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Committee

First 1000 days of life

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to the report*

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Health and Social Care Committee

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Summary

The first 1000 days of life, from conception to age 2, is a critical phase during which the foundations of a child's development are laid. If a child's body and brain develop well then their life chances are improved. Exposure to stresses or adversity during this period can result in a child's development falling behind their peers. Left unaddressed, experiences, such as abuse or conflict between parents, can stay with children throughout their lives, can cause harm to them and to others, and might be passed on to the next generation. Individuals with four or more adverse childhood experiences (ACEs) are at a much greater risk of poor health outcomes compared to individuals with no ACEs. They are also thirty times more likely to attempt suicide. Intervening more actively in the first 1000 days of a child's life can improve children's health, development and life chances and make society fairer and more prosperous.

Enhancing the ability of services to support and empower parents and families to take care of themselves and their children is vital, but not sufficient. Social stresses—poverty, poor housing and unstable employment—act against the ability of parents and families to create a safe, healthy and nurturing environment for their children. Improvements in service provision will only provide a 'sticking plaster' if the circumstances in which some of this country's poorest children grow up do not improve. We call on the Government to consider the needs of the most vulnerable families in all its policies across all departments.

Improving support for children, parents and families during this vulnerable period requires a long-term and coordinated response nationally and locally. The Government should lead by developing a long-term, cross-Government strategy for the first 1000 days of life, setting demanding goals to reduce adverse childhood experiences, improve school readiness and reduce infant mortality and child poverty. The Minister for the Cabinet Office should be given responsibility to lead the strategy's development and implementation across Government, with the support of a small centralised delivery team.

High-quality local services for children, parents and families should be founded on the following six principles:

- “proportionate universalism”, so services are available to all but targeted in proportion to the level of need,
- prevention and early intervention,
- community partnerships,
- a focus on meeting the needs of marginalised groups,
- greater integration and better multi-agency working; and
- evidence-based provision.

Each local authority area should develop, jointly with local NHS bodies, communities and the voluntary sector, a clear and ambitious plan to improve support for children, parents and families in the first 1000 days of life, which reflects these principles and

sets out how each area will meet key national goals. The Government should establish a fund, to which multiple departments contribute, to incentivise the transformation of local commissioning (including the pooling of resources between commissioners) and provision of services, in accordance with the six principles we have specified.

We have found significant variation in the way that local areas prioritise and support families in the first 1000 days. The Government must do more to bolster its ability to support local areas, hold them to account and intervene, when goals are not being met. In particular, the Government should seek to foster an environment of continuous improvement by filling gaps in research and encouraging local areas, through support and incentives, to identify, test, adopt and spread 'what works' to improve outcomes. We recommend the establishment of an expert advisory group to coordinate a national approach to filling gaps in research, and we agree with our colleagues on the Science and Technology Committee that local authorities would benefit from the support of a central specialist team with experience in effectively and sustainably implementing early intervention programmes.

We have found significant variation in staffing numbers, skills and the level of contact with families. Local areas must be supported to cultivate a skilled workforce, with an enhanced awareness of child development and adversity, and enhanced capacity and capability of staff to build relationships with the children, parents and families they work with. We recommend that the Government should publish a holistic workforce plan for services covering the first 1000 days. The plan should set out how the Government will support local areas at a system, placed-based and neighbourhood level to enhance the capacity, capability and skill mix of staff who support children, parents and families during the first 1000 days.

In 2009, the Government launched the universal Healthy Child Programme (HCP), with the aim of improving outcomes and reducing inequalities through a combination of universal provision and targeted support. The HCP is central to the delivery of the universal offer of prevention and early intervention services for children and families in England. 10 years on from its inception, we are calling for the Healthy Child Programme to be revised, improved and given greater impetus. We recommend that the programme should begin before conception, extend home visits beyond the age of 2½ years, become more family focused, and ensure children, parents and families experience continuity of care during this critical period.

Children and families who may need targeted support should be identified at the earliest opportunity, especially during pregnancy. Based on the experience of the Family Nurse Partnership and the Flying Start programme in Wales, we recommend that the Government should develop a programme that children and families who need more targeted support can access.

Investing in the early years is the best investment any government can make and saves money in the long-term. We recommend that the Government use the 2019 Spending Review as an opportunity to initiate the next early years revolution with a secure, long-term investment in prevention and early intervention to support parents, children and families during this critical period.

1 Our inquiry

1. Sir Michael Marmot’s review of health inequalities in 2010, the cross-party 1001 Critical Days Manifesto in 2013 and the Building Better Britons report by All-Party Parliamentary Group for Conception to Age 2 in 2015 all make a compelling case for more attention to be paid to the first 1000 days of a child’s life, from conception to age 2.¹ Support for children, parents and families during this critical period improves the health, development and life chances of future generations and benefits society. Our inquiry has focused on examining how current policy and practice supports children, parents and families during this period of a child’s life, with a view to making recommendations that may assist the Government and other bodies, nationally and locally.

2. Since we launched our inquiry, we have been pleased to see the Government’s Prevention Vision include within it an aspiration to give every child the best start in life, which builds on one of the key recommendations from Sir Michael Marmot’s review.² The Vision’s aspiration for the early years will be supported by the work of the Early Years and Family Support Ministerial Group, which was announced shortly after our inquiry launched.³ We welcome both the Government’s vision for prevention and the ministerial review. Our intention is to take oral evidence from Government, including representatives from the ministerial review, later this year.

3. We received almost 90 written submissions from our call to evidence from a broad range of parties with an interest in the first 1000 days. We also held an online forum on Mumsnet in which we heard directly from parents about their experiences of pregnancy and early parenthood, as well as the services they used during this time. We are hugely grateful to all those who took the time and effort to write to us. These submissions have provided a body of evidence which have formed the basis of our inquiry and helped inform our oral evidence sessions. We have used quotations from individual parents to illustrate the points we make throughout the report: those quotations can be found in boxes alongside the text of the report.

4. We held 3 oral evidence sessions as part of this inquiry during November and December 2018. In November, we visited the Blackpool Better Start project, run by the NSPCC and funded by the Big Lottery Fund, and held focus groups with representatives from councils, clinical commissioning groups and charities from across the country.

5. Our inquiry has focused on the importance of intervening early in childhood to improve people’s lives—their physical and mental health, their development and growth and their life chances—and the potential benefits of doing so for society. A safe, healthy start in life is important as an end in itself. Some children, for example those with a terminal illness, may through illness or disability not reach adulthood, or even school. For all others, their early years shape the rest of their lives. As we will show, children struggle to catch up when their health and development falls behind their peers during this period. The effects of adversity (neglect and abuse) during this time of a child’s life

1 Professor Sir Michael Marmot, Fair Society, Healthy Lives. The Marmot Review, 2010 APPG for Conception to Age 2 – The First 1001 Days, Building Great Britons, 2015, A cross-party manifesto, [The 1001 Critical Days: the importance of the conception to age 2 period](#), November 2015

2 Department of Health and Social Care, [Prevention is better than cure: Our vision to help you live well for longer](#), November 2018

3 Office of the Leader of the House of Commons, Cabinet Office and Rt Hon. Andrea Leadsom MP, [Leader of the commons to chair ministerial group on family support from conception to the age of two](#), 27 July 2018

can remain with them throughout their lives, causing repeated harm to themselves and sometimes harm to others. The cycle of adversity often continues between generations. By intervening successfully in this period to give every child the best start in life the Government can help make society fairer and more prosperous.

2 The first 1000 days from conception to age 2

6. The first 1000 days, from a child's conception to age 2, is a critical period. During this time of heightened vulnerability, the foundations of a child's health and development (physical, cognitive, social and emotional, and behavioural development) are laid and a trajectory is established.⁴ As Barnardo's told us:

When a baby's development falls behind the norm during the first year of life, for instance, it is much more likely that they will fall even further behind in subsequent years than catch up with those who have had a better start.⁵

7. With targeted and specialist support, it is possible to rebuild the brain properly and put children back on a course of healthy development,⁶ but doing so is very challenging.⁷ Sir Michael Marmot's review of health inequalities in 2010 stressed that "what happens in these early years, starting in the womb, has lifelong effects" on a person's health, wellbeing and life chances.⁸

8. In focusing on the first 1000 days of life, we do not mean to downplay the importance of intervention at other stages. The Early Intervention Foundation argued that it is important not to create a narrative where all opportunities to support child development are lost at the end of infancy.⁹ Interventions from age 2 can redress problems that occur during the early years of a child's life.¹⁰ Development continues throughout childhood and into adolescence. Risks and adversities children encounter later in childhood (e.g. parental conflict in the home or bullying at school) can prove detrimental to their future health, development and life chances.¹¹ Similarly, before conception, a parent's health can affect their child's health and development. Parents who are fit and healthy at the start of pregnancy tend to have healthier babies, as the Department of Health and Social Care point out.¹² To give every child the best start in life, intervention must begin before conception and continue throughout childhood.

9. Indeed, when thinking about interventions to improve health, development and life chances of future generations, it helps to take a transgenerational view,¹³ especially with regard to the prevention of the reoccurrence of abuse and trauma.¹⁴ Children are more likely to experience adverse experiences if their parents were also subject to abuse and trauma in childhood.¹⁵

4 [Q3](#) Anne Longfield, Lifestart Foundation ([FDL0036](#)), Barnardo's ([FDL0020](#)), Parent Infant Partnership (PIP) UK ([FDL0016](#))

5 Barnardo's ([FDL0020](#))

6 Early Intervention Foundation ([FDL0085](#)), Big Lottery Fund ([FDL0069](#))

7 [Q3](#) Anne Longfield

8 Professor Sir Michael Marmot, [Fair Society, Healthy Lives](#). The Marmot Review, 2010

9 Early Intervention Foundation ([FDL0070](#))

10 Early Intervention Foundation ([FDL0070](#))

11 Early Intervention Foundation ([FDL0070](#)), Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

12 Department of Health and Social Care ([FDL0067](#))

13 [Q145](#) Dr Alain Gregoire

14 WAVE Trust ([FDL0073](#))

15 WAVE Trust ([FDL0073](#))

10. Nevertheless, the first 1000 days is a critical period that deserves more attention from policymakers than it currently receives. During the late 1990s and the early 2000s, up to 2010, support for the early years was prioritised, according to the Marmot Review.¹⁶ A report by the Children’s Commissioner and the Institute for Fiscal Studies highlights that from 2000/01 to 2009/10 public spending on children rose rapidly, with increased spending on benefits for families and children’s services.¹⁷ During the late 1990s and early 2000s the Government prioritised reductions in child poverty, introduced the Healthy Child Programme and expanded the provision of SureStart centres across the country.¹⁸

11. According to the Marmot Review, published in 2010, these years resulted in a revolution in early years and parenting support. However, the review argued that continued investment and political commitment in the early years was needed to deliver long-term reductions in inequality.¹⁹ Instead, public spending on children has fallen, reversing some of the increases seen during the 2000s.²⁰ According to a report by the IFS and the Children’s Commissioner in June 2018 about public expenditure on children, child poverty (both relative and absolute poverty) had increased since 2010 and was projected to rise over the rest of the decade, in part due to planned cuts in benefit spending.²¹

12. Recently the Government has tended to focus on intervening later in childhood. The Government’s approaches to children’s mental health, obesity and even early childcare care focus more on intervening after age 2 than earlier in the crucial first 1000 days.²² A similar trend is evident locally. Clinical commissioning groups are responsible for commissioning mental health services for children aged 0–19, but very few provide services below age 5.²³ Where Government and public services do intervene in the early years, we have found that it has done so in a fragmented way, without any overarching strategic framework and with little join-up. The evidence we have received suggests much more can be done in the early years to tackle some of the major problems affecting children in our society today.

13. A child’s health and development are influenced by individual characteristics (e.g. genetics, personality and gender).²⁴ However, a child’s family, particularly their parents, their home, the community they live in and the wider society they are part of, all contribute significantly to their future health, development and life chances. These characteristics interact in a variety of often complex ways.²⁵ The characteristics that promote a child’s health and development (i.e. protective factors) and the characteristics that put their health and development at risk (i.e. risk factors) tend to be two sides of the same coin.²⁶ For instance, the Early Intervention Foundation point out that “poor parental mental health

16 Professor Sir Michael Marmot, [Fair Society, Healthy Lives](#). The Marmot Review, 2010

17 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018

18 Professor Sir Michael Marmot, [Fair Society, Healthy Lives](#). The Marmot Review, 2010

19 Professor Sir Michael Marmot, [Fair Society, Healthy Lives](#). The Marmot Review, 2010

20 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018

21 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018; Institute for Fiscal Studies, [Living standards, poverty and inequality in the UK: 2017/18 to 2020/21](#), November 2017

22 Frank Field (FDL0083), Parent Infant Partnership (PIP) UK (FDL0016), Maternal Mental Health Alliance (FDL0006), NCT (FDL0052), HENRY (FDL0037), Royal College of Paediatrics and Child Health (FDL0074)

23 Parent Infant Partnership (PIP) UK (FDL0016), Association of Child Psychotherapists (FDL0022),

24 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

25 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

26 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

may pose a risk to a child's healthy development, while good parental mental health may provide a protective factor against other negative child outcomes, such as behavioural problems or poor academic attainment."²⁷

14. The influence of a child's parents during these early years cannot be overstated. A child's health and development is influenced by their parents':

- physical health (e.g. diet, smoking, consumption of alcohol and substance misuse)²⁸
- mental health²⁹
- relationships (e.g. domestic violence and parental conflict)³⁰
- education³¹
- style of parenting and how they interact with their child, and³²
- choices for their child's health (e.g. on breastfeeding and immunisations).³³

15. Parental conflict, alcohol and substance misuse, mental health problems and a parent's own experience of trauma in childhood all increase the risk of adverse experiences in childhood.³⁴ These behaviours and experiences act against a parent's ability to interact, and form a healthy relationship, with their baby, which is vital for infants to form a secure attachment. Insecure or disorganised attachments are associated with a series of negative outcomes throughout childhood and across the life course.³⁵ The Children's Commissioner's report on vulnerability estimated the number of children in England living in families with adults who exhibit the key risk factors of domestic violence and abuse, alcohol and substance misuse and mental health problems. Over 1 million children aged 0–5, and almost 200,000 under the age of 1, live with an adult who has experienced domestic violence or abuse; just under 2 million children aged 0–5 live with an adult who has a mental health problem, including around 300,000 children under the age of 1; and over 600,000 children age 0–5 live with an adult with a reported substance misuse issue or who is dependent on drugs or alcohol, including over 100,000 children under the age of 1.³⁶

27 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

28 Public Health England ([FDL0077](#)), Nuffield Trust ([FDL0048](#)), Royal College of Paediatrics and Child Health ([FDL0074](#)), The Royal College of Midwives ([FDL0051](#)), WAVE Trust ([FDL0073](#)), Early Intervention Foundation ([FDL0070](#)), Association of Directors of Public Health ([FDL0059](#))

29 WAVE Trust ([FDL0073](#)), Maternal Mental Health Alliance ([FDL0006](#)), Association of Directors of Public Health ([FDL0059](#)), Royal College of Psychiatrists ([FDL0039](#))

30 Royal College of Psychiatrists ([FDL0039](#)), Tavistock Relationships ([FDL0071](#)), WAVE Trust ([FDL0073](#)), Early Intervention Foundation ([FDL0070](#)), The Royal College of Midwives ([FDL0051](#)), Institute of Health Visiting ([FDL0031](#))

31 Early Intervention Foundation ([FDL0070](#)), Association of Directors of Public Health ([FDL0059](#)),

32 WAVE Trust ([FDL0073](#)), Association of Directors of Public Health ([FDL0059](#)), Action for Children ([FDL0044](#)), National Children's Bureau ([FDL0050](#)), Insight Parenting/GroBrain ([FDL0064](#))

33 The Royal College of Midwives ([FDL0051](#)), Nuffield Trust ([FDL0048](#)), Royal College of Paediatrics and Child Health ([FDL0074](#)), Unicef UK ([FDL0004](#))

34 Royal College of Psychiatrists ([FDL0039](#))

35 WAVE Trust ([FDL0073](#))

36 The Children's Commissioner, [Estimating the prevalence of the toxic trio: vulnerability technical report 2](#) July 2018.

16. Risks to a child's health and development have some important characteristics. The risks to children in this early period are often not immediately identified, but can have lifelong consequences. These risks are often:

- hidden.³⁷ For example, most of what happens during this early period of a child's life takes place within the privacy of people's homes, rather than in public.³⁸ Many of those who responded to our online forum expressed feeling very lonely and isolated after their child's birth, especially when they had no family or services nearby.³⁹
- the consequence of behaviours that are very difficult, and often time consuming and resource-intensive, to support, manage and/or remedy. Stigma associated with these behaviours makes it difficult for a parent to disclose information and therefore for a practitioner to identify a problem.⁴⁰ For example, some women who responded to our online forum reported that they actively tried to hide that they were experiencing symptoms of postnatal depression from friends, family and professionals.⁴¹
- strongly influenced by wider social factors.⁴²

17. The risks to children from conception to age 2 and the outcomes they achieve are strongly linked to their social circumstances.⁴³ According to the Health Foundation:

Good development in the first 1000 days is also strongly socially patterned, with clear inequalities evident by socio-economic position from an early age. By the time children get to school, there are already big differences in their levels of development which persist and amplify over time.⁴⁴

18. Poverty, poor housing and unstable, low paid work are examples of social stresses that act against the ability of parents to provide a secure, healthy, nurturing environment during the early years of a child's life.⁴⁵ Poverty is a major factor for other risks too. Smoking in pregnancy, breastfeeding rates and obesity in pregnancy all adversely affect a child's health and are all more prevalent among poorer households.⁴⁶

We had to move into rented accommodation when my first daughter was small. I had had no idea how insecure rented accommodation was, especially for those who are not well off. We've negotiated and worked ourselves into a better position now, but many can't, or haven't, yet. Insecure housing is such a stress for parents and children suffer as a result.

Source: Mumsnet survey

37 Unite the union ([FDL0066](#))

38 Frank Field ([FDL0083](#))

39 See Annex 1

40 Institute of Health Visiting ([FDL0031](#)), Barnardo's ([FDL0020](#))

41 See Annex 1

42 The Health Foundation ([FDL0081](#)), Early Intervention Foundation ([FDL0070](#)), Royal College of Paediatrics and Child Health ([FDL0074](#)), Nuffield Trust ([FDL0048](#))

43 The Health Foundation ([FDL0081](#)), Early Intervention Foundation ([FDL0070](#)), Royal College of Paediatrics and Child Health ([FDL0074](#))

44 The Health Foundation ([FDL0081](#))

45 [Q2](#) Dr Angela Donkin, Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018, The Health Foundation ([FDL0081](#))

46 Nuffield Trust ([FDL0048](#)), Royal College of Paediatrics and Child Health ([FDL0074](#)), The Royal College of Midwives ([FDL0051](#))

19. A child’s home environment exerts an important influence over their future health and development.⁴⁷ A child’s home, family and community environment is a place where a lot of learning takes place during these early years. As the National Children’s Bureau explain, “parents who engage in meaningful activities that encourage thinking and talking to stretch a child’s mind as part of everyday life can enhance their child’s development significantly.”⁴⁸ We were told that enhancing the provision of home visits, especially for children in low-income families, should be a priority for future investment.⁴⁹

Improving support for children, parents and families in the first 1000 days

20. The challenge of giving every child the best start in life begins before conception and continues throughout childhood. The first 1000 days of a child’s life represent a critical phase of heightened vulnerability, but also a window of enormous opportunity. Many of the factors that influence a child’s health, development and life chances are amenable to policy intervention. By intervening in this period policymakers, working together with parents, services and local communities, can make a positive difference both to the lives of individuals and to society.

21. The multifaceted nature of the risks to children in this early period requires a holistic rather than a fragmented response, both nationally and locally. A long-term, holistic and coordinated approach to the first 1000 days should consist of interventions across, and between, the four pillars of population health outlined by The King’s Fund: people’s healthy behaviours and lifestyles; the places and communities where people live; the health and social care system people use; and the wider social determinants that impact on their health.⁵⁰

22. Services play an important role in supporting and empowering parents to take care of their children and themselves. However, the evidence we have seen in the course of this inquiry demonstrates that improving service provision is not sufficient. Social stresses—low income, poor housing and low paid insecure employment—act against the ability of parents to provide a safe, stable and nurturing environment for their children during this vulnerable period. Improved service provision will provide only a sticking plaster if the underlying circumstances in which some children grow up, particularly the poorest, are not improved. **We recommend that the Government consider the needs of vulnerable families in all policies.**

47 Frank Field ([FDL0083](#))

48 The National Literacy Trust, National Children’s Bureau (NCB), Peeples and the Foundation Years Trust, [Home Matters: making the most of the home learning environment](#), March 2018

49 Frank Field ([FDL0083](#)), Early Intervention Foundation ([FDL0085](#))

50 The King’s Fund, [A vision for population health: towards a healthier future](#), November 2018

3 Local service delivery

Principles for local service delivery

23. We heard throughout the inquiry that the following 6 principles should be used to underpin local approaches to the first 1000 days: ‘proportionate universalism’; a focus on prevention and early intervention; co-design of services with the local community; engaging with and supporting marginalised communities; multi-agency working; and delivering evidence-based interventions.

Proportionate universalism

24. The Marmot Review described the concept of ‘proportionate universalism,’ an approach to reducing health inequalities with a balance of universal and targeted services, whereby those services are delivered in proportion to the level of need.⁵¹ If targeted services exist without universal services, it is only the most vulnerable children who are identified, often very late, and there is no foundation for identifying other, less vulnerable children and families. If universal services exist without targeted services, there is no recourse to provide an enhanced level of support where appropriate.⁵²

25. The principle of proportionate universalism is supposed to guide the provision of the mix of universal and targeted provision that comprises the landscape of services covering the period from conception to age 2 in England.⁵³ In practice, however, these services are neither delivered nor commissioned in accordance with this principle, as demonstrated by the inadequate and unbalanced implementation of existing services such as the Healthy Child Programme, and variations in targeted services available locally, both discussed later in this report.

I feel because I seem quite outwardly capable there was an assumption from health professionals that I'd thrive with my second child because I'd done it once before, but I really didn't find that to be the case. No-one picked up how awful I was feeling. When I tried to explain how I felt the health visitor tried to play it down and made my experience fit a narrative that didn't really apply.

Source: Mumsnet survey

Delivering prevention and early intervention

26. Public spending in the United Kingdom, as in most OECD countries, increases proportionately as children get older.⁵⁴ A 2018 report by the Children’s Commissioner and the Institute for Fiscal Studies, which examined local authority spending on children’s services, noted that financial constraints and rising demands, such as child safeguarding

51 Professor Sir Michael Marmot, [Fair Society, Healthy Lives](#). The Marmot Review, 2010

52 Barnardo’s ([FDL0020](#))

53 Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays

54 Organisation for Economic Co-operation and Development, [‘Doing better for Families’](#), 27 April 2011

referrals and an increase in the number of looked after children, have meant that councils have focused on ensuring they meet statutory obligations, potentially at the expense of directing resources to prevention and early intervention.⁵⁵

27. In its inquiry on evidence-based early years intervention, the Science and Technology Committee called for a shift of expenditure towards earlier interventions, which they say may necessitate an initial increase in expenditure, but which is likely to lead to long-term savings.⁵⁶ **We agree with our colleagues on the Science and Technology Committee that the Government should incentivise and support local authorities to make long-term investment in the early years.**

Delivering community partnership

28. We visited Blackpool, one of five areas sponsored by the Big Lottery Fund's A Better Start Programme, in November 2018. As part of the programme, the Big Lottery Fund is putting £215 million over ten years into five socially disadvantaged areas in England. These areas are developing and testing new approaches to promoting early childhood development, prevention and early intervention. The following core principles apply to each of the five areas:

- putting people in the lead;
- being place-based and adapted to the local context; and
- working in partnership to ensure that services are delivered efficiently.

29. The A Better Start Partnership in Blackpool is delivering a truly place-based approach to the first 1000 days. This is built on a successful collaboration between local government, local NHS providers and commissioners, the private sector, the voluntary and community sector and the community itself. A Better Start in Blackpool is led by the NSPCC.⁵⁷ Having the voluntary sector in the lead enables the partnership to reach areas outside the usual remit of statutory services, and facilitates communities' involvement in all stages of design, implementation and evaluation of community-owned assets.

30. The A Better Start Partnerships have demonstrated the importance of an approach to service design that involves families and the wider community in improving existing evidence-based programmes. In Blackpool, A Better Start has invested £1 million into a transformation of the health visiting service, co-designed by parents and healthcare professionals. The result is an enhanced service with an increased number (from 5 to 8) of minimum contacts with a health visitor, alongside a revision of the content of the visits to more effectively support parental and infant mental health.⁵⁸

31. As well as giving local people power over the design of services, the A Better Start areas put people in the lead by giving them opportunities to be involved in service delivery. For example, in Nottingham, another A Better Start area, parents and community

55 The Children's Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018; Institute for Fiscal Studies, [Living standards, poverty and inequality in the UK: 2017/18 to 2020/21](#), November 2017

56 Science and Technology Committee, Eleventh Report, 30 October 2018, HC 506, para 146

57 [Blackpool Better Start website](#) (Accessed 29 Jan 2019)

58 [Blackpool Better Start Invests £1million into Transforming Health Visiting Service](#), Blackpool Better Start, 17 April 2018

members are employed as Family Mentors to provide peer support to pregnant women or families with young babies. All local families are offered access.⁵⁹ In Cornwall, Home Start Kernow is supporting around 600 families over three years with peer volunteers who provide regular home-based emotional and practical support for families.⁶⁰

Children's centres

The Sure Start programme was launched in 1998, with the aim of providing local services tailored to the needs of children and parents. The programme was initially rolled out in the most disadvantaged areas, but from 2003 the Government began to develop universal access. Children's centres were intended to be hubs in which families and preschool-age children could access integrated services, including education, childcare, parenting support, health visiting services and support for benefits and housing.⁶¹ The Government's 2013 statutory guidance defines the core purpose of children's centres as improving outcomes for young children and their families and reducing inequalities in development, school readiness, parenting skills, and child and family health and life chances.⁶² In April 2010 there were 3,632 Sure Start children's centres in England. The Sutton Trust estimated (in April 2018) that over 1,000 centres might have closed since 2009.⁶³

Delivering on the needs of marginalised populations

32. In 2016, the National Children's Bureau published research on the experience of low-income families in accessing children's services, finding that such families were less aware of services and felt less comfortable in using them, owing to a lack of support and information.⁶⁴ Families reported having limited opportunities to feed back about their experiences of services, and rarely heard how their feedback had been acted on. They also reported it taking too long to receive additional support, especially for housing, mental health problems and family support.

33. The Early Intervention Foundation has drawn attention to difficulties for the most vulnerable families in accessing universal services. Those difficulties can be related to the availability or distance of services, transport or other costs, or perceived stigma. In its Guidebook,⁶⁵ the EIF describes evaluations of the evidence of programmes that include a home visiting component that have been shown to improve outcomes for children and young people.

34. An example of an approach which delivers targeted services for marginalised populations is Flying Start, the Welsh Government's flagship early years programme.⁶⁶ Flying Start is aimed at families with children aged 0 to 4 living in disadvantaged areas

59 Nottingham CityCare Partnership CIC ([FDL0019](#))

60 Big Lottery Fund ([FDL0069](#))

61 Education Committee, Fifth Report, 11 December 2013, HC 364-I, para 37

62 Department for Education, [Sure Start children's centres statutory guidance](#), April 2013

63 Sutton Trust, [Stop Start: Survival, decline or closure? Children's centres in England, 2018](#), April 2018

64 National Children's Bureau, ['Young children's and families' experiences of services aimed at reducing the impact of low-income'](#), February 2015

65 [Early Intervention Foundation Guidebook](#) (Accessed 21 December 2018)

66 Welsh Government, ['Flying Start'](#), 26th May 2017

of Wales. The targeted programme is based on income benefit data, which is used as a proxy for deprivation.⁶⁷ In the geographical areas in which Flying Start is delivered, it is a universal service, to avoid stigmatisation.

Delivering an integrated, multi-agency approach

35. Families need access to a complex system of support in the first 1,000 days from primary care, health visiting, midwifery, mental health services, housing services, childcare, education, social services, and sometimes probation and prison services. The National Children’s Bureau described strategic and operational coordination between these multiple agencies as “a major challenge.”⁶⁸ They reported that early years providers and local authorities describe difficulties in planning for children’s educational needs because of a lack of information sharing between agencies, and have stressed the need for strong multi-agency working to deliver joined-up services.⁶⁹

36. An example of where multi-agency working seems to be performing well is the Big Lottery Fund’s five local A Better Start sites, each of which has a partnership board, bringing together community members and representatives of partner organisations.⁷⁰ The boards ensure that organisational leaders work in partnership to ensure that the A Better Start plans become embedded, scalable and sustainable, and also consider jointly where the barriers to progress are.

37. Several witnesses suggested a possible approach to improving multi-agency working in England based on Northern Ireland’s Infant Mental Health Framework. The Framework represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the antenatal period through to children aged 3 years old.⁷¹ The Framework highlights three priority areas—promoting and disseminating evidence and research; informing workforce development; and informing service development—and reports having supported systemic change and a joined-up approach across these areas.⁷²

38. As the Royal College of Midwives state, the National Maternity Review’s Better Births report recommended “bringing care together in community hubs: local centres that could be located in children’s centres, GP practices or midwifery units, where women can access elements of their care with different providers working together.”⁷³ However, we have heard several times during the inquiry that while co-location of multiple agencies and a multidisciplinary team in children’s centres is a necessary part of the universal offer for children, it is not sufficient. Deidre Webb of the Public Health Agency in Northern Ireland told us that more important than co-location is effective communication between services,⁷⁴ a point which we heard reiterated in focus groups with local authorities, who told us that attempts to move services into the same building as a way to improve co-

67 National Assembly for Wales Children, Young People and Education Committee. [Flying Start: Outreach](#), February 2018

68 National Children’s Bureau ([FDL0050](#))

69 National Children’s Bureau ([FDL0050](#))

70 Big Lottery Fund ([FDL0069](#))

71 Public Health Agency, [Infant Mental Health Framework for Northern Ireland](#), April 2016

72 Public Health Agency, [Infant Mental Health Framework for Northern Ireland](#), April 2016

73 Royal College of Midwives, [Summary of the report of the National Maternity Review ‘Better Births: Improving outcomes of maternity services in England’](#)

74 [Q274](#) Deidre Webb

ordination has not necessarily had this outcome.⁷⁵ Two examples of good practice are Lambeth Early Action Partnership,⁷⁶ which is doing work on co-ordination of services not just depending on being co-located but also about having time to set up protocols, with staff getting to know each other, and Barnardo's, who provided an example of good coordination at a children's centre in Leicester:

The centre employs a small team of family support workers and play workers who are co-located with a range of specialists including health visitors, midwives, early years support teachers, a speech and language therapist, a children centre teacher, a community food worker, a link to learning officer, and housing officer. Health visitors register new families with the children's centre and all parents with new-born babies are visited by the health team. Where there are concerns, the family is referred to the family support team for follow-up visits or involvement in a targeted group. Midwives also refer families where there are concerns even before the baby is born. They have regular 'cause for concern' meetings with local GPs, health visitors, and the wider integrated team to review families in need of support.⁷⁷

Delivering evidence-based interventions

39. As well as improving access to early childcare and education, there is a need to ensure that early years programmes are delivered on the basis of the best available evidence of effectiveness. In an analysis of 35 interventions by the Early Intervention Foundation, one of the What Works Centres,⁷⁸ the EIF found that only 13 had undergone a rigorous evaluation, and of those 13, only four had evidence of improving a relevant outcome.⁷⁹ The EIF describes difficulties both in demonstrating the effectiveness of individual programmes and, crucially, in demonstrating the extent to which programmes result in return on investment for commissioners, which they say might be a barrier to uptake. In evidence to the House of Commons Science and Technology Committee's inquiry on evidence-based early-years intervention, the EIF highlighted the lack of reliable information about the extent to which local authorities are using evidence-based interventions, although there is currently a peer-to-peer programme operating across local government which is seeking to compare local authorities.⁸⁰

40. Ailsa Swarbrick, Director of the Family Nurse Partnership National Unit, captured the difficulty of the evidence base in the first 1000 days, since in many cases there is no evidence, the evidence is of poor quality, or there is controversy in the evidence:

There should be investment in thinking about what is valuable evidence, and what different forms of evidence there might be in this space, given the need for thinking long term and given that we are dealing with very complex systems where it is not always easy to attribute direct cause and effect.⁸¹

75 See Annex 3

76 Big Lottery Fund ([FDL0069](#))

77 Barnardo's ([FDL0020](#))

78 UK Government, [What Works Network](#), 28 June 2013 (Accessed 15 January 2019)

79 Early Intervention Foundation ([FDL0070](#))

80 Science and Technology Committee, Eleventh Report, 30 October 2018, HC 506, table 1

81 [Q216](#)

Conclusion

41. These six principles should together drive local service delivery in the first 1000 days. An evidence-based, integrated, and inclusive approach, delivered universally and proportionate to need is, from the evidence we have heard, likely to be the most effective way to improve outcomes for children and to reduce inequalities between children. The five A Better Start areas in England are funded by £215 million over 10 years, meaning that each site has a fund of around £4 million per year to enable systems change in promoting early childhood development.⁸² **Drawing on the successes of the transformation funding for the A Better Start areas, we recommend that the Government should establish a fund to incentivise the transformation of local commissioning and provision covering the first 1000 days in accordance with the objectives set by the Government’s national strategy (see ‘Vision’ section), and the six principles we have outlined in this chapter.**

42. **Each local authority area should develop, jointly with local NHS bodies, communities and the voluntary sector, a clear and ambitious plan for their area, which sets how they will improve support for local children, parents and families during the first 1000 days and how they intend to achieve national goals. The development and delivery of these local plans should be led by a nominated officer, accountable for progress. Local plans should include a comprehensive assessment of local provision, including targeted and specialist interventions provided locally, and describe how each area will adopt the core principles for local service delivery outlined in this chapter.**

43. Adhering to these principles requires reforming the delivery of universal services, with a revised Healthy Child Programme, and investing in existing evidence-based targeted services. The following two sections—on the Healthy Child Programme and targeted services—discuss the practical implementation of these six principles in services in England.

The Healthy Child Programme (HCP)

44. In 2009, the Government launched the universal Healthy Child Programme (HCP), with the aim of improving outcomes and reducing inequalities through a combination of universal provision and targeted support.⁸³ The HCP is central to the delivery of the universal offer of prevention and early intervention services for children and families in England. Following the reforms instituted by the Health and Social Care Act 2012, in October 2015 local authorities assumed full responsibility from NHS England for commissioning public health services for children up to the age of five, including the HCP.⁸⁴

Current delivery of the HCP

45. We heard throughout the inquiry about variable implementation of both the statutory and non-statutory aspects of the HCP across the country. Legislation requires 5 health visitor family checks to be carried out on a mandatory basis.⁸⁵ These reviews are an important engagement point with families. They allow trained professionals to

82 [The National Lottery Community Fund: A Better Start](#) (Accessed 16 January 2019)

83 Department of Health, [Healthy Child Programme: Pregnancy and the first five years of life](#), October 2009

84 Department of Health and Social Care (FDL0067), para 5.

85 Department of Health, [Healthy Child Programme: Pregnancy and the first five years of life](#), October 2009

assess child development, identify any potential problems and refer families for targeted support. There is substantial regional variation in terms of the percentage of completed health visitor assessments.⁸⁶ The Institute for Health Visiting told us in oral evidence that 65% of families are not formally seeing a health visitor at all after their baby is aged six to eight weeks, and may instead be seeing other early years workers with less training in identifying relevant risks. We also heard that even if a “contact” is recorded as having been completed, owing to a lack of specificity in the definition of a “contact” it might be that families are only receiving a letter, not a visit.⁸⁷

46. The other countries of the United Kingdom mandate a higher number of visits: in Wales there are 9 reviews; in Northern Ireland there are 7 (with a planned increase to 9); in Scotland there are 11. Scotland and Wales additionally specify which reviews are to be carried out by a qualified health visitor, rather than another team member.⁸⁸

An amazing health visitor spotted my postnatal depression when I'd managed to successfully hide it from friends and family. I hear a lot about health visitors not being needed, I don't agree. If she hadn't spotted it I'm not sure where I would have ended up.

Source: Mumsnet survey

47. The Greater Manchester Eight Stage Assessment Pathway demonstrated the value of additional contacts beyond mandated health visitor assessments and set out how this could be delivered.⁸⁹ The pathway, part of Greater Manchester's Early Years Delivery Model, involves health visitors and outreach workers assessing children and families from pre-birth to age 5. Evidence-based interventions are then made available for children who are identified as requiring additional support to achieve age appropriate development and school readiness.⁹⁰ However, without additional resourcing, further mandated assessments might stretch budgets to unsustainable levels and increase caseloads to a dangerous level. In 2011, the Government introduced a plan in England to increase the number of health visitors, but despite the focused investment, there was a failure to achieve the aimed increase; there has been overall only a 1.7% increase since May 2010.⁹¹ In April 2018 the Government announced plans to increase the number of midwives by 3,000, by 2021.⁹²

48. The Institute of Health Visiting has recommended that local authorities work towards their health visitors having caseload size not exceeding 250 children per health visitor, or a maximum ratio of 1:100 in more deprived areas.⁹³ In Wales, the HCP is delivered with a set ratio of one health visitor to 250 children; and in Flying Start areas, it is one health visitor to 110 children.⁹⁴ While we have not seen strong evidence for a particular ratio, there has been consensus from the evidence we have heard during the inquiry that there are currently too few health visitors, and many have too many families on their caseload.

86 Public Health England, [Health Visitor Service Delivery Metrics: 2017/18 Annual Data](#), October 2018

87 [Q154](#)

88 Institute of Health Visiting ([FDL0031](#))

89 [Greater Manchester: Early years new delivery model](#), 3 August 2015 (Accessed 14 January 2019)

90 [Greater Manchester: Early years new delivery model](#), 3 August 2015 (Accessed 14 January 2019)

91 Royal College of Nursing ([FDL0042](#))

92 ["Women to have dedicated midwives throughout pregnancy and birth"](#), 27 March 18 (Accessed 1 February 2019)

93 Institute of Health Visiting ([FDL0031](#))

94 [Flying Start](#), 26 May 2017 (Accessed 1 February 2019)

49. We agree with the Science and Technology Committee that the first priority should be for every child to receive all the five mandated visits, in a manner that does not compromise the quality of these visits. We also agree with the Science and Technology Committee that the Government should set a date for when this will be achieved. However, we also recommend as part of a refresh of the Healthy Child Programme that the Government set out proposals for increasing the number of routine visits.

50. We recommend that all checks should be carried out by a health visitor, and that a minimum number of contacts should include a home visit.

Revising and refreshing the HCP

51. We have heard throughout the inquiry that, notwithstanding its successes, the Healthy Child Programme is not adequately supporting the improvements in health and wellbeing and reductions in health inequalities which it aims to do.⁹⁵ We have heard that improvements in public health outcomes for children would be best achieved by a refresh of the HCP in accordance with the six principles we discussed in the previous section. Therefore, 10 years on from its inception, we are calling for a revised Healthy Child Programme, with interventions that:

- are family focused;
- begin before conception;
- extend visits beyond 2 ½ years; and
- ensure continuity of care including improved links between health visiting, midwifery, obstetrics and primary care, and ensuring that women see the same midwife and same health visitor for each visit.

A family focus

52. While the child should remain at the centre of the Healthy Child Programme, we have heard throughout the inquiry that healthy attachment, and preventing or mitigating the impact of stressful or traumatic experiences in childhood—known collectively as adverse childhood experiences (ACEs)—depends on involving the whole family. All health professionals, and particularly health visitors, need to understand a child’s health and development in the context of their family environment.

53. The Fatherhood Institute conducted a survey of over 1800 fathers in Scotland, finding that fathers describe being excluded in the antenatal period, with potentially worrying consequences for the child of the family.⁹⁶ The National Children’s

Throughout the entire process I often felt unable to support my wife adequately because I was sidelined during appointments or barely acknowledged at all, leading to me feeling unconfident to ask questions or probe details. After the birth, I’ve never been sent any supporting information for new fathers and instead have to read whatever is given to my wife.

Source: Fatherhood Institute survey

95 Public Health England, Best start in life and beyond: Improving public health outcomes for children, young people and families, March 2018

96 Fatherhood Institute ([FDL0038](#))

Bureau is currently working with the Big Lottery Fund to pilot an informal parenting programme with young fathers in Lambeth, which is aiming to break barriers to improve the engagement and involvement of young fathers with service design and delivery.⁹⁷

54. Action for Children told us that perinatal services have focused largely on mothers presenting with severe mental health problems, and less on the child and fathers or partners.⁹⁸ A step towards resolving this has been made in the NHS long term plan, which has announced plans to offer assessments and signposting for support to the partners of women accessing specialist perinatal mental health services.⁹⁹

55. We recommend that a revised Healthy Child Programme should be expanded to focus on the health of the whole family and examine how this affects the physical and mental health of the child, recognising that the physical health and mental health of a baby's parents, and the strength of their relationships with each other and their child, are important influences on their child's health.

Beginning before conception

56. We heard evidence about the vital importance of the preconception period and intrauterine environment, and the health of both parents at these times, to postnatal infant health.¹⁰⁰ Pre-conception interventions can often be challenging to implement prior to a woman's first pregnancy, because a large proportion of pregnancies are unplanned;¹⁰¹ but there are opportunities subsequently to intervene between pregnancies, if women or their partners are identified as requiring additional support. Relationships and sex education at school is an ideal time to have discussions with young people about healthy relationships and healthy pregnancies.¹⁰²

57. We recommend that the revised Healthy Child Programme should include the provision of pre-conception support to parents who are planning a pregnancy, or to parents who could have benefited from more support prior to a previous pregnancy. This should begin at school, where there should be focused attention on healthy relationships, pregnancies, including advice about smoking, alcohol, substance misuse and parenting.

Extending beyond the first 1000 days

58. The Early Intervention Foundation raised concerns with us about a "cliff edge" when a child reaches the end of the early years, telling us that it is important to consider what happens after a child reaches the upper end of the age range of the Healthy Child Programme at age 5.¹⁰³ The last mandated visit by a health visitor in the HCP is at 2–2½ years, at which time the health visitor reviews the child's development.¹⁰⁴ In Blackpool, an additional visit is carried out at 3–3½ years, to assess and support 'school readiness'.¹⁰⁵ In areas of high

97 Big Lottery Fund (FDL0069)

98 Action for Children (FDL0044)

99 [The NHS Long Term Plan](#), January 2019

100 CLOSER, the home of longitudinal research (FDL0021)

101 [Q140](#)

102 UK Parliament, [Relationships and Sex Education](#), 25 June 2018 (Accessed 2 February 2019)

103 [Q86](#)

104 Department of Health, [Healthy Child Programme: Pregnancy and the first five years of life](#), October 2009

105 Blackpool Better Start, ["Blackpool Better Start Invests £1million into Transforming Health Visiting Service"](#), 17 April 2018 (Accessed 14 January 2019)

disadvantage around 50% of children do not reach a good level of development by age 5 in which they are deemed ready to start school (school readiness).¹⁰⁶ Improving school readiness, according to PHE, is a ‘best buy’ for public health.¹⁰⁷ Introducing additional checks delivered by health visitors after age 3 to assess school readiness, in order to identify children likely to need extra support, may help to identify children who may be off course for reaching this level of development.¹⁰⁸

59. We recommend that an additional mandated visit at 3–3½ years should be included in the Healthy Child Programme, to ensure that potential problems that may inhibit the ability of children to be ready to start school are identified and addressed.

Continuity of care

60. Women who have midwife or health visitor they know and trust are more likely to report domestic violence, mental health issues, or a personal history of adverse childhood experiences.¹⁰⁹ Presently, the multidisciplinary team often works in siloes, and there is inadequate communication between people, teams, and IT systems.

61. Research suggests that women who see the same midwifery team for each visit are less likely to have miscarriages and premature births, and continuity of care has been shown to be associated with reduced mortality.¹¹⁰ The Government announced in April 2018 its ambition for the majority of women to receive continuity of midwifery care (that is, care from the same midwives) throughout their pregnancy, labour and birth by 2021, starting with 20% of women being cared for with this model by March 2019.¹¹¹

62. We recommend that a revised Healthy Child Programme, with an increased focus on continuity of care, should include the explicit objective that so far as possible a family will see the same midwife and the same health visitor, at each appointment or visit.

Targeted provision

63. The Healthy Child Programme is the core of universal service provision in the first 1000 days. For some families, targeted support in addition to that available through universal services is helpful. The EIF defines two levels of targeted interventions: targeted selective interventions - those offered to families on the basis of broad ‘demographic risks’ such as low income, and which may prevent problems from occurring in the first place - and targeted indicated interventions - which are offered to families who have already been identified as having a problem which requires more intensive support.¹¹² As interventions move from universal to “targeted selective” to “targeted indicated”, they are more intensive, and are offered to fewer people.

64. Targeted and specialist services such as the Family Nurse Partnership and Parent Infant Partnership services provide extra support for families and children. The Parent

106 The Health Foundation ([FDL0081](#)),

107 Public Health England ([FDL0077](#))

108 Frank Field ([FDL0083](#))

109 [Q154](#)

110 [“Women to have dedicated midwives throughout pregnancy and birth”](#), 27 March 2018 (Accessed 14 Jan 2019)

111 [“Women to have dedicated midwives throughout pregnancy and birth”](#), 27 March 2018 (Accessed 14 Jan 2019)

112 Early Intervention Foundation: [What is early intervention](#) (Accessed 14 January 2019)

Infant Partnership service offers specialist psychotherapeutic services, relationship support, and a joined-up pathway of care to ensure that families get the right support at the right time.¹¹³

65. The Family Nurse Partnership is an intensive, preventive, home-visiting programme delivered by specially trained nurses and midwives.¹¹⁴ It is a programme for vulnerable first-time young parents and their babies, which “seeks to support women to have a healthy pregnancy, to improve child health and development, and to improve parents’ economic self-sufficiency.” At its peak in 2016, the FNP was delivered in 132 local authorities in England, and is currently reportedly delivered in 77.¹¹⁵ In Scotland, the FNP is being rolled out widely to teenaged mothers, and there are plans to extend it to eligible women up to 24 years of age.¹¹⁶

66. A Government-commissioned trial on the FNP demonstrated no evidence of benefit for the trial’s defined primary outcomes (smoking cessation, birthweight, second pregnancies, and Accident & Emergency visits), but the choice of these outcomes, and therefore the interpretation of the trial’s findings, has been widely questioned.¹¹⁷ The FNP is exploring an initiative (ADAPT) to learn from the trial’s findings by incorporating evidence-based innovation, learning and iterative improvement.¹¹⁸ The Science and Technology Committee has suggested that rather than disinvesting in the FNP on the basis of the Government-commissioned study, commissioners should act on the conclusions reached by the FNP’s initiative in due course.¹¹⁹ Based on five randomised controlled trials, the Early Intervention Foundation describes the FNP as having evidence of a long-term positive impact on child outcomes.¹²⁰

67. There is limited information about the extent to which local areas commission targeted and specialist pathways. The Maternal Mental Health Alliance publish data on provision and performance of services for families affected by perinatal mental illness in the UK.¹²¹ The MMHA told us that a postcode lottery exists, such that many parents cannot access services.¹²²

68. In written evidence the Royal College of Psychiatrists said that adverse childhood experiences such as maltreatment, domestic violence, parental imprisonment and poor mental health contribute approximately equally to increasing the risk of ill health.¹²³ They recommended that preventing adverse childhood experiences must be the core priority for interventions in first 1000 days, with targeted support for parents and children at risk of ACEs needing to be a key part of the approach.¹²⁴

69. We recommend that the Government, working with local areas and the voluntary sector, develop a programme into which children and families who need targeted

113 Parent Infant Partnership (PIP) UK ([FDL0016](#))

114 Family Nurse Partnership National Unit ([FDL0076](#))

115 [Q189](#)

116 [Progressing the Human Rights of Children in Scotland: A report 2015–2018](#), December 2018

117 Science and Technology Committee, Eleventh Report, 30 October 2018, HC 506, para 57

118 [Family Nurse Partnership: ADAPT](#) (Accessed 8 January 2019)

119 Science and Technology Committee, Eleventh Report, 30 October 2018, HC 506, para 59

120 Early Intervention Foundation Guidebook: [Family Nurse Partnership](#), July 2016 (Accessed 13 January 2019)

121 Maternal Mental Health Alliance ([FDL0006](#))

122 Maternal Mental Health Alliance ([FDL0006](#))

123 Royal College of Psychiatrists ([FDL0039](#))

124 Royal College of Psychiatrists ([FDL0039](#))

support can be referred, drawing on the experience of the Family Nurse Partnership in Scotland, Northern Ireland and in some parts of England, and of Flying Start in Wales. Children in need of such targeted support should be identified during pregnancy. We agree with our colleagues on the Science and Technology Committee that commissioners should continue to appraise the evidence base for the Family Nurse Partnership, as well as for other targeted interventions, and consider investment or disinvestment accordingly.

4 National strategy

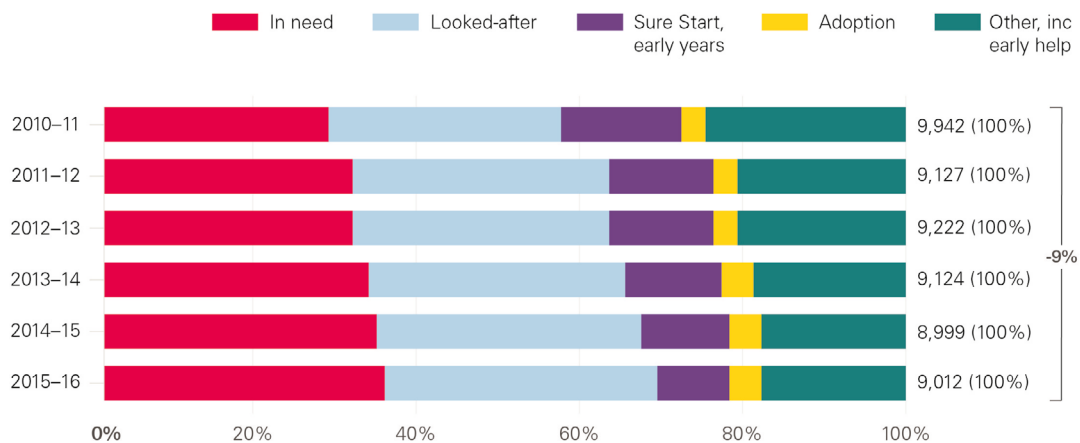
Funding

70. The evidence we have seen indicates that public expenditure on children has fallen since 2010/11. Total spending per child is projected by the Institute for Fiscal Studies and the Children’s Commissioner to fall by 12% in real terms between 2010/11 and 2020/21, thereby reversing some of rapid increases in spending that occurred during the early 2000s.¹²⁵ Spending on health and education have been relatively protected. In contrast, between 2010/11 and 2020/21, spending per child on benefits and on children’s services is projected to fall by 17% and 20% respectively.¹²⁶

71. Just under a third of public spending on benefits is directed towards supporting parents and families with children. This includes tax credits, child benefit and housing benefit. By 2019/20 benefit spending per child is set to be the same as it was in 2006/07, just before the financial crisis.¹²⁷ The IFS and Children’s Commissioner project a 2% rise in children living in absolute low income, as a result of the two-child limit on tax credit and Universal Credit.¹²⁸

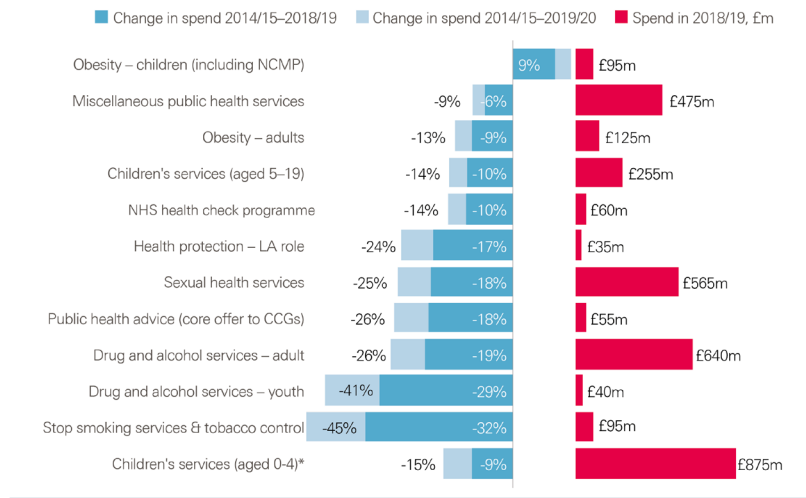
72. Councils have been operating in a tight financial climate and this trend is expected to continue with local government facing a £7.8bn funding gap by 2025, according to the Local Government Association.¹²⁹ From 2010/11 to 2016/17 spending on services such as public transport, libraries and children’s centres fell by a third.¹³⁰ Since 2010/11 councils have shifted spending on children’s services towards acute crisis management and away from prevention and early intervention, as Chart 1, from the Health Foundation, shows. Spending on most public health services has fallen considerably since 2014/15, as shown by Chart 2.

Chart 1: Local authority spending on children’s services from 2010/11 to 2015/16



125 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018
 126 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018
 127 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018
 128 The Children’s Commissioners and Institute for Fiscal Studies, [Public spending on Children in England](#), June 2018
 129 The Local Government Association ([FDL0072](#))
 130 The Health Foundation ([FDL0081](#))

Chart 2: Public Health Grant net expenditure and percentage change in spend since 2014/15



The Health Foundation © 2018
 Source: Health Foundation analysis using MHCLG, Local authority revenue expenditure data; DH, Public Health grant circular, December 2017; OBR, Public Finances databank, June 2018.

73. As noted above, responsibility for commissioning public health services for children aged 0–5 transferred from the NHS to local authorities in 2015.¹³¹ Councils spent more on this area of public health than any other, often exceeding the amount transferred over to them for this purpose.¹³² However, spending on public health services for children aged 0–5 years has fallen by 9% since 2014/15 and is projected, by the Health Foundation, to fall by another 15% by 2019/20.¹³³ Cuts to other public health services have been much deeper. The greatest reductions in expenditure have been on drug and alcohol services and stop-smoking services, both of which are important to addressing known risks to child health and development (see Chart 2).

74. Spending cuts have negatively affected universal, targeted and specialist services and the wider community assets (e.g. public amenities) available to children, parents and families. As a result of funding cuts, some local services have been closed or decommissioned while others have been reoriented towards more targeted approaches.¹³⁴ For example, since 2010 over 1000 children’s centres have closed, while others have moved away from an open access neighbourhood model towards a more focused approach in which services operate part-time and focus more on families who are referred or have higher levels of need.¹³⁵

I found my local children’s centre an absolute godsend when first daughter was little. I used to go there four out of five days a week. I think it probably saved my life, as I was very low and very isolated at that point. Please, please reconsider the closure of children’s centres, they are a fantastic resource.

Source: Mumsnet survey

131 The Health Foundation (FDL0081),
 132 Public Health England (FDL0077)
 133 The Health Foundation (FDL0081),
 134 Royal College of Speech and Language Therapists (FDL0043), Action for Children (FDL0044), Family Nurse Partnership National Unit (FDL0076), National Children’s Bureau (FDL0050).
 135 Action for Children (FDL0044), National Children’s Bureau (FDL0050).

The case for investment

75. The economic and human costs of intervening late are enormous. The Early Intervention Foundation has estimated the cost of late intervention to the public purse to be £17bn annually.¹³⁶ However, structural problems in the way Government departments and public services are funded, financed and commissioned disincentivise investment in early intervention. In particular, short-term, siloed approaches to funding and commissioning have presented major, longstanding and widely recognised barriers to investment in prevention and early intervention.¹³⁷

76. Effective early intervention requires long-term investment. Cashable savings are rarely immediate. Financial savings from early interventions can only be made once commissioners are able to remove costs from the system. This requires sizeable and sustained changes in demand, and existing services not to be used to address previously unmet need.¹³⁸ Early interventions directed towards supporting children and families are typically commissioned for between one and three years. Services struggle to demonstrate benefits over such a short period.¹³⁹

77. Siloed approaches to government funding, nationally and locally, act as a disincentive to investing in early interventions, as the long-term benefits, when accrued, are unlikely to benefit the department that made the initial investment. As an example, the Early Intervention Foundation explained that:

Investing to improve the home learning environment and the academic attainment of disadvantaged children, for example, may lead to higher employment, higher tax contributions and reductions in the welfare bill—all of which will benefit the Department for Work and Pensions, HM Revenue and Customs and society as a whole, but not the local authority that invested in the intervention to begin with.¹⁴⁰

78. Directing resources towards prevention and early intervention, and doing so effectively, is particularly difficult in a constrained financial climate.¹⁴¹ For instance, there is greater competition between services for the limited funding available. Councils and their public health teams, according to Public Health England, face “increasingly challenging decisions” over what services to invest and disinvest in.¹⁴² Some commissioners, for financial reasons, may choose to implement interventions that are less expensive, but also less effective or appropriate.¹⁴³

79. Early intervention, as our colleagues on the Science and Technology Committee have pointed out, is an “opportunity to make long-term, cost-effective improvements

136 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

137 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018, WAVE Trust ([FDL0073](#)), HENRY ([FDL0037](#)), Parent Infant Partnership (PIP) UK ([FDL0016](#)), The Health Foundation ([FDL0081](#)), Family Nurse Partnership National Unit ([FDL0076](#)), Barnardo’s ([FDL0020](#))

138 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

139 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

140 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

141 Association of Directors of Public Health ([FDL0059](#)), Royal College of Speech and Language Therapists ([FDL0043](#)), Royal College of Psychiatrists ([FDL0039](#))

142 Public Health England ([FDL0077](#))

143 Public Health England ([FDL0077](#))

in children’s lives—rather than a demand on resources.” By devoting resources to interventions during this early period of a child’s life the Government can improve the health, wellbeing and life chances of future generations.

80. The Government must use the Comprehensive Spending Review in 2019 to shift public expenditure towards intervening earlier rather than later. We recommend the Government use the 2019 Spending Review as an opportunity to initiate the next early years revolution with a secure, long-term investment in prevention and early intervention to support parents, children and families during this critical period.

81. Unfortunately, due to the way Government departments are financed, the department which invests in early intervention is often not the one that stands to reap greatest benefit. This structural problem in the financing of government is a barrier to early intervention. We recommend the ministerial group on Early Years and Family Support address this crucial issue. When we hear from Ministers following the conclusion of the group’s work, we will expect to question them on their proposals to tackle this problem.

82. Reflecting the contribution which early years provision makes to the objectives of a number of Government departments, funding for local plans (see paragraph 42) should be drawn from existing budgets across Government, including the Department for Work and Pensions, the Department for Education, the Home Office and the Ministry of Justice as well as the Department for Health and Social Care.

Whitehall

Leadership

83. The challenge of giving every child the best start in life, we heard repeatedly, requires national leadership, particularly political leadership, to:

- set a vision of the outcomes Government and public services should seek to achieve;
- coordinate the work of multiple departments and agencies;
- provide strategic direction to local areas and hold them to account; and
- ensure the issue remains a priority and continues to attract resources.

84. There were widespread calls for a political consensus on the importance of the early years, with many respondents praising the cross-party manifesto on the 1001 Critical Days. Douglas Hargreaves from the Nuffield Trust, a consultant paediatrician, argued that there should be a “cross-party societal consensus that the health, wellbeing and early development of children in the early years is a national priority.”¹⁴⁴

85. Within Government, we heard about the importance of ministerial responsibility and accountability for the first 1000 days, preferably with a seat at Cabinet. The establishment of the Early Years and Family Support ministerial group, led by Rt Hon Andrea Leadsom MP, was widely welcomed within the evidence we received. The ministerial group is made

up of ministers from multiple departments with responsibility for the first 1000 days: the Cabinet Office, the Ministry for Housing, Communities and Local Government, the Department for Education, the Department of Health and Social Care, the Department for Work and Pensions and the Treasury. Witnesses told us that it is important that this political leadership and cross-Government collaboration should continue. The Royal College of Nursing told us that a minister should be “responsible for the delivery of this strategy” and be “required to make regular reports on progress to Parliament.”¹⁴⁵ The overwhelming majority of organisations who submitted written evidence to our inquiry called for a cross-government approach to the first 1000 days. To be effective a minister responsible and accountable for the first 1000 days of life must be able to work cross-government to secure and maintain the contribution of different departments.

86. We recommend that the Cabinet Office Minister represented at Cabinet (currently the Chancellor of the Duchy of Lancaster) should be given specific responsibility for the development and oversight of a national strategy to give every child the best start in life. That minister should chair a new Cabinet sub-committee, consisting of ministers from across Government, who should each be responsible for ensuring the implementation of the strategy in their department and for holding one another to account for delivery of the strategy across government.

Cross-government working

87. Responsibility for supporting children, parents and families in the first 1000 days of a child’s life spans multiple departments and agencies. The evidence we received lists a variety of policies, projects and programmes taking place across different government departments and agencies. However, the current approach is fragmented. Anne Longfield, the Children’s Commissioner, pointed out that, despite occasional examples of good coordination, interventions across Government are conducted in “relative isolation”, with different interventions running across different departments at different stages.¹⁴⁶ Public Health England, in its written evidence, suggests that a national cross-government strategy could make existing cross-government arrangements more effective by providing a framework through which departments and arms-length bodies could “collaborate in a structured, visible way.”¹⁴⁷

88. We recommend that the Secretary of State should accelerate his consideration of a health in all policies approach to policy-making, as indicated in his statement on prevention in the House on 5th November 2018. This approach should be adopted as soon as possible to support the work of the relevant Cabinet minister and sub-committee.

89. We recommend that a small, centralised delivery team, within the Cabinet Office, should be established to support this new ministerial role. The team will be responsible for coordinating activity between departments and monitoring progress against the delivery of the strategy.

145 Royal College of Nursing ([FDL0042](#))

146 [Q12](#), Anne Longfield

147 Public Health England ([FDL0077](#))

Vision

90. A compelling, long-term strategic vision for giving every child the best start in life is needed nationally as well as locally. Nationally such a vision must extend beyond the 5-year political cycle.¹⁴⁸ Extending beyond the 5-year cycle is critical as the benefits of early intervention are not seen immediately.¹⁴⁹ As part of a national vision, Government has an important role in setting out the high-level outcomes that should be achieved nationally, and for holding local areas to account for their contribution (see the section on Oversight, support and intervention).

91. The King's Fund recently made the case for a set of "clear, time-limited, binding high-level national goals" to improve population health.¹⁵⁰ These goals should, according to The King's Fund, be carefully chosen so as to focus on areas where national leadership can support action regionally and locally, move public debate towards a focus on outcomes, reduce inequalities, and incentivise collaboration.¹⁵¹

92. The Government's recently published Prevention Vision sets out a series of actions government departments are taking to give every child the best start in life, many of which include interventions in the first 1000 days. In taking forward this vision, we would like to see the Government adopt high-level strategic goals that aim to deliver improved outcomes for children and reduce inequalities. Specifically, we would like to see the Government commit to reducing infant mortality, reducing adverse childhood experiences and increasing school readiness, with a focus on reducing inequalities in outcomes in those areas:

- **Infant mortality.** The majority of deaths in childhood occur before children reach their first birthday. We heard that improvements in infant mortality have stalled in the UK and have continued to lag behind other OECD countries.^{152, 153} Infant mortality is strongly socially determined, with strong links to maternal deprivation and teenage pregnancy, and is influenced by unhealthy behaviours, such as smoking during pregnancy.¹⁵⁴ A focus on reducing infant mortality should therefore involve a wide set of actions that encourage healthier pregnancies, with a focus on addressing inequalities.
- **Adverse childhood experiences (ACEs).** Exposure to adverse experiences in childhood (parental conflict and separation, parents with drug or alcohol problems, parents with mental health problems) is associated with poor health, development and life chances.¹⁵⁵ In 2017, a review of 37 studies, published in The Lancet, found that individuals with at least four ACEs were at much greater risk of poor health outcomes (such as problematic drug and alcohol use and self-directed violence) compared with individuals with no ACEs; attempting suicide

148 Liverpool First 1001 Critical Days Strategic Group ([FDL0049](#)), The Association for infant Mental Health (AIMH (UK)) ([FDL0032](#))

149 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018,

150 The King's Fund, [A vision for population health: towards a healthier future](#), November 2018

151 The King's Fund, [A vision for population health: towards a healthier future](#), November 2018

152 Royal College of Paediatrics and Child Health ([FDL0074](#)),

153 Nuffield Trust ([FDL0048](#))

154 Public Health England ([FDL0077](#)), Royal College of Paediatrics and Child Health ([FDL0074](#))

155 The Health Foundation ([FDL0081](#)), WAVE Trust ([FDL0073](#))

in adulthood had the strongest association.¹⁵⁶ People with four or more ACEs were thirty times more likely to attempt suicide.¹⁵⁷ As mentioned earlier, adversity during childhood can influence a person's parenting behaviour, resulting in the cycles of disadvantage that pass from one generation to the next.¹⁵⁸ Preventing the occurrence of childhood adversity, and its impact, requires action across government nationally as well as locally.

- **School readiness.** Almost a third of children in England do not reach a good level of development, known as school readiness, by the end of reception.¹⁵⁹ There has been a rapid increase from 2012/13 to 2016/17 in the rate of children achieving school readiness, up from 52% to 71%, but poorer children lag behind the rest. Only 56% of children on free school meals in 2016/17 were ready to start school at five.¹⁶⁰ Improving school readiness requires intervening early and addressing social inequalities. Income-related gaps in children's language development are evident by the time a child is 18 months old.¹⁶¹

93. We recommend the Government develop, as part of a national strategy, ambitious high-level goals to:

- **reduce infant mortality;**
- **reduce adverse childhood experiences; and**
- **increase school readiness,**

with a focus on reducing child poverty and inequalities, and their impact.

Workforce

94. Having people with the right knowledge, skills, and experiences, and deploying them effectively, is crucial to supporting and empowering parents and families to take care of their children and themselves. During this period of a child's life every contact children, parents and families have with services matters.¹⁶² The voluntary and community sectors can supplement services delivered by the NHS and local authorities, but must not be a substitute for them. To assist workforce planning more research is needed on how professional practice affects outcomes.¹⁶³ However, when thinking about the workforce covering the first 1000 days three key messages stood out. Government and local areas should:

156 Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L, Dunne MP. The impact of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health* 2017; 2:

157 The systematic review in *The Lancet* found that individuals with four or more ACEs had an odds ratio of 30.14 for suicide attempts (confidence interval of 14.73–61.67). This was the strongest association of all the outcomes covered, although suicide attempts are a rare outcome compared to the other outcomes included in the study (e.g. smoking) and are less well covered by population surveys. The odds ratio of 30.14 is based on three studies one of which only included students. When this study was removed the odds ratio fell to 12.53.

158 The Health Foundation ([FDL0081](#))

159 The Health Foundation ([FDL0081](#)),

160 The Health Foundation ([FDL0081](#)),

161 Early Intervention Foundation ([FDL0070](#))

162 National Children's Bureau ([FDL0050](#))

163 Family Nurse Partnership National Unit ([FDL0076](#)), Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

- **Invest in the capacity and capability of staff to build relationships with parents and families.** Some services are highly relational by design, such as targeted and specialist services (e.g. PIP and FNP),¹⁶⁴ but continuity of care is vital to the delivery of high-quality care throughout this period of a child's life, not just in targeted or specialist services or during pregnancy.¹⁶⁵ The ability of staff to build trusting relationships with the parents and families they work with helps them to identify risks, engage parents about how best to care for their child and themselves and support them to change their behaviour, if necessary.
- **Enhance awareness of child development, and its importance, including the factors that promote and threaten healthy development, among all staff working with children, parents and families during this period.**¹⁶⁶ This includes giving staff the skills and confidence to raise sensitive issues with parents, including issues about their lifestyle.¹⁶⁷
- **Cultivate a mixed workforce economy locally, with a diverse range of knowledge, skills and experiences.** Qualified professionals have an important role in delivering services, which should not be substituted for low-skilled staff. When properly resourced, qualified professionals can also help to upskill the wider workforce. A broad skill mix can enhance local provision. For example, peer support workers are being used effectively to support parents and families in a variety of ways. As the Big Lottery Fund explained, peer support is useful as, “some parents may find it easier to relate to a peer who has gone through similar experiences; they may feel that the peer understands what they are going through and won't judge them.”¹⁶⁸ The Government, and Health Education England, play a critical role in ensuring supply of suitably trained health professionals. However, cultivating a diverse workforce economy also requires action from those operating at local system (e.g. policies that retain healthcare professionals), place-based and neighbourhood levels (e.g. establishing and maintaining links with local volunteers).

95. Improving support for children, parents and families during the first 1000 days is likely to require transforming the way services are delivered. Workforce engagement is a vital part of this. During our visit to Blackpool, we heard how the Big Lottery Fund's investment had helped create headroom for staff, such as health visitors, to engage in transforming the way services are delivered locally. For example, local health visitors were actively engaged in the changes which has led to Blackpool offering 3 additional visits on top of the 5 mandated ones (see paragraph 29).¹⁶⁹ Engaging staff in transformation is difficult. Workforce shortages and rising demand mean that staff are under pressure to implement service changes while maintaining business as usual.

96. Staffing shortfalls across the universal, targeted and specialist services provided during the first 1000 days of a child's life are a barrier to high-quality support for children, parents and families. Shortfalls across universal services, particularly health visitors,

164 Family Nurse Partnership National Unit ([FDL0076](#)), Parent Infant Partnership (PIP) UK ([FDL0016](#))

165 WAVE Trust ([FDL0073](#))

166 National Children's Bureau ([FDL0050](#))

167 HENRY ([FDL0037](#))

168 The Big Lottery Fund, *A Better Start: 2018 Knowledge and Learning Programme Briefing*, December 2018.

169 *A service of first resort: How a refreshed and revitalised model for health visiting helped to transform the lives of deprived families in Blackpool, Lancashire, Community Practitioner, July/August 2018*

midwives and GPs, have drastically cut the time professionals spend with parents and families,¹⁷⁰ particularly those deemed to be less in need. We have also heard examples of qualified professionals, particularly midwives and health visitors, being substituted for less qualified staff.¹⁷¹ The Institute for Health Visiting's written evidence shows that the number of health visitors employed by the NHS has fallen since 2015 from just over 10,000 to just under 8000 as of April 2018 (though it should be noted that these figures do not provide a full picture of the total number of health visitors in England, as figures on health visitors working in non-NHS providers are no longer collected).¹⁷²

97. The absence of specialist skills in some local areas inhibits the uptake of targeted and specialist care and support across the country. A shortage of specialist skills means that some specialist services are not commissioned locally, which in turn acts as a disincentive for professionals to specialise, as PIP UK pointed out.¹⁷³ Many specialist roles do not exist in most areas, such as midwives and health visitors specialising in perinatal mental health.¹⁷⁴

98. As part of a national strategy, we recommend that the Government should publish a holistic workforce plan for services covering the first 1000 days. The plan should set out how the Government, and other national bodies, will support local areas at a system, placed-based and neighbourhood level to enhance the capacity, capability and skill mix of staff, including voluntary staff, who support children, parents and families during the first 1000 days.

Information sharing

99. Joined-up care and support for children, parents and families has been inhibited by barriers to sharing and linking information. Problems—both real and perceived—with sharing and linking information across professional and service boundaries appear to be ubiquitous.¹⁷⁵ These echo concerns about data sharing first raised during the Committee's 2016 inquiry into public health.¹⁷⁶ Evidence from the Liverpool First 1001 Critical Days Strategic Group provides an account of problems in sharing and linking information, which are common among other areas. According to the group:

A range of data systems are in use across sectors and organisations with limited if any, connectivity across. This is also coupled with sensitivities about information sharing from frontline staff, even in the presence of information sharing agreements. The limited connectivity across organisations also means opportunities for data linkage are at best, very limited.¹⁷⁷

100. One major barrier to sharing information is a fear on the part of professionals about what information they can share, with whom and in what way. Fear about sharing information stems from uncertainty about how to share information legally and in

170 Institute of Health Visiting ([FDL0031](#)), NCT ([FDL0052](#)), The Royal College of Midwives ([FDL0051](#))

171 Action for Children ([FDL0044](#)),

172 Institute of Health Visiting ([FDL0031](#))

173 Parent Infant Partnership (PIP) UK ([FDL0016](#))

174 Maternal Mental Health Alliance ([FDL0006](#))

175 See Annex 3, Surrey County Council on behalf of Surrey Health and Care Partnership ([FDL0056](#)),

176 House of Commons Health Committee, Public Health post-2013: second report of the 2016–17 session, July 2016 HC 140

177 Liverpool First 1001 Critical Days Strategic Group ([FDL0049](#)),

accordance with professional codes of conduct.¹⁷⁸ During our focus group in Blackpool we heard that the introduction of the new EU General Data Protection Regulation (GDPR) has created more uncertainty.¹⁷⁹

101. Separate data systems between local public services, as well as voluntary sector services that support them, present a physical barrier to providing integrated care for children, parents and families.¹⁸⁰ For example, we were told during our visit in Blackpool that health visitors, GPs and social workers had separate case management systems, which had restricted their ability to share information.¹⁸¹ As part of the Big Lottery Fund project, local organisations in Blackpool are being supported to develop a town-wide system to make it easier for local services to share and compare data. Other areas, such as Liverpool, are undertaking similar work in order to share information better and gain a more comprehensive picture of the needs of children, parents and families in their area and their use of services.

102. Public Health England told us that new national standards covering the electronic sharing of information are due to be published this year, as part of the Digital Child Health Programme. These standards will set out the mechanisms for transferring data electronically between clinical settings (interoperability). This is a positive step forward, although it is not clear which clinical settings will be covered within the guidance.¹⁸²

103. The inability to link data has inhibited the ability of those working at both a local and national level to gain a comprehensive picture of provision during the first 1000 days of life, including how public money is spent, how services are used and the effect of service provision on outcomes. Public Health England confirm that health datasets include unique identifiers which means that they can be linked to other health datasets as well as datasets covering other public services. For example, PHE suggest that linking the Community Services Dataset to the National Pupil Database is possible and would provide an opportunity for “educational progress to be baselined from age two to two and half years rather than at school entry.”¹⁸³

104. As part of a national strategy, we recommend that the Government provide guidance and support to local areas about how services for children, parents and families can effectively share information. Guidance must explain clearly what is permissible to share, with whom and in what way, in accordance with all applicable legislation.

Oversight, support and intervention

105. The evidence we have received favours a place-based approach, in which local areas are empowered to make decisions about the best way to meet the needs of their local population and to achieve nationally set outcomes. While we strongly support this approach, there are two key reasons why Government and other national bodies should play an additional and more active role.

178 [Q271](#), Dr Calderwood

179 See Annex 3

180 Liverpool First 1001 Critical Days Strategic Group ([FDL0049](#)),

181 See Annex 2

182 Public Health England ([FDL0091](#))

183 Public Health England ([FDL0084](#))

106. To begin with, there are widespread, and largely unwarranted, variations at a local level in the provision of services, including what is offered and how services are implemented, and in the outcomes that are achieved. A wide range of approaches have a robust evidence base to show that they can improve outcomes for children, yet these evidence-based approaches are often not commissioned at a local level (see paragraph 38).¹⁸⁴ Where evidence-based interventions are applied, they are often done so in a manner that reduces their efficacy, with the intention of saving money.¹⁸⁵

107. Secondly, Government and other national bodies can play an important role by helping local areas to continuously improve and adapt. Knowledge about the risks to children is progressing at a faster rate than the evidence base on how to effectively address or mitigate these risks.¹⁸⁶ We agree with the Early Intervention Foundation that “expanding the evidence base for early intervention requires national oversight to guide, coordinate and enable a range of new activity designed to fill critical gaps”.¹⁸⁷ The Early Intervention Foundation argue that one of the barriers to early intervention is gaps in the evidence base covering:

- interventions that address known risks to children;
- effective professional practice. For example, as noted in the section on workforce, more research is needed to understand the importance of relationships between staff and service users; and
- interventions that work at a system level. Understanding of what works at a whole system level locally is also progressing, but remains in its infancy.¹⁸⁸

108. Government, and other national bodies, can also help fill gaps in the evidence by enhancing the capacity and capability of local areas to generate evidence themselves about what works as well as the capability to apply proven interventions locally.¹⁸⁹

109. Currently, there is very little information held centrally about aspects of local provision, such as the targeted and specialist interventions commissioned and provided locally.¹⁹⁰ Similarly, difficulties in linking data has made it difficult to gain a sophisticated understanding of how services are used and the outcomes they deliver.¹⁹¹

110. Whole system approaches to improving support for children, parents and families are still in their infancy.¹⁹² However, we would like to see all local areas, through the development of local plans (see paragraph 42), commit to identify, test and, in time, adopt whole systems approaches that improve outcomes for children. The starting point and circumstances in each area will be different. The Government and other national bodies should develop a nuanced set of approaches to driving improvement tailored to an area’s needs and resources.

184 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

185 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

186 Early Intervention Foundation ([FDL0070](#))

187 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

188 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

189 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

190 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

191 [Q35](#) Elaine Kelly

192 Early Intervention Foundation, [Realising the Potential of Early Intervention](#), October 2018

111. The system levers at national level are weak. Much of the responsibility for commissioning services has been devolved to local authorities. Public Health England provide guidance, support and advice to local areas, but have no powers to compel them to take up this advice.¹⁹³ For example, PHE’s written evidence notes a risk that local areas, who are operating in constrained financial circumstances, may not decide to take up evidence-based approaches.¹⁹⁴ We have heard evidence of interventions being implemented that do not have a strong evidence-base such as infant massage in the general population.¹⁹⁵

112. The Government’s main levers over much of local provision are funding, which is significantly constrained, and legislation.¹⁹⁶ Where legislation is in place it has not necessarily been successful. For example, delivery of the 5 mandated checks, as part of the Healthy Child Programme, varies widely. Action for Children informed us that there are questions about the strength of legislation covering the early years. For example, the “The Childcare Act 2006 places a duty on local authorities to improve outcomes for children and reduce inequalities in the early years.” However, the Government does not monitor compliance with that duty.¹⁹⁷

113. The NHS, according to the NHS Long-term Plan, may play a stronger role in the commissioning of public health services which are currently undertaken by local authorities. The argument made within the Plan is that these services are closely linked to NHS care and are often provided by NHS trusts. This is a pragmatic step, but the Government should avoid substituting one silo for another. Instead, the Government and national bodies should support the NHS and local authorities to commission services collaboratively through the voluntary pooling of budgets and the establishment of joint commissioning teams, as advocated within the plan.¹⁹⁸

114. The Government must to do more to bolster its ability to support local areas, hold them to account and intervene, when necessary. In particular, the Government should seek to foster an environment of continuous improvement by filling gaps in research and encouraging local areas, through support and incentives, to identify, test, adopt and spread what works to improve outcomes. This applies to whole system approaches as well as single interventions. Local authorities should be prevented from continuing to pursue the delivery of programmes for which there is no evidence base.

115. We recommend that an expert advisory group should be established to support the Government by coordinating a national approach to filling gaps in research and to advise on how the national strategy should adapt accordingly over time to reflect this evidence.

116. We agree with our colleagues on the Science and Technology Committee that “local authorities would benefit from the support of a central specialist team with experience in effectively and sustainably implementing early intervention programmes.” We recommend this team should be comprised of, and where necessary be able to call

193 Public Health England ([FDL0077](#))

194 Public Health England ([FDL0077](#))

195 Early Intervention Foundation ([FDL0070](#))

196 [Q316](#) Professor Viv Bennett

197 Action for Children ([FDL0044](#))

198 NHS England, [The NHS Long-term Plan](#), January 2019

on the advice of other, experts from multiple disciplines, including those with specific professional expertise and skill sets (e.g. implementation science and quality improvement).

117. We support the proposals within the NHS Long-term Plan for the NHS to play a greater role in the commissioning of public health services. The Government and national bodies should encourage the NHS to work collaboratively with local authorities to commission these services, through encouraging the voluntary pooling of budgets and the establishment of joint commissioning teams.

5 Giving every child the best start in life: a national strategy for England

118. The health, development and wellbeing of the next generation should be protected, nurtured and invested in. We would like to see Government take up the challenge of delivering the second revolution in the early years, which Sir Michael Marmot's report in 2010 called for. Based on the evidence to our inquiry we recommend the Government develop an ambitious, long-term cross-Government strategy that seeks to give children in this country the best start in life.

119. Five recommendations we have made in this report should form the basis of this strategy:

- The strategy should include ambitious, high-level, measurable goals, which focus on reducing gaps in equalities for the poorest children, and provide a strategic framework under which the Government's current policies, projects and programmes can coalesce in pursuit of these goals.
- The Cabinet Office Minister (currently the Chancellor of the Duchy of Lancaster) should be given specific responsibility for the development and oversight of a national strategy to give every child the best start in life. That minister should chair a new Cabinet sub-committee, consisting of ministers from across Government.
- Each local authority area should develop, jointly with local NHS bodies, communities and the voluntary sector, a clear and ambitious plan for their area, which sets how they will improve support for local children, parents and families during the first 1000 days and how they intend to achieve national goals. The development and delivery of these local plans should be led by a nominated officer, accountable for progress. Local plans should include a comprehensive assessment of local provision, including targeted and specialist interventions provided locally, and describe how each area will adopt the core principles for local service delivery outlined in Chapter 3.
- The Government should establish a fund to incentivise transformation of local commissioning and provision of services covering the first 1000 days of life in accordance with the principles (as outlined in Chapter 3: 'proportionate universalism'; a focus on prevention and early intervention; co-design of services with the local community; engaging with and supporting marginalised communities; multi-agency working; and delivering evidence-based interventions). In particular, we would like to see clinical commissioning groups and local authorities pooling their budgets and jointly commissioning services, as part of a shared local plan.
- The Government should publish a workforce plan for all services covering the first 1000 days. The plan should set out how the Government, and other national bodies, will support local areas at a system, place-based and neighbourhood level to enhance the capacity, capability and skill mix of staff, including voluntary staff, who support children, parents and families during the first 1000 days.

120. Enhancing the ability of services to support and empower parents and families to take care of themselves and their children is vital, but not sufficient. If rising pressures, such as poverty, act against the ability of parents and families to create a safe, healthy and nurturing environment for their children, improvements in service provision will provide only a sticking plaster. We hope that this report helps the Government and other bodies, nationally and locally, in their aspiration to give every child the best start in life. By intervening successfully in the first 1000 days, we believe there is an enormous opportunity to improve people's lives and make society fairer and more prosperous.

Conclusions and recommendations

Improving support for children, parents and families

1. We recommend that the Government consider the needs of vulnerable families in all policies. (Paragraph 22)

Local service delivery

2. Each local authority area should develop, jointly with local NHS bodies, communities and the voluntary sector, a clear and ambitious plan for their area, which sets how they will improve support for local children, parents and families during the first 1000 days and how they intend to achieve national goals. The development and delivery of these local plans should be led by a nominated officer, accountable for progress. Local plans should include a comprehensive assessment of local provision, including targeted and specialist interventions provided locally, and describe how each area will adopt the core principles for local service delivery outlined in this chapter. (Paragraph 42)
3. We agree with our colleagues on the Science and Technology Committee that the Government should incentivise and support local authorities to make long-term investment in the early years. (Paragraph 27)
4. Drawing on the successes of the transformation funding for the A Better Start areas, we recommend that the Government should establish a fund to incentivise the transformation of local commissioning and provision covering the first 1000 days in accordance with the objectives set by the Government's national strategy (see 'Vision' section), and the six principles we have outlined in this chapter. (Paragraph 41)

Healthy Child Programme

5. 10 years on from its inception, we are calling for a revised Healthy Child Programme, with interventions that:
 - are family focused;
 - begin before conception;
 - extend beyond 2 ½ years; and
 - ensure continuity of care including improved links between health visiting, midwifery, obstetrics and primary care, and ensuring that women see the same midwife and same health visitor for each visit. (Paragraph 51)
6. We recommend that a revised Healthy Child Programme should be expanded to focus on the health of the whole family and examine how this affects the physical and mental health of the child, recognising that the physical health and mental health of a baby's parents, and the strength of their relationships with each other and their child, are important influences on their child's health. (Paragraph 55)

7. We recommend that the revised Healthy Child Programme should include the provision of pre-conception support to parents who are planning a pregnancy, or to parents who could have benefited from more support prior to a previous pregnancy. This should begin at school, where there should be focused attention on healthy relationships, pregnancies, including advice about smoking, alcohol, substance misuse and parenting. (Paragraph 57)
8. We recommend that an additional mandated visit at 3–3½ years should be included in the Healthy Child Programme, to ensure that potential problems that may inhibit the ability of children to be ready to start school are identified and addressed. (Paragraph 59)
9. We recommend that a revised Healthy Child Programme, with an increased focus on continuity of care, should include the explicit objective that so far as possible a family will see the same midwife and the same health visitor, at each appointment or visit. (Paragraph 62)
10. We agree with the Science and Technology Committee that the first priority should be for every child to receive all the five mandated visits, in a manner that does not compromise the quality of these visits. We also agree with the Science and Technology Committee that the Government should set a date for when this will be achieved. However, we also recommend as part of a refresh of the Healthy Child Programme that the Government set out proposals for increasing the number of routine visits. (Paragraph 49)
11. We recommend that all checks should be carried out by a health visitor, and that a minimum number of contacts should include a home visit. (Paragraph 50)

Targeted support

12. Children in need of targeted support should be identified during pregnancy. We recommend that the Government, working with local areas and the voluntary sector, develop a programme into which children and families who need targeted support can be referred, drawing on the experience of the Family Nurse Partnership in Scotland, Northern Ireland and in some parts of England, and of Flying Start in Wales. Children in need of such targeted support should be identified during pregnancy. We agree with our colleagues on the Science and Technology Committee that commissioners should continue to appraise the evidence base for the Family Nurse Partnership, as well as for other targeted interventions, and consider investment or disinvestment accordingly. (Paragraph 69)

Funding

13. Early intervention, as our colleagues on the Science and Technology Committee have pointed out, is an “opportunity to make long-term, cost-effective improvements in children’s lives—rather than a demand on resources.” By devoting resources to interventions during this early period of a child’s life the Government can improve the health, wellbeing and life chances of future generations. (Paragraph 79)

14. The Government must use the Comprehensive Spending Review in 2019 to shift public expenditure towards intervening earlier rather than later. We recommend the Government use the 2019 Spending Review as an opportunity to initiate the next early years revolution with a secure, long-term investment in prevention and early intervention to support parents, children and families during this critical period. (Paragraph 80)
15. Unfortunately, due to the way Government departments are financed, the department which invests in early intervention is often not the one that stands to reap greatest benefit. This structural problem in the financing of government is a barrier to early intervention. We recommend the ministerial group on Early Years and Family Support address this crucial issue. When we hear from Ministers following the conclusion of the group's work, we will expect to question them on their proposals to tackle this problem. (Paragraph 81)
16. Reflecting the contribution which early years provision makes to the objectives of a number of Government departments, funding for local plans (see paragraph 42) should be drawn from existing budgets across Government, including the Department for Work and Pensions, the Department for Education, the Home Office and the Ministry of Justice as well as the Department for Health and Social Care. (Paragraph 82)

Leadership

17. We recommend that the Cabinet Office Minister represented at Cabinet (currently the Chancellor of the Duchy of Lancaster) should be given specific responsibility for the development and oversight of a national strategy to give every child the best start in life. That minister should chair a new Cabinet sub-committee, consisting of ministers from across Government, who should each be responsible for ensuring the implementation of the strategy in their department and for holding one another to account for delivery of the strategy across government. (Paragraph 86)

Cross-government working

18. We recommend that a small, centralised delivery team, within the Cabinet Office, should be established to support this new ministerial role. The team will be responsible for coordinating activity between departments and monitoring progress against the delivery of the strategy. (Paragraph 89)
19. We recommend that the Secretary of State should accelerate his consideration of a health in all policies approach to policy-making, as indicated in his statement on prevention in the House on 5th November 2018. This approach should be adopted as soon as possible to support the work of the relevant Cabinet minister and sub-committee. (Paragraph 88)

Vision

20. We recommend the Government develop, as part of a national strategy, ambitious high-level goals to:

- reduce infant mortality;
- reduce adverse childhood experiences; and
- increase school readiness,

with a focus on reducing child poverty and inequalities, and their impact. (Paragraph 93)

Workforce

21. As part of a national strategy, we recommend that the Government should publish a holistic workforce plan for services covering the first 1000 days. The plan should set out how the Government, and other national bodies, will support local areas at a system, placed-based and neighbourhood level to enhance the capacity, capability and skill mix of staff, including voluntary staff, who support children, parents and families during the first 1000 days. (Paragraph 98)

Information sharing

22. As part of a national strategy, we recommend that the Government provide guidance and support to local areas about how services for children, parents and families can effectively share information. Guidance must explain clearly what is permissible to share, with whom and in what way, in accordance with all applicable legislation. (Paragraph 104)

Oversight, support and intervention

23. The Government must do more to bolster its ability to support local areas, hold them to account and intervene, when necessary. In particular, the Government should seek to foster an environment of continuous improvement by filling gaps in research and encouraging local areas, through support and incentives, to identify, test, adopt and spread what works to improve outcomes. This applies to whole system approaches as well as single interventions. Local authorities should be prevented from continuing to pursue the delivery of programmes for which there is no evidence base. (Paragraph 114)
24. We recommend that an expert advisory group should be established to support the Government by coordinating a national approach to filling gaps in research and to advise on how the national strategy should adapt accordingly over time to reflect this evidence. (Paragraph 115)
25. We agree with our colleagues on the Science and Technology Committee that “local authorities would benefit from the support of a central specialist team with experience in effectively and sustainably implementing early intervention programmes.” We recommend this team should be comprised of, and where necessary be able to call on the advice of other, experts from multiple disciplines, including those with specific professional expertise and skill sets (e.g. implementation science and quality improvement). (Paragraph 116)

26. We support the proposals within the NHS Long-term Plan for the NHS to play a greater role in the commissioning of public health services. The Government and national bodies should encourage the NHS to work collaboratively with local authorities to commission these services, through encouraging the voluntary pooling of budgets and the establishment of joint commissioning teams. (Paragraph 117)

Annex 1: Mumsnet Forum

As part of this inquiry, we held an online forum in December 2018 on Mumsnet. We received over 80 posts, which we heard directly from mums about their experiences of pregnancy and early parenthood, as well as the services they used during this time. The posts covered a wide range of issues from women's experiences of healthcare professionals and services as well as the impact of housing, employment and parental leave. This annex provides a summary of the key themes discussed on the forum.

During pregnancy, mothers who saw the same midwife often appeared to have a better experience. Many mums reported mistakes during pregnancy, health issues being missed or undiagnosed, which resulted in consequences for them and their children later. There wasn't much mention of the role midwives can play in delivering public health messages to mums and parents during this period. For many mums, their experience of labour was chaotic, and in some cases, very traumatic. Many told us of mistakes being made on busy labour wards. Immediately after birth many mums commented on a lack of support to help with breastfeeding.

Breastfeeding, including breastfeeding support, was an issue raised by many mums. Many spoke about a lack of consistent advice from the professionals they spoke to. We heard that mums often end up believing breastfeeding myths, as a result. One mum emphasised the value of breastfeeding support saying:

I would have given up if it was not for the support of my local hospital, who admitted me for breastfeeding support and didn't let me go until I was happy. Not everyone gets that help and so a lot of women give up. It's all very well encouraging women to breastfeed, but the support has to be there, otherwise you just cause a feeling of failure and depression.

Many mums we heard from suffered from anxiety and depression, particularly postnatal depression. For many their symptoms of postnatal depression were not picked up, while some actively try to hide these symptoms. Others did not seek help for various reasons. For example, some we worried about the effect of medication on their baby's health while they were breastfeeding, while others did not seek help as their local services were not easily accessible. Mums whose postnatal depression was known to professionals still described feeling very unsupported.

Mothers often reported feeling isolated during the early years of their child's life, especially if they lived in rural areas or did not have family close by. Their isolation was also compounded by a lack of local facilities, such as those in children's centres or libraries. Many mothers described children's centres as a lifeline. In the words of one mum:

I found my local children's centre an absolute godsend when my first daughter was little. I used to go there four out of five days a week, I think it probably saved my life as I was very low and very isolated at that point.

Mums valued not only the services and activities offered in children centres—the expertise of staff, the range of groups and parenting programmes available, and the offer of free vitamins—but the opportunity meet other people, particularly other parents, that children's centres provided. We also heard about how children's centres play a crucial role

in the identification of needs. One mum mentioned how she knew there was something wrong with her child, but wasn't sure what it was. Eventually, by seeing a speech and language therapist at the children's centre, her child was referred to paediatrician, who identified that her child had special needs. Some mums had noticed the impact for cuts to funding. One mum told us:

after my first child I used the children's centre several times a week. They had fantastic kind knowledgeable staff, offered lots of play groups (to help meet other parents), amazing various parenting/baby related courses that definitely helped me bond with my child and adjust to the new world of parenthood. However, with my second I certainly noticed the negative impact government funding cuts have had on these amazing places. It is tragic that something that offered so much support to new parents is suffering due to austerity measures.

Childcare was reported to be very expensive and of poor quality, especially in comparison to other countries. Women reported quitting their jobs to avoid paying for childcare.

People's experiences of healthcare services, particularly midwives, health visitors and GPs, was very mixed. Some of the mums we heard from gave glowing accounts of the care they received, while others provided examples of very poor care. Mothers' opinions of healthcare services and professionals was influenced by: staff attitudes; whether problems were identified and responded to effectively; communication between staff; the consistency of the information and advice they received; and continuity of care they experienced. Many mums reported that they did not see the same midwife, health visitor or GP. However, for those that did they tended to have a more positive view of their experience and more favourable opinions about the staff they saw. The mums we heard from often reported that staff appeared to be under a lot of pressure, which they felt gave rise to a box ticking approach to care that they experienced.

Mums often reported that they had only seen a health visitor once or twice. Others mentioned occasions where one of the mandated visits was missed. After receiving visits in the first few weeks after birth, mums were often told to see health visitors at a baby clinic, although mums frequently mentioned that these were full or very busy. Despite very mixed experiences, we heard examples that reinforced the vital role health visitors play, particularly in identifying issues. One mum told us that:

an amazing health visitor spotted my postnatal depression when I'd managed to successfully hide it from friends and family, I hear a lot about HV's not being needed, I don't agree. If she hadn't spotted it I'm not sure where I would have ended up.

In contrast, another mum told us how no one really picked up on her postnatal depression. She described herself as a middle-class, professional woman and that there was a subsequent assumption from professionals that she'd thrive. When talking about her postnatal depression, she mentioned that she tried to explain to a health visitor how she was feeling, but the "health visitor tried to play it down" and made her "experience fit a narrative that didn't really apply."

We heard about how problems with housing, particularly private rented accommodation, and employment can have on parents and families during the early years of their children's lives. Some mothers mentioned that there is a lack of part-time or flexible jobs. One mum told us that:

this inhibits efforts of professional mums to return to work, unless they are on low salaries. In my experience this contributes to stress, isolation, a loss of feeling “useful”, reduced standard of living, and means many mums don't contribute to our economy as much as they could.

We also heard about inflexible, and even unsupportive, actions by employers and how these actions compounded the pressures on parents and families. Women reported how pressures of family life were not recognised by employers. One woman told us that her employer tried to get her to sign a new contract before she went on maternity leave, which would have removed her annual bonus, her car allowance and reduced her pension by 3%.

Leave was another important issue. Where their husbands were self-employed, mothers mentioned that the father had no paternity leave and, consequently, returned to work very soon after the birth, leaving them without support for most of the day. We heard that if fathers were able to take more leave that this would help mothers during this period. One respondent told us that her partner's employer didn't permit him any annual leave after his two weeks statutory paternity leave. She said that feels:

... if fathers were allowed a slightly longer period of leave (maybe 6 weeks) it would have helped me cope better during those initial weeks with a newborn. He had four weeks off with my first child and it made a huge difference, especially when not everyone has extended family they can call on close by for support.

Another mum mentioned that the “very low take up of shared parental leave underlines something isn't calibrated right in how the system motivates people to combine work and family life.” On shared parental leave one woman mentioned that her and her husband were using shared parental leave as they both want time with their baby boy. Her husband planned to take 3 months of the shared leave, 2 weeks paternity leave and another 2 weeks of annual leave, whereas she was taking 10 months leave, including the remaining 9 months of their shared leave and another month of annual leave, before preparing to go part-time. On shared parental leave, she said, despite recognising that they both have relatively flexible employers, one year between both parents seemed far too little.

Housing, particularly rented accommodation, was another source of stress for some families. One woman mentioned that her landlady served her notice as she didn't want children in the flat. Talking about private rented accommodation, one mum mentioned that “the instability is a constant anxiety that you try not to pass onto your children, but it's inevitable. It's little things like letting them paint or use play dough, as you're petrified it will get on the walls or carpet.”

Annex 2: Visit to Blackpool's A Better Start Programme

Background

In November, the Committee visited the Blackpool Better Start project, run by the NSPCC and funded by the Big Lottery Fund.

Blackpool is one of five sites in England (Blackpool, Bradford, Lambeth, Nottingham and Southend) participating in a ten-year National Lottery funded programme focused on improving the life chances of babies and young children from pregnancy and in the first three years of life. The Big Lottery Fund has invested a total of £215 million into the five sites (around £45 million to Blackpool) over 10 years. The focus of the programme in Blackpool is on reducing pressures on families from common risk factors associated with adverse experiences in childhood: drugs, alcohol, mental ill health, domestic abuse and social isolation. Four years into the programme, the Committee wanted to see how Big Lottery Fund's investment is being used locally and what lessons the programme might have for policy and practice in England.

What the Committee did

In the morning, the Committee held workshops with staff and parents at a local children's centre. It heard how having a "one-stop shop" for families helped to provide seamless support and ensure professionals can build relationships with other and share information. It visited repurposed community spaces across Blackpool, including a library and an local park, both of which had been transformed by members of the local community to make them more suitable for families with young children. In the afternoon, a roundtable discussion took place with senior health and local authority leaders from across Blackpool about the benefits and challenges of the Big Lottery Fund's investment.

What the Committee learnt

Local councils and the NHS are operating in a financially constrained climate. Hearing from local leaders in Blackpool highlighted the value of relatively small sums of money giving services the headspace to engage in transformation. The Big Lottery Fund's investment helped:

- provide extra time, capacity and expertise to redesign local services, which Blackpool would not have otherwise had.
- foster strong partnership working between local services, made up of the local council, NHS commissioners and providers, the voluntary sector and the police.
- protect resources from being directed away from service transformation and towards the more short-term challenges in Blackpool.

Annex 3: Focus groups with local commissioners and charities

As part of the visit to Blackpool, the Committee held three focus groups with representatives working in councils, clinical commissioning groups and the other A Better Start sites across country. The discussions covered some of the common issues local commissioners face as well as views on what role the Government should play in the first 1000 days. This annex provides a summary of the following five areas covered: national priorities; universal and targeted approaches to local service delivery; integration; outcomes and performance; and prevention and early intervention.

National priorities

In terms of national Government, the Committee heard that local areas think a balance needs to be struck between the role of national and local bodies. Attendees widely supported the implementation of national framework, consisting of some high-level outcomes, that local areas needed to deliver. Strategic partnerships between key local players (commissioners and providers, including the voluntary sector) are critical.

Local service delivery: universal and targeted approaches

Some councils have seen 50% reductions in funding for children centres. However, one council which closed a local children's centre had expanded its outreach services. In making these changes, the Committee heard that, from the point of view of some representatives, communities can be attached to buildings, rather than the services that are delivered within them. National policy on children's centres is ambiguous in places. For example, the guidance says that children's centre provision needs to be "sufficient" to meet the needs of their population, but sufficiency is not clearly defined.

Government also has a role in spreading best practice by showing local areas the sorts of models they can move towards. The Troubled Families Programme had adopted a bid approach to funding, in which funding was allocated based on compliance with specified criteria. This was supported by some members, although others were concerned that this competitive approach was unhelpful, as areas bid against each other and there are always winners and losers.

Integration

On the subject of integration, data sharing was a major issue. Professionals locally were often using different case management systems, which is a barrier to data sharing. The General Data Protection Regulation (GDPR) was widely viewed to have made information sharing harder, and it can be a bugbear for local people when they are repeatedly asked for their consent.

The group emphasised the importance of a systems approach. Budgets across government need to be pooled together, rather than dispersed between departments. Currently, the fragmented system nationally means that it is up to local commissioners to pull money in from different pots, which attendees thought was inefficient.

Issues, such as geographical footprints and political dynamics, can make joint working difficult. One attendee mentioned that the post of Director of Commissioning had been created in their council to bring teams together, with closer commissioning relationships with CCGs. Another representative spoke about how their council had implemented joint commissioning across a range of disciplines, with a much greater emphasis on commissioning across a whole system.

Improving outcomes and performance

In terms of outcomes data, the Committee heard about A Better Start's common outcomes framework, and the challenges of data collection and interpretation therein. One representative wanted a review of outcome measures, and others thought that some measures, while rigorous, were not helpful in evaluation. Attendees said that they wanted the potential of data linkage between services to improve, including the ability to overlay social data with school and prison data. However, they reported that this is difficult because of poor communication between systems. The Committee heard about nascent life cohort studies being conducted in various areas, but also that these studies are usually not useful for real time analysis to identify and support individuals.

At a national level, some attendees called for the renewal of national child poverty indicators and a national target to reduce child poverty. Attendees raised this as an issue in terms of the knock-on effect it has on the co-ordination of services and continuity of care, for example when parents and families in temporary housing have to move because their contract has come to an end or their landlord has increased the rent.

Prevention and early intervention for first 1000 days of life

There was support for taking a 'child health in all policies' approach and an aim to address wider determinants of health in the first 1000 days. Ringfencing resources for prevention and early intervention was supported, but the Committee heard that this is only as good as the period for which it lasts. There needs to be a sustained commitment on longer cycles (for example 10 years rather than just for the duration of one parliament).

Formal minutes

Tuesday 12 February

Members present:

Luciana Berger	Andrew Selous
Mr Ben Bradshaw	Martin Vickers
Rosie Cooper	Dr Paul Williams
Johnny Mercer	

In the absence of the Chair, Dr Paul Williams was called to the chair.

Draft Report (*First 1000 days of life*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 120 read and agreed to.

Annexes agreed to.

Summary agreed to.

Resolved, That the Report be the Thirteenth Report of the Committee to the House.

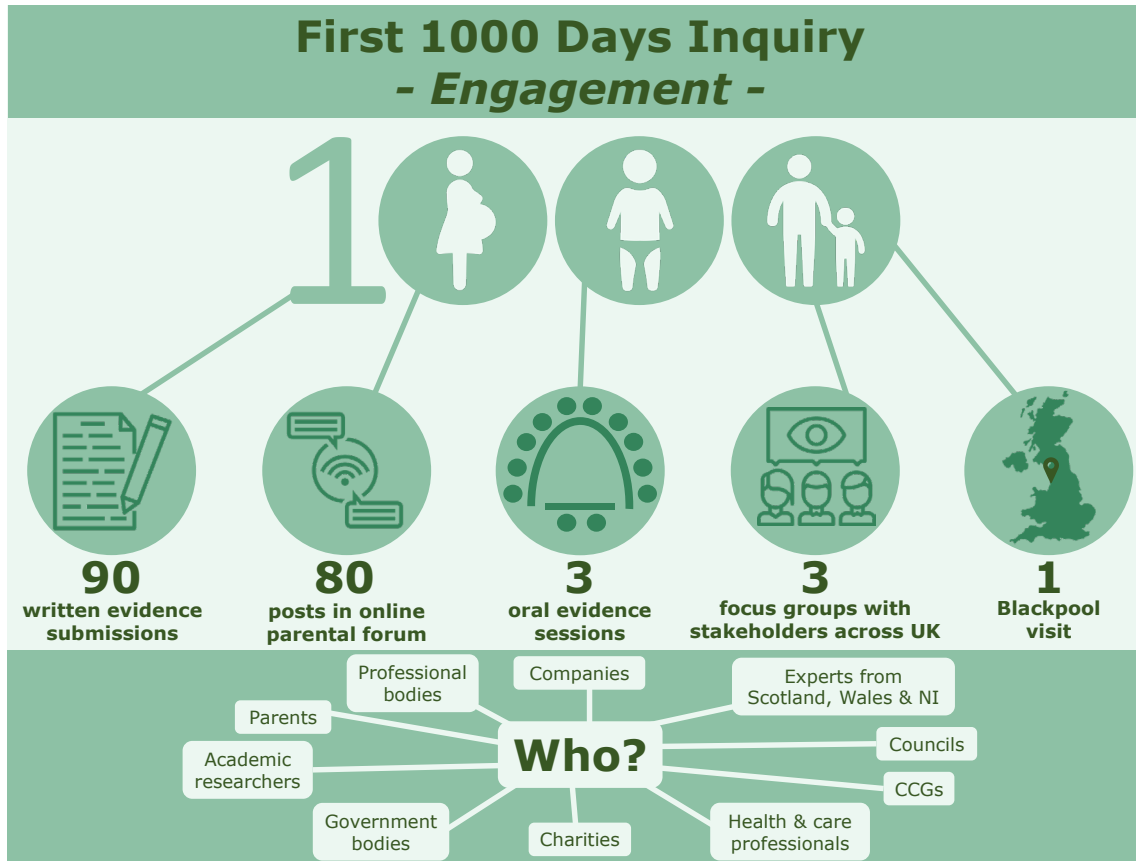
Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 26 February at 2pm

Engagement

The infographic below summaries the engagement the Committee has had with stakeholders and the public during the course of the first 1000 days inquiry.



Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 6 November 2018

Elaine Kelly, Senior Research Economist, Institute for Fiscal Studies, **Anne Longfield**, Children's Commissioner, **Dr Angela Donkin**, Chief Social Scientist, National Foundation for Educational Research [Q1–43](#)

Dougal Hargreaves, Honorary Consultant Paediatrician at University College London Hospital and Visiting Research Analyst, The Nuffield Trust, **Anthoulla Koutsoudi**, Director of External Relations, WAVE Trust, **Sarah Benioff**, Deputy Director of Strategic Funding, The Big Lottery Fund, **Dr Jo Casebourne**, Chief Executive, The Early Intervention Foundation [Q44–99](#)

Tuesday 13 November 2018

Elizabeth Duff, Senior Policy Advisor, National Childbirth Trust, **Dr Alain Gregoire**, Chair, Maternal Mental Health Alliance, **Anna-Marie Hassall**, Director of Practice and Programme, National Children's Bureau, **Javed Khan**, Chief Executive Officer, Barnardo's [Q100–152](#)

Dr Cheryll Adams, Executive Director, Institute of Health Visiting, **Ailsa Swarbrick**, National Unit Director, Family Nurse Partnership National Unit, **Gill Walton**, Chief Executive, Royal College of Midwives, **Dr Beckie Lang**, Chief Executive, Parent Infant Partnership (PIP) UK Ltd [Q153–218](#)

Monday 3 December 2018

Dr Catherine Calderwood, Chief Medical Officer, Scottish Government, **Deidre Webb**, Lead Children's Nurse, Public Health Agency, Northern Ireland, **Professor Charlotte McArdle**, Chief Nursing Officer, Department of Health, Northern Ireland, **Professor Jean White**, Chief Nursing Officer, Welsh Government, **Karen Cornish**, Deputy Director Children and Families Division, Communities and Tackling Poverty Department, Welsh Government [Q219–289](#)

Professor Viv Bennett, Chief Nurse and Director of Maternity and Early Years, Public Health England, **Dr Helen Duncan**, Programme Director, National Child and Maternal Health Intelligence Network, Public Health England [Q290–326](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

FDL numbers are generated by the evidence processing system and so may not be complete.

- 1 Action for Children ([FDL0044](#))
- 2 Arran, Miss Emma ([FDL0047](#))
- 3 The Association for infant Mental Health (AIMH (UK)) ([FDL0032](#))
- 4 Association of Child Psychotherapists ([FDL0022](#))
- 5 Association of Directors of Public Health ([FDL0059](#))
- 6 Auditory Verbal UK ([FDL0053](#))
- 7 Barnardo's ([FDL0020](#))
- 8 Best Beginnings ([FDL0014](#))
- 9 Better Start Bradford ([FDL0046](#))
- 10 Big Lottery Fund ([FDL0069](#))
- 11 BIVDA ([FDL0088](#))
- 12 Bliss ([FDL0058](#))
- 13 British Pregnancy Advisory Service ([FDL0026](#))
- 14 British Psychoanalytical Society (Institute of Psychoanalysis) ([FDL0015](#))
- 15 BSNA ([FDL0089](#))
- 16 Centre for Performance Science, Royal College of Music and Imperial College London ([FDL0005](#))
- 17 Centre for Research in Early Childhood (CREC) ([FDL0027](#))
- 18 Children North East ([FDL0062](#))
- 19 City of Bradford Metropolitan Council ([FDL0017](#))
- 20 CLOSER, the home of longitudinal research ([FDL0021](#))
- 21 Cornwall Council ([FDL0040](#))
- 22 Cullen, Mrs Sarah ([FDL0079](#))
- 23 Department of Health and Social Care ([FDL0067](#))
- 24 Durham University Infancy & Sleep Centre (DISC) ([FDL0057](#))
- 25 Early Intervention Foundation ([FDL0070](#))
- 26 Early Intervention Foundation ([FDL0085](#))
- 27 Family Links: the Centre for Emotional Health ([FDL0023](#))
- 28 Family Nurse Partnership National Unit ([FDL0076](#))
- 29 Fatherhood Institute ([FDL0038](#))
- 30 Field, Frank ([FDL0083](#))
- 31 Flynn, Ms Lynn ([FDL0012](#))
- 32 Foreman, David ([FDL0013](#))
- 33 The Health Foundation ([FDL0081](#))

- 34 HENRY ([FDL0037](#))
- 35 Insight Parenting/GroBrain ([FDL0064](#))
- 36 Institute of Health Visiting ([FDL0031](#))
- 37 Kent County Council ([FDL0009](#))
- 38 Kraemer, Dr Sebastian ([FDL0001](#))
- 39 La Leche League GB (LLLGB) ([FDL0028](#))
- 40 Lactation Consultants of Great Britain ([FDL0034](#))
- 41 Lifestart Foundation ([FDL0036](#))
- 42 Little Minds Matter: Bradford Infant Mental Health Service ([FDL0054](#))
- 43 Liverpool First 1001 Critical Days Strategic Group ([FDL0049](#))
- 44 The Local Government Association ([FDL0072](#))
- 45 Manchester Health and Care Commissioning ([FDL0078](#))
- 46 Martin, Mr Paddy ([FDL0010](#))
- 47 Maternal Mental Health Alliance ([FDL0006](#))
- 48 Maternity Action ([FDL0082](#))
- 49 mcutcheon, moira ([FDL0007](#))
- 50 Mental Health Foundation ([FDL0041](#))
- 51 Munday, David ([FDL0063](#))
- 52 National Association for Therapeutic Education ([FDL0003](#))
- 53 National Children's Bureau ([FDL0050](#))
- 54 NCT ([FDL0052](#))
- 55 Nottingham CityCare Partnership CIC ([FDL0019](#))
- 56 NSPCC ([FDL0075](#))
- 57 Nuffield Trust ([FDL0048](#))
- 58 Olliffe, Miss Katie ([FDL0030](#))
- 59 Out of Hospital Care Forum ([FDL0024](#))
- 60 Parent Infant Partnership (PIP) UK ([FDL0016](#))
- 61 Pennine Care NHS Foundation Trust ([FDL0008](#))
- 62 Pre-school Learning Alliance ([FDL0035](#))
- 63 Public Health England ([FDL0077](#))
- 64 Public Health England ([FDL0084](#))
- 65 Public Health England ([FDL0091](#))
- 66 Public Health Wales NHS Trust ([FDL0018](#))
- 67 The Royal College of Midwives ([FDL0051](#))
- 68 Royal College of Midwives ([FDL0086](#))
- 69 Royal College of Nursing ([FDL0042](#))
- 70 Royal College of Paediatrics and Child Health ([FDL0074](#))
- 71 Royal College of Psychiatrists ([FDL0039](#))

- 72 Royal College of Speech and Language Therapists ([FDL0043](#))
- 73 Smoking in Pregnancy Challenge Group ([FDL0080](#))
- 74 South London and Maudsley NHS Foundation Trust ([FDL0045](#))
- 75 SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST – LOCAL PERINATAL PROVISION / PARENT-INFANT SERVICE ([FDL0065](#))
- 76 South London and Maudsley NHS Foundation Trust/ Big Lottery Better Start Programme ([FDL0025](#))
- 77 Strong Start for All Children ([FDL0033](#))
- 78 Surrey County Council on behalf of Surrey Health and Care Partnership ([FDL0056](#))
- 79 Tavistock Relationships ([FDL0071](#))
- 80 Together for Short Lives ([FDL0055](#))
- 81 Unicef UK ([FDL0004](#))
- 82 Unite the union ([FDL0066](#))
- 83 WAVE Trust ([FDL0073](#))
- 84 Welsh Government ([FDL0087](#))
- 85 Wiltshire Council ([FDL0011](#))
- 86 World Breastfeeding Trends Initiative - UK Steering Group ([FDL0068](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353 (Cm 9669)
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392 (Cm 9620)
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642 (Cm 9627)
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650 (Cm 9695)
Eighth Report	Childhood obesity: Time for action	HC 882 (CP23)
Ninth Report	Long-term funding of adult social care	HC 768
Tenth Report	Appointment of the Chair of NHS England	HC 1351
Eleventh Report	Antimicrobial resistance	HC 962
Twelfth Report	Prison health	HC 963 CP 4
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451