

Health and Social Care Committee

Oral evidence: First 1000 days of life, HC 1496

Monday 3 December 2018

Ordered by the House of Commons to be published on 3 December 2018.

[Watch the meeting](#)

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

Questions 219 - 326

Witnesses

I: Dr Catherine Calderwood, Chief Medical Officer, Scottish Government; Deirdre Webb, Lead Children's Nurse, Public Health Agency, Northern Ireland; Professor Charlotte McArdle, Chief Nursing Officer, Department of Health, Northern Ireland; Professor Jean White, Chief Nursing Officer, Welsh Government; and Karen Cornish, Deputy Director Children and Families Division, Communities and Tackling Poverty Department, Welsh Government.

II: Professor Viv Bennett, Chief Nurse and Director of Maternity and Early Years Public Health England; and Dr Helen Duncan, Programme Director, National Child and Maternal Health Intelligence Network, Public Health England.

Written evidence from witnesses:

- [Public Health England](#)
- [Public Health England – supplementary evidence](#)



Examination of witnesses

Witnesses: Dr Calderwood, Deirdre Webb, Professor McArdle, Professor White and Karen Cornish.

Q219 **Chair:** Welcome. Thank you very much for joining us. I know that some people have travelled a long way to be here today. My name is Paul Williams. I am chairing this inquiry into the first 1,000 days of life.

This is a bit of an extraordinary day in Parliament, with statements taking place at the moment. If you see Members coming and going in the course of the next 50 minutes or so, please understand that they have other commitments that they have to attend to. We are expecting others to come in as well.

Will you, first, introduce yourselves and tell us what you do, and then we will have some questions to understand how Northern Ireland, Wales and Scotland have managed to prioritise the first 1,000 days of life?

Karen Cornish: I am head of children, families and early years in the Welsh Government.

Professor White: I am the chief nursing officer for the Welsh Government and nurse director of NHS Wales.

Dr Calderwood: I am the chief medical officer in Scotland. I am also a practising obstetrician and the only chief medical officer who still sees patients.

Deirdre Webb: I am the lead children's nurse for the Public Health Agency

Professor McArdle: I am the chief nursing officer for Northern Ireland.

Q220 **Chair:** You are very welcome. May I start with you, Charlotte? How do you manage to prioritise the first 1,000 days of life in Northern Ireland?

Professor McArdle: From a Government perspective at the highest level we have a draft programme for Government that, because of our position with the Executive, has never been published, but we do have an implementation plan that I think takes a similar approach to our colleagues in Scotland. It is an outcomes-based accountability model where outcomes are set at a high level.

One of the outcomes is that we give every child the best start in life, on which the Department for Education lead, which is key in health officials being involved in partnership working with education and other Departments.

Health leads on ensuring that everybody lives a long, healthy and active life, and that starts from pre-conception through early years and into adulthood.



I have a specific indicator about ensuring people have a good experience of public services, in particular health services.

We have taken those high-level outcomes and, through the development of process indicators, worked through co-production with communities, voluntary community groups, local populations and health providers to develop indicators that help us to put in place the measures that will deliver those outcomes.

Q221 Chair: Are those process indicators national ones, or are they different for each local area?

Professor McArdle: They are Northern Ireland indicators and stretch right across all Government Departments. Within health, we have specific ones in relation to healthy birth weight and the family nurse partnership. There are other ones.

Deirdre Webb: Breastfeeding.

Professor McArdle: Yes. We focus on a small number of indicators on which we think we can make progress. Supporting that are other policy directives—for example, the early intervention transformation programme, which is jointly funded work across six Government Departments, Atlantic Philanthropies and the delivering social change fund. There is a £30 million investment in that. It has four work streams: getting ready for baby; getting ready for toddler; there is one around older children who are on the cusp of going into care; and the fourth we have added more recently is around the whole ACEs work piece.

In addition, we have a children and young people's plan, which requires everyone who delivers services to children, regardless of the sector, to work together in an integrated and joined-up way so that services for children are commissioned across the whole of Northern Ireland.

Q222 Chair: I am hearing that there is a national plan with national indicators and that there has been some co-production to look at process indicators. There is an outcomes framework and process indicators. Lots of different Government Departments are all chipping in to fund the plan, and quite a lot of programmes to deliver the plan.

Professor McArdle: Yes.

Chair: Is there anything else from Northern Ireland before we move on to Scotland?

Q223 Luciana Berger: May I press you a little further on how all the different Government Departments are held to account? Each Department has indicators. How is that brought together? What is the co-ordination?

Professor McArdle: In theory, it would be the Executive Office—the Office of the First Minister and Deputy First Minister and Executive Ministers through the Assembly—but those arrangements are not working at the moment. The Executive Office holds each Department to account



HOUSE OF COMMONS

through the permanent secretary and lead officials. We report using a score card once a quarter and have meetings with the head of the civil service in the absence of Ministers.

Q224 **Luciana Berger:** How often do you do that?

Professor McArdle: We have to make a return every quarter to the Executive Office through the permanent secretary.

Q225 **Luciana Berger:** What is your breastfeeding target?

Deirdre Webb: We have the lowest level of breastfeeding of the four nations, so it has always been a particularly challenging area. We have had small improvements year on year. We have 59% initiation, and there has been a 1% improvement over the past five years, so that is why we need to keep a very close eye on it.

Q226 **Luciana Berger:** Do you have a target?

Deirdre Webb: We would like to see it improve, but we do not set targets for that; it is very hard to achieve—as long as we are improving.

Q227 **Chair:** Have you introduced any legislation in Northern Ireland to support this, or is this done through leadership, strategy and programmes?

Professor McArdle: We have not had any legislation. We have some legislation with regard to children, but it is not specific to outcome measurements, and because we have had no Executive for two years we have had no legislative developments in that period. Therefore, we just have the draft delivery plan for Government.

Dr Calderwood: I was wondering what it would be useful for you to discuss. Before being CMO for Scotland I was the national clinical director for maternity and women's health for NHS England, so I know your system quite well.

Q228 **Chair:** What is the difference?

Dr Calderwood: How long have we got? My population is about a tenth of yours. Geographically, we have about half the land mass and challenging geography with highland communities. In Scotland, we have a Minister for children and early years, and within the Government and civil service structure a directorate for children and families is embedded between health and education. It sits physically in education, but it works very closely with me in health. Therefore, from the civil service point of view, children and families are very strongly represented in the Executive team of the Scottish Government.

Q229 **Chair:** Is the Minister for children and early years at cabinet level?

Dr Calderwood: No. There is a cabinet secretary for health; there is a Minister for public health; and then a Minister for children and early years below that.



HOUSE OF COMMONS

Q230 **Chair:** The Minister sits within health and the civil service lead sits within education.

Dr Calderwood: Between education and health; they are equally divided between education and health. That is very important in the work we are doing, which has been a journey. You may know about Scotland's patient safety programme, which has been going for a decade. That is very much a quality improvement programme; it sets very ambitious stretch aims and works towards those.

We set up a variety of aims. First, we had an early years collaborative, which started in 2012. That was a multi-agency function between education, health, the police, justice and social services. That has joined with our Raising Attainment for All education colleagues so that we now have a children and young persons improvement collaborative. That uses quality improvement methodology; it sets aims and targets and is funded by central Government.

We have improvement advisers throughout our health boards—the equivalent of your trusts—who are in posts paid to do the quality improvement work specifically for children and young people. That is multi-agency work and includes the third sector.

We have made some key improvements. One area, which we would expect obstetricians to be very keen on, is that we have reduced the stillbirth rate in Scotland by nearly 23% over a five-year period. It had been static for the previous 30 years. That has been done with quality improvement methodology. The neonatal death rate has improved by 17%. The aim of those was to improve it by 15%, so we have exceeded both.

We have the aim for children to have their records—their red books—completed. You will know about that. There is a very ambitious aim for over 90% of children to have all their developmental stages measured. We are not at 95%, but we will get there.

That methodology makes a big difference to a country of our size. Central Government are able to spread that across the whole country because of size.

Q231 **Chair:** But there is also quite a lot of local leadership in what you have described.

Dr Calderwood: Absolutely. We have also allowed people to take our overarching aims and use them locally. For example, in Tayside, surrounding Dundee, there was a real issue with regard to continuity of carers and allied health professionals. Parents were coming forward to say they had multiple carers of different sorts. They did a very nice piece of quality improvement work, which has had very good results. There are the same number of children to be seen and the same number of practitioners, so they have just aligned those. From the parents' point of view, in a very short time that has made a huge difference.



HOUSE OF COMMONS

We have allowed local adaptation, depending on what might be particularly appropriate because of geography, demographics or because of a particular problem.

Q232 **Chair:** Has more money being going in as well?

Dr Calderwood: Yes. We have invested very significant amounts of money in the quality improvement programmes. There has been a lot of money for mental health services in Scotland as a whole, but we have carved out a significant chunk for perinatal mental health.

Q233 **Chair:** Is that national rather than local money?

Dr Calderwood: Absolutely; it is national money.

Q234 **Chair:** Maybe the witnesses can answer the same questions for Wales. How have you prioritised it? What are the magic ingredients in Wales?

Professor White: I will ask Karen to give you the legislative journey, and I will talk about some of the work we are doing. We have given you a written note summarising all this, if the note-taker misses any of it.

Karen Cornish: It was interesting to hear what our Scottish colleague said about governance. We too have a Minister for children—the Minister for Children, Older People and Social Care. He oversees public health and social care, and the executive team, my division, sits within the education and public services group, but we work very closely with health, broader education colleagues and our social care colleagues in how we deliver our programmes.

In terms of the journey, children and the early years have been a priority since devolution. We adopted the UNCRC in 2004. We were the first nation to have a children's commissioner. We have always been looking at how we ensure that children in Wales have the very best start in life.

We have developed a number of programmes, looking initially at Sure Start and then building in Flying Start and the foundation phase, which is our early years education programme, and building from there.

As to legislation, we have a children's rights Measure, which puts a duty on Welsh Ministers to consider the rights of children in their decision making.

We developed an early years childcare plan for Wales, which for the first time in Wales defined what we decided were the early years—pre-birth to the age of seven. Of course, the first 1,000 days fits very much within that and is an integral part of it.

We have legislated for the wellbeing of future generations. That legislation requires public services and others to work together in a collaborative way to consider and protect the future generations of the Welsh nation in the decisions that we then take.



Q235 **Chair:** So at least two major bits of legislation underpin all this.

Karen Cornish: Absolutely.

From there, similar to others, we have a programme for Government. The strategic document for us is Prosperity for All, which sets early years as a key theme for cross-government working—not silos—particularly for health, but for education and others. From there, we have developed the Healthier Wales programme and are currently working together on trying to understand what an early years system would look like and the type of work we would need to take forward, both nationally and locally, to develop that system, which builds on the work of the first 1,000 days collaborative.

Professor White: Are there any questions on that before I continue?

Q236 **Chair:** Are there any other questions about what Karen Cornish has said?

Professor White: On the way we have delivered services in Wales, we have a programme that concentrates geographically on children living in the most deprived areas of Wales. The programme is called Flying Start, which is an enhanced service of support that goes from nought to seven. It launched in 2006 and targeted 18,000 children living in those areas. In the year 2014-15 it more than doubled, so it is just over 36,000 children.

We target those areas by a number of indicators that show they need particular attention.

For the rest of children living in non-Flying Start geographical areas, we have brought together the health visiting service and asked, “What do you think you can offer to improve care?” They helped us to write the Healthy Child Wales programme, which sets out a programme of contacts. It is very similar to the different parts of the UK.

The Healthy Child Wales programme, which the Flying Start service uses as the main framework of contact but with additions to it, starts in the antenatal period and goes up to the age of seven. It is a combination of health visitor engagement, GP physical checks, midwifery support and things like vaccinations, making sure they hit particular milestones, checking maternal mental health, and looking at family resilience.

There is a programme of things that we do throughout the period, but for those children living in the Flying Start areas we have additional contacts. For the non-Flying Start areas, there are about eight contacts with a health visitor, which are clinical in the home, and 15 in the Flying Start area, so it is significantly more.

Q237 **Chair:** Does it make a difference to the outcomes in the Flying Start areas?

Professor White: I will turn to my colleague if I get a little stuck. For the Flying Start programme, you have to take a very longitudinal look at impact. What we have been measuring—I suppose that is the right word



HOUSE OF COMMONS

for it—is to see whether the children in the Flying Start areas, which are the most deprived parts of Wales, are as school-ready as the general population. Our evidence suggests that they are. We have feedback from head teachers that tells us they can tell the children from the Flying Start areas because they are ready to learn; they are present and engaged.

That is the intelligence we are getting and is what we want to do, which is make sure they are not left behind. That is a big concern for us.

Q238 **Chair:** Your magic ingredients in Wales are a bit of legislation, and definitely some targeting of resources in areas of highest deprivation, but a national programme from nought to seven with real clarity, so there is a universal offer as well.

Professor White: Yes.

Q239 **Chair:** None of you has mentioned political leadership. Is that a necessary requirement?

Professor White: Absolutely; it is embedded in the way we do things.

Q240 **Chair:** Elected politicians have driven forward this agenda.

Dr Calderwood: And having a Minister dedicated to early years and the first 1,000 days beyond that is very important.

Q241 **Chair:** So the structure of government is quite important.

Dr Calderwood: Yes.

Chair: You will know that in England we have a Minister for children but the post is an Under-Secretary of State in the Department for Education, not with any formal links to the Department of Health and Social Care.

Q242 **Luciana Berger:** It was great to hear mention of ACEs. We are increasingly taking account of adverse childhood experiences. An all-party parliamentary group with an interest in this has been created, so we are keen to capture that within this inquiry.

In your respective areas what is your approach to preventing or mitigating the impact of adverse childhood experiences? To what extent do you consider it, and what are you doing about it?

Professor McArdle: It is a combination of things. The Safeguarding Board for Northern Ireland has taken responsibility for ACEs and understanding how they affect our children, what the impact is and how we target resources effectively, but it is difficult to talk about ACEs without talking about the universal health visiting service—for example, the family nurse partnership.

In addition to that, my social work colleagues have developed thinking and training for social workers around Signs of Safety, using an asset-based approach to help families be together and stay well for as long as possible with interventions, particularly for the most vulnerable.



HOUSE OF COMMONS

We have had quite good success with family nurse partnerships. I know that is not available across the four countries of the UK, but we have just done a re-evaluation that shows that it is helping to break the cycle of disadvantage. Where young women under 20 have a trajectory that is worked out for them based on their vulnerability factors and family circumstances, working with the family nurse helps them to break that cycle. We now have some good evidence around that.

It is early days for Signs of Safety in social work, but we are investing £2.2 million in training 2,500 social workers to work with families.

For ACEs, it is a collective approach with all the professions working together.

Another mechanism is family support hubs. There are 20-plus family support hubs in Northern Ireland. All the people involved come together in delivering care to children across the various sectors and flag up families and children in need, signposting them to the right service more quickly to prevent traumatic cases from happening.

Q243 Luciana Berger: When did it start? You said in your introduction that there were four streams of work with the extra funding. How far are you into the programme?

Professor McArdle: There are probably eight a year.

Deirdre Webb: It is the last to come on stream. We have just appointed five leads across the different sectors. That is very much to raise awareness of ACEs and trauma-informed care. We are still in the very early stages of it, but we are beginning to make plans to approach trauma-informed care.

Dr Calderwood: In Scotland, going back to the point about political leadership, the First Minister and Deputy First Minister—he is the Cabinet Secretary for Education—have taken ACEs as a priority and written it into Government programmes in Scotland for prevention and raising awareness, as well as supporting people. We also have a cross-sectoral approach with health, justice and the police. The aim in Scotland is to have several strands of awareness-raising. We are scoping out what a routine inquiry would look like. There is some controversy about whether that is the right thing to do in all circumstances. We are doing a piece of work there. We are also working with our deep-end GPs—the 100 GP practices in the most deprived parts of Scotland—to look at routine inquiry, building some of that into their primary care services. We are at the start of getting all of this embedded.

The national trauma-informed education support service is up and running across sectors in Scotland, so we have a cohort of healthcare and other workers trained to offer support.

We have a very successful family nurse partnership programme as well. It is available for all women under 20 in their first pregnancy, across all



HOUSE OF COMMONS

of Scotland's mainland health boards. I think that has been available for three or four years and is quite mature. As colleagues have said, we have found that that is breaking the cycle for some of these young women.

Karen Cornish: Tackling adversity in childhood is a key priority in Wales. Again, it is in our national strategy, Prosperity for All; it is a key theme. It sits under the early years, but it is not about early years necessarily. We understand that it is a life-course issue.

In Wales we are beginning to look at our own policies and programmes through an ACE lens. We are currently piloting an approach looking at Flying Start through that method, and we hope to have a toolkit that other policies and programmes can consider and use later next year once we have done it ourselves.

We have developed and support the ACE support hub, which sits within Public Health Wales. The Welsh Government fund it. They funded it last year; they have funded it this year, and they intend to fund it next year. The support hub is raising awareness and is looking at how we develop the workforce so it is ACE-informed and trauma-informed.

We also have a programme working with the police through the Early Action Together project, which is funded through the Home Office for a period of three years. That is looking at policing through a vulnerability and ACE-informed lens.

We have a routine ACE inquiry pilot taking place in north Wales, and we have just had agreement to roll that out further into three other areas to test that approach. As my colleague said, we need to check that this will be the right way of doing things. We will be piloting that approach, and learning from it over the next six months to a year will be important.

In terms of information that is available, Public Health Wales has published a number of research documents on adverse childhood experiences and their impact on long-term health conditions, GPs, policing and education. We are working with them to ensure that across all of those key services we have ACE-informed public service, ACE-informed teachers and other workforce who are able to understand and respond appropriately when children show signs of adverse childhood experiences.

Q244 **Luciana Berger:** Dr Calderwood, in your introduction you mentioned increased funding for perinatal mental health, which is a key factor in our inquiry on the first 1,000 days. I am keen to hear from the other contributors as well. Perhaps they can share with us in particular whether that increased investment is going towards what they are investing in and their national approach not only in promoting good perinatal mental health but attachment, which we are looking at.

Dr Calderwood: I think you have heard evidence from Alain Gregoire and the Maternal Mental Health Alliance. I know them very well. I do not



need to repeat how compelling that evidence is for both early intervention during pregnancy and the ongoing picking up of issues as early as possible in the child. They may have quoted to you the statistic I often use, which is that for mothers with postnatal depression a proportion of those children will go on to have their own mental health issues. If, however, we pick up and treat postnatal depression, a tiny fraction of those children go on to develop their own problems.

Therefore, there is an easy, straightforward and not costly intervention. We do not look for that aggressively. There is as much postnatal depression as there are problems with blood pressure in pregnancy, yet on every visit in the antenatal period we measure blood pressure. We have nothing like that routine inquiry about people's mental health in pregnancy, despite the knock-on effects.

We have taken all the evidence we can and that is, I suppose, the reasoning behind having a specific investment in perinatal mental health services. At the very extreme end of the spectrum, we have provision in Scotland for two mother-and-baby units, but it is the staff underneath that because you will know that it is a very much more prevalent, but less severe, problem in the majority of women. We are doing a lot of work to ensure that there are midwifery training and mental health liaison services to try to embed those routinely in the way we would embed other medical services in antenatal care and have liaison psychiatric services so we can detect women with problems early.

Q245 **Luciana Berger:** Does anyone want to add to that?

Deirdre Webb: I have just taken over the support portfolio of work. Last year we launched a report from our regulation and improvement authority looking at perinatal mental health services, which are not as well developed as we would like them to be. We have set up an inter-agency group to try to take forward the recommendations of the report.

For this year, we are concentrating very much on the training of staff. We have a menu of a wide range of different levels of training available, so hopefully we can improve, in the absence of perinatal mental health services, existing staff skills to cope with perinatal mental health issues.

We are absolutely committed to trying to bring this forward. We appreciate that we do not have services at the minute for young mothers, and we understand that mental health can influence childhood health and wellbeing.

Q246 **Luciana Berger:** What is the specific approach on attachment?

Deirdre Webb: That is another very important area. The secure attachment of an infant or child to one parent is key to the success of the approach. We have an infant mental health strategy, and we have been able to develop the skills of some of our psychologists and practitioners and advanced health visitor skills to offer a variety of interventions for



HOUSE OF COMMONS

attachment, such as video interactive guidance and specialist one-to-one work.

All our health visitors are trained in the Solihull approach. One third of our midwives are trained in that approach, so that helps with emotional containment and makes parents more emotionally available to their child, enabling them to have a close relationship with the child and, containing their issues, modelling good behaviour for the child.

Our approach has been to have universal training of all our staff and, behind that, to have more specific services that respond when there is a greater issue. We know that probably one third to a quarter of children will display disorganised emotional attachment, so we need both advanced skills and universal skills in that area.

Professor White: We have separated mental health, ill health and mental wellbeing. There is a great deal of similarity with what my colleagues have previously said. In the antenatal phase we have invested in perinatal mental health services, so that every health board now has a midwifery lead but has mental health expertise and can support women who are experiencing ill-health issues. I performance-manage maternity services in Wales, so we have been focusing very much on the long-term and enduring mental illness that some women will have—for example, bipolar disorder and schizophrenia—to make sure they have integrated care plans.

Our next approach will be to look at those suffering lower grade mental distress and to make sure they are being referred. In the postnatal period, we regularly have maternal mental health assessments. We also use something called the family resilience assessment tool, FRAT. That has been designed specifically by clinicians in Wales and the academic community. We use FRAT to look at family resilience. That looks at some of the social and environmental factors as well as relationships within families that will lead to distress and could lead to mental illness, but certainly affect mental wellbeing. FRAT is done at particular assessment markers as part of the Healthy Child Wales programme; it is done at 10 to 14 days, six months, 15 months, 27 months and three and a half years.

If at any of those points there is any concern, they can be referred to additional support. That additional support could be about helping somebody to live well; it could be more about parenting and housing support and so on. We have a referral mechanism that takes us into a local authority-led programme called Families First, so there is somewhere for the health visitors. If they find a family is getting into distress, what do you do about it? Having identified a need, you have to go somewhere to get support.

In addition to Flying Start, which is a very specific geographical area with lots of additional support within it, if a need is identified for those families outside it there are other support mechanisms for them to be referred to.



HOUSE OF COMMONS

It is not just one thing; it is often a combination of things that causes mental distress. I think we need to be clear about mental illness and mental wellbeing, and all of that has an effect on the child.

Q247 **Chair:** I am hearing quite a lot about national strategy, local involvement and maybe a few legislative changes. What is the role of the voluntary and community sector in achieving success in your countries? How integral are they to your recipe for getting this working at local level?

Karen Cornish: At local level, if you take Families First and Flying Start as two key programmes, some of the services will be delivered through the voluntary and community sectors. They will be commissioned maybe to deliver some of the family programmes, parenting support programmes and some of the wider programmes.

Q248 **Chair:** They are commissioned, but they are not leading it locally.

Karen Cornish: No. Funding for those programmes goes via the local authority.

Q249 **Chair:** The reason I ask the question is that we have been to Blackpool to explore a model where the voluntary and community sectors have been very much at the centre of programme delivery.

Karen Cornish: There are five Children First areas in Wales, which take a broader approach: third sector organisations, the local authority, health and others would be involved, beginning to think about how collectively they can respond to support children and young people within a particular geographical area.

Q250 **Chair:** Are they pilot areas?

Karen Cornish: They are the five pilot areas we are looking at currently.

Professor McArdle: They are integral to the provision of services at local level but also at national level, from our perspective anyway. There are organisations like VOYPIC, Barnardo's and even Sure Start, which have a key role to play in keeping children safe, providing service and using an early intervention approach. That is played out mainly through our strategy for health transformation, which is a 10-year plan, launched by the previous Minister in 2016. Local and community groups were at the forefront of that. Partnership working and co-production are the main thrust of how we are going to transform our system over 10 years. I think they are integral to it, and in Northern Ireland there are signs that they are working together effectively at both levels.

Q251 **Chair:** Do you want to say anything else?

Dr Calderwood: No. Collaboratives have the third sector embedded.

Chair: Rosie is going to ask about workforce and training.

Q252 **Rosie Cooper:** The question is posed in three parts. Who are the key professionals involved in delivering services in the first 1,000 days? Do



HOUSE OF COMMONS

you have enough of them? Is it the right skills mix? How do you ensure that they continue to have the appropriate skills, education and training? Obviously, it is all related to the first 1,000 days.

Professor White: For Wales, the key professionals in antenatal would be mainly midwives and obstetricians. We have a requirement for the midwifery establishment to be fixed against a workforce planning tool called Birthrate Plus. We have some vacancies, but we are able to fill them. We have been increasing training for midwifery practice for a number of years, and it is now at one of the highest levels in recent years.

We do not have a particular problem. A recent report by the Royal College of Midwives has shown that we have more midwives now working for us with a slightly younger age profile, so midwives are okay.

As for obstetricians, obviously sometimes you need medical intervention. Catherine, who is sitting next to me, is an obstetrician; it is very important to have people like her involved. We have some challenges with that workforce. We have vacancies at junior grade and consultant grade, and they have to be managed as a requirement across the whole system. That applies across Wales.

Post-delivery health visitors are key workers both for Flying Start and the generic health-visiting service. We have a set requirement for the workforce. In the Healthy Child Wales programme, it is set at a ratio of one health visitor to 250 children; in Flying Start, it is one health visitor to 110 children. To have that number of health visitors is quite a rich mix. Currently, we are exploring how we use better skill mixing within the team and between generic and Flying Start. In some cases it would be perfectly reasonable to have other members of the team undertaking such things. For example, we have nursery nurses helping with potty training and weaning; we will have breastfeeding support and that sort of thing.

We have increased the number of health visitors who have been trained over many years, and there is continued investment in them. I would not say that we are particularly facing a shortfall. We might not necessarily have them all in the right place. There are some vacancies in the system, but I do not think that is because we have a shortage of them, and skill mix will probably sort out some of the issues we have had. After that we have paediatricians. There is a long list of folk you can call in as and when you need to, but our core is there. Apart from some of our medical practitioners, I would not say it is a massive concern to us, but there are vacancies in some places. It might be useful to point out that we have some training standards for other workers associated with our early years workforce plan.

Karen Cornish: We have a 10-year early years workforce plan. Its importance is that we want to make sure we are building capacity and capability across the workforce, ensuring we are attracting high-quality



HOUSE OF COMMONS

new entrants into the sector and raising skills and standards across the early years workforce as a whole.

In terms of the key professionals, particularly at the start of the first 1,000 days, the health visitor and midwifery service with GPs is a critical aspect. However, when they come across issues where additional support is required, being able to draw on a wider multi-agency team—because not everything will be clinical or medicalised in terms of a situation that a particular family might be facing—whether that is within the Flying Start area or, in our case, drawing down on Families First support, which is a family approach team, is absolutely critical.

Q253 **Rosie Cooper:** That sounds really good. Does it work all the time? Do you have enough to be able to deliver that end-to-end service?

Karen Cornish: We would all like to have more.

Q254 **Rosie Cooper:** Is it enough?

Karen Cornish: I do not think that is a question we can necessarily answer because it is a political one, but, in terms of being able to support families that most need it at this moment, we would endeavour to ensure that that happened in every local area.

Dr Calderwood: I will keep it brief and maybe focus on the differences, as I understand them, between Scotland and England. As for key staff, I will start with midwives. We have had a maternity services review called Best Start, and our aim is to have 100% of women with continuity of carer throughout their pregnancy—one primary midwife and one buddy midwife for the antenatal and postnatal period, and then either the primary midwife or a member of her team during labour. You would expect and know the person even during labour and would have met them before.

By 2021 we aim to have 75% of women covered in that way and eventually for all to be covered. I think that for Better Births it is a 20% continuity of carer-type model.

We have good midwifery numbers. This is a big change in how our model of care will need to be rolled out. There are obvious challenges with that. We have four early adopter health boards in Scotland, which are starting to look at how this will work practically. Of all the evidence there is about caring models, I think antenatal midwifery continuity of care is far and away the strongest. You can reduce pre-term delivery and low birth weight; you can increase the number of women who successively give up smoking and those who end up with less weight gain, including intra-pregnancy weight gain. There is very strong evidence that that can happen. The model we are aiming for has very good outcomes, but we are not there yet.

Rosie Cooper: What is the difference in cost between a team that is run like that and the ordinary service delivery model?



Dr Calderwood: In theory, there are the same number of women to be seen the same number of times, so there should not be an increase in the number of staff required. There is some thought that it is more efficient because, if you know the woman, you do not have to go over everything again each time, so your appointments are potentially shorter, and because you have a personal relationship some of it may be over the telephone. There are some economies in that, but we would be planning to deliver that without increased numbers of midwives.

Q255 **Rosie Cooper:** Let me declare an interest. I used to be chair of Liverpool Women's Hospital. In the days of the Cumberlege review we designed a system where a mother would meet the primary midwife, but a team of nine would be guaranteed to look after you. Every one of those units cost me £1 million more than the same system. I am interested to see how much extra it costs. I accept the value, because that was why we did it. There is a cost to it as well as economies, as you would describe them, but I would be very interested to see the business case for that model.

Dr Calderwood: I can certainly get you some written information on that.

The second group of staff would be health visitors. We have had a review of our health-visiting framework. We have 11 visits in the early years from health visitors. We are calling them core home visits rather than health visits. Of those 11 visits, three are assessments of the whole family. We have had to increase our health visitor numbers very substantially—by 50% in the past four years.

Q256 **Chair:** Where has the money come from for that?

Dr Calderwood: The Scottish Government again provided central funding to increase health visitor numbers by 50%.

Q257 **Chair:** Presumably, they are commissioned or employed by health boards.

Dr Calderwood: They are employed by health boards.

Q258 **Chair:** Is the money ring-fenced?

Dr Calderwood: Yes; it is committed.

Q259 **Chair:** Therefore, it is ring-fenced money to health boards specifically to increase by about 50% the number of health visitors so that the number of visits can be increased.

Dr Calderwood: Yes.

Q260 **Rosie Cooper:** Do you have a substantial number of people who find that intrusive, or not?

Dr Calderwood: They have an option; they do not have to accept all the visits. It would seem to be very positive.



Q261 **Rosie Cooper:** When you are doing your writing, could you let me know what that balance is?

Dr Calderwood: Yes. We are not there yet with the full number we would aim to have. Part of the issue is that these health visitors do not exist, so we are actively training them. We have enough in training at the moment to deliver that commitment to increased numbers by the end of this year or early next year.

Professor McArdle: I think we have consensus on who the key workers are, so I will not repeat that. To start with midwifery, in Northern Ireland we have about a 5% vacancy rate. It is okay in terms of vacancies, but we know from the demographics that that particular subset is ageing, and practically none of the midwives works full time. It is impossible to get midwives to work full time, and that is to do with years of experience, quality of life and that kind of thing, so we have increased the number of midwifery students in training.

Interestingly, the Nursing and Midwifery Council has just approved a consultation on the new standards for midwifery undergraduate training, and the key point in that is continuity of carer. We certainly support that in Northern Ireland and would want to see it developed with the new midwifery standards.

We have an ageing health visitor workforce under significant pressure. They tell us that a lot of their work is about looking after vulnerable people, safeguarding, attending case conferences and so on. We have had to look particularly at the health visitor workforce and workload.

We have a policy for safe staffing in Northern Ireland called Delivering Care, of which health visiting is phase 4. Under that, we have moved to recommending a caseload for a health visitor of about 180. We know that those in our FNP service, which looks after the most vulnerable people, have a caseload of 25 each. Therefore, we have increased the number of health visitors in training, and we have been doing that year on year for quite a few years now.

Interestingly, the turnover rate for nursing is just over 10%. That is an important figure. You cannot continue to recruit particularly health visitors and some midwifery staff without maintaining a core standard of nursing, because they are postgraduate training places. In the main, midwifery has direct entry, but there are still people who come through the shortened programme for midwifery, so it all works together. We have made huge increases in the number of undergraduate nursing places to support all the specialist programmes in the postgrad phase.

Under Delivering Together, which is our 10-year strategy, we are prototyping multidisciplinary teams. We have always had good integrated multidisciplinary teams in Northern Ireland. We had an integrated health and social care system back in the '70s. Over the years that was peeled away with efficiencies, savings and all the rest of it, to the point where



our GPs were telling us that they could not identify who their health visitor, midwife or mental health worker was. Under the transformation programme we are re-investing in multidisciplinary teams and supporting the prototypes with the correct number of health visitors, which will be 180. We are actively recruiting into those programmes at the moment, so significant investment has gone into the health visitor workforce in particular.

Deirdre Webb: I want to highlight that under the Early Intervention Transformation programme for antenatal care and education we have combined the Solihull approach to education with clinical care—clinical visits. That is working extremely well. Over 500 groups have delivered so far with very little extra resource, and about 30% of our first-time low-risk mothers are going through it at the minute. The feedback is extremely positive. We also measure confidence levels postnatally with a self-report and questionnaire, and it is coming back with tremendous results.

Q262 **Chair:** Is it the midwives delivering this?

Deirdre Webb: They are delivering group education and care together. The groups average about 10 mums. Fathers are invited. For those who do not have fathers, they can bring a friend or their own mother to the group. It is working extremely well and provides that continuity of care as well. It is just a different way from the Scottish model.

Q263 **Rosie Cooper:** You talked about creating undergraduate places. Are they full?

Professor McArdle: For nursing?

Rosie Cooper: Yes.

Professor McArdle: We have absolutely no difficulty attracting students to nursing or midwifery.

Q264 **Rosie Cooper:** In Northern Ireland, do you have a bursary system?

Professor McArdle: We do.

Q265 **Rosie Cooper:** You have no problem.

Professor McArdle: No.

Q266 **Dr Cameron:** Today is International Day of Persons with Disabilities. I chair the all-party parliamentary group on disability. I have had correspondence from families across the UK in that capacity saying it is very difficult to get the early multidisciplinary support at home that they need for diagnosis, or just in terms of practical support, when young children have disabilities. What more do you think we should be doing there? Are there particular issues?

Professor White: In Wales, under our Family First approach, where a family has a child with a difficulty or disability there is the ability to refer



on. We have had some challenges, like a lot of parts of the UK, in not having enough resources to meet need, but there is the ability to identify need and refer where that has been found to be the case.

It is a challenge to get things. There is always a need, is there not? It is quite difficult to meet all needs and we have to be realistic, but we certainly have the ability to identify and provide support. A number of pieces of legislation are being explored at the moment—for example, the Autism (Wales) Bill is being worked on—and there are other activities in this area.

Deirdre Webb: From our point of view, we have the foundations of a good, solid healthy child programme. If you are covering the visits well, you should be able to offer that support and identify early the children that need to be referred on for additional support at different levels. Some children will just need support at level 2, which might be a short-term intervention; other children will need much more complex intervention by a multidisciplinary group. By having a solid programme you can identify early and target appropriately, if you are covering the children, although I do think that resources and getting the right help to people are sometimes issues.

Dr Calderwood: I have not mentioned it so far, but having the named person in Scotland will help children and families when there is a danger of them falling through the net or when there is not good information sharing. The named person is usually a health visitor, before school age; when the child goes to school, the named person is usually a nominated teacher, often the head teacher.

The concept behind that is that there will be information sharing, because that one person is the one point of contact that families can go to. I do not know specifically that that is working for children with disabilities, but that was one of the theories—that those children often fall between different agencies, they do not have somebody who knows the whole story and struggle to navigate a system that would have benefits, equipment and so on. That person should be able to advocate for them.

Q267 **Dr Cameron:** Is that data that we will collect in future?

Dr Calderwood: At the moment, we are finding that for the vulnerable children we are worried about, those perhaps at risk of adverse childhood experiences, that seems to be working very well. I do not know that we are collecting data for disability, but for vulnerable children with all sorts of special needs we will have some data.

Chair: Thank you. This is really helpful for us, because we are trying to understand what works in different nations to help us to inform what recommendations we might make for England.

Q268 **Andrew Selous:** I apologise for being late. I had a meeting with a Minister that had been in the diary for a while.



HOUSE OF COMMONS

Some of the issues that we have heard about that cause problems in England relate to lack of continuity of care, the difficulty over information sharing, with systems that do not or are not allowed to talk to each other, and the difficulties of multiagency working. It would be really helpful to get your take on those three areas, in your jurisdictions or home nations, and to understand whether co-locating the different professionals has been part of the solution.

So I am asking about continuity of care, information sharing and multiagency working. How have you overcome those issues, as they seem to be presenting us with a few challenges in England?

Professor White: We have talked a little bit about continuity of care in the midwifery and maternity field. We have all agreed that—

Q269 **Andrew Selous:** There is no need to repeat that—apologies if I was not here to hear it.

Professor White: Having continuity with a single individual would be extraordinarily difficult. We would all strive towards having a team approach, and the smaller the team the better, so that they are people known to families. That means, in our communities, the midwifery teams, health visiting teams and our Flying Start teams, even down to GP practices; that is what we aim for. Continuity is a good thing, and we are all striving for policies to do that. We have a new maternity strategy next year, and the new midwifery education standards all talk about continuity of care.

For us, it is important how we share data—soft or firm intelligence—and the information that oils the wheels of all our services. We need to think about it in those sorts of ways. Certainly, we have had some experience of co-locating some of our teams, which improves intelligence and information sharing and helps systems to work together better.

Our whole approach in Wales is around integration and collaboration. We have developed a number of arrangements that, if you like, force people to work closely together. For example, regional partnership boards have been established, on which you have health and social care in joint commissioning. We have public service boards, where all the public services in a geographical area come together to make plans about how you make services work in that area. We are having to engineer the system at a local level, so you have teams of people physically together—but also through commissioning and getting big services, everything from fire to health and social care, in a room together to ask what they are going to do about early years.

There is some reluctance about data sharing across systems. People are fearful about sharing things and believe that it is inappropriate to do so. The public expect us to share, and they assume that we already share a lot of information—but the reality is that there are boundaries about doing that.



HOUSE OF COMMONS

We strongly feel that parents should hold data themselves. We have information that we give to parents to hold. In fact, I have brought with me the little red Welsh bilingual book, which they can have in their hand. They can see when they should have their checks and vaccinations, and they have contact points and so on. It is the same with "Bump, Baby and Beyond," which is a guide for women during pregnancy.

There is lots of information. There are things about reporting: we monitor performance, so data are gathered, particularly from the health service side. The Welsh Government are the headquarters of the NHS, and part of my job as Chief Nursing Officer is to performance-manage the NHS. I have annual health maternity boards, so I know every year what the caesarean section rate is, what breastfeeding rates are, and so on. We hold them to account. Those are our dashboards.

Your question is quite complex. There are things that you can do in a system to increase some of this, but there are some natural barriers within it as well around protocols of sharing.

Karen Cornish: The other thing is that in Wales our aim is to try to prevent problems escalating through provision of a responsive service within a culture of timely information sharing. That is one thing that we want to do.

However, through our work on early years and developing an early years system across the nought to seven age range, we have highlighted that it can be disjointed at a local level. At the moment, what we are trying to do—and there is growing agreement—is to build on and utilise the multiagency infrastructure that currently exists in Wales, through Flying Start or Families First. That builds on things that Jean talked about earlier in relation to the Healthy Child Wales programme, ensuring that we have potential to develop a much more integrated early years system. That will enable early years and prevention programmes to become embedded within that system, preventing, as far as is practicably possible, programmes operating in silos.

Prosperity for All sets that out. We have a national strategy, but also an internal senior board supporting that work. At the same time, we are working with one local public service board, made up of two local authority areas at the moment, on a co-construction project to look locally at what an early years system looks like. What are the core components; how do you overcome some of the issues that Jean has mentioned around data sharing in particular, but also around information sharing; and how do you ensure that there is a multiagency responsive approach for children and their families that can act at the earliest possible moment in time?

Q270 **Andrew Selous:** Do you have any tips from Scotland?

Dr Calderwood: I am conscious of time. We have some proposed legislation on data sharing, because of the issues that we are all very



HOUSE OF COMMONS

familiar with in Scotland. It has run into some difficulties because of concerns about data protection, so we intend to publish guidance on this early next year. You might want to look out for that.

Andrew Selous: That is guidance to try to encourage sensible and legitimate sharing.

Dr Calderwood: Exactly.

Q271 **Andrew Selous:** Do you think that guidance will be enough?

Dr Calderwood: The concern is that this becomes part of legislation without people knowing what they can and cannot do within the bounds of confidentiality. That has made people very nervous—and we are all bound by GDPR, of course. It has come to a halt because people are asking what they can and cannot do, what they can and cannot share, and who the data need to be shared with—the child, parents and so on.

Q272 **Andrew Selous:** Would you very kindly send the Committee a copy of the guidance when it is published?

Q273 **Chair:** It would be very interesting to understand a bit more about why the proposed legislation has come up against hurdles. Will somebody give us a brief on that, so that we are not making recommendations and repeating those mistakes?

Dr Calderwood: Yes—and I genuinely think that it is around confidentiality issues. It is absolutely right that families, and patients in general, think that we share all those things already when we do not. The idea of the legislation would be to join up our systems, because we need them to speak to each other. The concern from practitioners is whether they are sharing something with the justice system. As doctors, we have all sorts of very firm rules around confidentiality, quite rightly. That is where the anxiety has come in from clinical practitioners, as to where they might be overstepping boundaries, professional or otherwise, in sharing information to outside agencies. That is where the guidance will be very important.

Q274 **Andrew Selous:** Thank you so much. We need to be a little bit conscious of time and make some advances.

Northern Ireland, what can you enlighten us on in these areas?

Deirdre Webb: I want to add two things. On continuity of care, having respect for the relationship between services and client is the most important thing. The relationship needs to work so that the client feels that she is empowered and engaged with services. That is the most successful thing—it is how the Family Nurse Partnership works, and that is what its success is. We do not change people, or as much as possible we have one nurse with the same family the whole time, and key to that success is the success of that relationship in very vulnerable circumstances.



The second thing that I would like to say on interagency working and sharing information is that it is less about the legislation, policy and guidance and more about how we communicate with each other. Co-locating people does not always mean that they work well together. We need to consider our relationships with our colleagues and clients in sharing information, because we get into bother when people are not fully informed about the information that is being shared. Fundamentally, we have to take it back to how we communicate with others in the best interests of our clients.

Q275 Andrew Selous: Very briefly—I am conscious of time, so short answers would be great—is there any work that you do on preconception? This area was raised with us by the director of public health from a large local authority area in London a week ago, as a suggestion. If women already have a number of issues by the time they get pregnant, or perhaps are not thinking in the best way possible about future relationships in becoming pregnant, that can be an issue. Is there any work that you would like to draw attention to on preconception? If there is none, that is fine.

Dr Calderwood: That is the issue for us in maternity services—that people are not in our service when they are not pregnant.

Andrew Selous: So it would not be you.

Dr Calderwood: It is the age-old problem—it needs to be done outside, where people are just being people and are not necessarily in contact with any kind of service.

Q276 Andrew Selous: Do you think that it is an important area? Is it worthy of attention?

Dr Calderwood: Absolutely. The reason I am giving this preamble is that it is the sort of thing that we have really struggled with for a long time. I do not think that there is anybody who does this well. The importance is there, but it is probably about embedding it in the education system.

Andrew Selous: Yes, I would agree with you that it is cross-government.

Dr Calderwood: What we have within our maternity and children quality improvement collaborative is to have the first work stream for zero to five. The zero means as soon as a woman is pregnant, so we have a lot of interventions in helping women in early pregnancy to give up smoking and manage their weight.

Q277 Andrew Selous: So there is strong support for that area.

Are there any brief comments from Northern Ireland?

Deirdre Webb: We have a very similar situation. The clients are young people with long-term conditions, and the service is focused on giving them the right advice—but that is when clients are in contact with



HOUSE OF COMMONS

services, so they have the opportunity. When a young man comes towards his early twenties, they are focused on giving him advice, but that is the only thing. As my colleague said, schools are a place to start with that.

Karen Cornish: In Wales, we have just published a new relationships and sex education document, so it would be worth having a look at that; it is not something that I have information on here today, necessarily.

In developing the new curriculum for Wales, there will be an area of learning and experience that focuses on health and wellbeing.

There is also the Reflect project, which is for mothers, in particular, who have had a child removed. There is work being done with them on what to do next, where to go and how they might want to have a different type of relationship with—

Andrew Selous: I am just going to stop you, because I have two additional short questions

Karen Cornish: That is fine. Again, I can send you the information if that would be helpful.

Q278 **Andrew Selous:** That would be so kind, thank you.

There are two other areas where short responses would be really helpful.

We heard a couple of weeks ago about there being very high levels of foetal alcohol spectrum disorder in the UK. We are something of an outlier in this country. That also applies to the taking of illegal drugs during pregnancy. We learned last Monday of some research that was done in Glasgow, or a brief test on this issue. In a one or two-sentence answer, how big an issue is this and how worried should we be about it? Pithy answers please, because we are up against the clock a bit.

Dr Calderwood: The problem is much bigger than we realise. From the routine brief alcohol intervention that every woman is asked at every visit, we know that the amount of alcohol drunk by women who drink it is under-reported, and we know that the diagnosis of foetal alcohol syndrome is missed for many years. A lot of children in the learning disability parts of the education system have not had a diagnosis.

Q279 **Andrew Selous:** Would you encourage us to put a focus and spotlight on that issue?

Dr Calderwood: Absolutely.

Deirdre Webb: It is one reason why many children end up in the safeguarding system.

Andrew Selous: Often the effects do not get manifested until the child is four or five.

Q280 **Chair:** It has been proposed that some research might go on to look at



HOUSE OF COMMONS

screening during pregnancy, or screening of meconium.

Dr Calderwood: That is the Glasgow study. There has been a big study on babies' meconium, which gives us the breakdown products of alcohol. That has shown what we think is a much truer picture.

Q281 **Andrew Selous:** What concerns some of us is that there has been a study but there does not seem to be much follow-through in action—and, if we are an outlier, that is a concern.

What about the view from Wales?

Professor White: It is an issue, but we do not have anything in particular on it.

Q282 **Andrew Selous:** Finally, I am interested to what extent you involve fathers. Are your services for women, which men are welcome to come to, or is dad fully included in this area of work? I am just curious as to how much focus there is on fathers and maybe on strengthening that relationship between mum and dad, where it exists, to make it healthy, strong and respectful.

Professor White: Dads are welcome.

Q283 **Andrew Selous:** Dads are welcome, but they are not invited as of right, by design. That tells me what I was slightly fearful of.

Professor White: They should be there, and they are welcome to be there.

Q284 **Andrew Selous:** Okay—but are they actually invited? Are they as important as mum in getting along?

Professor White: Well, having two parents is better than not—so, yes. The First 1,000 Days initiative that Public Health Wales is running for us looks at the involvement of fathers and supports the man in the relationship with his child. So there is some work that we are currently looking at. I would not say that there is anything that would exclude the man, or not welcome him into it.

Karen Cornish: Parenting support is for both mothers and fathers. We are also looking at issues around interparental relationships, both positively and negatively, in terms of what support can be put in place.

Andrew Selous: I am pleased to hear that.

Karen Cornish: Within the programmes that we run, Flying Start and Families First, the support for fathers is there as much as it would be for mothers.

Q285 **Andrew Selous:** Is there Scottish involvement in this?

Dr Calderwood: Fathers need to be integral, and they are absolutely part of the services that we offer. There are some specifically for dads only, because sometimes that is a more comfortable space, but they are



HOUSE OF COMMONS

absolutely involved. For example, we have women stopping smoking and, if the partner also smokes, we would ensure that he would be offered the same smoking cessation course, because it is obviously much better for both to stop.

Q286 **Andrew Selous:** So it is a smoke-free household.

And in Northern Ireland?

Deirdre Webb: In Northern Ireland, in the Family Nurse Partnership and in care and education fathers are actively encouraged to be involved, and invited to be involved in every aspect.

One area of caution I would note is that one challenging area is there is an increase in intimate partner violence during pregnancy. We have to make sure that the relationship is respectful and a positive one for the child to experience. We need to get that balance right.

Andrew Selous: Thank you so much. That is all from me.

Q287 **Dr Cameron:** I have a final question about best practice. Do you have any particular examples of best practice or programmes that you think should be rolled out elsewhere—or even some examples of things that you thought would be good but which did not quite work out as they were expected to, or yield the results that you thought they would? This is a chance to blow your own trumpet or give us good advice on what not to focus on so much.

Professor McArdle: I think very highly of the FNP; it is an example of really good practice that should be rolled out. It has had some bad press in the past, because of an RCT undertaken in Wales in relation to how it was rolled out in certain parts of the UK.

As with any piece of research, you can critique it and make your own judgment. My personal belief is that it did not look at the right indicators. We have since done a re-evaluation of it, and I am very impressed with what we have found, which will add to the body of knowledge. I am not saying that the FNP is the be-all and end-all, but I definitely think that we have shown that it is value for money.

Q288 **Dr Cameron:** Sorry, what is the FNP?

Professor McArdle: The Family Nurse Partnership.

Chair: We have heard evidence about your work.

Professor McArdle: There is a strong body of evidence around universal services. The number of contacts is key. We were just discussing before we came in what the right number of contacts should be and whether the addition of all five, which will be available next year, will help us come to more common agreement on that. Across the four countries, there are different levels of health visitor interaction on the universal service, but it is the bedrock of good practice in promoting healthy children and good



HOUSE OF COMMONS

family support. So that should continue, and we should try to work to an agreed number of contacts.

Dr Calderwood: Where we have been really successful in Scotland have been with our quality improvement methodology. It is about choosing whatever method you want. We have set ourselves stretch aims and targets, which were very much maligned, when we talked about our stillbirth rate. We set the aim for a reduction of 15%, on a background of the stillbirth rate being static for 30 years. My colleagues said that it was just nonsense, and asked me where I got 15% from. I told them that I thought 50% was a bit much and 5% was a bit feeble, so it was really a compromise—but our stillbirth rate had reduced by 22.5% in Scotland, in five years.

We took the causes of stillbirth and broke them down into risks, then really invested in quality improvement—pieces of work on a number of layers, such as smoking cessation and detecting small babies.

I would point to those quality improvement programmes as key; we did not just say that it was a good idea but we did not have a method to deliver it.

Probably the size of the country really helps, but we have managed to make it an all-country thing in Scotland. We tend to start in one or two health boards to check that we have the right method and iron out the wrinkles, and roll it out. We are continuing to do that with maternal mortality and morbidity and neonatal and children in the acute sector, but we also have quality improvement running through our mental health and primary care services. The methodology of small tests of change seems to be really effective.

The setting of targets is much maligned, but we find them really helpful. We do not call it a target but a stretch aim, and we have had to adjust them because we have reached them—so we have had to reset them. When we lay out an ambition to work towards, we know that another country has reached a level, so we know it can be done. That has been the bedrock of why those improvement collaboratives have worked in Scotland. We have been very clear about the statistics that we want to aim for—there is evidence behind them.

We have invested in people locally, as well; that is the best practice roll-out. You cannot have individual practitioners saying, “I heard it at a conference so I’ve got to go away and do it.” Government in Scotland has really put resource in. People at the coalface have to do their jobs every day, and do not necessarily have the resource, time or wherewithal to do some of this improvement. So we bring external people in, and we fund a programme of work that enables the people at the coalface to have the time to deliver.

Where it has not worked is where we have not put in that extra investment in time and people, which, of course, costs money. Just



expecting people to be able to do something over here that is happening over there, when they are already feeling the strain of demand and doing all the things that our health service does, is not really fair.

Q289 **Dr Cameron:** So you cannot have the targets or stretch aims without resources and people to deliver them.

Dr Calderwood: Absolutely right.

Professor White: I absolutely agree with what Catherine has just said. We have an improvement methodology approach in Wales, too, and have been doing similar things to try to reduce our number of stillbirths. I am hoping that we will have exactly the same response, but you started many years before us. We are hoping that next year's stats will also see a shift. I agree with everything that she said about that.

Our evidence from the Flying Start programme suggests that, if you have a different offer, with more multidisciplinary and multi-agency work, and bring in a team around the family to provide them with ongoing support through nought to seven to try to get the child to be school ready, that intensive and enhanced support for those children with greatest need, from families in the most challenging circumstances, makes a difference to the start of the child's life. The evidence suggests that, if you start it right, you have a better chance of continuing it.

We have an ACEs hub, which has lots of resources, so that is quite a good thing to go to. It has lots of research, infographics and so on; it is there for people to pull in. It even has a little five-minute animation that you can play to almost anybody, and they get it—they understand what ACEs are all about. Things like that are quite nice. There are lots of other examples, but time is up.

Chair: Brilliant. May I say to all five of you how much we appreciate you travelling here today and sharing your words of wisdom? It has been exceptionally helpful. We are going to move on to the next panel now, but thank you very much indeed.

Examination of witnesses

Witnesses: Professor Bennett and Dr Duncan.

Q290 **Chair:** Thank you so much for your patience in sitting through that and waiting. We will be very snappy and try to give you the opportunity to answer a whole range of different questions. It will probably be much easier as there are two of you and it will feel much more like a conversation. Perhaps you could introduce yourselves, and then Andrew will ask the first questions.

Professor Bennett: I am chief nurse and director of maternity and early years at Public Health England. I am a health visitor and, essentially, my role makes me the chief health visitor for England.



HOUSE OF COMMONS

Dr Duncan: I lead on intelligence for child and maternal health in Public Health England, and I work across the health system and beyond with experts to drive up standards in the use of data, information and intelligence, with the aim of improving outcomes and reducing inequalities.

Q291 **Andrew Selous:** Thank you very much indeed. I start with the Healthy Child programme, to get your assessment of how effectively it has been commissioned and implemented. As a follow-on from that, could the programme be more oriented towards the whole family? That is to pick up on some of the questions that I asked towards the end of the previous panel.

Professor Bennett: I am sorry, but it is really difficult to hear you.

Q292 **Andrew Selous:** Yes, it is very noisy outside. I am sorry, because I am not usually accused of having a quiet voice. Basically, I am asking for your assessment of how effectively the Healthy Child programme is being commissioned and implemented. That is the first question. Do you think that it should have more of a whole family approach? I apologise for the noise outside in the corridor; I think that one of the staff is trying to quieten them down a bit so we can hear.

Professor Bennett: I shall answer that question in a couple of parts. The Healthy Child programme is 10 years old next year. The body of evidence around which that programme was designed still holds true, but we also have new evidence that could supplement it.

I think that your question was about how well it is being delivered now and whether it is future-proofed and fit for purpose. Parts of it are being commissioned well. Because of the financial circumstances in which local authorities find themselves, parts of the programme have been honed down to quite minimal commissioning. Public Health England issues commissioning support products to local authorities to get the best value for money from the programme and deliver it at the best taxpayer value, with the best outcomes.

As for what we would like to see for the programme, it starts at 28 weeks of pregnancy, as the previous panel touched on. Public Health England and the DH are currently in conversation about whether next year, when it is 10 years old, it will be time to refresh the programme. That being the case, and with a funding policy developed to do it, PHE would like to see the programme start at either conception or preconception. We would go back from 28 weeks to encompass some of the things you were talking about. In the first tranche, we would refresh up to the age of three—so we would really focus on the early years piece.

I know that one of your earlier witnesses suggested that it might be called a family programme. We would support the concept, but probably not the title. You arrive at an awful lot of difficulties in defining a family. The programme is developed around a notion that the child is



paramount; the Children Act is very clear that the child is paramount, and it is easy to define the child. Under the banner of the Healthy Child programme, we need to make sure that all that new evidence about the importance of families, whether at universal or progressive universal level, is emphasised and brought to the fore because, clearly, children live in the environment with a family, and we need to support the whole family. So, yes, I would support a family focus, but not necessarily a family title.

Andrew Selous: I am not so hung up on the title as long as the work happens, and I think that you are being broadly supportive of that, which is excellent. Thank you.

Q293 **Chair:** Is there anything that you heard from the last panel that made you think, “Oh, I really wish we did that in England”?

Professor Bennett: There was one specific thing. The family resilience assessment tool that Wales spoke about sounded very useful to explore. I have not come across it, and I have already asked my colleague to contact Wales tomorrow. Otherwise, I think that in principle we are all much in agreement that the first years of life really matter—that preconception, pregnancy and the first two years of life really matter. We deliver in different ways because of our geography and policy framework.

Q294 **Chair:** And our resource.

Professor Bennett: Yes, and our resource.

Q295 **Chair:** It appears to us that there is a diminishing resource for this particular policy area. Do you agree?

Professor Bennett: That depends which bit you are looking at, probably. For the maternity transformation programme, additional funding has gone in. There are the national maternity services under Baroness Cumberlege and previous Secretaries of State for Health. The maternity safety programme has come together, and there has been additional investment in that part of the programme. For the Healthy Child programme from 14 days onwards—the part commissioned by local authorities under the public health grant—clearly there has been a reduction in the resources available, because local authorities have had cuts to their central grant and their public health grant.

Q296 **Chair:** Does Public Health England take a view on what the impact of those cuts has been on the programme?

Professor Bennett: It is clear that the impacts of cuts to the public health grant are being felt in services. It is never a good thing to have to cut your expenditure locally on public health. We are certainly aware that, in terms of the interest of this Committee, it is a mixed picture locally—but it is impacting on services for nought to five-year-olds, yes.

Q297 **Dr Cameron:** My question is about visits. What is the evidence to support the delivery of the five mandated visits? Should they be delivered



by a health visitor, and are local variations in order?

Professor Bennett: At the time of the health visitor national programme, which I led, so I speak from having been around it, we looked at the evidence around the Healthy Child programme, health visiting practice and some of the reasons why the national programme was convened in the first place. Among other things, there were Lord Laming's reports into safeguarding.

We looked at the underpinning evidence from the Hall reports around child development and at the patterns of health visiting in the country, and we sought to design a new model.

The model is actually 4-5-6. There are four levels of service of health visiting: community, universal, universal plus and universal partnerships plus, which is multiagency intervention for complex needs. The five I shall come back to. The six are the six areas of intervention. We know that health visiting practice at least correlates strongly with improved outcome access or experience.

The 4-5-6 model was designed, and the five contacts chosen to be mandated were chosen either because there was evidence through research around the important times for child development, or the best professional advice available was that these would be the times. They were intended to ensure that, at a time when commissioning was moving from one NHS commissioner to 150 local authorities, we could be clear that there was a national level of universal service that would be delivered in the same way—the requirement to enable you to mandate part of the public health grant.

Are five enough? No, five were never meant to be the whole service, because there was the 4-5-6 model. Five formed the core of the universal offer. Health visitors and very highly qualified professionals are expected to use their clinical judgment about what else is offered around it.

Could we have mandated more? Politically, at the time, we would not have been able to mandate more. Were there to be a review of mandation, would we seek to mandate more? That is a possibility. Most commentators would agree that one of the losses, because of financial cuts, has been the contact offered previously around four months, which is a very critical time for early bonding, weaning, childhood obesity, your baby moving and home safety. Were there to be a consideration for a further one, I think there would be a lot of support for that.

I think the second part of your question was about variation.

Q298 **Dr Cameron:** Yes. I asked whether local variation in the delivery of the five mandated visits was warranted. I suppose that that is not so much about clinical judgment but about different areas doing different things.

Professor Bennett: The variation is not in whether they do it differently—it is in whether they do it. The mandation requirement on



HOUSE OF COMMONS

local authorities was to do at least as well as when they inherited it from the NHS. We did not inherit a position where there was no variation anyway. I shall look to Helen to supplement with advice about where we are with the outcomes. More or less, initially, the rates have held up as they were at the point of NHS transfer. What we know is that there is a lot of geographic variation within those rates.

Even with overall checks, which are still reporting at a high level, we know that there is geographic variation. Anecdotally, we are also hearing that the intention that these are health-visitor delivered has been diluted in some places. It is supposed to be that the mandation requires an individual delegation from a health visitor regarding an individual family. In fact, we understand that whole sections of checks are just being devolved to other staff.

Q299 **Chair:** Health visitors have told us during this inquiry that they feel that, when that happens, skills that a health visitor may have in picking up cues from the environment and things that remain unsaid to identify families in need are not being used, and there is a real risk that things are being missed. Would you agree with that?

Professor Bennett: I think that it is a real risk, yes. When we were setting in place the mandation, we talked about individual delegation. If a health visitor is with a family, the one-year visit is due, and there is no indication of a need for a health visitor, that could be individually delegated to a nursery nurse.

Q300 **Chair:** But you are saying that there are services where a whole group is being devolved. Who is watching that?

Professor Bennett: That is one of the challenges that we have talked about. There is fragmentation. The levers of deliberate devolution in the English system for local leadership mean that there are very few central levers and very little national monitoring. It would be for the regulators. If there is concern about a local authority, the hard levers are the public health grant and a breach of mandation.

The softer levers are sector-led improvement—local authorities working on their area, or in partnership with others, to drive up the quality—or regulation, with CQC and Ofsted doing patch-based inspection, or the CQC doing provider inspection. If the local authority is the direct provider of health visiting, it will be inspected by the CQC. If it is provided by the NHS through the independent sector, the provider will be inspected by the CQC.

Q301 **Chair:** Are there CQC inspections that are saying that health visiting services are inadequate?

Professor Bennett: I have not seen one rated inadequate, no.

Q302 **Chair:** Okay. That means that the CQC must be judging—



HOUSE OF COMMONS

Professor Bennett: Sorry, Chair, I did not mean to cut you off, but the CQC does not rate individual services, on the whole. It would be the provider.

Q303 **Chair:** So it may well look at a provider providing a range of different services, and it may inspect a provider and not even look in detail at the health visiting services that the provider is offering.

Professor Bennett: It could do that.

Q304 **Dr Cameron:** What level of the local variation are we talking about? What would be the baseline?

Dr Duncan: There is regional variation. For example, the north-east would be delivering above 90% for all mandated visits.

Q305 **Chair:** Do you mean contacts?

Dr Duncan: Yes, contacts.

Q306 **Chair:** We have already taken evidence that there are local authority providers that write letters to people and count that as a contact.

Dr Duncan: Because of the way we receive reports from local authorities, we cannot tell the difference between those. By comparison, London has concentrated on new birth visits, and is delivering well in excess of 90% on new birth visits but around 60% or 70% on the other visits. There are a handful of local authorities that are delivering to around 50% of the eligible cohorts. So there is quite a lot of variation across the country.

Q307 **Dr Cameron:** It sounds as if there is quality and quantity. Quantity could be high, but it could be letters. It may be that we need both the quantity and quality mandated to make sure that people get the right amount of support.

Dr Duncan: At the moment, we have a voluntary return of data from local authorities. Behind the scenes, we are working on moving this whole reporting piece across to the community services dataset, which is a record level return of data to NHS Digital. In that dataset, we can see much more detail about what is happening with the visits, how they were delivered, and whether they were face to face or not.

We have just published the methodologies for extracting the new indicators from this dataset. NHS Digital is doing some work, which will be published this month, to start to pull out some of those indicators so we can do comparisons.

Professor Bennett: We are talking about input measures here. It is really important that we can interrogate that and find out what difference it has made. As Helen has just said, we will be able to do that, and we are starting to be able to do it now, because what matters is what happens to those children. That is a really important piece in taking this forward through the information systems and improving outcome



HOUSE OF COMMONS

measures. It is about being able to use data to be much more specific. We know in general terms the evidence base for some of our more targeted programmes; what we do not yet have is the evidence about what will work with this family in this situation and this place. Some of the new information linkage will enable us to do that much better.

Q308 **Chair:** You have an evidence-based programme with five mandated visits, yet we are hearing evidence that some local authorities are failing to deliver those five visits. Families may or may not be vulnerable, and even when contacts are made they may not be made by a health visitor. Surely Public Health England, or somebody, needs to have some teeth at a national level to get a grip and hold local authorities to account.

Professor Bennett: Public Health England does not have the authority to hold local authorities to account.

Q309 **Chair:** Who should have that authority?

Professor Bennett: It is a policy decision to devolve those issues, so it would be a Government decision about how that is exacted. I would say, technically, they are required to deliver at the level of coverage when you took over, so you are not actually technically in breach of your mandation if it has not fallen below the level that you started with.

Q310 **Chair:** That is little solace to the vulnerable families who are not getting the care.

Professor Bennett: As you can imagine, Chair, that is not a happy position for any of us. I make the point only because, of the two hard levers that we have, one is not that hard—it is set at the level of transfer. It is a frustration, of course, and what matters is the children and our ability to leverage this up to the benefit of the children.

Q311 **Andrew Selous:** Forgive me if I have not understood this well, but you mentioned regulation or inspection by the CQC and Ofsted. What about the inspection of local authority children's services generally? Does the role of the health visitor not get covered within that, or is it only a small part and not sufficiently rigorous?

Professor Bennett: It gets picked up on CQC inspections—this is out of my real level of expertise—on the children services inspection, so children's social care services. There is usually a reference made to the health visiting service inasmuch as it interfaces with the specialist care system and those reports or the special educational needs system. It is not primarily looking at that service unless the local authority is the provider, in which case it might make more detailed comment.

We receive area reports for information only and our centre directors will work with the local DPH to address areas that are identified as having a weakness. The kind of things that it will say about health visitors is, on the positive side, there was very good communication between local health visiting services and services for children with special educational



HOUSE OF COMMONS

needs; on the less good side, it might say something such as a shortage of health visitors in this area is limiting the amount of support families have. Those are not verbatim, I would hasten to add: they are examples.

Andrew Selous: That is helpful. Thank you.

Q312 **Rosie Cooper:** We have heard quite a lot about the lack of joined-up, multidisciplinary working. My question, essentially, is what mechanisms can central Government and national bodies use to incentivise a more joined-up approach to commissioning?

Professor Bennett: The approach that we use is place based. We would title it under the broad heading of place-based working. It is important in a very devolved system that we think about that. On the question about integration, for example, in Greater Manchester there is a lot of work going on under the office of the mayor around how that work gets taken forward.

The place-based work that Public Health England is leading ranges from working with local communities to develop services locally to working with the NHS on the emerging integrated care systems and trying to use all those levers.

I know many of your witnesses expressed concern about moving commissioning for some of these services from the NHS to local authorities and expressed a strong desire to see it moved back or integrated in some way. The alignment of all the resource that we have available for pregnancy and early childhood is fundamental. We must bring it all together to see how to benefit people in those places, and I used to be a child health commissioner: that would start with understanding and alignment and end with full integration. Whether that decision gets made nationally or locally is a policy decision.

Q313 **Rosie Cooper:** Who overall is responsible for this? It sounds as though it has more holes in it than a Swiss cheese. Who is actually responsible for making sure that this all works, because there is a child and their life at the end of it who may or may not fit into this theory, may or may not live in Manchester and/or who may live perhaps in West Lancashire or some other rural place that may or may not have half a dozen of your place-based initiatives? Who joins the dots up?

Professor Bennett: That is a question around devolved systems and how they work. I am not sure I could answer that very well, Ms Cooper.

Q314 **Rosie Cooper:** Who should be held to account if there are gaps in that service, if it fails children?

Professor Bennett: At the moment, there would not be one accountable party because, as we have established, parts of it are commissioned by the local authority and parts by the NHS.

Q315 **Rosie Cooper:** In other words, this is like everything else I am coming



HOUSE OF COMMONS

across: the regulators are useless, everybody is accountable, but nobody is responsible. Welcome to 21st century NHS England.

Professor Bennett: I am not NHS England.

Rosie Cooper: No, okay—the NHS in England, if you like.

Q316 **Chair:** Let us turn this around. What do you think we can do to help? We share a desire to get the first 1,000 days of life—the start of life—right. What recommendations can help us to prioritise this and make it more successful?

Professor Bennett: Many of the difficulties that I am articulating are caused by cuts in the public health grant and the limits around the hard levers. We certainly would not wish to see any reduction in the leverage. In terms of the grant and mandation, unless and until there is anything better, our view would be that that should stay in place. That would be the first fundamental.

The resourcing and the leverage need to be done. The voice in central Government, I think, is very important, so this inquiry and the inquiry into adverse childhood experiences at the Science and Technology Committee, to which I gave evidence recently, are very helpful. The work that the Leader of the House is doing in focusing on this also is very helpful.

Fundamentally, if you recommended a review of the Healthy Child programme, that would make sure we have the right evidence, the right families, and would be an opportunity, to take Ms Cooper's point, to clarify some of these absolute accountabilities and responsibilities.

We also need to look at some of the bigger pieces of work that were being done to engage families, such as the marketing campaign for Change4Life and Start4Life. We need to recognise that we are working with a different population in a different way and that there are different ways of doing that. That kind of outreach is important and clearly comes at a cost. We need to support our professionals.

Having led the health visitor programme, of course it is a huge disappointment to me that the number of health visitors has fallen so much in that period. We need to support those professionals who are still there and to make sure it is still an attractive career for people to want to go into.

We need to harness the benefits of information and technology. We are working with a very digitally literate population. We know, for example, that smartphone coverage is not particularly economically distributed. How are we making those relationships with our families using those kinds of things? If in Government, as well as in place, we were trying to pull together some of those levers and speak to one narrative about our children's health, that would be an excellent thing.



Q317 **Chair:** Presumably this needs to be a cross-departmental Government strategy as well.

Professor Bennett: Yes. If I might add, Chair, that has been achieved, to a degree, with maternity services. The first part of your 1,000 days—the maternity services review across England, the national patient safety campaign and the Maternity Transformation programme, which pulls all the major partners and all the major stakeholders together with the investment—is starting to make a difference.

Q318 **Chair:** We are interested in influencing a national cross-government strategy. How do you think that strategy would work in practice across government?

Professor Bennett: In terms of the way it translates into practice, the commitment across Departments and on one story would be positive because currently it does feel fragmented.

Q319 **Chair:** Would that have one ultimate leader? We have heard that in Northern Ireland, Wales and Scotland there is one Minister with overall accountability.

Professor Bennett: I would doubt whether it is possible to have one, given the size of the Westminster Government, but certainly a focus would be really good.

Then there is an issue for official and professional partnership across the system. Currently, Public Health England is filling that gap, if you like. I host and chair with local authority chief executives a group that brings together all the Government Departments, the LGA and SOLACE—various professional bodies—where we try to do sense-making of policy and turn policy into action on the ground. Some formalisation of that kind of mechanism would be very helpful and it would be easier with a strong ministerial and policy concordat.

Q320 **Chair:** Are you also advising all these Departments on the social determinants of health?

Professor Bennett: Yes. We have done a lot of work on how we bring this together. For example, DWP and CLG are members of the panel. We have the opportunity to discuss much wider pieces of work, so we bring the health perspective, and we are working with the Department for Education. We have done some work on domestic parental conflict with DWP. It does help to sense-make and it does help people on the ground not to be completely submerged by what appears to be—I call it—policy plethora. That has been a helpful thing to do.

We have started to do some mapping of what “good” looks like and we have done that for universal services, more targeted services, so that people can see in one place—by “one place” I mean not one building but one area—what “good” looks like and how that may be invested in and assessed.



HOUSE OF COMMONS

It is particularly useful when we have consensus around one programme. Under the social mobility action plan, the big programme on school readiness, and in particular closing the word gap at the age of five, is something that that group has very much looked at together and how each Department can work. We are doing a specific partnership with DFE on how—it is a very big marker of inequality and a very big driver of school attainment—we can strengthen our professional, place-based approaches to make sure that those children who are being left behind in their speech at two are helped so that they are not entering school unable to communicate.

In terms of the sense-making and taking specific programmes through together, it has been a very useful forum, but it is not formal as such; it is a consensus of the willing and of those passionate about childcare trying to work together and hold the system together.

Chair: We are going to have to end this session now, I am afraid, because we will not be quorate. We have time for one last question from you, Andrew.

Q321 **Andrew Selous:** Forgive me, but I have a question that I asked of the earlier panel. I am very concerned about foetal alcohol spectrum disorder because we heard evidence earlier in this inquiry that the UK is an outlier compared with other countries in terms of the amount of alcohol being consumed by women who are pregnant. I think 40% was the figure of pregnant women in the UK who are consuming some alcohol. It also relates to the taking of illegal drugs. Personally, I think the situation is scandalous and that Government policy is woefully adrift of what needs to happen. I have seen some of the evidence of what happens to the children when this happens. What is your view, from PHE, or even individually?

Chair: It will have to be brief because I want you to have a chance to make a final statement as well.

Professor Bennett: We absolutely agree with you. The CMO has guidance that there should be no alcohol in pregnancy, so there is medical guidance there.

Q322 **Andrew Selous:** With respect, there is the guidance and we are still an outlier.

Chair: Let us have the answer, please.

Professor Bennett: PHE has focused on preconceptual care—advice to women beforehand. We have issued products and we are working with Tommy's on an app in terms of where that sits in the Maternity Transformation programme. We lead on preconceptual and preventive care in pregnancy. We are taking alcohol consumption very seriously, and I heard your previous comment on, "I have had enough studies and now I want action," with which I completely agree, but, Helen, you did say there was one further study in progress.



HOUSE OF COMMONS

Dr Duncan: The British Paediatric Surveillance Unit is doing some work to get an accurate prevalence on this, but we also have data that have flowed from the maternity services dataset that is looking like around 1% of women during pregnancy are reporting that they are drinking at that time.

Professor Bennett: If you think about what we have tried to do to stop women smoking in pregnancy, a whole lot of stuff has had to come together—community approaches to reducing smoking generally, carbon monoxide monitors for midwives, midwives giving the right kind of advice and family approaches. I think you could argue a similar case for alcohol. It is less easy to detect.

Q323 **Andrew Selous:** What about drugs? What about mothers taking cocaine when they are pregnant?

Professor Bennett: It is clearly a very bad thing.

Q324 **Andrew Selous:** Where is the policy? I think it is much more widespread than we realise. I have examples from my own constituency, but no one seems to test for it or be aware of it. I am sure there is some advice not to do it, but it does not seem to be cutting it.

Professor Bennett: I would have to come back to you with that answer. I do not know when in pregnancy—

Q325 **Chair:** It would be very helpful if there was anything else about which you could advise us. We have two more minutes left, but I want to give you the chance, without hesitation, repetition or deviation, to give us in your last minute anything else that you want us to know, to help inform us for this inquiry, that we have not asked you about. Helen Duncan, is there anything else that you would like us to know?

Dr Duncan: Both the maternity and the community services datasets are new and have a lot of potential to give us intelligence that we have not had before. They are already yielding interesting outputs. The maternity services dataset has very good coverage and the data quality is improving. The community services one is lagging in terms of the providers sending the data to NHS Digital, so if we could strengthen that—

Q326 **Chair:** We need some recommendations around strengthening that. Thank you very much.

Professor Bennett: If the narrative stresses the importance of universal services to provide support to all families—it is always a transition becoming a parent and all families need some support to do that—and identifies families who either predictively or very unexpectedly run into difficulty, coupled with investment in specificity of early intervention so that we better know what works and when, that would be a big step forward in how we get that balance between universal services and



HOUSE OF COMMONS

targeted services, the best outcomes for families and the best value for the taxpayer.

Chair: Thank you so much. I am sorry that I had to rush things at the end. Thank you very much to everybody for their evidence today, and thank you to my colleagues on the Committee for staying when I know that there are lots of unusual circumstances today that are dragging people in lots of different directions. Thank you very much indeed.