

## Health and Social Care Committee

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

Wednesday 3 September 2025

Ordered by the House of Commons to be published on 3 September 2025.

[Watch the meeting](#)

Members present: Danny Beales; Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton.

Also attended: Helen Hayes (Chair), on behalf of the Education Committee.

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

Questions 195 - 275

### Witnesses

[I](#): Ashley Dalton, Parliamentary Under-Secretary of State, Department of Health and Social Care, Liz Ketch, Director for Early Years, Children and Families, Department of Health and Social Care, and Susie Owen, Co-Director for Early Years, Childcare, Families and Analysis, Department for Education.

## Examination of witnesses

Witnesses: Ashley Dalton, Liz Ketch and Susie Owen.

**Q195 Chair:** Welcome to the final, ministerial evidence session for our inquiry into the first 1,000 days, where we are joined by Minister Dalton and officials from both the Department of Health and Social Care and the Department for Education. I am going to ask you to introduce yourselves before I go into my first question.

**Ashley Dalton:** Hello, I am Minister Ashley Dalton, and I am the Minister for Public Health and Prevention.

**Liz Ketch:** My name is Liz Ketch. I am the director for early years, children and families at the Department of Health and Social Care.

**Susie Owen:** Hi, I am Susie Owen. I am the director for early years, childcare and families in the Department for Education.

**Q196 Chair:** Thank you all very much. I will go straight into my first question. Barnardo's has recommended that the Government create a network of around 3,500 hubs across the country, costing approximately £2.7 billion. During our inquiry, other organisations and people have told us that they would like hubs to be on more of a statutory model, based within the community setting. The Government have only committed to provide 1,000 hubs by 2028, costing £500 million. Do you feel that is ambitious enough?

**Ashley Dalton:** As you are aware, in July, we announced a £500 million investment to roll out Best Start family hubs nationally. As you identified, 1,000 hubs will be created across the country by the end of 2028. That is specifically the Best Start in Life family hubs. This is the beginning of a decade of renewal, which we have discussed before, building on the legacy of Sure Start. It is a joint programme between the Department for Education and the Department of Health and Social Care. I will come to Susie in a moment, who can talk more specifically about the family hubs element, which is led by the Department for Education—

**Q197 Chair:** Minister Dalton, I don't mean to stop you mid-flow, but my question was, do you feel that the family hubs are ambitious enough?

**Ashley Dalton:** Yes. This is the beginning of our ambition to deliver the healthiest generation of children ever. As I said, this is a decade of renewal. We have identified the beginnings of that following the recent spending review. We have also put in place, from the Department of Health and Social Care, our key commitment in our 10-year plan to delivering neighbourhood health services. Some of those will be delivered through the specific family hubs, but some of those will be delivered through other community assets—some that will be created and some that already exist. It is really important that we build on existing community assets to do that.



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We are looking to make sure that every community has access to the services they need. Based on what we are able to put in place today, we have that ambitious aim for 1,000 specific family hubs. That does not mean that that is the only way we will be delivering for children and young people in our communities. I think Susie might be able to say a little bit more about the specific family hubs.

**Susie Owen:** I can say what is different about the Best Start family hub programme compared with what has come before, to respond to the question about ambition. More money will be going into these Best Start family hubs than in the previous programme, so there will be family hubs in every local authority, which is a really important part of growing the programme. There will be more funding for parenting and home learning environment interventions to reach more children and families, and they will be particularly targeted in disadvantaged areas to reach the families who stand to benefit most from those interventions.

We are also really focused on driving greater outreach. Obviously, it's not just a physical family hub building that makes a difference, but how you reach those families, so greater outreach will be funded through local authorities to make sure the groups most in need of those services can be reached.

Throughout it all, we are also providing more support for children and families with SEND, which we know is a real issue, not just in local services but in early years settings, so there will be a dedicated professional in every family hub who is there to guide families through the SEND system, help to identify those needs early and to make sure those children get the support that they need, whether that is through the family hub directly or in the settings that the children might be attending.

Throughout, parents will be involved in that decision making. There will be parent panels that can support the design of those services to make sure that they are providing the services that are needed. We are also requiring local authorities to develop ambitious Best Start for Life plans that will need to set out how local areas will be meeting the target that they have been set for more children reaching a good level of development by age five.

This is a step change from what has come before. As the Minister said, it is part of a longer-term programme that we have set out for giving every child the best start in life, with the first phase of that happening now and taking all the learning from Sure Start and from the previous programme, from Start for Life and family hubs, to build a better service for families and children.

Q198 **Chair:** Thank you for that. I will go back to Minister Dalton; you can pass this question on if you want to. I want just to push you a little bit on the overview, because other organisations had recommended more hubs, but the fact is that you will have only 1,000 hubs by 2028 and that in your 10-year plan you have increased the age from 1,000 days to five years old. Have I got that wrong? Let me finish my question. Could you help me to



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understand how you are not going to lose focus with the step change, with what you are trying to do?

**Ashley Dalton:** Since the launch of family hubs and the Start for Life programme, family hubs have offered support to families of children of all ages, but we maintain a focus on what we call the 1,001 days, actually, which is from conception to the age of two. That remains important. We have that continued focus from conception to age two, and that sits at the core of our Start for Life programme. Obviously, there is a slightly wider element for family hubs, because they are for children right up to the age of five, and beyond in fact. These are for families, regardless of the age of their children. But we still have that focus.

Q199 **Chair:** Sorry, we don't have much time. The point is this: how are we going to ensure that the focus is predominantly on the 1,000 days?

**Ashley Dalton:** We know that maintaining that focus is essential and we are prioritising the quality support during that formative period—

Q200 **Chair:** Just give me a couple of examples.

**Ashley Dalton:** I'm trying to answer the question. The new Best Start in Life website provides parents with everything they need, from conception and right through, and we retain that focus on nought to twos, particularly in working on speech and language facilities and ensuring that they are available from an early age. We know that providing services across the full range from nought to five ensures a holistic approach. That does not mean that we are not delivering services from nought to two; we retain that focus. I think Liz could expand a little bit more on some of the specific details of how we do that in the roll-out.

**Chair:** I'll let you have the last word, Liz.

**Liz Ketch:** What we have done so far in our work is worked very closely with local authorities to design the programme, so that we have a shared understanding of the outcomes we are trying to achieve, the types of support and services we are trying to provide to families, and then local authorities design those specifically, using a parent and carer panel to help them to design them to meet their local community needs. That will continue, and the way that operates is that the funding is linked to the focus on pre-conception to the age of two and that the things that we measure and the way we track performance are all linked to that. But it is also about recognising that at age two, the family's needs do not end, and that the wider early years focus goes up to the age of five. That is going to be really important in delivering the Best Start strategy and the goals as part of the opportunity mission. We will retain the focus but recognise that families need more help and support beyond the age of two as well.

**Chair:** Thank you.

Q201 **Dr Cooper:** Thanks for being here. I want to ask more about the neighbourhood health centres and family hubs. Minister Dalton, you have already outlined that there will be some overlap. Pragmatically, how will those two things work together? Presumably, the services are going to

complement each other. Where might they be distinct? Are there gaps that might need addressing?

**Ashley Dalton:** Neighbourhood health services are important, and I have been talking a lot about them since we launched the 10-year plan. It is not a thing or a building; it is services. It is about making sure that people have access to their health services as close as possible to their home or community. In some instances, that might be delivering it through a family hub, which are more of a thing, although not necessarily—in some cases it could be a virtual service or whatever. Through local commissioning, we are making sure that neighbourhood health services work in partnership with family hubs, schools, nurseries and colleges, so that timely support to children and their families is accessible as close as possible to where they are.

We are currently working up further details of how we are rolling out the neighbourhood health implementation programme, and those will come out in the coming months. Fundamentally, it is about saying that all our health services for everybody—from conception to death—are available as close to the community as possible. In some cases, that will mean linking with family hubs. It might mean linking with existing services such as community centres, mother and toddler groups—all different kinds of things that are in different communities. What we recognise with the neighbourhood health programme is that all communities are different and have different levels of assets. For instance, what works in a very urban city centre environment is not necessarily appropriate for people in a more rural environment. The commissioning should ensure that those neighbourhood services reflect the needs of the neighbourhoods.

**Q202 Dr Cooper:** That is clear, thank you. Looking at the commissioning, with neighbourhood services, it may well be a primary care or other provider that takes on that provision. If the neighbourhood health services are commissioned from the ICB or ICT, and family hubs are a separate entity, and I have a two-year-old and I am phoning the family hub, presumably if it is not appropriate for what I need, then there will inevitably be direct communication where the family hub—even if it is not physically together—will refer into the other commissioned services?

**Ashley Dalton:** Absolutely, yes.

**Q203 Dr Cooper:** Okay, that is clear. Moving on to how you decided to come up with Best Start family hubs—in which lots of words come together from different things—there is an ongoing evaluation of the predecessor of Best Start family hubs, which is family hubs and Start for Life. That evaluation is not due to report until 2026. Could you talk us through what evidence you used in deciding, prior to that evaluation, to integrate the services into Best Start family hubs?

**Ashley Dalton:** We had the previous service and, as you have identified, we are in the middle of evaluating it. That will report next year. This is a mission-led Government, which is about making sure that Government is joined up and not siloed. It continues as a joint project between the Department of Health and Social Care and the Department for Education.



Essentially, many of the services are the same, but we are building more on the lessons of Sure Start. Susie could probably talk a little more about how the Department for Education has looked at what it is prioritising and how to bring those together in the roll-out of its programme.

**Susie Owen:** Probably the most influential piece of research that has been done in recent years is the work done by the IFS on the long-run impact of Sure Start. That has been hugely influential and has obviously made a huge difference and impacted how we have designed this, because we have taken that evidence of what it showed really benefited those children.

The research looked at how close a child lived to a Sure Start centre, rather than whether they accessed it or not, and then looked at population-level data. It showed that children performed significantly better in educational assessments at age seven, 11 and 16. The proportion of children achieving five GCSEs at grades A\* to C increased, and, importantly, it had a really interesting impact on hospitalisations: it increased them for one-year-olds—our hypothesis is that this was due to greater identification of need—but it averted over 13,000 hospitalisations for 11 to 15-year-olds.

As well as understanding how that was done, we looked at how Sure Start was rolled out. It started off with Sure Start local programmes, which were located in the most disadvantaged communities. Over time, the model changed slightly. The IFS work was predominantly focused on that Sure Start local programme, which was very targeted at disadvantage, and that has informed how we are doing the national roll-out of Best Start family hubs.

In addition, the model has been informed by some work that was done in Doncaster, which adopted a family hubs model prior to the Best Start family hub programme. Again, that showed an important improvement in outcomes for children at age five who had attended the family hub, so we drew on that.

As the Minister says, we have lots of evaluations ongoing to look at it. We know that the impact of these sorts of programmes is long-run. You cannot see an impact in a year, 18 months or two years. It is the long-run work to look at how it affects the lives of children and families as they grow that is really important, hence why we are evaluating, but we need to interpret things cautiously. We need to understand what the data is telling us and what it is not telling us, to inform how this is rolled out. At the heart of it is the integration across education and health, which was a key factor of the programme when it was initiated back in 2021.

**Q204 Dr Cooper:** Thank you; that is really interesting. So you have taken the footprint of Sure Start and the data and evidence it has given you and built up from that, with some additional input from family hub pilots that happened in Doncaster—is that right?



**Susie Owen:** Yes. The other thing I would add is that the interventions that we pay for, whether that is Department for Education services or Health ones, are also informed by the latest evidence. We have What Works centres that have looked at the effectiveness of parenting programmes and evidence-based interventions. It is both the model of how the services are integrated and then what you choose to do with the families once they come in. That is informed on an ongoing basis by research coming out of the Nuffield Trust, Nesta, What Works centres, the EEF and so on, which really helps us to help local authorities to make the right commissioning decisions for their local populations.

Q205 **Dr Cooper:** Great. I have one final question. I do not think the data will contradict massively what you are saying, and as you say, it is ongoing data collection, but presumably when this evaluation reports next year, there is flexibility in the model to be able to adapt, depending on what it tells you.

**Susie Owen:** Yes. We have built test-and-learn into the new model. We have already done two test-and-learn pilots in Sheffield and Manchester. That is particularly around outreach and how you ensure those under-represented or seldom heard groups are targeted, but we are building test-and-learn into the approach for the whole model. We are encouraging local authorities to think creatively about their approaches and share that learning across the system—"So-and-so have done it over here. Does that apply to my area?" That is what commissioners need. We do not want to prescribe exactly what they should be doing everywhere, but we do want every local area to be informed by the best practice as it applies to them.

Q206 **Jen Craft:** I want to follow on with another question about family hubs, you will be unsurprised to hear, specifically looking at speech and language development. We had a very interesting session focusing on that area. The Royal College of Speech and Language Therapists noted in its written evidence—and this was picked up during our oral session—that the current guidance does not allow early language and home learning environment funding to be used to cover the first 1,000 days. Is that something the Government are looking at changing in the future?

**Ashley Dalton:** I am not sure that that is exactly how it is. We recognise that early detection of speech and language issues is vital. We have invested £3.4 million this year in the Early Language Support for Every Child programme, which is designed to support children in early years and primary school settings, and we continue to build on that. We are also looking at the important work of health visitors and how they are identifying need and feeding that through, and at some of the work that has been done around positive parenting—building up strong child-parent relationships—and the support in place to help people with that through either family hubs or health visitors going into the home.

All of that works toward and supports speech and language development, so there is certainly a commitment to ensure that speech and language development is core. That is something that we are looking at from birth; it is not that we are only allowed to intervene or provide services or



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support for children over the age of two. Having said that, we recognise that the two to two-and-a-half-year-olds review is one of the key ways of identifying where a child may still need further support, even though they might have had support through the early years, and we are taking action to improve that process as well.

**Q207 Jen Craft:** But the RCSLT did specifically pick up on the current guidance for early language and home-learning environment funding. In the 2022 to 2025 period, it could cover only three to four-year-olds and up, and that was extended to cover two to three-year-olds for 2025-26. They ask for that funding be able to be used from birth. Speech and Language UK suggests that you could even use it pre-birth, as some speech and language development does indeed take place in the womb, antenatally, but according to current guidance, they are not allowed to use that funding to cover that period.

**Ashley Dalton:** That is a very specific—

**Susie Owen:** It is a DFE programme.

**Ashley Dalton:** Yes, so it might be worth you talking a little bit about that, but before we move on to that, I want to say that that is a specific piece of funding. Susie will be able to talk specifically about it, but we do want to make sure that we are supporting families to create a language-rich home environment. Family hubs will support that, and we have the national Little Moments Together campaign, which is also helping to support it.

Susie, perhaps you could talk specifically about the funding stream that comes from the DFE. That would be helpful, I think.

**Susie Owen:** I would echo everything that the Minister said. We build speech and language through everything we do in the early years, right from conception all the way up. It is foundational. We know that those attachments and so on are so important for building speech and language.

The funding streams you refer to are specifically the home-learning environment and parenting strands of the existing programme funded by DFE. You are right; initially it was three to four-year-olds, and then it was dropped down to two-year-olds. We are currently going through the process of setting the new programme guide and putting advice to Ministers on that. We have not yet set out what the new programme will look like.

As the Minister said, the period post the two to two-and-a-half-year-old check is crucial. It is often where specific speech and language needs are identified. We also require that money to be spent on evidence-based interventions, so where the evidence base lies for the most effective interventions. There are numerous ones at ages two, three and four, and we think it is really important that children are getting those interventions and extra help. A lot of those children can be supported, whether in settings or at home, and then they can catch up to their peers and start school with the requisite speech and language skills. That is a really



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important age range to be focusing on, but, exactly as the Minister says, that does not preclude local authorities funding various services—as we already know they do—to support babies and children right through the age range.

**Q208 Jen Craft:** Thank you. Looking specifically at the first 1,001 days, what is the offer around speech and language therapies and interventions in the nought to two-year-old category,? The Committee visited Blackpool, where they have an extended health visitor programme. I am not going to get ahead of Andrew, who I think is going to talk about that, but one of the things that they offer is speech and language training for their health visitors, so they are able to identify where children may need additional help and support. As I am sure you will be aware, that can be done at a very early age, even when children first start to make eye contact and use certain iterations of noise—only a very tiny bit of speech and language is actual verbal communication. What were the plans around that 1,001 days to make sure that there is a sort of universal offer on speech and language interventions for all children?

**Ashley Dalton:** Right across DHSC, NHS England and the Department for Education, we are working to improve access to community health services, including speech and language therapy for children, because we do recognise that that can be improved. We are identifying examples of innovation and improvement, and what you described in Blackpool is the kind of thing that we are looking at. We are developing some guidance to support pathway redesigns, workforce models, and so on.

One of the key things that we are looking at is the review of the health visitor programme. In our manifesto we committed to improving the programme, and we are rolling that out at the moment, really focusing on what our health visitors provide and whether that meets the needs of families and is adequate. When we have finished the roll-out, we can look more closely at what training, support and development we must put in place to ensure that the health visitors we have are delivering what we need, including identifying where speech and language therapies are required, and signposting to the relevant organisations if families are not able to do that themselves.

**Q209 Jen Craft:** Is there a planned target for those who are most in need of this kind of therapy? There is quite a lot of evidence around disadvantaged communities not necessarily accessing some of the support that people in a higher economic bracket will access. Is there a plan for how will that will be targeted, or is the idea to roll it out and see where the need is?

**Ashley Dalton:** Obviously, commissioning health services is the responsibility of ICBs; they are best placed to know the requirements of their communities. We will see what happens when we finish the review of the health visitors, and how we best target that.

**Liz Ketch:** At the moment we are doing some quite intensive work with local authorities who are doing lower levels of checks at the two to two and a half check, but as the Minister and Susie outlined, when we roll out

Best Start family hubs we are really focusing on disadvantage and ensuring that the services are accessible to those in greatest need. As we refresh the programme and think about how we deliver the next phase, really focusing on families in need will be at the core of everything we do, recognising that services need to be accessible to those who have the greatest needs.

**Chair:** I will now hand straight over to Helen?

**Helen Hayes:** Thank you, Chair. I am Chair of the Education Select Committee. Thank you for having me as a guest.

**Chair:** You are guesting with us today and I really do welcome you; I apologise for not saying that.

Q210 **Helen Hayes:** Not at all; I am very glad to be here.

The interest of my Committee in this inquiry is twofold. We are just reaching the end of a very big inquiry on SEND; we will publish our report soon. We have resolved to undertake an inquiry on early years, which will launch very soon, so we are midway between two significant pieces of work that are relevant to the work of this Committee and this inquiry. My questions will be focused on those areas.

In our SEND inquiry we have received an unprecedented amount of written evidence. Much of it says that there is a need for much more early identification of need and much better access to the interventions that address those needs as early as possible in a child's life, and that at the moment the system does not deliver that very well at all.

My first question is relevant to some of the things that Jen asked about in relation to speech and language, but it is much broader than that. What is the strategy to ensure that the Best Start in Life programme delivers a step change in access to early identification of SEND needs and early intervention in support?

**Ashley Dalton:** That is very much focusing on the Department for Education, so I will hand over to Susie, who has that information.

**Susie Owen:** Hopefully you saw in "Giving every child the best start in life", the strategy that we published in July, a real focus on ensuring that early years provision is inclusive and is providing the right support for every child, so it does run through everything you set out. You will know that the Department is doing much broader work on the SEND systems, so I will focus today on the things that we talked about in the early years strategy.

Lots of things in the strategy about increasing early identification of need were very much welcomed by the sector. I mentioned the support that will go into every family hub. A trained professional will be there entirely to work with families to identify needs early, whatever they may be, then help the family to navigate the system and access the support they need. We know that is a problem in the system, particularly in the early years. Either families are not being identified early, or a need is first recognised



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when a child comes to an early years setting, but the setting does not necessarily have access to the right support for the family.

The role of the practitioner in a family hub will be to work with all its early years workforce and settings to help families to get the right support to the child at the right time. We also set out various ways that we will support the workforce with training, which will again be similar with what Jen was asking about regarding health statistics and so on. We need to make sure that everyone working in the early years is trained in identifying need. Of course, there will be some children born with very specific needs that are identified at birth, but for lots of children in the early years, their needs emerge over time. As I said earlier, much of that need can be supported in a mainstream setting, and children can catch up with their development if they are given the right support.

The idea is that by the end of the early years, you are working only with children who may need some ongoing support in the future. We are supporting our workforce to do that. We have already trained 7,000 practitioners in early years settings to have a SENCO qualification—a level 3 SEND qualification; we are training a further 1,000 this year and will continue that work. We have also published lots of additional resources for settings to help them support children with SEND.

We have also been investing in the ELSEC programme, a test and learn programme which has been running for two or three years. We have funded it for an additional year with the £3.4 million that the Minister referred to. That has had some great findings. The idea behind that programme is that it will inform local commissioning by testing various approaches, working with speech and language therapist-led services and then working with local workforces to make sure that children are getting the support they need. The findings emerging from that are positive and will inform ongoing SEND work.

The Committee know that that is an ongoing issue. The Department will be setting out more plans in the autumn on the wider SEND system, but there is an understanding that we need to get in right—or more right—in the early years, and so decrease the need for higher complex needs support later in a child's life.

**Q211 Helen Hayes:** Thank you. Another strand running through much of the evidence that we received relates to health. It is the view of many parents, professionals and local authorities that within the SEND system it is very hard to get Health to the table. NHS services are often absent and although we have education, health and care plans in the statutory part of the system, the H is missing. We heard again and again from our witnesses that you cannot get the H bit to the table. Health is not held to the same standards of accountability as other parts of the SEND system.

Minister and Liz, what difference is that work going to make in the early years to ensure that Health is properly at the table and working in partnership with local authorities, settings and other bits of the system

that support children and families? It is clear to the Committee that it is largely absent at the moment.

**Ashley Dalton:** Okay. It is concerning that that is the perception. One of the reasons we run Best Start family hubs as we do is that it is a joint programme between Health and Education, because we recognise that the two go hand in hand. That is important and why we approach it in that way. It is also why £126 million was announced for the continuation of the programme for the next financial year, £57 million of which was allocated to health-related Start for Life services.

When rolling out the neighbourhood health programmes it is important to have health working in partnership with all kinds of community services, including education services and community development, and through local authorities and ICBs. The intention is that ICBs work closely with local authorities. We also have the public health grant, which is administered by local authorities. We expect local authorities to ensure that their public health and education teams are joined up. This is something I am happy to take away to look at further, to understand what is going on at a more local level, and to see what support and work we can put in place to help develop that.

Q212 **Helen Hayes:** Your attention to that issue would be really helpful. It is not a local problem; it is a national problem. It relates in part to the structures for accountability. For example, SEND tribunals make recommendations that are binding on local authorities but not binding on health services, even though health services could be every bit as important to delivering a child's education. There is an imbalance in accountability for health. This is a big problem, and it is a problem across the country. Parents, professionals and local authorities have told us in no uncertain terms that health is not at the table as much as it needs to be when it comes to partnership working to support children with additional needs and their families. Your attention to that would be really helpful.

This is my final question. Thinking about SEND services as they are delivered in the early years, and then the passporting of those services through to the next stage of a child's education, another problem we heard about is that very often the need for a diagnosis acts as a gateway to support. In fact, that should not be the case; our system is set up not to require a diagnosis to act as a gateway to support, but all too often it is required, and often a diagnosis not provided in the first 1,001 days of a child's life. The services you are trying to deliver through the new strategy will, I presume, deliver support when a need is identified and not necessarily when a diagnosis is provided.

My question is about the interface between the early years and the formal part of a child's education. How will you make sure that when needs are identified, support is put in place in the early years through Best Start in Life, and that that support is easily passported to the next stage of the child's education and stays in place? We hear far too often from families that they have to battle again and again for the support they need at every stage of their child's education. That clearly needs to change.



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**Ashley Dalton:** A review is ongoing into the whole SEND and EHCP process. Susie, can you say more about what the Department for Education is doing around that?

**Susie Owen:** One of the big differences of having the strategy and thinking about the Best Start family services is integrating all the bits of the system. We recognise exactly what you are saying. We have had family hubs in one place, and early years settings, schools and health in others. We need them all to be working in concert to support children. There is a real emphasis on transition in the work we are doing, particularly between early years settings, because most children are in an early years setting aged 3 and 4, and reception, as well as a really big focus on the reception year. It is a really crucial year—children come into compulsory school age at the end of reception, and we assess children at age 5 as well. We are putting a real focus on the quality of teaching.

One of the things announced in the Best Start in Life strategy was nursery-school partnerships, which are about getting local settings to work with their schools and transfer knowledge either way, so that schools understand where those children have come from, and vice versa. We think that is particularly important for children with additional needs, so that parents are not having to fight again. How we can smooth those transitions into the school system is really important, while also making sure that the school leadership understand the importance of the early years and what has come before, right from birth onwards, so they can better support children on their school journey.

Q213 **Danny Beales:** Good morning, Minister. Thanks for joining us. I am going to ask you a few questions about vaccination rates, which the Committee has heard a considerable amount of evidence about during our inquiry. Since 2021-22, we have seen considerable falls in vaccination rates for mothers and babies in the 1,000 critical days period. In 2023-24, coverage decreased in all 14 vaccine areas. A new vaccine strategy was launched by NHS England in 2023, in the midst of that period. In the light of worsening performance, was the strategy wrong, or is it a problem with implementation and resources of the strategy?

**Ashley Dalton:** We are actually making progress on implementing the strategy and improving uptake. The latest data from April '24 to March '25 shows that vaccination coverage for children aged 20 months has actually remained broadly stable, with improvements in some areas. In England, the uptake of the first dose of MMR at 24 months has increased ever so slightly—not enough for me to say it is rocketing, but enough to say that we are confident that it is remaining stable at the moment.

You will have noticed, no doubt, that just two weeks ago we announced that from January next year, the MMR will become the MMRV; we will be adding the chicken pox vaccination into the MMR vaccinations. We have also launched flu vaccination campaigns, which went out on 1 September, targeting pregnant women and children to protect them during the winter season. None the less, we have identified—we will not pretend otherwise—

that although we have got the rates reasonably stable at the moment, we are still some way off the World Health Organisation targets.

**Q214 Danny Beales:** We are considerably off. I take your point that there might have been, in data that we have not seen, a slight shift on some measures, but on 14 measures there have been quite consistent decreases since 2022-23.

**Ashley Dalton:** One of the things that we have identified is what is stopping people from getting vaccines: the vast majority of those people are talking about a lack of access to them, so we have started to look at how we improve that. One of the key things that we have put in place is catch-up clinics in schools, GP practices and community settings. We have also now made it possible for people to get their children's vaccinations at pharmacies, which is making it far more accessible for people who may struggle to get to a GP.

We have identified that people are telling us that they do not necessarily know where their child is with their vaccines, so as part of the 10-year plan, and our shift from analogue to digital, we are rolling out the "my vaccines" element of the NHS app. That is going to launch in 2026-27, so that parents can check their child's vaccination status and then identify what they need to do in order to fill that up. One of the key things is health visitors.

**Q215 Danny Beales:** I am going to come on to health visitors. If your reading of the situation is that the strategy is right, and that there is not a problem with the implementation of resources, why are we so far behind and still falling on most if not all of the measures?

**Ashley Dalton:** It is a global issue in terms of the approach to vaccines, and we are working to build that up. We have identified that we need to target different areas, because different areas have different reasons for not hitting their targets. We have pilots in Birmingham—I cannot remember where else—about how we focus on those communities that are struggling to get access. It is a long-term roll-out. The strategy is being implemented, but obviously it is going to take a little bit of time.

**Q216 Danny Beales:** The strategy is the right one and it is being implemented—that is what I am hearing.

**Ashley Dalton:** Yes, and we are reviewing it on a regular basis.

**Q217 Danny Beales:** That is despite the strategy being in place for three years and us seeing a worsening picture for those three years—the strategy is working. You said it is a local issue. ICSs are going to play a more significant role from April 2026 and have more responsibility for vaccines and vaccine strategies. If it is a local issue, how will ICSs be held to account if their performance does not improve, and if their new powers and responsibilities are not met?

**Ashley Dalton:** The vaccination roll-out remains the responsibility of the vaccination board that I chair. ICBs will be expected to report into that, so there will be monitoring, and they will be expected to deliver on the basis



of the national strategy. We are also looking at how we roll that out from a very local perspective, as well as how we put in place access. That is why we have made it possible for you to get your vaccines at a pharmacy. It is why we are going to be rolling out vaccinations by health visitors, which has not happened previously. In 2026, we are going to be piloting the administration of childhood vaccinations during health visitor visits for families who face that barrier.

**Q218 Danny Beales:** We have heard about that before. Again, I come back to the fact that the NHS England strategy was launched in 2023. We have heard that there is piloting that will take place of health visitors delivering vaccines, with a possible national roll-out in 2026-27. It has been quite a number of years, and we are still talking about pilots in small numbers of areas for health visiting. We have a major problem with vaccination rates. We are having outbreaks of measles in Merseyside; a child died of whooping cough in the last few days. Do these small-scale initiatives and pilots—which are from a strategy from three years ago that is still being pursued despite ever-worsening rates—show a level of impetus, resourcing and prioritisation that is reflective of the scale of the problem?

**Ashley Dalton:** Vaccination remains a real priority for the Department, and we are working to increase uptake. In order to do that, we have to understand what the barriers are. We have been doing an awful lot of work to do that. From January next year, children will be eligible for the new vaccine, which I have highlighted, at routine GP appointments. They will not necessarily have to make an appointment to get that; if they are going for some other reason, the GP can offer them the immunisation if they have not had it.

We are also incentivising GPs by offering an additional £2 supplement per childhood vaccine to improve routine coverage and support GPs to deliver that. We have summer catch-up clinics, school-based services, and community outreach being rolled out and delivered in areas with historically low coverage. That is to strengthen routine vaccination and reduce inequalities.

Yes, we are piloting health visitors administering vaccinations because we must understand how it works best. We could roll out something right across the country straight away, but without really understanding what needs to be put in place to make that effective and what support health visitors need. This has to sit alongside all the other stuff they are doing, and we are trying to understand whether they are delivering what is needed. We are also working on the 10-year workforce plan to look at how we bring on more health visitors to deliver that.

We are expanding access to some vaccines, particularly flu vaccines. From autumn this year—so now—flu vaccines for two and three-year-olds will be available in nursery settings. I am aware we need to build on that.

**Q219 Danny Beales:** Are you confident that all the things you mentioned will lead to an increase in vaccination rates next year? Will we, as a Committee, be able to speak to you next year having seen an uptick in the

14 key vaccination areas?

**Ashley Dalton:** I certainly hope that that will be the case. That is what we are working towards.

**Q220 Danny Beales:** Are you confident, Minister?

**Ashley Dalton:** I cannot predict exactly what those figures will be. I can say that we are putting in place and implementing a strategy that we believe will deliver that.

**Q221 Danny Beales:** I cannot speak for the Committee, but I would personally say that we are in a vaccination crisis in this country among children and pregnant women, which is leading to some of the tragic incidents we are seeing. In the light of this, was it a good idea to remove the WHO 95% vaccine coverage target from NHS planning guidance? Was that the right decision?

**Ashley Dalton:** That remains a target, and we remain signed up to delivering it.

**Q222 Danny Beales:** It is not in the planning guidance.

**Ashley Dalton:** It is not specifically in that guidance, but not being specifically in the guidance does not mean that it is not an expectation.

**Q223 Danny Beales:** If we see further falls in most vaccine levels next year, would you consider putting it back in NHS planning guidance?

**Ashley Dalton:** I review vaccination rates regularly and meet the vaccine board several times a year. We are monitoring what we are rolling out, seeing what works and what doesn't work that we might need to change. We will make any changes that we believe are appropriate as we move forward; it is an iterative process.

**Q224 Danny Beales:** Would you agree that the strategy is not working if next year we still see further falls, or no progress in getting towards the 95% target? Is that failure? What is failure? It sounds at the moment that further falls in vaccine levels, further outbreaks, and not making any significant progress towards the 95% target are not considered failure.

**Ashley Dalton:** That is not what I am saying at all. What I am saying is that we are aiming to deliver that 95%, if not more, and the strategy is focused on doing that. I am keen to make sure that we review that regularly and that what we are doing is iterative and responds as quickly as possible to the reality on the ground so that we can deliver on increasing vaccination rates. What I can see is that they are stabilising, and we believe we are heading in the right direction. I will be monitoring that, and I do that on a monthly basis in terms of the rates we have, so we are working towards doing that.

**Q225 Danny Beales:** Stopping the further falls is positive, but I think we urgently need to get back not just to the levels we were at but to the 95% target, which is a key target for population coverage.

**Ashley Dalton:** It remains an ambition that we meet the WHO targets.

**Q226 Danny Beales:** Is there a deadline for meeting the WHO target?

**Ashley Dalton:** There is not at this stage, no. But we will review that as we move forward and look at the implementation.

**Q227 Danny Beales:** Do you think the Government should set a target?

**Ashley Dalton:** It is something that we will look at as we will review the implementation and the results of what we are putting in place.

**Danny Beales:** Thank you.

**Q228 Andrew George:** To be fair, you inherited a bit of a car crash as far as the workforce is concerned, with a 40% reduction in staffing within the sector since 2015. I understand from UNICEF, which has highlighted a Royal College of Midwives survey, that—it seems improbable—57% of midwives are contemplating leaving the service within the next year. One can understand that, given the intense pressure; we are estimated to be about 5,000 health visitors and 2,500 midwives short within the service itself. You mentioned the workforce plan. Can you be more specific about when that is coming out and whether these issues are going to be addressed within the plan?

**Ashley Dalton:** The 10-year workforce plan will be published later this year. That is as specific as I've got. I do not have an actual date.

**Q229 Andrew George:** Before 31 December?

**Ashley Dalton:** Later this year, yes. It is not just about numbers; it is about a new long-term professional strategy for nurses, health visitors, midwives and nursing associates across all settings in England. It is really important that, instead of just asking how many staff we need to maintain our care model, we ask how we do that given our reform plan. Given our 10-year plan for health, what workforce do we need, what should they be doing and where should they be deployed? What skills do they need to have to deliver not just what we are aiming to deliver today, but a decade of renewal and our 10-year health plan for an NHS that is fit for the future? That will set out the workforce plan that delivers the 10-year health plan. It will be published later this year.

At the moment, we have seen some improvement. It is nominal, but we saw a slight increase in terms of NHS-employed health visitor numbers in July. It is around 2% at the moment, but that is going in the right direction. As I said, we have a really focused review of health visitors, not only in terms of the numbers but in terms of what they are actually delivering and whether that is going to deliver the NHS fit for the future that we need to see.

**Q230 Andrew George:** I will come back to health visitors in a minute, but I notice that the Royal College of Occupational Therapists have strongly recommended that they shift a lot of their work out into the community, which, of course, is one of the three shifts that the Government are trying to achieve. They believe that they will have a greater impact by operating in the community, rather than quite so much in a hospital setting. In



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terms of your workforce plan and the delivery of services for the first 1,000 days of life, do you see that as being something that the Government can actually push and encourage?

**Ashley Dalton:** Yes. We have said very clearly in our 10-year plan that one of the key tenets is moving from hospital to community where possible. If things have to be delivered in an acute setting, obviously that is where they should be, but where things can be delivered in the community, they should be delivered in the community, particularly when—as you have highlighted—clinicians and professionals are saying, “You know what? We can actually have a better impact if we are doing that.”

It is not just about improving access for patients, children and families; it is about developing skills, making it easier for clinicians to roll out their services and putting them more in the community, because a lot of these interventions are far more impactful if they are done in a holistic way. If you are delivering something like occupational therapy, it is really helpful to be able to see the community and the home life that somebody lives in and what facilities are available in their community. That joined-up approach from hospital to community, really focusing on neighbourhood health and rolling out services wherever we can—as close as possible to home and communities—is absolutely crucial.

Q231 **Andrew George:** You mentioned health visitors. You said there was a proposed health visitor programme in the Labour manifesto. You also suggested that health visitors could take on a larger number of tasks—for example, the vaccine roll-out. At the same time, a large number of health visitors are struggling with stress. Retention is extremely difficult, and recruitment is not easy either. The guideline is a caseload of about 250. The vast majority—only 6%, I think—are below that number at the moment, and you are talking about heaping more responsibilities on them. How does this work?

**Ashley Dalton:** That is why I was talking about the workforce plan—it is not just about how many more we need; it is about what they can be doing. That is not only about giving them more and more to do. It is about saying, “What are they doing at the moment that actually might be delivered in a better way and a different way, which could free up time?” That is why we are focusing on not just, “Let’s get more,” but, “Let’s make sure that what they’re doing is actually what needs to be done in that environment.”

It is something we are looking at, and it is why the workforce plan is not just about numbers. It is about professional development. It is about retention. It is about supporting our clinical professionals to be able to deliver the services that they really want to deliver.

I understand this quite clearly. My niece is a health visitor, and I speak regularly to her about what she is doing. She loves her job but says it is difficult when about 90% of her work is safeguarding. It is about identifying what they are doing, where things can be done slightly



differently and where we can give not just health visitors but nurses, nurse practitioners and midwives opportunities to develop themselves as professionals. That is what our workforce plan is going to focus on.

**Q232 Andrew George:** I do not know whether your niece is saying this, but a lot of health visitors are saying they cannot do their job—there is not sufficient time to perform their duties. They do not feel it is a safe environment in which they feel satisfied that they are giving families the support they need. Are you confident that you can turn that around? The majority of the workforce feel that that is the case.

**Ashley Dalton:** We knew when we came into government that that feeling was not exclusive to health visitors. That is what staff in the NHS have told us time and time again. We know that staff in the NHS are dedicated to delivering the best possible service—that is what they want to do, and they have been frustrated by over a decade of what they see as an erosion of the support they need to deliver the services they believe they should be delivering. That is why we have the NHS 10-year plan for health, and it is why we are looking at a 10-year workforce programme, to really improve the experience for clinicians and, by extension, for patients.

**Q233 Andrew George:** As you know, there are five mandatory visits from health visitors. The Committee learned that in Blackpool, they have adjusted the way they manage the workforce there to achieve a target of eight visits, which they believe is a better way of both keeping in touch and maintaining an overview of the progress being made in a child's development. They have done that through the use of non-health visitors: band 5 staff nurses—registered nurses. Do you believe that sort of configuration is the way of achieving improvements in the range of services and giving families the preventive support they need?

**Ashley Dalton:** What is highlighted by the example of Blackpool is local areas identifying what is needed in their communities and being innovative and creative about how they deliver that. One model will not be the only model for everywhere; it will depend on the needs of the community. We encourage commissioners—local authorities and ICBs—to be innovative and creative and to respond to community need, because we are not about setting one national model that we expect everybody to fall in line with; it is specific. Liz has something she would like to bring in on this.

**Liz Ketch:** We have talked about the evaluation of the family hubs and Start for Life programme. There is a third evaluation that we are doing of a small number of workforce pilots. Local authorities that are part of the programme are also piloting mixed workforce models, perhaps similar to the one that you have heard about in Blackpool. The reason why we were keen to do that in the first phase of the programme was to start to understand different configurations of the workforce, where health visitors are still incredibly valuable but are supported by a mixed-skilled team, so the work is distributed slightly differently. We are not suggesting that we think there will be a one-size-fits-all answer, but we want to evaluate a small number of different workforce models so we can better understand

how those might help families to receive better services and the workforce to have a better, more sustainable career path.

**Q234 Andrew George:** This is happening across the NHS: the potential risk—or some might call it dumbing down—of saying that people trained to clinical level x can oversee or allow certain functions to be undertaken by someone who is not so well trained. Do you think those kinds of patterns are safe and deliverable?

**Ashley Dalton:** Well, it is up to those local areas to identify what is required. I think everybody would agree that, where there are activities or services that do not need that high level of clinical expertise, a multidisciplinary team working together might very well be an appropriate way for those communities to roll out those services. Where it is, we would support the innovation and creativity in doing that.

**Q235 Andrew George:** Okay, so it will not be done by a central diktat saying, “The Blackpool model will be rolled out nationwide.” It will be a framework within which there will be local flexibility.

**Ashley Dalton:** Yes. What is right for Blackpool might not necessarily be right for Basingstoke. That is why we have ICBs. Of course a lot of health visitor services are rolled out and delivered by local authorities, and we support them to do that through our public health grant. They are responding to community need, and that will be dictated by the socioeconomic make-up of the community, the geography of the community, the existing services and the assets that the community has in place at the moment.

**Q236 Jen Craft:** I want to touch more on the wider early years workforce. I was wondering what kind of plans you have in place to make sure that the expertise of specific professions, such as occupational therapy, physiotherapy, and speech and language therapy, is best deployed, and when the interventions in that space are best delivered by someone who does not necessarily need to have that level of professional expertise. What is the plan to make sure that those professions are accessed when they are most needed, and that everyone receives those interventions in the early years, so that there is that proportionate universality?

**Ashley Dalton:** What we have touched on already is the way that the Family Hubs and Start for Life programme will be able to identify those needs by working in partnership with health visitors, joining up all those services and signposting where appropriate. We have covered that in the conversations we have already had about speech and language therapy and access to wider health services through the neighbourhood health model. Was there something else? I feel like there’s something else you’re getting at that I’m not getting.

**Q237 Jen Craft:** Yes; to access a bunch of these services, you need a diagnosis or a referral, and we have been hearing again and again from professionals in this space that they spend a lot of their time not being able to do the kind of dedicated work that they want to do, because they are dealing with that referral process. Speech and language therapists are



not able to offer the interventions at the earliest opportunity they would like to, because they tend to see people only when they hit a certain level of crisis. Similarly, community paediatricians say that they cannot build the kind of relationship with their patients and their families that they would like to, because they tend to see people only when they are coming in through a crisis model or when something has reached a certain level.

Will there be something in the workforce plan that details how best to use the expertise in this space, and how best to disseminate that knowledge—task-shifting—down to people, so they do not need to be a speech and language therapist, for example, to deliver speech and language interventions? Is there something that delivers that model a lot more holistically so that professionals who have a level of expertise are able to deploy that at the earliest opportunity? Is there something along the lines of lowering the threshold for intervention or referral?

I can give a really good example; my daughter, as you all know, has Down's syndrome. She has hearing loss, but we were unable to access speech and language therapy for her until she had turned three—until there was a defined problem that they could see. You can say, "It would have been a miracle if she didn't have a speech and language delay", but there is a lot in the system where you can do interventions without the need to see an expert. We have also been hearing from these professionals that they would like to see people earlier, so they can make more effective interventions and build a relationship. Will the workforce plan reflect that?

**Ashley Dalton:** The workforce plan will focus specifically on recruitment, retention and professional development. Rolling out services, referrals and access to services is part and parcel of the roll-out of the 10-year plan for health and the family hubs and Start for Life programme. The neighbourhood health services and the Best Start family hubs should be able to identify families and children where support is required.

It sounds as though the review of SEND and EHCPs currently being undertaken by the Department for Education will highlight some of the disparities that a number of Committee members have highlighted, which includes the joining up between health and education and the issue of, "We need the health diagnosis before we can deliver the education services". That is being explored, as I understand it, through the review of the SEND and the EHCP programme.

**Susie Owen:** I can add to that. A lot of children are in settings in which the early years workforce—childcare practitioners and early years educators—are really key, and likewise the family support workers that will work in family hubs. It is really important that we support that workforce to understand what normal child development looks like, and train them to recognise what the important milestones that children need to reach, or should be expected to reach, are—obviously in children it is not linear, nor is it the same for every child.



The links with those professionals are also really important. Part of the focus of the Best Start family service is to build those links across professional bodies wherever you sit—whether you are in health or an early years setting—and to build trust and understanding between the specialist and the practitioners, so that practitioners feel that they can pick up the phone and check something about a child or a family, whether that is a safeguarding issue, a health-related issue or something else. Those softer connections and networks are so important.

That is the learning from the ELSEC programme—the early language support for every child—which has been a SALT-led model. The speech and language therapists are running the programme, but they are training practitioners in settings to identify it, so you are building those connections. That is what you are talking about; not just waiting until a family and a child have gone through a really long, possibly bureaucratic, process and setting and is frustrated and by then, need has escalated. That is the frustration of a professional who meets a family and thinks, “If I’d had some contact with this family earlier, I could have provided guidance.” It is about getting that right.

It is not always acute intervention; sometimes, it could be a phone call or a conversation to make sure that what the child is being provided in the setting is right, and that the advice to the family is appropriate, so they can provide the right environment in the home to support whatever that need may be. When we talk about the integration of services, that is such an important part of it—yes, it is about the service provision, but it is actually about how those professionals work together. How that trust is built locally and how they understand and work towards the same goals will be hugely important to reducing that friction that you describe in the system.

**Q238 Jen Craft:** We have heard it is also quite crucial for retention, because it allows professionals to do the job that they have entered the profession to do. That has been quite useful.

To touch on the issue of recruitment, there are obvious workforce shortages, not just in early years, but across the NHS. One specific area is speech and language. The demand for speech and language therapists has grown threefold since 2019, but the long-term NHS workforce plan does not include a target of a triplicate increase in speech and language therapists. Do you think the long-term workforce plan is sufficiently ambitious, or will the upcoming workforce plan have more ambition to recruit more people into these roles?

**Ashley Dalton:** Yes—and we are not waiting for the workforce plan on this, either. We are taking action now to increase the pipeline of speech and language therapists, and the NHS is supporting an increased number of students recruited on to the three-year degree programme. Numbers have increased: there were 817 in 2019 and now 1,434 in 2024-25, so we have seen a significant increase there. In addition to the traditional undergraduate degree route, we have now put in place a degree apprenticeship route. We are working to increase that pipeline of speech



and language therapists. As I am sure you appreciate, it takes time to recruit them, but by making it easier for people to choose that, and particularly the apprenticeship route, we have started to increase that number and we anticipate that it will continue to increase.

**Q239 Jen Craft:** Will the workforce plan reflect the rising level of demand? There has been a significant uptick in demand across the piece for speech and language, OT, physio and all those early years services. Or will there be an aim to reduce some of that acute demand, as opposed to meeting that demand via recruitment?

**Ashley Dalton:** We have laid out our 10-year plan for health, and part of that includes shifting from sickness to prevention, so that where possible, where we can prevent the need for acute services, we want to be able to do that by changing the environment and supporting people to make some of those healthier choices where appropriate—although that is less the case in terms of some of the issues you have been talking about. However, that is part and parcel of the programmes being delivered through family hubs and Start for Life, supporting parenting and nurturing to see off some of the more acute needs that might develop later on. The workforce plan is about delivering the 10-year plan for health—so, yes, it will be looking forward and saying, “What do we need to deliver our ambition?”

**Q240 Josh Fenton-Glynn:** My questions will focus on maternal mental health. Adverse childhood experiences are linked to a number of poor outcomes later in life, including mental health problems, heart disease and stroke. One such experience is some form of parental mental health breakdown, and we are currently seeing record high demand for perinatal mental health services. One in five mothers experience perinatal mental health issues and it is the biggest killer of parents between six weeks and a year of their child’s life. Currently, 68,000 women are accessing perinatal mental health services, or about one in 10 mothers—about half of the one in five who are suffering. Last time this Committee looked into the question, it found a postcode lottery in provision of mental health services. However, the Royal College of Psychiatrists now tells us that almost two thirds of ICBs are making real-terms cuts to their mental health services. Does that concern you?

**Ashley Dalton:** We are aware of some systemic issues with maternity and neonatal care, and we are making sure that we are providing high-quality, safe care and that all women and families are listened to. That includes post-natal care, including support for mental health. We know that many women and babies do receive excellent care, but it is unacceptable that that is not the case for everybody, and you will know that the Secretary of State has worked really closely with families of people who have experienced less than adequate maternal care, whether that is—

**Q241 Josh Fenton-Glynn:** There are two things here. One is dealing with the individual cases and understanding what has gone wrong there, and one is having the structural ability to take up an increase in demand. If we are cutting mental health services, as we are told two thirds of ICBs are, how



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are we going to keep up with that demand?

**Ashley Dalton:** In terms of maternal support, you will know that we have launched the independent national investigation into NHS maternity and neonatal services. The investigation is going to make clear sets of national recommendations by December this year to achieve high-quality, safe care right across maternity and neonatal services, while making sure that women and their families are listened to. On the wider support, ICBs need to make those decisions about how they roll out their services. We are supporting ICBs to do that. We have also increased the public health grant to support people to do that. On the specific point around 1,001 days and maternal health, that will be wrapped up in the maternity review—how that needs to dovetail with existing services.

Q242 **Josh Fenton-Glynn:** But very specifically on mental health services, you say that you are supporting ICBs. How are you supporting them to put more funding and more support into the mental health services that they are currently cutting?

**Ashley Dalton:** It is down to ICBs to decide how they allocate the funding that is provided to them and what is appropriate for their local communities. I think it is really important that, as we delegate that decision making to local areas—whether to ICBs or to local authorities through the public health grant—they do that. I am more than happy to come back to the Committee with some specifics on mental health—that is not something in my portfolio specifically, but I am more than happy to have a look at it and come back to you. I do not know whether Liz has more specific information on that.

**Liz Ketch:** There is one area that we can perhaps include when you come back to the Committee. One of the service strands that we fund in the family hubs and Start for Life programme is support for mild to moderate perinatal mental health difficulties, recognising that that period is critical. That is really important for the parent's health, for forming the bond with their child, and for the child's long-term health and wellbeing. It is one of the strands that we funded specifically through the programme, recognising that it is an area where more support was needed. We can perhaps wrap up more information on that in a more detailed response, if that would be helpful.

Q243 **Josh Fenton-Glynn:** My concern is that you are talking in generalities about maternal health, but there is one specific area of maternal health where there is a crisis. It is all very well saying that it is up to ICBs, but we know that ICBs are also having cuts. How are we going to make sure that those services are delivered, and find a way to deliver those services when we have record high demand and only about half the women experiencing these problems are currently accessing the service?

**Ashley Dalton:** What Liz has identified is that we have put that service into the family hubs and Start for Life programme. We have identified that, and provided that initial support through that programme. We can do a little bit more work—and I am happy to come back to the Committee on this—to look at how we dovetail that with the wider mental health

services. I am more than happy to look further at that and come back to the Committee on it.

**Q244 Josh Fenton-Glynn:** I guess that opens up another question. You are talking about broader training of health visitors and so forth. One suggestion that has come in on perinatal mental health is training health visitors and midwives to identify mental health problems, and to provide support. Is that something that might come up in the workforce plan?

**Ashley Dalton:** Whether that is specifically in the workforce plan, I cannot tell you. It is around professional development, recruitment and retention. Supporting those clinicians who people face on a more regular basis, so they are able to spot and signpost people for a variety of issues, is certainly something that we are looking to develop as part of our hospital to community programme.

**Q245 Josh Fenton-Glynn:** Thank you for that. I am now going to shift gears and talk about GDPR, because why not? We will move on to discuss the single identifiers. When do you expect the pilots of using the NHS number as a single identifier to be complete?

**Ashley Dalton:** The pilot activity, as you know, is under way, testing how that single unique identifier can be implemented effectively. I will hand over to Susie because that is firmly in the DFE's remit.

**Susie Owen:** Yes, that is one of our programmes, although we are obviously working very closely with Health. It is being designed as an iterative programme to understand how best to use a single unique identifier, with all the complexities that happen. As you know, the current pilot is under way in Wigan. It will then move through further phases to test specific things. At the moment in Wigan we are testing the ability of local authorities to automatically access the NHS number for children known to social care, to see how that operates. Further pilots will focus on how the use of that number can enrich the data that a professional has and enrich the datasets we have around safeguarding, and on the system changes that will be needed to make that a really seamless process.

The second pilot is starting in September. We have not yet given details about when we will be publishing findings from that, but obviously the whole way we are approaching this programme is to test and learn, starting on a small scale and identifying the challenges and problems that exist, both for professionals and the system issues that exist, and then building on that to move towards a further roll-out. We will definitely be sharing more details in future about how those pilots have gone to inform the next stages of that evolution.

**Q246 Josh Fenton-Glynn:** During the inquiry, one of the concerns we heard about the pilots is that we do not have NHS numbers for everybody—migrant children, for example. What are we doing to ensure that we get them?

**Susie Owen:** It is exactly those sorts of issues that the pilot will uncover. You have named one; there are also adopted children, where the NHS



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number changed when they were adopted. Those specific issues will be tested through the pilots, so we are making sure that we understand where this works for the majority of children and how it will operate for those subsets of children, who are likely to be a small minority. That will inform the work of the pilots as we go through. We are very aware of that issue, and are working to address it.

**Q247 Josh Fenton-Glynn:** Another thing—this is one all the kids are waiting for—is GDPR. We previously heard that professionals would find it helpful for there to be a national agreement about how to manage GDPR concerns and third-party data, to make sharing it easier. Is that something the Government are considering creating?

**Susie Owen:** We are working closely with the Information Commissioner's Office on this, as we know it is a key issue, and ensuring that data protection issues do not get in the way of safeguarding and promoting the welfare of young children. Current data protection law allows practitioners to share information where needed, and to identify children who have safeguarding and welfare needs. That provides a framework that enables that sharing in a fair, proportionate and lawful way, but we know that more needs to be done to make sure that is communicated.

You will probably also be aware that there is a provision in the Children's Wellbeing and Schools Bill around data sharing, to provide that legal framework and give confidence to professionals. Many are already doing that, but we know there are issues and specific areas to provide that underpinning legal framework, to enable them to have confidence to share the information in an appropriate way.

**Q248 Josh Fenton-Glynn:** I guess the problem is that if you have NHS numbers and NHS data being shared, the problem arises when it comes to sharing with education. We have heard about the challenges faced by the DFE when it comes to data linkage and children's experience before five. What are you doing to explore that data link between Departments?

**Susie Owen:** At the moment it is that specific thing of using a single unique identifier to ensure that professionals are speaking about the right children, and therefore have access to the right information as appropriate. It is not about open access, where you get a number and suddenly have access to all the data; this is very much about what is the appropriate unique identifier.

You will know that we are testing the NHS number—it is part of the pilot to test whether that is the appropriate one. That has not been decided yet, but all the issues that you are referring to are exactly the sorts of things that are being investigated through the pilots. That is why we are taking this very phased and iterative approach to the process, to make sure that we are surfacing issues—I am sure there will be others that you have not touched on—around this area. This is something that has been long wanted, but we need to do it carefully and intentionally to ensure that we are doing it in the right way.

**Q249 Chair:** On the back of that, what are the timescales for this?

**Susie Owen:** Pilot No.1 is under way now in Wigan, and the second one is starting in September 2025.

Q250 **Chair:** When will it finish, so we can start seeing some results?

**Susie Owen:** Obviously, it was a manifesto commitment from the Government, so there is an ambition to complete it by the end of the Parliament. But there is an iterative approach, so it will depend on what is found in the pilots and how quickly that can go. There is huge ambition to get this right and do it as quickly as possible, but in a considered and sensitive way, given the issues that your colleague has already identified.

Q251 **Dr Cooper:** To follow on from data collection and hopefully bring it to a positive conclusion, during the inquiry we had a lot of people giving evidence, and sharing frustrations about the lack of a common outcomes framework. As all three of you have rightly pointed out, that is health, education and children's social care.

For example, Alison Morton, the CEO of the Institute of Health Visiting, said that she would like "specific, small numbers of key metrics that we want to share across Departments...it is like a triangle." She did not mean "wheelbarrows full of questionnaires", which is heartening. I am sure this is something you have heard before but, as the Minister has pointed out, we are a mission-led Government. I wonder what the appetite is for a shared outcomes framework across the Departments, and whether any progress has been made.

**Ashley Dalton:** There really is an appetite for a shared outcomes framework, specifically, as you have identified, to integrate health, education and social care. The Best Start in Life strategy commits to exploring that. It is also worth pointing out that, separately, MHCLG are engaging with the local government sector on a draft local government outcomes framework. That will include the areas that local government is responsible for, including good levels of development at two to two and a half years, and at five, as outcome measures.

The intention is that the framework will be publicly available by April 2026. Susie will be able speak more specifically, as the DFE are working on the shared national outcomes framework that we have identified for health, education and social care.

**Susie Owen:** As the Minister said, it is a really good step forward that we have the local government outcomes framework. That is a really clear target. The good level of development both at age five and at two to two and a half is a broad-based measure that encompasses a range of things, and we think it is really important. As the Minister said, it will be confirmed, post the consultation, what measures will be in place by April 2026.

We are also following up with individual local authorities. We are setting individual local authorities targets around the age five metric, in line with the 2028 Best Start in Life target for 75% of five-year-olds to achieve a good level of development. As I said earlier, we are requiring local areas

to produce Best Start local plans. They should be building on plans that are already in place. Many local authorities already have, with their partners, a clear focus on the early years. We are just making sure that is consistent across them, and that those plans are in place.

As the Minister said, in the strategy we did not commit to looking at whether a more detailed outcomes framework is needed, drawing on the lessons from Every Child Matters. That needs to be done carefully because, as Alison said, we need to avoid the danger of wheelbarrows, metrics for metrics' sake and turning it into a bureaucracy. We need to ensure that, when you decide what metrics to measure, that drives behaviour. Sometimes that can drive the wrong behaviour, or there can be perverse incentives in there. It does need to be carefully considered, but we think the local government outcomes framework is a really good starting point.

We will build on that with the Best Start local plans. As you alluded to earlier, this whole programme needs to iterate and learn from what is working. We will consider that, rather than rush to a more detailed national framework, which could end up being quite a top-down, bureaucratic process. We need to get that balance right.

**Q252 Dr Cooper:** That makes sense. Are the available outcomes data that you have sufficient, or have you identified key gaps across the three directorates—the three areas—that you think we need to look at more?

**Susie Owen:** I can speak to age five, and maybe Liz or the Minister can come in on two to two and a half. At age five, every child is assessed at the end of reception year against the early years foundation stage profile, which covers a number of areas of learning. That is a comprehensive dataset. Obviously, the vast majority of children are in reception and take that dataset, so we are confident that we have that data. As I say, it is a broad-based measure, which is really helpful.

Obviously, within that dataset we can also break down at a local authority level, and we are also working to produce a tool that allows schools to look at their data in more detail and compare it with schools in similar contexts to see how that is coming out. We are doing a lot of work to give schools and local authorities the tools they need to understand that.

**Q253 Dr Cooper:** One specific thing on that. That is great, but when you are disaggregating that data and looking at disadvantage in that area, are you using free school meals as a proxy?

**Susie Owen:** We are.

**Q254 Dr Cooper:** Okay. I am sure that you are aware that there are issues there. It doesn't scrutinise non-working families, and that can cause real problems. I don't know whether you want to speak to the Committee about that, but there is a potential issue around that data.

**Susie Owen:** It is the proxy that we use, and we also look at SEND, because there are big gaps in the experiences with SEND. You are right that it is a blunt tool, as ever. As you can imagine, in every Department



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there are lots of debates about how to measure disadvantage in the most appropriate way. When we have set the local targets, we have required that to meet their target, they have to meet the overall target but also ensure the FSM children are moving at the same pace as the rest of the children. I take your point that that does not cover every—

**Q255 Dr Cooper:** On the non-working families thing, there has obviously been the very welcome announcement that we are going to fund childcare for working families. Great, but obviously we have non-working families, and we need to be really mindful about how we measure that potential gap.

**Susie Owen:** Yes. Obviously, one of the big focuses is on ensuring that those children who are entitled to the two-year-old offer, which is 15 hours for low-income families, are all accessing that offer, and driving that through. That will be part of the Best Start family service as well, to ensure that those families are being identified earlier and getting the support either through the family hub or, as I say, being referred on to settings where they are eligible for that entitlement. That is really key.

**Q256 Dr Cooper:** So you are aware of that particular glitch in the matrix; that is good.

I will ask you about disaggregation of data—as Josh says, it is another very exciting thing, but it is important. During our inquiry, we heard about waiting list times for children, and at the moment the disaggregation of data looks at adults and children, but there is not any further age-based disaggregation.

Dr Fuller, the medical director for primary care at NHSE, highlighted that she thought there should be greater disaggregation to include early years to give greater insights—because obviously, if you are two years old, waiting may have greater impact that it would on a 16-year-old. What do you think about further disaggregation of those data? Is that possible? Have you considered it at all?

**Ashley Dalton:** Obviously, we have got our electives plan which was published in January and sets the targets for an 18-week referral to treatment for all patients; that includes children and young people.

One of the big issues that you have identified is actually being able to identify the data. We have recognised that we have not been able to do that adequately, so we are putting in place a change to that so that we can report data on much smaller groups based on age. That is something that we had not been able to do in the past. That is something that we are exploring. I am trying to remember which ones we have got in at the moment—but yes, we are looking at that.

**Q257 Dr Cooper:** It would be good if you let the Committee know when we could expect to see the disaggregation of those data.

**Ashley Dalton:** Yes. We are looking at that data so that we can monitor waiting times by age, which we have not been able to do in the past.

**Q258 Ben Coleman:** Thank you very much for coming today, Minister. I would



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like to ask about the Government's plans to protect babies from much of the dangerous baby food out there at the moment. It is quite clear that too much of the baby food in our shops is over-sweetened, over-salted, innutritious, unnecessary mush that is actually contributing to childhood obesity and health decay. I get that from the evidence I have read and from the Government's paper. I hugely welcome the Government's new guidelines to crack down on sugar and salt in baby foods—baby drinks as well—and to crack down on misleading labelling and marketing.

When it comes to sugar and salt, the Government has committed to bring out a progress report. It has given food producers 18 months, so it is committed to bring out a progress report after—not in—February 2027, in the light of which it will consider "additional or alternative measures". Will there also be a report on labelling and marketing coming out to check whether companies have improved and are not claiming that things are healthy when they are not?

**Ashley Dalton:** As you have identified, we have issued new guidance not only on sugar and salt but on marketing and labelling. The industry has got 18 months to—

Q259 **Ben Coleman:** Will you be issuing a report on marketing and labelling as well?

**Ashley Dalton:** We will be reviewing how that is delivered. What we have said very clearly is that if the industry does not take adequate steps to meet those guidelines, we reserve the right to review that and then put in place mandatory guidelines, if necessary. So, yes, we will be reviewing labelling and marketing as well, because that is part and parcel of the guidance that we have issued.

Q260 **Ben Coleman:** By "mandatory measures", you mean that you are prepared to consider legislation.

**Ashley Dalton:** We will be looking at what we can put in place if industry does not respond. What we really want to do is to work with industry—that is why we have put the guidelines in place; the feedback from industry has been relatively positive. We will keep that under review and we will keep monitoring how that is being rolled out, but we have said very clearly that we reserve the right to look at other measures if the industry does not respond adequately.

Q261 **Ben Coleman:** Okay, so that may include legislation.

**Ashley Dalton:** It may do, but there are a variety of methods that we could look at.

Q262 **Ben Coleman:** That is very positive, but your timeframe says that it will be only after 18 months that you issue these progress reports. If they have not done what is needed—I hope that they will do what is needed—we are only then going to consider legislation. Given the time that that will take to prepare and go through Parliament, we may not get anything done on this absolute disaster, which is increasing childhood obesity and tooth decay, until after the next election. Is that good enough?



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**Ashley Dalton:** There are already very strict nutritional guidelines for baby food—you cannot have artificial sweeteners and so on. That is already in place. We have put 18 months because the process for the industry to potentially reformulate their products, test those products and get them on the shelves can have quite a long lead-in time. That is why it is an 18-month process. That is why we will review after 18 months to see whether they have been able to deliver that. It is not really possible to do it in a shorter period of time, because of the lead-in time that the industry needs to reformulate products where possible.

Q263 **Ben Coleman:** I take from that that it may be the case that, if they are not doing what is needed, and we require legislation to force them to do what is needed, babies are unlikely to get the protection they need from baby food until after the next election.

**Ashley Dalton:** We can look at a variety of options that do not require primary legislation, so we will be exploring those as we see how this is being rolled out by the industry. It does not necessarily mean that that will require primary legislation, which I am sure is what you are referring to in terms of the timescales in Parliament. There are a variety of different things that we can look at to bring that forward.

Q264 **Ben Coleman:** Brilliant. But isn't the thing about progress that it is not just a fixed point in time, and that you can assess progress towards things? We do not have to wait 18 months to see whether any progress is being made; the industry can inform you, on an ongoing basis, of the changes they are making. Shouldn't we be assessing and publicising the outcome of progress on an ongoing basis, in case we do find that we are going to need legislation, statutory instruments or further measures? I would like to suggest that we publish a report from now, every six months, on how the industry is doing in reaching the 18-month target. Would that be possible?

**Ashley Dalton:** We want business to work with us, and we need them to co-operate. So we work iteratively and communicate with business, and we can respond quickly to any concerns that they have. Issuing reports is not necessarily helpful given that timescale, because we know that changing the formulation of their products, marketing those products, getting them labelled and getting them on shelves is a longer process than that. I would not want to create an environment that suggests that less progress is being made than actually is, just because we have put unreasonable timescales in place.

Q265 **Ben Coleman:** I agree, but on reasonable timescales, you have given the 18-month timescale. I am not challenging that. Some people might, but I am not. But I have worked in business. When you ask somebody to deliver a project within a timeframe—you may give them six months or a year—you regularly check in with them to see how it is going, whether they are encountering any problems, and whether you need to give any support, push or nudge in the direction of getting to the outcome.

Just leaving it for 18 months until you do the analysis—and remember that you are going to do the report only after 18 months—will surely mean that



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it is far too late. Could you not, on the way, reassure yourself by seeing whether they are going in the right direction? If they are not, you may need to start to prepare additional measures sooner. Waiting 18 months is not what would be done in business, and I do not know why the Government would do that.

**Ashley Dalton:** Obviously we remain in contact with the industry, and we will continue to have conversations with them through that 18-month period to ensure that progress is being made and to respond to any issues that they raise with us about what is getting in the way. But there are currently no plans to issue public reports on the six-monthly basis that you have identified. We are not looking to do that at this stage.

Q266 **Ben Coleman:** If we as a Committee asked for a report in six months on whether you were satisfied that producers were starting to get their act together to implement the guidelines, would you be able to provide us with that?

**Ashley Dalton:** We are not going to be issuing a written report on that, but we do remain in conversation with the industry.

Q267 **Ben Coleman:** So we will have no assurance that they are actually doing anything until 18 months from now—or after 18 months, because it is after February 2027 that the report will be published.

**Ashley Dalton:** Well, we expect business to do that, because obviously, if they do not, they will face further measures. The conversations we have had with the industry suggest that they are willing to explore this. They want to do that in a co-operative way, and we are supporting them to do that.

Q268 **Ben Coleman:** I gather that, in the Government paper, it says that the metrics for assessing progress are being considered. What is the timeframe for developing those metrics? Are we expecting them to be delivered in three months or four months, or will it take longer?

**Ashley Dalton:** I do not have the specific timescale on that, but I can come back to you on it.

Q269 **Ben Coleman:** Would you be able to write back to the Committee on that? That would be great.

**Ashley Dalton:** Absolutely.

Q270 **Ben Coleman:** Finally, the industry, as you say, has been co-operative, but the history of the food production industry is not one of co-operation; it is one of only doing things when they are forced to do things, or being frightened that legislation is coming in. I do not know if you are aware, but I have been told by friends that one huge baby food producer, which I could name but I will not today, has just contacted a number of public affairs firms to bid on what they call a rapid influence campaign, to influence the development of healthy food standards, so you can expect some lobbying coming your way—seriously, even more than you have had already. I guess that part of it will be promoting the usual dubious claims



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by industry-related scientists about certain things, but they are planning to do this campaign, despite saying that they intend to improve matters.

It would be helpful if you could commit, over the next 18 months, to ensuring that all meetings between Ministers and civil servants, whether they are in the Department of Health, public health people or in other Departments, and the food industry, whether that is the food industry producers themselves or their public affairs consultants, are properly, transparently recorded and published—that all meetings between the industry and Government are transparently recorded and published.

**Ashley Dalton:** They always are. I never have a meeting with anyone without an official in the room and without the notes of that meeting being recorded.

Q271 **Ben Coleman:** If Members of Parliament stand up and make representations to the Government as this roll-out of the guidelines takes place, do you consider that they ought to say whether or not they have had meetings with and taken information from public affairs—

**Ashley Dalton:** That is a matter for the Speaker and the parliamentary standards committee.

Q272 **Ben Coleman:** So it is something the parliamentary standards committee might want to look into. Good. Well, I wish you luck with this. I think it is going to be fascinating progress. We will probably still want to have some idea of whether they are going in the right direction before 18 months are up, because otherwise, babies are going to get overweight and their teeth are going to fall out, as is happening now, for longer—although this should not happen at all—than is necessary.

**Ashley Dalton:** I also think, putting it into context, that although we are talking specifically about baby food in that instance, this is all part of a much bigger picture around what we are doing in terms of food. Today, we have announced the banning of the sale of energy drinks to under-16s, which I think is really important. We have also announced mandatory reporting for larger supermarkets and the out-of-home sector in terms of healthy foods. We also have the banning of junk food advertising to children, which is coming on board in January. It all comes together as a really concerted approach by Government to say, "It is not acceptable either to fill food with salt and sugar without people knowing about it, or to advertise it to children and babies."

Q273 **Ben Coleman:** That is brilliant, honestly. I thought the announcement this morning was terrific. I think we all here welcome what you are doing. It is a fantastic to have a Government who are actually taking these things seriously, finally. On the supermarkets having to have mandatory targets on healthy food, what is going to happen if they do not meet those targets?

**Ashley Dalton:** At the moment, there is reporting. We have not put in place the targets at all, as yet. That is not for this Parliament. It is reporting on what their baskets are—what healthy food they sell. The incentive for them is that they have a higher health rating, because that is

how people will judge where they go and buy their food. It also influences supermarkets in terms of what they market and where they position healthier foods. We are looking at what are realistic targets and how we enforce those. That is something we are looking at in the next Parliament.

**Ben Coleman:** I hope that all the healthy carrots you put in place work, and that you will not need to bring in a stick.

Q274 **Chair:** Can I ask one question? It is a really simple one. Ben spoke about a report every six months, which we understand you cannot give, but you are meeting with these people on a regular basis. It is not just that you are going to see them in 18 months' time; it is ongoing and you are seeing them regularly to monitor, even though you have not done a formal report. Is that right?

**Ashley Dalton:** Absolutely. All of this is an iterative process. We keep our eye on what is going on. We get feedback from the industry, the charity sector and officials about what is actually being rolled out. I think it is unrealistic to expect them to do it in quicker than 18 months, but we are alert and we have regular meetings to make sure that they are taking steps towards being able to deliver that.

Q275 **Chair:** Great stuff. Minister, just for clarity, at the beginning of the session, I talked about 1,000 days, and so did many Committee members throughout. That is because we are following on from a previous inquiry. We realise it is 1,001 days, but we are following on.

**Ashley Dalton:** That one day is really important!

**Chair:** I know. I had this issue in the first place, but we are following on from a previous inquiry. On that note, thank you for coming today. It has been a really interesting session. I really appreciated you and the Committee being so honest, as well as Susie and Liz. Thank you.