Parent-Infant Foundation response to 10-Year Health Plan consultation

2nd December 2024

Introduction

The Parent-Infant Foundation submitted an organisational response to the government's consultation on the 10-Year Health Plan for England. Drawing on our expertise in parent-infant relationships and early mental health, our submission responded to a selection of the structured questions set.

Where possible, we use lay terms to help anyone reading this understand the science behind infant mental health and to explain professional terminology. For more detailed information, we invite you to visit our website.

We hope our contribution supports the development of a health service that meets the needs of England's youngest and most vulnerable children.

The consultation questions and our responses

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The next NHS 10-Year Plan must prioritise infant mental health and parent-infant relationships by introducing a measurable target to ensure the needs of vulnerable babies (aged 0-2 years) are met. Infant mental health describes the social and emotional wellbeing and development of children in the first years of life. Infant mental health is heavily influenced by whether babies have a secure relationship with their parent or main caregiver.

According to the Government's own estimates, at least 10%[1] (nearly 60,000 babies) leave hospital each year at risk of 'disorganised attachment'. These babies are regularly experiencing trauma and are often overwhelmed with feelings of fear. If they continue to experience neglect and hostility, their health and development is affected. For that reason, NICE guidance encourages health professionals to talk to parents and carers about bonding, so that problems can be identified, and help sought to build a strong parent-infant relationship.

The 2019 NHS Long Term Plan envisaged a comprehensive offer of mental health support from birth, to support 'infant mental health'. However, interventions that promote good infant mental health, delivered by parent-infant relationship services and teams, are not widely available. The next NHS 10-Year Plan provides the opportunity to reach vulnerable babies who currently lack support.

[1] p. 81 Start for Life Programme Guide

Introduction

The NHS Long Term Plan acknowledged in 2019 that "a loving family" is a key factor influencing a young person's health and life chances. It highlighted the NHS plays a crucial role in improving children's health from pregnancy and birth through the early weeks of life. It promised to "extend current service models to create a comprehensive offer for 0–25-year-olds."

However, a persistent 'baby blind spot' has led to babies' needs being repeatedly overlooked in policy, planning, and funding. This oversight includes the failure of the 2019 Long-Term Plan to include any specific mental health targets for babies (0-2 years). Consequently, many mental health trusts do not accept referrals for under 2s. Those that do, commonly see only a handful of under 2s each year. By contrast, in Manchester, there are 10 specialised parent-infant teams working across the system, and an integrated perinatal and parent-infant pathway to identify vulnerable babies and refer families for specialist support.

The consequence of the 'Baby Blind spot'

The absence of any NHS target for the under 2s has had tangible consequences. Despite infant mental health and parent-infant relationships being explicit objectives within the Healthy Child and Start for Life programmes, commissioners have no policy levers pressing them to provide services. In 2019, our Freedom of Information requests to Clinical Commissioning Groups (CCGs) revealed that 42% were not commissioning mental health services for children under 2. This was despite clear evidence that the first 1001 days of life is a critical period for brain development when the foundations for good mental health are laid.

Five years later, with an even larger body of evidence supporting a range of clinical interventions, commissioning is still highly variable. In March 2024, we repeated our Freedom of Information requests but addressed to Mental Health Trusts (as CCGs had been disbanded). Alarmingly, one in five Trusts (n=43) still report that they do not accept referrals for under-2s. Among those that do, half report receiving fewer than 10 referrals annually. These findings expose significant variability in provision and a persistent lack of mental health support for vulnerable babies and toddlers in many parts of England.

Over the last three years, the national Start for Life programme has been a catalyst for the growth of parent-infant teams and services. However, current provision is estimated to be just one tenth of total estimated need. Start for Life allocated a modest £100m over three years for perinatal and parent-infant relationship support. Much of this supports families through primary prevention, providing universal and targeted services that promote wellbeing and address early risks. While some Start for Life funding has bolstered secondary prevention efforts too, notably specialised parent-infant teams focused on early intervention for emerging or complex needs, these models typically rely on funding from Integrated Care Boards (ICBs) or Child and Adolescent Mental Health Services (CAMHS).

Although we hope Start for Life will continue, progress is beginning to stall, due to uncertainty over the new government's plans for the programme. Some Start for Life areas report that they are beginning to scale back their infant mental health services. Areas that did not receive Start for Life funding are keen to join the programme. All rely on the NHS leading the development of specialist services that can support complex and high needs families. If the next NHS 10-Year Plan does not include measurable targets for the under-2s and drive sustained investment, the NHS will again fall short on its promise to provide a comprehensive 0-25 mental health service.

Specialised Parent-Infant Relationship Teams as a solution

Expanding mental health services for children aged 0–5 has been strongly recommended by the Royal College of Psychiatrists and other national stakeholders. RC Psych cite specialised parent-infant relationship teams as an example of how to deliver evidence-based interventions. They observe that, *"Early interventions are critical to preventing mental health conditions, as well as stopping these conditions from becoming more severe and difficult to treat."*

Specialised parent-infant relationship teams exemplify secondary prevention because they focus on supporting families where difficulties in infant mental health and parent-infant relationships have already emerged. This aligns with their role in addressing challenges such as attachment difficulties, postnatal depression, or trauma, that may hinder a baby's emotional and developmental wellbeing. The aim of these teams is to prevent these early challenges from escalating into severe mental health problems or entrenched relational difficulties.

Alongside providing direct support to families, specialised parent-infant relationship teams also play a vital system-wide role. This includes offering consultation, training, and reflective supervision to professionals in primary prevention services, such as midwifery and health visiting, to enhance their capacity to identify and respond to parent-infant relationship concerns. Through these collaborative efforts, the teams help strengthen parent-infant relationships and promote infant mental health across the local service ecosystem.

Parent-infant teams offer a range of assessments and therapeutic interventions deployed according to the varying nature and severity of families' needs. The specific intervention/s provided also depend on the team's expertise, the training they have undertaken, and the priorities set by their commissioners. Over the last ten years the evidence base that underpins interventions commonly used by parent-infant teams has deepened. Several of the most used interventions have a high-quality evidence base including systematic reviews. Examples of two of the most used interventions by teams are outlined below.

Parent-Infant Psychotherapy:
A systematic review of international evidence examined psychoanalytic, psycho-dynamically informed, and attachment-based interventions for babies and young children. The review found that these approaches, including parent-infant psychotherapy, have positive impacts

on infant attachment, emotional wellbeing, parental depression, and reflective functioning. Moreover, the evidence suggests that parent-infant psychotherapy is particularly effective for families with complex needs, including those from socially disadvantaged groups.

Video Feedback Approaches:
A Cochrane systematic review highlighted video feedback as an effective method for improving parental sensitivity and attachment security across a range of parent-infant relationships. The findings indicate that video feedback can be delivered to parents and babies facing diverse challenges, in various settings.

Furthermore, national and local service evaluations have shown that parent-infant teams not only address the mental health needs of babies (and parents), but they also strengthen early relationships, which is essential for long-term health and wellbeing.

Integrated early support models for Integrated Care Systems (ICS)
Parent-infant teams operate at the intersection of multiple systems—mental health, social care, health visiting, and the voluntary sector. The enable and thrive where there is a cohesive, multi-agency approach. Teams are uniquely positioned to "hold the baby in mind" and function as advocates throughout the local system, ensuring that vulnerable babies do not fall through the cracks. This model, exemplified by the Blackpool Better Start Partnership (2018), demonstrates how shared goals and integrated data systems can create a unified approach to identifying and supporting at-risk families.

Best practice examples:

- **Knowsley**: Commissioned by the NHS, the Building Attachment and Bonds Service (BABS) integrates parent-infant relationship support within social care. By improving parent-infant bonds, BABS supports families with babies at risk of entering care. The work addresses immediate needs while also reducing long-term inequalities and supporting parents and carers to overcome trauma and provide sensitive nurturing care for their babies (averting babies being taken into social care).
- **Greater Manchester**: With 10 parent-infant teams embedded across the region, Greater Manchester demonstrates how teams can function within Integrated Care Systems (ICS). The parent-infant teams provide direct support to families, train early years practitioners, work in partnership with CAMHs, social care and perinatal mental health to ensure relational difficulties are addressed early.
- **LEAP in Lambeth**: LEAP's multidisciplinary team collaborates with the voluntary sector, adult and children's mental health services, social care and early years services to identify babies in need and connect families to broader early years services. The Lambeth PAIRS (parent-infant relationship team) is at the heart of this multiagency offer. This model also shows how capacity and accessibility can be expanded to reach marginalised groups.

Parent-infant relationship teams are a key delivery mechanism for ICS' to deliver on priorities including addressing health inequalities and improving early years outcomes. The Greater Manchester model illustrates the scalability of parent-infant teams when

supported by ICS frameworks, shared goals, and collaborative funding approaches. Knowsley demonstrates how embedding parent-infant teams in deprived areas can break inter-generational cycles of trauma and support babies on the edge of care to remain safely with their parents, while LEAP shows how to reach marginalised families.

Workforce plans to support expanding parent-infant relationship services

Parent-infant relationship services can be expanded in alignment with the NHS Long-Term Workforce Plan. This explicitly includes provisions to train additional clinical psychologists and child psychotherapists—key professionals within multi-disciplinary parent-infant teams. The workforce plan projects a 20-33% increase in these roles, achieved through a 26% growth in training placements by 2033/34.

Furthermore, preparatory work has already been undertaken alongside the Start for Life programme, to support workforce expansion across a range of professions. A detailed workforce expansion proposal, the "PAIR (Parent and Infant Relationship) Workforce Solutions" paper, has been developed and shared with the Department of Health and Social Care (DHSC) and NHS England (NHSE). These proposals were created through extensive collaboration with key stakeholders, including:

- The Association of Infant Mental Health (AiMH-UK)
- The Association of Child Psychotherapists (ACP)
- The Institute of Health Visiting (Mental Health Lead)
- The Network Lead for parent-infant specialists within Perinatal Mental Health (PNMH)
- Clinical Leads of existing specialised parent-infant teams
- The CYP IAPT 0-5 Module Lead at the Anna Freud Centre
- Members of the working group on the draft for the British Psychological Society (BPS) Position Statement on 0-5's Well-Being and Mental Health.

Key initiatives to expand the workforce in these proposals include:

1. Upskilling existing staff: The Start for Life program already supports existing practitioners in acquiring competencies in parent-infant relationship work.
2. Recruit to train models: Recruitment strategies integrated with funded training opportunities allow professionals to enter specialised roles while addressing immediate workforce needs.
3. Clinical placements and post-qualification training: Funded and incentivised placements within Parent-Infant Relationship Services (PAIRS) contexts ensure a sustainable pipeline of trained professionals.

In addition to the professional groups contributing to these proposals, there is significant potential within the private sector and broader psychological professions:

- Private Practice Counsellors: A British Association for Counselling and Psychotherapy (BACP) workforce survey (2021) found that approximately 19,000 counsellors have specific training for working therapeutically with children and young people. Over half (55.5%) of this workforce reported capacity to take on more work. Post-qualifying training could redirect some of this workforce into the PAIR sector.

- Other HCPC-Registered Practitioner Psychologists: Educational psychologists, counselling psychologists, and others could also transition into parent-infant specialisms through targeted post-qualification programmes.

By leveraging these resources, the expansion of parent-infant relationship teams will complement existing mental health services like perinatal mental health teams.

In addition, significant progress has already been made to lay the foundations for workforce expansion with improvements in training, supervision, and professional standards.

There have also been advances in developing, professional-parent baby observation prompts, observational tools, service pathways, service specifications and commissioning frameworks.

Addressing rising health inequalities and the cost effectiveness of early intervention

As highlighted in key reports, national child health outcomes are deteriorating.

The Academy of Medical Sciences Report noted:

- Breastfeeding rates in the UK remain among the lowest compared to other high-income countries, missing an opportunity for better early-life nutrition and health outcomes.
- The majority of childhood vaccination rates have fallen below the World Health Organization's (WHO) recommended levels, leaving children vulnerable to preventable diseases.
- The prevalence of obesity among children is increasing.

The Independent Investigation of the NHS in England ("The Darzi Report"), in addition to the points above, also noted:

- The proportion of children with eight or more chronic conditions nearly doubled, rising to 14% between 2012–13 and 2018–19, highlighting the long-term implications of inadequate early intervention.
- Despite making up 24% of the population, babies, children and young people account for just 11% of NHS expenditure, signalling an underinvestment in this critical age group.

Both reports emphasise the urgent need for investment in babies, infants, and the early years to address these challenges and ensure long-term health and wellbeing. And it is highly cost-effective. The Heckman curve demonstrates the strong return on investment for early interventions, which can prevent costly and complex issues later in life. Recent analyses show that overall spending on early intervention services has fallen by almost £1.8 billion since 2010, a decline of 44%. In contrast, expenditure on late interventions has risen by nearly £3.6 billion, an increase of 57%. Mental health problems during childhood and adolescence are estimated to cost between £11,030 and £59,130 annually per child in the UK. Therefore, investing in early interventions, like parent-infant teams, is foundational to reducing inequalities, mitigating costs, and improving

outcomes for both children and families. This is clearly in line with the Government's Opportunity and Health missions.

We urge the inclusion of measurable targets and sustained investment in infant mental health and parent-infant relationship services within the 10-Year Health Plan. This is a vital step towards creating a healthier, fairer society, ensuring that the most vulnerable babies and their families have access to the support they need to thrive. Without these commitments, the NHS will miss a critical opportunity to build a system fit for future generations.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

A major challenge is the fragmentation of data systems between health and social care. This lack of integration makes it difficult for professionals to share information, coordinate care, and provide a seamless experience for families. Compounding this issue, babies' needs may be recorded as an addition to their parents' records rather than being captured on their own dedicated records, even when there are infant mental health concerns or challenges in the parent-infant relationship. This approach overlooks the importance of treating babies as individuals with distinct developmental and relational needs. Properly capturing babies' needs in their own records is fundamental to their future development, fostering a better understanding of their experiences and needs over time. Additionally, it has potential implications for treatment and approaches throughout their life course.

A single, unique identifier for babies is a critical enabler in addressing this challenge. As highlighted in the Children and Young People's Health Policy Influencing Group submission, a unique identifier can ensure that every child has their own health record from birth, enabling professionals to track their development, identify concerns early, and provide tailored interventions. This system would improve continuity of care and facilitate seamless coordination across health and social care services, addressing a significant barrier to effective technology use in early years care.

Inconsistent data capture across services further hampers the effective use of technology. Variability in how data is recorded prevents meaningful analysis and limits the development of solutions that depend on standardised inputs. A lack of understanding and awareness about observation and outcome measures, particularly for parent-infant relationships, is another significant barrier. Without widespread use of standardised metrics and comprehensive individual records for babies, the potential for technology to support early years mental health and future care remains underutilised.

To overcome these challenges, adopting agreed observation and outcome measures across services is essential. Standardised metrics will enable consistent data collection and interpretation, forming a foundation for the effective use of technology. Education and training for healthcare professionals can further support this effort by increasing their understanding of infant mental health outcomes and equipping them to use technology confidently and effectively. Enhanced digital platforms, such as integrated

digital health records and a unique identifier for each child, are critical enablers. These systems facilitate seamless data sharing and collaborative care planning, enabling professionals across sectors to work together more effectively.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Infant mental health (IMH) and parent-infant relationships are areas where timely intervention can substantially improve outcomes and mitigate risks.

High levels of mental health needs in babies and young children
Babies and young children currently experience significant mental health difficulties that require treatment to avert mental health disorders in later childhood. The prevalence of significant attachment difficulties (which increase the risk of later mental health issues) ranges from 10-25% in young children, influenced by factors such as family stress, trauma, and parental mental health. In England, the prevalence of mental health conditions in children aged 2-4 years is 5.5%.

A forthcoming study, led by the Office for Health Improvement and Disparities (OHID) and commissioned by NHS England (NHSE), will provide a prevalence estimate of mental health needs in the 0-4 age group. It is expected to confirm it is significantly higher than the figures noted above, while population need rises sharply in areas of deprivation. In this study, a mental health need is defined across three critical areas of development: socio-emotional development, behavioural development, and the parent-infant relationship. Preliminary findings indicate that mental health needs are notably higher in the 0-2.5 age group compared to children aged 2.5-4.5 years.

Although specific figures from this study cannot yet be quoted, the data underscores a key challenge: the high level of mental health needs among babies and very young children. This finding reinforces the importance of tailored approaches, as well as age-specific interventions and pathways, to ensure that the unique developmental needs of babies are adequately supported.

Challenges
A primary challenge is the fragmentation of early support services. Families often experience a disjointed and uncoordinated system that fails to align around the needs of babies and their parents. This is noted in the Start for Life vision, which states, “services are patchy, not joined up and often do not deliver what parents and carers need. This must change if we are to truly transform our society for the better.” Without a shared framework for identifying and addressing difficulties in IMH and parent-infant relationships, opportunities for early intervention are missed. The absence of a national pathway and framework to guide services exacerbates these issues, leading to significant regional disparities in care (Parent-Infant Foundation Pathway Template, 2023).

Additionally, there are prevention gaps at both the primary prevention level, within universal services, and the secondary prevention level, within targeted services. While

early support is ideal, higher levels of challenged parent-infant relationships require immediate intervention to prevent escalation into more severe issues. The absence of age-specific pathways for children under three compounds the problem. Many services focus on ages 3-5, neglecting the unique developmental needs of babies under three due to a lack of skills, resources, and commissioning incentives (Lambeth PAIRS, 2023; Greater Manchester Early Years Delivery Model, 2021).

This is explained by a professional reflecting on the work of the Lambeth PAIRS in their most recent service evaluation.

> *…Three-year-olds throwing temper tantrums would take more attention than the baby just lying quietly in a cot all day, because they're not crying, they're fine, but actually it's …the not crying (that) is (the) problem... So, I think it's definitely been helpful to shift that focus and to think more about the babies, and to bring them more in mind when they would normally get lost in … bigger and busier families. (Stakeholder)*

Significant progress has been made in recent years in building the workforce's understanding of IMH and parent-infant relationship needs. Professionals across early years and healthcare, including health visitors, midwives, and mental health practitioners, are increasingly aware of the importance of early relationships in shaping babies' emotional wellbeing and development. Initiatives such as Health Education England's (HEE) perinatal and infant mental health training programme and the development of specialist health visitors for perinatal and infant mental health have contributed to this growth in understanding. Furthermore, frameworks such as the Association of Infant Mental Health Competency Framework and the Association of Child Psychotherapy Competence Framework are helping to standardise and strengthen IMH expertise across professions.

However, these advancements are not yet universally embedded, leading to variability in understanding and practice. The result is many babies and young children with mental health needs and parent-infant relationship difficulties are still not being recognised by the workforce and therefore do not access the support they require. Emerging mental health problems in babies and young children often look different from those seen in older children and adults. Babies and young children can experience dysregulation, relational challenges, emotional difficulties, and behavioural problems such as withdrawal, separation anxiety, feeding issues, and sleeping difficulties. These challenges are often deeply rooted in the parent-infant relationship and require specialised understanding and approaches to address effectively.

While significant progress has been made in equipping the workforce to identify and respond to these unique presentations, there remain gaps in capacity and consistency. Strengthening workforce development further will ensure that opportunities for early intervention are fully realised. Establishing a specialised parent-infant relationship team in every local system would support the wider workforce to build on this progress, and to access the support and expertise that is needed to intervene appropriately. By embedding teams into local systems, we can complement the workforce's growing skills with the resources necessary to meet the unique needs of babies and their families. This

approach would ensure that IMH continues to be a priority and becomes an integral part of NHS planning and service delivery.

Another challenge is the range of different screening tools and assessment frameworks to identify distress in infants. Tools such as the Alarm Distress Baby Scale, Newborn Behavioural Observation, NHS Lanarkshire Infant Mental Health Observational Indicator Set, and Leeds Early Attachment Observation all offer effective ways to assess infant distress, but their use is not standardised across services. This inconsistency hinders the ability of professionals to systematically recognise and address early signs of relational or emotional difficulties.

Finally, mandated targets and sustainable funding for IMH services are the single largest challenge. While programmes such as *Start for Life* have highlighted the importance of early years support, the lack of long-term funding and accountability discourages commissioners from investing in services beyond temporary initiatives. (Children's Services Funding Alliance, 2020).

Enablers

One important enabler is the development of a national pathway and framework for IMH and parent-infant relationships. The Parent-Infant Relationship Pathway Template provides a model for aligning services and ensuring families experience joined-up care. Establishing a shared national framework for early identification of difficulties would standardise support across regions and improve outcomes by ensuring families receive the right support at the right time.

Investing in enhanced prevention frameworks is another enabler. Strengthening primary prevention through universal early support, combined with secondary prevention interventions targeted at high-risk families, would help address relational difficulties before they escalate. This is why we recommend an extension of the national Start for Life programme. Developing age-specific pathways tailored to children under three is another enabler, as this ensures services are designed to meet the distinct developmental needs of this age group (Greater Manchester Early Years Delivery Model, 2021).

Embedding IMH competencies in workforce training and pre-registration requirements is another enabler. This would ensure professionals are prepared to address infant mental health needs. We recommend that all relevant professions adopt competencies outlined in the Association of Infant Mental Health Competency Framework and the Association of Child Psychotherapy Competence Framework. Equipping professionals with these skills will enhance early identification and intervention capabilities. There is also a need to embed ongoing consultation, training and supervision as the workforce expands and upskills, to maintain quality and embed learning. The national centre for supervision in parent-infant relationships (funded through Start for Life) has begun to model this at a national level and local parent-infant teams are already delivering this at regional and local levels.

Further enablers have come from the Start for Life programme. For example, the Start for Life conversation prompts support practitioners in initiating sensitive and effective conversations with families. These tools enable professionals to engage families early, fostering a proactive approach to identifying and addressing concerns. The standardisation of screening tools and assessment frameworks across services is another enabler. Tools such as the Alarm Distress Baby Scale, Newborn Behavioural Observation, and Leeds Early Attachment Observation should be widely adopted to identify and respond to early signs of distress effectively. Training professionals in these tools will ensure systematic and consistent assessments.

Mandated targets and sustainable funding are necessary to secure sustainable growth of parent-infant relationship services, to reach more vulnerable babies. Establishing clear targets would drive accountability and incentivise commissioners to prioritise infant mental health services. Sustained funding in *Start for Life*, expanded to include all local health systems, would help prevent gaps in service delivery and improve continuity of care.

By addressing fragmentation, embedding IMH competencies in professional training, and leveraging standardised tools and frameworks, the health and care system can significantly improve its ability to spot illnesses earlier and tackle their root causes. A cohesive, well-funded system that integrates national pathways, workforce development, and evidence-based tools will ensure families, and their youngest members receive the timely and effective support they need for lifelong health and wellbeing.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- Quick to do, that is in the next year or so
- In the middle, that is in the next 2 to 5 years
- Long term change, that will take more than 5 years

To address the pressing and long-term needs in IMH and parent-infant relationships, we propose a phased approach. Each policy recommendation aligns with current gaps in provision and the evidence presented in key reports, and national strategies like the Start for Life programme.

Quick Actions (Next Year or So):

1. Secure continued funding and support for existing and emerging services:
    - Sustain and expand funding for specialised parent-infant relationship teams, ensuring continued support for existing services, including but not limited to Start for Life areas. Additionally, provide dedicated funding and support to enable areas without current provision to begin developing specialised parent-infant relationship teams, bridging critical gaps in service delivery and expertise.

    - Immediate funding assurance is critical to stabilise existing support systems and ensure continuity for vulnerable families.
2. Set mandated targets for addressing Infant Mental Health and Parent-Infant Relationship Needs:
    - Establish a clear mandate for NHS mental health services to address the IMH needs of 0–2-year-olds, including specific targets for outcomes, access, and secondary prevention services, to be reviewed and updated at regular intervals over the 10-year period.
    - This should be supported by guidance for commissioners and providers to ensure alignment with national and regional objectives.
3. Strategic leadership and multi-agency working:
    - Introduce a national clinical leadership role for parent-infant relationships and infant mental health, to provide cohesive strategic direction, foster partnerships across sectors (health, public health, social care, and education), and ensure integration across primary and secondary prevention services.
4. Expand training on Infant Mental Health:
    - Enhance professional development aligned with the NHS Workforce Plan to build the workforce capacity needed for primary prevention (universal services), and secondary prevention (targeted specialised parent-infant relationship teams and services).
    - Implement training programmes for early years and health professionals, supported by the supervision and training capabilities of existing parent-infant teams.
5. Support national and local supervision:
    - Provide dedicated resources to the national supervision centre established under the Start for Life programme.
    - Ensure sufficient funding for local parent-infant teams to sustain supervision and training at a local level.
6. Improve data sharing between agencies:
    - Create protocols and platforms for effective and secure data sharing between health, social care, and early years to improve coordinated care for families and reduce systemic inefficiencies.

Medium-Term Actions (2 to 5 Years):

1. Roll out a Unique Child Identifier and shared outcomes framework:
    - Introduce a unique identifier for each child to enable seamless tracking across services and measure outcomes through a shared national framework, facilitating early intervention and consistent care delivery.
2. Establish Integrated Pathways nationwide: Through Integrated Care Systems (ICSs), implementing standardised, nationwide pathways for infant mental health support, emphasising universal accessibility and consistent care standards. They need to be adaptable to meet the needs of local systems and co-produced with those with lived experience to deliver for local families. These pathways should consistently focus on those babies facing the greatest health inequalities.
3. Scale Parent-Infant Teams to meet immediate demand:

- Set an interim target of supporting at least 30,000 vulnerable babies annually through parent-infant relationship teams, leveraging the existing infrastructure while building towards long-term capacity.

Long-Term Actions (More Than 5 Years):

1. Expand capacity to support 60,000 vulnerable babies:
   - Develop a sustainable national network of parent-infant teams with sufficient capacity to support 60,000 vulnerable babies annually.
   - Ensure these teams are equitably distributed across regions to address disparities in access to services.
2. Embed Infant Mental Health across policies:
   - Institutionalise infant mental health as a core priority within all early years and health-related policies, embedding it into strategic frameworks, funding models, and legislative efforts.
3. Achieve full integration of health and care services:
   - Develop a comprehensive governance structure overseeing child health outcomes at the national level, ensuring all agencies work cohesively towards integrated service delivery and improved long-term outcomes for children and families.

This three-phase strategy ensures immediate stabilisation of existing services, builds medium-term infrastructure, and achieves long-term systemic integration.

References

1. **Academy of Medical Sciences. (2024).** Prioritising Early Childhood to Promote the Nation's Health, Wellbeing and Prosperity. https://acmedsci.ac.uk/file-download/16927511
2. **ABC-PIP. (2023).** Evaluation of Parent-Infant Psychotherapy Outcomes. https://www.barnardos.org.uk/sites/default/files/uploads/ABC%20PiP%204%20Year%20Learning%20Report%20FINAL%20240523%20%28002%29.pdf
3. **Association for Infant Mental Health UK (AIMH UK). (2019).** Infant Mental Health Competencies Framework. https://aimh.org.uk/resources/imh-competencies-framework/
4. **Association of Child Psychotherapists (ACP) (2017).** Competence Framework for Child and Adolescent Psychoanalytic Psychotherapists. https://childpsychotherapy.org.uk/acp-register-standards/standards-training-0/competence-framework
5. **Bakker, M., et al. (2023).** Video Feedback for Improving Parental Sensitivity: A Cochrane Systematic Review. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012348.pub2/full
6. **Better Start Bradford. (2023).** Early Years Intervention Reports. Little Minds Matter https://bsbinnovationhub.uk/project-evaluation-reports-2/
7. **Blackpool Better Start Partnership. (2018).** Comprehensive Early Years Program. https://blackpoolbetterstart.org.uk

8. **Centre for Early Child Development. (2021).** Supporting Infant Mental Health: Best Practices. https://blackpoolbetterstart.org.uk/wp-content/uploads/MWM-Report.pdf
9. **Children's Services Funding Alliance. (2020).** Analysis of Early Intervention Spending. https://www.barnardos.org.uk/sites/default/files/2021-07/Spending%20on%20children%27s%20services%20in%20England%20-%20July%202021.pdf
10. **Darzi, A. (2024).** Independent Investigation of the National Health Service in England ("The Darzi Report"). https://www.darziinvestigation.org.uk/fullreport
11. **Darzi, A. (2008).** High Quality Care for All: NHS Next Stage Review. Retrieved from https://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review
12. **Department of Health and Social Care. (2021).** Healthy Child Programme: Pregnancy and the First Five Years of Life. https://www.gov.uk/government/collections/healthy-child-programme
13. **Department of Health and Social Care. (2024).** Improving the Mental Health of Babies, Children, and Young People: A Framework of Modifiable Factors. https://www.gov.uk/government/publications/improving-the-mental-health-of-babies-children-and-young-people
14. **Department of Health and Social Care. (2024b).** Reflecting on Parent-Infant Relationships: A Practitioner's Guide to Starting Conversations. https://www.gov.uk/government/publications/parent-infant-relationships-starting-conversations-practitioner-guide
15. **Fonagy, P., et al. (2023).** The Evidence Base for Psychodynamic Interventions with Children Under 5 Years of Age and Their Caregivers: A Systematic Review and Meta-Analysis. https://discovery.ucl.ac.uk/id/eprint/10172494/
16. **Greater Manchester Early Years Delivery Model. (2021).** Integrated Early Years Pathway. https://www.greatermanchester-ca.gov.uk
17. **Heckman, J. J. (2012).** The Economics of Inequality: The Value of Early Childhood Education. *American Educator, 35*(1), 31-35. https://heckmanequation.org
18. **Infant Mental Health and Specialised Parent-Infant Relationship Teams. (2024).** A Briefing. Parent-Infant Foundation. https://parentinfantfoundation.org.uk/resources/
19. **Institute of Health Visiting. (2021).** Infant Mental Health Training Framework. https://ihv.org.uk/our-work/our-work-in-mental-health/perinatal-and-infant-mental-health-what-it-is-and-why-it-matters/
20. **Lambeth Parent and Infant Relationship Service (PAIRS). (2024).** Service Impact Report. https://story-of-leap.leaplambeth.org.uk/wp-content/uploads/2024/09/PAIRS-evaluation-executive-summary.pdf
21. **National Institute for Health and Care Excellence (NICE). (2020 and 2021)** Guidelines on Antenatal and Postnatal Mental Health. https://www.nice.org.uk/guidance/ng201 https://www.nice.org.uk/guidance/cg192
22. **NHS England. (2023).** Long-Term Workforce Plan. https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/

23. **Parent-Infant Foundation. (2019).** The Impact of Parent-Infant Teams. https://parentinfantfoundation.org.uk/wp-content/uploads/2023/09/Impact-of-teams-report-FINAL-Sept-2023.pdf
24. **Parent-Infant Foundation. (2024).** Start for Life Programme Survey Findings.
25. **Parent-Infant Foundation. (2024).** Parent-Infant Relationship Pathway Template. https://parentinfantfoundation.org.uk/tools/pathway-template/
26. **Parent-Infant Foundation. (2023).** PAIRs Workforce Solutions.
27. **Royal College of Psychiatrists (RCPsych). (2023).** Infant and Early Childhood Mental Health Policy Paper. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2023-college-reports/infant-and-early-childhood-mental-health--the-case-for-action-(cr238)#:~:text=In%20this%20landmark%20College%20report,get%20the%20support%20they%20need.
28. **Start for Life Programme Guide. (2022).** Family Hubs and Start for Life: Guidance for Local Areas. https://assets.publishing.service.gov.uk/media/62f0ef83e90e07142da01845/Family_Hubs_and_Start_for_Life_programme_guide.pdf
29. **World Health Organization, UNICEF, and World Bank. (2018).** Nurturing Care for Early Childhood Development. https://www.who.int/maternal_child_adolescent/child/nurturing-care-framework/en/