First 1001 Days Movement response to Health and Select Committee Inquiry Delivering Core NHS and Care Services during the Pandemic and Beyond.

8th May 2020

The First 1001 Days Movement

The First 1001 Days Movement is an alliance of over 110 charities and professional bodies spanning the children, family, mental health, maternity and baby sectors. We work together to drive change together by supporting and challenging national and local decision makers to value and invest in babies' emotional wellbeing and development in the first 1001 days, from pregnancy, as the critical foundation for a healthy and fulfilling life.

This submission covers:

- **The importance of protecting babies' wellbeing, given the pervasive and long-term impacts of stress and adversity during this critical stage in their development.**
- The need for **leadership** to protect the interests of babies in decision making.
- The need for a cross-Government **Recovery Strategy for Children** that fully addresses the needs of babies and their families. This should include:

  Workforce: rebuilding and strengthening community services.

  Identification and Assessment: a greater focus on the most vulnerable and a concerted effort to identify those who are at risk.

  Intervention: boosting capacity to deal with both the backlog and significantly increased need.

  Resourcing: investment now to prevent long-term costs.

  Ways of working: making careful, informed decisions before any new ways of working are normalised.

  Equity: ensuring all providers are supported to deliver safe and high-quality services.

The critical importance of protecting babies from stress and adversity

As charities and professional bodies that care deeply about the wellbeing and development of babies during pregnancy and the first years of life, we are concerned about the secondary impacts of COVID-19. Our specific focus is babies' emotional wellbeing and development, which is so critical to lifelong mental and physical health, but so often overlooked, including in the national response to COVID-19.

Across the UK, there are babies in lockdown in poor quality and overcrowded housing, with shortages of basic supplies, cared for by parents under immense pressure. Lockdown is stressful for everyone, but for babies (born and unborn) this is happening at a critical time in their development where they are particularly vulnerable to family stress and anxiety, therefore the

impact on them will be greater. Mothers and fathers who have faced birth and new parenthood under lockdown have also experienced particular stress at a key transitional point in their life.

Parents play an essential role in babies' lives, providing babies with the nurturing care they need to develop socially and emotionally. For many children, their parents will be providing them with emotional support through this unsettling time. But some parents will find it hard to give their babies the care that they need and will not have the emotional and practical resources they need to buffer the impacts of the crisis for their babies.

Too many babies were vulnerable in the UK before this crisis. 53% of families in the UK with a young child live in poverty.[i] 25,000 babies in England live in households where their parent(s) are already struggling with at least two significant issues - parental mental illness, domestic abuse and/or substance misuse.[ii] Families' problems will have escalated during the COVID-19 crisis as a result of a range of stresses such as economic hardship, job insecurity, isolation, anxiety about the virus and the stresses of lockdown. There is evidence of rises in domestic abuse,[iii] and abuse and neglect of children are likely to have escalated behind closed doors. The significant economic impact of the crisis will persist long after lockdown leading to an increase and deepening of child poverty. All of these issues put babies' wellbeing and development at risk.

There is an urgent need to support babies and their families to prevent immediate and long-term harm. A wealth of evidence shows that exposure to significant stress in the womb or early life can have pervasive and lasting impacts on multiple domains of development.[iv] The risks of early trauma and adversity can be mitigated with the right support. **Rapid action is needed so that babies do not become the "collateral damage" of actions to protect the nations' physical health, with long-term consequences for our children and our society.**

Leadership

Babies will not be protected by accident. A concerted effort is needed to protect and promote their wellbeing. The Select Committee's First 1000 Days Inquiry identified the lack of clear leadership and fragmentation of policy relating to early life across Government.[v] There continues to be a clear need for a cross-government strategy for improving outcomes for all children, starting from pregnancy, led by a single accountable government department and a cabinet-level Minister.

We worry that the current lack of clear responsibility for the wellbeing of young children means that their specific needs are often overlooked. During the COVID-19 crisis, Government's communications about vulnerable children have focussed on older, school-age children and the risks posed by the closure of education settings.[vi] Neither Government nor NHSE have explicitly recognised the particular vulnerabilities and needs of those in the first 1001 days, which have been exacerbated by the scaling back of services.

In response to a question asking "which member of the Cabinet has responsibility for representing the needs of babies and young children in discussions on the response to the COVID-19 outbreak", Government answered, "This issue cuts across multiple departmental responsibilities, as is the

case for many complex concerns, and therefore engages various Ministers..."[vii] Something that is everybody's business can be nobody's responsibility.

Going forward, the needs of the youngest children must be considered more explicitly and transparently by those making decisions about the response to COVID-19. There should be clarity on which junior Minister and which Secretary of State has responsibility for ensuring that policy decisions protect and promote the needs of young children.

Article 2 of the UN Convention of the Rights of the Child states that the bests interests of children should be the primary consideration in all actions concerning children. During the crisis, decisions have been made to scale-back services and relax standards, which have arguably not been in the best interests of children. Now we are "past the peak" the primacy of children's interests must be restored.

There has never been a time when cross-system action and leadership were needed more. We urge the Government to develop a Recovery Strategy for Children that fully addresses the needs of babies and their parents now and in the coming years of hardship.

Workforce

Vital services that would normally support parents and safeguard babies, such as the already depleted health visiting service, have suffered from huge staff shortages during the crisis, due to staff being ill, shielded or in self-isolation and because in some areas large numbers of staff (at least 50% in some cases) have been redeployed to provide other health services. There is a "perfect storm" of increased risk and decreased support for babies and their parents. Going forward, skilled professionals must be deployed where their skills can be best used to reduce harm – including hidden harm in communities.

As the Select Committee's inquiry identified, there is already huge unwarranted geographical variation in the quality and capacity of services in the first 1001 days, which does not reflect variation in local need, but rather differences in local decision making.[iii] Similarly, responses to COVID-19 have not been consistent across the country. Some areas redeployed staff, whilst others boosted services. There has been no guidance about redeployment from health visiting services, or about acceptable caseloads for staff who remain, no data collected about redeployment and no scrutiny of decisions made.[viii] Babies and their families face a significant "postcode lottery". This is not good enough - Government must take responsibility for ensuring that every baby and their family receives a core level of care regardless of where they live.

Now that we are "past the peak" Government, PHE and NHSE must work together to restore core services for babies and their families. Clear guidance should be published as a matter of urgency on how to ensure vital support is available for families. Government must encourage local decision makers to bring staff back into services such as health visiting, parent-infant and perinatal mental health teams - recognising that these services provide essential support to families at highest risk and are needed more than ever. It must be emphasised that contingency plans and guidance are a MINIMUM for what services should deliver, and services should aim to offer as full as service as they can as soon as possible. We hesitate to say that services should

"return to normal" because sadly many services such as health visiting have been so depleted in recent years, and other services are so patchy, that "normal" is not good enough, particularly in light of the trauma many of our nation's families have experienced. We must do better.

Action to support staff and boost recruitment and retention will be important to ensure the effective operation of services. This will require resource. Staff may have been ill, have lost loved ones, been redeployed into difficult roles, or left managing significant risks and large caseloads. This will have taken a toll on them and there is a risk of significant attrition without action. Action should be taken to ensure delays in training and qualification do not impact on future capacity.

Identification and Assessment

To protect babies from harm, services cannot just focus on those families known to be at risk before the crisis. Research by the Children's Commissioner shows that many babies who are at risk are not known to services.[xxviii] Furthermore, during the crisis, existing challenges are likely to have escalated and new problems emerged in families who may have previously been coping. Many families will be struggling behind closed doors. Normally, these babies might have contact with nurseries, children's centres, toddler groups or family and friends. Now, they, and their parents, may not be seen by any other adults. We can't expect that families in trouble will ask for help: we know that parents often hide their struggles for fear of stigma and judgment. Babies can't speak out.

It is therefore important that:

- As a minimum, all routine health visiting contacts with families are reinstated as soon as possible to enable contact with families and assessment of children's needs. These must involve personal contact – Government must be clear that contact by post is not sufficient.
- Additional contacts take place to "check-in" with families in the long gaps between the 6 week, 9-12 month and 2-2.5 yr contacts.
- Public services and charities in each locality coordinate their work to ensure vulnerable children are identified and families get the support they need. This includes ensuring good sharing of information and intelligence between services, including adult services being particularly alert to whether their service users have babies at home.
- Services should make active efforts to contact those who have been discharged from mental health and social care services within the last year, since these families may experience problems re-emerging or escalating during lockdown.
- Health visiting services should undertake face-to-face visits for core contacts where they need to assess a child, and in all cases where they might have concerns about a babies' welfare.
- Babies should be prioritised for visits in person by social workers, recognising that it is very difficult to assess a baby's welfare and development without being physically present.

- Lack of sufficient PPE has been a deep source of stress for frontline workers and the families they come into contact with throughout the pandemic.[ix] Social work, health visiting, perinatal and parent-infant teams and other core services should be equipped with sufficient PPE for face-to-face visits.

Working with the most vulnerable families is skilled work and dependent on trusting relationships, which enable parents to feel confident disclosing their challenges and receiving support. The churn of professionals within services can disrupt these important therapeutic relationships. Continuity of carer must be valued in planning of services. Services must aim not only to maintain "contact" with families but to enable effective work with families that ensures their needs are fully understood and met.

Intervention

As lockdown is gradually lifted, there are likely to be continued constraints on how health and social care services can work for a prolonged period. We call for the restoration of services for vulnerable youngest children to be prioritised – babies can't wait.

In the coming months, demands on services will grow significantly as they have to make up appointments missed during the lockdown. Professionals will need to proactively reach out to identify families who have missed contacts or have needs which are not being addressed. This will take effort and resource.

Some contacts done virtually will need to be repeated to undertake a full assessment of a child's needs and development, otherwise, critical issues may go undetected, with significant impacts for the child's wellbeing and development. This will require resource now to reduce demands on services in the longer-term.

There will be an increased need for services as a result of the pressures that families have experienced. While the situation is stressful for all families, the impact of COVID-19 will be greater for families who had fewer physical and social resources to begin with and will have suffered greater hardship through the lockdown. The impact of the lockdown, and the lack of access to services, mean that COVID-19 is likely to widen gaps in development between the poorest children and the rest. A concerted effort will be needed by all services to help children and families to recover. There must be evidence-based interventions for babies whose development is at risk from the early adversity that they have experienced. Intervention now can ensure that that these babies' exposure to stress and adversity will not have long-term effects.

We are also concerned about:

- A rise in birth trauma due to some women experiencing heightened anxiety and not having the same level of support during induction, labour and birth that they might normally have had from professionals and family members.
- The trauma experienced by babies in NICU and their parents where social distancing or social isolation rules in hospitals have prevented parents seeing their babies. Parents of

babies in NICU must not be considered as visitors and their presence should be encouraged. Testing symptomatic parents and of suspected contacts should be prioritised so that parents do not have to spend time unnecessarily away from their babies. Those families who have experienced early separation may need support to overcome this relational trauma.

- There will also be babies born after the lockdown who may have been conceived in abusive relationships and/or whose parents may have desired to terminate a pregnancy but not had the access to services to do so.

These families and their babies will need particular emotional support now and into the future.

A Recovery Strategy for Children must consider how services can adapt and grow to meet the additional needs identified above. Additional resources must be made available for health visitors, perinatal mental health and parent-infant teams and other early years services to enable them to offer evidence-based interventions to support parents and to promote and protect babies' wellbeing and development. There should be sharing of learning about how services can work effectively to identify and meet demand.

Resourcing

Activity to improve identification, assessment and intervention requires additional funding for services which were under-resourced before the crisis. When Government was asked about their plans to support services to meet potential increases in demand, they described money already made available to local authorities.[x] Although there has been £3.2bn made available to local authorities, this, and any funding to the NHS during the crisis, is likely to have been used to deal with immediate demands of the virus and to fill shortfalls in funding created by lost income. Without additional specific funding, it is unlikely that any of this funding is left to increase capacity in services for babies and their families.

Ways of working

During the lockdown, many services have worked virtually with parents and their babies. There are some benefits of this approach which can be utilised in future. Some families engage well in virtual contacts, and there are fewer costs and barriers to attendance than in face-to-face services. Many young parents seem to appreciate video-based services and in some cases, fathers, who are now at home with their family, will engage in a video-based contact whereas they would not previously have attended appointments.

There are important risks to virtual service delivery:

- Many families facing multiple disadvantage are digitally excluded, perhaps lacking smartphones, access to data or wifi, or the literacy and language skills to engage with services remotely. Others may lack private, quiet space to take a call. These families therefore face a double disadvantage of increased need and increased barriers to engagement.

- Not all providers have the right technology to enable effective virtual work with families. During the crisis, many professionals have relied on personal smartphones because their professional mobile phones an laptops did not enable effective delivery of services. There are also differences between the platforms that families prefer to use (WhatsApp and face Time) and those endorsed and enabled by NHS and other providers.
- It is very difficult to assess babies' wellbeing and parent-infant interaction through telephone or video contact with families. It is also more difficult to elicit need or identify safeguarding concerns as assessments rely largely on parental report and do not provide the additional contextual cues that can be achieved through a face-to-face home visit. Indeed, often the baby remains unseen through these contacts.
- Working remotely can make it hard to build and maintain trusting relationships with families, especially where a service hasn't had contact with a family before. It is harder to read non-verbal cues and make an emotional connection, and conversations may be interrupted by technical issues.

There is limited evidence for the effectiveness of a range of services that are now being delivered virtually and further research is needed to understand their impact and any unintended consequences before any changes are adopted more permanently.[xi] The value of face-to-face work, the importance of relationships, and the significance of professionals observing a baby and parent-infant interaction must not be forgotten.

Equity

The diversification in the market for children's and mental health services means that services can be provided by a range of private, NHS and third sector organisations. Many key services, including breastfeeding and mental health peer support, are often delivered by charities. COVID-19 has impacted organisations differently: NHS providers are more likely to have been redeployed but also are likely to have better access to PPE. Charities have seen more uncertainty in their funding. Moving forward, it is essential to ensure all providers are supported and have the practical and financial resources to offer safe and high-quality services.

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[i] Poverty amongst families whose youngest child is 0-4, using a measure of 60% median income after housing costs. Houses below average income 2018/19. https://www.gov.uk/government/collections/households-below-average-income-hbai--2

[ii] Miles, A. (2018). A Crying Shame A report by the Office of the Children's Commissioner into vulnerable babies in England

[iii] https://blogs.bmj.com/bmj/2020/05/07/domestic-violence-during-the-covid-19-pandemic/

[iv] For example, Yehuda, R *et al* (2005). Transgenerational Effects of Posttraumatic Stress Disorder in Babies of Mothers Exposed to the World Trade Center Attacks during Pregnancy. *Journal of Clinical Endocrinology & Metabolism*, and Center on the Developing Child (2007). *The Impact of Early Adversity on Child Development* (InBrief). Retrieved from www.developingchild.harvard.edu.

[v] Health Select Committee (2019) First 1000 days of life inquiry

[vi] For example, DfE (19 April 2020) Supporting vulnerable children and young people during the coronavirus (COVID-19) outbreak (https://www.gov.uk/government/publications/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people)

[vii] Written PQ 38867

[viii] Written PQs 38863 and 38854

[ix] https://blogs.bmj.com/bmjsrh/2020/04/17/midwives-masks/

[x] Written PQ 38866

[xi] https://www.eif.org.uk/report/covid-19-and-early-intervention-evidence-challenges-and-risks-relating-to-virtual-and-digital-delivery