



Department
of Health &
Social Care

Government response to the Health and Social Care Committee's fifth report of session 2024 to 2026 'The First 1000 Days: a renewed focus'



Government of the United Kingdom

Department of Health and Social Care

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Presented to Parliament by the Secretary of State for Health and Social Care by Command of His Majesty

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Introduction

This is the government's formal response to the recommendations made by the Health and Social Care Committee in its report [The First 1,000 Days: a renewed focus](#), published on 22 January 2026. The government welcomes the report and is grateful to everybody who contributed their time and expertise to the inquiry.

This government is clear on its ambition to raise the healthiest generation of children ever and to ensure every family has the support they need to give their child the very best start in life. We know that the [1,001 days from pregnancy to age 2 set the foundations for an individual's cognitive, emotional and physical development](#).¹ A range of complex factors impact babies, children and young people's health, which affects their lifelong health and life chances.² Investing in this period, ensuring families have access to quality support, provides a real opportunity to improve outcomes and tackle health disparities. Research indicates that investing in early childhood in the UK could generate £45.5 billion in value added for the national economy each year.³

Raising the healthiest generation of children includes supporting children and their families affected by domestic abuse. [Freedom from violence and abuse: a cross-government strategy to build a safer society for women and girls](#), published in December 2025, sets out the strategic direction and concrete actions to prevent violence and abuse, pursue perpetrators and support victims. As part of the strategy, the Department of Health and Social Care (DHSC) committed to:

- rolling out [Steps to Safety](#), a referral pathway from primary care into specialist support for victims and survivors of domestic abuse and sexual violence
- expanding the [Child House model](#) to provide therapeutic support to victims and survivors of child sexual abuse
- launching a new mandatory safeguarding learning programme for the NHS
- taking measures to support child victims and survivors of female genital mutilation

The government has also committed to improving our understanding of why pregnancy and the time after birth is a period of heightened risk for domestic abuse. Investments into

¹ National Scientific Council on the Developing Child. [The Timing and Quality of Early Experiences Combine to Shape Brain Architecture: working paper 5](#), 2007 (viewed on 2 June 2025)

² Harvard University. [Center on the developing Child](#), 2025 (viewed on 2 June 2025)

³ Deloitte for The Royal Foundation Business Taskforce for Early Childhood. [Prioritising early childhood for a happier, healthier society](#), 2024 (viewed on 2 June 2025)

children's social care and the Best Start Family Hubs will also enable family services to address domestic abuse.

The inquiry set out to understand what progress has been made since the predecessor committee's report in 2019 into the same topic and the necessary action required to deliver the government's commitment to give every child the best start in life.

The committee's report sets out its conclusions and made 15 recommendations against the following themes:

- Family Hubs and Start for Life programme - the committee welcomes the government's announced expansion of the family hub network to one in each local authority but encourages it to go further, providing access to a hub in every community, backed by long-term funding. It recommends that expansion prioritise equity and reach those with additional needs
- health visitors - the committee recommends the government recruit 1,000 extra health visitors immediately. It encourages increasing the number of mandatory health visitor contacts from 5 to 6
- workforce - the committee suggests the 10 Year Workforce Plan should include targets for increasing the early years workforce and encourages the publication of a separate child's health workforce strategy
- vaccinations - the committee recommends the government reinstates the 95% coverage target in NHS planning guidance and commits to achieving this by the end of this Parliament. It also suggests the government accelerate pilots for health visitor-led vaccination delivery
- integration between services - the committee calls on the government to produce a data-sharing toolkit to address the challenges providers face when sharing information. It asks the department to work towards data disaggregation to enable it to monitor waiting times for children under 2

This command paper provides the government's response to these recommendations and conclusions.

Recommendations and conclusions

Family Hubs and Start for Life programme

Recommendation 1

We call on the government to set out plans to further expand the network of family hubs to provide access to a hub in 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.

The government welcomes the committee's recommendation and shares its commitment to ensuring families across England have access to high-quality, integrated support services.

Evidence from Sure Start demonstrates that [large-scale, holistic interventions can be an effective - and cost effective - way to improve children's outcomes, with long-lasting benefits](#),⁴ Every £1 of up-front investment in Sure Start generated roughly £2.05 in long-term, direct and indirect benefits.⁵ Sure Start centres offered services for families with under-5s, but the impacts for those who accessed services were remarkably long-lasting. For example:

- access to a Sure Start centre between the ages of 0 and 4 significantly improved the educational achievement of children, with benefits lasting at least until GCSEs
- greater Sure Start coverage (as measured by the number of centres per 1,000 children under 5 in a local authority) substantially reduced the likelihood of hospitalisation during childhood and adolescence. While the likelihood of hospitalisation increased by 10% of the baseline at age one, it then fell by 8.5% by age 15
- although overall evidence of impact on children's mental health and behaviours was mixed, evaluation evidence suggests that children who had access to Sure Start had positive outcomes in relation to depression and anxiety disorders, including reduced

⁴ Carneiro, P, and others. [The short- and medium-term effects of Sure Start on children's outcomes](#), Institute for Fiscal Studies (IFS), 2025 (viewed on 2 June 2025)

⁵ Carneiro, P, and others. [The short- and medium-term effects of Sure Start on children's outcomes](#), Institute for Fiscal Studies (IFS), 2025 (viewed on 2 June 2025)

hospitalisations for mental health related causes at ages 12 to 14 by around 50% of their baseline⁶

This evidence has informed the government's approach to Best Start Family Hubs and Healthy Babies, which builds on the Family Hubs and Start for Life programme. In July 2025, the Department for Education (DfE) published [Giving every child the best start in life](#) - a landmark strategy backed by close to £1.5 billion over 3 years. This sets a long-term direction for a more joined-up, family-focused early years system, with better local leadership, simplified access and high-quality support rooted in evidence.

At the heart of this strategy is the rollout of Best Start Family Hubs. As of April 2026, over 200 new Best Start Family Hubs will open in previously unfunded local authorities, meaning that there will be Best Start Family Hubs in every local authority area in England. By the end of 2028 we will create up to 1,000 Best Start Family Hubs and 2,000 network sites that will extend the reach of hubs into local community venues.

We have also [published additional guidance](#) that sets out how we will expect local authorities to deliver on Best Start Family Hubs and Healthy Babies, backed by over £900 million from DfE and DHSC.

This rollout directly supports the Plan for Change ambition to give every child the best start in life. We have set an ambition that 70% of Best Start Family Hubs should be located in the 30% most deprived areas nationally. The wider network of up to 2,000 network sites in community venues will ensure support is available in places families already go, and delivered by the people they already trust. Local authorities, in consultation with local communities and recognising the benefits of existing provision, will make location decisions on this basis to help ensure support reaches those who need it most, including those families affected by domestic abuse.

The integration of health services in Best Start Family Hubs is fundamental to improving outcomes for babies, children and their families. By placing Healthy Babies (formerly Start for Life) services alongside wider universal and early health support, at the heart of Best Start Family Hubs, we strengthen delivery and integration across health and wider family services. This is fundamental to support delivery of the emerging neighbourhood health architecture.

Through the [10 Year Health Plan](#) we committed to match Healthy Babies to Best Start Family Hubs rollout over the next decade. The government has prioritised funding for the

⁶ Carneiro, P, and others. [The short- and medium-term effects of Sure Start on children's outcomes](#), Institute for Fiscal Studies (IFS), 2025 (viewed on 2 June 2025)

continuation of existing services in the 75 local authorities that received Start for Life funding. We are investing £200 million over the Spending Review period in infant feeding, perinatal mental health and parent-infant relationship support. By focusing resources on sustaining the existing provision, we can maintain the quality and consistency of support while preserving the progress made to date in these areas.

In November 2025, local authorities received their provisional funding allocations for Best Start Family Hubs and Healthy Babies for financial years 2026 to 2029.

In December 2025, we published [Best Start Family Hubs and Healthy Babies - preparing for implementation April 2026](#) to support local authorities to plan for delivery from April 2026. The document sets out the definition of a Best Start Family Hub, expectations on hub location and branding requirements and explains how Best Start local plans should be developed and aligned with neighbourhood health plans.

In March 2026, we published [further guidance for local authorities](#), setting out our strategic vision for Best Start Family Hubs and Healthy Babies and clear expectations about how the core services should be delivered.

Recommendation 2

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.

We share the committee's ambition to ensure that all babies, children and their families, regardless of their circumstances, are able to access the support they need. We know that this is not the case for too many families; 1 in 4 families with children under 5, and 1 in 3 low-income families, are unable to access local family services, with [particular gaps for families experiencing disadvantage and children with additional needs](#).

On 23 February, DfE published the schools white paper, [Every child achieving and thriving](#), which included a commitment to invest over £200 million over 3 years to strengthen the special educational needs and disabilities (SEND) offer in Best Start Family Hubs. This includes funding a family-facing practitioner in every hub to support children with additional needs and their families from the earliest stages. As a result:

- parents will be better supported to understand their child's development

- emerging needs will be identified sooner
- join-up between early years settings, health visitors and SEND teams will be made easier

Local authorities will receive further guidance about this in the coming weeks.

Best Start Family Hubs are designed as welcoming, non-stigmatising spaces for all families, with a particular focus on those who are disadvantaged or have additional needs. We are working with 5 national voluntary, community and faith sector (VCFS) partners to reach families furthest from opportunity through targeted outreach and peer support. These partners understand cultural nuances, speak community languages and have built trust over time through their work with faith organisations, cultural centres and community groups that families already know and use.

Local authorities are expected to work with parents and carers as well as VCFS partners to develop outreach strategies targeting under-served groups - including minority ethnic communities, fathers, young parents and those experiencing inequalities in health. In addition, while Best Start Family Hubs themselves should be open and accessible to all, we have set the expectation that local authorities should choose sites carefully to prioritise disadvantaged children and communities; we have set an ambition, detailed in 'Best Start Family Hubs and Healthy Babies - preparing for implementation April 2026' that 70% of hubs should be located in the 30% most deprived areas nationally.

The government will continue to consider how best to support families from all disadvantaged backgrounds as the programme develops, drawing on evaluation findings and learning from delivery.

Recommendation 3

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.

Meeting a baby's social and emotional needs can be difficult, and many parents need support. Perinatal mental health difficulties are common for both mothers and fathers. [Approximately 1 in 4 women experience mental health problems such as depression or anxiety during pregnancy or in the 2 years after childbirth](#), while estimates

suggest 5 to 15% of fathers experience anxiety during the perinatal period and 5 to 10% experience depression.^{7 8 9 10}

We know that these difficulties are more prevalent among some communities; although white women have higher diagnosis rates, [those from ethnic minority backgrounds have higher levels of self-reporting on mental health symptoms](#). There is also evidence that suggests that women from black and minority ethnic backgrounds have poorer access to community mental health services.¹¹

As well as having an impact on parents and carers themselves, perinatal mental health difficulties have been linked to early bonding.¹² Secure attachments are associated with a range of improved outcomes for children, including emotional, social and behavioural adjustment, as well as school achievement.^{13 14 15 16}

Every new parent and carer should have timely, compassionate mental health support, if they need it, from the moment they learn their baby is on the way. Historically, there has been a paucity of preventative support for perinatal mental health and parent-infant relationships. Investment has predominantly focused on [perinatal mental health for mothers experiencing moderate-to-severe and/or complex mental health difficulties and](#)

⁷ Darwin, Z, and others. [Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire \(BaBY\) cohort](#), BMC Pregnancy and Childbirth, 2017 (viewed on 12 August 2025)

⁸ Cameron, E, and others. [Prevalence of paternal depression in pregnancy and the postpartum: an updated meta-analysis](#), Journal of Affective Disorders, 2016 (viewed on 12 December 2025)

⁹ Paulson, J, and Bazemore, S. [Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis](#), Journal of the American Medical Association (JAMA), 2010 (viewed on 12 December 2025)

¹⁰ Darwin, Z, and others. [Assessing the Mental Health of Fathers, Other Co-parents, and Partners in the Perinatal Period: Mixed Methods Evidence Synthesis](#), Frontiers in Psychiatry, 2021 (viewed on 28 November 2025)

¹¹ Jankovic, J, and others. [Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities - a population-based study](#), BMC Medicine, 2020 (viewed on 1 December 2025)

¹² O'Dea, and others. [Associations between maternal psychological distress and mother-infant bonding: a systematic review and meta-analysis](#), Archives of Women's Mental Health, 2023 (viewed on 12 February 2026)

¹³ Ranson, KE, and Urichuk, LJ. [The effect of parent-child attachment relationships on child biopsychosocial outcomes: a review](#), Early Child Development and Care, 2008 (viewed on 8 October 2025)

¹⁴ Cooke, J, Kochendorfer, LB, Stuart-Parrigon, KL, Koehn, AJ, and Kerns, AK. [Parent-child attachment and children's experience and regulation of emotion: A meta-analytic review](#), Emotion, 2019 (viewed on 3 January 2025)

¹⁵ Yang, Y, Li, S, Xie, F, and Chen, X. [The Association Between Parent-Child Attachment and Academic Adjustment: A Multilevel Meta-Analysis](#), Educational Psychology Review, 2024 (viewed on 23 September 2025)

¹⁶ Deneault, AA, Hamond, SI, and Madigan, S. [A meta-analysis of child-parent attachment in early childhood and prosociality](#), American Psychological Association, 2023 (viewed on 23 September 2025)

[complex relational difficulties](#). Through Healthy Babies, we are investing £109 million from 2026 to 2029 to complement this existing provision with a particular focus on:

- parent-infant relationships
- support for mild-to-moderate perinatal mental health difficulties
- perinatal mental health support for fathers and co-parents

Local authorities who received funding through the Family Hubs and Start for Life programme will already have established models. The investment in Healthy Babies will be used to:

- refine existing models
- establish continuous improvement
- work towards sustainability

While Healthy Babies services are universal and should be available to all families who need them, local authorities are expected to proactively identify and offer support to families at higher risk of poorer perinatal mental health outcomes, including families from ethnic minority backgrounds. Local authorities are expected to adopt targeted, evidence-informed outreach approaches to identify and engage families who are least likely to access support. Working with partners and communities they should proactively build trusted relationships, reduce barriers and ensure families can access the full range of support, regardless of their circumstances.

Recommendation 4

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 to 2 year period, to allow providers the maximum flexibility in how they deploy this funding.

The government recognises the importance of supporting children's development from the earliest stages of life and is committed to ensuring families receive support across the full 0 to 5 age range. Focusing on the early years is the foundation of delivering long-term, sustainable progress on improving outcomes for babies and children.

The opportunity mission and the Best Start in Life strategy set a clear ambition for local partners to work together to improve outcomes for children, both in the short and long term.

We have set statutory targets for each local authority to increase the proportion of children achieving a good level of development (GLD) at the end of Reception by 2028. As leaders of local systems, and with the strongest understanding of their communities, local authorities are well placed to design and deliver targeted action to address the barriers children face.

Support for parenting and the home learning environment (HLE) is critical to achieving these ambitions - what happens at home is one of the most significant influences on children's life chances. We are therefore asking local partners to maintain a strong focus on family services that support families across the full 0 to 5 age range, recognising the critical importance of the earliest years in laying the foundations for future learning and ensuring that universal support is available at every stage of early childhood.

The HLE and parenting support funding is intended for use across the entire 0 to 5 age range. This supports local partners to provide a comprehensive, evidence-based offer to families with babies, toddlers and preschoolers, and gives them the flexibility to tailor provision to local needs. As part of this offer, our guidance on evidence-based interventions (EBIs) is designed to help local areas adopt approaches with the strongest impact.

Open-access parenting support and home learning activities - such as stay and play sessions, peer support and community outreach - will continue to be available for families with children across this age range, including babies and toddlers. Within this broad 0 to 5 offer, we are asking Best Start Family Hubs to apply enhanced focus for families with children aged 3 to 4, who are approaching the point of assessment against the GLD in 2028. This means ensuring that evidenced-based interventions support children's socio-emotional, behavioural and language development to help prepare them for school.

EBIs for families of children aged 3 to 4 forms only one part of this wider service offer and are intended to sit within a universal package of parenting and HLE support for families across the full 0 to 5 age range. Together, the range of universal and targeted activities ensure that families receive consistent, practical help to support their child's development from birth to age 5.

The period from conception to age 2 remains critical, and Best Start Family Hubs will continue to provide a universal offer focused on prevention and support for healthy development. This includes co-location of midwives and health visitors, peer support sessions, stay and play activities, and community outreach - all of which help parents build strong relationships with their babies, promote early bonding and support development from birth. Those local authorities receiving Healthy Babies funding will be expected to have a strong focus on this period. This will include encouraging secure attachments

through support for parent-infant relationships as well as support for perinatal mental health and infant feeding.

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.

The new neighbourhood health service will bring together integrated neighbourhood teams of professionals and partners closer to people's home - nurses, doctors, social care workers, pharmacists, health visitors, employment support, children's services, and more - to work together to support people and places to improve their health and wellbeing.

As we roll out the reforms of the 10 Year Health Plan and Best Start in Life strategy, Best Start Family Hubs and Healthy Babies services will support the transition to a neighbourhood health service by strengthening the delivery and integration of services within the local community, with a focus on prevention and early intervention.

Best Start Family Hubs should be positioned as a core component of emerging neighbourhood health architecture, alongside neighbourhood health centres. They will provide a physical space for health services, including Healthy Babies services, to be delivered within the community.

It will be important for Best Start Family Hubs to establish strong links with neighbourhood health centres, which, subject to local decision-making, may deliver specific services for babies, children and their families.

When planning where to deliver Healthy Babies services, local leaders should consider the full range of community assets available, including Best Start Family Hubs, neighbourhood health centres and other trusted community venues, to improve access and integration.

Neighbourhood health is a new and evolving policy area. As local areas develop their neighbourhood health plans, they will have the opportunity to shape what it means for them, considering the unique needs of their community as well as the shape of their workforce locally. Aligning Best Start local plans with neighbourhood health plans will

support local areas to commission services and utilise their community assets in a way that ensures seamless provision of services for families with young children.

Health visiting

Recommendation 5

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 1,000 health visitors.

We agree that the child health workforce - including midwife and health visiting teams - are central to how we support families. Their contact with parents, carers and children of all ages provides vital advice and support and helps ensure that health, development and safeguarding needs are identified early.

We are committed to strengthening health-visiting services so that all families have access to high-quality, personalised support.

This objective will be met through long-term sustainable reform in light of the forthcoming 10 Year Workforce Plan. This will set out how the health workforce will support delivery of the reforms in the 10 Year Health Plan, including its proposed system shift to prevention. We are working through how the plan will articulate the changes for different professional groups.

Our 10 Year Health Plan committed to a professional strategy for nursing and midwifery, which is expected to be published in spring 2026. This strategy will set out a professional direction of travel, up to 2040, for all England's nurses, midwives and nursing associates. We cannot commit to a specific number at this stage, but we are working closely with regions in relation to the current challenges for releasing staff to fill commissioned training places.

It is our intention to improve the capacity of health-visiting services, including through the development of a safe staffing tool, which will be developed over the next few years.

Recommendation 6

We are also highly concerned about the variation in performance among 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.

We recognise that there is unwarranted regional variation in the quality of health-visiting services and addressing this is an active priority. The latest published annual health visitor service delivery metrics for 2024 to 2025 show less variation in performance for the 2 to 2-and-a-half year review across local authorities compared to the 2023 to 2024 data quoted in the committee's report. In fact, the overall uptake of this review is at its highest level in recent years (80.8% in 2024 to 2025) and is [above pre-pandemic levels of delivery](#).

Through its regional public health teams, DHSC has already been carrying out rapid performance improvement activity with local authorities to improve uptake and quality of the 2 to 2-and-a-half year review, as part of the government's commitment for 75% of children to be achieving a good level of development at the age of 5 by 2028. We have also looked to ensure that delivery and reporting of the review takes place within the recommended timescales required for inclusion in national data sets.

To ensure continued strengthening of service quality and to promote consistency across the country, we have recently refreshed the healthy child programme guidance, which sets requirements for the commissioning and delivery of health-visiting services to make it clearer and reduce variation.

Local authorities' vital public health work is reflected in the [Local Outcomes Framework](#) (LOF), which signals the priority outcomes the government expects local authorities, working with local partners, to deliver over the spending review period. This includes important child health outcomes, which DHSC will monitor.

DHSC also carries out assurance of local authorities' public health grants and has also set the expectation that from this year every local authority will undergo an external peer review every 5 years. This will help each local authority develop a comprehensive, evidence-based understanding of its strengths and challenges. The peer reviews will be complemented by a programme of improvement support to help local authorities improve public health services and adopt best practice. It will also give local authorities better access to expert support to help build their capabilities and improve health outcomes locally.

We have also launched a quality improvement partnership forum to support roll out of best practice for the healthy child programme, including health visiting.

Recommendation 7

We recommend that the government commit to increasing the number of mandatory health visitor contacts for children in England from 5 to 6. 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.

Mandatory health and development reviews play an essential role in identifying issues and supporting families. We agree that getting this service right is essential. We work regularly with the devolved governments to share learning. Each country has different population sizes, structures and issues.

In Wales, families get a new birth contact and further contacts before 6 weeks if needed, then at 6 months, 15 months, 27 months and 3-and-a-half years. Antenatal visits are only offered under certain circumstances such as first baby. There are also offers of clinic appointments between 8 and 16 weeks to review the baby's growth and encourage immunisations. The Welsh Flying Start programme is offered in certain areas with high deprivation and includes enhanced health visiting. Geographical limitations result in mixed service provision for families with similar need. Wales is currently reviewing the evidence of value for their Healthy Child programme.

In Scotland, the child health programme is provided by NHS Scotland. This provides 8 home visits to all families in the first year of life (new baby, 2 at 3 to 5 weeks, 6 to 8 weeks, 3 months, 4 months, 6 months, 8 months) and 3 child health reviews between 13 months and 4 to 5 years. All visits should be offered in the home by health visitors with the aim of building strong relationships. Scotland also offers babies or carers who need it a sustained additional support (more than 3 month), which may include enhanced health visiting.

In England, the service is based on proportional universalism, so everyone gets support based on need. The 5 statutory health and development reviews for children aged 0 to 5 occur at crucial developmental and clinical timepoints (antenatal, new baby, 6 to 8 weeks, 9 to 15 months and 2-and-a-half years) and we recommend 3 additional contacts for children where possible (3 month, 6 month and 3 years). Those with the greatest need should receive a specialist, and more intense, level of service regardless of geographical location.

We will consider how we can continue to improve the service as we deliver the 10 Year Health Plan's shifts to community and prevention.

Workforce

Recommendation 8

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 1,000 days that, as a minimum, ensure that safe staffing ratios are delivered in all settings.

The 10 Year Workforce Plan will take a sustainable approach to workforce planning and ensure the NHS has the right people in the right places with the right skills to care for all patients, including children and young people, when they need it.

We recognise the committee's concern that a workforce plan must be credible, funded and deliverable. The plan will therefore set out a clear and phased delivery roadmap for all relevant staff groups, including those providing maternity, neonatal, health visiting, paediatrics, primary care and mental health services for babies, children and families in all settings. It will detail the actions required across recruitment, training, retention, skill mix, leadership and service redesign to address workforce pressures and build long-term sustainability.

We have committed to publishing regular workforce planning. The 10 Year Workforce Plan will include updated workforce modelling and its underlying assumptions when published in spring 2026. The updated modelling will be subject to independent scrutiny by our appointed external scrutiny panel.

While we recognise workforce challenges, we have been clear in the 10 Year Health Plan that workforce growth must slow to ensure the NHS workforce is on a sustainable footing for a future where staff are better treated, have better training, more exciting roles and are empowered to achieve much more.

We continue to work through how the plan will articulate changes for individual professional groups. We remain committed to working with partners to ensure the plan is ambitious, forward looking and evidence-based.

While the plan will be grounded in the best available data, modelling and clinical evidence, it would not be responsible to attempt to fix precise workforce numbers a decade into the future. Demand, technology, new roles, productivity improvements and models of care will continue to evolve, and so will our workforce planning. The plan therefore needs to be agile and responsive to change, setting out the actions needed to create a sustainable workforce that is fit for the future.

Recommendation 9

Many professions which play a key role in delivering children's healthcare 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 professionals can play in such teams.

Delivering the integrated care that people need relies on a range of professions from across NHS and non-NHS settings. Every day, [allied health professionals play a crucial role in treating, rehabilitating and improving the lives of patients](#). We know that healthcare is dependent on non-NHS services - such as social care, public health, local authorities and voluntary, community and faith sector organisations - to deliver the joined-up, quality services that service users expect.

While the scope of the 10 Year Workforce Plan is the NHS workforce, for this shift to be meaningful, multidisciplinary working and effective links with social care, public health and the voluntary, community and social enterprise sector will be vital.

There has been a long-concerted effort as part of the commissioning for national programmes to support multi-professional practice with children and young people, with a range of different multi-professional practice roles being commissioned. This includes allied health professionals such as child and adolescent psychotherapy and psychology as well as children's therapists that work alongside registered nurses and other professionals within acute community and mental health settings.

The 10 Year Workforce Plan will without doubt maintain the focus on these important roles as an overall package to support both the physical and mental health of children and young people.

In February 2026, [Information sharing in Multidisciplinary Teams \(MDTs\)](#) guidance was published, setting out how information should be used and shared safely across MDTs. We

are currently implementing these improvements across the NHS. We expect the messages to be reiterated in future neighbourhood health work. This will bring together integrated teams of professionals and partners closer to people's home, to organise health and care services around the needs of individuals more broadly, and not just their clinical needs.

Vaccinations

Recommendation 10

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 1,000 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.

It is vitally important that everyone has their recommended vaccinations.

DHSC is working with NHS England and the UK Health Security Agency (UKHSA) to encourage high uptake of all childhood immunisations, including in under-served communities and in groups with historically lower vaccination rates. Although annual data for April 2024 to March 2025 shows that vaccination coverage for children aged 24 months was stabilising, the latest quarterly data for July to September 2025 shows declines across the UK childhood immunisation programme are continuing.

There is more to do to improve uptake. That is why we have set out actions to improve uptake in our 10 Year Health Plan and our Best Start in Life strategy. To emphasise the benefits of vaccination for both individuals and the wider community, and to strengthen confidence in immunisation, we are delivering a national communication campaign across 2025 to 2026, which proactively highlights the value of vaccines and the risks associated with vaccine preventable diseases and builds confidence in vaccine efficacy and safety.

We are also exploring new ways of delivering vaccinations, including health visits and community pharmacy - with pilots for administering vaccinations as part of health visits stood-up also from January 2026.

Government partners are also working with healthcare professionals to ensure they are adequately equipped to discuss immunisations with concerned patients, as we recognise that the best recourse for patients with questions on vaccination is local healthcare professionals.

Finally, we are working to improve the consent process to help children get vaccines at school and, during 2026 to 2027, we will give parents access to their child's vaccination health record through the My Vaccines hub on the NHS App.

The 95% optimal performance standard for a variety of childhood vaccinations remains an established NHS target, as set out in the published [NHS public health functions agreement 2025 to 2026](#), the agreement that sets out national vaccination and screening objectives. It reiterates World Health Organization coverage targets for childhood and pregnancy vaccinations.

The [2025 to 2026 planning guidance](#) supports the shift towards prevention, stating: 'It remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and screening services.'

The NHS Oversight Framework 2025 to 2026, which sets out the approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts through a suite of metrics, also includes the measles, mumps and rubella (MMR) vaccine uptake rate as a non-scoring contextual metric, which gives an indication of NHS bodies' effectiveness.

Recommendation 11

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 current 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.

The commitments set out in our 10 Year Health Plan to improve vaccination uptake build on the framework described in the [NHS vaccination strategy](#).

The NHS vaccination strategy sets out a detailed long-term direction for improving vaccine uptake and equity across all communities in England, emphasising the importance of a consistent and accessible 'front door' to vaccination, with community engagement and outreach built into local services to address health inequalities, including that ICBs should have a named executive director responsible for vaccination, which is now in place.

It also included plans to deliver new digital systems so parents can access their children's vaccination record and book appointments on the NHS App, and test new ways to deliver

vaccinations, for example by piloting the delivery of vaccinations through community pharmacies and as part of health visits.

The approach set out actions to ensure clear and consistent communications between the NHS and parents, and to improve provider data capture and flow to increase data accuracy and visibility. These activities were rightly identified in the evidence received by the committee as having the potential to increase vaccine uptake, as well as the health visitor delivery model, which was also described in the strategy.

But it is delivering the changes outlined in the NHS vaccination strategy and 10 Year Health Plan that will make a difference. Actions already delivered to increase maternal and childhood vaccine uptake include:

- every ICB now having a board-level vaccination lead with structured plans to boost uptake in their area
- introducing a digital service to improve data capture, flow and reporting of vaccination data and the visibility of vaccination history for health professionals in maternity settings
- piloting a new digital service - 'MyVaccines' - that will enable parents to access their children's vaccination record and book appointments on the NHS App
- dedicated funding in place to support targeted outreach to underserved communities
- community pharmacies delivering flu vaccinations to 2 and 3-year-olds as a pilot in the 2025 to 2026 season
- making respiratory syncytial virus (RSV) and whooping cough vaccines available through selected community pharmacies in underserved areas for pregnant women
- requiring GPs to focus on maternal vaccinations in 2024 to 2025 and on human papillomavirus (HPV) vaccinations in 2025 to 2026 through their annual vaccination campaign
- introducing a financial incentive in 2025 to 2026 for GPs to administer childhood vaccinations by increasing the payment made for delivering a vaccination

As highlighted in evidence to the committee provided by the Child Health Unit, it is important to focus on maternal vaccination rates to support the health of mothers and babies and future vaccinations. The actions described above in the maternity setting, when combined with a national communications campaign, have contributed to a significant

increase in maternal pertussis uptake, from beneath the 60% optimal performance standard in April 2024 (58.9%) to a [significantly higher level a year later in April 2025 \(72.6%\)](#).

In addition, where we have taken action to deliver targeted outreach for MMR, we have seen [increases in uptake in underserved communities](#). Our new digital systems are improving the way people access their vaccinations, with significant improvements seen in school-aged vaccination consent rates, staff and patient satisfaction and workforce efficiency.

We recognise that childhood vaccination rates need to improve and the government, NHS England and UKHSA are committed to making that happen.

Recommendation 12

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.

Between January and March 2026, we are standing up 12 pathfinder sites in England to test options for administering a supplementary offer of vaccinations to babies and young children as part of health visits. The core offer of vaccination for this age cohort remains with general practice.

Pathfinders have planned their approach to case finding and population coverage in line with these contracts, and staffed them appropriately to enable them to deliver. The majority of the pathfinder workforce has been recruited and trained ahead of going live. In most cases, 12-month employment contracts have been issued, as it was not possible to attract staff for shorter contract terms.

Delivering a supplementary offer of vaccination through health visiting teams represents a significant shift and the evaluation is essential to better understand and inform decision-making on:

- optimum operating models and what would be needed to enable delivery of these models, given challenges in health visitor workforce capacity
- cost implications and value for money (we anticipate that this will be an expensive delivery model compared to the core offer, so would want to understand its impact and the benefits before committing to roll out more widely)

- how we can best support systems and providers to confidently utilise this service model to support local families and communities, and to improve vaccination uptake in the future

We are evaluating pathfinders for 12 months, reflecting our judgement on what is needed to produce robust evidence that will guide important decisions for further roll-out.

NHS England commits to sharing learning in real time wherever possible, to support non-pathfinder systems to explore whether this model could address identified local need and could be funded within existing funding allocations. As an example, we have opened the face-to-face pathfinder training sessions up to a select number of non-pathfinder teams where they have expressed an interest in exploring the model.

Integration between services

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.

DfE, DHSC and NHS England are jointly overseeing a series of single unique identifier pilots, ahead of legislation which will introduce regulation on the matter. There are currently 2 ongoing pilots, with a third planned for 2026. The purpose of the pilots is to explore the logistical implementation issues of applying a single unique identifier across health and social care sectors, focusing on the use of the NHS number. DHSC and NHS England are content to provide biannual updates on the progress of the pilots.

Recommendation 13

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 2, as a first step to minimising delay in accessing services at this critical stage in a child's development.

While the majority of reported NHS-commissioned children and young people community service waiting times occur beyond the first 1,000 days of life, work is underway within Community Health Services to improve data granularity by transitioning from aggregate SitRep reporting to collecting record-level data. Once this transition is complete, demographic data, including age, gender, ethnicity and geographic location data, will be reported. Although separate reports will not be published by age group, data will be extractable for children and young people under the age of 2. The timeline for transferring community waiting time reporting to record-level waits is still being confirmed.

The government has already delivered on a commitment to publish demographic data, as part of the waiting list minimum data set (WLMDS). This means for the first time we publish the number of waits where the patient is under 18, and how many of these are waiting below 18 weeks and over a year for consultant-led treatment.

There are currently no plans to disaggregate this data further at a national level. Publishing that level of granularity is restricted by statistical disclosure rules if numbers are very low. This is particularly true at provider level. However, providers already collect and have access to this data at a local level, and have a responsibility to ensure they are using it to target the waiting list accordingly, and to enable appropriate care and positive outcomes for patients of all ages.

In the longer term, it may be possible to include more granular WLMDS data publication nationally through the NHS Referral-to-treatment (RTT) dashboard, with the appropriate disclosure control applied through that data processing. However, its prioritisation will need to be balanced with ongoing resource constraints.

Recommendation 14

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.

NHS England provides information governance (IG) guidance to health and care organisations on its [IG Portal](#). This guidance is approved by national stakeholders, including the National Data Guardian and the Information Commissioner's Office.

Existing guidance:

- sharing for direct care statement: in 2023 there was a [joint call to action](#) from the National Data Guardian (Dr Nicola Byrne), the Information Commissioner (John Edwards) and the Chief Medical Officer for England at the time (Professor Chris Whitty) to all health and care staff. This encouraged frontline workers to share

individuals' health and care information more confidently across organisations and disciplines, to provide them with the best possible care

Planned guidance:

- model data-sharing agreement for sharing safeguarding data: NHS England and DHSC are working with DfE and the Home Office to produce a nationally approved model data-sharing agreement with an accompanying template data protection impact assessment to cover the sharing of safeguarding information between children's safeguarding partners. We are currently engaging with colleagues across health, social care, education and policing to ensure the content is fit for purpose across each setting. The templates will be publicly consulted on and embedded into the Children's Wellbeing and Schools Bill statutory guidance. This work will reduce burden upon local organisations and bring about a consistent and legally sound approach to the sharing of children's safeguarding information
- proxy access guidance: the report cites the Royal College of Paediatrics and Child Health (RCPCH) warning that there are issues around consent for sharing data and what age a child becomes an adult. We are currently producing guidance to support the [proxy access information standard](#) which will communicate to health and care organisations the importance of age milestones for children and young people consenting to sharing their information through the NHS App and becoming advocates for their own health information, versus younger ages where parents or carers have responsibility for making information sharing decisions on the child's behalf. Although the standard and guidance are specifically related to sharing children's information via the NHS App or other patient portals rather than information sharing in a more general sense, it will give health organisations more robust advice to follow regarding consent and parental responsibility for children at different ages
- other support to IG professionals: in addition to published guidance, we support IG professionals through our networks, including our fortnightly Data Protection Officer Webinars and our Data IG and forum for ICBs. Next year we will be piloting IG surgeries where IG professionals can bring complex data sharing issues and the 'surgery', comprising a group of IG professionals, will collectively problem solve. We hope that this will help unblock local barriers to sharing and allow best practice to be shared
- Control of Patient Information Regulations (COPI): DHSC is making changes to the COPI Regulations 2002 to make it easier for NHS bodies to share data for operational purposes and to improve services. This will include a public consultation, to ensure that we hear a wide range of views and can be confident that intended

changes both meaningfully address barriers to data sharing and maintain public trust in how data is used

Recommendation 15

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.

The government welcomes the committee's recognition of the importance of a shared outcomes framework and notes the recommendation regarding implementation planning and ministerial accountability.

On 9 February 2026, the Ministry of Housing, Communities and Local Government (MHCLG) published the LOF, which signals the priority outcomes that the government expects local authorities, working with local partners, to deliver over the 3-year Spending Review period. One of these priority outcomes is 'Best Start in Life - Improve early child development and health through improved family support and high-quality early education to give children in every part of the country the best start in life.' The LOF contains several metrics relating to children's health and wellbeing across ages, including the:

- proportions of children achieving a good level of development at 2 to 2-and-a-half and at 5
- percentage of 5-year-olds with experience of visually obvious dental decay
- rate of children looked after per 10,000 children

In 2026, DHSC will deliver a new improved Public Health Peer Review and External Support and Improvement Offer for local authorities through regional public health teams. This new support offer will help local government achieve more from public health funding and deliver on the local and national public health priorities, including but not limited to those included in the LOF.

Best Start Family Hubs and Healthy Babies is delivered in partnership by DfE and DHSC. The departments continue to work closely together on the design and delivery of family services, including through the development of the Best Start in Life strategy and the ongoing Healthy Babies programme.

The government is committed to exploring whether a more detailed national outcomes framework, based on lessons from Every Child Matters, would improve join up of services locally.

Children's outcomes are a shared and collective responsibility, and isolated services will not transform life chances. As set out in our schools white paper, we will create a new model of local partnership and shared accountability for children's outcomes across local communities. Our aim is to enable the conditions that allow a sense of collective endeavour and responsibility, binding local government, schools and trusts, integrated care boards, the police and other local stakeholders around the aim of delivering shared outcomes for children and young people.

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