

Health and Social Care Committee

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# First 1000 Days: a renewed focus

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Fifth Report of Session 2024–26

HC 802

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# Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and Social Care and its associated public bodies.

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## Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is (general enquiries) 020 7219 6182; the Committee's email address is [hsccom@parliament.uk](mailto:hsccom@parliament.uk). You can follow the Committee on X (formerly Twitter) using [@CommonsHealth](https://twitter.com/CommonsHealth), and on Bluesky using [@commonsHealth.parliament.uk](https://bsky.app/profile/commonshealth.parliament.uk).

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# Summary

The first 1,000 days of life—from conception to age two—are universally recognised as a critical window for child development. Positive early experiences shape brain development, emotional regulation and long-term health, while adversity during this period can lead to poorer outcomes across education, wellbeing and life chances. Investment in early intervention is highly cost-effective, yet England continues to record some of the worst child health outcomes in Europe, including rising obesity, uneven vaccination coverage and persistent inequalities.

Our inquiry set out to understand what progress has been made since our predecessor Committee's 2019 report and what action is needed to deliver the Government's ambition of giving every child the best start in life. We focused on Family Hubs and the Start for Life programme, health visiting, workforce, vaccinations and service integration.

- We welcome the Government's announced expansion of the **Family Hub network** to one in each local authority. The Government must go further and ensure there is access to Family Hubs in every community, backed by long-term funding. This expansion must prioritise equity, with clear targets for reaching families with the greatest need and roles dedicated to supporting parents of children with additional needs.
- **Health visitors** are the backbone of early years care, yet their numbers have fallen by 43% since 2015, leaving a shortfall of 5,000 posts. Remaining staff are therefore managing caseloads that can be dangerously high—sometimes exceeding 750 children. The Government must urgently rebuild the health visiting workforce. We call for a funded plan to recruit at least 1,000 additional health visitors immediately, the development of safe staffing tools, and a commitment to increasing mandated visits from five to six as capacity grows.
- The forthcoming **NHS 10 Year Workforce Plan** must include specific, funded targets for increasing the number of professionals working in early years roles, supported by updated modelling and a holistic child health workforce strategy. The Government must also set out its plans to support professions outside the NHS, by publishing a child's health workforce strategy alongside the Plan.

- **Vaccination** is one of the most effective public health interventions, yet uptake has declined steadily since 2012, with stark regional and ethnic disparities. We recommend reinstating the 95% coverage target in NHS planning guidance and committing to achieve it by the end of this Parliament. The Government should accelerate pilots for health visitor-led vaccination delivery and ensure Integrated Care Boards have named leads for coordinating local vaccination strategies.
- We welcome the planned production of a shared outcomes framework which should support greater **integration between services**. Implementation of this framework will depend on better data sharing and improved data quality. We call on the Government to produce a data sharing toolkit to address the practical challenges providers face when sharing information. We also recommend the Department work toward greater data disaggregation to enable it to monitor progress tackling waiting times for children under the age of two.

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# 1 Introduction

1. The first 1000 days of life<sup>1</sup> has been widely acknowledged as a critical period for a child through successive governments. At this age children are highly susceptible to their environment: language-rich environments and nurturing interactions are essential for stimulating neural pathways and supporting brain development, emotional regulation and cognitive skills.<sup>2</sup> In contrast, adverse child experiences or a lack of support during this period have been found to lead to increased risks of developmental problems, poor physical and mental health, lower academic achievement, poverty and infant mortality.<sup>3</sup>
2. Investment in early childhood is also highly cost-effective: it has been estimated that for every £1 invested in early intervention up to £200 are delivered in long term benefits.<sup>4</sup> The Department of Health and Social Care has stated that early intervention could generate an estimated £45.5 billion for the national economy each year.<sup>5</sup> However despite this acknowledgement of the potential of early intervention, children in the UK have some of the worst health outcomes in Europe.<sup>6</sup> This is across health conditions such as obesity and asthma, dentistry, mental health, vaccine uptake and infant mortality.<sup>7</sup>

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1 During this inquiry we have used the phrase “first 1000 days”, as that was the term our predecessor Committee used in its inquiry. Some other sources refer to the “first 1001 days” and we have treated them as interchangeable phrases for the purposes of this Report.

2 Mental Health Foundation ([FTD0078](#))

3 The For Baby’s Sake Trust ([FTD0015](#)); University of Bristol ([FTD0018](#)); The National Literacy Trust ([FTD0024](#))

4 British Dental Association ([FTD0062](#)); Breastfeeding Alliance ([FTD0088](#)); Centre for Mental Health ([FTD0110](#))

5 Department of Health and Social Care ([FTD0109](#))

6 College of Paediatrics and Child Health, Policy Report: [From left behind to leading the way; a blueprint for transforming child health services in England](#), September 2024

7 Department of Health and Social Care, [Obesity Profile - Fingertips](#) (accessed October 2025); Royal College of Paediatrics and Child Health, [State of Child Health: Asthma Evidence](#) (2021); Lord Darzi, [Independent Investigation of the NHS in England](#) (September 2024) p 41; Office for Health Improvement & Disparities, [Hospital took extractions in 0 to 19 year olds: short statistical commentary 2023](#), (February 2024); NHS England, [Childhood Vaccination Coverage Statistics England 2021-22](#) (September 2022); Public Health Wales, [Vaccine Uptake in Children in Wales COVER Annual Report 2022](#); Public Health Scotland, [Childhood Immunisation Statistics Scotland](#) (March 2023); Northern Ireland Audit Office, [Pre-school vaccinations in Northern Ireland](#) (April 2023); OECD, [Infant mortality rates](#)

3. In 2019, the previous Health and Social Care Committee conducted an inquiry into the first 1000 days of life, highlighting six key principles for early-years service delivery:
  - “Proportionate universalism”, with services available to all, targeted in proportion to level of need;
  - The importance of prevention and early intervention;
  - Community partnerships, involving families and the wider community;
  - A focus on meeting the needs of marginalised groups, who have the most difficulty in accessing universal services;
  - Greater integration and better multi-agency working; and
  - Evidence-based provision.<sup>8</sup>
  
4. Since our 2019 inquiry progress on proportionate universalism in the early years appears to have stalled. Over one third of parents from low-income households are not able to access children’s centres or Family Hubs in their local area, compared to 23% of parents on average incomes.<sup>9</sup> Vaccination coverage remains uneven, consistently falling since 2012/13 with “huge regional disparities” predicated largely on socioeconomic deprivation.<sup>10</sup> Stakeholders have also highlighted that early years services have remained siloed and fragmented across the country, due to inconsistent implementation of measures such as Family Hubs as well as funding instability.<sup>11</sup> Workforce shortages persist, with an estimated shortfall of 5,000 health visitors and 2,500 full-time midwives in England.<sup>12</sup>
  
5. This inquiry set out to understand why, despite efforts and ongoing commitments from multiple governments, early intervention measures and early-years care has continued to face challenges, and what action should be taken to reverse this trend. We have focused on the impact of the Family Hub model and the barriers to integration across the system. We

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(indicator)(2023); Draper ES, et al., on behalf of MBRRACE-UK Collaboration, [MBRRACE-UK Perinatal Mortality Surveillance, UK perinatal deaths for births from January to December 2021: state of the nation report \(2023\)](#)

8 Health and Social Care Committee, Thirteenth Report of Session 2017–19, [First 1000 days of life](#), HC 1496, summary

9 British Psychological Society ([FTD0022](#)); Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

10 The Association of the British Pharmaceutical Industry (ABPI) ([FTD0106](#)); [Q78](#) [Alison Morton]; [Q167](#) [Dr Skirrow]

11 Dorset Parent Infant Partnership (DorPIP) ([FTD0005](#)); The For Baby’s Sake Trust ([FTD0015](#)); The National Literacy Trust ([FTD0024](#))

12 NSPCC ([FTD0016](#)); National Children’s Bureau ([FTD0080](#))

are grateful to all the individuals and organisations who contributed to our inquiry and would like to express particular thanks to Blackpool Better Start for hosting our visit.

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## 2 Family Hubs and the Start for Life Programme

6. The Family Hubs and Start for Life programme is jointly managed by the Department for Education and the Department of Health and Social Care. It seeks to join up and enhance services for families with children of all ages through a network of Family Hubs.<sup>13</sup> Family Hubs are physical locations that aim to bring multiple different services together in a ‘one stop shop’. Family Hubs are staffed by a multidisciplinary workforce, that includes health visitors (HVs), midwives, GPs, youth workers, family support workers, and early years practitioners.<sup>14</sup> The exact range of services offered by each Family Hub will vary and is designed to meet local need, but could include: support for home learning, parenting classes, midwifery, health visiting, infant feeding advice and perinatal mental health support.
7. Family Hubs not only provide services relevant to the first 1000 days, but also offer support to parents, carers, pregnant women, partners, and young people up to age 19—or 25 if they have special educational needs or disabilities (SEND). Hubs can also support users in accessing other services that may be helpful to a family including: housing and debt advice, youth services or domestic abuse support.<sup>15</sup> The importance of this universality was stressed by Dame Andrea Leadsom, Chair of the Early Years Health Development Review Report for the previous Government,<sup>16</sup> who argued:

The ambition for family hubs is that they will be like a supermarket or a GP clinic; everybody goes there, so there is no stigma associated with going. If you have a child—whether it be your grandchild, your neighbour’s child, your niece, your daughter or your son—you would go there, because that is where everybody goes. The de-stigmatising is absolutely crucial for the success of family hubs.<sup>17</sup>

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13 HM Government, [Family Hubs and Start for Life programme guide 2025–26](#), February 2025

14 Department for Education, [Family hubs: Local support and advice for children and their families](#), 10 January 2024

15 Department for Education, [Family hubs: Local support and advice for children and their families](#), 10 January 2024

16 Department of Health and Social Care, [The Best Start for Life A Vision for the 1,001 Critical Days The Early Years Healthy Development Review Report](#), March 2021

17 [Q28](#)

8. We heard that effective well-developed Family Hubs could reduce stigma around support, offer early identification and intervention of needs, improve integration and joint working, and help to “create a community”.<sup>18</sup> Ofsted and the Care Quality Commission’s evaluation of the ‘Start for Life’ programme in 2024–25 found that in the six assessed local authorities, families who accessed Family Hub services had a positive experience, including confidence in feeding infants, parental mental health, and outcomes for children.<sup>19</sup>
9. Family Hubs can also be cost effective—a Hub in Sandwell reported a benefit to the state of £2.44 for every £1 spent, with Centre for Social Justice analysis reporting £2.60 saved per every £1 spent.<sup>20</sup> However, we also heard that Family Hubs continue to face challenges, including in funding and scope, and access to the service offer. We explore these in turn in this chapter.<sup>21</sup>

## The funding and scope of Family Hubs

10. Family Hubs are funded through a combination of central government investment and local authority resources. In 2022 the Department for Education and Department of Health and Social Care allocated £301.75 million to the Family Hubs and Start for Life Programme for 2022–25, available to 75 local authorities with the highest levels of deprivation and poorest health and education outcomes.<sup>22</sup> This funding comprised of:
  - £100 million for bespoke parent-infant relationship and perinatal mental health support;
  - £82 million to create a network of Family Hubs;
  - £50 million to establish breastfeeding support services;
  - £50 million to fund evidence-based parenting programmes;
  - £10 million to support local authorities to publish a clear ‘Start for Life offer’; and
  - £10 million to trial start for life workforce models.<sup>23</sup>

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18 NSPCC (FTD0016); Royal College of Speech and Language Therapists (FTD0082); Royal College of Psychiatrists (FTD0092); Parent-Infant Foundation (FTD0079); Saskia Jenkins (Senior UK Policy Advisor at UNICEF) (FTD0091); [Qq28–29](#), [Q34](#) [Dame Andrea Leadsom]; [Q210](#) [Susie Owen]

19 Ofsted and the Care Quality Commission, [Start For Life services: thematic review](#), 7 May 2024

20 Mental Health Foundation ([FTD0078](#)); [Q58](#) [Rukshana Kapasi]

21 Workforce was another frequently mentioned challenge which we consider in [Chapter 4](#)

22 HM Government, [Family Hubs and Start for Life programme guide](#), August 2022

23 HM Government, [Infants, children and families to benefit from boost in support](#), 2 April 2022

The funding was distributed to local authorities via non-ringfenced section 31 grants. The grants were contingent on local authorities meeting delivery expectations set out in the Family Hubs and Start for Life Programme Guide.<sup>24</sup> In addition to the Start for Life funding, a further 13 local authorities have received funding through the Family Hubs Transformation Fund, which supports local authorities in setting up Family Hubs.<sup>25</sup>

11. In the 2024 Autumn Budget, the Government announced £69 million of funding to continue delivery of Family Hubs in 2025–26. Of this, £53 million will be provided to the 75 most deprived local authorities. On 10 January the Government additionally announced that £57 million of Start for Life funding would be provided to those local authorities, focused on mental health support and infant feeding services.<sup>26</sup>
12. Under section 5A of the Childcare Act 2006, local authorities have a duty to make arrangements, so far as is reasonably practicable, for “sufficient provision of children’s centres to meet local need”.<sup>27</sup> Councils can choose to deliver all or some of this support via Family Hubs, regardless of whether they receive specific central government funding for a Hub. For example Hillingdon Council, which did not receive initial funding from Family Hubs or the Start for Life Programme, has established its own Hubs.<sup>28</sup> Some areas also choose to supplement national Family Hub funding with local funding, for example, Coventry, which received funding but also supported the work of its Hub from its Children’s Services funding and the local authority Public Health Grant.<sup>29</sup> In addition some services that are often delivered via Hubs, notably health visiting, are funded via that Grant (see also Chapter 3).
13. Despite the recent funding announcements, the level of financial support for Family Hub services was frequently raised by stakeholders. Impact on Urban Health told us funding was “the major barrier to delivering high-quality early years services.”<sup>30</sup> The British Psychological Society cited research published by the Centre for Young Lives in April 2025, which found that 49% of local authorities reported cuts to their budgets for Family Hubs and children’s centres between 2023–24 and 2024–25.<sup>31</sup> Witnesses also highlighted the challenges that the mixed model of funding for Hubs can cause. Rachel Roberts of Hull City Council told us she spent most of her time

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24 Department for Education and Department of Health and Social Care, [Family Hubs and Start for Life programme guide](#), August 2022

25 Transparency data, [Family hubs transformation fund: successful local authorities](#), 9 February 2023

26 HM Government, [Families to receive £126 million in early years support](#), 10 January 2025

27 Section 5a, [Childcare Act 2006](#)

28 Hillingdon Council, [FAMILY HUB STRATEGY \(DRAFT\) 2023-25](#)

29 Coventry City Council, [Coventry Family Hubs: Impact report – Coventry City Council](#) (accessed October 2025)

30 Impact on Urban Health ([FTD0083](#))

31 British Psychological Society ([FTD0022](#))

“juggling” finances between external funding and grant funding.<sup>32</sup> UNICEF evidence emphasised that short-term, fragmented national funding over the years had undermined the ability of local services to provide quality care.<sup>33</sup>

14. During our inquiry comparisons were made between the level of funding of the current Family Hubs Programme and the Sure Start Programme—introduced in 1998 as a multi-departmental programme of early intervention for children under four.<sup>34</sup> The Institute for Fiscal Studies noted that in 2010 Sure Start’s annual funding was £2 billion. In comparison, Christine Farquharson, Associate Director of the Institute said that even taking a “maximalist approach” to counting, the annual expenditure on Family Hub funding was less than £600 million a year,<sup>35</sup> although this was before the Government’s announcement of an additional £500 million to create up to 1000 hubs across the country by the end of 2028. Witnesses also highlighted the difference in the scope of Family Hubs compared to Sure Start, with the former providing a service for young people up to the age of 18 (or 25 in the case of young people with SEND). Dorset Parent Infant Partnership told us this had led to the Start For Life elements being “sidelined somewhat at times.”<sup>36</sup>
15. A significant number of witnesses called for an expansion of the Family Hub Programme. Barnardo’s, for example, called for the Government to develop a national programme of Family Hubs—one in every community—backed by ring-fenced central funding (3,500 hubs at a cost of around £2.7bn).<sup>37</sup> Similarly the Parent-Infant Foundation called for national roll-out of the Family Hubs and Start for Life Programme to all local authorities,<sup>38</sup> as did the National Children’s Bureau,<sup>39</sup> the Breastfeeding Alliance,<sup>40</sup> and UNICEF<sup>41</sup> amongst others.
16. On 7 July 2025, the Government published its policy paper, “Giving every child the best start in life”, which announced an expansion of the Family Hub network. Under the plans there will be new funding, £500 million between 2026 and 2029, to “rebuild crucial family services, under a ‘Best Start’ umbrella”, with Best Start Family Hubs created in every local authority area in England. Local authorities not currently in receipt of funding for Family Hubs will receive some funding in 2025–26 so that services can be set up

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32 [Q95](#)

33 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

34 House of Commons Library, [Sure Start \(England\)](#), Briefing Paper 7257, 9 June 2017

35 [Q94](#)

36 Dorset Parent Infant Partnership (DorPIP) ([FTD0005](#))

37 Barnardo’s, [Building families, building futures: The case for family hubs in every community](#), June 2025

38 Parent-Infant Foundation ([FTD0079](#))

39 National Children’s Bureau ([FTD0080](#))

40 Breastfeeding Alliance ([FTD0088](#))

41 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

quickly when Best Start funding starts from April 2026.<sup>42</sup> We explored with Minister Dalton whether this was sufficiently ambitious, given demands from part of the sector for a much bigger network of 3,500 hubs.<sup>43</sup> She replied:

Yes. This is the beginning of our ambition to deliver the healthiest generation of children ever. [...] This is a decade of renewal. We have identified the beginnings of that following the recent spending review.<sup>44</sup>

17. Following our oral evidence sessions, we were contacted by the Parent-Infant Foundation who raised concerns that, as of December 2025, the Department of Health and Social Care had not confirmed final funding arrangements for new areas and had indicated that new areas might not receive funding to establish services. They also noted that guidance has not been published on services supporting 0–2-year-olds. This was contrasted with the performance of the Department for Education who they said had contacted local authorities to provide guidance on intervention for 3–4-year-olds in October 2025. The Parent Infant Foundation argued that “local areas developing ‘Best Start plans’ focus on older children aged three and four.”<sup>45</sup>

18. **CONCLUSION**

We welcome the additional funding that the Government has announced for Family Hubs and its plans to open a Hub in every local authority. This is a positive step in increasing the support available to families during the critical first years of a child’s life. However, the funding available for these programmes is still significantly below the level of Sure Start, while Hubs are being expected to cater to a much broader age range of children and young people.

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42 Department for Education, [Giving every child the best start in life](#), 7 July 2025, CP 1362

43 Barnados, [Building families, building futures: The case for family hubs in every community](#), June 2025

44 [Q197](#)

45 Parent-Infant Foundation ([FTD0114](#))

19.

#### RECOMMENDATION

We call on the Government to set out plans to further expand the network of Family Hubs to provide access to a Hub every community. This plan must be supported by sustained and ringfenced funding. Previous research on the benefits of the Sure Start Programme clearly set out the long-term benefits and financial returns of such an investment and would directly support this Government’s ambition to give every child the best start in life. We also ask the Government to set out when it will confirm the funding arrangements for new areas and when it plans to issue guidance to those areas on services for children between the ages of 0 and 2.

## Access to Family Hubs

20. When our predecessor Committee last considered this topic it endorsed the principle of proportionate universalism which, as Professor Marmot described it, means that there is “a universal system available to everyone, but our effort is proportionate to need.”<sup>46</sup> The current Government has been targeting investment in Family Hubs at areas with the greatest level of deprivation and poorest health and educational outcomes,<sup>47</sup> with the Government’s “Giving every child the best start in life” paper saying that “joined up family services benefit all children, the benefits for children from low-income families are even greater.”<sup>48</sup> However, we heard that Family Hubs were struggling to reach families with the greatest need. Polling by YouGov for UNICEF UK found that over 35% of parents from low-income households could not access children’s centres or family hubs in their local area (compared to 23% of parents on average incomes).<sup>49</sup>
21. We received several suggestions for how this challenge, and related access issues, could be addressed. These included:
- Ensuring that outreach activity is non-stigmatising, inclusive, and community-led. As the Government itself recognises “too often, families can be put off from seeking support”. Its policy paper noted that 70% of parents with children aged 0–5 felt judged by others; and many reported “lower self-esteem, increased self-doubt, feelings of inadequacy, and sadness or unhappiness”.<sup>50</sup> The Government has committed to Hubs being “welcoming spaces where every family feels

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46 [Q6](#)

47 See paragraph 9

48 Department for Education, [Giving every child the best start in life](#), 7 July 2025, CP 1362

49 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

50 Department for Education, [Giving every child the best start in life](#), 7 July 2025, CP 1362

valued and confident to ask for help” saying that “no family should be turned away from a Best Start Family Hub having taken the step of seeking support”.<sup>51</sup>

- Open, inclusive and transparent language when communicating with families, as well as greater equality training.<sup>52</sup> The Centre for Mental Health and the Children and Young People’s Mental Health Coalition called for professionals working in early years services to be trained in cultural competence, anti-racism, and inclusive practices, and for funding to be allocated to recruiting and retaining a more diverse workforce that reflected the communities it served.<sup>53</sup>
- Specific targets for outcomes among disadvantaged children, including those with SEND, to ensure equity in service delivery and impact.<sup>54</sup>
- “Ensuring that services are being co-designed alongside those who usually face the greatest barriers in accessing them”. The Centre for Mental Health and the Children and Young People’s Mental Health Coalition called for services to be designed with “young parents, disabled parents, and racially minoritised communities” to ensure that interventions were “accessible, respectful, and relevant.”<sup>55</sup>
- Dedicated coordination roles within Family Hubs, to help families navigate the joint working and interdisciplinary landscape of early childhood care.<sup>56</sup> It was argued that this would be especially beneficial for families of children with the most complex needs, or from the most disadvantaged backgrounds.<sup>57</sup> The Government has announced that Best Start Family Hubs will include children and family services professionals specifically trained in working to support parents of children with additional needs, part of whose role will be to “assist parents in navigating what can be a complex landscape of services”.<sup>58</sup>
- A greater focus on hybrid services. Many hubs offer a range of digital tools to support families, such as online advice, information, learning and calls. Dame Andrea Leadsom spoke about online meetings improving access for parents who were working or did not feel

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51 Department for Education, [Giving every child the best start in life](#), 7 July 2025, CP 1362

52 The Traveller Movement ([FTD0010](#))

53 Centre for Mental Health ([FTD0110](#))

54 Professor Eva Lloyd (Emeritus Professor at University of East London) ([FTD0020](#))

55 Centre for Mental Health ([FTD0110](#))

56 The National Literacy Trust ([FTD0024](#)); Professor Angharad Beckett (Professor of Political Sociology and Social Inclusion at School of Sociology and Social Policy and Centre for Disability Studies, University of Leeds) ([FTD0055](#))

57 NSPCC ([FTD0016](#)); Better Start (Blackpool) ([FTD0061](#))

58 Department for Education, [Giving every child the best start in life](#), 7 July 2025, CP 1362

comfortable attending in-person.<sup>59</sup> We heard that digital access tools such as guides and AI apps could also help parents navigate the online early years support landscape, which Halton Borough Council described as “often fragmented and complicated.”<sup>60</sup>

- Delivering services in a greater variety of locations. Somerset Council wrote to us about plans to develop a “distributed family hub model” by identifying the places residents went to in their community to access local help (e.g. food banks, village halls) and delivering drop-ins and local services from those locations, which it argued was more “suitable for a large rural county”.<sup>61</sup>
- Increasing the focus on the role and needs of fathers. Professor Anna Tarrant, University of Lincoln, argued that fathers were “an underserved group” in Family Hubs and that access to “father-inclusive training” was “patchy and inconsistent”.<sup>62</sup>

## 22. RECOMMENDATION

Successive governments have rightly focused on targeting Family Hubs and other early year interventions on those with the greatest need. We welcome the announcement that Hubs will have staff specifically trained to support the parents of children with additional needs navigate the service. We recommend that Government consider creating similar roles to support the parents of children from other disadvantaged groups.

## Services provided by Family Hubs

23. As discussed earlier, the exact services that are provided in any Family Hub will vary, both based on the Hub’s assessment of local community needs and whether the Hub received funding from the Better Start Programme. The Family Hubs and Start for Life Programme guides set out the expectation both for services which are not receiving additional investment through this programme,<sup>63</sup> as well as the funded services.<sup>64</sup> They include minimum expectations and suggestions for how services could “go further”.<sup>65</sup>

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59 [Q28](#) [Dame Leadsom]; [Q63](#) [Rachel Roberts]

60 Halton Borough Council ([FTD0087](#))

61 Somerset Council 36 - get it published

62 Written evidence 45 - to be published

63 Department for Education and Department of Health and Social Care, [Annex F: Family Hub Service Expectations Family Hubs and Start for Life Programme guide](#), August 2025

64 Department for Education and Department of Health and Social Care, [Family hub model framework 2025-26](#), February 2025

65 Department for Education and Department of Health and Social Care, [Family hub model framework 2025-26](#), February 2025

24. We received some suggestions for expanding the core services offer. Dame Andrea Leadsom argued that two “laser interventions” would support Family Hubs in delivering on universality—antenatal checks and birth registration—neither of which are currently part of Hubs’ minimum expectation. She argued that these were great opportunities to get parents into Hubs and introduce them to other services on offer.<sup>66</sup>
25. During our oral evidence sessions, Parent-Infant Mental Health Services and Early Attachment Services, feeding support including breastfeeding, and early language support were all raised. We consider those proposals for extensions to the core offer below. There were several other suggestions, including infant feeding services, that we were not able to consider in detail during this inquiry, though we will continue to monitor them in future.

## Parent-Infant Mental Health Services and Early Attachment Services

26. The British Psychological Society highlighted the vital role that Parent-Infant Mental Health Services and Early Attachment Services could play in “supporting and strengthening the relationships between babies and their parents”, arguing that those services were important in helping parents struggling due to their own current circumstances or childhood experiences.<sup>67</sup> They noted that many young people referred to CAMHS had experienced attachment difficulties in their first 1,000 days.<sup>68</sup>
27. The Parent-Infant Foundation called on the Government to allocate £73m each financial year to enable every local authority area to develop at least one parent-infant team. They argued that this would enable 39,200 vulnerable babies to receive specialist support every year by 2028–29 and that the investment was relatively modest compared to the costs of inaction, pointing to a £8.1 billion estimated annual cost of perinatal mental health problems in England and a £16 billion estimated annual cost of inadequate support in early childhood.<sup>69</sup>
28. The Mental Health Foundation emphasised the importance of perinatal mental health, both to support mother and due to its impact on child development. They stated that maternal mental health difficulties could negatively affect mother-infant attachment, crucial for the child’s emotional and psychological development, leading to long-term issues in mental health, emotional regulation, and resilience.<sup>70</sup>

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66 [Q40](#)

67 [British Psychological Society \(FTD0022\)](#)

68 [British Psychological Society \(FTD0022\)](#)

69 [Parent-Infant Foundation \(FTD0079\)](#)

70 [Mental Health Foundation \(FTD0078\)](#)

29. Perinatal mental health support is listed as one of the core objectives of Family Hubs.<sup>71</sup> A significant proportion of the additional funding that was announced for the original 75 local authorities on 10 January 2025 was directed towards improving mental health support for families and promoting positive early relationships between babies and caregivers—with this accounting for £36.5 million of the additional £57 million for Start for Life.<sup>72</sup>
30. Yet evidence criticised a lack of focus on this aspect of support in favour of physical health.<sup>73</sup> The Maternal Mental Health Alliance told us that the mental health offer in Hubs was “often unclear”, with its conversations with local stakeholders suggesting that in most Hubs with a perinatal mental health offer, this was limited to peer support. Peer support, the Alliance argued, played an important role in helping families but needed to sit alongside statutory care.<sup>74</sup>
31. The Mental Health Foundation and the Maternal Mental Health Alliance also highlighted that perinatal mental health care was worse for mothers from ethnic minority backgrounds, with rates of postnatal depression and anxiety being 13% higher in mothers from these communities.<sup>75</sup> The National Perinatal Epidemiology Unit, University of Oxford, highlighted survey data showing that women from ethnic minorities were less likely to be asked about their mental health both before and after pregnancy.<sup>76</sup>

32. **CONCLUSION**

Perinatal mental health is as important as physical health, with poor mental health outcomes having potentially significant long-term consequences for both the mother and child. We were struck by how frequently mental health concerns were raised in evidence. Given that the Government’s new investment is available only to the original 75 local authority areas this will struggle to address the need identified by witnesses.

71 Department for Education, [Family hubs: Local support and advice for children and their families](#), 10 January 2024

72 HM Government, [Families to receive £126 million in early years support](#), 10 January 2025

73 Maternal Mental Health Alliance ([FTD0030](#)); Family Action ([FTD0039](#))

74 Maternal Mental Health Alliance UK ([FTD0030](#))

75 Mental Health Foundation ([FTD0078](#))

76 The University of Oxford ([FTD0102](#))

**33. RECOMMENDATION**

The Government should set out what actions it will take to improve access to perinatal mental health care within Family Hubs, supported by specific targets to improve access for women from ethnic minority backgrounds who have disproportionately poorer mental health outcomes.

## Speech and Language Support in Family Hubs

- 34.** Speech and language therapy (SLT) supports the development of communication, eating and swallowing skills in children. Among others, SLT supports premature babies and infants with difficulties; children with primary speech difficulties; and people with developmental conditions such as learning disabilities, autism and down syndrome.<sup>77</sup>
- 35.** The Royal College of Speech and Language Therapists' (RCSTL) emphasised that vocabulary and speaking ability at the age of two was a strong predictor for school readiness at age four, and that children with issues in this area were twice as likely than their peers to be unemployed and three times as likely to have mental health problems in adulthood.<sup>78</sup> Bristol University linked poor language and communication skills at a young age with long-term school conduct and achievement issues, and noted that children with these issues were twice as likely to self-harm with suicidal intent than their peers.<sup>79</sup>
- 36.** We asked Jane Harris, CEO, Speech and Language UK, about the charity's experience of delivering speech and language services through Family Hubs. She told us the situation was "haphazard":

It just depends on whether there are people in those family hubs who see this as a priority.<sup>80</sup>

Ms Harris also emphasised the important influence the wider child's health workforce could have on children's speech and language development, saying early years staff could "design their setting so that it prompts children to talk more. They can make sure their staff are skilled up in basic interactions."<sup>81</sup> Janet Cooper, a clinical lead speech and language therapist for Midlands Partnership Trust, who appeared on behalf of RCSTL, expanded upon this:

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77 Imperial College Healthcare, [Speech and language therapy](#) (accessed October 2025); Workforce issues related to speech and language therapists are discussed further in Chapter 4, Workforce issues

78 Royal College of Speech and Language Therapists ([FTD0082](#))

79 University of Bristol ([FTD0063](#))

80 [Q155](#)

81 [Q162](#)

On the focus on the nought to twos, the less experienced staff quite often get put in the baby rooms, and they often feel that they are just there changing nappies. There is definitely a need to focus on the education of that group of people, and to acknowledge that it is a really tricky job. You are taking somebody's most precious gift—it is quite often the first time they have been left—so there is a need for some qualifications around that, and a recognition that that is an enhanced role. We could perhaps award them something for being in that enhanced role, or encourage nurseries to put more experienced staff into those roles.<sup>82</sup>

- 37.** The 2022 Family Hubs Start for Life guidance expects parents, as a minimum, to be able to access information within Hubs on supporting a child's speech and language needs, including how to secure related therapy.<sup>83</sup> However, RCTSL noted that the current guidance for local authorities on Family Hubs and the Start for Life programme severely limited use of early language and home learning environment funding. In the 2022–25 period, funding had been restricted to training practitioners to support parents of 3–4-year-olds. This was extended to include 2–3-year-olds in 2025–26. The RCSTL welcomed the widening of that window, but noted that it still meant not being able to support parents with speech and language in the first 1000 days.<sup>84</sup> Janet Cooper also told us that the variability of the Family Hub model, and the lack of sufficient funding to focus on speech and language, prevented more activity focused on the younger age group.<sup>85</sup>
- 38.** When we raised this question of funding during our ministerial evidence session we were told that the Government “build speech and language through everything we do in the early years, right from conception all the way up.”<sup>86</sup> Susie Owen, Co-Director for Early Years, Childcare, Families and Analysis, Department for Education, told us that this specific funding stream concerned the home-learning environment and parenting strands of the existing programme funded by DfE and that they were “going through the process of setting the new programme guide and putting advice to Ministers on that. We have not yet set out what the new programme will look like.”<sup>87</sup>

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82 [Q162](#)

83 HM Government, [Family Hubs and Start for Life programme guide](#), August 2022, p 43

84 Royal College of Speech and Language Therapists ([FTD0082](#))

85 [Q156](#)

86 [Q207](#)

87 [Q207](#)

**39. RECOMMENDATION**

We recommend that the Department for Education revise its guidance on early language and home learning environment funding to allow it to be used to provide support that covers the 0-2-year period, to allow providers the maximum flexibility in how they deploy this funding.

## Neighbourhood Health and Family Hubs

- 40.** A core part of the Government’s 10 Year Health Plan, released in July 2025, is establishment of the ‘Neighbourhood Health Service’.<sup>88</sup> The aim is to create local community hubs with integrated multidisciplinary teams to enable the coordination of health, care and community paediatric services in one accessible setting, with integrated, locally tailored interventions to the specific needs of children and families in each area. This includes a commitment to establish a ‘Neighbourhood Health Centre (NHC)’ in every community, where multidisciplinary teams can operate. In February 2025, NHS England released guidance on Neighbourhood multidisciplinary teams (MDT), which made clear it aimed to provide “integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working”.<sup>89</sup>
- 41.** The plans to establish an NHC in every community as “a ‘one stop shop’ for patient care and the place from which multidisciplinary teams operate” bears some similarities with the Family Hub models which, as we saw earlier, bring together not just health services but broader services such as housing and debt advice,<sup>90</sup> something that the Government has also said it hopes to deliver through NHCs.<sup>91</sup>
- 42.** The 10 Year Health Plan includes information on the role the Government expects Family Hubs to play in its shift toward greater community delivery of health services:

Through local commissioning, we will ensure that Neighbourhood Health Services work in partnership with family hubs, schools, nurseries and colleges to offer timely support to children, young people and their families including those with Special Educational Needs and Disabilities (SEND).<sup>92</sup>

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88 Department of Health and Social Care, [10 Year Health Plan for England: fit for the future](#), 30 July 2025

89 NHS England, [Guidance on neighbourhood multidisciplinary teams for children and young people](#), February 2025

90 See paragraph 7 onwards

91 For example, NHS England, [Neighbourhood health services bringing care to Londoners’ doors](#), 8 October 2025

92 DHSC and Prime Minister’s Office, [Fit for the future: 10 Year Health Plan for England](#), 03 July 2025

43. When we asked the Minister how the potential overlap could be managed, particularly with demand on non-health service partners, we were told that further detail about implementation was being worked up:

In some cases, that will mean linking with family hubs. It might mean linking with existing services such as community centres, mother and toddler groups—all different kinds of things that are in different communities.<sup>93</sup>

44. **CONCLUSION**

We welcome the Government’s intention for Neighbourhood Health Services and Neighbourhood Health Centres to work in partnership with Family Hubs. Given that both models aim to bring together health and broader support services in a “one stop shop”, it will be important that families know where to go to access support and that partner organisations are not stretched too thin attempting to provide a presence in multiple locations. We invite the Government to provide further information on how it will manage potential overlap between Neighbourhood Health Centres and Family Hubs in its response to this report.

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## 3 Health visiting

- 45.** Health visits are the primary delivery mechanism for the Healthy Child Programme, the national blueprint for preventative public health in England.<sup>94</sup> It was formalised after the NHS Act 1946, initially commissioned centrally through NHS England before being transferred to local authorities in 2015 through the Public Health Grant (PHG).<sup>95</sup> Health visiting is undertaken by Health Visitors (HVs), who see a family at their home, a clinic, GP surgery or Family Hub. HVs assess a family's needs, child and adult health, and the child's development. Focuses include growth, feeding and physical checks; developmental milestones; maternal mental health and family wellbeing; and safeguarding / signposting to other services.<sup>96</sup>
- 46.** There are five mandated points of contact between HVs and families in the first 1000 days:
- antenatal visit (around 28 weeks of pregnancy),
  - new birth visit (10–14 days old),
  - 6–8 weeks,
  - 9–12 months and
  - 2–2.5 years developmental review.<sup>97</sup>

Local areas can choose to offer more than these five visits, and during our visit to the Better Start Centres in Blackpool we heard about their experience delivering eight visits.

- 47.** The Institute of Health Visiting (iHV) set out the central role that health visitors play in ensuring that families with babies and young children are reached and get good, joined-up support during the first 1000 days. Their evidence highlighted:
- Health visitors' universal reach, working with all families from pregnancy to school entry, noting that this was “particularly important for those on the margins of society who are often invisible to other services and/or will never attend a Family Hub”<sup>98</sup>

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94 Office for Health Improvement and Disparities, [Healthy child programme](#), 27 June 2023

95 Department of Health, [Transfer of 0-5 children's public health commissioning to Local Authorities](#), March 2015

96 NHS England, [Health visiting: Listening to parents, transforming services](#), 6 February 2015

97 NHS England, [Your baby's health and development reviews](#) (accessed October 2025)

98 Institute of Health Visiting ([FTD0026](#))

- The breadth of skills health visitors have “which incorporate child and adult health (both physical and mental health), child development, social needs and safeguarding, health visitors provide a highly skilled resource for identifying and assessing need, and ensuring that families get the right support”<sup>99</sup>
- Seeing children in their home, which “provides valuable insight into their unique strengths and difficulties”<sup>100</sup>
- The role they play connecting families to other services.<sup>101</sup>

**48.** Unicef-UK described health visiting as the “backbone of the early years [...] the safety-net around all families”,<sup>102</sup> while the Royal College of Nursing drew particular attention to the importance of health visitors in providing support to families during long waits for assessments by specialist services.<sup>103</sup> The NSPCC also highlighted the importance of health visits in addressing inequalities, noting that the continuity of care that health visitors could provide made it “easier for parents to discuss sensitive issues” and enabled “the professional to tailor their advice and support so that it is more relevant for families.”<sup>104</sup>

## Health visitor numbers

- 49.** There is currently a major shortage in the number of health visitors. According to the iHV, in 2015, when health visiting transferred from the NHS to local authorities, there were 11,192 health visitors in England. Data for December 2024 showed that there were now only 6,300 - a 43% reduction since 2015, and a 19% reduction since 2002 when the then Government committed to strengthening the health visitor workforce.<sup>105</sup> Overall the iHV estimates that there is a shortfall of 5,000 health visitors in England.<sup>106</sup>
- 50.** This shortfall was seen as having a significant impact on the ability of the health visiting workforce to deliver services. For example, the NSPCC told us that in 2023/24 18.3% of babies aged six to eight weeks did not receive their mandated health visiting contact.<sup>107</sup> The iHV’s 2025 Annual Survey found that 73% of health visitors believed workforce shortages impacted on their

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99 Institute of Health Visiting ([FTD0026](#))

100 Institute of Health Visiting ([FTD0026](#))

101 Institute of Health Visiting ([FTD0026](#))

102 UNICEF UK, [Early moments matter](#), 2022

103 Royal College of Nursing ([FTD0085](#))

104 NSPCC ([FTD0016](#))

105 Institute of Health Visiting ([FTD0026](#))

106 Institute of Health Visiting, [State of Health Visiting](#), UK survey report, January 2023

107 NSPCC ([FTD0016](#))

ability to support families when a need was identified, while only 46% were confident that they could meet the needs of vulnerable babies and children “all or most of the time.”<sup>108</sup>

51. Data on health visitor service delivery metrics for 2023–24 from the Office for Health Improvement and Disparities show that the national figure for visits uptake rates hide large variation in regional performance (see Table 1 below). The iHV has stated that this variation in delivery is “not linked to deprivation, levels of population need, or funding.”<sup>109</sup>

**Table 1: HV service delivery metrics, 2023 to 2024 April to March quarterly data, OHID.**

	Q1	Q2	Q3	Q4	Annual
New birth visits within or after 14 days	98.3% (87.1%-100%)	98% (87.4%-100%)	97.3% (13.2% -100%)	97.9% (92.2% -100%)	97.9%
6-to-8-week reviews	81.4% (4%-99.6%)	81.9% (2.9%-98.7%)	82.4% (2.6%-97.3%)	82.2% (2.8%-99.6%)	82%
12-month reviews by 15 months	84.8% (10.9%-99.6%)	86.8% (22.8%-97%)	87.4% (25.2%-98.8%)	88.6% (26.7%-99.6%)	86.9%
2 to 2½-year reviews	76.5% (4%-100%)	78.5% (3%-100%)	79.6% (3.9%-100%)	79.9% (8.4%-100%)	78.6%

Source: Office for Health Improvement and Disparities, cited by iHV<sup>110</sup>

52. UNCIF told us that only 6% of HVs were currently working within the recommended caseload.<sup>111</sup> Alison Morton, CEO, Institute of Health Visiting, told us that there were health visitors in England with caseloads of 500, 750 or 1,000 children. She compared this situation with other parts of the UK:

In Scotland, they have caseloads of about 200 [...] In Wales, the caseload is about 250, and Northern Ireland is the same, so England is an outlier. We do not have a safer staffing tool for England, so there is no bottom to this. It will keep falling off a cliff until someone draws a line and says, “That is too many. Nobody can cope with that—it is unrealistic.”<sup>112</sup>

108 Institute of Health Visiting ([FTD0026](#))

109 Institute of Health Visiting ([FTD0026](#))

110 Institute of Health Visiting ([FTD0026](#))

111 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

112 [Q79](#)

53. Ms Morton went on to say that iHV had recommended a caseload of around 250 but that this was dependent on the need of the families health workers were supporting. For the most deprived 10% they would recommend a caseload of about 100 and the least deprived 30% one of about 400. She thought it was worth repeating previous demand-driven workforce modelling.<sup>113</sup>

54. We heard that this reduction in health visitor numbers, and subsequent rise in caseload, had been driven by several factors, mostly notably reductions in the public health grant, with the iHV also drawing attention to shortages in student health visitor training places and workforce attrition.<sup>114</sup> The Institute of Health Visiting estimated the cost of 1,000 extra health visitor posts each year in the first three years to be £52.9m for year 1, £105.8m in year 2 and £158.7m for year 3.<sup>115</sup>

55. **CONCLUSION**

The Government will fail to deliver on its ambition to give every child the best start in life unless it takes urgent action to rebuild the health visitor workforce, which has been decimated over the last 10 years.

56. **RECOMMENDATION**

The Government must create a specific plan to rebuild the health visitor workforce in its forthcoming NHS Long Term Workforce Plan. This plan must be informed by safe staffing tools to ensure that health visitors have a manageable workload. As an initial step, we call on the Government to immediately commit to recruiting at least another 1000 health visitors.

57. **RECOMMENDATION**

We are also highly concerned about the variation in performance amongst local authorities in delivering health visits. While it is clear that the system as a whole needs additional resourcing, it is unacceptable that some local authorities managed 100% uptake while others were as low as 4%. We call on the Government to set out what action it will take to hold to account poorly performing local authorities and improve their delivery of health visits.

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113 [Q80](#)

114 Institute for Health Visiting ([FTD0026](#))

115 Institute for Health Visiting ([FTD0026](#))

## Number of health visits

58. We also heard calls for the number of visits that health visitors are required to undertake to be increased. iHV’s 2019 report, *Health Visiting in England: A Vision for the Future*, recommended increasing the number of mandated health visits from five to eight to allow for better relationship-building and early identification of issues. Alison Morton described the approach taken in England as being an “outlier” for health visiting provision, comparing its five mandated contacts with Scotland’s 11.<sup>116</sup> In Northern Ireland and Wales there are six and nine mandated visits respectively.<sup>117</sup> Action Cerebral Palsy called for three additional universal health visits contacts:

These should take place at: 3 - 5 weeks, 3 months, and 3.5 years. Increased health visitor screening of all infants at three months old will help to identify infants with emerging signs of cerebral palsy and refer them to specialised care pathways.<sup>118</sup>

York BabyLab, based in the Department of Language and Linguistic Science, University of York proposed “earlier, more regular, and consistent health visiting for all families” as well as targeted intervention for any babies deemed at risk of later speech and language problems.<sup>119</sup>

59. Our predecessor Committee called for a new check at 3–3½ years to help ensure school readiness, via the Healthy Child Programme.<sup>120</sup> The then Government rejected the Committee’s recommendation, but said it was working with Public Health England to reform the programme with an initial focus on the first 1,000 days of life.<sup>121</sup>

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116 Qq 84–5 [Alison Morton]; Scottish Government, [Maternal and Child health](#) (accessed October 2025)

117 Northern Ireland Executive, [Publication of ‘Healthy Child, Healthy Future - Health Review Statistics for Northern Ireland 2023/24’](#), 31 October 2024; Welsh Government, [Healthy Child Wales Programme: 2024](#), 10 June 2025

118 Action Cerebral Palsy ([FTD0076](#))

119 Dr. Catherine Laing (Senior lecturer at University of York); Professor Tamar Keren-Portnoy (Professor at University of York); Ms. Sab Arshad (Grant Manager at University of York); Dr. Laura Boundy (Research and Innovation Associate at University of York); Professor Sue Buckley (Director of Science and Research at Down Syndrome Education International); Dr. Kelly Burgoyne (Senior lecturer at University of Manchester); Professor Helena Daffern (Professor at University of York); Professor Mona Kanaan (Professor at University of York); Ms. Helen Tan (EY Standards and Improvement Officer, Children, Young People & Family Services at Hull City Council) ([FTD0086](#))

120 Health and Social Care Committee, Thirteenth Report of Session 2017–19, [First 1000 days of life](#), HC 1496

121 [Government response to the Health and Social Care Select Committee report on ‘First 1000 days of life’ - GOV.UK](#)

60.

**CONCLUSION**

The Government's ambitions for the number of health visits are woefully inadequate. Children in England receive fewer mandated health visits than children in any other part of the UK. While the Government's immediate priority must be supporting and growing the workforce to deliver the current programme of five visits, in the longer term the Government should aim to deliver a service comparable to the rest of the UK.

61.

**RECOMMENDATION**

We recommend that the Government commit to increasing the number of mandatory health visitor contacts for children in England from five to six. To help it deliver this it should look at the approach that the devolved administrations have taken, where families can expect between 6 and 11 contacts with a health visitor, and set out the lessons that it can learn from their approach in its response to our report.

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## 4 Workforce

62. A broad and diverse range of professionals, across the NHS, early years and specialist settings, are involved in supporting parents and children in the first 1000 days of a child’s life. Throughout this inquiry we heard about the valuable and vital contributions made by multiple professionals including, but not limited to, health visitors, midwives, children’s nurses, general practitioners, early years practitioners, speech and language therapists, paediatricians and psychologists.
63. Equally as consistent was the description of the pressures that this workforce faces. UNICEF, for example, told us “[i]n all areas of service provision for early childhood, the workforce is overstretched, undervalued and under-resourced”.<sup>122</sup> We discussed the shortage in health visitors in the last chapter, and the shortfall of over 2,500 midwives, which causes many services to operate below safe staffing levels, in our recent report on Black Maternal Health.<sup>123</sup> However they are by no means the only sector to report workforce shortages. For example:
- The charity Bliss highlighted a 66% shortfall in Neonatal Allied Health Professionals, Psychologists and Pharmacists,<sup>124</sup> and reported that one-fifth of Neonatal Intensive Care Units only had a psychologist available during the weekday.<sup>125</sup>
  - The Royal College of Occupational Therapists (RCOT) reported a 75% shortfall between recommended OT staffing levels and current provision, arguing that a lack of funding for full-time occupational therapist posts affected “the consistency of care [...] resulting in some vulnerable infants and families missing out.”<sup>126</sup>
  - A 2023 survey by the Royal Society for Speech and Language Therapists (RCSLT) found an average vacancy rate of 25% in children’s speech and language therapy services in England.<sup>127</sup>

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122 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

123 Health and Social Care Committee, [Black Maternal Health](#), Third Report of the Session 2024–2, HC895

124 Bliss - the charity for the newborn ([FTD0048](#))

125 Bliss - the charity for the newborn ([FTD0048](#)); University of Oxford ([FTD0102](#))

126 Royal College of Occupational Therapists ([FTD0077](#))

127 Royal College of Speech and Language Therapists, [Fail to plan, plan to fail: workforce planning in England](#), April 2023

- The Royal Colleges of Paediatrics and Child Health (RCPCH) has reported an average of a 20% shortfall in resident paediatric doctors on Tier 1 and Tier 2 rotas.<sup>128</sup>

While some of these examples apply to the children’s health workforce more generally, rather than the first 1000 days workforce specifically, they are consistent with the overall picture given by the evidence we received of significant shortages in this particular workforce.

- 64.** One reason given for the current shortfalls was the increasing level of demands facing services. RCPCH cited data from 2024 showing an increase of 166,740 additional patients since 2020, during which period there was an increase in paediatric consultants of 462 FTE – a 67% increase in patients waiting for care versus a 15% increase in consultant numbers.<sup>129</sup> An RCOT survey in 2023 found that 85% of occupational therapists reported an increase in demand since July 2022.<sup>130</sup>
- 65.** Poor pay was repeatedly highlighted as an issue for the early years workforce. This was particularly raised in the context of early years practitioners,<sup>131</sup> for example Family Action reported many Early Years practitioners leaving the profession due to low pay.<sup>132</sup> The Nuffield Foundation said that the perceived low value of the profession was a significant challenge that would be “difficult to resolve without improving pay”, and noted that research it had funded from the Education Policy Institute had recommended matching pay in early years with primary school teaching.<sup>133</sup> In 2023, 88% of local authorities reported difficulties recruiting early years practitioners, with 48% citing pay as a key reason.<sup>134</sup> The Royal College of Nursing also mentioned pay as “a critical factor” in attracting, retaining and rewarding staff, saying that nursing was “one of the lowest paid professions in the public sector “ and that only a “substantial and an above inflation pay rise” would begin to restore nursing pay.<sup>135</sup>
- 66.** Lack of training and development opportunities was also repeatedly raised. Better Start Blackpool wrote that investment in training and career progression was “needed to sustain a skilled and motivated workforce” and called for staff across all early years organisations to be able to be released to attend training for professional development,” noting that this would

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128 Royal College of Paediatrics and Child Health, [Paediatric workforce operating at a 20% deficit, December, 2024](#)

129 RCPCH, [Spotlight on the child health workforce](#), Policy briefing, June 2025

130 Royal College of Occupational Therapists ([FTD0077](#))

131 For role description please see <https://skillsengland.education.gov.uk/apprenticeships/st0888-v1-1>

132 Family Action ([FTD0039](#))

133 The Nuffield Foundation ([FTD0013](#))

134 Edpsy.org.uk, [Educational psychologists to take strike action](#), 14 November 2023

135 Royal College of Nursing ([FTD0085](#))

require “longer term funding commitments to [the] first 1000 days and early years.”<sup>136</sup> RCSLT noted that the need to meet staffing ratios could mean that early years settings were reluctant to release staff for training.<sup>137</sup>

- 67.** Several professions also told us there were insufficient training places available to meet the projected level of future demand. Speaking about speech and language therapists, Rachel Roberts of Hull City Council stated that even if the funding existed, there would be insufficient training and development to fill available spaces.<sup>138</sup> Similarly Dr Doug Simkiss, Chair, British Association for Community Paediatrics, told us there were more people who wanted to be community paediatricians than could be trained, calling for ring-fenced investment for the children’s workforce.<sup>139</sup>
- 68.** Witnesses told us that these workforce issues had a range of ramifications:
- **Waiting times:** We heard that staffing shortages led to long waiting lists. Reportedly over 75,000 children are waiting for SLT appointments, especially affecting those waiting for ASD and ADHD assessments and diagnoses.<sup>140</sup> The average wait time is also increasing, even with the most serious conditions. Children with cerebral palsy now wait on average for three years and four months between referral and diagnosis.<sup>141</sup>
  - **Missed early help referrals:** The decline in the workforce, especially amongst HVs and midwives, compromises the system’s ability to identify needs and refer families to support early on. The Government’s 2021–22 annual HV data showed a total of 458,454 mandated health visits were missed, and in 2023/24 nearly 1 in 5 (18.3%) babies aged 6–8 weeks did not receive their mandated health visiting contact.<sup>142</sup> The Parent-Infant Foundation described this as “thousands of missed opportunities to identify a vulnerable toddler, offer support and (where needed) draw on specialist support”.<sup>143</sup>
  - **Lack of continuity of care:** High turnover rates mean children and families often see many individuals over the course of the first 1000 days. The IHV’s 2025 Annual Survey found that only 45% of health visitors in England were able to provide continuity of care to families “all or most of the time”.<sup>144</sup> The National Childbirth Trust detailed how

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136 Better Start (Blackpool) ([FTD0061](#))

137 Royal College of Speech and Language Therapists ([FTD0082](#))

138 [Q81](#) [Rachel Roberts]; [Q161](#) [Janet Cooper]

139 [Qq122–125](#) [Dr Simkiss]

140 Children’s Hospital Alliance ([FDT0037](#)); [Q81](#) [Rachel Roberts]

141 Action Cerebral Palsy ([FTD0076](#))

142 NSPCC ([FTD0016](#)); Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#))

143 Parent-Infant Foundation ([FTD0079](#))

144 Institute of Health Visiting ([FTD0026](#))

the first six weeks’ postnatal care for mothers could be provided and commissioned by up to four different institutions (NHS hospital trusts commissioned by an Integrated Care Board, more local NHS trusts, local authorities, and GPs or physician associates in primary care).<sup>145</sup>

- **Increase in crisis services:** A reduction in Health Visiting and its staff could be linked to an increase in young children visiting acute and crisis services.<sup>146</sup> The IHV in 2023 identified a 42% increase in A&E attendance for children aged 0–4 over the last 10 years, labelling this a “knock-on consequence” of HV cuts.<sup>147</sup>
- **Uneven access:** We heard that workforce instability had led to an inconsistent service landscape, with numerous evidence submissions detailing a “postcode lottery” as a result of recruitment, retention, and training and motivation levels amongst staff, most seriously affecting disadvantaged areas.<sup>148</sup>
- **Deterioration of staff wellbeing:** Staff dissatisfaction was reported across professions. We were told about staff experiencing burnout, post-traumatic stress symptoms and moral injury.<sup>149</sup> Midwives in England reportedly work 120,000 hours unpaid overtime each week, and community paediatricians reported frustration that circumstances meant they could not improve matters.<sup>150</sup>

## Workforce plan

69. The previous Government published a Long Term Workforce Plan in June 2023. This contained several targets to increase the number of professionals working in roles critical to the first 1000 days, including:
- An increase in training places for HVs, district nurses, and qualified school nurses from 1,811 in 2022 to 3,788 by 2031.
  - An increase in GP trainee places from 4,000 in 2022 to 6,000 by 2031.

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145 NCT (The National Childbirth Trust) ([FTD0053](#))

146 Institute of Health Visiting ([FTD0026](#)); [Q187](#) (Dr Stewart)

147 Institute of Health Visiting, [Babies under one have the highest rate of A&E attendance: HVs can help](#), 15 December 2023

148 Auditory Verbal UK ([FTD0009](#)); Institute of Health Visiting ([FTD0026](#)); Bliss - the charity for the newborn ([FTD0048](#)); British Association of Teachers of Deaf Children and Young People ([FTD0054](#)); University of York ([FTD0086](#)); Breastfeeding Alliance ([FTD0088](#))

149 This refers to the psychological harm experienced when actions, omissions, or witnessing events conflict with a person’s moral or ethical code, leading to feelings of guilt, shame, and betrayal.

150 British Psychological Society ([FTD0022](#)); The Royal College of Midwives ([FTD0056](#)); [Q125](#) [Dr Simkiss]

- An increase in training places for SLTs from 817 in 2022 to 1,193 by 2031.
- An increase in training places for clinical psychologists and child and adolescent psychotherapists from 1,050 in 2022 to 1,326 by 2031.<sup>151</sup>

The Institute for Fiscal Studies (IFS) labelled the staffing targets of the 2023 Plan as “extremely ambitious”, with the National Audit Office describing “optimistic future assumptions”.<sup>152</sup> The 2023 Public Accounts Committee concluded it was not convinced that the Plan would “achieve its very optimistic assumptions”, describing it as “highly doubtful” that the NHS could retain 130,000 staff.<sup>153</sup> In 2024, there were only 4,096 GP specialty training places in general practice, and the Royal College of Nursing (RCN) reported that the nursing workforce was on track to half in size by 2029.<sup>154</sup>

- 70.** In December 2024, the Government announced it would publish a revised workforce plan, the NHS 10 Year Workforce Plan, in summer 2025.<sup>155</sup> Publication has been delayed multiple times. Minister Dalton told us during oral evidence on 26 September that the Plan would be out “later this year”. Following that session, the Government announced a ‘call for evidence’ for the workforce plan, which was open until 7 November. Subsequently it was reported that the publication of the plan had been pushed back to Spring 2026.<sup>156</sup>
- 71.** The Government has said that it will take a “different approach to workforce planning”:
- Instead of asking ‘how many staff do we need to maintain our current care model over the next 10 years?’, we are asking ‘given our reform plan, and our commitment to a sustainable NHS, what workforce do we need, what should they do, where should they be deployed and what skills do they need to deliver better care for patients and citizens?’

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151 NHS England, [NHS Long Term Workforce Plan](#), 30 June 2023, pp 40, 129

152 IFS, [Implications of the NHS workforce plan: Green Budget 2023 - Chapter 8](#), 30 August 2023, NAO, [Improvements needed in NHS England’s modelling for the Long Term Workforce Plan](#), 22 March 2024

153 Public Accounts Committee, Seventy-Third Report of Session 2022–23, [Access to urgent and emergency care](#), HC 1336, para 2. See also para 60 above

154 Royal College of Nursing, [Specialist nurse workforce on track to halve in size compared with two decades ago, as RCN urges government to intervene on eve of Darzi review](#), 11 September 2024; House of Lords Library, [Competition for specialist training programmes in the NHS: Sector views and the government’s plans for resident doctor training posts](#), In Focus, 10 July 2025

155 Department of Health and Social Care, [Government to tackle NHS workforce crisis with refreshed plan](#), 8 December 2024

156 Health Service Journal, [Government delays new NHS workforce plan](#), 24 October 2025

Ashley Dalton MP repeatedly told us that the new Plan was “not just about numbers” and that:

it is not just about how many more we need; it is about what they can be doing. [...] It is about saying, “What are they doing at the moment that actually might be delivered in a better way and a different way, which could free up time?”<sup>157</sup>

**72.** Witnesses told us there was appetite within the sector for an “ambitious” plan to rebuild the early years health workforce, that would take a “whole system approach” to recruitment and retention and consider the increased demand and complexity of child health.<sup>158</sup> Witnesses made several suggestions for what they wanted to see in the updated workforce plan. This included

- **A greater focus on community services.** This is one of the three shifts the Government has committed to delivering through its 10 Year Health Plan. In 2024, the Royal College of Occupational Therapists (RCOT) published a workforce strategy with a core aim being therapists “based primarily within communities”, working with the local population. It called for more accurate data recording to understand the numbers required to move to community services, as well as a universal offer at a population level, that tailored targeted services for those with most complex needs.<sup>159</sup> Dr Claire Fuller, Co-medical director for Primary Care at NHS England, called for there to be a shift towards having more training placements in the community and in general practice.<sup>160</sup> The Centre for Mental Health called for peer support and community-based mental health care to be integrated into maternity and postnatal care systems, in accessible and non-stigmatising settings such as community venues.<sup>161</sup>
- **Updated modelling.** The RCPCH emphasised the need to review the modelling on children’s health which underpinned the Long-Term Workforce Plan to reflect rising complexity and increasing demand in child health.<sup>162</sup> The National Audit Office’s report on the NHS Long Term Workforce Plan found that while the original plans were a “significant achievement, which provided a foundation for NHSE to build on”, the

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157 [Q231](#)

158 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#)); Centre for Mental Health ([FTD0110](#))

159 Royal College of Occupational Therapists, [Occupational therapy workforce strategy](#), 2024, pp 4, 6, 9, 13

160 [Q130](#)

161 Centre for Mental Health ([FTD0110](#))

162 Public Accounts Committee Inquiry: NHS England’s modelling for the Long Term Workforce Plan, [Written evidence submitted by the Royal College of Paediatrics and Child Health](#), May 2024

“modelling pipeline as a whole had significant weaknesses”, including a “lack of integration between different parts of the pipeline”, and some assumptions that might “be optimistic”.<sup>163</sup>

- **Exploring alternative staffing models.** Rukshana Kapasi, Director of Health at Barnardo’s, informed us that early years practitioners could be trained by health visitors to work in places of extreme shortages and to conduct measures such as two-and-a-half-year reviews, in a “very risk-stratified way”.<sup>164</sup> When we visited Better Start Blackpool, an infant health and support service, we heard that families received an enhanced offer of eight universal face-to-face home visits, led by Band 6 Health Visitors, accompanied by Community Nursery Nurses and Band 5 Staff Nurses for the 2–2.5 year and 3–3.5-year developmental reviews. Academics from Manchester University submitted written evidence about an enhanced Midwifery Continuity of Carer pilot where funding was provided to employ Maternity Support Workers. Staff involved in the pilot reported that it allowed both midwives and enhanced roles<sup>165</sup> to provide flexible, tailored care and individualised support and “to provide holistic support responsive to women’s needs.”<sup>166</sup> Evidence also cautioned that use of support staff should not be used as a replacement for properly trained staff.<sup>167</sup>
- **Greater cross skilling across professions.** We heard that on-site psychologists could also raise the overall mental health support profile by training non-specialists in settings such as Family Hubs.<sup>168</sup> Jane Harris, CEO, Speech and Language UK, told us about targeted interventions for speech and language issues that could be learned in “half a day” and delivered by non-specialists.<sup>169</sup>

**73.** Evidence to this inquiry supported a strong focus on the child health workforce in the upcoming Workforce Plan, acknowledging both the complexity of early childhood health and its centrality in preventing future illnesses.<sup>170</sup> In June 2025 the Royal College of Paediatrics and Child Health (RCPCH) called on the Government to develop “a comprehensive child health workforce strategy.”<sup>171</sup> Many of the staff that are essential to a child’s

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163 National Audit Office, [NHS England’s modelling for the Long Term Workforce Plan](#), 22 March 2024

164 [Q81](#)

165 MSWs, Care Coordinators, or Best Start in Life Advisors (BSiLAs)

166 Stephanie Gillibrand, Professor Jo Dumville ([FTD0031](#))

167 [Q233](#); [Q81](#) [Rukshana Kapasi]

168 Halton Borough Council ([FTD0087](#))

169 [Q162](#)

170 NSPCC ([FTD0016](#)); Academy of Medical Sciences ([FTD0034](#)); Alder Hey Children’s Charity ([FTD0051](#))

171 Royal College of Paediatrics and Child Health, [Spotlight on the child health workforce in England 2025 - policy briefing](#), June 2025, pp 4–5

health sit outside of the NHS—for example early years educators, nursery practitioners, and social workers. The Centre for Mental Health highlighted the need for an integrated children’s workforce strategy that valued multidisciplinary teams and ensured coordination between councils, the NHS, education providers and the voluntary sector.<sup>172</sup>

74. During oral evidence we explored how well the current guidance on neighbourhood multidisciplinary teams is being implemented. Dr Clare Fuller, Co-Medical Director, NHS England replied that it was “very good”, noting that while initially the focus had been on using multidisciplinary teams to support older people, a number of places with higher percentages of children and young people had developed integrated neighbourhood teams for young people.<sup>173</sup> Dr Simkiss, speaking for the RCPCH, emphasised the importance of not thinking of multidisciplinary teams as a single entity, noting that the needs of a child with asthma complications would be different from a child with cerebral palsy, so varied multidisciplinary teams would be needed.<sup>174</sup> Dr Sally Payne, Professional Advisor, RCOT, raised concerns that the guidance focused on medical and acute care while neglecting allied health professionals:

Occupational therapists, for instance, are mentioned once as professionals who might be included in the multidisciplinary team. Speech and language therapists are mentioned four times, nurses 22 times, paediatricians 30 times and GPs 103 times. You can see that the balance does not feel quite right if we are going to be thinking about the complexity of children’s needs.<sup>175</sup>

75. Susie Owen, Co-Director for Early Years, Childcare, Families and Analysis, Department for Education, emphasised that building links across professionals was a core part of the Best Start family service, saying that the goal was to “build trust and understanding between the specialist and the practitioners, so that practitioners feel that they can pick up the phone and check something about a child or a family, whether that is a safeguarding issue, a health-related issue or something else.”<sup>176</sup>

76. **CONCLUSION**

Throughout this inquiry we heard that the children’s health workforce is being stretched to breaking point. There are significant shortages across multiple disciplines which prevent professionals from delivering the care young children and their families need and that, in some cases, significantly impacts on patient safety

172 Centre for Mental Health ([FTD0110](#))

173 [Q132](#)

174 [Q135](#)

175 [Q133](#)

176 [Q237](#)

**77.**

**RECOMMENDATION**

The Government must take the opportunity presented by the forthcoming NHS 10 Year Workforce Plan to create a sustainable and well-resourced children's health workforce. While we understand the Government's desire for the workforce plan to go beyond numbers, a plan that does not set out a clear, achievable and funded road map for addressing staff shortages would completely lack credibility. We recommend that the workforce plan contains specific targets for recruitment to all disciplines that deliver care in the first 1000 days that, as a minimum, ensure that safe staffing ratios are delivered in all settings.

**78.**

**RECOMMENDATION**

Many professions which play a key role in delivering children's health care are not entirely or primarily employed by the NHS. We recommend the Government sets out how it plans to support those professions in non-NHS settings, particularly allied health professionals and early years practitioners, in a child's health workforce strategy that should accompany the NHS 10 Year Workforce Plan. We also recommend that the Government review its current guidance on multidisciplinary teams to ensure that due prominence is given to the role that allied health professional can play in such teams.

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## 5 Vaccinations

79. Vaccinations are one of the most effective public health interventions, preventing a range of diseases and reducing pressure on the NHS. The World Health Organisation (WHO) estimates that vaccination prevents between 3.5 million and 5 million deaths across the world annually.<sup>177</sup> The UK's routine immunisation schedule provides protection against 15 vaccine-preventable infections, across people's lifetimes, including in the first 1000 days of life. That offer is set out below:

### First 1000 Days Vaccination Schedule

Age	Vaccines
8 weeks	6-in-1 vaccine <sup>178</sup> Rotavirus vaccine MenB vaccine
12 weeks	6-in-1 vaccine (2nd dose) MenB vaccine (2nd dose) Rotavirus vaccine (2nd dose)
16 weeks	6-in-1 vaccine (3rd dose) Pneumococcal vaccine
1 year	Hib/MenC vaccine (for children born on or before 30 June 2024) Measles, Mumps and Rubella (MMR) vaccine (1st dose) Pneumococcal vaccine (2nd dose) MenB vaccine (3rd dose)
1 year and 6 months	6-in-1 vaccine (4th dose for children born on or after 1 July 2024) MMR vaccine (2nd dose for children born on or after 1 July 2024)
2 to 15 years	Children's flu vaccine (every year until children finish Year 11 of secondary school)

Source: NHS, [NHS vaccinations and when to have them](#) (accessed October 2025)

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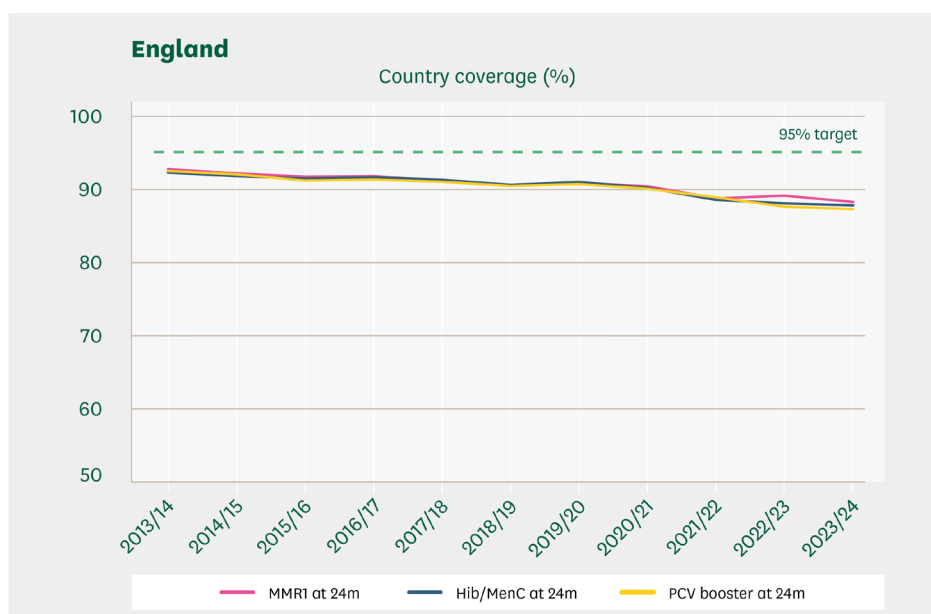
177 World Health Organisation, [Vaccines and Immunizations](#) [Accessed 07/11/25]

178 The 6-in-1 vaccine provides protection against 6 illnesses - diphtheria, hepatitis B, Hib (Haemophilus influenzae type b), polio, tetanus and whooping cough

80. Sanofi, a multinational pharmaceutical and healthcare company, set out the importance of vaccination in children:

Childhood immunisation is not only vital for helping protect young populations from preventable diseases, but programme failures and reduced vaccine uptake can have various consequences, risking public health (via transmission from paediatric populations to other vulnerable populations, for example influenza); disease outbreaks; costly catch-up campaigns (such as the recent measles, whooping cough and polio campaigns in England); increased hospital admissions; increased healthcare costs; and disruption to the workforce.<sup>179</sup>

81. Since 2012/13, pre-school vaccination rates in England have been declining, with an acceleration in decline during the COVID-19 pandemic.<sup>180</sup> While the UK Health Security Agency’s latest annual data shows modest increases in vaccine coverage for children up to age 5,<sup>181</sup> the latest quarterly data shows that coverage has decreased across all vaccinations and “represents a continuation of an ongoing declining trend in coverage”.<sup>182</sup> The trends from 2013/14- 2023/24 for children aged 2 is shown below:



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179 Sanofi ([FTD0107](#))

180 Child Health Unit, School of Public Health, Imperial College London ([FTD0027](#)); The Association of the British Pharmaceutical Industry (ABPI) ([FTD0106](#)); Q165 [Dr Aggarwal]

181 UKHSA, [Vaccination coverage statistics for children aged up to 5 years, England \(COVER programme\) report: April 2024 to March 2025](#), 2 October 2025

182 UKHSA, [Quarterly vaccination coverage statistics for children aged up to 5 years in the UK \(COVER programme\): April to June 2025](#), 04 November 2025

183 [Childhood Vaccination Coverage Statistics, Local Authority Time Series](#), (accessed 6 November 2025).

- 82.** There remains a large amount of variation in performance across the country and between ethnic groups. In 2023–24, whilst 22 local authorities achieved 95% or greater coverage of the 6-in-1 vaccine, 44 local authorities reported coverage below 90%, with 12 below 85%.<sup>184</sup> Children born to Caribbean mothers were 29% less likely to receive the full course of MMR in 2020–2021 compared to white British mothers.<sup>185</sup> Children living in more deprived areas are over 10% less likely to receive MMR vaccinations compared to children in more affluent areas.<sup>186</sup>
- 83.** Declining vaccination rates can have tragically fatal results. In 2024, the UK recorded the highest number of measles cases since 2012,<sup>187</sup> with 2,911 confirmed cases in 2024 and one child dying.<sup>188</sup> 11 infants also tragically died from whooping cough in the same year.<sup>189</sup>

## Targets and planning guidance

- 84.** The European Region of the WHO currently recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control.<sup>190</sup> Across England as a whole, this target has not been met for any routine vaccination programme.<sup>191</sup> The WHO target was removed from NHS planning guidance for 2025/26.<sup>192</sup> This was part of a broader reduction in the number of national priorities set in the guidance aimed at “giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local population.”<sup>193</sup> Following the publication of the new planning guidance the Secretary of State said:

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- 184 The Association of the British Pharmaceutical Industry (ABPI) ([FTD0106](#))
- 185 The University of Oxford ([FTD0102](#))
- 186 Child Health Unit, School of Public Health, Imperial College London ([FTD0027](#))
- 187 UK Health Security Agency, [Confirmed cases of measles in England by month, age, region and upper-tier local authority: 2025](#),
- 188 British Medical Journal, [Decline in UK childhood vaccine uptake](#), July 2025, BMJ 2025;390:r1500
- 189 UK Health Security Agency, [Confirmed cases of pertussis in England by month, 2024](#), 23 May 2025; Child Health Unit, School of Public Health, Imperial College London ([FTD0027](#))
- 190 These diseases are diphtheria, tetanus, pertussis, polio, Hib, measles, mumps and rubella; World Health Organization, [Global childhood vaccination coverage holds steady, yet over 14 million infants remain unvaccinated – WHO, UNICEF](#), 15 July 2025
- 191 UKHSA, [Vaccination coverage statistics for children aged up to 5 years, England \(COVER programme\) report: April 2024 to March 2025](#), 2 October 2025
- 192 Local Government Association ([FTD0112](#)); NHS England, [2025/26 priorities and operational planning guidance](#), 30 January 2025; UK Health Security Agency, [Vaccine update: issue 361, July 2025](#), 1 August 2025
- 193 NHS England, [2025/26 priorities and operational planning guidance](#), 30 January 2025

If everything is a priority, then nothing is. I want to empower NHS leaders to deliver the innovation and reform required to fix the NHS, rather than overload them with targets which have failed to deliver better outcomes for patients.<sup>194</sup>

85. When we raised the removal of this target for the planning guidance with Minister Dalton, she told us that:

It is not specifically in that guidance, but not being specifically in the guidance does not mean that it is not an expectation.<sup>195</sup>

The Minister continued that it remained the Government’s ambition to meet the WHO target and that the Government would “look at” setting a date for when the 95% update level should be reached as it reviewed the implementation of its vaccination strategy<sup>196</sup> and the results that it was delivering.<sup>197</sup>

86. **CONCLUSION**

The continuing decline in childhood vaccination levels since 2012 is a national disgrace; children should not be dying of entirely preventable diseases. The continued failure to effectively grapple with this is a significant and ongoing public health crisis and will lead to increased costs for the health service in the longer term.

87. **CONCLUSION**

We are disappointed that the Government has dropped the 95% vaccination coverage target from NHS planning guidance and were unconvinced by the Minister’s arguments that it remained an “expectation” despite its removal. While we agree with the Government’s desire for the NHS to have a smaller number of priorities, we believe that vaccination coverage must absolutely be one of those priorities.

88. **RECOMMENDATION**

We recommend that the Government immediately reinstate the 95% vaccination coverage target in NHS planning guidance for all vaccinations, including those given during the first 1000 days to mothers and children. We also call on the Government to commit to hitting this target no later than the end of this Parliament.

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194 Hospital Management, [NHS England streamlines priorities for patient care](#), 31 January 2025

195 [Q222](#)

196 Discussed further below.

197 [Qq226–227](#)

## Addressing barriers to increased vaccination rates

**89.** According to NHS England, factors that affect the uptake of childhood vaccines in England include:

- inconsistent communication between healthcare providers and parents or carers;
- difficulties making suitable and timely appointments;
- incomplete and potentially inaccurate data on vaccination;
- anti-vaccination messages;
- vaccine hesitancy among a small minority of parents and carers.<sup>198</sup>

Groups that submitted evidence to our inquiry had multiple suggestions for how these challenges could be addressed.

**90.** The importance of making it easier to get an appointment was frequently raised, with Child Health Unit, Imperial College London saying that appointments should be available on different days and at different times.<sup>199</sup> The NHS Confederation’s Primary Care Network welcomed the increase in financial incentives for delivering childhood vaccinations rate in the new GP contract (from £2 to £12.06). Other groups emphasised the importance of being able to access vaccination in other health care settings, with the Royal College of Nursing mentioning access via pharmacies, calling for a move away from the current practice where families had to visit multiple different sites depending on the vaccines they need to access.<sup>200</sup> Family Hubs were also identified as a potential setting for opportunistic vaccination,<sup>201</sup> while NHS Confederation argued that local health hubs, mother and child groups, faith groups, and homes were all settings in which vaccinations could be delivered, noting that there was a particular opportunity for primary care settings to “work with nurseries to improve MMR vaccine delivery.”<sup>202</sup>

**91.** Improving communication was another common theme. Bradford Health and Care Partnership noted that low levels of literacy in some communities excluded them from national and local campaigns and recommended

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198 House of Commons Library, [UK Vaccination Policy](#), 07 March 2022

199 Child Health Unit, School of Public Health, Imperial College London. ([FTD0027](#))

200 Royal College of Nursing ([FTD0085](#))

201 Alder Hey Children’s Charity ([FTD0051](#))

202 NHS Confederation ([FTD0081](#))

focusing on a “[B]asic language communications campaign to empower families [...] with messaging that includes vaccine information but within the wider context of healthcare.”<sup>203</sup>

92. The Bradford Partnership also referenced the importance of community outreach and engagement that allowed time for one-to-one conversations in order to dispel myths around vaccination, citing their experience of using “faith settings, community voices and trusted individuals such as faith leaders [to communicate in a way that] works to build social change.”<sup>204</sup> The importance of vaccination communication being based on trust was also mentioned by the Royal College of Nursing which stressed the importance of health visitors having the “time to build a relationship with families to support educated decisions.”<sup>205</sup>
93. The Child Health Unit, Imperial College London also emphasised the importance of focusing on maternal vaccination rates, both to support the health of mothers and babies but also due to its impact on future vaccination behaviours. It highlighted that mothers who were vaccinated in pregnancy were 40% more likely to have their child vaccinated with measles, mumps and rubella (MMR) compared to mothers who were unvaccinated in pregnancy, even after accounting for deprivation and ethnicity.<sup>206</sup>
94. In December 2023, NHS England published its ‘Vaccination Strategy’ to “shape the future delivery of NHS vaccination and immunisation services”. This included the routine immunisation schedule for infants, children, young people, adults and pregnant women, selective vaccinations for those at risk, COVID-19 vaccinations, and seasonal influenza vaccinations. There were three priority areas: improving access; delivery in convenient local places and targeted outreach to underserved populations; and a more joined-up prevention and vaccination offer. The strategy committed to devolving the commissioning of vaccination services to Integrated Care Boards (ICBs), which would be accountable for delivering vaccinations in a way that met the core priorities of the strategy from April 2025.<sup>207</sup> An update to the strategy was published in January 2024, which included consideration of how the system could train and deploy a “wider set of professionals” to deliver vaccinations, noting that local authority services for 0–5-year-olds had “unparalleled contact with underserved communities”, through health visiting and school nursing teams.<sup>208</sup>

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203 Bradford health and care partnership ([FTD0042](#))

204 Bradford health and care partnership ([FTD0042](#))

205 Royal College of Nursing ([FTD0085](#))

206 Child Health Unit, School of Public Health, Imperial College London. ([FTD0027](#))

207 NHS England, [Shaping the future delivery of NHS vaccination services](#), 13 December 2023, pp 3, 12, 15

208 NHS England, [NHS vaccination strategy](#), January 2024

95. The Association of the British Pharmaceutical Industry highlighted concerns about changes to vaccine delivery models (ICBs taking on this responsibility during the ongoing reorganisation in NHS England) given the requirement for ICBs to cut their operating costs:

The cut to ICB operating costs at the same time as they are taking on additional responsibilities for vaccination presents an obvious risk which should be carefully considered and managed. Our children cannot afford for delegation to ICBs to fail, resulting in a widening of inequalities in uptake rather than narrowing.<sup>209</sup>

96. We asked Minister Dalton whether she thought the vaccination strategy was working, given the ongoing fall in vaccination rates. We were told that vaccination rates were stabilising, and that the minister was personally monitoring vaccination rates on a monthly basis.<sup>210</sup> She also mentioned other measures the Government was taking to increase uptake including:

incentivising GPs by offering an additional £2 supplement per childhood vaccine to improve routine coverage and support GPs to deliver that. We have summer catch-up clinics, school-based services, and community outreach being rolled out and delivered in areas with historically low coverage.<sup>211</sup>

97. **RECOMMENDATION**

Despite the measures contained in the Government’s vaccination strategy, vaccination rates are continuing to fall and the strategy is failing to deliver the improved coverage that is so desperately needed. The Government should brand the currently strategy a failure and develop a new plan with a specific focus on improving vaccination uptake in early years settings. As part of this new strategy, we recommend that the Department consider having a named individual in each ICB who is responsible for co-ordinating the vaccine offer across ICB services.

## Health visitor delivery of vaccinations

98. One option being explored to increase uptake is to use health visitors to administer childhood flu vaccinations and other routine immunisations.<sup>212</sup> In February 2024 NHS England announced it would launch 12 ‘demonstrator sites’ to test new models for delivering vaccinations, led by ICBs, including

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209 The Association of the British Pharmaceutical Industry (ABPI) ([FTD0106](#))

210 [Q224](#)

211 [Q218](#)

212 NHS England, [Shaping the future delivery of NHS vaccination services](#), 13 December 2023, p 37; NHS England, [NHS vaccination strategy](#), January 2024

health visitors taking on delivery of catch-up jobs for children.<sup>213</sup> June 2025 saw an “urgent and emergency care plan” for 2025/26, which included ICBs testing the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. The July 2025 10 Year Health Plan reiterated the Government’s intention to use health visitors to vaccinate babies and children in underserved groups to increase overall uptake, with the introduction of “new models”.<sup>214</sup> The Minister told us that in 2026 it would be piloting the administration of childhood vaccinations during health visitor visits.<sup>215</sup>

**99.** We heard that enabling health visitors to deliver vaccines had the potential to be “hugely important” in closing vaccination uptake gaps, as they could be a trusted person to families.<sup>216</sup> Alison Morton, CEO of the Institute of Health Visiting, told us that health visitors themselves were supportive of the proposals, with four in 10 expressing interest in being involved in pathfinder projects immediately. Those who were not currently ready, she argued, were reluctant largely due to “workforce issues”.<sup>217</sup> Dr Helen Stewart, Officer for Health Improvement at the Royal College of Paediatrics and Child Health argued that a “big packet of support” would need to be in place to train and resource health visitors to administer vaccines.<sup>218</sup>

**100.** When we explored with the Minister whether there was scope to accelerate the pilot of health visitors delivering vaccinations, she defended the importance of proceeding with the pilot:

we must understand how it works best. We could roll out something right across the country straight away, but without really understanding what needs to be put in place to make that effective and what support health visitors need. This has to sit alongside all the other stuff they are doing, and we are trying to understand whether they are delivering what is needed.<sup>219</sup>

**101. RECOMMENDATION**

The plan for delivering vaccination by health visitors has real potential to help the Government achieve the 95% coverage vaccine target. We recommend the Government explore ways to accelerate the pilot programme and to report back on its findings within 6 months.

213 Pulse, Health visitors to do catch-up child vaccinations in new NHS England pilots, 9 February 2024

214 DHSC and Prime Minister’s Office, [Fit for the future: 10 Year Health Plan for England](#), 3 July 2025, p 36

215 [Q217](#)

216 [Q188](#) [Dr Stewart]

217 [Q89](#) [Alison Morton]

218 [Q187](#) [Dr Stewart]

219 [Q218](#)

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## 6 Integration between services

**102.** A recurring theme throughout our inquiry was the importance of effective integration and joint working between the multiple services involved in supporting families during the early years of their child’s life. In this chapter we consider two specific areas where we heard repeated calls for improvement to enable services to work more effectively together: improving data quality and data sharing and developing a shared outcome framework.

### Improving data quality and data sharing

**103.** A core part of the 2025 NHS 10 Year Health Plan, published in July 2025, is a shift from “analogue to digital”, modernising health services so that digital systems are default. This includes transforming the NHS App and linking it to a single patient record; using continuous monitoring to proactively manage patients; enabling patients to access digital tools to access, manage or treat their conditions; and enabling parents or carers to manage their children’s healthcare.<sup>220</sup> In its written submission, the Department says that difficulties sharing data between different services is a key barrier to delivering high-quality early years services. Over the course of this inquiry, we heard three main suggestions for improving data quality and sharing:

- introduction of a Single Unique Identifier;
- increasing the ability to disaggregate data sets to get specific insights and measure service delivery for the youngest children; and
- simplifying the process to share data between agencies.

### Single Unique Identifier

**104.** Currently, most children in England have the following unique identifiers:

- An NHS number, assigned at birth or to all children registered with an NHS health service.

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<sup>220</sup> Department of Health and Social Care, [Fit for the future: 10 Year Health Plan for England](#), 30 July 2025

- A Unique Pupil Number (UPN), assigned by local authorities to children enrolled in school, used by the Department of Education to collate a child’s educational records.
- LA-ID, assigned by a child’s local authority for internal records.
- A passport number (for children with a passport).

**105.** In 2022, the Children’s Commissioner for England produced a report describing the difficulties posed by having multiple different identifiers. To relate one identifier to another, an actor would need access to additional identifiers across datasets, such as full names, dates of birth, address and sex. There is no system that routinely relates identifiers, and the manual process relies on storing large amounts of data, is subject to error and relies on an “increasingly complex” linkage methodology.<sup>221</sup> Christine Farquharson, Institute for Fiscal Studies, told us that health visitors carry out checks at age two or two-and-a-half that is un-linkable to the child’s educational data.<sup>222</sup>

**106.** Witnesses highlighted the impact that having a ‘Single Unique Identifier’ (SUI) would have for children. Christine Farquharson and Alison Morton of the Institute of Health Visiting both labelled an SUI as the single most important measure the Government could take to improve data-sharing, with the latter labelling it as the ‘Holy Grail.’<sup>223</sup> It was argued that an SUI could enable better information sharing and tracking across a child’s lifetime between agencies and services, enabling smooth transitions between professionals.<sup>224</sup> It could also reduce burdens on families who must “repeat their stories endlessly” to different professionals, as well as help professionals flag any vulnerabilities to more effectively target interventions and safeguarding measures.<sup>225</sup> We heard this could lead to better and more targeted plotting of outcomes by enabling robust data linkage across different agencies.<sup>226</sup> Dr Doug Simkiss, Chair of the British Association for Community Paediatrics (BACP), cited Sweden’s use of an SUI since 1947 as enabling production of “huge amounts of valuable life course data” for children and their families.<sup>227</sup>

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221 Children’s Commissioner, [Utilising data to improve children’s outcomes](#), Annex to A positive approach to parenting: Part 2 of the Independent Family, December 2022, pg 26

222 [Q76](#)

223 [Qq74-76](#) [Alison Morton, Christine Farquharson]

224 National Children’s Bureau ([FTD0080](#))

225 NSPCC ([FTD0016](#)); [Q136](#) [Anna Bird]

226 Academy of Medical Sciences ([FTD0034](#))

227 Q190 [Dr Simkiss]

- 107.** The Department told us it was committed to “improving data sharing across all services” as “too often” families fell through the cracks of public services,<sup>228</sup> and that the introduction of a Single Inquiry Identifier was one of the main interventions aiming to address this.

### NHS Number as a Single Unique Identifier

- 108.** The Children’s Wellbeing and Schools Bill, first introduced as part of the 2024 King’s Speech, included a provision to pilot a “consistent identifier” for children across services.<sup>229</sup> In May 2025 it was confirmed that the NHS number would be piloted as the SUI for children.<sup>230</sup> Pilot number one began in Wigan in May 2025, with Pilot number two starting in September 2025.<sup>231</sup>
- 109.** Use of the NHS number as an SUI has garnered support across many stakeholders, including the NSPCC, NHS Confederation, Royal College of Occupational Therapists and NHS England.<sup>232</sup> The Royal College of Paediatrics and Child Health (RCPCH) recommended the NHS number as an SUI, but warned there could be issues with ensuring consent for sharing data, and for common agreement as to the age a child becomes an adult.<sup>233</sup>
- 110.** The RCPCH also cautioned that some ‘missing’ children, such as home-schooled, migrant or asylum-seeking children, might not have an NHS number or be represented in other systems.<sup>234</sup> Dr Simkiss of the BACP admitted there might be a risk, but said that in his experience and practice, “almost nobody does not” have an NHS number in England, including unaccompanied asylum-seeking children.<sup>235</sup> Susie Owen, Co-Director for Early Years, Childcare, Families and Analysis at the DfE, told us that the Government were taking a “very phased and iterative approach” to the pilot to ensure it surfaced potential issues, including how to manage an individual without an NHS Number. The ambition was to finalise the SUI pilot by the end of the Parliament.<sup>236</sup>

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228 Department of Health and Social Care ([FTD0109](#))

229 [Children’s Wellbeing and Schools Bill \[as amended in Committee\]](#), Clause 16LB

230 Department for Education, [Children’s Wellbeing and Schools Bill: policy summary notes](#), 19 March 2025, p 20; HL Deb, 22 May 2025, [col 429](#)

231 HL Deb, 22 May 2025, [col 429;Q250](#) [Susie Owen]

232 NSPCC ([FTD0016](#)), NHS Confederation ([FTD0081](#)), [Qq136–138](#) [Dr Fuller, Dr Payne]

233 Royal College of Paediatrics and Child Health, [NHS number as a single unique identifier for children - position statement](#), 2024

234 Royal College of Paediatrics and Child Health, [NHS number as a single unique identifier for children - position statement](#), 2024

235 Qq [Qq140–141](#) [Dr Simkiss]

236 Qq [Qq246–250](#) [Susie Owen]

**111. CONCLUSION**

The introduction of a Single Unique Identifier has the potential to significantly simplify data sharing across the early years landscape and we hope that currently planned pilots proceed smoothly and at pace. We ask that the Government commit to providing regular update on the progress of the pilots.

## Disaggregation of data

- 112.** While there is a broad acceptance about the importance of early intervention to support children at the start of life, it is often challenging to get specific data about the first 1000 days period.<sup>237</sup> For example, waiting time is disaggregated into adults and children, with no further age-based disaggregation, despite the acknowledgement of the impact that delays in accessing services can have on a child’s development during this critical period.
- 113.** Dr Claire Fuller, Co-medical Director for Primary Care at NHS England, told us that that whilst data was improving, it was not disaggregated between children and the early years, where the impact was “so much more significant” due to it being such a formative period for their development and long-term outcomes.<sup>238</sup> She added that there were insufficient datasets to target interventions at a local level, with current metrics at “too high a level”. This led to “blanket interventions”, rather than approaches such as proportionate universalism.<sup>239</sup>
- 114.** We were told that further disaggregated data, beyond age groups and based on ethnicity, disability, socioeconomic status, and service access could be crucial in identifying disparities and driving targeted improvements. The Mental Health Foundation called for Integrated Care Systems (ICSs) to publish annual reports on equity in early years provision, and how they were addressing disparities..<sup>240</sup> The Sands and Tommy’s Joint Policy Unit proposed new ambitions for child health, based on the best performing countries in Europe, that would require greater disaggregation of data, such as:
- A neonatal mortality rate of 0.5 neonatal deaths per 1,000 live births for babies born at 24 weeks’ gestation and over.
  - A preterm birth rate of 6.0% by 2035, with disaggregated data for iatrogenic and spontaneous preterm births.<sup>241</sup>

237 Until the child is 2 years old.

238 [Q115](#), [Q121](#),

239 [Q121](#)

240 Mental Health Foundation ([FTD0078](#))

241 Sands and Tommy’s Joint Policy Unit ([FTD0033](#)); Academy of Sands ([FTD0035](#)) Iatrogenic refers to illness caused by medical examination or treatment

**115.** Ashley Dalton MP, Parliamentary Under-Secretary of State, told us that her Department had recognised the inadequacy in data identification, and was implementing changes to report data on much smaller groups based on age.<sup>242</sup> Following her appearance she wrote to us to highlight the publication of the Waiting List Minimum Data Set for the first time, which includes the number of waits where a patient is under 18. However, she also stated that were “no plans to disaggregate this data further”.<sup>243</sup>

**116. CONCLUSION**

The Government does not have access the data it needs on children’s health outcomes during the first 1000 days. Without this data it will struggle to deliver meaningful improvements or implement a shared outcomes framework.

**117. RECOMMENDATION**

We recommend that the Government work with all NHS and early-years settings to produce plans for greater disaggregated data concerning service delivery and outcomes for children. This should include data broken down by age group, as well as ethnicity, disability, socioeconomic status, access to services, and other categories that will allow for more targeted interventions and specified outcome planning. As a minimum, we call for the Government to introduce separate reports on waiting times for children under the age of two, as a first step to minimising delay in accessing services at this critical stage in a child’s development.

## Rules and practices on data sharing

**118.** Data sharing in the UK is governed by a number of legislative and regulatory requirements, including the UK General Data Protection Regulation 2018 and the Data Protection Act 2018.<sup>244</sup> The core duties relevant to the early years settings include:

- data must be processed under a lawful basis, with health data requiring extra protection and justification;
- only what is necessary for care and support should be collected with strong security measures in place;

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242 [Q256](#)

243 Correspondence from Minister Dalton re First 1000 days evidence session, [15 October 2025](#); NHS England, [Waiting List Minimum Data Set \(WLMDS\) Information](#) (accessed October 2025)

244 [Regulation \(EU\) 2016/679 of the European Parliament and of the Council](#); [Data Protection Act 2018](#)

- parents and carers must be informed about what data is collected, how it is used and with whom it is shared, and can access, rectify or request deletion of their child’s data where appropriate;
- information may be shared without consent if necessary to protect a child from harm;
- data may be shared with third parties if there is a lawful basis, it is minimised, parents/carers are informed (unless there is risk of harm), and the relevant third parties must also comply with UK GDPR and Data Protection Act rules.<sup>245</sup>

**119.** We heard that data sharing between different parts of early years settings could be challenging due to concerns about breaching legislative requirements. For example, Alison Morton described the GDPR as “always a stumbling block”. The sharing of data about children’s parents was raised as a particular challenge as this incurs third-party GDPR duties as it relates to the sharing of third-party information.<sup>246</sup> Similarly Halton Borough Council highlighted how in practice the ability to share data “relies on organisations’ and services’ willingness to share information about families which is inconsistent depending on the individuals concerned”, saying that it had been successful in adopting information sharing agreements with two hospital trusts, but not with one of their NHS providers.<sup>247</sup>

**120.** Witnesses called for clearer rules and practices related to data sharing. Christine Farquharson, IFS, said that “removing barriers—doing a better job of providing guidance on things like GDPR or data collection systems” was her second priority for improving data quality of young children.<sup>248</sup> Foundation Years Information and Research Trustees’ evidence called for “appropriate support for consent, including data sharing agreements and client consent forms”, with Alison Morton suggesting life would be “an awful lot easier for all of us” if there was an agreement about managing GDPR and third party data issues at a national level.<sup>249</sup>

**121.** We heard some examples where strong data sharing systems were in place. The National Children’s Bureau shared cases of Better Start Partnerships which had “established local data sharing agreements and found this to be effective for information sharing” and then collected evaluation data to contribute to a ‘test and learn’ approach.<sup>250</sup> Alison Morton gave an example of a setting that had developed a “simple tick-box” system to facilitate data

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245 Gov.uk, [Data protection](#) (accessed October 2025)

246 [Q74](#)

247 Halton Borough Council ([FTD0087](#))

248 [Q77](#)

249 Foundation Years Information and Research (FYIR) ([FTD0084](#)); Q75

250 National Children’s Bureau ([FTD0080](#))

sharing by flagging records that contained third party information, to allow it to be redacted.<sup>251</sup> The NSPCC cited the DfE’s piloting of the NHS number as a SUI as an opportunity to improve data gathering and linkage.<sup>252</sup>

- 122.** The Government’s “Giving every child the best start in life” policy paper acknowledges the challenges in this area:

We know better sharing of information is key to providing children and families with the right services at the right time. That is why we have established a programme of work seeking to address deep-seated and well-known problems with how information about families and children is shared within and across organisations, including families having to tell their stories multiple times to different professionals.

It highlighted provisions in the Children’s Wellbeing and Schools Bill which would support professionals working with a child to share information by creating a duty for organisations to share information relevant for safeguarding and promotion of welfare purposes.<sup>253</sup>

**123. CONCLUSION**

Throughout this inquiry we heard that concerns about the legislation around data sharing was acting as a barrier to partners working effectively together. While some local areas have developed their own systems to support effective data sharing, stakeholders were clear they needed greater central support.

**124. RECOMMENDATION**

We recommend that the Department of Health and Social Care work with Integrated Care Systems to simplify data sharing guidance to improve data sharing between providers.

## Outcomes frameworks

- 125.** An outcomes framework is a structured tool that defines the results an initiative aims to achieve, along with the indicators used to measure progress toward those results. For children in England, there are two main outcome frameworks across education, health and social care: the Early Years Foundation Stage (EYFS) (set by the Department for Education) and the Healthy Child Programme (HCP) (set by the Department of Health and Social Care and NHS England).

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251 [Q75](#)

252 NSPCC ([FTD0016](#))

253 Department for Education, [Giving every child the best start in life](#), 12 September 2025

- 126.** The EYFS was initially established in 2008 under the Childcare Act 2006, and has been revised multiple times, including to more closely align with the Children and Families Act 2014.<sup>254</sup> It is recognised in all early years settings, mandating standards for learning, care and development from birth to five years old. The seven key areas of learning include three prime (communication and language; physical development; personal, social and emotional development) and four specific (literacy, mathematics, understanding the world, expressive arts and design). Practitioners must monitor progress at the “progress check” of two-to-three years and the EYFS profile at the end of reception.<sup>255</sup>
- 127.** The HCP is the health equivalent of the EYFS. Initially established in 2009, it has also been revised many times, including in 2014 to align closer with the Children and Families Act and the Special Educational Needs and Development (SEND) Code of Practice.<sup>256</sup> It offers structured public-health and development surveillance, led by health visitors and primary care staff. The HCP delivers universal health and developmental reviews—from the new-born check at two weeks to the two-year review—alongside screening, immunisation, breastfeeding promotion, support for parental well-being, and early identification of risk factors in families.<sup>257</sup>
- 128.** EYFS and HCP outcomes vary. In 2023–24, 67.7% of children achieved a “good” level of development by the end of the EYFS, though disparities persist, particularly across socioeconomic factors. In 2022/23 nearly a quarter of five-year-olds in England did not meet expected standards for communication and language, with nearly half of children from low income backgrounds failing to meet the standard.<sup>258</sup> Evidence labelled delivery of service under the HCP as a “postcode lottery”, with 18.3% of babies aged 6–8 weeks and 21.6% of two-year-olds not receiving their respective health visiting contacts and reviews in 2023/24.<sup>259</sup>

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254 [Childcare Act 2006](#), S 40; [Children and Families Act 2014](#)

255 Department for Education, [Early years foundation stage \(EYFS\) statutory framework](#), March 2014

256 [Children and Families Act 2014](#); Department for Education and Department of Health and Social Care, [SEND code of practice: 0 to 25 years](#), June 2014

257 Department of Health and Social Care, [Healthy Child Programme](#), 27 October 2009

258 Gov.uk, [Early years foundation stage profile results](#), November 2024; The National Literacy Trust ([FTD0024](#))

259 NSPCC ([FTD0016](#)); Institute of Health Visiting ([FTD0026](#)); Parent-Infant Foundation ([FTD0079](#))

## Developing a shared outcomes framework

- 129.** There is no nationally shared under-twos outcome framework with standardised targets between the EYFS and HCP, or between early education, development and health in general.<sup>260</sup> However multiple professionals we spoke to during the inquiry said that having such a shared outcomes framework would be beneficial. Alison Morton, CEO of the Institute for Health Living told us that a shared framework could allow changes in a child’s development to be tracked over time, with Rukshana Kapasi, Director of Health at Barnardo’s stating that “having monitoring and a consistent framework, and being able to measure impact, would be valuable” to identifying a child’s level of development before, and readiness for, joining school.<sup>261</sup> Jane Harris, CEO of Speech and Language UK, describing a shared outcomes framework as “probably the most important thing” that could be done to prevent issues such as speech and language problems.<sup>262</sup> Christine Farquharson, Associate Director at the Institute for Fiscal Studies (IFS), told us the lack of data sharing between different departments prevented the creation of an integrated picture of a child’s development in the earliest years of life.
- 130.** We heard that the current setup with multiple frameworks had several negative impacts on service delivery, including:
- **Duplication of efforts:** Health, education and social care services operating in silos could lead to duplication between initiatives. NHS England’s recently launched neighbourhood multidisciplinary teams for children and young people shared the same goals as Family Hubs, but coordination was lacking between the two programmes.<sup>263</sup> We note that, when gathering evidence for this inquiry, there was uncertainty between DHSC and DfE as to who was responsible for this area, which echoed the concerns we heard from witnesses about a lack of co-ordinated and cross-departmental working.
  - **Gaps in support:** A lack of data join-up between services led to children and families missing vital care—Rukshana Kapasi, Barnardo’s Director of Health told us that children and families fell through the cracks due to data being collected separately between education, health and social care.<sup>264</sup>

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260 Saskia Jenkins (Senior UK Policy Advisor at UNICEF) ([FTD0091](#)); [Q58](#) [Rukshana Kapasi]

261 [Q64, Q77](#)

262 [Q158](#)

263 NSPCC ([FTD0016](#))

264 [Q73](#)

- **Poor communication:** Even with the introduction of Integrated Care Systems (ICSs),<sup>265</sup> inconsistent data-sharing practices led to communication barriers and gaps between services and local authorities.<sup>266</sup>
- **Undefined outcomes:** Evidence described the outcome metrics under the current system as “blurred” or “sporadic”, making it difficult to compare regions, evaluate effectiveness of interventions, and build the case for investment.<sup>267</sup> As a result, Christine Farquharson told us there was “relatively little data” to give a national picture on the efficacy of Family Hubs.<sup>268</sup>

**131.** Whilst the Ofsted and Care Quality Commission’s evaluation of the ‘Start for Life’ programme in 2024/5 found positive outcomes infant feeding, parental mental health, and outcomes for children, it noted that:

Opportunities to measure outcomes in the current reporting framework are limited. Local areas need support to measure impact, including a set of shared national outcomes with optional local additions. Leaders felt that current reporting requirements were time-intensive and could be simplified to free up staff time.<sup>269</sup>

**132.** We heard that a shared outcomes framework could enable joined-up, child-centred care across agencies and enable the linking of early investment to long-term public service savings.<sup>270</sup> Dr Clare Fuller, Co-Medical Director of NHS England described the creation of a shared framework as the “core job of an integrated care system”, with all sectors “working towards the same goal”.<sup>271</sup> Witnesses called for a framework to span health, social care and education beyond medical indicators; to include a focus on outcomes for children with complex needs and the experiences of their families; and to be formulated relevant to local demography.<sup>272</sup> Alison Morton, Institute of Health Visiting CEO, called for “specific, small numbers of key metrics” that would be shared across departments, rather than “wheelbarrows full

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265 Integrated Care Systems are statutory partnerships of organisations including local NHS and authorities, who plan, buy and provide health and care services in their geographical area with the aim to provide more joined-up and preventative health and care services; NHS England, [What are integrated care systems?](#) (accessed October 2025)

266 Dorset Parent Infant Partnership (DorPIP) ([FTD0005](#)); The National Literacy Trust ([FTD0024](#))

267 Halton Borough Council ([FTD0087](#)); [Q94](#) [Rukshana Kapasi]

268 [Q71](#)

269 Ofsted and the Care Quality Commission, [Start For Life services: thematic review](#), 7 May 2024

270 Parent-Infant Foundation ([FTD0079](#)); [Q77](#) [Alison Morton]

271 [Q194](#)

272 [Qq144-145](#) [Anna Bird, Dr Payne, Dr Fuller]

of questionnaires”.<sup>273</sup> In 2025, the IFS concluded that for interventions such as Family Hubs to be truly effective, they needed to integrate outcomes, evaluation and data collection from the start.<sup>274</sup>

- 133.** Ashley Dalton MP, Parliamentary Under-Secretary of State, told us there “really” was an appetite for a shared outcomes framework integrating health, education and social care, pointing to the Government commitment to explore it within its ‘Best Start in Life’ strategy. She added the intention was for the framework to be publicly available by April 2026.<sup>275</sup>
- 134.** Several witnesses had views on the metrics that should be priorities and measured by a shared outcomes framework. Dr Fuller, Co-Medical Director for Primary Care, NHS England, emphasised that there were already “many really good examples of people who are already working on shared outcomes frameworks” and highlighted “reducing maternal smoking, reducing neonatal mortality and reducing A&E attendances” as key metrics.<sup>276</sup> Anna Bird, Contact, said that any national outcomes framework should have “a real focus on outcomes for children with complex needs, and that needs to be things like time taken to secure joint health and social care services, timely diagnosis and access to specialist care”.<sup>277</sup>

**135. RECOMMENDATION**

The absence of a shared outcomes framework undermines accountability and hinders strategic planning across local systems. We welcome the Government’s plans to produce a shared outcomes framework. We recommend that the final framework be supported by an implementation plan that sets out how the Government will use the introduction of the framework to drive improved integration across the early years landscape. The Government should set out clearly who holds ministerial responsibility for the shared outcomes framework in both the Department of Health and Social Care and the Department for Education and what further steps they will take to promote cross-departmental working.

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273 [Q77](#)

274 Institute for Fiscal Studies, [The short- and medium-term effects of Sure Start on children’s outcomes](#), 22 May 2025; For more information on Sure Start Centres, see Chapter 6, Service models

275 [Q251](#); Department for Education, [Giving every child the best start in life](#), 7 July 2025

276 [Q144](#)

277 [Q144](#)

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# Conclusions and recommendations

## Family Hubs and the Start for Life Programme

1. We welcome the additional funding that the Government has announced for Family Hubs and its plans to open a Hub in every local authority. This is a positive step in increasing the support available to families during the critical first years of a child's life. However, the funding available for these programmes is still significantly below the level of Sure Start, while Hubs are being expected to cater to a much broader age range of children and young people. (Conclusion, Paragraph 18)
2. We call on the Government to set out plans to further expand the network of Family Hubs to provide access to a Hub every community. This plan must be supported by sustained and ringfenced funding. Previous research on the benefits of the Sure Start Programme clearly set out the long-term benefits and financial returns of such an investment and would directly support this Government's ambition to give every child the best start in life. We also ask the Government to set out when it will confirm the funding arrangements for new areas and when it plans to issue guidance to those areas on services for children between the ages of 0 and 2. (Recommendation, Paragraph 19)
3. Successive governments have rightly focused on targeting Family Hubs and other early year interventions on those with the greatest need. We welcome the announcement that Hubs will have staff specifically trained to support the parents of children with additional needs navigate the service. We recommend that Government consider creating similar roles to support the parents of children from other disadvantaged groups. (Recommendation, Paragraph 22)
4. Perinatal mental health is as important as physical health, with poor mental health outcomes having potentially significant long-term consequences for both the mother and child. We were struck by how frequently mental health concerns were raised in evidence. Given that the Government's

new investment is available only to the original 75 local authority areas this will struggle to address the need identified by witnesses. (Conclusion, Paragraph 32)

5. The Government should set out what actions it will take to improve access to perinatal mental health care within Family Hubs, supported by specific targets to improve access for women from ethnic minority backgrounds who have disproportionately poorer mental health outcomes. (Recommendation, Paragraph 33)
6. We recommend that the Department for Education revise its guidance on early language and home learning environment funding to allow it to be used to provide support that covers the 0–2-year period, to allow providers the maximum flexibility in how they deploy this funding. (Recommendation, Paragraph 39)
7. We welcome the Government’s intention for Neighbourhood Health Services and Neighbourhood Health Centres to work in partnership with Family Hubs. Given that both models aim to bring together health and broader support services in a “one stop shop”, it will be important that families know where to go to access support and that partner organisations are not stretched too thin attempting to provide a presence in multiple locations. We invite the Government to provide further information on how it will manage potential overlap between Neighbourhood Health Centres and Family Hubs in its response to this report. (Conclusion, Paragraph 44)

## Health visiting

8. The Government will fail to deliver on its ambition to give every child the best start in life unless it takes urgent action to rebuild the health visitor workforce, which has been decimated over the last 10 years. (Conclusion, Paragraph 55)
9. The Government must create a specific plan to rebuild the health visitor workforce in its forthcoming NHS Long Term Workforce Plan. This plan must be informed by safe staffing tools to ensure that health visitors have a manageable workload. As an initial step, we call on the Government to immediately commit to recruiting at least another 1000 health visitors. (Recommendation, Paragraph 56)
10. We are also highly concerned about the variation in performance amongst local authorities in delivering health visits. While it is clear that the system as a whole needs additional resourcing, it is unacceptable that some local authorities managed 100% uptake while others were as low as 4%. We call

on the Government to set out what action it will take to hold to account poorly performing local authorities and improve their delivery of health visits. (Recommendation, Paragraph 57)

11. The Government's ambitions for the number of health visits are woefully inadequate. Children in England receive fewer mandated health visits than children in any other part of the UK. While the Government's immediate priority must be supporting and growing the workforce to deliver the current programme of five visits, in the longer term the Government should aim to deliver a service comparable to the rest of the UK. (Conclusion, Paragraph 60)
12. We recommend that the Government commit to increasing the number of mandatory health visitor contacts for children in England from five to six. To help it deliver this it should look at the approach that the devolved administrations have taken, where families can expect between 6 and 11 contacts with a health visitor, and set out the lessons that it can learn from their approach in its response to our report. (Recommendation, Paragraph 61)

## Workforce

13. Throughout this inquiry we heard that the children's health workforce is being stretched to breaking point. There are significant shortages across multiple disciplines which prevent professionals from delivering the care young children and their families need and that, in some cases, significantly impacts on patient safety (Conclusion, Paragraph 76)
14. The Government must take the opportunity presented by the forthcoming NHS 10 Year Workforce Plan to create a sustainable and well-resourced children's health workforce. While we understand the Government's desire for the workforce plan to go beyond numbers, a plan that does not set out a clear, achievable and funded road map for addressing staff shortages would completely lack credibility. We recommend that the workforce plan contains specific targets for recruitment to all disciplines that deliver care in the first 1000 days that, as a minimum, ensure that safe staffing ratios are delivered in all settings. (Recommendation, Paragraph 77)
15. Many professions which play a key role in delivering children's health care are not entirely or primarily employed by the NHS. We recommend the Government sets out how it plans to support those professions in non-NHS settings, particularly allied health professionals and early years practitioners, in a child's health workforce strategy that should accompany the NHS 10 Year Workforce Plan. We also recommend that the Government

review its current guidance on multidisciplinary teams to ensure that due prominence is given to the role that allied health professional can play in such teams. (Recommendation, Paragraph 78)

## Vaccinations

16. The continuing decline in childhood vaccination levels since 2012 is a national disgrace; children should not be dying of entirely preventable diseases. The continued failure to effectively grapple with this is a significant and ongoing public health crisis and will lead to increased costs for the health service in the longer term. (Conclusion, Paragraph 86)
17. We are disappointed that the Government has dropped the 95% vaccination coverage target from NHS planning guidance and were unconvinced by the Minister's arguments that it remained an "expectation" despite its removal. While we agree with the Government's desire for the NHS to have a smaller number of priorities, we believe that vaccination coverage must absolutely be one of those priorities. (Conclusion, Paragraph 87)
18. We recommend that the Government immediately reinstate the 95% vaccination coverage target in NHS planning guidance for all vaccinations, including those given during the first 1000 days to mothers and children. We also call on the Government to commit to hitting this target no later than the end of this Parliament. (Recommendation, Paragraph 88)
19. Despite the measures contained in the Government's vaccination strategy, vaccination rates are continuing to fall and the strategy is failing to deliver the improved coverage that is so desperately needed. The Government should brand the currently strategy a failure and develop a new plan with a specific focus on improving vaccination uptake in early years settings. As part of this new strategy, we recommend that the Department consider having a named individual in each ICB who is responsible for co-ordinating the vaccine offer across ICB services. (Recommendation, Paragraph 97)
20. The plan for delivering vaccination by health visitors has real potential to help the Government achieve the 95% coverage vaccine target. We recommend the Government explore ways to accelerate the pilot programme and to report back on its findings within 6 months. (Recommendation, Paragraph 101)

## Integration between services

- 21.** The introduction of a Single Unique Identifier has the potential to significantly simplify data sharing across the early years landscape and we hope that currently planned pilots proceed smoothly and at pace. We ask that the Government commit to providing regular update on the progress of the pilots. (Conclusion, Paragraph 111)
- 22.** The Government does not have access the data it needs on children’s health outcomes during the first 1000 days. Without this data it will struggle to deliver meaningful improvements or implement a shared outcomes framework. (Conclusion, Paragraph 116)
- 23.** We recommend that the Government work with all NHS and early-years settings to produce plans for greater disaggregated data concerning service delivery and outcomes for children. This should include data broken down by age group, as well as ethnicity, disability, socioeconomic status, access to services, and other categories that will allow for more targeted interventions and specified outcome planning. As a minimum, we call for the Government to introduce separate reports on waiting times for children under the age of two, as a first step to minimising delay in accessing services at this critical stage in a child’s development. (Recommendation, Paragraph 117)
- 24.** Throughout this inquiry we heard that concerns about the legislation around data sharing was acting as a barrier to partners working effectively together. While some local areas have developed their own systems to support effective data sharing, stakeholders were clear they needed greater central support. (Conclusion, Paragraph 123)
- 25.** We recommend that the Department of Health and Social Care work with Integrated Care Systems to simplify data sharing guidance to improve data sharing between providers. (Recommendation, Paragraph 124)
- 26.** The absence of a shared outcomes framework undermines accountability and hinders strategic planning across local systems. We welcome the Government’s plans to produce a shared outcomes framework. We recommend that the final framework be supported by an implementation plan that sets out how the Government will use the introduction of the framework to drive improved integration across the early years landscape. The Government should set out clearly who holds ministerial responsibility for the shared outcomes framework in both the Department of Health and Social Care and the Department for Education and what further steps they will take to promote cross-departmental working. (Recommendation, Paragraph 135)

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# Formal minutes

## Wednesday 13 January 2026

### Members present:

Paulette Hamilton, in the Chair

Danny Beales

Josh Fenton-Glynn

Alex McIntyre

In the absence of the Chair, Paulette Hamilton took the Chair

### First 1000 Days: a renewed Focus

Draft Report (First 100 Days: a renewed focus), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 135 agreed to.

Summary agreed to.

*Resolved*, That the Report be the Fifth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available (Standing Order No. 134).

### Adjournment

Adjourned till Wednesday 21 January at 9.15 am

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# Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee’s website.

## Wednesday 7 May 2025

**Professor Sir Michael Marmot**, Professor of Epidemiology, University College London, Director, UCL Institute of Health Equity [Q1–26](#)

**Rt Hon Dame Andrea Leadsom DBE**, Former Parliamentary Under-Secretary of State, Department of Health and Social Care, and the Government’s Early Years Health Development Advisor, Chair, Early Years Healthy Development Review [Q27–49](#)

## Wednesday 4 June 2025

**Dr Christine Farquharson**, Associate Director, Institute for Fiscal Studies; **Rukshana Kapasi**, Director of Health, Barnardos; **Rachel Roberts**, Strategic Lead for Early Help and Prevention, Children, Young People and Family Services, Hull City Council; **Alison Morton**, CEO, Institute of Health Visiting [Q50–106](#)

## Wednesday 2 July 2025

**Dr Doug Simkiss**, Chair of the British Association for Community Paediatrics, Royal College of Paediatrics and Child Health; **Dr Sally Payne**, Professional Advisor, Royal College of Occupational Therapists; **Dr Claire Fuller**, Co-medical director for Primary Care, NHS England; **Anna Bird**, CEO, Contact [Q107–147](#)

**Janet Cooper**, Expert Adviser, Royal College of Speech and Language Therapists; **Jane Harris**, CEO, Speech and Language UK [Q148–163](#)

**Dr Amit Aggarwal**, Medical Director, Association of the British Pharmaceutical Industry (ABPI); **Dr Helen Skirrow**, Clinical Research Fellow, Department of Primary Care and Public Health, Imperial College London; **Dr Helen Stewart**, Officer for Health Improvement, The Royal College of Paediatrics and Child Health [Q164–194](#)

## Wednesday 3 September 2025

**Ashley Dalton MP**, Parliamentary Under-Secretary of State for Public Health and Prevention, Department of Health and Social Care; **Liz Ketch**, Director for Early Years, Children & Families, Department of Health and Social Care; **Susie Owen**, Co-Director for Early Years, Childcare, Families and Analysis, Department of Education [Q195-275](#)

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# Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

FTD numbers are generated by the evidence processing system and so may not be complete.

- 1 \*\*\*Multiple submitters:Dr. Catherine Laing (Senior lecturer, University of York); Professor Tamar Keren-Portnoy (Professor, University of York); Ms. Sab Arshad (Grant Manager, University of York); Dr. Laura Boundy (Research and Innovation Associate, University of York); Professor Sue Buckley (Director of Science and Research, Down Syndrome Education International); Dr. Kelly Burgoyne (Senior lecturer, University of Manchester); Professor Helena Daffern (Professor, University of York); Professor Mona Kanaan (Professor, University of York); and Ms. Helen Tan (EY Standards and Improvement Officer, Children,Young People & Family Services, Hull City Council) [FTD0086](#)
- 2 \*\*\*Multiple submitters:Mr Keith Aubrey (Retired, n/a); and Mr David Mckenlay (Retired, n/a) [FTD0052](#)
- 3 \*\*\*Multiple submitters:Professor Samantha Johnson (Professor of Child Development, University of Leicester); and Professor Camilla Gilmore (Professor of Mathematical Cognition, Loughborough University) [FTD0017](#)
- 4 \*\*\*Multiple submitters:Stephanie Gillibrand (Research Fellow, The University of Manchester); and Professor Jo Dumville (Professor of Applied Health Research, The University of Manchester) [FTD0031](#)
- 5 Abbott, Dr Laura (Associate Professor, University of Hertfordshire) [FTD0003](#)
- 6 Academy of Medical Sciences [FTD0034](#)
- 7 Action Cerebral Palsy [FTD0093](#)
- 8 Action Cerebral Palsy [FTD0076](#)
- 9 Alder Hey Children's Charity [FTD0051](#)
- 10 Alder Hey Children's NHS Foundation Trust; Mersey Care Foundation Trust; and Liverpool City Council [FTD0066](#)

11	Alexandra Rose Charity	<a href="#">FTD0012</a>
12	Anna Freud	<a href="#">FTD0040</a>
13	Auditory Verbal UK	<a href="#">FTD0009</a>
14	Beckett, Professor Angharad (Professor of Political Sociology and Social Inclusion, School of Sociology and Social Policy and Centre for Disability Studies, University of Leeds)	<a href="#">FTD0055</a>
15	Better Start (Blackpool)	<a href="#">FTD0061</a>
16	Blackpool Parent Infant Relationship Service	<a href="#">FTD0025</a>
17	Bliss - the charity for the newborn	<a href="#">FTD0048</a>
18	Booktrust	<a href="#">FTD0032</a>
19	Brace, Mrs Debbie (specialist parent and infant practitioner, Hounslow PAIRS team)	<a href="#">FTD0002</a>
20	Brackley, Dayna (Partner, Bremner & Co)	<a href="#">FTD0094</a>
21	Bradford health and care partnership	<a href="#">FTD0042</a>
22	Breastfeeding Alliance	<a href="#">FTD0088</a>
23	British Association of Teachers of Deaf Children and Young People (BATOD)	<a href="#">FTD0054</a>
24	British Dental Association	<a href="#">FTD0062</a>
25	British Psychological Society	<a href="#">FTD0022</a>
26	CONTI, Professor GABRIELLA (Professor of Economics, University College London)	<a href="#">FTD0069</a>
27	Centre for Mental Health	<a href="#">FTD0110</a>
28	Centre for Social Justice	<a href="#">FTD0067</a>
29	Child Health Unit, School of Public Health, Imperial College London.	<a href="#">FTD0027</a>
30	Children's Hospital Alliance	<a href="#">FTD0037</a>
31	Dad Matters UK	<a href="#">FTD0104</a>
32	Daly, Dr Michael (Senior Research Associate in Public Health, University of Bristol)	<a href="#">FTD0018</a>
33	Department of Health and Social Care	<a href="#">FTD0109</a>
34	Dorset Parent Infant Partnership (DorPIP)	<a href="#">FTD0005</a>
35	Early Education and Childcare Coalition	<a href="#">FTD0068</a>
36	EasyPeasy	<a href="#">FTD0047</a>
37	Ei SMART CIO	<a href="#">FTD0064</a>

38	Elizabeth Bryan Multiple Birth Centre, Birmingham City University	<a href="#">FTD0058</a>
39	Eunice, Cllr (Councillor, Bensham Manor Ward)	<a href="#">FTD0057</a>
40	Family Action	<a href="#">FTD0039</a>
41	First Steps Nutrition Trust	<a href="#">FTD0100</a>
42	Foundation Years Information and Research (FYIR)	<a href="#">FTD0084</a>
43	HENRY	<a href="#">FTD0065</a>
44	Halton Borough Council	<a href="#">FTD0087</a>
45	Impact on Urban Health	<a href="#">FTD0083</a>
46	Institute of Health Visiting	<a href="#">FTD0026</a>
47	Jenkins, Saskia (Senior UK Policy Advisor, UNICEF)	<a href="#">FTD0091</a>
48	Kay, Gregory (Public Affairs and Media Officer, Royal College of Psychiatrists)	<a href="#">FTD0092</a>
49	Kipping, Ruth (Professor of Public Health, University of Bristol)	<a href="#">FTD0006</a>
50	Lloyd, Professor Eva (Emeritus Professor, University of East London)	<a href="#">FTD0020</a>
51	Local Government Association	<a href="#">FTD0112</a>
52	MSD	<a href="#">FTD0046</a>
53	Maternal Mental Health Alliance UK	<a href="#">FTD0030</a>
54	Mental Health Foundation	<a href="#">FTD0078</a>
55	NCT (The National Childbirth Trust)	<a href="#">FTD0053</a>
56	NHS Confederation	<a href="#">FTD0081</a>
57	NSPCC	<a href="#">FTD0016</a>
58	National Children's Bureau	<a href="#">FTD0080</a>
59	Novartis Pharmaceuticals UK Limited	<a href="#">FTD0099</a>
60	Parent-Infant Foundation	<a href="#">FTD0114</a>
61	Parent-Infant Foundation	<a href="#">FTD0079</a>
62	Parenting Programmes Alliance	<a href="#">FTD0050</a>
63	Royal College of Nursing	<a href="#">FTD0085</a>
64	Royal College of Obstetricians and Gynaecologists	<a href="#">FTD0014</a>
65	Royal College of Occupational Therapists	<a href="#">FTD0077</a>
66	Royal College of Speech and Language Therapists	<a href="#">FTD0082</a>
67	Academy of Sands	<a href="#">FTD0035</a>

68	Sands and Tommy's Joint Policy Unit	<a href="#">FTD0033</a>
69	Sanofi	<a href="#">FTD0107</a>
70	Speech and Language UK	<a href="#">FTD0023</a>
71	Swansea University	<a href="#">FTD0095</a>
72	Tarrant, Professor Anna (Professor of Sociology, University of Lincoln)	<a href="#">FTD0045</a>
73	The Association of the British Pharmaceutical Industry (ABPI)	<a href="#">FTD0106</a>
74	The Breastfeeding Network	<a href="#">FTD0089</a>
75	The Centre for Emotional Health	<a href="#">FTD0101</a>
76	The Centre for Emotional Health	<a href="#">FTD0008</a>
77	The Food Foundation	<a href="#">FTD0049</a>
78	The For Baby's Sake Trust	<a href="#">FTD0015</a>
79	The Natasha Allergy Research Foundation	<a href="#">FTD0059</a>
80	The National Literacy Trust	<a href="#">FTD0024</a>
81	The National Organisation for FASD	<a href="#">FTD0113</a>
82	The Nuffield Foundation	<a href="#">FTD0013</a>
83	The Royal College of Midwives	<a href="#">FTD0056</a>
84	The Traveller Movement	<a href="#">FTD0010</a>
85	The University of Oxford	<a href="#">FTD0102</a>
86	Thomas Coram Research Unit, University College London	<a href="#">FTD0098</a>
87	Triple P	<a href="#">FTD0111</a>
88	UK Council for Psychotherapy	<a href="#">FTD0028</a>
89	White, Dr Melanie (Consultant Psychologist, Norfolk and Suffolk NHS Foundation Trust)	<a href="#">FTD0004</a>
90	Wren, Professor Yvonne (Professor of Speech and Communication , University of Bristol)	<a href="#">FTD0063</a>
91	Parent and baby psychology service islington (PBPS) CAMHS	<a href="#">FTD0021</a>

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# List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

## Session 2024–26

Number	Title	Reference
4th	Community Mental Health Services	HC 566
3rd	Black Maternal Health	HC 895
2nd	Adult Social Care Reform: the cost of inaction	HC 368
1st	Appointment of the Chair of NHS England	HC 743
3rd Special	Expert Panel: Evaluation of Palliative care in England	HC 632
2nd Special	Expert Panel: Evaluation on meeting patient safety recommendations: Government Response	HC 617
1st Special	Pharmacy: Government Response	HC 602