House of Commons Health and Social Care Committee inquiry: The first 1000 days of life

Written evidence submitted by the Family Nurse Partnership National Unit, Tavistock and Portman NHS Foundation Trust.

Introduction

1. This submission is about public health prevention in pregnancy and the first years of life. Our aim is to improve outcomes for children, now and in their future lives; and to reduce inequalities. We draw on experience of leading the high-quality delivery and adaptation of the evidence-based Family Nurse Partnership (FNP) programme, at scale across England since 2007, to highly disadvantaged young parents and their babies.

The Family Nurse Partnership National Unit

2. The FNP National Unit's vision is that every baby, child and young parent can thrive, fulfil their aspirations and contribute to society. The Unit leads delivery of FNP in England, working with local areas who commission and provide the service for people within their communities. The Unit is also responsible for quality improvement, and for adapting FNP to meet the UK context and the changing needs of funders and clients. Finally, it develops approaches to share learning from FNP with other services, to benefit wider populations.

3. FNP is an evidence-based, preventive programme for vulnerable first-time young mothers and their babies, which seeks to support women to have a healthy pregnancy, to improve child health and development, and to improve parents' economic self-sufficiency. Over 40 years of robust US research suggests FNP can deliver significantly improved outcomes across the life-course for both mothers and children, and substantial cost savings. It offers intensive and structured home visiting from early pregnancy until the child is two. A learning programme, designed and delivered by the National Unit, enables nurses to develop the understanding and skills required to fulfil their roles.

4. The FNP National Unit is located within the Children, Young Adults and Families (CYAF) Directorate of the Tavistock and Portman NHS Foundation Trust, a leading UK provider of mental health services and training, with a strong focus on perinatal, child and adolescent mental health.

Executive summary

- The social and economic case for investment in services in the first 1000 days has been well made. This has also been translated into clear national policy aspirations.

- However, these aspirations are not fully reflected in activity on the ground. Public health budgets and other funding for services which benefit children have reduced in recent years, leading to cuts in services, including FNP. This is likely to have consequences for children's health and well-being. We believe that clear action needs to be taken so that the well-evidenced benefits of investment in the first 1000 days of life can be realised.

- Our recommendations are based on our understanding of theory and evidence, together with our experience of delivering, improving and adapting FNP across much of England. We engage with systems at multiple levels – national government, policy and academia, local service commissioning and clinical practice. Critically, we also listen to the experiences of FNP clients themselves, often highly disadvantaged young mothers and their babies, many of whom are reluctant to engage with services and feel poorly judged by them.

- In this submission we make recommendations for national strategic action. The intention is to add genuine value while respecting local communities' expertise and need to make decisions which reflect their contexts, priorities and populations.

Recommendations

- Any renewed focus on the first 1000 days should encompass mental and emotional health, physical health and social and environmental factors. This sets the scene for the following recommendations, particularly for long-term, cross-sector funding and a wider view of evidence. Evidence suggests that both physical and mental health, together with the environment in which a child lives are inextricably linked in this period and also contribute together to long-term health, development and happiness. There is also a strong correlation with inequality.

- A long-term funding settlement, across sectors, will add stability, improve planning and efficient use of resources, support the accumulation of learning and improvement, and enable better tracking and evaluation of longer-term outcomes. Intervention in the first 1000 days produces benefits that accrue across systems and in the long-term, but we see local short-term funding pressures mitigate against such long-term investment. The proposal for a ten year NHS plan offers a good anchor, providing the wider determinants of health are clearly recognised and funded.

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- Different approaches to evidence should be developed and used. Investment in publicly funded services should be based on good evidence. We argue that good evidence includes evidence that is produced in time to inform and influence service development in a fast changing context. It includes real time data to improve quality iteratively and continuously. It should recognise the complexity of local systems and the challenge of attributing direct, linear, cause and effect. It means genuinely viewing the experience of those who deliver and those who experience services as valid and valuable. It also means being able to view failure, in some circumstances, as offering learning for improvement. We are exploring an approach incorporating evidence based innovation, learning and iterative improvement within FNP ADAPT (Accelerated Design and Programme Testing).

- We need to learn more about the function, form and quality of service user/ practitioner relationships. We believe relationships matter but we know too little about how, and when, they help improve outcomes. Further learning in this area should help to focus investment. We need to understand better when a well-selected, well-trained and well-supported workforce is critical; while also identifying the value of other approaches, including technology and peer and community support.

Main submission

Context: the case for change

5. The social and economic case for investment in the first 1001 days has been well made, many times. The Heckman Curve shows that the highest rate of economic return comes from the earliest investments in children[1]. The Early Intervention Foundation estimated that the Government spends nearly £17 billion per year on "late intervention", a sum that does not capture longer-term impacts of failing to intervene early, nor the wider social and economic costs[2]. The cost of failing to deal adequately with perinatal mental health and child maltreatment has been estimated at £23bn each year[3]. Put simply,

[1] https://heckmanequation.org/resource/the-heckman-curve/

[2] The Cost of Late Intervention: EIF analysis 2016, Early Intervention Foundation (November 2016)

[3] Building Great Britons, First 1001 Days All Party Parliamentary Group (2015)

"many of the costly and damaging social problems in society are created because we are not giving children the right type of support in their earliest years, when they should achieve their most rapid development".[4]

6. This evidence is reflected in national policy priorities. The NHS Forward View suggests "*The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health*"[5]. Public Health England (PHE) has a clear vision and strategy for the first years of life[6], which includes action in six high impact areas. There are many other examples.

7. However, these aspirations are not fully reflected in funding, *"Funding through the public health grant has fallen in real terms by 3.2% a year from £2.9 billion in 2013–14 to £2.6 billion in 2017–18.123"*[7]. We see a reduction in services on the ground. The number of FNP sites has reduced from 132 to 78 since 2016, with money cited as a key reason for withdrawing the service. Other services relevant to the first 1000 days, including health visiting and stop smoking services have also been affected[8][9][10].

8. Clear national strategic and practical action is therefore needed to ensure that the benefits of investment in the first 1000 days of life can be realised.

Key areas of focus

9. Our recommendations are based on our understanding of theory and evidence. They also reflect our experience of translating this theory and evidence into practice, in the real and complex world, at scale. We have led the delivery, improvement and adaptation of FNP over the last eleven years across much of England, engaging with systems at multiple levels – national government, policy and academia, local service commissioning, clinical practice. Critically, we also listen to the experience of FNP

[4] Early Intervention: the next steps, Graham Allen MP (2011)
[5] Five Year Forward View, NHS England (2014)
[6] Health matters: giving every child the best start in life, Public Health England (2016)
[7] Securing the future, funding health and social care to the 2030s, Health Foundation and Institute for Fiscal Studies (2018)
[8] https://www.theguardian.com/society/2016/dec/08/babies-missing-out-on-key-checks-after-fall-in-health-visitor-numbers

[9] Feeling the Heat: The Decline of Stop Smoking Services in England, Cancer Research UK and Action on Smoking and Health (2018)
[10] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/Public-Spending-on-Children-in-England-CCO-JUNE-2018.pdf

clients themselves, many of whom are reluctant to engage with services and feel poorly judged by them,

"At our first meeting it was like the first time I really felt like a mum, a proper mum, not a silly girl… For the first time I wasn't ashamed or embarrassed." (FNP client)

"Family nurses are positive role models for a young family in a world of professionals which can sometimes seem overwhelming." (Home-Start co-ordinator)

10. We use this knowledge, experience and insight to make recommendations in relation to national strategic action where that can add value; while respecting local communities' expertise and need to make local decisions which reflect their context and populations.

A public health approach to the first 1000 days

11. We believe a public health approach is essential to improving outcomes throughout the life-course and to long-term health, development and well-being.

12. We applaud the focus the First 1001 Days campaign brought to this period, and to the importance of sensitive, responsive parenting and promoting good attachment,

"Such an environment allows the child to develop in the most optimal way, with emotional wellbeing, capacity to form and maintain relationships, healthy brain and language development leading onto cognitive development, school readiness and lifelong learning"[11]

13. However, we believe that any renewed focus on the first 1000 days should clearly encompass both mental and emotional health, physical health, and also environmental factors including poverty, housing, pollution and community spaces. These are important separately, and are also inextricably linked, "*when considering mental health and physical health the two should not be thought of as separate"*[12] There is also a strong correlation with inequality, as Sir Michael Marmot describes, "*There is a social gradient in health – the lower a person's social position, the worse his*

[11] Building Great Britons (2015)
[12] https://www.mentalhealth.org.uk/a-to-z/p/physical-health-and-mental-health

or her health."[13]; while WHO[14] notes, for example, associations between poor mental health, poverty and poor housing.

14. Specifically, for example, quitting smoking in pregnancy is important for both a mother's and infant's health. Physical activity can have benefits in pregnancy including reducing high blood pressure and the risks of thrombosis, as well as improving mental well-being, yet the proportions of women meeting minimum physical activity recommendations are lowest among those living in the most deprived areas. We witness the range of factors that can make it difficult for FNP clients to be physically active, including social isolation and stigma, low motivation and lack of routine.

15. The Healthy Child programme[15] supports a public health approach in the first 1000 days. For some of the most vulnerable families, FNP is more intensive, addressing issues in six domains, encompassing the emotional, mental and physical health of both parents and babies, as well as life-course development, relationships, the environment and accessing local services. As part of this, there is a strong focus on improving the daily, lived experience of the infant, facilitating better outcomes for children born into disadvantage.

Long-term, cross sectoral funding and oversight

16. We note above the positive policy intent in relation to the first 1000 days; and we welcome the additional focus this inquiry brings. We believe that a long-term, cross sectoral funding settlement and oversight is needed to deliver this.

17. Services in the first 1000 days produce benefits across the life-course. US evidence for FNP over 40 years has shown short, medium and long-term improvements for mothers and children including to antenatal health, children's injuries, school readiness and achievement, employment, welfare dependency and criminal activity[16]. But while it is important to take a long-term view of investment, we witness urgent short-term pressures on local services inhibiting this. Clear mechanisms for long-

[13] Fair Society, Healthy Lives (The Marmot review), Institute for Health Equity (2010)
[14] http://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf?ua=1
[15] Healthy Child Programme 0-19, Department of Health (2010)
[16] Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication, Prevention Science, Olds D, Vol. 3, No. 3, September 2002

term funding, beyond the electoral cycle, would add stability, improve planning and efficient use of resources, support the accumulation of learning and improvement and enable better tracking and evaluation of longer-term outcomes.

18. While the proposals for a ten year NHS plan offer a welcome anchor for a long-term funding settlement, it is important that funding for non-NHS forms of early intervention is also protected. Intervention in the first 1000 days produces benefits that accrue across systems including health, education, criminal justice, social care. It is therefore reasonable for those systems to each contribute funding.

19. Finally, our experience is that the development and implementation of good services, takes time to embed and mature, and requires co-ordination to share good practice and to accelerate improvement at scale. We do not make recommendations in relation to machinery of Government, on the basis that the Government will have many other considerations to address when considering structures. However, we do advocate stable national and local cross-sectoral leadership in order to take long-term investment decisions which will have impact across systems.

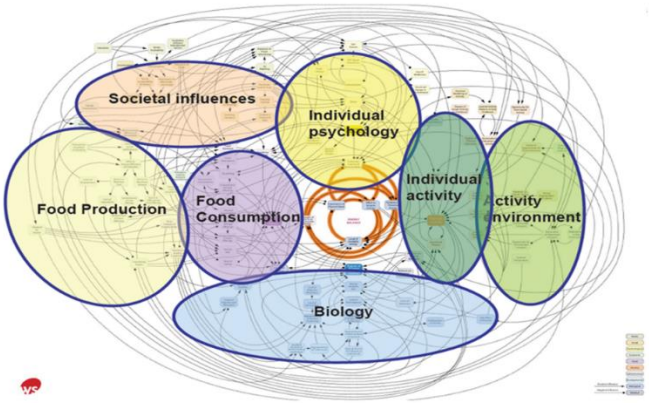
<u>Developing and using different approaches to evidence</u>

20. Investment in publicly funded services should be based on good evidence. However, much current evidence "*has largely been generated by tools and methods that were developed to answer questions about the effectiveness of clinical interventions, and as such are grounded in linear models of cause and effect*"[17].

21. While such evaluation has an important role, there is a growing body of literature which questions its utility for complex interventions and systems, "*in open systems characterised by dynamically changing inter-relationships and tensions, conventional research designs predicated on linearity and predictability must be augmented by the study of how we can best deal with uncertainty, unpredictability and emergent causality*"[18]. The obesity system map illustrates the complex inter-relationships which

[17] The need for a complex systems model of evaluation for public health, Rutter et al (2017)
[18] Greenhalgh and Papoutsi BMC Medicine (2018)

can influence obesity and the challenge of attributing cause and effect[19].



22. Currently conventional evaluation can also be slow, costly, costly, unsuitable for small populations and with a potential for average effects to mask variation.

23. We believe that good evidence includes good-enough information which is produced rapidly, in time to influence service development in a fast changing context. It requires investment in real time data (and in training staff to input and use it) to improve quality. It includes evidence which recognises the complexity of local systems and the challenge of identifying causality. It also includes evidence that views the experience of those who deliver and who receive services as valid and valuable.

24. However, while the issue has been identified, the development of methodologies for evaluating complex social interventions is at an early stage, with investment still weighted towards a "*bio-medical bubble*"[20] Shifting this requires "*substantial capacity building*"[21] on the part of researchers, a "*favourable environment for publishing such research*"[22], and a greater proportion of funding for research which includes evidence based innovation, learning and iterative improvement. This also means viewing failure, in some cases, as offering learning for improvement.

[19] Tackling obesities: future choices, Government Office for Science and Department of Health (2007)
[20] The Biomedical Bubble, Nesta (2018)
[21] Rutter et al (2017)
[22] Rutter et al (2017)

25. Our experience is relevant. FNP is built on a body of RCT evidence from the US[23], formative evaluation in England[24] and one Dutch trial. Replication was based on fidelity to the trialled model. However, an English RCT[25], conducted from 2008–2012 and reported in 2015, reported no effect in a number of outcomes, usefully identifying clear areas for improvement but offering few clues about how to improve.

26. Given continued widespread support for the programme, and the continued credibility of the wider evidence base[26], the National Unit launched FNP Next Steps, an innovation and improvement programme. This includes better data collection and visualisation for local sites; and a new quality improvement model for national monitoring, measurement and to inform decision making about quality improvement priorities across a number of sites. It also includes more focused innovation and testing for significant changes, ADAPT (Accelerated Design and Programme Testing), with partners at the Dartington Service Design Lab**.**

27. We broadly hypothesised that we needed to target FNP better, flex it to local context and client and local need, and update clinical content. ADAPT then drew on both academic literature and improvement science methods, co-designing with local areas changes to FNP, then rapidly testing and refining them in iterative cycles. We use a range of quantitative and qualitative data, including from FNP clients and family nurses.[27] Our aim is to improve FNP outcomes and cost effectiveness in England, to offer learning for other services to benefit wider populations, and also to contribute to the development of different methods for evidence based improvement.

<u>Reviewing the function, form and quality of service user/ practitioner relationships</u>

28. We believe relationships matter in the delivery of high quality services. A core element of FNP is the development of a stable, trusting, respectful and responsive client nurse relationship, which serves as a model for other relationships the client may have, especially with her child.

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[23] Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication, Prevention Science, Olds D, Vol. 3, No. 3, September 2002

[24] Issues emerging from the first 10 pilot sites implementing the Nurse-Family Partnership home-visiting programme in England. Ball, M., Barnes, J., , Meadows P, (2012)

[25] Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (building blocks): a pragmatic randomised controlled trial. Lancet, 387(10014), p146–55. Robling et al (2015)

[26] http://guidebook.eif.org.uk/ (2017)

[27] http://fnp.nhs.uk/media/1246/fnp-adapt-interim-report.pdf (2018)

29. However, we acknowledge we know too little about how, and when, relationships help improve outcomes, between which kinds of people and in relation to which intervention components. We recommend further learning in this area to help focus improvement and service design, to inform workforce development, planning, retention and sustainability. This is also necessary to help focus investment.

30. Work in the first 1000 days can be challenging and emotionally demanding, with practitioners needing to be technically expert, well-informed academically and empathetic while professionally boundaried. This requires a carefully selected, well-trained and well-supported workforce, with appropriate supervision. The FNP National Unit has taken first steps to develop methods for sharing learning from its work with other services.

31. However, a highly skilled and professional workforce is not always necessary, or even desired by service users. An important area for further inquiry is the value of other approaches, including practitioner skill mix, technology and peer and community support.

Conclusion

32. The FNP National Unit's vision is for every baby, child and young parent to thrive, fulfil their aspirations and contribute to society. This submission sets out key recommendations to achieve this. We would be happy to offer more information and to give oral evidence to the Committee.