

Health and Social Care Committee

Oral evidence: First 1000 days of life, HC 1496

Tuesday 13 November 2018

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Members present: Dr Paul Williams (Chair); Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Diana Johnson; Johnny Mercer; Andrew Selous; Martin Vickers.

Questions 100 - 218

Witnesses

I: Javed Khan, Chief Executive Officer, Barnardo's; Anna-Marie Hassall, Director of Practice and Programmes, National Children's Bureau; Dr Alain Gregoire, Chair, Maternal Mental Health Alliance; and Elizabeth Duff, Senior Policy Adviser, National Childbirth Trust.

II: Dr Cheryll Adams, Executive Director, Institute of Health Visiting; Ailsa Swarbrick, National Unit Director, Family Nurse Partnership National Unit; Gill Walton, Chief Executive, Royal College of Midwives; and Dr Beckie Lang, Parent Infant Partnership UK.

Written evidence from witnesses:

- [Barnardo's](#)
- [National Children's Bureau](#)
- [Maternal Mental Health Alliance](#)
- [Institute of Health Visiting](#)
- [Family Nurse Partnership National Unit](#)
- [Royal College of Midwives](#)
- [Parent Infant Partnership UK](#)

Examination of witnesses

Witnesses: Javed Khan, Anna-Marie Hassall, Dr Alain Gregoire and Elizabeth Duff.

Q100 Chair: Welcome, everyone. This is the second session of the Health and Social Care Select Committee looking at the first 1,000 days of life. My name is Dr Paul Williams. I am in the chair for this inquiry. Thank you very much, all four of you, for coming along today. Perhaps you could start by introducing yourselves and telling us about the organisation you represent.

Elizabeth Duff: Thank you very much indeed for asking me along. I am a senior policy adviser at NCT, also known as the National Childbirth Trust. We are the UK's largest charity for parents. We also focus on the 1,000 days from pregnancy through to the end of the second year of a child's life.

We do a number of things. We are quite well known for antenatal preparation for expectant parents, but increasingly we carry out many other projects, at the moment particularly in the realm of perinatal mental health, supporting parents through our peer support programmes and campaigning for better services for parents who are experiencing problems in that area. We are very much about supporting parents to do what they want to do, and improve, for the best start for their babies and children.

Javed Khan: I am Javed Khan, chief executive of Barnardo's, the UK's oldest and largest national children's charity. We support vulnerable children and young people between the ages of nought and 25, more or less, through over 1,000 programmes across the whole of the UK. In the last 12 months, that was about 301,000 children and young people, their parents and carers. I am delighted that the Committee has chosen to hold this inquiry, particularly in these difficult times, when I certainly feel that the needs of children and young people are not getting enough oxygen in Parliament and the debates going on here, so I look forward to contributing.

Anna-Marie Hassall: I am Anna-Marie Hassall. I am a director at National Children's Bureau, also known as NCB. National Children's Bureau is over 50 years old and has a broad range of interests. It is a leading development and research charity. Our interest includes early years right the way across the age range to children and young people, through to SEN and disability up to age 25. At the heart of our work is the voice of children and young people. We provide the secretariat to the all-party parliamentary group for children.

Dr Gregoire: I am Alain Gregoire, a consultant psychiatrist in perinatal mental health for the last 30 years. In more recent years, I have been chair of the Maternal Mental Health Alliance, which represents over 90



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UK-wide professional and patient organisations concerned with maternal and baby mental health.

Chair: Thank you very much. It is a nice coincidence that Andrea Leadsom's review was announced some time after our inquiry started gathering evidence. The focus of this inquiry is to look at guidance from you on what a national strategy should look like and what the cross-departmental ministerial review should be looking at. We are also really interested in what works locally and in local evidence around the economic benefit. We also want to know what does not work locally. We are going to start by asking some questions about local service delivery.

Q101 **Johnny Mercer:** I want to start by talking about proportionate universalism. Starting with you, Elizabeth, how does it actually work in practice?

Elizabeth Duff: We are talking about quite a lot of different services across the 1,000 days. The period we are particularly interested in looking at, because we feel there is a great deal of fragmentation where women fall through the gaps both in a chronological journey and because of their particular situations, is the postnatal period, after the birth of a child.

Most women give birth in hospital cared for by a hospital team. They move to the community and are looked after first by midwives, along, increasingly, with maternity support workers, who are not a regulated profession. They hand over to health visiting services, which have unfortunately been quite drastically reduced recently. At around six to eight weeks, women should receive a postnatal check from their GP. That does not always happen. We know that all those services, in spite of excellent work among many of those professionals, are overstretched. Therefore, the gaps between them widen, and women and their families fall through those gaps. That has an impact on a great deal that happens later in the whole period.

In terms of targeting, there is clear evidence about some women who have particularly unfortunate outcomes. For example, last week we heard from Embrace UK, which reports on maternal deaths and babies' deaths. Last week, it was about women who, unfortunately, die in the maternity period. One of the headline findings was that black women have five times the risk of death of white women. Fortunately, overall in the UK, we have relatively few maternal deaths. Deaths are clearly not the only thing to look at, but it seems pretty clear that that is the tip of a large iceberg and that many women from minority ethnic backgrounds are not, for a number of reasons, receiving the kind of care that they should. In that case, perhaps some targeting is a good idea to make sure that those women are better communicated with, and that they understand the need for antenatal care and for following it up right through the maternity journey, for example.



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Elsewhere, we are also very aware that, for example, perinatal mental health issues can strike women and their partners across socioeconomic levels. It is not necessarily associated with poverty, ethnic background or geographical areas.

Q102 Johnny Mercer: How effective is it at local level? You indicate that it is very tough to do. How do you make it effective? How do you make it work?

Elizabeth Duff: We are very keen on what is in current policy about individualised care, about tailored care plans for women, personalised care, listening to women and their choices. That does not mean, of course, that there is an endless budget for every woman if she wants a great deal of one-to-one care that cannot be there, but it is really important to understand women's values and understanding of their own needs, and to make sure that they are aware of and well signposted to all the services that are there. It is one of the things we do a lot of in our peer support programmes.

Voluntary peer supporters cannot do everything, but they can make sure that they know local services. There is an element of postcode lottery about what is available, so you need local people who know what is going on making sure that services are accessible, with a feeling of being psychologically safe for those who need them, and geographically accessible so that they are visible in the community. It is a tough question, because sometimes everyone needs a service; some continue to need it and others begin to be able to cope. Many women, by the time they are six weeks on, are fine and have good family and community support, and need less from statutory services, but many need a well-tailored plan that will bring in a number of professionals.

Q103 Johnny Mercer: Javed, would you like to add to that?

Javed Khan: The big challenge is how we as a country and agencies working within the system get the balance right between universal services, which are trying to target all expectant mothers and new mothers—we must not forget fathers—and yet at the same time target those who need the services most. That is a really difficult dilemma and difficult to get right. Our approach, whether it is through children's centres or, more increasingly, family hubs, which go beyond two years and through to age 19, is to make it universal—an open-door service where anyone can come in—with the belief that if we keep the net wide, it will bring people in and it will be non-stigmatised. Then, once they are with you, you start delving deeper and try to identify those who need the support most, and then the targeted intervention comes. If we simply went for targeted right from the start, the really hard to reach would not access it.

Q104 Johnny Mercer: You would miss too many.

Javed Khan: Yes.



Q105 **Johnny Mercer:** Anna-Marie, do you have something to add?

Anna-Marie Hassall: That was a really helpful summary of proportionate universalism; it is the offer of what is universal and available to all, but with the resources and the skillset to put in the extra boost to encourage those who may not readily take up what is universally there, those who are in greatest need. We have seen some good examples around the country through the good work of children's centres, for instance, where services are co-located, and there can be a mixture of universal and some additional help and support.

There are challenges where resourcing is more limited, and there is a bit of a tendency to move just to the targeted rather than the universal and the targeted combined. Proportionate universalism is quite a skill to keep available. There is always maybe the pressure to move solely into targeted, and the worst-case scenario is to have the universal without any of the additional support, because statistically we know that families who most often need that support do not readily take it up, so there is a whole cohort missing at that point.

Q106 **Johnny Mercer:** Alain, I noticed that you were nodding along to that.

Dr Gregoire: In the area of parental mental health, we have a substantial amount of research to guide us, both in terms of the outcomes, learning from where there are successes and failures, and from the voices of parents themselves, giving us clear and consistent messages through a number of different means and channels. We learn from that that all the different layers or levels of service provision are not only essential to the population we are interested in, to the parents and the young children at the very critical stage in their lives we are all concerned with in this inquiry, but that those different levels need to operate both for the target population and for each other. They cannot function without each other.

For example, the whole population needs a public health approach to reducing stigma. One of the greatest barriers to the effective provision of care in mental health is not just having the services. You can have cardiac outpatient clinics, and if people get a pain in their chest, on the whole, they will seek care. In fact 50% of people who seek care for cardiac pain do not have heart problems, but they go and are welcome nevertheless. With mental health, we know that at least 50% of people who are suffering and impaired in their functioning do not seek help.

Q107 **Johnny Mercer:** Have you seen that rate change over the last three to five years?

Dr Gregoire: A bit, but it is still—

Q108 **Johnny Mercer:** It is not fast enough.

Dr Gregoire: It is still a very prominent barrier and we are still seeing, with the most recent data in the last few years, 50% of mums in the



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perinatal period who have a diagnosed depressive illness, within a research context, not being recognised by services. That is in the context of that population receiving universal NHS contact. They are all in contact with midwives—

Q109 **Chair:** What is the impact of that on the first 1,000 days of a child's life?

Dr Gregoire: There is now a huge amount of evidence internationally in high-income countries, which we are still, and in low and middle-income countries, that there is a substantial and measurable impact on child development. We now know from prospective research, in other words research that starts in pregnancy and follows children from when they are fetuses until their 20s, that that impact remains, and is independent of all the other factors we know of that predict mental and physical health in those offspring. That is extremely important.

Being a good parent is more difficult than being an MP; I am sorry to shock you. For all of us, I think it is the most difficult thing that we ever do, and the one thing that is guaranteed is that we will at some point get it wrong. So, I would not wish to burden parents who are already burdened with the most difficult challenge any of us face in life with the additional horror that they may be influencing their children's lives forever, but at the same time it is a reality that we all accept; otherwise, why would we bother?

I do not think that our society and our state appreciate the huge long-term importance that this has for the future of the nation. We are talking about the mental functioning of the next generation, and, if we are not dependent on the mental functioning of our population for our future wealth and wellbeing, I do not know what we are dependent on. Speaking as a medic, it is not their liver function that is important; it is their mental functioning. We are talking about an impact on emotional wellbeing and functioning and cognitive, intellectual wellbeing and functioning, and it is economically substantial. We know from a report conducted by the London School of Economics in 2014, which involved extensive evidence-gathering from the available research at the time, that the cost to the nation is about £8.1 billion per annual cohort of women giving birth, if we leave care for mental health in the perinatal period as it is.

Q110 **Johnny Mercer:** Finally, if that evidence is so great, which clearly it is, what is the barrier to getting investment into the first 1,000 days?

Dr Gregoire: If we are talking about progressive universalism, universally, for everybody, we must do something to reduce stigma. We cannot just sit on our hands and do nothing about it, and that means a national programme about stigma, specifically relating to mental health in the perinatal period, in pregnancy, in the first 1,000 days, but also relating to needing help and support for being a parent struggling with parenting, which is a universal experience at some level or other, and



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feeling that it is shameful to receive support, be offered support or seek support. We need to change that attitude.

It is not easy being a parent, and it is not possible to be a parent completely on your own without the support of other people and the rest of society. It is about reducing stigma. We need public health education, and knowledge about mental health as well as physical health. Most women understand what it is to have a blood pressure cuff put around their arm, and, sort of, why that is done and why it might be important, but most women do not fully realise the possibility of their mental health suffering in pregnancy and postnatally, so that needs to be opened up.

Then we need all the staff in our universal services to be educated in that area. Most midwives and health visitors do not formally get an education in mental health, yet it is a substantial proportion of what they do, which is part of the inheritance of stigma in our services, let alone in society. We do not have specialists in our universal services, so there are areas where specialist mental health midwives and specialist mental health visitors operate extremely effectively in informing and supporting their colleagues in doing this work, but we do not have them everywhere. Most services do not have health visitors who are specialist in mental health, and nearly half of services do not have midwives with that specialism, and we could carry on through the system.

Chair: Thank you.

Dr Gregoire: I have spoken too much.

Q111 **Andrew Selous:** No, that was fantastic. I want to check exactly what you were talking about in what you said extremely well and powerfully. You were partly talking about attachment theory, as regards the impact on the children, as well as the ongoing impact on the mother's mental health, so there are two aspects. You mentioned the £8 billion figure. Was that for the women, the children or for both?

Dr Gregoire: About three quarters of the £8.1 billion per year figure relates to costs for outcomes for the child over the subsequent 10 years only, because at the time we only had 10-year follow-ups. We now have published 20-year follow-ups. A quarter of the costs relates to the outcomes for the mother, and £1 billion of the £8 billion are direct NHS costs, but the other costs relate to social care costs, criminal justice system costs and so on.

Q112 **Andrew Selous:** We have known about the importance of attachment theory for quite some time, haven't we? I can think of several parliamentarians from all parties who have been involved in this for at least a couple of years. Are there other parts of the world that are doing it better, and have really got the significance of the issue and embedded proper provision to deal with it that you could point us to?

Dr Gregoire: It is not just attachment theory. We have a growing body of evidence that there are, for example, biological factors operating in



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pregnancy. It looks as if there is a resetting of the fight and flight hormonal system in fetuses whose mothers suffer from chronic anxiety problems, for example. There may be epigenetic effects, which are effects that do not just go on for the next generation but maybe even for subsequent generations. There are a number of different mechanisms operating in addition to, very clearly, disturbances in attachment in the offspring.

As to whether there are other countries doing it better, one can certainly point to countries that invest more in parents and families. We are always pointing to Scandinavian countries doing things in a slightly better way when it comes to social support and support within society, and that is certainly the case, but in some areas of perinatal mental health we lead the world. Unfortunately, we do not lead the world equitably. We lead the world in research, for example, but most women in our country do not get the benefit of the results of that research, which seems a terrible tragedy for an, effectively, relatively wealthy country.

Q113 Diana Johnson: I want to go back to the issue of stigma and what it is. How do you remove stigma? What do we do?

Dr Gregoire: Again, we have some world-leading experience in programmes to reduce stigma around mental health generally, which have been running for over five years at national level, and are eroding stigma. It is a slow process, but it seems to be working. There is a wealth of experience in this country about how to do that, and indeed other countries in the world are learning from us.

Q114 Diana Johnson: Can you give some examples? What does it mean?

Dr Gregoire: The Time to Change campaign has had television adverts, for example, and has engaged opinion leaders and celebrities in speaking out; it has engaged parliamentarians and MPs in speaking out about their mental health problems. The royal family has spoken out about its mental health problems. It is part of a snowball effect, so it is partly a response to a small reduction in stigma, but it can have an exponential impact. It started with a dedicated, funded programme to try to crack the problem. We absolutely need that with parenting and the early years as well.

Elizabeth Duff: I want to flag up the current NCT campaign, which is called the Hidden Half and specifically refers to the people that Alain was talking about just now. Half of new parents, mainly mothers but also fathers, who are experiencing mental health disorders, either do not feel able to disclose them, or they disclose to somebody but do not in the end get the diagnosis and treatment they need. We have found a lot of people responding to our campaign, which calls for better treatment and care, as well as a really good postnatal six-week check with a focus on mental health. Lots of women and some dads have come to us saying, "Thank goodness you are doing this, and this is my story"; some of them got good care and it worked, but others suffered for longer because they did not.



Javed Khan: On the mental health front, there is the approach of clearly identifying services for those who want support with mental health issues, but the alternative—probably they are complementary anyway—is running services that do not pitch themselves in that way. It is the universal approach of the open door, welcoming everybody in, all mothers, and them not being stigmatised, not coming through a door because there is a particular sign saying, “If you have mental health issues, come in here.” That works. It really does work, because it is an open attraction.

They may come in just for the childcare, or they may come in because they want to register the birth in a children’s centre—because we make sure that that happens—but when they are there you realise that people want to talk. As long as the staff are trained to spot the signs, and we invest heavily at Barnardo’s in training our staff around mental health, trauma-informed practice, adverse childhood experiences and all of that stuff, that proves to be a way of identifying the need in a very different way from somebody walking into a bespoke service that might attach more stigma to them, and being able to be confident enough to do that.

Q115 **Mr Bradshaw:** Forgive me, but we will have to ask for a bit more self-discipline in the answers because we are still on question 1 and we have a long way to go, so, if you could, keep your answers as short and concise as possible.

I want to ask about targeting. You have already touched in quite a lot of detail on the difficulty of targeting and identifying the people we need to target when it comes to mental health. What are the other challenges and difficulties in identifying children and parents who need targeting with specialist support? Anna-Marie, you have not said anything for a while, so do you want to come in on that?

Anna-Marie Hassall: That is the most significant challenge. I would not disagree with colleagues in saying that mental health is a particular issue, often an undiagnosed issue, and that, if practitioners were better informed and more ready and able to spot it at an early stage, that would be hugely beneficial. As we know from some recent work that we have conducted ourselves through conversations with parents, they did not realise that they had mental health issues at a particular stage when their baby was very young, or when their child was very young; it is more retrospectively, looking back, that they can see that those challenges were there and that they neither asked for nor realised that they actually required support.

It is twofold. The challenge is that it is a combination of the well-informed practitioner and, further than that, the well-informed community. If we could really change the narrative, we could have a better position, where we could openly talk about emotional wellbeing, because that is what it is about, essentially: at the heart of it is emotional wellbeing, and that means having good mental health. If everybody, from the pharmacist to the shopkeeper, to somebody at the school gates, other parents, were



better versed in need and knew where to go, it would genuinely make a difference. It is about changing the narrative and making it everybody's business.

Q116 Mr Bradshaw: Can we move the conversation away from mental health? I know it is really important, but we have a lot to cover, and we want to know the other areas where it is difficult to identify neglect, abuse, substance abuse, whatever, and it is really important. Can we focus on those? Who are the children falling through the gaps at the moment when it comes to identifying specialist services?

Anna-Marie Hassall: It is poor children. Essentially, if you were to ask, "What is the root cause?", I would say poverty. Families are living in circumstances where they are making tough decisions about the number of meals to provide. We know that millions of children are in food poverty out of school term; in school holidays, we know that families are going hungry and that families are essentially at breaking point. If we could tackle poverty, I believe it would make a fundamental difference to mental health. If you said, "Sort one thing," I would say sort poverty.

Q117 Mr Bradshaw: Why is it particularly to identify children from poor families or families who are poor, in terms of the challenges they face? If they are being offered universal services, which they should be—at least some—why are we failing to identify where the problem is?

Anna-Marie Hassall: Percentage-wise, it is the poorest families that are the least likely to engage readily, and they might need more support.

Q118 Mr Bradshaw: With universal services.

Anna-Marie Hassall: Yes, with the universal services. We have a fantastic offer. I have come back from speaking at a conference in the States about early years; what we have is the envy of the world, but our children are not achieving the outcomes that other countries are, yet we are investing. It is about doing it differently and making sure that the universal offer is taken up not by 75% but by close to 100%.

Javed Khan: I would build on that. Poverty, as we understand, is critical. There are 4.5 million children living in poverty. More than 60% of those children have working adults, so it is not as if they are unemployed, or just on benefits. There is a different kind of poverty that is even more difficult to spot, and that is the poverty of hope in a lot of communities, the most disadvantaged, deprived communities who are not accessing services, and who just cannot see any hope. That is really difficult to spot and it is difficult to engage with them as well.

The other big challenge is that for a long time we built up responses that have been around buildings. That was the thing about Sure Start and traditional children's centres: you set up a building and people have to access services in that building. The answer is that there has to be much more investment in outreach, reaching deep into communities, where you have virtual children's centres or family hubs or whatever the solution is,



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where we are going out into communities and reaching people who need to be reached and who themselves do not have the wherewithal, the knowledge or the understanding of the system to come to us.

Q119 **Chair:** Are there people doing that? Is there anybody in a local area watching the realtime data in order to work out who is accessing services and who is not?

Javed Khan: There are a number of people who are responsible for doing that. Of course, there are the local authorities—children’s services, adult services and so on—who have a statutory duty, but they cannot do it alone.

Q120 **Chair:** Are they watching that data? Are they able to know the individuals who are getting the services and the individuals who are not, and then do outreach to find different ways of engaging the children who are not getting access to the services?

Elizabeth Duff: It is the role of health visitors, I believe, from the beginning of the 1,000 days that we are talking about. The Healthy Child programme that is the basis for commissioning health visitor services requires an antenatal visit so that health visitors get to know the family beforehand, but they are not often able to do that. They should then be able to provide support right through those years, and they should be looking at data that shows which families are most in need, but, very sadly, I have spoken to health visitors who say that, essentially, their job ends up as safeguarding. They can only work for the families who are most at risk of serious tragic outcomes, but they are not able to give the service to many they would like to who are struggling to cope and may be going downhill. It seems to me that it is the service that should be there throughout the period and needs support as much as any other, or more, to expand and do the job it is meant to do.

There is also a public health element. Poverty is associated with poor diet, with lack of exercise, with outcomes that end up with high levels of obesity, smoking and sometimes alcohol and drug use, although that is by no means just poorer people. Of course, that impacts on health through pregnancy and early years and on how children are fed; very low breastfeeding rates, for example, have long-term effects on children.

Dr Gregoire: There is a particular group that is not often targeted because we do not identify them, and that is parents who have themselves suffered abuse, neglect and adverse childhood experiences. They are an extremely high-risk group, but nobody systematically identifies them.

I would completely agree that, if we want a dedicated tailored response for individuals, health visitors are absolutely key; they are suffering desperately, and, therefore, so are the populations they serve. In terms of other departments, it is housing. Housing for families is really



desperate among the poorest, and we know that has a very direct effect on their outcomes.

Anna-Marie Hassall: You asked specifically whether anybody knows and whether anybody has access to the data. You will probably be familiar with the generous investment of the National Lottery, the Big Lottery Fund, in five Better Start areas in England—Blackpool, Bradford, Nottingham, Southend-on-Sea and Lambeth. It is precisely the cohort that you are looking at—pregnancy through to just before the fourth birthday. Because of the investment in those areas, there is a lot of very rich data. There is tracking of unique beneficiaries, being very clear about which services are engaging parents and making a difference. That work is now in its fourth year. I would like to offer, if you wish it, additional evidence from those areas, and to provide some summary reports for you. I think you would find that of benefit to the inquiry.

Q121 **Chair:** Those areas are showing what can happen, but is the reality in other areas that individual tracking is not happening?

Javed Khan: The reality is that it is a fragmented system—the various agencies that have responsibility to talk to each other and to share information. It is not happening consistently.

Q122 **Chair:** What would make it less fragmented? What policy recommendations should we be making?

Javed Khan: If you are talking about, say, a future strategy on early years, I would say early intervention, which is broader than just early years, because the challenges do not stop at age 2. You have to carry on and be consistent, and that requires a really strong message about the multi-agency response that is required, with interdependency between agencies, understanding each other's needs, understanding how the shoes pinch and pooling resources, with some really strong and clear guidance centrally that tells them the what, not the how. The how should be left to local discretion, but the what—the key principles of working together and jointly owning the outcomes—has been part of the problem.

Q123 **Chair:** You want a national strategy and clear national guidance, but local delivery with pooled budgets and local leadership.

Javed Khan: Local flexibility is important, and local partners have to come together, but tell them that they have to come together and they may only get the funding if they can prove that they are working together and jointly owning the outcomes.

Elizabeth Duff: On the ground, we need more continuity, more personal continuity of carer for families, so that they know the person who is looking after them, and, when one service has to hand over to the other, that person, whether it is midwife to health visitor or to somebody else, knows the person they are handing over to, so the advice and help the family are getting is consistent and continuous, and they are not left with



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gaps or given conflicting advice, which can be a horrible waste of time and end up with the wrong things happening.

Chair: That might bring us to some of Andrew's questions.

Q124 **Mr Bradshaw:** Before that, you said at the moment resources are so stretched that the health visitors, who are the canaries in the mine at this stage, are basically just doing safeguarding.

Elizabeth Duff: In some areas.

Q125 **Mr Bradshaw:** That is certainly the experience in my own area.

Elizabeth Duff: Yes, indeed.

Q126 **Mr Bradshaw:** They are totally overwhelmed.

Elizabeth Duff: It is better in some cases, and I know that there is a lot of tremendously good work going on in mental health and other support, but they are not doing what they used to do, which was a great support and safety net for families.

Q127 **Andrew Selous:** Can I go back briefly, Anna-Marie, to something you said earlier? I wrote it down. You said that we are the envy of the world and we are investing, and then you made the point that people were not managing to access the services. How come we have a good architecture of design that we are putting money into but it is not reaching the people we want? That is really bizarre, isn't it?

Anna-Marie Hassall: Yes. It is curious, isn't it? We have universal entitlement, but we know that some of the poorest families, or those in greatest need, are not necessarily taking up those services. None of us disagrees with that. However, the stretched resources—we have heard about the pressures on health visitors—mean that there is not the time to coax, to persuade or to follow up. We know from a range of evidence and research that relational approaches really make a difference, and where it is possible to build a consistent relationship, it can make the greatest difference to families who are less inclined to take up what is there, for them to take up services. It is a sad position when we know that some families opt out of immunisations because they feel it is the only choice that they can make. It is not necessarily based on a well-informed decision but because they have a right to say no.

Q128 **Andrew Selous:** Following up on what Javed said earlier about it not just being about buildings but a virtual children's centre, going out and meeting families in their own homes, is your almost No. 1 ask to increase the health visitor workforce? We tried that under the previous Prime Minister; there was a commitment to that. Is that what you would like us to go back to?

Anna-Marie Hassall: Great strides were made on recruiting to the health visitor workforce, but, with a maturing cohort, natural attrition has meant that that was not repeated. That was a real effort.



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Q129 **Andrew Selous:** No. I am sorry, my question was: if you had some money, would you spend it, No. 1, on more health visitors?

Anna-Marie Hassall: I would not do that alone. It is also about involving parents and communities in the co-production of how services work. It is absolutely key that parents and communities better understand the benefits of services. That sometimes takes a slowing down and more time invested. The relational approach is absolutely key.

Q130 **Andrew Selous:** That leads me nicely to my next question, about the co-ordination of the services. We heard quite a lot of frustration last week about a siloed approach. There are data confidentiality issues with a slightly older age group. I have huge frustration that the national child measurement programme data seems to stay in the school and does not flow to the GP, because, I am told, of data confidentiality issues, which seems complete nonsense to me. Is the earlier age bedevilled by that data confidentiality problem?

Anna-Marie Hassall: Reflecting back to my early days as a social work practitioner, I always said that no child died through information-sharing but many children did through not. I do not think we have got it right at the moment. There is a lot of fear of problems through sharing information, and it is children who are suffering the consequences. There is a mixture of a need to co-locate staff from various disciplines so that they are not working in silos. The benefit of children's centres as a place was that there was blurring of the lines of professionalism, not of responsibility or accountability, and practitioners were more likely to talk to each other informally and freely. Those opportunities were there.

Q131 **Andrew Selous:** Going back to the Chair's earlier point, isn't this a classic case where clear national direction on sharing data should set a lot of these worries to rest—a clear statement on the wall from the Secretary of State that you are expected to share data, and we'll be cross with you if you don't?

Anna-Marie Hassall: Yes, absolutely. If you did one thing, I would say find a way of providing a unique reference number for children before they go to school. They all have a number once they go to school; and they have the NHS number that comes when they are registered at birth, but that is not routinely used to share and to track children.

Q132 **Andrew Selous:** Why couldn't we use the NHS number, given that we already have it? We do not need another, do we?

Anna-Marie Hassall: Apparently, we would need legislative change.

Q133 **Andrew Selous:** To use an NHS number in other services.

Anna-Marie Hassall: Yes, to use the NHS number for children's social care, for instance. I remember being at a conference of the Association of Directors of Children's Services a couple of years ago when there was a groundswell of support from directors that they would stand up and use the NHS number, and it would be the best way of making sure that



children did not fall through the net. They were apparently told that it would be contra to law and that there would need to be legislative change for them to be able to use the NHS reference number for children's social care. If you could make that happen, it would be hugely empowering.

Q134 Andrew Selous: Okay. You might just have prompted us towards a recommendation in our report, but that is to come later.

There is another group falling through the net as well, isn't there, and that is fathers? Why are fathers not fully involved in this stage? The evidence is very overwhelming about the positive impact they can have, or the negative impact if things do not go well. The impact of their own mental health is important. I understand that the NHS pregnancy notes direct the healthcare professional to ask the mother questions. That seems slightly out of the ark, doesn't it, in modern attitudes towards families? What do we need to do about it?

Javed Khan: It is a critical point. It is really difficult to engage fathers, to put it simply, across a whole range of services. Usually the ones you really need to engage are the most difficult, especially the fathers. Our response at Barnardo's is that, as I was saying, in children's centres and family hubs in particular—the new emerging model—we are working with the local birth registration services and bringing them on site, so the father is compelled to come; if he wants his name on the birth certificate, he attends, sometimes kicking and screaming, but he attends. When he is there, a whole range of other support and services suddenly becomes available and we are finding that that has a dramatic effect on engaging with fathers.

Secondly, there is a whole range of bespoke, father-only services that we run, group sessions, workshops and so on, usually at the weekend, trying to catch them at a time that is free. I have seen that in practice in services around the country. It works best when the session is run by a male. That makes a big difference, it seems. It is easier said than done, because most of the people who work in these services are women. We have a responsibility to recruit more men into the project worker-type role, and that requires a concerted effort.

I saw one fantastic fathers' group where there was a whole mixture of fathers, some who had learning difficulties themselves and others who brought their children with them because they were single carers. There were some who were on visitation orders and had been accompanied to the session—a whole mixture. The brilliance of it was the male project worker, who was speaking a language that they understood, and they could relax. It had a dramatic effect, I was told, on the attendance, in the frequency that people turned up.

It is a responsibility that we all have. Local authorities have a responsibility. Every local authority should have a designated lead on engagement with fathers. They do not have that at the moment; there is no statutory responsibility, but something that would help is somebody



who regularly thinks about how we include fathers. We need better data because a lot of this is anecdotal. There is no data system that captures the involvement of fathers. Maternity services need to contribute to recording the father's details too, not just the mother's, as often happens.

Q135 **Andrew Selous:** Elizabeth, you look keen to come in.

Elizabeth Duff: I am, because NCT for 50 years or so has been trying and succeeding in involving fathers from as early as possible in the pregnancy, certainly encouraging fathers to come to antenatal preparation and attend the birth if they wish, and if the mother wishes, and being as engaged as they can. We have lobbied for increased paternity leave, which is quite an important thing so that fathers can spend that early time.

We helped draft the legislation for shared parental leave, which we are aware has low take-up but is increasing slowly, and it sets a model for the acceptance of that practice. More recently, we have been involved in the type of project Javed talked about where dads are caring on their own, where they are no longer in the couple, or perhaps never were, with the mother of the child. In some of our 300-plus branches around the UK we have helped with projects teaching dads to cook meals for their children, which can be a very basic skill. It is hard to look after young kids unless you know what they like to eat, but with an edge on what would be quite healthy for them to eat, things like that, and games to play with them, mostly when kids get older; but with quite young babies you need to know how to care for them, how to play with them and have fun with them.

Q136 **Andrew Selous:** Alain and then Anna-Marie, but quite quickly because we have other questions to get to.

Dr Gregoire: It is pretty clear that fathers are engageable if there are people to engage them who have time to do it.

Q137 **Andrew Selous:** And do it well.

Dr Gregoire: For example, the experience with the Family Nurse Partnership, where there was a strong emphasis on engaging young teenage fathers, supposedly very hard to engage and hard to reach, was that they managed to engage them because time was taken, it was quite domiciliary and it was at flexible times.

Chair: We have the FNP on the next panel.

Anna-Marie Hassall: An example of what I think is really good emerging practice is something that we included in the submission; it is a parenting programme called Game of Two Halves, currently being delivered in the Lambeth area. A group of fathers came together to work with practitioners on co-designing a parenting programme that includes



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evidence-based input; practitioners, who are broadly female, provide the input, but it is facilitated by a male worker who has built confidence.

It is called Game of Two Halves because the dads routinely come together for a parenting session, and then they have a game of football for the other part of the session. That model is cheap, very cost-effective and could be replicated. Not everybody would want to play football; you would have to be flexible with what the other half was. Obviously it has been attention-grabbing, but the key characteristic is that fathers got involved in helping to shape the programme and felt a sense of ownership, and, therefore, the want and the will to learn from the practitioners. There is input around diet, speech and language, and what they can do to support their children's development—bite-sized nuggets presented in a useful way but drawn from evidence—where they feel that they are being treated as co-partners in doing their best towards their child's development and outcomes.

Q138 Dr Cameron: I have a quick follow-up about the importance of grandparents. Particularly, we have had a number of cases in the constituency of paternal grandparents who really want to be involved and feel they could make a great contribution and difference, but feel that the way services are set up, and the statutory implications, mean that they do not always have access. Can we have some quick comments about the importance of grandparents in early development?

Javed Khan: I have seen the opposite of that in a range of children's centres and family hubs where grandparents regularly bring the children because both parents are at work, or the single parent is. That is with permission, of course. The difficulty is when there is not permission, and grandparents want to get involved, but that is different.

Q139 Dr Cameron: Could we do more to make sure that there are ways that grandparents could get permission to be important and have that role in children's lives? Is that something that is important to their development?

Dr Gregoire: This is a good example of where we need to change the narrative around the whole of parenting. I know this sounds a bit touchy-feely and fluffy, but I do not think there is a publicly accepted view that parenting on your own is difficult, and I really think we need to change that. That includes involving neighbours and grandparents, although I do not put them in the same category, and the wider family. We do not do that enough, and our services do not do it. Dads are only just welcomed in antenatal clinics. It is changing, but it is not very active, and some national central guidance is required over the issue: services need to speak to each other, but they need to speak to the whole family and they need to think about the whole family.

Chair: I would like to move us on, if I may, to questions about what a national strategy should look like, both the scope of a national strategy and the priorities.



Q140 Rosie Cooper: I am going to join them up, primarily because time is running out. Should intervention begin before conception, and, if so, when? How should Government intervene, and, actually, what role do central Government have in informing that service provision?

There is also a little bit about targets under the Children Act 2006. The Secretary of State can set targets for local authorities to improve the wellbeing of young children and reduce inequalities. Are you aware of any such targets being imposed on local authorities? The big wrap-up is: in what circumstances do you think local government has a role to do that?

I started out thinking that is where we were, but, listening to you, I am almost down to the fact that we are back to the general thing in this country, which is everyone is accountable, nobody is responsible, everybody is looking at each other, but who is actually supervising it and delivering it? In terms of scope and intervention, who, what, how and why, and have you seen it on the frontline?

Elizabeth Duff: There are quite a lot of different questions. I have to say again that as we are a charity for parents, although we are profoundly concerned with the wellbeing of the child, we look at it through the parents' lens. We believe that, if you support parents in the right way at the right time, they will be the best people to look after the wellbeing of their children, with the support of the services around.

You talked about preconception care, which is interesting, but it is very hard to reach people, women and their partners, before they are pregnant with their first baby. Quite a large number of pregnancies are still unplanned, so reaching those women is pretty tough. However, only about half of pregnancies are first ones—slightly less than half—but there are a great many families with a gap between the first and the second or the second and third, and so on, child, and that is a very important time. Before the conception of the next child, where there have been problems, physical, mental or social, around the birth of a first child, is an incredibly important time to pay attention to the family and see how help can be provided, which may be the physical and mental health of the mother or father, or other social circumstances, to improve what happens to the whole family for subsequent children. I would look at that.

There are all sorts of things, from housing, which has been mentioned, to physical health, public health and getting time when they are in touch with services to improve their understanding of things like diet, smoking, and so on. That will help. Overall, it is keeping in mind the journey of the woman having the babies, and of the family, with holistic care for the family as they go through the peaks and troughs, when they need intensive support, and letting them pick up and go forward with confidence.

Q141 Rosie Cooper: What role do Government have in intervention and when—as targets?



Anna-Marie Hassall: I do not think there is a perfect point for intervening, because to say that would almost make it seem that, if we missed that opportunity, we were past the point of making a difference, and I do not think that is ever the case. There is always an improvement that can be made by intervening. However, during pregnancy, parents are at their most potentially suggestible, and open and receptive to hearing about either lifestyle or behaviour change that could make the biggest difference for their children. I have seen it over and over again. I have never yet met a parent who does not want the best for their child, so during pregnancy is often a good time to make recommendations about lifestyle changes, to intervene around obesity and so on.

However, you could also argue that working with children and young people when they are at a formative stage, before they develop longer-term relationships, is a really good point at which to influence safe, healthy relationships. We know this from some of the work that we do at NCB through the Sex Education Forum and relationships and sex education, plus the recent work of Baroness Shackleton in recommending intervening in the teenage years, essentially, to encourage good strong relationships. Good strong relationships are absolutely fundamental and are at the heart of emotional wellbeing, mental health and so on.

Javed Khan: I do not want to repeat what colleagues have said, so I will come at your question from a broader sense about the approach the strategy should take as opposed to individual interventions. There are some key ingredients that I would encourage you to think about.

Any strategy needs to be a long-term commitment from central Government, giving a clear direction beyond, dare I say it, political cycles. Short-term sticking-plaster stuff does not work for the challenges we are talking about. It has to be sustained and long term, and the recipients of the strategy, including us, have to know that there is a long-term agenda that we can stick to and hold on to, and try to make a difference.

Secondly, the issue of fragmentation has to be addressed, so that you are giving a clear direction to all the agencies that have a responsibility—from local authorities to the NHS and all the health workers, the voluntary sector as well as schools and everyone else—that working together is a critical part of the strategy, and none of us can do it alone. That needs to be incentivised. A carrot and stick approach has to be part of it, not just, “Do it if you want to,” but, “Do it because it is essential, otherwise you won’t get the money.” That is the kind of incentive I am talking about, asking us to pool our resources, and jointly own the targets and be accountable for them, as opposed to each individual looking after its own little bit. That has been tried and it does not work.

The strategy should look beyond the 1,000 days, although the 1,000 days are absolutely critical, of course, but it cannot be done in isolation from the other challenges that families face beyond two years. There needs to



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be recognition that early intervention is even required for teenage children; today's kids are tomorrow's adults. All the knock-on effects have to be seen in the round.

Finally, we have a great opportunity next year with the comprehensive spending review; it cannot be ignored. That is an opportunity for Government to make a very significant statement about the importance of children and the plight that children and their parents are living through at the moment. If we are to change society and create a better world for all of us, the CSR is a way of driving some of that with a financial commitment underpinning the strategy that you, I hope, are going to come up with.

Q142 **Rosie Cooper:** In the questioning, when I rolled them all up, I talked about the Secretary of State setting targets for local authorities. Do you know of any of those?

Javed Khan: There are lots of targets out there at the moment, but it is not clear in terms of what we are talking about today.

Q143 **Rosie Cooper:** Let me just read this question clearly: the Secretary of State can set targets for local authorities to improve the wellbeing of their young children. One presumes that means that there can be a lot of different targets, but have you seen it imposed and really work anywhere?

Anna-Marie Hassall: I believe that local authorities take seriously the outcomes of children in their locality. One of the challenges is that, due to reducing resourcing, their thresholds have changed significantly, and that means there is less early intervention and, regrettably, fewer opportunities to support children in the early years. There is more focus on what are deemed to be statutory services. Local authorities most frequently set their own local determinants, although there is some national reporting too. There is an inspection framework that holds local authorities to account, should the outcomes for children not be as comparable with other areas.

Elizabeth Duff: To go back to health visiting, health visitors now work for local authorities, and the Healthy Child programme sets requirements for the visits and the contacts they have to have. There is data that says how often health visitors are able to achieve those and whether they are able to do it at the time they should. It is most certainly not 100%. That does not exactly sit in my head as a target. You would assume that 100% is the target.

Q144 **Chair:** It sounds like something from a committee rather than—

Elizabeth Duff: Exactly.

Q145 **Rosie Cooper:** It seems like tick-boxing and not actually making a difference.



Javed Khan: Part of the problem with the premise of the question is that there is a flaw, in that it is one Secretary of State. In this case, I presume you are talking about Education, but the contributing factors that will drive the outcomes we are looking for also involve Housing, Communities and Local Government, Health and Social Care, Justice and DWP. There is a whole range of factors that have to be taken on board. That is part of the problem, and that is what drives the silos.

Rosie Cooper: Leadership.

Dr Gregoire: Leadership at local and national level is required, and, in my experience, it is not there. At national level, we need it spelt out very clearly that the early years, and the things we know we can do to make a difference, are important, because they are not being prioritised when times get tough. Certainly at local authority level, the cutting back in health visitor numbers is absolutely clear in the current difficulties, but we are also seeing that in health. We have huge investment nationally in specialist perinatal mental health, but at local level CCGs are already saying, "We can siphon some of that off to pay for our overspend in A&E departments." It is going to a completely different area. That requires both national holding to account and direction-setting, and local leadership and local responsibility, and it absolutely needs all the systems.

Finally, we need a transgenerational view, constantly saying, "Are we intervening early enough in pregnancy? Shouldn't it be before pregnancy?" In fact, there is no early intervention. We need to intervene at every point in the cycle, and sometimes we are actually looking at the outcomes for the next generation, not this generation, and maybe even the generation after that. At every point, we need to intervene so that we can really break the constant cycle that is going on.

Anna-Marie Hassall: There is a strong economic argument at the heart of this. It is not just moral and a principle about improving outcomes; we are not spending precious resources wisely enough. Dame Sally Davies, the chief medical officer, back in 2012, wrote the report "Our Children Deserve Better: Prevention Pays." She made a clear correlation—scientific evidence—to show spending on primary healthcare making a big difference for child outcomes, yet we have not done sufficient to implement some of the recommendations of that writing. International economists such as James Heckman say in similar ways that spending in the early years saves later.

Q146 **Mr Bradshaw:** Do we have a cultural problem as a nation? I get bombarded, as we all do, with hundreds of letters a week from constituents about animal welfare. I do not think I have ever had a letter from a constituent about child welfare, children's poverty or the neglect of children. Doesn't the way children are sometimes treated by wider society filter down to the way some parents treat children? There is a massive cultural problem that we have in comparison with other countries



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I have lived in, such as Germany and Scandinavia, where attitudes are completely different.

Dr Gregoire: I think that is absolutely right. Nobody would individually like to say that they do not like children—well, some people say it. As a nation, and I am half Norwegian and can tell you, it is starkly obvious to me that we do not appreciate families, let alone children.

Q147 **Mr Bradshaw:** Then should we not be more censorious as a society of child neglect and of the way children are sometimes treated, including sometimes by their own parents?

Dr Gregoire: Criticism does not generally encourage good patterns of thinking and behaviour. It is encouragement that does, and reinforcing. If we set models and encouragement in our system for valuing families and for valuing good parenting, or good enough parenting, we will achieve a lot more than our current system, for example, of so-called child protection, which is really just waiting for damage to be done and then stamping on it in a really traumatising way, in my experience.

Elizabeth Duff: Alain is absolutely right about the generation-to-generation problem, particularly young people who have been brought up without good parental models, looked after in local authorities and so on. They may be doing absolutely the best they can, but it is very hard for those young women and men to bring up children themselves with little support, and to get really positive models. A lot of agencies, including ourselves, have done their best to offer parenting courses and so on, but it is hard to reach all those who are hard to reach.

Chair: They are great insights, thank you.

Q148 **Diana Johnson:** Javed, a few moments ago you talked about a very compelling vision of what we should be doing, and you were looking to the CSR and hopefully some further investment to make that vision happen. If we could go back to the reality of today, and the pressures that local authorities are under financially, what changes do you think could be made now to make sure that services are provided or commissioned to reduce the impact of poverty on children and families during the first 1,000 days?

Javed Khan: I spent 10 years in local authorities before I came into the voluntary sector as a director, and I fully understand the pressures, and they have got worse. All my colleagues who are still directors of children's services are literally pulling their hair out. It is not about preparing for the cliff edge; the cliff edge has come and gone, and they are falling over the edge now. The number of local authorities going into special measures or falling over various inspection regimes is growing by the day, so there is a massive problem.

One of the critical challenges within that is the ability of the local authority to respond. The way it currently works is that a small group of people in a local authority will identify a problem. It could be around



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children in care, it could be around family support services, integrated systems, or whatever it is. An even smaller group will lock themselves in a room and try to work out the solution on their own, and then they bang out tenders and ask people like us and many others to submit bids. We then get into a mass scramble of using donors' money, which is not what the money is given to us for, to compete against each other, which is not what we want to do, to try to win a tender. That system is completely unsustainable.

The sharper local authorities have realised that and are beginning to think much more radically. We are helping them do that as well. We are saying, "This isn't sustainable; this isn't what the resource is for. It is a waste of resource, and it isn't going to give you the right solution anyway because you have tried to work it out in isolation and not thought about your place, and all the contributors to the place that you are responsible for. All you are thinking about is the resource that you directly control, which is not enough anyway. You know that and that is why you are doing it."

Up and down the country, we are working with a number of authorities on what we call strategic partnerships, where we are invited in right from the start of thinking about what the problem is, bringing in all our national experience of what works in other places and sharing that with the thinkers there, co-creating, co-producing, to use your language earlier, what the solution should be, and then we or others are brought in to co-deliver it. That is happening on a small and large scale in small local authorities and large counties, beginning a systemic rethink of what the right solution is.

For example, we have been working in Newport for the last five or six years on a long-term strategic partnership, and lots of independent evaluation has gone. It is an integrated family support system. Half the staff are actually Barnardo's staff and half are Newport City Council staff. The head of the service is one of my team seconded in. We put 20% of the resources in, they put in 80%, and they are outperforming all their statistical neighbours on everything we are working on together. Independent evaluation has shown that, for every £1 we have spent, the value for money is £32. That is fantastic return on investment.

There are many other places that are thinking of being like that. There is a nugget of a solution within that, of completely rethinking systemically what the answer is for children's services. If we carry on as we are, there is not enough resource and demand is increasing. Just look at the children in care numbers; they have gone up. Infant mortality has started going up in the last two years for the first time in 100 years. These are really significant statistics that we need to wake up to as a society, and, as legislators, you have an opportunity to do something about it.

Elizabeth Duff: I thoroughly support that. NCT, quite typically, managed to get some money from the Department of Health to train our peer



supporters, particularly in our Parents in Mind programme, which is peer support for parents suffering mental health problems. We have a similar one, of more general community support, Birth and Beyond.

With Parents in Mind, we have two years' money. It will run out in March. We have three programmes well set up and running, trained and managed and very well evaluated, but by March, unless we can find another partnership, all that work will be lost, which we feel is tragic. Therefore, we are putting a huge effort into finding the money, but it is taking our own resources to do the work, as Javed described, and two years is not enough to get a new programme up and running and sustainable.

Much of it is about signposting, making sure that women who are often very isolated understand where there are midwives, health visitors, medical services and social services. It is not about solving all their problems, but about being a friend to them, bringing them together with others, understanding the importance of community and giving them the confidence to move on. Often, our trained peer supporters themselves find their lives improved, and some have gone on to train as midwives. It is a great pleasure to us that we have kicked off that process.

Q149 Diana Johnson: Last week, the Children's Commissioner called for "a national drive supported by ambitious targets to address vulnerabilities children face in the first 1,000 days." Could you say something about what those targets would be to generate the greatest dividend for children, how you would monitor performance and what you think should be the levers to make sure that poor performance is addressed? It is quite a lot to put into one question, but if you could do it in a couple of minutes that would be great.

Elizabeth Duff: I do not know if someone else would like to start on that.

Javed Khan: I will pitch in. There are two ways of thinking about it. There are short-term targets and longer-term targets, and they need to be considered together. In the short term, I would put things such as parental engagement, because that is critical; that is what we have been talking about. Then there would be reducing infant mortality, school readiness, admissions to accident and emergency, dental health and obesity. Things like that would be in the short-term focus.

The longer-term stuff should recognise that children often continue with their challenges through teenage life and early adulthood, so it would include reduction in serious youth violence, the topic of the day. When you look at the young people who are victims, or committing serious youth violence, often their case studies are very similar; there is early life trauma, unsupported adverse childhood experiences, attainment issues in later life, mental health and not being in education, employment or training.



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Q150 **Chair:** They are all cross-departmental issues, aren't they?

Javed Khan: Absolutely, yes.

Q151 **Chair:** They require investment from some Departments in order to yield benefits in other areas.

Javed Khan: From other Departments, yes. Politically, that is always going to be a difficulty.

Dr Gregoire: I completely support that and would add not just the engagement of families but the engagement of whole families, and the documenting of those most at risk. The biggest risk factor we know of across the board is adverse childhood experiences. Very few services are systematically asking people, yet we know from the research that people are very open to being asked. They understand that their experiences of childhood affect their parenting, so we absolutely need services to identify them and then let services like health visitors or the voluntary sector get on and do what they are good at doing, but let us identify who they are.

Anna-Marie Hassall: We need some real specific focus on early years. With tight resources, there is a need for smarter commissioning, as we have heard, around the country, but if there could be a strong voice for the youngest children—

Elizabeth Duff: From pregnancy.

Anna-Marie Hassall: Yes, from pregnancy and the early years—really making that an important focus. I appreciate that some of the indicators and measures would be very short term, looking in the early years, but maybe that is important to drive the focus.

Q152 **Chair:** Nobody has mentioned breastfeeding, for example. Is that an important target?

Elizabeth Duff: Yes. I slipped it in somewhere. It is something that the NCT is quite famous for—support with infant feeding across the board. We know things have moved away from it being an A or B, "Do you bottle feed or breastfeed?" Most families in the end opt for some breastfeeding and some formula feeding, but women need support with both; they need to understand how to do it best. They need support, advice and help right from the beginning, particularly with breastfeeding.

The services that were giving that advice and help, unfortunately, have been vastly cut—community midwives, health visiting again, and voluntary services such as our own, although we continue to get some good contracts with local authorities who employ our breastfeeding counsellors to help. It is a fantastic investment, and I am sure you all know the benefits for both mother and baby when it can happen, but equally how horribly disappointing it can be for mums who really want to



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do it, but, through inadequate support, have to change their minds when they do not want to.

Dr Gregoire: It is not just mums who need that support; it is a great example where you can engage fathers. People often say, “Dads and breastfeeding—no, no,” but absolutely yes, yes, yes. That is why a lot of families mix breast and bottle feeding; dads can get involved, but dads can also be involved in the breastfeeding decisions and process, and that is really important.

Javed Khan: There is little point in teaching the mum to breastfeed if she has not eaten, so there is the interconnectedness—

Chair: With poverty.

Javed Khan: Yes. The interconnectedness with poverty must not be forgotten.

Chair: Thank you very much, all four of you, for your contributions. We have to move on to the next panel. We really appreciate all your insights and wisdom. Thank you.

Examination of witnesses

Witnesses: Dr Cheryll Adams, Ailsa Swarbrick, Gill Walton and Dr Beckie Lang.

Q153 **Chair:** Hello, welcome and thank you to the second panel. My name is Dr Paul Williams. I am chairing this inquiry looking at the first 1,000 days of life, some elements around national strategy, local service delivery and barriers to implementation of what we know works.

We have a possible vote coming up in about 15 minutes, which will be a brief interruption, so I am sorry. If a bell rings and people move, please stay here so that we can carry on. We will all come back. Maybe you could start by introducing yourselves.

Dr Adams: I am Dr Cheryll Adams, the executive director of the Institute of Health Visiting. I and three others set up the Institute of Health Visiting four years ago because we believe that health visitors can change the world. Given the right circumstances, and enough of them, with the right working models, access to parents and the evidence base and training, we know that working with every family, as health visitors do, we can have colossal impact on outputs not only for children and families but for society.

The institute particularly focuses on training, research, leadership, partnership work and quality assurance work, and we have achieved a lot in the last six years, but it is a little more difficult these days.

Ailsa Swarbrick: I am Ailsa Swarbrick. I am the director of the Family Nurse Partnership National Unit, based in the Tavistock and Portman NHS Foundation Trust. For those of you who do not know, the Family Nurse



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Partnership is an intensive home visiting programme, evidence based, from early in pregnancy until the child is two, so there is real continuity of care and a developing relationship. It is highly structured, based on evidence, and it works with both mothers and their babies, and fathers where possible, and seeks to address some of the intergenerational issues that I heard about in the previous session. The aim is to improve pregnancy outcomes, to support good child health and development, and to help to improve the parents' life course as well.

My team, the national unit, oversees delivery across the country, in nearly 80 local authorities. Our role is really about oversight. We train family nurses with a specialist training programme. We support quality improvement, we have an information system that collects data on clients, what is being delivered and short-term outcomes, and we use that both to assure ourselves of quality and to seek to improve quality. We are also doing work to improve and adapt the programme so that it is relevant to the UK context, and to share some of the learning from FNP with wider services.

Gill Walton: My name is Gill Walton. I am the CEO of the Royal College of Midwives. I am not going to explain to you what midwives do. We represent the majority of midwives in the UK and we are very engaged with national policy, not just to deliver healthy babies, but the future of the child and the family and the opportunities we have to do that.

Dr Lang: I am Beckie Lang, chief executive of Parent Infant Partnership—PIP—UK. We are a national charity and we support the development of services that provide psychotherapeutic support to families where the parent-infant relationship is struggling, during pregnancy and up to the age of two. We have a network of eight services across the country, and they are made up of multidisciplinary teams, predominantly psychotherapy-led but with a range of interventions that support the relationships. They offer support when the complexities in the family need more than a universal offering can supply.

We also campaign and raise awareness around infant mental health and the importance of parent-infant relationships, and provide the secretariat for the all-party parliamentary group for conception to age two.

Chair: Thank you. We are going to ask most of our questions about local service delivery and the commissioning of local services.

Q154 **Dr Cameron:** The first question is about the health visitor implementation plan. How effectively are the four levels of support in the health visitor implementation plan delivered in practice? We heard some concerning evidence this morning that health visitors are so under the cosh of levels of stress at work and demands upon their work that safeguarding is really the main work that is now being done.

Dr Adams: Unfortunately, we have a very fragmented picture of health visiting across the country. We probably have 152 local authorities with



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152 different models of health visiting. As you can imagine, that is having quite a significant impact on the range of service that is being delivered up and down the country.

It is really hard to know, but my hunch is, from our most recent survey, that possibly 20% to 25% are doing quite well, and Blackpool is even investing in health visiting, which is great, but quite a proportion have made very dramatic cuts to health visiting numbers. A lot of health visitors are telling us—obviously not all—that they feel as if their role has become trying to deliver the five mandated contacts and safeguarding, and if they did not have the five mandated contacts they probably would not be doing those at all, so it is really important that they are mandated. They are feeding back that the social care thresholds for safeguarding have gone up, so they are holding very vulnerable children for much longer.

Health visitors work within the Healthy Child programme. The Healthy Child programme is a unique and brilliant document. It is evidence based and a programme for all, for every child in this country. They obviously take varying amounts out of it depending on what their levels of need are. It is not being delivered any more for children.

There are contacts. We know, certainly from our figures and feedback, that probably only 50% of families are receiving the antenatal contact. We also know that there is a little bit of jiggery-pokery that goes on in how some of those contacts are delivered—for instance, sending families a letter that says, "Get in touch," so you can get the figures up. That worries us enormously because, at the antenatal contact in particular, normally a health visitor would spend about an hour with a family. We have heard a lot about the importance of relational activity. During that hour the health visitor forms a relationship with the family and she is able to delve into some of the things that you have already talked about this afternoon, such as, "What was your childhood like? What do you want for your parents?"

First of all you have to build the relationship and then you can touch on more difficult issues. She obviously gives a lot of information, and perhaps talks through breastfeeding, which may encourage mums to breastfeed who were not going to, and she talks about immunisation. If there is a bowl of cigarette butts there, she will talk about secondary smoking and so on. The skill of the health visitor is in that home visit and being able to pick up need. She will have quite an extensive conversation with the family through rambling over different topics, but each one is predetermined in its importance for the family. If you do not have that, you do not get off to a very good start.

We are also hearing that a lot of health visitors are not able to deliver continuity of care, so a different member of the team is going out to do each contact. They are sort of managing risk that way, but, from the family's point of view, you are not building a relationship. We know from



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midwifery just how important that relationship is, and it is just as important after the baby is born. It is just as important as with a teacher that you have that relationship. Things are very difficult but very fragmented.

Q155 Dr Cameron: If it is not the same health visitor, you are not going to make a connection with the person and you will be much less likely to let them know if you are having difficulties.

Dr Adams: You are not going to tell a stranger that you are a victim of domestic violence. You have to be able to build a relationship to get to the difficult things that health visitors work with. Something like that could affect anybody from any social strata.

Q156 Dr Cameron: We heard a bit about fathers not being involved in family appointments this morning. Is there anything in the way health visitors are working that you think we could try to do to make sure that fathers are included more at the early stages?

Dr Adams: I do not think health visitors would ever not want to include fathers. The difficulty is that fathers are at work usually.

Q157 Dr Cameron: Is it about scheduling appointments at different times? Is that a possibility?

Dr Adams: Possibly, and it happens sometimes. I have had colleagues who have run a child health clinic on a Saturday morning; they put themselves out to do that because it meant that fathers could come as well, and, yes, perhaps going into the evening. One area where fathers can be involved is in an antenatal parent-craft programme, when both the mother and father attend. That is incredibly helpful. But, again, they have obviously also been somewhat cut back recently.

Q158 Dr Cameron: More generally, how effective are children's services at identifying which children and families are in need of which levels of support that they should be getting at this early stage? That is a wider question.

Dr Adams: Shall I let somebody else have a turn?

Ailsa Swarbrick: Could you repeat the question?

Q159 Dr Cameron: How effective are children's services in identifying which children are in need of which levels of support—high levels or low levels of support—at a very early stage, so that children are not falling through the net and the support is tailored to their needs?

Ailsa Swarbrick: It is very difficult to know how successful they are at doing that, but we can assume that if there is a decline in universal services, and if the concept of proportionate universalism is not being fully delivered, children are not being identified as early as they might be.

Gill Walton: I want first to support what Cheryl just said about the impact of health visitors and providing very basic services. It is a unique



opportunity when women are having babies, particularly their first baby, because women come to see midwives and quite often it is the first time in their lives when they have had sustained contact with a health professional. There are loads of opportunities then for the midwife, particularly the named midwife, in the continuity of care you are talking about, to really support women, get underneath some of the issues, refer women appropriately to child services or social services and provide support, so that there is longer-term health gain.

The midwife works hard with women and families antenatally. We have really engaged support antenatally. Postnatally, it drops off. After they have had the baby, quite often that is when all of that good work drops off, and then the referrals to health visiting, GPs, social services and mental health start becoming chaotic. The opportunity that has been created in the antenatal period becomes lost.

There is definitely an issue, which Cheryll has talked about already, with the number of families that are very vulnerable and potentially will have children who need extra support after they are born. The antenatal contact that midwives and health visitors had with women and families was brilliant. Where it has worked well, families have been identified that previously would not have been, and the multi-professional team put in a plan of support that lasts in the antenatal period, the postnatal period and longer, as the child grows. That actually makes a difference, but without the people in place only the basic support is happening.

Dr Lang: To build a little on what Cheryll was saying about the five contacts in observing the parent-infant relationship and how that is developing, if in some of those contacts a physical visit is not happening, there is no opportunity to observe the child with their main caregiver. It might not be mum but a grandparent, a foster parent or whoever. Also, in midwifery and health visiting specifically, there is no core training in observing parent-infant relationships. They learn about early child development and interaction, but there is no routine training in understanding the parent-infant relationship and identifying problems.

Sometimes, specialist health visitors and specialist midwives might be additionally trained in that when local areas have identified a need and provided funding, so that programmes can be delivered by people like the IHV, but also just in primary and universal care. Although for our service, which is specialist, the main referrers are health visitors, across the piece it is quite patchy in terms of professionals being able to identify when there might be a problem. It is about identifying families at risk as much as families where there is already an established problem, and trying to intervene early.

Q160 **Mr Bradshaw:** Dr Adams, you confirmed earlier what one of the witnesses in the first panel said, that health visitors are so stretched that they are just firefighting on safeguarding. You said that the thresholds had increased, meaning that they were holding more children.



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Dr Adams: Yes.

Q161 **Mr Bradshaw:** What does that mean?

Dr Adams: You see a child at risk of being hurt and you pick up the phone to social care. They have what is called a threshold as to what point they will take that child in terms of the danger the child is in. I am sorry it is a technical expression, but we talk about the threshold going up.

Q162 **Mr Bradshaw:** What do you mean by holding? Is a child not going into care who previously would have gone into care?

Dr Adams: No. Actually, the referral is not being accepted by social care, so it means that, instead of doing the upstream preventive work, health visitors are working with very vulnerable children. They have no problem with that in principle, but they are not social workers—they are health workers, and they should be doing upstream preventive work.

Q163 **Mr Bradshaw:** That is really important. I came across an instance in my own constituency just last Friday where, admittedly for an older child, they were trying to get the social worker to intervene, and they had terrible problems because the thresholds had gone up. The numbers of children being held in this way, as you say, and managed without being eligible for the proper referral, were growing all the time.

Dr Adams: Yes.

Q164 **Mr Bradshaw:** That is causing a problem at the same time as the number of health visitors is being cut.

Dr Adams: Yes. As you can imagine, those children are so vulnerable that they take an awful lot of time, so that heavy time is going into individuals.

Q165 **Mr Bradshaw:** Am I right in thinking that one reason that the number of health visitors is being cut is that the funding has been given to local government, and some local governments are spending the money on it but others are choosing not to?

Dr Adams: A lot of money has been taken out of the public health budget.

Q166 **Mr Bradshaw:** But, before, it came through health, didn't it? Has it always come through local government?

Dr Adams: No. It came through health before, so a lot of the money is coming out. I think it is going to be £800 million up to 2020.

Q167 **Mr Bradshaw:** It is partly as a result of the Lansley reforms, but then, on top of that, there is the cutting.

Dr Adams: Yes. There has been a big cut to local authority public health budgets, but it is also local decision making—how the money is spent, how different services are prioritised. I have come to realise that our



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babies—that is why you are all here—are our most vulnerable; they are our future, so can we actually leave that decision to 152 organisations? We need to protect them much higher up, nationally, as we once did.

Q168 Mr Bradshaw: You want to increase the number of mandated visits, but is that sensible or realistic given that we have also heard that children are not getting the number of mandated visits that they are supposed to be getting already?

Dr Adams: We obviously want to increase the number of health visitors as well.

Q169 Mr Bradshaw: How many more do we need?

Dr Adams: It is difficult. The more you have, the better the job you do. It is as simple as that really. The outcomes will be titrated against the numbers. If you have a small caseload, you can spend time with people. If you have a big caseload, you cannot. If you have a small caseload, you can find need and do something about it. The health visitor is at the hub of a wheel. She works with all the other services, so it is really important that you have a good voluntary sector, good speech and language and so on, to refer on to. It is not just about health visitors.

Q170 Mr Bradshaw: But you think that the Government legislating and mandating stuff is important, and it works.

Dr Adams: We know that, if they had not, there were some local authorities—maybe even before the public health budget was cut—who did not value the health visiting contribution and were going to cut it and spend that money elsewhere. That is a minority. It may even only have been one, but it was certainly something we were hearing about.

Q171 Mr Bradshaw: Leading on from that and broadening the conversation, are there any other things in the first 1,000 days that you would like to see mandated that currently are not, and that we could recommend should be?

Gill Walton: One of the things is the opportunity in the early postnatal period for a multi-professional team—health visitors, GP, maybe mental health and social care—to work with families to plan their ongoing support. At the moment, that process is quite linear: the midwife ends; the health visitor starts, if they are lucky; there is some sort of referral to a GP, which may or may not happen; and there are other services that may or may not be involved. Women, especially if they are vulnerable, can absolutely lose any contact with people who can help them plan a healthy future for them, their family and child. If there is something to be mandated, it is how we make sure that, after they have had their babies, women and their families have a multi-professional team working with them to plan longer-term support, depending on their needs.

Ailsa Swarbrick: I absolutely support the mandation of the health visitor checks and investigating whether it should be continued, but it is about



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national Government action as much as mandation. There is a case for the very clear, long-term, cross-sectoral funding that the previous panel talked about.

It is critically important that we have a good data system, which again was referred to before, so that people know what is actually happening with the money that is being spent and with what may be mandated, and that decisions about what is mandated are based on very good evidence. Then there is something about workforce training, not just for the clinicians who may be at the forefront of the delivery of some of the interventions, but for those who may support them in a kind of mixed economy. There is a very strong case for concerted Government action, in some cases possibly mandation, but I think it is broader than that.

Q172 **Mr Bradshaw:** Beckie, is there anything you would like to add?

Dr Lang: To build on that, although it replicates it slightly, it would be mandation around services working together at national and local level. It was mentioned in the previous session. We have talked a lot about local authority and public health, but it is also about NHS systems and CCGs in terms of mental health elements. Where is the accountability? For example, CAMHS are commissioned to provide services for nought to 18, yet very few deliver anything under the age of five. There is an opportunity there.

We are working with some CCGs that are looking at the development of their under-five service, and especially their nought to two service, and what a specialist service might look like, but within the context of the whole system, how the services link up and connect. Data sharing, which was picked up earlier, is a real barrier to families getting the support they need and agencies being able to communicate with each other in an efficient and timely way. As has been talked about already, it is national and local strategy around co-ordination.

Q173 **Mr Bradshaw:** Going back to the threshold issue, because I think it is really important and I do not fully understand it, I am afraid, if local authorities are raising the thresholds constantly, putting more pressure on your members and on schools, can they just do that infinitely? Are there no statutory levels at which local authorities have to intervene? Can a threshold just be meaningless under law?

Dr Adams: I am sorry, but I am not close enough to local authorities to be able to answer that question.

Q174 **Mr Bradshaw:** Is anyone on the panel close enough? Maybe we can find out from someone else.

Dr Adams: As I understand it, if the child is at risk of significant harm, then, yes, they should be intervening.

Q175 **Mr Bradshaw:** But, in theory, you could be ending up in a situation where nothing is happening until a child is in danger of significant harm,



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and the kind of problems we are storing up for ourselves as a society as a result of that are absolutely horrendous.

Dr Adams: That is the issue. It is about getting in early, isn't it? If you can see a child is at risk, you want to do something then.

Gill Walton: It is the preventive work. Midwives find the same issues; there is not enough support for families. Even when there is a problem identified antenatally, midwives are trying their best to support the family, but it ends up being a really serious problem after the baby is born because the preventive work cannot happen. It is about how you break that cycle.

Dr Adams: I am slightly worried that it is sounding as if we are beginning to knock local authorities. Local authorities have lost a lot of money in their budgets, and they are really struggling and doing their best with the circumstances they have.

Ailsa Swarbrick: Local authorities have statutory responsibilities, and, as I understand it—I think the Children's Commissioner report that was produced recently also supported this on spend—more and more, because of the decrease in budgets, they are tending to focus on delivering their statutory responsibilities, which is where we have the gap between prevention and early intervention, so it is kind of cure, not prevention.

Q176 **Martin Vickers:** Ben has covered some of the ground I wanted to go through. It is the link between local authorities and what should be mandatory and so on. Dr Adams, I think the figure you used was 152 variations on what are laid down as supposedly national guidelines.

We continually hear, and we heard it from the first panel as well, that people want national guidelines, or whatever, but they want local delivery. Local delivery usually means the local authority playing the lead role, but that becomes more and more difficult with all the various agencies involved. Do you genuinely think that local delivery is best, or should there be a mandatory across-the-board scheme that all local authorities would have to deliver in a certain way? It would be inspected and they would have to meet a standard level.

Dr Adams: We are three years in to health visiting moving to local authority commissioning. In that time, we have lost probably about one in four health visitors. Okay, that is because of budgetary cuts, but it is also because of local decision making. You have to forget the professionals and think about the children. Every child has the right to a good service wherever they live, and it should be a high-quality service.

We have the Healthy Child programme, which is an excellent document. Next year, it is 10 years old and I would like to propose that you might make a recommendation that it becomes the healthy family programme, because that would bring in fathers. It would also bring in what is going on around the child. What happens to the child, they have no control



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over, so it is actually about what is going on around them in their environment. You need always to think about the child in their environment.

We need to be looking at some form of joint, integrated commissioning between the NHS and local authorities. What health visitors are telling us is that 35% of them see a GP once a month, and all the others say they see a GP less often. I used to see a GP three times a day when I was in practice.

Q177 **Chair:** You are talking about joint commissioning taking place locally.

Dr Adams: Yes.

Q178 **Chair:** Would that be, as we heard from the previous panel, mandated joint commissioning or incentivised joint commissioning?

Dr Adams: Nationally probably, through the Healthy Child programme, or what should become the healthy family programme, and some national standards that it would have to be delivered against. There need to be some other checks and balances to make sure that wherever a child is living they have access to the same high-quality programme. Obviously, some children need a lot and some need a little, and that is determined locally.

Dr Lang: In terms of what happens at local level, I agree with Ben, and what was mentioned on the last panel: at the local level, there needs to be some autonomy about how things are co-ordinated and work. Certainly we find that with PIP services in some areas, it is the CCG that is delivering, pulling the different agencies together; in other areas it is the local authority; and in others it is the third sector.

It would be worth looking at some of the programmes that have been delivered through things like Better Start, where they are looking at systems-wide change, and how that is working and implemented, and what are the barriers and opportunities within that. There are also things like MABIM—the Mums and Babies in Mind project—which in various areas are pulling the right agencies together around perinatal and infant mental health. There are programmes going on that we can learn from about how much mandation there needs to be from the top level, and how much can be left for local areas to develop and find out which might be right for their area depending on population need. There is probably some learning there.

Ailsa Swarbrick: I would endorse that. As I said before, national action, national vision and national funding in some areas is important to set the framework, but if you want to make things happen on the ground, it is important that you engage local decision makers who know their own communities and their own priorities, and who have relationships with others on the ground as well. They can think about how these things are going to be delivered in what is—I do not mean now—always inevitably quite a messy real world where things do not work and systems might



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make things difficult, or where they make things really productive. It is critical to think about how local systems can work, and what their local accountabilities and responsibilities can be. Things like the model of integrated care systems are useful to look at as we think about how to make the first 1,000 days services work in practice.

Gill Walton: In the maternity transformation programme, there is a model called hubs and spokes; it starts antenatally with opportunities for women to access a midwife in a centre, which could be a children's centre or a maternity centre, where there are other services. It is particularly useful if families are vulnerable in some way because they get used to the people in the centre, and are more likely to access the services after the baby is born.

Unfortunately, the number of children's centres in the country has diminished, by about 1,000; again, they are mainly local authority centres. Where that was starting to work, and I have certainly had experience very recently of that model, we were finally getting multi-professional teams supporting vulnerable families well in a hub. Once it closes, everybody is back to antenatal care in a cupboard in a GP surgery, never seeing the health visitor, with women never knowing where they are going for their next bit of care. It becomes so disjointed that the benefit has really been lost.

Q179 **Martin Vickers:** I have one final point. Would it be fair to say that you would not want too much tampering with the present structure, with local authorities and the NHS, CCGs and so on? It can be made to work without tampering with the structure.

Gill Walton: I am not sure. I don't think we are saying that.

Ailsa Swarbrick: One of the most important things is about political will, relationships and funding. My personal view is that structures are important, but you can make things work if you have a permissive environment in which there is space to do things.

Q180 **Martin Vickers:** Is that a universal view?

Gill Walton: Yes.

Q181 **Chair:** You mentioned integrated care systems, Ailsa, as a possible way of getting the collaboration that is required. Are integrated care systems working on the right scale in their closeness to neighbourhoods for this kind of work and on the right timescales?

Ailsa Swarbrick: I do not know enough to say categorically whether or not that is the case, but from what I understand there is a model for bringing local stakeholders and local funders together to find workarounds and ways of delivering within what sounds like a more permissive environment.

Q182 **Chair:** Do you think health and wellbeing boards are the right place for



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that to sit?

Ailsa Swarbrick: They could be. As I said before, it is less about structures, and more about will and the environment in which people are working and the priorities that are being set both locally and nationally.

Chair: Thank you. We are going to stay on universal services before we move on to learning a bit more about some of the targeted services.

Q183 **Diana Johnson:** I want to ask what might seem to be a controversial question. It is about the use of people who are not health visitors and perhaps have a different skill mix. How useful could they be in ensuring that families receive all the visits that you would like to see them receive? Would anyone like to pick that up? Why does it have to be a health visitor?

Dr Adams: Health visitors have worked with a skill-mix team for many years. Nursery nurses in particular, who have quite a high level of training in child development and working with families, are really useful members of that team.

It needs to be a health visitor—it does not need to be solely a health visitor—because health visitors have very high-level skills of assessment. Unless you do those assessments, you do not know what the need is. If you think about an iceberg, conspicuous need is the tip of the iceberg; the rest of the need is buried—it has to be found. Their training is not appropriate to ask lower-grade workers in the teams to look for that need.

It is the health visitor's role to find the need and then determine what support the family needs. It could be the nursery nurse coming in and supporting the mother around attachment with her baby, or it could be referral to a Home-Start service or speech and language or whatever. What the health visitor offers is high-level skill in assessment. They also need to be able to build a relationship over time, to get under the skin of some of the difficult issues that we have talked about—mental health issues, substance abuse, safeguarding and domestic violence. It is not either/or; I think it is both. It certainly is not one instead of the other, because you would miss so much that way.

Q184 **Diana Johnson:** The health visitors have a triage approach to what the issues are.

Dr Adams: Yes, high-level triage.

Q185 **Diana Johnson:** Then you can bring in other people with different skills who might be best suited.

Dr Adams: We do.

Q186 **Diana Johnson:** You do that already.

Dr Adams: We do it already, yes. Health visitors are trained in high-level interventions; for instance, around perinatal mental health they might



offer cognitive behavioural therapy or non-directive therapy over a period of time with a mother, if they have time. There is other high-level training that they can use, such as video interactive guidance, when a mother is not connecting with the baby very well, but, generally, they do not have time to do that, so they refer on to others who have the time.

Q187 **Diana Johnson:** But the five visits are supposed to be by health visitors.

Dr Adams: They should be by health visitors. We have heard that currently—we have just completed a survey—65% of parents are not formally seeing a health visitor after their baby is aged six to eight weeks, which is worrying.

Q188 **Diana Johnson:** Are they seeing anybody?

Dr Adams: They see a nursery nurse or a staff nurse at eight months, and again at two and a half, but they are not actually seeing a trained health visitor after that. If you are thinking about looking for need, some of all the needs I have just mentioned might be picked up, but the developmental checks will be task-orientated; they will not be a holistic assessment of need, which is what the health visitor does.

Chair: We are going to talk a bit more about targeted services.

Q189 **Andrew Selous:** Indeed. My question is directed to Ailsa and Beckie, if I may. I am trying to get a feel of the scope of your organisations geographically. If I understand correctly, the Family Nurse Partnership is in 130 local authorities. Is that right?

Ailsa Swarbrick: No. At its peak it was in 132 local authorities, in 2016, and now it is down to, I think, 77.

Q190 **Andrew Selous:** It is quite a decline.

Ailsa Swarbrick: It has been a decline, but it is still in around half of all local authorities.

Q191 **Andrew Selous:** What about the Parent Infant Partnership? What is the geographic spread?

Dr Lang: We have eight in England that are through PIP, but there are other specialist infant mental health teams that come through the statutory services. There are about eight specific teams that we are aware of. In some areas, you might get a parent-infant therapist, whether it is a psychologist or psychotherapist, who works within a perinatal team, but there are very few specialist teams.

Q192 **Andrew Selous:** Are there other people doing the same work as PIP?

Dr Lang: It is similar, yes. It is the same thing, but they are just funded in different ways; that is all. The work is similar.

Q193 **Andrew Selous:** Did you say that some of them were statutory? You are a national charity.



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Dr Lang: Yes.

Q194 **Andrew Selous:** Who is doing this work statutorily?

Dr Lang: The CCGs. Some of them are funded through CAMHS and some partly through perinatal. The PIP ones are usually a combination of local authority and third sector, and we have one that is CCG. It depends on the local authority, because there is no national model as there is for health visiting or whatever.

Q195 **Andrew Selous:** I know the issue within mental health is getting enough staff, but there is quite a lot of additional funding heading towards mental health. Is there the expectation that the statutory services that mirror what you do will increase?

Dr Lang: We have an opportunity to really look at what CAMHS are delivering as part of their nought to 18 service and whether there are any doing nought to 2 work. At PIP, we are about to start doing some mapping work of what exists out there already, because that is not collected nationally, to find out where services are being delivered and by whom, and to demonstrate where CAMHS are being held to account. They are being given the funding, but we know that it is being shifted into the older age groups, and that is more expensive when you are treating. Actually, we might well save money if we invested in a bit more preventive work earlier on.

Q196 **Chair:** It is intuitive that investing earlier makes a difference in reducing mental health problems in older children. Is there a strong evidence base around that?

Dr Lang: There is evidence to show that intervention early on can prevent mental and physical health conditions. The long-term evidence on specific interventions is not there yet. That is still a building evidence base. I know you had the Early Intervention Foundation in last week talking about some of that, and, yes, we know that is there. We know the economic benefits of intervening in the early years too. At the moment, understandably, CAMHS are firefighting in the older age group.

Q197 **Andrew Selous:** When I think of CAMHS and some of the work they do, I do not naturally think of them doing the relationship support work that you do. Would you ever worry that that work would not be done?

Dr Lang: No. It is more about where the funding is coming from. The work can still be delivered within a community setting as it is now, through children's centres where they still exist, and through other community hubs, as the rest of the panel talked about, where other services for families are co-located. That is really important because, certainly in PIPs, therapists work very much with all the different agencies involved with families.

It is about where the funding comes from, and there being a level of accountability, measurement and metric around how families are being



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seen, in what way, and what benefits are being delivered as part of the pathway of care. It is looking at the structures. That was one of the things we were talking about earlier; it is not just local authorities that work in this space. There are CCGs working in this space, and we need better understanding of what that looks like and how it can be developed.

We have one PIP where there is a pooling of funds between the local authority and the CCG to deliver the service. They know it is working well in a local area, but it is about them putting their heads together and asking how they can fund the therapists.

Q198 Andrew Selous: It is a very confused picture, isn't it? Your services are working in some local authorities and not others. In some places, you say the local authority is taking the lead, and in others it is the clinical commissioning group. I am trying to think of an organogram and it is quite complicated—the question of who is in charge and who is monitoring outcomes.

Dr Lang: That is where national leadership and a pathway of care is really important in looking at what can be delivered universally, targeted and into specialists, what we do in other areas of health and who delivers what and where. We have seen health visiting move from NHS to local authorities. We are talking specifically about the parent-infant relationship and what we call infant mental health, the social and emotional development of infants.

It is looking at where that might be best located, or rather how it is funded and located. That is where it comes down to local areas being able to think about what else is within their local structures, what other services are provided and how they link up. From a funding point of view, there is potentially already a channel; it is just about making sure that the money is getting to where it ought to be.

Q199 Andrew Selous: Coming back to you, Cheryll, if I may, I was very taken and enthusiastic, if I may say so, about your suggestion of moving towards a healthy family programme when we review the now 10-year-old Healthy Child programme. Do you think there would be an opportunity for the Government to review the coverage, review who is doing what and how it is joined up as we move to a whole-family approach?

Dr Adams: I do. The evidence base has increased enormously over the last 10 years. The Healthy Child programme is still pretty robust, but we could make it more so. There is an awful lot of work that Public Health England is doing along pathways, looking at different areas of child health, whether it is good nutrition or oral health and so on, and I think that could be built in very helpfully. I am not sure how aware of the Healthy Child programme parents are any more. I do not think anybody wants to promote it because they know they cannot deliver it.

Q200 Andrew Selous: Who is the guardian of the Healthy Child programme at



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the moment?

Dr Adams: I think it is Public Health England.

Q201 **Andrew Selous:** You think it is Public Health England.

Dr Adams: It is Public Health England.

Q202 **Andrew Selous:** That is devolved to local authorities, so is it really directors of public health locally?

Dr Adams: Yes. Directors of public health would be responsible for the local delivery. What has happened with the mandation is that five key contacts have been picked out of the Healthy Child programme. We felt that a really important one was missing. We think there should be more still. We have a six to eight-week contact and then another at eight months to a year, but actually three to four months is an optimal time for picking up mental health issues. It is also just before parents start to wean their children, and we start talking about solid food, and the baby is starting to move around so it is more prone to accidents.

Q203 **Andrew Selous:** What, in your view, would a good healthy family programme look like? How would it be different? How would it be added to from what we have at the moment?

Dr Adams: It would have more pathways in it.

Q204 **Andrew Selous:** What do you mean by that?

Dr Adams: By pathways, I mean looking at particular topics, as I just outlined—oral health, nutrition or whatever. The way it is laid out at the moment is that it is universal, and universal plus for families who are very vulnerable, with expectations of what they would each need. The emphasis could be changed around the family, and supporting the family within thinking about the outcomes for the child.

The other thing that is happening next year is the publication of "Health for All Children 5," which is a child-health promotion almanac that is coming up to 30 years old. It was due a refresh, so that is coming out. It has very much looked at the evidence base. Putting the two together could produce a really helpful document. Some of the work, such as the work that Beckie is leading, we were not doing in the same way 10 years ago. There is a lot that could go in and be refreshed, and, hopefully, it would deliver better outcomes. There would be something that was national rather than a lot of different local decision making.

Q205 **Andrew Selous:** Gill, earlier, you made the point particularly well that the midwife was perhaps the first health professional that a woman has regular contact with, and builds a bit of a relationship and trust with, so presumably you would see midwives being quite central to this.

Gill Walton: Absolutely. I like the idea of a healthy family programme. Midwives talk about women and families. Quite often, grandparents and dads come to antenatal appointments and antenatal opportunities. Let's



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not lose that, because we can influence the wider health issues of the whole family and support the whole family during pregnancy and birth. Why can't that continue?

I mentioned earlier the gap after the baby is born. Some of that is linked to a resource issue. Midwives have to provide safe care. If there are not enough midwives, they look after women in labour and then they stop providing family support postnatally. We have to pull whole-family support together, right from the antenatal programme through into postnatal care and into the wider multi-professional team.

Andrew Selous: Excellent. Thank you very much.

Q206 **Chair:** To focus on the FNP for a minute, does the Family Nurse Partnership work?

Ailsa Swarbrick: I believe it does, yes. The evidence suggests on the whole that it works. First, it is based on theory, so it is based on some of the theories we have talked about today—attachment theory, human ecology theory and self-efficacy theory—so it has a very strong theoretical base. It has had over 40 years of rigorous evaluation, including RCTs in the States, the Netherlands and England, and other evaluation as well. I do not know if you are thinking about that; the English RCT showed that the FNP did not achieve the primary objective it was measured against, but it did achieve some important secondary objectives, including around child development, relationships within the family and those kinds of things. We have been doing an intensive programme of work to build on what we now know from that evidence to try to improve some of the other outcomes, and using the data that we collected to do that.

We have also been looking in much more detail at how we can target the programme even more tightly, so that it is more likely to improve outcomes for those who need it most. I think, on balance, we can say that it works. The EIF have included it in their handbook as one of their recommended programmes. It is really important, though, that it is targeted very well, so that there is good value for money, basically. One of the reasons that we want to be able to disseminate more of the learning from FNP is so that that value can be dispersed across the system.

Q207 **Chair:** It is interesting that you think it perhaps should be targeted more, because, of course, it is targeted very specifically at first-time mums who are under the age of 20 in areas of highest deprivation. What do you say to local authorities looking to widen their offer to people who are vulnerable? Are they right to move away from FNP and develop more bespoke services?

Ailsa Swarbrick: We are already testing offering the programme to non-teenagers, as part of the changes we have been making. We are trying to make it much more flexible and responsive to local needs and



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local priorities. We will continue with that programme of work. It is really important to do it in a careful, evidence-based way because we do not just want to throw the baby out with the bathwater, I suppose.

We are also doing a lot of work to focus the content of the programme on the mother's needs, so that it is located well within the environment it is working in. There is a lot of work to involve FNP clients in sharing assessments of their own readiness for change, their own behaviour change, and to help to plan their care.

We are doing a lot to make it more flexible. However, there are other vulnerable groups who may not be getting the kind of support that they need. That is why the proportionate universal approach we talked about earlier is really important, with universal services, a range of different targeted services, depending on the needs of individuals and families, and then highly specialised services.

Q208 Chair: I once spent an afternoon with an FNP practitioner and I found it inspirational. I came away thinking: why is this not happening at a much larger scale in many more places? Why shouldn't it be mandated? Why shouldn't it be something that every local authority offers?

Ailsa Swarbrick: Personally, I think every local authority should have the opportunity to have it. I know, though, that sometimes local authorities choose to arrange their services in different ways, so I would not want to impose a programme on a local authority that did not want it. I think if more people knew about the benefits of FNP, and knew about the changes that we are making to the programme, and had the resources to commission it, and if we were able to engage in a conversation about how it could be targeted well in their area, it would be spread much more widely than it is.

Q209 Chair: Thank you. We have to finish in about five minutes and there is not going to be a vote, just in case people are still on the edge of their seat about that one.

We will finish by asking a very broad question. There is a cross-departmental ministerial review taking place. We, as a Committee, want to inform that review, look at what the review is recommending and hold them to account. What would you like the Leadsom review to focus on? It is a final question to catch anything you have not had the chance to say.

Dr Lang: For me, it is having national leadership around this, with a Minister or a Department that has babies as part of their remit—or it might be nought to five, as some have said—and they are really checking that there is a pathway for the importance of the universal services in supporting all families and identifying those who need targeted specialist interventions. You cannot have one without the others. They all have a role to play and they are all equally important, but there needs to be some national guidance around what that might look like and for support at local delivery.



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Importantly, it should look at the systems-wide change locally that is needed to be able to deliver this effectively for families, so that they are not being shunted here, there and everywhere, not knowing who is coming to see them next. We should make sure that money is spent effectively and well on preventing things before they happen, so that we are not seeing things like behavioural difficulties and lack of school readiness and mental health difficulties further down the line. That would be my answer.

Q210 **Chair:** I am hearing a need for national leadership.

Dr Lang: Yes.

Q211 **Chair:** Potentially, a Minister for early years or someone with overall responsibilities.

Dr Lang: Yes.

Q212 **Chair:** I am hearing national guidance as well.

Dr Lang: Yes.

Q213 **Chair:** But you want a better structure locally for co-ordination, and potentially some targets that every area is working towards.

Dr Lang: Absolutely, so that we can see what is happening, and, as was mentioned, long-term funding; we cannot have this tied up in Government cycles. It is just not long enough.

Q214 **Chair:** A combination of shorter-term targets and longer-term targets, because some of the benefits of this approach—

Dr Lang: Are further down the line.

Q215 **Chair:** They are felt 20, 30 or maybe even 60 years later.

Dr Lang: Yes, they are intergenerational.

Gill Walton: You cannot start with nought to five. You have to start pre-birth.

Dr Lang: Nought is pre-birth. We start in pregnancy.

Gill Walton: It is really important to get the opportunities embedded for influencing the family antenatally, and that that opportunity and the huge inroads that are made in supporting women and families to think differently about their health, their mental health, and to reach out and get the right opportunities, do not end as soon as the baby is born.

It is important that there is some way of creating local and national leadership for us all, so that all the services are working together to make sure that it is easy for women and families to access ongoing support once the baby is born, and that they are not dotted all over the city getting their smoking cessation support, their mental health support,



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their health visiting support and the midwife preconception care for the next baby. It has to be as easy as possible for them to access.

Q216 **Chair:** Because at the moment it is complex and difficult.

Gill Walton: It is all over the place. We do not even understand it, let alone women who have just had babies.

Ailsa Swarbrick: I would echo everything that has been said about national leadership, good co-ordination, long-term funding that goes beyond the political cycle and allows space to invest in prevention. There is something about Government taking the financial risk, because prevention and early intervention can be seen as risky for local authorities or other local agencies, and I think that can be a legitimate role for Government if they are thinking very long term.

I mentioned evidence before, and I think I want to balance that. There should be investment in thinking about what is valuable evidence, and what different forms of evidence there might be in this space, given the need for thinking long term and given that we are dealing with very complex systems where it is not always easy to attribute direct cause and effect. At the same time, as part of that, there is something about relationships as well. We have all talked about relationships and continuity of care, and who should be delivering what practice. A taskforce might helpfully look more closely at the value of relationships. We all know that they are really important.

Q217 **Chair:** It is not just a series of transactions; it is much more relational.

Ailsa Swarbrick: Yes. What is it in the relationship that makes the interaction work or that helps to make the intervention work? We talk a lot about evidence in terms of targets and delivery, but we should think more about what happens between people and how we can augment and develop that.

Dr Adams: I am not going to say anything very different; I do not think you will be surprised. I support everything that has been said.

We need to see a shift of money upstream, so instead of dealing with the problems we need to be preventing them from happening. Maybe that would take some courage. Scotland seems to be doing it: they are investing in 11 home visits, all by health visitors. They want Scotland to be the best place to grow up in.

There is something else that came up earlier in the afternoon that we have not really touched on, and that is about trying to change hearts and minds towards infants and pregnant ladies.

Q218 **Chair:** That is what Ben was talking about, the cultural change.

Dr Adams: There is something about the culture in this country, not at an individual level but somehow at a national level, and, if we could shift that, maybe society would be happier to see more money perhaps being



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shifted upstream. We know where money goes now and why it goes where it goes, but it probably does not need to take that much. If we could then build in the research processes around that, we could demonstrate the benefits, which I think we would do quite quickly, and the savings. I firmly believe that, otherwise I would not have been a health visitor for all these years.

Chair: Thank you, all four of you, for your insights and your guidance. We really appreciate you all coming today. That is the end of the session. Thank you. Thanks to the Committee members as well.