Best Start in Life: Evidence review

Final version

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<tbody>
<tr>
<td>BSiL</td>
<td>Best Start in Life</td>
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<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
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<tr>
<td>CEYSP</td>
<td>Childcare and Early Years Survey of Parents</td>
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<tr>
<td>CHAOS</td>
<td>Confusion, Hubbub and Order Scale</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DWP</td>
<td>Department for Work and Pensions</td>
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<tr>
<td>ECCE</td>
<td>Evaluation of Children’s Centres in England</td>
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<td>ECEC</td>
<td>Early Childhood Education and Care</td>
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<td>ECERS</td>
<td>Early Childhood Environmental Rating Scale</td>
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<tr>
<td>EEF</td>
<td>Education Endowment Foundation</td>
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<td>EIF</td>
<td>Early Intervention Foundation</td>
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<tr>
<td>EPPSE</td>
<td>Effective Pre-school, Primary and Secondary Education</td>
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<td>EYFS</td>
<td>Early Years Foundation Stage</td>
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<tr>
<td>FNP</td>
<td>Family Nurse Partnership</td>
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<td>HCP</td>
<td>Healthy Child Programme</td>
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<td>ITERS</td>
<td>Infant and Toddler Environmental Rating Scale</td>
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<tr>
<td>NESS</td>
<td>National Evaluation of Sure Start</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>QED</td>
<td>Quasi-experimental design</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<tr>
<td>PISA</td>
<td>Programme for International Student Assessment</td>
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<td>SEED</td>
<td>Study of Early Education and Development</td>
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<td>SSLP</td>
<td>Sure Start Local Programmes</td>
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Summary

Newham’s Best Start in Life (BSiL) programme is an integrated early years support model which provides universal and targeted support to families, ranging from information advice and guidance and sign posting, to group activities and family support. The aim of BSiL is to improve outcomes for children and parents. This evidence review was commissioned by Newham Council to assess the evidence for the BSiL approach and outcomes. The report will inform the Mayor’s review of BSiL.

Aims and approach

The aims of the evidence review were to:

1. Assess the quality of the evidence base for the existing Best Start in Life model, covering four aspects of the guarantee: early education; stay and play; parenting interventions; and health support.

2. Identify the most effective interventions for achieving the Best Start in Life outcomes: school readiness; parenting aspirations, self-esteem and parenting skills; and child and parent health and life chances.

The search focused on UK evidence since 2010, although the scope was broadened where evidence was lacking or to in order to include significant relevant research.

Findings

Early education

There is a strong evidence base for improving school readiness through early education. Early education for three and four year olds is associated with consistent positive effects on cognitive, language and social development. Outcomes of two year old early education are more mixed with some negative as well as positive outcomes.

The effectiveness of early education is strongly influenced by two factors: the child’s home environment and the quality of the Early Childhood Education and Care (ECEC) provision. Children from disadvantaged backgrounds benefit the most from high quality early education and provision, while poor quality provision can have neutral or negative effects.

Evidence for the particular benefits of the government funded part-time places for two, three and four year olds is not yet established although research designed to specifically address that question is underway. The effects on children of the forthcoming extension to 30 hours is also not yet clear. However, if the policy results in higher incomes for disadvantaged families, the children will be likely to benefit from improved family context as well as through the early education.
Stay and play

The review found very little high quality evidence on stay and play. The informal nature of the provision means that it is not well-suited to large-scale, robust impact evaluations. However, recent evidence from the national evaluation of children’s centres confirms the value of stay and play as a way for children’s centres to engage vulnerable families. In the same evaluation, children's centre staff spoke about the importance of stay and play for identifying needs, providing additional support and modelling positive parent-child interactions. The positive effects of stay and play on parenting and home environment outcomes provide some evidence to support this. Overall, evidence suggests that stay and play is not the most effective intervention for promoting school readiness and parenting outcomes but may help to build the relationships with families that enable them to participate in other, more focused interventions.

Parenting interventions

For most parents, the universal health services provided through the Healthy Child Programme (HCP) are sufficient to achieve positive outcomes but parents who are disadvantaged are more likely to need additional support. The evidence is strongest for parenting interventions that are targeted at early signals of child development risk such as attachment, behavioural self-regulation and language development. A number of programmes have been shown to be effective when targeted at specific needs and are widely delivered in the UK. Example effect sizes from individual studies include: Triple P (0.61), Incredible Years (0.63), Family Nurse Partnership, Family Foundations (0.21 - 0.46 across different outcomes) and Empowering Parents, Empowering Communities (0.38) Areas identified as requiring further research include the impact of universal methods of parenting support (through leaflets, apps and websites), interventions focused on specific groups including fathers and parents with learning difficulties and the long-term effectiveness of parenting support.

Health support

The HCP is supported by a strong evidence base, focusing on six high impact areas where health support is considered to be most effective and structuring interventions around four levels of service across a spectrum from universal to targeted support. The evidence for effective interventions is probably strongest for maternal mental health with clear guidance on when facilitated self-help approaches, high intensity CBT or medication is required. There is also strong evidence for the impact of specific health programmes supporting early attachment, the instigation and continuation of breastfeeding; promoting healthy weight and increasing home safety. The evidence is less strong for the impact of antenatal classes on pain in labour, low birthweight and the onset of maternal depression. Overall, a strong case has been made for early intervention based on evidence from the UK and other countries over decades. Since inequalities are established early in a child’s life and become self-reinforcing, early intervention can help alter a child’s trajectory.
Evidence and implications for the BSiL model

Overall, there is strong evidence to support the BSiL model.

- The intervention most directly effective for **school readiness** is early education. Universal support delivered through the HCP is also important for school readiness through enabling parents to support positive child health and development. Targeted parenting interventions where children have specific needs have beneficial outcomes relating to school readiness.

- **Parenting aspirations, self-esteem and parenting skills** are effectively supported by midwives and health visitors from before birth. The most effective interventions for addressing difficulties with parenting are targeted at early signals of risk and include Triple P, Incredible Years and Family Nurse Partnership. Delivering evidence-based programmes according to the model is essential for effectiveness.

- Interventions aimed at **child and parent health and life chances** delivered by health visitors within the ‘4-5-6’ health visiting model have a strong evidence base, reflected in NICE guidelines.

For some of the detailed aspects of service delivery (such as adult-child ratios and skills needed in health visiting teams), the evidence is sparse. There are also areas within each area of BSiL provision where further evidence is needed. However, the way in which the elements of the BSiL model are combined and delivered is strongly supported by the evidence. In particular: (1) the spectrum of universal to targeted services, responding to level of need, is aligned to the social gradient in health outcomes; and (2) the integration of services and partnership working within the children’s centre context supports holistic support and early intervention for families and children, particularly those who are vulnerable and ‘hard to reach’.
1 Introduction

1.1 The Best Start in Life guarantee and outcomes

Newham’s Best Start in Life programme (BSiL), introduced in April 2016, represents a strong commitment to provide universal and targeted support to improve outcomes for parents and young children in the borough. The programme is embedded in a new service delivery structure characterised by the integration of childcare, children’s centre and early years’ health provision and a neighbourhood ‘hub and spoke’ children’s centre model led by schools which is intended to ensure access to local services. A range of free, universal services is guaranteed to every family, with targeted elements, with the intention of improving school readiness, child and family health and parenting aspirations (Figure 1:1).

Figure 1:1 The Best Start in Life model

BSiL is part of the wider ‘resilience agenda’ in Newham which aims to build personal, economic and community resilience to improve outcomes¹. Newham faces significant challenges as a result of residents’ economic disadvantage and transience. This

¹ https://www.newham.gov.uk/Pages/Services/Resilience.aspx
programme provides continued investment to improve the integration of services providing early intervention support for young children and families.

1.2 Aims and scope of the review

Newham commissioned this evidence review to provide a robust independent assessment of the Best Start in Life model based on the literature. The evidence review will feed into the wider BSiL review which will assess the effectiveness of the programme in achieving the intended outcomes and whether existing provision is fulfilling the BSiL guarantee.

The specific aims of the evidence review were to:

1. Assess the quality of the evidence base for the existing Best Start in Life model, covering four aspects of the guarantee: early education; stay and play; parenting interventions; and health support.

2. Identify the most effective interventions for achieving the Best Start in Life outcomes: school readiness; parenting aspirations, self-esteem and parenting skills; and child and parent health and life chances.

The review focused on UK evidence since 2010, broadening the scope of the search where necessary to find relevant evidence.

1.3 Summary of methods

The methodology for this evidence review was designed to comprise a combination of light and intensive review to cover the broad range of interventions in the Guarantee. Full details are provided in the Appendix. For the light review, emphasis was placed on locating and summarising evidence from relevant and high quality systematic reviews using a pre-determined search strategy and inclusion criteria. For the intensive review, we added to the light review methods by conducting further searches for relevant primary sources of evidence using appropriate databases and search engines. The primary evidence was assessed using the Early Intervention Foundation’s standards of evidence which are closely aligned to other well-known scales, recently developed and appropriate for the topic of this study. The standards of evidence indicate the extent to which results can be trusted. In addition, some statistical details of primary research are provided where available.

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2 The fifth aspect of the guarantee focussed on employment is being reviewed by LBN as part of another research programme.

3 More details about the sources for searching, and search teams across the research themes are included in the methodology annex at table 9.1.

4 http://guidebook.eif.org.uk/the-eif-standards-of-evidence
Table 1  Definitions of statistical terms

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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Confidence interval</td>
<td>This is provided for survey estimates, to indicate the range within which the true value within the population lies (taking account of sampling error).</td>
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<tr>
<td>Effect size</td>
<td>This is the standardised mean difference between the intervention and control group) indicating the size of impact. An effect size closer to 0 would indicate a small programme effect, whereas an effect size closer to 1 would be large.</td>
</tr>
<tr>
<td>Regression coefficient</td>
<td>This indicates the strength of relationship between predictor and outcome variables</td>
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<tr>
<td>P value</td>
<td>This is the probability that any observed effect is due to chance. P&lt;0.05 indicates a statistically significant result at the 95% confidence level.</td>
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1.4 Report outline

The following four chapters assess the quality of evidence supporting four aspects of the BSiL guarantee: early education (Chapter 2), stay and play (Chapter 3), parenting provision (Chapter 4) and health support (Chapter 5). The evidence is set out against specific research questions posed by Newham, focusing on the highest quality and most relevant evidence available. Chapter 6 identifies the most effective interventions for each of the three BSiL outcomes: school readiness; parenting aspirations, self-esteem and parenting skills; and child and parent health and life chances. Finally, Chapter 7 considers the implications of the evidence for the Best Start in Life model.
2 Early Education

2.1 Early education policy context

Free early education is the primary component of the BSiL guarantee which targets improvements in school readiness by the age of five. In line with national policy, funded provision was introduced in Newham under the National Childcare Strategy in the late 1990s initially for all four year olds, extending to three year olds by 2004. More recently in 2013, free early education was extended to disadvantaged two year olds. Further expansion is planned – from September 2017, the Government plans to extend free early education and childcare for three and four olds from 15 to 30 hours per week for parents in work (NAO, 2016). LBN is one of eight councils across England where the extension of free early education is being piloted in advance of the policy being rolled out. This chapter summarises the evidence linking early education and childcare with school readiness outcomes, covering take-up at different ages, for different numbers of hours, and the impact of the quality of provision.

2.2 Evidence on promoting take-up for two year olds

Since September 2013, disadvantaged two year old children from households where a parent claims an eligible benefit (e.g. Jobseekers Allowance), who are looked after by the council, have a current statement of special educational needs (SEN), receive Disability Living Allowance (DLA) or are under a special guardianship order have been eligible for 15 hours of funded early education per week during term time. This was extended in September 2014 to cover two year old children in the households that fall within the lowest two fifths on the income distribution. The funded provision is available in formal Ofsted registered settings such as day nurseries, childminders, nursery schools and nursery classes (HM Government, 2013).

During the three years since the free early education policy was introduced, take-up among two year olds has gradually increased. In the London Borough of Newham, take-up was 55 per cent (Spring term 2016), 58 per cent (Summer term 2016) and 66 per cent (Autumn term 2016). The Department for Education’s (DfE) Early Years Census found that 58 per cent of eligible families nationally were using their entitlement in January 2015. The DfE’s most recent Childcare and Early Years Survey of Parents (2014/15) measured take-up among two year olds (n=121) for the first time in the survey series, which has been running since 2004 and found that, similar to the Early Years Census, 54 per cent of eligible families were using their entitlement (Huskinson, et al., 2016). The survey is based on a nationally representative sample of 6,198 parents and is an Official Statistic, so constitutes a reliable source of data.

By comparison, take-up of free early education is higher among three and four year olds (90 per cent in survey data reported in Huskinson, et al., 2016) and 95 per cent across

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5 DfE census data appears to slightly overestimate take-up for four year olds (with over 100% take-up in some areas) because of double-counting between pre-school settings and school reception classes.
three years olds and four year olds in DfE census data). This is understandable given that the entitlement has been universal for longer, so awareness of the entitlement is high, and the children are closer to school age, so acceptability of early education among parents may be higher.

The Study of Early Education and Development (SEED) was commissioned by the DfE in 2013 to evaluate the impact of the funded two year old provision, and, alongside the CEYSP survey, provides the best source of evidence on understanding what influences take-up (Speight, et al., 2015). The estimates are based on a nationally representative longitudinal survey completed with 5,643 parents of two year olds. SEED investigated take-up among two year olds sooner after the policy was introduced than the CEYSP survey, so take-up rates were found to be lower (48 per cent of the most disadvantaged group).

The main barriers to take-up identified in these studies were awareness of the entitlement, personal preference and availability of provision. The CEYSP study (Huskinson, et al., 2016) found that just over one quarter (27 per cent) of parents who were not using free early education (for children aged two to four) but who were eligible were unaware of the provision. Evidence from a trial of the free early education ahead of the roll-out (DfE, 2013c) addressed the need to raise awareness, finding that self-referral systems and external marketing materials were effective strategies in engaging parents.

The main reason for not taking up early education at two years among the most disadvantaged families in the SEED study was personal preference (Speight, et al., 2015). This was given as the main reason by 50 per cent of those not taking up the entitlement. Other reasons were cost (17 per cent), availability (12 per cent), a perception that the child was too young (11 per cent) and the parent not working (3 per cent). As the authors highlight, the decision-making process around early education and childcare is complex and ‘personal preference’ captures a range of considerations. The higher proportion of non-working (than working) mothers citing personal preference as a reason for not taking up early education for their two year old demonstrates how decisions around working and childcare are linked.

The main source of data on the availability of provision comes from the DfE’s survey of Childcare and Early Years Providers, which is a repeated nationally representative study of providers. The 2014 survey (Brind, et al., 2014), based on interviews with 7,758 group-based providers, 902 childminders and 1,791 school-based providers) found that fewer than 75 per cent of full day care and sessional settings were delivering funded provision for two year olds at the time of the survey, and only seven per cent of childminders were doing so. These findings concur with the findings from the SEED study of low engagement among childminders who perceived that families were being encouraged to take up the places in a group-based setting (Callanan, 2014). However, the Brind study also highlighted that 49 per cent of providers who did not offer provision at the time data were collected reported that they were planning to do so, which is a positive sign of increased availability over time.

There is a lack of high quality evidence on effective methods for promoting take-up of free early education for two year olds, possibly because the policy is relatively new and so the opportunity for fully documenting families’ motivations, facilitators and barriers for use or indeed non-use has been limited. However, taking into account the barriers as well as parents’ motivations for using early education and childcare (which centre on supporting employment and children’s development) it is likely that activities aimed at raising
awareness of the benefits of early education among eligible populations and increasing the amount of provision available would be the most effective strategies.

2.3 Evidence on effectiveness of 15 hours for two year olds

The review did not find evidence specifically commenting on the effectiveness of 15 hours free early education for two year olds. However, research is underway to address this question. The Study of Early Education and Development, commissioned by DfE, aims to assess the effectiveness of early education by following thousands of two year old children who became eligible for the provision soon after it was introduced through to their early years at school. The first impact findings are expected to be published in 2017.

However, there is already strong evidence on the effectiveness of early education and childcare more broadly, especially for disadvantaged children. Last year, Melhuish et al. (2015) published a comprehensive and high quality review of international research on the impact of early childhood education and care (ECEC) provision on children’s development, using studies reported from a wide range of sources including journals, books, government reports and diverse organisation reports. For children aged zero to three, the effects of ECEC are strongly influenced by two factors: whether the child’s home environment is disadvantaged and the quality of the ECEC provision (explored in more detail in section Error! Reference source not found.). For disadvantaged children (who are the eligible population for the 15 free hours), high quality ECEC is associated with benefits for cognitive, language and social development. Low quality childcare and early education provision leads to either no benefits or negative effects. For children who are not disadvantaged, ECEC in the first three years can also be beneficial, but again, quality is important.

The findings from the Melhuish review concur with evidence from the Effective Pre-school, Primary and Secondary Education (EPPSE) study which has followed nearly 2,600 children from early childhood in the late 1990s, when funded early education was first introduced, to the age of 16 (with analysis of 2,582 young people for whom GCSE outcome data were available) (Sylva, et al., 2014). Using longitudinal data about children and their families, the study has been able to investigate the long-term benefits of early education in combination with the influence of family background, the home environment, school education and out of school learning on students’ later outcomes (Sylva, et al., 2012). Multilevel statistical models were used to test which factors predicted students’ outcomes in different domains, and have consistently found positive effects of pre-school experiences on child outcomes throughout primary and secondary school (Sylva, et al., 2004; 2008; 2012; 2014). For example, students who had attended high quality pre-school (compared to no pre-school) were found to have higher scores at GCSE (effect size=0.37, p<0.001) (Sylva, et al., 2014).

Focusing on two year olds, the EPPSE study found that attending an early education setting before the age of three was related to better intellectual development. Quality was an important factor determining positive outcomes, particularly for disadvantaged children. Settings with a mixture of children from different social backgrounds were also associated with positive outcomes.

6 The forthcoming SEED evidence on impact will be Level 3 evidence according to the EIF Standards of Evidence since it is a high quality quasi-experimental study.

7 The EPPSE study is Level 3 since it is a high quality quasi-experimental study.
The evidence on impact is not all positive, however. Whilst a number of key positive effects of early education have been documented, several studies have identified negative impacts for particular groups of children and in relation to particular formats or aspects of delivery. A more prolonged and intense exposure to ECEC has been linked to negative impacts, (as is explained more fully later in this chapter). For example, a UK study based on data from the Families, Children and Child Care study by Barnes and Eryigit-Madzwamuse (2012), found that entering childcare for a short period before the age of two (which is outside the age scope for this project, though still relevant) did not affect behavioural outcomes in children, but that prolonged exposure to centre-based care before two years of age was linked to greater likelihood of behavioural problems at later ages. (When controlling for child characteristics, the estimated impact of early centre-based child care on behavioural change was 0.49 which indicated that for higher levels of exposure to centre-based child care difficult behaviour showed an increase as opposed to a decrease. Sample size = 1,201.) International evidence (Coley, Lombardi and Sims, 2015) using nationally representative data looked at links between centre-based ECEC and children’s cognitive skills and behavioral functioning in first grade in a nationally representative sample of Australian children. Analysis of the Longitudinal Study of Australian Children found that more prolonged and intense exposure to ECEC was predictive of small detriments to behavioural functioning, with children showing lower attention skills, higher conduct problems and lower prosocial behaviours. The analytic method was linear regression with the coefficients expressed as standard deviations. The predictive effects were fairly small ranging from 0.02 SD to 0.06 SD for intensity of centre-based care.

2.4 Evidence on effectiveness of 15 hours for three and four year olds

From September 2010, all three and four year olds in England became entitled to 15 hours a week of state funded education (an increase from the 12.5 hours that was offered previously). This free entitlement was described by the National Audit Office as ‘the Department for Education’s main financial intervention in children’s early education’ (NAO, 2012). Parents are able to select the childcare they want to use across a range of public, private and voluntary providers and pay for additional hours, though some use less than the full entitlement. The 15 hours allowance can be used flexibly by parents; for example, using it to fund two and a half days or five half-days per week, depending on preference and work arrangements. The financial subsidy is paid directly to the provider which means that parents do not pay up-front to access the entitlement. The majority of families in the UK take advantage of the free 15 hours (95 per cent across three and four year olds.

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8 A continuous measure of exposure to centre-based care was created based on the number of months during the child’s first two years in which centre-based care was the dominant form of childcare (as distinct from maternal care or home-based non-maternal care), averaging 12 or more hours per week. ‘Prolonged’ is defined not just as 12 or more hours per week, but the proportion of months in which centre-based care was the main form of childcare.

9 Individual growth modelling (Singer & Willett, 2003) was used to examine both within and between individual variations in difficult behaviour.

10 This study is Level 2 or 3 data since the analysis is based on longitudinal data without a counterfactual.
nationally and 86 per cent in Newham according to 2016 figures from the latest DfE census data\(^1\).

The evidence consistently demonstrates positive effects of ECEC for three and four year olds on cognitive, language and social development. Comparative evidence from the PISA study\(^2\) demonstrates that children who attended some formal early education before primary school were on average, a year ahead of their peers (OECD, 2011; Melhuish, et al., 2015). Children from disadvantaged backgrounds appear to benefit the most from early education, particularly when the provision is socially mixed (Melhuish et al., 2008), and the benefits have been found to persist well into adulthood resulting in fiscal savings for the state as well as benefits to the individual (Melhuish et al., 2015). Again, an important factor supporting the effectiveness of provision on child outcomes is that the quality of provision is high, and Melhuish’s report which considers research from a wide range of international studies distinguishes a number of characteristics of high quality provision (section 2.5).

However, whilst the benefits of ECEC for children aged three and four have been widely documented, distilling evidence on the specific effects of the 15 hours free early education is more complicated. This is because it is hard to separate the impact of the 15 hours from other forms of childcare (or wraparound childcare) that many families access while also taking into account the influence of family background and the home environment. Future analysis from the SEED study may go some way to addressing this evidence gap.

### 2.5 Elements of quality childcare: what is quality?

Good quality childcare has been described as ‘care which best advances children’s cognitive, social and behavioural development’ (Gambaro, Stewart and Waldfogel, 2015). There are standardised measures of childcare quality such as the ECERS, ITERS and Caregiver Interaction Rating Scale as well as Ofsted measures. Across the studies included in this review, there was consistent, robust evidence that high quality provision can have positive, long-term impacts, especially for more disadvantaged children (and that low quality provision can have neutral or negative effects). Findings also broadly show that high quality ECEC has the potential to help narrow the gaps between children from different backgrounds and improve life chances and outcomes, especially for disadvantaged children and when exposure to high quality provision is maintained over time (Melhuish, et al., 2015; Zaslow, et al., 2010).

Several important studies define essential elements of quality in ECEC provision. The first is Melhuish’s review of research on the effects of ECEC on child development which considered studies mostly from the EU and the US since 2000. The review outlines a number of characteristics which have proven to be central to advancing children’s development and therefore define good quality ECEC\(^3\). The factors are wide ranging and include the way in which provision is organised and care is given:

- Adult-child interaction that is responsive, affectionate and readily available
- Well-trained staff who are committed to their work with children
- A developmentally appropriate curriculum with educational content

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3. The following bullet points are taken directly from the Melhuish review.
• Ratios and group sizes that allow staff to interact appropriately with children\(^{14}\)
• Supervision that maintains consistency in the quality of care
• Staff development that ensures continuity, stability and improving quality
• Facilities that are safe, sanitary and accessible to parents.

Other studies have taken a different approach to categorising and analysing key quality factors. La Paro et al. (2012) reviewed studies between 2003 and 2010 to clarify issues around the definition and measurement of quality provision in ECEC\(^{15}\). Drawing on work undertaken by Vandell and Wolfe (2000) and others, they outlined that two broad dimensions could be categorised as critical facilitators of children's development and learning:

- **Process quality**, includes the quality of the curriculum and pedagogical practices, supporting positive relationships and children's emotional development. Indicators of process quality focus on the more dynamic aspects of ECEC.
- **Structural quality**, includes factors such as adult-child ratios, caregiver qualifications, group size and characteristics of the physical space. These indicators are often the more regulated aspects of classrooms and programs.

Evidence from the EPPSE study in England concurs that process and structural factors are both important predictors of later child outcomes. This study found that quality was strong when qualified teachers interacted with children for a substantial amount of time, and where staff and managers in particular, were well qualified (Sylva, et al., 2004). Other studies have also found that children make more progress in pre-school settings where staff have higher qualifications, particularly if the manager or curriculum leader was highly qualified (Brind, et al., 2014; and Hillman and Williams, 2015). Gambaro’s study (Gambaro, Stewart and Waldfogel, 2015), which investigated how the quality of early childhood education and care accessed by three and four year olds in England varied by children's background, reported that higher staff–child ratios, and a higher proportion of trained staff (especially with teaching qualifications), were predictors of higher observed quality\(^{16}\).

Following evidence on the importance of staff qualifications for childcare quality and child outcomes (Sylva, et al., 2004), the Coalition Government introduced the Early Years Teacher qualification for graduates and Early Years Educator qualification for staff without graduate status (DfE, 2013a; DfE 2013b). There were also changes to registration and inspection with Ofsted given sole responsibility for inspecting early years’ provision (including childminders) and a reform of Early Years Inspections. Furthermore, all Ofsted registered early years providers are obliged to follow the Early Years Foundation Stage

\(^{14}\) Melhuish’s review highlights that optimum ratios for under two-year olds in ECEC settings is consistently stated as 1:3. For two-three year olds this rises to 1:4-1:5. Ideal group sizes for under two year olds in ECEC settings are recommended to be six to eight children, and for two to three year olds, 10-12 children.

\(^{15}\) Published, peer-reviewed research articles that used the ECERS-R to measure ECEC quality between 2003 to 2010 were included in this study.

\(^{16}\) Taken from a sub-sample of Millennium Cohort Study (MCS) children, the Quality of Childcare Settings in the Millennium Cohort Study (QCSMCS). This is a descriptive study without a counterfactual so constitutes Level 2 evidence.
(EYFS) which sets standards for the learning, development and care of children from birth up to the age of 5 years (end of Reception year).

The UK has a mixed economy of childcare and early education with a wide range of different types of providers (Lloyd and Penn, 2012). Evidence from a recent review suggests that provision in the maintained sector (e.g., school-based nursery classes) is better than private and voluntary settings at providing high quality care, thus supporting positive child outcomes. This has been found to be particularly true in disadvantaged areas (Hillman and Williams, 2015).

The Childcare and Early Years Survey of parents found that parents had a slightly different focus when considering the definition and characteristics of quality provision. Parents valued the learning environment being a happy and sociable place for their children as well as there being small ratios of children to staff (Huskinson, et al., 2016).

There is a good understanding of what quality is, and recent policy developments have made efforts to use evidence on quality to support how provision is delivered and targeted. However, as Bertram and Pascal (2014) note in their review, more evidence in needed on optimal staff-child ratios and staff qualifications.

2.6 Direct and indirect benefits of 30 hours (new policy) on child outcomes

From September 2017, free early education and childcare will be extended to 30 hours per week in England for all three and four year olds in households where the parent(s) are in work and paid the equivalent of at least 16 hours a week at the national minimum wage. Parents also need to earn under a defined income threshold\textsuperscript{17}. Although the main driver for this policy is to increase parental employment, it represents a major expansion in the ‘free entitlement’, building on the existing, universal three and four year old early education entitlement; and the two-year-old entitlement for disadvantaged children (DfE 2015).

At the time of conducting this review, the 30 hours policy is being piloted to some working parents in eight ‘early implementer’ areas across England, including the London Borough of Newham. The Department for Education has commissioned an evaluation focusing on generating learning that can be used by all local councils ahead of the national implementation in September 2017\textsuperscript{18}. The DfE’s Childcare and Early Years Survey of parents will also track the progress of the policy from the parent’s perspective although it is not designed to assess the impact on child outcomes.

Even though it is too early to present evidence specifically relating to the free 30 hours for three and four year olds, evidence relating to the intensity of early education is relevant and the picture is mixed. For example, the English EPPSE study (Sylva, et al., 2004) found no evidence that full-time participation in early education resulted in better outcomes than part-time. Similarly, Melhuish’s review identified two US studies\textsuperscript{19}, (which are worth

\textsuperscript{17} Each parent must have an annual income of less than £100,000 to be eligible for the 30 hours free early education and childcare.

\textsuperscript{18} http://www.parliament.uk/written-questions-answers-statements/written-question/commons/2016-06-08/40077

\textsuperscript{19} These studies included the National Centre for Early Development and Learning (NCEDL) Multi-State Study of Pre-Kindergarten and the State-Wide Early Education Programmes Study (SWEEP) cited in Howes, et al., (2008).
consideration given the UK-based evidence is limited) which also found no evidence of advantages in cognitive development in relation to full-time attendance at day care (Howes, et al., 2008 as cited in Melhuish, et al., 2015). However, there is some evidence that suggests there may be additional benefits to full-time ECEC for disadvantaged children (Melhuish, et al., 2015).

Other studies suggest that there may be some negative impacts of increased exposure to ECEC. For example, the Australian study by Coley (Coley, Lombardi and Sims, 2015), which looked at connections between children’s early education and care and their cognitive and behavioural functioning, found that greater duration and intensity of centre care exposure was predictive of small detriments to behavioural functioning, with children evidencing lower attention skills, higher conduct problems and lower prosocial behaviours. Melhuish’s review also presents evidence that identifies some negative educational outcomes relating to a full-time attendance. However, it is worth noting that a number of studies referred to in Melhuish’s review examine the impacts of childcare lasting for more than 30 hours a week and therefore do not give an accurate indication of likely impacts of the policy currently being piloted and rolled out in England.

Overall, it seems that the evidence on outcomes for children attending ECEC for longer hours is mixed. It is however relevant to note that the primary policy driver for the extended entitlement is not child development but supporting parents who wish to move into work or to work more hours, by reducing the costs of childcare and increasing the availability of provision (DfE, 2015). The government’s productivity plan ‘Fixing the Foundations: Creating a more prosperous nation’, highlighted that many people face unfair barriers to work, including women, resulting in under-used skills (HM Treasury, 2015). In the context of rolling out the extension of free early education the government has indicated that, ‘there is potentially a huge economic prize from enabling parents to play a fuller role in the economy’ (DfE, 2015). Sustained, progressive employment is crucial for escaping and avoiding poverty (Smith and Middleton, 2007), and higher household incomes impact directly on child outcomes (Hills, 2014). In a systematic review of 34 high quality studies from across the OECD and EU, robust evidence was found that low income directly affected children’s wellbeing and development, including cognitive development, attainment, anxiety and behaviour (Cooper and Stewart, 2013). The authors conclude that, “income increases have effect sizes comparable to those identified for spending on early childhood programmes or education” while at the same time have positive influence on other factors affecting children such as parenting and the home environment (p.72).

Therefore, if the policy proves to be successful in raising employment and incomes in low income families then children will benefit.

2.7 Summary

The first element of the BSiL guarantee which aims to improve school readiness through early education has a strong evidence base. The positive effects of early education for three and four year olds’ cognitive, language and social development are found consistently across OECD countries over recent decades. Outcomes of two year old early education

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20 This study is Level 2 or 3 data since the analysis is based on longitudinal data without a counterfactual.
are more mixed with some negative as well as positive outcomes, but, on balance, the
evidence supports the use of early education for disadvantaged two year olds. The
effectiveness of early education is strongly influenced by two factors: whether the child’s
home environment is disadvantaged and the quality of the ECEC provision. Children from
disadvantaged backgrounds benefit the most from early education and provision that is high
quality in terms of process and structural factors leads to better outcomes for young
children, while poor quality provision can have neutral or negative effects. The evidence for
the particular benefits of the funded part-time places for two, three and four year olds is not
yet established although research designed to specifically address that question is
underway. The effects on children of the forthcoming extension to 30 hours is also not yet
clear. If the policy results in higher incomes for disadvantaged families, the children will be
likely to benefit from improved family context as well as through the early education.

3 Stay and Play

3.1 Overview of the evidence

‘Stay and play’ is a term used to describe informal group sessions in community spaces for
parents/carers and their pre-school aged children to attend together. Despite it being the
most commonly provided and used service within children’s centres, the review found very
little high quality impact evidence on stay and play. The lack of evidence may be due to the
loose definitions and varied aims of the provision which make it difficult to test through the
kinds of large-scale, robust impact evaluations that this review seeks to examine and
synthesise. The way in which provision is delivered differs between services and providers
and there are overlaps between stay and play and other related forms of provision. Stay
and play is notably absent from the Early Intervention Foundation’s Guidebook which rates
programmes across a range of outcomes, including child development and parenting, in
relation to the quality of evidence available\textsuperscript{21}. There is however one recent and relevant
large-scale study (Sammons, et al., 2015\textsuperscript{a}) which we draw on across this chapter.
Evidence on the theoretical rationale for stay and play provision and the wider literature on
play and learning are also discussed.

3.2 Definitions of stay and play

In the UK, the term ‘stay and play’ is widely used to describe informal drop-in sessions
where a parent/carer and child are present together in a community-based setting (often a
children’s centre). Sessions are free, open to all families with a child of a certain age and
typically last between one and three hours. They are usually facilitated by an early years’
professional.

Within the research literature, policy documents and Newham’s own information, stay and
play sessions can involve many different types of thematic play including messy play,
heuristic play, music and movement, sensory play, story time, soft play and sessions for
children with special educational needs (SEN).

\textsuperscript{21} http://guidebook.eif.org.uk/programmes-library
The focus of stay and play sessions and related provision differs according to a range of considerations including the needs of local communities and the time and resources available to providers. The Evaluation of Children’s Centres in England (ECCE) highlighted that a strong focus of these services was to improve parenting behaviours (Evangelou, et al., 2014; Sylva, et al., 2015). The National Evaluation of Sure Start Local Programmes (SSLP) identified the key aim of stay and play as ‘gateways to encourage parents to take part in other services’ (Anning, Chesworth and Spurling, 2005). Sure Start providers indicated that play sessions delivered through SSLPs aimed to also support healthy family relationships and child development outcomes.

3.3 Stay and play provision in the context of Sure Start and children’s centres

The Sure Start Local Programme (SSLP), launched in 1998, was perceived to be a key part of New Labour’s agenda to tackle disadvantage and child poverty (influenced by the US Head Start programme). SSLPs were established within communities to provide multi-agency support to families with children under the age of five. Their main purpose was to enhance the health and development of children through integrated provision of health, social care and education services via a ‘universal offer’. SSLPs offered drop-in play facilities to all families as a central feature of the provision which was thought to serve as a ‘gateway’ for disadvantaged families to access other services they might need (Anning, Chesworth and Spurling, 2005).

Stay and play sessions have remained a key component of family support as SSLPs were replaced by children’s centres. The Evaluation of Children’s Centres in England (ECCE) found that stay and play was the most prevalent service provided within a list of over 40 services (Poole, Fry and Tanner, 2015). The nationally representative survey of children’s centre managers revealed that 100 per cent of Phase 1 and 2 children’s centres (those in the most deprived areas) offered some form of stay and play service in 2011 and when followed up in 2013. (The sample size for the baseline survey was 509, response rate=60 per cent, and 98 for the follow-up survey, response rate=80 per cent). Stay and play service provision was examined in more detail during subsequent site visits with 121 children centres which involved qualitative interviews and surveys to investigate the provision, management and structure of services. The data from these visits charted the move away from single site provision towards clustered structures which resulted in stay and play sessions being spread among a number of children’s centres locally (Goff, et al., 2013; Sylva, et al., 2015), a development that was also noted in the 2014 Ofsted Early Years Annual Report (Ofsted, 2014)

The restructures in children’s centres have been prompted by significant budget cuts In the ECCE national survey for example, 42 per cent of managers noted that budget cuts had affected services and resources, resulting in a reduction in universal services and greater targeting (Poole, Fry and Tanner, 2015). Associations were found between the financial pressures on children’s centres and various measures of family functioning (Sammons et al., 2015b). Stay and play take-up
Patterns in the take-up of stay and play alongside other children’s centre services were investigated through the longitudinal survey of children and families within the Evaluation of Children’s Centres in England (ECCE). Families with a child aged 9-18 months were selected from 128 of the 500 children’s centres that took part in the national survey (reported above) and 2,602 parents were interviewed when the child was 9-18 months, aged two and aged three. The most commonly used service when children were 9-18 months was stay and play or play and learn sessions (61 per cent) (Maisey, et al., 2013). Sixty-seven per cent of families attended these sessions at least once a week and in the majority of cases (89 per cent) it was the mother who attended with the child. Stay and play sessions were popular among the parents interviewed who expressed an interest in more frequent sessions and greater variety. Convenience, timing and availability were important factors in relation to take-up.

The longitudinal evidence from ECCE showed that stay and play sessions were the most frequently accessed children’s centre service for families with children up to the age of three years old. After this age, attendance at children’s centres declined as children entered early education provision. (When the selected child was aged three, 54 per cent of families attended the named children’s centre, compared to 85 per cent when the child was 9-18 months.) The disadvantaged children and families were more likely to stay engaged, highlighting the continued importance of such services for more vulnerable families and the effectiveness of outreach efforts (Maisey, Poole and Chanfreau, 2015; Sammons, et al., 2015a).

3.4 Effectiveness of stay and play

The highest quality evidence available on stay and play is from the recent Evaluation of Children’s Centres in England (Sammons, et al., 2015a). The analysis is based on the longitudinal survey data collected from families and children who were registered with Phase 1 and 2 children’s centres (as described above). The research investigated the effects of children’s centre usage on child, parent and family outcomes when the child was three years old using multilevel statistical models which took into account a wide range of relevant factors. Since there was no counter-factual group of children and families in the design, the evaluation approach was to compare outcomes by level of children’s centre engagement (e.g., limited and heavy use) and the characteristics and delivery models of provision. One particular issue that makes interpretation challenging, however, is that without a comparison group, the analysis could not fully control for selection effects (that is, unmeasured factors that influence both the take-up of services as well as outcomes). As a result, the associations between service use and outcomes are interpreted sometimes as impacts and sometimes as the effective targeting of those with high levels of need, depending on the context.

Participation in stay and play and other associated organised activities at children's centres predicted small improvements in maternal physical health (effect size= -.10 to -.13 for limited to heavy use of children’s centres at baseline, compared with inconsistent use, p<0.05), improved home learning environment scores (effect size=0.19, p<0.05), lower parental distress and improved family functioning (effect size=−0.24 for Confusion, Hubbub

23 The study is Level 2 or 3 evidence according to the EIF Standards of Evidence since the analysis is based on longitudinal data without a counterfactual.
and Order Scale, p<0.01). The positive associations with parenting and the home environment reflect the emphasis of stay and play on supporting parenting (rather than targeting child outcomes directly), as described by children’s centre staff (Evangelou et al., 2014).

Participation in stay and play over a longer time period was also associated with negative child outcomes at age three including higher scores for internalising behaviours (effect size=0.15, p<0.05) and lower prosocial scores (effect size=-0.14, p<0.08) and poorer health. The authors’ explanation for the association between stay and play use and poorer child outcomes is not that stay play had a negative impact on children but rather that children’s centres were effective in reaching out to more vulnerable families where children had difficulties.

The wider evidence on early years’ interventions demonstrates that support needs to be more structured and intensive than stay and play to have a positive impact on child outcomes. Bertram and Pascal (2014, p.40) note that, “Programmes that support children directly need to be high quality, regular and long-term (dosage and intensity are both important).”

### 3.5 Theoretical models for stay and play

The limited evidence on the effectiveness of stay and play needs to be viewed within the context of what providers are trying to achieve. Within children’s centres, stay and play has two main purposes: it serves as a gateway to other services and provides an environment for parenting support.

Despite the financial pressures on children’s centres and the move to greater targeting, stay and play has been retained as a universal, open access service. In the detailed data collection from over 100 children’s centres (which were nationally representative of Phase 1 and 2 centres), managers and staff described stay and play as important for:

- making contact with new families;
- identifying needs; and,
- prevention and early intervention (Goff, et al., 2013).

Building relationships between staff and parents was considered important for encouraging and sustaining parent attendance at children’s centres (Evangelou, et al., 2014) and the skills of staff were central to this (Goff, et al., 2013). The professional facilitation of stay and play in the context of children’s centres distinguishes the provision from the peer-led playgroups of earlier decades (Needham, 2011).

Evidence from a qualitative observation study of playgroups targeted at disadvantaged families in Australia (Jackson, 2013) supports this view. The open access approach of these facilitated playgroups supported engagement between a range of professionals and parents in a non-stigmatising, non-clinical environment which led to increased take-up of other services.

The second purpose of stay and play is parenting support, including the modelling of positive parenting behaviours. Children’s centre staff described stay and play as valuable
for modelling how to praise children (97 per cent), how to increase interactions between adults and children (97 per cent) and develop an increased parental interest in their children's lives (97 per cent), based on visits to 121 children's centres (Evangelou, et al., 2014). Some children’s centres also offered stay and play sessions targeted at fathers (Evangelou, et al., 2014).

Notably, stay and play is not usually intended to impact on child outcomes directly which helps to explain the lack of impact research.

### 3.6 Play and development

After our initial search parameters were found to yield little in the way of high quality evidence on stay and play, we expanded our search and inclusion criteria and, in conjunction with Newham, put together a further set of search terms (see Appendix). Unfortunately these more specific ‘play’ terms, for example ‘heuristic play’, did not yield any further high quality evidence that we were able to include in this report. However, a number of lower quality studies were uncovered on various play-based interventions, as well as a number of studies looking very broadly at play and child development. The literature on play and child development stresses that all aspects of a child’s development and learning are developed through play (Evangelou, et al., 2009). Its importance is further recognised and enshrined in the UN Convention on the Rights of the Child (UNHR, 1989).

Child-initiated play with active adult support and focused learning with adults guiding the learning both fall in the middle of the structured-unstructured play spectrum, which provides the best outcomes for children’s development and learning (DCSF, 2009). Play also holds an important role in children’s emotional, social and intellectual development, leading to positive cognitive and health outcomes (Santer, 2007; Goswami, 2015). Equally, adults have a key role in facilitating opportunities for play, and high quality training of adults working with children is required to help develop the role of play in child development (Goswami, 2015). Consequently, play deprivation is found to be related to negative outcomes for child development.

### 3.7 Summary

The lack of high quality evidence linking stay and play with outcomes for parents and children was noted at the start of the chapter. The informal nature of the provision means that it is not well-suited to large-scale, robust impact evaluations. Recent evidence from the national evaluation of children’s centres, however, confirms the value of stay and play as a way for children’s centres to engage vulnerable families. The positive effects of stay and play on parenting and home environment outcomes provide some evidence to support this. Overall, the evidence suggests that stay and play is not the most effective intervention for promoting school readiness and parenting outcomes but may help to build the relationships with families that enable them to participate in other more focused interventions.
4 Parenting Interventions

4.1 Context

Newham’s Best Start in Life Guarantee includes programmes, workshops and sessions offering evidence-based advice and guidance to improve parenting capacity in each neighbourhood. This element of the Guarantee is targeted primarily at improving parenting aspirations, self-esteem and parenting skills. This section of the review assesses the evidence for the effectiveness of parenting interventions and how they are delivered. The evidence is drawn primarily from high quality recent reviews of parenting interventions in the UK context which investigate their impact on aspects of parenting which also relate to the home environment and child development outcomes. The chapter considers the evidence across the continuum from universal to the most targeted programmes as delivered within a neighbourhood context such as children’s centres.

4.2 The importance of parenting

The ways in which parents interact with their children and the context they provide affect children’s long-term physical, emotional, social and educational outcomes (Donkin, 2014). Positive, warm parenting, with firm boundaries and routines, supports social and emotional development and reduces behavioural problems. Parent choices around breastfeeding, nutrition and lifestyle impact on children’s physical health. Parent-child interactions from the earliest age are also vital for the development of language and communication skills (Axford, et al., 2015b; JRF, 2016).

Parental circumstances influence parenting ability. Low income, stress, mental health problems or substance misuse can make it harder for parents to bond with their children and adopt positive parenting practices (Donkin, 2014; Hills, 2014). Recent research with parents of young children from disadvantaged areas found that poor family functioning (including measures of parent-child dysfunctional interaction) were related to high levels of financial disadvantage (effect size=0.15 in CHAOS score for high versus low disadvantage), being in an out of work household (effect size=0.27 in Parental Distress between never worked and professional), larger families (effect size=0.13 in CHAOS score for one to two siblings) and lower maternal qualifications (effect size=0.11 in CHAOS score for low qualifications, effect size=0.28 on Parent-Child Dysfunctional Interaction scale for no qualifications) (Sammons, et al., 2015a). Relationships between parents as well as between parents and children are also important for children’s long-term outcomes (Harold, et al., 2016). Parents who engage in frequent, intense and poorly resolved inter-parental conflict undermine children’s mental health and future life chances.

Through parenting practices, differences in socio-economic status between parents can result in inequalities for the next generation. However, a growing body of evidence is

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24 Confusions, Hubbub and Order Scale developed by Matheny, et al. (1995). This is a standardised measure of whether the home environment is disorganised, chaotic, calm or routine.
showing that with early intervention and appropriate support, parenting attitudes and behaviours can be improved, with positive results for children. As the Allen Review (2011) noted, it’s what parents do, not who they are, that is important for outcomes. Nevertheless, it is logical that parenting interventions will be more effective if parents’ social circumstances as well as their actions are addressed (JRF, 2016).

4.3 Universal services

Parenting and family support in the UK is provided through a structure of universal services (e.g., antenatal midwifery support), open access services targeted at disadvantaged communities or families (e.g., stay and play in children’s centres), and more specialist services targeted at families at risk (e.g., Family Nurse Partnership) or with identified problems (e.g., speech and language therapy). It is generally accepted that both universal and more targeted services have their place in supporting parents, with universal services (such as those delivered through the Healthy Child Programme) playing an important role in prevention and early intervention (Eisenstadt, 2011). Universal health-based services such as breastfeeding support, infant sleep advice and smoking cessation advice all potentially impact on parenting (Donkin, 2014) and are discussed in detail in the following chapter.

In relation to parenting aspirations, self-esteem and parenting skills, the benefits of universal services are harder to establish than for targeted services and the evidence base is weaker. This may be due to the ‘ceiling effect’: most families using universal services already have a good level of parenting, leaving little room or need for improvement (Axford, et al., 2015b). It may be the case that some groups of parents benefit more from universal interventions than others but in general, they are unlikely to be sufficiently intensive or specialist to improve outcomes for those with entrenched or multiple problems (Axford, et al., 2015b).

Universal services may be equally offered but the evidence shows that they are not equally accessed. A recent survey for the Social Mobility Commission (Gulc and Silversides, 2016), based on a sample of 1,000, indicated that working class social groups were less likely to access services antenatally and in the first year of the child’s life. This study provided descriptive evidence that these groups were less likely to develop social connections for themselves and their child(ren) and were less well informed about childcare costs and school options.

The Evaluation of Children’s Centres enabled the combined effects of universal family support services on parenting to be assessed. Across the first three years of their child’s life, most parents had attended a drop-in session with a midwife or health visitor (85 per cent) or stay and play (69 per cent), both of which aimed to support parents or parenting in some way (Maisey, Poole and Chanfreau, 2015). Alongside these most commonly used services, families also accessed other kinds of support through the children’s centre and elsewhere. Children’s centre service use was associated with improvements in family functioning, specifically reduced CHAOS scores (effect size=−0.24, p<0.01) and improved home learning environment (including reading with the child and teaching numbers), providing evidence of how universal family support can support parents (effect size=0.19, p<0.05) (Sammons, et al., 2015a). For the users of children’s centres, social background characteristics were still the strongest predictors of parent, family and child outcomes when

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25 All 12 reports from the evaluation are available here: https://www.gov.uk/government/collections/evaluation-of-childrens-centres-in-england-ecce
the child was three years old, but engagement with children’s centre services went some way to ameliorate the negative effects of poverty (Sammons, et al., 2015a).

4.4 Targeted services

While there is widespread agreement within the literature on the value of universal family support services for parents as well as children, the evidence is clear that targeted interventions are more effective in achieving change in specific outcomes. The most effective parenting interventions are those that target families based on early indicators of risk in child development. Three recent reviews (each building on the one before) have assessed the strength of evidence.

The first of these was the review by Graham Allen MP in 2011, ‘Early Intervention: The Next Steps’ (Allen, 2011), which made the scientific and economic case for early intervention, leading to the establishment of the Early Intervention Foundation. This was a high quality review, selecting programmes according to agreed standards of evidence with the support of an expert panel. Allen argued that it is possible to support parents to do things differently through the right kinds of support. Allen identified 19 programmes that met high standards of evidence. The Evaluation of Children’s Centres in England, frequently referenced in this review, investigated whether children’s centres offered these evidence-based programmes, the number of families that benefited and the extent to which they maintained fidelity (Evangelou, et al., 2014).

This was followed by two reviews commissioned by the Early Intervention Foundation. The ‘Best Start at Home’, led by the Social Research Unit (Axford, et al., 2015b), identified types of interventions that are effective in improving early interaction between parents and young children in order to achieve improvements in attachment and parental sensitivity, children’s social, emotional and behavioural development and language and communication skills. This was a rapid scoping review using systematic methods which assessed the quality of evidence for UK-based programmes.

The ‘Foundations for Life’ review (Asmussen, et al., 2016) assessed the evidence for the 75 early intervention programmes available to UK commissioners that were identified through the Best Start at Home. They were all programmes that directly engaged with the parent to support the development of children from conception to age five. The evidence was reviewed and rated by EIF, external experts and the EIF Evidence Panel of leading academics. It identified 17 programmes with good evidence and a further 18 with preliminary evidence.

4.5 Evidence of effectiveness

This section describes the parenting programmes with the strongest evidence as reported in the Foundations for Life review earlier this year. The evidence is structured around three areas: programmes that support the attachment relationship, those that aim to improve children’s behaviour and those that support children’s early cognitive and language development.
4.5.1 Programmes effective for attachment

Attachment security has long been known to be important for child development and specifically, for children learning to trust themselves and to interact confidently with others. Interventions that support the attachment relationship focus on parental sensitivity. The review identified two effective programmes for attachment that met Level 3 or above according to EIF’s Standards of Evidence.

Family Nurse Partnership

The Family Nurse Partnership provides voluntary support to young mothers (aged 19 or younger) who are having their first baby. Mothers are supported by specially trained nurses throughout their pregnancy until the child is two years old. The programme aims to support healthy pregnancies, improve the health and development of children in early years and help mothers plan for their futures. FNP has been rolled out throughout England as part of the Healthy Child Programme.

The FNP programme was developed in the United States by Professor David Olds and extensive research has been carried out on FNP over recent years. This evidence (classified by EIF as Level 4+) demonstrates that the programme can lead to a wide range of benefits for vulnerable young mothers and their children in the short, medium and long-term, through improving health, education and job prospects for mothers and their children. The US research also provides evidence of positive economic returns.

Impacts on children include improved attachment security and responsiveness, improved early cognitive skills, and reduced behavioural problems in later childhood. Parent outcomes include increased sensitivity; reduced smoking; reduced relationship problems and fewer subsequent pregnancies.

FNP is delivered in England as part of the Healthy Child Programme. Early evidence from a feasibility study in the UK showed positive results but a large-scale independent RCT, Building Blocks, recently reported mixed findings raising questions as to whether and how much value FNP adds over and above ‘business as usual’ (Robling, et al., 2015). The trial (which is the largest of FNP to date, involving 1,600 first-time mothers) found a number of positive outcomes including intention to breastfeed (58.4 per cent compared to 50.4 per cent), cognitive development at 24 months (8.1 per cent with developmental concerns compared to 12.6 per cent), levels of social support (25.7 per cent reported maximum levels of social support compared to 20.3 per cent), partner relationship quality and general self-efficacy.

However, surprisingly, the trial did not find impacts on the primary outcomes of smoking, birth weight, hospital visits or second pregnancies. While the authors concluded that programme continuation is not justified on the basis of current evidence, others have questioned whether the results, in particular whether the medical focus of the primary outcomes was justified given the focus of FNP on parenting, parent-child relationships and support (Barlow, et al., 2016). Academics have suggested that the outcomes may have been more positive if the focus was more on psychological measures and that since benefits may appear as the children get older, it was too early for definitive statements about ongoing investment (Asmussen, et al., 2016).

A wider programme of research is establishing how best to implement the FNP programme in England with studies on the family nurse workforce, use of interpreters in delivering the FNP programme, eligibility and local costs. The FNP National Unit is examining ways of improving delivery and programme effectiveness in light of the trial findings by focusing on targeting, increasing its reach among vulnerable young mothers and improving maternal mental health, safeguarding and addressing domestic violence.

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26 Average scores of 29.0 and 28.4 for FNP and control mothers at 12 month follow up on a scale from 7 to 35.
27 Average score of 34 and 33 for FNP and control mothers at 12 month follow up on a scale from 10 to 40.
Family Foundations

Family Foundations is a universal intervention for couples expecting their first child with a level 4 evidence rating. Families attend nine group sessions in which they learn strategies for establishing a positive co-parenting relationship prior to and after the birth of their child. Parents receive coaching on how to respond more sensitively to their child, enhance children’s emotional security, and discourage unwanted child behaviour. The programme was first developed and evaluated in the United States, but has been implemented in various sites across England.

Asmussen’s review highlighted that Family Foundations is cost effective in comparison to other interventions reviewed by EIF. Furthermore, evidence from two RCTs observed improved relationship satisfaction and functioning amongst Family Foundations participants. Family Foundations couples were reported to experience significantly less overall parenting stress and greater satisfaction in the sharing of household duties and responsibilities around child care. They also reported less depression and anxiety in comparison to those not participating in the programme. Furthermore coded video-taped observations of parent–child interaction at ten months suggested that Family Foundations children were better able to soothe themselves (effect sizes across outcome measures range from 0.21 - 0.46). Longer term benefits in two follow-up studies across a range of child and parent outcomes are also cited in the review.

4.5.2 Programmes effective for behaviour management

Aggressive and defiant behaviours in young children are a normal part of early development, but some children do not independently manage to go on to develop effective communication skills. There is growing evidence to suggest that some behavioural problems can be prevented through parenting interventions that minimise parents’ use of verbal arguing and physical punishment. Interventions that help parents manage their children's behaviour teach parents behavioural management strategies and methods for communicating effectively with their child. Four programmes were identified by the Foundations for Life review (Asmussen, et al., 2016) to be effective with high standards of evidence.

Incredible Years Preschool BASIC

The Incredible Years (IY) Preschool Basic Programme is targeted at parents who have concerns about the behaviour of their child between the ages of three and six years old. The programme consists of around 20 weekly group sessions in which parents learn strategies for interacting positively with their child and help to manage aggressive or unwanted behaviours. A key aim of the IY model is to increase parents’ perception of their own efficacy as a parent as well as to promote positive attachment with their children.

Sessions are led by qualified facilitators who structure them around exercises and child-directed activities. Support is enhanced through regular calls from the facilitator and a parent buddy system. An advanced programme can be put in place for those who need it which supports families for a further 10-12 weeks.

The IY programme has strong evidence of improving outcomes for parents and children from 14 RCTs, three of which were conducted in England and Wales and is rated as Level 4. Findings from the UK trials observed improvements in children’s behaviour and parenting practices (e.g., IY achieved an effect size
of 0.63 on the Eyberg child behaviour inventory problem scale (Hutchins, et al, 2007). Impact appears to be greater if the programme is targeted on those families who need the support, and impacts seem to decrease over the longer term.

**Triple P Group programme**

Group Triple P is one of 20 interventions developed as part of the suite of Triple P programmes. It is an intervention for parents with a child up to the age of 12 years old who have concerns about their child’s behaviour. Group sessions are delivered to parents by a trained clinical psychologist to support them in adopting strategies for improving unwanted behaviour. The programme is diverse in its activities involving role play, discussions and positive examples.

The Triple P Group Programme is widely offered throughout the UK. Several high quality reviews show that improvements can be observed across a number of parenting behaviours, couple satisfaction and feelings of parenting efficacy. However, the evidence is somewhat mixed.

The Asmussen review rates the Triple P Group programme at Level 3/ 3+ (lower than IY and FNP which are both rated at Level 4). Evidence suggests that the programme works less well when delivered at a universal level and in supporting long-term impacts. An RCT undertaken in Germany highlighted that similar improvements were noticeable in the control group over a period of time, bringing into question the usefulness of the intervention (Heinrichs et al: 2014). Furthermore, a systematic review undertaken in 2012 also identified concerns with regard to the risk of bias, poor reporting and conflicts of interest with researchers involved in the studies reviewed.

However, Wilson et al's (2012) meta-analysis involving 23 studies found that Triple P was considered to be better than no intervention with a summary effect size of 0.61 (with a 95% confidence interval of 0.42, 0.79), and more recent findings highlighted in Asmussen’s review suggest a potential preventive effect for child behaviour problems for families who engaged with the programme. Newham’s own analysis of administrative data found that parents who took part in Triple P (who were known to social care Triage) experienced reductions in their levels of need, which indicates the value of the programme if it is delivered on a targeted basis.

**Empowering Parents/ Empowering Communities**

Empowering Parents/Empowering Communities (EPEC) is another targeted intervention with a strength of evidence rating level 3, which provides disadvantaged families with parenting support with an aim to improve child and family outcomes. The programme works with families where behavioural difficulties have been identified in a child between the ages of two and 11. Parents attend weekly sessions facilitated by trained practitioners for eight weeks where they learn ways to communicate effectively with their child, increase confidence in parenting and decrease negative behaviours. The programme was designed in the UK to be delivered in community settings.

EPEC has been evaluated in South London using an RCT (Day, et al., 2012) and demonstrated improvements in positive parenting practices and child problems (effect size=0.38, p=0.01, sample size=116). The RCT concluded that EPEC was a ‘promising method’ for providing effective parenting support to families considered harder to reach through more mainstream services.

**Family Check-Up (FCU)**
Family Check-up (strength of evidence rating 3+) is an intervention that teaches parenting practices to support child development, mental health and risk reduction. The intervention comprises of two phases, an assessment and a parenting training programme to build skills in positive behaviour and relationship building. The second phase can be delivered either as a prevention or treatment programme which can consist of up to 15 parenting sessions. In comparison to some of the other examples discussed in this review, Family Check-up is personalised to address the specific needs of each family and can be delivered more flexibly across a range of different kinds of settings including for example schools and community centres.

Two RCTs have been carried out to look at the effectiveness of Family Check-up, one of which highlighted improvements in parenting behaviour that linked to later improvements in child behaviour. Asmussen’s review also notes that the evidence on this intervention reports good retention of disadvantaged programme participants, something that is less well documented for other programmes.

4.5.3 Programmes effective for cognitive and language development

How children learn to think, understand and communicate is strongly influenced by their early environment and parenting. The Asmussen review (2016) highlights that social disadvantage is consistently linked to gaps in young children’s cognitive and language development and there are a number of interventions that aim to support children’s early cognitive and language development through teaching parents age-appropriate methods for structuring or ‘scaffolding’ learning tasks.

Fewer parenting programmes have been identified as effective for cognitive and language development than for other areas. There are programmes that have not yet been rigorously evaluated and that therefore may not have been identified through recent reviews, including Best Start at Home (Axford, et al., 2015b). The two programmes described below meet high standards of evidence.

REAL (Raising Early Achievement in Literacy)

The Raising Early Achievement in Literacy (REAL) programme is a targeted intervention aimed at improving child literacy in disadvantaged communities through working with parents. The programme develops parents’ knowledge of the importance of literacy development and practices for supporting their pre-school children (aged three to five). The programme consists of five group sessions delivered by trained teachers, supplemented with up to 10 home visits over 12-18 months.

REAL impacts on a number of child outcomes, including cognitive outcomes (Nutbrown, 2005). The evidence is rated as Level 3 by the EIF as impact results have not yet been replicated in a high quality study showing long term impacts.

Key features of the programme thought to be relevant to its efficacy are qualified teachers, sharing of strategies with parents (particularly in this case around supporting early literacy development), and the delivery of a low-intensity, short duration programme (Asmussen, et al., 2016). REAL was developed as a stand-alone intervention, and is now offered alongside or as part of other early years’ programmes across different settings.
Let's Play in Tandem

Let’s Play in Tandem is another targeted programme aimed at families with a pre-school aged child living in disadvantaged communities. The programme which runs for a year is typically delivered through children’s centres and aims to support parents with strategies to improve the cognitive development of their children. Families meet weekly with a qualified teacher who delivers educational activities to support pre-reading, numerical skills and vocabulary. The programme is designed to work with families in a personalised way and to teach parents key scaffolding skills. These particularly focus on supporting the child’s school readiness.

A high quality RCT with 60 young children was carried out on Let’s Play in Tandem which showed statistically significant positive impacts across several child outcomes, including knowledge, numerical skills and listening skills (Ford, McDougall and Evans, 2009). A series of independent-samples t tests indicated that the intervention group outperformed the comparison group in all domains (knowledge: \( t(58) = 4.02; \) pre-reading skills: \( t(58) = 5.18; \) numerical skills: \( t(58) = 3.23; \) all \( p<0.01 \) two-tail).

4.6 Parenting provision in the context of children’s centres

Evidence from the Evaluation of Children’s Centres (ECCE) highlights some of the difficulties that children’s centres encounter when deciding how best to provide the parenting support that families need, juggling universal and more targeted evidence-based provision.

The majority of children’s centres implemented at least one evidence-based programme from the Allen list (Allen, 2011; Goff, et al., 2013). The most commonly delivered programmes were Incredible Years, Triple P and FNP. However, these programmes were only available to small numbers of families because of the high costs and resources required to deliver them as intended. To widen their family support offer, children’s centres ran a varied range of programmes that lack higher standards of evidence, including for example Baby Massage and Every Child a Talker which are cheaper to implement and deliver than the targeted evidence-based programmes on the Allen list. These programmes and others such as stay and play are understood to act as a gateway to other services, particularly if additional needs are identified in families that attend (Goff, et al., 2013).

4.7 Key elements of delivery

Across the evidence considered for this review, a number of key elements of delivery have been identified that are important for commissioners to consider in the pursuit of effective provision. They relate to the scope, reach and components of parenting programmes that have been tried, tested and are currently being delivered in across the UK.

In summary, the evaluation evidence indicates that the design of programmes and the approach to service delivery is crucial to success. Programmes that are less intensive, last for less time, do not act early and do not deal with multiple issues can be overall less effective, whilst those that are more integrated, act early in a targeted way, are more intensive, and are facilitated by trained professionals appear to have better, longer-term impacts (Bertram and Pascal, 2014).

1. Targeted and universal provision

Evidence is strongest for programmes that are targeted based on early signals of risk with regard to child development (specifically, attachment security, behavioural self-regulation...
and early learning). As Asmussen points out, this does not mean that universal programmes or those that target on the basis of the needs of local communities, such as Let’s Play in Tandem, are not important, but that they may not lead to the same levels of impact in families with varying needs. Decisions around implementation and delivery of parenting programmes should be taken with a view to whether there is a local need and the necessary infrastructure and resources to support delivery.

2. The importance of a skilled workforce

From reviewing the parenting programmes, it is apparent that having skilled facilitators and teachers with qualifications at particular levels is important in supporting effective outcomes. This is true for Empowering Parents, Incredible Years and Raising Early Achievement in Literacy, which specify the need for a trained practitioner or teacher. Building on this, Asmussen also highlights that that the understanding and skills of the wider workforce involved in delivering parenting interventions could be improved so that signs of risk are better identified and parents can be referred to appropriate provision promptly.

3. Programmes that focus on behavioural self-regulation

Programmes which focus on children’s early behavioural self-regulation tend to have better evidence of effectiveness than those focused on attachment or cognitive development (Asmussen, et al., 2016). Consequently, the evidence is more compelling for programmes such as Incredible Years as they help parents manage behaviour through teaching behavioural management strategies and methods for communicating effectively. Asmussen suggests that further high quality evaluation is needed for the other outcome domains (cognitive development and attachment). It is not necessarily that they are not as effective, but the evidence is not as strong.

4. Integrated provision that addresses other issues

It is clear that for interventions to be effective they should go some way to addressing other concerns a family might have as well as explore the source of problems. For example, Allen (2011) cites Westminster City Council’s Family Recovery Programme (FRP) as an example of an intervention that takes a ‘whole family’ approach to address the causes as well as the effects of social breakdown. Other researchers such as Sylva have also commented on the importance of highly integrated services which focus on supporting parents’ personal circumstances as well as parenting, in considering the delivery of services through children’s centres (Sylva, et al., 2015).

A Public Health England (PHE) review carried out by Donkin (2014) looked at the importance of parenting interventions that could reduce inequality by supporting health and successful transitions from home to school. She also highlighted the importance of tackling a number of other issues that might be happening in the mother’s life or family home such as substance misuse, low income and poor mental health which can all impact on the child’s health and development. To avoid considering parenting in isolation, Donkin called for action to:

‘Consider the wider conditions in which parents and carers are living. Good mental health, freedom from domestic violence, services that reduce alcohol dependency and drug addiction all contribute to parents being able to engage with and support their children. It
also means that they can participate in any locally provided specific parenting programmes.’ (Donkin, 2014: pg35)

5. Fidelity to the model

A number of reviews highlighted the importance of implementing programmes with close adherence to their intended delivery models (Allen, 2011) since poor fidelity can significantly reduce the impacts of the intervention. This salient point is continuously echoed by researchers, including in a recent review of evidence-based positive parenting programmes in Spain carried out by José Rodrigo, who concluded that effectiveness is closely linked to quality assurance and programme fidelity (José Rodrigo, 2016).

The Evaluation of Children’s Centres in England (ECCE) found variable practice in relation to the delivery of evidence-based programmes (Goff, et al., 2013). Although centre staff believed they were implementing programmes rigorously (by following a programme ‘in full’), in fact, a smaller proportion were shown to implement programmes with fidelity, for example, through the use of checklists, supervision, and external fidelity checks. There was also evidence to suggest that centre staff struggled with the concept of evidence-based practice and were not always able to or did not want to adhere strictly to fidelity. In instances where programmes were rolled out in a more variable manner this was for reasons such as resource limitations or the view that modifications would better suit groups of parents locally. FNP, Triple P and Incredible Years were however, shown to have been implemented with more fidelity than other programmes centres offered.

6. Duration and intensity

The amount of intervention a parent or family receives has also been linked to impact. Bertram and Pascal’s (2014) literature review reported that programmes which support children directly should be regular and long-term. The National Academy of Parenting Practitioners also highlighted that there is a need to ensure that parents sustain attendance and to increase the level of intensity for those with more complex needs. This is echoed in the Marmot review (2010) in which it was established that in order for provision to be effective it should be proportionate to the level of disadvantage. This was referred to as ‘universal proportionalism’.

4.8 Summary

The evidence on the importance of parenting attitudes and behaviours for child outcomes is unequivocal. For most parents, the universal health services provided through the Healthy Child Programme (discussed in the following chapter) are sufficient to achieve positive outcomes but parents who are disadvantaged are more likely to need additional support. The evidence is strongest for parenting interventions that are targeted at early signals of child development risk such as attachment, behavioural self-regulation and language development. A number of programmes have been shown to be effective including, Incredible Years and Family Nurse Partnership and are widely delivered in the UK. Areas identified as requiring further research include the impact of universal methods of parenting support (such as through leaflets, apps and websites), interventions focused on specific groups including fathers and parents with learning difficulties, and the long-term effectiveness of parenting support (Axford, et al., 2015b).
5 Health Interventions

5.1 Policy context

The Healthy Child Programme (HCP) is a universal prevention and early intervention programme at the heart of Public Health England’s commitment to give every child the ‘best start in life’ (PHE, 2016). In 2013, local authorities took over the commissioning of the HCP and its delivery via the universal health visiting service and the number of health visitors expanded by 4,200. To deliver the HCP, health visitors work within the ‘4-5-6 model’ which sets out the four level of service, five universal health reviews and six high impact areas where health visitors are considered to have the greatest impact on child and family health and well-being. In Newham, health visitors work closely with midwives, children’s centre staff, speech and language therapists and other partners to support specific outcomes such as healthy eating, physical activity, good mental health and mastering key developmental stages such as eating and toilet training. This section reviews the evidence for health interventions and for how health visitors can work most effectively.
5.2 Evidence around health visiting

Health visitors play an important role in providing universal health support to children and parents, identifying additional needs and providing (or making referrals to) targeted interventions. There are two high quality recent reviews that synthesise the evidence on health visiting and provide the main evidence for this chapter.

‘Why Health Visiting? A Review of the Literature about Key Health Visitor Interventions, Processes and Outcomes for Children and Families’ (Cowley, et al., 2013) was undertaken to support the Health Visitor Implementation Plan (DH, 2011). The review explored the key components of health visitor interventions across the four levels of service delivery which increasingly target families with additional needs. The service levels are defined by Cowley as community, universal, universal plus and universal partnership plus. The review included 348 studies identified through:

- A broad general search of databases covering a range of subject areas relating to nursing and health focussing on 2004 onwards, following the publication of ‘Every Child Matters’ (HM Treasury, 2003).
- A structured search using terms of particular interest to health visiting including breast feeding and non-accidental injury.
• Targeted searches on seminal pieces of evidence published before 2004.

The ‘Rapid Review for the Healthy Child Programme 0-5’ (Axford, et al., 2015a) updated the evidence base for the HCP covering 2008-2014. The consortium, led by the Social Research Unit synthesised evidence from 160 systematic reviews and 50 RCTs on the following areas: parental mental health, smoking, alcohol/drug misuse, intimate partner violence, preparation and support for childbirth and transition to parenthood, attachment, parenting support, unintentional injury in the home, safety from abuse and neglect, nutrition and obesity prevention, speech, language and communication. This was supplemented with searches for high quality primary evidence on obesity prevention zero to three, attachment, parenting support, speech, language and communication. The review also considered the evidence for particular aspects of delivery:

• Identifying families in need of additional support, delivery/effective implementation of interventions at programme/service/practitioner level.

• Workforce skills and training.

• Economic value/costs benefits of HCP.

5.3 Universal health interventions to support development of children aged 0-4 (+ pre-birth)

Extensive evidence to support the six high impact areas of the HCP is synthesised in the two reviews and summarised in this section.

5.3.1 High impact area 1: Transition to parenthood

Health visitors and midwives provide support during pregnancy and the postnatal period to help parents prepare for childbirth and make the transition to parenting. Antenatal education has traditionally focused on improving outcomes such as pain in labour, low birthweight, breastfeeding and antenatal health behaviours. A Cochrane review of RCTs (Gagnon and Sandall, 2011) concluded that the effects of general antenatal education for childbirth or parenthood were not clearly established. Nine trials, involving 2284 women, were included. Educational interventions were the focus of eight of the studies (combined sample size = 1009). The largest of the included studies examined an intervention to increase vaginal birth after caesarean section. This study showed similar rates of vaginal birth after caesarean section in ‘verbal’ and ‘document’ groups (relative risk 1.08, 95% confidence interval 0.97 to 1.21). Another large-scale high quality review (Schrader-McMillan, Barlow and Redshaw, 2009) reviewed the effectiveness of group-based antenatal education on any aspect of pregnancy, childbirth and early parenthood. The key findings were:

• There was little evidence that techniques taught in childbirth classes could reduce pain in labour, although there was some evidence for promoting relaxation.

• Effective interventions for breastfeeding were found (see impact area 3).
• There was mixed evidence on the effectiveness of antenatal support for low birthweight.
• There was an association between antenatal education and maternal health behaviours.
• There was no evidence of impact on the onset of depression (see impact area 2).
• There was little evidence of effectiveness for specific groups (e.g., women in prison, drug-dependent women). Some evidence suggests that fathers benefit from men-only sessions within antenatal classes.

There is evidence to support home visiting as effective for improving maternal behaviours such as sensitive interaction with infants and particularly with pre-term infants (Axford, et al., 2015a). Cowley’s review also highlighted the home as an optimum place for delivering health visiting services. This was linked to the fact that the home environment can foster good health visitor-client relationships to support parents to disclose information.

Considering the evidence together, further research is needed to establish the most effective ways of supporting parents for childbirth and parenting.

5.3.2 High impact area 2: Maternal depression and other mental health problems

Maternal mental health problems during pregnancy and the postnatal period impact on the foetus/infant as well as the mother. Poor mental health during pregnancy can affect cellular growth and brain development in the foetus with consequences for physical, cognitive, social and emotional development in childhood. Postnatally, maternal mental health can affect parent-child interactions and child social and emotional development.

NICE guidance recommends a key role for health visitors in the prevention, identification and treatment of maternal mental health problems (NICE 2014) based on a series of systematic reviews. NICE recommends that health visitors assess a mother’s mental health through standardised instruments at her booking visit during pregnancy and postnatally, using further depression inventory questions to monitor mental health. There is evidence from a review of 28 RCTs supporting preventive interventions including interpersonal psychotherapy, intensive home visiting by professionals and peer-led telephone support (Dennis and Dowswell, 2013). Evidence shows that positive mental health outcomes can be achieved for families by training health visitors to identify depressive symptoms in mothers and provide psychologically oriented support through home visiting (Cowley, et al., 2013).

The treatment recommendations vary according the level of severity. There is evidence for the benefits of facilitated self-help for women with depressive symptoms or mild-moderate depression. Medication and/or high-intensity psychological intervention is recommended for women with more severe depression. The recommended treatment for women with anxiety symptoms or disorders is facilitated self-help or high-intensity cognitive-behavioural therapy (CBT).

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29 Twenty-eight trials, involving 17,000 women, contributed data to the review. Overall, women who received a psychosocial or psychological intervention were significantly less likely to develop postpartum depression compared with those receiving standard care (Relative Risk = 0.78, confidence interval = 0.66 to 0.93).
Further research is needed to identify interventions that can be delivered by midwives and health visitors to support women experiencing anxiety and depression antenatally and to understand comparative effectiveness of different kinds of interventions (Axford, et al., 2015a; Morrell, 2016).

5.3.3 High impact area 3: Breastfeeding

Health visitors play an important role in supporting mothers with the initiation and continuation of breastfeeding (Yonemoto, et al., 2013). In Renfrew et al.’s (2010) review of breastfeeding support (including 54 RCTs), all forms of support had a positive effect on the duration of breastfeeding, including from peers (one-to-one or in group setting) and structured support from professionals. Face to face support was found to be more effective than telephone and there is some new evidence supporting the effectiveness of online support/ e-based interventions (Axford, et al., 2015a).

Marshall and Godfrey’s study (2007), discussed in the Cowley review, found that health visitors played an important role in providing reassurance to women about breastfeeding and building confidence. Supporting mothers with the skills to breastfeed has also been shown to be important, especially in increasing breastfeeding duration (Spencer et al, 2010). Cowley concludes that a personalised and non-judgemental approach delivered by health visitors can have more positive impacts in relation to breastfeeding (Cowley, et al., 2013).

Specific targeted interventions found to promote breastfeeding included Kangaroo Mother Care in low birth-weight infants (which also improved infant growth and mother-infant attachment) and Skin-to-Skin Care (which also improved cardio-respiratory stability and reduced infant crying) (Axford, et al., 2015a).

Based on the evidence, NICE recommends coordinated programmes across different settings to increase breastfeeding: raising awareness of the benefits; information and advice on how to overcome barriers; training for professionals; peer support; education and information for pregnant women on how to breastfeed; proactive support during postnatal period; and structured programmes to encourage breastfeeding.

5.3.4 High impact area 4: Healthy weight, healthy nutrition

Cowley’s review found that health visitors play a key role in supporting mothers with infant feeding decisions which can help to avoid obesity as the child grows older. Advising on weaning provides an opportunity for health visitors to also support mothers to make good decisions around food and portion size. However, other evidence suggests that parents’ decisions around weaning and cultural influences can sometimes conflict with the advice given by professionals (Watt, et al., 2009), which may undermine the effectiveness of health visiting guidance on this issue. Sensitive engagement, ongoing support and empathy are essential to properly engaging families and Cowley notes the need for a clear knowledge base to support health visitors to confidently raise issues of risk in relation to obesity.
The most effective interventions for reducing obesity for children are holistic, addressing diet and physical activity in the different domains of a child’s life involving parents, the whole family and childcare providers or teachers (Wolfenden, 2016). Narrow interventions focusing on specific interventions are less likely to achieve change. Some effective components of interventions were identified in the Axford (2015a) review:

- Effective interventions for reducing sedentary behaviour were identified and parent training was found to be effective in reducing screen time.
- The most effective strategies for increasing children’s acceptance of unfamiliar (healthy) foods included intensive, incorporated behaviour strategies and clear messages tailored to the educational level/material resources of the family.
- Whole family interventions were found to be more effective in promoting healthier diet and more exercise to reduce BMI.
- There was some high quality evidence (on children zero to three) that home visiting programmes during the postnatal period had positive effects increasing the duration of breastfeeding, weaning later and reduced use of food as a reward.

Overall, the evidence shows that effective preventive strategies are: decreasing pre-schoolers’ screen time; decreasing consumption of high fat/calorie foods/drinks; increasing physical exercise; increasing sleep; changing parent attitudes to feeding; and promoting authoritative parenting. In terms of treatment (rather than prevention), the review found limited evidence for effective lifestyle weight management for obese and overweight children under the age of six.

5.3.5 High impact area 5: Managing minor illness and reducing accidents

Due to their close contact with families, health visitors are particularly well placed to support families to prevent accidents in the home (Cowley, et al., 2013). Parenting interventions were found to be effective in improving home safety (e.g., promoting use of smoke alarms, safe storage of medicines and cleaning products, increasing stair gate use, reducing baby walker use) and reducing child injury (Axford, et al., 2015a). By comparison, there is a lack of evidence on effective interventions to prevent dog bites, improve window safety (locks, limited opening) and use of non-slip bath mats. NICE (2010) recommends integrating home safety into home visits with professionals providing home safety advice and referring families to agencies that can carry out a home safety assessment. High risk families included those in rented or overcrowded accommodation with high levels of turnover.

Based on the evidence about sudden infant death syndrome (SIDS), NICE recommends that parents/carers be advised that there is an association between co-sleeping and SIDS and that the risk is greater if the parent smokes, has recently consumed alcohol/used drugs or of the infant was low birthweight or premature.

Factors facilitating home safety included home visits and requiring families to make small changes. Barriers included socio-economic constraints, parental habits, cultural norms, low trust, lack of control over home environment and professionals having insufficient time to discuss accident prevention (Axford, et al., 2015a; Cowley, et al., 2013).

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30 10 trials were relevant and included in the review. A total of 1053 childcare services participated across all trials.
31 Evidence is stronger for children above six years (Waters, et al., 2011).
Further research is needed to identify specific interventions that are effective for reducing fall-related injuries, protecting children from unintentional injuries, poisoning prevention and home safety (Axford, et al., 2015a).

This section only provides evidence on reducing accidents as the review did not cover managing minor illness.

5.3.6 High impact area 6: Health, wellbeing and development of the child aged 2

Development at age two is one of the high impact areas because it is when problems such as tooth decay, speech and language delay and behavioural issues emerge and when early intervention can be most effective (PHE, 2016). Health visitors carry out the health and development review at this age (which may be integrated with the Early Years Progress Check if the child is in early education) assessing developmental progress with the Ages and Stages Questionnaire (ASQ-3™) covering communication, gross motor, fine motor, problem-solving and personal-social development.

Health and development at age two is strongly influenced by the other high impact areas including good parental mental health, home safety and nutrition. Interventions to support early attachment are described in the section on parenting. The most effective programmes are shorter in duration, provide services directly to parent-child dyad, are delivered by qualified staff and involve assessment of parent-child interactions with free-play tasks.

Interventions effective for improving maternal sensitivity include home visiting and a video feedback intervention to promote Positive Parenting (VIPP) which was found to improve parental sensitivity and secure attachment, leading to improvements in emotional availability, child behaviour and the family environment (Axford, et al., 2015a).

5.4 Targeted health interventions to support children from deprived backgrounds

Socially disadvantaged children are more likely to have poorer development across oral health, speech, language and communication development, peer relationships, emotional development and social behaviour. As a result, targeted interventions tend to be focused on children from deprived backgrounds either as a preventive or treatment measure.

The Axford review (2015a) identified a number of outcomes for which evidence of effective interventions can be found.
5.4.1 Antenatal

Mothers from low income households are much less likely to attend standard antenatal classes\(^{32}\) (Axford, et al., 2015a). Targeted antenatal programmes for couples considered to be at high risk due to personal, social or relational issues were found to be effective in reducing relationship deterioration after their baby was born and for strengthening parent roles. The strongest evidence was for home-based interventions for couples with multiple difficulties. The interventions were expensive and recommended as part of a ‘stepped care approach’.

5.4.2 Infancy and early childhood

Although the evidence does not find impacts of baby massage on the general population, there is evidence of benefits for disadvantaged and depressed mothers in the middle tier of need (i.e., not high risk). In the Axford review (2015a), fourteen factors needed to be present for baby massage to be effective including consistency of the facilitator, small groups in appropriate settings and the teaching of infant cues\(^{33}\).

Home visiting for at risk families can have positive benefits for parent-child interaction, parenting behaviour, and children’s cognitive and social emotional development (including programmes such as FNP that are discussed in the parenting chapter). NICE guidance on social and emotional well-being recommends that health visitors or midwives offer a series of intensive home visits by a trained nurse to parents needing additional support (covering maternal sensitivity, home learning and parenting skills).

Evidence points to effective interventions for specific outcomes for disadvantaged children. Targeted group-based parenting programmes can be effective in improving the emotional and behavioural outcomes and conduct problems for children zero to three. High quality early childhood education and care has been found to have particular benefits for the cognitive, social and behavioural development of children from disadvantaged backgrounds (Melhuish, et al., 2015). Evidence demonstrates the effectiveness of interventions aimed at improving young children’s speech, language and communication through helping parents to read to and use enriched language with their children. Interventions are mostly targeted at socio-economically disadvantaged children or children with difficulties in speech, language or literacy. Disadvantage is also associated with lack of physical activity and universal health care checks provide an opportunity to identify needs for additional support.

5.4.3 Vulnerable families

In mapping the evidence across the ‘universal plus’ and ‘universal partnership plus’ levels, the Cowley review highlights the important role of health visitors in providing additional services to vulnerable families. The review focuses on the ‘seldom heard populations’, such as those living in insecure or temporary accommodation or in travelling communities. The evidence highlights that health-vising teams require an awareness of the complex nature of some families’ lives, and detailed skills and knowledge to work successfully with more disadvantaged families. It also outlines that they must be able to work in partnership

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\(^{32}\) A survey carried out by the Royal College of Midwives and Netmums found that only one quarter of low income mothers attended antenatal classes.

\(^{33}\) The fourteen factors are described on pages 100-101 of the Axford review.
with other organisations to navigate support for those with particular issues such as asylum claims, highlighting the value of multidisciplinary, integrated teams.

In addition to working with vulnerable populations in a routine way, there is an acknowledgement in the implementation plan that the health visiting role contributes to safeguarding and child protection services. Cowley reports that health visitors identify children who are at risk of experiencing significant harm and can be the first professionals to begin formal safeguarding procedures with a family. Studies covered in the review also show that health visitors prioritise families on their caseload according to key risk factors to ensure safeguarding cases are captured.

The evidence reviewed by Cowley shows that health visitors need specific skills to identify families that require intervention. Cowley also highlights that health visitors can contribute to the reduction of risk factors, such as parenting behaviours and maternal anxiety. The review however does not find conclusive evidence that child maltreatment can be prevented by health visiting practice.

Some studies identified in the Cowley review refer to various forms of structured assessment protocols or guidance that local authorities have implemented to standardise safeguarding identification with health visiting teams. However, the evidence suggests that these can sometimes be unhelpful as they inhibit relationship-formation and trust and do not therefore improve the identification of risk.

5.5 Key principles and models for good quality health visiting

At the ‘community service level’, the role of the health visiting service is to build relationships with other services and local communities and ensure that families are aware of the services on offer. Evidence suggests that health visiting services should reach out to families, be personalised in nature and build trust to enable families to access the help they need, including initiating further contact if required (Cowley, et al., 2013). Having open and transparent health visiting services that are placed within communities and that seek to develop strong relationships with families therefore seem to be essential in the development of a broad service offer.

At the ‘universal service level’, health visitor provision acts as a gateway to other services, enabling those with additional needs to be identified and supported. The focus on health rather than illness sets health visiting apart from other professionals in the delivery of health and social care services (Cowley, et al., 2013). This creates what Cowley calls a ‘service journey’ for families, enabling them to access health visiting as well as more specialist services.

Two key principles identified as underpinning good health visitor practice are an ‘orientation to practice’ delivered through a ‘triad of core practices’ (Cowley, et al., 2013). The orientation to practice is defined as supporting human health and well-being (termed as ‘salutogenic’), demonstrating positive regard for others (human-valuing) and taking account of the individual’s circumstances (human ecology). The triad of core practices constitutes the development of strong relationships with families, home visiting and needs assessments. The development of strong health visitor-client relationships is mentioned in detail throughout the Cowley review. Strong relationships are considered especially
important in enabling uptake by families who may find services hard to access. In order to develop strong relationships, the review identifies interpersonal skills and empathy as key skills required of health visitors. The relationships, skills and knowledge of the health visitor need to be assessed and suitable support put in place. Flexible working is another key principle and model of practice identified in the Cowley review as central to good health visiting practice. Drawing on elements of the 'orientation to practice’, health visitors should work in non-judgemental ways and with families in their own contexts, to raise issues and offer support in a flexible way. The ability of health visitors to choose when they tackle particular issues with families and support them through their service journey is perceived to be important. Managers and commissioners of health visiting services need to find ways to support and enable this level of flexibility.

The integration of health visiting practice across service levels and with other local services is an important theme in the Implementation Plan. Evidence suggests that more work needs to be done to achieve good integration between health visiting and midwifery services (Donetto, 2013; Aquino, 2016). Cowley’s review cites the Brighton and Hove model detailed by Hawker (2010) whereby an integrated service for families is achieved through bringing together local authority and NHS staff to form a multi-disciplinary team under one organisation. Cowley reports that this is a strong example of a health visiting service that is co-ordinated and personalised and ensures that all families are in contact with the local children’s centres and health visiting services.

The evidence demonstrates the importance of health visitor workforce skills and training for good quality practice. Cowley (2013) and Malone (2016) note that there is a particular need for improved initial health visitor training as well as for more continuing professional development opportunities to ensure professionals have the most up-to-date skills and knowledge to put into practice. The review for the HCP outlines specific implementation and workforce issues for each outcome area which are reflected in NICE guidance (Axford, et al., 2015a). For example, professionals assessing or supporting mothers with mental health problems should understand variations in symptoms and development, and the implications for treatment (NICE 2014). There are a number of workforce recommendations in relation to obesity prevention which focus on appropriate training. Staff providing lifestyle weight management programmes are required to be knowledgeable in nutrition, obesity, physical activity and to have skills in delivering knowledge, empathising, working collaboratively with families, tailoring interventions to needs and to use problem-solving techniques to address relapse (NICE 2013; Bond, et al., 2010).

5.6 What is the best mix of skills within the health visiting team?

The commitment to a mixed-skill health visiting team is not new. Research with health visitors in 2007 found that over 73 per cent worked in a ‘skillmix’ team (Cowley, et al., 2007) and this approach has since been widely implemented. The Cowley review reports that defining an effective combination of skills and abilities within the health visiting workforce is however difficult. She cites a review undertaken by Fisher (2009) looking at ‘skillmix’ and ratio issues in health visiting which called on the government to undertake more research and issue clear guidance.

The evidence is mixed on the benefits of having a range of skills and abilities in a health visiting team. On the one hand studies suggest that the introduction of junior staff, including
community and staff nurses can reduce stress where there are staff shortages. This can be particularly useful in difficult economic climates, when local authorities are trying to make savings across services, as it can free up the time of qualified health visitors to focus on families with the greatest needs. It also has the benefit of broadening the skills and services of the team. Furthermore, a high quality systematic review which assessed 158 relevant studies (mostly trials carried out in the US) found that paraprofessional home visitors (who are not clinically trained) contributed to significant improvements in the health and development of young children, suggesting that health visitors can usefully be supported by less well qualified staff (Peacock, 2012).

Challenges of mixed skill teams were however raised in the Cowley review, linked to reductions in service quality:

- Using team members interchangeably led to concerns about missed opportunities for health promotion.
- Some evidence challenged the idea that skill mix reduced stress and workload because of the additional time health visitors spend supervising less qualified staff.
- One large survey of mothers found a preference for retaining a relationship with one health visitor rather than a team, even if advice was consistent across the team (Russell, 2008).

Cowley concludes that decisions about how to form teams with a mix of skilled staff should not be uniform. Rather, the resources and requirements of each team should be carefully considered and planned with the needs of the local community in mind. Fisher and Cowley agree that more research into this complex area would be beneficial to better understand the barriers and facilitators to achieving an effective mix of skills and resources.

5.7 Summary

Newham offers a wide range of universal and targeted health support services in line with the national Healthy Child Programme. The HCP is supported by a strong evidence base, focusing on six high impact areas where health support is considered to be most effective and structuring interventions around four levels of service across a spectrum from universal to targeted. The evidence for effective interventions is probably strongest for maternal mental health with clear guidance on when facilitated self-help approaches, high intensity CBT or medication is required. There is also strong evidence for the impact of specific health programmes for supporting early attachment, for the instigation and continuation of breastfeeding; promoting healthy weight and increasing home safety. The evidence is less strong for the impact of antenatal classes on pain in labour, low birthweight and the onset of maternal depression. Overall, a strong case has been made for early intervention based on evidence from the UK and other countries over decades. Since inequalities are established early in a child’s life, and become reinforcing, early intervention can help alter the trajectory.
6 Evidence for the Best Start in Life outcomes

The previous chapters have reviewed the quality of evidence for four elements of the Best Start in Life guarantee addressing specific research questions about effectiveness and delivery. This chapter reviews the evidence from the perspective of the BSiL outcomes, identifying the most effective interventions for achieving improvements in school readiness, child and family health and life chances and parenting aspirations, self-esteem and parenting skills. The extent of overlap with the previous section indicates the strength of evidence linking the BSiL model and outcomes.

6.1 School readiness

Nationally, 31 per cent of pupils do not achieve a good level of development in the Early Years Foundation Stage Profile which indicates schools readiness across the domains of communication and language; physical development, personal, social and emotional development; and literacy and maths (DfE, 2016). In Newham, achievement of a good level of development on the EYFSP was higher than the national average with 73 per cent achieving expected levels (compared to 69 per cent for England as a whole)\(^34\). Also, the gender gap was 12 per cent compared to 15 per cent nationally.

Pupils from economically disadvantaged backgrounds are less likely than their peers to be ‘school ready’ with a gap of 19 percentage points. Between 2007 and 2015, over 500,000 children did not reach a good level of development age the start of school (Social Mobility Commission, 2016). There is strong evidence demonstrating the effectiveness of early education on school readiness outcomes (Melhuish, et al., 2015; Sylva, et al., 2014). The positive effects of early education for three and four year olds cognitive, language and social development are consistent. Comparative evidence from the PISA study\(^35\) demonstrates that children who attended some formal early education before primary school were on average, a year ahead of their peers. Outcomes of two year old early education are more mixed with some negative as well as positive outcomes.

The effectiveness of early education is strongly influenced by two factors: whether the child’s home environment is disadvantaged and the quality of the ECEC provision. Children from disadvantaged backgrounds benefit the most from early education, with positive effects persisting into adulthood (Melhuish, et al., 2015). Provision that is high quality in terms of process and structural factors leads to better outcomes for young children, and poor quality provision can have neutral or negative effects (Hillman and Williams, 2015).

The evidence for the particular benefits of the funded part-time places for two, three and four year olds is not yet established although research designed to specifically address that question is underway. The effects on children of the forthcoming extension to 30 hours is also not yet clear.

The best sources of evidence on the relative effectiveness of different interventions for school readiness in the UK are the Education Endowment Foundation’s (EEF) Early Years

\(^34\) Results are available in the Main Tables: SFR 50/2016 document accessible from: https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-20

\(^35\) http://www.oecd.org/pisa/aboutpisa/
Toolkit\textsuperscript{36} and the Early Intervention Foundation’s (EIF) Guidebook\textsuperscript{37}. These ‘what works’ centres review, synthesise and rate the quality of evidence and the effectiveness of interventions.

Measured as 'months progress', the most effective early years' interventions are aimed at self-regulation (seven months, limited evidence, low cost) which is the child’s ability to manage his or her behaviour or learning through self-control. Activities often involve helping children to plan, articulate and reflect on their behaviour. Communication and language approaches have an average of six months progress, the evidence is strong and the costs are very low. Interventions focus on spoken language and verbal interaction with a trained adult working one-to-one or in small groups with children to model language and reasoning. Other effective interventions with good or moderate quality of evidence include early literacy and numeracy approaches and parental engagement strategies.

The EIF Guidebook lists the specific programmes that are most effective for achieving certain outcomes. Effective programmes for ‘early child development’ with high quality evidence include Family Nurse Partnership and Incredible Years BASIC preschool programme (both Level 4), and Family Foundations, Let’s Play in Tandem, Families and Schools Together, Helping the Noncompliant Child, Incredible Years Toddler Basic, New Beginnings UK and New Forest Parenting Programme (Level 3).

6.2 Parenting aspirations, self-esteem and parenting skills

There is considerable evidence to show that poor quality parenting is one of the most important precursors of early-onset conduct problems. Inadequate parenting is typically characterised by ineffective parenting skills, including low levels of parental supervision and involvement (Furlong, 2012).

Research has explored why certain groups of parents find it more difficult to develop effective parenting skills. A link has been noted between parental circumstances and parenting ability and it is evident that factors such as low income, mental health problems and substance misuse for example can make it more difficult for parents to adopt strong, positive parenting practices (Donkin, 2014; Sammons, et al., 2015a). There is however a growing body of evidence to show that appropriate support which acts early can improve parenting attitudes and behaviours. This links to conclusions made by Allen that parents can make a difference to outcomes for their children through positive engagement with support and that chances should not necessarily be defined only by the parents’ circumstances (Allen, 2011).

In fact the evidence from some studies is very positive in highlighting the appetite parents have to build confidence and develop skills as parents. Accessing local services can give parents the resources and resilience to have a positive influence on their children (Pordes Bowers, et al., 2012). The evidence review undertaken by Pordes Bowers explains that pregnancy and the point just after birth are particularly effective times to help parents who might be in need of support to access services to help improve their parenting skills and

\textsuperscript{36} https://educationendowmentfoundation.org.uk/resources/early-years-toolkit

\textsuperscript{37} http://guidebook.eif.org.uk/
A review of 47 interventions of ‘anticipatory guidance’ given to mothers by health workers showed that these types of programmes led to reduced stress and improved parenting confidence.

The evidence on how programmes should be organised, (in terms of whether they are universal or targeted) to have the most impact on parenting practices is mixed. Whilst the evidence is strongest for targeted provision, especially in respect of the most disadvantaged families, universal provision also has an important role to play. This is particularly relevant to bringing families closer to services to access more evidence-based targeted interventions they might need. This function of children’s centres has been described as a ‘gateway’. Further, the ECCE study on parenting services in children’s centres found that in general children’s centre services had a strong focus on supporting improvements in parenting behaviours. This included working with parents to demonstrate modelling behaviours, praise children, and increase parental interest in their children’s lives (Evangelou, et al., 2014).

The most effective evidence is for programmes that are targeted based on early indicators of risk in child development. The parenting programmes reviewed by Asmussen in the ‘Foundations for Life’ review (Asmussen, et al., 2016) detail effectiveness across three key areas. The following three programmes which focus on attachment and behaviour have strong evidence for parenting outcomes and are widely delivered in the UK:

- **Family Nurse Partnership (FNP)** (Level 4+) is an intensive home visiting programme which has been shown to improve parenting sensitivity, reduce relationship problems and result in few subsequent pregnancies. Though historic robust evaluation highlights positive results, more disappointing findings from a recent UK study have shown that there are challenges in understanding evidence within the UK context.

- **Incredible Years** (Level 4+) is delivered to parents where behaviour problems have been identified. Consistent impacts identified for parents across 14 RCTs include increased positive parenting, warmer expressed emotion, reduced stress, reduced depression and greater parenting efficacy.

- **Triple P** (Level 3+ since there is less evidence of impacts replicated over time). Similar to Incredible Years, the programme supports parents who are concerned about their child’s behaviour and evaluation has shown impacts across a range of parent impacts including improved parenting, increased parental self-efficacy and improved relationship satisfaction.

Several key factors have been identified as contributing to effective provision. They show that provision that is more integrated (in that it addresses other issues), acts early, is more intensive, and facilitated by trained professionals appear to have better, longer-term impacts (Asmussen, et al., 2016; Bertram and Pascal, 2014). A number of reviews also highlighted the importance of implementing programmes with close adherence to their intended delivery models, (Allen, 2011) since poor fidelity can significantly reduce the impacts of the intervention.

### 6.3 Child and parent health and life chances

The early years are a critical time for child development, and inequalities in experiences at this age persist, affecting life chances throughout childhood and into adulthood (Social Mobility Commission, 2016). Child and family health are strongly associated with social
inequalities at different levels, resulting in a ‘social gradient in health’ (Marmot, 2010). The wide-ranging impact of social inequalities on health and life chances is most strongly exemplified by the gap of seven years in life expectancy between the richest and poorest in England, whether measured by neighbourhood or social class38 (Marmot, 2010; DH, 2011).

Since needs are spread across the social gradient, Marmot argues that support needs to be universal, but with the scale and intensity of intervention adjusted to the level of need – what he terms, ‘proportionate universalism’. The Healthy Child Programme is aligned to this recommendation, with four levels of service tailored to differing needs. The design and implementation of the HCP is based on strong evidence (Axford, et al., 2015a), reflected in NICE guidelines for health practitioners. Six outcome areas have been identified as ‘high impact areas’ in the HCP model based on evidence of their influence on later outcomes: transition to parenthood; maternal mental health; breastfeeding; nutrition and obesity; managing minor illnesses; and health, well-being and development at age two. These areas are inextricably linked with each other as well as the other outcomes, school readiness and parenting, requiring an integrated approach.

The evidence for effective interventions is probably strongest for maternal mental health with clear guidance on when facilitated self-help approaches, high intensity CBT or medication is required. There is also strong evidence for the impact of specific health programmes for supporting early attachment, for the instigation and continuation of breastfeeding; promoting health weight and increasing home safety. The evidence is less strong for the impact of antenatal classes on pain in labour, low birthweight and the onset of maternal depression.

Overall, a strong case has been made for early intervention based on evidence from the UK and other countries over decades. Since inequalities are established early in a child’s life, and become reinforcing, early intervention can help alter the trajectory. The costs of late intervention are calculated by the Early Intervention Foundation as nearly £17 billion per year across England and Wales (Chowdry and Fitzsimons, 2016), borne largely by local authorities, the NHS and DWP. These are the costs of demand for acute services such as hospitalisation and incarceration which are needed when children and young people face significant difficulties. The largest costs were related to looked after children, cases of domestic violence, and benefits for young people who were not in education, employment or training.

As well as addressing emerging problems early, there is also a strong case for addressing the causes of inequalities in health outcomes and life chances. In assessing the evidence for how best to improve life chances, the review ‘An Equal Start’ emphasises the importance of parenting which is shaped by the parent’s context (Porders Bowers, et al., 2012). Poverty increases pressures for parents and families, making harder to adopt positive parenting practices. It is logical therefore that reducing poverty would improve health and life chances and that interventions will be more effective if parents’ social circumstances as well as their actions are addressed (JRF, 2016).

7 Considerations for Best Start in Life

This evidence review was commissioned to assess the quality of the evidence base for the existing Best Start in Life model and to identify the most effective interventions for achieving the BSiL outcomes. This concluding section considers the implications of the review for the BSiL model to inform the wider review and ongoing development.

7.1 Early education

- The quality of evidence is high and demonstrates the effectiveness of early education for three and four year olds, and for disadvantaged two year olds in particular.
- Take-up of the free education for two year olds among eligible families was between 54 and 58 per cent in 2015, two years after the start of the policy. Activities most likely to raise take-up are increasing awareness of the entitlement, communicating the benefits to parents who may be unaware and ensuring adequate provision.
- The quality of provision is critical to achieving positive outcomes (and avoiding negative outcomes). Structural and process aspects of quality are both important including: responsive adult-child interaction; well-trained staff; ratios and group sizes that support adult-child interaction; and a developmentally appropriate curriculum.
- Children benefit from settings that are social mixed rather than homogenously disadvantaged.
- The direct impact of extended early education (to 30 hours) on young children needs to be assessed once the policy is fully underway and considered in combination with the potential longer-term benefits of increased household income.

7.2 Stay and play

- The quality of evidence for stay and play is weak with only one recent evaluation providing relevant quantitative evidence of effectiveness.
- Other interventions are likely to be more effective for achieving child development and parenting outcomes.
- The value of stay and play is mainly that it acts as a gateway to other services and enables staff to engage vulnerable families and assess need.
- The play literature demonstrates the value of play for learning but does not provide strong recommendations for how stay and play should be structured. Drawing on aspects of the Early Years Foundation Stage may be helpful for supporting school readiness in the stay and play context.

7.3 Parenting interventions

- The quality of evidence on parenting interventions is strong and growing. The Early Intervention Foundation’s Guidebook identifies effective interventions and these are analysed in a recent review.
• The evidence is strongest for interventions that are targeted at early signals of child development risk such as attachment, behavioural self-regulation and language development.

• Programmes shown to be effective include Triple P, Incredible Years, Family Nurse Partnership, Family Foundations and Empowering Parents, Empowering Communities.

• Parenting is undermined by the stresses caused by poverty and social disadvantage, so interventions are likely to be more effective if the root causes of parenting difficulties are addressed in tandem.

• Universal services to support parenting attitudes do not have a strong evidence base, possibly due to the ceiling effect caused by most parents having positive attitudes.

• Successful delivery requires a skilled workforce, integration with other provision and fidelity to the model.

7.4 Health support

• Family support provided through the Healthy Child Programme is based on high quality evidence that underpins NICE guidelines. The evidence for the HCP was updated in 2015.

• The quality of evidence and the size of impacts varies across the six high impact areas of the HCP. The 2015 review summarises evidence across all areas of health visiting practice which can be used to guide decisions about specific interventions.

• The importance of the relationship between health visitors and families is integral to prevention, early intervention, assessment and support.

• Health visitors are most effective when they work in an integrated way alongside other professionals and in mixed skill teams.

• The need for high quality initial training and ongoing workforce development were emphasised as important for health visitors who need wide-ranging expertise.

For some of the detailed aspects of service delivery (such as adult-child ratios and skills needed in health visiting teams), the evidence is sparse. There are also areas within each area of BSil provision where further evidence is needed. However, the way in which the elements of the BSIL model are combined and delivered is strongly supported by the evidence. In particular: (1) the spectrum of universal to targeted services, responding to level of need, is aligned to the social gradient in health outcomes; and (2) the integration of services and partnership working within the children’s centre context supports holistic support and early intervention for families and children, particularly those who are vulnerable and ‘hard to reach’.
8 References


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9 Appendix: Review methods

9.1 Overview

This section sets out our methodology for the Best Start in Life evidence review, assessing the quality of the evidence base for four aspects of the BSiL guarantee: free early education for two, three and four year olds; stay and play; universal parenting support; and family health support and health visiting. The research questions that were addressed through the evidence review are summarised below alongside the sources and search terms used.

To ensure that we searched through the most relevant sources of evidence and were able to identify key literature in this field within the time-constraints of the project, this literature review draws on some key principles of rapid evidence assessments. These include an a priori determined search strategy and inclusion criteria, transparent procedures for screening identified studies and data extraction from included studies and an unbiased synthesis of findings.

On the basis of the steer provided by the Newham, we devoted more resource to understanding the evidence base for stay and play and take-up of the two year old early education places. Light review methods were used for the other themes within early education and for parenting and family health support, as the table below demonstrates (see Table 9.1).

We broadly structured the search to include high quality evidence published in the UK from 2010. However, we were able to be flexible in our approach to ensure that our strategy remained fit for purpose throughout the project. If it became apparent that this approach was not yielding as many sources of information as we would have expected, or if the quality of the identified studies was not of a high enough level, we adapted the method or scope of the searching, for example to facilitate the inclusion of international literature (first focusing on the EU, the USA and Australia, with further broadening when required). Equally, with regard to timescales it was necessary to adjust the timeframes for each topic area in line with key policy changes and seminal studies. For example, for the research question on health we looked to focus on studies published since the transition of health visiting to local authorities.

The search results for some of the research questions yielded many more relevant sources of evidence than it was possible to review and synthesise within the time and resource boundaries for this project. In these cases we screened and reviewed a portion of the results ordered by relevance in consultation with Newham - our guiding principle in defining the scope of the search was to prioritise robust evidence drawn from the highest quality research.

9.2 Light Review

For the light review, emphasis was placed on locating and summarising evidence from relevant and high quality systematic reviews. Evidence from systematic reviews was prioritised in order to limit unnecessary duplication, minimise resources needed to screen and summarise primary evidence and minimise the potential bias and/or error which could be incurred by reviewing primary evidence rapidly. In the absence of systematic reviews,
high quality and/or recent primary studies were included, as well as landmark and oft-cited studies. The process for searching and identifying literature for the light elements of the review covered the following steps:

- Search for reviews using a number of well-known databases which identify relevant research through agreed search criteria.
- Use Google Scholar and Google search engines to top-up search for more recent, relevant or landmark reviews and primary studies. Similar approaches to determining the quality and strength of evidence will be applied to the primary studies included.

### 9.3 Intensive review

Stay and play was the main focus for the intensive review covering evidence for the key principles and models underpinning high quality, effective stay and play provision. With this in mind, we allocated a greater proportion of time to searching and scoping for evidence on this set of research questions (as well as looking at the promotion and take-up of early education for two year olds). The approach for the intensive review builds on that adopted for the light review (outlined above), using search engines and databases (including EBSCOhost) to conduct searches for relevant primary sources of evidence. Evidence was then (as with the light review) subjected to the same rigorous quality checks to ensure that the review focuses on robust evidence. The process for searching and identifying literature for the intensive elements of the review covered the following steps:

- Identify primary sources of evidence using online databases and search engines.
- Use Boolean and proximity operators to conduct advanced searching to refine results and ensure all relevant studies are included.
- Search abstracts and full text, especially if primary strategy to focus on abstracts does not yield the desired number of results.
- Conduct forward and backward citation tracking and use other snowballing techniques when required.
- Use Google and Google Scholar searches to identify any research that might not be identified through the database searches.

### 9.4 Quality of evidence

Primary evidence was assessed using the Early Intervention Foundation’s standards of evidence which are closely aligned to other well-known scales, recently developed and appropriate for the topic of this study:39

### Table 9.1 Sources and search terms

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<tr>
<th>Research theme</th>
<th>Light/ intensive review</th>
<th>Sources for searching</th>
<th>Search terms</th>
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| Early education: current and changing policy                                     | Mostly light. Intensive for promotion and take-up of early education for two year olds. | The EPPI Centre evidence library The Campbell Collaboration library British Education Index ERIC (Education Resources Information Centre) EBSCOhost (for intensive review) Google Scholar/ Google search engine | ‘2(two) year old offer’ ‘3(three) and 4(four) year old offer’, ‘disadvantaged 2(two) year olds’ 2(two) AND ‘Early education’, ‘childcare’, ‘pre-school’, ‘nursery’, ‘universal childcare’  
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<td>Universal parenting support</td>
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<td>The Cochrane Collaboration Cochrane Central Register of Controlled Trials NICE website</td>
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*Search ‘play’ and ‘parenting’ with:*  
‘theoretical models’, ‘staff ratios’, ‘frequency’, ‘age’, ‘younger’  
‘baby’, ‘babies’, ‘optimal’  
*Further targeted searching using:*  
*Further searching with:*  
| 'parent outcome' |
| 'Deprivation', 'disadvantage', 'low income', 'inequality' |
| 'Depression', 'mental health', 'diabetes', 'SALT', 'speech language', 'obesity' |
| 'Health visiting', 'staff skill*', 'co-location', 'models', 'staff*' |