

Health and Social Care Committee

Oral evidence: [The First 1,000 Days: a renewed focus](#), HC 802

Wednesday 7 May 2025

Ordered by the House of Commons to be published on 7 May 2025.

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Members present: Paulette Hamilton; Danny Beales; Jen Craft; Josh Fenton-Glynn; Alex McIntyre; Gregory Stafford.

In the absence of the Chair, Paulette Hamilton took the Chair.

Questions 1 - 49

Witnesses

[I](#): Professor Sir Michael Marmot, Professor of Epidemiology at University College London, and Director at UCL Institute of Health Equity.

[II](#): Rt Hon. Dame Andrea Leadsom DBE, Former Parliamentary Under-Secretary of State, Department of Health and Social Care, and the Government's Early Years Health Development Advisor and Chair at Early Years Healthy Development Review.

Examination of witness

Witness: Professor Sir Michael Marmot.

Q1 Chair: This is the first session of the Health and Social Care Committee inquiry into the first 1,000 days. I am Paulette Hamilton, a member of the Committee and the vice-Chair, but I will be chairing today's meeting because Layla is away. I welcome the first panel. Professor Marmot, will you introduce yourself?

Professor Sir Michael Marmot: I am Michael Marmot. I am director of the UCL Institute of Health Equity. As you may know from reading the previous report on this topic, which I wrote, I led the strategic review of health inequalities in 2010—the Marmot review. We published “Health Equity in England: The Marmot Review 10 Years On” in February 2020, and we have done a whole series of reviews for particular localities around England, Wales and Scotland.

Q2 Chair: The 2020 review showed that the picture on health inequalities had actually worsened. What do you think are the main blockers in addressing health inequalities?

Professor Sir Michael Marmot: In my 2010 review, we laid out six domains of recommendations that we said would improve health and reduce health inequalities, based on a review of the evidence: No. 1, give every child the best start in life; No. 2, education and lifelong learning; No. 3, employment and working conditions; No. 4, everyone should have at least the minimum income necessary for a healthy life; No. 5, healthy and sustainable places in which to live and work, including housing; and No. 6, take a social determinants approach to prevention.

Those are closely linked. Housing is a poverty issue, and poverty is a housing issue; if you are paying too much for housing, you cannot afford good food. Children who grow up in cold homes have damaged lungs, their mental health is worse and they do less well in school. So you can see that, although these are six separate domains, they are closely linked.

If we look at what happened post 2010, pretty well all the policy changes were in the opposite direction from what I recommended in my 2010 review. Child poverty went up. Spending on early childhood went down. The spend per child on education went down. Unemployment went down, which was very welcome, but there was fragility of employment—the gig economy.

On No. 4—income—I have already said that child poverty went up. There was some debate in Parliament about the abstruse measurement of child poverty. Do you measure it as less than 60% median income, which is the international standard? Or do you measure it as 60% of median income in 2010, look at how that has changed and call that absolute poverty? I would not; I would look at destitution, which the Joseph Rowntree Foundation does. That went up, with 1 million children living in a state of



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destitution, doing without two or more of six basics: housing, heat, light, food, clothing and toiletries. There was a 2.5-fold increase in five years. We know we have a housing crisis. One third of UK households are below the minimum income threshold or in housing where the energy conservation level is not up to C, B or A—one third.

Q3 Chair: Can I push you a little further? Covid-19 was absolutely horrific for families in the UK. Has that introduced new challenges into everything that you have just talked about? What were the issues relating to covid-19? What issues then were thrown in the mix with the pre-existing issues?

Professor Sir Michael Marmot: Well, we said at the beginning—I wrote a little commentary piece, I think in March 2020, and said this—that covid would reveal the underlying inequalities in society and amplify them. When His Royal Highness the Prince of Wales, as he then was, got covid and the Prime Minister got covid, people said, “Everyone is at risk,” and we said, “No, it will follow the social gradient.” When you look at covid mortality, if you classify people by where they live, and classify where they live by level of deprivation, you see a social gradient—the more deprived the area, the higher the covid mortality—which looks almost exactly parallel to the social gradient for all-causes mortality. It is slightly steeper for covid.

We said it would reveal the underlying inequalities and amplify them. It was slightly steeper for covid because, we think, for people in the bottom three deciles of deprivation, living in overcrowded households and being exposed to covid in the workplace—frontline exposure—would amplify it. What we saw, certainly in the first wave of covid, was that the UK had the highest excess mortality of any rich country. In general, there was a correlation between how poorly health had improved in the decade before covid and how poorly we managed covid or the impact of covid.

There was a US publication looking at life expectancy in 2020, 2021 and 2022, compared with 2019. The US had the biggest decline in relation to all-causes mortality and in life expectancy, and then Scotland, Northern Ireland, Germany, England and Wales. We did really poorly among the rich countries. We had a decline in life expectancy, in three years of covid, that was not seen in other rich countries; it was in the US.

So what we saw with covid was that it exaggerated the pre-existing inequalities. Then, of course, there is the whole issue of the steps we took—and rightly. I hold my hand up: when people asked me at the time about school closures, I was mixed—I cannot claim great insight and that I knew the right thing to do. On the one hand, I was terribly concerned about the education divide and that closing schools would have a disproportionate impact on children from deprived areas. On the other hand, I did not want to spread covid. I was genuinely mixed, so I cannot claim great insight. In hindsight, it looked like we overreacted in closing the schools, but I did not know that at the time.

Q4 Chair: I just want to push you a little further regarding inequalities. You have talked about America in relation to covid and inequalities, and you



have talked about Scotland; I think you highlighted it. If you were to highlight some other countries, where would you say that we should be looking to learn from on the issues of inequality and our young people?

Professor Sir Michael Marmot: The Prime Minister of Norway invited me to do a rapid strategic review of health inequalities and social determinants of health in Norway. When presenting one of my reports, I am so used to just saying, "This has gone wrong, and that's gone wrong. This is not working, and we need to pay attention to this." When I presented the Norwegian report to the Norwegian Government, I said, "You're doing pretty well on early childhood—things seem to be improving. Your policies of universal access seem to be working." The Norwegians were saying, "We want to do even better. We're aware that we have inequalities. We may be doing well by your lights, but we want to do better." They looked pretty good, I have to say.

Q5 **Chair:** Thank you for that. One of the objectives that came out of your 2010 review was to, "Give every child the best start in life". You have always advocated for that holistic approach, rather than targeted, individual aspects of health. More targeted models, such as family hubs, are actually being used in the UK at the moment. How can they be most successful? We have not really gone for the holistic approach; we have gone for the more targeted approach at the moment.

Professor Sir Michael Marmot: Let me give you a figure, with a caveat, on social mobility. The caveat is that the problem with measures of social mobility is that it is a zero-sum game: if somebody is up, someone is down. That is the way it is usually measured, so that is the caveat; we want to improve things for everybody.

Let me take the US as an example; it has good figures. For somebody born in the 1940s, there was something like an 80% chance that their children, when they grew up, would be richer than them. For somebody born in the 1980s, it was 50:50. Goodness! That is dramatic. If you were born in the 1940s, you could be pretty confident that your kids would have a richer, more prosperous life than you. If you were born in the 1980s, it is 50:50.

One way of looking at social mobility is, what is the probability that somebody born into the 10th centile of income could make it to the 50th? We know that, in general, rich parents have rich children and poor parents have poor children, when they grow up, and that is in every country. The question is: at the current rate of social mobility, how many generations would it take for somebody born into the 10th centile to get to the median, or the 50th? In Denmark, it would take two generations. In Norway, Finland or Sweden, it would take three generations. In the US and the UK, it would take five generations. In Brazil, it is nine.

Why is there this big difference? There are two kinds of explanations. First, there is the magnitude of income inequality: the greater the income inequality, the greater the distance between the rungs of the ladder and



the more difficult it is to climb from one rung to the next, for the next generation.

Secondly, there is investment in early childhood. If you look at OECD figures from UNICEF—I think the latest figures that I can find are from 2022—the average spend per child aged nought to five is \$6,000 per child per year, at purchasing power parities. In Norway, they spend a bit more than \$12,000. In the other Nordic countries, it is \$9,000 or \$10,000, and in France it is about \$9,000. The average is \$6,000. We seem to be about average. The US is \$3,000. Brazil is not in the OECD countries, but Mexico and Colombia are, and they are below \$3,000, so Brazil is probably down there.

If we have big income inequalities and do not spend on early childhood, our children do not have a chance of getting out of poverty. We are condemning them to the same level of poverty that their parents have; we are not giving them a chance.

I prefer the notion of giving every child a start. It is not that we want this child to get up and that one to get down; we want every child to have a chance—we would like to improve things for everybody. That is where the investment in early childhood really matters. In a way, that is the link between focusing on deprived, poor families, and my approach, which is that we want to improve things for everybody. I would say that we want less income inequality and greater expenditure on early childhood for all our children.

Q6 Chair: Before I hand over to my colleague Jen, my last point is that some people start at a lower level, so we are not all starting from the same starting point. The problem is that, when we put money into a system, sometimes those who need it most do not actually get the money. With your ideas and that holistic approach, how would you ensure that we get equality, even in inequality, if that makes sense?

Professor Sir Michael Marmot: I know you want to ask, and I want to talk, about proportionate universalism, but we do it in the NHS; we know how to do it. When we define need clinically, we do not spend the same amount of money on every person in Britain. If you have diabetes, peripheral vascular disease, renal complications and hypertension, we spend a lot more on you, and rightly so. We have a universal system available to everyone, but our effort is proportionate to need. The need is defined clinically, and we know how to operate proportionate universalism. It is the very basis of our national health service.

I would be delighted if I never saw a doctor again—I would not think my taxes were wasted—but when I fell off my bicycle and fractured my femur, I was very happy that the ambulance came and that the whole system kicked in and gave me what I needed. If I fell off a cliff at age 99, as I fell to my death, I would not say, “Damn, I paid all those taxes.” It is a universal system available to all of us, with effort proportionate to need, and as my need increases, it is there for me.



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Let us take that idea and apply it to need defined in a different way—to do with deprivation, with poverty. How do we get a universal system? How do we get the best? We know how to do good education in this country—we have terrific education. How do we apply those principles, so that this is available to everyone?

We also need to work harder. It has been put to me that the middle classes have sharp elbows—we have a universal system, but people with sharp elbows will get their way in, while other people, who are used to saying, “This is not for me”—the ones who need it most—will be elbowed out. That is where the effort proportionate to need comes in. Some of our work with Barnardo’s is trying to deal with exactly those issues, making sure we are not focusing exclusively on people most in need, but focusing sufficiently to make sure that they do not miss out.

Chair: Fantastic. Thank you for that brilliant opening. I will hand straight over to my colleague Jen Craft.

Q7 Jen Craft: That was a rather good example of proportionate universalism in healthcare, but one thing that struck me is that that still relates to the principle of acute care rather than prevention. When we are looking at early years, we are looking at prevention. There is a very obvious way that you do proportionate universalism in terms of acute care, because the need is right in front of you, in the example you gave, whereas with prevention, the need is not always obvious as to how that should be applied. Are there examples, particularly in the early years space, where the principle of proportionate universalism is being applied, that are particularly successful?

Professor Sir Michael Marmot: Can I start with a negative example, where the opposite principle was applied? We just did this at the end of last year, looking at life expectancy for every local authority in England in 2010-12. We then looked at the subsequent reduction in local government spending power up to 2020. We saw that the shorter the life expectancy, the steeper the reduction in local government spending power in the subsequent 10 years. This is effort inversely proportionate to need, and it was a gradient. There were one or two really deprived communities that had all their money taken away, but the shorter the life expectancy, the more money that was taken away, and it was graded. This is a perfect counter-example. It is effort inversely proportionate to need.

If you were applying a principle of proportionate universalism, you would say that the greater the need of the community, the more money we would put in, because they need more services. We would not just target the most needy; we would do what this graph showed, but I would have it sloping completely the other way. We have a principle being applied completely counter to morality—completely immoral, in my view—and to technical competence, improving the health of the population and reducing inequalities. What possible justification is there for doing that? We kind of know how to do it; we chose to do it the wrong way.



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Your point is incredibly important, because when I talk about universalism in the NHS, we know that the type of interaction differs by socioeconomic position of the patient. Discussions about prevention are more likely. Again, the chattering classes might; my neighbours have just read on some website that watercress is good for preventing cancer this year, so they want to discuss with the doctor whether they should be having more watercress—I am being only slightly trivial. We know the quality of the type of interaction between the patient and their doctor is different depending on their socioeconomic position. That is most unfortunate, and there are things we can do about that.

- Q8 **Jen Craft:** Specifically in early years, if we look at where local authorities have the ability to make decisions on where they target funding, are there examples where they have used the principle of proportionate universalism, even given their funding constraints, to drive improvements on a local basis?

Professor Sir Michael Marmot: I wanted to have ready for you today answers to that question, but I have not got it ready. We have 50 Marmot places around England, Wales and Scotland. We are gathering the evidence on early childhood—on the kinds of interventions. I wanted to be able to tell you about them today, but I cannot, because we are in the process of gathering it.

What I can say is that there are lots of good examples. For example, Liverpool declared itself a Marmot city two weeks ago. When I was in Liverpool, not the last time but the time before, I said that I thought it was up to the Chancellor of the Exchequer to reduce child poverty, and that what local action could do would be to break the link between child poverty and poor outcomes. The citizens advice people—the CAB in Liverpool—said, “No, we do both. We make sure that children and their families get all the benefits to which they are entitled. We help parents get into work and find employment. We are actually reducing poverty as well as providing services.”

I do not want to get into the deep politics of Liverpool, but Everton football club has a wonderfully inspiring community hub, and people from the red half of Liverpool were proud to show me what the blue part was doing. It is wonderfully inspiring, and among their various activities is supporting young mothers and children. They are really trying to make a difference for the more deprived parts of Liverpool.

- Q9 **Jen Craft:** So there is currently no specific evidence to speak to proportionate universalism working in early years?

Professor Sir Michael Marmot: I am always looking for good examples that are not just targeted. We have got universal and we have got targeted, and I am looking for good examples of how they bring them together. I am still on that search.

School meals is past your first 1,000 days, but we are getting closer on school meals. The argument for universal free school meals is quite good. They have them in Wales. You might say, “Well, that is universal; that is



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not targeted—that is not proportionate universalism.”, but for example in Japan they do have universal school meals. All the children are involved, but the richer families pay, so it is a bit closer to proportionate universalism. It is a universal approach to school meals, and it is free for the poorer kids. The richer kids pay, but they get the same meals, and they participate in the same programme. The children prepare the meals themselves. They buy from local producers, so it is part of education in Japanese culture, of environment and of how society functions. It is about economic relations as well as good nutrition. That is close to an example of proportionate universalism.

- Q10 **Jen Craft:** Coventry was the first Marmot city, and it has had broad success in reducing relative deprivation, but not so much in improving early years outcomes. What do you think is the reason for that disparity?

Professor Sir Michael Marmot: In the last figures I saw from Coventry, the percentage of children aged five with a good level of development had gone up. We do not have a good counterfactual, and this is not a randomised controlled trial, so it is difficult to say what would have happened had it not been a Marmot city—but still, it is moving in a good direction. The percentage of children aged five with a good level of development did go up.

- Q11 **Jen Craft:** You say there is no real way to have a randomised trial, but there is a potential argument that the covid-19 pandemic provided something of a randomised trial in terms of early intervention and the broader early years space, since those face-to-face interventions were not necessarily popular. Do you think that maybe has borne out some of those principles on the need for early intervention, given that there was a lack of it and given the impact that is having on the children who are now reaching school age?

Professor Sir Michael Marmot: It is very concerning. We know that for the ones who were of school age, as I mentioned in response to the Chair's question, there was an increase in the educational divide. Children from more deprived backgrounds were less likely to have laptops and computers, and the schools in deprived areas were doing less in terms of online lessons compared with the ones in less deprived areas, where the students were more likely to have laptops and iPads and the like at home. So there was an increase in the educational divide. I don't know the figures for the impact of what happened on preschool; I have not actually seen the data for what happened, but I am concerned.

- Q12 **Jen Craft:** If we take it that there has been a drop-off in early years interventions, potentially following the pandemic or maybe even a longer period before, what kind of road to recovery is there? How do you build a service? You spoke briefly about mission-led government. Is there something about pulling together not just one Government Department, and is that something that can be replicated at a local level?

Professor Sir Michael Marmot: Let's take Sure Start. We know that something like 1,000 Sure Start children's centres closed in the decade of austerity. When the first evaluation of Sure Start was done—it was not



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randomised, but it was supposed to be a controlled comparison—the problem was that it got rolled out rather quickly, because of political imperatives, which from a scientist's point of view rather messed up the evaluation. It was probably quite good for the children, but not terribly good for the scientists, so the evaluation was equivocal. If you thought that the principles of Sure Start were surely valid, you could comb over the data and find evidence to support your view, and if you thought it was a waste of money and effort, you could look at the data and say it did not look very promising. There was something in it for—putting it crudely—both sides of the debate.

Then, some years later, the Institute for Fiscal Studies said that children who had experience of Sure Start had lower rates of hospitalisation. And then some years after that—I think it was even last year—they said children exposed to Sure Start did better at GCSEs. I looked at the data, hoping for a demonstration of proportionate universalism, but it showed that it was the more deprived kids who benefited. I was hoping I could see it graded, so I could not quite get the data to speak to me in the way I wanted it to, but it certainly showed benefit at GCSE.

What it meant was that you have to be in there for the long term. An investment like that had long-term benefits. Anybody who visited a Sure Start centre was unsurprised that it had benefits. Here were committed people, working with families and trying to do good things, and you think, "How could it not improve things?" As I say, it looked equivocal.

Coming back to your question, what could we do? It does not necessarily mean we have to resurrect Sure Start children's centres in exactly the way that they were before, but what we do know is that principle, and for my money it does get close to the principle of proportionate universalism. From the millennium cohort, if you look at parenting activities such as speaking to children, reading to children, playing, singing—doing good stuff—it follows a social gradient. It is not just that poor parents from deprived backgrounds do not do those things, it is graded: the lower the income, the less likely those good things are to happen.

It has been put to me that I blame poor people for being bad parents—I do not; I blame poverty of circumstances for making it harder for people to juggle all the pressures and needs upon them. But we can support them. That was part of what children's centres were supposed to be doing. We need to support people across the gradient. To come back to Norway, every child has state-subsidised childcare. It is not just for the poor kids; every child has it, and the quality of the childcare really matters. After 12 months, you are into the state-subsidised childcare. That is a principle of universality, and, ideally, they recognise kids with special needs and they put in extra effort. That is the principle.

Q13 Jen Craft: So Sure Start did not do proportionate universalism, because it exclusively targeted people in deprived areas—is that a kind of crude reading of the it?



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Professor Sir Michael Marmot: I argued at the beginning of Sure Start—when it was starting. I showed the gradient graph and said, “Don’t make it just for poor kids; look at the gradient in early child development and have it for everybody.” The argument that was made against me was that the middle classes would elbow out the poorer people.

- Q14 **Jen Craft:** Do you think that the principle of proportionate universalism is generally accepted, or do we still need to make a political case for it?

Professor Sir Michael Marmot: No, I do not think it is generally accepted. Take child benefit: if I say to my friend, who is a lawyer, “Well, it should be universal. Why would you want to start looking at people’s means and saying, ‘You get it—you don’t.’?”, my friend says, “Why should I get child benefit? I don’t need it; why give it to me? I’m perfectly happy to do without it because I’m well paid.” I am not sure it is generally accepted, because it sounds like a perfectly reasonable argument to say, “I’m well paid; don’t give me that child benefit, a universal benefit.”, whereas I would say, “Give it to everybody, and have progressive taxation so that some people give it back, or give some proportion of it back.”

- Q15 **Jen Craft:** Very briefly, at the local authority level, with constrained finances, it is perhaps difficult to make the case for proportionate universalism rather than targeting those most in need. Is that proving a difficulty?

Professor Sir Michael Marmot: You will have noticed that I paused when you asked whether it was generally accepted. I was trying to think, “Is it generally accepted?” and I have given you a counter-instance, but, in the local authorities that we are working with, it is generally accepted. They are not trying to deal only with the poorest members of their communities; they are trying to improve things for all children.

Chair: Thank you for that, Jen. I am going to go straight over to Greg.

- Q16 **Gregory Stafford:** Thank you very much. I am going to move on to the finances and the money behind this. This year’s NHS planning guidance saw the removal of the ringfencing of funding to allow for greater local control over finances. I think you have advocated for devolving funding and empowering local authorities to implement any sort of tailored strategies that address the specific health challenges of those communities. How would you change the funding arrangements to deliver this?

Professor Sir Michael Marmot: I have not dealt with that in detail. Certainly, the first principle relates to what I said earlier about effort inversely proportionate to need. I would want to restore an approach to funding that recognised need. One way I would do that is by deprivation, which is a graded phenomenon—the index of multiple deprivation. I would want to make sure that the funding allocation was proportionate to need, not inversely proportionate to need. That is very important.

Secondly—and I have had this discussion with local areas—there is an intellectual tussle. They are saying, “We want it to be ours. We want to do



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our thing,” and somebody like me is saying, “But you want to do things that work.” They say, “We don’t want an expert telling us what to do,” and I say, “But what I do is look at the evidence.” We would like to have evidence guidelines of the things that are effective but then have local control over how you apply those.

I do not know if that is an answer to your question, but there are two things. First, I would make sure the funding arrangements were proportionate to need, defined by, for example, the index of multiple deprivation. Secondly, I would try to find a way through this tussle when we say, “The evidence shows that these kinds of interventions are effective.”

To come back to what I was saying about Sure Start before, if I were convinced that Sure Start did not work, no matter how much respect I had for the people staffing those centres, I would not be strongly pushing it. The fact is, I think it does work, so we have an evidence base for saying that it is a good thing to do, but the way you do that in Rotherham—that is a non-random example, because we are working in that part of the world—might be different from the way you do it in Scotland. That is fine.

- Q17 **Gregory Stafford:** When we had the Secretary of State in front of us a few weeks ago, he was very clear that he wanted powers to be devolved to local level, and thus decisions and finances presumably become local as well. Is that something you support? Do you think that would be an effective way of dealing with some of the disparities you are talking about?

Professor Sir Michael Marmot: The funding mostly comes from the centre. If it was all at a local—

Gregory Stafford: It does now. The suggestion is that there could be much more local targeted funding, and I am trying to tease out whether that is something you would support.

Professor Sir Michael Marmot: I am nervous. There was a comparison between the US and Canada several years ago, before the current nonsense. One big difference was that programmes in the US tended to be funded from property tax, and in Canada they tended to be funded at the provincial, if not the federal, level.

The problem with funding from property tax is that poor communities have a lower income base, so they have less money for schools, amenities, playing fields and all those things, because they do not have a basis for raising money, whereas in Canada, where it was funded at a provincial level, you can make up for some of those problems. I would be a bit nervous about too much of the fundraising going down to local level. That may increase inequalities.

- Q18 **Gregory Stafford:** This may not be within your scope, but how do you think the merger of NHS England and the Department of Health and Social Care might benefit or have a disbenefit for the funding streams that you are talking about?



Professor Sir Michael Marmot: First, in general, it is a good thing to merge them for the obvious reasons: the bed blocking and so on. Secondly, people in the NHS may feel that they are not well paid—there has been lots of stuff about that—but compared with the NHS, payment in social care is appalling. I looked at this a few years ago: the average hourly pay for frontline workers in adult social care was below the real living wage.

Why should people doing such vital work in our communities not be paid a real living wage? If they were put on some kind of parity with NHS employees that would be a great benefit, and if they had job prospects like in the NHS. I am making it sound like there is some kind of utopia for NHS employees, which I doubt any of the unions would agree with, but compared with adult social care it is a good deal better. There is the obvious principle of trying to get these combined, so that you can discharge people from hospital knowing that there is good care in the community. I am also concerned about conditions of employment and hence conditions of care currently in adult social care.

Q19 Gregory Stafford: A final question from me—still on money, I am afraid. Do you see a disparity between the amount that the UK spends on adult health and social care as compared with children's health and social care along that distribution of income and poverty that you have described?

Professor Sir Michael Marmot: I do not know whether it is politically incorrect, but there is an urban myth that some very high proportion of lifetime expenditure on healthcare is in the last year of life. I look at my NHS colleagues and I say, "Can't we do better at predicting who is going to benefit from that inordinate expenditure and who is not?"

Moving into that age group, I think that this is really quite an important issue. To have people spend their last year of life hooked up to tubes and goodness knows what—that does not prolong their life and does not do anything for the quality of their life. We spend an inordinate amount of money in the last year of life, and some of that might be better spent in the first years of life. That is in no way saying that we should throw older people on the scrapheap. It is a challenge to my medical colleagues that we ought to do better at trying to figure out who is going to benefit from that extra treatment.

A member of my family has just been through it. She had a recurrence of cancer. She was a highly educated person, and two months of her last year were needlessly spent in hospital. She would have been much better being treated at home. They messed around and ruined the quality of the end of her life. It could have been handled much better—quite apart from how much money they spent. It did not do anything for the quality of her life. I just watched that playing out, somehow powerless to do anything about it.

That is in no way saying we should ignore older people, but somehow getting that balance right, of guaranteeing a high-quality of exit from this life, with palliative care support and so on, might actually save a bit of



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money that could be spent earlier in life. Notice that I have not mentioned the whole thing about voluntary assisted dying. It is not about that. It is about quality of care for people in the last year of life.

Gregory Stafford: Thank you very much. We could have a very long moral and philosophical discussion about all that.

Q20 Danny Beales: Thank you for your contribution so far. We are awaiting the 10-year plan for health to be announced very soon. In that context, where do you think the 1,001 critical days agenda sits? Specifically, we are envisaging that these three shifts will feature quite heavily in the plan: from sickness to prevention, from hospital to community, and from analogue to digital. Do you think that they are as relevant and helpful in the 1,001 critical days perspective?

Professor Sir Michael Marmot: When the Secretary of State and everybody involved in the 10-year plan talk about prevention, I say, "Great, but where's the reduction of child poverty in your health mission? That is vitally important." They said, "Well, that is not for the Health and Social Care Department." Yes, but it is for Government. Prevention is a whole-of-Government responsibility. I have just written a little essay for *The Lancet* about free school meals, but it could have been about the first 1,000 days.

There is a moral argument; we can come back and have the moral discussion. Children are born into poverty through no fault of their own. Why should they get damaged, when we could take the intervention that would improve things, and interfere with that link between parental poverty and poor child outcomes? There is the practical argument: it is a very good intervention. It improves children's health through the life course; it is likely to improve their education.

Q21 Danny Beales: I am getting the sense of perhaps "no". To be devil's advocate, in your view would the best 10-year health plan be nothing related directly to health care but simply—

Professor Sir Michael Marmot: No, I said the prevention part of the 10-year plan; I did not say nothing related to health care. We need high quality health care, the other two parts of the plan, but the prevention part needs focus on the social determinants of health. I mentioned my six principles before, and we have added two: tackle racism, discrimination and their outcomes; and pursue environmental sustainability and health equity together. My approach to the prevention part of the 10-year plan would be to focus on the Marmot eight principles.

Q22 Danny Beales: You would lean quite heavily on the six domains, the role of destitution and inequalities in driving these outcomes from an early age. In terms of the 1,001 critical days agenda, we have talked a lot about family hubs and other early years interventions. Would your theory and evidence suggest that the best thing to do would not necessarily be investing in early years, health visiting and other programmes, but just to have programmes that would tackle those domains—poor housing, income inequality, employment outcomes—as the most effective way to spend the



money, rather than the current available programmes?

Professor Sir Michael Marmot: No, they are both important. I would never say, "Don't provide football kits; just reduce poverty. Don't provide music lessons; just reduce poverty." I would never say that. One pathway that kids from more privileged backgrounds benefit from is football, music, art—a range of good communal activities. We need those things. I would never say, "As long as you have dealt with poverty and deprivation, there is nothing else you need to do." What goes along with doing it is those good activities that encourage children's growth and development.

Q23 Danny Beales: One of the challenges of Government and the nature of politics is distributing finite resources, making those trade-offs and balanced decisions. I suppose any strategy that will do that will ultimately strategise on where to focus investment. If you had to write the strategy and finance it, regarding 1,001 critical days among your six domains, where would you prioritise? If you could not fund everything, if you could not have the sports clubs, tackle all poverty or fund all health care need—an ideal scenario—where among your six domains would you prioritise action?

Professor Sir Michael Marmot: The first thing to say is that the 50 Marmot areas that we are working with are dealing with their current financial settlement. None of them has said to us, "We're so strapped that we will ignore most of what you're saying—we can do only one or two things." They are not saying that; they are really trying to work across the board.

My starting position is not at all to do nothing until more money is available—it is, "Wow! Look at all the good stuff that people are doing on early childhood." In Leeds, they are prioritising housing. In South Yorkshire, they are working with 10-year-olds and in Birmingham they are working with younger children.

Q24 Danny Beales: Is there any evidence of what the most impactful prioritisation is, or is it that just doing anything is good?

Professor Sir Michael Marmot: There is not the kind of evidence base that I—and presumably you—would like. I would like an evidence base to say which among our eight principles is most effective and under which circumstances, but that would be the most massive research project imaginable, with extraordinary logistical difficulties. I have spent my life as a researcher and I would really like that kind of evidence, but we do not have it. I cannot say to you, "Do this rather than do that."

Rather, we are saying that we have a set of principles, based on the best evidence. What we are doing is watching it play out in different ways in different communities and circumstances. We put in a measurement framework in all the places we work, so we will get some kind of answer. In my guarded answer about Coventry, I said that we do not have the counterfactual, but I do know that the percentage of children aged five with a good level of development has increased and that the percentage of 18 to 24-year-olds not in employment, education or training has gone



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down. Those are good results, but even calling them results is perhaps going beyond what the evidence permits.

I am giving you as honest an answer as I can. It may not be the one that we all want—"What we know is you should do this one and ignore all the rest!" I would never say that we should forget housing and just focus on football clubs.

- Q25 **Danny Beales:** I appreciate that the issues are complex. A lot of your domains sit in the context of the broader family that a child is born to and brought up in. Do you think that the 1,001 critical days agenda has too much focus on the child to the detriment of the familial context? A lot of your domains—the poverty, the unemployment—are family based.

Professor Sir Michael Marmot: I would like to expose you to the public health doctor from Leeds who joined a seminar. She was so enthusiastic. It had been a Marmot city for two years and listening to her talk about it was life enhancing.

When Leeds started as a Marmot city, they said that they had two priorities: children and young people, and housing. We said, "Fine—we'll work with your priorities because they are yours. Great!" But in practice if you are focusing on the first 1,000 days you have to look at poverty. You have to look at housing because that is relevant, quite apart from the fact that people in the bottom 10% have to pay 18% of household income on home energy, on average, and 40% on rent in the private rental sector.

I am running out of mental arithmetic ability, but that is 58% of their income. It would cost half your household income to eat healthily—that is 108%—so if your children need clothes, forget it.

Those issues of housing and poverty relate to the first 1,000 days. The quality of food that you feed your children relates to how much you are spending on housing. I do not for one moment think that a focus on the first 1,001 days somehow distracts our attention from the other things; it is a way of looking at the whole system, because that relates to it.

We know that, of people of working age below the poverty line, the majority—something like two thirds—are in households where at least one adult is working, so work is not the way out of poverty. That means that if we focus on the first 1,000 days, we have to think about a real living wage and who earns a real living wage. We have to think about universal credit, which pays 70%—

- Q26 **Danny Beales:** My challenges are: are those interventions time-limited to the 1,001 critical days period, or is this about delivering an economy that delivers a living wage, or a housing system that delivers good-quality and low-cost housing? Will interventions focused on the critical 1,001 critical days period deliver those?

Professor Sir Michael Marmot: Most of the things I am talking about that would improve the first 1,001 days would improve the lot of pensioners, because if you improve housing or make it more affordable, if

nutritious food were more affordable, or if community amenities were better, that would improve not only life in the first 1,001 days, but the lot of pensioners. Other specific things are focused on that age period, which is why I said before that I would not focus on the specific and ignore the general and broader, nor would I focus on the broader and ignore the specific. We need both. That will improve things.

If we do the kinds of things that I am talking about—I will call them the more general—that would improve conditions for everyone. It would reduce health inequalities across the age span. There are also some specific things related to the first 1,000 days, but I do not think that they are instead of other things. If pensioners do not go out because of fear of crime, and we decide to do something about levels of crime, or fear of crime, I would not think that that is at the expense of supporting young mothers with babies. One is not at the expense of the other; we need to do both. In fact, if we invest in early childhood, we know that we will reduce crime rates subsequently. Those kids who have real investment in the first 1,000 days are less likely to be in trouble with the law subsequently.

Chair: Professor Marmot, it is always wonderful to hear you speak. You are professor of epidemiology at University College London and director of the UCL Institute of Health Equity. You do an awful lot and you add a lot to what people do. We thank you for coming to see us. We have really appreciated your input. We will now swap panels.

Examination of witness

Witness: Rt Hon. Dame Andrea Leadsom

Q27 **Chair:** Good morning—I will call you by your full name this morning—Dame Andrea Leadsom, former Government early years adviser and chair of the Early Years Health Development Review Report, which I know an awful lot about because I did a lot of work with you at the time. Dame Andrea, is there anything you want to add before we go into questions?

Dame Andrea Leadsom: Thank you very much, Chairman, for allowing me to give evidence to this inquiry. To me, the 1,001 days is the critical period of life. There were a couple of points I wanted to make.

First, humans are unique in the animal kingdom in the extent of their underdevelopment at birth. There is no other animal that cannot fend for itself in any way at all until it is a year old. That means human beings are uniquely susceptible to their environment during those 1,001 critical days—the period from pregnancy to the age of two. What happens to you in the womb and when you are first born profoundly influences your lifelong emotional and physical health.

The second thing I wanted to say before we start this session is that, during the period when I was early years adviser to the previous Government, we did a huge amount of research with parents and carers on what they want, in order to provide them with better support to give



their baby the best start for life. What was very clear is that there were three things. The first is information. If you are expecting a baby, you need to know what you might need, and if you need it, where you would find it, so information is critical.

Secondly, services should be universal. This is where I take issue with some of the things Professor Marmot said. What families worry about is stigma. They worry that if they are called in for a particular service or intervention, it is because someone is judging that they might not be up to parenting. Parents are very worried about stigma, so they want their services, family hubs and start for life support to be universal—that is, available to everyone.

Thirdly, families really want those services to be on a one-stop shop basis, so that if you have a six-year-old, a two-year-old and a bump, you do not have to get a bus from one side of town for your antenatal checks to the other side of town to weigh the toddler, and so on. They want a one-stop shop for universal services and to be given the information needed to help them to give their baby the best start for life. But I will leave it there. As you know, Chair, this is my absolute passion, and I know you also share that passion.

Chair: Absolutely. We will go straight into questions—we have some really good ones for you today.

Q28 Gregory Stafford: Dame Andrea, thank you very much for attending. You have already briefly outlined the key things you heard from parents and carers during your review. Could you expand on the really fundamental things that they wanted, and on how we might achieve them?

Dame Andrea Leadsom: Information—every parent and carer says if you are having a baby for the first time, you do not know what to expect. We all sort of joke about where the off button is for a baby that will not stop crying. Equally, antenatally, there was a recent little study that says that lots of women are scared of giving birth. That is no surprise—it is entirely rational—so you need to know what to expect. If you are going into hospital for a cancer or hip operation, you are given a blow-by-blow account—what time to turn up, what to wear, what will happen, what the anaesthetic will do, the stages of recovery, and so on.

Where pregnancy is concerned, there is very little clear advice on the sorts of things you might need and where you can find them. The whole vision for the 1,001 critical days is based, to begin with, on a “start for life” offer. Every couple or single person expecting a baby would be given a QR code to look up, with their phone, a leaflet or a website where they can look at the exact steps during pregnancy, and the first period when the baby is born, to see when they may need services and where they can find them. That is really critical.

Secondly, Professor Marmot highlighted very well the problems with poverty and insecure work. A lot of families will not be aware of statutory maternity and paternity pay, or even statutory maternity and paternity



leave. They need to be given that information and then helped through it, perhaps to understand their own financial position and so on. Many family hubs provide an antenatal financial health check for families who are wondering whether they will be able to pay the mortgage or whether they will lose their job—all those practical concerns about having a baby that can lead to a lot of anxiety.

Then there is the issue of stigma. I am a huge fan of Sure Start, as the Chair will know. I have been working with Sure Starts in the early years space for 30 years, including in one of the first phase 1 Sure Starts when they were introduced by David Blunkett and Tessa Jowell. For me, family hubs are a 21st-century version. They go from pregnancy to age 19. The big challenge with Sure Starts is that they went only from nought to five. As we know, a lot of entrenched problems happen during pregnancy. There is a lot of depression antenatally. Unfortunately, domestic violence can begin antenatally because of the pressures that the couple are under, and lots of couple breakdowns happen in that perinatal period. Very often, Sure Starts were just a bit too late for families to be able to use them, and the family hubs have sought to learn from that.

Family hubs take you from your first antenatal checks—in the best family hubs, that is where you go for your antenatal sign-up—all the way through. There are classes on antenatal preparation, parenting and, for men, transitioning to becoming a dad. Advice on concerns about potential domestic violence, smoking cessation or finances is available within a family hub, in a non-stigmatising environment. The ambition for family hubs is that they will be like a supermarket or a GP clinic; everybody goes there, so there is no stigma associated with going. If you have a child—whether it be your grandchild, your neighbour's child, your niece, your daughter or your son—you would go there, because that is where everybody goes. The de-stigmatising is absolutely crucial for the success of family hubs.

The final thing to say is that having all those services under one roof is crucial, so that you are not having to travel around if you have transport problems or logistical issues. Having everything there, where you need it, both physically and virtually, is important. That is particularly true for a lot of dads, who unfortunately have been far too written out of childbirth. A lot of men feel completely left out the whole perinatal period. What we want to do with family hubs and start for life is make sure that dads feel included. Very often, that may involve providing a hybrid or virtual group on parenting, because dads, either by dint of working or just because they do not want to turn up to a place where they do not necessarily feel that comfortable, may wish to join virtually. These days—again, family hubs are the 21st-century version of Sure Start—it is very easy to facilitate that. Some of the best family hubs are very much doing that with great take-up rates and great success.

- Q29 **Gregory Stafford:** In your review, you outlined six action areas, some of which you touched on there. Which areas do you think have made the most and the least progress, and why has that been the case?



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Dame Andrea Leadsom: Rather divide it into action areas, I would say that implementation is the challenge. Three of the action areas are family facing and three are system facing. The one that has been most successful is a welcoming place for families to go. I visited about 80 family hubs during my time in government as early years adviser, and most of them are doing a fantastic job. Families really love to go there; I note that several members of the Committee have very successful family hubs in their areas. Cornwall is great; Isle of Wight is great; Hull is great; Uxbridge is great. Each of those areas is represented by one of you, so that is fantastic news.

Them being welcoming places has been a big tick, but them having universal services has been more mixed. Some family hubs have managed, for example, to get midwives in for antenatal checks. If you are thinking about how to get everybody to use a family hub, the best way to do that is to say, "This is where you come for your antenatal checks." If everybody comes in, that means that everybody gets to see the family hub and it then feels like their place. Once someone has had the baby, and perhaps they have had a bad night and they want to go somewhere, they remember that the family hub is a great place to go. I visited Hull recently, and they have a fantastic family hub where they are seeing 95% of all women antenatally because they have their antenatal checks there. That is superb news, because it basically means that virtually the whole community knows that the family hub is the place you go when families need some help and advice. The welcoming place is the biggest hit; universal services are slightly more mixed, because some family hubs seem to still not make their services available universally.

In terms of the system-facing action areas, there has been a huge effort by the start for life unit in DHSC to create better support for the health workforce. There were some virtual courses on trauma-informed care, and on how to communicate with new families. Sometimes it is quite difficult if somebody comes into a family hub, looks very nervous and does not want to talk to anyone, so knowing how to start a conversation about how you are feeling about your baby is important. Very often, families who have particular relationship problems with their baby will present saying, "I think my baby hates me. All he does is cry." Of course, a baby is not capable of hate. A baby does not have that level of cognition. A baby cries because something is wrong and relies on a loving adult carer to soothe their feelings, reduce their cortisol levels and get them back into a steady state. Even sometimes just explaining that to parents—these things are not intuitive; we all need education—will help them to feel more capable and less anxious and to feel that they can cope better. That has huge benefits for the parent-baby relationship. That kind of system work has been really good. There has been a real upgrading and uptraining of the early years workforce.

The area that I would say is the biggest "not there yet" is the digital version of the red book. That would be a huge win for both families and professionals. Effectively, that would mean that there would be one central source of information about the baby. That information would range from



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"Was it born with forceps?", "Was it in an ICU?", "Did mum have post-natal depression?", "Is there another partner?", or "How are the baby immunisations?", all the way up to how feeding is going and whether the baby's two-year ages and stages check has gone well. All those things would be in one place for the family and the early years professionals to look at. For families where there have been terrible issues, such as miscarriages and stillbirths, it would save them constantly having to tell their story again and again to different professionals. A digital version of the red book would be a huge win. Unfortunately, it has not made much progress, but I was delighted to see that the new Government are committed to delivering on it.

Q30 Gregory Stafford: In a word, would that digital red book be the key priority for you for this Government to get right?

Dame Andrea Leadsom: Yes.

Chair: Thank you. I will go over to Danny, who had a quick question.

Danny Beales: My question might be better after Josh's question.

Q31 Josh Fenton-Glynn: Thank you. I am going to talk a bit about the difference between family hubs and Sure Start. Obviously, one of the differences is scale. *[Interruption.]* Sorry—there are some strange noises in the background, and we are trying to ascertain if it is a fire alarm. No, it is a flotilla of boats apparently; I assume it is a VE Day thing.

Obviously, there are about 400 family hubs, but at the peak there were 3,600-ish Sure Starts. Over the previous Government, we saw that number progressively go down. Do you regret supporting the closure of Sure Starts?

Dame Andrea Leadsom: As I said at the start, I am a big fan of Sure Starts. I was involved in the early days of Sure Starts 30 years ago. Moving forward, the beauty of family hubs is that they build on the legacy of Sure Starts. They go from pregnancy through to the age of 19, and 25 where there are disabilities. Right from pregnancy, all the way through childhood—they support families in that critical period. Obviously, the whole virtual world and the ability to support people remotely at 2 o'clock in the morning with breastfeeding support, mental health support and so on is much greater now than it was during the Sure Start days.

On the numbers, Mr Beales, let me say that Lord Farmer, who has long supported family hubs, has uncovered through FOI that there are really about 950 family hubs. That is a huge tribute to local authority areas that, even though they have not received funding under the Government's start for life and family hub funding, have decided to build family hubs anyway. In fact, Uxbridge is one of those places. I was recently at Hillingdon family hub, which is doing a fantastic job and has not received Government funding, so I think there are many more family hubs—

Josh Fenton-Glynn: Let me just cut you off for a second. First, Danny Beales is the good-looking ginger one. I am Josh Fenton-Glynn.



Dame Andrea Leadsom: Sorry.

- Q32 **Josh Fenton-Glynn:** That's all right. To get back to the question, I was in a local authority that fought really hard to keep our Sure Starts going. Do you regret that you were part of a Government that saw the funding reduced by two thirds in 2017, and saw a number of them close between 2010 and 2015?

Dame Andrea Leadsom: What I was going to add was that a significant number of Sure Starts continue to operate and a number are converting into family hubs, and that is brilliant news for families. The interest in the 1,001 critical days has been cross-party in nature. During all the time that I was a Member of Parliament, there was huge cross-party support for the 1,001 critical days manifesto, which I was fundamental in creating back in 2011. That has gone from strength to strength.

- Q33 **Josh Fenton-Glynn:** I do not doubt that at all, but do you think it would be easier to build up if there were more pre-existing Sure Start centres? You make a good point that we can expand the work of Sure Start centres, but where they have closed there is obviously no provision for those families. You talk about universalism, but it is the poorer authorities that have seen more of their Sure Start centres close.

Dame Andrea Leadsom: I think there are still significant numbers of children's centres, and I am delighted that the last Government built on that and so will this Government. The support that is being delivered now is really significant and is improving. There is a long way to go, and a lot of that is in the implementation. Of the previously phase 1 Sure Starts—you will know that there were 1,800 of those—pretty much all that are open are converting to family hubs. That is brilliant because it provides that essential support from pregnancy through to 19 for families.

- Q34 **Josh Fenton-Glynn:** Would you say that the main advantage is the pre-pregnancy stuff, or the pregnancy and onwards stuff? Is that the advantage that family hubs have over Sure Start?

Dame Andrea Leadsom: It is actually the level of services too. To be a family hub, you have to have midwifery, health visiting, parent-infant relationship support and infant feeding support, including breastfeeding support. The difference between that and Sure Starts, as I recall from 30 years ago, is there was not that definition of what services you had within a Sure Start. The buildings were there for nought to fives, but there was not that definition of services.

As I said earlier, the beauty of family hubs is that you can get everybody to go in antenatally to have their antenatal checks. That very often also brings in dads and other partners, because they want to come and hear the baby's heartbeat. What that means is that it creates a community. If you talk to parents in some of the family hubs about what they like about family hubs, they do not say, "Well, I like the antenatal check." They say, "I like the fact that I can come here, meet other parents and make friends. It's part of the community." So I think that is really key. Sometimes the greatest motivation for learning is when you are expecting



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a baby, because once you have had the baby, it is just overwhelming—as anyone who has had one knows. But when you are pregnant and there is all that expectation, you do want to go and meet people who are going to have babies at the same time, and that is the lovely thing about the antenatal focus of family hubs.

Josh Fenton-Glynn: Yes, I have a memory of lots of classes about birth and not as many classes about the succeeding 18 years.

Dame Andrea Leadsom: You're on your own then, aren't you?

- Q35 **Josh Fenton-Glynn:** Indeed. Luckily there are lots of services available, but as you say, sometimes the key is accessing them. I do think there is a problem in general—although you talked about the problem of Sure Start's focus being more on deprived areas—with services being much more available in better heeled areas, just because there is a greater council tax base and there are probably more motivated individuals who have the extra time to provide them. So I wonder whether some of the targeted help—to provide help that wasn't there—is in a worse situation because we no longer have some of the Sure Start centres because of the cuts by the last Government.

Dame Andrea Leadsom: I would say that that is absolutely not the case. When the funding was provided for the family hubs and start for life programme back in October '21, the 75 upper-tier local authority areas that were provided with central Government funding were those in the highest deprivation indices areas, with a slight inclusion of some that were more rural, because otherwise you would end up with 75 largely inner-city areas. For example, Cornwall and Northumberland received funding, but a lot of more deprived inner-city areas did too.

So in fact, the funding was focused on those areas with the highest level of deprivation and not by any means on those in the more well-heeled areas, as you put it—I do not agree with that. I do think what is interesting is that as well as the 400-plus areas that received funding, there are another 400-plus that have not received funding but are building family hubs anyway.

- Q36 **Josh Fenton-Glynn:** We talk a lot in this Committee about focus and priorities, and obviously the Government dropped some of their priorities so that they could focus on other ones. My question about the first 1,000 days is whether you think it is easy for family hubs to focus on the first 1,000 days when they are also focusing on everything up to 19.

Dame Andrea Leadsom: From my experience of visiting hubs, I would say yes, they have done that, because the "Family Hubs and Start for Life programme guide" sets out very clearly what you need to do to be a family hub from a start for life perspective. As I say, you have to have midwifery, health visiting, parent-infant relationship support and infant feeding support. There are those four services alone, and in addition there are funded services for effectively preparing for parenthood.



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All those things have been the start point for family hubs, so if anything, there is a skew towards pregnancy to age two. Then the local authority areas have added on older children, and actually with some great success. One of the challenges for lots of family hubs is where to locate, because obviously you do not want Bumps and Babies in the same area as teenagers having—I don't know—a snooker night. So it has been a case of having separate areas of a large building.

Going back to your earlier points about Sure Starts, that is why in so many of the phase 1 Sure Starts, which were by definition very large buildings with lots of different areas, it has been very easy to put the best start for life on the ground floor, say, so that it's buggy-easy, and then the older children on the first floor and second floor. That has actually worked quite well, so I do not think that that has been a problem in reality.

Chair: I am going to bring in Danny Beales—whom you referred to earlier, Dame Andrea—to ask a supplementary question.

- Q37 **Danny Beales:** It was worth the wait, because I got called handsome by Josh, which is the nicest thing he has ever said to me. Dame Andrea, you mentioned the Uxbridge family hub, which, as you say, is a great facility in many ways. One of the challenges that many people have reported to me is that when family hubs emerged, it seems that broader services in neighbourhood settings may have been withdrawn and consolidated within them.

The emerging 10-year plan talks about a shift to community in terms of health and care, and lots of evidence talks about neighbourhood-based services being the way forward in terms of accessibility and the integration of services in everyday places—for example, if you are a mother, your childcare setting might have employment support and other support. Do you think that, with the family hub model, we have seen the reverse of that neighbourhood model and, in effect, the concentration of more services in quite large geographies and the removal of other spoke services?

Dame Andrea Leadsom: The bottom line is that I cannot say for certain, but in Cornwall, for example, there are 38 family hubs, and in Northumberland there are 45 family hubs. In my experience, local authorities have tried to go for a hub and spoke model—you have family hubs and family spokes, with the spokes taking the services much more into the community—but they are clearly focused on a one-stop shop.

The research we did with parents and carers showed that they do want services under one roof. I would have thought that that leans into what you were just saying about neighbourhood community services, but perhaps finding them in one place rather than lots of different places. That has been my experience with the family hubs.

- Q38 **Danny Beales:** I do not want to become too parochial, but when you see all the youth centres and many of the libraries closed down in a place, and one hub in the town hall, that does not seem to me like a more community-based model of support. I agree with the principle of

integration, but those spokes do not always seem to be there in practice. Perhaps it is something for us to look at.

In the previous panel, Sir Michael talked a lot about the social determinants of outcomes. Do you think the family hub model is doing enough around those social determinants—poverty, broader issues of employment and work, housing and so on? In your experience, does that need to happen more, or is it happening in certain places and not others?

Dame Andrea Leadsom: That is such a good point; it is really key. The idea of family hubs is that they are a one-stop shop. I could reel off names of places, but in some of the places where we find best practice, you can go in as a parent expecting a baby and use a computer. You can dial into a citizens advice bureau and get a personal financial health check, with advice on statutory maternity pay, for example. In other places, they will have employment advice within the family hub, through either a virtual meeting or a drop-in. Some family hubs have drop-in advice for oral hygiene for your baby, teaching you how to brush your baby's teeth.

In other places, they will have baby banks and food banks, so you will be able to get the support you need. At the same time, you will be there doing your antenatal preparation with people who are perhaps middle class and in work, and do not really need that baby bank or food bank, but it is all in the same place so it is un-stigmatising and nobody feels awkward or embarrassed to go there.

I remember going to a lovely family hub in central London, where there were a couple of white British mums with their child, and a young migrant Muslim woman, and their children were playing beautifully. They said to me that it was so lovely they had met each other and they were now great friends, that they felt they would never have met if it had not been for the family hub, and what a great thing it was for community.

That one-stop shop is incredibly valuable, but as you rightly say, it is in the implementation. I would urge all family hubs to be really focused on that one-stop shop, and on bringing services in that support people with issues of poverty and deprivation, as much as with preparation for parenting.

Q39 **Alex McIntyre:** Thank you for your answers so far, Dame Andrea. Building on Danny's questions, we have spoken about the consistency that family hubs provide, and about having a consistent model where you can go in and know the services that you will be able to get there. What evidence is there that they can also respond to different local needs? In your experience, where is there good practice of responding well to local needs that might differ?

Dame Andrea Leadsom: Interestingly, in the last month or six weeks, I have visited Hull and Hillingdon. Both stuck in my mind because they happened to have 107 different languages spoken, and both said that that made them one of the most diverse parts of the country—interesting that one is in west London and the other is in the north of England. I thought

that was interesting because they were absolutely catering to their local community.

Although the hubs both had diverse languages, they nevertheless had interestingly diverse needs. In Hillingdon, safe housing is more of an issue than in Hull, but in Hull, there were some significant issues of English language being spoken, and some very varied areas of deprivation that required them to be focused on the needs of their local population. Different local authorities have made their own efforts to meet the particular needs of their community.

One of the things in the family hub and start for life programme that we were keen to promote—to make a requirement of funding—was that local areas should develop their own parent and carer panel. In effect, they would have a standing panel of 10 or 12 parents of diverse backgrounds that would meet perhaps every couple of months with an external person to facilitate the meeting. They would then provide feedback on what they like and do not like, and what they feel the family hub should do more or less of.

That has worked very well in areas that have properly implemented it, so that they are hearing from parents who are expecting a baby or have a new baby about exactly what they would find helpful. That kind of community feedback has been crucial for those who want to respond to local need.

Q40 Alex McIntyre: You mentioned Hull and Hillingdon. What are the key factors that make them so successful in your view? How can we make sure that we are taking the best from them to the rest of the country?

Dame Andrea Leadsom: It is a great question, and in my view it is the universality. The laser intervention is to have your antenatal checks in a family hub. Why? Because everybody is motivated to go for their antenatal checks, particularly the first one—the sign-up—where you go and hear the baby’s heartbeat. Lots of dads and other partners are also motivated to go to that initial sign-up.

Once you have gone into the family hub, that can be the opportunity to say, “Look, while you’re here, let me show you around. Let me show you the different groups we have going. Once the baby’s born, there’ll be this and that—here’s the timetable. Here’s the QR code where you can sign up for all these different support areas. And come and meet some people while you’re here.” That first laser intervention is the antenatal checks.

The second laser intervention is birth registration in the family hub. Again, that is something you have to do, and very often the dad and other partner will want to come too, and the other children—if you have them—will be taken along as well. It is an opportunity for the family hub to do a lovely little celebration.

I remember going to a Northumberland family hub where they have little parties to celebrate the naming—the registration of your baby’s birth. The rest of the family is invited along, you get to meet other families who are



local, and they have a lovely little folder where you put the birth registration certificate. It becomes a great way to help you to bond, if you like, with the family hub, so you remember it. It becomes your place—the place where, you will recall, you can go to get help, advice and friendship.

- Q41 **Alex McIntyre:** You mentioned having the early health checks, and I remember vividly—it was only two years ago—doing ours with our little boy. I was very motivated to go to the first one, but that is a function of the health service and the wider health system. How do we better join up the services being provided by family hubs with the wider health service to make sure that we create that one-stop shop?

Dame Andrea Leadsom: The Government's decision to merge DHSC and NHS England is a good one for that very reason: it puts all the perinatal professions under one area of management, which is a really good thing. For my money, I would want midwifery, health visiting, parent-infant relationship support, which is crucial, CAMHS, the parent-infant psychotherapist, the CBT therapist, the video interaction guidance professionals, the people who do therapeutic baby massage—all the people who provide first-line and second-line support for families who are struggling with their mental health during the 1,001 critical days—all to be working under one roof. That is crucial.

The implementation is key. Unfortunately, in too many areas you still have midwives saying, "Well, do you know what? We prefer working at the hospital. We just prefer it there," whereas families want them to be in the family hub. It is not about what the midwives want; it is about what works best in terms of providing support for new families. There is an element of persuasion and consultation, but it is about making it clear that a one-stop shop is what families want and is going to deliver better outcomes for babies.

A wealth of evaluation has been under way since the programme started in October '21. The Start for Life unit in the Health Department is going to demonstrate the value of that one-stop shop. That should in itself persuade all those perinatal health professionals to work together. Over the many years I have been involved in this area, they have always said they would like to be much more joined up, and many of them believe that the digital red book would provide the means to do that.

I am also absolutely convinced that it will help to have professionals working together in the family hubs. Instead of having to ring each other from the other side of town, they will literally just walk next door to have a word with each other about a particular family. There is a wealth of evidence—anecdotal so far—that that really does help with providing continuity of care for families, which is what it is all about.

- Q42 **Alex McIntyre:** You segued quite well to my next question, which is about the digital red book. You said that would be your No. 1 priority. What needs to be done to deliver it?

Dame Andrea Leadsom: My wish list was always that at the time of birth, a baby is allocated an NHS number on the basis that the midwife



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tells the system that the baby has been born. What could happen fairly easily is that you could get your NHS number and your personal health record, which is now available for every adult. That personal health record could be allocated to you, complete with the NHS number, with proxy access for your mum—the person who just gave birth to you. Obviously, that would require some systems changes, but it is not beyond the wit of man.

Of course, in the small percentage of cases where the baby is taken away on delivery for safeguarding reasons, you would have to manually remove the proxy access from the mum. But in almost all cases that would be so much better than just having an NHS number and then at some point later on mum or dad registers you with the local GP, you get allocated a health record, and then they have to apply manually for proxy access and the GP has to manually approve that proxy access.

The benefit of that kind of digital red book is that the midwife could then input the electronic maternity notes, which have just been delivered, into the baby's digital red book. In that way if, for example, you grew up as an adult and your parents sadly passed away young, you would have a record of your own birth experience, as well as it being part of your mother's health notes. Obviously, all the immunisations and so on would be there, as well as the breastfeeding and any issues with your physical health as a baby.

Mental health issues are also really important. We have not come to this yet, but the mental health of parents—particularly antenatally, but also post-natal—has such a profound impact on the development of their baby that the mental health situation of parents should be massively prioritised. If that were part of a digital red book, that would enable much better interventions for many more infants who at the moment really suffer from insecure attachment, which goes on to have lifelong implications for their physical as well as emotional health.

Q43 Alex McIntyre: In their Children's Wellbeing and Schools Bill, the Government propose a single unique identifier for children. The intention is to be able to share information better between different agencies. Do you think that will enable better joined-up care and promote the improved outcomes we are hoping for?

Dame Andrea Leadsom: A unique identifier does nothing. It simply says that this is Baby X. The digital red book, which contains the context, is the critical thing. As I said at the start, human babies are unique in the animal kingdom in the extent of their underdevelopment at birth. They can do nothing for themselves. They are a function of their experience in the womb and their experience outside the womb. They are not able to tell you, "I am cold, I am hungry, I am frightened, I am bored." They are only able to cry, sleep or look around, and they rely on a loving adult carer to soothe them, fend for them, love them and cherish them. It is as a result of that loving, cherishing relationship that the prefrontal cortex develops—peak period is six months to 18 months—and the neural connections are made that enable that baby to develop a cognition that says, "This is my



mum, this is my dad, this is the dog, the world's a good place." Many babies, where there is insecure attachment, or, worse still, disorganised attachment, do not develop that sense, and that has profound implications for their sense of self, their sense of self-worth, their own mental health and their own physical health. A unique identifying number does nothing. The context set out in words in a digital red book could potentially enable far better support for families during that crucial 1,001 days.

Q44 Alex McIntyre: A final question from me and then I will hand back to the Chair. My colleague Josh Fenton-Glynn tried to ask this question a couple of times and you gave new MPs a brilliant example of how not to answer a difficult question when quizzed by a Committee. You are clearly very passionate about this area and about Sure Start centres. We heard in the previous panel that health inequalities for young people massively increased between 2010 and 2020. Do you regret that the funding for Sure Start centres was cut by two thirds during that time?

Dame Andrea Leadsom: I have always been passionate about the 1,001 critical days. I would always advocate for much better support for families during that crucial period, because, at the end of the day, the state is not raising children. It is not raising the next generation, but the next generation, the babies being born today, will be governing our country. They will be sitting where you are all sitting now, where I was sitting, in government, trying to run the country and create a successful economy and so on. For me it is not about whether you should spend X amount or Y amount. This is where I fundamentally disagree with Professor Marmot. It is about outcomes—loving outcomes. It is about providing support for families so that they are then capable of providing the loving attention that their babies need. For different families, that requires different things. For a couple who themselves were poorly parented, who were perhaps care leavers or who had childhood traumas themselves, it might be very difficult to become good enough parents—not perfect, but good enough—without the kind of intervention, support, advice and help that too few people get right now to help them to become good enough parents.

The other thing I would say is that no parent wants to be a bad parent. Every parent wants to be a good parent, no matter what the problems, deprivations, addictions or brutality that they might have experienced themselves. Every parent wants to be a good enough parent, so the Government need to put in place a good enough level of support in a one-stop shop, un-stigmatising, with proportionate support. For those needing more support, there should be a greater level of attention. I do not think it amounts to the pounds, shillings and pence that Professor Marmot talks about. It is about providing a loving environment. So often what families want is someone else who has had kids to say, "I know what you are going through." They want volunteers, they want charity support, they want peer support, but that does need to be facilitated in the family hub that is provided by the local authority. So the implementation is crucial.

Chair: Andrea, thank you so much, and thank you, Alex. I am going to hand straight over to Josh.

Q45 Josh Fenton-Glynn: I will pick up on that last question before I go into questions about leadership. You said it is not about funding, it is about outcomes. Obviously, we do have evidence that between 2010 and 2024, outcomes got worse. Do you think that is something that the last Government could have got better?

Dame Andrea Leadsom: I am really pleased that we introduced the vision for the 1,001 critical days. I have been clear that it is absolutely critical to the success—

Q46 Josh Fenton-Glynn: Do you think in the totality of the 14 years, they could have got it better?

Dame Andrea Leadsom: Of course, any Government can always get things better. In my first time in politics, I used to sit with Dame Tessa Jowell in the Pugin Room and talk to her about how we could improve Sure Starts and outcomes for babies. This is a cross-party agenda, and I really hope that it continues to be for ever. In my view, the best thing we could do is to get the annual education budget to extend back into pregnancy. If we had an annual budget from pregnancy all the way through to age 19, along with the family hubs, that would be the complete win in my view.

Q47 Josh Fenton-Glynn: I am going to pick up on that. Your review highlighted that ministerial responsibility is scattered across multiple Departments and portfolios. I am looking at a section of your review that lists the things that the Department for Education has to do, the Department of Health and Social Care, the Home Office, the Ministry of Housing, Communities and Local Government, the Department for Work and Pensions, plus all the people for whom safeguarding is a responsibility. Do you think we are anywhere close to getting cross-Government working right?

Dame Andrea Leadsom: That is a multi-billion dollar question, isn't it? When I first chaired a cross-Whitehall group on this in 2017, as Leader of the House of Commons at the time, it was so apparent that across Whitehall people had different bits of the picture. The outcome of that review was a proposal that there needed to be a vision for what good looks like in the 1,001 critical days. That vision was the creation of that March 2021 report, which then became Government policy.

In a sense, cross-Whitehall agreed that better Whitehall join-up was needed. That vision in March 2021 was the culmination of, "Right, so what should we do?" My partial answer is, "Yes, therefore, there is better joined-up working." Except, as I said at the start, unfortunately so much of it is in the implementation.

If you like, the formula is there—the family hubs and Start for Life programme guide—which sets out how to achieve and deliver better outcomes across Whitehall and across local authority working. If you look at different local authorities, some are doing it really well and others just are not. As ever in government, it is in the implementation.

Q48 Josh Fenton-Glynn: Are local authorities failing to implement or is it



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cross-Government working that is failing to implement it properly?

Dame Andrea Leadsom: As I have already said, the merger of NHS England and DHSC is a really good idea. That is going to remove some of the barriers to cross-Department working. That is a huge tick in my view and really positive. I do not want to point the finger of blame, but local authorities now really have the opportunity to do that join-up at the local level. That means that they need to join up midwives with health visitors or, as in Hull, they have GPs dropping in to do a drop-in at the family hub, which is brilliant. Parents who are worried because, "My baby has a rash," or, "He didn't sleep last night," can literally drop in to get a word of advice, without having to wait a couple of days for an appointment when, as we all know, with a young baby the need is absolutely immediate. That also eases the pressure on A&Es. That is just an example of how better cross-government working delivered through family hubs can make a real difference.

Q49 **Josh Fenton-Glynn:** You talked about a Minister for Start for Life. Do you think that that is still needed? What do you think should be done alongside that?

Dame Andrea Leadsom: I am pleased that the Government have kept that role, the Minister for Start for Life, which is wrapped up with primary care and public health. That was the last job I had until last July when I stepped down. It was a very good job in the sense of being able to look across the different delivery areas. I still think that there should be a Cabinet member for the Start for Life. There should be a Cabinet member for the 1,001 critical days, in the same way as there is for women and equalities, for example, because it is such a cross-society and cross-departmental issue that there should be representation at Cabinet level. This is the future; this is the next generation that we are looking at here.

Josh Fenton-Glynn: That is a useful place to leave it. I think you are beaming in from overseas, so thank you for taking our Committee international as well.

Chair: Dame Andrea Leadsom, thank you for joining us today. Enjoy your time abroad.