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A preventive and integrated approach to early child development: What's Missing?

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1 Introduction

This is one of two companion documents addressing the next steps towards a preventive and integrated approach to early childhood development. This document captures 'What's Missing'. The companion document responds to what's missing and recommends 'Next Steps'.

2 The evidence for a preventive, integrated approach

In recent years authoritative studies in both England and Scotland have recurringly signalled the importance of a switch by public services to both more integrated and preventive approaches.

In 2010 'Prioritise Prevention' was a 'Priority Objective' of the Marmot Review[1], which also states: 'An important step in tackling the social determinants of health at a local level would be greater integration of health, planning, transport, environment and housing…'

2011 brought a series of such reports. The Allen Review's[2] (January 2011) recommendation four to Government is 'an essential shift to a primary prevention strategy'. The Review also welcomes Health and Wellbeing Boards as appropriate bodies to allow local authorities to promote integration of health, adult social care and children's services.

In May 2011 the Munro Report[3] stated that preventative services can do more to reduce abuse and neglect than reactive services and that 'preventative services to support parents are a key strategy'. Munro links this principle to integration, saying that 'coordination of services is important to maximise efficiency'.

The joint Department for Education (DfE)/ Department of Health (DH) report Supporting families in the Foundation Years[4] (June 2011), which drew on the Allen, Field, Munro and Tickell reports, emphasised the importance of early years' preventive programmes and services to ensure best outcomes for children, stressing that these should begin in pregnancy.

Developing the NHS Commissioning Board[5] (July 2011) set out features that characterise the culture of NHS England and the Healthy Child Programme, emphasising prevention, and promoting integration, working across boundaries and working in partnership.

While these reports were being produced in England, in Scotland the Christie *Commission on the future delivery of public services*[6] (June 2011)

was stating 'we must prioritise spending on public services which prevent negative outcomes from arising'. Further: 'A cycle of deprivation and low aspiration has been allowed to persist because preventative measures have not been prioritised. **It is estimated that as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach.'** They are also clear that integration is part of the answer, stating: 'Unless Scotland embraces a radical, new collaborative culture throughout our public services, both budgets and provision will buckle under the strain.'

2013 brought further reports recommending prioritising integration and prevention. In January the National Audit Office report *Early Action*[7] stated that a shift from reactive to preventative spending could improve value for money from public spending 'although the political and practical challenges are considerable'. In March the National Audit Office report *Integration across government*[8] stated that 'Integration of public services and programmes offers government the potential for substantial cost savings and service improvements'. The report also states: 'Better integration of health and social care services is a key priority for the NHS and local authorities', further observing that 'Integration requires strong commitment on the part of all implementation bodies to realise the potential benefits', with the need for a shared vision for integrated working.

Also in March 2013, in the joint DfE/WAVE Trust report *Conception to age 2 – the age of opportunity*[9], the evidence for a preventive approach to early childhood development and child maltreatment was presented with detailed recommended actions. The economic case was set out, showing that primary prevention in the early years has the possibility to be extremely cost-effective, resulting in significant savings both locally and nationally.

In September 2013 the Society of Local Authority Chief Executives, SOLACE, report *Principles for Health and Social Care Reform*[10], stated: 'There is now a broad recognition in public policy that the balance between 'reactionary' and 'preventative' spend must change. This can be seen in numerous policy areas: in children's services, in employment and in public health.' This report, too, calls for more integration, stating: 'The return of public health to local government also offers the opportunity for an integrated, place-based approach to wellbeing.'

It is not the role of this document to repeat the evidence so expertly marshalled in the ten documents above, and many others such as Frank Field's *The Foundation Years: preventing poor children becoming poor adults*[11].

Our focus is why, despite all these authoritative and often government-backed reports, in many and probably most local areas across the country prevention and integration are not happening, or are not happening to any significant degree. Indeed, we in WAVE receive many reports from anguished front-line workers telling us that far from being prioritised, prevention services are being cut as statutory services receive priority in a landscape with less and less money to go around.

This 'What's missing' document sets out the results of a series of interviews carried out with local authorities and professionals in the field of early years, to identify what they believe are the main barriers to adoption of a preventive and integrative approach to early child development and disadvantage, and to determine what are the conditions required to promote a preventive and integrated approach to early child development in practice. Those interviewed ranged, in local areas, from Clinical Team Leaders through Heads of Early Years, Prevention and/or Early Intervention, Heads of Children's Services and Lead Officers for Health, Heads of Joint Commissioning, Commissioning Advisors and Commissioning Directors, and Directors of Children's Services, People, Public Health and Strategy, and two local authority Chief Executives. The early years' experts consulted came from CAMHS, the Institute of Health Visiting, Family Nurse Partnership, the NHS Alliance, the Royal College of Midwives, Public Health England, as well as professors and expert consultants. We believe their views are representative, though we were more successful in getting local responses from local authorities than from health trusts.

3 What are the barriers to a preventive approach?

We asked local areas and early years' professionals: why, despite such overwhelming expert support for a preventive approach to early child development, it is not happening?

The principal barriers identified related to:

- funding constraints
- lack of knowledge of, or lack of confidence in, the evidence base
- lack of leadership
- factors which encourage short-term commissioning; and
- absence of clear government policy.

This section of the report summarises the main barriers described by our respondents.

Funding

Respondents identified the principal barrier to adoption of preventive policies as being lack of available funds, citing in particular the impact of continuing local government funding reductions. This was highlighted by one Director of Children's Services, who said 'Given the level of savings that local authorities are required to find over the next four years (in our case around £100 million) it will become more and more difficult for local authorities to fund services which are non-statutory'. Several respondents commented on the fact that funding for reactive but statutory requirements in their areas was being prioritised over spending on prevention.

Some respondents, who identified funding as a core issue, emphasised the barriers created by lack of government investment in primary prevention, together with the absence of an NHS imperative to provide preventive or health-promoting services. Many identified as problems the lack of funding specifically targeted at prevention in the early years and a lack of direction from government to spend money in a preventive way. Others pointed to more local factors, such as risk averse local cultures, short-term decision-making with pressures to deal with current problems rather than looking at future needs, and the length of time taken to see a return on investment. Some mentioned the rising demand for statutory services, caused by demographic factors. Some in (or close to) commissioning pointed out that, in the health services, financial incentives to invest were weighted against prevention.

Evidence base

A second major barrier perceived by our respondents related to the evidence base for prevention. Despite the many formal reports and significant amounts of research concluding that prevention is the best strategy for child development, we were told there is still commonly a lack of awareness of the arguments for prevention in local areas. In addition, a number of people cited the lack of a robust UK evidence base in terms of economic value and effective preventive interventions as further hindering the shift. Respondents also identified a lack of understanding of the evidence at a senior level and the accessibility of the evidence at all levels to be a barrier.

Leadership

A further commonly highlighted limiting factor related to leadership. Our respondents suggested that a lack of consistent, strategic and committed leadership, both locally and nationally, was a major restrictive factor inhibiting a shift to a preventive approach. Poor quality leadership resulting in a lack of strategic direction is a potential issue for some local areas, and is compounded by a lack of innovation and bravery in decision making.

Commissioning

There was a view that practices in commissioning were acting as barriers to shifting to a preventive approach. A recurring theme was that commissioning was short-term in its focus, typically year to year, and that this does not support prevention and thinking ahead to longer-term consequences. A number of respondents commented on the risk averse culture in local commissioning. According to some respondents, there is not effective use of commissioning 'levers' that could drive a preventive and integrated approach.

Government guidance and direction

A number of respondents felt the core of the problem was the absence of a clear government instruction or political drive to promote investment in prevention. While this 'top-down' approach may run counter to government's stated philosophy, there are policy areas where such instructions are issued – and central government could be said to be picking up a very expensive tab for failure to prevent at local level through costs in educational waste, welfare, criminal justice, addiction and later life health problems (see Christie Commission, above). Others pointed to the inspection framework and its focus on safeguarding rather than prevention, and the absence of an NHS imperative to provide primary prevention or health promoting services. Lack of priority to perinatal mental health was also mentioned.

Other factors

A number of responses referred to a **lack of understanding**, both of the evidence behind a shift to a preventive approach and what this would mean and look like in practice. Some suggested that there is not a universal understanding of the importance of attachment and attunement at all levels of the workforce and also from the community. A lack of understanding of the early years' field by people in leadership positions was also indicated as a barrier.

Other people mentioned that the **organisational culture** can often inhibit a change in approach, for example, from curative treatment to preventive services.

Another set of comments related to **workforce training, knowledge and skills**. The quality of the early years' workforce was highlighted as a barrier to a shift to a preventive approach. Some respondents identified a failure to appreciate the value of well supported, qualified and expert practitioners as a key restriction. Finally, the lack of professional development in the workforce often means that there can be teams working in the early years without sufficient knowledge, skills and qualifications.

4 What are the barriers to integration in children's health and wellbeing services?

We also asked local areas and early years' professionals: why, despite such overwhelming expert support, is an integrated approach to early child development not happening?
The principal barriers identified related to:

- organisational culture
- information sharing
- other factors including lack of integrated budgeting or commissioning.

This section summarises the main barriers described by our respondents.

Organisational culture / attitude shift

Respondents identified that the organisational culture and attitude present in organisations can often inhibit integration. Territorial thinking and silo working are common and are the antithesis of an integrated approach. Some commented on the combination of these factors with a desire by both individuals and organisations to remain in their comfort zone. Other restrictive factors cited included (i) unilateral decision-making without consultation across partnerships, and (ii) local power struggles between different organisations.

Information sharing

Difficulties in appropriate information sharing were identified as significant issues detrimental to a shift to an integrated approach. Respondents suggested there is a lack of confidence about the security and confidentiality of shared information. In addition IT systems are often incompatible or don't translate shared data well.

Other factors

Other issues which were identified included a lack of integrated approaches to budgets resulting in 'territorialism' rather than thinking about total resource. Particularly problematic issues were identified where commissioning was not truly 'joined-up' or integrated. Furthermore, there was concern from some areas that commissioners did not have a true understanding of the reality of what happens in practice. A lack of professional respect between organisations was highlighted as a destructive factor. So too was the presence of strict professional and organisational boundaries that hinder effective partnership working and appropriate information sharing. Finally, some respondents were concerned that the dominance of focus on adult integration in national policy and publications was a barrier to integration in services for children.

5 What can we do? Next steps

We also asked local areas what they believed would be required to overcome these barriers in order to see a shift to a preventive, integrated approach to the earliest years. The companion document 'Next Steps' summarises the conclusions from this part of the study.

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