Foundation Years Information and Research (FYIR)

Response to the Call for Evidence from the Public Services Committee 'The role of public services in addressing child vulnerability'

This response addresses the Committee's questions largely in relation

to the first 1000 days of life, 0-2 year olds

Research shows an inter-generational continuity of maladaptive patterns in parenting that needs to be interrupted. (Madden et al, 2015) This can best be achieved by focussing on the first 1000 days of life, the period of peak neuroplasticity, when infant neurobiology and psychology are being shaped by the immediate environment (Balbernie, 2017)

Summary

We need to give special attention to services for the first 1000 days of life: infants' dependency makes those days high risk, while their brains' neuroplasticity gives the best possible opportunity for building foundations of health and well-being and interrupting the intergenerational transmission of damaging patterns of parenting. While acknowledging the many definitions of child vulnerability, we should beware of an overfocus on severe vulnerabilities that can fail to give sufficient emphasis to building whole society resilience and support systems. 'Proportionate universalism' will only thrive when attitudes and budgets everywhere respect and resource the concept and end the 'postcode lottery' which is far too common in England - despite statutory attempts to standardise quality provision. The professional development of health visitors, tasked with achieving much of the prevention and early intervention in the early years, has not kept up with the demands of the role, nor includes the necessary right to appropriate supervision. The German Bundesinitiativ Frühe Hilfen offers us a model of how an entire country's systems can be brought together, with buyin from all local and national stakeholders, to create a comprehensive public service approach to infant vulnerability. To achieve a similarly integrated approach, England needs to bring all spending and provision for young families together within a National Foundation Years Service, under the leadership of a dedicated Minister for Families.

1.Child vulnerability: definitions [Q1]

-Vulnerability is a normal part of the human life cycle. In particular, all new babies and their mothers are vulnerable and need support from family and wider society: 'Human babies enter the world utterly dependent on caregivers to tend to their every need. Although newborns of other primate species rely on caregivers, too, human infants are especially helpless because their brains are comparatively underdeveloped.' (Wong, 2012). This vulnerability is consistently reflected in homicide statistics: the Office for National Statistics (ONS,2021) reports the homicide rate for infants of 0-12 months between April 2019 and March 2020 as the highest for any age group, only equivalent to that for 16-24 year olds.

-Definitions of vulnerability are varied and elusive. The Children's Commissioner's Office identified 42 different groups in 2017 and 70 groups a year later (Clarke et al 2019). Public Health England (PHE) (2020) summarised 'vulnerable children and families' under three categories: (i) clinical vulnerability (ii) increased risk due to family or social circumstances, where there is a statutory entitlement (iii) higher risk due to determinants of health, family stressors and social circumstances who may not be known to services.

-Most definitions focus on specifications of service entitlement or provision, which in turn, tilts interest towards the more severe forms or end results of childhood vulnerability. Concentrating on risk can detract from family strengths and resilience, which are important.

-There is a large swathe of infants and children whose vulnerability could be recognised but is not, or for whom preventative action is still possible. A system is needed to identify these groups, and to support them to reach appropriate help.

-In theory, the universal health visiting service should achieve this purpose, but (see Q6) the numbers of qualified health visitors in post has reduced below the point at which they can sure of identifying all vulnerable families, or of having time to help them.

2.Addressing underlying causes of vulnerability and support through intervention and prevention. [Q2 & Q6]

-The answer to questions 2 and 6, as with many others about provision for this age group, currently depends greatly on location: the 'postcode lottery' of adequate intervention and prevention is typically driven by the underfunding of local authorities and the consequent choices of those responsible for them. The problems of this patchwork system have been compounded by the stresses and redeployments of the COVID pandemic (Conti & Dow, 2020).

-Underlying causes of child vulnerability can be picked up as a major focus for health visitors and others, such as family support workers, family centres (Donetto & Maben, 2015,Hogg, 2019,Kemp et al, 2011), working in a preventive/promotive capacity in the community. Health visiting is provided for all families with a newborn baby, until the infant reaches school age. It has been long established as a broad, universal service, which is widely accepted as non-stigmatising and helpful (Institute of Health Visiting 2019).

-Where the service operates as intended, health visiting provides a gateway into every family, a mechanism for early identification of vulnerability that allows evidence-based prevention according to need. The broad range of physical, mental and social vulnerability can be identified early, leading to suitable referrals or other rapid interventions.

- The evidence suggests that both 'universal' and 'targeted' provision are needed. Marmot (2010) called for a system of 'proportionate universalism', in which all families receive a minimum provision, but those who need more receive it.

3. Concerns about health visiting in England

-In England, all parents receive a minimum offer of five health reviews, which should be relationship based and flexible according to the parents' situation, with additional contacts planned according to need, in order to meet the requirements of proportionate universalism.

-Health visiting provision is commissioned by local government in England, following specifications drawn from the 'Healthy Child Programme' (HCP) first published in 2009, but updated at intervals,

including reference to the '4-5-6' commissioning model developed about 10 years ago and the 'Best Start in Life' (PHE, 2018,PHE, 2020).

-In practice, the five health reviews (despite being in statute) are often regarded as a maximum rather than a minimum. They may be all that is offered and may be completed remotely or in clinics. They may be delegated to less skilled members of the health visiting team, who do not have the specialist training required to assess the breadth of potential vulnerability.

-Much of health visitors' training is concerned with identifying early signs of vulnerability, including phases of normal development and identifying variations, then about stepping in with appropriate support, ranging from simple signposting or advice to offering formal, evidence-based programmes for supporting normal development and addressing barriers to its achievement. This is a vast, specialist area, and the allotted 45-week time (half theory and half practice) allowed for the qualifying programme is too short for the level of expertise required (Malone et al, 2016). Any changes to the length, content and funding of health visitor training are complicated by its being bound up with the nursing register: the Specialist Community Public Health Nursing section is currently being reviewed by the Nursing and Midwifery Council.

-In Scotland, the minimum offer consists of 11 home visits carried out by a health visitor. In Wales and Northern Ireland, the minimum is 8-10 health reviews with some skill mix permitted but decisions and accountability clearly lie with the health visitor (which allows relational continuity and personalised care), rather than being decided at an organisational level.

-Often, early intervention can be successfully provided by preventive services, like health visitors or children's centres that draw on the lessons of Sure Start (Cattan et al,2019), but it may mean referral to more specialist provision. Where those services are lacking, restricted through stringent referral criteria or long waiting lists, the purpose of early identification is foiled. Preventive services can become skewed into focusing mainly on those with acute needs.

4. Professional supervision groups for those working with infants and their families – 'Space to breathe between the thoughts'

-Perceptions of a service or organisation's care for those who serve in it are critical to its success in achieving its objectives and recruiting and retaining staff, particularly at times of stress such as the pandemic. While the Early Years Foundation Stage Guidance has from 2012 mandated 'supervision' for staff, this can mean many things, some of which can be hard to distinguish from management sessions.

-More significantly for this submission, the statutory guidance only applies to school staff, childcare providers and childminders. It is notable that the Family Nurse Partnership and the Blackpool Better Start, innovative programmes which often depend on professionals working on their own (in 'normal' times face-to-face with families, currently often by Zoom or Teams) set strong store by staff supervision. In Blackpool as well as having a minimum of eight contacts with new families, health visitors have peer supervision and one-to-one supervision. But many health visiting and other services are not part of such a culture, although the work can be lonely and challenging.

-Statutory guidance should mandate that all staff working with the 0-2 age group, whether in local authorities, health services or voluntary groups should be offered a 'safe space for reflection' to raise concerns and anxieties in a confidential setting and work through them with colleagues, ideally facilitated by an external professional (Hale 2020, Obholzer 2019).

5. A long-term coherent model to address infant vulnerability: the Bundesinitiative Frühe Hilfen

The Bundesinitiative Frühe Hilfen, the federal German initiative set up to address national alarm about figures for child abuse in the early 2000s through early intervention and preventative

services, is an interesting and innovative approach to prevention and intervention (Renner et al, 2018). Nine experimental projects ran for 5 years from 2007 and were succeeded by a ten year implementation programme across all 16 Länder [states]: its design drew on the experimental findings.

The aims of the programme

Child Protection

- improvement of child protection by implementing early intervention programs
- linking health care with social welfare and charitable activities in the field
- enforcing strong laws protecting children

Primary Prevention

- reinforcing parental competences and responsibilities

Elements of the programme

a. The upskilling across Germany of midwives as 'family midwives', who become close, through regular visits, to households expecting a baby and maintain that contact through birth to the infant's first birthday. They thus undertake, without stigma, carefully designed informal assessments of progress and relationships within the family and have immediate access to additional levels of support as needed.

b. Every state has a Network for Early Intervention incorporating:

-Project associates and local members of all professional disciplines in the area of prevention and intervention in early childhood

-Generation of cooperative-structures in order to mediate appropriate interventions

-A local coordinator who leads on bringing services together.

c. The Nationales Zentrum Frühe Hilfen (NZFH), the National Centre for Early Prevention, an innovative idea in itself, coordinates, supports, and evaluates activities in the Länder, provides programme suggestions and takes responsibility for knowledge exchange between centre and periphery and vice versa.

-The programme runs until 2022, with a current annual budget of approximately €44 million.

-The Bundeskinderschutzgesetz, a ten year 'administrative agreement' between 600 municipalities and the Federal Government agreed in 2013, incorporating commitment to action and funding on both sides, has been a powerful driver of sustained collaboration within the programme.

6. A National Foundation Years Service [Q4, Q5, Q9, Q10]

-Establishment of an integrated National Foundation Years Service could resolve completely, or resolve to a considerable extent, the problems identified in many of the questions posed by the Committee.

-The Service would commission and co-ordinate services from existing statutory and voluntary bodies and ensure proper support for informal child care within a framework of participation and consultation with parents, carers and professionals.

-This would require the establishment of a dedicated Ministerial post and the protection of dedicated, appropriately ring-fenced, budgets (Field, 2010, HSCC 2019). A Minister for Families with broad oversight should take responsibility for the promotion of a joined-up Government vision and agenda to deliver coherence, rather than the current fragmentation, across the foundation years and facilitate local programming and initiative.

-Such a national structure would give the most vulnerable in society (the small infant) a voice and representation in the affairs of state.

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Academics, professionals and policy makers formed Foundation Years Information and Research in 2014 to promote the vital importance of the earliest years to children's development and well-being. The group seeks evidence from research and innovation across the world to help advance policy and practice in the UK and elsewhere. Website: fyir.org.uk.