline in UK-born parents and a growing share of births to non-UK-born populations.

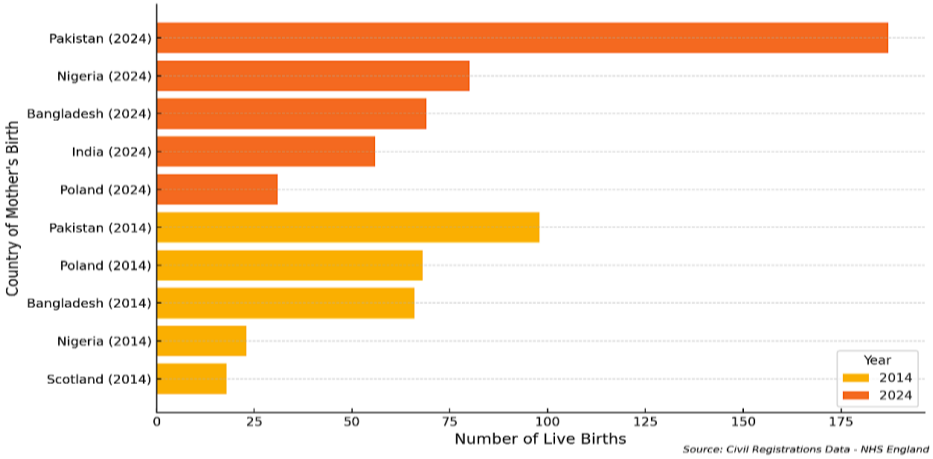
6.4.1 Decline in UK-born parents

Between 2014 and 2024, births to English-born mothers fell from 2,518 to 1,748 (–30.6%), and to English-born fathers from 2,413 to 1,655 (–31.4%). This reflects both falling birth rates and changes in the local population.[156]

6.4.2 South Asian births

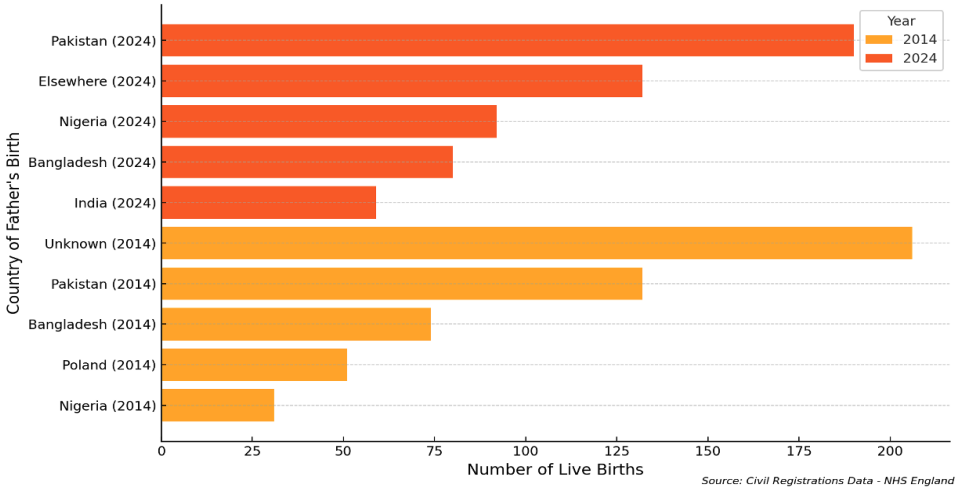
Pakistan remains the most common non-UK country of birth. Births to Pakistani-born mothers almost doubled from 101 in 2014 to 196 in 2024 (+94.1%), with fathers rising from 125 to 170 (+36.0%). This growth reflects wider demographic shifts in Tameside's South Asian community.[157]

Figure 11: Top 5 countries of mother's birth (excluding UK), Tameside (2014 vs 2024)



By 2024, India and Nigeria had joined the top five non-UK countries of birth for both mothers and fathers. Births to Indian-born mothers rose by 211% (18 to 56), while Nigerian-born mothers rose by 150% (18 to 45). Several smaller groups also saw sharp increases, including Eritrea (1 to 14), Ghana (6 to 28), Iraq (3 to 17), Sudan (2 to 10), Afghanistan (4 to 15), and Ethiopia (2 to 12), highlighting emerging diaspora communities in the borough.

Figure 12: Top 5 countries of father's birth (excluding UK), Tameside (2014 vs 2024)



6.4.3 European declines and Brexit effects

In contrast, births to EU-born parents have fallen. Polish-born mothers dropped from 101 in 2014 to 56 in 2024 (–44.6%) and Romanian-born mothers from 85 to 47 (–44.7%), reflecting wider migration shifts linked to Brexit.[158] [159]

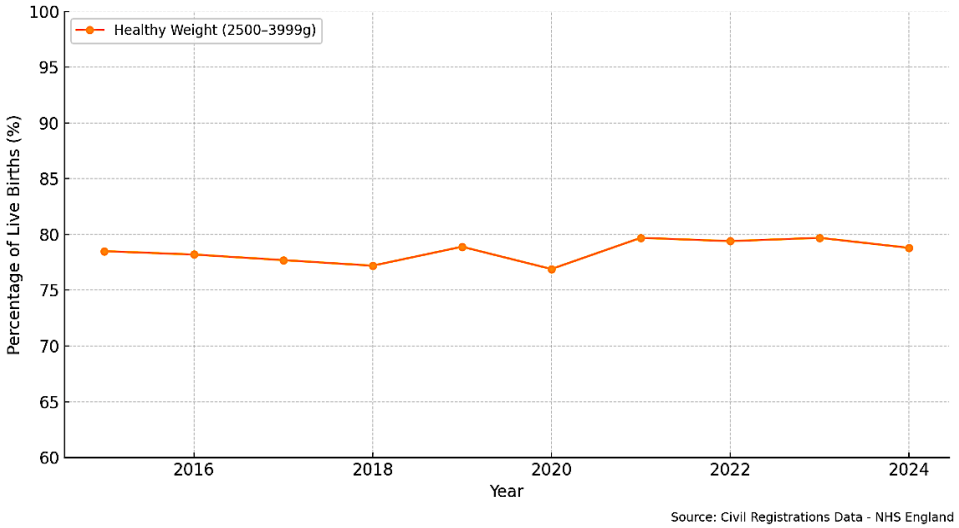
6.4.4 Implications of cultural and ethnic diversity

Tameside's increasingly diverse maternity population presents both risks and opportunities for maternal and early years healthy weight. South Asian families, particularly Pakistani and Bangladeshi, face higher risks of gestational diabetes, insulin resistance, and long-term obesity despite lower average birthweights.[160] [161] [162] [163] At the same time, rising births among African, Middle Eastern, and smaller migrant groups introduce varied health risks and cultural perceptions of infant size and diet.[164] [165] Refugee and recent migrant families often face additional barriers such as language, food insecurity, trauma, and limited engagement with UK health systems.[166] [167] With many non-UK-born families concentrated in deprived wards, place-based delivery through trusted community settings is essential. Monitoring demographic change, particularly the decline in EU-born parents and rapid growth of smaller groups such as Afghan and Eritrean families, will be critical to ensure services remain inclusive and responsive.[168] [169]

6.5 Birthweight Trends and Inequalities in Tameside (2015–2024)

Analysis of live birthweight data in Tameside between 2015 and 2024 shows borough-wide stability, but with persistent ward-level inequalities. Across the period, between 76.9% and 79.8% of live births fell within the healthy weight range (2,500–3,999g), closely reflecting national trends.[170]

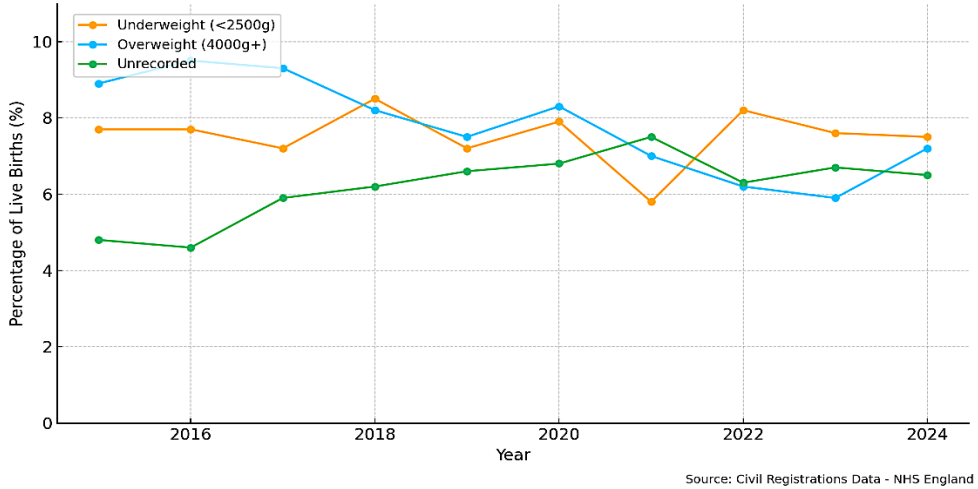
Figure 13: Percentage of live births in healthy weight range in Tameside (2015-2024)



In 2024, 7.5% of babies (189) were born with low birthweight (<2,500g), above the UK average of 6.5%.[171] The North West has the highest proportion of preterm births nationally at 8.5%, which may partly explain this persistent excess.[172] At the other end of the spectrum, higher birthweight births (≥4,000g) declined from 9.5% in 2016 to 4.9% in 2023, before increasing again to 7.2% (180 babies) in 2024. This pattern broadly mirrors national stability within the 6–8% range.[173]

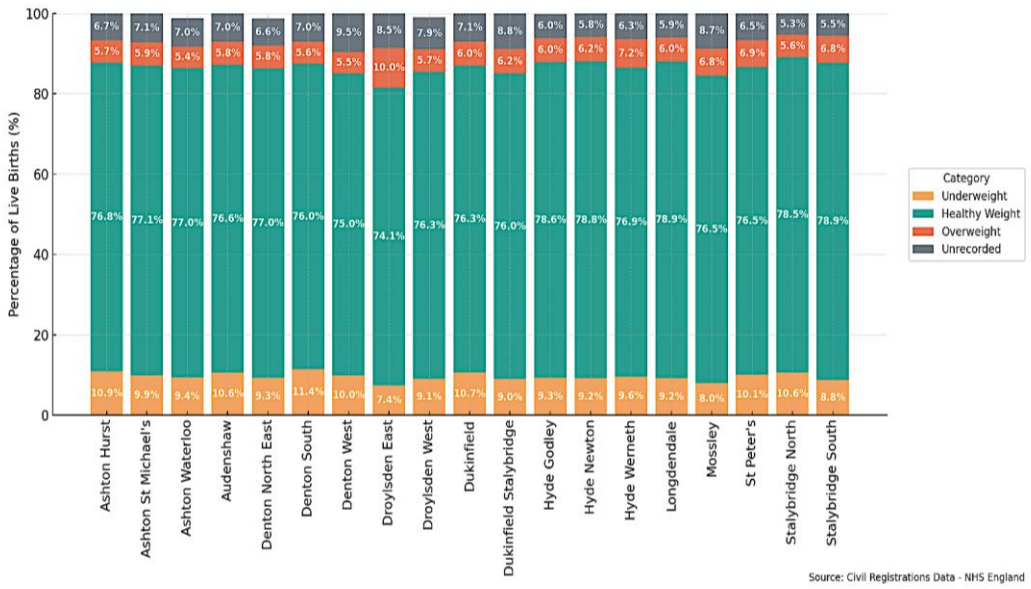
The proportion of unrecorded birthweight data rose from 4.6% in 2015 to 7.5% in 2021, before stabilising. As all babies are weighed at birth, missing data is more likely to reflect system or reporting errors rather than clinical omission. Similar challenges with NHS data completeness have been noted elsewhere, emphasising the need for consistent and robust recording to support accurate monitoring and service planning.[174]

Figure 14: Percentage of live births by child weight at birth (excluding healthy weight) Tameside



Ward-level analysis (2022–24 combined) reveals clear variation. Low birthweight exceeded 10.5% in Ashton Hurst, Dukinfield, Audenshaw, Denton South and Stalybridge North. Droylsden East and Hyde Werneth showed higher proportions of births ≥4,000g. In contrast, Longdendale, Mossley, Hyde Godley, Hyde Newton and both Stalybridge wards recorded over 78% of births within the healthy range.

Figure 15: Birthweight distribution by Tameside ward (2022-2024 combined)



6.5.1 Implications for healthy weight interventions

Tameside's birthweight profile demonstrates borough-level stability, but persistent inequalities remain:

- **Low birthweight**: At 7.5%, the borough remains above national levels, underlining long-term risks such as infant morbidity, cardiovascular conditions and type 2 diabetes.[175] [176] Ongoing focus on maternal health behaviours (nutrition, smoking, antenatal attendance) is needed.
- **Higher birthweight**: The longer-term decline in ≥4,000g births, alongside recent fluctuation, warrants continued monitoring,

particularly in the context of rising maternal BMI and gestational diabetes.[177] [178]

- **Ward variation**: Local disparities reinforce the need for place-based targeting, with higher risks of both low and high birthweight in specific wards, often aligned with deprivation profiles.[179] [180]
- **Data quality**: Gaps in recorded birthweight data limit the reliability of monitoring. Strengthening reporting processes is essential to ensure equitable and responsive service planning.[181]

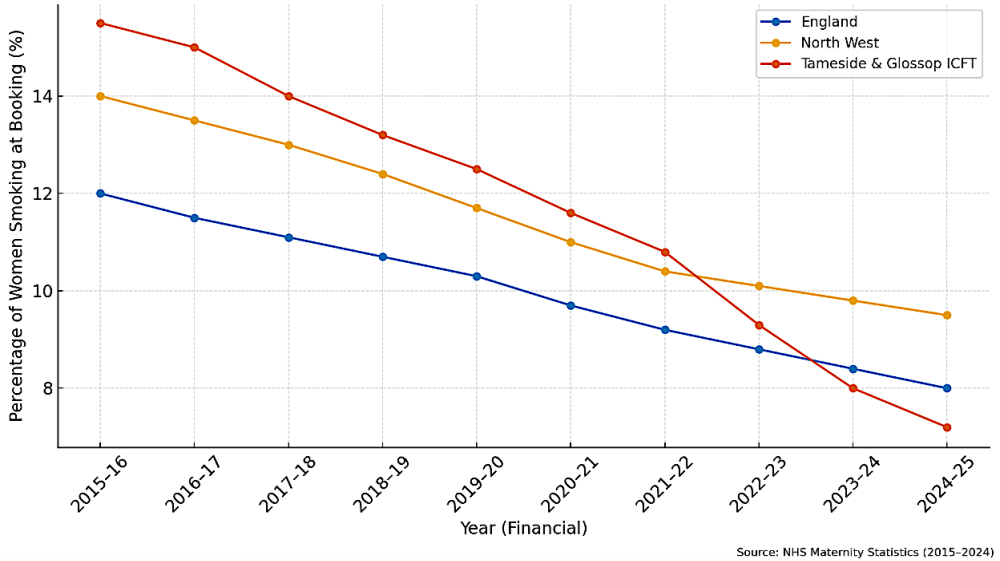
6.6 Smoking in Pregnancy: Booking to Delivery Trends (2015–2024)

Smoking during pregnancy remains a key preventable risk factor for low birthweight, premature birth, and perinatal mortality. National policy has long targeted reductions, with an ambition for rates at delivery to fall below 6%.[182] While national trends show steady improvement, Tameside has achieved particularly strong progress, especially since 2022.[183]

6.6.1 Smoking at booking

In England, the proportion of women smoking at their booking appointment fell from 12.0% in 2015/16 to 8.0% in 2023/24. The North West followed a similar trend, from 14.0% to 9.5%.[184] Tameside & Glossop ICFT outperformed both, with rates halving from 15.5% in 2015/16 to 7.2% in 2023/24. These improvements, drawn from NHS Maternity Services Data Set (MSDS) submissions, reflect both earlier identification of smokers and improved access to cessation support.[185]

Figure 16: Smoking at booking appointment. Long-term trends (2015-2024)

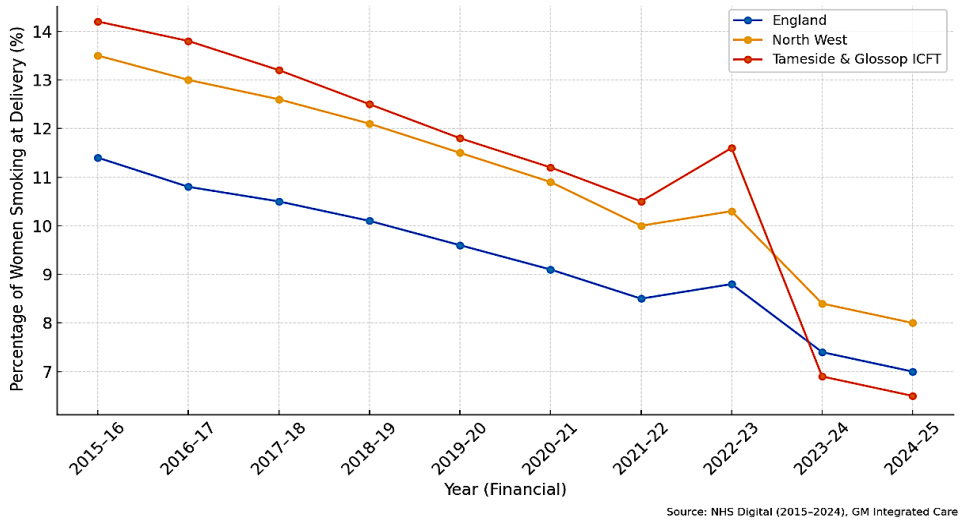


6.6.2 Smoking at delivery

Smoking at delivery also declined across all geographies. In England, rates fell from 11.4% to 7.4% between 2015/16 and 2023/24; in the North West, from 13.5% to 8.4%.[186]

Tameside achieved an even steeper fall, from 14.2% to 6.9%. The sharpest drop occurred between 2022/23 (11.6%) and 2023/24 (6.9%), the largest year-on-year improvement in Greater Manchester (GM Integrated Care, 2024).[187]

Figure 17: Smoking at time of delivery. Long-term trend (2025-2024)



This accelerated decline coincided with the full rollout of the Greater Manchester Smokefree Pregnancy programme, which includes:

- Universal CO monitoring at every antenatal appointment
- On-the-spot referrals to stop smoking advisors
- Free nicotine replacement therapy (NRT)
- An incentive scheme rewarding sustained abstinence

6.6.3 Implications for early years and maternity services

The marked decline in smoking during pregnancy in Tameside is likely to contribute directly to improved maternal and infant outcomes. Smoking remains one of the most preventable causes of low birthweight, intrauterine growth restriction, and preterm birth.[188] [189] The borough's sharp reductions at both booking and delivery stages therefore support the relatively stable birthweight profile observed over the past decade. These improvements are particularly encouraging in the context of historically elevated low birthweight in some wards, though it remains important to ensure progress is distributed evenly across all communities.

The timing and scale of change also provide useful lessons for maternity and early years services. The halving of smoking at booking since 2015/16 reflects both wider declines in smoking among women of childbearing age[190] [191] and system improvements, such as universal carbon monoxide monitoring. The dramatic fall at delivery between 2022 and 2024 suggests that structured support — including behavioural interventions, nicotine replacement therapy, and incentives — is working effectively in practice.[192] [193] The Greater Manchester Smokefree Pregnancy Programme, implemented in full during this period, has clearly been a catalyst, showing how whole-system models can accelerate change.[194] [195] However, smoking in pregnancy continues to be more prevalent among younger mothers and those from deprived backgrounds.[196] [197] Sustained equity-focused action will be critical to prevent these gains from disproportionately benefiting more advantaged groups and to reduce long-term inequalities in early childhood outcomes.

6.7 Breastfeeding Initiation and Continuation in Tameside

Breastfeeding is a critical component of early child health, influencing infant nutrition, immune development, and maternal wellbeing. National policy recommends exclusive breastfeeding for the first six months of life,[198] yet rates vary widely across localities and are strongly patterned by socioeconomic status.

6.7.1 Borough-level trends

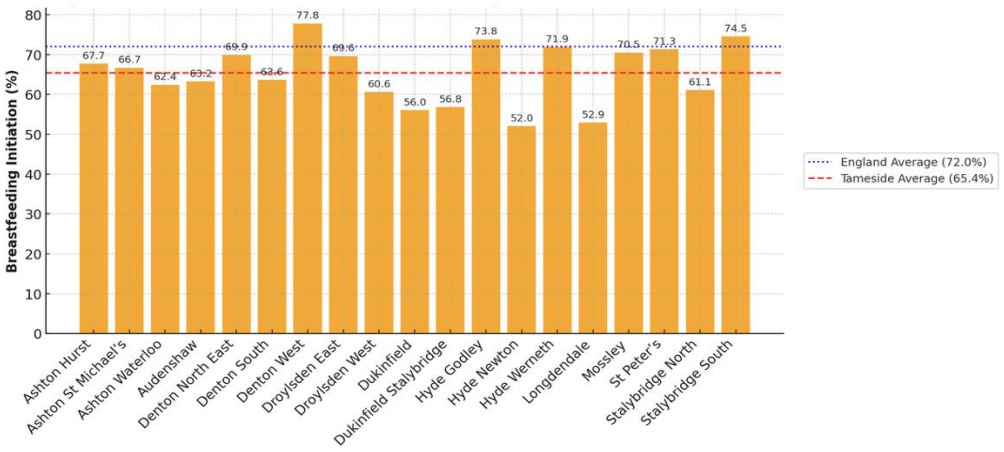
In 2023/24, 55.6% of babies born in Tameside received breast milk as their first feed, compared with 70.1% across England and 67.3% in the

North West.[199] Although below national and regional averages, this represents an improvement from 50.2% in 2022/23.

Local provider data shows higher initiation rates. Tameside & Glossop ICFT reported 66.4% in 2023/24, based on hospital discharge records.[200] The discrepancy with national figures reflects differences in data capture, timing, and completeness. National returns are collated via community services and CSDS, while local provider data often reflects more immediate hospital-based records. Concerns about comparability of this indicator have been noted nationally.[201]

Ward-level data reveal significant differences, with a gap of over 25 percentage points between the highest and lowest wards. Initiation was highest in Denton West (77.8%), Stalybridge South (74.5%) and Hyde Godley (73.8%), but lowest in Hyde Newton (52.0%), Longdendale (52.9%), and Dukinfield (56.0%).[202]

Figure 18: Breast feeding initiation rates by Tameside ward (2023/24)

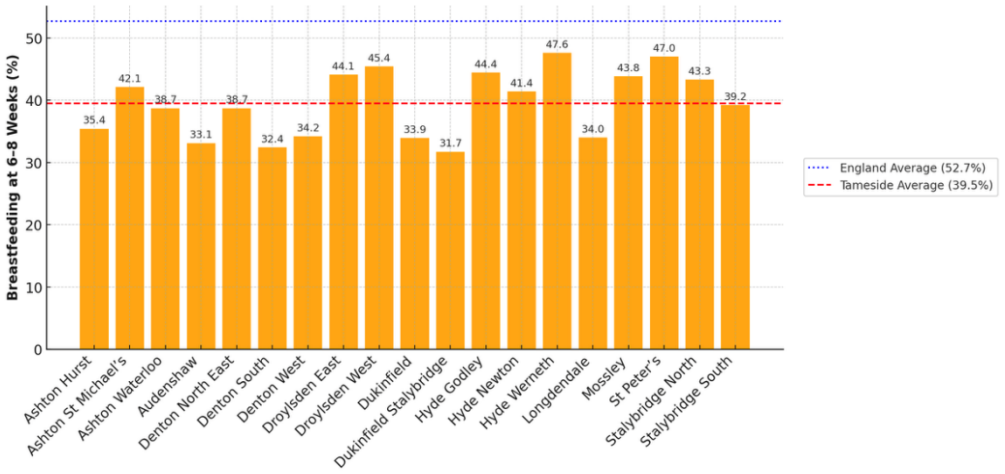


Source: Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT) (2024)

Breast feeding continuation rates (six to eight weeks), in Tameside shows a steady upward trajectory over the past five years, rising from 35.4% in 2018/19 to 45.5% in 2024/25. Over the same period, prevalence in the North West increased from 46.2% to 49.9%, and in England from 46.2% to 52.7%.[203] The gap between Tameside and the national average has therefore narrowed slightly, potentially reflecting recent investment in infant feeding support and peer programmes, however the gap between Tameside other areas remains significant at around seven percentage points.

Ten out of 19 wards fall below the borough average, highlighting intra-borough inequalities. Continuation rates range from a low of 31.7% in Dukinfield to a high of 47.6% in Hyde Werneth. These disparities underline the importance of maintaining a place-based approach and ensuring targeted investment in communities with the lowest rates. These differences broadly align with deprivation. Affluent wards such as Hyde Werneth and Hyde Godley perform above average, while more deprived wards, including Dukinfield and Denton South, report the lowest levels. Ethnic composition may also help explain these patterns. According to Census 2021, wards such as St Peter's, Ashton Hurst, and parts of Hyde (Hyde Werneth, Hyde Godley) have higher proportions of residents identifying as Asian, Asian British or a background other than White.[204] National data shows that breastfeeding initiation and continuation rates are generally higher among Black and Asian groups.[205] St Peter's therefore stands out as a ward where cultural norms, alongside local service accessibility and community support, may be influencing outcomes despite high deprivation.

Figure 19: Tameside breast feeding continuation rates at 6-8 weeks (2023/24)



Source: Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT) (2024)

6.7.2 Implications for early years healthy weight

Breastfeeding data in Tameside presents both challenges and opportunities:

- Breastfeeding provides protection against obesity, type 2 diabetes, and supports maternal health.[206] Lower local rates limit these protective benefits, reinforcing the need to prioritise support in the early weeks after birth.
- The sharp postnatal decline, from 66.4% initiation to 39.9% at 6–8 weeks — highlights gaps in postnatal support, with implications for early childhood nutrition.[207] [208]
- Patterns follow deprivation gradients, reinforcing the role of social determinants.[209] Tackling barriers in disadvantaged wards is essential to address health inequalities.[210]
- Positive outliers, such as St Peter's, offer learning opportunities for scaling protective factors.
- Data discrepancies between local and national sources constrain monitoring. Improved data quality and alignment would support better planning and equity-focused interventions.[211]

6.8 Borough-Level Trends: Healthy Weight (Obesity, Overweight, Underweight)

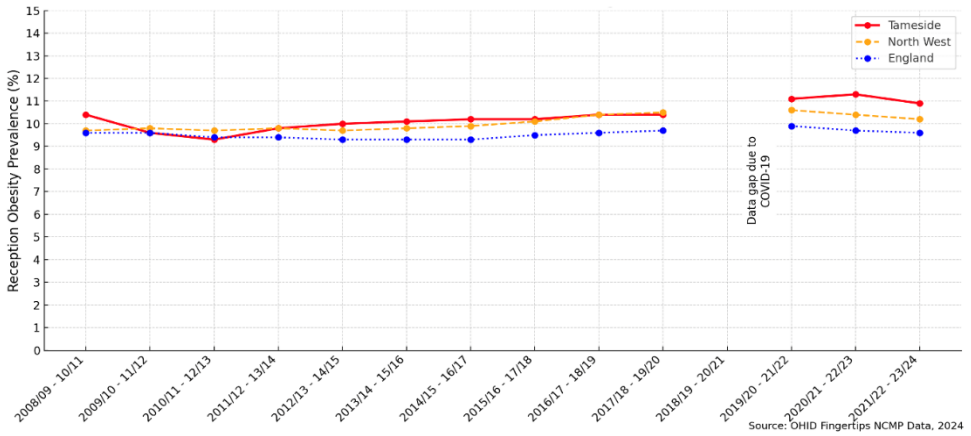
Monitoring healthy weight in the early years is hindered by inconsistent routine measurement before school entry. The National Child Measurement Programme (NCMP) provides the earliest and most reliable dataset for population-level analysis, with Reception (age 4–5) data offering vital insight into early life weight trajectories.[212]

Between 2021/22 and 2023/24, 23.9% of Reception-aged children in Tameside were classified as overweight including obesity, compared with 21.9% across England.[213] This equates to nearly one in four children starting school above a healthy weight.

Over the past decade, excess weight prevalence in Tameside has remained relatively stable, fluctuating between 23.5% and 24.7%. By contrast, England has seen a modest decline—from 22.8% in 2008/09–2010/11 to 21.9% in the most recent three-year period. While local levels have not worsened, the difference suggests a slowly widening gap driven by national improvement rather than local change.[214]

Reception obesity (a subset of the total) currently affects 10.9% of children in Tameside, compared with 9.6% in England. For much of the past decade, the local–national gap ranged between 0.7% and 0.9%. This gap widened during the pandemic (2020/21–2022/23) to 1.6%, before narrowing slightly to 1.3% in the latest period.[215] These figures highlight that excess weight in the earliest years of school remains a consistent and significant challenge in Tameside.

Figure 20: Trend in reception obesity prevalence (3-year rolling average)



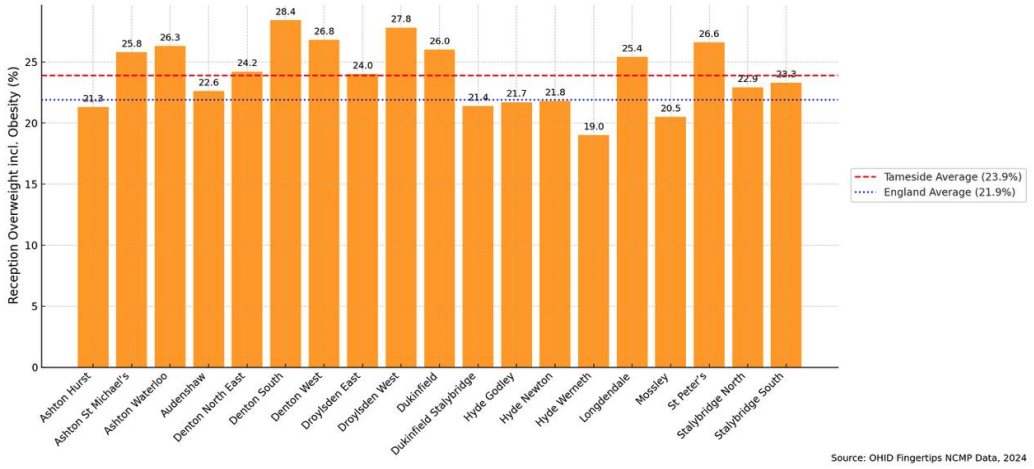
While the primary concern is excess weight, a small minority of children are recorded as underweight. In Tameside, around 1.0% of Reception children and 1.4% of Year 6 children were underweight in 2021/22.[216] Nationally in 2023/24, underweight prevalence was 1.2% in Reception and 1.7% in Year 6.[217] Local 2023/24 figures are not yet publicly available. Although the absolute numbers are small, the presence of underweight highlights the importance of considering both extremes of unhealthy weight within a balanced "healthy growth" approach.

Underweight prevalence has also remained consistently low over time, both nationally and locally, typically affecting around 1–2% of children in each age group. National NCMP data show no meaningful long-term trend, reinforcing that while underweight is an important marker of inequality and child health, it remains a small minority compared with the burden of excess weight.[218]

6.8.1 Ward-level variation in weight status

Ward-level analysis reveals marked inequalities. Overweight including obesity ranges from 19.0% in Hyde Werneth to 28.4% in Denton South. Thirteen wards exceed the England average (21.9%), and eight are above the borough average (23.9%). Particularly high levels are recorded in Ashton Waterloo (26.3%), Droylsden West (27.8%), and St Peter's (26.6%).[219]

Figure 21: Reception overweight (inc. obesity) by ward (2023/24)



Obesity-only prevalence shows similar variation, from 6.3% in Hyde Werneth to 14.9% in Denton South. Eleven wards exceed the borough average of 10.9% (Figures 19–20). The highest-burden wards largely mirror those with the greatest levels of combined excess weight, reinforcing the persistence of place-based disparities.[220]

These spatial patterns align with deprivation, reflecting the cumulative impact of environmental, economic, and structural risk factors on child weight outcomes.[221]

6.8.2 Implications for early years healthy weight

Although Reception children (aged 4–5) fall just beyond the early years window (0–4), NCMP data provides the earliest consistent measurement of child weight at population level. In the absence of routine monitoring during infancy and toddlerhood, this data is essential to understanding when and where inequalities in weight emerge.[222] Several implications follow:

- **Early emergence of inequalities**: Most wards exceed national levels of overweight at Reception, with entrenched patterns in some localities. This confirms that weight inequalities are established before formal schooling and require upstream, multi-agency intervention.[223]
- **Overweight as a warning signal**: Children identified as overweight but not yet obese represent a critical window for prevention. Evidence shows they are significantly more likely to progress to obesity later in childhood and adolescence if unaddressed.[224]
- **Flatlining local trends vs national improvement**: While England shows modest improvement, Tameside's rates remain static. This highlights the need for renewed local focus and system-wide prevention strategies.[225]
- **Place-based responses**: The ward-level data supports targeted intervention. Family Hubs, early years providers, and the voluntary sector could play a central role in co-designing hyper-local approaches that respond to family needs and lived experiences.[226]

6.9 Conclusions: Informing the Needs Assessment

Although some important datasets—such as maternal BMI at booking, early antenatal engagement, or access to services—were unavailable or not provided at the required level of detail, the information analysed here offers a strong foundation for identifying priorities and inequalities. Several core themes emerge:

- **Inequalities across communities**: Birth volumes, breastfeeding, birthweight, and childhood obesity all vary significantly by neighbourhood. More deprived wards typically experience a higher burden of risk, underlining the need for localised approaches that respond to the specific pressures and conditions of different communities.
- **Changing demographics reshaping need**: The maternity population is becoming older and more ethnically diverse, with notable increases in births to mothers born in Pakistan, India, Nigeria, and other diaspora communities. These demographic changes bring differing risks and cultural considerations, which should be reflected in future planning for healthy weight and early years services.
- **Birth trends shaped by deprivation as well as volume**: It is not only the number of births that matters, but where they occur. More deprived wards continue to account for the majority of births, concentrating need in areas already facing structural disadvantage.
- **Falling birth rates altering scale and focus of need**: The number of live births has declined over the past decade, with the under-five population also reducing. Although there has been a modest uptick since 2021, national projections suggest that birth rates will remain stable or decline further. This shift affects service planning, workforce deployment, and targeting of interventions, and requires ongoing monitoring to ensure services remain proportionate.
- **Mixed and uneven progress**: Some indicators, such as smoking in pregnancy, show notable improvement, while others remain static or below national averages. Breastfeeding rates

remain low, and excess weight at Reception age has not reduced in a decade. Some wards face consistently higher levels of challenge than others, pointing to entrenched inequalities.

- **Data gaps limiting understanding**: Data availability and completeness are inconsistent. In breastfeeding and birthweight, discrepancies exist between national and local sources, while for maternal risk factors by ethnicity or service access, usable data were not available. These gaps constrain interpretation and need to be addressed through wider system and community engagement.
- **Community and system insight needed next**: While the data analysis highlights patterns, it cannot capture lived experience or explain causation. The next stage of the needs assessment will therefore focus on engagement with stakeholders, professionals, and local families to understand barriers, identify opportunities, and co-design solutions.

The evidence from this section highlights key themes and challenges that warrant deeper exploration in the next phase of assessment. They point to both entrenched risks and emerging opportunities, offering a robust starting point for shaping future priorities around maternal and early years healthy weight in Tameside.

7. Stakeholder Perspectives on Maternal and Early Years Healthy Weight in Tameside

7.1 Introduction

Understanding the perspectives of those working within and alongside the system is essential to shaping an effective maternal and early years healthy weight strategy. To capture these views, two complementary forms of engagement were undertaken:

- A stakeholder survey (n=39) capturing perspectives from across local authority, NHS, education, voluntary and community sector (VCFSE), and frontline practitioners.
- In-depth stakeholder interviews (n=15) with a diverse mix of professionals, including commissioners, practitioners, voluntary sector leaders, and policy influencers.

This synthesis brings these insights together to provide a cohesive narrative of stakeholder perspectives. It reflects both the quantitative patterns captured in survey responses (with graphs presented alongside the text) and the qualitative richness of interviews, supported by direct quotes.

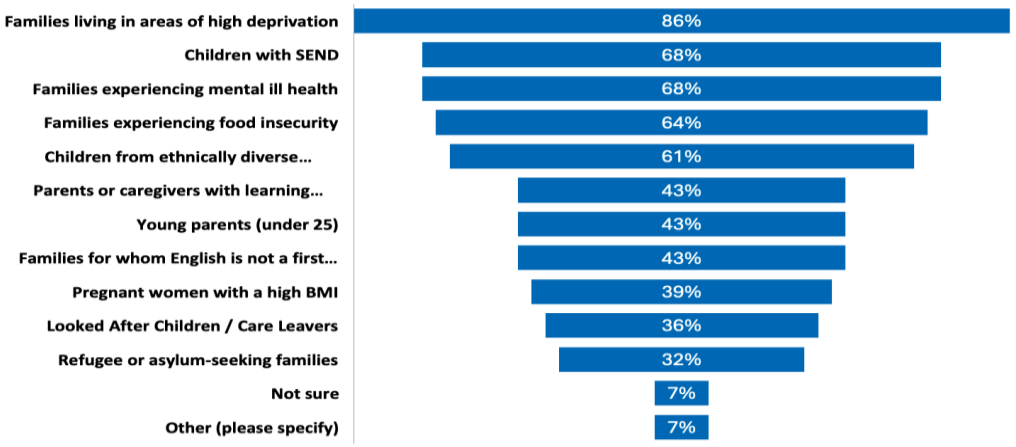
Stakeholders consistently highlighted the significance of early life as a critical period for intervention, but also described systemic challenges: fragmented provision, inequitable access, limited prioritisation, and underinvestment in prevention. Alongside this, they emphasised significant assets including workforce commitment, dedicated service offers, community resilience, and trusted local spaces.

7.2 Local Context and Wider Determinants

Stakeholders were clear that maternal and early years healthy weight cannot be separated from the wider social and economic realities facing families in Tameside. Poverty, food insecurity, housing pressures and the commercial environment shape everyday choices in ways that no single programme can fully counteract. The survey and interviews highlighted these broader determinants as the backdrop against which all services and interventions must operate, underscoring the importance of proportionate universalism and place-based responses.

Stakeholders consistently identified deprivation, poverty, and the cost-of-living crisis as key drivers of unhealthy weight in Tameside. These themes were raised repeatedly in both the survey responses and interviews, often alongside concerns about the commercial food environment and the limited time and resources available to parents. Nearly 9 in 10 respondents (86%) highlighted families living in areas of high deprivation, while significant proportions also pointed to families experiencing food insecurity (64%), children from ethnically diverse communities (61%), and parents or carers with learning disabilities (43%). The findings underscore the importance of addressing structural and place-based disadvantage if progress is to be made on reducing inequalities and improving outcomes in the early years.

Figure 22: In your experience, do any specific groups or communities face disproportionate burden of unhealthy weight?



Note: Response options shown above reflect the categories included in the co-produced survey tool; no additional options were available to respondents."

As one survey respondent noted: *"Families are making impossible choices between heating, eating and bills — healthy eating isn't always feasible when every penny counts."*

Interviewees echoed this strongly, best reflected by one stakeholder who observed: "*When a parent must decide between putting money on the meter or buying fresh food, that's not a choice. It's survival."* Others highlighted the saturation of fast-food outlets and convenience stores in deprived neighbourhoods: *"Parents are competing against what's available on every corner,"* said one health professional.

Cultural and social determinants also emerged. The survey pointed to language barriers and the need for culturally appropriate services. Interviews reinforced this, with one stressing that *"one-size-fits-all approaches alienate families who don't see themselves reflected in the support on offer."*

Maternal mental health was repeatedly identified as a determinant of healthy weight outcomes. Several interviewees emphasised that supporting mothers' wellbeing was inseparable from addressing children's routines: *"If mum isn't coping, nutrition advice won't stick,"* as one practitioner put it.

Equity was a recurring theme: ensuring services are accessible to families regardless of language, cultural background, or immigration status was seen as essential. *"Healthy weight can't only work for the mainstream — it has to work for everyone,"* one voluntary sector leader explained.

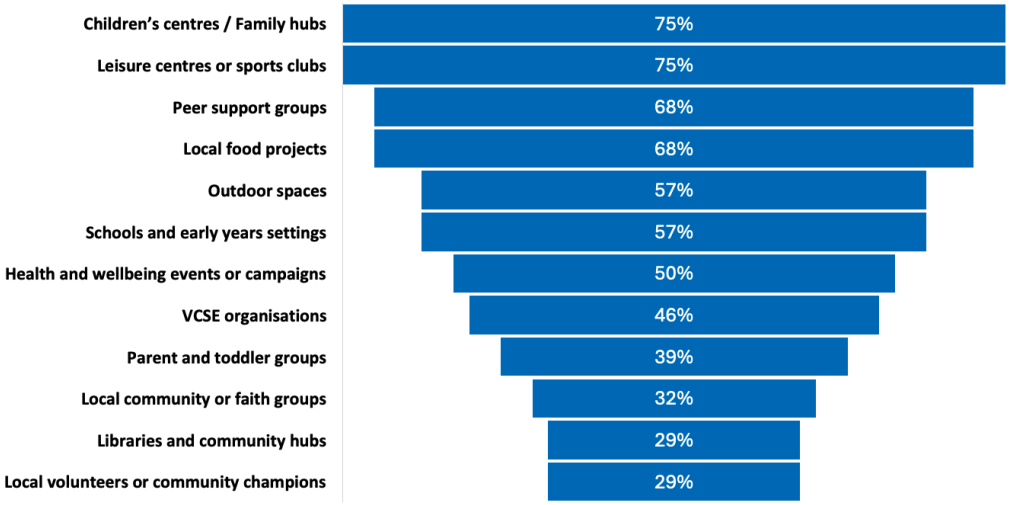
The findings show that helping children achieve a healthy weight in the early years is not just about what parents know or how motivated they are — it's also about the conditions in which families live. Tackling deprivation, improving access to healthy food, supporting maternal mental health, and making services culturally inclusive all need to be central parts of any local strategy. Without action on these wider factors, services can only achieve so much. With them, Tameside has a real chance to reduce inequalities and give all children a healthier start in life.

7.3 Community Assets and Strengths

Community assets were consistently highlighted as one of Tameside's greatest strengths in supporting maternal and early years healthy weight. Stakeholders recognised that while structural inequalities and service gaps persist, the borough benefits from a strong base of trusted spaces, committed practitioners, and resilient families. These assets provide a platform on which more effective and sustainable support can be built, particularly if they are nurtured and better connected.

Survey results pointed to the value of family hubs (children's centers), schools, and the VCFSE in providing accessible and trusted spaces.

Figure 23: What community assets are currently supporting healthy weight?



Interviews reinforced this, with many stressing the role of peer support. One noted: *"Parents often trust other parents most. Peer supporters open doors professionals sometimes can't."* Whilst another emphasised the strength of voluntary groups: *"They are embedded in communities, they understand cultural nuance, and families turn to them first."*

The workforce itself was seen as a major strength. Across interviews, stakeholders praised the dedication of health visitors, midwives, early years practitioners, and volunteers who work to support families often in challenging circumstances. *"Staff really care — they want to do the right thing,"* one respondent commented.

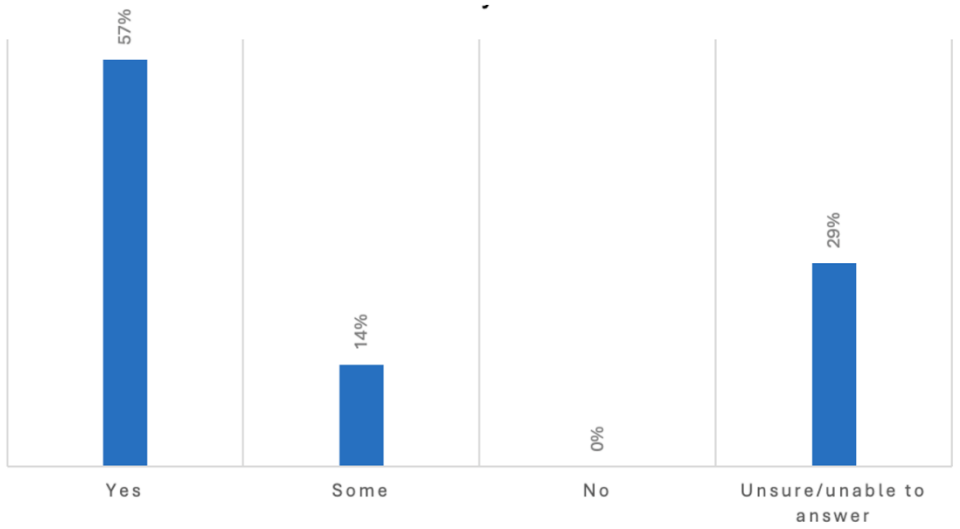
Community resilience was also highlighted: *"Families are resourceful, they share tips, recipes, childcare. That peer network is an asset,"* explained one practitioner.

Several stakeholders also urged that families themselves must be more fully involved in shaping solutions. As one voluntary sector respondent put it: *"Parents know better than anyone what works for them. If we don't ask, we'll keep missing the mark."* This emphasis on co-production was seen as key to building trust and designing interventions that families will genuinely use.

Survey responses highlighted strong confidence in the potential to build on existing assets. Over half of respondents (around 57%) felt there was clear scope to strengthen or expand community-based provision, with a further 14% saying there was at least some potential. This suggests that while assets are valued, there is also recognition that many could achieve greater impact if supported with additional resources, capacity, and coordination.

Patterns emerging from the responses suggest that Tameside already has the building blocks for a strong community-based response. The challenge is not a lack of assets, but ensuring they are consistently resourced, expanded, and connected into wider pathways. With greater coordination and investment, these existing strengths could play a pivotal role in embedding prevention, building trust with families, and enabling early years healthy weight to become everyone's business

Figure 24: Is there potential to strengthen or expand community assets?



7.4 System Prioritisation, Leadership and Policy Alignment

Stakeholders were clear that without system-wide prioritisation, efforts to address maternal and early years healthy weight will remain fragmented and underpowered. Leadership was seen not only as about visible champions but also about embedding accountability into governance structures, commissioning frameworks, and performance measures. Several emphasised that prioritisation needs to move beyond rhetoric and be evidenced through consistent investment, workforce development, and the integration of healthy weight objectives into wider policy agendas. In short, leadership is required at both strategic and operational levels to drive consistency, sustain momentum, and ensure that healthy weight is treated as a core determinant of long-term health and wellbeing rather than a peripheral issue.

The survey showed mixed views on whether maternal and early years healthy weight is currently prioritised. While 68% (n=17) felt it was partially embedded, many described it as under-resourced and overshadowed by acute service pressures.

One survey respondent wrote: *"We talk about prevention, but the funding never follows, and acute demand always wins."*

This was echoed across interviews, with stakeholders repeatedly describing the *"project churn"* that undermines long-term progress: *"We run a brilliant programme one year, then the funding disappears. Parents notice, staff get disheartened, and momentum is lost."*

A particularly consistent theme across both surveys and interviews was leadership. Stakeholders argued that maternal and early years healthy weight needs the same system-wide prioritisation and visible leadership that smoking cessation has received. Without that, healthy weight risks being lost between agendas. *"If smoking got the attention, it did, why can't healthy weight? The evidence is just as strong — but the leadership isn't there."*

"We need someone to bang the drum for this, otherwise it keeps being sidelined."

Interviewees emphasised that leadership should not just come from public health, but be embedded across council departments, NHS partners, and schools. A clear champion or governance structure was seen as vital for sustained change.

Policy alignment was highlighted as an essential enabler. Stakeholders argued that all related strategies — from maternity and health visiting to family hubs, school readiness, obesity, and wider prevention — must explicitly reference maternal and early years healthy weight. "*If it isn't in the strategies, it won't be in the delivery,"* one commissioner explained. Ensuring healthy weight is visible across policies was seen as a prerequisite for accountability and sustained focus.

Across the findings, there is a strong appetite among stakeholders for a more coherent and ambitious approach to maternal and early years healthy weight. They want to see this issue elevated as a system-wide priority, with clear leadership, aligned policies, and long-term investment. Alongside this, they call for practical steps — mapping services, clarifying pathways, building workforce confidence, and involving families in shaping support. The message is consistent: the foundations are in place, but sustained leadership and integration are essential if Tameside is to shift from fragmented provision to a joined-up system that gives every child the best start in life.

7.5 Current Services and Programmes

Stakeholders provided a nuanced picture of current provision to support healthy weight in the maternal and early years pathway. Both survey and interview findings point to a system with notable strengths but also significant inconsistencies. While there are valued programmes and committed practitioners, support is often fragmented, short-term, or dependent on local champions rather than embedded in a clear, system-wide offer. Visibility of provision is uneven, particularly before and during pregnancy, and there are concerns about whether staff have the tools, time, and training to provide consistent support.

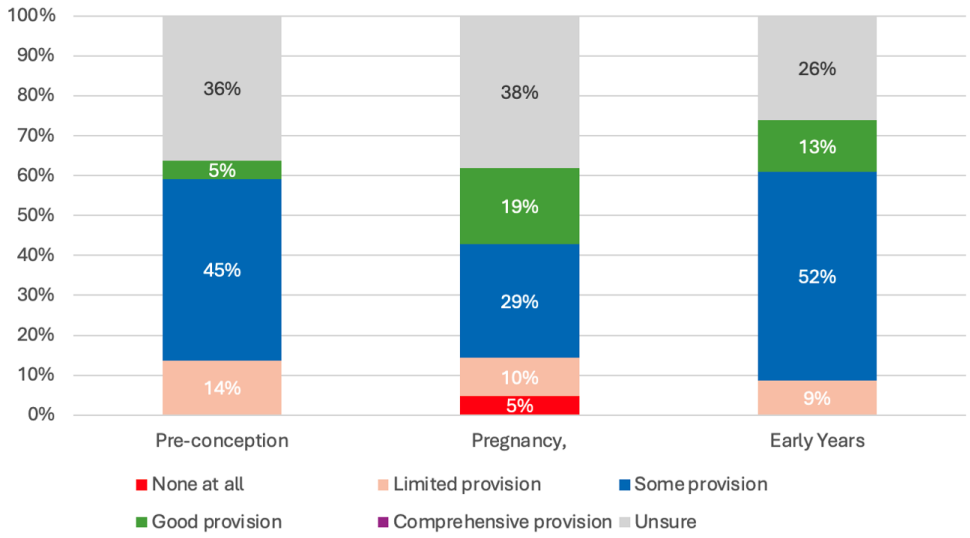
Figure 21 presents stakeholder views on the extent of service provision across the life course (n=42). Responses indicate that provision is perceived to be weakest at the pre-conception stage. Nearly half (45%, n=19) described support as only 'some', while 14% (n=6) felt it was limited, and just 5% (n=2) considered it good. This suggests a lack of visibility and coherence in pre-conception support.

During pregnancy, perceptions were somewhat stronger, though still mixed. Around 1 in 5 respondents (19%, n=8) rated provision as good, while 29% (n=12) saw it as some, and 10% (n=4) as limited. A small number (5%, n=2) felt there was no provision at all. While provision is clearly more established at this stage than pre-conception, stakeholders still did not view it as comprehensive.

Support in the early years was perceived most positively. Over half of respondents (52%, n=22) identified some provision, and 13% (n=5) described it as good. Only a small minority viewed provision as limited or absent. This reflects greater visibility and accessibility of early years services compared to the earlier stages.

It is worth noting that a proportion of respondents selected 'unsure' across all three stages. This likely reflects differences in professional focus, with some stakeholders less directly involved in particular phases of the life course, but it also underlines a broader issue of awareness and communication around what services exist.

Figure 25: To what extent are there services or programmes in place to support healthy weight across each of the following stages?



Interviews painted a similar picture of a patchwork system. Breastfeeding peer support was praised but described as inconsistent. The NHS Healthy Start scheme was valued but underused due to barriers in eligibility and access: "*It's a brilliant scheme in principle, but too many families miss out,"* one stakeholder noted.

Practical support was strongly emphasised. Cooking and weaning programmes were described as effective but too often short-lived. As one voluntary sector leader put it: *"Parents want hands-on help, not just leaflets. They love cooking sessions — but then they stop after a few months."*

Workforce confidence in delivering these services varied. Several stakeholders raised concerns that staff felt underprepared to raise sensitive conversations about weight, diet, and lifestyle with families. *"Some health visitors are brilliant at this, others shy away — they need the tools and confidence,"* said one manager. Training in cultural competency was also raised as an area for strengthening.

The findings suggest that while Tameside has important assets and committed services, provision is not yet universal, consistent, or sufficiently visible across the life course. Strengthening the pre-conception and pregnancy offer, embedding practical programmes for families, and investing in workforce confidence and cultural competency were all highlighted as priorities. A more joined-up and sustained approach could help move provision from being patchy and short-term to being embedded, reliable, and trusted by families.

7.6 Pathways, Access and Integration

Alongside views on overall provision, both survey and interview findings highlighted major challenges around service pathways. A consistent message was that families often encounter a fragmented and inconsistent system, with referral routes unclear or varying significantly by locality. The survey data reinforced this picture, with a high proportion of respondents selecting 'unsure' when asked about referral processes and pathways. While some uncertainty may reflect differences in professional focus, it is notable that all respondents work within the field, suggesting that the lack of clarity is a system issue rather than simply gaps in individual knowledge.

At the pre-conception stage, only two of stakeholders described referral pathways as clear and effective, while 60% (n=12) were unsure. In pregnancy, just one saw pathways as well-established, with over half (57%, n=12) uncertain. Just three stakeholders identified clear pathways for Early years, yet 39%, (n=9) remained unsure.

Interviews brought this to life. One practitioner explained: *"What a family gets depends on who they see and where they live. That's not acceptable."* Stakeholders also noted that thresholds frequently leave families without adequate support, not meeting criteria for specialist services but requiring more than universal provision. As one commissioner observed: *"The majority could benefit from prevention, but the system doesn't catch them."*

Many argued that systematic service mapping should be the first step, as no single organisation currently holds a comprehensive overview of what exists, how services link, or where the gaps are. As one voluntary sector leader put it: *"We don't even know the full menu of what's out there, so how can we guide families?"* Another added: *"Mapping services and pathways must come first. Only then can we see the gaps and build a coherent journey for families."*

Digital and information-sharing barriers were also raised. *"Different organisations use different systems, families end up repeating their story,"* said one practitioner, creating duplication and leaving families having to repeat their story multiple times. Ensuring equity in referral processes was also highlighted, with several pointing out that current systems often assume English fluency and digital access. As one respondent cautioned: *"Referral processes often assume English fluency and digital access, but not every family has that."*

On balance, these findings show that the challenge is not only about the volume of provision, but also about the clarity, equity, and coherence of the pathways into and between services. Addressing this will require joint ownership across organisations, systematic mapping, and investment in shared systems that reduce duplication and ensure families experience a joined-up journey of care.

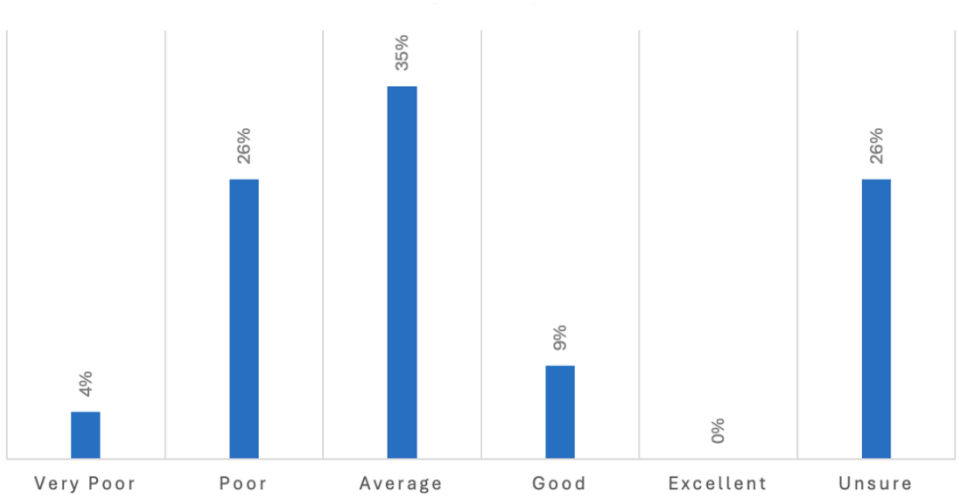
7.7 Communication and Information

Communication emerged as a consistent theme across the survey and interviews. Stakeholders agreed that while there are committed professionals and some valued initiatives, the way information is shared with families and across services remains uneven. The consequences are that families often do not know what is available, professionals sometimes give conflicting advice, and opportunities for early intervention are missed. At the same time, there were examples of good practice that show the potential to build on existing strengths.

Survey data highlight the scale of the challenge. Only 9% (n=2) of respondents rated communication as good, and none considered it excellent. Over a quarter (26%, n=6) described it as poor, while 35% (n=8) felt it was only average. A further 26% (n=6) were unsure. Taken together, this means nearly two-thirds of stakeholders did not view communication positively, despite all working in the sector. This reinforces the perception that families and professionals alike are navigating a system where information is not consistently clear or accessible.

Interviews reinforced this picture, with many describing how families receive different messages depending on which service they encounter. As one practitioner put it: *"Parents hear one thing from a midwife, another from the GP, and something different again from a children's centre."* Others noted that communication materials are often not culturally appropriate or accessible for families with limited English or digital literacy.

Figure 26: How would you rate communication and engagement between services and communities around healthy weight in pregnancy and early years?



Information-sharing between professionals was also raised as a barrier, with different IT systems preventing a joined-up approach: *"It's not just about telling families where to go, it's about professionals talking to each other too,"* one commissioner reflected.

Despite these challenges, stakeholders pointed to some positive examples that could be built upon. Family hubs (children's centres) were seen as trusted places where families know they can access reliable information. Peer support networks also play a vital role in spreading messages in a way that feels authentic and culturally sensitive. Digital resources developed during the pandemic, such as online weaning and cooking sessions, were also highlighted as valuable innovations that should not be lost.

These insights collectively suggest that communication is both a weakness and a key opportunity. Improving consistency, accessibility,

and cultural appropriateness of information, while scaling up what already works well, such as trusted community hubs and peer-led networks, will be essential. Strengthening information-sharing across organisations will also reduce duplication and ensure that families experience a joined-up system. Effective communication is not an optional extra but a foundation for ensuring that families can navigate support and services with confidence.

7.8 Future Priorities and Opportunities

Stakeholders were clear that progress on maternal and early years healthy weight will only be possible if the system shifts towards prevention, consistency, and long-term commitment. Survey data and interviews converged on a shared set of priorities, many of which were expressed with striking consistency across different professional groups and sectors. Importantly, these priorities were not abstract aspirations, but practical, grounded reflections of what families and practitioners experience every day.

Survey responses and interviews consistently placed prevention at the top of the agenda. Stakeholders stressed that healthy weight should be everybody's business, embedded across all stages of the life course. One interviewee reflected: "Healthy weight should be everybody's business — the same way smoking cessation became embedded into every contact." Stakeholders argued that prevention must be universal, proportionate to need, and visible across health, education, and community settings.

Professional training was repeatedly emphasised. While some staff were described as highly skilled in engaging families, others lacked the confidence to raise sensitive conversations about weight, diet, and lifestyle. This theme emerged strongly in both interviews and the survey's free-text responses, where stakeholders highlighted variable staff confidence and a lack of consistent training in cultural competence. Several interviewees also stressed the importance of cultural competence: *"If advice doesn't reflect people's lives, cultures, or budgets, it won't land."*

Improving 'Healthy Start' uptake was widely seen as *"low-hanging fruit."* Both survey and interview feedback suggested that awareness among families and staff is inconsistent, and application processes remain a barrier. Stakeholders described Healthy Start as a highly valued but underutilised scheme: *"It's a brilliant offer, but too many miss out because they don't know about it or can't get through the system."*

Maternal mental health was also identified as a priority. Stakeholders argued that supporting mothers' wellbeing is inseparable from addressing children's nutrition and routines. One practitioner commented: *"If mum isn't coping, nothing else sticks. You can't build healthy routines on exhaustion and stress."* This message was echoed consistently across interviews and surveys.

Co-production with families was seen as a foundation for future change. Stakeholders argued strongly that families must be involved in shaping what support looks like, to ensure relevance and uptake. Survey findings also confirmed appetite for greater family involvement, with most respondents seeing parents as the most trusted messengers of healthy weight advice.

The use of trusted community spaces was another clear priority. Family hubs, schools, nurseries, and voluntary groups were consistently described as places where families feel comfortable and supported. Building services around these spaces, rather than expecting families to navigate complex systems, was seen as key to accessibility.

Finally, stakeholders stressed the need for policy integration and leadership. Healthy weight should be visible across local strategies — not siloed within public health, but embedded into maternity, early years, education, housing, and wider determinants. This was linked to accountability and prioritisation: *"If it's not in the strategy, it slips off the agenda."*

Together, the findings represent a strong and consistent message from stakeholders. They underline the need for a prevention-focused, long-term, and family-centred system that values lived experience, builds professional confidence, and embeds healthy weight into the fabric of local policy. While challenges remain, the alignment across stakeholders provides a clear foundation for shared action. The opportunities identified here offer a roadmap for building a coherent, sustainable approach that gives every child in Tameside the best start in life.

7.9 Final Reflections – Stakeholder Conclusions Informing the Needs Assessment

The survey and interview findings present a consistent and compelling picture. Stakeholders in Tameside are clear that the borough has many of the foundations for effective maternal and early years healthy weight support: a dedicated workforce, strong community assets, and growing recognition of the importance of prevention. Family hubs (children's centres), schools, and voluntary groups are trusted entry points, and there is evident passion among staff and communities to improve outcomes for children.

At the same time, stakeholders repeatedly identified systemic weaknesses that constrain impact. Services are fragmented and referral pathways unclear, leaving families' experiences inconsistent and sometimes inequitable. Access barriers, from digital exclusion and language needs to eligibility thresholds that leave families *"falling through the gaps,"* reinforce inequalities rather than close them. Short-term funding cycles and project-based initiatives compound these issues, making it difficult to sustain what works or embed change over time.

A consistent conclusion was the need for stronger system leadership. Stakeholders want healthy weight to be prioritised in the same way smoking cessation once was — a clear, cross-system commitment backed by coherent strategy and accountability. As one interviewee put it: *"Healthy weight should be everybody's business. Until we see it as core, we'll always be patching rather than preventing."*

There was also a strong sense that without mapping what currently exists, progress will remain limited. Stakeholders called for a comprehensive picture of services and referral routes to guide families, reduce duplication, and build a coherent life course offer. Alongside this, they urged a more consistent approach to communication, ensuring families receive clear, culturally relevant messages, and that professionals share information effectively.

Survey responses reinforced these points, highlighting prevention, long-term investment, and co-production with families as priorities for the future. Maternal mental health was repeatedly singled out as a critical enabler of healthy routines, and Healthy Start was described as *"low-hanging fruit"* that could deliver immediate benefits if uptake were improved.

What comes through most clearly is a message of cautious optimism. As one survey respondent concluded: *"We have the knowledge, the evidence, and the passion. What we lack is joined-up leadership and the investment to stick with it."* One stakeholder reflection echoed this sentiment: *"Every child deserves the best start. At the moment, postcode and poverty still dictate outcomes. That gap must close."*

These conclusions provide a strong platform for the needs assessment. They underline that while assets are present, the system will only achieve its potential if leadership, coherence, and equity are placed at the centre. Families and communities are ready to be part of the solution — but they need structures that enable, sustain, and amplify what works

8. Community Perspectives and Lived Experience

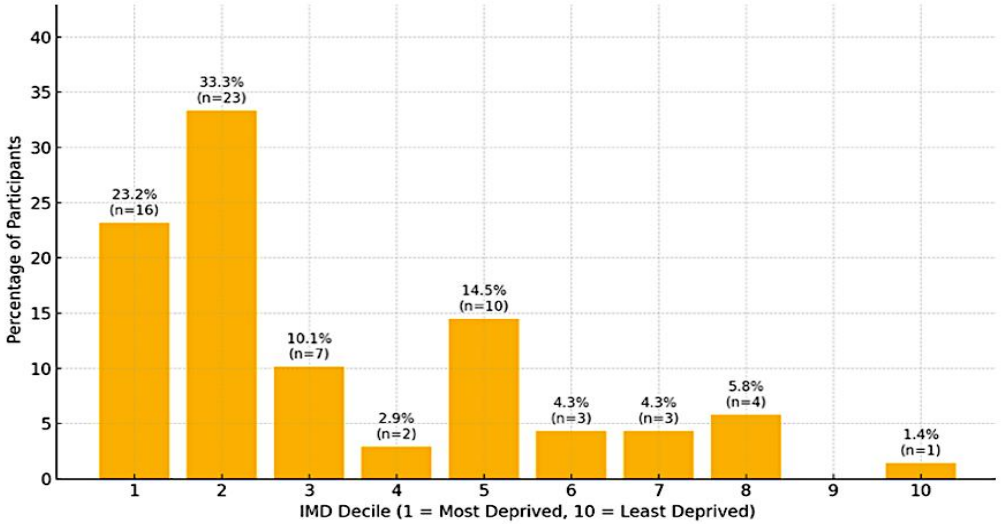
Understanding the lived experience of families is essential to building a complete picture of maternal and early years healthy weight in Tameside. To complement professional and system-level perspectives, a community survey was undertaken with parents and carers, including those currently pregnant and those caring for children under five. The survey captured both the context of families' lives (demographics, household circumstances, and community setting) and their views on barriers, assets, service experiences, and future priorities. By grounding the needs assessment in community voice, this section highlights not only the challenges families face but also the strengths they bring and the changes they want to see. These insights ensure that the needs assessment is anchored in lived realities, providing a crucial counterbalance to professional perspectives.

8.1 Survey Respondent Profile

A total of 85 parents and carers contributed to the community survey, offering a valuable window into the lived experiences of families navigating pregnancy and the early years in Tameside. The survey sample included both those who were currently pregnant (17%, n=16) and those caring for children under the age of five (83 per cent, n=69), ensuring that perspectives spanned across different points of the maternal and early years journey.

All respondents had at least one child, with just under a third (30%) having two children and 3% having three children. One parent had four children and one with five.

Figure 27: Survey respondence by Index of Multiple Deprivation decile



Responses were skewed towards communities experiencing disadvantage. Over half of participants (56.5 per cent, n=48) lived in areas ranked within the two most deprived deciles nationally. This reflects the intended focus of the engagement and ensures that the data captures the voices of families most affected by the social and economic determinants of health. The high proportion of respondents from deprived neighbourhoods is a strength of the dataset, providing perspectives from those who are often least heard yet most at risk of poor health outcomes.

The ethnic profile of the sample was broadly reflective of local demographics, while also highlighting diversity within the borough. Nearly three-quarters of respondents identified as White British (74%, n=62), with the remainder drawn from a range of ethnically diverse backgrounds. Most notably, these included:

- Pakistani (6.3%)
- Mixed: White and Asian (3.8%)
- Black African (3.7%)
- Any other ethnic group (6.3%) where they identified as capturing some of Tameside's growing Eastern European communities, including Lithuanian, Polish, and Czech families. These groups, while sometimes hidden in official statistics, are increasingly visible locally and face challenges in accessing culturally appropriate support.

This is echoed in the language profile of responders:

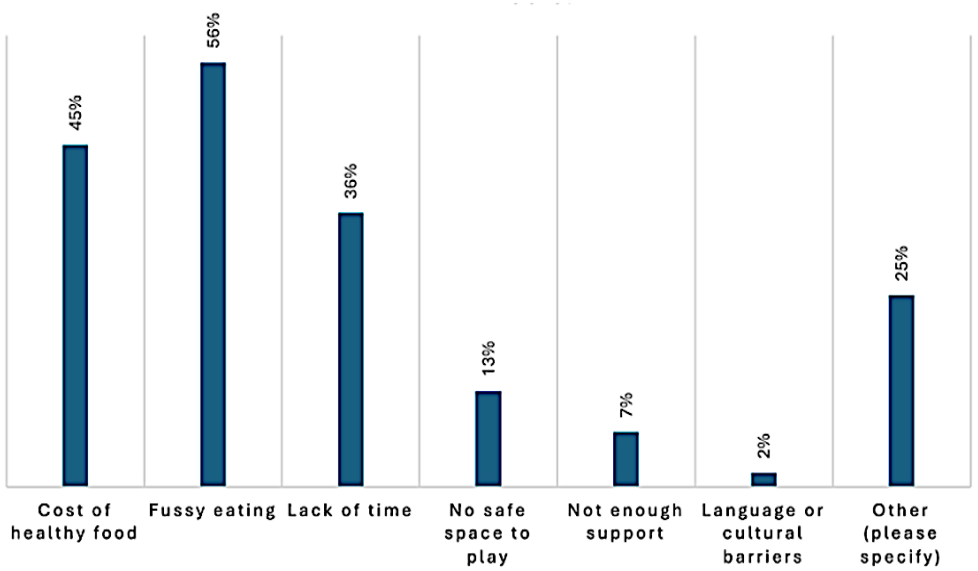
- 93.8% reported speaking English at home
- 6.2% reported speaking Polish, Urdu, Bengali (Sylheti), Gujarati, Punjabi, or Portuguese
- A further 3.75% selected "other", including Lithuanian and Czech

While the survey cannot claim to be representative of all families across Tameside, it provides a rich source of insight from those living in communities where health inequalities are most pronounced. It ensures that the voices of those navigating the daily challenges of pregnancy, parenting, and caring for young children are central to the needs assessment.

8.2 Everyday Pressures and Constraints

Parents and carers identified a set of practical, financial and environmental pressures that make it harder to sustain healthy routines during pregnancy and the early years. These constraints reflect the intersection of parenting, financial hardship, time poverty, environmental factors, and emotional stress. The top issues reported were fussy eating, the cost of healthy food, and time constraints, with additional barriers linked to the local environment, practical support, and language/cultural factors.

Figure 28: What are the biggest challenges for your family in terms of helping your children maintain a healthy weight?



Fussy Eating was the most frequently cited challenge, with parents describing the difficulty of encouraging variety in children's diets. This issue was also reflected in other responses, where several respondents requested more advice on weaning, feeding, and fussy eating. This suggests a need for both practical strategies and reassurance, particularly for first-time parents.

The cost of healthy food was highlighted by nearly half of respondents, linking healthy eating challenges to affordability. One parent highlighted: *"Purchasing a bag of vegetables knowing I cannot eat it all and the children will probably just push it around their plates puts me off spending the money."* This connects to suggestions raised by parents for budget-friendly cooking advice and aligns with Tameside's higher-

than-average deprivation levels, where cost is a significant barrier to healthy eating.

Over a third of respondents reported time constraints, limiting their ability to plan, prepare, or seek out healthier meals and activities. While a smaller proportion highted environmental and support barriers including a lack of safe outdoor play spaces, insufficient practical support, or language/cultural barriers.

Our community insight demonstrates that families are not lacking overall motivation to support healthy routines but face intersecting pressures that limit their ability to sustain them. Fussy eating was the most frequently cited challenge. While this reflects wider evidence that feeding difficulties are among the most common concerns for parents of young children,[227] local feedback indicates that parents are unsure how best to manage these difficulties and would value more practical guidance. This points to a potential service gap, as much of the current support focuses on breastfeeding and weaning, with less emphasis on feeding challenges in the years that follow.

The impact of cost and time poverty also mirrors national evidence, with studies showing that healthier diets remain least affordable for those in deprived communities.[228] Stress and environmental barriers further compound these challenges, reflecting wider findings that poor mental health and the concentration of fast-food outlets both contribute to unhealthy weight trajectories.[229]

For Tameside, this suggests that tackling maternal and early years healthy weight will require approaches that combine family-level support with system-level action to address affordability, time poverty, and the wider determinants of health. In addition, strengthening provision to help families with common feeding challenges such as fussy eating could provide more consistent and accessible support.

8.3 Support Needs Across Pregnancy and Early Life

Alongside the everyday pressures outlined in Section 8.2, survey respondents described the types of support that would help them to maintain healthy weight routines. These responses highlight how challenges and priorities evolve across the pathway, and the importance of providing joined-up, consistent, and practical support throughout.

8.3.1 Pre-pregnancy healthy weight advice

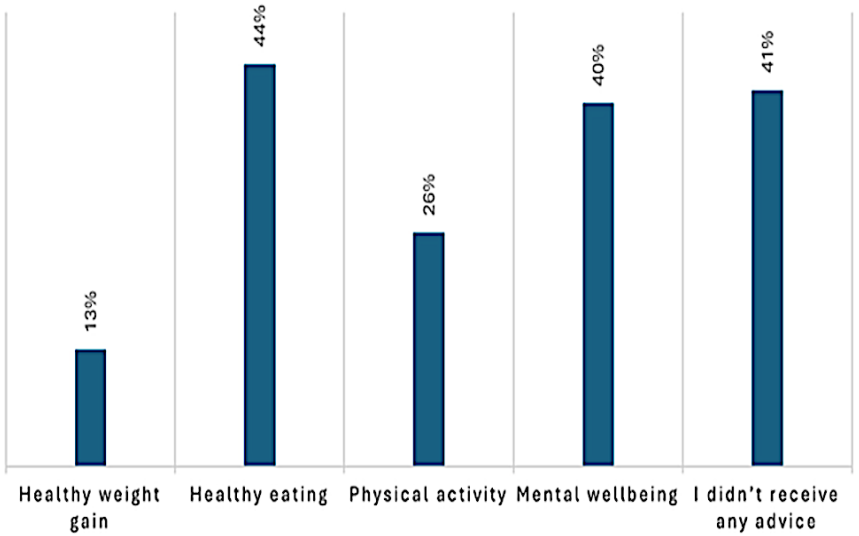
Fewer than one in ten survey (n=7) respondents reported receiving any pre-pregnancy support or advice relating to healthy eating, physical activity or weight, very few received advice before pregnancy. This is potentially a significant finding, considering the importance of preconception health for maternal and early years outcomes and could signal a missed opportunity for preventative support and early intervention.

Among those who did receive support, the GP, doctors and nurses, and health visitor workforce were cited as the source, with one referring to Polycystic Ovary Syndrome (PCOS) as a reason for discussion. There were also informal sources of support mentioned, such as Google. This highlights potential gaps in accessible, trusted preconception health information and/or opportunities to deliver messages through digital platforms.

As all survey respondents were already parents, this feedback reflects experiences of advice given before previous pregnancies. It does not demonstrate whether respondents were planning subsequent pregnancies at the time of the survey. However, it suggests that services already in contact with families — such as health visitors and early years providers — could have a role in reinforcing healthy weight messages that may support future pregnancies.

Confidence amongst responders in managing weight and wellbeing needs during pregnancy varied considerably. While a fifth of women (21%) felt "very confident" managing weight and wellbeing during pregnancy over a quarter (27%) were not so confident or not confident at all, highlighting the importance of support and advice.

Figure 29: Do you recall receiving any advice on these topics during pregnancy?



More than two in five (41.4%) survey respondents reported not receiving any advice during pregnancy on either healthy eating, weight gain, physical activity, or mental wellbeing.

This is a significant gap, given the importance of pregnancy as a key opportunity for preventative support and early intervention. Among those who did receive advice, only 12.9% (n=9) received guidance specifically on healthy weight gain. Healthy eating and emotional wellbeing were more frequently covered, while physical activity was less consistently addressed (just 26%).

Advice most often came from midwives (53%), followed by health visitors (12.1%) and GPs or nurses (9.1%). It should be noted that health visitors would not normally be in contact prior to a first pregnancy. This feedback therefore reflects advice received in relation to later pregnancies, or advice offered postnatally that parents associated with future pregnancy planning.

Smaller proportions reported informal or non-clinical sources, including online/social media (9.1%) and community or faith groups (3.0%). Open-text responses also highlighted specialist clinical input and informal networks, for example:

"I had gestational diabetes so the diabetic midwife." "Specialist service at St Mary's."

"Slimming World (due to previous weight loss before second pregnancy)." "Friends and family."

While subgroup analysis is limited by small numbers (n=19), responses did not vary significantly by ethnicity or language. This suggests that gaps in advice during pregnancy, particularly around weight gain, healthy eating and physical activity are system-wide rather than concentrated in specific ethnic or linguistic groups.

8.3.2 Perceptions about advice received during pregnancy

Four in ten respondents, 38.2% (n=26), said they did not receive any advice relating to healthy weight during pregnancy. Among those who did receive advice, feedback on it was mixed. While clarity was strong (83% (n=35) saying it was "*clear and easy to follow")*, fewer found the advice culturally tailored or practically relevant**.** *(*38% (n=16) found it "*practical for daily life").*

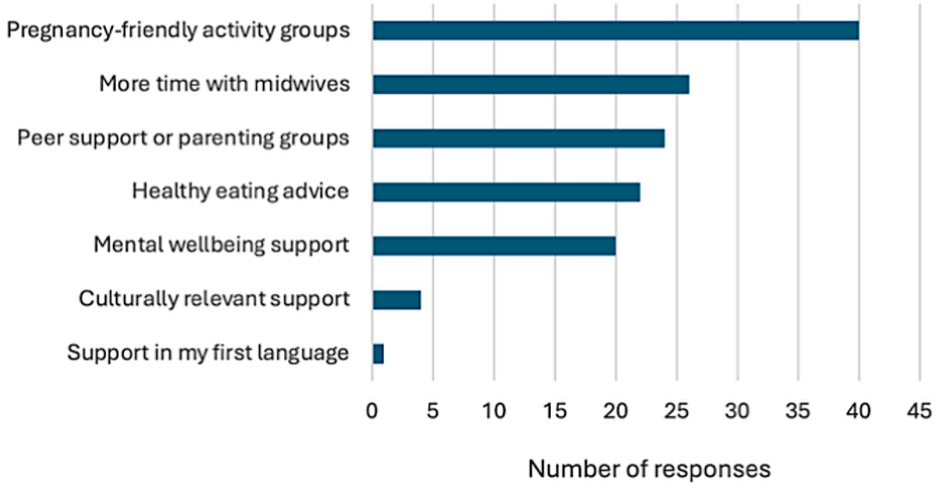
When the data is filtered to respondents whose language spoken at home was not English (n=17) only 2 (12%) said the advice was in their preferred language and that it was culturally sensitive. And when filtered to respondents from a background other than White British (n=24), only

3 (12.5%) said the advice was in their preferred language and only 2 (8.3%) said it was culturally sensitive. While caution must be taken due to the very small sample size making it impossible to draw firm or generalisable conclusions, the consistently low proportions across both groups suggest that language and cultural relevance may be important barriers for some families and point to the value of further exploration.

Additional support needs during pregnancy

Three quarters of respondents identified additional support that would have helped them more in relation to health weight in pregnancy. Of those that did, almost two-thirds of respondents (64%) said '*pregnancy-friendly activity groups'*, whilst 41% wanted '*more time with midwife'* and 38% wanted 'access to *peer support or parenting groups'.* '*Healthy eating advice'* and '*mental wellbeing support'* where also highlighted by around a third of responders

Figure 30: What would have helped you in relation to healthy weight during pregnancy?



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Others commented on:

- A lack of confidence to exercise safely, despite being physically active pre-pregnancy
- The absence of weight monitoring or support despite being classed as high-risk
- The minimal attention paid to diet or exercise during routine maternity care:

Responses to these questions from a background other than White British women showed broadly similar patterns of confidence and support needs to the wider group. However, a higher proportion (20%) selected '*culturally relevant support'* as something that would have helped during pregnancy, suggesting a stronger desire for services that reflect cultural identity and lived experience.

8.3.3 Implications for support and service design

Together, these findings point to significant gaps in the consistency, reach, and cultural relevance of healthy weight support across the pregnancy pathway. The survey results suggest that while midwives are the most common source of advice, large proportions of women receive little or no guidance, with physical activity and gestational weight gain advice particularly under-emphasised. This mirrors national evidence, which highlights variable coverage of these topics in maternity care.[230] [231] [232] The reliance on informal or commercial sources, such as family, online platforms, or slimming groups, further reflects wider research showing that many women navigate pregnancy advice independently, often encountering inconsistent or non-evidence-based messages.[233] [234]

The low proportions of respondents reporting culturally tailored or language-specific support, though based on small numbers, are also consistent with national concerns that maternity services can be insufficiently responsive to the needs of diverse populations.[235] [236]

Across the data, the evidence indicates that the challenge is not isolated to particular groups, but reflects a system-wide shortfall in accessible, inclusive, and practical healthy weight support during pregnancy.

8.4 Support Needs Across Breast Feeding and Weaning

Breastfeeding initiation and continuation emerged as important themes within the community survey, with responses suggesting more positive patterns than those seen in routine data. However, comparisons underline a continued need for local action to support sustained breastfeeding and to build confidence around weaning.

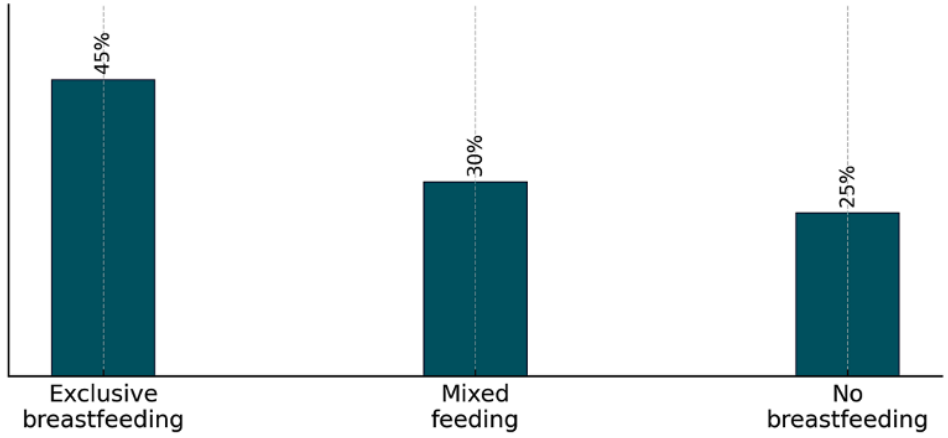
8.4.1 Breastfeeding initiation

Among survey respondents, three-quarters reported initiating breastfeeding, higher than the England average of 70.1%.[237] Nearly half (45%) of all respondents breastfed exclusively.

While these findings are encouraging, they contrast with local population-level figures. In 2023/24, just 55.6% of babies born in Tameside received breast milk as their first feed, substantially below both the national (70.1%) and regional averages (67.3%).[238] Local provider data from Tameside & Glossop ICFT reports a higher figure of 66.4%, based on hospital discharge records.[239]

The higher initiation rates reported in the survey are likely to reflect a small, self-selecting sample more engaged with health and early years issues and therefore cannot be directly compared to borough-wide data reported by OHID or ICFT.

Figure 31: Breast feeding initiation rates among survey responders

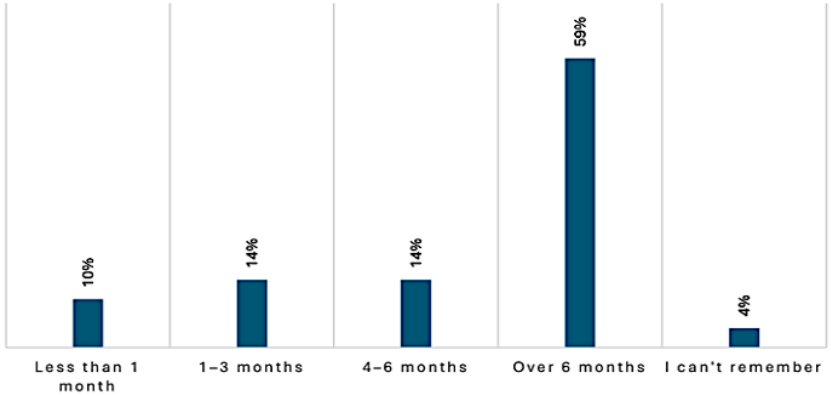


8.4.2 Breastfeeding duration

Survey findings also suggested higher breastfeeding continuation rate than routinely observed locally, with more than half of respondents breastfeeding beyond six months. This contrasts with sharp drop-offs in Tameside's routine data, which shows only 39.9% of babies being breastfed at 6–8 weeks,[240] well below the England average of 52.7%.[241]

These findings highlight the persistent challenge of sustaining breastfeeding beyond the early postnatal period. While the survey paints a more positive picture, routine data suggests many local families struggle to continue breastfeeding, often linked to practical, social, and emotional barriers

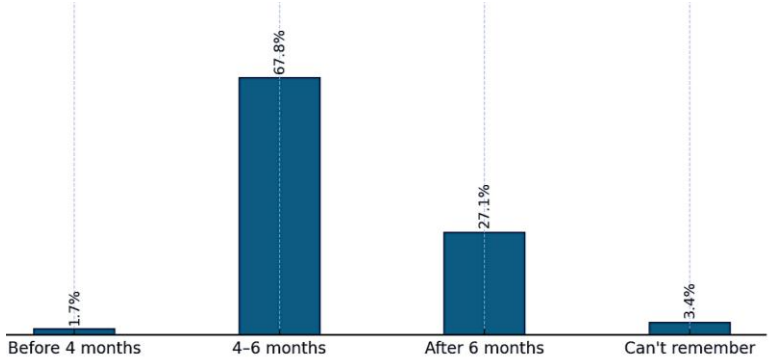
Figure 32: Duration of breast feeding among survey responders



8.4.3 Weaning

When asked about the age at which solid foods were introduced (n=59), most respondents reported following NHS guidance to begin at around six months. Only one respondent reported early weaning before four months.

Figure 33: Age at which solid foods were introduced amongst survey responders



The survey wording used a broad 4–6-month category, which makes it difficult to distinguish between those following NHS guidance to start "around six months" and those introducing solids earlier. This limits the precision of interpretation but still highlights variation in weaning practices and the need for clear, consistent support for families.

The proportion reporting weaning beyond six months (27%) may include both parents who introduced solids shortly after six months (e.g. at six months and one week, when their child was deemed ready) and those who introduced solids much later. The survey wording does not allow us to distinguish between these groups, so this should not be interpreted solely as a "delay". Nonetheless, the variation reinforces the need for personalised support and culturally competent advice on timing and approach to weaning.

Survey responses indicate variation in parental confidence around weaning and infant feeding. Fewer than one in ten (8.3%) described themselves as "extremely confident" and around one in three (31.7%) as "very confident". Almost half (46.7%) felt only "somewhat confident", while a further 13.3% expressed low levels of confidence ("not so confident" or "not at all confident"). These findings suggest that while many families feel moderately assured, a significant minority may benefit from additional targeted support to ensure consistent feeding practices. It should be noted that all respondents were already parents, so levels of confidence may reflect previous experience with older children.

When asked about sources of advice, health visitors were most frequently cited (54.8%), underlining their pivotal role in early years nutrition. Online and social media sources were accessed by almost one third of respondents (32.3%), while over a quarter (27.4%) drew on friends and family. Engagement with Family Hubs was reported by 25.8% of respondents, and a smaller proportion sought advice from GPs or nurses (8.1%). Notably, one in eight families (12.9%) reported receiving no advice at all.

Families also valued community-based and voluntary sector input. This included advice from community nursery nurses, voluntary organisations such as Spoons (a neonatal support charity), and Home-Start, which provides parent-to-parent support in the early years. As one respondent reflected: *"The community nursery nurse at the children's centre gave the most useful advice — practical, easy to understand and tailored to my child."*

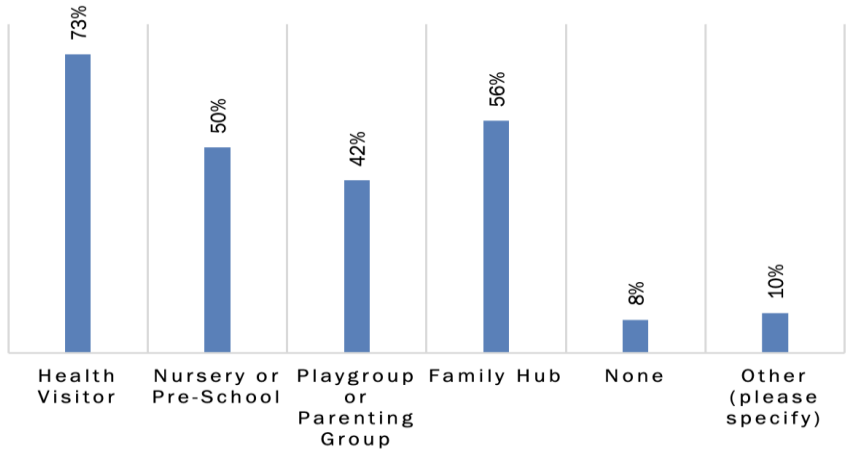
These findings point to both opportunities and gaps. Families are drawing on a diverse mix of professional, community, and digital sources. However, reliance on online information and the absence of support for some households highlight the need for more consistent and accessible weaning advice across the system. Sustained breastfeeding support, culturally responsive weaning guidance, and stronger outreach to families with lower confidence will be critical to improving early nutrition and healthy weight outcomes in Tameside.

8.5 Access and Experience of Early Years Settings

Most respondents (92%) reported engaging with at least one early years' service. Health visitors were the most commonly accessed (73%), followed by Family Hubs (56%). Around half of respondents had used nursery or pre-school settings (50%), while just over two in five (42%) reported attending playgroups or parenting groups. A smaller proportion reported accessing other sources of support (10%), and fewer than one in ten (8%) indicated that they had not used any early years services.

Home-Start was frequently mentioned, alongside references to breastfeeding support groups, twin groups, and telephone advice. Families also highlighted the role of community-based activity groups, such as sensory, swimming, and music sessions, as well as libraries. This suggests that parents draw on a broad mix of statutory, voluntary, and informal services to support both child development and maternal wellbeing

Figure 34: Use of early years services amongst survey responders



Experiences of early years services were generally positive. Over four in five respondents (81.4%) reported that services were easy to access, and nearly three-quarters (72.9%) found them welcoming and inclusive. It should be noted, however, that these views may reflect a degree of self-selection: many respondents were likely engaged via an early years' service promoting the survey, and therefore more positively connected to provision than the wider population.

Among respondents not identifying as White British (n=14), only 30.8% reported services as culturally appropriate and 23.1% as available in their preferred language. Although numbers of responders are small, these findings reinforce the importance of culturally responsive provision.

8.5.1 Suggestions for improving early years services to support healthy weight

Parental exercise and fitness: The most common theme raised by parents in the survey was the need for opportunities for parents, particularly new mothers, to be physically active in ways that fit around

childcare. This included pregnancy-friendly classes, outdoor activities for parents and children together, and affordable family-focused initiatives.

"More outdoor activities for young children and parents, so both can be active together."

"Pregnancy friendly exercise classes that are affordable and accessible."

Weight management and monitoring. Respondents stressed the importance of consistent weight monitoring for both mothers and children, and follow-up where concerns arise. Some expressed frustration about missed opportunities for early intervention.

"Weight taken at midwife appointments and postnatal checks, with advice if there's a concern."

"I didn't hear anything at all about healthy weight after my baby turned one – more follow-ups would help."

Healthy eating and nutrition education. Parents highlighted a need for practical, affordable nutrition advice, including cooking sessions and meal planning. Some explicitly linked this to the cost-of-living crisis.

"By giving us information about healthy eating that's practical and easy to follow."

Health visitor services. Several responses called for greater visibility of health visitors, including presence in community venues. This reflects wider survey findings about the importance of trusted professionals.

Weaning and nutrition guidance. Respondents highlighted a lack of consistent follow-up after breastfeeding advice, particularly around the transition to solids. One parent specifically requested clearer guidance on fussy eating:

"More advice regarding fussy eating and what is normal."

Alongside this, some noted gaps in provision for single parents and families needing more tailored support, while a few respondents expressed satisfaction with current services. One emphasised the value of integrating healthy weight advice with broader maternal wellbeing support, such as counselling.

8.6 Awareness, Use, and Perceived Usefulness of Local Services

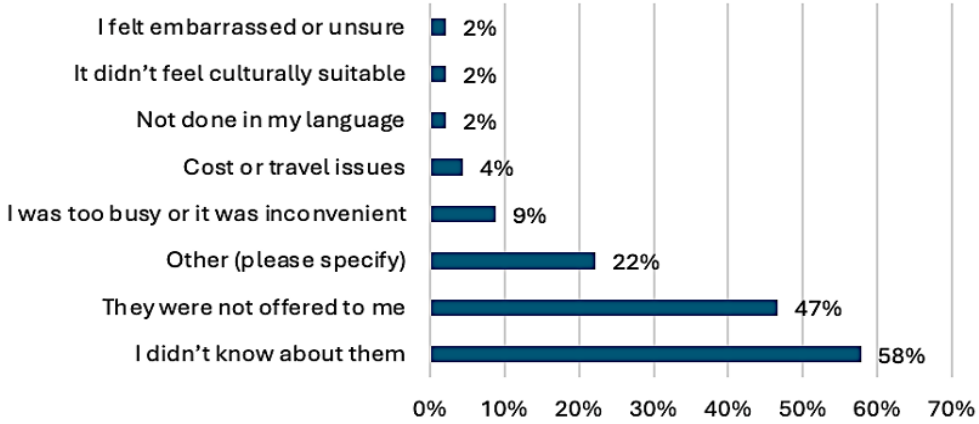
Survey respondents (n=61) reported varying levels of awareness of local maternal and early years services. Awareness was highest for statutory or long-standing offers, including the Health Visiting Service (70.5%), Infant Feeding Team (63.9%), the NHS Healthy Start scheme (54.1%), and Family Hubs (52.5%). By contrast, fewer respondents had heard of Be Well Tameside (36.1%), Cook4Life (13.1%), the Children's Nutrition Team (13.1%), or Jumps 4 Life (3.3%).

Among those who had used services, perceived usefulness was consistently high. The Health Visiting Service was described positively by over nine in ten users, with 42.9% finding it "very useful" and 47.6% "somewhat useful". The Infant Feeding Team was also highly rated, with 65.5% of users describing support as "very useful". Family Hubs (children's centres) received the strongest endorsement, with all respondents who used them reporting a positive experience. Smaller numbers of families had engaged with Be Well Tameside or the NHS Healthy Start scheme (though this is not a universal offer and only 1–2,000 families in Tameside are likely to be eligible), but many of these users found them helpful.

Barriers to uptake were primarily linked to lack of awareness and absence of a proactive offer. Over half of those not using services reported that they "didn't know about them" (57.8%), while nearly half (46.7%) said services "were not offered to me". These findings are particularly striking for statutory offers: almost a quarter of respondents (24.6%) reported not using the Health Visiting Service, which is a universal entitlement under the Healthy Child Programme, so most

probably reflects recall issues. For Healthy Start, although not all families would be eligible, the fact that over half of respondents reported not using it may still indicate that some eligible families are missing out due to barriers around awareness or application.

Figure 35: Reasons for not using early years services



Qualitative feedback reflected this mixed picture. Parents often praised group-based provision within family hubs (children's centres) and noted that Healthy Start was widely promoted.

"Friends and family have used children's centres and have spoken positive words about the classes and groups there. Healthy Start is promoted so I see a lot about that despite not being eligible."

However, others reported more negative experiences, particularly around infant feeding support. One respondent described feeling undermined and pressured, despite their baby thriving:

"I overall had a very negative experience… I was left with absolutely no confidence and only carried on breastfeeding due to peer support, online support and Home-Start…"

When asked directly about positive experiences with maternal or early years services, the majority (80.7%, n=46) said they had benefitted, though nearly one in five (19.3%) said they had not. Families particularly valued breastfeeding and infant feeding support delivered by Home-Start, flexible approaches that allowed them to choose their level of involvement, and high-quality care in specialist contexts such as pregnancy loss or diabetes in pregnancy. As one parent put it:

"When I lost my baby at 16 weeks the staff were amazing with me and my partner. Also, with my previous pregnancy I got a lot of help with my diabetes."

Even within broadly positive feedback, gaps were identified. Some parents felt that postnatal follow-up was limited, particularly for mental health support:

"Midwives once involved were great but once I had the baby I never heard from them again despite reaching out. I feel postpartum mental health involvement is equally as important pre and postpartum."

This feedback highlights the importance of seamless handover between midwifery and health visiting, ensuring families know where to turn after discharge from maternity care. It points to the value of a 'no wrong door' approach, where parents are supported to navigate the system and do not feel responsibility lies solely with one service.

8.7 Improving Services and the Local Environment for Healthy Weight and Wellbeing

Parents and carers described what would make local services more useful, what prevents them from eating well or being active, how their local area could be improved for healthy living, and what new maternity or early years services they would like to see. These findings point to opportunities for both service development and wider environmental change.

8.7.1 Service visibility, accessibility and eligibility

A recurring theme was that many families were unclear about what support was available or how to access it, echoing earlier findings on limited awareness as a major barrier. Parents highlighted the need for better advertising and signposting, with updated timetables, social media promotion, and clearer information at health appointments. Concerns were also raised about eligibility, with some families feeling that support was targeted only at low-income households, leaving working families excluded. Flexibility was another priority, with calls for evening and weekend options to accommodate parents in employment. As one parent explained: *"Being given information about all the available services to enable me to make informed decisions around what we could access."*

8.7.2 Affordability and financial support

Cost was raised relating to both healthy food and access to activities. Families suggested expanding the NHS Healthy Start Scheme, subsidising toddler and baby groups, and providing more free or low-cost opportunities for family activity, underlining the role of affordability as a determinant of healthy behaviours. Though the NHS Healthy Start Scheme is a national scheme of which the eligibility cannot be changed locally in Tameside.

8.7.3 Quality and scope of provision

Parents expressed a desire for more varied and higher-quality provision in family hubs (children's centres) and local parks. Suggestions included additional parent-and-child groups, more consistent breastfeeding advice, and stronger postnatal mental health support. Families also called for exercise classes tailored to pregnancy and postnatal recovery (including after caesarean birth), parent–child activity sessions, and cooking or healthy eating classes designed for the whole family. One parent described the need for more integrated support: *"Maternity and health visiting to provide whole family food and meal support — cooking classes, with weaning etc., exercise classes for mums and toddlers… More breastfeeding support and acceptance."*

8.7.4 Local environment and safety

Parents also drew attention to environmental barriers to healthy living. Concerns included poor condition of parks and play areas, lack of age-appropriate equipment, and spaces geared only to very young children. Safety was also raised, with antisocial behaviour, dog fouling, unsafe dogs off leads, litter, and poor maintenance all reducing families' confidence in using outdoor spaces. In addition, the limited availability of healthy food options in local shops and the high density of fast-food outlets were cited as barriers, alongside accessibility challenges for disabled parents and poor pedestrian infrastructure. As one parent commented: *"Parks are dull and uninviting. Local groups such as story walks and outdoor explorers are great, but poorly advertised… No healthy eating advice for average weight families."*

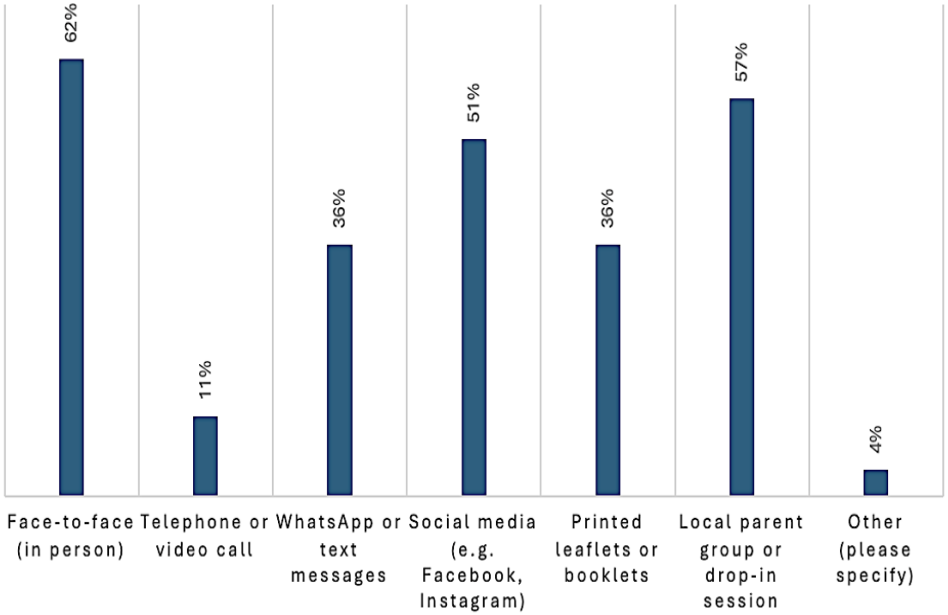
What comes through most clearly is that while services and community assets play an important role in promoting healthy behaviours, their visibility, affordability, and inclusivity remain uneven. Families also view improvements to the local environment as central to supporting healthier lifestyles during pregnancy and the early years.

8.8 Preferred Ways to Receive Information and Support

At the end of the survey, respondents were asked how they would most like to receive information or support about healthy eating, physical activity, or child health.

Face-to-face contact was the most popular choice overall (62.3%), reflecting the value parents place on personal interaction and the opportunity to ask questions directly. Within this, local parent groups or drop-in sessions were also highly favoured (56.6%), underlining the importance of informal, community-based settings where peer support is available alongside professional advice.

Figure 36: Communication channels preferred by parents/carers for healthy weight information



Social media was selected by just over half of respondents (50.9%), highlighting the importance of digital platforms in reaching families quickly and consistently. More than one in three respondents said they would welcome communication via WhatsApp or text messages (35.9%), suggesting demand for accessible and immediate updates through everyday channels. Printed leaflets or booklets were also valued (35.9%), with parents noting their usefulness for reference or sharing within the household. Fewer families expressed interest in telephone or video calls (11.3%, n=6), though these may still have value for specific needs or follow-up.

The findings point to the need for a blended approach. Families value both direct contact and community groups, alongside flexible use of digital and printed media. Tailoring the channel to the type of information and level of interaction required will be key to ensuring messages are both accessible and effective.

8.9 Final Reflections – Community Conclusions Informing the Needs Assessment

The community survey provides a valuable insight into how families in Tameside experience services, navigate everyday challenges, and perceive opportunities for healthier routines in the early years. While the findings should be read alongside service data, stakeholder interviews, and national benchmarks, several themes stand out that are important in shaping the wider needs assessment.

Parents and carers described strong satisfaction with peer-led and community-based offers such as Home-Start breastfeeding groups and family hub sessions, particularly where they were flexible, welcoming, and responsive to family needs. Specialist and compassionate care in circumstances such as pregnancy loss or complex health conditions was also highly valued. These examples highlight the difference that trusted relationships and personalised support can make in enabling families to sustain healthier behaviours.

At the same time, the survey highlighted persistent barriers. Many families remain unaware of available services or have not proactively offered them, even when provision is statutory or universal. Access is shaped by affordability, availability in certain areas, and flexibility of timing, which can limit engagement for working parents or those with restricted transport. Consistency and quality of advice were also raised, with some families reporting gaps or discouraging experiences, particularly around breastfeeding, postnatal care, and managing fussy eating.

Environmental barriers add another dimension. Parents described poor-quality play spaces, safety concerns, and limited availability of affordable healthy food, underlining the influence of local conditions on

family routines. At the same time, families offered constructive ideas for improving communication, suggesting that a blended approach combining face-to-face contact, group-based support, digital channels, and printed information would be most effective.

While the survey was self-selecting and may over-represent families already engaged with services, or those with particularly positive or negative experiences, it nonetheless provides an important window into lived realities. The demographic profile confirms that many respondents were drawn from areas of high deprivation, adding weight to findings around cost, access, and affordability. Some comments also pointed to the need for culturally appropriate provision and clearer information for families whose first language is not English, although these were less frequently reported.

Collectively, these insights suggest that Tameside has a strong base of trusted, valued provision to build upon, but further work is required to ensure awareness, accessibility, and environmental enablers are consistently in place. Addressing these issues will be critical in achieving equitable outcomes for families across all communities.

9. Bringing the Findings Together

Bringing together population data, stakeholder perspectives and community insight provides a consistent picture of the factors shaping maternal and early years healthy weight in Tameside. Across sources, there is agreement on the strengths of existing provision, the barriers families face, and the underlying needs that drive inequalities.

Strengths to build from

Families consistently described positive experiences with community-based and peer-led provision, including Home-Start breastfeeding groups and family hub activities. These services were valued for being flexible, welcoming and responsive to family needs. Stakeholders echoed this, emphasising the importance of continuity and relationship-based care across maternity, health visiting and early years pathways. National evidence supports this emphasis on trusted, local provision, with continuity and peer support linked to improved maternal and child health outcomes.[242] [243]

Persistent barriers

Across all data sources, several barriers emerge consistently. Cost and affordability were central, with families directly linking difficulties in sustaining healthy diets to rising food prices and limited household budgets. This reflects wider research showing that healthier diets are least affordable for families in deprived communities.[244] [245] Time pressures and competing demands were also repeatedly cited, with parents describing how “time poverty” made it harder to plan meals or be active.

Service-related barriers were evident in both community responses and stakeholder reflections. Families reported a lack of awareness of what is available, confusion about eligibility, and frustration at limited scheduling or follow-up. Stakeholders similarly highlighted gaps in consistency, with variation in postnatal and feeding advice leaving some parents feeling unsupported. These issues contribute to uncertainty and missed opportunities for prevention.

Environmental influences

The role of the local environment was also raised across evidence sources. Community responses described poor-quality or unsafe parks, antisocial behaviour, and a lack of affordable healthy food options, while local data shows higher densities of fast-food outlets in deprived areas. These concerns mirror national findings that neighbourhood food and activity environments strongly influence weight outcomes.[246] [247]

Equity as a cross-cutting theme

Equity threads through all sources. Local data shows a steep social gradient in early years outcomes: for example, reception obesity rates are higher in the most deprived wards and breastfeeding continuation remains below national averages. Families in deprived areas most often reported cost and transport challenges, while survey responses also highlighted the need for culturally appropriate provision and materials in accessible languages. Stakeholders underlined the same point, warning that services risk being less visible or inclusive for some communities. These findings reinforce national policy emphasis on proportionate universalism and culturally responsive care.[248] [249]

Maternal wellbeing as a foundation

Maternal mental health was repeatedly identified as a prerequisite for sustaining healthy family routines. Parents linked stress and low confidence to difficulties in feeding and activity, while stakeholders described maternal wellbeing as essential to behaviour change. National reviews confirm this connection, with perinatal mental health problems associated with adverse child development and obesity trajectories.[250] [251]

System leadership and coordination

Across stakeholder and community insight, a consistent message emerged around the need for clearer system leadership, better mapping of services, and more coordinated infrastructure. Families described confusion about eligibility and a lack of clear signposting, while stakeholders emphasised the risk of fragmentation without stronger alignment across maternity, health visiting, early years, and voluntary sector provision. Both groups highlighted the importance of sustained investment and continuity, noting that short-term projects or variable offers undermine trust and engagement. The survey findings on limited awareness of core services reinforce this point, suggesting that system-level coordination, visibility, and accountability are as important as individual service improvements.

Summary

The evidence converges on a clear picture. Tameside has a base of trusted, valued provision rooted in community and peer-led models. Yet inequalities remain entrenched, with outcomes closely tied to deprivation, cost pressures and environmental constraints. Families and professionals identify similar needs: clearer information and proactive offers, more consistent and culturally appropriate support, and environments that enable rather than constrain healthy routines. These needs manifest less in a lack of knowledge or willingness, and more in the intersecting pressures of affordability, accessibility and maternal wellbeing.

10. Recommendations

The synthesis of findings points to consistent priorities across families, professionals and local data. To address these, recommendations are organised under five domains: system leadership and infrastructure, services and pathways, families and communities, workforce, and environment**.**

1. System Leadership and Infrastructure

Rationale: The assessment shows fragmentation and variability in provision, with families and stakeholders highlighting confusion about service eligibility and a lack of clear leadership. Strengthened system coordination and sustained investment were consistently identified as necessary to prevent short-term, piecemeal delivery.

Actions:

- Establish clear local leadership for maternal and early years healthy weight, with accountability across council, NHS and VCFSE partners.
- Work to secure sustained investment in early years and prevention programmes, moving beyond short-term pilots to longer-term system commitments.
- Continually review and ensure 'Grow' is updated and includes relevant and up to date borough-wide directory of services and assets for maternal and early years support, including VCFSE and community-based provision, to improve coordination, visibility and support referral pathways for both residents and professionals.
- Continue to strengthen governance and partnership arrangements so healthy weight becomes a cross-cutting priority, embedded across maternity, early years, public health and wider determinants agendas.
- Recognise and place greater value on community-based assets, ensuring their sustainability and integration, given the strong evidence from families and stakeholders that these services are trusted, accessible and impactful.

2. Services and Pathways

Rationale: Survey and stakeholder feedback pointed to poor visibility of services, limited scheduling options, and inconsistent pathways across maternity, health visiting, and early years. Families described missing support due to unclear information and disjointed referral processes, reinforcing the need for more coherent, accessible pathways.

Actions:

- Improve visibility and clarity of local services through coordinated promotion, proactive offers at key contact points, and simple eligibility messaging. This should include consistent communication to both professionals and families, so frontline staff are confident in what schemes are available and can actively signpost families.
- Seek to provide equitable access to services and targeted provision in underserved neighbourhoods.
- Strengthen continuity and relationship-based care across maternity, health visiting, early years and VCFSE provision, helping families to experience more seamless pathways and better understand what support is available at each stage of the journey.

3. Families and Communities

Rationale: Families consistently valued peer-led and community-based support, such as Home-Start groups and family hubs, but also called for more practical, culturally appropriate offers. The data shows that inequalities are shaped by deprivation, ethnicity, and language, underscoring the need to strengthen community-anchored models that reach and reflect diverse populations.

Actions:

- Build on valued models of peer support and broader community-anchored assets, increasing their reach and integration with statutory services.
- Co-produce practical support offers with parents (fussy eating, weaning, cooking on a budget, affordable family activity).
- Prioritise equity by tailoring communication and support for families whose first language is not English and embedding culturally competent practice.

4. Workforce

Rationale: Evidence highlights variable staff confidence in discussing weight, feeding, and routines, with some families reporting inconsistent or conflicting advice. Previous training offers have had limited uptake, suggesting that leadership prioritisation and accessible formats are needed to enable staff to build and sustain skills across the system

Actions

- Seek to invest in and enable workforce development by building staff confidence in sensitive conversations about weight, nutrition, routines, and maternal mental health awareness. This should include leadership commitment to prioritise training, releasing staff time, and developing accessible formats (e.g. recorded or modular offers) to ensure consistent uptake.
- Provide consistent tools and resources for health visitors, midwives and early years staff, ensuring families receive coherent messages.
- Support cross-agency pathways and information flows to reduce duplication and fragmentation.

5. Environment

Rationale: The assessment highlighted how the local food and activity environment shapes maternal and early years weight outcomes. Families described barriers such as poor-quality or unsafe parks, limited affordable leisure options, and high densities of fast-food outlets in deprived areas. Survey and stakeholder evidence also stressed the importance of accessible green space and affordable healthy food in reducing inequalities and supporting healthy family routines.

Actions:

- Improve the quality, safety and accessibility of parks and play spaces to encourage family use.
- Address local food environments through healthier food availability and tackling high fast-food density in deprived wards.
- Enhance transport and pedestrian infrastructure to support access to services, particularly for families without cars.

6. Cross-Cutting Priorities

Rationale: The assessment found significant gaps in early years weight surveillance, particularly before school entry, alongside discrepancies between national and local breastfeeding and birthweight data. Stakeholders highlighted the difficulty of planning without reliable information on service access, maternal risk factors, or equity of outcomes. Strengthening data quality and insight, and combining routine data with lived experience, is therefore essential for monitoring progress and shaping proportionate responses.

Actions:

- Ensure an inequalities lens is embedded as a core part of the healthy weight agenda.
- Apply proportionate universalism, ensuring universal offers but with extra support in high-inequality wards.
- Address current data gaps, strengthening ward-level monitoring of breastfeeding, healthy weight, and service uptake to guide targeted action.

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