Written evidence submitted by Parent-Infant Foundation (FTDOO79)

Parent-Infant Foundation

Response to Health and Social Care Committee Inquiry The First 1000 Days: a renewed focus

Summary

We are the Parent-Infant Foundation. We are the only national charity driving the growth and quality of parent-infant teams across the UK.

Our vision is of a UK in which all parents and carers are supported to create sensitive, nurturing relationships with their babies to lay the foundation for lifelong mental and physical health.

Government estimates indicate that 60,000 babies in England leave hospitals each year at risk of disorganised attachment, which means they are living in fear, confusion and distress[1]. Not everyone bonds easily with their baby. Parents can be overwhelmed by trauma from their own childhood. Some are struggling with mental or physical health difficulties.

Parent-infant teams support and strengthen relationships between babies and their parents (or carers). Parent-infant teams improve parents' anxiety and mental health and enhance parents' responsiveness to their babies' needs, supporting the emotional and social development of babies. A summary of evidence and research proving their impact is available here.

Teams are multi-disciplinary and include highly skilled mental health professionals such as clinical psychologists and child psychotherapists. They undertake one to one therapy-based work for families with complex needs. Teams often drive improvements across the wider system too, leading group work with families and supporting other professionals through training and supervision. They are a catalyst for integration of services and a champion for babies, ensuring babies needs are kept front and centre across different services.

A key recent driver of the increase in parent-infant teams and services has been the Family Hubs and Start for Life programme. Start for Life allocated £100m over three

[1] Family Hubs and Start for Life Programme Guide (publishing.service.gov.uk), 2022, p 81

years for perinatal and parent-infant relationship support. Although this has mainly been used for universal and targeted support, the funding has also enabled parent-infant teams to scale up and drive improvements across the wider system.

As our map shows, there are now 47 parent-infant teams across the UK, as well as 30 or more emerging teams and services. However, these services need development to reach a larger proportion of vulnerable babies (currently we estimate teams reach 13% to 19% of babies in need. We estimate 400 teams are needed across England to reach vulnerable babies in all postcodes.

The cost of increasing parent-infant teams and services is relatively modest compared to the costs of inaction. The cost of perinatal mental health problems is estimated to be £8.1 billion per year[2], while inadequate support in early childhood costs England more than £16 billion every year, according to research commissioned by the Royal Foundation from LSE.[3] Research we have commissioned, to be published shortly[4] estimates supporting parent-infant relationships would deliver at least £900m benefit each year.

We recommend:

- **National roll-out of the Family Hubs and Start for Life programme to all local authorities. As part of this, allocate £73m each financial year to enable every local authority area to develop at least one parent-infant team. This would enable 39,200 vulnerable babies to receive specialist support every year by 2028/29.**

Alongside this, we recommend government set a measurable target to ensure the needs of vulnerable babies (aged 0-2 years) across England are met. As the DHSC is the main funder of services that support babies, and in view of the government's ambition to raise 'the healthiest generation of children ever', we recommend the forthcoming 10-Year Health Plan prioritises infant mental health and parent-infant relationships. Details of how are set out in our submission to the government's 10-year plan consultation.[5] After many years of under-investment, these steps are essential to make good on the promise of every baby having the 'best start in life'.

Q1. What progress has been made since the previous Committee's 2019 First 1000 days of life report in terms of outcomes for children and young people?

[2] The costs of perinatal mental health problems; __lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer, M_Bauer_Costs_perinatal_ mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

[3] The Report - CFEC

[4] Maternal Attachment and Child Outcomes: A review of associations using the Millennium Cohort Study data, Stephen McKay (2025)

[5] NHS-10-year-plan-response-final.pdf

What progress has been made on delivering integrated early years through Family Hubs? In particular, what progress has been made on the calls in the Committee's 2019 report for a) Proportionate universalism and b) Greater integration and multi-agency working?

Since the Committee's 2019 report into the first 1001 days of life, the overall picture for child health has worsened. Children and young people's health outcomes have deteriorated, as documented by Lord Darzi [6] and the Academy of Medical Royal Colleges [7]. To address this decline, experts recommend, 'frontloading investment in the earliest years, including preconception and during pregnancy'. [8] As the Committee recognised in its 2019 report, that's because, 'The first 1000 days of a child's life represent a critical phase of heightened vulnerability, but also a window of enormous opportunity. Many of the factors that influence a child's health, development and life chances are amenable to policy intervention.'

So, what are we to make of this decline in child health outcomes? Both policy decisions and external factors beyond the control of government, have played a role.

Notable external factors include the COVID-19 pandemic, when services struggled to reach babies, and many new parents experienced social isolation. For further insight see our 2020 report, "Babies in Lockdown"[9]. Also in recent years, the cost-of-living crisis has pushed more families with young children into poverty. While government does not have control over external factors, their policy response is key. To know if their approach is working, they must also measure and track outcomes.

As the Committee's report recognised, services and programmes that support babies are led by an array of different government departments. And different programmes monitor different outcomes. Improving child health outcomes requires coordinated action across government departments, working towards shared outcomes.

The main data source for tracking the health and development of babies in England is the Healthy Child programme – the national, universal prevention and early intervention public health framework. It includes screening, immunisation, health and development reviews, health improvement, wellbeing and parenting. One of the Healthy Child programme's aims is to ensure that babies at risk are identified at the earliest opportunity.

However, the data indicate a two-fold issue. Firstly, child development outcomes at age two are still below pre-pandemic levels. In 2023/2024, 80.4% of two-year-olds

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[6] **Darzi, A. (2024).** Independent Investigation of the National Health Service in England ("The Darzi Report"). Independent investigation of the NHS in England - GOV.UK

[7] **Academy of Medical Sciences. (2024).** Prioritising Early Childhood to Promote the Nation's Health, Wellbeing and Prosperity. https://acmedsci.ac.uk/file-download/16927511

[8] Ibid.

[9] Babies in Lockdown - Parent-Infant Foundation

achieved the expected level of development in all five domains - in 2019/2020 it was 83.3%.[10] Secondly, more than one in five (21.6%) two year-olds are not getting their review. This means thousands of missed opportunities to identify a vulnerable toddler, offer support and (where needed) draw on specialist support.

- **Health visitor workforce shortages must be addressed to reach every baby and toddler with developmental checks, through the Healthy Child Programme, which are meant to be universal, but are not reaching one in five toddlers.**

Workforce development is also important to identify the most vulnerable babies and provide early intervention to strengthen bonding and attachment. Specialist health visitors are trained in Perinatal and Infant Mental Health, but there are very few posts – less than one hundred in the whole of the UK[11]. And when a baby is at risk of disorganised attachment and in need of specialist support, a parent-infant team is needed, to work through complex issues and trauma. However, with workforce shortages and gaps in services, only a small proportion of babies ever receive the help they need. We estimate that parent-infant teams are seeing between 13-19% of babies that require specialist support. So further investment in specialist services is needed alongside investment in universal services (and workforce).

The Committee's 2019 report recommended a national strategy to bring government departments together, operating at Cabinet level. This would bring accountability for child health outcomes to the top of government. Following that report, a national strategy was announced by the last government - the Family Hubs and Start for Life programme.

Despite this welcome attempt to align services and work towards common outcomes, a recent thematic review found that, 'Opportunities to measure outcomes in the current reporting framework are limited.' and 'Local areas need support to measure impact, including a set of shared national outcomes with optional local additions.'[12] Work on a shared set of baby outcome measures has been undertaken but is not yet published.

With a change of government last year, cross-departmental working is still in place. DHSC leads the Start for Life programme and DfE leads its 'twin' – the Family Hubs programme. In an unusual arrangement, there is a Senior Responsible Officer in both departments. This twin-track approach was intentionally designed to join-up services across health, social care and early education. The Start for Life element of funding focuses on services (infant feeding, parent-infant relationship support and perinatal

[10] Office for Health Improvement and Disparities Child development outcomes at 2 to 2 and a half years, 2023 to 2024: statistical commentary - GOV.UK

[11] Specialist Health Visitors in Perinatal and Infant Mental Health - IHV

[12] Start For Life services: thematic review, Start For Life services: thematic review - GOV.UK

mental health). We hope the two departments will continue to synchronise to support joined-up working and longer-term certainty.

A further mechanism that could help join up departments was introduced in 2024 with the 'mission boards'. We welcomed the health mission's aspiration to raise 'the healthiest generation of children ever'. Also, the 'opportunity mission', which was sub-titled 'best start in life'. The latter includes the Family Hub and Start for Life programmes, and a new 'mission milestone'.

The milestone is for 75% of five year-olds to reach 'a good level of development' by 2028. While welcome, the new milestone will not necessarily focus efforts on the most effective period - the first 1001 days. As we know the first 1001 days is the most effective time to intervene to improve a child's life chances, a supporting national target is needed to reach vulnerable babies, along with full implementation of the Healthy Child programme.

Noting the Committee's interest in inequalities, supplementary policy levers are also needed to ensure that the new mission milestone does not reduce investment in young children with higher needs. Without this, the mission milestone could inadvertently worsen existing inequalities, as services focus on getting those 'easiest to lift' across the threshold.

Family Hubs and Start for Life

The Early Years Healthy Development Review, led by Dame Andrea Leadsom marked a welcome return to government focusing on the first 1001 days. Their 'Best Start for Life' policy paper[13] set out an approach to join up and integrate early years services, working through local authorities, and included extensive analysis of the importance of the first 1001 Days and parent-infant relationships. Six 'action areas', included providing 'Seamless support for families' through a Start for Life offer, and a 'welcoming hub for all the family', where Start for Life services could be accessed. Funding was made available to around half (75) of upper-tier local authorities, using a methodology largely based on deprivation (although also including a rural weighting element).

The programme has:

- helped join up services that support babies, parents and carers
- improved new parents' access (through family hubs) to essential information and practical support
- established a national supervision centre to support local authorities to develop services for babies

[13] The best start for life: a vision for the 1,001 critical days - The best start for life: a vision for the 1,001 critical days - GOV.UK

- funded expansion of infant feeding, parenting, perinatal and parent-infant relationship services in 75 local areas

A progress report was published in February 2023[14] . A further progress report was expected in 2024 but was not published due to the General Election. This should be published in 2025.

A thematic review of the Family Hubs and Start for Life programme was undertaken by the Care Quality Commission and Ofsted in 2024[15]. The regulators visited six participating local authorities and found that families who access Start for Life services through a Family Hub had a positive experience. Parents said they are more confident in feeding their infants and have better perinatal mental health, and that their children achieve better outcomes. The regulator report finds that, 'Co-location of services helps with information-sharing and was welcomed by professionals and families.' They explain this is because co-location gives staff access to multi-agency training opportunities and leads to improved joint working between health, social care, early years education and family hub team members. However, they also observe that recruitment of health visitors and limited midwifery capacity is a challenge in most areas.

Although national evaluation is still underway, many of the programme's constituent elements (e.g. breastfeeding support, parenting programmes, parent-infant relationship teams and perinatal mental health services) already had a strong evidence base. Start for Life is not a panacea. It works best in combination with additional specialist services that can support complex and high needs families. However, it is squarely focused on the needs of babies and children and enables more joined-up working at the local level. Against a backdrop of a long-term decline in investment in preventative services, the programme has bolstered services in some areas, and reached hundreds of vulnerable babies who would otherwise have remained invisible.

In July 2024 we surveyed Start for Life leads in local authorities. We also contacted service leaders in 15 parent-infant teams who had received Start for Life Funding. We received responses from commissioners and clinical leaders in 26 of the 75 Start for Life areas. We asked them what difference the Start for Life programme, and funding, has made to local families, and what the impact would be if funding ends next year.

In summary:

- Every respondent said the Start for Life programme had enabled them to support more babies
- Most local areas used Start for Life funding to expand access to parent-infant relationship support

[14] The best start for life: a progress report on delivering the vision - GOV.UK
[15] Ibid

- Respondents said services would either dramatically decrease, or be completely disbanded, if Start for Life funding was not available
- Without the programme, local leaders worry for the mental health of some families, and fear there would be a heightened risk for vulnerable babies
- Local leaders warn that a reduction in preventative services would lead to increased demand for acute services
- Local leaders say if the programme is de-funded, with no better alternative, this would be 'devastating for many families', and some babies would inevitably 'fall through the gaps'

After campaigning throughout last year for the programme to continue, we were delighted another year of funding was recently confirmed - until 1 April 2026. However, this is still limited to 75 local authorities. With the squeeze on local government funding from acute demands - social care and other services – our survey shows these services will likely not exist if there is not dedicated funding for them.

We hope the forthcoming spending review will provide longer-term sustainable funding, and an uplift to support rolling out the programme to all local authorities, as recommended by the regulators. Prior to the most recent budget, some Start for Life areas reported that they were beginning to scale back their infant mental health services. As noted in the Care Quality Commission/Ofsted review referenced earlier, ongoing uncertainty is difficult for service continuity and staff, so a longer-term commitment is needed.

Q2. What should the Government prioritise in upcoming funding allocations for early years services?

The Darzi Report emphasises the urgent need for investment in babies, young children and the early years to address the challenges of rising health inequalities and ensure long-term health and wellbeing. Investment in the first 1001 days is highly cost-effective. The Heckman curve[16] demonstrates the highest rate of economic returns comes from the earliest investments in children, as these can prevent costly and complex issues later in life.

Analysis of government figures undertaken by Pro Bono Economics commissioned by the Children's Charities Coalition, finds that between 2010-11 and 2022-23, spending on late intervention services increased by 57% while expenditure on early intervention fell by 44%. Early intervention spending now accounts for less than one-fifth (18%) of total spending on children's services, down from over one-third (36%) in 2010-11. As the authors observe, disinvestment in early intervention is ultimately counter-

[16] The Heckman Curve - The Heckman Equation

productive for local government, as higher costs are inevitably incurred through late intervention.[17]

Mental health problems during childhood and adolescence are estimated to cost between £11,030 and £59,130 annually per child in the UK.[18] As the Royal College of Psychiatrists advise, early intervention to support infant mental health can help prevent or reduce the severity of mental health conditions in children[19] . Investing as early as possible in a child's life, in parent-infant relationship services that work both in neonatal settings and community settings, is foundational to reducing inequalities, mitigating costs, and improving child health outcomes.

As the Committee's 2019 report acknowledges, 'The effects of adversity (neglect and abuse) during this time of a child's life [the first 1001 days] can remain with them throughout their lives, causing repeated harm to themselves and sometimes harm to others. The cycle of adversity often continues between generations.'

We recommend that government:

1. **Allocate £756m across the three-year spending review period to roll-out the Family Hubs and Start for Life Programme to all upper-tier English local authorities, as recommended by the CQC and Ofsted.**
    - **This is based on doubling the existing programme budget to also reach the 78 upper-tier local authorities currently excluded from the programme**
2. **As part of this, allocate £73m each financial year to enable every local authority area to develop at least one parent-infant team. This would enable 39,200 vulnerable babies to receive specialist support every year by 2028/29.**
    - **The combined current budget for the Family Hubs and Start for Life programme for 2025-26 is £126 million, across 75 upper-tier local authorities. This includes £36.5 million for perinatal and parent-infant relationship support.**

For further details of these costings please see our spending review submission here.

[17] Struggling against the tide: Children's services spending, 2011-2023 | Pro Bono Economics
[18] NHS England » New resource to improve young people's mental health services
[19] college-report-cr238---infant-and-early-childhood-mental-health.pdf

Q3. How effective have Family Hubs and the introduction of integrated care systems been in improving early childhood outcomes?

Integrated and coordinated services are crucial for the effective care of vulnerable babies. Babies move rapidly through a range of services as they enter the world, and signs of distress can easily be missed. From intensive and high-frequency contact in hospital settings, most babies are discharged into the community soon after birth. From that point, the extent of contact that babies and new parents have with public services varies.

The most vulnerable babies require specialist support, and input from multi-disciplinary teams. A range of services and professionals may be involved – for instance social care, perinatal mental health, early help, peer support and parent-infant relationship services. Partnership working, effective information-sharing and shared pathways are key to coordinate across the voluntary sector and a range of public services that can be involved. This avoids parents having to repeat their story multiple times, helps build trusted relationships and ensures that risks are identified, to keep babies safe.

Effective multi-agency working relies on shared information and alignment of goals at each level of decision-making (neighbourhood, place and system level). So, for babies, Integrated Care Systems (ICSs) were a potentially positive development, as they promised to better integrate and join-up services.

Many Integrated Care Partnerships (ICPs) cite 'early intervention' or the 'first 1001 days' as a strategic priority, which we welcome. However, an analysis of ICP strategies[20] has found wide variation in how the needs of babies and children are considered, as well as variation in the scale and scope of delivery plans. In many cases, the availability of services varies across the ICS. This is not surprising given that an ICS has a large footprint and may include local authorities that receive Start for Funding and others that do not. In some areas this creates a 'postcode lottery', with services only supporting families in certain postcodes.

Given there are babies born in every postcode in England, we recommend a national roll-out of Family Hubs and Start for Life, as well as full implementation of the Healthy Child programme, so that all families can access universal services, like breastfeeding support. Every ICS should have a delivery plan that supports the development and needs of babies in their area. To reach babies with higher needs, family hubs should be located in more deprived postcodes, and specialist services must be available also. Currently Start for Life areas are expected to develop a local perinatal and parent-infant relationship strategy. This should be 'the norm' for every area, along with the resource to provide services.

[20] Integrated Care Systems and the health needs of babies, children and young people

In summary, integration through ICSs holds the potential to benefit babies, but different areas are at different points in their integration and planning journey. In Manchester, where integration happened first and is most advanced, we see more integrated services and local pathways that join up different services (including ten parent-infant teams). Further detail of that is below.

Given the low level of provision in many areas, we recommend a national target to reach vulnerable babies is included in the forthcoming 10-Year plan for health, local pathways are developed in every local area and a commitment to specialist provision is made with funding to expand parent-infant teams.

Q4. What are the key barriers to delivering high-quality early years services, particularly in Family Hubs and through neonatal and paediatric services, and how can they be addressed?

(i) Gaps and inconsistencies in specialist provision for infant mental health and parent-infant relationships

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 Start for Life funding has bolstered parent-infant relationship services (particularly those focused on early intervention for emerging or complex needs), specialised services typically rely on additional funding from Integrated Care Boards (ICBs) or Child and Adolescent Mental Health Services (CAMHS). Based on data collected from parent-infant teams in 2023, we estimate teams offer direct therapeutic support to between 4,400 and 6,500 families directly each year, across the UK. Their main source of funding is health, but approaches to commissioning vary widely.

Back in 2019, the NHS Long Term Plan highlighted that the NHS plays a crucial role in improving young children's health from pregnancy and birth through the early weeks of life. It promised to 'extend current service models to create a comprehensive mental health 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 twos. Those that do, commonly see only a handful of under twos each year. While 'infant mental health' is an unfamiliar concept outside of the mental health sector, babies can experience ongoing fear, distress and confusion. If left unsupported, this can develop into behavioural and mental health difficulties in later childhood. As the Royal College of Psychiatrists advise, early intervention to support infant mental health can help prevent or reduce the severity of mental health conditions in children[21] .

Our recent Freedom of Information requests suggest that the commitment in the NHS Long-Term Plan for a comprehensive 0-25 mental health service is not being met in many local areas. In March 2024 we sent FOIs to the 50 Mental Health Trusts that cover England. Five trusts said they don't take any referrals for under twos (n=45). Among those that do take referrals, most only get between 0-10 referrals a year.

Expanding mental health services for children aged 0–5 has been strongly recommended by the Royal College of Psychiatrists and other national stakeholders. The Royal College of Psychiatrists 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." More recently, parent-infant teams have also been recommended by the Centre for Mental Health and Foundations in their Practice Guide – Parenting Through Adversity, which was commissioned by the Department for Education[22].

We recommend this is addressed in the forthcoming 10-Year NHS Plan with a measurable target to ensure the needs of vulnerable babies (aged 0-2 years) across England are met. This should be supported by guidance for commissioners and providers to ensure alignment with national and regional objectives. Otherwise, the NHS will likely continue to fall short on its promise to provide a comprehensive 0-25 mental health service.

ii) Lack of focus in early years services on infant mental health and parent-infant relationships

Currently, families often experience disjointed and uncoordinated systems that fail to align around the needs of babies and their parents. This is noted by a range of key stakeholders including the Institute of Health Visiting, Royal College of Psychiatrists and the Local Government Association. The Start for Life vision document states that "services are patchy, not joined up and often do not deliver what parents and carers

[21] college-report-cr238---infant-and-early-childhood-mental-health.pdf
[22] Invest in childhood - Centre for Mental Health

need. This must change if we are to truly transform our society for the better." We agree.

Without a shared framework for identifying and addressing difficulties in infant mental health 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.

Specialised Parent-Infant Relationship Teams and a National Parent-Infant Relationship Framework are the solution.

Parent-infant teams operate at the intersection of multiple systems—mental health, social care, health visiting, and the voluntary sector. Working in community settings, teams are a catalyst for a more 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. But many places lack this joined-up approach.

To address this, we are working with partners to develop a National Parent-Infant Relationship Framework. Once developed, we hope it will be adopted by government.

iii) Workforce capacity and understanding re: infant mental health and parent-infant relationships

Some progress has been made in recent years in building the workforce's understanding of infant mental health 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 infant mental health expertise across professions.

However, recent developments are not yet 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, so families do not get the support they require. [23]

[23] For more information about the workforce and possible solutions, see

To address this, we recommend the introduction of a national clinical leadership role for parent-infant relationships and infant mental health. This role would provide cohesive strategic direction, foster partnerships across key sectors—including health, public health, social care, and education—and support greater integration across both primary and secondary prevention services.

We also recommend enhanced professional development aligned with the NHS Workforce Plan to build the workforce capacity needed for primary prevention (universal services), and secondary prevention (targeted and specialised parent-infant relationship teams and services). Also, an appropriate level of training is needed for early years and wider health and care professionals, which can be supported by the supervision and training capabilities of existing parent-infant teams.

Q6. How can the Government most effectively tackle inequalities in access and infant health outcomes for those from underserved groups including those with disabilities, or from ethnic minority or deprived backgrounds?

To tackle inequalities in infant health outcomes and access to support, the Government must invest in integrated, relationship-based services that are embedded in and responsive to local communities—particularly those in areas of high deprivation and diversity. Strong examples exist, including Healthy Little Minds in Nottingham and PAIRS (Parent and Infant Relationship Service) in Lambeth. These models show what works in practice.

(i) Invest in locally-rooted, specialist early intervention services

The Healthy Little Minds service in Nottingham shows how services can effectively reach families traditionally underserved by mainstream provision. According to evaluation data:

- Over 75% of families lived in the most deprived areas of Nottingham.
- Nearly 40% were from racialised communities—closely mirroring the local population.
- Referral reasons reflected structural vulnerabilities, such as parent/carer mental health (48.8%), bonding issues, and safeguarding concerns.

Similarly, PAIRS in Lambeth—a parent-infant relationship service delivered by South London and Maudsley NHS Foundation Trust—demonstrates the impact of a specialised, therapeutic team working in a highly deprived area, where 68% of children live in "very deprived" neighbourhoods. Over time, PAIRS:

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https://parentinfantfoundation.org.uk/wp-content/uploads/2025/01/Workforce-solutions-for-the-Parent-Infant-sector.pdf

- Increased its parent-infant psychotherapy appointments from 97 to 777 annually
- Reached families experiencing multiple disadvantages, with 60% living in the most deprived 30% of areas nationally
- Supported two-thirds of families from Black, Asian or multiple ethnic backgrounds, demonstrating strong cultural reach and relevance

(ii) Ensure timely access and continuity of care

Healthy Little Minds achieved swift access for families, with an average wait of 17 days from referral to assessment, and 21 days to first intervention.

This is critical for vulnerable families, who often disengage from services with long waits.

In Lambeth, PAIRS' antenatal focus (with 74% of psychotherapy referrals made before birth) shows how early and preventative support can be embedded into existing care pathways, such as midwifery continuity teams.

(iii) Fund place-based, cross-sector partnerships

The success of PAIRS and Healthy Little Minds is mirrored in wider whole-system models tested by the National Lottery's 'A Better Start programme' and 'Thrive at Five', which show the value of coordinated, area-based early years systems. Key features include:

- Strong links between maternity, mental health, social care, early years, and VCS organisations.
- Emphasis on shared learning, consistent messaging, and joint workforce development.
- Creation of safe, trusted spaces for families often excluded from statutory services.

In Lambeth, PAIRS helped develop and join up local services by delivering workforce training, reflective supervision, consultation to professionals, and group-based therapeutic support.

(iv) Embed equity from the outset

To address longstanding health inequalities, services must:

- Use culturally sensitive approaches,
- Recruit and train a diverse, trauma-informed workforce,
- Design with and for families with lived experience, and
- Track inequities in access and outcomes using integrated data.

PAIRS' ability to engage families who may otherwise face barriers to mental health support was attributed to their flexibility, cultural competence, and deep collaboration with local services.

Q7. What could the Government learn from examples of best practice that exist in local authorities, NHS Trusts, or internationally?

In addition to the example above, the Government can learn significantly from Greater Manchester's whole-system, integrated approach to perinatal and parent-infant mental health. This model demonstrates the power of coordinated action across NHS Trusts, local authorities, and voluntary sector organisations to support the earliest relationships in life—and improve outcomes for infants and families.

(i) Build Integrated, Cross-Sector Pathways

Greater Manchester's model is grounded in integration, intentionally "knitting together" services that have traditionally operated in silos—such as maternity, adult mental health, health visiting, social care, and voluntary sector partners. Their whole-system offer includes:

- Specialist Perinatal Mental Health Teams
- Parent-Infant Mental Health Services
- IAPT services adapted for the perinatal period
- Peer and community-led support (e.g. Home-Start, Dad Matters)

All of these work within a shared, locality-wide integrated pathway, ensuring that families receive timely, appropriate support without falling through service gaps.

(ii) Use a Shared Conceptual Framework

Greater Manchester uses the THRIVE framework to promote a shared language and understanding across agencies. This focuses on supporting families based on their level of need—not diagnosis—and balances prevention, early intervention, and more intensive care. This ensures families don't need to be in crisis to get help.

(iii) Embed Parent-Infant Relationships at the Heart of the System

A defining feature of the GM model is its dual focus: supporting both parental mental health and the developing relationship between parent and baby. Parent-infant teams work at multiple levels—providing direct therapeutic intervention, training and consultation to the wider workforce, and strategically shaping local systems.

In Tameside and Glossop, for example, the Early Attachment Service provides an exemplary hub model that supports both clinical complexity and system-wide capacity-building.

(iv) Prioritise Equity and Inclusion

The Greater Manchester approach recognises that some families—especially those facing multiple disadvantages—need more than "universal" services. It specifically aims to reach those less likely to access support, including:

- Parents from ethnic minority backgrounds
- Migrant and refugee families
- Parents with learning disabilities or mental illness
- Fathers and partners, who are often overlooked

All services are expected to support early identification and offer proportionate, culturally sensitive interventions, including peer support for harder-to-reach families.

(v) Deliver at Scale Through Devolution and Strategic Leadership

The devolution of health and care budgets has enabled Greater Manchester to align strategic plans and investment across health, early years, education, and social care. This whole-region focus gives scale to innovations and supports consistent delivery across ten local authorities.

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