First 1001 Days Movement – Spending Review Submission

September 2021

The First 1001 Days Movement is an alliance of nearly 200 charities and professional bodies from across the UK. We work together to inspire, support and challenge national and local decision makers to value and invest in babies' emotional wellbeing and development in the first 1001 days.

Summary

In March, The Government set out a compelling "Best Start for Life Vision". In the upcoming Spending Review, the Chancellor must provide the resources required to ensure that this Government policy becomes a reality for babies and their families across England.

The Chancellor has said that the Spending Review will ensure "strong and innovative public services" and level up across the UK to "increase and spread opportunity." Achieving these goals is impossible if we do not focus on creating strong and effective services that give our children the best start in life.

Science shows us that action in early life can prevent problems that can be costly to individuals and society. Economics shows that investment at the start of life generates the greatest returns.

We are calling for investment and action to make a reality of the Government's Start for Life vision. This should ensure that there are resources in local systems to enable all services to operate effectively, including – but not limited to – maternity, health visiting, infant feeding support, perinatal and infant mental health services.

In this submission, we set out the case for:

- A £500 million ringfenced uplift in the Public Health Grant over the next three years. This will enable local authorities to create strong and innovative health visiting services able to play their role in increasing opportunity for our citizens and reducing long-term burdens on the NHS.
- £88 million for the development and employment of a specialist parent-infant workforce, and a national development programme. This will mean that by 2025, specialised parent-infant teams are operating in all areas of England. It will deliver not only the Start for Life Vision but also the NHS Long Term Plan commitment to provide specialist mental health care for all children and young people from 0-25.

This investment will transform local systems to enable them to deliver seamless support to families that will improve outcomes and tackle inequalities. It will improve the quality of local services, building a stronger workforce able to work compassionately and effectively with families. It will lay the foundations for the future health and happiness of our babies and our society.

Contents

The period from pregnancy to age three is when children are most susceptible to environmental influences. Investing in this period is one of the most efficient and effective ways to help eliminate extreme poverty and inequality, boost shared prosperity, and create the human capital for economies to diversify and grow.'

World Health Organization, United Nations Children's Fund, World Bank Group [1]

The case for action

Investment in the earliest years can be extremely cost-effective and generate long-lasting benefits.

1. Development during pregnancy and the first years of life shapes the architecture of a child's growing brain. During this time, foundations are laid which will ultimately influence their education, physical and mental health, and their eventual career and lifelong wellbeing[2]. This is an important period to influence lifelong health and happiness.
2. The brain is more 'plastic' or malleable during the earliest years of life, whereas it is harder to make changes later on. Studies following children exposed to extreme neglect, for example, have shown that those adopted earlier were much more likely to achieve normal levels of development[3]. Similarly, research has shown that the impact of exposure to unpredictable environments is much more significant if it occurs during the earliest years of life[4].
3. Children's brains adapt to their early environments. Children ho experience early adversity and trauma can develop in a way that increases their vulnerability to later mental health problems[5].
4. Given that what happens early in life has such a fundamental impact, it is a critical time for investment. This is when we can make a real difference to children's wellbeing and future social, educational and economic success.

5. During the first 1001 days, we have the opportunity to set children on a positive developmental trajectory. Getting things right early in life brings cumulative benefits, as children are better able to take advantage of later interventions and opportunities. For example, if a child starts school with basic skills such as language and emotional regulation, they will be more likely to engage with learning, and therefore will benefit more from what happens in the classroom. This not only benefits children, it also means investment in our education system will generate greater returns.
6. If we miss opportunities to support families facing adversity during a child's early years, those children are less likely to achieve their full potential and their families are likely to need more help from public services throughout their child's lifetime.

'Investing in the early years is one of the smartest things a country can do. Early childhood experiences have a profound impact on brain development – affecting learning, health, behaviour and ultimately, lifetime opportunities.'
World Health Organization, United Nations Children's Fund, World Bank Group [6]

7. Early interventions can be extremely cost-effective and generate long-lasting benefits. Conversely, if a child has a difficult start and falls behind in developing important emotional and social skills, it is harder, and more expensive, for services to make a difference to their outcomes later. Investing later, once children have fallen further behind their peers, may not be effective in tackling inequality or in increasing productivity in society[7,8,9.] The Nobel economist James Heckman has shown that the most economically efficient time to invest in developing children's skills and social abilities is in the very early years.

The rationale for an early years focus:

• An individual's experiences in early childhood, particularly their early relationships and interactions, have significant and long-lasting impact on their future health and wellbeing

• Early years interventions can be extremely cost-effective, generate long-lasting, cumulative benefits and at the same time reduce the need for remedial spending later in life

• Effective early years interventions will ensure that children are more responsive to follow-on interventions as they grow older
GLA Economics[10]

'The Heckman Curve shows… the economic benefits of investing early and building skill upon skill to provide greater success to more children and greater productivity and reduce social spending for society'[11]

There are significant costs of inaction.

8. If we fail to act early in a child's life, we can miss opportunities to mitigate problems that bring costs to children, families, and public services. The consequences of interventions that come too late are significant.

The Early Intervention Foundation has estimated that in England and Wales, the cost of late intervention in 2016/17 was £17 billion, equivalent to around £300 per person, because of the need for services to address problems such as mental ill-health, youth crime and exclusion from education [12,13].

Mental health problems during childhood and adolescence are estimated to cost between £11,030 and £59,130 annually per child in the UK[14]. These are immediate and short-term fiscal costs. The longer-term cumulative costs, over decades, will be considerably larger.

Without stable, nurturing relationships in the earliest years, children can develop an 'insecure attachment' style. Research has found a striking difference between the costs to public services for at-risk young people who are securely attached to their parents and those who are not. For example, the annual costs for health, education and social services for at-risk young people who were insecurely attached to their fathers were ten times more than those who were securely attached[15]. This difference remained significant, even after adjusting for other confounding factors such as family income, education, intelligence and antisocial behaviour.

The authors conclude *'Since adolescent attachment security is influenced by caregiving quality earlier in childhood, these findings add support to the public health case for early parenting interventions to improve child outcomes and reduce the financial burden on society.'*

Our children of today are the workforce of tomorrow.

9. Investing in early childhood development, particularly for children facing disadvantage provides a return to society through increased personal achievement and productivity. Research in developing countries has found that children not reaching their full developmental potential in the first five years of life results in an average adult annual income deficit of 19.8%[16]. UK research has found that psychological problems in childhood, are associated with a reduction in family income of 28% at age 50[17]. Studies show how early childhood programmes can improve economic participation for today's parents, for their children, and even for subsequent generations.

A World Health Organisation study[18] has shown that children who receive home visits to provide nutritional advice and cognitive stimulation, show improved development when they are young and increased earnings in adulthood. In addition, when the participants of the study grew up and had children of their own, those children developed better. So, early investment can have social and economic benefits for generations.

10. In just a couple of decades, today's babies and toddlers will be preparing to work in and ultimately run the UK's business and public services. What we do for them now will profoundly affect their success and productivity at work and have implications for all our futures and our future economy.

Our services are not resourced to provide sufficient, high-quality support.

11. Services for families in early childhood are fragmented and funded in many different ways. While NHS funding has largely been protected, funding that local authorities receive for public health and children's services has been significantly reduced. This is the funding that is used for services such as health visiting, family hubs and early years family support.

- Estimated funding for local authority children and young people's services fell by 23% between 2010/11 and 2018/19[19]
- Reductions in overall funding mean the 'early intervention' allocation has fallen by 64% during that period[20]
- Public Health Grant allocations have fallen in real terms from £4.2 billion in 2015–16 to £3.3 billion in 2021–22. This equates to a cut of 24% per head[21]

This led to reductions in spending on families.

- Local authority spending on early intervention services for children and young people has fallen from £3.5 billion to £1.9 billion between 2010/11 and 2018/19 – a 46% decrease[22]
- Annual public health expenditure on services for 0–5-year-olds dropped by 20% between 2016/17 and 2019/20[23]

12. In difficult economic times, prevention and early intervention services are more likely to be cut, with funding focussed instead on crisis services or later interventions[24]. There is growing evidence that this is what has happened in local authorities across England since 2010 [25,26]. Services working with our youngest children have been hit particularly hard, in part because many services for babies are not statutory. However, this is a short-sighted approach that will have long-term implications.

'…preventative activity is hindered by the pace of cuts, loss of organisational capacity and the fact that immediate fiscal benefits will not be felt or may flow to other organisations. These not only harm individual welfare and constrain opportunities but are likely to be storing up problems for the future – problems which will require expensive public service responses at a later date.'

Joseph Rowntree Foundation[27]

Health visiting

13. Since health visiting was transferred from the NHS to councils, the Public Health Grant has been reduced by £700m in real terms[28] and the number of health visitors has declined[29].

14. In July 2019 there were 6,615 full-time equivalent health visitors in the NHS in England, compared with 10,309 in October 2015[30]. There are estimated to be around 900 health visitors employed outside the NHS, but the fall is still significant – more than a quarter of the workforce[31].

15. Health visitors are having to manage increased caseloads, resulting in less time and fewer resources to support families. The Child Safeguarding Practice Review Panel's Review of sudden unexpected death in infancy warned that the pressures on health visitors are limiting the opportunity to build relationships and explore vulnerabilities, particularly in families living in areas of high deprivation, with potentially catastrophic consequences[32].

16. As a minimum, all families in England should be offered five mandated reviews by health visiting services. Many families are not receiving their mandated checks with a health visitor, let alone able to access additional, timely support. If families do get reviews, they are often not conducted by a health visitor but by a less qualified professional or families may only receive a letter with no face-to-face contact at all. Many families see several different professionals over time and do not have opportunities to build trusting relationships.

17. The cuts in services – which are still taking place - mean that many families no longer receive a good service and there is a "postcode lottery" of support. Health visitors are operating with caseloads of 800-1000 families in some areas, services are designed so that there is a lack of continuity in care, and opportunities to see families face-to-face are restricted. In these circumstances, even the most skilled professionals cannot work effectively.

- Research about which assessments health visitors carried out found: the majority conducted new birth visits (79%) and 6–8-week assessments (67%), but far fewer conducted antenatal visits (35%), 9–12-month assessments (17%) and 2-2.5-year-old check (10%). These were generally conducted by a less qualified practitioner[33]
- Nationally, around 20% of children miss out on their 2-2.5-year-old check. This number is as high as 65% in some areas[34] This is the only routine contact that families have with health visitors after babies are 9-12 months old. It is a crucial time to identify and act on developmental and social concerns.
- A survey of 2,000 mothers in England before COVID found that a quarter had reviews conducted by letter, text message or phone call, instead of face-to-face[35]
- An NSPCC survey found that only 6% of families had been supported by the same health visitor during the perinatal period[36]

'With the service stretched so thin and with so few contacts for universal families, we lose the ability to develop relationships with families. This is a barrier to being able to offer timely support to families as new concerns arise with children and families.'

"In some areas of the county our teams are down to 52% of the health visitors they should have and this means that all we can do is firefight".

"We have no choice but to look for alternatives to deliver the healthy child programme because we do not have enough staff to even deliver the five mandated contacts, we really struggle to deliver the antenatal and 6-8 week contacts and all of our developmental reviews at 12 months and 2 years are completed by the community health workers"

Quotes from health visitors[37]

Funding to deliver the Start for Life vision

"...I know my right hon. friend the Chancellor is determined to ensure that we get the proper funding for early years because the investment that we make in those first three years repays society and families massively." Boris Johnson, House of Commons, 7th September 2021

18. We were delighted to see the Government publish its Start for Life policy in March. To achieve the vision for a coherent and joined up Start for Life Offer in every local area, Government must provide additional funding to our stretched local systems.
19. Funding is required to strengthen our maternity, health visiting, infant feeding support and mental health services alongside local authority children's services and voluntary sector services that support families. In this submission, we specifically focus on funding for health visiting and infant mental health services. However, we do highlight other important areas for investment.

Investment in health visiting

20. We are calling for a £500 million ringfenced uplift in the Public Health Grant over the next three years. This will enable local authorities to create strong and innovative health visiting

services able to play their role in increasing opportunity for our citizens and reducing long-term burdens on the NHS.

Who are health visitors?

21. Health visitors are a workforce of skilled specialist public health nurses, with the expertise required to provide holistic care to families. They support babies, children and adults, and are the infrastructure that can deliver preventative and community healthcare services.

22. Health visitors offer a proactive universal service, which means that – if services are operating effectively - all families are offered contacts where a health visitor can build relationships, discuss important health promotion messages, and assess the families needs to plan ongoing support or referrals to other services if needed.

23. Health visitors can take the pressure off GPs and A&E departments and can help children to have the early experiences required to arrive at school better able to control their behaviour and ready to learn. They can also reduce burdens on children's social care through identifying concerns and referring families to early help services before problems escalate. Health visitors play a key role in ensuring families have a happy healthy start in life.

24. As skilled health professionals, health visitors play a safety-critical role identifying and managing common and serious health problems for women and babies after birth. They can identify early signs of illness or developmental delay; help to prevent illness and accidents, and give families the confidence to look after their child's health and support early development. They can also provide invaluable support to mothers and fathers.

Case study – perinatal mental health

Leanne had birth trauma and severe postnatal depression after her first son was born. During her second pregnancy, she started to struggle to control her anxiety around the birth and talked to the family's health visitor, Holly, for extra support. Leanne's describes the support offered to her and her family:

"… Holly was there for me throughout. No matter how bad things felt I knew I could pick up the phone to her and she would be there to support me through it… I've lost count of the number of times she has phoned me to check in or come back to me long after her working day must have finished. I honestly don't know where I would be without Holly and I can't thank her enough!"

Our Spending Review ask

25. When health visiting services are invested in, they can work in new, evidence-based and innovative ways to provide excellent services, especially to our most vulnerable families. A £500 million ringfenced uplift in the Public Health Grant over the next three years would enable growth in health visitor numbers and strengthening the leadership in health visiting services.

26. We are calling on Government to invest enough to reach a total of 5000 new health visitors over the next 5 years, with 3000 in this spending review period. Research by Professor Gabriella Conti[38] suggests that at least 5000 new health visitors are needed in England to deliver the service that families need. This would enable services to be closer to a point where health visitors have, on average, a caseload of 250 families. This is the caseload level achieved in Scotland and Wales, and that experts recommend to enable a high-quality service for families. In reality, health visitors would not have uniform caseloads; those in

areas of high need or deprivation might have smaller caseloads to reflect the greater need amongst families.

27. In addition, we are asking for £4m over the spending review period to increase the leadership capacity in health visiting services. This additional capacity would enable service leaders to drive excellence in practice through workforce development, research, service innovation and strong integration with other services. It would also facilitate the employment of Specialist Health Visitors in Perinatal Mental Health, who play a key strategic role in supporting parents and infants in pregnancy and the earliest years.

The costs of health visitor workforce development are shown in the table below:[a]

	2022/23	2023/24	2024/25
Substantive band 6 health visitor posts	£38m	£76m	£114m
Training student health visitors (band 5 salary)	£86.9m	£86.9m	£86.9m
Leadership	£0.8m	£1.6m	£2.4m
Total	£125.7m	£164.5m	£203.3m

Investment in infant mental health

28. We are calling for £88 million over the Spending Review period for the development and employment of a specialist parent-infant workforce, and a national development programme so that by 2025 specialised parent-infant teams are operating in all areas of England.

What are specialised parent-infant relationship teams?

29. Specialised parent-infant relationship teams are multidisciplinary teams with the specialist skills required to work with babies and their families where there are severe, complex and persistent problems in early parent-infant relationships. They provide direct therapeutic care to babies, toddlers and young children and their parents where there is a need for specialist mental health support. They also develop local universal and targeted services through the provision of training, consultation and supervision to the local workforce in health and children's services, including the voluntary sector and early years settings.

30. Parent-Infant teams provide interventions that enhance parental sensitivity and strengthen the parent-infant relationship and therefore have the potential to improve lifelong mental health and to make significant savings within a generation. They have the specialist expertise to support families where there are severe, complex and persistent problems in, or risks to, early parent-infant relationships. If left untreated, these types of problems jeopardise babies' lifelong mental health and their cognitive, social and emotional development.

31. The NHS Long Term Plan set out a goal to provide specialist mental health care for all children and young people from 0-25 who need it. Despite the proven importance of early relationships for building the foundations for good mental health during the first years of

[a] These figures include 1000 new band 6 health visitors each year, and 1000 more in training. The three year total is £494m.

life, and its influence on a wide range of outcomes including lifelong mental health and wellbeing, our mental health system does not cater well for the needs of this group.

In a recent survey of NHS CAMHS professionals, only 9% of respondents felt there was "sufficient provision available for babies and toddlers whose mental health was at risk" in their area. Many professionals reported gaps in their skills and experience relating to work with the youngest children.[39]

Our Spending Review ask

32. £88m could fund the workforce required for the roll-out of parent-infant teams across England together with a national development programme to support the effective set-up and operation of teams.

33. These costings are developed using analysis by Professor Gabriella Conti at UCL, and a workforce model developed by Dr Pauline Lee in Greater Manchester. This assumes a multidisciplinary team of 5.13 WTE professionals for an area with a total population of 280,000. Each team could see around 150 babies per year directly and offer training and supervision to the wider workforce in universal and targeted services. Using this model, there would need to be 202 teams in operation to cover the whole of England[b], this number of teams could see 30,300 babies and their parents directly. These are families whose challenges are most difficult to resolve and most likely to jeopardise babies' lifelong mental health and their cognitive, social and emotional development if left untreated.

34. We propose a gradual rollout of teams to reflect the readiness of different systems to provide parent-infant services and the need for workforce development. Our modelling sees the full funding of 40 teams in the first year of spending review (made up of those teams already in operation but able to scale up their work and in areas where there is already emerging provision). More teams would begin operation each year of the spending review. There would be 135 in full operation in the final year of the spending review, and development in 67 more sites – enabling 202 teams to be operational from April 2025, when funding for infant mental health provision should be included within NHS baselines.

35. The funding of £88m over three years covers:

    1. the costs of post-qualification training to enable mental health professionals to develop specialisms in parent-infant work
    2. the employment costs for sufficient professionals to staff 202 teams by the end of 24/25
    3. funding for a development programme of national oversight, capacity building, support for teams and evaluation.[c]

Year	22/23	23/24	24/25
Number of teams operating fully from 1 April that year	40	80	135

[b] In reality this would be the average size of teams. There would not be 202 identical teams. Teams would vary in size to cater for different geographical areas with different levels of need. In some cases they would form part of a wider early years mental health service catering for 0-4 year olds.

[c] It does not cover pre-qualification training of professionals (assuming this is covered in other elements of the NHS workforce plan and budget). It does not cover other costs associated with service delivery, which local commissioners would need to fund.

Labour costs of teams fully operational[d]	£9.5m	£19.6m	£34m
Labour costs of teams coming into operation[e]	£4.8m	£6.7m	£8.5m
Cost of training for teams coming into operation[f]	£0.4m	£0.8m	£1.0
Development programme[g]	£0.5m	£1m	£1m
Total each year	£15.2m	£28.1m	£44.5m

Investment in the wider Start for Life vision

36. Whilst we focus in this submission on health visiting and specialist parent-infant teams, it is important to recognise the need for a full system of care for families:

37. We strongly support investment in maternity services. It is important that there is a sufficient, skilled workforce in maternity services not only to ensure safety for parents and their babies, but also to provide emotional and mental health care as described in the newly revised NICE guidelines.

38. Infant feeding support is offered as part of maternity and health visiting services, but families also rely on a range of expert professional and volunteer support provided by third sector organisations which work closely with local health services. It is vital that this full spectrum of high-quality support is recognised and funded as part of the Start for Life offer in every local area.

39. The third and voluntary sector plays an important role in providing accessible, often peer-led, support to parents experiencing perinatal mental health problems across all ranges of severity. This support can make a lasting difference to parents, families and communities. Alongside funding for NHS perinatal mental health services, it is important that there is sustainable funding for third and voluntary sector services to be commissioned as local pathways of care for parents and their families.

40. Many babies and toddlers start using formal early education and childcare before their second birthday. When families use childcare, it is important that care is high-quality and provides babies with the sensitive, responsive, consistent relationships that they need to thrive. Because the focus of much Government funding is on children aged two and above, provision for those under two can sometimes be overlooked. We support the calls for sustainable funding for the early education and childcare sector, and for investment in workforce development within this sector to ensure high-quality provision for all children including the youngest. It is also important to recognise the important role of services such as stay-and-play, toddler groups and library services, which work with parents to support early learning and play in the home and community.

[d] Includes salary costs and 14% uplift to cover non wage costs such as national insurance and pension contributions. Assumes a 3% pay increase each year.

[e] Includes labour costs for half a year – assuming that the team will be recruiting gradually over the year.

[f] Based on a budget of £16k per team over two years for some specialist training in infant mental health and particular interventions. Pre-qualification training is not covered here.

[g] Includes national and regional work to build capacity in local areas, support for teams and evaluation.

Reducing the pressures on families

41. Stress factors, such as – but not limited to – poverty, domestic abuse, mental illness, substance misuse and unresolved trauma can make it harder for parents to protect, support and promote young children's development. The occurrence of adversity within families increases need for our public services, and also increases the complexity of the issues that public services have to address. Therefore, Government's approach to giving children the best start in life should have two prongs – reducing adversity and providing support to families. For this reason, we support calls for the Government to tackle child poverty.

42. Households with young children face the highest risk of poverty in the UK. In the last decade, poverty has risen faster for this group than for other children. 1.3 million (30%) of the 4.3 million children in poverty in the UK are babies and young children under the age of five[40] and 34% of families with at least one child under five now live in poverty[41]. Families with young children are also more likely to be experiencing poverty that is severe and persistent. A quarter of young children currently experiencing poverty are experiencing "deep poverty" (living below 50% of the poverty line)[42].

43. Living in poverty has a range of direct and indirect impacts on babies' wellbeing and development. Research suggests that poverty can impact early brain development due to reduced opportunities for positive stimulation, increased exposure to stress and/or because the stress associated with poverty can make it harder for parents to provide their babies with the sensitive, nurturing care they need to thrive[43]. Poverty also interacts with other risk factors facing a family; for example, there is evidence to show that maternal mental health problems have a greater impact on child development in households with lower income[44].

44. We support calls on Government to use social security to level up and spread opportunity across the UK, and to consider calls from child poverty charities to:

    - Stop the proposed £20 a week cut to universal credit and increase legacy benefits by £20 a week – reducing child poverty by 350,000
    - Scrap the benefit cap and two child limit – this would only cost £1.9 billion and would pull nearly 300,000 children out of poverty
    - Increase child benefit by £10 a week – providing a small income boost to all families affected by COVID. This would reduce child poverty by 450,000

Contributing to the Chancellor's Spending Review goals

First 1001 days and "levelling up"

45. Babies and their families have different experiences, needs and outcomes. There are differences too in public spending and the quality and quantity of support available for families in different areas. Often there is a mismatch: The level of support available for families does not necessarily reflect the level of need.

46. The quality and sufficiency of services that support families in the first 1001 days vary greatly between different areas, leading to some families getting a very different offer of support to others. Tackling these inequalities will be key to 'levelling-up' and ensuring equality of opportunities across the country.

47. Differences in local priorities, combined with difficult decision making forced by austerity and gaps in national policy have led to significant variation in the services available for families. The box below illustrates some of this variation.

- Several studies point to significant differences in the provision of children's centres and family hubs across England. The extent of cuts to children's centres, the number of centres and hubs that remain open, and the range of services on offer vary significantly[45].
- There are disparities in the proportion of children who have contact with health visitor services and the nature of these contacts[46] . The latest data from Public Health England found that, while 85% of toddlers had had their 12-month health visiting review by the time they reached 15 months old, the number of children having this check on time in different local areas ranged from 11% to nearly 100%[47] .
- Although there have been developments in recent years, there are less than 40 specialised parent-infant relationship teams across the UK. There are huge variations in the mental health support available for families, even where there are concerns about babies' wellbeing and development. In 2019, research found that 42% of CCGs in England reported that their mental health services would not take a referral for a child aged two or under[48].

'...provision is fragmented and highly variable across England, with inadequate effective oversight mechanisms for the Government and others to monitor what local authorities are delivering'
House of Commons Science and Technology Committee[49]

48. Services in more disadvantaged areas are more likely to be of poorer quality than in richer neighbourhoods (although there are many examples where this is not the case). The inverse care law suggests that the availability of good care tends to vary inversely with the need in the population served[50]. There are many reasons for this. In the case of children's services, for example, research has found that there are variations in workforce quality between areas, with services in deprived areas being more likely to struggle to recruit a high-quality workforce[51].

49. Over the last decade differences in service provision between local areas have been exacerbated by spending decisions. Disadvantaged areas in England – those likely to have the highest levels of need – have seen the most rapid decline in funding and therefore service provision.

50. As described earlier in this submission,there have been significant cuts in central government funding for children and young people's services over the last decade. Funding was cut faster for more disadvantaged areas. Central government funding for children and young people's services for the fifth most deprived local authorities fell more than twice as fast as for the least deprived over the last decade [xiv].

'The reality is that despite the efforts of local government the poorest places and the poorest people are being the hardest hit, with those least able to cope with service withdrawal bearing the brunt of service reduction.'

Joseph Rowntree Foundation[52]

51. Changes in how local authorities are funded – with less central government funding and more reliance on local revenue – has disadvantaged more deprived areas. These areas used to receive more from central government funding based on higher need and usually have less capacity to raise their own revenue [53]. This has led to very significant declines in the total resource available to spend on services. Therefore, local spending on children and young people's services has fallen even faster than central government funding. *Spending* on these services in the fifth most deprived local authorities has fallen five times faster than spending in the least deprived over the last decade[54].

52. There are also enormous regional differences in spending cuts. Between 2010/11 and 2018/19 spending on children's services fell three times as fast in the North as in the South of England.

53. Areas facing the largest cuts and the greatest reductions in spending are the ones facing the greatest demand. Reductions in funding are therefore likely to further entrench inequalities. Local authorities servicing more deprived communities are experiencing higher demand and greater financial pressures, leading services to 'screen out' more cases, work with families for shorter periods, and spend less per child in need[55].

54. Research has shown a greater reduction in service use amongst families in disadvantaged areas. For example, between 2014/15 and 2017/18 there was a drop of 18% in the number of families using children's centres in England. This was not uniform, usage in the most deprived areas fell by 22%, but in the least deprived by 12%[56].

55. Investment in services for families during the First 1001 Days -with a particular focus on increasing capacity and quality of services in areas of deprivation - will be vital in achieving the Chancellor's goal to increase and spread opportunity in England.

First 1001 Days and the NHS

56. Investing in services that give children the best start in life reduces demands on GPs, hospitals and social care. It means children start school ready to learn and to achieve, so our schools can be more effective.

57. Many of the issues that result in under 5s using NHS services are preventable:

- Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are among the leading causes of attendances at Accident & Emergency and hospitalisation amongst the under 5s.
- 80% of accidents to under 5s are in the home, with children from the poorest families more likely to be killed or seriously injured.
- Dental caries are the most common reason for children being admitted to hospital. Removal of teeth is the highest cause of anaesthesia in under 5s.

Counting the costs

- In 2017 it was estimated that the annual costs of hospital admissions for RSV (Respiratory Syncytial Virus) in children aged 5 and under were £37.5million[57]. Health visitors can help to prevent the occurrence of RSV by promoting breastfeeding, avoidance of cigarette smoke and hand hygiene at the home. They can also support early action which prevents cases reaching hospital.
- There are also 450,000 visits to A&E departments and 40,000 emergency hospital admissions in England each year because of accidents at home among under-fives[58]. The cost of treating children's accidents as outpatients and inpatients has been estimated at more than £275 million a year. It can cost as much as £250,000 to treat one severe bath water scald[59].
- In 2015, the cost of tooth extractions for children aged 4 years and under was approximately £7.8 million[60].

58. Health visitors are a trusted source of knowledge, advice and information for parents. They should have an important role in building parents' confidence in how to manage minor illness. If they have the opportunity to develop trusting relationships with mothers and fathers, they could be first point of contact for parents who are unsure on the best course of action when their child is unwell. This can help reduce the number of times parents access GP surgeries and A&E departments for problems that can be dealt with elsewhere.

59. For younger children, health visitors have a crucial role in the promotion of breastfeeding, bottle hygiene awareness, immunisations, and supporting parents to give up smoking, all of which can reduce attendances at A&E and subsequent hospital admissions.

Health visitors and immunisation

Coverage for all routine childhood vaccinations administered to children under five in England was declining, even before the pandemic[61]. In 2019 the UK has lost its World Health Organisation 'measles-free' status.

Researchers have stated that the reduction in public health services, like health visiting, has contributed to this decline and has led to families researching vaccines in other ways, including accessing information from inaccurate sources on social media.62

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