

Health and Social Care Committee

Oral evidence: First 1000 days of life, HC 1496

Tuesday 6 November 2018

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Members present: Dr Paul Williams (Chair); Luciana Berger; Mr Ben Bradshaw; Andrew Selous.

Questions 1 - 99

Witnesses

I: Elaine Kelly, Senior Research Economist, Institute for Fiscal Studies; Anne Longfield OBE, Children's Commissioner; and Dr Angela Donkin, Chief Social Scientist, National Foundation for Educational Research.

II: Dougal Hargreaves, Honorary Consultant Paediatrician at University College London Hospital and Visiting Research Analyst, The Nuffield Trust; Anthoulla Koutsoudi, Director of External Relations, WAVE Trust; Sarah Benioff, Deputy Director of Strategic Funding, The Big Lottery Fund; and Dr Jo Casebourne, Chief Executive, The Early Intervention Foundation.

Written evidence from witnesses:

- [Nuffield Trust](#)
- [WAVE Trust](#)
- [The Big Lottery Fund](#)
- [The Early Intervention Foundation](#)

Examination of witnesses

Witnesses: Elaine Kelly, Anne Longfield and Dr Donkin.

Q1 Chair: Good afternoon everybody, and welcome to the first session of the Health and Social Care Select Committee's inquiry into the first 1,000 days of life. My name is Dr Paul Williams. I am chairing this inquiry. Thank you very much to our three witnesses for coming along today. Could you start by introducing yourself, and say where you are from and a bit about why you are interested in this particular area?

Dr Donkin: I am Angela Donkin. I am the chief social scientist at the National Foundation for Educational Research, but I was previously the deputy director for the Institute of Health Equity working on inequalities with Michael Marmot. Prior to that, I managed the two Graham Allen reports, so I have a long-standing interest in early years, particularly the impact of the early years on later life outcomes.

Anne Longfield: I am Anne Longfield. I am the Children's Commissioner. I have a long-standing interest in this area. A lot of my attention is on children who are, I believe, marginalised and therefore fall beneath their potential. I have been convinced for many years that you need to start early in helping them overcome the challenges. I was involved in setting up the Early Intervention Foundation in my previous life, and in the charity I ran we ran a lot of early intervention and early years services.

Elaine Kelly: I am Elaine Kelly. I am a senior research economist at the IFS—the Institute for Fiscal Studies. I am also now head of economics research at the Health Foundation. I am here more in my IFS capacity, because I co-authored a report on public spending on children for the Children's Commissioner that was published earlier in the year. My main interests are in health and healthcare, but I have done some work on early childhood interventions.

Q2 Chair: Thank you very much. The first question is very broad. We are looking to you to set the scene for us to begin our inquiry, both from a why this is important point of view and from a public finances and public response perspective. First, what are the social determinants of health that affect the period from conception to age two? Then perhaps you could talk about different social determinants in different parts of the phase from conception to the age of two.

Dr Donkin: Can I start from the basis that you know what social determinants are? They are the social and environmental factors that impact on your health behaviour or they might impact on your lifestyle. Early years is in itself a social determinant of health later. I am going to talk about the impact of the other social determinants of health on early years.



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Starting in pregnancy, sufficient income to have a healthy diet is important, because, if you do not, you are at risk of low birth weight. There is a social gradient in low birth weight. In addition, low income at that point can lead to material factors to do with nutrition, such as the quality of housing and so forth. There are also psychosocial factors that can relate to poor mental health and what we call suboptimal coping strategies; you are more likely to drink too much, take drugs and smoke, and all of those can have an impact on low birth weight. Low birth weight is bad because of infant mortality and a wide range of other things that I will talk about later.

Income remains important in the nought to two age range because it links to the quantity of different experiences that children have in the home and elsewhere. In addition, later on, poor mental health in women has a social gradient with low income, and if a mother has poor mental health she is less likely to bond with her child. That has longer health impacts.

The quality of housing is important: cold, damp and overcrowded housing has been associated with increased risk of asthma and communicable diseases such as TB and the Epstein-Barr virus. Parental education is another important factor, as is access to flexible, good-quality work, access to high-quality affordable child care and access to maternal mental health support and social support, so as not to be socially isolated.

Q3 **Chair:** Is there anything you want to add to that list, Anne?

Anne Longfield: My starting point is slightly different in that, in the experience of the child as they grow up, these are particularly vulnerable years in any case. They are particularly important years in child development because that is the point when the child's brain develops. We know that there is impact from an awful lot of what Angela talked about on brain development, much of which cannot be caught up on or, is very difficult to catch up on, if it starts to go wrong at that stage. We know, for instance, that children who are neglected or are not getting love, support and the like at that age will develop a kind of almost fight or flight syndrome that affects the way they think, and can be seen through the whole lifecycle. Of all the ages of children, this is the age when so much is set in terms of the brain but also in their experiences of the world.

Vulnerability for children is a slightly different way of talking about the determinants. I have been doing annual data collection on levels of vulnerability. About 2 million children of all ages are living with parents with severe mental health issues, drug or alcohol dependency or violence in the home. Some data we produced only about a month ago showed that around 16,000 children under the age of one—babies—were living in those environments without any kind of real support.



Of the 2 million children living with parents with those issues, about 1.5 million of them do not have discernible support. There are risks that very young children are carrying. There are lots of stats I could talk about. There is a very strong link to deprivation. Often those children are invisible, but invisible babies can often become visible teens when they hit the headlines in terms of gangs, exclusions and the like. There is a clear link, in my view, but we can talk about that in more depth as we go along.

Q4 Chair: I want to link that to a question about inequalities in outcomes. You have talked about socioeconomic inequalities and the different outcomes to do with birth weight, which we are measuring, and a socioeconomic gradient in mental health issues. What other inequalities can manifest themselves?

Dr Donkin: Obesity has a social gradient. Low birth weight and excess birth weight are both linked to obesity. Children in low socioeconomic groups are more likely to be obese. There is a social gradient in impaired social and emotional skills, language acquisition and infant mortality. In the longer term, the impacts of the early years are not just on child health immediately; in the longer term, there are impacts in heart disease, cancer, chronic lung disease, stroke and diabetes, so it is quite wide-ranging in terms of health.

Elaine Kelly: From an economics perspective, there has been a lot of work studying inequalities and the impacts of early life shocks or resources on later life outcomes. Other work has looked at trying to understand the mechanisms behind those inequalities, because if we want to try to do something about them we need to understand why they exist.

There are lots of reasons why children from poor families might not do as well as children from rich families, either in cognitive or non-cognitive outcomes in health. They may be more likely to suffer bad shocks; their parents might be more likely to become unemployed and they might live somewhere that is more polluted. If they suffer bad shocks, they have fewer resources to compensate for them. If someone becomes unemployed in a richer family, there might be someone else in the family who can step in. There may be differences in the amount of other resources they have.

There are also differences in what we would describe as production technologies. For example, even if you gave a rich parent and a poor parent, or, more accurately, an educated parent and a less educated parent, the same number of resources, you might expect the more educated parent to use the resources to encourage child development more. It is important to think about what the inequalities are, what is causing them, the degree to which they are amenable to policy in some way and what can be done about them.



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Anne Longfield: There are things such as self-regulation, which has a high formation at this stage of development. We know that is a really strong indicator for behaviour in school and indeed involvement in crime and the like, so it is a really important stage of development.

Q5 **Chair:** What do you mean by self-regulation—the ability to sit still on a chair type of thing?

Anne Longfield: To regulate your emotions and have agency; it is your self-regulation within that. We know that later in life children on free school meals are 16 times more likely to be excluded from primary school than others. There is the 22-month point when children with high cognitive abilities on low income get overtaken by children on higher incomes with lower cognitive abilities unless there is support at that point. That clearly has had an impact in policy terms over recent years. There is also speech and language development. We know that 28% of children are below the language development they should have by the end of reception year.

Q6 **Chair:** That is a big indicator for later performance.

Anne Longfield: Exactly. If you go through exclusions from school and the number of kids in YOIs, more than half will have poor communication skills—in some cases 90%.

Q7 **Chair:** We know all this and we have known some of it for a long time, and our knowledge about it is increasing all the time. To what extent is the vision of giving every child the best start in life being realised?

Dr Donkin: It is really encouraging that there have been reviews and that people are talking about early years. The Department of Health, for instance, looked at health visitors and the programme that they were going to provide and improved it, and there was increased roll-out, I believe, of the family nurse partnership.

One issue is that actually, on the ground, it does not feel like the investment is there to support early years particularly. Some local authorities have been struggling to fund enough health visitors, because the public health budget went to local authorities, and there has been a decrease in places such as Sure Start centres or children's centres. Services like CAMHS are overstretched. The infant mortality rate in this country is a third higher than in Europe on average. Mental health problems are a real issue and are forecast to rise. We know that poverty is a social determinant and that the numbers of children in poverty are increasing. While some great things have been said, some good things are happening and the evidence base is improving, there is more to be done on the ground with regards to roll-out.

My final point is about focus. There seems to be increased targeting. For instance, if you just target on the bottom quintile, the bottom 20% of income distribution, you are only hitting some of the problem. Although there is a lot to be said for focusing on the people most in need, actually,



if there is to be a real shift, we need to be thinking across the distribution and what can be done.

Q8 **Chair:** Proportionate universalism.

Dr Donkin: Yes.

Q9 **Andrew Selous:** May I follow up on a few of the fascinating points that were raised? Can I go back to diet, which you mentioned early on? How much work have you done on looking at families where there is enough income to provide a good diet but maybe the food being chosen is not good for the child and the pregnant mother? When the Committee visited Amsterdam on the childhood obesity inquiry recently, there was some work being done there to teach healthy cooking skills to low-income immigrant communities, for example. Have you focused on that at all? Poor diet and poverty can absolutely be related, but they are not necessarily the same if poor choices are being made.

Dr Donkin: I personally have not studied that area in any depth. The research I was quoting emanated from what we used to call the Barker hypothesis, which looked at folate and iron in pregnancy. If we look at surveys of consumption, we see that people on low incomes are eating less fruit and vegetables and less lean meat. The problem is not just not enough calories; in fact, that is often not the case at all. The issue is that foods high in nutrients are an expensive form of calories. Lean meat and fresh fruit and vegetables are quite an expensive way to fill yourself up. It seems that, when people on low incomes are choosing food, they might be choosing the things they can afford.

Q10 **Andrew Selous:** Can I put the question another way? What do we need to do to help improve diet among low-income communities?

Anne Longfield: A lot of children's centres put a big onus on that. They have provided healthy eating groups; they have helped with cooking skills; and they have supported mothers and parents throughout pregnancy. They have recognised that and done a lot towards it. Angela is completely right that some of the cheap fill-up stuff is high in sugar and carbs and the like, and it is cheap. There is the dreadful point where kids are eating too much of the wrong things, and you can see that as well. There is the whole issue about healthy diets, healthy start and healthy schools—schools that have looked at this as an ongoing area of activity. There are lots of examples of good community health support, but it is whether it is there for the long term.

I think people want to take part. I was in a holiday play-scheme over the summer. Not only were they providing hot lunches for the kids—and during the holidays that was very welcome—but they were doing cooking classes too and they were absolutely inundated. There is interest and demand for that.

At some point, can we go back to whether we are providing a good start, a healthy start?



Q11 **Chair:** Yes. We would like to hear your opinion on that.

Anne Longfield: The intentions in several programmes on that are good, but they are not yet in any way providing the kind of assurance that we are offering all children the best start we possibly can. We have a situation where a lot of the policy interventions have been either about the mothers, or the parents, or about the child. In health terms, the patient is often seen as one patient, either the child or the parents. Obviously, when they are small, you have to look at them both together. There is not very much focus on families and their children.

The main policy interventions have been around health visitors or have leapt to the age of three. That has been a bit of a gap and a black hole. We have a really fragmented system where the stuff that is delivered is delivered by many different people. Health visitors are with public health; midwives are with NHS trusts, with the NHS; and children's centres, and a whole range of people, are with local authorities. If childcare is provided, there is a whole range of private and voluntary sector people. We have a fragmented system. While people might do really good work for an aspect of that time, they are not doing it in any kind of joined-up way, with a joint mission. There is not a group of people co-ordinating and working with a family and their children to give them the kind of seamless support that would enable them to get the springboard they need.

Often, there is a divide between what is education and what is health; when children are this young, they are both about developing. We need to see under-threes as important in education, and to see physical and emotional health as something that is linked. There are opportunities to do that in policy terms; we have the spending review, the 10-year plan and the like, but it has not been done before, and at the moment it has created a kind of gap that the kids who are the most open to some of the difficulties and negative aspects we talked about are falling through.

Q12 **Chair:** What is the policy response to deal with the issue of fragmentation, to deal with the issue where, to use your words, there is not somebody in overall charge?

Anne Longfield: Someone taking responsibility. The first building block of the policy response is that it is a cross-Government priority, because at the moment there are interventions at different stages and different times by different Departments, but they are done in relative isolation. I am generalising, obviously. There may be good co-ordination on the ground occasionally, where you have a particularly "can do" set of people or they are at that stage of development, but it is not something where we can all sit back and say that the infrastructure is in place to make that happen. Children's centres were attempting, or are attempting, to do a lot of that, but it depends on a whole range of different things: are they there, do they have the resources, and do they have the will of the different agencies? Co-ordination is absolutely key.



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We need a national drive with ambitious targets for reducing those vulnerabilities. You can reduce the risks from all the things we talked about in terms of social determinants or vulnerabilities, whatever we choose to call them. If you do not reduce the risks, the vulnerabilities do not go away; they just get shunted on to a different age.

Q13 Chair: We need a national drive with ambitious targets for local authorities to deliver.

Anne Longfield: You might say local authorities, or you might say some kind of joint commission between health and local authorities. You might choose to look at all manner of mechanisms as to how that might be done locally, but there needs to be a mechanism locally, I believe, that can take a lead, and, obviously, clear accountability is part of that. At the moment there is a space, in policy terms, and all those different aspects of services, which are costing the public purse quite a lot—various armies of people are delivering good work—are falling short of the impact they could have if they were driving forward as one, systematically identifying families that need help, children that need help, and then looking at how they might do that as the child grows up.

Q14 Mr Bradshaw: Were things different or was co-ordination better when we had a Department for children, which I think was Ed Balls's baby, wasn't it? Did it feel different or better?

Anne Longfield: With certain programmes—children's centres were very much part of that—with the Department then, there was a requirement for children's plans locally. They assessed need and responded with a plan. That required good data collection in an area for a good plan that brought together individual departments in councils and other agencies. Some areas continue to do that because once people have done it, done it well and can see the benefits, they wish to continue to do it. There is no requirement for people to do that now, so some do not. It really means that you are taking away part of that infrastructure.

I would argue that not only would investment—attention—at this age drive social impact and improvements socially in policy terms for those children, but it would deliver savings in the long term. Not all of these families or children will need help all the time, and nor are we talking about state intervention in families' lives; we are talking about families having help at hand if they need it, when they need it. The if and when are really important.

Q15 Mr Bradshaw: There is stuff around the machinery of government—having a Minister or Department to drive that through.

Anne Longfield: There is—completely. The machinery of government at national level, which is not there adequately, I would say, and the machinery of government in delivery terms, locally, needs to be developed, and refined where it is working better.



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Elaine Kelly: Both the cause and the consequence of that fragmentation is that we do not collect as much information as we need to at national level. One thing that came out of the report we wrote on public spending on children is how little we know about what happens to kids. We know what happens to kids in school and when they are in hospital, but when they are in the community we know very little.

Q16 **Chair:** Don't we have a unique identifier for each child that helps us to link all that information?

Elaine Kelly: No, we do not. We cannot really link GPs and hospitals properly across the whole country. We definitely cannot link to community care, we cannot link to health visitors, we do not know on a national level who uses Sure Start, and we do not have a national database on variation in care or who gets put into care at different points on a kind of individual characteristics level.

There is so much on nought to two that we do not know, even within services. As to trying to look across services and asking whether people who go to Sure Start end up in hospital more or end up in hospital less, or whether the children end up being looked after, we have absolutely no idea. It is difficult to work out the spending on children from nought to 17 or to work out what mental health spending is on them, let alone nought to two or five to 10. We have so little idea about that. It is very hard to work out whether we are spending money well, or whether services are linked up, if we do not know what is happening. It may be collected at local level, but there is no obligation to pass it upwards at all. We know almost nothing outside hospitals and schools.

Q17 **Chair:** Should we be making some recommendations to improve that?

Elaine Kelly: Yes. That is an urgent priority. It is important for the whole population. What often happens, for example, is that women come out of hospital, and they then see a midwife and a health visitor and their GP. None of those people knows what the other has done. That is not helpful to patients on one level, but it matters for everybody, particularly for vulnerable children: at what stage do things start going wrong and when could we intervene—those types of things? We just do not have the apparatus to do that at the moment.

Q18 **Andrew Selous:** I want to go back to something you mentioned earlier, Anne. You mentioned love, which I was very pleased to hear. We know from the research of Graham Allen and others about the importance of attachment and the development of the child's brain and so on, and whether there is a loving relationship between a significant person, usually the mother, but it could be either parent, and the child. Could you say a little bit more about research in that area, particularly perhaps on the relationship between mum and dad, where dad is present and around, and the significance of that on the child's development and outcomes? What are your findings in that area, Anne?



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Anne Longfield: You have the WAVE Trust coming next, who can give you extensive evidence on that.

Q19 **Andrew Selous:** Yes, we have, but I would like to hear your view too.

Anne Longfield: Drawing on that and the research you did with Graham Allen, it is very clear that this is a crucial period for attachment and security, and, if children and babies do not have that sense of security, it is the period when they develop all the fight or flight kinds of mechanisms in their brain. It is also the period when they grow, and are able to develop and establish the stability with their parents and those around them that will enable them to develop healthy, trusting relationships over time.

We know that domestic violence in the household absolutely works against all of that. Until recently, there was very little questioning in any domestic violence incident about whether there were children in the house. You can see it from lots of different aspects, but attachment during this period is a really important kind of springboard into positive development throughout childhood.

Q20 **Chair:** You said that a parent's mental health problems can affect that as well.

Anne Longfield: Yes. When parents in the household have their own problems, which might be mental health issues or dependency on drugs and alcohol, they are obviously not going to be able to give the children the level of stability they need.

Q21 **Andrew Selous:** Can I come back on the drug and alcohol point? It was put to me relatively recently that quite a lot of ADHD is misdiagnosed foetal alcohol spectrum disorder. I would be interested in your findings on the impact on children when mothers consume excess alcohol or take illegal drugs during pregnancy. How prevalent is that issue, and what are your findings on the outcomes of that on children?

Anne Longfield: I do not have the exact prevalence rates.

Q22 **Andrew Selous:** No, but as Children's Commissioner you will have come across this area.

Anne Longfield: Of course. All the evidence shows that, when children are born with alcohol in their body and foetal alcohol syndrome, it lasts throughout their childhood and throughout their adult life too, with really negative consequences. The aspects that will be really affected are around their self-regulation and emotional development.

Q23 **Andrew Selous:** Can I ask you about the policy response to that? I think it is hugely underpowered. We have a photo of a pregnant lady and a bottle of wine with a line through it and there is a bit of public health information, but, personally, I think we do scandalously little in this area. Are you of a similar view?



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Anne Longfield: In policy response terms, yes, I would like there to be very strong advice and guidance, as strong as it could possibly get. During the antenatal period there is a real opportunity to talk to mothers, and indeed fathers, before the baby is born. I would like them to get very strong messages on that, as well as strong messages to prepare them for the emotional arrival of their baby, because it is all quite mechanistic and physical sometimes. I went to an antenatal session, but it was all, "This happens, then this happens, and then you have a child."

No one can prepare you for the emotional effects of the birth of your child, and if you have a huge number of things going on in your life anyway it will be very difficult for you to cope. People worry too much about whether we are offering too much advice or interfering too much in parents' lives when a child is born. I have yet to meet a group of parents who would not take advice because, frankly, at that point you will take anything that is coming. We should be explicit about it. In all of this, clearly we know an awful lot more than is acted on. Knowing that, there is a moral imperative to ensure that we respond and help parents to understand, and support them in their role as parents.

Chair: We are going to move on because in my first outing as Chair we have asked only two out of the first eight questions in half the time available. Can we move on to economic conditions and public spending?

Q24 **Luciana Berger:** I have three questions. The second two are directed specifically at Elaine and Anne, but the first is an open question. I do not want everyone to feel obliged to respond to it, but obviously do so if there is anything you would particularly like to say.

In the piece of work that you did at the IFS supported by the Children's Commissioner on public spending on children in the period 2000 to 2020, you said in the report that child poverty is due to increase between now and 2021. You also say that public spending on children will fall during the remaining element of this period. In light of those trends, what do you think the Government should be doing to protect the critical period of child development that we are discussing today?

Anne Longfield: Elaine has all the statistics and data. We have clearly said, and the report shows, that over the 20-year period children spend was largely static, but that the spend now goes on a much reduced number of children. The startling figure is that half of all children's budgets now go on the 72,000 children who are in care. For those who are on child protection plans with acute need, you are looking at 77% of all children's services spend, which leaves very little for early intervention for others. Reductions in Sure Start are about 60%, and at the same time there has been a disproportionate effect of welfare changes on families with children.

It is disproportionate when you look at the spend on pensioners too. They have not only had the triple lock, but pensions increased by 54% over the period, while child benefit is set to reduce by 17%. It is cumulative, and



the impact on families with children is real. There is an opportunity to redress that through the spending review.

Looking at this particular age range, it is an area where there has been an under-focus in policy terms. I am strongly of the belief that investment at this point will bring back savings in the long term—yes, in economic terms but also in social benefits to the children. When I ask local authorities what it would take, because there is unsustainability in what is happening with the increased focus on spending on children in crisis, they want to bring it back, but they often do not have an amount to invest early while carrying on spending on statutory responsibilities. When I ask them what kind of sums they are talking about—these are not scientific numbers—generally it is between £5 million and £10 million for a medium to large-sized authority to start bringing it back towards early intervention. When I ask what they would spend it on, they say, “The youngest children and families—support for families at that point.”

There is a big policy piece to co-ordinate pre-school and to support children to be school-ready, and there is a particular gap in co-ordination, and indeed in some areas, to invest in the 1,000 days within that. The good news is that we spend a lot of money already, so we can get a lot more from the money that is being spent and identify the gaps.

Elaine Kelly: The report that we put out looked at a variety of aspects of public spending on children, as much as we could get hold of: education, health and children’s services, which Anne was talking about, and benefit spending. The main headlines were that spending on kids went up a lot in the 2000s and then fell back during the period of austerity. It is still higher than it was in 2000 in real terms but is 10% below its peak in 2010.

There has been a shift, in that the statutory services—education, health, hospital services and looked-after children—have broadly remained frozen because there are regulations on how much you can spend on those. Where there have been reductions, as Anne said, they were in services for children more generally that are not aimed at the most vulnerable, Sure Start being the most obvious example, and in benefit spending. The reductions in benefit spending have contributed to the projected increase in both relative and absolute poverty, largely the two-child limit and cuts in various other types of benefits that disproportionately fall on families. That is where the spending goes.

The question is about directing money towards those services. Sure Start is one of the examples where we can see where the money probably went, in that it went to under-fives, but there is a question about whether we are interested in under-fives or whether we are interested in under-twos, and we do not actually know the relative effects of, say, reductions in Sure Start for the under-twos versus the under-fives. There is a question about exactly how much. We know that the spending reduced,



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but we do not know what the balance is of under-twos, two-to-fives, five-to-10s and that kind of thing.

Anne Longfield: But we know that children are likely to be in some kind of early years education for three and four-year-olds, and 40% of the most disadvantaged are likely to be in places for two-year-olds, some of which might be in Sure Start and some might not. It is a decent guess that there might be a disproportionate impact on the under-twos because Sure Start is wrapping itself around those other services. I do not have the data to prove that, however.

Elaine Kelly: I mention this as it might be interesting for the Committee. Colleagues of mine at the Institute for Fiscal Studies are doing an evaluation of the Sure Start policy to try to understand what the impacts were when it rolled out and, therefore, if the reverse is true. The evidence on health report is coming out in early 2019. They have had a series of problems, though, in trying to understand what else is going on.

They have the hospital episode statistics—the hospital administrative records—and that is fine, but they have not been able to get any information on who uses Sure Start. They tried to use the national child measurement programme, but they can only use it through Public Health England running the code for them and Public Health England does not have the resources to do that any more. They cannot access the health survey for England because NHS Digital decided that GDPR applies and the respondents haven't been told. It is one of those things where people are trying; there is no lack of will from anybody, but we actually do not know what it did in the first place and we do not yet know what rolling it back did either, unfortunately.

Anne Longfield: Locally, they might well know.

Elaine Kelly: Yes, locally they might, but on a national basis we do not.

Dr Donkin: There are some clever ways of thinking, moving forward, about the reduction on children's spending and an increase in child poverty. For instance, on the social determinants of health that impact on the nought to three age group, first, some of the budgets are not within the Health and Social Care budget, so we are looking at the Department for Work and Pensions and spending on benefits, for instance, and working-age benefits where people are in work.

The other thing is to push some of the cost of supporting workers more on to employers, and some of the costs of supporting better housing quality on to landlords. There are ways to utilise the money in the system and to get other people to pay for improvements in families' lives.

We are increasing the evidence base, and we need to make sure that when there is funding we use the best-evidenced systems and programmes we can, and decommission anything that is not effective.



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- Q25 Luciana Berger:** I want to move us on, if that is okay, because there are some quite important elements to draw out. I am very keen to know whether you were able to do any sort of analysis for your report of not just the overall picture but whether there are more pronounced inequalities as a result of some of the decisions on how to cut up the pie. It is not just about what is in it overall.

For example, if I draw on my own experience as an MP in Liverpool, we have seen a 64% reduction in our local authority budget, and the council are struggling to do anything more than what is legally required of them. Do you have analysis of that for the country? Are there more pronounced impacts on areas that already have high levels of deprivation and that are, therefore, having an impact on widening inequalities and the life chances of the children we are talking about today?

Elaine Kelly: The report we put out did not cover the variations, which were beyond the scope, but last week a colleague of mine put out something on education that almost went the opposite way, in that there has been a movement towards funding for poor pupils or that in areas where there are more poor pupils it has actually increased.

- Q26 Luciana Berger:** But there is nothing that is not education; there is nothing on what we are talking about today.

Elaine Kelly: No, for sure. For under-twos, it is not really relevant, you are right, but there has not been anything.

Anne Longfield: We are working with a number of local authorities to get local authority-level data. We know that 85% of local authorities are facing cuts and reducing their budgets, and we know from places such as Northampton and Torbay that a lot of them are falling over the edge, sometimes for relatively small amounts. In Torbay, the increase in the number of children going into care was 20%, which cost £2 million. That is what pushed them over the edge in terms of sustainability.

Again, there are other pots of money we could look at, one of which is the health 10-year plan and early years being part of the consideration in that. The other is the troubled families programme, which is coming to an end in 2020, and will be another half billion. There is the potential to focus more of that on this age range.

- Q27 Luciana Berger:** Your report says that, if councils are unable to direct resources to prevention and early intervention, it could store up problems for later. Could you briefly embellish that point and share with the Committee your evidence to support that claim?

Elaine Kelly: There is still quite a lot that is unknown about what happens in the early years and what exactly are the critical periods, but, in general, there are a few things that are understood to have worked, based on a range of evidence: making sure that women are vaccinated against flu in pregnancy, reducing alcohol consumption while women are pregnant and in early years, reductions in pollution and that type of



thing. There are certain interventions—largely public health interventions, I guess—to improve the health of women in pregnancy that we know have implications both for early life and for later life. If you cut back on that prevention, assuming that the prevention actually succeeds in preventing, you would expect it to have an effect later on.

- Q28 Luciana Berger:** Anne, looking back at the period between 2000 and 2010, and at the evidence available in your reports, to what extent do you think that the public spending increases we saw on benefits for low-income working-age families and children's services delivered better outcomes for children, if at all?

Anne Longfield: There was a period of rapid investment, so there was clearly a big increase. There were international comparisons as well; it was not just in this country. There are some areas where there was a real increase; the number of children going to university, for instance, is very different today from what it was then. There were many excellent services that were not around for very long, or were not evaluated to the level they needed to be to be able to answer you properly on some of that. Some of it was rushed in terms of set-up. If you had that time again, you would think about how it might be done in a more strategic and planned way. Some of the machinery of government—the mechanisms that might have enabled that to continue—was not really put in place.

Having said that, we now have measurements for the early years foundation stage and there is a two-and-a-half-year-old check in place. Many things are there. There was certainly investment that brought results. You cannot say that every one of those interventions had the impact that they might have had at optimal level. It would be wrong to say that, because some of them were in their infancy and they were long-term plans, and you cannot track some of those impacts.

Elaine Kelly: The balance of academic evidence is that income seems to matter for kids' outcomes. An increase in income tends to produce bigger improvements in outcomes for poor kids versus rich kids, as you might imagine. It is one of those things. Child poverty is going up. If you take the evidence we already have, material deprivation is not good for kids. Those two facts exist.

- Q29 Chair:** If you had to choose, you might want to put cash in families' pockets rather than provide services.

Anne Longfield: You do both. You want both.

Elaine Kelly: It is not clear. The one thing to remember, and obviously you all know this, is that these outcomes do not exist in a vacuum, in that you have the family context. If you were to improve kids' diets, it might help a little bit, but it does not help that the mother is depressed or the father does not have a job.

Chair: You need both.



- Q30 **Mr Bradshaw:** Seriously, is it possible at all to disaggregate the relative benefit of putting money into people's pockets as opposed to spending money on services, assuming the services are good and having a positive effect? Is there any research or evidence?

Elaine Kelly: The Joseph Rowntree Foundation did a systematic review of the literature. My reading of it is that they said it is approximately the same.

Anne Longfield: Frank Field's review of the foundation years came out with both.

- Q31 **Mr Bradshaw:** Related to that, which brings me back to the economics, and some of the social and economic terms we were talking about at the beginning, is it possible to disaggregate the impact of absolute poverty as opposed to relative poverty? The argument you often hear made by people who would argue against much of what we have been saying this afternoon is, "Oh, well, we are a relatively affluent country. Even the poorest people here are much better off than in developing countries where their kids seem to do perfectly well." Just as you have discussed the difference between services and putting cash in people's pockets, what is the balance of argument between absolute and relative poverty? That is probably one for you, Elaine.

Elaine Kelly: Are we interested in inequalities or are we interested in levels? Clearly, we would like it if infant mortality fell—that would be a good thing—but we may also be interested in inequalities in cognitive outcomes, school outcomes and so on. There is a question about what your outcome is. Even if you had the same level of absolute poverty, relative poverty might matter in the sense that potentially it affects, for example, parents' mental health. I do not think we can necessarily say that people are richer now and therefore everyone should be better off. The gradient is going to matter, and inequalities in themselves, even if you are getting richer, may also matter for families.

- Q32 **Mr Bradshaw:** There has been quite a lot of research, in "The Spirit Level" and since then, about the impact of inequality, and unequal societies being the worst in lots of areas. Does that also show when it comes to young children, Dr Donkin?

Dr Donkin: I was going to go back a step. The issue with absolute poverty is that what you are really picking up is material deprivation. Material deprivation has the strongest link to health outcomes, more so than income or parental employment, for instance, because you are looking at sufficiency, where the importance is having a measure of having enough income. Once you have got over a certain amount of enough income, the relative poverty argument comes in. Having enough income affects material things such as nutrition, housing and so forth at the bottom end of the distribution, and has less impact on the rest of the distribution.



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Relative poverty has an impact across a wider set of the distribution; it is very much more about self-esteem, how you feel about yourself, and mental health. For the nought to threes, material deprivation feeds into whether there is enough money to have a good diet and a decent house. The relative poverty links to the mental health issue.

Anne Longfield: There is something about entrenched poverty as well, which might be over several generations; you are looking for a policy response that can break that cycle of disadvantage. That relates to both of those, but, certainly in local solutions in policy terms, that really needs to play in.

Q33 **Andrew Selous:** I want to go back to the increase in the number of children in care—the 72,000 you mentioned earlier, Anne. Why is that happening, and what would be the most effective things we could do to set it on a steeply declining curve?

Anne Longfield: There is a range of ideas as to why it is happening. Certainly there are some children going into care who would not need to go into care if they had strong family support to stay with their families. If children need to go into care, they need to go into care, but we are looking at a steep increase in many areas. Some of the family courts talk about children who are going into care because social services do not feel that there is support for any alternative, and they cannot take a risk.

When I talk to local authorities, I ask them what it would take to bring those numbers down. A lot of children who go into care are referred several times and are sent back before they get a place in care. It is not an easy transaction. That is what local authorities talk about. Clearly, those children are on the edge of care, where you can offer packages of support around families, but the greater, bigger switch towards early intervention is something where local authorities say that if they had a transition fund of some kind, a sum of money that could be ring-fenced, it would enable them to start bringing services back and bring that crisis down. It is unsustainable for that to continue to increase on all fronts.

Chair: Andrew, do you want to ask the final questions about the cross-governmental review?

Andrew Selous: I will have to pass, because I need to leave, so can I give them back to you?

Q34 **Chair:** Of course.

As you know, a cross-departmental ministerial review was announced, and that ministerial group has started meeting. What advice would you give them, based on what you have described to us this afternoon, about what they should be achieving?

Anne Longfield: I welcome the review. It is a period in children's lives that I have long believed needs more attention, so it is putting a welcome spotlight on it. They should be ambitious, and there is an opportunity,



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especially with the health 10-year plan, to look again at what the best start means for children in health terms. We have an opportunity to look at some additional funds, or to look at some funds in a different way, for health visitors to work with other specialists to provide support and family support.

They should look at a cross-Government infrastructure, and a local infrastructure to deliver. Children's centres, and indeed family hubs, would offer that basis. They should work on the basis that there is an established need and evidence that drives it. The policy response is something that is seen around the country, but not coherently. There are already services, but there are gaps.

This is an opportunity to reframe how we offer children the best start in life in a way that reduces the vulnerabilities that we know are coming up time and time again. When I see older children, they tell me when things have gone wrong—exactly where they went wrong—throughout their lives, and many of those will start before school. Then they will progress. Vulnerabilities do not go away; they just get more and more pronounced and more expensive as children's lives go on. There is an opportunity to reset that balance.

Q35 **Chair:** Is there any more advice to the ministerial group?

Elaine Kelly: Yes. One thing that might not surprise you is that, in order to provide a high-quality service to the under-twos across the whole country in a reasonably uniform but locally appropriate way, I think we need to know what is provided, and we need to understand how bits of the system link together. At the moment, we do not have the information to allow us to do that. That seems like a major shortcoming. Trying to address that will take some doing, but it is really important.

The other thing I would always campaign on is making sure that decisions are made based on the evidence we have, as I am sure you try to do. It is obviously tricky, given that in some areas we do not have as much evidence as we would want, but there are lots of cases where things sound like a great initiative, but actually we do not really know. That would be the other thing: what evidence do we have, how strong is that evidence and what would we need to know in five years' time to work out whether our review and our plan had worked? What outcomes would we need and what information would we need to gather?

Q36 **Chair:** What outcomes do you think we would need?

Elaine Kelly: I stepped into that, didn't I? I guess there needs to be one set of outcomes that you want for everyone, because we actually want not just the extremely vulnerable children but all children to achieve a certain level of health and cognitive and non-cognitive development. You would also want a separate set of outcomes, I imagine, for vulnerable children, but I would probably defer to my colleagues.



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Anne Longfield: We have the checks for two-and-a-half-year-olds. You would want them to enter the two-and-a-half-year developmental checks at a more progressed rate than they do now.

Q37 **Chair:** That is the key outcome that you would be looking for to judge whether—

Anne Longfield: They exist. They are quite new. They have not been used to full impact yet, but they are a gateway.

Q38 **Chair:** Not all children get them. I have seen data that suggests that maybe 80% of children do not get all five mandated checks.

Anne Longfield: It is not perfect, but it exists. It is relatively new, and it is there to be used, so use it as a way to work out what support children need in the next phase, to give them a springboard towards school, but make sure that the nought to twos are prepared for the best possible place they can be in as they go into that.

Elaine Kelly: Make sure that that is linked to other services: we know child A—we do not need to know their name—ends up in this school and they do this well, or they end up in this hospital. It is not just knowing that 80% of people had the check.

Q39 **Chair:** What I am hearing is a need for better data linkage but also better co-ordination based around families.

Elaine Kelly: All of those, yes.

Q40 **Chair:** Angela, do you have any advice?

Dr Donkin: Yes; advice on focus. I know it is at age five, but looking at the early years foundation stage profile in schools illustrates big differences between local areas for children on free school meals and children not on free school meals. Some areas have managed to reduce the attainment gap. There is lots potentially to learn, and more to do to learn from areas that are doing well. We have a system of health visitors, and we need to ensure that those areas have sufficient funding to ensure that the staff are able to do what they have been trained to do. We need to reduce child poverty, but maybe a good start would be looking at making work pay, which would reduce the stress on parents. It would help with attachment and the material issues that we talked about.

In terms of outcomes, when I was at IHE, we were waiting for the two-and-a-half-year-old measure, and it seemed like you had to ask whether or not somebody was willing to do it. If we are going to use that, we need to make it mandatory, otherwise it will be quite biased.

Public Health England—PHE—already collates data on social determinants, as does the Institute of Health Equity. It depends on what your goal is. Ultimately, there are things such as the social mobility index and lots of measures that are already around.



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Q41 **Mr Bradshaw:** Anne, in light of the Budget where, as I understand it, the budgets for public health are going to be further cut, have you made representations to the Chancellor about all of this?

Anne Longfield: We are in the process of doing that. We have been doing it for some time; we briefed thoroughly on the IFS report, and we are continuing to do that.

Q42 **Mr Bradshaw:** Not least, we had the Secretary of State going out this week saying that prevention is going to be his big new thing at the same time as continuing to cut public health budgets. The two are completely contradictory.

Anne Longfield: Yes. We have clearly been linking the impact of vulnerability to things such as school exclusion, serious violence and the like.

Q43 **Chair:** Is there anything that we have not asked about that you wanted to tell us today?

Anne Longfield: In the past, one of the things WAVE looked at on the 1,000 days was the potential for Sure Start and children's centres to play a more active role. I would be happy to let you have a note on some of that if you wished.

Chair: Okay. Thank you very much. Thank you for your time today. Thank you for coming along.

Examination of witnesses

Witnesses: Dougal Hargreaves, Anthoulla Koutsoudi, Sarah Benioff and Dr Casebourne.

Q44 **Chair:** Thank you to the second panel. Maybe you could begin by introducing yourselves. I am Dr Paul Williams. I am chairing the second panel of our first session. We have invited you as experts of organisations working in the field of the first 1,000 days. We are looking to you to make recommendations for us about some of the things we should be saying to Government.

Dougal Hargreaves: My name is Dougal Hargreaves. I am a consultant paediatrician at University College Hospital. I am senior lecturer at Imperial College London and I am a visiting research analyst at the Nuffield Trust, with research interests in measuring and understanding outcomes of children's inequalities, particularly international comparisons of health systems for children and young people.

Sarah Benioff: I am Sarah Benioff. I am a director of the Big Lottery Fund, which is the UK's largest community funder. I am here today to talk a bit about our Better Start programme, which is a £250 million 10-year investment in five locations across the country focusing on early childhood development. I am pleased to say that it follows on from some



of the data and evidence we have just received. It focuses on diet, nutrition, emotional development and language and communication skills.

Q45 **Chair:** We are going to visit one of the Better Start sites a bit later in this inquiry.

Sarah Benioff: Yes, I am so pleased.

Dr Casebourne: I am Jo Casebourne. I am chief executive of the Early Intervention Foundation. We are the Government What Works centre on early intervention that was set up as a result of the Graham Allen reviews. We have done recent work on the Healthy Child programme, which I may touch on today, as well as a report last week on realising the potential for early intervention and what needs to happen next.

Anthoulla Koutsoudi: I am Anthoulla Koutsoudi from WAVE Trust. We are a charity that focuses on primary prevention and the healing of trauma and ACEs that drive a lot of behaviour later in life.

Q46 **Mr Bradshaw:** Could you start by giving us your assessment of the effectiveness of the current universal services for the first 1,000 days, and whether they are really universal at all?

Dr Casebourne: Universal services are vital in the support they provide to all families and children, particularly because they enable the identification of families where more support is needed. The Healthy Child programme is one example of such a universal service that we have looked at. We think it is exemplary in the way it has been designed. It is very much an evidenced-based programme that draws on a range of good evidence of what works for vulnerable families—indeed all families.

The five mandated checks that are part of the Healthy Child programme are very important and are sensibly timed from a child development perspective. They enable us to pick up issues where more support may be needed. It is very important that those mandated checks are happening. If they are not happening across the country, it is an issue that we think needs to be resolved.

There are various enhancements that could be made to universal services and the Healthy Child programme. The evidence recommends that more intensive health visiting would be very supportive for low-income families in particular, where there is a range of gaps, as we heard in the earlier session, and socioeconomic gradients open up. In things like early language development, there is a real opportunity for more intensive health visiting to support low-income families.

Our report identified a range of interventions that could be delivered as part of universal services, such as the Healthy Child programme, by health visitors and other health professionals that show evidence of improving outcomes for parents and children.



Dougal Hargreaves: I support a lot of that. There is an interesting mismatch between some of the policy, which I agree is exemplary, evidence-based and very well thought through, and its implementation and some of the outcomes we are seeing. Recently, the Royal College of Paediatrics and Child Health published work showing that on current trends we will move from having infant mortality that is 30% higher than comparable countries to well over double that of comparable countries by 2030. That is the overall infant mortality figure. We know that for the last five years or so infant mortality has been increasing steadily among low-income groups, so after 100 years of steady reductions, and throughout all the things that have happened in the country, in the last five years we have started to see a reversal of that among low-income groups, and a plateauing of those improvements across all children in the country.

I support some of the discussions in the earlier session and the comments you made about universal services. Internationally, the Netherlands, the US and many other countries have up to 12 routine well baby checks for every child, often home visits by experienced people. We have between two and three, depending on how you look at it. That is not to say that we do not need targeted services. They have much greater ability to flag up, intervene early and bring in extra resources for targeted services when needed. We need exactly the proportionate universalism that we talked about.

Q47 **Mr Bradshaw:** The figures for infant mortality are staggering, and it is a terrifying projection. What is causing that?

Dougal Hargreaves: It is all the things we talked about earlier. Some of them are social determinants, such as increases in child poverty; some of it is the health of women of reproductive age in the country; some of it is obesity, smoking and the use of other substances; some of it is appropriate early access to services, booking late and not getting the support that is needed in the antenatal period; some of it perhaps is perinatal care; and some of it perhaps is paediatric care. It is across the piece. It is about health services; it is a lot about fragmentation within the health service and between the health service and social care, education and other services. It is also about social determinants and poverty. To tackle it, we need a joined-up approach that deals with all those different elements.

Q48 **Mr Bradshaw:** On current projections, in 30 years, the figure will have doubled.

Dougal Hargreaves: By 2030. This was work we did to inform the NHS 10-year plan. They are projections on current trends from now until 2030. As I said, currently we are 30% of the median for comparable countries; on current trends, by 2030 we will be at 140%, well over double the infant mortality rate of comparable countries.

Q49 **Mr Bradshaw:** Sarah and Anthoulla, do you want to say anything about



universal services?

Anthoulla Koutsoudi: We take the view that you need both universal and targeted services. As regards universal services, we think Healthy Child is wonderful, as do fellow panellists, but we know that there are gaps between what we advise should happen and Healthy Child. In 2014, we worked with the Department of Health to identify where the gaps are to beef it up and make it better and fill in what is not there.

Universal is crucial, not just because we are looking at the families that might be obvious but also at families that might not be obvious. With a universal approach, you will pick up the not so obvious cases. For us, in the period of 1,001 days, there are certain key steps you need to see what is happening to a child and family. Long before age two, we need to find out what the entrenched issues are and handle them, because if we wait until two or three it is rather too late. It is not that it cannot be made better, but it is very much harder. The emotional brain is formed largely in the first 18 months of life, so wouldn't it be nice to do more pre and post-natal checks as early as possible? Put in the very cheap support then, so that very few families need targeted support later. We need both.

Sarah Benioff: We found that, with Better Start, we absolutely put proportionate universalism into practice. The Healthy Child programme is great, but we have enabled our sites to adapt it to local contexts, so they are doing it for us. We have given them the tools they need and systematic technical advice and support to adapt it where they need to. All our programmes under Better Start are place-based and context-based, with the child and parents at the centre, adapted and iterated as we go along. We call it a test and learn approach, which seems to be working.

Q50 **Mr Bradshaw:** What about targeted services and the pathways to targeted services? How is that working, or how would you like to see it working better?

Dr Casebourne: Targeted services are critical alongside universal services. We know that some families will need more specialist support, whether it is around attachment, parenting issues or a whole range of other issues that might crop up and impact negatively on children's outcomes. One of the issues touched on by the first panel is that we just do not know enough about which targeted services are being delivered at local level. There is no central data that make it clear and easy to see what is being delivered, or if what is being delivered works. We think there is something to be done on that. Anecdotally, from the local places we work with, we hear that there is not enough targeted service provision being delivered for this age group.

Q51 **Mr Bradshaw:** The issue of whether stuff is actually being delivered seems to be a common one. You even suggested earlier that we are not even sure if the Healthy Child programme—a universal scheme—is being



properly delivered at local level. Is that because the data are not being collected, or has no one done the work?

Dr Casebourne: We think it is important that local and central Government do more to see whether mandated checks are happening and to make sure that they are, where they are not. Anecdotally, we hear at local level that there is not enough health visiting capacity. One thing that central Government could look at is increasing the capacity of health visitors to make sure those checks are happening, given how vital they are for child development.

Dougal Hargreaves: We published some work recently on a very specific dataset, so it is not nationally representative, showing that about 87% of children in that cohort, which probably slightly overestimates the national picture, had not had their full developmental checks, and, of that cohort, that group was more than four times as likely to be admitted to hospital, or have emergency hospital care, as the 87% who had had all those checks.¹

Q52 **Chair:** There is an inverse care law: the people most in need are the ones least likely to get it. You all think that the universal services in theory are very good. We are hearing that in practice they are not always delivered to those who need them most. What do people in the communities you work with say about universal services?

Sarah Benioff: An example in Blackpool is the health visitor service there. We have enabled the programme to increase from six to 10 visits. They did that first by doing a fundamental review of the services. Across the professions, communities, parents and everybody involved, they did a review and realised that within the same cost envelope they could provide more. They did that by having both health visitors and healthcare assistants, with health visitors doing more on the medical side and healthcare assistants doing everything else, freeing up the health visitors to do their job better and in a more in-depth way. Of course, parents are incredibly satisfied with that, but the important thing is that they were able to do it at the same cost. We have examples throughout the five locations of targeted services and reviews working that way.

Anthoulla Koutsoudi: I am not sure that is happening across the country.

Sarah Benioff: No.

¹ Note from Witness: - our study found that only 87% of children had received all recommended developmental checks
- our cohort isn't fully nationally representative and the true national figure may well be lower than 87%
- the 13% who didn't get all their recommended checks had more than 4 times higher risk of unplanned admission to hospital (exact Hazard ratio is 4.63 (95% confidence interval 4.55-4.71))



Anthoulla Koutsoudi: It would be wonderful if it were. We know that the number of health visitors has decreased in England. We also know that, three to four years ago, Scotland invested £40 million to increase its health visitor numbers. It is aiming for 500, but I do not think it yet has 500 extra ones. It is doing 11 checks per child and it is universal. That has to be a good thing. It may seem expensive to begin with, but in the long run we will prevent a lot of problems further down the stream.

Q53 **Mr Bradshaw:** Who is currently responsible for ensuring that this stuff is done? If the stuff is not being done on the ground, who is responsible in central Government, or centrally, for ensuring that it is done, or is nobody responsible for it?

Anthoulla Koutsoudi: That is a great question, isn't it?

Dr Casebourne: Public Health England has a role to play specifically in the Healthy Child programme initiatives in ensuring that mandated checks are happening. We think there is a role for local leadership, too, in setting a clear vision and strategy for the early years and for vulnerable children throughout childhood and adolescence. Reviewing what is happening in local service provision should be part of that.

Dougal Hargreaves: Can I make a quick point about continuity? Mandated checks and recording whether they happen are really important, but as a paediatrician, when I see a child in clinic that I am worried about, if I can phone a health visitor who has worked with that child, knows them, is trusted and is able to get information about what is going on in that household, it is a very different conversation and a very different level of support for that child from the situation where someone in a team has managed to go out and go through the checklist, but does not have an individual relationship or build-up of trust.

Anthoulla Koutsoudi: You make a great point. When we are dealing with a trauma-informed communities project, one thing we are advocating for is an always available adult, one person who is trusted, for families to open up to. That is crucial.

Q54 **Andrew Selous:** Apologies for not being here earlier. I am hopping between Committees this afternoon. The Government have proposed an increased number of child obesity health weight checks, haven't they?

Dougal Hargreaves: Yes.

Q55 **Andrew Selous:** Is there scope for doing an all-round check when those more frequent obesity checks come in, and might that be part of the answer to the problem you have been outlining to us, Dr Hargreaves?

Dougal Hargreaves: Potentially. It is interesting to see the kickback responses to the proposals for an annual weight check.

Q56 **Andrew Selous:** Who opposed it?



Dougal Hargreaves: I did a talk radio interview where there were lots of phone-in callers saying, "This is more nanny state people telling us how to live our lives. If we have regular checks, I'll keep my child off school because I don't want people telling me how to manage my children and run my family."

It comes back to trust. If we are going to do more checks, there are lots of opportunities to identify problems early and intervene, but we need to do the work to build up relationships and get people to understand that we are on the same side. That needs changes on our side as much as on their side in order to make it a productive partnership process.

Q57 **Andrew Selous:** It is changing the attitude of people to how they parent their children and their attitude towards their children's health.

Dougal Hargreaves: That is part of it, but what I am getting at is the attitude of families to authorities, whether health authorities, education or social care. Sometimes that goes back to relationships. If people have good experiences, and find them supportive and useful, they are very receptive to further investigation and support. If early contacts do not build trust, it can be very difficult, and it takes a lot more work to re-engage people afterwards.

Q58 **Chair:** Some people fear that their children will be taken into care, and there is the understandable fear that they are being judged.

Sarah Benioff: To give another example, part of our healthy nutrition programme, in Lambeth, is the community activity and nutrition service, which was based on research from King's College Hospital. It has a great evidence base, which is everything that underpins Better Start. We had a people-centred approach. We thought, "This sounds great," and Lambeth decided to implement it but realised that women were not engaging. It was for pregnant women with a very high BMI, particularly those from black African and Caribbean communities. They were not engaging with it. We talked to them and asked what was going on, and they explained that they were put off for various reasons. They redefined the programme and it is now incredibly well subscribed; 100 women sign on each year to Lambeth's Better Start programme. That is an example where, if you really immerse yourself in what parents, community members and frontline staff are thinking, you can design a service that will engage and not alienate or stigmatise certain members of the population.

Q59 **Luciana Berger:** I want to go back to your contribution about health visitors and checks by health visitors more generally. There was an aspiration for an increase in the number of health visitors to 4,200. It is not just about numbers, but from the data we have here we have seen only a 1.7% increase in the number of health visitors since 2010, which is not commensurate with the increase in children. I do not know whether you have any reflections on that, but perhaps you would build on your point about the need for checks and health visitors.



Anthoulla Koutsoudi: One issue is that experienced health visitors are leaving the profession early. However many new ones we recruit, we need experience passed down to new health visitors. It is not just about numbers, but we need numbers. When a health visitor tells you, "I've got a caseload of 800," how on earth will they ever see half of those families, let alone a quarter? We need more health visitors.

In London, we are trying to replicate what Scotland has done with the violence reduction unit. When a senior police officer in that unit was asked if he wanted 100 extra police officers on the streets, he said, "No. I want 100 extra health visitors." The minute the police go through the door, they see that most of the problems are trauma led; trauma is what drives a lot of the behaviour they have to deal with later on.

Dr Casebourne: We certainly think that an increase in health visiting capacity and numbers is very sensible, given that we know that not all the mandated checks are happening. One of the key things we could do to enhance the effectiveness of the Healthy Child programme is to have many more frequent checks, particularly for low-income families, to close the gaps between them and other families.

Q60 **Luciana Berger:** We know about the "Building Great Britons" report that was published in 2015. That report set out seven essentials for good local service provision. Reflecting on those essentials, do you think they are the right ones? Is anything missing? What do you think are the principles that should underpin local service delivery?

Dr Casebourne: Principles for local service delivery should start with the fact that things should be evidence based. There is still quite a large gap between what is actually being delivered and what is evidence based. We published a report last week on realising the potential of early interventions, which set out that gap. Services should be evidence based and targeted to local need, and we think that local authorities and their partners are best placed to know what the needs of their local population are. They should then commission services that are evidence based to meet those needs.

One of the key principles should be that services are monitored and evaluated, so that over time we grow the evidence base as to what works. There are still some critical gaps where we do not know enough about what to do to support some parents—for instance, those with substance abuse problems.

Anthoulla Koutsoudi: I take the view that all of them should stand as they were written. However, one of the recommendations is that a special post be created at Cabinet level for a Minister to handle these issues. It may be that that will not be practical, but, if there is someone with ministerial responsibility, that person must be able to have some real credible influence on all the spending Departments that are impacted by the adverse childhood experiences that they see later. We need those



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seven in our view, and we need to give real power to whoever is appointed to a ministerial role to put them into practice.

Dougal Hargreaves: Can I reinforce the data point that Elaine made earlier? From the clinical perspective of looking after children now this week, structures and data systems that would allow us to link to social care, primary care, community services and education services, where relevant, would transform the way we are able to join up care and understand the needs of each individual family and child. They would also transform the way we evaluate interventions and understand the long-term impact. If there is any way of linking the national pupil database with the NHS number that allows us to link different parts of the health service and social care, it would be enormously positive. We are certainly trying to do that at local level in different parts of London, but if we could do it in a more rigorous way nationally it would be transformative.

Q61 **Chair:** You are not talking about doing that just in order to evaluate; you are talking about doing it to provide clinical care on a day-to-day basis.

Dougal Hargreaves: Yes, both.

Dr Casebourne: That is particularly important, given that lots of the positive outcomes that will accrue for children by intervening early take some years to see. Educational attainment might be hugely improved over time, but we need those datasets to enable us to look at the longer-term perspective.

Q62 **Chair:** Given that we agree with some of the principles, what are the most cost-effective activities that you think we should be doing, if you had a local authority's budget?

Sarah Benioff: We do not have the evidence yet, because Better Start is a 10-year programme, but we have a national evaluation team working on helping us to build an evidence base. All our interventions, of which there are 100 across the five sites, are based on the best evidence we have from around the world. We started with that, and we are helping our partnerships to measure, record and share the learning from what they are doing in real time. The Big Lottery Fund has invested in Preventonomics at the London School of Economics to help the sites to do a cost-benefit analysis and compare their interventions with others in this country and other countries, and feed that back into, hopefully, a really rich evidence base going forward.

Dr Casebourne: We have over 80 evidence-based programmes in the EIF guidebook, for a range of different child outcomes. They provide evidence of cost and for the strength of the impacts. A lot more can be done in delivering evidence-based initiatives. Too often, what is delivered is not necessarily evidence based. We think there is a real opportunity there.

Q63 **Chair:** Do you know whether or not the evidence-based things are being delivered in any given local area? Does anyone know?



Dr Casebourne: That goes back to the problem that there is no central dataset that shows what services are being delivered locally. We know that some of the services in our guidebook are being delivered in some parts of the country, but there is no monitoring at national level. Too often, low-intensity services are delivered to families with complex needs that those services are not designed to support. Therefore, we are not seeing the outcomes when light-touch interventions are made in complex family situations.

Q64 **Chair:** A family might have had five visits, and at one of those visits they may have been identified as needing a higher level or targeted service, but the locally provided service may be completely inappropriate for that family.

Dr Casebourne: Yes. It may not be, but it may be. A lot of interventions have not been evaluated. We are not saying they do not work; we just do not know enough about whether they work. We have identified some things being delivered that do not work. In our review of the Healthy Child programme, we came across some of those. Infant massage is an example. It is delivered to healthy full-term infants and mothers. It does not impact on child outcomes, although mothers may benefit from going to those services and enjoy them, and indeed may be referred to other services.

Q65 **Chair:** It is a social benefit.

Dr Casebourne: We cannot afford to deliver services where there is no serious chance of them making a difference, particularly when we know that there are evidence-based programmes that are not being delivered locally.

Q66 **Chair:** Are we being prescriptive enough about what we tell local authorities to commission, or are we being too permissive?

Dr Casebourne: It is really important to acknowledge that local authorities are best placed to understand their local populations and what the needs are in their local area, but it is critical that they then commission an evidence-based intervention that meets those local needs. We are not calling for top-down prescription, but our report last week suggested that we need a What Works acceleration fund, which would mean that local authorities could bid for the support and resources they need to deliver evidence-based services in their area.

Dougal Hargreaves: I completely endorse the caveats you have made about some outcomes, but, going back to infant mortality, there is a huge evidence base, both internationally and in this country, about what is effective in reducing it. Recent work has been published in *The Lancet* showing that a big part of the difference between us and other countries—probably the majority—happens before children are born, so it is about women's health, antenatal care and improving the perinatal care side of things. Lots of very good policy work has been done, but there are very big difficulties in staffing units in a way that provides continuity,



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allows staff development and provides the best care from doctors, midwives, health visitors and other antenatal community services.

Q67 **Chair:** We know what works and we have the buildings, but we do not have the staff to build relationships and provide continuity of care. That is your analysis.

Dougal Hargreaves: Yes. Some of the rotas in our hospital are very stretched. In labour wards, lots of rotas are very stretched. People are still doing their best to provide a safe service, but it does not always allow us to spend the time with individual patients that we would want.

Q68 **Chair:** A named midwife initiative was announced a while ago. Do you know how that is progressing?

Dougal Hargreaves: I am afraid I don't.

Chair: It is not your area.

Q69 **Andrew Selous:** Can I go back to the data point? Several of you said that it would be enormously helpful if all these datasets could be joined up, and we could track children's progress across a range of different services. I am struggling to understand the barriers to achieving that. Is it that computer systems do not talk to each other? Is it data confidentiality? Is it fear of the Big Brother state? Is it GDPR, or all of the above? What are the problems, and how do we solve them?

Sarah Benioff: We have tried it in three sites, Lambeth, Bradford and Nottingham, and it is all those things. There is also a cultural issue across professions. We had GPs who did not know that they were able to look at health visitors' notes, much less understand each other's notes. There are lots of technical issues, and lots of fear around GDPR. We have enabled it to happen, and it is a revelation for all of them. We have also enabled professionals to shadow one another for a month, particularly in Lambeth. GPs, health visitors and midwives spent a month doing that.

Q70 **Andrew Selous:** I am sorry to interrupt, Sarah, but did that require the parents to give permission for the data to be shared, or were you just able to do it?

Sarah Benioff: I would need to check on that. I am not 100% sure. They have made it happen and it is happening now, but I can check that.

Q71 **Andrew Selous:** Has the local success in the three areas you mentioned really been publicised around the children's services world?

Sarah Benioff: Yes, it absolutely has, and, of course, there is lots of interest from areas outside Better Start about how that has been able to happen. Clearly, our money has helped, but I do not think it is that; it is systems change in action, and we are trying to demonstrate shoots of it, which I hope others will take up. It did not necessarily take a huge amount of money, but it took a lot of will and a huge amount of partnership and collaboration between different professions and the community.



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Dr Casebourne: There is also an issue around policy fragmentation across Whitehall as well; there is no one person with responsibility at the moment. We are recommending that a cross-Government taskforce needs to be set up, with a senior Cabinet Minister chairing it.

Q72 **Andrew Selous:** Is that not what Andrea Leadsom's review is doing?

Dr Casebourne: We think it is important that it is not just up to the age of two, because we see problems emerging at any stage in childhood and adolescence and, indeed, in early adulthood. There is a need for a join-up for vulnerable children and families across the age range, and a central Government perspective that starts with understanding what we are spending and what kind of services have been commissioned, helping to oversee a new kind of What Works fund and providing support to local places.

Q73 **Andrew Selous:** But would you commend it as a good start, even if you would like the age range to be stretched?

Dr Casebourne: Definitely. The early years are a very important part of our work, given that we know that they lay the foundations for happy, healthy and productive lives going forward. Child development is critical, but we also know that there are problems that emerge at any time. Parental conflict has a very negative impact on children and can occur at any time in childhood. Bullying can lead to mental health problems later in childhood; there is a range of other issues where we think there needs to be a co-ordinated focus.

Q74 **Chair:** My next questions were going to be about spreading best practice, but you have already talked about the acceleration fund. Is there anything else anyone would like to say about what could be done to spread best practice?

Dr Casebourne: Could I make another best practice-related point? We think that what should be spread is actually what works, not best practice. The term "best practice" is often used to talk about things when there is only anecdotal evidence as to whether something works or not, or, indeed, no evidence. It is really important that what works is what is spread.

Dougal Hargreaves: That is right. Something we struggle with in health services research is the idea that an intervention could work in a certain way but it may need to be adapted to specific contexts. It is about understanding what works for whom in what context, not just understanding what works. That is a balance that we as researchers and professionals need to get much better at making: understanding the key elements of an intervention and which bits need to be co-designed and adapted locally.

Q75 **Chair:** There is a lot of variation in what is being adopted in different areas. Is some of that variation appropriate, because different parts of the country have different needs?



Dougal Hargreaves: Absolutely. We are working in Newham with young people with diabetes, and the challenges of addressing ethnic diversity across diabetes in a very small patch of east London are very different from the challenges of addressing young people's engagement with diabetes in a different context, in a different part of the country. A lot of the principles around engagement, behaviour change and being interested in your health—valuing yourself enough to be interested enough in your long-term health—are the same, but the ways it is done in practice can be very different.

Dr Casebourne: There is also a role for workforce bodies in spreading what works evidence, embedding it into professional qualifications and, indeed, continuing professional development. It is not all for central Government to do. Local leaders can play an important part in setting a clear, evidence-based strategy and a vision for children and young people in their areas that helps to spread what works.

Q76 **Chair:** What do you think of the speed of the spread of evidence-based practice?

Dr Casebourne: Our view is that it is not happening fast enough. We have a role as a What Works centre in doing lots more to spread best practice and, indeed, what works evidence. More can be done, and the What Works acceleration fund would for us be a key way to get a step change in the support that we provide to vulnerable children and families.

Q77 **Chair:** How much are you talking about?

Dr Casebourne: We have not gone into numbers in our report. We want to get Departments to think about the spending review bids they are making and think collaboratively across Government, so that we do not have policy fragmentation. Can we pool some of the existing pots of funding and make sure they are more evidence based? There is a need for more funding, but there is also a need for smarter use of existing resources in the system.

Chair: We will move on to talking about national strategy, so that is a good link to Andrew's questions.

Q78 **Andrew Selous:** What are the essential things that the Government should do to avoid duplication of effort? You have touched on some of that already and given us the Blackpool example, which sounded a good one. How can we go about spending the money more efficiently and avoid duplication?

Dr Casebourne: Some of it is about making sure that we are actually delivering what works, and some of it is about filling some of the gaps in the evidence. There are still really important areas where we do not know enough about how to support families. When risks are identified in the mandated checks, as we said earlier, we do not know how to support parents who have substance misuse problems, for example. There is a role for national Government in helping to fill some of the gaps in the



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evidence base, as well as ensuring that what is being delivered is actually what works.

Q79 Andrew Selous: Of relevance to our inquiry is the substance misuse issue, and I asked the earlier panel this question. I am rather underwhelmed by the Government's approach to the taking of excessive alcohol and illegal substances during pregnancy. What is your take on what the policy prescription should be?

Dr Casebourne: Looking at the evidence, we see a number of areas where issues like that, which have a major impact on child outcomes, are still happening in pregnancy. More needs to be done. Smoking cessation is another, because rates are still too high, and are particularly high in certain areas of the country.

Q80 Andrew Selous: In Blackpool I think it is 22%, isn't it?

Dr Casebourne: I do not have the exact figures, but certainly there is huge variation. There are evidence-based smoking cessation programmes that should be delivered. We know less about how to support parents with alcohol and drug misuse; that is a gap in the evidence. One of our sister What Works centres, the Education Endowment Foundation, funds trials to help to fill some of the gaps. In this area, there is a need to fund trials of new interventions so that we find out more about what works.

Q81 Andrew Selous: Can I go back to the reduction of parental conflict, which you mentioned earlier? You said you had a handbook of programmes that have a good evidence base. I am a bit concerned about the work that the Department for Work and Pensions is doing in this area, which is focused on a small number of local authorities. I am not sure how long it will take to evaluate it. What is your take on what is most effective in reducing parental conflict?

Dr Casebourne: We did some of the evidence that led to the Department for Work and Pensions rolling out its reducing parental conflict programme to raise the profile of the issue. The impact that parental conflict could have on child outcomes was not well understood until that point. Indeed, many of the couples or relationship support interventions do not always measure the outcomes for children. It is really important that the DWP is focusing on that; it is testing interventions that have been used elsewhere, such as the United States, and bringing them over, and using some UK-based interventions as well. More needs to be done in that space, because it is really important for child outcomes.

Q82 Andrew Selous: If everything works as you want it to, what would success look like in 10 years' time, say, if everything was integrated and evidence based?

Dr Casebourne: For us, a key measure of success would be a huge reduction in the gap between low-income families and their peers and children not in low-income families. The social and economic gradient



that we see is too wide on a whole range of issues, including early language development. There is a range of things that can be done, which we have touched on today. A long-term vision, a 25-year plan, is needed from Government, with a senior Cabinet Minister driving cross-Government co-ordination, with more funding and support for what works evidence, and filling in some of the gaps where we do not know enough. Those are some of the things we would suggest.

Anthoulla Koutsoudi: For us, success looks like this: communities all across the UK being trauma informed. By communities, we mean not just professionals or families but everyone in the community. We have found from our recent work with focus groups that there is an overwhelming desire from professionals and families for a trauma-informed approach to be used. Families that do not engage do not do so because they feel they are not understood; they feel that professionals do not know what adverse childhood experiences are and that their trauma is not understood.

If we could get over that hurdle, where everyone is talking about trauma and adverse childhood experiences, it is not going to do anything other than open up a lot of possibilities. When you have the whole community talking about trauma, you create a cultural shift. Professionals also have to look at their trauma, because a lot of professionals who have trauma work in the caring professions. If you create a cultural shift, you will prevent a lot of those problems even from beginning. For us, that is a great long-term goal.

Q83 **Andrew Selous:** Is it the case that there is greater understanding of the issue of early childhood trauma in Scotland, Wales and Northern Ireland than there is in England?

Anthoulla Koutsoudi: Yes, there is.

Q84 **Andrew Selous:** Why is that? Why are those three areas of the UK more advanced than England on the issue?

Anthoulla Koutsoudi: That is a long one to answer. In short, we found that reception to looking at early adversity in childhood fell on open ears at that time. I do not know why. It might be something to do with the fact that we had been badgering them for a long time and working with them. Wales has carried out its own adverse childhood experiences study, as have Blackburn and Hertfordshire. There is growing interest in England for adverse childhood experiences, but we may have been preoccupied with a few other things in England.

Q85 **Andrew Selous:** Dougal, in the national strategy, is there room to include modifiable health issues, such as smoking, nutrition, breastfeeding, adverse birth outcomes and infant mortality, or are those areas already covered in the maternity transformation programme?

Dougal Hargreaves: No, they absolutely need to be. My answer to the previous question links to that, in that what success would really look like



for me is that in 10 years there should be cross-party societal consensus that the health, wellbeing and early development of children in the early years is a national priority. We have seen that in other countries; we have seen it in Scotland and the Netherlands, where they had high infant mortality.

This is not a criticism of lots of people who have, heroically, been doing a very good job, but for various reasons we have not seen that being a consistent national priority. If we did that, a lot of the elements of the strategy to achieve it would work themselves out. A lot of those strategies have been designed or could be implemented. It is about having that as a national priority, and the resources to go with it, and having sustained attention at national and local level to achieve it.

Anthoulla Koutsoudi: When the Finance Committee of the Scottish Parliament looked at the whole issue, they said that there might not be evidence that prevention worked, but that they were going to do the right thing because science told them it was the right thing to do, and they would collate the evidence afterwards. As Dougal said, they made a commitment to a national strategy.

Q86 **Chair:** That is interesting. We are interested in what your advice to the Government would be about framing this, so that the first 1,000 days of life become a priority. David Cameron framed his work in this area as a life chances strategy. There could be an inequalities reduction strategy or a long-term cost-saving strategy. How would you advise Government to frame this to achieve the outcomes that we are all looking for?

Sarah Benioff: We take a very practical approach at the Big Lottery Fund. For me, it is about how to make it happen on the ground. I remember the four Ps, starting with people. I agree with what you said about local authorities knowing their population, but people know themselves, so we should put mothers and fathers in the lead. Then there is the partnership approach, across sectors and professions, along with prevention—tackling problems before they happen, as we are doing on all our long-term strategic investments; Better Start is just one. Then there is the place-based approach, whereby we adapt our programmes and projects based on local need. Practically, we are finding that that is what works across all our strategic investments.

Dr Casebourne: Framing it around inequality and the social ability action plan is helpful, given that so many gaps open up early, by the time children are three, and continue to widen throughout childhood and adolescence. Thinking about inequality is really important.

The early years, which we think of as up to the age of five, are a critical period, but we are keen that the narrative is not that it is all over by the child's second birthday. Lots of child development continues throughout childhood and adolescence and, indeed, into early adulthood, and problems can emerge at any time in childhood. We would not want the increased investment we hope to see in this period to come at the



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expense of increasing investment in later periods of childhood and adolescence.

Q87 **Chair:** Is there any other advice about framing it?

Anthoulla Koutsoudi: We sometimes refer to the work of James Heckman, the Nobel prize-winning economist, who said that if we really want a healthy and productive society we have to invest in human capital. He was talking about the economy and society being better if we give children the soft social skills in the first two years of life. I do not know how you wish to frame it, but for me it is about how we can create the next generation of prosocial citizens. Everything else will follow, if we are doing prevention in the early years.

Dougal Hargreaves: A soundbite that we have used at the Royal College of Paediatrics and Child Health is that children are 20% of our society but 100% of our future. I do not know whether that is the right thing to engage everyone, but the point of it is that sometimes for policymakers, certainly stretched local authority policymakers, there is a sense that children are a bit of an additional burden. They do not vote and they are not working adults supporting others; they are a bit of an extra burden that society has to support. I do not think that is how people see their own children, and other societies do not necessarily view them in that way; they see investing in children as investing in ourselves and all of us.

Q88 **Chair:** How much of that is the responsibility of central Government, particularly the Department of Health, and how much is it for local authorities?

Anthoulla Koutsoudi: In my view, the Government have quite a big role to play, because they can lead, and on this particular subject they are not doing so. If we look at the seatbelt campaign, there was no evidence that if we all wore seatbelts we would have fewer car accidents. There was no evidence for that. It seemed like a sensible thing to do and it was done through a public awareness campaign led by Government. The Government can lead by making the right awareness.

To touch on an earlier point about alcohol, for instance, when I was expecting children, I did not know that even drinking pre-conception could affect children. Fortunately, I do not drink much, and my children are fine. The UK has a far higher alcohol consumption among expectant mothers than the global average, which is about 9.7%; the UK average for expectant mothers drinking is about 40%. We have a phenomenal rate of foetal alcohol spectrum disorder. I do not know whether that accounts for some of the early deaths you were referring to, but we have a serious problem, so we could run a campaign about how no alcohol is safe if you are carrying a child.

Q89 **Chair:** A national campaign.



Anthoulla Koutsoudi: Yes. That is one thing you could do. As I said earlier, it would be good to create a Minister with some deep influence in the Cabinet, working across Departments, and to have a ring-fenced budget. If you do not have a ring-fenced budget, I do not see how you will make change happen at local level.

Q90 **Chair:** A few people have mentioned a ministerial position—a Minister for early years. Do other organisations think that that might work? If so, how does it fit in with the mechanics of Whitehall?

Dr Casebourne: In our report last week on early intervention, we recommended a cross-Government taskforce chaired by a senior Government Minister.

Chair: Like we've got.

Dr Casebourne: But not just for the first two years of a child's life; for vulnerable children across the age spectrum, because we need to think holistically about early intervention. We know that at least seven Government Departments have an interest, plus other agencies like Public Health England. We need a much more joined-up and strategic approach that starts with knowing how much we are spending and looks at whether we are spending it effectively. Investing in things like the social and emotional development of young children can often benefit multiple Departments that are not the ones doing the initial investment in building children's resilience. It can prevent knife crime for the Home Office, or mental health issues for DHSC, for example.

Q91 **Chair:** A problem with that is that the Department that incurs the cost may not get the benefit within its budget, and within the political timeframe that people often work to in policy terms. How do you overcome that?

Dr Casebourne: We need a kind of 25-year plan for vulnerable children. We have seen Government thinking long term in other areas, such as environment and housing, and we need to garner resources around a much more long-term approach. Then the Minister and the taskforce could help to ensure that they have the buy-in of all Departments and that we have a more joined-up approach.

Q92 **Chair:** You think there should be a Minister as well, with responsibility to hold the taskforce together.

Dr Casebourne: We think there should be a Minister who holds the taskforce together at senior Cabinet level.

Anthoulla Koutsoudi: The only way that is going to happen financially is if all the Departments that will benefit through not having increased crime or health problems contribute a specified sum to a pot of money controlled by the Minister for children. Otherwise, how would it work? It would just go round and round the houses.



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Q93 **Andrew Selous:** I am 100% signed up to a very significant role for national Government and for local authorities, but given that you have just told us that 40% of women in the UK are drinking excess alcohol during pregnancy—

Anthoulla Koutsoudi: I did not say excess; I said any alcohol—40% drink alcohol.

Q94 **Andrew Selous:** Compared with 9.7% globally, so that is four times more alcohol overall.

Anthoulla Koutsoudi: Yes.

Q95 **Andrew Selous:** The Government could be doing everything right and local authorities could be doing everything right, but you could have a big group of parents not doing the right thing. How can we be successful in getting parents to try to be as responsible as possible and do the right thing by their children as much as possible? What is the evidence from around the world about what has been most effective in inducing culture change in a positive direction in this area?

Anthoulla Koutsoudi: We know from studies that certain steps taken at Government level have made big reductions. For instance, in Iceland they had a major problem a few years ago with young people and alcohol, and they took a series of measures that were not very expensive but were led by central Government and led to a great reduction in drug-taking and alcohol abuse.

If we are talking about teenage expectant mothers and alcohol abuse, we are talking about a lot of babies being born who might have a safer journey into the world. Various things can happen, but we do not actually say anything to expectant parents about what is safe or not, or what one might do, in pregnancy. When we started on the seatbelt campaign, for instance—

Q96 **Andrew Selous:** Isn't it a fairly extraordinary omission that we don't?

Anthoulla Koutsoudi: Yes, it is. There are factors that lead to excessive drinking, such as trauma that is self-medicated through alcohol, for instance, but that cannot explain all of it. Some of it is pure ignorance; a lot of middle-class expectant mothers who drink think that it is a social thing to do, but one drink could be one drink too many. It is not acceptable that people do not know that, because we know from the charities that specialise in foetal alcohol spectrum disorder that one drink could be the one that does the damage, and it is permanent structural damage that one cannot alleviate after birth.

Q97 **Andrew Selous:** What is the advice from Public Health England during pregnancy? Is it not to drink any alcohol at all, or is it just in moderation?

Anthoulla Koutsoudi: No, it is not a clear message, as far as I know.

Q98 **Andrew Selous:** Perhaps Dougal could help us.



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Dougal Hargreaves: My understanding was that the advice from the chief medical officer was not to drink any at all.

Q99 **Andrew Selous:** But it is quite muted. It says quite a lot in itself that a consultant paediatrician is not entirely sure. That may be quite a powerful response in itself about where we are nationally.

Dougal Hargreaves: For me, a lot of this stuff comes back to the universal services. When you are doing a quick screening exercise that has to be done in a 10-minute slot, or whatever it is, it is very hard to have an honest conversation about alcohol intake, let alone do anything useful about it that might change behaviour. Some universal services spend a lot more time with people to understand their lives.

In the Netherlands, when you go home with your first baby, you have an average of 38 hours of support in your own home over the next week. That is not normally from a qualified health visitor—we talked about the skill mix earlier; it is from a nursery nurse, but someone trained in picking up safeguarding issues and vulnerabilities that might benefit from intervention. That is the kind of route. Of course, there is stuff for national campaigns and greater education, but behaviour change is about relationships and trust. At the moment, our universal services do not always have the time to do that.

Anthoulla Koutsoudi: I agree that the Netherlands is a good example, but there are programmes that can be less resource intensive. One of them is a programme that has been tested in Spain and Dublin. I visited Dublin, and it was being delivered in the most deprived area of Ireland. They had a massive reduction in disorganised attachment and a very significant increase in secure attachment. It was a programme delivered alongside the usual checks that one does in a family centre, such as weighing the baby and looking at feeding; at the same time, they looked at some of those issues.

There are ways to do it that look universal and are not seen by families as targeting them. What was amazing about that particular programme was the buy-in; 80% of those families in the most deprived area of Ireland took part. It started off with 40% or 50% reporting to their friends and peers that it was a great programme and bringing them into it. The programme was seen as supportive and helpful to them; it looked at their relationships, the development of the child and the bonds between parent and child. Things like that do not have to cost a lot of money, but we need family centres, Sure Start units or somewhere, manned by people who can deliver them.

Dr Casebourne: And we need evidence-based programmes to be available, once issues have been identified as part of mandated checks and as part of screening in universal services. There is a whole range of programmes in our guidebook that help to improve attachment and behavioural problems, as well as helping expectant parents to prepare for the arrival of the baby, improving relationship support for them, and so



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on. A range of things could be added to universal services to make them more effective.

Chair: Thank you for taking us on that journey from what works locally to national strategy and what Government could be doing, then back to focusing on the evidence again. Thank you for your time today; it is much appreciated.